International Journal of Drug Policy 26 (2015) 475–483

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

Social and recovery capital amongst homeless hostel residents who use drugs and alcohol

Joanne Neale [a,b], Caral Stevenson [c,*]

[a] Addictions Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, 4 Windsor Walk, Denmark Hill, London SE5 8AF, UK
[b] Centre for Social Research in Health, University of New South Wales, Sydney, NSW 2052, Australia
[c] Department of Psychology, Social Work and Public Health, Oxford Brookes University, Jack Straws Lane, Marston, Oxford OX3 0FL, UK

ARTICLE INFO

Article history:
Received 29 July 2014
Received in revised form
23 September 2014
Accepted 24 September 2014

Keywords:
Homelessness
Drug and alcohol
Qualitative research
Social capital
Recovery capital
Social networks
England

ABSTRACT

Background: Homeless people who use drugs and alcohol have been described as one of the most marginalised groups in society. In this paper, we explore the relationships of homeless drug and alcohol users who live in hostels in order to ascertain the nature and extent of their social and recovery capital.
Methods: Data were collected during 2013 and 2014 from three hostels. Each hostel was in a different English city and varied in size and organisational structure. Semi-structured interviews were conducted with 30 residents (21 men; 9 women) who self-reported current drink and/or drug problems. Follow-up interviews were completed after 4–6 weeks with 22 residents (16 men; 6 women). Audio recordings of all interviews were transcribed verbatim, systematically coded and analysed using Framework.
Results: Participants' main relationships involved family members, professionals, other hostel residents, friends outside of hostels, current and former partners, and enemies. Social networks were relatively small, but based on diverse forms of, often reciprocal, practical and emotional support, encompassing protection, companionship, and love. The extent to which participants' contacts provided a stable source of social capital over time was, nonetheless, uncertain. Hostel residents who used drugs and alcohol welcomed and valued interaction with, and assistance from, hostel staff; women appeared to have larger social networks than men; and hostels varied in the level of enmity between residents and antipathy towards staff.
Conclusion: Homeless hostel residents who use drugs and alcohol have various opportunities for building social capital that can in turn foster recovery capital. Therapies that focus on promoting positive social networks amongst people experiencing addiction seem to offer a valuable way of working with homeless hostel residents who use drugs and alcohol. Gains are, however, likely to be maximised where hostel management and staff are supportive of, and actively engage with, therapy delivery.

Introduction

In this paper, we explore the relationships of homeless hostel residents who use drugs and alcohol in order to ascertain the nature and extent of their social and recovery capital. Homelessness is a complex historically, socially, culturally, psychologically and legally constructed concept (Neale, 2008; Neale & Stevenson, 2013). It can, for example, encompass sleeping on the street, staying in temporary forms of accommodation (such as hostels or bed and breakfast hotels), and living in overcrowded, substandard or insecure accommodation (Edgar & Meert, 2006; Fitzpatrick, 1998; Neale, 2008). The term homeless hostel includes diverse forms of organised short-term accommodation, ranging from large single sex shelters to smaller more 'family-like' living arrangements catering for specific groups of homeless people. One useful conceptualisation of hostel accommodation is provided by Busch-Geertsema and Sahlin (2007) who explain that homeless hostels tend to involve shared spaces, limited (or no) private space and some kind of supervision.

Although the notion of social capital has existed for many years, it is also difficult to define (Bourdieu, 1985, 1986; Bourdieu & Wacquant, 1992; Coleman, 1988; Portes, 1998; Putnam, 1995). In essence, social capital refers to the benefits that individuals gain by participating in groups (Bourdieu, 1985). Nonetheless, there is more to social capital than the existence of a relationship alone, and not all relationships result in social capital. Accrual of benefits from social networks depends on individuals being able to claim access

* Corresponding author. Tel.: +44 1865482645; fax: +44 1865485297.
E-mail addresses: cstevenson@brookes.ac.uk, caral.stevenson@gmail.com (C. Stevenson).

http://dx.doi.org/10.1016/j.drugpo.2014.09.012

to the resources that other group members have and the amount and quality of those resources (Portes, 1998).

The family is one of the most fundamental sources of social capital and the amount of time and attention exchanged between family members affects the quality of the social capital developed (Barker, 2012). Relationships between friends, neighbours, ethnic and religious groups, work colleagues, members of community organisations, and connections forged over the Internet are all also important (Bourdieu, 1993; Phulari et al., 2010; Putnam, 1995). For social capital to develop within networks, certain norms, values and understandings – such as trust, good faith, mutual obligation, and reciprocity – should be present (Barker, 2012; Portes, 1998). Conversely, factors that can undermine social capital include negative expectations within groups or significant life changes, such as geographical relocation or illness, which result in individuals losing access to particular networks and their associated resources (Ellison, Steinfield, & Lampe, 2007; Portes, 1998; Putzel, 1997).

In recent years, the concept of recovery capital has gained currency across the drug and alcohol sector. Recovery capital refers to the sum of resources that individuals can draw upon to initiate and sustain processes of addiction recovery. The term was introduced into the addictions by two American social scientists, Cloud and Granfield (2001, 2008). Drawing upon the earlier literature on social capital, Cloud and Granfield have argued that recovery capital comprises four key components: 'physical capital' (e.g. income, savings, investments, property); 'cultural capital' (e.g. values, beliefs and attitudes that promote social norms); 'human capital' (e.g. education, knowledge, skills, hopes, health and heredity); and social capital (e.g. relationships, including family, friends and broader social networks). According to Cloud and Granfield (2008), people who have access to recovery capital are better placed to overcome their substance misuse-related problems than those who do not have such access.

Homeless people who use drugs and alcohol have been described as one of the most marginalised groups in society (Coumans & Spreen, 2003; Pleace, 2008). They frequently have complex psychosocial needs, poor health, low incomes, and difficult family relationships, including histories of childhood physical and sexual abuse, personal experiences of being in care, relationship breakdown as adults, and separation from their own children (Koegel, Melamid, & Burnam, 1995; Neale, 2001; Zlotnick, Kronstadt, & Klee, 1998). Hostels are an important source of accommodation for homeless people who use substances, routinely providing food, companionship, and support with health, addiction and other problems. Despite this, shared bedrooms and communal living areas mean that there is often little scope for solitude (Busch-Geertsema & Sahlin, 2007; Edgar & Meert, 2006). Furthermore, many hostels operate strict rules and policies, sometimes prohibiting visitors or enforcing curfews that can undermine residents' sense of autonomy and leave them feeling 'watched' (Stevenson, 2013).

