Scientific findings from a book about Recovery Pathways: Measurable factors that can improve or impede our outcome rates

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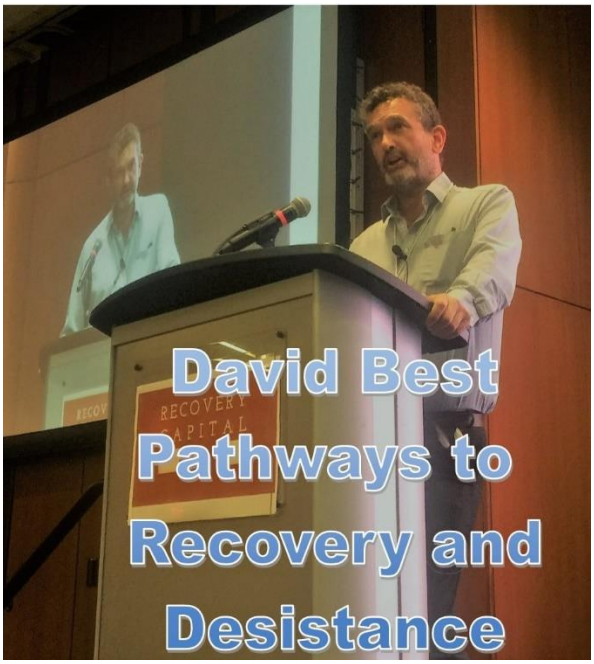
David Best's *Pathways to Recovery and Desistance: The role of the social contagion of hope* (2019), as he said in a keynote address at Recovery Capital Conference, New Westminster (Vancouver Canada) late in 2018, months before the book's release "was seven or eight years of study and research." The result for us, is a 200-page read, along with another twenty pages of notes and references for the keeners and skeptics in the audience.



From the podium Best described the book as being about "a model of recovery that happens interpersonally. Recovery isn't something that happens without people; but it's something that also happens between people. Recovery is a social movement and a social movement for good."

A professor at the University of Derby, previously Sheffield Hallam University and visiting Associate Professor of Addiction Studies at Monash University, Melbourne, David Best specializes in criminology and finds some commonality in desistence from crime and recovery from addiction. In fact, his work overlaps, helping England with the first recovery prison, changing the culture for staff and inmates. Any of you who works in corrections, law enforcement, whose story includes doing time, or take meetings inside correctional facilities, there is a good deal of fascinating experience and findings that will appeal to you. For the purposes of this book review, I will leave this out of our discussion.

Research that went into this book includes over 2,000 recovery stories from Scotland, Wales, Australia, New Zealand, and America. He looked for a common element that everyone did, which he could not find. However, "What I've discovered from all of these stories is that nobody recovers alone." Therefor *Pathways to Recovery and Desistence* is a social model of recovery.

What about spontaneous remission? We know that people overcome process and substance addictions without treatment or mutual aid. But are they recovering alone? Best's findings suggest, that the individual recovering "on their own," has some recovery capital active in their life. Best spends a good deal of space talking about social models of recovery/ recovery capital that have nothing to do with going to mutual aid groups or treatment centers: work/life satisfaction, family, community, role models, etc. "People can and do mature out of addiction if the environment and the context is rich and enables them, supporting that process of change."

Fun fact from the Best research: For any group of people who detox from alcohol or other substance use disorder, with the intention of maintaining abstinence, people who know at least one person who is abstinent—this factor alone—yields a 27% better chance at sustainable permanent recovery over others who know no one who is clean and sober.

Return to the crack house or the band on tour, or any other profession that glorifies or rewards drinking/using behavior, without anyone in their circle who lives clean and sober—this isn't to say this individual can't get sober. But this peerless lone wolf has a 27% less likely chance of achieving long term sustainable recovery.

"Recovery is a long-established phenomenon but as a professional phenomenon, we still struggle for it gain adequate traction," Best reports. "There still huge barriers, misconceptions, professional jealousy and attitudes that block recovery. It's been a very gradual process."

