Published in final edited form as:
J Subst Abuse Treat. 2010 January ; 38(1): 51–59. doi:10.1016/j.jsat.2009.06.003.

What are your priorities right now? Identifying service needs across recovery stages to inform service development

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Abstract

Substance use disorders (SUD) are, for many, chronic conditions that are typically associated with severe impairments in multiple areas of functioning. 'Recovery' from SUD is for most, a lengthy process; improvements in other areas of functioning do not necessarily follow the attainment of abstinence. The current SUD service model providing intense, short-term symptom-focused services is ill suited to address these issues. A recovery-oriented model of care is emerging that provides coordinated recovery support services using a chronic care model of sustained recovery management. Information is needed about substance users' priorities, particularly persons in recovery who are not currently enrolled in treatment, to guide the development of recovery oriented systems. As a first step in filling this gap, we present qualitative data on current life priorities among a sample of individuals that collectively represent successive recovery stages (N = 356). Findings suggest that many areas of functioning remain challenging long after abstinence is attained, most notably employment and education, family/social relations, and housing. While the ranking of priorities changes somewhat across recovery stages, employment is consistently the second most important priority, behind working on one's recovery. Study limitations are noted and the implications of findings for the development and evaluation of recovery oriented services are discussed.

Keywords

Recovery; recovery-oriented systems; recovery management; addiction treatment services; addiction; chronic care model; qualitative methods

1. Introduction

1.1 Paradigmatic shift in substance abuse services: Recovery as a guiding vision

Although addiction is best conceptualized as a chronic disorder for many affected individuals (McLellan, Lewis, O'Brien, & Kleber, 2000; National Institute on Drug Abuse, 2007),

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treatment for substance use disorders (SUD) has historically been delivered using an acute care model: intense episodes of professionally-directed care during which a person seeking treatment is screened, assessed, treated, discharged and presumed to no longer require professional care —all in a relatively short time (Dennis & Scott, 2007). Growing evidence for long addiction and treatment 'careers' consisting of multiple cycles of intensive and costly treatment episodes (Dennis, Scott, Funk, & Foss, 2005) followed by return to active addiction (Scott, Foss, & Dennis, 2005) for a significant subgroup of substance users has led to the conclusion that the acute-care model is ill suited to address SUD as a chronic condition (Hser, Anglin, Grella, Longshore, & Prendergast, 1997; McLellan, 2002; McLellan, McKay, Forman, Cacciola, & Kemp, 2005). Noting the disappointing outcomes of the current system for severely dependent persons, and the many similarities between SUD and other chronic illnesses, the Institute of Medicine and leading addiction researchers have called for SUD treatment to shift from the acute care model to one of recovery management akin to the chronic care model used in the treatment of other chronic conditions.

While the most prevalent form of recovery management has historically been participation in 12-step fellowships and methadone maintenance, this is beginning to change. Acute episodes of biopsychosocial stabilization are now being wrapped within a more extended continuum of supports spanning pre-recovery engagement, recovery initiation, recovery maintenance and enhanced quality of life in long-term recovery (White, 2008). Considerable interest is being focused on recovery-support services emphasizing post-treatment monitoring and support that include telephone-based continuing care (McKay, Lynch, Shepard, & Pettinati, 2005), 'recovery management checkup' and early re-intervention (Scott & Dennis, 2002), recovery homes (Jason, Olson, Ferrari, & Lo Sasso, 2006), recovery coaching, and assertive linkage to communities of recovery (Scott, White, & Dennis, 2007; White & Kurtz, 2006). The recovery management approach appears effective at minimizing relapses while also being cost effective . The shift from acute to chronic care is increasingly occurring in the context of an even more fundamental change in SUD services that is driven by converging forces; these forces include a transformation in the mental health field with its focus on consumer-driven recovery oriented services, evidence supporting the need for comprehensive individualized services, and changing norms and expectations of services in response to recommendations from the Institute of Medicine (Institute of Medicine, 2001; Institute of Medicine, 2005). Most central to this fundamental transformation in substance abuse services is the Substance Abuse and Mental Health Services Administration's (SAMHSA) commitment to recovery: "The concept of recovery lies at the core of SAMHSA's mission, and *fostering the development of recovery-oriented systems of care is a SAMHSA priority*" (Center for Substance Abuse Treatment, 2006, p.8).

