

Long term recovery from addiction : criminal justice involvement and positive criminology?

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Published version

BEST, David and ASTON, Elizabeth (2015). Long term recovery from addiction : criminal justice involvement and positive criminology? In: RONEL, Natti and SEGEV, Dana, (eds.) Positive criminology. Routledge frontiers of criminal justice (23). Routledge, 177-193.

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Long-term recovery from addiction: criminal justice involvement and positive criminology?

Abstract

The positive criminology perspective looks at positive life influences that distance individuals from offending, and enable the growth of personal and social strengths. Within a recovery model for alcohol and drug addiction, as part of a strengths-based approach to understanding sustainable change, 'recovery capital' is the currency for measuring the personal and social resources available to achieve and sustain change, and the community factors that help or hinder these efforts (sometimes referred to as community capital). However, it has been argued that adverse experiences, particularly chronic mental health and serious criminal recidivism, are barriers to change, and constitute 'negative recovery capital'. Based on secondary analysis from the Glasgow Recovery Study, and two other studies of pathways to recovery, this chapter examines the impact of prison history on recovery outcomes. The paper concludes that a 'better than well' model of change can explain the 'rebound effect' from serious adverse life events. This is embedded within a social identity model of recovery transformation, which fits well with the positive criminology perspective of personal transformation in developing a new 'non-offending' identity.

1. The emergence of an addictions recovery movement

Positive criminology has recently been put forward as a perspective that can incorporate a range of theories and models which emphasise ‘positive experiences that may potentially prevent or discourage continued criminal behavior’ (Ronel and Elisha, 2011 p.305). Across a range of disciplines a strengths based model has become increasingly prominent (Ronel and Elisha, 2011), building on the work of positive psychology (Seligman, 2002), asset-based community development models (e.g. McKnight and Block, 2010) and the emergence of a recovery movement in mental health (e.g. Slade, 2009), alcohol and drugs (White, 2009; Best, 2012) and criminal justice (Ronel and Elisha, 2011). In both mental health and the addictions field this has represented a significant paradigm shift and so the slow emergence of a supporting literature. Humphreys and Lembke (2013) have argued that there are three areas of solid empirical support for a recovery model in addiction – around the importance of recovery housing, around the positive role of the mutual aid groups, in particular the 12-step fellowships, and around peer-based delivery of interventions.

Nonetheless, there is a very limited evidence base about what recovery looks like (UKDPC, 2007) and about the pathways and predictors of successful recovery from substance addiction (Hser, Longshore and Anglin, 2007). Laudet and White (2010) looked at the priorities of 356 individuals in drug recovery (both heroin and crack cocaine) in New York City and argued that services should not focus on abstinence alone and that ‘services ought to aim to give clients the necessary resources and strategies to achieve enhanced quality of life and improved functioning and to assume responsibility. In other words, symptom reduction is critical but it is a means to an end’ (Laudet and White, 2010, p.57). The resources and strategies described in the recovery literature fit well within a positive criminology perspective, in that the focus is not on addressing deficits but on building resources and strengths and switching the focus from professionals to community and peer based models and interventions.

In one of the few UK studies to focus on experiences of recovery, conducted with former heroin users in long-term recovery, Best and colleagues (2008) found that what enabled former heroin users to maintain their recovery was largely about moving away from substance using peer networks and developing appropriate

recovery support networks. More recently, Best et al. (2011) conducted an assessment of quality of life in 205 former alcoholics and heroin addicts in Glasgow (the Glasgow Recovery Study) and found that higher quality of life was associated with a longer duration of recovery, but also with current lifestyle factors. Those who reported spending more time with other people in recovery and those more actively involved in a range of activities (parenting, volunteering, education, training and employment) reported significantly greater quality of life. The promotion of rehabilitation through self-help groups has been cited as an example of social acceptance within the positive criminology perspective (Ronel and Elisha 2011), and is consistent with an emphasis on an increasing role for peers and social networks in the journey to rehabilitation.

Hibbert and Best (2011) have linked the recovery process to quality of life in a study of 53 recovering alcoholics in Birmingham, England, and have reported that quality of life growth continues as an ongoing process in recovering drinkers. Their results are also significant in that they suggest particularly strong growth in recovery around social and environmental aspects of quality of life measurement in those in long-term recovery, and that this growth may exceed general population levels of quality of life – generating the idea that recovery may not be about remission to a ‘normal’ state but rather a transcendence to a state that can be characterised as ‘better than well’.

However, much of the ongoing debate has revolved around what we mean by recovery with each of two consensus group definitions (UKDPC, 2007; Betty Ford Institute Consensus Panel, 2007) suggesting three elements to recovery – Wellbeing, Sobriety, and Citizenship. There has also been increasing interest in the epidemiology of recovery with White (2012), based on a population survey in South-eastern Pennsylvania, estimating that 9.45% of the adult population are in recovery from a substance abuse history (other than tobacco). In a separate review of 415 scientific reports on recovery rates published between 1868 and 2011, White (2012) concluded that of adults surveyed in the general population who once met lifetime criteria for substance use disorders, an average of 49.9% (53.9% in studies conducted since 2000) no longer met those criteria at the time of the survey. Therefore, it is estimated that around half of all those who have a lifetime addiction problem will eventually achieve recovery, but there is relatively little research indicating who will fall into either the successful or the unsuccessful

categories, but this is based on a narrow definition of recovery focused primarily on the disappearance of active symptoms of addiction. Ronel and Elisha (2011) have called for an increased focus for research on factors which are experienced as positive and distance an individual from crime, and this is consistent with attempts to measure the size of the 'in recovery' population and their pathways out of addiction and/or offending.

