

UNIVERSITY OF DERBY

WHAT IS THE ROLE OF
COMMUNITY ENGAGEMENT IN DEVELOPING
WOMEN'S RECOVERY CAPITAL?

*Independent research by thesis forming a part of
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Glossary

ABCD: Asset based community development

ABCE: Asset based community engagement

ARC: Alcohol Recovery Community (at Sheffield Alcohol Support Service)

ARC member: An individual attending the Alcohol Recovery Community

CHIME: Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment

REC-CAP: Recovery capital questionnaire

SASS: Sheffield Alcohol Support Service

SIM: Social identity mapping

SMART: Self-Management and Recovery Training

START: Sheffield Treatment and Recovery Team

Preface

I declare that this thesis has been composed solely by myself and that it has not been submitted, in whole or in part, in any previous application for a degree.

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I would like to express my gratitude,

To my supervisory team, David Best and David Patton, and to Jamie Irving. This experience has been one of both personal and professional growth. Thank you for your copious amounts of guidance and wisdom, and for inspiring me to pursue a research career in the field.

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~

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To Sheffield Alcohol Recovery Community. Thanks for sharing your lives with me. I hope this gives your voices the recognition they deserve.

To those of you who are sadly no longer with us. We miss the charisma and energy you brought to the recovery community. This is dedicated to each of you.

~

"It's a journey of being, belonging and becoming."

Individual in recovery who participated in the research

Abstract

Introduction: Recovery from alcohol use is generally regarded as a socially mediated process, with the formation of pro-social networks and engagement in community resources acting as a catalyst for the building of the social and community capital required to sustain recovery. Whilst gender is a key mediator of pathways in to and out of substance use, literature exploring the experiences of women is somewhat limited.

Rationale: This thesis seeks to identify the role of community engagement in developing women's recovery capital. Within this, the findings endeavour to highlight key components of community capital and the impact of community capital on personal recovery growth through a gendered lens. To aid this, the thesis builds on the existing literature, including Asset Based Community Development (ABCD), to provide evidence-based, practical outputs to support recovery-orientated policy and practice.

Methods: The research implements a mixed methods design, utilising both longitudinal and cross-sectional data collection techniques across four studies, with 337 individuals recruited through Sheffield Alcohol Support Service (SASS).

Results: The findings emphasise the importance of social networks and community engagement on recovery outcomes. Within the quantitative data, females were more likely to be engaged in meaningful activities from the onset and the forms of community engagement undertaken differed from their male counterparts. Barriers to engagement varied across the cohort and men reported lower levels of social support, highlighting the need for pathways into new community resources being tailored to the needs of the individual.

Within the qualitative data, the cohort collectively emphasised the value of community engagement as a means to promote feelings of connectedness and inclusion, and engagement in recovery-orientated resources was often the starting point in individuals' journey to wider engagement. Whilst the importance of gender-specific support was recognised and other nuances by gender existed, it must be acknowledged that the research was carried out in a mixed-gender service, potentially limiting the extent to which gender differences could have been noted amongst the cohort.

Implications: Recovery is a journey of personal growth and whilst it requires the commitment of the individual, social networks and communities have an equal role to play. Individuals who present to recovery services with lower levels of recovery capital must be prioritised and assertively linked in with pro-social networks and meaningful activities to aid recovery progress.

To aid this, the ABCE framework was developed and is a unique output of the thesis. This recognises the importance of identifying current levels of community engagement and barriers to engagement in order to foster empowerment and enhance personal capital. Recovery pathways must be gender-responsive and the ABCE framework is intended to support this in that it is a strengths-based tool which is to be utilized to provide holistic and person-centered pathways into community resources for those in need. If done successfully, engagement with such resources not only promotes the growth of recovery capital but can generate a social contagion of recovery, enhancing community cohesion and promoting pro-social behaviour.

Future work which utilises the ABCE framework should consider its use alongside other methodological approaches to mapping recovery progress in a way which supports the growth of recovery capital and empowers individuals to take ownership of their own recovery and formation of new, pro-social networks. Tracking recovery capital and community engagement over a longer period will enable causal factors of recovery outcomes to be noted, further contributing to the gendered recovery literature base.

Chapter 1: Introduction

“Harmful use of alcohol is accountable for 7.1% and 2.2% of the global burden of disease for males and females respectively. Alcohol is the leading risk factor for premature mortality and disability among those aged 15 to 49 years, accounting for 10 percent of all deaths in this age group.” (World Health Organisation, 2018, p. 1)

Rates of alcohol consumption have increased over previous years, placing more individuals at greater risk of its use (Public Health England, 2016). It is estimated that 586,780 individuals are classified as ‘dependent drinkers’ in England, with over 7,000 of these individuals residing in Sheffield (Public Health England, 2019). For those individuals who perceive their alcohol consumption to be problematic within their lives, seeking recovery from its use may be a desired outcome.

The multifaceted process of recovery not only requires the commitment and determination of the individual themselves to gain sobriety, but the formation of networks that are supportive of the individual’s recovery are critical to its success. Without access to such networks, individuals have limited access to social support and community resources which are required to act as a catalyst to recovery progress. Throughout the recovery process, individuals must draw on internal and external resources to support their recovery, also known as recovery capital: “it’s about making your world bigger again” (Individual in recovery who participated in the research). Although the role of gender is likely to mediate this process (Best et al., 2015a; Cano et al., 2017; Andersson et al., 2020), there is substantially less work in this field than the wider recovery capital literature.

Thus, the overall aim of this thesis is to detail the role of community engagement in developing women’s recovery capital. This work documents the lives and experiences of 337 individuals seeking recovery with the support of Sheffield Alcohol Support Service. It is an account of their recovery journeys – including periods where individuals made significant strides forward, as well as periods where they relapsed, became stuck or faced barriers to the accumulation of recovery capital.

Conceptual framework

The thesis is underpinned by the conceptual framework of recovery capital, although this work does not stand alone. It is instead strengthened by the inclusion of three other key bodies of literature, which

also contribute to the overarching conceptual framework. Given their profound inclusion throughout the thesis, they are outlined now to recognise their influence on the work which unfolds.

Firstly, Best and colleagues (2017) 'ice cream cone model of recovery' (Figure 1.1). This importantly recognises the intrinsic and dynamic nature of recovery capital. As such, recovery is a socially mediated process which requires the utilisation of social and community resources to help the individual prosper.

Secondly, Leamy's (2011) work which since originating from mental health recovery has become widely applicable to the alcohol recovery field. This acknowledges that for recovery orientated practice and wider reintegration to support recovery growth successfully (thus supporting the accumulation of recovery capital) it must, provide a sense of connectedness; hope and optimism about the future; pro-social identity; meaning in life and empowerment.

And finally, Kretzmann and McKnight's (1993) work on Asset Based Community Development. Gaining much traction over recent years, their work recognises the value of mobilising existing community resources – a process which is integral to supporting recovery capital growth at a community level.

Contribution to the field

In light of the central research question and building on the conceptual frameworks outlined, the thesis seeks to make two main contributions to the field. Firstly, by contributing to the body of recovery research which is responsive to the specific needs and experiences of gender. Within this, the thesis is one of the first of its kind to explore the role of gender on the accumulation of recovery capital, using the implemented methodology.

Secondly, although literature recognises the importance of social and community factors to support recovery, the thesis not only seeks to demonstrate the key components of community engagement and impact of such engagement on recovery pathways through a gendered lens, but also provides a practical output to mapping community resources. This builds on the previous work of Kretzmann and McKnight (1993) and is a unique output of the thesis. This strengths-based tool is intended to support future recovery orientated work. It is hoped that as a result of its implementation, it is not only the individual in recovery who will benefit from increased engagement with community resources, but this process will also generate a social contagion of recovery, enhancing community cohesion and promoting pro-social behaviour.

Structure of the thesis

The thesis is structured over nine chapters. Chapter Two will present a review of existing literature. This will firstly provide an overview of alcohol use and the prevalence of use before attention is turned to the concept of recovery. The outlined conceptual frameworks are given particular attention within this chapter. Here, alcohol policy will also be reviewed to contextualise the thesis. Chapter Three will outline the methodology of the research, providing detail in regard to the rationale and method, sampling technique and analysis implemented throughout. Here, ethical and philosophical consideration will be given, as well as detailing the role of those with first-hand experience of alcohol use within the design of the methodology. Chapter Four will introduce findings to the thesis, describing baseline and change differences by gender in levels of recovery capital. Chapter Five will build on this, utilising a longitudinal dataset to explore recovery capital growth and assess differences by gender. Here, the impact of community engagement on recovery capital growth will also be detailed. Chapter Six will focus on the mapping of community resources and detail the narratives of those discussing the impact of engagement which such resources. Chapter Seven, the final findings chapter, will present interviews undertaken with a small sample of women engaged throughout the research process. Chapter Eight provides a summary of the findings in light of previous literature, before discussing the implications of the research. Here, personal reflections on the research process are given. The final chapter, Chapter Nine, provides an overall conclusion to the thesis.

~

“Recovery, it’s not about perfecting your life, just strengthening aspects of it”.

Individual in recovery who participated in the research

Chapter 2: Literature Review

Introduction to chapter

To provide context and rationale to the thesis, this chapter firstly sheds light on alcohol use broadly, before turning its attention to what we know about how and why people recover from alcohol use. The conceptual frameworks which underpin the thesis are then introduced, and attention is paid to how community engagement can be utilised as a mechanism to support the growth of recovery capital.

Alcohol use and the prevalence of use

Alcohol use remains commonplace in the UK, with the sales of alcohol increasing by 42% since the 1980s (Public Health England, 2016). This increase is thought to be driven by three main factors, which as Public Health England (2016) state, includes the increased strength of alcohol products; its increasing affordability; and a noted increase of use amongst women. Whilst for many people, alcohol is often positively linked with social aspects of life, the effects of its use are associated with many health, social and economic implications (Alcohol Change UK, 2018; Mold, 2019), and for some, drinking can be associated with greater levels of harm, especially for those classified as ‘alcohol dependent’ or ‘harmful drinkers’.

Alcohol dependency and harmful drinking are two forms of behaviour which, as defined by The National Institute for Health and Care Excellence (NICE, 2011), are referred to under the umbrella term of alcohol use disorders. Alcohol dependency is “characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequence”, whereas harmful drinking is defined as “a pattern of alcohol consumption causing health problems directly related to alcohol” (NICE, 2011, p.1). Whilst in clinical terms alcohol dependency is specifically defined and assessed, it is perhaps more appropriate to picture drinking behaviour on a continuum, depending on the extent and severity of its use. Within this thesis, the term alcohol use is used when discussing these two forms of behaviour collectively as it better reflects the drinking behaviours of those whose experiences are documented within the current research. If the literature referred to is however specific to alcohol dependency, such as when referring to statistics, this is specified, and if the associated literature is not alcohol specific but instead refers to alcohol and other drugs, the term substance use is used.

Estimates show there are 586,780 individuals classified as dependent drinkers in England, with 7,124 of these individuals in Sheffield (Public Health England, 2019). On a local level, alcohol use data in

Sheffield estimates that 7% of the overall population are at an increased risk of alcohol related harms, including those who are alcohol dependent (Sheffield DACT, 2016). Alcohol use is known to contribute to a myriad of issues that can have a severe effect on an individual's physical and psychological health, social behaviour, social interactions and social environment (Klingemann, 2001). Life domains commonly affected by alcohol use include education, employment, housing, social relationships and health (Livingston et al., 2012).

Despite what is known about alcohol use and the prevalence of the issue it is important to turn attention to the experiences of those reducing their use or abstaining from alcohol. By doing so, we can seek to better understand how individuals may be supported to overcome their alcohol use.

Defining addiction recovery

For those wanting to make positive changes to their substance use, maintaining and sustaining recovery is a key aspect of moving towards a more fulfilled life (Daddow & Broome, 2010; Pettersen et al., 2019). While there have been various attempts to define addiction recovery, academics recognise that this has failed to achieve consensus over previous years (White, 2007; Neale et al., 2013). This contested understanding of recovery can be reflected by its complexity, with the term being understood as a personal journey, as opposed to a fixed state or destination (Laudet, 2007; Neale et al., 2015; Manley et al., 2015). It is argued that the journey of recovery typically takes around five years (otherwise defined as stable recovery) (Betty Ford Institute Panel, 2007) and that acceptance and reintegration are necessary to sustain recovery beyond this (Best & Savic, 2014).

The emergence of the recovery paradigm (White, 2004; White, 2005; Best & Lubman, 2012) has resulted in the concept gaining popularity over recent years and although achieving consensus of a definition of recovery may not be necessary for those in recovery themselves, having a shared sense of understanding of what recovery constitutes is important when it is used as a guiding approach to policy development, research and practice. This does however generate the risk of creating challenges when evaluating and measuring the effectiveness of recovery orientated services, as White (2006) explains, as confusion lies over when recovery is achieved, lost and reacquired. As such, rigidly defining the concept could be associated with potential harm if it dictates "who is seen as socially redeemed and who remains stigmatised" (White, 2007, p. 230). With this in mind, holistic definitions of recovery which attempt to capture this as a multifaceted journey may be more useful in a practical sense and enable the individual seeking recovery to do so in a way which is not too rigid or narrow.

This would allow understandings of recovery to be fashioned by the individual themselves (McIntosh & McKeganey, 2000).

Several definitions acknowledge that recovery entails gaining control of or abstaining from substance use (Betty Ford Institute Consensus Panel, 2007), although this alone is not enough to achieve recovery and this is often recognised. For example, themes cited alongside this acknowledge the importance of improved health and wellbeing; strengthened social outcomes (Betty Ford Institute Consensus Panel, 2007; Best & Laudet, 2010; Timpson et al., 2016; Martinelli et al., 2020); and work and citizenship (Best et al., 2015a). Following a systematic review of addiction recovery literature, Inanlou and colleagues (2020, p. 178) formulated a working definition of recovery which is used throughout the thesis:

“Recovery is an intentional endeavour, reclaiming a self-journey, through which a person in recovery with the use of recovery capitals manages the residual drug use effects for sustained control over the substance use, maximizing their health and well-being, having a meaningful life and citizenship, and pursuing other life goals”.

Similar definitions, such as White and Kurtz’s (2006) also recognise the value of individuals utilising recovery capital (explored in depth later in the literature review, *A way to document recovery progress: Recovery capital*) to aid their recovery journey. Whilst the theoretical approach of recovery capital underpins the current thesis, understanding recovery in this way (as defined by White & Kurtz, 2006 and Inanlou et al., 2020) may also help professionals working within the sector to better understand this as a journey which entails improvements in a variety of life domains, additionally to sustaining control over their substance use. As well as defining recovery and understanding the themes associated with this journey, it is important to explore the different approaches to supporting recovery.

The role of gender

Where both sex and gender have been used interchangeably to refer to the traits associated with distinguishing males and females, sex refers to physical and biological characteristics whereas gender refers to social and cultural traits (American Psychological Association, 2012). Whilst the conversation regarding gender has evolved over recent years to include the experiences of those identifying as transgender for example, the current thesis refers to gender in relation to the experiences of men and women. The reasoning for this is two-fold. Firstly, the thesis seeks to focus on the experiences of women, and men have historically been the comparison group. This is evidenced within the recovery literature which is subsequently explored. Secondly, the literature drawn upon and chosen research

methodology does not consider the biological characteristics of males and females and the interplay of such characteristics with substance use and addiction. Instead, the thesis is socially situated, exploring themes such as social networks and the role of communities, and therefore is better aligned to focus on the role of gender.

When looking at gender disparities within the literature, it is thought that alcohol dependency is more common in men (6% of the population) than in women (2% of the population) (Public Health England, 2016), and traditionally, alcohol use has been perceived to be more socially acceptable for males (McCreary et al., 1999; Hecksher & Hesse, 2009). As argued by Samuelsson (2015), variation in societal reactions to drinking may be attributable to different perceptions of masculinity and femininity. For example, drinking goes against traditional perceptions of the roles of wives and mothers, and it is noted that women experience greater levels of stigmatisation when using substances compared to their male counterparts (Covington, 2002; Lee & Boeri, 2017).

It is known that gender is a key mediator of patterns of substance use, substance using histories and that whilst individuals have overlapping needs, these are often distinct in the context of gender (Neale, 2004; Ettore, 2004; Grella et al., 2008; Greiff & Skogens, 2017). Women for example often attribute substance use and relapses to intimate relationships (Leverentz, 2006; Light et al., 2013) thus, highlighting the social mechanisms associated with this journey. Moreover, women are known to have shorter substance using histories (17.7 years on average in comparison to 22.4 years for men) and when they do access support to start their recovery journeys, have been shown to be younger in the research on recovery journeys (37 years old in comparison to men at 39 years old; Best et al, 2015a).

Whilst the experience of using alcohol or other substances is gendered in nature, so are the implications of its use (Andersson et al., 2020). For example, literature demonstrates that females are more likely to have specific needs in relation to their health and relationships (Andersson et al., 2020). As detailed in the Life in Recovery survey (Best et al., 2015a), 16.5% of women were reported to have lost custody of their child whilst using in comparison to 8.1% of men, and 8.6% of women experienced domestic violence whilst using substances, in comparison 4.9% of men. Men however are known to have higher levels of need in relation to physical health (Andersson et al., 2020). Attention is now turned to how the recovery journey is supported, with reference to gender-specific experiences and needs where relevant.

Supporting the recovery journey: what works?

Similarly to alcohol use, the ways in which people recover are individualised and whilst they are also thought to be gendered in nature (Neale et al., 2014; Cano et al., 2017), the literature which considers this is limited (Thom, 2010). Before specifying the different pathways to recovery, it is useful to understand the overarching themes which underpin recovery orientated practice. Originating from the mental health recovery field and based on a review of evidence, Leamy and colleagues (2011) used the acronym CHIME to highlight five principles to aid recovery orientated practice. These five principles – Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment – fit well with what is known about how recovery is aided and are now commonly cited within the addiction recovery literature (Best et al., 2018; Best, 2019).

CHIME: What does this mean for recovery orientated practice?

Looking at each of these five principles in turn, firstly starting with connectedness, it is known that isolation can amplify an individual's drinking (Yawger, 2018) and has detrimental effects on an individual's health and wellbeing (Heikkinen & Kauppinen, 2004). Often exacerbated by the stigmatisation associated with using substances, isolation can put individuals at risk of relapse (Best & Lubman, 2012; Buckingham et al., 2013), subsequently hindering their opportunity to recover (Lim & Gleeson, 2014) and likelihood to participate in social activities (Victor et al., 2005). With this in mind, supporting individuals in their journey of recovery and providing them with the opportunity to connect (for example, to other peers in recovery, support services or the wider community), should be a critical component of recovery practice (Dingle et al., 2015a; 2015b; Harrison et al., 2020). If done successfully, then the formation of these pro-social connections, supportive of an individual's recovery attempts, are a known predictor of recovery outcomes (Longabaugh et al., 2010; Best et al. 2012). Work by Covington (2002, p. 3) highlights this is particularly important for women in recovery, as establishing connections allows women to “develop a sense of self and self-worth”.

It is thought that if individuals can be connected to those who are supportive of their recovery attempts, then the positive social support this provides helps to promote the “belief that change is possible, generating a sense of hope that energises attempts to manage change” (Best, 2019, p. 6). This is important, given that a lack of hope can act as a major barrier to recovery (Sælør et al., 2014; Harrison et al., 2020). If individuals can however begin to have positive aspirations about living a life free of substances, then the motivation to remain sober is increased (Korcha et al., 2011; McKay, 2017). This is perhaps particularly important for those experiencing greater levels of stigmatisation, such as what

we know about women's experiences of substance use and recovery, and instead of being further shamed must be offered hope in order to promote recovery (Leamy et al., 2011). Literature has alluded that this can be supported by encouraging women to develop connections outside of their recovery sphere in order to be able to begin to detach from the stigmatisation they face (Collinson & Hall, 2021).

The effect of promoting connection and hope within recovery orientated practice is that individuals are able to fashion new identities (Biernacki, 1986; Dingle et al., 2015a) which may otherwise have been damaged throughout their using histories (McIntosh & McKeganey, 2002). The formation of these new and aspirational identities which often replace an individual's former 'using identity' (Dingle et al., 2015a; 2015b) are internalised and learned through exposure to recovery peers and recovery groups (Buckingham et al., 2013). Thus, highlighting the need for recovery orientated practice to provide opportunities for individuals to connect with others and participate in meaningful activities (Burrow & Hill, 2011; Yeager et al., 2012; Best et al., 2017; Collinson & Best, 2019). For women specifically, engagement in meaningful activities which are not solely recovery-centric is thought to support the formation of a more holistic identity (Collinson & Hall, 2021). This is particularly important, given the layers of disadvantage women may face. In light of identity formation for example, patriarchal social constructions which often idealise women as "good mothers" (Gunn & Canada, 2015, Peterson, 2018), may in fact hinder a woman's recovery progress. As such, mothers who have used substances are faced with the challenge of managing a 'spoiled identity' (Goffman, 1963) and thus, recovery orientated practice must support women in a way in which new holistic identities, supportive of their recovery, can be fostered.

If community engagement which is supportive of the individual's recovery and new identity formation can be encouraged, individuals will begin to experience feelings of meaning and empowerment that exhorts the virtues of citizenship. An increased sense of meaning and empowerment (linked to self-esteem and self-efficacy) is a critical aspect of recovery trajectories (Moos, 2007; Del Vecchio, 2012) and is important to overcome adversity (Martin et al., 2011).

Pathways to recovery

CHIME (Leamy et al., 2011) is a useful conceptual framework to underpin recovery orientated practice however, the approaches to promoting recovery, otherwise referred to as pathways, vary. As explored in the REC-PATH study, an exploration of recovery amongst individuals in England, Scotland, the Netherlands, and Belgium, the following five pathways to recovery were identified: 12-Step mutual

aid support; peer based recovery support; residential and community treatment; specialist outpatient treatment; and natural recovery (Best et al., 2018).

The reasons for entering a chosen pathway are known to be influenced by gender (Timko et al., 1993; Tucker, 2001; Schmidt & Weisner, 1995; Grella et al., 2008). For example, in an American based study, it was highlighted that men are more likely to be referred to treatment through the criminal justice system, as opposed to women whose referral is often initiated through community based services such as health care, child welfare, or mental health services (Grella et al., 2008). Moreover, the trajectories through these pathways are not always linear and individuals may experience lapses or relapses as part of this journey. To put this into context, statistics from Public Health England (2018) showed that 60% of those entering treatment either did not complete this or relapsed within the first six months of leaving treatment. The causes of relapse are also known to be gendered. Women for example are more likely to relapse when living apart from their children, experiencing mental ill-health or being in a problematic relationship. As stated by Kenny and Barrington (2018), women who have lost custody of their children often reported disadvantaged social networks and low support, perhaps contributing to the risk of relapse as they are further distanced from the resources that recovery requires. For men however, relapse is associated with social pressure and living alone (Grella et al., 2008).

Traditionally, our understanding of recovery pathways have been tailored to the needs of men and thus have neglected the experiences of women (Covington, 2002; Simpson & McNulty, 2008; Salter & Breckenridge, 2014). Whilst the available pathways to recovery are often the same for men and women, the different experiences of women have not previously been adequately addressed (Best & Abdulrahim, 2005, p. 2). The recognition of gender-responsive care is however beginning to be addressed in research (Wincup, 2016; Agenda, 2017; Andersson et al., 2020; Collinson & Hall, 2021) yet women are often still outnumbered in treatment.

Recent statistics from Public Health England (2019) noted that annually, out of those accessing treatment for alcohol use alone in England, 44,664 were male (60%) and 29,954 were women (40%). A much lower percentage of women however were accessing treatment for substance use (21,997 men (73%) in comparison to 8,265 women (27%)). It must however be noted that individuals in recovery from alcohol commonly access community support services and levels of engagement with such services are not reported within this data.

The lower percentage of women reported accessing treatment perhaps reflects the greater stigmatisation associated with substance use for women. As Radcliffe (2009, p. 1) notes, recovery

pathways are most likely to be “successful when they acknowledge women’s specific experiences of disadvantage and structural inequality”. Thus, it can be assumed that there is a ‘dark figure’ for women in need of recovery support, who because of factors such as stigmatisation (Cloud, 1987; Hammarlund et al., 2018), or parenting i.e., apprehension of having their child taken into custody (Becker & Duffy, 2002; Grella et al., 2008; Wincup, 2016; Wolfson et al., 2021) avoid accessing support. When women are reluctant to seek support, they may be left feeling stigmatised, marginalised and demoralised (Ettorre, 2004). For contextual purposes, it is now important to explore these different recovery pathways before introducing the theoretical framework of recovery capital (Granfield & Cloud, 1999).

A continuum of recovery support: A shift to recovery orientated systems of care

The noted shift to a recovery focused paradigm over recent years has been widely recognised in practice, particularly within recovery pathways, and is supported by several factors. Most notably, for those who access formal treatment or support, there has been a shift from medicalised models towards recovery-oriented systems of care (ROSCs) (Humphreys & Lembke, 2014), despite previous confusion regarding the implementation of this within practice (Best & Laudet, 2010). Recovery-oriented systems of care are defined as:

“A coordinated network of community-based services and supports that is person-centred and builds of the strengths and resilience of individuals, families and communities to achieve abstinence and improve health, wellness, and quality of life for those with or at risk of alcohol and drug problems” (White, 2021, p. 1)

It is essential for ROSCs to offer support at all stages of an individual’s substance using and recovery career, most notably at the following stages: prevention, intervention, treatment and post-treatment. This shift has been beneficial, given that it recognises that it is not reasonable to assume the recovery journey will occur solely whilst in treatment (Skogens & Greiff, 2014). Instead, services and support available should be flexible, offering autonomy to the individual to choose a recovery pathway which is suited to their own needs and is not time-limited (Sheedy & Whitter, 2009). Ensuring a continuum of care is readily available (Bassuk et al., 2016) has become a favoured approach (McLellan et al., 2000; Humphreys & Tucker, 2002; White et al., 2005), as it acknowledges the complexity of recovery and recognises this as a journey.

Residential and community treatment

In the UK, statutory alcohol treatment is offered through community agencies who provide detoxification and structured psychological interventions as well as residential agencies who provide in-patient detoxifications and rehabilitation (Rose & Cherpitel, 2011; Gilbert et al., 2015). To support the delivery of these services, the National Treatment Agency developed Models of Care for alcohol use as a way to provide best practice for both commissioning and the delivery of local treatment services for those seeking support for their alcohol use (Department of Health, 2006). In response to austerity however, whilst commissioners must continue to strive to meet the needs of those seeking recovery in a cost-effective way (Buykx et al., 2020), the recovery landscape has witnessed a reduction in detoxification and residential rehabilitation (Phoenix Futures, 2021).

Motivation to engage with treatment may differ depending on gender (Wolfson et al., 2021). For example, is it known that parenting acts as a strong incentive to engage positively as individuals desire to become better parents (Best et al., 2015a). This is supported by Radcliffe (2009) who identified that motherhood has important implications on ones' identity and can in fact be transformative for recovery. Furthermore, it is noted that becoming pregnant can in fact act as an opportunity for substance using women to engage with treatment (Radcliffe, 2009). Contradictory research however identified motherhood as a barrier to recovery (Gueta & Addad, 2015). This was particularly apparent when women felt condemned for their circumstances; held responsible for the wellbeing of their children (Jackson & Mannix, 2004); and experienced role strain, subsequently placing pressure on recovery progress (Collinson & Hall, 2021). This implies the relationship between motherhood and recovery is complex and susceptible to several factors. It is therefore important for treatment to be guided by principles of practice which seek to best support women in an individualised manner, and recognise the multiple factors involved in this. Existing research shows those engaged with treatment show improved outcomes such as a reduction in alcohol intake and alcohol related harms (Gossop et al., 2001; 2003). Historically, the challenge with measuring treatment effectiveness is that this has previously been understood in terms of the completion of treatment and abstinence, as well as other related factors such as a reduction in criminal activity and gaining stable housing. As recognised by Nutt (2012), if abstinence is our only measure of success, then it can be argued that no treatment currently used is particularly successful. It would perhaps be more appropriate to adopt a more strengths based approach which is not only focused on the deficits of the individual. A different approach for example, and one which aligns with what we understand in light of recovery, would be to assess wider outcomes such as improvements in health and wellbeing, social networks and engagement with communities more broadly. Not only would this offer treatment provisions more flexibility to deliver work which is not solely focused on achieving abstinence but also provides a

greater sense of hope and empowerment for those seeking recovery, as well for families and communities more broadly.

Recovery orientated community support services

Many people do however recover without formal treatment through the use of community based recovery supports (Sobell et al., 2000; Humphreys, 2004). These must be available to both complement treatment as well as occurring independently. Community-based recovery supports have gained popularity over recent years (Timpson et al., 2016), perhaps due to their reliance on the voluntary sector; their accessibility to communities; and their underpinning philosophies of overcoming substance use. Unlike professional treatment, the measures of effectiveness for such services tend to be much more holistic, acknowledging the importance of engagement in meaningful activities; reduced involvement with the criminal justice system; housing stability; improved health; social connectedness and quality of life (Fulfilling Lives, 2021; Project 6, 2021). More so, these services are often strengths-based, utilising community resources and collaborative ways of working.

12-Step mutual aid and peer based recovery support

12-Step mutual aid and peer based recovery support are common features within community services and have also gained popularity over recent years (Parkman & Lloyd, 2015; Roth et al., 2016). For alcohol users in particular, these recovery pathways tend to be more commonly used than formal treatment (Best et al., 2011). Such recovery support is delivered on a peer to peer basis, where those with first-hand experience of substance use and recovery use their lived experience and experiential knowledge (Borkman, 1999) to support others in sustaining and maintaining their own recovery (Granfield & Cloud, 2001; Laudet et al., 2002).

For individuals attending 12-step mutual aid groups, an emphasis is placed upon helping others as it is both encouraged practice and is argued to have therapeutic and spiritual implications (Riessman, 1965; Smith, 2007). The known success of this approach can be understood in light of Christakis's and Fowler (2009) work on the hyperdyadic spread – the process of behaviours being passed through social networks through social learning. The way in which this pathway of recovery is beneficial for recovery outcomes is also thought to differ for men and women. In his study of the mechanisms of action of 12-step mutual aid groups, Kelly (2017) found that for women, the approach is particularly advantageous to encourage changes in self-efficacy whereas for men, is it advantageous to encourage changes in social networks.

Whilst various pathways to recovery exist, it is useful to provide a theoretical framework to recovery progression which is applicable to all of these. Within the thesis, the chosen theoretical framework, recovery capital (Granfield & Cloud, 1999) is now introduced as a means to document recovery progress.

A way to document recovery progress: Recovery capital

Following earlier work by Bourdieu (1986), Coleman (1988) and Putnam (1993), Granfield and Cloud (1999; 2001) introduced the theoretical framework of recovery capital as a strengths-based metric for measuring recovery progress. Whilst the work of Granfield and Cloud builds on existing capitals literature, from those listed above, it takes most influence from the work of Putnam (1993), particularly in relation to social capital (explained in greater detail below).

Recovery capital is defined as “the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol and other drug problems” (Granfield & Cloud, 1999, p. 32). While there have been numerous classifications of recovery capital, Hennessey’s (2017) systematic review provides an overview of these developments. Within the thesis, White and Cloud’s (2008) framework is used, categorising recovery capital into three domains: personal, social and community capital. This categorisation of recovery capital is chosen within this context given it reflects that applied within the REC-CAP (a measure of recovery capital utilised within the thesis and outlined in Chapter 3). Within this model and related work which has followed (Best & Laudet, 2010), cultural capital is embedded as a component of community capital. It is noted that recovery capital, both the quality and quantity, is a predictor of recovery outcomes (White & Cloud, 2008; Yates, 2014) and helps us to understand why some individuals are more successful in their recovery than others (Connolly & Granfield, 2017). That said, recovery capital research which is drug specific appears in abundance (with some examples including Laudet & White, 2008; Keane, 2011; and Zschau et al., 2016) when compared to that which is solely alcohol related: this highlights a current gap in the evidence base.

When taken into consideration with an individual’s drinking severity, recovery capital can be a helpful tool to determine the type and level of recovery support which will be most appropriate for an individual (White & Cloud, 2008). In particular, those with lower levels of recovery capital and high levels of drinking severity may struggle to initiate and sustain their recovery (Neale et al., 2015). If individuals can however be supported in acquiring recovery capital, then the growth of this can signal a ‘turning point’ in one’s journey to initiating and sustaining their recovery (Laudet, 2007).

Similar to an ecological framework, the scope of recovery capital reflects a similar nature – covering aspects at a micro (personal), meso (social) and macro level (the community) (Laudet & White, 2008; Hennessy, 2017). As such, research in the field must acknowledge the intersecting relationship between these aspects and if seeking to identify how the growth of recovery capital can be supported, must do so in a way which is not only conducive to the individual in recovery themselves, but also communities more broadly.

As the concept was introduced as a strengths-based measure, it seems logical to presume that recovery capital provides a positive sum game – with that which an individual retains or acquires contributing positively to their recovery attempts. In line with this and to aid research in the field, the Assessment of Recovery Capital (Groshkova et al., 2013) and REC-CAP (Cano et al., 2017) have become popular strengths-based tools to chart the development of recovery capital. Whilst recovery capital offers a theoretical framework for recovery related research to be built on, there has been a lack of consistency with quantifying recovery capital for a single population (Hennessy, 2017). Most notably, in the development of recovery capital as a theoretical framework and its associated measures (such as the ARC and REC-CAP), there has been a lack of consideration of gender (Hennessy, 2017). This can be attributed to the concept originally being developed based on white, male adults in natural recovery (Hennessy, 2017).

It is also important to consider factors which could hinder one's efforts and “keep people trapped in a world of addiction” (Cloud & Granfield, 2008, p. 1977). As outlined by Cloud and Granfield (2008) these factors include: age, gender, mental ill-health and incarceration. Whilst classified as ‘negative capital’ in the original paper (Cloud & Granfield, 2008; see also Portes & Landolt, 1996), it may be more appropriate to see these as elements which may interact with recovery capital, or otherwise be identified as relapse risks. As highlighted by Hennessy (2017) there is a gap for research to explore the relationship between these factors and levels of recovery capital and as identified by Ganapati (2012) literature which explores the gendered dimensions of recovery capital is almost nonexistent (other than Cano et al., 2017).

Personal Capital

Within White and Cloud's (2008) conceptualisation of recovery capital, physical capital and human capital are merged to form personal capital. Physical capital (Cloud & Granfield 2008; Granfield & Cloud 1999; White & Cloud 2008) has been defined as “tangible capital including material resources such as money, property, cars, availability at public treatment facilities, having insurance, and having

essential needs met such as food and housing” (Hennessy, 2017, p. 354). Human capital (Cloud & Granfield 2008; White & Cloud 2008; Neale et al. 2014) on the other hand has been defined as:

“Personal characteristics to achieve goals, such as knowledge, marketable employment skills, interpersonal skills, emotional stability or mental health, problem-solving capacities, physical health, genetic inheritance, self-esteem, self-awareness, self-efficacy, sense of meaning, informal knowledge, life skills, hopes and aspirations” (Hennessy, 2017, p. 354).

Personal capital exists at a micro level and helps to understand the intrapersonal relationship that an individual will have with oneself (Terrion, 2013). As such, if an individual’s levels of personal capital can be improved, so will their ability to initiate and sustain their recovery (Best et al., 2010; Sælør et al., 2014). Whilst such capital is essential to promote change (Simoneau & Bergeron, 2003; Connors et al., 2013), factors such as poor physical health and mental ill-health, as well as deficits in skills (Palombi et al., 2019) may however have an intersecting effect on the development of personal capital. Mental ill-health is thought to be more prevalent amongst women, with 45.6% of women receiving support for emotional and psychological problems whilst in recovery, in comparison to 29.8% of men (Best et al., 2015a). Such factors may act as a barrier to recovery, given the known importance of an individual’s personal investment and determination to instigate the necessary change associated with recovery.

Social Capital

Cloud and Granfield (2004) acknowledge that whilst transformation at a personal level is crucial to aid recovery, this cannot occur in isolation but instead is situated more broadly within a social context. Originating from Bourdieu (1985) and Putnam’s work (1993), social capital asserts that “membership in a social group confers resources, reciprocal obligations, and benefits on individuals” (Cloud & Granfield, 2008, p. 1973). As such, it can be perceived that through the structural and reciprocating function of social networks (Cloud & Granfield, 2001), an individual is able to gain access to information, resources and social support (Best et al., 2015b; 2015c; Boeri et al., 2016).

To support recovery endeavours, it is important that individuals begin to psychologically disassociate themselves from groups which promote substance use and transition towards groups which support recovery (Moos, 2011; Weston et al., 2018). When group membership is supportive of an individual’s recovery attempts, these positive social interactions and the social capital acquired from these contexts contributes to both recovery success (Zywiak et al., 2002; Cloud & Granfield, 2004; 2008; Mawson et al., 2015; Best et al., 2016) and the reduced risk of relapse (Litt et al., 2009). Elucidating to specific

examples, strong interpersonal relationships (Stokes et al., 2018) and marital relationships (Simon & Barrett, 2010) are found to be associated with improved wellbeing and reduced substance use (Simmons et al., 2009).

This has resulting implications on an individual's social identity and can be framed within the Social Identity Model of Recovery (SIMOR) (Best et al., 2016). This builds in part on social identity theory (Tajfel & Turner, 1979; see also Haslam et al., 2020) which posits that in a range of social contexts, our sense of self is derived from our membership in certain groups, and that the resulting identities can structure and change a person's perceptions and behaviours. If social identity change can therefore be encouraged by surrounding an individual with recovery-orientated networks, it may provide the individual with a greater chance of envisaging their recovery and working towards it.

More so, when members of a group have shared pro-social aspirations, it is not only their newly forming social identities which are fostered (Best et al., 2015c; Dingle et al., 2015b; Best et al., 2016), but individuals will also benefit from improved health and wellbeing outcomes (Jetten et al., 2011; Johnstone et al., 2015). Subsequent work has however shown that such effects are not present within groups which face marginalisation and exclusion, and in a study of individuals experiencing homelessness, group membership in this context instead acted a barrier to wellbeing (Jetten et al., 2016). Whilst not specific to alcohol use, this is further supported by the work of Best (2016) which notes that groups associated with deviant behaviour, such as substance use, have a higher risk of health deficits and vulnerability. As recognised by Mehravi et al. (2016) and Landale and Best (2013) the effect of this can subsequently lead to further marginalisation and exclusion from community resources.

When explored in the context of gender, it is thought that the impact of substance use on women's social networks, including their families and relationships, is likely to be multifaceted and interconnected (Collinson & Hall, 2021) and it is suggested social networks differ between men and women (Lowndes, 2000; Molyneux, 2002; Godquin & Quisumbing, 2008). Whilst research has highlighted that two concepts often present in the narratives of women using substances are a lack of healthy relationships or experience of trauma (Covington, 1999; Covington, 2002), further research shows that when in recovery from substance use, women tend to have stronger social relationships; connection to others; and found it easier to form new, non-substance using networks (Gunn & Canada, 2015; Collinson & Hall, 2021). That said, Francis and colleagues (2020) highlighted that networks which provide critical recovery support for women can simultaneously pose potential relapse triggers. In light of intimate relationships, these can particularly present risk if characterised by inconsistency

and strain (Simon & Barrett, 2010), and are therefore often discouraged in practice, especially for those early in recovery (Diffy, 2011). Furthermore, establishing the effect of familial relationships for women is also complicated, given that women are likely to have family members who also use substances (Gunn & Canada, 2015), a risk factor associated with relapse (Dingle et al., 2015a; 2015b).

For women, new social networks formed within community support services are often fostered on the basis of shared experiences, such as addiction, trauma or motherhood (Collinson & Hall, 2021). It has however been recognised that peers may in fact perpetuate stigma through intragroup tension, particularly when women whose sense of self is constrained by societal expectations of their gender role make comparative judgments (Gunn & Canada, 2015). That said, further research has shown that networks which are initiated within recovery services for women often end up expanding beyond the recovery sphere (for example, participating in activities together within the wider community), strengthening women's formation of a holistic identity (Collinson & Hall, 2021) and thus, alleviating stigma. It is also thought that women tend to rely on informal, smaller scale networks however it is usually these smaller networks which are ignored by mainstream social capital literature (Edwards & McCarthy, 2004).

The profound implications that social networks have on recovery (Best et al., 2015; Batish et al., 2017) also act as a psychological resource and form of social support. In turn, this not only protects an individual's wellbeing (Iyer et al., 2009; Biswas-Diener & Diener, 2006; Ysseldyk et al., 2013; Haslam et al. 2020), but provides an individual with access to resources, such as community assets, which may further support their recovery attempts. This phenomena is referred to by Jetten and colleagues (2011) as the social cure.

To aid this, professionals and researcher working in the field may utilise the Social Identity Mapping tool (SIM) (Best et al., 2016) to visualise an individual's social network and to help identify those who may be most in need of linkage into wider community resources. Within this, it is also important to consider the dynamics within and between social networks as this will influence the levels of social support and access to resources an individual is afforded access to.

[The dynamics within and between social networks: Bonding and bridging capital](#)

Bonding and bridging capital have been conceptualised to further understand the dynamics of social networks and their interaction between one another (Gittel & Vidal, 1998; Narayan, 1999; Putnam, 2000). Bonding capital is commonly present within homogeneous groups (Leonard, 2004) and is often characterised by tight bonds and the development of trust and solidarity between group members. The benefits of such capital are often internal (Putnam, 2000) and lead to strengthened identities which are

exclusive to the network (Ferlander, 2007). These groups however have been reported to exert strain on group members and may have negative implication on individual's health (Due et al., 1999). Moreover, because of the stigma and exclusion they experience, group members may have limited access to social and community capital which is conducive to aiding their recovery. Within the recovery context however, bonding capital between in group members provides high levels of emotional and psychological support (Ferlander, 2007) and provides access to resources directly through others within the group (Bluic et al., 2017) thus, holding advantages if managed appropriately.

Forming connections with the community more broadly and developing a network of people from across social groups is achieved alternatively through bridging capital (Ferlander, 2007). Bridging capital is associated with a myriad of benefits and as described by Leonard (2004) helps group members to achieve their full potential. As Putnam (2000, p. 23) highlights, where bonding capital enables people to 'get by', bridging capital allows them to 'get ahead'. That said, the ties associated with bridging capital are not as tightly knit as those associated with bonding capital however do afford access to wider resources and knowledge they would not have otherwise gained access to (Putnam, 2000).

When thought of in the context of recovery, it is a combination of these forms of social capital which will enable individuals to prosper. There is a risk that if individuals become too embedded within their recovery community, they risk only building bonding capital, and having depleted stocks of bridging capital. A study by Landale and Best (2012) found that when a group of substance-using individuals were assertively linked in to sporting activities, individuals not only benefitted from the new pro-social networks formed, but also gained access to wider community resources through those they met. Whilst both bonding and bridging can aid recovery, the growth of such capital must be promoted using a bottom up approach. By doing so, this ensures an individual's recovery pathway is individualised and suited to their own needs and interests.

Community capital

Community capital can be understood in terms of community resources, such as activities and transport links; groups and facilities; recovery communities; as well as non-stigmatising attitudes within the community (Best & Laudet, 2010). Within the addiction recovery field, community capital has most commonly been explored in light of recovery resources. While the benefit of engagement with such resources is well documented (Dingle et al., 2015a; 2015b; Best et al., 2016; Collinson & Best, 2019), assessing the influence of wider community resources – outside of the immediate recovery sphere –

has not been explored in the same detail (one of the only existing examples includes Nordaunet et al., 2018). Participation with such community resources (both recovery-orientated and non-recovery-orientated) are known to be an important aspect of supporting recovery journeys, and within the context of the thesis, are referred to as a form of ‘community engagement’. This is explored in greater detail in the next sub-section.

Cultural capital lies within community capital (White & Cloud, 2008) and is described by Best and Laudet (2010, p. 4) as a form of capital that includes “values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours”. This can be understood in terms of both the individual’s personal attitudes and beliefs towards becoming engaged within their communities, as well as the community’s attitudes and values to those who have used substances and are seeking recovery.

Community engagement: the relationship with community capital

It is acknowledged that the “invitation for social inclusion” often lies within the community (White, 2009, p. 155) and therefore assessing the impact of wider community engagement (which falls outside of the direct recovery sphere as well as within) should be an encouraged aspect of recovery orientated research. Identifying and utilising existing assets within the locale in a strengths based manner can help the social integration of the individual and enhance community cohesion. The interrelated relationship with social capital is central to this: individuals with higher levels of social capital have greater access to community capital and thus, have enhanced opportunity to build the resources needed for sustained recovery (Best et al., 2016). If individuals with depleted stocks of social capital can successfully be linked into pro-social, meaningful resources (referred to here as community engagement), it is not only their sum of community capital which is enhanced, but recovery capital as a whole. Similarly, this can also be assessed using measures such as the SIM (Best et al., 2016; Cruwys et al., 2016) (referred to also below, see *A symbiosis of recovery capital: The ice cream cone*) (Figure 1.1), to firstly identify those with lower stocks of social capital. This process can then be further supported using techniques such as Asset Based Community Development (Kretzmann & McKnight, 1993) (referred to also below, see *How communities are intended to identify community resources: Asset based community development*) to identify resources within the locale that individuals can be linked in to. Given the importance of linkage into new pro-social resources, community engagement is therefore integral to accumulating community capital and as the wider literature shows, has a therapeutic value, improving one’s health and wellbeing (Alpass et al., 2007; Adams et al., 2011; Gilmour, 2012).

Otherwise termed social participation, community engagement can be defined as “involvement in interpersonal interactions outside the home, including social, leisure, community activities and work” (Goll et al., 2015, p. 2). A key aspect of this is that these interactions are positive (Johnstone & Lane, 2018) and take place either within the community and/ or with others in the community. It is such engagement which has begun to be recognised within recovery orientated practice, particularly within recovery orientated community support services, such as that used as the research setting within the thesis.

Following a systematic review by Levassereur and colleagues (2010), the following five themes were identified to help better understand community engagement: who, how, what, with whom and where. Within this, they also outlined six levels of community engagement:

Table 1.1: A six step ladder of community engagement (Levassereur et al., 2010).

Level	Description of level involvement
1	Doing an activity in preparation for connecting with other people
2	Being surrounded by others
3	Interacting with others without physical contact
4	Doing an activity with others
5	Helping others
6	Contributing to a community

Whilst the importance of community engagement is noted within the recovery literature (Best et al., 2017; Collinson & Best, 2019), research is yet to explore the influence of community engagement in this way. Although the work of Levassereur et al. (2010) is not specific to addiction recovery, it is potentially an important lens to use to embed within how we understand concepts of community capital. Lower levels of community engagement (see Table 1.1, level 1-3) are likely to be witnessed when an individual first accesses treatment or support, and as improvements are noted at a personal level (assessed through measures such as the REC-CAP), the individual then becomes more embedded within their community (see Table 1.1, level 4-6) (as assessed through measures such as the SIM and ABCD). A similar approach to recovery progress is also supported by White and Cloud (2008) who recommended a seven step approach for professionals working within the sector to follow. These are as follows:

Table 1.2: White and Cloud’s (2008) seven step approach for professionals within the substance use sector to follow to support the accumulation of recovery capital.

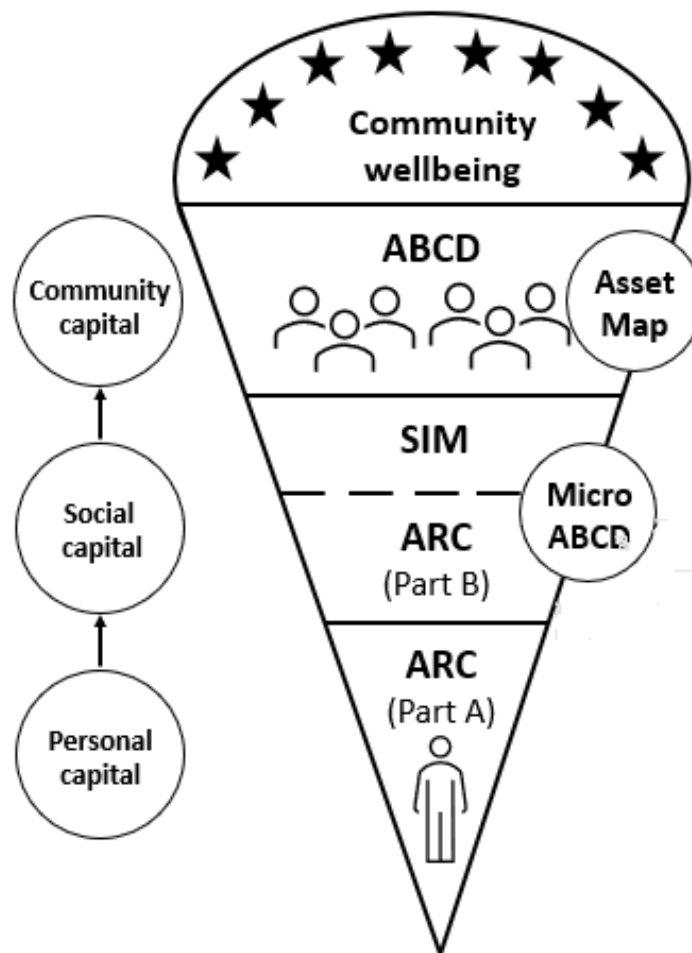
Stage	Description of stage
1	Screen for recovery capital early in the therapeutic relationship
2	Actively engage those with lower recovery capital in terms of outreach and planned intervention
3	Regularly assess for recovery capital growth or barriers encountered
4	Recovery capital level can help determine the level of care or intervention needed
5	Consider recovery capital holistically; personal, social, and community
6	Support cultural and community development through recovery capital enhancement programmes
7	Recovery capital can then be used to evaluate outcomes

If used in conjunction with Table 1.1, Table 1.2 can be used in a complementary manner to identify when wider community engagement may be a desired outcome for those in recovery. This must however be done in strengths based manner, based on the individual’s own interests.

A symbiosis of recovery capital: The ice cream cone

Whilst each of the three domains of recovery capital (personal, social and community) are independent, the link between them is dynamic and complex (Elswick et al., 2018). To demonstrate this interaction and explore techniques for building recovery capital, Best and colleagues (2017) developed the ‘ice cream cone’ model of recovery (see Figure 1.1).

Figure 1.1: The ‘ice cream cone’: characterizing recovery capital through layers of community engagement.



The elements of recovery capital (personal, social and community) shown within the ice cream cone (Figure 1.1) represent that of an ecological framework, covering aspects at the micro, meso and macro level. The ice cream cone recognises that recovery is an intrinsically social process, underpinned by the formation of positive social networks and community engagement, with resulting implications on the individual’s social identity. The model discusses three techniques – the Assessment of Recovery Capital (Groshkova et al., 2013), Social Identity Mapping (SIM) (Best et al., 2016) and Asset Based Community Development (ABCD) (Kretzmann & McKnight, 1993) which are intended to support the growth of recovery capital by maximizing the resources available to the individual in recovery and generating residual social and community capital as a result of the process. At the bottom layer of the cone, the Assessment of Recovery Capital (ARC) (Groshkova et al., 2013) is used as a tool to assess

levels of recovery capital and identify recovery strengths. This is then built on at a social level, using the SIM (Best et al., 2016) to assess an individual's network of group memberships, as represented in the middle of the cone. This visual technique helps to identify social networks which may either help or hinder an individual's recovery attempts. By doing so, the individual in recovery will be able to see how changes need to be made to their social world to fully support their recovery. In other words, it is both an explanatory model and a diagnostic one that suggests areas for action to support recovery pathways. When used in practice, it is intended these two techniques will help identify who is most in need of assertive linkage into assets identified within the community (referred to in further detail below, see *How communities are intended to identify community resources: Asset based community development*). In other words, those with lower levels of recovery capital and a lack of pro-social networks will require the support at a social and community level to help enhance recovery outcomes. Whilst previous work has addressed that the framework of recovery capital may limit its use with certain subpopulations (Hennessey, 2017), it makes considerable contributions within practice. Most notably, it allows for disparities in capital to be identified, especially for marginalised populations, which in turn can contribute to the development of appropriate supports to build capital (Cloud & Granfield, 2004; White & Cloud, 2008).

How communities are intended to identify community resources: Asset based community development

Represented at the upper level of the ice cream cone (Figure 1.1), Asset Based Community Development (ABCD) (Kretzmann & McKnight, 1993; 1996) is drawn upon to identify community resources which can be utilised to support recovery pathways. Defined by Vital and Keating (2004, p. 126), community development is “a place based approach: it concentrates on creating assets that benefit people in poor neighbourhoods, largely by building and tapping links to external resources”. The key here is a shift from a traditional needs based approach – in which a community is defined by their deficits – to a strengths-based approach which recognises that communities should be built on the capacities and assets of the people and the place (Kretzmann & McKnight, 1993; 1996; Kretzmann et al., 2005). This is not to disregard problems which may exist within a community, but instead to use the strengths of the locale to underpin collective action. If a community is able to identify its own assets, then its citizens will begin to view the locale in light of these strengths (Haines, 2009; Kretzmann & Russel, 2018). More so, this will then encourage communities to invest their energy in further developing the assets which already exist.

Integral to this approach is asset mapping. Assets have been defined as the “gifts, skills and capacities” of “individuals, associations and institutions” (Kretzmann & McKnight, 1993). Similar to an

ecological framework (and recovery capital), this acknowledges strengths at an individual, social and community level and encourages an inventory of the assets or capacities of individuals within the locale; local associations and organisations; and local institutions such as libraries, community colleges and hospitals, to be documented (Kretzmann & McKnight, 1993). Within this approach, communities must be thought of in terms of the strength in people, things, organisations, and resources that exist (Nuture Development, 2021). This also has the ability to identify assets which otherwise may go unrecognised and underutilised. Whilst mapping assets initially enables a community to take stock of its strengths, the identification and mobilisation of networks between these is critical. Within the context of community development, highlighting the interconnections among assets (or in other terms, the bridging capital opportunities) is essential to ensure the resources do not sit in silos but instead are cross-cutting and pathways into such resources are accessible for those in need. While this may appear straightforward, motivation amongst those involved in this process is key to help develop, maintain and sustain links within the community. If this can be achieved successfully, then each individual's knowledge and understanding of their locale will be strengthened as a result. Within the recovery context, this is particularly important for those who have been identified as having depleted stocks of recovery capital, as they will subsequently benefit from improved pathways into community resources.

Literature highlights that the work of those within the recovery sector is predominately office based, with referrals to community resources often being passive, aided by the use of leaflets and flyers (Best et al., 2017). As opposed to community-based working, this approach holds limitations and is understood to be less effective. The process of "assertive linkage" (Manning et al., 2012) can help to overcome this, connecting individuals into appropriate resources matched to their needs and interests (Weiss et al., 2000; White, 2006). As outlined by White (2006) the three main aims of assertive linkage are: to aid the initiation of recovery; to connect individuals to others with shared experience, strength and hope; and provide guidance through the recovery journey. Findings from Moos and Moos (2005) identified that 40% of individuals leaving treatment did not engage with recovery orientated support, providing rationale for the need of assertive linkage. More so, Manning and colleagues (2013) found that when individuals from a residential treatment setting were assertively linked into mutual aid meetings, they showed better attendance during and following discharge from treatment and also showed lower levels of substance use at the three-month follow-up point. Being assertively linked into these meetings meant individuals were met by a peer who explained to them the purpose of the meeting; accompanied them to the meeting; and spent time with them afterwards to discuss their engagement.

What are the associated challenges with community engagement?

Within White and Cloud's (2008) conceptualisation of community capital, both forms of capital (community capital and cultural capital) are mutually enforcing and essential to aid recovery. A community may have an abundance of resources which can be utilised however, it is vital to consider how accessible and desirable these resources are to an individual in recovery (Best & Savic, 2015). More so, encouraging community engagement may not be straightforward and integral to this are themes of social inclusion, social integration and social activity (Johnstone & Lane, 2018). To better understand how themes can be promoted within recovery orientated practice it is necessary to pay attention to potential barriers to community engagement.

Within the wider literature which is not recovery specific, barriers to community engagement include illness and disability; loss of contact to social connections; an absence of a supportive community; unavailability of transport (Victor et al., 2005); absence of appropriate social opportunities (Masi et al., 2011; Wilkie et al., 2007); finances (Bukov et al., 2002); confidence and opportunities that support an individual's preferred identity. Such barriers tend to exist at a micro, meso and macro level and the translation of this to recovery literature is supported by Neale and colleagues (2014) who found that access to such resources for women in recovery was dependent on three factors across each of these levels: health (micro), relationships (meso) and housing (macro).

More so, fear of social rejection or losing valued aspects of identity have also been identified as barriers to community engagement (Goll et al., 2010). This may be exacerbated for substance using populations, given the levels of stigmatisation they are known to face (Horsfall et al., 2010; Schomerus et al., 2011; Luoma, 2014; Best et al., 2016). Whilst the role of communities is essential in the process of change associated with recovery, it can have a counteracting effect if levels of stigma and discrimination are high. As stated by Wincup (2016), the stigmatisation faced by substance using women, and the oppressive systems they are more likely to face result in greater difficulty of acquiring community and cultural capital. The same principles can be applied to other sub populations who face issues of marginalisation such as the elderly, youth, ex-offenders or those with mental ill-health. Termed urban marginality by Wacquant (2008), it is these groups who are often distanced from society on a physical, spatial and economic level, as structural barriers to citizenship are more prominent.

Specifically in the context of ABCD, whilst this has brought innovation to the field of community engagement and has gained great popularity over recent years (Mathie & Cunningham, 2003; Foot, 2012; Harrison et al., 2019), such approaches are challenging for those experiencing social exclusion.