1.2 Recovery-oriented systems of care

Recovery-oriented systems of care (ROSC) is an emerging service model that provides person-centered, strength-based continuity of care for individuals, families and communities to take responsibility for their health, wellness, and recovery from alcohol and drug problems across the lifespan (Clark, 2008). ROSC (http://www.pfr.samhsa.gov/rosc.html) offers a multi-system, comprehensive menu of services and supports that can be coordinated and integrated to meet the individual's needs, recovery stage and chosen path to recovery (Clark, 2007; Connecticut Department of Mental Health and Addiction Services, 2006; Kirk, 2007). ROSC services may include education, employment and job training, housing services, childcare, transportation to/from treatment and work, case management and linkage to other services (e.g., food stamps), outreach, relapse prevention, recovery support services, substance abuse education for family members, peer-to-peer services and coaching, self-help and support groups, life skills, faith and spiritual support (Kaplan, 2008). The *system* in ROSC is not a single treatment agency but a macro-level organization of a community or a state (e.g.,

Connecticut). Central to ROSC relative to the prevalent model of SUD treatment is the recognition that 'recovery,' the ultimate goal of services, requires more than abstinence . Therefore SUD services must give clients the tools to improve their life in all areas, not only to help them achieve abstinence. This is particularly important in light of emerging evidence that controlling for duration of abstinence, satisfaction with overall quality of life prospectively predicts sustained abstinence (Laudet, Becker, & White, 2009). The ROSC model is intuitively appealing and well-suited to address a condition that, in its chronic form, affects a broad range of areas of functioning – the 'addiction related areas' typically assessed by standardized measures such as the Addiction Severity Index . We recently reported that a significant portion of outpatient SUD treatment clients who left treatment before completion said that they would have liked practical help and services targeting areas other than substance use – e.g., housing, education and training, family-related services; one third of non-completers said that they would have remained engaged in services if these broader needs had been addressed (Laudet, Stanick, & Sands, 2009).

1.3 Study objectives

To date, the perspective and experiences of (current or former) substance users remains neglected in services research (Carlson, 2006) although researchers have noted that "patients' perspectives on treatment may have a role in treatment outcomes and should be explored as a dimension of the treatment process" , p. 313). As a result, we currently know little about the priorities and service needs of SUD-affected persons from their perspective, especially persons who are not currently enrolled in services, such as individuals in recovery who have achieved and maintained abstinence for several years. Most importantly as relates to the recovery oriented model of care, we lack information about whether and how priorities and services needs change as recovery unfolds. Unlike the current SUD service model that focuses on short-term specialty care, ROSC is designed to address all service needs in a coordinated and integrated manner, and to support the individual's recovery as it unfolds over time. Among the cardinal features of the ROSC model is that services are *research-based, outcome-driven, and require ongoing monitoring and feedback for systems improvement* (Center for Substance Abuse Treatment , 2006; Clark, 2008). This requires knowledge about service needs over time. This exploratory study is a first step in filling that gap. Drawing on a sample that collectively represents successive stages of recovery, from initiation to stable recovery, we capitalize on a rich qualitative dataset to address the following questions:

1. What are the service needs and priorities of persons in recovery?
2. How, if at all, do priorities change over time as a function of recovery 'stage'?

This information is critical to guiding the development, funding and evaluation of recovery oriented services but it is currently lacking.

