Chapter 7

Recovery and Restorative Justice: Systems for Generating Social Justice

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Abstract

Theories underpinning restorative justice (RJ) overlap significantly with work around addiction recovery, in particular, the concept of "recovery capital". Whilst both movements are relatively new, RJ has a longer-standing history and a greater application in practice settings, yet both are inherently 'relational theories' and should be evaluated as such. There is great value in a comparative review of the concepts, assessing how the theories and practices align, as well as how each framework may inform the other. Granfield & Cloud (2001) have shown that recovery is enhanced by establishing previously non-existent social networks through building "social capital" to access support networks and resources in the community. Similarly, Zehr & Gohar (2002:23) posit that the third pillar of any legitimate RJ practice is a social process inclusive of dialogue and engagement with those who have a "legitimate interest or stake in the offense and its resolution". Elsewhere, Best et al. (2015) have argued that a key component of recovery theory is "community capital" and the importance of community attitudes/resources as a predictor of recovery longevity, a model that draws on Braithwaite's reintegrative shaming theory from the RJ discourse (Braithwaite, 1989). This chapter aims to advance thinking and the Volume's objectives of challenging the RJ field by suggesting that the common implication is that the effective implementation of these principles may facilitate the generation of a virtuous cycle enhancing the wellbeing of disputants and their communities and providing sustainable pathways to effective reintegration by building capital in communities and creating a 'therapeutic landscape' for restoration and rehabilitation.

Introduction

This chapter aims to contribute to the Volume's central objectives by providing an original, theoretical contribution that compares two related paradigms predicated upon similar principles: RJ and addiction recovery. We believe that whilst the parallels have been recognised, previous literature has not yet demonstrated clearly how they align and where they can learn from one another. Throughout the chapter, we focus upon the concept of community reintegration by arguing that, as adherents of Positive Criminology theory, this is where they most coherently parallel one another. Both seek to create positive social bonds, in which the wellbeing of all those involved, on micro (individual), meso (social/community), and macro (broader systems of social justice) levels (Gavrielides, 2015), are restored through the formation of a generative virtuous cycle, which creates resources to facilitate further positive change. We argue that RJ and Recovery Oriented Systems of Care (ROSC; Sheedy & Whitter, 2009; White, 2008) are ultimately "levers" that power individuals towards reintegrative forces, although it is ultimately wider societal structures (both meso and macro levels) that enables the full reintegration process to occur. We believe UK Restorative Cities (such as Hull and Leeds) are, arguably, a demonstration of this process functioning fully, generating community wellbeing and enhancing social justice by challenging exclusion and stigmatisation of marginalised groups who are attempting to reintegrate. We therefore suggest the construction of a "Recovery City", based upon the infrastructures, principles, and culture of "Restorative Cities".

The Paradigm Shifts: Human Potential within a Strengths-Based Genre

Recently there has been a paradigmatic shift that represents a recognition amongst scholars, researchers and practitioners that the Risk Need Responstivity (RNR) model of rehabilitation should be reshaped into the Good Lives Model (GLM) (Ronel & Segev, 2015; Gavrielides & Worth, 2015). Whilst both approaches are fundamentally rehabilitation focused, the RNR model is ultimately concerned with pathological deficits at biological, psychological and social levels, and focus on individual, rather than contextual factors whilst the GLM is positive, holistic, and restorative (Gavrielides & Worth, 2015). In the criminal justice field, the GLM is often associated with the positive criminology school yet it extends to other domains, such as psychology (Seligman, 1998) and recovery (Best & Laudet, 2010) with authors demonstrating that the model is a vehice to enable these distinct but related disciplines to enrich one-another (Vyver et al, 2015; Gavrielides & Worth). Maruna and Lebel (2015) distinguish between risks-based, needs-based, and strengths-based strategies to prisoners within the prison re-entry context. Risks-based approaches are typically associated with managing behaviours as well as broader recidivism rates, whilst needs-based approaches are associated with helping prisoners gain independence through treatment enforcement, yet both assign control, restrictions, and management to offenders and their behaviours and thus fit better under the RNR umbrella (Maruna & LeBel, 2015). Conversely, rooted in a humanistic school,

a strengths-based approach implements a restorative ideology, treating prisoners as individuals with talents, abilities, and indeed strengths, and as valued members of the community to which they can make a positive contribution (Maruna & LeBel, 2015). There are complexities to this analysis, as some scholars from the RNR school posit that the model is in fact stengths-based (Andrews Bonta & Wormith (2011) cited in Gavrielides & Worth, 2015), however, more commonly, a strengths based approach is associated with the GLM, whereby a positive starting point is thought to bring about better results and less harm to those that come in contact with social, legal, or justice institutions or interventions (Ronel, 2015). It thus looks to engender social justice for individuals, families, as well as broader communities and cultures. These approaches form key themes of this chapter.

