



## Let's celebrate recovery. Inclusive Cities working together to support social cohesion

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## **Let's celebrate recovery**

### **Inclusive Cities working together to support social cohesion**

#### **Abstract**

Recovery from illicit drug and alcohol use takes place over time and is characterized by a dynamic interaction between internal and external components. An integral part of all recovery journeys is effective community reintegration. After all, recovery is not mainly an issue of personal motivation rather it is about acceptance by family, by friends and by a range of organisations and professionals across the community. Therefore to support pathways to recovery, structural and contextual endeavours are needed to supplement individually-oriented interventions and programmes. One way to do this, is by introducing and promoting Inclusive Cities. An Inclusive City promotes participation, inclusion, full and equal citizenship to all her citizens, including those in recovery, based on the idea of community capital. The aim of building recovery capital at a community level through connections and 'linking social capital' to challenge stigmatisation and exclusion is seen as central to this idea. Inclusive Cities is an initiative to support the creation of Recovery-Oriented Systems of Care at a city level, that starts with but extends beyond substance using populations. This paper describes (and gives examples of) how it is possible to use recovery as a starting point for generating social inclusion, challenging the marginalisation of other excluded populations as well by building community connections.

## **Introduction**

### ***Overview***

Recovery from illicit drug and alcohol use is mostly defined as a process, with the Betty Ford Institute Consensus Group estimating that this process takes on average around five years before an individual reaches 'stable recovery' (Betty Ford Institute, 2007). This process is unique to every individual, but in general it could be regarded as a non-linear, gradual, multidimensional process that involves growth in connectedness, hope, positive identity, meaning and empowerment (Leamy et al, 2011). Recovery does however not happen in a vacuum. Instead, it should be considered as a social process of community integration.

The framework of recovery as a social process is explored in this paper to assess how the development of recovery systems and communities can have a wider social justice impact in addressing exclusion and stigmatisation. The main goal of the paper is to raise the idea of developing and promoting Inclusive cities. It will lay out the basics of how such an Inclusive City may look like and consider what lessons can be learned from existing recovery systems and processes that may point the way to a more ambitious approach to Inclusive Cities.

This paper starts with reflecting on the evidence base around recovery to assess the role of the community to promote and facilitate (stable) recovery. While the community could be central to recovery by building and strengthening bridges between excluded and non-excluded groups, this community could also act as a barrier to recovery, arising from the discrimination, stigmatization and exclusion towards people who use drugs through the imposition or retention of structural barriers such as legal checks and exclusions of those on certain types of treatment and medication. This paper will touch upon these barriers before describing what a recovery system looks like. Furthermore, it will explore, using case study examples, how this might impact on the inclusion and reintegration of people in recovery. To conclude, we argue that this might ultimately impact a broader range of excluded and vulnerable groups, starting with people in both recovery from drug use and desistance from offending, and using the successes with these groups to extend the impact to a wider range of populations.

### ***Recovery meaning and recovery capital***

Recovery can be characterised as a dynamic interaction between internal and external elements, consisting of personal, social and community factors. In this regard, an emerging body of research has been dedicated to the concept of 'recovery capital' (Granfield & Cloud, 2001; Best & Laudet,

2010). Based on the idea of recovery capital, White and Cloud (2008) developed a threefold recovery capital model consisting of a range of personal, social and community resources that facilitate recovery. 'Personal recovery capital' consists of physical capital such as health, financial assets, housing and human capital such as educational/vocational skills, self-esteem, perception of one's past/present/future, sense of meaning and purpose in life. 'Social recovery capital' includes supportive and prosocial relationships with family or friends. 'Community recovery capital' refers to the attitudes and perceptions of community and policy related to recovery (-oriented initiatives) and encompasses initiatives to reduce recovery-related stigma or the availability of support and treatment in local communities. In this paper, community applies in two senses - the first, geographic, relating to the lived environment for vulnerable groups; the second, based on networks and so potentially including online groups, but also memberships such as 12-step groups and church involvement.

These three types of recovery capital interact to promote and support initiating and sustaining recovery. Research indicates that higher degrees of recovery capital contribute better to recovery stability and progression than the availability of less capital (Laudet & White, 2008). Some researchers focus on the individual needs related to recovery capital and the stage of their recovery process i.e. early stage versus later stage of recovery (Laudet & White, 2008)., In this way, some recovery capital resources supporting initiation may not apply to support its continuity (Best et al, 2015). While personal and social recovery capital seems necessary to initiate recovery, the role of the (wider) community is crucial in providing opportunities to sustain recovery (Best et al., 2015). In fact, although recovery is a personal journey, it occurs within a social context. As such, effective community reintegration is an integral part of all successful recovery journeys: social structures, such as employment, housing, education have to be configured in such a way that the individual is afforded the opportunities to complete the reintegration process. This is central to our current argument about community recovery capital.

