Addiction Recovery in Services and Policy: An International Overview

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Contents

66.1 Introduction 1066
66.2 Recovery Becoming Guiding Vision of a Substance Use Services and Policy 1066
66.3 What Does "Recovery" Mean? 1068
66.4 What Does Adopting a Recovery Orientation Mean for Addiction Treatment Services? 1069
66.5 What Do Recovery-Oriented Addiction Services Systems Look Like? 1070
66.6 Recovery-Oriented Systems of Care 1071
66.7 Individual Recovery Support Services Elements 1072
66.8 What Can Medical Professionals Do to Promote Recovery Among Substance-Using Patients? 1075
66.9 Conclusion 1077
References 1077

Abstract

This chapter provides an overview of the sweeping changes occurring in the addiction field in the United States and abroad, with special emphasis on the growing focus on recovery as the goal of services and the guiding vision of drug policy. "Recovery" goes well beyond substance use patterns to encompass improved functioning in life areas impaired by active substance use, as well as improved overall quality of life. Because research shows that substance use disorders are often chronic, recovery is

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conceptualized as a process that unfolds over time and requires a continuing care approach. We describe emerging service models including Recovery-Oriented Systems of Care (ROSC) and peer-driven recovery supports and review the implications of this new orientation for service providers and evaluation research. We conclude with some recommendations on strategies that medical professionals can use to promote recovery among substance-using patients.

Keywords
Recovery • Peer support • Addiction • Treatment

66.1 Introduction

As healthcare is changing on a number of fronts, healthcare professionals are grappling with new systems and care models while continuing to diagnose and treat human conditions that are, in many cases, as old as the human race. Substance use, abuse, and dependence is likely one such condition. However, the way society views it has changed over time – from moral failing or crime to chronic brain disease (McLellan et al. 2000). Parallel with these changes come changes in how addiction is addressed by systems and healthcare providers. In this chapter, we describe and discuss the increasingly popular "recovery" orientation to substance use problems: a model where the desired outcome goes beyond changes in substance use to a broader notion of improved personal functioning and quality of life. After describing the model and corresponding services, we end with a brief discussion of consequences of this new orientation for healthcare professionals.

66.2 Recovery Becoming Guiding Vision of a Substance Use Services and Policy

Treatment systems addressing substance use disorders (SUDs) and the federal agencies regulating them (e.g., in the United States, SAMHSA – the Substance Abuse and Mental Health Services Administration) have begun to effect a shift in their emphasis, with recovery becoming the guiding framework. There are two key, empirically based elements to this paradigmatic shift: the reconceptualization of SUD as chronic disorders and the broadening of what "recovery" means. First, research in the past decade has suggested that addiction is best conceptualized as a chronic disorder on par with other chronic conditions such as diabetes, asthma, or hypertension (McLellan et al. 2000). However, unlike these other conditions, treatment for substance use disorders (SUDs) has historically been delivered and evaluated using an acute care model: intense episodes of care during which a person, often in crisis, is assessed, treated, and released – ideally "cured" – all in a relatively short time (Dennis and Scott 2007). Growing evidence for long addiction and treatment "careers" consisting of multiple cycles of intensive and

costly treatment episodes (Dennis et al. 2005) followed by return to active addiction (Scott et al. 2005) has led to the conclusion that the acute care model is ill suited to address SUD as a chronic condition (Hser et al. 1997; McLellan et al. 2005a; O'Brien and McLellan 1996). Noting the disappointing outcomes of the current system and the many similarities between SUD and other chronic illnesses, the Institute of Medicine and leading addiction researchers have called for SUD treatment to shift from the acute care model to one of recovery management akin to the chronic care model used in the treatment of other chronic conditions (Dennis and Scott 2007; Humphreys 2006; Institute of Medicine 2005; McKay 2005; McLellan et al. 2000; Miller 2007; White et al. 2002, 2005b). A continuum of care model consistent with chronic disease is also aligned with the experience of persons in recovery who overwhelmingly describe recovery as "a process" vs. "an end point" (Laudet 2007).

The second element of the paradigmatic shift to a recovery orientation is rooted in the growing recognition that recovery goes well beyond making changes in one's substance use patterns (see next section). McLellan and colleagues may have put it best where stating: "typically, the immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety – i.e., recovery" (McLellan et al. 2005b, p. 448). Thus, the emerging recovery-oriented model of care provides a continuum of service and support designed to promote and sustain improvements in substance use (abstinence or significant reductions) and psychosocial functioning. This recovery framework reconciles a public health response to chronic care with a strength- and community-based focus that places the individual at the heart of their own recovery journey and emphasizes personal empowerment and individual ownership of the definition of and pathway to recovery. Promoting recovery requires giving individuals the tools and strategies to develop "capital," a strength-based approach that has gained prominence in both psychology (Seligman 2003) and criminology (Ronel and Elisha 2011) and is embodied in the addiction field by the construct of "recovery capital" (Granfield and Cloud 2001).

The emerging emphasis on recovery in addiction services is paralleled by a similar shift at the federal policy level. In the United States, the President's National Drug Control Strategy emphasizes the importance of promoting recovery, regardless of pathway (Office of National Drug Control Policy 2011) and calls for the expansion of recovery support services across community-based settings. The White House Office of National Drug Control Policy (ONDCP, the so-called drug tsar office) has also begun several interagency initiatives that emphasize the centrality of the recovery orientation to addressing SUDs, the need for recovery support services, and the importance of eliminating legal barriers to recovery (e.g., restrictions on housing and student loans for persons with a drug-related criminal history). For example, ONDCP is working in the US Department of Education that adopted the goal of providing a continuum of recovery supports at all levels in academic settings (Dickard et al. 2011). ONDCP has created a Recovery Branch to coordinate these efforts and engage federal partners, state

and local governments, membership and advocacy organizations, service providers, and other stakeholders in the design and development of policies, systems, services, communication campaigns, and other activities that support long-term recovery (Office of National Drug Control Policy 2011).

The growing emphasis on recovery-supportive services and policy unfolding in the United States is also observed in other countries. The United Kingdom is undergoing its own system transformation at the service and policy levels (Best 2012; United Kingdom Drug Policy Commission Consensus Group 2007). The UK Home Office that oversees most drug and alcohol policy in England and Wales has endorsed recovery as a goal of treatment services (HM Government 2010). That has been seen as a core component of the government "personalization" agenda, although the impetus for change has arisen in part from a dissatisfaction with the effectiveness of drug treatment in England and Wales (Easton 2008; McKeganey 2010). This shift in the United Kingdom followed an earlier change in Scotland, whose government's "Road to Recovery" (Scottish Government 2008) is a blueprint to system transformation. The origins of SUD recovery orientation were different in Scotland from England, with the policy document citing the success of the mental health recovery movement in Scotland, in particular its coordinating organization, the Scottish Recovery Network (Scottish Government 2008). In England, the policy shifts reflect the unique recovery context – i.e., the mounting critique of a treatment system predicated on low-intensity treatments (Best 2012) and a dissatisfaction with the prevailing treatment system and philosophy. In both countries, this was combined with a growing awareness of the burgeoning US recovery movement and a baseline of recovery activity in mutual aid and therapeutic communities to drive practice and policy change.

