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Rebuilding Social Networks in Long-term Social Recovery from Substance-Use Problems

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Abstract

Rebuilding one's social network is essential to long-term social recovery from a substance-use problem. Despite this awareness, studies are needed for showing how people in long-term social recovery describe their networks and what they perceive as important in developing these networks. This study has sought to investigate (i) how people in long-term social recovery from substance-use problems describe their social networks and (ii) what they experience as key factors in developing their networks. We interviewed seventeen participants in long-term social recovery and mapped out their person-centred networks. Most of the participants were satisfied with their social networks, although some felt their networks were small and wanted more friends in the future. The qualitative thematic content analysis suggested that rebuilding networks was experienced as a demanding, anxiety-filled, long-term process. Access to social arenas, prolonged time spent with others and identification with and

recognition from others were key to developing social networks. We argue that there is a need for tailored assistance and long-term support for people in long-term recovery to help them cope with the stresses of entering new social arenas, overcome societal stigma and develop social networks.

Keywords: long-term social recovery, socially integrated, social network, stigma, substance use

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Introduction

Long-term social recovery (LTSR) from substance-use problems can be described as the process of becoming socially integrated and solving the problems (Mezzina *et al.*, 2006) that hinder people's ability to 'lead full and participatory lives as active citizens' (Tew, 2013). Human beings and their environment are central analytical perspectives within the social work tradition, emphasising analysis of individuals' life challenges within their lived situations or contexts (Richmond, 1917). Social integration into the community facilitates sustainable recovery (Mezzina *et al.*, 2006; Borg and Davidson, 2009; Topor *et al.*, 2009; Tew *et al.*, 2012; Vigdal *et al.*, 2022).

LTSR is associated with efforts to switch from a social network often dominated by substance-using peers to networks including peers in recovery and people without a substance-use history (Groh *et al.*, 2008; Kelly *et al.*, 2009; Best *et al.*, 2015; Vigdal *et al.*, 2022). Building new personal relationships and extending community belonging are associated with improved social support, quality of life and physical and mental health (Mezzina *et al.*, 2006; Best *et al.*, 2015). In a recent meta-synthesis, Vigdal *et al.* (2022) investigated how social communities assisted LTSR and found that by way of social interaction, communities perceived as safe and non-stigmatised could play a role in self-change and increased self-confidence. Social communities were understood as human systems including interactions, conversations or activities that build relatedness (Vigdal *et al.*, 2022). A systematic review of mechanisms of behavioural change at Alcoholics Anonymous (AA) showed that AA provided free and easy long-term access to social support (Kelly *et al.*, 2009). A literature study by Groh *et al.* (2008) showed a relationship between involvement in self-help communities such as AA and having more friends in one's social networks. Best *et al.* (2015) found that individuals with two years of recovery had changed the composition of their networks to include more people in recovery and fewer people actively using

substances. These social network changes led to greater quality of life and less anxiety and depression (Best *et al.*, 2015).

Both structural and individual barriers to recovery and citizenship have been documented (Mezzina *et al.*, 2006; Corrigan and Rao, 2012; Ness *et al.*, 2014; Rowe, 2015). Lack of access to the '5Rs' (rights, responsibilities, roles, relations and resources) and a deficient sense of community belonging are structural barriers to recovery and citizenship (Rowe, 2015; Rowe and Davidson, 2016). A systematic review by Harrison *et al.* (2020) concluded that work is essential to the recovery process. However, possible barriers to employment include the lack of education, work experience and job skills as well as mental and/or physical health problems (Bauld *et al.*, 2013; Harrison *et al.*, 2020). Other factors that hinder recovery and citizenship are commonly connected with living conditions, such as lack of adequate housing, poor finances and lack of supportive social networks (Mezzina *et al.*, 2006; White, 2007; Cloud and Granfield, 2008; Tew, 2013; Rowe and Davidson, 2016). Stigma, self-stigma and discrimination pose significant challenges for individuals in recovery when re-entering social arenas and developing new interpersonal relationships (Link and Phelan, 2001; Corrigan and Rao, 2012; Roche *et al.*, 2019).