### **The role of the community in recovery: recovery as a relational process**

Best et al. (2008) found that sustaining recovery is strongly predicted by shifts in social networks i.e. a transition from a network supportive of using drugs to a recovery-supporting network. This gives rise to the suggestion that sustaining recovery may be about social and community processes and factors, and that accessing supportive and visible role models may play a vital role in persuading individuals that the struggle to attempt recovery is worthwhile (Moos, 2007; Best et al., 2015). The idea of group memberships that relate to sustaining recovery (Dingle et al., 2015), has been derived from the Social Identity Theory (Tajfel & Turner, 1979), which acknowledges that people's identity is

shaped by their memberships of social groups, with the greater the centrality of the group, the stronger the influence on the individual. Applying this Social Identity Theory to the recovery field, it indicates that recovery is characterized by a change in group memberships resulting in a change in social identity and that recovery is supported through shared recovery-supporting values and norms (Best et al, 2016). However, Social Identity Theory has its origins partly in Self-Categorisation Theory (Turner, 1979) where group membership is partly defined by the existence of out-groups who are 'othered', and this othering may form the basis for exclusion, as happens with people who use drugs. The benefits of a membership to a social group supportive to recovery may contribute to wellbeing and access to social and community recovery capital, making long-term recovery possible.

Best, Bird and Hunton (2015) described recovery as a social phenomenon, "*a social contagion*" that is transmitted through processes of social control and social learning (Moos, 2007). Earlier, White (2010) indicated that recovery is "*contagious*" through interpersonal connections within a community (White, 2010). White identifies "*recovery carriers*", who spread the possibility of recovery among those who need it most. These carriers make recovery attractive and are the living example that recovery is possible. At a community level, the visibility and accessibility of such recovery champions generates what Wilton and DeVerteuil (2006) referred to as a 'therapeutic landscape of recovery'. Furthermore, the 'helper principle' (Riessman, 1965) would suggest that the process of helping is at least as beneficial to those who are delivering as to those receiving the help, something that is well known to adherents of the 12-step philosophy where Step 12 suggests that people maintain their recovery through helping others ("you keep it by giving it away").

Recovery could be achieved and sustained through the relationships we have with each other and the context in which these relationships are embedded. Recovery is a relational process depending on social recognition. The notion of community recovery capital (Best & Laudet, 2010) is based on the idea that access to resources in the community is a mechanism of triggering recovery. Indeed, one implication of the CHIME model (Leamy et al, 2011) implicit in the idea of Inclusive Cities, is that Connection generates Hope that in turn provides the impetus for engagement in Meaningful activities that affords the opportunities for changes in Identity and a growing sense of Empowerment. The CHIME model is discussed in more detail below.

### **The community as a barrier: stigma as an obstacle to stable recovery**

The community is not always supportive towards persons who (problematically) use drugs, even towards those in recovery. When Cloud and Granfield (2008) introduced the concept of negative recovery capital, their focus was on individual level factors like a forensic or mental health history,

yet community level factors like social fragmentation, lack of housing and employment, and stigma and exclusion are likely to be critical factors. Therefore, starting from the threefold definition of recovery capital, Best and Savic (2015) developed the notion of 'negative community recovery capital'. This concept acknowledges the barriers to sustained recovery including discrimination, stigma and exclusion by a part of the general public and professionals (Best et al., 2017). It emphasizes the role social and societal responses might play in the perpetuation of substance use disorders and the extent to which they may disrupt ongoing recovery journeys and pathways. These problems are not only about attitudes but also about professional and civic structures and systems. This raises the idea that a recovery system can pave the way for challenging exclusionary structures and practices that prevent effective reintegration.

Several studies acknowledge the negative effects of stigma on people suffering with substance use disorders (Room, 2005). The general public holds stereotyped and negative views, considering persons who (problematically) use drugs as lacking self-discipline (Jones, Simonson & Singleton, 2010) and as 'dirty' (Sloan, 2012, 407). This could impact not only several life domains, such as employment, housing and social relationships but also access to treatment (Radcliffe & Stevens, 2008). Public stigma is the most prominent and studied type of stigma and occurs when the general public agrees with stereotypes. Another type of stigma, self-stigma, occurs when people internalize these public attitudes and experience negative consequences as a result. The stigma of substance use exceeds that of other health conditions both physical and mental health conditions. According to several studies (Room, Rehm, Trotter, Paglia & Ustun, 2001; Corrigan, River, Lundin, Wasowski, Campion et al., 2000) substance use disorders are highly more stigmatized than other health conditions.