Addiction Recovery

In line with this broad paradigmatic shift, there has recently been a theoretical and practical shift within the alcohol and other drugs (AOD) recovery domain, which has reconsidered both the parameters and possibilities of addiction recovery. Until recently, addiction was framed as weakness of the will and body, rooted in human pathology, occurring at brain level as a chronic relapsing brain disease (White, 2007). Consequently, many intervention approaches were rooted in the RNR school by being "problem and treatment" driven (Chen & Gueta, 2015: 221) with low aspirations, assuming both the powerlessness of the addict and the central role of experts for deploying psychological and pharmacological therapies (Best & Savic, 2015). The premise was a need to correct human flaws through deficit and clinical-based intervention models, in which professionals handled addiction as if it were a genetic disease, implying that recovery is a difficult (if not impossible) state to achieve (White et al., 2003; White, 2007). Empirical evidence has emerged challenging the disease model by demonstrating that, on average, over half of AOD addicts will recover from addiction (White, 2012; Sheedy & Whitter, 2009), many without clinical interventions. As studies continue to show high rates of recovery, the implication is that addiction recovery must be something beyond a diseased-based pathology of the mind, if not at the point of onset then certainly through the process of resolution.

To help explain these trends, the "recovery capital" model has been developed. Recovery capital has been defined as the "sum of resources necessary to initiate and sustain recovery from substance misuse" (Best & Laudet, 2010:2), which can be accumulated and/or exhausted when attempting cessation (Granfield & Cloud, 2001; Cloud & Granfield, 2009, Best & Laudet, 2010). The model has been used to illustrate how (theoretically and empirically) individuals are able to garner the resources needed to support them in their recovery (Best, 2012; Granfield & Cloud, 2001; Cloud & Granfield, 2009). Recovery capital represents a significant shift in rhetoric; instead of characterising addiction as a disease within a negative clinical doctrine, recovery becomes a strengths-building exercise. This has given the discipline new found optimism, with similar effects on family members, professionals engaged in recovery support and the wider public through hope-based narratives. Whilst the recovery capital model has been ground-breaking for transferring AOD addiction recovery into a positive, strengths-based arena, it is also predicated on the idea of something that can be measured and counted and that is open to rigorous testing (Groshkova et al, 2013; Best & Laudet, 2010). This also creates a framework for translating ideas of recovery capital to clinical practice as a 'currency' that can be measured and improved. As the discipline moves from a disease-based conceptualisation, the relational (social and community) aspects of recovery capital continue to be emphasised, with evidence strongly indicating that access to these dimensions make individuals better placed to overcome addiction (Best & Laudet, 2010). As a method for assessing wellbeing, recovery capital also provides opportunities for bridging beyond specialist treatment care contexts, supporting the movement away from professional and medicine-based interventions and settings into strength-building, community and social driven, models for supporting and sustaining addiction recovery (McKnight & Block, 2010; Humphreys, 2004). In other words, the transition to a strengths-based model through the capital framework removes the medicalisation of recovery and bolsters the relational components of recovery.

Restorative Justice and Restorative Practices

Whilst not limited to the criminal justice (CJ) field (Liebmann, 2015), RJ has most commonly found itself developing new ideologies and related practices within offender, victim and community harm resolution (Bazemore & Walgrave, 1999; Huang et al., 2011). Although there is no single definition of RJ, with experts struggling to form a consensus upon this (Llewellyn et al., 2013), Zehr & Gohar (2002:40) define RJ as: "a process to involve those who have a stake in a specific offense to collectively identify and address harms, needs and obligations in order to heal and put things as right as possible". RJ is therefore a holistic and collective process, which relies upon experience with the broader community, although intrinsically interpersonal and predicated on assumptions of de-professionalisation and a commitment to social justice. RJ is as much a system of ideals and principles underlying practices than a system of practices themselves; it is, as Gavrieldes has articulated, an 'ethos.'

(Gavrielides, 2007, p. 139; Gavrieldes, 2014). Whilst 'modern' RJ set it roots in CJ, and it is within that milieu that it has had global application (Gavrieldes, 2014; 2005), RJ lends itself to translation into other contexts, as we demonstrate. We do not set out to align either with those who argue for a purist approach to RJ (McCold, 2000), nor with those who argue for a wider application, e.g. Walgrave's (2000) 'maximalist'. Rather, we posit that RJ is a single contextual application of restorative principles, and that those - and thus its - underlying prinicples have broader application.

