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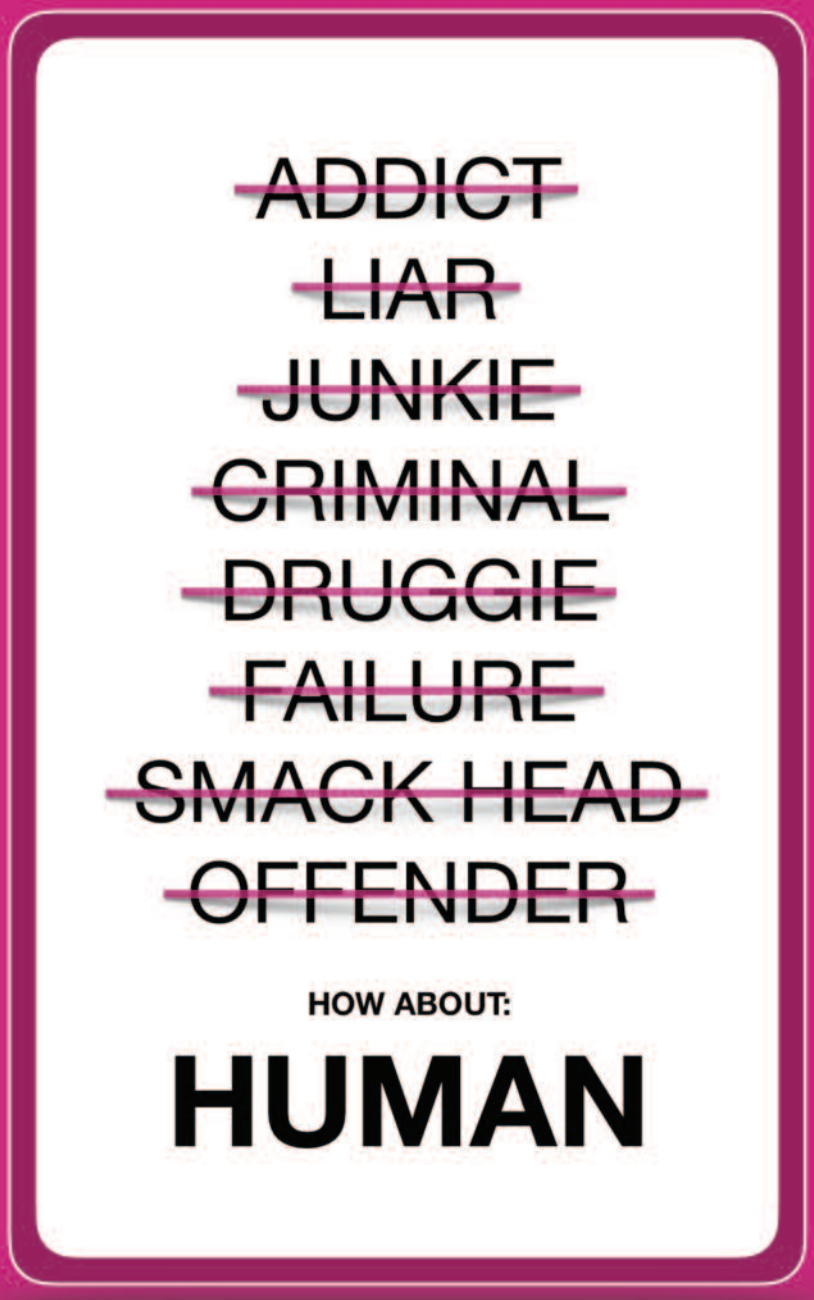

Special Edition

Recovery in Prison

Definitions of Recovery

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Background

Since people have begun to consider 'addiction' as a form of disease or disorder, there has been debate about what substances and activities it should be applied to (for example, smoking, chocolate, gambling, work and exercise) and how it should be defined (by substance, the user, frequency and quantity of use, the route of administration, the severity of withdrawals or cravings). Similar issues apply to recovery, with what would appear to be a clear behaviour (stopping or moderating use), not being regarded as a satisfactory or adequate criterion for recovery. This chapter will examine some of the definitions that have been put forward, and some of the broader structural and contextual factors that are relevant. The chapter will conclude by explaining not only what recovery is but how it is likely to come about.

