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

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Abstract

Social capital, and more particularly the social networks that define its existence**, is** said to benefit health and wellbeing. **In individuals recovering from alcohol and drug addiction, social capital accruing from social networks support treatment, recovery and maintenance. Therefore, the concept of social capital is important for public health practitioners working in recovery interventions**. This qualitative study seeks to explore what practitioners perceive as **the** importance of social capital and how they apply the concept in interventions to support individuals recovering from drug and alcohol addiction. Eight public health practitioners involved in drug and substance abuse interventions in West Yorkshire, England, were interviewed. The results of the interview were then deductively coded using two priori themes of perceived impact of social capital on health outcomes and application of social capital theory in recovery interventions. The findings reveal that practitioners understand the impact of social capital **as the effects of social networks** on recovery and apply the concept in their interventions. However, the nature of interventions created based on similarities in condition (alcohol and substance addiction) and intended outcome (recovery) create bonding social capital with mixed outcomes. This paper argues that the wider benefits to service users are unintentionally inhibited by the overwhelming downsides of bonding social capital. For instance, closed support groups comprised of individuals with high similarities further exclude the already socioeconomically deprived service users from integrating and accessing resources outside their groups.

Key Words

Social capital, Recovery capital, Recovery, Social networks, Alcohol and drug misuse,

What is known about this topic

- Social capital enables initiation of treatment, adherence, cessation and prevention of relapse.
- The impact of social capital on recovery from alcohol and substance abuse has been difficult to evidence conclusively.
- The application of social capital theory in professional practice is under-researched in public health and health promotion settings.

What this paper adds

- Practitioners draw upon social capital theory to support creation of positive social networks amongst service users to promote changes in attitudes and behaviour.
- The problematic application of social capital theory in public health interventions makes it hard to realise deliberate gains from the concept.
- Focus on similarity-based networks prevents acquisition of linking and bridging social capital jeopardising the recovery process.

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

voluntarily maintained lifestyle marked by abstinence, health and wellbeing, social participation and connectedness (UK Drug Commission, 2008). Diversely, service users view recovery in numerous ways. For instance, some define recovery as a form of 'new life' while others perceive it as cessation (Laudet, 2007). There is consensus among scholars **however**, that recovery is a process that continues decades after one withdraws from substance abuse (Best et al., 2016; Boeri, Lamonica, & Harbry, 2011). **It seems intuitive therefore to consider both practitioners' and service users' perceptions of recovery in research undertaken in therapeutic settings**. By doing so, it helps to enhance practitioners' understanding of how theories can underpin interventions **and consequently increases** their ability to support clients to become more connected and adopt healthy lifestyles.

Similar to recovery, social capital is a multidimensional concept **whose taxonomy has grown over time**. **For example**, Putnam**'s later work** (2000) **introduced different forms** of social capital**,** bonding and bridging. **Later**, Szreter & Woolcock (2004) added a third type, linking social capital, **to the nomenclature**. Putnam (2000) **and others (Harpham et al., 2002) express** bonding social capital **as** interactions **and access to resources that take place between groups with similar characteristics. B**ridging social capital **tends to occur between dissimilar groups**. **In this case, the access to resources usually arises through connections between groups of different socioeconomic status or other dissimilar characteristics**. T**he third form of social capital, linking social capital** illustrates the potential benefits of individuals' connection to institutions and those in powerful positions (Szreter & Woolcock, 2004). **It is mostly referred to in practical applications where the need to equalise power between local communities and formal institutional structures is paramount to**

the building of social capital at local level. None of the three forms of social capital can exclusively provide all benefits of social networks and relationships (Campbell, 2019; Cai, 2017; Hawkins & Maurer, 2009). Hence, the need to possess or access proportionate levels of any of the social groupings depend on the desired individual or group gains.

