Therapeutic communities and the local community: isolation or integration?

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Abstract

Purpose – The purpose of this paper is to test the feasibility of utilising an Asset-Based Community Development (ABCD) model in the context of an Alcohol and Other Drug Therapeutic Community, and to use this as a way of assessing how TCs can contribute to the local communities in which they are sited.

Design/methodology/approach – This is a qualitative action research project, based on an evolving model in which key stakeholders from participating sites were instrumental in shaping processes and activities, that is a partnership between a research centre, Turning Point in Melbourne, Australia and two Recovery Services operated by the Salvation Army Australia Eastern Territory (TSA). One of these is the Dooralong Transformation Centre on the Central Coast of New South Wales and the other, Fairhaven, is in the Gold Coast hinterland of Queensland, Australia. The project was designed to create "rehabilitation without walls" by building bridges between the treatment centres and the communities they are based in, and improving participation in local community life. This was done through a series of structured workshops that mapped community asset networks and planned further community engagement activities.

Findings – Both of the TCs already had strong connections in their local areas including but not restricted to involvement with the mutual aid fellowships. Staff, residents and ex-residents still in contact with the service were strongly committed to community engagement and were able to identify a wide range of connections in the community and to build these around existing Salvation Army connections and networks.

Research limitations/implications – This is a pilot study with limited research findings and no assessment of the generalisability of this method to other settings or TCs.

Practical implications – Both TCs are able to act as "community resources" through which residents

and ex-residents are able to give back to their local communities and develop the social and community

capital that can prepare them for reintegration and can positively contribute to the experience of living in the

local community.

Social implications – This paper has significant ramifications for how TCs engage with their local communities

both as a mechanism for supporting resident re-entry and also to challenge stigma and discrimination.

Originality/value – The paper and project extend the idea of ABCD to a Reciprocal Community Development

model in which TCs can act as active participants in their lived communities and by doing so can create

a “therapeutic landscape for recovery”.

Keywords Qualitative research, Therapeutic communities, TC practice, Residential, Leaving care,

Re-entry

Paper type Research paper

Introduction

Traditionally, Therapeutic Communities have been considered as unique communities that exist typically in remote locations so that the “community as method” process is untainted by outside influences and temptations (DeLeon, 2000). This is particularly true in the early engagement and immersion phases although less so in the emergence phase where it is assumed that the resident is ready for more active engagement in the local community. In the alcohol and other drug (AOD) area, the focus of this paper, this often occurs through attending mutual aid meetings and through volunteering or work activities. This helps to provide not only essential

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skills for the transition to the community on departure from the TC but also prepares the resident to make that change, and to have resources they can tap into.

This includes social resources or social capital, defined by Robert Putnam as "connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them" (Putnam, 2000, p. 19). He draws the parallel to "civic virtue" in the sense that social capital is at its strongest in "a dense network of reciprocal social relations". In Putnam's model, social capital benefits those directly involved but also benefits the society at large – they are "simultaneously a 'private good' and a 'public good'" (Putnam, 2000, p. 20). The concept of social capital has been used in the AOD field as the basis for a model of recovery capital. Recovery capital research (e.g. Best and Laudet, 2010; Granfield and Cloud, 2001) has focused on mapping the resources and supports available to individuals to support them in their recovery journey. There are three key types of capital that are relevant to the TC process. The TC provides a safe and protective community that is supportive of the recovery journey, and a location within which the individual can build the positive personal recovery capital (Groshkova et al., 2012) such as resilience skills, self-esteem, self-efficacy and hope that will support them in their recovery journey. The TC environment also provides strong social capital by offering significant opportunities for "bonding" with staff and other residents and for building their own commitment to the group.

However, within a recovery capital framework, the risk is that the strength of growing bonding capital within the TC comes at a cost in terms of bridging capital, as the resources are within the group and so minimise the connections made with assets in the outside world. In the classical model of social capital advanced by Robert Putnam (2000), access to community resources and supports (what would be community capital in this model) is defined not by the immediate group and its members but by the "reach" of the group to other groups and resources in the

broader community, including the communities residents will return to when they leave the TC. From a social capital perspective, the commitment to bonding capital is at risk of neglecting the bridging capital (see Landale and Best, 2013) that is essential to generate access to the resources that are available in the community. Unless these bridges can be built during the reintegration phase, there is a significant risk of poor outcomes, regardless of how well the resident does while in treatment. This is because of a lack of access to recovery capital available in the community, such as bridges to housing, college courses and family support groups.

