

The practitioners' perspective on the upside and downside of applying social capital concept in therapeutic settings

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3 The practitioners' perspective on the upside and downside of applying social capital concept
4 in therapeutic settings
5

6 Abstract

7
8 Social capital, and more particularly the social networks that define its existence, is
9 said to benefit health and wellbeing. **In individuals recovering from alcohol and**
10 **drug addiction, social capital accruing from social networks support treatment,**
11 **recovery and maintenance. Therefore, the concept of social capital is important**
12 **for public health practitioners working in recovery interventions.** This qualitative
13 study seeks to explore what practitioners perceive as **the** importance of social capital
14 and how they apply the concept in interventions to support individuals recovering from
15 drug and alcohol addiction. Eight public health practitioners involved in drug and
16 substance abuse interventions in West Yorkshire, England, were interviewed. The
17 results of the interview were then deductively coded using two priori themes of
18 perceived impact of social capital on health outcomes and application of social capital
19 theory in recovery interventions. The findings reveal that practitioners understand the
20 impact of social capital **as the effects of social networks** on recovery and apply the
21 concept in their interventions. However, the nature of interventions created based on
22 similarities in condition (alcohol and substance addiction) and intended outcome
23 (recovery) create bonding social capital with mixed outcomes. This paper argues that
24 the wider benefits to service users are unintentionally inhibited by the overwhelming
25 downsides of bonding social capital. For instance, closed support groups comprised
26 of individuals with high similarities further exclude the already socioeconomically
27 deprived service users from integrating and accessing resources outside their groups.
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1
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3 Key Words
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6 Social capital, Recovery capital, Recovery, Social networks, Alcohol and drug
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8 misuse,
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14 What is known about this topic
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- 18 • Social capital enables initiation of treatment, adherence, cessation and
19 prevention of relapse.
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 - 21 • The impact of social capital on recovery from alcohol and substance abuse
22 has been difficult to evidence conclusively.
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 - 24 • The application of social capital theory in professional practice is under-
25 researched in public health and health promotion settings.
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35 What this paper adds
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- 39 • Practitioners draw upon social capital theory to support creation of positive
40 social networks amongst service users to promote changes in attitudes and
41 behaviour.
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 - 43 • The problematic application of social capital theory in public health interventions
44 makes it hard to realise deliberate gains from the concept.
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 - 46 • Focus on similarity-based networks prevents acquisition of linking and bridging
47 social capital jeopardising the recovery process.
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1. Introduction

Social capital is considered both as the conceptual origin and an essential component of recovery capital (Neale & Stevenson, 2015; Cloud & Granfield, 2008). Defined as resources inherent in and accessible through one's social networks (Lin, 2001), social capital is considered an external resource that partly constitutes recovery capital. Cloud & Granfield (2004) explain that recovery capital comprises internal resources that include individual values, self-esteem and confidence, and external resources such as one's community and social networks that can be leveraged by practitioners in interventions aimed at achieving and maintaining sobriety. Consequently, the premise that practitioners can enable access and help mobilise the resources inherent in social networks to support recovery of individuals misusing alcohol and drugs provides an opportunity for professionals to elicit important pathways for the recovery process (Best et al., 2016;2014; Groh et al., 2008). The same premise forms the foundation of the relationship between social and recovery capitals and the rationale for creation of recovery groups (Neale & Stevenson, 2015; Granfield & Cloud, 2001). Despite social capital's potential in positively influencing health and wellbeing through the development of social networks, our understanding of how to apply it in practice is weak and can potentially lead to adverse effects for individuals and communities (Moore & Kawachi, 2017; Portes, 2014). This study aims to contribute to further understanding in practice by exploring public health practitioners' perceptions of impacts of social capital on recovery and its utilisation in supporting service users recovering from alcohol and drug misuse.

