

A tale of two towns: A comparative study exploring the possibilities and pitfalls of social capital among people seeking recovery from substance misuse

WESTON, Samantha, HONOR, Stuart and BEST, David
<<http://orcid.org/0000-0002-6792-916X>>

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Abstract

Background: Social capital has become an influential concept in debating and understanding the modern world. Within the drug and alcohol sector, the concept of 'recovery capital' has gained traction with researchers suggesting that people who have access to such capital are better placed to overcome their substance use-related problems than those who do not (Cloud and Granfield, 2008), leading to requests for interventions that focus on building social capital networks (Neale & Stevenson, 2015). While accepting that the concept of social capital has enormous potential for addressing the problems associated with drug use, this paper also considers its 'dark side'.

Methods: Data were drawn from semi-structured interviews with 180 participants including 135 people who use drugs and 45 people who formerly used drugs.

Results: High levels of trust, acquired through the establishment of dense social networks, are required to initiate recovery. However, these 'strong bonds' may also lead to the emergence of what is perceived by others as an exclusive social network that limits membership to those who qualify and abide by the 'rules' of the recovery community, particularly around continuous abstinence.

Conclusions: Depending on the nature of the networks and the types of links participants have into them being socially connected can both inhibit and encourage recovery. Therefore, the successful application of social capital within the drugs and alcohol field requires a consideration of not only the presence or absence of social connections but their nature, the value they produce, and the social contexts within which they are developed.

Keywords: Social capital, recovery, recovery capital, drugs, treatment

Introduction

The notion of social capital has existed for many years and has, particularly since the 1990s, influenced a range of policy developments and initiatives including, but not limited to, school attrition and academic performance, sources of employment, prevention of juvenile delinquency, immigration, and desistance from offending (Li, 2015). The political presence and popularity of the concept can be attributed to the work of Bourdieu (1985), Coleman (1988), and Putnam (1995; 2000) who have defined and applied social capital in different ways but nevertheless agree that 'relationships matter' (Field, 2003: 1). Central to the notion of social capital is the idea that social networks are a valuable asset. Interaction, a sense of belonging and the relationships of trust and tolerance developed within social networks, are said to help build communities and bring about benefits to those involved (Bartkus and Davis, 2009). On the other hand, neighbourhoods bereft of social capital, indicated primarily by depleted networks, are less able to realise common values and maintain the social controls that foster social cohesion – a crucial determinant of population health (Sampson, 2006; Kennedy, Kawachi, & Brainerd, 1998).

While noting a direct correlation between social capital and recovery from substance use, Granfield and Cloud (2001) coined the term 'recovery capital', defined as 'the sum total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation' (Cloud and Granfield, 2008:1972). There are four components of recovery capital. These are: social capital, referring to the amount of supportive relationships an individual may have; physical capital, referring to tangible items such as property and money; human capital, referring to an individual's aspirations, skills and positive health; and cultural capital, which is made up from a person's beliefs, values and attitudes which link to social conformity (Cloud and Granfield, 2008). Accordingly, those who have access to these kinds of resources have a greater capacity to terminate substance misuse than those who do not.

Of the four components of recovery capital – social capital, physical capital, human capital and cultural capital – this paper pays attention to the component 'social capital', referring to the amount of support that can be accrued from relationships an individual may have (Cloud and Granfield, 2008). Belonging to

one or more social networks has been identified as supportive of recovery (Best, et al, 2010; Terrion, 2013) and results in better treatment outcomes (Zywiak et al, 2009; Panebianco, et al., 2015). Findings such as these have made 'recovery capital', and the development of supportive social and personal relationships a central feature of UK policy and guidance (HM Government, 2010) and called for attention to be paid to how capital can be integrated into the service practices of front-line addiction professionals (White and Cloud, 2008). However, the very way in which social capital can form positive outcomes, can also lead to perceived 'negatives'. As Portes argues (1998: 2), the application of 'social capital has evolved into something of a cure-all and, like other sociological concepts... The original meaning of the term and its heuristic values are being put to severe tests by increasingly diverse applications.' There is more to social capital than the existence of relationships alone, and not all relationships result in positive consequences. Identified as its 'dark side', social capital can be drawn upon for negative as well as positive goals (Putnam, 2000) providing a reminder that when considering networks it is important to ask what is being connected, and how inclusive those networks and connections may become.

