An Evaluation of a Local Authority Addiction Recovery Provision: The Impact of Change on Service Users

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A Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

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September 2019

Abstract

The character and focus of drug and alcohol services has seen major changes in the last decade. The period 2005-8 saw a shift away from dominant harm minimisation approaches to those advocating a recovery focus. By 2011 a drive for abstinence was fundamental to service delivery. The commissioning of drug and alcohol services also changed with the implementation of the Health and Social Care Act in 2012; local authorities now have more powers to determine how health services should be commissioned and re-commissioned to provide 'population focused' health provision. This research investigated how concepts of recovery were implemented within addictions recovery services in one locality in the North East of England and how the changes to service through regular re-commissioning affected the recovery journeys of those attending the services and the staff delivering recovery provision.

Sequential qualitative design was adopted, comprising of a systematic literature review of qualitative evidence of facilitators and barriers to recovery from addiction and semi-structured interviews and thematic analysis of data from service users, service staff, service managers and a service commissioner. Normalisation Process Theory (NPT) was used to frame interviews and interrogate the qualitative data.

Multiple factors facilitate or hamper recovery success, including ability to identify with others, creation of a non-addict identity, access to positive peer support and meaningful activities and avoiding the 'cliff edge' of treatment services. The use of NPT indicates that changes in service delivery, although inevitable, must consider certain criteria (including supportive routines / staff changes / consultation with service users / service location and layout) to prevent detrimental effects on recovery.

Recovery is a complex and non-linear process that can be impacted by numerous domains. Maintenance of routine, support of bonds with other service users and staff and encouragement to have ownership of their own future are all aspects important in creating a sustainable recovery.

Acknowledgements

As the last seven years now draw to a close,

The tiredness of my eyes and the grey hairs start to show,

The journey comprised a roller-coaster of highs and lows,

Yet I still sit here smiling whilst these comments are composed,

When I started this voyage my son was a boy,

Now as an adult he has his own journey to enjoy,

I hope the times he watched me at my studying regime,

Inspires him to keeping fighting and to always dream,

With the 'hobby' almost over, a social life may now be shared,

But not before some words of thanks are declared.

I am beholden to Durham Constabulary for their faith and support in me. Without the ongoing support I would not have been able to work full-time, raise a family and complete my PhD. I am also indebted to Durham County Council for their financial support for this PhD research. Dr Claire Sullivan was fundamental in gaining the finances, so for this a huge thanks to Claire!

Special thanks must go to my outstanding supervisory team. To Prof. Dorothy Newbury-Birch, you may have beaten into me a love of systematic reviews (although I may not embark on another one till I recover from the last). To Prof. Luke Vale, thank you for keeping me motivated when my doubts set in – and thank you for distracting me with horse talk when required. To Prof. Janet Shucksmith – thank you for your ongoing support throughout, especially for helping me get my head around the world of

theory (not that I'm sure I will ever fully understand) - I will miss our supervisor coffee shop meetings – in particular the cake and your dogs!

Thank you to my family and friends – who often offered a much needed distraction, tea making facilities and a coffee and a chat, (although my mam has still not made that spice loaf she kept promising…). Finally, last but not least, I thank my hairy, furry and shelled family – although they will never read this thesis I need them to know how they kept me sane throughout (even though certain ones walked across the laptop keyboard inserting nonsensical letters into my text).

Of course none of this would have been possible without my magnificent participants – I cannot thank you enough for sharing your thoughts and stories with me! I met some wonderful and inspiring people and truly hope to see you all again on the next Recovery Walk.

"*It does not matter how slowly you go as long as you do not stop*"
(Confucius)

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List of Acronyms

AA	Alcoholics Anonymous
ABCD	Asset Based Community Development
ACPO	Association of Chief Police Officers
ARP	Alcohol Rolling Programme
CASP	Critical Appraisal Skills Programme
CCGs	Clinical Commissioning Groups
CGL	Change Grow Live
CIC	Community Interest Company
CSAT	Centre for Substance Abuse Treatment
CPN	Community Psychiatric Nurse
DACT	Drug and Alcohol Commissioning Team
DALYs	Disability Adjusted Life Years
DISC	Developing Initiatives Supporting Communities (now called Humankind)
DRAW	Durham Recovery And Wellbeing centre
ESA	Employment and Support Allowance
LA	Local Authority
LSOA	Lower layer Super Output Area
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring Service
NECA	North East Counselling for Addictions
NHS	National Health Service
NPT	Normalisation Process Theory
OST	Opiate Substitution Treatment
PCP	Pioneering Care Partnership

PCT	Primary Care Trust
PICO	Population, Intervention, Comparator, Outcome
PHE	Public Health England
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
RAD	Recovery Academy Durham
REBT	Rational Emotional Behavioural Therapy
RSPH	Royal Society for Public Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SDP	Structured Day Programme
SIMOR	Social Identity Model Of Recovery
SIT	Social identity Theory
SMART	Self-Management and Recovery Training
SMOG	Simple Measure of Gobbledegook
SPICE	Setting, Perspective, Intervention, Comparison, Evaluation
TA	Thematic Analysis
TC	Therapeutic Community
TSG(s)	Twelve Step Group(s)
TUPE	Transfer of Undertakings Protection of Employment
UK	United Kingdom
WHO	World Health Organisation

Chapter 1. Introduction

1.1 Chapter Overview

This doctoral thesis presents a qualitative study of the views of addiction service users, service staff and a service commissioner towards types of service provision and the frequent changes to services necessitated by the commissioning process. The research took place between 2012 and 2019, during which time the landscape of commissioning of these services changed. The responsibility for the commissioning of addiction services shifted from Primary Care Trusts (which were abolished during the research time frame) to Local Authority. The initial and main focus of this research was alcohol dependence, specifically examining an alcohol abstinence service that was commissioned under the then Primary Care Trust. However, following the changes to service delivery within the Local Authority where the research was based (the service evolved to cover both drugs and alcohol combined within the same delivery process), the second phase included alcohol and substance addiction, albeit the main focus was still on abstinence, as the services where both phases of research were conducted were grounded in the delivery of abstinence based principles to recovery.

This chapter will first look at the prevalence of alcohol and drug misuse in the UK and globally and the magnitude of the impact of these economically, before moving on to look at how services have been designed and commissioned to address these problems.

1.2 The Prevalence of Alcohol and Drug Problems for Western Societies

1.2.1 Alcohol Use

The harmful use of alcohol is considered a prominent risk factor for poor health globally, accounting for 3 million deaths in 2016 (5.3% of all deaths) and 132.6 million disability adjusted life years (DALYs) (World Health Organisation, 2018). However, global figures can be misleading, since the use and abuse of alcohol is strongly skewed towards some societies. Less

than half the worlds' population overall consumes alcohol (3.1 billion aged over 15 years of age abstaining in the previous 12 months). However, alcohol is consumed by more than half the population in three World Health Organisation (WHO) regions: the Americas, Europe and Western Pacific (World Health Organisation, 2018). Within England, alcohol misuse 'is the biggest risk factor attributable to early mortality, ill-health and disability for those aged 15 to 49 years; for all ages it is the fifth most important' (Public Health England, 2016 p.14).

The importance of dealing with alcohol issues is not simply a modern concern (overall dating back centuries (Hogarth, 1751)). However, rising standards of living, changes in the licensing laws, along with the increased commercialisation of drinking has brought about a different landscape of consumption. The emphasis on identifying and treating hazardous and harmful alcohol consumption in primary care settings has increased over the last two decades. (Carrington Reid, Fiellin and O'Connor, 1999), with alcohol related issues representing immense economic loss (financially and at a societal harm level) to populations around the globe (Babor, Higgins-Biddle, Saunders and Monteiro, 2001). The impact on a societal level includes the increased possibility of risky sexual experiences linked to alcohol consumption (Sullivan, Martin, White and Newbury-Birch, 2017) and the association between alcohol use and crime (Newbury-Birch, Ferguson, Landale, Giles, McGeechan, Gill, Stockdale and Holloway, 2018).

Literature relating to alcohol consumption often varies in the terms used to describe drinking levels and the risks associated. Hazardous drinking refers to a pattern of drinking that could place the consumer at risk of adverse health concerns, whereas harmful drinking is a pattern of consumption that directly relates to adverse health conditions (both physically and mentally and some would also consider social consequences among the harms) (Carrington Reid, Fiellin and O'Connor, 1999, O'Flynn, 2011, Babor, Higgins-Biddle, Saunders and Monteiro, 2001). For the purpose of this thesis harmful and hazardous drinking will be referred to as risky drinking and the focus of the thesis is on dependence.

1.2.2 Alcohol Dependence

Alcohol dependence is a:

> cluster of behavioural, cognitive, and physiological phenomena that may develop after repeated alcohol use. Typically, these phenomena include a strong desire to consume alcohol, impaired control over its use, persistent drinking despite harmful consequences, a higher priority given to drinking than to other activities and obligations, increased alcohol tolerance, and a physical withdrawal reaction when alcohol use is discontinued (Babor, Higgins-Biddle, Saunders and Monteiro, 2001 p.5)

In 2016-2017 there was an estimated 590,000 adults with alcohol dependency in England, a figure which has remained stable over the last five years, suggesting that, rather than a fall in prevalence, the figure more likely reflects a fall in numbers accessing treatment, with only one in five of those requiring treatment actually accessing it (Public Health England, 2018a). A recent study examining the prevalence of alcohol conditions in UK hospitals found that one in five hospital patients use alcohol harmfully and one in ten are alcohol dependent (Roberts, Morse, Epstein, Hotopf, Leon and Drummond, 2019). Within County Durham in this time frame (April 2017 to March 2018), there were 1,101 people accessing treatment for alcohol only and a further 367 for non-opiate and alcohol misuse (National Drug Treatment Monitoring System, 2019a) (note these figures are likely to include risky drinkers as well as dependent drinkers).

1.2.3 Drug Use

Illicit drug use is also associated with significant harm to health worldwide, The Global Burden of Disease Study found that approximately 585,000 people died and 42 million years of “healthy” life were lost as a result of drug use in 2017 (52% of the deaths relate to untreated hepatitis C, 29% attributed to drug use disorders and 11% to HIV / AIDS), both lives lost and “healthy” life lost relate especially from the use of opioids (United Nations Office on Drugs and Crime, 2018). Around 5.6% of the world’s population (275 million), between the ages of 15 and 64 used drugs at least once during 2016, with 31 million suffering drug use disorders (United Nations Office on Drugs and Crime, 2018).

Research conducted in the UK found that heroin, crack cocaine and methamphetamine were the most harmful drugs to individuals, whereas alcohol, heroin and crack cocaine were the most harmful to others; overall alcohol was found to be the most harmful drug, with heroin being in second place (Nutt, King and Phillips, 2010).

During the reporting year 2016 to 2017, people in treatment for opiates accounted for over half the overall population in treatment (53%) (Public Health England, 2018a). Between April 2017 and March 2018 there were 1,497 people accessing treatment in County Durham for opiate use (National Drug Treatment Monitoring System, 2019a). These individuals had the lowest rate of successful exits (successfully completing the treatment regime free from addiction), at just 26% (Public Health England, 2018a).

1.3 Changes to Service Delivery Policies

Over the years, various approaches have been proposed in an attempt to reduce the harms that alcohol and drugs do to individuals and their families and to contain the costs to society of such behaviour. Trends in treatment types are identifiable and can be tracked through the patterns of service commissioning.

1.3.1 *Enter the Recovery Agenda*

The UK Advisory Council on the Misuse of Drugs, 1988 report entitled "Aids and Drugs Misuse" contained, according to McKeganey (McKeganey, 2011), a "16 word sentence that virtually changed the entire direction of UK government drugs policy":

> The spread of HIV is a greater danger to individual and public health than drug misuse. ((Advisory Council on the Misuse of Drugs, 1988) cited in (McKeganey, 2011))

The practice of harm reduction or harm minimisation (meaning acceptance of an individual's choice to take drugs, whilst attempting to avoid personal or social harms emanating from the practice) came to dominate the treatment landscape from the 1980s onwards, having gained momentum

by reducing HIV threats linked to the sharing of needles (Canadian Paediatric Society, 2008).

The field of harm minimisation acquired further impetus with advice and education programmes aimed at reducing the potential harms caused by party drugs in the 1990s (Wardle, 2012, Duff, 2005). Wardle identified two factions within the harm minimisation movement, at play during the 1980s and 1990s:

> on the one hand, a radical, public health wing…keen to "normalize" drug use as a mass phenomenon, ethically indistinguishable from other mass forms of legal drug use…this evolving and developing public health approach to harm reduction championed a non-judgemental approach…[However] this approach…was displaced, marginalised and neutralized by the growth and development of a more pragmatic, stigmatizing form of harm reduction based on the newly evidenced conviction that a massive expansion of methadone maintenance treatment would significantly reduce acquisitive crime (Wardle, 2012 p.295)

The result of these approaches was that the number of individuals in drug treatment had more than doubled between 1998 and 2008 (from 85,000 to 207,580), with over 70% of identified drug users in treatment being prescribed methadone (McKeganey, 2011). The National Treatment Agency (NTA) announced, at its summer conference in 2005, that targets set within UK National Strategy, i.e. the ten year treatment plan, had been achieved (deeming the programme a success). However, questions began to be raised regarding the UK drug treatment system (Wardle, 2012). The main focus of this criticism was aimed at notions of methadone maintenance; following research in 2004 that interviewed 1007 drug users, and in which the majority of participants stated that their primary focus for seeking treatment was to become drug free (McKeganey, 2011). This questioned the foundations of maintenance, suggesting a focus towards abstinence should be considered.

Between 2005 and 2008 a shift began within the substance treatment field ('substance' at this point referring to drugs rather than including alcohol); the previous process of harm minimisation as the main focus for treatment plans was gradually replaced with notions of 'recovery', following what

Wardle claimed was a ‘full frontal assault’ on harm minimisation approaches (Wardle, 2012 p.294). By 2008 the Scottish nationalist government announced a new drug strategy that placed the essence of recovery at the base of its strategy (McKeganey, 2011). Shortly after, England’s Minister for Public Health announced that abstinence must be the primary objective of treatment services (McKeganey, 2011). The premise of abstinence became a clear focal point of the 2010 coalition government strategy on drug treatment services (Home Office, 2010). *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*, (2010) was released as the Government strategy for tackling drug abuse. The 2010 Drug Strategy was structured around three themes: Reducing Demand; Restricting Supply; and Building Recovery (Home Office, 2010). The key policy objectives was to reduce demand for illicit drugs by preventing use and restricting supply into the UK; Support those dependent on drugs and alcohol to recover, ensuring more people are tackling their dependence, recovering fully and contributing to society (Home Office, 2010).

DrugScope, a UK based charity which aimed to inform the public about drugs, reduce drug-related harms and shape policy, provided a response to the 2010 UK Drug Strategy (DrugScope closed in March 2015). DrugScope applauded the focus on recovery and social (re)integration and the acknowledgment in the Drug Strategy that recovery requires a holistic approach (DrugScope, 2010).

Within the UK Drug Strategy alcohol dependence was also considered ‘where appropriate’, as acknowledgment that recovery from severe alcohol dependence raises similar concerns to those involved in drug misuse treatment, with the treatment providers for both drug and alcohol often being ‘one and the same’ (Home Office, 2010 p.3). By 2011, it was recognised that nearly 7,000 deaths were directly attributed to alcohol, a rise of 26% since 2001 (Health and Social Care Information Centre, 2013).

1.3.2 Recovery Approaches

‘Recovery’ approaches to drug and alcohol addiction sit within a family of methods known as ‘asset-based approaches’ and are in stark contrast to

previously highly medicalised interventions to remedy addiction. Asset-based approaches to recovery from substance misuse derive from an approach to community development and public health known as Asset-Based Community Development (ABCD) (Kretzmann and McKnight, 1993). In contrast to prevailing 'top down' solutions to social and health problems, ABCD aims to empower and encourage communities to drive their own solutions, enhancing sustainable community-driven development (Kretzmann and McKnight, 1993). Social relationships, and the systems, norms and trust that exist within a community, are fundamental to ABCD; it is these networks that create social capital (The Asset Based Community Development Institute). The notion of 'recovery capital' is closely linked to that of social capital. Recovery capital describes the quantity and quality of internal and external resources that an individual can draw upon to promote and sustain recovery (Granfield and Cloud, 1999).

Key notions of recovery relate to building the four components of capital (social, physical, human and cultural), alongside developing a motivation in the individual for change. Social capital stems from belonging to supportive relationships and groups, physical capital develops from access to financial resources, human capital relates to attitudes, health and skills and education that the individual possesses and cultural capital derives from wider societal norms and values (Cloud and Granfield, 2008, Best, McKitterick, Beswick and Savic, 2015).

Individuals are said to recover through a series of discrete decisions and as part of a gradual process. However, achieving recovery is different to maintaining active recovery (Henwood, Padgett, Smith and Tiderington, 2012). Treatment of addiction may initiate recovery, however, there are additional influences external to treatment that assist (or prevent) individuals in sustaining their recovery in the long term (Best, McKitterick, Beswick and Savic, 2015). In this context recovery is a journey and not an event, and can take approximately five years before being considered to be self-sustaining (Cano, Best, Edwards and Lehman, 2017). Stages of recovery can be roughly defined as 'early sobriety' (first year of abstinence), 'sustained recovery' (1-5 years) and 'stable recovery' (5 or more years abstinent) (Groshkova, Best and White, 2013).

Pivotal events and key people can influence the success of recovery pathways. For instance, maintaining recovery often requires stability of housing, continuing relationships with significant others, and sustained motivation (Henwood, Padgett, Smith and Tiderington, 2012). Thus whilst internal factors like agency, self-efficacy and, empowerment, are key drivers in recovery (Neale, Nettleton and Pickering, 2013), external factors (aspects of social and physical capital) must also be in place for a 'successful' recovery pathway (Duffy and Baldwin, 2013). 'Success' comes from being in recovery or taking steps towards recovery (Farquhar, Ryder, Henderlong, Lowe and Amann, 2014) and learning to 'like yourself' (Waters, Holttum and Perrin, 2014): it is about freedom from dependency - an 'internal awakening' (Yeh, Che, Lee and Horng, 2008 p.921). Individuals become empowered in their recovery journey, each offering support for those newer to recovery than themselves.

The recovery-orientated systems of care (ROSC) model is characterised by 'networks of organisations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders' (Sheedy and Whitter, 2009 p.3). ROSC provides a more holistic approach to recovery, using a coordinated multi-system methodology, focussing on sustained recovery management and places the individual at the centre of the care (Sheedy and Whitter, 2009). Promoting and developing ROSC is a priority for Substance Abuse and Mental Health Services Administration (SAMHSA) (Sheedy and Whitter, 2009). In 2005, SAMHSA's Centre for Substance Abuse Treatment (CSAT) convened a National Summit on Recovery where delegates (including policymakers, clinicians, and consumers) agreed on the following definition of recovery: 'Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life'(Sheedy and Whitter, 2009 p.1). Twelve guiding principles emerged from the summit, these principles were intended to provide direction to SAMHSA / CSAT, along with other stakeholders, as the field shifted towards ROSC. The twelve principles were:(Sheedy and Whitter, 2009).

1) There are many pathways to recovery.

2) Recovery is self-directed and empowering.
3) Recovery involves a personal recognition of the need for change and transformation.
4) Recovery is holistic.
5) Recovery has cultural dimensions.
6) Recovery exists on a continuum of improved health and wellness.
7) Recovery emerges from hope and gratitude.
8) Recovery involves a process of healing and self-redefinition.
9) Recovery involves addressing discrimination and transcending shame and stigma.
10) Recovery is supported by peers and allies.
11) Recovery involves (re)joining and (re)building a life in the community.
12) Recovery is a reality.

Summit participants agreed that 'there will be no wrong door to recovery' and that ROSC need to provide 'genuine, free and independent choice' (Sheedy and Whitter, 2009 p.2). The following 17 features of ROSC were identified:

1) Person centred;
2) Inclusive of family and other ally involvement;
3) Individualised and comprehensive services across the lifespan;
4) Systems anchored in the community;
5) Continuity of care;
6) Partnership-consultant relationships;
7) Strength-based;
8) Culturally responsive;
9) Responsiveness to personal belief systems;
10) Commitment to peer recovery support;
11) Inclusion of the voices and experiences of recovering individuals and their families;
12) Integrated services;
13) System-wide education and training;
14) Ongoing monitoring and outreach;
15) Outcomes driven;

16) Research based; and
17) Adequately and flexibly financed.

(Sheedy and Whitter, 2009)

The ROSC features highlight an individualised and integrated provision that involves family and the wider community in the recovery practices. In addition, the importance of continuity of care is featured, suggesting a continuous transition from service support into community support is beneficial.

The recovery orientated approach moves away from 'treating' substance misuse through the use of prescriptions, and moves towards a holistic approach, where recovery from dependence becomes the priority (Home Office, 2012). In 2016, the Royal Society for Public Health (RSPH), described a 'new vision for a holistic public health-led approach to drugs policy at a UK-wide level' (Royal Society for Public Health, 2016 p.4). This vision stated it was 'artificial and unhelpful' to divide drugs, asserting that '"drugs" are not just those substances that are currently illegal. They also include socially-embedded legal substances, such as alcohol and tobacco…At both individual and population level, alcohol and tobacco cause far greater harm to health and wellbeing than many of their illegal counterparts' (Royal Society for Public Health, 2016 p.4). Drug and alcohol services are often integrated under the recovery approach. Furthermore, assistance with housing, education and training, and family/relationship support are often offered alongside addiction support.

1.4 Service Commissioning

> 'Commissioning is the process by which health and care services are planned, purchased and monitored…Commissioning comprises a range of activities, including: assessing needs, planning services, procuring services [and] monitoring quality…The concept of commissioning was introduced into the NHS in the early 1990s, when reforms separated the purchasing of services from their delivery, creating an "internal market". It was argued that making providers compete for resources would encourage greater efficiency, responsiveness, and innovation' (The Kings Fund, 2019 www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing [accessed 1/6/19]).

Commissioning responsibilities lie with Clinical Commissioning Groups (CCGs), NHS England and Local Authorities, Table 1.1 describes the role of these organisations, along with the finances allocated from the NHS England overall budget for the running of the health service (The Kings Fund, 2019):

Table 1.1 Commissioning Organisations

Commissioning Organisation	Commissioning Responsibilities	Financial Allocation
Clinical Commissioning Groups (CCGs)	Urgent and emergency care, Acute Care, Mental Health Services, Community Services, (Increasingly involved in commissioning primary care and some specialised services)	£85.4 billion (2017 / 2018)
NHS England	Neonatal services, Treatments for rare cancers, Primary care (including GPs, pharmacists, dentists and opticians (although these are beginning to be shared with CCGs) Immunisation and screening programmes Health care for prisoners and those in secure units Health care for some armed forces services	£24.5 billion (2017 / 2018)
Local Authorities (LAs)	Publically funded social care services (including services delivered to people in their own homes as well as residential care services) Since 2013, LAs have been responsible for many public health services including sexual health services, school nurses, health visitors and addiction services	£21.3 billion (Social Care Services) (2017 / 2018) £3.1 billion (ring-fenced public health grant for 2019 / 2020)

The period in which the thesis was undertaken was one of unprecedented upheaval, financial austerity measures and major administrative alignments, all of which combined to cause a re-examination of the ways in which services were offered. Analysis by the Health Foundation shows a '£900m real terms reduction in funding between 2014/15 and 2019/20. The core public health grant has fallen by a quarter (25%) per person since 2014/15' (The Health Foundation, 2018 www.health.org.uk/news-and-comment/news/new-reductions-to-the-public-health-grant-will-heap-more-pressure-on-local [accessed 9/9/19]). Troublingly for public health, 'these funding cuts come at a time when life expectancy improvements are stalling and inequalities are widening,' (The Health Foundation, 2018 www.health.org.uk/news-and-comment/news/new-reductions-to-the-public-health-grant-will-heap-more-pressure-on-local [accessed 9/9/19]).

The provision of accessible, affordable treatment services can reduce harmful consequences of substance misuse (World Health Organisation, 2018). Treatment services vary from relatively demedicalised services such as peer support based programmes such as the 12-step model, to more medicalised substitute prescribing and / or inpatient detoxification. The 12-step model is used by both alcohol and drug dependent individuals, peer groups (Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) etc.) and service providers and consists of following a program of personal recovery, whereby an individual works through a series of steps (with the help of peer support). The steps are described in appendix A and can be found in (Mooney, Dold and Eisenberg, 2014). Other models such as Self-Management and Recovery Training (SMART) are also utilised within recovery provision, SMART uses a four point training programme of Building and maintaining motivation, Coping with urges, Managing thoughts, feelings and behaviours and Living a balanced life (UK SMART Recovery, 2019).

There is some variety across the UK in how drug and alcohol services are commissioned. Prior to 2012 drug and alcohol services in England were jointly commissioned by the NHS and local authorities. In 2012 the Health and Social Care Act meant that local authorities became solely responsible for the commissioning of these services. In Scotland,

legislation was introduced in 2016 that created an integrated system of health and social care, with Integrated Authorities responsible for the delivery of localised provision. Provision in Wales is delivered through area planning boards, commissioners and Local Health Boards. In Northern Ireland the service is provided through Locality Health and Social Wellbeing Improvement Teams (in partnership with Drug and Alcohol Coordination Teams). In the Republic of Ireland addiction counselling and treatment is delivered through Health Service Executive Local Health Offices.

In 2012, the *Government's Alcohol Strategy*, a strategy which calls for a 'radical change in the approach and seeks to turn the tide against irresponsible drinking' (HM Government, 2012) was published. Also within this strategy the notion of 'taking the right action locally' is raised. Here the policy describes allowing local businesses, communities and services to tackle alcohol in a way they feel fits the individual community culture (HM Government, 2012 p.10). The Health and Social Care Act 2012, introduced key changes into the service delivery forum, the responsibility for the commissioning of community based alcohol and drug services was passed to local authorities (Department of Health, 2011). On the 1st of April 2013 these changes came into effect: upper tier and unitary local authorities were now provided with a public health grant to deliver 'population focused' health provision such as sexual health and addiction services.

A year into the localised commissioning process, a review was conducted by Public Health England (PHE) and the Association of Directors of Public Health, which highlighted the following key themes:

- except where there had already been retendering exercises underway or recently introduced, 2013-14 had been a year of steady state for drugs and alcohol commissioning
- 2014-15 and 2015-16 were expected to see a focus on reassessing current service provision with the view to recommissioning services

- over 70% of respondents indicated that they were not planning to reduce funding in 2014-15. Of the 70%, over 50% reported no change, nearly 10% an increase in funding, while the remainder indicated uncertainty as to future plans

- the public health grant had not yet been announced for 2015-16. Fifty per cent of localities said they had not yet decided funding levels, but over 30% said that, in advance of the national funding announcement, they were not planning reductions

- there were planned realignments of resources between alcohol and drug services – with alcohol assessed as the greater need

- there was a focus on improving outcomes, continuing the move to a recovery model

- improved delivery and performance by providers was a clear aim in all recommissioning, with a focus on improving treatment completions

- many areas were exploring the integration of services – integration with alcohol services, and with wider services such as housing, younger people services, criminal justice, and local health delivery

- the involvement of public health and PHE had been welcomed, particularly the advice and support on commissioning. Further support from PHE on evidence based interventions was requested- particularly about the impact that investment in drug and alcohol services might have on improving wider health and wellbeing and reducing demand on other services

- the view of DrugScope, representing service providers, was similar to the views that had been expressed locally. There

was a focus on the volatility of funding during this time of change, the continuous drive to reassess and retender services, and the need for commissioners to understand the impact frequent tendering processes had on providers

- the Association of Chief Police Officers (ACPO) emphasised the value it places on the importance of effective drug treatment services to the criminal justice agenda and the need to ensure any reductions in investment or changes to current provision did not reduce the effectiveness of services, as this could prejudice the crime-reduction benefits of the current approach (Public Health England and the Association of Directors of Public Health, 2014).

As this demonstrates, the commissioning, and subsequently re-commissioning of services is a complex process, which involves continually assessing the needs of the local populations, striving to understand those needs and securing appropriate services to meet the needs, all within a set financial budget and all within a recognised time frame.

1.5 The Impact of Change

Research around the effects of the commissioning and re-commissioning of services in this field is still relatively new. Alcohol Concern were asked to undertake a review of alcohol services in England to examine the impact of the recent health and social care changes on service user journeys, commissioning, staff training and the needs of specific groups (Alcohol Concern, 2015). This research presented a number of key findings:

- More guidance from a national level is required
- The alcohol field remains enthusiastic about involvement in the debate about its future
- Gaps remain in meeting the needs of those individuals with a dual diagnosis for mental health and substance use
- Change resistant drinkers display complex behaviour – more direction and support is needed in this area

- Insufficient access to residential rehabilitation
- Staff working in the profession required further training
- The balance between commissioning competition and meeting the needs of service users presents problems
- The turnover of provision may cause breakages between services (non-specialists become unsure where to turn for service provision) (Alcohol Concern, 2015)

These findings suggest that commissioning has become problematic, potentially seated in wider historic issues around reforming the NHS to introduce market principles, creating a division between purchasers and providers. The Kings Fund highlights concerns relating to mounting deficits in the NHS budget (with two thirds of acute hospitals being in deficit in 2015) and reductions in local authority funding leading to 'cuts in social care, reducing access to services and increasing pressure on the NHS. With estimates suggesting a potential funding gap of more than £4 billion by 2020/21' (The Kings Fund, 2015 www.kingsfund.org.uk/publications/three-priorities-new-government?gclid=EAlalQobChMlworHjtiM5AIV04bVCh3DyAmvEAAYASAAEgJW6 D BwE [accessed 1/6/19]).

1.6 Rationale, Aims and Objectives

1.6.1 Rationale for the Research

The way in which drug and alcohol services have been commissioned and re-commissioned has changed in recent years. Therefore there is lack of evidence around how these recent changes affect service users and staff in alcohol and drug services. This doctoral study will take one locality, County Durham in the UK, and explore how these changes impact on service users and staff in that local authority.

Since 2011, County Durham has experienced four changes in the provision of alcohol services. The Durham Recovery and Wellbeing Centre (Time Point 1), was a dedicated alcohol recovery service in the centre of Durham, which was operational from September 2011 until the end of March 2015. In April 2015 Lifeline (TP2) took over the contract for alcohol (and drug) recovery. TP 3 relates to an interim service provider and TP 4

is the current provision (as at September 2019). These time points are discussed in more detail in Chapter 2.

1.6.2 Research Aims

The aim of this research is to explore factors that may inhibit or promote recovery from addiction within service delivery. In addition, it examines how changes to the commissioning and delivery of alcohol (and drug) services impact on service users and staff. Do changes in the treatment commissioning process jeopardise the normalisation and sustainability of recovery based models for treatment for alcohol misuse.

1.6.3 Research Questions

1. What does the literature, both from the UK and The Republic of Ireland tell us about the perspectives of service users and staff working within the addiction treatment and recovery arena?

A systematic review of qualitative evidence of service delivery approaches to recovery from addiction was carried out (Chapter 3). The review focused on the perspectives of service users and staff working within the addiction treatment and recovery arena.

2. What are the barriers and facilitators for service users in accessing alcohol and drug treatment / recovery and for the staff working within them?

In depth interviews were carried out with eight service users and three staff members at Time Point 1 (TP1) to ascertain barriers and facilitators to using the alcohol only service and perceptions of the change to a new service which incorporated drug and alcohol services. These interviews also explored how service users understand the issue of recovery capital and how service users felt about the notion of being ‘recovered’ in contrast to ‘in recovery’. In addition these interviews explored how service staff understood the issue of recovery capital, assisted service users in developing capital and how service staff perceived the notion of being ‘recovered’ in contrast to ‘in recovery’. Further interviews with seven service users, one service manager and one service commissioner were conducted at Time Point 3 (service users and staff had undergone 2

changes to service provision since TP1). TP3 interviews also looked to examine the barriers and facilitators for service provision.

In addition, themes uncovered in the systematic review also described barriers and facilitators to recovery within research conducted in other areas around the UK and the Republic of Ireland.

3. Does Normalisation Process Theory (NPT) provide a useful model to understand how clients and service delivery staff operate in community based North East service(s) for treating alcohol and drug misuse? For example:

- How are community based recovery methods of treatment of addiction **understood** (**coherence**) by patients / clients and service delivery staff in the context of the local service?
- Are treatment methods **believed** to be successful and are all staff and clients fully recruited to treatment using this recovery model (**cognitive participation**)?
- What **procedures** and **actions** are taken by service users and staff to deliver and receive treatment in this model (**collective action**)?
- Are staff and service users able to review the treatment model and adapt it to individual circumstances or contextual change, in order to ensure smooth running and sustainability (**reflexive monitoring**)?

Interviews from both phases were examined.

4. What are the recommendations for future commissioning of drug and alcohol services?

The findings from the study were reviewed and a set of recommendations produced for local authorities to consider when commissioning and delivering drug and/or alcohol services.

1.7 Structure of Thesis

The remainder of the thesis is arranged as follows: Chapter 2 provides an overview of the local structure of commissioning and delivery for addiction

services within the local authority where this research was conducted. Included in this chapter is a synopsis of each of the services that operated within the research timeframe and number of individuals in treatment, both nationally and in County Durham.

Chapter 3 is a systematic review of factors that promote or inhibit recovery from addiction, examining qualitative literature from the UK and the Republic of Ireland. This chapter includes the process of the review (inclusion / exclusion criteria, search strategy, screening and data extraction) as well as the results and key findings.

Chapter 4 provides the methodology and methods of the qualitative section of the research (interview phases). This chapter describes the research paradigm and the stages of research and analysis.

Chapters 5 and 6 describe the findings from the qualitative phases of research; Chapter 5 the interview results from DRAW (Durham Recovery And Wellbeing) centre members and staff and Chapter 6 the interview findings from RAD (Recovery Academy Durham) and community outlet service users, service manager and the service commissioner.

Chapter 7 is a synthesis of findings from Chapter 5 and 6 where prominent themes arising from the research are uncovered and placed within the wider research context of the systematic review findings. This chapter also discusses the use of NPT within the addiction services setting.

Chapter 8 provides a summary of the findings, followed by a return to the research aims and objectives. Recommendations for service delivery are also covered within this chapter. Chapter 8 closes with an overview of how the thesis contributes to research, discusses strengths and limitations and suggestions for future research. The thesis conclusion is then offered, followed by a full bibliography and appendices.

Chapter 2. Commissioning and Delivery of Addiction Services in County Durham

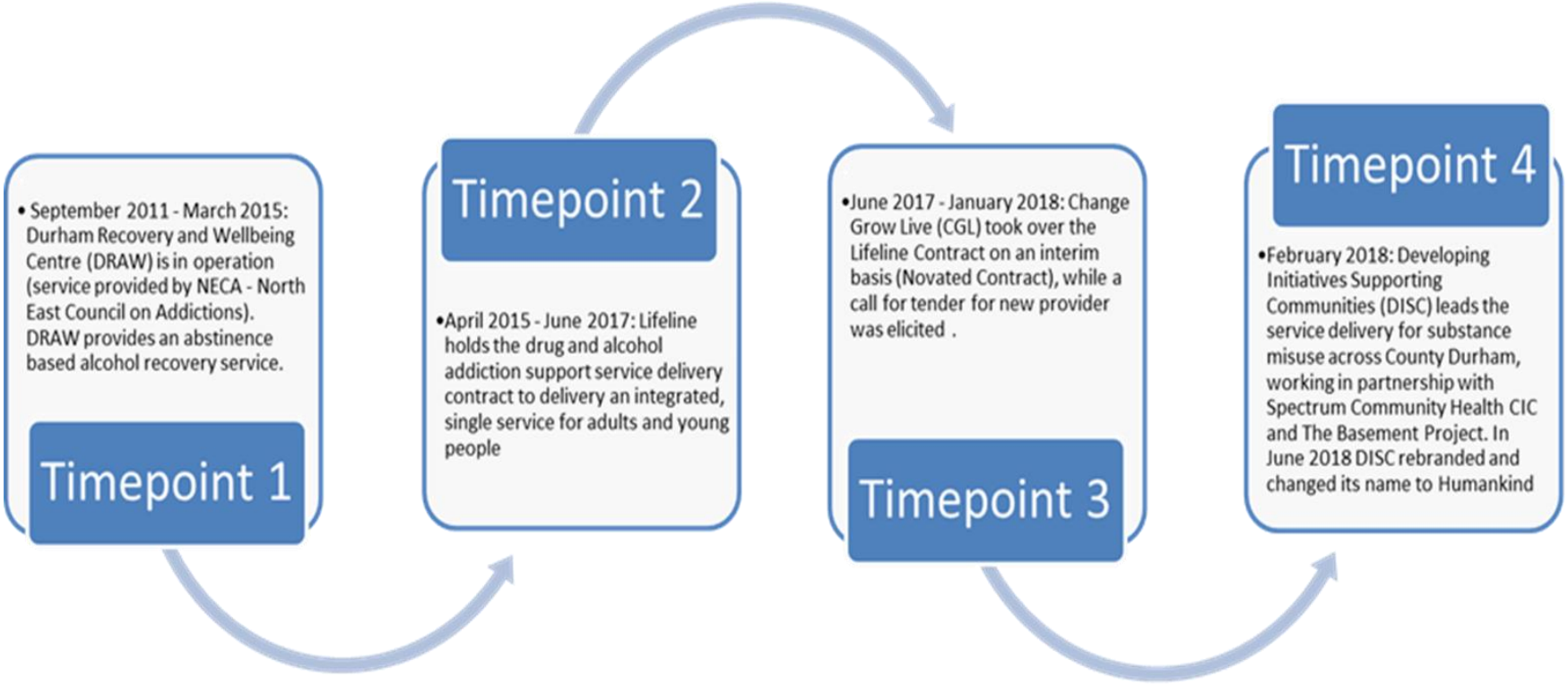
2.1 Chapter Overview

In this chapter, I will outline the background for the specific local study on which this thesis is based. County Durham is in socioeconomic decile 4 (where 1 is the most deprived and 10 is the least deprived Lower layer Super Output Areas (LSOAs)) (Public Health England, 2017). In 2016/2017, Durham ranked 14th out of 16 similar local authorities for alcohol treatment summary (1st is the best and 16th the worst), and was 7th for proportion of dependent drinkers not in treatment (with 79.4% not attending a service) (Public Health England, 2017). Although Durham was ranked as the best out of the 16 similar local authorities for the proportion of people waiting more than 3 weeks for alcohol treatment, it was ranked second worst for successful completion of alcohol treatment and for number of deaths in treatment (Public Health England, 2017). Regarding drug treatment, Durham ranked 5th out of 16 similar local authorities for drug treatment summary; 2nd for proportion of opiate users not in treatment; 8th for proportion waiting more than 3 weeks for drug treatment; 11th for successful completions and 10th for deaths in drug treatment (Public Health England, 2017).

2.2 Changes in Service

Since 2011, County Durham has experienced four changes in the provision of addiction services (as highlighted in Figure 2.1 below, which demonstrates 'Time Points' referred to in this research)

Figure 2.1 Addiction Service Delivery Changes in County Durham



The Durham Recovery and Wellbeing (DRAW) Centre (Time Point 1 (TP1)), was a dedicated alcohol recovery service in the centre of Durham City, which was operational from September 2011 until the end of March 2015. During this period a separate provision provided alcohol treatment (i.e. provision for those considering reducing alcohol, in need of harm minimisation advice or those looking to become abstinent and requiring detoxification or reduction process advice before entering DRAW); this service was called the Community Alcohol Service (CAS). In addition, during this time frame, further addiction services (drug and alcohol) were also provided by the Recovery Academy Durham (RAD). The RAD (which is still in operation in 2019), is a quasi-residential abstinence based program based on the 12-step model. The RAD offers a Structured Day Programme (SDP), which is described later in this chapter. More traditional approaches to addiction, including opiate prescription services and harm reduction support were also provided within County Durham during this time period, although only DRAW was specifically focused on for the first phase of this research. In April 2015, Lifeline (TP2) took over the contract in Durham for alcohol (and drug) recovery. TP 3 relates to the interim service Change Grow Live (CGL) that took over a contract of novation following the administration and insolvency of Lifeline in summer / autumn 2017. TP4 relates to the current provision (as of 2019), Humankind (formerly known as Developing Initiatives Supporting Communities (DISC).

2.3 Durham Recovery and Wellbeing Centre (Time Point 1)

DRAW was the first dedicated alcohol only recovery centre in County Durham. The centre first opened on the 1st September 2011. The centre was designed with aspects of the *Drug Strategy* 2010 in mind; recovery from addiction being fundamental to the strategy ‘An individual, person-centred journey, as opposed to an end state, and will mean different things to different people’ (HM Government, 2010 p.18). An ‘end state’ refers to the consensus that recovery is on-going, not a fixed point that an individual reaches at any given moment. Recovery is understood as a process requiring a holistic approach, with successful recovery involving building recovery capital (Granfield and Cloud, 1999). This approach is

supported by the Home Office strategy *Putting Recovery First – The Recovery Roadmap*: 'recovery should encompass real changes, including improved well-being, increased personal and social responsibility and freedom from dependence' (Home Office, 2012). This is a view also supported by the *Alcohol Strategy*: 'recovery goes beyond medical or mental health issues to include dealing with the wider factors that reinforce dependence, such as childcare, housing needs, employability and involvement in crime' (HM Government, 2012 p.25).

At the time when DRAW was first considered and developed (early 2011) County Durham Drug and Alcohol Commissioning Team (DACT) had responsibility for commissioning substance misuse services. The DACT commissioned two recovery focused centres within County Durham, one for substance misuse (located in Peterlee) and DRAW for alcohol (located in Durham City). The development of DRAW was based around community development principles, encouraging the centre members to promote recovery among themselves, their communities and to encourage engagement / re-engagement into their neighbourhoods (Wood, 2012).

> 'The ethos of the centre will be empowering individuals to move on with their lives...making a positive contribution to their families and communities with a focus on improving health and well-being, retraining, learning new skills, gaining employment, peer mentoring / volunteering opportunities or accessing further education' (Wood, 2012 p.15).

Fundamental to community development is the notion of empowering individuals and groups to exert power and influence over their own lives but also within their communities, encouraging them to fully engage and take ownership rather than being passive and powerless to enact change. In this context community development portrays similarities to the idea of social capital, where the emphasis is in growing and building social networks and improving relationships. It is as a result of the community focus that the term 'member' was used to describe those that attended the centre, giving them a feeling of belonging and ownership rather than using the more clinical term of 'client'.

Building links within the community was an initial focus for DRAW development; the first centre manager for DRAW was from an employment/training background and therefore facilitated links with training and employment providers. The building itself was chosen for its central location, being placed opposite the main bus station in Durham City, meaning that members could access the service with relative ease. The inside of the centre offered a spacious, non-clinical, light and 'homely' feel 'purposefully designed to be conducive to an individual's recovery' (Wood, 2012 p.25).

The contract for the management of DRAW was held by the North East Council for Addictions (NECA), which described itself as a regional charity providing those suffering with substance misuse problems and their families with support and a range of services (from advice about benefits to counselling and mediation). NECA staff were tasked with delivering the objectives for DRAW as set out by the then local NHS Alcohol Commissioning manager.

The DRAW Centre was a therapeutic, non-medical support centre that offered a range of structured advice, peer support, activities and employment and training opportunities, facilitating the development of relationships and promoting health and well-being.

2.3.1 Membership Criteria

The centre members all previously attended the Community Alcohol Service (CAS) or the Alcohol Rolling Programme (ARP) (a subsidiary of CAS), where they received treatment for alcohol dependency. CAS was the alcohol treatment service (that was in operation at the time of DRAW), which was delivered within local communities throughout County Durham. ARP was a programme delivered to offenders both within local prisons and in local communities.

The criteria for DRAW membership included:

- Referral through CAS or ARP
- Resident in Co Durham
- Be 18 or over

- Be maintaining abstinence and working towards positive outcomes (increased self-esteem, sense of hope)
- To promote the maintenance of a harmonious atmosphere in the Centre with no disruptive or abusive behaviour (Wood, 2012).

Following referral to the centre, prospective members could visit prior to attending (some may have already been familiar with the centre, as CAS often operated from a room in the building). On arrival for the first day of attendance a membership form would be completed, recording personal information and highlighting the rules and values of the centre. In addition, a fire safety induction would be conducted. Furthermore, an outcomes profile would be initiated, this collected data regarding quality of life and aspirations. The evaluation tool used to assess progress was the Alcohol Outcomes Star (Triangle Consulting and Alcohol Concern, 2010) (see figure 2.2). Progress would be re-evaluated at various points during the individuals membership at DRAW, with the star used to capture any progress (or reduction) in capital growth. Each point on the star represents an area of an individual's life they may wish to address, for each point there is a detailed ladder to help the individual ascertain where they are at that moment in time (see figure 2.3). The scores on the ladder provide the stages on each point on the star. The red line on the star is an example of where an individual may feel they are at entering the service, the green line is an example of where they may feel they are at exit or any given point for evaluation throughout their journey.

Figure 2.2: Alcohol Outcomes Star

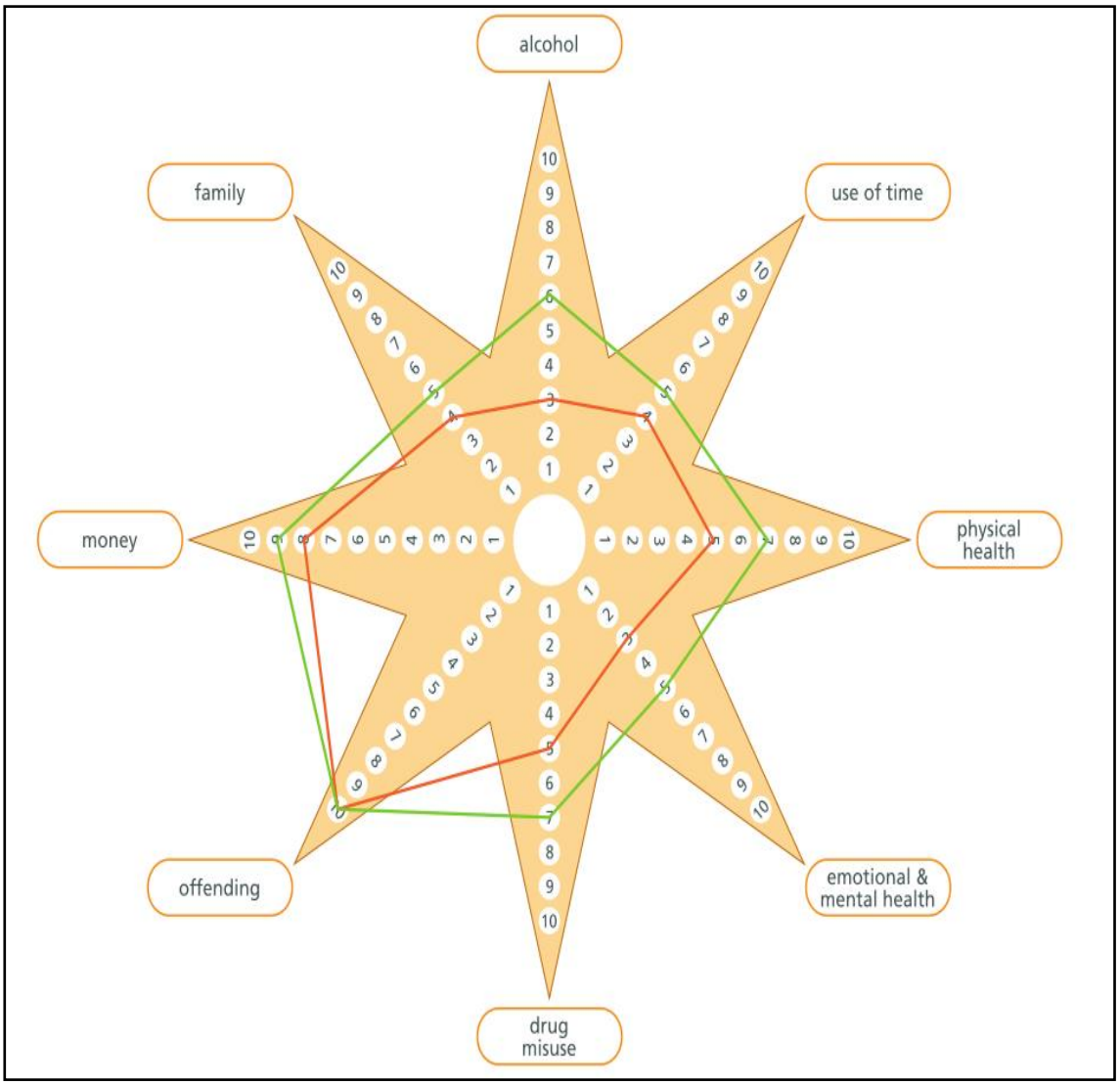


Figure taken from file:///C:/Users/ihslocaluser/Downloads/ALCOHOL-STAR-USER-GUIDE.pdf (Triangle Consulting and Alcohol Concern, 2010)

Figure 2.3:The Journey of Change Ladder

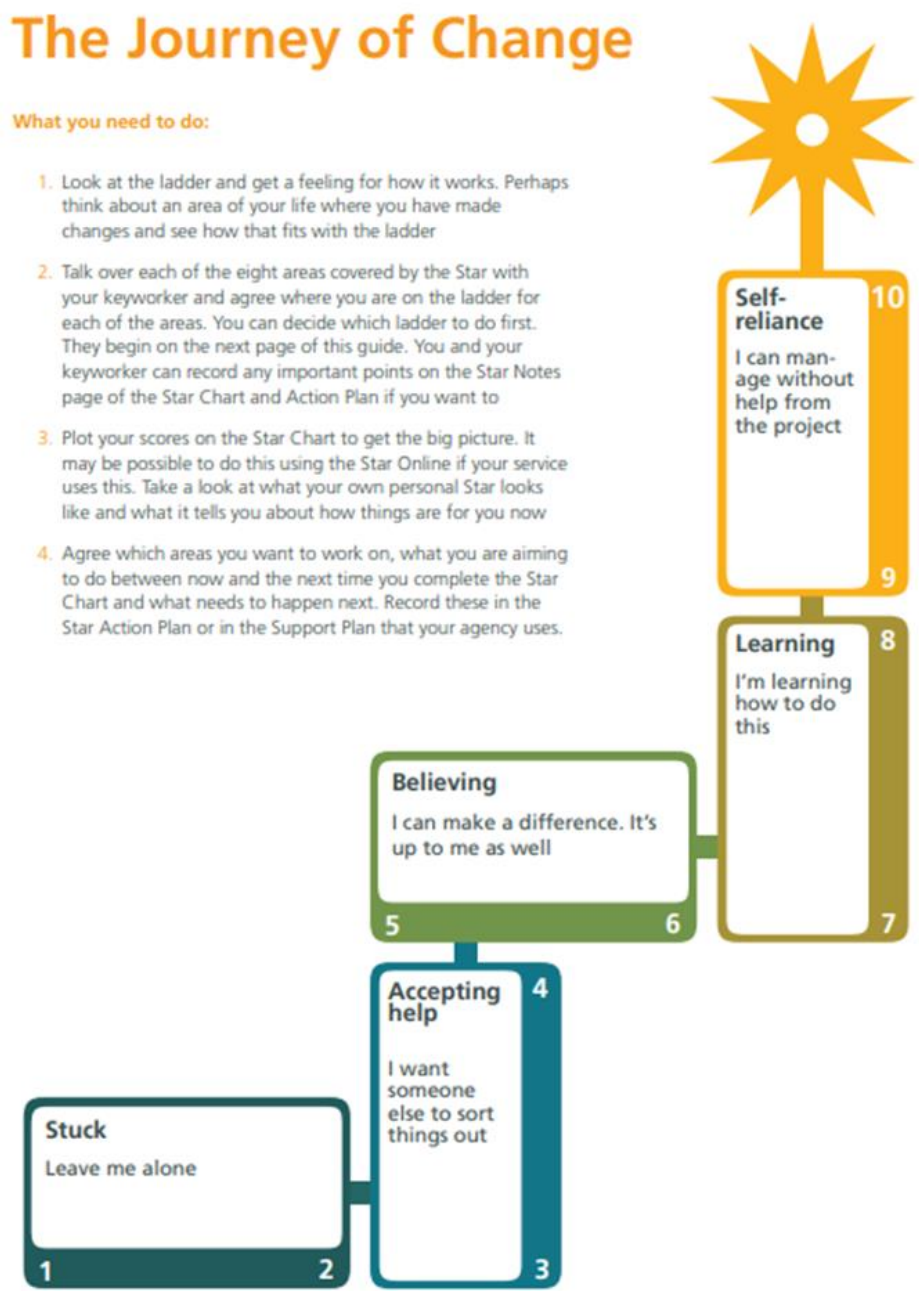


Figure taken from file:///C:/Users/ihslocaluser/Downloads/ALCOHOL-STAR-USER-GUIDE.pdf (Triangle Consulting and Alcohol Concern, 2010)

During the first year of operation (September 2011 to September 2012), DRAW instigated a range of activities and interventions including health and nutritional advice groups, arts classes alongside structured recovery support meetings and unstructured one to ones with staff. Towards the end of the first year peer led activities began, such as cooking classes (run by a DRAW member who was a qualified chef), the running club, table tennis and the 'community meal day' (where members each brought something in and ate together).