There is a small but growing literature on the relationships and social networks of homeless people who use drugs and alcohol. For example, in a study exploring associations between social network characteristics and clinical outcomes among 130 homeless people diagnosed with substance abuse and severe mental illness, Trumbetta, Mueser, Quimby, Bebout, and Teague (1999) found that social networks tended to be small, smaller networks predicted alcohol use over time, and substance use disorder remitted when individuals had fewer substance users in their baseline networks. Research has also shown that drug use can hinder the formation of intimate relationships among homeless adults (Blais, Côté, Manseau, Martel, & Provencher, 2012). Nonetheless, having an intimate partner can have a beneficial effect on a homeless person's drug use, self-esteem, wellbeing and motivation to move away from a street-based lifestyle (Nyamathi, Wenzel, Keenan, Leake, & Gelberg, 1999; Stevenson & Neale, 2012). Additionally, positive and encouraging relationships with the staff of homeless hostels can improve social capital and overall wellbeing amongst homeless drug and alcohol users (Stevenson, 2013).

Within the addictions literature more generally, it has been reported that people experiencing problems with drugs or alcohol are often involved in criminal, violent, abusive and exploitative relationships (Farris & Fenaughty, 2002; Neale, 2001). Nonetheless, many still have supportive family, partners, and friends, including individuals who both do and do not themselves use drugs (Neale, Pickering, & Nettleton, 2012; Neale, 2001; Simmons & Singer, 2006). These more supportive relationships have been shown to discourage drug use and enable better management of addictions (Alverson, Alverson, & Drake, 2000; Laudet, Magura, Vogel, & Knight, 2000). Equally, they can provide diverse forms of emotional, financial and practical assistance, including money, gifts, childcare, employment, transport, meals, assistance with laundry, and a place to stay (Neale, 2001; Neale et al., 2012).

The homelessness literature has similarly shown that people who are homeless can have complex supportive and unsupportive relationships. Thus, the family members, partners and friends of homeless people can make demands, create conflict, or be abusive (O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998; Savage & Russell, 2005). Indeed, marginalisation (Coumans & Spreen, 2003) and loneliness (Rokach, 2005) are key characteristics of homelessness, with young homeless people often engaging in intimate relationships to fill a void, break isolation, enhance self-esteem, and provide protection from street-based dangers (Blais et al., 2012). More positively, small groups of homeless people are known to form dense closely connected networks where most members know everyone else (Mostowska, 2013). Homeless people can also have family, partners and friends who provide valuable forms of financial, emotional and in-kind support (Hawkins & Abrams, 2007).

The study and methods

Data for our study were collected during 2013 and 2014 from three hostels, with ethical approval granted from a university research ethics committee. We deliberately selected hostels that varied in size, organisational structure and geographical location in order to try to capture diverse experiences of hostel living. Hostel A was a 56-bed hostel in a medium-sized city. It provided a range of services to clients, including seven emergency accommodation beds, move up and move on spaces, and day services for homeless people who were rough sleeping. Hostel B, the largest hostel, was in a densely populated major city and provided 57 single rooms. Hostel C was in a small city and had 17 beds in 1 triple, 5 twin, and 4 single rooms. Hostels A and B permitted residents to remain in the hostel during the day, whereas hostel C residents had to vacate the building between 8 am and 6 pm. All hostels operated no visitor policies.

In each hostel, an experienced qualitative researcher (CS) conducted one-to-one interviews with 10 residents who self-reported current drink and/or drug problems ($n = 30$). The researcher recruited participants by reviewing current bed lists and then randomly selecting individuals to approach, whilst trying to ensure a good gender and ethnic mix. On initial contact with a potential participant, the researcher explained the nature of the research and what participation would involve, asked them whether or not they considered that they currently had a problem with drugs or alcohol, and emphasised that participation was voluntary. If the potential participant was eligible and interested, written information about the study was provided and a time to conduct the interview was agreed. After 4–6 weeks, the researcher attempted to contact all participants again, either through the hostel or via telephone, to

conduct a follow-up interview. The 4–6 week follow-up period was chosen for pragmatic reasons: specifically, homeless people who use drugs and alcohol comprise a very transient population who are difficult to re-contact over longer time frames.

Initial interviews followed a semi-structured topic guide and covered (i) demographic information (age, ethnic background, education, employment, health, income, sexual orientation etc.); (ii) current and previous housing circumstances (including any housing-related support received); (iii) current and previous drink and drug use (including details of any treatment episodes); and (iv) current and previous relationships (inside and outside the hostel). To assist participants in recalling key people in their lives, we also used a simple structured questionnaire called the Important People Drug and Alcohol Interview (IPDA) (Copello, Williamson, Orford, & Day, 2006; Zywiak et al., 2009). The IPDA yields basic quantitative information on, inter alia, the number of people in an individual's network, levels of contact, and drinking and drug use by network members. 'Contact' in both the interviews and administration of the IPDA was defined broadly to include face-to-face meetings, emails, text messages, phone calls, and social networking etc.

Follow-up interviews mirrored the first interviews and repeated the IPDA, but the topic guide was modified to include any salient issues emerging from the earlier interviews and any changes in social networks and network support. All interviews were conducted in privacy in one of the hostel rooms. Both initial and follow-up interviews lasted 45–60 min and were audio recorded. Participants were asked to sign a consent form prior to each interview and offered a £10 high street voucher on its completion. In presenting the data, quotations are used to illustrate key findings and pseudonyms are adopted to protect participant anonymity.

Data coding and analysis

Audio recordings of all interviews were transcribed verbatim and entered into the software package MAXQDA for systematic coding. After the interview transcripts had been entered into the MAXQDA software, the authors jointly devised a preliminary coding frame based on the interview topic guides ('deductive coding') and then CS coded all of the data, adding new codes as they arose during the coding process ('inductive coding'). This generated multiple main and sub codes, including a main code for participants' 'current core relationships' (that is, the relationships that participants described as most central to their lives) and six separate sub codes for (i) 'family members', (ii) 'professionals', (iii) 'other hostel residents', (iv) 'friends outside of hostels', (v) 'current and former partners' and (vi) 'enemies'.

