Defining Recovery



*We will shape the future of recovery with a detached silence or*

*with a passionate voice.*

*~ Bill White*

**Overview**

This module will explore some historical ideas about addiction recovery. The focus of the module will be on discovering current definitions of recovery, reasons for the changing language in the recovery community and addiction profession. This module will also include a discussion and developments in Recovery to Practice nationally and in Texas.

**Objectives**

* Recall the definition of recovery as developed by Substance Abuse Mental Health Services Administration’s (SAMHSA);
* Develop an understanding of resilience; and
* Review 2 reasons using appropriate language when referring to addiction and recovery is important

**Americans in Recovery**

William White researched and published Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011 for SAMHSA. In this work, White reported 5.3 – 15.3%, or 20 and 45 million Americans report being in recovery. Of those Americans who, at one time, met criteria for Substance Use Disorder, 49.9% of them no longer meet these criteria (White, 2012).

**Findings of the William White Research**

***Recurrence of Use***

Once called “relapse”, replaced by “recurrence of use”.

In this report, White also analyzed 276 treatment follow-up studies that showed recovery (remission) rates as 47.6% for adults and 42% for adolescents. Information such as White gathered in this report is in low supply due to few sources tracking recovery rates. White suggests this information could be traced through bi-annual community health surveys.

From his analysis, White concluded addiction and recovery should be viewed as fluid, rather than fixed.

Most who return to use following professional services return to use within days and weeks of completion of services. White asserts this points to the need for and value of post-treatment monitoring, support, and early re- intervention (White, 2012, p. 4).

***Community***

The professional intervention has less of a long-term impact than relationships with family and social support.

***Recovery is the Norm***

White found recovery a more frequent outcome of addiction than death or “insanity” (White, 2012, p. 5).

***Abstinence is Relative***

How people define “abstinence” differs. Also, the level of severity of disorders changes from person-to-person. Both of these issues contribute to the difficulty determining exact recovery, remission, and recurrence rates (White, 2012, p. 8).

***Varied Interpretation***

When interviewing people over a two-year period following treatment, White points out various interpretations people have of “abstinence” as:

* Continuous abstinence for the duration of time;
* Virtual or partial abstinence;
* Minimal abstinence – such as, abstinence for the 3-months prior to the two-year interview;
* Current abstinence at the time of the interview only; and
* Involuntary abstinence due to hospitalization or incarceration (White, 2012, p. 5).

***Clinicians Misinforming***

Clinicians working in addiction treatment often see a person at his or her most severe point in the addiction. Therefore, clinicians often interpret this to mean (and frequently say) addiction is progressive, chronically recurring, and only successfully arrested through professional intervention and continuous abstinence. An issue with the viewpoint of many clinicians is that only 1-3% of people with Alcohol Use Disorder exhibit these levels of drinking patterns.

Clinicians are misinforming people in treatment with this information. Epidemiologists who study substance use in the community find 75 -90% of people who experience substance problems do not seek professional interventions. Therefore, epidemiologists view substance problems as self-limiting, rather than progressive.

One of the discrepancies with these two vantage points is in the way addiction is portrayed with such contradiction to the community. Clinicians who report addiction with a regularly recurring nature are portraying recovery as an ongoing attempt to cease use, rather than being a stable state (White, 2012, pp. 11-12).

***Non-Problematic Return to Drinking***

The 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) surveyed 43,093 adults and included data on both abstinent and non-abstinent remissions. Non-abstinent remissions = drinking without symptoms of an alcohol use disorder. This surmises that not everyone who considers themselves in recovery or who previously met criteria for Alcohol Use Disorder are motivated toward change but are not totally abstinent (White, 2012, pp. 25-26).

Details about these findings can be further studied through reading the contents of [Recovery/Remission from Substance Use Disorders](https://www.naadac.org/assets/2416/whitewl2012_recoveryremission_from_substance_abuse_disorders.pdf): An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011 by William White.

**Stable Remission**

*\*Note the outdated diagnostic language used in this study that concluded in 1996. At that time the language was current.*

A long-term study conducted by George E. Vaillant in 1996 attempted to determine the duration of abstinence required for one to achieve stable remission. In this study, two diverse groups of men were the subjects.

The subjects were 268 undergraduate students from Harvard University and 456 non-delinquent inner-city adolescents. This core group was studied bi-annually since 1940. At some point in their life, 21% of the undergraduate cohort and 33% of the inner-city adolescent cohort met DSM-III criteria for Alcohol Abuse.

By 60 years old, 18% of the undergraduate alcohol abusers had died, 11% were abstinent, 11% were controlled drinkers, and 59% were still abusing alcohol.