This is attributable to stigma, self-exclusion, lack of access, lack of social capital and unclear pathways into positive community groups. Whilst assertive linkage into community resources is a key part of ABCD, the challenges associated with community engagement are not adequately addressed within the current model. Whilst the ABCD approach has been hugely valued by communities, it is argued that it is vague and unsystematic (MacLeod & Emejulu, 2014), giving no direct guidance to those wanting to adopt it. Mapping alone and simply creating a directory of assets offers limited solutions: as stated by Blickem et al. (2018), it lacks methodological clarity. As such, the model has failed to generate empirical questions that have been adequately tested (Collinson & Best, 2019) and must be further developed in order to utilise the models potential for socially excluded populations.

Unless those facing marginalisation can be engaged within their locale, this type of strengths-based work cannot be successfully implemented (Blickhem et al., 2018). If this can however be encouraged, then it is hoped individuals will be more empowered to contribute to community development within their locale. Given that social inclusion is known to reduce health inequalities and support the needs of disadvantaged groups, developing healthy and sustainable communities is essential. This is supported by the World Health Organization (2018) and Marmot et al (2010) who highlight the importance of communities utilising their local assets to maximise health and wellbeing outcomes, providing rationale for the further developing ABCD. More so, it is also argued that the use of ABCD unconsciously privatises public issues such as inequality and power relations (MacLeod & Emejulu, 2014). With this in mind, future research utilising ABCD should focus on the importance of the inclusion and empowerment of socially marginalised groups.

Given the barriers to community engagement that exist for those in recovery, it is important for future research to consider how engagement may be successfully encouraged and supported in practice. Building on the social capital literature, this must also be considered in the context of bonding and bridging capital, with recovery orientated practice seeking to strengthen the levels of bridging capital of those in recovery. When engagement within the locale can be encouraged for those whom assertive linkage is appropriate, then it is not only the individual who will benefit from these “improved pathways” (Best et al., 2017, p. 10) but also communities more broadly. Improvements noted in community wellbeing and cohesion are demonstrated by the ‘sprinkles’ on top of the ice cream (see figure Y). As supported by Christakis and Fowler’s (2010) explanation of hyperdyadic spread – when there is presence and visibility of recovery amongst the lived community, the contagion of such behaviour is strengthened (Best et al., 2015b), and has a residual impact on the community in which it occurs. The effect of this is that the likelihood of subsequent generations of those using substances

initiating and sustaining recovery is improved as individuals will “serve as recovery carriers in their daily interactions with the community” (White, 2010, p. 5).

Alcohol policy

To situate the aforementioned, paying attention to current alcohol policy is necessary. There is a long-standing history of previous tensions between moral, medical and penal ideologies within the development of substance use policy within Britain (Smart, 1984; Berridge, 1999; Mold, 2008). In line with the emergence of the recovery paradigm, the concept of recovery has been seen to shape policy across the UK (HM Government, 2010, 2012, 2017; Northern Ireland Executive, 2011; Scottish Government, 2008, 2018; Welsh Assembly Government, 2008). Whilst dated, the Alcohol Strategy (HM Government, 2012) recognises the importance of ‘supporting individuals to change’ through treatment and recovery pathways. The Drug Strategy (HM Government, 2017) similarly notes the importance of building recovery, albeit only mentions alcohol use briefly. Both strategies do however recognise that the journey of recovery is applicable to a variety of life domains, and in the Drug Strategy (HM Government, 2017), acknowledgement is given to the importance of partnership working and engagement in meaningful activities to support individuals in a more holistic manner.

The Alcohol Strategy (HM Government, 2012) now faces particular pressure given it is nearly 10 years old and whilst a cross-government addiction strategy was promised in 2020 (Conservative Party, 2019), the Conservative Party failed to deliver on this. The most recent development, Dame Carol Black’s Independent Review of Drugs (UK Government, 2021a), does not pay attention to alcohol use either, arguably, failing not only the alcohol recovery community but communities more broadly. As we know, alcohol and its related harms are related to a range of health, social and economic costs (Public Health England, 2016) and there is growing frustration across England at the lack of priority this has been given (Buykx et al., 2018). On a local level, this has perhaps been given more recent attention, with alcohol use outlined as a health and care need (see Sheffield’s joint strategic needs assessment), and the need for readily available and flexible recovery pathways being a key feature of its most recent Alcohol Strategy (2016-2020).

In regard to gender, little attention has been given within substance use policy to the particular needs of women (Wincup, 2016; 2019; Andersson et al., 2020) and thus, despite what is known about the differing experiences of recovery by gender, there is a gap between policy and practice (Collinson & Hall, 2021). Although the latest report of the Commission on Alcohol Harm (Alcohol Health Alliance UK, 2020) does shed light on several of the issues faced by alcohol using women, including children, families, and domestic abuse, there is little acknowledgement of the influence of gender specifically

on these factors. There is now pressure for policy to reflect the experiences and needs of alcohol using women (Wincup, 2016; 2019), to ensure treatment and recovery pathways are responsive. Perhaps the way forward for policy, practice, and research in the field of substance use is to, as Neale et al. (2014, p. 4) states:

“Treat gender as an important structure but simultaneously recognise that it is multidimensional (...) a promising way forward is intersectionality (...) women’s experiences are shaped by gender, in conjunction with other factors (race, class, culture, income, education, age, ability, sexual orientation (...)). An intersectional approach recognises the significance of gender but does not assume that this is the most important axis of experience, power or oppression. Instead, interactions between different aspects of social identity, the impact of systems and processes of oppression and domination, and the multiplicity of lived experiences are emphasized”.

Once outlining the prevalence of alcohol use within England, the literature review turned attention to what is known about how and why people recover. The application of the recovery capital framework underpinned this discussion, with consideration given to what the CHIME model (Leamy et al., 2011) means for recovery orientated practice. Further developing this argument, the ice cream cone model of recovery (Best et al. 2019) (Figure 1.1) was introduced, identifying the role of pro-social networks and community engagement to aid recovery capital growth. This acknowledged current bodies of work, such as ABCD (Kretzmann & McKnight, 1993) whilst remaining mindful of the potential challenges this work faces when applied to recovery populations. Drawing on this knowledge, the thesis now considers the methodological approach which will be undertaken to answer to central research question.

Chapter 3: Methodology

Introduction to chapter

The previous chapter has shown that the concept of recovery capital and what is known so far about its relationship with gender is complex. Although the three domains of recovery capital are independent, their interaction with one another is dynamic. Whilst recovery capital is a predictor of sustained recovery (Laudet & White, 2008; Best & Laudet, 2010; Groshkova et al., 2013), less is known about the gendered parameters of the concept. The current chapter outlines the four research studies undertaken for the thesis which, utilising a mixed methods research design, seek to better understand the interaction between recovery capital and gender. Once the research aims and philosophical position are outlined, each of the four studies are considered in the context of the rationale of the chosen methodology, associated sampling, analysis and ethical considerations. The chapter then finally explores how those with first-hand experience of substance use helped shaped the design of the methods (detailed through Public and Patient Involvement), and how the methods where feasible, were piloted prior to use.

Central and subsidiary research questions

The central research question is: “What is the role of community engagement in developing women’s recovery capital?”, was devised in response to the parameters outlined by the sponsor for the PhD, Alcohol Change UK. From the onset, the main parameters were an inclusion of gender and alcohol use and, following a review of the literature, the scope of the study was refined. Although the review of literature (Chapter 2) identified nuances in how recovery capital changes over time and the influence of gender, the evidence base is somewhat limited. Whilst the importance of engagement in meaningful activities is noted within the literature – the consideration of this engagement in light of the accumulation of recovery capital is lacking, and systematic approaches to mapping such resources could be better developed to aid the uptake of community engagement in recovery orientated practice. In response to this, the subsidiary research questions for the study are as follows:

- 1a. How does each aspect of recovery capital differ by gender at different stages of recovery journeys?
- 1b. Are there different predictors of recovery outcomes by gender?
2. What is the best way to assess recovery resources at the community level?

3a. What are the key components of community capital?

3b. How can we demonstrate the impact of community capital on personal recovery growth?

3b.i. How does the impact of community capital on personal recovery pathways differ by gender?

Research setting: Sheffield Alcohol Support Service

The research partner for the study is a Sheffield based charity, formerly known as Sheffield Alcohol Support Service (SASS). Whilst the service was renamed Project 6 during the completion of the thesis, it is referred to throughout as SASS, given that this is reflective of the time period and geographical location in which the data was collected. SASS is a harm reduction and recovery focused service which offers support to individuals using substances and their families members (Project 6, 2021). Whilst the service now operates across Yorkshire in Keighley, Sheffield and Doncaster, at the time of data collection (when it was formerly known as SASS), their work was solely Sheffield based. At the end of 2018, SASS and Project 6 merged in order to “benefit from cross locality learning and greater financial stability” (Project 6, 2021). At the time of data collection, the community based organisation (given the umbrella term of SASS) comprised of four independent services. These were the Alcohol Recovery Community (ARC) (the setting for the data collection, outlined in detailed below); Families Together¹; Fresh Start² and Waypoint Training³.

The ARC, funded by the National Lottery Community Fund, works closely with statutory and other voluntary sector organisations across the city – in particular, Sheffield Treatment and Recovery Team (START), the statutory single point of access for substance use support. Individuals can access the ARC either through referral (such as from their GP or START) or self-referral. When referred into the service, the ARC work with individuals in recovery from alcohol use by helping them accumulate recovery capital – “the personal, social and community resources that will help an individual move on from addiction” (Project 6, 2021). In order to achieve this, the work of SASS is underpinned by the

¹ Families Together is “a specialist, therapeutic intervention service for families who are facing challenges in meeting the needs of their children”, working with families where there are “child protection concerns regarding the child remaining safely in the family home” (Families Together, 2019). Families Together has now been decommissioned.

² Fresh Start “support mothers who have recently had one or more children accommodated by the local authority to take time out from parenting in order to address their loss, build resilience, increase well-being and develop new skills for future living” (Project 6, 2021)

³ Waypoint Training: “training and facilitation that improves the effectiveness of staff and services working with people” (Project 6, 2021)

five ways to wellbeing (The New Economics Foundation, 2008). The five principles of this work, centred around social relationships, physical activity, awareness, learning and giving, are aimed at enhancing an individual's wellbeing. To aid this process, the ARC runs a timetable of group based activities⁴ seven days a week with the help of recovery peers. By doing so, the service aims to provide “hope, choice and opportunities for adults in or aiming for recovery” (Project 6, 2021). Within the context of the thesis, those who have, or are accessing the ARC, are referred to as ARC members – this terminology is most reflective of the community-based environment fostered through engagement with the service.

In the previous year (2020-2021), the ARC has seen a dramatic increase in those accessing the service, perhaps attributable to increasing levels of alcohol consumption amongst the UK population during the COVID-19 pandemic (Kim et al., 2020; Calina et al., 2021). Trends of engagement over the last five years are as follows:

2020-2021: 544 individuals engaged with the service;

2019-2020: 313 individuals engaged with the service;

2018-2019: 262 individuals engaged with the service;

2017-2018: 298 individuals engaged with the service;

2016-2017: 286 individuals engaged with the service.

Statistics during the last year show that 61% of new referrals to the ARC are male and 39% are female (Project 6, 2021). This however changes when longer-term engagement (defined roughly as 6 – 24 months (see also *Phase 3*, outlined below)) is assessed, with a higher percentage of women (49%) noted. This perhaps signifies that women are more reliant on the service for a longer period, whilst men may either disengage, or potentially make quicker progress and therefore transition into, or back into, employment or other similar activities sooner and thus, have less time to engage with the service. It is this type of engagement which plays a central role in the work of SASS, as outlined below in the four-phase model⁵ their work is founded on:

Phase 1, Engaging with recovery (1 – 2 months): This phase enables the individual to find focus within their recovery and by beginning to connect with others, seeks to create a sense of

⁴ At the time of data collection, the eight main groups offered to ARC members were as follows: Moodmasters, Active Citizenship, Arts and Crafts, Men's group, SASSY ladies, SMART, ladies only SMART and the drop in. The groups are explained in detailed in Appendix 12.

⁵ The timeframes provided are roughly estimations outlined by SASS. Not all phases run consecutively, and there is also overlaps between phases.

hope within the individual. It is within this phase that groups run internally to the service are promoted.

Phase 2, Collective impact (1 – 6 months): This phase encourages people to connect to the ARC community and to embrace personal growth and discovery by engaging in new activities. By doing so, this phase aims to contribute to a growth in confidence and introducing positive experiences into ones' life.

Phase 3, Better than well (6 – 24 months): This phase seeks to help the individual progress in their recovery journey by offering a range of training and volunteering opportunities within the ARC. Training is offered to volunteers as part of this.

Phase 4, Employment and life chances (6 months onwards): This phase emphasises a progression pathway to support people outside their recovery. ARC members are encouraged to access training, higher education, work placements and employment when they feel ready to do so.

Acknowledging that recovery is an individualised journey, there is no prescribed time for the individual to progress within the four phases. It is important to outline this model however, in light of the current thesis, given the potential of these phases to contribute to the accumulation of recovery capital. This model also recognises the value of community engagement, an important aspect of recovery trajectories noted in the review of literature (see *Chapter 2*), albeit a heavy focus is on returning to the workforce which, as the literature shows (see also *Chapter 2*), may not be a feasible outcome for all individuals. While these four phases have evolved within the service during the course of the thesis, there has been an emphasis within the ARC on increasing an individual's sense of 'active citizenship' throughout this process. This is intrinsically linked to community engagement, given that if an individual makes progress with their recovery journey and is thus actively participating in activities which suit their own skills and interests (as seen in Phases 2-4), feelings of 'active citizenship' will likely be improved. This feeds into the design of Study 2, as explained in greater detail below.

The findings of the current thesis, particularly assessing differences by gender and the impact of community engagement on recovery pathways, will be valuable in shaping any future developments in the model which ARC is founded on.

Research design

Carried out in partnership with the ARC at SASS, the research utilises one secondary data source and three primary data sources. While subsequent sections of this chapter will break each of these data

sources down in detail, following an overview of the research strategy, associated philosophy and ethical considerations, an outline of each of these, defined as ‘Study 1’, ‘Study 2’, ‘Study 3’ and ‘Study 4’ is provided below for contextual purposes:

Study 1: Secondary analysis of existing data collected by SASS using a user-friendly version of the Assessment of Recovery Capital, developed by SASS staff;

Study 2: Prospective analysis of change, using the REC-CAP, in a cohort of individuals new to service to assess patterns of recovery capital change (tracked over two phases: baseline (Time 1) and six months (Time 2)), mediated by community engagement;

Study 3: Asset mapping using the Asset Based Community Engagement workbook to assess individuals’ active engagement with community resources;

Study 4: Reflective interviews with women to explore changes in REC-CAP scores and levels of community engagement.

Research strategy

Across the four studies, both quantitative and qualitative research strategies are utilised, resulting in a mixed methods design. Such designs field the dichotomy between quantitative and qualitative strategies and thus, enable researchers to answer “multifaceted questions by seeking multiple, multi-layered answers” (Teddlie & Tashakkori., 2015, p.615). Although mixed method designs have gained popularity (Onwuegbuzie et al., 2013) they should only be used if both strategies add understanding to the overall research question. While the two strategies have been used alone within social science research, research combining the two has commonly been implemented within addiction recovery studies (VanDeMark, 2007; Bliuc et al., 2017; Carroll, 2020), demonstrating its applicability to the field.

Teddlie and colleagues’ (2015) research highlights that there are three main beliefs which determine the extent to which qualitative and quantitative research strategies can be combined. The first of their belief posits that whilst quantitative and qualitative research strategies are distinct in nature, mixed methods designs must endeavour to build a bridge between the two. By doing so, both strategies must “add explanation and understanding” to the overarching research question (Teddlie & Tashakkori, 2015, p. 619). Whilst the two strategies may sit independently, either conducted sequentially (→) or simultaneously (+) to one another, they must be brought together during and/ or after the research study. If the research studies are carried out in chronological order, the design is sequential (→), and

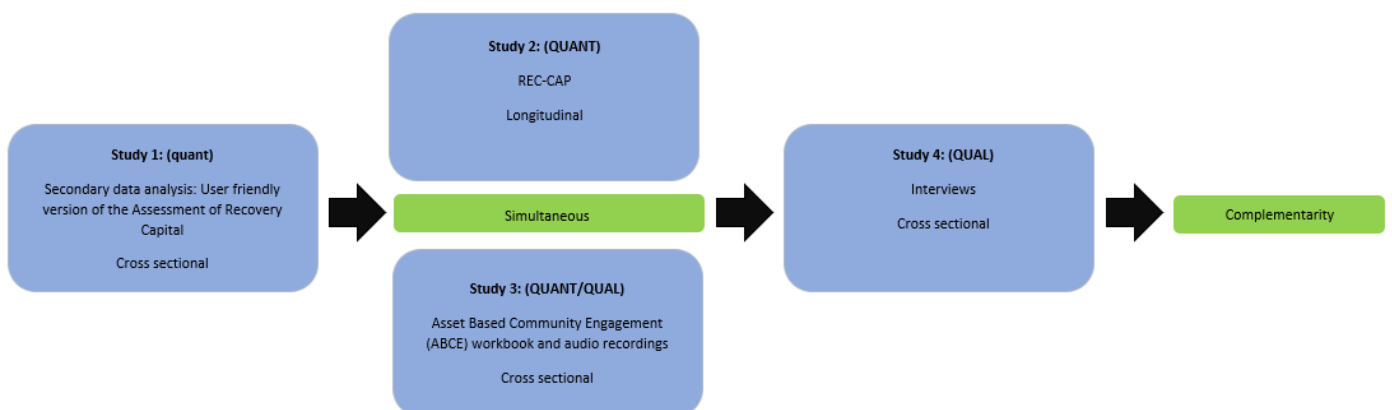
each aspect of the study tends to inform the next. Simultaneously studies (+) however are carried out in parallel with one another, within a similar time frame.

The second of their beliefs emphasises the need for the researcher to outline whether the quantitative or qualitative strategy is dominant, or if they are of equal priority (Teddlie & Tashakkori, 2015). Combined with the first belief, this is done using the mixed methods notation outlined by Morse (1991; 2003). Within this, researchers use upper-case letters to signify the dominant strategy. For example, QUANT + qual signifies a quantitatively driven study, conducted simultaneously (+) with a qualitative component. The opposing strategy (in the example given, the qualitative), must however add value to the overall research. The current study uses the following notation:

quant → QUANT + [QUANT+QUAL] → QUAL } →

The notation shows each of the four studies, with Study 1 (the secondary data analysis), being of least importance. Its inclusion within the research did however influence the planning of the following three studies, highlighting its added value. The role of Study 1 and its influence on the wider thesis is detailed below (see *Study 1: Rationale and method*). The notation is also demonstrated in the visualisation below (Figure 1), with more detail associated with the studies provided:

Figure 2.1. Visualisation of research strategy and design



As Figure 2.1 demonstrates, the project utilises both a sequential and simultaneous approach. That is, that Study 2 and 3 are carried out simultaneously to each one another, but sequentially to Study 1 and 4. Following the completion of all four studies, complementarity will be used to create the meta-inferences between the results. This means that the study findings and associated methods will be elaborated and clarified from one with that of another (Molina-Azorin, 2016).

Teddle and colleagues' (2015) final belief seeks to remove the previous dichotomy experienced between the two strategies by positing that differentiation between the two is not necessarily needed. Instead, the inquiry of the study should be guided by the research question instead of the paradigm. With this in mind, it is necessary to include multiple perspectives within the study and the methodology must be selected based on what is needed to provide the best answer(s) to the central research question. As such, the researcher was guided by choosing the appropriate methodology for each of the studies based on wanting to robustly answer the central and subsidiary research questions.

Research philosophy

Following the consideration of the research strategy, attention must be paid to the associated research philosophies. As highlighted by Lincoln and Guba (1985), there are distinct areas of contrast between the two opposing research paradigms (the beliefs by which our actions are guided by: Denzin & Lincoln, 2005), which are often attributed to the dichotomy between the two research strategies. When considering the research philosophy, it is important to consider the epistemological and ontological positions associated with quantitative and qualitative research strategies, before considering how these fields are brought together in mixed methods research.

Epistemology is concerned with what is understood as acceptable knowledge and acts as a crucial foundation for research (Willis, 2007; Benton & Craib, 2010), questioning whether the same principles can be used to study both natural and social sciences (Bryman, 2012). Ontology however is concerned with the nature of reality and what is believed to exist (Goertz & Mahoney, 2012). Differences are however noted between the associated epistemology and ontology of qualitative and quantitative research strategies, given their opposing approaches to data collection and analysis. Put simply, where quantitative data is associated with the quantification of phenomena and statistical analysis, qualitative data is non-numerical and typically collected through methods such as interviews, observations and focus groups, and is therefore based on foundations of subjectivity.

Qualitative approaches are therefore most commonly aligned with the epistemological position of interpretivism and ontological position of constructionism (Blieker et al., 2019; Williams et al., 2019). The result of this is that social phenomena, such as addiction recovery, are perceived as not being beyond our influence and are viewed through a particular social lens of interpretation. Our understanding is therefore produced through social interactions and is continually revised, as opposed to remaining stable. Quantitative approaches are however most commonly aligned with the epistemological position of positivism and ontological position of objectivism. Objectivism

comparatively views social phenomena as external facts which are in fact beyond our influence (Bryman, 2012).

Over recent years, elements of both of these approaches have emerged within addiction recovery research. In the context of the current study, the researcher adopted a pragmatic approach: being guided instead about what works best in practice. With this in mind, it was most appropriate to choose methods based on their appropriateness to answer the research questions. Pragmatism as an epistemological belief acknowledges the strengths of both research strategies and enables the researcher to adopt flexibility and creativity in the methodology chosen. Supporting the multifaceted view that knowledge “is both constructed and based on the reality of the world we experience and live in” (Onwuegbuize et al., 2009, p.122), its use is particularly advantageous in the thesis as the quantitative data measures concrete aspects of recovery (e.g. recovery capital) whilst also capturing the narratives of those in recovery. Given the work of Deegan (1988) emphasises that recovery is a personal and unique experience, a mixed methods approach in this instance enabled the voices and experiences of those who are impacted by the research to be centralised.

Most commonly used in parallel with pragmatism is the ontological position of multiple realities – emphasising the value of understanding and exploring the social world from different perspectives. To achieve this, the research seeks to document experiences of recovery; the accumulation of recovery capital; and experiences of community engagement from a range of perspectives. That is not to say these perspectives will be the same, but instead recognises the added value of each one.

As a result of the associated philosophical position, the current study is underpinned by an abductive mode of inquiry. Opposed to inductive or deductive modes of inquiry where the use or development of theory is achieved through either a top down or bottom up approach, abductive approaches shift between the two – enabling the researcher to use prior knowledge or primary findings to be further examined throughout the research, to then devise supplementary knowledge (Charmaz, 2009).

A four-part mixed methods design: The studies

Underpinned by pragmatism, the research comprises a mixed methods design, utilising four independent studies (as outlined in Figure 1). Each of these seek to build on one another in a complementary manner, whilst adding value in light of the central research question. Below, details of each of the four studies are given, with attention paid specifically to the rationale and method, sampling and analysis.

Study 1: Secondary analysis

Rationale and method

Study 1 consists of the secondary analysis of quantitative data collected by SASS. Individuals new to the ARC were required to complete a user friendly version of the Assessment of Recovery Capital (Groshkova et al., 2012) (see Appendix 1) at three time points (entry to the service; four weeks after engagement; and 12 weeks after engagement). This user friendly measure was amended from the original Assessment of Recovery Capital based on the feedback from ARC members and staff and enabled the service to gain a baseline understanding of an individual's level of recovery capital and any appropriate support which may have been required to aid the accumulation of recovery capital.

Once the secondary data was reviewed by the researcher, it became apparent that its usability was limited as specific variables across the data set were missing or incomplete. Key information such as gender was missing in many of the remaining cases and therefore, could not be used in the analysis, given the centrality of this variable in light of the research question. The incompleteness of the data can perhaps be attributable to the nature of voluntary organisations collecting and monitoring their own data, which may be seen as resource intensive for staff and thus, leads to errors in data collection.

Since its development in 2012, limitations of the Assessment of Recovery Capital (Groshkova et al., 2012) as a standalone measure have also been raised, given that it does not accurately account for community capital (Cano et al., 2017). As community capital is a key component of recovery capital (Best et al., 2016), and central to the thesis, it is essential that measures which seek to assess recovery capital are in factor holistic, strengths based, and have practical application as to support recovery care planning (Cano et al., 2017). Subsequently, Study 1 (as shown in the notation: see Figure 2.1) is not classified as a dominant research component (as defined by Teddlie & Tashakkori, 2015), but instead is key to laying the foundations for the primary research components to build upon. Study 1 therefore takes the form of being exploratory and the rationale for inclusion of this data was to provide context to the overall thesis and to assess the feasibility of recovery capital measurement with this population.

Whilst the findings of this study may be limited due to the nature of the measure, it is intended to provide a baseline understanding for if engagement with SASS contributes to the accumulation of recovery capital, and if any nuances are noted among the cohort in light of gender. This is important to explore, given that previous research has highlighted that such engagement (albeit specific to recovery residences) provides individuals with the opportunity for recovery growth through the opportunities it provides to engage with meaningful activities and thus, develop a new sense of self and identify (Burrow & Hill, 2011; Cano et al., 2017). Given that the Assessment of Recovery Capital

is intended to be recovery capital specific, it provides a foundation for the following studies to be built upon.

Sampling

As Study 1 utilises secondary data, the original sample was not determined by the researcher. All new ARC members who entered the service between 2016 and 2017 were however required to complete the user friendly version of the Assessment of Recovery Capital and thus, the sample should accurately represent those accessing the service during this time period. The limitation to this however lies with the data set being in some instances, incomplete (as detailed above).

Analysis

Given that data was collected from ARC members, where feasible, at three time points, Study 1 utilises a longitudinal design. This is particularly useful to help assess change over time and the use of this data is intended to provide a foundation for the subsequent studies to build upon. The following statistical analysis⁶ will be undertaken for Study 1, with gender differences assessed at each stage:

- 1) Reporting of Time 1 data including descriptive statistics, and bi-variate analysis including correlations;
- 2) Analysis of differences with those who retained in the cohort at Time 2 and those who were not, to assess the representativeness of the retained cohort;
- 3) Reporting of Time 2 data including descriptive statistics, and bi-variate analysis including correlations;
- 4) Analysis of differences with those who retained in the cohort at Time 3 and those who were not, to assess the representativeness of the retained cohort;
- 5) Reporting of Time 3 data including descriptive statistics, and bi-variate analysis including correlations;
- 6) Reporting of change through the use of repeated measures analyses of variance (RMANOVAs) and repeated measures t-tests.

⁶ See the presentation of data from Study 1 (Chapter 4) for an outline of which research questions the data is analysed in light of.

Study 2: REC-CAP

Rationale and method

Due to the limited use of the data and measure within Study 1, it was, in line with central and subsidiary research questions, essential to choose a measure which more accurately assessed recovery capital (including community capital). Doing so would allow a prospective analysis of change to be conducted, whilst identifying potential differences between genders. Study 2 therefore consisted of the completion of the REC-CAP (Best et al., 2016) (see Appendix 2) by new ARC members across two time points (entry to the service and six months after engagement). This study therefore utilises a longitudinal quantitative research design, and the follow up time point of six months was selected based on the feasibility of data collection, following discussions with the staffing team at SASS.

The REC-CAP is a psychometrically validated measure which in its development, sought to advance the Assessment of Recovery Capital (ARC) (Groshkova et al., 2013). The table below provides a breakdown of the data collected within the REC-CAP, as well as detailing where each of these measures has been sourced from. As demonstrated, additional measures are included alongside the ARC, subsequently building on this earlier work. Since the development of the REC-CAP, it has been approved for use in several overall studies (see for example the evaluation of Double Impact, 2019; Hall, 2019; Odyssey, 2021). The REC-CAP is a strengths based measure which encapsulates key elements of personal, social and community capital. By doing so, it translates this into a summary of recovery strengths and potential associated barriers that can be used to support an individual’s recovery planning (Best et al., 2016). This provides added value to the REC-CAP, given its ability to support recovery planning.

Table 2.1: An overview of the REC-CAP and its measures

Scales included in the REC-CAP	Measure	Original source of measure
Demographic information	Age	
	Gender	
	Ethnicity	
	Time in residence	
	Meaningful activities	Adapted from the Treatment Outcome Profile (TOP; Delgadillo et al., 2013),

Barriers to recovery	Accommodation risk	Adapted from the Treatment Outcome Profile (TOP; Delgadillo et al., 2013),
	Substance use in the past 90 days	
	Any risk taking e.g. drug injecting	
	Involvement with the criminal justice system	
	Lack of meaningful activities	
Service involvement and needs	Service involvement	Developed for the REC-CAP
	Satisfaction with the service	
	Unmet needs	
Recovery capital	Personal	50-item Assessment of Recovery Capital (ARC; Groshkova et al., 2013)
	Social	
Involvement in recovery groups and the local community	Recovery participation	Recovery group participation scale (RGPS) (Groshkova et al., 2011)
Commitment to sobriety scale	Sobriety scale	Kelly and Greene (2014)
Social support	Social support scale	Jetten et al. (2012)
Wellbeing rulers	Perceived quality of life and satisfaction	Adapted from the World Health Organization's quality of life assessment (WHOQOL-BREF; Skevington et al., 2004)

By capturing the following data, the REC-CAP has become a systematic and simple way of quantifying recovery capital that can be used to chart progress as an individual proceeds in their recovery journey. As shown in Table 2.1, whilst the REC-CAP enables individuals to document involvement with recovery groups and the local community (otherwise seen as its measure of community capital), it does not provide individuals with the opportunity to map which community resources they are currently engaged with, or the form this engagement takes. The REC-CAP did not intend to do this but given that the review of literature (Chapter 2) highlights the importance of community engagement to aid

community capital growth, the REC-CAP was amended in this instance to reflect this need. Whilst it is acknowledged that the amendments to the measure were not psychometrically tested or validated, this was instead intended to be included as an exploratory element to better understand the impact of community capital (and community engagement) on recovery pathways. Amendments to the REC-CAP (see Appendix 2, *Section 7: Part 2*) provided individuals with space to document their current levels of community engagement. This was twofold, detailing engagement internal and external to SASS. Whilst the exploration of internal engagement is specific in this instance to SASS, it could be tailored to other recovery orientated support services if needed. When mapping internal engagement, individuals were required to detail which groups they were attending and the frequency of this engagement. This was identified as being important given that the identification with groups is thought to have lasting implications for the development of social identities (Tajfel & Turner, 1979; Jetten et al., 2012). Thus, it can be presumed that the more an individual may engage with a group, the stronger the levels of bonding capital between group members becomes (Putnam, 2000). Resultantly, levels of social support will be enhanced with resulting implications of the development of social capital.

The latter half of the amendments looked at external engagement and perceptions of engagement. The focus on perceptions of engagement was linked to the emphasis on increasing a sense of ‘active citizenship’ through engagement with the ARC. To ensure consistency, this was also replicated within Study 3, given that the samples for these two studies differed. In brief, Study 2 utilised a purposive sample with only those new to the service being invited to participate. Study 3 however (outlined in more detail in the next section) utilised a convenience sample and was open to participation by any ARC member. Intricate details of the measure added to the REC-CAP are therefore given in the next section (see Study 3: Rationale and method).

Sampling

When the planning for the research was undertaken (2017), estimates showed 298 individuals were accessing the ARC. Following initial engagement, approximately 120 of these individuals remained in contact with the service. Using these statistics, a power analysis was carried out. This is an important aspect of experimental research designs as it allows the researcher to determine the sample size required to detect an effect of a given size with a given degree of confidence (Cohen, 1988). In this context, the power analysis showed that data needed to be gathered from 67 out of the 120 individuals to result in an ‘acceptable’ margin of error, with a necessary 95% confidence level. Gathering data from this number of ARC members would therefore enable the analysis to detect a between groups difference based on gender. With this in mind, Study 2 aimed to collect Time 1 data from 100

individuals, with a response rate of approximately 70% intended for the completion of Time 2 REC-CAPs. Whilst a gender split of 50/50 would be the ideal, it was likely that the split of Study 2 would reflect that of the referrals into SASS (61% men: 39% women).

Upon entry to the ARC and following introductions with ARC staff, all individuals were invited by staff to participate in the study. For those who showed interest in participating and consented to staff passing on their contact details to the researcher, contact was made within five days. Following an explanation of the study, if individuals were still interested, a meeting with the researcher was scheduled. Ensuring flexibility within this approach was essential, allowing individuals to meet where they felt most comfortable (whether that be at SASS or other public spaces across the city) and at a time of day (between 9am and 7pm) best suited to themselves to work around potential commitments such as employment or childcare. Where access was challenging, individuals were given the option of receiving the REC-CAP in the post with a pre-paid envelope to return to the researcher. The researcher was mindful that meeting face to face would have allowed for rapport to be built between the two parties and would also allow for questions to be asked throughout the process if required. With this in mind, for those wanting to receive the REC-CAP by post, they were also given the option to speak with the researcher on the phone prior to, during and/or following completion, should they have wanted to.

Contact was made with all of those who completed Time 1 REC-CAPs five months later in order to schedule the completion of Time 2 REC-CAPs, at the six month time point. It was hoped that these would be completed by individuals who were both still engaged, or not engaged, with the ARC at this time point. Due to the longitudinal commitment of Study 2, individuals were given a £10 shopping voucher following completion of both REC-CAPs. Although it was not feasible for this to be a direct reimbursement (for example, for travel expenses), this was a way for the researcher to thank individuals for their contribution to the study.

Analysis

When implemented within a longitudinal design, the REC-CAP is a particularly useful tool to map change over time (Cano et al., 2017) and by doing so, factors which may help or hinder the process of recovery can be identified. This study is also the first UK study (Cano et al., 2017, was based on data from Florida, USA), which will utilise the REC-CAP to assess gender differences in pathways to recovery, emphasising the originality of the study.

The following statistical analysis⁷ will be undertaken for Study 2, with gender differences assessed at each stage:

- 1) Reporting of Time 1 data including descriptive statistics, and bi-variate analysis including one way analysis of variance, correlations and regressions;
- 2) Analysis of differences with those who retained in the cohort at Time 2 and those who were not, to assess the representativeness of the retained cohort;
- 3) Reporting of Time 2 data including descriptive statistics, and bi-variate analysis including one way analysis of variance, correlations and regressions;
- 4) Reporting of change through the use of repeated measures analyses of variance (RMANOVAs) and repeated measures t-tests.

Study 3: Asset based community engagement

Rationale and method

Study 3, conducted simultaneously to Study 2, utilised a within-study mixed methods, cross-sectional design. Developed for the purpose of the thesis, the Asset Based Community Engagement (ABCE) framework (see Appendix 3) and associated workbook (see Appendix 4) formed the basis of this study. The ABCE workbook was developed alongside Sheffield Addiction Recovery Research Panel (ShARRP), a public and patient involvement panel, and piloted with ARC members prior to use to strengthen its validity. An overview of this involvement is provided later in this chapter (see *Public and Patient Involvement: Study 2*).

ARC members completed the associated ABCE workbook (forming the quantitative data component) whilst the conversations had with the researcher were recorded (forming the qualitative data component). The audio recordings were intended to provide further detail to the stages outlined below, allowing the researcher to better understand key factors which could underpin or undermine the process of community engagement.

Detail is now provided of the rationale behind the development of the ABCE framework and workbook, and its value within the current thesis, before the sampling technique and proposed approach to analysis is outlined. This seeks to add richness to the data collected within Study 2, as well as adding a developmental component to the research. The rationale for doing so is twofold: whilst the REC-CAP allows for community capital to be assessed, its focus is predominately on engagement

⁷ See the presentation of data from Study 2 (Chapter 5) for an outline of which research questions the data is analysed in light of

with recovery-based resources. Although this is immensely valuable for recovery growth, engagement in wider community resources offers important support for longer term recovery. With this in mind, Study 3 firstly sought to provide a space in which individuals could reflect on their current levels of community engagement and perceptions of engagement. This was done using the same measure also added to the REC-CAP, thus, providing an element of continuity between Study 2 and Study 3 (refer back to *Study 2: REC-CAP, Rationale and method*, for more detail). Secondly, whilst the mobilisation of community resources is a critical component of community development (as identified in the Asset Based Community Development literature, see Kretzmann & McKnight, 1993), systematic approaches to mapping community resources (particularly for specific and excluded populations) are in fact limited. Thus, Study 3 sought to address the identified gaps by creating a practical and systematic tool to mapping community resources (the ABCE workbook), whilst identifying the impact of community engagement on recovery pathways. This systematic approach to promoting recovery through engagement with community assets endeavours to eliminate the ‘blind spot’ of ABCD. It does so in a way which is attentive to the challenges associated with ABCD (see *Chapter 2: What are the associated challenges with community engagement?*) and adds to the empirical evidence base in this area.

The ABCE framework has a particular focus on the inclusion of marginalised populations, which is built on a six-stage model. Each of these stages is part of a dyadic process – one which is reliant on both the individual in recovery and in this particular instance, the researcher. Outside of its use in this research context, it is anticipated the second person would be the individual’s recovery worker (or in the context of SASS, ARC staff). An outline of Stages 1-4 is outlined below, as these are integral to the method itself and associated ABCE workbook. Stages 5 and 6 however are more widely related to the ABCE framework and its intended use within recovery practice and thus, are referred to in greater depth when discussing its practical application (see *Chapter 8: Discussion*). Whilst an overview of the method is given below, more detail on the development of this can be read in the associated paper published by Collinson and Best (2019) (see Appendix 3).

1. Identify current levels of community engagement through asset mapping

The first stage of the framework encourages individuals to list any assets they are currently engaged with, this is done in the ABCE workbook. Assets could be either recovery-orientated (e.g. a SMART group) or non-recovery-orientated (e.g. a gym class) and are mapped over the following four domains: peers and mutual aid; sports, recreation and arts; professional services and education, employment and

training. These domains are specific to the recovery context in this instance and influenced by previous literature (see *Chapter 2* and Collinson & Best, 2019). Within the ABCE workbook, one page is designated to each of these domains.

As opposed to the asset mapping process outlined in the ABCD literature (Kretzmann & McKnight, 1993) which encourages communities to collectively map their assets, the mapping process outlined in the ABCE framework is person centered and thus, supports this stage of data collection being undertaken on a one-to-one basis. This stage of the process also takes influence from the SIM tool (see also *Chapter 2: A symbiosis of recovery capital: The ice cream cone*) (Figure 1.1) however builds on this by not only aiming to identify levels of social capital but provide a clearer understanding of community capital too. It can be presumed that those who list more assets, evidencing a level of connection to their community, will possess higher levels of community capital.

2. Exploration of assets

Once assets have been mapped, the strengths and limitations of these are next explored within the workbook, and assets are rated by those who have mapped them, over the following categories: affordability, accessibility (location and transport links), connectedness and social networks. The rationale for these categories is based on previous literature (see *Chapter 2: Literature review*, and Collinson & Best, 2019).

Each asset is explored using a traffic light system, with individuals rating assets green, amber or red. This system for example would indicate if an asset was ‘very accessible’ (green), ‘fairly accessible’ (amber), or ‘not accessible’ (red). The rationale for this method was determined by ShARRP and is referred to again later in the chapter (see *Public and Patient Involvement: Study 2*). Although this approach can be seen as being subjective, its simplicity makes it understandable and easy to interpret by the individual and implemented within practice.

3. Explore the personal interests of the individual

Once current levels of engagement have been identified (Stage 1) and these assets have been explored in greater detail (Stage 2), the next stage seeks to explore the individual’s interests and skills by asking them if there are other groups they would like to attend, and if so, what these groups are. This is both person-centred and strengths-based, as it looks to support the individual to engage in new meaningful

activities, if desired. For those early in recovery this process provides a sense of empowerment, allowing individuals to reflect on their personal interests and previous passions.

4. Identifying barriers to community engagement

If wider engagement is to be supported and encouraged (as explored in Stage 3), it is important to recognise that barriers to community engagement may exist. Acknowledging barriers to engagement at a micro, meso and macro level, is a unique aspect of ABCE and the list of barriers incorporated in the ABCE workbook is based on existing literature (see *Chapter 2: What are the associated challenges with community engagement?*).

Whilst in the context of the thesis, stages 1-4 are used for research purposes, it is hoped that if the ABCE framework and workbook are used within recovery-orientated practice, these stages will also support the recovery worker to build bridges into new community resources which are suited to the interests of the individual and mindful of their personal circumstances (such as their current levels of engagement; willingness to engage in other groups; and barriers to engagement). It is this element of the ABCE framework, as well as Stage 5 (Highlighting the role of assertive linkage) and Stage 6 (Assertive linkage and community engagement) which are described in greater depth in the associated paper (Collinson & Best, 2019). As they are not methods based, Stages 5 and 6 are not outlined here but instead, are returned to within the discussion of the thesis (see *Chapter 8*) in light of the practical implications of the research.

This is the first time the REC-CAP has been combined with a supplementary asset mapping technique, offering a novel component to the research and allowing greater potential for meta-inferences between these studies.

Sampling

It was anticipated that 30 individuals would complete the ABCE workbook whilst the conversations had with the researcher were audio recorded. This was based on a convenience sample, with individuals recruited based on their availability on the days that the researcher was on site at SASS. It was anticipated that the data would be collected over a time frame of ten working days, with three people completing the workbook per day (one in the morning; one at midday and one in the afternoon). This would provide the researcher the opportunity to spend time with each individual on a one to one basis to talk through the research, and it was deemed inappropriate to collect this data in a focus group setting as this would take away from the researcher and ‘participant’ (ARC member) interaction which

was deemed to be an integral part of the data collection. The planned ten days of data collection for this particular study were spread over a one months' time frame, with data collected on each day of the week. It was hoped that this would allow the researcher to capture a range of ARC members, which would attend SASS on different days depending on which groups they were attending.

While this sampling technique can be critiqued due to its representativeness, this was the most feasible and practical means of recruitment in this context. Adopting this sampling technique allowed ARC members at any stage of their recovery journey to participate, and the length of which they had engaged with SASS for was documented in the workbook. Given the practicalities of the sampling, those who were available on the days the researcher was at the service, and willing to participate, were included in the cohort. While a larger sample would have strengthened the robustness of the findings, this was determined by what was practically possible and was seen as a way to both pilot the ABCE workbook in practice and see if its application gained traction – both practically and empirically.

Analysis

The data collected from the ABCE workbooks and the audio recordings which were collected alongside of these were subject to the following analysis⁸, with gender differences assessed where feasible. There are three main data sources associated with Study 3, each of which are their own unique entity. These include:

- 1) Quantitative data collected within the ABCE workbooks;
- 2) Visualisations associated with the quantitative data;
- 3) Audio recordings collected whilst the ABCE workbooks were completed.

Further detail is now provided to each of the three data sources, with an overview of the specific analysis which will be run, and their application to the wider thesis.

Quantitative data

Data from the workbooks will be inputted into SPSS and the assets listed, as well as the user ratings given to these, will be quantified. The following statistical analysis will then be undertaken:

- 1) Report of descriptive statistics;

⁸ See the presentation of data from Study 3 (Chapter 6) for an outline of which research questions the data is analysed in light of

- 2) Bivariate analysis including correlations;
- 3) Independent samples t-test to identify gender differences.

Visualisations

As yet, there has been no attempt to visually map the community resources within Sheffield for recovery populations. Whilst a directory of what is available in Sheffield can be found online (see Sheffield's Mental Health Guide), the mapping technique implemented within the research adopts a more systematic and creative approach to this work. This data source will provide a visualisation of the assets identified within the ABCE workbook, and will be undertaken using QGIS, a mapping software. The coordinates of each asset will be mapped onto boundary data of Sheffield before a qualitative account of the map is provided. This will be presented alongside the user ratings given to each asset (as detailed in *Stage 2: Exploration of assets*).

Audio recordings

The final data source is qualitative, and conversations had with the researcher during the completion of the ABCE workbooks are to be audio recorded and transcribed verbatim. These are not perceived to be interviews as such, but instead are intended to document the conversations to add richness to the quantitative data and visualisations associated with this data. It was presumed that whilst individuals mapped the assets they were engaged with, they would likely have conversations about this engagement with the researcher. These conversations sought to add qualitative detail to the four stages associated with the ABCE framework (see the previous section, *Study 3: Rationale and method*).

Once transcribed, these were analysed using NVivo 11 to assess the impact of community engagement on recovery pathways. Braun and Clarke (2006) explain that the process of thematic analysis offers a manageable and theoretically adaptable approach to analysing qualitative data. Within the context of the thesis, this form of analysis allows for themes to be identified within the data – drawing similarities between the documented experiences. Whilst it is recognised that this analytical method offers great flexibility as articulating themes allows for different perspectives to be drawn upon (Braun & Clarke, 2006), it must be acknowledged that this approach unavoidably involves subjective choices. This is particularly challenging where the researcher does not have access to multiple persons to code the data with, and thus, documenting the choices associated with the coding process is important.

Study 4: Interviews

Rationale and method

Whilst Study 2 explores the accumulation of recovery capital and Study 3 explores the impact of community engagement on recovery pathways, it is important to explore the relationship between these overlapping but separate entities. Study 4 therefore seeks to do so, by providing women who have participated in the previous components of the research the opportunity to discuss their recovery journeys in a reflective manner. Given the focus on gender throughout the thesis, and the frequency of previous work in the field often being male dominated, Study 4 sought to provide a platform for the women within the study to give voice to their experiences and thus, hoped to instil feelings of empowerment for the women through the opportunity to document their narratives. That is not to disregard the experiences of males, but to better understand some of the differences between men and women which may be identified within Study 1, 2 and 3.

To aid this process, a semi-structured interview schedule was devised (see Appendix 5). Semi-structured interviews are particularly advantageous when they seek to explore particular themes (Bold, 2011) and are a validated approach to documenting experiences (Squire, 2008). The interview schedule was constructed in three stages: life narration and background; discussion of recovery capital and community engagement scores (taken from Study 2); and reflection on the noted changes and moving forward. The first stage, life narration and background, was deemed to be essential, given that the context in which women begin to use substance may resultantly influence their recovery trajectories. Adopting a semi-structured approach would allow for women to disclose as much or as little information as they felt comfortable to do so. Following this, women will be presented with their completed Time 1 and Time 2 REC-CAPs before discussing any changes identified with the researcher in a reflective manner. To ensure the interviews are strengths based, the interview schedule concludes with questions about moving forward in their recovery journeys. This provides women a space to discuss their future goals and aspirations, and achievements to date.

Sampling

Due to the nature of this study, it was anticipated that four women would be interviewed. The rationale for this was twofold: firstly, this was deemed to be most feasible by the researcher as it was anticipated that the interviews may be labour intensive, given the nature of their purpose. Secondly, including four interviews aligned with the method adopted, as now outlined. Individuals were to be selected from a purposive sample, dependent on their recovery capital scores and levels of community engagement. This was to be determined by plotting the scores for these two variables on a scatter graph and splitting

this into quartiles, with one woman from each quartile, chosen at random, being asked to participate in an interview. The quartiles were as follows: high recovery capital/ high community engagement; high recovery capital/ low community engagement; low recovery capital/ high community engagement; low recovery capital/ low community engagement.

It is hoped that this approach will allow similarities and differences to be drawn between the data, reflective of the quartiles in which the women are placed within. For example, as the literature highlights engagement in meaningful activities aids the accumulation of recovery capital (Best et al., 2017; Collinson & Best, 2019), it can be presumed that other aspects of an individual’s life may compensate for community engagement if recovery capital scores are high, but community engagement scores remain low. It may also help to identify what supports may need to be put in place to best encourage recovery growth, particularly for those with either low community engagement and/or low recovery capital.

Analysis

The interviews will be transcribed verbatim and thematically analysed⁹ using NVivo 11. This follows the same thematic approach utilised for Study 3 (see *Study 3: Analysis*). This data will however be presented in case study format, albeit still analysed in light of the three domains of recovery capital to ensure consistency with the earlier thematic analysis (Study 3).

Study summary

The table below summarises the four studies which are to be undertaken for the thesis.

Table 2.2: An overview the four research studies

Study	Study 1	Study 2	Study 3	Study 4
Strategy and priority	quant	QUANT	QUANT + QUAL	QUAL
Method	Secondary analysis	REC CAP	Asset mapping	Interviews

⁹ See the presentation of data from Study 4 (Chapter 7) for an outline of which research questions the data is analysed in light of

Analysis software	SPSS	SPSS	NVivo and SPSS	NVivo
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Ethical and practical considerations

Within each of the four studies, it is essential that ethical and practical considerations are considered throughout. This section of the chapter details how the research will abide to good ethical practice and considers how each of the studies will comply with the relevant data management requirements. Ethical approval for the study was received from Sheffield Hallam University¹⁰ (see Appendix 6).

Avoiding Harm

Due to the potential vulnerability of those accessing SASS, the researcher holds a duty of care to act responsibly and sensitively to minimise any risk of harm. Denscombe’s work (2017) considers five key principles in relation to avoiding harm. These are now outlined in consideration of the research undertaken for the thesis:.

1. *Prevent physical harm.* The physical safety of those engaged with the research and the researcher must be considered throughout. Where feasible, data will be conducted onsite at SASS with ARC staff to hand, should individuals want to speak to a member of staff following their participation. Where this is not possible, it will be reiterated to individuals that should they require support, they are able to contact SASS or external support by phone. For those who cannot meet at SASS, they will instead be met by the researcher in public spaces, such as cafes and libraries. The collection of data will take place between 9am and 7pm, with an external party known to the researcher being informed of their whereabouts. It is also considered that to prevent physical harm, those involved in the research should not face “physical retribution from those they may discuss during the research” (Heap & Waters, 2018, p. 48). No information disclosed to the researcher is to be shared with any third parties and thorough debriefing following participation will minimize any potential risk of harm.

2. *Avoid psychological harm.* Due to the vulnerability of those accessing SASS, and the nature of the study, it was noted that, at times, the research may address areas of sensitivity. The use of information sheets (see Appendices 7, 8 and 9) and consent forms (see Appendix 10) ensure

¹⁰ The doctorate was started at Sheffield Hallam University and all data collection was undertaken prior to transferring to the University of Derby

those participating are clear about the purpose of the research and individuals are provided with the contact details of both the researcher and external support, should they experience any discomfort following participation. It will be reiterated throughout that individuals can withdraw from the research at any time, without justification, and that the research will be stopped if individuals become distressed. Thorough debriefing following data collection will minimize any potential risk of harm, and all participants will take home a debrief sheet (see Appendix 11).

3. *No personal harm from disclosing information.* Individuals participating in the study will be reminded that although the research is in partnership with SASS, all information disclosed is confidential and is not to be shared with ARC staff. In the case of the disclosure of information that raises safeguarding issues, individuals will be informed that this may, where necessary, have to be shared with a member of ARC staff or external service.
4. *The benefits of the research.* It is anticipated that in the context of the study, providing individuals with the opportunity to talk about their recovery experiences may perhaps hold therapeutic value. Moreover, the qualitative data collected in Study 3 and 4 seeks to actively empower ARC members and give them a voice. It is also anticipated, in the long term, that the data will seek to add value to the evidence base associated with recovery orientated practice and enable the local community to have identified assets within the locale to support community engagement. Described by one ARC member, "it's to help those of us who haven't quite got here yet".
5. *Treating people equally and fairly.* This remained central to the study, with the researcher seeking to build strong working relationships with ARC members throughout the process. The research sought to provide a platform for ARC members' voices to be heard, and the study was accessible to all of those who wished to be involved.

Consent and deception

For the secondary data source (Study 1), consent was gained by SASS to use this data for research purposes and therefore issues of retrospective consent did not need to be considered. The data set was anonymised by the manager at SASS prior to it being shared with the researcher.

For ARC members participating in any of the three primary data sources (Study 2, 3 and 4), consent was gained. Consent forms were printed out and given to ARC members to complete prior to the research, alongside the information sheet. Due to the potential vulnerability of the cohort, the researcher read through the information sheet if requested and allowed time for questions to be asked. Individuals were provided with contact details for the researcher and Director of Studies in case questions arose following participation.

The information sheets explained the purpose of the studies and how data would be stored and managed. As the research findings are to be shared with SASS, it was not appropriate to have a third-party present during data collection due to issues of anonymity and confidentiality. ARC staff were however available, if needed.

Privacy, confidentiality and anonymity

Due to the nature of the research and the findings being shared amongst the organisation, it was of the utmost importance to anonymise those who participated. Details of how this was achieved in each of the four studies is outlined below. All consent forms from Studies 2-4 were scanned and stored on a password protected computer with the original files destroyed once uploaded to the database.

Study 1 – ARC members' dates of birth, surnames and addresses were removed from the data set by the manager before the data was shared with the researcher. This meant only aggregate data was presented and no individuals could be identified.

Study 2 – ARC members were assigned a unique identification code which allowed data from Time 1 and Time 2 to be matched. This also enabled individuals to ask for their data to be removed from the study, should they have wished to¹¹.

Study 3 – ARC members were not required to disclose their name in the ABCE workbook. If names were disclosed in the audio recordings, these were changed for the purpose of anonymity when transcribed. Each ABCE workbook was assigned a unique identification code to ensure they could be matched with the relevant audio recording. This also enabled individuals to ask for their data to be removed from the study, should they have wished to¹².

Study 4 – Names of the individuals interviewed as well as any names disclosed in the audio recordings were changed for purposes of anonymity within the interview transcripts. It is

¹¹ No one withdrew their data from Study 2

¹² No one withdrew their data from Study 3

however recognised that due to the nature of these, those who participated may be identifiable, especially to ARC staff. This was discussed with individuals prior to participation and the consent forms were altered accordingly to acknowledge this. Those who were interviewed were happy with their narratives being shared in this format¹³.

Due to the focus of the research, the names of places or organisations disclosed within Study 3 and 4 were not changed given the focus on engagement in community resources. Changing this information would extract the richness of this data and limit its practicality and therefore was not feasible. False names are given to those mentioned in the thesis write up to uphold anonymity.

Comply with the laws of the land: Data management

The storage of data for all four studies complied with the Data Protection Act (1998). Any databases associated with the study were stored on a password protected computer, and original files (whether that be audio recordings or paper copies of the REC-CAP, ABCE workbooks and consent forms were destroyed once uploaded to the database). Data collection was however impacted by changes to GDPR regulations (2018) which meant that any existing contact information for ARC members had to be erased. The impact of this meant that some individuals could no longer be contacted to participate in the research, and was particularly problematic for Study 2, as certain individuals could no longer be contacted to complete the REC-CAP at Time 2.

Methodological summary

In summary, the research methodology utilises a mixed methods design, split across four independent studies. Whilst each study is unique in its approach, each of these build on one another. The methodological approach implemented was guided by the research's pragmatic philosophical position and it is anticipated that the meta-inferences derived from the studies will advance current knowledge within the field of substance use recovery. Specifically, helping to better understand the role of community engagement in developing women's recovery capital. Before data from the four studies is presented, attention is now turned to the pilot studies and the influence of public and patient involvement within the development of the studies.

¹³ No one withdrew their data from Study 4

Public and patient involvement

Following on from the methodology, this section details how the researcher worked collaboratively with Sheffield Addiction Recovery Research Panel (ShARRP), an addiction recovery public and patient involvement panel. ShARRP volunteer their time to meet on a bi-monthly basis to consider and review current and future research in the field. The aim of the panel is to empower those with relevant first-hand experience to shape how drug and alcohol related research is undertaken (ShARRP, 2021). By engaging with the panel, the researcher sought to ensure the voices of those with first-hand experience were at the heart of the research design and any study developments. In doing so, this section of the chapter pays attention to the importance of such involvement in health related research before the findings of each of the four studies are presented in turn in the subsequent chapters.

The importance of public and patient involvement

Public and patient involvement (PPI) is described as “research being carried out ‘with’ or ‘by’ members of the public rather than ‘to’, ‘about’ or ‘for’ them” (INVOLVE, 2015, p.6). Over recent years PPI has gained much interest in health related research (Maccarthy et al., 2018), which in part is attributable to the increasing requirement of PPI inclusion from funding bodies (Richards et al., 2016).

When considered in light of research epistemology, those with first-hand experience of a particular phenomenon (referred to as the PPI contributors) may have differing knowledge to the researcher, particularly if they themselves do not have first-hand experience of the phenomena being studied. This amplifies the importance of PPI and the duty of care held by the researcher to engage with the process, to learn from the experiences and insight of the PPI contributors. It is argued that PPI has always been a crucial component of research in regard to ethical values and follows a moral imperative in which those with first-hand experience of the phenomena being studied have a right to be involved in the research process (Gradinger et al., 2015). This is particularly importance, given that research outcomes are likely to directly and indirectly effect the services which they receive. This core principle of PPI may also lead to its PPI contributors feeling increasingly empowered, given that they are helping to shape the direction of research and related outputs (NHS, 2013). PPI should however be formed on the basis of a dyadic relationship, with researchers committing to sharing their own knowledge, skills and resource. As such, PPI should be recognised as a social practice, with its meaning and value for its contributors extending beyond direct involvement with a specific research study (Reynolds & Beresford, 2020).

Undoubtedly, the overall quality and relevance of the research is likely to be shaped by PPI (Domecq et al., 2014). This can be achieved in a number of ways, with some examples including: making the

language and content of information more appropriate and accessible; ensuring the proposed methodology is acceptable and sensitive to the situation of participants; and by helping ensure that research outcomes are important to the public (Andrews et al., 2015).