Although developing social networks is an essential process for people in LTSR, we do not know how they experience and manage the process of rebuilding their networks. In particular, studies are lacking on how people in LTSR experience their networks and the key factors in developing social networks (Best *et al.*, 2015; De Ruysscher *et al.*, 2017; Bjornestad *et al.*, 2020; Francis, 2020; Vigdal *et al.*, 2022). This article investigates how people in LTSR describe their social networks and what they consider to be key factors in developing them.

Material and methods

Design

We chose a qualitative methodology to investigate the participants' social networks and what they found to be critical factors in developing them. We took a thematic analysis approach (Braun and Clarke, 2006, 2019) within an interpretative–phenomenological framework (Lindseth and Norberg, 2021). The interpretative approach led to data being generated throughout the course of the interviews from reflexive dialogue between the participants, who had a first-person perspective, and the researchers. The phenomenological element entailed collecting the observations of individuals with lived experience of substance-use problems in order to discover and interpret the meaning of this kind of experience within its broader contexts (Lindseth and Norberg, 2021). The study was approved

by the Regional Ethics Committee in Norway (reference number 131212) and evaluated by the Norwegian Centre for Research Data (reference number 804223).

Sample and recruitment

The sample was recruited as part of the ongoing Stavanger project on trajectories of addiction (Stayer study) ($n = 202$), a prospective naturalistic follow-along study of substance-use disorder (SUD) change trajectories in Rogaland, Norway (Hagen *et al.*, 2015; Svendsen *et al.*, 2017). The Stayer team recruited individuals from outpatient and residential treatment facilities between March 2012 and December 2015. Criteria for inclusion as a participant in the Stayer included the commencement of a new treatment sequence, fulfilment of criteria for SUD and being sixteen years of age or older (Hagen *et al.*, 2015; Svendsen *et al.*, 2017). From the Stayer study, we recruited participants who had been in long-term social recovery (of five or more years) from substance-use problems and were at least eighteen years of age. In this study, we define people in LTSR as active citizens leading full and participatory lives. The study's participants were active as employees or students and carried out everyday activities related to parental obligations, peer group participation and/or hobby and sports activities.

The author (T.S.S.) provided information about the study orally to twenty-six eligible participants in the STAYER cohort and sought their permission for the author (M.I.V.) to obtain their telephone numbers. M.I.V. contacted all who stated they were interested in participating in the study. Five did not respond to M.I.V.'s contact attempt, three stated it would be difficult to participate for educational or work reasons and one did not wish to participate in the study. The sample consisted of seventeen participants, three of whom had episodes of hashish, cocaine or benzodiazepine use in 2021. We decided to include them in our study. We assessed the danger of shading the processes around recovery by excluding participants with episodes of substance use from the study. See Table 1 for information on the characteristics of the participants interviewed for this article.

In the Results section, we refer to seventeen participants as 'all', eleven to sixteen as 'most', eight to ten as 'many' and three to seven as 'some'.

Measures

We used a person-centred map to investigate each participant's social network (Fyrand, 2016). We used the map to communicate about the