2.3.2 Review of DRAW

Following a review of the centre (administered late 2011 until January 2012), certain areas for improvement were highlighted. Staff were interviewed and expressed concerns that the centre at that time 'had failed to embrace, and fully acknowledge the "recovery" needs of its members' (Wood, 2012 p.25). From January 2012 the emphasis of the centre was focused towards recovery and peer led opportunities. A new short-term manager was employed to develop stronger recovery in the community links. A local Alcoholics Anonymous (AA) group established weekly meetings from the centre around this time alongside further peer led (and peer requested) training such as IT workshops. By May to September 2012 there were more recovery meetings held at the centre and members were encouraged to attend at least one meeting a week. Links were also established with the Pioneering Care Partnership (PCP) to develop and run training based around the Health Trainers model, this allowed those further on in their recovery to be able to train to become peer mentors within the first stage of the treatment system, making recovery visible from the start.

In the months up to the end of the financial year 2015 the provision of recovery services (like DRAW) went out to tender, NECA was unsuccessful in winning the recommissioned contract, with Lifeline being awarded it. In April of 2015 drug and alcohol services in County Durham were restructured under Lifeline, drug and alcohol provision was merged, along with treatment and recovery services. A number of original NECA employed staff moved into the new service under the Transfer of

Undertakings Protection of Employment regulations (TUPE). This allowed bonds between staff and service users to be retained where possible.

2.4 Lifeline (Time Point 2)

Lifeline provided an integrated single service for adults and young people, offering addiction support provision from initial request for help, through treatment to recovery. The services provided included prevention and pre-treatment programmes, harm reduction services (e.g. needle exchange and prescribing), access to community and / or inpatient detoxification, quasi and residential rehabilitation, access to mutual aid programmes / recovery hubs and peer support. The provision operated out of six locations throughout County Durham.

The annual North East Report of 2014/15 produced by Lifeline described the contract wins of Durham and Hartlepool as enabling them to extend their current range of services by over £6.4million and increasing their workforce for the North East to 300 members of staff (Lifeline Project, 2015). At that particular time Lifeline held contracts in Newcastle and Sunderland areas as well. However, Lifeline entered into administration in May of 2017.

2.5 Change Grow Live (Time Point 3)

Change Grow Live (CGL) took over the operation of the majority of services provided by Lifeline on the 1st June 2017. This included transferring over 1,000 staff and 40 service delivery contracts (from around the UK). This arrangement was provided through a contract of novation, whereby a new party assumes responsibility for obligations incurred by an original party. Following a call to tender in late 2017, Humankind were granted the contract.

2.6 Humankind (Time Point 4)

Humankind (formerly known as DISC – Developing Initiatives Supporting Communities) was awarded the service delivery contract in January 2018. The service is operated in conjunction with the Basement Project, which is a community based organisation, and Spectrum Community Health a Community Interest Company (CIC) which is a social enterprise that

delivers a range of health care services on behalf of the NHS. Humankind still hold the contract as of September 2019.

2.7 Recovery Academy Durham (active through all Time Points)

The Recovery Academy Durham (RAD) provides recovery housing and a structured day programme (SDP). The recovery housing refers to specific houses that provide accommodation for a set number of individuals in recovery (depending on house size and gender of clients), providing a 'safe' environment away from outside distractions that may hinder an abstinence based recovery.

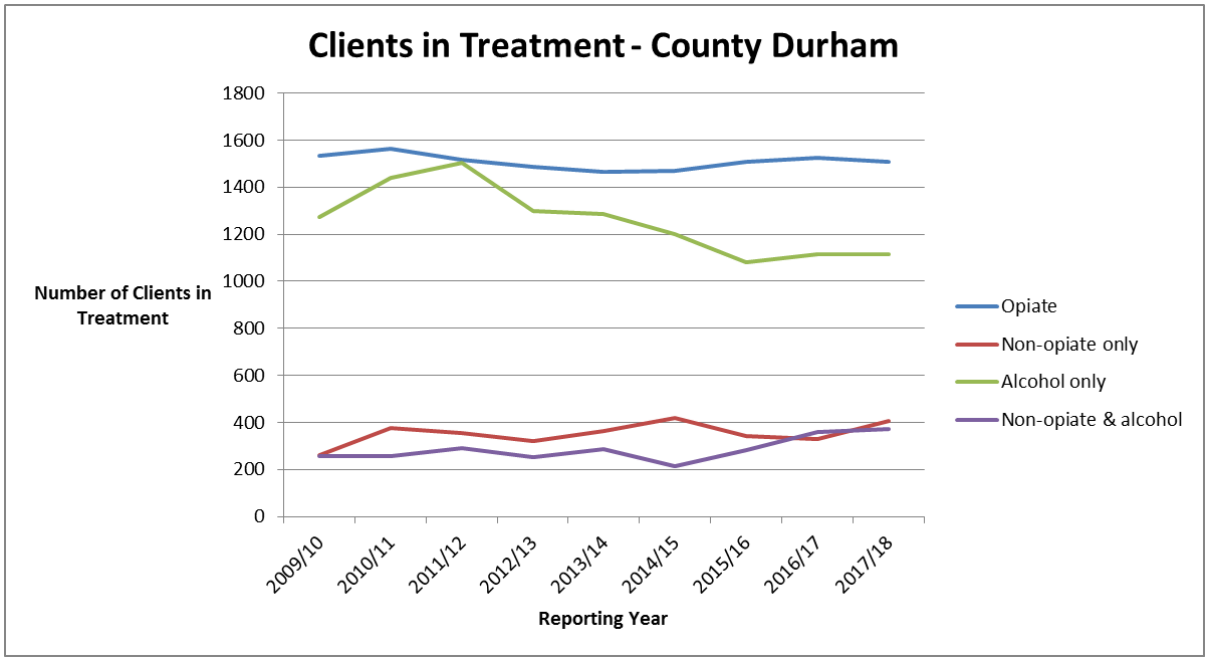
> SDPs are characterised as a tier 3 treatment intervention. This refers to any service that is structured, community-based service where referral is initiated by other services such as probation, prescribing, or residential care… SDPs deliver a program of care, from trained counsellors that include care planning, focused, short-term counselling, group work, education, relapse prevention, and established pathways to aftercare… The aims of SDPs are generally structured to encourage the initiation and maintenance of abstinence; to improve social functioning, community rehabilitation, personal independence and responsibility; and the ongoing development of psychological and physical health. (Parkman and Lloyd, 2016 p.275)

The RAD provides a series of recovery based activities (as described above) for a period of 12 weeks and requires clients to attend the centre every day Monday to Friday. The programme is abstinence based and works through the 12-step process.

2.8 Clients in Treatment

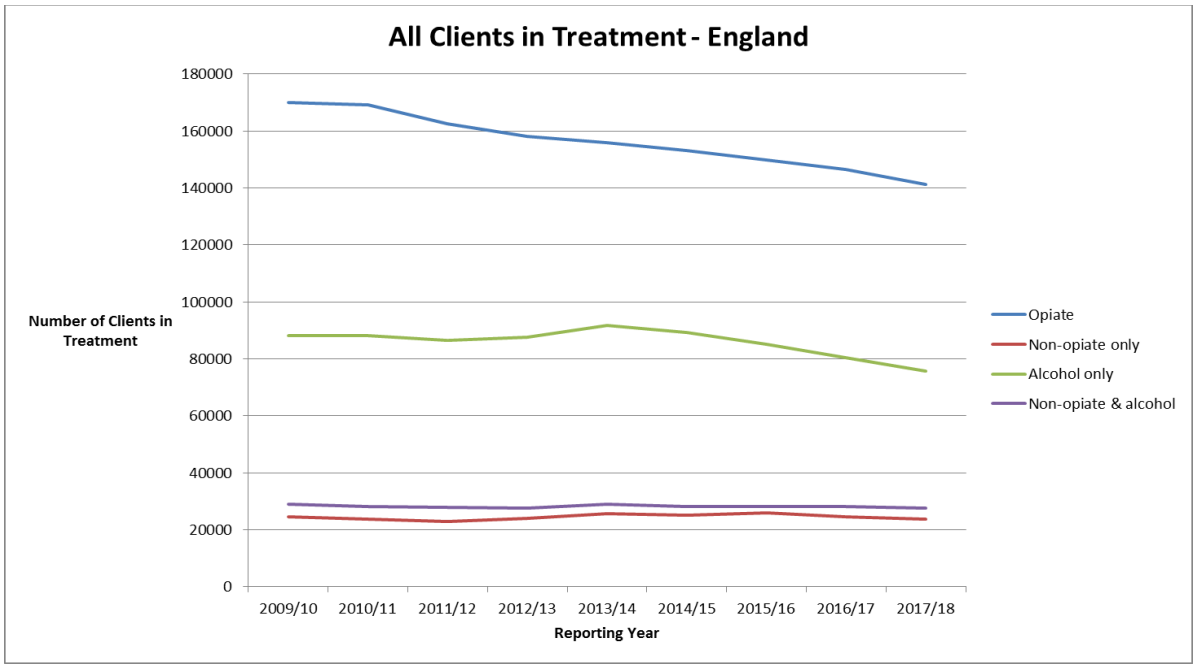
Data relating to Durham (see figure 2.4), provided on the National Drug Treatment Monitoring Service (NDTMS), shows a decline in the numbers of clients in treatment for alcohol only from 2011, (National Drug Treatment Monitoring System, 2019b):

Figure 2.4 Clients in Treatment in County Durham



National figures for England shows a steady decline in numbers in treatment for alcohol only from 2013/2014 and for opiate only from 2010/2011 (see figure 2.5) (National Drug Treatment Monitoring System, 2019b):

Figure 2.5 Clients in Treatment in England



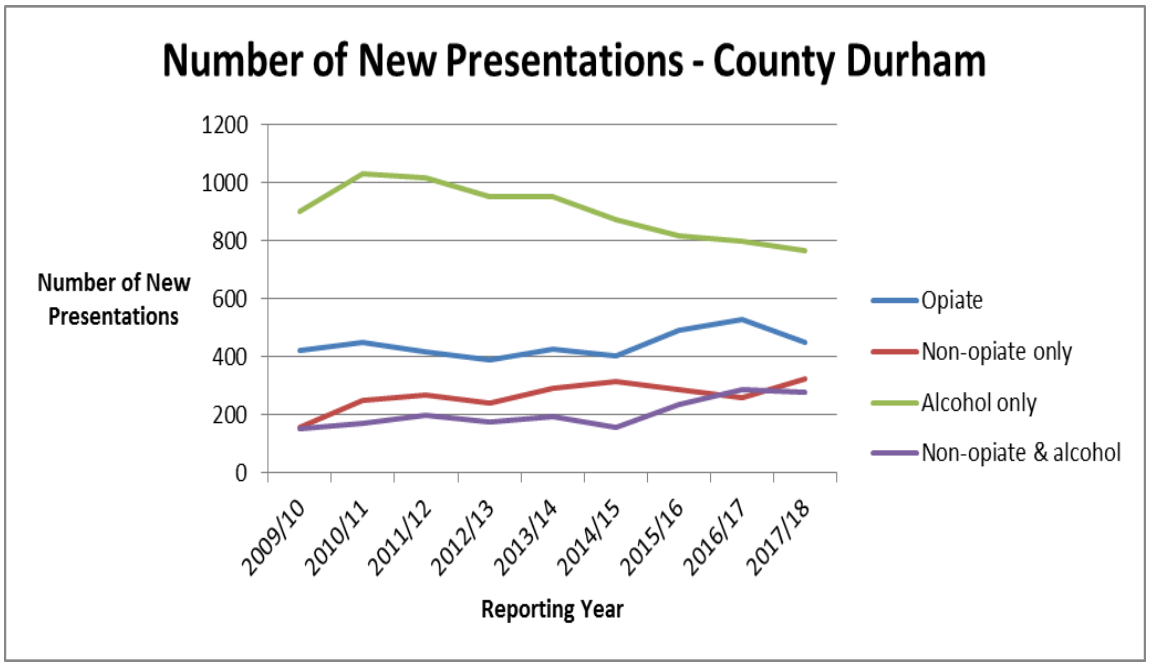
There was a slight decrease in the percentage of males and increase in females in treatment in Durham between the 2011/2012 reporting year

and 2015/2016 (61% males in 2011/2012 to 59% in 2015/2016) (National Drug Treatment Monitoring System, 2019b). However, these numbers are relatively small and could simply represent natural variation. The proportion decreased again for males (58%) and increased for females (42%) by the 2017/2018 reporting year (National Drug Treatment Monitoring System, 2019b). These figures differ from the national trend which was more stable during these years for England, with males remaining at around 60% of the client population throughout (National Drug Treatment Monitoring System, 2019b).

With regards specifically to alcohol dependency rates in County Durham in 2016/2017 the rate per hundred of the adult population was 1.70 compared to 1.35 for England overall, this was an increase on the previous reporting year where the rate was 1.62 for County Durham and 1.38 for England (National Drug Treatment Monitoring System, 2019b).

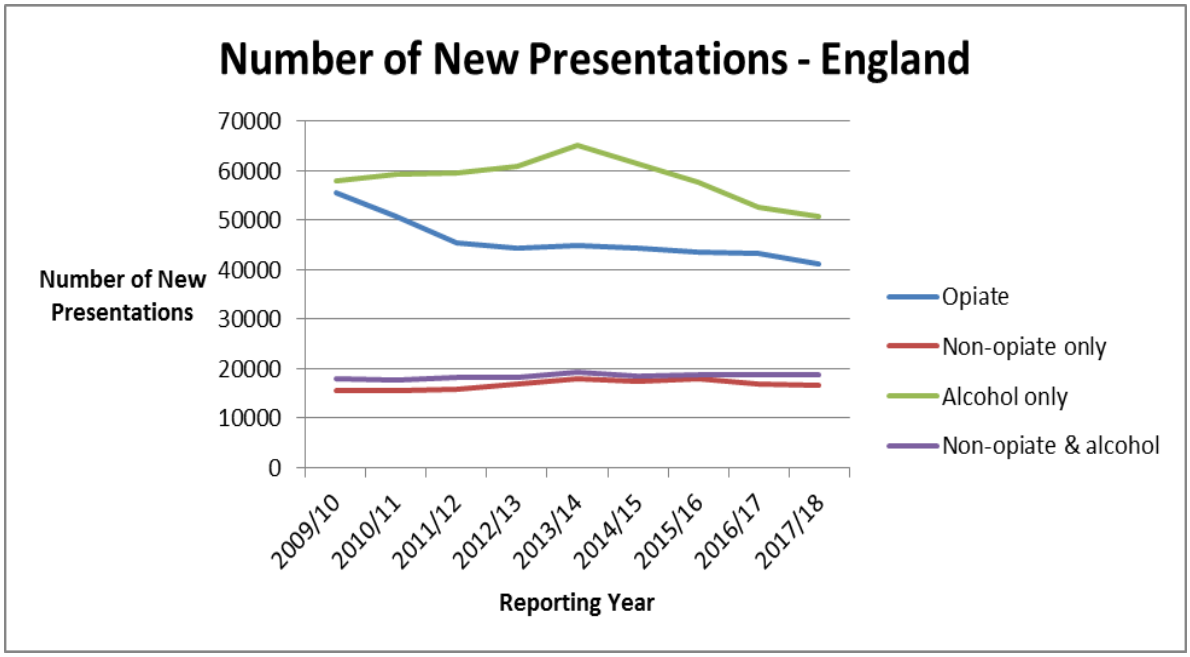
There was a decrease in the new presentations in Durham (see figure 2.6), presenting with alcohol only, during this research time frame (steadily declining from 1030 in 2010/2011 to 765 in 2017/2018) (National Drug Treatment Monitoring System, 2019b):

Figure 2.6: New Presentations to Treatment in County Durham



Figures for England show these numbers decreasing from 2013/2014 for alcohol only, with opiate only starting on a downward trend from 2009/2010 (see figure 2.7) (National Drug Treatment Monitoring System, 2019b):

Figure 2.7: New Presentations to Treatment in England

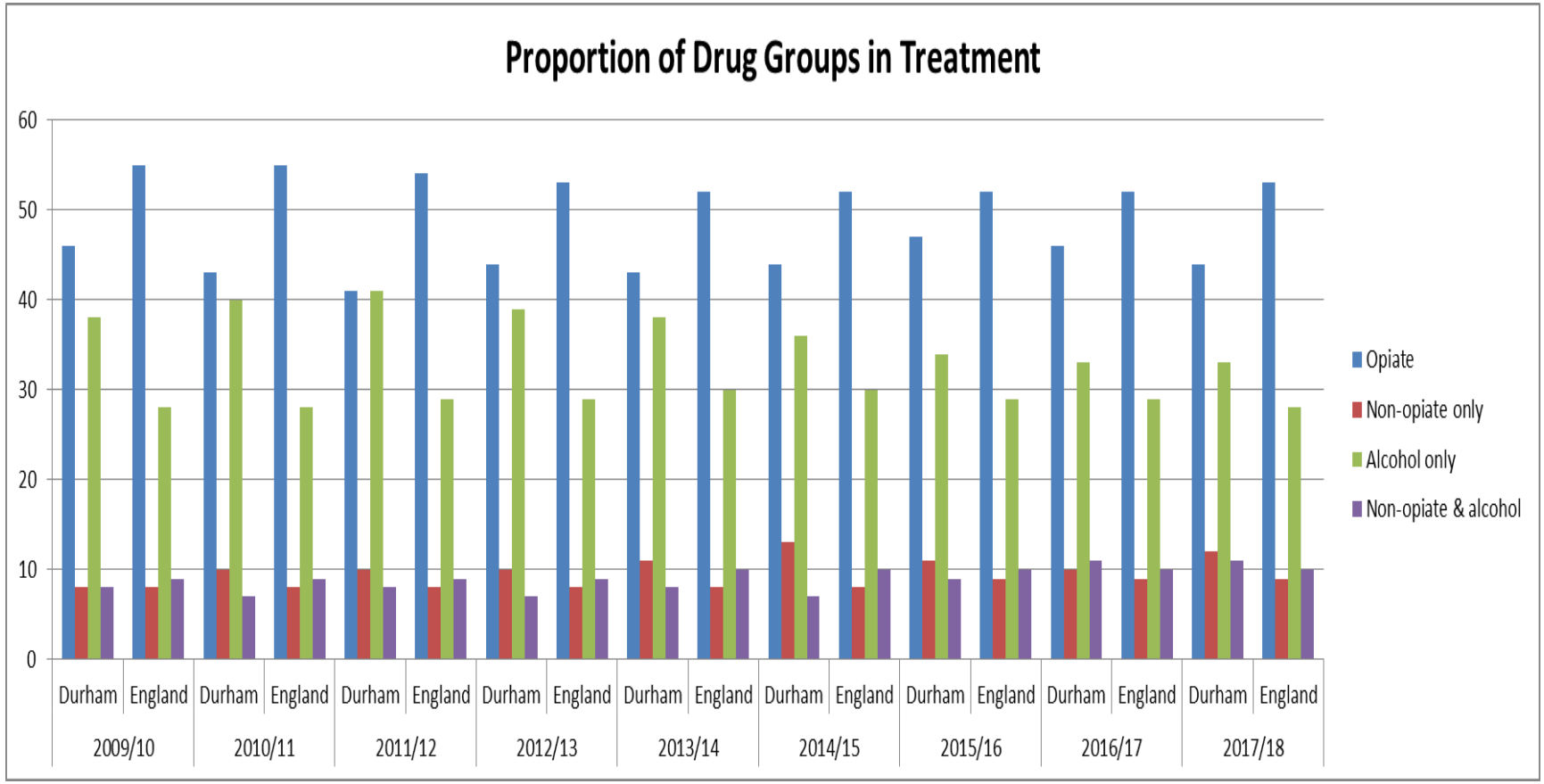


It remains unclear whether any reduction in new presentations infers a drop in need or a reduction in service provision, resulting in less individuals being able to access required provision.

In Durham, the percentage of 'new presentation' males remained reasonably stable throughout the time frame (staying between 58-63% for all clients in treatment) (National Drug Treatment Monitoring System, 2019b). Figures for England are again stable with males accounting for around 62% of new presentations throughout (National Drug Treatment Monitoring System, 2019b).

Durham has a higher proportion of alcohol only clients in treatment than England overall (throughout the time frame), although opiate users still account for the greatest proportion in treatment (see figure 2.8) (National Drug Treatment Monitoring System, 2019b):

Figure 2.8: Proportion of Drug Groups in Treatment in Durham and England



Nationally, 48% of individuals in treatment are discharged as ‘treatment completed’ (clinical judgement states client is no longer in need of treatment, having achieved care plan goals and overcoming dependent use of a substance). Of this group opiate clients had the lowest rate of completion (26%) and alcohol only clients had the highest (61%) (Public Health England, 2018a). Around a third of clients (35%) ‘dropped out/left’ treatment (exiting treatment without completing, 7% of these transferred to another provider (but were not registered within 21 days) and 4% were transferred to treatment in prison (opiate clients accounting for the largest proportion of these) (Public Health England, 2018a). Qualitatively, there is little research as to reasons for ‘dropping out’ or completing a treatment programme, suggesting a need to examine barriers and facilitators to recovery from the perspective of those using or working in recovery provision. This chapter described the local provision that this thesis was based upon, highlighting where Durham sits nationally. In addition the services delivered within the time frame of the research have been described; this assists in setting the scene for the qualitative chapters that follow.

Chapter 3. A Systematic Review of Qualitative Evidence of Approaches to Recovery from Addiction in the United Kingdom and the Republic of Ireland

3.1 Chapter Overview

A central aim of this thesis was to explore factors that promote or inhibit recovery from addiction within the service delivery field. This chapter presents a systematic review of literature from the UK and Republic of Ireland to identify factors that facilitate or create barriers to recovery from addiction. The chapter begins with an overview of the reviews aims and objectives, before defining the methods used, describing the search strategy, (including inclusion and exclusion criteria), review process and approaches to analysis and quality assessment. The findings of the review will then be discussed. The systematic review provided a method of triangulation for the qualitative interviews conducted (findings of which are reported in chapters 5 and 6), corroborating findings that described barriers and facilitators to addiction recovery (as discussed in chapter 7).

3.2 Methods

3.2.1 Rationale for Review

Chapters 1 and 2 have shown that the harms attributed to alcohol and drug dependency continue throughout the UK, with an estimated 82% of adults in need of specialist treatment for alcohol dependency and 46% of opiate clients in need of specialist treatment have an unmet need (Public Health England, 2018a).

Health care practitioners, service commissioners and general decision makers need to have the best possible information available to assist them in designing and delivering services that meet population needs; with a wealth of information available it can become problematic to uncover the best evidence based findings. Systematic reviews ‘aim to identify, evaluate and summarise the findings of all relevant individual studies, thereby making the available evidence more accessible to decision makers’ (Centre for Reviews and Dissemination, 2009 v). Systematic reviews often

focus more on quantitative research, frequently focusing on the results of randomised control trials, which are generally considered to be the gold standard of evidence on relative effectiveness of interventions (i.e. how one treatment compares with another) due to the specific methodology used that reduces bias through the randomisation of participants and the use of controls. Previously there have been concerns about how to include non-experimental and qualitative research to inform policy and practice due to uncertainty about how to include these areas in a systematic review (Harden, Garcia, Oliver, Rees, Shepherd, Brunton and Oakley, 2004). However, qualitative reviews are becoming more prevalent and can deliver a significant contribution, as they offer a person centred (and client centred) perspective to the decision making practice (Evans and Pearson, 2001). In addition, they can provide evidence of efficacy at an individual level, uncovering an understanding of how people experience certain factors, illuminating the 'why' aspect which helps inform practice and build theory (Seers, 2015).

3.2.2 Aim of the Review

This review aimed to systematically examine the literature from the perspectives of service users (former and current) and practitioners working in the recovery field in the UK and the Republic of Ireland, in relation to potential barriers and facilitators to building recovery capital growth. Furthermore, it aimed to report how service-users feel connected to society, how and whether service provision prepares them to integrate or reintegrate into society and whether they feel they are assets to their communities. As the focus of this review was to uncover the 'voices' of those in recovery, only studies containing qualitative research were included, this allowed for an understanding of the processes of recovery, explained by those living the experience.

The systematic review had the following objectives:

- To establish the extent of literature regarding approaches to recovery from drug and alcohol addiction from the perspective of service users and those working in service delivery.

- To identify the value of community / asset based approaches on recovery capital growth from the perspective of service users / staff in the recovery field.
- To identify, from the opinions of those involved in the recovery field, those factors that promote or inhibit recovery.

3.2.3 Review Process

The protocol is registered with Prospero ID number CRD42015027979.

PROSPERO was initially searched in September 2015 to determine whether a similar review had been conducted. The search was negative. A further search was conducted prior to submitting this thesis (September 2019), and again no other reviews were currently registered that contained similar aims as this one; although it was evident the field had grown.

Searches

Following an initial scope of the literature to establish what articles were available in the chosen subject area, specific key words and search terms were initially identified through a general scoping of addiction and substance misuse literature. Medical Subject Headings (MeSH) were also used to direct searches, as they provide functional headings for specific databases. The databases utilised in this review were Scopus, Web of Science and PubMed. These were interrogated using ‘article title’, ‘abstract’ and / or ‘keywords’ searches (depending on database options). PubMed encompasses over 25 million citations for literature, primarily from the Medline database. Scopus, owned by Elsevier, is a large citation database of peer reviewed literature. Web of Science, (previously known as Web of Knowledge) is also a citation indexing service, which is maintained by Thompson Reuter.

Searches were administered using the search terms defined in table 3.1

Table 3.1 Systematic Review Search Terms

Concept 1: Qualitative (Searched using 'or')	**Concept 2: CAB** (Community Asset Based) Approaches (Searched using 'or')	**Concept 3: Recove**ry (Searched using 'or')	**Concept 4: Addictio**n (Searched using 'or')
Qualitativ*	Communit*	Recover*	Addiction*
Interview*	Asset*	Free*	Alcohol Dependence
Opinion*	Involvement	Recuperation	Alcoholism
Perspective*	Public	Healing	Alcohol Abuse
Focus group*	Action	Wellbeing	Abstinence
Oral histor*	Participation*	Recovery Capital	Moderation
Evaluat*	Societ*	Social Capital	Substance Use Disorder
Effectiv*	Kinship	Peer Support	Drug Addiction
Participant*	Unity		Substance Dependence
Attitude*	Identit*		Substance
Belie*	Cooperation		Sloshed
View*	Asset Based		Cocaine
Perception*	Development*		Crack
Assessment*	Therapeutic*		Heroin
Appraisal*			LSD
Valuation*			Cannabis
Thought*			Meth*
Feeling*			Marijuana
			Skunk
			Alcohol*
			Intoxicat*
			Booze
			Drunk
			Pissed
			Wrecked

Concept 1: Qualitative

This relates to all areas of qualitative research to ensure views, opinions and voices were included.

Concept 2: Community Based Approaches

This incorporates not only Asset Based Community Development (ABCD) approaches but any research focusing on unity and kinship that therapeutic communities are focused around, therefore encapsulating other notions of ‘community’.

Concept 3: Recovery

Recovery includes areas of healing and wellbeing. This was specific to eliciting studies that focused on gaining freedom of dependence rather than those that focused on treatment outcomes.

Concept 4: Addiction

These terms were to ensure searches included a substance element, to safeguard against receiving studies that focused specifically on mental health. All the terms relate to a drug type or alcohol consumption to prevent studies relating to gambling or sex addiction appearing in sifts.

Only studies conducted in the UK or the Republic of Ireland were included, due to the distinctive history, process and funding provision of services in the UK and the Republic of Ireland. The UK NHS is centrally funded by the government, paid for through taxation and National Insurance contributions: with the exception of a handful of services (such as prescriptions and dental care), residents in the UK can access health provision free of charge. Literature from The Republic of Ireland was included as it is accessible, relevant and transferable and how individuals felt about service provision was considered to be similar, even if the funding for provision emanates from a different source.

Databases were searched from January 1993 to October 2018. The ABCD approach was first published in 1993, making this a rational choice for the search start date (Kretzmann and McKnight, 1993). The review was conducted in three stages, initially starting in 2015 (therefore first date range was 1993 to October 2015), this search was then updated to May 2017 and then again in October 2018. The PRISMA diagram (Figure 3.1) reported later in this chapter reported the process and results of this searching.

Grey Literature

Grey literature refers to documents not published by commercial publishers, which can include government documents and organisational reports; these frequently prove ‘highly influential’ in reviews as researchers seek to add ‘practitioner-held data and also account for possible publication bias. Publication bias is the tendency for significant, positive research to be more likely to be published than non-significant or negative research, leading to an increased likelihood of overestimating effect sizes in meta-analyses and other synthesis. The inclusion of grey

literature…aims to include all documented evidence and reduce susceptibility to bias' (Haddaway, Collins, Coughlin and Kirk, 2015 p.3).

Grey literature was searched as part of this review, using the *Global Health* database, *Alcohol Policy*, *Public Health England* and HM Government webpages in October 2018. These searches consisted of using the search terms 'alcohol', 'drugs', 'addiction', 'recovery', and 'treatment'. In addition, references from relevant sources (i.e. reference lists of included studies) were also examined for grey literature.

The search strategy was initially developed utilising the PICO framework (Population, Intervention, Comparator, Outcome) (Liberati, Altman, Tetzlaff, Mulrow, Gøtzsche, Ioannidis, Clarke, Devereaux, Kleijnen and Moher, 2009) (Stone, 2002). However, as the focus of the review was qualitative research the SPICE (Setting, Perspective, Intervention, Comparison, Evaluation) framework was then applied (and then utilised during the extraction phase) (Table 3.2):

Table3.2: SPICE Framework

SPICE				
Setting	**Perspective**	**Intervention**	**Comparison**	**Evaluation**
Community and / or asset based recovery centres	Those that have used the service and / or worked in the recovery field	Recovery assistance / service provided	N/A (not set, however, some studies may describe possible comparisons)	Value of recovery capital growth / service provided according to service users / staff
Linked to search strategy concept 2 (CAB approaches)	Linked to search strategy concept 1 (Qualitative)	Linked to search strategy concepts 3 and 4 (Recovery and Addiction)		Linked to search strategy concepts1, 3 and 4 (Qualitative, Recovery and Addiction)

The SPICE framework splits the PICOs Population component into Setting and Perspective, this is to recognise 'that evaluation within information practice is typically subjective and requires definition of the specific stakeholder view that is the focus' (Booth, 2006 p.363). The perspective aspect incorporated individuals in recovery from alcohol and or drug addiction / dependence, ranging from early stage recovery ('new' service users including those on substitute programmes) to those in long term / stable recovery. Those working in the service delivery or the recovery field were included. The interventions examined in the review were services delivering a recovery orientated programme which includes asset based community approaches / recovery centres and services based within a community setting which includes 'created' communities. The term community for the purposes of this review refers, not only to the geographical concept of a locality, but also to a collection of people with a similar trait or interest (i.e. veterans, street sex workers or those in a Therapeutic Community (TC) – including prison wings specifically for recovery or TCs). There is no specific comparison group or service under investigation in this review, although some studies included comparable factors. The SPICE framework replaces Outcomes (from the PICO) with Evaluation, as this term can incorporate concepts such as 'outputs' and 'impacts' (Booth, 2006) which may be deemed more suitable for qualitative studies. The evaluative component refers to the value recovery provision provided on encouraging growth in recovery capital. This value is considered from service users' / recovery staff / service providers' perspective.

Inclusion Criteria (Published and Grey Literature)

1) Qualitative (opinions / views of service users and / or recovery staff - this can include recovery champions / ambassadors etc. Recovery champions and ambassadors being those in stable recovery who provide visible peer support within services and the community). Qualitative research refers to including data collated through interviews (in-depth / semi-structured), focus groups, ethnographical and observational studies.

2) Community based intervention (including recovery homes / house, day centre / hub / services for individuals with a common characteristic) in the UK and the Republic of Ireland.

3) Recovery focused (i.e. not just treatment / detox focused - must include elements of recovery capital as described in the introduction chapter).

4) Addiction from substance and or alcohol use / misuse (not solely mental health).

5) Study population included individuals aged 18 and over (although studies that state the range to be 16 to 25 were included if the data for 18+ was given separately.

6) The date range for papers was January 1993 until October 2018 (start date reflects the initial publication on Asset Based Approaches as mentioned in the introduction to this chapter) (The Asset Based Community Development Institute)

Exclusion Criteria (Published and Grey Literature)

1) Papers that solely focussed on alcohol / drug use without the specific mention of a 'community' element / asset based approaches and / or recovery.

2) Papers based on research conducted outside of the UK and the Republic of Ireland. Non-UK and Republic of Ireland research was excluded due to the differences in delivery of service provision. Therefore studies not reported in English were also excluded.

3.2.4 Data Collection and Analysis

Screening

As screening can be a subjective experience, it is recommended that more than one person screens and where possible extracts data (Higgins and Green. S., 2011). All titles and abstracts were screened by one researcher with 20% screened by a second researcher (DNB). Full papers were then screened by two researchers and any disagreements were discussed until

an agreement was reached. It is recognised that a single researcher may miss 8% of eligible studies, whereas a pair of researchers working independently tend to miss none (Edwards, Clarke, DiGuiseppi, Pratap, Roberts and Wentz, 2002). However, due to time constraints of the second researcher, only 20% of the papers were double checked during the first sift. Endnote VX7.8 was used to manage citations.

Data Extraction

Data extraction was carried out by one researcher following the second sift, with checks made by another researcher of 20% of the included papers. Data from each of the papers was extracted into Microsoft Excel under the headings of reference, study design, context / intervention, study population, themes / aims, analysis technique, results, limitations, conclusions and quality assessment.

Preliminary results presented difficulties in determining the essential characteristics of ABCD approaches to addiction recovery. The term 'community based' itself posed issues, since a community can be determined by proximity, but can also refer to a group of individuals who have similar characteristics (i.e. people suffering the same addictions or dependencies that are drawn together create a community, regardless of where they actually live). The latter notion of community was accepted for the review, regardless of where clients presented for help. In order to be considered as an 'asset based' approach, it was decided that a programme should encourage empowerment and a focus on social relationships and / or networks that strive to build recovery capital using facilities and sources available (as referred to in chapter one).

Quality Assessment

Although the quality of studies was not defined as an inclusion or exclusion criterion; an assessment of the included studies remains an important part of testing for rigour. Therefore, included studies were quality assessed using the Critical Appraisal Skills Programme (CASP) (Critical Appraisal Skills Programme, 2018) (see appendix C). The CASP Qualitative Checklist is an appraisal tool designed to assist the researcher in determining how valid each study is, whether the methodology is

appropriate, how clear aims and results are and how valuable the research is.

Data Synthesis

Thematic synthesis was used to analyse the included studies: this aims to identify recurring themes or issues that surface within the literature, analysing and drawing conclusions (Harden, Garcia, Oliver, Rees, Shepherd, Brunton and Oakley, 2004). The extraction of study data requires each paper to be 'deconstructed' and then collectively be 'reconstructed' in a standardised format (Harden, Garcia, Oliver, Rees, Shepherd, Brunton and Oakley, 2004). Deciding what to extract from a qualitative study, what classifies as 'data' can be problematic, some researchers look to extract what they determine to be 'key concepts' (Campbell, Pound, Pope, Britten, Pill, Morgan and Donovan, 2003). However, this approach can be complicated by differing reporting styles, misinterpretation of quotes and subjectivity around what is a 'finding' (Sandelowski and Barroso, 2002).

For the purpose of this review the technique described by Thomas and Harden (Thomas and Harden, 2008), which requires the inclusion of all text reported to be findings or results (including quotes and discussion). The thematic synthesis then involves three stages; stages one and two involved the coding of the text and developing descriptive themes. During this phase data from the studies were translated into emerging concepts. Stage three required the generating of analytical themes. The themes derived from the inductive coding during stage two allowed for the data from each of the studies to merge as one; stage three allowed for the synthesising of these merged codes.

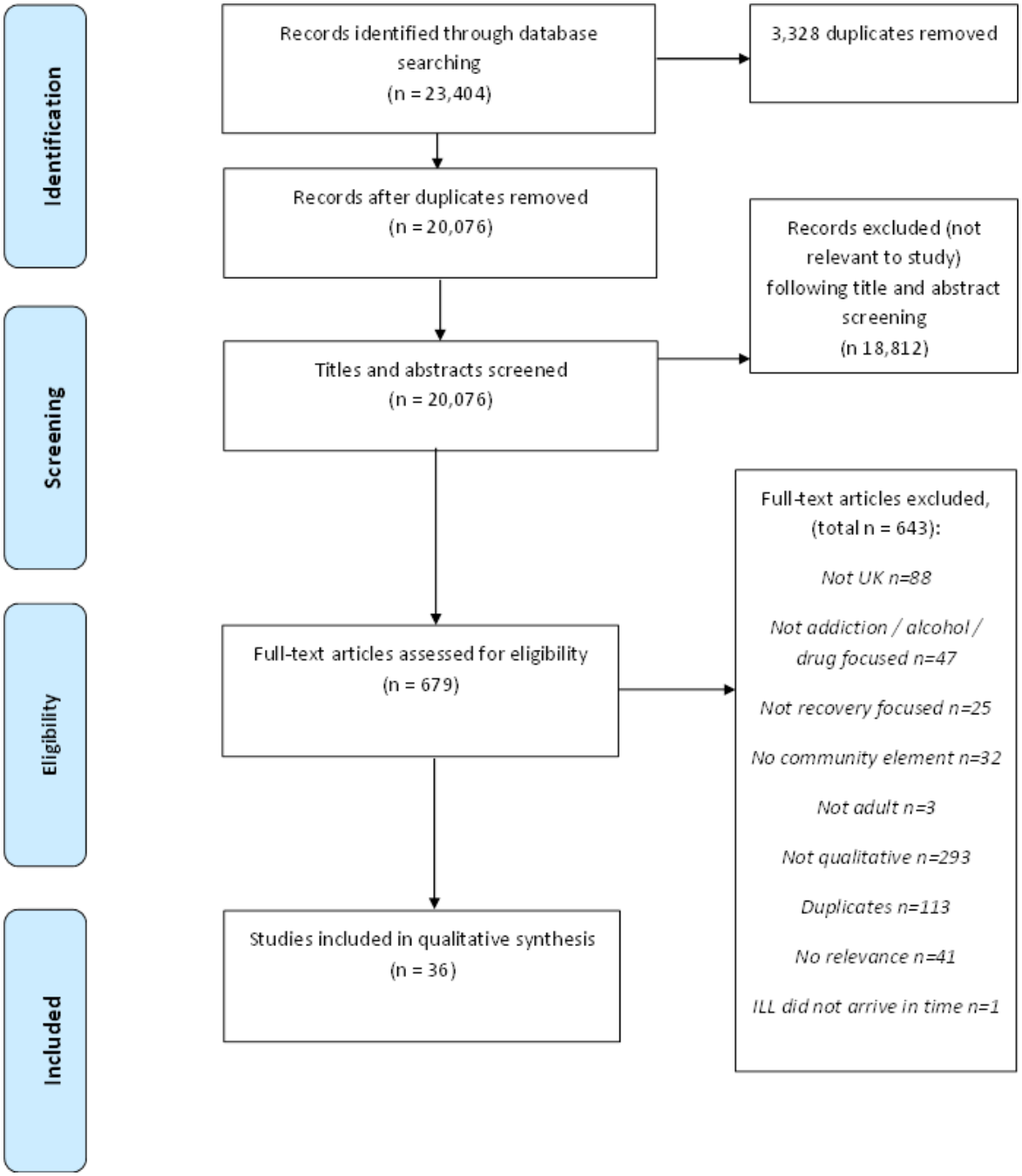
3.3 Results

3.3.1 Description of Included Studies

The search strategy identified 20,076 potential articles to be selected for abstract / title screening. Following this screening of titles and abstracts 679 full text articles required assessing for eligibility. Of these 36 met the inclusion criteria, the majority of those rejected were dismissed for not containing qualitative research or not being conducted in the UK or the

Republic of Ireland. The data from the included studies was then extracted. Figure 3.1 describes the PRISMA flow diagram:

Figure 3.1PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) Flow Diagram of Systematic Review



(Moher, Liberati, Tetzlaff and Altman, 2009)

3.3.2 Quality Assessment of Included Studies

All of the included studies were deemed to have a clear statement of aims and utilised a qualitative methodology appropriately (6 of the studies also reported quantitative findings, although these were not quality assessed

due to the interest being specifically on the qualitative outcomes). Four studies provided limited information on the research design, therefore could not be defined as one that addressed the research issue. Thirty-two studies provided clear recruitment strategies and thirty-four collected data in a suitable way to meet research aim. Three studies considered the relationship between researcher and participants, and 26 stated ethical approval had been sought and granted. Thirty studies provided information regarding a rigorous analysis process, but all provided clear statements of findings. All the studies provided potential value describing credible findings, with nineteen of them found to provide potential to high value due to the areas reported on. High value was deemed to be areas where there are currently limited research findings. Three studies were graded as Potential / Limited as the findings were so specific to one type of provision they could not be generalised to similar types of provision (see appendix B for breakdown of results as according to the CASP checklist).

The majority of papers involved conducting interviews and / or focus groups within their study design (thirty used interviews, seven used focus groups, four used both interviews and focus groups to collect data). Thirty-four of the thirty-six studies were conducted with service users, and seven of the studies were conducted with service staff, commissioners or partner agency staff. Perspective is covered in the table below.

Table 3.3 presents the setting, population, intervention and evaluation (or conclusion) of the eligible studies (following the SPICE framework), ordered alphabetically based on the first authors surname. Where there was a comparator in the research papers this has also been highlighted in the table.

Table 3.3 SPICE breakdown of eligible studies

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
McIntosh, J. and N. McKeganey (2000).	Recovery in general (no service specified). Location – Scotland	70 People in recovery (36 female / 34 males. Ages 20 to 43. Heroin the most popular drug of choice)	Recovery Process - creating a new identity	No comparison used or referred to	Identity transformation and a turning point are key to recovery process. 3 elements to constructing a non-addict identity: 1) Re-interpreting the addict lifestyle. 2) Reconstructing the sense of self. 3) Providing an explanation for recovery. In addition, 'significant others' play an important part in the construction of recovery narratives (i.e. addiction literature, staff and counsellors) - highlighting that accounts may be not so much about reflecting the nature of recovery but also be a product of the socially constructed nature of the narrative process
Colley, E. and J. Blackwell-Young (2012).	Therapeutic Community (TC) in a female prison wing in the UK	5 female offenders who are graduates of the TC programme (no further information provided)	Therapeutic community provision	Pre-TC feelings of emotional discontent compared to after TC	Highlights benefits of TC prison programs for female offenders. Supports previous work looking at chronic female drug users experience significantly high levels of emotional discontent - this study noted pre-TC participants experienced high levels of depression, sadness, apprehension, agitation and negative self-worth. The pre-TC coping strategies were maladaptive - childish, isolated and substance using. TC is designed to address these issues by promoting change, reconnecting and promoting interactions
Tober, G., *et al*. (2013).	Addiction aftercare (location is not stated, however, funding was provided to Leeds, York and Bradford)	29 project stakeholders (service users, mentors, university and clinical staff) (no further information provided	Learning to Live Again (aftercare provision)	No comparison used or referred to	4 overarching themes: 1) Achieving common ground. 2) Roles and responsibilities. 3) The activity programme. 4) The road to recovery. Some of these themes were more important to others among the different participant groups. Sub themes were also reported in the study.

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
Waters, K., *et al.* (2014).	Psychological Therapy Provision (Location not stated, however, authors based at services in Kent and London)	7 service users (3 male / 4 female. Aged 40-54)	Addictions psychological therapy	No comparison used or referred to	Psychologists acted as a secure attachment figure providing closeness and proximity, a safe haven and a secure base. Separation caused distress and the internalising of the psychologist. Suggests that recovery occurred through the replacement of insecure attachments with the surrogate secure attachment provided by the psychologist
Radcliffe, P. and A. Stevens (2008).	Drug treatment services in 3 English Drug Action Team areas (Locations not specified)	53 problematic drug users / former clients. (39 males / 14 females. Ages 19 to 50) 16 staff were also interviewed (no further information)	Outpatient treatment that provides opiate substitution, day services, structured counselling	No comparison used or referred to	4 main themes: 1) Stigmatisation of the 'junkie' identity. 2) Shame and the treatment service (stigmatisation in services). 3) Stigma and the treatment regime (restricted service hours and 'segregation' in pharmacies / consumption rooms). 4) Community of users (friends and peers who are using)
Neale, J. and C. Stevenson (2015).	Homeless Hostels in 3 English cities (Locations not specified)	30 residents of the hostels who report issues with alcohol or drugs (21 males / 9 females)	Hostels provision for increasing social and recovery capital	No comparison used or referred to	Homeless hostel residents have various opportunities for building social and then subsequently, recovery capital. Friends in the hostel as well as external can be important sources of support. Family Is a key resource especially for those who have children - this can be a driving force for recovery. Therapies need to focus on positive outcomes and support the growth of positive social networks

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
Sheridan, J., *et al.* (2011).	Drug Action Teams or Drug and Alcohol Teams in England (Locations not specified)	32 front line treatment workers (13 male / 19 female)	Delivery of treatment services	No comparison used or referred to	3 areas that impact on service delivery: 1) Structural impacts (resources / targets / commissioning / partner agency demands). 2) Impact of local organisation (processes and care planning / duplication). 3) Impact of working practices (communication / supervisors / support / training). Good communication is seen as a key facilitator to delivery. An understanding of each others roles would assist with partnership working. Liaison between mental health staff and substance misuse staff can be difficult due to different theoretical understanding of the issues
Notley, C., *et al.* (2015).	Rural community drug treatment service in UK (Location not specified, however, ethics granted in Norfolk)	27 service users (18 male / 9 female. Mean age of 47) and 10 treatment professionals (no gender or age information)	Opiate substitution	No comparison used or referred to	Participants experienced long term OST as a transition between illicit drug use and recovery. Recovery was seen as a process rather than a fixed goal, confirming that there is a need for services to negotiate individualised recovery goals, spanning harm minimisation and abstinence oriented treatment approaches
Neale, J., *et al.* (2013).	Community drug services, pharmacies and residential treatment providers (Location in Southern England)	30 heroin users (15 male / 15 female) at start of treatment and 27 (14 male / 13 female) after 3 months	Recovery orientated treatment	No comparison used or referred to	Heroin users are not 'forced' into detox and abstinence programmes, but they are willingly subjecting themselves to rapid detox in a drive to become 'normal'. Service users must be provided agency in the decision making process, their prior negative experiences of detox confirms their commitment to being 'well'. Support from those who have personally attempted recovery provide a crucial resource for those contemplating recovery.

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
Irving, A. (2011).	Therapeutic Community (Phoenix Futures) (No location specified, however, researcher was based in Nottingham at the time of study)	3 TC service users (2 male / 1 female. Average age 36. Heroin the named drug of choice)	Therapeutic community residency and its role on identity reconstruction	No comparison used or referred to	Accounts of process of writing and exploring a life story provide evidence of three observable means of identity reconstruction: through selection and editing life story content, a heightened awareness of life story events, and by renegotiating power and control issues in the recovery process.
Duffy, P., Baldwin, H. (2013).	Post-treatment provision (Location – Northern England)	45 service users (30 males / 15 females. Ages 22 to 54)	Drug treatment service	No comparison used or referred to	Motivation, confidence and enthusiasm for recovery needs to be harnessed. Barriers around local and national policy need to make sure they don't de-rail this enthusiasm. Those in recovery leaving service provision need signposting to a broad range of options to ensure they make the most out of their life after substance use
Lopez Gaston, R.S., *et al.* (2010).	Peer based support group (AA) in Birmingham	125 drug and alcohol users (97 male / 28 female, age range 19 to 65)	12 step recovery support	Compares 12-steps to other statutory services	Study reports that AA is cost effective, widely available and offers practical strategies to combat dependence, although barriers to attendance included the perception of a heavy focus on religion, prior negative experiences in 12-step meetings and failure to identify with other members. Compared to other statutory services 12-steps is associated with positive outcomes.

