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Recovery as a social phenomenon: What is the role of the community in supporting and enabling recovery?

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Introduction and rationale

There has been growing interest in the idea of recovery from alcohol and drug addiction and what this means, with international consensus groups focusing on improvements in wellbeing, meaningful engagement in community life and reductions in substance use (Betty Ford Consensus Panel, 2007; UK Drug Policy Commission, 2007). Recovery from alcohol and drug addiction can be understood more broadly in social terms as a social contagion that is transmitted through processes of social control and social learning (Moos, 2007), where individuals learn to recover through the observation and imitation of others and are nurtured through the initial stages of recovery by peers and recovery communities, such as mutual aid groups (Humphreys, 2004). In this way, recovery can be understood as a personal journey but one that occurs in a social context.

Recovery can be understood as a social process culminating in a change in social identity (Jetten, Haslam, & Haslam, 2012) from an excluded identity of a user to a recovery identity that is internalised and learned through exposure to recovery peers and recovery groups that create a sense of belonging and a set of social supports that protect against future relapse (Buckingham, Frings, & Albury, 2013). Buckingham and colleagues reported significantly reduced rates of relapse in individuals who reported much closer identification with recovery social groups and identity than with using groups and identity.

This has been a key part of the policy promotion of a recovery model in the UK (HM Government, 2010; ACMD, 2013) aiming to support the emergence of 'recovery communities' that can support personal journeys to stable recovery but that also have a preventative effect, where a community focus on generating visible recovery communities and champions will reduce the likelihood of relapse and provide support and early interventions for those who do lapse (White, 2009). The UK drug policy describes 'recovery champions' (HM Government, 2010) as a core mechanism for enabling change through

visible activities that raise awareness of, and access to, recovery supports for those in the early stages of their recovery journeys.

Our assertion is that recovery is contextually shaped – it is socially constructed and socially negotiated, and it is located in the culture and values of particular communities. It is socially constructed in the sense that recovery relies on changes in social identity (Jetten, Haslam, & Haslam, 2012; Buckingham, Frings, & Albury, 2013) that are driven by supportive peers and social networks that offer opportunities for social learning and the constraining influences of social control (Moos, 2007). But these social constructions rest on the availability and accessibility of social networks and role models, who can provide the direction and support that will enable social identity change. This availability will be inversely associated with cultural stigmatization of discrimination towards those in recovery.

Therefore, community stigma and continued exclusion of those who strive to achieve recovery represents a formidable barrier to individual recovery and to the viability of recovery groups and communities. Additionally, we will consider recovery in people with additional vulnerabilities and complexities as an important population in driving the development of communities that support recovery.

Given the over-representation of cognitively impaired persons with alcohol or other drug (AOD) issues, the existence of this group must be addressed in any discussion of the community response to the recovering addict. The cognitive damage associated with substance use affects critical skills underlying independent functioning, including the capacity to formulate and pursue goals, initiate action, and to sustain motivation (Oscar-Berman & Marinkovic, 2007; Verdejo-García, Lopez-Torrecillas, Orozco Gimenez, & Perez-Garcia, 2004). Social skills may be impaired, further damaging the capacity of the individual to engage with family and support networks. Without an empathetic understanding of these issues, the cognitively impaired individual may be regarded as deliberately failing to engage with offered supports, being “resistant” to change, “unmotivated” and “hopeless”. Informed community support for families is crucial for the maintenance of care and opportunity for reintegration.

We want to outline four factors about community recovery that have direct parallels to positive criminology:

1. How the community can block recovery pathways through stigma and discrimination,
2. How communities of recovery can be central to recovery by creating bridges to non-stigmatised and non-excluded groups,
3. A model for recovery that is grounded in social and contextual models of asset-based community development, and
4. How families are central to the effective experience of recovery as a socially constructed experience.

1. Context and the impact of stigma and discrimination

In Granfield and Cloud's original articulation of recovery capital (Granfield & Cloud, 2001), they referred to four types of recovery capital – personal, physical, cultural and social - to cover the material possessions, personal skills and capabilities, support and friendship networks, and community resources. While much of the work that has been done – for example in the development of the Assessment of Recovery Capital (Groshkova, Best, & White, 2012) - has looked at personal, physical and social capital, the current chapter will focus much more on the context of recovery in terms of the community and the family. There has been interest in the addictions field in the UK in the work of John McKnight and colleagues (e.g. McKnight & Block, 2010) and the principles of Asset-Based Community Development (ABCD, Kretzmann & McKnight, 1993) in which the most important resources in a local community are its people, informal groups and formal organisations; all of which represent community (or cultural) capital.