Consensus groups and expert opinions

The Betty Ford Institute Consensus Panel defines recovery from substance use disorders as a 'voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship'.[1] The group recognised that recovery takes time and identified stages of recovery as 'early' (first year of recovery), 'sustained' recovery of between one and five years, and 'stable' recovery of more than five years. This staged process is based on work by Dennis, Foss and Scott[2] who in an eight-year outcome study, showed that the risk of relapse in the first year post-detoxification was above 50 per cent but, for individuals who achieved five years of continuous sobriety, their recovery could be described as 'self-sustaining' with little external support needed to sustain positive change.

In the UK, a similar consensus group was established by the UK Drug Policy Commission, who defined recovery as 'voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society'.[3] Consistent with the Betty Ford Group, there are three common elements—something about sobriety (albeit with a less stringent requirement for complete abstinence in the UK version), something about global health and wellbeing and something about citizenship or active participation in the lived community.

Both of these definitions are behavioural and static—in other words they do not capture the subjective and experiential components of recovery that, for example, Deegan[4] has identified as essential for mental health recovery. Deegan argued that the personalisation of ownership of recovery was both intrinsic to the experience and empowering. The definition also does not convey the sense of a journey or an aspiration that is characterised in Dennis and colleagues' work on stages of recovery.[5] The importance of the subjective experience has been taken to a logical conclusion by Phil Valentine[6] who has argued that 'you are in recovery if you say you are' Although this is an extreme position to adopt, it recognises that recovery can be an aspirational state as much as an achievement and that, for many, recovery feels like a journey rather than as a destination.

A third definition comes from the Substance Abuse and Mental Health Services Administration, who agreed on the following working definition of recovery: 'A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.'[7]

1. Betty Ford Institute Consensus Panel (2007) 'What is recovery? A working definition from the Betty Ford Institute', *Journal of Substance Abuse Treatment,* 33: 221-228. https://doi.org/10.1016.j.jsat2007.06.001 (p222)
2. Dennis, M., Foss, M. & Scott, C. (2008)An eight-year perspective on the relationship between the Duration of Abstinence and Other Aspects of Recovery, Evaluation Review, , 31, 585. https://doi.org/10.1177/0193841X07307771
3. United Kingdom Drug Policy Commission (2008) Reducing drug use, reducing offending: *Are programmes for problem drug-using offenders in the UK supported by the evidence?* London, England.
4. Deegan, P. (1996) 'Recovery as a journey of the heart', Psychiatric Rehabilitation Journal, 19 (3), 91–97.
5. Dennis, M., Foss, M. & Scott, C. (2008)An eight-year perspective on the relationship between the Duration of Abstinence and Other Aspects of Recovery, Evaluation Review, , 31, 585, DOI: 10.1177/0193841X07307771.
6. Valentine, P (2011). Peer based recovery support services within a recovery community organisation: The CCAR experience. In J.F. Kelly and W.L.White (Eds), *Addiction Recovery Management* (pp.259-279). New York: Humana Press.
7. SAMHSA - https://store.samsha.gov/system/files/pep12-recdef.pdf

Policy-based definitions of recovery

What systems and processes support and facilitate recovery pathways? In 2008, the Scottish Government[8] issued a new recovery based drug strategy that talked of making a 'fresh start' in tackling drug problems. The document defined recovery as 'a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society.' The sense of subjectivity is captured in the further explanation that 'In practice, recovery will mean different things at different times to each individual person with problem drug use.'

In England, it took a further two years for recovery to be embedded in drug strategy[9] asserting that 'A fundamental difference between this strategy and those that have gone before is that instead of focusing primarily on reducing the harms caused by drug misuse, our approach will be to go much further and offer every support for people to choose recovery as an achievable way out of dependency'. The UK drug strategy (2010) recognised both the subjective and journey aspects of recovery in describing recovery as: 'An individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people. We must therefore, put the individual at the heart of any recovery system and commission a range of services at the local level to provide tailored packages of care and support'.

Not only do each of these definitions recognise individualised pathways, they assert systems and services should be responsive to individual needs and that are predicated on opportunities and strengths. Although the 2017 Drug Strategy in England[10] switched back to more of a health and harm reduction focus, Chapter 3 outlines a model of recovery that claims 'We will raise our ambition for recovery by enhancing treatment quality and improving outcomes through tailored interventions for different user groups' The focus is increasingly on a partnership model that recognises the complexity of recovery and the need for addressing issues such as housing, trauma, education and employment, stigma and exclusion.