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
McPhee, I. and Fenton, D. (2015).	Modified Therapeutic Community in Scotland	7 Homeless Poly-drug Using Males (ages 37 – 46)	Residential Treatment Program	No comparison used or referred to	A range of treatment options are required to address recovery - including residential care and respite. It can take a number of attempts over a long period of time to alter entrenched addicted behaviour. Language is important in recovery, along with an identity change away from the old addict self is needed
Morse, N., *et al.* (2015).	Addiction Recovery and Mental Health in North East England	Overall 59 addiction service users and 85 mental health service users. Qualitative aspect of research involved 12 addiction service users and 9 mental health service users (no further information other than 'mixed age, gender')	Museum outreach service	Discussed stages of attendance (first, mid and last session)	The mixed-method data showed that participant levels of confidence, sociability and wellbeing improved over the course of the museum sessions though it is not clear to what extent the nature of the museum-focused activities or participation in a collaborative creative process produced gains above that of being part of a group. The study showed that progress could be made over 10 weeks and suggests that future interventions should be conducted with this period of time as a minimum requirement. As a non-clinical intervention, the programme showed that museum outreach sessions developed within an asset-based model have the potential to contribute to positive outcomes linked to the recovery service-users in mental health and addiction services.
Morton, S., *et al.* (2016).	Substance rehab centre in Ireland	17 service users (7 male / 10 female, ages 19 – 49) midway through program and 14 on completion (no further information provided)	Fitness and education programme	No comparison used or referred to	Findings support the use of education and fitness in developing social and personal capital in the lives of those seeking recovery from substance use. The unintended positive impacts on participant's families and their own community engagement would suggest a wider value in building social capital than may previously have been recognised

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
Parkman, T. and Lloyd C. (2016).	Treatment service (abstinence based day program) in the North of England	16 service users (9 male / 7 female. Age range 24-61. Primary substance alcohol)	12-step abstinence based program	Comparisons were made between data collected at baseline, 3 month follow-up and on leaving / aftercare	Day treatment in this format has considerable self-reported benefits for people attempting recovery from substance dependency. The structure and routine that were provided by the intensity of the program, in conjunction with the "tools" they learn from the program encouraged many clients to make great strides in a comparatively short period of time. However, there are issues surrounding the different types of people who are able to attend such an intense program that need addressing if the program is going to continue to evolve.
Timpson, H., *et al*. (2016).	Recovery communities in the North East and North West of England	32 service users (8 from a local authority service, 5 male / 3 female and 24 from a peer led service, 19 male / 5 female)	Statutory service and a peer-led community	Some comparisons were made between the two groups (local authority service and peer led provision)	Recovery experiences and outcomes are not centred entirely on the individual but are wider, more holistic. Maintaining recovery involves being connected to themselves and to the wider environment (family, friends, peers and society). A one size fits all outcome(s) framework is not sufficient, instead an approach that empowers those in recovery to determine what information is collected is most useful - top down should be balanced with a grass roots approach. Recovery is embedded in a social and cultural context - meaning recovery should incorporate the impact of recovery for broader stakeholders - namely significant others (family, friends, immediate community and local and national authorities).

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
Aslan, L. (2016).	Phoenix Futures Recovery services in Trafford, Sheffield and Wirral	8 service users (5 males / 3 females. Ages 20 – 50. Alcohol primary drug)	Recovery Through Nature (RtN)	No comparison used or referred to	Activities in the natural environment aided wellbeing. Main themes emerging related to the Process (Childhood and innocence, nature, 'community as method' and staff lead) and Change (the old versus the new and self-development)
Aslan, L. (2015).	Phoenix Futures Recovery services in Wirral, Sheffield and Hampshire	13 service users who discharged early (5 who were asked to leave and 8 that left of own accord. No further information provided re gender, ages)	Therapeutic community provision / post provision	No comparison used or referred to	4 main themes: 1) 'I should not have left'. 2) Positive experience of TC. 3) Accessed further treatment following leaving TC. 4) TC was a positive use of time.
Harris, A.H. (2015).	Coolmine Programme, Therapeutic Community in Dublin	21 TC clients (7 from each of the 3 services took part in a focus group. 6 were interviewed – 3 from male residential, 2 from female residential and 1 from day programme)	Mindfulness Based Relapse Prevention (MBRP)	No comparison used or referred to	MBRP was received quite positively and appears to fit in well with the holistic approach of a TC. Study suggests MBRP to be beneficial and valuable for many clients in a TC. MBRP is a self-help approach which uses community as method - a cornerstone of the TC modality of drug treatment

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
Gilbert, H., *et al*. (2015).	Community Alcohol Services (CAS) in 3 London boroughs	20 service users (11 male / 9 female. Ages 22 – 55)	Alcohol Care Pathway (delivered in CAS)	No comparison used or referred to	7 overarching themes emerged: recognising tipping points, treating alcoholism and working with drinking, characteristics of active engagement, the role of self-efficacy, making sense of alcohol dependence and being an alcoholic, journeying around the treatment system, and the role of 12-steps.
Day, E., *et al*. (2015).	Substance misuse services in Birmingham	58 clinicians (16 male / 42 female. Roles included drug workers, nurses, doctors, counsellors, probation workers and a psychologist)	12-step Group (TSG) (Narcotics Anonymous)	Refers to a similar study done 10 years ago but no direct comparison reported	TSG popularity is increasing (compared to a similar study conducted 10 years ago) staff knowledge of TSG can increase attendance as can education. Stereotypes re TSG can put potential clients off.
Best, D., *et al*. (2016).	Social enterprise model of recovery called Jobs, Friends, Housing in Blackpool	11 individuals involved with the program (including new starters, trainee builders, a cook, a trainee accountant and 2 members of office staff. No gender or ages provided)	Jobs, Friends, Housing (JFH) Building Programme	No comparison used or referred to	The model supports personal transformation and aspiration as well as training and skills development. Programme also contributes to the therapeutic landscape of recovery by being visible in the wider community

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
Collins, A., McCamley, A. (2018).	Long term recovery (no specific location stated, however, researcher based in Sheffield	6 individuals (3 male / 3 female) in long-term recovery (for qual. aspect of research, full research involved 40 people 30 males / 10 females. Ages 41-55)	Recovery process	No comparison used or referred to (for qualitative section of research)	People in long term recovery report growth in psychological elements of recovery, such as developing perspective, improvement in self-esteem, spirituality as well as contributing to wider social involvement
Weston, S., *et al*. (2018).	Recovery provision from 2 services under the same council (no location information provided)	180 current (135) and former (45) drug users (127 males / 53 females. Age range under 29 to 44+)	Social capital	No comparison used or referred to	Depending on the nature of the networks and the types of links participants have into them being socially connected can both inhibit and encourage recovery. Therefore, the successful application of social capital within the drugs and alcohol field requires a consideration of not only the presence or absence of social connections but their nature, the value they produce, and the social contexts within which they are developed.
Shortt, N.K., *et al*. (2017).	Recovery café in central Scotland	9 service users (5 males / 4 females. Ages 31 – 55)	Photovoice	No comparison used or referred to	Elements of the natural environment were largely referred to as supportive and therapeutic, as was quotidian spaces. However, the persistent availability and marketing of alcohol posed risks.

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
O'May, F., *et al*. (2017).	Hospital Based Alcohol Treatment Centres in two large cities in Scotland	20 heavy drinkers (10 from each city. 15 males / 5 females. Ages 34 – 67)	Alcohol policies	No comparison used or referred to	Population level policy initiatives to reduce alcohol consumption, such as minimum unit pricing, will impact on the families and social networks of heavy drinkers in addition to the drinker. The most vulnerable may be affected disproportionately. Alcohol policy changes and evaluations need to consider consequences for drinkers, families and communities.
Neale, J., *et al*. (2017).	Residential addiction services in two different regions in England	22 interviews with current (13) and former (9) service users (13 males / 5 females. Ages 23 – 57. 1 female was interviewed twice)	Therapeutic Community informed model	No comparison used or referred to	Overall, relationships between peers within residential treatment seemed to generate some positive but more negative social capital; undermining the notion of the community as a method for positive behaviour change. Research suggests that residential treatment providers should more routinely open the "black box" of "community as method" to consider the complex and dynamic nature of the relationships and social capital inside.
Kiernan, M.D., *et al*. (2018).	Substance misuse service based in North East of England	19 veterans (18 males / 1 female. Ages 35 – 64)	Service provision	No comparison used or referred to	The findings of this study suggest that veterans who misuse alcohol have a range of distinctive and unique difficulties that subtly differentiate them from the wider civilian substance misuse population, and that the use of peer-support models would appear to mitigate against disengagement from alcohol treatment services.
Jeal, N., *et al*. (2017).	Services used by SSW in Bristol	24 current and exited street sex workers (SSW) with current or previous problematic drug use. (Gender not stated, however, results and discussion focuses on females. Ages 26 – 54)	Drug treatment service	No comparison used or referred to	SSWs face many barriers to effective drug treatment. SSW-only treatment groups, continuity of care with treatment staff and contact with female staff, particularly individuals who have had similar lived experience, could improve the extent to which SSWs engage and benefit from drug treatment services. Service engagement and outcomes may also be improved by drug services that include identification and treatment of trauma-related symptoms.

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
Ivers, J.H., *et al*. (2018).	Detox Program, Ireland	10 service users (5 males / 5 females. Ages 27 – 41)	Opiate dependent detoxification program	No comparison used or referred to	Recovery was seen as a process that was not always linear, and lapse and relapse were viewed as part of this process. Patients reported insight into "risk factors for relapse," information and knowledge gained over several years and many treatment episodes. Findings illustrate the role insight plays in any learning and growth experience and the emphasis that is placed upon it within the treatment journey; insight is a fundamental underpinning to any real growth and development.
Chambers, S.E., *et al*. (2017).	Online mutual aid facility for problematic alcohol users (recruitment required participants to be based in the UK)	31 members and ex-members of online mutual aid (6 males / 25 females. Ages 25 – 65)	Soberistas (online mutual aid service)	No comparison used or referred to	Engagement with online mutual aid might support recovery by affording users the opportunity to construct and adjust their identities in relation to their problematic alcohol use; individuals can use the parameters of being online to protect their identity, but also as a mechanism to change and consolidate their offline alcohol-related identity.
Bliuc, A-M., *et al*. (2017).	Online recovery community provided by JFH, Blackpool	Facebook site users (JFH program participants, JFH staff, community members). 609 individuals involved in full research – 2 of these were interviewed as case studies (both male aged 30 and 45)	Online recovery community belonging to Jobs, Friends, Houses (JFH)	No comparison used or referred to	Positive online interactions between members of recovery communities support the recovery process through helping participants to develop recovery capital that binds them to groups supportive of positive change.

Table 3.3 SPICE breakdown of eligible studies continued

Reference	Setting	Perspective	Intervention	Comparison	Evaluation (Results)
Kondoni, T., and Kouimtsidis, C. (2017).	Opiate substitution service based in London	10 service users at baseline (7 males / 3 females) 7 of these completed 3 month follow-up (4 males / 3 females. Ages 37 – 65)	Junction Clinic Opiate Substitution service	Different stages of attendance discussed and briefly compared	Treatment providers, instead of focusing their efforts on stable service users in promoting treatment exit, should focus on new service users, avoiding coercion to treatment aims and rushed detoxifications. Study confirms results of other recent studies on the same theme and argues for the importance of the quality of the treatment experience of new people accessing treatment.
Public Health England, (2018).	Addiction Provision throughout England	270 stakeholders (commissioners, service users and partners) from 14 Local Authorities	Treatment services	No comparison used or referred to	'Deep dive' suggests that the context in which treatment is currently commissioned and provided, including financial pressures and service reconfiguration, has affected alcohol treatment numbers more than treatment numbers for other substances.
Powis, B., *et al*. (2014).	Drug Recovery Wing (DRW) in 5 adult prisons in England (Brixton, Bristol, Surrey, Stockton-On-Tees, and Manchester)	115 participants (36 DRW staff, 12 partner agency staff, 16 wider establishment staff and 44 current DRW participants and 7 DRW that did not complete their stay on DRW)	Drug Recovery Wing	No comparison used or referred to	The issues identified by the study provide some valuable lessons for any future development and running of DRWs. Report states further research is needed to establish whether the examples of developing good practice described in the study translate into reduced reoffending and continuation towards abstinence.

3.3.3. Thematic Synthesis

Overall many of the themes derived from the 36 included studies linked to the components of recovery capital (Social, Human, Physical and Cultural), with each of the studies alluding to one or more of the components, although not always directly using these terms. Social capital relating to relationship resources, such as support derived from groups, family and friends (although these can also entail commitment and obligations) (Best and Laudet, 2010, Cloud and Granfield, 2008). Human capital refers to health (physical and mental), aspirations, hope, skills (including education and training) (Best and Laudet, 2010, Cloud and Granfield, 2008). Physical capital relates to physical assets such as housing, money, and employment (Best and Laudet, 2010, Cloud and Granfield, 2008). Cultural capital includes attitudes, values, beliefs and social integration, which can change over time, especially throughout a recovery journey (Best and Laudet, 2010, Cloud and Granfield, 2008). Many aspects of life can overlap these concepts; employment and education can provide physical capital (finances and progression), but can also relate to human capital, improving skills and well-being. Employment and training can also provide new relationships (colleagues and new friendships) which can infer an increase in social capital, as well as providing new forms of social integration, which is an example of cultural capital.

The findings reported in the included studies related to motivation to change (what led the participants to seek help), notions of abstinence (including harm minimisation), specific group dynamics (including 'hard to reach groups'), gender focused delivery, identity change / self-image, commitment to the process (buy into delivery and driving change), community / peer support (including the influence of negative peers). All the eligible studies reported factors that may facilitate recovery; most (n=28) also reported barriers to recovery, these will be discussed in turn below. Table 3.4 highlights which themes were uncovered in each of the eligible studies (x indicates theme present in study):

Table 3.4 Themes Derived from the Eligible Studies

Reference	Motivation for Change / Help Seeking Behaviour	Abstinence / Harm Minimisation	Hard to Reach / Specific Group Dynamics	Gender Focused Delivery / Differences	Identity Change / Self-Image	Commitment / 'Buying' in to delivery / Driving change	Community / Peer Support / Negative Aspects of Peers or Relationships	Barriers	Facilitators
Aslan, L. (2016).	X				X	X	X		X
Aslan, L. (2015).	X	X			X	X	X		X
Best, D., *et al*. (2016).	X				X	X	X		X
Bliuc, A-M., *et al*. (2017).			X		X	X	X		X
Chambers, S.E., *et al*. (2017).		X	X		X	X	X		X
Colley, E. and J. Blackwell-Young (2012).	X		X	X	X			X	X
Collins, A., McCamley, A. (2018).					X	X	X	X	X
Day, E., *et al*. (2015).	X	X		X	X	X	X	X	X
Duffy, P., Baldwin, H. (2013).	X	X			X	X	X	X	X
Gilbert, H., *et al*. (2015).	X	X				X		X	X
Harris, A.H. (2015).	X				X	X		X	X
Irving, A. (2011).	X	X			X	X	X	X	X
Ivers, J.H., *et al*. (2018).	X	X		X	X	X	X	X	X
Jeal, N., *et al*. (2017).	X	X	X	X	X	X	X	X	X

Table 3.4 Themes Derived from the Eligible Studies continued

Reference	Motivation for Change / Help Seeking Behaviour	Abstinence / Harm Minimisation	Hard to Reach / Specific Group Dynamics	Gender Focused Delivery / Differences	Identity Change / Self-Image	Commitment / 'Buying' in to delivery / Driving change	Community / Peer Support / Negative Aspects of Peers or Relationships	Barriers	Facilitators
Kiernan, M.D., *et al*. (2018).	X		X		X	X	X	X	X
Kondoni, T., Kouimtsidis, C. (2017).	X	X			X	X	X	X	X
Lopez Gaston, R.S., *et al*. (2010).		X					X	X	X
McIntosh, J. and N. McKeganey (2000).	X				X		X	X	X
McPhee, I. and Fenton, D. (2015).		X	X		X		X	X	X
Morse, N., *et al*. (2015).					X	X	X		X
Morton, S., *et al*. (2016).	X	X			X	X	X		X
Neale, J. and C. Stevenson (2015).	X	X	X	X	X	X	X	X	X
Neale, J., *et al*. (2017).	X		X		X	X	X	X	X
Neale, J., *et al*. (2013).	X	X			X	X	X		X
Notley, C., *et al*. (2015).	X	X			X	X	X	X	X
O'May, F., *et al*. (2017).		X			X		X	X	X
Parkman, T. and Lloyd C. (2016).	X	X				X	X	X	X
Public Health England, (2018).								X	X

Table 3.4 Themes Derived from the Eligible Studies continued

Reference	Motivation for Change / Help Seeking Behaviour	Abstinence / Harm Minimisation	Hard to Reach / Specific Group Dynamics	Gender Focused Delivery / Differences	Identity Change / Self-Image	Commitment / 'Buying' in to delivery / Driving change	Community / Peer Support / Negative Aspects of Peers or Relationships	Barriers	Facilitators
Powis, B., Walton, C., Randhawa. (2014).								X	X
Radcliffe, P. and A. Stevens (2008).	X		X	X	X		X	X	X
Sheridan, J., *et al*. (2011).	X					X	X	X	X
Shortt, N.K., *et al*. (2017).	X	X			X	X		X	X
Timpson, H., *et al*. (2016).	X	X			X	X	X	X	X
Tober, G., *et al*. (2013).		X			X	X		X	X
Waters, K., *et al*. (2014).	X	X			X	X		X	X
Weston, S., *et al*. (2018).	X	X			X	X	X	X	X

Motivation for Change / Help Seeking Behaviour

Various aspects that can drive a person to seek recovery from substance abuse problems (God, family, need to eradicate stigmatisation and striving for a 'normal life') were described in the included studies (McIntosh and McKeganey, 2000, Duffy and Baldwin, 2013, Neale and Stevenson, 2015, Neale, Tompkins and Strang, 2017, Weston, Honor and Best, 2018). Family, although often supportive and a driver for help seeking behaviours could also hinder the recovery process by purchasing alcohol or creating an environment which required commitment and responsibility that could encumber the individual (O'May, Whittaker, Black and Gill, 2017, Neale and Stevenson, 2015). Although the need to eradicate stigma was reported to drive an individual to seek help, stigmatisation was also described as a barrier to help seeking, especially for individuals from specific communities (i.e. street sex workers) (Jeal, Macleod, Salisbury and Turner, 2017). Motivation to attend services or help seeking discourse varied depending on the background of the participants. Some described not being able to relate to others in service which could present a barrier for continued attendance (Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016). For some individuals help seeking was characterised by first hitting 'rock bottom', where the individual feels they can get no lower in life, or a feeling of being 'out of control' (McIntosh and McKeganey, 2000, Parkman and Lloyd, 2016, Gilbert, Drummond and Sinclair, 2015). The process of seeking help was often reported to be the first stage in a long process of recovery (Ivers, Larkan and Barry, 2018, Best, Beswick, Hodgkins and Idle, 2016). Coming to terms with past traumas and aspects of their lives that needed to change also drove participants to seek help (Waters, Holttum and Perrin, 2014, Notley, Blyth, Maskrey, Pinto and Holland, 2015, Neale, Nettleton and Pickering, 2013, Kondoni and Kouimtsidis, 2017). A lack of control (or even lack of a father figure) was reported as a factor for drug or alcohol use in the first instance (Irving, 2011, Gilbert, Drummond and Sinclair, 2015). The substance was also described as no longer providing the recipient with pleasurable effects; therefore its use was becoming irrelevant (McIntosh and McKeganey, 2000). Some studies reported the barriers for help seeking. They described the need to remain in a known social group or a feeling that drug use is so embedded in their

self-concept that life without its use would be too difficult. Both of these were felt to be preventing recovery (Radcliffe and Stevens, 2008, Notley, Blyth, Maskrey, Pinto and Holland, 2015). Others described potential engagement with treatment programmes as a means to avoid a custodial sentence, rather than attendance following a motivation to recover from addiction (Sheridan, Barnard and Webster, 2011) For others, the normalisation of alcohol use in their past meant that even realising there was an issue to address was often problematic (Kiernan, Osbourne, McGill, Greaves, Wilson and Hill, 2018). Participants also described having to produce a 'genuine reason' for quitting to legitimise their recovery to others (McIntosh and McKeganey, 2000). Poor emotional states and negative coping strategies were among the reasons presented for drug or alcohol use in the first instance: these areas were often reported to be the first areas participants tried to deal with in their initial stages of recovery (Colley and Blackwell-Young, 2012) (Waters, Holttum and Perrin, 2014). For some participants the continued use of opiate substitution is 'often initiated and maintained as a coping strategy for difficult emotions or traumatic memories' (Notley, Blyth, Maskrey, Pinto and Holland, 2015 p.11).

Notions of Abstinence / Harm Minimisation

A critical difference identified was between individuals assessing services where abstinence was regarded as the only option for recovery, and provision which felt harm minimisation approaches should also be offered (Notley, Blyth, Maskrey, Pinto and Holland, 2015, Waters, Holttum and Perrin, 2014). As presented above, opiate substitution appeared to offer a 'normal life' without the fear of withdrawal, although some in this study reported how unwell they felt on the substitute medication (Notley, Blyth, Maskrey, Pinto and Holland, 2015). In a further study, participants described how attendance for detox was not as unpleasant as others had led them to believe, although this study stressed the importance of following a short rehab provision with a follow-up, explaining that without further care rehab is like 'putting a plaster on a shark bite' (Neale, Nettleton and Pickering, 2013 p.167). Fear of relapse often prevented service users from stopping opiate substitution (Kondoni and Kouimtsidis,

2017). Others, however, described lessons learned from a temporary relapse as almost a supporting factor in their on-going recovery (Irving, 2011). The prescribing of methadone could also be a barrier to recovery (or at least abstinence based recovery), holding participants in their stigmatised identity (McPhee and Fenton, 2015). Some provision described programmes which allowed the options of complete abstinence as well as those seeking to reduce consumption (Morton, O'Reilly and O'Brien, 2016).

For a number of participants in other studies in the review, the importance of being in a 'risk free' environment of abstinence-based support that provided a 'safe haven' was described as fundamental to their recovery, with those still using substances perceived to pose a risk to their recovery (Waters, Holttum and Perrin, 2014, Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013, Weston, Honor and Best, 2018). One study reports the provision of services being on the condition of abstinence, with residents being breathalysed prior to being permitted entry. In this scheme, some participants described it as a 'necessary evil', others expressed a dislike for the rule, although most agreed that sobriety led to 'trouble generally staying on the streets' (Neale and Stevenson, 2015 p.480). For some participants family support was perceived to be provided if striving for abstinence rather than opting for reduction (O'May, Whittaker, Black and Gill, 2017). Environmental triggers (alcohol marketing and availability) were described as potentially damaging challenges to abstinence, creating 'risky' situations that could trigger relapses (Shortt, Rhynas and Holloway, 2017). A number of services or peer support provision described in the eligible studies were specifically abstinence based (Lopez Gaston, Best, Day and White, 2010, Parkman and Lloyd, 2016, Aslan, 2015, Gilbert, Drummond and Sinclair, 2015), and discourse around perceptions of abstinence varied depending on the type of provision participants chose to attend (Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016). A service being abstinence based could put potential service users off attending, posing challenges around committing to being alcohol free (Chambers, Canvin, Baldwin and Sinclair, 2017), or pose a barrier for staff referring potential clients, often believing their

clients to be looking to reduce use rather than stop altogether (Day, Wall, Choham and Seddon, 2015).

The term recovery has become synonymous with abstinence, as recent models have shifted towards recovery oriented models of substance use (Notley, Blyth, Maskrey, Pinto and Holland, 2015, Duffy and Baldwin, 2013), although recovery should not be viewed as a fixed state but rather as a process that may require a period of substance substitution to stabilise an individual before they can progress to the next phase of recovery. Indeed, for some, abstinence is the chosen route from initiation into services, whilst for others, reducing medication is the first step of their recovery (Waters, Holttum and Perrin, 2014). For some, recovery is described as meaning more than just abstinence and so requires a more holistic approach than just focusing on removing the substance (Ivers, Larkan and Barry, 2018).

Hard to Reach / Specific Group Dynamics

A number of the included studies described specific group dynamics which could act as a barrier to service attendance but also noted that these individuals may need more tailored provision. Veterans (ex-military personnel) reported needing provision that understood their background, preferably where there was peer support and staff or recovery champions who were ex-military (Kiernan, Osbourne, McGill, Greaves, Wilson and Hill, 2018). Homelessness was also described as causing further barriers to recovery, triggering further stigmatisation of potential service users (McPhee and Fenton, 2015). Some participants report becoming homeless to escape issues and abuse at home (Neale and Stevenson, 2015). Street sex workers described feeling stigmatised and unable to discuss their work in a peer support environment, explaining that staff understanding and specific group provision would better benefit their recovery (Jeal, Macleod, Salisbury and Turner, 2017). For others, not having things in common with other service users led them to feel isolated; a view that others in the group are ‘not like me’ prevented engagement (Neale, Tompkins and Strang, 2017 p.42). Often the provision of an online

forum assisted with geographically isolated substance users seeking support (Chambers, Canvin, Baldwin and Sinclair, 2017, Biluc, Best, Iqbal and Upton, 2017). Offenders also present as hard to reach and requiring a specific group dynamic. One of the studies reported the need for those in prison to be placed on specific drug recovery wings, as this promotes recovery, whilst providing a space away from other prisoners (Powis, Walton and Randhawa, 2014).

Gender Focused Delivery / Differences

Female only provision was also identified by the included studies as potentially beneficial (Ivers, Larkan and Barry, 2018, Jeal, Macleod, Salisbury and Turner, 2017, Colley and Blackwell-Young, 2012, Day, Wall, Choham and Seddon, 2015). It was reported that these could allow service users to be 'oneself' and share experiences in a safe environment (Ivers, Larkan and Barry, 2018). Staff often felt that service users may be at risk due to their vulnerabilities in a peer support setting where both genders attended (Day, Wall, Choham and Seddon, 2015). As described above, where groups presented specific dynamics, female service delivery staff would also benefit recovery (Jeal, Macleod, Salisbury and Turner, 2017). Many females reported their drug use was often the result of earlier trauma and / or abuse (both domestic and child abuse); for these people substances were used as coping mechanisms (Colley and Blackwell-Young, 2012). These women struggled to express or accept emotional responses, making them appear 'hard-faced'. Successful treatment / recovery programmes for this category of participants requires introducing different ways of expressing emotions, accepting others' expressions of emotions and providing alternative coping mechanisms other than misusing substances.

Identity Change / Self Image

The majority of the studies, (30 of the 36), reported elements of self-image or identity change. For those service users who described a pre-recovery or drug using past, this was associated with negative perceptions of themselves, with them describing emotional discontent, poor coping strategies, low self-confidence, feeling a failure, being stigmatised and

expressing guilt and shame (McIntosh and McKeganey, 2000, Colley and Blackwell-Young, 2012, Neale and Stevenson, 2015, Irving, 2011, Harris, 2015, Jeal, Macleod, Salisbury and Turner, 2017, Kondoni and Kouimtsidis, 2017). For some individuals, recovery services were actually perceived to increase stigma (Jeal, Macleod, Salisbury and Turner, 2017); for others, the online provision provided an opportunity to present an identity in an anonymous fashion, providing a sense of freedom (Chambers, Canvin, Baldwin and Sinclair, 2017).

A number of the studies described how previous substance using identities were ingrained in the individual's sense of self, creating difficulties in early recovery (Radcliffe and Stevens, 2008, Notley, Blyth, Maskrey, Pinto and Holland, 2015, McPhee and Fenton, 2015, Kiernan, Osbourne, McGill, Greaves, Wilson and Hill, 2018, Kondoni and Kouimtsidis, 2017). More positively, participants reported that attendance at service or support provision had led to more positive notions of themselves, creating better coping techniques and life skills (Ivers, Larkan and Barry, 2018, Chambers, Canvin, Baldwin and Sinclair, 2017, Shortt, Rhynas and Holloway, 2017, McIntosh and McKeganey, 2000, Colley and Blackwell-Young, 2012, Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013, Waters, Holttum and Perrin, 2014, Neale, Nettleton and Pickering, 2013, Morse, Thomson, Brown and Chatterjee, 2015, Morton, O'Reilly and O'Brien, 2016, Aslan, 2016, Duffy and Baldwin, 2013). For others a lack of personal space (Neale, Tompkins and Strang, 2017), feeling excluded from within the group or connecting with negative peers in the provision or seeing 'old friends' reduced the possibility of a positive identity change (O'May, Whittaker, Black and Gill, 2017, Weston, Honor and Best, 2018). Often connecting with 'something outside' reminded participants of the world around them that benefited their identity or took them back to a pre-using time when they felt happy (Shortt, Rhynas and Holloway, 2017, Aslan, 2016).

Overall, for identity development and personal growth to occur, the emphasis in provision needs to focus on recovery as a journey (Collins and McCamley, 2018) that does not focus solely on the individual but also

attends to issues which are wider and more holistic (Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016).

Commitment to the Process / 'Buying' into Delivery / Driving Change

Viewing recovery as a process requires the buy-in of participants (and staff) to a long and, at times, difficult journey. It is apparent that everyone recovers at a different pace; there is not a 'one size fits all' recovery pathway. Recovery is depicted as a gradual process made up of various 'stages' requiring on-going commitment (Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013, Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016, Gilbert, Drummond and Sinclair, 2015, Best, Beswick, Hodgkins and Idle, 2016, Collins and McCamley, 2018). Often personal relationships were viewed as important in driving recovery (providing they are healthy) (Neale and Stevenson, 2015). Likewise possessing a 'fighting spirit' and creating a positive identity construction energises recovery (Irving, 2011 p.188). Finding non-substance using activities maintains direction: trying new things, finding structure to the day - all require commitment, but will ultimately support recovery (Duffy and Baldwin, 2013, Morse, Thomson, Brown and Chatterjee, 2015, Morton, O'Reilly and O'Brien, 2016, Parkman and Lloyd, 2016). The recovery process often presented challenges: the fear of relapse often kept participants 'trapped' in a cycle (Ivers, Larkan and Barry, 2018, Jeal, Macleod, Salisbury and Turner, 2017), whereas, for others, opiate maintenance stabilised them to continue their journey (Kondoni and Kouimtsidis, 2017). Some reported feeling accountability to peers and noted that the support provided by peers and staff drove their recovery (Chambers, Canvin, Baldwin and Sinclair, 2017, Biluc, Best, Iqbal and Upton, 2017)

Furthermore, pushing someone through the stages before he/she is ready may hinder client recovery rather than assist; the pressure placed on people to conform within a set time-period could force a relapse (Duffy and Baldwin, 2013). In addition, services placed under strain could mean even the most committed staff being overwhelmed and unable to provide the quality of provision needed (Sheridan, Barnard and Webster, 2011). Goals change over time, so those in recovery must remain flexible to change and

embrace it, but at their own pace, becoming aware of the ‘tidal wave’ of emotions and beginning to view life through ‘fresh eyes’ (Waters, Holttum and Perrin, 2014 p.226-227).

Community and / or Peer Support (including Negative Aspects to Peers)

For some participants in the studies, breaking free from old ties and friendship groups proved difficult: often these groups provided a source of identity and meaning, or funds to support each other’s drinking or substance use (Radcliffe and Stevens, 2008, Notley, Blyth, Maskrey, Pinto and Holland, 2015, Aslan, 2015, O'May, Whittaker, Black and Gill, 2017).

Peer support in service provision received mixed reviews. For some participants access to the advice from a ‘wounded healer’ (Irving, 2011 p.190) or the provision of social or physical capital in terms of finances or social sustenance (Neale and Stevenson, 2015) provided positive support. Peers were reported to improve self-efficacy, confidence, quality of life and a sense of belonging (Duffy and Baldwin, 2013, Weston, Honor and Best, 2018, Lopez Gaston, Best, Day and White, 2010, Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016, Morse, Thomson, Brown and Chatterjee, 2015, Parkman and Lloyd, 2016), all factors that could encourage re-engagement in the community (Morton, O'Reilly and O'Brien, 2016, Collins and McCamley, 2018, Ivers, Larkan and Barry, 2018). However, other participants describe how peers can trigger a relapse (Ivers, Larkan and Barry, 2018), cause issues by arguing and being disruptive (Neale, Tompkins and Strang, 2017) or lead to distrust (Neale and Stevenson, 2015).

The sharing of recovery stories was also described as both positive, providing a shared common identity or sense of cohesion (Chambers, Canvin, Baldwin and Sinclair, 2017, Ivers, Larkan and Barry, 2018, Irving, 2011), but also as occasionally negative, with some participants not being willing to open up in front of strangers or presenting difficulties in trusting others (Neale, Tompkins and Strang, 2017). Participants in another review study, based in a residential rehab provision, reported suspicions that some service users attended mutual aid groups in order to leave the

provision for a few hours, as they were not usually permitted to leave the service otherwise (McPhee and Fenton, 2015).

Sharing experiences often meant users had the ability to help others, the notion of a ‘generative script’ (generating a gift to be given to the next generation) creating a network that brought individuals together (Irving, 2011 p.191), and creating or adding to the social contagion of recovery (Best, Beswick, Hodgkins and Idle, 2016). However, this view was counteracted by what some people described as the ‘dark side’ of peer support, where an ‘exclusive bubble’ can be created amongst a sub group, leaving some individuals feeling further isolated and disconnected (Weston, Honor and Best, 2018, Neale, Tompkins and Strang, 2017). Developing a sense of belonging is important to the recovery journey (Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016), listening to the views or stories of others is one aspect but self-agency or self-governance is another, in Foucaultian terms individuals are active in their own decision making-processes, they listen to others but ultimately came to their own conclusion about treatment (Neale, Nettleton and Pickering, 2013).

Barriers to Recovery

For the most part obstacles to provision can be grouped into intrapersonal, interpersonal and social barriers to recovery, with many of these concepts overlapping (Notley, Blyth, Maskrey, Pinto and Holland, 2015). A number of the studies described intrapersonal barriers to recovery that the individuals themselves posed. Shame, guilt, stress, social anxiety, social isolation, low self-esteem, depression, and negative thoughts were all reported to prevent or reduce the ability to seek help (Kondoni and Kouimtsidis, 2017, Waters, Holttum and Perrin, 2014, Radcliffe and Stevens, 2008, Ivers, Larkan and Barry, 2018, Jeal, Macleod, Salisbury and Turner, 2017, Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016, McPhee and Fenton, 2015, Irving, 2011, Notley, Blyth, Maskrey, Pinto and Holland, 2015). However, some of these aspects could be reduced by better understanding and less stigmatisation in service provision. Poverty and illness similarly caused barriers (O'May, Whittaker, Black and Gill, 2017). Often participants pushing themselves to take on too much caused a barrier to recovery; the process needed to be fluid with the ability to

progress, but not at too fast a pace (Collins and McCamley, 2018, Duffy and Baldwin, 2013)

Tension and group dynamics, relationship issues, inability to bond with peers or staff, drug using peers and feeling stigmatised within the peer group all posed interpersonal barriers to recovery (Kondoni and Kouimtsidis, 2017, Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013, Jeal, Macleod, Salisbury and Turner, 2017, Ivers, Larkan and Barry, 2018, Neale, Tompkins and Strang, 2017, Weston, Honor and Best, 2018, Parkman and Lloyd, 2016, McPhee and Fenton, 2015, Notley, Blyth, Maskrey, Pinto and Holland, 2015, Neale and Stevenson, 2015). Isolation within the peer groups was also harmful to recovery and created a barrier to cohesion (Neale, Tompkins and Strang, 2017, Weston, Honor and Best, 2018, Lopez Gaston, Best, Day and White, 2010).

Social barriers to recovery included provisions being aimed at opiate substitution treatment (OST), stigma in attending services, (Jeal, Macleod, Salisbury and Turner, 2017, Weston, Honor and Best, 2018, Notley, Blyth, Maskrey, Pinto and Holland, 2015, Radcliffe and Stevens, 2008). The normalising of alcohol or drug use in society as a whole also posed a barrier, as this issue could lead to an inability to identify personal problematic use, as well as making the leaving behind of old social groups isolating (Kiernan, Osbourne, McGill, Greaves, Wilson and Hill, 2018). Risky environmental aspects such as alcohol availability and marketing created a risk of relapse and stress for some individuals in recovery (Shortt, Rhynas and Holloway, 2017). Lack of stable housing, education and employment opportunities were also reported barriers to recovery (Weston, Honor and Best, 2018, McPhee and Fenton, 2015, Duffy and Baldwin, 2013, Notley, Blyth, Maskrey, Pinto and Holland, 2015, Neale and Stevenson, 2015).

Fear of relapse was a barrier that was reported interpersonally, intrapersonal and socially, as the anxiety associated with relapse affected participants' willingness to come off OST, concerned them around drug using peers, and the stigma associated with the continued use of substitute drugs socially caused reported levels of stress and concern

(Ivers, Larkan and Barry, 2018, Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013, Kondoni and Kouimtsidis, 2017, Harris, 2015, Day, Wall, Choham and Seddon, 2015, Parkman and Lloyd, 2016). Some participants also stated 'normal' events could trigger a relapse (Ivers, Larkan and Barry, 2018). Relapse being described as a 'normal' part of the journey to recovery was felt by some to pose a risk to recovery, (Ivers, Larkan and Barry, 2018, Weston, Honor and Best, 2018, Parkman and Lloyd, 2016), although this was also described by others as a facilitator, as it prevented individuals feeling a failure when it happened (Ivers, Larkan and Barry, 2018).

Aspects of service delivery also presented barriers to attending. Frequent staff turnover, lack of staff training or perceived knowledge or compassion, services being too busy, services not focused enough on the needs of the user, lack of referral pathways, and services offering only a 'tick box' approach to delivery were all said to impede engagement (Public Health England, 2018b, Powis, Walton and Randhawa, 2014, Jeal, Macleod, Salisbury and Turner, 2017, Gilbert, Drummond and Sinclair, 2015, Harris, 2015, Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013, Lopez Gaston, Best, Day and White, 2010, Neale and Stevenson, 2015, Sheridan, Barnard and Webster, 2011). Programmes could become repetitive, which caused participants to lose interest (Parkman and Lloyd, 2016). A lack of personal space in provision also presented conflict (Neale, Tompkins and Strang, 2017). Staff also reported issues regarding service delivery, stating poor data quality, loss of expertise among staff, staff turnover, financial pressures, frequent service reconfiguration, senior staff not buying into delivery and the commissioning context as barriers to recovery and effective service delivery (Sheridan, Barnard and Webster, 2011, Powis, Walton and Randhawa, 2014, Public Health England, 2018b) The 'cliff-edge' for clients following their exit from a form of service delivery was also described as a barrier to on-going recovery: following an intense and structured support programme, participants could feel abandoned and struggle to maintain their journey (Parkman and Lloyd, 2016)

Mutual aid provision such as 12-steps groups (TSGs) could often create a barrier to attendance, with some resisting this method's focus on

accessing a higher power (often thought to be of a spiritual kind), its focus on complete abstinence, or its need for clients to admit being powerless to the drug. Such aspects, and the emphasis placed on peer support and the power of the 'share' was not always reported to facilitate recovery (Day, Wall, Choham and Seddon, 2015, Parkman and Lloyd, 2016, Lopez Gaston, Best, Day and White, 2010). Other participants, however, reported the benefits of TSGs and described them as facilitators (covered below).

Facilitators to Recovery

Structure, stability, the provision of meaningful activities were all aspects that were described as facilitating recovery (Neale and Stevenson, 2015) (Lopez Gaston, Best, Day and White, 2010) (Neale, Nettleton and Pickering, 2013) (Duffy and Baldwin, 2013) (Shortt, Rhynas and Holloway, 2017) (Aslan, 2015, Aslan, 2016) (Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016) (Parkman and Lloyd, 2016) (Collins and McCamley, 2018) (Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013). Flexibility regarding the length of stay, rules and provision within service were also aspects which service users described as facilitators to recovery (Neale and Stevenson, 2015). Co-producing delivery, learning something new, having focus and being able to note achievements also drove recovery forward (Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013) (Neale, Nettleton and Pickering, 2013).

Feeling safe, having positive role models, experiencing a closeness, often with staff acting as 'positive parents' supported participants to explore their emotions (Waters, Holttum and Perrin, 2014 p.226). Facilities that promoted self-awareness, where service users could learn to deal with their emotions and learn new coping mechanisms were all said to enhance recovery prospects (Harris, 2015) (Gilbert, Drummond and Sinclair, 2015) (Best, Beswick, Hodgkins and Idle, 2016) (Chambers, Canvin, Baldwin and Sinclair, 2017).

Services that provide provision free from stigma with supportive, well trained staff would benefit service users and encourage recovery (Radcliffe and Stevens, 2008) (Aslan, 2016). A range of provision for those

seeking abstinence, as well as those looking to reduce or substitute with methadone was expressed to be favourable, with options for mutual aid among other provisions that needed to be signposted (Duffy and Baldwin, 2013) (Lopez Gaston, Best, Day and White, 2010). Services also needed to adopt a holistic approach providing psychological support during and following OST (Notley, Blyth, Maskrey, Pinto and Holland, 2015) (Neale, Nettleton and Pickering, 2013). Aftercare was also described to be a requirement to successful provision (Duffy and Baldwin, 2013)

Staff reported that although target setting and the commissioning process can have a negative effect on staff they can also address poor performance and create competition (Sheridan, Barnard and Webster, 2011). Effective communication, good supervision, support and training were also described by staff as facilitating service provision and ultimately assisting individuals in their recovery journey (Sheridan, Barnard and Webster, 2011, Powis, Walton and Randhawa, 2014, Public Health England, 2018b). Furthermore, staff having a good understanding of TSG and attending open meetings would support signposting to mutual aid (Day, Wall, Choham and Seddon, 2015). Staff enthusiasm to help service users, who were motivated in their roles are further drivers to support recovery (Public Health England, 2018b, Powis, Walton and Randhawa, 2014)

Having a supportive family and friends also acted as a motivator, along with having resident children, although this could also cause a fear of relapse (Notley, Blyth, Maskrey, Pinto and Holland, 2015). Peer support and connection to ‘healthy’ groups by building social capital (Weston, Honor and Best, 2018) (Kondoni and Kouimtsidis, 2017), as well as having good role models where identification and inspiration could occur would facilitate recovery (Neale, Tompkins and Strang, 2017). Often specific role models with lived experience could support this identification, especially for particular groups (Jeal, Macleod, Salisbury and Turner, 2017, Kiernan, Osbourne, McGill, Greaves, Wilson and Hill, 2018). Access to other forms of capital such as training, education and employment opportunities also drove recovery (Duffy and Baldwin, 2013, Timpson, Eckley, Sumnall,

Pendlebury and Hay, 2016, Collins and McCamley, 2018, Ivers, Larkan and Barry, 2018).

One study described how relapse could actually make the recovery journey stronger, providing knowledge that enhances resilience and supports future coping mechanisms (Irving, 2011). This study describes how the cycle of relapse is a common feature in the narratives of recovering drug addicts, taking the average heroin addict six attempts over six years to become drug free (Irving, 2011).

Overall opportunities to learn, try new things, build confidence, create positive outcomes, cultivate a sense of health and well-being (both physical and mentally) where hope would develop were all seen as facilitators to the recovery process (Lopez Gaston, Best, Day and White, 2010, Morse, Thomson, Brown and Chatterjee, 2015, Morton, O'Reilly and O'Brien, 2016, Parkman and Lloyd, 2016, Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016, Best, Beswick, Hodgkins and Idle, 2016, Collins and McCamley, 2018, Shortt, Rhynas and Holloway, 2017, Biluc, Best, Iqbal and Upton, 2017).

Social Capital

‘Constructing a new/non-addict identity’ was a theme which linked each of the four recovery capital components (McIntosh and McKeganey, 2000 p.1501, Irving, 2011). Whether discarding the ‘junkie’ stigmatisation (Radcliffe and Stevens, 2008) or learning new skills (human), changing their environment (physical), or embracing spirituality (cultural), those in treatment are creating a new ‘self’. The social aspects refer to striving to remove ‘shame’ associated with drug use, and become the person they felt they were ‘at heart’ (Radcliffe and Stevens, 2008, McIntosh and McKeganey, 2000). Participants in one particular study reported segregation at pharmacies, making them feel isolated and driven out of their local communities (Radcliffe and Stevens, 2008). A major component of social capital involves building new relationships, as well as ‘fixing’ some broken familial ones (Duffy and Baldwin, 2013). A number of the studies report the need for peer support, especially having people to ‘share’ experiences and emotions with, but this has to be away from

‘using’ friends if they are to instigate and maintain abstinence (or reduction) (Neale, Nettleton and Pickering, 2013, Neale and Stevenson, 2015, Duffy and Baldwin, 2013, Colley and Blackwell-Young, 2012). However, enemies within a group or community can cause anxiety and fear, hindering recovery (Neale and Stevenson, 2015) or exclusion within a group can cause disconnection (Weston, Honor and Best, 2018).

Physical Capital

The importance of a ‘safe place’ was referred to in the included studies, when discussing physical capital (Neale and Stevenson, 2015). Access to training, education and employment opportunities were described to maintain recovery (Duffy and Baldwin, 2013, Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016, Collins and McCamley, 2018, Ivers, Larkan and Barry, 2018).

Human Capital

Engaging in meaningful activities arose within many of the studies (Duffy and Baldwin, 2013, Parkman and Lloyd, 2016, Collins and McCamley, 2018, Shortt, Rhynas and Holloway, 2017). The importance of finding new things to do, new skills, new drivers was essential to many (Shortt, Rhynas and Holloway, 2017, Lopez Gaston, Best, Day and White, 2010, Morse, Thomson, Brown and Chatterjee, 2015, Morton, O'Reilly and O'Brien, 2016, Parkman and Lloyd, 2016, Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016, Best, Beswick, Hodgkins and Idle, 2016, Collins and McCamley, 2018, Biluc, Best, Iqbal and Upton, 2017).

Cultural Capital

Building self-esteem, ‘learning to like yourself’, developing new coping mechanisms were all areas described as fundamental to driving recovery (Waters, Holttum and Perrin, 2014, McIntosh and McKeganey, 2000, Colley and Blackwell-Young, 2012).

Inter-relating Themes

Many of the themes that emerged from the synthesis of the included studies overlapped; some even contradicted one another. Motivations for

change span across human and social capital domains, such as working towards a return to work (human) and creating a new identity / rebuilding relationships; these are both incentives for change.

Contradictions or contrasting views were also evident in the studies. Some participants reported the need for structure in the shape of rules within a service, but the notion of following rules put other participants off attending. Participating in local communities (physical capital) is important to recovery but maintaining a 'risk free' environment of abstinence, away from a chaotic or 'using' society (especially for those recovering from alcohol dependence, alcohol being freely available in many cultures) is equally as fundamental to recovery.

The importance of support was an overarching theme that all studies referred to in one context or another. This could derive from a number of locations, such as a 'higher power', communities, economics, recovery champions, peer support or bonds with staff. Support is a concept that stretches through each area of recovery capital. To gain human capital individuals may require support regaining health and developing skills (either educationally or developing coping mechanisms away from substance use), both professional and peer support will improve these prospects. Cultural capital support refers to beliefs and attitudes that encourage social conformity, peer support and access to recovery champions will drive this area. Social capital relates to relationships, not just from immediate family but from friendship circles as well as the surrounding community. Access to assets in the form of housing and finance (physical capital) can be found in support from family, professionals and the wider community.

3.4 Discussion

The review highlights a range of views about what is most likely to facilitate or act as a barrier when providing recovery from substance addiction support. Entry into recovery programmes, where completely voluntary, can help clients who have reached a critical turning point and a 'state of readiness' for change. However, clients can often be catapulted into programmes for a variety of other, more instrumental reasons, like the

need to find accommodation or appease family demands. Thus, motivation levels may vary within the service-user group and methods may need to accommodate this variation. In addition, if recovery is visualised as a set of steps or a staged process, people will inevitably need to move through the programme at a different pace. Evidence appears to suggest that being pushed through these stages too fast (perhaps as a consequence of insensitive commissioning which limits time using the service) may undermine success. Even once 'recovery' is achieved, attention needs to be paid to developing different strategies to maintain that state.

This review found that no single form of provision for recovery support will fit everyone's needs. Services providing both support for those striving for abstinence as well as those seeking to reduce consumption or utilise a substitute programme need to be provided, although not necessarily from the same location; often more specific but non-judgmental or stigmatising provision would be better suited.

The concept of 'recovery capital' is helpful in that it helps users understand how being 'well' or 'cured' will take more than just stopping drug or alcohol consumption, but can only be achieved through developing a range of different personal skills. Social capital aspects emphasise the need for a new non-stigmatised identity and the shrugging off of old social networks which might drag individuals back into chaos and old habits. Physical capital highlights the need to secure safe comfortable accommodation and physical connection to the environment and community. Human capital persuades individuals of the value of setting small achievable goals which will help build towards bigger goals of becoming an asset within the recovery community, and potentially securing employment in the wider community beyond that. Cultural capital may be enhanced for some by engaging with spirituality, for others extending their training and / or education provided cultural capital. In all cases, these skills will need to be modelled and demonstrated, learned and practised ostentatiously and reinforced until they become automatic.

As previous research has highlighted, practitioners need to understand that 'treating' addictions alone is insufficient to develop recovery capital; a range of personal and interpersonal transitions are required.

Community based asset schemes can allow recovering individuals to re-engage with society, develop new skills, recognise their own development and make a contribution to the recovery community in return. In order to achieve this, such schemes must look to build on all areas of recovery capital (social, physical, cultural and human) and empower people to gain (or regain) control of their lives and drive forward their own solutions. Such schemes highlight how recovering from alcohol or drug use is more than simply a matter of ceasing negative behaviour. It also involves the construction of a new identity which can be built through developing self-respect, new skills and positive motivation for change. All these factors need to be considered within the commissioning cycle to ensure the needs of service users are met and demand on provision is reduced.

3.5 Strengths and Limitations of Review

This review supports existing research that highlights the importance of building recovery capital in order to enhance recovery prospects and drive a move to stable recovery. In addition, the review findings offer a voice to both those in recovery and those working within the recovery field, highlighting themes described as important to these individuals as well as potential barriers to delivery. These notions will support consideration for future commissioning and service delivery. This review will also support future research into the effectiveness of different recovery provisions.

The limitations of this review include issues about the terminology surrounding community delivery of such services within the UK and the Republic of Ireland. Often provision was delivered in what was described as an asset based approach, using facilities already available in the community. However the term also applied to specific communities or groups of individuals sharing similar attributes and using their own developing strengths in recovery as ‘assets’ to be shared with fellow clients. A further limitation refers to the delivery of treatment. Initially the review sought to only include ‘recovery’ provision, excluding services focusing on treatment phases only. This proved difficult, especially when the searches were updated in 2018, as much provision appears to be designed to offer a ‘one stop shop’ approach for both ‘treating’ the initial phase of service entry as well as providing on-going recovery support.

In addition, it is noted that there may be criticism of the final stage of a synthesis (where themes are derived) as this is 'dependent on the judgement and insights of the reviewers' (Thomas and Harden, 2008 p.7). However as the eligible articles agreed for data extraction were agreed between two parties and the methodology for analysis clearly described and methodical, this potential bias has been reduced. Although, only one researcher conducted data extraction, which may have caused bias caused by the researchers' own opinions towards the research, another researcher may have noted different themes.

3.6 Chapter Summary

For the most part, the emerging themes from the review, can be classified under the four components of recovery capital (Social, Physical, Human and Cultural), with some themes overlapping these components. The goals, motivations for change and help-seeking behaviours demonstrated by participants in the studies contained similarities, although opinions on abstinence versus harm-reduction varied.

This review presents the findings from a range of view/perception based studies. Collectively they demonstrate that service provision must cater for all areas of recovery need, including those wishing to reduce consumption rather than abstain. Recovery provision should include (but not be limited to) access to peer support, psycho-social interventions, behaviour modelling, and coping strategies. In order for individuals to feel like they are recovering and possess assets for their local community, services must look to build on all areas of recovery capital (social, physical, cultural and human) and empower people to gain (or regain) control of their lives and drive forward their own solutions. These aspects of service delivery, covering facilitators and barriers to recovery will be examined further in chapters five and six and correlations between the findings of the review and themes uncovered in the qualitative research will be discussed in chapters seven and eight.