RJ has led to a refocusing upon reintegration, recidivism, and validation within the justice process (as opposed to punishment, shame, and depreciation) (Braithwaite & Mugford, 1994), and so to greater openness, community ownership, and accessibility to justice practices. RJ theory assumes that offenders hold potential to heal "those who have a stake in the offence" (Zehr & Gohar, 2002: 4); they are able to put right, repair harm, and make up for wrongdoing. This has changed the narratives associated with offenders; they become individuals with capabilities, abilities, and no longer innately 'bad' or atomistic people (Llewellyn et al., 2013). This creates a possible transformation of the CJ field itself into a strengths-based genre, a paradigmatic shift that resembles the AOD recovery doctrine (Braithwaite, 1989; Zehr & Gohar, 2002; Braithwaite & Mugford, 1994). This has implications for professional-service user relationships and status, for locus of power and control, and for assessing and interpreting impact and effectiveness of the justice process. Both paradigms offer an egalitarian approach in which those who had previously been labelled as problematic individuals to whom things are done, become individuals with strengths and capabilities able to flourish under positive circumstances, and who are empowered to do so. There is a further drive towards self-determination shaped by prosocial activities shaping reparation and community re-engagement. Both on theoretical and practical levels, RJ and recovery have embraced interpersonal change as an intrapersonal, holistic, and relational phenomenon (Llewellyn et al., 2013; Best & Laudet, 2010) and they rely upon mechanisms within broader communities to leverage change at a personal level by providing forums in which positive change is made a reality through strengths-building exercises.

Recovery and Restorative Justice as Relational Theories

As ROSC (Sheedy & Whitter, 2009; White, 2008) are founded upon social and community predicators, abstinence is not considered the only or even necessarily the primary goal of care (Best & Laudet, 2010; Granfield & Cloud, 2001). Newer care models consider success within life-course perspectives to include health and wellbeing, social networks, employment, finance (Wittouck et al., 2013) education and training, mental and/or physical health, relationships, criminal justice, social engagement and meaningful activities, and these are personally articulated (Manning et al., 2016; Savic et al., 2014; Laudet et al., 2009; Kodner & Kyriacou, 2000). Recovery is further seen as a process rather than a state (and one which typically takes around five years expecting that these objectives will not only differ between people, but will also change over the course of a recovery journey) (Betty Ford Institute Consensus Group, 2007). The underpinning assumption is akin to Maslow's (1943) Hierarchy of Needs in which the achievement of lower order objectives generates the capacity to aim higher for more complex aspirational goals.

In the same way, RJ's measurement parameters move beyond traditional CJ analyses, by considering community, subculture, and relationship successes (Llewellyn et al., 2013) as well as democracy building (Braithwaite, 2016). Llewellyn (2013) has argued that this creates challenges for evaluation and comparative assessment, as it is much more difficult to demonstrate effects and indeed causes when the desired outcomes involve relationships and community level domains such as safety and connectedness. As the relational components are emphasised, experts have applied the notion of "social capital" to the recovery domain (Bourdieu, 1986; Coleman, 1988, Putman, 2000; Granfield & Cloud, 2001; Best et al., 2016). Relationships are valuable assets for initiating recovery success and the model provides a lens for examining both the positive/negative roles that social networks play in enabling/disabling recovery (Granfield & Cloud, 2001; Best et al., 2016). The "capital" aspect of the model refers to a dynamic process of exchanging social networks, bolstering motivation to change, and building capacity to inaugurate recovery through social control/networks, mutual acquaintances, family support, group membership and expectations of others (Granfield & Cloud, 2001; Cloud & Granfield, 2008; Best, 2016). In other words, social capital refers both to the sum of groups and networks that individuals can call upon and to the extent of their bind and commitment to those groups. Within the recovery literature, there is an assumption that accessing prosocial groups generates social recovery capital by creating models for 'social learning' and through the norms and values of the group referred as 'social control' (Moos, 2007). Indeed, recovery chances are enhanced when addicts engage in social networks concordant with a non-using lifestyle with the literature showing that those with a stake in "conventional" life have greater capacity to control drug use (Blomqvist, 2002; Murphy & Rosenbaum, 1999; Granfield & Cloud, 2001).

