Recovery networks and community connections: identifying connection needs and community linkage opportunities in early recovery populations

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Recovery networks and community connections: Identifying connection needs and community linkage opportunities in early recovery populations

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Abstract

There is a consistent evidence base showing that recovery pathways are initiated and enhanced by positive social networks and the underlying changes in social identity that is associated with the transition from stigmatised and excluded groups to positive and prosocial groups. There is also a growing literature that focuses on community engagement as a vital ingredient of recovery journeys, with engagement in recreational activities, training and employment, volunteering and mutual aid and other peer activities seen as important components of a Recovery-Oriented System of Care (ROSC). The mechanism for identifying such community assets that has been widely used is Asset-Based Community Development (ABCD), and the process for engaging people in such groups is known as Assertive Linkage. The current paper introduces two innovative research methods - Social Identity Mapping (SIM) - and shows how this can be linked with Assertive Linkage and ABCD to create a model for identifying individuals in early recovery in need of community support and strong linkage approaches. The resulting 'ice cream cone' model of assertive community connections provides a practical framework for implementing one aspect of generating a ROSC, building individual recovery capital through positive networks and building community assets, underpinned by the idea of recovery capital as a metric that can be quantified and used as the basis for recovery support and planning.

Keywords: Asset-Based Community Development (ABCD); community connections; assertive linkage; recovery; Recovery-Oriented Systems of Care (ROSC)

Introduction

Overview: There has been a growth in interest in the idea that long-term recovery requires effective engagement in meaningful activities and involvement in pro-social groups that are supportive of the individual's recovery attempts. This paper is about two innovative techniques that have been developed to support clinicians and peer workers in enabling these endeavours - one based on a visualisation technique to map the size and recovery-supportiveness of the person's social network and the other that links this approach to engagement with pro-social and positive groups in the community. The overall framework for this approach is based on the idea of recovery capital, and that establishing supportive social networks and engaging in positive activities in the community generate capital that can support recovery pathways.

Recent work by Best, Irving & Albertson (in press), have drawn comparisons of change mechanisms evident in hitherto only loosely related areas of work; the desistance paradigm and recovery oriented fields of study. Social processes have been seen as key to not only the addiction recovery processes but also to desistance from offending - Giordano, Cernkovich and Rudolph (2002) have deployed a symbolic interactionist approach to desistance which emphasises the significance of social processes, social interactions and socially derived emotions, while Sampson and Laub (1992) have used the idea of informal social control to explain how important relationships have a critical role in shaping both access to opportunity and emergent values and beliefs consistent with the desistance process. This parallels a similar model within addiction recovery in which social factors have been highly prominent. Longabaugh, Wirtz, Zywiak and O'Malley (2010) found that a strong predictor of recovery from alcoholism is shifting from networks supportive of drinking to networks supportive of recovery, while Litt, Kadden, Kabela-Cormier and Petry (2007) have shown how important adding just one sober friend to a network can be in maintaining sobriety. Similarly, Best et al. (2008) reported that, while initial cessation of use was triggered by psychological change and significant life events, maintaining long-term recovery was more strongly predicted by transitions in peer groups from using to recovery-focused. As part of the Melbourne Youth Cohort Study, following

150 young people entering specialist alcohol and drug treatment, Best and Lubman (2016) found that outcomes were linked to changes in social networks. First, young people who returned to their pre-treatment social networks were significantly more likely to relapse and recidivate; second, those who moved away from their social networks did not relapse or re-offend but showed significant deteriorations in social functioning, psychological health and wellbeing. It was only the group who maintained the size of their social network but reduced the proportion of substance users within it that showed the biggest improvements not only in substance use and offending, but also in psychological health and wellbeing.

In the addictions recovery field, Biernacki (1986) argued that "addicts must fashion new identities, perspectives and social world involvements wherein the addict identity is excluded or dramatically depreciated" (p. 141). More recently, McIntosh and McKeganey (2000) argued for the 'restoration of a spoiled identity' as central to the idea of addiction recovery. Further work on changes in identity by Marsh (2011) demonstrated the mechanisms of identity change promulgated by engagement with 12-Step fellowships also supported the desistance process. This is paralleled in the desistance from offending literature. Maruna (2001) argued that to desist from crime, ex-offenders needed to develop a coherent, pro-social identity, with the self-narratives of the desisting cohort in his study often being care-orientated and other-centred. Similarly, Bottoms and Shapland (2011) emphasised both the importance of identity and social networks in predicting change and in particular the role of offending friends as a barrier to desistance.

