Understanding the whole person

Part One of a series of literature reviews on severe and multiple disadvantage

What are the common concepts for recovery and desistance across the fields of mental health, substance misuse, and criminology?

Lankelly Chase

Acknowledgements

Contents

Introduction

This paper looks at journeys of personal change. These journeys are undertaken by many individuals across the world, and although complex and difficult, they are often successful. Change is made up of a number of components and causes; each combination of factors is unique to each person, but there are common themes. The absence of something negative is not enough - it is about a life with purpose and meaning. While public services tend to focus on crisis and immediate need, these journeys involve building a fulfilling life over the long-term. However, for many people this means moving away from very marginalised, stigmatised and difficult experiences. Chronic drug or alcohol dependency, frequent offending, and institutionalised mental health care all make building a healthy, enjoyable life a considerable challenge.

Revolving Doors is producing a series of literature reviews as part of a research network project bringing together the evidence on severe and multiple disadvantage, or multiple and complex needs.[1] Researchers from different backgrounds view people facing multiple needs through their disciplinary prisms, such as criminology, psychology, or homelessness. These all offer vital but partial perspectives. The focus of this literature review reflects the aims of the network: it reviews commonalities in research on the processes of recovery from (or in) mental illness; recovery from drug and alcohol problems; and desistance from crime.

Overlapping needs is the norm for many people

Although research takes place within disciplinary boundaries and policy is designed in silos, the reality of many people's lives is navigating multiple needs and journeys.

Hard Edges: Mapping severe and multiple disadvantage in England found that the majority of offenders and homeless people also face at least one additional problem of either substance misuse, offending or homelessness. At least 58,000 people experience all three.

Mental health problems were also prevalent within the sample. At least 41% of people facing multiple needs have poor mental health and 85% experienced trauma or neglect in childhood.

Research must incorporate the reality of facing multiple needs, which does not marry with strictly defined professional and academic boundaries. Addressing the multiplicity of experiences will better inform evidence-based policy for people facing multiple and complex needs.

(All statistics from *Hard Edges,* Bramley and Fitzpatrick: 2015)

Because many people experience a breadth of need, it is important to understand the cross-cutting themes across these three journeys as conceptualised by the fields of mental health,

---

[1] Research Network webpage: http://www.revolving-doors.org.uk/partnerships--development/research-network/

criminology and substance misuse, as well as the distinctive elements. This has key policy implications (although no easy solutions). Aspects of these journeys include developing social capital and a meaningful 'role' in life. However for people with multiple needs, things like a stable family or fulfilling employment may be very far away possibly *because* they have experienced such a combination of problems, including long-term social exclusion, very low educational attainment, childhood trauma and neglect (Bramley and Fitzpatrick, 2015). The combination of needs makes *each* journey harder: leaving a life of crime or drugs may lead to fewer friends, and isolation is bad for mental health. However, we know that people facing multiple needs can and do recover, and may well go through all three journeys.

Each person's journey towards change will be unique and cannot be predicted based on the literature. Common themes may not apply to any one person; and factors of change are determined by personal, social, economic and community contexts. Understanding common themes is important for policy, research and individuals (see White, 2007), but these journeys cannot be imposed by a service or manufactured by an intervention. Opportunities for change have to be meaningful to individuals and their life. Additionally, people recover and desist from crime without or *despite* services - however there are still important policy implications.

In addition, the literature reviewed on these journeys focuses primarily on individuals, rather than macro-level causes of change. It is still important to understand how wider issues can shape experiences for different people, such as women and people from ethnic minorities. For example, in mental health, recovery has been critiqued for failing to incorporate the effects of racism on wellbeing.

Currently the evidence base for support for people facing multiple needs is under-developed (Revolving Doors and Centre for Mental Health, 2015). Understanding the common themes across these journeys brings us closer to knowing how difficult journeys of change are achieved, and how policymakers and professionals can either support or impede these journeys.

How we completed this paper
A detailed methodology is available in Appendix A.

The key themes introduced in this paper are based on a review of the literature within three separate disciplinary fields; on the processes of desistance from offending, recovery from mental illness and recovery from substance misuse. Our review focused on papers from the last twenty years, prioritising UK based research where possible.

Research on processes of change sometimes involves tracking participants over many years, and uses a mixture of quantitative data and in-depth interviewing. Often, research relies on recruiting people actively accessing treatment services. This may exclude the 'hardest to reach' as well as those who change without formal support, and so will influence how processes of change are conceived and described.

The table below shows an overview of the papers reviewed within each domain. A full breakdown is available in the bibliography (Appendix B).

Mental Health Recovery Literature	Desistance from Crime Literature	Substance Misuse Recovery Literature
16 papers reviewed including Anthony (1993), Bradshaw et al (2007), Davidson et al (2012) Deegan (1988), Glover (2012), Kalathil (2011), Repper and Perkins (2003).	**18 papers reviewed** including Farrall et al (2014), Laub and Sampson (2001), Leverentz (2014), Maruna (2001), McNeill (2004, 2012), Rumgay (2004).	**19 papers reviewed** including Best and Lubman (2012), Groshkova and Best (2011), Laudet (2007), McIntosh and McKeganey (2001), Tracy et al (2010), White (2007).

Findings

A. Common themes

An ongoing journey

"It [recovery] is a continuous process for me. … I think like anything in life we are constantly re-appraising and we are constantly doing certain things in a certain way to be in a certain place. So to me that is recovery; it is continuous." (Participant in Kalathil, 2011: p.64)

The literature is clear across all three domains that recovery from/in mental illness, recovery from substance misuse and desistance from crime are processes that take considerable time and effort. The journeys involve deciding to change (whether gradually or suddenly), and then consistently maintaining that decision in the face of stigma, anxiety and fear, barriers to opportunities and social exclusion. Maintaining a process of change is different from and harder than deciding to change (Maruna, 2001; Best et al, 2008). Lapses and setbacks are part of most journeys, which are non-linear, even if the overall trajectory is upwards (Anthony, 1993). In mental health literature, 'recovery' involves building a meaningful life even if in the face of ongoing mental illness.

Maintaining the process of desistance or recovery is dependent on things like personal skills and capabilities, support networks, self-confidence and location. For example, recovery from drug misuse may require building up a new community of supportive friends, and moving away from contacts who encourage using (Tracy et al, 2010). Unsurprisingly then, the process involves setbacks, lapses, and trying again. Deegan (1988: p.14) describes her own experience of recovering from mental illness and the parallels with a friend's physical rehabilitation. Both started with small steps:

"I rode in the car, I shopped on Wednesdays, and I talked to a friend for a few minutes. He applied for benefits, he got a van and learned to drive…One day at a time, with multiple setbacks, we rebuilt our lives."

While the journeys are difficult, many people can and do recover and a majority desist from crime, giving considerable cause for optimism (Laub and Sampson, 2001; Groshkova and Best, 2011). Best et al (2008) interviewed ex-heroin users who had tried unsuccessfully to stop many times, before becoming abstinent for an average of ten years. We know that past behaviour does not predict future behaviour here: relapse is a natural part of most journeys, which involve shifts in motivation, action, and circumstances. The journey becomes easier with the cumulative increase in social and personal capital, which means access to more resources and healthier ways to cope with adversity and pain, and so relapses and setbacks become less frequent (Harris et al, 2011; Farrall and Calverley, 2006).