Inclusion of public patient involvement within the studies

The researcher worked collaboratively with ShARRP throughout the study and each of the primary data sources (Study 2, 3 and 4) were explored with the panel over a series of meetings. Attendance at the meetings varied from four to 12 PPI contributors.

Below, detail is given to the role of ShARRP in Study 2, 3 and 4. Whilst what is detailed is specific to the panel's input prior to, and during data collection, findings of the studies were also shared with the panel following data collection, demonstrating an element of continuity. Key points within each meeting were recorded by both the researcher and panel administrator.

Public and patient involvement: Study 2

Meeting one

The panel informed the planning and development of Study 2 both prior to (discussed in meeting one), and during (discussed in meeting two), data collection. PPI contributors were firstly given an overview of the REC-CAP and its application within the study for contextual purposes. It was explained that given the REC-CAP is a validated tool, no amendments could be made to the original measure itself and thus, the focus of meeting was on the administration of the REC-CAP and additional measure added to this (see Appendix 2: *Section 7, Part B*)

In regard to the additional measure, the barriers to community engagement identified in the literature (see *Chapter 2: What are the associated challenges with community engagement?*) were discussed with the panel. Given that the identified literature was not always specific to those in recovery, PPI contributors were provided with an opportunity to discuss whether they thought the barriers listed in the additional measure were appropriate, and whether any barriers were missing.

The panel stated that they did not feel as though any additional barriers needed to be added and commented on the additional measure overall being user-friendly and easy to interpret. Other areas commented on included:

- 1) Individuals should be given the choice of completing the REC-CAP either in the company of the researcher or by themselves;

- 2) If the REC-CAP was to be completed face to face with the researcher, it is essential that the researcher spends time prior to this building rapport with the individual and time is allocated to talking through the measure or answering any additional questions if required.

In response to the feedback, individuals were given a choice of completing the REC-CAP with or without the researcher, and time was spent prior to data collection building rapport with individuals. This is considered in further detail in the discussion (See *Chapter 8: Personal reflections on the research process*).

Meeting two

The researcher returned to the panel following the collection of Time 1 REC-CAPs and updated PPI contributors on the research to date. The researcher was particularly interested in utilising the meeting to discuss ways to minimise attrition rates between Time 1 and Time 2. Feedback from the panel was as follows:

- 1) It was advised that a sim card was purchased specifically for the study, allowing the researcher to text individuals as opposed to calling them from a university landline where the incoming call showed as unknown;
- 2) To host an event with food and refreshments provided to bring together those due to complete their follow-up REC-CAPs.

In line with the suggestions, a sim card was purchased and those due to complete the Time 2 REC-CAP were contacted additionally by text message. This was intended to remind individuals that this was due for completion and to give notice that they would receive a call from the researcher on an unknown number. This also provided the opportunity for the researcher to send text message reminders of scheduled appointments, conducive of improving attendance on the day REC-CAPs were planned to be completed.

An event was organised in December 2019 (towards the end of data collection for Study 2) and individuals still due to complete their Time 2 REC-CAP within the outlined time frame were invited to attend. Lunch and refreshments were provided, and the researcher was on hand to sit to complete the REC-CAP with individuals, if required. The event proved to be successful, resulting in the completion of 12 REC-CAPs.

Public and patient involvement: Study 3

Meeting one

The ShARRP panel were provided with an overview of the study and underpinning rationale behind the ABCE framework. PPI contributors were enthusiastic about the framework, firstly supporting the grouping of the four domains (as outlined above, see *Study 3: Rationale and method*). The panel stated that this would be particularly useful in practice when wanting to gain knowledge quickly and systematically of what is available in a local area. Another PPI contributor, working as a support worker, asked if participation in Study 3 was only for those accessing SASS as they felt individuals they were currently supporting would benefit from participation. An example given was in relation to an individual who, due to a long-term degenerative disorder was unlikely to achieve abstinence, as drinking was a means of coping with the disorder. As a result of this, the support worker believed that the encouragement of community engagement would minimise current levels of isolation and be conducive to reducing their drinking. Whilst it was explained that within the context of the current study, participation was only feasible for ARC members, this request was encouraging to hear in light of ABCE and the rationale behind the framework. The panel also commented that they thought visual outputs of the data would be particularly helpful in this regard. One individual commented on the lack of aftercare they had received following detox and emphasised that information relating to resources within the locale would have been helpful to support their recovery pathway and to ensure a continuity of care.

Given that the panel was supportive of the proposed ABCE framework, they were presented with the drafted ABCE workbook and encouraged to suggest as many edits as necessary. Individuals were already familiar with some of the content outlined, given it shared similarities with the additional measure added to Study 2 and discussed in the prior ShARRP meeting. Feedback received from the panel in light of the drafted workbook included the following:

- 1) Clarification was needed over the user ratings ‘accessibility’, ‘affordability’ and ‘connectedness’ (see above, *Study 2, Rationale and method*). The panel recommended that a simple explanation of the terminology should be printed on each page of the workbook;
- 2) The original 1-5 point Likert scale the researcher had originally intended to use for the user ratings (accessibility; affordability and connectedness) was deemed to be too difficult to interpret and the panel instead advised to use the ‘traffic light scale’ detailed earlier (see above, *Study 2: Rationale and method*);
- 3) A key associated with the rating scale should be printed on each page of the workbook.

The feedback from ShaARRP was invaluable and the ABCE workbook was altered in line with the suggested recommendations. The collaborative approach undertaken to shape the workbooks design resulted in its improved functionality.

Public and patient involvement: Study 4

Meeting one

The proposed methodology and intended recruitment process for Study 4 was outlined to ShARRP and the researcher showed the panel the proposed outline or the interview schedule. The aim of the meeting was twofold: to identify if the drafted questions were appropriate, and to identify gaps within the interview schedule.

PPI contributors spoke openly about their own experiences of their substance use and recovery journeys, and through these narratives were able to identify themes they felt should be incorporated in the interview schedule. Overall, the panel agreed that the questions drafted were suitable and made no major amendments to these. They did however make some recommendations to add clarity to specific questions and added two additional questions at the end of the interview schedule in regard to the participants' proudest achievements to date, and goals for the future. This helped to reinforce the strengths-based emphasis placed on the end of the interview. The finalised interview schedule can be seen in Appendix 5, with the alterations made by the panel shown in bold.

Following the review of literature, the current chapter sought to outline how each of the four studies were developed in response to the central and subsidiary research questions. Within these discussions, consideration is given to the rationale and method, sampling technique and planned analysis. The chapter later outlined the involvement of individuals with first-hand experience of alcohol use in the design and development of the research methods, particularly in light of the ABCE workbook. The chapters which now follow provide the analysis for each of these four studies.

Personal reflections

Given their influence on the research which unfolds, personal reflections on the research process are now provided in three stages. Firstly, reflecting on involvement with SASS and ARC members, before then detailing personal and professional development and learnings.

As a white, young and middle-class female researcher with no direct first-hand experience of addiction or recovery, it was important to remain conscious of this throughout and consider the potential power dynamics. This was twofold, both between me and the researched, and between me as a female and the males within the cohort. This was an aspect frequently considered when introducing myself to individuals accessing SASS. The process was far more than ‘simply’ collecting data and writing the thesis and thus, for myself, I was hesitant to introduce myself as ‘researcher’ when asked about my involvement with the service. In line with the research paradigm, immersing myself within the recovery community was critical to help develop a better understanding of the group’s experiences within the service and to provide a platform to voice these experiences within the thesis. The result of this was that I often did not feel like a researcher, but instead part of the community too.

It is hoped that this was reflected in my efforts to engage with SASS: participating in activities; making teas and coffees; annually entering a team into the Recovery Games (aimed at celebrating substance use recovery, bringing together teams of service users, staff and volunteers to compete against other teams from services across the UK... of which the trophy will come home to Sheffield with us one year soon); singing at the SASS Christmas concert and much more.

In terms of my positionality, I strived to provide additional support to individuals where I could, as this was perceived to be a crucial component of the research process. This ranged from emotional and psychological support to more practical support, such as finding out more information about wider community resources which individuals expressed the desire to become more engagement with. Whilst in some regards there were differences between those who participated in the research and I, there were often many similarities. The working relationships formed felt non-hierarchical, based on foundations of rapport and human connection.

Those who I had the privilege of spending time with – staff, volunteers and ARC members – made a lasting impression. The research process was not always easy. As alluded to in the introduction to the thesis, you witness periods where individuals relapsed, became stuck or faced barriers to the accumulation of recovery capital. That said, there were others who made significant strides forward - not only gaining sobriety but envisioning a new future for themselves and blossoming. Behind each of the 337 individuals whose experiences are collectively shared within the thesis laid a unique story – a

person and their journey to living a more fulfilled life. It is saddening that some of those whose voices this research shares are no longer with us. This thesis is not only dedicated to them, but the impact of their charisma and energy has been a driver for this work. It is hoped that the outputs of this thesis help to better the lives of those in recovery. As one individual who participated in the research described, *“this is for those of us who are not here yet”*.

The value of meaningful activities and connection, written about throughout this work, has also held powerful implications for my own personal life. Having played netball competitively over the last 10 years and recently joining a CrossFit box, I have experienced the benefits of such connection myself, growing on a personal and social level. I guess I could also call myself a connector (the role of which, within the context of the research findings, is written about next). This appears to be an aspect of my life which has perhaps organically developed throughout the PhD process, having witnessed the importance of connection.

On a professional level, first and foremost, the research process has substantially developed my methodological knowledge and writing. It also inspired me to step away from a career in teaching, realising that my passion lies not only in research, but spending time with the people for whom the research is for. It also taught me to approach research with flexibility, and great adaptability. Sometimes research may not always go the way you expect it to, but that’s ok – it’s perhaps how research in this field works best anyway.

The research process also made me conscious of the language we use within our work. Not only to describe those who the research is about (of which alcohol use/ user was chosen within the current work), but how our work is written and presented in a way which should always be accessible to those who it is for. This is an element of development that ShARRP did brilliantly – helping me sense check myself and the work as it evolved. A particular example which comes to mind is when a panel member turned around and asked, “what even is research?”. Good question! It was moments like these that made me take a step back and reflect how we present ourselves as ‘researchers’. It is our responsibility to ensure that the language we use is inclusive for all. The following testimony from a ShARRP panel captures this powerfully:

“Unfortunately, there has previously been a massive gap between academics, people with extremely valuable lived experience, and the two worlds that they inhabit. It’s a real shame that this gap exists, because the most important part of research - especially that concerning topics such as addiction and recovery - is that it should positively impact

people's lives. Sadly, I think many PPI members have, in the past, been made to feel 'inferior' or 'stupid' because they don't understand the big fancy words and research methods that researchers use and talk about. Similarly, in the past, researchers have sometimes felt out of place at the PPI because they are used to only inhabiting their own academic world, which is often very competitive".

Not only has the involvement of ShARRP been invaluable to the research, but also to my own professional development. The involvement also emphasises the accountability that we, as researchers, have. I firmly believe that research must be undertaken and disseminated in a way which makes a difference (regardless of the field we work in). When working as a lecturer in Criminology previously, this was always the first question I'd ask to dissertation students: and so what? What do you hope the impact of your research to be? How will it make a difference? For me, this question never changes – no matter how qualified or experienced we become – if we are not doing our jobs to make the world a better place, then what are we in it for?

Chapter 4: Study 1

Introduction to chapter

Following on from the methodology, this chapter is the first of four findings chapter and will present the quantitative analysis for Study 1¹⁴. This secondary data, collected by staff at SASS between 2016 and 2017, is based on a user-friendly version of the Assessment of Recovery Capital. As outlined in Chapter 2, recovery capital is a means to measure recovery progress, and as such, the use of the measure enables SASS to identify levels of recovery capital upon entry to the service and to explore how this changes overtime.

Quantitative reporting

The quantitative data reported is broken into the following sections:

- 1) Reporting of Time 1 data including descriptive statistics, and bi-variate analysis including correlations;
- 2) Analysis of differences with those who retained in the cohort at Time 2 and those who were not, to assess the representativeness of the retained cohort;
- 3) Reporting of Time 2 data including descriptive statistics, and bi-variate analysis including correlations;
- 4) Analysis of differences with those who retained in the cohort at Time 3 and those who were not, to assess the representativeness of the retained cohort;
- 5) Reporting of Time 3 data including descriptive statistics, and bi-variate analysis including correlations;
- 6) Reporting of change through the use of repeated measures analyses of variance (RMANOVAs) and repeated measures t-tests.

The results are analysed to address the following subsidiary research questions:

- 1a. How does each aspect of recovery capital differ by gender at different stages of recovery journeys?
- and 1b. Are there different predictors of recovery outcomes by gender?

¹⁴ Data is not included in the appendix but is available on request

Where possible, all statistical values will be reported to three decimal points to ensure consistency of reporting. There is a 95% confidence level presumed, with statistical significance reported if values are below 0.05. The p value is reported in full each time, with (ns) signifying the p value is not of statistical significance and (s) signifying the p value is of statistical significance. Chi values will be interpreted in line with Cohen's (1998) analysis of effect sizes as the following: 0.1 (small), 0.3 (moderate), 0.5+ (large).

Variables of interest

Once demographic information including gender and age are reported, the chapter will explore the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993) drinking scores for individuals, alongside each domain of recovery capital and overall recovery capital scores. These are presented for both the overall cohort, and by gender at Time 1, Time 2 and Time 3. The change analysis will then explore how recovery capital growth changes over time, and whether differences are present between men and women.

Other variables reported, which were collected at Time 1, include the individuals accommodation status; employment status; and parental status (as these are the only demographic variables captured in the service database).

Time 1

Demographic information

Three hundred and forty-three individuals were included in the database originally, although gender is only reported for 244 individuals at Time 1, with a gender split of 86 females (35% of the overall cohort) and 158 males (65% of the overall cohort). The data presented below only refers to those whose gender was reported within the database, given the centrality of gender throughout the thesis.

Age

Individuals ranged in age between 19 and 72 years ($SD = 10.978$) with the mean age for males being 45 years ($SD = 10.598$) in comparison to 43 years for women ($SD = 11.634$). As assessed by independent samples t-test, while the mean age of men (45 years) was slightly higher than females (43 years) this was not of significance, as shown by $t = -1.306$, $p = .193$, $df = 239$ (ns). The mean age for women within this cohort falls below the national average of those receiving treatment for alcohol misuse (45-49 years old) (Public Health England, 2019) however does support the work of Best et al. (2015) which highlights women are thought to be younger when they start their recovery journeys.

Employment status

Upon entry to the service, individuals were asked if they were currently employed, with 46 individuals stating they were working either full time or part time (20% of the overall cohort). This was not however recorded again at Time 2 or Time 3. Table 3.1. reports the employment status of the cohort, split by gender:

Table 3.1: Employment status by gender at Time 1

Time 1	Employed	Unemployed
Men	31 (20% of men)	127 (80% of men)
Women	15 (17% of women)	71 (83% of women)

As shown in Table 3.1, there was little variation within the cohort and as assessed by chi-square (1) = .173, $p = .678$ (ns), there were no significant differences between employment status and gender. This does however identify the need for recovery orientated support to be flexible and accessible, to ensure those working are able to engage with such support.

Accommodation status

Table 3.2 reports the accommodation status of the cohort at Time 1. Within the data collected by SASS, individuals were asked to state whether they were living at home; in rehab; in supported accommodation; experiencing homelessness; or in another form of accommodation (listed as ‘other’). Those living at home are reported under ‘stable accommodation’ and those in rehab, supported accommodation or experiencing homelessness are reported under ‘unstable accommodation’. Those listed as ‘other’ were excluded from this categorisation, given that their living situation was unknown to the researcher.

Table 3.2: Accommodation status by gender at Time 1

Time 1	Stable	Unstable
Men	96 (82% of men)	21 (18% of men)
Women	49 (83% of women)	10 (17% of women)

A similar percentage of men and women were observed to be living in stable and unstable accommodation (see Table 3.2). As assessed by chi-square (1) = .027, $p = .869$ (ns), there were no significant differences between accommodation status and gender.

Parental status

Table 3.3 reports the parental status of the cohort at Time 1. Individuals were asked if they had children and if so, whether they were living with their children.

Table 3.3: Living arrangements by gender at Time 1

Time 1	No children	Children (living together)	Children (living elsewhere)
Men	55 (51% of men)	18 (17% of men)	35 (32% of women)
Women	18 (33% of women)	21 (38% of women)	16 (29% of women)

As shown in Table 3.3, a higher percentage of men (51%) reported not having children compared to women (33%), and a higher percentage of women reported living with their children (38%) compared to men (17%). A new variable was then computed, based on if the individual had children or not. This classified those living with their children, or those whose children were living elsewhere together. As assessed by chi-square (1) = 5.941, $p = .015$ (s), there was a significant difference between parental status and gender, with a higher percentage of women (71%) reporting being parents compared to men (53%). This supports findings from Chapter 2 which highlighted women are more likely to be primary care givers, and present to services with parental related needs.

Alcohol use

Individuals completed an AUDIT upon entry to the service, scored out of 40. It is suggested that scores between one and seven suggest low risk alcohol consumption; scores between 8 and 14 suggest harmful alcohol consumption; and scores of 15 and above indicates likelihood of alcohol dependence (AUDIT, 2021). The mean score for women was 18 (SD = 1.107) and the mean score for men was 19 (SD = .828). As assessed by an independent samples t-test, there were no significant differences by gender, as shown by shown by $t = -.285$, $p = .776$, $df = 162$ (ns).

Recovery capital

Each of the three domains of recovery capital were scored out of 10, with a collective score given for recovery capital, reported out of 30. The mean scores for personal, social and community capital, as well as overall recovery capital, split by gender and the t and p values associated with the independent samples t-tests are detailed in the table below. One hundred and thirty-seven individuals completed the Assessment of Recovery Capital at Time 1, with a gender split of 83 males (61% of the overall cohort) and 54 females (39% of the overall cohort). The mean scores are presented in the table below:

Table 3.4: Mean scores and differences by gender for recovery capital domains at Time 1

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t-test: t value, p value and degree of freedom
Personal capital	6.187 (SD = 2.277)	6.655 (SD = 2.250)	5.779 (SD = 2.425)	t = 2.144, p = .034, df = 138 (s)
Social capital	5.066 (SD = 2.044)	5.218 (SD = 2.252)	4.982 (SD = 2.031)	t = .643, p = .522, df = 138 (ns)
Community capital	4.436 (SD = 2.352)	4.436 (SD = 2.498)	4.488 (SD = 2.346)	t = -.123, p = .902, df = 136 (ns)
Overall recovery capital	15.789 (SD = 5.204)	16.5 (SD = 5.432)	15.328 (SD = 5.284)	t = 1.254, p = .212, df = 135 (ns)

As shown in Table 3.4, both men and women's personal capital scores were the highest out of the recovery capital domains, and differences in levels of personal capital between men and women were of significance, with women reporting higher levels (6.655, SD = 2.250) compared to men (5.779, SD = 2.425). Given the importance of personal capital to help initiate and sustain recovery (Connors et al., 2001; Simoneau & Bergeron, 2003), it is positive to see this score highly for both genders. As previous literature has highlighted, mental ill-health, a known factor to intersect with the accumulation of personal capital, is often more prevalent amongst women in recovery (Best et al., 2015a) and thus,

it is positive to see women score so highly in the current study. Consideration must however be given to the potential effects of men having lower levels of such capital upon entry to the service.

Recovery capital scores were then correlated against AUDIT scores, with a negative significant correlation ($r = -.346$, $p = .000$) (s) identified. This shows that those with higher levels of drinking severity are less likely to have access to recovery capital and thus, may be in more immediate need of engagement with recovery support services to make recovery progress.

Assessing the representativeness of the follow-up sample at Time 2

The next stage of analysis will explore whether those who did not complete the Assessment of Recovery Capital at Time 2 differ significantly to those who did, as a mechanism for assessing the representativeness of the retained cohort. Within this section, when the term ‘between groups’ is used, this refers to those who retained at Time 2 and those who did not. Similarly, the next stage of analysis for the representativeness of the sample and the Time 2 data only refers to those within the cohort whose gender was reported.

Demographic information

Gender

As assessed by chi-square ($\chi^2 = 1.266$, $p = .531$ (ns)), the differences noted in attrition rates by gender were of not statistical significance, with a similar percentage of men (72% of the overall male cohort at Time 1) and women (68% of the overall female cohort at Time 1) not being retained in the sample at Time 2.

Age

As assessed by an independent sample t-test, $t = .058$, $p = .954$, $df = 238$ (ns), the differences noted in attrition rates by age were of not statistical significance, with those retained in the sample at Time 2 and those not retained being the same mean age (44 years old). The other variables of interest were either assessed by an independent samples t-test, or chi-square¹⁵, to identify any differences between groups. These are reported below in Table 3.5 and 3.6.

¹⁵ Independent samples t-tests are used for continuous variables and chi-square is used for nominal variables

Table 3.5: Analysis between groups for continuous variables of interest for those retained and not retained at Time 2

Variable	Mean score and standard deviation (retained at Time 2)	Mean score and standard deviation (not retained at Time 2)	Independent samples t-test: t value, p value and degree of freedom
AUDIT	18.45 (SD = 9.088)	18.48 (SD = 8.251)	t = .022, p = .983, df = 162 (ns)
Personal capital	6.086 (SD = 2.391)	6.155 (SD = 2.402)	t = .169, p = .866, df = 138 (ns)
Social capital	5.258 (SD = 2.227)	4.921 (SD = 2.020)	t = -.938, p = .350, df = 138 (ns)
Community capital	4.825 (SD = 2.319)	4.223 (SD = 2.406)	t = -1.485, p = .140, df = 135 (ns)
Overall recovery capital	16.349 (SD = 5.716)	15.314 (SD = 5.015)	t = -1.129, p = .261, df = 135 (ns)

Table 3.6: Analysis between groups for nominal variables of interest for those retained and not retained at Time 2

Variable		Retained	Not retained	Chi-square: degree of freedom, value and p value
Employment status	Employed	30% (n = 14)	70% (n = 32)	(1) = .041, p = .840 (ns)
	Unemployed	71% (n = 140)	29% (n = 57)	
Accommodation	Stable	29% (n = 42)	71% (n = 103)	(1) = .518, p = .472 (ns)
	Unstable	23% (n = 7)	77% (n = 24)	
Parental status	Children	29% (n = 30)	71% (n = 74)	(1) = .024, p = .877 (ns)
	No children	28% (n = 20)	72% (n = 52)	

In summary, there were no statistically significant differences between groups, as shown in Table 3.5 and 3.6. Subsequently, this has no effect on the upcoming analysis of Time 2 data which the chapter will now move to.

Time 2¹⁶

Alcohol use

Scored out of 40, the mean AUDIT scores at Time 2 were as follows: 3.30 (SD = 6.979) for women and 3.01 (SD = 6.469) for men. As assessed by an independent samples t-test, there were no significant differences by gender, as shown by shown by $t = .231$, $p = .817$, $df = 117$ (ns). Given that scores are reported out of 40, mean scores for both men and women are particularly low, highlighting progress towards individual's recovery trajectories.

Recovery capital

Seventy-three individuals completed the Assessment of Recovery Capital at Time 2, with a gender split of 45 males (62% of the overall cohort) and 28 females (38% of the overall cohort). The mean scores for personal, social and community capital, as well as overall recovery capital, split by gender and the t and p values associated with the independent samples t-tests are detailed in the table below.

Table 3.7: Mean scores and differences by gender for recovery capital domains at Time 2

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t-test: t value, p value and degree of freedom
Personal capital	7.105 (SD = 1.687)	6.982 (SD = 1.572)	7.182 (SD = 1.768)	$t = -.490$ $p = .626$, $df = 71$ (ns)
Social capital	6.873 (SD = 1.787)	6.875 (SD = 1.642)	6.871 (SD = 1.890)	$t = .009$, $p = .993$, $df = 71$ (ns)

¹⁶ Collected four weeks after Time 1

Community capital	6.363 (SD = 2.300)	6.518 (SD = 2.266)	6.267 (SD = 2.341)	t = .451, p = .653, df = 71 (ns)
Overall recovery capital	20.341 (SD = 4.905)	20.375 (SD = 4.387)	20.320 (SD = 5.249)	t = .046, p = .963, df = 71 (ns)

As shown in Table 3.7, and similarly to Time 1, out of the three domains of recovery capital, personal capital scores were the highest for both men and women. There were no significance differences across any of the domains of recovery capital by gender. Overall recovery capital was then correlated against the Time 2 AUDIT scores, with no significant correlation identified ($r = -.133$, $p = .301$) (ns).

Assessing the representativeness of the follow-up sample at Time 3

The next stage of analysis will explore whether those who did not complete the Assessment of Recovery Capital at Time 3 differ significantly to those who did, as a mechanism for assessing the representativeness of the retained cohort. Within this section, when the term ‘between groups’ is used, this refers to those who retained at Time 3 and those who did not. Again, the next stage of analysis for the representativeness of the sample and the Time 3 data only refers to those within the cohort whose gender was reported.

Demographic information

Gender

As assessed by chi-square ($\chi^2 = .037$, $p = .846$) (ns), the differences noted in attrition rates by gender were of not statistical significance, with a similar percentage of men (68% of the overall male cohort at Time 2) and women (70% of the overall female cohort at Time 2) not being retained in the sample at Time 3.

Age

As assessed by an independent sample t-test, $t = .767$, $p = .013$, $df = 68$ (s), the differences noted in attrition rates by age were of statistical significance, with those retained in the sample at Time 3 being younger (39 years old) than those who were not retained (46 years old).

The other variables of interest were either assessed by an independent samples t-test, or chi-square¹⁷, to identify any differences between groups. These are reported below in Table 3.8 and 3.9.

Table 3.8: Analysis between groups for continuous variables of interest for those retained and not retained at Time 3

Variable	Mean score and standard deviation (retained at Time 3)	Mean score and standard deviation (not retained at Time 3)	Independent samples t-test: t value, p value and degree of freedom
AUDIT Time 2	4.33 (SD = 7.782)	1.89 (SD = 4.981)	t = -1.248, p = .217, df = 59 (ns)
Personal capital Time 2	6.909 (SD = 1.722)	7.127 (SD = 1.666)	t = .503, p = .616, df = 69 (ns)
Social capital Time 2	6.977 (SD = 1.749)	6.780 (SD = 1.794)	t = -.433, p = .667, df = 69 (ns)
Community capital Time 2	5.818 (SD = 2.754)	6.612 (SD = 2.026)	t = 1.361, p = .178, df = 69 (ns)
Overall recovery capital Time 2	19.704 (SD = 5.480)	20.518 (SD = 4.575)	t = .651, p = .517, df = 69 (ns)

Table 3.9: Analysis between groups for nominal variables of interest for those retained and not retained at Time 3

Variable		Retained	Not retained	Chi-square: degree of freedom, value and p value
Employment status	Employed	36% (n = 5)	64% (n = 9)	(1) = .182, p = .669 (ns)
	Unemployed	70% (n = 40)	30% (n = 17)	
Accommodation	Stable	36% (n = 15)	64% (n = 27)	

¹⁷ Independent samples t-tests are used for continuous variables and chi-square is used for nominal variables

	Unstable	27% (n = 2)	73% (n = 5)	(1) = .135, p = .713 (ns)
Parental status	Children	27% (n = 8)	73% (n = 22)	(1) = .397, p = .529
	No children	35% (n = 7)	65% (n = 13)	(ns)

In summary, there were no statistically significant differences between groups for any of the variables expect age. Those retained at Time 3 were statistically younger than those who were not retained, highlighting a level of disengagement from the older adults. This will be referred back to in the discussions of the findings, with consideration given to its implications.

Time 3¹⁸

Alcohol use

Scored out of 40, the mean AUDIT scores at Time 3 were as follows: 1.094 (SD = 3.974) for women and .978 (SD = 4.563) for men. As assessed by an independent samples t-test, there were no significant differences by gender, as shown by shown by $t = .105$, $p = .917$, $df = 68$ (ns). These mean scores show particularly low levels of drinking amongst the cohort, a positive finding in light of recovery progress and reduced drinking.

Recovery capital

Twenty-two individuals completed the Assessment of Recovery Capital at Time 3, with a gender split of 14 males (64% of the overall cohort) and eight females (36% of the overall cohort). The mean scores for personal, social and community capital, as well as overall recovery capital, split by gender and the t and p values associated with the independent samples t-tests are detailed in the table below.

Table 3.10: Mean scores and differences by gender for recovery capital domains at Time 3

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t-test: t value, p value and degree of freedom
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¹⁸ Collected 12 weeks after Time 1

Personal capital	7.489 (SD = 2.301)	7.906 (SD = 2.121)	7.267 (SD = 2.433)	t = .626 p = .538, df = 21 (ns)
Social capital	7.784 (SD = 2.190)	7.188 (SD = 3.023)	8.125 (SD = 1.577)	t = -.816, p = .435, df = 9.227 (ns)
Community capital	6.630 (SD = 3.262)	6.400 (SD = 4.280)	6.783 (SD = 2.529)	t = -.255, p = .803, df = 13.219 (ns)
Overall recovery capital	23.147 (SD = 5.328)	23.093 (SD = 7.245)	23.178 (SD = 4.195)	t = -.035, p = .972, df = 20 (ns)

As shown in Table 3.10, out of the three domains of recovery capital, personal capital scores were highest for women, and social capital scores were highest for men. This perhaps shows some variation in terms of their recovery capital growth. There were no significance differences across any of the domains of recovery capital by gender. Recovery capital was then correlated against the Time 3 AUDIT scores, with no significant correlation identified ($r = -.155$, $p = .553$) (ns). Given that AUDIT scores across the cohort were so low at Time 3, this may appear unsurprising.

Change analysis

Recovery capital

A RMANOVA was run to determine whether the changes in recovery capital were of significance.

The f and p values as well as changes in mean scores for the overall cohort are reported in below.

Table 3.11: Within-Subject effects for recovery capital domains by condition (Time 1 to Time 2)

Variable	Cohort	Time	Mean score	MANOVA: f value, degree of freedom and p value	Significance
Personal capital	Overall cohort	Time 1	6.187 (SD = 2.277)	f = 12.022, df = 1, p = .001	s

		Time 2	7.105 (SD = 1.687)		
	By gender			f = .614, df = 1, p = .436	ns
Social capital	Overall cohort	Time 1	5.066 (SD = 2.044)	f = 47.353, df = 1, p = .000	s
		Time 2	6.873 (SD = 1.787)		
	By gender			f = .397, df = 1, p = .531	ns
Community capital	Overall cohort	Time 1	4.436 (SD = 2.352)	f = 60.280, df = 1, p = .000	s
		Time 2	6.363 (SD = 2.300)		
	By gender			f = .803, df = 1, p = .803	ns
Overall recovery capital	Overall cohort	Time 1	15.789 (SD = 5.204)	f = 70.891, df = 1, p = .000	s
		Time 2	20.341 (SD = 4.905)		
	By gender			f = .203, df = 1, p = .654	ns

As shown in Table 3.11, significant changes were noted for the overall cohort for all three domains of recovery capital between Time 1 and Time 2. Despite the significant changes for the overall cohort, there were no gender differences in recovery capital improvements as there was no significant main effect of gender. Additionally, mean scores for the overall cohort were highest for personal capital at Time 1 and Time 2. This is a positive finding, given the importance of personal capital to initiate change (Connors et al., 2001; Simoneau & Bergeron, 2003).

Table 3.12: Within-Subject effects for recovery capital domains by condition (Time 1 to Time 3)

Variable	Cohort	Time	Mean score	MANOVA: f value, degree of freedom and p value	Significance
Personal capital	Overall cohort	Time 1	6.187 (SD = 2.277)	f = 35.539, df = 2, p = .000	s
		Time 3	7.489 (SD = 2.301)		
	By gender			f = .392, df = 2, p = .678	ns
Social capital	Overall cohort	Time 1	5.066 (SD = 2.044)	f = 43.674, df = 2, p = .000	s
		Time 3	7.784 (SD = 2.190)		
	By gender			f = 5.855, df = 2, p = .006	ns
Community capital	Overall cohort	Time 1	4.436 (SD = 2.352)	f = 34.974, df = 2, p = .001	s
		Time 3	6.630 (SD = 3.262)		
	By gender			f = .304, df = 2, p = .925	ns
Overall recovery capital	Overall cohort	Time 1	15.789 (SD = 5.204)	f = 41.887, df = 2, p = .000	s
		Time 3	23.147 (SD = 5.328)		
	By gender			f = .453, df = 2, p = .640	ns

As shown in Table 3.12, significant changes were noted for the overall cohort for all three domains of recovery capital between Time 1 and Time 3. Despite the significant changes for the overall cohort, there were no gender differences in recovery capital improvements as there was no significant main

effect of gender. In comparison to the previous change analysis (between Time 1 and Time 2) social capital became the highest mean score at Time 3. This is encouraging, given that whilst it is acknowledged that transformation at a personal level is essential, this cannot occur in isolation and instead relies on the wider social context (Cloud & Granfield, 2004) and social networks (Zywiak et al., 2002; Mawson et al., 2015; Best et al., 2016).

Summary

In summary, the findings from Study 1 highlight that to an extent, there are some differences by gender in relation to recovery capital. Upon entry to the service, women are more likely to be parents, living with their children and have higher levels of personal capital. Whilst both men and women make significant progress in regard to the accumulation of recovery capital over time, there is no main effect of gender. Despite some nuances being identified within Study 1, the relationship between recovery capital and gender is complex, and this is challenging to fully understand within the context of the current study, given the associated limitations. Most notably, as the measure is based on a user-friendly version of the Assessment of Recovery Capital, the variables which data is reported on is limited. Thus, factors which may in fact interact with the accumulation of recovery capital overtime (such as community engagement), cannot be explored. Moreover, the data set was limited in its usability, given that gender was not reported for several individuals. A wider discussion of these limitations are outlined in the discussion (see Chapter 8). Despite these challenges, the findings from this study are useful for contextual purposes, understanding baseline and change differences among the cohort. The next chapter, presenting quantitative data from the first primary data source, Study 2, aims to build on this.

Chapter 5: Study 2

Introduction to chapter

The purpose of this chapter is to present the quantitative analysis for Study 2¹⁹. As examined in the literature review (see Chapter 2) and Study 1 (see Chapter 4) - recovery capital, broken down into personal, social and community capital, is the currency for measuring recovery progress. The REC-CAP is a means to capture and quantify recovery capital and is used within Study 2 to map recovery progress over a 6 month time frame. In line with the research questions, additions were made to the REC-CAP to further understand the impact of community capital on personal recovery pathways. Within this, particular focus was given to the interaction between community engagement and community capital – seeking to explore the impact of such engagement on recovery in a way which is unique to the thesis. Attention is also paid to how community engagement may differ between men and women.

This chapter follows the secondary analysis of data collected by SASS, analysed in the previous chapter, and seeks to build on this in light of the research questions. Data was collected from individuals new to SASS, upon entry to the ARC. Sixty-eight REC-CAPs were completed at Time 1, with 50 (73%) of this original cohort completing a REC-CAP at Time 2 (six months later).

This chapter begins with an overview of the quantitative data reporting and outlines the key variables of interest, before the analysis of data is conducted in the following format:

1. Report of Time 1 data including descriptive statistics, and bi-variate analysis including one way analysis of variance, correlations and linear regressions;
2. Analysis of differences with those who were retained in the cohort at Time 2 and those who were not to assess the representativeness of the retained cohort;
3. Report of Time 2 data including descriptive statistics, and bi-variate analysis including one way analysis of variance, correlations and linear regressions;
4. Report of change through the use of repeated measures analyses of variance (RMANOVAs) and repeated measures t-tests.

¹⁹ Data is not included in the appendix but is available on request

The results of the REC-CAP are analysed in light of the subsidiary research questions. Firstly:

- 1a. How does each aspect of recovery capital differ by gender at different stages of recovery journeys?
- and 1b. Are there different predictors of recovery outcomes by gender?

Secondly, the REC-CAP analysis will also contribute understanding to the latter parts of research question 3:

- 3b. How can we demonstrate the impact of community capital on personal recovery growth?
- 3b.i. How does the impact of community capital on personal recovery pathways differ by gender?

Within this chapter, findings are presented and interpreted, with a further discussion of the results given in Chapter 8.

Collection of data

Time 1 data was collected between 2017 and 2018 with Time 2 collected between 2018 and 2019. Where possible, Time 2 REC-CAPs were collected six months later and to ensure consistency amongst the data, if individuals had not completed their Time 2 REC-CAP after 12 months, they were marked as unreachable.

Quantitative reporting

The reporting of data is treated autonomously, and descriptive statistics will be broken down by gender through the use of independent samples t-tests, to assess the differences between groups. Parametric tests, which assume reasonably normal statistical distribution, will be used for data which is normally distributed and nonparametric tests which are not reliant on distribution will be used when the data does not satisfy the conditions for normality (Chan, 2003).

Where possible, all statistical values will be reported to three decimal points to ensure consistency of reporting. There is a 95% confidence level presumed, with statistical significance reported if values are below 0.05. The p value is reported in full each time, with (ns) signifying the p value is not of statistical significance and (s) signifying the p value is of statistical significance. Chi values will be interpreted in line with Cohen's (1998) analysis of effect sizes as the following: 0.1 (small), 0.3 (moderate), 0.5+ (large). For the purpose of clarity, variables that have been identified as holding

importance for the quantitative analysis will be discussed in the order they are presented in the REC-CAP. Where all the information from the statistical tables is not presented in the write up, the associated SPSS tables are presented in the appendices.

Variables of interest

In line with the central research question, it is essential all domains of recovery capital are reported at Time 1 and Time 2 before reporting on the change analysis. Personal, social and community capital as well as overall recovery capital, will be reported for the overall cohort, and by gender. Within the REC-CAP, personal capital is reported within the following measure (personal recovery capital from the Assessment of Recovery Capital), social capital is reported within the following measures (social recovery capital from the Assessment of Recovery Capital and with the Social Support measure taken from Jetten and colleagues (2013)) and community capital is reported within the following measure (involvement in recovery group and your local community, Recovery Group Participation Scale (RGPS); Groshkova et al., (2011)) (see also Table 2.1, Chapter 2).

As the central research question is specific to recovery pathways, substance use will be reported across both time points. Whilst alcohol is the substance of focus within the thesis, if other substances are listed as “has been a problem” or “used within the last 90 days”, this data is included within the analysis. Disregarding this would be unethical and lead to a misrepresentation of those accessing SASS, as well as wider statistics on those using alcohol and other substances. All of those who completed the REC-CAP stated that alcohol “has been a problem” at some point during their lives.

Demographic variables including gender, age and ethnicity are firstly reported, with gender differences analysed throughout. In line with the research questions in which the REC-CAP is analysed in light of, other variables of interest have been selected on the basis of previous literature (see Chapter 2) and data presented from Study 1 (see Chapter 4). The process for identifying these variables is detailed below.

Research question 1a. “How does each aspect of recovery capital differ by gender at different stages of their recovery journeys?”, can be analysed looking at the three domains of recovery capital and gender. Analysis to contribute to 1b however: “Are there different predictors of recovery outcomes by gender?”, must include other variables of interest. In line with the ideas discussed in Chapter 2, it is understood that when individuals in recovery are linked into positive community resources, we can anticipate that improvements will be noted in personal, social and community capital (Best et al., 2017;

Cano et al., 2017; Collinson & Best, 2019). As detailed in the methodology (see Chapter 3), the original REC-CAP measure was further developed for the purpose of this thesis to capture wider community engagement in such resources. Owing to this development, key variables of interest to be analysed in light of recovery capital growth and recovery outcomes are:

- Number of groups engaged with at SASS²⁰;
- Frequency of engagement with groups at SASS²¹;
- Engagement with assets in the local community;
- Satisfaction with community engagement;
- Barriers to community engagement.

Within the thesis, the variables detailed above are referred to as aspects of community engagement. As detailed in Chapter 2, community capital encompasses community resources available to an individual to help promote recovery. Based on this understanding, the community engagement variables seek to help broaden our understanding of community capital – detailing engagement with community resources and potential barriers to engagement. Analysis of these variables will help us understand the impact of such engagement on recovery pathways, including 3b. “How can we demonstrate the impact of community capital on personal recovery growth?”, and 3b.i. “How does the impact of community capital on personal recovery pathways differ by gender?”. The REC-CAP also asks whether individuals are working full-time, part-time, volunteering or in education. Given this also fits with the criteria of community engagement, this is also identified as a variable of interest.

Lastly, whilst the focus of the research is specific to recovery capital, literature discussed in Chapter 2 acknowledges that improved quality of life also reflects better recovery outcomes. This is demonstrated within definitions of recovery (Best & Laudet, 2010; Inanlou et al., 2020) and is a desired outcome of recovery orientated practice alongside improvements in health and wellbeing (Cano et al, 2017) and housing stability (Jason et al., 2006; Polcin et al., 2010). Owing to this, quality of life and satisfaction, and accommodation status are also variables of interest.

²⁰ This is reported as the number of groups an individual was accessing at SASS out of a possible eight. These eight groups (mixed SMART, women’s only SMART, moodmasters, SASSY ladies, men’s group, arts and crafts, drop in and active citizenship) were run on a weekly basis or more frequently, during the time period of data collection.

²¹ This is reported as a number which reflects the frequency of attendance, for example, a lower number would signify the individual is only accessing the group once a month and a higher number would signify the group is accessed either weekly, or more than once a week.

Table 4.1 details all variables of interest. All the scale variables were tested for outliers and normality, as checked by kurtosis scores. Where appropriate, these scores are reported below.

Table 4.1: Variables of interest with kurtosis scores reported for continuous variables²²

Variables of interest	Kurtosis scores
Quality of life and satisfaction, T1	0.23
Quality of life and satisfaction, T2	-.675
Accommodation status, T1	N/A
Accommodation status, T2	N/A
Substance use, T1	N/A
Substance use, T2	N/A
Work, training and volunteering, T1 (meaningful activity)	N/A
Work, training and volunteering, T2 (meaningful activity)	N/A
Personal recovery capital, T1	-.524
Personal recovery capital, T2	-.840
Social recovery capital, T1	-.345
Social recovery capital, T2	-.899
Involvements with recovery groups and your local community, T1	-1.141
Involvements with recovery groups and your local community, T2	-1.336
Recovery capital (accumulated), T1	-.431
Recovery capital (accumulated), T2	-.356
Social support, T1	-.397
Social support, T2	-.529
Barriers to engagement (accumulated), T1	.682
Barriers to engagement (accumulated), T2	.884
Groups attended at SASS (accumulated), T1	.464

²² Variables of interest which are nominal are listed in the table however kurtosis scores can only be computed for continuous variables. If a variable is nominal, N/A will be reported under the kurtosis score.

Groups attended at SASS (accumulated), T2	1.840
Frequency of attendance at groups, T1	.432
Frequency of attendance at groups, T2	4.830
Resources listed (accumulated), T1	.879
Resources listed (accumulated), T2	.892
Number of domains assets are listed under, T1	-.517
Number of domains assets are listed under, T2	-.285

As reported in Kim (2013), for samples between 50 and 300, when the z-value exceeds 3.29, which corresponds with an alpha level 0.05, the data is not normally distributed. This was apparent for one variable, frequency of attendance at groups at SASS (Time 2). Whilst in some instances, this would lead to non-parametric tests being used in any analysis run with this variable, parametric tests were used in this instance. This will be returned to in the discussion (see Chapter 8), to detail why this decision was made.

Time 1

Demographic information

Sixty-eight individuals completed the REC-CAP at Time 1, with 23 identified as female (34% of the overall cohort) and 45 identified as male (66% of the overall cohort). No one identified as trans or specified any other gender. The gender split of the cohort is similar to Study 1 (65% male and 35% female), and national statistics, falling somewhere between the percentages of women accessing treatment for alcohol only (40% female) and alcohol and non-opiates (27% female) (Public Health England, 2019).

Individuals ranged in age between 22 and 75 years ($SD = 11.288$) with the mean age for males being 44 years ($SD = 11.436$) in comparison to 48 years for women ($SD = 10.819$). This also reflects statistics from Public Health England (2019) which highlights those aged between 45-49 account for the largest percentage of those receiving treatment for alcohol use (16% of those in treatment). As assessed by independent samples t-test, while the mean age of women (48 years) was slightly higher than males (44 years) this was not of significance ($t = 1.281$, $p = .205$, $df = 66$ (ns)).

Sixty four individuals identified as white British (94% of the overall cohort). While statistics from Public Health England (2019) report those who are white British as the highest percentage of those

accessing treatment for alcohol use only (85% white British) or alcohol and opiates (83% white British), the percentage reported within the thesis is marginally higher. Two individuals identified as mixed race (3% of the overall cohort); one Indian (1.5% of the overall cohort) and one Spanish (1.5% of the overall cohort). While white British individuals were over-represented within the thesis, the other ethnicities identified (mixed race, Indian and Spanish) were not under-represented based on the statistics presented by Public Health England for those accessing treatment for alcohol use (2019). This potentially highlights as a gap of certain ethnic groups who are not engaging in SASS.

Exploration of dependent variables

Quality of life and satisfaction

Each variable within the quality of life and satisfaction measure (psychological health; physical health; quality of life; quality of accommodation; and support network) is reported individually out of 20, before an overall score for the measure is presented out of 100. Mean scores for each of the variables are reported below, split by gender, with higher values representing better wellbeing. This is also accompanied by the t and p values associated with the independent samples t-test (see Table 4.2).

Table 4.2: Mean scores and differences by gender for the quality of life and satisfaction measure at Time 1

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t-test: t value, p value and degree of freedom
Psychological health	11.044 (SD = 4.493)	10.913 (SD = 4.358)	11.111 (SD = 4.608)	t = .171, p = .865, df = 66 (ns)
Physical health	11.868 (SD = 4.593)	11.565 (SD = 5.298)	12.022 (SD = 4.254)	t = .386, p = .701, df = 66 (ns)
Quality of life	11.706 (SD = 4.558)	12.087 (SD = 5.484)	11.511 (SD = 4.059)	t = -.445, p = .659, df = 34.687 (ns)
Quality of accommodation	13.926 (SD = 4.903)	13.652 (SD = 5.685)	14.067 (SD = 4.514)	t = .328, p = .744, df = 66 (ns)

Support network	14.397 (SD = 4.388)	15.000 (SD = 4.602)	14.089 (SD = 4.294)	t = -.808, p = .422, df = 66 (ns)
Overall quality of life	62.941 (SD = 17.040)	63.217 (SD = 20.878)	62.800 (SD = 14.972)	t = -.085, p = .933, df = 66 (ns)

As shown in Table 4.2, satisfaction with support network scored the highest for both women and men. Despite small differences between their mean scores, as assessed by the independent samples t-test, the differences by gender are not of significance for any of the five wellbeing indicators or for overall wellbeing.

Accommodation

Table 4.3 reports the accommodation status of the cohort at Time 1. Within the REC-CAP, individuals are asked to state their accommodation status for the last 90 days. To ensure consistency with Study 1 (see Chapter 4: *Accommodation status*), those in one fixed address for the full 90 days are reported under ‘stable accommodation’ and those in more than one form of accommodation over the last 90 days are reported under ‘unstable accommodation’.

Table 4.3: Accommodation status by gender at Time 1

Time 1	Stable	Unstable
Men	37 (82% of men)	8 (18% of men)
Women	18 (78% of women)	5 (22% of women)

As shown in Table 4.3, 18 women (78% of the female cohort) reported being in stable accommodation at Time 1 in comparison to 37 men (82% of the male cohort). As assessed by chi-square (1) = .154, p = .694 (ns), there is no significant association between accommodation (stable/ unstable) and gender.

To ensure further consistency between Study 1 and Study 2, accommodation was also assessed in light of who the individual lived with. The rationale for this was twofold. Firstly, within Study 1 (see Chapter 4: *Parental Status*) there was a significant association by gender between those living with their children and those not living with their children. Secondly, previous literature identifies isolation as a factor which can lead to increased alcohol consumption (Buchanan, 2004; Yawger, 2018), a lack of social support (De Silva et al., 2005) and a diminished opportunity for personal recovery (Lim & Gleeson, 2014). In light of parenthood, the recovery literature also highlights that once entering treatment or accessing support for substance use, parenting can provide a strong rationale for positive

engagement with the recovery process (Best et al., 2015a). Collectively, these factors provide the rationale for the development of the new variable, based on the following categories within Study 2: living alone; living with others but not their children; and living with others including their children. Those categorised as ‘living alone’ or ‘living with others but not their children’ may still have been parents but this data was not recorded. Table 4.5 outlines these categories split by gender.

Table 4.4: Living arrangements by gender at Time 1

Time 1	Alone	With others (not children)	With others (with children)
Men	25 (61% of men)	12 (29% of men)	4 (10% of women)
Women	9 (41% of women)	8 (36% of women)	5 (23% of women)

As shown in Table 4.4, a higher percentage of women reported living with others in comparison to men and there was a higher percentage of men living alone compared to women. These differences were not however of statistical significance, as assessed by chi-square (2) = 2.982, $p = .225$ (ns).

A one-way analysis of variance was then carried out with recovery capital and living arrangements, to assess the impact of such living arrangements. No statistical significance was identified between an individual’s living arrangements and personal capital ($f = 1.595$, $df = 2, 60$, $p = .211$) (ns), community capital ($f = .473$, $df = 2, 58$, $p = .626$) (ns), or overall recovery capital ($f = 2.016$, $df = 2, 57$, $p = .143$) (ns). Statistical significance was however identified between an individual’s living arrangements and social capital ($f = 6.076$, $df = 2, 59$, $p = .004$) (s). Specifically, those who lived with others but not their children had significantly higher social capital than those who lived alone, highlighting the importance of living arrangements for those in recovery. Given what we know about social capital, it is likely the individuals who live with others may have more immediate access to social support (Best et al, 2015; Boeri et al., 2016). Thus, engagement in recovery orientated resources may be a prioritised means for those living alone to gain access to social capital and social support. There were no significant differences however between those who lived alone and those who lived with children.

Substance use

At Time 1, individuals were asked the following questions in relation to a number of listed substances:

- Has the substance ever been a problem?²³

²³ This was based on the individual’s self-perception.

- Has the substance been used in last 90 days?
- How many days out of the last 90 day has the substance been used?
- Average daily usage of the substance²⁴.

The whole cohort (n = 68) stated that alcohol had previously been used problematically. Other substances that were also listed as having previously been problematic are detailed below.

Table 4.5: Lifetime use of substances at Time 1

Substance: Ever been a problem?	Value (n) overall cohort
Cannabis	19 (28%)
Cocaine powder	17 (25%)
Crack cocaine	12 (18%)
Amphetamines	12 (18%)
Heroin	11 (16%)
Methadone (prescribed)	6 (10%)
Benzos (prescribed)	6 (10%)
Benzos (street)	6 (10%)
Methadone (street)	5 (7%)
Buprenorphine (street)	5 (7%)
Buprenorphine (prescribed)	4 (6%)
MDMA	2 (3%)
Spice	2 (3%)
Opioids	2 (3%)
Ketamine	2 (3%)
Ecstasy	1 (1%)

Thirty-six individuals (68% of the overall cohort of women and 50% of the overall cohort of men) stated they had used a substance other than alcohol within the last 90 days, all of whom had also consumed alcohol. As assessed by chi-square (1) = .879, p = .349 (ns) there were no statistically

²⁴ See Appendix 2: this was measured in terms of units per day for alcohol

significant differences between patterns of substance use and gender. Amongst those who had consumed alcohol in the last 90 days, the average number of days individuals had drunk alcohol within the 90 days' time frame prior to REC-CAP completion was 40.64 days (SD = 33.389), and the average number of units drunk per drinking day was 22.909 (SD = 16.713). There was also some overlap with the use of other substances within the last 90 days, these are outlined below.

Table 4.6: Substances used in the last 90 days at Time 1

Substance: Use within the last 90 days	Value (n) overall cohort
Cannabis	6 (10%)
Crack cocaine	4 (6%)
Benzos (prescribed)	2 (3%)
MDMA	2 (3%)
Spice	2 (3%)
Opioids	2 (3%)
Ketamine	2 (3%)
Heroin	1 (1%)
Amphetamines	1 (1%)
Methadone (prescribed)	1 (1%)
Ecstasy	1 (1%)

Whilst the use of other substances was lower than that of alcohol use across the cohort, it is important to acknowledge that other substances were also present in the lives of some individuals and thus, supports the use of substance use related literature being at times drawn on throughout the thesis, as well as alcohol specific literature.

Meaningful activity

The REC-CAP asks individuals to report if they are: working full time, working part time, volunteering or currently in education. From this data, a new variable was computed reporting whether the individual was undertaking any 'meaningful activity' – this was reported as yes if the individual stated they were doing one or more of the listed options. Meaningful activity, broken down by each variable,

is reported below in Table 4.7. As recovery is an individualised process, it cannot be anticipated that work will be an outcome for everyone (and certainly not immediately), providing the rationale for computing these variables together. Wider engagement with other meaningful activities (engagement with SASS and engagement outside of SASS) is reported later (see *SASS engagement and engagement outside of SASS*).

Table 4.7: Meaningful activities at Time 1²⁵

Meaningful activity	Number of individuals engaged with meaningful activity (overall cohort)
Full time work	19% (n = 13)
Part time work	8% (n = 5)
In education	3% (n = 2)
Volunteering	13% (n = 9)
Total	n = 29

As shown in Table 4.7, 30 individuals were engaged in meaningful activity at Time 1. As assessed by chi-square (1) = 4.629, $p = .031$ (s), there is a significant difference between meaningful activity and gender, with 56% of the overall cohort of women and 30% of the overall cohort of men being involved in meaningful activity. The strength of this difference is as follows: $\phi = .263$, $p = .031$. Given that existing literature states women present to services with more support needs (Grella et al, 2008; Neale, 2004), the number of women engaged in meaningful activity is perhaps higher than what may have been anticipated.

Recovery capital

Personal capital

Personal capital scores were computed for each individual. Within the REC-CAP, personal recovery capital is broken down into five categories (recovery experience, psychological health, physical health, risk taking and coping and life functioning), each containing five items scored as 0 (no) or 1 (yes). It is to be noted that psychological health and physical health within this variable differ from the

²⁵ It is possible for an individual to be listed in more than one category. For example, working part time and volunteering.

psychological and physical health variables listed within the quality of life and satisfaction measure. Scores are reported out of 25, with higher scores indicating greater levels of personal capital.

Social capital

Social capital scores were computed for each individual. Within the REC-CAP, social recovery capital is broken down into five categories (meaningful activities, substance use and sobriety, social support, housing and safety and citizenship). It is to be noted that meaningful activities within this variable differs from the meaningful activity variable reported earlier (computed to include working full time, working part time, volunteering or at university or college). Scores are reported out of 25, with higher scores indicating greater levels of social capital.

Community capital

Community capital scores were computed for each individual, based on the involvement in recovery groups and local community measure. Scores for this measure are originally reported out of a total of 14 but for the purpose of the analysis, all three domains of recovery capital were to be equally weighted. Community capital scores were therefore re-calibrated to be reported out of 25 also, with higher scores indicating greater levels of community capital.

Overall recovery capital

Once scores for each of the three domains of recovery capital were computed, a collective score was given for overall recovery capital, reported out of 75.

The mean scores for personal, social and community capital, as well as overall recovery capital, split by gender, are reported below. This is done so alongside the t and p values associated with the independent samples t-test, assessing if differences are present by gender.

Table 4.8: Mean scores and differences by gender for recovery capital at Time 1

Variable	Mean score and standard deviation	Mean score and standard deviation	Mean score and standard deviation (male cohort)	Independent samples t-test: t value, p value and degree of freedom
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	(overall cohort)	(female cohort)		
Personal capital	16.102 (SD = 5.985)	16.565 (SD = 5.975)	15.866 (SD = 6.043)	t = -.453, p = .652, df = 66 (ns)
Social capital	16.492 (SD = 5.503)	16.956 (SD = 5.514)	16.250 (SD = 5.545)	t = -.496, p = .621, df = 65 (ns)
Community capital	11.039 (SD = 7.003)	11.180 (SD = 7.971)	10.963 (SD = 6.527)	t = -.119, p = .906, df = 64 (ns)
Overall recovery capital	43.584 (SD = 13.013)	44.701 (SD = 13.408)	42.972 (SD = 12.323)	t = -.509, p = .612, df = 63 (ns)

As shown in Table 4.8, out of the three domains of recovery capital, the highest mean score for the overall cohort (as well as for men and women separately) is social capital. Despite some small mean differences in mean scores by gender, none of these were of statistical significance. Given that recovery is a socially mediated process, and that social capital will provide individuals with emotional and psychological support, as well as access to other resources to aid their recovery, this is an encouraging finding within the Time 1 data.

SASS engagement

While the REC-CAP's community capital measure captures an individual's involvement with recovery groups, as well as asking individuals to detail what recovery groups (both in person and online) they have been attending, it does not afford the individual the opportunity to list other meaningful activities they are engaged with. In response to this and within the context of the thesis, a new scale was developed and added into the REC-CAP (see Chapter 3: *Study 2: Rationale and method*).

Individuals listed which groups at SASS they had recently attended (out of a possible eight)²⁶ as well as the frequency of their attendance (whether the groups listed had been accessed once in the last 30 days, once a week or more than once a week). The mean score for number of groups attended at SASS was 1.514 (SD = 1.227), signifying lower attendance, given this was reported out of a possible eight.

²⁶ These eight groups (mixed SMART, women's only SMART, moodmasters, SASSY ladies, men's group, arts and crafts, drop in and active citizenship) were run on a weekly basis or more frequently, during the time period of data collection.

