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THE AUSTRALIAN LIFE IN RECOVERY SURVEY

MAY 2015

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and TURNING POINT

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Turning Point, Easternhealth and South Pacific Private would like to acknowledge colleagues and staff who have worked on this project and dedicated their time. Special thanks goes to Michael Savic and Jock MacKenzie at Turning Point.
In addition, many thanks are also extended to the volunteers who helped with the survey collation as well as all those in recovery who were willing to tell their stories and share their histories.

CONTENTS

BACKGROUND:

METHODOLOGY & HISTORY

“Recovery introduced me to myself. The hardest but most rewarding journey I have ever undertaken.”

Recovery from alcohol and drug addiction is now widely recognised as a journey that takes place over time and in a multitude of ways that reflect personal circumstances, supports and resources. Recovery has been a highly contentious term in Australia and overseas as it has become increasingly prominent in policy discussions.

Yet we still have relatively little evidence (particularly in Australia) about what the experiences are of people who have made this transition in their lives. The purpose of this current report is to summarise the findings of the first major Australian study on personal experiences of recovery and the contrast between what life was like as an addict compared to what life is like now in recovery. To do this, we have built on work from the international recovery movement, using an adapted version of a method and a questionnaire that was distributed in the US.

In 2012, the US recovery advocacy organisation, Faces and Voices of Recovery (FAVOR) published the findings of an online survey of people in recovery to measure the changes in a range of aspects of their wellbeing from the time of their active use to their recovery. The survey was distributed online so that people could preserve their anonymity if they chose to and so the survey could be completed by both those ‘visible’ in their recovery journeys and those who did not want to be a visible recovery figure.

This is a critical way of examining the impact of recovery on people’s lives and there was a strong commitment to repeat this work in Australia, particularly given the opposition to the idea of recovery from a number of prominent clinical and policy figures. A study like this cannot tell us anything about how ‘typical’ these recovery journeys are but it can provide both a sense of hope and direction for those early in their recovery journey about what is possible and the basis for understanding, comparing and mapping recovery experiences across different groups and populations.

With the support and blessing of FAVOR, and encouragement and assistance from William White, the survey was amended to better meet the requirements of the Australian context, and an Australian version was piloted, developed and circulated through the networks of Turning Point and South Pacific Private. Additional questions were added that were considered particularly pertinent about recovery, in relation to social networks and social media, but primarily the questions used were mostly constituted by the same questions in the FAVOR survey to allow comparison between the recovery experiences of the American and Australian recovery populations.

What follows is a summary of the findings of this survey.

METHODS

The starting point for the survey was the US Life in Recovery survey designed by Alexandre Laudet and colleagues on behalf of Faces and Voices of Recovery.

The Life in Recovery survey was adapted to meet the research interests of the Turning Point team and to be suited to the Australian context and was developed for completion as an online tool using Survey Monkey. This was to ensure that the survey could be widely distributed and returned with minimum administrative burden.

The tool was disseminated through all local networks in Victoria through Turning Point and in New South Wales through South Pacific Private, and was more broadly disseminated through the personal networks of those involved, as well as through social media. Additionally, a part-time researcher was recruited in Victoria who used a snowballing technique to recruit an additional sample who completed the instrument on a face-to-face basis.

For the latter purpose, a paper-based version was also produced to ensure that the survey was accessible to those without internet access or who were less comfortable working in this medium. The survey consisted of the following sections:

- About you
- Health and quality of life
- Substance use history
- Recovery journey
- Involvement with treatment and mutual aid groups
- Use of online recovery supports
- Experiences in active addiction
- Social networks in active addiction
- Experiences in recovery
- Social networks in recovery

Questions were primarily tick box completion but participants were given several opportunities to respond to open text boxes to provide more qualitative responses to the questions asked. In total, the Australian Life In Recovery (ALIR) survey consisted of 69 items.

A total of 573 forms were completed and entered directly online or subsequently entered by the research team at Turning Point.

RESULTS

WHO WERE THE PARTICIPANTS?

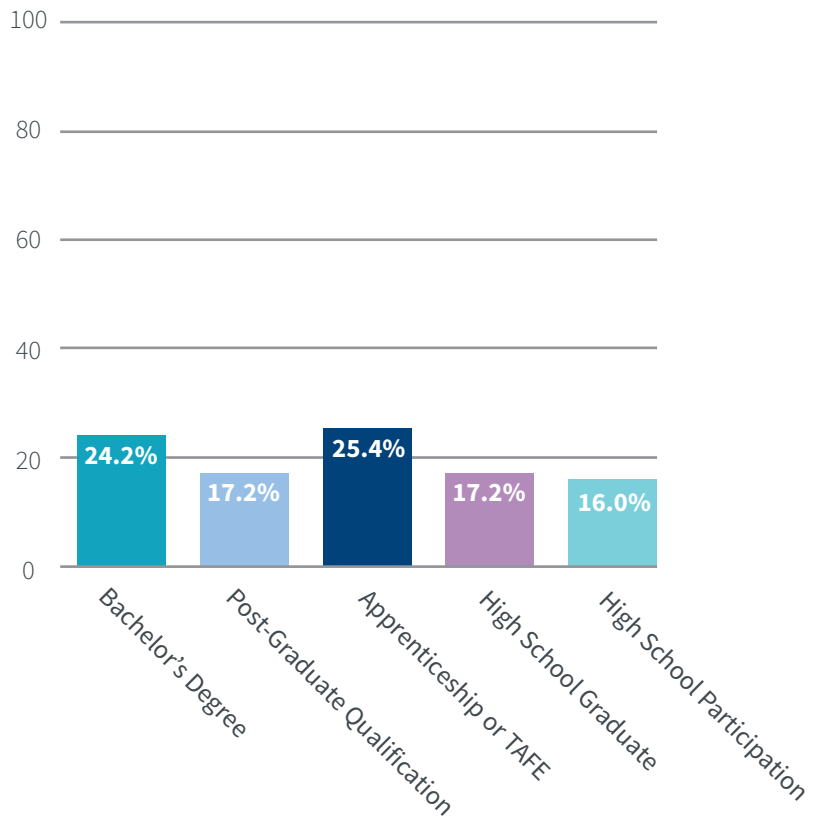
Just over half of those who participated were female (54.6%), and the average age of participants was 43.6 years (although the range was from 15 to 76 years). The vast majority of participants lived in Australia (97.3%) although small numbers of participants completed the survey who lived in the US, Europe, Indonesia and South Africa.

Participants were educated to varying degrees – just over 40% had a university qualification.

In addition, 24.2% had a bachelor's degree and a further 17.2% had a post-graduate qualification. A further 25.4% had an apprenticeship or TAFE qualification, 17.2% were high school graduates and 16.0% had some high school participation, as the graph indicates.

In terms of relationship status, 48.1% of participants were married or in a relationship, 21.1% were single, divorced, separated or widowed and 30.4% were single and never married. Around one-third of participants had dependent children (34.4% of participants had between 1-4 dependent children under the age of 18).

Figure 1: Participant Education



Occupational status varied markedly across the group with just under half (44.6%) employed full time, 19.8% employed part-time, 5.8% self-employed and 5.4% students. In other words, 75.6% were involved in employment or education with the remainder retired (5.6%), involved in home duties (3.2%) and unemployed or on disability support pension (15.7%).

LIFE HISTORIES

Participants were asked about their primary addiction – for 35.3% this was alcohol only, for 11.1% it was drugs only and for 53.6% it was both drugs and alcohol. Nonetheless, the primary problem substance was predominantly alcohol (for 66.0% of participants), followed by heroin and other opiates (14.1%), methamphetamines (4.2%), cannabis (3.7%), cocaine (2.9%), other amphetamine type substances (1.9%) and pharmaceutical opioids (1.9%).