Most recently, seeds of transformation are also being planted in the Australian state of Victoria where the second author (DB) is spearheading a growing number of recovery initiatives including the promotion of policy change, the challenge of stigma through recovery walks and other events, and the development of a university-based teaching and research program on recovery (Recovery Academy Australia 2012). This has resulted in a state-level reform road map (Victorian Department of Health 2012) where the principles of recovery are prominent and will drive the restructuring of the treatment system.

66.3 What Does "Recovery" Mean?

The term "recovery" has been ubiquitous in the substance abuse field for half a century if not longer but, until recently, had remained undefined. Researchers typically operationalized the term in studies by measuring short-term abstinence (typically a year or less), some from a single substance (e.g., alcohol) and others from all substances (for a discussion, see Laudet 2007). The field began to delve into the meaning of "recovery" in 2005 when the Center for Substance Abuse Treatment (CSAT), a division of the Substance Abuse and Mental Health Services Administration (SAMHSA), convened a panel of experts representing a number of key stakeholder

groups (Center for Substance Abuse Treatment 2006). The following year, the Betty Ford Center convened a smaller panel of experts and stakeholders that published the first consensus definition of "recovery" as "voluntarily maintained lifestyle composed characterized by sobriety, personal health, and citizenship" (Belleau et al. 2007, p. 221). Other definitions have since been formulated, but all share the premise that SUD recovery goes well beyond the reduction of/desistance from substance use and extends to improved functioning in key life areas typically impaired but active use. Stated differently, one can regard recovery as currently conceptualized as non-problematic substance use (or total abstinence) *plus* improved functioning in such areas as physical and mental health, employment, economic, family, and social life, to name only a few. Central to this new model is that recovery is a dynamic and individual process whereby the combination of factors defining recovery is individually determined and may well change over time as recovery progresses.

66.4 What Does Adopting a Recovery Orientation Mean for Addiction Treatment Services?

Broadly stated, the two elements of the paradigmatic shift discussed above mean that SUD services need to be expanded in time, in philosophy, and in scope. In terms of time, SUDs have thus far been addressed using intensive, short-term episodes of professionally delivered services in in- and/or outpatient settings. While the effectiveness of treatment has received support (Waldron and Turner 2008; Weisner et al. 2003b), the rate of return to active use following treatment, even among those who had achieved abstinence (the goal of treatment in the United States), is high (Dennis et al. 2005; Laudet et al. 2007; McLellan et al. 2005a). This typically leads to treatment reentry (be it in the community or in jail settings) as well as to numerous costs to the individual, to his/her community, and to society. On the other hand, there is evidence that participation in ongoing recovery support – typically 12-step fellowship meetings such as Alcoholics Anonymous, often the only available community-based recovery support resource until very recently but also less structured forms of community engagement and activities – is associated with decreased rates of return to active substance use (Fiorentine and Hillhouse 2000; Kyrouz et al. 2002; Laudet et al. 2007; Tonigan 2008) and with utilization of costly services (Humphreys and Moos 2001, 1996). Taken in a broader context, the empirically demonstrated usefulness of mutual aid recovery support groups emphasizes the importance of peer and most notably the critical role on ongoing support to sustaining recovery (see later section).

In terms of scope, a recovery orientation requires the provision of comprehensive services designed to address needs in all life areas that are typically impaired during active addiction and where improvements are considered an inherent part of recovery – e.g., physical and mental health, employment, economic, family, and social life (see preceding section). Services addressing these issues have thus far often been referred to as "ancillary" in status or "aftercare" in the timing of delivery in spite of their importance to clients, and their evidences impact on the transition to

stable recovery (Laudet et al. 2009; Laudet and White 2010). One study illustrating the importance of non-addiction-related services to treatment clients interviewed individuals who had left treatment before completion – in that study, 60 % of the cohort has left before completion, a finding on par with the national average (Substance Abuse and Mental Health Services Administration Office of Applied Studies Treatment Episode Data Set (TEDS) 2005, 2008). We asked clients why they left the program and whether they felt there was anything the program could have done differently to keep them engaged in services longer (Laudet et al. 2009). Answers fell into one of three broad categories, none of which mentioned addiction treatment services: need for social services (54.2 % – job training, help with housing, childcare, stable housing), need for more supportive staff (25.8 % – e.g., encouraging, trusting, and caring), and need for greater schedule flexibility to accommodate other responsibilities, including work (20 %). These findings are consistent with that of another study we conducted examining current challenges and life priorities in a sample of 356 community-based persons in abstinent recovery from severe polysubstance dependence (Laudet and White 2010). Participants' responses were examined as a function of how long they had been abstinent: under 6 months (28 %), 6–18 months (26 %), 18–36 months (20 %), and over 3 years (26 %). Across these stages, working on one's recovery (e.g., staying sober, "making recovery a priority") was consistently cited as the top priority (cited by 34–49 % across stages); notably, employment was the second most frequently mentioned priority at all stages, cited by the same percentage of persons abstinent over 3 years as working on one's recovery (34.1 % each). Taken together, findings from these studies underline the importance of services designed to foster improvement in non-addiction functioning among both individuals in treatment and those at various stages of the recovery process.

The comprehensive recovery-oriented service model is significantly different from the currently prevalent model where services focus, by necessity, on substance use-related issues and are delivered by trained addiction professionals. Note that delivering a comprehensive recovery-promoting approach does not require that all services be delivered in a single setting, nor does it signify the approaching disappearance of "addiction treatment" as practiced today. In the next section, we summarize prevalent models of recovery support services.

