UKDPC

UK DRUG POLICY COMMISSION

The UK Drug Policy Commission Recovery Consensus Group

A vision of recovery

Policy Report
July 2008

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Background

In recent months an increasingly polarised debate has developed in the UK which has tended to portray abstinence and maintenance approaches to drug treatment as an 'either/or' issue. At its most extreme, the debate appears to suggest that substitute prescribing is incompatible with recovery.

The UK Drug Policy Commission (UKDPC) felt that this debate was becoming increasingly divisive, with little reference to the evidence on treatment effectiveness which indicates a treatment system should be composed of a range of different services to meet different needs. It appeared to be diverting attention away from more legitimate questions, such as whether individuals in need of drug treatment have enough choice, particularly with respect to residential rehabilitation, the variability in quality of sevices of all types and if there has been too much focus on numbers in treatment and retention rates rather than outcomes, i.e. progress toward recovery. There was also concern that the debate risked undermining the wider public message that drug treatment (generally) is a good thing that should be supported and properly-funded.

Part of the issue behind the debate appears to be a lack of clarity and agreement about what treatment is trying to achieve and what we mean by the term "recovery". Without greater clarity about the goals of treatment and rehabilitation and the dimensions of benefit, it is obviously hard to commission or deliver the individually tailored packages of care that are required to meet the very varied needs of individuals with different presenting and underlying problems.

As an independent, charitably-funded body established with the aim of stimulating informed evidence-based debate about drug policy, the UKDPC wished to make a positive contribution. Inspired by the work on recovery being undertaken in the mental health and addictions fields in the UK and internationally, the Commission decided it would be helpful to identify the common-ground and develop a clearer understanding of recovery that could be applied to **all** individuals tackling problems with substance misuse, and all services helping them, without reference to particular treatment modalities. The need to consider and include the full range of experiences of recovery was considered essential. As US expert on recovery William White has commented: "How recovery is defined has consequences, and denying medically and socially stabilized methadone patients the status of recovery is a particularly stigmatizing consequence"[1].

THE RECOVERY CONSENSUS GROUP

The UKDPC took a recent report of the Betty Ford Institute Consensus Panel[2] in the US (which involved key individuals in the field of Addictions and Recovery in the US, including William White and Thomas McLellan) as a starting point for undertaking a similar process in the UK. A group of 16 people (see Table), with a wide range of individual perspectives, were brought together to see if they could identify common-ground and reach a consensus on what constitutes 'recovery' from problematic substance misuse.

The members of the group were invited to participate as individuals, not as representatives of their organisations or of the UKDPC. The UKDPC is extremely grateful for the time and commitment given by all those involved. The group included several people in recovery and family members as well as local commissioners and practitioners coming from services providing a full range of types of care and support, including: 12-step, substitute prescribing, general practice, residential rehabilitation and peer and family support groups. Participants also came from different parts of the United Kingdom and different ages and cultural backgrounds.

Members were able to draw from a range of personal and professional experiences which meant that while the group was necessarily of a size that would allow in-depth discussion, a wide range of perspectives were represented.

Table: Members of the UKDPC-convened recovery consensus panel.

Bob Campbell	Business & Development Manager	Phoenix Futures
Alex Copello	Professor of Addiction Research & Consultant Clinical Psychologist	The University of Birmingham & Birmingham and Solihull Substance Misuse Services
Robin Davidson	Consultant Clinical Psychologist	University of Ulster
Kate Hall	Head of Tier Four Services	Greater Manchester West Mental Health Foundation NHS Trust
John Howard	User Involvement Manager	Reading User Forum (RUF)
Dot Inger	Carer & Project Co-ordinator	SPODA, Derbyshire
Brian Kidd	Consultant Addictions Psychiatrist	NHS Tayside Substance Misuse Services
Tim Leighton	Director, Centre for Addiction Treatment Studies (CATS)	Clouds/Action on Addiction
John Marsden	Research Psychologist & Senior Lecturer	National Addiction Centre, Institute of Psychiatry, London
Soraya Mayet	Specialist Registrar - Addictions	Tees, Esk and Wear Valley NHS Trust
Tom Philips	Consultant Nurse – Addiction	Humber Mental Health Teaching (NHS) Trust
Roy Robertson	GP & Reader with many years experience in the field of addictions and HIV	Edinburgh University