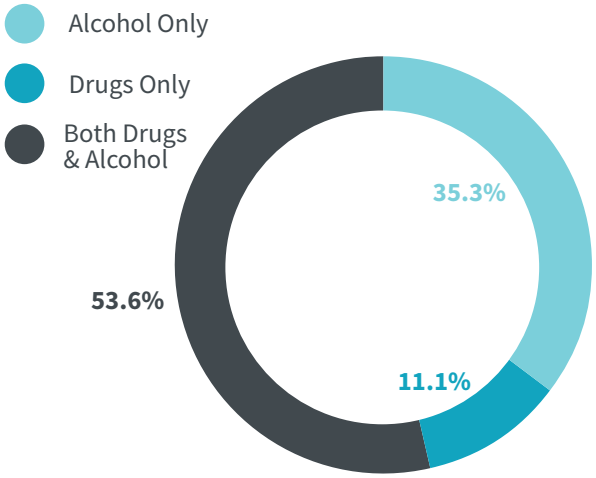


Figure 2: Primary Addictions (Alcohol & Drug Comparison)

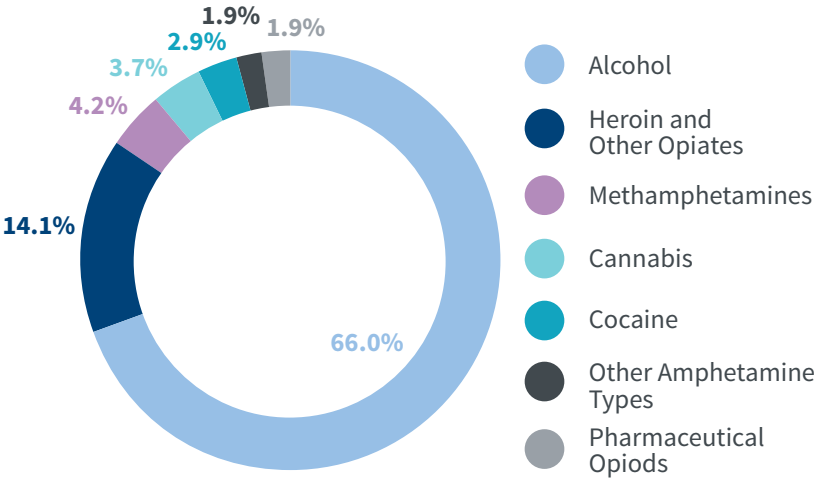


Figure 3: Primary Addictions (Primary Problem Substance)

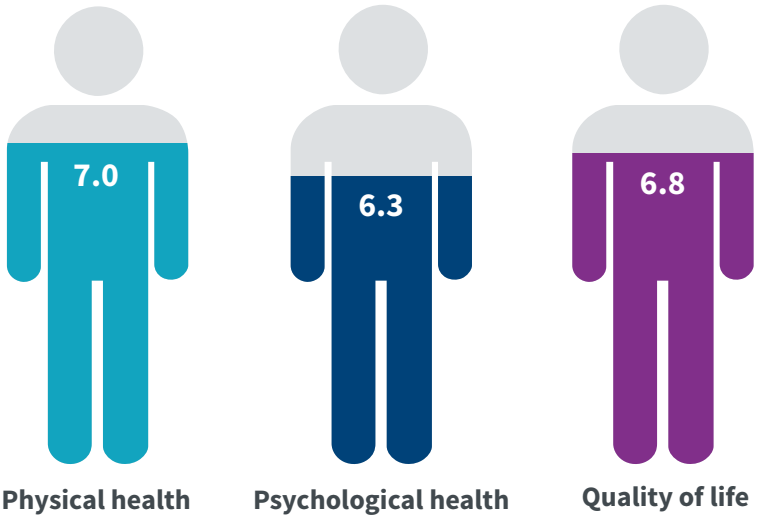
Participants had typically experienced lengthy addiction careers – reporting an average of 18.6 years of AOD use (ranging from 1 to 47 years) and an average of 12.5 years of active addiction (ranging from 1 to 47 years).

There was a significant rate of adverse life events reported across the participants with 91.5% reporting life time mental health challenges and 56.8% reporting some current involvement in mental health treatment.

In contrast, current wellbeing was rated positively on the three wellbeing scales taken from the Australian Treatment Outcome Profile (ATOP) form:

Physical health	Mean = 7.0 (range =0-10)
Psychological health	Mean = 6.3 (range = 0-10)
Quality of life	Mean = 6.8 (range = 0-10)

What this means is that participants were generally in a positive space although some participants had poor wellbeing across all three indicators.



RECOVERY CAREERS

On average, participants reported that it had been 8.5 years since their last use of alcohol or drugs (although that ranged from less than one year to 55 years).

It is interesting to note that the average length of time in recovery is actually slightly longer at 9.3 years suggesting that for many, their recovery journeys started before they achieved stable abstinence. This means that the average age reported at the start of the recovery journey was 34.8 years – although again there is enormous personal variability ranging from 14 to 75 years of age.

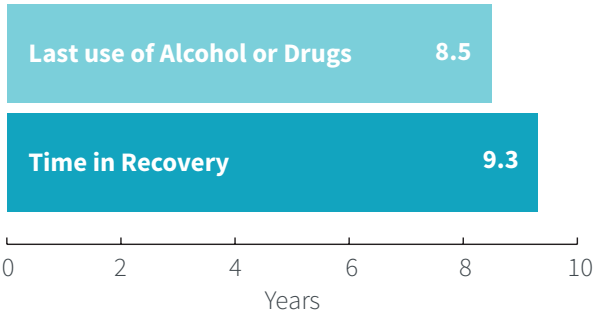
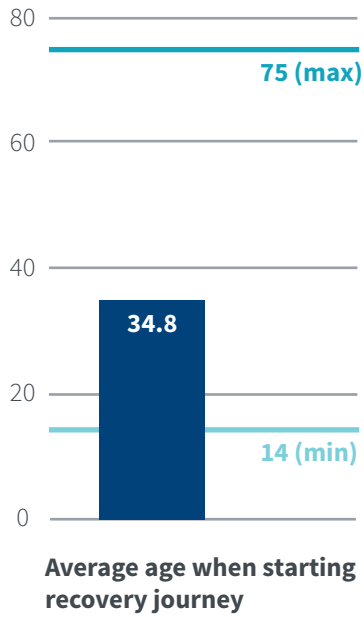


Figure 4: Last use compared to time in recovery



Using the category scheme from the US survey, 28.6% of participants were less than three years in recovery, 29.5% were three to 10 years in recovery and 41.9% were more than 10 years into their recovery. Table 1 shows how length of time in recovery is related to wellbeing:

Table 1: Recovery duration and wellbeing

	Up to three years in recovery (n=83)	3-10 years in recovery (n=161)	More than 10 years in recovery (n=177)	Statistical significance
Physical health	7.0	7.1	7.3	F=0.66 (ns)
Psychological health	5.9	6.8	7.2	F=10.40, p<0.001
Quality of life	6.5	7.1	7.5	F=7.70, p<0.01

Those in the first three years had significantly poorer psychological health and quality of life than those more than three years into their recovery journey but there was no difference in physical health, in terms of statistically robust differences. Nonetheless, there is a stepwise increase in mean scores in wellbeing on all three measures with longer time in recovery.

RECOVERY CAREERS

At the time of the interview, 298 participants (52.0% of the overall sample) were receiving help or treatment for mental health problems. As is shown in Table 2 below, there are marked differences in wellbeing between those still receiving mental health treatment and those not:

Table 2: Currently receiving mental health treatment by wellbeing

	No mental health treatment currently	Mental health treatment currently	Significance
Physical health	7.4	6.7	T=3.92, p<0.001
Psychological health	7.2	5.5	T=8.67, p<0.001
Quality of life	7.5	6.2	T=7.39, p<0.001

It is probably not surprising that those in ongoing mental health treatment or emotional support have reported markedly lower wellbeing scores than those who are not receiving such support.

What is clear is that this diminishes over time – while 86.1% of those in the first three years of recovery are receiving some form of help or treatment for emotional or mental health problems, this is the case for 58.0% of those between three and ten years in recovery and 33.5% of those more than ten years into their recovery journeys ($\chi 2 = 61.23$, $p<0.001$). This may mean that those who have ongoing emotional or mental health problems do not manage to sustain their recovery or that such problems gradually diminish for most of the people who maintain recovery journeys to ten years or more.

RECOVERY STATUS

There was considerable variation in how people described their recovery:

- 79.8% described themselves as 'in recovery'
- 6.3% described themselves as 'recovered'
- 4.5% described themselves as in 'medication-assisted recovery'
- 3.7% reported that 'they used to have an AOD problem but don't any more'
- 5.7% used other ways of describing themselves

Thus, for the vast majority of participants, recovery is seen as an ongoing process.

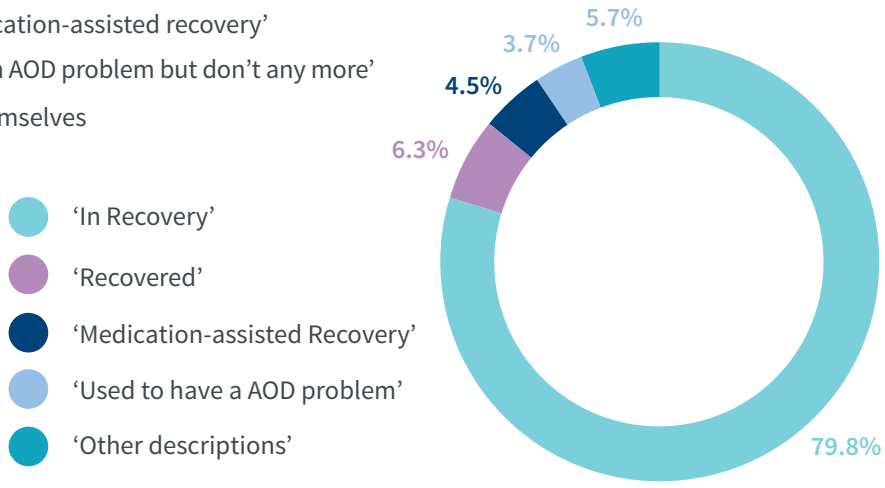


Figure 5: Recovery status

TREATMENT AND MUTUAL AID HISTORIES

The majority (69.8%) reported that they had accessed alcohol and other drug (AOD) treatment services meaning that 30.2% had never done so. Of those who had, 36.6% had taken medications prescribed by a health care professional to help them deal with their drug and alcohol problems. At the time of the survey, 41 individuals (7.2% of the total sample), were currently receiving prescribed medication to deal with their drug and alcohol problems.