A crucial criticism of social capital theories relates to their emphasis on dense social networks. Within recovery networks, social support is considered a positive characteristic and is more likely to be effective when those who provide it are seen to embody a shared sense of identity (Haslem, et al. 2005; Jetten, et al. 2014) and engage in a process of reciprocity whereby members within the network are able to provide support as well as receive it (Gordon & Zrull, 1991). Yet as Putnam (2000) posits certain types of social networks, those made up of dense and 'bonding' capital, can produce situations of social isolation and 'high walls' excluding those who do not qualify. While relationships developed between like-minded people may help to define a shared sense of identity they can also promote homogeneity leading to the fostering of group boundaries, self-interest and the emergence of an exclusive social capital that can be detrimental to both the group and 'outsiders' (Zmerli, 2010). Furthermore, relationships that consist of high trust levels are not always regarded as socially desirable (Schuller, Baron and Field, 2000). For example, emphasising the importance of social capital, Radcliffe and Stevens (2008) illustrate how participation in a community of people who use drugs can be damaging to the prospects of recovery. They suggest that day programmes in particular, which are inhabited by acquaintances from the local drug

market, can provide a barrier to the creation of contacts that are outside the world of drug use. Similarly, Neale and Stevenson (2015:481) found that people who were homeless had social capital in the form of reciprocal, practical and emotionally supportive relationships but these relationships were not uniformly positive and access to capital was frequently undermined by issues such as 'difficult family backgrounds, relationship breakdowns, bereavements, drinking and drug use, mental health problems, lack of trust, broken confidences and dishonesty'.

Therefore, instead of placing emphasis on the establishment of social capital alone, Granovetter (1973:1360) argues that emphasis should be placed on the development of 'weak ties' – commonly referred to as bridging capital (Putnam, 1995; 2000) – as the collection of 'lightly engaged strangers' are critical for integrating communities of otherwise disconnected people. Such heterogeneous networks offer their members the opportunities to interact with people from different backgrounds, which may result in successful cooperation, trustful relationships, and reductions in stigmatising attitudes. A community completely partitioned into cliques, such that each person is tied to every other in his clique and to none outside inhibits social inclusion. While weak ties are likely to be more fragile they are critical for accessing social resources because they integrate the community by way of bridging together disconnected subgroups exposing individuals to new information, ideas, influences, and the 'knowledge of the world beyond his own friendship circle' (Granovetter, 1973:1371).

A more recent expansion of social capital theory is the incorporation of 'linking' form of social capital, which implies links to neighbourhood institutions and other individuals who have greater access to resources (for example, to provide access to services, employment or resources). It is this form of capital that is generated from the weaker connections but result in the most valuable outcomes as it provides access to resources, ideas, and information beyond the immediate community (Woolcock, 2001).

While some have considered how strong social bonds between those using drugs and their associations with drug-using networks serve to retain drug users in these practices (Bourgois, 1998; Radcliffe and Stevens, 2008), few have considered the negative implications of the strong social bond between those who formerly used drugs. Drawing on data collected from semi-structured interviews with people who use

and have formerly used drugs across two communities in the Midlands area of England, the findings presented in this paper attempt to unpack the nuances identified in the literature relating to the nature and value of social networks, and how such networks translate into social capital. Firstly, it is the aim of the paper to illustrate how the social networks developed by people who formerly used drugs during their stages of recovery operate and the extent to which these 'strong bonds' are perceived as necessary in the early stages of recovery. However, as acknowledged in the literature, the way in which social capital can form positive outcomes, may also lead to perceived 'negatives' and barriers to the growth of recovery communities. Therefore, the second aim of this paper, and where its original contribution lies, is to consider these 'negatives'. Attention is paid to how the 'strong bonds' and the high levels of trust developed within these networks may lead to the emergence of what is perceived as an exclusive social network that limits membership and engagement to those who qualify and abide by the 'rules' of the recovery community. The types of social networks and support accessible to people who use or have formerly used drugs, and how these might be partly contingent on their use or abstinence status, are considered. Also taken into account are the structural influences, as identified by Parkin (2015), particularly those that pertain to the availability and accessibility of services and social support within the community towns selected underlying decisions relating to drug use.

