Understanding recovery: the perspective of substance misusing offenders

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Abstract

Purpose – *The purpose of this paper is to critically regard the concept of recovery from the perspective of substance misusing offenders. It intended to understand how these individuals came to define recovery by asking "what does recovery mean to you?"*

Design/methodology/approach – *In total, 35 semi-structured interviews were undertaken with individuals with a history of heroin and crack cocaine use as well as convictions for a range of offences. Interviews took place in both prison and community settings, reflecting a spectrum of experience.*

Findings – *Whilst the constellation of recovery varied, it was at times made up of the same "stars" – and some re-occurring themes emerged; recovery was transient, fragile and unpredictable, it was ongoing, lacking a definitive end, it was more than abstinence and often involved a total psychological overhaul, recovery was about reintegrating with society and feeling "normal".*

Practical implications – *Practitioners and services need to value the individual interpretations of recovery rather than being prescriptive around what it "should" look like. The components of recovery that were raised by participants permit specific recommendations for practice to be made.*

Originality/value – *This study sought the perspectives of those actually affected by and experiencing drug treatment in the Criminal Justice System. It allowed participants to tell their story without preconceived ideas or hypotheses, putting their voice at the centre of the stage. The study uses feedback from the ground to make informed recommendations for practice.*

Keywords *Crime, Substance misuse, Offenders, Recovery, Heroin, Desistance*

Paper type *Research paper*

Introduction

The link between drugs and crime can be seen to be a costly relationship both socially and economically. Whilst the Home Office, the UK government department responsible for crime and drug policy, estimates that class A drug-related crime costs approximately £13.9 billion annually (Home Office, 2013; Singleton *et al.*, 2006), there are also huge social ramifications tied to the use of heroin and crack cocaine at both an individual and aggregate level. These include loss of earnings through unemployment, separation from family through imprisonment or substance misuse in itself, and health impacts including heightened risk of blood-borne viruses and premature deaths (Wall *et al.*, 2000). Heroin or crack cocaine users are said to be responsible for a somewhat disproportionate amount of crime (MacDonald *et al.*, 2005) and frequently reappear in the criminal justice and treatment systems as reported by the National Treatment Agency (2012), the body that was set up in 2001 to monitor the effectiveness of drug treatment. This goes someway in highlighting the importance of recovery and why it forms the focus of much contemporary drug-related policy in the UK. This marks a move from an emphasis on prescribing and methadone maintenance in the 1960s, harm reduction discourse in the 1980s and a crime reduction focus following the Government's "Tackling Drugs Together" strategy

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(HM Government, 1995) to a more holistic-based approach highlighting well-being and reintegration which was reported to be more in line with the desires of substance misusers themselves (McKeganey *et al.*, 2004).

Duke *et al.* (2013) note recovery as a particularly hot topic between 2008 and 2010 peaking with the Government's 2010 drug strategy which highlights "building recovery" as one of three key aims. Indeed the term "recovery" now makes an appearance in a plethora of UK policy documents, for example in Public Health's annual overview of drug treatment, the UK's drug policy commission, local authority protocols and service specifications. Yet, despite its abundant use amongst policy makers, mission statements of third sector organisations, practitioners and academics, there remains little consensus over what this key-term delineates. To this end, the "recovery" field can be criticised for failing to thoroughly consider what is meant by this central concept. Indeed, it has been previously noted "while we know a great deal about addiction, we know very little about recovery" (Laudet *et al.*, 2002, p. 305). Achieving a universally accepted definition of recovery, or clarifying what each group means when they discuss the term, is of great importance in ensuring groups are communicating about the same thing and working to the same agenda with matched goals. In addition, as was recently noted at the 2015 Drugs and Alcohol Today conference, how one defines recovery decides who is socially redeemed and who is socially isolated, who is hired and who is fired, who receives custody of their children and so forth. Understanding recovery is also highlighted as imperative by considering recent statistics from the Office of National Statistics which shows the highest levels of deaths related to drug misuse since records began in 1993. Deaths involving heroin and cocaine both rose sharply within these figures compared to previous years. Therefore the intention of this study is to consider how offenders with a history of heroin and crack cocaine usage define and understand the notion of recovery. It can be argued that by exploring what recovery means to those enacting the concept, practitioners and policy makers can be better placed to support recovery for substance misusing offenders.