Recovery is a multidimensional concept, and its meaning differs between practitioners and service users (Laudet, 2009). Practitioners view recovery as a

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3 **voluntarily maintained lifestyle marked by abstinence, health and wellbeing,**
4 **social participation and connectedness (UK Drug Commission, 2008). Diversely,**
5 **service users view recovery in numerous ways.** For instance, some define
6 recovery as a form of 'new life' while others perceive it as cessation (Laudet, 2007).
7
8 There is consensus among scholars **however**, that recovery is a process that
9 continues decades after one withdraws from substance abuse (Best et al., 2016; Boeri,
10 Lamonica, & Harbry, 2011). **It seems intuitive therefore to consider both**
11 **practitioners' and service users' perceptions of recovery in research**
12 **undertaken in therapeutic settings.** By doing so, it helps to enhance practitioners'
13 understanding of how theories can underpin interventions **and consequently**
14 **increases** their ability to support clients to become more connected and adopt healthy
15 lifestyles.
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18
19 Similar to recovery, social capital is a multidimensional concept **whose taxonomy has**
20 **grown over time. For example,** Putnam's later work (2000) introduced different
21 **forms** of social capital, bonding and bridging. **Later,** Szreter & Woolcock (2004) added
22 a third type, linking social capital, **to the nomenclature.** Putnam (2000) and others
23 **(Harpham et al., 2002) express** bonding social capital **as** interactions **and access to**
24 **resources that take place between groups with similar characteristics. Bridging**
25 **social capital tends to occur between dissimilar groups. In this case, the access**
26 **to resources usually arises through connections between groups of different**
27 **socioeconomic status or other dissimilar characteristics. The third form of**
28 **social capital, linking social capital** illustrates the potential benefits of individuals'
29 connection to institutions and those in powerful positions (Szreter & Woolcock, 2004).
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31 **It is mostly referred to in practical applications where the need to equalise power**
32 **between local communities and formal institutional structures is paramount to**
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3 **the building of social capital at local level.** None of the three forms of social capital
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5 can exclusively provide all benefits of social networks and relationships (Campbell,
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7 2019; Cai, 2017; Hawkins & Maurer, 2009). Hence, the need to possess or access
8
9 proportionate levels of any of the social groupings depend on the desired individual or
10
11 group gains.
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14
15 Putnam's (2000) classification of strong bonds and **weaker** bridging relationships and
16
17 their associated merits and demerits originate from Granovetter's (1973) sociological
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19 theory of weak and strong ties. Granovetter argues that despite the supportiveness
20
21 and ease of accessibility of one's high-density groups characterised by high similarities
22
23 and strong closely-knit relationships, weak ties are critical in sustaining the strong ties
24
25 and making them more beneficial. He suggests that a weak tie, such as an
26
27 acquaintance **or a professional**, acts as a bridge between different clusters of closely-
28
29 knit relationship groups and enables members to get information on opportunities that
30
31 could have been impossible in the absence of the acquaintance connecting two groups
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33 of closely related individuals. The limitations of highly homogenous groups constituting
34
35 strong ties and the need for weak ties as illustrated by Granovetter (1973), can be
36
37 compared to the deficiencies of bonding social capital and the progressiveness of
38
39 bridging social capital. The former **pertains** to inclusivity and its potential downside
40
41 and the latter **highlights** the benefits arising from access to information and resources
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43 external to closely-knit homogenous groups (Portes, 2014; Putnam, 2000). However,
44
45 social networks are not binary and may constitute a blend of both bonding and bridging
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47 social capital characteristics, although in varying proportions (Campbell, 2019). For
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49 instance, recovery groups tend to constitute more bonding social capital as they are
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51 formed on similarities in substance misuse and common goal of recovery, with a focus
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53 on achieving abstinence with less emphasis on other equally important needs, such
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3 as employment and housing that are crucial to sustaining recovery. Therefore, building
4 **bonding** social capital to support recovery may inadvertently exacerbate inequalities
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6 and further disenfranchise the service users (Zschau et al., 2015; Boeri, Gibson &
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10 Boshears, 2014).

