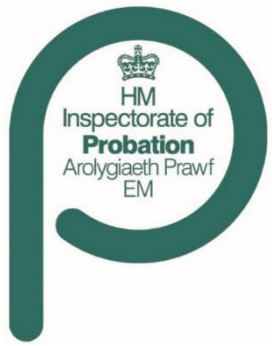

A model for resettlement based on the principles of desistance and recovery

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Foreword

HMI Probation is committed to reviewing, developing and promoting the evidence base for high-quality probation and youth offending services. *Academic Insights* are aimed at all those with an interest in the evidence base. We commission leading academics to present their views on specific topics, assisting with informed debate and aiding understanding of what helps and what hinders probation and youth offending services.

This report was kindly produced by Professor David Best, reviewing the latest research evidence from the field of addiction recovery. The importance of social and societal factors for sustaining recovery is now clear, encompassing social connections, groups and networks and social learning, identity effects and control. There are obvious overlaps with the desistance literature, which similarly highlights the importance of social context and connections, and it is important that these two fields of research continue to learn from each other. Within HMI Probation, we will continue to monitor the combined evidence base when reviewing the standards for inspecting probation and youth offending services.

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David Best is Professor of Criminology at Sheffield Hallam University and Honorary Professor in the School of Regulation and Global Governance at The Australian National University (Canberra, ACT). He has worked in the area of addiction research, policy and practice for around 25 years with a specific focus on pathways to stable recovery. The focus of this research is on social factors that are applicable to desistance and resettlement, including the importance of social and community capital and the central role that social identity change plays in sustaining recovery and desistance. He is currently leading European and Australian longitudinal research studies on social components of addiction recovery and his sixth book, The Social Contagion of Hope, will be published later in 2019.

The views expressed in this publication do not necessarily reflect the policy position of HMI Probation.

1. Introduction

Over the course of a number of research studies on addiction recovery, conducted between 2008 and 2019, in Scotland, England, Wales, the US and Australia, I have collected over 2,000 personal accounts of addiction recovery. They are incredibly varied and show the most amazing reserves of courage, commitment and determination – but they all have one common feature. Nobody does it alone. For every single story, there is an inspirational figure or group that has acted as a catalyst or a 'tipping point' in their recovery journey.

For me, this is clear evidence that recovery – like desistance – is a process that is generally driven by social and societal factors and, once I have outlined some issues around definitions and around prevalence, I will go on to outline what these are, and then talk about their central role in supporting the desistance process through probation practice.

According to both of the key international consensus groups, the Betty Ford Institute (2007) and the UK Drug Policy Commission (2008), addiction recovery involves three factors. These are:

(i) control over or cessation of problematic substance use;
(ii) improvements in global health and wellbeing; and
(iii) active participation in and a contribution to community or society.

In other words, it may not involve total abstinence, but even if it does, that is not sufficient to fulfil recovery criteria. So how many people achieve this?

Sheedy and Whitter (2009) summarised the evidence from a range of studies on recovery prevalence rates and concluded that around three in five (58%) of those who have a lifetime substance use disorder will eventually achieve stable recovery. The Betty Ford document incorporates evidence showing that 'stable recovery' should be estimated as achieving around five years of abstinence or controlled use (i.e. no illicit drugs or alcohol), based on what we know about relapse rates up to and after this point.

We also know who is likely to succeed and who is not based on their 'recovery capital' (Granfield and Cloud, 2001), that is the resources available to them to support their recovery journey and pathway. Positive factors include pro-social friends, jobs and houses, while 'negative recovery capital' (Cloud and Granfield, 2008) includes factor such as time spent in prison and severe and enduring mental health problems. However, the focus of this paper is on strengths and in particular what and how social capital plays into this.

2. Recovery and the social/societal factors

In my own earliest published study on recovery (Best et al, 2008) we found that while the initial catalyst to stop was often a combination of being tired of the lifestyle and an adverse life experience such as being arrested or thrown out of home, the reasons for sustaining recovery were overwhelmingly social. This had two components:

(i) moving away from using networks; and
(ii) moving into pro-recovery social networks.

This is consistent with one of the key findings from the large alcohol outcome study, Project MATCH, conducted in the US which concluded that one of the core predictors of recovery from alcohol was switching from a social network supportive of drinking to one supportive of recovery (Longabaugh et al, 2010).

This peer and social normative effect will surprise none of the readers and is of no assistance unless we can unpick the underlying mechanisms.

2.1 Social learning and social control

In 2007, Litt and colleagues reported on a randomisation study involving a group of problem drinkers completing residential detoxification treatment. They were randomly assigned to either standard aftercare support or to what was referred to as 'network support', which involved attempting to add at least one sober person to their social networks. There was a 27% reduction in likelihood of returning to drinking in the year following treatment among those in the network support condition.

Why is this the case? Moos (2007) attempted to identify the psychological changes associated with alcohol recovery and suggested that the two key factors were:

(i) social learning – having role models to imitate and to obtain support from; and
(ii) social control – the influence that sober role models and group exert to support and encourage ongoing recovery.