Although there have been previous efforts to consult substance misusing offenders on this issue (e.g. Bennett and Holloway, 2009; McIntosh and McKeganey, 2001; Patel, 2010), such work has been rare and the understanding of recovery has not been the focal concept. Instead, recovery has been ruminated upon in mental health circles and within substance misusing groups without a criminal background (e.g. Hänninen and Koski-Jannes, 1999; Hughes, 2007; Nettleton *et al.*, 2010; Ochocka *et al.*, 2005; Vigilant, 2005).

The breadth of discussion thus far around recovery queries whether recovery is defined by total abstinence, the role of substitute medication, whether it is an end state or a continual process and whether it should focus solely on drug consumption or a more holistic level of social functioning (Doukas and Cullen, 2009; Jacobson and Greenley, 2001; Laudet, 2007; White, 2007). Even abstinence itself within the definition of recovery may be complex with regards to whether it refers to the problem drug, prescription medication or legal substances such as tobacco and alcohol (White, 2007). The definition provided may vary according to the type of treatment method individuals ascribe to, e.g. methadone maintenance or 12 step programmes as seen in Alcoholics Anonymous, affording consideration to the therapeutic climate the individual resides within. In accordance with White's (2007) acknowledgement that those impacted by the definition of recovery should have a chance to define it themselves, substance misusers can offer fruitful insights into why recovery (whatever that may look like to them) is important and sought after.

Recovery is not a unilateral concept – rather it is multidimensional and has historically been considered through the academic lens of identity (McIntosh and McKeganey, 2002), resilience (Harper and Speed, 2012) and motivation (Ryan and Deci, 2000). Similarly, recovery represents a continuum of time pervading initiation and maintenance. The decision to change and recover presents a different set of elements to be analysed compared to the tools and skills required to uphold this decision. Discussions around recovery must also attend to factors beyond the individual. This includes societal level macro factors as well as social networks, peers and relational ideas. Having motivation for change in an unprepared climate (therapeutic or wider) may be problematic (Kelly *et al.*, 2012). Poor employment opportunities, inappropriate housing situations and stigma from surrounding communities may not provide or support the motivation and ability to change. Logically, it seems absurd to expect an individual to make a radical

transformation whilst the environmental constraints around them remain the same. However, many recovery discussions, definitions and therapeutic interventions fail to consider the broader environment, focusing almost exclusively on individual responsibility for behavioural change. This can be criticised for creating a sense of disempowerment and hopelessness in individuals. The rationale behind such oversight could represent recognition, conscious or otherwise, of the difficulty in changing societal structures such as inequality and injustice compared to individual substance misuse and motivation.

There is also an argument that the notion of recovery may be misleading, indicating that upon disbanding their current "chaotic" life individuals return to a previous state inhabited before substance misuse or offending took hold. Again such a position may fail to consider that the "state" one is striving to return to may be partly responsible for propelling the individual into drug use in the first instance. It could be proposed that recovery is about finding new meaning and purpose (Anthony, 1993). In this way terms such as "procovery", "discovery" or "uncovery" may be more suitable for describing this journey (White, 2007).

In summary, recovery is complex and may not be as straight forward as indicated by this one word. Many have hypothesised and ruminated over the concept – and the aim of this research is to put the responsibility of definition in the hands of those recovering. The research questions this paper strives to address are therefore:

RQ1. How is recovery defined by individuals who have offended and misused substances?

RQ2. How can services help individuals engage with and maintain recovery in the future?

Methodology

Design and sample selection

The design of the research was qualitative utilising a flexible, semi-structured interview schedule to conduct one to one interviews. Qualitative methods were chosen as they permit a depth of interaction with research participants. Rather than removing findings from their context, as per quantitative approaches, qualitative findings are embedded in their environment (Marshall and Rossman, 2010) allowing the researcher to undertake an emic not etic position (Denzin and Lincoln, 2011).

The research considered offenders currently in prison (deemed the relapsing cohort) as well as those doing "well" in the community (deemed the recovering cohort) in order to reflect a full spectrum of recovery experiences and get a sense of the recovery journey. For those offenders in prison, a list of participants was identified using the National Drug Treatment Monitoring System with the application of the inclusion criteria set out below:

- male;
- 18 or over; and
- drug of choice heroin and/or crack cocaine.

