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BEST, David <<http://orcid.org/0000-0002-6792-916X>>, SAVIC, Michael <<http://orcid.org/0000-0002-6161-4511>>, BATHISH, Ramez <<http://orcid.org/0000-0002-9831-1848>>, EDWARDS, Michael <<http://orcid.org/0000-0003-2866-9200>>, IRVING, James <<http://orcid.org/0000-0001-9994-3102>>, CANO, Ivan and ALBERTSON, Kathy

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Life in Recovery in Australia and the UK: Do stages of recovery differ across national boundaries?

David Best, PhD*, Michael Savic, PhD, Ramez Bathish, Michael Edwards, Jamie Irving, Ivan Cano,
Kathy Albertson

*Corresponding author

Professor David Best

Sheffield Hallam University

Room 213

Collegiate Campus

Collegiate Crescent

Sheffield

S101QS

Abstract

The evidence is now clear that more than half of those who have a lifetime addiction to alcohol or drugs will eventually achieve stable recovery. As documented in the Life in Recovery Surveys and elsewhere, recovery often brings about positive changes across a diverse range of life domains. While this suggests that there are some universal experiences of recovery, there has been a lack of comparative recovery research examining the variations in recovery experiences across different settings and cultures. Using a combined dataset of the UK and Australian Life in Recovery surveys and the three-stage model of recovery, we compare life achievements at each stage across the two settings. There are differences in patterns of recovery, with elevated levels of ongoing mental health problems in Australia, and significant involvement with the criminal justice system in the UK, suggesting a contextual and structural role in understanding recovery pathways. The implications for policy and practice are reviewed around structural barriers and the role of social justice in advancing recovery models and pathways.

Key words: Recovery; Life in Recovery; mental health; criminal justice; stages of recovery

Introduction

The Betty Ford Institute Consensus Panel defines recovery from substance dependence as a “voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship” (2007, p. 222). However, they went further in describing recovery as a three-stage process, suggesting that the first year of recovery should be considered 'early', years 1-5 as 'sustained' and more than five years as 'stable' recovery. The reason why this is crucial is that the likelihood of relapse is estimated to reduce from around 50-70% in the first year to around 15% after five years of continuous recovery. Dennis, Scott and Laudet (2014) have argued that it is after five years that recovery becomes self-sustaining, while prior to that point external supports are required. It is not clear whether this is seen as a stage theory or whether change is continuous with the defined points as markers on a pathway to long-term recovery.

A review for the US Substance Abuse and Mental Health Services Administration (SAMHSA) concluded that of all those who experience a lifetime substance dependence, 58% will achieve stable recovery (Sheedy and Whitter, 2009). This was slightly higher than the estimate produced by White (2012) following a review of 415 papers, yet the estimate remained in excess of 50%. The introduction of the idea of recovery capital (Granfield and Cloud, 2001) has provided a frame to make sense of who will recover, by suggesting that certain core factors - social supports, financial resources, human capabilities - make recovery more likely to occur. Best and Laudet (2010) suggested that there are three main categories of recovery capital - personal (such as resilience and coping skills and self-efficacy), social (support and engagement in prosocial groups) and community (access to the resources that are available in the lived community). However, Cloud and Granfield (2009) went further in suggesting that there are also “personal circumstances, individual attributes, behaviours, values, etc., that actually impede one’s ability to successfully terminate substance misuse and keep people trapped in the world of addiction” which they referred to as negative recovery capital (Cloud and Granfield 2009, p. 1977). These included such factors as

histories of mental health problems, histories of criminal justice involvement as well as female gender and older age at the start of the recovery journey. The notion of negative recovery capital highlights that recovery is not a level playing field and that who you are, what groups you belong to (Best et al, 2016) and what kind of community you live in will influence your chances of initiating and sustaining a meaningful recovery.

It is within this context of developing a framework for understanding the pathways to recovery - and celebrating the diversity and individuality of pathways - that the series of Life in Recovery surveys sit. Many of the papers in this volume provide overviews of the methods and findings of the surveys in the US, UK and Australia, so that will not be repeated here. This paper is based on combining two of the datasets from national surveys - the UK (Best et al, 2015) and Australia (Best, 2015) - to allow meaningful comparisons to be made. This is important because relatively little research on recovery has compared how experiences of recovery differ according to cultural context. For instance, it is not clear whether stages of recovery are invariant across national boundaries or whether pathways to recovery need to be framed in the context of cultural, structural and systemic factors that may influence community resources and supports for recovery.