Chapter 4. Qualitative Methodology and Methods

4.1 Introduction

This chapter focuses on the methods for the qualitative empirical phase of the research (the systematic review methodology having been described already in Chapter 3). The first section of the chapter covers the justification for adopting a qualitative approach and gives an overview of the research paradigm within which the research was conducted. The second section focuses on the methods used to collect and analyse the data. Ethical considerations for the research are then presented. This is followed by a section discussing validity and how the trustworthiness of the design was strengthened. Finally the chapter will conclude with a discussion on the strengths and limitations of the study design.

This study used the COREQ (COnsolidated criteria for REporting Qualitative research) developed from (Tong, Sainsbury and Craig, 2007) (Checklist available in Appendix C).

4.2 Qualitative Approach

Qualitative research does not look to address questions within research such as ‘how many’, or seek to determine statistical significance, nor does it wish to examine strength of association between variables. Rather it looks to ‘make visible and unpick the mechanisms which link particular variables, by looking at the explanations, or accounts, provided by those involved’ (Barbour, 2014 p.13). Qualitative research looks to delve into understanding human behaviour and the reasons that govern the behaviour, answering the why and how of decision-making (Bryman, 2008).

A qualitative approach was chosen to allow rich in-depth data needed to understand the complex contexts involved in addiction recovery and the commissioning and delivery of services to be obtained. Qualitative approaches can provide a holistic view of a field of study, examining relationships, interpretations and processes as important features of a multifaceted social environment (Patton, 1987) (Mason, 2002). This

research looked to understand barriers and facilitators to recovery service provision (both accessing services and in the delivery of provision), focusing on how commissioning changes may impact on service delivery and the recovery journeys of those attending recovery services. Therefore, techniques aimed at observing and documenting the processes involved in service provision and the relationships between service users and staff within these services are fundamental to understanding.

4.2.1 Research Paradigm

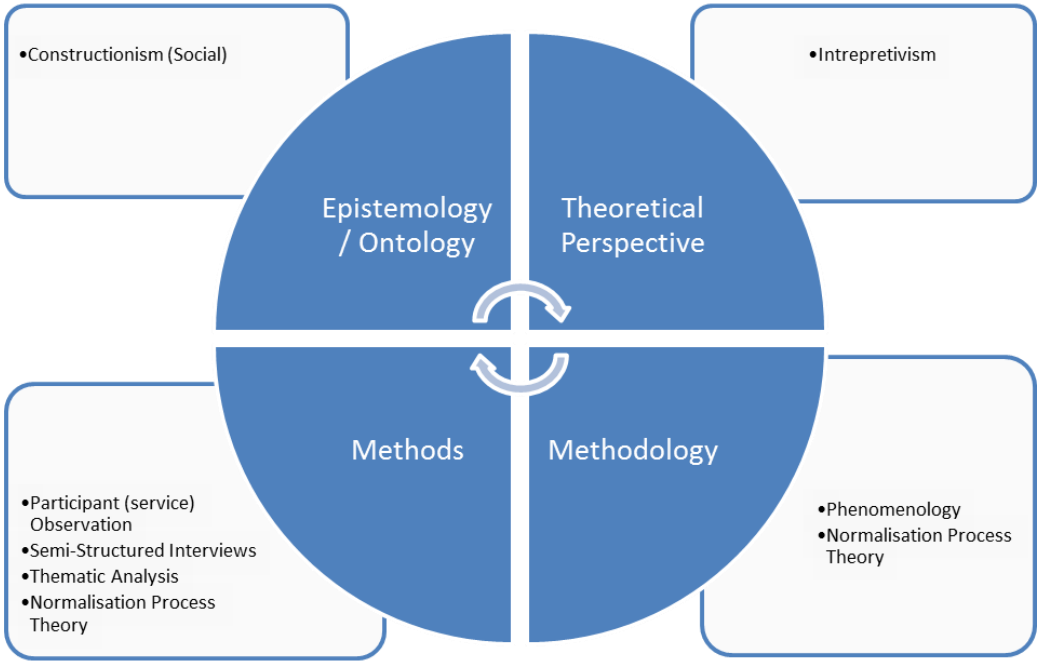
A research paradigm is “the set of common beliefs and agreements shared between scientists about how problems should be understood and addressed” (Kuhn, 1962). When developing a study proposal, Crotty (2013) suggests the researcher should ask two questions, what methodologies and methods will be used in conducting the research and secondly, how can these choices be justified (Crotty, 2013). Justification for the choices should be born from the assumptions about reality that the researcher brings to their work, their theoretical perspective, their understanding about how humans ascribe to knowledge (Crotty, 2013). Here a model for designing a research structure forms. Crotty describes four features to a research paradigm: Epistemology, Theoretical Perspective, Methodology and Methods; each of these elements inform one another (Crotty, 2013). Table 4.1 below provides a summary of these elements.

Table 4.1: Research Paradigm (text taken from (Crotty, 2013))

Element	**Question**	**Meaning**
Epistemology	What epistemology informs the theoretical perspective?	The theory of knowledge embedded in the theoretical perspective and thereby in the methodology.
Theoretical Perspective	What theoretical perspective lies behind the methodology in question?	The philosophical stance informing the methodology and thus providing a context for the process and grounding of its logic and criteria.
Methodology	What methodology governs our choice and use of methods?	The strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes.
Methods	What methods do we propose to use?	The techniques or procedures used to gather and analyse data related to some research question or hypothesis.

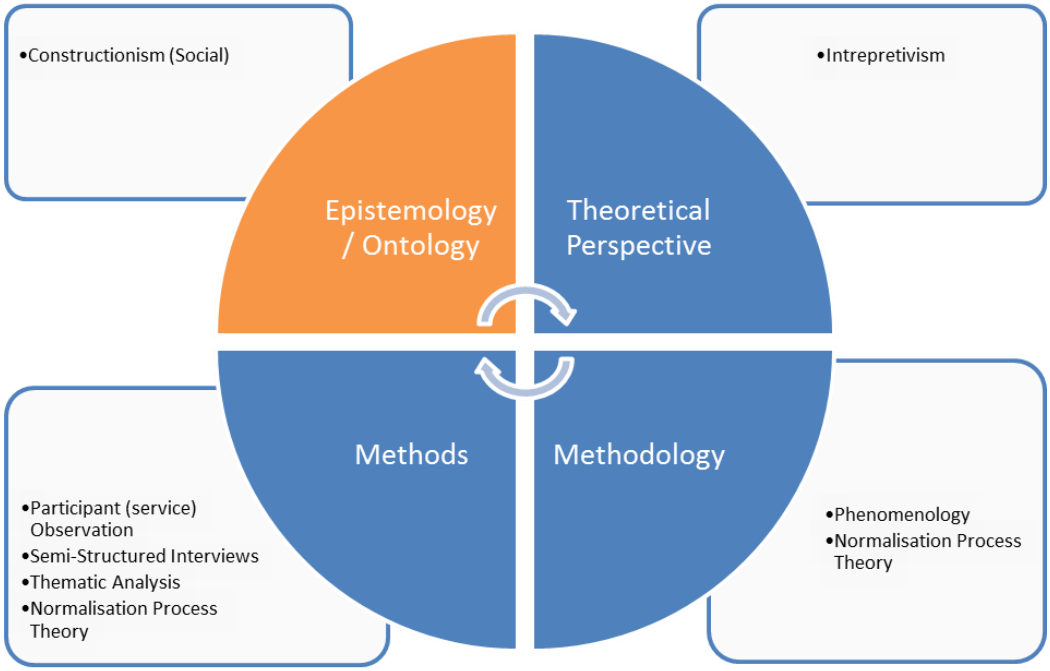
An additional aspect to the research paradigm (as described by Crotty) is that of ontology, “Ontology is the study of being. It is concerned with ‘what is’, with the nature of existence, with the structure of reality as such” (Crotty, 2013 p.10). It ‘refers to our views as to what constitutes the social world and how we can go about studying it’ (Barbour, 2014). According to Crotty, ontology also informs the theoretical perspective alongside epistemology, stating that the two tend to emerge together (Crotty, 2013). Figure 4.1 presents the chosen features for this study in line with Crotty’s model for research design.

Figure 4.1 Study Paradigm



Each of these constructs will now be discussed in turn, starting with Epistemology / Ontology (note Figure 4.1 is reproduced several times in the next section to remind the reader).

Figure 4.1a: Study Paradigm – Epistemology and Ontology



4.3 Epistemology and Ontology

Epistemology looks to uncover “the nature of knowledge, its possibility, scope and general basis ” and ontology is concerned with the nature of existence, the structuring of reality (Hamlyn, 1995). Epistemology concerns ‘the principles and rules by which you decide whether and how social phenomena can be known, and how knowledge can be demonstrated’ (Mason, 1996 cited in Barbour, 2014 (Barbour, 2014 p.35)). The epistemological standpoint provides the theoretical grounding and justification for the chosen methodology and methods (each informing one another). In the context of this thesis the ontological and epistemological standpoint is grounded in interpretations of reality (rather than assuming there is a ‘single reality’ as the positivist approach considers). Here the proposition is that individuals and groups of individuals (in this instance service users and staff) construct reality through interpreting their surrounding world and experiences, and that it is through these interpretations that meaning is attributed to events and activities (i.e. service provision and concepts of recovery).

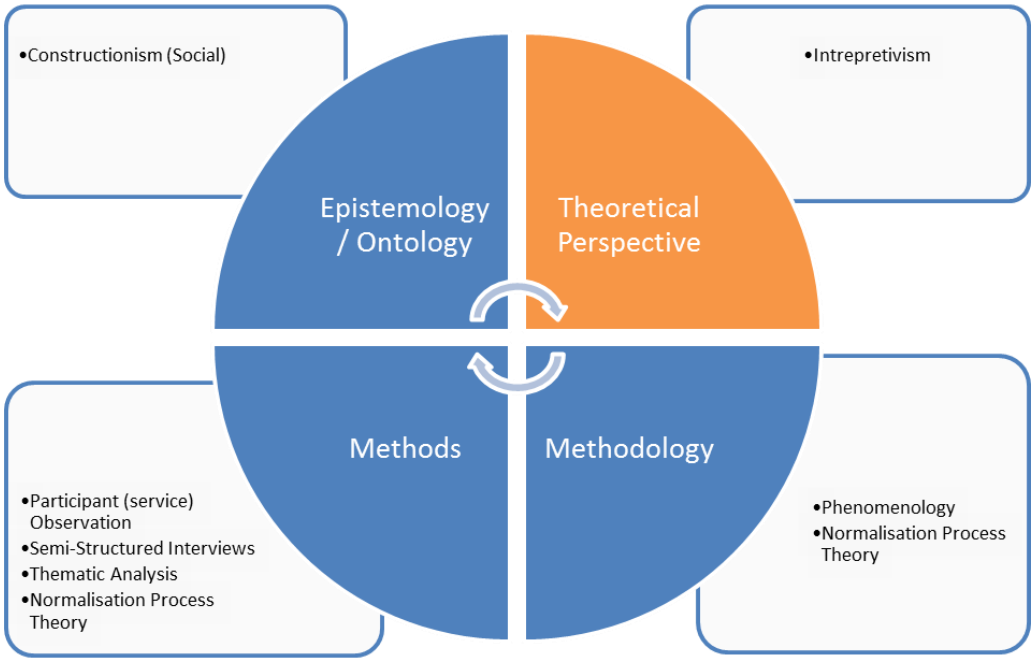
4.3.1 Constructionism

Constructionism asserts that meaning and knowledge is formed through our interaction with the world around us; thus it is constructed. Therefore, different people may construct differing views of the same situation. Social constructionism emphasises this notion, suggesting that ‘“society is actively and creatively produced by human beings”, social worlds being “interpretive nets woven by individuals and groups”’ (Marshall, 1994, cited in Crotty, 2013 (Crotty, 2013 p.54)). By this perception the social world is constructed through our interactions within it, and information is taken into our consciousness through our unique experiences and viewpoint; hence situations are witnessed subjectively. The positivist stance, on the other hand, indicates an objective stance; observations must be viewed independently of individual experiences. Constructionism asserts that social phenomena and their meanings are continually being accomplished by actors, and are not only produced through social interaction but are also constantly reviewed (Bryman, 2008). Social constructionism was selected for this study due to its focus on contextual detail. In the context

of recovery and / or service provision it provides an acknowledgement that individuals (in this case the participants) will construct their own meanings of recovery, experiences of services and commissioning processes. In addition, the changing landscape of recovery service provision lends itself to an ontological perspective that recognises a constant state of revision in social orders and how the various actors respond to change. Constructionism recognises that each individual will have a different, but equally valid, experience from the next person. This supports a phenomenological approach to the data gathered (as discussed below), concentrating on the opinions of the interview participants' reflections on the service (from their individual perspectives).

4.4 Theoretical Perspective

Figure 4.1b: Study Paradigm – Theoretical Perspective



A theoretical perspective refers to the philosophy that underpins the methodology, the approach the researcher takes to understand the social world. Generally, the study topic generates the research question(s), which, in turn, drives the methods and methodological stance (Edwards and Holland, 2013).

"there's nothing so practical as a good theory" (Lewin, 1951 p.169)

Finding out how a society operates, organisations function, or what the interactions between individuals are, and what meaning can be ascribed to these interactions can be a complex process to understand and analyse. Theories provide 'researchers [with] different "lenses" through which to look at complicated problems and social issues, focusing their attention on different aspects of the data and providing a framework within which to conduct their analysis' (Reeves, Albert, Kuper and Hodges, 2008 p.631). Grounding research into a theoretical framework not only assists researchers in developing an understanding of their study results, uncovering what factors lie beneath the behaviour or societal structure but also helps support the translation of the findings for policy makers and healthcare providers (Reeves, Albert, Kuper and Hodges, 2008). Theories can help practitioners 'move beyond individual insights gained from their professional lives to a situation where they can understand the wider significance and applicability of these phenomena' (Reeves, Albert, Kuper and Hodges, 2008 p.634). In this context theories (and the research derived) can explain service processes from the interpretation of those individuals that use that service, highlighting barriers, enablers, understanding, all factors which need to be considered when planning and structuring service provision (to make them both 'successful' and viable as commissioned entities).

4.4.1 Interpretivism

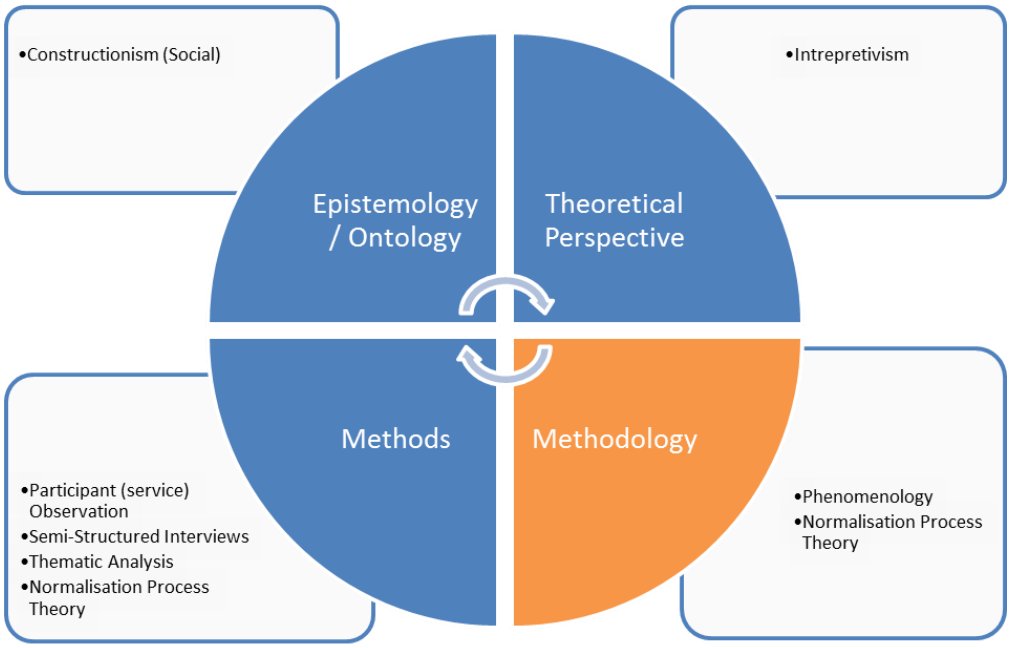
Interpretivism is concerned with '*Verstehen*'[1], understanding social phenomena from the perceptions of the individuals involved, 'thus … knowledge takes the form of explanations of how others interpret and make sense of their day-to-day life and interaction' (Yanow and Schwartz-Shea, 2006 cited in (Edwards and Holland, 2013 p.16). Interpretivism offers an alternative perspective to the positivist orthodoxy, and is 'predicated upon the view that a strategy is required that respects the differences between people and the objects of the natural sciences and therefore requires the social scientist to grasp the subjective meaning of social action' (Bryman, 2008 p.13). Individual perspectives about service

[1] Verstehen means literally 'to understand'. Since late 19th century the term has been used in social sciences as an interpretive or participatory understanding of human behaviour.

provision may be affected by clients' previous experiences and knowledge, and this therefore constitutes a subjective stance (fitting with interpretivist philosophy). It is for this reason that this approach was chosen for the study. The positivist stance would have proposed an objective viewpoint, whereby reality is described as concrete and less disputable. For the positivist 'reality' is a single truth, it can be measured (with the focus being on valid tools for measuring the outcome) rather than considering that reality is something that is interpreted (each individual having a different 'reality' to the next person). This study set out to explore how different service users (and staff) experience alcohol and drug recovery services and if / how commissioning changes impact on their recovery journey, therefore an individual approach was more desirable.

4.5 Methodology

Figure 4.1c: Study Paradigm – Methodology



Theories generally fit into three types: Grand or Macro theories (concerned with large scale societal practices, and can be non-specific and fairly abstract), Mid-range (or Meso) theories (consider specific phenomena, usually at a local level) and Micro theories (relate to individual interactions, also take local context into account but can be restrictive in their use in a wider context due to their focus on specific concepts of interest) (Reeves, Albert, Kuper and Hodges, 2008).

Qualitative research can 'explain *how* the macro (i.e. social class position, gender, locality) is translated into the micro (i.e. everyday practices, understandings and interactions) to guide individual behaviour' (Barbour, 2014 p.13). Fundamental to this research was developing an understanding of individual behaviour and opinions towards service provision.

4.5.1 Phenomenology

Phenomenology is a micro-level theory, having a specific empirical focus on the individual, their encounters and their lived experience, 'the essence of consciousness as experienced from the first person point of view' (Reeves, Albert, Kuper and Hodges, 2008 p.631). It is this principle of prioritising the individual perception of clients' lived experience that determined the phenomenological approach of this thesis rather than approaching the research with pre-conceptions. The foundations of phenomenology in social sciences can be traced back to Alfred Schutz (1899 – 1959) who talked of social reality having a specific meaning and relevance for those living within it. He stated that people:

> *By a series of common-sense constructs… have pre-selected and pre-interpreted this world which they experience as the reality of their daily lives. It is these thought objects of theirs which determine their behaviour by motivating it. The thought objects constructed by the social scientist, in order to grasp this social reality, have to be founded upon the thought objects constructed by the common-sense thinking of men [and women], living their daily life within the social world* (Schutz, 1962 [posthumous publication] cited in Bryman, 2008 (Bryman, 2008 p.16)).

As social reality has meaning for people, this asserts that human actions are meaningful, and therefore people will act upon the basis of these meanings and their understanding of said meanings. Schutz also suggests that the role of the social scientist is to access these interpretations and thinking and interpret them as the participants' views of the social world as they see it (Bryman, 2008).

Phenomenology advocates a ‘natural’ emergence of data, focusing on an individual’s perception of the meaning of a phenomenon rather than what the occurrence meant externally. By gathering multiple perspectives of a service / encounter a general overview of what it is like to experience the provision can be collated.

4.5.2 Normalisation Process Theory

Qualitative exploration allows the research to access ‘embedded’ social practices conducted in peoples everyday lives (Barbour, 2014). Building on the values of phenomenology, that are concerned with how individuals make sense of their world, Normalisation Process Theory (NPT) provides a framework for examining how people embed systems experienced in their life course into routines.

NPT is a mid-range theory, which focuses on local systems, recognising cultural or contextual variations (Reeves, Albert, Kuper and Hodges, 2008). ‘Middle-range theories are described as frameworks for understanding problems and for guiding the development of interventions in a practical sense…Drawing its roots from sociological theory in the main, NPT can be used to understand the fluid, dynamic, and interactive processes that are at play between contexts, people, and objects’ (McNaughton, Steven and Shucksmith, 2019 p.4).

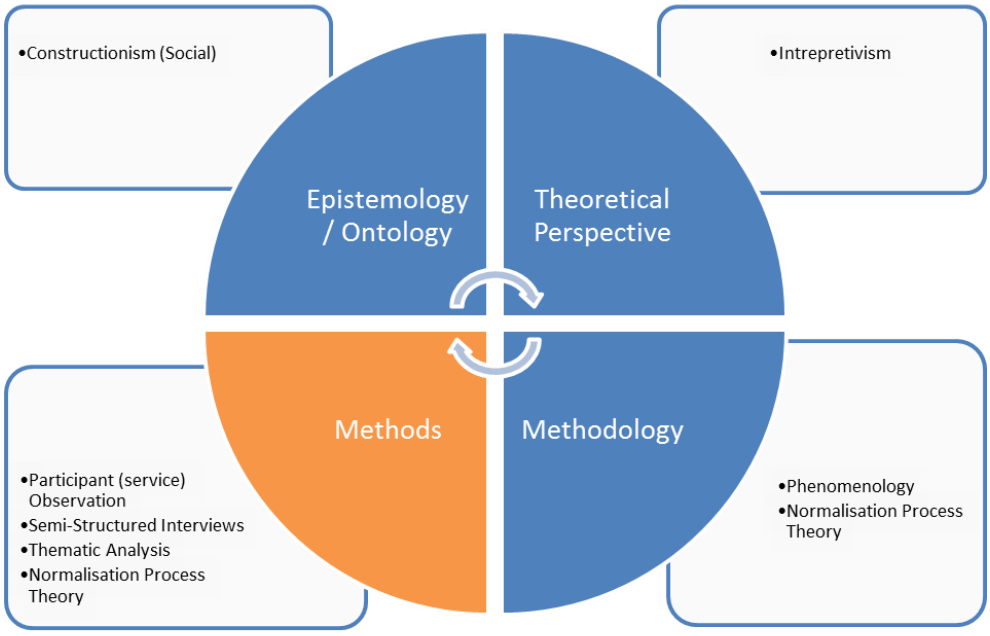
NPT ‘is concerned with the social organisation of the work (implementation), of making practices routine elements of everyday life (embedding), and of sustaining embedded practices in their social contexts (integration)’ (May and Finch, 2009 p.538). There are four main components to NPT; these do not link in a linear fashion but rather they are in ‘dynamic relationships with each other and with the wider context of the intervention, such as organisational context, structures, social norms, group processes and conventions’ (Murray, Treweek, Pope, MacFarlane, Ballini, Dowrick, Finch, Kennedy, Mair, O'Donnell, Ong, Rapley, Rogers and May, 2010 p.2).

Previous uses of NPT focused on organisational settings (usually within the health sector) and how people operated within these structures, how they understand these practices, engage with them and accept them as

routines. Within this research NPT was used on a more individualised way, in that it was used as a lens by which to understand how individuals considered and understood notions or recovery, how they related to others and the services they attended. Aspects of the research also looked at how the service staff looked to embed principles of recovery into the provision, but the greater focus was on notions of recovery rather than specific organisational practices. NPT was adopted for the research presented in this thesis as a framing tool to examine how participants understand service delivery, the changes in provision, how they 'buy into' a service, constructing both what they as individuals and as social groups do in order to normalise the processes involved. NPT provided a structure to consider aspects of decision making (how thoughts are transferred into actions and how the opinions of others may influence the individuals drive to act out a process). It is the use of NPT as a tool for analysis that will be discussed in the methods section below.

4.6 Methods

Figure 4.1d: Study Paradigm – Methods



Research methods refer to the tools or techniques by which a researcher gathers his/her data to answer the study aims and objectives. The methods reflect the chosen methodology (background theory), the theoretical perspective (philosophy) and the epistemological and

ontological standpoint (assumptions about the world). These features must be consistent and intrinsically linked, methods being the most visible aspect but requiring the foundations of the other features (Easterby-Smith, Thorpe and Jackson, 2012). Qualitative research methods entail exploration, unfolding and interpreting personal and social accounts of participants (Smith, 2015). Qualitative data is collated through naturalistic approaches (observations / interviews) and analysed through the textualisation of this data (interview transcripts) (Smith, 2015). In order to gain an understanding of service provision and gather in-depth accounts of service users and staff, periods of service observation and interviews were chosen as methods for this research study.

4.6.1 Participant and Service Observations

'Observation of behaviours, actions, activities and interactions is a tool for understanding *more* than what people say about (complex) situations, and can help to comprehend these complex situations more fully... observation is not limited to "watching" but extends to the *direct* gathering of information' (Bowling, 2009 p.386). Through observations the researcher can, to an extent, glimpse through the eyes of the target population, viewing their experiences first hand alongside them. Conducting observations in a service environment also allows for the learning of the language (in this instance the terminology of recovery). Becker and Geer (1957) claim that the 'participant observer is in the same position as a social anthropologist visiting a distant land, in that in order to understand a culture the language must be learned (cited in (Bryman, 2008 p.465)). This learning of a language allows for sense-making of the themes that may arise in interview. Similarly, an interview participant may discuss a particular event or technique delivered in a service and if this event can also be witnessed by the researcher, a deeper understanding can arise.

4.6.2 Semi-Structured Interviews

Often presented as the 'gold standard' of qualitative research, the technique of interviewing is both an art and a science (Barbour, 2014 p.111). Approaches to interviewing cover a wide continuum. At one end (the realist perspective), where there is a clear focus on content; this

requires an emphasis on eliciting respondent views with technical skills. At the other end, (constructionism) the focus is on structured content, interaction and the construction of meaning (Barbour, 2014). The majority of studies fall somewhere in the middle of this spectrum, where the researcher considers techniques to elicit the best data from participants (often with the use of props or prompts) in addition to consideration of form and the constructing of responses.

In-depth interviews that evaluate services can be viewed as 'testimony studies' (St Leger *et al*, 1992, cited in (Bowling, 2009)). Qualitative interviews involve collating viewpoints and stories from interviewees, gathering their emotions, experiences and what meanings they give to events, which cannot otherwise be collected via other means (Rossetto, 2014). Interviews should be conducted until the researcher gets a 'reliable sense of thematic exhaustion and variability within [their] data set' (Guest *et al*, 2006 cited in Bryman, 2008 (Bryman, 2008 p.462)).

A semi-structured interview uses a schedule with a list of questions / topics that are to be covered (in order to meet the research aims and objectives); this schedule is more of a guide rather than a rigid directive that must be adhered to. Questions do not need to be followed in a linear fashion; often the interviewee will address the questions themselves through the freedom to talk openly without interruption, or with the use of a slight prompt in that direction by the interviewer. If a question appears to be misunderstood by the respondent the interviewer can ask again in a different way, using different terms. Semi structured interviews allow the researcher to probe for clarification and elaboration to any answer given, generating a greater dialogue with the participant (May, 1997). In addition, they allow for the balance between the researcher's agenda and providing the interviewee with the opportunity to raise anything pertinent to them (Barbour, 2014). As semi-structured interviews maintain a degree of flexibility, this allows the researcher to capitalise on any new information or themes that arise and probe further (supporting the phenomenological methodology).

4.7 Approaches to Analysis

There are two fundamental approaches to qualitative analysis, the deductive and the inductive approach. Deductive approaches involve the use of an organised or predetermined structure to analyse data; Inductive involves analysing data with no or very little predetermined theory (Burnard, Gill, Stewart, Treasure and Chadwick, 2008).

Analysis in this study was conducted in two distinct phases; the first was concerned with allowing themes to arise naturally, in line with principles of phenomenology. This lends itself to an inductive approach to data analysis. Inductive reasoning allows a 'bottom up' approach to research, whereby the researcher uses the data collected to create a picture of the phenomenon being studied (Lodico, Spaulding and Voegtle, 2010 p.10). During this stage thematic analysis (discussed below) was utilised.

'The resulting conceptual description therefore emerges from, is based on, or is grounded in the data about the phenomena. The focus shifts from: what is said by participants…to: exploring and explaining what is "underlying" or "broader" or to "distil" essence, meaning, norms, orders, patterns, rules, structures etcetera (the level of concepts and themes)' (Rapley, 2016 p.332).

Phenomenology allows the researcher to 'be led down novel and unexpected paths, to be open and to be fascinated. Potential ideas can emerge from any quarter…' (Rapley, 2016 p.336). Rapley encourages the researcher to follow a hunch that may lead to 'fruition much later in the project', he also warns that this can end in frustration if your 'idea does not hold water' (Rapley, 2016 p.336).

The second stage of analysis involved a more structured framework using NPT (again presented below) which adopts a deductive approach. NPT allowed dimensions important to the study to be refined, for example an examination of how service users understand the principles of recovery or how service staff embed the service culture into the day to day provision. In addition, as the research was conducted over two phases (two years apart), the study did lend itself to a hybrid mix of inductive and deductive reasoning, the deductive elements arising as the researcher was aware of

potential themes that were presented during the first phase (i.e. similarities that may occur with previous respondents).

4.7.1 Thematic Analysis

The purpose of thematic analysis (TA) is to identify codes and themes that emerge across the dataset that are important to the phenomenon under investigation, providing a systematic approach to organising them (Burnard, Gill, Stewart, Treasure and Chadwick, 2008) (Clarke and Braun, 2017) (Braun and Clarke, 2006). The aim of TA is to interpret key features of the data, not merely to just summarise (Clarke and Braun, 2017). Clarke and Braun (2017), state the hallmark of TA is its flexibility, not simply theoretical flexibility but 'in terms of research question, sample size and constitution, data collection method, and approaches to meaning generation' (Clarke and Braun, 2017 p.297). Braun and Clarke (2006) propose a six stage model to conducting thematic analysis; this includes a two stage review process whereby proposed themes are reviewed against the coded data as well as the entire data set, this reflexivity helps produce rigorous and high-quality analysis (Clarke and Braun, 2017) (Braun and Clarke, 2006). The six stage model is presented in additional depth in a later section of this chapter.

4.7.2 Normalisation Process Theory

Normalisation Process Theory was utilised during a second stage of analysis to assist in making sense of the emerging themes. Once themes were categorised using Braun and Clarke's six stage thematic analysis, each theme was considered in line with the constructs of NPT. This allowed for a discussion to develop into how new service provision and procedures became embedded through examining the corpus of data. NPT was chosen as previous research has suggested its benefits for 'helping to identify factors that promote and inhibit implementation of complex interventions' (McEvoy, Ballini, Maltoni, O'Donnell, Mair and MacFarlane, 2014 p.10), in the case of this research the complex intervention is the process of recovery. In addition, although there was no wish to force the data into a framework, hence the use of phenomenology,

NPT did provide a structure by which to consider stages of recovery. Furthermore, NPT examines how

> knowledge is held, transferred, and created within and across professional groups, but also seeks to understand the work that actors…have to engage in to implement new knowledge in practice…NPT pays attention to the legitimacy of the intervention and the role of opinion leaders; it is concerned with understanding trust and interpersonal relationships within social networks as they impact on the introduction of innovation (McEvoy, Ballini, Maltoni, O'Donnell, Mair and MacFarlane, 2014 p.2-3).

These elements are fundamental to examining the notion of addiction and recovery, how do those suffering from dependency understand what is required by entering an addiction service (or indeed embarking on recovery), how are they effected by the opinions of others towards the addiction service (or intervention) and how do they go on to build trust in the service and / or peers.

The next section of the chapter will describe the process by which the research data was collected.

4.8 Methods – Process for Collecting Data

This section will start by describing the research process and the phases by which the data was collected. It will then outline how each stage of the data collection attempted to answer the research questions of the study. The methods used during the observation phase are then discussed. Then the interview process is described in some detail, e.g. sampling methods used for each of the participant groups, approach to interviewees and role of gatekeepers, and then conduct of the interviews is discussed. The procedures used to analyse the data will then be described. Finally ethics, validity (trustworthiness) and strengths and limitations of the research design are covered.

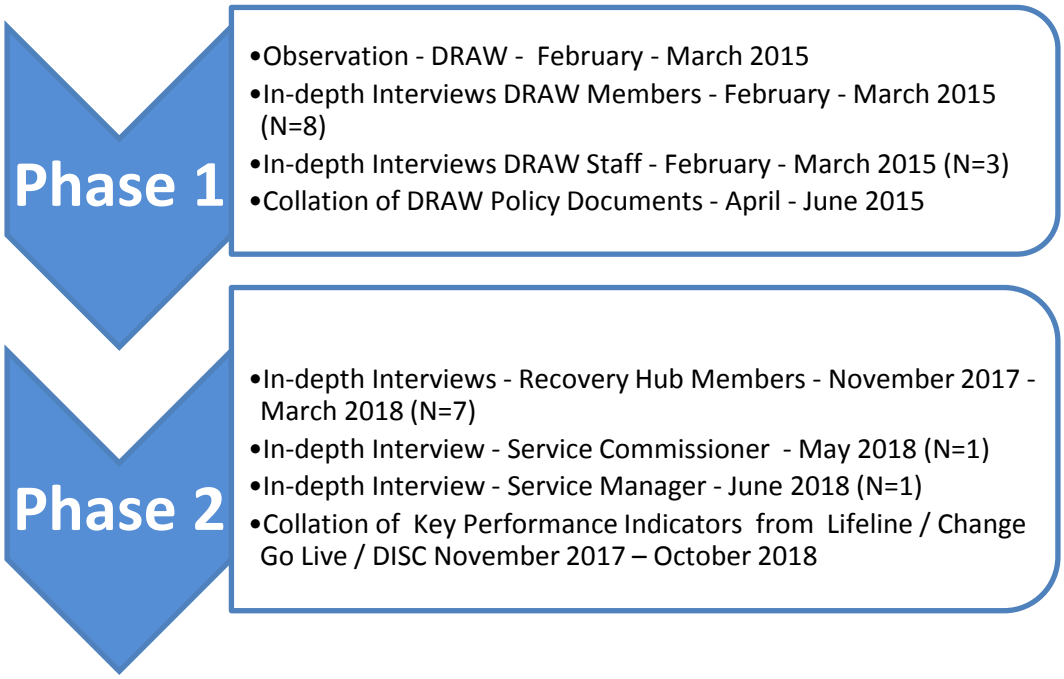
4.8.1 Research Process

This study employed the qualitative methods of participant and service observations and in-depth interviews. All the data was collated by myself as part of this PhD thesis. In addition, policy documents relating to the

commissioning of the local authority recovery provision were collated and corroborated against the interview and observational findings. Issues of commercial confidence meant that some potentially valuable documents (e.g. commissioning proposals and tenders) were not fully made available and the level of information in the documents that were provided meant that no formal analysis could be conducted. They were therefore used more as an introduction to the service user demographics and to provide an overview of service provision (as discussed in Chapter 2).

The research was conducted over two time phases, as described in Figure 4.2.

Figure 4.2: Phases of the Research



Research phase one took place throughout timepoint one and into timepoint two (see Figure 2.1 in Chapter 2 for timepoints). Although, no interviews were conducted in timepoint two, only the collation DRAW policy documents following the closure of DRAW. During timepoint one the DRAW service was provided by NECA who held the contract to deliver alcohol abstinence recovery provision in County Durham. CAS was also in operation during timepoint one, for alcohol treatment (including harm minimisation approaches). The RAD was also operating during both timepoints one and two, providing abstinence based provision (for drugs and alcohol, using the 12-step model). For the duration of timepoint two Lifeline provided the addiction support, this was a combined provision for alcohol and drugs, from 'treatment' (including early help and harm minimisation) to recovery.

Research phase two took place during timepoints three and four, as Change Grow Live took over Lifeline's contract on an interim basis (through a contract of novation), then as Humankind (formerly known as DISC) were later awarded the contract. Humankind operated in conjunction with a community based organisation called the Basement Project as well Spectrum Community Health, who deliver health care services on behalf of the NHS.

The methods of observations and in-depth interviews were used to address a number of the research questions. Table 4.2 presents the methods of data collection, the data obtained, research question addressed and the phase and location where the research took place.

Table 4.2: Research Questions Addressed Through Data Collection

Data Collection Method	**Data Obtained**	**Research Question Addressed**	**Phase and Location of Data Collection**
Participant / Service Observation	Field notes collated during observational period within the service provision	2. What are the barriers and facilitators for service users in accessing alcohol (and drug) treatment/recovery and for the staff working within them? 3. How are concepts of recovery capital embedded, encouraged and normalised within policies and structuring of addiction recovery centres?	Phase 1: DRAW
In-depth Semi-Structured Interviews	In-depth accounts from service users, service staff, and service commissioner	2. What are the barriers and facilitators for service users in accessing alcohol (and drug) treatment/recovery and for the staff working within them? 3. How are concepts of recovery capital embedded, encouraged and normalised within policies and structuring of addiction recovery centres? 4. Does Normalisation Process Theory (NPT provide a useful model to understand how clients and service delivery staff operate in a community based North East service for treating alcohol misuse? 5. What are the recommendations for future commissioning of drug and alcohol services?	Phase 1: DRAW Phase 2: Recovery Hub(s)

4.8.2 Participant / Service Observation

The initial phase of the research was observational in nature and involved conducting an informal scoping of the operational aspect of DRAW. Observational methods allowed for familiarisation with the service environment, an ideal introduction for myself to participants and an opportunity to witness the natural activities and interactions that occur within a recovery service environment. This linked to the phenomenological approach adopted for the research, where the key focus is on individual or micro-level interactions. Furthermore, with a certain level of familiarisation of the researcher's presence with service users occurring, any negative effects that could have potentially risen from gatekeepers were reduced, as the researcher was able to access participants without the need for direction to particular participants by gatekeepers. Holloway, Brown and Shipway (2010) suggest gatekeepers may restrict access to key informants which can hamper data saturation (Holloway, Brown and Shipway, 2010).

Observational periods were conducted on three occasions, ranging from one hour to four hours. The research was explained to service users by DRAW staff (phone conversations having already taken place between myself and staff to arrange visits), but introductions were made when I arrived as well. The nature of the research (aims and objectives) were outlined and reiterated at the start of each visit to ensure all service users were aware and comfortable with my presence. It was explained to all persons present (staff and service users) that general observations were being recorded in a research diary, for example what classes or training was being held, types of interactions between service users and staff (i.e. formal / informal / supportive) and what items of delivery seemed to be important (i.e. conversations around what service users wanted delivering). During these periods I interacted on a general level with both staff and service users, discussing topics such as recovery goals, service provision as well as more generalised topics such as family, hobbies and pets. In addition, these periods allowed for open discussion regarding reason for the research (part of PhD programme) and my research interests overall.

During the observation periods the notes taken reflected the interactions between staff and service users, as well as between service users themselves. These notes were fundamental in designing the interview schedules (discussed below), as themes began to develop, highlighting what appeared to be important to service users and how staff responded to requests from service users. Both staff and service users talked very openly and frankly with one another (and myself as an observer). In addition, what the service delivered in terms of courses, recovery-oriented sessions and support functions could be observed within this context, allowing for corroboration with the interview findings. It was felt that the observational periods had allowed for a relaxed relationship to develop which helped with the future interviews, I also hoped this would reduce any assumptions and potential bias (by myself gaining observational experience of a recovery service first hand).

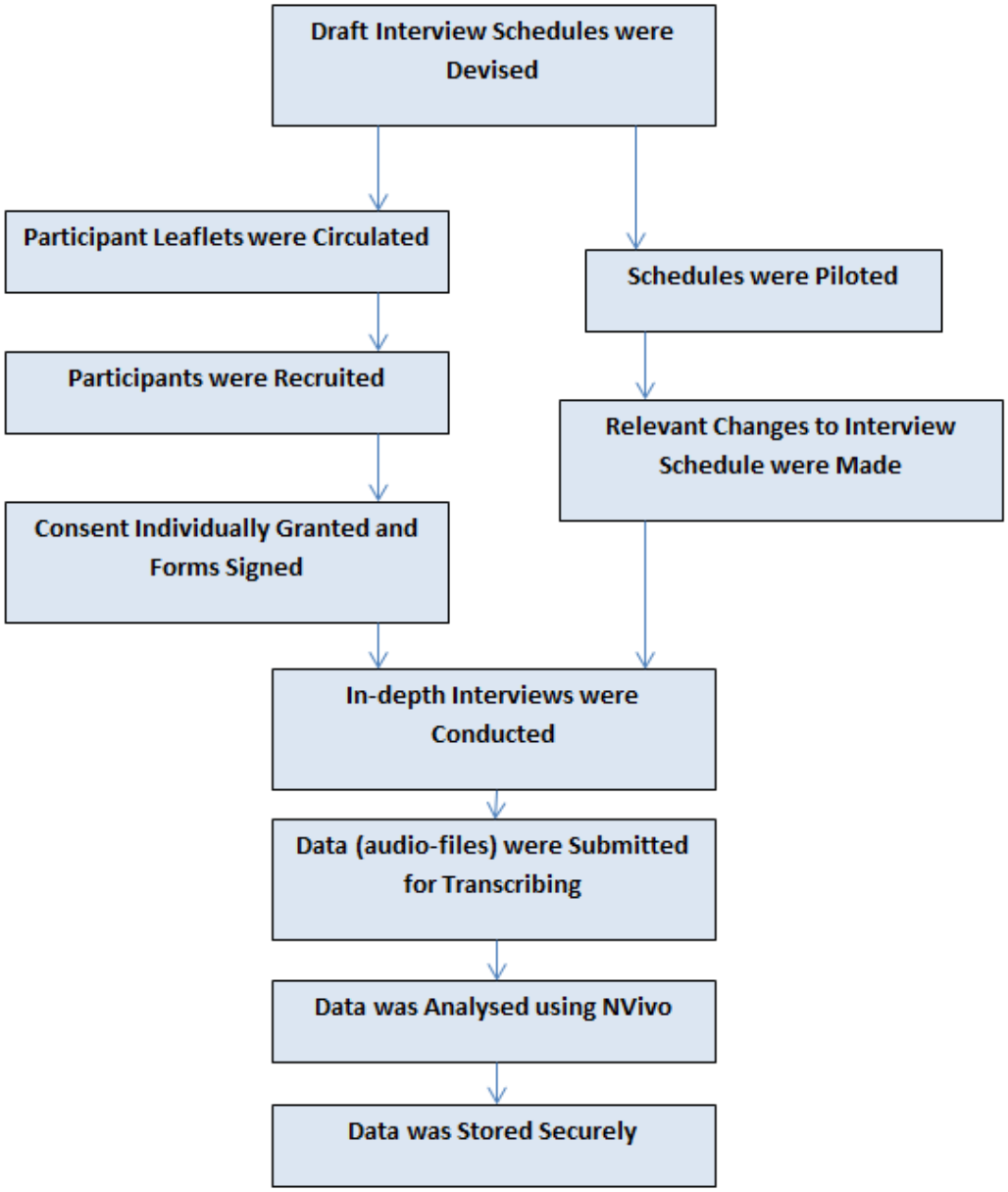
No formal analysis of the observational data was conducted; however, the observations still informed the results by assisting with a familiarisation with the data (in line with thematic analysis techniques) as well as validating the credibility of the interview findings. In addition, the impact of service re-configuration could be witnessed first-hand, for example during one of the observational periods a visit to the service that was to take over the DRAW provision was conducted, here the interactions between DRAW members with each other and DRAW staff highlighted their concerns about loss of identity (losing the name DRAW, no longer being ‘members’) This visit also led to discussions among members about the layout of the new service (being a mix of harm minimisation and recovery based provision) as well as the ‘lack of space’ within the building (no room for cookery sessions or reiki etc.). Some of the issues observed were also discussed during the interviews conducted in phase one.

4.8.3 In-depth Semi-Structured Interviews

The interviews were conducted in two phases (Phase 1 being Feb-March 2015 and Phase 2 being Nov 2017 – June 2018).

The procedure for conducting both phases of interviews is presented below in Figure 4.3.

Figure 4.3: Interview Process Chart



4.8.4 Pilot Schedules

An early version of the interview schedule was piloted with two contacts made by myself during the preliminary phase of the PhD (where concepts of recovery and service provision in County Durham were being examined for background information). In order to gauge whether the schedules contained the correct level of context and meaning (as well as being understandable) the researcher approached the two 'pilot' interviewees at

an open AA meeting (having already spoken to them at an earlier event). Although no interview took place, both pilots provided detailed accounts of where questions could be misconstrued; for example one of the original questions on the schedule delved straight into asking about services attended. Following feedback this was changed to a more generic initial question asking the participant to describe their background, then how they arrived at services. In addition, some of the terms used in the schedule were amended to avoid confusion and misunderstandings and increase participant engagement.

4.8.5 Sampling: Participant Sampling Frames

Five groups of participants were interviewed throughout the life of the research, the first consisted of members of the Durham Recovery and Well-being Centre (DRAW), the second group were DRAW staff, the third were members of recovery hubs / academies, the fourth was the local authority service commissioner and the fifth was a service manager, who had experienced the various changes in County Durham service provision. There were 20 participants overall, across both phases of research.

Participant Group 1

The DRAW members were all in various stages of recovery from alcohol dependence (see description of services and service users presented in Chapter 2). They were recruited through a targeted approach, using a maximum variation sampling strategy, which aimed to comprise clients with diverse employment statuses, as well people at different stages of the recovery process. A sampling grid was constructed to ensure the desired ranges of recovery experiences were covered and that all voices would be represented. The grid was comprised of various stages of recovery / attendance at DRAW (ranging from 3 months to 2 plus years), gender and employment (employment levels were left flexible following initial conversation with recovery service staff that indicated that the majority of their members were unemployed at that time due to their alcohol dependence but that many had had successful employment previously). The observational phase assisted in directing the researcher towards a selection of these individuals. Analysis of demographic data from DRAW

highlighted that the DRAW participants interviewed provided a good representative sample of the DRAW members overall (as presented in Chapter 5).

Participant Group 2

Three members of DRAW staff were recruited using a stratified purposeful sampling strategy, which illustrated different characteristics or opinions towards recovery from different subgroups within the DRAW staff setting. This sampling strategy was chosen as selecting purposeful samples (i.e. staff from a mix of service delivery dimensions) can lend credibility to a research project. During the observational scoping phase, discussions were held with the staff to determine their backgrounds and this led directly to the request to interview the selected three members. In this case, one of the three was a recovery champion (a person in long term recovery), one was a service manager and the remaining one a service delivery practitioner. The staff interview topics aimed to determine in detail how recovery was encouraged within the centre and what potential barriers service users endured.

Participant Group 3

The third group of participants were involved in phase two of the research after the service had been reconfigured (see detailed account in chapter 2) and were recruited via convenience sampling, which was a pragmatic choice due to service alterations and as access to participants changed. An original intention to track individuals through the service configuration was abandoned when recurring service changes made it almost impossible to maintain contact with previous DRAW members and staff. However, three previous members of DRAW did come forward to be interviewed through the recovery forum. Other participants volunteered through the recovery forums, where information about the research had been circulated and / or presented (during different dates).

Participant group 3 also included one participant that presented to services for addiction to drugs, rather than alcohol. All other participants in this study presented for alcohol, although some did raise previous drugs

use as problematic but described alcohol as the reason they sought treatment.

Participant Type 4

Participant 8 was the service commissioner for Durham County Council. This participant also had previous experience working for service provision, and was therefore able to describe service delivery as well as providing an overview of the procedure of tendering and commissioning.

Participant Type 5

Participant 9 was a service manager. This participant had experience the changes in provision from pre-DRAW delivery through to the current provider (*Humankind* which was formerly known as *DISC*).

4.8.6 Consent and Access to Participants

A participant information leaflet was produced and circulated at DRAW (phase one) (see Appendix D) and recovery hubs (phase two) (see Appendix E) prior to the interviews being conducted. Participants had access to the leaflets for between one and three weeks prior to the interviews being conducted. The SMOG (Simple Measure of Gobbledegook (McLaughlin)) criteria for confirming clarity of wording was used to test the leaflet's readability. The leaflet scored 15/16 (Comparable to a level two – GCSE level students - in terms of the National Adult Literacy standard or a *Sun* newspaper reader (McLaughlin)).

In phase one, permission to approach the staff at DRAW had previously been requested and granted by the management team of NECA (North East Counselling for Addictions, who employed the DRAW staff).

As familiarisation with members at DRAW had already occurred via the researcher previously attending the centre in order to scope the setting and observe their processes (as discussed above), many of the DRAW participants were already aware of the research. However, it should be noted that no questions were asked of the members prior to ethical approval being obtained and consent to participate being granted from each prospective participant.

Each service user participant who contacted the researcher demonstrating a clear interest in taking part in the study was re-contacted (either directly by the researcher or through a gatekeeper – i.e. service staff) to arrange a suitable time and location for interview. Staff participants who wished to take part each emailed the researcher directly and arranged interview date and times. Information regarding the nature of the study was provided (or reiterated) verbally (either through discussing the research at DRAW during the observational phase or through presenting at Recovery Forums) as well as through the information leaflets (Appendices D and E) provided.

Prior to discussing consent, each participant was asked to confirm they had read the information leaflet and understood what the study entailed. The consent form was explained to participants by the researcher both during the observational phase and prior to interview; at any point throughout the research process questions could be asked. Consent indicated that the information provided by the participant would remain anonymous (unless they stated they were going to harm themselves or another person, in which case an appropriate person would need to be contacted), that a pseudonym or participant number would be provided for direct quotes where applicable and that participants could withdraw from the study or refuse to answer any questions at any time they wished. Finally, a signature was then requested prior to the start of the interview (see Appendix F and G for consent forms for both phases of research). A demographic data sheet (Appendix H) was also completed by the participant, detailing gender, age range and time in recovery. The consent process was the same for both phases of interviews, although access to arranging dates for some of the interviews in the second phase were arranged though RAD centre managers (due to some RAD members being in a residential recovery housing that does not permit phones or internet).

4.9 Conduct of Interviews

All interviews were conducted by one researcher, myself, on a one to one basis (just the participant and I present). Interviews were all conducted on service premises (either in DRAW or recovery hub centres) in pre-booked

private rooms. Earlier observations and conversations with staff had not raised any concerns regarding researcher safety if this protocol was followed. The process adopted an informal approach, whereby I started the conversation discussing general topics such as weather or travel; this led to participants' appearing more at ease. The general reason for the research was then reiterated so that participants could again ask any questions if they wished. Notes were taken during the interviews, which the participants were informed of prior to interview.

Interviews lasted between 0:23:51 and 2:31:45 minutes and were recorded using a Dictaphone (with participants' consent). Semi-structured interview schedules (see Appendices I to M) were used to promote conversation, in line with meeting the aims and objectives of the research, and were designed to probe the participants' opinions and feelings towards recovery and the recovery service provided.