The challenge for policy-makers is how to translate those broad definitions into things that can be monitored and measured. In both Scotland and England, there remain questions about how effectively these lofty aspirations have been realised, with more basic questions around mechanisms and underpinning activities also remaining unanswered. In the next section, we move onto a consideration of a predominantly US literature that has attempted to create a framework for the implementation of a recovery model.

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Recovery as a multi-layered and social concept

There is a growing recognition that recovery is not simply a series of behaviours or even an experiential state but also has the potential to be something much more social and societal. In their conceptualisation of recovery as a social movement, Beckwith, Bliuc and Best[11] suggested that 'recovery' is a group or movement that an individual can belong to as well as a series of experiences and changes they undergo. The article also considered whether recovery has an intrinsically social component where group membership and the resulting sense of belonging is central to the experience and expression of recovery. This idea of recovery as a social identity is described in the Social Identity Model of Recovery (SIMOR),[12] in which 12-step fellowships were used as an example of this idea of recovery as a group identity. In 12-Step programmes, the transition to stable recovery is characterised by changing from 'using' groups to 'recovery' groups as the main social supports the individual has. SIMOR makes the point that changes in social group membership involves the internalisation of the values, norms and attitudes of the new group and that this influences future identity and behaviour.

8. Scottish Government (2008) The Road to Recovery; Available at: http://www.emcdda.europa.eu/attachements.cfm/att_53209_EN_Scotland%20Strategy%202008.pdf (Accessed 26/05/2015).
9. Home Office (2010) Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a *Drug Free Life.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf
10. UK Government (2017) 2017 Drug Strategy, Home Office: London.
11. Beckwith, M., Best, D. & Bliuc, A. (2016) What the recovery movement tells us about pre-figurative politics, *Journal of Social and Political Psychology,* 4(1), 238-251.
12. Best, D., Irving, J. & Albertson, K. (2016) Recovery and desistance: What the emerging recovery movement in the drug and alcohol area can learn from models of desistance from offending, Addiction Research and Theory. https://doi.org/10.1080/16066359.2016.1185661

So, when Longabaugh et al[13] asserted that one of the key characteristics of successful recovery was the transition from membership of groups supportive of substance use to groups supportive of recovery, they were characterising recovery in terms of both a behaviour change and a transition in identity.

This is illustrated in a randomised trial conducted by Litt and colleagues[14] which involved a group of problem drinkers who, after detoxification, were randomised to either standard aftercare or to a Network Support condition (in which participants were assertively linked to at least one person to befriend who was in long-term recovery). For individuals who had at least one completely sober person added to their social network, their likelihood of relapse to substance use was reduced by 27 per cent in the following year.

Recovery oriented systems of care

Recovery does not usually occur in isolation and so systems and services should be designed in such a way that the likelihood of sustainable change is maximised. On behalf of the Substance Abuse and Mental Health Services Administration, Sheedy and Whitter[15] outlined the concept of a Recovery-Oriented System of Care as 'networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders' They draw on a paper from Gagne, White and Anthony[16] which outlined key principles for a recovery approach: in which recovery is characterised as a personalised and individualised process of growth that unfolds along a continuum and there are many pathways to recovery; that people in recovery are active agents of change in their lives and not passive recipients of services; and that people in recovery often talk about the importance of family and peer support in making the difference in their recovery. From a service perspective they suggest that recovery-oriented systems should recognise that each person is the agent of his or her own recovery and all services can be organized to support recovery, and they need to offer choice, honour each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction.

Sheedy and Whitter also outline guiding principles of recovery which supplements the above by adding principles indicating that recovery involves a personal recognition of the need for transformation and change, that it is holistic, culturally embedded, that it involves (re)joining and (re)building a life in the community, and that recovery emerges from hope and gratitude. They go on to suggest that recovery also involves addressing discrimination and transcending shame and stigma.

To support these goals for recovery, Sheedy and Whitter build on the definitions of recovery to argue that a recovery system can be assessed against the extent to which it:

- ❒ Is person-centred;
- ❒ Includes family and other supporters;
- ❒ Provides individualised and comprehensive support across the life course;
- ❒ Is anchored in the community;
- ❒ Continues care seamlessly between services;
- ❒ Includes consultant relationships;
- ❒ Focuses on strengths;
- ❒ Is culturally responsive and responsive to personal belief systems;
- ❒ Committed to peer recovery support;
- ❒ Include the voice of the person in recovery and their family members;
- ❒ Be integrated
- ❒ Involves system-wide education and training;
- ❒ Includes ongoing monitoring and outreach;
- ❒ Is outcomes and research based; and
- ❒ Is adequately and flexibly financed.

