**RUNNING HEAD:** Chapter 3.1.1 Recovery Community Resources and Settings

**Community Resources and Public Health in Recovery Community Settings**

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**Introduction**

Recovery is characterised as a unique and personalised process and one that is embedded in a relational context both at the individual and at the societal level. Social group membership, social networks, and social identity have all been reported as central to the process of recovery, and this network of relationships is also embedded in societal processes and structures (Best et al, 2016). This chapter will define recovery as an intrinsically social process (cf. Tucker & Witkiewitz, Chapter 1 this volume) and considers the accrual of recovery capital as its underlying mechanism. Within this model, the personal resources needed to sustain a recovery journey build in a dynamic and interactive way based on the social and community resources the person is able to access and his or her ability to transcend exclusion and stigma, in an ongoing journey of personal growth and social and societal belonging.

**How has recovery been defined and what are its characteristics?**

According to two of the most frequently cited consensus group definitions of recovery (Betty Ford Institute Consensus Group, 2007: UK Drug Policy Commission, 2008), recovery can be characterised as consisting of three component parts – sobriety, historically but not uniformly defined as abstinence; global health and wellbeing, and citizenship and active participation in community life. The Betty Ford definition goes on to describe recovery as a process that typically lasts for around five years until ‘stable recovery’ is achieved, based on the research findings of recovery pathways by Dennis, Scott, and Laudet (2014).

A key research question that emanates from recovery studies explores the proportion of people that recover from substance use disorders (SUD). A review for the United States (US) Substance Abuse and Mental Health Services Administration (SAMHSA) by Sheedy and Whitter (2009) concluded that of all those who experience a lifetime SUD, 58% will achieve stable recovery, although there was marked variability in rates among the studies included in the review. Similarly, in a review of 415 studies, White (2012) concluded that the overall recovery rate is just over 50%. More recently, Kelly and colleagues (2017) asked the prevalence question in a different way assessing what proportion of the US adult population defined themselves as being ‘recovered’ or ‘in recovery’. The overall reported rate, from a survey of 39,809 adults, was 9.1% indicating that just under one in ten of the US population would regard themselves as being in recovery. At the time of writing, this survey has not been replicated in any other countries.

Another issue in defining recovery concerns its time course. Dennis, Foss and Scott (2007) examined the relationship between abstinence duration and other recovery outcomes related to health and wellbeing and found that mental health problems increased through years one to three of abstinence and then diminished, while physical health problems appeared to increase. The authors also reported that it typically took over three years for significant improvements in financial status to occur, in spite of employment starting much earlier and criminal offending largely being eliminated in the first year of recovery. The authors were keen to caution that, even among those who maintained abstinence for five years, about 14% subsequently returned to substance use on more than one occasion (“relapse”), suggesting that recovery is not a journey that is ‘completed’. Rather, it should be considered as an ongoing and dynamic change process. Nonetheless, as discussed next, such prevalence and proportions alone do not adequately address the question of who will recover, and when or why.

**Quantifying recovery pathways: Recovery capital as a system of measurement and planning**

This section addresses the question of pathways to recovery including candidate mechanisms that predict recovery change and the emergence of the metric ‘recovery capital’, which has been operationalised to quantify recovery growth and wellbeing (Cano et al, 2017). The concept of ‘negative recovery capital’ is introduced to examine factors that can act as a barrier to effective recovery progress. Early empirical evidence about recovery pathways and mechanisms was provided by Moos (2007). His review of the evidence on the psychological mechanisms underpinning recovery concluded that there were two fundamental interpersonal processes – social learning (in which role models provide an example of how to live recovery) and social control (through which group members will learn and conform to the group’s norms). In addition, opportunities for social learning by observing and imitating the recovery behaviours of more experienced peers in recovery promote the two changes – first, the development of coping skills, and second, the development of and engagement in rewarding alternative activities other than substance use (e.g., school and work, physical activity), which can promote recovery and protect against relapse (Bickel & Vuchinich, 2000). Over time, positive attitudes, beliefs, and expectations that support sustained recovery come to dominate the individual’s value system.

The intrinsically social component of the majority of recovery pathways is further illustrated by the work of Litt and colleagues (2009). In this randomised controlled trial, people who completed residential detoxification from alcohol were randomly allocated to either ‘treatment as usual’ (which was standard aftercare) or to a ‘network support’ condition that involved developing a relationship with at least one non-drinking peer. Compared to standard aftercare, those who added at least one non-drinking member to their social network showed a 27% increase at 12 months post-treatment in the likelihood of treatment success (defined as being without alcohol 90% of the time).