More recently, Best and colleagues (2016) have produced a Social Identity Model of Recovery (SIMOR) which suggests that the identity change that is linked to recovery is as much social as personal in nature and is largely managed through group connections. Based on earlier work by Beckwith, Best, Dingle, Perryman and Lubman (2015), and Dingle, Mawson, Best, Beckwith and Lubman (2015) demonstrating the importance of transitioning from an 'addict' to a 'recovery'

identity in sustaining abstinence and wellbeing, the assumption is that the growth of a recovery identity is associated with the reduction of the 'addict' identity and improvements in treatment retention and a range of clinical outcomes. Underpinning the SIMOR model is the assertion that engagement in recovery groups leads to the internalisation of the rules, norms and values of these groups (Jetten, Haslam & Haslam, 2012), creating a form of informal social control that increases both the motivation to be in recovery and access to supports that help to sustain it. SIMOR suggests that increased commitment to a recovery group increases the salience and accessibility of the group's values and the likelihood that these will be recalled at times of risk. Likewise reducing the ties to non-abstinent, pro-drug using groups diminishes the commitment to the values and beliefs of those groups and their capacity to draw the individuals back into risky and problem behaviours. A similar model for therapy groups has been developed by Frings and Albery (2015) asserting the importance of commitment to and engagement in group activities.

In the section below, we overview how one technique, Social Identity Mapping, has been used to apply social identity approaches to the assessment of individual social networks. The rationale here is that it is possible to operationalise social identity and use this to increase awareness of group memberships and the person's relationship to values and risky or protective behaviours.

Innovation 1: Social identity mapping

Social Identity Mapping (SIM) was originally developed for use in organizations, to improve team and organizational identification (see Haslam, Eggins & Reynolds, 2003; Eggins, O'Brien, Reynolds, Haslam & Cocker, 2008; Reynolds, Eggins & Haslam, 2010), based on the identification of perceived group memberships, their salience and importance to members.

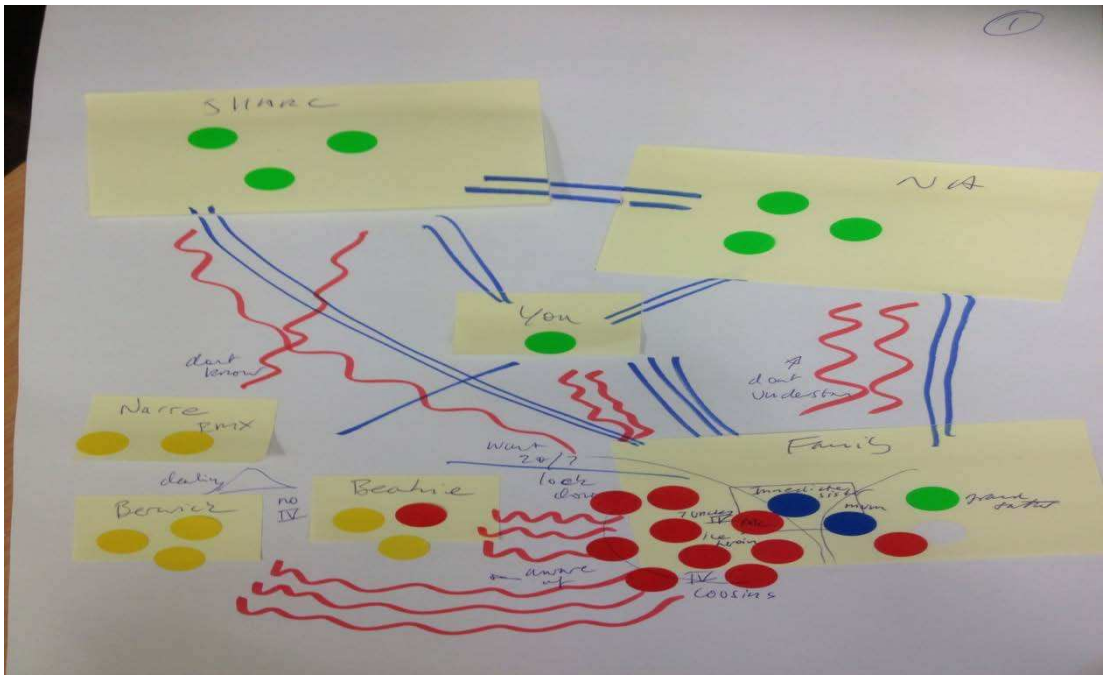
Best and colleagues (2016) applied this model to the addiction recovery field and adapted the visualisation technique to map the groups people in early recovery belong to and how protective or

risky they are in terms of their substance use. As shown in Figure 2 below, the model is designed to provide an instant visualisation of two areas:

1. How connected or isolated an individual is

2. For those who are connected, how consistent their social networks are with a recovery pathway

Figure 2: An example of a social identity map



In the example of a social identity map shown above, each group is represented by a post-it note (variations in size indicate how important the group is), while the dots are colour coded to represent the using status of members of the social network. In this example, red dots represent problematic users while yellow dots represent non-substance users. Additionally, straight lines indicate coherence between groups and zigzag lines conflict. In the initial pilot of this technique, with residents of a Therapeutic Community in Victoria, Australia, all six of the participants requested a copy of the resulting map. This was a clear indication of the power of visualisation process, as it allows a person to 'see' the social context and identify positive connections that have the potential to promote successful recovery. This model is now being used in a large cohort study with 300

patients from five Therapeutic Communities in Australia (Best et al., 2016), which is mapping changes in social identity during and after treatment in Therapeutic Communities and its impact on a range of recovery outcomes. This process allows the clinician, peer mentor and participant to have a snapshot of the protectiveness or riskiness of their social networks, the cohesion/ conflict between groups to encourage discussion and planning around social network changes that may be needed to support recovery.

Why does this matter? The hypothesis is that those clients with strong social recovery capital (i.e. who belong to many groups that consist of people who are non-users or people in recovery) and who have access to greater community recovery capital have significantly enhanced opportunity to build the resources needed for sustainable recovery. While the relationship between these practical initiatives and recovery capital is discussed at the conclusion of this paper, it is worth noting that Best and Laudet (2010) classified recovery capital as consisting of personal, social and community capital. In developing these ideas further, Best and Savic (2015) have argued that increasing the accessibility of community resources to individuals in early recovery promotes their capacity to develop new positive networks ('bridging capital'; Putnam, 2000) and so build positive social capital. These resources, or 'social capital', included football clubs, mutual aid organisations, community volunteering groups and a range of options and opportunities that support recovery and are linked to the community.

Innovation 2: Assertive linkage to community resources

One of the major challenges in addiction treatment and criminal justice reintegration programmes (including probation) has been a reduction in staff time and availability resulting in case working being more office based and less active in the community. This has meant that referral to community activities is more likely to be undertaken through passive referrals in the form of leaflets.

There are two parts to effective engagement with positive community resources - identifying appropriate community resources (Asset Based Community Development (ABCD)) and then assertively linking people into them.

ABCD

Kretzmenn and McKnight (1993) investigated the relative strengths and characteristics of successful communities, finding that professionally delivered interventions in communities tended to focus on negative conditions that indicated social, health and economic decline. The authors argue that in order to attract continuing funding for social programmes, negative indicators cause communities to lose drive. Social decline continues as more resources are sequestered to 'solve' community problems resulting in a form of iatrogenisis.

