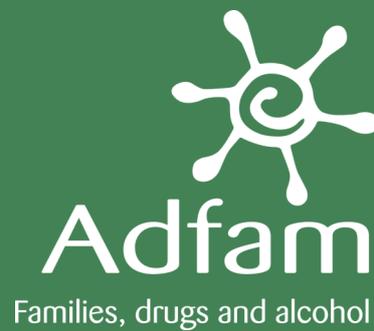


# Building Recovery Capital: Recovery & Relationships



On behalf of the  
Recovery Partnership

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## Introduction May 2016

This briefing focuses on the theme of recovery and relationships, providing an overview of the evidence and related practice examples. It is informed, in part, by a policy and practice seminar held by Adfam on behalf of the [Recovery Partnership](#) in December 2015, chaired by Roger Howard, former Chief Executive of the UK Drug Policy Commission, to whom we would like to extend our thanks. The event was part of a wider programme of work by the Recovery Partnership around 'Building Recovery Capital,' to support the development of social recovery capital for those with drug and alcohol problems, which previously included a focus on mental health.<sup>1</sup> Attendees included academics, practitioners from drug and alcohol treatment, family support and peer support services and civil servants. The discussion considered the whole range of relationships that may support an individual in their recovery, from family and friends, to peers and professionals and beyond.

The literature on social recovery capital and accounts from individuals in recovery, their families, friends and the professionals and volunteers supporting them evidences that positive relationships can support recovery from drug and alcohol problems. Whilst the 2010 Drug Strategy recognises that recovery is an '*individual, person-centred journey*,' the importance of improved relationships with family members, partners and friends for many people in recovery is acknowledged, as is the role of peer support and mutual aid networks as sources of support.<sup>2</sup> It notes that recovery involves three overarching principles: wellbeing, citizenship and freedom from dependence, and places '*recovery capital*' at the heart of

the strategy. Cloud and White identified four components of recovery capital; one of which – ‘*family/social recovery capital*’ – is the focus of this paper, and encompasses intimate, family and kinship relationships, as well as social relationships that are supportive of recovery.<sup>3</sup>

*“Family/social recovery capital is indicated by the willingness of intimate partners and family members to participate in treatment, the presence of others in recovery within the family and social network, access to sober outlets for sobriety-based fellowship/leisure, and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations).”<sup>4</sup>*

However, it is important to remember that relationships can sometimes present a challenge in recovery or have a negative impact – and not everyone will have equal access to recovery capital. For example, there is evidence to suggest that people with multiple and complex needs are often further from the support of family and friends than others and, as such, are more likely to seek professional support.<sup>5</sup> That is not to say, however, that professional support always resolves substance use and related issues; significant problems can persist or develop despite professional intervention. The question thus posed is: how can policy and practice nurture the development of supportive relationships, which help build recovery capital, for service users, to ensure they are sufficiently supported and encouraged through their recovery journey? This briefing does

not provide an exhaustive examination of all the policy and practice issues related to relationships and recovery, merely an introduction to the issues, with examples.