A higher proportion (82.0%) had attended a 12-step meeting, with 68.8% attending 12-step meetings at the time of the survey. Current 12-step group attendance involved Alcoholics Anonymous for 57.1% of the sample, Narcotics Anonymous for 24.6%, Gamblers Anonymous for 2.3% and Crystal Meth Anonymous for 1.0%. 11.3% were currently attending Al-Anon (as a loved one or family member) and 6.8% reported that they were currently attending other 12-step groups that included Sex and Love Addicts Anonymous, Overeaters Anonymous, GROW (for co-morbid alcohol and mental health problems) and Adult Children of Alcoholics. SMART Recovery was being attended by 0.5% of the survey participants.

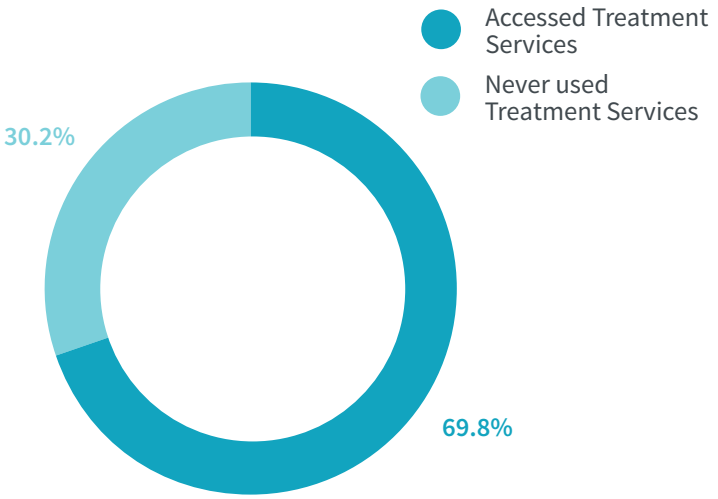


Figure 6: Treatment services

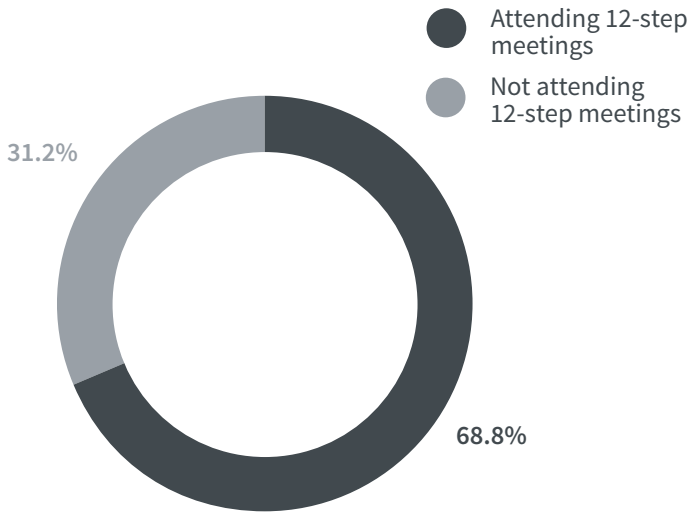


Figure 7: Current attendance of 12-step programs

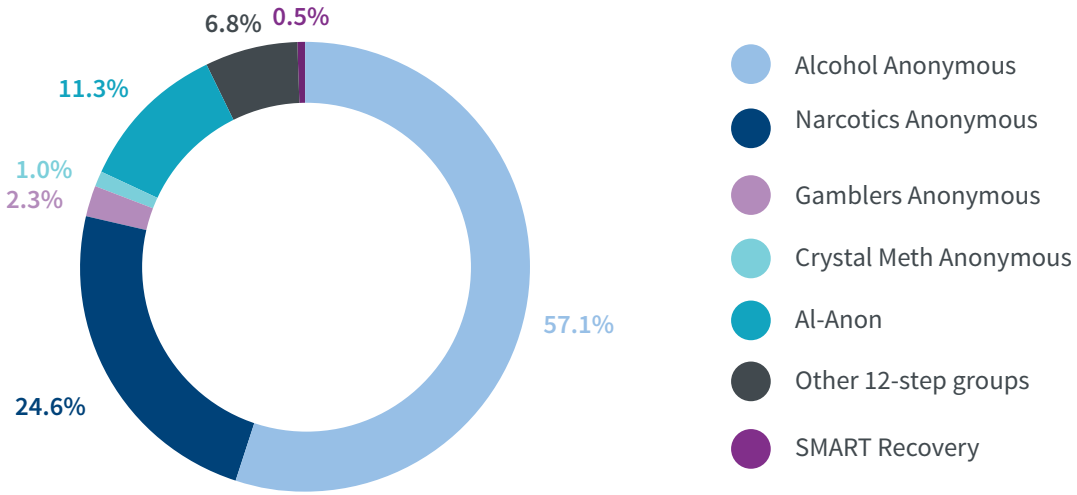


Figure 8: Current 12-step group attendance breakdown

THEN AND NOW:

CHANGES REPORTED IN KEY DOMAINS OF WELLBEING & LIFE

WELLBEING & LIFE

The majority of the sections of the survey ask about a series of life domains as they affected individuals during the active period of their addiction and as they influence them at the time of completing the survey.

Each of the following sections is constructed around a chart that summarises the change from addiction to recovery in each of these life areas.

1. FINANCES

The first set of eight questions asked about the management of finances and the payment of taxes (see Figure 9).

Figure 9: Changes in financial situation from active addiction to recovery

There were marked improvements in paying bills on time, in having your own place to live, in having a good credit rating and paying taxes from when participants were in active addiction to when they were in recovery.

2. FAMILY AND SOCIAL LIFE

Figure 10 presents the same contrast in functioning across a range of domains from the time of active addiction to the time of recovery:

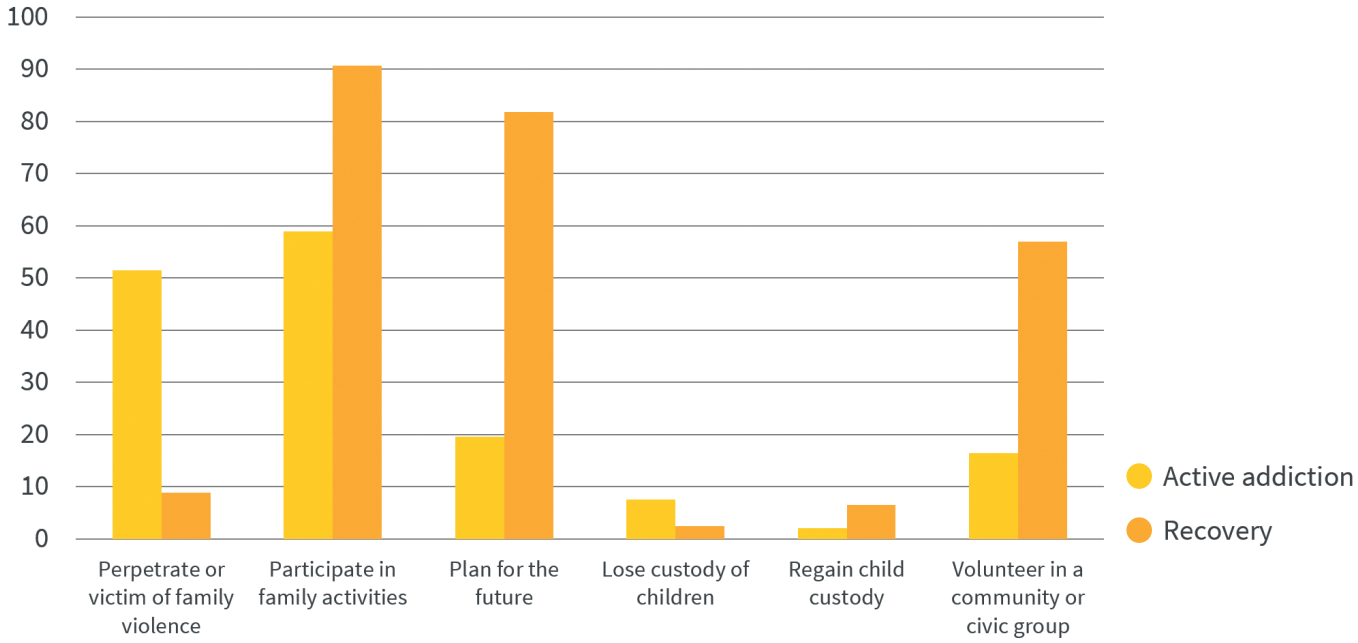


Figure 10: Changes in family and social life from active addiction to recovery

As can be seen, there were **marked reductions in the experience of family violence** from around half of the participants during active addiction to less than 10% in recovery, that were accompanied by positive improvements in participation in family activities and planning for the future. There was also a clear improvement in children returning from care and a massive increase in participation of community and civic groups.

