Exploring clinician attitudes to addiction recovery in Victoria, Australia

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Abstract

Internationally, the alcohol and other drug (AOD) field has an increasing focus on recovery-oriented care, however there has been little research addressing the impacts in Australia. This study explores the attitudes of AOD clinicians towards recovery-oriented care in Victoria. Data was collected from 50 AOD clinicians and managers across six AOD services. Data collection included completion of a structured questionnaire addressing recovery attitudes and beliefs, and semi-structured group interviews. While participants agreed with the broad concept of recovery, there was disagreement over the appropriateness of 'recovery' as a term. The findings support that the development of a set of guiding recovery principles would be more useful than a simple definition.

Keywords: Alcohol, drugs, recovery, clinician attitudes

Introduction

Despite long-term studies leading to the widespread acceptance of addiction as a chronic, relapsing condition, current treatment provision is typically episodic in nature, with limited support offered once the person's drug use is stabilised (Kelly & White, 2011). Drug addiction is extremely heterogeneous, and it can take several decades and multiple treatment episodes before stable recovery is achieved (Hser & Anglin, 2011). Limitations of current treatment provision include a lack of consistency between episodes of treatment, a tendency to focus upon a primary problem rather than routinely addressing related social, health and legal difficulties (White & Kelly, 2011), and the absence of regular involvement of family and significant others in treatment and recovery (Victorian Department of Health, 2012). In addition to formal treatment, engagement with community mutual aid groups, such as Alcoholics Anonymous, can support treatment gains and improve recovery outcomes; however research indicates that treatment clinicians do not routinely refer clients to such supports (Day, Lopez Gaston, Furlong, Muralia & Copello, 2005).

Recovery is a social approach which focusses on building personal strengths and resources, and creating a sense of community spirit and support for individuals, families and peers (Best, 2012). The strongest predictor of recovery is 'recovery capital', which refers to the personal, social and community resources a person can access to manage their journey towards recovery (Granfield & Cloud, 1999). These resources are both internal and external, and can be possessed or accumulated; examples include social group and family membership, financial and material security, employment, personal skills and stable health (Cloud & Granfield, 2008). As well as providing specialist interventions where indicated, clinicians can support building recovery capital; for example by motivating clients and inspiring hope, as well as assertively engaging clients with community supports and supporting people to find a sense of purposeful community involvement (Granfield & Cloud, 1999).

There is no universal definition of recovery, however a definition is important in order to advance academic research, evaluate recovery outcomes, and communicate clearly with stakeholders (Laudet, 2007). One prominent recovery definition from the United States comes from the Betty Ford Consensus Panel, which defined recovery as *'a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship*' (Betty Ford,

2007). Consistent with its strong prohibition stance and the historical roots of recovery in the 12-step movement, abstinence is a core component of recovery in the US (Laudet, 2007). In support of the above definition, Laudet (2007) looked at how recovery is understood by 289 people who self-identified as being in recovery, in New York City. She found that 86.5% of participants define recovery as total abstinence, but that recovery also requires personal growth towards a better life (Laudet, 2007). The UK Drug Policy Commission (2008) also developed an influential recovery definition, which states that '*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*'. Whereas the US endorses total abstinence, recovery in the UK involves freedom from dependence, but may include controlled or moderate use of substances for some people (UK Drug Policy Commission, 2008).

While the above definitions have been useful in guiding policy and demonstrating the scope of recovery as beyond substance use, the subjective and experiential nature of recovery cannot be defined in operational terms (Best, 2012). Additionally, recovery is widely considered a process (rather than an end state), and so is difficult to measure. In lieu of a simple definition, the essence of recovery may be better captured by a number of key principles (CSAT, 2009). Recently, the Recovery Academy Australia developed a set of 15 guiding recovery principles for an Australian context. Researchers from the mental health field developed the CHIME framework for mental health recovery processes, which consists of Connectedness, Hope and optimism for the future, Identity, Meaning and Empowerment (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). The CHIME framework is applicable to addiction recovery and comprises one of the recovery principles in Australia (Recovery Academy Australia, 2012). Other principles for recovery include recovery as a transformative experience of personal growth, abstinence as an individual choice, and the importance of family and community support (Recovery Academy Australia, 2012).

