



Recovery Academy

Recovery starts with
understanding

Newsletter – Volume 1 Issue 2 / 3

1st Annual Conference **Special Edition**

Celebrating Recovery in the UK: **The Evidence Base**

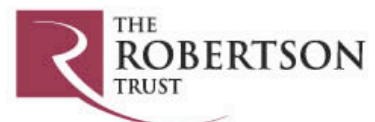
First annual Recovery Academy conference 2010
Woodside Hall
Glasgow

Friday 24th September

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Kindly supported by:





Conference programme

9.15 Registration

10.00 Welcome – David Best, Recovery Academy chair.

10.05 Keynote address - Scottish Government Minister for Community Safety: Right Honourable Fergus Ewing, MSP.

10.25 Conference chair – Stephen Bamber, Recovery Academy Honorary President.

10.40 Phil Hanlon – Professor of Public Health, Glasgow University.

11.00 Stephen Bamber: Recovery and spirituality.

11.15 David McCartney: LEAP and the links to local communities of recovery.

11.30 BREAK

11.50 Rowdy Yates: The Role of Therapeutic communities.

12.05 David Best: Assessing Recovery Capital at an individual and a collective level.

12.20 Teordora Groshkova: Measuring recovery in individuals and groups and groups.

12.35 Mark Gilman: The North West Recovery Forum and growing recovery communities.

12.50 LUNCH

1.45 Workshops # 1

2.45 Workshops #2

3.45 Coffee

4.00 Marion Logan

Alexandre Laudet address
Bill White statement

4.15 Closing remarks: David Best

Workshops #1 (1.45)

1a. Matthew Kidd and Michaela Jones: Making Recovery work in the community.

1b. Jane Rowley: Recovery and education.

1c. Ruth, Michael & Kane: Lessons from the Serenity Cafe .

1d. Brendan Georgeson: Comorbidity and Recovery

Workshops #2 (2.45) How to...

2a. Run a Recovery service – Lanarkshire Addictions Recovery Consortium

2b. Design a Recovery system – Mark Gilman

2c. Develop Recovery research – David Best

2d. Integrate Recovery into post-treatment supports – Nick Barton

Or:

3a Talking about DARE: a walking recovery group - A walking workshop with Wulf Livingston, exploring the role of recovery on the move. (Waterproofs maybe required).

All conference literature including: newsletter, workshop handouts, all presentations using Powerpoint, the Alexandre Laudet address and the Bill White statement will be available to view and download from the Recovery Academy website from Sunday 26 September: www.recoveryacademy.org



Introduction

Stephen Bamber

Welcome to this special edition of the Recovery Academy (RA) newsletter, which is being published in print for our first annual conference in Glasgow. The newsletter contains a series of articles from Recovery Academy board members and colleagues – addenda to the presentations, workshops and addresses of the conference.

The theme of the conference is “Recovery starts with understanding”. With that in mind, it is my great pleasure to offer a warm welcome to all delegates, presenters and workshop leaders. We’re absolutely delighted you’re able to partake in this unique opportunity to share knowledge, exchange experience, engage in discussion and collectively broaden our understanding of recovery at this transformative period in the history of the UK’s drug treatment system. Your presence here encourages innovation in research, theory, policy and practice; for that, we are grateful.

Recovery is often characterised as a highly personal journey. However, coming together for events such as this reflects the communal dimensions of recovery and highlights the importance of pro-actively nurturing recovery cultures in order to reap the full social benefits of recovery success. This conference is not merely a vacuous intellectual exercise but a living, material expression of the diversity and richness of UK recovery cultures.

On behalf of the Recovery Academy and all conference delegates I’d like to offer special thanks to the Right Honourable Fergus Ewing, Scottish Government Minister for Community Safety and MSP for Inverness East for kindly joining us and delivering the keynote speech. I’d also like to thank William White and Alexandre Laudet for writing addresses for the conference and William White for his powerful article “Recovery is Contagious”. Thank you to all our presenters and workshop coordinators and to our primary sponsors The Robertson Trust, Phoenix Futures, and Action on Addiction. Without their generosity this event could not have taken place. Finally, thank you. Your support is the life-blood of the Recovery Academy. Have a wonderful day!

Recovery is contagious

William L. White

(Amplification of the closing of the keynote address at the NorthEast Treatment Centers (NET) Consumer Council Recognition Dinner celebrating the recovery progress and service activities of NET members and the 40th Anniversary of NET, April 14, 2010, Philadelphia, PA)

Many of us in this room know that addiction is contagious. Addiction was not a purpose we set out to achieve. We grew up in a world that castigated people with drug problems as *dope fiends, crack heads, drunks, winos*, and worse. None of us wrote an essay in 5th grade saying we wanted to be an *addict* when we grew up. One day in our lives, we chose to pick up, but we didn’t choose what followed. None of us wanted to so wound ourselves and those we love. We tried but could not prevent that harm from happening. Our addiction was not a choice; it was something we got caught up in and lost control over. Addiction is a disease of exposure—a collision between personal vulnerability and social opportunity. And that opportunity is often bred within psychological and social circumstances that made picking up again and again an attractive choice.