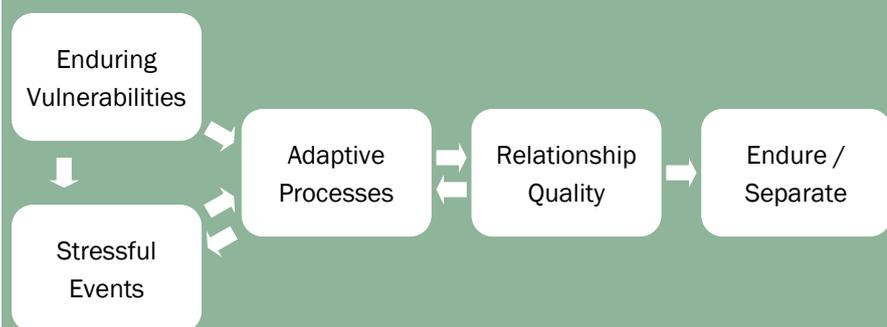
## The importance of relationships

The wide ranging impact of drug and alcohol use felt not only by the individual but by their families and communities has been well evidenced.<sup>6</sup> A number of theories and approaches recognise the central role of relationships for people in recovery, and place relationships at the very fore of their philosophy. One such example is social behaviour and network therapy (SBNT): an evidence-based psychosocial intervention, developed in the UK, by integrating strategies found to be effective in other substance misuse treatment approaches, and built upon the premise that social network support is central to the resolution of addictive behaviour. The core principle is that positive change is promoted by support from a close network of family members and/or friends, who provide a person who wishes to abstain from or reduce substance use with positive social support for change. Whilst SBNT is majorly predicated upon the role of relationships, myriad other approaches to treatment and recovery recognise and explore the integral role of relationships for people in recovery. For instance, the widely used 12-step model specifies, amongst other things, that substance users must make a list of individuals to whom they have caused harm, and make amends with those people. Additionally, involvement in such groups aims to provide participants with support via a social network (the '*fellowship*') with which to affiliate.<sup>7</sup>

Case Study:  
**OnePlusOne  
Model**

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OnePlusOne is a charity which uses the latest research evidence to help people strengthen and improve their relationships. It recognises that romantic relationships are a major factor in a person's wellbeing, and uses a Vulnerability-Stress-Adaptation (VSA) model to help the couple relationship.



It is a model of relationship quality, which accounts for traits, events and processes that predict relationship quality and outcome, and can be used to work with couples affected by substance use. It is helpful in guiding intervention, for example: allowing for the screening and targeting of those at greater risk, improving relationship quality in other areas (in order to help coping with specific stressors), offering support and guidance with adaptive or coping processes, building resilience and breaking the cycle of stressful events and relationship breakdown. This allows for well-targeted relationship interventions, which can improve the quality of couple relationships and build a more enduring support network. In turn, this can improve the recovery chances for the substance user and wellbeing for affected family members.

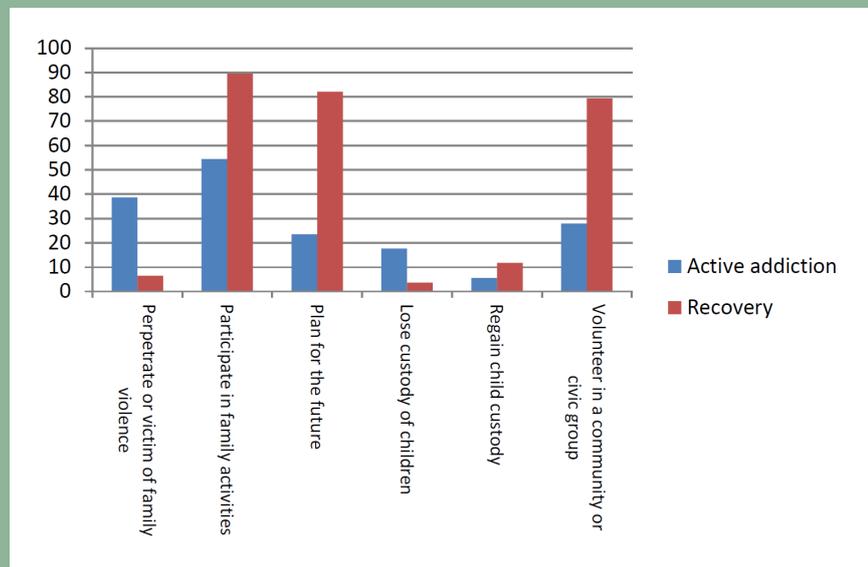
Seminar participants emphasised that humans are social animals, and that relationships are not simply a category of recovery capital, but the means by which '*almost everything happens.*' One participant discussed how addiction has been characterised in literature as a '*disease of relationships,*' propounding the notion that recovery centres on rebuilding damaged or lost relationships. Alongside housing, employment, family support and meaningful leisure activities or hobbies, participants stressed the primacy of relationships and felt that effective treatment is significantly dependent on relationships with others. Participants also proposed that '*as the state shrinks*' the role of families and other relations will become ever more important to an individual in recovery.

Case Study:  
UK Life in  
Recovery  
Survey 2015

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Having been inspired by earlier studies in the US and Australia, the UK Life in Recovery survey sought to capture respondents' recovery experiences, reports on their pathways to recovery and details of the impact recovery had on their quality of life.