Following recovery initiatives implemented in the United States and United Kingdom, there is increasing interest in incorporating recovery frameworks into policy and practice in Australia. While recovery is clearly articulated in the National Drug Strategy (Ministerial Council on Drug Strategy, 2011), only recently governments and services have considered how to implement the concept in practice (Victorian Department of Health, 2012). In

Victoria, recovery-oriented care is now considered a core component of service delivery (Victorian Department of Health, 2012).

Specialist AOD treatment services provide an opportunity for people to make changes in their lives, and clinicians have a key influence on client engagement and outcomes (Best, 2012). Research supports that clinician attitudes can influence client outcomes, where clinicians who are more positive about being able to support client recovery achieve better client recovery outcomes (Simpson et al, 2009). Conversely, ambivalent or negative clinician attitudes are associated with increased client relapse and re-entry into treatment (White, 2008). Clinician attitudes can be influenced by the organisational philosophies, values and norms of the program they work for (Boyle, Loveland & George, 2011).

Alcohol and other drug clinicians are at the forefront of treatment delivery and will be directly influenced by the introduction of recovery principles into practice. A grass-roots understanding of clinicians views is important in developing a shared understanding of recovery and understanding the treatment sector's readiness for recovery-oriented service delivery. The first aim of this study is to explore what the term 'recovery' means to AOD clinicians in Victoria. The second aim is to understand clinicians' perceived risks and benefits of a transition to recovery-oriented care. Thirdly, the study aims to explore whether attitudes towards recovery and recovery-oriented care appear to be influenced by key variables of AOD service type, or clinician variables such as age, gender, years' of experience or professional background. The final aim of the study is to understand clinicians' expectations for clients with lifetime substance dependence to eventually achieve recovery.

Method

Participants and Recruitment

Study participants were recruited from specialist AOD services in metropolitan Melbourne and regional Victoria. Six services were selected that covered varying treatment modalities of community counselling, residential withdrawal, residential rehabilitation and needle and syringe programs.

Initial email contact was made with managers of selected services with an invitation to participate and an attached flyer to distribute to clinicians. A follow-up phone call was made to managers where no response was received within a week of the email being sent.

Once services consented to participate, the student researcher attended a team meeting with AOD clinicians at their workplace, with the exception of one team which chose to complete only the questionnaire component of the study. Participants consisted of 50 AOD clinicians who completed the questionnaire. Of the 50 participants who completed the questionnaire, 35 participated in a group interview with the researcher. Data collection generally took between 30-60 minutes to complete at each service.

Ethical approval was obtained from the Eastern Health Human Research Ethics Committee (reference number LR22/1213).

Measures

The study employed a mixed method approach, consisting of a self-administered questionnaire followed by an audio-taped group interview.

Questionnaire

Demographic information from participants was collected including age, gender, years of experience and professional background. One forced-choice item addressing recovery definition was used from Laudet (2007): "Which of the following statements most closely corresponds to your personal definition of recovery?" Response categories were Moderate / controlled use of any drug and alcohol, No use of drug of choice / some use of other drugs and alcohol, No use of any drug (including pot) and some use of alcohol, and No use of any drug or alcohol. One item addressing recovery belief was used from the Addiction Belief Inventory (Luke, Ribisi, Walton & Davidson, 2002, as cited in Laudet, 2007): "Recovery is a continuous process that never ends". Response categories were Strongly Disagree, Disagree, Don't Know, Agree or Strongly Agree. Consistent with the aims of the current study, participants were asked to estimate the percentage of people with lifetime substance dependence who will eventually achieve recovery.

The Assessment of Recovery Attitudes Questionnaire (ARAQ) (Best and McCluskey, 2012) was used to measure recovery attitudes. The ARAQ consists of statements covering recovery attitudes of hope and perceived barriers as well as achievements and expectations relating to recovery. Items on the ARAQ are rated on a 5-point Likert scale ranging from Strongly Disagree to Strongly Agree (Best & McCluskey, 2012). The use of a Likert rating scale allowed comparison of responses between different participants as well as comparison of broad trends across organisations. Questionnaire items were scored out of 4, ranging from 0

(Strongly Disagree) to 4 (Strongly Agree). Items were then grouped into subsets for analysis, using an amended version of the subsets in the ARAQ. Subsets consisted of Recovery Hope (6 items), Recovery Barriers (5 items), Recovery Oriented Services (3 items) and Recovery Journeys (8 items). The ARAQ instrument is included as Appendix 1.