In this model, the community is both the source of resources to support the recovery journey, and the potential source of barriers to effective change. Within a recovery model, mutual aid and other peer organisations represent key community assets and nodes of recovery support and belonging, alongside access to safe housing, and opportunities for volunteering, training and employment (Best, Honor, Karpusheff, Loudon, Hall, Groshkova, et al., 2013). This is consistent with a wider definition of social capital from Bourdieu as "the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance or recognition" (Bourdieu, 1986, p.248). In a subsequent development of the social capital model, Putnam (2000) differentiated between bonding capital, to refer to the quantity

and types of relationships and intensity of close links, and bridging capital as the connections to supports and resources. Within a community recovery model, social capital includes both the social supports and, crucially, the bridges to resources available in the community. What stigmatisation and discrimination may do is to burn those bridges, and restrict the social capital of excluded populations to other members of the same groups. In this model, recovery and rehabilitation are dependent on the part of growing resources in the individual but with the corollary that the community (including but not restricted to recovery groups) provide an environment in which they can be nurtured and grown.

Braithwaite (1989) has argued, in his work on reintegrative shaming, that "stigmatisation is disintegrative shaming in which no effort is made to reconcile the offender with the community" (Braithwaite, 1989, p.101), resulting in the 'offender' being outcast and their delinquency becoming a dominant identity. He contrasts this with the reintegrative shaming approach in which substance users are ritually accepted back into the community as they seek forgiveness from those whom they have caused hurt. Where disintegrative shaming occurs, one consequence is that access to community capital is shut off and the only social support that is available is through other members of the excluded group, and so creating a spiral of exclusion and the dominance of the addict identity. Within a recovery model of positive criminology, the response of the community influences the chances that the early shoots of personal recovery will be nurtured or crushed, in part as a consequence of exclusion and discrimination.

Reintegrative shaming directs shame at behaviour rather than the individual, but can be seen as conceptually unclear and may risk stigmatic shaming (Morris, 2001) and there is evidence that it can be experienced as shaming (e.g. drug courts seeing increased reoffending rates due to perceived increased stigma, Miethe, Lu, & Reese, 2000). Additionally, this approach rests on the willingness of the community to be actively involved in reintegration. This includes the environmental factors including wider community attitudes and beliefs about addiction, offending and the likelihood of recovery / rehabilitation. In other words, as with stigma, the efforts at community bridge building relies not only on structures, but also on the beliefs, expectations and attitudes of community members.

There is considerable evidence (WHO 2001 in SIARG, 2013; UKDPC 2011) to show that stigma is a major problem for addiction. The World Health Organisation found that illicit drug dependence is the most stigmatised health condition in the world, and alcohol dependence the fourth most (WHO 2001 in SIARG, 2013). Stigma has been demonstrated to

have a damaging impact on efforts by individuals to tackle their alcohol and drug problems, as well as on their families, and also adversely affects policy aimed at tackling AOD problems. This includes damaging self-esteem and the perceived possibility of recovery, hindering willingness to access treatment and support for other health and social issues, and resulting in increased alienation (UKDPC 2011, SIARG 2013). Within labelling theory, this spiral of secondary deviance and deviance amplification will result in further exclusion that will further limit the availability of bridging capital. Braithwaite (1989) has argued that this exclusion will also contribute to the development of a master identity or status as 'offender' and so perpetuate both the exclusion by others and the self-exclusion that reduces ties to community capital.

The community can be understood as the setting for exclusion or reintegration that will be manifest in its willingness to provide suitable houses and jobs, family reunification and community reintegration in informal settings. In the US, Phillips & Shaw (2013) have shown that substance users are more stigmatised both when active users and when they are in recovery, suggesting that stigma persists even when active addiction is left behind. This establishes two barriers to reintegration – first, the highly stigmatised status of addiction, and secondly, the failure of the US study participants to differentiate between active addiction and recovery – in other words, not to believe that people 'really' recover from substance use problems. This exclusion may be compounded by co-occurring mental health problems, brain injury and other issues that may additionally lead to self-exclusion and stigmatisation.