Data and methods

Data for our analysis were drawn from a larger case study developed to identify the extent to which 'networks of support and other assets within the community - mutual aid, peer support, community groups and recovery communities' (National Treatment Agency, 2011:1) – functioned for people resident across two community settings, referred to in this paper as 'North Town' and 'South Town'. The study was commissioned by the County Council that serves the two towns; therefore, both areas were located within the same county council area. The towns were selected by the Council's drug treatment commissioner due to them being broadly similar in terms of population demographics, and social and economic histories relating to decline and deindustrialisation, but diverse in terms of the drug and alcohol services available. Both North and South Town had similar provision of one-to-one psycho-social support, prescribing

services, and structured day programmes. However, provision for residential services and support groups were slightly different. While residential rehabilitation and detoxification are available to residents of both North and South Town the location of these services was in North Town, and access to the county's main recovery community network was only available to those who graduated, and abstained from all drugs including prescribed Opioid Substitute Therapy (OST), from this service.

Data were collected using one-to-one semi-structured interviews with 'people who use drugs' and people who described themselves as 'in recovery'¹. Participants were identified using 'privileged access interviewing' (Griffiths et al., 1993; Hammersley and Dalgarno, 2013) whereby interviewers use their social networks to interview as many of their peers as they can, both in and out of treatment, more commonly known as 'snowball sampling' (Avico et al, 1998). Eight peer interviewers were recruited via a number of local workshops across the two areas inviting individuals who were either currently engaged in services or were in 'recovery'. Research training consisted of four weekly sessions covering basic interviewing techniques and designing interview schedules. All peer interviewers and interviewees were paid for their time (£10 per interview for participants, and £5 per interview for peer interviewers).

When carefully and sensitively managed, privileged access interviewing is a powerful research tool for studying 'hidden populations' and activities like drug use. It allows access to groups whose existence is hidden from official view and, because it relies on members of the population interviewing other members of the same population, it overcomes issues identified by Davies (1987) who suggested that people who use drugs will present themselves in markedly different ways to 'straight' professional interviewers than they will to peer interviewers.

Interviews lasted between 30-45 minutes and followed a semi-structured topic guide that included a mixture of quantitative and qualitative questions. While the quantitative questions elicited helpful information about participants' backgrounds and circumstances the use of qualitative in-depth questioning enabled a more collaborative conversation whereby participants were asked about their housing situation,

social networks (including who participants lived with and spent time with), what activities they engaged in to fill their days, their financial situation, their health, wellbeing and ambitions, and their experiences of the criminal justice system. Having these kind of discussions enabled the authors to identify an individual's level of personal capital and the extent to which this hindered or facilitated their recovery (Cranfield and Cloud, 2008). Where extracts from interviews are presented, and consistent with ethical principles, pseudonyms have been used to protect the identity of participants.

Sample demographics

The study sample of 180 included 135 people who were using drugs (75 in South Town, 60 in North Town) and 45 people who formerly used drugs (15 in South Town, 30 in North Town). The demographics of the participants are shown in Table 1. The distribution of gender corresponds to reported demographics of people who use drugs across the two areas (Public Health England, 2013a). In terms of age, the sample includes a higher proportion of over 40s than the local profile but when compared to the national picture the sample group is perhaps more reflective as the over 40s 'have become the largest age group starting treatment' (NTA, 2012:3). The demographics of people who formerly used drugs were similar to people who use drugs although there were slightly more women in the recovery sample than in the sample of people who used. However, the sample did differ by location?? on variables relating to employment, housing and the services used. Those 'in recovery' from North Town were more likely to be in employment, living in stable accommodation and have drawn on North Town's residential rehabilitation service to enable their recovery.

[Insert Table 1 about here]

Data analysis

¹ The term recovery is a contentious concept and there exist a number of different definitions. The only definition we

Transcription of the audio-recorded interviews and analysis were conducted by the authors. In accordance with a grounded theory approach (Glaser and Strauss, 1967), the initial process of analysis was to thematically code the interview transcriptions by becoming familiar with the content, and looking for patterns and themes that helped to make sense of the data. By drawing on the conceptual tool of 'social capital', the analysis also included a degree of analytical induction. For example, to more thoroughly understand the relationships and networks of people who use or formerly used drugs the analysis involved paying attention to the nature of interpersonal relationships and how they impacted on their sense of belonging and connectedness to others, - indicators that have been validated by Carpiano and Hystad (2011) who found that a sense of community belonging is most closely capturing aspects of one's social capital. This process of data analysis generated multiple main and sub codes relating to these issues. Data were then organised in Excel following the approach put forward by Meyer and Avery (2009) allowing for comparative data analysis identifying changes in social networks over time, across place and identified differences in relationships between people who use and formerly used drugs. The nature of the relationships described, and the kinds of support they provided or problems they caused were identified resulting in the findings presented below.