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13 Social networks in which people can negotiate connections and networks within and
14
15 between different groups create social capital (Burt, 2017). Social networks are a vital
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17 resource for effecting motivation, initiation, support and maintaining the recovery
18
19 process amongst recovering individuals (Best et al., 2016; Neale & Stevenson, 2015;
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21
22 Boeri, Lamonica & Harbry, 2011). Hence, social networks stand as a critical variable
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24 in social capital application. The knowledge about the contribution of social networks
25
26 to the recovery process could aid therapeutic practice. This study therefore seeks to
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28 answer the questions: what practitioners perceive as the importance of social capital
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30 and how they apply the concept in interventions to support individuals recovering from
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32 drug and alcohol addiction.
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36 37 2. Methods

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39 The study was located in West Yorkshire, England, and undertaken within therapeutic
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41 settings in which public health practitioners support individuals undergoing recovery
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43 from drug and alcohol misuse. This research utilised a qualitative approach using
44
45 purposive sampling to recruit a cohort of eight **professionals** who were then
46
47 interviewed using semi-structured interviews. Verbal data was captured using a digital
48
49 recorder during interviews. The recordings were transcribed verbatim and
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51 transcriptions were checked by all the participants for accuracy. Thematic analysis
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53 was used to analyse the transcribed data (Braun & Clark, 2006).
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2.1 Sampling and Recruitment

Potential participants were identified by conducting a thorough search on forumcentral.org.uk - a central website for all third sector organisations (**TSOs**) in West Yorkshire. **TSOs** were chosen rather than public or private organisations as this reflects the increasing commissioning trend of health and wellbeing service delivery since the Health and Social Care Act was introduced in the UK in 2012 (Ham et al., 2015). Potential participants from these organisations were initially screened with the use of a questionnaire to elicit pertinent information such as the level of operation, the duration of their professional experience, the nature of health interventions they were involved with and the location of their professional practice. This was to ensure that recruited participants offered a diversity of experience and perspectives about social capital. From the twelve candidates identified, eight satisfied the inclusion criteria set out for this study. These criteria demanded an active involvement in public health/health promotion and at least one year's experience of working on interventions that attempt to directly improve health and wellbeing of recovering persons through social interventions. **The four professionals excluded from the study did not meet the minimum one-year experience set as a criterion for inclusion.** The final sample comprised a mixture of professionals working in either residential or **community-based** programmes or both. The characteristics of the eight participants selected for this study are showed in *Table 1*.

This study chose **purposive sampling** as it had the potential to yield in-depth information rather than empirical generalisations (Patton, 2005). This sampling method proved to be ideal for identifying a diverse and knowledgeable cohort of professional practitioners who could offer valuable insights about social capital in action (Ulin et al., 2005). The adequacy of this sample size (eight) was based on the

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3 concept of information power (Malterud et al., 2016). According to Malterud et al., the
4 specificity of the sampling methods, the quality of interviews, the use of existing theory
5 and the extent to which the sample group identifies with the aims of the research and
6 the topic under investigation **determines the level of information power**. In this
7 study, the sampling techniques used ensured the selection of highly informed and
8 experienced participants. Semi-structured interviews were designed using existing
9 definitions of social capital theory to foster participant engagement on those issues
10 which directly addressed the aims and objectives of this study. This was substantiated
11 by the quality of data collected at the subsequent phase of data handling and analysis.
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24 2.2 Data collection