Group interview

Semi-structured group interviews were conducted following completion of the questionnaire. Several questions were designed to capture more rich and detailed information about participants' beliefs and attitudes towards recovery, for example participants were asked "What would you consider to be the essential elements of recovery?". Other questions were designed to elicit broader contextual information about perceptions of the recovery movement in Australia, and a transition towards recovery-oriented treatment provision, for example "What do you perceive to be the benefits and risks associated with the Victorian reform of the AOD sector?".

Overview of Analysis

Statistical analysis was performed on quantitative data from the questionnaires using the Statistical Package for the Social Sciences (SPSS) version 20. Analysis included descriptive statistics and exploration of relationships between variables using a Peasons correlational analysis. A one way analysis of variance (ANOVA) was conducted to compare the means of multiple variables and determine whether there are significant differences. Post-hoc testing using Scheffes test of multiple comparisons was then conducted to indicate where the significant differences are (Field, 2005).

Qualitative data from the group interviews were analysed using a thematic analysis. A thematic analysis was chosen in order to organize and identify themes in the data. The thematic analysis followed a 6-phase guide developed by Braun & Clarke (2006) to identify repeated patterns of meaning in the data. Group interviews were transcribed and then coded manually into basic meaningful segments of data. Examples of codes in the data include 'recovery is client driven' and 'confusion over the meaning of recovery'. The prevalence of each code was noted by counting how many times it appeared in the data, for example 'confusion over the meaning of recovery' was raised 8 times across the interviews. Based upon relative prevalence as well as relevance to the initial research questions, codes were grouped together to form key themes. The themes were then reviewed to ensure they

represented the broader data set, and themes were then named and defined in relation to the overall data.

Results

Participant Characteristics

Participants were 50 specialist AOD clinicians consisting of 17 males and 33 females. The mean age of participants was 41.09 (*SD* =9.62) years, and participants had a mean of 8.6 (*SD* = 7.25; range 0.5-30) years of experience working in the AOD sector. Participants worked at one of five types of services: residential withdrawal (*n* = 18*)*, needle and syringe program (*n* = 13), telephone support service (*n* = 8), residential rehabilitation (*n* = 6) and community counselling (*n* = 5).

Participants came from a range of professional backgrounds: AOD counselling (*n* = 11), social work (*n*= 7), mental health (*n* = 6), nursing (*n* = 6), AOD support (*n* = 6), medicine (*n* = 1) and other (*n* = 13), where 'other' consisted of teacher, psychologist, outreach worker, youth worker, public health, community health, welfare, harm reduction, therapist, science and counsellor.

Quantitative Findings

The participants' personal definition of recovery distribution is outlined in Table 1. Nine (18%) participants declined to answer the question.

(TABLE 1)

Table 1 indicates that responses were split between recovery as abstinence or recovery as moderate / controlled substance use.

Basic frequency distributions for the four recovery attitude subscales are shown in Table 2. Raw scores have been rescored out of 50 for clarity, with higher scores representing stronger affiliation with particular attitude subscales.

(TABLE 2)

Pearsons correlational analysis showed a significant positive relationship between recovery hope scores and viewing recovery as a journey ($r = 0.40$, $p = 0.01$). Additionally, viewing recovery as a journey was significantly associated with a strong perception of having a recovery oriented service ($r = 0.31$, $p = 0.05$). There was a negative association between perceived recovery barriers and both recovery hope ($r = -0.25$) and viewing recovery as a journey ($r = -0.37$), however these were not significant.

Pearsons correlation of recovery attitudes against demographic variables showed a significant negative correlation between number of years working in the AOD sector and perceived barriers to recovery ($r = -0.36$, $p = 0.05$). In other words, barriers became more surmountable with greater experience.

Twenty eight (56%) participants estimated the percentage of people with a lifetime substance dependence who will eventually achieve recovery. The range of responses was between 2-85%, with a mean of 33.61% ($SD = 25.64$). Males ($n = 8$) gave a mean of 40% ($SD = 30.12$), whereas females ($n = 20$) gave a mean of 31.05% ($SD = 23.99$). The difference between male and female scores was not significant, $t(26) = 0.83$, $p = 0.41$.