Hypotheses:

H1: That there will be differences in the profile of recovery stages between the UK and Australia and in the patterns of recovery gains at each stage

H2: That these differences in recovery pathways will be consistent across the three stages of recovery as defined in the Betty Ford Consensus Group work

Method: Detailed methodological reviews are provided in Best (2015), Bathish et al., (2016), Best et al (2015) and Best et al., (2017) for the Australian and UK Life in Recovery surveys respectively.

Crucially, the same basic method was used: A survey was adapted to the local context and distributed primarily through online methods using a range of social media to promote recruitment.

This was supported by distribution of hard copies to those groups and individuals who were not able or not willing to complete the online version. Inclusion criteria for both were deliberately inclusive and required participants to be over the age of 18 and to regard themselves as being in recovery with no objective requirements for what this meant set by the research team.

All the core variables, relating to experiences in active addiction and in recovery were exactly the same in the Australian and UK samples, with only minor differences in the demographic questions. These instruments were both adapted from the LiR survey reported by FAVOR (2012) and seek to report differences in a range of behaviours between the period of active addiction and recovery.

Sample: The total sample of clean cases that could be used for the current analysis was 1,359 - 790 (58.1%) of cases from the UK and 569 (41.9%) of cases from Australia. Half of the sample were female (49.7%), and the most frequent age range was people aged 40-49. Approximately half of the sample were similar proportions of each sample were in full time work (41.9%), followed by part-time work (14.9%) and unemployed individuals (15.6%). Roughly equal proportions of the samples were married or living with a partner (46.8%) and 36.7% of respondents lived with dependent children. In terms of presenting problems, the majority of participants reported problems with alcohol only (39.4%), followed by drugs and alcohol (28.5%), and drugs only (24.5%). On average, the duration of substance use was 19.59 years, with a mean of 7.98 years since last use. Regarding stage of recovery, respective percentages for stable, sustained and early recovery were 58.2%, 27.1%, and 14.7% since last use. Average time in recovery was 8.1 years, having started at a mean of 36.86 years of age. Participants reported means of 7.25 in physical health, 6.72 in psychological health and 7.53 in quality of life. The number of important people in individuals' lives in recovery was 3.37.

Data Analysis: Z scores were calculated to allow comparisons between the demographic characteristics of the two populations compared, while t-tests are used to compare on continuous variables. T-tests are also used for comparisons of variables in career and wellbeing factor for each

stage of recovery, and Chi-square is used to assess differences between the countries in categorical variables.

Results

1. Socio-demographic differences between the UK and Australia

In the UK, 46.1% of the sample was female compared to 54.8% in Australia ($z = -3.19$, $p < 0.01$). As the age variable was categorised into bands, z scores were also used for comparisons across the two countries - Australian participants were more likely to be aged between 18 and 20 (2.1% compared to 0.4%; $z = -3.34$, $p < 0.01$); to be between 21 and 29 (10.0% compared to 3.8%; $z = -4.62$, $p < 0.01$) and to be between 30 and 39 (27.9% compared to 19.1%; $z = -3.81$, $p < 0.01$). In contrast UK participants were more likely to be between 40 and 49 (38.4% compared to 26.9%; $z = 4.43$, $p < 0.01$) and slightly more likely to be between 50 and 59 (24.6% compared to 20.9%; $z = 1.59$). There were no differences in whether participants had dependent children in Australia (34.6%) or the UK (38.1%; $z = -1.30$, ns) or in marital status - 46.9% of those from the UK sample were married or lived with a partner compared to 48.1% in Australia ($z = -0.46$, ns). Differences in employment status are shown in Table 1 below

Table 1: Employment status at time of completing the survey

	UK (n=790)	Australia (n=569)	Z-test, significance
Disability	4.2%	4.5%	$z = -0.31$, ns
Full-time	42.1%	44.6%	$z = -0.89$, ns
Part-time	12%	19.9%	$z = -3.95$, $p < 0.01$
Home duties	1.4%	3.3%	$z = -2.23$, $p < 0.05$
Retired	9.8%	5.6%	$z = 2.74$, $p < 0.05$
Self employed	5.3%	5.8%	$z = -0.35$, ns