66.5 What Do Recovery-Oriented Addiction Services Systems Look Like?

As clinicians and researchers have come to recognize the chronic nature of SUD, they have developed and evaluated a growing menu of interventions designed to help clients sustain and build on their treatment gains – i.e., relapse prevention. Perhaps the most prevalent form of aftercare consists of *a stepped down course of services typically following intensive inpatient* or residential treatment (McKay 2001, 2009; McKay et al. 2009); in spite of its established existence and intuitive appeal, few clients access these resources and the evidence for the effectiveness of the approach

remains limited (Godley et al. 2007; McKay 2001). In the past decade, clinicians have also started to capitalize on health technology such as telephone-based continuing care (McKay et al. 2005), and several large treatment agencies are developing proprietary web-based online recovery maintenance and support programs for clients to use after they leave service; one example is Hazelden's MORE.[1]

66.6 Recovery-Oriented Systems of Care

In the United States, the shift to a recovery orientation in SUD services has been primarily spearheaded by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is advancing the Recovery-Oriented Systems of Care (ROSC) model that constitutes an organizing framework for recovery support services. A key premise underlying recovery supports is that addiction is typically a chronic rather than acute condition. While a chronic condition cannot be "cured," the symptoms can be arrested and the condition managed. The need for this new model was perhaps stated most explicitly by Dr. Clark, a SAMHSA official: "Recovery is more than abstinence from alcohol and drugs; it's about building a full, meaningful, and productive life in the community. Our treatment systems must reflect and help people achieve this broader understanding of recovery" (Clark 2008b, p. 2). As described in SAMHSA materials,[2] ROSC's goals are to intervene early with individuals with SUDs, to support sustained SUD recovery, and to improve the health and wellness of SUD-affected individuals and families. Consistent with the multidimensional and developmental nature of recovery discussed earlier in this chapter, the ROSC model proposes a multisystem, person-centered continuum of care in which a comprehensive menu of coordinated services and supports is tailored to individuals' recovery stage, needs, and chosen recovery pathway (Clark 2008a, b). Services and supports are provided in a comprehensive array of recovery-related domains including education and job training, housing, childcare, transportation to treatment and work, case management, spiritual support, as well as SUD-focused services – e.g., relapse prevention, recovery support, SUD education for family members, peer-to-peer services and coaching, self-help, and support groups (Kaplan 2008; Sheedy and Whitter 2009).

Services are intended to address the multitude of life areas adversely affected by active substance use and to respond to clients' changing needs across their life span. ROSC is responsive to calls from the Institute of Medicine and leading addiction researchers for a shift in SUD treatment from the acute care model to one more akin to the model used in other chronic conditions (Humphreys and Tucker 2002; Institute of Medicine 2005; McLellan et al. 2000; White et al. 2005a). From a systems perspective, this means that the case management and care coordination function of services is conferred a more prominent role in treatment design and delivery.

[1] http://www.hazelden.org/web/public/more_demo.page

[2] http://partnersforrecovery.samhsa.gov/rosc.html

Key principles guiding the recovery orientation include primacy of participation; promoting access and engagement; ensuring continuity of care; employing strength-based assessment; offering individualized recovery planning; functioning as a recovery guide; community mapping, development, and inclusion; and identifying and addressing barriers to recovery (Kirk 2008, 2010; Tondora and Davidson 2006).

Implementing ROSC nationwide in the United States will require transformative changes in agencies that address SUD directly as well as within those serving the population through other avenues (e.g., mental health and social service agencies). This has implications for the training and evaluation of staff and service managers and those responsible for commissioning and evaluating treatment services. The Affordable Care Act's expansion of Medicaid and the creation of health insurance exchanges give states added resources to make these changes. At this writing, ROSC is gradually taking hold as more states and cities are implementing components of the model (Evans 2007; Kaplan 2008; Kirk 2008). Still, the ROSC model is still in its infancy at the level of field implementation and, at this writing, has not been formally evaluated. There is, however, emerging evidence supporting its potential usefulness. Statewide data from Connecticut – the first to begin implementing a true ROSC in 1999 (Kirk 2010) – provide early support for the effectiveness and cost-effectiveness of the approach: this includes a 24 % decrease in expenses, 25 % decrease in annual cost per client, 46 % increase in number of people served statewide, 62 % decrease of acute care, 40 % increase in outpatient care, and 14 % lower cost with recovery support. Internationally, untested belief that a recovery-oriented approach is prohibitively expensive has been a significant barrier to implementation and one that needs to be tested with adequate effectiveness and cost-effectiveness evaluations and health economic research.

66.7 Individual Recovery Support Services Elements

In addition to the emerging system-level recovery orientation embodied by ROSC, the field is also witnessing the development of a growing menu of recovery support services (RSS) described in a number of recent articles and monographs that also review the emerging science supporting the approach (Kaplan 2008; Laudet and Humphreys 2013; Sheedy and Whitter 2009; White 2008, 2009). Unlike professionally delivered aftercare (see earlier), peer-based RSS are not solely conceptualized to be delivered after treatment but can also be provided in addition to or even in lieu of professional services. This is important as there are a number of barriers to SUD treatment that include wait lists, finances, stigma, and ambivalence about seeking professional help (Appel et al. 2004; Cunningham et al. 1993; Laudet et al. 2009; Zemore et al. 2009).

At least two aspects of RSS are unique. First, RSS are often delivered by peers, individuals who have experiential knowledge (Borkman 1999) and work as volunteers or as paid service workers (Kaplan 2008) to assist others in initiating and maintaining recovery and enhancing their quality of life (White 2009).

Other healthcare fields have capitalized on peers to promote symptom management in the context of chronic conditions (e.g., asthma, cancer, psychiatric illness, and diabetes – Greenfield et al. 2008; Kyrouz et al. 2002). A randomized clinical trial using a prospective design with repeated measurements documented the effectiveness of adding a peer-based component to clinical treatment in reducing substance use (Rowe et al. 2007) among clients dually diagnosed with a mental health and a substance use disorder, and peers have also proven effective at designing and disseminating mutual help-related public service announcements to increase involvement in mutual aid/self-help groups for a range of chronic problems, including SUD (Humphreys et al. 2004). The use of peers is intuitively appealing and empirically demonstrated to be useful in the addiction field as well. Research has shown that social support, particularly from other individuals in recovery, predicts successful substance use outcomes (Humphreys et al. 1999, 1997; Weisner et al. 2003a). Many individuals in recovery report that being in the company of peers is helpful (Granfield and Cloud 2001; Laudet et al. 2002; Margolis et al. 2000; Nealon-Woods et al. 1995). In Glasgow, Scotland, one study found that the two strongest predictors of positive quality of life in recovery were spending time with other people in recovery and engagement in meaningful activities – including working, training, volunteering, and involvement in community groups (Best et al. 2011).

The second unique aspect of peer-based RSS is that they can be delivered in a broad range of community-based settings – e.g., recovery community centers, faith-based institutions, jails and prisons, health and social service centers, and addiction and mental health treatment agencies (Faces and Voices of Recovery 2010). This is important not only because it increases the accessibility of recovery support literally (i.e., to persons who may not have the means of transportation to go to a treatment program) but also more figuratively by removing some of the stigma and ambivalence that are sometimes attached to “seeking help” in a traditional healthcare or SUD treatment setting.