This would be entirely in keeping with the research findings (e.g. Vanderplasschen et al., 2013) that shows continuity of care and treatment completion predict the best outcomes for TC residents. The transition to the community is a major challenge for most TCs because of the geographic spread of locations that services recruit from unless ex-residents living in the community are encouraged to relocate to the area around the TC. This makes aftercare problematic, which is a significant concern as there is strong evidence that aftercare increases treatment effectiveness (White, 2009). Thus, there are risks to the gains achieved during treatment being lost during the transition to the community. From a recovery capital perspective (Best, 2014), this transition can involve not only a loss of the secure identity and routines established in the TC, but also lack of access to social support and to community resources – information and access to houses, college courses, volunteering and work opportunities and so on.

This notion of community resources and community capital is linked to the notion of "therapeutic landscapes of recovery". The idea of therapeutic landscapes originates in health geography (Williams, 1999) and relates to the idea that there is something about some locations (either physical or social) that promote health and wellbeing. This idea was tested by Wilton and DeVerteuil (2006) in their work on the recovery community of San Pedro in California where they identified a strong and visible recovery community in which many individuals who completed treatment not only remained in the area but also remained active and visible in the local recovery community. This resulted in an accessible and supportive network of individuals and groups that created a sense of hope and possibility to those in treatment and at earlier stages of the recovery

journey. This model is based on the assumption that the TC may well be a therapeutic landscape but that the local community may not and that the transformation of the local community requires a structured and systematic “assertive” intervention from the TC and its connections in the wider community.

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TCs exist as communities embedded within a wider local community that can be either a source of support and resources for the TC or a hostile environment unhappy to have alcohol and drug users in the neighbourhood and who can actively oppose the TC and its residents and block their participation in community activities. While supportive links to the community would constitute positive community capital, hostile associations, characterised by stereotypes and discriminating attitudes, constitute negative community capital, and represent the therapeutic landscape in which individuals attempt their recovery journey, particularly for that cohort of residents who move into the local community on departure from the TC.

In recovery work in the UK in particular, the issue of such community linkage has been dealt with in part through the model of Asset-Based Community Development (ABCD) (Kretzmann and McKnight, 1993) where communities are used as resources to identify groups and activities that can assist individuals in their recovery journey. Asset mapping typically involves identifying and engaging active community members (referred to as “community connectors” by McKnight and Block, 2009) to link people in recovery with individuals, informal associations and groups and organisations in the community that can support recovery efforts. This has been used as the initial stage for identifying resources that may be suitable for linkage and for shaping staff efforts to engage the community.

Rationale

The rationale for the current project is that context matters in terms of both providing opportunities and in constituting the source of community recovery capital, whether it refers to community engagement in the emergence phase of treatment (referred to as the “Re-entry

phase" in the participating Salvation Army TCs) or the post-treatment experience of living in the local community. This is strongly influenced by the idea of the lived environment as a "therapeutic landscape for recovery" (Wilton and DeVerteuil, 2006) which can offer a network of positive supports and a visible community of recovery or as a context that can be hostile to recovery and so acts as a barrier to the resources and supports necessary for long-term recovery (Best and Savic, in press).

The paper is based on a project that is a partnership between a research centre, Turning Point in Melbourne, Australia, and two Recovery Services operated by the Salvation Army Australia Eastern Territory (TSA). One of these is the Dooralong Transformation Centre on the Central Coast of New South Wales and the other, Fairhaven, is in the Gold Coast hinterland of Queensland, Australia. The project attempted to change the ethos of the services to create a "rehabilitation without walls" by making the TCs active players in their local communities. The project aimed to build bridges between the treatment centres and the communities they are based in, and to improve participation in local community life.

The aim of the project is to assess staff willingness to engage in community engagement activities and to identify opportunities for the two TCs and their residents to take an active part in meeting the needs of the local community and to develop the idea of a "TC without walls".

The aim of this paper is to describe the method used to undertake this task and the preliminary findings about active community engagement beliefs and expectations.

Method

Services

Fairhaven is a 56-bed TC with an 11-bed detoxification unit also offered as the first stage of treatment. Dooralong is a 125-bed residential Recovery Centre. Both services are run by the Salvation Army, and are funded through a combination of internal resourcing and funding from State and Commonwealth Governments. The Salvation Army is a member of the Association of Therapeutic Communities in Australia. Both centres primarily recruit clients from the state in which they are based but both are located in rural areas and so the majority of residents are not

from the immediate area around the services. Both services operate three phases of treatment – engagement, treatment and re-entry, and have a range of existing links to the local communities that the current project aimed to build upon.