2. Materials and Methods

2.1 Setting and recruitment

Recruiting for the 'Pathways to Long-term Abstinence' project was conducted in New York City through media advertisements placed in free newspapers and flyers posted throughout the community over a one-year period starting in March 2003. The study maintained a toll-free telephone number that interested persons called to undergo a brief screening (10–12 minutes; see Laudet, Morgen, & White, 2006). Eligibility criteria for the study were: 1) fulfilling the DSM-IVR criteria for substance abuse or dependence of any illicit drug for a year or longer, 2) self-reported abstinence for at least one month, and 3) not being enrolled in residential treatment.[1] Eligible callers were re-contacted within a week to schedule an in-person interview. Seven hundred and two unduplicated screeners were conducted; of those, 440 were eligible;

356 were interviewed (81% of eligibles)[2] and constitute the sample for this study. Following the signed informed consent procedure, the interview was conducted, lasting 2.5 hours on average. Participants were paid $30 for their time. The study was approved by the NDRI Institutional Review Board and we obtained a certificate of confidentiality from our funding agency.

2.2 Data collection and Measures

The semi-structured instrument was administered via computer assisted-interviewing using the QDS software (Nova Research, Inc.). The interviewers were trained in both quantitative and qualitative data collection methods including how to probe respondents when the initial response to an open-ended question was vague, and how to record participants' answers verbatim in the QDS software. We collected information about basic demographics, history of substance use, of substance abuse treatment and participation in community-based 12-step meetings using standardized instruments (see . Information on participants' *current life priorities* that constitutes the focus of this study, was obtained from answers to the open-ended question: "What are the priorities in your recovery and in your life right now?"

2.3 Qualitative data coding

Codes for the verbatim answers to the open-ended question were developed on the first 30 completed interviews; based on a subsample of 35 randomly selected instruments coded by two independent researchers (the first author and a clinically trained collaborator), inter-rater reliability was .91. We used an iterative process whereby the first stage of coding (described above) was as specific as possible to retain the richness of the data; for this study, after examining frequencies on the initial codes, codes were grouped by general topic; for example, the 'family and social relationships' category consists of three codes: Family members (children, parents, siblings), friends, and romantic relationships. Up to three answers were coded for each participant so that the percentages presented in the next section and in the table sum to over one hundred percent; when more than three answers were provided, the first three mentions only were coded.

3. Results

3.1 Sample descriptives

The sample was 56% male; 62% African-American, 16% non-Hispanic white, and 22% of other or mixed ethnic/racial background; 19% were of Hispanic origin. Participants ranged in age from 19 to 65 years (mean = 43, Std. Dev = 8). Educational attainment averaged 12 years (Std. Dev = 2). Nineteen percent were employed part-time, 21% full time; 60% cited government or other benefits (e.g., Veteran's pension) as their primary source of income. Nearly one quarter (22%) reported being sero-positive for HIV antibodies and 30% for Hep C. Most (82%) had no current involvement with the criminal justice system. Lifetime dependence severity measured by the Non-alcohol Psychoactive Substance Use Disorders subscale of the Mini International Neuropsychiatric Interview (M.I.N.I. - was high (mean score = 11 where possible scores range from 0 to 14). The majority of participants had been polysubstance users; most frequent primary problem substance was crack (58.3%) followed by heroin (18.5%). Duration of self-reported abstinence from drugs and alcohol ranged from one month to ten years (median = 14 months, range = 1 to 231 months). Almost all (89.6%) had participated in community-based 12-step meetings such as Narcotics Anonymous and 86.8% had been enrolled in professional SUD treatment at least once; at recruitment, 5.3% (N

[1]The study was a naturalistic investigation of the role of psychosocial factors on long-term recovery, and we wanted to be able to assess the role of baseline community-related factors on subsequent outcome.
[2]The study stopped enrolling eligible callers once the target sample size was met.

= 19) were receiving methadone maintenance and 28.6% (N = 102) were in an outpatient treatment program.

Recovery Stages—Substance use history was collected using a list of substances included in the Addiction Severity Index (McLellan et al., 1992). For each substance "ever" used once or more, participants provided the last date of use. A variable was computed for time abstinent from *each* substance ever used; overall duration of abstinence for a given participant represents time since *most recent use of alcohol or any of the illicit drug* ever used, in months. Four time-linked recovery benchmarks were computed based on duration of self-reported overall abstinence: Under 6 months (28%, Group 1), 6 to under 18 months (26%, Group 2), 18–36 months (20%, Group 3), and over 3 years (26%, Group 4). As detailed elsewhere (Laudet & White, 2008), these stages were selected based on a review of the extant literature and on focus groups with persons self-identified as in recovery for various lengths of time. In this dataset, this classification also afforded four groups of relatively equal size.