2. Recovery capital and negative recovery capital

While there is increasing evidence that people can overcome addictions, the mechanisms that enable that transition are much less clearly understood or articulated, and this parallels similar questions raised about pathways to offending desistance by Maruna (2001). One suggestion for conceptualising the transition from active addiction to recovery is in terms of 'recovery capital' (Granfield and Cloud, 2001). Recovery capital has its origins in the concept of social capital defined as 'connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them' (Putnam, 2000, p.19). There are two main types of social capital which are often described as 'bridging' and 'bonding' capital. Bonding social capital relates to the values of social and emotional support and reciprocity which is generated within similar groups and communities. Bridging social capital refers to information sharing and acquisition generated through external networks and sources.

In its initial articulation in the addictions field, Granfield and Cloud (2001) suggested that recovery capital exists on a scale with both positive and negative sides where positive elements strengthen and support a person's recovery and negative elements obstruct it. In this model, there are four types of recovery capital – social capital, cultural capital, physical capital and human capital. It is people's strengths and assets which are likely to predict long term change, rather than measures of problems and deficits (White and Cloud, 2008), although this has been subjected to almost no empirical research. White and Cloud have argued that the transition to a recovery model will involve our capacity to measure the growth of strengths and resources, and to map their changes over time in the same way that we have measured changes in symptoms and pathologies to quantify gains in acute treatment services. Groshkova, Best and White (2012) have since published the Assessment of Recovery Capital (ARC) as a metric of recovery progress as part of that commitment to developing a science of recovery.

More recently, Cloud and Granfield (2008) have suggested that imprisonment will have a negative impact on 'social and cultural capital', resulting in 'negative recovery capital'. The authors argued that 'There are situations where recovery capital can be seen as resting on the minus side of zero ... 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' (Cloud and Granfield, 2008, p.1979). Along with age, gender and mental and physical health problems, the authors suggest that significant levels of contact with the criminal justice system, in particular incarceration, can represent negative recovery capital, particularly for those who adopt the identity of the 'hardened criminal'. Cloud and Granfield (2008) assert that 'the experience of prison is a direct assault on two of the key forms of capital that constitute recovery capital (social and cultural) and, for many, results in the creation of negative recovery capital' (Cloud and Granfield, 2008, p.1983).

The argument here is that imprisonment erodes not only social relationships and support networks, but also provides a sub-culture of norms and values that discourage recovery. These factors combine to impede recovery and indeed merely serve to prolong substance misuse, or to increase the levels of social exclusion and in turn increase hopelessness and learned helplessness. However, this argument could not be explored further as none of the respondents in their research on natural recovery had any extensive contact with the criminal justice system. In much of the criminology literature (e.g. Laub and Sampson, 2003) adverse life events are viewed as being connected to continuation of offending through their impact on social bonds e.g. to family and work. It has been widely acknowledged (e.g. Sykes, 1958; Foucault, 1977) that there are various pains associated with imprisonment and Crewe (2011) divides these into those which relate to: features inherent to incarceration; deliberate abuses and derelictions of duty; and systematic policies and institutional practices. Average levels of distress are high in prison, although participation in future oriented programmes can help alleviate this (Liebling and Crewe, 2012). Various aspects within prison, for example: levels of trust between prisoners and staff; treatment-oriented settings; spaces where prisoners are able to express themselves, can have an impact on how prison life is experienced (Liebling and Crewe, 2012). Nevertheless, imprisonment involves deskilling and stigmatizing people, and it has a negative effect on employment and

family relationships (Sampson and Laub 1993). Whilst imprisonment can provide an opportunity to engage people in some form of treatment (e.g. Kinlock et al., 2008), Strang et al. (2006) found that of those in their sample who had used heroin prior to imprisonment 70% continued to do so in prison. In terms of its impact on recidivism the effect of imprisonment may be hypothesised to be negative and damaging (due to unpleasant experiences) or positive -due to constructive experiences (Liebling and Crewe, 2012). Although some programs show positive effects with certain individuals (Liebling and Crewe, 2012), prison has an overall criminogenic effect (Nagin, Cullen and Johnson, 2009).

3. Evidence from drug treatment and criminal justice samples

A considerable body of research with drug treatment and criminal justice samples has shown that drug use and offending are associated in these populations. Bennett, Holloway and Farrington (2008) conducted a meta-analysis that showed that the odds of offending were three to four times greater for drug users than non-drug users. In the UK, 78 out of a sample of 100 entrants into treatment reported heroin use and 56 of the heroin users reported involvement in acquisitive crime in the month prior to treatment, but crack users reported the highest levels of drug expenditure and the most crime (Best et al., 2001). Best et al. (2003) found that 60% of opiate misusers in treatment reported an average of more than 70 crimes each in the three months prior to the research interview. The UK based National Treatment Outcome Research Study (NTORS) study reported that reductions in regular heroin use were strongly associated with reductions in crime (Gossop et al., 2000).