Data from the relationship main and sub codes were exported from the coding software into Microsoft Office Word files and then analysed by both authors following an approach known as Framework (Ritchie & Spencer, 1994). Framework is a systematic method of analysing qualitative data that is particularly suited to applied and policy-oriented research, where there tends to be a predesigned sample and a priori issues for exploration (Srivastava & Thomson, 2009). In analysing the data, each Word file was reviewed line-by-line to explore the nature of the relationships described and the kinds of support they provided or problems they caused. Additionally, changes in social networks for particular individuals over time and any apparent differences in relationships between men, women and the three hostels were considered. Findings were subsequently linked back to the existing literature and to the concepts of social and recovery capital.

Qualitative research is generally characterised by an absence of numbers (Neale, Miller, & West, 2014), but the use of the IPDA provided us with complementary quantitative data against which it was possible to triangulate the qualitative accounts and thence produce some simple numeric data on the number and type of core relationships in each participant's network. For this paper, no further quantitative analyses of the IPDA data were undertaken.

Table 1
Participants' characteristics at interview 1.

	Male ($n=21$)	Female ($n=9$)	Total ($n=30$)
Mean age (range) in years	36 (23–54)	35 (21–51)	38 (21–54)
Hepatitis C positive	11	2	13
HIV positive	1	1	2
Self-reported mental health problems	16	8	24
Been in prison	16	6	22
Current (last month) drug use			
Heroin and crack cocaine	9	2	11
Heroin only	3	1	4
Heroin, crack cocaine and alcohol	2	3	5
Alcohol and cannabis	3	1	4
Alcohol only	2	1	3
Powder cocaine and MDMA	1	1	2
Heroin and alcohol	1	0	1
Current drug injector	10	2	12
Previous drug injector	2	2	4

Participants

At interview 1, the 30 participants included 21 men and 9 women, of whom 22 (16 men; 6 women) were re-interviewed. Of the 22 re-interviewed participants, 19 continued to live at the same hostel. Of the 8 participants not re-interviewed, 2 declined to be re-interviewed, 2 had moved to another hostel, 2 had moved on to their own accommodation, one had moved on to a residential rehabilitation project, and one had been evicted.

Ages at first interview ranged from 21 to 54 years (mean 38 years). Thirteen participants said that they had hepatitis C and two participants said that they were HIV positive. Twenty-four self-reported mental health problems (ranging from mild depression to paranoid schizophrenia) and 22 stated that they had ever been in prison. In terms of current (last month) drug use at first interview, most participants reported polydrug use. Twelve also reported current drug injection and a further 4 reported previous drug injection (Table 1). At interview 2, 3 participants said that they were no longer using their main drug stated at interview 1 and 8 participants stated that they were using less of their main drug. In contrast, 8 participants said that their substance use had escalated.

Length of homelessness at first interview varied from a few days to 20 years, with many individuals reporting intermittent periods of being housed or being in prison. Participants' reasons for their homelessness included relationship breakdown, loss of tenancy following imprisonment or unemployment, eviction, mental health problems, arguments with parents, and parental ill-health or death. Participants frequently related their homelessness directly or indirectly to their drug or alcohol problems; in particular, highlighting how intoxication or drug-related aggression had been the cause of relationship breakdowns and how drug dealing had led to eviction from private rented accommodation. Beyond this, participants often blamed their addiction for other problems they were currently experiencing, including poor physical and mental health (such as blackouts and paranoia), falls and accidents, and children being taken into care. The majority of participants reported that they wanted to stop using drugs and alcohol and many spontaneously discussed their desire to go to a residential detoxification or rehabilitation facility.

Findings

Table 2 shows the main relationship categories discussed by the study participants, and the number of individuals within each relationship category for each participant, at both interviews. Network size ranged from 3 to 13 people, excluding enemies. The mean network size was 8 people at interview 1 and 7 people at interview 2. Participants in hostel A reported the largest social networks with a mean of 9 people, reducing to 7 at follow up. Participants from hostels B and C both identified a mean of 8 social network members at interview 1. At interview 2, this dropped to 6 network members in hostel B and 7 members in hostel C. In hostel A, women gave a mean of 8 network members at interview 1 and 7 at interview 2 (compared with 9 and 8 for men). In hostel B, they had a mean of 10 network members at interview 1 and 8 at interview 2 (compared with 6 and 6 for men). There were no women staying in hostel C at the time of data collection.

Family relationships

Participants discussed relationships with family members more often than any other relationship category, occasionally referring to relatives who had drug or alcohol problems. Having a drinker or drug user in the family was identified as causing stresses and strains, especially when those relatives behaved abusively or in an uncontrolled way. For example, Chloe, explained that she did not see her mother as often as she would like because her stepfather had a drink problem and was very abusive when drunk. Similarly, Sarah described how her homelessness had started after she had left home as a teenager to escape her mother's alcoholism. In addition, some participants associated their unhappy childhood relationships with subsequent episodes of poor mental health and more general feelings of rejection and loss:

> When I was a kid, she [mother]... didn't protect me... She weren't a decent mum to me basically. (Andrea, aged 35, hostel A, interview 1)

Despite this, many of our participants reported current good relationships with immediate family members and often spoke positively about their extended family. Reflecting this, many described spending time with parents, siblings or children away from their hostel; for example, meeting up for a meal, helping out with work or odd jobs around their houses, or looking after children. Significantly, however, the amount of family member contact participants reported varied considerably between individuals and also between their first and second interviews. Thus some participants, particularly women, described daily family contact whilst others, particularly men, said that they only saw relatives a few times a year.

Of the 21 participants who discussed family members at interview 1, 11 referred to contact with those same relatives at interview 2. Emma had regular contact with 7 family members at interview 1, but was only in contact with her mother at interview 2. She attributed this to her own laziness. John had had a lot of contact with his family at interview 1 but considerably less at interview 2, blaming this on his escalating heroin use. Ross, meanwhile, reported virtually no contact with his adult children at interview 2, and explained that this was because his drug use had decreased and he was currently busy looking for work and independent accommodation.