Restorative practice and recovery

There are wider movements in criminology and criminal justice that are relevant to the recovery model that also rely on a combination of professional attitudes and responses to offending and on the active engagement of the community: positive criminology, therapeutic jurisprudence and restorative practice with the last in these in particular reflecting some of the key community and exclusion issues dominant in the model of community recovery presented here. Restorative practice is about bringing people together and aims to use the impact on (hurt caused to) family and community, and impact of family and community (love, respect, burden-sharing, responsibility, hope) to work towards recovery collectively through an emotive process. The language and emotion employed is very important – love over shame, not about punishment or blame - focusing

on working through injustices (including substance misuse) towards restoration/recovery (King, 2008).

There are key elements of the restorative model that are consistent with a recovery model: it is a strengths-based approach (love, respect, hope) involving a democratic intervention and the free choice to restore (Braithwaite, 2001), it actively involves the community in burden-sharing and locates the community as the locus of resolution, and it is about actively re-integrating the 'offender' in the community (Braithwaite, 2004; Morris 2001). The restorative approach acknowledges that family and community are integral to recovery - prioritising and binding these into the journey and challenging stigma and discrimination – while also opening up the possibility of generating new community assets, and building social and community capital through bridging between previously separated and hostile groups and individuals.

3. How the recovery community can contribute to reintegration and recovery capital

Unlike the history of rehabilitation from offending, there is a long history of AOD recovery involving formalised peer networks, in particular the mutual aid groups like AA and NA. However, there are a vast array of community and peer based recovery activities that have emerged in recent years including recovery cafes, sports teams and volunteer groups – a summary of these for the UK is provided in a special issue of the Journal of Groups in Addiction and Recovery entitled "Recovery in the UK" (Roth & Best, 2012). There is also a second recovery tradition that stems from treatment services, including residential rehabilitation of recovery houses and recovery communities (eg Humphreys & Lembke, 2013). These traditions – mutual aid, recovery peer groups and recovery housing and aftercare – provide a 'therapeutic landscape' of recovery (Wilton & DeVerteuil, 2006) that creates beacons of hope and opportunity for people starting their recovery journey (and for their family members) and a source of social learning and social support.

While Braithwaite has argued, for the rehabilitation of offenders, that treatment specialists needs the support of the community to marry motivation and support (Braithwaite 2004), in the alcohol and drug recovery field some of these community organisations already exist and provide resources for recovery. There are a number of accessible community resources available although in the UK at least (Gaston-Lopez, Best, Day, & White, 2010), the links between mutual aid groups and treatment are not always strong and supportive. There has also been a slow journey to recognizing that the

'solution' to addiction problems lies not merely in pharmacotherapy and counseling but in engagement with the lived community (Best, 2012).

Central to this model of recovery as a socially constructed and mediated process is that the extent of linkage between recovery groups and the local community (including specialist addiction treatment providers) is central to breaking down stigma and building recovery capital and recovery resources in the community. Addresing the stigmatisation of addicts who attempt to achieve recovery, by raising the profile of recovery through visible recovery communities, is cental to making recovery more available and accessible, particularly to vulnerable and excluded populations, including those with cognitive function problems. The advent of the grassroots recovery organisations – Faces and Voices of Recovery in the US, Recovery Academy Australia in Australia, the UK Recovery Foundation and Recovery Group UK in England, and Recovery Cymru in Wales – has provided a more sustainable platform for community engagement. These organisations have aimed to create a highly visible 'face' of recovery that interacts not only with the addict and recovery community – but with the wider community through public events and activities – to challenge discrimination by exposure to contrary examples. They not only provide a higher level of visibility (at regional and national level), they can link local groups (providing information on 'what works' and so on) and can act as a politicial pressure group. But crucially, they provide a visible presence for recovery, challenge the belief that recovery is not possible and offer an active sense of pride and social identity that could be translated to the activities around positive criminology.