The high rate of offending among drug users in treatment is reflected in the literature from offender populations. Oerton et al. (2003) found that 55% of assessed arrestees in a UK sample reported recent use of heroin. US-based research (Peugh and Belenko, 1999) found that 2 out of 3 of prisoners in their sample were under the influence of alcohol or drugs at the time of their crime, had committed a crime to get money for drugs, had histories of regular illegal drug use or had received treatment for alcoholism. A survey conducted in Scotland's Young Offender Institution (McKinley, Forsyth and Khan, 2009) reported that 73% of inmates were serving a sentence for a violent offence and 56.8% blamed their current offence on drinking. A larger percentage (36.3%) blamed alcohol alone as compared to illegal drugs alone (9.7%, mainly diazepam) and 20.4% blamed alcohol

in association with other drugs. Lo and Stephens (2002) reported that 58.9% of incoming prisoners in their US-based sample who were addicted to at least one substance perceived that drugs has been a factor in their criminal behaviour. However, it should be acknowledged that drug users are over represented in arrestee samples, compared to other offenders (Stevens, 2008). Nevertheless, intensive community working between criminal justice drug services and the police can help dependent drug using offenders to reduce their offending (e.g. Best et al. 2010).

Cloud and Granfield have argued that a history of incarceration represents negative recovery capital and as a result that a history of incarceration represents a substantial barrier to recovery, through the resulting loss of personal and social capital compounded by discrimination and labelling processes. What is outlined in this chapter is evidence from three sources – the Glasgow Recovery Study (a study led by DB), a second study of recovery among offenders in the North-East of England (a PhD study that DB partnered in the analysis and writing of), and third the evidence from the recent US Life in Recovery Survey (Laudet, 2013), to examine this notion of negative recovery capital critically before outlining a social identity model of recovery that addresses transformative issues around the recovery process. One of the authors of the chapter has therefore been involved in two of the three studies selected for this review and is currently involved in developing an Australian version of the Life in Recovery project and so has worked closely with the author and commissioners of the third study. Each of the three provides important insights into this issue around criminal justice involvement and recovery / rehabilitation pathways. The rationale for the chapter is to use current or recent research studies in addiction recovery to provide some empirical scrutiny of the concept of negative recovery capital, as the original argument that incarceration constitutes negative recovery capital is not based on any empirical evidence.

4. The Glasgow Recovery Study re-analysis

This section presents a re-analysis of data from a study that involved retrospective interviews with 205 individuals in recovery from heroin or alcohol addiction, recruited through a multi-method approach (Best et al, 2011). The aim of the re-analysis was to examine the prevalence of criminal justice involvement in a group

self-identifying as having criminal justice histories and linking this to levels of recovery and functioning.

For the purpose of the project, a person ‘in recovery’ was defined as, *‘someone who believes that at some point in their lives they were dependent on alcohol or heroin, but they have not used that primary substance for the last 12 months, and they believe themselves to be either recovered or in recovery’*. Sampling was opportunistic, and participants were compensated for giving up their time with a £10 shopping voucher. As wide a range of individuals (who fulfilled the inclusion criteria) as possible were invited to participate, by using a variety of recruitment channels and methods: via treatment services, inviting ‘graduates’ of programmes to participate; via local user groups; via a snowballing method; and external advertisement via radio and local newspaper. A total of 205 participants who were all living independently in the community were recruited – 107 former alcoholics and 98 former heroin addicts.

Alcohol cohort: Seventy individuals (65.4%) had ever been arrested at an average age of 23.2 years and 59 reported an initial conviction at an average age of 24.0 years. Thirty-one (29%) had ever been in prison – averaging 2.8 years (range = 6 months – 12 years), with the mean initial imprisonment at 24.7 years and most recent imprisonment at 30.5 years.

Heroin cohort: Eighty (81.6%) heroin users in recovery reported that they had ever been arrested, with an average age of first arrest of 17.6 years (± 5.0) and 73 reported an average age of first conviction of 19.3 years (± 4.6). Fifty-one (52.0%) reported that they had ever been in prison on an average of 3.9 occasions (range = 1-17), and, for the 33 people this information was available for, they had spent an average of 4.4 years in prison.

Across the sample, 150 (73.2%) had ever been arrested, at an average first age of 20.8 years (range = 7-57 years). A slightly smaller number (64.4%) had ever been convicted, at an average first age of 21.4 years. In total, 82 individuals had ever been to prison at a first average age of 22.6 years, with an average age at most recent imprisonment of 29.6 years. The average amount of time spent in prison 3.6 years. The majority of the recovery participants had criminal justice histories, and

just under half had ever been to prison. There was almost no involvement with the criminal justice system at the time of the addiction recovery interview.

Those with a history of imprisonment were more likely to be male, single, former heroin users and to have been homeless at some point. They also reported less structural social capital in that they had spent less time married, fewer years of employment and more time single (see Table 1 below):

Table 1: Differences between those who had and had not ever been in prison

	No prison (n=122)	Prison history (n=82)	X2 / t
Primary drug user	38.5%	61.4%	10.40, p<0.01
% female	79.4%	20.6%	16.72, p<0.001
Always single	44.3%	62.7%	6.78, p=0.079
Ever homeless	22.9%	77.1%	17.86, p<0.001
Years of full-time employment	15.4 years	10.9 years	2.57, p<0.05
Total years of marriage	12.2 years	8.8 years	2.24, p<0.05
Total time spent homeless	1.0 years	2.6 years	4.44, p<0.001

In spite of these differences in historical experiences of adversity, they were not significantly different in terms of current functioning – either in terms of self-reported quality of life or in terms of community engagement - as shown in Table 2 below:

Table 2: Differences between those who had and had not ever been in prison in current functioning

	No prison (n=122)	Prison history (n=82)	X2 / t
Meaningful activities in last month	11.1 days	11.9 days	0.37, p=0.71
Days working in last month	4.2	5.5	0.90, p=0.37

WHOQoL BREF total score	78.9	84.2	2.55, $p < 0.05$
Self-esteem	36.7	38.9	1.65, $p = 0.10$
Self-efficacy	34.7	36.5	1.96, $p = 0.05$
Time since last use	5.2 years	7.3 years	1.88, $p = 0.06$

In spite of the earlier adversity, the individuals with a prison history scored slightly higher on measures of self-efficacy on the Client Evaluation of Self and Treatment (Joe et al., 2002) and on the WHOQOL-BREF, the WHO measure for assessing quality of life (Skevington et al., 2004). In other words, on standard measures of functioning and wellbeing, those ex-prisoners who make it to addiction recovery have slightly higher mean scores suggesting that there is no ‘diminished’ form of recovery in those with prison histories. Indeed the quality of life score is significantly higher in the prison history group and self-efficacy is also significantly higher in this group.