The 'journey' metaphor is commonly used in the literature and by people with direct experiences, but it is not always clear what the person is travelling away from and towards. What propels a decision to change can be a gradual process or a sudden event, and does not have to be hitting 'rock bottom', even for people in substance misuse recovery. What seems clear is that people do move "into something" (McNeill, 2012: p.13). Journeys tend to involve rebuilding a new, positive alternative: "not only … about giving up one way of life, but also about adopting another" (Farrall and Maruna, 2004: p.363; see also White, 2007).

Subjectivity

The literature across all three domains depicts these processes as highly subjective. It is about the 'lived realities' of people's lives, not a prescribed service intervention or a combination of factors that automatically propel someone forward (McNeill, 2004; Anthony, 1993; White, 2007; Ryan et al, 2012). Recovery and desistance happen largely outside formal treatment settings and support services. Professional roles are to support and facilitate these journeys, although Glover (2012: p.15) argues that the main responsibility of professionals is simply to not "get in the way" of recovery. While research does show key events and resources that are strongly associated with successful change, such as marriage or family support (Best and Lubman, 2012; Laub and Sampson, 2001), these must be realistic and meaningful events for an individual. An offender may have apparent opportunities to change but whether these make an impact depends on how they perceive these and whether they have reached the motivation stage (Rumgay, 2004). "Nothing inherent in a situation makes it a turning point" (Maruna, 2001: p.24).

The crucial role of subjectivity and agency is not always reflected in how recovery has been applied by professionals. People with experience of mental health problems have spoken about the appropriation of recovery to become a 'management tool', with client progress measured against a uniform 'recovery star' (a visual tool commonly used to record progress in certain areas e.g. "work", "managing mental health"[2]) (Kalathil, 2011). This may or may

---

[2] As an example see http://www.humber.nhs.uk/about-our-trust/recovery-star.htm

not incorporate an individual's own goals and does not always reflect the importance of individual 'meaning-making' in the process. For example, it is not simply that 'getting a job' helps successful recovery, but rather a role that the individual finds stimulating and meaningful.

The primacy of subjectivity is counterbalanced by some research. Harper and Speed (2012) argue that the recovery model obscures structural causes of distress. Some desistance research theorises that certain events simply make it harder or less convenient to commit crime: for example, marriage limits time to spend with offending peers (Laub and Sampson, 2001). Henwood et al (2012) note that institutionalisation can enforce sobriety, but White (2007) argues that enforced abstinence should not be mistaken for enduring recovery.

Identity and agency

"She did not completely change her personality. But she had to find a new way of 'being Sandra'."
Farrall, 2005: p.380

One of the most fundamental aspects of successful journeys of recovery and desistance that emerges from the literature reviewed is a strong, coherent and positive personal identity. People must be able to imagine themselves beyond the identities of addict, offender, or mental health patient. This new identity must also be reaffirmed by others (Farrall, 2005). Without this robust sense of a 'good' self, which is meaningful to the individual, it is hard to believe in the possibility of change.

In addiction recovery and desistance in particular, a feeling of shame or dislike around what one has 'become' is fairly common, but must be accompanied by a sense of a positive future for oneself (McIntosh and McKeganey, 2001). How people reconcile their past to their identity varies. Some adopt labels which incorporate their journey and denote progress: 'ex offender', 'wounded healer', 'recovering alcoholic', 'mental health survivor'. The experiences are an important *part* of oneself without constituting the *whole*. Recovery in mental health can be about living well *with* a mental illness: but people must be able to generate a sense of self which is "not institutionally or externally defined" (Ryan et al, 2012: p.3). In mental health treatment, patients are often defined by symptoms and risk levels, and so understanding oneself beyond this is important.

Elsewhere, people locate past problems outside their 'core' selves, as something that happened to them or took over the good person they really are (Maruna, 2001). Hill and Leeming (2014) spoke to AA members who felt their 'drinking self' was inauthentic, 'not the real me'. Some even referred to themselves in the third person when discussing drinking histories. They did assume the label of 'alcoholic', but this represented progress: self-awareness and acceptance. There are also examples of people entirely divorcing their current selves from previous incarnations and downplaying their past experiences, at least in self-descriptions (Henwood et al, 2012). People need to 'make sense' of their new identity and life changes, and do so in different ways.

Developing a positive identity often involves the painful task of overcoming a feeling of guilt and shame. However, the very act of developing a new identity can allow people to distance themselves from the person who did previous, shameful things (Hill and Leeming, 2014). Even in mental health, unfortunately, shame and fear can be internalised by mental health service users. Overcoming this often takes the form of openness and embracing one's 'authentic self'. It may involve questioning psychiatric labels, fighting prejudice and challenging power imbalances in services (Rethink, 2009; Davidson and Roe, 2007).

Developing a strong sense of identity is an even steeper task for those who experience other forms of exclusion or discrimination. Leverentz (2014) highlights the considerable task for women who are seen as 'doubly deviant', as 'failing' mothers and criminals. Most women she spoke to also experienced both racism and sexism, marginalised within an already deprived community. Kalathil (2011) highlights the effects of racism and sexism on women's mental health and the need to overcome or challenge these factors as a key part of the recovery journey.

Agency

In overcoming marginalisation, institutionalisation and poor life chances, people desisting and in recovery often emphasise the importance of their own agency and empowerment. Agency might look like the freedom to take risks and make decisions other than a professional would choose; it may look like deciding not to do something that would trigger drug use; it might be deciding to take a 'legitimate' job over an opportunity to commit acquisitive crime. Agency in mental health is a vital, somewhat politicised component: it is about overcoming "iatrogenic service environments" that reinforce a sense of inability and institutionalisation (Glover, 2012: p.22). People are experts on their needs, not "passive recipients" of care (Ryan et al, 2012: p.2). Recovery in mental health emphasises living in the community, choosing one's own care and pursuing opportunities outside of the mental health environment.

Narratives of change across all three domains reflect this importance of pushing back against the power of others, and having responsibility, choice and self-reliance (e.g. Neale et al, 2014). Redemption scripts of successful ex-offenders present a tale of 'triumph' over circumstances (Maruna, 2001). This is not to underplay the role of structural factors on life chances. However, it is a paradox of desistance research that those who have not stopped offending appear to be more realistic about their own prospects than successful ex-offenders (Maruna, 2001). An 'inflated' sense of agency may be a necessary strategy: and, while it is difficult, people from the most difficult backgrounds can and do succeed.[3] Substance misuse recovery literature often emphasises the need for self-management. Yet narratives often emphasise 'powerlessness', and, reflecting the prevalence of AA and NA (Narcotics Anonymous), surrender to a 'Higher Power'. Seeking spiritual support for the intimidating journey of recovery externalises the problem (Hill and Leeming, 2014) and gives

---

[3] For example, Groshkova and Best (2012) discuss studies of US-based young offenders from unstable homes and poor backgrounds in which the cohorts achieved surprisingly high levels of positive outcomes in adulthood

a sense that someone is looking out for you (Callicott, 2012). This tension reflects the dynamic nature of change where agency interplays with structure (Weaver and McNeill, 2015). An individual's sense of capability and strength is reinforced by others, be that friends, family, or God.