One type of peer-based recovery support service that is increasingly being implemented in the United States is peer recovery coaching: a peer mentors the individual seeking recovery (e.g., assists in setting recovery goals and a recovery plan, serves as role model in recovery). This aims to help the individual connect to recovery-supportive resources needed to restructure life (e.g., professional/nonprofessional services including housing and employment) and serving as an advocate and liaison to formal and informal community supports, resources, and recovery-supporting activities. While no formal evaluation of peer recovery coaching has been conducted to date, a clinical trial of an integrated case management including using peer coaches to help integrate SUD treatment and child welfare services for parents in substance-involved families enhanced access to treatment and resulted in increased family reunification rates compared to standard care (Ryan et al. 2006). Moreover, reports compiled in the context of broader recovery-oriented efforts have provided emerging evidence for the benefit of peer coaching (Mangrum 2008).

There are a handful of other models of peer-based recovery support that we only briefly describe here as they are more fully discussed in a recent review

article (A. Laudet and Humphreys 2013). One model is the sober residence, a home that offers mutual help-oriented, financially self-sustaining, self-governed, democratic communal-living environments where individuals in recovery can reside for as long as they choose after inpatient treatment or incarceration, during outpatient treatment or as an alternative to treatment (Polcin 2009). The most prevalent model of sober residences is Oxford House (OH) with 1,300 houses in the United States (Jason and Ferrari 2010). The benefits of the model in terms of substance use and related domains (e.g., employment, criminal involvement) have been extensively documented in prospective peer-reviewed studies across subpopulations (Alvarez et al. 2006; Jason et al. 2001, 2009; Majer et al. 2002, 2011; Millar et al. 2011), as has been its cost-effectiveness (Lo Sasso et al. 2012; Olson et al. 2006). Most recent and perhaps most innovative is the campus-based Collegiate Recovery Program (CRP) model that is emerging nationwide. The high prevalence of substance use on college campus can jeopardize recovery for young people at a time of their development where fitting in with peers is central to their identity; for some, that may lead to foregoing or postponing college in the absence of a readily available sober network (Baker and Harris 2010; Botzet et al. 2007; Harris et al. 2008; Laitman and Lederman 2007; Smock et al. 2011; U.S. Department of Education Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention 2010; Woodford 2001). The CRC developed to meet the needs of college students with a history of SUD who have successfully remitted from the disorder and seek to pursue educational goals. Central elements of the CRC model include a peer-driven approach informed by 12-step tenets and services such as drug-free housing, on-site peer support, and counseling provided by a small staff, as well as opportunities for sober recreational activities, relapse prevention, and life skills workshops. Little documentation is currently available about specific CRC services across programs, but it is believed that the breadth of service varies (Bell et al. 2009). Common to all are on-site 12-step and other recovery support meetings, a campus-based location where students can meet and spend time with sober peers; some offer sober housing and peer academic support. All function with minimal professional staff as the emphasis is clearly peer driven. The model seems consistent with the continuing care paradigm within a “recovery management” system that experts recommend (Godley et al. 2002). CRCs are also responsive to calls for appropriate campus-based infrastructure to support recovering students (Misch 2009), with recent shifts in drug (Office of National Drug Control Policy 2010) and with the US Department of Education’s goal of ensuring a continuity of care from high school to college to postgraduation (Dickard et al. 2011). The model is growing in popularity nationwide: in the past decade, growing concerns about substance use on campus and federal agencies’ focus on building a community-based continuum of care system for youths have fueled a fivefold increase in the number of CRPs, from four in 2000 to 32 in 19 states today. No formal evaluation has been conducted yet, but site-specific reports document

encouraging outcomes – low relapse rates, above school average GPAs, graduation rates, and perceived helpfulness (Baker et al. 2011; Bell et al. 2009; Cleveland et al. 2007; Harris et al. 2008). The first author is currently conducting an NIH-funded survey of all CRC programs and student participants nationwide to learn more about the breadth of services offered and the characteristics and needs of students served; that knowledge will inform a subsequent large-scale evaluation of the model. In the same vein as CRCs though professionally rather than peer delivered are recovery high schools (Moberg and Finch 2008) that typically function as charter schools in a public school system and serve students who recently left SUD treatment. This model is currently undergoing systematic evaluation.

The three initiatives discussed above – around education, housing, and peer activities – are all consistent with three core tenets of recovery-oriented services: a care coordination across a range of service sectors requiring case management skills and "outward-looking" specialist treatment services, an increased role for peers and a recognition of the validity of "expertise by experience," and a continuity of care model that acknowledges the need for integrating acute services with those targeting longer-term changes in well-being and social integration. This grassroots or "bottom-up" approach represents a drastic departure from the current SUD service model. Moreover and importantly, it is accessible to individuals who have reservations about the mutual aid movement (12 steps in particular) and is consistent with an asset-based community development model (Kretzmann 1993) and with the public health model to addictions that is gathering momentum in the United Kingdom and elsewhere in Europe.

Overall, a growing menu of professionally and peer-delivered recovery support services is being developed and implemented, with the professionally driven efforts being spearheaded (in the United States) by federal funding agencies, principally SAMHSA. None of the peer-driven strategies have been formally evaluated though state-level data report encouraging outcomes. These findings are of course preliminary; the approaches need to be systematically evaluated, and the stability of the documented improvements over time remains to be determined.

66.8 What Can Medical Professionals Do to Promote Recovery Among Substance-Using Patients?

Given the prevalence of substance use disorders and how frequently medical and substance use disorders co-occur, medical professionals routinely come into contact with patients who are or were abusers of/dependent drugs and/or alcohol. This section briefly outlines suggestions for medical professionals to promote the initiation and maintenance of recovery from substance use disorders.