Louise Sell	Consultant Addictions Psychiatrist & Clinical Director	Greater Manchester West Mental Health Foundation NHS Trust
Nicola Singleton	Director of Policy & Research	UK Drug Policy Commission
John Strang	Professor of the Addictions and Clinical Director	National Addictions Centre, (Institute of Psychiatry and SLaM South London & Maudsley NHS Foundation Trust)
Ian Wardle	Chief Executive	Lifeline Project, Manchester

THE CONSENSUS PROCESS

An initial two-day meeting was held in Sussex in March 2008, facilitated by Professor A. Thomas McLellan who had been a prime mover in the Betty Ford Institute Consensus Panel. In preparation for the meeting all participants had also read the Betty Ford Institute paper. Selected members of the panel gave presentations and consideration was given to work being undertaken in the mental health field[3] and work in Scotland[4] and the US.

From the outset there was recognition that a full consensus might not be achieved but that the group would focus on identifying areas in which there was agreement whilst accepting there may always be some areas of disagreement. There was agreement that the focus should be on the outcomes being sought for the individual problem drug user, not on the services required to achieve this. Above all, it was recognised that recovery is a very personal and individual experience that can be achieved in many different ways and any statement describing this would therefore need to be necessarily and deliberately broad: a 'vision' rather than a 'definition'.

Through an iterative process a number of key features of recovery were identified which were then used to develop the vision of recovery. After several attempts a simple statement that the group felt encompassed the key features of recovery that had been identified was agreed upon by all 16 members.

Since the meeting in March the group has consulted with the wider field to see if the statement accorded with others' views and to identify areas that might need clarification or amendment. The group felt that the best way to achieve this was through face-to-face presentations and meetings which would allow us to extend the iterative process. Therefore we have presented the statement for discussion at conferences[5] and members of the group have also discussed it with colleagues in a number of meetings, formal and informal, around the country. A follow-up meeting of the group was also undertaken which included a number of additional individuals. Following these consultations, some changes to the wording of the statement and the accompanying key features of recovery have been agreed by the Consensus Group. However, the core points identified at the initial two-day meeting have withstood this scrutiny well and remain largely unchanged.

KEY FEATURES OF RECOVERY FROM PROBLEMATIC SUBSTANCE USE

As is widely recognised in the recovery literature, in the field of drugs[6] and in the related field of mental health, recovery will differ between individuals. Their will be

variation in the causes and extent of problems associated with problematic substance use, the personal and external resources available, and the personal priorities of individuals. Therefore the final end-point, the way in which recovery is achieved and the time required to achieve it will differ. Similarly, recovery may be associated with a number of different types of support and interventions, including medical treatments, or none at all.

For some people recovery is an on-going process and they may always consider themselves 'in recovery' rather than recovered, while others may eventually feel that they are no longer at risk of relapse and are fully recovered. This diversity of experience lies behind much of the debate around recovery in the drugs field and poses a challenge to anyone seeking to define it. Within the consensus group discussions, it was clear that there was good agreement on the key components of the recovery process but that it was harder to define a single end-point that satisfactorily captured the diversity of experiences of recovery that the group had observed. The consensus statement therefore focuses on the recovery *process*. However, as the main purpose of the exercise was to develop a vision of recovery that might provide a focus for the development of services, in the broadest sense, that would assist people with substance use problems at various different points, this focus on recovery as an on-going process seems appropriate.

Some of the key features of recovery from any problematic substance use identified by the group are:

- Recovery is about the accrual of positive benefits, not just reducing or removing harms caused by substance use.

- Recovery requires the building of aspirations and hope from the individual drug user, their families and those providing services and support.

- 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 is **a process**, not a single event, and may take time to achieve and effort to maintain. The process and the time required will vary between individuals.

- Recovery must be **voluntarily-sustained** in order to be lasting, although it may sometimes be initiated or assisted by 'coerced' or 'mandated' interventions within the criminal justice system.