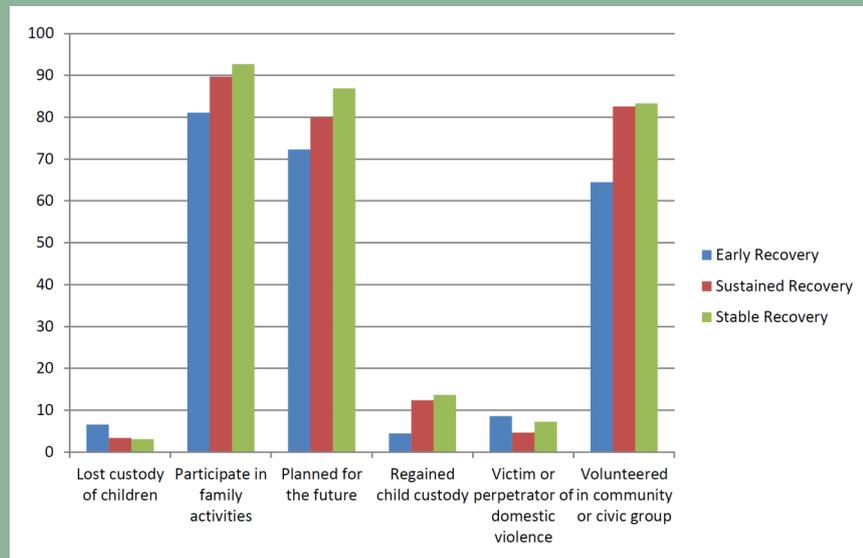
A total of 802 forms were completed. At the time of survey completion, just under half (46.8%) of participants were married or living with a partner, around a quarter (25.4%) were divorced, separated or widowed and just over a quarter (27.9%) were single or never married. The survey asked about events in a series of key life domains as they affected individuals during the active period of their addiction and again as they experience them at the time of completing the survey. The graph below shows changes in family and social life from active addiction to recovery.



*Changes in family and social life from active addiction to recovery*

The rate of involvement in family violence (either as a perpetrator or victim) drops from approximately 40% to around 6% in the process of moving from active addiction into recovery. As individuals overcome active addiction, they are also significantly less likely to lose custody of a child, and 12% of those in recovery managed to be reunited with children previously taken into care. The rate of engagement in community and civic group activities doubled in recovery stage, which suggests that those in recovery are committed to and have an active role in the community: nearly 80% had volunteered in community or civic groups since the start of their recovery. Similar patterns were found when looking specifically at the family: almost 90% of those in recovery reported participating in family activities, compared to around half the sample during active addiction.

Longer durations of recovery were found to be associated with higher levels of functioning. The graph below shows the rates of family involvement by recovery duration and that many of the key personal, social and societal benefits of recovery continue to increase over time.



*Family involvement by recovery duration*

When comparing UK data with findings in US and Australian studies, patterns for effective family functioning are consistent across all three countries, with significant reductions in involvement in domestic violence incidents and substantial improvements in risk of losing custody of children and subsequently achieving reunification. The survey found clear net benefits in terms of family reunifications and health and wellbeing, reductions in criminal involvement and positive impacts on employment and economic participation.

## Relationships with family and friends

It is considered good practice that families are both supported themselves and involved in their relative's treatment. The 2010 Drug Strategy explicitly recognises that '*treatment is likely to be more effective, and recovery to be sustained, where families, partners and carers are closely involved.*' NICE guidance also recommends the involvement of families and carers in decisions around the treatment and care of the user,<sup>8</sup> as does the Carers Trust's '*Triangle of Care*' guide, which emphasises the importance of ensuring that carers receive the support they require for themselves, whilst also promoting the involvement of families in their relative's recovery.<sup>9</sup>

A number of studies have revealed positive outcomes associated with providing support to family members in their own right (i.e. as an individual, rather than as an 'add-on' to their relative's substance use treatment). Where family members are supported, a number of improvements are observable, including in self-esteem, ability to set boundaries, coping skills, relationships with friends and other family relations, levels of independence, psychological stress and overall family functioning. One study that examined the effectiveness of intensive interventions for families found that once family members had undergone the intervention, they were often described as being happier, more confident and assertive, less anxious and depressed and/or eating better or smoking less.<sup>10</sup> Adfam's study of one family support service found that significant outcomes were achieved for family members, with the service generating £145,000 worth of value specifically for the family members attending.<sup>11</sup> This figure was calculated having

looked at the resulting benefits to families' health and wellbeing, regaining of independence, bettering of relationships with others and improvements in financial situations.