Findings

Developing a recovery community: The benefits of social capital

Accessing support through bonding and bridging capital

Interaction, a sense of belonging and the relationships of trust and tolerance were consistent features of responses from people who have formerly used drugs, illustrating the types of benefits that can be brought about by social networks that embody these characteristics. The supportive roles of family members and close friends featured commonly in their expressions particularly when talking about how their recovery journeys were initiated:

"My mother and my kids supported me throughout my recovery" (Isacc, age 37)

“My little brothers keep me motivated and my mum keeps me grounded which has helped a lot in my recovery” (Leigh, age 23)

“Through supporting and standing by me they [my family and friends] got me to my appointments and have picked up my scripts, if I have ever been at work” (Oscar, age 29)

Identified in the literature as bonding capital, these intimate relationships between people who use drugs and their networks of family and friends are clearly important in the initial stages of recovery – a finding consistent with those that suggest motivation to abstain from drug use manifests from family, group memberships and friends whose norms and values are supportive of recovery (Best, et al. 2010).

The data presented here also suggests that further sources of support might come from contact with a recovery-oriented network that is capable of nurturing recovery and is shaped by the norms, values and expectations of the group. A number of advantages of belonging to such a group emerged from the expressions of those in North Town, including the skills and motivation gained from attendance and the social support developed:

“It’s improved my confidence, but also helped me to remain motivated, also keeps me focused knowing I have somewhere to go” (Vic, age 35)

“It has helped me in a lot of ways. Widened my support network, meeting new people, gave me good advice, made me feel a part of something” (Erica, age 30)

“It has taught me a new way of life, given me confidence, love, care, and support and it has helped me to help others” (Gail, age 45)

“I no longer feel alone. It has given me the ability to deal with any problem life throws at me. Overall it has awakened me to what is important in life” (Alan, age 42)

Others in North Town made reference to either paid or voluntary work with organisations supportive of recovery:

"[Drug service] on Monday and Tuesday, and the YMCA rest of the week volunteering. I also meet up with some clients from [drug service] and [rehab] for a coffee and a chat" (Vince, age 44)

"Volunteering for [recovery group] mostly. I also see friends who are in recovery and go to the recovery café" (Michael, age 28)

For these participants, the boundaries between work and social life became blurred. Social networks emerged from the voluntary opportunities and involvement with services, because their friends were also their peers in recovery. Also consistent within these social networks is the norm of reciprocity. People who formerly used drugs across North Town who had graduated from the residential rehabilitation service engaged in a process of exchange whereby they both received and provided support to other network members, consistent with models of recovery capital.

Even in the minority (6 of the 30 interviewed in North Town) of cases where paid or voluntary work was not mentioned, participants described engagement with others in recovery:

"I don't do a lot really, watch the TV, go and see mates, do my weekly shopping, look for work, go for coffee in town to meet people from the [local rehab]. Go see family, have dinner with them once a week" (Debbie, age 31)

The picture emerging from these findings suggest that people who formerly used drugs in North Town appear to have a broad social network. Those in North Town were bonded together not only with family, partners and friends, but also with 'abstinent' friends made through their attendance at support groups and access to the recovery community made available to those graduating from the residential rehabilitation service in the area.

'Feeling connected' through linking capital

The contacts made through the various voluntary and other employment opportunities facilitated by the local residential rehabilitation service also enabled their graduates to feel connected, not only to each other, but to the wider community:

“With doing my voluntary work with the YMCA I get to visit different areas and help others” (Vince, age 44)

“Before I was robbing off the community, but now I am helping put people back into the community clean and sober” (Joe, age 32)