3. HEALTH

Figure 11 outlines the health changes reported from active addiction to recovery:

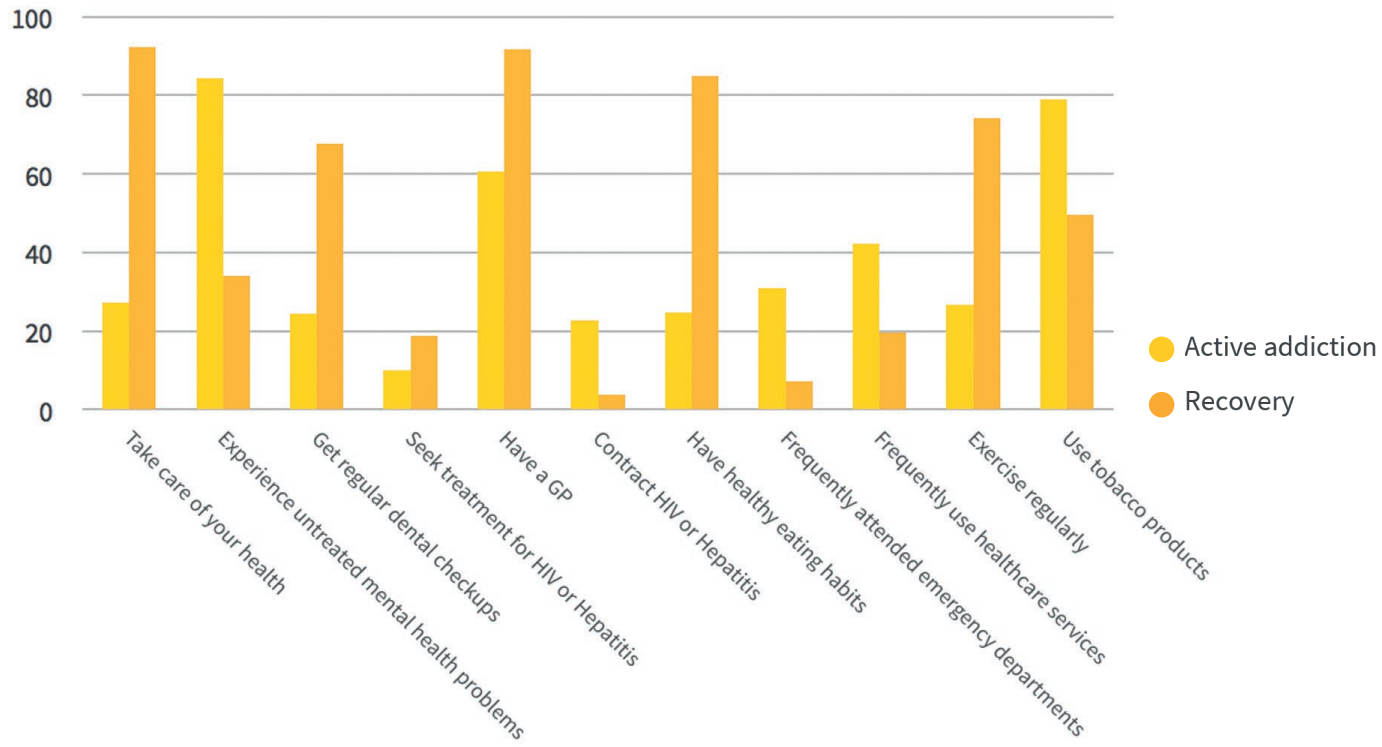


Figure 11: Changes in healthcare from active addiction to recovery

There are marked differences in health functioning as reported by participants with clear improvements in a range of self-care activities – improved engagement with GPs, regular dental check-ups, improved diet and nutrition and regular exercise. At the same time there is a clear reduction in health service utilisation indicated by marked reductions in the frequency of use of healthcare services and emergency department attendance and improvements in the rate of smoking. There is also a significant reduction in experiencing mental health side effects.

Finally, the transition to recovery is associated with marked reduction in incidence of blood borne viruses and some improvement in the level of health seeking for such conditions.

4. LEGAL ISSUES

Figure 12 outlines the changes in criminal justice involvement from active addiction to recovery

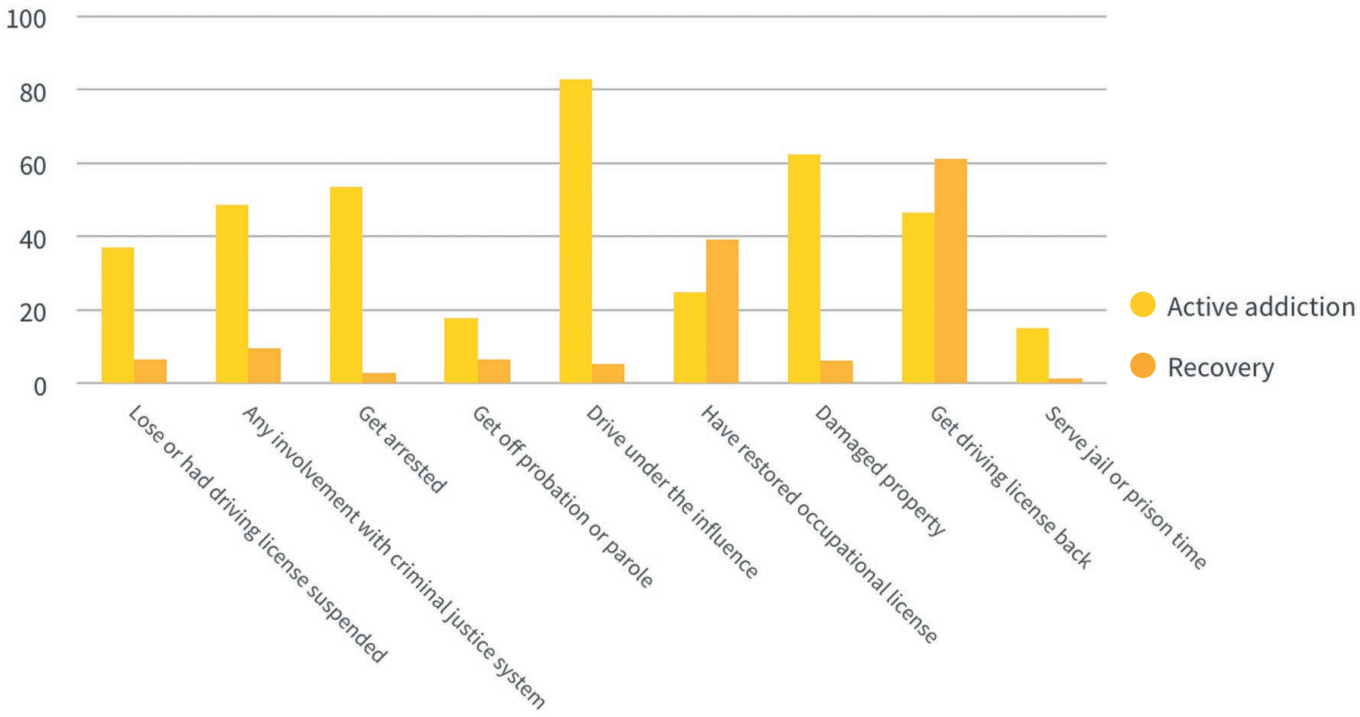


Figure 12: Changes from active addiction to recovery in offending and criminal justice system involvement

There are very striking transitions in involvement with the criminal justice system and overall offending with the most marked transition from 82.9% reporting driving under the influence while in active addiction to fewer than 5% while in recovery.

Likewise, while more than half of the sample had been arrested in active addiction, this dropped to around 2% in recovery, leading to significant reductions in family disruption as well as significantly reduced costs to society. This is also reflected in the more than 90% reduction in imprisonment from active addiction to recovery, while there were considerable improvements in re-obtaining both professional registration and the right to drive once in recovery.