Addressing active substance use in primary care as Screening, Brief Intervention, and Referral to Treatment (SBIRT)[3] is increasingly being implemented and evaluated. The rationale behind SBIRT is simple yet effective: identifying (screening) a substance use problem early reduces the risk that it will progress to clinical levels (in this case, chronic SUD); this secondary prevention approach (preventing disease progression) is accomplished either through a brief intervention delivered by the professional conducting the screening, immediately following detection of a problem, or through referral to specialty care (i.e., SUD treatment) when the severity of the identify problem warrants it. There is a growing body of evidence for the effectiveness of SBIRT across populations (adults, youths, veterans) and across settings – e.g., primary care and emergency departments (Agerwala and McCance-Katz 2012; Gonzales et al. 2012; Gryczynski et al. 2011; Lotfipour et al. 2013; Madras et al. 2009; Mitchell et al. 2013; Murphy et al. 2013; Young et al. 2012). The effectiveness of brief intervention has long been established, with the largest trial being conducted by the World Health Organization (WHO): 1,661 heavy drinkers in 8 countries were randomly assigned to a control condition (no intervention) or to one of two forms of brief intervention to reduce drinking. At a 6-month follow-up, participants receiving either of the two brief interventions showed significant reductions in drinking outcomes compared with the control group (WHO Brief Intervention Study Group 1996). Implementing SBIRT in primary care is especially critical in view of the fact that studies of SUD treatment clients show that two decade or more pass between first and last uses (Dennis et al. 2005). Fewer than 10 % of individuals needing SUD treatment seek it in a given year (Kessler et al. 1996; Wang et al. 2005), about a third in their lifetime (Compton et al. 2007; Hasin et al. 2007). Therefore, it is critical to capitalize on opportunities to address substance use problems early, and primary care settings (as well as emergency departments) represent very promising venues to achieve that goal. Addressing substance use in primary care is also essential because substance use can complicate the course of other diseases and jeopardize adherence to and outcome of treatment (Braithwaite et al. 2007; Oyugi et al. 2007; Watson et al. 2007). In addition to promoting the initiation of recovery through such strategies as SBIRT, healthcare professionals are also in a position to help support recovery *maintenance*. Continued screening for substance use in patients with former SUD is desirable to detect any relapse early – as is currently routinely done for mental health problems during office visits. Moreover, active addiction has numerous negative consequences for many major organs and systems (e.g., liver, heart, and lungs) as well as the potential for undiagnosed infectious disease (e.g., HIV/AIDS and Hep C); years of active addiction often result in neglected self-care, increasing the odds that any developing medical condition progresses unaddressed. Therefore, because individuals with an SUD history have lower access to health services (Samet et al. 2007), they may be at enhanced risk for developing chronic

[3]http://www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf

conditions; it is important that healthcare professionals educate themselves about the consequences of active addiction and screen patients with a history of SUD for conditions frequently associated with an addiction history. Studies have documented the high rate of co-occurring chronic medical (and mental health) conditions among persons with a history of SUD, both of which complicate also the attainment of recovery outcomes such as seeking employment A cross-national trial of brief interventions (Laudet 2012). Overall, the evidence suggests that substance use (be it active or past) interacts dynamically with physical health, enhancing the need for healthcare professionals to engage patients in an honest, nonjudgmental dialogue about their current and past substance use.

Finally, though a full discussion is beyond the scope of this chapter, the treatment of acute and chronic pain for patients in recovery from an SUD is a growing area of research and of practice for healthcare professionals, discussed in details in several recent book chapters and articles (Brown et al. 2012; Cruciani et al. 2008; Miotto et al. 2012; Portenoy et al. 2005).

66.9 Conclusion

The emerging recovery orientation builds on a growing addiction science and an evidence base that shows the effectiveness of a range of treatment interventions. It also represents a paradigmatic shift in the way SUD recovery is conceptualized and how recovery services are delivered both at the individual and at the systemic level. Recovery is an organizing concept that promotes empowerment and choice within a change model based on a chronic disorder with unpredictable rates of relapse necessitating a service model that integrates acute interventions with holistic, comprehensive care coordination and community engagement. Recovery services approaches are consistent with the needs of the recovery community as documented in a handful of studies summarized here and have a burgeoning evidence base around peer support, around recovery housing, and around long-term transitions to training and employment. Healthcare professionals in all sectors should become familiar with the breadth and growing availability of recovery services and supports in their communities as these resources supplement and for some may replace traditional SUD treatment. Doing so will allow providers to have a larger menu of options to discuss with and offer patients, with the ultimate goal of reducing the duration and impact of active substance use and SUD, and giving patients the resources necessary to improve their overall health and functioning.

References

Agerwala SM, McCance-Katz EF (2012) Integrating Screening, Brief Intervention, and Referral to Treatment (SBIRT) into clinical practice settings: a brief review. J Psychoactive Drugs 44(4):307–317

Alvarez J, Adebanjo AM, Davidson MK, Jason LA, Davis MI (2006) Oxford House: deaf-affirmative support for substance abuse recovery. Am Ann Deaf 151(4):418–422

Appel PW, Ellison AA, Jansky HK, Oldak R (2004) Barriers to enrollment in drug abuse treatment and suggestions for reducing them: opinions of drug injecting street outreach clients and other system stakeholders. Am J Drug Alcohol Abuse 30(1):129–153

Baker A, Harris K (eds) (2010) Questions. . .more answers: creating effective relapse prevention strategies for recovering college students. U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration, Rockville

Baker A, Laudet A, Harris K (2011) Collegiate recovery communities: student membership and prospective outcomes. Paper presented at the 73rd annual scientific meeting of the College on Problems of Drug Dependence (CPDD), Hollywood

Bell NJ, Kanitkar K, Kerksiek KA, Watson W, Das A, Kostina-Ritchey E, Harris K (2009) "It has made college possible for me": feedback on the impact of a university-based center for students in recovery. J Am Coll Health 57(6):650–657

Belleau C, DuPont R, Erickson C, Flaherty M, Galanter M, Gold M, White W (2007) What is recovery? A working definition from the Betty Ford Institute. J Subst Abuse Treat 33(3):221–228

Best D (2012) Addiction recovery: a movement for social change and personal growth in the UK. Pavilion Publishing, Brighton

Best D, Gow J, Knox T, Taylor A, Groshkova T, White W (2011) Mapping the recovery stories of drinkers and drug users in Glasgow: quality of life and its associations with measures of recovery capital. Drug Alcohol Rev 15

Borkman T (1999) Understanding self-help/mutual aid: experiential learning in the commons. Rutgers University Press, New Brunswick

Botzet A, Winters K, Fahnhorst T (2007) An exploratory assessment of a college substance abuse recovery program: Augsburg College's stepUP program. J Groups Addict Recover 2(2–4):257–287

Braithwaite RS, Conigliaro J, Roberts MS, Shechter S, Schaefer A, McGinnis K, Rodriguez MC, Rabeneck L, Bryant K, Justice AC (2007) Estimating the impact of alcohol consumption on survival for HIV + individuals. AIDS Care 19(4):459–466

Brown ME, Swiggart WH, Dewey CM, Ghulyan MV (2012) Searching for answers: proper prescribing of controlled prescription drugs. J Psychoactive Drugs 44(1):79–85

Center for Substance Abuse Treatment (ed) (2006) National summit on recovery: conference report. Substance Abuse and Mental Health Services Administration, Rockville

Clark W (2008a) Recovery-oriented systems of care: SAMHSA/CSAT's public health approach to substance use problems & disorders. Paper presented at the aligning concepts, practice, and contexts to promote long term recovery: an action plan, Philadelphia. www.ireta.org

