People Power

Mark Gilman argues that being part of a social network should not be regarded an optional extra for the recovering addict. It could be a matter of life and death.

Over recent years we have seen three phases in the modernisation of treatment for substance misuse problems. The first phase saw waiting times dramatically reduced and the numbers of people entering treatment increasing to over 200,000. The second phase was to retain as many of these people in treatment long enough for the treatment to have an effect. The third and final phase is recovery. In essence, this is the process by which people successfully complete and leave bio-medical and psychotherapeutic treatments and engage in social networks. Recovery is a social activity. This is seen in the slogans associated with recovery; *"I can't but we can", "You alone can do it but you can't do it alone"*.

From this perspective the quality of the recovering person's social relationships is a matter of life or death. Researchers in Glasgow are wrestling with the fact that men in particular die much earlier than their socio-demographic equals in Manchester and Liverpool. Bruce Alexander first introduced us to the 'Rat Park'. This research showed that rats living in isolation without contact with other rats would self-administer drugs of addiction to the point of death. Alexander has gone on to describe the 'Globalisation of Addiction' among humans as an overwhelming attachment to substances as a way of coping with social isolation and a general lack of meaning.

Public health colleagues recognise the importance of social relationships in the prevention of premature mortality. In their 2010 paper *Social relationships and mortality risk: a meta-analytic review.* Holt-Lunstad and colleagues noted, "Social relationship– based interventions represent a major opportunity to enhance not only the quality of life but also survival"

Duncan Selbie, CEO of Public Health England (PHE) has said that PHE will focus on the three most important things that will promote good health; jobs, homes and friends. For those people who are overwhelmingly involved with drugs and alcohol, the good news is that we can find them friends. A recovery community is, in essence, a social network of people coming together to create social relationships that support and sustain recovery. Recovering addicts and alcoholics will be joined in recovery communities by people recovering from mental health problems and the friends and families of all those effected. A recovery community is a 'big tent'.

Looking at the world of substance misuse treatment from the perspective of Public Mental Health and Wellbeing is a sobering experience. Suddenly our long held, evidence based and self-justifying mantras seem to ring a little hollow. Injecting heroin is one of the most destructive forms of addiction. Unprecedented levels of investment have been directed to treating injecting heroin addicts and from a clinical healthcare point of view services this investment has been justified. Addicts are kept alive, out of prison and free of HIV.

However, many of those in treatment are still dependent on prescribed medications, alcohol and tobacco and are dying prematurely as a result of chronic lifestyle problems within a context of social isolation. It is difficult to see how

this massive investment has made any significant contribution to improving mental health and wellbeing and the struggle for social justice. Wealth is no protection against addiction. But, addicts with money can buy very different kinds of clinical healthcare services. Services for wealthy addicts will invariably be abstinence based and three dimensional: bio-medical; psychotherapeutic and social network integration. Addicts in disadvantaged communities will typically be offered a one dimensional bio-medical intervention such as Opioid Substitution Treatment (OST). The Public Mental Health and Wellbeing agenda seeks to address these inequalities in provision and improve the situation for the poorest addicts the fastest to improve resilience and address this inequality by the adoption of 'assets based approaches'. One of the biggest assets in England is the anonymous 12 step fellowships and the more secular and scientific alternative SMART Recovery.

Successful recovery from addiction to alcohol and other drugs is about moving through the narrow corridor of clinical healthcare services into the wide world of positive social relationships. Recovery is constructed with others in communities of recovery or recovery communities.

Written in the 1930s, the book of Alcoholics Anonymous (aka *The Big Book*) describes the recovery process like the aftermath of people from all walks of life being rescued from a shipwreck where they are quite literally all in the same boat;

Unlike the feelings of the ship's passengers, however, our joy in escape from disaster [addiction] does not subside as we go our individual ways. The feeling of having shared in a common peril [addiction] is one element in the powerful cement which binds us. But that in itself would never have held us together as we are now joined. The tremendous fact for every one of us is that we have discovered a common solution."

More recently the work of political scientist Robert Putnam in his books *Bowling Alone* and *Better Together* draws our attention to the limitations of 'bonded social capital' and the possibilities offered by 'bridging social capital'. What's the difference? The very worst place to be for any addicts or alcoholic is on their own thinking. Their very best thinking got them to the point where they needed treatment. Better to be in the local service's user group. But many service user groups represent a form of 'bonded social capital' a limited social network often comprised of a homogeneous group of very similar people. 'Bridging social capital' refers to social networks between heterogeneous groups. For example, as a member of a 12 step fellowship such as AA or NA or CA you can get off a plane anywhere in the world and bridge into a social network made up of a broad cross section of society.

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So meetings of anonymous 12 step fellowships are, at their best, examples of 'bridging social capital' in action. Places where working class and middle class addicts meet on common ground with the common purpose of helping each other in mutual aid.

It is in these meetings that socially isolated and disadvantaged addicts and alcoholics often find jobs, homes and friends. Recovery communities can be geographical entities and/or virtual, online communities of interest using internet discussion groups, blogs and social media. Advising on the construction of geographical recovery communities offering a 'common solution' in each of the 152 local authorities is one of the tasks facing Public Health England. These recovery communities will be built using an Asset Based Community Development (ABCD) approach. AA, NA, CA and SMART Recovery are the most obvious assets that will form the nucleus of these recovery communities.

Recovery communities are best supported by recovery champions. There should be at least three kinds of recovery champion. The strategic recovery champion might be the Director of Public Health (DPH). Therapeutic recovery champions are people working inside treatment services whose job is to get people out of medical treatment and into social recovery communities. The NTA have produced a guide to show therapeutic recovery champions how to assertively link people to mutual aid. If, as is practically likely, the therapeutic recovery champions efforts are thwarted by more senior people in the treatment services, the DPH should be played in to remind treatment providers how essential recovery communities are. Recovery communities are independent but their creation must have strategic support from those involved in delivering public health outcomes from within the local authority. Recovery communities are not a threat to treatment services but they are, and should always be, independent. Commissioners of new systems need to ensure that recovery communities are sufficiently resourced. Moreover, these resources need to be tied to the most flexible of governance arrangements. If possible a dedicated recovery community centre could be provided. Probably the best UK example of this can be found in Halifax, Calderdale at the Basement Project http://www.thebasementproject.org.uk/ .

Public health's recognition of the importance of social relationships casts mutual aid groups such as AA in a new light. Assertive linkage to mutual aid and other positive social networks is every bit as important as the bio-medical and psychotherapeutic treatments. This is now recognised by commissioners and providers of substance misuse treatment services. As these recovery communities grow, recovery will become ever more visible and contagious. As this happens we will begin to see more instances where people with a substance problem choose to go to mutual aid meetings as a first resort and then subsequently seek out the necessary bio-medical and psychotherapeutic treatments. Support from experts by experience via mutual aid groups is available 24 hours a day, 365 days a year and is completely free of charge.

In summary, recovery communities exist to address the five ways to well-being to all who need them. Firstly, they provide social connections. Secondly, they provide access to physical activities of all kinds from walking groups to fishing clubs. Thirdly, they provide opportunities for everyone to become a volunteer and become one of the third kinds of recovery champion – a community recovery champion. Fourthly, a recovery community will help everyone to find ways of finding their passions in life whether its poetry or pottery. Fifthly, a recovery community will promote a daily awareness of the joy in being alive by taking notice and being mindful of the simple things in life.

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