

Preparing and Guiding Individuals through the Process of Recovery

With significant emphasis in the UK on indicators, monitoring and targets in recent years, working with individuals towards a comprehensive plan for recovery from drug and alcohol problems, particularly in the early stages of treatment, has been reduced on all sides to an unproductive and formulaic procedure. Many service providers we talk to express concern that the relationship between worker and service user is sorely tested by too much emphasis on bureaucracy and little time to establish a therapeutic relationship. This problem should not be overlooked as a key finding from the literature is that an early therapeutic alliance appears to be a consistent predictor of engagement and retention in drug treatment. An early alliance also appears to influence early improvements during treatment. There is relatively little research on the determinants of the alliance however. Service user demographic or diagnostic pre-treatment characteristics do not appear to predict the therapeutic alliance, whereas modest but consistent relationships have been reported for motivation, treatment readiness and positive previous treatment experiences.¹ This paper argues that with a likely focus by Government on improving outcomes, service providers need to more fully engage service users in the change process, guiding them towards sustained recovery. The paper therefore sets out an explanation of the change process that leads to sustained recovery. The model offers a comprehensive way to assess and build upon service user's readiness and inherent ability to change, in order to arrive at an individual recovery plan.

Motivation and Commitment to Change

In order to achieve improved service user outcomes, service providers first need to identify at an early stage a person's physical, psychological and social needs including the risks to self and others. Second, providers need to give sufficient time and emphasis to exploring and strengthening a service user's motivations to change as well as enhancing the recovery capital at the individuals' disposal.²

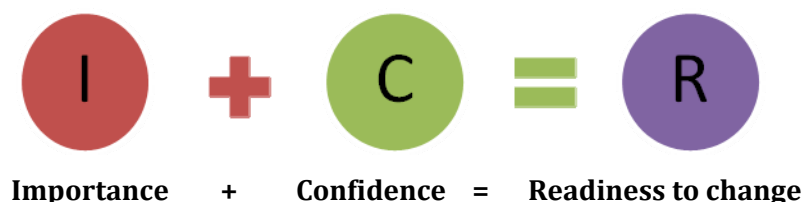
¹ Meier, P. S., Barrowclough, C. and Donmall, M.C. (2004) The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction*, Vol. 100, No. 3 pp. 304-16

² For further reading see Granfield, R and Cloud, W. (2001) Social Context and 'Natural Recovery'; the Role of Social Capital in the Resolution of Drug-associated Problems. *Substance Use and Misuse*, Vol. 36, No. 11, pp. 1543-70. On recovery see Best, D. (2009) STRADA presentation 'Mapping routes to recovery and the role of recovery groups and communities', University of West of Scotland. Also Best, D. (2009) Politics of Recovery *Druglink*, Vol.24 Issue 4.

Individuals using drugs and alcohol problematically often do so because they are motivated to use drugs in a particular way and have the opportunities to continue to do so. Psychologists sometimes define behaviour (B) as something influenced by motivation (M) as well as opportunity (O). Put simply **B = M + O**



What is therefore needed is a thorough investigation about what motivates or prompts drug taking behaviour as well as establishing the scope of opportunity in the daily life of the user to continue drug taking (the opportunities). Motivational interviewing offers a way of exploring the reasons for use as well as the reasons for change.³ When a service user comes forward for treatment, the reasons for doing so are often multifarious. External pressures such as getting arrested, experiencing family breakdown, losing one's job or facing illness are just some of the factors that prompt help-seeking behaviour. Sometimes however individuals remain resistant even at the point of seeking help. This is often because they have been coerced, perhaps by family, friends or the courts, into seeking help for a 'problem' activity that they, themselves, are ambivalent about. This can lead to behaviour that seems on the face of it 'help-seeking' but is in fact resistance – *"If I go along with this, perhaps they'll stop nagging me"*. Ignoring or challenging 'resistant' behaviour in a confrontational way is an entirely useless enterprise. Arguing and forcing one's viewpoint on a person who is not ready to take steps to change, counterproductive. Instead resistant behaviour needs to be recognised and viewed as an opportunity to activate the change process. Change becomes more likely when change becomes personally important to an individual. Likewise confidence in their ability to change – their behaviour, lifestyle and beliefs - can help bring a person closer to making change. It may be helpful to construe being 'ready to change' this way:⁴