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27 Data **were** gathered using semi-structured **interviews**. **Questions** posed from the
28 schedule were designed to elicit data to address the research questions seeking to
29 find out practitioners' perception of the importance of social capital and how they apply
30 the concept in interventions to support individuals recovering from drug and alcohol
31 addiction. For instance, **regarding** the former, participants were asked: 'What are the
32 effects of **social networks** on the community (alcohol and drug users) you work with?'
33 and regarding the latter, participants were asked 'How do your interventions help
34 members to benefit from groups and social networks?'
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46 By request, all eight interviews were conducted in the workplace and lasted for
47 approximately thirty minutes. Verbal data was digitally recorded, whilst non-verbal data
48 was captured by the researcher who made notes during the interview. The physical
49 interaction that took place during the face to face interviews allowed the observation
50 of non-verbal cues such as intonation, posture, and voice. These were crucial for
51 developing probes to further explore issues of interest that emerged during the
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3 interview (Opdenakker, 2006). Many such probes developed out of unclear or
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5 incomplete answers given by participants during the process.
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8 All transcribed interviews were returned to the participants for member checking to
9
10 ensure the content and process had been captured accurately. All eight participants
11
12 confirmed that the transcripts were an accurate account of their responses and did not
13
14 make any changes or objections to their use. Enabling participants to check the
15
16 verbatim transcripts was **necessary** for this study as it enhanced the credibility of the
17
18 findings (Polit & Beck, 2010; Creswell & Miller, 2000).
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22 23 2.3 Ethical Considerations

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25 General information about the purpose of the study was issued to all eight participants,
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27 and written consent was obtained before data collection commenced. Consent
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29 permitted the researcher to record interviews digitally and to disseminate findings of
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31 the study via publication and any other method of dissemination selected by the
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33 researcher. Confidentiality of all participants was ensured by eliminating identifying
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35 information from the outputs of this study (Wiles et al., 2008). Ethical approval for this
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37 research was obtained from the author's institution and participants understood that
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39 participation was entirely voluntary and that they could withdraw from the study at any
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41 point before the stage of data analysis.
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45 46 2.4 Data analysis

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48 Thematic analysis (Braun & Clark, 2006) was used to code and interpret the data. This
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50 involved the researcher identifying patterns across all eight of the practitioners'
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52 perspectives that specifically related to the research question on the use of social
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54 networks to build social capital by practitioners working with recovering drug and
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56 alcohol users (Bazeley, 2009). The first stage of analysis began with data
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familiarisation, necessitating the repeated reading of transcripts and the replay of recorded interviews so that the researcher became fully immersed in the data. The second stage of analysis involved coding the data and this was performed manually using both deductive (Bazeley, 2009) and inductive approaches (Hayes, 2000). Open coding was first used to identify the initial codes from which themes and sub-themes could eventually be organised (Braun & Clark, 2006; Saldaña, 2015). This was done manually by interrogating the transcripts line by line, highlighting the emerging codes using colour to differentiate the codes. Related codes were given the same colour code and then grouped to form a sub-theme. The second level of coding was then undertaken to analyse and organise these sub-themes into themes which related directly to this study (Bazeley, 2009). Developing a hybrid coding method ensured that the analysis suited the unique aim of the study and optimally addressed the research questions (Bazeley, 2009; Saldaña, 2015). The outcome of the analysis was a group of inductively identified sub-themes categorised under priori themes which are presented in the findings.

3. Findings

The findings of this study which sought to find out if, and how practitioners understood social capital and how they applied the concept in interventions to support individuals recovering from drug and alcohol addiction are summarised in *Table 2* below:

3.1 Perceived impact of social capital on alcohol and drug recovery

The study found that professional practitioners' understandings/interpretations of the term social capital was limited to the operation of social networks. In this, practitioners found utility and applied their knowledge to shape the recovery process. The value of

1
2
3 social capital was portrayed as an essential component of long-term recovery, social
4 support, behaviour and attitude change, a source of necessary information and
5 sharing valuable interpersonal experiences. However, it was equally evident that
6 social capital was not inherently positive and could potentially lead to unintended
7 negative outcomes before, during and after recovery interventions.
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15 3.1.1 Benefits of social capital