Meaning in life

> "*My sponsee looks up to me. It's that feeling functional and feeling useful*"
> Participant in Callicott, 2012: p.404.

Identity is strongly tied to meaningful roles in life, which validate new positive identities, making people feel part of the 'mainstream' and giving self-worth. People's roles reinforce their identities, defining themselves by their occupation, their role in the community, their relationship to others: mother, friend, carer, expert by experience, counsellor. Longitudinal data shows a strong association between higher life quality and engagement in meaningful activity (Best and Lubman, 2012). But (re)assuming these roles is not always easy. It is hard to reassert parental authority following residential care or prison (EnglandKennedy and Horton, 2011). New roles can also come with their own difficulties. Weaver and McNeill (2015) write about the challenges for one ex-offender with multiple needs working in the construction industry, in which a culture of heavy drinking after work was detrimental to his recovery and marriage.

How meaningful roles are chosen or given

Gender roles shape people's identity, as people absorb messages around expected gender roles (Schön, 2010) and often define successful progress within traditional frameworks: in Andersen (2015: p.678), female drug treatment recipients spoke about their future as a protective mother, or a social worker - caring roles. Socio-economic contexts also influence the availability of roles. Some older desistance studies have highlighted the importance of employment, but people must find meaning elsewhere in contexts of very low employment rates and the decline of manufacturing (as noted in Farrall et al, 2014). And the importance of meaningful roles has particularly challenging implications for people facing multiple needs. Their work and educational history is extremely sparse and interpersonal relationships are often destructive and traumatic (Bramley and Fitzpatrick, 2015). There is no 'before' in which to find guidance on which roles to perform and how (Rumgay, 2004). A study on the process of recovery from substance misuse for homeless people with experience of severe mental illness found full-time employment was rare for participants and some were socially isolated (Henwood et al, 2012).

People find meaning in "the bleakest of life histories" (Maruna, 2001: p.9). Desisting ex-offenders sometimes become 'wounded healers', emphasising their desire to make an important contribution to their peers and communities. There is often a spiritual dimension to this type of meaning-making, invoking fate or God. Laudet spoke to people in recovery from drug addiction who were "becoming what they were meant to be" (2007: p.252).

Mutual aid organisations like AA provide a ready-made way to use one's negative experiences for good with a system of sponsors and sponsees.

Meaning can also be found in episodes of serious mental illness, prompting consideration of what is really important and what needs to change:

"I get to a point, when the depression is not so severe, I get to a point, and only I know when that is, and I know in my bones, when I can choose either to change certain ways I live, attitudes I have, or to go back to the old ways which will probably result in another depression. It's rather like having a dream which is telling me something. I take no notice so it recurs and recurs until I do."
(Participant in Ridge and Ziebland, 2006: p.1046).

This approach to the past is not universal. Some participants in Ridge and Ziebland viewed their depression through a more biological lens, rather than relating it to external circumstances.

Social networks and inclusion

The literature across all three domains shows that developing a meaningful identity cannot be separated from social capital. Social networks provide emotional support, empathy, inspiration, encouragement, opportunities, roles, practical help, a chance to give help as well as receive, and motivation to change. Best and Lubman (2012) found that supportive social networks are a strong predictor of quality recovery from substance misuse. Deegan (1988: p.3) writes on the role of others in the early stages of recovery:

"They did not overwhelm us with their optimistic plans for our future but they remained hopeful despite the odds. Their love for us was like a constant invitation, calling us forth to be something more than all this self-pity and despair."

Of course, the quality of these networks matters, and healthy relationships are elusive for certain groups, including people facing multiple needs.

Interpersonal networks

Longitudinal data finds a strong association between healthy relationships and desistance or recovery, especially in the fields of substance misuse and criminology (Best and Lubman, 2012; Laub and Sampson, 2001). Friends, families and partners can provide vital sources of support, as the Deegan quote above exemplifies. Their role in providing hope and encouragement can develop and sustain optimism, by reminding someone of what they have the potential to be or what they were before (Schön, 2010). Peers with similar experiences provide empathy, a living reminder of the possibility of change, relevant advice and reassurance that one is 'not alone' (Rethink, 2009; Deegan, 1988). New relationships or children provide a vision of an alternative, or prompt a determination to 'do better' (Henwood et al, 2012). Small things like including people in family celebrations and marking their birthday can make people feel 'normal' (EnglandKennedy and Horton, 2012). As well as emotional support, interpersonal networks provide practical help and resources to help people along their journeys. For example, a place to stay in the early stages of recovery;

childcare while accessing treatment or support groups; tips and coping skills on maintaining sobriety; information or signposting to a job (Tracy et al, 2010).

"My little boy… him being at home, him being happy and healthy… that proves to me that I'm in recovery, I can look after him, I can bring him up, I can have him at home with me" (Participant in Rethink, 2009: p.16).

Interpersonal relationships do not just offer support; they provide meaningful roles and opportunities to give back. Traditional roles of 'parent' or 'employee' are not the be all and end all. What is meaningful and realistic to the individual matters. Social connections bring roles such as caring, bearing witness, telling one's story, activism, supporting and creating (Rethink, 2009; Jacobson and Greenley, 2001).

Family and romantic partners are not always helpful, and may be entirely absent. Loss, discouragement, infantilisation, judgement, manipulation, abuse and opportunities to relapse are all ways in which relationships can and do impede recovery (Palmer and Daniluk, 2007; Rethink, 2009; Tracy et al, 2010). People facing multiple needs have commonly experienced rejection and abuse in their early years, which leads to difficulties in forming healthy relationships. Drug use and offending is often done in groups; leaving a life of crime is harder for drug-using offenders than alcohol-using offenders (Schroeder et al, 2007). Gender also plays a role. While marriage is thought to be important to desistance, the timing and quality matters, and data largely focuses on male offenders (Laub and Sampson, 2001) whereas for women, romantic relationships may be problematic (Uggen and Kruttschnitt, 1998). Women offenders are particularly marginalised as 'deviants'. In substance misuse recovery, even mutual aid organisations such as AA can be spaces of harassment and discrimination. As a result women- and LGBT-specific AA/NA meetings have emerged to provide support from people who have similar combinations of experiences (Leverentz, 2014; Matthews et al, 2005).

Spirituality or religious belief is often helpful for seeking support from something 'bigger than me' especially when positive interpersonal relationships are rare (Laudet, 2007). Professional contacts cannot replace social bonds, but can themselves offer emotional support and 'sow the seeds of change' (McNeill, 2015; Herzog-Evans, 2015).

Social integration

External and internalised stigma facing people overcoming marginalised and difficult experiences is a big barrier to recovery and desistance. A female ex-offender in Leverentz (2014: p.61) described the 'big red X' on her back. It is not enough to have some good friends or supportive relatives, it is key to believe in one's role in the wider community and society. Success often looks like feeling 'normal'; buying into mainstream citizenship values (Farrall et al, 2014); and "positive participation and contribution to communal life" (White, cited in Best et al, 2010: p.266). We address the nuances of social *integration* or *inclusion* (key to mental health literature particularly) in the following section. Nevertheless 'belonging' is broadly important across the literature in all three domains.