To gain access to recovery via the residential rehabilitation service in North Town people who formerly used drugs go through a process whereby both bonding, bridging and linking capital is established. People are encouraged to draw on their networks of family and friends to initiate recovery (bonding social capital) and then they are supported to develop new networks with others in recovery (bonding and bridging social capital) and with groups in the local community (linking social capital). Many of these relationships are based on the norm of reciprocity whereby members of the network are both receiving and providing support establishing trust between group members. These findings illustrate the efforts made in North Town to develop and promote a community that is not only based on mutual trust and cohesion but that is conducive to supporting and building recovery. While acknowledging that these features are perceived as necessary in recovery networks, particularly in the early stages of recovery to ensure safety and wellbeing of members, the remainder of this paper illustrates how they may create a community that is perceived by others as exclusive and impenetrable. In other words, unless individuals (both people who use drugs and those who may not have graduated from North Town’s residential rehabilitation service) can claim access to the type of social capital generated by active recovery communities and the benefits it elicits, recovery could be delayed and access to recovery capital diminished for those who do not meet the criteria for recovery group membership .

Discarded and disconnected communities: The dark sides of social capital

While accepting the huge potential of social capital for developing new ways of thinking about how to address drug and alcohol issues the expressions made by participants of this study have also helped to shed light on its potential dark sides. Firstly the emphasis placed, in the literature and in policy, on the need to develop supportive relationships does not always take into account existing relationships that people who use drugs have nor the challenges that leaving existing relationships and networks might

create. Often referred to as 'negative' social capital the way such capital operates to further reinforce drug use will be shown below. Secondly, in an effort to distinguish between 'negative' forms of social capital and depleted or no social capital, the expressions of people who formerly used drugs across North Town about the opportunities provided there will be presented highlighting the shortage of appropriate support networks in South Town. Therefore, in areas that are bereft of social capital, the question that remains is how people who use or formerly used drugs residing in those areas access the recovery capital generated in areas, like North Town, that have an active and visible recovery community.

The social capital of people using drugs

While people who use drugs are often not short of social capital it is important to make a distinction between positive and negative forms of capital. Many of those interviewed who use drugs were in long term relationships but in many cases these relationships were with people who also used drugs and alcohol. These participants also had large networks but, again, these consisted mainly of people who also used drugs/alcohol:

"Apart from four people, I only know drug users" (Sam, age 37)

"Because I am a smack head the only people I know are on drugs" (Harry, age 48)

"The only people I know are drinkers and it's always same shit, different day" (Helen, age 35)

Consistent with Best et al's (2008) findings many of those interviewed had experienced periods of abstinence but when asked about reasons for relapse, rejoining social networks of people who use drugs was commonly cited as the main factor, confirming that certain forms of capital are capable of delaying recovery:

"I relapsed because I was going back to where I used to live and seeing old friends" (Gary, age 35)

"Engaging with circle of friends who used made me start using again" (Sarah, age 35)

"I started using again because I got back involved with the same crowd" (Kelly, age 32)

While the high levels of trust produced through positive forms of bonding capital was identified by those who formally used drugs as helpful when abstaining from drug use, the negative forms of bonding capital accessed by people who use drugs serve to only reinforce their drug use. As Sugrue (1995) acknowledges, social capital can be drawn upon for negative as well as positive goals. For example, some have found that dense networks that are composed of a larger number of drug-using members facilitate access to substances and risk factors for relapse (Laitkin, et al., 1995; Harocops, et al., 2009; Koram, et al., 2011). The norms that govern these relationships invert those that are normally ascribed to social networks and are based on a normative structure that supports drug use rather than supporting recovery. Therefore, the ‘collective recovery capital’ referred to by Best and Laudet (2010), that provides support for those pursuing recovery, appears to be hindered by the dense bonding capital available to those who use drugs, and their embeddedness and commitment to these groups.

Depleted social capital in and among people using drugs

Despite their access to bonding social capital the shared sense of identity and feelings of not ‘being alone’ or being ‘a part of something’, expressed by those who formerly used drugs in North Town, did not feature in the accounts of those that use drugs across the two towns. Some people expressed feelings of being discarded and disconnected from their wider local communities, indicating a lack of social capital:

“I’m too scared to leave my house most of the time, so I just watch TV and read” (Charline, age 44)

“Get up at eleven, have a few cans, drink methadone, watch TV. Not much else really. Some days I don’t see anyone” (Phil, age 33)

“Nothing really, I just doss at home. I feel like I’m not living. I’m just existing” (Hannah, age 35)

Where reasons were provided for feelings of disconnectedness, they included housing issues, limited social networks and fear of stigmatisation.