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Initial engagement: The aims of the project were agreed following discussions between the first author from Turning Point (D.W.B.) and senior managers from the Salvation Army (authors D.P. and G.B.). This resulted in an initial meeting and training session which was held at Dooralong with ten staff and volunteers in which the rationale and aims were presented along with the ABCD model for community engagement.

Following this initial discussion workshops were held in each location over a three-hour period, with between 25 and 35 staff and volunteers (including former residents) at each session.

In these sessions, the lead researcher presented the community recovery model and the rationale for ABCD and active community engagement. Participants were invited to comment on this and discuss the implications for the model before two tasks were undertaken. All staff were willing to proceed and there was unanimous support from all participants both for the need for this kind of community engagement project and for the method to be undertaken.

Task 1. The first task is derived directly from the work of Kretzmann and McKnight (1993) and involved groups of workers (divided up by the geographic areas they worked in) identifying resources that would be available to help residents in their recovery journey. This basically meant splitting the overall group into five sub-groups based on the areas they lived or worked in to map out the community resources they were aware of and had previously engaged with. Groups were asked to identify three groups:

’ individuals who could support active engagement in recovery groups and activities and social networks that would be free from the risk of drinking and drug use;

’ informal groups and associations in the local community such as mutual aid groups, sports and recreation groups and other community groups; and

’ institutions and organisations that could provide practical resources and supports.

The groups were asked to start the task and then complete them subsequently through e-mails and follow-up meetings. At the end of the initial session, as is typically the case for ABCD mapping, the sub-groups by location were asked to report back to the overall group and agree on next steps around engaging the community assets identified.

Task 2. The second task is a more original version of this process and is an attempt to move from the ABCD model of Kretzmann and McKnight (1993) to an innovative approach called Reciprocal Community Development. This was also undertaken in the same sub-groups based on area of work or residence. This is based on the idea that effective and sustainable community engagement must be based on mutual benefit and should be based on the idea that the TC – building, staff and residents – represents an opportunity to provide a valuable resource for the local community. This involves not only volunteering and working but actively engaging with a range of community groups. The reason for this is to challenge stigma through active participation and contribution to the local community. Within this task, there were two activities:

1. to consider methods for addressing what the unmet needs were in the local community that the TC could help to address; and
2. to identify resources and opportunities from within the TC to address these local community needs.

The session in each location closed with a discussion of next steps – identification of local leads, a project planning process and a communication strategy.

Participants

The participants were around 60 individuals connected to the Salvation Army in each location. This consisted of current employees at the TC, former residents in the community (who had settled in the community since graduating) and other key Salvation Army staff who were potential community links, and several of the participants fulfilled more than one of these roles. Individuals were not asked to specify their status as part of a process of creating a coalition around community recovery rather than focusing on the individual status of

participants.

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Data collation and analysis: Although each session was attended and observed by the first author (D.W.B.), the primary data sources were the asset maps generated by the workshop sub-groups and the recorded action plans subsequently produced. These were summarised and reviewed by the first author and sent to the coordinators of each group for confirmation.

Results

In each of the settings, there was a general and positive endorsement of the community recovery model and agreement to participate in the process – all participants agreed:

1. that there was a need for greater community engagement; and
2. that a systematic mapping and engagement strategy was a useful way of building on existing ad hoc relationships.

Participants recognised that, while community linkage was something that both centres currently engaged in, it was generally done in an unstructured way and without a coherent underpinning model.

The first significant achievement is that a member of staff in each site agreed to be the site coordinator and the first “recovery champion” within each site, and they have continued to coordinate the activities of the groups in each locality area. Second, in each location five groups – based on geographic areas their service covered – were established and coordinators agreed to collate and report on the processes. Third, and most important, key lists of community assets were identified in the local areas consisting primarily of individuals and informal groups. Within the Salvation Army TSA, there is already in existence a strong network of community groups and hubs that were widely cited along with significant engagement with mutual aid groups in the community. Many of the ex-residents of the two TCs who attended as candidate champions were heavily involved in their local mutual aid groups and had significant opportunities to link to community assets through existing resources within the Salvation Army and through the

contacts and connections of the staff and ex-residents of the service.