The interviews were topic based (phase one represented below in table 4.3 and phase two in table 4.4). Descriptive questions probed what was delivered at the services attended, an analytical facet then provided a deeper probing of the reasons why events occurred (a member's feeling that recovery capital has grown for example – the interviews explored the reasons why). Participants were asked questions regarding their past and present involvement with services (e.g. CAS, DRAW). In addition, phase 2 interviews examined the participants' understanding of changes to service provision and how these changes had impacted on their recovery journey. As phase 2 participants were at the time of interview going through a change from interim provider CGL to the newly awarded service Humankind (formerly DISC), they were also asked about their feelings towards information provided by the forthcoming provider. Interview schedules were used to gain assurance about data saturation; their use enables the structuring of similar questions to be asked of several individuals; otherwise achieving data saturation would be like chasing a constantly moving target (Guest, Bunce and Johnson, 2006) (Fusch and Ness, 2015).

No participants requested to be removed from the study. Three interviews were interrupted: one was not continued following the interruption, due to time constraints, although the participant was still thanked for his/her time and asked if they had any questions. The other two interviews were continued following interruption.

4.9.1 Interviews Phase One

Following a pilot of the interview schedule, phase one interviews took place between November 2014 and March 2015 at a meeting room in DRAW. Demographics of participants and themes arising from interviews are reported in Chapters 5 and 7)

DRAW Members

In total eight DRAW members were interviewed. This number represented approximately 8% of the overall population of DRAW (according to data from the previous year) (demographics are referred to in chapters 5 and 7, topic areas are discussed below). Interviewees were asked about presentation to the Community Alcohol Service (CAS) (if any), what the service provided, what barriers were present, and how their recovery journey progressed.

Topic Areas for DRAW Members

The interview schedule for DRAW members was broken down into topic areas (below); these were delivered in a non-linear fashion using the interview schedule (as discussed above), enabling the interviewee to map their treatment and recovery pathway in a natural way (i.e. the researcher allowed the interviewee to move back and forth through the narrative of their recovery journey rather than as a timeline). The topics were flexible, to reflect the phenomenological basis of the research design, allowing further topics to develop from the interviews, being partially led by the participants and what they wished to express about recovery and the service received (with basic direction from the interview schedule that provided prompts towards ensuring the research objectives were met).

Table 3 presents the topic areas under the four sections of the interview schedule (Background prior to Community Alcohol Service (CAS), Service delivery at CAS, Service delivery at DRAW and Current recovery status).

Table 4.3: Topic Areas Discussed with DRAW Members

Topic Areas			
Background Prior ro CAS	**Service Delivery at CAS**	**Service Delivery at DRAW**	**Current Recovery Status**
Prior Alcohol Use	Place of Attendance	Recovery goals set / discussed	Attendance at DRAW
Support (peer and family)	How often attended	Based on empowerment	Attending anywhere else
Help seeking reasons	Recovery discussed from onset	How is recovery measured	Peer / personal support
Education level	DRAW / recovery centre discussed	Skills developed	CJS involvement (including previous)
Employment status and type	Abstinence during CAS	Coping mechanisms	Re-presention
Criminal justice involvment	Understanding of recovery	Individual involved in the process	Abstinent
What is important in service provision	Was this delivered	Abstinent whilst attending	Concept of recovery
		Peer / group support	Employment opportunities

DRAW Staff

DRAW staff were also interviewed at DRAW using a semi-structured schedule (as discussed above) As with the DRAW member interviews, these were also conducted in a non-linear style, allowing each participant freedom to raise any theme they felt relevant at any point in the interview.

Topic Areas for DRAW Staff

For DRAW staff the topic areas were:

- Current position at DRAW and what the role entails
- Explaining the facilities at DRAW and what the service offered (courses / training / support)
- Members' attendance – method of recording / tools used (i.e. the Recovery Star)
- Summing up recovery – what they felt recovery meant to members as well as to themselves (either as recovery champions or as observers to the process)

4.9.2 Interviews Phase Two

When the service provision in County Durham changed (as discussed in Chapters 1 and 2), the research developed from an evaluation of DRAW to examining the impact of commissioning changes on the recovery journeys of service users. At this stage Normalisation Process Theory was utilised as a conceptual framework for establishing how the service provision was understood and accepted. This allowed for investigation into how the participants managed the changes in service provision, how much they were aware, how much they understood and 'bought into' the changes. Table 4.4 below highlights how questions within the schedule were developed in line with NPT framework.

Normalisation Process Theory within the Interview Schedule

Table 4.4 presents how NPT is represented within the interview schedule. SU refers to service user, S refers to service staff, SM refers to service manager and SC refers to service commissioner. Table amended from original source of: (May, Rapley, Mair, Treweek, Murray, Ballini, Macfarlane, Girling and Finch, 2015)

Table 4.4: Representation of NPT within the Interview Schedule

NPT Concept / Sub-construct Definition	**Question(s) to be answered (through interview schedule / interrogation of policy documents)**
Coherence (internal / planning phase): *The process of sense making and understanding that individuals have to go through in order to promote or inhibit the routine embedding of a practice to its users. These processes are energised by investments of meaning made by participants* (Finch et al., 2012.) *How people understand and make sense of a practice with an emphasis understanding and conceptualisation of interventions and their work* (McEvoy et al., 2014.)	
Differentiation: An important element of sense-making work is to **understand how a set of practices and their objects are different from each other.**	How does the current service differ to others you have attended? (S & SU) How are concepts of recovery built into the service? (S & SU) Can you explain how this differs from other services you have used / worked within (S & SU) Do you feel the priorities set by commissioners / service delivery plan matches the needs of people experiencing recovery? (S & SU)
Communal Specification: Sense-making relies on working together to **build a shared understanding** of the aims, objectives and expected benefits of a set of practices.	Do staff and other centre members share your ideas regarding recovery? (S & SU) How are recovery goals set within the service? (S& SU) How involved were you in setting out your goals? (SU) Do you feel staff are involved in setting the service priorities? (S& SU)

Table 4.4: Representation of NPT within the Interview Schedule continued

NPT Concept / Sub-construct Definition	**Question(s) to be answered (through interview schedule / interrogation of policy documents)**
Coherence (internal / planning phase): *The process of sense making and understanding that individuals have to go through in order to promote or inhibit the routine embedding of a practice to its users. These processes are energised by investments of meaning made by participants* (Finch et al., 2012.) *How people understand and make sense of a practice with an emphasis understanding and conceptualisation of interventions and their work* (McEvoy et al., 2014.)	
Individual Specification: Sense making has an individual component too. Here participants in coherence work need to do things that will help them **understand their specific tasks and responsibilities** / round a set of practices.	What specific interventions are offered within the service? (S& SU) What guidance is provided within the policies around how these tasks should be delivered? (S) How clear are the interventions to deliver? (S) How clear were the interventions to you? (SU)
Internalisation: Finally, sense-making involves people in work that is about **understanding the value, benefits and importance of a set of practices.**	How easy do you feel the service delivery plan / tasks / interventions are to administer? (S) Or adhere to (SU) What value do you feel they offer to the recovery program overall? (S&SU)

Table 4.4: Representation of NPT within the Interview Schedule continued

NPT Concept / Sub-construct Definition	**Question(s) to be answered (through interview schedule / interrogation of policy documents)**
Cognitive Participation (Internal / Planning Phase): *The process that individuals and organisations go through in order to enrol individuals to engage with a new practice. These processes are energised by investments of commitment made by participants* (Finch et al., 2012.) *How people engage and participate with a practice with an emphasis on notions of legitimation and buy in, both in terms of the individuals involved and involving others* (McEvoy et al., 2014)	
Initiation: When a set of practices is new or modified, a core problem is whether or not key participants are **working to drive them forward.**	How do you build concepts of recovery into every day delivery of the service? (S) Do you feel this works? (S&SU) How do you specifically look to administer the tasks (mentioned above)? (S)
Enrolment: Participants may need to **organise or reorganise themselves and others** to collectively contribute to the work that may involve rethinking group relationships between people and things.	Are you required to attend all the sessions suggested to you or are you 'free' to drop into as many / as few as you want? (SU) Are the interventions delivered within a time frame / or at times suitable to you? (SU)

Table 4.4: Representation of NPT within the Interview Schedule continued

NPT Concept / Sub-construct Definition	**Question(s) to be answered (through interview schedule / interrogation of policy documents)**
Cognitive Participation (Internal / Planning Phase): *The process that individuals and organisations go through in order to enrol individuals to engage with a new practice. These processes are energised by investments of commitment made by participants* (Finch et al., 2012.) *How people engage and participate with a practice with an emphasis on notions of legitimation and buy in, both in terms of the individuals involved and involving others* (McEvoy et al., 2014)	
Legitimation: An important component of relational work around participation is the work of ensuring that other **participants believe it is right for them to be involved, and they can make a valid contribution to it.**	Do you feel other service users 'buy into' what is being delivered? (S&SU) Are service users given the opportunity to request what they need from a recovery service? (S&SU)
Activation: Once it is underway, participants need to collectively **define the actions and procedures** needed to sustain a practice and stay involved.	How valuable are the interventions to you personally? (SU). How are recovery goals re-examined / refreshed? (&SU)

Table 4.4: Representation of NPT within the Interview Schedule continued

NPT Concept / Sub-construct Definition	**Question(s) to be answered (through interview schedule / interrogation of policy documents)**
Collective Action (External / Doing Phase): *The work that individuals and organisations have to do to enact the new practice. These processes are energised by investments of effort made by participants* (Finch et al., 2012.) *The distribution of work required among stakeholders and the resources to support that with an emphasis on; organisational resources, training, divisions of labour, confidence and expertise as well as the workability of the intervention* (McEvoy et al., 2014.)	
Interactional Workability: The **interactional work** that people do with each other, with artefacts, and with other elements of a set of practices, when they seek **to operationalize** them in every day settings.	What other support do you have / need to sustain recovery? (S) What tools do you use to assist with the recording of recovery practices (i.e. alcohol recovery star) (S) How effective is this tool / easy to use? (S) Do staff record your progress? If yes how? (SU) What is your understanding of the tool? (SU)
Relational Integration: The **knowledge work that people do to build accountability and maintain confidence** in a set of practices and in each other as they use them.	Did you find you required additional training in order to deliver what the commissioners / service provider required of you? (S) Is the training adequate? Provided during work time? (S) Do you feel staff are trained efficiently in what they deliver? Do you feel they believe in what they say? (SU) Are recovery champions visible in the centre? (S&SU) How important are these to your everyday life? (SU) How do these assist in driving recovery? (S&SU)

Table 4.4: Representation of NPT within the Interview Schedule continued

NPT Concept / Sub-construct Definition	**Question(s) to be answered (through interview schedule / interrogation of policy documents)**
Collective Action (External / Doing Phase): *The work that individuals and organisations have to do to enact the new practice. These processes are energised by investments of effort made by participants* (Finch et al., 2012.) *The distribution of work required among stakeholders and the resources to support that with an emphasis on; organisational resources, training, divisions of labour, confidence and expertise as well as the workability of the intervention* (McEvoy et al., 2014.)	
Skill Set Workability: The **allocation work that underpins the division of labour** that is built up around a set of practices as they are operationalized in the real world.	Do you feel commissioners / service managers value the importance of peer support / recovery champions? (S&SU) Do you feel staff have a good enough understanding of recovery to support you fully? (SU)
Contextual Integration: The resources work – managing a set of practices through the **allocation of different kinds of resources and the execution of protocols, policies and procedures.**	Do you feel you are able to give each centre user the time they require? (S) Do staff have enough time to spend with you? What sort of things do they discuss with you? (SU)

Table 4.4: Representation of NPT within the Interview Schedule continued

NPT Concept / Sub-construct Definition	**Question(s) to be answered (through interview schedule / interrogation of policy documents)**
Reflexive Monitoring (External / Doing Phase): *The formal and informal appraisal of a new practice once it is in use, in order to assess its advantages or disadvantages and which develops user's comprehension of the effects of a practice. These processes are energised by investments in appraisal made by participants* (Finch et al., 2012.) *How people reflect and appraise its (practice) effects. With an emphasis on appraising and monitoring implementation work* (McEvoy., 2014.)	
Systematisation: Participants in any set of practices may seek to **determine how effective and useful it is for them and for others, and this involves the work of collecting information** in a variety of ways.	How will you utilise practices developed at the centre in everyday life to continue on your recovery path? (SU) What techniques to encourage growth in recovery capital were employed at the centre? (S&SU) How useful were these (S&SU) Are you able to reflect on what has worked / what hasn't at the centre? (SU)
Communal Appraisal: Participants work together – sometimes in formal collaboratives, sometimes in informal **groups to evaluate the worth of a set of practices**. They may use many different means to do this drawing on a variety of experiential and systematized information.	Will you remain in contact with other service users? (SU) What will you hope to achieve from this? (SU) Are you and other service users asked for regular feedback about what the centre delivers? (SU) Are staff asked for feedback about the service delivery plan? (S)

Table 4.4: Representation of NPT within the Interview Schedule continued

NPT Concept / Sub-construct Definition	**Question(s) to be answered (through interview schedule / interrogation of policy documents)**
Reflexive Monitoring (External / Doing Phase): *The formal and informal appraisal of a new practice once it is in use, in order to assess its advantages or disadvantages and which develops user's comprehension of the effects of a practice. These processes are energised by investments in appraisal made by participants* (Finch et al., 2012.) *How people reflect and appraise its (practice) effects. With an emphasis on appraising and monitoring implementation work* (McEvoy., 2014.)	
Individual Appraisal: Participants in a new set of practices also work experientially as individuals to **appraise its effects on them and from the contexts in which they are set**. From this work stem actions through which individuals express their personal relationships to new technologies or complex interventions	What do you hope to achieve in the future? (SU) Has the service helped prepare you for that? (SU) If yes what specific parts What does recovery mean to you? (S&SU) Is the prospect of 'being recovered' possible? (S&SU)
Reconfiguration: Appraisal work by individuals or groups may lead to **attempts to redefine procedures or modify practices** – and even to change the shape of a new technology itself.	If you don't feel something is working at the centre do you feel able to make the changes? (S&SU) Are the processes fairly fluid or rigid? (S&SU) What would you change if you could? (S&SU) Are you asked your opinions about the commissioning process and what a recovery service should look like? (S&SU)

4.9.3 Interview Debrief

All Participants

A debrief followed each interview where the participant's rights were reiterated (see Appendix N). Furthermore, each participant was reminded at this point of the purpose of the project, how the results would be used and details of how to contact myself should they require further information. Participants were reminded of the anonymity of the research, thanked for their time and informed they could receive feedback regarding the study once it was complete if they so wished. At this point service user participants were given a £10 gift voucher for their time.

4.10 Analysis Methods

The initial approach to analysis of phase one data was phenomenological, using thematic analysis techniques. As the research progressed, it became evident that the service was due to change and this period of potential transition/disruption was affecting the service users (highlighted in both the observational aspect as well as the phase one interviews). At this point the impact of change emerged as a probable focus for future interviews. As noted above, NPT was then considered as an ideal framework to investigate the impact of change for recovery service users, and to examine how new service processes became normalised. The use of NPT provided a structured approach to investigate how intervention implementation becomes normalised within service provision.

Although an observational period at DRAW was conducted prior to the interviews, this was an informal scoping exercise to assist in the framing of the interview schedule; therefore no formal analysis was undertaken, although the field notes were used to cross-reference against the phase one interviews to increase rigour. The in-depth interviews were subject to thematic analysis as discussed below.

4.10.1 Transcribing of Interview Data

Once interviews were completed, the data was uploaded and transcribed verbatim, with pauses, laughing and colloquialisms included. 'Verbatim transcription serves the purpose of taking speech, which is fleeting, aural,

performative, and heavily contextualised within its situational and social context of use, and freezing it into a static, permanent, and manipulable form' (Lapadat, 2000 p.204). Transcriptions were conducted by an out-sourced team provided by the university, due to my time commitments, although each transcript was checked alongside recordings to ensure quality was not lost. Due to lack of follow-up contact the transcriptions were not able to be viewed by the participants for comment (time between interviews and receiving transcripts was considerable), however, field notes and initial themes were discussed with each participant.

Lapadat (2000) suggests four stages to obtaining a good quality transcription (each of these were adhered to in this research):

1) Obtaining a good record. Ensure recording equipment is in excellent working order and appropriately positioned for recording (close to participant with low levels of background noise).
2) Collate recording alongside in-depth field notes to provide context to spoken words.
3) Produce a transcript convention to ensure whoever transcribes the recording is aware of researcher's wishes (i.e. verbatim and inclusive of pauses).
4) Checking of transcripts against recording and field-notes to increase rigour.

Before every interview the Dictaphone was charged and tested for sound quality. Each transcription was dated and lines of transcription numbered in chronological order (in line with the transcription guide (Appendix O). Each interviewee was provided a pseudonym and participant number in order to keep the participants anonymous but to allow for direct quotes to be included in the research findings. Each transcript was read alongside listening to the recording to ensure accuracy and familiarisation with the data. In addition, the field notes taken during the interviews were cross matched against transcriptions and recordings to confirm tone of the interviewee.

4.10.2 Analysis of Transcriptions

Thematic Analysis

Thematic analysis was conducted by myself and all themes derived naturally from the data. Braun and Clarke's Six Stages to Thematic Analysis was adopted for the analysis of the transcribed data from phase one interviews:

1) Familiarisation with the data
2) Generation of initial codes
3) Searching for themes
4) Reviewing themes
5) Defining and naming themes
6) Producing the report

Each of these will now be presented in turn below.

Stage 1: Familiarisation with the data.

Initially each transcript was dealt with on an individual basis. The transcript was read alongside listening to the original recording and checking against notes taken during the interview. This ensured 'personality' and tone was accounted for in the dialect. Preliminary observations about potential discrepancies in participant accounts and numbering of relevant lines were made at this point for future reference.

Stage 2: Generation of initial codes

Each transcript was re-read (at least once more), this allowed for further immersion in the data, as well as providing an opportunity for researcher bias and preconceptions to be considered. At this stage the data was uploaded onto NVivo (initially version 10, then version 11 for phase two of the research). NVivo assisted with the organisation and coding of the data, whereby preliminary themes and phrases were starting to emerge. Full and equal attention to every aspect of the data was given at this stage to ensure nothing was ignored. A multitude of themes began to materialise at this stage (which were reduced at later stages).

Stage 3: Searching for themes

At this point all data had been initially coded. Here the focus shifted to analysis of the broader themes, driving them into overarching themes. Relationships between themes and sub-themes began to develop, with the significance of some themes starting to separate from others. No data was disregarded at this stage; however, some began to appear redundant.

Stage 4: Reviewing themes

This stage involved refining the themes. Some themes required further breakdown, or shifting to another sub-theme. Each sub-theme was examined in turn, with the entire data set then being checked. At this point some data was removed as irrelevant. Patterns became clearer during this stage of analysis and here the developed themes could be cross-matched against constructs of Normalisation Process Theory (involving a hybrid of inductive / deductive approaches to analysis).

Stage 5: Defining and naming themes

During this stage each over-arching theme was described by a process of 'define' and 'refine'. Here each theme was labelled, with descriptive contexts provided, capturing what the theme contains as well as how it links to others.

Stage 6: Producing the report

Chapters 5, 6, and 7 present the reported themes, providing both descriptions and direct quotations.

<u>Normalisation Process Theory Analysis</u>

Following the thematic stages of analysis of phase one interview data, the themes were revisited and restructured using the concepts of NPT. NVivo was again used as a management tool for organising the large corpus of data. Phase two transcript analysis used NPT incorporated into thematic analysis stage 3 (searching for themes), here a deductive approach was utilised, whereby themes emerging from the data were lifted into a pre-defined NPT concept. Table 4.5 below provides the framework used for

the NPT stage of analysis, using examples of quotes provided (full quotes and findings are presented in Chapters 5, 6, and 7). P refers to phase, DM DRAW member, DS DRAW staff, SU Service user (phase 2), SM service manager and SC Service commissioner.

Table 4.5: Analysis Using NPT as a Framing Tool

NPT Concept / Sub-construct Definition	**Theme / Quote (phase / participant number)**
Coherence (internal / planning phase)	
Differentiation: An important element of sense-making work is to **understand how a set of practices and their objects are different from each other.**	Previous Service(s) (Pre-DRAW) *They tend to do it in a, a less rigid way. They'll sit and have a big chat with you and a big catch-up….If there's anything to be wrote down, generally they'll … but it's not done in that, sort of, very official - (Sighs) a lot of people get put off by ….And that works, you know. And it's not that it's done underhand. Erm, I mean, I found it quite unusual when I first come here because I've got experience with working in other day services… so, you know, it was all very much daily logs and the way things around all your client contacts… It's very, very rigid, the way you have to keep every single phone call, everything, sort of, monitored and recorded, down to the, the full stop….You know. Erm, and it's a lot more relaxed the way it's done here. And I think because of that we've got better relationships with the staff, so when there is a problem it's easier to talk to them*. (P1 / DM2)
Communal Specification: Sense-making relies on working together to **build a shared understanding** of the aims, objectives and expected benefits of a set of practices.	Overcoming Denial *I think it's always apparent at first, then people find their similarities as opposed to their differences after a while, you know, and I have heard people say that when they first come, they just see themselves and think, 'How am I going to fit in with these people, who are very different from me?'. But then after a while, it just doesn't matter anymore. They find that the things in common far outweigh the things that are different*. (P1 / DS2)

Table 4.5: Analysis Using NPT as a Framing Tool continued.

NPT Concept / Sub-construct Definition	**Theme / Quote (phase / participant number)**
Coherence (internal / planning phase)	
Individual Specification: Sense making has an individual component too. Here participants in coherence work need to do things that will help them **understand their specific tasks and responsibilities** / round a set of practices.	Admitting Powerless *you go through a lot of emotions and a lot of different feelings about, you know, let's say step one which, you know, if you look at it you think it's relatively simple. But I couldn't admit to being powerless over alcohol or drugs…I had to formulate it in my own mind a way for me to accept it. But the staff were good like, you know. I felt I wasn't…progressing and they just say, you know, you are where you're supposed to be. (P2 / SU2)*
Internalisation: Finally, sense-making involves people in work that is about **understanding the value, benefits and importance of a set of practices.**	Looking within yourself *it's about engaging with something in yourself, you know, like this higher power thing, so you have to find that* (SU2).

Table 4.5: Analysis Using NPT as a Framing Tool continued.

NPT Concept / Sub-construct Definition	**Theme / Quote (phase / participant number)**
Cognitive Participation (Internal / Planning Phase)	
Initiation: When a set of practices is new or modified, a core problem is whether or not key participants are **working to drive them forward.**	Being convinced *I wasn't convinced with the total abstinence type of thing* (P2 / SU1)
Enrolment: Participants may need to **organise or reorganise themselves and others** to collectively contribute to the work that may involve rethinking group relationships between people and things.	Fitting in *First, when I first started coming here I was in denial, I was – just thought, "What the fuck's this all about?" I was like, "I don't need to be here, I haven't got a problem." And like I just thought, "Everybody's not the same as me here…" (P1 / DM5)* *I think it's always apparent at first, then people find their similarities as opposed to their differences after a while, you know, and I have heard people say that when they first come, they just see themselves and think, 'How am I going to fit in with these people, who are very different from me?'. But then after a while, it just doesn't matter any more. They find that the things in common far outweigh the things that are different. (P1 / DS2)*

Table 4.5: Analysis Using NPT as a Framing Tool continued.

NPT Concept / Sub-construct Definition	**Theme / Quote (phase / participant number)**
Cognitive Participation (Internal / Planning Phase)	
Legitimation: An important component of relational work around participation is the work of ensuring that other **participants believe it is right for them to be involved, and they can make a valid contribution to it.**	Believing there is something in recovery *…when I first came I was kind of forced to go. I was told like by the staff in the supported accommodations that if you didn't start engaging we're going to discharge you…So like a programme because you're too chaotic and we cannot manage you…And so I started engaging because of that, to kind of appease other people at first, like family and stuff like that. And then I kind of like thought there must be something there*. (P2 / SU3)
Activation: Once it is underway, participants need to collectively **define the actions and procedures** needed to sustain a practice and stay involved.	Support from group backing *I get like a lot of, a, a lot of positivity from here, which gives me confidence to kind of, it might only be a little bit, but it, it, it builds up and builds up, erm, and then sometimes I'll turn round and say to myself, "Yeah, I can do that." But whereas if I didn't have that kind of backup, if you like, or that kind of support, I probably wouldn't think the same.* (P1 / DM5)

Table 4.5: Analysis Using NPT as a Framing Tool continued.

NPT Concept / Sub-construct Definition	**Theme / Quote (phase / participant number)**
Collective Action (External / Doing Phase)	
Interactional Workability: The **interactional work** that people do with each other, with artefacts, and with other elements of a set of practices, when they seek **to operationalize** them in every day settings.	Choices within the community *we're actually expanding the choice to people that if they don't feel that Twelve Steps is for them then there's actually other options for them as well, so including, you know, we have a structured day programme that actually accommodates for both. … we have things like SMART recovery, a structured day programme that actually functions for a number of choices for people really. Erm and then also as well what we do is we very much encourage the use of mutual aid out in the local community. And that's really what the Basement project bring to the table in terms of they are very, very grass roots, very sort of community focused in terms of the recovery community themselves and what we've brought them in to do is actually manage the recovery, or help to manage in partnership the recovery community which is very vibrant in County Durham. (P2 / SC)*
Relational Integration: The **knowledge work that people do to build accountability and maintain confidence** in a set of practices and in each other as they use them.	Changes in provision is counter intuitive to maintaining confidence *pulling the rug out from under your feet when you're ready to start… you're going to fall on the ground and you're going to have to wait until you get back up again and feel ready to start again… people are in recovery because they've had some difficult issues in their life. People don't have issues with alcohol and drugs because everything's hunky dory for ever…Now, if they're going to find out what those things are they're going to need to feel pretty safe and secure in order to do that, with all the support and encouragement and around them. Now change seems to go counter to that… That's a crucial point in recovery is that any sort of like change or disruption to the continuity is going to have an adverse effect on somebody's recovery.* (P2 / SU1)

Table 4.5: Analysis Using NPT as a Framing Tool continued.

NPT Concept / Sub-construct Definition	**Theme / Quote (phase / participant number)**
Collective Action (External / Doing Phase)	
Skill Set Workability: The **allocation work that underpins the division of labour** that is built up around a set of practices as they are operationalized in the real world.	Understanding what a recovery meeting should include *I mean I'm actually training online at the moment to do SMART facilitator meetings, and I can see everything that goes into that and I know the importance of actually… not controlling the meeting as such but guiding the…the meeting …to me people should leave a meeting, a recovery meeting, feeling as if their batteries have been recharged. (P2 / SU1)*
Contextual Integration: The resources work – managing a set of practices through the **allocation of different kinds of resources and the execution of protocols, policies and procedures.**	Creating new routines *I think the last meeting I had with me CPN we worked on me making sure I get up and I get ready and then if I don't want to go out of the house at least I'm ready. If something comes up, I can leave the house. Erm, so I've started to set routines and get meself into a routine. Some days if I didn't feel like getting ready I would stay in bed all day. I would get up to go to the toilet and then go back. I wouldn't eat, erm, and I would just stay in bed under the covers all day. So that's the kind of thing that I'm trying to get out of.* (P1 / DM3)

Table 4.5: Analysis Using NPT as a Framing Tool continued.

NPT Concept / Sub-construct Definition	**Theme / Quote (phase / participant number)**
Reflexive Monitoring (External / Doing Phase)	
Systematisation: Participants in any set of practices may seek to **determine how effective and useful it is for them and for others, and this involves the work of collecting information** in a variety of ways.	Peers engaging others to attend services *Ambassadors could get people into the hubs…. The clients loved it. They'd seen an ambassador's going to be trained. They'd seen them get their education. Seen them apply for jobs. Seen them gain jobs. They've seen them working in the centres there… We have a visible recovery in there. We had an ambassador who would be cooking along with one of our workers. So they see visible recovery. They're actual showing of what you can turn into and what can happen. (P2 / SM)*
Communal Appraisal: Participants work together – sometimes in formal collaboratives, sometimes in informal **groups to evaluate the worth of a set of practices**. They may use many different means to do this drawing on a variety of experiential and systematized information.	Recovery triangle of support *there are three sort of aspects to the recovery community in Durham. You've got local authority… They're ultimately providing the services…You've got a service provider who's, you know, happy doing the service on behalf of the person who's paying the bills or giving them the contract, which has been various people, Lifeline, CGL and now it's apparently DISC but then you've got the services users…those three sort of bodies need to be able to somehow come together, and I think the recovery forum should be set up in such a way as to make it easy to transfer information and anything really. It should be a two-way thing so that service users can feed into their part of that triangle and then that can go to the others.* (P2 / SU1)

Table 4.5: Analysis Using NPT as a Framing Tool continued.

NPT Concept / Sub-construct Definition	**Theme / Quote (phase / participant number)**
Reflexive Monitoring (External / Doing Phase)	
Individual Appraisal: Participants in a new set of practices also work experientially as individuals to **appraise its effects on them and from the contexts in which they are set**. From this work stem actions through which individuals express their personal relationships to new technologies or complex interventions	Putting your own recovery first *…what you do learn in recovery is it's your recovery that comes first. … if you have met a friend in recovery and that friend lapsed, you could easily be pulled down with that friend and lapse with them. So you've got to be really careful on that side of it.* (P1 / DM7) *[discussing peers relapsing] Initially, for me, I felt that was a threat to my recovery…So that is why I chose to keep the distance. If it's something - someone I haven't got an emotional attachment to, then I'm okay, if that makes sense…But to go and see someone who I've seen in recovery who's become a friend, … constantly be harming themselves…I find too painful to watch… because I'm quite an emotional person. So it's not so much about me relapsing, but the damage of watching them damage themselves. And I can't be a part of that* (P1 / DM2)
Reconfiguration: Appraisal work by individuals or groups may lead to **attempts to redefine procedures or modify practices** – and even to change the shape of a new technology itself.	Providing a critical friend *if they, you know, feel that the services aren't reaching where we need to reach or there's not enough provision of, you know, the variety of supports that people want, or people have got a complaint that they want to take they can actually do it through their own recovery forum* (P2 / SC8)

4.11 Ethical Approval

The study was granted ethical approval by Newcastle University board of ethics on the 17th October 2014 (00801_1/2014). The research was also subject to approval by Durham County Council (DCC) Research Advisory Group, which was granted on the 12th December 2014. Amendments for ethical approval from Newcastle University were submitted as a result of contextual and service changes at several points; these modifications were granted on the 12th July 2017 (00801_3/2017), the 6th November 2017 (00801_4/2017), and the 19th of February 2018 (00801_5/2018). A revised submission to DCC Research Advisory Group was also applied for following the service changes; this was approved on the 14th September 2017.

Each service user who participated in the research received a £10 gift voucher for their time contributing to the study. Neale *et al*, 2017, found that although some service users in their early stages of recovery would prefer cash (deeming vouchers often patronising), those in later stages of recovery (like the majority of participants interviewed in this study) are happy to receive easily redeemable vouchers (that can be used in high street shops) (Neale, Black, Getty, Hogan, Lennon, Lora, McDonald, Strang, Tompkins, Usher, Villa and Wylie, 2017).

4.12 Validity and Rigour / Trustworthiness

Cresswell and Miller (2000) suggest that the researcher's choice of validity processes is directed by two angles: the lens researchers choose to validate their research and the researcher's paradigm. Here the lens in qualitative research is 'not based on scores, instruments, or research designs [as with quantitative research] but a lens established using views of people who conduct, participate in, or read and review a study' (Cresswell and Miller, 2000 p.125). The lens taken to determine credibility in this research required a repeated re-visit to the data, a process where researchers return to their data 'over and over again to see if constructs, categories, explanations, and interpretations make sense' (Patton (1980) cited in Cresswell, 2000 (Cresswell and Miller, 2000 p.125)). This required deciding how long to stay in the research field, in this instance the

observational scoping of DRAW. For this aspect, the ‘field’ was visited until familiarisation was felt to have occurred, where individuals were perceived to be comfortable and natural with an ‘outsider’ present. Additionally, a data saturation plan (presented below in table 4.6) was devised to ensure deep and relevant themes were emerging throughout the data collection.

‘Failure to reach data saturation has an impact on the quality of the research conducted and hampers content validity’ (Fusch and Ness, 2015 p.1408). Fusch and Ness (2015) point to three key areas to ensure data saturation has been reached: ‘there is enough information to replicate the study …when the ability to obtain additional new information has been attained… and when further coding is no longer feasible’ (Fusch and Ness, 2015 p.1408). A data saturation plan (presented below in table 4.6) evolved throughout the interviewing process, with developing themes being added as each interview was conducted. This allowed for two of the three points above to be covered. The third being addressed through the coding and re-coding of the data.

Table 4.6: Data Saturation Checklist

Theme	**Interview Covered**
Background to Misuse (relationship breakdown / family issues / life / social)	
Coping Mechanisms (confidence / loneliness / peers)	
Readiness for Change (family / health / regrets / triggers / denial)	
Vulnerability (in recovery / prior / general / blip / mental health)	
Sustaining Recovery (routine / family / peer support / AA / finding faith / abstinence / shared stories)	
Staff Support (knowledge / empathy / recovery champions / approach / rapport / 1 to 1s / motivating service users / explaining service changes)	
Visible Recovery (community / recovery champions)	
Service Processes (policies / paperwork / dual diagnosis / tools)	
Access to Services (location / opening times / building facilities / service changes)	
Risks to Recovery (peers / past friends / family / stress / service changes / staff turnover / uncertainty)	
Barriers to Services (location / staff turnover / access to recovery / signposting / no voice)	
Concepts of Recovery (meaning / abstinence / learning / aspirations / community)	

As each interview was conducted, ticks were placed in the right-hand-side column. New themes were added as the research progressed, with previous interviews being re-analysed to uncover if the new themes were raised in previous interviews.

Sandelowski (1986) designates four factors to achieving rigour in qualitative analysis; truth value, applicability, consistency, and neutrality (Sandelowski, 1986). She points to ‘credibility (rather than internal validity) as a criterion for truth value and fittingness and the avoidance of specific threats to validity (rather than external validity) as strategies for achieving applicability. She then describes auditability (rather than reliability) as an indicator of consistency and confirmability (rather than objectivity) as a criterion for neutrality’ (Lapadat, 2000 p.211). Sandelowski builds on previous work by Lincoln and Guba (1985), who suggest that the trustworthiness of a research study is central to gauging its worth. They name four key domains that a study should address: Credibility, Transferability, Dependability and Confirmability. How each of these areas of trustworthiness are addressed in this research is presented in table 4.7.

Table 4.7: Trustworthiness of the Research Study

Value	Description	Addressed within the Research
Truth Value: Credibility	Relates to the trustworthiness of the data, how credible or believable it is. It is concerned with the confidence that can be placed on the findings.	Prolonged engagement with participants during the observational phase assisted in validating the credibility. Interview data was cross-matched against field notes (both from observational periods and from alongside interviews). In addition, the systematic review of service user and service staff perspectives (chapter 3) validated the findings.
Applicability: Transferability	Refers to the degree to which the data can be generalised to similar settings, noting that 'generalisations… don't apply to particulars' (Lincoln and Guba, 1985 p.297))	The research context has been described fully to enable the reader to apply the findings to appropriately similar settings. Overall the research looked to provide a rich context for a particular setting rather than a generalizable situation.
Consistency: Dependability	Refers to the consistency by which the results could be replicated in a similar setting, taking into account the changing nature of research.	The context of the research changed through the commissioning cycle (covering the lifetime of the research). This was clearly documented. Should the findings need to be repeated in a different setting, a new researcher could consider those elements.
Neutrality: Confirmability	Acknowledges that researcher bring their own unique view and perspective to the research which can impact on interpretation.	The results of the research can be traced back to the raw data. In addition, the revisiting of the data in cyclical style allowed for checking and re-checking at various stages.

4.13 Strengths and Limitations of the Research Design

As with any research, this design is not without criticism. All the service users were recruited through provision provided by the local authority, which at both points of interview was in a transient state. During the first phase the service was about to change, therefore, participants may have been more likely to present DRAW in a positive light as they were unhappy about losing a service they appeared to enjoy attending. During early stages of phase two, participants were aware that Lifeline had gone into administration and that Change Go Live (CGL) was operating in an intermediary capacity, so they may have felt in a state of flux, unsure what future provision might look like. Those interviewed in the latter stages of phase two were interviewed as the newest service (Humankind, formerly DISC) had just taken over management of the service, so, again, may have been uncertain what the forthcoming provision would deliver. However, interviews were conducted with individuals from a mix of recovery stages so some would not have been as reliant on service provision as others.

Additionally, an observational period could not be conducted during phase two due to the recurring service changes, relationships with staff could not be formed as many of the original contacts made during phase one had moved to other forms of employment (or locality areas).

Although the points raised above offer some limitations to the study, the same reasons also provide strengths. As the service was restructured three times throughout the lifetime of the research this provided an ideal time to examine the effects of commissioning changes.

4.14 Chapter Summary

This chapter described the methodological foundations for the research as well as the methods deployed to meet the research objectives. The qualitative technique of semi-structured interviews with service users, service staff, a service manager and a service commissioner provided an overview of service provision in this locality, highlighting barriers and facilitators to recovery. The following chapters will present these research findings.

Chapter 5: Results of Qualitative Interviews: Phase One – On the Cusp of Change

5.1 Introduction

The following two chapters will present the research findings from the empirical qualitative work. This chapter covers findings from the initial interview phase (Phase One) with DRAW members and DRAW staff (Time Point 1 as described in figure 2.1 in chapter 2), and this is followed by Chapter 6 which will describe the second phase (Phase Two) of interview findings (Time Points 3 and 4). Time point 2 was the Lifeline period of service delivery, where no interview data was collected. This chapter commences with a descriptive overview of the phase one interviewees, which were collected during time point 1, highlighting how far they reflected the general DRAW population and wider recovery population overall. Next the themes embedded within the data (from observational field notes and in-depth interviews), are presented with linkage to Normalisation Process Theory (NPT) constructs, illustrated through verbatim quotes. NPT has been utilised within this study as a conceptual framework to explain processes and procedures associated with service delivery that promote or inhibit recovery. Themes that emerged from both participant interviews and observations have been collated and analysed under each of the NPT constructs and sub-constructs. In presenting direct quotes from the interviews, the brackets following the quote show ‘DM’ for DRAW member and ‘DS’ for DRAW staff, alongside the allocated participant number. The findings from the interviews with service users will be presented as a journey from the initial decision making processes that led to seeking help for addiction through to feelings towards change and commissioning processes.

Phase one interviews and observations took place when the DRAW service was already under review, between February and March 2015. At this time the DRAW building was closing and the service was relocating to the Centre for Change, which is located in a separate area of Durham City. This service was to be operated by Lifeline (as introduced in Chapter 2). This may have affected the data collected, as both service users and

service staff may have been concerned about the forthcoming changes and feeling unsettled, which in turn may lead to more negative feelings towards change overall. Service users attached to DRAW, who felt positive about attending DRAW, may be more likely to view the potential changes to service provision as potentially damaging to their recovery journey.

5.2 Participant Demographics

5.2.1 DRAW Members

Eight DRAW members were interviewed during phase one of the research. Table 1 demonstrates the DRAW member demographics. The majority were male: During the operation of DRAW more males than females attended overall, therefore the sample figures are generally characteristic of DRAW members (60% were male in 2014). Additionally, the *UK Life in Recovery Survey* (Best, Albertson, Irving, Lightowlers, Mama-Rudd and Chaggar, 2015) suggests that more males than females are in recovery (790 participants in this survey provided gender details, which showed 53.1% were male).

Most DRAW member participants were between 36 and 55 years of age: Similarly, the *UK Life in Recovery Survey* showed most recovery participants are in their middle years, i.e. 40-49.

The majority of the DRAW member participants were unemployed at the time of interview; however, most discussed prior employment either during the observational scoping of DRAW or in the subsequent interviews. These figures differ somewhat from those in the *UK Life in Recovery Survey*, as the majority of respondents in the UK Survey reported being in full time employment (46.3%). However, the UK Survey participants were predominantly (57.3%) in stable recovery (more than five years), which could account for the increased likelihood of employment compared to all the service using participants in this research, who were generally in the early stages of recovery (up to one year) or period of sustained recovery (between one and five years) where the focus is on ‘getting well’. Most of the DRAW member participants (76%) had spent less than a year in treatment prior to attending DRAW.

Table 5.1: Phase 1 – DRAW Member Participant Demographics

Participant Number	Gender	Age Range	Time in Treatment	Time at DRAW	Employed (Current)	Employed (Previous)	Re-presented Previously	Mental / Health Issue	Crime
1	Male	36-45	0-6 Months	2-3 years	Volunteering	yes	no	Health	yes
2	Female	36-45	0-6 Months	2-3 years	Paid employment	yes	unstated	Health	yes
3	Female	26-35	0-6 Months	0-6 months	Volunteering	unstated	yes	Mental Health	yes
4	Male	46-55	0-6 Months	1-2 years	Unemployed	Yes	yes	Mental Health	yes but not arrested
5	Female	36-45	1-2 years	1-2 years	Unemployed	unstated	yes	Mental Health	none reported
6	Male	36-45	6 months - 1 year	6 months - 1 year	Unemployed	Yes	yes	None reported	none reported
7	Male	46-55	2-3 years	2-3 years	Unemployed	Yes	yes	Mental Health	none reported
8	Male	46-55	0-6 Months	1-2 years	Unemployed	Yes	Yes	Mental Health	none reported

Re-presentation could reflect any point in their recovery process not specifically during attendance at DRAW.

5.2.2 DRAW Staff

Three members of DRAW staff were interviewed during phase one of the research. This number represented the entire staff operating at DRAW at the time of interview. The demographics of the staff are presented below in Table 5.2:

Table 5.2: Phase 1 – DRAW Staff Participant Demographics

Participant	Gender	Age	Time at DRAW	Role at DRAW	Recovery Champion
1	Female	26-35	3-4 years	Recovery project worker	No
2	Female	36-45	2 years	Centre manager	No
3	Male	36-45	2-3 years	Recovery project worker	Yes

5.3 Normalisation

Normalisation refers to the 'work that actors do as they engage with some ensemble of activities (that may include new or changed ways of thinking, acting and organising) and by which means it becomes routinely embedded in the matrices of already existing, socially patterned, knowledge and practices' (May and Finch, 2009 p.540). For practices to become embedded, those involved must work both individually and collectively to implement them; 'implementation is operationalized through four generative mechanisms (*coherence; cognitive participation, collective action; reflexive monitoring*)' (May and Finch, 2009 p.540). These components are affected by elements that stimulate or constrain routine embedding and, as such, require continuous effort by the actors involved.

Constructs of NPT (and how they relate to this study of participants in recovery or working with those in recovery) will be reflected upon at each NPT construct (mapped as the participants' recovery accounts progress). Tables 5.3 to 5.6 describe the constructs and sub-constructs of each NPT segment at the start of each section to assist the reader in understanding how the mechanisms of NPT link to the data. Questions posed during analysis of the data are also provided within the tables.

5.4 Coherence – What is Recovery?

Coherence is the first internal or planning phase of NPT; it is concerned with how a practice is understood, how individuals make sense of the practice, and what they believe it will mean to them. Coherence requires the practice and its components to first be defined on a cognitive level, then understood and internalised. For the participants in this study the concept of a practice refers not just to the actual service of DRAW but also to the notion of recovery and the basic principles that underpin recovery. For the service user participants this involves not just the process of considering recovery and embedding (or trying to embed) the principles of this 'new' practice but also shedding their old belief systems around drinking or drug use behaviour, which for many was a deep-rooted normalised lifestyle. To consider recovery the service users must give up their previous concepts of what is normal and replace them entirely with new processes and behaviours. This produces internal conflicts, confusion and vulnerabilities, but also hope and desire for change; these factors may inhibit or promote recovery. For service users the mechanisms of coherence involve understanding recovery (the very notion of what it means and how it will differ from their previous life); it involves the work they do communally, discussing recovery (and how they look to identify with those in recovery); they also need to consider how they will own their recovery, what it requires of them individually; and finally how they decide to engage. Do they believe in what DRAW as a service can provide? Service users will work back and forth through these sub-constructs (or mechanisms) as they uncover new aspects of recovery and strive to consider new behaviours to drive and embed recovery principles. Therefore the sub-constructs will be introduced as they were presented within the data (spontaneously rather than linearly). Table 5.3 highlights how the construct (and sub-constructs) of coherence was linked to the phase one interview findings:

Table 5.3: NPT: Coherence – What is Recovery?

What is 'Recovery'			
Coherence Component (internal /planning phase - thinking about 'getting well' and what recovery means)			
'Coherence: the process of sense-making and understanding that individuals and organisations have to go through in order to promote or inhibit the routine embedding of a practice to its users. These processes are energised by investments of meaning made by participants.' (Finch, 2012) • What does the practice of recovery mean – how is recovery conceptualised? • What will recovery involve for service users? How is 'recovery' explained by service staff? • What factors will promote or inhibit recovery?			
Sub-constructs – mechanisms of coherence			
Understanding recovery **(Differentiation)**	**Talking about recovery** **(Communal Specification)**	**Owning recovery** **(Individual Specification)**	**Deciding to engage** **(Internalisation)**
'An important element of sense-making work is to understand how a set of practices and their objects are different from each other.' (May, 2015)	'Sense-making relies on people working together to build a shared understand of the aims , objectives, and expected benefits of a set of practices.' (May, 2015)	'Sense-making has an individual component too. Here participants in coherence work need to do things that will help them understand their specific tasks and responsibilities around a set of practices.' (May, 2015)	'Finally, sense-making involves people in work that is about understanding the value, benefits and importance of a set of practices.' (May, 2015)
How does recovery differ from the service user's previous life? How does DRAW vary from previous services?	Does seeing others in recovery act as a driving force? How is recovery discussed? Can 'new' service users identify with those in recovery?	What will recovery bring the service user? What specifically will they need to do? How do they identify their own individual needs?	Do they believe in the requirements of DRAW? (i.e. abstinence) How do they assess their own readiness to engage?

(May, Rapley, Mair, Treweek, Murray, Ballini, Macfarlane, Girling and Finch, 2015) (Finch, Mair, O'Donnell, Murray and May, 2012)

Participants first described how they came to realise they had a 'problem' with alcohol, how they felt different to others and what led them to feel they needed to bring about change within their lives. Backgrounds to participants' alcohol misuse naturally varied but common traits involved chaotic childhoods and teenage years, relationship breakdowns and life stressors (finance / employment / family). Some participants described drinking during their early years as a factor for later dependency:

> *Well, I was brought up with alcohol from a very early age, from about fourteen years old. And I started drinking… I had a hard childhood. So drink was an escapism for me…I drank to blank a lot of things out and it just became a habit, really…* (DRAW Member participant 8)

> *I've drank since I was a kid like, since I was about 15, but I've always been on and off…. I think it was like a way of me, me thinking. The way I thought, because things weren't so good when I was a kid and so me thinking was a bit skewed* (DRAW Member participant 4)

These participants describe normalising their drinking, how alcohol consumption became a habit. Their young minds rationalised the drinking as a tool to blank out negative aspects of their lives; as an adult looking back, DM4 felt his thinking was 'skewed'. DM4 later described how, as an adult, his thought processes did not initially improve:

> *… I was getting worse, like my behaviour was like more erratic and not making any sense. What I was doing wasn't just, I don't know, it just wasn't right. But then paranoia and like, just thought, like me thoughts…I got to a point where I was scared, I was like terrified all the time* (DM 4)

Many of the participants described similar vulnerabilities and isolation associated with their thought processes and behaviour, often involving low confidence levels or lack of self-respect:

> *I lacked so much confidence within myself, so that, that drink, kind of gave me the confidence to get out of the house* (DM5)

> *You lose your family, you lose your jobs, you lose your self-respect, and it just gets worse. It doesn't get any better, it just gets worse.* (DM8)

Others felt their ‘life’ or aspects overall in their life brought about their addictions:

> *Because, nine times out of ten that’s why you are an alcoholic, because your life is a mess. It’s not because you like drink, it’s because you have problems in your life. Do you know what I mean? And that [alcohol] used to be the medication for that*. (DM7)

> *I’ve had a problem with life, as I’ve never learned to live it.* (DM4)

Considering NPT here helps to categorise how the participants start to make sense of their addiction. They start to challenge internalised norms, in as far as they deemed their consumption not specifically ‘normal’ compared to the general population but that they considered the consumption necessary to get through the day or their life overall. Here they start to understand what recovery may mean, ultimately leaving their previous activities behind. During this element their personal beliefs and knowledge about the practice of addiction are identified and quantified as they look to consider change, debating what the change will mean to them individually (Individual Specification).

As participants start to make sense of their backgrounds and how certain aspects led them to misuse alcohol, they start to realise how they differ, both from other family members and/or the general population overall (with regards to their feelings towards alcohol).

> *That was my reality. I knew that, like, it was different to, like, ‘cause my…my sister’s a teacher, the other one’s a copper, you know? All the family members have got decent jobs and that, so I’m like the odd one, you know? But I just thought that, that’s the way it is, it’s not going to change*. (DM4)

> *Because I felt like I was… I don’t know, I felt different* (DM5)

Participants explained having inner battles. In one respect they felt different to others (usually non-drinking family members or friends or associates who did not have problems with alcohol) as these people had very different relationships with the practice of alcohol consumption (Differentiation). However, conversely they related to their drinking group

who possessed shared beliefs or practices (the behaviour of drinking) which reinforced their continued drinking (Communal Specification). Communal specification relates to shared beliefs and knowledge about the purpose of the practice (May and Finch, 2009). Hence feelings of conflict arise: in one respect the individual begins to understand that change is required, but to shake off the previously normalised and reinforced behaviour gives rise to contradictory emotions.

Some participants described previous drinking social groups and how these drinking days and evenings were very much the norm. The practice (or process) of addiction here had become routinely embedded in their social contexts; this behaviour was continually confirmed collectively among the group as each individual (or agent) of the group continued to drink, reaffirming and reproducing the practice. Participants described how they felt nothing would change in their lives, how 'this would be it' until they died. They had internalised that way of life:

> *I didn't think I'd ever get a job again. I didn't think I'd ever see myself sober. I thought I would have died an alcoholic. And I tried on a few occasions to kill myself …* (DM3)

> *I didn't care whether I was going to wake up or not. I, basically, wasn't bothered whether I died in my sleep, or nothing. I wasn't bothered, because you don't care. It just numbs your brain to a certain point.* (DM8)

Considering entering recovery meant participants had to adjust their thought processes and sense making in relation not just to alcohol consumption but to their current way of life:

> *I wouldn't go out with old friends because they're all drinkers… That's something that I'm struggling with a little bit… my family have all been big drinkers and when I first came into recovery no-one talked about alcohol. It was the big elephant in the room that no-one spoke about at the time. Erm, they wouldn't mention going to the pub…. But that's becoming normal life again where they are going to the pub so I'll get there and say, "Oh, who wants a cuppa?" and they're going to the pub and… it's not really something that I'm ready to do four, five times a week go to the pub for a pint, well a pint of coke. So, yes, I'm struggling with that a bit. I'm not distancing myself from family*

but I do think I'll be spending more time with people in recovery. (DM3)

The practice of alcohol consumption (to the level the participants were drinking at) and the relationship that participants describe they had with alcohol led them to feel dissimilar to others (Differentiation). This led to a disparity between their previous personal beliefs and knowledge about drinking (Individual Specification) and how their non-addicted family and general population act towards alcohol (Communal Specification). Participants then start to define (or challenge their previous definition of) the value of drinking and prepare to absorb recovery practices, assessing their own readiness for change (Internalisation).