Clark W (2008b) Recovery as an organizing concept. http://www.nattc.org/learn/topics/rosc/docs/drwestleyclarkinterview.pdf. 7 Feb 2008

Cleveland HH, Harris KS, Baker AK, Herbert R, Dean LR (2007) Characteristics of a collegiate recovery community: maintaining recovery in an abstinence-hostile environment. J Subst Abuse Treat 33(1):13–23

Compton WM, Thomas YF, Stinson FS, Grant BF (2007) Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States: results from the national epidemiologic survey on alcohol and related conditions. Arch Gen Psychiatry 64(5):566–576. doi:10.1001/archpsyc.64.5.566, 64/5/566 [pii]

Cruciani RA, Esteban S, Seewald RM, Altilio T, Bookbinder M, Sheu R, Portenoy RK (2008) MMTP patients with chronic pain switching to pain management clinics. A problem or an acceptable practice? Pain Med 9(3):359–364. doi:10.1111/j.1526-4637.2006.00224.x, PME224 [pii]

Cunningham JA, Sobell LC, Sobell MB, Agrawal S, Toneatto T (1993) Barriers to treatment: why alcohol and drug abusers delay or never seek treatment. Addict Behav 18(3):347–353

Dennis M, Scott CK (2007) Managing addiction as a chronic condition. NIDA Addict Sci Clin Pract Perspect 4(1):45–55

Dennis M, Scott C, Funk R, Foss MA (2005) The duration and correlates of addiction and treatment careers. J Subst Abuse Treat 28(Suppl 1):S51–S62

Dickard N, Downs T, Cavanaugh D (2011) Recovery/relapse prevention in educational settings for youth with substance use & co-occurring mental health disorders: 2010 Consultative sessions report. US Department of Education, Office of Safe and Drug-Free Schools, Washington, DC. http://www2.ed.gov/about/offices/list/osdfs/recoveryrpt.pdf

Easton M (2008) Drug treatment – success or failure? http://www.bbc.co.uk/blogs/thereporters/markeaston/2008/10/drug_treatment_officials_were.html

Evans A (2007) The recovery-focused transformation of an urban behavioral health care system. http://www.attcnetwork.org/learn/topics/rosc/docs/arthurcevensinterview.pdf. Retrieved 7 Feb 2008

Faces and Voices of Recovery (2010) Addiction recovery peer service roles: recovery management in health reform. Faces and Voices of Recovery, Washington, DC

Fiorentine R, Hillhouse MP (2000) Drug treatment and 12-step program participation: the additive effects of integrated recovery activities. J Subst Abuse Treat 18(1):65–74

Godley MD, Godley SH, Dennis ML, Funk R, Passetti LL (2002) Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. J Subst Abuse Treat 23(1):21–32

Godley MD, Godley SH, Dennis ML, Funk RR, Passetti LL (2007) The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. Addiction 102(1):81–93

Gonzales A, Westerberg VS, Peterson TR, Moseley A, Gryczynski J, Mitchell SG, Buff G, Schwartz RP (2012) Implementing a statewide Screening, Brief Intervention, and Referral to Treatment (SBIRT) service in rural health settings: New Mexico SBIRT. Subst Abus 33(2):114–123. doi:10.1080/08897077.2011.640215

Granfield R, Cloud W (2001) Social context and “natural recovery”: the role of social capital in the resolution of drug-associated problems. Subst Use Misuse 36(11):1543–1570

Greenfield TK, Stoneking BC, Humphreys K, Sundby E, Bond J (2008) A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. Am J Community Psychol 42(1–2):135–144

Gryczynski J, Mitchell SG, Peterson TR, Gonzales A, Moseley A, Schwartz RP (2011) The relationship between services delivered and substance use outcomes in New Mexico’s Screening, Brief Intervention, Referral and Treatment (SBIRT) initiative. Drug Alcohol Depend 118(2–3):152–157. doi:10.1016/j.drugalcdep.2011.03.012, S0376-8716(11)00138-4 [pii]

Harris K, Baker A, Kimball T, Shumway S (2008) Achieving systems-based sustained recovery: a comprehensive model for collegiate recovery communities. J Group Addict Recover 2(2–4):220–237

Hasin DS, Stinson FS, Ogburn E, Grant BF (2007) Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry 64(7):830–842. doi: 10.1001/archpsyc.64.7.830, 64/7/830 [pii]

HM Government (2010) Drug strategy 2010: reducing demand, restricting supply, building recovery: supporting people to live a drug free life. HM Government, London

Hser YI, Anglin MD, Grella C, Longshore D, Prendergast ML (1997) Drug treatment careers. A conceptual framework and existing research findings. J Subst Abuse Treat 14(6):543–558

Humphreys K (2006) Closing remarks: swimming to the horizon–reflections on a special series. Addiction 101(9):1238–1240

Humphreys K, Moos RH (1996) Reduced substance-abuse-related health care costs among voluntary participants in Alcoholics Anonymous. Psychiatr Serv 47(7):709–713

Humphreys K, Moos R (2001) Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care? A quasi-experimental study. Alcohol Clin Exp Res 25(5):711–716

Humphreys K, Tucker J (2002) Toward more responsive and effective intervention systems for alcohol-related problems. Addiction 97(2):126–132

Humphreys K, Moos RH, Cohen C (1997) Social and community resources and long-term recovery from treated and untreated alcoholism. J Stud Alcohol 58(3):231–238

Humphreys K, Mankowski E, Moos R, Finney J (1999) Do enhanced friendships networks and active coping mediate the effect of self help groups on substance use? Ann Behav Med 21(1):54–60

Humphreys K, Macus S, Stewart E, Oliva E (2004) Expanding self-help group participation in culturally diverse urban areas: media approaches to leveraging referent power. J Community Psychol 32(4):1–12

Institute of Medicine (2005) Improving the quality of health care for mental and substance use conditions. National Academy Press, Washington, DC

Jason LA, Ferrari JR (2010) Oxford House recovery homes: characteristics and effectiveness. Psychol Serv 7(2):92–102

Jason LA, Davis MI, Ferrari JR, Bishop PD (2001) Oxford house: a review of research and implications for substance abuse recovery and community research. J Drug Educ 31(1):1–27

Jason LA, Aase DM, Mueller DG, Ferrari JR (2009) Current and previous residents of self-governed recovery homes: characteristics of long-term recovery. Alcohol Treat Q 27(4):442–452

Kaplan L (2008) The role of recovery support services in recovery-oriented systems of care: DHHS publication No. (SMA) 08-4315. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Rockville

Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank RG, Leaf PJ (1996) The epidemiology of co-occurring addictive and mental disorders: implications for prevention and service utilization. Am J Orthopsychiatry 66(1):17–31