Conclusions from the Glasgow Recovery Study

For the recovering alcohol/drug users in this sample this history of more problematic behaviour – prison, homelessness, less work and fewer relationships – does not appear to predict worse functioning in the group who had ever been in prison. Indeed, those who reported a prior history of imprisonment reported better overall quality of life, and higher average scores for social and psychological life quality than those who have never been in prison. Given the link between imprisonment and negative recovery capital suggested by Cloud and Granfield (2008) a surprisingly high proportion of our Glasgow sample of recovering alcohol and heroin users had been to prison, at just over 40%. As this is a recovery sample we cannot say anything about how many people go to prison and experience negative outcomes. However, we have found that a significant proportion of those in our sample have been to prison yet they have managed to recover from addiction.

Long-term recovery has been possible despite having a history of imprisonment, i.e. incarceration has not prevented sustained recovery for this sample, and interestingly those who had been to prison reported higher quality of life scores than those who had not been to prison. This research does not enable us to

explain why this is the case, but possible reasons include: prison providing an opportunity to abstain from or reduce alcohol /drug consumption; participation in drug or other rehabilitation programmes in prison; the impact of other aspects of prison life on inmates; or the impact of support provided on release. A positive criminology perspective relating to subjective interpretation could also be applied here as a stressful event may provide an opportunity for positive change (Ronel and Elisha, 2011). There is also the possibility that a ‘better than well’ (Hibbert and Best, 2011) effect occurs where those who have experienced considerable adversity, with appropriate support, be able to use those adverse experiences to create a strong and robust recovery pathway, with a greater sense of hope and satisfaction in their recovery journey.

The impact of criminal justice involvement on pathways to recovery is beyond the scope of this chapter. What these findings suggest is that a history of incarceration does not limit the amount of recovery, irrespective of whether it reduces its likelihood.

What is more, this group actually reported slightly better quality of life and life functioning than those who have not been to prison. This may be consistent with previous reports of populations achieving a status that is ‘better than well’ (e.g. White, 2007; Hibbert and Best, 2011) and that may imply that those who experience negative recovery capital at the start of their recovery journeys but then do subsequently recover may actually have a greater ‘rebound’ effect, and report more satisfaction with various indices of life quality. This may be a consequence of hitting ‘rock bottom’ and so having little choice but to embrace a recovery programme, and to experience its impact on life circumstances and quality of life. It is of note that the areas of the WHO quality of life measure where differences arise as a function of prison experience are social and psychological quality of life, consistent with the suggestion that the ‘better than well’ phenomenon may be reflective of a primarily social effect. This would be consistent with the CHIME effect reported by Leamy and colleagues (2011) for mental health recovery – where recovery is characterised in terms of Connectedness; Hope; Identity; Meaning, and Empowerment (CHIME).

Although the central focus of this chapter is on the impact of imprisonment on long-term recovery from addiction it is worth incorporating a brief discussion of

theories relating to desistance as well as recovery, both of which could be encompassed within a positive criminology perspective. The above would also be consistent with the developmental model of desistance proposed by Sampson and Laub (1993) in their analysis of the long-term outcomes for 500 male delinquents aged ten to 17 years, and 500 non-delinquents matched case by case on age, race/ethnicity, IQ, and low-income residence. Their developmental model rejected the importance of early risk factors in favour of a trajectory model in which key life events (particularly marriage and employment stability and satisfaction) were much more important in understanding desistance from offending in the long-term. The authors argued that social bonds at all stages of the life course are important, and that turning points are of critical importance for understanding change in adulthood. Having conducted life-history interviews with their sample, Laub and Sampson (2003) acknowledged the importance of human agency in understanding of desistance. In contrast to theories which emphasise identity shifts as being necessary for desistance to occur (e.g. Maruna, 2001) they concluded that desistance is facilitated by changes in situational and structural life circumstances (turning points), in combination with individual actions (personal agency). Discussing the use of life course perspectives in relation to drug abuse and turning points, Groshkova and Best (2011) state that

Within a life-course model, there are ‘windows of opportunity for change’ that represent the turning points in a developmental trajectory. The challenge for science is to identify when and why these occur and what makes the changes sustainable. The latter question provokes key questions about the operationalization of the concept of ‘recovery capital’ and what is needed to enable growth in the key areas of personal, social, and community recovery capital (Groshkova and Best, 2011, p.37).

Within this kind of developmental model, a historical event like imprisonment is likely to provide a potential turning point – but not an irreversible one. What the preliminary data from the Glasgow Recovery Study would suggest is that criminal justice involvement, particularly imprisonment, is likely to have adverse consequences but that, to the extent that this generates ‘negative recovery capital’, it is not irreversible, and will depend on both how long ago it occurred and what ongoing impact it has on identity, social connectedness and wellbeing. Furthermore a positive perspective ‘sees crises and stressful events as an opportunity for positive change towards development and growth, rather than a

negative, destructive direction' (Ronel and Elisha, 2011 p.309). The key implication from this study is that those with multiple life complexities (addiction, criminal justice involvement) can achieve lasting recovery / rehabilitation and that the lessons learned from such examples are critical to the establishment of a science of positive criminology.