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17 The study found that the practitioners deemed service users who had strong social
18 networks as having better recovery rates. **Hence**, the practitioners expressed **value** of
19 social capital in interventions. One of the practitioners working in alcohol detoxification
20 programme explained their role in encouraging creation and access to useful networks
21 by stating:
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30 *“We do try to encourage them all the time to involve their families, partners,*
31 *social networks, and positive peers in their care package. Because we find*
32 *that people who succeed are the people who have got a lot of positive social*
33 *support.” (Participant 1).*
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37 The participants described the pathways through which social networks supported the
38 recovery journey **via** both external and internal impetus. For the external, social
39 networks were perceived as points of conversations that encouraged and motivated
40 their participants to attend appointments and through sharing personal experiences of
41 the most helpful and least helpful factors in the recovery process. The internal control
42 and resultant trust from group membership **were** thought to trigger an internal drive in
43 individuals to recover in a bid to conform to the group’s common goal. One practitioner
44 in charge of an alcohol anonymous group run by a multipurpose charity explicated this
45 by quoting her service users:
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58 *...Yeah and again that's where I come back to the groups because that is*
59 *positive support network some people say, “well I don't want to upset this*
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3 *positive network that I have built and I don't want to upset people that*
4 *matter..." (Participant 3)*
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8 3.1.2 Disadvantages of social capital 9

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12 Whilst the cohort acknowledged the benefits of networks to the recovery process, they
13 also voiced some caution as some networks proved to be detrimental to the recovery
14 process by fostering co-dependency rather than recovery. A practitioner working
15 around sexual and reproductive health with the service users elucidated:
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24 *...a lot of our service users often spend a lot of time together with each other.*
25 *We have a lot of people in co-dependent relationships where they think they*
26 *are supporting each other really they are co-dependent they are as bad as*
27 *each other. One blames the other, but they feel that they are supporting each*
28 *other in some way, shape or form. (Participant 7)*
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32 Moreover, practitioners also expressed concern that their work to support social
33 network building within the intervention could be undermined by social capital activities
34 outside of their control. For example, service users' families and immediate community
35 could pose a risk of relapse into problematic behaviours by acting as negative
36 influence, thereby, sabotaging the fragile process of recovery:
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46 *"... Yeah definitely, I think so. again everybody is different so if they take*
47 *themselves out of the circle if you like they tend to use less or probably not at*
48 *all if they are stable in their prescription and you know they are motivated and*
49 *they want to stop using then they tend to do that and distant themselves away*
50 *from obviously coz that's a trigger for them coz if other people are using*
51 *around them then that's a trigger for them to use as well..." (Participant 6)*
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54 3.2 Application of social capital using network-based interventions 55 56 57 58 59 60

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3 The practitioners considered social capital both an individual and a group resource.
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5 **Their belief in the resourcefulness of social groups** and their understanding of
6
7 role of social networks to build or access the resource was key to the nature of
8
9 interventions to support recovery.
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13 3.2.1 Facilitating creation of social networks 14 15 16 17

18 Findings from this study show that participants created opportunities for the service
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20 users to build their social connections. These directly involved enrolling the service
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22 users into the available social support groups, creating online and offline platforms for
23
24 social interactions and involving family members in the recovery process. One of the
25
26 participants mentioned the creation of a book club as a means of building their service
27
28 users networks by providing an opportunity to interact and meet new people. This
29
30 reflects the perspectives of the majority of the practitioners who considered
31
32 themselves as not proactive at building bonds between people but mere creators and
33
34 providers of the structure for bonds to emerge by themselves.
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40 *“... we promote social reintegration all the time... we've got a book club that we*
41 *run with organisation X in the city centre to promote people to meet other*
42 *people, to get back involved.” (Participant 2).*
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45 Participants explained that during the formation of social connections, a key factor was
46
47 identifying ‘commonalities’ amongst the group. For example, sharing similar goals,
48
49 circumstances and interests brought individuals together. The overarching similarity in
50
51 alcohol or drug addiction overruled interpersonal differences such as age, race, social
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53 class and gender when creating social networks to aid recovery. The alcohol detox
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55 professional explained that despite the inter-individual differences, alcohol was the
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57 common factor in all the groups:
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3 *“...cos we know that alcohol support networks the common*
4 *denominator is alcohol, and alcohol dependency affect anyone of any age,*
5 *race, social background of all sorts so when people attend these meetings*
6 *that is the common denominator.” (Participant 1)*
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10 When asked to highlight some of the factors that bring people **together**, an
11 operations manager of a charity mentioned:
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14
15 *“... having the same goals and wanting to do the same things.” (Participant 5)*
16
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18 The same participant explained the difficulties and **potential** for **groups** fallouts due to
19 differences and emphasised the need to reiterate the importance and preference of
20 making groups based on similarities. **It seemed at least in the early stages of**
21 **recovery, helpful relationships amongst service users were more easily forged**
22 **between those with similar characteristics. The potential benefits of connecting**
23 **with those who are dissimilar to them as a means of enhancing the group’s access**
24 **to information and external resources seemed to be less important.**
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35 3.2.2 Breaking of social networks