In one local example – in Barnsley in South Yorkshire in England – an initial training programme for workers and peers in recovery and interested community members led to the development of a voluntary Barnsley Recovery Coalition, who initially set out a recovery vision and mission for the area and then set about planning a series of activities that started with a float in the Lord Mayor's Parade, followed by a Recovery Walk and a sports fun day (Best, Loudon, Powell, Groshkova, & White, 2013). While people had initially been anxious about disclosing their recovery status for fear of discrimination and adverse consequences for them and their family, the collective endeavours and shared sense of social identity between workers, people in recovery, family members and volunteers, created a positive and visible shared identity and goals. What happened in

Barnsley was that a visible social identity of recovery grew in the town leading to a strong and coherent group that challenged the stereotypes and assumptions of professionals as well as the local community and had a positive and beneficial effect on the town.

In the language of Putnam (2000), the recovery group created two kinds of social capital – relational social capital based on the positive interactions and experiences of being in the group and the categorical social capital that arises out of identifying with the category of 'recovery group member' or champion. The visibility of the group as both attractive and engaging acts as a visible message that recovery is possible but also challenges the idea that addiction is something that cannot be overcome for people in active use as well as those in recovery, for family members and crucially for other members of that community.

The visible presence of a recovery community provides clear opportunities for challenging stigma by providing clear evidence of community and success; but it also challenges internalised stigma among active and recovering addicts by witnessing not only recovery success (and thus providing access to social learning) but also through creating a positive categorical social identity (ie recovery is a viable social identity that is worth striving for). Those who are part of successful public recovery events not only are bound more strongly to the group but also witness the effective integration of recovery with everyday activities. In Barnsley, the Lord Mayor's Parade, the sports day and the recovery walk were all events that created a high visibility for recovery, that were supported by a cross-section of the community and that created high social reinforcement.

This is even more the case for events that directly support the community – in the UK these have included tidying up a riverside, clearing snow from drives and houses and a diverse array of community supports and activities that recovery groups have engaged in, (Recovery Cymru had high visibility volunteers cleaning the River Taff in Wales; and the provision of breakfasts by the Basement Recovery Group in Calderdale to homeless street drinkers). In this way, recovery groups can constitute community recovery assets that, in turn, can create bridging capital between people in recovery (and the groups they belong to) and community assets and resources. These are also activities that create bonding capital and engagement and that are accessible to a wide range of people in recovery who may not be willing to access mutual aid groups and activities. However, there is almost no research on the impact of such activities on the sense of recovery identity among groups and individuals, of the type of activities that serve this purpose, or of their effects on community stigma and discrimination. The application of this model to positive

criminology is also untested but the evidence for reintegrative shaming and restorative practice would suggest that it is viable in this domain.

4. Recovery, identity and social contagion

For the purpose of the current model of recovery based on the ideas of social contagion and visibility, the other key issue that arises is about the impact of the emergence of a visible recovery community on the social contagion of recovery. This section provides a framework for how a desired and attractive behavior (recovery / rehabilitation) might spread in social networks.

Based on the ideas developed by Christakis & Fowler (2010) from the Framingham Heart Study, which is about the spread in social networks not only of physiological conditions like obesity and heart disease, but also social activities like divorce and binge drinking, the idea of contagion can be extended to recovery from alcohol and drug problems. The idea of recovery contagion is predicated on transmission of behaviours through social networks based on exposure of attractive and socially normative attitudes and behaviours that are adopted and transmitted through carriers. In other words, recovery spreads through a community where it is socially networked, visible and attractive. Within a recovery or rehabilitation sphere, for that contagion to happen, the social group where recovery is visible and accessible makes the likelihood of contagion much stronger. Thus the 'node' is the group and positive recovery norms and values are the behaviours that are transmitted.

If successful community events take place, the commitment of the group members to a social identity of recovery should be enhanced and there should also be fewer community barriers to engaging in recovery activities. The impact of successful community recovery events should be fewer active barriers in the community (through bridging capital and increased exposure to recovery among the general public). This should positively influence people in recovery by reducing internalised barriers to engaging in recovery activities and groups among those who observe or learn about successful recovery events. This reduced barrier to accessing recovery, coupled with increased visibility of recovery in the community, should increase recovery contagion to include those with fewer personal recovery resources, including those with co-occurring disorders and cognitive deficits.