Social inclusion goes beyond having supportive family and friends. It is about citizenship: living in a stable home, in a safe area, and participating in local activities. It may be useful to put commitments and activities on hold while working on early recovery, but this cannot last forever (Repper and Perkins, 2003). Links with the wider community provide a fuller, richer life. So-called 'weak ties' or 'bridging' social capital refers to the loose contacts and social connections found with the wider community. These can open more opportunities than immediate family and other close relationships, as they provide access to a broader range of networks (Granovetter, 1973).

Achieving integration is a considerable ask of service providers, policymakers and communities - as well as individuals. Service environments can even reinforce a sense of 'us and them', separating service users from the world of the 'normal' and denying their capabilities and potential (Deegan, 1988). People do not always have access to basic human rights essential to inclusion - like shelter, physical health, choice, equality of opportunity, dignity and freedom (Jacobson and Greenley, 2001). Finding a job or participating in 'mainstream' activities is hard in a context of meagre public transport, poor educational history and low income (Bradshaw et al, 2007: p.44). Committing crime violates the 'social contract' between people, and offenders are then more likely to be socially excluded (Weaver and McNeill, 2015).

Hope and focusing on the future

"A person with severe mental illness wants and needs more than just symptom relief" Anthony, 1993: p.522

The literature is clear that the processes of recovery and desistance are future-focused; a future not defined by people's wrongdoings, illness, symptoms, needs or risk level (Farrall and Calverley, 2006; Deegan, 1988). The causes of desistance are not the flipside to causes of criminal behaviour (McNeill, 2004); the remarkably high levels of desistance and recovery for those with very difficult starts in life is testament to this (Laub and Sampson, 2001). Because they are about so much more than absence of a negative, these are inherently hopeful journeys. Hope is core to motivation to change: people must be able to see an opportunity to change and their ability to seize it. But hope is not just about individuals - society and communities and professionals must convey the message that change is possible. Best et al (2010) critique the 'clinical fallacy' of learned pessimism. Professionals who see the same faces repeatedly, who do not change, are liable to assume that this applies to all people in recovery or desistance (in fact, evidence suggests that people who go through services time and time again can also recover). In mental health recovery literature, hope is, like agency, politicised. It rejects the pessimism of institutionalising people, of medical professionals who discourage aspiration, choice, and the prospect of independence (Jacobson and Greenley, 2001).

The presence of hope reinforces all other factors such as identity, meaningful roles, and social capital. And in turn it is developed by these other factors - good friends sustain

optimism and a positive role provides a reason to be hopeful. Self-belief is necessary for identity change - as exemplified by the inflated sense of agency and optimism found in successful desisting ex-offenders compared to pessimistic persistent offenders (Maruna, 2001).

But it is important to not pathologise the range of emotions people go through. A range of emotions and periods of depression, are, after all, a part of 'normal' life. Anger, regret, despair, guilt and depression may be appropriate responses at certain times and do not preclude the possibility of change (Deegan, 1988; Repper and Perkins, 2003). Being cautious, realistic and non-complacent may also be a necessary strategy for early or precarious recovery (Neale et al, 2014). Hope and 'moving on' should not be co-opted to dismiss real and important barriers to recovery such as racism, sexism and poverty (Fitzpatrick et al, 2014; Kalathil, 2011). Hope evolves in response to outside influences and is nurtured by achieving small steps, but can be dismantled through the actions of others. It becomes more concrete as a journey progresses, often accompanied by other positive emotions like pride, being trusted, and happiness (Farrall and Calverley, 2006).

B. Distinctive themes

Recovery from what?

"[Recovery is] living a safe, dignified, gratifying, self-determined life in the face of an ongoing mental illness" Davidson et al, 2012: p.86.

It is clear that all three processes involve moving towards *something more*: a positive, meaningful life. However, what people recover *from* differs across the literature. Important user-led aspects of mental health recovery are not paralleled in addiction recovery and desistance, although they potentially hold important insights.

Recovery from institutionalisation

The mental health recovery model is not primarily about recovery from mental illness symptoms. It emerged in the era of de-institutionalisation and is about recovery from long-term inpatient care, discrimination, and the effects of being a mental health patient (Jacobson and Greenley, 2001; Anthony, 1993; Davidson et al, 2012; Repper and Perkins, 2003). The term *iatrogenic* is common in the literature: illness caused by medical examination or treatment (Anthony, 1993; Glover, 2012). Descriptions focus on the disabling effects of society, not the condition:

"If you are faced by a world that regards those with mental health problems as incompetent, it is difficult to continue to believe in yourself and see anything positive in your experiences." Repper and Perkins, 2003: pp.9-10

Here, services and systems are often portrayed as the biggest barriers to recovery, in undermining choice, personhood, hope, and self-control. The way treatment is delivered and

recorded, especially in inpatient care, reduces people to a cluster of symptoms (Repper and Perkins, 2003). Coercive treatment and long-term hospitalisation is harder to recover from than symptoms (Glover, 2012). And experiences are gendered and racialized. Recovery may be from the disempowering effects of racism, or "from the distress caused by society's attitudes towards a certain kind of woman" (Kalathil, 2011: p.35).

Recovery in mental health is, then, conceptualised as a social and political process more than a medical or behavioural one. It is influenced by the social model in disability rights (Davidson and Roe, 2007). Although Anthony (1993: p.531) states that in recovery "more of one's life is lived symptom free", he also notes that it is about overcoming disadvantage and dysfunction imposed after a loss of rights and self-esteem. Institutions and treatment can unfortunately impede one's freedom, relationships, opportunities, choice, control, and sense of purpose. This underlines the politicised nature of agency in mental health.

Relevance to desistance and addiction recovery

Mental health recovery literature reflects a specific context and focus but has relevance across all three domains. The practices and labels of the criminal justice system also impede people's progress, self-esteem and sense of control (McNeill, 2012). Overcoming the effects of institutionalisation is key to desistance from crime, to self-belief, and to finding purpose in life. Stigmatising practices in drug treatment can also impact on self-esteem and hope. For example methadone clinics which give patients little privacy, dignity, discretion or respect uphold a 'clean/dirty' divide (Harris and McElrath, 2012). Common substance misuse treatment practices can convey pessimism and discouragement, focusing solely on stabilising people (Best et al, 2010).

Who defines success?

> *"Recovery is more likely to be promoted by the person's efforts to reclaim his or her life despite symptoms or impairments rather than waiting for the symptoms or impairments to disappear."*
> Davidson et al, 2012: p.33

The goals of much of the recovery mental health literature emphasise client independence and moving on from 'patient-hood' by building a "self-determined life in the face of an ongoing mental illness". Complete absence of illness is not a central determinant of successful recovery: recovery *while still being mentally ill* is possible in a way that successful desistance while offending is not. Davidson and Roe (2007) point to a service user who defined 'recovery' as taking his medication without other people watching, because he could do this himself.

There is little room for continuing to offend in successful desistance. Desistance is the study of how and why people stop offending, and what else they move into (Farrall and Maruna, 2004; Laub and Sampson, 2001). These journeys are dependent on others and are socially situated but do involve a personal process of maturing; of motivational, identity and behavioural change (Laub and Sampson, 2001; Farrall and Calverley, 2006; Rumgay, 2004).

