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Building recovery capital through peer harm reduction work

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Abstract

Purpose – *Peer harm reduction programmes engage service users in service delivery and may help peers to develop employment skills, better health, greater stability, and new goals. Thus far, peer work has not been discussed as an intervention to promote recovery. The purpose of this paper is to provide findings related to two research questions: first,do low-threshold employment programmes have the potential to contribute to positive recovery capital, and if so, how? Second, how are such programmes designed and what challenges do they face in supporting the recovery process?*

Design/methodology/approach – *Using a community-based research approach, data were collected at a Toronto, Canada community health centre using in-depth interviews with peer workers (n = 5), staff (n = 5), and programme clients (n = 4) and two focus groups with peer workers (n = 12). A thematic analysis was undertaken to describe the programme model and to explore the mechanisms by which participation contributes to the development of recovery capital.*

Findings – *The design of the Regent Park Community Health Centre peer work model demonstrates how opportunities for participation in community activities may spark cumulative growth in positive recovery capital within the community of PUDs. However, the recovery contagion of peer work may lose momentum with insufficient opportunities for new and experienced peer workers.*

Originality/value – *Using the concept of recovery capital, the authors demonstrate how low-threshold employment interventions have the potential to contribute to the development of positive recovery capital.*

Keywords *Harm reduction, Employment, Recovery capital, Peer workers, Low threshold, People who use drugs*

Paper type *Research paper*

Introduction

Peer harm reduction work, based on a low-threshold model, is part of a trend towards involving people who use drugs (PUDs) in programmes and policies that affect their lives (Marshall *et al.*, 2015; Cheng and Smith, 2009). Studies show the effectiveness of peer-delivered services to reach a wide range of PUDs and to promote safer drug use behaviours (Broadhead *et al.*, 1998; Mason, 2006; Janssen *et al.*, 2009; Marshall *et al.*, 2015). Although some studies have demonstrated benefits to peer workers themselves, such as improved health, stabilized substance use, and reduced social isolation (Hilfinger-Messias *et al.*, 2009; Mason, 2006; Cheng and Smith, 2009; Sherman *et al.*, 2009; Mackenzie, *et al.* 2012; Marshall *et al.*, 2015), none have discussed the potential of peer harm reduction work as an intervention to promote recovery.

"Recovery" is an evolving concept referring to anything from complete abstinence from all drugs and alcohol to managed use of substances (Hunt, 2012). Here, we employ an understanding of recovery that is aligned with harm reduction to describe a self-directed process that contributes to health and well-being, empowerment, and social inclusion (UK Drug Policy Commission, 2008).

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Granfield and Cloud (2001) offer the concept of "recovery capital" to refer to the sum of resources that can facilitate the recovery process. Their model of recovery capital includes four components (Cloud and Granfield, 2008) and a fifth component later added by Best and Laudet (2010):

1. social capital includes the sum of resources that each person has as a result of their relationships;
2. physical capital is defined in terms of tangible assets, such as income;
3. human capital is defined as both inherited and acquired skills, positive physical and mental health, aspirations and other personal resources;
4. cultural capital includes the values, beliefs, and attitudes that align with social norms; and
5. collective recovery capital refers to the resources within a community that support the recovery process.

This model conceives of recovery capital as existing on a continuum with positive and negative sides: positive recovery capital supports; and strengthens a person's recovery, while negative recovery capital is an impediment (Cloud and Granfield, 2008). The quality and quantity of recovery capital plays a major role in predicting recovery success, and Cloud and Granfield contend that the growth of positive recovery capital can potentially spark the recovery process. Nevertheless, they note that the ways in which recovery capital can be built are not well understood.

Low-threshold services and recovery capital

According to Islam *et al.* (2013), "low-threshold" is a term widely used in the substance use literature to define services that do and that do not include abstinence as a requirement. Islam *et al.* suggest a more precise definition of low-threshold programmes to be those that "offer services to drug users; do not impose abstinence from drug use as a condition of service use; and endeavour to reduce other documented barriers to service access" (p. 221).

