

Social Transmission of Recovery as a Helix of Connectivity, not a Service Checklist: A Conversation with Dr David Best

The Frontiers of Recovery Research Interview Series – William Stauffer

What is this series of interviews?

In April of 2024, I had the distinct honor of being asked by William White author and thought leader of the new recovery advocacy movement to present his words as the keynote to open up the first annual NIDA Consortium on Addiction Recovery Science (CoARS) conference. The paper was titled [Frontiers of Recovery Research](#). It is one of his most important writings. It should serve as a blueprint for the future of recovery research in America. One of the challenges we have suffered for at least the last six decades is a deficit focus in respect to addiction treatment and recovery research instead of a recovery orientation. His paper properly orients future research efforts on long term recovery and resiliency. To that end, I have decided to do interviews with key thought leaders on the future direction of recovery research across the 12 domains that Bill White delineated in his 2024 paper.

The 12 domains Bill White addressed in his Frontiers of Recovery Research paper include, the Definition & Measurement of Recovery, the Neurobiology of Long-Term Recovery, Incidents and Prevalence of Recovery, Resolution and Recovery Across the Severity Spectrum, Pathways and Styles of Recovery Across Diverse Geographical / Cultural / Religious Contexts and Clinical Subpopulations, Recovery Across the Lifecycle, Stages of Recovery, Social Transmission of Recovery, Family Recovery, Recovery Management & Recovery Oriented Systems of Care, New Recovery Support Institutions, Service Roles and Recovery Cultural Production and Flourishing / Thriving in Recovery. In this interview, Dr. David Best is focused on the social transmission of recovery.



Who is Dr David Best?

Dr David Best is a university professor who has held a number of professorial titles at four different universities – Sheffield Hallam, Derby, the Australian National University (as an Honorary Professor) and Leeds Trinity University where he set up the first UK Centre for Addiction Recovery Research. His work moves beyond traditional university academics as it is focused on community application. He is not a traditional academic with a traditional academic discipline. He trained as a psychologist and as a criminologist, yet he sees himself as a social researcher and a research activist who, has led the endeavors to provide an academic legitimacy and evidence base to the incredible work done by people in recovery. He is an avid writer on the subjects of addiction treatment, recovery and about criminal justice – eight books or edited collections, around 230 journal articles and about 70 technical reports or book chapters. Most central to his efforts is the developing science of recovery capital.

I started following Dr Best's work just under a decade ago. The work he has done on recovery capital resonated with me. Nearly every other academic who had explored the science of recovery capital has done so from the limited lens of individual recovery capital. Dr. Best has concentrated on the science of community level recovery capital generation and transmission. I suspect that he had the wisdom to focus on this because he has spent a lot of time listening to and working collaboratively with communities of recovery. Through that listening process, he appreciated it as a vital area of understanding to develop. While Dr. Best would be the first to acknowledge he is not a person in recovery, he does have lived experience of familial addiction. He is a close ally of our community who has contributed a lot to what we know about recovery transmission, in the UK, in the US and globally.

1. In Respect to the Social Transmission of Recovery, what progress have we made in the last twenty years? What in your estimation has driven the progress or hindered forward momentum?

This is such a fascinating and important question from an historical perspective! I know we are both deeply appreciative of the contributions of Bill White, who from my perspective contributed immensely in two primary areas of knowledge relevant to the social transmission of recovery. The first being on the framing of recovery as a social contagion and the second in respect to the conceptualization of a recovery-oriented systems of care (ROSC). Recovery as a social contagion is vital to understanding how recovery transmission occurs. It has the potential to move us away from a two-dimensional treatment model. It forces us to consider how to measure long term recovery in the context of individual, family and community as additive elements. It is not simply limited to the narrow context of someone entering into treatment and the pathology of addiction is removed from their lives. Expansion of our lens in this way would elevate us above the narrow treatment paradigm into a more relevant public health model.