Substance recovery literature also portrays clear boundaries around what constitutes success. A high proportion of people in recovery do not allow for any form of drug or alcohol consumption in their definition (Witbrodt et al, 2015; Laudet, 2007) although this is contested. Lapses are acknowledged and do not preclude full recovery, but for many success means sobriety. Use of substitute opiates is also contentious, summarised in White (2007) who himself argues that meaningful recovery is possible with prescribed drugs. Sobriety debates aside (the detail of which is beyond the scope of this paper), addiction recovery definitions fairly consistently include resolving drug and alcohol-related problems. Literature on addiction recovery and desistance from crime focus on individual change and the social contexts that either support or impede this. In mental health literature, on the other hand, authors often challenge institutions and structures to change.

Integration or inclusion?

In discussing the importance of social capital we emphasised the key component of 'belonging', of feeling normal, and of being part of mainstream society (Leverentz, 2014). Those successfully desisting are more likely to affirm mainstream values around contributing to society, fairness, and "working and paying taxes" (Farrall and Maruna, 2004: p.362). Drug use is a particularly marginalising experience, so moving back to 'normality' is a key albeit difficult task (Tracy et al, 2010). In her study of institutional narratives of recovery Andersen (2015: p.6756) quotes a participant who emphasised the unwholesome, pernicious networks of a drug user: "you sometimes socialise with people that you never wanted to associate yourself with".

However, in mental health recovery there is a strong emphasis on acceptance on 'my terms': inclusion not integration. In integration, as per Davidson et al (2012) one re-engages once one is well enough and symptoms have disappeared or reduced. Inclusion on the other hand does not involve overcoming or fully recovering from mental illness or disability before one can participate (see also Anthony, 1993). It is important that people with severe mental illness get an opportunity to contribute. Society must facilitate this through provision of human and civil rights, social adaptations, and a safety net to enable independent living. Mental health recovery also emphasises discovering (or re-discovering) the 'authentic self' and resisting peer pressure:

"Well, whose life is it? You've got to live your life according to your morals, principles, likes, preferences, and the rest. And it's your story, um, you do what you like so long as you're not hurting, offending, and upsetting other people. Um, but how many people do we all know who live nice protected lives because their parents expected of them, because peer group pressure, because everybody in this village behaves like this? Well sod that."

(Ridge and Ziebland, 2006: 1048).

Mental health recovery literature again echoes the disability rights movement: people should not have to conform to society, society should stop excluding and disempowering people

with mental illnesses. For some people their recovery journey reinforces the need to resist social norms and pressures to do what is expected.

Themes are informed by research approach

The different methodologies used in these domains explain some of these differences (as well as the fact that offending violates social norms in a way that mental illness does not). Mental health recovery literature contains a high level of user-led research, widely cited in peer-reviewed journal articles and often with rigorous methodologies (e.g. Rethink, 2009). It is politicised in a way that the other domains are not. While ex-offenders can become academics, there is little evidence of user-led literature in this domain. Participants in substance misuse recovery are often recruited from treatment or mutual aid organisations. Where research studies people who change by themselves, the themes of recovery are intriguingly different (e.g. Christensen and Elmeland, 2015). Exploring the experiences of change for people facing multiple needs would be worthwhile, as they do not fit neatly into any category.

C. Policy and service implications

i. What is the role of support and treatment services?

The policy implications of this literature review extend to community infrastructure, legal and societal discrimination, and human rights. However, support services such as probation, support work, and treatment have a key role in supporting individual journeys. Their role is both to not "get in the way" (Glover, 2012) and also play an active part in validating people's progress and offering emotional support. Things like stigmatising language, denying people's full potential, and failing to genuinely consult people about their treatment options are all examples of getting in the way of recovery and desistance (Deegan, 1988; Harris and McElrath, 2012). Mental health recovery literature has focused particularly on the demoralising and disempowering effects of mental health treatment from which one 'recovers'; however criminal justice and drug treatment services can also undermine people's progress and sense of self through unhelpful rhetoric, policy and practice. It is unhelpful to respond to lapses or setbacks with counterproductive emotions, or focusing too much on what has gone wrong (Hylton, 2014) (although making sense of the past is important). A sense of both agency and hope is key to successful journeys and services can and do undermine these.

More positively, much of the literature highlights ways for services to *actively support* recovery and desistance. This could be linking people in with community-based pro-social figures or groups (Rumgay, 2004); providing emotional support; promoting hope and optimism (Best and Lubman, 2012); skills development in challenging others or distancing oneself from negative peer influences (Schroeder et al, 2007); and talking therapy or engagement techniques which help people explain their journey and develop a sense of their 'real' self (Ridge and Ziebland, 2006). It is likely that people facing multiple needs will need

intensive support in developing skills and resilience in order to avoid relapse; and this will not come quickly. Professionals can also encourage self-belief and optimism through demonstrating that they see someone's potential.

ii. Supporting, not delivering

This review highlights the dynamic nature of change. People do not respond to external factors in the same way; it is a truism by this point to say that everyone's journey is different. But services and systems have misused the concepts of recovery and desistance as a management tool: picking the common themes from literature, creating a standardised, manualised intervention which incorporates all of these themes, and then measuring people's progress against each area (McNeill, 2004). Choice and autonomy are given lip service, as 'personal support plans' remain locked in office cabinets and designed and managed by professionals (Glover, 2012). Frontline staff must keep detailed records to satisfy monitoring requirements (Clark et al, 2015), which is time-consuming. As a result service users then experience recovery or desistance as another method of professional control (Kalathil, 2011) and their specific requirements and goals are not sufficiently addressed.

Professionals support desistance and recovery, and cannot deliver it. As UK policy considers a nationwide programme for people facing multiple needs, this must be remembered. Services need to offer a variety of options, from which a service user has genuine choice, alongside meaningful opportunities that are right for them. People need to be able to make some choices that a professional might disagree with.

Understanding the complexities of identity and diversity

This individualised approach also means understanding how and why the journeys are steeper for certain groups (McNeill, 2012). Developing identity, social capital and inclusion is difficult for those who have experienced societal oppression, sexism or homophobia within support groups, or conflict or confusion around their sexuality or racial identity (Kalathil, 2011; Farrall, 2005, Matthews et al, 2005). People often need to overcome or come to terms with these experiences as part of their recovery journeys. People may well make sense of their own experiences in a different way to professionals, e.g. highlighting mental illness as routed in structural oppression rather than individual biology (Kalathil, 2011). Peer-led support can help, as well as community engagement from services, and routes into activism (Leamy et al, 2011).

People with multiple needs will also encounter particular and multiple barriers in their journeys. These journeys will interact with each other and the combination may make each individual journey harder, and more complex. Continuous and flexible support, that is not time-limited, is therefore important. Support that transcends professional boundaries with little relevance to the reality of people's lives is vital. It will be harder for people in this group to build healthy social networks, find meaningful roles, and achieve wellbeing and a strong sense of self. Like other people facing exclusion, they may wish to work to change

mainstream society even as they move towards it (Maruna, 2001; Schroeder et al, 2007; Terry, 2015).

iii. Meaningful roles for people

It is not enough to receive good quality support to meet one's needs: recovery and desistance are about finding alternatives, meaningful ways to spend time, and roles which involve reciprocal obligations (Weaver and McNeill, 2015). We noted above that this has challenging implications for people with multiple needs, because they are often excluded from obvious roles like parenting or employment. The role of 'wounded healer' or 'expert by experience' is one way to find meaning and purpose, although it will not be right for everybody and Farrall et al (2014) note the frustrations of some ex-offenders with histories of substance misuse that their employment options seem to be limited to rehabilitation work. Services can also support people to find meaningful roles elsewhere: in developing social networks, signposting to relevant training and fulfilling employment, and offering parenting support.