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37 According to most of the participants, shared characteristics were responsible for the
38 breaking of social networks as much as they were fundamental to making recovery
39 groups. Unlike similarities in circumstances and recovery goals that justified the
40 formation of recovery groups, commonalities due to undesirable behaviours that
41 promoted continuous use of drugs and alcohol or resulted in co-dependency justified
42 the breaking of the latter groups. In some situations, practitioners narrated that they
43 had to break the harmful networks and in their place enable creation of a new social
44 network or signpost to trusted health promoting social networks. One rehabilitation
45 professional explained:
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3 *"...and again with drug users, they tend to associate with other drug users.*
4 *So, it's kind of that circle, and it's about breaking that, and that's why the*
5 *groups come in."* (Participant 4).
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9 Therefore, participants in this study perceived their role as modifying social networks
10 by breaking harmful social groups or creating beneficial ones when applying social
11 capital in interventions.
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15 16 17 4. Discussion 18

19 The findings of this study reveal that the participants hold a limited version of social
20 capital narrowed to Putnam's bonding capital and Granovetter's strong ties and an
21 understanding that these can aid the recovery process. This view is evidenced by the
22 overwhelming data on social networks rather than social capital that was intended in
23 the study. Nonetheless, these findings add to the existing literature that show that the
24 introduction of social networks based interventions among alcohol and drug addicts
25 enable initiation of treatment, treatment adherence, treatment success and prevent
26 relapse (Best et al., 2016; Neale and Stevenson, 2015; Boeri, Lamonica, & Harbry,
27 2011). **In the first instance at least the attributes of bonding social capital**
28 **seemed to have high relevance in the early stages of recovery but a wider set of**
29 **connections were necessary to sustain it.** The practitioners in this study explain
30 that individuals with high levels of social and recovery capitals are more likely to
31 abstain from drug use, have better mental and physical health, and show increased
32 productivity compared to those with little or no social capital in the form of resourceful
33 social networks. This association is summarised by Best et al. (2016) who state that
34 high social capital is commensurate to high personal and recovery capital. Hence, the
35 interventions used by the practitioners build recovery capital by increasing the service
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3 users' social connections, creating channels for social support, information sharing on
4
5 best practices for recovery and creation of positive self- identity (Best et al., 2016).
6
7

8 Practitioners explained that the creation of social networks was primarily based on
9
10 similarities among service users. **When creating social networks**, differences
11
12 between individuals was seen as a hindrance to the formation of peer-peer
13
14 relationships and the overall recovery process. Similarity-based social groups were
15
16 deemed easy to establish as the practitioners explained that the service users
17
18 naturally 'clicked' and easily got along with each other. McPherson, Smith-Lovin and
19
20 Cook (2001) explain that homophily dictates the formation of most social networks and
21
22 relationships among individuals leading to creation of homogenous social networks.
23
24 In the case of recovery groups, homogeneity is with regard to type of substance one
25
26 is addicted to, age, life experiences and personal characteristics (Neale, Tompkins, &
27
28 Strang, 2017). In contrast to recovery gains associated with strong social ties and
29
30 peer-peer relationships (Best et al., 2016; Knight, Logan & Simpson, 2001), highly
31
32 homogenous groups may limit resources available to individuals leading to a more
33
34 negative than positive social capital (Neale, Tompkins, & Strang, 2017; McPherson,
35
36 Smith-Lovin & Cook, 2001).
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43 Creating social networks purely on similarities of circumstances does not fully support
44
45 the recovery process and at worst leaves the service users in a perpetual state of
46
47 recovery with little possibility - if any - for successfully reintegrating into society
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49 following exit from an in-patient agency or completion of a community based
50
51 programme. Furthermore, concern for individual recovery focuses only on what
52
53 happens in the therapeutic settings or community programmes and not what happens
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55 after completion of the respective programmes, putting the recovery interventions
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57 process at risk. For instance, Anderson (1998) explains that involvement with external
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3 groups that include those that service users belonged to before treatment or close
4 family members that still abuse alcohol and drugs presents **challenges to** values and
5 behaviours that are incompatible with recovery. Therefore, findings from this study
6 infer that when designing interventions, practitioners ought to consider that recovery
7 does not end at the level of sobriety or being drug-free but is a continuous process
8 that is completed by integration and active citizenship (Scottish Government, 2008).
9