Putnam's (2000) classification of strong bonds and **weaker** bridging relationships and their associated merits and demerits originate from Granovetter's (1973) sociological theory of weak and strong ties. Granovetter argues that despite the supportiveness and ease of accessibility of one's high-density groups characterised by high similarities and strong closely-knit relationships, weak ties are critical in sustaining the strong ties and making them more beneficial. He suggests that a weak tie, such as an acquaintance **or a professional**, acts as a bridge between different clusters of closely-knit relationship groups and enables members to get information on opportunities that could have been impossible in the absence of the acquaintance connecting two groups of closely related individuals. The limitations of highly homogenous groups constituting strong ties and the need for weak ties as illustrated by Granovetter (1973), can be compared to the deficiencies of bonding social capital and the progressiveness of bridging social capital. The former **pertains** to inclusivity and its potential downside and the latter **highlights** the benefits arising from access to information and resources external to closely-knit homogenous groups (Portes, 2014; Putnam, 2000). However, social networks are not binary and may constitute a blend of both bonding and bridging social capital characteristics, although in varying proportions (Campbell, 2019). For instance, recovery groups tend to constitute more bonding social capital as they are formed on similarities in substance misuse and common goal of recovery, with a focus on achieving abstinence with less emphasis on other equally important needs, such

as employment and housing that are crucial to sustaining recovery. Therefore, building **bonding** social capital to support recovery may inadvertently exacerbate inequalities and further disenfranchise the service users (Zschau et al., 2015; Boeri, Gibson & Boshears, 2014).

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

2. Methods

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

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

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

2.2 Data collection

Data **were** gathered using semi-structured **interviews. Questions** posed from the schedule were designed to elicit data to address the research questions seeking to find out practitioners' perception of the importance of social capital and how they apply the concept in interventions to support individuals recovering from drug and alcohol addiction. For instance, **regarding** the former, participants were asked: 'What are the effects of **social networks** on the community (alcohol and drug users) you work with?' and regarding the latter, participants were asked 'How do your interventions help members to benefit from groups and social networks?'

By request, all eight interviews were conducted in the workplace and lasted for approximately thirty minutes. Verbal data was digitally recorded, whilst non-verbal data was captured by the researcher who made notes during the interview. The physical interaction that took place during the face to face interviews allowed the observation of non-verbal cues such as intonation, posture, and voice. These were crucial for developing probes to further explore issues of interest that emerged during the

interview (Opdenakker, 2006). Many such probes developed out of unclear or incomplete answers given by participants during the process.

All transcribed interviews were returned to the participants for member checking to ensure the content and process had been captured accurately. All eight participants confirmed that the transcripts were an accurate account of their responses and did not make any changes or objections to their use. Enabling participants to check the verbatim transcripts was **necessary** for this study as it enhanced the credibility of the findings (Polit & Beck, 2010; Creswell & Millller, 2000).

2.3 Ethical Considerations

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

2.4 Data analysis

Thematic analysis (Braun & Clark, 2006) was used to code and interpret the data. This involved the researcher identifying patterns across all eight of the practitioners' perspectives that specifically related to the research question on the use of social networks to build social capital by practitioners working with recovering drug and alcohol users (Bazeley, 2009). The first stage of analysis began with data

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

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

3.1.1 Benefits of social capital

The study found that the practitioners deemed service users who had strong social networks as having better recovery rates**. Hence**, the practitioners expressed value of social capital in interventions. One of the practitioners working in alcohol detoxification programme explained their role in encouraging creation and access to useful networks by stating:

> *"We do try to encourage them all the time to involve their families, partners, social networks, and positive peers in their care package. Because we find that people who succeed are the people who have got a lot of positive social support*." (Participant 1).