Conversely, other participants stated that they had reconnected with relatives between their first and second interviews, and were now rebuilding family relationships in a way that felt empowering. At interview 1, Kyle only had contact with his sister via a social networking site, but by his second interview he had had his first sober face-to-face meeting with her in months:

> It was absolutely fantastic to actually see her... to like see my sister [whilst I was] sober, and for my sister to see me sober as well... I [used to be] all confrontational... It was nice to sit with her in a coffee shop... and be in a normal state and have a decent conversation with her. (Kyle, aged 29, hostel A, interview 2)

Fifteen of the study participants also said that they had children, some of whom were now grown up and independent. Younger children lived with ex partners, other relatives or were in care. Whilst just over a third of our participants stated that they did not have any contact with their sons or daughters at interview 1, almost two thirds retained some interaction. Indeed, several participants said that they were working hard at overcoming their substance dependence in order to be able to live with their children again or, at least, to have regular contact with them. Others talked enthusiastically about recent visits to see their children, particularly if relationships with ex-partners were also improving:

> I was really pleased when she [ex partner] said... 'it would be really nice to have you round and have dinner and you babysit and I can catch up with work and have a break'... I babysat for the day and had a great time with the kids. (Greg, aged 36, hostel C, interview 2)

Less positively, a number of participants described feeling like a failure and carrying a lot of guilt in relation to their children, emotions that they again related to subsequent episodes of depression and poor mental health. Brian felt that the worst thing he had ever done was to lose contact with his son and daughter. Andrew, meanwhile, explained that he desperately wanted more involvement with his children who were in care. However, he was not currently permitted any contact and was finding this painful:

> I am going to write them a letter. I have started it already... 'I am so sorry I am a failure', this is how it starts. 'I know I am a failure as a father'. (Andrew, aged 44, hostel B, interview 1)

Lastly, nearly a third of participants (all men) did not appear to have any contact at all with family members at either interview. Furthermore, several spoke with great sadness about relatives they had lost from drug-related deaths or other preventable causes. Peter's circumstances were extreme but not completely atypical:

> My brother was only 21 and he died. He got out of prison, someone injected him with heroin and he died. A year later someone beat my sister to death... Then my mum died and then my dad committed suicide. Then Christmas just gone, my partner passed away... And, during that time, I've been sectioned loads of times. (Peter, aged 37, hostel A, interview 1)

Relationships with professionals

Relationships with professionals also featured very prominently in the accounts of many of our participants. Although most referred to hostel staff, they also spoke positively about workers in day services and drug services for homeless people, general practitioners, pharmacy staff and probation officers. Andrew felt that his general practitioner and pharmacist were particularly supportive in relation to his substance use and Richard believed that his probation officer was key to helping him secure accommodation. For some participants, professionals actually comprised the majority of their social networks. Thus, Jack identified 9 people in his network at his first interview and, of these, 5 were hostel staff.

In comparison to relationships with family members, our analyses indicated that there seemed to be more stability in relationships with professionals over the study period. Indeed, most professionals who were mentioned at interview 1 were mentioned again at interview 2. Additionally, 2 participants who did not mention any professionals at interview 1, named 3 professionals at interview 2. The main exception to this was Mark who identified 4 professionals at interview 1 and only 1 at interview 2. This appeared to reflect the fact that Mark had been relatively new to the hostel at his first interview but, by the second interview, had settled into hostel life and was spending more time with other residents.

Significantly, many participants talked of how hostel staff did more for them than their job required and expressed gratitude for this. This included staff being flexible about hostel rules and extending hostel tenancies even when participants had reached their maximum length of stay. In hostel C, participants commented that staff really seemed to 'care about them' and would make time to listen to their problems, even when they were very busy. Additionally, there were reports of hostel C staff protecting participants by warning if it was unsafe to leave the building because of fighting outside, allowing residents to use the telephone to call family members, and just generally being responsive to an individual resident's needs:

> They are not just going to turn me out back on the streets... The manager here took me back in because I wasn't that well, even though she knew I should have gone back to [another city] in September. (Patrick, aged 46, hostel C, interview 1)

Despite these positive experiences, some participants in hostels A and B (but not hostel C) felt that the staff did not do enough for them. In particular, they expressed a desire for more help with their problems. Indeed, whilst they recognised that hostel staff had busy schedules, they still complained that workers were idle and wasted time when they could have been with residents:

> Because you're homeless... they [think they] are doing us a favour... I know they have got to look after reception, there has got to be a couple of people there, but to sit all day long just reading papers and doing nothing... (John, aged 54 hostel A, interview 1)

One organisational issue that repeatedly impinged negatively upon our participants' relationships with hostel staff was the no visitor policies operating in all three hostels. In hostel C, participants reported that staff carefully explained to all residents that the policy had to be implemented for funding and safety reasons. Hostel C participants did not like the policy but were generally not antagonistic towards staff because of the rule. In hostels A and B, the no visitor policy generated strong antipathy towards staff, with participants stating that staff did not care that they were lonely or isolated or that the policy made it hard for them to maintain relationships with people in the community.

Relationships with other hostel residents

Socialising with other hostel residents was a routine aspect of life amongst male and female participants in all three hostels. Furthermore, relationships with other hostel residents identified at interview 1 were generally sustained at interview 2, unless individuals had moved on to new accommodation between interviews. In hostel A, men socialised with other residents more than in any other hostel and more than the women in hostels A and B. Indeed, men

Table 2
Core relationships discussed by participants at interviews 1 and 2.