By 60 years old, 28% of the inner-city alcohol abusers had died, 30% were abstinent, 11% were controlled drinkers, and 28% were still abusing alcohol.

Three similarities between the two dissimilar groups were concluded:

* After 5 years of abstinence, return to use was rare.
* Return to controlled drinking often resulted in relapse.
* Alcohol abuse could continue for decades without remission or progression of symptoms (Vaillant, 1996).

Read [Conversation with George Vaillant](https://onlinelibrary.wiley.com/doi/full/10.1111/j.1360-0443.2005.00999.x) where Vaillant was interviewed by Society for the Study of Addiction.

Read [A Doctor Speaks](https://www.divisiononaddiction.org/html/reprints/vaillant.htm) where George Vaillant was interviewed by The Grapevine, the Official International Journal of Alcoholics Anonymous.

**Challenges with Defining Recovery**

Defining recovery can be challenging. There are several reasons for the challenge:

* No person or organization has been designated the authority of recovery.
* From what a person is recovering appears to influence the way some define recovery.
* The definition can be subjective and often based on personal experience.
* Whether or not abstinence is required to consider a person in recovery is highly controversial.

**Recovery in History**

As you will see in greater detail in the module related to history, attempts to bring aid to those with Substance Use Disorder can be seen as early as 1730’s in Native American tribes.

In 1799, in Native America, [The Handsome Lake Movement](http://nativeamericannetroots.net/diary/610) was formed, evolved into the Handsome Lake religion that still exists today. The core of this religion is abstinence of alcohol and rejecting all other European folkways.

American medicine acknowledged alcoholism as a medical condition in the 1950’s when the [American Medical Association](https://www.ama-assn.org/) (AMA) assigned a list of symptomologies.

It has likely been as far back as when addiction was recognized that people had ideas for how to define recovery. Until the last decade, the biggest voice determining what describes recovery believed recovery occurs through following the 12-steps. However, majorities of people in recovery do not adhere to the 12-steps at their lone program of recovery.

**Many Definitions**

What is your definition of recovery?

Another problem in society, and even in the addiction counseling and recovery field, is there are many definitions of recovery.

*Review Handout 1, What is Recovery?*

**Betty Ford Institute**

****

The Betty Ford Treatment Institute began in 1949 and founded the Betty Ford treatment center in Rancho Mirage, California in 1982.

The Betty Ford Institute and treatment center was co-founded by the former first lady, Betty Ford. Betty Ford sought treatment for her addiction to alcohol and prescription drugs when she was 60-years old. The Betty Ford treatment center is non-profit.

Betty Ford was an outspoken advocate for Alcohol Use Disorder and one of the first public figures to speak of her own journey in recovery.

In 2014, the Betty Ford Center merged with Hazelden.

Hazelden began in the 1940’s is likely one of the most well-known treatment centers in the nation. Hazelden is located in Minnesota. When it first opened, Hazelden was for professional men and treated “alcoholism”. Hazelden is a strong 12-step centered treatment center.

Review The Journal of Substance Abuse Treatment [publication](https://www.naadac.org/assets/1959/betty_ford_recovery_definition.pdf) on this panel.

Betty Ford Institute definition of [recovery](https://www.naadac.org/assets/1959/betty_ford_recovery_definition.pdf):

*“Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship” (Betty Ford Institute Consensus Panel, 2007).*



Betty Ford

**The United Kingdom**

The United Kingdom Drug Policy Commission Recovery Consensus Group formed due to the debate in the UK around how one defines recovery. Similar to the debates in the United States, many in the UK had negative opinions about prescribing medications to a person in treatment or in recovery.

Due to a need for consensus, an independent commission was formed and funded by charitable donations. The commission was tasked with coming to a conclusion about the definition of recovery. The commission began by reviewing the Betty Ford Institute’s definition of recovery.

The UK commission included individuals in recovery and family members of those in recovery; commissioners and practitioners from a wide range of types of care. The participants were from different parts of the UK and consisted of people of different ages and backgrounds. Anyone in the group who worked for an organization was asked to participate according to his or her personal opinion rather than the stance of the organization.

An initial meeting occurred in March 2008 and was facilitated by Professor A. Thomas McLellan, who was also involved on the Betty Ford Institute panel. The definition of recovery was unanimously agreed upon by the group.