Table 1. Characteristics of interviewed participants

Characteristics	Baseline	Year 1	Year 2	Year 5	Year 8
Demographics					
Age	25.2 (5.2)	–	–	–	–
Male/female	8/9	–	–	–	–
Education, years	11.3 (1.6)	–	–	–	–
Substance-use history					
Age of initial use	13.3 (2.0)	–	–	–	–
Years of drug use	11.8 (5.6)	–	–	–	–
AUDIT sum score	13.4 (12.4)	3.7 (6.7)	2.3 (4.3)[d]	2.13 (3.32)	5.06 (9.77)
DUDIT sum score	30.5 (13)	7.4 (13.0)	2.9 (11.4)[d]	0 (0)	2.1 (5.9)
Treatment history					
Previous treatment attempts, median (range)	0 (0–8)	–	–	–	–
Outpatient at baseline, *n* (%)	8 (47.1)	–	–	–	–
Inpatient at baseline, *n* (%)	9 (52.9)	–	–	–	–
Self-help group at baseline,[a] *n* (%)	7 (41.2)	–	–	–	–
Social variables[b]					
Permanent housing, *n* (%)	10 (58.8)	14 (82.4)	14 (82.4)	8 (47.1)	17 (100)
Stable income, *n* (%)	11 (64.7)	14 (82.4)	15 (88.2)	8 (47.1)	15 (88.2)
Employed/student, *n* (%)	14 (82.4)	14 (82.4)	15 (88.2)	8 (47.1)[e]	15 (88.2)
Abstinent friends,[c] *n* (%)	12 (70.6)	13 (76.5)	14 (82.4)	8 (47.1)[e]	17 (100)
Mental health					
SCL-90-R GSI	1.3 (0.7)	0.7 (0.7)	0.4 (0.3)[d]	0.4 (0.5)	0.4 (0.4)
SWLS, sum score[d]	17.2 (6.7)	21.4 (7.0)	25.2 (4.8)	26.3 (4.4)	27.2 (4.6)
BRIEF-A GEC, t-score	67.4 (11.9)	56.4 (12.9)	51.7 (10.7)	50.2 (10.1)	45.6 (8.9)

All data are mean (SD) unless otherwise specified.
SCL-90-R GSI: Symptom Checklist-90 Revised Global Severity Index T-score; BRIEF-A GEC: Behavioural Rating Inventory of Executive Function—Adult Version Global Executive Composite T-score; SWLS: Satisfaction With Life Scale; AUDIT: Alcohol Use Disorders Identification Test; DUDIT: Drug Use Disorders Identification Test.
[a]Currently in self-help group, such as NA/AA and the like.
[b]Social variables are positive responses to yes/no questions.
[c]Friends without a history of substance use.
[d]Two participants did not complete this measure, $n = 15$.
[e]Nine participants did not respond to this item.

network and visualise it and as a tool to invite the participants to talk about their experience of their relations, the function of the network and the process of developing their social network (Fyrand, 2016). The person-centred map consisted of a circle divided into five zones: (i) family in the same household, (ii) other family members, (iii) colleagues, (iv) professionals and (v) friends (including friends still using drugs).

Procedure

M.I.V. conducted all interviews between August 2020 and December 2021. Interviews lasted forty-five minutes on average (range: 37–120 minutes). The semi-structured interview guide was collaboratively

developed by the co-authors and an expert by experience employed at the Centre for Alcohol and Drug Research at Stavanger University Hospital. Collaboration with this expert led to new follow-up questions being included in the interview guide.

The Covid pandemic meant ten interviews were conducted digitally and seven face to face. M.I.V. had no relationship with the participants prior to the interviews. At the beginning of each interview, the participant received a NOK 400 gift card for participating in the study and their signed consent.

Each interview began with the following statement:

> One often hears that it is important to acquire a new social network to master a life without the problematic use of substances. What do you think about this statement? Furthermore, what was your experience of the process of rebuilding your social network?

The interviews were audiotaped and transcribed verbatim by an experienced secretary. The participants mapped their person-centred social network whilst describing the various relationships they found valuable. In the digital interviews, M.I.V. held up this map and located persons on it according to the participants' instructions.