Participant	Hostel	Family members		Professionals		Hostel residents		Friends outside of hostels		Current and former partners		Enemies		Total network size excluding enemies	
		Time 1	Time 2	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2
Jack	Hostel A	0	0	5	4	4	5	0	0	0	0	0	2	9	9
Emma		7	1	0	0	1	1	0	0	2	1	0	0	10	3
Mark		0	0	4	1	5	4	0	2	1	0	0	0	10	6
Peter		0	0	1	1	2	3	3	3	0	0	1	1	7	7
Andrea		2	2	2	2	1	1	0	1	1	1	1	1	6	7
Chloe		4	4	2	1	1	1	0	0	2	2	1	0	9	8
John		4	2	1	1	0	5	0	0	3	1	0	0	8	9
Sarah		7	6	2	2	1	0	0	0	1	1	0	0	11	9
Kyle		2	1	0	3	9	4	1	0	0	0	0	1	12	8
Karen		3	[a]	3	[a]	2	[a]	0	[a]	0	[a]	3	[a]	8	[a]
Janet	Hostel B	1	1	4	2	1	1	1	1	2	1	0	0	9	6
Rick		0	0	5	4	1	2	4	3	0	0	0	0	10	9
Josh		0	0	1	1	2	2	0	0	0	0	3	3	3	3
Andrew		3	0	4	5	1	1	0	0	0	0	0	0	8	6
Amy		1	[a]	5	[a]	3	[a]	0	[a]	1	[a]	0	[a]	10	[a]
Anthony		0	[a]	2	[a]	1	[a]	0	[a]	1	[a]	2	[a]	6	[a]
Helen		4	2	0	0	1	1	6	5	1	2	0	0	12	10
Dave		3	2	1	1	1	1	0	0	0	0	1	1	5	4
Lauren		4	[a]	2	[a]	0	[a]	3	[a]	1	[a]	0	[a]	10	[a]
Luke		2	[a]	1	[a]	1	[a]	0	[a]	1	[a]	0	[a]	5	[a]
Patrick	Hostel C	0	[a]	2	[a]	0	[a]	6	[a]	0	[a]	0	[a]	8	[a]
Ben		0	0	1	1	0	1	3	4	0	0	1	0	4	6
Colin		5	[a]	0	[a]	0	[a]	0	[a]	1	[a]	0	[a]	6	[a]
Richard		0	0	3	2	3	3	0	2	0	0	0	0	6	7
Brian		6	4	4	5	1	1	1	0	1	1	0	0	13	11
Paul		7	[a]	0	[a]	0	[a]	2	[a]	1	[a]	0	[a]	10	[a]
David		3	1	0	3	1	0	0	0	1	1	0	0	7	5
Greg		2	2	1	1	2	0	1	3	1	1	0	0	7	7
Nathan		3	2	1	0	0	0	6	7	0	1	0	0	11	10
Ross		4	2	3	4	0	0	2	0	0	0	0	0	9	6

[a] Denotes no follow-up interview.

in hostel A had contact with a mean of 4 other residents compared to a mean of just 1 in all other groups.

In terms of what hostel residents did when socialising, participants described both substance-related and non-substance related activities. Thus, they reported using tobacco, drugs and alcohol together, as well as 'helping each other out' when money or drugs were scarce:

> [She'd] give me a hug, give me a cuddle when I was rattling [withdrawing]... She gave me £2 to go and get a drink if I am sick [withdrawing]... She is just absolutely lovely. (Jack, aged 37, hostel A, interview 1)

Additionally, participants played cards, board games and table tennis with other residents, watched television or just 'hung out':

> He makes dinner for me sometimes. We just sit in there watching television and that together and have a little nice talk. So it nice to have some kind of company in the evening. (Janet, aged 41 hostel B, interview 1)

Hostel residents additionally described providing diverse kinds of support for each other. One man from hostel A had recently undergone surgery and another resident helped him around the hostel, fetched his meals and checked up on him. Another participant, who only had a small support network, received a lot of help from his one and only friend:

> My TV is broken, so he always just leaves me in his room... He goes out... and I am watching his telly... Just a good pal, my best pal on this planet. (Andrew, aged 44, hostel B, interview 1)

In all three hostels, our participants commonly judged their relationships with other residents by whether or not it was possible to lend someone money and be repaid or to trust them with a secret. However, many participants emphasised that other residents were untrustworthy, broke confidences and stole, and some stated that this increased their own feelings of isolation and vulnerability. They also explained how having other substance users or dealers around tempted substance use and encouraged criminal behaviours such as shoplifting. Participants equally found it stressful when other residents constantly asked them for cigarettes, tobacco, drugs or drug paraphernalia. Furthermore, being forced to share rooms could cause arguments about space, noise, personal hygiene, and untidiness:

> I snore quite loudly, but I think he had a few issues himself anyway. But that got quite stressful, you know. [He would] wake me up, shaking my bed and sort of being quite threatening. (Greg, aged 36, hostel C, interview 2)

Significantly, in hostel C, the residents were breathalysed before being permitted entry to the building each evening and they were declined entry if they were over the specified alcohol limit. Whilst many participants expressed dislike of this rule, they accepted it as a 'necessary evil', noting that staff had explained to them why drunkenness was not tolerated. Furthermore, they agreed with staff that the 'no intoxication' policy meant that 'trouble generally stayed outside the building', disagreements within the hostel tended not to escalate, and relationships between residents were generally more respectful. In hostels A and B, conversely, a number of participants explained how they routinely had to deal with stressful hostel relationships by avoiding particular residents or avoiding all relationships, even if this meant staying away from communal spaces, such as computer rooms and dining areas, and thus depriving themselves of food or hostel facilities:

> If he was having his dinner in the dining room, I'd wait until he'd finished and then I'd go and have my dinner. Or if he came in, I wouldn't finish my dinner. I'd just put my dinner in the bin and walk out. (Mark, aged 35, hostel A, interview 1)

Relationships with friends outside of the hostel

Alongside their hostel friends, around half the study participants (12 men; 4 women) reported that they had friends living in the community. These community friends were mostly housed and did not use drugs or alcohol problematically. Participants visited them at their homes, in bars or cafes, and sometimes contacted them online. Such relationships were identified as sources of emotional and practical support, as well as companionship. For example, one participant had a non-using friend who was looking after his possessions while he was homeless and others said they had non-using friends who would proactively intervene to stop them from using substances:

> If he ever seen me pick up a syringe, he would break me hand. (Patrick, aged 46, hostel C, interview 1)

Although some friendships outside the hostel seemed to lapse between interviews 1 and 2, there was evidence of a degree of stability. Reflecting this, some participants described their friends as being like adopted or surrogate family:

> They're like my family... Like sometimes on a Sunday, [name of friend] will phone up and say 'Oh mum's said you're welcome round for dinner'. So I go round her mum's and I call her mum, mumsy. (Peter, aged 37, hostel A, interview 1)

Importantly, several individuals reported that they had developed new friendships over the study period. For example, Greg was doing well in his recovery and had stopped drinking completely by his second interview. He had also started to attend a community drama group where he had met new people. Greg felt that these new contacts trusted him, were reliable, and had the potential to become good friends in the future.