Time for the next fun fact from the book? How many people do you think recover from process or substance use disorder? What percentage? No, 5% is not factual. The whole industry massively underestimates the outcome rates.

The findings of Best et al. is 58% will eventually achieve stable recover—effectively five years abstinent from their drug of choice.

"Why five years? That has to do with relapse risk." Between leaving our first detox and making it to five years, the likelihood of relapse for both opioids and alcohol is 50 to 70%--you or I are more likely to relapse in our first year, so researchers have learned that getting well is not an uninterrupted (relapse-free) trip for all of us. By five years our relapse rate is 14% or less. Researchers argue that after five years, recovery is self-sustaining. People can do it by themselves at that point. The determinants of outcome rates, of getting people from that first year to the five-year mark has a lot to do with the quality of community.

If your guess about outcome rates was lower than 58%, you are not alone. There is pessimism among treatment workers. Best asked a group of Welsh workers, "What do

you think the likelihood of success is among your clients; how many people do you think come to treatment and then find long-term recovery? The science says 58%. The average (guessed) score from Welsh drug workers was 7%. You might reasonably think, 'Well, if that's what you expect, that's what you'll get; because you'll convey that message of hopelessness.' This is what is referred to as a clinical fallacy. One of the massive challenges we have to overcome is the pessimism of the workforce."

Borrowed from studies on mental health recovery, successful recovery interventions have five component parts that are essential, and they came up with an acronym: CHIME:

1. Connectedness
2. Hope
3. Identity
4. Meaning
5. Empowerment

Any system (including mutual aid groups) that embodies all five of these, in Best's observations, will succeed. Any system that does not, will not succeed. So, it's not Step *this* or Noble Truth *that* or affirmation-*A* or Cognitive Behavioral Therapy technique-*B*. All of these professional therapies and peer to peer supports can work equally well, so long as they incorporate these five essential elements.

She Recovers has intentions and guiding principles, Buddhist based recovery follow an eight-fold path, in LifeRing, efforts to strengthen the Sober Self and weaken the Addict Self are achieved by a do-it-yourself program. Like the 12 steps or a stylized AA philosophy, any of these "programs" relates the experiences from one substance use sufferer to another. Trust and engagement of a group and placing faith in a process, seems to facilitate better outcome rates, regardless of the group or the process.

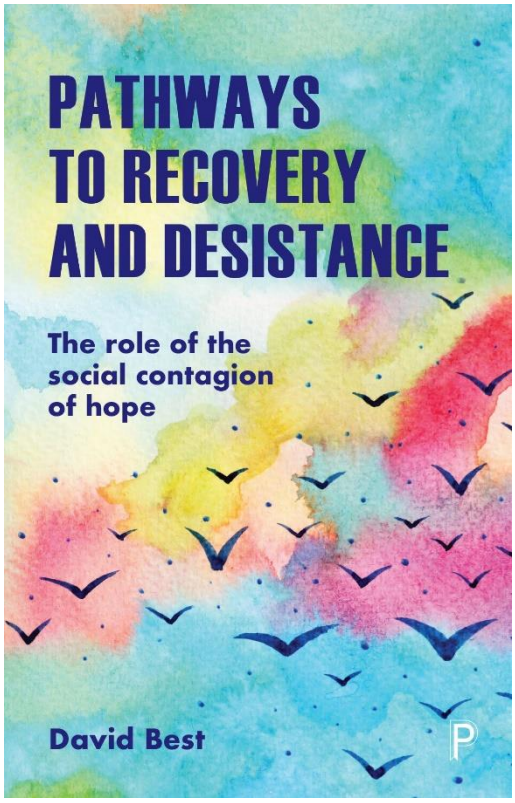
Johann Hari famously concludes that the opposite of addiction is not sobriety, it is connection. That makes a great bumper-sticker but like most reductionism, it holds only a modicum of truth. Lots of people have connection and community if they go back to the bar, the crack-house or into the arms of an enabling partner. The type of connection that leads to sustainable recovery is connection that channels hope. the connection to a community that models recovery lifestyle. The example of fellow sufferers who are coping and/or thriving in a life of abstinence. "If they can do it, I can do it."