Analysis

First, we analysed the first research question regarding participants' descriptions of their social networks. The analysis was guided by questions regarding the structure and interactional features (Fyrand, 2016). Structural elements of a network have quantifiable aspects, such as number of relationships and different types of relationships (e.g. colleagues, friends and families) in the social network (Groh *et al.*, 2008; Fyrand, 2016). 'Interactional features' refers to the participant's subjective experience of interacting with the people in their social network (Groh *et al.*, 2008; Fyrand, 2016). The following questions guided the analysis:

1. How many people are in each zone?
2. Where does the participant locate the person on the map?
3. What kind of relationship is this?
4. Is it a long-term relationship?
5. Is there reciprocity in the relationship?

The visual network map assisted in the interpretation of the transcribed texts.

Secondly, we conducted a qualitative thematic content analysis according to Braun and Clarke's (2006, 2019) structured framework with regard to the second research question, regarding what the participants found to be key factors in developing their social network. The following steps

were involved: (i) M.I.V. acquainted herself with the data by carefully reading the transcribed interviews, forming an overall impression of the participants' experiences and noting potentially important themes such as the discomfort of being social and the struggle to rebuild social networks; (ii) M.I.V. and L.B.S. generated initial codes, defined as the most basic segments of raw data assessed concerning key factors in developing the network (such as participants' descriptions of how they handled their insecurity and fear of being stigmatised in social settings); (iii) M.I.V. and L.B.S. engaged with data, codes and preliminary themes in several meetings, moving back and forth between data, codes and themes and adjusting code names and theme names, with some new codes and themes evolving that deepened the researchers' understanding of our data (e.g. theme, prolonged time and identification with others arose from the authors' growing understanding of the data); (iv) all of the authors met to review the themes, consider the stories the themes told and develop a coherent thematic map, to include consideration of the validity of the individual themes in relation to the data-set and (v) all of the authors collaborated to define and name the themes. Throughout these steps, the authors regularly discussed how theoretical and disciplinary assumptions, personal experience and socio-cultural anchoring may have influenced the interviews and analyses. The analytic process was concluded when refinements no longer added substantially to the themes.

Results

Small but satisfactory social networks

Our first research question investigated the participants' descriptions of their current social networks. Many participants had never mapped their network before. See Table 2 for detailed information on the size and composition of the networks.

All participants emphasised having rebuilt or changed the composition of their social networks during their LTSR processes. They emphasised the importance of developing new relationships with people not using drugs in order to have someone who supported their recovery journey and not be tempted to start using again. Most participants said they were satisfied with their social network, despite a typical statement being 'My network is not big'. Some said they would like to have more friends in the future, and some wished for a partner or better connections with siblings. On average, the participants had twenty-one people in their networks (range: 4–65), which they found valuable in their lives. One participant, who had been nine years in recovery, reflected on the size of her network, saying: 'At the treatment institution, there was a lot of talk

Table 2. Details of the size and composition of the person-centred social networks

Participants	Family one lives with	Other family members	Colleagues	Professional helpers	Friends using drugs	Friends not using drugs	Sum
1. Male	4	4	2	0	1	1	12
2. Female	0	4[a]	0	0	0	0	4
3. Female	3	6	5	0	1	2	17
4. Male	0	3	0	0	0	7	10
5. Female	3	4	0	6	0	13	26
6. Female	1	4	2	2	0	1	10
7. Female	2	9	1	0	0	9	21
8. Male	3	4	5	0	0	8	20
9. Male	1	7	4	0	0	2	14
10. Male	4	3	10	1	0	7	25
11. Male	4	7	2	1	7	5	26
12. Female	0	5	5	1	6	10	27
13. Female	1	4	3	0	50[b]	7	65
14. Male	1	8	5	0	0	8	22
15. Female	1	7	2	0	0	6	16
16. Female	0	3	2	8	0	8	21
17. Male	0	4	4	0	2	10	20

[a]This female had four family members in her network but lived alone with a dog. She was not employed at the time and conveyed that she wanted to build a new network where she would feel surrounded by people whom she could experience as authentic in the relationship. She had many acquaintances but none she regarded as close or as friends.
[b]This female expanded her social network to include people who used narcotics. The size of the network associated with people using narcotics amounted to fifty people.

about the importance of a big network. I've always been the one who is a little embarrassed that I don't have a large network'.