Case Study:  
**SIAS, Involving  
Families in  
Treatment and  
Recovery**

Solihull Integrated Addiction Service (SIAS) is a partnership between four organisations jointly responsible for the delivery of the Drug and Alcohol Services in Solihull, and also delivers support to families/friends affected and young people.

Lara's story:

*Lara had attempted detox in drug and alcohol treatment services several times and was suffering a marked deterioration in her physical and mental health. Lara's mother expressed concern and requested help, and was subsequently supported with her own mental health issues. Home visits were arranged with other professionals to ensure appropriate support was in place for the family, and the professionals involved shared information to increase the support network. Together, the family network was explored and further family members were enlisted to support and be part of the treatment plan. Treatment was also offered to Lara's brother, who required opiate support. Lara was detoxed and continues to receive Antabuse prescriptions, and her brother is now stable on an opiate script. Lara's family members have been trained in Naloxone administration and have been provided with packs for the home.*

One of the most pervasive effects of drug use on family members is damage to and reduction of social relationships because of stress, anxiety, stigma and isolation. A study that looked at the interplay between social relationships and mortality in the general population found that individuals with strong social relationships have a 50% greater likelihood of survival compared to those with weak social relationships.<sup>12</sup> The magnitude of this effect is comparable with stopping smoking and exceeds many well-known risk factors for mortality, such as obesity; thus epitomising the extent of damage that familial drug use can have on people close to the substance user. Further research suggests that providing support to families helps combat stigma and prejudice in the wider community and the media.<sup>13</sup>

The government's 2010 Carers Strategy encourages the tailoring of support to fit the individual's needs and circumstances, enabling carers to reach their full educational and employment potential, so that they are able to have a family and community life, whilst being supported to remain physically and mentally well.<sup>14</sup> Secondary effects arising from improved relationships, health and wellbeing are plentiful, including an improvement in work-life balance or education. When individuals are supported to feel better in themselves, this can positively reflect on all aspects of their life.

Case Study:  
Jobs, Friends  
and Houses  
(JFH)

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Jobs, Friends and Houses is a social enterprise, developed by Lancashire police. Its aim is to build a recovery community, through empowering and employing people in recovery from addiction, mental health problems, offending, family breakdown and other problems. JFH offers on the job training supplemented by adult apprenticeships and embeds positive social networks with recovery role models to help sustain recovery. It also renovates and refurbishes properties to rent to people in the recovery community, and provides individuals with tools to improve their health and wellbeing; from financial guidance or relationship advice, to medical referrals and counselling. Using a holistic approach, support is tailored to suit individual need. In the first year of the project none of the participants engaged in offending behaviour and 39 of 40 had not relapsed.

The family is a fundamental source of social support for many people in recovery, often providing emotional support, food, money and shelter, as well as supporting loved ones to engage with treatment.<sup>15</sup> Yet, there is much left to learn about the role of families in supporting individuals who recover without the support of drug and alcohol services. The needs of families affected by substance use should be recognised '*in their own right*', regardless of whether or not they have maintained their relationship with their family member who has a substance use problem or chosen to disengage. Indeed, the dissolution of family and other close relationships due to substance use is not uncommon; however, the rebuilding of family relationships, in particular relationships with children, can be an important motivator to sustain recovery.<sup>16</sup>

*“Having children at home may also be a factor in preventing [parents] from developing more serious drug-related problems, and could motivate them to enter treatment for their addiction. It may also mean they have a stronger foundation from which to start their recovery and rebuild their lives.”<sup>17</sup>*

People with drug and alcohol problems are often partners, spouses and friends. In a study of recovering heroin users, some participants discussed how a partner could potentially play a role in initiating or escalating drug use; *‘I don’t know if I’d have started [using heroin] again if I hadn’t met [boyfriend].’<sup>18</sup>* Many also suggested that it is extremely difficult to stop using drugs whilst having a partner who was still using, and substance use was often cited as a key reason for relationship breakdown.<sup>19</sup> In the same study, recovering heroin users differentiated between individuals they had used drugs with and those they considered *‘real friends.’* Many participants were saddened by how few genuine friendships they felt they had, though many felt supported by relationships they had developed in treatment and peer support groups.