Kirk T (2008) Creating a recovery-oriented system of care. http://www.facesandvoicesofrecovery.org/pdf/recovery_symposium/GLATTCInterviewKirk.pdf. Retrieved 7 Feb 2008

Kirk T (2010) Connecticut's journey to a statewide recovery-oriented health-care system: strategies, successes, and challenges. In: Kelly J, White W (eds) Addiction recovery management. Springer Humana Press, New York, pp 2009–2235

Kretzmann J (1993) In: McKnight J (ed) Building communities from the inside out: a path towards finding and mobilising a community's assets. ABCD Institute, Evanston

Kyrouz E, Humphreys K, Loomis C (2002) A review of research on the effectiveness of self-help mutual aid groups. In: White B, Madara E (eds) American self-help group clearinghouse self-help group sourcebook, 7th edn. American Self-Help Group Clearinghouse, Dover, pp 71–86

Laitman L, Lederman L (2007) The need for a continuum of care: the Rutgers comprehensive model. J Groups Addict Recover 2(2–4):238–256

Laudet A (2007) What does recovery mean to you? Lessons from the recovery experience for research and practice. J Subst Abuse Treat 33(3):243–256

Laudet AB (2012) Rate and predictors of employment among formerly polysubstance dependent urban individuals in recovery. J Addict Dis 31(3):288–302

Laudet A, Humphreys K (2013) Promoting recovery in an evolving context: what do we know and what do we need to know about recovery support services? J Subst Abus Treat 45(1):126–133

Laudet AB, White W (2010) What are your priorities right now? Identifying service needs across recovery stages to inform service development. J Subst Abuse Treat 38(1):51–59

Laudet AB, Savage R, Mahmood D (2002) Pathways to long-term recovery: a preliminary investigation. J Psychoactive Drugs 34(3):305–311

Laudet A, Stanick V, Sands B (2007) The effect of onsite 12-step meetings on post-treatment outcomes among polysubstance-dependent outpatient clients. Eval Rev 31(6):613–646

Laudet AB, Stanick V, Sands B (2009) What could the program have done differently? A qualitative examination of reasons for leaving outpatient treatment. J Subst Abuse Treat 37(2):182–190

Lo Sasso AT, Byro E, Jason LA, Ferrari JR, Olson B (2012) Benefits and costs associated with mutual-help community-based recovery homes: the Oxford House model. Eval Program Plann 35(1):47–53

Lotfipour S, Howard J, Roumani S, Hoonpongsimanont W, Chakravarthy B, Anderson CL, Weiss JW, Cisneros V, Dykzeul B (2013) Increased detection of alcohol consumption and at-risk drinking with computerized alcohol screening. J Emerg Med. doi:10.1016/j.jemermed.2012.09.038, S0736-4679(12)01210-3 [pii]

Madras BK, Compton WM, Avula D, Stegbauer T, Stein JB, Clark HW (2009) Screening, Brief Interventions, Referral to Treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: comparison at intake and 6 months later. Drug Alcohol Depend 99(1–3):280–295

Majer JM, Jason LA, Ferrari JR, North CS (2002) Comorbidity among Oxford House residents: a preliminary outcome study. Addict Behav 27(5):837–845

Majer JM, Angulo RS, Aase DM, Jason LA (2011) Gambling behaviors among Oxford House residents: a preliminary investigation. J Soc Serv Res 37(4):422–427

Mangrum L (ed) (2008) Final evaluation report: creating access to recovery through drug courts. Texas Department of State Health Services, Mental Health and Substance Abuse Services Division: Gulf Coast Addiction Technology Transfer Center, Austin

Margolis R, Kilpatrick A, Mooney B (2000) A retrospective look at long-term adolescent recovery: clinicians talk to researchers. J Psychoactive Drugs 32(1):117–125

McKay JR (2001) Effectiveness of continuing care interventions for substance abusers. Implications for the study of long-term treatment effects. Eval Rev 25(2):211–232

McKay JR (2005) Is there a case for extended interventions for alcohol and drug use disorders? Addiction 100(11):1594–1610

McKay JR (2009) Continuing care research: what we have learned and where we are going. J Subst Abuse Treat 36(2):131–145

McKay JR, Lynch KG, Shepard DS, Morgenstern J, Forman RF, Pettinati HM (2005) Do patient characteristics and initial progress in treatment moderate the effectiveness of telephone-based continuing care for substance use disorders? Addiction 100(2):216–226

McKay JR, Carise D, Dennis ML, Dupont R, Humphreys K, Kemp J, Schwartzlose J (2009) Extending the benefits of addiction treatment: practical strategies for continuing care and recovery. J Subst Abuse Treat 36(2):127–130

McKeganey N (2010) Controversies in drug policy and practice. Palgrave Macmillan, Basingstoke

McLellan AT, Lewis DC, O’Brien CP, Kleber HD (2000) Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA 284(13):1689–1695

McLellan AT, McKay JR, Forman R, Cacciola J, Kemp J (2005a) Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. Addiction 100(4):447–458

McLellan AT, Weinstein RL, Shen Q, Kendig C, Levine M (2005b) Improving continuity of care in a public addiction treatment system with clinical case management. Am J Addict 14(5):426–440

Millar JR, Aase DM, Jason LA, Ferrari JR (2011) Veterans residing in self-governed recovery homes for substance abuse: sociodemographic and psychiatric characteristics. Psychiatr Rehabil J 35(2):141–144

Miller WR (2007) Bring addiction treatment out of the closet. Addiction 102(6):863

Miotto K, Kaufman A, Kong A, Jun G, Schwartz J (2012) Managing co-occurring substance use and pain disorders. Psychiatr Clin North Am 35(2):393–409. doi:10.1016/j.psc.2012.03.006, S0193-953X(12)00023-8 [pii]

Misch DA (2009) On-campus programs to support college students in recovery. J Am Coll Health 58(3):279–280

Mitchell SG, Gryczynski J, O’Grady KE, Schwartz RP (2013) SBIRT for adolescent drug and alcohol use: current status and future directions. J Subst Abuse Treat. doi:10.1016/j.jsat.2012.11.005, S0740-5472(12)00438-2 [pii]

Moberg DP, Finch AJ (2008) Recovery high schools: a descriptive study of school programs and students. J Groups Addict Recover 2:128–161

Murphy MK, Bijur PE, Rosenbloom D, Bernstein SL, Gallagher EJ (2013) Feasibility of a -computer-assisted alcohol SBIRT program in an urban emergency department: patient and research staff perspectives. Addict Sci Clin Pract 8(1):2. doi:10.1186/1940-0640-8-2, 1940-0640-8-2 [pii]

Nealon-Woods MA, Ferrari JR, Jason LA (1995) Twelve-step program use among Oxford House residents: spirituality or social support in sobriety? J Subst Abuse 7(3):311–318