Most participants mapped people into several zones, such as family, colleagues and friends. The participants indicated that they simultaneously built relationships through their different roles—that is through interaction as a colleague, a friend and, in some cases, a family member.

Family

All participants referred to regular contact with family members. Participants described social life with family as consisting of everyday activities such as sharing meals, visiting each other, relaxing together or engaging in leisure activities with children. Our findings show that the participants all had between three and eight family members with whom they did not live and whom they perceived as close or moderately close. Most participants found relationships challenging due to family members struggling with physical or mental health issues or substance use. Most participants shared their home with one or more family members, such

as a spouse, cohabitant, children or siblings and about half-lived with their children. Some of the participants stated that they lived alone.

Colleagues

Most of the participants were employed or studying at the time of their interview. One participant was not employed. According to our findings, most participants marked their colleagues as friends in their network. Most participants said they found their relationships with colleagues valuable for their well-being and LTSR. Work and meetings with colleagues were essential for filling their days with meaningful activities, developing friendships and conversing with colleagues. Many participants said their manager had been an essential partner in confidential conversations. Our findings show that most participants were cautious about sharing their stories of substance use with colleagues other than their manager until they felt safe in these relationships. Some said they did not share their story because they feared stigmatisation, having had negative experiences when telling their story earlier on the recovery journey. Some said they had not used drugs for many years and it did not feel natural to introduce the story into new relationships.

Continuing bonds with professionals

Some participants had contact with professionals throughout their recovery, whilst others had contact over the two previous years. The participants described conversations with professionals as necessary, especially at times when it was emotionally challenging for them to handle something. Participants described this as emptying themselves of their frustration and getting help to sort their thoughts and feelings. One participant maintained their relationship with these professionals after the formal contact had ended and referred to this relationship as a 'dear relationship'.

Friends

On average, most of the participants said they had six (range: 1–13) friends who were not using drugs and marked one or more as close friends. One participant said she did not have friends. Most participants had close friends who had previously used drugs. The participants described these relationships as vitally important because they could talk confidentially and openly about the past without feeling condemned. Most participants underscored the importance of friendships that had lasted for many years. One participant reflected on the value of his

friendship: 'Then you can say straight out whether you are doing well or poorly. You can speak honestly from your heart. You don't need a mask because they know you' (participant with nine years in recovery).

Some participants discussed long-lasting friendships with people who were still using drugs. They typically understood these friendships as valuable because of the long periods they had spent together when using drugs. Some of these friendships dated to kindergarten or elementary school. Other participants discussed having only informal digital contact, such as using social media to send funny movies and pictures. Two participants who had used drugs the year before their interview said they had broadened their network by adding new friends who were using drugs. The participants said that their social life with friends consisted of several everyday activities, such as having meals together, visiting each other and a few voluntary organised activities.

Growing social networks

Our second research question investigated what the participants considered to be key factors in developing their networks. The qualitative thematic content analysis of key factors generated four themes: (i) a demanding, anxiety-filled, long-term process; (ii) access to social arenas; (iii) prolonged time spent with others and (iv) identification with and recognition from others.

A demanding, anxiety-filled, long-term process

Most of the participants said rebuilding networks was a long-term process that took several years. Some had found it exhausting to build a new social network. The long-term process of obtaining new friends required them to endure the discomfort of social anxiety, vulnerability, self-stigma and their lack of confidence in social situations. One participant described her discomfort in social settings as follows:

> I was terrified about whether people would like me or not and whether I was good enough, simply if I was interesting enough to hang out with or be around. When you have this going on in your head, it's hard to communicate or be normal in a social setting. (Participant with ten years in recovery)

Additionally, some said they did not know where to meet new people or how to build new friendships. One participant said: 'It is hard in this society to know where to go when you really need someone. Where do ordinary people who feel lonely go?'