Should the focus of recovery capital continue to be on abstinence as an endpoint, it is unclear what role low-threshold services may play in the development of recovery capital. However, Cloud and Granfield (2008) acknowledge that positive recovery capital may buffer the negative effects of substance use such that people are able to maintain their substance use in a way that insulates them from negative repercussions (e.g. loss of housing, hitting "rock bottom"). Furthermore, they suggest that individuals with positive recovery capital become adept at balancing behaviours associated with competing lives (i.e. "drug life" vs conventional lives that include employment). This suggests that the concept of recovery capital need not focus on abstinence but may be aligned with a more inclusive understanding of recovery that emphasizes health, well-being, social inclusion, and empowerment.

Peer harm reduction work: an example of recovery through employment

Our study asked: Do low-threshold employment programmes have the potential to contribute to the development of positive recovery capital, and if they do, how? How are such programmes designed and what challenges do they face in sustaining the recovery process?

To consider these questions, we share findings from a study of a low-threshold employment programme embedded within a harm reduction service at a community health centre in Toronto, Canada.

The Regent Park Community Health Centre (RPCHC) provides a range of health and social services to the residents of Regent Park, an inner-city neighbourhood characterized by high concentrations of problematic substance use, homelessness, and poverty. As part of RPCHC's harm reduction programme, a PUD community-capacity building initiative was developed in 2005 to offer training in safer drug use, HIV and hepatitis C prevention, and low-threshold volunteer opportunities as harm reduction kit-makers. The popularity of the programme amongst PUD and

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the benefits to PUD accrued through participation spurred an expansion of the programme to include low-threshold employment opportunities as drop-in supervisors, outreach workers, and relief-staff.

Below, we argue that a continuum of low-threshold employment opportunities such as those offered by the RPCHC programme may contribute to the development of positive recovery capital at the individual and community level. However, scarce opportunities for peer workers, insufficient programme resources, and a wider systemic context in which PUD are criminalized, marginalized, and stigmatized may limit the potential of such programmes.

Methods

Using posters displayed at RPCHC, we recruited peer workers to participate in preliminary focus groups and used these data to develop interview guides for qualitative interviews and focus group discussions. Programme staff assisted in the recruitment of peer workers and clients who access peer services to participate in semi-structured interviews. Programme supervisors were also invited to participate. Eligibility requirements included ability to speak English, and to be age 16 years or older. After reviewing the consent form and emphasizing the importance of confidentiality, focus group participants provided verbal consent and interview participants provided signed consent.

The interview and discussion guides included questions about the goals, benefits, and challenges with the peer programme. Focus group discussions and interviews were conducted by team members with no supervisory role at RPCHC. We hosted two focus groups with peer workers (i.e. male ($n = 3$), female ($n = 7$)). Semi-structured interviews were conducted with peer workers ($n = 2$ women, $n = 3$ men), with clients ($n = 2$ men, $n = 2$ women) and programme staff ($n = 3$ women, $n = 2$ men). All participants were asked to complete a short questionnaire about their demographic background, drug use, and service use. Interviews and focus group discussions were audio recorded and transcribed verbatim by a confidential typist. Transcripts were reviewed for completeness and accuracy. Questionnaire data were entered into SPSS.

Analysis of the transcripts was undertaken by team members with no supervisory role at RPCHC (i.e. Strike, Penn, and Mukkath). Using an iterative approach, the transcripts were hand-coded by one team member and then the three team members met to discuss coding and develop consensus about the codes and their interpretation. Feedback from the team was then used to refine the analyses. A secondary thematic analysis was undertaken using themes from the recovery literature. By mapping our findings onto the concept of recovery capital, we were able to explore the potential of peer harm reduction work to contribute to the development of recovery capital, and extend the concept of recovery capital from a harm reduction perspective.

Findings

We mapped out the components of the peer programme based on the descriptions provided by participants to show that the programme offered a continuum of peer opportunities, anchored at one end by peer participation activities, and at the other end by employment development opportunities. PUDs spoke about moving or not moving along the continuum according to their desires, needs and the availability of opportunities. For the sake of clarity, we refer to PUDs who engage in peer participation activities as “peer volunteers” and those involved in employment development opportunities as “peer workers”.

