

Recovering happiness

Why should we embrace recovery? Because it can bring vital quality to life beyond addiction, say **David Best** and **Mark Gilman**

In the introduction to his 2003 book *Authentic happiness*, Dr Martin Seligman – known to psychology students worldwide as the originator of thinking about learned helplessness – talks about the life expectancy of nuns. Why did he do this? Because of a study that examined the essays of 180 novice nuns and used these to predict how long they would live.

Based on the assumption that nuns are pretty consistent in their lifetime use of alcohol, tobacco, drugs and guns, this was thought to be a population that had a fairly standard lifestyle, and so it would be interesting to look at what predicted their longevity.

To quote Professor Seligman, 'when the amount of positive feeling [in the novitiates' essays] was quantified by raters who did not know how long the nuns lived, it was discovered that 90 per cent of the most cheerful quarter was alive at the age of 85 versus only 34 per cent of the least cheerful quarter'. Having controlled for other factors, Seligman concluded that only the amount of positive feeling in the sketches predicted how long the nuns lived.

Seligman was famous for his work on depression but is now devoting his professional life to what is called 'positive psychology' because it is his belief that a focus on misery and pathology is misleading and largely self-fulfilling. Like depression, the addictions field is one that has been dominated by a pathology model in which the both our science and our interventions have been designed to reduce symptom severity and alleviate distress.

The first parallel to recovery is not to denigrate such science or clinical practice but to suggest that, alone, they are not sufficient. The starting point for the recovery movement in the UK is that, irrespective of disease or symptoms, our goal should be wellness and happiness – why should drug users (or alcohol users or people with mental illness) not expect the science and practice of addiction professionals to offer them suggestions about a better and fuller life?

At the very least, the recovery movement should encourage all users to ask their social workers, drug workers, GPs and psychiatrists about what is on offer that will make them live happier, and hopefully longer, lives. This is empowerment by raising awareness and expectations.

So what does recovery offer? Through this article we want to suggest that we have a hierarchy of goals for a recovery movement and look at how we might

measure the success of such endeavours. What is proposed is a set of concentric circles that are the long-term yardsticks of recovery as a lived experience for individuals, families and communities. As William White described in 2007, the rings are not mutually exclusive but are in effect a series of milestones for those attempting to create recovery-oriented systems of care:

Intensity, extent and frequency of personal recovery

At the most basic level, the measure of an effective recovery system is how many people experience enduring, satisfying life quality that transcends not only their experiences while addicted, but their lives before addiction.

The impact of personal recovery on intimates

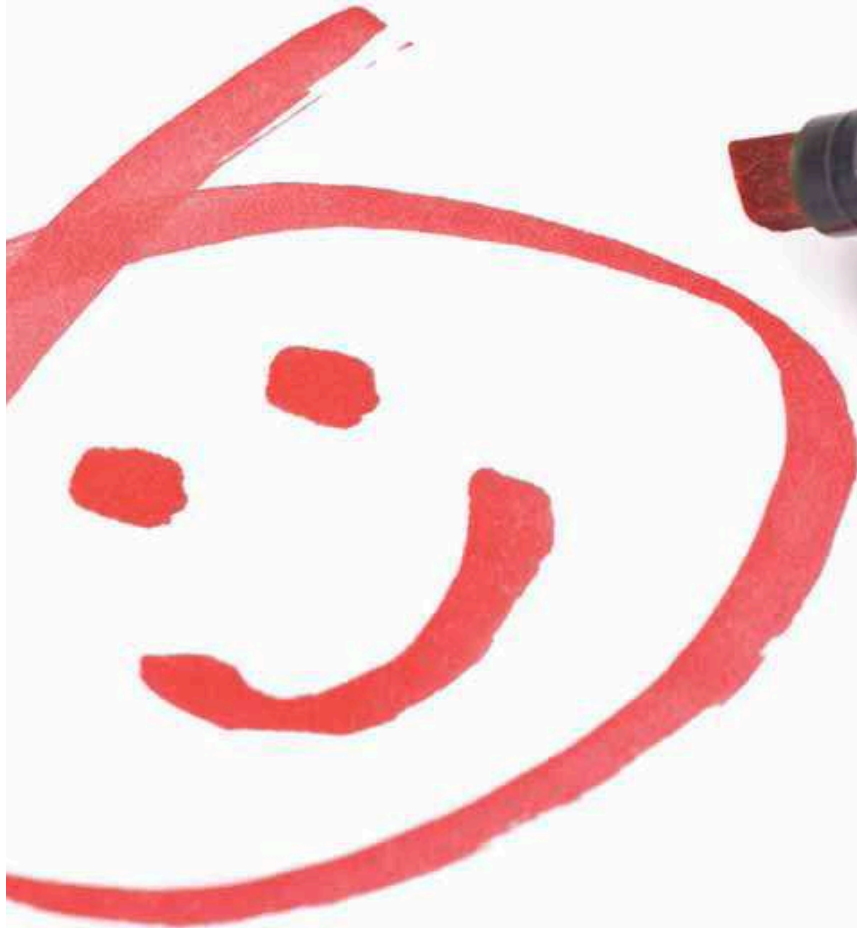
Andreas and Callan (2009) have shown that participation in mutual aid groups by fathers after treatment results in significant reductions in psychiatric symptomatology in their children. Personal recovery is crucial but the political and economic viability of recovery means that the measures of quality of life gain must be extended to partners and other family members. This should also include 'hard' measures of reductions in numbers of children on child protection registers and in care and the levels of domestic violence among the family members of those in recovery.