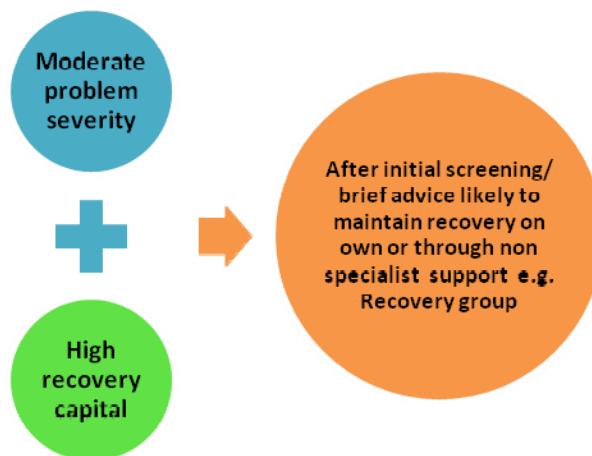
³ Miller, W. R. and Rollnick, S. (2002). *Motivational Interviewing: preparing people for change* (2nd ed.). New York: Guilford Press. See also Miller, W. R. and Rollnick, S. (2008). *Motivational Interviewing in Health Care; Helping Patients Change Behavior*. New York: Guilford Press

⁴ The concept of Readiness to Change was first detailed by Rollnick and Miller in 2002. See Miller, W. R. and Rollnick, S. (2002). *Motivational Interviewing: preparing people for change* (2nd ed.). New York: Guilford Press.

Not only is it important to assess motivations and opportunities to stay using and motivations to change, in addition there is a need to assess the assets, both internal and external, that collectively are known as 'recovery capital'.

Identifying Recovery Capital

Every individual possesses some recovery capital, the internal and external assets which initiate and sustain recovery.⁵ In the early stages of treatment identification of recovery capital needs to be attempted. Individuals with low to moderate alcohol or other drug problem severity and moderate to high recovery capital often resolve their alcohol/drug problems on their own through family and community supports or non specialised brief interventions.⁶



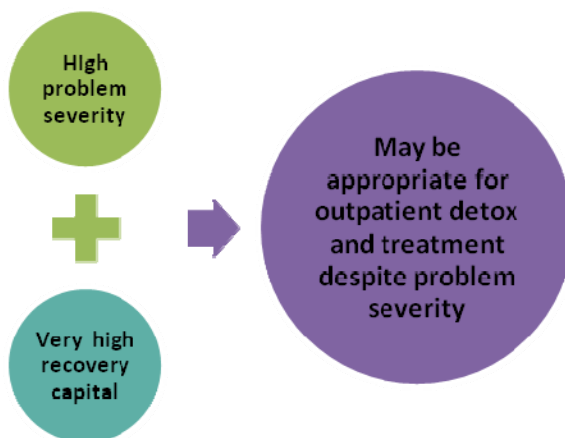
Other Interactions between Problem Severity & Recovery Capital

The interaction between problem severity and recovery capital can produce a set of circumstances that lead to different treatment responses. For example, those with high problem severity who also have exceptionally high levels of recovery capital (internal and external) may, surprisingly perhaps, cope well with community based support. Granfield and Cloud report that

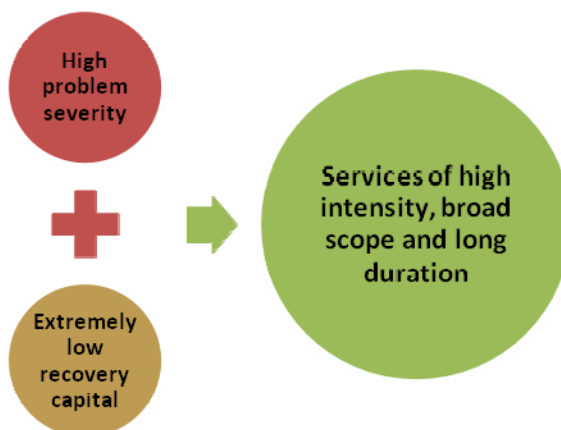
⁵ See recovery literature: White, W. (2006) Recovery across the life cycle. *Alcoholism Treatment Quarterly*, Vol. 24 (1/2), pp. 185-201; White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, Vol. 36, pp. 146-58.