As a culture, we have recognized this process of social contagion. We have long referred to surges in alcohol and other drug problems as *epidemics*—a term most often applied to communicable diseases. But I am not here tonight to talk about disease. I am here to talk about recovery—something we rarely think of in terms of contagion. We usually think of recovery as something that arises from deep inside someone. We think of it as those rare transformative experiences like Bill Wilson experienced in a hospital room and Malcolm X experienced in a jail cell, or we think of it as a slow process of internal change—a process of spiritual awakening.

Folk wisdom says recovery comes only when we hit our own personal bottom. But recovery did not



come to some of you in this room by hitting bottom. Some of you lived on the bottom, and recovery remained a stranger. Some of you were drowning in pain, had lost everything but your life to addiction—and recovery still did not come. When it finally arrived, it wasn't forced on you and you didn't initially choose it. You caught recovery in spite of yourself. And you caught it from other people in recovery—from people here at NET and from people in the recovery fellowships meeting every day throughout this city.

Let me be clear and brutally honest. Some of you did not come to NET seeking recovery. Many of you had never even seen long-term recovery in the flesh—had no idea what it even looked like. Many of you came to treatment not because of the monkey on your back, but the people on your butt. Some of you came looking not for recovery but respite—a break from the life, not an end to it. Some of you came to escape the threat of jail. Some of you came to keep or get back important people in your life. The reasons were many and may have changed every day, but recovery was not at the top of that list. And yet many of you have started what will be a lifelong recovery journey. So how did this miracle happen?

My message tonight is a simple one: Recovery is contagious. That message is the centerpiece of the recovery revolution sparked by the leadership Dr. Arthur Evans, Jr. brought to the City of Philadelphia more than five years ago. That message is what has made NET one of the leading treatment centers in the country. And there is no better example of this process than what is happening right here, right now. This night is a celebration of the contagiousness of recovery and the fulfilled promises recovery has brought into our lives. Some of you did not leave the streets to find recovery; recovery came to the streets and found you. And it did so through volunteers of the NET Consumer Council walking those streets. They put a face and voice on recovery. They told you that recovery was possible, and they offered their stories as living proof of that proposition. They told you they would walk the road to recovery with you. Some of you hit low points in the early days of that journey, and it was your brothers and sisters in this room that lifted you back up—who called when you missed group, who, in some cases, went and got you. Many of you were buried deep within a culture of addiction—

a way of thinking, feeling, acting, and relating as powerful as the drugs you were taking. The NET community and the larger recovery community of Philadelphia helped you escape and welcomed you into membership in another world—a culture of recovery. And this moment we are sharing together tonight stands as witness to the vitality of that recovery culture.

Recovery is contagious only through interpersonal connection—only in the context of community. For those still in the life to find hope and recovery, they must take the unlikely risk of leaving their cocooned world or we must risk going to get them. The outreach work of the NET Consumer Council has a poignant message for this country's efforts to prevent and treat addiction. If we are really serious about addiction, then we should reach those who are at early stages of their addiction careers and not wait until decades of devastation finally bring them to the doors of a treatment center. We need to correct the community conditions in which addiction flourishes. We need to protect those most vulnerable to addiction. We need assertive intervention programs that shorten addiction careers and extend recovery careers. To achieve those goals, we must carry resilience and recovery into the very heart of local drug cultures. We must make the transformative potential of recovery visible to those who need it the most.

The contagion of addiction is transmitted through a process of infection—the movement of addiction disease from one vulnerable person to another. The contagion of recovery is spread quite differently—not through infection, but affection.¹ Those who spread such affection are *recovery carriers*. Recovery carriers—because of the nature of their character and the quality of their lives—exert a magnetic attraction to those who are still suffering. Recovery carriers affirm that long-term recovery is possible and that the promises of recovery are far more than the removal of drugs from an otherwise unchanged life. They tell us that we have the potential to get well and to then get better than well. They challenge us to stop being everyone's problem and to become part of the solution. They relate to us from a position of profound empathy, emotional authenticity, respect and moral equality—lacking even a whisper of contempt. Most importantly, they offer us love. Yeah, some of us got loved into recovery, and I don't mean in the way some of you



with smiles on your faces may be thinking. The affection at the heart of the recovery community you have created here at NET is being extended as a force for building resistance, resilience, and recovery within the larger Philadelphia community and beyond.