The emergence of recovery champions

In the key studies of UK recovery (McIntosh and McKeganey, 2005; Best *et al*, 2007), social learning has been a central principle of the recovery experience. Having a 'mentor' or simply seeing an individual recognised as a peer who has achieved significant recovery can act as a significant catalyst for change. Not only is the identification of peer champions of recovery an essential component of a burgeoning recovery system, they are at the heart of a contagion that has characterised the most successful UK recovery communities.

Growing recovery from individual to community level

This is measured not only in terms of the range and diversity of recovery groups (AA, NA, CA groups, SMART groups and other peer-led community groups) but



also in terms of what they do. In the language of recovery definition, this is the operationalisation of 'citizenship' (Betty Ford Institute Consensus Group, 2007; UKDPC, 2007; White, 2008), not as a measure of how many people have a job but what the range of community activities the recovery community are engaged in. This means politicisation, community engagement and challenging stigma as three catch-alls for the domains of activity.

Reaching the 'tipping point'

Using Malcolm Gladwell's idea from 2000 of a 'tipping point', the ultimate indicator of a mature recovery system is reached when it is sufficiently prominent and active in a local community that it begins to exert influence on the substance-using behaviour of the general population. This has previously been observed in the drinking cultures of native American townships but has not been studied in a UK context – and it is the point at which recovery exerts an influence in terms of primary prevention.

So where is the evidence? To be blunt, at present, the evidence is American, learned from the mental health movement, and anecdotal. The work of William White has begun the process of collating the international evidence around addiction recovery but with a heavy reliance on the US. In the UK, Mike Slade has written a key text, *Personal recovery and mental illness* (2009), that charts the evidence around the achievements of the mental health recovery movement and the astonishing speed with which this has influenced mainstream and clinical thinking.

Finally, there is the gradually growing evidence from evaluations and personal accounts in diverse media such as *Wired In*, the Serenity Cafes, the Lothian and Edinburgh Abstinence Project (LEAP) and Burton Addiction Centre (BAC). But that is not good enough or robust enough, so we have a major challenge in testing the applicability of the recovery principles, and this task is underway.

Our research group has been privileged to enlist the trust and support of the Welsh Assembly and the local commissioning teams in North Wales to put some of these questions to the test.

Over the course of 2010, we have been commissioned to develop a recovery

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systems approach that starts with an extension of the treatment effectiveness work conducted in Birmingham and the North-West of England (Simpson *et al*, 2009; Best *et al*, 2009).

In clinical research terms, the basic aim is to extend the engagement component of the treatment process model (Simpson, 2004) to consider sustainable psychosocial change and how workers can initiate recovery community engagement and give post-treatment recovery support.

However, the aims of the project are much more ambitious, reflecting Slade's commitment to culture change in staffing, structures and systems of service delivery, and to the longer term goals of generating communities of recovery where the aim is not only personal recovery, growth and wellbeing, but community engagement and change.

The aim of the recovery movement is not to work out which nuns are happier but to make the nunnery a better place to live and a kernel of growth and hope in ailing communities.

Dr David Best is reader in criminal justice at the University of the West of Scotland and Mark Gilman is NTA regional manager for the North West