Along the continuum of peer opportunities at RPCHC, peer volunteers and peer workers engaged in a range of tasks that were informed by different discourses and that varied in their degree of formality and level of responsibility. The peer programme began by offering peer participation activities to any client who wished to participate in aspects of the harm reduction programme. The peer participation programme was informed by a health promotion discourse with the goal to build community-capacity among PUD. It was described as having a focus on relationship-building, a commitment to work with peer volunteers in a low-threshold, non-coercive manner, and to be inclusive (i.e. open to anyone regardless of their levels of stability,

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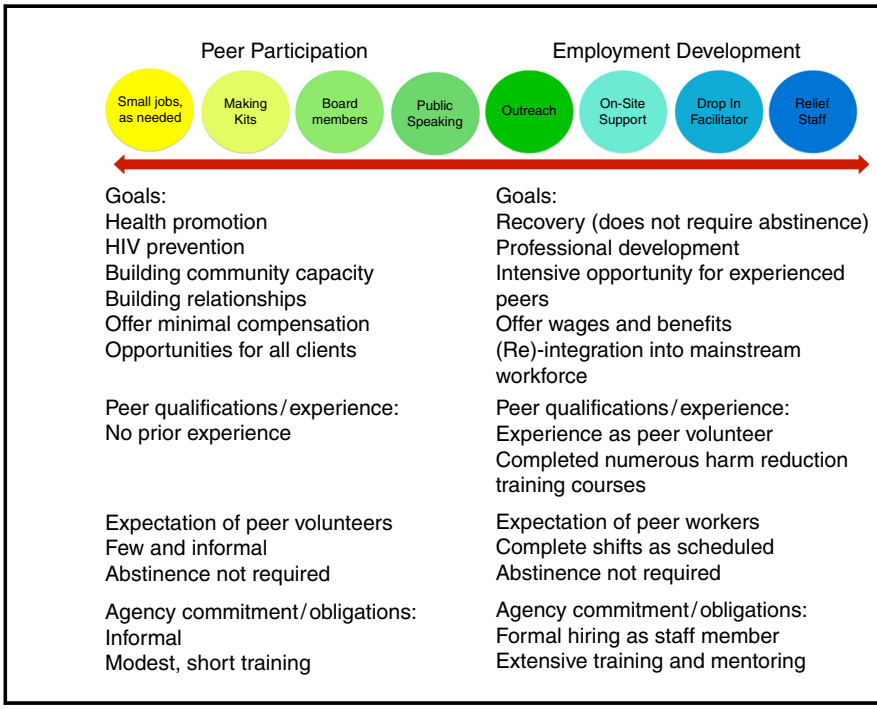
experience or skill). Peer volunteers required only basic training to complete supervised instrumental tasks such as assembling safer injection kits. The programme aimed to provide opportunities for peer volunteers with the belief that such participation would have health promoting benefits. For example, by providing a supportive environment, health education, and harm reduction supplies, and building community-capacity to share information within their social networks, participation would help peer volunteers increase control over their health. Peer volunteers received minimal compensation per "shift" (e.g. $10 CAD for kit-making).

The peer participation model offered a critical entry point to the process of recovery by providing opportunities for PUDs to develop skills and self-confidence and perhaps, to spark their interest and ability to embark on more advanced "peer worker" training, employment opportunities, and recovery. Successes in the peer participation programme created a demand to expand the programme along the continuum (see Figure 1), which led to the creation of employment development activities. Found at the other end of the continuum, the employment development model embraced a recovery-oriented approach to provide a supportive workplace-training environment. This approach concentrated resources on a small group of PUDs who voiced a desire to make substantial changes in their lives, primarily in the area of employment.