10 Arguably, the creation of recovery capital through social networks founded upon
11 service user similarities matches the 'bonding' form of social capital that is described
12 by Putnam (2000). At the level of service delivery, this results in social networks
13 comprising members in recovery who share similar socioeconomic characteristics and
14 circumstances – with the assumption that members would provide mutual support for
15 each other. While bonding networks of this kind may initially be beneficial in
16 maintaining sobriety and enhancing quality of life of those in recovery, Portes (2014)
17 argues that such ties of similarity can be limiting and act to further alienate the group
18 members from more diverse members of the society. The professional practitioners'
19 conceptualisation of social capital in this study is limited, therefore, restrictive. This, as
20 a result, reduces the potential levels of social capital for members of the recovery
21 groups and limits the prospect of any related social capital gains that could be used to
22 maintain positive health gains and socioeconomic conditions such as learning of
23 employment opportunities.
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49 Members of socially engineered groups are therefore doubly disadvantaged: firstly, by
50 the limited nature of group membership and what members may or may not be able
51 to offer in the way of social capital gains; and secondly by the reinforcement and
52 reproduction of existing structural inequalities that have already served to limit the
53 group members' access to resources and power (Campbell, 2019; Neale et al., 2014).
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3 According to Bourdieu (1999), Harper (2001) and Everingham (2003), access to
4 resources and power is key to acquiring and increasing social capital. Acquiring social
5 capital, however, is made difficult by other individual socioeconomic factors such as
6 low levels of income and poor educational attainment (Casswell et al., 2003).
7
8 **Although disputed by some studies (Lewis et al., 2018; Li & Caltabiano, 2017),**
9 **Katikireddi et al. (2017) and Erickson et al. (2016) explain that the same factors**
10 **characterise individuals suffering from alcohol and drug-attributable harms such as**
11 **service users highlighted in this research. By contrast, those who can access more**
12 **heterogeneous (and therefore more resourceful) social networks can expand their**
13 **access further to more resources and use them to increase their health and wellbeing.**
14
15 The disparity between those who can access resourceful groups that have high levels
16 of social capital and those who cannot, effectively widen the inequalities gap leading
17 to the empowerment of some individuals at the expense of others (Campbell, 2019;
18 Carpiano, 2006). This is problematic for the public health practitioners for the
19 foundational values of equality and empowerment underpin both health promotion
20 theory and practice (Labonté, 2016). Practitioners attempt to mitigate consequences
21 of inequalities through building co-operative partnerships with both governmental and
22 community-led organisations to engage the recovering individuals in community
23 networking events, vocational training and employment that enable the recovering
24 persons to gain more control of their lives (Boeri et al., 2016; Aveling & Jovchelovitch,
25 2014; Boisvert et al., 2008).