⁶ Tuchfeld, B. S. (1981). Spontaneous remission in alcoholics: Empirical observations and theoretical implications. *Journal of Studies on Alcohol*, 42, pp. 626-41. Biernacki (1986) Spontaneous Remission from the Problematic Use of Substances: An Inductive Model Derived from a Comparative Analysis of the Alcohol, Opiate, Tobacco, and Food/Obesity Literatures, *Substance Use & Misuse* Vol. 21, No. 1 , pp. 1-23

those who possess larger amounts of social capital, perhaps even independently of the intensity of use are likely candidates for less intensive forms of treatment.⁷

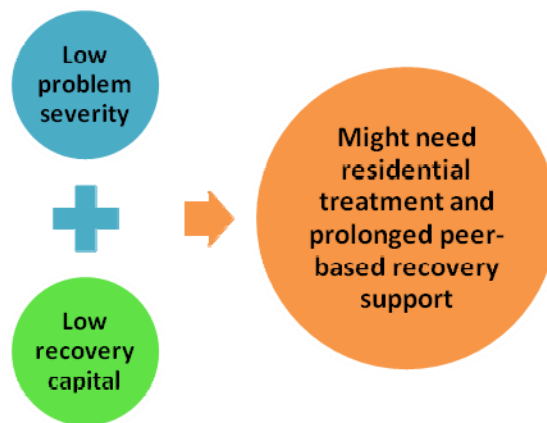


Conversely high problem severity but low recovery capital may suggest that the individual requires intensive treatment, often of long duration;



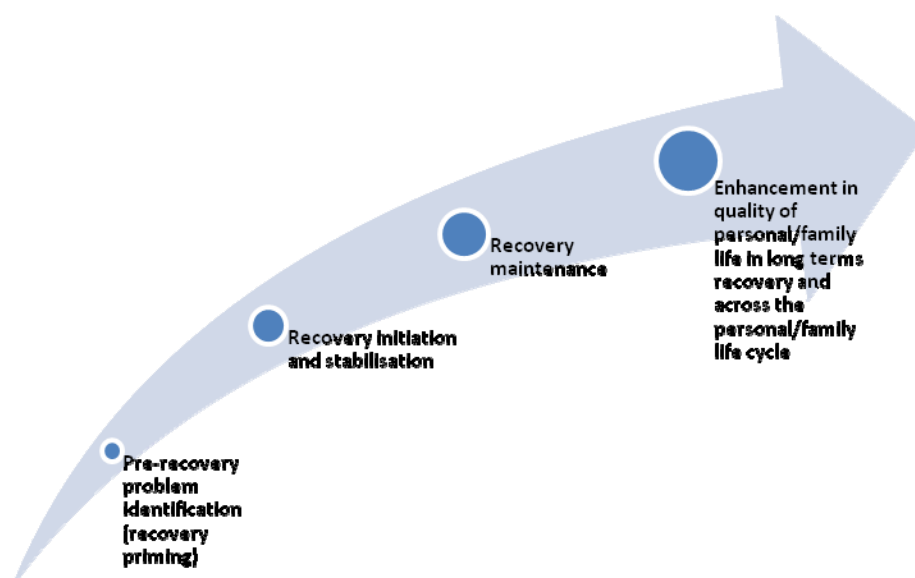
Likewise those whose problem is low in severity but who possess low recovery capital may require intensive support from services with long term support in the community. This is because recovery capital is vital for sustained recovery. People recovering from severe drug and alcohol problems can find relationships that are recovery-supportive beneficial. Such relationships tend to be natural (reciprocal), accessible at times of greatest need and potentially enduring. Mutual aid and community groups such as advocacy groups and peer based support groups may help, whilst others focusing on housing, education, employment and leisure may well be beneficial also.

⁷ Granfield, R. & Cloud, W. (2001). Social context and “natural recovery”: The role of social capital in the resolution of drug-associated problems. *Substance Use & Misuse*, 36, pp. 1543-70.



Towards a Model of Recovery

A growing body of literature suggests that addiction recovery is characterised by predictable stages and milestones. Within each stage there are developmental tasks and skills to master, perspectives to develop and issues to address before movement to the next stage can occur. According to Best, treatment interventions must be strategically selected to resolve key issues and achieve mastery over key developmental tasks inherent in individuals' current stage of recovery. Best argues that one of most consistent conclusions drawn from studies of stages of recovery is that the influences that later sustain recovery (maintenance factors) are different from those that serve to initiate early experiments in recovery (triggering mechanisms).⁸



⁸ Best, D. (2010) Road to Recovery, NDEG Report for the Scottish Government.