A 2009 national online survey conducted by Corrigan, Kurabawa and O'Shaughnessy showed that the general public perceived substance use disorders to be more blameworthy and dangerous than a mental illness. Phillips and Shaw (2013) showed that, when compared with smokers and obese people, the general public (in the US) preferred greater social distance from persons with substance use disorders. What is troubling about this study is that it would appear that social distance did not markedly diminish when those persons were described as being in recovery, suggesting that, for many people, a substance use disorder is an irreversible strain.

Equally worrying are the findings of a follow-up study conducted in the UK (Cano et al, in preparation) with a group of trainee health and criminal justice professionals, indicating the same issues persisted. Thus, not only is there limited openness to recovery among members of the general

public, that scepticism persists among professionals as well. This evidences two sets of barriers that people in recovery must overcome - the perception that substance use disorders are a lifetime stain in the general public, and the resulting scepticism about meaningful change in professionals who are tasked with supporting their recovery pathways.

In 2010, the UKDPC commissioned a survey of 3 000 adults living in private households across the UK (Jones, Simonson & Singleton, 2010). The findings indicated that people recognize the importance of providing support for individuals in recovery and the need for them to be part of the community. However, they do not want them as neighbours and are fearful of having treatment and support services in their neighbourhoods. Nearly half of the respondents agreed that 'people with a history of drug dependence are a burden of society' and over 40% agreed that 'I would not want to live next door to someone who has been dependent on drugs' (Cano et al, in preparation). In an earlier version of the survey (UKDPC, 2008), almost two-thirds of employers who participated in a survey reported that they would not employ a former heroin or crack user even if they were fit for the job. Such attitudes are central to the idea of 'disintegrative shaming' (Braithwaite, 1989) in which exclusion persists beyond official sanctions and marginalised populations are forced to exist on the periphery of communities (and generally outside of the law) because of the depth and persistence of barriers to reintegration.

The fear among members in our community is mostly not based on personal experiences since less than half of the respondents reported knowing someone with a history of substance use disorders in the Cano et al study. Less negative attitudes have been found among those people who currently, or in the past, had lived, worked or been friends with someone with a history of substance use disorders, compared to those who did not. This indicates that contact is generally associated with lower levels of stigmatising behaviours and attitudes. It also means that ignorance about substance use disorders and recovery fuels negative perceptions and stigma-promoting ideas and actions, and encourages those who exclude to close their minds to reintegration. However, the risks of such ghettoization are high as a consequence of the marginalisation, health inequalities and exclusion from community resources that results for the stigmatised group.

A society that discriminates, stigmatizes and excludes, imposes negative consequences for sustaining the recovery process of her citizens. Following Braithwaite's theory (1989), people get disconnected from prosocial groups and become increasingly marginalized. This results in both a growing sense of apathy and hopelessness, and increased inequalities and divisions between those who can and cannot access the resources that exist in the community. There is also a self-labelling (Lemert, 1961)

and self-stigmatising component to this exclusionary spiral. Applying a Social Identity Theory (Tajfel & Turner, 1979, see earlier) to recovery also means that persisting membership of drug using-networks instead of recovery-supporting networks, may fuel social exclusion and stigmatization rather than promoting wellbeing and access to social and community capital (Best et al, 2016). In terms of the Social Identity Theory of Recovery, the transition to recovery requires the availability of accessible and visible recovery groups that the person with (problematic) drug use has the opportunity to engage with and become a part of. As Jetten and colleagues (2015) have argued in the context of homeless populations, social group membership only promotes health and wellbeing where there is access to prosocial groups and communities. Where structural and attitudinal barriers persist, the gap from excluded and marginalised groups is further and the pathway to recovery harder to traverse. These societal barriers, discrimination and stigma from the community, consisting of both the general public and professionals, can pose significant threats to long-term recovery.

Addressing structural barriers as well as personal exclusions and stigmatisations are essential to maximise the likelihood of long-term recovery. Too often, the community hinders a successful reintegration of a person in recovery. Therefore, attention should be paid to changing the attitudes and related actions in the community.