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52 The impact of social capital on health remains controversial and particularly so in
53 relation to the service user group highlighted in this paper (Portes, 1998). There are
54 specific challenges for this group in terms of dependency – not only **about** their
55 addiction but relationships also, and these individuals may find it harder than most to
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3 leave old networks to forge new health promoting ones. However, in the case that this
4
5 is successful, they may gain increased quality of life and hasten their recovery but at
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7 the cost of reintegration back into their societies or their family social networks. As
8
9 mentioned previously, the external social networks deemed harmful are often
10
11 dismantled and in their place recovery promoting groups created. Bearing in mind that
12
13 the service users undergoing recovery do not eternally remain in these artificial social
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15 networks, the void that is left from the initially broken groups without replacement
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17 creates a higher likelihood for the members to re-join the harmful groups and relapse
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19 (Boeri et al., 2016). Boeri et al. support this logic and explain that social groups can
20
21 only achieve moderate levels of bonding **and** bridging social capital among members
22
23 of a recovery group with similar social status. Their findings show that most service
24
25 users relapse after treatment; hence, the need to multiply efforts aimed at providing
26
27 access to as well as participation in social networks outside the recovery groups. The
28
29 risk of relapse is higher in individuals whose social networks predominantly comprise
30
31 family members and acquaintances from previous treatment groups when compared
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33 with those with high bridging social capital post-treatment (Panebianco et al., 2016).
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35 So whilst professional interventions to modify the social environment of others may be
36
37 seen as an essential step to promote recovery and minimise relapse in drug and
38
39 alcohol users, practitioners should take care to avoid the adverse effects that may
40
41 arise **from such interventions. It may be that social network interventions need**
42
43 **to develop so they can take account of the types of social capital that may be**
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45 **beneficial to service users at each stage of the recovery process.**
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54 4.1 Methodology weakness 55 56 57 58 59 60

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3 The exploratory findings of this qualitative study are obtained from a small sample
4 size, hence, lack generalisability. The study does not compare the practitioners'
5 perspectives to the service users' as the latter were not included in the study. As a
6 result, the findings give a partial view of perceived role and mechanisms of social
7 capital in recovery.
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14 15 16 5. Conclusion and recommendation 17 18 19 20

21 The findings of this study show that the building of recovery group networks, using
22 social capital, from a practitioners' perspective can have both positive and negative
23 implications on the health and wellbeing of service users. The recovery groups build
24 recovery capital or social capital by increasing the service users' social connections
25 that in turn nurture positive self-identity, create channels for social support and enable
26 sharing information about what works or does not work in the recovery process. While
27 these groups are important for recovery support, they fail in sustaining recovery and
28 reintegrating service users back into the communities for meaningful engagements.
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30 The similarity-based social groups disenfranchise the service users by limiting the
31 nature of their group membership and by reinforcing and reproducing the structural
32 inequalities that further serve to limit the group members' access to resources and
33 power. In light of these findings, this study recommends that practitioners working to
34 create recovery social groups should facilitate opportunities to bridge and link with the
35 external mainstream social networks such as professional and civil institutions. By
36 working collaboratively with other social institutions such as places of worship,
37 schools, sports clubs and community organisations in the various localities, the service
38 users have an increased chance of building purposeful social relationships and
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3 developing lifelong networks key to both sustaining recovery and getting opportunities
4 for socioeconomic gains (White, 2009).
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Tables

Table 1: Sample characteristics

	Gender	Ethnic group	Worker role	Intervention
Participant 1	Female	White British	Manager	Alcohol detoxification
Participant 2	Female	White British	Support worker	Drug rehabilitation
Participant 3	Female	Other white	Social worker	Multipurpose charity
Participant 4	Female	Black British	Support worker	Alcohol rehabilitation
Participant 5	Female	White British	General Operation	Multipurpose charity
Participant 6	Female	Other white	Support worker	Drug rehabilitation
Participant 7	Male	White British	Manager	Sexual and reproductive health
Participant 8	Female	Asian British	Manager	Access to health care

Table 2: Summary of findings

Themes	Sub-themes
Perceived impact of social capital on alcohol and drug recovery	<ul style="list-style-type: none"> • Benefits of social capital • Disadvantages of social capital
Application of social capital using network-based interventions	<ul style="list-style-type: none"> • Facilitating creation of social networks • Breaking of social networks