A one way independent measures analysis of variance (ANOVA) was conducted to explore the impact of specific variables (namely service type, professional background and personal recovery definition) on the percentage of people with lifetime dependence who will eventually achieve recovery. These outcomes are summarised in Tables 3.

(TABLE 3)

There was a significant difference in percentage of people who will eventually recover based on service type which was not in the predicted direction, $F(4) = 3.79$, $p = 0.02$. Despite low response rate by some services, results indicate that community counselling and telephone service participants predicted much higher percentage of people to eventually recover as compared with rehabilitation and withdrawal participants.

There was no statistically significant difference between percentage of people who will recover based upon professional background, $F(6) = 1.82$, $p = 0.14$.

A significant difference was found for percentage of people who will recover based upon personal recovery definitions, $F(3) = 3.42$, $p=0.04$. Post-hoc testing indicated that there was a significant difference in percentage of people who will eventually achieve recovery for participants who defined recovery as 'moderate / controlled use of AOD' compared with defining recovery as 'no AOD use'. In other words, differing perceptions of rates of recovery may reflect different thresholds for inclusion as being in recovery.

Qualitative findings

Five themes emerged following the application of a thematic analysis.

1. Recovery as a process towards a meaningful life

Participants from all services viewed recovery as a process involving a holistic approach to improving all areas of life, as demonstrated by two participants; *'the person's substance use is not causing problems in terms of health, relationships, finances, employment'* (counselling participant) and *'that's what I see recovery as – restoration of the mind, the body, the soul'* (rehabilitation participant).

Participants considered recovery to begin once a decision to change has been made, and the process is then driven by what the client wants. Rehabilitation and telephone service participants also felt that recovery is about gaining something in the process; *'It's not about homeostasis and getting back to year zero, it's about making sure your life is much better than it was before' (*rehabilitation participant); *'I think it also means something not just not using anymore or using less or using in a less destructive way, I think it means moving further, like gaining something from that'* (telephone support participant).

1. (b) Differing views towards the need for abstinence

There were differing thoughts about whether recovery requires abstinence from substance use. Participants from counselling and NSP services strongly felt that abstinence is an individual choice; *'If someone wants to use drugs, and they're happy to use drugs and they're happy to be drug dependent, why should I have a problem with it? I mean, if they're causing no harm to others'* (NSP participant); *'some people do continue to use but in a non-problematic way, and that doesn't mean they haven't recovered, well that's the way I view it'* (counselling participant).

In contrast, participants from the rehabilitation service considered abstinence to be a key part of recovery; '*we rarely talk about drugs and alcohol except in broad terms here. That's not what it's about… You don't think about it, you don't want it, it doesn't come as a part of life once you've done that program'* (rehabilitation participant).

2. Language implications and the word 'recovery'

Participants from all services raised the issue of language and implications of the term 'recovery'. Participants from the counselling service, telephone support and NSP all mentioned confusion over what 'recovery' means; *'I'm a bit confused… by what the meanings of recovery actually are. Is it a philosophy, or an actual practice, and I think when I hear about what people think about recovery most clinicians say 'oh yeah', and nod their heads, but they're a bit confused'* (counselling participant). A telephone support participant observed in relation to recovery discussions '*That's what can make it so heated, I think, coz it is so personal, people become quite adamant that this is how to do it and this is how to achieve it'.*

Participants from the counselling, withdrawal and NSP services also spoke about implications of the term in relation to a disease model. One participant from a withdrawal unit stated that '*the word recovery is associated with a disease model... I find it helpful sometimes to explain the disease model to clients like with epilepsy or diabetes, which they can relate to. Although it can be a double edged sword – 'illness' can be distressing also. It can be good for some and not for others'.* One NSP participant strongly opposed the term; 'W*hat I don't really like about the word recovery, is that recovery is what you do when you're sick, when you're diseased, and I don't think that someone who chooses to use alcohol or other drugs is necessarily sick or diseased'.*

In contrast, participants from the rehabilitation and withdrawal services seemed more comfortable with the term; '*We've always talked about it. I'm from a 12 step background where it was used a lot. It's not new'* (withdrawal participant); *'I'm delighted to see us talking about people having the potential to recover and be happy'* (rehabilitation participant).