One of the explicit aims of a recovery model based on community capital and contagion is about extending the reach and impact of recovery to those who do not possess the same

recovery capital. What the visible, attractive and accessible recovery community offers is a bridge to both social and community capital, and a means of breaking barriers that have been established through stigma and discrimination. This has its origins, in part, in a social identity model of recovery where engagement in a group is based on the perceived attractiveness and desirability of the group (Jetten et al., 2012) and its perceived fit and compatibility with personal goals. In other words, if the group is visible and seen to be successful and attractive, then it will provoke the desire to be a member among those attempting to initiate their recovery journeys.

Group membership then not only provides social support and the resulting positive effects on health and wellbeing (Jetten et al, 2009), it also provides a lens through which the world is perceived and one that becomes more salient with its use as an effective method of managing the daily travails of life. Within the context of recovery, people will join recovery groups because they are seen to be a realistic source of support in overcoming addiction, but they will stay with the group because they feel a part of it, they internalize the recovery values of the group and the recovery group becomes a part of them. They then can be transmitters of recovery practices and processes and can impact on the availability and accessibility of recovery supports and resources to those currently excluded.

The concept of social identity change in recovery contagion is also connected to the idea of the 'helper therapy principle' (Reissman, 1965). Here, an individual takes on a role centred on helping others facing similar experiences to his or her own, and thereby helps him or herself too. This 'role' may occur very naturally in settings shared by people with substance misuse problems, or may be formally constructed within a recovery community, but involves the helper using experiences they may previously have viewed as negative as a key to helping others. The helper becomes a role model of recovery, and by doing so transforms their own experience into something positive. Peer support can be said to be a 'win-win' situation in that it helps the person receiving the support, and also (and some argue most powerfully) helps the person doing the helping (Gartner & Riessman, 1984 in LeBel, 2008) by entailing a very deliberate and fundamental shift in sense of identity and personal narrative (Maruna, 2001). The binding of the more experienced recovery helper to the group in the role of helper also provides a very clear role model (Moos, 2007) to allow the social learning of the techniques of recovery and a positive social identity for observation and imitation.

In terms of building recovery in communities, the helper therapy principle stands to have a very positive double impact: helping the self by helping others promotes the social contagion of recovery, and through publicly acknowledging such recovery activities, this challenges stigma and social exclusion, thereby creating a more recovery-ready community. This also creates a stronger visible and sustainable recovery community by binding existing members who do not see the group simply as a stepping stone to a better life, but whose commitment to the group is evidence to new members of its effectiveness and its desirability.

5. The role of professionals in tackling stigma

The impact of the recovery movement on community stigma and discrimination is also influenced by the link between community recovery groups and specialist treatment services. AOD professionals have a key role to play in recovery initiation and support, and in addressing social exclusion and discrimination. Buchanan (2004) argued that social exclusion is the most significant barrier to recovery and that the professional sector needs to do more to recognise and counter this. Buchanan claimed that the AOD sector may benefit individuals more effectively through acknowledging the extent to which social exclusion impacts on many (not all) of those with AOD use problems. He claimed that social exclusion is not widely recognised by professionals who tend not to have personal experience of addiction themselves (UKDPC 2011) and so may under-estimate its impact. As a consequence their focus is typically on 'curing the disease' rather than on addressing social and community factors that block attempts at change and recovery. Buchanan (2004) accused the alcohol and drug 'professional treatment' sector of ignoring reintegration thereby hindering the prospect of long-term recovery (Buchanan 2004). Raising the visibility of recovery is one means by which the sector can not only tackle social exclusion, but also promote (re)integration and the perception that recovery is both viable and a realistic and attractive goal. But professionals also have a core role in acting as community connectors and linking their clients in with community resources, particularly groups and individuals who are successfully managing their own recovery journeys (Best, 2012).

White, Evans and Lamb (2009) have argued that professionals have a key role to perform in addressing stigma. Their suggestions include developing service relationships that are built on trust and respect; being a carrier for recovery (by telling stories of recovery and highlighting success whenever possible); by being active advocates for the recovery movement; by being active and supportive of local peer recovery groups and by being an

educator in the community. It is through these activities that professionals can challenge stigma through their own participation in recovery events and activities as members of the community and not as 'workers'. AOD workers, like their criminal justice equivalents, need to 'get their hands dirty' by leaving their offices, by engaging with and in the community and actively advocating for recovery in the daily lives and lived communities of those in recovery. The attendance of professionals at recovery events – in their own time, and away from the warrants of professional status – is an essential component of challenging barriers and exclusion. It also complements and supports the generation of a 'therapeutic landscape of recovery' where professionals and peers are actively engaged in and with the community as part of promoting the viability and efficacy of recovery.