In the employment development model, "peer volunteers" transitioned to a new status as "peer workers", a position perhaps most akin to an "intern". Though not official employees, peer workers held a more formal role than peer volunteers. They were responsible for assigned shifts and worked alongside programme staff or independently to provide outreach, health education, and harm reduction supplies. Honoraria were higher to reflect peer workers' increased experience and skills. Supervision of peer workers involved giving feedback about job performance, providing support for navigating the workplace and balancing competing demands between work and life, and assisting with applications to college programmes or mainstream job opportunities. Employment development opportunities continued to be low-threshold: abstinence was not required and supervisors worked with the peer workers to sustain their employment and engender success. They took into account employment barriers that PUD face (e.g. poverty, homelessness, criminalization, and addiction) while also nurturing the development

Figure 1 Continuum of peer work



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of skills needed to transition to mainstream employment (such as being on time). Successes at this far end of the continuum prompted RPCHC to hire peer workers as casual-relief workers, putting them on payroll and granting them official employee status.

Building recovery capital through peer harm reduction work

Although the term "recovery" was not explicitly used, participants described positive outcomes that mapped onto the components of recovery capital as described by Cloud and Granfield (2008) and further elaborated by Best and Laudet (2010). Mapping the remarks about their experiences onto the components of recovery capital revealed how the peer programme helped to build their recovery capital. In addition, we found there were challenges to the peer programme as a way to stimulate the growth of positive recovery capital, due in part to programme constraints (e.g. insufficient funding, inadequate human resources) as well as wider social and systematic factors, such as stigmatization and criminalization of PUDs and the dominance of an abstinence-oriented approach to drug policy in the wider society.

Social recovery capital

Participants discussed the importance of the mutual support that developed between peer workers. In addition to support, these relationships, and those with staff members, increased their access to resources needed to enhance other areas of recovery capital, particularly human capital (e.g. increased skills and self-esteem, improved health). Peer 5 talked about how being a peer worker expanded her circle of support:

> I get through [a rough patch] better because [I've] got more supports […] really strong supports. I've got [staff from RPCHC and other agencies], like everywhere I turn right? You meet so many people now (Peer 5).

Being part of the peer worker team increased their use of other health centre services. Staff 2 understood the greater use of services to be related to the increased knowledge of available services, but also to the development of relationships between peer workers and RPCHC staff members:

> [A peer worker] may come in and grab a worker and say "I need you. I'm working right now, but I need you to help me out, find housing" […]. Because of their proximity to us, they've had a lot of exposure to the workers here so it's a lot easier for them to open up and talk about some of the issues that they're facing and utilise some of the supports here.

Greater access to services was linked to an increase in self-esteem, or human capital, that enabled peer workers to recognize that they deserve help:

> One of the biggest things that I've seen happen is their self-esteem, their self-worth. It goes up; it shoots up, to like, they feel a 100% like they deserve things. So they can ask for help (Staff 4).

Cloud and Granfield (2008) argue that group membership is a source of social capital not just in terms of support from others within the group, but also because of an individual's commitments to the group to which they belong. Peer workers spoke about their obligations to the peer team, to the programme supervisor who had given them "this chance", and to the clients they served. As a member of the peer worker team, they felt obliged to be a positive role model and representative of RPCHC. However, peer workers experienced role tensions related to their social position at RPCHC: that of both client and worker. The social capital that they gained through membership in the peer worker team was contrasted to their continued membership in a stigmatised group: street-involved people who use drugs. Staff 2 described the challenge:

> We expect our peers to work alongside staff in the delivery of a service for people who have addictions [...] And at the same time, they wear these two hats when they're talking with someone that they may have just last night done drugs with […] it's one of those things, they wear these two hats, as a client as well as a peer worker.

While Cloud and Granfield (2008) described how those with abundant recovery capital could maintain substance use without jeopardizing positive perceptions that others have of them, the peer workers and their parallel status as a client of the harm reduction programme impeded

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their ability to use their new found "social capital" to obscure or override their membership in a stigmatised group. Nevertheless, employment as a peer worker assisted some to reconnect with estranged family members, which in turn, increased their self-esteem and commitment to "keep moving upward". Employment could be leveraged to re-acquire social capital but often led to relinquishing social relationships with other PUDs who were jealous and attempted to sabotage their successes as a peer worker.