These same criteria were applied to a cohort of individuals in the community, except there was a condition that they had not used or offended for a minimum of three months and were ideally prescription free. However, in practice we had to relax the criterion of being "prescription-free" as it was not possible to recruit sufficient numbers. Those who were "most recovered" and prescription free were no longer using services and therefore difficult to identify and contact. The community services used as recruitment sites were largely drug services (e.g. Open Road) offering drop in, structured day sessions and groups. One interviewee was recruited through an after care facility following residential treatment. For the most part, recruitment of the community sample was through key-worker communication. Key workers were sent information packs and asked to contact individuals they thought met the inclusion criteria to arrange an interview.

The emphasis on crack cocaine and heroin users followed from a desire to understand recovery from those most entrenched in substance misusing and offending. Heroin and crack cocaine have been acknowledged as highly addictive substances correlated with a particularly increased risk of acquisitive crime, supply of drugs and sex work (Moyle and Coomber, 2015). Information

about offending and drug taking was through self-report or via the referring agency and was not verified by drug test. Self-report and self-definition of recovery were consistent with the study ethos of placing the user voice centre stage. Two of the prison interviewees turned out to be users of speed and cocaine rather than heroin or crack cocaine and were not on any medication. This was following confusion of the definition of a "problematic drug user" in prison jargon which was clarified shortly after these interviews took place. Whilst these individuals did not meet the inclusion criteria they still provided useful information on recovery and were therefore included. Participants were male due to the fact that recruitment was through an integrated drug recovery service which was being piloted in a male prison.

Favourable ethical approval was gained from the National Research Ethics Service in the east of England and the National Offender Management Service.

Sample composition/demographics

In total, 35 participants were interviewed. Ages ranged from 20-54 years with an average age of 32 years in the prison cohort (nine aged 20-29, six aged 30-39 and three over 40-49) and 39 years in the community cohort (two aged 20-29, six aged 30-39, nine aged 40-54). All but two participants had a history of heroin and/or crack cocaine use. This was identified by them as their primary drug of choice although they may have also been using other substances such as cannabis or alcohol in addition. All but three of those interviewed in the prison were on the drugs recovery wing (DRW) (two because they were not heroin or crack users and the third was a heroin user on methadone but did not like the DRW as he felt more prone to stigma there). Many, but not all of those interviewed in prison, were on prescriptions although this was not routinely recorded. The community sample was also generally on substitute prescription with 13 taking methadone or subutex. Sentences for prison participants ranged from eight weeks to imprisoned for public protection, with no specified release date. One-half of the prison sample were either on remand or had short-term sentences of less than a year. Index offences included theft, burglary, supply of class A drugs, common assault, possession of an offensive weapon, affray, breach, fraud and damage to property. Acquisitive crime was particularly common and was a named index offence for 13 of the 18 prison participants. Participants were white British with the exception of one Eastern European, one European and one black British participant.

Procedure

Interviews in the prison mainly took place on the DRW with the presence of a key holder. This was to facilitate entry and exit to the interview room and prison more generally. Participants were reassured this individual was not there to partake in the interview and was not involved in their treatment so as not to affect the content of the discussion. A third person was not present for the community interviews. Prior knowledge gleaned from the literature helped define the interview schedule, understand jargon and direct appropriate questions throughout. Each interview commenced with participants being asked to provide a "monologue" about their life to date, providing information regarding their substance misuse and offending. In essence the interview sought to ask "what is your story?" with emphasis on participants' recovery journey including questions on how they became involved in drugs and crime. This was in line with the autobiographical style of narrative interviewing outlined by McAdams (1993) which advocates the consideration of life as a book. In accordance, the interview structure attempted to capitalise and seek information on key events, significant people, personal ideologies, problems encountered or perhaps unresolved as well as a future script. Wherever possible the interview was intended to feel like a "conversation with a purpose" (Burgess, 1984, p. 102).