Case Study:  
Hope House,  
Action on  
Addiction  
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Hope House is a safe, secure and comfortable place for women to recover from drug or alcohol dependence and receive additional support for other compulsive disorders. Hope House is special in that it's just for women. Many of their clients have a history of difficult relationships and find an all-female environment a supportive place to work through issues and

begin the process of recovery. Living with other women in similar situations, women will benefit from the care of the counsellors and therapists and encouragement of their peers.

Its programme is based on a 12-step abstinence model. Upon arrival, women are shown to their room and assigned a '*buddy*'. Mutual support is crucial to clients' recovery, as they'll help each other rebuild their confidence and learn or re-learn life skills. Everyone participates in the running of the house, including shopping, tidying and budgeting, as well as making decisions about domestic and community matters. We encourage clients to share the food shopping and cook and eat together.

The women are involved in their own treatment planning and participate in daily groups and workshops where they can share their experiences, as well as one-to-one counselling in private therapy rooms. Hope House helps their clients focus on relapse prevention and work with them on health, family and housing issues.

Hope House believes that rebuilding close relationships with family is vital to recovery, and encourages facilitated meetings between their clients and their family. Children under 12 are permitted to stay overnight at weekends.

## Relationships with practitioners

Seminar participants stressed how building positive relationships must be at the top of the practitioner's agenda, both between themselves and the service user, and supporting the service user to gain new and rebuild old relationships. Whilst this may seem self-evident and many practitioners will be doing this effectively, participants said, they felt it was nevertheless worth making relationship building an explicit priority to prevent it being forgotten by professionals with heavy workloads and stretched capacity. There was concern that drug and alcohol treatment staff focus too heavily on the substance use, forgetting their role in supporting people in recovery back into the community and helping them build (or re-build) social networks. Working with professionals in universal services (e.g. midwives, GPs) on the ways in which they relate to and work with people in recovery and their families is, according to seminar participants, also important when looking at how best to support recovery. The value of home visits was discussed by participants, who advocated a whole family approach that empowers the family to work towards recovery together, on the family's 'home turf.' The cost associated with home visits, together with capacity issues in services was, however, recognised as a potential barrier to such practice.

The role of the therapeutic relationship has been found to be a critical factor in effective treatment, and some have proposed that it is perhaps more important than the treatment modality itself i.e. the type of intervention provided. According to Harris, this alliance comprises a '*strong bond, working towards goals the client values and uses tasks that the client perceives as*

*helpful.*<sup>20</sup> Harris argues that outcomes of different types of therapies are comparable regardless of modality, and that an analysis of treatment effects show the type of intervention accounts for only a small percentage of overall outcomes.<sup>21</sup> Others have similarly contended that a strong working relationship between therapist and client is linked to better engagement and retention in treatment,<sup>22</sup> and is *'one of the strongest and most robust predictors of treatment success.'*<sup>23</sup>

Whilst for some recovery may be possible without accessing services, for many others contact with services and professionals is crucial, and relationships with professionals play a fundamental role in recovery. In a study of homeless hostel residents with substance use issues, many participants had social networks encompassing friends and family within and outside the hostel, whereas for others, professionals comprised the majority of their social network; and these relationships (with hostel staff, drug workers, probation officers, GPs, and pharmacists) were found to be particularly stable.<sup>24</sup> The authors found the gains of recovery were more likely to be maximised where hostel management and staff actively support and engage with treatment delivery.

## Excerpts from The Everyday Lives of Recovering Heroin Users

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In a study of recovering heroin users, the aspect of treatment and support that individuals most often valued was the opportunity to have positive and meaningful relationships with others:

*"I see [name of worker] from [voluntary sector drug service] once a week. She's so wonderful, really, she's great. I love her... I think she really like understands how I feel, you know. She's the kind of person to go way out of her way for me... I think she'll probably come, you know, she will come and see me at rehab and stuff... She's lovely... She's great. [I] really feel really supported by her, you know."*

Diane, aged 34

Establishing good relationships was especially important in residential services:

*"The things that is helping me to stay here, keeping me here, is that I've got people here that actually care about me and that. Who don't... want anything from me. And the help that I'm getting is mind blowing. All the staff's time and efforts that they've put into me. It's like, 'Well why? You shouldn't be wasting your time on me'. That's how I was thinking at first, but it's like, 'No', because... I'm not saying I deserve it, but I need their help to make myself better, to improve myself, and I am so grateful for that."*

Ellie, aged 29

Seminar practitioners suggested that whilst training and professional competency is vital, the importance of practitioners being able to engage and empathise with their clients on a human level should not be understated.