- Recovery requires **control over substance use** (although it is not sufficient on its own). This means a comfortable and sustained freedom from compulsion to use. This is not the same as controlled use, which may still be harmful. Having control over one's substance use means being able to make the choice to use a substance in a way that is not problematic for self, family or society. For many people this will require abstinence from the problem substance or all substances, but for others it may mean abstinence supported by prescribed medication or consistently moderate use of some substances (for example, the occasional alcoholic drink).

- Recovery **maximises health and well-being**, encompassing both physical and mental good health as far as they may be attained for a person, as well as a satisfactory social environment. The term 'maximises' is used to reflect the need for high aspirations to ensure that users in treatment are enabled to move on and achieve lives that are as fulfilling as possible.

- 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**. The word 'rights' is included here in recognition of the stigma that is often associated with problematic substance use and the discrimination users may experience and which may inhibit recovery. Recovery 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.

THE VISION STATEMENT FOR RECOVERY

Each element of the vision statement was carefully selected from the key features of recovery, and it is important to refer back to these for further explanation of the terms:

> ***The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.***

The term "control over substance use" is deliberately inclusive of both abstinence and maintenance approaches to recovery – both can provide the necessary control over substance use, as can other approaches. However, it was agreed that neither 'white-knuckle abstinence' (with a constant fear of relapse) alone nor being 'parked' on prescribed drugs (with little consideration of individual needs and aspirations which may change over time) constituted recovery.

As reflected in the second half of the vision statement, it was also considered very important to recognise that recovery is more than reducing or removing harms caused by substance misuse as it must also encompass the building of a fulfilling life. Above all, the group recognised that the individual must be placed at the heart of recovery but their relationship with the wider world (family, peers, communities and wider society) is an intrinsic part of the recovery process.

ACHIEVING RECOVERY

Recovery may be achieved in a variety of ways including through medically-maintained abstinence. The various elements of the recovery process can all be achieved by a person without professional assistance. For other people the process can be assisted by focused professional help, which would aim to achieve a defined set of targets within the process. One use of such an overarching definition might be that it could

help substance misuse professionals maintain an overall vision of recovery to which all services can contribute, rather than seeing their own area of intervention as 'the only way'.

There was consensus that recovery is composed of all the aspects included in the above definition, so measuring recovery solely in terms of substance use ignores important dimensions of recovery for both the individual and society at large. Also, as already noted, the nature and extent of problems being 'recovered from' will vary considerably from person to person and from family to family. Therefore, the salience of progress in each of the areas may differ between individuals, depending on their particular needs, 'deficits' and circumstances, as will the sequence in which changes occur and the end point achieved. The importance of properly recognising the relative gains made by persons with more disadvantages and fewer resources was identified and the idea of 'added value' was considered one possible mechanism for this.

It was also noted that the problem drug user, their family, service providers and society may prioritise the different aspects of recovery described above differently, but in delivering recovery-oriented services the views of the individual drug user need to be central. However, the need for what White & Kurtz[7] describe as "family recovery" also needs to be recognised and support provided to family members to help them and the family unit adjust.

It is also important to recognise that the term 'recovery' implies that the person has the objective perhaps of returning or regaining what is lost. In some cases this may not be feasible in the strict sense of the term, e.g. chaotic adolescents who have never really had a 'fulfilling life' to which they can aspire to return, but in these cases recovery may instead be conceived as regaining missed opportunities.

The importance of aspirations within recovery, and the problem of the low aspirations that both substance users and professionals may have, was highlighted. This issue has also been raised in the recent work on recovery in the mental health field[8] in which hope and the establishment of a positive identity are key components to recovery. In the health psychology literature the term 'Post Traumatic Growth' is used to describe positive outcomes against a background of challenge and loss. It is characterised by three sets of change, notably change in self, change in relationships and a changed philosophical outlook. With regard to the latter some long term trauma survivors can report greater appreciation of life and more balanced judgement than prior to the trauma. Priorities can be altered through reconstruction of the individual's assumptions or "world view". This in turn is reflected in permanently improved health behaviour.