The participants described the pathways through which social networks supported the recovery journey **via** both external and internal impetus. For the external, social networks were perceived as points of conversations that encouraged and motivated their participants to attend appointments and through sharing personal experiences of the most helpful and least helpful factors in the recovery process. The internal control and resultant trust from group membership **were** thought to trigger an internal drive in individuals to recover in a bid to conform to the group's common goal. One practitioner in charge of an alcohol anonymous group run by a multipurpose charity explicated this by quoting her service users:

> *…Yeah and again that's where I come back to the groups because that is positive support network some people say, "well I don't want to upset this*

positive network that I have built and I don't want to upset people that matter…" (Participant 3)

3.1.2 Disadvantages of social capital

Whilst the cohort acknowledged the benefits of networks to the recovery process, they also voiced some caution as some networks proved to be detrimental to the recovery process by fostering co-dependency rather than recovery. A practitioner working around sexual and reproductive health with the service users elucidated:

…a lot of our service users often spend a lot of time together with each other. We have a lot of people in co-dependent relationships where they think they are supporting each other really they are co-dependent they are as bad as each other. One blames the other, but they feel that they are supporting each other in some way, shape or form. (Participant 7)

Moreover, practitioners also expressed concern that their work to support social network building within the intervention could be undermined by social capital activities outside of their control. For example, service users' families and immediate community could pose a risk of relapse into problematic behaviours by acting as negative influence, thereby, sabotaging the fragile process of recovery:

"... Yeah definitely, I think so. again everybody is different so if they take themselves out of the circle if you like they tend to use less or probably not at all if they are stable in their prescription and you know they are motivated and they want to stop using then they tend to do that and distant themselves away from obviously coz that's a trigger for them coz if other people are using around them then that's a trigger for them to use as well..." (Participant 6)

3.2 Application of social capital using network-based interventions

The practitioners considered social capital both an individual and a group resource. **Their belief in the resourcefulness of social groups** and their understanding of role of social networks to build or access the resource was key to the nature of interventions to support recovery.

3.2.1 Facilitating creation of social networks

Findings from this study show that participants created opportunities for the service users to build their social connections. These directly involved enrolling the service users into the available social support groups, creating online and offline platforms for social interactions and involving family members in the recovery process. One of the participants mentioned the creation of a book club as a means of building their service users networks by providing an opportunity to interact and meet new people. This reflects the perspectives of the majority of the practitioners who considered themselves as not proactive at building bonds between people but mere creators and providers of the structure for bonds to emerge by themselves.

> *"... we promote social reintegration all the time... we've got a book club that we run with organisation X in the city centre to promote people to meet other people, to get back involved."* (Participant 2).

Participants explained that during the formation of social connections, a key factor was identifying 'commonalities' amongst the group. For example, sharing similar goals, circumstances and interests brought individuals together. The overarching similarity in alcohol or drug addiction overruled interpersonal differences such as age, race, social class and gender when creating social networks to aid recovery. The alcohol detox professional explained that despite the inter-individual differences, alcohol was the common factor in all the groups:

> *"…cos we know that alcohol support networks the common denominator is alcohol, and alcohol dependency affect anyone of any age, race, social background of all sorts so when people attend these meetings that is the common denominator."* (Participant 1)

When asked to highlight some of the factors that bring people **together, an** operations manager of a charity mentioned:

> *"… having the same goals and wanting to do the same things."* (Participant 5)

The same participant explained the difficulties and **potential** for groups fallouts due to differences and emphasised the need to reiterate the importance and preference of making groups based on similarities. **It seemed at least in the early stages of recovery, helpful relationships amongst service users were more easily forged between those with similar characteristics. The potential benefits of connecting with those who are dissimilar to them as a means of** enhancing **the** group's access to information and external resources seemed **to be less important**.

3.2.2 Breaking of social networks

According to most of the participants, shared characteristics were responsible for the breaking of social networks as much as they were fundamental to making recovery groups. Unlike similarities in circumstances and recovery goals that justified the formation of recovery groups, commonalities due to undesirable behaviours that promoted continuous use of drugs and alcohol or resulted in co-dependency justified the breaking of the latter groups. In some situations, practitioners narrated that they had to break the harmful networks and in their place enable creation of a new social network or signpost to trusted health promoting social networks. One rehabilitation professional explained:

> "…*and again with drug users, they tend to associate with other drug users. So, it's kind of that circle, and it's about breaking that, and that's why the groups come in."* (Participant 4).