Two relevant areas of investigation is the both the famous [Framingham Heart Study](#) that was started in 1948 and the second one is the work of Professors Catherine Haslam and Alex Haslam of the University of Queensland in Australia on [The social cure: Identity, health and well-being](#). Heart disease is much more about what happens long before a person gets to the hospital with a cardiac problem that requires a medical intervention. It is about who and what people know and what they do about it well prior to that juncture. The Framingham Heart Study shifted the lens from the medical interventions into community education and prevention strategies, based on social networks and social connections. The Social Cure work of Haslam and Haslam does a very similar thing in respect to physical and mental health, but with the focus on social identity (a sense of belonging to groups) more than just on individual connections. It advances the knowledge base on how group memberships, and the social identities associated with them, holds great promise moving forward. It considers how connection determines people's health and well-being, and that positive group belonging is protective of health and wellbeing. We have barely scratched the surface on that body of knowledge in respect to addiction recovery. We need to understand how a sense of belonging and a positive identity relate to recovery, the prevention of addiction and the broader vitality of individuals, families and whole communities.

Forgive me this, but as an example if I was working with you when you were in active addiction, the way to think about this is not to consider what I can do for you to change your use, but rather how I consider your environment, who you spend time with and the things you are doing in order to enhance not just your wellbeing but the wellbeing of the whole community. This is an entirely different lens than how we tend to think about things currently. It focuses us beyond the treatment lens and it furnishes us with the capacity to understand broader areas of community prevention, resiliency and wellbeing.

Over the years, I have attended a lot of summits and meetings on the notion of a recovery-oriented system of care (ROSC) in the UK and in the US. At all these events, we all sit around and make list of the facets of a ROSC like it is a checklist of ingredients. Take recovery ready employment, add a dash of collegiate recovery mixed in with some treatment, prevention and peer support and topped off with a recovery high school or two and you have a ready to serve ROSC. We are missing the forest for the trees. There were several really important contributions early on in respect to ROSC starting with William White 2008 with [Recovery Management and Recovery-oriented Systems of care: Scientific Rationale and Promising Practices](#) and the edited book he wrote with Dr. John Kelly in 2011, [Recovery management: What if we really believed that addiction was a chronic disorder?](#) Also, the [Sheedy and Whitter review for SAMHSA](#) in 2009 summarising the underlying evidence. Yet, much of what has transpired since then has added scant little to develop the conceptual clarity of the model. It is just window dressing.

Much of what is occurring is the listing of services inside of a service orientation with no emphasis on community. We are just listing menus of things inside an acute service framework. The whole conceptual framework of recovery happening in sodality. The role of community level social and recovery capital generation are missing. It was the very core of the transformative model. As you wrote about in [Valuing the Forest and Not Just the Individual Trees](#), we have seen a focus on the peer service element and profound neglect of the recovery community element. This has led to the erosion of the recovery-oriented vision. Peer services without a flourishing and pluralistic recovery community translates into just another service not supporting the transmission of recovery capital at the community level. And for me the essential elements are that recovery is 'accessible, attractive and visible'. This is the key to effective transmission at a community level.

Here in the UK, ROSC is business as usual for the acute treatment system with a few agreements of referral and other things mixed in. It is the same people, the same programs and the same allocation of resources. That is not what ROSC was intended to be at all. It is more indicative of what has been termed 'spray on recovery' and what you and I have talked about in respect to performative recovery in which peers are props for the existing agendas, a form of 'business as usual' with large-scale treatment providers. That is a large part of why I have focused on Inclusive Recovery Cities that include mapping of related community resources beyond the formal service structures. One that values and includes every community as inherently different, comprised of people who have unique talents that form into macro level relational change agents. That is the unrealized, transformative potential of a recovery-oriented system of care.

2. Why is Social Transmission of Recovery an important area of focus?

It is perhaps the most important area of focus. We need to understand how recovery is transmitted between people and within communities in order to foster more of it. One of the principal truths that Bill White championed is that recovery is not dependent on formal treatment by specialists. Recovery can precede treatment, occurs beyond treatment and also without it. Consider the two-dimensional ROSC menus our systems have generated in recent years. They are centered on formal care systems, when in reality they are not always either needed or even the main event in respect to how and where recovery is generated and transmitted, particularly if we understand recovery as a form of public health activity rather than a medicalized version of 'treatment', and so inclusive of prevention and early intervention at a community level.

We have these linear models in both the UK and the US, and they fail to consider what we could be developing by focusing on the science of social networks and community level recovery capital. These (treatment-centric) systems operate like sausage machines and see people as broken at the beginning, and then they go through the menus of services and supports and emerge whole beings on the other end of the grinder. People are not sausage meat, and we treat them like they have no talent or value and that the specialists are the change agents, which is not even close to the potential that ROSC has in respect to dramatically magnifying the capacity for the transmission of recovery within a recovery-oriented system grounded in community, building on the talents and capabilities of individuals and groups.