WELLBEING & LIFE

5. WORK AND STUDY

The transitions from active addiction to recovery in the areas of work and study are reported in Figure 13 below:

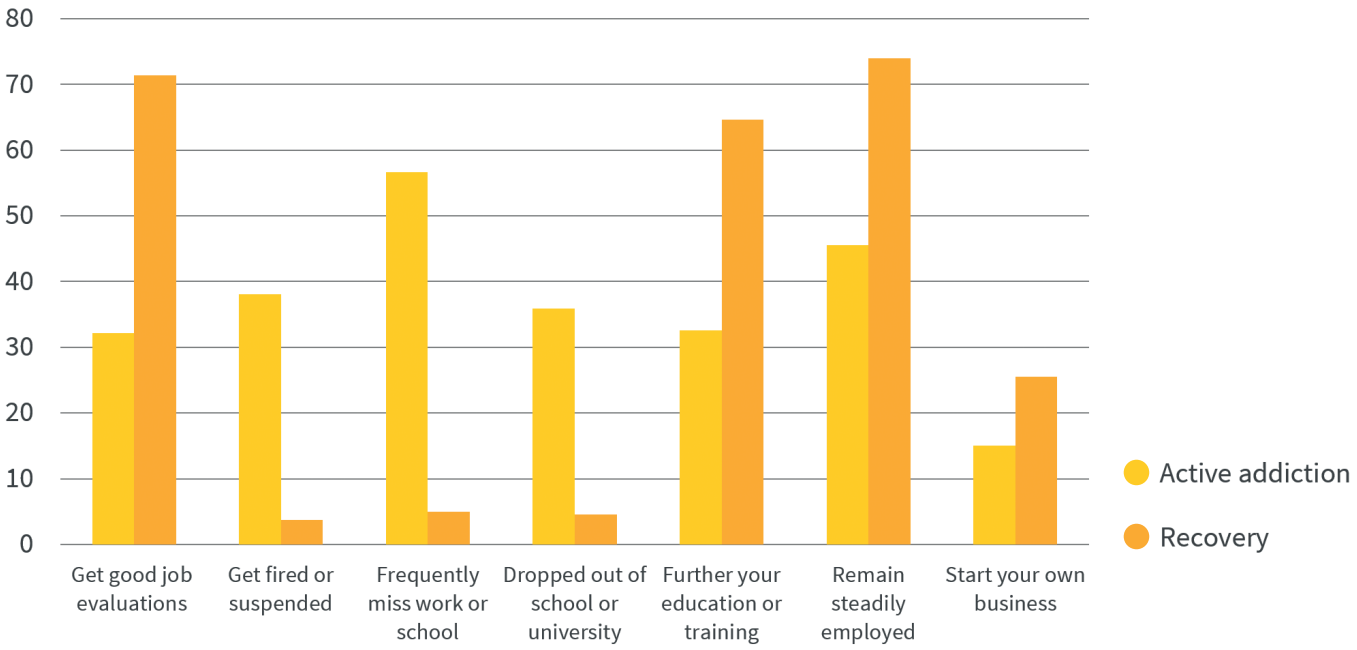


Figure 13: Changes from active addiction to recovery in work and studying

Missing work and being fired or suspended, which had been frequent occurrences in active addiction, were extremely uncommon in recovery, as was dropping out of school and university. In contrast, there were clear improvements in positive job appraisals, in further education and in remaining in steady employment.

Thus, across all of the five areas assessed, there was considerable improvement in the key domains of health, relationships, justice involvement, work and finances reported by participants in the study.

THE SOCIAL NETWORKS AND SOCIAL IDENTITIES OF ACTIVE ADDICTS AND PEOPLE IN RECOVERY

Figure 14 shows the change in the proportion of users in the social network from active addiction to being in recovery:

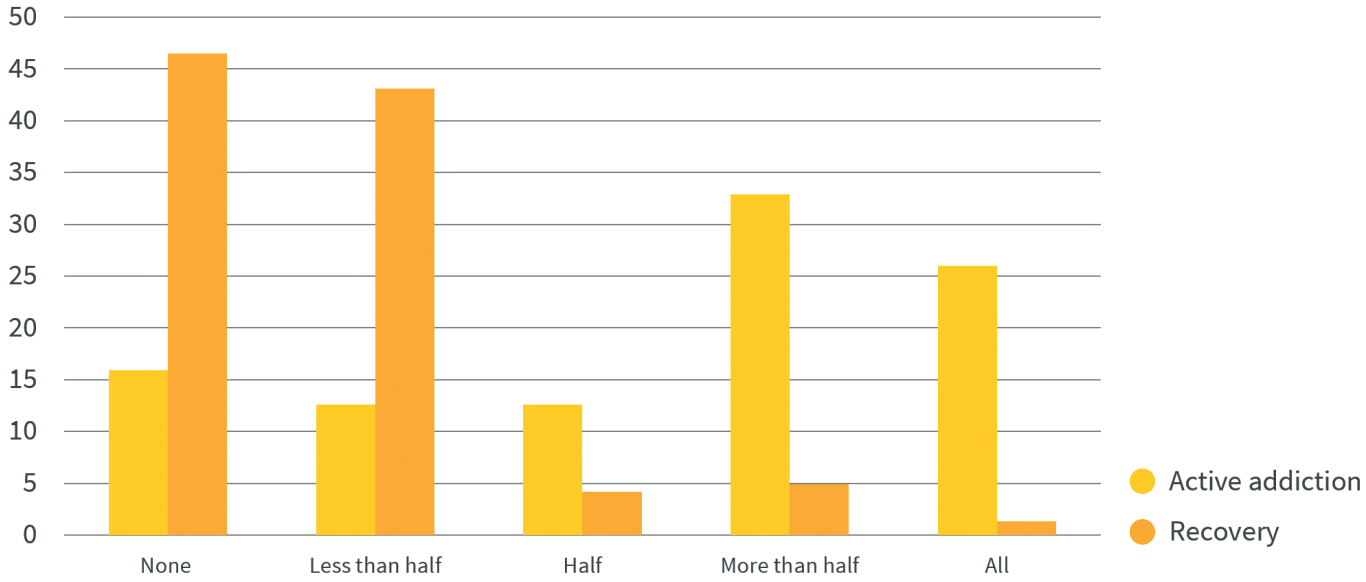


Figure 14: Proportion of social network who are active users while the participant is in active addiction and in recovery

The opposite situation is shown in Figure 15 for the proportion of the social network in recovery:

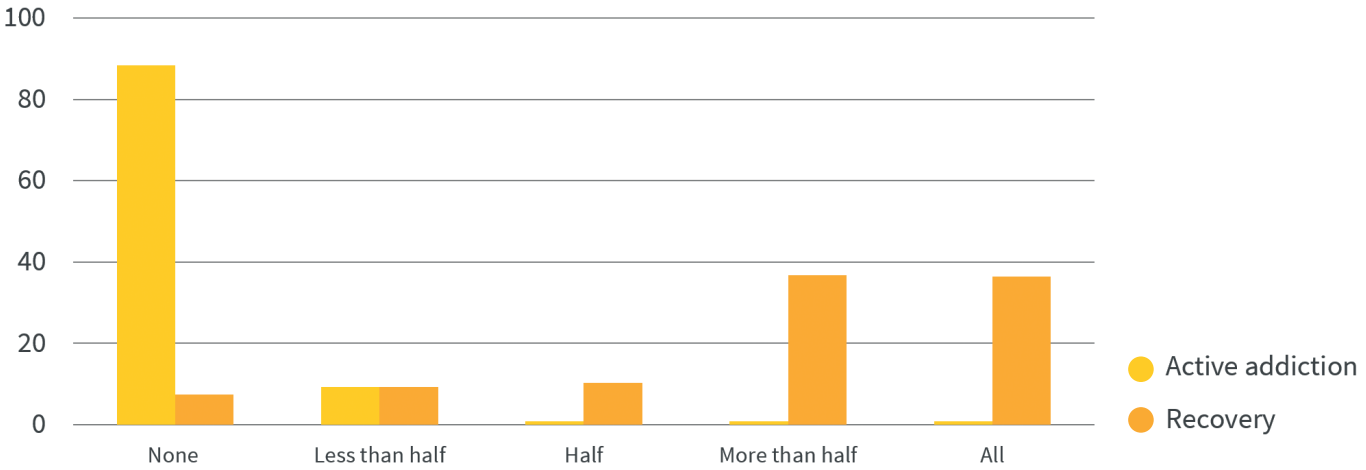


Figure 15: Proportion of social network who are in recovery while the participant is in active addiction and in recovery

Here the position is even more dramatic with the vast majority of participants reporting no contact with people in recovery while they were active addicts, but that this situation is reversed to the extent that 36% of people in recovery have a social network made up only of people in recovery and with less than 10% reporting no social network of recovery.

THE SOCIAL NETWORKS AND SOCIAL IDENTITIES OF ACTIVE ADDICTS AND PEOPLE IN RECOVERY

This is reflected in 'qualitative social capital' – in other words the number of people individuals can rely on. At the peak of their addiction, 38.3% of participants reported that they had nobody they could discuss important things with compared to 2.0% who reported the same in their recovery. By contrast, while 8.6% of participants reported that they had four or more people they could discuss important things with in active addiction, this increased to 65.9% in their recovery.