For most people recovery is a gradual process which may take years and during which time relapse is common, sometimes in the form of short-term lapses and other times for longer periods, but progress is progressive and cumulative between relapses. As in all lives, people with substance use problems have good events and bad experiences which enhance or inhibit recovery and the aging and maturing process often influences behaviour in a positive direction. . The associated health and social problems connected with injecting drug use such as blood borne virus infection, vascular damage

and criminal justice encounters inevitably have an impact on recovery, as does therapy.

The challenge of ensuring that high aspirations are maintained in the face of relapse and set-backs cannot be underestimated and will not be solved simply by any definition of recovery. Nevertheless, the definition highlights the domains of recovery and within which change is needed. It is possible to view all these as a continuum along which progress can be charted and towards which all services may contribute and the individual problem drug user is likely to require a range of different sources of help and support at different stages in their recovery. The use of a single definition may help in the development of a system that works together as required to support the recovery process for each individual.

NEXT STEPS

Although this is the final version of the statement as developed and agreed by the Consensus Group, it is not intended to be 'set in stone' or the 'ultimate answer'. Also, while a consensus process was used to identify common ground and develop the statement amongst the 16 individuals in the group, the aim is not to 'impose' this consensus on the wider world.

Rather, the statement is proposed as a starting point for discussion - among policy makers, service providers, commissioners and, importantly, service users – from which we hope will flow further consideration of what recovery-orientated services might look like. Clearly, drug-free programmes will not necessarily be recovery-orientated just because of their abstinence philosophy and, similarly, maintenance programmes will not necessarily lack a recovery orientation just because they involve the use of medication. Therefore there is a requirement to identify what characteristics make services (and the treatment system generally) recovery-orientated, regardless of the specific modalities employed. We believe the statement can help all services to recognise their role in the recovery process and to make important changes to enhance that role.

Identification of the key components of recovery also allows the development of measures of recovery that can be used in research to enhance our understanding of how recovery can best be supported and for monitoring of outcomes. Further work is needed to consider the extent to which current instruments, such as the Treatment Outcomes Profile (TOP)[9] and others, can measure recovery and how these might be used to improve service provision in the future.

It is clear that there is an increasing focus on recovery, as shown by the work in Scotland[10] and the emerging recovery networks[11] and we hope that our vision of recovery can add impetus to the movement. However, as has been shown in the field of mental health, the development of recovery-oriented services will require a different relationship between service users and professionals and thus there will be many challenges in adopting this approach[12]. Recovery might place the individual at its core, but the onus is on the rest of society and practitioners in the field to ensure that it fosters an environment that is conducive to it. Nevertheless, we feel there is a real

opportunity here for a radical improvement in outcomes for those affected by the problems of substance misuse.

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1 White, W.L. (2007) "Addiction recovery: Its definition and conceptual boundaries" J. Substance Abuse Treatment 33, 229-241.

2 Betty Ford Institute Consensus Panel (2007) "What is recovery? A working definition from the Betty Ford Institute" Journal of Substance Abuse Treatment, 33, 221-228

3 Shepherd G, Boardman J & Slade M (2008) Making Recovery a Reality London: Sainsbury Centre for Mental Health; Scottish Recovery Network http://www.scottishrecovery.net/content/ (accessed 20/06/08).

4 Scottish Advisory Committee on Drug Misuse (2008) Essential Care: a report on the approach required to maximize opportunity for recovery from problem substance use in Scotland

5 Drug and Alcohol Today events in London and Glasgow, and conferences held by UKESAD, the NTA conference and the London Drug Policy Forum, all in May and June 2008.

6 White, W. & Kurtz, E. (2005) The Varieties of Recovery Experience.Chicago, IL: Great Lakes Addictions Technology Transfer Center.

7 ibid

8 Shepherd G, Boardman J & Slade M (2008) Making Recovery a Reality London: Sainsbury Centre for Mental Health.

9 See: http://www.nta.nhs.uk/areas/outcomes_monitoring/ (accessed 06/07/08)

10 Scottish Advisory Committee on Drug Misuse (2008) *op cit*;
Scottish Government (2008) *The Road to Recovery*. Edinburgh: The Scottish Government

11 See, for example http://www.wiredin.org.uk/ and http://www.trntv.co.uk/ (accessed 06/07/08).

12 Shepherd G, Boardman J & Slade M (2008) *op cit.*