Physical recovery capital

Peer volunteers noted that the honoraria they received were modest but provided the initial incentive to engage in peer participation activities. PUDs only had to show up for the activities to receive the incentive. This low-threshold approach encouraged many to take that first, small step towards reducing their social isolation and building social and human capital that might or might not be later leveraged to access the employment development opportunities.

Although physical capital is often thought about in terms of financial assets, increased housing stability may be considered a form of physical capital. Staff members reported that many of the peer workers who had been homeless secured housing as they moved along the peer work continuum. Increased housing security was attributed to overall improved well-being and more "managed" drug use. Nevertheless, staff members noted that the employment development approach was not an immediate panacea for all substance-related problems and the poverty that characterized the lives of their clients:

> Peers are still experiencing barriers, discrimination as drug users, poverty. They're still living in poor housing. So they have all these things that they are experiencing but then they're still coming to work (Staff 4).

Peer workers worked part-time and remained on social assistance. Many longed to leverage the skills and capital they acquired as peer workers into more work hours, and ultimately their goal of securing a full time job and getting off of social assistance: "I just want a job, a stable job" (Peer 4).

Human recovery capital

Employability is a component of human capital. The employment development approach provided a low-threshold environment to acquire new skills and gain experience. It also provided a venue where peer workers experienced an increase in their self-esteem, improved health, greater management and/or moderation of their substance use, and the development of new goals, all of which were believed to enhance employability. Peer 5 described overlapping and mutually reinforcing processes where doing peer work facilitated improvements in her health and well-being (i.e. human capital) through access to employment and physical capital such as money and food, which in turn, helped her to accumulate more human capital (i.e. employability):

> It really helped me to get more employment, to better my lifestyle, to cut back […]. It helped me as a person, it helped me mentally, psychologically, emotionally, physically. Yeah, benefits are always in the money. I love the money. Food, you get to eat the food in the program too. So if I'm working three drop-ins a week, I'm getting breakfast three days a week [...].

Staff members noted overlapping connections between human and physical capital through improved health, self-esteem, access to services, and participation in peer work. They also observed that an increase in peers' self-esteem sparked the development of new goals for them. Staff 2 stated:

> [Peer work helps] their ability to manage their health, get the care they need. I think it does translate into their work as simply as, you know, they're feeling better, they're able to work better […] I tend to notice a difference with folks that get to that place where they can see their own potential, and there seems to be a click that happens around professional identity.

Perhaps most notable were participants' accounts of how peer work provided an incentive and structure to make changes in their substance use. Peer workers were not required to be abstinent or to have abstinence as their goal:

> Abstinence wasn't required to work. You know, people had to show up in reasonable shape, they couldn't be all messed up. But other than that, if they used on their private time, it wasn't a concern for us (Staff 1).

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However, peer workers frequently made changes in their drug use patterns in order for them to "do a good job". For example, Staff 1 remarked:

> People organised their substance use in a more functional way so they could come to meetings more reliably. They were able to make those changes without us telling them […] They knew what they needed to work on and we just provided the structure, support and resources that they needed.

Peer workers linked changes in their substance use to accumulating physical and human capital, including greater housing stability, reduced involvement in the criminal justice system, and improved health:

> I find it helps me deal with my own addiction […] It gives me a thought, you know, I must be trying to help myself a little bit. I mean, I cut back a lot […] seven years ago, I was smoking hard, and had no place to go. For the last seven years, I've had a place. I've been out of jail for seven years! (Men's focus group participant).

One participant hoped to gradually work towards abstinence. He described how his job as a peer worker contributed to this new goal:

> My first year out of jail, when I started doing outreach, my first thought was: "That went well. I've been out of jail for a year. I'm doing outreach". I did about six courses, [public] speaking, first aid [...] And everything worked out well. And made me feel good everyday […]. I say everyday: "Man that works out good. Must be doing something good". And hopefully next year, I'll be done smoking crack. That's the way I feel now. (Men's focus group participant).

Despite increases in positive human capital, the peer workers continued to experience instances where negative human capital diminished their future employability. Many noted that they had had prolonged absences from the workforce, lacked the education required for other mainstream jobs (e.g. 30 per cent of our peer interviewees had not completed high school), and had criminal records that prevented them from being hired.