We all have the potential to be recovery carriers. Becoming a recovery carrier requires several things. It requires that we protect our recoveries at all cost—*Recovery by any means necessary under any circumstances*. It requires that we help our families recover. It requires the courage to reach out to those whose lives are being ravaged. It requires that we give back to NET and other organizations that helped us along the way. And it requires that in our new life, we try to heal the wounds we inflicted on our community in our past life.

Addiction is visible everywhere in this culture, but the transformative power of recovery is hidden behind closed doors. It is time we all became recovery carriers. It is time we helped our community, our nation, and our world recover. To achieve this, we must become recovery. We must be the face and voice of recovery. We must be the living future of recovery.

So to all who are here tonight—individuals and families in recovery and allies of recovery, I leave you with this message. Recovery is contagious. Get close to it. Stay close to it. Catch it. Keep catching it. Pass it on.

Treatment and Mutual Aid

David McCartney

A new understanding is developing around the benefits of building community recovery capital and of the protective and healing effects of linking people into recovery communities. (Best & Laudet, 2010) Recovery communities are perhaps most clearly visible in the wide network of mutual aid groups in the UK.

Increasing quality and quantity of social relationships in a person's life has been directly linked with good mental health, and reduced

morbidity and mortality. In a recently published meta-analysis (Holt-Lunstad et al, 2010) it was found that having strong social relationships has an effect on survival comparable to that of quitting smoking and more than addressing obesity or high blood pressure. Addiction has considerable morbidity and significant mortality. We already know that the risk of relapse in the year following treatment is associated with the number of heavy drinkers in a person's social network. Conversely the risk reduces with social networks that promote abstinence and connecting clients to these sober networks is likely to be protective (Litt et al, 2009) Grella and colleagues found (2008) that compared to those who continued to use, individuals who made the transition to recovery had a greater proportion of friends who were clean and sober and those who relapsed were less likely to use self help groups.

There are almost 7000 weekly meetings of mutual aid groups in the United Kingdom, an enormous resource by any standard. In addition, there are dozens of service user groups and a growing number of grassroots community organisations available. What do treatment providers make of this resource and how strong are the links between treatment and mutual aid? The answer is that we don't know though evidence exists for their benefits and also for the practice of assertive linkage (Weiss et al, 2000), a way of maximising the chance that clients will actually get to a meeting.

William White has advocated for greater connections between treatment and mutual aid, but also a reframing of the relationship, which includes seeing treatment as an adjunct to mutual aid rather than the other way around. (White & Kurtz, 2006), a sentiment echoed by Best and Laudet (2010) who suggest that treatment providers or commissioners are "often best placed to act as guides to recovery communities". Recovery success in turn is likely to have a positive effect on workers in the field as they see the fruits of connecting people to such communities.

Wouldn't it be interesting if we turned our current approach on its head and put our energies into actively linking those seeking recovery to communities of recovery and at the same time helped to grow and support these communities by prioritising resources to these ends? This transition



will perhaps be challenging for professionals but there is evidence already of a gradual culture change and this needs to be encouraged.

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What is the recovery movement in the UK?

David Best

Recovery is not new in the UK or indeed anywhere else. As is well documented in “Beating the Dragon” the history of mutual support groups does not start with Alcoholics’ Anonymous in 1935, but has a much older history that varies across countries in part as a result of the substance using profile and the nature of social structures – this is as true of the

UK as anywhere else. The UK has a proud tradition of residential rehabilitation, therapeutic communities and self-help organisations that is not new. So what are we claiming is new? Two things – the emergence of an evidence base, and the beginnings of a movement towards creating local systems around recovery. Surprisingly, this is new, as is the idea that the system of supports is not structured around ‘treatment’ and will be judged in terms of the number of people whose lives improve, as do those of their families and communities, irrespective of engagement, retention and completion of treatment.

So what does this mean?

On the positive side this involves a commitment to community and residential rehabilitation, to effective engagement with housing and employment services, as well as increased focus on success and the role of the peer in enabling and supporting it. One of the key aspects of the recovery movement in the UK has been the emergence of the idea of a recovery champion operating in and around a recovery community.

Recovery champion: Within a recovery system, there is a central role for peers as the carriers of hope and guidance – while similar to the role of a mentor in 12-step, the recovery champion is not linked exclusively to any philosophy but is a visible icon of recovery who carries the message that recovery is possible and provides the support and linkage to meaningful support and recovery groups. This group will involve lots of people who are themselves in recovery but can also include workers (“therapeutic champions” who can change the cultures and professional practice of their colleagues) and managers and commissioners (“strategic leaders”) who work together to support each other and increase the reserve of community recovery support.