In a secondary analysis of Project MATCH data, Longabaugh et al. (2010) found that greater opposition to a person's drinking from within their social network predicted more days without alcohol use both during and after treatment, and fewer heavy drinking days post-treatment. In addition, less frequent drinking within the person's social network predicted more days without alcohol use during and after treatment. The role of social norms was also a key feature of Best et al.’s (2008) United Kingdom study of recovery pathways, in which sustained recovery was associated with moving away from drug-using or drinking networks and actively engaging in social networks supportive of recovery. Thus, changes in social networks and identities are associated both with the initiation of recovery and with managing and sustaining the ongoing recovery journey.

**Social capital and recovery capital**

The previous section introduced some of the evidence about social factors in recovery, highlighting that creating bonds and networks of people in recovery and with others who do not use substances are critical components of many individuals’ recovery journeys, as is the process of leaving behind social groups that use substances and personal identities that were associated with active use patterns. To incorporate this component within a coherent model of recovery, the concept of recovery capital and its origins in the concept of social capital are described next.

Bourdieu (1985) argued that social networks are a valuable asset and that social interaction, a sense of belonging and the relationships of trust and tolerance that are subsequently developed, are key resources particularly in communities where there is a lack of financial capital and a resulting limitation in access to community resources. In the US, Putnam (2000) described social capital as a resource that individuals can draw upon, as well as a commitment to the group. As such, reciprocity is central to Putnam’s conceptualisation of social capital. He differentiated between 'bonding' capital (the strength of links within established groups) and 'bridging' capital which referred to the links and associations between groups. Putnam argued that individuals from marginalised communities can have strong bonds in their social networks but still have little access to community resources if there are not bridges to more groups that are engaged effectively with community assets and resources.

The history of social capital writing is central to our understanding of the emerging concept of recovery capital as the set of “resources and capacities that enable growth and human flourishing,” and we put this in quotation marks because this will be our working definition of recovery capital for the remainder of this chapter. This fits with the broader characterisation of recovery in this book as a dynamic process of behaviour change. The assumption here is that recovery capital is a key marker of recovery progress and wellbeing and will increase or diminish in reasonably predictable ways in response to social and societal activities and forces. This assumption hinges on White and Cloud’s (2008) assertion that long-term recovery pathways are better predicted on the basis of building strengths rather than managing or attempting to reduce deficits.

The term recovery capital was originally coined by Cloud and Granfield (2008) as “the sum total of one’s resources that can be brought to bear on the initiation and maintenance of substance misuse cessation” (Cloud & Granfield, 2008, p. 1972). Cloud and Granfield (2008) argued that recovery capital applies not only to assets and strengths but they also discussed the concept of 'negative recovery capital' for factors that constitute barriers to recovery change. Cloud and Granfield identified four such barriers, suggesting that recovery is more difficult for those with histories of mental health problems, histories of involvement with the criminal justice system, for people who are older and, more controversially, for women. Within the model outlined in this chapter, it is also important to recognise that recovery is a dynamic concept that will change over time and is bi-directional, meaning that it is just as likely to go down as to go up if an individual experiences adversity and the removal or inability to access desired goods or resources.

The other key advance precipitated by the introduction of the recovery capital concept was the promise of quantification and the development of a metric. While there have been a number of ways of characterising recovery capital, Best and Laudet (2010) argued that there are three primary domains to recovery capital:

1. Personal recovery capital which refers to those qualities and capabilities a person acquires in the course of their recovery journey including resilience, coping skills, communication skills, self-esteem, and self-efficacy.
2. Social recovery capital which refers to the relationships a person has and, crucially, as Putnam (2000) argued, to the strength of their commitment to those relationships and networks.
3. Community recovery capital which refers to the resources in the community that the person can access such as educational courses, safe and secure accommodations, and meaningful employment opportunities. Community recovery capital also includes recovery specific resources in the community like mutual aid groups, visible recovery champions and recovery-oriented treatment services.

As Best (2019) argued, these components of recovery capital do not accrue consistently or evenly, and there are grounds for suggesting that the transition to recovery as a self-determined state (Dennis et al, 2014) is, for many, about utilising social and community capital as scaffolding around the individual to afford them the opportunity to grow core personal attributes and skills necessary to support sustainable recovery pathways.

Two research studies illustrate how this can be achieved. The first is the Glasgow Recovery Study (Best et al., 2011) in which 202 individuals in recovery from alcohol and heroin dependence were assessed in terms of wellbeing and quality of life. There were two central predictors of wellbeing in recovery – how much time participants had spent with other people in recovery and how much time people spent in meaningful activities (defined as average hours in a week spent on childcare, volunteering, community group activities, education, and employment). In other words, spending time with people who acted as social learning role models and engaging in meaningful activities were associated in greater wellbeing and quality of life.