There was very little difference between women’s mean scores (1.521, SD = 1.238) and men’s mean scores (1.511, SD = 1.236), and as assessed by an independent samples t-test, these were not of significance ($t = -.034$, $p = .678$, $df = 33.800$) (ns). This was then correlated against recovery capital, with the r and p values associated with this reported below.

Table 4.9: Number of groups attended at SASS correlated with recovery capital domains at Time 1

Variable	Correlations: r values and p values
Personal capital	$r = -.099$, $p = .423$ (ns)
Social capital	$r = .042$, $p = .737$ (ns)
Community capital	$r = .320$, $p = .009$ (s)
Overall recovery capital	$r = .076$, $p = .545$ (ns)

The significance noted in Table 4.9 with community capital may be attributable to the fact that the REC-CAP’s community capital measure focuses specifically on engagement in recovery groups and thus, shares similarities with the reporting of data of the number of groups the individual attended at SASS. Given the importance of such engagement to support recovery growth, it can be expected that significance will be noted with other domains of recovery capital at Time 2.

Community engagement

Individuals also listed resources under the same four domains²⁷ as those explored in Study 3 (see Chapter 4). From this data, two new variables were computed: one which gave a total for number of assets listed across all four domains and another which gave a score out of four, for the number of domains assets had been listed under.

Table 4.10 details the mean scores for engagement with assets, by both domain and gender. It also outlines the t and p values associated with the independent samples t-test run to assess the differences by gender.

²⁷ Professional services; Sport, recreation and arts; Peers and mutual aid; and Education, employment and training.

Table 4.10: Mean scores and differences by gender for community engagement at Time 1

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t-test: t value, p value and degree of freedom
Total number of assets	2.735 (SD = 2.155)	3.304 (SD = 2.162)	2.444 (SD = 2.116)	t = -1.574, p = .120, df = 66 (ns)
Total number of domains	1.611 (SD = 1.014)	1.826 (SD = 1.029)	1.500 (SD = 1.000)	t = -1.255, p = .214, df = 65 (ns)
Professional services	.926 (SD = 1.069)	.869 (SD = 1.057)	.955 (SD = 1.086)	t = 312, p = .756, df = 66 (ns)
Sport, recreation and arts	.867 (SD = 1.195)	1.434 (SD = 1.471)	.577 (SD = .916)	t = -2.551, p = 0.16, df = 30.982 (s)
Mutual aid	.750 (SD = .887)	.739 (SD = .915)	.755 (SD = .883)	t = .072, p = .943, df = 66 (ns)
Education, employment and training	.191 (SD = .496)	.260 (SD = .540)	.155 (SD = 2.000)	t = -.826, p = .412, df = 66 (ns)

The highest mean score for the overall cohort (as well as for men and women separately), when split by domain is professional services. Given that individuals completed Time 1 REC-CAPs upon entry to SASS, it can be presumed that they may also have been linked in with other professional services to support their recovery journeys, and it may well have been those services that referred them to SASS, providing explanation for this being the most common domain reported. It can be presumed that over time, as individuals make progress with their recovery, there will be a reduced demand for support from professional services and uptake of engagement in assets under other domains. These changes can be expected to be seen at Time 2. As assessed by independent sample t-tests, the differences in mean scores by gender are not of significance across any of the variables except sport,

recreation and art, with women being more likely to be engaged with such assets (see Table 4.12). This indicates that the forms of engagement undertaken between men and women differ.

The total number of assets listed, and number of domains assets were listed under, were then correlated with recovery capital. The *r* and *p* values associated with the total number of assets can be seen in Table 4.11, and those associated with the total number of domains assets can be seen in Table 4.12.

Table 4.11: Total number of assets listed correlated against recovery capital at Time 1

Variable	Correlations: r values and p values
Personal capital	<i>r</i> = .003, <i>p</i> = .979 (ns)
Social capital	<i>r</i> = .030, <i>p</i> = .811 (ns)
Community capital	<i>r</i> = .083, <i>p</i> = .509 (ns)
Overall recovery capital	<i>r</i> = .061, <i>p</i> = .623 (ns)

Table 4.12: Total number of domains listed correlated recovery capital at Time 1

Variable	Correlations: r values and p values
Personal capital	<i>r</i> = .064, <i>p</i> = .609 (ns)
Social capital	<i>r</i> = -.005, <i>p</i> = .969 (ns)
Community capital	<i>r</i> = .120, <i>p</i> = .340 (ns)
Overall recovery capital	<i>r</i> = .092, <i>p</i> = .468 (ns)

As shown in Table 4.11 and 4.12, no statistical significance was noted across these variables. As acknowledged in the literature review, engagement in meaningful activity is thought to contribute to the growth of recovery capital (Best et al., 2015a; Best et al., 2017; Collinson & Best, 2019) and thus, it can be assumed that changes may not be noted until Time 2.

Each of the four domains were then correlated against overall recovery capital. The *r* and *p* values associated with each domain are reported below.

Table 4.13: Domains of community engagement correlated against overall recovery capital at Time 1

Variable	Correlations: r values and p values
Mutual aid	r = .068, p = .593 (ns)
Sports, recreation, and arts	r = .061, p = .631 (ns)
Education, employment, and training	r = .020, p = .872 (ns)
Professional services	r = -.011, p = .932 (ns)

As shown in Table 4.13, there were no significant associations identified between engagement in any of the four domains and overall recovery capital. Changes can perhaps be expected to be identified at Time 2, as individuals begin to engage in more assets to support their recovery.

Satisfaction with level of community engagement

Twenty-one individuals (30% of the overall cohort of women and 33% of the overall cohort of men) stated they were dissatisfied with their levels of community engagement. As assessed by chi-square (1) = .031, p = .860 (ns) there were no statistically significant differences by gender. It was presumed that individuals may have stated they were satisfied with their community engagement if they were seen to be involved in meaningful activities (working full time, working part time, volunteering or currently in education). Out of those engaged in meaningful activities, 47% of this cohort stated they were satisfied with their community engagement, but as assessed by chi-square (1) = .874, p = .350 (ns) the relationship between meaningful activity and satisfaction of community engagement was not of significance.

Satisfaction of community engagement was then assessed in relation to whether the individual stated they were engaged in assets within the wider community (see *Engagement outside of SASS*). While no significant relationship was noted, as assessed by chi-square (1) = .704, p = .402 (ns), those who were engaged with at least one asset within the wider community were much more likely to state they were satisfied with their community engagement (89% of the overall cohort) than those engaged in meaningful activity (working full time, working part time, volunteering or currently in education) (47% of the overall cohort). This could perhaps be attributed to the nature of the meaningful activity

variable, and the fact that work and education may not necessarily be directly associated with an individual's local community. For example, an individual may work outside of their local community, or not perceive work as a form of community engagement. Engagement in wider community assets however, undertaken for personal gratification, may therefore provide a more meaningful sense of engagement, leading to higher rates of satisfaction.

Do you view yourself as an active citizen?

Individuals were then asked if they viewed themselves as an active citizen. Forty-four individuals (64% of the overall cohort of women and 70% of the overall cohort of men) stated they did view themselves as an active citizen. As assessed by chi-square (1) = .250, $p = .671$ (ns) there were no statistically significant differences by gender.

Are there any groups you would like to attend but you have not?

Individuals were then asked if there were other groups, either recovery orientated and/ or non-recovery orientated, that they would like to attend. Thirty individuals (74% of the overall cohort of women and 33% of the overall cohort of men) stated there were other groups they would like to attend. As assessed by chi-square (1) = 10.041, $p = .002$ (s), the differences by gender were of significance, with women more likely to state that they wanted to join other groups. This is important to note, given that failure to successfully engage with groups, despite the desire to do so, may generate feelings of exclusion in women and subsequently be detrimental to their recovery progress.

Barriers to community engagement

Individuals were then presented with a list of potential barriers to community engagement and asked to tick any that applied. Out of 17 potential barriers, the mean score for the overall cohort at Time 1 was 3.741 (SD = 3.137). When split by gender, the mean score for women (4, SD = 3.211) was fractionally higher than men (3.605, SD = 3.132), although as assessed by an independent samples t-test, $t = -.452$, $p = .653$, $df = 56$ (ns), the differences by gender were not of significance. Table 4.14 details the percentages of those who indicated the listed barrier was detrimental to their community engagement. Each barrier was also assessed by chi-square to identify if the differences by gender were of significance.

Table 4.14: Gender differences in barriers to community engagement at Time 1

Barrier	Overall cohort %	Female cohort %	Male cohort %	Chi-square
I can't get there easily	46%	52%	43%	(1) = .491, p = .483 (ns)
Lack of confidence	43%	48%	41%	(1) = .294, p = .587 (ns)
Lack of motivation	40%	44%	39%	(1) = .147, p = .701 (ns)
I don't know enough about the group	38%	39%	37%	(1) = 0.24, p = .878 (ns)
It's too expensive	32%	26%	35%	(1) = .535, p = .465 (ns)
I don't want to go by myself	30%	39%	21%	(1) = 2.681, p = .102 (ns)
Family constraints	23%	26%	21%	(1) = .227, p = .634 (ns)
I don't have enough time	22%	26%	19%	(1) = .436, p = .509 (ns)
Health concerns	20%	17%	21%	(1) = .119, p = .731 (ns)
I might be judged for attending	18%	13%	21%	(1) = .627, p = .429 (ns)
Work constraints	18%	30%	12%	(1) = 3.563, p = .059 (ns)
Lack of specific opportunities	17%	14%	19%	(1) = .297, p = .586 (ns)
Unsupportive community	14%	17%	12%	(1) = .375, p = .540 (ns)
Unsupportive friends	12%	17%	9%	(1) = .920, p = .337 (ns)
It isn't age appropriate	9%	4%	12%	(1) = .961, p = .327 (ns)
It isn't gender appropriate	6%	4%	7%	(1) = .182, p = .670 (ns)
Religion	6%	4%	7%	(1) = .201, p = .654 (ns)

As shown in Table 4.14, there were no statistically significant differences by gender across any of the listed barriers. Whilst some differences by percentages are apparent, the number of women within the sample was lower and thus may explain why significance was not shown for these specific variables. The barriers most commonly noted included not being able to get to a resource easily and a lack of confidence and motivation. Barriers to engagement were then correlated with recovery capital. The χ^2 and p values are reported in the table below.

Table 4.15: Barriers to community engagement correlated against recovery capital domains at Time 1

Variable	Correlations: r values and p values	Significance
Personal capital	r = -.504, p = .000	s
Social capital	r = -.408, p = .002	s
Community capital	r = .158, p = .241	ns
Overall recovery capital	r = -.311, p = .019	s

As shown in Table 4.15, barriers to community engagement were negatively correlated with personal, social and overall recovery capital, highlighting the impact such barriers can have on community engagement if not addressed. The listed barriers were then correlated against each of the four domains²⁸ of engagement. The r and p values associated with this are detailed in the table below.

Table 4.16: Barriers to community engagement correlated against each of the four domains of engagement at Time 1

Variable	Correlations: r values and p values	Significance
Sport, recreation and arts	r = .097, p = .417	ns
Mutual aid	r = .121, p = .367	ns
Employment, education and training	r = .151, p = .257	ns
Professional services	r = .294, p = .025	s

As shown in Table 4.16, barriers to community engagement were positively correlated with professional services. When the assets listed under this domain were broadly grouped together, the prevalent themes were drug and alcohol supports, primary health care, mental health support and housing. This highlights increased service usage amongst those who list more barriers to community engagement.

²⁸ Professional services; sport, recreation and arts; peers and mutual aid; and education, employment and training.

Community engagement scale

A new summary measure, the community engagement scale, was then computed based on the last four variables: do you view yourself as an active citizen, are you satisfied with your level of community engagement, are there other groups you would like to attend and barriers to community engagement. The latter two variables were reversed scored so a higher score for the scale (out of a total of 20) signified higher levels of community engagement. This meant the individual was satisfied with their engagement, viewed themselves as an active citizen, did not feel as though there were other groups they would like to attend and identified less barriers to engagement.

A principal components analysis of the community engagement scale identified a single factor structure. Only one eigenvalue was greater than one (= 2.026), with the other three eigenvalues all falling below one (see Appendix 13). Therefore, the scale all loads on a single component.

Table 4.17 details the mean scores for the community engagement scale, split by gender. It also outlines the r and p values associated with the independent samples t-test run to assess the differences by gender.

Table 4.17: Community engagement scale by gender at Time 1

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t-test: t value, p value and degree of freedom
Community engagement scale	15.173 (SD = 3.687)	14.789 (SD = 3.980)	15.393 (SD = 3.552)	t = .565. p = .574, df = 50 (ns).

As shown in Table 4.17, the differences by gender were not of statistical significance. The slight variation in mean scores however can be explained by the higher percentage of women who stated there were other groups they would like to attend but had not (see above: *Are there any groups you would like to attend but you have not?*). The community engagement scale was then correlated against recovery capital. The r and p values associated with these results are listed in the table below.

Table 4.18: Community engagement scale correlated recovery capital at Time 1

Variable	Correlations: r values and p values	Significance
Personal capital	r = .576, p = .000	s
Social capital	r = .422, p = .002	s
Community capital	r = -.161, p = .260	ns
Overall recovery capital	r = .364, p = .009	s

As highlighted in Table 4.18, positive statistical significance is noted with personal capital, social capital and overall recovery capital. This is a prominent finding within the Time 1 data, providing strong rationale for the development of the new scale and supporting its position within the research. What is important to note here is that the new scale does not account for how engaged an individual is (in terms of time) but instead how satisfied they are with their level of engagement and the barriers to community engagement they face. Given that such engagement is an individualised process, it may be those reporting lower scores on the community engagement scale that are more in need of support to encourage wider engagement. It is also important here to consider the negative correlation between the community engagement scale and community capital. Although this is not significant, this suggests that those who are heavily involved in recovery groups are likely less to become engaged in wider community resources. This may perhaps be attributable to individuals who are earlier in their recovery journey being more likely to rely on recovery orientated supports, and potentially experiencing more barriers to wider engagement.

Social support measure

The final variable of interest explored is social support: out of a total of four items (scored between one and seven), an overall score for the social support received from others was computed. Out of a maximum score of 28, the mean score for the overall cohort was 18.879 (SD = 5.438). When split by gender, whilst the mean score for women was marginally higher (19.250, SD = 3.918) than men (18.684, SD = 6.129), these results were not of significance, as assessed by an independent samples t-test, $t = -.374$, $p = .710$, $df = 56$ (ns). Social support was then correlated against recovery capital, with the associated r and p values reported in the table below.

Table 4.19: Social support correlated with recovery capital domains at Time 1

Variable	Correlations: r values and p values	Significance
Personal capital	r = .385, p = .003	s
Social capital	r = .388, p = .003	s
Community capital	r = -.073, p = .592	ns
Overall recovery capital	r = .307, p = .023	s

As shown in Table 4.19, social support was significantly positively correlated with personal capital, social capital and overall recovery capital. Given the dynamic relationship between social capital and social support, the significance noted here is not unexpected. The significance noted however with personal capital and overall recovery capital highlights the importance of social support to promote recovery growth.

Time 1 predictors of recovery capital

To complete the Time 1 analysis, a backwards elimination linear regression model was run to identify predictors of overall recovery capital. Quality of life and satisfaction, barriers to community engagement, the community engagement scale and social support all showed statistical significance when correlated against recovery capital at Time 1. As barriers to community engagement were however included in the community engagement scale, they are excluded from the regression as a standalone variable. Thus, leaving the other variables which did show statistical significance to be included.. Gender is also included, given its importance in light of the research question. The regression output is displayed below:

Figure 1: Variables entered/ removed from Time 1 regression

Model	Variables Entered	Variables Removed	Method
1	Gender; support measure; quality of life and satisfaction; community engagement scale ^b	.	Enter

a. Dependent Variable: Overall recovery capital, b. All requested variables entered.

The overall model was significant ($F = 3.066$, $p = 0.28$) and the Adjusted R square was 0.168 suggesting that the model predicted 16.8% of the variance in recovery capital with only quality of life approaching significance from the variables entered into the regression model, although all were retained in the final model. The model summary and coefficients associated with this are displayed in Appendix 14.

The overall model highlights the importance of gender, quality of life and satisfaction, the community engagement scale score and social support, for those new to the ARC at SASS. Therefore, it can be presumed that those presenting with lower scores for quality of life and satisfaction, the community engagement scale and social support upon entry to SASS may require more intensive support.

Summary of Time 1

In summary, significant differences were noted across several variables at Time 1, with some nuances by gender. For example, women were more likely to be engaged in meaningful activity; more likely to be engaged in assets listed under sports, recreation and arts; and more likely to state there were other groups they would like to attend but had not.

Levels of personal, social and community capital as well as overall recovery capital did not however differ by gender. Some domains were however significantly correlated with other variables. Specifically, quality of life and satisfaction; barriers to community engagement; the community engagement scale; and social support, were all positively significantly correlated with personal capital, social capital and overall recovery capital. Engagement in assets listed under professional services however was in fact statistically negatively correlated with recovery capital.

Out of the key variables which did show significance with recovery capital and were included in the regression (quality of life and satisfaction; the community engagement scale; and social support), these collectively predicted overall recovery capital at Time 1. The next stage of analysis will assess the representativeness of the cohort who were followed up at Time 2.

Assessing the representativeness of the cohort at Time 2

The next stage of analysis will explore whether the 18 people who did not complete Time 2 REC-CAPs differ significantly to those who did, as a mechanism for assessing the representativeness of the retained cohort. As per Time 1 analysis, all key variables of interest will be explored. Within this

section, when the term ‘between groups’ is used, this refers to those who retained at Time 2 and those who did not.

Demographic information

Gender

As assessed by chi-square (1) = 8.739, $p = 0.003$ (s), the differences noted in attrition rates by gender were of statistical significance, with a great percentage of men (38% of the overall male cohort at Time 1) not being retained in the sample at Time 2, compared to women (4% of the overall female cohort at Time 1). The strength of this difference is reported as $\phi = .358$, $p = .003$.

Age

As assessed by an independent sample t-test, $t = -2.636$, $p = .011$, $df = 66$ (s), the differences noted in attrition rates by age were of statistical significance, with those retained in the sample at Time 2 being older (mean age of 47 years) than those not retained (mean age of 39 years). The mean age of those retained in the sample is in line with statistics from Public Health England (2019) and the Life in Recovery survey (Best et al., 2015) which identifies those aged 40-49 accounting for the largest percentage of individuals in treatment for substance use. The other variables of interest were either assessed by an independent samples t-test, or chi-square²⁹, to identify any differences between groups. These are reported below in Table 4.20 and 4.21.

Table 4.20: Analysis between groups for continuous variables of interest

Variable	Mean score and standard deviation (retained at Time 2)	Mean score and standard deviation (not retained at Time 2)	Independent samples t-test: t value, p value and degree of freedom
Overall quality of life	62.800 (SD = 16.534)	63.235 (SD = 19.450)	$t = -.090$, $p = .929$, $df = 65$ (ns)
Personal capital	16.240 (SD = 5.943)	15.722 (SD = 6.257)	$t = -.313$, $p = .756$, $df = 66$ (ns)

²⁹ Independent samples t-tests are used for continuous variables and chi-square is used for nominal variables

Social capital	16.734 (SD = 5.548)	15.833 (SD = 5.479)	t = .591, p = .556, df = 65 (ns)
Community capital	10.677 (SD = 6.745)	12.079 (SD = 7.822)	t = .708, p = .481, df = 64 (ns)
Overall recovery capital	43.492 (SD = 13.658)	43.844 (SD = 11.370)	t = .095, p = .925, df = 63 (ns)
Frequency of attendance at SASS	2.437 (SD = 2.201)	2.201 (SD = 2.201)	t = -1.127, p = .264, df = 64 (ns)
Number of groups attended at SASS	1.580 (SD = 1.196)	1.333 (SD = 1.328)	t = .728, p = .469, df = 66 (ns)
Total assets listed	2.680 (SD = 2.084)	2.888 (SD = 2.398)	t = -.350, p = .727, df = 66 (ns)
Number of domains assets are listed under	1.591 (SD = 1.039)	1.666 (SD = .970)	t = -.266, p = .791, df = 56 (ns)
Barriers to engagement	3.707 (SD = 2.985)	3.823 (SD = 3.547)	t = -.127, p = .899, df = 56 (ns)
Community engagement scale	15.250 (SD = 3.548)	15.000 (SD = 4.098)	t = .224, p = .824, df = 50 (ns)
Social support	18.609 (SD = 5.629)	19.52 (SD = 5.051)	t = -.583, p = .562, df = 56 (ns)

Table 4.21: Analysis between groups for nominal variables of interest

Variable	Variable response	Mean score and standard deviation (retained at Time 2)	Mean score and standard deviation (not retained at Time 2)	Chi-square: degree of freedom, value and p value
Substance use in last 90 days	Yes	29 (58%)	21 (42%)	(1) = .032, p = .857 (ns)
	No	10 (56%)	8 (44%)	
Accommodation	Stable	42 (76%)	13 (24%)	

	Unstable	8 (62%)	5 (38%)	(1) = 1.187, p = .276 (ns)
Meaningful activity	Yes	28 (63%)	13 (37%)	(1) = 1.261, p = .262 (ns)
	No	21 (81%)	5 (19%)	
Satisfaction with community engagement	Yes	15 (71%)	6 (29%)	(1) = .032, p = .857 (ns)
	No	33 (73%)	12 (27%)	
Do you view yourself as an active citizen	Yes	15 (71%)	6 (29%)	(1) = .094, p = .759 (ns)
	No	33 (75%)	11 (25%)	
Would like to attend other groups	Yes	22 (67%)	11 (33%)	(1) = 1.418, p = .234 (ns)
	No	24 (80%)	6 (20%)	

In summary, the only statistically significant differences between groups were by gender and age. No statistically significant differences were noted across any of the other variables of interest, as shown in Table 4.21 and 4.22. This will be returned to in the discussion of the findings (Chapter 8). This chapter will now move to the analysis of Time 2 data.

Time 2

Data reporting

The next stage of analysis will look at the data from Time 2 and will follow the same format as that followed for Time 1. This stage of analysis is to be treated separately, in that no comparisons are made against the Time 1 variables of interest. This will instead follow in final stage of analysis: the change analysis.

Demographic information

Fifty individuals completed the REC-CAP at Time 2, resulting in a 73% retention rate from the original sample. Twenty-two identified as female (44% of the overall cohort) and 28 identified as male (56% of the overall cohort). Whilst the percentage of women included in the sample at Time 2 is higher than

that at Time 1 (34%), it reflects similarly to the gender split of those in treatment for alcohol use, published by Public Health England (2019).

Individuals ranged in age between 23 and 74 years (SD = 11.342) with the mean age for women remaining the same as Time 1 (47 years) and mean age for men increasing from 44 years to 48 years. As assessed by an independent samples t-test, these differences were not of significance, as shown by $t = .093$, $p = .926$, $df = 48$ (ns).

Forty-five individuals (94% of the overall cohort) identified as white British; two individuals identified as mixed race (4% of the overall cohort) and one individual identified as Indian (2% of the overall cohort).

Exploration of dependent variables

Quality of life and satisfaction

The mean scores for the quality of life and satisfaction measure, split by gender, are reported in the table below. This is also accompanied by the t and p values associated with the independent samples t-test.

Table 4.22: Mean scores and differences by gender for the quality of life and satisfaction measure at Time 2

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t-test: p value and degree of freedom
Psychological health	13.440 (SD = 4.031)	13.364 (SD = 4.467)	13.500 (SD = 3.736)	$t = .118$, $p = .907$, $df = 48$ (ns)
Physical health	12.680 (SD = 4.743)	12.773 (SD = 5.326)	12.893 (SD = 4.332)	$t = .088$, $p = .930$, $df = 48$ (ns)
Quality of life	14.080 (SD = 4.065)	14.409 (SD = 4.532)	13.821 (SD = 3.722)	$t = -.504$, $p = .617$, $df = 33.274$ (ns)
Quality of accommodation	16.160 (SD = 4.022)	16.045 (SD = 5.313)	16.250 (SD = 2.716)	$t = .164$, $p = .870$, $df = 29.541$ (ns)

Support network	15.260 (SD = 4.425)	15.864 (SD = 4.892)	14.786 (SD = 4.049)	t = -.853, p = .398, df = 48 (ns)
Overall quality of life	71.898 (SD = 16.908)	72.454 (SD = 20.101)	71.444 (SD = 14.175)	t = -.206, p = .838, df = 47(ns)

As shown in Table 4.22, satisfaction with quality of accommodation scored the highest for both women and men. Despite small differences between their mean scores, as assessed by the independent samples t-test, the differences between gender are not of significance for any of the five wellbeing indicators or for overall wellbeing.

Accommodation

Table 4.23 reports the accommodation status of the cohort at Time 2. Split by gender, this details whether individuals were in stable or unstable accommodation.

Table 4.23: Accommodation status by gender at Time 2

Time 2	Stable	Unstable
Men	23 (85% of men)	4 (15% of men)
Women	20 (91% of women)	2 (9% of women)

As shown in Table 4.24, 20 women (91% of the female cohort) reported being in stable accommodation at Time 2 in comparison to 23 men (85% of the male cohort). As assessed by chi-square (1) = .370, p = .543 (ns), there is no significant association between accommodation (stable/unstable) and gender. The data was then assessed in light of who the individual lived with, with each of the living categories, split by gender, shown below.

Table 4.24: Living arrangements at follow-up by gender at Time 2

Time 2	Alone	With others (not children)	With others (with children)
Men	10 (40% of men)	13 (52% of men)	2 (8% of women)
Women	7 (33% of women)	8 (38% of women)	6 (29% of women)

As shown in Table 4.25, a higher percentage of women reported living with their children, and a higher percentage of men reported living with others, but not their children, or living alone. These differences were not however of statistical significance, as assessed by chi square ($\chi^2(2) = 3.398, p = .183$ (ns)).

A one-way analysis of variance was then run with recovery capital and living arrangements, to assess the impact of such living arrangements. No statistical significance was identified between an individual's living arrangements and personal capital ($f = .623, df = 2, 42, p = .541$) (ns); social capital ($f = 1.702, df = 2, 39, p = .196$) (ns); community capital ($f = .651, df = 2, 42, p = .527$) (ns); or overall recovery capital ($f = .970, df = 2, 39, p = .388$) (ns). Although significance was noted at Time 1, with those who lived with others but not their children having significantly higher social capital than those who lived alone, it can be presumed that as individuals engage with community resources, access to social capital through alternative means is increased. Resultantly, those living alone are no longer at a disadvantage of social capital accumulation than those living with others. This is also promising, given the interrelated nature between social capital affording access to social support (Best et al, 2015; Boeri et al., 2016).

Substance use

Twenty-two individuals (57% of the overall cohort of women and 37% of the overall cohort of men) stated they had used a substance within the last 90 days, most of whom (92% of the overall cohort) had consumed alcohol. Out of those who had consumed alcohol, the average number of days individuals had drunk alcohol within the 90 days' time frame prior to their Time 2 REC-CAP completion was 44.53 days ($SD = 30.594$) and the average number of units drunk per drinking day was 15.882 ($SD = 15.090$).

There was also some overlap with the use of other substances within the last 90 days. Five individuals (10% of the overall cohort had used cannabis); two individuals (4% of the overall cohort) had used cocaine powder; two individuals (4% of the overall cohort) had used prescribed methadone; one individual (2% of the overall cohort) had used street methadone; and one individual (2% of the overall cohort) had used prescribed benzos.

Meaningful activity

Corresponding with Time 1 data, meaningful activity, broken down by each variable, is reported in the table below.

Table 4.25: Meaningful activities at Time 2³⁰

Meaningful activity	Number of individuals engaged with meaningful activity (overall cohort)
Full time work	18% (n = 9)
Part time work	15% (n = 7)
In education	6% (n = 3)
Volunteering	23% (n = 11)
Total	n = 30

As shown in Table 4.25, 30 individuals were engaged in meaningful activity at Time 2. As assessed by chi-square (1) = 3.063, $p = .080$ (ns), there was no significance noted between meaningful activity and gender, despite a higher percentage of women (71% of the overall cohort of women) being engaged in such activity in comparison to men (46% of the overall cohort of men).

Recovery capital

The mean scores for personal, social and community capital, as well as overall recovery capital, split by gender, are reported in the table below. This is done so alongside the t and p values associated with the independent samples t -test, assessing if differences are present by gender.

Table 4.26: Mean scores and differences by gender for recovery capital at Time 2

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t -test: t value, p value and degree of freedom
Personal capital	18.489 (SD = 5.583)	17.772 (SD = 5.943)	19.074 (SD = 5.312)	$t = .809$, $p = .423$, $df = 47$ (ns)

³⁰ It is possible for an individual to be listed in more than one variable. For example, working part time and volunteering.

Social capital	17.916 (SD = 5.953)	18.045 (SD = 5.681)	17.807 (SD = 5.844)	t = -.654, p = .892, df = 46 (ns)
Community capital	9.949 (SD = 8.679)	11.444 (SD = 9.049)	8.730 (SD = 8.336)	t = -1.091, p = .281, df = 47 (ns)
Overall recovery capital	46.742 (SD = 16.477)	48.800 (SD = 17.720)	45.239 (SD = 15.690)	t = -.712, p = .480, df = 43 (ns)

As shown in Table 4.28, out of the three domains of recovery capital, the highest mean score for the women is social capital, and the highest mean score for men is personal capital. Despite some differences in mean scores by gender, none of these were of statistical significance. Both personal and social capital however scored highly for men and women which is a promising finding at Time 2. Given it is known that such capital affords access to community resources (Best et al., 2017; Collinson & Best, 2019), this may subsequently promote the growth of community capital overtime.

SASS engagement

The mean score for number of groups attended at SASS was 1 (SD = 1.697), and as assessed by an independent samples t-test, there were no significant differences by gender, as shown by t = -.034, p = .973, df = 66 (ns). This was then correlated against recovery capital, with the r and p values reported below.

Table 4.27: Number of groups attended at SASS correlated against recovery capital at Time 2

Variable	Correlations: r values and p values	Significance
Personal capital	r = .130, p = .372	ns
Social capital	r = .323, p = .030	s
Community capital	r = .541, p = .000	s
Overall recovery capital	r = .466, p = .001	s

As highlighted in Table 4.27 the number of groups attended at SASS was statistically positively correlated with social capital, community capital and overall recovery capital. The significance noted here highlights the importance of involvement in recovery orientated groups to aid recovery growth.

Engagement outside of SASS

Table 4.28 details the mean scores for engagement with assets, by both domain and gender. It also outlines the r and p values associated with the independent samples t-test run to assess the differences by gender.

Table 4.28: Mean scores and differences by gender for engagement with assets at Time 2

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t-test: t value, p value and degree of freedom
Total number of assets	2.490 (SD = 2.166)	3.090 (SD = 2.598)	2.071 (SD = 1.698)	t = -1.592, p = .120, df = 34.440 (ns)
Total number of domains	1.490 (SD = 1.102)	1.723 (SD = 1.241)	1.321 (SD = .983)	t = -1.291, p = .203, df = 48 (ns)
Professional services	.686 (SD = .860)	.863 (SD = 888)	.571 (SD = 835)	t = -1.193, p = .239, df = 48 (ns)
Sport, recreation and arts	.960 (SD = 1.165)	1.272 (SD = 1.241)	.750 (SD = 1.075)	t = -1.594, p = .118, df = 48 (ns)
Mutual aid	.588 (SD = .962)	.681 (SD = 1.086)	.500 (SD = 881)	t = -.654, p = .517, df = 48 (ns)
Education, employment and training	.254 (SD = .560)	.272 (SD = 631)	.250 (SD = 518)	t = -.140, p = .889, df = 48 (ns)

The highest mean score for overall cohort, (as well as for men and women separately) when split by domain is sport, recreation, and arts. Lower scores for mutual aid and professional services may indicate positive change, signifying that individuals are less reliant on formal groups and organisations and instead are beginning to seek alternative activities related to improved health and wellbeing more broadly. As assessed by independent samples t-tests, the differences in mean scores by gender are not of significance.

The total number of assets listed, and number of domains assets were listed under were then correlated with recovery capital. The r and p values associated with the total number of assets can be seen in Table 4.29, and those associated with the total number of domains assets were listed under can be seen in Table 4.30.

Table 4.29: Total number of assets listed correlated with recovery capital at Time 2

Variable	Correlations: r values and p values
Personal capital	$r = .161, p = .270$ (ns)
Social capital	$r = .318, p = .033$ (s)
Community capital	$r = .560, p = .000$ (s)
Overall recovery capital	$r = .460, p = .001$ (s)

As shown in Table 4.29, the total number of assets listed was significantly correlated with social capital, community capital and overall recovery capital.

Table 4.30: Total number of domains listed correlated with recovery capital at Time 2

Variable	Correlations: r values and p values
Personal capital	$r = .171, p = .241$ (ns)
Social capital	$r = .290, p = .054$ (ns)
Community capital	$r = .606, p = .000$ (s)
Overall recovery capital	$r = .460, p = .001$ (s)

As shown in Table 4.30, the total number of domains assets were listed under was significantly correlated with community capital and overall recovery capital. Collectively, these are important findings, highlighting the importance of community engagement to aid recovery growth.

Each of the four domains were then correlated against overall recovery capital. The r and p values associated with each domain are reported below (Table 4.34).

Table 4.31: Domains of community engagement correlated against overall recovery capital at Time 2

Variable	Correlations: r values and p values
Mutual aid	r = .463, p = .001 (s)
Sports, recreation, and arts	r = .304, p = .042 (s)
Education, employment, and training	r = .351, p = .018 (s)
Professional services	r = .051, p = .740 (ns)

As shown in Table 4.31, assets listed under all three of the domains (mutual aid; sports, recreation and arts; and education, employment and training) were significantly correlated with overall recovery capital. This is very encouraging and recognises the importance of engagement in a diverse range of meaningful activities. It must however be acknowledged that engagement within each domain may contribute to the accumulation of each component of recovery capital in a unique way.

Satisfaction with level of community engagement

Thirty-nine individuals (14% of the overall cohort of women and 26% of the overall cohort of men) stated they were dissatisfied with their levels of community engagement. As assessed by chi-square (1) = 1.127, p = .288 (ns) there were no statistically significant differences by gender. The relationship between engagement in meaningful activity and satisfaction of community engagement was then assessed. Out of those engaged in meaningful activities, 85% stated they were satisfied with their community engagement. As assessed by chi-square (1) = 1.355, p = .244 (ns) this relationship was not of significance, implying that engagement in meaningful activity did not contribute to satisfaction with community engagement.

Do you view yourself as an active citizen?

Thirty-eight individuals (81% of the overall cohort of women and 78% of the overall cohort of men) stated they did view themselves as an active citizen. As assessed by chi square (1) = .072, p = .788 (ns) there were no statistically significant differences by gender.

Are there any groups you would like to attend but you haven't?

Eighteen individuals (48% of women and 30% of men) stated there were other groups they would like to attend. Similar to Time 1 which found a higher percentage of women stating there were other groups they would like to attend, if these individuals are not adequately supported to do so, this may result in feelings of exclusion and marginalisation and thus, be detrimental to their recovery progress. The differences by gender at Time 2 however are not of significance, as assessed by chi-square square (1) = 2.018, p = .155 (ns).

Barriers to community engagement

Out of 17 potential barriers, the mean score for the overall cohort at Time 2 was 3.369 (SD = 3.414). When split by gender, the mean score for women (4.350, SD = 3.787) was higher than men (2.615, SD = 2.965), although as assessed by an independent samples t-test, t = -1.746, p = .088, df = 44 (ns), the differences by gender were not of significance. Table 4.32 details the percentages of those who indicated the listed barrier was detrimental to their community engagement. Each barrier was also assessed by chi-square to identify if the differences by gender were of significance.

Table 4.32: Gender differences in barriers to community engagement at Time 2

Barrier	Overall cohort %	Female cohort %	Male cohort %	Chi-square
I can't get there easily	40%	48%	35%	(1) = .704, p = .401 (ns)
It's too expensive	34%	38%	31%	(1) = .188, p = .665 (ns)
I don't know enough about the group	33%	43%	25%	(1) = 1.524, p = .217 (ns)
Lack of motivation	32%	38%	28%	(1) = .495, p = .482 (ns)
I don't have enough time	26%	38%	17%	(1) = 2.522, p = .112 (ns)
Work constraints	26%	33%	21%	(1) = .873, p = .350 (ns)
Lack of confidence	24%	33%	17%	(1) = 1.554, p = .213 (ns)
Lack of specific opportunities	22%	24%	21%	(1) = .039, p = .843 (ns)

I don't want to go by myself	20%	29%	19%	(1) = 1.508, p = .219 (ns)
Unsupportive friends	18%	24%	14%	(1) = .627, p = .428 (ns)
Family constraints	18%	24%	14%	(1) = .726, p = .394 (ns)
Unsupportive community	16%	19%	14%	(1) = .152, p = .696 (ns)
Health concerns	16%	24%	10%	(1) = 1.506, p = .220 (ns)
I might be judged for attending	12%	14%	10%	(1) = .142, p = .706 (ns)
It isn't age appropriate	8%	5%	10%	(1) = .567, p = .451 (ns)
It isn't gender appropriate	8%	10%	7%	(1) = .091, p = .763 (ns)
Religion	6%	9%	3%	(1) = .740, p = .390 (ns)

As shown in Table 4.32, there were no statistically significant differences by gender across any of the listed barriers. Whilst some differences by percentages are apparent, the number of women within the sample was lower and thus may explain why significance was not shown for these specific variables. The barriers most commonly noted included not being able to get to a resource easily; the resource being too expensive and not knowing enough about a resource. Barriers to engagement were then correlated with recovery capital. The *r* and *p* values are reported in the table below.

Table 4.33: Barriers to community engagement correlated against recovery capital at Time 2

Variable	Correlations: r values and p values	Significance
Personal capital	r = -.503, p = .000	s
Social capital	r = -.529, p = .000	s
Community capital	r = .049, p = .754	ns
Overall recovery capital	r = -.314, p = .049	s

As shown in Table 4.33, barriers to community engagement were statistically negatively correlated with personal, social and overall recovery capital. This highlights the detrimental impact such barriers

can have on recovery capital growth and emphasises the importance of supporting individuals in a strengths based manner to begin to overcome some of these.

The listed barriers were then correlated against each of the four domains³¹ of engagement. The r and p values associated with this are detailed in the table below.

Table 4.34: Barriers to community engagement correlated against each of the four domains of engagement at Time 2

Variable	Correlations: r values and p values	Significance
Sport, recreation and arts	r = -.041, p = .719	ns
Mutual aid	r = .037, p = .811	ns
Employment, education and training	r = -.176, p = .248	ns
Professional services	r = .167, p = .274	ns

As shown in Table 4.34, barriers to community engagement were not statistically correlated with any of the four domains. This perhaps suggests that the relationship between barriers to community engagement and actual engagement is complex, and that a reduction in barriers does not necessarily translate to the uptake of wider engagement.

Community engagement scale

Table 4.35 details the mean scores for community engagement scale, split by gender. It also outlines the r and p values associated with the independent samples t-test run to assess the differences by gender.

Table 4.35: Community engagement scale by gender at Time 2

Variable	Mean score and standard deviation	Mean score and standard deviation	Mean score and standard deviation	Independent samples t-test:

³¹ Professional services; sport, recreation and arts; peers and mutual aid; and education, employment and training.

	(overall cohort)	(female cohort)	(male cohort)	t value, p value and degree of freedom
Community engagement scale	15.780 (SD = 3.711)	14.823 (SD = 1.061)	16.391 (SD = .652)	t = 1.323, p=.194, df = 38) (ns)

As shown in Table 4.35, the differences by gender were not of statistical significance. The community engagement scale was then correlated against recovery capital. The r and p values associated with these results are listed in the table below.

Table 4.36: Community engagement scale correlated against recovery capital at Time 2

Variable	Correlations: r values and p values	Significance
Personal capital	r = .575, p = .000	s
Social capital	r = .615, p = .000	s
Community capital	r = .079, p = .647	ns
Overall recovery capital	r = .448, p = .007	s

As highlighted in Table 4.38, positive statistical significance is noted with personal capital, social capital and overall recovery capital. This is an important finding, again supporting the development of the community engagement scale and recognising its importance to help support recovery growth. Perhaps given the community capital measure is predominantly recovery focused, no significance is noted here with the community engagement scale as individuals may still likely be attending recovery groups, but this is not to say barriers to wider community engagement do not exist.

Social support measure

The final variable of interest is social support. Out of a maximum score of 28, the mean score for the overall cohort was 19.312 (SD = 6.779). When split by gender, the mean score for women was higher (21.666, SD = 5.948) than men (16.812, SD = 6.949), and as assessed by an independent samples t-test (t = -2.083, p = .046, df = 29) (s) the differences by gender were of significance. When looked at

in light of other variables, it was noted that engagement with assets was correlated with social capital (which is known to be interlinked with social support). With this in mind, engagement in community assets to help gain access to social support may be particularly helpful for males to augment the lower levels of social support reported. Social support was then correlated against recovery capital, with the associated *r* and *p* values reported in the table below.

Table 4.37: Social support correlated recovery capital at Time 2

Variable	Correlations: <i>r</i> values and <i>p</i> values	Significance
Personal capital	<i>r</i> = .428, <i>p</i> = .016	s
Social capital	<i>r</i> = .523, <i>p</i> = .005	s
Community capital	<i>r</i> = .220, <i>p</i> = .235	ns
Overall recovery capital	<i>r</i> = .468, <i>p</i> = .007	s

As shown in Table 4.37, social support was significantly positively correlated with personal capital, social capital and overall recovery capital. It is perhaps surprising that there is no significant relationship between social support and community capital, given that the community capital measure focuses on recovery group participation (in which peer support is a key ingredient). This potentially highlights that an individual's stock of social support lies outside of their recovery sphere, for example, with friends and/ or family.

Time 2 predictors of recovery capital

To finish the Time 2 analysis, a backwards elimination linear regression model was run to identify predictors of overall recovery capital. Variables which showed significance with recovery capital at Time 2 were: Quality of life and satisfaction; barriers to community engagement; the community engagement scale; social support; frequency of attendance of groups at SASS; the number of groups attended at SASS; total number of assets listed within the wider community and number of domains assets were listed under.

Given the high number of variables which showed significance with recovery capital at Time 2, consideration was given to which would be used in the regression. To strengthen this aspect of the analysis, it did not logistically make sense to include all the variables in the regression, given that there was some overlap between these, and others were of less importance when considered in light in regard

to the wider context. For example, as barriers to community engagement were included in the community engagement scale, it was presumed that these two variables would be likely to have a high level of collinearity. Subsequently, barriers as a variable on its own was excluded. The number of groups attended at SASS and frequency of attendance at these groups were also excluded. The rationale for this was twofold. Firstly, the ARC emphasises engagement in the wider community as individuals progress in their recovery (see Chapter 3: *Research setting: Sheffield Alcohol Support Service*) and thus, focusing solely on engagement within the service may hold less value for better understanding how longer term recovery progress can be supported. Secondly, individuals were also given the opportunity to list resources they were engaged with under the four domains of community engagement and therefore, there may have been some overlap between these two variables. Taking into consideration earlier findings, the number of domains an individual is engaged with is thought to hold greater value to recovery progress than the number of resources listed. Inclusion therefore of the number of domains an individual was engaged with was selected based on both this rationale and supporting literature that identifies engagement in a diverse range of groups acts as a psychological resource, conducive to health and wellbeing (as supported in the SIMOR, Best et al., 2016) and the social cure (Jetten et al., 2012). Finally, given that the regression model was to identify predictors of recovery capital (which includes social capital), it was identified that social support is in fact a subcomponent of social capital, and therefore it did not seem logical to use. This resulted in the following variables being used within the regression:

- Gender;
- Quality of life and satisfaction;
- The community engagement scale;
- Number of domains assets were listed under.

The regression output is displayed below:

Figure 4: Variables entered/ removed from Time 2 regression

Model	Variables Entered	Variables Removed	Method
1	Total number of domains (out of 4) engaged with; Quality of life and satisfaction; Gender; Community engagement scale ^b	.	Enter

a. Dependent Variable: Overall recovery capital Time 2

b. All requested variables entered.

The overall model was significant ($F = 4.971, p = .003$) and the Adjusted R square was .312 suggesting that the model predicted 31% of the variance. None of the variables entered into the regression approached significance alone, but all were retained in the final model. The model summary and coefficients associated with this are displayed in Appendix 15.

The overall model highlights the importance of gender, quality of life and satisfaction, the community engagement scale score and the number of domains an individual was engaged with, for those within the cohort at Time 2. Therefore, it can be presumed that those presenting with lower scores for these variables will require additional support to aid recovery growth.

Summary of Time 2

In summary, whilst significant differences were also noted across several variables at Time 2, there were fewer nuances identified by gender in comparison to Time 1. The only variable which showed significance by gender was social support, with women reporting higher levels.

Furthermore, levels of personal, social and community capital as well as overall recovery capital did not differ by gender, although some domains of recovery capital were significantly correlated with other variables. Similar to Time 1, quality of life and satisfaction; barriers to community engagement; the community engagement scale; and social support, were all positively significantly correlated with personal capital, social capital and overall recovery capital. More so, the number of groups an

individual was attending at SASS; the total number of assets they listed they were engaged with within the wider community; and number of domains assets were listed under, were also positively significantly correlated with aspects of recovery capital and overall recovery capital.

Engagement in assets listed under mutual aid; employment, education and training; and sports, recreation and arts, were also statistically positively correlated with recovery capital, highlighting the importance of a diverse range of community engagement.

Out of the key variables which showed significance with recovery capital and were included in the regression (quality of life and satisfaction; the community engagement scale; and the number of domains assets were listed under), these collectively predicted 31% of the overall variance in recovery capital at Time 2, as well as the number of domains assets were listed under also showing significance as a standalone variable. This emphasises the value of such community engagement as a key component of recovery support.

The next stage, and final, stage of analysis, will explore changes from Time 1 to Time 2.

Analysis of change

This final stage of analysis will assess change between Time 1 and Time 2 data. Fifty individuals completed the REC-CAP at both time points, and 22 identified as female (44% of the overall cohort) and 28 as male (56% of the overall cohort). When percentages of the cohort are detailed within the change analysis, this refers solely to those who completed the REC-CAP at both time points. For this reason, any data presented from Time 1 may appear different to that presented earlier (see *Study 2, Time 1*), as those who were not retained in the sample at Time 2 are excluded.

To undertake the change analysis, McNemar's test will be used to assess the change between dichotomous variables and repeated measures analysis of variance (RMANOVA) will be used to assess if changes in recovery capital are of significance. The effect of gender will also be assessed throughout. If the results from the RMANOVA show there is a significant interaction effect, planned comparisons are run using paired samples t-test to explain the interaction. As there are only two levels (Time 1 and Time 2) of the within subjects' factor, sphericity of data is assumed.

Quality of life and satisfaction

A RMANOVA was run to determine whether the changes within the quality of life and satisfaction measure were of significance. The *f* and *p* values as well as changes in mean scores for the overall cohort are reported in Table 4.38.

Table 4.38: Within-Subject effects for quality of life and satisfaction variables by condition

Variable	Cohort	Time	Mean score	RMANOVA: <i>f</i> value, degree of freedom and <i>p</i> value
Psychological health	Overall cohort	Time 1	11.040 (SD = 3.880)	f = 20.827, df = 1, 48, p = .000 (s)
		Time 2	13.440 (SD = 4.031)	
	By gender			f = .595, df = 1, p = .444 (ns)
Physical health	Overall cohort	Time 1	11.520 (SD = 4.500)	f = 7.100, df = 1, p = .010 (s)
		Time 2	12.840 (SD = 4.743)	
	By gender			f = .102, df = 1, p = .751 (ns)
Quality of life	Overall cohort	Time 1	12.060 (SD = 4.442)	f = 13.498, df = 1, p = .001 (s)
		Time 2	14.080 (SD = 4.065)	
	By gender			f = .578, df = 1, p = .451 (ns)
Quality of accommodation	Overall cohort	Time 1	14.040 (SD = 4.952)	f = 14.661, df = 1, p = .000 (s)
		Time 2	16.160 (SD = 4.022)	

	By gender			$f = .776, df = 1, p = .383$ (ns)
Support network	Overall cohort	Time 1	14.140 (SD = 4.458)	$f = 2.684, df = 1, p = .108$ (ns)
		Time 2	15.260 (SD = 4.435)	
	By gender			$f = .001, df = 1, p = .970$ (ns)
Overall quality of life	Overall cohort	Time 1	63.061 (SD = 16.601)	$f = 19.501, df = 1, p = .000$ (s)
		Time 2	71.898 (SD = 16.908)	
	By gender			$f = .642, df = 1, p = .427$ (ns)

As shown in Table 4.38, significant changes were noted for the overall cohort across most of the quality of life and satisfaction variables, with higher mean scores reported for psychological health, physical health, quality of life, quality of accommodation and overall quality of life. Despite the significant changes for the overall cohort, there were no gender differences in quality of life and satisfaction improvements as there was no significant main effect of gender.

Accommodation

The table below details changes in accommodation status for the overall cohort.

Table 4.39: Change in accommodation status over time

		Accommodation (Time 2)		Total
		Unstable	Stable	
Accommodation (Time 1)	Unstable	1	7	8 (16%)
	Stable	5	36	41 (84%)
Total		6 (12%)	43 (88%)	

As shown in Table 4.39, there was little noted change between those in stable accommodation at Time 1 (84% of the overall cohort) and Time 2 (88% of the overall cohort). That said, there were 14 people (across both timepoints) experiencing unstable accommodation at some point. As assessed by McNemar test ($p = .774$) changes in accommodation status overtime were not of significance.

Substance use

The table below details changes in alcohol use for the overall cohort.

Table 4.40: Change in alcohol use over time

		Alcohol use (Time 2)		Total
		No	Yes	
Alcohol use (Time 1)	No	13	5	18 (40%)
	Yes	10	17	27 (60%)
Total		23 (51%)	22 (49%)	

As shown in Table 4.42, there were some noted changes in alcohol use between time points³². Twenty-seven individuals (60% of the overall cohort) reported using alcohol at Time 1, in comparison to 22 individuals (49% of the overall cohort) at Time 2. Thirteen individuals maintained sobriety across the two timepoint, whereas other individuals who had not drunk at Time 1 had at Time 2, and vice versa. This highlights the non-linear process of recovery, in that individuals may fluctuate between periods of abstinence and drinking, particularly in the earlier stages of their recovery journeys. As assessed by McNemar, changes in drinking behaviour between Time 1 and 2 were not of significance ($p = .302$) (ns). Alcohol use at Time 1 was however significantly positively correlated with alcohol use at Time 2 ($r = .863$, $p = .000$) (s), demonstrating those drinking upon entry to SASS were most likely to still be drinking at Time 2. A RMANOVA was then run to determine whether the changes in drinking behaviour, both the number of days drunk in the last 90 and units drunk per drinking day, were of significance. The f and p values are reported in the table below (Table 4.41).

³² Reported in the last 90 days prior to REC-CAP completion.

Table 4.41: Within-Subject effects for individuals who had drunk in the last 90 days at both time points by condition

Variable	Cohort	Time	Mean score	MANOVA: f value, degree of freedom and p value
Alcohol use: days used in the last 90	Overall cohort	Time 1	42.92 (SD = 34.917)	f = 5.135, df = 1, p = .047 (s)
		Time 2	51.17 (SD = 30.133)	
	By gender			f = 3.186, df = 1, p = .105 (ns)
Alcohol use: units consumed on drinking days	Overall cohort	Time 1	18.166 (SD = 9.888)	f = .016, df = 1, p = .902 (ns)
		Time 2	17 (SD = 17.157)	
	By gender			f = .016, df = 1, p = .902 (ns)

As shown in Table 4.41, for those who had drunk alcohol within the last 90 days at both Time 1 and Time 2, the changes in mean scores were of significance, with individuals reporting drinking for more days within the last 90 day period at Time 2 than Time 1, but consuming slightly less units on each drinking occasion. Whilst these changes were of significance for the overall cohort, there were no gender differences in number of days drunk, as there was no significant main effect of gender.

Meaningful activity

The table below details changes in meaningful activity for the overall cohort. Within this, meaningful activity includes those either working full-time, working part-time, volunteering or in education.

Table 4.42: Change in meaningful activity over time

	Meaningful Activity (Time 2)	Total

		No	Yes	
Meaningful Activity (Time 1)	No	17	10	27 (56%)
	Yes	3	18	21 (44%)
Total		20 (42%)	28 (58%)	

As shown in Table 4.42, there were some noted changes in meaningful activity between the two timepoints. Twenty individuals (42% of the overall cohort) reported being engaged in meaningful activity at Time 1, in comparison to 28 individuals (58% of the overall cohort) at Time 2. Out of those engaged in such activity at Time 2, ten of these individuals had not previously been engaged at Time 1, signifying a positive uptake of meaningful activities. Whilst three individuals moved in the opposite direction – from meaningful activity to no meaningful activity – it can be presumed that previous commitments may have been stopped or put on hold to provide the individual the opportunity to engage in recovery supports. As assessed by McNemar, changes in meaningful activity were not of significance ($p = .092$) (ns).

Recovery capital

A RMANOVA was run to determine whether the changes in recovery capital were of significance.

The f and p values are reported in the table below as well as the changes in mean scores.

Table 4.43: Within-Subject effects for recovery capital by condition

Variable	Cohort	Time	Mean score	MANOVA: f value, degree of freedom and p value
Personal capital	Overall cohort	Time 1	16.224 (SD = 6.004)	f = 5.805, df = 1, p = .020 (s)
		Time 2	18.489 (SD = 5.583)	
	By gender			f = .655, df = 1, p = .422 (ns)

Social capital	Overall cohort	Time 1	16.688 (SD = 5.603)	f = 2.049, df = 1, p = .160 (ns)
		Time 2	18.177 (SD = 5.694)	
	By gender			f = .154, df = 1, p = .697 (ns)
Community capital	Overall cohort	Time 1	10.788 (SD = 6.771)	f = .811, df = 1, p = .373 (ns)
		Time 2	9.672 (SD = 8.550)	
	By gender			f = 1.090, df = 1, p = .302 (ns)
Overall recovery capital	Overall cohort	Time 1	43.337 (SD = 14.022)	f = .827, df = 1, p = .369 (ns)
		Time 2	46.019 (SD = 16.197)	
	By gender			f = .131, df = 1, p = .720 (ns)

As shown in Table 4.43, the overall cohort had significantly higher mean scores for personal capital at Time 2, but no significance was noted for social capital, community capital or overall recovery capital. Despite the significant changes for the overall cohort, there were no gender differences in personal capital improvements as there was no significant main effect of gender. Identifying a significant change in personal capital however is a positive finding, as framed within the ice cream cone of recovery (Best et al., 2017) (Figure 1.1), changes at a personal level are then conducive to social and community capital growth.

SASS engagement

A RMANOVA was run to determine whether the changes in number of groups attended at SASS within the last 30 days were of significance. The f and p values and changes in mean scores at reported in the table below.

Table 4.44: Within-Subject effects for number of groups attended at SASS in the last 30 days by condition

Variable	Cohort	Time	Mean score	MANOVA: f value, degree of freedom and p value
Number of groups attended	Overall cohort	Time 1	1.580 (SD = 1.196)	f = 6.038, df = 1, p = .018 (s)
		Time 2	1.020 (SD = 1.708)	
	By gender			f = .832, df = 1, p = .366 (ns)
Frequency of attendance at groups	Overall cohort	Time 1	2.367 (SD = 2.166)	f = 4.733, df = 1, p = .035 (s)
		Time 2	1.363 (SD = 2.555)	
	By gender			f = .909, df = 1, p = .346 (ns)

As shown in Table 4.44, significant changes were noted for the overall cohort for both the number of groups attended at SASS and frequency of attendance at groups, with mean scores for both variables decreasing. Despite the significant changes for the overall cohort, there were no gender differences for either variable as there was no significant main effect of gender.

Engagement outside of SASS

A RMANOVA was run to determine whether the changes in number of assets listed and number of domains assets were listed under were of significance. The f and p values as well as the change in mean scores are reported in the table below.

Table 4.45: Within-Subject effects for number of assets listed and number of domains assets were listed under by condition

Variable	Cohort	Time	Mean score	MANOVA: f value, degree of freedom and p value
Number of assets	Overall cohort	Time 1	2.705 (SD = 2.071)	f = .331, df = 1, p = .557 (ns)
		Time 2	2.490 (SD = 2.166)	
	By gender			f = .001, df = 1, p = .979 (ns)
Number of domains	Overall cohort	Time 1	1.600 (SD = 1.030)	f = .467, df = 1, p = .498 (ns)
		Time 2	1.460 (SD = 1.091)	
	By gender			f = .049, df = 1, p = .825 (ns)

As shown in Table 4.45, neither variable showed significant change over time. The relationship between engagement at Time 1 and Time 2 was then explored to see whether levels of engagement was retained. Forty-two individuals (86% of the overall cohort) listed assets at Time 1, in comparison to 40 individuals (82% of the overall cohort) at Time 2. Out of these, nine individuals who listed assets at Time 1 did not at Time 2, and seven individuals who did not list assets at Time 1 did at Time 2. Despite small variation, these changes were not of significance ($p = .804$), as assessed by McNemar.

Satisfaction with level of community engagement

The table below details changes in individuals' satisfaction with their levels of community engagement.