O'Brien C, McLellan A (1996) Myths about the treatment of addiction. Lancet 347(8996):237–240

Office of National Drug Control Policy (2010) National drug control strategy. Office of National Drug Control Policy, Washington, DC

Office of National Drug Control Policy (2011) National drug control strategy. Office of National Drug Control Policy, Washington, DC

Olson BD, Viola J, Jason LA, Davis MI, Ferrari JR, Rabin-Belyaev O (2006) Economic costs of Oxford House inpatient treatment and incarceration: a preliminary report. J Prev Interv Community 31(1–2):63–72

Oyugi JH, Byakika-Tusiime J, Ragland K, Laeyendecker O, Mugerwa R, Kityo C, Bangsberg DR, Mugyenyi P, Quinn TC (2007) Treatment interruptions predict resistance in HIV-positive individuals purchasing fixed-dose combination antiretroviral therapy in Kampala, Uganda. AIDS 21(8):965–971

Polcin DL (2009) A model for sober housing during outpatient treatment. J Psychoactive Drugs 41(2):153–161

Portenoy R, Payne R, Passik D (2005) Acute and chronic pain. In: Lowinson J, Ruiz P, Millman R, Langrod J (eds) Substance abuse: a comprehensive textbook. Lippincott, Williams and Wilkins, Philadelphia, pp 863–904 (Reprinted from: 4th)

Recovery Academy Australia (2012) Recovery academies. http://home.vicnet.net.au/~recoveryacademy/principles/

Ronel N, Elisha E (2011) A different perspective: introducing positive criminology. Int J Offender Ther Comp Criminol 55(2):305–325. doi:10.1177/0306624X09357772

Rowe M, Bellamy C, Baranoski M, Wieland M, O'Connell MJ, Benedict P, Sells D (2007) A peer-support, group intervention to reduce substance use and criminality among persons with severe mental illness. Psychiatr Serv 58(7):955–961

Ryan JP, Marsh JC, Testa MF, Louderman R (2006) Integrating substance abuse treatment and child welfare services. Soc Work Res 30(2):95–107

Samet JH, Walley AY, Bridden C (2007) Illicit drugs, alcohol, and addiction in human immunodeficiency virus. Panminerva Med 49(2):67–77

Scott CK, Foss MA, Dennis ML (2005) Pathways in the relapse–treatment–recovery cycle over 3 years. J Subst Abuse Treat 28(Suppl 1):S63–S72

Scottish Government (2008) The road to recovery: a new approach to Scotland's drug problem. Scottish Government, Edinburgh

Seligman M (2003) Authentic happiness. Nicholas Brealey Publishing, Boston

Sheedy CK, Whitter M (eds) (2009) Guiding principles and elements of recovery-oriented systems of care: what do we know from the research? HHS publication No. (SMA) 09-4439. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Rockville

Smock S, Baker A, Harris K, D'sauza C (2011) The role of social support in collegiate recovery communities: a review of the literature. Alcohol Treat Q 29:35–44

Substance Abuse and Mental Health Services Administration Office of Applied Studies Treatment Episode Data Set (TEDS) 2005 (2008) Discharges from substance abuse treatment services, DASIS series. Substance Abuse and Mental Health Services Administration, Rockville

Tondora J, Davidson L (eds) (2006) Practice guidelines for recovery-oriented behavioral health care. Connecticut Department of Mental Health and Addiction Services, Hartford

Tonigan JS (2008) Alcoholics anonymous outcomes and benefits. Recent Dev Alcohol 18:357–372

U.S. Department of Education Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention (2010) Meeting the needs of students in recovery. http://www.higheredcenter.org/files/prevention_updates/august2010.pdf. Retrieved 26 Oct 2010

United Kingdom Drug Policy Commission Consensus Group (2007) Developing a vision of recovery: a work in progress. UKDPC, London

Victorian Department of Health (2012) New directions for alcohol and drug treatment services: a roadmap. Victorian Department of Health, Melbourne

Waldron HB, Turner CW (2008) Evidence-based psychosocial treatments for adolescent substance abuse. J Clin Child Adolesc Psychol 37(1):238–261

Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC (2005) Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. Arch Gen Psychiatry 62(6):629–640. doi:10.1001/archpsyc.62.6.629, 62/6/629 [pii]

Watson B, Conigrave KM, Wallace C, Whitfield JB, Wurst F, Haber PS (2007) Hazardous alcohol consumption and other barriers to antiviral treatment among hepatitis C positive people receiving opioid maintenance treatment. Drug Alcohol Rev 26(3):231–239

Weisner C, Delucchi K, Matzger H, Schmidt L (2003a) The role of community services and informal support on five-year drinking trajectories of alcohol dependent and problem drinkers. J Stud Alcohol 64(6):862–873

Weisner C, Matzger H, Kaskutas LA (2003b) How important is treatment? One-year outcomes of treated and untreated alcohol-dependent individuals. Addiction 98(7):901–911

White W (ed) (2008) Recovery management and recovery-oriented systems of care: scientific rationale and promising practices. Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services, Pittsburgh

White W (ed) (2009) Peer-based addiction recovery support: history, theory, practice and scientific evaluation. Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services, Philadelphia

White W, Boyle M, Loveland D (2002) Alcoholism/addiction as chronic disease: from rhetoric to clinical reality. Alcohol Treat Q 20:107–130

White W, Boyle M, Loveland D, Corrington P (2005) What is behavioral health recovery management? A brief primer. www.addictionmanagement.org/recovery%20management.pdf. Retrieved 13 Feb 2008

White W, Scott C, Dennis M, Boyle M (2005b) It's time to stop kicking people out of addiction treatment. Counselor 6(2):12–25

WHO Brief Intervention Study Group (1996) A cross-national trial of brief interventions for heavy drinkers. Am J Public Health 86(7):948–955

Woodford M (2001) Recovering college students' perspectives: investigating the phenomena of recovery from substance abuse among undergraduate students. Dissertation abstracts international section A: humanities & social sciences, 62(7-A), University of Virginia

Young MM, Stevens A, Porath-Waller A, Pirie T, Garritty C, Skidmore B, Moher D (2012) Effectiveness of brief interventions as part of the screening, brief intervention and referral to treatment (SBIRT) model for reducing the non-medical use of psychoactive substances: a systematic review protocol. Syst Rev 1:22. doi:10.1186/2046-4053-1-22, 2046-4053-1-22 [pii]

Zemore SE, Mulia N, Yu Y e, Borges G, Greenfield TK (2009) Gender, acculturation, and other barriers to alcohol treatment utilization among Latinos in three National Alcohol Surveys. J Subst Abuse Treat 36(4):446–456