Recovery communities: Within the recovery model, one of the underlying assumptions is that recovery is inherently social and interpersonal. As White has indicated, recovery groups provide a range of benefits

- Experience of acceptance and belonging
- Build esteem through identification with a large organisation
- Provide a belief system through which



shame and defeat can be transformed into victory

- Provide a vehicle for the safe discharge of powerful emotions
- Provide a consistent set of rituals that facilitate emotional release and value-focusing
- Provide a forum for consultation on daily problem solving
- Provide rituals that allow the group to celebrate success

So where are we in the UK?

There is an astonishingly rich diversity of recovery activities ongoing in the UK – and an incredible array of champions who carry a range of recovery messages. The vehicles for delivery include recovery cafes, recovery walks, recovery-focused training, education and employment opportunities. But the key is the coordination of champions – what we are beginning to see is the effective linkage of champions within systems of care that are designed to enable recovery contagion.

There is a long way to go – recovery projects are too rarely evaluated and there is still insufficient coordination and planning – but there is a unique opportunity to build on policy opportunities, a growing commissioning consensus and the wonderful array of skills and shared commitment to make recovery a sustainable and viable model for empowering change.

Peer Support and Recovery in the Community

Matthew Kidd

Recovering communities are often associated with residential rehabilitation. Having a visible community that can support and provide for people before, during and after treatment is a fairly new concept to the UK, although peer support organisations and self-help groups are well established within the US. In the US people frequent self-help groups for a

variety of chronic health conditions. However, in relation to the drug and alcohol field we understand self-help to mean peer-operated groups, services or organisations who are devoted to helping individuals with addiction problems (Humphreys et al 2004).

In the US peer support services are accessed frequently, and are viewed by those who attend as being equally valid as the professional services, if not more so. They appeal to a broad spectrum of people, and are seen as affordable in relation to many residential rehabilitation centres. “Addiction related problems are clearly the most common motivator for self-help group attendance“; (Kessler et al., 1997; Room & Greenfield, 1993). “In fact, Americans make more visits to self-help groups for substance abuse and psychiatric problems than they do to all mental health professionals combined” (Kessler et al., 1997).

Having activities which unite people along each and every stage of their recovery journey is essential in terms of achieving sustainable communities of recovery in which people can “get well in the town in which they got sick”. Humphreys et al recommend that policy makers should support the development of innovative peer led/peer support services. Examples in the US have been the CSAT’s (Centre for substance abuse treatment) recovery communities’ services program. We are now looking to develop and establish such services in the UK.

We should view peer support services as a provider of a continuum of care rather than as a substitute for treatment services. (Humphreys et al 2004)

The role of peer support cannot be underestimated in terms of building recovery capital. Recovery is rarely experienced in isolation; those who achieve recovery invariably build a network of support. Traditional models of relapse prevention encourage people to only make friends who have never experienced a substance misuse problem. In my experience this is flawed logic for two main reasons:

1. In the early stages of recovery making new friends is difficult. There often needs to be a common bond which unites people, contrary to the belief of many, this common bond is an affiliation with recovery and the process of “getting better” rather than an



affiliation with substances.

2. This approach seeks to isolate people in recovery from those who need to see that recovery exists. Service users and frontline staff don't see recovery happening and don't experience the infectious nature of recovery.

Another feature of communities of recovery is that people can pick and choose how and when to engage with different activities. A peer support group such as SMART recovery will be right for some; helping out in a drop-in will be the choice of others. There are many ways of combating boredom, isolation and lack of purpose. Some will involve only those who are either in or working towards recovery, others will mainly involve supporting those in active addiction, as well as a host of activities and opportunities which can benefit both. The individual in recovery will know what is right for them. Gaining such self-awareness is a key component of recovery.

In conclusion I would say that developing a recovery identity often gives people the strength both to learn from their experiences and to share this experience with others. That is not to say that there aren't stresses and problems associated with mixing with people in active addiction, but that these stresses and problems become part of every day life. They also go hand in hand with the infectious spread of recovery, and the sense of wellbeing that comes with seeing others experience recovery. Shelter from the outside world, and all the triggers and temptations it involves, will only ever work for so long.

Communities of recovery are invaluable support networks. They act as a community resource that people can access before, during and after treatment. Inevitably there will be relapses, but people need to accept that relapse also occurs as a result of isolation and lack of recovery capital.

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The North West Recovery Forum and growing communities of recovery

Mark Gilman

Firstly, I would like to refer those with an academic thirst to Gilman & Yates (2010) and a subsequent article on 'The North West Recovery Forum by myself and Rowdy Yates which should be published in the forthcoming special edition of JGAR. Now I want to tell you a story about The North West Recovery Forum and our efforts to grow recovery communities in the North West of England.