Therefore, participants in this study perceived their role as modifying social networks by breaking harmful social groups or creating beneficial ones when applying social capital in interventions.

4. Discussion

The findings of this study reveal that the participants hold a limited version of social capital narrowed to Putnam's bonding capital and Granovetter's strong ties and an understanding that these can aid the recovery process. This view is evidenced by the overwhelming data on social networks rather than social capital that was intended in the study. Nonetheless, these findings add to the existing literature that show that the introduction of social networks based interventions among alcohol and drug addicts enable initiation of treatment, treatment adherence, treatment success and prevent relapse (Best et al., 2016; Neale and Stevenson, 2015; Boeri, Lamonica, & Harbry, 2011). **In the first instance at least the attributes of bonding social capital seemed to have high relevance in the early stages of recovery but a wider set of connections were necessary to sustain it**. The practitioners in this study explain that individuals with high levels of social and recovery capitals are more likely to abstain from drug use, have better mental and physical health, and show increased productivity compared to those with little or no social capital in the form of resourceful social networks. This association is summarised by Best et al. (2016) who state that high social capital is commensurate to high personal and recovery capital. Hence, the interventions used by the practitioners build recovery capital by increasing the service

users' social connections, creating channels for social support, information sharing on best practices for recovery and creation of positive self- identity (Best et al., 2016).

Practitioners explained that the creation of social networks was primarily based on similarities among service users. **When creating social networks**, differences between individuals was seen as a hindrance to the formation of peer-peer relationships and the overall recovery process. Similarity-based social groups were deemed easy to establish as the practitioners explained that the service users naturally 'clicked' and easily got along with each other. McPherson, Smith-Lovin and Cook (2001) explain that homophily dictates the formation of most social networks and relationships among individuals leading to creation of homogenous social networks. In the case of recovery groups, homogeneity is with regard to type of substance one is addicted to, age, life experiences and personal characteristics (Neale, Tompkins, & Strang, 2017). In contrast to recovery gains associated with strong social ties and peer-peer relationships (Best et al., 2016; Knight, Logan & Simpson, 2001), highly homogenous groups may limit resources available to individuals leading to a more negative than positive social capital (Neale, Tompkins, & Strang, 2017; McPherson, Smith-Lovin & Cook, 2001).

Creating social networks purely on similarities of circumstances does not fully support the recovery process and at worst leaves the service users in a perpetual state of recovery with little possibility - if any - for successfully reintegrating into society following exit from an in-patient agency or completion of a community based programme. Furthermore, concern for individual recovery focuses only on what happens in the therapeutic settings or community programmes and not what happens after completion of the respective programmes, putting the recovery interventions process at risk. For instance, Anderson (1998) explains that involvement with external

groups that include those that service users belonged to before treatment or close family members that still abuse alcohol and drugs presents **challenges to** values and behaviours that are incompatible with recovery. Therefore, findings from this study infer that when designing interventions, practitioners ought to consider that recovery does not end at the level of sobriety or being drug-free but is a continuous process that is completed by integration and active citizenship (Scottish Government, 2008).

Arguably, the creation of recovery capital through social networks founded upon service user similarities matches the 'bonding' form of social capital that is described by Putnam (2000). At the level of service delivery, this results in social networks comprising members in recovery who share similar socioeconomic characteristics and circumstances – with the assumption that members would provide mutual support for each other. While bonding networks of this kind may initially be beneficial in maintaining sobriety and enhancing quality of life of those in recovery, Portes (2014) argues that such ties of similarity can be limiting and act to further alienate the group members from more diverse members of the society. The professional practitioners' conceptualisation of social capital in this study is limited, therefore, restrictive. This, as a result, reduces the potential levels of social capital for members of the recovery groups and limits the prospect of any related social capital gains that could be used to maintain positive health gains and socioeconomic conditions such as learning of employment opportunities.