Key features of problematic substance use the group identified were:

* Recovery is about the accrual of positive benefits, not just reducing or removing harms caused by substance use.
* Recovery requires the building of aspirations and hope from the individual drug user, their families and those providing services and support.
* Recovery may be associated with a number of different types of support and interventions or may occur without any formal external help: no ‘one size fits all’. • Recovery is a process, not a single event, and may take time to achieve and effort to maintain. The process and the time required will vary between individuals. • Recovery must be voluntarily-sustained in order to be lasting, although it may sometimes be initiated or assisted by ‘coerced’ or ‘mandated’ interventions within the criminal justice system.
* Recovery requires control over substance use (although it is not sufficient on its own). This means a comfortable and sustained freedom from compulsion to use. This is not the same as controlled use, which may still be harmful. Having control over one’s substance use means being able to make the choice to use a substance in a way that is not problematic for self, family or society. For many people this will require abstinence from the problem substance or all substances, but for others it may mean abstinence supported by prescribed medication or consistently moderate use of some substances (for example, the occasional alcoholic drink).
* Recovery maximises health and well-being, encompassing both physical and mental good health as far as they may be attained for a person, as well as a satisfactory social environment. The term ‘maximises’ is used to reflect the need for high aspirations to ensure that users in treatment are enabled to move on and achieve lives that are as fulfilling as possible.
* Recovery is about building a satisfying and meaningful life, as defined by the person themselves, and involves participation in the rights, roles and responsibilities of society. The word ‘rights’ is included here in recognition of the stigma that is often associated with problematic substance use and the discrimination users may experience and which may inhibit recovery. Recovery embraces inclusion, or a re-entry into society and the improved self-identity that comes with a productive and meaningful role. For many people this is likely to include being able to participate fully in family life and be able to undertake work in a paid or voluntary capacity (UKDPC, 2008).

View the [report](http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20A%20vision%20of%20recovery_%20UKDPC%20recovery%20consensus%20group.pdf) in entirety.

United Kingdom (UK) Drug Policy Commission Recovery Consensus Group definition of [recovery](http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20A%20vision%20of%20recovery_%20UKDPC%20recovery%20consensus%20group.pdf):

*“Recovery is voluntarily sustained control over substance use, which maximises health and well-being and participation in the rights, roles and responsibilities of society” (UKDPC, 2008).*

**Scottish Government**

The intention of the Scottish government was to determine key areas of recovery in order to develop an evidence-based philosophy for treatment systems. William White was involved in the writings used for the government’s purpose.

Some of the poignant findings:

Recovery is most successful when the person being provided services is at the center of the process.

Voluntary recovery increases participation.

There are many paths to recovery.

Medication Assisted Treatment and Recovery must be considered as one of the pathways to recovery.

Concurrence with the William White determined characteristics of recovery include the three core dimensions of change:

* remission of the substance use disorder;
* enhancement in global health (physical, emotional, relational, occupational and spiritual); and
* positive community inclusion (*Scottish government, 2008, as cited by White, 2007).*

The Scottish government’s definition of [recovery](http://www.gov.scot/Publications/2008/05/22161610/12):

*“Recovery is a process through which an individual is enabled to move on from their problem drug use towards a drug-free life and become an active and contributing member of society” (2008, P. vi).*

**New York State**

New York State Office of Alcoholism and Substance Abuse Services (OASAS) answer the question, “What is recovery” on their website in a series of phases:

* The **transition/stabilization** **phase** usually occurs within the first 90 days of recovery, as a person realizes his or her coping mechanisms are no longer helpful and begins the recovery process.
* The **early recovery phase** generally occurs between 90 days and one year, when a person begins to integrate the initial changes in thinking, feeling and action into his or her life. During these first two early recovery phases, a person may attend self-help meetings; mutual assistance meetings, work with a counselor or therapist, or a recovery coach; participate in recovery group therapy; and/or connect with recovery-supportive friends; and/or connect with a faith institution and/or recovery community center. Early recovery has to be sustained and solidified to move into the mid-recovery phase.
* The **mid-recovery phase** occurs after early recovery is stabilized and solidified. It often occurs after approximately one to three years. It is often at this time when the person in recovery may choose to address past issues while establishing a balanced and stable life. A person in this phase of recovery is usually well connected with a recovery-supportive social network and may be involved in individual and/or group counseling with a qualified therapist to address past issues.
* The **maintenance phase**, occurs after about three years of recovery, and it is at this point the process of recovery typically becomes a way of life. A recovering person has accomplished major changes on the physical, mental and spiritual levels, and he or she may now choose to focus on personal interests and ambitions. At this phase of recovery, a person often finds it helpful to reach out to support others on their journey of recovery.
* The**sustained recovery phase** occurs as the person masters the skills to maintain recovery and to continue to pursue health and wellness. Statistically, the risk of return to active addiction is minimal after five or more years. Although sustained recovery has not been studied to any great extent, we do have access to stories of inspiration and hope from individuals and families and communities that were lost and re-emerged in strength, humility and wisdom (New York State OASAS, n.d.).