In discussing their friends outside of hostels, our participants focused on the positive aspects of these relationships. This was perhaps unsurprising given these associations were voluntary so would probably not have been sustained if they were experienced negatively. Despite this, a number of participants (8 men; 2 women) recognised that they needed to move away from or end on-going negative relationships with substance-using friends in the community. This was not, however, an easy task:

> It is going to be hard to stay away if I am having a really bad day... Like my mate... I really like her and that, but I know that I can't really be hanging around with her... She is going to want to go and score [obtain drugs]. (Nathan, aged 23, hostel C, interview 2)

Relationships with current and former partners

At their first interview, 8 participants (3 men; 5 women) discussed current partners and a further 8 participants (5 men; 3 women) reported that they still had close relationships with ex-partners, many of whom lived in the same hostel. In addition, several participants had multiple sex partners, including one woman who was engaging in sex work. Some current and ex partners were identified as substance users and others were not.

Between their first and second interviews, a small number of participants began or ended relationships and 4 stopped seeing

their ex-partners. According to our participants, intimate relationships generated positive feelings of being loved and having someone to love. Additionally, some current and former partners lent them money, took care of their children, generally looked out for them, and were understanding about their addiction. Thus, Sarah explained how her current partner was helping her to address her drinking and drug use:

> He's very supportive . . . I don't think I'd be able to do this [stay away from drugs and alcohol] without him. . . I think if it weren't for him I'd have been back on it every day now. So he sort of keeps me strong. (Sarah, aged 33, hostel A, interview 2)

Only 2 male participants described being in very negative current relationships, involving arguments and little trust. Both of these individuals reported that this had had a detrimental impact on their mental health and self-esteem, and had resulted in increases in their substance use. Others reported previous relationships where partners had been unfaithful, controlling or manipulative, had stopped them from seeing children, or where contact with ex-partners had led to drug and alcohol binges. When relationships went wrong or broke down, participants mostly blamed this on drug use and drug-related behaviours. Nonetheless, several individuals also commented that their on-going mental health problems and previous experiences of abuse, betrayal and neglect meant that they found it difficult to establish and maintain loving and trusting intimate relationships.

Enemies

As indicated in the various sections above, our participants often referred to individuals who in some way impacted negatively on their lives. However, there was a final type of relationship that warranted the separate and more formal heading of enemy. According to our participants, enemies were individuals who repeatedly caused them acute distress and were very difficult to avoid. In practice, all identified enemies were heavy substance users who lived in their hostels, were part of the groups that gathered outside their hostels, or were members of their wider substance using networks. Eight participants (5 men; 3 women) identified an enemy at interview 1 and 6 participants (5 men; 1 woman) identified an enemy at interview 2. Although there were no examples of relationships with enemies being resolved during the study period, it was unusual for participants to mention the same enemies at both interviews.

On all but one occasion, people who reported enemies lived in hostel A or hostel B. Participants in hostel C referred to disagreements with other residents but this tended to be contained, with hostel C residents commonly emphasising the need to show respect to other residents and staff and explaining that residents had to try to get on well together to make the hostel function. Reasons why participants called some individuals enemies related to previous incidents of intimidation, assault, and racial abuse, as well as friendships that had soured over money or complex feuds. For example, Peter blamed Karen for the drug-related death of his brother. Meanwhile, Karen denied the accusations and experienced a lot of problems in the hostel as a result of Peter's allegations:

> There's one person that's moved in, and he's made my life hell now. Most people still do talk to me, but a lot of them don't because there's this bloke come in here called Peter. . . And he reckons I killed his brother (by injecting him with drugs). (Karen, aged 37, hostel A, interview 1)

Lastly, there were some substance users who were so noisy and disruptive that our participants described their behaviour as intolerable for everyone and they were universally reviled and feared:

> He leaves the shower curtain outside the shower so the water goes all on the floor. . . He blocks up the toilet with hundreds of hand towels. . . He will put something in the microwave and it will overflow and he will just walk away, or he will come in angry and start smashing the bin, kicking the bin around the kitchen. The other week. . . I was sleeping and he came in drunk and was kicking my door going 'I am going to kill all your family'. (Josh, aged 54, hostel B, interview 1)

Discussion

Findings from our study provide new insights into the nature and extent of social and recovery capital amongst people who are homeless and use drugs and alcohol. Consistent with Trumbetta et al. (1999), we found that social networks, and thus available sources of social and recovery capital, were relatively limited. Specifically, network size ranged from 3 to 13 people, with a mean of 8 people at interview 1 and 7 people at interview 2. Key network members included family members, professionals, other hostel residents, friends outside of hostels, and current or former partners. However, some homeless drug and alcohol users living in hostels had very few non-professional network members at all. In addition, a significant minority spoke of enemies, a particular type of heavy substance using network member that persistently caused anxiety, disruption and danger and was therefore a problem rather than a resource.

Despite this, our analyses confirmed that homeless hostel residents who use drugs and alcohol are not devoid of social capital. On the contrary, their relationships involved diverse forms of, often reciprocal, practical and emotional support, encompassing protection, companionship, and love. Our participants had access to people who would cook them meals, take care of their possessions, loan them material resources, but also look after their children, provide them with a roof and encourage them to address their addictive behaviours (c.f. Alverson et al., 2000; Laudet et al., 2000; Neale et al., 2012; Neale, 2001). Often this support came from those who themselves might have limited social capital, including other hostel residents. Nonetheless, relationships were not uniformly positive and access to social capital was frequently undermined by difficult family backgrounds, relationship breakdowns, bereavements, drinking and drug use, mental health problems, lack of trust, broken confidences, and dishonesty.

Importantly, the extent to which our participants' relationships provided a stable source of social capital over time was also uncertain. Even within the 4–6 week period between interviews, relationships, particularly with family members, often lapsed. Indeed, the most constant relationship types appeared to be with hostel staff and other residents. Yet as hostel accommodation is temporary, those relationships were perhaps unlikely to last long-term. Geographical mobility and constant change undermines social capital (Ellison et al., 2007; Portes, 1998; Putzel, 1997). Nonetheless, amongst homeless drug and alcohol users, transience could offer benefits because enemies and drug and alcohol using associates (negative social capital) also moved on. Moreover, change brought opportunities for developing new non-using friendships and reconnecting with children and valued people from the past.

Beyond this, our data showed how social capital interacted with other forms of recovery capital in complex ways (c.f. Neale, Nettleton, & Pickering, 2014; Neale & Stevenson, 2014). Being homeless and having to share rooms and communal spaces (lack of physical capital) disrupted social networks and undermined relationships by creating interpersonal stresses and tensions. This, in turn, resulted in some individuals going without food (which could compromise health or human capital) or depriving themselves of hostel facilities, including computer rooms (which could

have boosted human capital via education and training). Relationships with peers often encouraged drug taking and law breaking (so affecting cultural capital), whilst relationship breakdown negatively affected mental health (so reducing human capital). In contrast, positive social relationships provided access to physical capital via accommodation, money and loaned possessions, as well as cultural capital by promoting love, trust, honesty and reciprocity.