Many of the participants emphasised difficulties associated with securing a stable place to live and suggested that this often prevented them from engaging with their local community:

"I am here, there, and everywhere really. Just staying on sofas" (Carly, age 41)

"I try to keep a distance from people in the community. At the minute I'm all over the place" (Stan, age 34)

Others referred to the limited social networks they have consisting mainly of people who use drugs:

"I've been here a year and I only know drug users, so I try to keep myself to myself" (Aaron, age 28)

"It's okay, but wish I knew more normal people" (Ashley, age 38)

The fear of stigma from the local community was also suggested as being a barrier to community connectedness:

"The town know I shoptlift, so I can't go anywhere and don't feel connected to anything" (Ben, age 57)

"I don't belong to one group or another. I am trying to stay away from negative folk, but am not accepted by wider society" (Sean, age 36)

"I have lived here most of my life but my using has disconnected me from the community" (Kelly, age 32)

"Most people just see me as a junkie. Everyone in the town knows your business and they judge you" (Hannah, age 35)

"I've been made to feel like an outcast, we are looked down upon" (Guy, age 31)

In a community like South Town that has limited positive social capital, indicated primarily by depleted forms of networks there and the higher salience of using networks, it can be even more difficult for people who have formerly used to create or access it on their return, leaving them vulnerable to potential relapse:

"Made a good start. It's difficult in [South Town] as there's nothing here to help you move on. You battle your way out of services and then are offered pretty much nothing. You're on your own and it's a lonely feeling. The two blokes I've known who got sorted with me moved back to North Town, as it was too much for them around here" (Terry, age 47)

“There doesn’t seem to be any support for people in [South Town]... I came back from [the rehab in North Town] over 12 months ago and there’s nothing here, no links... A few of us from [South Town] came back and some couldn’t stand it here because of the lack of support” (Bill, age 52)

Consistent throughout these interview extracts are feelings of isolation based on geography and separately concerns about relapse. Those who refer to housing issues as a source of disconnectedness talk about being ‘here, there and everywhere’. Similarly, those who refer to having limited social networks suggest that they ‘keep themselves to themselves’, while those who make reference to stigma express feelings of ‘not being accepted’, and ‘made to feel like an outcast’. These expressions contrast sharply with those who formerly used in North Town who typically identify themselves as no longer being ‘alone’ and becoming ‘a part of something’. Many of the participants interviewed, therefore, were socially isolated having limited or no social networks and so no social capital to draw on to initiate and/or sustain recovery.

Exclusion and isolation: The ‘dark sides’ of social (bonding) capital

While the shared sense of identity with others in abstinent recovery provides important social and psychological support, it might have the unfortunate effect of excluding those that do not qualify or who are seen as a threat to the wellbeing of the group (Van Deth and Zmerli, 2010). Participants who perceived themselves as being ‘in recovery’ described a process of distancing themselves from those who were closely linked to drug use, including those who have relapsed:

“Although I know people in my area I keep myself to myself apart from other people in recovery”
(Gail, age 45)

“I suppose I live in a recovery bubble and a lot of the people I spend my time with are in recovery”
(Diane, age 36)

“We are connected but not as much as I think we should be, recovery can be a bit exclusive”
(Michael, age 28)

This process of distancing was reflected in the accounts of those who had previously been in recovery, suggesting that they had felt discarded from the local recovery community because they had relapsed:

“When I came out of rehab I couldn’t maintain my sobriety. When I relapsed nobody wanted to know” (Chris, age 46)

“Because I relapsed since leaving rehab I don’t feel connected, because I just feel like I’m part of the scum again now” (Paul, age 34)

Others expressed feeling excluded simply because they did not meet the criteria for entry to the residential rehabilitation service thus preventing them from accessing the recovery community:

“I went to the [residential rehab] and they said they were going to send me to another town, but I said no, I didn’t want to be picked up in one town and put down in another. So I was told from the worker there that I could get sorted at the residential rehab. Then they rang me and said ‘sorry we don’t think you are ready, so now I just think I’m a bit long in the tooth and I may as well just carry on the way I am” (Steve, age 41).

“More things for people to do, like activity centres where it keeps us busy and stops us being bored, as this is when we take drugs and drink. There is no local link with the recovery community if you’re out there” (Callum, age 31).