However, service user involvement offers benefits to many people. Meaning is found in using one's negative experiences for good (Hill and Leeming, 2014; Laudet, 2007). If people can effect real change, services should be genuinely co-produced, with people with lived experiences in design, delivery and oversight roles – evaluation, monitoring, support, and training. Davidson et al (2012) argue that boards focused on service design and improvement should comprise a majority of service users.

iv. Supporting healthy relationships

The literature is clear that it is not enough for people to develop personal capabilities and skills; healthy social networks are essential (McNeill, 2004). Other people provide informational, emotional and tangible support (Tracy et al, 2010). Services can support this through group work although not all relationships found here will be healthy. Trained peer supporters in stable recovery are likely to offer very relevant and positive support; this is also valuable where peers can empathise with relevant experiences of e.g. racism or sexism. Family-focused work is often very important, however some people need support to regain control from controlling or undermining relationships (Rethink, 2009). People will need specialist support to move on from unhealthy or abusive relationships; this is likely to be particularly relevant to drug users and women in the criminal justice system (Schroeder et al, 2007; Tracy et al 2010). People with multiple needs commonly have experience of trauma, and specialist psychological support around relationships may be necessary.

This goes beyond services of course and is about developing inclusive, active communities which provide ways to connect with others. Bradshaw et al (2007) notes that some participants needed to move on from spaces associated with mental illness, and develop friendships elsewhere. People may find support from religious leaders (Rumgay, 2004) or joining in a sport or other activity and faith or religious belief may be vital for those facing

long-term exclusion. Peer support helps many, in providing relevant advice, empathy, and a model of the possibility of change.

Facilitating participation

Services have made the mistake of focusing on the most obvious needs associated with problems, such as criminogenic or addiction related needs (Maruna and LeBel, 2002). But wider health and social care provision supports the forming of healthy relationships and finding meaningful opportunities. Mental health recovery literature in particular emphasises human rights provision as a key component (Jacobson and Greenley, 2001), highlighting the need for a sufficient income and decent quality housing. Living in a precarious space such as a squat or a violent and deprived neighbourhood is a barrier to recovery, associated with exploitation, vulnerability and danger (Leverentz, 2014; Terry, 2015). Poor public transport makes it harder to get and keep a decent job, or to keep in touch with loved ones. Highlighting high levels of poverty and material exclusion, Bradshaw et al (2007) argue that mental health social work should include a degree of class advocacy and social justice work.

As well as material resources associated with safety and stability, communities need to have accessible and welcoming social spaces – a key task for place-shaping policy. This includes sober spaces.

v. Societal and legal inclusion

Eliminating discrimination, stigma and inequality will support people's journeys of recovery and desistance. Society plays a role in offering awareness, empathy, active inclusion, diversity, representation and role models to people with marginalised experiences. Unfortunately other people can also provoke shame and stigma, and so tackling this is necessary. Mixed-purpose spaces can break down boundaries: Davidson et al (2012) point to a mental health hospital co-located with a crèche and highlight co-operative workforces with a mixed employee base of both disabled and non-disabled people as models of inclusion. In Bristol, a community centre hosts ESOL classes, lunch clubs, an affordable café, a carers' group and mental health support.[4] Activism, training delivered by service users, and the testimonies of public role models can also challenge stigma and discrimination. Employing experts by experience undermines distinctions between 'us and them' (Hylton, 2014).

Some literature argues that services should consider addressing the barriers to mainstream access before providing an alternative. Glover (2012) asks why mental health patients cannot have their non-mental health needs met in 'mainstream' environments. Her test of a true opportunity for inclusion asks "is it difficult for someone without an identity of illness to participate in the same initiative?" (2012: p.29). Without participation in mainstream opportunities, services and activities, social inclusion will only be an 'illusion', she argues.

---

[4] The Barton Hill Settlement website: http://www.bartonhillsettlement.org.uk/

Rehabilitation is important in cases of wrongdoing: both legal and moral rehabilitation. The law can promote social rehabilitation, publicly affirming someone's progress, for example by removing barriers to employment for offenders (Herzog-Evans, 2015). Maruna and LeBel (2002) advance the idea of a strengths-based re-entry court as a way to publicly recognise and affirm successful desistance through the active inclusion of ex-offenders. This would have no powers to punish, but could offer a legal 'clean slate' to reward progress. It could offer community services that are voluntary, challenging and that use people's talents.

vi. Be optimistic

A welcome implication of this review is the importance of optimism. Many people do recover and desist from crime: data varies but suggests the majority do. Desistance literature researching people with experience of drug dependency (by definition facing multiple needs) finds many can and do desist, finding agency, hope, and meaning via an undoubtedly long and difficult journey (Farrall et al, 2014; Maruna, 2001). A meaningful, dignified and gratifying life is very possible including where severe mental illness does not ever disappear for good (Davidson and Roe, 2007).

Practitioners should take heart from this and respond to relapses effectively and sensibly, in the knowledge that this is an expected part of many journeys. Services and commissioners should allow for failure and re-engagement, knowing that their continued support will make success more likely in the long run. Policy-makers should be hopeful for the possibilities of people's lives, and look for more than just the basics for people with multiple needs. Ultimately, supporting people to realise their own ambitions, social circles and skills will benefit both individuals and society.

vii) Promoting user-led and interdisciplinary research

The literature review also suggests some emerging priorities for the funding and delivery of research. Broadly, it highlights the benefits of papers which reference and review across discipline and sector, in recognition that this can only lead to a fuller understanding of complex and multifaceted issues. The review also shows user-led research has made a significant contribution to mental health literature and with investment could also provide unimagined insight to the research areas of substance misuse and desistance from crime.

This is a secondary research piece focusing on separate pre-existing disciplines. Cross-disciplinary, primary research which examines how people's personal journeys interact would add much to the evidence-base for people facing multiple needs. Some of the papers we reviewed do highlight the interaction between drug/alcohol recovery and desistance (e.g. Schroeder et al, 2007) but this could be greatly expanded. Research could explore whether these journeys can occur at the same time or consecutively, how they influence each other, and if and how there are tensions between competing priorities. This would have key policy implications for effective support for people facing multiple needs. Bringing in further perspectives such as surviving domestic abuse and adjusting to physical disabilities would further enhance what we know about this group and what can work for them.

Conclusion

This review brings together research on different journeys that many people have to navigate concurrently or consecutively. They have to find their way out of a cycle of repeat contact with the criminal justice system, poor mental health, and substance misuse. Yet support services are set up, evidenced and judged according to singular criteria and research is often confined to specific, boundaried domains.

The themes emerging across the three domains of criminology, mental health and substance misuse offer key areas to focus on when supporting people to overcome multiple problems. We know that these are highly personalised journeys which cannot be imposed through manufactured interventions or formal treatment, although there are many ways in which policy and service delivery can support these journeys. People with multiple needs are likely to require a particularly flexible, holistic and long-term approach as they navigate the many barriers to change. Agency is key. In mental health recovery this has emerged out of a historically disempowering approach to treatment including long-term institutionalisation and medication. But there are lessons across the board about the effects of services in potentially undermining people's choice, control and responsibility. For those in repeat contact with the criminal justice system this is likely to be highly pertinent. Ongoing punishment, criminalisation and imprisonment are likely to confirm people's self-conception as 'offender'. People need to remember or learn for the first time their capabilities, agencies and motivations.