3.2 Current life priorities

Priorities by recovery stage are summarized in Table 1. As mentioned in the Methods section, up to three answers to the priority question were coded; 23.9% of participants (N = 85) provided a single priority, 32.6% (N = 116) gave two answers, and 43.5% (N = 155) gave three or more answers. Key themes follow with illustrative quotes, presented in the same order as they appear in Table 1; the percentage of individuals citing a given priority category in each recovery stage, from early to stable recovery, is indicated in parentheses.

Question: What are the priorities in your recovery and in your life right now?

Recovery from substance use (49.9%, 43.2%, 52.7%, 34.1%): 'Stay clean,' and 'try to stay clean" (by far the two most popular statements in this category), 'not picking up a drink or a drug,' 'remain sober and drug free because if so, anything is possible,' 'to continue on this recovery journey,' 'stay sober and go to my outpatient program,' and 'make meetings, stay in contact with my sponsor, work the steps.'[3]

Employment (31.1%, 36.2%, 35.1%, 34.1%): 'Just get a job,' 'get a real job,' 'seek full employment,' 'find a good job,' 'keep my job,' "embark on a career,' 'advance more in my work,' 'work on my career', 'get back to my profession;' some participants mentioned a specific profession, with 'become a drug counselor' being the most frequently cited.

Family and social relationships (19.8%, 23.5%, 23%, 24.4%): 'My family – rebuild my relationship with them,' 'have a trusting relationship with my loved ones,' 'stay connected to my friends,' 'taking care of them of my parents,' 'take care of my family,' 'being a good great-grandparent to my great-grandchild and taking care of my wife,' 'get my marriage back together,' 'take care of my family and being a better husband,' 'spend time with family,' 'stay close to my family,' 'take care of my family and provide a nurturing home for my daughter,' 'raise my daughter, take care of my mother since my father died, meet someone to marry,' 'get married and have a family,' and 'raise my kids the right way.'

Education and training (17.9%, 16%, 23%, 14.6%): 'Get my GED,' 'finish school,' 'go back to school,' 'I want to graduate from a school for once,' 'go to college,' 'get a certification to teach high school,' 'finish my internship,' 'I want to go take a training and get my CDL (commercial driver's license)', 'get a degree,' and 'go back to school to become a social worker.'

[3]This statement refers to going to ('making') 12-step meetings and working the 12-step program of recovery.

Achieve and enjoy improved, 'normal' productive life (17%, 19.3%, 26.8%, 27.9%): 'Live a good clean life,' 'try to contribute to society,' 'live a normal life,' 'set up a plan for my life,' 'live well, just be normal again,' ' just be a responsible member of society,' 'make a positive difference in the world,' 'be a good influence on the people around me,' 'try to fulfill my commitments to myself and to others;' this category also included mentions about the pursuit of or return to hobbies such as: 'get back into horses - ride more', 'be able to dance again,' and 'finish reading a few books that I started and travel.'

Family reunification (15.1%, 11.7%, 18.9%, 7.3%): 'Regain custody of my kids,' 'get all of my kids back from the state,' 'need to have my children back in my life and living with me,' and 'find my son.'

Emotional health and self-work (15.1%, 14.8%, 21.7%, 6.1%): 'Get myself together,' 'do what I got to do for me, take care of myself,' 'have peace of mind,' 'keep the stress level down,' 'keep strong for me and my kids,' 'improve in every way possible,' 'keep working on myself; working on the issues that I believe make me pick up,' 'learn more about myself,' 'be comfortable with the person that I am' and 'realize the type of person I was and who I can be.'