As the service user participants decided to engage in recovery, they described seeking help. Some approached their GP; others contacted support groups or approached the Community Alcohol Service (CAS) direct. For others, with mental health conditions, their CPN (Community Psychiatric Nurse) or support worker directed them to CAS. The only route into DRAW was through CAS. This was reported as a potential failing in the system by one of the staff interviewees (DS3), as it meant that direct referrals from mutual support groups could not be admitted, or that individuals could not self refer directly (i.e. individuals that had been sober but who felt they needed more enhanced recovery support due to a particular trigger in their lives; they had to register for treatment at CAS and progress through treatment phases first). Participants reported a mix of triggers that led them to seek help. One described being arrested for drink driving; one had access to money taken off him by his mother (to try and reduce his drinking); another explained how he ended up in a 'mental hospital'. For others, gaining access to their children and re-engaging with their families were the main focus for seeking initial support.

DRAW as a service required abstinence; the service could not be attended for harm minimisation purposes. For staff that meant that there was a clear understanding of what was required from service users:

I think if it wasn't completely abstinent, then it's such a grey area. Abstinence is very clear, it's very defined… it has to be completely abstinent. I couldn't see it being any other way…. I

> *think they feel safe because they know that when they walk through the door, there's not going to be anyone who is under the influence and that everyone is working towards the same goal, really, and it's just a clear message… (*DS2)

> *It has to be abstinent, because I think recovery is contagious and if you don't see people around you with the same struggles, the same concerns, or the same… or people going through personal growth, then it becomes less attractive. So you need that abstinence-based recovery to be visible for it to really work… I think people need to have that around them to keep themselves sober, especially in the early days. It's really important*. (DS1)

Abstinence was explained to potential DRAW members when they first visited DRAW. For them to attend the centre they had to be willing to internalise this notion both mentally and on a behavioural level. Some members explained how this differed to other services they had attended, with most deciding that abstinence was a requirement for them, explaining how attending a service where people are still actively using either alcohol or a drug felt to them a potential trigger to return to misuse. Here participants demonstrate their readiness to consider abstinence as a key feature of recovery, they conceptually understand and 'buy-into' the notion that never drinking again is a requirement. Not every participant had experience of other drug or alcohol services; some had only previously attended the Community Alcohol Service (CAS) prior to joining DRAW. Others had experience of mental health services, which created often greater complexities in their access to alcohol recovery services and further support overall. Those with histories of poor mental health described feelings of isolation and depression when trying to initiate change in their lives. Participants described the referral into addiction recovery services as often obscure (or obsolete), with some explaining how they could only access recovery once they had a mental health assessment and Community Psychiatric Nurse, or that they could only access mental health services once they were receiving assistance for their drug or alcohol addiction. The confusion participants felt when trying to access both mental health and addiction support created factors that inhibited the practice of recovery. A lack of understanding as to why there

appeared no link between services generated further isolation and pushed service users away from accessing the support they needed:

> *…getting into DRAW was a nightmare. … When I took me first overdose the alcohol team came to see me in hospital. Erm, they couldn't help because they said it was mental health problems and depression, because I was self-harming as well at the time. Erm, the mental health team came up and said they couldn't help because there was alcohol abuse still going on. So I was kind of stuck in the middle of people fighting and no-one helped for a long time. It was probably about a year and a half before I actually got into here where I started to receive the help and see that I probably could have sorted myself out a lot sooner had I known about all the other things that were out there. So getting into recovery, I don't think it's as easy as it should be really. (DM3)*

Not being able to make sense of the referral process into recovery (or lack of a clear process) restricted the level of coherence these participants could establish.

DRAW members were able to relate to others at the centre, and understand the shared benefits of a 'similar' future away from alcohol addiction. One member described entering recovery as:

> *I suppose it's like nursery school for adults, isn't it? That's what it is man, … we're all just stuck somewhere where we don't want to be, and this is a good way to get out of it… we all know there's something … happened to us, we've all got different stories and that, but we all just want to get the same way….Nice easy life, a quiet life, a couple of quid you know, job, whatever, get it all sorted*. (DM4)

Once new members relaxed into the practices of recovery they were able to accept this shared and mutual understanding that everyone there is also internalising the values associated with recovery:

> *You're nervous when you first come, because you're just yourself, but you've had your own problems in your life, and you've had your own reasons for drinking in your own life, but you come here and you just chat. And everybody's, basically, the same, and, you know, it's the same story, but with different bits…. everybody's in the same boat.* (DM6)

This internalisation drives forward elements of cognitive participation as members define and organise what is required of them to take the meaning associated with recovery and turn it into a commitment. Table 5.4 reminds the reader of the sub-constructs associated with cognitive participation.

5.5 Cognitive Participation – Engaging in Recovery

Cognitive participation is the second internal or planning phase of NPT; it is concerned with the relational work that participants undergo to instigate change or enrol into a service. For the service user participants it relates to how ready they were to engage with recovery, what drivers assisted in enrolling into recovery and how they legitimised their involvement, what drove the belief in recovery. This construct covers the commitment that participants needed to invest in recovery to make it work. As such the mechanisms overlap with coherence; once participants decide to engage (internalisation) they look for avenues that support engagement (drive their ability to 'buy-into' recovery). The sub-constructs (or mechanisms) of cognitive participation refer to the participant's readiness to initiate and engage in recovery (from both service user and staff perspective); how service users enrol into notions of recovery and access the DRAW service; how they legitimise their involvement, creating a belief in recovery; and finally how they drive recovery forward, sustaining activation. Again, the sub-constructs will be introduced as they were presented within the data and will, therefore, move throughout the sub-constructs in a natural manner. In addition, many of the ideas presented overlap with coherence, demonstrating the complexities of utilising NPT in a study involving individuals with very complex multifaceted needs. Table 5.4 reveals how aspects of cognitive participation was uncovered in the data:

Table 5.4: NPT: Cognitive Participation – Engaging in Recovery

Engaging in Recovery			
Cognitive Participation Component (internal /planning phase – instigating change and committing to recovery)			
'Cognitive participation: the process that individuals and organisations have to go through in order to enrol individuals to engage with the new practice. These processes are energised by investments of commitment made by participants.' (Finch, 2012) • How do service users instigate change (i.e. start recovery process)? • How is their commitment to recovery supported? • What factors will promote or inhibit recovery?			
Sub-constructs – mechanisms of Cognitive Participation			
Readiness for recovery **(Initiation)**	**Enrolling in recovery** **(Enrolment)**	**Believing in recovery** **(Legitimation)**	**Driving recovery** **(Activation)**
'When a set of practices is new or modified, a core problem is whether or not key participants are working to drive them forward.' (May, 2015)	'Participants may need to organise or reorganise themselves and others in order to collectively contribute to the work involved in new practices. This... may involve rethinking individual and group relationships...' (May, 2015)	'An important component of relational work around participation is the work of ensuring that other participants believe it is right for them to be involved, and that they can make a valid contribution to it.' (May, 2015)	'Once it is underway, participants need to collectively define the actions and procedures needed to sustain a practice and to stay involved.' (May, 2015)
How do staff gauge whether service users are ready to engage / re-engage? What drives service users to instigate change?	How do service users access the service and 'buy-into' delivery? How do they 'shake-off' their old habits?	How do service users legitimise their involvement? How are vulnerabilities pushed through to create belief in recovery?	What do service users do to drive forward recovery? How do staff keep service users engaged and moving forward?

(May, Rapley, Mair, Treweek, Murray, Ballini, Macfarlane, Girling and Finch, 2015) (Finch, Mair, O'Donnell, Murray and May, 2012)

As participants entered DRAW many described the internal conflicts they had to overcome. Their previous process or practice of drinking needed to be left behind to allow for new patterns to be defined and organised. The 'work' that participants needed to undertake now related to how they engaged with DRAW, what resources and processes DRAW provided to help embed new practices of recovery and how they utilised these processes to enrol and drive recovery.

Initiating recovery meant admitting a problem with alcohol and challenging what had become the norm for them, often overcoming denial:

> *First, when I first started coming here I was in denial, I was – just thought, "What the fuck's this all about?" I was like, "I don't need to be here, I haven't got a problem." And like I just thought, "Everybody's not the same as me here…"* (DM5)

> *I think it's always apparent at first, then people find their similarities as opposed to their differences after a while, you know, and I have heard people say that when they first come, they just see themselves and think, 'How am I going to fit in with these people, who are very different from me?'. But then after a while, it just doesn't matter any more. They find that the things in common far outweigh the things that are different*. (DS2)

The second quote (by a DRAW staff participant) highlights not only how participants entering the service first only notice differences with those already there, but as attendance becomes normalised and a commitment to engage is instigated, a shared understanding and belief in the process of recovery start to embed. Participants worked together to provide each other with support, often in place of outside family support or structure:

> *I haven't [got family support]; I live on my own. I've only got one member of my family left, and that's my brother. That's all I've got. But, as I say, without this programme [DRAW] and AA, I think I would've been… it's strange, because I was coming up to the age of 21, and I was planning on drinking myself to death at the age of 21 years old.* (DM8)

Peer or mutual support provided at DRAW was apparent throughout the interviews and observational periods. Members and staff alike referred to the bonds created in DRAW and how these support networks helped drive and sustain recovery. In addition, demands of entering recovery required

work on an individual level. Participants needed to find confidence in themselves to strive for change, often leaving 'unhealthy' relationships and friendship groups behind. The vulnerability and loneliness associated with addiction, and also entering recovery was raised by participants:

> *…in recovery you're vulnerable, very, very vulnerable to new things and changes within your own life structure.* (DM1)

> *It's not really a social network now; it's really a lonely place. But you learn to have to accept that loneliness without the addiction.* (DM7)

Embedding the practice of recovery meant that members needed to engage with options that promote recovery, often participating in new forms of social activities, this drove the activation and legitimation components of NPT. Members discussed attending Alcoholics Anonymous (AA), setting up ping pong nights and sober bar evenings to absorb collective support, but also taking up reading, art, baking or practicing mindfulness to sustain and drive recovery on an individual basis. Many participants described the initial stages of recovery as a journey of self-discovery, learning new things about themselves, defining who they were as sober versions of themselves. New coping mechanisms needed to be learned and entrenched, for some attendance at AA and working through the 12-steps process helped support this. Staff at DRAW encouraged members to enrol in as many different support groups as possible:

> *I always say "Try everything. Pick and mix. Try NA, try CA, try SMART. Pick out whatever you like from each one to make it work for you".* (DS1)

> *I will always say to people, right from when they first come in with a worker, I will say, "It's good to try as many different groups as you can go and try them all, because you never know what is going to work for you unless you have given it a go."* (DS2)

Making recovery work requires buying in to what is being offered. Whether the member follows the 12-step process or SMART (Self-Management and Recovery Training), they need to understand the value of the practices. For members this meant following a pathway of abstinence. All members interviewed (both staff and service users) described the

importance of abstinence. Some initially struggled with the notion of never drinking again (or at least not for the foreseeable future); others explained it as a requirement of their current journey and how they had to maintain it:

> *I tried that one where I convinced myself that I don't always have to be abstinent, and that's how I'm getting myself back involved with the drink… to the extent where I've took that first drink and then I couldn't stop drinking, so, yeah, kind of need to be abstinent…For this moment in time anyway it's gonna take another – I don't know if I'm gonna be in recovery for the rest of my life or it's something that I've gotta do for the next five or ten year and then maybe one day I might just wake up, might be able to have one glass of wine a week. I don't know. (DM5)*

> *Which is hard for the rest of your life, because when you've been used to a life like me – I mentioned before that most of my life was associated with friends, drinking; playing pool, playing darts, drinking.(DM7)*

However difficult the notion of abstinence is to initially consider, participants describe it as fundamental to recovery, at least in the early to stable period. Participants enrolling at DRAW need to believe it is right for them to follow a path of abstinence. This is key to establishing their readiness for recovery. During the observational period in the centre, members talked about witnessing others attend services but being unable to absorb the notion and process of abstinence, ultimately returning to their previous drinking culture; highlighting the difficulties people face entering recovery, facing the adversity of shaking off old behaviours to initiate change.

Participants described having to develop resilience to the outside world and to gather confidence to engage in the service, overall as well as in individual sessions. Many sessions delivered at DRAW required members to talk about how they were feeling. This was easier for some members than others and often required a period of time to watch how others behaved before participating themselves. This provides an example of legitimation in NPT terms; participants establish whether it is right for them to be involved. Staff did not push members to engage; rather they would prompt and encourage, driving recovery forward (an example of activation). During observational periods staff explained how the more that

members engaged, the more successful their initial phases of recovery would be, although some members took longer than others to gather confidence to speak at open sessions. Confidence is a key element for members to drive forward practices required for recovery, and push through vulnerabilities. One member described AA and faith as providing confidence:

> *I, kind of, got into Christianity for a few years, and that, kind of, helped me a lot. Because I used to have a really bad speech impediment from a very early age, and I didn't really have much confidence. I was full of fear, and bitterness, and I was just tied up inside. Knotted up inside… But…I found faith… I found God… in the Alcoholics Anonymous – the twelve-step programme … God gave me a lot of confidence, and peace, and happiness. (DM8)*

Another member described the optimistic aura of the centre as helping build her confidence:

> *I get like a lot of, a, a lot of positivity from here, which gives me confidence to kind of, it might only be a little bit, but it, it, it builds up and builds up, erm, and then sometimes I'll turn round and say to myself, "Yeah, I can do that." But whereas if I didn't have that kind of backup, if you like, or that kind of support, I probably wouldn't think the same.* (DM5)

Relationships at DRAW between members appeared very close (this was witnessed during observations but also discussed during interviews); people seemed to know each other well, often challenging each other's behaviour. During one interview another member interrupted to ask when his interview was going to be. At this point the recorder was paused, the member being interviewed then scolded the other member and received an apology. This did not appear to be out of the norm. Staff also challenged members by making them face things they may not want to:

> *… the staff are really good, like. They want to help you, and that. Sometimes, it's a bit difficult, because you can be told things what you don't want to hear, but it's only for the best for you, really, because they want to help you.* (DM8)

> *What helps you the most is they tell you how it is. They don't hide anything….You become an addict where you have to learn to face up to… you can't act like a child, you can't be a child. If*

> *you have problems you've got to learn to face up to them. But, most of my problems, they know in here I can't face on my own. But for a long time, they're the only ones that has ever realised and helped me in that way*. (DM7)

Relationships at DRAW were often described as family-like by both staff and members. Often members had little or no family support away from DRAW, so relied on the relationships formed at the centre to provide that element of support.

> *A very relaxed atmosphere. It's kind of like that welcoming family of people who will understand where someone has been and what they have been through*. (DS2)

> *What's great about DRAW is… the people are so nice, you know? And they're like family, really. Everybody cares for each other and they try to help each other – how you're keeping, and that. If someone's having a bad day, they'll say, "Are you alright, mate?"* (DM8)

> *I find like DRAW is my little, you know, my little family, my little … network. Because I don't know my dad, I don't speak to my mum, and I don't have nothing to do with the family, so it was a bit like when I grew up in the care system, they were my family…So like, I see these as like my little bunch. Do you know what I mean? And it kind of – I'd be knackered without them to be honest. I really would because I've got problems with my confidence and anxiety and stuff anyway, because I'm on medication for it, but to get that praise and, and the knowledge and the education here on like a daily basis, it's a good thing. (DM5)*

The building space at DRAW also provided the means for members to develop. Some described how there were quiet areas to which they could retreat and experience being alone if they needed to 'think' or meditate. There was also a large kitchen and cookery area for sessions aimed at encouraging members to cook healthier meals. Reiki and art classes were also delivered, which aimed to develop creative ways the members could relax or express themselves to assist with coping strategies. This space also provided elements of collective action (the next NPT component to be discussed) to develop.

Some members explained the need to learn how to interact with people again, trust others and rebuild their lives following the breakdown of relationships with their family following their addiction. This often led to emotions of regret and guilt surfacing which needed to be addressed for members to move on. Those that follow 12-steps described this in terms of how the steps address this through conducting a moral inventory and examining character defects as well as being willing to make amends to those that have been harmed (see (Mooney, Dold and Eisenberg, 2014) for information relating to the 12-steps programme).

Cognitive participation involves the work members do to instigate change and commit to recovery. It involves the need to build relationships and buy-in to principles of recovery. The sessions delivered at DRAW encouraged participants to drive recovery forward, inspiring them to collectively contribute to their own and others recovery. Through the relational work delivered through the use of peer support, members began to feel they were able to make an effective contribution towards recovery and were able to develop mechanisms by which they could start to maintain recovery.

5.6 Collective Action – In Recovery

Whereas the first two constructs are about understanding and believing, Collective Action is the first external or 'doing' phase of NPT. It is concerned with how participants structure and organise activities to make the process work. In this case the process is recovery, so it covers what the staff do to make recovery work for the service users, what the service users do, both at DRAW as well as away from the service, to sustain the recovery. This construct covers the maintenance work that participants need to invest in recovery to make it work, and as such is energised by investments of effort. As with previous constructs there are overlapping themes, as participants move between committing to recovery and enacting the practices required to sustain motivation. The sub-constructs (or mechanisms) of collective action refer to the participants' abilities to use new (or different) coping mechanisms to cope with life stressors, how they build bonds and what skills they utilise to continue to structure their recovery. Embedding recovery requires the participants to perform

practices associated with recovery, abstinence, a focus on moving forward, developing new goals and coping strategies for when negativity or barriers to recovery arise. Participants need to build on their understanding and commitment to now enact the routines of recovery. Table 5.5 demonstrates how these recovery routines link to the NPT construct of Collective Action:

Table 5.5: NPT: Collective Action – In Recovery

In Recovery			
Collective Action Component (external/ doing phase – maintaining recovery)			
'Collective Action: the work that individuals and organisations have to do to enact the new practice. These processes are energised by investments of effort made by the participants.' (Finch, 2012) • How do service users make recovery work? • How do service users (and staff) structure activities to keep recovery maintained? • What factors will promote or inhibit recovery?			
Sub-constructs – mechanisms of collective action			
Recovery tools **(Interactional Workability)**	**Building bonds** **(Relational Integration)**	**Maintaining recovery** **(Skill-set Workability)**	**Structuring recovery** **(Contextual Integration)**
'This refers to the interactional work that people do with each other, with artefacts, and with other elements of a set of practices, when they seek to operationalize them in everyday settings.' (May, 2015)	'This refers to the knowledge work that people do to build accountability and maintain confidence in a set of practices and in each other as they use them.' (May, 2015)	'This refers to the allocation of work that underpins the division of labour that is built up around a set of practices as they are operationalized in the real work.' (May, 2015)	'This refers to the resource work – managing a set of practices through the allocation of different kinds of resources and the execution of protocols, policies and procedures.' (May, 2015)
How are new coping mechanisms developed to assist with life in the 'real world'?	How important are social bonds in recovery? Can bonds also create further vulnerabilities?	How is motivation to maintain recovery achieved? Do service users feel they have the skills now to achieve recovery?	How are principles of recovery structured or constrained?

(May, Rapley, Mair, Treweek, Murray, Ballini, Macfarlane, Girling and Finch, 2015) (Finch, Mair, O'Donnell, Murray and May, 2012)

The importance of establishing a routine was highlighted both during interviews and in an open conversation witnessed during an observational visit. Especially where members also had a history of poor mental health:

> *I think the last meeting I had with me CPN we worked on me making sure I get up and I get ready and then if I don't want to go out of the house at least I'm ready. If something comes up, I can leave the house. Erm, so I've started to set routines and get meself into a routine. Some days if I didn't feel like getting ready I would stay in bed all day. I would get up to go to the toilet and then go back. I wouldn't eat, erm, and I would just stay in bed under the covers all day. So that's the kind of thing that I'm trying to get out of. And when I am really stressed or something comes up that I don't really want to deal with I pick up and I go out… and I can come here and I can go and sit around people and talk or I don't need to talk and then if I do need to be alone I can go and sit in a different room and then go back when I'm ready for company again…* (DM3)

> *…when I was drinking, I was drinking through the day. But, I didn't have anything to do, and then, when my doctor got me to the Waddington Street mental health centre in Durham, I started to do things. I was getting a routine where I was doing things…So, like, in DRAW… in the alcohol service, here, what we try to do… we try to keep it where we've got a routine, where we've got things to do each day to keep ourselves occupied. Because if you're sitting there and dwelling on things, your head will go. You know what I mean? And you'll get bored…There's a saying in Alcoholics Anonymous – the place whereabouts I go. It's called HALT. The word's called HALT: Hungry, angry, lonely, and tired.* (DM8)

Establishing healthy routines such as getting up, eating regularly, keeping busy and going to bed at a similar time were all aspects that were described during the observations and interviews as key elements to support and sustain recovery. By adopting new, healthier patterns in their lives members were supporting their recovery capital growth. Routines hence provide a conceptual resource to structure and maintain recovery. The production, and repetition of processes that the general public may take for granted present a fundamental shift for those in recovery. DM8 suggests that through skills he has developed in AA and DRAW he can

now recognise triggers such as HALT (Hungry, Angry, Lonely, Tired) occurring and action it to prevent a negative outcome.

Through listening to shared stories, members were encouraged by peers' 'success' to keep striving forward, this provided support for their own journey, fortifying the belief that they too have a right to recovery and that they can also make valid contributions to their recovery and the recovery of others. 'Shares' (where individuals talked about their experiences in front of others in recovery and staff), encouraged members to look at themselves, their past and their relationship with alcohol:

> *…in DRAW, you'll get… visits from lads or women that have been dry for a long time. And they give us a talk about share… they call it a share, whereabouts they talk about their experiences of their alcohol in their life and how they got clean, and… so, you get encouraged that way, as well. You can understand what they say. You get, what they call, feedback… Because what they've been through, you've been through yourself…*(DM8)

> *…looking at your past and other people giving you [stories] and looking at how bad things were and that the more sober I get the more I can look back and think, "Why?" and look at that sorry place I was in. That deep, dark hole I was in six months ago and know I never want to go back there again…I'll never pick up another drink again... I know I can't do it.. they say in one of the fellowships that drug and alcoholism is… an obsession of the mind and an attitude of the body and that is what I actually believe it is. One's too many and a thousand's never enough… So my view of alcohol has changed dramatically in the last six months really* (DM3).

Listening to the recovery journeys of others, helped members operationalise their view of alcohol, by reinforcing their commitment to recovery and supporting them in maintaining abstinence. The shares often provided 'tips' or tools to build on recovery, providing members with suggested new mechanisms to cope with adversity. The shares also helped members define what actions were required to sustain recovery by avoiding what one member (DM5) termed a 'blip' (returning to alcohol misuse following a period of abstinence and then returning to recovery).

> *… someone had said they hadn't relapsed but they'd learnt so much from the stories they'd heard of the people that did and he said he learned more from people's relapse stories than anything else and he said that's what keeps him clean and sober… and I find the same pretty much. You learn a lot.* (DM3)

Access to recovery champions (people in long term recovery), also provided support for members, providing an aim for where they wanted to progress to. One of the staff members was in long-term recovery (10 years plus) and members explained how having someone who understood addiction through lived experience helped. DRAW members were each at various stages of recovery, which appeared to help new members; during observations it was noted how members would refer to someone who was six months further on in recovery than them, using them as a target to aspire to. Often people too far ahead did not seem 'real' enough for those in early recovery.

> *I feel I can talk to them [recovery champions / those further down the recovery process] about anything really … they've got the knowledge. They're … they are a couple of years maybe clean and sober. It's not a huge amount but it's like, it's close enough ago that they can still remember the feelings and things like that. … Seeing they've have been clean and sober for that long and what they've achieved …gives you a goal. I want to be like that in so many months or by the time I'm two year's sober* (DM3)

> *The older members tend to take a lead on that and look after individuals and members* (DM1)

> *I think it's the willingness of the members to be as honest as they are and to learn from each other. I think they have a real power about that, that us as a staff team we can't give that that comes directly from the members.* (DS1)

Recovery champions are an example of 'non-professional' assets that are utilised in the treatment process; their experiences are critical to service users, especially those commencing the journey. Many participants described the rapport and bond with staff as key to their recovery. Staff (including those who were 'professional assets' i.e. not recovery champions), provided support with all areas of recovery capital, from housing and financial support (help filling forms in and making phone calls)

to signposting to other relevant services (mental and physical health) to advice about rebuilding familiar relationships. They provided guidance towards employment and education skills as well as ‘one to ones’ to encourage reflective procedures such as REBT (Rational Emotional Behavioural Therapy) and motivational tracking to keep recovery progressing. Staff were described as ‘amazing’, treating the members with a personal touch, which some had not experienced before. The bonds formed with staff appeared to provide almost paternal care; some members approached the staff for all sorts of queries, some of a highly personal nature, highlighting how, through building bonds, vulnerabilities reduced and confidence rose. This provides an example of relational integration, highlighting how building confidence in the staff, the processes the staff activate as well as confidence from the individual to discuss their concerns can support and maintain recovery.

DRAW provided a relaxed approach to recovery, which many members appreciated, as it allowed them to build knowledge and confidence at their own speed. Members also commented on how the relaxed approach helped build bonds with staff, as they seemed easier to approach and talk to than staff from previous services where everything was logged and recorded (also an example of differentiation as these processes differed from individuals past experiences of service provision):

> *I've got experience with working in other day services… so, you know, it was all very much daily logs and the way things around all your client contacts… It's very, very rigid, the way you have to keep every single phone call, everything, sort of, monitored and recorded, down to the, the full stop….You know. Erm, and it's a lot more relaxed the way it's done here. And I think because of that we've got better relationships with the staff, so when there is a problem it's easier to talk to them*. (DM2)

Some members described the laborious processes they endured in previous services. One member in particular shared his dislike for paperwork:

> *I’ll be honest I didn’t really engage with it [an alcohol service] because it was paperwork. And I was like, “I’m not filling paperwork in. If you want to know something, ask me. I’ll tell*

> *you. I'd rather verbally tell you."……I said, "If you chuck papers at us," I says, "I won't come back. I cannot handle paperwork." And he was like, "Okay."* (DM1)

Completion of paperwork or arduous form-filling acted as a barrier to recovery, potentially putting people off attending a service; possibly as a result of an individual feeling vulnerable enough without being asked to continually explain their needs (certainly before a bond with staff had been formed). During staff interviews they explained how during one to one sessions with members (which was a weekly requirement), goal setting tasks would be completed, however, these took many forms (not always utilising the completion of paperwork). These one to ones aimed to keep members on track with their recovery, often suggesting new areas of development that a member could work on (i.e. developing better IT skills).

Participants described using charts and seven day tasks to encourage healthy living and confidence. Confidence to open up about feelings was also encouraged at DRAW. Members could share how they were feeling at open meetings or during one to ones with staff. Often tools such as word cards were used whereby members picked a word card from a box; they then had the option to talk about the emotion displayed on the card and what it meant to them. Some were more keen then others to engage in this activity; for some, usually newer centre members, expressing emotions related to their feelings or vulnerabilities were areas that required more work internally or during one to ones before they were ready to share openly in a group context. During an observational phase open sharing was witnessed. This was often informal, where members gathered around a table for lunch and generally conversed about challenges they were facing or how they were feeling overall. Other members (as well as staff) would listen, often agreeing or suggesting potential solutions. This in turn encouraged other members to open up and also discuss their current problems. During observations, staff were witnessed prompting some other members to make suggestions or share their experience of a similar situation. Later DS1 explained that this was a technique also utilised during one to one sessions, involving reflective procedures and motivational interviewing techniques based on Rational

Emotive Behaviour Therapy (as mentioned above), which encourages members to devise their own solutions to problems (David, Cotet, Matu, Mogoase and Stefan, 2018). Members were encouraged to organise or reorganise their lives in a new way (compared to their previous method of simply drinking when faced with a problem):

> *I've accumulated a lot of coping strategies in here, where, if I'm in a bad place, they've taught me I need to realise a happy place, do you know what I mean? A happy part of me that knows I can still be happy if I can try… and just approach the worst part in a better way than I used to.* (DM7)

REBT was utilised regularly at DRAW; Central to REBT is a focus on thought and feelings as these are what drives emotions and behaviours. Techniques involving REBT aim to help clients change their thought processes, which in turn should develop their behaviours to drive out negativity.

Collective action encompasses the work members do to structure and maintain recovery. Building bonds, developing skills and utilising taught techniques are all key mechanisms to shaping recovery. Through continued engagement with peers and recovery champions, members continue to maintain recovery, enhancing their understanding and commitment to the processes and building a platform for successful maintenance and a new way of life.

5.7 Reflexive Monitoring – Reflecting on Recovery

Reflective monitoring is the second external or 'doing' phase of NPT; it covers how participants evaluate a practice both through formal and informal processes. The construct is concerned with how participants reflect upon and appraise advantages and disadvantages of the DRAW service (and perhaps recovery overall). The mechanisms (or sub-constructs) involve participants considering how effective the service was, whether they were able to provide feedback into the service, what worked (and did not) within the provision and what being in recovery and looking towards a different way of life means. Table 5.6 highlights these mechanisms:

Table 5.6: NPT: Reflexive Monitoring – Reflecting on Recovery

Reflecting on Recovery			
Reflexive Monitoring Component (external / doing phase – sustaining recovery and planning for the future)			
'Reflexive monitoring: the informal and formal appraisal of a new practice once it is in use, in order to assess its advantages and disadvantages and which develops users' comprehension of the effects of a practice. These processes are energised by investments in appraisal made by participants' (Finch, 2012) • Is being 'recovered' ever an option? • How can recovery be sustained and planned into the future? • What factors promote or inhibit recovery?			
Sub-constructs – mechanisms of reflexive monitoring			
Having a voice **(Systematisation)**	**What works** **(Communal Appraisal)**	**Being 'recovered'** **(Individual Appraisal)**	**Different way of life** **(Reconfiguration)**
'Participants in any set of practices may seek to determine how effective and useful it is for them and for others, and this involves the work of collecting information in a variety of ways.' (May, 2015)	'Participants work together – sometimes in formal collaboratives, sometimes in informal groups to evaluate the worth of a set of practices. They may use many different means to do this drawing on a variety of experiential and systematised information.' (May, 2015)	'Participants in a new set of practices also work experientially as individuals to appraise its effects on them and the contexts in which they are set. From this work stem actions through which individuals express their personal relationships to new technologies or complex interventions.' (May, 2015)	'Appraisal work by individuals or groups may lead to attempts to redefine procedures or modify practices – and even to change the shape of a new technology itself.' (May, 2015)
How involved are staff and service users in evaluating recovery services?	What works in recovery provision? What facilitators and barriers are present?	Do service users and staff believe in being recovered? Or is recovery a life-long notion?	What does a future of recovery look like?

(May, Rapley, Mair, Treweek, Murray, Ballini, Macfarlane, Girling and Finch, 2015) (Finch, Mair, O'Donnell, Murray and May, 2012)

Although evaluating long term effects of the service in this study would be difficult, as stable recovery is not reached until approximately five years, the value of what is delivered short term in DRAW can be evaluated. 'Patterns of collective action and their outcomes are continuously evaluated, both formally and informally, by participants in implementation processes, and the formality and intensity of this monitoring work reflects the nature of their cognitive participation and collective action' (May and Finch, 2009 p.545). As the service users continually considered what they were learning and engaging in they were continually evaluating the service as it was at the time of interview, and determining the effectiveness and usefulness of what was delivered. These continuing evaluations by participants, both individually and collectively, present examples of communal and individual appraisal. 'Formal patterns of monitoring focus attention on normative elements of implementation. These frame how things *ought* to be, rather than the conventions that frame how things are worked out in practice' (May and Finch, 2009 p.545). This framing of what ought to be is covered by participant views of the forthcoming service following the closure of DRAW. The participants were asked various questions regarding aspects considered detrimental to recovery, barriers to service provision, and what should remain or be introduced in future services. These elements will be covered in this final section of the chapter.

Features that may pose a risk to recovery include stress and failing to understand how to deal with difficult phases of life. Developing coping mechanisms through sessions delivered in services assist with negating this concern, although some members still described stress, insecurity and uncertainty as elements that caused worry. At the time of interview the service was about to move to a new location, with the closure of DRAW. Members expressed various concerns regarding this. For some the location of the new service was an issue; lack of sufficient nearby parking, including lack of disabled parking, for one member meant having to leave her disability car at home, which, as she explained, defeated the purpose of having it. In addition, the new location was a distance from the city centre, meaning no shops nearby (which as one member described was a

potential issue for ‘bring and share’ events, where the group each placed money into a kitty or each brought something to eat). One member described how it would take an extra bus journey from the city centre to get there; otherwise there would be a distance to walk from the central bus station, which also meant having to walk past a large number of licensed premises:

> *Having to walk through Durham from where Whinney Hill is, I’ve already counted how many bars you walk past to get to the bus station and there must be eleven. So the first one you pass it’s alright, then you come to another one and it’s… Do you know what I’m saying?* (DM7)

> *because you have to pass about 15 pubs…Erm, I mean, for - if you're having a bad day or even if you're really nervous, you don't travel well, you get off the bus station now and you've got 20 or 30 paces and you're through the door [into DRAW], somewhere safe… between having to get through all the pubs, and there's quite a few between here and the prison. If you're having a vulnerable day and you're really, really struggling not to pick up a drink, to walk past all them pubs with all them doors open, with all that smell of booze-…that's gonna be a very difficult journey for anybody*. (DM2)

One member described the new location as seemingly isolated, ‘tucked away’ as if being in recovery was something people should be ashamed of; contradicting the notion of visible recovery. Members talked about potentially losing the term ‘member’ and going back to being referred to as ‘clients’:

> *…even the term 'members' as opposed to 'clients' makes a big difference to people…feeling like they belong to something rather than being cared for, fixed… so I hope they keep even just the little things like that*. (DM2)

For some the worry was that the new centre was a combined drug and alcohol service that provided harm minimisation approaches (for example where addicts could obtain methadone prescriptions) and this caused anxiety.

> *Because at the end of the day, you’re putting all these recovery units all together. You’ve got a rehab up there, you’ve got recovering addicts that’s going in for the methadone and*

> *medication up there. So, for addicts that have been clean for over two years, so to mix it all up again…. When you first come to DRAW, you learn to keep yourself away from all of that. … It's them that's inviting us into that again. Whereas we've had to take our lives away from it, we're getting reintroduced into it...* (DM7)

However, others stated that everyone needed help; suggesting that, for those still using drugs or alcohol, seeing people getting healthy might encourage them to enter recovery.

During an observational period at DRAW, some members went to visit the new centre. In the course of the walk to the new centre members conversed about their concerns. Some felt they were losing their group identity, the name DRAW was not transferring to the centre, although the Recovery Academy Durham (RAD) was also based at the centre and was keeping its name. Once at the centre, some members were upset at having to wait in the foyer, then access their area of the building with a buzzer. They felt this created feelings of distrust (as if they couldn't be trusted to know the access code). One member commented that the foyer felt clinical and 'treatment heavy'. The allocated area for them in the building was also a lot smaller than they were used to. There was no large kitchen where they could cook, and a number of the rooms were to be shared with other services (RAD) or booked out for use, which also caused complaints. In addition, centre rules did not permit them to come and go freely and with the flexibility they had received at DRAW, which again did not meet with approval. Members continued to compare what they had at DRAW to the new service, usually finding DRAW to be more favourable. In these aspects the reconfiguration mechanism starts to present the members with a different way of 'service life' that overall was not deemed positive. Following the visit to the new service, members were encouraged to give thought and discuss with each other and staff to highlight and try to problem solve their concerns. Here they were provided with the chance to appraise both collectively and individually and express their worries, having a voice being important for their recovery. For some members being 'further on' in their recovery journey meant they were less concerned about the changes, as the support they felt they now needed

could be provided at mutual aid groups (such as AA), so the new service location and delivery did not affect them as much as others (an example of Individual Appraisal).

Turnover of staff or losing staff when the new service commenced was raised as an issue during observational periods, as well as during interviews. The importance of rapport and bonds has already been discussed but the concern of losing that connection is also an aspect detrimental to recovery. Some felt the security provided by DRAW was going to be lost, which quite visibly was causing some members distress; losing a staff member they felt comfortable with exacerbated that worry. In addition, changes naturally left the staff with a lack of job security.

The benefits of peer support have already been covered. However, there is also a potentially detrimental side to mixing with peers. Members highlighted that every individual needs to put his/her own recovery first, as other people returning to drink or the stresses associated with helping others could cause a risk to their own recovery:

> *…what you do learn in recovery is it's your recovery that comes first. … if you have met a friend in recovery and that friend lapsed, you could easily be pulled down with that friend and lapse with them. So you've got to be really careful on that side of it. (DM7)*

> *[discussing peers relapsing] Initially, for me, I felt that was a threat to my recovery…So that is why I chose to keep the distance. If it's something - someone I haven't got an emotional attachment to, then I'm okay, if that makes sense…But to go and see someone who I've seen in recovery who's become a friend, … constantly be harming themselves…I find too painful to watch… because I'm quite an emotional person. So it's not so much about me relapsing, but the damage of watching them damage themselves. And I can't be a part of that* (DM2)

Participants described how they needed to consider their own recovery first, especially during early recovery stages, and evaluate the potential effects other peers may have on it (another example of Individual Appraisal).

Believing yourself to be ‘fixed’ was also described as damaging to recovery. Members and staff described witnessing others leave services due to the notion they were ‘recovered’ and no longer needed support, only to return to services again within months. For some this caused an element of fear:

> *I don’t want to ever consider myself recovered because it’ll make me over- confident. Like, the last time it did. I thought that way, and I thought, I’ll be a casual drinker. It just all escalated again, do you know what I mean? Now I know I can’t be a casual drinker: I’ll always be fighting my addiction…* DM7)

> *… to not be around recovery still is when I think that I'm fixed. And I, I know from experience that this is something I'll always live with… I'll always have the urge to drink. I still have the urge to have a bag of heroin (Laughter) on occasion and I haven't had one for 14 years. Erm, and it's just that thought pops into your head … It's just always going to be there.* (DM2)

For most, recovery was described as a learning process that starts with abstinence and teaches you how to deal with life and prepare for a future in recovery:

> *I don’t think recovery is all about just your drink or drug of choice. I think recovery is a way of life. It’s something that you need to learn to do again. That abstinence is just one part of it. Erm, so recovery is building a life back up. Learning to deal with life on a daily basis. Everything that comes after the initial abstinence I think.* (DM3)

> *I’ve had a problem with life, as I’ve never learned to live it. Now I’m learning it, you know? That’s all; I think that’s like the best thing or the main thing about recovery, just getting away from what you were doing and learning to deal with it again.* (DM4)

> *I’ve found out who I am... Without my recovery I don’t think I would have. I wouldn’t be on the journey that I'm on now to getting myself better and, and to know who I am as a person. Whereas now I'm kind of learning to find out who I am ….I don’t think you can ever say that you’ll ever be… recovered; I think that’s probably the wrong word to use. .. if you’ve got an issue with, like, drug, alcohol, whatever, I think you’ll always … be in recovery… that’s the way I feel right now about what I'm saying but if you ask me again in four years’ time the answer might be different ….So it could be different in a few years’ time*. (DM5)

> *I think it's a personal thing... but me personally, I don't have a drug and alcohol problem any more. I haven't had a drug and alcohol problem for about nearly ten, eleven years. What I do have is a messed-up thinking problem, you know, and some days I'm recovered and some days I'm recovering, you know, it depends on how I feel. But as for my drug and alcohol use, yes, I'm fully recovered from that because I don't do that anymore, you know, but I'm in recovery from dysfunctional thinking and belief systems and I think that for me is just going to be an ongoing thing, you know.* (DS3)

This on-going need to drive recovery demonstrates the level to which concepts of recovery need to be bought into and sustained. Embedding notions of recovery requires often life-long effort. This may also require a collective approach, a buy-in from family members as their lives would also require reconfiguration and effort to support those in recovery.

Certain elements requiring consideration for future provision, were proposed during both interviews and observations (Reconfiguration), which will be discussed in chapters 7 and 8. As previously covered, the concept of being 'in recovery' versus being 'recovered' is very much an individualised notion, but what is clear is the range of factors that can promote or inhibit recovery which have been highlighted within this chapter.

Chapter 6. Results of Qualitative Interviews: Phase Two – Recovering Through Change

6.1 Introduction

As with chapter 5, this chapter will continue to present research findings. This chapter covers findings from the phase two interviews at time points 3 and 4 with service user participants that experienced Lifeline, Change-Grow-Live, Recovery Academy Durham (RAD), as well as those that had previously attended DRAW. In addition, a service manager and the service commissioner were interviewed during this phase of the research. The chapter will begin with a descriptive overview of the service user interviewees, highlighting how far they reflected the general service population at the time of interview and wider recovery population overall. As in chapter 5, this chapter will then present the themes rooted within the data (from observational field notes and in-depth interviews), together with verbatim quotes, illustrated with linkage to NPT constructs. Where direct quotes from the interviews have been used, the brackets following the quote will show 'SU' for service users, 'SM' for service manager and 'SC' for service commissioner, alongside the allocated participant number.

Phase Two service user interviews took place at The Centre for Change, Whinney Hill, County Durham, and Newton Aycliffe RAD Centre, between the 17th November 2017 and the 7th March 2018. The service commissioner interview took place on the 17th May 2018 at County Hall, Durham. The final interview, the service manager interview took place at Eden House Service Delivery Centre, Consett on the 18th June 2018. Since the time point 1 DRAW interviews were conducted, service provision in County Durham has undergone three changes (as described in Chapter 2). The members of DRAW were initially relocated to the Centre for Change, which was operated by Lifeline. When Lifeline went into administration Change Grow Live operated as an interim provider until the time of retender. Following the retendering process, DISC was awarded the contract which commenced in February 2018. Recovery Academy Durham (RAD) operated throughout the changes, albeit under different providers. These changes are reflected in the greater focus on the impact of change to service provision that arose in phase two interviews

compared to the previous (phase one) interviews. DRAW operated with an asset based approach to delivery, with members having a significant stake in what the service provided. DRAW did operate with professional staff, these were recovery support workers and a service manager, however, the RAD operated with staff who were addiction therapists or counsellors with the service having a more clinical feel to it. The RAD did still have visible recovery champions employed within its section, but the RAD only made up one section of the new service, with a harm minimisation aspect as well. On entering the building there was a clinical style waiting room with a receptionist behind a glass window who took the clients' information and would buzz those accessing the recovery section through (once a chaperone had arrived to take them upstairs to the recovery provision). Those accessing the service for OST waited for a member of staff to collect them and take them to a private room in another area of the building.

6.2 Participant Demographics

This section will present the demographics of the participants, highlighting how they fit with current service users overall. Table 6.1 below presents the demographics of the participants from phase two interviews.

Table 6.1: Phase 2 Participant Demographics

Participant Number	Participant Type	Alcohol / Drugs	Attended DRAW	Attended Lifeline Hub (+CGL)	Attended CAS	SMART / AA	Residential RAD	Service Attending at Time of Interview	Gender	Age Range	Number of Previous Services Attended	Time Attending Last Service	Time Attending Recovery Hub	Time in Recovery
1	Service User	Alcohol	Yes	Yes	Yes	SMART	No	Community Hub	Male	46-55	3	1-2 Years	1 Year	3-4 Years
2	Service User	Alcohol (used drugs prior)	No	Yes	Not Stated	AA	Home Detox Prior to RAD	RAD	Male	56-65	2	6 Months -1 Year	6 Months -1 Year	6 Months-1 Year
3	Service User	Alcohol	No	Yes	Not Stated	AA	Resid-ential	RAD	Female	18-25	2	1-2 Years	1-2 Years	1-2 Years
4	Service User	Alcohol	Yes	No	Not Stated	Both	No	Community Hub	Male	56-65	4	Not Stated	1-2 Years	7 Years +

Table 6.1: Phase 2 Participant Demographics continued

Participant Number	Participant Type	Alcohol / Drugs	Attended DRAW	Attended Lifeline Hub (+CGL)	Attended CAS	SMART / AA	Residential RAD	Service Attending at Time of Interview	Gender	Age Range	Number of Previous Services Attended	Time Attending Last Service	Time Attending Recovery Hub	Time in Recovery
5	Service User	Alcohol	No	No	Yes	AA	Resid-ential	RAD	Female	56-66	1	1-2 Years	0-6 Months	2-3 Years
6	Service User	Alcohol	No	No	Yes	Both	Day Attend-ee	RAD	Male	46-55	3	6 Months –1 Year	1-2 Years	7 Years +
7	Service User	Drugs	No	Yes	Not Stated	Both	Resid-ential	RAD	Female	36-45	5+	2-3 Years	0-6 Months	7 Years +

Table 6.1: Phase 2 Participant Demographics continued

Participant Number	Participant Type	Alcohol / Drugs	Attended DRAW	Attended Lifeline Hub (+CGL)	Attended CAS	SMART / AA	Residential RAD	Service Attending at Time of Interview	Gender	Age Range	Number of Previous Services Attended	Time Attending Last Service	Time Attending Recovery Hub	Time in Recovery
8	Service Commiss-ioner	Not Applicable (N/A)	N/A	N/A	N/A	N/A	N/A	Previously worked for services and in current position commissioned Lifeline, CGL and DISC	Female	N/A	N/A	N/A	N/A	N/A
9	Service Manager	Not Applicable (N/A)	N/A	N/A	N/A	N/A	N/A	Worked through service changes	Female	N/A	N/A	N/A	N/A	N/A

6.2.1 Service Users

Seven service users were interviewed during phase two of the research. The majority of these presented to services for issues relating to alcohol (6 in total). There was a more equal gender split during phase two than phase one research, with four males and three females being interviewed. Between April 2017 and March 2018 the gender split of clients attending County Durham services was 69.4% male and 30.6% female.

Compared to phase one interviewees the average age was older in the phase two participants. Most DRAW member participants (phase one) were between 36 and 55 years of age: Whereas most (71%) in phase two were aged 46-65. This age range accounted for 24% of the population of service clients between April 2017 and March 2018. The majority of the *UK Life in Recovery Survey (Best, Albertson, Irving, Lightowlers, Mama-Rudd and Chaggar, 2015)* participants were aged between 40-49, averaging younger than the phase two participants.

The majority (86%) of the service user participants had experience of attending more than one service prior to interview, potentially as a result of recent changes in provision in County Durham. Three (43%) of the participants in phase two were in stable recovery (over 5 years), a further three (43%) were in sustained sobriety (1-5 years) and one participant was in early sobriety (up to one year free from alcohol or drugs). Compared to the DRAW participants (phase one), the phase two participants had been in recovery longer, this is similar to the *UK Life in Recovery Survey* where over half of the participants were in stable recovery.

6.2.2 Service Manager and Service Commissioner

One service manager, who discussed operation during all the recent changes and the service commissioner were interviewed during phase two of the research. The service manager had worked within the field of drug and alcohol for approximately twenty years. The service commissioner previously worked for Lifeline and had a host of experience in public health service provision prior to becoming a commissioner.

Sections 6.3 till the close of the chapter present the findings, utilising the same NPT constructs framework as in chapter 5, albeit with a greater focus on the impact of commissioning changes.

6.3 Normalisation against the background of constant service changes

Chapter 5 explained how normalisation requires actors to participate in activities (both mentally and physically) to embed newly learned behaviours into their core knowledge and practices. A question posed during phase two of the research asked how can new thoughts and behaviours become normalised when routines may be broken through changes in service provision? For example how can recovery become maintained and sustained if the delivery of a recovery service changes? Do service users specifically notice the changes or is the transition between provision relatively smooth, with limited disruption to delivery?

As with Chapter 5, tables 6.2 to 6.5 will remind the reader of the constructs and sub-constructs of each NPT segment at the start of each section, and again questions posed during analysis of the data are also provided within the table. Stages of analysis were undertaken in a similar style to chapter 5, albeit with a greater focus on the impact of service changes (as these service users had witnessed more changes in delivery than those interviewed for chapter 5).

6.4 Coherence – What is Recovery?

Coherence within this study relates to how individuals understand the requirements of recovery, how participants make sense of how recovery differs from their previous life and / or how the services they have attended differed. How they come to view recovery, identify their own needs and decide to engage are elements of coherence. Table 6.2 describes of the how the data linked to components of the NPT construct of Coherence:

Table 6.2: NPT: Coherence – What is Recovery?

What is 'Recovery'			
Coherence Component (internal /planning phase - thinking about 'getting well' and what recovery means)			
'Coherence: the process of sense-making and understanding that individuals and organisations have to go through in order to promote or inhibit the routine embedding of a practice to its users. These processes are energised by investments of meaning made by participants.' (Finch, 2012) • What does the practice of recovery mean – how is recovery conceptualised? • What will recovery involve for service users? How is 'recovery' explained by service staff? • What factors will promote or inhibit recovery?			
Sub-constructs – mechanisms of coherence			
Understanding recovery **(Differentiation)**	**Talking about recovery** **(Communal Specification)**	**Owning recovery** **(Individual Specification)**	**Deciding to engage** **(Internalisation)**
'An important element of sense-making work is to understand how a set of practices and their objects are different from each other.' (May, 2015)	'Sense-making relies on people working together to build a shared understand of the aims, objectives, and expected benefits of a set of practices.' (May, 2015)	'Sense-making has an individual component too. Here participants in coherence work need to do things that will help them understand their specific tasks and responsibilities around a set of practices.' (May, 2015)	'Finally, sense-making involves people in work that is about understanding the value, benefits and importance of a set of practices.' (May, 2015)
How does recovery differ from the service user's previous life? How do services differ?	Does seeing others in recovery act as a driving force? How is recovery discussed? Can 'new' service users identify with those in recovery?	What will recovery bring the service user? What specifically will they need to do? How do they identify their own individual needs? Accept being 'powerless'? (12-steps)	Do they believe in the requirements of abstinence? How do they assess their own readiness to engage? Referral process?

(May, Rapley, Mair, Treweek, Murray, Ballini, Macfarlane, Girling and Finch, 2015) (Finch, Mair, O'Donnell, Murray and May, 2012)

For those in recovery, considering a life without substances can be daunting and at times unfeasible, the notion of a life of abstinence (or even reduced use or consumption) requires a fundamental shift in their lifestyle and thought processes. For some participants a trigger (being arrested or injured leading to depression and heavy drinking) led them to realise help was required to reduce alcohol (or drug) use. For others a 'push' by a GP or family member, or even internal realisation brought them to seek help. One participant explained how he had previously attended services, and then believed himself to be:

> *all right as long as I don't go daft…And then gradually…I mean it wasn't overnight but gradually the drinking sort of got back to the levels where it was before, until I just realised yeah, that obviously inside I'm still the same…And that's what I need to address…because I just thought I am doing this because I want to do it now. And I think that's the key…it's probably why I've maintained sobriety since I've walked through the door here in March 2016…the penny had sort of dropped, type of thing, and you can't talk that into somebody, you know, even if they know you're telling them the truth and what you're saying is right. I think that's something that somebody's got to come to that point themselves.* (SU1)

This quote demonstrates that there needs to be a readiness within an individual to instigate change for themselves, not just for others. SU1 recognised that 'inside' he was the same. He was previously not ready to embed the principles of recovery (in this instance abstinence) when he accessed services last time, whereas this time he was ready to internalise; he understood what he needed to do to make sense of recovery.