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Whilst much of the evidence around recovery is drawn from the mental health recovery field, there is

13. Longabaugh, R., Wirtz, P. W., Zywiak, W. H., and O'Malley, S. S. (2010). Network support as a prognostic indicator of drinking outcomes: The COMBINE study', *Journal of Studies on Alcohol and Drugs*, 71(6), 837.
14. Litt, M.D., Kadden, R.M., Kabela-Cormier, E., & Petry, N. (2007). Changing network support for drinking: Initial findings from the Network Support Project. Journal of Consulting and Clinical Psychology, 75, 542
15. Sheedy C. K., and Whitter M., (2009) Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.
16. Gagne, C., White, W., Anthony, W.A. (2007) Recovery: A common vision for the fields of mental health and addictions. *Psychiatric Rehabilitation Journal,* 31(1): 32-37.

significant support for some of the constituent elements outlined above and the research into recovery from addiction is increasing.

This means that we are now able to start to build recovery models that are predicated on evidence, and define recovery in a way that includes all different types of people and groups.

CHIME

In this section we describe how these elements of recovery are combined into a single model that has been amended from the mental health field. In 2011, Leamy and colleagues[17] reviewed the evidence around mental health recovery and attempted to identify 'essential elements' of effective recovery-oriented interventions, based on 97 research papers conducted in 13 countries. They identified 13 characteristics of the recovery journey:

- ❒ Recovery is an active process
- ❒ Recovery is a unique and individual process
- ❒ Recovery is a non-linear process—people have ups and downs
- ❒ Recovery is a journey
- ❒ Recovery occurs in stages or phases
- ❒ Recovery is a struggle
- ❒ Recovery involves change in many aspects of a person's life (multi-dimensional)
- ❒ Recovery is a gradual process
- ❒ Recovery is a life-changing experience
- ❒ Recovery can occur without there being a cure
- ❒ Recovery is aided by a supportive and healing environment
- ❒ Recovery can occur without professional intervention
- ❒ Recovery can often be a trial and error process while each person learns what works for them

The review concluded that there are five essential elements of the recovery process that make up the acronym CHIME. CHIME stands for Connectedness; Hope; Identity; Meaning and Empowerment, and Table 1 below outlines the key factors involved in each element of recovery:

Table 1: Essential components of CHIME

Connectedness	Peer support and support groups Relationships
Hope	Support from others Being part of the community Belief in the possibility of recovery Motivation to change
	Hope-inspiring relationships Positive thinking and valuing success Having dreams and aspirations
Identity	Dimensions of identity Rebuilding and redefining a positive sense of identity Overcoming stigma
Meaning	Giving meaning to mental illness experiences Spirituality Quality of life Meaningful life and social roles Meaningful life and social goals Rebuilding life
Empowerment	Personal responsibility Control over life Focusing upon strengths

In the conclusion to the paper, Leamy and colleagues pointed out that the vagueness of the term recovery has led to considerable uncertainty for policy makers and practitioners. They hoped that CHIME offered an 'empirically based conceptual framework which can bring some order to this potential chaos' In our view, the real contribution of CHIME is that it explains personal recovery and also suggests what helping agencies/services should focus on to help people in their recovery journey.

A social identity and recovery capital model of CHIME

In this section of the paper, we will bring together two of the models outlined above, CHIME and SIMOR (the Social Identity Model of Recovery) to consider how personal pathways to recovery it with what we know about how people change and what support they need.

A new concept, Recovery Capital[18] was introduced by Granfield and Cloud in 2001[19] to describe the assets and resources available to an individual in their recovery journey. Recovery Capital is defined as with the sum