“More places for people to go and get support, somewhere people can go and talk to someone and get help to stay clean and sober. The residential rehab is okay, if you can get in, but the rest of us are left out really. When you relapse you feel like you’ve failed and there’s nobody here to catch you when you fall” (Gary, age 35)

“Something like the [facilities available to the recovery community in North Town] that is open to people that may not be abstinent, so everyone has the opportunity to have somewhere safe to go where they can talk” (Matt, age 47)

“Drop-ins need to be opened up to everyone. Not just those in there [the residential rehabilitation service]” (Rob, age 43)

The data presented here suggests that the recovery community in North Town may be perceived by those external to it as an ‘exclusive bubble’ for those who successfully engage with the residential rehabilitation service in the area. Certainly, those in recovery in North Town have a stronger sense of community

connection generated by their dense ties to each other, on the basis of a common purpose to be abstinent, and wider involvement in community initiatives that help to further their own recovery. However, as Zmerli (2010) acknowledged, networks that pursue individual aims tend to foster group boundaries and self-interest, leading to the emergence of a social capital that cannot then be accessed by other networks or individuals who do not meet a very particular definition of recovery (generally predicated on abstinence). In the absence of a recovery network in South Town and/or other neighbouring communities, this type of situation leads to the emergence of an exclusive social capital that potentially isolates those outside, especially those who might still be using substances and in the earlier stages of recovery, or whose definition of recovery does not involve abstinence. Therefore the bonding capital available to people who use drugs, and discussed at the beginning of this section, serves additional purposes to those previously acknowledged. Seeing 'old friends' and getting 'involved with the same crowd' may provide a refuge for people who formerly used drugs, particularly where experiences of stigma and social isolation from the wider community as well as from those in recovery are common, leading to relapse and hindering their recovery.

Discussion and conclusions

Findings from this study provide additional insights into the concept of social capital, a critical component of recovery capital. It has been established that the initiation of recovery generally requires high levels of trust, acquired through the establishment of dense social networks and the norm of reciprocity around help-seeking and help-giving. This finding is consistent with previous studies that have suggested integrating people who have formerly used into relationships based on trust and mutual reliance with non drug-using others produces social capital that helps to support their abstinence (Cheung and Cheung, 2003; Cheung, 2009).

While accepting that the concept of social capital has enormous potential for addressing substance use problems our findings offer an opportunity to also take account of its 'dark side'. Some of the data presented confirm that dense social networks drawn upon by people who use drugs can reinforce and even facilitate drug use, and act as barriers to transition to groups that support recovery. However the

substantive part of the paper, and its original contribution, illustrates how the strong bonds required to initiate abstinent recovery communities, and allow them to prosper, may have unintended and adverse consequences. By limiting new membership to individuals who meet a very particular definition of recovery (generally predicated on abstinence) strong bonded recovery groups might prevent some from accessing recovery resources and supports in their communities, without which recovery may feel like a difficult and isolating journey.

While the closed network of people who formerly use drugs and who are pursuing abstinence are insulated against outside forces by limiting membership to individuals who meet certain criteria, the high levels of trust developed within these networks and the blurred boundaries between work and social life within these recovery communities leads to the emergence of what appears to 'outsiders' as an exclusive form of social capital that cannot be easily accessed, resulting in an unexpected barrier to the initiation of or continuance of recovery journeys. Where a recovery community has developed as a result of one particular pathway (based typically on a therapeutic community or 12-step philosophy) and where that pathway may not be appropriate or available for all, then that community may be perceived by others as 'gated' whereby the potentially protective factors offered by membership are only available to a privileged few. This is particularly true when strict abstinence is a requirement for group membership. For example, the recovery community in North Town appears to function for people engaged with the 'service' but not for the population of the community as a whole. Beyond this pathway, the pictures in North Town and South Town are not too dissimilar. Although there is a significant lack of recovery oriented services and resources in South Town, for those in North Town who do not follow the residential rehabilitation pathway or have relapsed since graduating there is a perception that the visible recovery community may in fact be out of reach or 'in there'.

In the absence of local support groups and active recovery networks that do not insist on abstinence, many of this study's participants had very little social recovery capital to draw on, although they were generally aware of the recovery community that was out of reach. Not only were they unable to escape their previous bonding capital with drug-using friends but neither could they establish new bridging capital

because of the absence of support networks that would help to generate these types of contacts. This so-called 'structural hole' (Burt, 2005) exposes individuals to the risk of relapse and highlights the need for social capital to be accessed via multiple pathways and at different stages of the recovery journey, thus exposing otherwise disconnected groups to new information, ideas, influences, 'knowledge of the world beyond his own friendship circle' (Granovetter, 1973:1371) and improving reciprocity both within and between groups.