Granfield & Cloud (2001: 1545) first explored this idea by evidencing that individuals leading a "double life" with a "stake" in the non-drug using world had higher chances of natural recovery success. Possession of "conventional" social assets, which generally referred to preservation of employment, financial security, relationships, information, expectations, institutions and lifestyle) were maintained alongside associations with alternative drug-using cultures (Granfield & Cloud, 2001). Individuals embedded in networks comprising of norms, values and rationales consistent with a using lifestyle were likely to adopt negative behaviours (Granfield & Cloud, 2001). Litt and colleagues used the 'gold standard' of randomised controlled methods, to evaluate 187 individuals going through either: i) standard aftercare; or ii) aftercare with a social support component (establishing a relationship with a non-drinking peer) (Litt et al., 2007). The researchers found that those with social capital derived from new prosocial network engagement (condition 2) had a 27% higher chance of increasing abstinence one year later in comparison to those administered standard aftercare (condition 1) (Litt et al., 2007). Likewise, Longabaugh et al. (2010) reported that the strongest predictor of long-term recovery stability, in a cohort of problem drinkers, was successfully making the transition from a social network supportive of drinking to a social network supportive of recovery. Elsewhere, research shows that social capital is strengthened via exposure to social networks/communities that hold positive values/attitudes/beliefs, which strengthen control capacity and social connectedness (Buckingham, Frings, & Albery, 2013; Best, Bird & Hunton, 2015; Granfield & Cloud, 2001; Best 2014). Best et al. (2008) demonstrated that ex-heroin addicts remained clean due to movement away from using networks into non-using recovery circles, and that while psychological change and life experience may have been the catalyst for initial change, it was a combination of social factors that were most strongly associated with sustained abstinent recovery over time.

These studies each imply that overcoming addiction strongly correlates to social context and the existence of social recovery capital, generated by moving from excluded groups (who have limited access to community resources), towards prosocial groups (who can provide not only practical support and resources but also access to knowledge and information about the local community). Recovery positive group membership is crucial, as positive social platforms facilitate social contagion in which norms, values and culture are spread through social control, social learning (Moos, 2007), reciprocity, connectedness, acquaintances, emotional support, expectations and obligations (Best et al., 2015). One possible mechanism is around social identity encapsulated by the Social Identity Model of Recovery (SIMOR; Best et al., 2015), which suggests that access to prosocial groups offer attractive and viable models of recovery, engage and motivate change, and promote recovery success. It also exposes individuals to new values and group norms that bind them to the group and in doing so they internalise the rules and behaviours of the group. What is important about social capital is the emphasis upon the relational aspect of recovery capital formation, which is also central to RJ. Restorative conferencing acts as: i) family group conferences; ii) victim-offender meetings; iii) neighbourhood accountability boards and; iv) peace-making circles (Bazemore & Umbriet, 2001). RJ processes rely upon a joint dialogue between stakeholders (Zehr and Gohar, 2002), which builds trust and reciprocity (Bazemore, 2005). Bazemore (2005:136) considers restorative processes as "forums for community members to share and affirm norms and values as means of developing social cohesion" in a model that mirrors aspects of SIMOR. Similarly, Braithwaite (2000) defines RJ as multi-sectorial processes that bring together victims, offenders, friends, loved ones, and representatives of the state. Llewellyn et al. (2013) argue that RJ should be considered in terms such as "equality of relationship" parameters, such as, mutual care, concern, respect and dignity (Llewellyn et al., 2013). The relational aspect is the cornerstone of both systems.

Perhaps the best practical examples to illustrate relational components of these processes are recovery 12-step fellowships such as AA and Narcotics Anonymous (NA) (AA, 1943; NA, 1992; Kaskutas, 2009) and circles of support and accountability (COSA; Thomas et al., 2014). During fellowship meetings, a circle is formed around the recovering addicts, and each individual in turn becomes the core member. Individuals are given the opportunity to discuss progress, failures, and successes to a wider pool of members, within 12 steps and 12 principles, and a structured meeting format. AA meetings are both open and closed (the former open to anyone but the latter restricted to members) and meetings that are dedicated to particular groups (e.g. women, young people, addicted doctors) and for particular purposes (such as 'Big Book' meetings, where there are readings from the key text of the organisation). COSA (a circle model that operates RJ principles) has been widely applied in the UK, for example, with sex offenders attempting to rehabilitate (Thomas et al., 2014) in which the offender also becomes the core member of a supportive circle and members collaborate to discuss strategies for prevention of further sexual offending. Many of the group will be volunteers, although professionals may also be included in the circle, as well as a coordinator for the meetings. In both cases, positioning the individual at the centre of a generative circle facilitates construction of meaningful relationships and positive social ties with other stakeholders to oversee sustainable prosocial behaviour (whether that is relationship building, desistance, recovery, or something broader). Both models are concerned with "making good", a concept affiliated with the desistance paradigm (Maruna, 2001; Maruna & LeBel, 2015). Within RJ processes (such as COSA) "offenders' obligations are to make things right as much as possible" (Zehr, 2003: 83); for instance, through apology, change and restitution (Umbreit

& Roberts, 1996; Walker, 2015). Similarly, within fellowships, Steps 8 and 9 state: "made a list of all persons we had harmed, and begin to make amends to them all" and "make direct amends to such people wherever possible, except when to do so would injure them or others" (Alcoholics Anonymous, 1939). "Making good" bolsters social reintegration and strengthens social capital ties within both examples through the broader relational dimension (Maruna & LeBel, 2015). It is clear that both models assume that change strategies extend beyond individual choices/incentives, require the fullness of a wider pool of social resources and, therefore, establish practical responses where recovery/restoration can be contextually negotiated. If strong empirical research suggests social capital impacts practical outputs within recovery groups (Best et al., 2015), similar conclusions can be applied to RJ platforms, given their theoretical, practical, and methodological similarities.