Closely related to feeling empowered and capable is having a strong sense of self. A positive identity of something *beyond* mental illness, addiction or criminal behaviour provides a reason for change. Developing this identity often involves making sense of the past and how it fits. Other people help prop up new identities, making them seem more legitimate and valid – both personal relationships and community integration are highly important. For people with multiple needs, resisting unhelpful connections and forging relationships with stable and supportive people is a big ask. Policy, local commissioning, community infrastructure, service user involvement and peer support can all play a key role here. Peer support may need to empathise with particular combinations of experiences: for example being a woman with an offending and drug dependency background is particularly marginalising.

Having meaningful activities, obligations or responsibilities is highly beneficial to positive change. It is important to be creative and personalised in considering which roles may be right for people. Blanket ambitions for full-time employment, for example, are unlikely to be an effective application of recovery or desistance-informed practice.

As multiple needs policy continues to develop, it should consider the value in understanding complex processes of personal change conceptualised across a multitude of disciplines, and how these journeys can be supported. The implications are wide ranging and there is no

easy intervention to 'fix' problems of exclusion, dependency, and criminality – but this review is encouraging that change is possible and there are a myriad of ways to support it.

Appendices

Appendix A: Detailed methodology

The key themes introduced in this paper are based on the literature on the processes of desistance from offending, recovery from mental illness and recovery from substance misuse; as conceptualised across the three respective disciplinary fields.

The review includes key authors across all three domains; largely within peer-reviewed journals as well as other academic texts and significant voluntary sector and user-led research. In tracking journeys of personal change, longitudinal studies are common, using a mixture of official data, self-reported quantifiable data, and qualitative data from in-depth interviewing. Hierarchies of evidence which prioritise clinical trials are not applicable to understanding complex processes of change which are socially situated (Best et al, 2010; McNeill, 2012).

Quite often, the research reviewed was reliant on participants who voluntarily access support or who are 'easier to reach'. Some desistance literature avoids this, with examples of more persistent or creative recruitment in Weaver (2012) and Farrall et al (2014). Substance misuse recovery literature often recruits participants accessing mutual aid such as Alcoholics Anonymous (AA), and this will influence the emerging themes (see Christensen and Elmeland, 2015).

Database searching for this paper took place between August and October 2015. We searched for key terms in databases including Google Scholar, the British Library, Wiley Online, the Cochrane Library, PsycINFO and CINAHL. Key terms included *desistance from crime, desistance from offending, routes out of offending, secondary desistance, desistance for women; recovery from problem drug use, recovery from alcoholism, recovery from substance misuse, addiction recovery; recovery from mental illness, recovery in mental illness, recovery model mental health.* As well as the database search, we issued a call for evidence to our network of multidisciplinary researchers, and experts in the field advised on key authors.

In selecting the papers to review, we limited scope to English language papers focusing on adults (not young adults). We prioritised literature originating in the UK and published in the last 20 years, but important development of these concepts originates outside of these confines. We prioritised academic materials and peer-reviewed papers. Literature focusing solely on clinical recovery (relief from symptoms) was excluded. Literature focusing on desistance from serious offences such as sex offending was excluded.

We reviewed all three areas separately, noting the key themes within each domain and the crossover where applicable. As such establishing the common themes across all three domains and understanding what is distinct was an iterative process.

Validity and reliability of this review

This is a comprehensive review of the evidence, but it is not systematic. There may be some gaps in the literature reviewed. In addition, the paper is necessarily broad rather than deep. It cannot fully represent the variation in experiences of different groups, cultural contexts and time periods: we do not cover in great detail the specific experiences of women or BME groups, although we do summarise key themes emerging in the literature reviewed. Additionally, in substance misuse literature, the experiences of those who change 'naturally' are under-researched (Yates, 2013). Finally, this paper does not claim to cover macro trends in mental illness, crime rates or drug consumption, focusing instead on the experience of going through a process of change.

Appendix B: Bibliography

DRUG AND ALCOHOL RECOVERY LITERATURE

Andersen, D. (2015). Stories of change in drug treatment: a narrative analysis of 'whats' and 'hows' in institutional storytelling. *Sociology of health & illness,* 37(5), 668-682.

Best, D. W., Best, D. W., Ghufran, S., Best, D. W., Ghufran, S., Day, E., & 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., Bamber, S., Battersby, A., Gilman, M., Groshkova, T., Honor, S. & White, W. (2010). Recovery and straw men: an analysis of the objections raised to the transition to a recovery model in UK addiction services. *Journal of Groups in Addiction & Recovery*, 5(3-4), 264-288.

Best, D. W., & Lubman, D. I. (2012). The recovery paradigm: A model of hope and change for alcohol and drug addiction. *Australian family physician*, 41(8), 593-597.

Callicott, Q. (2012). Exploring strengths of gay men in 12-step recovery. *Journal Of Gay & Lesbian Social Services: The Quarterly Journal Of Community & Clinical Practice*, 24(4), 396-416.

Christensen, A. S., & Elmeland, K. (2015). Former heavy drinkers' multiple narratives of recovery. *Nordic Studies on Alcohol and Drugs*, 32(3), 245-257.

Groshkova, T., & Best, D. (2011). The evolution of a UK evidence base for substance misuse recovery. *Journal of Groups in Addiction & Recovery*, 6(1-2), 20-37.

Harris, K. S., Smock, S. A., & Tabor Wilkes, M. (2011). Relapse resilience: a process model of addiction and recovery. *Journal of Family Psychotherapy,*22(3), 265-274.

Harris, J., & McElrath, K. (2012). Methadone as Social Control: Institutionalized Stigma and the Prospect of Recovery. *Qualitative Health Research*, 22(6), 810-824.

Hill, J. V., & Leeming, D. (2014). Reconstructing 'the Alcoholic': Recovering from Alcohol Addiction and the Stigma this Entails. *International Journal of Mental Health and Addiction*, 12(6), 759-771.

Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of substance abuse treatment*, 33(3), 243-256.

Matthews, C. R., Lorah, P., & Fenton, J. (2005). Toward a grounded theory of lesbians' recovery from addiction. *Journal of lesbian studies*, *9*(3), 57-68.

McIntosh J. and McKeganey, J. M. N. (2001). Identity and recovery from dependent drug use: The addict's perspective. *Drugs: education, prevention, and policy*, *8*(1), 47-59.

Neale, J., Tompkins, C., Wheeler, C., Finch, E., Marsden, J., Mitcheson, L. & Strang, J. (2014). "You're all going to hate the word 'recovery' by the end of this": Service users' views of measuring addiction recovery. *Drugs: education, prevention and policy*, *22*(1), 26-34.

Palmer, R. S., & Daniluk, J. C. (2007). The perceived role of others in facilitating or impeding healing from substance abuse. *Canadian Journal of Counselling and Psychotherapy/Revue canadienne de counseling et de psychothérapie*,*41*(4), 199-212.