This is reflected in changes in social group membership – a proxy for connectedness and wellbeing. When asked to rate their membership of social groups out of 10 while they were in active addiction, the mean rating was 2.2 while in recovery it had increased to 4.8.

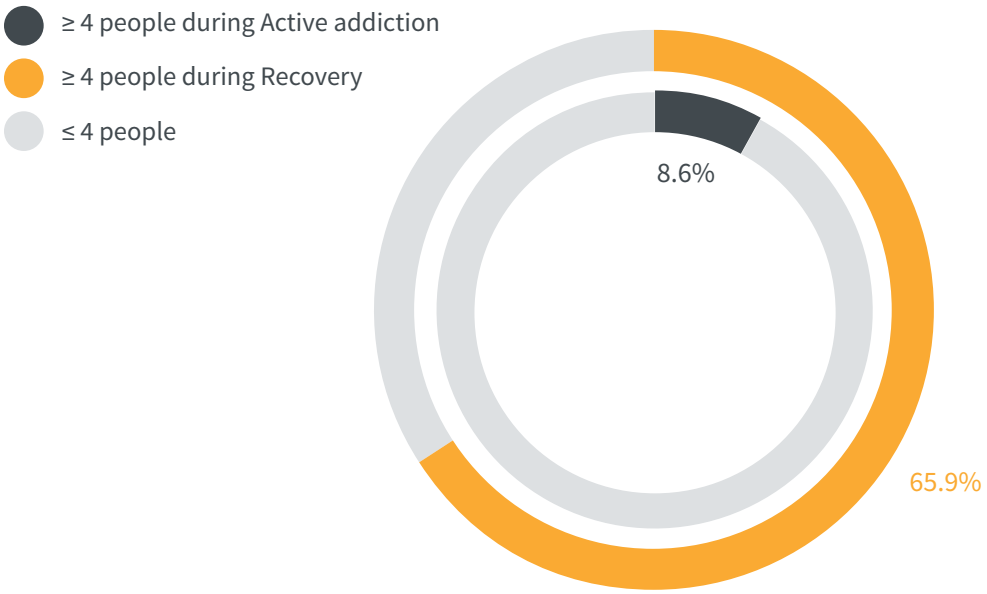


Figure 16: Qualitative social capital (Individuals to rely on)

The same issue arises for social identity – at the time of active addiction, individuals gave a mean rating of 5.9 (out of 10) for how much they identified with people in active addiction compared to a mean rating of 2.1 with people in recovery. While in recovery, this had shifted – the social identification with active use was rated at roughly the same on average at 6.0, the social identification with recovery had increased to a mean of 6.5.

In other words, our participants' social identification with addiction had not diminished but their social identification with recovery had grown enormously.

PERSONAL ACCOUNTS OF RECOVERY

In this section, we summarise the responses to open-ended questions about recovery in the survey, and this will be done in six sub-sections:

- The experience of addiction
- The recovery journey
- Recovery life and experiences
- Positive role of treatment or mutual aid
- Negative experiences of mutual aid
- Multiple paths and multiple sources of help

1. THE EXPERIENCE OF ADDICTION

The pain and trauma of addiction is clearly illustrated in the reports of participants. Active addiction is seen as having destroyed the person's own lives and taken many of the lives of their peers.

"Ruined my life in all areas, physically, mentally, emotionally and spiritually",

"I am alive, none of my peers from that time are alive. Only 5 of the 33 people I was in rehab with are still alive".

"Active addiction completely destroyed any semblance of normality in my life. Everything was reduced to absolutes: the need to get drugs so I could not feel sick, and the use of drugs to numb any emotional or physical pain".

PERSONAL ACCOUNTS OF RECOVERY

2. THE JOURNEY TO RECOVERY

This journey is not perceived as a quick or easy journey by most of the participants. Many recognised that they have had persistent problems long into their abstinence. However, for most people it is a generally positive transition.

"it is difficult for me to remember a lot of the time I was in active addiction because I blacked out so much or was hungover. I am now six and a half years sober and I am glad I am through the 12 steps but I thought that certain areas of my life would have improved more than they have and I thought that my self-confidence would have improved more by now. I never want to go back so I will keep practising one day at a time sober".

"Addiction was part of my journey, I don't regret it but recovery is so much more comfortable".

"After over five years of intermittent relapses and struggling to re-invent myself, I can safely say that I feel at ease in my own company for the first time in my life. I trust that I will do the right thing by myself and my family".

3. THE EXPERIENCE OF BEING IN RECOVERY

Building on the previous section, this was generally very positive and the following examples illustrate the perceived benefits. Many people spoke of what they had achieved since starting their recovery journey.

"I am a productive member of society today: a good partner, parent, employee, daughter, sibling and friend, and I was not any of those things before".

"I experience long periods of peace of mind. I can manage problems really well. I am less inclined to react negatively to adverse events. I have recovered from Hepatitis C. I have deep and meaningful relationships with friends and family. I feel a wide range of emotions and can (mostly) sit with them. I have experienced 15 years of being engaged with and liked by the community instead of being a pest to society and that is absolute gold".

PERSONAL ACCOUNTS OF RECOVERY

4. POSITIVE ROLE OF TREATMENT OR MUTUAL AID

There were a striking number of comments supportive of 12-step groups, as illustrated by the following:

"AA saved my life because I gradually changed and got my self-respect back"

"AA saved my life; I would be dead without AA"

"I have a brand new life thanks to AA. For me, my children and my grandchildren. I am responsible at work and pay my bills"

"In nearly 30 years I have literally witnessed many hundreds of people turn their lives around from chaos and mayhem to lead similarly fruitful lives to the one I live today, overwhelmingly through the agency of their involvement in 12 step programs"

"I could not stop drinking on my own. AA has shown me a new way of living. Life is not perfect but I can now live like a 'normal' person. I have self-respect and dignity and I am a good worker and mother"

5. NEGATIVE EXPERIENCES OF MUTUAL AID

However, not all participants were as positive about mutual aid groups. Mutual aid groups were frequently cited by participants in their survey responses, reflecting the levels of mutual aid involvement in the sample. However, they were not universally endorsed. Engagement in and satisfaction with mutual aid groups varied across the sample as is indicated by the following statements.

"I don't identify with recovery. My alcohol and drug use was both problematic and pleasurable over the past 25 years and albeit it caused great duress",

"The only people I ever met when I was struggling with addiction who used the word 'recovery' were 12 step followers and their approach was completely useless to me."

"AA and other self-help groups were not helpful to me at all: in fact I found them depressing. My support came from professionals who cared for me and my health and recovery – I am indebted to them and would not be here if it were not for them".

PERSONAL ACCOUNTS OF RECOVERY

6. COMBINED APPROACHES

Furthermore, as is consistent with the literature, a number of respondents talked about the benefits of bespoke and blended support from both mutual aid groups and professional treatment services.

"I am an active participant in the AA program – the 12 steps are my program for recovery. Putting the 12 steps in my life and putting the skills I learned at South Pacific Private into my life have given me a life that is full of understanding, patience, great relationships and love".

"Detox set me on the path to recovery and AA helped me to sustain my recovery", while a third respondent reported that "recovery through detox, rehab clinic, 12 step program with AA has completely changed my life and my attitude to life. I feel free and have choices and I am happy for the first time in years".

The overall conclusion by the majority of participants is that recovery is experienced as liberation and is an opportunity not just for a normal life but a meaningful and fulfilling one. That does not mean recovery is without regrets or without problems as highlighted by these two participant statements:

"It [addiction] came close to killing me and robbed me of the thing I most wanted to be in the world and that was to be the best mother I could be. My grown up children are proud of me for my recovery but I lost part of their growing up years that I can never get back".

"My addiction was hell, my recovery has been amazing. I will be forever grateful for the second chance I was given. It took a long time to feel a part of the world when coming out of addiction. It was so hard to fit in with a world I felt so uncomfortable in. But now I love every day. I suffer with depression, and it has been harder than active addiction was but it is in remission and I have learned to live with it. My children are my greatest blessing and I have been able to break the cycle".

COMPARISONS:

US & AUSTRALIAN LIVES IN RECOVERY

In the US, a total of 3,228 people completed the online survey and as in the Australian survey just over half of the sample was female. The samples were also very similar in that the mean length of the substance using career was 18 years in the US and 18.6 years in Australia. The average ages of recovery initiation were also very similar – 34.8 years in Australia and 36 years in the US. 66.0% of the US recovery group had children, compared to 34.4% in Australia – although this is not directly comparable as we only asked about 'dependent children' in the Australian survey.