Analysis process

A hybridisation of narrative and thematic analysis was utilised in order to capture the idiosyncratic nature of participant stories as well as the aggregate patterns. Narrative analysis is concerned with the study of socially interesting, high-impact topics, rather than "abstract intellectual issues" (Gergen, 2009). Criminality, particularly desistance from offending, can be seen to correspond to such material and narrative approaches have been adopted previously to study this phenomenon

(e.g. Maruna, 2001). In particular, self-narratives can be seen to apply "order to disorder". Thematic analysis was applied to the narrative data due to its flexible nature and compatibility with a social constructionist approach. The "hybridisation" (Robinson and Smith, 2010) of narrative and thematic analysis allowed discussion and analysis to permeate social context and individual narratives and the relationship between the two. Utilising plural methods of qualitative analysis has been commended elsewhere in its application to complex social phenomena (Chamberlain *et al.*, 2011). Further, the marriage of thematic and narrative analysis has previously been noted as successful, broadening understanding (Floersch *et al.*, 2010).

Thematic analysis was used to interrogate the data set as a whole and consider themes that emerged across participants, incorporating the constant comparison approach (Butler-Kisber, 2010) considering similarities as well as differences between individuals, prison and community cohorts. Although a thorough literature review had taken place prior to the interviews as well as the researcher delivering some recovery groups within the prison service, an inductive, bottom up method was undertaken for analysis. As much as possible, themes were derived and grounded in the text, rather than being imposed on the data from pre-existing theory. Latent, rather than semantic analysis, was also the focus in accordance with the interpretative level of analysis associated with social constructionist approaches (Braun and Clarke, 2006).

Following transcription, each interview was read a number of times, highlighting quotes that seemed to be particularly powerful and captured the essence of the narrative. Initial thoughts were annotated in the margin. Prevalent and repeated thoughts then became translated into codes and were recorded in a separate Word document. A theme was defined in accordance with Braun and Clarke (2006) to mean "a patterned response or meaning within the data set" (p. 11). Codes were grouped together and initial theme titles were generated. Following this process, a summary and description of each theme was initiated, adding the most relevant and exemplary quotes where possible. One overarching theme relating to the research question was identified: conceptualising recovery.

Results

The presentation of the findings merges evidence and data from both the prison and community cohorts. This is because the design of the research as "relapsing" (prison) and "recovering" (community) was seen to be artificial at the analysis stage. Codes identified in both cohorts, when analysed separately, were largely similar rather than distinct. Where differences did occur in how points were discussed, this will be noted throughout the analysis. The master theme is outlined below with accompanying subthemes:

1. Conceptualising recovery:
    - recovery as fragile: triggers to relapse;
    - mental and physical recovery: the role of substitute medication; and
    - The benchmark of "normal".

Conceptualising recovery

Recovery was presented as an idiosyncratic concept across the cohort as a whole. Although there were some unanimously important components which shall be represented by the subthemes, participants demonstrated diversity in their discussions around recovery and its parameters.

Recovery as fragile: triggers to relapse. The perception of the fragile nature of recovery was overwhelming. Recovery was defined as being uncertain and impermanent as well as somewhat never-ending:

> I suppose I will always be in recovery won't I […].
>
> [Interviewer] […] can anyone ever say they are recovered full stop?
>
> Only when you're dead […] (Josh[1], age 54, community cohort on methadone).

Participants alluded to the fact that recovery would never be complete, required constant attention and was advocated to be undertaken in a gradual or procedural manner:

> I am recovering, a bit, instead of getting the foil out, I will get the joint out [laughs] but it is a slow process, you can't do something suddenly (Mick, age 39, community cohort, on methadone).

In accordance with the fact that recovery traditionally involved much to-ing and fro-ing, participants noted multiple triggers to relapse. Inappropriate or lack of housing was consistently highlighted as a challenge for recovery. Participants noted occasions where they had been released from prison homeless or given accommodation that meant they were mixing with other drug users or dealers. This presented challenges with will-power and motivation but also made more practical foundations for recovery difficult to secure:

> I was still homeless, I was still going to all the agencies saying "look I need some help, I can't move forward with my life, I can't think about getting back in to work, if I haven't got the most basic of needs which is heat and shelter" (Luke, age 30, community cohort, on Subutex).

