Paul Wells

# A Bridge Not Far Enough

*Walk the line* (*Druglink* July/August) clearly demonstrated the vulnerable position that service users can be placed in when the recovery agenda is poorly understood or implemented. The change of emphasis in the 2010 Drug Strategy has done more than simply shake the complacency of some drug services who had put more effort retaining service users in treatment rather than helping them move through the treatment process. It has now become the ideologues' charter, reinforced in March by *Putting Full Recovery First*, which describes an agenda focused on "full independence from any chemical." But in many areas neither commissioners nor providers have a clear understanding of the critical concept of recovery capital.

Recovery capital has been defined as "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD (alcohol and other drug) problems". It has been categorised as having four components; social capital, physical capital, human capital and cultural capital; with the integration of social, human and cultural – as particularly important. Recovery had previously been defined by the UK Drug Policy Commission as "voluntarily sustained control over substance use" but is now seen as "full independence from any chemical". We now have an abstinence-based policy underpinning the implementation of recovery within a framework of payment by results.

Recovery should be about the ability to integrate back into society, not being maintained in a network that is built around the problem they have hopefully resolved. Poor commissioning is promoting the establishment of groups bound together by 'bonding capital' rather than 'bridging capital'. Bridging capital describes closer connections between people and is characterised by strong bonds. It is often provided by horizontal networks of family and socially similar others at a local level. Crucially it is good for *getting by* in life. Bridging capital on the other hand, describes more distant connections between people and is characterised by weaker ties which connect them to wider social networks – friends of friends, acquaintances – creating opportunities. It is good for *getting ahead* in life.

Increasing an individual's recovery capital can signal a turning point in their drug use and ability to benefit from treatment. However, merely relying on developing bonding capital is not going to deliver the quality and quantity of recovery capital required to deliver successful outcomes both in and out of treatment. The role of the recovery champion within this context is very exposed and vulnerable. While they may possess charismatic qualities they will frequently be poorly connected outside of their historical peer group which is key to helping people get ahead. This is characterised by the weakness of strong ties, whereas success is greater when there is strength in weak ties.

As Perri 6, (the noted British social scientist David Ashworth who famously changed his name) observed in relation to job training, in most cases it puts unemployed people only in contact with other unemployed people on the same course, who, if they are weakly tied, are links to people who cannot, in most cases, offer them many opportunities for making an exit from poverty and unemployment. Few programmes of job training impart the kinds of skills that people need to work networks of weak ties.

Similarly, poorly supported recovery champions will put recovered drug users only in contact with other recovered drug users, who, if they are weakly tied, are links to people who cannot, in most cases, offer them many opportunities for making an exit from poverty and unemployment. Too few recovery programmes impart the kinds of skills that people need to work networks of weak ties.

To paraphrase Perri 6 again – a network that is rich in weak ties which span holes in social networks to reach acquaintances and friends of friends across many walks of life proves to be much more effective – at least in the long run – than having a narrow network of strong ties to kin, immediate neighbours and people much like oneself.

Unless commissioners and service providers clearly understand the type of recovery support they are developing and its relationship to opportunities in the wider society, then they are missing the point of the concept they are attempting to implement. In all this, the recovery champion, will fail to be the vector of recovery contagion, promoting the spread of recovery capital, but will instead remain the standard bearer for a group of highly vulnerable people prone to relapse.

**Paul Wells** is an independent commentator on drug policy