Student	5.6%	5.1%	$z = 0.42$, ns
Unemployed	19.6%	11.2%	$z = 4.06$, $p < 0.01$

UK participants were more likely to be retired or unemployed, while Australian participants were more likely to work part-time or to have home duties. In terms of their primary problem, UK clients were more likely to be alcohol only (47.4% in the UK and 35.6% in Australia; $z = 4.16$, $p < .01$) and to be drug only (37.1% in the UK and 11.2% in Australia; $z = 10.23$, $p < 0.01$), but Australian participants were more likely to have both drug and alcohol problems (53.2% in Australia and 15.5% in the UK; $z = -14.24$, $p < 0.01$). Table 2 below illustrates the differences in recovery careers and stage of recovery career between Australia and the UK

Table 2: Differences in recovery journey between the UK and Australia

		UK	Australia	t or z, significance (effect size)
Age started recovery		38.35 years	34.76 years	$t = 6.04$, $p < 0.001$ ($d = 0.35$)
Time in recovery		8.29 years	9.28 years	$t = -1.93$, ns
Recovery stage	Early (less than 1 year)	13.3%	16.7%	$z = -1.75$, ns
	Sustained (1-5 years)	28.7%	24.8%	$z = 1.62$, ns
	Stable (More than 5 years)	58%	58.5%	$z = -0.20$, ns

Although there were no significant differences in recovery stage between the countries, Table 3 below shows the overall differences in wellbeing in the two countries:

Table 3: Differences in wellbeing between the UK and Australian samples

	UK	Australian	t, significance, effect size
Physical health	7.4	7.0	t = 3.43, p<0.01, d=0.19
Psychological health	7.0	6.3	t = 5.40, p<0.001, d=0.31
Quality of life	8.2	6.8	t = 11.08, p<0.001, d=0.65

As is illustrated in Table 3, there is a consistent effect that participants from the UK reported significantly higher mean scores on all three of the wellbeing indicators - physical health, psychological health and quality of life (with all scales rated between 0 and 10, with higher scores representing better wellbeing). Part of the explanation for this may be that the reported rates of lifetime mental health help-seeking was significantly higher in Australia (91.5% compared to 79.0% in the UK; $\chi^2 = 37.49$, df = 1; p<0.001), as were the rates of current engagement with mental health services (56.8% in Australia; 36.9% in the UK; $\chi^2 = 49.20$, df = 1; p<0.001).

5. Comparisons within each recovery stage

5a. Differences in early recovery

There were data available for 202 individuals in early recovery (within the first year of the self-reported start date of the recovery journey), 105 from the UK and 97 from Australia. Table 4 compares key variables across the two countries:

Table 4: Differences in recovery experiences between people in early recovery in the UK and Australia

	UK (n=105)	Australia (n=97)	t or chi, significance, effect size
Physical health	7.0	6.9	t = 0.25, ns
Psychological health	6.2	5.2	t = 2.94, p<0.01, d=0.41

Quality of life	7.5	5.7	$t = 5.01, p < 0.001, d = 0.73$
Years of AOD use	19.9 years	16.4 years	$t = 2.31, p < 0.05, d = 0.33$
Age started recovery	42.0 years	35.8 years	$t = 3.63, p < 0.001, d = 0.51$
Had your own place to live	83.2%	88.4%	1.00, ns
Had debts	32.3%	48.3%	$\chi^2(1) = 4.86, p < 0.05, RR = 0.66,$ 95% CI [0.47 -0.96]
Active volunteering	64.5%	38.4%	$\chi^2(1) = 12.24, p < 0.001, RR = 1.68,$ 95% CI [1.24 -2.29]
Untreated mental health problems	40.6%	34.9%	$\chi^2(1) = 0.61, ns$
Criminal justice involvement	46.3%	10.3%	$\chi^2(1) = 28.47, p < 0.001, RR = 4.48,$ 95% CI [2.32 -8.62]
Further education or training	63.4%	40.5%	$\chi^2(1) = 9.02, p < 0.01, RR = 1.57,$ 95% CI [1.15 -2.13]
Steadily employed	36.7%	58.9%	$\chi^2(1) = 8.01, p < 0.01, RR = 0.62,$ 95% CI [0.45 -0.87]
Started own business	6.6%	21.3%	$\chi^2(1) = 7.77, p < 0.01, RR = 0.31,$ 95% CI [0.13 -0.75]