Table 4.46: Change in satisfaction with community engagement over time

		Satisfied with community engagement (Time 2)		Total
		No	Yes	
Satisfied with community engagement (Time 1)	No	6	9	15 (30%)
	Yes	4	29	33 (70%)
Total		10 (20%)	38 (80%)	

As shown in Table 4.46, 33 individuals (70% of the overall cohort) reported being satisfied with their community engagement at Time 1, in comparison to 38 individuals (80% of the overall cohort) at Time 2. This is promising, showing that although changes in engagement do not change dramatically over time (as shown in the section above, Table 4.45), a higher percentage of individuals report being satisfied with their engagement. Given that engagement must be individualised, recognising where the individual is on their recovery journey is important to consider. Despite the increase in those reporting they were satisfied, the changes noted above were not of significance ($p = .267$), as assessed by McNemar.

Do you view yourself as an active citizen?

The table below details changes in whether individuals viewed themselves as active citizens.

Table 4.47: Change in whether the individual viewed themselves as an active citizen over time

		Do you view yourself as an active citizen (Time 2)		Total
		No	Yes	
Do you view yourself as an active citizen (Time 1)	No	6	9	15 (33%)
	Yes	4	27	31 (67%)
Total		11 (23%)	36 (77%)	

As shown in Table 4.47, 31 individuals (67% of the overall cohort) reported viewing themselves as active citizens at Time 1, in comparison to 36 individuals (77% of the overall cohort) at Time 2. This indicates a positive level of change, and is supportive of recovery growth, given that themes of active citizenship are often cited in recovery stories. As assessed by McNemar, the changes were not however of significance ($p = .267$).

Are there any groups you would like to attend but you haven't?

The table below details changes in individuals stating whether there were other groups they would like to attend but had not.

Table 4.48: Change in whether there were other groups the individual would like to attend between over time

		Groups (Time 2)		Total
		No	Yes	
Groups (Time 1)	No	16	6	22 (50%)
	Yes	11	11	22 (50%)
Total		27 (61%)	17 (38%)	

As shown in Table 4.48, 22 individuals (50% of the overall cohort) reported there were other groups they would like to attend but had not at Time 1, in comparison to 17 individuals (38% of the overall cohort) at Time 2. This is another indicator of positive change, demonstrating that those who initially wanted to become more engaged had either begun to do so, or no longer felt the need to – perhaps if they felt more satisfied with their current levels of engagement at Time 2. Despite the changes however, these were not of significance ($p = .238$), as assessed by McNemar.

Barriers to community engagement and community engagement scale

A RMANOVA was run to determine whether the changes in number of barriers to community engagement and scores for the community engagement scale were of significance. The f and p values as well as the change in mean scores are reported in the table below.

Table 4.49: Within-Subject effects for barriers to community engagement and community engagement scale by condition

Variable	Cohort	Time	Mean score	MANOVA: f value, degree of freedom and p value	Significance
Barriers to engagement	Overall cohort	Time 1	3.700 (SD = 2.848)	f = .904, df = 1, p = .348	ns
		Time 2	3.250 (SD = 3.410)		
	By gender			f = .053, df = 1, p = .820	ns
Community engagement scale	Overall cohort	Time 1	15.125 (SD = 3.589)	f = 3.367, df = 1, p = .076	ns
		Time 2	16.187 (SD = 3.505)		
	By gender			f = .550, df = 1, p = .464	ns

As shown in Table 4.49, the changes over time were not of significance for either variable. This illustrates that barriers to engagement – existent at a micro, meso and macro level – cannot simply be ‘overcome’, and individuals must be supported to better understand potential barriers to engagement and what can be done to begin to dismantle or better address those presented.

Social support

A RMANOVA was run to determine whether the changes in social support were of significance. The f and p values and change in mean scores are reported in the table below.

Table 4.50: Within-Subject effects for social support by condition

Variable	Cohort	Time	Mean score	MANOVA: f value, degree of freedom and p value	Significance
Social support	Overall cohort	Time 1	18.580 (SD = 5.302)	f = .691, df = 1, p = .413	ns
		Time 2	19.193 (SD = 6.857)		
	By gender			f = 1.870, df = 1, p = .182	ns

As demonstrated in Table 4.50, changes noted in the social support measure were not of significance. When looked at in light of the other variables, it can be presumed that the opportunities to build social capital and social support are still to be augmented, given that no significant changes were noted in the other variables which may support its growth (such as engagement in assets; and being faced with fewer barriers to community engagement).

Summary

Together these results provide important insight into the change of recovery capital over time. Significant changes were noted between Time 1 and Time 2 for psychological health, physical health, quality of life, quality of accommodation and personal capital, signifying an upward trajectory of recovery growth. A significant reduction was noted in the number of groups attended at SASS, although there was no significant main effect of gender present.

Chapter 6: Study 3

Introduction to chapter

The purpose of this chapter is to present the quantitative and qualitative analysis for Study 3³³. As the literature review explored (see Chapter 2) identifying the community resources available to individuals in recovery is crucial to building and strengthening recovery communities (Best et al., 2017; Edwards et al., 2018; Collinson & Best, 2019). If done successfully, this approach is also central to aiding the accumulation of recovery capital, as explored in Study 1 (see Chapter 4) and Study 2 (see Chapter 5). To date however, systematic approaches to mapping resources and building bridges to engaging with these resources for recovery populations are limited in research although widely used in practice (MacLeod & Emejulu, 2014; Blickem et al., 2018). As detailed in the methodology (see Chapter 3), the ABCE workbook has been developed to address this omission.

This chapter follows on from the quantitative analysis of REC-CAP data, analysed in the previous chapter. Using the ABCE workbook, data was collected from 22 ARC members. Alongside completion of the ABCE workbook, audio recordings of the conversations were transcribed and thematically analysed. Two ARC members did not consent to the conversations being recorded resulting in 20 transcribed and analysed audio recordings.

The chapter is broken into three sections which represent each of the following data sources. These are analysed and presented independently in the following order:

- 1) Analysis of quantitative data collected within the ABCE workbooks;
- 2) Visualisations associated with the quantitative data;
- 3) Analysis of qualitative data associated with the audio recordings.

The quantitative data is presented first for contextual purposes. This provides a foundation for the rest of the chapter by addressing how engaged individuals are with community resources. This is then followed by visualisations of some of the workbook data which aims to bring the quantitative components to life. The chapter then finishes with an analysis of the audio recordings, adding narrative and depth to the data presented and considering how such engagement impacts recovery growth. By doing so, this begins to draw parallels between the ABCE workbook, community engagement and its relationship with recovery capital.

The results are analysed to address the subsidiary research questions. Firstly:

³³ Data is not included in the appendix but is available on request.

2. What is the best way to assess recovery resources at the community level?

Secondly, the ABCE analysis will also contribute to two parts of research question 3:

3a. What are the key components of community capital?

3b. How can we demonstrate the impact of community capital on personal recovery growth?

Within this chapter, findings are presented and interpreted, with a further discussion of the results given in Chapter 8.

Quantitative data

The model of analysis adopted to report on the quantitative data is conducted in the following format:

- 1) Report of descriptive statistics;
- 2) Bivariate analysis including correlations.

The reporting of data is treated autonomously, and descriptive statistics will be broken down by gender through the use of independent samples t-tests, to assess the differences between groups. Statistical values are reported in the same format as Study 1 (see Chapter 4) and Study 2 (see Chapter 5).

Demographic information

Twenty-two individuals completed the ABCE workbook, with 14 identified as male (64% of the overall cohort) and eight as female (36% of the overall cohort). No one identified as trans or specified any other gender. The gender split of the cohort is similar to both Study 1 (65% male and 35% female) and Study 2 (66% male and 34% female).

Individuals ranged in age between 29 and 64 years ($SD = 10.107$), and as assessed by independent samples t-test, while the mean age of women (50 years) was higher than males (44 years) this was not of significance ($t = -1.257$, $p = .223$, $df = 20$) (ns). Again, this is similar to the earlier study (Study 2: 44 years for males and 48 years for females).

Nineteen individuals identified as white British (86% of the overall cohort); two individuals identified as British Pakistani (9% of the overall cohort); and one individual identified as South American Latino (5% of the overall cohort).

Unlike Study 1 and Study 2 which collected data from individuals upon entry to the service, the cohort for Study 3 was based on a convenience sample and thus, individuals ranged in terms of how long they had been in recovery/ had recovered for. The mean duration was three years (SD = 39.479 months). Individuals were also asked how long they had engaged with SASS for. This varied from one month to 12 years, with a mean score of 30 months (SD = 34.162).

Community engagement

Individuals listed resources under the same four domains³⁴ as those explored in Study 2 (see Chapter 4). From this data, two new variables were computed: one which gave a total for the number of assets listed across all four domains and another which gave a score out of four, for the number of domains assets had been listed under.

Table 6.1 details the mean scores for engagement with assets, by both domain and gender. It also outlines the t and p values associated with the independent samples t-test run to assess the differences by gender.

Table 6.1: Assets engaged with split by domain and gender

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples test: t value, p value and degree of freedom
Total number of assets	6.272 (SD = 3.010)	6.875 (SD = 1.171)	5.928 (SD = .773)	t = -.701, p = .492, df = 20 (ns)
Total number of domains	2.954 (SD = .843)	2.875 (SD = .991)	3 (SD = .784)	t = .327, p = .747, df = 20 (ns)

³⁴ Professional services; sport, recreation and arts; peers and mutual aid; and education, employment and training.

Peers and mutual aid	2.363 (SD = 1.61)	2.625 (SD = 2.262)	2.214 (SD = 1.88)	t = -.563, p = .580, df = 20 (ns)
Professional services	1.500 (SD = .912)	1.750 (SD = .707)	1.357 (SD = 1.008)	t = -.970, p = .344, df = 20 (ns)
Sport, recreation and arts	1.590 (SD = 1.991)	1.375 (SD = 1.302)	1.714 (SD = 2.334)	t = .376, p = .711, df = 20 (ns)
Employment, training and education	1.227 (SD = 1.716)	1.25 (SD = 1.807)	1.285 (SD = 1.728)	t = .206, p = .839, df = 20 (ns)

The highest mean score for the overall cohort (as well as for men and women separately), when split by domain is mutual aid. Given the importance of peer support to aid recovery (Bassuk et al., 2016), it is promising to see such a high level of engagement here. Moreover, the mean score for number of domains assets were listed under (out of a total of four) falls just below three, signifying a high level of engagement across the array of domains. This is also promising when framed with the social cure literature (Jetten et al., 2012). As assessed by an independent sample t-test, the differences in mean scores by gender are not of significance across any of the variables.

Satisfaction with levels of community engagement

Eight individuals (13% of the overall cohort of women and 50% of the overall cohort of men) stated they were dissatisfied with their levels of community engagement. Despite the noted variation between men and women, as assessed by chi-square (1) = .079, p = .079 (ns) there were no statistically significant differences by gender.

Satisfaction of community engagement was then assessed in relation to whether the individual stated they were engaged in assets within the wider community (see *community engagement* above). As assessed by an independent sample t-test, the differences were of statistical significance (t = 2.960, p = .008, df = 20) (s), with those who listed a lower number of assets stating they were dissatisfied with their community engagement. This highlights the importance of encouraging community engagement as a part of recovery trajectories.

Do you view yourself as an active citizen?

Fifteen individuals (50% of the overall cohort of men and 100% of the overall cohort of women) stated they did view themselves as an active citizen. As assessed by chi-square (1) = 5.867, $p = .015$ (s) there were statistically significant differences by gender. The strength of this relationship is reported as $\phi = .516$, $p = .015$. This is an important findings to note and highlights the need for men to be supported to engage with their communities to help improve self-perceptions of active citizenship.

Are there any groups you would like to attend but you haven't?

Sixteen individuals (86% of the overall cohort of men and 50% of the overall cohort of women) stated there were other groups they would like to attend. As assessed by chi-square (1) = 3.274, $p = .070$ (ns), there were no statistical significance when cross tabulated by gender. The mean difference is however important to acknowledge in light of the above finding, emphasising the need for men to be supported to engage with assets when they show desire to do so.

Barriers to community engagement

Individuals were then presented with a list of potential barriers to community engagement and asked to tick any that applied. Out of 17 potential barriers, the mean score for the overall cohort was 4.045 (SD = 3.228). When split by gender, the mean score for men (4.714, SD = .963) was higher than that for females (2.875, SD = .766). As assessed by an independent sample t-test, $p = .206$, $df = 20$ (ns), the difference by gender were not of significance. Table 5.2 details the percentages of those who indicated the listed barrier was detrimental to their community engagement. Each barrier was also assessed by chi-square to identify if the differences by gender were of significance.

Table 6.2: Gender differences in barriers to community engagement

Barrier	Overall cohort %	Female cohort %	Male cohort %	Chi-square
I can't get there easily	23%	13%	29%	(2) = .749, $p = .387$ (ns)
Lack of confidence	36%	13%	50%	(2) = 3.094, $p = .079$ (ns)
Lack of motivation	46%	36%	50%	(2) = .321, $p = .571$ (ns)

I don't know enough about the group	41%	12%	57%	(2) = 4.197, p = .040 (s)
It's too expensive	41%	25%	50%	(2) = 1.316, p = .251 (ns)
I don't want to go by myself	27%	25%	29%	(2) = .033, p = .856 (ns)
Family constraints	14%	25%	7%	(2) = 1.378, p = .240 (ns)
I don't have enough time	50%	63%	43%	(2) = .786, p = .375 (ns)
Health concerns	23%	25%	21%	(2) = .037, p = .848 (ns)
I might be judged for attending	14%	0%	21%	(2) = 1.985, p = .159 (ns)
Work constraints	23%	25%	21%	(2) = .037, p = .848 (ns)
Lack of specific opportunities	14%	0%	21%	(2) = 1.985, p = .159 (ns)
Unsupportive community	14%	13%	14%	(2) = .014, p = .907 (ns)
Unsupportive friends	5%	0%	7%	(2) = .599, p = .439 (ns)
It isn't age appropriate	18%	0%	29%	(2) = 2.794, p = .095 (ns)
It isn't gender appropriate	9%	13%	7%	(2) = .177, p = .674 (ns)
Religion	9%	0%	14%	(2) = 1.257, p = .262 (ns)

As shown in Table 6.2, there was statistically significant differences by gender for *I don't know enough about the group*. The strength of this relationship is as follows: Phi = -.437, p = .040, with men more likely to list this as a barrier to community engagement. This identifies the importance of knowledge of local resources being widely disseminated to support men to access such resources, where desired. Whilst no significance was identified, there was also a notable difference between men and women for *Lack of confidence*, with men more likely to also list this as a barrier. Across the cohort, the barriers most commonly noted included a lack of time and motivation.

Community engagement scale

In line with Study 2 (see Chapter 5), the community engagement scale was computed³⁵. Table 6.3 details the mean scores for the community engagement scale, split by gender. It also outlines the t and p values associated with the independent samples t-test run to assess the differences by gender.

Table 6.3: Community engagement scale by gender

Variable	Mean score and standard deviation (overall cohort)	Mean score and standard deviation (female cohort)	Mean score and standard deviation (male cohort)	Independent samples t-test: t value, p value and degree of freedom
Community engagement scale	15.381 (SD = 3.528).	17.500 (SD = 2.507)	14.076 (SD = 3.499)	t = .565. p = .574, df = 50 (ns).

As shown in Table 6.3, the differences by gender were not of statistical significance. The slight variation in mean scores can be explained by the higher percentage of women who stated they viewed themselves as an active citizen and by the fewer barriers to community engagement they listed (see above: *Do you view yourself as an active citizen?*).

Summary

The quantitative analysis provides context for the rest of the chapter. In summary, whilst some nuances were identified between men and women with most of the mean differences suggesting more effective community engagement for women, statistical significance was noted only across two variables. Firstly, women were more likely to view themselves as active citizens and secondly, men were more likely to state that not knowing enough about a group was a barrier to engagement. This highlights the unique nature of recovery trajectories, emphasising the need for recovery support to be tailored to an individual’s needs, with consideration given to the factors which may influence their desire, and ability, to engage with their community. Moreover, a significant relationship was highlighted between

³⁵ The community engagement scale was computed based on the following variables: do you view yourself as an active citizen, are you satisfied with your level of community engagement, are there other groups you would like to attend and barriers to community engagement. A higher score for the scale (out of a total of 20) signified higher levels of community engagement.

an individual’s satisfaction with their community engagement, and the number of assets they listed that they were engaged with.

The next stage of analysis will present the visual components developed from the ABCE data, based on the resources which were listed and the user ratings of those most commonly listed.

Visual components of the ABCE workbooks

The next data output presented shows the visual components of the ABCE workbooks. The table below outlines how many resources were listed under each of the four domains, across the 22 completed workbooks.

Table 6.4: Total number of resources listed across the four domains of community engagement

Domain	Professional services	Peers and mutual aid	Sports, recreation and arts	Education, employment and training
	13	11	24	10

A detailed breakdown of Table 6.4 can be seen in Appendix 16, outlining all of the resources which were listed. Based on the data collected, this was then inputted into QGIS, a mapping software, where feasible. This was done for the resources assigned to a definite location, but mapping was not feasible for all items listed in Appendix 16 as resources such as the gym and AA where not given a precise location. For those that could be mapped, coordinates were assigned to the location of the resource, and the data was mapped onto boundary data of Sheffield downloaded from the Office for National Statistics census data.

As demonstrated below, each resource when mapped was assigned a coloured star dependent on the domain under which it was listed. The key associated with this is as follows:

Professional services:



Peers and mutual aid:



Sport, recreation and arts:

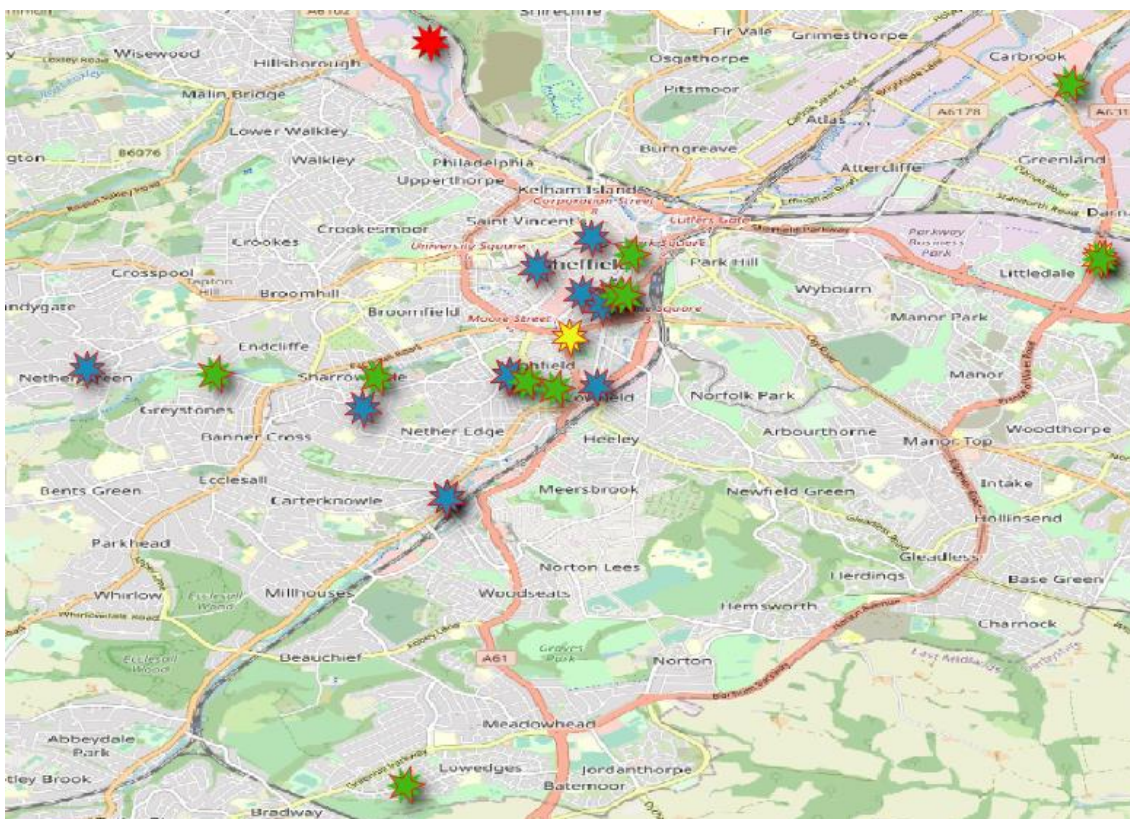


Education, employment and training:



It must also be noted that there is some overlap between the resources listed. For example, SMART (listed under peers and mutual aid) and arts and crafts group (listed under sport, recreation and arts) were both groups run by SASS and thus, are only mapped as SASS (professional service).

Figure 6.1: Overview of resources mapped across Sheffield



As shown in Figure 6.1, only one resource was mapped under both peers and mutual aid (see yellow star) and education, employment and training (see red star). As shown in Appendix 16, other resources were listed under both of these domains but could not be mapped as they were not always based in the same location and thus, coordinates could not be assigned easily. For example, some individuals listed Alcoholics Anonymous but did not specify where they attended this particular meeting. With several

meetings taking place across the city, it was not feasible to assign coordinates to each of these. That said, fewer resources were listed under both peers and mutual aid (11 resources listed) and education, employment and training (10 resources listed). Although the importance of engagement in all four domains is recognised as holding importance for recovery growth (see Study 2), this highlights some potential disparity in the resources across the city under these domains.

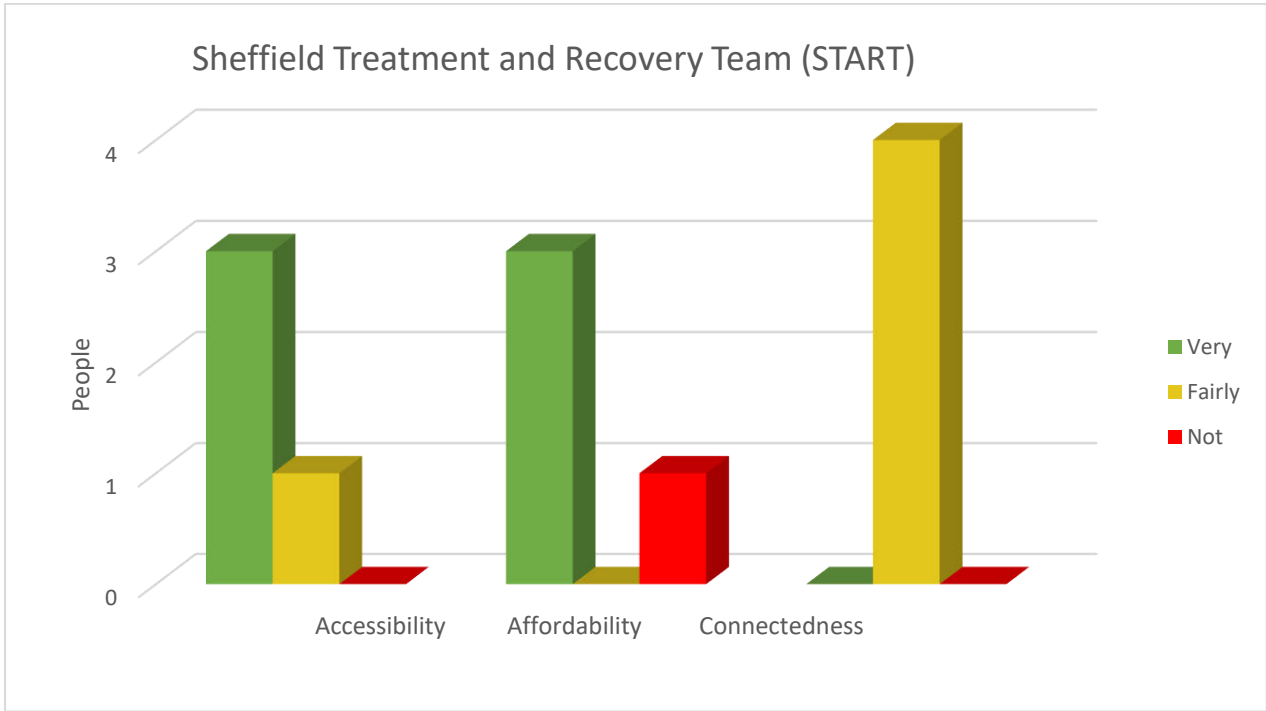
As Figure 6.1 highlights, the resource which is mapped for education, employment and training is outside of the city centre. Later consideration will be given to the impact of the accessibility of resources. Other resources (particularly those mapped under professional services and sports, recreation and arts) appear to be fairly central to the city, or located towards the Northwest, where SASS is located. Although this may be due to a sampling effect in that all individuals were accessing SASS at the time of completing the workbooks, taken by itself the map does visually allow 'gaps' in asset provision to be identified (particularly in the North of the city). This will be returned to in the discussion of the findings (see Chapter 8).

As detailed in Chapter 3, *Study 3: Rationale and method*, assets were rated in terms of accessibility, affordability and connectedness. For the assets listed by four or more people within the cohort, bar charts were then created based on the user ratings assigned to these. Each asset is explored using the traffic light system detailed in Chapter 3, with individuals rating assets green, amber or red. This system for example would indicate if an asset was 'very accessible', 'fairly accessible', or 'not accessible'.

User ratings for resources listed under professional services

The figure below outlines the user ratings given to any resources listed under the professional services domain by four or more people.

Figure 6.2: User ratings for Sheffield Treatment and Recovery Team

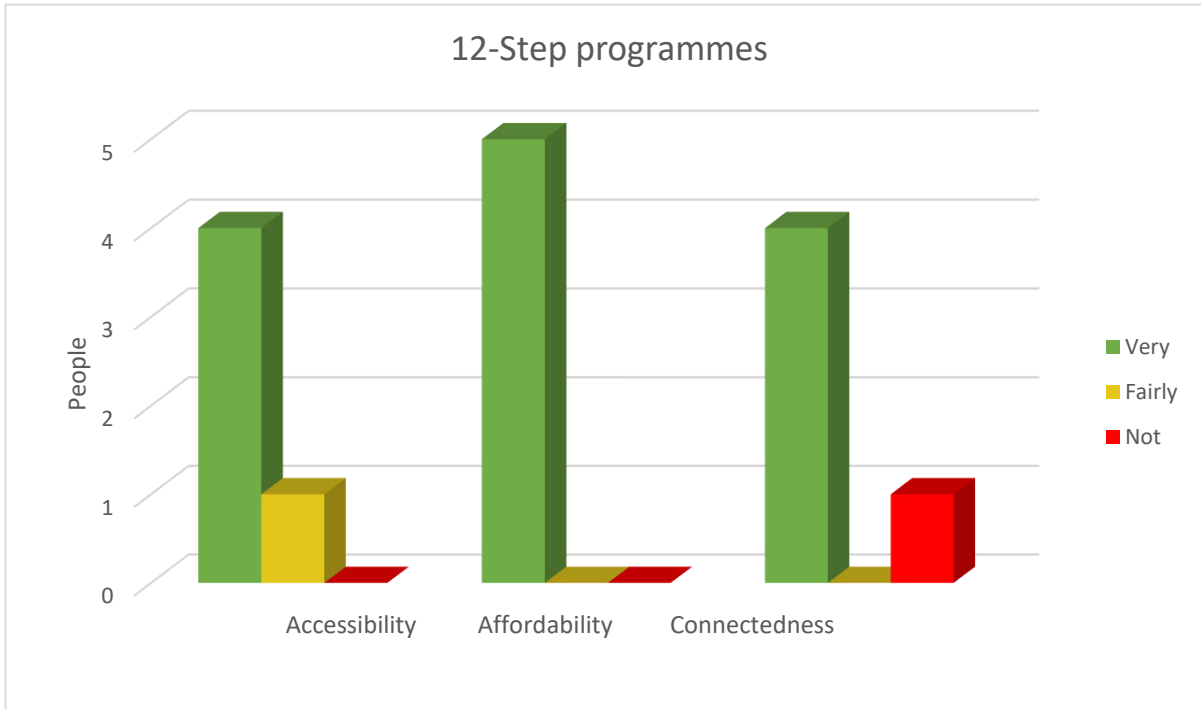


Four individuals listed Sheffield Treatment and Recovery Team (START) as a professional service they were engaged with. Most individuals stated this was very accessible, although one individual stated this was not very affordable. Given START is free to attend, this associated cost may be attributed to the cost of travelling to the service. All individuals rated feeling fairly connected to START. The final data source which includes a thematic analysis of the audio recordings may help to shed light on factors associated with individuals reporting higher levels of connectedness.

User ratings for resources listed under peers and mutual aid

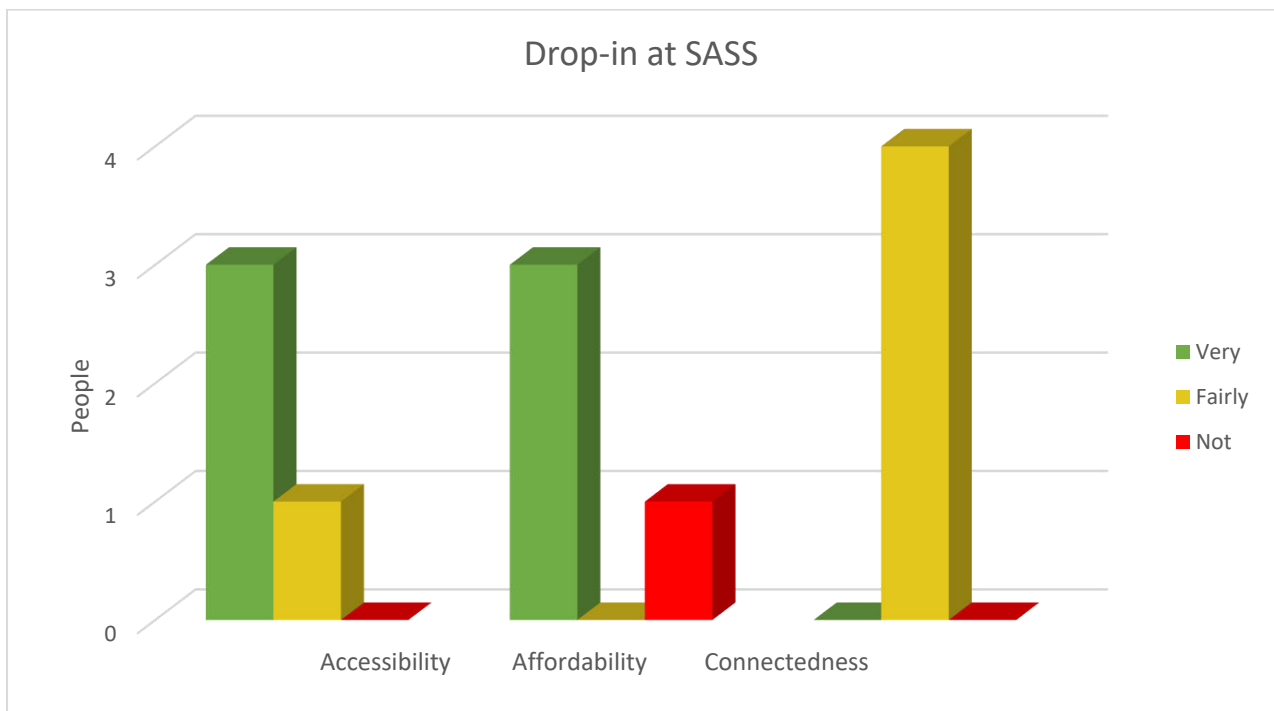
The figures below outline the user ratings given to any resources listed under the peers and mutual aid domain by four or more people.

Figure 6.3: User ratings for 12 step programmes



For the purpose of the visualisation, Alcoholics Anonymous and Narcotics Anonymous were grouped together as 12-step programmes, with five individuals in total listing these groups. Other than one individual rating this as fairly accessible, and another rating not feeling connected, all the other ratings were green.

Figure 6.4: User ratings for the drop-in at SASS

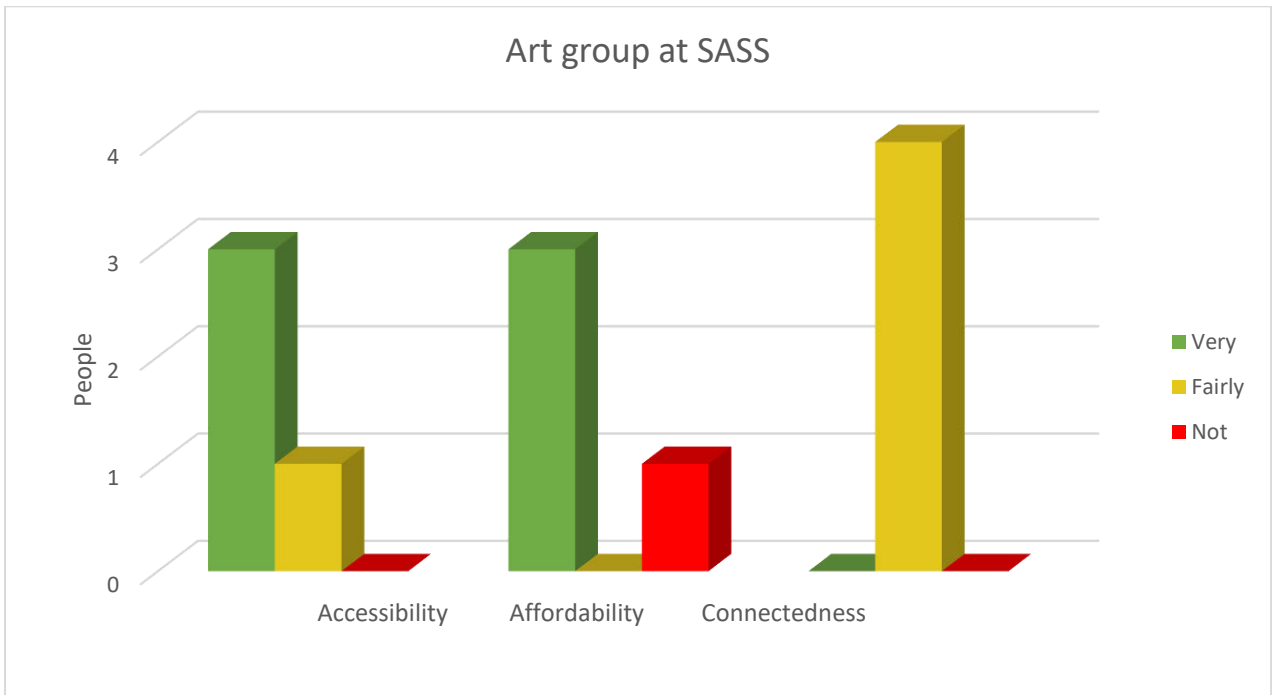


Four individuals listed the drop-in at SASS, with all four of these rating feeling fairly connected to the group. This may be attributable to the informal nature of the drop-in, and the likelihood that attendance at this group often changes, both amongst ARC members and the volunteers running the drop-in.

User ratings for resources listed under sport, recreation and arts

The figure below outlines the user ratings given to any resources listed under the sport, recreation and arts domains by four or more people.

Figure 6.5: User ratings for the arts group at SASS



Four individuals listed the art group at SASS, and similarly to the drop-in (listed under peers and mutual aid), all four individuals rated feeling fairly connected to this. Given both of these groups are run at SASS, there seems to be some commonality amongst groups associated with the service.

None of the resources listed under education, employment and training were listed by five or more people and therefore, are not included in the bar chart visualisations.

Qualitative data

Following the presentation of the visual data, attention is now turned to the final data source associated with the audio recordings. For consistency with the other studies (see Chapter 4 and 5), the qualitative data is presented and interpreted but a discussion of these findings with reference to the wider literature is given in the discussion (see Chapter 8).

The audio recordings, once transcribed, were thematically analysed utilising an abductive mode of inquiry. As opposed to inductive or deductive modes of inquiry (see Chapter 3: *Research philosophy*),

abductive approaches shift between top down and bottom up approaches - meaning prior knowledge and findings (including those from Study 1 and Study 2) were utilised to aid the analysis of the data, but also allowed for supplementary knowledge to be devised if appropriate. As such, the coding framework was initially formed on the basis of recovery capital, given its centrality within the thesis. The researcher however approached this with flexibility, allowing new codes to emerge from the data where necessary. Once the transcripts had been read through and key areas of these were highlighted as relating to either personal, social or community capital, these were then further broken down, with the researcher identifying explicit codes within each of the recovery capital domains (see Table 6.5). The user ratings assigned to each asset (affordability, accessibility and connectedness) also formed codes. Whilst these factors have previously not necessarily been linked directly to recovery capital, it seemed appropriate to include them in the coding framework to better understand how they influence an individual's level of community engagement. This also allows more detail to be provided in the context of the visualisations provided above. After reading the transcripts, it seemed appropriate to include accessibility and affordability under community capital, given the importance of these two factors to afford access to assets. Moreover, connectedness was identified as sharing similarity with some of the social capital literature and other associated codes (such as social networks) and thus, is included here.

Once the coding process had been undertaken, the coding framework and quotes associated with each of the themes were shared and discussed with the supervisory team for the thesis. This helped to strengthen the reliability of the analysis, and as a result of this discussion, one quotation was removed.

Table 6.5: Codes used for thematic analysis, split by each study of recovery capital³⁶

Personal capital	Social capital	Community capital	Other
Aspiration	Belonging and connection	Accessibility	Gender
Confidence	Familial relationships	Affordability	
Enjoyment	Social networks	Citizenship	
Mental health	Support	Opportunities	
Physical health		Stigma	
		Time	

³⁶ A detailed break down of these codes is available on request.

	Social capital as a means to access resources		
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As shown in Table 5.4, gender is excluded from the recovery capital framework. As such, it does not fit under any of the three domains of recovery capital and was only mentioned when individuals were asked if the gender appropriateness of a resource was a barrier to engagement. As gender was not prevalent in other aspects of the transcripts, it is not presented as a standalone theme. Within the analysis, direct quotations are presented using either the letter M (male) or F (female), as well as a number. Each number was randomly assigned to the transcripts for the purpose of the analysis. If extracts are used which include dialogue from the researcher, I (interviewer) is used.

Before the findings are presented, it is important to revisit the ice cream cone model of recovery (Best et al., 2017) (Figure 1.1), which highlights the dynamic relationship between the domains of recovery capital. As such, the analysis must be approached in a similar manner, acknowledging the potential overlap between personal, social and community capital, and the themes presented within these.

To underpin the qualitative data which follows, the quotation below effectively summarises the potential impact of community engagement to aid recovery growth.

“I've never been to so many groups in all my life. I have never done this much. I have always been like, where do you meet new people? Oh, the pub. And now I've found out just by accessing one place you can find other places. It just opens it up and it stops you from only meeting people in pubs. You find places where you can meet people where it's not even on the internet or in the pub, which is handy.” (F43)

The analysis which now follows works through each of the three domains of recovery capital, beginning with community capital.

Community capital

The themes which follow are either directly linked to community capital or identified as interacting with the accumulation of community capital. Some of the factors which assets were rated by within the ABCE workbook (including the accessibility and affordability of assets), are included within this section, given the influence they have on individuals' physically being able to engage with assets within the community.

Opportunities

Recovery provided individuals with the chance to engage in new opportunities: *“I want to see and experience other things”* (F50); *“What I do need to do since I stopped drinking is find alternative things on an evening to do”* (M16). Resultantly, access to such opportunities aided the growth of community capital and was perceived to be a part of the recovery trajectory which was to be embraced: *“I’ve got a life to live now. I will fill it with whatever you can give me”* (M72); *“I put all that hard work in, I should make the most of what’s offered”* (F14).

SASS was integral to this process, acting as a catalyst for community engagement, as it was often the first step in a person’s journey to recovery. By presenting individuals with opportunities to engage in new and meaningful activities, engagement with SASS helped individuals to transition away from drinking, and towards recovery:

“It’s introducing things into our lives that try and break that [drinking] and that’s what it is. I think that in here [SASS] they do it, like they try and do outings like once a month or something like that.” (M69)

As such, SASS could be described as a ‘CHIME’ service (Leamy et al., 2011) by providing individuals with opportunities to form a sense of connection, hope, identity, meaning and empowerment. It did this not only by affording access to recovery-orientated resources but by opening a window for individuals to discover and rediscover new skills and interests outside of the physical location of SASS:

“It’s a recovery community and that is just what it is. We do things outside of the groups as well.” (F63)

Whilst SASS was integral to the growth of community capital, wider engagement outside of the recovery sphere was also critical, highlighting the importance of wider opportunities to aid recovery growth:

“SASS have always been there, and they’ve had a massive impact but the changes that I’ve seen in the last 12 months have been down to the church and that’s where I think that SASS have got me 90% of the way, but they’ve never got me that final 10%.” (M65)

Whilst wider engagement must be an encouraged aspect of recovery trajectories, this must be tailored to the individual's own skills and interests. What SASS did well was to facilitate the discovery of new skills and interest: *"What I'm doing at the minute is finding new directions to go in"* (M18); *"I just thought I would try something different."* (M68)

The value of these opportunities was recognised by those engaged, *"They have all helped me, every group I have been to has helped me. They all give you something different"* (F67). This is consistent with the social cure model which recognises that engagement in a diverse range of groups is conducive for positive health and wellbeing (Jetten et al., 2011). That said, engagement in a single group was recognised as holding great value, as it had the potential to produce a ripple effect of wider engagement through the opportunities it provided:

"It might change into something else, mightn't it, the fact that I am not sat at home reading a book, I am out doing something. It's a start." (M16)

"It's a meet up. Initially it's for people that need to use the food bank, but they also do like a cooking group, so even if you are using the food bank you can turn up to the- do group cooking and eat." (M18)

SASS therefore was often the first step towards recovery orientated engagement and also lead to providing opportunities to engage in wider community resources. Engagement both internal and external to the recovery sphere was important to encourage longer term recovery progress. That said, other factors, such as stigma (explored next), had lasting implications on individuals' ability and desire to become engaged with resources.

Stigma

Whilst recovery provided individuals with the opportunity to engage in meaningful activities, ensuring there were non-judgemental attitudes from others when doing so was important to encourage engagement. Individuals frequently reported feeling a sense of inclusion when engaging with recovery orientated resources, where those they were engaging with had shared experiences: *"It's not judgemental [SASS], it is never judgemental"* (F19); *"People are friendly, yeah, not judgemental"* (F63).

For two individuals, the stigmatisation they had experienced from wider members of the community was noted as being problematic and had acted as a barrier to engagement. One woman had a

particularly negative experience involving a consultant when in hospital. Fortunately, in this case, the woman had already engaged with SASS but as she explains, “*The consultant just slated SASS*” (F73). This particular woman also felt stigmatised for her drinking, and these feelings of stigmatisation were exacerbated by the consultant’s perception of her:

“He [the consultant] said ‘Oh, you read The Guardian’, and I thought, shall I say yeah, but that’s three days old and I have not been able to get past the first headline, and I said ‘Yeah’, because I do, and he said ‘What do you do?’ and I told him [my occupation], and he said ‘What is your specialism?’ and, forgive me, I thought ‘Right, I am going to fucking have you here’ so I told him and he had no idea! (laughter) and he was like ‘You’re an intelligent woman, so you need to just stop [drinking]’ (...). It doesn’t help if you are going into somewhere like that for help at that kind of initial point and then if they are going to be, I don’t know, almost make you feel stigmatised or judge you, you’re not helping anything... You just need to stop. It’s like ‘Oh, really, well thank you very much.’” (F43)

Similarly, another woman described how she had received “*derogatory comments from people*” (F50) whilst attending a group which had discouraged her from attending again. Both of these experiences are strong examples of ‘negative’ community capital and highlight the impact of stigma on those in recovery.

Others discussed internal stigma which arguably is a result of negative community capital: “*I have had to put a lot of stigma on things, haven’t I*” (F14); “*There is only me who’s a bad egg*” (M16), highlighting the personal impact of external stigmatisation. The effect of experiencing stigmatisation was noted on other factors also listed under community capital, such as an individual’s perception of themselves, and their sense of citizenship.

Citizenship

Through their drinking histories, individuals reported a loss of sense of citizenship which was often attributed to a lack of confidence and self-worth. This highlights that stigma and exclusion at a community level are often internalised and cause damage to self-esteem and other aspects of personal capital. The prevalence of negative community capital, stigma and exclusion was still apparent when individuals discussed their levels of community engagement, with an identified divide between ‘us’ (those in recovery) and ‘them’ (others within wider society). One individual phrased this as, “*They’re in the community, and I am not*” (M16).

That said, individuals expressed a desire for “*Wanting to be part of something*” (M18) and “*being involved with your community*” (F63). As highlighted, this was reliant on the right conditions being present (for example, non-stigmatising attitudes and environments). When achieved successfully, individuals reported that feelings of citizenship were aided by being “*more engaged with the community*” (M74) or by being “*somebody that's giving back to the community*” (M15).

Such engagement varied across the cohort. For example, for some, community engagement simply involved “*[being able to] engage with people, exchange ideas and thoughts*” (F19); “*just being involved in society (...) not necessarily doing stuff, but like moving around the city, being seen. Communicating*” (M64).

For others however, this involved engagement in which the individual was an active contributor of something:

“I think that is important to engage in these activities. So if they're doing a baking thing then I will have a go. I can bake, but do you know what I mean? Join in and give what you can back to the community. We've done clothes sales, I've cleared out all the clothes and given them to charities that are supported by SASS” (F19);

“Well, an active citizen, I am retired, and I believe that, well, it is just my belief that I think that we all should help out as volunteers a little bit. Perhaps just give one day or something like that, rather than just fritter away our time.” (F63)

When paid work was discussed, there was no agreed consensus amongst the cohort of how this interacted with experiences of citizenship. For some, having a job was related to them viewing themselves as an active citizen: “*I am still part of the world. Although I am on sick leave (...) I have a job*” (F73); “*For me it's somebody who's at work. I'm on benefits still and one of my goals is to get off benefits and back to work*” (M45); “*Someone who will be like – involved in the community, they will have a job*” (M99).

Others however thought that citizenship was derived from involvement in other recreational activities: “*I think work and doing these other things, that's maybe your baseline and then making an active citizen is what you do to go beyond that and use your spare time to do more*” (M44); “*I am becoming more and more active as a citizen, but I am not fully there yet. I am not doing volunteering, or anything else, which I want to get to that point, so it's in the middle*” (F43).

Whilst individuals began to report feelings of citizenship as a result of having opportunities to engage with resources which were non-stigmatising and non-judgemental, there were practical elements of this engagement, including time, affordability, and accessibility that interacted with the accumulation of community capital and thus, are important to consider next.

Time

The discussion of time was twofold, acting as both a facilitator and barrier to community engagement. Firstly, some individuals reported having additional time on their hands once they stopped drinking and keeping busy through community engagement was often the most conducive way to fill this void:

“I was so drunk, and I came out and I was just sat in the house on my own and I thought ‘I’m going to stop this’ and I got my diary out and I thought the only way I can stop this is by keeping myself really busy and that is what I did (...) I didn’t even have it in my head that I was going to have a drink because I was so busy and I thought it’s a much better life doing all these things, than sat here drinking all day” (F67);

“Oh, when you’ve stopped drinking you have bags of time (...) Because you’re not in a pub.” (M74)

Whilst recovery provided individuals with an opportunity to fill their time with meaningful activities, for others it was reported as a barrier to community engagement. This was particularly evident amongst those with family or work commitments:

“I would like to do a lot more, but it is just due to my work and just due to seeing my kids and stuff like that (...) it is what it is and I am just lucky enough that I manage to have this time.” (M68).

Taking this into consideration, community engagement had to be balanced with such commitments, and was also dependent on what other groups were already part of their weekly structure: *“I’ve got a lot on my plate at the moment (...) it’s finding time to get there” (M15); “I can’t fit anything else in to be honest” (F63); “It’s just the timing I think. With trying to fit it into my schedule. I could probably do it but it’s – (...) it’s just finding the time yeah” (M44).* This highlights the need for pathways to community engagement to be individualised.

Whilst time was both a barrier and facilitator of community engagement, the accessibility of resources was also considered in light of this.

Accessibility

As well as having the time to engage with resources, affording access to community capital was also reliant on the accessibility of these. This was commonly dependent on two factors: the location of a resource and transport links to the resource: *“It's the distance I've got to travel”* (M15); *“I think what makes it accessible is to be able to first of all attend (...) Easy to get to”* (F63); *“As long as it's easy to get to”* (M64).

For some individuals, particularly those with poorer physical health (explored also under personal capital), accessing resources could be challenging: *“It's a bit difficult for me to get to it if I've got a bad leg (...) I've got sciatica, so if I'm suffering with that and I can't walk here, I've got to use the bus”* (M18). Resources that were central to the city were favoured, with those outside the city centre or harder to access via public transport often being underutilised:

“I'd manage it but only if it's in the boundaries of the city centre” (M74);

“I actually have a knitting group, to be fair, but it's out at Healy City Farm, which is fine but it's the wrong end of town for me, so I am out of that one” (F19);

“If I had to go the other side of town I probably wouldn't bother because I'm not going to drive there at that time. I might not even bother catching the bus because it's too busy at that time. So, yeah, being close, walking distance, that's ideal for me.” (M44)

There was frustration that access could have such a substantial impact on community engagement: *“I [volunteer] can get people to come and do stuff but they can't get there”* (M65); *“That's [AA] on Sundays but the buses aren't really running much on Sundays”* (M74) as individuals recognised its importance to aid recovery: *“I need them to be very accessible otherwise I wouldn't be able to carry on”* (M72).

As well as being able to physically access resources, the suitability of these, including opening days and hours, held equal importance to affording access to community capital. For those with other commitments such as work or caring responsibilities, accessing resources was described as being *“impossible”* (F73) and *“not very acceptable”* (F14). Whilst some groups were held on an evening, these were limited: *“Apart from the Tuesday [SMART meeting] which happens after work time. Even then, I couldn't get here at that time when I was at work and everything else happens in the day”* (F73).

Likewise, those with childcare responsibilities who had to factor their community engagement around these commitments (such as dropping off and picking up their children from school), and relying on public transport, struggled to access resources: *“Their appointment [support service] is half two and I have got to be back no later than three home. I wasn’t driving at the time, and it takes a good hour for my bus to get all the way”* (F14). As such, it can be presumed that these factors may hinder an individual’s progress, if their own recovery and wellbeing loses priority to other responsibilities and commitments. To better support these individuals, there was a perceived need for additional resources on a weekend and evening:

“It would be good to have more stuff that happens say on a weekend, because there is nothing really that happens here on a weekend. There is only that one thing [SMART] on a Tuesday that happens after work time (...) For people who are still working, to have more accessibility on a weekend and on an evening, it would make a huge difference.” (F73)

Despite accessibility being recognised as a barrier to engagement, if such engagement was deemed to be worthwhile and the benefits of this on the individual’s recovery were recognised, individuals would often make the effort to engage: *“[The public transport links] are shit (...) [but I attend] because it’s something I love doing. It’s really bad transport”* (M16); *“The only reason they have got me to keep going is because they have counselling and they think that will be useful for me”* (F73). The accessibility of resources, as well as being determined by individual factors such as childcare or work, were also interlinked with factors such as affordability, explored next.

Affordability

The accessibility of resources was also interrelated with affordability, including the cost of travelling to a resource and the cost of engagement (e.g. entry costs and membership fees). Whilst the extent to which this was discussed by individuals may have been dependent on their own financial capital (which has not necessarily been linked to community capital in recovery literature previously), it is discussed here as it is supplementary to the themes discussed above (particularly accessibility and opportunities).

Specifically, transport costs (linked to the accessibility of resources) were either associated with driving - *“There will be [a cost] now with petrol”* (F14) - or public transport use, *“I’ve got to buy a bus pass because I need a bus pass to travel around. I can drive but I choose not to at the moment. So the cost involved is just the bus”* (F19).

It was clear that the affordability of resources was interlinked with accessibility: *“Yeah if I weren't paid the bus fare then it would be quite inaccessible”* (M45). In some instances, this resulted in an alternative form of engagement being undertaken: *“Sometimes I have to go local, to an indoor climbing wall rather than going out to the Peak District because I can't afford the bus and train”* (M16) or leading to limited engagement due to a *“Lack of money”* (M74).

Travel expenses were consciously considered to ensure engagement was feasible:

“I always make sure I buy a weekly ticket [for public transport] when I get paid, so I can attend” (F63);

“I've got to put other things to one side in order to keep in recovery, so obviously my transport costs come first. Apart from my electric and my gas and whatever, but they are now part of my bill.” (M72)

Alongside transport costs, the cost of engagement, such as entry costs, was also considered in a similar manner: *“The activities that I do, do cost money and whilst they're just about- I have to be really careful with all my other money to make sure I've got enough money to do that at weekends”* (M65). Comparably to accessibility, if engagement held value for an individual's recovery, then the expense associated with this was seen to be worthwhile:

“Now that is very expensive, yes, I do have to pay for that, the mosaicking. Put a red dot [user rating in workbook], yeah. It is definitely not cheap (...) But it has helped with my recovery no end. I think art does” (F67).

Whilst the value of community engagement was recognised by individuals, this had to be considered in light of the individual's personal circumstances, including their access to financial capital.

Community capital summary

In summary, the importance of community engagement to aid the growth of community capital was identified throughout. Entering recovery meant that individuals had time to spend discovering and rediscovering skills and engaging in opportunities which they may not have had a chance to before. SASS was critical within this process, acting as a catalyst for community engagement which was both internal and external to the service. Importantly, wider community engagement was deemed to be integral to supporting longer term recovery progress, yet consideration must be given to factors which

may help or hinder this process, such as work or childcare commitments. Specifically, time, affordability and accessibility must be considered in the context of an individual's personal circumstances, and engagement must be fostered in non-judgemental and non-stigmatising environments. If supported appropriately to engage with community resources, the individual will benefit from increased access to community capital.

Social capital

Following the discussion of community capital, attention is now turned to social capital. The themes which follow are either components of social capital or themes which are identified as interacting with the accumulation of such capital. Consideration is also given to how social capital affords access to resources, including those within the community. The first sub-theme to be explored is connection and belonging.

Connection and belonging

Many individuals reported a loss of social connection and feelings of isolation whilst drinking: *"I'd become quite isolated when I was drinking and doing drugs. I had no sense of belonging"* (M15); *"I didn't go out the house for a long time. Years and years and years"* (F50); and *"I didn't talk to anybody"* (F50). There was however a noted shift when individuals moved into recovery, with an explicit awareness that isolation was a barrier to recovery progression: *"Isolation is not good for me. If I'm not an active citizen (...) going out into the community and engaging with other people, then I'm isolated"* (M18). The formation of pro-social networks and community engagement was critical to supporting this: *"My main issue is the isolation, so going to groups and people being open with me has helped me to do other things as well"* (F43). This also acted as a form of social control, conducive to recovery:

"Keeping me on the straight and narrow. It's given me someone to talk to whenever I need to. Whenever I get the thoughts of using or drinking, I can always ring someone and they're there. I can talk to them" (M15);

"One person might be able to understand difficulties I may face whereas another one wouldn't because they hadn't had them difficulties, so there is a mixture of life (...) relating to any problems I may have and there is advice there as well that can be listened to." (M72)

For those who experienced periods of isolation during their drinking histories, forming membership status within a pro-social group was an important aspect of community engagement, helping individuals feel a sense of belonging: *“I'm feeling connected, it's about feeling loved”* (M65); *“I'm a valid member of the community there”*; *“I mean you walk through the door and I know everybody (...) everyone knows me in church so I've found kind of where I fit”* (M65); *“It's about like, connecting with people ain't it, you know like eye to eye”* (F50). As highlighted, forming connections to others supportive of recovery endorsed the acquisition of social capital and the formation of new social identities, explored in depth next.

Social identity

Such feelings of connection and belonging were often strengthened through an individual's sense of social identity, in that group members often had shared experiences (such as drinking and entering recovery): *“We've got a lot in common first and foremost, haven't we. I used to have issues with alcohol and now I haven't, so I guess that is the main thing that I have got something in common”* (M16); *“Everybody is in the same boat, no matter who you are”* (F43); *“We're all dealing with the same problems”* (M74) and *“We're all like got the same issues and some have been through it”* (M99).

Having these shared experiences with other group members and forming a sense of social identity encouraged engagement: *“I probably would be more likely to go to people that understand”* (F63). More so, the advantage of this meant individuals were provided with an opportunity for social learning: *“Sharing with people and learning different techniques”* (F19); *“People can learn from you as well it's not just you're there as a burden”* (F50); and *“I've gone through it and I know how people feel, I've got a lot of empathy and I think I understand people. I think there's a lot there to share”* (M65), highlighting the power of peer support for those in recovery.

This sense of social identity with recovery peers also helped individuals manage feelings of stigmatisation and discrimination associated with their drinking identity: *“I'm not a bad person, I've never been a bad person but I feel bad because people have made me feel bad. I'd like to just feel comfortable you know”* (F50); *“[I have] something in common with everyone (...) even if it's not something good we've got in common, it's something that we're – you know, we're all on that same journey, trying to stop or have stopped”* (M99); *“Everybody is in the same boat, no matter who you are. There is no judgement. We are all still in it together really”* (F43). This demonstrates the detrimental impact of stigmatisation on an individual's perception of their self and self-worth, highlighting the importance of recovery communities as a means of support:

“Coming to places like here and seeing people not react in a bad way to what I’m saying makes me come here more, because that is part of the thing that talks me out, thinking oh my god, I don’t want to be around new people. And it’s helped.” (F43)

These shared experiences between individuals in recovery not only helped to manage experiences of stigmatisation and act as a form of social learning, but also provided individuals with access to pro-social networks which were crucial to underpinning recovery progress.