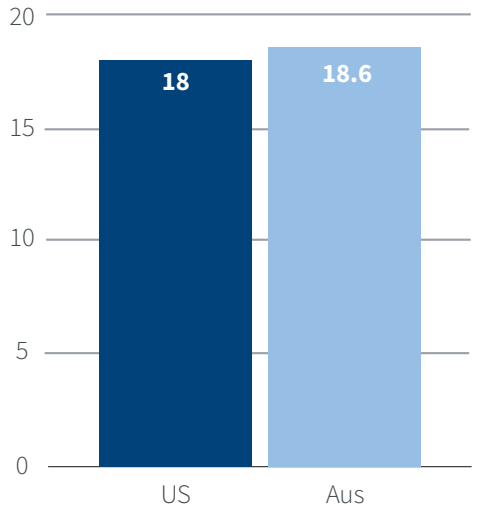


Figure 17: Mean length of substance using career (years)

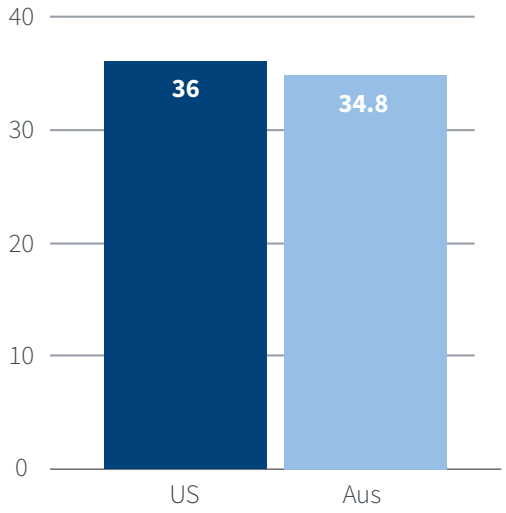


Figure 18: Average age of recovery initiation (years)

While 75.2% of the US sample described themselves as being 'in recovery' and 13.7% as recovered, this was true for 79.8% and 6.3% respectively in Australia – however, we also had the category of 'used to have a drug problem but don't any more' which was endorsed by 3.7% of the Australian sample.

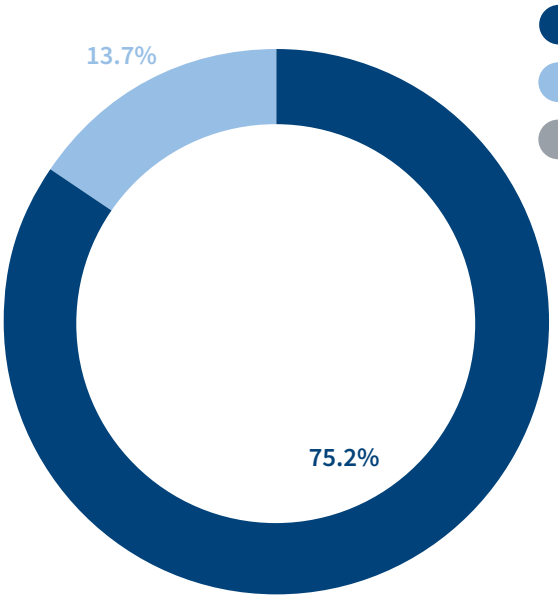


Figure 19: US sample status description

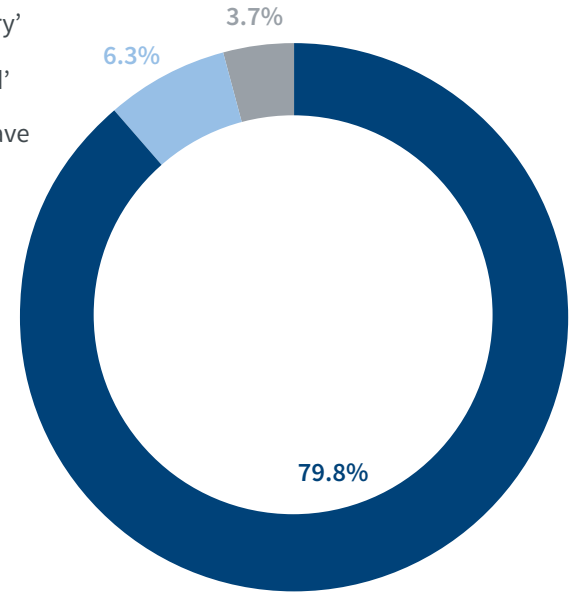
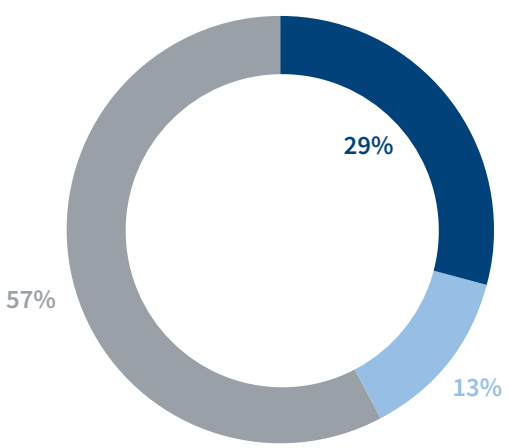


Figure 20: Australian sample status description

In terms of problem profile, primary alcohol was the problem for 29% in the US and 35% in Australia, drugs only for 13% in the US and 11% in Australia, and both alcohol and drugs for 57% in the US and 54% in Australia.



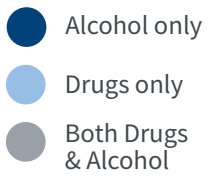


Figure 21: US problem profile

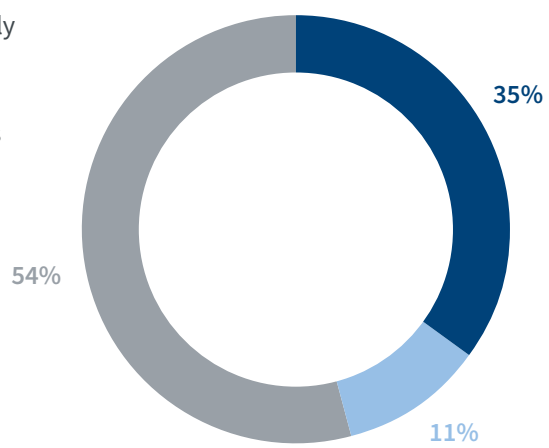


Figure 22: Australian problem profile

In terms of their pathway to recovery, 70.5% of the US sample had received formal treatment, compared to 69.8% in Australia; 94.6% of the US recovery group had attended 12-step meetings compared to 82.0% of the Australian sample. Although a wide range of other mutual aid groups was reported, there was much less frequent use of mutual aid groups other than 12-step in Australia.

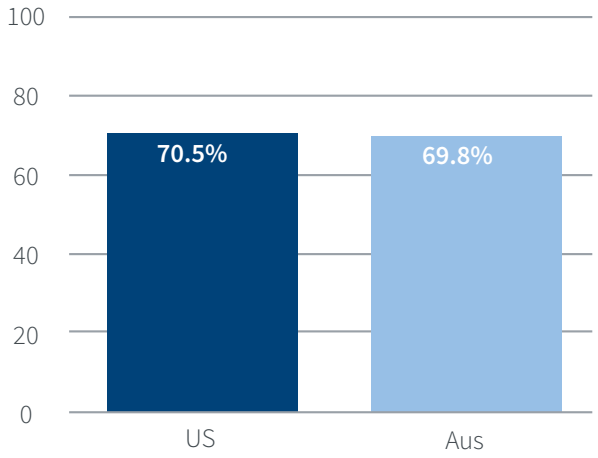


Figure 23: Had received formal treatment

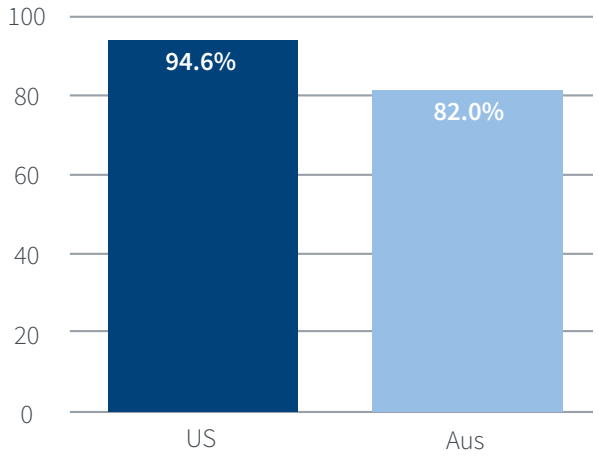


Figure 24: Had attended 12-step meetings

There is a higher rate of lifetime mental health problems in Australia – while 62.4% of the US sample had been treated for a mental health condition, 91.5% of the Australian sample reported lifetime mental health problems and 56.8% reported current involvement with mental health services.

In the US, 55.6% had a bachelor or graduate degree, while this was true for 41.4% in Australia. At the time of the survey, 70.8% of the US sample was employed compared to 68.2% of the Australian participants.

Thus, it is reasonable to conclude that the histories and careers of the Australian sample were very similar to their American counterparts.