5. The Second Chance study

Second Chance was set up in 2005 through the Drug Intervention Programme of the UK Home Office to help substance using offenders recover by engaging them voluntarily in regular coached sports sessions, and participation in the football team that grew out of the initiative. The findings here relate to 19 adults who were taking part in Second Chance as part of their recovery from a substance using and offending lifestyle, and who achieved significant benefits from their participation, and have previously been reported by Landale and Best (2012). The current section summarises these findings and re-interprets them in the context of a positive criminology model.

In-depth, semi-structured interviews were conducted with respondents at three points, with six month intervals. Criteria for inclusion in the research study were that respondents, when recruited for the interviews, were on the Second Chance programme, and registered in some form of treatment for their alcohol or drug use problems. The 19 respondents examined in this chapter were male, and their average age was 29 years old (range 19– 46 years). Respondents had been arrested at least five times in their lives, with 17 of the 19 individuals having served at least one prison sentence. Their 'primary addicting substance' was heroin (n=12), alcohol (n=4), and stimulants and/or cannabis (n=3), and they were included in this analysis on the basis of their successful engagement in a programme. The study was a cohort follow-up study with the data derived from the 19 cases where the individuals had shown clear and positive recovery gains.

For this group of successful engagers in the program, engaging in the sports programme had a significant and beneficial impact on their substance use and offending underpinned by a number of common mechanisms:

1. Developing a positive sense of identity including a sense of self-efficacy that was generally linked to their experiences of the football and fitness
2. Perceiving improvements in physical health and wellbeing

3. Developing positive social networks including recovery networks, based on the development of a positive social identity around the Second Chance program
4. Identifying role models who provide social learning in successful recovery techniques, so that the participants had a chance to observe successful recovery and to learn from it
5. A sense of hope and a positive vision for the future that was in part a result of the new networks and connections that they made through the program

Prior to Second Chance, only a small number of respondents had any access to meaningful activities on a regular basis. Therefore the opportunity to start Second Chance was welcomed as it helped to fill the void that stopping alcohol and drug use had created in their lives, both in terms of daily routines and in terms of a social identity of belonging. In the early stages of recovery, respondents had few people in their lives that they considered to be “real friends”, so developing social networks at Second Chance was an important benefit of the programme and these friendships continued outside the programme. This sense of belonging and responsibility was central to the emergence of a collective social and recovery capital within the team, and that allowed them to forge a new social identity embedded in and around the team. Additionally, there was clearly a dynamic growth in personal and social recovery capital with support and a sense of belonging creating the ground for growing self-esteem and resilience skills in the group. This is a group of substance users diverted from the criminal justice system who have successfully engaged in a community-based, strengths-building program that allowed them to generate a positive cycle of personal and social recovery capital growth, and to develop a positive social identity that emerged over the course of the study.

Maruna and Farrall (2004) suggested that ‘secondary desistance’ involves developing a new identity and moving away from the former addict or offender identity. The development of positive self-identity is provided as an example of a positive criminology approach (Ronel and Elisha, 2011). In Second Chance, participants assumed the identities of sportsmen, team-mate, students, fathers, and volunteers. These include social identities (Jetten, Haslam and Haslam, 2012) that afford not only social support and access to community resources and information (Putnam, 2000) but also a valued set of social roles and rules

consistent with their emerging identity, and that creates a disjunction from the 'addict' and 'criminal' identities of the past. As their social capital increased, their identities were transforming and this process was theorised as a turning point, and so the limitations imposed by their criminal justice histories were reduced in personal salience and impact on daily routines. A number of the participants ended up in new houses, on college courses and in jobs as part of the positive 'spin' resulting from a recovery-oriented turning point (Ronel and Elisha, 2011), that enabled any 'negative recovery capital' from previous incarceration to be minimised in impact.

The key conclusion from the Second Chance study is that recovery pathways are consistent for addiction with desistance from offending in this population through common mechanisms of improved recovery capital and positive social identity changes. The recovery and rehabilitation pathway for this group is about the emergence of personal strengths but would suggest that these are mediated by interventions that foster hope and social inclusion and that open doors to resources in the local community. This has fundamental implications for a positive criminology that will require not only strengths-based interventions but also community engagement and pathways that challenge discrimination and social exclusion.

6. Life in Recovery

The third retrospective account of recovery experiences that is relevant in this context is the recently published account of the Life in Recovery Survey by Faces and Voices of Recovery (Laudet, 2013). This is an opportunistic survey of 3,228 people in recovery from alcohol or illicit substance misuse conducted in November and December 2012 in the USA. Participants were asked to rate a range of life functioning domains both while 'in active addiction' and 'since you entered recovery'.

Just over one third of the population had spent time in prison while in active addiction, but rates of imprisonment diminished rapidly once they had achieved recovery – in the three years after the start of their recovery journey, 10% were imprisoned. For those who were more than ten years in recovery, less than 5% had been imprisoned since the 10-year recovery anniversary. In other words, addiction recovery does not guarantee immunity from prison, but significantly diminishes the

likelihood of imprisonment. Risk of prison does reduce with increased age and so this effect may be an artefact of maturational effects.