Social networks

Entering recovery, individuals recognised that the social networks they had previously associated themselves with had often encouraged drinking behaviour and disassociating from these networks was a crucial aspect of recovery progress:

“‘What about your friends that are drinking?’, I said ‘Well, we will soon find out whether they were boozing partners or friends’, so I don’t associate with them anymore, and it’s not the loss of a friendship (...) I am not suited to be sat in a pub getting pissed. I don’t want to. Not interested” (M72);

“I’ve got rid of all the idiots. You know, just putting my background behind basically, you know what I mean?.” (F14)

As such, engagement in recovery-orientated groups was a catalyst for recovery progress. Wider community engagement however was also valued to form new networks: *“It will give me a chance to meet other people, like not just in recovery” (F43)*, and such community engagement helped to aid the acquisition of social capital, further underpinning the shift away from networks associated with drinking:

“I just hang around with my climbing friends nowadays. Most of them drink very little so being in that environment again where I am with non-drinkers really. My social life has changed completely. I used to hang around with drinkers and I drank, and now I don’t hang about with drinkers and I hang about with people who do activities like climbing and stuff, so everything has changed actually.” (M16)

Seeing that wider engagement was valued so highly was positive to see, as homogeneous groups in which networks have shared experiences can at times provide less access to bridging capital. It was

however apparent that individuals gained access to bridging capital through other newly forming social networks, sometimes even initiated through SASS to begin with: *“It’s given me quite a varied group of friends coming here, outside of the groups as well. We have a community outside of the group as well”* (F63). This highlights the ability of social networks to provide access to bridging capital, an aspect of recovery trajectories which is crucial to supporting wider community engagement.

The formation of these social networks was often a driver for engagement - *“I come down here for social as much as anything”* (M16); *“It’s a meet up [cooking group] (...) and it’s a social environment”* (M18) - and often took precedence over the actual activity itself: *“I am only doing that [group at SASS] to meet people”* (M16); *“You also get a tremendous amount of company. We have such a lot of fun”* (F67). This highlights the importance of community engagement, both with recovery and non-recovery orientated networks, to aid the accumulation of social capital. Family relationships were also important to consider as a social network within themselves. Attention is now turned to how these networks afforded access to social capital, and instances where they both helped and hindered recovery.

Familial relationships

Whilst social networks often exerted a positive influence on recovery trajectories, familial relationships did not always have the same effect, and at times placed strain on the individual, especially if they were the carer of a child, family member or partner. For these individuals, accessing resources was challenging due to these commitments: *“If I don’t help my daughter out she hasn’t got nobody else so she will have to pack her job in. She will be homeless, won’t be able to pay the rent, so I have to do whatever I can”* (F14) and community engagement was described as being put *“on hold”* (F14) as a result.

There was clear role conflict for these individuals and the impact of this was detrimental to recovery progress: *“In school holidays I’ve got them [my grandchildren], so I don’t get a break. It’s shit. I hate it. It gets me down and I wouldn’t blame myself if I just started drinking again”* (F14); *“I would like to do a lot more (...) just due to seeing my kids and stuff like that”* (F68) and *“I’ve not been concentrating on myself for the past 12 months or so, I’ve been concentrating on Georgia’s³⁷ [partner] needs most of the time so I’ve not been as active”* (M18). Thus, for those accessing services (or not accessing services depending on the level of impact their familial relationship has), consideration must

³⁷ Name changed for purposes of anonymity

be given to how these individuals can best be supported to ensure such familial relationships are not in fact detrimental to their recovery, nor does their recovery lose priority.

Positive familial relationships however were seen to provide access to social capital and social support - *“I've only got my brother and he'd love me to go to SASS more often”* (M74) - but if not managed carefully, exerted additional pressure on individuals. This highlights the importance of community engagement to be tailored around an individual's current commitments and emphasises the need for wider social networks and social capital to help support individuals with familial responsibilities. Considered collectively in light of social networks more broadly, when these networks were seen to support an individual's recovery, they provided a vital source of social support.

Social support

Engagement with community resources and the formation of pro-social networks provided individuals with social support. It is important to note here that engagement with resources was not always continuous and needed to be flexible, working around the individual, their commitments and personal circumstances - *“I did have a period a while since, about 14 months, where I was completely sober and I had a relapse so this time I've come back into it [community support service]”* (M15); *“While I'm dealing with this emotional stuff I need to be here”* (M18); *“The GP's been really supportive. Obviously, it's not doing much with me at the minute but he's always there in the background if I need it”* (M65). This is synonymous with what is known about recovery, given this is not a linear journey and individuals may engage and reengage with supports as and when they require them.

Services such as SASS which ran informal drop-ins helped to encourage flexible engagement whilst also providing individuals with a sense of stability as support was available when needed: *“It's given me someone to talk to whenever I need to”* (M15); *“The issues that obviously are bugging you or something and you can talk about, just like anything here”* (M68). Having this stability was crucial, and individuals recognised its value:

“What can I do to support you, this is what you can do to support me. That was quite hard for me because I am quite a strong person. I think I can do it all on my own and clearly I've learned you can't.” (F19)

As well as the stability which recovery services provided, the formation of recovery-orientated networks (as also discussed under social networks and social identity), provided a unique type of social support: *“If it's something surrounding like mental health or addiction then you want people there*

that have got either mental health issues or people who are recovering” (F43): *“They may be struggling, you may be struggling, I might be struggling and we are helping one another”* (M72), which was acknowledged as being integral to recovery progress: [When asked what has had the biggest impact on their recovery] *“I think here [SASS] and the peer support”* (F73). From this, it is evident that SASS was often a catalyst for the formation of such support networks and was a critical part of an individuals’ recovery trajectory. Not only did these networks afford access to social support, but as touched upon earlier within the *Opportunities* sub-theme and detailed in depth below, also provided access to wider community resources.

Social capital and access to resources

Not only did such networks provide access to social learning, social control and social support, but also afforded access to wider community resources. Whilst community engagement was a means to develop social capital, those early in recovery initially reported depleted stocks of social capital to draw on. This at times resulted in a lack of bridging capital, as the social networks which would usually afford access to such resources were not always present, especially for those who were most isolated. This often meant individuals had to reach out to recovery-orientated resources of their own accord, and individuals reported a sense of apprehension in doing so:

“The hardest thing to ever do is to come for the first time. That is the hardest thing (...) but then, once you’ve come for the first time, everybody is in the same boat and everybody is welcome” (F73);

“When I was coming here for the first time, you do have that sort of sense of trepidation about what it's going to be like. But once you know everyone and you know what you're coming into, then it's just easier.” (M44)

As highlighted, feelings of apprehension were reduced once individuals engaged with a resource for the first time, especially when other factors associated with the formation of social capital such as social support were present. Whilst this supported access to recovery-orientated resources, accessing resources beyond the recovery-sphere was still challenging, particularly for those with lower levels of social and bridging capital. Resultantly, this meant awareness of community resources was limited and the individual themselves often had to do the groundwork to initiate engagement: *“I have got to find some groups, but I am not aware of all the groups, so I need to do research on that”* (M16); *“There should be more information, more leaflets and more publicity”* (M74).

To help bridge this gap, some individuals indirectly discussed the role of community connectors (similar to those discussed by Kretzmann & McKnight, 1996; Collinson & Best, 2019 and as also further detailed in the discussion, see Chapter 8) as a means to assertively link individuals into community resources. These community connectors were often supporting the individual in some capacity (e.g. support worker) and through their knowledge of the local area, were able to link individuals into new resources based on their support needs, skills and interests:

“Well I met [recovery worker] down at Matilda Street and he said ok meet me SASS and then I came and he said, there’s a meeting mate, do you want to sit down so basically he just fucking blagged me (laughs) and then I sort of like, started to taste the water but I think that was quite good otherwise I wouldn’t have done it” (M31);

“Sometimes that can be really helpful for people. It’s like, were you aware of this that’s available for you?” (F19);

“[recovery worker], she is going to find out what I like, what I don’t like, and that is why I am doing them all so I can relay it back to what she can offer me, whatever’s available” (M72);

“So anytime he [recovery worker] sees something that he thinks might be worth my while he mentions it to me.” (F43)

Once individuals were linked in with a resource, frequent engagement helped individuals feel more comfortable - *“I’ve only been to two meeting so I still feel like – sharing – and coming to the meetings is a bit, you know like testing the water” (M99); “People talk to me nice a bit now because they got used to my face” (F50)* – and continued meaningful engagement often resulted in lasting social networks being formed:

“There’s people that come here that I’ve been seeing their faces for the past seven years and I couldn’t- I mean I’ve not been here for six, seven months and I know I can walk in here ... and I’ll see somebody like Johnny straightaway. I’ve not seen Johnny for six months. I’m smiling.” (M18)

As these networks were formed and individuals became familiar with others who also attended the group, the benefits of such networks were noted: *“It’s De Hood [which has had the biggest impact on my recovery]. I grew up there (...) you know. I mean you walk through the door and I know everybody” (M65); “The same faces sometimes, familiar faces and for me that makes it more relaxing” (F50); “Yeah I think it does [encourage engagement], yeah, because I know- generally I know who’s going to*

be here, I know there's familiar faces, I know the people who are going to be leading the SMART meetings” (M44). This highlights the interrelated nature of attendance at groups and feelings of connection and belonging.

Social capital summary

The relationship between social capital and community engagement seems to be reciprocal. Whilst those with higher levels of social capital were afforded access to resources more easily than others, engagement with resources was also a means to build social capital for those previously more isolated. The process of linkage into resources however can be challenging, and at times requires the support of staff, or those who can act as community connectors.

In summary, community engagement was a means to aid the growth of social capital and citizenship. When individuals began to engage with pro-social resources and form new social networks, the benefits associated with this were conducive to personal growth and recovery progress. Most notably, there was a shift in social networks from those associated with drinking to those supportive of the individual's recovery, and a shift in social identity which accompanied this. Resultantly, individuals reported feelings of connection and belonging, and shared experiences between recovery peers was critical to this process. Whilst at times these social networks afforded access to wider community resource, known as bridging capital, this process was dependent on these networks being formed to begin with. For individuals with lower stocks of social capital and social support, this was heavily reliant on support from an individual supporting them, such as a recovery worker or community connector. The relationship between social and personal capital, explored next, was also dynamic and mutually reciprocating.

Personal capital

To finish the thematic analysis, attention is now turned to personal capital. The themes which follow are either components of personal capital or themes which are identified as interacting with the accumulation such capital. Consideration is also given to the relationship between community engagement and personal capital. The first sub-theme to be explored is aspiration – a component of recovery journeys which was noted as individuals began to envisage their recovery.

Aspiration

As individuals were afforded access to community capital and social capital through community engagement, the effects of such engagement on personal capital was also noted. Individuals began to reimagine their lives and showed aspiration for the future, with goal setting helping to shape the direction of their recovery: *“You need some sort of like goals”* (M99) and *“I want to see other things and experience other things”* (F50). Once individuals were making progress in their recovery, the prospect of wider community engagement was aspired to, highlighting the importance of a more holistic identity development which is not solely recovery-centric: *“Even SASS itself I’d never turn my back on it, but I’d like to stretch a bit further maybe sometime soon”* (F50).

For some, aspirations were recreationally focused, *“I would like to go to a pottery class (...) I’ve always wanted my own kiln. If I got my own kiln I’d be as happy as”* (M18); *“I’d like to do some languages or something like that”* (M65); *“I would love to be able to do that [hair and make up]”* (F43).

For others however, aspirations were employment focused:

“I’m going to do some more work on counselling and behavioural stuff, because the way I see it Beth, I think what’s going to happen is, I want to do that much work and volunteer work and get trained up here that I’ll probably end up getting some kind of paid work in the till as well” (M65);

“I am hoping to work towards being a mentor in the hospital (...) and I also am hoping to go to Northern College next year to do two counselling courses” (F67);

“The ultimate aim of getting full time employment in whichever I feel comfortable with (...) Because I’ve got a big bag full of certificates I had before I had a drink problem.” (M74)

The variation of individuals’ aspirations highlights the importance of recovery pathways being person centred. As it cannot be assumed that employment is a feasible or preferred outcome for all, engagement in a range of resources must be encouraged to promote the growth of personal capital. Having such aspirations and working towards them was a result of improved personal development and also helped to underpin further personal growth.

Personal development

To hold such aspirations, individuals had to possess a level of self-confidence which had often been diminished during their drinking histories. Resultantly, this hindered their self-worth and their

perception of their ability to engage with community resources, demonstrating the impact of stigmatic barriers to recovery:

“Probably lack of confidence sometimes, like an anxiety thing that can linger. I don’t know, because I went to that Kickback recovery and I didn’t know what to expect and stuff but yeah, I would say that really, lack of confidence really” (M68);

“The same with SMART, I didn’t want to come for most of these reasons. Then I think it’s just trying to get the confidence to actually come.” (M44)

Individuals did however report a growth in confidence once they stopped drinking - *“I have got much more confidence since I stopped drinking. I tend to think if I want to do something I tend to go and do it now” (F67)* – and this was further enhanced through opportunities to engagement with community resources: *“They’ve given me a lot of training as well (...). Which has built my confidence” (F63); “[Community engagement] helps with my confidence, my mental state” (M69)*. Perceptions of self where however at times still a barrier to engagement, particularly for those earlier in their recovery journeys: *“It’s just self-worth, you know. I don’t feel like I am pulling my- you know, doing my bit if you know what I mean” (M44)*.

As individuals were supported and encouraged to engage in community resources, improvements in personal development were noted, but were not however always immediate: *“It’s took me a long time to feel like I weren’t a burden to anybody” (F50)*. This process over time had lasting implications on other aspects of personal development, such as self-worth: *“It’s about feeling loved, it’s about feeling self-esteem coming back” (M65)*, and gave individuals confidence to engage in activities that they may have previously been unable to:

“The Recovery Games last week, that first one we were climbing up that netting, I says I couldn’t have done that a few months ago. I said I know you’ve got me on the end of the rope but I’d have fell off five months ago, I wouldn’t have done that” (M72);

“I’ve found myself talking to people on buses, people at the bus stop. A lot of people just stop and talk to me now and I don’t know, I think that it’s opened me up and changed how I carry myself. People never used to approach me, I used to wear full-on goth gear and I used to stomp through town, head down, going from A to B, now I just wander around, take it all in, and talk to so many people.” (F43)

As highlighted, this was a journey of personal growth which evolved over time, and was reciprocal with social and community capital also, in that the more engaged individuals became, the greater the benefits:

“I’m in there [SMART] because other people can see things in me and it sheds light on me and I can see things that- when I walk out of there, that I couldn’t see before I went in there” (M18);

“I used to be really, really judgemental, really judgemental. Not talking to people because I think oh they’re not up my alley, then coming to here and talking to people from different walks of life obviously we have all got the same sort of issues but whereas normally I would write that person off, I am actually talking to them andyou know what, they are actually not bad people.” (F43)

Although individuals reported a lack of confidence and self-worth at the start of their recovery, the benefit of community engagement to encourage the growth of personal capital was supported throughout, with individuals having confidence both in themselves, their ability to sustain their recovery, and engage in activities they had not previously. As well as noting improvements on a personal level, this was also underpinned and discussed in light of the enjoyment associated with engagement, explored next.

Enjoyment

Linked with the personal development which individuals experienced through engagement with community resources, individuals often spoke about finding enjoyment in the activities they participated in - *“Well I enjoy it, because it gets me out”* (F14); *“It’s something I love doing”* (M16) – with such feelings used to describe both the reason for engagement and participation in the activity: *“[Going dog racing] should be lovely, good fun”* (F19); *“I enjoyed the Recovery Games. Meeting different people from different cities, different organisation, and it’s fun”* (M69).

This was often discussed of in light of their previous drinking: *“You are actually producing something, you have actually made, and you think look, I can actually do something instead of sitting there drinking all day”* (F67); and individuals found great pleasure in recreational activities which were not necessarily associated with recovery:

“None of this is about drugs, this is just about people being together and doing things (...) So it’s the drop in [at SASS], I have never done that before, but, we just ended up doing some colouring

in! [A friend] said what are you going to do this afternoon and I said I think I am playing Bingo! (laughter)” (F73);

“We were going to go dog racing tomorrow night and I would have come to bingo on Saturday (...) it’s just a case of let’s have a look and see where I’m at and where I can be at, in a nice environment (...) And have a few pork sandwiches (laughter).” (F19)

This highlights the strength of community engagement and positive social connection to promote the growth of personal capital and the power of social connection as a means to enhance newly forming identities, conducive to an individual’s recovery. This is summarised in the following quotation, which also emphasises the importance of activities which are non-recovery centric as a driver for recovery capital growth more broadly:

“The activities are... they’re not so much about what they are, I mean I could sit there knitting, it’s not about that, knitting is not something that I would actively go and look to do, it’s about the people that are there. So even though I could be sat there fiddling with a pair of knitting needles it’s not about that, it’s about... that’s just a vehicle for everything else that’s happening.” (M18)

It was apparent that engaging in recreational activities where feelings of enjoyment and fun were reported, were intrinsically linked to the growth of self-esteem. This is a positive development in light of the accumulation of personal capital. An individual’s ability to engage with resources and the effect of this engagement was however at times, influenced by their mental and physical health, explored next.

Mental health

Whilst there were noted improvements in personal capital as a result of community engagement, elements of what has previously been categorised as ‘negative’ personal capital, including mental ill-health were acknowledged as a barrier to engagement:

“I do suffer with anxiety, and this is why I go to [professional support service], because I was getting to the stage where I didn’t want to go out and my stress levels were getting really high” (F14);

“Like my mental health, for example when my anxiety gets bad like my social anxiety might stop me from leaving my flat so I could just like order a takeaway and not just leave or do my shopping online [laughs].” (M99)

If these barriers were still noted when an individual did begin to engage with a resource, they often impeded their ability to engage meaningfully: *“I came to SMART for a month or two but that wasn’t, or I wasn’t in a fit state of mind to accept what they had got to offer”* (M72).

This was however twofold, as others discussed that if initial barriers to engagement could be overcome, improvements in mental health were noted. Engagement was often initiated as a way to keep busy and keep *“your mind active”* (F67) (linked to the discussion of the use of time within community capital), and was seen as a vital source of emotional support if individuals were struggling with their mental health: *“While I’m dealing with this emotional stuff I need to be here [SASS]”* (M18).

Individuals reported feelings of positivity as a result of community engagement: *“It makes me feel positive (...) stops you from feeling down”* (M69) and often resources listed under sports, recreation and arts were discussed as a means to promote positive mental health and wellbeing:

“It’s doing something that benefits you mentally as well as physically as well, but it just makes such a big difference (...) But when I did it, when I tried it and I started running and I started going to the gym, I realised how it actually does help and it’s a bigger impact than I thought it would have” (M44);

“Like gym and MMA and stuff like that is just like a thing in your brain, you know that thing that makes you feel a bit better” (M68);

“Because the serotonin, its good, you get that, you get that nice feeling don’t you?.” (F50)

Improvements in mental health were a hugely valued aspect of recovery progress, and often linked to community engagement, as summarised here:

“My mental health is the best it’s ever been, whereas before I would always describe it as flat, but it is neither good nor bad, but now I will say it’s good because I am getting out, I am doing stuff, I am not brooding on things.” (F43)

Through the accounts, it was evident that mental health could both help and hinder an individual’s levels of community engagement. At first, for those experiencing mental ill-health, this was often detrimental to their ability to engage with resources, as well as their ability to engage meaningfully. If individuals could however be appropriately supported throughout this process, it is noted that community engagement, particularly with recreational activities, was a means to promote positive wellbeing. This must however also be considered in the light of physical health, detailed next.

Physical health

Similar to mental ill-health, physical health was also discussed in light of community engagement. Whilst not all individuals were affected by poor physical health, this had a significant impact for those who did. Poor physical health was mentioned as a risk factor to drinking - *“It’s killing me. I’ve had enough, it was why I drank as well, because it eased the pain”* (F14) - and as a barrier to community engagement: *“They’re giving you medication, painkillers what dope you up to the eyeballs, so you are falling asleep all day”* (F14). This highlights the detrimental effect of poor physical health, and the need for this to be considered in light of recovery pathways.

That said, when individuals showed motivation to engage with resources, and saw the benefits of engagement on their own health and wellbeing, participation was encouraged and seen as a vital way to keep pre-occupied:

“If you look at four walls you’re going to go under, aren’t you. I can’t just sit there moping, ‘Oh I’m in pain, I’m in pain’, you have still got to get on with life at the end of the day, but it’s just that I wish I wasn’t doing as much as I am.” (F14)

Physical health therefore seems to have a similar interaction with community engagement as that noted with mental health and emphasises the importance of recovery trajectories being person-centred.

Personal capital summary

In summary, whilst mental and physical health were at times seen as a barrier, if these factors could be managed and supported appropriately, then the effects of such engagement were often positive. When initiated, community engagement was linked to personal development, including improvements in self-worth and self-confidence. Again however, when stocks of personal capital were low, encouraging initial engagement was challenging and highlighted the effect that this may have on social and community capital growth. As individuals began to engage with resources, they were able to envisage a life free of drinking and developed aspirations for the future. Whilst engagement with recovery-orientated resources held great value, the ability to just have fun, and engage in recreational activities had hugely positive implications of self-efficacy, subsequently conducive to personal growth.

Chapter summary

The current chapter has been presented in three parts: the quantitative analysis, visualisations, and qualitative analysis. Each of these are intended to complement one another, beginning to identify the

key components of community engagement, and the impact of such engagement on recovery pathways.

As demonstrated in the quantitative analysis, some nuances were identified by gender in relation to perceptions of active citizenship and barriers to community engagement, with men appearing to be more likely to not perceive themselves as an active citizen and listing not knowing enough about a resource as a barrier to engagement. This signifies the importance of recovery pathways being individualised and tailored to the gendered experiences of men and women. A significant relationship was also identified between an individual's satisfaction with their community engagement and the number of assets they listed being engaged with, emphasising the importance of community engagement.

Building on this, the second data output sought to add wider context to the chapter, with the visualisations mapping out resources across Sheffield and outlining the user ratings associated with those most commonly listed. Based on a descriptive analysis of the map of Sheffield, resources seem to be clustered in the city centre or Northwest of the city, where SASS is located. The findings acknowledge that this may be attributable to the sampling, given that all individuals who completed the workbooks were accessing SASS. That said, the accessibility of resources was a prevalent theme within the qualitative data, and individuals expressed that they were unlikely to, or unable to, fully engage with resources outside of the city centre.

The final part of the chapter sought to tie these two data outputs together by undertaking a thematic analysis of the audio recordings collected during the completion of the ABCE workbooks. This adds narrative to the two earlier outputs and by identifying themes associated with personal, social and community capital, begins to explore barriers and facilitators of community engagement, as well as the impact of such engagement on recovery growth. This highlighted that whilst consideration must be given to how community engagement is encouraged, particularly in light of the individual's personal circumstances, if done successfully then community engagement is a valuable means to building recovery capital.

Chapter 7: Study 4

Introduction to chapter

The purpose of this final analysis chapter is to present the qualitative data for Study 4³⁸. Drawing the findings to a close, Study 4 combines aspects of both recovery capital (see also Study 1 and 2) and community engagement (see also Study 2 and 3). Based on the data collected for Study 2, four women who completed the REC-CAP were approached to participate in a reflective interview, with data being collected from three of these four. The rationale for interviewing women only, and how the women were selected, is outlined below. The premise for this final study was to add narrative to the quantitative data earlier collected, and to explore in depth any disparities between levels of recovery capital and community engagement.

The chapter is broken down into three parts, each of which represent a case study for the three women interviewed. In parallel to Study 1, 2 and 3, data is presented in light of the framework of recovery capital. The results of study are analysed in the context of the subsidiary research question:

3b. How can we demonstrate the impact of community capital on personal recovery growth?

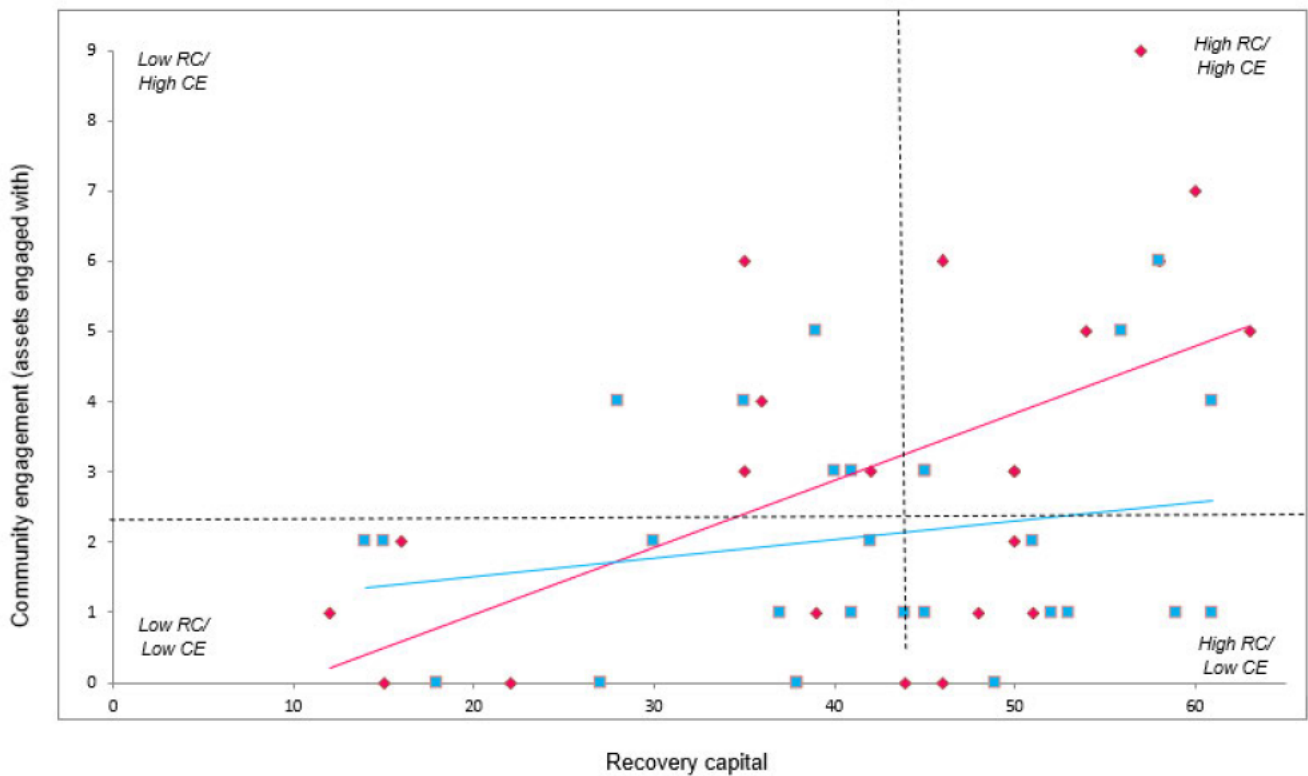
Collection of data

Following the collection of REC-CAP data (see Study 2), scores for overall recovery capital and the total number of assets the individual was engaged with at Time 2 were plotted against one another on a scatter graph. The rationale for this was twofold. Firstly, this sought to visualise how the cohort as a whole scored across the two variables. For example, whilst findings from Study 2 highlighted that community engagement was positively correlated with recovery capital, the entire cohort did not necessarily score high on both of these variables. Secondly, whilst the qualitative accounts detailed in Study 3 (see Chapter 6) highlighted the impact of community engagement on recovery trajectories, it was expected there would be nuances amongst the cohort based on personal experience.

The scatter graph can be seen in the figure below, and is followed by an explanation to understand the data presented:

³⁸ Data is not included in the appendix but is available on request

Figure 7.1: The total number of assets an individual was engaged with plotted against recovery capital scores Time 2



- Female data
- ◆ Male data

As shown in Figure 7.1, recovery capital scores were plotted on the X axis, against the number of assets the individual was engaged with on the Y axis. Once the data was plotted, this was split into quadrants which placed the cohort (men represented in blue and women represented in pink) into one of the following categories: low community engagement/ low recovery capital; low community engagement/ high recovery capital; high community engagement/ low recovery capital; high community engagement/ high recovery capital. Each quadrant (see black dotted lines in Figure 7.1) was determined based on the mean scores for the two variables. The pink line (associated with women’s data) and blue line (associated with the men’s data) signifies the trend lines for the two groups. As shown in the figure, the data is fairly evenly distributed across all four quadrants.

Based on this data, it was intended one interview would be carried out based on each of the quadrants, thus, better understanding the distinctions amongst the cohort. The literature review (see Chapter 2)

identified some gender differences in pathways to recovery and findings from Study 1, 2 and 3 further highlighted some nuances between men and women regarding the accumulation of recovery capital. That said, research to date has most commonly been based on the experiences of men and women collectively, or men alone, with fewer studies solely focusing on the experiences of women (see also Chapter 2). With this in mind, it was decided the sample for Study 4 would solely include women. This was not to disregard the experiences of men but to provide a platform for women's recovery narratives and to allow them to tell their stories which, due to levels of marginalization, have not previously been shared to the same extent of men. This is also intended to complement recent work which has highlighted the specific complexities that women face (see Collinson & Hall, 2021; Andersson et al., 2020) by helping re-address the balance of women specific literature.

From the plotted data (see Figure 7.1), one woman was selected at random from each quadrant and invited to participate in a reflective interview. The interviews were intended to give the women a chance to discuss how their recovery capital scores (recorded within Study 2) had changed over time, and the impact of community capital on personal recovery growth. The interview schedule can be seen in Appendix 5.

Out of the four interviews intended to be conducted, it was only possible to data collect from three women. None of the women in the low recovery capital/ low community engagement quadrant were contactable. This is an important finding in itself, perhaps signifying the need for these individuals to be provided with additional support throughout their recovery, particularly until improvements in either recovery capital and/ or community engagement can be noted. This will be returned to in the discussion and reflected upon in light of the wider findings. Given that all women had participated in Study 2, it can be presumed that to some extent, they had been in recovery for a similar length of time, given that Study 2 data was collected from individuals upon entry to the service.

The scatter graph was created immediately after the collection of REC-CAP data (Study 2) and thus, the following two parts of analysis had not yet been undertaken:

- 1) Re-calibrating community capital so it was scored out of 25 instead of 14, and therefore equally weighted with personal capital and social capital³⁹;
- 2) Computing the community engagement scale.

³⁹ See Chapter 5: Study 2, Community engagement scale for rationale as to why this was re-calibrated

As the interviewees were invited to participate in Study 4 prior to this analysis having been completed, the approach implemented to plotting the data on the scatter graph could have better represented the analysis of Study 2. If the analysis of Study 2 had been undertaken beforehand, the sampling technique for Study 4 may have been differentially influenced. This would have then meant overall recovery capital scores (with community capital equally weighted), would have been plotted against the community engagement scale, as opposed to the number of assets the individual was engaged with. This will be returned to in the discussion (see Chapter 8: *Study 4*).

Analysis of data

The interviews, once transcribed, were thematically analysed utilising an abductive mode of inquiry, similar to that implemented in *Study 3: Analysis of qualitative data*. This meant that whilst existing literature (see Chapter 2) and findings (see Study 1, 2 and 3) were utilised to aid the analysis of data, supplementary knowledge could also emerge from this. As per the previous analysis, the recovery capital framework shaped the initial approach to coding the transcripts. To retain the narratives of the case studies however, themes under each of the recovery capital domains were not prescribed. This meant the researcher did not approach the thematic analysis looking for specific sub-themes within each domain of recovery capital but aided the researcher to pick out key aspects of the women's narratives which seemed most prominent in their accounts.

Following the coding process, the quotes associated with each of the domains of recovery capital were shared and discussed with the supervisory team for the thesis, helping to strengthen the reliability of the analysis. No quotes were removed following this discussion, although it was outlined that at times extra detail from the transcripts was needed to provide wider context. Each case study is written up based on the women's accounts of personal, social and community capital. Once each case study is presented, solely focusing on the individual narratives of the women, discussion turns to identifying similarities and differences amongst the cohort. It is at this stage that sub-themes identified within these narratives are presented, as this was done retrospectively. Within this chapter, findings are presented and interpreted, with a further discussion of the results given in Chapter 8.

Case study one: Harriet

Harriet is a 47 year old, white British female. Harriet participated in Study 2 and based on her REC-CAP data at Time 2, was situated in the high recovery capital/ high community engagement quadrant. Harriet had previously been into rehab and was now living alone in Sheffield. She is a mother and her

younger⁴⁰ children lived in the care of her older⁴¹ daughter – she had recently started to have contact with them all again.

Community capital

Harriet was actively engaged in the recovery community at SASS and spoke about engagement in meaningful activities as a means to keep busy - *“I just keep busy. Tire myself out through the day”*. Harriet recognised the importance of this, adding both structure to her recovery and acting as a form of social control: *“I just keep busy. Knowing not to go back down that road anymore because of the chaos, and I don’t want chaos”*.

She frequently attended the women’s only group - *“[Recovery worker] a few weeks ago took us to the Hilton Hotel where we had a spa day and we went swimming there. That was nice”* – but as she made progress with her recovery, she was provided with wider opportunities for community engagement. Harriet soon became a peer mentor for SASS, demonstrating a level of progression in regard to her engagement:

“Last week [recovery worker] asked me to just come in and have a few words with one of the ladies just to let her know how I actually felt when I first started coming here and what this place has done for me”.

Hand in hand with her role as a peer mentor, Harriet showed a strong willingness to help others, a commonly noted aspect of recovery trajectories (see for example, Riesman’s helper principle, 1965):

“When there’s new people coming in, I do try and help them as well to let them know that this is a safe place to be and that there are loads of things you can get involved in and focus on recovery and stuff”.

The effect of being able to give back to the recovery community in this way was also interlinked with Harriet’s personal development, as she stated such engagement helped provide her with a sense of purpose: *“It makes me feel worthy, yeah, definitely. Knowing you can help somebody else when you can see that they’re struggling and stuff, and it does take you back a bit”*. As such, it can be presumed that engagement in meaningful activities is a catalyst for positive personal change and thus acts as a

⁴⁰ Younger children refers to those under the age of 16 years

⁴¹ Older children refers to those over the age of 16 years

driver for wider or continued engagement. This was reflected in the following quotation, as Harriet showed willingness to engage with the community beyond the immediate recovery sphere at SASS:

“I went to Together Women a few weeks ago to see what goes off there, because I thought I'm coming here every day and I could do with spreading my wings a little bit more and trying to find something else”.

It is evident throughout Harriet's account that community engagement, both at SASS and the wider community, was a means to accumulate community capital. Harriet showed a strong desire to invest her time in engaging in meaningful activities, both as a 'participant' (attending groups) and as a 'contributor' (as a peer mentor). Such involvement was not only linked to the accumulation of community capital, but social capital and personal capital.

Social capital

In line with Harriet's community engagement, she also acknowledged the need for changes within her social network to support such engagement and aid her recovery. As part of this, Harriet found it necessary to disassociate herself from some of her family: *“There's come a point in my life now where I've had to put a stop to that. I don't need that no more. Obviously through being in recovery I don't need that as well”.* To aid the transition from networks which did not support her recovery, to those that did, Harriet relied on community engagement as a means to do so: *“I come here every day to make sure that I'm doing something through the day and then when I'm going home at night I'm not feeling as alone”.*

Through doing so, Harriet not only reduced feelings of isolation but began to form a sense of connection to SASS and those associated with the service. Supportive of this, Harriet described feeling *“part of something”* and referring to SASS as her *“second home”*. Wider community engagement also acted as a catalyst for connection with others, and the local community: *“Seeing the dog walkers, saying good morning to them in the morning, and a couple of people that live in the flats that are okay – and just saying hello to them and a bit of general conversation”.*

The effect of such engagement aided the formation of new social networks which were essential to support recovery:

“I've got a lot of new friends. More friends than what I've ever had because friends before were just like drinking buddies, which as friends here, that I've noticed, are more genuine and in

recovery the same as me. So I've built up quite a few good friends and engaging with everything, doing all the SMART groups to keep on top of my recovery”.

The formation of these networks also afforded access to social support, a critical component of recovery trajectories: *“I get loads of support. Even some days when I'm feeling really down and depressed and I know I'll get the support here”*. More so, Harriet described building new friendships with those she had met at SASS, which were often built on the foundations of peer support:

“There's a lady that does volunteering here and they were having a buddy system, and it was somebody to phone up when you're struggling in your recovery and I've actually made a good friendship with her as well, where I actually go and see her at her house or we'll meet up and do stuff”.

Harriet recognised the importance of drawing on a range of social support, in addition to that derived from her recovery peers. This comprised of both the family she still had contact with - *“support from my family”* – and wider professional services such as housing and mental health.

“I have had a housing officer come out to see me to see if I've settled in the flat okay and I've told them that I've got this support worker from Shelter and she's going to be tapering off soon and they've actually said that they can actually give me extra support where somebody might just come in and see me once a month just to see that I'm doing okay in the flat”;

“I am actually having counselling here now”.

Harriet's family, in particular her children, largely influenced her recovery. When describing her drinking history, there was an evident role conflict between her social identity as a drinker and her social identity as a mother:

“I knew that I had a problem because my daughter kept mentioning ‘mum, your drinking is getting a bit out of hand’. But I didn't really do anything. This is what I mean. I didn't really do anything about it and I think that this is where I have suffered the consequences of it. My children getting took out of my care but thank God they're [younger children] with my daughter and she's doing a brilliant job”.

In addition to this and supportive of previous literature, Harriet described the amplified stigma faced as a result of being a mother who used substances, and external pressure from formal figures may have subsequently exacerbated this:

“The solicitors that kept telling me to stop, ‘You need to stop drinking now or you’re not going to have no contact with your children’ and so that really frightened me and I thought I need to do something about this straight away”.

Despite having her children removed from her care whilst she was drinking, they had a strong influence on her recovery trajectory, influencing decisions she made throughout this process. For example, Harriet declined a place in a female only rehab as *“they were way out in London, and I wouldn’t have been able to see my kids hardly at all then”*, highlighting the role conflict faced by Harriet, as prioritising the ability to see her children impacted decisions she made in light of accessing services.

As such, it was evident that motherhood acted as a catalyst for change once Harriet stopped drinking. Harriet was gradually able to spend time with her children again and described this as being motivational to sustain her recovery:

“It’s my kids, thinking about them. Because it’s like this is where I play it forward and know the consequences because if I picked up again, my daughter, because she’s got special guardianship, she can actually stop me from seeing the boys and I ain’t risking that”.

Through the process of reconnecting with her children, the external validation she received was a powerful means to aid her recovery: *“Hearing my boys actually saying that they are proud of me, that I’m doing so well. And that’s more determined, and to keep me going and to stay sober”.*

Throughout Harriet’s account of her drinking and recovery, the effect of social networks were prominent. Community engagement was a critical means to form new social networks, supportive of her recovery and enabled her to draw on a range of social support – from peers, professionals and her family. Whilst motherhood placed potential strain on Harriet whilst drinking and during her early recovery, this was seen to have a profound effect in the long term, acting as a form of social control.

Personal capital

The discussion associated with personal capital was twofold - firstly acknowledging how Harriet’s previous experiences influenced her drinking and recovery, and secondly how community engagement

aided the accumulation of personal capital. Harriet disclosed several previous traumas, including experiencing child abuse, domestic abuse from an ex-partner, and the death of her children's father:

"I think that's why I drank a lot, because of all the abuse that I put up with as a child";

"I went through domestic violence with one my ex-partners";

"I couldn't cope anymore. It was horrible. I mean seeing my children grieving and I was actually grieving myself as well (...) That's why I ended up turning to drink more".

Not only did these experiences severely impact Harriet's mental health and wellbeing, but it also had a profound effect of her drinking behaviour. Whilst Harriet was no longer living with the perpetrator from whom she suffered violence from, the anxiety associated with this had a lasting effect, and subsequently made Harriet's living situation challenging – a potential risk to her recovery.

"Because of what he'd done to me and stuff it made me really scared, you know, being there and everything, so I ended up where I was just staying with a friend for a bit until I got moved. So I'm right at the other end of the town now where he doesn't know where I am. I do feel a lot more safer".

Managing the pain and trauma associated with these experiences often presented barriers to recovery, and impacted Harriet's engagement with services and supports:

"When we were in group, in therapy, we were like there was men as well as women and then we were living like in the same houses as them and some of the men were really arrogant and I started finding it really hard to talk about stuff. About all the abuse that I put up with. It made me feel uncomfortable because some of the men were really arrogant and would sit there laughing in the group".

Despite the challenges associated with mixed-gender environments, Harriet showed great strength in accessing SASS (a mixed-gender service), but the female-specific support offered through the service was a crucial component of encouraging engagement.

"You can be more open around females. Because sometimes I do feel a bit on edge when there is men about. Sometimes it can make me feel a little bit uncomfortable and so I've noticed that sometimes I won't open up as much, but when I'm in a women's group, because I know the women that come, that I can open up more and I will talk more as well".

Having the opportunity to engage in female-only environments was conducive to Harriet's recovery progress and resultantly there were noted improvements in both her self-confidence - *"my confidence has come back. My confidence was just non-existent. Now I'll say hello to people, and I can talk to people, that I've noticed"* – and self-worth: *"I am actually proud of myself that I've come this far and I am quite open about it as well"*.

To further emphasise Harriet's recovery progress and provide her with validation of how far she had come, this was externally recognised, and Harriet was presented an award for her progress at the Sheffield Recovery Awards. As she described, *"getting recognised last week, that were brilliant"*. As a result of these experiences, Harriet's perception of herself and her willingness to engage with her community was positively influenced:

"These three old ladies I see at the bus stop on a Friday morning, they get their bus into town and I actually let them know that I was going to the town hall to get an award for how well I'd been doing in my recovery and they actually talk to me about it in the morning. It's nice".

The relationship between community engagement and personal growth was reciprocal, and the more engaged Harriet became, the more optimistic she was in terms of the future. As part of this, Harriet discussed her goals and aspirations:

"My dreams are to have more contact with my kids and start having them in the flat. And where it can be unsupervised, where I can start taking them out, taking them to the cinema, taking them bowling, or just taking them to the park by myself. It would be nice to do stuff like that".

Harriet recognised the importance of continued community engagement to aid recovery growth and showed an awareness of still needing to make further progress in light of her own mental health and wellbeing before looking at taking the 'next step'. As such, her current aspirations were mostly family orientated, yet she stated that once she'd finished her counselling she wanted to "start doing some volunteering".

In summary, whilst Harriet disclosed several traumas, she showed an awareness of the effect of these on both her previous drinking behaviour and recovery. Throughout her account and the REC-CAP data (showing high levels of recovery capital and community engagement), Harriet had made significant progress with her recovery to date. This was both internally and externally recognised – by her family, local community and service providers. It was evident throughout that Harriet's high levels of

community engagement (with professional services, recovery peers, and her family) were conducive to the accumulation of recovery capital and the effects of this were mutually reinforcing.

Case study two: Stephanie

Stephanie is a 54 year old, white British female. Stephanie participated in Study 2 and based on her REC-CAP data at Time 2, was situated in the low recovery capital/ high community engagement quadrant. Stephanie had recently returned to Sheffield, following a period of time living close to her brother elsewhere and had two older⁴² daughters – neither of which were living with her. Stephanie was currently working and had recently undertaken some voluntary work as well.

Community capital

Due to her work commitments, Stephanie had limited time to engage in wider community resources, *“Some of the activities as well, although now that I'm back at work I don't- It's more difficult to get involved in anything”*, highlighting the need for community engagement to be considered in light of an individual's own commitments. In order to participate in wider community activities, she had recently booked time off work to volunteer at an arts festival, something she stated she was happy to have done:

“I was doing like five or six days a week and then I took two weeks annual leave the week before the festival and the week of the festival and that was exhausting but possibly one of the best things that I've ever done”.

The effect of this engagement was that it helped Stephanie foster a sense of meaning and purpose, as she reports: *“It [work and volunteering] has helped my recovery. Definitely. It's given me a bit of purpose back as well and it's given me some more money”*. Whilst Stephanie was working (an aspect of recovery trajectories not always desired or feasible for all individuals) she showed self-awareness that her return to work could have hindered her recovery or affected her health and wellbeing: *“I owed it to myself to try it but I went back to work with the thought in my head that if it didn't work out then that was okay and I would give it up, if it was going to affect my recovery”*.

Whilst Stephanie seemed well engaged with her community (working, volunteering, and attending recovery groups when she could), she described the importance of non-stigmatising attitudes and

⁴² Older children refers to those over the age of 16 years

environments to ensure that community engagement could be facilitated: *“I think that with him [recovery worker] it was a lack of judgement really”*. In light of her own engagement specifically, Stephanie acknowledged the stigmatisation she faced as a woman (also consistent with the literature outlined in Chapter 2), and how this posed challenges to her community engagement personally. Stephanie described this when talking about her facilitation of SMART meetings: *“I don’t want to just facilitate women’s meetings. I want to get more experience, not just being pigeonholed in that slot because I’m a woman”*.

In summary, Stephanie showed awareness of the impact working could have had on her recovery progress, but in this context, it helped her develop on a personal level through increased levels of meaning and purpose. That said, wider community engagement on a recreational level was challenging, and in the example given, was reliant on Stephanie booking time off work.

Social capital

In light of the accumulation of social capital, Stephanie discussed engagement with SASS as a means to form new social networks supportive of her recovery. Through this process, Stephanie demonstrated increasing agency and self-awareness in relation to those she formed friendships with:

“I’ve made a couple of really good friendships through here. I am still very kind of careful about my relationships, I think. And I’ve actually pulled back from a friendship that I made here, quite consciously. Which is something I’ve not really ever done in the past”;

“Making friends with some of the people here and keeping away from some of the people here as well has also been quite empowering, if that makes any sense. People that you think ‘Well I don’t want to be friends with you’”.

This demonstrated a level of empowerment, subsequently enabling Stephanie to form networks with those whom she perceived as exerting a positive influence on her. Whilst these friendships were often initiated through engagement with SASS, they tended to extend beyond the boundaries of the recovery community:

“One of the best friendships I’ve made here, she goes to AA and so I have been to a couple of meetings with her but it’s been, to be honest, it’s been more of a kind of social thing, come over, we’ll go to a meeting and then have a sleepover (laughter) you know, so that’s been like an incidental”.

These friendships also provided Stephanie with access to social support, a critical component of recovery progress. Stephanie found forming social networks with those of the same gender was of importance, as the support she acquired from these differed to that which she would receive in a mixed gender environment:

“I am always amazed at how amazing women are at supporting each other, as opposed to- Well, they do it differently don't they from the way that men support each other. I think that it's easier to be honest about your feelings. It's easier to talk about feelings in a women's group than it is in a man's group, a mixed group”.

This supports the value of female only groups being run within mixed-gender support services, as they appear to be critical in providing the social support required to initiate and sustain recovery. Stephanie did however discuss the formation of social networks with men however these were often discussed in the context of intimate relationships:

“I've had a couple of sexual relationships that have been good for me in some ways, because I felt like it was important that I get out there again and I've actually thought I'm not that bothered (laughter) you know, but that was good for me confidence-wise I suppose, that I'm not that past it”.

The discussion of these intimate relationships highlights the dynamic relationship between social capital and personal capital, in that they enabled Stephanie to grow in terms of self-confidence and self-worth.

The final component of social capital discussed by Stephanie was in light of her familial relationships, describing the role strain of being a mother during her drinking history:

“I went to Leeds for Christmas with my daughters, and I was completely pissed as a fart the whole time and I think that my daughters said to my brother ‘We can't cope’ (...) and I was just oblivious to all this because all I really cared about was drinking”.

As evidenced throughout Stephanie's narrative, the conflict she experienced between her identity as a mother and identity as a drinker exerted additional pressure on her to become sober:

“She [daughter] just said ‘I'm going to have to give up uni, I can't go back for my final year because of you, because I can't do this anymore, I am going to have to give up uni and come back home and look after you’ and that was a horrifying thought to me that she would do that.

It made me really ashamed, and I've been ashamed of things in the past but that somehow seemed worse”.

Due to the strain motherhood placed on Stephanie during her drinking history, she described how this continued to have a lasting impact once she embarked upon her recovery journey.

“My eldest daughter, my relationship is very strained now. I don't know. I know that she feels- There is a big issue with my eldest daughter. I don't know quite what to do about that. It's almost as if she feels like she doesn't have to put up with me anymore now I'm sober. She doesn't have to worry about me quite so much and therefore she doesn't have to- Because I think I irritate her, but we're still in contact and we do speak”.

Despite the relationship between Stephanie and one of her daughters being strained, she spoke positively about the relationship with her other daughter: *“I've always had a really great relationship with my youngest daughter”*. The ability to reconnect with her daughters was a valued aspect of her recovery journey and being able to ‘give back’ to her daughters promoted feelings of self-worth: *“I think that it's [proudest achievement] being able to say to my daughter ‘Stop worrying about that money [for her final degree show at university]. I've got it covered”*.

In summary, community engagement was a means for Stephanie to form new social networks supportive of her recovery attempts. She demonstrated a strong sense of awareness in regard to who she formed connections to and particularly valued the friendships formed with female recovery peers who acted as a critical source of social support. Whilst Stephanie had contact with her daughters and they acted as a motivating factor throughout her recovery account, the strain placed on this relationship whilst she was drinking was still apparent.

Personal capital

The themes associated with personal capital were discussed in light of both Stephanie's drinking behaviour and the relationship it subsequently had with her community engagement.

Stephanie discussed the impact of previous experiences on her drinking behaviour, although these were not specified: *“I had reasons why I drank. It was that this had happened in my childhood, and this had happened when I was a young woman”*. Resultantly, Stephanie had counselling which she described as a process of personal growth and learning:

“Counselling that I did maybe five or six years ago here would – that made me a bit more self-aware and then I had taken a couple of years to kind of work through that and understand that better but without it changing very much, but it was there, so it’s like kind of learning”.

Throughout her recovery narrative however, Stephanie still suffered from poor mental health and disclosed trying to take her own life the year before:

“I went off sick in the November before somebody found out what I was doing and then I tried to kill myself at the end of November and so for December I went into a safe house and that didn’t work”.

Whilst Stephanie was now engaging with recovery services and showed determination to sustain her recovery, she demonstrated a lack of self-confidence and self-worth: *“I was embarrassed to go out, partly because of how unhappy I was with how I looked and so I didn’t want that”.* As she stated, her mental ill-health acted as a barrier to both her recovery, and willingness to engage with the community, highlighting the importance of recovery pathways being person-centric and mindful of the barriers to recovery faced by individuals. In Stephanie’s narrative, it was apparent that recovering from substance use and mental-ill health at the same time was challenging, and the two experiences (substance use and mental-ill health) may have in fact been exacerbating one another. This highlights the need for recovery support to acknowledge the interrelated nature of substance use and mental ill-health, and the potential impact these experiences can have on the accumulation of personal capital.

Stephanie did however describe noting improvements in her physical health whilst in recovery: *“I think feeling physically better and having more energy as well. I think now that I’m used to getting up to go to work and because I’ve lost weight, I do have more energy as well, so physically I feel better”*, demonstrating positive personal capital.

In summary, the accumulation of positive personal capital was affected by Stephanie’s mental ill-health and lack of self-confidence and self-worth. Whilst Stephanie was now engaging with recovery supports and accessing counselling, continued support was still necessary to help aid her recovery trajectory. She described feeling physically better.

Throughout Stephanie’s account and her REC-CAP data (showing low levels of recovery capital and high levels of community engagement), it was apparent that whilst Stephanie was highly engaged with the community (particularly through paid and voluntary work, and the ladies’ SMART group), she perhaps had limited time to engage in recreational activities which, similarly to the discussion of her voluntary work, were linked to feelings of meaning and purpose. Community engagement did however

afford Stephanie access to social capital, and she spoke highly of the female friendships she was able to form through SASS. Whilst her familial relationships were under strain throughout her active drinking and whilst in recovery, this was in fact discussed as a motivating factor within her recovery account. Given the dynamic relationship between personal, social and community capital, it can be suggested that the accumulation of greater stocks of recovery capital may have been diminished by Stephanie's poor mental health.

Case study three: Toni

Toni is a 47 year old, white British female. Toni participated in Study 2 and based on her REC-CAP data at Time 2, was situated in the high recovery capital/ low community engagement quartile. Toni had previously detoxed, was living in Sheffield, and working part-time some evenings. She had three older children⁴³ but was not living with them.

Community capital

Community engagement was a means for Toni to accumulate community capital, and she acknowledged the importance of support services, including SASS and START, to aid her recovery:

"I rate SASS so highly now because I've come back myself when I detox again, and they have helped. It's only been this time and I haven't been here that much because I've been going to the one on Sidney Street [START]".

Despite recognition of the importance of SASS, her engagement was limited which she attributed to accessibility:

"SASS has always been the one I come to first after [relapsing], you know to kind of come back to yeah, and it does, you know, it does help me a lot. But then I think I would come more if it was closer".

Although she was not able to access SASS as often as she would have liked to, the non-stigmatising and non-judgemental environment fostered at SASS was noted as a facilitator of engagement and was supportive of her recovery progress: *"I just talk and it doesn't matter, they don't judge me, no one judges, and it makes me feel good and then I listen to other people"*. Expanding on the importance of

⁴³ Older children refers to those over the age of 16 years

the environment to afford access to community capital, Toni spoke about two professional services comparatively:

“It's not the building- that's what I mean- it's the environment, that's the word. It's not- it's not so welcoming that's what I could say. They are- the staff and everything, but it's not like here [SASS], there's always different- You don't know if they're staff or not here. Yeah, I think it's so- it just seems so much more comfortable”.

Whilst Toni was not linked in with other community resources outside of the recovery sphere (except SASS and Sidney Street), she felt she was active within her community which was conducive to her recovery: *“Well just going out (laughter) I do a lot more things”*. Toni did however emphasize the role of her family (discussed next under social capital), as a means to fill her time and thus, felt expressed less desire to become more engaged with the wider community.

Social capital

Toni spoke about social networks in light of both her drinking and recovery. She spoke about two intimate relationships in which substance use was present (both her own use, and her partner's use in one instance), but described a shift in mindset when entering recovery, recognising that she was happy to be single, and live independently:

“To be honest when I was drinking, I never thought I could live by own, I had to have someone and all my life, I've seen that you've had to have a partner, you know, I gone from one partner to another but this time, I just want- you know, we're [referring to ex-partner] good friends now would you believe”

In regard to her recovery, engagement with SASS provided Toni the opportunity to form social networks that were supportive of her recovery - *“I talk to Shauny (...) he's doing so well here [at SASS] (..) he's done so well”* - and such networks also afforded her access to social support, which she acknowledged was critical for her recovery progress: *“What I've realised if it weren't for the support of people like you and people like that [Shauny] - I would of lost my house and I'd of lost I would of been one of them”*.

Whilst Toni's engagement with SASS and other community resources was limited (as demonstrated in the number of assets she was engaged with, recorded in the REC-CAP), Toni's family played a predominant role in her narrative – with Toni acknowledging the impact of her drinking on her family,

and the importance of her family to aid her recovery. Toni spoke about the affect of her drinking, particularly on her son, “*I was coming home pissed but I mainly had the youngest [son] so he saw a lot of it*”, and Toni recognised the strain this placed on her children:

“When he first played it to me [a song her son wrote about her] I cried, it’s about - it’s all about him and me, thinking will she be dead when I get up in the morning (...) I was all laid out and listening to it I thought gosh that’s what he went through”.

Having acknowledged the effect of her drinking on her family, Toni expressed gratitude for being able to rebuild connections with her family when in recovery: “*In stopping that horrible thing as I call it for me erm what I’ve gained is unreal my family to have the family*”. In the process of rebuilding these relationships, Toni described an increased sense of trust and honesty with her family too:

“You know because I know she’s not worried that I’m going home now to drink. I’m so honest with her now and me youngest son, and he’s like phoning me saying I’m sorry to worry about this and I went no, I’m in a better place now son, I’d rather you tell me and he’s like no, I know you’re in a better place”.

The accumulation of social capital, derived from these familial relationships, also provided Toni with external validation of her recovery progress - “*there’s been a lot of recognition you know I feel proud*” – which subsequently aided the growth of personal capital. Moreover, Toni began to form connections with her wider family who she had not previously been connected to: “*Even my sister in law texting me saying a thank you for something and another couple of words (...) I’ve never had that before*”. These strengthened social networks with her family led to Toni expressing feelings of belonging and connection - “*My family I think now I feel that I’m part of*” – an importance aspect of recovery trajectories.

Personal capital

Aided by engagement with recovery services (albeit Toni admitted this was limited), and strong family connections, Toni discussed the accumulation of personal capital in light of her recovery progress. Within this, she recognised the importance of prioritising her wellbeing and making the time for community engagement when needed:

“I used to just think oh I don't need that [recovery support] I'm alright (...) but if I start feeling a bit- I will make an appointment and go (...) I will go because I think that's an hour and a half [SMART meeting] that's all it is”.

Through engagement with recovery services, Toni demonstrated self-awareness, acknowledging the importance of not becoming complacent with her sobriety. This encouraged engagement in recovery-orientated groups as means to ‘check in’ with her recovery progress:

“I went to [mutual aid group] because you forget what you was like yourself. This is how I look at it like, when you go there and you listen to someone who's just coming to the first meeting it makes you think ‘god that was me’. This is the way I look at it I think ‘oh I'm not going back there’ it just reminds you of that and you know so you want to go”.

Toni described the impact of her mental health on both her drinking and recovery and disclosed being bipolar. Despite fluctuations with her health over time, she noted significant improvements whilst in recovery, and engagement with her community and social networks helped to support this as her time was often occupied: *“I do get a lot of anxiety still- not as much but (...) I've got so much back from not drinking, I'm so busy”.*

In line with these improvements, Toni showed resilience in light of recent adversity she had faced and the recognition of doing well during this time acted as a driving motivation to sustain her recovery:

“I'm more determined as well (...) it's been a rough six months with illnesses and other things but you know, I would never had been able to cope with that. I know exactly what I would have done, bam, bam, bam, and even more and so I could just blank it out”.