Tracy, E. M., Munson, M. R., Peterson, L. T., & Floersch, J. E. (2010). Social support: A mixed blessing for women in substance abuse treatment. *Journal of social work practice in the addictions*, *10*(3), 257-282.

White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of substance abuse treatment*, *33*(3), 229-241.

Witbrodt, J., Kaskutas, L. A., & Grella, C. E. (2015). How do recovery definitions distinguish recovering individuals? Five typologies. *Drug and alcohol dependence 148*, 109-117.

Yates, R. (2013). In it for the long haul: developing recovery capital for long-term recovery sustainment. *Journal of Substance Use*, *18*(5), 339-339.

RECOVERY IN MENTAL HEALTH LITERATURE

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial rehabilitation journal*,*16*(4), 11-23.

Bradshaw, W., Armour, M. P., & Roseborough, D. (2007). Finding a place in the world: The experience of recovery from severe mental illness. *Qualitative Social Work*, *6*(1), 27-47.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, *16*(4), 459-470.

Davidson, L., Flanagan, E., & Styron, T. (2012). Designing policies to foster the community inclusion of people in recovery. *Empowerment, lifelong learning, and recovery in mental health: towards a new paradigm.* London: Palgrave Macmillan, 85-98.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, *11*(4), pp.11-19.

Fitzpatrick, R. and Kumar S., Nkansa-Dwamena O. and Thorne L. (2014). *Ethnic Inequalities in Mental Health: Promoting Lasting Positive Change.* London: LankellyChase.

Glover, H. (2012). Recovery, Life Long Learning, Social Inclusion and Empowerment: Is a new paradigm emerging?. In P Ryan, S Ramon & T Greacen (eds.)*, Empowerment, lifelong learning and recovery in mental health: towards a new paradigm*. New York: MacMillan, pp.15-35.

Harper, D. J., & Speed, E. (2012). Uncovering recovery: The resistible rise of recovery and resilience. *Studies in Social Justice*, *6*(1), 9-26.

Kalathil, J. (2011). *Recovery and Resilience: African, African-Caribbean and South Asian women's narratives of recovering from mental distress*. London: Mental Health Foundation.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric services*, *52*(4), 482-485.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445-452.

Repper and Perkins (2003). *Social Inclusion and Recovery: A Model for Mental Health Practice*. London: Elsevier Science.

Rethink, 2009. *Getting back into the world: Reflections on lived experiences of recovery.* London: Rethink recovery series.

Ridge, D., & Ziebland, S. (2006). "The old me could never have done that": how people give meaning to recovery following depression. *Qualitative Health Research*, *16*(8), 1038-1053.

Ryan, P., Ramon, S., Greacen T., (2012), "Introduction" In Ryan, Ramon & Greacen (eds.)*, Empowerment, lifelong learning and recovery in mental health: towards a new paradigm*. Basingstoke: MacMillan, pp.1-12.

Schön, U. K. (2010). Recovery from severe mental illness, a gender perspective. *Scandinavian Journal of Caring Sciences*, *24*(3), 557-564.

DESISTANCE FROM CRIME LITERATURE

Farrall, S., & Maruna, S. (2004). Desistance-Focused Criminal Justice Policy Research: Introduction to a Special Issue on Desistance from Crime and Public Policy. *The Howard Journal of Criminal Justice*, *43*(4), 358-367.

Farrall, S. (2005). On the existential aspects of desistance from crime. *Symbolic Interaction*, *28*(3), 367-386.

Farrall, S., & Calverley, A. (2006). *Understanding desistance from crime: Emerging theoretical directions in rehabilitation and resettlement*. Maidenhead: Open University Press.

Farrall, S., Hunter, B., Sharpe, G., & Calverley, A. (2014). *Criminal Careers in Transition: The Social Context of Desistance from Crime*. Oxford: Oxford University Press.

Herzog-Evans, M. (2015). Rethinking What Helps? Beyond Probation and Desistance. *The Howard Journal of Criminal Justice*, *54*(3), 314-315.

Hylton, J. (2014). Acknowledging desistance: A practitioner response to 'A view from the inside out'. *Probation Journal*, *61*(3), 286-291.

Laub, J. H., & Sampson, R. J. (2001). Understanding desistance from crime. *Crime and justice*, 1-69.

Leverentz, A.M. (2014). *The ex-prisoner's dilemma: how women negotiate competing narratives of reentry and desistance.* New Brunswick, New Jersey: Rutgers University Press

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives.* London: American Psychological Association.

Maruna, S., & LeBel, T. P. (2002). Welcome Home-Examining the Reentry Court Concept from a Strengths-Based Perspective. *Western Criminology Review*, *4*(2) 91-107.

McNeill, F. (2004). Desistance, rehabilitation and correctionalism: Developments and prospects in Scotland. *The Howard Journal of Criminal Justice*, *43*(4), 420-436.

McNeill, F. (2012). Four forms of 'offender' rehabilitation: Towards an interdisciplinary perspective. *Legal and Criminological Psychology*, *17*(1), 18-36.

McNeill, F. (2015). Rethinking What Helps? Beyond Probation and Desistance. *The Howard Journal of Criminal Justice*, *54*(3), 311-312.

Rumgay, J. (2004). Scripts for safer survival: Pathways out of female crime. *The Howard Journal of Criminal Justice*, *43*(4), 405-419.

Schroeder, R. D., Giordano, P. C., & Cernkovich, S. A. (2007). Drug use and desistance processes. *Criminology*, *45*(1), 191-222.

Uggen, C., & Kruttschnitt, C. (1998). Crime in the breaking: Gender differences in desistance. *Law and Society Review*, 339-366.

Weaver, B. (2012). The relational context of desistance: Some implications and opportunities for social policy. *Social policy & administration*, *46*(4), 395-412.

Weaver, B., & McNeill, F. (2015). Lifelines Desistance, Social Relations, and Reciprocity. *Criminal Justice and Behavior*, *42*(1), 95-107.

CROSS-DISCIPLINARY AND MISCELLEANOUS

Bramley, G. and Fitzpatrick, S., with Edwards J., Ford, D., Johnsen, S., Sosenko F., and Watkins D., (2015). *Hard Edges: Mapping Severe and Multiple Disadvantage across England.* London: LankellyChase.

Clark, M., Cornes, M., Manthorpe, J., Hennessy, C., & Anderson, S. (2015). Releasing the grip of managerial domination: the role of communities of practice in tackling multiple exclusion homelessness. *Journal of Integrated Care*, *23*(5), 287-301.

EnglandKennedy, E. S., & Horton, S. (2011). "Everything that I thought that they would be, they weren't:" Family systems as support and impediment to recovery. *Social Science & Medicine*, *73*(8), 1222-1229.

Granovetter, M. S. (1973). The strength of weak ties. *American journal of sociology*, 1360-1380.

Henwood, B. F., Padgett, D. K., Smith, B. T., & Tiderington, E. (2012). Substance abuse recovery after experiencing homelessness and mental illness: Case studies of change over time. *Journal of dual diagnosis*, *8*(3), 238-246.

Revolving Doors Agency and Centre for Mental Health (2015). *Comprehensive services for complex needs: assessing the evidence for three approaches.* London: Revolving Doors Agency.

Terry, L. (2015). *A Good Life: Exploring what matters to people facing multiple and complex needs.* London: Revolving Doors Agency.