3. Benefits associated with moving to a recovery oriented service system

Participants agreed that the move to a recovery oriented service system provides a good opportunity to reflect on current practice, and what can be improved upon. One counselling

participant noted that *'It could also be seen on kind of a broader scale in terms of that treatment can be seen as reductionistic in its approach and this is a way of expanding our sense of the individual within their context again'.*

Participants from the rehabilitation service were particularly positive about a recovery framework, and felt that this fits very well with their philosophy of care; '*for this service, I think we'll absolutely embrace it. I think it's what we're all about. And for me personally, I'd say it's about time'.*

4. Concerns associated with moving to a recovery oriented service system

Participants from counselling, telephone support and NSP services expressed several concerns with a move to recovery oriented practice. In one sense, participants felt that recovery is what they do already; *'One of the things I've heard particularly, and I certainly think so myself is – so what's new?'* (telephone support participant).

Participants from the NSP service were particularly concerned about the potential for clients to be excluded from services if they did not appear to have recovery goals; *'If the system's based on recovery, and you don't want that, that's not what you ascribe to – then you don't exist. So there's no services for you'.*

Participants from the NSP & counselling service were unclear how recovery fits with harm minimisation; '*like is it going to replace that* [harm minimisation] *as the overarching framework or is it going to sit alongside that. That's my concern*' (NSP participant). Another NSP participant was concerned about funding for harm minimisation services; *'there's the possibility that services that aren't predicated upon the recovery model, which might be damn effective in say reducing people going to prison or reducing HIV and Hepatitis C, won't get funding'.*

There were also concerns about the cost of a recovery oriented service system, particularly given the perceived lack of definition over the term recovery; *'I am concerned though if it's agenda regarding funding from the government… I don't think it's defined and there's an evidence base if you look at functional recovery and social recovery and so forth but if you're using it as a broad term I think it's tricky and potentially incredibly expensive unless you know what you're funding'* (counselling participant).

A further concern was the perceived association between recovery and the 12-step movement, which was particularly noted by counselling and NSP participants; *'It goes back to my associating it with 12 step movements and them forever trying to impose recovery. And I really struggle with it'* (counselling participant).

5. The significant role of treatment providers in recovery

Participants from all services believe that treatment providers have an important role in supporting individuals with their recovery. Participants from counselling and rehabilitation services spoke about being there for the client as they may come in and out of the service; '*And you come in a second time, we raise the bar for you. We expect much more from you from day one, and by and large people meet those expectations' (*rehabilitation participant); '*the role we have is being available as people move through the process because at times they may seek treatment and go through use and non-use but it's about relationships that people have and it's about people. Clients come to see people, not the organisation'* (counselling participant).

The latter quote demonstrates the perceived importance of individual relationships with clients in supporting recovery. The need for hope by clinicians was perceived as paramount '*we are dealing with a group of people who are highly sensitive… they know if you don't think they can do it'* (rehabilitation participant); *'if we don't have that optimism we convey a negative attitude to our clients'* (counselling participant).

Rehabilitation participants spoke of the value of exposing individuals to people in long-term recovery for providing individuals with hope; *'To come to a place like this and see long term recovering addicts in the staff, to be taken to NA and AA meetings and to hear that you've got members there who are 50 years and for many people it's their first exposure to think – hang on, I could do this'.*

NSP participants spoke about the varied role of treatment providers in responding to the holistic needs of the client; *'I think the role of the service provider is to see if there's anything else we can do to help them, whether it's around their physical health or their mental health or their drug and alcohol use or whatever they want'*.

Discussion

This study used an opportunistic sample of Victorian AOD clinicians to explore attitudes and beliefs towards recovery and a recovery oriented system of care. Key findings are discussed below in relation to the study aims.

What recovery means to AOD clinicians: Agreement over the concept but not the term

Participants agreed with the overall philosophy of recovery and what it stands for; that is, a holistic process which is about positive outcomes and life improvement rather than a focus on pathology. Consistent with current recovery literature (e.g. Best, 2012; Laudet, 2007), key aspects of recovery included social support, hope, finding meaning, and having individual goals. Participants expressed the belief that the philosophy of recovery (in its broad sense) encapsulates what treatment is all about.