### **One way to acknowledge and promote the role of the community in recovery: an Inclusive City**

It is against this backdrop of the exclusion of vulnerable groups and the risk of disintegration of community ties, that the drive for Inclusive Cities arises. A city consists of many real and virtual communities and hosts stakeholders such as the city council, public and private organisations, treatment providers, employers, landlords and neighbours who could support the person in recovery towards stable employment and housing and make recovery-oriented network visible. The aim of such an inclusive city is to minimise negative recovery capital as both an inter-personal and structural barrier to reintegration and to utilise the process of transformation as a means of generating inclusion and engagement as core values of a city. This is an aspirational goal that will face many challenges (particularly in the time of a Global Financial Crisis) but should remain an aspiration that has its roots in social justice and the benefits of social inclusion.

The central idea in an Inclusive City, is that no one should walk the recovery path alone. Several members of the city -the city council, public and private organisations, employers, landlords and neighbours- work together with the recovering individuals to promote their recovery process. The general aim of Inclusive Cities is to make recovery visible, to celebrate it and to create a safe environment supportive to recovery.



After all, several aspects of our daily life involve rituals and celebrations, such as shaking hands when meeting someone or wedding ceremonies (Maruna, 2011). The role of such ritual is to foster social bonding, strengthen solidarity and social cohesion by bringing people together (Maruna, 2011). While we celebrate several transitions in life, from birth over graduations to retirement, recovery is mostly kept silent. We do not have the tendency to celebrate successful recovery journeys, outside the confines of anonymous fellowships. Instead, only the negative consequences of problem drug use may be visible in our communities through drug-related nuisance or drug-related problems (including acquisitive offences). However, following the work of other scholars (Braithwaite, 1989; Walker & Kobayashi, 2015; Maruna, 2006; 2011), we believe that forgiveness and reintegration rituals celebrating the change process of a person in recovery could be beneficial, not only for the person himself/herself, but for the community as a whole. This is where the lessons from recovery systems have ramifications for collective wellbeing.

One of the first steps to celebrate recovery, is to make recovery visible (White, 2010). This has been one of the overt aims of the 'recovery movement' advocating for patient rights in health care, fighting prejudice, discrimination and stigma and promulgating the knowledge that recovery is a reality (Beckwith, Bliuc & Best, 2016). Related activities such as recovery marches and recovery cafes have been an attempt to create a visibility about recovery, to create a common bond and to challenge exclusion and stigmatisation. The sense of a movement associated with recovery has provided impetus and credibility to local groups and organisations. It has offered a collective voice that has developed influence among professional organisations and at the policy table, for example in the UK (Beckwith, Bliuc & Best, 2016). The idea of recovery as a prefigurative political movement outlined in the Beckwith paper (2016) is really about empowerment, and providing a voice to an excluded population. This represents a form of collective or community capital (Best & Laudet, 2010) that both increases the visibility of recovery and its perceived efficacy and impact, through both increasing bonds of those in recovery and by generating bridges to wider parts of the community. Thus, visible activities are one mechanism for generating inclusion and building social linking and bridging capital.

Inclusive Cities is about making whole cities 'therapeutic landscapes for recovery'. These Inclusive Cities are not only beneficial for the person in recovery, but also for the community and city as a whole. This is based on the 'helper' principal (Riesmann, 1965), suggesting that engaging in helping behaviour is salutogenic and that frequently the peer who provides the help benefits as much, if not more, than the targeted recipient. In this model, it is not only the outcome (improved engagement

for the participant) but also the process that is important: the helper and the helped benefit, but importantly, social and collective capital at a community level grow, and improvements in bridging and linking capital increase community engagement and activity. There is also evidence from the UK Life in Recovery survey (Best et al, 2015), that for people who achieve stable recovery, their levels of contributing to community health and wellbeing increases. Thus, 80% of the individuals who were in stable recovery in the survey reported actively volunteering in their local communities - this is twice the rate reported by the general public. Additionally, more than 70% were in stable employment, also boosting the local economy and reducing benefits costs. This is a critical message in two senses - firstly to challenge the negative immutability of substance use disorders, but also to promote the idea that people in long-term recovery are a valuable asset, who are able to offer binds in society. This has to be part of an educational message for communities - exclusion costs, and while reintegration is not without risk, the effective completion of recovery pathways generates positive social assets and community capital.

This creates what have become known as 'therapeutic landscapes' described as "changing places, settings, situations, locales and milieus that encompass the physical, psychological and social environments associated with treatment or healing" (Williams 1999, pg 2). This has been applied to recovery from alcohol and drugs and the importance of context in recovery. Wilton and DeVerteuil (2006) describe a cluster of alcohol and drug treatment services in San Pedro, California as a 'recovery landscape' as a foundation of spaces and activities that promote recovery. This is done through a social project that extends beyond the boundaries of the drug treatment services into the community through the emergence of an enduring recovery community, in which a sense of fellowship is developed in the wider community.