Many participants said they lacked the communication and relationship skills to contact people without a history of substance use. Some said it

had never been easy to find new friends, and some said that building friendships as an adult and in their life situations was complicated. One participant put it this way:

> The first few years were tough. Making friends is not easy! You can't just walk down the street and say, 'Hey, do you want to be friends with me?' People would have looked at you strangely then. (Participant with eight years in recovery)

Access to social arenas

Participants said that, on average, they made new friends in different social arenas (range: 1–4), such as work or studies, leisure activities, peer communities and random meetings. Two arenas stood out as particularly significant in rebuilding networks: the workplace and peer communities. Most of the participants highlighted employment and peer communities as most important to them when they were developing new relationships and friendships during recovery. These arenas shared a structure and regularity that promoted networking. The participants emphasised the structure and regularity, which led them to meet the same people frequently.

Additionally, social arenas such as the workplace and peer communities had rules for interaction, which helped them know what to do to get along with others. For example, when interaction focused on work-related topics, they could choose when to share personal, potentially stigmatising, information and how much of it. One participant said: 'I gave [information] to them little by little; I trusted them more and more. I eventually told them about my past, which was well received, and we started hanging out in our spare time, so it was a steady development.'

Our findings show that most participants emphasised the importance of access to arenas with people with a history of previous substance use to facilitate the development of close friendships. The participants developed both new and old friendships through peer communities. Many participants had previously joined NA; some were still going to NA meetings, and others had not yet been involved in NA communities. One participant with nine years in recovery had this to say about the NA arena:

> I went to work and meetings five times a week. Those were the things I did. I formed many relationships and met many people when attending meetings. I also had a friend I had used substances with, and we found each other again.

Some participants visited and developed new friendships in social arenas such as sports clubs or hobby activities. These participants said they wanted new people in their network who were not associated with substance use.

Prolonged time spent with others

There was a clear pattern of most participants emphasising prolonged time spent with others as a key factor in rebuilding their social networks. Spending prolonged time with others allowed the participants to become familiar with others by continually meeting the same people, which the participants said was decisive in the formation of relational bonds. The participants perceived three essential aspects of spending time with others.

Consistently meeting with others

The participants indicated that their bonds were formed by consistently meeting with others, such as by being with peers in NA communities or with colleagues. One participant with nine years in recovery pointed out the importance of spending prolonged time with others to build enough confidence within the NA community to share: 'A bit scary at first, but you get used to it the more often you go there. Initially, I just sat down, crossed my arms, and said hello, my name is (...), and I'm addicted to drugs. I don't feel like sharing today. That's it! That's how I was for several weeks. I didn't share.' Spending more time meeting with others provided a sufficient boost in confidence and understanding of the group's social interaction to share.

Time to get to know oneself when with others

There was a clear pattern of most participants reflecting on the following questions: Who am I when I'm not using drugs? What feelings do I have inside and how can I handle them? What do I like to do and with whom? Most participants said it took time for them to get to know themselves. A participant with nine years in recovery said: 'It took a long time to grow up, become confident, and realise that it is me. I'm still learning.' Two participants felt they were a shell, without knowing what was inside of the shell. Most participants said it often took four to five years of practice in social settings before they developed a sense of who they were when interacting with others.

Time to get a sense of safety when with others

There was a clear pattern of most participants experiencing self-stigmatisation as a barrier to forming new social ties. They found it time consuming to overcome self-stigma and dare be themselves with others. Being oneself was portrayed as removing one's mask and showing others who one is as a person. One participant with ten years in recovery discussed time as a key factor in feeling safe when with others as follows:

> It takes a very long time before I open up to people. I need a long time, and they must be patient. It took me three years to finally relax and understand that she does not hate me. Now I feel like I can be myself 100% without thinking, 'Why did I say that, or did I say too much?'