Initial stages of the 12-steps process require accepting alcohol (or drug) use has left the individual powerless and that life has become unmanageable. One AA attendee explained the initial steps as:

> *it's about engaging with something in yourself, you know, like this higher power thing, so you have to find that* (SU2).

Here the notion of accepting help from a 'higher power' is internalised as the individual identifies his / her own needs, and seeks to find support from within themselves to engage in recovery. As with SU1 quoted above, SU2 describes that there has to be a change or acceptance within yourself for

an investment in recovery to occur. Admitting you are powerless can also be an issue that needs to be overcome to encourage 'buying in' to recovery, or at least the 12-step process of recovery:

> *you go through a lot of emotions and a lot of different feelings about, you know, let's say step one which, you know, if you look at it you think it's relatively simple. But I couldn't admit to being powerless over alcohol or drugs…I had to formulate it in my own mind a way for me to accept it. But the staff were good like, you know. I felt I wasn't…progressing and they just say, you know, you are where you're supposed to be. (SU2)*

Coming to terms with stages of recovery (or steps if you follow 12-steps), is a gradual process, understanding what is required to become well, and how to promote those practices requires thought and support. As SU2 describes, staff did not rush him; instead they explained he will reach each stage when he is ready. SU2 described how he thought he would just stay with the 12-step programme till step 5, but that each step becomes more relevant, making it easier to accept the next one. This is an example of not just internalising the process but believing in it (legitimation) and actively investing effort (elements of collective action).

12-steps requires its members to be abstinent, rather than reducing consumption. For some individuals considering recovery this notion can be confusing, with many attempting to reduce alcohol consumption before the realisation that a more structured approach to recovery was needed:

> *I attended trying to reduce my alcohol … and I did quite well up to a point. I did very well after I was seeing the nurse sort of one-to-ones and then I was …having to see different ones because they were moving to different jobs. …And …so after about a year … reducing the alcohol I finished, I stopped going really … when I shouldn't have and started drinking again…and then that went on for quite a few years till…I got back in contact with the services. By that time it had changed …to Lifeline…And then … I was using recovery groups … as there'd been a change to CGL…and then I was in the RAD …around that time and then that was just changed to DISC now…But the idea of going to rehab… I just - it was so early - and I didn't understand what it would mean …maybe if I'd known about day care then … it could have helped a bit more. But er even the groups there weren't many…I was still struggling with*

> *abstinence and the idea that I couldn't drink again. I just couldn't get my head around it and in the back of my mind, even though I knew I had to stop and I was trying to stop, I sort of was and I wasn't, and in the back of my mind I thought … I still need a drink. … and it wasn't until I'd made myself a lot worse that I realised, you know, I just have to stop. There's no question, you know, but then it was how* (SU6).

This quote explains how the changes in service delivery not only acted as a potential barrier (not having day care explained as an option, lack of groups to attend and continual changes in staffing), but that entering residential rehabilitation (the RAD) was not sufficiently explained or understood. For the principles of recovery to be understood, service users need to establish what options for 'getting well' there are, how they can engage and what is required of them. Clear signposting from practitioners would assist with this, along with the ability to bond with particular staff members to enhance the possibility of opening up and internalising what recovery could mean. Even when SU6 realised that he had to stop drinking he could not make sense of how to do it initially. What was involved in rehab seemed unclear, and the general changes in provision and staffing left a chaotic ensemble of choices.

Some participants had a good understanding about what the service delivered:

> *So it's all cognitive behaviour therapy and addressing how you think, how you behave. … I'm enjoying it much more than the Twelve Steps. I get it, really get it... and it makes me think … it's complemented with AA and the Twelve Steps. So we can go to any AA meetings we want. We go to an NA, Narcotics Anonymous, meeting once a week, which is slightly different but it's just as good…so to me it is a good blend … you get the cognitive mental stuff through the PSI but you still need the spiritual …wellbeing kind of stuff that you get from AA…So for me…the combination works.* (SU5)

Although SU5 also continues by suggesting elements she would like delivered in the service to complement the main recovery programme (acupuncture, yoga, meditation). SU5 understood and bought into what the service provided, describing how it works, the way in which thought processes around alcohol are challenged in the cognitive therapy

elements and the wellbeing and spiritual help that can be found in the 12-steps programme.

SU6 highlighted above the internal battle around understanding abstinence, the need for realising that one cannot drink again and (even when that realisation hits) how the question remains for the individual of how to get to that level of focus. Here communal specification, talking about recovery, could assist; hearing how others managed to overcome these hurdles could provide support. Group support is required for those in the contemplation phase; witnessing recovery in the community can act as a driving force to instigate change.

> *And you bump into some faces that you haven't seen for a long time. And it's surprising how much warmth there is there because if you've sat in a room and bared your soul to somebody in a recovery meeting, because you trust them to that level and then they've shared with you … you know… that's not something you get in everyday life.* (SU1)

Hearing another 'bare their soul' helps with identification, a bonding that, as SU1 describes, is not an everyday occurrence. Coherence requires an understanding about what is different, (how recovery may differ from a life of dependence), but also how others have moved on from addiction into a 'new' life in recovery to demonstrate what positives recovery can bring. Often the professionals working in services fail to engage service users:

> *it wasn't their fault. It's just they didn't have the level of therapy… they're just professionals really… So like I say, it's not their fault, it's just that they couldn't engage to that depth as someone who's been through it can* (SU2)

Again, identification assisted clients in engaging with recovery services. For some, a deeper level of understanding amongst staff and supporters around what dependency had meant was required. Another service user, however, suggested that a mix of backgrounds amongst staff was beneficial to service provision, highlighting training (academic background) mixed with recovery knowledge as more important, as long as the staff have empathy (SU5). SU1 described how those in recovery can tell whether a staff member or worker has come through recovery themselves

> *You seem to get a sense that yeah, you've been there, you know what you're talking about. And I think that engenders a lot more trust… You're not putting down people who don't need to have had an issue with addiction of any sort in order to know what…how to… address the issue. But, I think, certainly from the service user's point of view, you can generally tell which staff have been there and possibly that is because of their … natural empathy. They don't have to think about it; they just know.* (SU1)

Empathy from those who have experienced addiction creates a shared understanding of recovery; empathy was a factor that was raised a lot during the interviews, with many service users describing it as an important factor to successful service delivery.

The manner of referral to services was also described as an important facilitator or barrier to initial recovery journeys, but access varied among participants, with SU1 describing the process as a lottery, depending on which GP you got to see.

> *Erm it's a bit of a lottery. I had a doctor, a GP, once, who was very keen on recovery services and he knew a bit about it and he knew…who to put you in touch with…he's left. I've had other doctors in the same surgery who they look at you as if …like why are you asking me about alcoholism. You know, as if they're prejudging, like you don't look … as if you've been sleeping rough or whatever. Why do you need that?* (SU1).

Prejudiced attitudes could drive a pre-contemplator away from service provision, especially as the majority of participants describe the vulnerabilities associated with addiction, where empathy is required for engagement. This potentially supports the notion that there should be more people in recovery visible in the community to encourage initial conceptions of entering recovery. SU1 went on to state:

> *I always say that some of the nicest people I've ever met in my life are people in recovery, because they've got that humility and they know how to support others without being prejudicial or judgemental in any way, and I think that's a massive… part of being a good human being… just a pity you've got to go through recovery to get to there [laughs].* (SU1)

SU1 had earlier discussed access to those in recovery as an 'untapped pool of talent' that should be utilised more within communities. This sentiment was shared by the service manager (SM9) who raised the value of recovery ambassadors on numerous occasions. These ambassadors are service users in stable recovery, who operate in various positions in the treatment or recovery arena. They engage new service users, work alongside staff in the centres and give talks within the community to ensure recovery is visible. Ambassadors potentially bridge the gap that SU2 raised, that often workers could not fully engage service users as they did not fully understand the issues they faced. SU6 also raised the benefits of seeing these recovery 'volunteers' in the service, stating that there were not any working in the centre at that time (time of interview) but that he had heard they were coming back under the new provider.

Thinking back to his initial assessment at the Community Alcohol Service, SU1 described how the conversation with the worker was focused around completing a drinks diary and thinking about ways to reduce consumption. These conversations were probably aimed at getting the service user ready to consider recovery (or at least reduction). However the underlying causes of the drinking habits were not discussed until further into the service provision. Potentially so bonds could be created, encouraging service users to open up, although, as has already been highlighted staff turnover was seen as high during the attendance at services during this interview phase. Keeping a drinks diary and thinking about what changes can be made allows service users to start to make sense of what recovery will mean for them, what their responsibilities are and what specific tasks will be required of them (not drinking to those levels and engaging in services, being open to change and willing to discuss the benefits of the changes).

Creating bonds with staff, and the potentially negative effect of staff turn-over due to service changes was raised by participants:

> *When I was attending the hub … there were a couple of workers there that I particularly bonded with, one in particular. But a few faces around…and they went and … it just seemed like the whole place was dead, and I'm sorry to see them go …*

> *I think the volunteers were told that … they couldn't be taken on by the new company and the staff …was just because it was so uncertain what was happening and the work seemed to be drying up so they kind of found other jobs…I know one didn't want to leave, but it's just that uncertainty and then a job came up so they took it. … but upstairs I suppose it was all new to me and I was … just getting to know the staff*. (SU6).

SU6 continued to explain how bonding with staff is similar to working the steps (12-steps in AA), describing it as a process where an interruption could 'set things back', which would not conducive to recovery.

The importance of getting the right staff member, or initial set-up was raised by interviewees:

> *I have attended other services …I'd attend them once or twice but they never stopped me doing what I was doing and in fact I always felt more like drinking when I got out of any of the interviews with them. They were all one-to-one's as well. So this is the first service I really engaged with by going to meetings and stuff. So I like seeing other people and even like done CBT before coming here…* (SU2)

For SU2 the shared conversations that developed during one to ones actually increased the likelihood he would have a drink, highlighting that communal and individual specification can sometimes have an adverse effect. SU2 appears disappointed at there being so many one to ones; however SU6 preferred discussions on a one to one basis and initially struggled with groups:

> *I remember the first time I was in CAS I … really didn't want to be in a group... I was happy with the one-to-one…but with Lifeline at the time they said they'd stop doing one-to-ones, I couldn't have that apart from to register and they would take me through the registration but after that it would be groups. So and I was that desperate I just thought I would go and … I mean I'm still not very good in groups. One-to-one I'm all right. I struggle, erm but it's not as bad as I thought it would be. But then I didn't know what to expect and it's just a fear really.* (SU6)

This suggests that different options need to be available from providers so that the needs of different service users can be addressed. Fear of not knowing what was about to happen to them, or what the service was going

to deliver, how they would need to act or behave or what was required of them was a barrier to accessing and engaging in recovery. For some participants, considering recovery brought about feelings of guilt:

> *It even felt a bit strange. I can't say it was really uncomfortable. I mean like that when they said … how do I feel about being there and my first reaction was to say I feel guilty. I'm guilty for being here…Well I didn't have this sad story like other people. I wasn't abused as a kid or like I didn't have these great marital traumas…And so I did feel a bit guilty because I had a relatively decent life…but, you know, everyone's got their own journey* (SU2).

Although SU2 could not initially identify with the 'sad stories' told at early AA meetings, he was able to recognise that everyone had a journey that led them to seek help and engage in recovery, allowing a shared understanding of recovery to embed. The 'shares' at AA allow for the expected benefits of recovery to be raised and bought into, helping principles of recovery to be conceptualised.

However, talking about recovery can also be problematic, as one service user explained:

> *Some meetings are better than others, it has to be said…any meeting's only as good as the people who are there and the facilitator* (SU1)

SU1 continued by explaining that the structured meetings are the best, as they have set parameters, they involve a check-in, where people raise any positives or negative moments they've faced that week:

> *It's a very simple idea but if you get a group of people together who are at varying points in their recovery then there's usually somebody who's been through what you're going through…it's not that they're going to say this is what you need to do, but they can relate to what you're saying and maybe talk about how it affected them…they could say what they did and what worked for them but that's not to say you've got to do the same. But the fact that somebody else has been there, sometimes you can take that horrendous thing, yeah, it's all right, I'm not the only person in the world that's doing this…and that level of support and encouragement and …the fact that you're sharing things on a deeper level than you would in everyday life it's very…*

> *powerful I think…You can look at somebody and hear their stories and think, oh well if they've been there and look where they are now, then I can do it* (SU1)

Peer led meetings could be difficult, depending on who was leading the group. Inexperienced leadership could lead to people being taken to a negative place, whereas, when there was an experienced leader there, the meeting could be steered back to living life in recovery and end on a positive note (SU1). In addition, if someone is struggling as a peer mentor leading a recovery group, the strains involved in taking on this role could lead to triggering an episode in themselves. They too needed an avenue to offload, and good support, encouragement and appropriate training. (SU1).

In addition, mixing with peers could also prove problematic as SU3 describes:

> *I think sometimes like my head was in recovery and I went into recovery and there was a lot of people who, in my opinion, didn't really want to be here and they were talking about drugs and alcohol and they were wanting the break the rules. But then I didn't want to break the rules with them because if I did I didn't want to be kicked out, and I had to put my own recovery first.* (SU3)

This demonstrates the risks that can arise in group work or sharing a residential facility, SU3 had made sense of recovery on an individual level, understanding her own involvement in recovery, but communally the group had not developed a shared understanding.

Part of identifying their own needs when considering engaging led to feelings of worry about what would follow the initial treatment phase, SU6 explained:

> *I remember before I came in I sort of a worry is that there'll be nothing there afterwards… and about moving on, especially because I've never had a steady job, haven't worked a lot really, so getting those structures and things in place, you know, courses, to help towards not necessarily a job but hopefully a job or voluntary work or just having those things to do, to just explore finding things that I enjoy doing so that I can carry that on when I leave. Erm so try and identify skills, things*

I'd be good at as well as enjoy, and then or be pointed to places and it's difficult now because there's colleges and that, they're expensive and there's problems with hours and money, things like that… some kind of direction really…it's about having meaning and purpose in life to go on, so it's finding that really and having some help… (SU6)

Here SU6 demonstrates a good understanding of what recovery could bring from the onset but still worried about what help was available for him to meet long term stability in recovery, of which financial stability, work and happiness were all factors.

What recovery services should deliver should include:

..acceptance of people coming through the door … their attitudes of being non-judgemental. Erm being warm, welcoming. Erm and just its being a safe place to share. Erm the confidentiality is important as well. And I think a lot of times, especially [for] people who live alone or have isolated lives, I think that a massively important step is to find somewhere where they can actually be with other people who care about what they're up to and what they're doing. (SU1)

SU1 also highlighted that initial phases of treatment and recovery need to make you feel better about yourself, stating that addiction strips away self-esteem so this needs to be rebuilt during the early stages of recovery. Recovery meetings should make you feel like:

..things are turning around…I'm on top of this and I've taken some strength from what I've done today. I'm going to move forward (SU1)

Sense making also requires owning recovery and accepting responsibility. For one interviewee accepting responsibility meant he could not 'buy into' what AA offered:

I think the way that there's some understanding of it or some way it's put across to me is that you surrender to a higher power, and I just think for me I can't get my head around that because I just think I'm still making those choices at the end of the day…And what does that even mean, surrender to a higher power? I just think does that mean well it's not me doing it anymore it's you. I just think no, it's an abrogation of responsibility. I just think yeah, you can realise that this thing's

> *got hold of you and you can, for me personally, with my religious beliefs I can pray for the strength to overcome it, but that's not to say that that's the end of it for me because I've still got to do it.* (SU1)

This quote also provides a recognition by the service user that knowing what must be done is not enough alone. There must be an action attached to the emotion that drives the individual to commit to and activate recovery. Internalising aspects of recovery then drives forward components of cognitive participation as individuals consider what is required of them to take the implications associated with recovery to drive forward commitment to participate. Table 6.3 reminds the reader of the sub-constructs associated with cognitive participation.

6.5 Cognitive Participation – Engaging in Recovery

Cognitive participation encompasses the processes actors instigate to activate change and commit to recovery. For participants in phase two this also required coming to terms with changes in service provision. Phase one participants had also experienced change but not as often as the participants in phase two (some experienced three separate providers in a three year period). It could be argued that these changes required a greater commitment and investment, not allowing the changes to become an excuse to drop out of recovery. Table 6.3 suggests how NPT components of Cognitive Participation can be considered in terms of recovery:

Table 6.3: NPT: Cognitive Participation – Engaging in Recovery

Engaging in Recovery			
Cognitive Participation Component (internal /planning phase – instigating change and committing to recovery)			
'Cognitive participation: the process that individuals and organisations have to go through in order to enrol individuals to engage with the new practice. These processes are energised by investments of commitment made by participants.' (Finch, 2012) • How do service users instigate change (i.e. start recovery process)? • How is their commitment to recovery supported? • What factors will promote or inhibit recovery?			
Sub-constructs – mechanisms of Cognitive Participation			
Readiness for recovery **(Initiation)**	**Enrolling in recovery** **(Enrolment)**	**Believing in recovery** **(Legitimation)**	**Driving recovery** **(Activation)**
'When a set of practices is new or modified, a core problem is whether or not key participants are working to drive them forward.' (May, 2015)	'Participants may need to organise or reorganise themselves and others in order to collectively contribute to the work involved in new practices. This… may involve rethinking individual and group relationships…' (May, 2015)	'An important component of relational work around participation is the work of ensuring that other participants believe it is right for them to be involved, and that they can make a valid contribution to it.' (May, 2015)	'Once it is underway, participants need to collectively define the actions and procedures needed to sustain a practice and to stay involved.' (May, 2015)
Can service users buy into abstinence? What drives service users to instigate change? How can you re-enrol to a new service?	How do service users access the service and 'buy-into' delivery? How do they 'shake-off' their old habits?	How do service users legitimise their involvement? Do they believe in the contribution of others?	What do service users do to drive forward recovery? How are the cravings to drink or use pushed through?

(May, Rapley, Mair, Treweek, Murray, Ballini, Macfarlane, Girling and Finch, 2015) (Finch, Mair, O'Donnell, Murray and May, 2012)

For some participants this commitment required coming to terms with abstinence

> *I wasn't convinced with the total abstinence type of thing* (SU1)

Abstinence as a concept has been covered in the coherence phase, but here it can be viewed as a potential barrier to enrolling. Thinking about abstinence is one factor (coherence) but actually activating and agreeing to it is another (cognitive participation). SU1 continues by explaining how in the early days of attending DRAW he went as a result of his partner feeling fed up with him:

> *I look back now and I admit that I wasn't fully committed to it. I was doing it because my partner was getting fed up with me and the doctor said my health would suffer because of drinking too much... so I basically was saying oh, you know, I'd better be a good boy and I better do what other people want… so I'd …go to DRAW. Spent my time, a few hours there and attended the meeting, and then left. And then halfway home jump off the bus and gaan to the pub. …But too often in those days I would come out of meetings and just think I need to switch off…. It might have been just where I was at that particular point in my life in with my recovery … I definitely hadn't embraced the fact that I was going to be sober for the rest of my life….And I maybe …wasn't ready for it.* (SU1)

DRAW was an abstinence based service, so potential members were informed prior to attending that they needed to be abstinent, SU1 had supposedly agreed to the concept but then carrying out the action was a different issue. He admits himself he was not initially ready. SU3 also initially attended for the sake of others, but then bought into it:

> *…when I first came I was kind of forced to go. I was told like by the staff in the supported accommodations that if you didn't start engaging we're going to discharge you…So like a programme because you're too chaotic and we cannot manage you…And so I started engaging because of that, to kind of appease other people at first, like family and stuff like that. And then I kind of like thought there must be something there*. (SU3)

As SU3 began to believe in recovery, the process became legitimised; she started to consider it was right for her to be involved and that it might help her.

Sometimes attendance was a requirement to access another service:

> *So I twisted my spine in a…in a sort of incident and … I got really depressed. Started drinking …I realised I couldn't cope on my own so I start engaging what they call the hub, downstairs…A really nice lady Vicky ran it. And it's probably due to her that I kept engaging because I'd knew I needed a detox and …I couldn't manage without, although I tried. So I engaged with them because part of the conditions of getting the detox was to engage. So I started coming to the recovery which was downstairs. Er eventually it got me a detox which I did in March and er and then I kept coming to recovery because by now it was I felt a relief for having the detox and starting to recover….And again it was the hub that sort of kept me engaged, the mixed people, nice people.* (SU2)

SU2 continues by adding that initial engagement, then detox, then the RAD and 12-steps felt like: 'natural progression' and that:

> *I felt like I was erm paying back the trust that they'd given me in getting me the detox in the first place, because they weren't easy to arrange.* (SU2)

This notion of paying back the trust staff instilled in SU2, not only legitimised his involvement but kept him driving his recovery forward, providing examples of initiation, enrolment and activation; SU2 organised himself to attend the centre, contributed to the work involved in order to sustain a practice (getting onto rehab) and stay involved in recovery.

Sometimes service users were considered to be 'playing the game' in order to gain access to provision (such as housing). This appeared to annoy other service users:

> *And so I think they feel it as well if someone's just playing the game…Or come here to get a house or something like that. [Do you think that happens? Do people play the system that way?] Definitely. Yeah. Well she got a house out of it….But I wouldn't say everyone's in it for that…But then you can see there are some chancers or people who've just come out of prison and they've got no option but to come here and…or go back to*

> *prison …and they don't last. I haven't known one of them last, to be honest.* (SU2)

From a collective perspective, this led to a rethinking of the involvement of other service users, creating a suspicion of the motives for participation. To instigate real change service users need to really buy into and commit to the processes involved in recovery, not just attend. Legitimation can be considered here in terms of group participation, not just from an individual's perspective; Individually, SU2, appears to consider that these 'game players' could not make a valid contribution to the group dynamic or collective element of recovery; they were not legitimate participants in enrolment.

Access to services was raised by participants as a major factor in recovery:

> *The most important factors of recovery? Erm…I think…[pshh] well access is the first thing. Now, it's a nightmare trying to get into recovery... Because you're not in recovery. You're not. You haven't accessed the service. It's how you actually get to it. Access is the first and foremost thing* (SU1)

Initiation and activation requires actual access to the provision needed, as covered under coherence section, the referral process into services can be a 'lottery' depending on what GP is visited. The quote above highlights the fact that referral might be an initial stage (almost a conceptual element), but that the process of recovery only really begins (in a physical sense) when access is actually made.

Following the activation of access to services, and potentially an initial period of abstinence, the cravings for alcohol can still remain:

> *There's a phrase …that you've probably heard called 'white knuckling'… where, you know, you can stop drinking, but the urges and the cravings will just be there every day. You're just clinging on for dear life not doing it. And that's not recovery for me …that's abstinence. But that's not what I'm striving for …I'm going for like recovery and…and that's another thing altogether* (SU1)

This demonstrates the difference between abstinence and recovery. Abstinence in this sense is an initiation element of recovery, something

that is required to drive recovery forward but that to sustain the practice of recovery (getting well) an action that may be required is enduring the urges and cravings, living through the process of 'white knuckling'. Activation hence contains an individual meaning, rather than the traditional collective definition usually utilised with NPT.

Recovery can be perceived as a staged process, a journey, which, as one interviewee explained, can elicit feelings of fear about the unknown:

> *Then once you're in, in recovery…I think it would be useful to know the stages of recovery and then try and match the level of service provision to each stage so that it's obviously going to be more costly, I think, to provide services for the initial stages of treatment in recovery … but you don't want to sort of keep people locked into that stage because they're frightened of moving to the next stage. It's like being trapped in a relationship you don't want to be in but you're frightened of the alternative, so you don't leave. It's you should naturally think like okay, I've come to that point, and then you should just say, right well, where's next? So, you know, it's almost like taking people along on a journey* (SU1)

SU1 explains that knowing what stages are to come in the journey would facilitate recovery; understanding what work will be required next and having the support to help you move to that phase would be beneficial. Fear can prevent the progression to the next level, so staff (and potentially peers) need to act as prompts and guides to continually drive forward recovery.

Choice is also a facilitator:

> *we now get to kind of choose which meetings we go to…Which we didn't get that for a long time. Erm and most of the alcohol prefer AA or the CA… they work from the big book, which is the AA book… but NA they've wrote their own… specifically for drug users, you know. So I prefer NA….They speak my language in there* (SU7)

Not only is choice a facilitator but identifying with the language used presents as fundamental to legitimation and activation. Believing that Narcotics Anonymous (NA) 'speaks the same language' ensures that SU7 feels she can make a valid contribution and sustain involvement, so much

so that she later describes her willingness to travel to Newcastle to maintain involvement (as there are limited NA meetings in Durham). This also provides evidence for the support of peers in driving enrolment in recovery. The recovery community, particularly individuals further into stable recovery, can be viewed as a

> *…lighthouse, if you like, you know. They show you where the safe you know, maybes where the rocks are so to avoid them …but that there is sort of land over there somewhere, you know, head for that. Erm and they can be very encouraging just by being there* (SU1)

These beacons of support, promote the future life that is waiting as each service user drives further into their recovery journey, again legitimising each actor's involvement in the process. Viewing stability whilst feeling still relatively vulnerable helps embed the culture of wellness, which renews commitment and investment.

Service changes can reduce stability for an individual's journey, particularly in the preliminary stages of recovery:

> *Now in the early stages of recovery you've taken a massive step to actually seek… to address your issues around whatever substance it is that you…that's causing a problem… what you're looking for is some sort of stability and continuity and so therefore changes are going to run contrary to that because we…you may just come in to somewhere and think well after a little while … think right, it's okay, I'm fine here. I've found a safe place that I come to that's, you know, giving me encouragement and support then all of a sudden it's like oh this is all changing, I'm going to have to go somewhere else. And at times that can be…I don't know if I can face that again. I don't know if I can do that again…. Erm or be tempted just to give up and just think, oh this is never going to work. I knew I couldn't do this. And it's…it's all those feelings of because you're talking about people generally, I mean maybe talking about myself more than anything, but you talk about people with low self-esteem, lack of self-worth erm who've been sort of battered down a lot and in those early days it doesn't take much to push somebody back down*. (SU1)

Collectively and individually, the changes to provision can act as a barrier to recovery; enrolment requires that actors contribute to practices of

recovery. The service changes may mean rethinking of the practices are then presented negatively reducing the level of activation. As SU1 explains, when people have been 'battered down' it does not take much to push someone away. Stability for someone who may have lived a previously chaotic life is key for driving recovery. Furthermore, participants described witnessing how the service changes had impacted on others in recovery:

> *I see a lot of demoralisation and overwork… I think there's a lot of that. And I think erm you feel that and, like from the people who live in the residential, you can see at the moment, seems since I've been here and now they don't get any night cover or evening cover so they're…often they're trapped in the house because they can't leave without secondaries or permission or bus passes, and they have to accompany each other and there's no minibus on the night for them anymore…If they want anything in the house it seems like a chew to get it…so it impacts more on them than it does on me, because obviously when three o'clock comes I'm out of here.* (SU2)

SU2 continued by describing how service changes had meant the loss of a valued member of staff, explaining how service users 'need people who stand out in the storm', and how losing staff such as that particular worker (who a number of service users had bonded with) could put other people off attending the service. Another interviewee (SU5) described how staff seemed positive about the upcoming provider (DISC), suggesting that anecdotally things might change for the better. Positivity can drive forward the belief in recovery, legitimising the actor's involvement as well as sustaining involvement, keeping service users engaged and contributing.

External to service provision, service users often have 'battles' to sustain motivation for recovery. SU1 described having to endure an Employment and Support Allowance (ESA) tribunal:

> *They took me off ESA because I didn't get enough points on the questionnaire… because I answered it honestly. When they're asking well what's your typical day like, can you do this, can you do that, can you travel about, do you look after yourself, do you wash, do you dress, do you cook for yourself, and I was saying, well yes I do all that because I'm in recovery…Erm you take away the support and the encouragement and the*

> *guidance that I've had in recovery and substitute that with… at a vulnerable stage in my recovery …. putting me on to job seekers and having to go down and talk to them about how many jobs I've applied for and what I'm doing for this that and the other. Well I felt there's other pressure because I was on ESA initially because of mental health issues like stress, depression, anxiety … and … combined with that … would … be more likely to push me back to a relapse…To think, you know…I can't take this anymore, I'm just going to start drinking. And I honestly felt that that would be the case.* (SU1)

Participants can drive forward recovery to an extent on their own, but circumstances beyond their control (i.e. access to benefits to provide financial support whilst they recover), can damage their ability to remain engaged. SU1 continued by stating he won the tribunal and presented evidence he researched himself:

> *…the ACMD…did a report which I found to be pretty useful… you know…don't ditch somebody just as soon as they start getting, you know, taking their recovery seriously and actually doing the things you asked them to do. Erm it says here … "It may not be possible to tell whether someone has achieved stable recovery until five years after their overcoming their dependence on drugs or alcohol." Now I used that in my arguments but if you think about recovery services and the amount of change that there has been, and the type of services that they provided. I think we need to understand more about what a recovery journey is and how long it can take.* (SU1)

This reiterates a point made earlier that abstinence is only an initial stage of recovery; sobriety being only one element. Stability and being well may not surface in an individual's recovery journey for a number of years. The level of energy required to invest and commit to recovery requires so much focus that additional pressure such as returning to work too early can impair activation and may prevent the participant from being able to fully enact the process of recovery. The quote(s) above also provide an example for collective action, demonstrating the action that SU1 had to take (the effort he had to invest researching and fighting his case) in order to continue to maintain his recovery. In the context of interactional workability, collectively (i.e. SU1 and the benefits agency) one party was

initially working against the other, rather than together. Collective action as a concept will now be discussed in more detail.

6.6 Collective Action – In Recovery

By way of reiteration from chapter 5, the reader is reminded that the first two phases of NPT are about understanding and believing in recovery. Collective Action is the first ‘doing’ concept, it is concerned with investments of effort; how the service users (and staff and commissioner) promote and maintain recovery practices. Table 6.4 highlights how the ‘action’ mechanism of NPT relates to aspects of enacting recovery:

Table 6.4: NPT: Collective Action – In Recovery

In Recovery **Collective Action Component (external/ doing phase – maintaining recovery)** 'Collective Action: the work that individuals and organisations have to do to enact the new practice. These processes are energised by investments of effort made by the participants.' (Finch, 2012) • How do service users make recovery work? • How do service users (and staff) structure activities to keep recovery maintained? • What factors will promote or inhibit recovery?			
Sub-constructs – mechanisms of collective action			
Recovery tools **(Interactional Workability)**	**Building bonds** **(Relational Integration)**	**Maintaining recovery** **(Skill-set Workability)**	**Structuring recovery** **(Contextual Integration)**
'This refers to the interactional work that people do with each other, with artefacts, and with other elements of a set of practices, when they seek to operationalize them in everyday settings.' (May, 2015)	'This refers to the knowledge work that people do to build accountability and maintain confidence in a set of practices and in each other as they use them.' (May, 2015)	'This refers to the allocation of work that underpins the division of labour that is built up around a set of practices as they are operationalized in the real work.' (May, 2015)	'This refers to the resource work – managing a set of practices through the allocation of different kinds of resources and the execution of protocols, policies and procedures.' (May, 2015)
How are new coping mechanisms developed to assist with life in the 'real world'? How much involvement do service users get regarding provision?	How important are social bonds in recovery? Can bonds also create further vulnerabilities?	How is motivation to maintain recovery achieved? Do service users feel they have the skills now to achieve recovery?	How are principles of recovery structured or constrained? To what extent to changes effect delivery?

(May, Rapley, Mair, Treweek, Murray, Ballini, Macfarlane, Girling and Finch, 2015) (Finch, Mair, O'Donnell, Murray and May, 2012)

The service commissioner (SC8) discussed how the procurement process involves a health needs assessment and how they (the new provider) conducted engagement events to get people to 'buy into' what the service was offering, make suggestions and voice their concerns. This provides a prime example of interactional workability, the commissioner, new provider and service users networked to discuss elements required for successful recovery and service delivery. In addition, many of the interviewees mentioned the new provider (DISC in conjunction with the Basement Project) visiting the centres to ask service users to create a 'wish list', although some did state that, following the initial consultation, they had neither seen the person nor heard of anything happening since the visit (which potentially reduced confidence in the new provider).

Phase one interviews with DRAW members highlighted that the changes in service provision created a mixed response. Some DRAW members looked forward to changes; others raised how vulnerable they already felt in recovery and worried that any changes could potentially risk their recovery. Phase two interviewees had undergone these changes (for some attending from DRAW to the most recent provider, the incoming DISC). A general consensus among many of the interviewees appeared to suggest that any risk that changes could create depends on what stage an individual is at within their recovery journey. SU1 suggested that if you are early in your recovery you may be more at risk of adverse effects of change:

> *I've found a safe place that I come to that's, you know, giving me encouragement and support then all of a sudden it's like oh this is all changing, I'm going to have to go somewhere else. And at times that can be…I don't know if I can face that again. I don't know if I can do that again…And it's a case of well whatever. They just stay behind my front door instead…Erm or be tempted just to give up and just think oh this is never going to work. I knew I couldn't do this.* (SU1)

Services, when going through change, need to safeguard against these negative feelings for change and not allow changes in provision to become an excuse for an individual to fail. New service users or those early into

their recovery must be provided with even preliminary tools to combat against worrying about change towards the end of a provider's term.

Building bonds with other service users and staff could assist in reducing the impact of change on service users. A number of participants discussed how opening up to staff members can be difficult until you develop a relationship with them; changes in provision often meant that staff left to find job security elsewhere. One service user described change as:

> …*pulling the rug out from under your feet when you're ready to start… You're going to fall on the ground and you're going to have to wait until you get back up again and feel ready to start again… People are in recovery because they've had some difficult issues in their life. People don't have issues with alcohol and drugs because everything's hunky dory for ever…Now, if they're going to find out what those things are, they're going to need to feel pretty safe and secure in order to do that, with all the support and encouragement and around them. Now change seems to go counter to that… That's a crucial point in recovery … that any sort of .. change or disruption to the continuity is going to have an adverse effect on somebody's recovery.* (SU1)

Change as described by SU1 is counter intuitive to building accountability and maintaining confidence in service provision (relational integration). Other service users talked about how the changes were demoralising for staff and service users:

> *I'd like to see staff less demoralised, because you can…it's tangible sometimes, you know…you'd like to see them have the support to where they could help rather than, you know, have more time, not be so stressed themselves, not to have this constant er not knowing what's happening…You know, some concrete plans. Knowing there's funds there, you know. Like I say, the cuts impact on everyone, you know…And everyone should be motivated on what they're doing and trained and happy….It must be a heavy workload and it also impacts …on the staff… I felt it when people, some people, would come and you'd get to like them and then they'd go, or they'd fail, you know, and they'd relapse or something like that. So you felt bad when that happens so imagine if you're the staff and somebody you've invested this time and energy into and then they fail must be awfully hard to deal with again and again and again…So the whole cut thing and the regimes and the*

> *changes are bad full stop. You know, this is an organisation that needs stability because the people within it need stability…You know. There's the clients and the staff and the management, they need that stability and they need the funding and they need the motivation.* (SU2)

Collective action refers to the operational work that is undertaken, in this instance motivation and time to spend with service users. The quote above from SU2 not only highlights how change may reduce client motivation, but also increase the likelihood of staff feeling worried about their own stability and therefore less able to provide stability for service users. It also indicates how investing time and energy into a client who then 'fails' might leave staff feeling unhappy and potentially demotivated. As staff leave to find more stable jobs (potentially in other areas of work), remaining staff are left with greater workloads and less time to spend engaging and bonding with service users. Furthermore, if staff are 'demoralised', as SU2 suggests, it may be difficult for them to embed the practices of the service provider both within their own mind-sets but also to promote the principles within the service and to the service users. Interactional workability refers to how the staff might operationalise principles of the service. If they are over stretched in their workloads there may be concerns that delivery is affected. Relational integration refers to how practices are understood and carried out by the networks of people involved. Witnessing what an individual considers to be demoralisation may reduce the understanding of what the service is providing. If stability is a factor that a service user is seeking and this is not available (or perceived to be unavailable) than their motivation to attend may reduce. A number of service users commented on how those attending the residential element of RAD were more affected than those in day care overall, with comments around lack of a bus to take clients to evening meetings, reduced staffing, women having to live in the house alone and not able to go anywhere (as men and women are segregated). SU6 described that having stability at home made him feel 'lucky in very many ways'.

Where some service users had felt negative towards a service, this could lead to them influencing others not to attend:

> *I struggled with the change from DRAW to be honest, and I think a few people did that I talked to at the time. I never actually came up to this one at Whinney Hill when the move occurred. I bumped into a couple of people that I'd known from DRAW in Durham, and they weren't too keen and I just at that time, for whatever reason, I just thought no, it's not for me, I'll stick with.. I'll just keep myself right and er it didn't work…I gradually found that I was slipping back to where I'd been in the past levels of drinking and …I just thought right, I know it's there. So I think…and what was key for me was that I made the decision to actually get the number and ring and I came to the centre myself. This centre at Whinney Hill* (SU1)

SU1 describes being influenced by the opinions of others he had known at DRAW before attending Lifeline. Although he was not instigating the beginning of his recovery journey, having already been in recovery prior to service changes, the changes had led to him feeling he could 'keep himself right' without the support of a service. Collectively the influence of others had kept him from attending the service Although initially he had confidence that he could maintain sobriety alone, this did not work and he had to reinvest his energy into contacting the service provider and attending the 'new' service.

As service users progress to the maintenance stage of recovery they become more aware of what work is required to sustain recovery. Involvement in everyday practices (that do not require a constant focus on addictions) accompanied with recovery meetings to preserve a focus appear to be fundamental to the process at this stage. Meetings are only as good as the facilitator and those that attend (as discussed in cognitive participation), poorly operated meetings can leave feeling depressed and demotivated. SU1, who is currently training to become a SMART facilitator was aware of the work that goes into a meeting from a facilitator perspective and had a good understanding of what a meeting should involve:

> *I mean I'm actually training online at the moment to do SMART facilitator meetings, and I can see everything that goes into that and I know the importance of actually… not controlling the meeting as such but guiding the…the meeting …To me people*

should leave a meeting, a recovery meeting, feeling as if their batteries have been recharged. (SU1)

Meetings should leave attendees feeling motivated about recovery, inspired to keep going and generally confident that they are progressing.

Often service users felt there were obstacles to their recovery, especially with service changes. This appeared more apparent for those service users who had attended DRAW or were entering their maintenance phase rather than 'newcomers' to the service, presumably as the new service users had nothing or limited service knowledge to compare to. The change in 'atmosphere' from DRAW to the Centre of Life caused some discomfort to one service user in particular:

Well at the old DRAW when you went in the door…It was very laid back and a nice atmosphere. A great atmosphere actually… but with regards to here …you've got to be buzzed in because it's coded. ...and then you're met with people who are behind the glass partition … There was rules and regulations for here which … were not applicable in DRAW .. where they were applied more leniently to get what I would call the desired effect, i.e. the friendliness, the openness, the things that are essential for recovery, like, you know, meeting your fellow service users. You know, yeah, you could go into meetings…but you could also just sit there and have a chat. You did not need to be, as I call it for here, chaperoned. … I'm a grown man. I'm, you know, I've been in the service since DRAW, so we're going back seven, nearly eight year now, you know. So I think I can be trusted to sit in a room either by myself and have a cup of tea or with the likes of yourself or a fellow service user. … When we first came here we were told that the room down immediately below us was going to be our room. By 'ours' I meant the people coming from DRAW. … you can just come in and sit down. You can do i.e. similar to what we could do at DRAW. That was the big kitchen, we could use that with the RAD, and the smaller one we would get to share with certain members of staff…But gradually, piece by piece, all of that got eroded. (SU4)

The dissatisfaction with the being 'buzzed' through into the recovery hub was something that was also witnessed during the observational phase (during phase one) at a visit to the Centre of Life. Although you had to be initially buzzed into the foyer at DRAW once inside the members were free

to access the whole facility (presumably there was a staff room that was out of bounds, although this was never discussed). Members could also open the door to let other members in the front door at DRAW as well though, as they all seemed to recognise one another. SU1 does suggest though that:

> *People have forgotten when you went to DRAW you had to press the buzzer and somebody would let you in…And then you had to sign in* (SU1)

Although, SU1 does continue by adding DRAW was:

> *…much more relaxed and it was more of a safe place, that drop-in...That is a miss…there's no getting away from that* (SU1).

Some service users raised issues relating to the rules they had to follow, both at residential and day access to RAD. For some, the amount of rules was something they nominated for change on the 'wish list' presented to the new provider (discussed earlier); others, however, deemed the rules necessary to provide structure to already chaotic lives. SU2 describes some of the rules:

> *There is quite a few. You have to hand in your mobile phones in the morning and obviously you have to be polite and respectable as is normal here and I suppose in a not-too controversial, not sexist or anything like that. But obviously we're all human, so it's allowed a bit, but.. you know. So, and any personal confrontations are seen as sort of like micromanaged maybe by the therapists….some sort of arbitration if two people are having a personal conflict which I've only seen two or three times where the therapist stepped in. But it was pretty vile but usually one of them goes… For the residential things are much stricter. Yeah, no phone calls, no internet access, no newspapers…They can't go out on their own. …You've got to have a secondary … who's …deemed responsible enough. Erm so obviously they've been here a while. Erm so it's just the primaries that can't go out. And even the secondaries are limited….They still have to obey the rules and you can't go on licensed premises… you get a contract. Three contracts, you're out. So that's always hanging above your head… because you're not allowed that corner on your own… So you can't go for a cigarette on your own when you're*

> *a primary. I mean I was nearly contracted for that but there was mitigating circumstances. So I wasn't.* (SU2)

Secondaries are generally those who have reached beyond step five of the 12-step programme and are considered stable enough to be allowed certain 'privileges' such as going to the shops alone or assisting in looking after primaries (especially in residential). Providing a level of care to others appeared to be expected of some of the secondaries, although generally it seemed no-one really minded doing this as it is part of the process of recovery, but there were times when some struggled.

> *So if there's someone in secondary and it's going to take someone else four and a half, five months, to get into secondary, you know, that's a long time of looking after someone. It just felt like babysitting sometimes as well, you know…I mean sometimes you don't mind, and we've got to help each other out and support each other… So, you know, help me work on a bit of patience I suppose…I felt like I was quite restricted and stressed. Yeah, very stressed about some of the stuff because you get pretty chaotic. Very chaotic, you know… Just it's like babysitting, you know. It's like looking after a child. We're not here to care for other people, to be a carer…we're here for our own recovery, for ourselves.* (SU7)

Emphasis must remain foremost on the individual's recovery, then on the collective support to be provided to others. This provides an example of how the division of labour needs to be allocated during the maintaining recovery phase. The secondaries execute the required procedures, as is expected of them, but must also consider how this effects their own recovery practices.

If service users do not get along with one another, they can go to staff for advice, which a number discussed. Advice from staff on dealing with the issue varied from praying for the person to talking through the issues. Some service users raised the issue that individuals were often shunned or 'cold shouldered out' from the group if they don't commit to the 'common goal' or 'shared value' (SU2). Often personalities interrupted recovery: not everyone can get along, even if they are all there to be in recovery:

> *One time there is a guy in the RAD who's obviously a fantasist you know. He just makes stuff up. I couldn't bear listening to him, you know, I just switched off… I think he got my feelings though because he wanted to hug me and I just swerved him and just didn't bother engaging with him. ...Ninety-nine per cent of people I like…There are a few that you know straight away. Even when I came there was one guy who again I couldn't bear. Every time he opened his mouth I had to get my stress buster out because he was dumb and I just thought he's not going to make it on the outside anyway… I felt sorry for him but it didn't mean I have to like him…It's hard to trust everyone here…. I've got instinct. I mean that fantasist I was telling you about, that got on my gut instinct. As soon as I saw him I didn't like him but I thought, you know, because of the nature of the programme now, you know, give someone a second chance, you know. They're in recovery, maybe they're changing themselves and that. But he was a tosser from number one anyhow…* (SU2)

SU2 tried to identify with the individuals, give them a chance as they were also in recovery. However, he could not interact with them and had no confidence that one of them would 'make it on the outside' anyway. The 'outside' in this case being away from the centre, living and operating back within the community.

Being back within the general community also brought challenges to maintaining recovery, a number of interviewees talked about the 'what next' element to their recovery. What would happen when they leave either residential or day attendance at RAD? Following the closure of DRAW, there appeared a gap in services, namely a place where service users could 'drop in' and just catch up with others who are in recovery:

> *I'm finding now that eighteen months into my recovery where I've moved on from coming to the centre a lot, because I got there about a year into my recovery … What I do think would be better is that, when you get to a certain stage in your recovery, you need to move on. You don't want to be just coming to a centre every day, like five days a week, and that's not recovery; that's… excluding yourself from life. It's you substituting spending all day in a pub to spending all day sitting in here so that you can't go to the pub…You know, it's as if you're frightened to go out in the world because there's bad things out there and they'll get you…Whereas I think if my version of*

recovery is you get all the help and support you need and there's no time limit on it, it's just that when you feel ready take those steps back into the world … don't just lock yourself away and just think right, I've had this issue in my life so therefore …I need this support of a centre where I can go spend every day…There may be times when people need to spend a lot of time in the centre, and that's fine, but I mean once you've taken those steps to get out in the community, what I found is there's nothing out there. And this is the type of thing I've spoken about recently and I would like to see the Durham recovery community in general have things. It can be there for as long as you need. For as long as you want them. You know, there might be people who've been in recovery five years, ten years. They're still, in my eyes, they're still part of the recovery community. (SU1)

This quote also provides an example of reflexive monitoring; SU1 is appraising the process and considering that somewhere to drop in would assist those in recovery. For many, attendance at AA or SMART filled the gap slightly, however, most of the phase two interviewees raised the view that they hoped a drop in would be something the new provider (DISC in conjunction with Basement Project) would provide. With a growing recovery community, the commissioner explained that the onus was moving towards the community itself to provide the follow on care. This meant adopting a community asset based approach to recovery, where buildings and services already provided in the community are adopted to utilise for recovery services:

..where people get sort of reengaged with their own local community and actually, you know, there is opportunity. As they move through their recovery journey they can actually work with others to give back as well which, you know, a lot of service users are very keen obviously to getting their own recovery to actually give back to others as part of their own recovery process… Then also ..what we do is we very much encourage the use of mutual aid out in the local community. And that's really what the Basement project brings to the table in terms of they are very, very grass roots, very sort of community focused in terms of the recovery community themselves. And what we've brought them in to do is actually manage the recovery, or help to manage in partnership the recovery community which is very vibrant in County Durham. There's a lot of people engaged with the recovery forum and I

> *think, you know, there's…I get a sense that there's some quite big changes in there really of people actually getting to grips with the forum for themselves. Me as the commissioner, I sort of support around the sides by going back to the independent body, because what we also use the recovery forum for is to actually access the critical friend…So if they, you know, feel that the services aren't reaching where we need to reach or there's not enough provision of, you know, the variety of supports that people want, or people have got a complaint that they want to take, they can actually do it through their own recovery forum* (SC8)

Although, as SU1 points out, some service users:

> …*feel unable to put them across themselves now and it's something to look at as to how we do that. Now I can already hear [the commissioner] saying but that's what the recovery forum is for [laughs] and it is…It is in a way. But that needs to be better organised so that … We get to communicate because it's a two-way thing to all service users on a regular basis, and they know how to get their views, because they may feel easier to talk to another service users to say have you heard about this, I'm not happy about that like, you know, blah, blah, blah, and you'd say well do you want to say something. Oh I don't. I couldn't stand up and say that*. (SU1)

Putting the onus onto the recovery community to provide the element of on-going peer support removes the potential for a co-dependence on the service provider, which is a concept raised by the service manager (SM9):

> *And so clients were given that responsibility whilst…well in a matter of fact it's the client's responsibility. We will give you stuff that will help you get well and stay well, but you have to work on your own recovery and there's things external to the services you'll need to do, or else you will be attached in them services to drugs and alcohol forever, and then I'm always very keen on not on co-dependency.* (SM9)

Reducing co-dependency on service provision and supporting those in recovery to support each other provides an example of how recovery practices can be operationalised in the real world setting. The onus for on-going recovery support (division of labour) is placed on those in recovery to maintain and sustain not just their own individual recovery but to support the collective and visible identity of recovery in the community

overall. The door to services is never closed: if individuals need to return following a relapse or change in their circumstances they can re-contact services and re-attend. The issue around how long a service should be provided for on each term of attendance is fairly open, the RAD programme operates for approximately 12 weeks; after that day care is provided, and after that general recovery in the community support (AA and / or SMART). Alternatively, individuals who are not in the RAD programme can attend the day centre, although the time-frame for attendance is not specifically set as it can depend on the individual, their risk of relapse and the level of support and intervention they require. SU1 summarises stages of recovery with relapse risk:

> *Depending on how you're doing in your recovery you're at a different stage of your recovery, and statistics have shown that at different stages of a long line there is a likelihood which can be quantified as to how…how much danger of relapse there is to people in each stage. Now, obviously as you'd imagine, further along into recovery you get, the less likely it is that you'll relapse because many of the life changes that are going to come around like, you know, relationships, jobs, money, life, death, birth, all of those good and bad things in life will happen naturally in that time scale and so they reckon - this is what they say in the report - that once you've got to five years you've probably experienced most of the things that are going to be triggers and they're going to risk a relapse. If you've made it through that far, you're pretty much percentage wise going to be okay, you know. Nothing's ever certain but, you know, if you can get in it…but what that means is you can't then just say right, okay, well we're going to set up recovery services so we'll set up a centre where everybody can come to and you can be here for five years, because that wouldn't be appropriate. But if they said, well you can come here for a year and then it's like we'll slap you on the back as you go to the door and say well off you go, well done. What I'm interested in now, at my stage, is what's next.* (SU1)

SU1 then describes being in his second phase of recovery, the community phase:

> *That second phase, and it all comes under the community, if you like, the feeling of that community. Because once you've come into recovery community you don't really ever leave it as*

> *long as you, you know, you're living life in the either abstinence or some people aren't totally abstinent I suppose. But, you know, in recovery you'll stay that way hopefully for as long as you… maybe the rest of your life…And I think the more support you've got around you to do that, at whatever level you feel to be appropriate to whatever stage you're at…somebody once said do you know, I'm fed up of actually having to think about this all the time.* (SU1)

SU1 later describes what the second phase of recovery means to him, a stabilised life where he doesn't think about drinking for ninety per cent of the time. Instead he thinks about his course work, allotment or general day to day things like shopping and housework. He also explains that recovery is not nine till five; therefore individuals need to fulfil their time away from service provision. This becomes the maintenance stage of recovery, the resource work that is required moves away from having to think about recovery all the time to investing energy in 'normal' routines and having the confidence to do so without risking relapse.

Once the new practice of maintained recovery status beds into an individual's life they can seek to appraise the practices to determine the effectiveness both for them as individuals in recovery and for the collective recovery movement as a whole. This concept in terms of NPT is reflexive monitoring, which will be discussed in the final section of this chapter.