I joined the NTA in November 2001. Conceptually, the NTA's job was simple. Increase the numbers of people getting into structured treatment for substance use disorders and get rid of the waiting times. Once people with substance use disorders are in treatment make sure they are retained there long enough for the treatment to have an impact (i.e. over 12 weeks or 90 Days). By the spring of 2005, we had got the numbers in, the waiting lists had gone and most people were retained. In June 2005, we started to talk seriously about recovery. In fact, our first discussions were about abstinence. Namely, we wanted to ensure that abstinence based treatment options were available. We became the North West Recovery Forum in an attempt to recognise and respect different recovery pathways that may, or may not, be abstinence based. I put together a very crude PowerPoint presentation on recovery and went round the region



presenting it. We had decided to go for an early adopter methodology. That is, if people didn't understand what we wanted to do, were wary or hostile we crossed them off the list. We only wanted those who understood, could see where we were going and wanted to come with us. We didn't have time to cajole and persuade. We would go with the early adopters and hoped the rest would follow (they have).

The first challenge was to get some movement into the system. We met people who were stuck in treatment. They were retained in treatment. They weren't dead and they weren't in prison but they weren't happy either. They were stuck in a constipated treatment system. They were waiting to get on board the freedom train to the land of recovery. The system needed unblocking and the people in treatment who wanted to move on had to organise and move on together. Many had tried to do this on their own. They couldn't. We built a bridge from the land of treatment to the land of recovery. People from the land of recovery told us that we could achieve things together that we could only ever dream of achieving alone – "I can't but we can". Dr David Best was almost a founder member of the North West Recovery Forum and it was he who introduced us to the literature on social contagion and connectedness. We are social animals. We mirror, model and influence each other's behaviours.

Perhaps the most poignant and pertinent parts of the North West Recovery journey came when one of our members suggested that the test for commissioners and providers of services was very simple. Would you use, or let your loved ones use, the treatment services that you commission and provide? If you can't look in a mirror and honestly answer yes, then you need to explain why. Then, having decided what services would look like, if they were to be used by those who commission and provide, get on and provide them for everyone. The latest development in the North West Recovery Forum's attempts to grow recovery communities is our focus on Asset Based Community Development (ABCD). Recovery is a reality. Recovery is contagious. Your history is not your destiny. Yesterday is history. Tomorrow is a mystery. All we ever have is today. You can't change the world in a day but you can change yourself right now. Can you hear the whistle? The recovery train to freedom is

coming. Get a ticket and get on board.

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Recovery: A Journey of Self-Transformation

Stephen Bamber

Who are you?

Are you the same person as you were yesterday?

How about a year ago? Two years? Am I the same Stephen Bamber as I was aged 16? What's different? What's changed? What elements of our self-identity remained the same?

The cluster of questions that orbit around the concepts of self and self-identity are acutely significant when considering addiction recovery. The shift towards long-term thinking taking place from top-to-bottom throughout the UK's treatment ecosystem provides a valuable opportunity to creatively re-vision our understanding in fresh, unconventional ways (although there is a modest body of literature on addiction and identity, there is little on *recovery* and identity). Positing recovery as a journey of self-transformation is an approach that can help stimulate innovation and foster new understanding. It is particularly congruent with the conceptual foundations of mainstream recovery thought, which emphasise empowerment, individualisation and long-term, holistic change.

The addict self is a particularly well-defined subjectivity (experience of ones own self) that has developed over the past 200-300 years (Levine, 1978. Cf. Warner, 1994; Porter, 1984), evolving into a distinctive variety of the deviant identities formed in opposition to the normative post-Enlightenment ideal of the autonomous, self-determining individual able exercise restraint and self-control; regulating



their behaviour without disturbing the delicate balance of the social contract.

The modern “addict-self” (reified contemporarily as the Problem Drug User, or PDU) refers to a genus of non-productive individuals who require particular kinds of moral, medical, and juridical interventions in order to subjugate, analyse, control and ultimately reform them into economically productive individuals capable of maintaining the levels of self-control demanded by advanced liberal societies. In this sense recovery is simply an extension of a governmental logic that seeks to maximise the productive and consumptive efficiency of the populace (Bamber 2009).

For those tied to this addict identity and the cultures and discourses that produce them, the journey of recovery represents a profound reclamation, or transformation of the self. As Alexandre Laudet - friend of the Recovery Academy and distinguished scholar - observes of the Pathways Project: “A recurrent theme was that recovery is [the process of] regaining an identity (a self) lost to addiction” (Laudet 2007). We may quibble over definitions and competing accounts of recovery yet there appears to be a theoretical subtext running through all expositions of recovery: we sacrifice an old self and lay claim to a new self in the making.

We tend to assume we have stable, enduring, self-identity, yet the continuity of this can be disputed. The journey of recovery from addiction is an exquisite example of how individual selves can, and do, change over time. Although we sense there is some connection with the person we *are* today and the person we *were* when living in the chaotic tempest of full-blown addiction, it is difficult to isolate and identify the elements that connect or separate these two diametrically opposed ways of life.