### ***How Recovery Oriented Systems of Care can generate Inclusive Cities***

The concept of an Inclusive City is founded on an empirical evidence base, consisting of recovery models such as CHIME (Leamy et al, 2011) and Recovery Oriented Systems of Care, ROSC (White, 2008). These models will not be discussed in detail. Instead, we aim to present some basic principles that might be essential in developing the idea and theoretical foundation of Inclusive Cities further.

The first model that fits within the Inclusive Cities model is Recovery Oriented Systems of Care (ROSC), identified by SAMHSA. The central focus of ROSC is to create a "system of care" with the resources to address drug problems within communities. In figure 1, the core characteristics of ROSC are identified.

1. Person-centred
2. Inclusive of family and other ally involvement
3. Individualized and comprehensive services across the lifespan
4. Systems anchored in the community
5. Continuity of care
6. Partnership-consultant relationships
7. Strength-based
8. Culturally responsive
9. Responsiveness to personal belief systems
10. Commitment to peer recovery support services
11. Integrated services
12. System-wide education and training
13. Inclusion of the voices and experiences of recovering individuals and their families
14. Ongoing monitoring and evaluation
15. Evidence driven
16. Research based
17. Adequately and flexibly funded

*Figure 1 Core characteristics of ROSC*

ROSC is a network of community-based person-centered services. It builds on the strengths and resilience of individuals and acknowledges the role that families, friends and the community can play in recovery. It is a model for both community engagement and for integrating community growth with professional systems and practices. It also has the potential to start from a perspective of working with drug using populations and developing this with other vulnerable and marginalised groups. As such, an Inclusive City supports the creation of Recovery-Oriented Systems of Care at city level.

Furthermore, there are some examples from the US, written up in the key text "Addiction Recovery Management" edited by Kelly and White (2011) that have provided evidence of the matching up of top-down policy advances with bottom-up engagement of community groups and assets to create recovery-oriented systems of care. In the chapter outlining the implementation of a recovery-oriented health system in Connecticut, Thomas Kirk (2011) identified a number of key lessons learned. These include a focus on community life and natural supports, addressing cultural needs and

address health disparities, all of which would be key goals of an Inclusive City. Similarly, in Philadelphia, Achara-Abrams, Evans and King (2011) use core principles of empowering all stakeholders, celebrating success and strengthening the community, with the latter including grants to grass-roots community organisations, and participation in a mutual arts organisation. The key issue for Inclusive Cities is that the implementation of recovery systems has created resources that benefit other vulnerable groups and the overall community.

The second theoretical model on which Inclusive Cities have been founded is the CHIME model. A systematic review and narrative analysis conducted by Leamy et al (2011) led to the development of the CHIME model. This model originated as a review of evidence for effective interventions supporting mental health recovery and consists of the main characteristics and outcomes of a recovery journey. These characteristics provide a framework to guide recovery interventions. CHIME is an acronym and stands for Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment. These are regarded as characteristics of programmes and interventions but they also apply at a macro level and characterise the relationships central to policy and practice - to transforming structure as well as to changing processes.

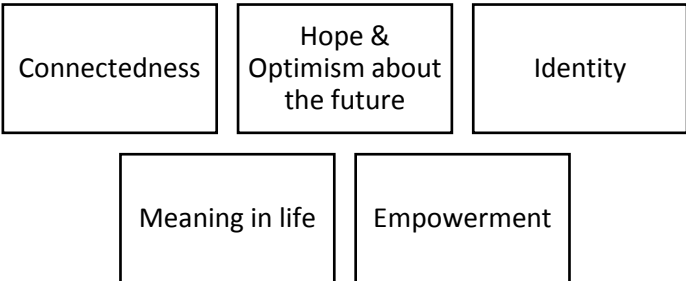


Figure 2 The CHIME model (Leamy, et al., 2011)

The fundamental assumption of the CHIME model is that these should be characteristics of effective recovery programmes - that they can generate and sustain these elements. What this current paper adds to this model is to suggest that this occurs at a systems level as well as an individual and service level. The generation of connections and hope drives the remaining components and builds recovery capital at the level of a community, boosting wellbeing and connectedness.