While there were no significant differences in physical health, the UK participants in early recovery were significantly older ($U = 3384.5, z = -4.329, p < 0.001$), and had longer drug careers ($t = 2.31, p < 0.05, d = 0.33$); they also reported better psychological health ($t = 2.94, p < 0.01, d = 0.41$) and quality of life ($t = 5.01, p < 0.001, d = 0.73$).

5b. Differences in sustained recovery

There were data available for 370 individuals in early recovery (within 1 and 5 years of the self-reported start date of the recovery journey), 229 from the UK and 141 from Australia. Table 5 compares key variables across the two countries:

Table 5: Differences in recovery experiences between people in sustained recovery in the UK and Australia

	UK (n=229)	Australia (n=141)	t or chi, significance, effect size
Physical health	7.6	7.0	t = 2.81, p<0.01, d=0.30
Psychological health	7.1	5.1	t = 4.46, p<0.001, d=0.47
Quality of life	8.4	5.7	t = 8.17, p<0.001, d=0.90
Years of AOD use	21.4 years	19.1 years	t = 2.08, p<0.05, d=0.22
Age started recovery	40.6 years	35.4 years	t = 4.82, p<0.001, d=0.51
Had your own place to live	90.2%	93%	$\chi^2(1) = 0.79$, ns
Had debts	28%	28.8%	$\chi^2(1) = 0.02$, ns
Active volunteering	82.6%	46.5%	$\chi^2(1) = 48.77$, p<0.001, RR = 1.78, 95% CI [1.46 - 2.17]
Untreated mental health problems	24.0%	34.6%	$\chi^2(1) = 4.43$, p<0.05, RR = 0.69, 95% CI [0.49 - 0.97]
Criminal justice involvement	43.1%	16.0%	$\chi^2(1) = 26.51$, p<0.001, RR = 2.69, 95% CI [1.76 - 4.10]
Further education or training	80.4%	67.2%	$\chi^2(1) = 7.09$, p<0.01, RR = 1.20, 95% CI [1.04 - 1.38]
Steadily employed	60.2%	75.8%	$\chi^2(1) = 8.19$, p<0.01, RR = 0.79, 95% CI

			[0.68 -0.92]
Started their own business	10.6%	16.7%	$\chi^2(1) = 2.50, ns$

The differences reported for early recovery persist into sustained recovery with UK respondents reporting better functioning across all three measures of wellbeing - physical ($t = 2.81, p < 0.01, d = 0.30$), psychological ($t = 4.46, p < 0.001, d = 0.47$) and quality of life ($t = 8.17, p < 0.001, d = 0.90$). UK respondents also reported slightly longer substance using careers and a markedly later age at the start of the recovery journey. This gap is markedly wider than for the early recovery group with almost a five year difference in starting points for Australian and UK participants. $p < 0.01, RR = 1.20, 95\% CI [1.04 - 1.38]$

UK participants in sustained recovery were almost twice as likely to be active volunteers in their local community (82.6% *cf.* 46.5%, $p < 0.001, RR = 1.78, 95\% CI [1.46 - 2.17]$), to be involved in education and training and were much less likely to have untreated mental health problems. The situation with employment and criminal justice is reversed however, with Australian participants in sustained recovery more likely to be steadily employed, and slightly more likely to have started their own businesses but much less likely to be involved in the criminal justice system, mirroring the comparison for early recovery.