Cultural capital

Cloud and Granfield (2008) argued that those who share values and norms with conventional society are at an advantage for overcoming addiction. Some of our study participants shared ideas that reflect dominant social norms related to substance use, employment, and citizenship. For example, a peer worker attributed his job helping people to be a way for him to "climb up the ladder through the levels and getting established as a clean, straight human again". Participants expressed conflicting feelings about the title "peer worker", many of who expressed a desire to be seen as a "normal kind of worker". There were hints in our study that those who made the leap into mainstream employment sought to distance themselves from their past employment as peer workers because it disclosed to clients and new colleagues that they were current or former street-involved drug users. However, other peer workers contested dominant ideals of the necessity of sobriety for employment and, as suggested above, continued to use although in a managed pattern.

Collective recovery capital

Best and Laudet (2010) added a new dimension, collective recovery capital, to Cloud and Granfield's dimensions (2008). They argued that the growth of recovery capital within members of a community can generate "collective recovery capital", that is, recovery capital at the community level. In turn, collective recovery capital provides support for individuals to embark on and sustain the recovery process, often by encouraging community participation. Our study found that collective recovery capital may be enhanced by low-threshold employment opportunities, such as those offered by the RPCHC peer participation programme. Staff members described the importance of community participation:

> The peers were so eager, just hungry to belong somewhere, to contribute somehow, to do something positive in their life, to help others […] I've seen real positive outcomes in a short period of time without us, the service provider, actually pushing it on them. We just created an environment where involvement was encouraged and nourished […] (Staff 1).

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> [The program supports] a sense of belonging and a greater connection to the community and the sense that they have something to give (Staff 2).

The programme's expansion into employment development opportunities may have further developed collective recovery capital by inspiring other PUDs to seek similar employment development opportunities or, on a more modest level, to begin to consider that their options in life were not limited completely by continued drug use. Peer workers served as "visible recovery" role models to other PUD (Best and Laudet, 2010):

> On outreach, when we met friends of the peer, the assumption was "The peer is working, well they must be abstinent". So there was an opportunity to educate other people: "You don't have to be abstinent in order to be involved in something positive". So that's a good outcome of using peers […] it showed other people that even though you're still using, you can still add to your life, you know, in good positive activities (Staff 1).

Offering employment development opportunities through peer work may have created a "recovery contagion" (Best and Laudet, 2010) and contributed to the community's collective recovery capital. Even on the modest scale of peer participation activities or the more intensive employment development model, the RPCHC peer programme provided the opportunity for active community engagement and to "give something back to the community" – an opportunity seldom offered to PUD.

The sustainability of recovery contagion was threatened by insufficient opportunities for new and experienced peer workers. As noted, the popularity of the peer participation activities led to expansion into employment development. Financial constraints, however, limited opportunities for the increasing number of PUDs who benefitted from peer participation activities and felt ready to take on employment development opportunities. RPCHC also faced constraints in its ability to accommodate the desire of current peer workers for more shifts, and a "real job", while also maintaining introductory opportunities for first-time peers. Competition between peer workers for a limited number of shifts increased as their skills and stability increased. In efforts to continue to "grow" the programme, staff members felt stretched between the competing demands of service provision, peer supervision, and funding applications. Access to sustained funding was suggested to be a critical component to the development of collective recovery capital.

These constraints were said to create a conundrum: whether to support a programme that offers peer participation activities or employment development opportunities. The employment development model requires concentrating resources on a small group of more experienced peer workers committed to substantial changes, including mainstream employment. However, this reduced opportunities for those who preferred or required less responsibility and more informality as offered by the peer participation model. The idea of offering a continuum of peer work appealed to many. Staff 2 said: "I'd just love to see people be able to participate no matter what's going on for them". Another explained the importance of giving people a chance: "We've accepted in our program people that we weren't sure about because they were just too chaotic on the street. It just didn't seem like they would be able to keep up with the structure – but they did!" (Staff 1).