Additionally, other studies identified evidence based components of recovery practices such as mutual aid, peer-delivered interventions, recovery housing (Humphreys & Lembke, 2014), access to

meaningful jobs (McNeill, 2014) and positive prosocial networks (Best et al, 2008; Longabaugh et al, 2010). An Inclusive City will create pathways to hope and opportunity that both tap into existing social and community assets but in doing so generate new community capital and create an inclusive environment of hope. The combination of these theoretical and empirical concepts, aimed at increased community participation, community cohesion and reductions in stigma and exclusion, provide a structure around which Inclusive Cities can be oriented.

This empirical evidence base brings us to the main principles and operational elements of an Inclusive City, as summarised in table 2 below grouped together according to the CHIME principles listed above.

**Table 2. Components of an Inclusive City**

<b>Theoretical component of an Inclusive City</b>	<b>Operational elements</b>
Connectedness and social cohesion	<ul style="list-style-type: none"> <li>• Peer support and involvement</li> <li>• Community support and involvement</li> <li>• Mutual aid</li> <li>• Relationships with others</li> <li>• Establishing bridging and linking capital to increase cohesion and minimise exclusion, and marginalised groups</li> <li>• Building new nodes and links and increasing the equality of connections across social groups</li> </ul>
Hope about the future	<ul style="list-style-type: none"> <li>• Belief in the possibility of recovery</li> <li>• Champion visibility of recovery and celebrate success</li> <li>• Motivation to change</li> <li>• Hope-inspiring relationships</li> <li>• Positive thinking and valuing success</li> <li>• Having dreams and aspirations</li> <li>• Hope about the community</li> </ul>
Promoting a recovery identity around social inclusion and social	<ul style="list-style-type: none"> <li>• Rebuilding/redefining positive sense of identity</li> <li>• Challenging exclusionary labels and practices - work with housing services, employment agencies etc to challenge exclusionary</li> </ul>

participation	processes and structures
Meaning	<ul style="list-style-type: none"> <li>• Meaningful life and social roles: access to meaningful jobs and accessible recovery housing</li> <li>• Contribute and giving back to the society, and valuing membership of the community</li> <li>• Opportunities for volunteering and access to community resources - this can be undertaken using the Asset Based Community Development method (ABCD; Kretzmann and McKnight, 1993)</li> </ul>
Empowerment and strength-based	<ul style="list-style-type: none"> <li>• Personal responsibility</li> <li>• Control over life</li> <li>• Focus on strengths</li> </ul>

Ideally, an Inclusive City focuses on all five components listed above. However “becoming” an Inclusive City is a process that takes time and even small steps, mostly focusing on making recovery visible in the community by raising public awareness, are steps towards the right direction.

According to the resources available in the community, the role of the community can range from the provision of mutual aid and peer support for people in recovery and educational campaigns, over establishing inter-sectoral partnerships to promote social inclusion, to carrying out activities and setting up structures to change attitudes and reduce stigma towards recovery, providing incentives for employers to employ persons in recovery and implementing anti-discrimination policy (WHO, 2001)

***Promising inclusive examples from cities around the globe***

In several cities across the globe, inclusive examples can be found that fit in the above mentioned components (Figure 2). These examples could be small steps, focusing on making recovery visible in a city such as bike rides or more structural steps such as establishing a social enterprise model.

This paper does not attempt to evaluate existing practices, rather it aims to provide inspiration for possible practices.

Some of the most promising examples come from the restorative cities model (eg ACT Reform Advisory Committee, 2017) where a range of governmental processes have been amended to increase inclusion and to reduce adversarial and discriminatory practices. This restorative cities

model was initially a model for criminal justice but in cities such as Canberra, Leeds and Hull, this model of inclusion has been extended to disputes in education, local government and further afield.

However, similar examples also exist in the drug recovery sphere. What is presented below is not meant to be either unique nor representative - they are simply examples known to the authors of innovation and success in this area. What is presented below are examples of how recovery innovations in various countries have been extended to impact on the wider community challenging stigma and increasing inclusion.

For example, in the US, the recovery movement and its successes are visibly illustrated in the award-winning film *The Anonymous People*, directed by Greg D. Williams in 2013 and its companion book "Many Faces, One Voice" (Mikhitarian, 2015) provides a powerful illustration of the history of recovery walks and recovery celebrations to challenge stigmatising and exclusionary attitudes.

In the UK, Roth and Best (2014) compiled an edited volume of recovery successes in the UK, including the success of the Serenity Café in Edinburgh. The Serenity Café is a social place where people can support each other in their recovery journey. Because the café aims to promote social integration and broaden social networks, it is open to everyone: people in recovery, volunteers and the general public. Also activities are regularly organised in the café, including training programs to become recovery coaches, social and hobby groups and recovery support groups (Campbell, Duffy, Gaughan et al., 2011).