While participants agreed with the overall notion of recovery, considering a recovery definition and its implications proved more contentious. The importance of language in terms of definition has been well documented previously (White, 2007), and is echoed in the current study. The origin of 'recovery' in relation to the 12 step movement has continued to influence perceptions of what recovery is about (and in particular its associations with abstinence) (White, 2007). Further debate over the appropriateness of the term was based on philosophical grounds. Whereas in the US addiction is widely considered as a chronic and relapsing disorder (Laudet, 2007), participants in the current study had mixed views about whether or not they agreed. Part of this philosophical divide may be explained by the historical presence of two distinct approaches towards addressing substance use. Prior to the more extensive development of specialist AOD treatment services, the main options for addiction treatment were either by medical professionals, or by non-government charitable organisations which subscribed to alternative rather than medical models (McArthur, 1999). In addition, organisational philosophy and treatment type is likely to have contributed to clinician attitudes (White, 2008).

This study supports the view proposed by recovery research (e.g. CSAT, 2009) that recovery may be best explained by a set of overarching principles rather than a specific definition.

Attitudes towards adopting a recovery-oriented system of care: Mixed views

Related to their interpretation of 'recovery', participants expressed differing views towards a recovery oriented system of care and what this meant to them. As interpretations of recovery

will necessarily be influenced by cultural and contextual factors, so will a recovery oriented system of care need to be implemented in a way which is conducive to an Australian context. Recovery efforts in the US and UK both noted that such a reform will take time and involve considerable efforts to work with and challenge existing organisational philosophies and clinician attitudes (Best, 2012; Kelly & White, 2011).

Some NSP and community counselling participants raised concerns that an association between recovery and abstinence may threaten existing harm minimisation services as well as exclude or stigmatise clients who do not have goals consistent with a recovery framework. Concerns included a lack of clarity over key factors such as whether 'recovery' under the reform would require abstinence, and how existing harm minimisation services would be integrated. In contrast, rehabilitation participants were extremely positive towards the AOD reform. They identified key aspects of their service which are consistent with a recovery framework, such as the value of exposing clients to other people in recovery, particularly staff members. Recovery models strongly promote the idea of 'recovery coaches', where people in recovery work directly to support current substance users (Hser & Anglin, 2011).

The view that specialist treatment will have an important ongoing role under a recovery framework is supported by literature (e.g. Hser & Anglin, 2011). The notion of 'treatment career' describes the need for most clients to engage in multiple periods of treatment over time, which can contribute to incremental progress (Hser & Anglin, 2011). A recovery framework aims to ensure consistent and integrated treatment for clients, rather than discrete episodes of treatment (Victorian Department of Health, 2012).

Research indicates that clinician factors have a central role in influencing client outcomes, over and above specific treatment modalities used (Najavits et al, 2000). Factors such as professional background and the recovery status of clinicians do not appear to influence outcomes; rather, therapeutic alliance, empathy, enforcement of clinic rules, ability to make appropriate referrals and attitudes towards substance use disorders may be more important (Najavits et al, 2000). The importance of a positive therapeutic alliance with clients which endures over time may be one way in which AOD clinicians strive to provide more consistency for clients as they come in and out of treatment. Key clinician attitudes of hope and positivity in supporting client outcomes are supported by literature (Simpson et al, 2009).

Factors influencing clinician attitudes

The current study found that clinician attitudes towards recovery were significantly related to their years of experience and perception of how recovery oriented their service was. Findings suggest that more experienced clinicians are able to overcome potential barriers to recovery for their clients. This may be related to factors such as increased confidence in their role and greater knowledge of available resources. The role of organisational factors in influencing clinician attitudes has been discussed previously (Boyle et al, 2011; White, 2008). This can include overall philosophy of the organization, as well as perceived support such as supervision, training, workload and support from colleagues (Skinner & Roche, 2005). While training and education can be useful, it is important that organisations have the available structures in place to support the implementation of new learning and practices (Boyle et al, 2011). In addition, existing cultural norms of an organisation can influence clinician values and beliefs (Boyle et al, 2011). In creating a culture supportive of change and best client outcomes, a balance is required between providing organisational support to clinicians as well as clinicians being aware of the importance of their attitudes (Najavits et al, 2000).