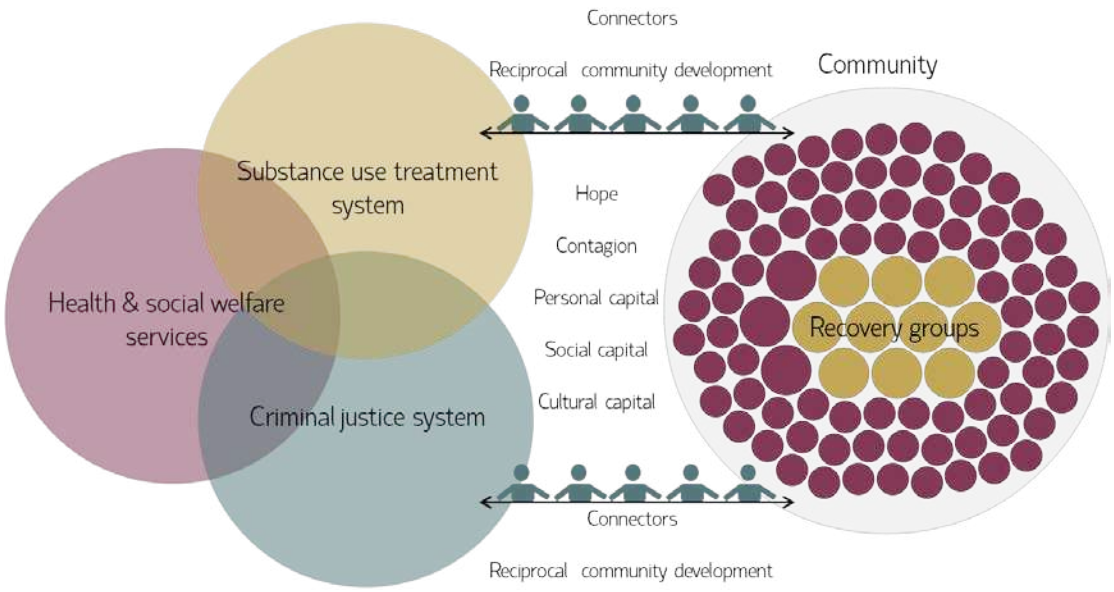
Asset Based Community Development (ABCD) offers an innovative framework for supporting community development that differs from needs based approach which has been the dominant form of governmental community interventions and service delivery (Mathie & Cunningham, 2003). The attraction to ABCD strategies and techniques emanates from the premise that communities have in existence many of the necessary assets needed to develop further, that these are often unrecognised, and persons residing in the community often have the skills, resources and talents needed to mobilise these assets for the greater good of the community.

In this model, the most important resources in a local community are its people, informal groups and formal organisations, all of which represent community (or cultural) capital. McKnight and Block (2010) have argued that building integrated and supportive communities rests on “more individual connections and more associational connections” (McKnight & Block, 2010, p. 132), which in turn relies on identifying those who have the capacity to connect others in our communities. McKnight

and Block (2010) refer to such people as community connectors, and they argue that, to make more accepting and integrated communities, "we want to make more visible people who have this connecting capacity. We also want to encourage each of us to discover the connecting possibility in our own selves" (p. 132).

One of the current authors (DB) has been involved in a number of ABCD projects including a recent study of assertively linking clients convicted of repeat substance-related offending in the Dandenong area of Melbourne to community groups (Best & Savic, 2015). This is a deprived area of Melbourne, yet the mapping exercises identified 99 accessible community resources as shown in Figure 2 below:

Figure 2: Identified community assets in Dandenong, Melbourne



In an ABCD project in York, England, Best et al. (2015) found that bringing people together to map and mobilise the assets available has the potential to become an asset in its own right as participants feel they are becoming part of something of value and, through the connections made in ABCD workshops, there is a generative sense of hope and energy. Thus, participants in the York project became connectors and identified new connections through the process of engaging in ABCD mapping.

Assertive linkage

Manning et al. (2013) conducted a randomised clinical trial of techniques for assertively linking people to attend mutual aid meetings (in this case, Alcoholics Anonymous, Narcotics Anonymous or Cocaine Anonymous) in a residential treatment setting. 151 participants were allocated to three conditions - a quasi-control where new patients on the ward were given a leaflet, a condition where the booking in doctor recommended attendance and a third condition in which a peer came to explain the purpose of the meeting, to take the participant to the meeting and to discuss it with them afterwards. When clients had a peer come to take them to their first meeting and talk about what had happened afterwards, they had better attendance at mutual aid meetings during the hospital stay, and following discharge, had lower rates of substance use in the three months follow-up. This was based on an earlier US study by Timko, DeBenedetti & Billow (2006) which showed a similar effect of greater engagement in mutual aid groups as a result of assertive engagement methods. While Timko and colleagues' study primarily tested for engagement in mutual aid groups, the rationale applies equally to any prosocial or positive group, such as sports clubs, community volunteering organisations and peer support groups.