Furthermore, a social enterprise model – Jobs, Friends and Houses - was set up in Blackpool, engaging people in recovery in a building program. After volunteering, participants completed a training program to learn to renovate and refurbish houses, participants started a (paid) apprenticeship at Jobs, Friends and Houses (JFH). The social enterprise bought houses, renovated or refurbished them and either rented them out as recovery housing or sold them for profit, after which the profits were reinvested in the social enterprise. Not only does this model offer employment opportunities in the construction industry for people in recovery, it also gives them a sense of pride and meaning (because of the learned skills, paid work and contributions to the community). Furthermore, it is linked to increased recovery housing and a growth of a visible recovery community in the city of Blackpool (Best, Beswick, Hodgkins & Idle, 2016). In one particular incident, a team of JFH trainees - all former persons who (problematically) used drugs and prisoners - intervened in a hotel fight saving the life of an innocent woman, leading to positive media coverage for JFH and a commendation from the police (Best, 2016). Other successes are the rise of the Recovery Academy across the UK for combining research and advocacy around recovery, the recovery hill-walking and

the therapeutic communities work. In the UK and in Australia, there are regular recovery marches and recovery celebration events to create visibility and provide a platform for championing recovery communities and Inclusive Cities.

In Belgium, Villa Voortman, a community-based place within the city of Ghent aims to offer a meeting place for persons with dual diagnosis, called *visitors*, who often lost connection to other clinical and social care settings. Villa Voortman is open on weekdays from 9 am till 5 pm. During this time, they offer a wide range of (voluntary) activities such as art projects, cooking and philosophy classes. Importantly, the activities are embedded in the community. Every first Thursday of the month, the Villa organises an 'Open Door' afternoon during which visitors, neighbours and other citizens share coffee and talks, while they enjoy poetry and music performances made by the visitors. Research indicates that Villa Voortman succeeds in beating social isolation (De Ruyscher, Vanheule & Stijn Vandeveld, 2017). Visitors experience Villa Voortman as a place to feel safe and accepted, as well as a place that feels like home. Furthermore, it also helps them to re-create positive identities and decrease self-stigma (De Ruyscher, Vanheule & Stijn Vandeveld, 2017).

In Italy, a drug rehabilitation community, San Patrignano, started in 1979. One of the corner stones of the program is that people in recovery are empowered and get the chance to discover and develop their skills. The program is based on vocational job training, supporting education and re-socialization skills (Triple R, 2017). Special attention is also given to sport, music and arts to nurture passions and talents of people in recovery. Furthermore, the program encourages the involvement of family members. As such, the program aims to promote social reintegration and to increase the chances to achieve long-term recovery, for example by increasing the chances to find a job upon program completion (Triple R, 2017).

### **Inclusive Cities for other excluded and vulnerable groups**

The purpose of this paper is building and promoting Inclusive Cities for people who are in recovery from illicit drug and alcohol use. As mentioned earlier in this paper, the larger aim, however, is to challenge exclusion and stigma through a championed model of reintegration for other excluded and vulnerable populations in the near future.

In first instance, we think about persons in both recovery from drug use and desistance from offending. Although most of the (conceptual and empirical) work on recovery capital has been carried out with an alcohol or illicit drug misusing sample (Laudet & White, 2008), some study the role of recovery capital in a sample consisting of people who have been using drugs and who have



been committing offences (see for example Best, Irving & Albertson, 2016). This is not surprising. Because of the well-known relationship between drug use and offending, we notice an overlap in populations involved in drug use and offending (Best & Savic, 2015; Bennett, Holloway & Farrington 2008). As a result, we also see commonalities between recovery from illicit drug and alcohol use and desistance from offending: they are both transformational processes, which are not linear but dynamic, gradual and subject to relapse. Furthermore, similar internal and external components seem to influence both processes of change (Marsh, 2011; Colman, 2015).

Similar to recovery, desistance theories acknowledge the importance of societal responses, next to personal and social factors. Maruna (2001, p. 166) argues that “Societies that do not believe that offenders can change will get offenders who do not believe that change is possible”. McNeill (2014) added the concept of ‘tertiary desistance’ to Maruna and Farrall’s dual framework of ‘primary’ (an offence-free period) and ‘secondary desistance’ (the development of a new identity as a non-offender). With this concept, McNeill emphasizes one’s sense of belonging to a (moral) community and focuses on the fact that identity change is a social process as much as a personal one. Recently, an alternative terminology to primary, secondary and tertiary desistance has been developed by Nugent and Schinkel (2016) who acknowledge that desistance is more than a linear process. Nugent and Schinkel’s alternative terminology does not suggest sequencing in time or importance. They differentiate between ‘act-desistance’ for not committing offences, ‘identity desistance’ for the creation of a new non-offending identity and ‘relational desistance’ for the recognition of change by society.