My attitude changed from resignation about dying an addict's death to the possibilities presented to me my recovery community. And as I look back, they had hope for me before I could muster the integrity to do it for myself. Their hope—the hope from the community—was contagious; I caught hope, I didn't muster it.

Connection is more involved than attendance. Connection comes from engagement. When trust and commitment are inspired from the community, that is the basis of a healthy connection.

Identity brings into context the value of special purpose mutual aid groups like secular AA but a change in identity is important to all. As David Best reports:

> "...The impact of identity of social group membership. The Social Identity Model of Recovery (SIMOR) frames recovery as a process of social identity change in which a person's most salient identity shifts from being defined by membership of a group whose norms and values revolve around substance abuse to being defined by membership of a group whose norms and values encourage recovery."[i]



That makes sense, going from a community where using/drinking behavior is modeled, my identity was tied to my using, which was tied to being a renegade, a member of the in-crowd cool subculture. Then, hanging around people in recovery long enough, I started modelling their behavior and developing their identity as a person beyond drugs and drinking, someone who chose recovery as a self-image. But there is more; Best goes on to say, "For this model to apply, the new group that the person aspires to join has to be attractive..."

If the heteronormative language of AA literature bums your recovery high, listening to shared experiences in meetings for LGBTQ+ will be more attractive for you. This is true for youth or women, Black, Indigenous, People of Color (BIPOC) and secular AA for agnostics, atheists—anyone who isn't from or rejects a Judeo/Christian look at the world. When we find ourselves saying, "These people are a lot like me," we identify and if we can identify, we can imagine modeling their recovery behavior. Identification is tied to self-image and identity.

Meaning: "We found that two best predictors of recovery and recovery wellbeing are 1) how much time did you spend with people in recovery and 2) how much stuff did you do? The number one biggest predictor of quality of life for people in recovery from alcohol and heroin was meaningful prosocial activity." Of course some of that is in the

rooms, but meaningful employment, volunteering and family life also discourage relapse events. Best et al. call it GOYA. "Get off your ass." Do something, find a sense of purpose, and stay clean and sober.

As a side-effect of this search for meaning, society benefits. Best talks about a study of people in long-term recovery in the UK. 79% were doing charity or some other form of community work. What do you think the average rate was of this kind of generous civic engagement among the UK general population? About half of the recovery community's activity. So it pays for governments and communities to invest in recovery. We have heard this from advocates before: every dollar spent on treatment/recovery, comes back two or three-fold in terms of productivity improvements, etc.

Empowerment: "Within a social identity model of change, this involves a virtuous circle of social engagement, purposeful action and an increased sense of wellbeing manifest in a growing sense of self-esteem and self-efficacy. ... recovery capital is captured in the empowerment component in which the individual derives personal strengths (and awareness of those strengths) from this cycle of positive identity change, engagement in meaningful and pro-social activity, and increased empowerment and self-determination." (p. 184)

I can see CHIME in how my sobriety came to be and how it goes, today. I also see in others whose vastly different path than mine, the same Connection, Hope, Identity, Meaning and Empowerment at work in their recovery. I guess that all of our stories—then and now—are as individual as our own thumbprints. This book is a great source of the latest science; it challenged some of my views and it also validates some of my own anecdotal folk-wisdom. You may find—as I have—that the book is also a useful tool to test one's unique journey against measurable recovery capital characteristics. To finish off from *Pathways to Recovery and Desistance*:

> "This is the heart of the CHIME ... the start of a radius of trust which can inspire the drive and motivation that will enable a sense of empowerment and self-esteem that will inform the development of a new set of social identities linked to positive groups and activities." (p. 198)

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[i] David Best, *Pathways to Recovery and Desistance: the role of the social contagion of hope* Bristol/Chicago: Policy Press, 2019 p.64