MacIntosh and McKeganey discuss a need for a change in self-perception and identity. They suggest there is a need to 'repair' the user's identity and stress the importance of differentiating between factors associated with striving for, and achieving, initial recovery and factors associated with sustaining recovery.⁹

Recognising not only when a person is ready to make the necessary changes but when it has taken place is also important. Changes or remission of the substance misuse pattern, enhancement in global health (physical, emotional, relational, occupational and spiritual) and signs of positive community inclusion are one way of defining as well as measuring successful outcomes of treatment and they also mark progress on the road to recovery.¹⁰ As service users start to make positive progress, it is important to include family and significant others as the transition is not only difficult for the individual user but for those around him/her. Family members/significant others can be harmed by the drug/alcohol problems of one or more family members. It is thus important to view the whole family unit as in recovery. There may well be, for example, a need to repair family rules and roles as well as relationships. In the long term also, participation in mutual aid societies often enhances long term recovery rates. It also reduces post recovery costs to society.¹¹

The Individualised Recovery Plan

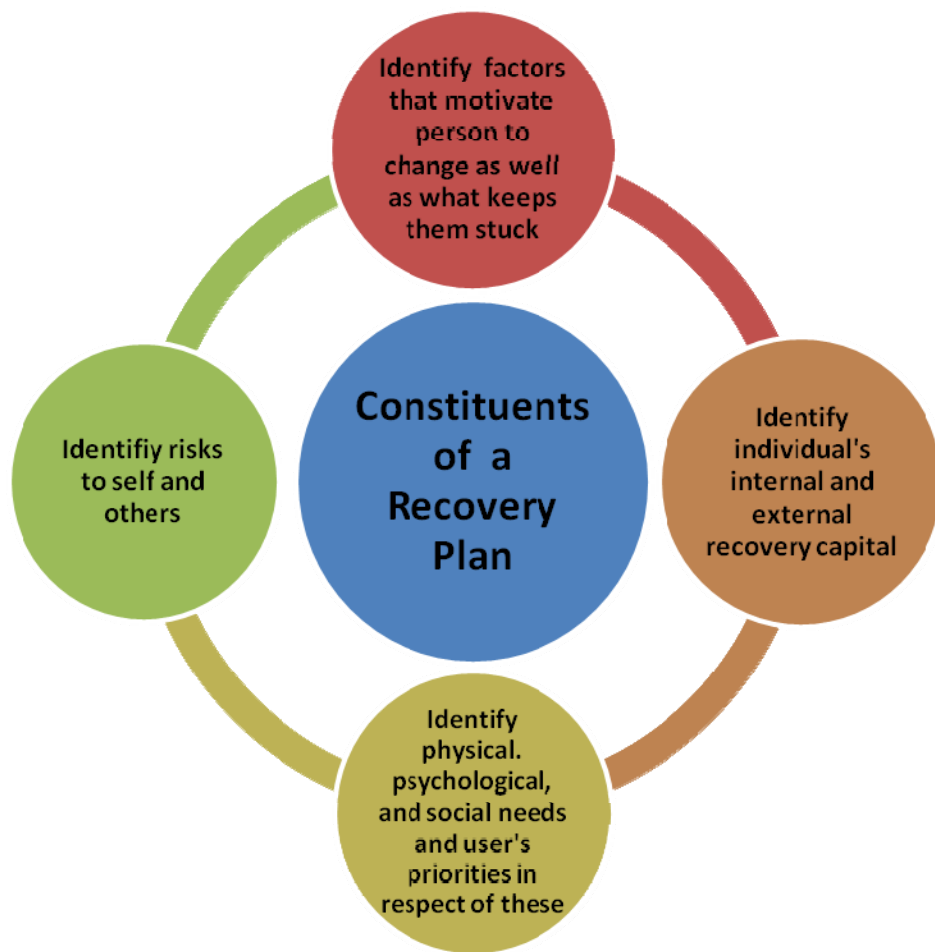
"Give us the fortitude to endure the things which cannot be changed, and the courage to change the things which should be changed, and the wisdom to know one from the other."
(Oliver J. Hart)

An important outcome for any individual who has engaged with services involved in the treatment of addiction is, having had the opportunity to reflect on past and current behaviours, and set goals for the future, is to arrive at a recovery plan which the individual has full confidence in. Our diagram overleaf illustrates the core elements that make up this process. This is not a one off activity, and the recovery goals, and plan will require revisiting intermittently.

⁹ McIntosh, J. & McKeganey, N. (2002) *Beating the dragon: the recovery from dependent drug use*. Prentice Hall: Harlow, Essex.

¹⁰ White, W. (2007) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, Vol. 33 issue 3, pp. 229-41.

¹¹ Kelly J.F., & Yeterian, J. (2008). *Mutual-help groups*. In W. O'Donohue, & J.R. Cunningham (ed.), Evidence-based adjunctive treatments, pp. 61-106. New York: Elsevier. See also White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, pp. 146-58.



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