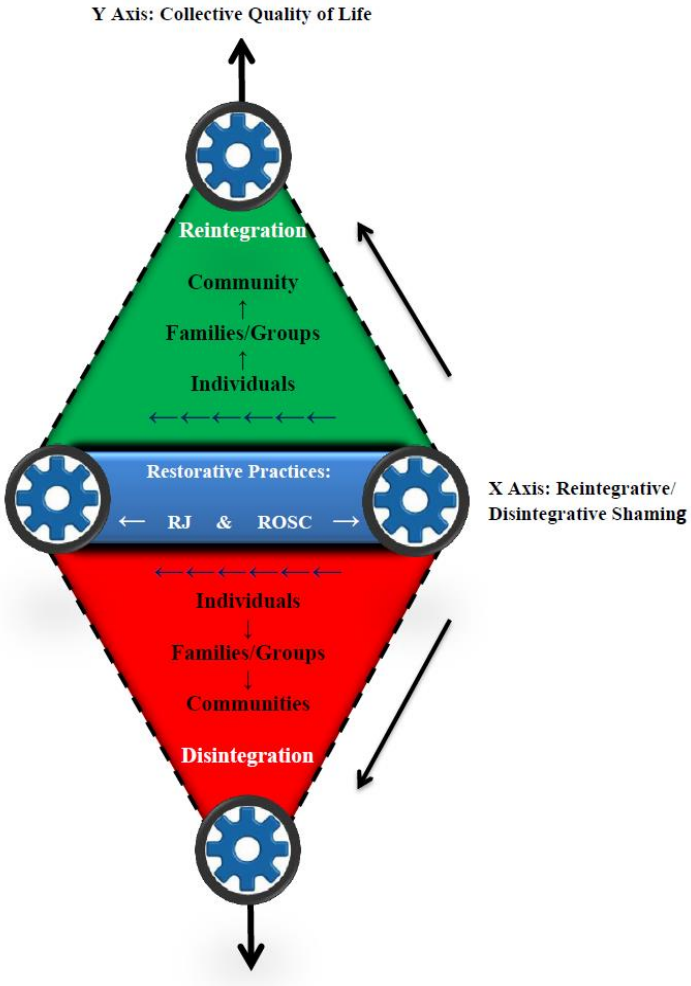
Extension of the Relational Component: Community Capital and Reintegrative Shaming

Common characteristics between recovery and RJ paradigms are most salient within discussions around stigma and exclusion and the resulting pressures individuals face when attempting to reintegrate and access resources within their local community (Best & Laudet, 2010). Ideas around reintegration can be found within recovery's "community capital" model and RJ's "reintegrative shaming" theory respectively (Best & Laudet, 2010; Braithwaite, 1989). In the former, recovery groups themselves can be characterised as a mechanism for building social capital whilst enabling and facilitating access to community resources. The latter focuses on the ritual processes of reintegrating individuals following sentencing or punishment to ensure that they are enmeshed within society. In both cases, it is assumed that: i) the community responses to the offender can expedite reintegration by creating bridges into non-stigmatised groups, or that; ii) community attitudes can debilitate reintegration through stigma and discrimination leading to exclusion by prolonging stigmatising labels, processes, and structures. In this sense, both discourses sit within Positive Criminology theory, which is concerned with how positively construed reintegrative experiences help to generate prosocial behaviours (whether that be in context of the addict or the offender) (Ronel, Frid, & Timor, 2013). We argue that therefore recovery and RJ overlap within their discussions around reintegration. Best & Lubman (2016) explore the "dark side" of social contexts, indicating that social ties are not inherently positive/pro-social forces and may entice drug-using behaviours through isolation from positive networks. This builds on work with homeless populations in Australia by Jetten et al. (2014) in which it was argued that strong binding ties to excluded populations could act as barriers to effective reintegration in spite of the benefits they may confer in terms of a sense of belonging and wellbeing. Similarly, in a study of members of an Australian therapeutic community, Dingle and colleagues (2015) found that maintaining social identification with a substance using population even whilst engaged in recovery oriented activities resulted in poorer outcomes. Putman's (2000) differentiation between "bridging" and "bonding" capital is relevant; whilst "bonding" capital refers to the quality/intensity of relationships (positive or negative), "bridging" capital refers to connections ("bridges") to wider positive community structures (Putman, 2000). Strongly bound marginalised groups may be highly valued by members yet act as barriers to reintegration through their exclusion from community capital and a lack of bridges to community resources.