*“One explanation is that the quality of seeming genuine, long recognised as one of the keys to effective therapy, can suffer from drilling in techniques and in withholding normal caring responses in order to adhere 100% to motivational principles.”<sup>25</sup>*

Just as families need support in their own right, so do staff; especially when working in a challenging environment, sometimes with people with multiple and complex needs, and often stretched to capacity. It was noted that in order to ensure that staff foster positive and supportive relationships, investment must be made in them and their wellbeing, including paid staff, volunteers and peer supporters.

## Relationships with peers

Alongside friends and family, support from others in treatment or recovery in a range of settings (informally and through peer support/mutual aid groups) can help people in their journey through recovery. For those at the start of recovery, 12-step groups and other mutual aid and peer support structures can aid with the accumulation of social capital.<sup>26</sup>

Engagement with '*recovery-supportive networks*' help spread stories of hope, demonstrating that recovery is possible and counteracting the damaging effects of stigma.<sup>27</sup> Peer support is a well-developed model both within and beyond the drug and alcohol sector. With reference to recovery from mental health problems, a study by Rethink suggests that interacting with others who have gone through similar experiences enables a peer supporter to feel empowered by giving help to others.<sup>28</sup> The relationship between peer supporters and professional treatment organisations has tended to fluctuate, with periods of tension, separation, competition and conflict. The current growth of peer support services has been said to mark a visible return of people in recovery into the field of addiction treatment.<sup>29</sup> Peer support is not limited to the drug user, and a significant amount of family support is informal and peer led by others who have been affected by a loved one's substance use,<sup>30</sup> thus highlighting the interconnectedness of families, friends and recovery.

Seminar participants painted a picture of increasing emphasis on recovery champions and peer mentors, and attributed this to the continuing cuts to treatment service budgets. On the one

hand, participants saw the peer relationship as the most authentic and credible, but noted that it should not be seen as a replacement for a competent and skilled professional worker. Some commented on the need for wider workforce development and the importance of volunteers receiving supervision, support and all they need to develop and maintain positive and effective relationships. If peers are to play a constructive role, it is essential they feel supported themselves – and this requires investment.

Case Study:  
Si Parry, Co-  
Founder of  
MORPH

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**What motivated you to set up MORPH?**

At the time, I experienced a five month wait for a script. If you are an injecting heroin addict that's a long time - there's a chance you might not be alive. So that was 2004, and having stopped using we decided to agitate for those needing treatment in the future. We started with a weekly meeting in a voluntary centre where we could use for free and they didn't mind we were ex-addicts, we then found out about advocacy and started sending out warnings about dodgy batches of drugs that were circulating locally.

**What were the biggest challenges in setting up MORPH?**

Once we had got going as an independent charity it was initially getting used to a whole new language, whole new acronyms, initials and how the whole system worked, being in meetings and having to stop people, asking '*what's X mean?*' We knew nothing about fundraising, committees and stuff like that, but we were in the voluntary service and that info was easy to find. People were a bit suspicious about it to start with, it was a new concept

having people they would see as clients, from the other side of the tracks, at the meeting. At one meeting we were told off the record *'there was discussions about whether if you didn't get your own way you'd be climbing across the tables to punch people'*. Right at the start we started fundraising as we were paying for the warning posters out of our benefits. It was suggested we rent space in the voluntary centre, we got a bit of support and did a funding application, got some funding for a desk, a printer and office space, internet and land-line, a mobile so we took it from there. We just got on with it really, we came from a background of DIY culture, putting on gigs, punk rock/alternative, and we applied the same kind of thinking to MORPH.

**Which were the key relationships you built in establishing MORPH?**

The commissioners, managers of the treatment services, the GPs, voluntary services. We hooked up with a regional advocacy forum, and created the Hampshire Users Federation, we called ourselves user-activists, we'd meet up and discuss stuff. Finally the NTA sponsored our regional South East forums, which was a useful two-way street.

**What are the best things that have come out of MORPH?**

Our drug early warning system - it was used as example of good practice by PHE. Also peer support for people who aren't opiate users, don't quite fit or are still using - we found from anecdotal feedback that people feel they can come to us, and we aren't going to give them grief. We are a source of info they can trust.