We have memories of course, and external fixed points that re-enforce our sense of self: our living space, our habits and proclivities, our commitments, our community, family and friends: in short, our way of life. We find ourselves reflected in other people and places as much as we do in the mirror of our own self-awareness. The greater the difference in our relationship between these exterior sources of the self - the wider the gap between addiction as a way of life and recovery as a way of life - the greater

our chance of solidifying recovery into a concrete mode of being capable of propelling us safely through the fragmented and ephemeral territories of 21st century life.

Translating the abstract sphere of recovery identity theory into meaningful guidelines for practice is no easy task. However, viewing recovery from the perspective of identity transformation opens up valuable new ways of thinking about the initiation and sustainment of recovery in groups, communities and individuals. For example, recognising, as pioneers in the field of natural recovery did, that re-situating the self in new social contexts hastens and supports the construction of a non-addict identity, we immediately see the value of identifying and demarcating the boundaries of local recovery cultures and orientating ourselves towards them

Perhaps the most notable benefit of an identity-transformation approach is it allows us to move beyond the weary dualism of medical and moral accounts of addiction and recovery. Focusing not on the perceived rights and wrongs of particular decisions or behaviors, but instead taking a long-term view in terms of the choices we have with respect to our identity. Rather than asking, “*What should I do?*” we can engage with the much more profound question of “*Who do I want to become?*”

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What does “recovery” mean?

David Best

This has proved to be an extremely contentious question for two reasons – the first is that it is generally regarded as a lived experience that is personal and the second is that it is often characterised as a journey rather than a destination, and a journey that may vary from one person to another. This makes definition problematic but has not prevented two ‘consensus groups’ – one in the US and the other in the UK from attempting to define recovery.

In the US, the Betty Ford Institute Consensus Panel (2007, p. 222) defined recovery as “*a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship*” while in the UK, a consensus group brought together by the UK Drug Policy Commission provided a statement that characterised recovery as ‘*voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society*’ (UK Drug Policy Commission, 2008, p6).

The definitions share three common characteristics – a focus on improved wellbeing or quality of life, some measure of avoidance of substance use and some evidence of engagement in civic or community activities. While there has been little challenge to the first of these, there have been considerable anxieties raised about the need for some threshold of non-use (should it allow ongoing prescribing or occasional recreational or controlled use of substances?) and about whether people in recovery should be ‘required’ to participate in the ‘responsibilities of society’.

A less demanding definition comes from the mental health field where a recovery advocate, Pat Deegan, has described recovery as “*the lived experience of people as they accept and overcome the challenge of disability... they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability*” (Deegan, 1998). While this definition is potentially less

‘demanding’ it incorporates one important characteristic of recovery – that purpose and meaning in recovery do not require the person to be symptom-free.

The Centre for Substance Abuse Treatment (2009) took a further step by outlining a series of ‘principles of recovery’ which may be more accessible and inclusive than a formal definition. Their principles are:

- There are many pathways to recovery
- Recovery is self-directed and empowering
- Recovery involves a personal recognition of the need for change and transformation
- Recovery is holistic
- Recovery has cultural dimensions
- Recovery exists on a continuum of improved health and wellbeing
- Recovery emerges from hope and gratitude
- Recovery involves a process of healing and self-redefinition
- Recovery involves addressing discrimination and transcending shame and stigma
- Recovery is supported by peers and allies
- Recovery involves rejoining and rebuilding a life in the community
- Recovery is a reality

Why might the principles be a better way of moving forward than a definition? First, they are less open to suggesting that some people are ‘in’ while others are ‘out’. And this relates strongly to the second issue which is who has the right to define. Recovery is not a clinical or diagnostic state, and refers to a lived experience of people in different places having travelled by a wide range of routes. Definitions may be helpful for people in recovery, for professionals and for the wider community but only if they are deployed to support and engage – not if they are used by ‘experts’ to categorise or label. Recovery should be something to be celebrated not something put into a particular box by professionals or experts. Recovery communities



Establishing recovery communities

Matthew Kidd

Suggestions as to how we can help to establish Recovering Communities:

Training as part of aftercare programmes around reintegration in to the community

As part of any “exit Plan” we should run workshops and/or group activities which are focussed on accessing mutual aid groups, community projects and virtual recovering communities

Training for staff around attitudes, beliefs and awareness

People in recovery can play a key part in reshaping the attitudes and beliefs of staff, in particular in convincing them of the benefits of peer support and/or mutual aid. As a result of this we can help to remove barriers that occur as a result of certain members of staff being ill informed.

There should be more in place to encourage people to make use of different services

There are training programmes designed to encourage peer mentors and peer supporters to act as an “honest broker” within a peer led organisation or group. It is suggested that signposting be a key feature of emerging recovery organisations. More service user groups should be able to access these training programmes.