Furthermore, following Toni reconnecting with her family, she reported feeling a greater level of responsibility to not let those around her down, which also acted as a motivation to sustain her recovery: *“I'm not letting anyone else down. All I used to think about when drinking was me, I didn't give a shit about letting people down. Now I'm more conscious and I don't want to let people down”.* Consequently, the reconnection to her family subsequently shaped her aspirations and aspects of life she was looking forward to: *“I've looked forward to that [holiday with daughter]. I would of never of thought that that would ever happen”;* *“I feel so proud (...) I want to be with my kids and with my grandkids”.* The demonstrates the value of familial relationships for Toni, acting as a form of social

control and subsequently enhancing personal capital. In summary, the discussion of personal capital was predominantly in the context of Toni’s recovery journey, although reference was made to how her mental health had influenced her drinking. Toni demonstrated a positive mindset and was determined to sustain her recovery.

Throughout Toni’s account and her REC-CAP data (showing high levels of recovery capital and low levels of community engagement), it was apparent that her low levels of community engagement (whilst potentially hindered by the accessibility of resources such as SASS), were compensated through strong familial relationships (positive social recovery capital). As such, the time she spent with her family and the social support received from these networks aided her recovery growth and motherhood played a predominant role in her recovery journey.

Chapter summary

Harriet, Stephanie and Toni each shared their narratives, detailing their substance use and journeys into recovery. Following the presentation of these case studies, the following table was created to identify similarities and differences between each of these accounts. This was shaped by the sub-themes which emerged within each of the domains of recovery capital. Where boxes are blacked out, this signifies that a particular sub-theme was not prominent within the woman’s narrative. Whilst some sub-themes are evident across all three case studies, the way in which they interact with the acquisition of recovery capital is likely to differ. Furthermore, where a sub-theme is marked with an asterisk (*), it is to be acknowledged that these factors may have had a negative interaction with recovery capital.

Table 7.1: Themes under the three domains of recovery capital identified within each case study⁴⁴

	Harriet	Stephanie	Toni
	(High community engagement/ high recovery capital)	(High community engagement/ low recovery capital)	(Low community engagement/ high recovery capital)
Personal capital	Trauma*		
	Mental health	Mental health	Mental health
	Counselling	Counselling	

⁴⁴ A detailed breakdown of these codes is available on request

	Validation		Validation
	Aspiration		Aspiration
			Determination
		Confidence	
			Self-awareness
		Purpose	
		Physical health	
Social capital	Shift in social networks	Shift in social networks	Shift in social networks
	Recovery peers	Recovery peers	Recovery peers
	Social support	Social support	
	Social control		
	Connection		Connection
	Motherhood	Motherhood	Motherhood
		Intimate relationships	Intimate relationships
Community capital	Female only spaces	Female only spaces	
	Stigma*	Stigma*	Stigma*
	Time	Time	
	Voluntary work	Voluntary work	
		Paid work	
	Giving back	Giving back	
	Wider community engagement		
			Accessibility
		Active citizenship	

The table highlights key similarities and differences amongst Harriet's, Stephanie's and Toni's narratives. Across all the women's narratives, the themes which appeared in all three accounts included: mental health; a shift in social networks; recovery peers; motherhood and stigma. That said, the influence of these themes, and the degree of which they affected the women's drinking history, and recovery, varied. The women's narratives are now discussed collectively in light of one another, before attention is paid to whether the quadrant model was an appropriate way to identify key differences amongst the cohort.

Community capital

Whilst Harriet and Stephanie both scored highly in terms of community engagement, when looked at in depth it was evident that the forms of community engagement they were involved in varied. Most notably, Stephanie was working full-time and struggling to participate in wider community activities, despite showing a desire to do so. Whilst she recently took time off work to engage in a short-term voluntary position, this relied on her booking time off work and thus was not sustainable in the long term. Stephanie did however comment on this voluntary work providing her with purpose and meaning, perhaps signifying its ability to have a lasting positive effect on her mental health, should she have been able to sustain the position in the long term.

Harriet by comparison, whilst also scoring highly for community engagement, was engaged in a voluntary role as a peer mentor. Harriet alluded to the sense of purpose and meaning this provided her, as she was able to give back to the recovery community. As a result of having more time available, Harriet was able to engage in wider community activities – both at SASS and more broadly within the community. Taken into consideration with findings from Study 2 and 3, engagement in a range of assets across all four domains is known to contribute to better recovery outcomes. With this in mind, this potentially helps to understand some of the nuances between Harriet and Stephanie's recovery accounts. Whilst Stephanie was mainly involved in activities which fell under the Education, Employment and Training domain, Harriet was engaged in a more varied range of activities – across all four of the domains consistent with the social cure model of the benefits of involvement in multiple diverse groups. Compared to both Harriet and Stephanie, Toni fell in the low community engagement quartile and other than working part time, disclosed there were no other activities she was regularly engaged with. For Toni, the accessibility of services such as SASS was identified as a key barrier to engagement. Although she expressed a desire to attend SASS more regularly, other aspects of her recovery narrative seemed to take precedence, perhaps providing a rationale for why her levels of recovery capital were still high. The implications of these findings support those identified earlier in the thesis, highlighting the importance of community engagement which is not solely recovery orientated. Most notably, this aligns with the findings from Study 3 which emphasise the value of recreational engagement to aid personal growth. Whilst employment may provide individuals with a sense of purpose, the formation of holistic identities must be encouraged through wider engagement which, as highlighted in the ABCE workbook, spans across all four domains. It is this diversity of engagement which will be largely conducive to recovery progress.

All women also discussed the impact of stigma. For Harriet, the impact of this was interwoven with the external pressures she faced from being a mother who had formerly used substances. Specifically,

it was the stigmatisation she experienced from her solicitor which exerted additional stresses on her to stop using substances, or to heighten the risk of losing contact with her children. In the case of Stephanie and Toni however, whilst motherhood was also discussed within their narratives (explored in further depth under social capital), their specific discussion of the impact of stigma was in light of their community engagement. In regard to this, both women stressed the importance of non-stigmatising environments to encourage community engagement. The significance of this however varied across the cohort. It may be that for those presenting with lower levels of recovery capital initially, the need for such environments was heightened to ensure that engagement (at least with recovery orientated supports) could be encouraged and sustained to help support recovery growth. Moreover, not only did these environments need to be non-stigmatising, but for Harriet and Stephanie the importance of female-only spaces was also discussed.

Social capital

The influence of social networks was acknowledged by all three women, recognising the importance of a shift in social networks towards those supportive of their recovery. In terms of intimate relationships, Harriet and Toni both disclosed the necessity of moving away from such relationships. For Harriet, this was attributable to previous trauma she had experienced, and for Toni this was attributable to previously using substances in the context of a partner. Whilst Stephanie did not allude to the impact of intimate relationships in the context of her drinking, she did discuss these in light of her recovery journey. Whilst the discussion of relationships varied for all three women, they all disclosed feeling empowered in light of the decision they had taken to best benefit their own recovery journey.

Within all three accounts, engagement at SASS was critical to helping form new networks with recovery peers, and these networks also afforded access to social support. That said, the women's ability to utilise such support varied, dependent on the time they had available to dedicate to such networks. For Stephanie for example, she was unable to engage with recovery support frequently due to work commitments. Resultantly, she spoke about the benefit of the formation of networks with peers which she could also spend time with outside of SASS (in her free time, such as in the evenings). Whilst Toni alluded to the social support she gained from recovery peers, her ability to rely on this regularly was minimised due to her inability to access the service. Alternatively, she relied on social support received from family members. Whilst social networks which were supportive of the women's recovery and provided access to social support were a constant theme amongst all three narratives, the means in which this was acquired differed vastly.

The discussion of motherhood was also a constant sub-theme across all three accounts. To some degree, all women described the strain motherhood had placed on them whilst drinking, and the lasting impact of this whilst in recovery varied. The strain of motherhood may have been experienced differently for Stephanie and Toni, given that their children were of an older age. From their accounts, it seemed apparent that their children had witnessed greater levels of their drinking in comparison to Harriet. The effects of this were noted in their recovery narratives too, with Toni discussing the song her son played to her whilst in recovery, and Stephanie discussing her daughter considering leaving university to help support her. Taken into consideration with the external pressure Harriet experienced from her solicitor, all three women faced role conflict between their drinking histories and motherhood.

Despite this, when in recovery, the ability to reconnect with their children (and wider family in some instances), was spoken about as being transformational, acting as a source of social control and motivation to sustain their recovery. The prevalence, importance, and reliance on familial networks seemed greater however in Toni's recovery account, and the social networks and associated social support Harriet and Stephanie accumulated from recovery peers, Toni seemed to account from her family. This may be attributable to the greater levels of time Toni spent with her family.

Personal capital

All three women alluded to the impact of mental ill-health on their drinking histories and recovery journeys. Harriet and Stephanie both disclosed the impact of previous trauma and the detriment this caused to their own mental wellbeing, and both women were engaged in counselling services. Moving into recovery, whilst Harriet and Toni both noted improvements in their mental health, Stephanie's seemed to be noticeably poorer. Having attempted to take her own life the year before, Stephanie described the challenges associated with recovering from alcohol use and mental ill-health synonymously. More so, Stephanie also disclosed the impact of poor physical health, although did note improvements in this regard.

It is important to acknowledge the interrelated nature of the domains of recovery capital here, and the impact which lower levels of personal capital have on wider recovery capital growth. As such, perhaps Stephanie's lower levels of overall recovery capital were hindered in this context by her personal capital. This emphasises the importance of ensuring appropriate support is in place for those in recovery, to ensure this growth of all three domains of recovery capital can be encouraged.

Summary

Although some distinct similarities and differences existed amongst the case studies, these were each unique. Given the interrelated and dynamic relationship between the three domains of recovery capital, it is challenging to explicitly outline the impact of the sub-themes discussed. Whilst the quadrant model categorised the women in light of their recovery capital scores and levels of community engagement, the differences between them were not always straight cut. Thus, while the quadrant model does make efforts to helping identify recovery strengths and areas of potential development for each woman, it does not seem substantial enough to use this model alone. The model can however be used to begin to identify who may be most in need of assertive linkage into new community resources, particularly for those presenting with lower levels of social and community capital. This is supported by the fact that no one within the low community engagement/ low recovery capital quadrant was able to participate in the interviews, due to reasons such as relapse. The use of the model must however be considered in light of its associated limitations. Particularly, the quadrant model was computed based on recovery capital scores (before the community capital measure was re-calibrated) and on the number of assets an individual was engaged (as opposed to the community engagement scale). Should this model have been developed, and interviews carried out, after the analysis of Study 2, this perhaps would have been shaped differently. Given the unique nature of these narratives, these must be looked at holistically, exploring each of these in depth to better understand the personal circumstances of Harriet, Stephanie and Toni. Doing so will allow for their recovery growth and associated community engagement to be supported in a way which is person-centred and tailored to their own needs and experiences.

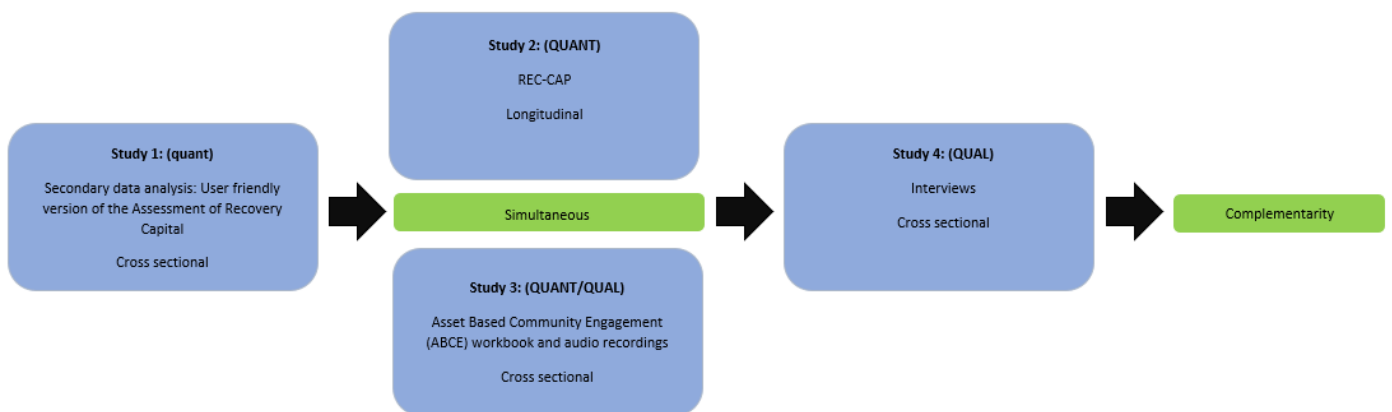
Chapter 8: Discussion

Introduction to chapter

This chapter summarises the key findings of the thesis, describing how each of the four studies build on one another – providing answer to the central and subsidiary research questions. Within the discussion, the key findings of each study are outlined and then discussed in the context of existing literature. Attention is paid to the implications of the research and consideration is given to how the ABCE framework can be used as a methodological tool to support recovery orientated practice. Limitations of the studies are considered, and this is done in light of recommendations for future research. The chapter also includes personal reflections on the research process.

The four previous chapters have presented each study in turn. Due to the interrelated nature of these, it was most logical to discuss the implications of these findings collectively. The iterative sequential mixed methods design undertaken for the research was done so in a way which intended for the studies to build on one another. For contextual purposes, the visualisation of the research strategy and design, also presented in Chapter 3, is shown below:

Figure 8 .1. Visualisation of research strategy and design



All four studies sought to contribute to the central research question: What is the role of community engagement in developing women’s recovery capital? To date, limited literature has explored recovery capital through a gendered lens (Ganapati, 2012; Hennessy, 2017), and to the knowledge of the researcher, only one previous study (Cano et al., 2017) has assessed gender differences using the REC-CAP (see Chapter 1). The thesis therefore contributes greatly to the gendered recovery literature.

Overview of the response to the central research question

In light of the central research question, it must be noted that the relationship between community engagement, recovery capital and gender is complex. Nuances by gender did exist among factors which are thought to interact with recovery capital (such as the forms of community engagement undertaken) and gender was also a predictor of recovery outcomes. That said, as assessed by the REC-CAP, there were no statistical differences by gender across any of the domains of recovery capital.

In light of the variables which did differ by gender, men reported lower levels of social support and there was variation in levels of community engagement. Specifically, women were more likely to be engaged in meaningful activity⁴⁵ and assets which fell under the sport, recreation, and arts domain at Time 1. Despite this, no differences were noted by gender in relation to the number of groups attended or frequency of attendance. This perhaps signifies that community engagement more broadly does not differ by gender, but it is the nuances within this that are likely to show variation.

The thesis therefore provides a partial confirmation of the central research question, highlighting that community engagement does in fact have a role to play in developing recovery capital. Although in the context of the thesis, there is no significance in the domains of recovery capital by gender, the underlying mechanisms for the accumulation of recovery capital do in some instances differ. The remainder of this chapter will revisit each of the four studies in turn, discussing this in greater depth, and outlining what constitutes the component parts of this answer. When exploring each study, the key findings are presented, before a more detailed discussion of this is outlined in light of literature.

The subsidiary research questions for the thesis were as follows, with each of the studies contributing to one or more of these:

- 1a. How does each aspect of recovery capital differ by gender at different stages of recovery journeys?
- 1b. Are there different predictors of recovery outcomes by gender?
2. What is the best way to assess recovery resources at the community level?
- 3a. What are the key components of community capital?
- 3b. How can we demonstrate the impact of community capital on personal recovery growth?

⁴⁵ Measured in the REC-CAP as work, education and/ or volunteering.

3b.i. How does the impact of community capital on personal recovery pathways differ by gender?

Across the four studies, data is presented from 337 individuals. Study 1 was based on a secondary analysis of data already collected by SASS and represents that of those accessing SASS prior to the primary data collection beginning. Study 2, 3 and 4 are however based on the same sample and data were collected prospectively. Similar to statistics which highlight the number of those accessing support for alcohol use (NDTMS, 2019), the ratio of men and women within the thesis is consistent with national data (40% women: 60% men). No one within the cohort identified as transgender. The table below builds on Figure 8.1, detailing the specifics of each study.

Table 8.1: Overview the four research studies

Study	Study 1	Study 2	Study 3	Study 4
Strategy and priority	quant	QUANT	QUANT + QUAL	QUAL
Method	Secondary analysis	REC CAP	Asset mapping	Interviews
Analysis software	SPSS	SPSS	NVivo and SPSS	NVivo
Sample size	n = 244	n = 68	n = 22	n = 3

A discussion of the key findings within each study is now provided. The limitations associated with these are not discussed within each separate study, but instead are discussed collectively later in the chapter.

Discussion of the studies

Study One

Study 1, the secondary analysis of data already collected by SASS, enabled a preliminary assessment of baseline and change differences in recovery capital for men and women to be outlined. This data, based on a user-friendly version of the Assessment of Recovery Capital (ARC) (Groshkova et al., 2012), highlighted that at Time 1 women were more likely to be parents and present to the service with higher levels of personal capital. Over time (between Time 1 and Time 3), the changes in the three domains of recovery capital, and overall recovery capital, were of significance for the whole cohort. There was also a significant main effect for the accumulation of social capital, with this being greater for men.

Firstly, it is encouraging to see that women present to the service with higher levels of personal capital, given that existing literature states they are more likely to present to services with mental ill-health and previous experiences of abuse and trauma (Becker & Duffy, 2002; Neale et al., 2014; Best et al., 2015a). The higher levels of meaningful activity noted amongst women are also positive to note, relying on these activities supporting the involvement of wider community engagement. This is supported by the work of Collinson and Hall (2021) who recognise that engagement in activities which are not explicitly recovery focused aid the development of holistic identities, an important component of recovery, especially for women. The impact of such engagement on recovery growth cannot however be determined looking at this data alone, and thus relies on the subsequent studies to build on this understanding. Perhaps, the involvement in such activities is conducive to the accumulation of personal capital, as this is likely to promote feelings of self-worth and self-efficacy.

Moreover, the variation in the accumulation of social capital over time perhaps reflects differences in the pathways to recovery for men and women. Women were not necessarily at a disadvantage here, as their rates of social capital also increased significantly over time. Given that those who completed the measure at Time 1, 2 and 3 were currently engaged with SASS, the findings do however support the value of recovery orientated support services to aid the accumulation of recovery capital. What cannot however be identified here are the predictors of recovery capital growth over time, and if gender has a main effect within this. That said, the findings from Study 1 are useful for contextual purposes, understanding baseline and change differences among the cohort.

Study Two

Study 2, the first primary research study, aimed to build upon the preliminary findings from Study 1 by using the REC-CAP (Best et al., 2016) as a way to quantify recovery capital, chart change as individuals proceeded in their recovery trajectories, and identify differences by gender.

Key findings in relation to recovery capital

Within Study 2, there were no observed differences in levels of recovery capital at Time 1 or Time 2 between men and women. This is contradictory to Study 1, which found women had higher levels of personal capital. Given Study 1 was however based on the ‘user friendly’ (abridged) version of the ARC, it is necessary to treat the findings from this study cautiously. More so, whilst Study 1 identified significant changes across all of the domains of recovery capital over time, the only significant differences in the change analysis for Study 2 were for personal capital. There were also no differences by gender in the accumulation of recovery capital over time.

The community capital measure however must be discussed here, given it showed no significance with several variables, including social support; barriers to community engagement; and the community engagement scale, at Time 1 or Time 2. These variables were however significantly correlated with the other domains of recovery capital. The lack of significance with community capital was surprising, given that it could have been presumed that involvement in recovery groups (as assessed in the community capital measure), would be intrinsically linked to both social support, and community engagement. This needs further attention to be better understood, but perhaps identifies a limitation of the REC-CAP’s community capital measure and suggests the need for this to better reflect wider community engagement.

When exploring variables that are known to interact with the accumulation of recovery capital, men were statistically more likely to report lower levels of social support. Perhaps, as they did not report lower levels of social capital, this highlights variation between levels of social capital and perceived access to social support. The work of Putnam (2000) can be drawn on here, as levels of bonding and bridging capital amongst these networks may help to explain lower levels of social support. Specifically, the males’ social networks may be perceived to possess lower levels of bonding capital, given that it is known higher levels of bonding capital often afford access to social support (Putnam, 2000; Ferlander, 2007).

Although the accumulation of recovery capital over time did not differ by gender, when assessing predictors of recovery capital at Time 1 and Time 2, there was a main effect by gender. Specifically,

at Time 1, gender, quality of life and satisfaction, the community engagement scale and social support all predicted higher levels of recovery capital. At Time 2 however gender, quality of life and satisfaction, the community engagement scale and number of domains assets were listed under all predicted higher levels of recovery capital. This suggests that whilst it may not initially seem as though recovery capital differs by gender, the mechanisms which underpin this process are likely to be different. As the community engagement scale predicts recovery capital at both time points, this strengthens the rationale for its inclusion within the thesis and supports the theoretical implications of its use within recovery orientated practice. The next section, exploring the impact of community engagement on recovery growth, will add to this.

Key findings in relation to the new component: Community engagement

The inclusion of the community engagement measure, and associated scale, added a unique perspective to Study 2. This not only ensured consistency with Study 3 (discussed next) but enabled the impact of community engagement (perceived to be a vital component of community capital accumulation) to be analysed in the light of the REC-CAP data.

Key findings highlighted that the number of groups individuals were engaged with at SASS, as well as frequency of attendance, significantly declined over time. The analysis also showed however that the total number of assets listed, and number of domains assets were listed under were significantly correlated with recovery capital. There were however no differences by gender across these variables. This emphasises the importance of community engagement to support the growth of recovery and will be discussed shortly in reference to wider literature and the contributions it makes to the field.

Whilst levels of engagement were not dependent on gender, the type of engagement was. Specifically, women were more likely to be engaged in meaningful activity more broadly (work, volunteering or education) and were more likely to engage with assets that were sports, recreation, and arts focused. Women were also more likely to state that there were other groups they would like to attend although mean scores for barriers to community engagement showed no significance by gender and no statistical changes were noted over time in relation to the number of barriers listed.

When discussing the key findings aforementioned it is worth turning attention to the relationship of two of these factors, recovery capital and community engagement, in light of gender. Although previous research has classified gender as a form of ‘negative recovery capital’ (Cloud & Granfield, 2008), it is perhaps more appropriate to view gender as a factor which solely interacts with recovery capital. That is not to say this interaction is negative – as shown in the current thesis, neither men nor

women were at an advantage of accumulating recovery capital. Although previous research highlights women are more likely to present to services with a mental health need (Grella, 2015; Best et al., 2015a), other research highlights men are known to have higher levels of need in relation to physical health (Andersson et al., 2020). Given that within White and Cloud's (2008) definition of personal capital, and within the REC-CAP, mental and physical health are both classified as personal capital, this perhaps provides explanation as to why there were no noted differences regarding personal capital by gender. Resultantly, while it would appear at face value that gender differences do not exist as assessed by the REC-CAP, there may be nuances within this broader category.

A similar trend can also be seen when looking at social capital: while no differences existed between men and women as assessed by the REC-CAP, differences were noted amongst levels of social support. Given that previous literature highlights that social capital often affords access to social support (Best et al, 2015; Boeri et al., 2016), it may be appropriate to assume that for men in the study, there was a disconnect between reported levels of social capital and perceived social support. This may be attributed to the way in which men and women utilise their social capital, as women may be more likely to rely on their social networks for emotional and psychological support. Assessed in regard to other findings from the thesis (including those from Study 1), men were more likely to be living alone. Men therefore may be more likely to rely on social networks formed through recovery supports and wider community resources to augment lower levels of social support. Given the importance of social support to help individuals initiate and sustain their recovery, it is important to consider how individuals are supported to utilize their social networks.

The same trend is also seen in relation to community capital – with no significant differences identified by the REC-CAP between men and women. Differences did however exist in the forms of community engagement men and women were engaged in, again suggesting nuances within the mechanisms in which community capital is accumulated. Given that existing literature states that women present to services with more support needs (Neale, 2004; Grella et al, 2008) and are often responsible for childcare (Rowan-Szal et al., 2000; Andersson et al., 2020), the levels of meaningful activity amongst women were higher than anticipated. Previous literature, whilst dated (Ebaugh & Ebaugh, 1988), suggests that women engage in educational and employment activities to compensate for a lack of social and cultural capital. That said, the women within this cohort did not show lower levels of social or community capital (in which cultural capital is embedded) and thus do not support this presumption. The findings evidence that despite other commitments, women are actively engaged within their communities. The promotion of meaningful activities must however be considered in light of these commitments, ensuring that the individual's health, wellbeing and recovery are prioritised.

As indicated by existing literature, the link between these three domains of recovery capital is dynamic and reciprocal (Daddow & Broome, 2010; Best et al., 2017). With this in mind, it is extremely encouraging to note significant changes in personal capital and overall quality of life after an initial six-month period. Existing literature emphasises the importance of social support and community connections to increase personal capital (Collinson & Best, 2019) and as individuals gain access to wider community resources, the growth of recovery capital will be maximised and evolve over time (Best et al., 2011). This is based on the assumption that recovery is a socially mediated process (Best et al., 2017). Pathways into new community resources must however be tailored to the needs of the individual and emphasises the necessity for those presenting with lower levels of social support (men in particular in the present study) being prioritised within this process.

The ability of meaningful activities to encourage the growth of recovery capital has already been documented (Best et al., 2017; Collinson & Best, 2019) however the current thesis sought to build on this by exploring how engagement may change over time and what the effect of such engagement is on recovery pathways. Findings showed the number of domains an individual was engaged with was associated with positive outcomes. This finding is supportive of the ‘social cure’ literature (Jetten et al., 2012) which recognises the value of identification with multiple groups, and the SIMOR (Best et al., 2015b) as engagement in a diverse range of groups are likely to support the formation of new social identities which are supportive of an individual’s recovery. The process of social identity change is likely to begin when an individual becomes engaged in pro-social assets, supportive of their sobriety (Frings & Albery, 2015). In the context of the current study, this is likely to begin when individuals engage with SASS. Not only do these newly forming identities provide individuals with a sense of shared experience and peer support but continued engagement will lead to a strengthened sense of belonging and connection to the group, as also reflected in the work of Dingle et al. (2015). More so, the internalisation of these new identities which provide access to social support is known to be a predictor of positive recovery outcomes (Zywiak et al., 2002; Best et al., 2015b) and helps to protect against future relapse (Buckingham et al., 2013). In light of the contributions of the thesis, this finding is particularly important in light of the ABCE framework and supports the inclusion of the four domains under which assets were listed.

Building on the work of Jetten et al. (2012) in a way which is specific to recovery populations and in line with the ABCE framework, assets listed under peers and mutual aid; sport, recreation and arts; and education, employment and training were significantly correlated with higher levels of recovery capital at Time 2. The fact that assets listed under professional services are not included in this correlation is positive, signifying that to make substantial recovery progress, it is more important that

individuals transition away from professional services (such as drug treatment or mental health treatment) towards wider meaningful activities. This is however reliant on the individual's needs, such as whether further recovery or mental health support is needed. As the level of need for professional services is reduced, the importance of engagement in the other domains becomes more pertinent. It is these wider domains (mutual aid; sport, recreation and arts; and education, employment and training) which mirror themes of work and citizenship noted as key components of recovery trajectories in the existing literature (Best & Laudet, 2010; Best et al., 2015a; Timpson et al., 2016).

Whilst engagement in these domains collectively is known to contribute to positive recovery outcomes, the ways in which the individual domains are associated with these improvements is unique. This emphasises the importance of community engagement being an encouraged aspect of recovery planning although it cannot be presumed there will be a 'one size fits all' approach and engagement must suit the individual's own needs, interests, skills and passions.

As the findings highlighted, no significant changes were noted in relation to the number of barriers listed at Time 1 and Time 2. This demonstrates that barriers faced at a micro, meso and macro level are not simply 'overcome' when an individual enters recovery. Within the thesis, those with higher community engagement scores stated they were satisfied with their engagement; viewed themselves as an active citizen; did not feel as though there were other groups they would like to attend; and identified less barriers to engagement. The role of the community engagement scale within recovery orientated practice will be later discussed (see *Implications of the research*).

Study 2 makes substantial progress in identifying the nuances by gender in relation to recovery capital, predictors of recovery outcomes over time, and the impact of community engagement on personal recovery pathways. Richness is now added to this quantitative data within the next study.

Study Three

Study 3, rolled out sequentially to the REC-CAP, utilized the ABCE workbook to map assets whilst conversations with individuals were audio recorded. The impact of community engagement on recovery pathways has been evidenced in the findings so far (see Study 2) and the current study sought to build on this, beginning to reveal the key components of community capital. The ABCE framework and associated workbook are original aspects of the thesis.

Findings from Study 3 identified a plethora of resources within Sheffield, although these were often located in the centre, or Northwest of the city. As discussed within Study 3, the sampling technique

may have an effect here, given all individuals completed the workbooks whilst attending SASS. Taken into consideration with the wider findings however, individuals discussed the importance of resources being centrally located in order to access them. Moreover, when thought of in light of observations of the research more broadly, when completing the REC-CAPs with individuals for Study 2, it was commonly those who resided in the North of the city who expressed the desire for the Time 2 REC-CAP to be posted to them, or requesting that the researcher met them in a public space closer to their homes. When engaged in conversations with these individuals, they found accessing SASS challenging from the North of the city due to transport issues. This perhaps highlights some disparities in the access and availability of recovery resources within Sheffield.

When assessing community engagement in depth, men and women were most likely to be engaged in assets which fell under the mutual aid domain and whilst resources external to SASS were listed across the four domains, these were often recovery focused. This perhaps identifies a gap between engagement which is specifically recovery orientated, and that which is in the wider community. Better understanding this relationship is important, given the value of wider engagement to support the formation of holistic identities.

The analysis of barriers to engagement sought to shed some light on this. Although there were no differences by gender in terms of the number of barriers to community engagement listed, men were statistically more likely to report not knowing enough about a resource. This was noted as acting as a barrier to engagement. Taken into consideration with the earlier findings, this may be attributable to the types of social networks men reporting having, and the lack of social support present within these. It can be assumed that if levels of bridging capital were enhanced amongst these networks, men may be afforded greater access to knowledge about local resources and also benefit from improved pathways into these. Given this was not evident amongst the cohort, this identifies a gap for service provision to help best support men. Other barriers commonly noted across the cohort were a lack of time, motivation, and expense associated with accessing the resource. Although these barriers may not all be able to be directly overcome, they provide insight into some of factors which may be reconsidered in light of further engagement and thus, contribute evidence to the practice of recovery orientated supports.

When considered in regard to existing literature, these findings are firstly considered in light of White and Cloud's (2008) model of recovery capital. Within this, culturally appropriate, community-based recovery supports are a key component of community capital (Hennessy, 2017). Based on this, the

thesis recognizes that community engagement and pathways into resources are essential to the acquisition of community capital. The findings from the thesis however recognise the importance of a diverse range of community engagement, which is not solely recovery orientated. Whilst this is supportive of contemporary ideas of recovery that more broadly recognize the importance of active participation in communities (Betty Ford Institute Consensus Panel, 2007; Cano et al., 2017; Inanlou et al., 2020), this is not necessarily reflected in definitions of community capital (such as White and Cloud's, 2008). More so, it is often the engagement with recovery orientated resources (such as mutual aid groups) which receives more attention with the literature (Parkman & Lloyd, 2015; Roth et al., 2016).

The contributions of the findings from the thesis therefore suggest two areas of development. Firstly, the need to explore the impact of wider community engagement and secondly, the need for definitions of community capital which are specific to recovery to also acknowledge this. This is further supported by White (2009, p. 151) who states, communities are “the soil in which such problems grow or fail to grow and in which the resolutions to such problems thrive or fail to thrive over time”. It can therefore be presumed that if engagement is solely recovery orientated, then the relationship between recovery communities and the wider community becomes fragmented. This has subsequent implications for the social inclusion of individuals, an essential ingredient of recovery success (White, 2009). If done successfully, engagement with resources that are supportive of an individual's recovery not only provides a platform for personal development and improvement but can also trigger a social contagion of positive behaviour and improve connectedness within communities.

Whilst the findings recognise the importance of recovery orientated and non-recovery orientated engagement, this can be pictured on a continuum, but one in which overlaps between groups may be present. At one end is the recovery community, and at the other is the broader community. This understanding of community engagement shares parallels with the work of Levassereur et al. (2010) (detailed in Chapter 2: *Community engagement: The relationship with community capital*) which describes levels of engagement on a six-step ladder. Engagement with the wider community is more likely to reflect those at the upper end of Levassereur and colleague's ladder.

For such engagement to be both encouraged and beneficial however, certain components of community capital must exist. This is an element the thesis began to explore, with individuals rating assets based on their accessibility, affordability and connectedness within the ABCE workbook. Given that individuals listed assets they were currently engaged with, it was unsurprising that the majority of

assets were rated highly across these three categories. This perhaps highlights a disconnect between the assets listed and broader resources which may exist but be unrecognised or underutilised. Supportive of the work of Victor et al. (2005) individuals talked about the importance of assets being accessible in terms of physical location, opening times and days. Whilst the affordability of engagement was also considered, if engagement with an asset was seen to hold beneficial value to an individual's recovery, then the expense associated with engagement was deemed worthy. This builds on previous literature which has identified affordability as a barrier to community engagement (Bukov et al., 2002), suggesting that the relationship between this factor and engagement is more complex – perhaps dependent on the perceived value of engagement. The other main parameter of community capital discussed was the importance of non-stigmatising and non-judgemental environments. Stigma has previously been categorised as a form of negative capital (Cloud & Granfield, 2008) and whilst the understanding of 'negative capital' was not applied in the current thesis, it is important instead to acknowledge as a factor which interacts with the accumulation of community capital. Given the importance of accessibility, affordability and non-stigmatising environments as identified in the thesis, it may be appropriate to assume that assets within the broader community which were not listed may be rated lower across these domains.

Whilst the factors above (accessibility, affordability and stigma) are identified as key parameters of community capital, factors at a personal and social level were also noted as having an interacting effect on community engagement. This supports that notion that the relationship between personal, social and community capital is dynamic and complex, as reflected in the ice cream cone model of recovery (Best et al., 2017) (Figure 1.1). Factors listed at a personal level included physical and mental health, confidence, and motivation. At a social level, individuals discussed the importance of social networks, including familial relationships and other commitments, such as work. Across the listed barriers to engagement included in the ABCE workbook, men were statistically more likely to report not knowing enough about a resource as a barrier to engagement, which would be regarded as a key facet of social capital (access to knowledge and information). These findings add significance to the role of a recovery navigator as a support mechanism to help individuals begin to overcome barriers to engagement and create pathways into community resources. More so, it highlights the importance of a mechanism of knowledge sharing to ensure those wanting to engage with the wider community are aware of what is available to them.

Taken into consideration with Study 1 and 2, it is those with lower levels of recovery capital and social support who may be in more immediate need of immediate assertive linkage. Existing literature

recognizes the value of assertive linkage into resources (Landale & Best, 2013; Manning et al., 2012). As engagement is encouraged and individuals grow on a personal level, bridges into the wider community which are supported and fostered through social capital and assertive linkage, can help communities blossom, minimising stigma and encouraging inclusion. The subsequent effect of this is improved community wellbeing (represented in the upper level of the ice cream cone of recovery, see Best et al., 2017) (Figure 1.1). Further consideration of this within practice is detailed later in the chapter.

The qualitative narratives from Study 3 also support the SIMOR (Best et al., 2015b): endorsing the notion that recovery is underpinned by a shift in social networks. Individuals describes a disassociation from substance using peers and a shift towards networks which were supportive of their recovery. This process was underpinned by engagement in community resources and most notably, SASS acted as a mechanism for these networks to be formed. While engagement was often within the recovery sphere, peers began to participate collectively in activities within the broader community. This is interesting when thought of in light of bonding and bridging capital (Putnam, 2000) and suggests high levels of bonding capital amongst recovery peers. This is perhaps attributable to the levels of stigma and exclusion they may have previously faced (Horsfall et al., 2010; Schomerus et al., 2011; Luoma, 2014; Best et al., 2016), thus resulting in the development of trust and solidarity between recovery peers – known characteristics of bonding capital (Putnam, 2000). For those in recovery, access to bonding capital is essential to provide emotional and psychological support. It is bridging and linking capital however which affords access to the wider resources which underpin further recovery growth. The relationship between bonding and bridging capital was often interrelated within the findings, with groups of recovery peers accessing community resources through one another. Given that the other resources mentioned were most often also recovery orientated, there is perhaps a lack of bridging and linking capital present. This is where the process of assertive linkage, supported by recovery navigators, is critical to afford access to wider social and community capital. This is however reliant on ABCE and asset mapping to identify resources existent within the locale which can be utilised to support individual recovery pathways.

Study Four

Drawing the findings of the thesis to a close, Study 4 sought to pull together aspects of Study 2 and 3, exploring nuances amongst the recovery capital and community engagement data. Given the

importance of these two variables throughout, this study utilized a quadrant approach⁴⁶ to broadly group the data. The interviews were intended to be reflective, allowing women to discuss changes in levels of recovery capital and community engagement, and the impact of this on their recovery progress. Although it was intended that one woman from each quadrant would be interviewed, no one within the low community engagement/ low recovery capital quadrant was available to participate, with some women reporting that they had entered formal treatment and others reporting that they had relapsed. This is an important finding itself and as described in the discussion of the three previous studies, further amplifies the degree to which those who enter services with lower levels of recovery capital and community engagement are to be prioritized in terms of assertive linkage to help strengthen support networks and maximize personal capital.

Other key findings from Study 4 highlighted the individualized nature of community engagement and its subsequent impact on personal recovery pathways. Although the quadrant model highlighted some similarities and differences amongst the cohort (such as the importance of social networks and social support), the ways in which these manifested in the women's narratives varied hugely. Taking this into consideration, whilst the utilization of the quadrant approach may help to broadly identify individuals who are experiencing more barriers to recovery progress, the individualized nature of these accounts emphasizes the need for recovery planning to be person-centered.

What however was evident across the cohort was the dynamic nature of recovery capital. As also shown in the ice cream cone model (Best et al., 2019) (Figure 1.1), growth at a personal level is vital to support the acquisition of social and community capital. This was particularly evident in Stephanie's account in which her levels of overall recovery capital were hindered in this context by her personal capital. In light of this consideration, the impact of and ability to form pro-social networks varied for the women and the processes which supported the formation of these networks were often discussed in light of previous experiences including trauma, intimate relationships and domestic violence. This is supportive of existing literature which shows that women are more likely to have specific needs in relation to relationships (Andersson et al., 2020) and further emphasizes the importance of the social contexts in which people use alcohol and recover to be considered. For example, Hazel's experiences of trauma and domestic violence contributed greatly to her discussion of gender-responsive services. SASS was spoken highly of in this regard, offering women only spaces such as women's SMART and SASSY ladies. This is important, given that if services do not adequately support women's specific

⁴⁶ High community engagement/ high recovery capital; high community engagement/ low recovery capital; low community engagement/ low recovery capital/ low community engagement/ high recovery capital.

experiences, they may be reluctant to access support and subsequently be left feeling stigmatised, marginalised and demoralised (Becker & Duffy, 2002; Ettore, 2004).

The willingness and ability to engage with community resources varied for each of the three women. Not only was it important that the components of community capital (discussed in Study 3) were present, but wider personal and social factors also had to be considered – such as familial or work commitments. Although the benefits of community engagement were recognised by all three women, levels of engagement differed and thus, individuals must be supported in a person-centred way to ensure the uptake of further community engagement is to take into consideration existing social networks and wider commitments. If done successfully, the benefits of this can be noted both internally and externally – with the women commenting on feeling better in themselves, and their recovery progress being noted by those around them.

Summary

While each of the four studies alone contribute to our understanding of the recovery process, it is a combination of these which help to understand the role of community engagement in developing recovery capital more holistically. The collective understanding and key insights from the thesis highlights that the relationships between the domains of recovery capital are complex and dynamic and are supportive of previous works (see the ice cream cone model of recovery, Best et al., 2019) (Figure 1.1). Community engagement also interacts with this, and thus, drawing on the qualitative and quantitative insight across the four studies is critical to better understanding this process and is a significant part of the novel contribution of this thesis.

Given the way the research is designed, each of the studies enables the story to unfold and builds on the previous studies to create a cumulative and iterative picture – firstly outlining how recovery capital is acquired and changes overtime (explored in Study 1 and 2), before then exploring the value, and impact of, community engagement (explored in Study 2 onwards). By doing so, the research (particularly in Study 1 and 2), lays the foundations for expanding our current understanding of recovery capital (in the specific context of SASS), before beginning to unveil the role of community engagement. Given that the focus on community engagement is novel to the research and is a new empirical component to measurement of recovery capital theories and models, as well as a new ‘concept’ in its own right to explore in relation to recovery capital (particularly in relation to wider community engagement which is not recovery orientated), each study is intended to support one another and ‘pave the way’ for the components of data which follow. The cumulative narrative is

outlined below. Recovery is an individualized journey which is reliant on the support of social and community resources. While evidence from Study 1 and 2 showed changes in personal capital were most prevalent, Study 2 began to explore the relationship between such personal growth and the reliance of social and community resources. Within this, the importance of social networks, social support, and engagement in community resources were identified as key components of recovery success. Although the presentation, and accumulation of recovery capital does not always differ by gender, as shown in Study 1 and 2, the mechanisms of which personal, social and community capital are acquired are likely impacted by gender. For example, Study 1 found women were more likely to be parents and to be engaged in work or volunteering activities upon entry to SASS; Study 2 demonstrated differences in how social support was drawn upon; and Study 2 and 3 demonstrated differences in the forms of community engagement undertaken, with women more likely to engage in resources listed under Sport, Recreation and Arts. This is a key message, as it emphasizes the importance of recovery supports being gender responsive, regardless of whether key differences are always observable from the outset. Whilst the interplay of personal, social and community capital began to be explored in Study 1 and 2, the qualitative narratives drawn from Study 3 and 4 further develop this and add depth to our understanding of how community capital works in practice.

The findings also emphasize the role of community engagement in aiding recovery capital growth. This was firstly highlighted in the quantitative data from Study 2, but further built upon in Study 3 and 4, with these additional findings deepening our understanding of the relationship between community engagement and themes identified at a personal, social and community level. This process is also supported by the ABCE framework, a unique output of the thesis. It is this framework which helps us to both better understand current levels of engagement and potential barriers to further engagement – two components which must be considered to ensure engagement with community resources is done so in a way which is individualized. Whilst the underpinning rationale for the framework is also explored in Collinson & Best (2019), the thesis supports its use within practice, given community engagement (as measured through the workbook, and explored as an additional section within the REC-CAP) was found to be a predictor of recovery outcomes.

As shown in Study 2 and 3, engagement in a diverse range of community resources is particularly beneficial, but just as recovery journeys are individualized, so is engagement. This was explored in Study 3 and 4, which found that this process is often reliant on the individual's own commitments, and ability and willingness to become engaged in their community (as assessed in the community

engagement scale). Such engagement can also be pictured on a continuum – starting from that which is solely recovery-centric and shifting towards engagement within the wider community. Whilst this was initially identified in Study 2, it was the added detail from Study 3 which identified the types of resources individuals were engaged in across the city, and the value such engagement had on personal and social growth. It is both the diverse range of engagement as well as that outside of the recovery sphere which will be conducive to the formation of more holistic identities (discussed also in the work of Collinson & Hall, 2021), and thus support recovery progress. Although community engagement is identified as a mechanism to support recovery growth, this too (like the domains of recovery capital) is complex and dynamic. As Study 3 highlighted, components of community capital (such as affordability, accessibility and connectedness) must be present to support community engagement, and the interaction with personal and social capital must too be considered. While this was firstly explored in Study 3, Study 4 sought to further build on this, better understanding the effect of lower levels of community engagement and/ or recovery capital. From these studies combined, it is clear that those who present with lower levels of recovery capital and community engagement are likely to be at a greater risk of relapse or making slower recovery progress as they do not have access to the same positive community connections and empowerment through engagement with meaningful activities. These individuals should therefore be prioritized in terms of recovery support and assertive linkage into meaningful activities which support their recovery attempts. While access to pro-social networks and community engagement are often key ingredients to recovery success, the studies collectively identify the unique nature of these journeys. That said, the final study did demonstrate that levels of recovery capital are not always reliant on community engagement. This was explored in the narrative of Toni who presented with low levels of community engagement and high levels of recovery capital. In this case study, it appeared that other positive factors in Toni's life (such as strong familial relationships) compensated for the absence of wider community engagement.

Although the studies individually all add value to our understanding of the recovery process, it is the collective narrative seen across all four studies which best understand the relationship between gender, recovery capital and community engagement. Following an exploration of the limitations of the research next outlined, consideration is later given to the implications of the collective findings within policy and practice.

[Limitations of the research](#)

Whilst each of the four studies contribute to the central research question, the associated limitations must firstly be considered before recommendations for future research and the implications of the

thesis are discussed. Firstly, whilst Study 1 and 2 sought to capture data from individuals upon ‘entry’ to the service, individuals may have in fact accessed treatment or other support prior to engagement given the nature of SASS. This is important to note as baseline measures may have showed some variability across the cohort.

Moreover, fully understanding the relationship between gender and recovery capital is challenging due to the complex nature of this interaction. This is particularly difficult in Study 1 alone, given that the data is based on a user-friendly version of the Assessment of Recovery Capital. Resultantly, significant findings within this study must be treated tentatively, and explored in greater detail through the subsequent studies. Due to the nature of this measure, limited data was collected on other variables which may have interacted with the accumulation of recovery capital. Out of those that were reported (such as employment, accommodation status and parental status), these were only collected at Time 1, therefore limiting the change analysis. The question has also been raised about the Assessment of Recovery Capital measure, given it is thought to not accurately represent community capital (Cano et al., 2017). The usability of the data was also restricted, as in many instances, gender was not reported. This highlights the issue of voluntary organisations collecting and reporting their own data, as this may be seen as resource intensive and result in the incompleteness of datasets. Is it important to also however consider that in some instances, this may not have been due to staff members forgetting to report this data, but that some individuals may have not wanted to disclose their gender. This is not to dispute the importance of those who may not have wished to disclose their gender, but practically in the context of the thesis and to aid data management, the analysis of data in Study 1 only includes that of individuals who identified as either male or female.

Specific to Study 2, it was recognised that one variable (frequency of attendance at groups at Time 2) was not evenly distributed (see Chapter 4: *Study 2, Variables of interest*) Parametric tests were however still used, rather than non-parametric tests. Whilst it is acknowledged that this may push the boundaries of the robustness of the data, it was perceived that within the relatively small sample size, the outliers would remain. The reason for this was that no error was present within the reporting of data, but one individual did in fact report a score of 12 (the identified outlier). This higher score signified the individual was engaged in several resources, most or all of which they attended frequently (more than once a week). It did not seem fair to alter the analysis run for this variable, given this was a true representation of engagement amongst a member of the cohort.

Within the context of the thesis overall, although some gender differences did exist, these tended to be nuances amongst each of the three domains of recovery capital and forms of community engagement

undertaken. It must however be acknowledged that the research was carried out in a mixed-gender service, potentially limiting the extent to which gender differences could have been noted amongst the cohort. For example, for those who have experienced high levels of trauma, a commonly noted theme within the narratives of many women who have used substances (Covington, 1999; Covington, 2002), accessing mixed-gender treatment or recovery supports may not be desirable.

Finally, while the development of the ABCE workbook was a unique component of the thesis and sought to compliment ABCD whilst being attentive to its challenges, the workbook still faces challenges of its own. In its current preliminary use, the workbook is not a standardized measure. The findings do however support its use, highlighting the importance of community engagement to aid recovery and the use of the community engagement scale to help identify those most in need of improved pathways into community resources. Although the workbook was co-designed with the ShARRP public and patient involvement panel and piloted prior to use, which strengthened the robustness of the measure, its generalizability and application to other settings needs to be tested. Furthermore, edits may be suggested to the future use of the workbook. Based on the thesis, it is suggested that when asking individuals if there are resources they wish to become engaged with, this should be based on the four domains of community engagement. This is appropriate, given engagement in a broader range of these domains is known to contribute to positive recovery outcomes. The workbook in its current form however provides the first systematic and practical measure to assessing recovery resources at the community level, one of the aims of the thesis.

Directions for future research

The thesis is, to the knowledge of the researcher, one of the first of its kind to explore the gendered nature of recovery capital utilising the REC-CAP (employing a different type of analysis to the earlier work of Cano et al., 2017). The results are partially supportive of Cano's findings however, highlight no differences in the domains of recovery capital by gender (as assessed in Study 1 and 2). The current thesis however builds on this work, as it highlighted the "need for further exploration of gender-specific meaningful activities that may differentially support recovery journeys" (p. 16). Although the findings make substantial contribution to this, future research must build on this evidence base. It is recommended that this should be done next amongst two populations: those accessing gender-specific recovery services, and those not yet accessing community based support services.

In light of the focus of ABCE, although the data collected in this instance was specific to Sheffield, the method was designed in a way which can be replicated in other geographical areas. It may however

be beneficial that future research seeks to identify assets within the locale which are underutilised by recovery populations. By firstly identifying these resources and then engaging in discussions with the recovery community about why they are underutilised, any proceeding community development work can endeavour to improve pathways into these resources, subsequently improving outcomes at a personal and community level. As recognised by Best and Savic (2015) this approach to asset mobilisation strengthens the total sum of capital existent within communities. Following Sheffield being successfully awarded Changing Futures funding in July this year (UK Government, 2021), the programme manager has expressed interest in further developing the asset mapping component of the thesis as part of the city led work. This will build on the work to improve pathways into community resources for individuals experiencing multiple disadvantage, as defined by the programme as a combination of homelessness, substance use, mental-ill health, domestic abuse, and contact with the criminal justice system.

In terms of collecting associated data, if future work is to utilize the ABCE framework, consideration should be given to other methodological tools which may complement its use to map recovery trajectories in a way which supports the growth of recovery capital and empowers those in recovery to take ownership of their recovery and the formation of new, pro-social networks. This is particularly important, given that the findings from the thesis have highlighted the diversity of community connections amongst individuals at various stages of their recovery journeys. Tracking recovery capital and community engagement over a longer period will enable causal factors of recovery outcomes to be noted, further contributing to the gendered recovery literature base.

A recommended approach for recovery orientated services undertaking research (as being currently piloted by Odyssey, a recovery organization in New Zealand) is to structure the implementation of research and the associated methodology around the ice cream cone model of recovery (Best et al., 2017) (Figure 1.1). This is appropriate, given that it is known that the domains of recovery capital are dynamically linked and if pathways to community resources can be improved, benefits on a personal and social level are subsequently noted, as well as amongst communities more broadly. The findings within this thesis and the associated publications to date (Best et al., 2017; Collinson & Best, 2019; Collinson & Hall, 2021) have directly contributed to this evidence base, highlighting the contribution to the field this body of work has made.

The recommended approach would be to use the REC-CAP (Best et al., 2016) with individuals entering a service so that recovery strengths and barriers can be charted. Repeated use of the REC-CAP (for example every 3-6 months) will allow for individuals to assess their recovery progress and allow for

appropriate recovery care plans to be implemented. It is at this stage that the SIM (Best et al., 2016) and ABCE framework would then come into use. Primarily, use of the SIM will enable individuals to visualise their current social networks, identifying if and where changes could be made to enhance the growth of recovery capital. The ABCE framework can then be used in a complementary manner and the use of this is two-fold. Firstly, the individual can map assets which they are engaged with and can discuss with the professional supporting them what other resources they may wish to be assertively linked in to. The accumulation of this data then holds value for the wider recovery community as a ‘directory’ of assets is formed. This is supported by Czuchry and Dansereau (2003) who recognize such visualization techniques as being meaningful and accessible to those involved in the process. This data can then be used in a way to support those showing willingness to become more engaged within their locale, with the recommendation of assets being done on a peer-to-peer basis.

Specifically considering future research which utilizes the REC-CAP, consideration must be given to how this captures levels of community engagement. As recognized in the findings, there was a lack of significance with community capital against several variables, particularly in comparison to personal and social capital. Given that the community capital measure is specifically focused on involvement in recovery groups, it may be necessary to include supplementary measures, such as elements of the ABCE workbook. This would aid research to gather a more holistic understanding of community capital, factoring in for community engagement which is both recovery orientated, and non-recovery orientated.

Implications of the research findings

Synonymous with the definition of recovery used to underpin the thesis, the research findings are supportive of the statement that:

“Recovery is an intentional endeavour, reclaiming a self-journey, through which a person in recovery with the use of recovery capitals manages the residual drug use effects for sustained control over the substance use, maximizing their health and well-being, having a meaningful life and citizenship, and pursuing other life goals.” (Inanlou et al., 2020, p. 178)

That said, what this definition as well as others (such as the Betty Ford Consensus Panel, 2007) fail to appropriately acknowledge is the importance of community connection – recognised as being central to recovery growth in the thesis, and wider community development (Kretzmann & McKnight, 1993; Edwards et al., 2018; Collinson & Best, 2019). Whilst a shift has been noted in recovery orientated

practice towards ROSCs, the journey of recovery is not linear, and community connection and engagement should be recognised as an important part of the continuity of care and encouraged at all stages of recovery pathways, including within treatment and community support services. Future definitions of substance use recovery may therefore wish to consider the importance of such connection.

To support this within practice, it is important that professionals working in the field understand community engagement as existing on a continuum – recognising that encouraging engagement must be done in a way which is person-centred (potentially supported by the utilisation of tools such as the community engagement scale), responsive to the needs of individuals, and acknowledges the value of a diverse range of engagement. The ABCE framework can be utilised as a framework to underpin this, although the success of this within practice is reliant on a dyadic relationship between the individual in recovery and recovery navigator. Building on the first four stages of the ABCE framework outlined in the methodology (see Chapter 3: *Study 3, Rationale and method*), it is stages five and six which are now important to consider. Whereas Stages 1-4 are completely unique to the ABCE framework, Stages 5 and 6 share similarities to existing literature – particularly that associated with ABCD (Kretzmann & McKnight, 1993). These stages collectively are therefore intended to sit alongside, and support, ABCD.

Stages 5 and 6 are as follows:

5. Highlighting the role of assertive linkage to the recovery navigator

To aid the ABCE framework within practice, the role of assertive linkage is critical, should individuals have stated there are other resources they would like to engage with. As detailed in the literature review (see Chapter 2: *How communities are intended to identify community resources: Asset based community development*), this process encourages, prepares and supports individuals to engage in community resources. To be most successful however, this relies on a dyadic relationship between both the individual in recovery and individual supporting them. Whilst within the ABCD literature (Kretzmann & McKnight, 1993) those undertaking this role are known as community connectors, in the ABCE framework, it is most appropriate for the person supporting the individual in recovery to do this. This could for example therefore be a member of staff at SASS. This is appropriate, given that they will have already formed a working relationship with the individual and have started to gain understanding of their interests.

It is however suggested that those adopting this approach in practice have a ‘pool’ of navigators internal to their service to assist with this process. This is presuming that the pool of individuals

supporting this are likely to have their own expertise and knowledge about the local area. As detailed in the paper by Collinson and Best (2021), others may also be drawn in to support this. For example, there may be a pool of external community connectors who are knowledgeable of the wider community and well connected. If the individual wishes to be linked into a community resource the recovery worker has little knowledge of, a community connector already linked with the specific resource may be asked to support the process of assertive linkage.

Those involved in this process may also be specialists in one of the domains listed within the ABCE workbook. In a similar project undertaken in a recovery residence in America (Cano et al., 2017), this role was done by those with first-hand experience of substance use and recovery. This is appropriate to consider, given that ‘giving back’ to an individual’s recovery community is often a noted aspect of recovery growth, and acts as a powerful means to reconnect with the community (Jacobson & Greenley, 2001). In the 12-step literature, this is described as the ‘helper principle’, and is thought to have therapeutic and spiritual effects for the individual themselves (Smith, 2007). Utilising those who show willingness to become further engaged with their communities and give back to their recovery community may therefore provide access to another ‘pool’ of connectors. This process can therefore become mutually reciprocating, in that through heightened levels of community engagement for the connector themselves, they are likely to note the effects on their own levels of recovery capital.