Thus we have three activities at two levels - at the level of community recovery capital, there is Asset- Based Community Development as the method of identifying positive community resources and assertive linkage as the way of linking into them. Second, at the social capital level, we have the process of Social Identity Map. These processes are linked through an overall model of recovery capital that links the three components of recovery originally laid out in Best and Laudet (2010):

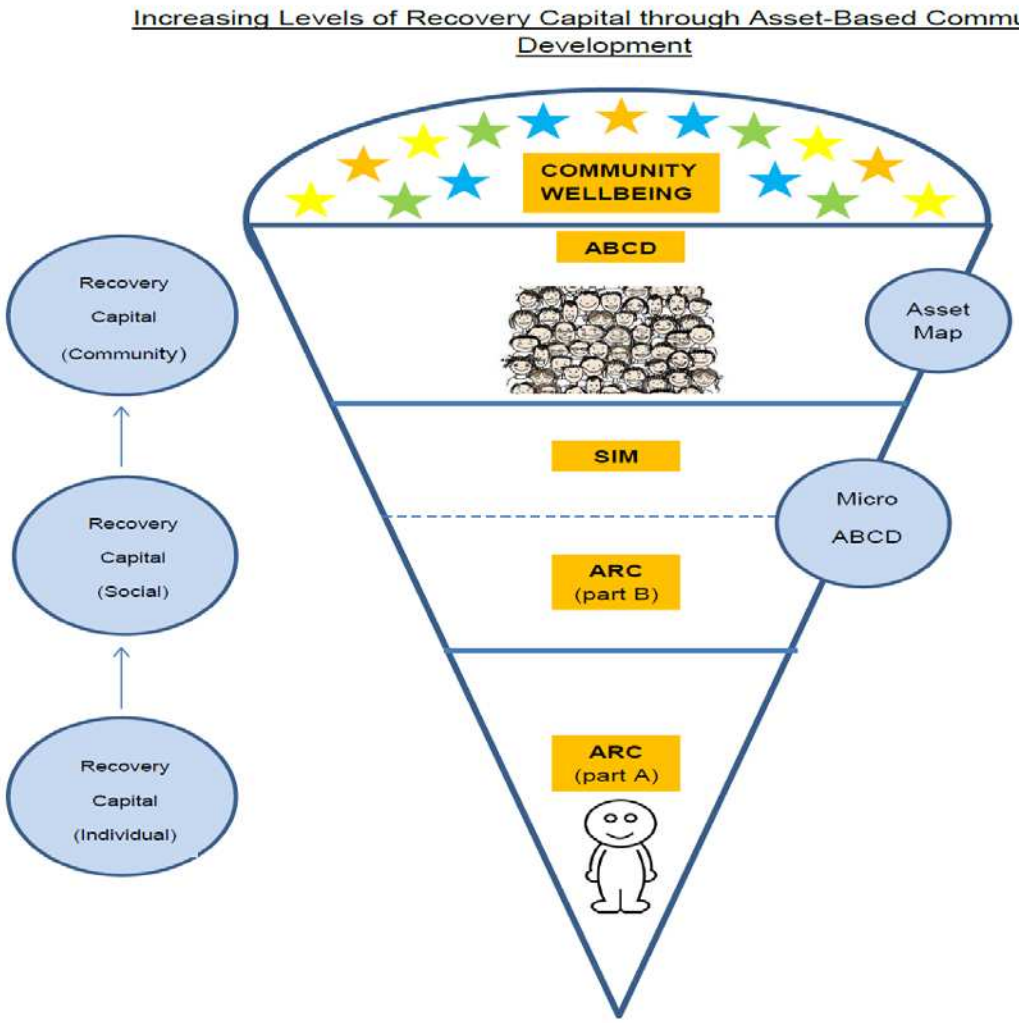
- personal recovery capital- the sum of resources and supports available to individuals at the beginning of their recovery journey.

- social recovery capital - the sum of resources and supports available to groups of persons in recovery.

- community recovery capital- the sum of resources and supports available to individuals and groups that exists in the community.

These models are interconnected in the diagram shown in Figure 3 below:

Figure 3: The 'ice cream cone': Characterising recovery capital through layers of community engagement