Crucially being able to endure periods of success as well as lapses with the ability and resilience to return to recovery was key in securing its longevity. Some people understood that recovery entailed lapses and difficult days with urges and cravings but accepting the slow pace of recovery was not something everyone was ready for. As one participant noted addicts were creatures of habit and a lack of noticeable progress was cited as a trigger for relapse. Feeling that recovery efforts were futile, especially where environmental conditions remained unchanged, instigated behaviour that had become engrained, habitual and entrenched:

> […] you're just going back to the same thing. It is easier to go back than to go forward, going back to what I know (Jacob, age 49, prison cohort, index offence supply of class A drugs).

The sense of uncertainty about the longevity of recovery was portrayed more acutely in the prison cohort, perhaps as a result of wider uncertainty about life after release. The notion of recovery as being transient was highlighted in part by the use of specific terms such as "probably", "hopefully" and "fingers crossed":

> […] obviously there are going to be bad times when I will probably use and that but hopefully I will just take my 'tex [slang for Subutex, a substitute medication] and that will help […] (Daniel, age 34, prison cohort, index offence theft).

Being institutionalised for many years made reintegration back into the community more of a challenge and contributed to a sense of needing a reliable coping mechanism to deal with day to day life. Participants noted how this sense of alienation and unfamiliarity could lead to drug use again which they were more familiar or comfortable with:

> […] even just crossing out in to big wide open space, because I spent so much time of my life in prison […] I liked being told what to do and when to do it and I know at certain times, boom, head down, you become accustomed to it and I know I need to get past that stage (Elliott, age 50, community cohort on Subutex).

Whilst Elliott highlighted the difficulty in every-day living, the unpredictability of life more generally was unsettling and in particular a sequence of tragic or bad events meant that substances were an important source of comfort:

> […] we were side swiped by a drink driver and the car flipped. She died on the spot […] I went on a downwards spiral of self-destruction after that […] then my dad died […] it destroyed me, that hurt, I didn't really recover from that too well [crying] and I just started using so heavy again (Archie, age 49, community cohort on methadone).

Although a breadth of triggers to relapse was discussed ultimately participants recognised that anything could be framed as an excuse to lapse or relapse should their mind-set allow it:

> […] most drug users will use any excuse to use […] as they have something to blame it on […] I will put something somewhere and I can't find it and I will use that as an excuse to use […] (William, age 32, prison cohort, index offence burglary).

This leads on to the next subtheme and highlights the important relationship between physical and mental recovery.

Mental and physical recovery; the role of substitute medication. The role of substitute medication in recovery, such as subutex and methadone, was a point of controversy and mixed opinions. Some individuals equated recovery with total abstinence, not viewing abstinence as an option but a necessity. For Logan, abstinence included a "mental" abstinence from thoughts around drugs and recovery needed to encompass a restructuring of thoughts and mental attitude:

> I know people to go in to treatment […] stopped drugs and having to go back […] because their head is fucked and I think, addiction, when you don't use, that is just part of the illness […] for me the only way forwards is abstinence […] it's an obsession of the mind […] just because they're not using drugs doesn't mean they're not thinking (Logan, age 40, prison cohort, index offence robbery).

By advocating total abstinence, Logan simultaneously expressed distaste and disapproval of substitute medication in recovery. Other participants did not approve of remaining on a prescription, suggesting this stilted or prevented the progress of recovery. In this way the "habit" was discussed as being prolonged rather than left behind. Several participants alternated between prescriptions and illicit drugs for decades failing to address the underlying, root cause of the behaviour:

> In the prison and in life, you get a bit clean and you get off the gear and you get on to Subutex or methadone or whatever it is and you come out but you haven't actually dealt with anything […] you've still got all this stuff going on […] (Leslie,age 41, community cohort in after-care and prescription free).

The idea that recovery was mental and physical meant that methadone did not always prevent use, tackling only the superficial physical elements. To this end it was framed as another addiction to overcome, sometimes more potent and difficult to come off of than heroin. Jack referred to methadone as a "chemical walking stick" and participants expressed anxiety at the prospect of leaving methadone behind:

> I have been on it for such a long time […] my little safety net and I don't know what I am going to do when I am off it, how I am going to feel, like all my emotions will probably come back (Liam, age 29, prison cohort, index offence robbery and possession of an offensive weapon).

Opinions on methadone were often venomous. In the community Jack quoted methadone as being "seven times more addictive than heroin", Mark described it as "evil" and Todd believed it should be banned. In contrast, some participants stated that abstinence from heroin and crack cocaine would suffice in terms of qualifying for recovery, but there was a place for substitute medication:

> I would consider myself to be in recovery because I am on methadone (Josh, age 54, community cohort on methadone).