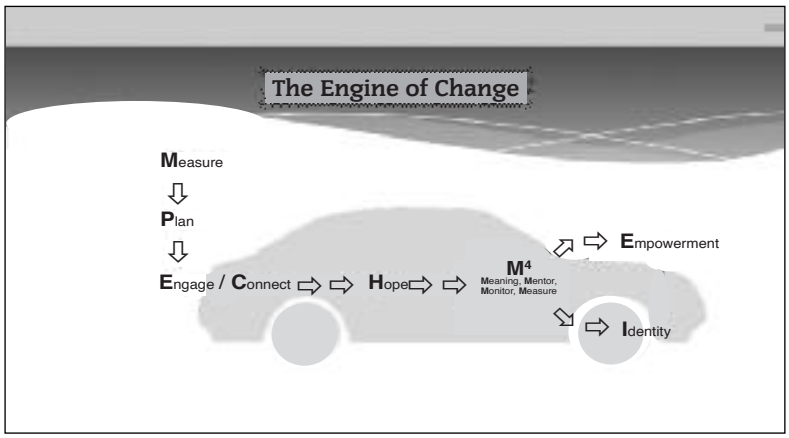
17. Leamy, M., Bird, V., Le Boutillier, C., Williams, J., and Slade, M. (2011) 'A conceptual framework for personal recovery in mental health: systematic review and narrative synthesis', British Journal of Psychiatry, 199, 445–452.
18. See Best, Hall and Collinson article in this journal for a more detailed description.
19. Cloud, W. and Granfield, R. (2008) 'Conceptualising recovery capital: Expansion of a theoretical construct', Substance Use and Misuse, 43:1971-1986.

total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation'[20]. This paper also introduced the concept of negative recovery capital to describe those life factors (such as significant mental health problems or prolonged involvement with the criminal justice system) that could act as barriers to recovery. Best and Laudet[21] divided recovery capital into three broad categories—personal, social and community capital. The gradual transition to a quantifiable model for recovery capital has come to fruition in Cano et al's[22] model of REC-CAP (also described in the Best, Hall and Collinson article in this issue).

The ability to measure recovery wellbeing is important for those supporting people on a recovery journey as it provides a means of assessing how an individual is doing and what resources they have to support their recovery journey. Measurement needs to include all three elements of personal skills and competences, social supports and social ties, and resources that are available and accessible in the local community. REC-CAP not only records personal progression but also assesses the accessibility and utility of recovery groups and networks in the lived community.

In a CHIME model, the importance of social factors and social support is emphasised in the Connectedness component. One way of conceptualising CHIME as a process is as a vehicle in which connections generate hope and hope is then the fuel that fires an engine that can drive changes in activity leading to changes in identity and a sense of empowerment as shown in Figure 1 below:

Figure 1: CHIME and addiction recovery



The idea here is a simple one—as outlined in the Social Identity Model of Recovery, engagement with individuals or groups who support recovery and who create a tie of belonging and identity—generates a new sense of social identity. Connections to new groups (particularly peer groups) generate a sense of hope through seeing other people succeed and social learning through observing their behaviours that generates hope and self-belief. However, this needs to inspire activity as this will be the catalyst to changes in how the person is perceived by others and how they perceive themselves.

The CHIME model explains how this works: connections to individuals or groups who are in recovery provide opportunities for social learning and social control around recovery[23]. This exposure to successful recovery creates a 'social contagion' in which recovery is transmitted from one person in recovery to another[24] The CHIME model adds the insight that what is transmitted is a sense of Hope. Thus, through watching other people succeed in recovery, the individual not only learns the techniques of successful recovery but is inspired in the belief that it is possible for them as well.

In the image of the car in Figure 1, hope is seen as the fuel that drives the engine of recovery change, (previously generally been referred to as motivation). In the CHIME model, the combination of external support (connection) and internal motivation (hope) then creates a virtuous circle of meaningful activities, a sense of empowerment and a positive change of identity (that is socially mediated as outlined in the SIMOR model).

So, consistent with the evidence from our previous work on the importance of meaningful activities in recovery[25,26] involvement in a diverse range of prosocial activities, such as volunteering, further education, team sport, fitness activities and employment, provide an impetus towards positive change. Engagement in meaningful activities has a positive effect on self-perception and identity, and generates self-esteem, self-efficacy and feelings of wellbeing. In Best et al's 2016 research, engagement in a recovery community that was based on

20. Cloud and Granfield (2008) as above (p.1972).
21. Best, D. & Laudet, A. (2010) The potential of recovery capital. RSA Projects. Royal Society for the Arts.
22. Cano, I., Best, Edwards, M. & Lehman, J. (2017) Recovery capital pathways: Mapping the components of recovery wellbeing, Drug and Alcohol Dependence, 181, 11-19.
23. Moos, R.H. (2007). Theory-based active ingredients of effective treatments for substance use disorders. Drug and Alcohol Dependence, 88, 109–121.
24. White, W (2010). Recovery is contagious. www.williamwhitepapers.com/pr/2010%20Recovery%20is%20Cantagious.pdf
25. Best, D., Gow, J., Taylor, A., Knox, A. & White, W. (2011) Recovery from heroin or alcohol dependence: A qualitative account of the recovery experience in Glasgow. Journal of Drug Issues, 11 (1), 359-378.
26. Cano, I., Best, Edwards, M. & Lehman, J. (2017) Recovery capital pathways: Mapping the components of recovery wellbeing, Drug and Alcohol Dependence, 181, 11-19.