**SAMHSA's Early Definitions**

One of the well-respected authorities is The **Substance Abuse and Mental Health Association (SAMHSA). SAMHSA** is an agency of the United States government and falls under The US Department of Health and Human Services. SAMHSA’s mission is to “reduce the impact of substance abuse and mental illness on America’s communities” (Elliot, 2013).

SAMHSA has worked to define recovery for multiple years.

SAMHSA defined recovery in 2010:

*“Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence, improved health, wellness and quality of life”* (Center for Substance Abuse Treatment Recovery Summit, 2010).

SAMHSA redefined recovery in 2011 and 2012:

*“Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (*SAMHSA, 2011).

*“Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential in context of health, home, purpose and community”* (SAMHSA, 2012)



**Current Definition**

For this course, we will adhere to the current SAMHSA definition of recovery.

After a years-long effort, on December 22, 2011 SAMHSA released a working definition for “recovery”. In August 2010, SAMHSA convened a meeting of behavioral health leaders, consisting of mental health consumers and individuals in addiction recovery. Together these members of the behavioral health care community developed a draft definition and principles of recovery to reflect common elements of the recovery experience for those with mental disorders and/or substance use disorders (SAMHSA, 2011).

SAMHSA invited comments from the public. There were 1000 students, nearly 500 ideas, and over 1,200 comments on the ideas. Many of the comments received have been incorporated into the current working definition and principles.

**Recovery**

*A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, 2011).*

**Thoughts About Recovery**

**Unique**

Each person is unique; therefore, their recovery path is, as well. Recovery consists of continual growth and improvement. What works for one person does not work for another.

**Abstinence**

The SAMHSA definition of recovery does not include reference to substances. Abstinence is not necessarily a marker of recovery.

**Culture**

Culture must be considered for people in recovery.

**Connection**

Relationships in recovery are important. Relationships with family, friends, and community who support recovery promote resilience and counteract the guilt and shame that often accompany addiction.

**Support**

Recovery support includes treatment services, healthcare, mental healthcare, social relationships, peer services, family, friends, faith-based support, and others in recovery. An increase in recovery support can assist a person new in recovery with staying engaged.

**Resilience**

Resilience is an ability to cope with adversity and challenges. Developing resilience is an important part of recovery growth, as life is full of obstacles and challenges.

**Resilience**

Resilience is the ability to respond to stress, anxiety, trauma, crisis, or disaster. Resilience develops over time and is the culmination of multiple internal and external factors. The work of enhancing resilience for persons with mental and/or substance use problems has its greatest impact during the formative stages to prevent more severe conditions and to promote health (Sheedy, 2013).

**Recovery Related Language**

A person in recovery knows if they are in recovery and how they define recovery for him or herself. The development of a universal definition for recovery is not as important for those in recovery as it is for society.

Over the years, addiction and recovery language have changed.

| **“Old” language** | **“Newer” language** |
| --- | --- |
| DrunkardInebriateAlcoholismJunkieChemical Dependency | In RecoveryRefraining from use Deceleration of usePerson in recoverySubstance Use Disorder |

Perhaps, you can see how language has moved from blaming and harsh into a more person-first idea. How we refer to addiction and recovery is important if we want to have an impact on changing the way society views people with addiction and in recovery. Material in future modules will provide more examples of language changes.

**Language When Seeking Help**

It is important to decrease the shame many feel for having an addiction. Shifting our language can do this. It can also assist to better educate those who may not understand facts about Substance Use Disorder and/or recovery. Many people have a desire to help reduce societal stigma of addiction and recovery by sharing their knowledge and lived experiences. Having one voice and speaking the same language, if you will, is important.



**Consider This….**

Imagine a mother attempting to understand the reason her son continues to use substances despite his many promises and attempts to quit may have multiple conversations or read several articles online about this situation. Imagine the confusion this mom might feel when hearing conflicting language and suggestions.

**Neighbor to mom:** I know what you mean. My great uncle was hooked on crack in 1994. He had to really hit bottom. I mean, we had to pull the rug out from under him. The whole family kicked him to the curb and told him we wouldn’t let him come over, give him money, or even talk to him if he didn’t get some help. That is what you have to do when someone is a drug addict. He ended up being homeless for a while and going to prison before he knew how serious it was. That is hard but it had to be done. Tough love is what you have to practice on addicts.

**Best friend to mom**: That boy just needs Jesus. He doesn’t even go to church with you anymore. He is out running around and making bad decisions. No doctor can cure him. Only Jesus can do that. You keep praying and your prayers will be answered. You know, I read once that God hears the prayers of mothers over all others. You keep praying and you keep telling him how much God wants him to stop. Jesus is what you have to do to get him to stop acting up.