Members of socially engineered groups are therefore doubly disadvantaged: firstly, by the limited nature of group membership and what members may or may not be able to offer in the way of social capital gains; and secondly by the reinforcement and reproduction of existing structural inequalities that have already served to limit the group members' access to resources and power (Campbell, 2019; Neale et al., 2014).

According to Bourdieu (1999), Harper (2001) and Everingham (2003), access to resources and power is key to acquiring and increasing social capital. Acquiring social capital, however, is made difficult by other individual socioeconomic factors such as low levels of income and poor educational attainment (Casswell et al., 2003). **Although disputed by some studies (Lewis et al., 2018; Li & Caltabiano, 2017), Katikireddi et al. (2017) and Erickson et al. (2016) explain that the same factors** characterise individuals suffering from alcohol and drug**-attributable harms such as** service users highlighted in this research. By contrast, those who can access more heterogeneous (and therefore more resourceful) social networks can expand their access further to more resources and use them to increase their health and wellbeing. The disparity between those who can access resourceful groups that have high levels of social capital and those who cannot, effectively widen the inequalities gap leading to the empowerment of some individuals at the expense of others (Campbell, 2019; Carpiano, 2006). This is problematic for the public health practitioners for the foundational values of equality and empowerment underpin both health promotion theory and practice (Labonté, 2016). Practitioners attempt to mitigate consequences of inequalities through building co-operative partnerships with both governmental and community-led organisations to engage the recovering individuals in community networking events, vocational training and employment that enable the recovering persons to gain more control of their lives (Boeri et al., 2016; Aveling & Jovchelovitch, 2014; Boisvert et al., 2008).

The impact of social capital on health remains controversial and particularly so in relation to the service user group highlighted in this paper (Portes, 1998). There are specific challenges for this group in terms of dependency – not only **about** their addiction but relationships also, and these individuals may find it harder than most to

leave old networks to forge new health promoting ones. However, in the case that this is successful, they may gain increased quality of life and hasten their recovery but at the cost of reintegration back into their societies or their family social networks. As mentioned previously, the external social networks deemed harmful are often dismantled and in their place recovery promoting groups created. Bearing in mind that the service users undergoing recovery do not eternally remain in these artificial social networks, the void that is left from the initially broken groups without replacement creates a higher likelihood for the members to re-join the harmful groups and relapse (Boeri et al., 2016). Boeri et al. support this logic and explain that social groups can only achieve moderate levels of bonding **and** bridging social capital among members of a recovery group with similar social status. Their findings show that most service users relapse after treatment; hence, the need to multiply efforts aimed at providing access to as well as participation in social networks outside the recovery groups. The risk of relapse is higher in individuals whose social networks predominantly comprise family members and acquaintances from previous treatment groups when compared with those with high bridging social capital post-treatment (Panebianco et al., 2016). So whilst professional interventions to modify the social environment of others may be seen as an essential step to promote recovery and minimise relapse in drug and alcohol users, practitioners should take care to avoid the adverse effects that may arise **from such interventions. It may be that social network interventions need to develop so they can take account of the types of social capital that may be beneficial to service users at each stage of the recovery process.**

4.1 Methodology weakness

The exploratory findings of this qualitative study are obtained from a small sample size, hence, lack generalisability. The study does not compare the practitioners' perspectives to the service users' as the latter were not included in the study. As a result, the findings give a partial view of perceived role and mechanisms of social capital in recovery.

5. Conclusion and recommendation

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

developing lifelong networks key to both sustaining recovery and getting opportunities 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	• Benefits of social capital • Disadvantages of social capital
Application of social capital using network-based interventions	• Facilitating creation of social networks • Breaking of social networks