### **Possible bottlenecks related to building inclusive cities**

Of course there are huge challenges to creating an agenda for community growth based on recovery systems of care. There is an extremely limited evidence base for recovery systems outside the US, and there have been concerns expressed that recovery communities in the UK can be exclusive to those not adhering to one particular recovery model (Weston, Honor and Best, 2017). Therefore, it is essential that persons in recovery are included in identifying and implementing interventions, and that recovery is defined as inclusively as possible. There are also huge challenges in providing the state support for such a model when there are so many competing demands for limited resources and support. In order to maximally eliminate stigma, empowerment should be encouraged and the contribution of people in recovery, and by extension all excluded populations, should be recognized. We should avoid that outsider experts define recovery and implement initiatives within the framework of Inclusive Cities, without involving the voices and expertise of persons in recovery.

No plan for Inclusive Cities can have any chance of acceptance and implementation without a positive mindset and the buy-in of key stakeholders involved in local government. There needs to be a long-term vision for the inclusion of vulnerable populations that incorporates the reintegration of marginalised groups and embeds this within models of health inequality, public health and social justice. At a city level, there are often frequent changes in administration, and a lack of fluidity in governance processes.

## **Conclusion**

Researchers acknowledge the importance of societal factors, besides personal and social factors in initiating and sustaining recovery. Particularly the role of the (wider) community is crucial in providing opportunities to nurture and sustain in recovery.

People in recovery often experience discrimination and stigma from different members in the community, such as landlords who refuse to rent a place to persons in recovery or employers who are reluctant to hire a person in recovery, even if that person is fit for the job. These stigmatizing attitudes and actions could lead to continued exclusion and represent a barrier to stable recovery.

While discrimination and stigma originate at the level of the community, the community could also be an important resource and setting to prevent and tackle the causes and effects of discrimination and stigma. A community connects different actors and sectors who could provide access to safe housing and adequate training as well as opportunities for meaningful employment.

Therefore, the idea of Inclusive Cities has been raised, an initiative to support the creation of Recovery-Oriented Systems of Care at city level. Although the Inclusive Cities model starts from recovery to improve social inclusion at city level, it aims to extend this model (in the near future) to other groups experiencing social exclusion as well, such as persons in the dual process of recovery and desistance. The current paper attempts to reconcile the models of recovery capital and recovery systems with the CHIME model of recovery effectiveness, to suggest how recovery successes may have wider benefits. This has conceptual strength but almost no empirical support at present. We are reliant on a small number of systems studies from the US, and indicative evidence from self-reported Life in Recovery studies about community engagement. This is a weak research base but a strong conceptual foundation that merits further testing. There have also been significant successes around

community reintegration through models of connection, for example through our own work in Sheffield (Edwards, Soutar and Best, 2018)

An Inclusive City promotes participation, inclusion, full and equal citizenship to all her citizens, also to those in recovery. In contrast to some traditional, clinical or judicial approaches, the Inclusive City model does not focus on the deficits of persons in recovery but rather on their strengths. The central idea of an Inclusive City, is that no one should walk the recovery path alone. Several members in a city, including the city council, public and private organisations, employers, landlords and neighbours, should be encouraged to work together with the recovering individuals to promote their recovery process.

The aim of Inclusive Cities is to make recovery visible, to celebrate it and to create a safe environment supportive to recovery. The method and the outcomes of Inclusive Cities are predicated on improvements in connectedness, inclusion and civic participation, leading to greater bridging and bonding capital and stronger, more connected communities.

Today, several cities across Europe, such as Gothenburg, Ghent and Doncaster, have raised their interest to become an Inclusive City. The first step is bringing several actors, from different organizations responsible for employment, housing, social welfare, in each city together to make an overview of existing practices for people in recovery, as well as to identify current gaps. They will also define the city's mission, vision statement and related (short-time as well as long-term) goals and actions to support recovery, in line with the available resources and the people's needs. People in recovery, as well as their families, will be included in defining these actions, leading to services being better used and tailored to their needs. The second step is implementing the identified actions, while monitoring and evaluating the process.

By building a learning set of cities across Europe, the idea of Inclusive Cities will be implemented and tested in practice. When several cities engage with the idea of Inclusive Cities, ingredients and – hopefully- more good practices to improve social justice and community engagement could be shared.

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