Overall more than half of the recovery sample reported criminal justice involvement during their period of active addiction (lower than reported in the two UK studies above) but this was the case for less than one in ten in recovery. So overall there are two implications for the notion of recovery capital – first a criminal justice history is commonplace not just among active addicts but also among those in recovery, and second, that previous offending may have been a barrier but one that they managed to overcome. Again the conclusion is clear – criminal justice involvement – with the consequent implications for labelling and secondary deviance – is widespread in self-identified recovery populations.

The other major implication of this, the largest addiction recovery census conducted to date, is that this is a group of people with multiple morbidities while in active addiction – 67% reported untreated mental health problems, half had been fired or suspended from work and less than half had had a primary healthcare provider. In other words, during active addiction, this is a population who had experienced complex multiple morbidities but it had not prevented them from achieving long-term recovery. But the other key factor in this study is as has been reported previously – life would appear to get better the longer that people are in recovery. 71% of those with less than three years in recovery volunteered in the community vs. 89% of those with more than 10 years; employment also generally improves as recovery becomes longer - 76% of those with less than three years in recovery reported getting good job performance evaluations, compared to 94% of those 10 years or more in recovery. And this is the key point about negative recovery capital – its impact diminishes with time as life happens to people. This is consistent with a model of evolving human agency and a developmental approach to recovery where adversity may create diversions on a recovery journey but does not preclude it. One of the core components of this model is that the social engagement and commitment that happens during recovery (to family, to sober friends, etc) in itself buttresses and reinforces recovery capital and creates this virtuous circle of a social identity of recovery.

The Life in Recovery survey utilised a cross-sectional design with opportunistic recruitment of those available to complete the online survey and who perceived

themselves as appropriate for the study. They may also have reconstructed a 'redemption narrative' (Maruna, 2001) that exaggerated problems experienced during active addiction and that under-estimated their current problems. Nonetheless, this is a large-scale survey that shows that recovery from addiction is consistent with significant reductions in offending and criminal justice involvement and that promotes a positive criminology model predicated on active citizenship and meaningful contribution to society.

7. Towards a developmental model of recovery and positive social identity

The samples presented here are all biased in that they are all based on the accounts of those who have achieved and sustained recovery – and so say nothing about the probabilistic impact of imprisonment or other criminal justice involvement on the likelihood of starting a recovery journey. However, for those identified in addiction recovery research what the findings do suggest is a strong representation of those with a prison history and at least as positive a quality of life as those who have recovered without being in prison. Indeed, the fact that current quality of life is higher in the incarcerated group would suggest some higher level of satisfaction to be derived from overcoming this form of multiple adversity. In this respect, while mental health treatment histories and incarceration both add complexities and challenges in the recovery pathway, both are so common in active addiction and recovery populations that it may be unhelpful to regard them as negative recovery capital. Perhaps it is more helpful to understand imprisonment (alongside other factors) as having an impact on recovery capital, rather than resulting in the creation of something separate (i.e. negative recovery capital).

In the Glasgow Recovery Study, the history of the prison group suggests a more difficult history and transition to recovery with greater experiences of homelessness, fewer average years of employment and fewer average years of marriage – all of which would be regarded as indicators of reduced recovery capital (Granfield and Cloud, 1999) or weakened social bonds (Laub and Sampson, 2003). Yet this group reported slightly higher quality of life in the survey perhaps indicating some kind of 'rebound' effect from multiple adversity. There are two possible mechanisms for this – the impact of a positive 'recovery spin' (Ronel and Elisha, 2011) and the notion that the 'better than well' phenomenon reported by Hibbert and Best (2011) suggests a rebound effect where those who do recover

from multiple adversities may have a more positive prognosis than those whose recovery is from less dramatic circumstances. These are not, however, inconsistent positions and it is possible that it is the speed and trajectory of the recovery spin that enables the ultimate achievement of elevated quality of life and so the 'better than well' phenomenon.

However, the other key variable in the studies is time. In all three of the studies highlighted (Best et al., 2011; Hibbert and Best, 2011; Faces and Voices of Recovery, 2013), higher levels of quality of life and wellbeing are associated with longer time in recovery in itself likely to be associated with greater distance from the adverse effects. It may be the case that the greater the time that elapses since adverse events, the greater the opportunity for intervening mediators and opportunities to create a new self and social world.

Although there is limited evidence around the impact of identity change, there is a good evidence base that recovery is associated with changes in both social networks – moving from networks supportive of substance use to networks supportive of recovery (Longabaugh et al., 2010) – and changes in personal identity (McIntosh and McKeganey, 2002). Furthermore, Nettleton, Neale and Pickering (2010) draw attention to embodied dimensions of recovery and demonstrate that, in addition to social practices, identity transformations are rooted in habitual action. This is consistent with a social identity model of identity change (Jetten, Haslam and Haslam, 2012) in which social networks (in this case of recovery) afford a new and salient social identity and confer supports and practical guidance on initiating and sustaining lasting recovery.

It should also be acknowledged that various structural constraints may hamper attempts to create new identities. In contrast to the notion of an offender making a conscious decision to 'make good' (Maruna 2001), Laub and Sampson (2003) argue that most offenders desist in response to structural turning points, referring to this as 'desistance by default'. However, social capital is central to desistance and there is significant support for the idea that 'interactions *between* life transitions, social bonds and changes in identity are often associated with processes of desistance' (McNeill and Whyte 2007, p.50-51). This is entirely consistent with a social identity model of change. In this framework, social group membership is seen to confer not only a sense of belonging and practical support, but also the

incorporation of the values, norms and attitudes of the group. Engaging in recovery group activity – in the addictions field this has most commonly occurred via the 12-step fellowships and through the Therapeutic Community movement – would create the conditions for a new recovery identity to emerge in which personal and social recovery capital can grow, and where the impact of previous identities and roles diminished.