However, there is a second implication – that if recovery communities are to develop in challenging stigma and adversity in the local community, this must include the family of those in recovery.

6. The role of families and the recovery journey of the family

AOD problems are often transmitted inter-generationally within families, and the family represents the immediate context for recovery endeavours. Callan and Jackson (1985) have argued that parental recovery can act as a barrier to inter-generational transmission of addiction as one of the potential benefits of recovery role modelling and social contagion. There is also empirical support for the suggestion that better family integration results from ongoing parental engagement in recovery mutual aid groups (Andreas & O'Farrell, 2009). Therefore, in this context, one can also speak of the need for 'community recovery' (White, 2009), including effective parenting and family engagement.

Families are often victims who deserve honouring with support without having to resort to the criminal justice system (Braithwaite, 2001); the restorative practices approach supports this process by providing the opportunity to express hurt caused within an asset-based framework and the collective to provide adequate support.

As White (1996) has argued, the recovery journey of the family is often a complex one and it may not coincide in timing or pathway with that of the person in recovery, but the

transmission of the belief in recovery will have benefits for the family members, while the breaking down of community stigma and discrimination will also reduce the adverse treatment of family members and their willingness to be available as recovery resources and supporters.

While there have been a number of family focused interventions, developed in the alcohol and drugs field, probably the most relevant to this work is Social Behaviour Network Therapy (SBNT; Copello, Orford, Hodgson, Tober, & Barrett, 2002). This intervention, designed for the UK Alcohol Treatment Trial (UKATT Research Team, 2005), is based on the idea that the best chance of a positive outcome derives from providing people with the opportunity to access a social network supportive of change. SBNT is based on a supportive network that will typically involve family members as allies in the recovery process, and is based on the idea that treatment can tap into positive supports and influences in the existing social networks of addicts and alcoholics.

This is consistent with the recovery linkage approach here – that recovery can be initiated but crucially can be sustained by engagement in recovery groups that promote a sense of positive recovery identity that rests on belonging to positive social networks. As with family involvement approaches, they are predicated on the assumption that there are positive influences in the social network and indeed that the social network – and the family – are not the causes and initiators of addictive behaviours. Where the family has been identified as the source of or agonist for addictive behaviours, then withdrawal from the family may be a necessary prerequisite for recovery.

The family has a key role to play in enabling and sustaining recovery pathways, but that is reliant in part on a change in professionals' attitudes and beliefs about the nature of recovery and the role of the family. It is also reliant on professionals attending to the resources and social capital that an individual has access to and can utilize in supporting their recovery journey. Within a model in which recovery is co-produced in community settings, there needs to be an alliance between professionals, those in recovery and their families that generates a challenge to stigma for both family members and people in recovery, and offers the maximum opportunity for building community resources and strengths.

7. Conclusion

The model of recovery as a social contagion explains the barriers to social integration for the recovering addict and offers a framework to provide direction for recovery

interventions, including the promotion of community and family roles in providing active and positive care. By making recovery the focus (and responsibility) of not only addiction professionals but also the wider community, the aim is to make the salience of recovery more visible and the belief that recovery is possible more accessible to a wider population. This is critical given the population that is being targeted through public policy focused on recovery. Destigmatisation is central to this process and the stigma associated with drug and alcohol addiction may be compounded by the additional stigmas associated with mental illness and cognitive disabilities that frequently co-occur in this population. If recovery is not to remain the preserve of those with established resources and supports (Granfield & Cloud, 1996), these barriers will only be adequately addressed in 'assertive' models of community recovery (Best, 2012; Timko, Dixon, & Moos, 2006), where communities are engaged and stigma diminished to allow the more vulnerable individuals the opportunity to access community capital and the social support systems of recovery.

For this reason, recovery cannot be expected to be something that people chance upon when they are ready. It requires assertive support and engagement in the community, the establishment of peer supports and resources and the development of accessible and engaging networks of visible recovery groups that challenge stigma and discrimination by their activities and endeavours. Ideally, they will also contribute to the community and through their direct engagement with the community, challenge stereotyped perceptions and beliefs about addicts and recovery.

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