Instead of building lists of existing services, we should be building community and thinking of the model more like a double helix in which bonds between and across formal and informal community of support run between the strands across the width and breadth of the structures. This would create structures that are strong, flexible, resilient and responsive to challenges in ways that our professionalized service system is unable to achieve unless embedded collaboratively and co-productively into recovery communities

Bruce Alexander, in his writings on the Globalization of Addiction: [A Study in Poverty of the Spirit the social](#), explores the circumstances that spread addiction in a conquered tribe or a falling civilization are also built into today's globalizing free-market society. These are facets in why we are seeing more and more addiction, and the solution for an effective response is social and political, rather than an individual one. Focusing on social solutions has preventative facets that reduce incidences of addiction and do what menu based, sausage making linear models simply cannot achieve. While those models may work for some limited strategies like detoxification or 12 sessions of CBT in an outpatient program, they are not as useful at all to support community led level change. Communities have the capacity to heal, if they have the resources and connections to create the requisite synergy to do so. This is a much more effective model as every community act of recovery connection is also an act of community building and positive network development.

This is why I have focused a great deal of energy on the development of Inclusive Recovery Cities. As I spoke last year about in [the allegory of the lake: The implications of an Inclusive Recovery Cities model for prevention and early intervention](#), embedding support within recovery communities result in two things, The end of the cycle of chronic relapse and brief periods of stability and the phenomenon known as "[better than well](#)" not just at the level of the individual, but within families and the whole community. As I noted, fundamentally, the goal of the recovery model is to transcend addiction, not by addressing symptoms but by building strengths within a model that is referred to as "[recovery capital](#)." Most simply framed, the aim of the recovery model is to support people to achieve 'somewhere to live, someone to love and something to do' with supportive social networks and meaningful activities the 'golden threads' that run through it. These are the bonds in the helix of connectivity that keep it flexible, strong and effective. And at its heart it is dynamic and generative.

A focus on [Inclusive Recovery Cities](#) will lead to us focusing efforts on defining and developing key aspects of recovery, that include facets of Connectedness, Hope, Identity, Meaning, and Empowerment (CHIME). It would support our understanding of how we build recovery capital not just at an individual level but within families and communities, each one having unique talents and resources to support the transmission of recovery. It will support our capacity to understand contagions of recovery within community and help move us from a treatment-oriented model of recovery support to an ecological model of recovery support. The recovery community has long known that recovery ultimately occurs as a function of community. It is high time our science catches up with the lived experiential knowledge of our recovery communities.

3. What do you have to add to what Bill has written? Did he miss anything? Are there applications you would expand upon?

Bill's [Frontiers of Recovery Research](#) is a phenomenal work and properly delineates not just the central focus of recovery research to consider moving forward, but also on coproduction and coownership of the research and associated services and supports across all of our communities. For all the talk in academia about inclusiveness, we are quite insular and myopic. Look over the body of academic work and there are few collaborative efforts with people outside of academia. In this way we can become isolated and miss the mark on what we could add to a recovery research knowledgebase. Questions that support not just what are interesting and beneficial in the halls of academia but in useful insights that can expand the transmission of recovery within all of our varied communities. So, for that reason, I think the starting point of any recovery research model has to be relevance – we cannot become another university department that is inward-looking, abstracted and self-serving – our work has to be in constant dialogue with and valuable to people at all stages of their recovery journey.

I think Bill White covered the major areas in his paper, but in so many of these areas, we academics have paid scant attention to collaborative efforts with non-academics who are experts on the ground. Few if any resources go beyond the ivory towers and support collaboration that would improve what we know in ways that augment what communities actually need. We have not done it in ways that are co-productive with the communities who we can learn the most from and who would use this knowledge to support healing. This is the busted flush of the academic world in respect to addiction recovery research. It needs to change – we need to be relevant and useful.