The second task, which also captured the imagination of both groups, was around identifying skills and resources in the TC and methods for linking these to needs in the local communities. This was consistent with the values of the Salvation Army (TSA) and there was a general recognition that there were two types of activity that would be relevant here:

1. Residents and graduates assessing and then addressing the needs of the local community, particularly in terms of groups of high need, including the elderly and those in highest need. This activity would involve active "field testing" of what is needed and this would be reviewed on an ongoing basis.
2. However, there was also the recognition that the physical resource of the TC was a potential hub for community intervention and support, with the resources available in the buildings and grounds potentially being made accessible to the local community.

Participants were keen to build on TSA existing work but also to do things that were unique to the current initiative and that broke down the barriers of the TC and allowed the public to make use of the resources and facilities and to engage with the clients. The key in both locations was the active recruitment of community members known to support recovery and to create an active coalition between staff, residents and ex-residents of the programme living in the local community and individuals known to be community activists, including but not restricted to members of The Salvation Army.

Mapping social networks and community engagement

Fairhaven: social networks and resources

There was a recognition that the Salvation Army was in a unique position to bring together a core recovery community group based on staff, ex-residents, residents, family members of both staff and residents, volunteers and people from the wider Salvation Army Church. There was also the recognition that this group had an additional network of contacts that could be deployed

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through their engagement in mutual aid groups (where ex-residents were particularly strongly represented), through the Salvos Stores, Men's Shed and the Lions Club. In other words, the group participating in the workshop recognised that there were already existing links to a range of structural community resources that could be tapped into. These were supplemented by membership of local community groups such as the Community Fire Brigade, fishing and cycling clubs, the Botanical Gardens, and other sporting clubs that the emerging Reciprocal Community Development team were already linked to. All of this was separate from the key local institutions such as housing, employment and benefits services, dental and medical services, further education colleges and universities and specialist alcohol and drug providers.

The recovery mapping work identified a key contact in the drug courts who has been approached and has agreed to be an indigenous cultural adviser, and existing contacts have been mapped in the following key areas: homelessness; domestic violence; women's accommodation services; Citizens Advice Bureau. These were supplemented by volunteering options – these include Sailability Runaway Bay (a disability programme for yachting and sailing), and Volunteer Gold Coast, a service provider that gets the community into suitable volunteer programmes; and volunteering with aged care populations.

Overall, there were strong existing links to professional agencies and to mutual aid groups, but also more informal links to clubs, organisations and individuals whose potential participation was recognised.

Fairhaven: identifying and meeting the needs of the local community

Participants were posed the question "What skills and assets do we have within our Fairhaven community of staff and residents that could help to meet some of those needs?"

The initial audit of skills suggested that the assets held in the community that could address community needswere across a diverse range of areas. These included "Entertainment –musicians, actors"; "Handyman services – gardening, window cleaning, trade jobs, hairdressing"; "Events management – business skills, accounting, transportation (buses)"; "Communication skills – building community networks" at two separate locations and "Clients facilitating

skills-based training at Fairhaven as part of service work – working with disadvantaged, youth and long-term unemployed with limited skills" (including existing work through Employment Plus). It was recognised that some of these supports and resources could be provided on an ongoing basis (both at the site of the TC or in the community) or could take the form of one-off events – with an open day and a family fun day both suggested as candidate activities.

Dooralong: social networks and resources

The first task of identifying candidate community connectors yielded a total of 69 names of people who are linked to Dooralong through staff, clients and graduates and their personal connections in the Salvation Army, through the mutual aid groups and through their involvement in the local community. This group split into four to cover four distinct geographic areas and each outlined a number of recovery groups and local community resources such as Men's Shed, neighbourhood centres and youth centres, as well as Salvation Army groups such as the Women to Women Group, the Parenting Group and the Hope Group.

Key local groups and institutions identified in different sites included football (Australian Rules Football) and soccer clubs, further education colleges and universities, the Lions Club, drumming and dance clubs, Board riders, Community Fire Authority, neighbourhood centres and the local library.

In response to the question "What skills and assets do we have within our Dooralong community of staff and participants that could help to meet some of those needs?" three groups addressed the question of what the TCs could contribute to the wellbeing of the local community, and there were general categories of support suggested (odd jobs, restoration and clean up, transport, volunteering) as well as utilisation of the physical resources owned by the Salvos (for instance, for functions and community activities, and to provide ongoing community hubs). Specific groups' suggestions included education and awareness workshops, support groups for families

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and young mothers, outreach to graduated clients in isolated communities and greater support

around housing.

