A SOCIAL CONTRACT

Treatment offers to get the dispossessed and addicted back into mainstream society, but for many this offer simply lacks credibility. **Richard Phillips** on how the recovery movement can offer people a tangible route out of addiction.

Last year, I watched an intriguing television programme about a radical educational experiment in a deprived neighbourhood of New York. A black professor of economics explained his own journey from "the ghetto" to academic success at Harvard and also his radical experiment in educational rescue.

For the schools he was working with, the statistics were as depressing as they were familiar, with only a small proportion of students actually completing school and boys landing in the morgue more often than college. His remedy was simple: provide monetary payments to pupils based on attendance, good behaviour and course completion. The sums of money were significant and diligence could result in many hundreds of dollars at the end of term. The evidence he was presenting suggested impressive results.

This was interesting enough, with obvious similarities to contingency management for addictions, but what I found intriguing was his explanation as to why this approach worked and was morally justified.

He pointed out that white, affluent students in the leafy suburbs of the same city had a very clear understanding of what the trade-off was for the hard work of school. If you work hard at school there will be ample reward for you later. You can expect a good job, your own house, a car and indeed the rest of the American dream.

To the economist, white middle class achievement in school is powerfully incentivised by a credible promise of future reward. To the kids in the deprived inner city schools, the promise of future reward, even if loudly made or repeated often, is simply not believable. The financial incentives he put in place simply brought the rewards of education forward in time, into the lived experience of the students. This helped them value education and hopefully benefit from it in the long term.

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You are probably wondering what an earth this has to do with recovery from problems of addiction.

The parallel is the idea that treatment offers to get the dispossessed and addicted back into the blossom of society, but for many this offer simply lacks credibility, just as the value proposition of those deprived schools was not believed by their students. I want to explore whether self-help, mutual-aid and recovery communities are helping treatment services bring forward the benefits of recovery and create more realistic pathways to social re-integration.

So what does treatment 'offer'? When we invite people into treatment we put an offer on the table that makes the case as to why they would be better off in treatment than not. In the simplest terms, treatment offers to ease or relieve suffering, make the life in treatment, better or more bearable than life without. Given the readiness of service users to stick with treatment, I think it reasonable to accept that treatment does a pretty good job of achieving this basic goal. From research, we can also be confident that treatment is helping keep people alive, healthier and communities safer. This is an impressive set of achievements and has for 20 years justified a remarkable level of public investment in these services.

Treatment often helps people re-integrate back into society. We should not forget, for example, that many people build on the stability offered by substitute prescribing to get jobs and rebuild families. Others benefit from residential rehab and effective packages of aftercare. The system, overall, has not lived up to the hopes and aspirations of service users. Too many remain bleakly isolated and on the fringes of society. Too few are enabled to step out from the isolation of addiction and build a self-image and lifestyle as a fully involved

and valued member of the community.

Of course these are generalisations and some services do a great deal to aid social re-integration – but a mismatch remains between what treatment services have been able to deliver and what people in treatment feel they were offered. Linking back to our example of education in the deprived neighbourhoods of New York, the treatment system offers social reintegration just as those schools seem to promise economic success – but the promise does not seem credible.

So where is the evidence for this mismatch of expectations, this pent up need – and if this is so important, what should be the response?

The answer to both questions is emerging up and down the country in the remarkable growth of recovery communities, a phenomenon I believe to be the single most important development in this field since harm reduction.

In my work promoting SMART Recovery I have been invited to speak at service user forums, peer involvement conferences, recovery community events and meetings named from every permutation of the words recovery, involvement, forum, peer and communities. What I have seen is a remarkable, broad-based and grass roots movement of people in recovery working together to build up their stake in society. It is an emergent movement, all the stronger for the absence of a singular ideology or national leadership. It is driven by both broad based involvement and also dozens of remarkable people taking on leadership roles within individual projects and groups, whether as SMART recovery facilitators, spreading fellowship meetings or within any of the two dozen or more other peer support structures already established or being tried across the country.

The main thing that makes this a common community is perhaps the guiding adage that "We alone can do it, but we cannot do it alone".

This recovery movement is not driven by ideology and is beyond a belief in self-reliance, mutual aid and social reintegration. For most, it is not even specifically about abstinence. Although a political debate about abstinence has run alongside these developments, many groups are proving able to include and embrace the methadone maintained, fellowship attendees and people at almost every stage of recovery.

Through self-help, peer support, user forums, mutual aid and similar groups, people recovering from addictions are regaining the foothold in society that the treatment system alone has not been in a position to provide. This should not be directed or taken as a criticism of treatment, but a little humility may be needed to acknowledge that for all the time and effort trying to create wrap around provision, through-care and after-care, there has been something missing that only people in recovery could provide for themselves.

A SIMPLISTIC BUT I THINK HELPFUL VIEW OF RECOVERY IS SIMPLY TO BUILD THE INVERSE PATH, TO BRING FORWARD THE BENEFITS OF SOCIAL RE-INTEGRATION SO THAT THE OPTION OF CONTINUED OR RESUMED ADDICTIVE BEHAVIOUR SIMPLY LOSES ITS APPEAL

A few organisations seem to take the position that 'we don't do recovery'. This is a failure to understand a transition of real importance to service users, though I predict such services will quickly change their minds or face extinction at the hands of frustrated commissioners!

A few others claim to do recovery 'all in-house'. There are important things that can be done within services, but failure to build links to organic, user-led or other independent groups suggests that the point has been missed. We should be wary of 'Potemkin' recovery communities, smoke and mirror creations put together for tenders rather than to meet the aspirations and needs of clients.

Yet other services see this recovery agenda as important, but correctly handled entirely by service users or people in recovery. They don't want to get involved because they don't want to interfere with what should be peer–led. This is more benign and shows greater understanding of the nature of the recovery movement, but still sells their service users short.

The best approach is partnership. Providers can do much to support, assist or strengthen recovery communities and encourage their service users to get involved early in treatment. Many providers now offer practical help where help is needed but step back when more independence is requested. With these approaches, providers will help bring forward some of the benefits of recovery and show to their service users that their hopes of social integration really are possible to fulfil.

Finding the best relationship between treatment and recovery communities will take time. This is new terrain and we should live with the fact that some things will work and others not.

There should be nothing unfamiliar about social contingencies, responsibilities and relationships supporting or mediating recovery from addictive behaviour, though personally I subscribe to the description of addiction put forward by William Burroughs: "You become a narcotics addict because you do not have strong motivations in the other direction. Junk wins by default." A simplistic, but I think helpful view of recovery, is to build the inverse path, to bring forward the benefits of social re-integration so that the option of continued or resumed addictive behaviour loses its appeal.

Recovery communities offer new and pro-social identities to people who have much to leave behind, reinforcement of healthy moral codes, the encouragement of those who have walked the same path and pride in helping others. The growth of recovery communities will probably improve treatment outcomes, by building up the long-term social contingencies that reinforce recovery, but we should not wait for such evidence to accrue before deciding whether such communities should be supported or encouraged. The reason for building bridges between treatment and recovery communities is foremost a moral one, that the desire for self-respect, community and the bonds of friendship are such basic human needs that the default position should be to support this wherever possible.

Get this right, however, and just perhaps we will achieve a treatment system where the promise of a stake in society is credible and at last recovery will win by default.

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