A similar relationship was found in a later study of recovery residences in Florida (Cano et al, 2017). Based in eight recovery residences that were members of the Florida Association of Recovery Residences, structured equation modelling showed that longer duration of stay was associated with lower barriers to recovery and less unmet needs, thus generating higher levels of wellbeing. However, there was also a second path to wellbeing that was ‘strengths-based’. For those who used their time in residence to engage in more positive and meaningful activities, there was growth in personal and social recovery capital that was associated with positive changes in overall wellbeing. The authors concluded that while treatment duration confers a beneficial effect, it is the active engagement in meaningful activities that generates recovery wellbeing.

The above study utilised an emerging metric for recovery capital, the REC-CAP (Cano et al., 2017), which included an earlier scale, the Assessment of Recovery Capital (Groshkova, Best, & White, 2012). The aim of these measures, which have acceptable psychometric properties, was to assess the resources that individuals have and, in the case of the REC-CAP, to utilise the scores derived on the scale to inform recovery care planning. What is most important about the measures is that they are based on strengths and predicated on the assumption that strengths build further strengths. Moreover, the use of a ‘positive’ model of measurement in itself contributes to an emerging sense of self-esteem and self-efficacy in study participants and that it is part of a relational approach in which recovery capital presumably grows through relationships with both the recovery community and the local, lived community. The scale provides an immediate score profile in an accessible form when completed online that the client and his or her recovery mentor, referred to within this approach as a ‘recovery navigator’, can use to plan further recovery actions. The impact this has on personal identity is discussed in the following section.

**Social identity and the role of group belonging in recovery change**

Since the early work of Biernacki (1986), it has been recognized that identity change is a central part of addiction recovery, and Biernacki asserted that the transition to recovery required “new identities, perspectives and social world involvements” (Biernacki, 1986, p. 141). McIntosh and McKeganey (2000, 2002) collected the recovery narratives of 70 former addicts in Glasgow, Scotland and concluded that substance misuse may result in *"*identities [that] have been seriously damaged " (McIntosh & McKeganey, 2002, p. 152). They concluded that for recovery to happen, the individual required the restoration of identity. This has been challenged, however, by subsequent work that suggested that identity is a much more complex issue. For example, Radcliffe (2011) used motherhood as an example of a positive identity that could assist in overcoming the addiction identity and enable an initiation of recovery endeavours.

The early focus on personal identity has gradually transitioned over time into an increased research focus on identity that is embedded in group membership and in the sense of belonging that emerges from recovery identity (Best et al, 2016). The switch to a social lens for understanding identity dates back to the work of Tajfel and Turner on Social Identity Theory and Self-Categorisation Theory, respectively (Tajfel & Turner, 1979; Turner et al, 1987). The model emphasises the importance of group belonging on identity and in particular how membership in a group involves adherence to the norms and rules of the group and the internalisation of its values. The more important the group is to the person, the more salient will be its rules and values be across multiple life domains.

In terms of health and stigmatisation this was brought to particular prominence by work on “the social cure” (Jetten, Haslam, & Haslam, 2012). This refers to the health benefits that are associated with active group memberships and their potentially protective effects against adverse life experiences and, in particular, the importance of group membership and group support in times of key life transitions. This perspective has been adapted to support understanding of addiction recovery processes in the Social Identity Model of Recovery (SIMOR; Best et al, 2016), which asserts that individuals’ “identification with a recovery group will shape their understanding of substance-related events (e.g., an offer to go to the pub with friends) and their response to it (rejection on the grounds that it would put their recovery at risk). Thus, group memberships exert influence on individuals through the transmission of social norms which are internalised, and shape subsequent attitudes and behaviour" (Best et al., 2016, p. 9). What SIMOR outlines is a model that frames recovery as a process of social identity change in which a person’s most salient identity shifts from being defined by membership in a group whose norms and values revolve around substance use to being defined by membership in a group whose norms and values encourage recovery.

The SIMOR model, which focuses specifically on the process of change for those engaged with Alcoholics Anonymous (AA), is based on a growing body of research evidence. Dingle et al. (2015) assessed retention and treatment outcomes among residents of a Therapeutic Community in Queensland, Australia and showed that longer retention was associated with the growth of a recovery identity as well as with the diminution of a SUD identity, and that this transition was associated with better treatment outcomes. Similarly, Beckwith et al. (2015) undertook research in the same Therapeutic Community and showed that the extent of change from a dominant SUD identity to a dominant recovery identity was associated with positive outcomes in this population.