Identification with and recognition from others

Most participants pointed out that identifying with and having recognition from others depended on similarities and differences in how they looked and behaved. Participants found it easier to talk to others when they had something in common, such as parents attending parent meetings, participating in leisure activities with children, or being together as neighbours. Some participants said there were situations in which they did not feel like everyone else, such as when someone would notice and comment on visible syringe marks or when they felt they looked different in some other way. One participant with nine years in recovery said the following about changes she made to fit in:

> I felt I had to change my whole look. I went from having black hair and dark clothes to dyeing my hair blonde, sunbathing, getting a tan and looking healthy, and buying more normal clothes. So, you could say that I was a proper mother because I was afraid that people would judge me since I became a mother and that they would think that I was doing things. I was always concerned about what other people thought about me, which made meeting people difficult.

One theme that some participants highlighted as significant was the underlying similarities and differences in the use of alcohol. Some participants drank alcohol and said they used alcohol in social contexts at work and private gatherings. Given their history of substance-use problems, some participants did not drink alcohol, which they saw as creating obstacles to network building. One participant with nine years in recovery said this about alcohol use:

> I thought it might have been easier to get in touch with colleagues or others, that you [could] have a few pilsners together. However, I am not like the others, so I do not think a pilsner is just a pilsner to me. I do not know what it would have done to my head.

Living conditions and ways of life

Living conditions and material goods facilitated the development of the participants' networks. Most participants highlighted the importance of identifying with other people's living conditions and practices, such as being employed, taking care of family, making dinner, mowing the lawn, painting the house and going on vacation. Having decent living conditions and a sense of well-being gave rise to a feeling of being like others. In the words of a participant with ten years in recovery:

> Now I have a job where people see me quite clearly. They get to see that things are going well with their own eyes. I often hear that I have done an excellent job. I have not always had a good reputation here, so it is very good to be an ordinary neighbour. I feel I have a calmness that I have not had before. You go to work every day, make dinner every day, mow the lawn, pay bills, and talk to people.

Our findings emphasise equality in living conditions and social positions as essential for reducing the problems associated with societal stigma. The participants indicated that being able to assume such social positions as neighbours, parents and workers made them feel seen as equals.

Discussion

This study explores a vital practice area in social work: how people in long-term social recovery from substance-use problems create and develop supportive social networks. Our article contributes to the knowledge in this area by exploring how people describe and develop their social networks in the context of LTSR. Our discussion is organised around three overarching themes which are essential to highlight. First, we discuss the need to help people in LTSR to endure the lengthy and demanding network-building process. Secondly, we discuss the importance of access to structured and durable social arenas. Thirdly, we consider the importance of equality in terms of being socially integrated.

Help to endure the process of network building

Our study findings show that rebuilding social networks is a long-term process that involves overcoming several difficult obstacles. This is consistent with the previous studies that refer to the social vulnerability experienced by people in recovery (Bjornestad *et al.*, 2019; Abram and White, 2020). Ness *et al.* (2014) suggest that stigma and a lack of tailored assistance impede recovery and that stigma and self-stigma can impede connection with others (Mezzina *et al.*, 2006; Corrigan and Rao, 2012).

On the basis of our findings and previous research, we suggest facilitating tailored assistance to help people in LTSR overcome self-stigma and rebuild social networks. Our results are also in line with a meta-synthesis (Vigdal *et al.*, 2022) highlighting the importance of connection with safe, non-stigmatising communities. This meta-synthesis underscores the importance of health and social services not taking for granted that social networks can be developed without the active measures and support of others. Previous research has emphasised the importance of having supportive relationships and growing networks (Best *et al.*, 2015). Our analysis, as well as meta-syntheses and primary studies from various countries, show that obstacles are extensive, persistent and international and need attention. People within communities and networks need to be aware of the importance of being inclusive and non-stigmatising, and social services need to pay more attention to people's social life by familiarising themselves with how social network development occurs.