Discussion

The analysis presented here suggests that the structure of a low-threshold peer employment programme that offers employment opportunities along a continuum of increasing responsibility may provide opportunities for PUD to build recovery capital. We expand upon Granfield and Cloud's model of recovery capital by applying it to a context where abstinence is not required or seen as the ultimate endpoint. In doing so, we provide support for and validation of the potential for low-threshold employment as a model that contributes to recovery, as understood to include wellness, social inclusion and empowerment. Our findings suggest that a drug policy approach fixated on abstinence as a requirement for employment and recovery may limit opportunities for PUD to embark on a process that can contribute to improvements in overall well-being.

Our findings add to a growing critique of the prevailing assumption in the addictions literature that drug use is incompatible with employment (Richardson *et al.*, 2010, 2012, 2013; DeBeck *et al.*, 2011; Harling, 2007; Sherman *et al.*, 2006). The stigma attached to drug use and related beliefs

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that PUDs are unwilling, uninterested, and unable to participate in the labour force underlie this assumption. The implications of our findings and those of others (Richardson *et al.*, 2012) prompt the consideration of employment as a potentially stabilizing force in people's lives that may precede drug use cessation. This approach is supported by other evidence showing that many people continue to participate in the labour force whilst engaging in high frequency and high intensity illicit drug use (e.g. Harling, 2007; Richardson *et al.*, 2010, 2012, 2013; DeBeck *et al.*, 2011; Sherman *et al.*, 2006). We may draw parallels with the Housing First movement, which has demonstrated that the security of low-threshold housing without a commitment to and/or evidence of abstinence can lead to numerous health and social benefits for PUDs (Atherton and McNaughton Nicholls, 2008; Kirst *et al.*, 2014). Our findings and those suggested above point to the potential of low-threshold employment development models as another pathway towards recovery for PUDs.

The idea that employment may facilitate abstinence has been taken up in interventions such as employment-based abstinence reinforcement, a form of contingency management (CM). Unlike the approach we report here, access to employment or to wages in CM interventions is contingent upon biologically verified drug abstinence, most often through urine screening (Richardson *et al.*, 2012). Such programmes have demonstrated that financial reinforcement supports employment participation and decreased drug use (Defulio *et al.*, 2009), and that people with long histories of chronic unemployment and drug dependence can acquire employment skills relatively quickly (Dillon *et al.*, 2004). Questions remain regarding the durability of effects of CM; thus far studies have not demonstrated that changes persist after the reinforcement is removed (Silverman *et al.*, 2007; Richardson *et al.*, 2012). While these programmes hold promise, abstinence is not the choice or a realistic option for all, and our findings suggest a path to recovery that is not contingent on abstinence.

A limitation of this study is that it reports findings from one of many agencies that offer peer harm reduction programmes in Toronto. The design of peer programmes varies widely (Marshall *et al.*, 2015). Our sample was not random; focus group participants were recruited using posters, but programme supervisors recruited the peer interviewees. As noted above, "recovery" is often defined in relation to abstinence, however, our findings support the notion that recovery is self-defined and its path may be achieved without abstinence. To borrow from epidemiology, our findings are "right censored" and capture a brief segment of time. We did not follow participants over time and perhaps their definition of recovery in relation to substance use changed. This requires future investigation.

Our findings add to the literature demonstrating the potential of low-threshold harm reduction employment to lead to benefits such as reduced and stabilized drug use amongst peer workers (Sherman *et al.*, 2009; Mackenzie *et al.*, 2012). Despite the potential of these programmes and their popularity, there are very few low-threshold employment positions (DeBeck *et al.*, 2011; Penn *et al.*, 2011). Our findings provide modest support for Best and Gilman (2010) who describe a ripple effect of "collective recovery capital" that provides support to those in recovery and stimulates community engagement. However, the generation of recovery capital is clearly contingent on resources and small programmes are likely to generate modest collective recovery capital. In the field of public health research, focus on "implementation science", which necessitates scale-up of interventions to assess population impact, is likely the avenue through which collective recovery capital can be built, evaluated and, depending on results, supported with evidence.

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