Participants, mainly in the community, spoke about the ways that substitute medication had helped them reduce or desist from using heroin. Substitute medication seemed to be most effective as a recovery tool when individuals could choose their own pace alluding to a level of autonomy that shall be revisited in the discussion. Elliott had been on the same Subutex prescription for three years but he felt it limited his using and in that way, facilitated his recovery from heroin:

> […] there has been no "right that is it you're coming off your 'tex'" – that decision lies with me and when I feel comfortable […] there would be days that I might feel like a bag of shit and […] it would just take it all away […] but knowing that I have the "tex" […] stops me from doing that […] (Elliott, age 50, community cohort on Subutex).

Abstinence also extended to other drugs, and participants considered themselves to be in recovery if they were abstinent from problematic drugs but not necessarily other illegal or legal substances:

> I started drinking and I was drinking every day, obviously I am not doing heroin and crack, I was giving clean urine samples but I was drinking every day (Henry, age 27, prison cohort, index offence affray, possession of offensive weapon, criminal damage).

In essence, most participants could see that abstinence equated to a higher level of recovery but did not necessarily relinquish the title of being in recovery if substances other than heroin and crack were being used. Whether abstinence was a feature of recovery was largely based on the

participants' independent definition of recovery and how "far" they wanted to push themselves. It was not clear whether the recovery definition fuelled the view of substitute medication or if the definition was moulded to fit the current status of abstinence.

The benchmark of "normal". Participants across both cohorts, but predominantly in the community cohort, centred recovery goals and ambitions on the desire to live a "normal" life. A life of drugs and offending meant that participants expressed a sense that they had missed out on a lot of "normal" experiences:

> I left school and started taking drugs and went to prison […] I missed out on a lot of stuff even just maturing, growing up, doing normal things that other people do, I started to feel a bit left behind and it was nice to have things, even to dress smart […] (Rhys, age 30, community cohort on methadone).

In this way recovery could represent either a return to normality or a discovery of normality that had not been encountered before:

> Some people […] haven't had a life before they started taking heroin so they don't know what it is like to live a normal life […] I have actually had it […] a job, a car, a flat, a girlfriend and all that so I know what I want to get back (Benjamin, age 28, prison cohort, index offence supply of class A drugs).

Ray implied that recovery and normality also entailed reintegrating with society. This reflected the sense of marginalisation other participants discussed:

> I have had a good quality of life at one stage, with my wife, we had an apartment in France, I had nice cars, our own house we had a good life, I want to get that back, I am fed up of feeling ill all the time and people looking down their nose at me and what have you (Ray, age 40, community cohort on methadone).

"Normal" was often synonymous for "non-using", particularly when considering peer networks and again this shaped recovery goals:

> […] Just like get normal friends like people who never take drugs or who have never seen a drug in their life […] normal people (Tim, age 31, community cohort on methadone).

A further perceived barrier to normality was the combination of drug use and crime. Participants discussed the segregation of behaviour and their internal self, othering their behaviour and attributing it to substance misuse:

> I am not actually a bad person it's just when I am a drug addict I am a horrible person […] (Oliver, age 25, prison cohort, index offence possession of cannabis, burglary, conspiracy to defraud, legacy fraud and theft).

In summary the theme "conceptualising recovery" explored the perceived permanence of recovery, physical and psychological recovery and the benchmark of normality as an indication of recovery success.

Discussion

The varied definitions participants put forward for recovery have advanced the discussion on recovery and further challenged the idea of this as a singular concept. The diverse ways both recovery and the place of abstinence were discussed by the current sample would support the contention that the term "recovery" over-simplifies a complex phenomenon and that differential terms might be used to more accurately represent ones in recovery status (White, 2007).