This model has been examined in considerably more depth in the Social Networks and Recovery Study (SONAR; Best et al, 2016). The study was a longitudinal cohort study that followed 307 individuals entering one of five Therapeutic Community (TC) services in three states in Eastern Australia from admission to six months (around the time of planned discharge and then at 12 months after admission, when all participants should have returned to the community). Haslam et al. (2019) interviewed participants about about their individual- and group-based social relationships prior to treatment entry, their social identification with the TC and as ‘a user’ and a person ‘in recovery’, and their current recovery capital and quality of life. A key finding was group identities (for instance, to families, mutual aid groups and friendship groups) reported by participants prior to TC admission predicted the extent of their engagement with the treatment service they attended. Individual identities did not predict outcomes. Furthermore, a mediation analysis indicated that TC identification was the mechanism through which social group memberships prior to TC admission protected quality of life in the early phases of treatment.

Collectively, this research shows the importance of transitioning from social group membership in groups committed to substance use and the related lifestyle and to the consequent engagement in pro-social groups. The mechanism that underpins this transition is about identification and the complex inter-play between membership in a group and the adoption and internalization of its beliefs, values, and norms. Thus, being part of a social group that uses substances is not simply about ‘peer pressure’ to use, but also about a shared set of assumptions and values around the merits of substance use and the resultant lifestyle. Conversely, immersion in recovery groups is about a different set of social norms and beliefs and a different set of expectations around membership that extend beyond sobriety and involve decisions about the merits and drawbacks of substance use and sobriety (Moos, 2007).

There is one further aspect of this process that links the concepts of social identification with two types of recovery capital – social and community. This concerns access to community resources among people in groups that use substances and are marginalized and excluded compared to groups of individuals in recovery who are embedded in multiple pro-social networks. Jetten et al. (2015), in the context of studying homelessness, initially observed that all groups were not equal in terms of the merits and benefits of membership. Membership in marginalized groups, like individuals who are homeless and those with SUD, does not afford the same psychological benefits (e.g., to self-esteem, self-efficacy and so on) or practical benefits as does membership in pro-social groups engaged in meaningful activities that are consistent with conventional norms and values. The link to personal and social capital is that engagement in a recovery group acts as a form of linking and bridging capital (Putnam, 2000) to community resources that would otherwise be denied the individual. This includes not only practical assistance but informational resources about job opportunities, available college courses, and access to housing. However, this is a dynamic process that is bi-directional, and changes in access to social and community capital can generate reductions as well as increases in social capital.

**Connectedness Hope Identity Meaning and Empowerment (CHIME) and the role of social networks**

While much has been written about definitions of recovery and recovery stages and processes, there is much less evidence on what can be done by others to support recovery pathways and processes. Much of the evidence that does exist has focused on peer processes and mutual aid groups (White, 2009; Humphreys & Lembke, 2013), whereas relatively little attention has been given to what support services (statutory and third sector as well as peer-based) should do to support the individual and the group in their recovery journey.

A systematic review of the mental health recovery literature by Leamy et al. (2011) concluded that there were five essential elements in recovery supportive programmes - Connectedness; Hope; Identity; Meaning and Empowerment (CHIME). The evidence was based on 97 papers that reviewed 87 distinct studies and supported the authors’ conclusion that these are 'essential elements' in an effective recovery programme relating to recovery processes. What is crucial about this model is that it outlines what external agencies and groups can do to support an individual in their recovery journey, and thus switches the focus to the conditions or facilitators of individual and group recovery.

Best (2019) translated this model to the addiction recovery area and suggested that there is a clear order to the model. As in the acronym, Connection is the starting point with the social contagion of recovery effectively starting with a social contagion of Hope, and so the catalyst for the process is fundamentally social and interpersonal. Visible and successful role models create the belief that recovery is possible, and generate the energy, conviction and focus to allow individuals to overcome barriers and exclusions, including lethargy, fear and self-doubt, to taking meaningful action. The first two stages are connection and hope but what they then trigger is a virtuous circle of meaningful activities (Meaning), growth in self-esteem and self-efficacy (Empowerment), and changes in both self-perceptions and group membership and belonging (Identity). It is at this point that the cyclical and ongoing nature of CHIME continues to promote and enhance recovery change, although that does not mean that recovery is linear or that positive growth is inexorable.

Overall, this integrative model of recovery capital, social contagion, and social identity emphasises that recovery is a change process and one that is firmly embedded in social and societal triggers and sustained by group involvement. Public policy, public attitudes, and community connections are all important contextual drivers for recovery (in both positive and negative directions). Access to visible recovery champions and community resources are essential contextual facilitators of addiction recovery.