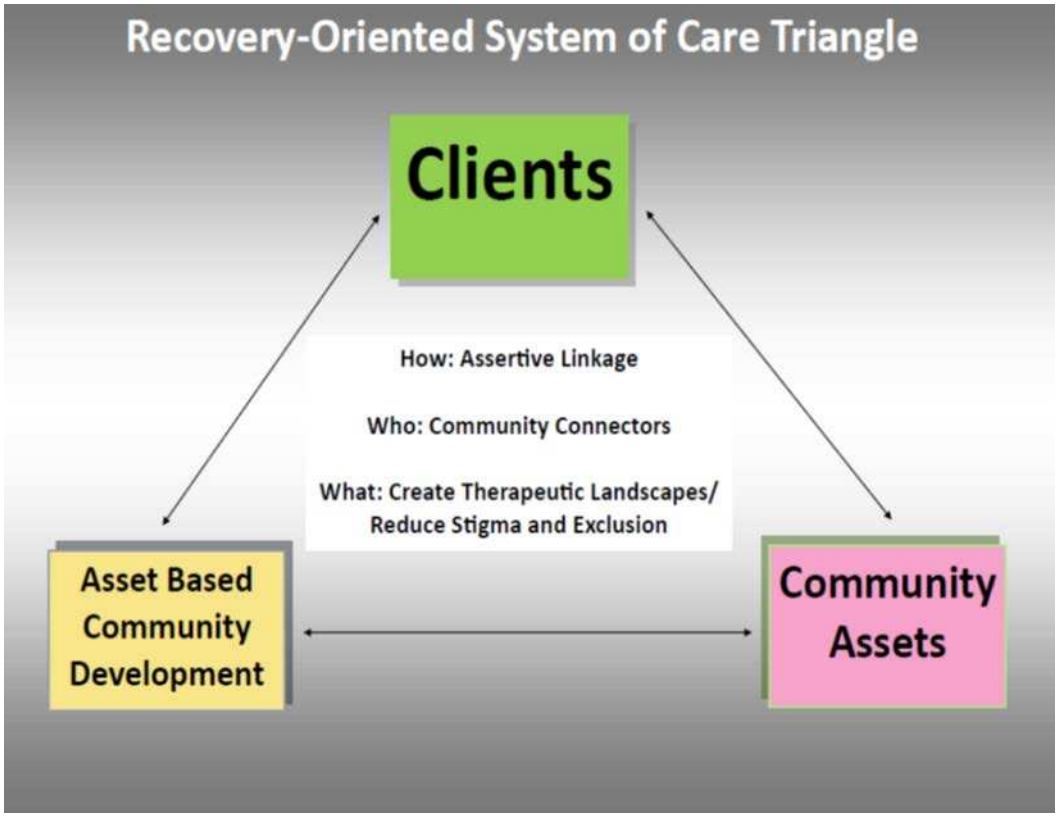
In this model, the overall aim is to build recovery capital as measured using the Assessment of Recovery Capital (Groshkova, Best & White, 2013) as represented by the figure at the base of the

cone. The aim is to increase personal capital (in the form of coping and resilience skills, self-esteem, self-efficacy and communication skills) through social support. This is done at a local level by building knowledge and awareness of social group memberships and its risk and protective components, and, where appropriate, through assertively linking to assets identified in the community.

The rationale for this model is that there is a strong and dynamic relationship between the three component parts of recovery capital. In the model, the techniques that have been developed are all intended to support the growth of recovery capital by maximising the resources available to each individual, and based on the assumption that recovery is an intrinsically social process and one that needs not only personal commitment and determination but also the support and engagement of the social network and support system.

To further demonstrate the dynamic quality of the recovery support system, and to draw a parallel to the 'ice cream cone' model illustrated here, we have also visualised a triangular model showing the dynamic interplay of individual growth with community engagement. Two other key points about this model is that central to the growth triangle are community connectors who provide bridging and linking capital to clients lacking in social support and engagement in meaningful activities, and who are a central part of the lived community. There is also an emerging change in the communities themselves, described as a therapeutic landscape of recovery (Wilton & DeVerteuil, 2006). A therapeutic landscape emerges when a critical mass of recovery connections and assets exist in a community increasing the options for recovery support that challenge stigma and exclusion in the community. Once linked into a pro-social, supportive network, the individual reciprocates the process by feeding back into the community assets, by attending, participating and engaging with activities and opportunities.

Figure 4: Individual growth and the emergence of a therapeutic landscape of recovery



In the model outlined in Figure 4, clients benefit from improved pathways to social networks and support (social capital) and enhanced opportunities to engage with a range of community resources that are made more accessible through the process (community capital). Our attempts at capturing the effectiveness of client engagement with this process and its impact on their wellbeing is described in the final of overview of innovative techniques below.