THE IMPACT OF RECOVERY IN THE US AND AUSTRALIA

The most dramatic and powerful findings of the US survey, that addiction involves **"many heavy costs ... to the individual and to the nation"** and that **"recovery from alcohol and drug problems is associated with dramatic improvements in all areas of life"** (FAVOR, 2013, page 1) are clearly replicated in the Australian context.

As in the US, where 4 out of 10 individuals experienced financial problems while in recovery, this was also the case for around one in 3 in Australia who owed back taxes and / or had bad debts. However, there were dramatic effects in Australia as in the US of family functioning with significant reductions in domestic violence.

The Australian study also successfully replicates the US findings around health and criminal justice – with marked improvements in positive health markers such as regular exercise, registering with a GP and regular dental check-ups and significant reductions in negative health factors such as ED attendance and untreated psychological problems.

As in the US sample just over half of the Australian sample had a lifetime arrest history (although significantly fewer Australians in recovery had been incarcerated following sentence), the reduction in arrests and in any involvement with the criminal justice system was even more dramatic – around 40% of the US sample and 90% of the Australian sample had no criminal justice system involvement while in recovery.

There were similarly positive differences in work and study – showing the same overall pattern of reduced burden to the taxpayer and the same improvement in personal, family and community wellbeing and connectedness.

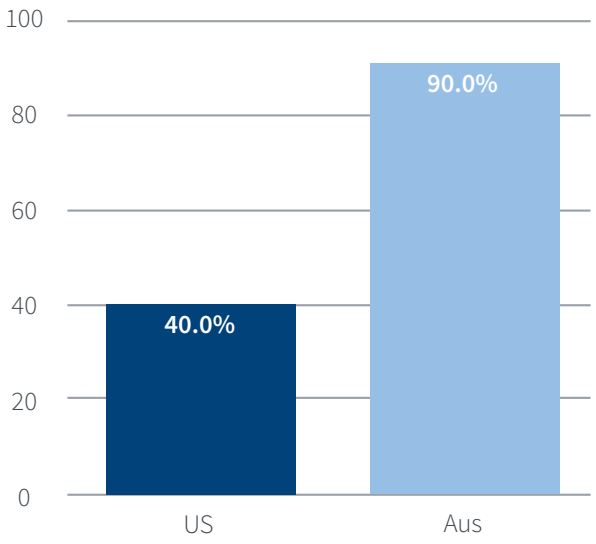


Figure 25: No involvement with the criminal justice system while in Recovery

CONCLUSIONS

This is the first attempt at undertaking a recovery survey in Australia and the results are unequivocal in showing that there is an accessible population of Australians who will classify themselves as being in recovery or recovered and who are willing to complete a survey about their experiences. There is a critical message here for policy makers and treatment providers – that people in Australia can and do recover from addiction problems.

However, there are two nuanced factors that are important to emphasise. The first is that this is a long and challenging journey for many people and that there will still be residual and ongoing problems for many throughout the recovery journey. The second is that, while the majority of participants see themselves as being 'in recovery', for around one fifth of the participants this is not a term they would use preferring to regard themselves as recovered or choosing some other way of describing themselves.

The findings also emphasise the fact that those in recovery are a very diverse population and that there is no single road to recovery, with a proportion of those participating describing themselves as in 'medication-assisted recovery' and a much larger population having ongoing contact with specialist services for addiction or mental health issues.

Nonetheless, the transition reported from active addiction to recovery is a dramatic one as shown in the figures that constitute the core set of results for this study.

This is particularly striking in key areas around social and family functioning where the rate of involvement in domestic violence decreased from more than 50% to less than 10% and in volunteering where participation increased from less than 20% to more than 50%.

Similarly, there is a dramatic reduction in involvement with the criminal justice system from around half to less than one in ten, particularly involving the areas of drink-driving and criminal damage. There is also a dramatic improvement in both employment and education, and in successful engagement and retention of jobs. This is a story of overcoming adversity and transforming lives to make a significant and positive contribution in their families, in their communities and to society.

These results are consistent with the findings of the US Life in Recovery Survey (Laudet et al, 2013) in showing dramatic reductions in pathology and improvements in wellbeing from active addiction to recovery.

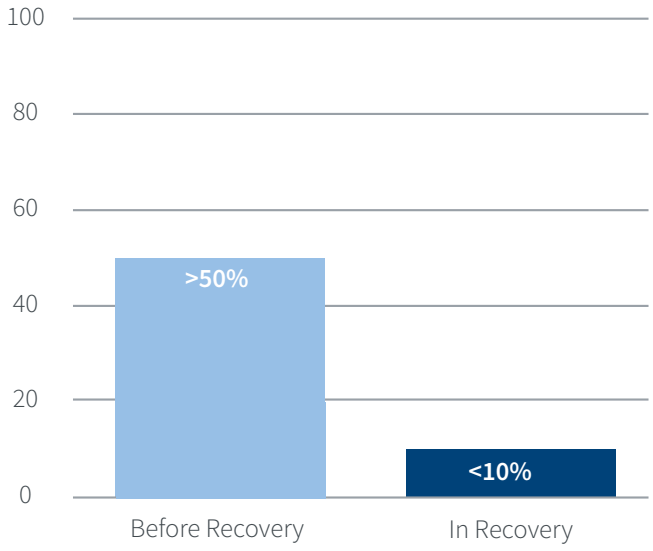


Figure 26: Rate of involvement in domestic violence

CONCLUSIONS

The Australian results are also important in that they support the suggestion that there are clear improvements that happen over time in recovery. Those in recovery for the longest term report markedly higher levels of psychological wellbeing and quality of life and much lower levels of need for professional support for emotional or mental health issues.

The other more surprising domain of consistency with the US results is around the demographics and career factors of those who took part.

Average age at time of survey completion, average duration of recovery and average length of addiction career are all markedly similar across two countries with differing cultures, treatment systems and philosophies around addiction and recovery.

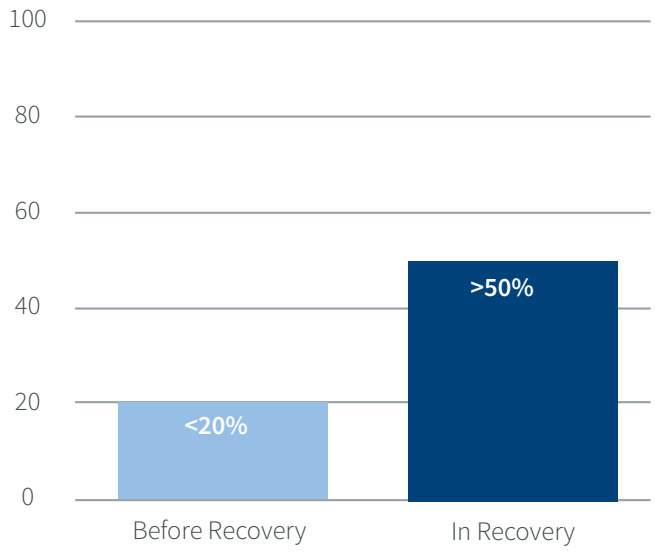


Figure 27: Volunteer participation

RECOMMENDATIONS

POLICY RECOMMENDATIONS

It is critical that the implications from the Australian Life in Recovery survey are acknowledged and addressed at a federal, state and local level to ensure that the achievement of recovery is extended across families, communities and professional settings (such as health and legal systems). As such, the following policy recommendations are suggested for consideration:

1. Policy makers should acknowledge and recognise in drug and alcohol commissioning the key role that recovery organisations play in the initiation and sustaining of recovery journeys that benefit wider society and challenge stereotypes and stigma around addiction
2. Greater policy and funding commitment to recovery support services to ensure that those who initiate recovery journeys are supported to maximise their own wellbeing and their contributions to family and community
3. That greater funding is provided for alumni and aftercare organisations to enable the informal community support that is essential to build recovery capital and recovery communities

This story is only starting to be told. We have much work to do – and we hope to do this through academic publications and presentations – to challenge the stereotypes of both the general public and our own professionals. There is one core message that the data presented here in Australia and by FAVOR in the US.

Addiction may well be a chronic, relapsing condition but people can and do recover. They can change and that change is not only personal but social and societal. The next step on this journey is to repeat and augment this work. At the date of publication this survey has already been approved and will be conducted in the UK and we we await the survey outcomes with great interest. This survey has already followed in the footsteps of the FAVOR survey with almost no resources and supports and we should aim both to do this in more countries and to continue to repeat the surveying to allow us to map global changes and implications in recovery pathways (see final recommendations below).

LIFE IN RECOVERY SURVEY RECOMMENDATIONS

1. That the 'Life in Recovery survey' is undertaken in other countries to increase the comparability and so that a shared evidence base can be generated.
2. That repeat surveys are undertaken in Australia to assess change in the nature of the recovering population and in the journeys and stories they provide.
3. That the results from this survey are widely distributed and used to contribute to the policy debate about recovery in Australia.
4. That the results from the current survey are used for academic journal publications to augment the empirical evidence base around recovery.

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