**What's the one piece of advice you'd give to someone setting up a peer support group?**

Be careful about giving advice to other people, it may end up being inaccurate and come back to bite you! Don't worry and stress about feeling you have to have all the answers all the time, and be all things to all people. Be as independent as you can be for as long as you can be.

## Relationships online

Advancements in technology and the internet have meant that an increasingly large number of people access support online. Seminar participants acknowledged the opportunities that technology offers, in terms of diversifying support options, and were enthusiastic about widening support for those who are reluctant to go into treatment services and people living in rural areas. However, the need for forums and online resources to be well-moderated was stressed, due to concerns over gossip-spreading and cyber-bullying. It was also noted that online support may exclude certain groups, such as the elderly and homeless people.

### Case Study: SMART Recovery Family and Friends

[read more](#)

SMART Recovery® Family & Friends (F&F) aims to provide a network of support meetings for people who are affected by the addictive behaviour of someone close to them. Rather than focusing on their Loved One, the F&F programme invites participants to spend time concentrating on themselves and their goals, this also includes looking at some of their habitual responses to their Loved One and exploring whether these are helpful or not. SMART F&F explores ways that participants can look after themselves better, even in difficult and stressful circumstances, and establish healthier relationships with their Loved One.

The programme combines elements of SMART Recovery and the Community Reinforcement and Family Training (CRAFT). SMART Recovery® is a skills-based, self-help programme for individuals struggling with dependencies of all kinds. An alternative to 12-step models such as Alcoholics Anonymous, SMART Recovery

uses well-established techniques from modern psychology to equip people with practical skills and tools to overcome their addiction.

SMART run an online community, with a '*social networking*' system to help participants build up their contacts with others using SMART Recovery in their local area and across the country. This platform can be used to share ideas, videos and articles that have helped individuals in their recovery, whilst for others, the community can be used to organise local events or provide feedback to help improve the service.

Case Study:

**HAGA**

[read more](#)

HAGA is an alcohol action charity, tackling the harm caused by alcohol by supporting people to cut back on their drinking, reducing risk and raising awareness, and working with families and communities affected by alcohol. Recently, HAGA has focused on bringing a variety of technological innovations to the early identification and treatment of alcohol misuse. HAGA first developed an online screening, advice and referral tool, DontBottleItUp, and then DrinkCoach, a smartphone and tablet app. 40,000 people visited DontBottleItUp in 2014 and it is currently commissioned in several local authorities. If an individual is drinking above recommended limits, DontBottleItUp will offer them the opportunity to book an online appointment via Skype. Feedback from people who've already used the service has been very positive. The HAGA Online Support Service has attracted those who are at work or have other commitments in the day or simply don't want to attend an alcohol treatment service.

Mark Holmes, Telehealth Coordinator at HAGA, on why technology may offer more people the support they need to make changes to their drinking:

*“There are many reasons why people may not seek support with their drinking. The stigma of entering an alcohol service remains a major one. We know that despite the high numbers excessively drinking, the majority of people at risk of alcohol-related harm are not accessing alcohol services... Retention is also a problem with national and international statistics indicating that from 40% to 60% of people who enter alcohol treatment services drop out within as little as two sessions. If we want to achieve The Department of Health’s Alcohol Needs Assessment Research Project benchmark of engaging 15% of the problem drinkers in a given area into treatment, then alcohol services must not only deliver high quality specialist support but also find innovative approaches to reaching risky drinkers. Telehealth technology is increasingly being looked to as one way to reach people with all sorts of health advice, information and support.”*

## Relationships with the wider community

Not only can positive relationships with family, friends, peers and professionals be conducive to an individual's recovery journey, but so too can relationships with the wider community, such as neighbours, employers and community groups. Best and Gilman have posited that the growth of recovery has generated 'collective recovery capital,' that engages people in a variety of activities in the local community.<sup>31</sup> This, they contend, leads to greater active participation in community life, and is a positive force in the local community that goes beyond managing substance use issues. Services and commissioners should seek to actively support local movements aimed at recovery and community cohesion.