Assessing Recovery Capital (REC-CAP)

REC-CAP (Best et al, in preparation): This is a technique for assessing personal, social and community resources that are available to support the recovery journey, and that the individual draws strength from to support their recovery journey. The Assessment of Recovery Capital (ARC; Groshkova, Best & White, 2013) has been embedded within a broader tool that incorporates subjective recovery goals, motivation and recovery group engagement to create a review and planning model to support recovery journeys. The REC-CAP consists of the following elements:

- Demographics

- Treatment Outcome Profile (Marsden et al., 2008); to assess acute substance use and related problems that may have arisen
- Level of engagement and satisfaction with ongoing specialist service engagement
- Maudsley Addiction Profile (Marsden et al., 1998); to assess physical and psychological health
- Assessment of Recovery Capital (Groshkova, Best & White, 2013); to assess personal and social capital
- Recovery Group Participation Scale (Groshkova, Best & White, 2011); to assess involvement with a range of community recovery support groups
- Social Support Scale (Haslam et al., 2005); to assess support satisfaction that is not related to the level of involvement in recovery groups
- Commitment to Sobriety Scale (Kelly & Greene, 2014); to assess motivation and abstinence self-efficacy

The REC-CAP attempts to capture the key components of personal, social and community recovery capital and to translate this into a summary of recovery strengths and barriers that can be used to support the ongoing recovery pathway and journey. One of its component parts - the Assessment of Recovery Capital (Groshkova, Best & White, 2013) was developed to provide a strengths based assessment of personal and social recovery capital (broken down into ten sub-scales), but the instrument has largely been used for research purposes. The REC-CAP, in contrast, is designed for use in peer and treatment recovery settings and can be used as a systematic form of recovery care planning that monitors progress and activity over time. The REC -CAP is accessible and meaningful to the participant as well as to a range of peer mentors and professionals, and is designed both to be used in specialist treatment settings, and to enable self-monitoring after the completion of specialist help.

At present, the REC-CAP is being piloted in both the US (in partnership with the Florida Association of Recovery Residences) and the in UK (in partnership with the Rehabilitation for Addicted Prisoners

Trust). More than 500 REC-CAP surveys have been completed to date, allowing norms to be established and ensuring that sufficient data is available that full psychometrics will be published in due course.

Summary

The concept of recovery capital is now common parlance, in both the US and the UK; however, the operationalisation of recovery capital has been much slower, with limited practitioner and academic engagement with measurement issues in this area. The dominant approach has been an acute model of care, often isolated and stand-alone interventions, shaped by an addiction treatment system wedded to medialisation, and professional control. Recovery is time dependant, the model of care therefore has to shift, to one that acknowledges the chronicity or long term approach that is needed to sustain recovery and build recovery capital (White & Kelly, 2011). The focus on symptoms and negative effects of addiction needs to move to a strengths based approach with the overall goal of wellness at the heart of long term care (Laudet, 2008). Developing recovery capital in the individual means developing the right kind of supports, recovery is socially located with its concomitant supports, and is intrinsically linked to the growth and development of families and communities.

The purpose of this paper and the innovative techniques described within it, is focussed on creating an application of key concepts that is relevant to the individual in recovery, supporting empowerment at both the individual and collective level. In addition, these techniques provide practical resources and tools to the peer mentors or professionals who are supporting an individual's recovery efforts. The current approach delivers engaging and participative methods to support the principles of CHIME - Connectedness, Hope, Identity, Meaning and Empowerment (Leamy, Bird, Boutillier, Williams & Slade, 2011) - offering practical ways of engaging individuals, communities and a diverse range of stakeholders in building recovery capital at each of the three levels of personal, social and community recovery capital. Empirically and practically, the model links the three types of

recovery capital, providing a basis for measuring and operationalising some of the key aspects of a Recovery Oriented System of Care , (ROSC) namely, social/familial relationship and health dimensions that are depleted in addicted persons (White, 2009; Kelly & White, 2011)). The result is a develop evidence base around what works in the recovery areas of practice and partnership. This latter point is critical to the programme of work we are undertaking - the aim is to support a system of care that engages positive relationships embedded in wider community participation and support for recovery, and to do so in a way that is operationalisable and quantifiable in terms of the impact on the person in recovery.

This remains preliminary work in that several of these pieces are at the early stages of empirical testing and validation. However, this paper is designed to provide a model that links the key components together within a coherent theoretical framework around recovery capital and its application at the clinical and community levels. This is an ambitious programme of research based on a range of applied innovations that we are continuing to test in a range of settings - including a project with addicted veterans engaged in peer recovery support, the development of a recovery research partnership in Sheffield and a programme to develop community connectors in health services. However, the key aim is to create a recovery-oriented systems model where pathways to community resources are improved, champions of recovery are identified and supported and individual pathways are supported by recovery measurement techniques that are supportive and empowering.

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