5c. Differences in stable recovery

There were data available for 732 individuals in stable recovery (defined as more than 5 years since the self-reported start date of the recovery journey), 421 from the UK and 311 from Australia. Table 6 compares key variables across the two countries:

Table 6: Differences recovery experiences between people in stable recovery in the UK and Australia

	UK (n=421)	Australia (n=311)	t or chi, significance, effect size
Physical health	7.5	7.1	$t = 2.34, p < 0.05, d = 0.18$
Psychological health	7.2	6.7	$t = 2.37, p < 0.05, d = 0.18$
Quality of life	8.3	7.1	$t = 6.55, p < 0.001, d = 0.52$
Years of AOD use	19.8 years	19.1 years	$t = 0.85, ns$
Age started recovery	36.0 years	34.0 years	$t = 2.58, p < 0.05, d = 0.21$
Had your own place to live	93.8%	95.9%	$\chi^2(1) = 1.3, ns$
Had debts	31.9%	22.8%	$\chi^2(1) = 6.02, p < 0.05, RR = 1.40, 95\% CI [1.06 - 1.85]$
Active volunteering	81.5%	70.7%	$\chi^2(1) = 9.46, p < 0.01, RR = 1.15, 95\% CI [1.05 - 1.27]$
Untreated mental health problems	33.8%	34.3%	$\chi^2(1) = 0.02, ns$
Criminal justice involvement	49.7%	5.8%	$\chi^2(1) = 126.13, p < 0.001, RR = 8.56, 95\% CI [5.09 - 14.38]$
Involved in further education or training	83.4%	78.6%	$\chi^2(1) = 2.11, ns$
Steadily employed	76.6%	88.9%	$\chi^2(1) = 13.99, p < 0.001, RR = 0.86, 95\% CI [0.80 - 0.93]$
Started own business	25.4%	35.2%	$\chi^2(1) = 6.27, p < 0.01, RR = 0.72, 95\% CI [0.56 - 0.93]$

While the gaps in means appear to have closed for the career variables, with no significant differences in addiction career lengths and only a two year gap in the age of recovery onset, UK

respondents in stable recovery reported older age at the start of their recovery journey (36 years *cf.* 34 years, $t = 2.58$, $p < 0.05$, $d = 0.21$), and also reported significantly better scores on physical health ($t = 2.34$, $p < 0.05$, $d = 0.18$), psychological health ($t = 2.37$, $p < 0.05$, $d = 0.18$) and quality of life ($t = 6.55$, $p < 0.001$, $d = 0.52$) all three indicators. The national differences in untreated mental health problems and involvement in further education and training are not apparent in the stable recovery groups, but there persist higher rates of volunteering among the stable UK participants. In contrast, Australian participants in stable recovery are more likely to be steadily employed and to have started their own businesses and are markedly less likely to have ongoing involvement with the criminal justice system.

Discussion

There are broad consistencies in the populations comparing the surveys, although the Australian cohort has a slightly higher rate of women, and Australian participants are much more likely to regard themselves as being in recovery from both alcohol and illicit drugs, and the UK participants were more likely to describe themselves as unemployed at the time of the survey. There are no differences in housing situation or dependent children.

The first conclusion we can draw is that despite similar recruitment strategies, the surveys have engaged with slightly different recovery groups and populations. For that reason, some of the conclusions presented below about more detailed differences have to be treated with some caution about sampling and representativeness. Nonetheless, it is notable that there are a number of significant differences that appear to persist across all stages of recovery - UK participants reported better life functioning across all three of our indicators and Australian participants reported more untreated mental health problems in early and in sustained recovery. Additionally the Australian participants were employed more consistently at all stages, and lower levels of criminal justice involvement. Although the rates of lifetime and current mental health treatment seeking is high in both contexts, with more than 90% of the Australian sample reporting lifetime involvement in

mental health services and more than half actively involved in mental health treatment in recovery, it would indicate that mental health issues pose a significant problem for many people long after they have achieved stability in their recovery. As White (2009) has argued, the pathway to recovery is an ongoing process that may result from unresolved traumas and adverse experiences, and reflects the exceptionally high rates of mental health problems in problematic drug and alcohol using groups. Since the start of the mental health recovery movement (Davidson and Strauss, 1992), the two movements have evolved in parallel and there is insufficient attention to the role of mental health recovery in overcoming a factor that Cloud and Granfield (2008) identified as a major barrier to addiction recovery.