**Treatment center counselor to mom**: Chemical dependency is a disease. Your son needs treatment for his chemical dependency just like a person with diabetes needs treatment. My treatment center has a 90-day program that will help him change his life. Your son has a chronic condition. His willpower alone is not enough to stop his use. Your support will be important to him while he is in treatment. Treatment is what he needs.

**Person in 12-step recovery to mom**: I know what he is going through. I put my mom through the same thing when I was out there. Tell him to get to a meeting. That is the first thing. Once he gets there he needs to get a sponsor and work the steps. He has to stay away from the people, places, and things that keep him sick. The steps are what he needs.

**Blog found on the Internet**: There is no evidence that addiction is a disease. People can change if they want it badly enough. People that believe this are just being victims. They don’t need treatment. They don’t need 12-steps. They need to change their behavior. Education and analyzing behavior can help him with that. Addiction cannot be treated but behavior can be changed.

Each scenario is based on actual conversations. Everyone has a different experience with addiction and recovery; therefore, everyone has a different idea of the best course of action to change. There is truth in all of these scenarios. There is definitely truth to the person sharing their advice. I am sure you can now envision how these conflicting pieces of guidance might confuse the person seeking solutions.

A number of other organizations and writings support defining recovery by ***quality of life*** rather than the historically more rigid definitions.

**Surgeon General’s Report**

In November 2016, The Surgeon General released the first report on Alcohol, Drugs, and Health. With 23.5 million Americans experiencing issues with substance use, one might wonder the reason this is the first report to ever be released. The findings in the report echo information the recovery community has long believed and experienced.

The key findings of the report show us:

**Neurobiology of substance use, misuse, and addiction**:

* Addiction is a chronic brain disease and has the potential for recurrence and recovery;
* The addiction progress involves a three stage cycle that becomes more severe when continued;
* Brain functioning as the addiction cycle progresses reduces the person’s ability to control use showing disruptions in three areas of the brain: the basal ganglia, extended amygdala, and the prefrontal cortex. Those disruptions: increase desire for substance; reduce pleasure/reward experience and increase brain stress system; reduce function in the executive control system
* Changes in the brain last long after substance use stops;
* Adolescence is a critical period for being “at risk” for use and addiction and all addictive drugs have especially harmful effects.

**Prevention programs and policies**:

* Predictors for risk and protective factors exist from birth to adulthood showing consistency across many different cohorts;
* Many prevention programs are cost-effective and prevent initiation, misuse and long-term substance problems;
* Communities are paramount to making a difference;
* Policies decreasing availability and amplifying cost of alcohol have positive impact;
* Laws related to impaired driving have cut traffic related deaths involving alcohol in half; and
* Evidence lacking to determine impact state policies made to reduce opioid medication prescribing.

**Early intervention, treatment, and management of Substance Use Disorder**:

* Recovery is achievable “…with recurrence rates no higher than those for other chronic illnesses such as diabetes, asthma, and hypertension (Surgeon General's Report, Key Findings, 2016).” with comprehensive continuing care;
* Approximately 1 in 10 people with Substance Use Disorder get specialty treatment.  There is a notable shift occurring;
* Substance use disorders can be “reliably and easily identified” during screening. Brief interventions are effective;
* Treatment for Substance Use Disorder is cost-effective compared with no treatment;
* Treatment goals for Substance Use Disorder are the same for other chronic illness;
* Treatment using Evidence Based Practices (EBP) show better outcomes than non-evidence based treatment, however, EBP are often implemented with “limited fidelity…(Surgeon General's Report, Key Findings 2016).”; and
* The use of electronic health records “could improve access, engagement, and continuing care” (Surgeon General's Report, 2016).”

**Recovery: The Many Paths to Wellness:**

* Abstinence is not always sufficient to define recovery. Recovery includes positive change in the whole person.
* Approximately 50% of adults who once met criteria for Substance Use Disorder are now in stable remission. That equals about 25 million people currently;
* There are many paths to recovery and people will choose the best fit for their needs;
* Mutual aid groups are a key component to effective continuing care;
* 12-Step programs focusing on alcohol are effective;
* Evidence suggests many other recovery supports also have effectiveness; and
* Many other recovery supports have not been studied.

**Health care systems and Substance Use Disorder**:

* Separation of substance use disorder treatment and mental health services has created obstacles to successful care coordination;
* Integration of Substance Use Treatment and mainstream health care can help address health disparities, reduce health care costs for both patients and family members, and improve general health outcomes;
* Many people do not seek specialty treatment;
* Integrating care for substance use disorders into mainstream health care can increase the quality, effectiveness, and efficiency of health care.
* Insurance coverage for substance use disorder services is becoming more robust;
* Health care delivery organizations are being developed to better integrate care;
* Use of Health IT is providing better outcomes;
* One fundamental way to address racial and ethnic disparities in health care is to increase the number of people who have health insurance coverage; and
* The current Substance Use Disorder provider workforce does not have the capacity to meet existing needs.