Our research was conducted with a small number of participants in only three hostels, so we cannot claim to have undertaken any rigorous subgroup analyses. Nonetheless our findings point to apparent gender differences worthy of further exploration. In particular, women seemed to have more contact with family members and slightly larger social networks overall than men (c.f. Neale, Nettleton et al., 2014). They were also more likely to have partners living with them in hostels, a finding that is not surprising given the high male to female ratio amongst hostel populations and drug users (Homeless Link, 2011; Neale, Nettleton et al., 2014). In addition, there appeared to be better social relationships and hence greater social capital within hostel C than hostel A or B. To what extent that was a function of hostel C's small size or the fact that it was single sex accommodation cannot be determined from our data. However, our participants' reports revealed that caring staff attitudes and a service ethos of explaining rules, regulations and policies to residents were having a positive impact on relationships, suggesting that individual hostels can, to a greater or lesser extent, influence the social capital of their residents.

Within the addictions sector more broadly, research has already shown that therapies that focus on promoting positive social networks amongst people with drink problems can increase treatment initiation, improve treatment outcomes, and reduce the likelihood of relapse (Barber & Crisp, 1995; Marlatt & Gordon, 1985; McCrady et al., 1986; Stout, McCrady, Longabaugh, Noel, & Beattie, 1987). These interventions (e.g. Pressures to Change, Community Reinforcement, Behavioural Couples Therapy, and Network Therapy) are based on the premise that social network members who support an individual to change their addictive behaviour play a crucial role in facilitating recovery. More recently, Social and Behaviour Network Therapy (SBNT) has been designed to assist substance users who are socially isolated and have difficult relationships with potential network members (Copello et al., 2002, 2006). Our findings suggest that social network focused therapies, such as SBNT, could provide a valuable way of working with homeless drug and alcohol users living in hostel settings. Yet, this will likely need the active participation and support of hostel management and staff to facilitate the cultivation of positive non-drug using relationships, the termination of using relationships, and the disruption of intimidating and violent social networks on and near hostel premises.

Conclusions

Homeless hostel residents who use drugs and alcohol have various opportunities for building social capital that can in turn foster recovery capital. Family members are a key resource, especially when there are children who provide a motivation to regain stability and avoid substance misuse (c.f. Barker, 2012; Neale, Miller et al., 2014; Neale, Nettleton et al., 2014). Additionally, friends both within and outside the hostel setting can be important sources of support, particularly if they do not themselves have a problem with drink or drugs. Despite this, relationships are unstable and seem likely to benefit from professional nurturing within an environment that is safe and secure. Indeed, our data revealed how homeless hostel residents who use drugs and alcohol particularly welcomed and valued interaction with, and assistance from, hostel staff. Therapies that focus on promoting positive social networks amongst those experiencing addiction seem to offer a valuable way of boosting social and recovery capital amongst homeless hostel residents who use drugs and alcohol. Nonetheless, the gains are likely to be maximised where hostel management and staff actively support and engage with treatment delivery.

Acknowledgements

The authors would like to thank the Sir Halley Stewart Trust and the Pilgrim Trust for funding the research, and all of the hostel staff and residents who made the study possible. We also wish to acknowledge our collaborators on the project: Professor Alex Copello and Dr Ed Day. Joanne Neale is part funded by the National Institute for Health Research (NIHR) Biomedical Research Centre for Mental Health at South London and Maudsley NHS Foundation Trust and King's College London. The views expressed are those of the authors and not necessarily those of the Sir Halley Stewart Trust, the Pilgrim Trust, the NHS, the NIHR, or the Department of Health.

Conflict of interest

The authors report no conflict of interest.

References

Alverson, H., Alverson, M., & Drake, R. E. (2000). An ethnographic study of the longitudinal course of substance abuse among people with severe mental illness. *Community Journal of Mental Health*, *36*, 557–569.
Barber, J. G., & Crisp, B. R. (1995). The 'pressures to change' approach to working with the partners of heavy drinkers. *Addiction*, *90*, 268–276.
Barker, J. D. (2012). Social capital, homeless young people and the family. *Journal of Youth Studies*, *15*, 730–743.
Blais, M., Côté, P., Manseau, H., Martel, M., & Provencher, M. (2012). Love without a home: A portrait of romantic and couple relationships among street-involved young adults in Montreal. *Journal of Youth Studies*, *15*, 403–420.
Bourdieu, P. (1985). The social space and the genesis of groups. *Theory and Society*, *12*, 723–744.
Bourdieu, P. (1986). The forms of capital. In J. G. Richardson (Ed.), *Handbook of theory and research for the sociology of education* (pp. 241–258). New York: Greenwood Press.
Bourdieu, P. (1993). *Sociology in question*. London: Sage.
Bourdieu, P., & Wacquant, L. J. D. (1992). *An invitation to reflexive sociology*. Chicago: University of Chicago Press.
Busch-Geertsema, V., & Sahlin, I. (2007). The role of hostels and temporary accommodation. *European Journal of Homelessness*, *1*, 67–93.
Cloud, W., & Granfield, R. (2001). Natural recovery from substance dependency: Lessons for treatment providers. *Journal of Social Work Practice in the Addictions*, *1*, 83–104.
Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use & Misuse*, *43*, 1971–1986.
Coleman, J. (1988). Social capital in the creation of human capital. *American Journal of Sociology*, *94*, S95–S120.
Copello, A., Orford, J., Hodgson, R., Tober, G., Barrett, C., & on behalf of the UKATT research team. (2002). Social behaviour and network therapy: Basic principles and early experiences. *Addictive Behaviors*, *27*, 345–366.
Copello, A., Williamson, E., Orford, J., & Day, E. (2006). Implementing and evaluating social behaviour and network therapy in drug treatment practice in the UK: A feasibility study. *Addictive Behaviors*, *31*, 802–810.
Coumans, M., & Spreen, M. (2003). Drug use and the role of homelessness in the process of marginalization. *Substance Use and Misuse*, *38*, 311–338.
Edgar, B., & Meert, H. (2006). *Fifth review of statistics on homelessness in Europe*. Brussels, Belgium: National Correspondents of FEANTSA's European Observatory on Homelessness.
Ellison, N. B., Steinfield, C., & Lampe, C. (2007). The benefits of Facebook 'friends': Social capital and college students' use of online social network sites. *Journal of Computer-Mediated Communication*, *12*, 1143–1168.
Farris, C. A., & Fenaughty, A. M. (2002). Social isolation and domestic violence among female drug users. *The American Journal of Drug and Alcohol Abuse*, *28*, 339–351.
Fitzpatrick, S. (1998). Homelessness in the European Union. In M. Kleinman, W. Matznetter, & M. Stephens (Eds.), *European integration and housing policy* (pp. 197–214). London: Routledge.
Hawkins, R. L., & Abrams, C. (2007). Disappearing acts: The social networks of formerly homeless individuals with co-occurring disorders. *Social Science & Medicine*, *65*, 2031–2042.
Homeless Link. (2011). *Survey of needs and provision 2011. Services for homeless single people and couples in England*. London: Homeless Link.
Koegel, P., Melamid, E., & Burnam, M. A. (1995). Childhood risk factors for homelessness among homeless adults. *American Journal of Public Health*, *85*, 1642–1649.