Housing and living environment (12.3%, 21.3%, 13.6%, 8.6%): 'Find a permanent residence,' 'move out of the transitional housing,' 'work on getting stable housing,' 'get my own place,' 'find another place to live, a bigger apartment,' 'finish remodeling my apartment,' 'buy a house,' and 'leave New York eventually, move to a different state.'-

Physical health (11.3%, 11.7%, 6.8%, 20.7%): 'Stay healthy', 'get my health back,' 'be as healthy as I possible can,' 'take care of myself because of my HIV,' 'get my health issues taken care of,' 'stay on top of my medical condition,' 'stop smoking,' and 'learn to live healthy and lose weight.'

Spirituality and religion (9.4%, 9.6%, 2.7%, 2.4%): 'Work on my relationship with God,' 'keep in close contact with God,' 'rebuild my relationship with God,' 'keep practicing my faith,' 'go to church,' 'spiritual practice,' and 'stay spiritually connected'

Financial and material (6.6%, 14.9%, 8.1%, 7.3%): 'get off welfare', 'achieve financial stability,' 'learn to manage my money and pay bills,' 'get a steady income,' 'improve my financial situation' 'be able to pay my rent on time,' 'save money for a trip,' and 'set up a retirement fund.'

Give back, help others (1.9%, 3.2%, 6.8%, 3.7%): '[stay clean and] maybe help somebody else stay clean,' 'be some kind of mentor,' '[go back to school and] help people,' '[learn more about addiction so] I can help others,' 'get my ministry going to help other people' and 'motivate people to get their drug use in check.'

Legal *issues* (0%, 1.1%, 1.4%, 0%): "Finish parole' and 'stay out of trouble.'

As shown in Table 1, working on one's recovery and employment were the two areas mentioned most by participants in all four recovery stage groups. Recovery issues were mentioned by nearly half of study participants in all recovery groups except the longest, emphasizing the fact that 'recovery work' does not end with the attainment of abstinence. The importance of employment did not markedly change across abstinence groups. Employment and recovery where mentioned by an equal portion of respondents in the longest abstinence group (34.1%); the third most frequently cited priority in that group was the broad category "achieve and enjoy improved, productive life' that includes achieving goals, living a healthy life, and getting back to one's hobbies. Of note, physical health was mentioned nearly twice as often by the longest

abstinence group as by the earliest group (20.7% vs. 11%); this may reflect the worsening of health conditions that developed and went untreated during active addiction, as well as the natural aging process - participants in the 3+ years of abstinence group were, on average, 5.5 years older than those in the other three groups (47.2 years vs. 41.6, $F = 32.3$, $p<.001$). Housing/living environment, employment and financial issues were mentioned by a greater percentage of respondents in the 6 to 18 months group than by the earlier group, suggesting that these areas may gain preeminence after the immediate business of 'getting clean' is somewhat underway (see later discussion).

4. Discussion

4.1 Reprise of key findings

We set out to examine life areas that constitute priorities among individuals at various stages of recovery, and to determine whether priorities change as recovery unfolds. Our findings show that in addition to working on one's recovery, participants at all stages of recovery express concern about multiple areas of functioning, most notably employment, education and training, and housing. Though some differences emerged in how these priorities ranked across abstinence duration subgroups, these life domains were identified as high priorities by all groups.

Findings emphasize not only the many areas of concern (need) to persons in recovery but equally important, the fact that *most of these concerns endure as recovery unfolds*. Working on recovery, employment, and family/social relationships ranked as the top three priorities among persons abstinent for up to 18 months (Groups 1 and 2). The relationship category consisted of mentions about relationships with friends and relatives, as well as about romantic relationships (e.g., getting married or engaged). Family and social relationships are often severed or strained during active addiction; in addition, individuals in recovery are encouraged to establish a sober network, often causing a disruption in social (and romantic) ties before a new network is firmly established.