\*The research conducted to result in the Surgeon General’s Report indicates findings using “well-supported” evidence and “supported” evidence. The evidence is defined as “Well-supported”: when evidence is derived from multiple rigorous human and nonhuman studies; “Supported”: when evidence is derived from rigorous but fewer human and nonhuman studies (Surgeon General's Report, 2016).

You can read the [Surgeon General’s Report](https://addiction.surgeongeneral.gov/) in entirety.

**The Recovery Movement**

The Recovery Movement has turned the focus to community support for people in recovery. A number of significant events occurred in the 2000’s.

* People in recovery, from all walks of life, begin uniting to advocate.
* Training is offered to teach members of anonymous groups how to share about their personal recovery without violating anonymity.
* The Association of Recovery Schools is formed. Recovery High Schools and Collegiate Recovery Programs are being created.
* Recovery Rallies spring up across the country.
* Recovery oriented media grows.
* Peer Recovery Coaching aids people in early recovery.
* A bi-partisan, equity act is signed into law to protect people seeking treatment from being discriminated against.
* The White House Office of National Drug Control Policy creates a Recovery Branch.
* Young people begin finding their voice in recovery advocacy.
* Documentaries about recovery are premiered throughout the United States, including: The Anonymous People [film webpage](http://generationfoundfilm.com/)  and Generation Found [film webpage.](http://generationfoundfilm.com/)

The recovery movement shifts the focus to Recovery Management versus historical treatment focusing on Relapse Prevention. Recovery Management is explained as a time-sustained, recovery focused collaboration between service consumers and traditional and non-traditional service providers toward the goal of stabilizing, and then actively managing the ebb and flow of substance use and other co-occurring disorders until full remission and recovery has been achieved, or until they can be effectively self-managed by the individual and his or her family (White, Boyle, Loveland, and Corrington, 2005).

[What is Behavioral Health Recovery Management](http://www.bhrm.org/media/pdf/pub/BHRM_Primer.pdf)? Explains the idea in more depth.

**Recovery Capital**

The well-known phrase *Recovery Capital* is similar to a bank account. The more you have, the more likely you can achieve long-term recovery. Recovery success is no longer focused solely on the amount of time a person is free from substances. There is much more to recovery than “clean time” that reflects a quality of life increase.

Internal and external assets are necessary for successful recovery. Focusing on Recovery Capital shifts the emphasis from the pathology of addiction to the quality of life that the individual can acquire in recovery (Cloud & Granfield, 2004).

Prior to the idea of Recovery Capital, a person was often told by others in recovery – and even treatment professionals – he or she would have to go back to “square one” following a recurrence of use. The old idea does not account for the experience one acquires during each period in recovery.

Three types of Recovery Capital outlined by Cloud & Granfield are:

**Personal Recovery Capital**

* Physical Personal Recovery Capital
* Physical health
* Financial assets
* Health insurance
* Safe shelter that is conducive to recovery
* Clothing
* Food
* Access to transportation

Having safe and secure shelter, food to eat, clothes to wear, and the ability to get from one place to another is as important as coping with new emotions and the development of adaptive coping skills in recovery. If a person leaves a treatment program with deficient Personal Recovery Capital, they may struggle to stay in recovery more than a person with a full account.

**Human Recovery Capital** is less *tangible, but just as important*.

* Values
* Knowledge
* Education, Vocational training and credentials
* Problem-solving skills
* Interpersonal communication skills
* Problem-solving skills
* Self-awareness, self-esteem and sense of self-efficacy
* Hopefulness and optimism
* A sense of meaning in life
* A perception of one’s past, present, and future

**Treatment in Texas**

Licensed treatment centers in Texas are required to provide groups and individual counseling that focus on many of the areas identified in the category of Human Recovery Capital. However, having the knowledge of adaptive and recovery focused skills alone will cause many obstacles to a fully realized recovery journey. It is important for the person leaving treatment to continue skill building through practice and development of richer skills as recovery continues. The more Human Recovery Capital developed the healthier and fulfilling the long-term recovery.

**Important Factors in Recovery**

**Family/Social**

It is difficult to maintain recovery without support. Family support is optimal, but not always possible. The loved ones of people in recovery can also benefit from the supportive recovery services in a community. Building a relationship and kinship with networks that support recovery may take work and commitment on the part of all who are in the relationship. Networks, social, and organizational relationships are also important in sustaining recovery. When other individuals are willing to engage in supporting a person in recovery, the chances for success are increased.