Importantly, participants demonstrated their ability to reflect upon and define recovery – they had clear ideas about what it meant to them which had implications on the methods, approaches and goals they undertook within their recovery. The parameters individuals across both prison and community used to define recovery highlighted the variety of interpretation. Yet in light of individual nuances, there seemed not to be too much variation or an apparent, obvious distinction in the way that recovery was discussed between those in the prison or the community. Instead they were united by several key components of recovery which were individually endorsed to varying degrees. Recovery was said to be ongoing, physical and psychological and represented a striving for normality. Recovery was discussed by participants as occurring on multiple levels

(multiple recoveries; Vigilant, 2008) and was not just about being "clean" or "sober" but embodied a total thought overhaul. Participants were keen to emphasise that recovery continued even after abstinence was achieved. In line with previous research (e.g. Scott *et al.*, 2005), participants did acknowledge abstinence or desistance from the problem drug as an important component of recovery but it simply was not the only criteria to be considered when conceptualising recovery. Some individuals were happy to abstain from heroin but use Subutex or methadone, whilst others wanted to be free from illicit and prescription drugs. To this end, the notion of "abstinence", much like recovery, was idiosyncratic in the way it was defined by individuals.

Participants expressed a desire to be perceived as normal, mix with "normal" others and do "normal" things. Nettleton *et al.* (2013) also suggest a desire to be subsumed into the majority, not the minority, is an important benchmark for recovery and normality. By stressing the importance of being viewed as "normal" by society as well as themselves, participants could be seen to express a desire to own and exhibit a "pro-social identity" which has been related to desistance from offending elsewhere (e.g. Maruna, 2001). The expressed goal of being normal simultaneously suggested that participants did not currently feel normal. The portrayed sense of exclusion from the category of "normal" was perhaps symbolic of participants' marginalised status, the stigma directed towards them from a range of sources and the resulting shame (cf. Radcliffe and Stevens, 2008; Rhodes *et al.*, 2007; Rødner, 2005). Whilst this has been acknowledged in previous work, the current study's focus on offending substance misusers promoted a consideration of "double deviance" (Lloyd, 1995) whereby individuals may have suffered prejudice and stigma about their using and offending.

The current research has highlighted how external stigma and internalised shame can make the identified goal of becoming "normal" complex to navigate and negotiate, particularly as a substance misusing offender. This affords consideration not just to the definition of recovery but also the process of recovery and recovery initiation whereby individuals acknowledge their behaviour to be bad but struggle to confront themselves as a bad person – owning the behaviour but also positioning the self as an outsider looking in (Appleton, 2010).

Participants stated that recovery was a constant process with no definitive end. In addition, participants framed recovery as unobtainable in a permanent way, and was described and portrayed as a somewhat elusive concept that individuals in the prison and community were struggling to maintain. Although the sense of "to-ing" and "fro-ing" portrayed by current participants has been noted elsewhere (e.g. Hser *et al.*, 1997; Scott *et al.*, 2005), participants in the current study were able to shed some light on why this may be (e.g. unexpected tragedy, an inability to cope with reality, inappropriate housing). Although the triggers to relapse were vast, the emphasis on recovery being sustained if it came from within was a useful directive for practitioners and services to strive for in order to combat recovery's fragile nature.

This study built on previous work in the field of recovery in that it directly consulted substance misusing offenders' conceptualisation of recovery, utilising individuals from a range of points on the recovery spectrum in both custody and community settings. The division of the cohort into relapsing and recovering according to location (prison or community) has been enlightening in its artificiality, with the potential to influence future methodologies and approaches to recovery definitions – seeing it in a cyclical rather than linear way.

Practical recommendations

Several important practical recommendations are able to be made on the basis of the findings from this research. It is important to note that these derive from the "ideal" and it is acknowledged that not all recommendations will be possible in the climate of austerity measures and public spending cuts. However, utilising finite resources to the best ability, achieving better outcomes for individuals through approaches that are more in line with their preferences and understanding of recovery may contribute to a realisation of financial savings and streamlined, effective service provision. In essence, it is postulated that by adhering to recommendations from the "ground" the likelihood of individuals engaging in recovery services may be improved with resultant better outcomes including reduced drug use and offending behaviour. Although it is acknowledged some commissioned services are already undertaking these recommendations, such as Inside Out and Open Road in

Essex, the findings consolidate the importance of incorporating them as a specification in operating models nationally. This would also serve as a way of ensuring that recovery services are consistent across the country and the components that individuals highlight as being important or essential to their recovery are addressed no matter where they are receiving support. Understanding recovery from the perspective of substance misusers can also aid the creation of assessment tools to adequately "tap" into the construct of recovery.