The argument here is not that individuals with co-occurring criminal justice and alcohol and other drugs (AOD) histories do not have additional challenges to address, but that the negative impacts of each are not static units of adversity. Rather, in keeping with the positive criminology perspective, a developmental model of social recovery would suggest a dynamic model of growth based on social embeddedness, and where overcoming adversity may result in greater recovery resources and capital.

References

- Bennett, T., Holloway, K. and Farrington, D. (2008) 'The statistical association between drug misuse and crime: A meta-analysis', *Aggression and Violent Behavior*, 13 (2): 107-118.
- Best, D. (2012) *Addiction Recovery: A movement for personal change and social growth in the UK*. Pavilion: Brighton.
- Best, D., Sidwell, C., Gossop, M., Harris, J. and Strang, J. (2001) 'Crime and expenditure amongst multiple drug misusers seeking treatment: The impact of prescribed methadone and crack on criminal involvement', *British Journal of Criminology*, 41, 119-126.
- Best, D., Hernando, R., Gossop, M., Sidwell, C. and Strang, J. (2003) 'Getting by with a little help from your friends: The impact of peer networks on criminality in a cohort of treatment-seeking drug users'. *Addictive Behaviours*, 28: 597-603.
- Best, D., Ghufuran, S., Day, E., Ray, R. and Loaring, J. (2008) 'Breaking the habit: A retrospective analysis of desistance factors among formerly problematic heroin users', *Drug and Alcohol Review*, 27 (6): 619-624.
- Best, D., Walker, D., Aston, E., Pegram, C. and O'Donnell, G. (2010) 'Assessing the impact of a high-intensity partnership between the police and drug treatment service in addressing the offending of problematic drug users.' *Policing and Society: An International Journal of Research and Policy*, 20 (3): 358-369.
- Best, D., Gow, J., Taylor, A., Knox, T., Groshkova, T. and White, W. (2011) 'Mapping the recovery stories of drinkers and drug users in Glasgow: Quality of life and its associations with measures of recovery capital', *Drug and Alcohol Review*, 31(3): 334-41.
- Betty Ford Institute Consensus Panel (2007) 'What is recovery? A working definition from the Betty Ford Institute', *Journal of Substance Abuse Treatment*, 33(3): 221-228.

Cloud, W., and Granfield, R. (2008) 'Conceptualizing recovery capital: Expansion of a theoretical concept', *Substance Use and Misuse*, 43(12-13): 1971-1986.

Crewe, B. (2011) 'Depth, weight, tightness: Revisiting the pains of imprisonment', *Punishment and Society*, 13(5): 509-529.

Foucault, M. (1977) *Discipline and Punish: the Birth of the Prison*. Harmondsworth: Penguin.

Gossop, M., Marsden, J., Stewart, D., and Rolphe, A. (2000) 'Reductions in acquisitive crime and drug use after treatment of addiction problems: 1-year follow-up outcomes', *Drug and Alcohol Dependence*, 58: 165-172.

Granfield, R., and Cloud, W. (1999) *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.

Granfield, R. and Cloud, W. (2001) 'Social context and natural recovery: The role of social capital in overcoming drug-associated problems', *Substance Use and Misuse*, 36: 1543-1570.

Groshkova, T. and Best, D. (2011) 'The evolution of a UK evidence base for substance misuse recovery', *Journal of Groups in Addiction and Recovery*, 6: 20-37.

Groshkova, T., Best, D. and White, W. (2012) 'The Assessment of Recovery Capital: Properties and psychometrics of a measure of addiction recovery strengths', *Drug and Alcohol Review*, 32(2): 187-94.

Hibbert, L. and Best, D. (2011) 'Assessing recovery and functioning in former problem drinkers at different stages of their recovery journeys', *Drug and Alcohol Review* 30: 12-20.

Humphreys, K. and Lembke, A. (2013) 'Recovery-Oriented Policy and Care Systems in the United Kingdom and United States', *Drug and Alcohol Review*, 33(1): 13-8.

Hser Y., Longshore D., and Anglin M.D. (2007) 'The life course perspective on drug use - A conceptual framework for understanding drug use trajectories', *Evaluation Review*, 31(6): 515-547.

Jetten, J., Haslam, S.A. and Haslam, C. (2012) 'The case for a social identity analysis of health and wellbeing'. In J. Jetten, C. Haslam and S.A. Haslam (eds.) *The Social Cure: Identity, Health and Wellbeing*. New York: Psychology Press.

Joe G.W., Broome K.M., Rowan-Szal G.A., and Simpson D.D. (2002) 'Measuring patient attributes and engagement in treatment', *Journal of Substance Abuse Treatment*, 22(4): 183-96.

Kinlock, T. W., Gordon, M. S., Shwartz, R. P and O'Grady, K. E. (2008) 'A Study of Methadone Maintenance for Male Prisoners: 3-Month Postrelease Outcomes', *Criminal Justice and Behaviour*, 35(1): 34-47.

Landale, S. and Best, D. (2012) 'Dynamic shifts in social networks and normative values in recovery from an offending and drug using lifestyle', In: Johnston, C.D. (ed.) *Social Capital: Theory, Measurement and Outcomes*. New York: Nova Science Publishers Inc.