**Community**

The health of the community to a recovering person is vital. Community encompasses the general attitudes in the community toward addiction and recovery, local regulations and policies that govern addiction treatment and persons with addiction issues and the resources available to treatment and other service agencies. Imagine attempting to maintain a healthy recovery in a community that welcomes you and has accessible services to support your journey rather than a community that treats you as an outcast.

Some areas of community focus could include:

* Efforts to address and reduce stigma
* Diverse local recovery role models
* A full-continuum of substance abuse and mental health treatment that is recovery-focused
* Accessible resources
* Multiple local support organization

**People and Organizations of Note**

**William L. White**

William “Bill” White is a prolific writer and researcher of recovery. NAADAC says about him:

*A major advocate and contributor in addiction and recovery is William “Bill” White. Bill has worked in the addiction and recovery field since 1969. He has spent the last two decades focused on recovery. Bill has authored and co-authored more than 400 articles, papers, peer-reviewed journals, research findings, books, and book chapters. His contributions to the shift the focus from addiction to recovery (have) significantly impacted the direction of the profession. Bill White contributed a great deal of information to the National Association of Addiction Professionals* (NAADAC) Recovery to Practice initiative (NAADAC, 2012).



**Faces and Voices of Recovery**

The Faces and Voices of Recovery website is a wealth of information. On their website we find:

Turning the focus from addiction to recovery is a relatively new phenomenon. Founded in 2001, Faces and Voices of Recovery works to eliminate the stigma associated with people in recovery. FAVOR has indicated that more than 23 million Americans are in recovery from addiction. Faces and Voices of Recovery has been successful in mobilizing people in recovery, friends and family members of people in recovery, and other allies of recovery to share their stories and advocate for changes with laws and attitudes.

Faces and Voices of Recovery (FAVOR) have been considered one of the first and biggest contributors to “the Recovery Movement”.

In 2016, FAVOR:

* Trained 100 Recovery Ambassadors on recovery messaging and the science of addiction and recovery;
* Developed a curriculum and hosted a webinar series on the effects of Addiction on housing and homelessness in America;
* Provided 6,125 advocacy alerts that resulted in people taking action, including messages to congress in support of the 21st Century
* Cures Act that was signed into law in December 2016;
* Honored individuals making a difference in their communities in organizations removing barriers for individuals and families;
* Honored three recovery trailblazers; and
* Hosted a leadership academy for over 100 members of the Association of Recovery Community Organizations.

**Recovery Month**

Another tool to help de-stigmatize and educate about recovery is Recovery Month.

Recovery Month began in 1989 as Treatment Works! which honored the work of substance use treatment professionals in the field. The observance evolved into National Alcohol and Drug Addiction Recovery Month in 1998, when it expanded to include celebrating the accomplishment of individuals in recovery from substance use disorders. The observance evolved once again in 2011 to National Recovery Month (Recovery Month) to include all aspects of behavioral health (SAMHSA, 2016).

Texas has held The Big Texas Rally for Recovery (BTRR) since 2011. The Big Texas Rally for Recovery took place in Austin, Texas at the state capitol from 2011 – 2014. After 2014 the BTRR moved to different cities and the most recent year saw 10 rallies in cities throughout

2011 – Austin

2012 – Austin

2013 – Austin

2014 - Austin

2015 – Downtown Houston

2016 - Dallas

2017 - Galveston

2018 - San Antonio

2019 – Dallas Fort Worth

2020 - The Rally for Recovery was unique this year as we all lived through COVID-19 pandemic social isolation. The Big Texas Rally for Recovery followed suit and held a 3-day virtual event.

2021 - Houston

2022 - Rallies were held in Austin, Dallas, Fort Worth, El Paso, Houston, Midland, and San Antonio.

2023 - Rallies occurred in 10 Texas cities, including Abilene, Austin, Dallas-Fort Worth, El Paso, Houston, Lufkin, Midland, Tyler, San Antonio, and San Marcus.

**Members of the Betty Ford Institute Consensus Panel**

Charlene Belleau Manager, Assembly of First Nations

Robert L. DuPont, M.D. Director, Institute for Behavior and Health

Carlton K. Erickson, Ph.D. Director, Addiction Science Research and Education Center, University of Texas

Michael T. Flaherty, Ph.D. Executive Director, Institute for Research, Education, and Treatment of Addiction

Marc Galanter, M.D. Professor of Psychiatry and Director, Division of Alcoholism and Drug Abuse, New York University

Mark Gold, M.D. Distinguished Professor and Chief, McKnight Brain Institute, University of Florida

Lee Ann Kaskutas, Dr.P.H. Alcohol Research Group, University of California at Berkeley