It was suggested that the greatest resources the TC could contribute to the local communities were in the form of people and time. There were specific skills and capabilities that could be tapped into in the form of drivers (with vehicles), landscaping and gardening, peer support, coordinating local volunteering options and skilled labour – often enhanced through tools and equipment owned by the Salvation Army.

The recovery champions in each site provided the maps to the first author for analysis and created local action plans based on the resources and needs identified, and the next phase of the community engagement project will involve active engagement with the community.

Discussion

What this paper has done is to assess the feasibility of a TC as an active participant in the lived community it is located within, and its potential to create a reciprocal model where residents and ex-residents benefit from community engagement and the community is enhanced, which in turn makes it a more suitable place for residents to return to on completion of their treatment.

The current approach was pilot tested with two therapeutic communities run by the Salvation Army (known as Transformation Centres) on the East Coast of Australia. There was considerable interest and enthusiasm among the residents, staff and alumni of the TC about the community connections model and considerable engagement in the process of creating a community engagement hub through the centre, building on the formal links that already exist in each centre. What is new is linking these to the informal links that exist through social connections and networks that can be mobilised as community recovery capital. It is particularly important for this model that the core team embrace the role of “bridges” or “community connectors” who can link residents and ex-residents to social networks and activities in the community.

The key finding of this pilot work is that there is a solid foundation for the application of a community connections model – at least in terms of the Salvation Army TCs through strong local connections and community engagement. Many of the staff – some of whom themselves

are in recovery – had strong local connections to a diverse range of community groups and activities and these were already partially, but not consistently or systematically, mobilised to support resident re-entry.

The model outlined in this paper – which is increasingly commonly used in the UK in community recovery services – extends the notion of active engagement with the community to a model based on identifying and utilising the resources available in the TC to enhance the community and actively contribute to it. This is based on two key principles: the idea of creating a therapeutic community of recovery for residents and ex-residents to transition to when they leave, and to enable this to challenge and overcome community stigma and discrimination that may block the recovery endeavours of TC graduates. Each of these points will be discussed in turn before addressing the question of whether this approach is consistent with TC philosophy.

This has obvious ramifications for TCs who service their local community in terms of both supporting and maintaining contact with residents leaving the treatment centre, but also by creating meaningful links into the local community. Furthermore, in recovery capital terms (Best and Laudet, 2010), this creates a resource in that community that provides not only social networks and support but also access to community resources and opportunities (Landale and Best, 2013). For the residents of the two Salvation Army TCs, much of this work already happened informally through 12-step fellowships and through the Salvation Army church and community activities but the project formalised the model and identified gaps in local provision. What the project aimed to do was to create more structured and formal links, with the ambition of contributing to local community life, in order to create a therapeutic landscape of recovery that would enhance the prospects of long-term change for residents in the “re-entry” phase of treatment and for those relocating in the local community on departure from the TC.

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There is a corollary to the aim of building connections and resources in the community and that

is the impact of community engagement on attitudes and stigma in the community. As shown by the UK Drug Policy Commission (2010) substance users are among the most excluded and stigmatised groups and one of the core aims of the community development initiative is to challenge these views through active engagement in the community. This happens at different levels and, through the other social activities of the Salvation Army, starts with challenging stereotyped and negative views of professionals in the AOD field and linked areas of work. The aim of this part of the initiative is about giving back to the community and generating the perception that

people in recovery have a valuable and positive role to play in supporting the local community, and that recovery is possible with sufficient support and community engagement.

This model is at odds with some perceptions of what TCs are and how they should operate. The TC has traditionally been the isolated "house on the hill" deliberately segregated from the local community to preserve the integrity of the TC model, and to avoid the risks associated with extended community contact. This includes exposure to opportunities for alcohol and drug use, but also the risks of distraction from the programme and from the internal community of the TC. The aim of this project is to have a TC "without walls" but this does not mean that clients, particularly those in the early stages of treatment, are exposed to unnecessary risk, with the primary target populations for this intervention being those in the "re-entry" stage of treatment and residents who have graduated from the programme and live in the local community.