One example of this that I am focusing energy on is family resiliency and healing in respect to addiction within the family constellation. This includes efforts through the [Global Family Recovery Alliance](#) to bring together people with a passion for family recovery and expertise in the recovery field to expand this area of understanding. We are creating a table for authentic collaboration and co-production. This is an example of how academia should help build tables at which communities of recovery not just have a seat but help build the knowledge in ways that they are both included in the process and also meaningfully benefit from the outcomes. Strategies that move us beyond performative inclusion of communities of recovery.

Extending the discussion on family recovery in the context of community, moving forward, we should focus on mapping the ripple effects of individual or familial recovery experiences across different communities. When you got into recovery, what impact did that have on your family and close community connections over the course of time? What were the economic impacts in the community of your recovery? What are the variations of experience here? If a person gets into recovery and reengages with their family and their community what does that look like? If they stay isolated, what does that look like over time? What can we learn to support recovery pathways for others in these communities?

As we are investigating recovery in the context of family, we are finding three broad groups in the early stage of their own recovery as they are in treatment or initiating recovery support in community. One is where a person in early recovery wants nothing to do with their family and perceives that their family is the source of their problems or at least significantly contributive to what is wrong in their lives. The second is when the person in early recovery adulates their families and credits them with the support they needed to heal. The third group are families who experience their own healing processes independent from what is occurring with a person struggling to sustain recovery. We should not gloss over these variations; there are opportunities to explore pathways to health across these varied trajectories. There are huge questions about families and recovery (and similarly around friendship groups and neighbourhoods) if we remove

the individualized and solipsistic lens that has dominated our field, akin to the model of ‘magic bullet’ solutions to addiction.

We also need to consider what are views of how people can change influences the outcomes. There are studies on social determinants of health that consider variables like obesity, tobacco use and even sex offenders that show us that societal perceptions of causation and potential for change have really broad implications. No one wants anything to do with a person who has been a sex offender, and this has very significant impacts on the trajectory of resolution. We need to understand how these dynamics including the variation in social proximity dynamics to support healing. Do the communities we live in believe that people can and do recover? Do people in the communities believe that a person can sustain a full year of recovery? What happens when people are open about their addiction or recovery status in these communities that do not see recovery as a probable outcome? One of the things we want to work on to understand in respect to inclusive recovery cities is how these variables work bidirectionally.

4. Looking forward twenty years, where would you hope we are at in respect to our knowledge in this domain? How do we get there?

I would like to see that the developing science of recovery, both internal to the individual and within the context of familial and social systems, has its own space. We are not an orphan of the school of the pathology of addiction. We need our own metrics and measures more akin to public health models than medical treatment models. We are several layers down in the existing schools of thought and this is an impediment to realizing the full potential of recovery research. We should not be considered a branch of existing medical or psychological study. While insights in these areas can contribute to what we learn, we also get lost as a unique area of focus buried underneath these long-standing institutions. Ours has to be a science of inclusion and hope, that is framed around what matters and what helps individuals, families and communities.

This would include the funding of recovery research to move beyond a professional treatment model and shift into resourcing community-based solutions. Looking at employment trajectories, housing dynamics and civic engagement, not just acutely or in early recovery but over the course of years in consideration of pathways to recovery, stage of life in which recovery is initiated, ethnic and cultural variations and what formal and informal resources that persons use and often end up being contributive to as part of their own recovery processes.

It is my sense that one of the areas most worthy of pursuing improved insight is on the impact of healing within the family, both on the trajectory of healing at the individual level but also within the broader community. How does healing in families impact social regeneration in our society? How do we create networks of hope within our own vicinities as well as regionally and beyond? We certainly have a sense that recovery has a ripple effect. We need to study how it does so and what we can do to increase the generation and transmission of recovery more effectively and more broadly.

One of the most significant facets both the pervasive negative perceptions across our society about addiction and those who are in recovery from it and that we are tethered under other institutions of learning is how we think about the peer role and function. This work is not CBT or Motivational Interviewing for dummies. Those stances perhaps say more about what is wrong with our systems than anything else.

The core of recovery science is about alliance, connection, meaning and purpose and supporting the development of resiliency intrapersonal and interpersonally across communities. How do we get more of this? How do we develop effective partnerships, coalitions and multidisciplinary teams that honor and support the science of recovery transmission? The answers to these questions can and will change most of what we think of in respect to the condition of addiction and its resolution at the individual, family and community levels. Not to develop a checklist, but a strong, flexible, and adaptive helix of connectivity.

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