Several trends across recovery stages are noteworthy. First, working on one's recovery was the top priority, cited by about half the sample in all recovery groups except the longest, where one third of participants mentioned it as a priority. This is consistent with the growing recognition that recovery from substance use in its chronic form is a process that often takes time and continues to unfold long after abstinence has been reached (Flynn, Joe, Broome, Simpson, & Brown, 2003; Laudet, 2007). In an exploratory study among formerly drug-dependent persons abstinent for an average of 9 years, Margolis and colleagues reported that the majority of subjects identified passing through a phase (lasting one to three years) almost solely focused on remaining abstinent (Margolis, Kilpatrick, & Mooney, 2000). Second, employment is cited as a priority by about one third of respondents in every recovery group, suggesting that it is an enduring issue that is not being addressed adequately at present. Employment, one of the key outcome domains collected for SAMHSA's National Outcome Measures (NOMs; Substance Abuse and Mental Health Services Administration, 2008), provides not only financial resources but also a valued and respected role in society; this is important for persons who had often been stigmatized and discriminated against because of their substance use history. Mentions of housing and living environment increased in frequency, almost doubling, from Group 1 to Group 2. Living conditions likely become more important once abstinence is reached and a healthier lifestyle is increasingly adopted; as abstinence is attained and maintained, one's focus can start to shift from being previously centered solely on remaining drug-free 'one day at a time,' to the hope of a better life ('a normal life') and better life conditions. Further, for some, as recovery progresses and lifestyle changes are made, leaving 'the old neighborhood' (relocate) may become a priority. This may be especially true of under-served groups such as participants in this study as many inner-city

communities are also, regrettably, areas where drugs are sold and openly used. Surprisingly, financial issues were mentioned by relatively few participants; this seems to be a somewhat artificial finding that underestimates the economic difficulties in this population, since employment, a related concern, is consistently ranked as the second priority across subgroups. Finally, on a more positive note, "achieve and enjoy a normal, productive life" becomes a more important priority as recovery progresses. This category increases in importance from 5th ranking among individuals with 18 months of abstinence or less, to third for Group 3 and the 2nd most frequent priority in the 3+ year group, ranking immediately after working on recovery and employment that are tied for first ranking. Of note, mentions of 'giving back, helping others' increased from 1.9% in Group 1, to 6.8% in Group 3, likely coinciding with a period where the 'boon' of recovery starts to be truly felt and past struggles can be rendered meaningful by using one's experience to help others.

4.2 Study limitations

Several study limitations must be noted when interpreting results. The study was conducted in New York City only; the sample consisted mainly of underserved minorities who had experienced a long and severe addiction to 'hard drugs;' therefore findings may not generalize to persons of different ethnic or socioeconomic backgrounds, to individuals who were not as severely affected by SUD or to persons who reside in other settings or geographical areas such as suburbs or smaller urban areas. Nonetheless the sample is generally comparable to those used in large scale drug treatment studies (Craddock, Rounds-Bryant, Flynn, & Hubbard, 1997) and it is representative of clients served in publicly funded programs in large metropolitan areas , a very large group whose needs are many and complex yet remain under-investigated. Second, the abstinence subgroup classification is based on self-reported information. However, we have reported good concordance rates (>.80) between self-reported abstinence and biological sampling at follow-ups in this cohort (Laudet & White, 2007; Laudet, 2007), affording confidence that the self-reported baseline information was for the most part, accurate. Finally, the recovery stage subgroups are relative small, particularly those representing longer recovery durations (>18 months), further limiting the generalizability of findings.

4.3 Implications of findings for service development

This study is among the first to examine life priorities among persons at various stages of recovery. In particular, findings are unique in speaking to successive recovery stages including stable recovery (3+ years) among persons who were not recruited in the context of a treatment study, thus casting a wider 'net' and capturing the recovery experience long after treatment ends (when it was sought). Commenting on findings from a study on reasons for seeking SUD treatment, Orford and colleagues noted that "the most striking aspect (…) was the sheer number of problems that people were experiencing" , p. 167). Our findings highlight the fact that individuals in recovery continue to experience many difficulties and to need support in many areas of functioning long after abstinence has been reached. Abstinence has historically been considered a proxy for good function in other areas that comprise recovery (McLellan, Chalk, & Bartlett, 2007). Abstinence is a prerequisite for and is generally associated with sustained improvement in other areas . However, the connections between substance use and functional status in the other domains are complex (McLellan, Luborsky, Woody, O'Brien, & Kron, 1981; Simpson, 1981). We cannot assume that abstinence 'leads' to employment or to better living conditions . In fact, abstinence rarely brings instant relief (Vaillant, 1995); it is not atypical to see reductions in drug use without significant concurrent improvement in other life areas . The severe impairments that result from decades of active addiction among the chronically dependent require extended time to resolve. Our findings show that difficulties remain for several years after abstinence is achieved, particularly in the area of employment.