There are a number of major limitations to the current project. The work presented here is a pilot study extending a model that has only had limited empirical support in the AOD field (primarily from community services) to the context of residential TCs. There are also no long-term outcome or impact components to this approach which remains in its infancy. Indeed, we are still developing appropriate measures and mechanisms for assessing whether the project is effective and what its impact is on community capital, and so we cannot report on the impact on either residents or the local community. The information presented here is really preliminary application of a conceptual model that has met with significant support and enthusiasm from the staff and management of the

two participating Salvation Army TCs. There may also be questions about how the model piloted with the Salvation Army, who already have a range of community hubs and supports through church and community services, may be applied in other TC organisations, or indeed whether it is appropriate to call the participating services TCs (modified or otherwise).

There are, however, some important research and practice implications. In the two participating services, there are already strong community connections but these are often ad hoc and based on individuals who can move away or change roles. Developing effective, and evidence-based, strategies for linking to the community and for generating sustainable partnerships is something that is valued by staff and should be subject to systematic research into the effectiveness of re-entry activities and the longer-term recovery rates of residents, particularly those who choose to relocate to the local area. Longitudinal analyses of residential treatment effectiveness should, as part of the assessment of continuity of care, address the question of whether community integration or community isolation results in better long-term outcomes for residents.

The overall conclusion from this project is that there is considerable opportunity for residential Therapeutic Communities to play an active and significant role in their lived communities and to promote the growth of recovery capital in their residents by doing so. The project aims to reduce the trauma of the transition to community for TC residents going through the “re-entry” phase of treatment (and then subsequent discharge) by generating community connections and actively engaging with the local community. Both of the participating TCs are located in communities with significant needs and the approach here is that the TC – and its residents – have both an opportunity and an obligation – to be an active part in promoting the wellbeing of that lived community.

References

Best, D. (2014), Strengths, Support, Setbacks and Solutions, Pavilion Publishing, Brighton.

Best, D. and Laudet, A. (2010), “The potential of recovery capital”, RSA Projects, Royal Society for the Arts.

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Best, D. and Savic, M. (in press), “Substance use and offending: pathways to recovery”, in Sheehan, R. and

Ogloff, J. (Eds),Working within the Forensic Paradigm: Cross-Discipline Approaches for Policy and Practice,

Cambridge University Press, Cambridge.

DeLeon, G. (2000), The Therapeutic Community: Theory, Model and Method, Springer Publishing Company,

New York, NY.

Granfield, R. and Cloud, W. (2001), “Social context and natural recovery: the role of social capital in

overcoming drug-associated problems”, Substance Use and Misuse, Vol. 36, pp. 1543-70.

Groshkova, T., Best, D. and White, W. (2012), “The assessment of recovery capital: properties and

psychometrics of a measure of addiction recovery strengths”, Drug and Alcohol Review, Vol. 32 No. 2,

pp. 187-194.

Kretzmann, J. and McKnight, J. (1993), Building Communities from the Inside Out: A Path Towards Finding

and Mobilising a Community’s Assets, ABCD Institute, Evanston, IL.

Landale, S. and Best, D. (2013), “Dynamic shifts in social networks and normative values in recovery from an

offending and drug using lifestyle”, in Johnston, C.D. (Ed.), Social Capital: Theory, Measurement and

Outcomes, Nova Science Publishers Inc., New York, NY, pp. 219-36.

McKnight, J. and Block, P. (2009), The Abundant Community: Awakening the Power of Families and

Neighbourhoods, Berrett-Koehler Publishers, San Francisco, CA.

Putnam, R. (2000), Bowling alone: The collapse and revival of American community, Simon and Schuster,

New York, NY.

UK Drug Policy Commission (2010), Getting Serious About Stigma: The Problem with Stigmatising Drug

Users, UKDPC, London.

Vanderplasschen, W., Colpaert, K., Autrique, M., Rapp, R.C., Pearce, S., Broekaert, E. and Vandevelde, S.

(2013), “Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented

perspective”, The Scientific World Journal, doi:10.1155/2013/427817.

White, W. (2009), Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific

Evaluation, Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioural

Health and Mental Retardation Services, Chicago, IL.

Williams, A. (Ed.) (1999), “Introduction”, Therapeutic Landscapes: The Dynamics between Place and

Wellness, University Press of America, Lanham, MA, pp. 1-11.

Wilton, R. and DeVerteuil, G. (2006), “Spaces of sobriety/sites of power: examining social model alcohol

recovery programs as therapeutic landscapes”, Social Science and Medicine, Vol. 63, pp. 649-61.

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