The ‘contagion’ component of the model also draws heavily on the work of Christakis and Fowler (2010) and the principles of social epidemiology. Specifically, if recovery is both visible and attractive in its presentation, then it is likely that it will spread more rapidly through social networks both as a behavioural phenomenon among individuals with addiction histories but also as a socially desirable and acceptable aspiration within communities. This in turn should open more doors and create further pathways that increase the opportunities for sustainable recovery growth and change. These are the ideas that have generated the “Recovery Cities” (i.e., Inclusive Cities) movement (Best & Colman, 2019), promoting community inclusiveness based on the principles of the recovery movement and designed to continue to support effective recovery pathways. The Recovery Cities / Inclusive Cities initiative involved three cities initially – Doncaster in the UK, Ghent in Belgium, and Gothenburg in Sweden. In all three cities, the aim was to mobilise community resources through a recruited cohort of ‘community connectors’ to challenge exclusion and create pathways to community resources for people who misuse substances and then to other marginalised and stigmatised groups. The initiative has now extended to a number of other cities in Europe and New Zealand, and is building a community model for supporting and enhancing personal journeys to wellbeing.

**Conclusions**

The evidence presented here challenges the dominant tendency historically to view addiction as a disease (White & Cloud, 2008). The disease model has oftentimes been critiqued for having the effect of overly individualising, pathologising, and dehumanising the person and the perceived problem (Pienaar, & Dilkes-Frayne, 2017), while at the same time individualising the responsibility for resolution. Individuals have differentiated capacities and resources to overcome addiction (Cloud & Granfield, 2008). The same set of factors can and do affect individuals differently depending on their personal, situational, social contexts, and resources. However, this differentiated capacity is also deeply affected by factors, forces, and structures that operate at the meso and macro levels.

Therefore, the dynamics operating in individuals’ recovery journey are nuanced, interactive, and dynamic and are not always within the control or responsibility of the individual. To simply individualise and ascribe responsibility to the person in recovery for their lack of ‘success’ does little to acknowledge the existence of the social inequalities and dire social realities, levels of exclusion and stigma faced by certain populations within the recovery population (Cloud & Granfield, 2008). There will be some individuals who can recover in stigmatising and hostile settings if they have enough personal and social recovery capital. For most, however, it will be the ability to access community resources (houses, jobs, meaningful activities, and recovery support groups) as well as personalised and individualised relationships, that will be prerequisites for sustainable change. This is why CHIME offers a model for how recovery-oriented services should deploy their resources and assess their impact and effectiveness.

It has been argued by some that substance use has become a normalised activity (Aldridge et al., 2011; Parker et al., 1998), whilst Lloyd (2010) has highlighted that those who experience drug and alcohol problems are one of the most stigmatised groups. The forces of exclusion and stigma manifest in different guises that can block or impede continuing routes out of addiction. O’Gorman (2016, p. 253) usefully questioned “why the use of similar drugs and similar drug using behaviours by different social groups is differentially accommodated and accepted by mainstream society?” to highlight the relative as well as differentiated nature of acceptability and accommodation of harmful drug use and related behaviours.

As recovery is centered around relationships embedded in societal processes and structures, the Recovery Cities initiative is one example of attempting to change societal responses in order to address structural barriers to effective group engagement. Individuals in recovery need both ‘the will and the ways’ on their journey (Burnett & Maruna, 2004). It is acknowledged that this transition at the meso and macro levels is not simple, quick, or easy. Therefore, mapping existing assets in the community that promote belonging, inclusion, provide meaningful activities, act as social connection points, build awareness of existing strengths, and offer a vision for the future. These processes highlight the powerful impact that environments and organisations can have in promoting recovery.

Building on this further to create inclusive cities that promote participation and inclusion whilst challenging stigmatisation and exclusion is key (Best & Colman, 2019). This is predicted on the idea that individual recovery journeys have the ability to generate further community recovery capital and to increase the visibility and accessibility of recovery. The Recovery Cities / Inclusive Cities model is based on the assumption that there is a generative dynamism between individual transformation and collective recovery potential, although this model has not yet been evaluated. Operating from this framework requires us to rethink and redefine our understanding of the operation of recovery in a way that transcends the personal to incorporate the social, community, and societal forces that are essential to promoting growth and human flourishing. Through building inclusive and recovery-oriented systems and communities, we are suggesting a form of ‘giving back’ that is transformative in placing the values of recovery at the heart of communities and, in doing so, promotes a broad base of community connections and active participation as fundamental for growth and wellbeing at a collective level.

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