This "bridging" synergy has been most famously demonstrated by McNeill's (2016) tripartite model, building on Maruna & Farrall's (2004) earlier articulation of primary and secondary desistance, in which the tertiary stage of desistance from offending involves community acceptance. Within this approach, change relies on the acceptance of the immediate social networks such as family but also the absence of structural barriers to key community resources such as housing, jobs and positive relationships. In the recovery field, this idea was first applied in Cloud and Granfield's (2009) cultural capital concept, and was adapted latterly into Best & Laudet's (2010) three-pronged recovery capital model (which included personal, social and collective) (See Figure 1). It is within the latter part of the model which Best and colleagues (2016) have demonstrated the significance of community attitudes for igniting the process of reintegration. By extending to wider community structures/attitudes, "capital" becomes a powerful force in which entrenched community stigma impacts reintegrative efforts with the expectation that it impedes individual recovery progress and the viability, visibility and accessibility of recovery groups (Best, Bird, & Hunton, 2015). Treatment outcomes are more positive for those who are able to overcome stigma by accessing community capital, augmenting their "recovery" identity through participation in meaningful activities and social groups that have the most positive recovery outcomes (Best et al., 2014; Best et al., 2011; Zywiak et al. 2009). In the Glasgow Recovery Study (Best et al., 2011), the strongest predictors of higher levels of recovery wellbeing were predicted by social capital (time spent with others in recovery) and community capital (being able to access meaningful activities such as work, education and volunteering). The World Health Organisation (2001) found drug addiction to be the most stigmatised health condition across the globe, with alcohol addiction the fourth most stigmatised.

Braithwaite (1989) provided an explanation for RJ's effectiveness within his reintegrative shaming theory (Ray et al., 2011; Harris, 2006)**.** Braithwaite separates "reintegration" from "disintegration" as a shame management tool within CJ systems (Braithwaite & Mugford, 1994; Braithwaite, 1989; Zehr & Gohar, 2002). Reintegrative shaming processes (such as RJ) ritually reaccept offenders by directing shame towards the act rather than offender, whilst disintegrative shaming (i.e., "typical" CJ practices) outcast individuals through spirals of shame so perpetrators internalise "offender" as their master status (Braithwaite, 1989). As reintegration becomes the locus of the restoration process, RJ therefore intends to strengthen support within communities (Braithwaite, 1989). What is important is that the factors are structural rather than individual, indicating the importance of community level processes, and their role in creating the environments that can facilitate bridging capital to positive groups with the resulting impact on personal resources and wellbeing. Reintegrative shaming ceremonies, such as RJ, rely upon two structures: a) presence of individuals to support the offender (social capital) and; b) confrontation within a wider pool of individuals from the community to enable reintegration via positive shaming (community capital) (Brathwaite & Mugford, 1994). However, they also provide 'bridges' to communities and professionals, and mechanisms for managing exclusion and the adverse consequences of stigmatisation. The core synthesis of the above reflections on recovery and reintegration capital is summarised in the figure below in which the personal, social and community aspects of capital are linked and RJ and ROSC involve organisational and structural requirements at a locality level.

A Gear System Model to Represent Reintegration and Future Directions



The "restoration" process is therefore equally applicable to RJ and ROSC, and both can be thus considered "restorative practices". Both re-establish a connection between perpetrating individuals and close relationships such as family (on micro level) and the wider community (on meso level) by representing a broader change in belief system (on macro level), thus creating a virtuous cycle in the form of a therapeutic landscape (see Figure 2) (Llewellyn et at, 2013). Restorative practices themselves operate as gears on the X Axis that power individuals

toward reintegration or disintegration via the shaming process, generating positive (reintegrative) or negative (disintegrative) power. However, it is ultimately the wider community that provides the structure and the space to harness the powers initiated by the gears, making reintegration (or disintegration) a reality. In other words, reintegration occurs through a reciprocal relationship with the community, which reaccepts the individual and by doing so, strengthens itself. As the X Axis produces positive energy (though reintegrative shaming), the micro, meso and macro levels rise, creating a virtuous cycle of social justice at systems level. This is represented by the Y Axis, which enhances (or diminishes) quality of life on a collective level, reflected by the anti-clockwise rotation and generation of the green triangle. If the X Axis produces negative (disintegrative) energy, the power draws down and quality of life on the Y Axis also drops, reflected by the clockwise rotation and generation of the red triangle. As the power rises or drops, the effect is felt at rising (or falling) levels from the individual (micro) to families and community levels (meso) and to a broader culture of social justice (macro). Whilst restorative practices (represented by the gears on the middle band) are crucial for generating restoration, they have limited power when practiced in isolation. Instead, they reach full capacity when drawing upon assets (or gears) found within wider communities, a change that must be reflected at policy level. Embedding restorative practices into policy, as the UK has done with recovery (UKDPC, 2008), is a critical step which must be sustained in order to enhance the power of the system.