The study does have some limitations. Peer interviewers inevitably lack the skills and experience of professional researchers and basic training does little to compensate for this. To overcome this problem various checks were built in to the questionnaire and field work process. Involving peer interviewers in the design of the interview schedule meant that they had some ownership of it and were aware of its aims and objectives. Peer interviewers were also regularly supervised and often accompanied by a research methods trained fieldwork manager.

The use of peer interviewers also means that the data were collected using snowball sampling techniques. This type of non-probability sampling procedure has its acknowledged drawbacks, the main one being the issue of selection bias (Van Meter, 1990; Kaplan et al, 1987) as the choice of the subject depends on the network of peer interviewers. This issue was partly addressed by the selection of a large sample but also by replication of results, which thereby strengthens the validity of the findings.

Despite these limitations, the findings presented in this paper reveal that the community and the connections made between people within it are central to an understanding of how to overcome substance dependence and that being socially connected can both encourage and inhibit recovery. There has been some attempt in the UK to engage with these types of sociological approaches to recovery from substance dependence - the UK's 2010 Drug Strategy makes a specific commitment to support services to 'work with individuals to draw on (social, physical, human and cultural) capital in their recovery journey' (HM Government, 2010: 18-19). The Department of Health (2012: forward) outlined plans to shift treatment under the umbrella of public health situating addiction firmly within a social and economic context and recognising that are wider contextual and structural issues that impact upon people's use of

substances. These strategic directions have become embedded within local and regional initiatives, such as 'Recovery Central' that aims to provide a one-stop shop for the recovery community and has been specifically designed to make Birmingham the 'recovery capital of the UK' (BVFC, 2016). Moreover, substance misuse services up and down the UK have developed specific posts, such as 'recovery champions', designed to work with service users to help build their own 'recovery capital' (Change, Grow, Live, 2016)

Yet there remains little advice available about how exactly such networks should be established. For example, while public health guidance promoting mutual aid groups exists (Public Health England, 2013b) it tends to oversimplify the complexity of relationships, time taken to develop new recovery-oriented networks, and fails to take account of social contexts, including the community (Best et al, 2015) and centrality of place relating to drug-using environments (Parkin, 2015).

Therefore, the successful application of social capital within the drugs and alcohol sector requires a consideration of not just the presence or absence of social networks but the nature of those networks and the value they produce. While it is necessary to establish dense social capital among those in recovery to ensure that recovery does not become undermined by the presence of others who might still be using substances of various sorts, attention should be paid to how those early in the recovery journey can be exposed to recovery groups and networks who have more established recovery resources and community connections. The efforts made by the residential rehabilitation service in North Town to develop and promote a community that is based on mutual trust and cohesion and that is conducive to recovery illustrates how people who have used drugs can be successfully integrated into non drug-using networks. However, as this paper illustrates, the applications of social capital to aid recovery is a complex one and consideration should be given to developing some of the concepts problematised in this paper such as how one group's recovery protection – i.e. bonding capital – can be accessed by outsiders to form the necessary bridging capital to initiate and sustain recovery for them.

A further consideration for policy makers and commissioners, and one that has been discussed at length by Parkin (2015), is the relevance of the social context within which social capital is developed. While White

and Cloud (2008) acknowledge the variance of social capital amongst people who use drugs and access treatment services they do not sufficiently consider the structural influences underlying decisions relating to drug use. The findings of this paper have revealed a 'structural hole' in South Town characterised by an absence of appropriate support networks that, when confronted by experiences of stigma and social isolation, potentially encourages people who formerly used drugs to draw on established and entrenched 'street-level capital' (Parkin, 2015) exposing them to the risk of relapse. It is this type of capital that has been 'socially, culturally, economically and symbolically shaped by drugs, drug use and other drug users' (Parkin, 2015:6) and is a form of capital that is drawn on by those who originate from disempowered, disenfranchised and deindustrialised communities, such as those selected in this study. Therefore, when developing services which facilitate recovery support networks, policy-makers and commissioners should also take account of situational contexts and the potential within them for sustained and continued attentiveness to street-level capital that might hinder the development of recovery capital.

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