Laub, J. H. and Sampson, R. J. (2003) *Shared Beginnings, divergent lives: delinquent boys to age 70*. Cambridge, Massachusetts: Harvard University Press.

Laudet, A. (2013) "*Life in Recovery*": *Report on the survey findings*, Washington, DC: Faces and Voices of Recovery.

Laudet, A. and White, W. (2010) 'What are your priorities right now? Identifying service needs across recovery stages to inform service development', *Journal of Substance Abuse Treatment*, 38: 51-59.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. and Slade, M. (2011) 'Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis', *British Journal of Psychiatry*, 199: 445-452.

Liebling, A. and Crewe, B. (2012) 'Prison life, Penal power, and prison effects' in Maguire, M., Morgan, R. and Reiner, R. (eds.) *The Oxford Handbook of Criminology fifth edition*. Oxford: Oxford University Press.

Lo, C. and Stephens, R. (2002) 'Arrestees perceived needs for substance-specific treatment: Exploring urban-rural differences', *American Journal of Drug and Alcohol Abuse*, 28(4): 623-642.

Longabaugh, R., Wirtz, P., Zywiak, W. and O'Malley, S. (2010) 'Network support as a prognostic indicator of drinking outcomes: The COMBINE study', *Journal of Studies on Alcohol and Drugs*, 71, 837-846.

Maruna, S. (2001) *Making Good: How ex-convicts reform and rebuild their lives*. Washington DC: American Psychological association Books.

Maruna, S. and Farrall, S. (2004) 'Desistance from Crime: A Theoretical Reformulation' *Kolner Zeitschrift fur Soziologie und Sozialpsychologie*, 43.

McIntosh, J. and McKeganey, N. (2002) *Beating the dragon: The recovery from dependent drug use*, Harlow: Pearson Education.

McKinley, W. Forsyth, A.J.M. and Khan, F. (2009) *Alcohol and Violence among Young Male Offenders in Scotland (1979-2009)*, SPS Occasional Paper No. 1 / 2009.

McKnight, J. and Block, P. (2010) *The abundant community: Awakening the power of families and neighbourhoods*, San Francisco: Berrett-Koehler Publishers Inc.

McNeill, F. and Whyte, B. (2007) *Reducing Reoffending: social work and community justice in Scotland*. Cullompton: Willan.

Nagin, D. S., Cullen, F. T, and Jonson, C. L (2009) 'Imprisonment and Re-offending', in M. Tonry (ed.) *Crime and Justice: A Review of Research*, Vol XX. Chicago: University of Chicago Press.

- Nettleton, S. Neale, J. and Pickering, L. (2010) ‘I don’t think there’s much of a rational mind in a drug addict when they are in the thick of it’: towards an embodied analysis of recovering heroin users’, *Sociology of Health and Illness*, 33(3): 341-355.
- Oerton, J., Hunter, G., Hickman, M., Morgan, D., Turnbull, P., Kothari, G. and Marsden, J. (2003) ‘Arrest Referral in London police stations: A key point of intervention for drug users’, *Drugs: Education, Prevention and Policy*, 10: 73-85.
- Peugh, J., and Belenko, S. (1999) ‘Substance-involved women inmates: Challenges to providing effective treatment’, *Prison Journal*, 79(1), 23-44.
- Putnam, R. (2000) *Bowling alone: The collapse and revival of American community*. New York: Simon and Schuster.
- Ronel, N. and Elisha, E. (2011) ‘A different perspective: Introducing positive criminology’, *International Journal of Offender Therapy and Comparative Criminology*, 55(2): 305-325.
- Sampson, R. J. and Laub, J. H. (1993) *Crime in the Making: Pathways and turning points through life*. Cambridge: Harvard University Press.
- Seligman, M. (2002) *Authentic Happiness: Using the new positive psychology to realise your potential for lasting fulfilment*. New York: Free Press.
- Skevington S.M., Lotfy M., and O’Connell K.A. (2004) *The World Health Organization’s WHOQOL-BREF quality of life assessment: psychometric properties and results of the international field trial*. A report from the WHOQOL group, *Quality of Life Research*, 13, 299–310.
- Slade, M. (2009) *Personal recovery and mental illness: A guide for health professionals*. Cambridge: Cambridge University Press.
- Stevens, A. (2008) ‘Weighing up crime: The estimation of criminal drug-related harm’, *Contemporary Drug Problems*, 35: 265-290.

Strang, J., Gossop, M., Heuston, J., Green, J., Whiteley, C. (2006) 'Persistence of Drug Use During Imprisonment: Relationship of Drug Type, Recency of use and Severity of Dependence to Use of Heroin, Cocaine and Amphetamine in Prison,' *Addiction* 101(8): 1125-1132.

Sykes, G. (1958) *The Society of Captives: A Study of a Maximum-Security Prison*. Princeton, NJ: Princeton University Press.

UK Drug Policy Commission Consensus Group (2007) *Developing a vision of recovery: a work in progress*. London: UKDPC.

White, W. (2007) 'Addiction Recovery: Its Definition and Conceptual Boundaries', *Journal of Substance Abuse Treatment*, 33(3): 229-241.

White, W. (2009) *Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation*, Chicago: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioural Health and Mental Retardation Services.

White, W. (2012) *Recovery / remission from substance use disorders: An analysis of reported outcomes in 415 scientific reports, 1868-2011*. Philadelphia: Philadelphia Department of Behavioural Health and Intellectual Disability Services and the Great Lakes Addiction Technology Transfer Center.

White, W. and Cloud, W. (2008) 'Recovery capital: A primer for addictions professionals', *Counselor*, 9(5): 22-27.