Laudet, A. B., Magura, S., Vogel, H. S., & Knight, E. (2000). Support, mutual aid and recovery from dual diagnosis. *Community Mental Health Journal*, *36*, 457–476.
Marlatt, A., & Gordon, J. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviours*. New York: Guildford Press.
McCrady, B., Noel, N., Abrams, D., Stout, R., Nelson, H., & Hay, W. (1986). Comparative effectiveness of three types of spouse involvement in outpatient behavioral alcoholism treatment. *Journal of Studies on Alcohol*, *47*, 459–467.
Mostowska, M. (2013). Migration and homelessness: The social networks of homeless Poles in Oslo. *Journal of Ethnic and Migration Studies*, *39*, 1125–1140.
Neale, J. (2001). *Drug users in society*. Basingstoke: Palgrave.
Neale, J. (2008). Homelessness, drug use and hepatitis C: A complex problem explored within the context of social exclusion. *International Journal of Drug Policy*, *19*, 429–435.
Neale, J., Pickering, L., & Nettleton, S. (2012). *The everyday lives of recovering heroin users*. London: Royal Society of Arts.
Neale, J., & Stevenson, C. (2013). A qualitative exploration of the spatial needs of homeless drug users living in hostels and night shelters. *Social Policy and Society*, *12*, 533–546.
Neale, J., Miller, P., & West, R. (2014). Reporting quantitative information in qualitative research: Guidance for authors and reviewers. *Addiction*, *109*, 175–176.
Neale, J., Nettleton, S., & Pickering, L. (2014). Gender sameness and difference in recovery from heroin dependence: A qualitative exploration. *International Journal of Drug Policy*, *25*, 3–12.
Neale, J., & Stevenson, C. (2014). Homeless drug users and information technology: A qualitative study with potential implications for recovery from drug dependence. *Substance Use and Misuse*, *49*, 1465–1472.
Nyamathi, A., Wenzel, S., Keenan, C., Leake, B., & Gelberg, L. (1999). Associations between homeless women's intimate relationships and their health and well-being. *Research in Nursing and Health*, *22*, 486–495.
O'Farrell, T. J., Hooley, J., Fals-Stewart, W., & Cutter, H. S. G. (1998). Expressed emotion and relapse in alcoholic patients. *Journal of Consulting and Clinical Psychology*, *67*, 744–752.
Phulari, S. S., Khamitkar, S. D., Deshmukh, N. K., Bhalchandra, P. U., Lokhande, S. N., & Shinde, A. R. (2010). Understanding formulation of social capital in online social network sites (SNS). *International Journal of Computer Science Issues*, *7*, 92–96.
Pleace, N. (2008). *Effective services for substance misuse and homelessness in Scotland: Evidence from an international review*. Edinburgh: Scottish Government Social Research.
Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology*, *24*, 1–24.
Putnam, R. D. (1995). Bowling alone: America's declining social capital. *Journal of Democracy*, *6*, 65–78.
Putzel, J. (1997). Accounting for the 'dark side' of social capital: Reading Robert Putnam on democracy. *Journal of International Development*, *9*, 939–949.
Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman, & R. G. Burgess (Eds.), *Analyzing qualitative data* (pp. 172–194). London: Routledge.
Rokach, A. (2005). Private lives in public places: Loneliness of the homeless. *Social Indicators Research*, *72*, 99–114.
Savage, A., & Russell, L. A. (2005). Tangled in a web of affiliation. *The Journal of Behavioral Health Services & Research*, *32*, 199–214.
Simmons, J., & Singer, M. (2006). I love you ... and heroin: Care and collusion among drug-using couples. *Substance Abuse Treatment, Prevention, and Policy*, *1*, 1–13.
Srivastava, A., & Thomson, S. B. (2009). Framework Analysis: A qualitative methodology for applied policy research. *JOAAG*, *4*, 72–79.
Stevenson, C. (2013). A qualitative exploration of relations and interactions between people who are homeless and use drugs and staff in homeless hostel accommodation. *Journal of Substance Use*, *19*, 134–140.
Stevenson, C., & Neale, J. (2012). 'We did more rough sleeping just to be together'–homeless drug users' romantic relationships in hostel accommodation. *Drugs: Education, Prevention, and Policy*, *19*, 234–243.
Stout, R. L., McCrady, B. S., Longabaugh, R., Noel, N. E., & Beattie, M. C. (1987). Marital therapy enhances the long-term effectiveness of alcohol treatment. *Alcoholism: Clinical and Experimental Research*, *11*, 213.
Trumbetta, S. L., Mueser, K. T., Quimby, E., Bebout, R., & Teague, G. B. (1999). Social networks and clinical outcomes of dually diagnosed homeless persons. *Behavior Therapy*, *30*, 407–430.
Zlotnick, C., Kronstadt, D., & Klee, L. (1998). Foster care children and family homelessness. *American Journal of Public Health*, *88*, 1368–1370.
Zywiak, W., Neighbors, C., Martin, R., Johnson, J., Eaton, C., & Rohsenow, D. (2009). The Important People Drug and Alcohol Interview: psychometric properties, predictive validity, and implications for treatment. *Journal of Substance Abuse Treatment*, *36*, 321–330.