*"Society as a whole will need to welcome and embrace those trying to achieve recovery, from employers to local communities, or they will not achieve the support and social re-integration necessary to sustain freedom from dependence. All members of society have a part to play to create communities where recovery from drug or alcohol dependence is possible and sustainable, including tackling stigma against those seeking help with drug or alcohol problems or those on a recovery journey."*<sup>32</sup>

When an individual recovers, it is recognised that the family also recovers; however, this also applies to the broader community, since the individual, family and community are interconnected.<sup>33</sup> Research suggests that working with employers, including addressing stigmatising language and changing attitudes towards drug and alcohol users generally can increase opportunities for those in recovery.<sup>34</sup> Indeed, this was one gap

identified by seminar participants, who pressed the importance of working with employers when aiming to combat stigma.

Case Study:  
**Becoming  
Visible: The  
Somali  
community  
and substance  
use in London**  
[read more](#)

The Somali community in the UK has been viewed as *'impenetrable'* and *'uncommunicative'* and is therefore classified as *'hard to reach'* by policy makers and service providers. Somalis experience a range of difficulties, causing marginalisation and making it less likely that they will access mainstream services. Low uptake of drug treatment services from BME communities could be attributed to a number of reasons, including a lack of cultural sensitivity by drug services, the language barrier, a mistrust of confidentiality and the failure of drug services to target BME communities.<sup>35</sup> Substance users and their families have been found to encounter difficulties in accessing services.<sup>36</sup>

In a Somali students' focus group, participants doubted the ability of Somali community services to deal with the issues affecting the Somali community, and a level of scepticism and mistrust was evident. On the subject of drug use in the Somali community, there was agreement amongst the students that the problem was getting worse, and that older generation were unable to address this. Young people consulted reported feeling comfortable accessing services, yet they did not report accessing mainstream services, such as Connexions, a service for young people offering advice on issues including employment, housing, rights, health and relationships.

Women consulted felt there was a lack of information on drugs, meaning that they were unable to determine whether their children were using illegal substances and address the issue in the community. Many of the women struggled with English, and would use community centres, which often had limited resources and restrictive opening times, as a point of access to other services. Another issue which emerged from the focus group was the perceived institutional failure of Social Services to work with the Somali community in London.

There was much discussion in the men's consultation over the inability of Somalis to access basic services, which hindered their ability to express concerns: *'there is no information so you don't know where to go.'* A community worker from Haringey said: *'Here [in the UK] there is a system, back home there is no system. People don't know the law; therefore they do not know what they are entitled to.'* Somali community workers identified three key issues: the need to give the Somali community a united *'common voice'* in British society, the lack of confidence amongst Somali community organisations in the UK and the need to increase the capacity and institutional strength of Somali community organisations to address issues such as drug misuse and youth crime. There was consensus that a lack of experience of the voluntary sector in Somalia meant there was a failure to understand community-based organisations in the UK. It was suggested that local organisations should work together through a forum to share information and resources, in order to meet the challenges collectively.

## Appendix One – Attendee List

The seminar discussion to inform this briefing took place on 1 December 2015 in London. More information on this strand of work (Building Recovery Capital) is available on the Recovery Partnership website. We would like to thank the participants of the roundtable for their valuable contribution to the event and to this briefing.

Roger Howard (chair), UK Drug Policy Commission/Building on Belief

Tim Sampey, Building on Belief

Jolanta Kaczmarek, OnePlusOne

Alec Martin, OnePlusOne

David Best, Sheffield Hallam University

Lauren Hall, Sheffield Hallam University

Natalie Harris, SIAS/Aquarius

Ruth Spencer, SIAS/Aquarius

Helen Smith, SIAS/Aquarius

John McCracken, Department of Health

Carole Sharma, FDAP

Jonathan Graham, Homeless Link

Patrice Lawrence, Clinks

Hazel Jordan, PHE National

Jenna Marsh, Home Office

Karen Rofe, Home Office

Rebeca Sandu, Dartington Social Research Unit

Paul Hayes, Collective Voice

Huseyin Djemil, Buckinghamshire County Council

Rebecca Mistry, RAPt

Rana Bain, CRI

Janet Gambell, HMP/YOI Lifeline Transform

Vicky Cupit, Inclusion Cambridgeshire

Cate Talbot, Inclusion Cambridgeshire

Irene MacDonald, CPSG

Ian MacDonald, CPSG

Emma Bond, Tower Hamlets Council

Emily Ashegba-Edeworm, Lewisham supported housing service

Lauren Garland, Adfam/Recovery Partnership

Oliver Standing, Adfam

Shaneka Knight, Adfam

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