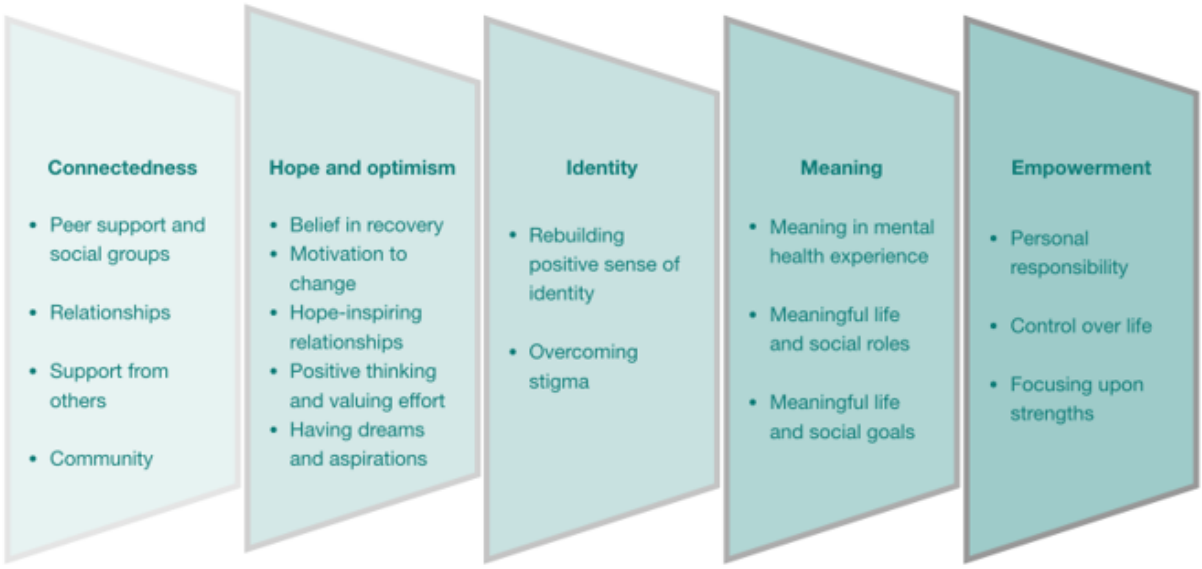
However, there may be gender differences in this effect. In his review of the mechanisms of action of 12-step mutual aid groups, Kelly (2017) concluded that while, for men, the main mechanism of effectiveness is switching from using or drinking to recovery social groups, for women the primary mechanism of action is around increases in abstinence self-efficacy. In other words, for men the most important influence is typically around changing social networks, while for women it is about growing self-belief that recovery is possible.

What all of these studies point to is a central role for peers. Indeed, when reviewing the evidence around what works in recovery, Humphreys and Lembke (2014) concluded that all three forms of provision with incontrovertible evidence – (i) recovery residences, (ii) mutual aid groups and (iii) peer-delivered interventions – involved peers and their social support as central to the change process.

2.2 Social identity effects

While there is a considerable literature on the role of identity change in desistance from offending (e.g. Maruna, 2001) and recovery from addiction (e.g. McIntosh and McKeganey, 2000), the focus has largely been on personal identity. Based on the idea of a "Social Cure" (Jetten et al., 2011), recent research interest has emerged around the importance of social identity and our own work on a Social Identity Model of Recovery (SIMOR; Best et al, 2016) which argues that in a range of social contexts, people's sense of self is derived from their membership of various social groups. This is in part based on our work in Therapeutic Communities in Australia which showed that one of the strongest predictors of positive outcomes was changing from a dominant addict identity to a recovery one (Beckwith et al, 2015). It is the sense of belonging to a group that leads to the person internalising the norms, values and beliefs of the group, which can support and sustain positive change.

2.3 CHIME and the engine of change



Leamy et al. 2011

In the mental health literature, a review by Leamy and colleagues (2011) summarised the key components of effective recovery-oriented services and interventions in the acronym CHIME which stands for: Connectedness; Hope; Identity; Meaning; and Empowerment. I have used this approach in my work in addiction recovery in translating this into a Chime In Action model (Best, 2019) in which positive social connection is the critical starting point for the initiation of recovery.

This positive social support drives the belief that change is possible, generating a sense of hope that energises attempts to manage change. What that in turn does is to generate the capacity to engage in meaningful activities (Best et al, 2011; Cano et al, 2017) that creates a sense of empowerment (linked to self-esteem and self-efficacy) which in turn helps to build a positive sense of identity. This creates a virtuous circle of positive social support and positive identity predicated on active participation and engagement in activities that promote and support recovery.

2.4 Recovery Capital and Assertive mechanisms of engagement

Recovery Capital has been characterised as the breadth and depth of resources available to an individual to support their recovery journey. In our earlier work (Best and Laudet, 2010) we identified three domains of recovery capital – (i) personal, (ii) social and (iii) community – that can all contribute to supporting positive change.

This is a strengths-based model that builds hope in that even those with low levels of resource can be supported to access the resources and assets available in their communities (community recovery capital) through the guidance and assistance of individuals or groups who can be professionals, peers, family members or employers, neighbours or friends who provide help and support (social recovery capital). What this implies is that one of the core objectives of people attempting to support the pathways to recovery and/or desistance is to act as or work with 'Community Connectors' (McKnight and Block, 2010), who can be the human bridges to resources and supports in the community. These will include mutual aid groups like AA and NA, but will also include sport and recreational activities, churches, training and education centres and opportunities for volunteering and engaging in local community groups and activities.

This is work that our team is currently doing in both prisons and in community settings to support individuals who are lacking in recovery capital to have access to resources through building bridges to supports that are already out there.

3. Conclusion

There is clear and consistent evidence that, while recovery requires personal commitment, determination and courage, it is not something that happens in isolation, and it can be argued that recovery is an intrinsically social process. While using (and offending) peers can act as barriers to recovery ('negative recovery capital'), transition to prosocial groups – and the resulting access to resources in the community – is a critical part of the recovery process.

While the science is still emerging, the body of evidence would suggest that by copying others in recovery and abiding by their rules, new identities emerge that are linked to social groups and networks, and that promote changes in the core personal resources needed (self-esteem, self-efficacy, resilience, coping skills and communication skills) to sustain a recovery journey.

Importantly, these factors can also be applied to the transition to desistance for offenders, particularly for those whose criminality is linked to their drug and alcohol use.

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