The virtuous cycle has the potential to grow, strengthen, and gain power as success at all levels continues during this cumulative healing process, and to make communities more inclusive by minimising marginalisation of sub-groups. As more participants are engaged, active and empowered by RJ/ROSC methods and accepted into the wider community, it becomes a functioning reintegration platform, bolstering quality of life collectively. As the process repeats itself, the community gets stronger, and so do the individuals within it including (but not limited) to those being reaccepted. Continued movement up the Y axis increasingly bolsters overall quality of life for those both within and outside of RJ/ROSC through the networks of inclusion and support from community members, professionals and peer champions of recovery and RJ. However, the reversal of this process moves downwards on the Y axis, creating a negative cycle for each of the micro-meso-macro dimensions. The idea of the figure is that there is a constant tension between the pressures towards punishment and exclusion, often driven by community fears and populist political rhetoric on the one hand, and the commitments to neighbourhood, social justice and inclusion on the other. In principle, this is an empirically testable question around structures and systems linked to community attitudes and beliefs about reintegration, and their effects on individual attempts at doing so. The diagram further depicts the idea that RJ and recovery should be understood and measured in terms of its relational component and as a broad experience that relies upon restoration or relationship building with the community, rather than simply individual visions of success, or prosperity on a smaller scale (Llewellyn et al., 2013).

Best & Laudet (2010) posit that community recovery capital includes the visibility, accessibility and acceptability of recovery groups. When recovery groups are seen as valuable in the community, when the champions of recovery are visible, and when they are linked to a diverse range of community resources, the space can be characterised as a "therapeutic landscape for recovery" (Wilton & DeVerteuil, 2006). The idea is that spaces can be transformed to accept and engage with recovery groups/communities, and this is an emerging property of community life (not only for those in recovery but also for the broader community). This is something which accumulates over time, increasing the likelihood that future generations will consider it viable and realistic. The gear model implements this idea by characterising the positive or negative impetus to reintegration that results from the implementation and visibility of these processes. The system level creates the space for individual growth and relational development through providing access to assets in the community, to visible and positively valued recovery and reintegration groups, and to role models of successful change.

The idea of a therapeutic landscape has already been implemented with success in the recovery sphere within the Asset Based Community Development model (ABCD; McKnight & Block, 2010; Kretzmann & McKnight, 1990). ABCD is a mechanism for identifying positive assets in the community, creating links to them and deploying community assets to support the recovery journeys and pathways of individuals who had previously been excluded and marginalised. It works by identifying indigenous community resources (community capital) and linking them together to create support networks for vulnerable individuals (social capital). By looking inwards to their own assets, such as, people, informal groups, and formal organisations (who represent community capital) networks of community resources and recovery champions are created and held together by local people who already have established links and connections to wider community groups, who then act as “community connectors” (generating bridging capital) (McKnight & Block, 2010; Putman, 2000). Our own work in Sheffield around identifying the levels of social capital of drug and alcohol users to determine the extent to which they will need assertive linkage to community assets (Best et al., 2016) is an attempt to utilise asset models to target community partnerships to support recovery and, in doing so, to encourage recovering individuals to make active

and sustained contributions to their lived communities. It is important that the group does not work in isolation but instead engages with wider community networks to facilitate reintegration. As Best et al. (2016a) have shown, this is a model that energises communities by activating their resources through supporting the growth of connectors, improving the opportunities and wellbeing for excluded groups, and increasing the pool of those who are active champions. As depicted in the figure, as this process repeats, the power of the community becomes stronger, thereby producing the virtuous cycle.

In many ways, RJ has already developed a piecemeal approach to this process through development of Restorative Cities, both in the UK and internationally. Over the past decade, Restorative Cities have developed although their definitions tend to be more amalgamations of intangible principles than tangible criteria. Hull in the UK marks the world's first ever Restorative City (Macdonald, 2012; Green et al., 2013), and was developed as a vision to create "social and economic restoration of an entire city" by extending beyond resolution of individual harms (Green et al, 2013). The aim was for restorative language to have a commonplace, not only in justice settings, but also in social services, education contexts, thus providing families, children, young people and communities with the appropriate tools for resolving problems and conflicts in everyday life (Green et al., 2013). In the UK, Restorative Cities have since been extended to Leeds (Wachtel, 2012), also aiming to use models that shares "'power' across communities and with families" so that solutions lie within broader relational dimensions (Finnis, 2014). Again "restorative" values have extended beyond the CJ sector by changing attitudes as well as behaviours (Finnis, 2014), representing a broader change in culture. Another more quantifiable approach comes from a recent proposal put forward by The Institute for the Future, which provides a futuristic model for Oakland, California also with the purpose of creating their city as a Restorative City. The rationale was to provide a service of peace centred on RJ principles to move away from a culture of punitivism and the associated stigma brought to offenders. The authors provided a map as “an attempt to reimagine the urban landscape through a restorative lens, bringing people out of prisons and the criminal economy, into productive and useful work in the service of their own communities” (Ross, 2016). The proposed model has been premised upon seven basic principles: i) healing the city; ii) community-focus; iii) listening; iv) food sovereignty; v) positive contact, and vi) environmental justice. Most significant to each of these three cities is a change is culture around social justice by embodying a new way of thinking. In turn, this generates sustainable reintegration for individuals passing through RJ models as a more accepting broader community premised upon an egalitarian philosophy.