The fact that participants strongly articulated a psychological component to recovery suggests that the use of prescription medication in isolation is seemingly insufficient in addressing the issues that lead to substance misuse and offending as well as supporting long-term recovery. All criminal justice services supporting substance misusers should incorporate a psychosocial component to recovery and rehabilitation endeavours . Co-location of prescribing services within psychosocial provisions, which has already been adopted by some services and is part of the prison IDTS policy, acknowledges the duality of physical and psychological recovery. However, despite co-location becoming more common, those in the prison reported IDTS was still too "superficial" and was not adequately targeting or tackling "deep" recovery. Furthermore, the implications of the delivery of services in a bespoke DRW within the prison needs to be considered. Participants were generally in favour of the DRW as it meant they got their needs met fairly immediately and they were with other prisoners who "understood" their issues. However, as this was a local remand prison it did also mean that prisoners were mixing with others they knew from the outside world and this sometimes made it hard to "recover". Some participants also identified the DRW as a source of stigma and shame from the general prison population as it was seemingly associated more with drug taking (present or historical) rather than a drive to recover.

Individuals identified a strong desire to feel "normal" and aligned this with recovery. To this end, practitioners should be mindful of the issue of stigma and isolation and seek opportunities for substance misusing offenders to develop elements of their identity that are positive and pro-social. Being involved in sports or physical activity has been noted as helpful when recovering from heroin use (Neale *et al.*, 2012) and multiple participants mentioned the gym as being a useful recovery tool. Helping individuals to seek employment, voluntary or paid, could be one way of encouraging structure as well as a pro-social identity and a sense of feeling "normal". Linked to this, participants in prison and community discussed the difficulty in transitioning from a highly structured environment in the prison to "empty" days in the community. Therefore, structure was seen to be paramount to maintain recovery efforts, so the application of regular appointments and schedules was advocated. Community services that offer a regular, weekly timetable for individuals to ascribe to may be optimal.

A final recommendation relates to the user consensus that recovery was an ongoing process with many peaks and troughs along the way. This needs to be acknowledged by policy makers, commissioners and practitioners with regards to setting achievable key performance indicators and goals within individual care plans.

Limitations

Although a considerable sample size for qualitative work, the number of individuals interviewed and the fact they were an all-male sample recruited within an isolated geographical area may limit the ability of findings to be generalised across the substance misusing offending population. Recent research suggests only small differences between the recovery experience of male and female heroin users (Neale *et al.*, 2014) albeit it not in an offending sample.

Conclusion

The research has highlighted the idiosyncratic, personal and complex nature of recovery and addiction and the need to consider the impact of psychological processes (e.g. identity and motivation) and sociological constructs (e.g. wider societal facilitators or barriers such as stigma, housing and employment). Whilst the research sought to uncover and clarify the definition of the term recovery, and what it meant to those experiencing it, the findings suggest there can in fact be no clear, concise or definitive answer to this elusive construct. Participants demonstrated their ability to theorise and hypothesise over the meaning and makeup of recovery and were able to

highlight its important features highlighting the worth of this exercise in research, practice and policy. Largely, participants exhibited consensus over recovery's important components but these were still expressed with a level of individual nuance. The ability of substance misusing offenders to define their recovery themselves supports the case for this to be sought throughout treatment, rather than imposing pre-defined professional or academic parameters. The need for personalised recovery interventions, which was voiced by the majority of participants, can be seen to align with autonomy in Self Determination Theory (Ryan and Deci, 2000). It is imperative to ensure treatment allows the individual to define recovery and the recovery plan themselves akin to their own ideology of recovery. This type of mutual agenda setting allows the individual to take ownership and direction of their recovery whilst being professionally supported (Vansteenkiste and Sheldon, 2006). If the individual decides the parameters of recovery, competence is also likely to ensue, attending to the abilities of the individual and serving to empower rather than the idea of being "set up to fail" that many participants discussed. The importance of individualised treatment as well as the need to incorporate a breadth of approaches, rather than strictly adhering to one, was consolidated. Commissioners and practitioners should seek to support this level of creativity and autonomy rather than being prescriptive about the recovery approach adopted within services.

Note

1. Pseudonyms have been used for the names of participants.

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