The authors of an extensive qualitative examination of recovery from mental health issues noted that "When considering both the basic material needs and citizenship dimensions to recovery, we are struck by how generic and universal the responses were. Just like any group of American adults, the responses included a compelling belief in the "American Dream" of economic opportunity, self-sufficiency, liberty, and the pursuit of happiness." (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002, p. vii). This conclusion applies equally well to our findings on the priorities of persons in recovery from severe substance use disorders. Recovery, the ultimate goal of treatment, requires abstinence but goes well beyond abstinence . "Recovery is about building a full, meaningful, and productive life in the community. *Our treatment systems must reflect and help people achieve this broader understanding of recovery*" (Clark, 2007), p.2). The goal of SUD services ought not be fostering abstinence as an end in itself. Rather, services ought to aim to give clients the necessary resources and strategies to achieve enhanced quality of life and improved functioning, and to assume social responsibility. In other words, *symptom reduction (abstinence) is critical but it is a means to an end*.

Overall, our findings bolster the conclusion that fostering recovery requires two important paradigmatic shifts in service delivery: the adoption of a model of sustained recovery management, and a coordinated multi-system approach that integrates services and supports across agencies to best meet an individual's needs given one's recovery stage, recovery path and resources -'recovery capital' (Granfield & Cloud, 2001; Laudet & White, 2008). Recovery oriented systems of care (see earlier) incorporate these two key elements and represent a promising approach to supporting persons in recovery to rebuild their lives. At this writing, the model has yet to be fully implemented in more than a few isolated cities or states; most importantly, it has not yet been evaluated. Researchers are encouraged to collaborate with service systems such as the state of Connecticut and the city of Philadelphia (Evans, 2007; Kirk, 2007), that have fully made the transition to a recovery orientation, to assess the effectiveness and cost effectiveness of this approach. In keeping with the person-centered, continuum of care elements of the model, the usefulness of such research to service development will be maximized by using a long-term prospective design that includes qualitative information tapping into clients' experiences.

Acknowledgments

This work was supported by NIDA Grant R01DA14409 and by a grant from the Peter McManus Charitable Trust.

The authors gratefully acknowledge study participants who generously shared their experiences with our staff.

Beth Moses, MSW, collaborated with the author in developing codes and coded verbatim answers to the open-ended questions.

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Table 1

Current life priorities by abstinence duration stage[4]

	ABSTINENCE DURATION STAGE			
	<6 mos N = 106	**6 – 18 mos. N = 94**	**18 – 36 m N = 74**	**3 yrs + N =82**
Recovery from substance use	49.9%	43.2	52.7	34.1
Employment	31.1	36.2	35.1	34.1
Family and social relationships	19.8	23.5	23.0	24.4
Education and training	17.9	16.0	23.0	14.6
Achieve and enjoy improved, 'normal' productive life	17.0	19.3	26.8	27.9
Family reunification	15.1	11.7	18.9	7.3
Emotional health and self-work	15.1	14.8	21.7	6.1
Housing and living environment	12.3	21.3	13.6	8.6
Physical health	11.3	11.7	6.8	20.7
Spirituality and religion	9.4	9.6	2.7	2.4
Financial and material	6.6	14.9	8.1	7.3
Give back, help others	1.9	3.2	6.8	3.7
Legal issues	0	1.1	1.4	0

[4] Total >100% because up to three answers were coded per respondent