Alexandre Laudet, Ph.D. Director, Center of Study of Addictions and Recovery, National Development and Research Institutes

Carol McDaid Principal, Capitol Decisions Consulting Group

A. Thomas McLellan, Ph.D. CEO, Treatment Research Institute

Jon Morgenstern, Ph.D. Vice President for Research, National Center on Substance Abuse and Addiction at Columbia University

Eugene Rubin, M.D., Ph.D. Department of Psychiatry, School of Medicine, Washington University in St. Louis

John Schwarzlose, M.S. CEO, Betty Ford Center

William White, M.A. Senior Research Consultant, Chestnut Health Systems

**Members of United Kingdom Drug Policy Commission Recovery Consensus Group**

Bob Campbell Business & Development Manager Phoenix Futures

Alex Copello Professor of Addiction Research & Consultant Clinical Psychologist The University of Birmingham & Birmingham and Solihull Substance Misuse Services

Robin Davidson Consultant Clinical Psychologist University of Ulster

Kate Hall Head of Tier Four Services Greater Manchester West Mental Health Foundation NHS Trust

John Howard User Involvement Manager Reading User Forum (RUF) Dot Inger Carer & Project Co-ordinator SPODA, Derbyshire

Brian Kidd Consultant Addictions Psychiatrist NHS Tayside Substance Misuse Services

Tim Leighton Director, Centre for Addiction Treatment Studies (CATS) Clouds/Action on Addiction

John Marsden Research Psychologist & Senior Lecturer National Addiction Centre, Institute of Psychiatry, London

Soraya Mayet Specialist Registrar - Addictions Tees, Esk and Wear Valley NHS Trust

Tom Philips Consultant Nurse – Addiction Humber Mental Health Teaching (NHS) Trust

Roy Robertson GP & Reader with many years experience in the field of addictions and HIV Edinburgh University 4

Louise Sell Consultant Addictions Psychiatrist & Clinical Director Greater Manchester West Mental Health Foundation NHS Trust

Nicola Singleton Director of Policy & Research UK Drug Policy Commission

John Strang Professor of the Addictions and Clinical Director National Addictions Centre, (Institute of Psychiatry and SLaM South London & Maudsley NHS Foundation Trust)

Ian Wardle Chief Executive Lifeline Project, Manchester

**Resources**

**SAMHSA**

For more information related to addiction, recovery, Recovery Month events, and more, visit the SAMHSA [website](http://www.samhsa.gov).

Congress established the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1992 to make substance use and mental disorder information, services, and research more accessible. SAMHSA provides a publications clearinghouse for free materials.

SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

**Contact information**:

5600 Fishers Lane
Rockville, MD 20857
Phone: 877-SAMHSA-7
TTY: 800-487-4889

**FAVOR**

Faces and Voices of Recovery

840 1st St. NE, 3rd Floor
Washington, DC 20002
Phone: (202) 737-0690
Fax: (202) 737-0695

<http://facesandvoicesofrecovery.org>

**References**

*Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011* (Publication No. Grant No. 5 UD1 TI013593-0). Chicago, IL: Philadelphia Department of Behavioral Health and Intellectual disability Services and the Great Lakes Addiction Technology Transfer Center.

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *What Is Recovery? A Working Definition from the Betty Ford Institute,* *33*(221), 228th ser. doi:https://www.naadac.org/assets/1959/betty\_ford\_recovery\_definition.pdf

Conversation with George Vaillant [Interview by Society for the Study of Addiction]. (2005, October 12). Retrieved April 03, 2018, from https://onlinelibrary.wiley.com/doi/full/10.1111/j.1360-0443.2005.00999.x

Elliot, S. (2013, May 13). About Us. Retrieved from https://www.samhsa.gov/about-us

K., J. (2001, May). A Doctor Speaks. *AA Grapevine: The International Journal of Alcoholics Anonymous*, *57*(12).

New York State. (n.d.). Office of Alcoholism and Substance Abuse Services. Retrieved October 25, 2018, from https://www.oasas.ny.gov/recovery/whatis.cfm

Sheedy, C., M.A. (2013, March). Resilience Annotated Bibliography. Retrieved September 01, 2018, from https://www.samhsa.gov/sites/default/files/resiliency-annotated-bibliography.pdf

*St. Andrew's House. (2010, September 08). Scottish Government. Retrieved November 06, 2017, from https://www2.gov.scot/Publications/2010/08/18112230/6*

*The UK Drug Policy Commission Recovery Consensus Group A vision of recovery* (Rep. No. 020 7812 3790). (2008). Sussex, UK: UK Drug Policy Commission.

White, W. L., M.A. (2012). *Recovery/Remission from Substance Use Disorders:* Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry, 53*, 243- 249.