So why should ongoing mental health problems (treated and untreated) and lower life satisfaction be a stronger feature of the Australian than the UK recovery experience? While it may be the case that the differences reflect differential recovery policies and practices with the more overtly open and supportive recovery policies in both Scotland and England (Scottish Government, 2008; UK Government, 2010) creating more integrated pathways, exploration of the role of policy was beyond the scope of this paper. Further, there may be subtle differences deriving from cultural factors in how people make sense of quality of life questions, or factors related to pathways to recovery (Bathish et al, 2017) that may influence self-perceptions. What this and the other differences between the Australian and UK samples show is that there are not invariant pathways to recovery. Crucially, and what this paper is designed to illustrate, is that recovery capital rests not only on personal and social recovery capital, but on community resources (Best and Laudet, 2010).

There appear to be factors in Australia that promote recovery - higher rates of steady employment, lower rates of unemployment, and less ongoing involvement in the criminal justice system - that may reflect wider socio-economic differences between the countries; whereas the higher rates of volunteering in the UK may reflect a more collectivist approach to community and society in the UK,

but this is largely speculative. What this paper is designed to illustrate is that community factors create both negative recovery capital and barriers to significant change.

To explain this, we draw on the desistance literature in criminology where theorists have argued that there is a three stage process in desisting (Maruna and Farrall, 2004; McNeill, 2014). In this process, the person must first give up offending (stage one); then they must form new social support systems and networks that inform a new personal and social identity (stage two); but that for completion of the journey to effective reintegration into the community, the person must be accepted back - by being allowed access to community resources such as good jobs, decent housing and access to community groups and activities. Our own work in this area (Best et al, 2017) would make a similar claim for addiction recovery: in other words, that there is a societal commitment to supporting and actively engaging recovery processes to enable full and effective reintegration, which would include support around ongoing health and wellbeing issues, and the challenge to stigma. It is recognised by the World Health Organisation that illicit drug use is the most stigmatised health condition (and alcohol addiction fourth; WHO, 2001), and that stigma represents a form of negative community capital, that must be addressed to enable individuals to overcome issues of exclusion, and to complete the 'tertiary' stage of their recovery journey.

The second larger conceptual issue that this paper has attempted to address - that is something less of a failure in the desistance literature - is the absence of adequate comparison studies around recovery (White, 2017). In the desistance literature (and more generally around causes of crime) there have been considerable debates about the role of individual choice (agency) and the role of social systems, laws and institutions (structure) as predictors of behaviour and behaviour change (eg Weaver, 2016). While the addiction field has focused on motivation and commitment as internal drivers of change, we have given relatively little consideration to factors that may impede or support recovery that are beyond the control of individual factors (one exception to this has been a body of research exploring gender factors (eg Covington, 2002). What the current paper has attempted to do

is to initiate a recovery research programme that starts to examine cultural and structural factors that may shape recovery pathways and processes that are outside of individual control, relating as they may do to societal resources (the availability of jobs and affordable housing), legal processes that may prevent effective reintegration and social attitudes and beliefs about the viability and likely success of recovery journeys and pathways.

Braithwaite (1989) has argued that societies can be divided into those that are disintegrative where transgression becomes an indelible stain, or reintegrative where people who have breached societal norms are afforded ways of reintegrating fully into society. Our data would suggest that there are different structural barriers even for those in stable recovery in Australia and in the UK. In Australia, the barriers are more to do with ongoing mental health problems that are not adequately treated (and which may relate to stigma and exclusion) whereas in the UK barriers may be more strongly related to ongoing involvement with the criminal justice system (perhaps related to sentencing and probation requirements) and to maintaining stable employment.

The study is limited by the cross-sectional nature of both data sets and the anonymity of participants, which meant that we are not able to follow up individual participants to examine their experiences of structural barriers or pathways further (although anonymity can also be a strength if it permits more frank disclosure). We also have very limited (and self-reported) markers on each of the domains of functioning reported in this study. Nonetheless, this type of research reiterates that recovery is possible and by many routes, but that even for those who achieve stable recovery there are potentially ongoing barriers and restrictions to their wellbeing and functioning.

However, it is important to regard this paper, as all of the papers in this collection, as contributing to a growing body of knowledge and research that should inspire further investigation into what recovery looks like and how it can be supported, not only at the individual level but also at a social and societal level. Recovery is a celebration of resilience and human endeavour, but we should not make the mistake of thinking it occurs in a policy or practice vacuum and this paper should start a

process of research that examines cultural, gender, ethnic and geographic variations in recovery pathways, with consequent implications for health and social care models designed to support lasting change and community wellbeing.

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