We propose the piloting of Recovery Cities to enhance the reintegration journeys for those in recovery, based on the same ideology around activating social justice. Changes in systems and processes at community level would increase active engagement with marginalised groups through the promotion of recovery groups and communities and their engagement with a diverse range of community assets. However, the broader objective of this model is to create social and community capital to kickstart a contagion of connection and participation by a wide range of stakeholders who sign up to the Recovery Cities model. The proposed model adapts features from the ROSC, and parallels the Restorative Cities model by providing a community space in which recovering individuals can be supported in an equal way to RJ participants within Restorative Cities. We believe that Sheffield should be construed under this title, as it contains a group of active researchers attempting to engage individuals in recovery, a range of ROSC based around relational principles, and is increasingly breaking down the stigma attached to addicts from the overly-medicalised model. That is no reason not to look to Restorative Cities to provide an outline of what a recovery city would be; indeed, the very opposite is true. As with Restorative Cities, we suggest that Recovery Cities are more about culture and ethos than specific guidelines processes, with the latter being merely the manifestations of the former within the context and confines of the given community. However, what is important is to recognise that these cities might provide the fundamental gear that reintegrates individuals in recovery through stigma management and community reacceptance, which research strongly demonstrates is the cornerstone of any recovery journey.

Conclusion

As the history of, principles underlying, and debates concerning RJ are extensively discussed throughout the other chapters of this Volume, our intention was to bring the readers up-to-date with the recovery literature by giving a comprehensive overview of its newer, older, and more contensted areas. Furtheremore, we aimed to show how its growth has been co-occuring with RJ, as the two align to one another by virtue of: i) their strengths-based approaches and their positive reconceptualization of ‘deviant’ individuals; ii) their holistic outlook on success indicators iii) the significance of the relational component and the importance of considering outcomes at the level of networks, relationships and communities, and; iv) their similar ideologies around reintegration/disintegration.

Even where they are not overlapping, the scaffolding that supports both RJ and recovery processes share many elements making the theoretical borders between them blur, or rather, interlock. The gear model depicts a

cumulative process, which gains power as the process repeats itself and the community gets stronger. Each of the "micro", "meso" and "macro" components can be seen as gears that power the full restoration process but as soon as one cog stops working, so do the others. As the paradigm shift within the addiction recovery domain gains momentum, we posit that both RJ and ROSC facilitate a reciprocal relationship between the gears, generating a virtuous cycle that enables full restoration for the individual, families, and the community, and a broad change in culture. This is a mechanism and model for generating community participation by marginalised populations through creating social and community capital from which the entire community will benefit as a result of increased community cohesion and improved social integration (Sampson & Laub, 2003). It is at the level of community that RJ and recovery efforts create the pathway to reintegration, and according to both desistance and recovery theories, there can be no full recovery or restoration without reacceptance from the community. This chapter has therefore proposed a unique model to integrate principles of RJ and addiction recovery, looking at the practices through new lenses to support innovation.

We posit that reintegration is equally foundational to both type of restorative practice, and, thus, that these platforms must work with the community to improve and enhance both the private and public good through this virtuous cycle. Reintegration by definition necessitates community action and involvement. Community involvement, in turn, is constructed on the scaffolding of the structure and ethos of the organisational components of the community, i.e., the governing, social support, economic and ecological systems. Stated differently, effective reintegration, which we have argued is the hub of the restorative and recovery-focused action, has as a predicate part the existence of strong community capital. The aims of reintegrative communities are about improving community cohesion for all not only targeting those who are marginalised and excluded. Best and colleagues (2015) reciprocal community development concept illustrates the process and value of it, and is based on the idea that vulnerable groups should not only tap into the assets in communities through linkage but should engage in a Hobbesian social contract by ensuring that they have a commitment to giving back and enhancing existing assets as part of the process of engagement. These well researched principles help also explain the workings of reintegrative shaming theory within RJ, and create a model for improving the attractiveness of engagement to the wider community. Furthermore, bringing these paradigms together creates a strong partnership, whereby research, theory and practice can be fine-tuned through mutual acquaintance across the disciplines.

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