There should be more help with finances and debt for service users/people in recovery. Extending from this, more help with practical needs in general

In order for people to move forward and become active within their community they often need to deal with their practical problems first.

Training around service users/people in recovery

developing their social skills could be improved.

Many people will not access community resources because of a lack of confidence and self-esteem.

There should be a wider variety of group work and activities on offer. There is too much of a focus on one to ones and traditional clinical interventions. Whilst it is accepted that there is a place for this, it should exist alongside a more varied and recovery focused system of care

The Cycle of change and relapse prevention are tried and tested but they do not address the social and community needs of individuals.



Workshop Session One

Lessons from the Serenity Café

Ruth Campbell, Mikey Gaughan, David Tomlins
and Kane Duffy

The Serenity Café aims to provide a hub in Edinburgh for the recovery community, building social networks, creating personal development opportunities and supporting collective action for people recovering from addiction to drugs and alcohol, helping to strengthen long term recovery and enabling people to regain a positive and fulfilled life.

The Serenity Café was established in 2009 in Edinburgh by people recovering from addiction, with the support of community development agency Comas. In 2010 the Serenity Café won the Community Action Award of the SCVO Scottish Charity Awards. The Serenity Café uses an action research approach, helping people in recovery to share their experiences and expertise, and it is also based on a community development model, ensuring that people involved gain skills and experience to continue to promote recovery in policy and practice.

The workshop shares the story of the Serenity Café, inviting participants to share their thoughts and perspectives on the challenges we have experienced during its development.

These challenges include:

- The community development process, how to support people in recovery to identify

their own needs and solutions to building recovery capital

- Working with volunteers in recovery
- Employability and the pressure to ‘move on’
- Funding community development, social enterprise and recovery: getting people interested in what we do, and why it is needed

The workshop will include a question and answer session, which will be reported on www.serenitycafe.org.uk and www.recoveryacademy.org

Workshop presenters:

Kane Duffy is a volunteer with the Serenity Cafe who takes a lead responsibility for policy development in the steering group and has conducted focus groups with members of the recovery community on various aspects of recovery, including mental health, and spirituality. He is currently a student of psychology at Heriot Watt University. Kane has been in recovery for 3 years, after 15 years of addiction.

Mikey Gaughan is a volunteer with the Serenity Cafe and works in hospital theatre support services. Mikey has been in recovery for 4 years after 22 years of addiction. Mikey has a commitment to supporting people in early recovery and has been active in helping establish CA (Cocaine Anonymous) in Edinburgh. Mikey co-facilitated focus groups as part of our research.

David Tomlins is a volunteer with the Serenity Cafe who has been in recovery for two years. He is studying counselling and is a peer supporter with Lothian and Edinburgh Abstinence Project. He is a member of Serenity Cafe steering group and has taken a lead role in recruitment of staff and volunteer development.

Ruth Campbell works for the community development agency Comas, supporting the Serenity Cafe to develop.

Comorbidity and Recovery



Brendan Georgeson

1. For the purpose of this workshop comorbidity means: people who have mental health problems **and** alcohol or other drug problems.
2. Outline some ideas of what recovery from comorbidity looks like which can possibly best be illustrated by the experience within the mental health field.
3. Briefly share my own experience of recovery from comorbidity.
4. Outline some principles for progress in this area

The rest of the workshop is facilitating feedback/ discussion/ experience from the participants

The central message of this workshop is ‘hope and optimism - never give up’

Brendan Georgeson is an ex-service user in recovery from addiction and mental illness currently employed as the treatment coordinator at Walsingham House, a tier 4 service that specialises in working with dual diagnosis and complex needs service users.

Email: brendangeorgeson@yahoo.co.uk

Workshop Session Two

How to: Deliver recovery focussed services

Derek McCabe and LaRC

1. Introduction and welcome: Derek McCabe
2. Small group exercises: Jed Brady
3. Feedback on small group exercises: Jed Brady
4. A living breathing example of recovery champions in action-LaRC: Derek McCabe
5. Working with community champions: Brian Hutchinson and Frank Balfour

Small Group Exercise- points for discussion

- **Group 1:-** How do we involve family and others in the recovery process?
- **Group 1:** How do we make sure that the guiding principles of recovery (hope, choice and inspiration – for staff and clients) can be delivered?
- **Group 2:** How can we coordinate care across service systems e.g. employment, housing, benefits, treatment, mutual aid?
- **Group 2:** How can we promote empowerment within the therapeutic alliance?
- **Group 3:** How can we make sure that a recovery orientated system of care impacts on DNA rates?
- **Group 3:** How can we develop our strategic, therapeutic and community champions?