The importance of access to structured and durable social arenas

Our findings highlight work and peer communities as the most important social arenas for developing social networks. Access to social arenas, particularly work, provides a structure for long-term interaction that gives individuals time to develop relationships. Previous research has shown that it is essential for people in LTSR to work or to have other meaningful activities in their everyday lives (Harrison *et al.*, 2020). Our study expands on the understanding of why the work–life structural framework plays an essential role in building social networks. We suggest that the importance of access to work may be transferable to other contexts. Although previous research indicates the importance of having a job, people in LTSR still experience obstacles to finding jobs (Roche *et al.*, 2019). However, facilitating employment is not regarded as an element of substance-use treatment in the services, and the therapy provided is often short term (Harrison *et al.*, 2020). Bridging the gap between people in LTSR and the employment services would seem to benefit the individual and the community (Harrison *et al.*, 2020). Access to social arenas can allow one to use multifaceted resources, such as a developed and supportive social network. On the basis of our study and previous research, we emphasise the need to develop sound research-based knowledge about reducing the barriers to work participation, together with strategies for implementing this knowledge and networks that support people in LTSR so that they receive the help they need to make their role transition.

The importance of feeling oneself equal to others

Our study findings emphasise that recognition of, and identification with, other people's lifestyles and living conditions facilitated network growth. There may be other social norms at work in other societies. Regardless, the experience of equality and access to resources and recognised positions in society is of central importance and has transfer value in other countries. Our study supports Rowe's (2015) theoretical framework concerning the importance of stronger connections to the 5Rs to achieve growth in networks and an improved sense of belonging in society. Rowe and Davidson (2016) suggested using the concept of 'recovering citizenship', according to which people in LTSR can recover and create a meaningful life through access to the 5Rs and belonging to communities. Our study findings highlight that enabling one's performance of social roles—such as being an employee, having responsibility for a home, being a parent, maintaining relationships with colleagues and neighbours and having access to financial resources—helps one participate in social arenas on an everyday basis and improves one's connections to society.

Strengths and limitations

First, our findings are context dependent and pertain to the participants and the setting of this study. Although we conducted this study in a Norwegian context, many studies from other countries support the findings presented here, which indicate that societal stigma, inequality in living conditions and access to resources such as work and social positions have transfer value and need attention universally. Secondly, digital interviews provide only limited access to non-verbal communication, which means informants' non-verbal communication may be overlooked. Thirdly, the interviewer was not facing the participants when drawing social network maps according to their instructions, which may have affected the mapping process. A strength of this study is its access to longitudinal follow-up data from participants who had been in LTSR for at least eight years.

Implications

We want to emphasise that stigma, as shown by this and other studies, is widely present and creates significant obstacles for people in recovery. Society, networks and professionals need to learn more about the problematic sides of stigmatisation and how to work against stigma. The analysis shows the importance of having access to recognised social positions and decent living conditions. In addition, our study contributes

knowledge about how societal stigma can be reduced by giving people in stigmatised positions access to structured arenas where they can meet others over time and create relationships without the damaging influence of stigmatisation. We argue that there is a need for tailored assistance and enhanced long-lasting support for people in LTSR to help them withstand the stresses of entering new social arenas and rebuilding their networks. On the basis of our study and previous research, we propose that the services should facilitate work access for people in LTSR and also assess how enabling living conditions for people in LTSR can positively affect the development of their social networks.

Conclusions

Our article explores a vital practice area within social work: How people in long-term recovery from substance use create and develop supportive social networks. We find that people experience the rebuilding of networks as a demanding, anxiety-filled, long-term process. Regular access to structured social arenas over time promoted networking and identification with and recognition from others were key factors in rebuilding their social networks. We argue that there is a need for tailored assistance and improved long-term support for people in LTSR to help them cope with the stresses of entering new social arenas and rebuilding their networks.

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