6. Assertive linkage and community engagement

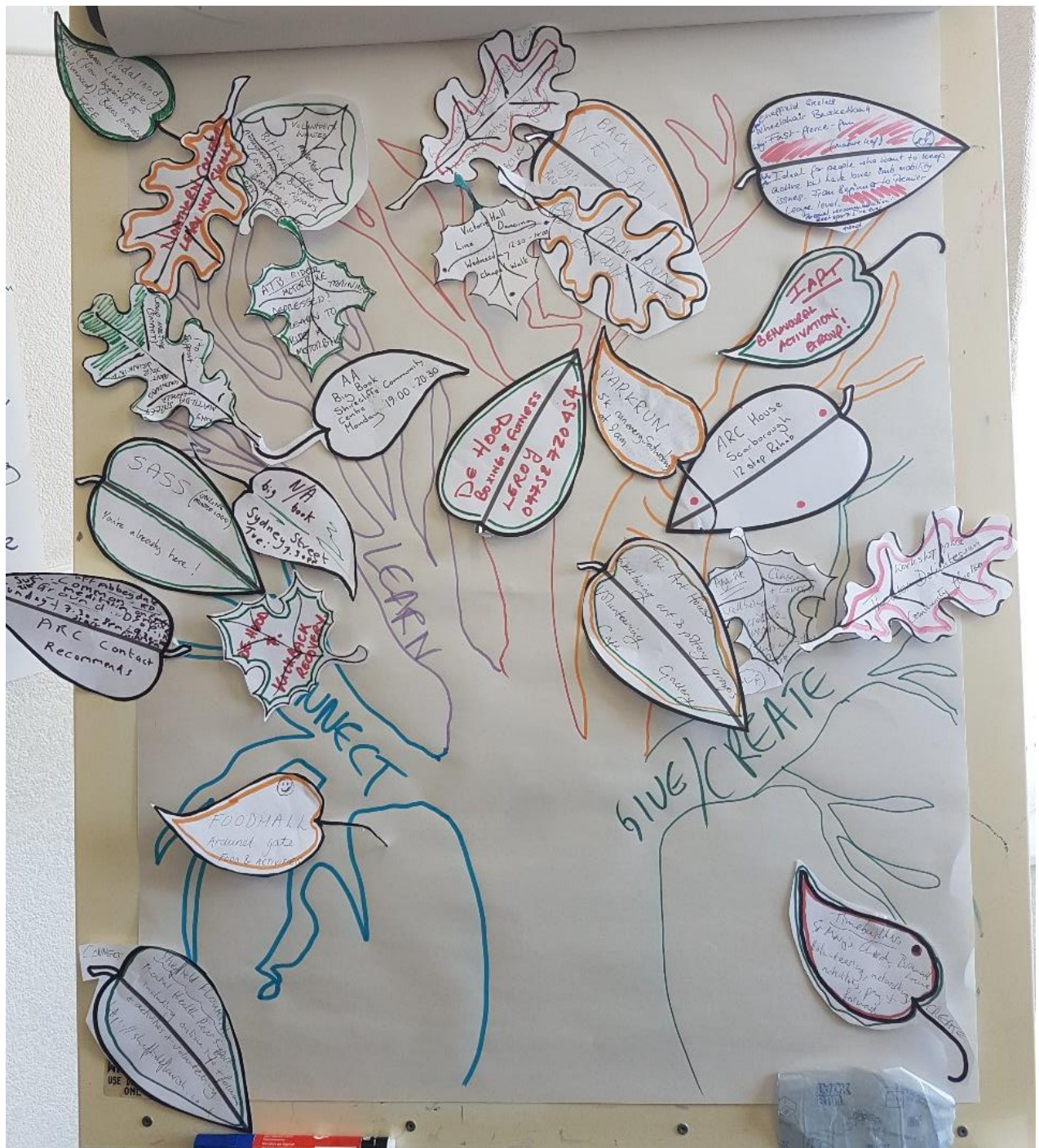
Once the process of assertive linkage is understood by those assisting the process (whether this be recovery workers, peers, or wider community connectors), it is then their role to support the individual in recovery to engage with any resources they may have listed within the Stage 3 of the ABCE workbook (*Explore the personal interests of the individual*). As detailed above, it may be that those supporting this process have different expertise and therefore cover different domains (professional services; peers and mutual aid; sport, recreation and art; and education, employment and training), dependent on their knowledge. Research by Edwards et al. (2018) support the process of assertive linkage for those in recovery from substance use. This work also detailed the importance of training for those supporting this process.

If done successfully, engagement with community resources that are pro-social and afford access to meaningful activities not only provides a platform for personal development and improvement, but also can trigger a social contagion of positive behaviour and improve connectedness within communities (Collinson & Best, 2019). Through wider engagement with both recovery-orientated and

non-recovery orientated resources, individuals' levels of recovery capital will be enhanced, benefitting overall recovery progress.

To hold the most value for recovery communities, the process of ABCE must be done in a way in which knowledge can be shared amongst those in recovery and recovery navigators. Additional time was spent with staff and those accessing SASS following data collection to discuss how this could best be utilized to support the service. The images presented below (Image 1 and Image 2) are not new data, nor do they contribute to the central research question but are included here for added value to help demonstrate the practical implication of the research. Following conversations with staff and ARC members as how best to utilize the data captured within Study 3, it was decided by those accessing the service that an 'asset tree' would be painted on the wall of the communal meeting space as a means to share knowledge about local community resources. Image 1 and 2 provide a visualisation for how members of SASS wanted this to look, with leaves added to share knowledge of assets within the locale.

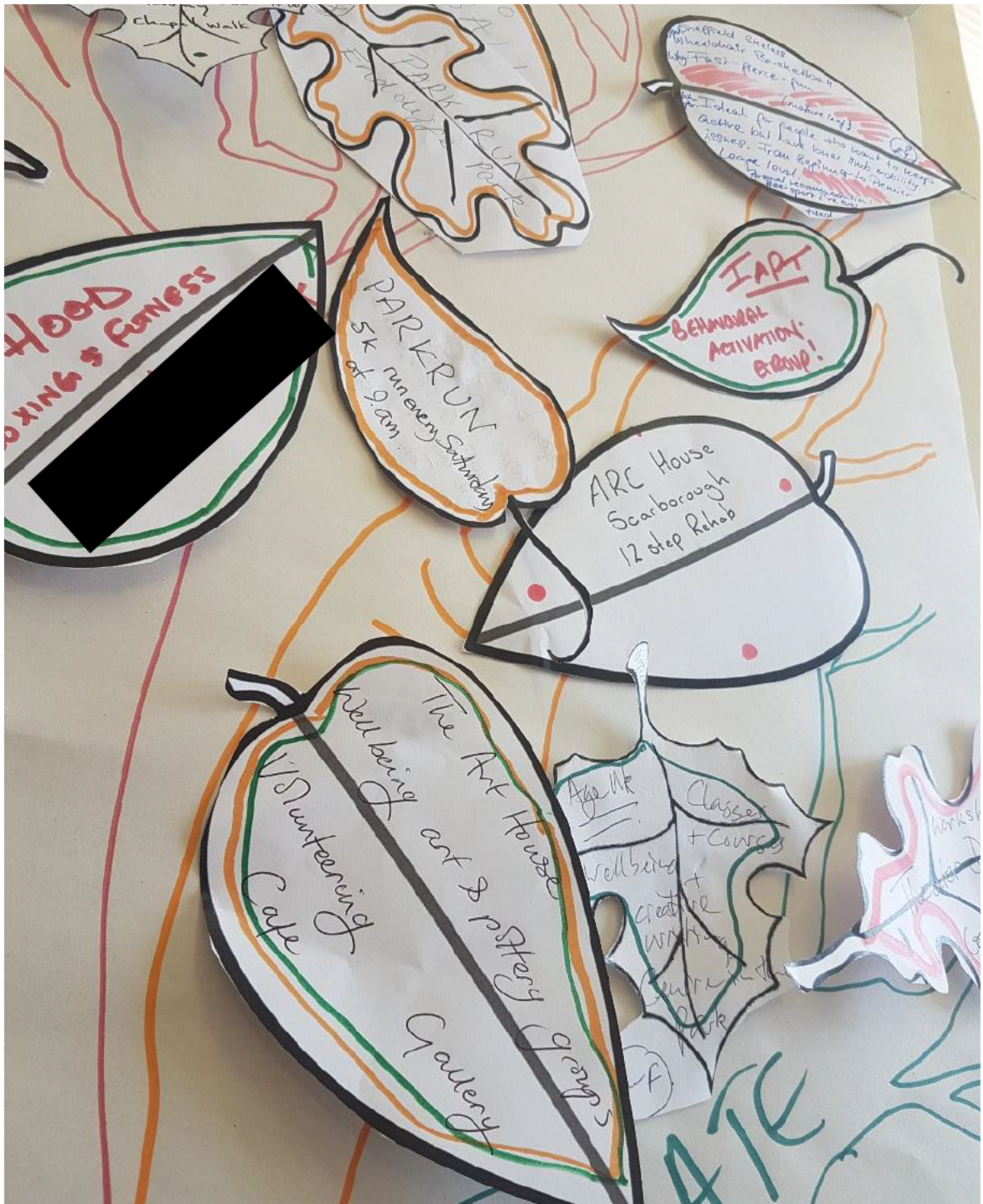
Image 9.1: A visualization of the assets mapped within the ABCE workbooks, shared on an 'asset tree'⁴⁷



The next image provides a closer visualization of how the leaves would look, and what information about the asset may be included on these.

⁴⁷ Sticker placed on image for purpose of anonymity

Image 9.2: A visualization of the leaves included on the 'asset tree'⁴⁸



⁴⁸ Sticker placed on image for purpose of anonymity

Whilst the initial idea was to have four branches, each representing one of the four asset domains, individuals suggested it would be more helpful for the branches to each represent one of the five ways to wellbeing (The New Economics Foundation, 2008) given that this is the current model used to structure the recovery practice at SASS. Individuals were also mindful that there needed to be a way to distinguish between recovery-orientated and non-recovery-orientated resources (perhaps represented in the ABCE workbook by the social network associated with the asset) and thus, it was suggested this could be achieved through the use of different coloured leaves (see Image 2: with leaves with both green and brown edges).

Following the visualization of this, the asset tree has now been painted on the wall of the communal area at SASS and individuals accessing the service are able to place leaves on the tree. The next desired step would be to create maps of this data which can be shared both in hard copy and electronically amongst the Sheffield recovery community. A longer-term vision of this work would be to develop an app which, in a 'Trip Advisor' like manner, could promote community resources on a peer-to-peer basis.

This approach is however reliant on cross-community partnership working to be most successful as this enables knowledge to be shared amongst those within the locale and pathways into resources to be both identified and utilised. A challenge associated with this is that in the current alcohol recovery landscape, models of funding often drive competitive behaviours between service providers. This approach does not lend itself directly to the ABCE framework which is reliant on partnership working. That said, if 'gaming behaviours' between service providers can be discouraged, taking a holistic and partnership orientated approach to recovery promotion will provide a positive sum game, benefiting individuals seeking recovery; staff supporting these individuals; and communities more broadly. In the face of austerity, this will subsequently ensure that the substance use recovery sector is in a better position to deal with potential future funding cuts as pathways into community resources will already exist. This is particularly important, given that in recent years the effects of austerity on alcohol services (Buykx et al., 2018) has meant that activities which are neither abstinence nor employment focused have not been given recognition. Subsequently, meaningful activities often lose priority within service delivery (as seen following the retendering process at SASS most recently). The findings from the thesis highlight the importance of broader engagement being a necessary component of service delivery but for this to be underpinned within practice, it must also be recognised at a policy level with adequate funding designated to this process. Supporting this recommendation, it can be presumed that if community engagement can firstly be encouraged within the recovery sphere, both communities and its citizens will feel the benefits of its effects. Once this form of engagement can be encouraged and

individuals begin to develop on a personal level, bridges into the wider community - supported and fostered through social capital – can help communities blossom, minimising ‘negative’ community capital and stigma, and encouraging social inclusion. This is a reciprocal cycle which benefits both the individual and wider community. More so, a shift towards viewing the importance of community engagement within policy, practice and definitions of recovery would offer services more flexibility to deliver work which is not solely focused on achieving abstinence but also provides a greater sense of hope and empowerment for those seeking recovery.

The thesis offers the first empirical evidence to support the use of the ABCE framework and it is hoped that this will help to shape subsequent work in the field. The implementation of the ABCE framework within practice may however require further preliminary work with professionals working in the sector to ensure they are clear of its theoretical underpinning and the benefits of its approach in order to be most effectively used. Once the evidence base for the ABCE framework is further built on, it may be appropriate for the ice cream cone model of recovery (Best et al., 2017) (Figure 1.1), used as an underpinning framework for the current thesis, to be revised to include ABCE in the model. It is intended that this would sit at the upper level, between community capital and ABCD (see Figure 1.1).

Chapter 9: Conclusion

For those who perceive their drinking to be problematic within their lives, seeking recovery from its use may be a desired outcome which, with the support of recovery orientated services such as SASS, can move towards living a more fulfilled life. This process of personal growth can be both initiated and sustained by individuals drawing on internal and external resources, also known as recovery capital.

This thesis begins to reveal the role of community engagement in developing women's recovery capital, and emphasises the complexity of this in relation to gender. Founded on the conceptual framework of recovery capital, the findings suggest that gender is likely to interact with the accumulation of personal, social and community capital and the pathways which support recovery capital acquisition are gendered in nature. Alongside recovery capital, three other key pieces of literature were utilised to underpin the thesis. These were the ice cream cone model of recovery (Best et al., 2017) (Figure 1.1); the CHIME model (Leamy et al., 2011) and Asset Based Community Development (ABCD) (Kretzmann & McKnight, 1993). The thesis both supports, and contributes to, the evidence base associated with these works. As the ice cream cone model (Figure 1.1) recognises, the relationship between the domains of recovery capital is mutually reciprocating and dynamic. Recovery is, as the existing definitions highlight (Inanlou et al., 2020), and the thesis validates, a journey of personal growth and development which surpasses sobriety. This is in fact a socially mediated process which is deeply reliant on the formation of pro-social networks and the ability to engage with community resources. Although these two aspects are central to aiding recovery progress, the thesis identifies that the way in which men and women experience these are likely to differ. For example, females were more likely to be engaged in meaningful activities from the onset and the forms of community engagement undertaken often differed from their male counterparts. Men reported lower levels of social support, and barriers to engagement varied across the cohort highlighting the need for recovery-orientated support and pathways into new community resources being tailored to the needs of the individual.

The thesis makes considerable progress in better understanding the impact of community engagement on recovery as a mechanism to enhance feelings of connectedness and recovery capital growth. It outlines key components of community capital such as the accessibility of resources and non-stigmatising attitudes and environments which, if present, help to underpin wider engagement and foster inclusivity. It is however recognised that this process is multifaceted, particularly for those who have formerly used substances, given the layers of marginalisation and stigmatisation they are likely to experience.

In light of community engagement specifically, improving pathways into a range of resources which fall across the following four domains: professional services; sports, recreation and arts; mutual aid and education employment and training, should be an encouraged aspect of recovery orientated practice given their ability to improve recovery outcomes. Engagement internally to the recovery sphere is often the starting point on this journey, although wider engagement, if undertaken, was found to have lasting positive implications on recovery progress and the development of holistic identities.

To support this process, the Asset Based Community Engagement (ABCE) framework and workbook were developed. These are original aspects of the thesis, making significant contributions to the field both theoretically and practically. Whilst emerging evidence has begun to recognise the importance of community engagement to aid recovery (Burrow & Hill, 2011; Yeager et al., 2012; Best et al., 2017; Collinson & Best, 2019), systematic approaches to mapping these resources and identifying pathways into such resources have been limited to date, particularly for recovery populations. Building on the existing evidence of ABCD and its associated challenges, the thesis offers a structured and strengths-based approach to asset mapping, ABCE. This enhancement of ABCD recognises the importance of identifying current levels of community engagement and barriers to engagement in order to foster empowerment and enhance personal capital. Recovery pathways must be gender-responsive and the ABCE framework is intended to support this in that it is a strengths-based tool which is to be utilized to provide both holistic and person-centered pathways in community resources for those in need. The community engagement scale created during this PhD research can help to identify those most in need of assertive linkage into new community resources.

In light of the central research question, whilst the thesis makes substantial contributions to the field, there is still considerable work to do. Whilst nuances amongst gender were identified, the research was carried out in a mixed-gender service, potentially limiting the extent to which gender differences could have been noted amongst the cohort, such as experiences of domestic violence and trauma which are often noted in women's narratives of alcohol use and recovery (Covington, 2002; Collinson & Hall, 2020). Existing alcohol policy is dated (HM Government, 2012), failing both those seeking recovery and communities more broadly. Future developments in research, policy and practice must acknowledge gender as a mediator of pathways in to, and out of alcohol use, to bridge the existing gap between emerging evidence and policy. Additionally, whilst understanding and definitions of recovery recognise the process as one which applies to a variety of life domains (such as Inanloyu et al., 2020), these are yet to fully recognise the importance of community connection. Connection to, and engagement with, networks and resources that are meaningful, not only provides a platform for

personal growth, but further has the capability to trigger a social contagion of positive behaviour and improve connectedness within communities.

~

“It’s a journey of being, belonging and becoming.”

Individual in recovery who participated in the research

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Appendix

Appendix 1: A user friendly version of the Assessment of Recovery Capital



Appendix 2⁴⁹: REC-CAP with the inclusion of the additional community engagement measure

REC-CAP

Identifier: _____ Date: _____ Location: _____

Section 1: Demographic characteristics

1.1 Gender: MALE FEMALE TRANSGENDER OTHER, PLEASE SPECIFY _____

1.2 Age: _____ years

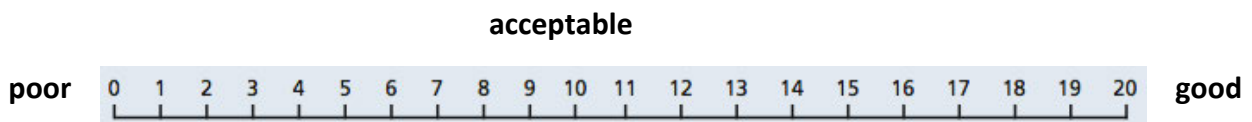
1.3 Ethnicity: _____

1.4 Post code (outcode only): _____

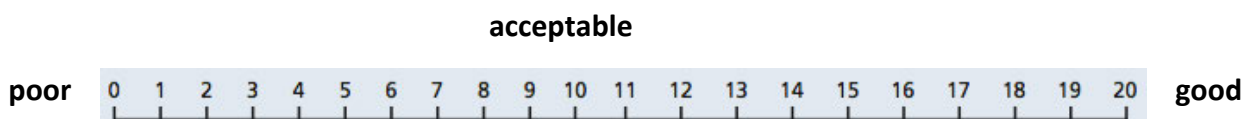
Section 2: Quality of life and satisfaction

For each of the questions below, please give a rating on the scale for how you are feeling **today**, where higher scores mean you are feeling better and lower scores that you are not so satisfied with this part of your life. Indicate your score by marking on the 'rulers'.

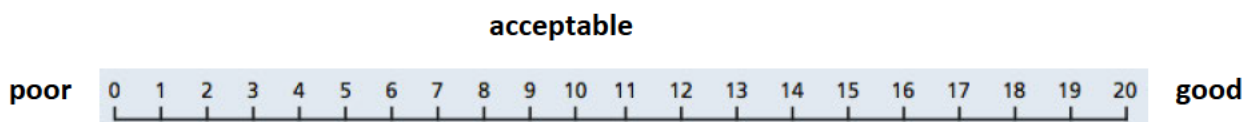
1.1 How good is your psychological health?



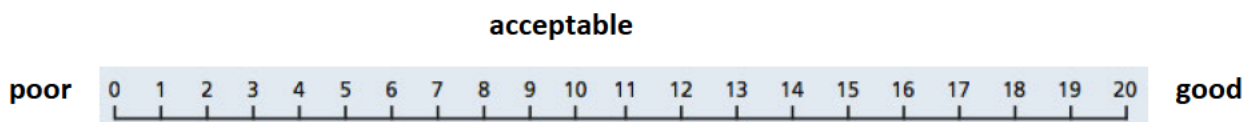
1.2 How good is your physical health?



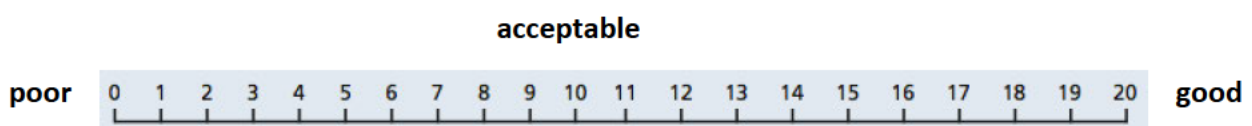
1.3 How would you rate your overall quality of life?



1.4 How would you rate the quality of your accommodation?



1.5 How would you rate your support network?



Section 3: Barriers to recovery

3.1 Accommodation

3.1.1 At any point in the last month have you been:

At risk of eviction No Yes

Had acute housing problems No Yes

3.1.2 Number of days in last 3 months (90 days) you have been living in:

	Days		Days		Days
Own home		Supported accommodation		Hospital	
With family		Hostel		Treatment centre	
With friends		On streets/rough sleeping		Prison	
Recovery house					

Who do you live with? _____

3.1.3 Have you or do you experience any difficulties securing housing on account of historic or current debt issues? No Yes

3.2 Substance use

Have you used any substances in the last 90 days? No Yes

If 'No' please respond to the first column below then move to section 3.4.

If 'Yes' please respond to all columns below and record information as indicated.

	Ever been a problem?	Used in the last 90 days	Days used in the last 90 days	Avg daily amount
Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ units/day
Heroin	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ g/day
Crack cocaine	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ g/day
Cocaine powder	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ g/day
Amphetamines	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ g/day
Cannabis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ spliff/day
Methadone (prescribed)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ mg/day
Methadone (street)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ mg/day
Buprenorphine (prescribed) (Subutex)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ mg/day
Buprenorphine (street) (Subutex)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ mg/day
Benzos (prescribed) (specify _____)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ mg/day
Benzos (street) (specify _____)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ mg/day
Other problem substance? (specify _____)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____ g/day

3.3 Risk taking

Have you injected drugs in the last 90 days? No Yes
(if No, skip to 3.4)

If yes, how many days have you injected on? (0-90 days) _____ days

Have you injected with a needle or syringe used by someone else? No Yes

Have you injected using a spoon, water or filter used by someone else? No Yes

3.4 Involvement with the criminal justice system

Are you currently involved in offending? No Yes

Are you currently involved with the police? No Yes

Are you currently on a community order? No Yes

Are you currently on licence? No Yes

Have you any other form of involvement with the criminal justice system? No Yes

If yes, please specify:

3.5 Work, training and volunteering

Are you currently working full-time? No Yes

Are you currently working part-time? No Yes

Are you currently at college or university? No Yes

Are you currently volunteering? No Yes

If yes, please describe the amount and nature of your volunteering work:

Section 4: Services involvement and needs

The following table assesses what services you are engaged with and whether your current level of service involvement is meeting your support needs?

	Are you currently engaged with this kind of services?	If you are, are you satisfied with the service you are getting?	Do you need help or additional help in this area?
Drug treatment services	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Alcohol treatment services	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mental health services	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Housing support	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Employment services	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Primary healthcare services (GP, medical services)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Family relationships	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other specialist help or support (please specify):			

Section 5: Personal recovery capital

Please read the following statements and tick a statement only if you agree with it entirely and unreservedly. Do not linger over the question but give your initial feeling at this moment. If you disagree or are unsure, leave it blank. These are how you currently feel and to things that have happened to you in the last 3 months (90 days).

	Tick if you agree with this statement
Having a sense of purpose in life is important to my recovery journey	
I am able to concentrate when I need to	
I am coping with the stresses in my life	
I am free from worries about money	
I am happy dealing with a range of professional people	
I am making good progress on my recovery journey	
I cope well with everyday tasks	
I do not let other people down	
I am happy with my appearance	
I engage in activities and events that support my recovery	
I eat regularly and have a balanced diet	
I feel physically well enough to work	
I have enough energy to complete the tasks I set myself	
I have no problems getting around	
I have the personal resources I need to make decisions about my future	
I have the privacy I need	
I look after my health and wellbeing	
I make sure I do nothing that hurts or damages other people	
I meet all my obligations promptly (things you have made a commitment to do)	
I sleep well most nights	
I take full responsibility for my actions	
In general I am happy with my life	
What happens to me in the future mostly depends on me	
I have a network of people I can rely on to support my recovery	
When I think of the future I feel optimistic	

Section 6: Social recovery capital

Please read the following statements and tick a statement only if you agree with it entirely and unreservedly. Do not linger over the question but give your initial feeling at this moment. If you disagree or are unsure, leave it blank. These are how you currently feel and to things that have happened to you in the last 3 months (90 days).

	Tick if you agree with this statement
I am actively involved in leisure and sport activities	
I am currently completely sober and/or clean from drug use	
I am actively engaged in efforts to improve myself (training, education and/or self-awareness)	
I am happy with my personal life	
I am proud of my home	
I am proud of the community I live in and feel a part of it – sense of belonging	
I am satisfied with my involvement with my family	
I am free of threat or harm when I am at home	
I engage in activities that I find enjoyable and fulfilling	
I feel safe and protected where I live	
I feel that I am in control of my substance use	
I feel that I am free to shape my own destiny	
I get lots of support from friends	
I get the emotional help and support I need from my family	
I have a special person that I can share my joys and sorrows with	
I have access to opportunities for career development (job opportunities, volunteering or apprenticeships)	
I have had no lapses or relapses	
I have had no recent periods of substance intoxication	
I regard my life as challenging and fulfilling without the need for using drugs or alcohol	
It is important for me to contribute to society and or be involved in activities that contribute to my community	
It is important for me to do what I can to help other people	
It is important for me that I make a contribution to society	
My living space has helped to encourage my recovery journey	

My personal identity does not revolve around drug use or drinking	
There are more important things to me in life than using substances	

Section 7: Involvement with recovery groups and your local community

7.1 Please tick if you agree with any of the following statements about any group you have attended in the community in the last month to supports your recovery. These questions refer to any group – formal or informal – that you attend that supports your recovery, including AA, NA, SMART Recovery, local peer groups, aftercare groups and any other types of recovery group you belong to:

	Tick if you agree with this statement
I attend recovery group meetings on a weekly basis or more frequently	
If I did not make a meeting at my group for two weeks, people would call to see if I was okay	
I speak at recovery meetings	
I perform service at recovery meetings	
I carry a message of hope to others (and openly talk about my own recovery)	
I socialise before and / or after meetings	
I attend recovery social events	
I visit a recovery centre or café	
I read recovery supportive literature	
I carry a recovery object (something that reminds me of my ongoing recovery)	
I have people from my recovery group who support my recovery	
I use daily recovery rituals (things I do every day to support my recovery journey)	
I do voluntary service to help my recovery group	
I encourage others to attend my recovery group	

7.2 Please specify what recovery groups you have attended in the last month:

7.3 Please specify what online recovery groups you have accessed in the last month:

7.4 Whether or not you are currently using any of the following, do you feel that you need additional support from:

- | | | |
|---------------------------------------|-----------------------------|------------------------------|
| 7.4.1 Peers support | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.2 12 step mutual aid groups | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.3 Other community recovery groups | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.4 Online recovery groups | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Section 7, Part 2: Community Engagement

Part 2a) Please tick if you have attended these groups in the last 30 days at SASS. If you attend a group once a week or more than once a week, please tick in the appropriate box.

	Once in 30 days	Once a week	More than once a week
SMART (mixed)			
SMART (women's only)			
Moodmasters			
Active citizenship			
Drop in			
Arts and crafts			
Men's group			
SASSY ladies			
Other (please specify)			

Part 2b) Outside of SASS, please list any other groups you attend, both recovery orientated **and** non-recovery orientated.

Sports, Recreation and Art e.g. De Hood	Professional Services e.g. GP	Education, Employment and Training e.g. Northern College	Mutual Aid e.g. NA/ AA

Part 2c) Are you satisfied with your level of community engagement? No Yes

Part 2d) Do you view yourself as an active citizen? No Yes

Part 2e) Are there any groups you would like to attend but you haven't? These can be at SASS or somewhere else in Sheffield, both recovery orientated **and** non-recovery orientated. No Yes

Part 2f) What other groups you would like to attend if you could.

Part 2g) Would any of these factors stop you from attending more groups/ activities? Please tick no or yes.

7.4.10 I don't know enough about the group No Yes

- | | | |
|--|-----------------------------|------------------------------|
| 7.4.11 I don't want to go by myself | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.12 It's too expensive | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.13 I can't get there easily | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.14 I might be judged for attending | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.15 I don't have enough time | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.16 Health concerns | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.17 Religion/ culture | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.18 Family constraints | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.19 Lack of confidence | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.20 Work constraints | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.21 It isn't gender appropriate | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.22 Lack of motivation | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.23 Lack of specific opportunities | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.24 Unsupportive community | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.25 Unsupportive friends | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.26 It isn't age appropriate | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7.4.27 Other | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If yes please specify _____

Section 7, Part 3: Support

7.5 How much support do you get from other people?

For each of the questions below, please give a rating on the scale for how you are feeling about the question **today**, where higher scores mean you receive more support and lower scores mean you receive less support. Indicate your score by circling the number that best describes your feeling.

7.5.1 Do you get the emotional support you need from other people?

1	2	3	4	5	6	7
Not at All	←—————→					Complete ly

7.5.2 Do you get the help you need from other people?

1	2	3	4	5	6	7
Not at All	←—————→					Complete ly

7.5.3 Do you get the resources you need from other people?

1	2	3	4	5	6	7
Not at All	←—————→					Complete ly

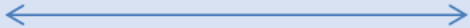
7.5.4 Do you get the advice you need from other people?

1	2	3	4	5	6	7
Not at All	←—————→					Complete ly

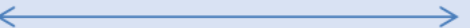
Section 8: Commitment

For each of the questions below, please give a rating on the scale for how you are feeling about the question **today**, where higher scores mean you strongly agree and lower scores mean you strongly disagree with this statement. Indicate your score by circling the number that best describes your feeling.


8.1. Staying sober/clean is the most important thing in my life.

1	2	3	4	5	6
Strongly Disagree					Strongly Agree


8.2. I am totally committed to staying off of alcohol/drugs.

1	2	3	4	5	6
Strongly Disagree					Strongly Agree

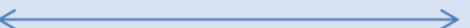
8.3. I will do whatever it takes to recover from my addiction.

1	2	3	4	5	6
Strongly Disagree					Strongly Agree

8.4. I never want to return to alcohol/drug use again.

1	2	3	4	5	6
Strongly Disagree					Strongly Agree

8.5. I have had enough alcohol and drugs.

1	2	3	4	5	6
Strongly Disagree					Strongly Agree

Section 9: What do you see as your needs?

Please respond to the following questions as fully as you need and wish to do, including using the back of the page if more space is required.

9.1 Where do you see yourself in your recovery journey?

9.2 What are your current life goals?

9.3 What do you need to help you get to the next goal in your life journey?

9.4 Who do you rely on to help you with your recovery?

As part of the study, I will need to contact you again in 6 months to complete the same questionnaire.

I can either meet with you to fill out the questionnaire or send you a hard copy via post with a pre-paid envelope.

Please leave your contact details below:

Name:

Phone number:

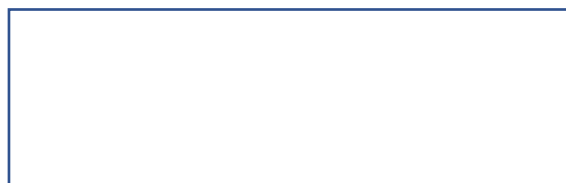
Email address:

And/ or home address:

Preferred method of contact:

Please note these contact details will not be shared with anyone

Your name is only for contact purposes; once I have contacted you again this contact sheet will be shredded. In the meantime, this information will be kept in a locked cupboard.



Appendix 3: ABCE framework

Collinson, B., & Best, D. (2019). Promoting Recovery from Substance Misuse through Engagement with Community Assets: Asset Based Community Engagement. *Substance abuse: Research and Treatment*, 13.

Available at⁵⁰: <https://journals.sagepub.com/doi/full/10.1177/1178221819876575>

⁵⁰ Due to formatting issues this article could not be inserted into the appendices

Appendix 4: ABCE workbook

Asset Based Community Engagement Workbook



Section 1: Demographic characteristics

1.1 Gender:

- Male
- Female
- Transgender
- Other, please specify _____

1.2 Age:

_____ years

1.3 Ethnicity:

1.4 Postcode (outcode only):

Section 2: Recovery support

2.1. How long have you been engagement in recovery support?

_____ years _____ months

2.2. How old were you when you started your recovery? (Enter age when you initiated recovery)

_____ years

2.3. Which category best describes how you define yourself now, with respect to your prior alcohol and/ or drug use?




- In recovery
- Recovered
- Ex addict or alcoholic
- Used to have an alcohol or drug problem but don't anymore
- In medication - assisted recovery

2.4. Thinking about the answers you provided to the previous question, how long have you been in recovery/ recovered? (Enter the durations in years and months)

_____ years _____ months




Peers and mutual aid

List any assets you are currently engaged with under this domain: <u>Mutual Aid</u>	Accessibility Transport links, location	Affordability Expense associated with the asset. Are there any costs involved?	Connectedness Are you familiar with the group? Are you a well-known member of the group?	Network associated with asset Non-user (N) Social user (S) Active user (A) In recovery (R)

		
Not accessible Not affordable Not connected	Fairly accessible Fairly affordable Fairly connected	Very accessible Very affordable Very connected




Sport, recreation and arts

List any assets you are currently engaged with under this domain: <u>Sport, recreation and arts</u>	Accessibility Transport links, location	Affordability Expense associated with the asset. Are there any costs involved?	Connectedness Are you familiar with the group? Are you a well-known member of the group?	Network associated with asset Non-user (N) Social user (S) Active user (A) In recovery (R)

		
Not accessible Not affordable Not connected	Fairly accessible Fairly affordable Fairly connected	Very accessible Very affordable Very connected




Professional services

List any assets you are currently engaged with under this domain: <u>Professional services</u>	Accessibility Transport links, location	Affordability Expense associated with the asset. Are there any costs involved?	Connectedness Are you familiar with the group? Are you a well-known member of the group?	Network associated with asset Non-user (N) Social user (S) Active user (A) In recovery (R)

		
Not accessible Not affordable Not connected	Fairly accessible Fairly affordable Fairly connected	Very accessible Very affordable Very connected

Education, employment and training

List any assets you are currently engaged with under this domain: <u>Education, employment and training</u>	Accessibility Transport links, location	Affordability Expense associated with the asset. Are there any costs involved?	Connectedness Are you familiar with the group? Are you a well-known member of the group?	Network associated with asset Non-user (N) Social user (S) Active user (A) In recovery (R)

		
Not accessible Not affordable Not connected	Fairly accessible Fairly affordable Fairly connected	Very accessible Very affordable Very connected

1) Are you satisfied with your level of community engagement?

- Yes No

2) Do you view yourself as an active citizen?

- Yes No

3) Are there any groups you would like to attend but you haven't?

- Yes No

4) If yes, please specify what groups you would like to attend if you could.

5) This final question looks at barriers to community engagement. Tick any that apply.

- | | |
|--|---|
| <input type="checkbox"/> I don't know enough about the group | <input type="checkbox"/> I don't have enough time |
| <input type="checkbox"/> I don't want to go by myself | <input type="checkbox"/> Health concerns (mental/ physical) |
| <input type="checkbox"/> It's too expensive | <input type="checkbox"/> Religion/ culture |
| <input type="checkbox"/> I can't get there easily | <input type="checkbox"/> Family constraints |
| <input type="checkbox"/> I might be judged for attending | <input type="checkbox"/> Work constraints |
| <input type="checkbox"/> It is not gender appropriate | <input type="checkbox"/> Unsupportive community |
| <input type="checkbox"/> It isn't age appropriate | <input type="checkbox"/> Unsupportive friends |
| <input type="checkbox"/> Lack of confidence | <input type="checkbox"/> Lack of specific opportunities |
| <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Other (please specify below) |

Appendix 5: Interview schedule for Study 4

[Check in since last time we saw one another]

[Check in/ catch up since last time we saw one another]

1. How did you first come to access SASS? **What was your referral pathway? (GP, self-referral, court, treatment). Was there anything that stopped you from accessing support to begin with?**
2. Are you happy to give me a little background to your life before you came to access SASS? **Are you from Sheffield?** (Childhood/ school/ family/ relationships etc).
3. What made you start your recovery journey? **How long had you been drinking/ using for prior to this? Has your family/ housing situation changed along the way?**
4. Had you tried to recover previously and if so what was different this time?

[Show REC-CAP scores – chat through these before moving on to the next section]

[Look at original REC-CAPs - assets are listed/ barriers to engagement]

5. What do you think has been the most significant change you have made over the last 6-12 months?
6. What supports have enabled you to make those changes? (Organisations, groups, activities, family, friends, relationships, **volunteering**)
7. What community resources are you engaged with and why? **What do you get out of going to these groups?**
8. What challenges/ barriers have you faced along the way?
9. Where do you feel you are now **in your recovery? How does this compare to where you were a year ago?**
10. **What's your proudest achievement?**
11. Where do you see yourself going in the next year? **What are your goals/dreams? What support do you need to get there?** [refer back to REC-CAP and answers at the back]

Appendix 6: Ethical approval



Our Ref AM/KW/D&S-366
27 April 2017

Beth Collinson
Post Graduate Researcher
Department of Law and Criminology
Heart of the Campus
Collegiate Crescent Campus
Sheffield S10

INTERNAL

Dear Beth

Request for Ethical Approval of Research Project

Your research project entitled "**Investigating recovery capital, whilst identifying gender similarities and differences in pathways to recovery from alcohol.**" has been submitted for ethical review to the Faculty's rapporteurs and I am pleased to confirm that they have approved your project.

I wish you every success with your research project.

Yours sincerely



Professor A Macaskill
Chair
Faculty Research Ethics Committee

Appendix 7: Information sheet for Study 2

REC-CAP information sheet

As part of my PhD research project, I would like to invite you to participate in this research which explores how recovery capital differs by gender⁵¹. The collection of this data will happen over the space of 6 months and you will be required to fill out the REC-CAP questionnaire twice (once now, and again in 6 months' time).

Why have you asked me to take part?

You have been asked to take part as you are a new ARC member at SASS. For my research to be effective, the REC-CAP must be completed by individuals upon entry to SASS, and again in 6 months.

You do not have to take part. Participation is completely voluntary. A copy of the information provided here is yours to keep along with the consent form if you do decide to take part. You can still decide to withdraw at any time without giving a reason or you can decide not to answer a particular question.

What will I be required to do?

You will be required to fill out the REC-CAP questionnaire two times over the space of 6 months. This will take approximately 20 minutes to work through. You will be expected to fill out the questionnaire now (and I will be here to assist you if needed), and then again in 6 months' time.

Where will this take place?

You will complete the questionnaire whilst at SASS in any free time you have during the day.

How often will I have to take part, and for how long?

The questionnaire will take approximately 20 minutes to fill out. You will be asked again in 6 months to repeat this, completing the questionnaire once more.

When will I have the opportunity to discuss my participation?

You can discuss your participation in the research before, during or after completion of the questionnaire. Please do not hesitate to ask questions or contact me via email. Alternatively, I visit SASS on a frequent basis so you will also be able to speak to when I'm at the service.

Who will be responsible for all of the information when this study is over?

As principal researcher I will be responsible for all of the information.

Who will have access to it?

The only individuals who will have access to the information will be my PhD supervisors if necessary and I. If you wish, you may access your own information, but access to information regarding other individuals who participate will not be allowed.

What will happen to the information when this study is over?

⁵¹ Title of the thesis changed during write up and therefore now inaccurate on forms

When the study is over, the information will be used to assess change in levels of recovery capital over a six month period. Once the information is no longer required, it will be disposed of in a way that it can no longer be accessed. Questionnaires will be shredded.

How will you use what you find out?

The results that will be obtained from the information provided will be written up as part of obtaining my PhD qualification. Information from the questionnaires will be inputted into a dataset on the computer. This will be stored securely on a password protected laptop. From this, I will run an analysis on the results. You will be anonymised at all times.

Will anyone be able to connect me with what is recorded and reported?

No. When you fill out the questionnaire, you will create an identification number so that you do not have to give your name or any identifiable information. When you fill out the questionnaire for the second time, you will use the same identification number so I can match up your two questionnaires.

How long is the whole study likely to last?

6 months.

How can I find out about the results of the study?

After I have collected all the data and once I have written up my results you will be able to contact myself in order to access the results of the study or any write ups of the findings. You will be able to contact myself during this time if you wish to find out any more information and will be eligible for a copy of the write up once completed if requested.

What if I do not wish to take part?

Participation is completely voluntary so if you decide against participation, you may do so without any justification.

What if I change my mind during the study?

Again, if you change your mind about participating in the study, you have the right to withdraw at any point without justification up until April 2019. Any information from you will be disposed of and will not be used in the report.

If you have any questions regarding the study, please do not hesitate to contact me on the details below and I will be happy to address any concerns or questions you may have.

Researcher details

Beth Collinson

Doctoral Researcher

Sheffield Hallam University

b.collinson@shu.ac.uk

01142 252639

Supervisor details

Professor David Best

Sheffield Hallam University

d.best@shu.ac.uk

01142 255435

Legal Basis for Research Studies:

The University undertakes research as part of its function for the community under its legal status. Data protection allows us to use personal data for research with appropriate safeguards in place under the legal basis of public tasks that are in the public interest. A full statement of your rights can be found at:

<https://www.shu.ac.uk/about-this-website/privacy-policy/privacy-notices/privacy-notice-for-research>

However, all University research is reviewed to ensure that participants are treated appropriately, and their rights respected. This study was approved by ethics committee within the Department of Law and Criminology. Further information at

<https://www.shu.ac.uk/research/ethics-integrity-and-practice>

Contact Details:

Details of who to contact if you have any concerns or if adverse effects occur after the study are given below:

You should contact the Data Protection Officer if:

- you have a query about how your data is used by the University
- you would like to report a data security breach (e.g. if you think your personal data has been lost or disclosed inappropriately)
- you would like to complain about how the University has used your personal data

DPO@shu.ac.uk

You should contact the Head of Research Ethics (Professor Ann Macaskill) if:

- you have concerns with how the research was undertaken or how you were treated

a.macaskill@shu.ac.uk

Postal address: Sheffield Hallam University, Howard Street, Sheffield S1 1WBT.
Telephone: 0114 225 5555

Appendix 8: Information sheet for Study 3

ABCE information sheet

As part of my PhD research project, I would like to invite you to complete this Asset Based Community Engagement (ABCE) workbook. This requires listing assets (activities/ groups/ organisations/ places) in Sheffield that you are currently engaged with.

Why have you asked me to take part?

You have been asked to take part as you are an ARC member at SASS.

What will I be required to do?

You will be required to participate in the activity that will take approximately 20 minutes. During this time, I will ask you to list assets (activities/ groups/ organisations/ places) you are currently engaged with in Sheffield. You will then use stickers to code how connected you feel with these assets, how accessible they are and how affordable they are. Conversations we have during this time will be audio recorded.

Where will this take place?

The activity will take place at SASS.

How often will I have to take part, and for how long?

You will only have to participate once. This will take approximately 20 minutes.

When will I have the opportunity to discuss my participation?

You can discuss your participation in before, during or after completion of the activity. Please do not hesitate to ask questions or contact me via email. Alternatively, I visit SASS on a frequent basis so you will also be able to speak to when I'm at the service.

Who will be responsible for all of the information when this study is over?

As principal researcher I will be responsible for all of the information.

Who will have access to it?

The only individuals who will have access to the information will be my PhD supervisors if necessary and I. If you wish, you may access your own information, but access to information regarding other who take part will not be allowed.

What will happen to the information when this study is over?

When the activity is over, I will look at all the information provided to see what assets are being utilised in Sheffield. This information will be stored in a secure place. I will be the only person to have access to it. The audio recordings will be transcribed. This means that

what has been said will be written up. You will not be able to be identified by this. By audio recording the conversations I can understand more easily why you may or may not access an asset and further understand what impact this engagement may have on your recovery. Once the data has been transcribed, the audio recording will be destroyed.

How will you use what you find out?

The results that will be obtained from the information provided will be written up as part of obtaining my PhD qualification. I will look at what assets are identified and used within Sheffield, the impact of this engagement on recovery, and if this differs between men and women.

Will anyone be able to connect me with what is recorded and reported?

No names are needed therefore no one will be able to connect you with what is recorded. If names are mentioned on the audio recording, these will be swapped for false names in the transcriptions.

How long is the whole study likely to last?

20 minutes.

How can I find out about the results of the study?

After I have collected all the data and once I have written up my results you will be able to contact myself in order to access the results of the study or any write ups of the findings.

What if I do not wish to take part?

Participation is completely voluntary so if you decide against participation, you may do so without any justification.

What if I change my mind during the study?

Again, if you change your mind about participating in the study, you have the right to withdraw at any point without justification up until 28th April 2018. Any information from you will be disposed of and will not be used in the report.

If you have any questions regarding the study, please do not hesitate to contact me on the details below and I will be happy to address any concerns or questions you may have.

Researcher details

Beth Collinson

Doctoral Researcher

Sheffield Hallam University

b.collinson@shu.ac.uk

01142 252639

Supervisor details

Professor David Best

Sheffield Hallam University

d.best@shu.ac.uk

01142 255435

Legal Basis for Research Studies:

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- you would like to complain about how the University has used your personal data

DPO@shu.ac.uk

You should contact the Head of Research Ethics (Professor Ann Macaskill) if:

- you have concerns with how the research was undertaken or how you were treated

a.macaskill@shu.ac.uk

Postal address: Sheffield Hallam University, Howard Street, Sheffield S1 1WBT.
Telephone: 0114 225 5555

Appendix 9: Information sheet for Study 4

Interview information sheet

As part of my PhD research project, I would like to invite you to take part in an interview.

Why have you asked me to take part?

You have been asked to take part as you have accessed SASS and took part in an earlier stage of the research.

What will I be required to do?

You will be required to take part in a reflective interview. This will be based on the information you provided in an earlier stage of the research (REC-CAP questionnaire). You will be presented with your REC-CAP scores (scores of your recovery capital) and will be asked to reflect on this. This is to allow you the opportunity to reflect on your recovery journey to date, focusing specifically on what things have been particularly advantageous. The interview will be audio recorded.

Where will this take place?

The interview will take place at SASS.

How often will I have to take part, and for how long?

You will only have to participate once. It is anticipated the interview will last approximately 30 minutes but if you wish this to be shorter or longer that is no problem.

When will I have the opportunity to discuss my participation?

You can discuss your participation in before, during or after completion of the interview. Please do not hesitate to ask questions or contact me via email or phone. Alternatively, I visit SASS on a frequent basis so you will also be able to speak to when I'm there.

Who will be responsible for all of the information when this study is over?

As principal researcher I will be responsible for all of the information.

Who will have access to it?

The only individuals who will have access to the information will be my PhD supervisors if necessary and I. If you wish, you may access your own information, but access to information regarding other participants will not be allowed.

What will happen to the information when this study is over?

When the interview is over the audio recording will be stored on a password protected computer. This will then be transcribed. This means that what has been said will be

written up. You will not be able to be identified by this. By audio recording the interview I can better understand how your levels of recovery capital and community engagement have changed over time, and other factors which may have played a role within this. Once the data has been transcribed, the audio recording will be destroyed.

How will you use what you find out?

The results that will be obtained from the information provided will be written up as part of obtaining my PhD qualification. I will look to identify factors which have potentially helped or hindered your recovery.

Will anyone be able to connect me with what is recorded and reported?

No names are needed therefore no one will be able to connect you with what is recorded. If names are mentioned on the audio recording, these will be swapped for false names in the transcriptions.

How long is the whole study likely to last?

30 minutes approximately.

How can I find out about the results of the study?

After I have collected all the data and once I have written up my results you will be able to contact myself in order to access the results of the study or any write ups of the findings.

What if I do not wish to take part?

Participation is completely voluntary so if you decide against participation, you may do so without any justification.

What if I change my mind during the study?

Again, if you change your mind about participating in the study, you have the right to withdraw at any point without justification up until 10th October 2019. Any information from you will be disposed of and will not be used in the report.

If you have any questions regarding the study, please do not hesitate to contact me on the details below and I will be happy to address any concerns or questions you may have.

Researcher details

Beth Collinson

Researcher

Sheffield Hallam University

b.collinson@shu.ac.uk

01142 252639

Supervisor details

Professor David Best

Sheffield Hallam University

d.best@shu.ac.uk

01142 255435

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The University undertakes research as part of its function for the community under its legal status. Data protection allows us to use personal data for research with appropriate safeguards in place under the legal basis of public tasks that are in the public interest. A full statement of your rights can be found at: <https://www.shu.ac.uk/about-this-website/privacy-policy/privacy-notices/privacy-notice-for-research>

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Contact Details:

Details of who to contact if you have any concerns or if adverse effects occur after the study are given below:

You should contact the Data Protection Officer if:

- you have a query about how your data is used by the University
- you would like to report a data security breach (e.g. if you think your personal data has been lost or disclosed inappropriately)
- you would like to complain about how the University has used your personal data

DPO@shu.ac.uk

You should contact the Head of Research Ethics (Professor Ann Macaskill) if:

- you have concerns with how the research was undertaken or how you were treated

a.macaskill@shu.ac.uk

Postal address: Sheffield Hallam University, Howard Street, Sheffield, S1 1WBT.
Telephone: 0114 225 5555

Appendix 10: Consent form

Consent form: How recovery capital differs by gender⁵²

Please answer the following questions by ticking the response that applies

	YES	NO
1. I have read the Information Sheet for this study and have had the details of the study explained to me.	<input type="checkbox"/>	<input type="checkbox"/>
2. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any point.	<input type="checkbox"/>	<input type="checkbox"/>
3. I understand that I am free to with withdraw from the study within the time limits outlined in the Information Sheet, without giving a reason for my withdrawal or to decline to participate in all aspects of the workshop without any consequences to my future treatment by the researcher.	<input type="checkbox"/>	<input type="checkbox"/>
4. I agree to provide information to the researcher under the conditions of confidentiality set out in the Information Sheet.	<input type="checkbox"/>	<input type="checkbox"/>
5. I wish to participate in the study under the conditions set out in the Information Sheet.	<input type="checkbox"/>	<input type="checkbox"/>
6. I consent to the information collected for the purposes of this research study, once anonymised (so that I cannot be identified), to be used for any other research purposes.	<input type="checkbox"/>	<input type="checkbox"/>
7 ⁵³ . I understand that the session will be audio recorded and transcribed, and that this will, be used for research purposes.	<input type="checkbox"/>	<input type="checkbox"/>

Date

Participants Name (Printed)

Participants Signature

Contact Details (Optional)

Researchers Name (Printed) Beth Collinson

Researchers Signature

⁵² Title of the thesis changed during write up and therefore now inaccurate on forms

⁵³ Included only on the consent form for Study 3 and Study 4

Appendix 11: Debrief

Debrief sheet

Thank you for engaging in this research project.

Who is doing the research?

My name is Beth and I am a PhD student from the Helena Kennedy Centre at the Department of Law and Criminology at Sheffield Hallam University. The research you have participated in will contribute to my PhD qualification.

What is the purpose of the research?

Aim of the questionnaire: To explore how recovery capital differs by gender⁵⁴. Recovery capital refers to the internal and external resources necessary for an individual to achieve and maintain recovery from substance misuse.

Objectives of the questionnaire: To identify factors which may aid the accumulation of recovery capital and assess gender differences.

How will my questionnaire data be used?

The data will be analysed and the findings written up into a PhD thesis and may be used for other academic purposes, like publications of papers and books.

Can I change my mind after participating?

Yes! If you change your mind about your data being used in this way after completion - then please get in touch with me (contact details overleaf) before the data provided on the information sheet. I will delete your data and ensure it is not included in the research. I am more than happy to do this - so please do get in touch with me should you have second thoughts.

⁵⁴ Title of the thesis changed during write up and therefore now inaccurate on forms

What if the questionnaire brings up uncomfortable feelings?

If you feel worried, disturbed or unsettled by anything after participating in the research, some time, maybe even days after participating, or you feel that certain aspects of this have triggered negative emotions then you are very much encouraged to make contact with the support below that is freely available to you:

- The Samaritans of Sheffield: Call **0114 276 7277**
- Mind: Call **0808 801 0440** for advice on mental health and available support.
- Sheffield Alcohol Support Service: **01142 587553**

Any further questions about the research?

If you would like any further information about the research, please contact

Beth Collinson

E-mail: b.collinson@shu.ac.uk

Post: 1.05 Heart of the Campus, Sheffield Hallam University, Collegiate Crescent,
Sheffield, S10 2BP

Telephone: 01142 252639

Or, if you wish to contact someone other than the researcher, please contact my supervisor

Professor David Best

E-mail: D.Best@shu.ac.uk

Telephone: 0114 225 5435

Thank you again for your participation.

Appendix 12: An overview of the groups run at SASS

Moodmasters: Moodmasters is founded on the premise of cognitive based therapy. Each session run through SASS is designed to focus on a particular mood, feeling, or specific topic which may be related to alcohol use or recovery, such as depression or anxiety.

Arts and Crafts: An arts and crafts based group which allows individuals to express their creativity through various artistic methods. These sessions were often externally facilitated.

Active Citizenship⁵⁵: A series of four workshops that new ARC members were expected to attend. The aim of these were two fold. Firstly, aiming to make individuals view themselves as assets and secondly, promoting the importance of engagement in community resources. At the end of the four workshops, individuals were encouraged to host a one off event (examples included a bingo night for ARC members and a tabletop sale of items made in the arts and crafts group).

Men's group: A men's only group where male ARC members would engage in an activity in the community together. Examples include a walk in the peak district or fishing trip.

SASSY ladies: A women's only group where female ARC members would engage in an activity in the community together. Examples include a spa day or trip to Chatsworth market.

SMART: SMART (Self Management and Recovery Training) is a programme that provides training and tools for people who want to change their behaviour. Sessions are run by a facilitator, who often has first-hand experience of substance use themselves. The programme is built on principles of cognitive behaviour therapy and motivational techniques (SMART recovery, 2021)

Ladies only SMART: As above although these SMART sessions are only hosted for women.

Drop in: An informal session, run by SASS volunteers, which ARC members can attend to socialise with recovery peers or gain support from volunteers.

⁵⁵ These sessions are no longer held at SASS in the same form that they existed in during the collection of data for the thesis

Appendix 13: Principal components analysis of the community engagement scale

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	2.026	50.660	50.660	2.026	50.660	50.660
2	.898	22.456	73.116			
3	.620	15.498	88.614			
4	.455	11.386	100.000			

Extraction Method: Principal Component Analysis.

Component Matrix^a

	Component 1
Barriers reverse scored (old 0 is now 17) Time 1	.737
Other groups reversed scored 1	.559
Are you satisfied with your community engagement	.722
ActiveCitizen	.806

Extraction Method: Principal Component Analysis.

a. 1 components extracted.

Appendix 14: Backwards linear regressions models to predict recovery capital at Time 1

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	Change Statistics			Sig. F Change
						F Change	df1	df2	
1	.499 ^a	.249	.168	11.26565	.249	3.066	4	37	.028

a. Predictors: (Constant), 1.1 Gender, Support measure, time 1, Quality of life and satisfaction, time 1, CE scale Time 1

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients Beta	t	Sig.	95.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error				Lower Bound	Upper Bound	Tolerance	VIF
1	(Constant)	22.563	9.713		2.323	.026	2.881	42.244		
	Quality of life and satisfaction, time 1	.245	.128	.365	1.916	.063	-.014	.504	.559	1.788
	CE scale Time 1	.118	.641	.038	.185	.854	-1.180	1.417	.488	2.050
	Support measure, time 1	.437	.424	.172	1.031	.309	-.422	1.297	.728	1.374
	1.1 Gender	-2.921	3.596	-.118	-.812	.422	-10.208	4.365	.970	1.031

a. Dependent Variable: NEW Overall RC time 1

Appendix 15: Backwards linear regressions models to predict recovery capital at Time 2

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	Change Statistics			Sig. F Change
						F Change	df1	df2	
1	.625 ^a	.391	.312	13.63177	.391	4.971	4	31	.003

a. Predictors: (Constant), Total no. of domains (out of 4) individual is engaged with TIME 2, Quality of life and satisfaction, time 2, 1.1 Gender, CE scale Time 2

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error	Beta			Lower Bound	Upper Bound	Tolerance	VIF
1	(Constant)	7.605	13.841		.549	.587	-20.623	35.833		
	1.1 Gender	-2.253	4.900	-.069	-.460	.649	-12.247	7.741	.884	1.131
	Quality of life and satisfaction, time 2	.213	.155	.223	1.372	.180	-.103	.529	.746	1.340
	CE scale Time 2	1.190	.719	.277	1.655	.108	-.277	2.658	.703	1.423
	Total no. of domains (out of 4) individual is engaged with TIME 2	6.350	2.201	.418	2.885	.007	1.861	10.840	.936	1.068

a. Dependent Variable: NEW Overall RC time 2

Appendix 16: Resources listed by the cohort within the ABCE workbooks

Domain	Professional services	Peers and mutual aid	Sports, recreation and arts	Education, employment and training
Resources listed	<ol style="list-style-type: none"> 1. Cathedral Archer project 2. South Yorkshire Housing 3. Drink Wise Age Well 4. Together Women 5. START 6. Phoenix Futures 7. Mind 8. Argel House 9. St Wilfrid's 10. SASS 11. GP 12. Acorn rehab 	<ol style="list-style-type: none"> 1. Kickback Recovery 2. Mind café 3. Solace ladies 4. SMART 5. Drop in at SASS 6. Moodmasters 7. AA 8. NA 9. SASSY ladies 10. Straight Ahead 11. Saturday social at SASS 	<ol style="list-style-type: none"> 1. Bingo 2. Yorkshire arts space 3. Showroom cinema 4. Park run 5. Ship shape 6. Crowded House church 7. Cooking classes at Grace Food Bank 8. Bowling 9. De Hood 10. Recovery Games 11. Quiz at SASS 12. Football 13. Gym 	<ol style="list-style-type: none"> 1. Hillsborough College 2. Northern College 3. Hospital mentor scheme 4. Ambassador scheme 5. Volunteer, who me? 6. Waypoint 7. REC-CONNECT 8. Mentor training 9. Families Together 10. Active Citizenship

	13. SEAPS		14. Rages to Riches 15. Arts and craft 16. Peak climbing group 17. MMA 18. Cycling 19. Yoga 20. Thursday Project 21. Ride to recovery 22. Walking group 23. Ironing at St Mary's 24. Baby group	
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