building recovery housing in the north of England was associated with improvements not only in substance use and offending, but also in psychological health and personal recovery capital, including factors such as self-esteem and self-efficacy. The CHIME model is fundamentally social and societal in its focus. The reliance on connection and contagion as the triggers for change mean that, for all but the small minority who can achieve recovery without any external supports (what Granfield and Cloud[27] referred to as 'natural recovery') there is a need for accessible, attractive and visible recovery groups, resources and champions to promote and catalyse the recovery process. In the SIMOR paper (Best et al, 2016) we use the example of Alcoholics Anonymous to describe the process of group engagement and identification, this recovery model relies on individuals (referred to as sponsors) to support ongoing recovery processes.

There is also a further level that is relevant to Recovery Oriented Systems of Care and that is the community or societal level. It is essential that individuals who are trapped in addiction have access to visible sources of support and inspiration to create a 'therapeutic landscape' that increases the accessibility and visibility of recovery and the perception that it is a realistic objective. They not only initiate recovery but sustain it through access to resources in the community including but not restricted to peer and mutual aid groups, and by taking advantages of opportunities for a sense of belonging and engagement in the local community. Some of these things are beyond the gift of the person in recovery and will require a societal commitment to reintegrate and support people in recovery.

So what does the CHIME model of addiction recovery add to the existing literature and knowledge base? CHIME offers a framework for how people can both initiate and be sustained in their recovery journey and describes what kind of personal support and structural support is needed to support this process. At a social level, the aim is to create a group of visible recovery champions and groups to enact the contagion and to support the resulting process of change. In the prisons, this would mean an emphasis on peer champions being identified and having an active role in supporting recovery not only in the prison but with continuity of care to post-release. At a societal level, pathways to reintegration are needed to build the virtuous circle of access to housing, jobs and community engagement that will fuel the journey to recovery. This boosts the personal responsibilities and growing sense of agency that individuals must develop over the course of the personal and individual recovery journey.

How is this relevant to the prison population?

There is a significant overlap between offending and problem drug using populations: whilst drugs do not automatically lead to crime, the interplay is undeniably significant[28]. 64 per cent of the prison population have been identified as having problem drug use, and substance use is a strong predictor for recidivistic crimes[29] suggesting a strong reciprocal relationship. So, the first reason why the recovery model is relevant to prisons is that a high proportion of the prison population will need to recover. There is a second area of overlap which involves shared characteristics between the recovery journal and a journey to rehabilitation and to reintegration from a marginalised and excluded identity and status[30]. The same mechanisms of accessing community capital and building positive prosocial relationships are as highly relevant to the desistance process as are changes in self-esteem, self-efficacy and identity (both personal and social).

Conclusion

Recovery is a concept that has grown in political status and academic interest in recent years. It is still a highly contested term, in spite of 10 years of attempts to capture and encapsulate key aspects of its meaning—not only in the addictions field but also in the mental health area. Although behavioural correlates like employment, abstinence and health are generally included in definitions, it is clear that recovery is an individualised experience that will evolve over time and that it has a strong subjective component. The components of recovery can be measured and quantified using the framework of recovery capital and this provides a strengths-based approach that is more consistent with a model to build personal and social wellbeing. However, it is also clear that recovery is not a linear pathway, and that it requires personal commitment and drive, as well as also the opportunity for reintegration afforded by friends and family, and by employers, housing authorities and communities. To this extent, recovery requires a shared commitment to social justice and a belief in the capacity to rehabilitate and to participate fully in the community.

28. Van Roeyen, S., Anderson, S., Vanderplasschen, W., Colman, C. & Vander Laenen, F. (2017) Desistance in drug-using offenders: A narrative review, European Journal of Criminology, 14(5), 606-625.
29. Nurco, D. (2009) A long-term program of research on drug use and crime, Substance Use and Misuse, 33(9), 1817-1837.
30. Best, D., Irving, J. & Albertson, K. (2016) Recovery and desistance: What the emerging recovery movement in the drug and alcohol area can learn from models of desistance from offending, Addiction Research and Theory, DOI: 10.1080/16066359.2016.1185661