Expectations for recovery

Debate over the meaning of the term recovery may have contributed to only just over half of participants agreeing to provide an estimation of the percentage of clients they believe will eventually recover. The average participant estimate of 33.6% was considerably lower than that reported by the literature. A review of 450 recovery outcome studies found that on average 49.9% of people with lifetime substance dependence eventually achieve recovery; this figure was higher at 53.9% for studies conducted since 2000 (White, 2012). Part of the difficulty in measuring recovery is due to the extremely heterogeneous nature of addiction, and different ways of interpreting what constitutes recovery (White, 2012). Individuals entering treatment are likely to have higher dysfunction and lower recovery capital, compared to those who do not seek treatment (Best, 2012). Furthermore, clinicians may have lower overall expectations for recovery due to the clients they see having more severe associated problems (White, 2012).

Participant expectations were strongly influenced by service type and personal recovery definition. Perceived threshold for recovery would clearly affect recovery expectations. Rehabilitation participants expected lower overall rates of recovery. This was related to a higher threshold for recovery (abstinence), and qualitative discussions suggestive

of recovery being sustained long-term change. In contrast, counselling, telephone support, and NSP participants had lower thresholds for recovery (more likely to view as moderate/controlled use) and did not discuss what timeframe they would consider recovery to require, so reported higher average expected recovery rate.

There are a number of limitations to this study. The study was limited in scope and duration due to its nature as a student project. Convenience sampling of participants introduces potential selection bias and limits generalizability to a wider population of AOD clinicians. Additionally, the inclusion of only one organisation for each service type limits robust comparison between groups. The low response rate for some questions may have further limited robustness of findings. The ARAQ instrument does not have existing psychometric testing of its properties, limiting reliability and validity of quantitative data. The term 'recovery' was used throughout the ARAQ without operational definition; leading to responses based on individual interpretation of the term. However, this was considered appropriate given the study's aim to explore interpretations of recovery.

Conclusion

It is clear that the term 'recovery' is a contentious one, with many different interpretations and associated attitudes. In implementing change, it will be important to take time to work with clinicians and organisations to create an atmosphere supportive of a recovery oriented system of care. A set of overarching principles of recovery is likely to be more inclusive and useful rather than a 'recovery definition' as such. Due to a perceived lack of clarity by some clinicians, ongoing discussions by recovery advocates may help to clarify concerns raised. Future research is required to develop a standardised measure of clinician recovery attitudes with psychometric testing of validity and reliability. This can then be used to evaluate the effectiveness of training programs and readiness to embrace a recovery framework. Further research with a larger sample size could also investigate the role of organisational factors in influencing recovery attitudes, and the preparedness of organisations for change while supporting staff to adjust to a recovery oriented service system.

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Appendix 1: Addiction Recovery Attitudes Questionnaire (ARAQ)

	Strongly disagree	Disagree	Don't Know	Agree	Strongly agree
1. Recovery is a continuous process that never ends					
2. Recovery from addiction is possible no matter what you think may cause it					
3. All people with addiction problems can strive for recovery					
4. The recovery process requires hope					
5. Most clients don't want to come off their scripts					
6. I don't have the time to support clients who want to achieve recovery					
7. I don't have the training to support clients who want to achieve recovery					
8. This service helps clients to achieve lasting recovery					
9. Stability is as much as we can hope to achieve with most of our clients					
10. Most heroin users will never achieve complete recovery					
11. Most problem drinkers will never achieve complete recovery					
12. The job of treatment services is about improving health only					
13. Most of our clients are happy to be on methadone or buprenorphine					
14. Abstinence is a realistic goal for virtually all drug users					
15. Recovery is possible for all people with addictions					
16. Recovery requires the person to take responsibility for their decisions					
17. Recovery does not always mean being completely free from addiction					
18. Recovery requires the person to have support and partnership					
19. Recovery is not a linear process					
20. Everyone's recovery journey is different and personal					
21. Recovery involves redefining one's identity					
22. Recovery involves having meaning and purpose in life					