How to: Design a recovery system - The North West Recovery Forum and growing communities of recovery

Mark Gilman

The workshop will be led by Mark Gilman, National Treatment Agency for Substance Misuse North West Regional Manager

Principles

The workshop will examine the principles that should guide the establishment of Recovery Forums and the growth of recovery communities

Roles and Responsibilities

It will determine who is responsible for the establishment of Recovery Forums and the growth of recovery communities

Building and sustaining

It will explore how Recovery Forums can be established and how recovery communities can be built and sustained

The role of treatment

It will examine the role of treatment in the establishment of Recovery Forums and the growth of recovery communities

How to: Integrate recovery into post-

treatment support

Nick Barton and Kirby Gregory

An **Action on Addiction** Workshop

admin@actiononaddiction.org.uk
www.actiononaddiction.org.uk



The workshop will be led by Nick Barton, Chief Executive and Kirby Gregory, Director of Client Services.

Principles

The workshop will examine the principles that should guide the organisation of post treatment support

Roles and Responsibilities

It will determine who is responsible for identifying and integrating that support into recovery and how they might go about it

Building and sustaining capital

It will explore how recovery capital across all domains can be built and sustained

The role of treatment

It will examine the role of treatment in what happens after treatment.

Talking about DARE: a walking recovery group -

A walking workshop exploring the role of



recovery on the move

Wulf Livingstone

This workshop tells the story of an informal recovery orientated mountaineering group, based in North Wales. It seeks to use the narrative process as a means of evidencing the existence of recovery groups outside the confines of buildings, illustrating their diversity and exploring the issues of knowledge and power that arguably construct and restrict recovery agendas. What will be shared is both a successful and typical mutual aid story (all be it in a more unusual context), springing from accidental beginnings but then progressing through initial bonding and forming to the long-term realisation and maintenance of support. It will explore why belief in others, acts of giving and sharing, access to resources and the taking of risks are fundamental ontological considerations for the recovery movement. Finally, this tale of philosophies, knowledge, ownership, power and recognition of achievement will provide evidence of what in other sectors would be called successful treatment outcomes. This will be done on the move, outside of the environments of the conference hall and along the streets and back waters of Glasgow, irrespective of the prevailing weather.

The Recovery Academy Conference was kindly

supported by:

Phoenix Futures

Ending dependency, transforming lives



Phoenix Futures is the leading provider of care and rehabilitation services for people with drug and alcohol problems across the UK. Through nearly 40 years experience of transforming lives we have developed a diverse portfolio of services in community, prison and residential settings.

We also run several unique personal development programmes in England and Scotland which complement our core services and help hundreds of people gain skills, confidence, motivation and employment.

As one of the most diverse substance misuse organisations in the UK, we take pride in our ability to support changed lives from the street through to resettlement.

Our approach to the provision of services is encapsulated in our vision, that every person who is dependent on drugs and alcohol has the potential to rebuild their life. Our organisational values that underpin this are to be effective, caring, person-focused and committed.

Through our expertise we are able to support our service users at every stage of their recovery.

Our organisational vision has a visible partnership ethos and approach. True partnership working comes from a shared understanding and appreciation of each other's specific contribution and expertise.

Our approach will promote and celebrate recovery as a desirable and achievable aim. We achieve this by ensuring those in need receive timely, sensitive



and appropriate support. This support extends to family members and the local community to engender meaningful, visible, communities of recovery.

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and



ACTION ON ADDICTON

Action on Addiction was formed in April 2007 through the merger of Clouds, The Chemical Dependency Centre and the former Action on Addiction. The merger of the three charities has resulted in a charity that is unique to the addiction field in its scope, covering everything from prevention to recovery, treatment (both residential and non-residential), research, support for families and children, workforce development, education and campaigns.

The Charity takes action to disarm addiction in all its forms through a uniquely comprehensive approach. Action on Addiction’s vision is to see people free from addiction and its effects. In taking action to disarm addiction, Action on Addiction works both

directly and indirectly on behalf of beneficiaries.

Action on Addiction offers a range of services, in various parts of the country. These services include residential treatment and rehabilitation at Clouds House in Wiltshire and Hope House (for women only) in London; family and children services through Families Plus, including the Moving Parents and Children Together (M-PACT) programme; community-based Structured Day Treatment is offered at SHARP London, SHARP Liverpool and SHARP Bournemouth and Poole. The latter also provides Progress, a pre-treatment service, Continuing Care and Working Recovery supporting clients to develop work and skills training for those in recovery.

The centre for Addiction Treatment Studies designs and teaches courses in Addictions Counselling resulting in the award of Foundation and Honours degrees by the University of Bath. Continuing Professional Development Courses are offered as well as consultancy support to treatment organisations.

Nick Barton is the Charity’s Chief Executive; Kirby Gregory is the Director of Client Services.

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and also



Thank you!



Notes: