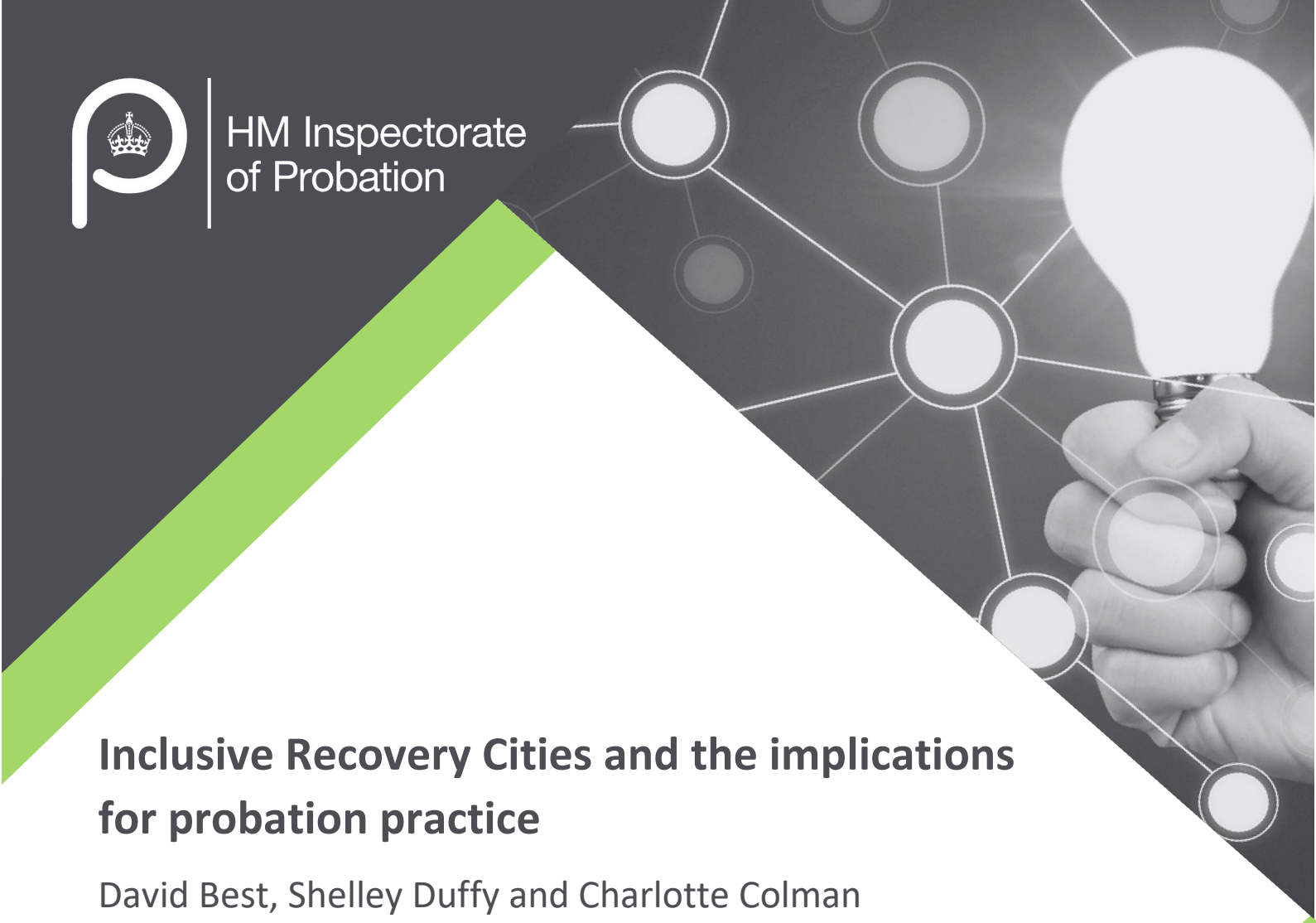
HM Inspectorate of Probation



Inclusive Recovery Cities and the implications for probation practice

David Best, Shelley Duffy and Charlotte Colman

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Contents

Foreword

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

This report was kindly produced by David Best, Shelley Duffy and Charlotte Colman, introducing the Inclusive Recovery Cities model which has been introduced in locations across the UK and the rest of Europe. Accessing community resources and social support for recovery, and maximising the role of lived experience, is at the heart of the model, bridging across and mobilising existing networks and services, and linking previously unconnected individuals and groups. This not only benefits those in recovery through creating opportunities for more sustainable integration, but also the wider community through improving its cohesion and connectedness. Importantly, it is not an addiction (or mental health) specific model and applies to other marginalised groups including people desisting from crime. The inclusive part of the model is about reducing stigma, exclusion and marginalisation by creating events and activities that are both visible and accessible, and that benefit the whole community through improvements in overall wellbeing, health and safety. It is an approach that helps to ensure that recovery and desistance are not seen simply as isolated and individual events but as collective efforts that benefit everyone.

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Head of Research

Author profile

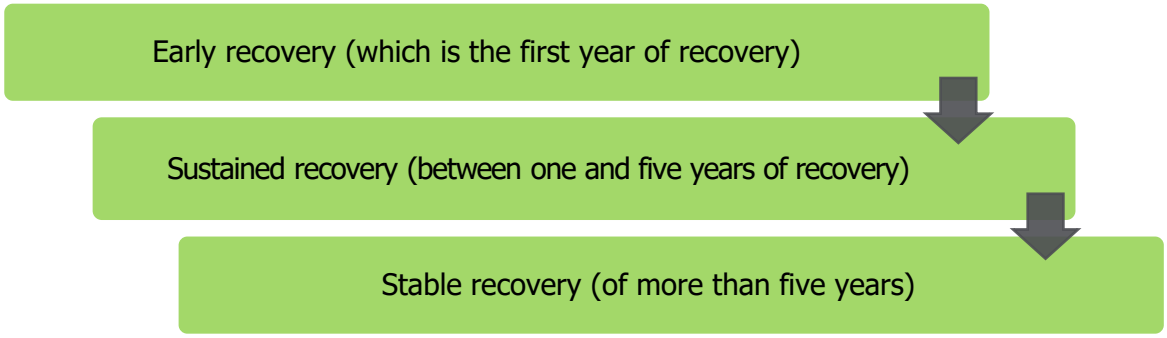
David Best is the world's first Professor of Addiction Recovery and Director of the Centre for Addiction Recovery Research (CARR) at Leeds Trinity University. He has worked in the area of addiction research, policy and practice for around 25 years with a specific focus on pathways to stable recovery. The focus of this research is on social factors that are applicable to desistance and resettlement, including the importance of social and community capital and the central role that social identity change plays in sustaining recovery and desistance.

Shelley Duffy is currently undertaking a PhD on addiction and recovery, and is working as a research officer for STAR (Standing Together Around Recovery) which is a world-wide consultancy dedicated to providing expertise to organisations that support individuals who are overcoming a wide range of addictions. She also has lived experience with addiction and addiction recovery, having overcome a decade long drug and gambling addiction.

Charlotte Colman is a Professor in Drug Policy and Criminology at the Institute for International Research on Criminal Policy (IRCP), Ghent University. Since 2007, she has been conducting and coordinating international, EU and national research projects relating to the different aspects of the drug phenomenon. Charlotte is also the President of the General Drug Policy Cell – National Drug Coordinator (Belgium).

1. Introduction

With addiction having such a catastrophic impact on the lives of individuals, their loved ones, and the community overall, it is important to consider the ways in which addiction recovery can be achieved. Recovery is generally categorised as a process of change involving three primary characteristics: control over substance use, improved health and wellbeing, and increased engagement in the community (Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2008). The Betty Ford document (2007) also categorises recovery through the following three stages:



However, recovery is not seen as a linear journey and it will vary significantly between individuals, whose access to resources (and ability to navigate barriers) differs. This is referred to as 'recovery capital' (Cloud and Granfield, 2008; Best and Laudet, 2010), defined as the breadth and depth of internal resources available to support an individual in their recovery journey (Granfield and Cloud, 1999; see also Academic Insights 2019/03). It is typically divided into three categories:

- personal recovery capital – internal qualities and physical resources
- social recovery capital – networks supportive of wellbeing and recovery
- community recovery capital – resources in the community such as access to jobs and houses.

Recovery capital can be negative (acute barriers and unmet needs) as well as positive. It is a dynamic process that is reliant upon social support and community responses to addiction and recovery. Within the criminal justice system, the further concept of 'justice capital' highlights the specific role of justice organisations and practitioners in delivering recovery capital in an equitable and responsive way – crucially, access to the required capital for desistance can be improved or damaged by the operation of the criminal justice system and the way its key agencies deliver services (see Academic Insights 2022/10).

It is important to recognise, and address, any potential barriers to addiction recovery. Two barriers are repeatedly highlighted in research studies involving people with lived experiences, namely stigma and discrimination/exclusion. We tend to think of stigma at three levels. There is social stigma where individuals are discriminated against because of their membership of a marginalised or dispreferred group. At a societal level, we see structural stigma which includes barriers to certain kinds of jobs or houses for people who have a history of addiction. And the consequence of both is 'internalised stigma' where people with their own history of addictions come to accept the negative labels attached to them, and the limitations on their goals and aspirations that society places on them (Ahmedani, 2011). Notably, one of the most devastating implications of stigmatisation and discrimination is how they will often prevent

people from seeking help. It is therefore important to acknowledge the social and emotional implications for those in addiction when faced with these barriers.

When we adopt a 'clinical' approach to recovery, our model is inevitably individualistic, dealing with each person's own aspirations, goals and needs as they come along, through recovery coaching, accessing recovery housing and, more recently, support into recovery-friendly workplaces. But many of the great successes, historically, of the recovery movement are social in their approach and collectivist in their rationale. The mutual aid movement, in particular 12-step groups such as AA and NA, have been successful through social processes of mentorship. A similar rationale underpins the Therapeutic Communities model, and as is increasingly seen in the UK and US, through Collegiate Recovery Programmes that provide recovery supportive networks in colleges and universities (such as Teesside, Birmingham, and Sunderland Universities).

In 2009, this collectivist approach was consolidated into a model proposed by the US Substance Abuse and Mental Health Services Administration when they reviewed the concept of a 'recovery-oriented system of care' (Sheedy and Whitter, 2009). It has been defined by William White (2008: 28) as:

> '*the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes'.*

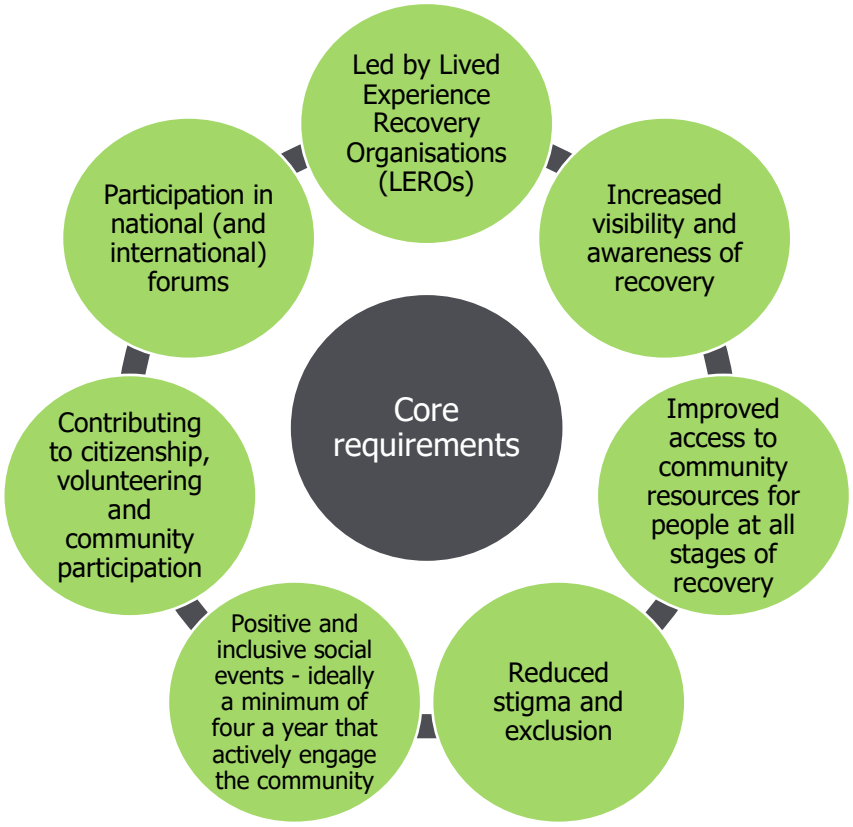
2. Recovery as a collective phenomenon – Inclusive Recovery Cities

2.1 The origins of Inclusive Recovery Cities

Best and Roth (2013) compiled a special issue of the *Journal of Groups in Addiction and Recovery* outlining the growth of recovery as a visible social movement in the UK, providing examples of innovation around recovery cafes, walking groups, annual recovery colleges/conferences and marches, demonstrating that recovery was becoming a social movement. However, this has largely remained outside of the treatment system and the funding mainstream, and has continued to grow in a piecemeal and localised way.

The idea of the Inclusive Recovery City (IRC) essentially builds on the Recovery Oriented Systems of Care (ROSC) framework but with a core vision that is based on celebration and the process of public engagement by recovery communities.[1] It brings together local policy makers, public and private organisations, employers, landlords, people in recovery, their families and their neighbours to promote recovery journeys (Best and Colman, 2019). The intention of an IRC model is to create a framework not only for internal growth within participating cities but also to create a network for the exchange of ideas and innovation and to provide support and mentorship to build this movement.

The core requirements to be an IRC are as follows:



[1] This Channel 4 news link provides an early overview of the work: https://youtu.be/b4eNZBQ5wdY?si=VkmaH9bBp92aAIWe

At present, there are a total of 29 IRCs across Europe. This includes ten in the UK, which can be seen on the map below.

At the heart of the model of IRCs is the idea of recovery as a 'social contagion' (White, 2010). This refers to the way in which people in recovery inspire and support other people in need of recovery and provide a safe space and place to develop recovery capital (Best and Laudet, 2010). This includes the access to community resources and social support for recovery that is at the heart of the IRC model. The fundamental assumptions are that:

1. recovery is primarily passed on through social learning from visible recovery champions
2. the more visible and accessible recovery success is, and the more social and structural barriers can be addressed, the more viable addiction and mental health recovery becomes
3. people in recovery have huge untapped potential that can be realised through the IRC model.

Therefore, whilst encouraging recovery, connectedness and growth at an individual level, the IRC model also promotes positive engagement throughout the community, and beyond. This not only benefits those in recovery, but also augments the wider community by improving the wellbeing and cohesion of the community overall (Collinson and Best, 2019).

2.2 Why the Inclusive Recovery City approach is so important

By building IRCs, visible recovery is promoted and celebrated throughout entire communities. The social contagion of the model results in widespread hope and a community of understanding and support, whilst also highlighting the benefits to the community of being inclusive of recovery.

The inclusive part of the model is about reducing exclusion and marginalisation by creating events and activities that are accessible and that benefit the whole community. In doing so, to use the language of Robert Putnam around social capital (Putnam, 2000; see also Academic Insights 2021/06), the aim is to link previously unconnected individuals and groups and to bridge across hierarchies within existing networks and communities. Why this is helpful and important is not only in creating a sense of community but in generating what is referred to as 'collective efficacy'.

This term was developed by the criminologist Robert Sampson in his book *The Great American City* (Sampson, 2012) to refer to the sense of social cohesion and shared expectations about community involvement and trust across neighbourhoods in Chicago. The key finding of this work was that greater collective efficacy was associated with less violence, better health outcomes and lower adolescent delinquency. In other words, inclusive and connected cities improve public health and public safety.

This is related to reducing stigma, exclusion and marginalisation. When considering stigmatisation, a key contributory factor is the common misconceptions attributed to those in recovery. For example, the idea that people in recovery are unreliable and a drain on society. Yet the results from the 2015 *Life In Recovery Survey* (Best et al., 2015) showed that four in five people (79 per cent) in long-term recovery actively participated in their communities – this is almost exactly double the rate for the general population.

People in recovery who are visible and accessible not only challenge stigma and discrimination in the general public, but they also create visible role models for those in the early stages of recovery (Moos, 2011) and for family members who may despair about the possibility of recovery. Further, their community engagement opens doors and pathways through bridging and linking capital: people in recovery can build new relationships that may offer fresh perspectives, hope and encouragement. These new connections can help reduce feelings of isolation, which is often a barrier to sustained recovery, and promote a sense of belonging and purpose. Also, pathways can be created that connect people in recovery to broader community resources, encompassing employment, education, healthcare and housing, all of which are vital sources that might have been previously unavailable or unknown to them.

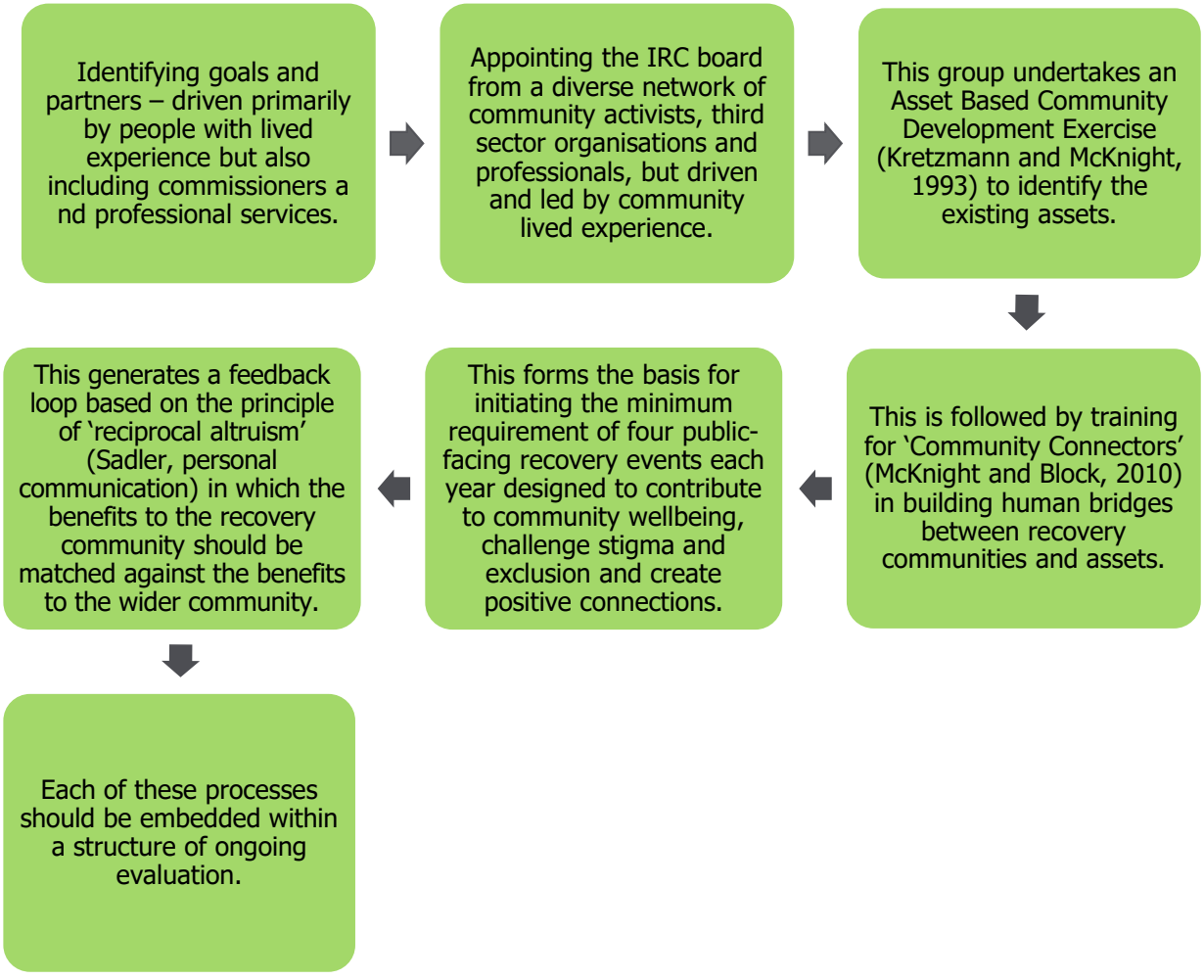
This approach ensures that recovery is not seen as a solipsistic, isolated and individual journey but as a collective effort that benefits everyone, in which each visible success and living enactment of successful recovery positively alters the landscape through creating more accessible recovery capital.

2.3 Inclusive Recovery Cities through the lens of Recovery Capital

As described above, recovery capital is a term that has gained traction over recent years, encompassing the volume of internal and external assets available to someone that can aid in the initiation and sustainment of addiction recovery. Not only does recovery capital provide a conceptual framework for measuring recovery – and something that Sharynne Hamilton and colleagues have attempted for youth justice for Aboriginal youth in detention (Hamilton et al., 2020; see also Academic Insights 2022/10 in relation to the criminal justice system more generally) – but also a metric for measuring progress and success. This is something that, to date, we have attempted to measure primarily at the individual level (e.g. Cano et al., 2017; Bunaciu et al., 2023) but there is also considerable scope to measure this at the community level.

This is in effect what an IRC is – a community that has visible and accessible resources to support recovery and which, through its efforts, generates a strong sense of community connectedness and 'collective efficacy' (Sampson, 2012) – this referring to the social cohesion and shared positive expectations about collective trust and action within a community.

Thus, the aim of an IRC is to build community resources, assets and connections to improve the wellbeing of people seeking recovery but also other marginalised and excluded groups such as people desisting from crime, those struggling to overcome mental health problems, or those marginalised on the basis of some other personal characteristic. The evolution of an IRC is unique to the location but a broad staged model would involve:



The point of this model is to build on existing networks and resources to create momentum through a social contagion led by those in recovery (including affected others and family members) to replicate the CHIME model at a community level. CHIME (Leamy et al., 2011) stands for:

- Connectedness
- Hope
- Identity
- Meaning
- Empowerment

While this is something that has been shown to be highly effective in supporting individuals with mental health and addiction problems, it has generally been applied at an individual level. The concept of CHIME, however, has a clear application at a community level and is not specific to addictions.

3. Conclusion

What has been outlined here is an attempt to build on the evidence base around addiction recovery at a personal level to create the conditions that maximise the chances of personal recovery based on three fundamental principles:

1. the concept of collective (or community) recovery capital
2. CHIME (connectedness, hope, identity, meaning, empowerment)
3. the social contagion of recovery as a peer-driven process

This is not an addiction (or mental health) specific model. Rather it is a set of principles and processes also directly relevant to the criminal justice system, not least because of the proportion of people on probation and in prison with ongoing addiction and mental health problems. It is a model based on mobilising existing networks and resources and building momentum to challenge exclusion and create opportunities for effective reintegration. It is a model that aims to enhance social cohesion and to make pathways to hope, connections and opportunities for people in recovery visible, ultimately leading to more sustainable outcomes. It focuses on the collective effort, rather than seeing the change process as an isolated and individual event. In essence, this is a top-down model for facilitating tertiary desistance – the recognition by others that a person has changed, along with the development of a sense of belonging (McNeill, 2006).

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