6.7 Reflexive Monitoring – Reflecting on Recovery

The reflexive monitoring component of NPT, in this study, is concerned with how participants appraise the practice of recovery, how they assess the advantages and disadvantages of the service provision and how they consider the future in recovery. Table 6.5 demonstrates how components of reflexive monitoring linked to the interview data:

Table 6.5: NPT: Reflexive Monitoring – Reflecting on Recovery

Reflecting on Recovery **Reflexive Monitoring Component (external / doing phase – sustaining recovery and planning for the future)** 'Reflexive monitoring: the informal and formal appraisal of a new practice once it is in use, in order to assess its advantages and disadvantages and which develops users' comprehension of the effects of a practice. These processes are energised by investments in appraisal made by participants' (Finch, 2012) • Is being 'recovered' ever an option? • How can recovery be sustained and planned into the future? • What factors promote or inhibit recovery?			
Sub-constructs – mechanisms of reflexive monitoring			
Having a voice **(Systematisation)**	**What works** **(Communal Appraisal)**	**Being 'recovered'** **(Individual Appraisal)**	**Different way of life** **(Reconfiguration)**
'Participants in any set of practices may seek to determine how effective and useful it is for them and for others, and this involves the work of collecting information in a variety of ways.' (May, 2015)	'Participants work together – sometimes in formal collaboratives, sometimes in informal groups to evaluate the worth of a set of practices. They may use many different means to do this drawing on a variety of experiential and systematised information.' (May, 2015)	'Participants in a new set of practices also work experientially as individuals to appraise its effects on them and the contexts in which they are set. From this work stem actions through which individuals express their personal relationships to new technologies or complex interventions.' (May, 2015)	'Appraisal work by individuals or groups may lead to attempts to redefine procedures or modify practices – and even to change the shape of a new technology itself.' (May, 2015)
How involved are staff and service users in evaluating recovery services?	What works in recovery provision? What facilitators and barriers are present?	Do service users and staff believe in being recovered? Or is recovery a life-long notion?	What does a future of recovery look like?

(May, Rapley, Mair, Treweek, Murray, Ballini, Macfarlane, Girling and Finch, 2015) (Finch, Mair, O'Donnell, Murray and May, 2012)

As covered in collective action, recommendations for a community based 'drop in' type centre were suggested by service users:

> *I just think it would be so much better if once they'd gone back into the community, I think like myself, if there were things where there could be a drop-in somewhere or there could be anything from a walking group to a photography group or a nature group, you know, anything that if people could sit by themselves and just say, has anybody got an interest in such and such? Does anybody fancy getting together once a month doing this? And it would just be …that would be your recovery community. It would be a circle of friends and people you knew but with the added …dimension, if you like, that you know that they've been where you were and that you're all moving forward together and that they're there for you if you ever need them. And I think that would be somewhere to go to from the initial services like, you know, that are provided here.* (SU1)

Meeting up with other service users or those in recovery to form collaborative systems of informal care provide an example of communal appraisal, individuals are gathering together to create groups with like-minded individuals to sustain recovery. These groups then become safe havens, where communities of people with similar interests can meet and form relationships, without alcohol or drugs being a feature. In this sense both as individuals and as a collective they are creating their own aftercare plans.

SU4 raised a lack of aftercare planning, suggesting there was limited scope under the current regime, and that this can leave service users to 'feel abandoned', adding that the only way to access continued care was to relapse. SU1 also commented that the drop-in facility that was available at DRAW was a miss to provision. As mentioned earlier the service manager (SM9) and commissioner (SC8) were keen to stress that sustaining recovery and taking responsibility for their own journey's long term were factors that individuals, supported by the recovery forum, must take on themselves, otherwise a co-dependency on service provision may occur. SU5 suggested there was a form of aftercare, albeit for those still in early recovery (whereas SU4 was more describing a lack of long term community support). SU5 had experienced recovery services in other parts of the country and suggested that Durham actually provided more

and that some service users could perhaps benefit from experiencing other areas of the country where provision is less supportive. This also provides an example of differentiation (from the coherence component of NPT) as well as reflexive monitoring, as SU5 was able to make sense of how the service provision differed, as well as reflect on how Durham fared better.

Service users that had met the new provider (DISC and Basement Project), who had discussed a 'wish list' for future provision, provided a varied response as to whether they believed any of these aspects would be provided. Some service users were willing to give the new provider the benefit of the doubt and remained hopeful (SU5 and SU7), others suggested that they were further on in their recovery so any new provision was almost irrelevant to them (SU2) Others were sceptical, feeling that further false promises were being made (SU4). However, the service manager (SM9) and Service commissioner (SC8) were both very optimistic, implying the combination of delivery that the new provider was offering was a really positive method. The new provider brought a combined approach, involving DISC, Spectrum (as the clinical provider) and the Basement Project who provide recovery support. SC8 presented real passion for the recovery movement overall, describing how she had:

> ..*left drugs and alcohol [work] altogether and went to work for a hospice, and the only reason that I came back into drugs and alcohol is because of the recovery movement…Because I always felt drug and alcohol services we didn't have a back door. We got you in, we could help you get well but we had nothing then... People can get off drugs and alcohol. It's the living off drugs and alcohol.* (SM9)

SC8 provides an example of individual appraisal and reconfiguration, highlighting that individuals can respond to complex interventions (treatment service provision) but that redefining or modifying practices (living in recovery) is also required to meet long term aims of sustaining recovery and staying well.

Service users in phase two reflected on the recent service changes:

> *And if you're feeling vulnerable in recovery you especially don't like change. Erm I'm learning not to feel the change as much, but hand on heart it still takes me, you know. I like to have enough notice about change to actually let it sink in and think about it…. Being in recovery is quite a vulnerable state to be in and therefore changes can sometimes take on more significance than it really has because your initial reaction to hearing about change is that it's going to be bad and I don't like it when in actual fact it often leads for the better. Erm or it's just different; it's neither better nor worse. Erm but I think it's how you manage change… I think a lot of the times … it always depends on the individual. I mean it depends on …how their view changing because sometimes, I mean, … I can sometimes use change as an excuse to back up what I was going to do anyway. It's given me an excuse… It's given me a get-out. Now…and I can see that has been an issue with some people, some service users, there they've just said oh I'm not going to bother going anymore …I just think nah, that's nonsense. You're just using that as an excuse*. (SU1)

SU1 here also provides an example of collective action, by outlining the excuses some service users are using to allocate blame for their own lack of labour (their commitment and motivation) on the service provision.

> *You can feel the cuts all over. You can feel the pressure…I think it would be really sad if this place has to go… You sort of you hear whispers don't you?...You hear this and that. You know, we're pretty much not kept in the dark like* (SU2).

Similarly to the quote from SU1 Above, SU2's quote can also provide an example of collective action. The whispers can relate to elements of interactional work that service users (and staff) do within the practice of service provision. SU2 implies that service users are kept in the dark. SU5 has a slightly different slant, suggesting that service users are provided with what information they need so that fear cannot escalate:

> *My feeling is it was almost business as normal because they'd gone through it before. Erm the staff do make every effort to keep things as seamless as they can, but obviously they can't achieve that a hundred per cent. But they do try to make it business as normal… I've done all that sort of stuff and I know all about tendering and everything. I think people know but probably didn't understand what tendering meant, and that it would mean a completely different provider and that it could be*

a different contract …But I do think, as I say, because of the vulnerability of a lot of people in the client group, they need to have some information, but too much information could probably disrupt them and get them in to fear, fear mode…So I think they give information where it's relevant and pertinent but probably things that the client doesn't really need to know don't get discussed, which is fine by me…I think there's so much cynicism within the group that it's almost well it's going to be another…another provider, same old same old rubbish, whatever… There's just a huge amount of negativity to change ..I think that the feeling is that the newcomer always makes promises and then doesn't keep them and that root services do get cut, but what they probably don't understand is that that may not be the fault of the provider. It could be the budget that they've been set and the logistics and everything else (SU5)

Again, this quote can describe an action carried out in the service (and therefore represent collective action component), as SU5 describes how staff try and maintain a 'seamless' service so that confidence in provision can be maintained, this is a division of labour that they take on and operationalise. The quotes have been presented within this section as they refer to the service users looking back on recent changes, reflecting and appraising the provision.

Some service users described not being given a voice to air concerns about service provision (SU4, SU7). As already described, the recovery forum is an avenue for future negotiations, although, as SU1 has already stated, some service users lack confidence in communicating and look to others to speak for them. He also suggests:

..that sometimes people in recovery and people, service users, they're too timid…. they haven't found their voice because this feeling like as if nobody's going to listen to me anyway. (SU1)

SU6 suggested they are told what is happening:

to some extent. I mean we've been asked how we're feeling about things and told what's happening. Erm when they find out …but I think it's really hard to know what you want when you don't know any different …And you don't know what is possible and at the end of the day if there's no money and they can't do anything, so we're stuck [laughs]…That's the way it is. So I do feel that people here listen, which is the main thing. So

> *someone to talk to. But quite often … well they could only do what they can really…You've just got to accept things sometimes. But I know things can always be better*. (SU6)

Having a voice to express their concerns about service provision and the commissioning of services allows service users to feel they have ownership of their recovery practices. A notion that SU4 suggested when he stated services needed:

> *..to be less about shareholders and more about service users* (SU4)

The recovery forum creates an opportunity for collaboration, a collective voice to provide communal appraisal. SC8 describes the recovery forum as an opportunity for service users to be a 'critical friend':

> *if they, you know, feel that the services aren't reaching where we need to reach or there's not enough provision of, you know, the variety of supports that people want, or people have got a complaint that they want to take they can actually do it through their own recovery forum* (SC8)

This means that a service user who is perhaps more vocal than another could represent the collective identity of service users. Although as SU1 highlights, the forum needs a mix of voices so that everyone is represented:

> *But if the recovery committee is going to mean anything at all, it should be able to embrace everybody. It should represent everybody, you know, young, old, men, women, black, white whatever. It should represent everybody in the Durham area who's in recovery for whatever reason. Erm and it should be a vibrant community…And the community itself, I think, would respond to that* (SU1)

SU1 continued by adding that:

> *There are three sort of aspects to the recovery community in Durham. You've got local authority… They're ultimately providing the services…You've got a service provider who's, you know, happy doing the service on behalf of the person who's paying the bills or giving them the contract, which has been various people, Lifeline, CGL and now it's apparently DISC, and then you've got the services users…Those three sort*

> *of bodies need to be able to somehow come together, and I think the recovery forum should be set up in such a way as to make it easy to transfer information and anything really. It should be a two-way thing so that service users can feed into their part of that triangle and then that can go to the others.* (SU1)

In this instance the recovery forum becomes a communal appraisal by which a formal collaborative (as well as informal groups presumably feeding into their recovery representative prior to the forum if they do not feel confident speaking out) evaluate and appraise the service provision. This then would feed a new collective action, as change in resources or practices would then be actioned and operationalised in the service.

A further aspect to the recovery 'triangle' is that of recovery champions or recovery ambassadors. Ambassadors (as discussed earlier under the coherence component) are individuals who are in long term or stable recovery and who undergo training (provided by services / local authority) to deliver recovery and service messages, not just within the actual service but out in the community. They look to engage prospective service users, acting as advertisements for recovery. SM9 was very passionate about the use of ambassadors, and discussed at length how they were utilised:

> *Ambassadors could get people into the hubs…. The clients loved it. They'd seen an ambassador's going to be trained. They'd seen them get their education. Seen them apply for jobs. Seen them gain jobs. They've seen them working in the centres there… We have a visible recovery in there. We had an ambassador who would be cooking along with one of our workers. So they see visible recovery. They're actual showing of what you can turn into and what can happen. (SM9)*

On an individual level the ambassadors appraise the process or service provision by becoming part of it to encourage others to instigate and drive forward their recovery. This also involves systemisation, as the ambassadors seek and collate the information about provision and distribute to those that need it. By encouraging others into recovery, and in the long run helping to create further future recovery ambassadors, they then change or reconfigure the service provision.

The ambassadors complement the service provision by acting as examples of community reintegration, having gone through treatment, into stable recovery and working (both as volunteers and in paid employment) within the service provision. The commissioner described four elements to a successful recovery service provision:

> *So I think there's almost like four pillars of recovery that need to be in place. So you need to have prevention and early intervention; you need to have care coordination into recovery and support. You need to have the ability to allow access into detoxification and rehabilitation, so be that either in-patients our out-patients and community detoxes. and then also as well that sort of community reintegration as well. So they're sort of four models of what you, you know, what you need to put into any service, and obviously a clinical element throughout all of those as well underpinning.* (SC8)

These phases of care coordination can be considered in terms of the stages of recovery as well as using a harm minimisation approach (which does not necessarily require abstinence). Both routes to a healthier lifestyle require each NPT construct as the service user makes sense of what service is to be provided, decides whether to engage, actively uses the provision and evaluates their status in terms of using the service.

Each participant in phase two was asked what recovery meant to them and / or how they look to live a life in recovery. This was to consider what reconfiguration or approaching a different type of life was like to service users and how they evaluate or appraise what being in recovery means to them individually. The responses varied often depending where they were in their recovery journey. SU2 and SU3 were still relatively new into recovery:

> *…found such a relief of being clean again and sober and starting to rebuild and got that mindset (SU2).*

> *I'm going to miss the people and miss the lectures and just like the support. Because the support network and you're constantly around other people who understand you, so it makes it a lot easier. I know I can still go to meetings and that, but it's just not going to be the same…I'm worried about relapse, but hopefully I won't.* (SU3)

Although SU3 had been in recovery services intermittently for a number of years, at the time of interview she was in the process of leaving RAD and moving into her own home. SU2 was more confident but reflected on rebuilding his life, which is an element of early stage recovery. SU7 was also preparing to leave the residential services of RAD, and again, although had attended services in the past, felt positive about staying off heroin this time:

> *…obviously staying clean and sober. Erm…what does recovery mean. It's about…staying alive, basically…And to change and not just putting the drink and drugs down. Learning how to live in a new way. Erm and having all of other things that I've always hoped for, you know, a job, a family, being a member of society and stuff, you know…And just being a happy person and a good person. (SU7)*

Learning to live differently provides an example of not just reconfiguration but also of a collective action, as a 'new' way of life is learned through process of recovery this is then put into action and then reflected on. Interestingly, SU7 implies she did not feel part of society as an addict and states she hopes to become a member and be a happy and good person. This reiterates what SC8 (the service commissioner) wants, community reintegration.

Not feeling part of society was also hinted at by SU4 when he described how he ended up becoming alcohol dependent:

> *It's called things in life that affect you. Your environment, your soundings, your education, your parents. … It's that simple, you know. Erm brought up in a rough area … I understand that, you know, these people who'll go such and such turned out okay. So you've always got two sides to the argument. But it certainly is a breeding ground for that….It's not a set-in-stone factor, but it's certainly not one that could be, you know, easily overruled or, you know, dismissed easily. It's a…it's an amalgamation of things, you know. Erm and I'm not religious but it's the old saying like he who is without [sin] cast the first stone… You know, as far as I'm concerned that's…Society views people with alcohol problems and drunk problems, you know. They kind of look down their noses a bit at them and I'm thinking, you know, you might only be two or three drinks away yourself.* (SU4)

Those who have been in recovery longer and considered themselves to be in more stable recovery, described recovery almost in hindsight, like a phase they were well established in or at least see others in recovery now at:

> *You've stabilised your lifestyle. You've sort of like looked at what's been…what you're not happy with and what needs to change, and you're implementing those changes and hopefully you'll get to one, to the stage where you just start and you raise you head up and you look up and you think right, okay, now then. Or what is my possibility, what can I do*? (SU1)

Although SU1 does continue by adding a desire to drive to the next stage:

> *I get impatient. I think it's probably at that stage of recovery where, and the age that I'm at, that I just think no…I need to get back to work, I need to do it…But, you know, it will maybe just happen when it happens and erm but I am conscious that it's not just me, there's a lot of people who come to get to this stage in their recovery and they just think yeah, there's a lot of ability out there that needs to come back in, and I think it's there's an obstacle there to get back into work, because if I go for interviews now they'll just think when did you last work. That was four years ago. And what have you been doing? Erm I mean for a couple of those years I can, you know, I was caring for my dad who died and stuff like that, so I can sort of fob off and things like that. But it's still, you know, it's learning how to put that into a positive* (SU1).

SU1 reflects on his current stage almost being a transitional one, whereby he is starting to feel ready to progress to the next (or final) stage, where employment can be considered again. Here he seeks systematisation as well as reconfiguration, he feels a 'need to get back to work', determining this element as effective in his recovery journey.

Often as recovery can mean a different life, it can be perceived as initially a lonely place, learning to live a different way and away from previous friendship groups may leave a void. Although knowing recovery can bring a healthier, happier life in the long run, SU6 described recovery as:

> *…peace of mind… And have that through…a sense of purpose and meaning. Yeah. Having a full life, really…So who connecting with other people…erm…yeah, it's an addiction. It's*

like having a void, an emptiness inside…And it has to be filled. And then …yeah, just living for the day, sober. (SU6)

Connecting was a theme throughout both phases of the research. Social aspects from the previous life of drinking in particular could be missed by participants:

That's what I miss most... I miss the social side, you know. (SU4)

Participants in phase two were also asked what they thought of the terms 'recovery' and' recovered'. This was to establish whether they feel they are ever 'cured' of their addictions. SU4 worried that being viewed as cured or 'fixed' meant that services could be withdrawn:

I just worry about the fact that is that how they're categorising us now? Is that what they think, you know, one size will fit all? Do they think …or you're cured…We're never cured. … I'm satisfied that I know I'm one of the sort of fortunate ones that, you know …it's as much to do with … how you can learn good habits, you can relearn bad ones (SU4)

This notion of learning good habits or relearning bad habits also includes elements of collective action. Those in recovery have to 'work' to build new habits, the effort being on making recovery possible. SU1 also alludes to the work that must be done in recovery, describing it in terms of the individual and their motivation to drive it:

Recovery is a phrase that I'll use because everybody knows what it means. Well everybody thinks they know what it means. They know what you're referring to when you talk about being in recovery. And I must admit, when I first heard the phrase that used to like jar. You know, I used to think what? What are you on about? Are you in recovery? So that naturally to me says well one day you'll be cured….And you just think no, that's not right because you…it depends on how you … look at it. Is it an illness? …but what I've come to realise for me, personally, is it doesn't really matter whether it's genetic, whether it's an illness…Or whether it's physical or mental or whatever, it's just I know that life is better now than when I was drinking. Erm and I'm not prepared to take the risk of social drinking to find out whether I was right or wrong about what would happen if I start drinking again. And I find, me personally, that as time goes by …I don't miss the drinking and you've got to actually do the

> *work in recovery, and …you've got to be honest enough to admit why you were drinking.* (SU1)

The service manager (SM9) suggests that whether a service user considers themselves to be in 'recovery' is determined by what process they follow:

> *I tend to find people who do the fellowship are in recovery. Sometimes people who don't, aren't in the fellowship, might say they're recovered. And I think it's the lingo that's used within them, and I think it's a personal choice. But do I see people? Well, you bet I do… I see some of them lads I work with first have got their house, they've got a car, they've got a job, they've got a partner, and I look at them and I can bust for them. So I'm…I mean and I'm not talking about one or two, I can show you quite a few.* (SM9)

SU6 reiterates this suggestion of terminology, indicating that, although you could recover from the addiction, there are no half measures, so abstinence is key to his recovery journey:

> *It is a difficult one…because it's an ongoing process …I am recovering from alcoholism and people do recover but the addiction, whether you see it as a disease or whatever, it's still there. It has to be dealt with…so yeah, sobriety is a difficult one to… define really. It's something I think you discover yourself…but yeah. I mean it's an abstinent programme so you have to be abstinent and that's simple as that really …It's the only way. There's no half measures…if I could just have one drink then I wouldn't be alcoholic.* (SU6)

SU6 reflects on the process of abstinence, deciding its effectiveness, confirming that (for him at least) it is the only way. Recovery is an on-going process; however you view the original addiction (a disease, a factor of the life you grew up in or a habit that became out of hand), participants appraise the process both individually and collectively and at various stages of their recovery journey.

6.8 Chapter Summary

Changes to service provision were a greater influence on the interviews conducted at phase two. The participants in phase two had witnessed more recent changes than those in phase one, the DRAW members were

just about to go through a service change at the time of interview, whereas some phase two participants had attended during two service changes and were at the time of interviewing going through a third service change. As with chapter five findings, service changes need to consider the voice of the service user, recovery champions or ambassadors need to be utilised to provide the link back into the community and barriers such as the referral process need to be overcome. In addition, facilities that provide on-going support in a community ‘drop-in’ style would also benefit service users and add to the notion of visible recovery in the communities.

The next chapter will present an interpretation of the findings, discussing further the factors that promote or inhibit recovery. In addition, how the findings from chapters three, five and six should be considered in terms of wider recovery research.

Chapter 7. Synthesis of Findings

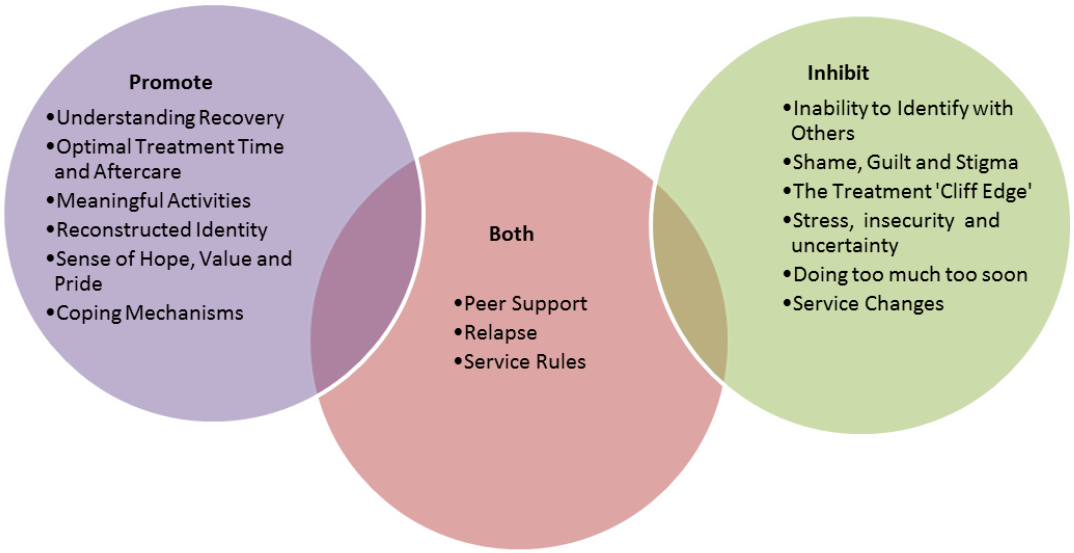
7.1 Chapter Introduction

This chapter will provide a synthesis of findings, collated through the qualitative work and the systematic review. The discoveries from the qualitative work are placed within the wider research context of the systematic review findings, either by way of correlating or contradicting the findings, as well as highlighting links to broader fields of research (outside of the review).The chapter will then move on to describe how NPT can be utilised in research into the delivery and commissioning of addiction services.

7.2 Key Emergent Themes

Themes uncovered through the two phases of interviews and the systematic review are grouped below under facilitators and barriers to recovery. Some themes or concepts could be considered to both promote and act as a barrier to recovery, depending on the situation. Factors that promote recovery are first discussed, followed by a discussion of issues or areas than may inhibit the recovery process. Overlapping concepts are then covered. Figure 7.1 demonstrates how these themes intersect.

Figure 7.1 Themes that Promote and / or Inhibit Recovery



7.2.1 Factors that Promote or Facilitate Recovery

Various factors can promote recovery; individuals need to understand what recovery will mean for them, with success signifying something different to everyone. How services are delivered: time in treatment and meaningful activities developed will drive forward recovery. At an individual level the creation of a new or redeveloped identity away from addiction will promote long term recovery, along with an emerging sense of hope for the future and the development of coping mechanisms to combat times of stress. These themes are discussed below.

Understanding Recovery – What does success look like?

A successful recovery journey will naturally vary between individuals, with 'success' requiring different elements depending on each person's situation. Interviewees (from Chapters 5 and 6) talked about how recovery is a personal journey, how it must feel like a natural progression and overall a learning process. The journey can be instigated by concerns raised by a GP, family member or often the penny drops (as raised by SU1, Ch6) and change is pushed for individually.

Recovery has become synonymous with abstinence, with the terms often being used interchangeably (Notley, Blyth, Maskrey, Pinto and Holland, 2015). However, wider definitions support emphasis being on recovery as a process rather than a linear road with a fixed end state (Ivers, Larkan and Barry, 2018, Notley, Blyth, Maskrey, Pinto and Holland, 2015). Unique personal experiences make empirically defining and measuring recovery difficult (Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016), although a general consensus within the systematic review literature, and among the participants interviewed for this research, implies that recovery is a process whereby gaining or regaining control over one's life, building recovery capital, healing, improving quality of life and increasing the ability to 'live right' are all features (Ivers, Larkan and Barry, 2018, Aslan, 2015, Notley, Blyth, Maskrey, Pinto and Holland, 2015, Mooney, Dold and Eisenberg, 2014, Duffy and Baldwin, 2013). Interviewees in Chapter 6 raised how abstinence is just one element of recovery, which for them was required in the initial stages, however, getting well and developing a 'peace of mind' (SU6, Ch6) is *actual* recovery. 'Success should be measured as personal to the service user through looking at changes in thinking and behaviour, relationships, psychological well-being, employment and accommodation status as well as at a societal level through reductions in relapse and reoffending rates' (Aslan, 2015 p.75). Although within a utopian style model these elements would all be desired, the reality is that commissioning budgets may only allow focus for certain elements. To an extent the development of the Recovery Forum in County Durham seeks to provide a focus, in that it provides service users with a voice, acting as a critical friend to delivery and future commissioning. If they feel a particular direction is required they can voice this through the forum with feeds the commissioning cycle (or at least aims to).

Often success depended on how individuals viewed their status. For example, Notley *et al* (2015) identified two distinct groups of individuals on opiate substitution treatment (OST). The first group viewed their methadone prescription as one element of their complex illness regime; these (the 'chronically ill group) no longer viewed themselves as part of the illicit drug using world, but rather perceived themselves to be

recovered from illicit drug use even though they were not abstinent from the replacement medication (Notley, Blyth, Maskrey, Pinto and Holland, 2015). The other group (the 'identifying drug user group') saw their prescription as a continuum of their previous heroin addiction: these found it difficult to consider themselves as recovered (Notley, Blyth, Maskrey, Pinto and Holland, 2015). Notley's study demonstrated that for some the OST left them feeling normal and able to cope, which in itself can signal success, being able to work, re-establish relationships but for others it left them in limbo, unable to fully re-engage with society (which does not signify a full success). All of the interviewees from this thesis research were on a path based around abstinence, although a number had previously attended OST. One in particular talked about how she felt more positive about her future now: 'staying clean and sober' were aspects of recovery important to her (SU7, Ch6). This reiterates how some individuals can feel dirty (as in the opposite to 'clean'), when using, even if they are on an OST programme, as they feel they are still using.

The notion of success can depend on whether the service the individual attends is abstinence based or adopts a harm minimisation approach. In recent years addiction service delivery policies have become directed towards abstinence and recovery orientated programmes, shifting away from the previous harm minimisation approach (Notley, Blyth, Maskrey, Pinto and Holland, 2015, Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016, Duffy and Baldwin, 2013, Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013, Neale, Nettleton and Pickering, 2013), but, as the research by Notley *et al* highlights, there is still a need to consider substitute programmes. Services may need a distinct pathway though, rather than mixing harm minimisation with abstinence. Staff and service users interviewed during the course of my research were quite clear on that aspect, suggesting that anything other than abstinence is a 'grey area' and that an abstinence based service provides safety. Although many struggle with the notion of a life in abstinence initially, once they absorbed the notion and started to move away from their previous life, they began to commit to this process. Facing a life of abstinence is well documented as a concern for those entering recovery, especially in

Alcoholics Anonymous and Narcotics Anonymous literature, leaving ‘chemical friends’ and social groups behind (Mooney, Dold and Eisenberg, 2014), but developing an understanding of what recovery means and defining what success may look like (both individually and communally) can facilitate the process. As already stated, the interviewees in this research were all on an abstinence programme so it may be inferred that they would prefer this route, as this is the pathway they chose. However, here my research contradicts Notley’s, as the stress there was placed on there being a definite need for OST. I do stress a need for choice: however, none of the participants I interviewed suggested a harm minimisation approach was desirable for them.

Optimal Treatment Time and After Care

Service using participants in my research suggested that access to services should remain available until such time as they felt they were no longer needed, but that this should vary depending on the time in recovery, suggesting that an enhanced structure was required at the start of the process (to replace the time spent drinking / using), but that this should reduce as the journey progresses to allow for opportunities for building capital (employment, training etc.) to develop. Interviewees from DRAW (Chapter 5), described how they felt DRAW would have been available for as long as they needed it, even if it was just to call in and briefly visit others. Some of my participants described how they did not want to believe themselves ‘fixed’, as this could be dangerous to their recovery, with the process being a gradual learning that required time.

The studies described in the systematic review reported various optimum treatment durations, with some suggesting length of time in treatment predicts better outcomes (Hubbard *et al*, 1997; Gossop *et al*, 1999; Simpson, 2001; Jones *et al*, 2009 cited in (Neale, Nettleton and Pickering, 2013)), but others stated that between nine and twelve months reaps the most positive rewards (Wexler and Williams, 1986; Wexler *et al* 1990 cited in (Aslan, 2015)). For some authors the length of time in treatment is not of specific importance but rather that the stay is long enough to facilitate the client’s treatment goals, which can only be assessed on an individual level

(Greenfield *et al*, 2004; Meier, 2005 cited in (Aslan, 2015)). Although it can be unclear as to whether these studies report on an average time in treatment rather than specifically what participants have told researchers. Twelve of the studies in the systematic review relate more to drug addiction (rather than alcohol, although some make reference to both) and often report findings from a prison TC approach. Nonetheless, they draw attention to the need for an individually focused service delivery timeframe. The need for aftercare was reported both in the systematic review as well as during this thesis research; this is discussed in the barriers to recovery section below.

Meaningful Activities

Participants in my research study raised the importance of structure, stability and also of having meaningful activities in driving their recovery. Activities acted not only as a distraction from previous habits but also as a means to build capital, by developing further social networks and learning new skills. Activities noted included mutual aid groups but also mindfulness, baking and attending sober bar evenings. Research uncovered during the systematic review also highlighted the importance of meaningful activities, noted how these interests averted boredom and provided focus to the day, but that these needed to stretch beyond self-help groups, into the community, getting people out and 'actually doing the activity' (Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013 p.229). This correlated with what the service users in this thesis research alluded to. They described having access to sports, reiki, art classes and alike, although more so in the first phase of interviews (with DRAW members). The second round of interviews raised a lack of access to 'outside' activities, although these participants also raised the importance of structure to their days. The work of Best and colleagues (Best et al, 2011 and Best et al, 2013, cited in (Best, Beswick, Hodgkins and Idle, 2016)) suggested that greater involvement in recovery social networks and more active involvement in a range of activities were the two strongest predictors of well-being; 'where people in recovery reported ongoing or new engagement in meaningful activities, they reported higher levels of physical and psychological health and better quality of life than

those people who had no engagement in meaningful activities or stopped this during the study window' (Best, Beswick, Hodgkins and Idle, 2016 p.4). Structure and routine was reported as a facilitator to recovery, both from my interviews and the systematic review (Parkman and Lloyd, 2016). Structure, especially in the early stages of recovery, was described as a necessity, but participants felt that intense programmes could become repetitive towards the end. In addition, shifting from being enveloped within an intensely regulated structure straight into the community (with no in-between provision) could also leave individuals feeling vulnerable. This 'cliff-edge' factor will be covered in the barriers to recovery section below. Learning new things often supported recovery through increasing confidence, creativity, pride and achievement (Morse, Thomson, Brown and Chatterjee, 2015). Activities based on exercise led to participants feeling an improvement in their moods, being calmer, more able to manage emotions and communicate, and generally to feel less angry (Morton, O'Reilly and O'Brien, 2016).

Reconstructing a 'New' Identity

Participants in both phases of my research expressed a need to change, a need to learn how to live again and interact with people. One participant described early recovery as 'nursery school for adults', just as pre-school teaches children behaviour development and how to form relationships. This notion of rebuilding from inside links to a concept of reconstructing or constructing a new identity was also a prominent feature in the systematic review findings. Getting to know and understand themselves was reported by participants to be a treatment objective (Neale, Nettleton and Pickering, 2013), highlighting the importance of self-awareness on identity reconstruction. Awareness and an acceptance of feelings and emotions can lead to an understanding of what may cause a relapse (therefore preventing it) (Harris, 2015), again suggesting that knowing and understanding yourself and your environment facilitates recovery. Being able to recognise potentially negative emotions and prevent any harm they may cause assisted in developing the reconstructed identity going forward. This notion links to developing coping mechanisms that is discussed below.

Lack of identity has been described in relation to places, ‘most alcoholics have low self-esteem, in part because they feel they have no identity with particular places. Often places represent failure, threats or feelings of being unwanted. Therapy for alcoholics might usefully include establishments of refuges, places with positive images, where identity could be established’ (Gesler, 1992 cited in (Shortt, Rhynas and Holloway, 2017 p.148)). The study by Shortt *et al*, reports how participants reconnected with something outside themselves whilst moving through the natural environment, one participant in Shortt’s study described how she previously negotiated the city without lifting her head due to the shame she felt: discovering her therapeutic landscape had encouraged confidence to grow (Shortt, Rhynas and Holloway, 2017). Interviewees in my research also described feelings of connecting with nature or art as important to their recovery, reminding them that they often missed out or failed to notice the world when they were using alcohol or drugs.

My interviewees described addiction as stripping away their self-esteem, leaving feelings of vulnerabilities and lack of confidence. This correlated with studies reported in the systematic review. Where a negative self-image, feelings of no self-worth, regard for their physical appearance and emotional numbness was reported to create a lack of motivation to stop using drugs, but following a therapeutic intervention these participants described improved feelings towards themselves (Colley and Blackwell-Young, 2012). ‘The greater the increase in the individual’s recovery identity and the greater the reduction in the addict identity, the better the treatment outcomes the individual achieved. This is based on the idea that people learn the appropriate way to behave and absorb the linked attitudes, beliefs, and values as part of a gradual internalisation of a recovery identity’ (Best, Beswick, Hodgkins and Idle, 2016 p.4). Interviewees in my research, in particular the first phase at DRAW, described how staff would also challenge behaviour (which links to the recovery being like ‘nursery school’ mentioned above), here some interviewees describe how they needed to interact appropriately with people again. Addiction had made them feel selfish and they needed to learn to share, take turns in a reciprocal conversation and listen to others.

These feelings were more evident in the interviews with my participants who reported not having a strong support network away from recovery.

Identity is not just formed at an individual level, constructing a social identity away from 'using' groups also forms a significant part of the recovery process. Interviewees in my research often described having to distance themselves away from even their families (if their families were 'big drinkers'), as they felt unable to connect with their family's values or that they had to disconnect from their previous entrenched values to buy into the principles of recovery. Research proposes that behavioural risk factors can be influenced by personal relationships, especially long-term ones (Brown, 2016). Social Identity Theory (SIT) proposes that 'group membership is fundamental to understanding adherence to the norms and values of social groups…identification and engagement with valued groups shape individuals' behaviour through a desire to be part of the group' (Biluc, Best, Iqbal and Upton, 2017 p.111). From a health perspective this 'social cure' (Jetten, Haslam and Haslam, 2012) approach supports recovery by providing access to 'healthy' social networks that encourage positive behaviour. This approach was applied to recovery in the Social Identity Model of Recovery (SIMOR) (Best et al, 2016 cited in (Biluc, Best, Iqbal and Upton, 2017)) which suggests that 'recovery is associated with transitioning from the more excluded group membership of "using groups" to groups that are supportive of recovery; this transition includes a shift to more positive values, beliefs, attitudes, and ultimately behaviours' (Biluc, Best, Iqbal and Upton, 2017 p.111). Here recovery is facilitated by a gradual transference to a new social group and therefore a new healthier independent and social identity. For some commentators, (Giddens, 1992, cited in (McIntosh and McKeganey, 2000)) identity is not found in a person's behaviour or the reactions of others, but in how that individual presents her 'biography'. Although others dispute Gidden's proposition that narrative is the foremost factor of identity development, it is nevertheless important that an individual can maintain a narrative of who they are (McIntosh and McKeganey, 2000). Recovery requires the 'individual coming to an understanding that his or her 'damaged sense of self' has to be restored together with a reawakening of the individual's old

identity and / or the establishment of a new one' (McIntosh and McKeganey, 2000 p.1503). Although the 'moralistic' viewpoint of an addict having a 'spoiled identity' has received warranted criticism (Best, Beckwith, Haslam, Haskam, Jetten, Mawson and Lubman, 2015) it does nonetheless highlight an awareness of the individual that there is a different version of the self that recovery can drive. This notion of change within was echoed in the interviews conducted as part of this thesis with participants reporting 'engaging with something in yourself' (SU2), others described having to fill a void inside (SU6). One participant described what recovery meant to them by stating that being a happy and a 'good person' (again highlighting the negative image one has of themselves during active addiction). Waters *et al* also reported recovery required learning to 'like yourself' (Waters, Holttum and Perrin, 2014). McIntosh and McKeganey (2000) describe three key areas in which addicts formulate a new non-addict identity 'firstly, in relation to their reinterpretation of aspects of their drug using lifestyle; secondly, in relation to the reconstruction of the individual's sense of self and thirdly in relation to the provision of convincing explanations for their recovery' (McIntosh and McKeganey, 2000 p.1504). Part of reinterpreting the addict lifestyle requires reconsideration of the aspects of former drug use that was once pleasurable; finding that the enjoyment once found no longer exists. Participants in the thesis study talked of how alcohol and / or drugs once gave them a source of enjoyment, often a chance to escape their lives, but they then went on to say how over time more and more substances were needed to elicit the original feelings of pleasure and finally how this became damaging. Reconstructing the sense of self involved differentiating between the sense of self before drugs were being used, whilst drugs were being used and the sense of self they aspired to be. Often participants in this thesis study referred to how they felt 'damaged' prior and during drug use (including alcohol use), but that they could see themselves now (in recovery) becoming the person they knew they could be, using terms such as 'happy' and 'content'. The participants described times where they had stolen or lied to get alcohol or drugs, how damaging their behaviour had been for their families but that how now in recovery they were moving towards repairing these relationships. This

reconstruction of their new identity leads to the need to provide explanations for their recovery (the third aspect to constructing a non-addict identity); the reasons for recovery provide evidence for their conviction of how they are changing. Reasons for recovery varied in the thesis research, some explained how the doctor told them their health was at risk, or how their families had had enough of the using behaviour, and these all provided powerful justification for their transformation and facilitated their recovery. Being able to identify their former selves as not their 'real' identity provided a platform for recovery. 'Like successful de-coupling from a spouse, a dependent drug user in recovery must, in a sense, split from their relationship with the drug, to which so much of ones' sense of a "spoiled identity" had been based' (Irving, 2011 p.184). Distinguishing who they were, who they are now (in recovery) and who they are seeking to become facilitates recovery by driving the individual forward as well as reminding them they are not the person they used to be, the drug using self was not the 'real' them. One participant in the first round of interviews described how alcoholism causes a dysfunctional belief system, convincing people they are not good enough, this needs to be

> *worked through to get to get to a place where they can make adult responsible choices and be aware and see the consequences of those choices whether they be negative consequences or positive consequences, you know. I think people, in my experience anyway, need to learn that stuff… I think most people have when you're meant to learn that stuff as a teenager they've been drinking all the way through it so they missed that bit and that needs to be relearnt* (DS3)

DS3 was a recovery champion, being ten years in recovery, and so was well placed to discuss what needed to be relearned. Involvement with providing support for others in recovery, especially acting as a peer mentor or recovery champion helped develop ones identity further (Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013). This was witnessed during the observation phase and interviews for the thesis, participants talked about how good it made them feel to help others and how it 'kept them on the straight and narrow'.

Sense of Hope, Value and Pride

Visibility of recovery provides a valuable social identity, creating a sense of pride which maintains recovery; support and praise from others creates a 'ripple effect' and a sense of hope (Biluc, Best, Iqbal and Upton, 2017 p.115). Interviewees from my research describe how progressing with their individual recoveries felt like they were paying back staff for the trust and support they gave them, which created a sense of value and pride. Others highlighted that the visibility of recovery champions or ambassadors provided them with hope, some suggesting that not only could they relate to them (when they delivered sessions in a staff capacity) but that knowing they had been in the same place as them initially allowed a sense of hope that one day they would also be free from addiction. The 'phenomenon of hope' was also reported in a study by Lopez-Gaston *et al*. Here the positive aspects of 12-step participation were described as creating a shared identity and opportunities for learning, whereby peers provided practical advice through their lived experiences (Lopez Gaston, Best, Day and White, 2010 p.314). The 'successful stories' led newcomers to feel 'if they can do it, so can I' (Lopez Gaston, Best, Day and White, 2010 p.314). 'Shares' were also described as supportive by interviewees in my research, with some suggesting that they helped cement bonds in recovery, knowing that others had experienced troubles and triumphs in their recovery journeys too.

Other studies in the systematic review reported how being part of a supportive social network, that also creates employment, created a 'recovery social contagion' that inspired a 'sense of self-esteem and ambition – a hope that related not only to recovery but to a career that would offer esteem and satisfaction' (Best, Beswick, Hodgkins and Idle, 2016 p.8). This provides an example of building capital, being part of a social enterprise that supports employment, skills development as well as social support increases an individual's physical and social capital which in turn facilitates recovery. Some of the interviewees from my research described how they were inspired through their recovery journeys to go on to help others by working as ambassadors or recovery champions. Other

interviewees described how they aspired to go on to help others in other areas in society as their journeys progressed.

Developing Healthy Strategies for Coping

One study in the systemic review described how for a number of individuals in recovery substances had provided a means to cope with past trauma or abuse (Colley and Blackwell-Young, 2012). Research into adverse childhood experiences has found associations with alcohol abuse and illicit drug use (Stein, Conti, Kenney, Anderson, Flori, Risi and Bailey, 2017). Recovery provision that helps service users develop new, healthier means of coping supports the recovery process (Harris, 2015, Chambers, Canvin, Baldwin and Sinclair, 2017, Best, Beswick, Hodgkins and Idle, 2016, Gilbert, Drummond and Sinclair, 2015, Irving, 2011, Waters, Holttum and Perrin, 2014, McIntosh and McKeganey, 2000, Colley and Blackwell-Young, 2012). Service users interviewed during both phases of my thesis research described how they had learnt or were in the process of learning new techniques so that when they are faced with times of anguish they would have new skills to help them cope. Whereas once they may have turned to alcohol or other substances, now they report taking exercise, talking through their concerns or pursuing meditation as ways of releasing tension and stress. One particular thesis participant described developing resilience to the outside world by as soon as she felt a darkness she tried to realise a happy place. Learning life skills (such as time management, housekeeping) and dealing with normal or ordinary events can be challenging for individuals in recovery (Ivers, Larkan and Barry, 2018). Participants from DRAW, (phase one of the research), described how staff at DRAW had supported them above and beyond the normal provision, by helping them arrange appointments, sort finances as well as providing much needed support for dealing with the loss of loved ones.

7.2.2 Factors that Inhibit or Impede Recovery

Factors that impede recovery generally fit into three categories: intrapersonal (shame, stress, anxiety); interpersonal (tension relating to group or environment dynamics); or social (service delivery and social

stigma) (Notley, Blyth, Maskrey, Pinto and Holland, 2015). A number of these will be covered below with some of these sub-themes overlapping.

Inability to Identify with Others in Recovery

The creation of a social identity facilitated recovery, however, not everyone in recovery can assimilate. Some participants in my thesis study reported not feeling the same as others, often feeling 'guilty' for not having the same 'sad story' as others (SU2). Another thesis participant described how they thought some people in recovery 'played the game' to get what they want, this distrust was echoed in a study covered in the systematic review, where a participant described hypocrisy and a lack of honesty in 12-step meetings as a reason for not engaging (Lopez Gaston, Best, Day and White, 2010). Additionally, similar trust issues were reported in studies from the systematic review covering residential recovery services, where participants were reluctant to associate with those they deemed to be 'not like me' (Neale, Tompkins and Strang, 2017 p.42). Although other thesis participants reported that although they knew they came from different backgrounds to others in recovery, they recognised they were all there to get well. *The Recovery Book* talks of 'fitting in under the recovery umbrella', how 'individual differences fade next to the power of the one common tie: the disease of alcoholism / addiction' (Mooney, Dold and Eisenberg, 2014 p.164). This text goes on to discuss how belonging to a specific community (i.e. Latino), may draw an individual to seek out a recovery group with a similar background or lived experience. This notion was also present in a number of the studies included in the systematic review, these reported how a lack of provision specifically directed to exclusive group identities acted as a barrier to recovery (McPhee and Fenton, 2015, Kiernan, Osbourne, McGill, Greaves, Wilson and Hill, 2018, Jeal, Macleod, Salisbury and Turner, 2017).

A number of interviewees in the first phase of my research described how they felt losing their titles of DRAW members and DRAW no longer being the service name felt like an identity loss to them. This matter was amplified by the fact that the RAD had kept its name, with some participants describing a feeling of them and us even among the recovery community. It can depend how the individual views their drug use as to

how they identify with others. The study by Notley *et al*, as mentioned above, reported two distinct opinions towards opiate substitution treatment (Notley, Blyth, Maskrey, Pinto and Holland, 2015). For some of the participants in the Notley study, drug using 'had become so firmly embedded in their self-concept that life without drugs or OST felt too difficult' (Notley, Blyth, Maskrey, Pinto and Holland, 2015 p.236), this notion of fear of relapse or life after use will be discussed shortly.

Shame, Guilt and Stigma

The Recovery Book talks of self-destructive feelings of shame and guilt, and proposes that those feelings can give rise to surrendering to the need to change (Mooney, Dold and Eisenberg, 2014). Guilt towards the wrongs done whilst using features in the 12-step process, with step eight referring to compiling a list of those who have been harmed and be willing to make an amends. Participants in my research described how addiction had stripped away their self-esteem and that confronting guilt and shame, especially where they felt they had harmed loved ones was a difficult process (but rewarding once instigated). Sometimes shame and guilt prevented relationships being rebuilt, or could not be re-established due to death of those harmed (Kondoni and Kouimtsidis, 2017, Irving, 2011). Where interviewees in my research had come from 'drinking' families they often struggled to re-bond, one participant in particular described how she felt visiting parents where once they would have all gone to the pub and yet now she felt she held them back from going which made her feel guilty.

Attendance at 12-step groups also presented stigmatisation, either through the stereotyping of the religious nature of delivery or by merely being seen to attend meant identification as a user (Day, Wall, Choham and Seddon, 2015). The religious aspect was described by participants in my thesis study to also be off-putting although for one participant in particular, as a practicing Catholic, it was not the religious side that deterred him, but that he needed to admit to being powerless. For others the focus on the 'share' acted as a barrier, although for some this was seen as a supportive element, which is discussed later in this chapter.

Radcliffe and Sevens describe the numerous levels by which a drug dependent individual can feel stigmatised, from on an individual level, through society and even in the services and treatment regime (Radcliffe and Stevens, 2008). They explain how risking being perceived as a 'junkie' can put individuals off entering services, and how substitute prescribing provision often disrupted economic activity (Radcliffe and Stevens, 2008). Being on a methadone programme can keep individuals trapped into the stigma of drug use (Neale, Nettleton and Pickering, 2013), and kept some still feeling like an addict (Notley, Blyth, Maskrey, Pinto and Holland, 2015). Participants in Radcliffe and Stevens (2008) study described how they did not view themselves as 'heavy drug users', but that they were recreational or medical users of substances. One male in the Radcliffe and Stevens study refused the 'shaming junkie identity in favour of a definition of himself as a medical user of heroin, thus part of a dominant moral community' ((Radcliffe and Stevens, 2008 p. 1069). Similarly, Notley *et al* also found two distinct groups of users, the chronically ill and the identifying user (as mentioned above) (Notley, Blyth, Maskrey, Pinto and Holland, 2015). During the first phase of my research the service which was to replace DRAW was visited with service users, some of the interviewees commented on how the provision appeared to be 'tucked away' on the outskirts of the city as if attendance was something to be ashamed of or hidden. On the walk to the centre one participant commented on the location being near a prison stating 'that says it all', inferring that attending the service gave rise to feelings of criminality.

For those requiring support for alcohol dependency, the context in which services are delivered may also be a barrier. Perceptions that services focus on the needs of drug users over alcohol dependence may prevent engagement (Public Health England, 2018b). In addition, a loss of alcohol treatment expertise and an alcohol specific referral pathway has also caused a reduction in numbers of individuals accessing support for alcohol addiction (Public Health England, 2018b).

The ‘Cliff Edge’

Although structure and routine has been highlighted as a facilitator to recovery, leaving a controlled environment that provided such intensity can leave individuals facing a ‘cliff edge’ (Parkman and Lloyd, 2016 p.282). The rigid schedule that service users experience within a structured day or residential rehabilitation programme provides them with the stability required to focus on getting well, however, when this programme ends there is often limited aftercare provided, meaning they may reduce from daily planned provision to perhaps just one or two half days of aftercare (Parkman and Lloyd, 2016). The worry regarding this cliff edge was also noticed by my thesis participants who often commented on concerns about what followed treatment; one participant noted that a lack of aftercare left a feeling of being abandoned (SU4). This was especially evident for the service users who had attended RAD, as this was a structured day programme. Although, other interviewees who had not attended RAD but had attended other, perhaps less structured centres (such as DRAW), also noted the lack of aftercare was a concern. A number of studies in the systematic review reported the importance of aftercare, describing it as ‘critical’ and the ‘most important ingredient of an effective treatment package’, suggesting that post-treatment factors have positive long term outcomes on recovery (Duffy and Baldwin, 2013 p.2, Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013 p.225). Individuals who undergo rapid detoxification programmes without subsequent support often report using drugs again soon after (Neale, Nettleton and Pickering, 2013).

Stress, Insecurity and Uncertainty

Individuals in recovery often report battling with stress and anxiety which exacerbates their drink or drug using habits (Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016) (DM5) (SU1). The availability of alcohol was reported to create a ‘risky environment’: ‘the single biggest element of risk was the retail environment, including both the sale and marketing of alcohol’ (Shortt, Rhynas and Holloway, 2017 p.151). This aspect of risk was also described by thesis participants who expressed stress and anxiety when raising the issue of alcohol availability. The first round of

interviews with DRAW members discussed their concerns about the location of the service that was to replace DRAW; this was located away from the centre and central bus station, meaning they had to pass a number of licensed premises to get there whereas DRAW was situated directly opposite the bus station. Two members in particular were expressing concern about the new location, stating that if you are feeling vulnerable getting passed so many risky situations could be problematic (DM7 and DM2).

Changes in service provision were defined as causing potential stress, insecurity and uncertainty during the first phase of interviews in particular. At this time DRAW was closing and the recovery provision was relocating and changing provider. This apprehension was quite visible during the observational periods at DRAW as well as during interviews; participants described losing their DRAW identity under the new provision, fears relating to changes in building and potential loss of staff they had bonded with were of particular concern. The importance of identity has been described above, so losing an aspect of an individual's identity would obviously cause distress. DRAW members would not only no longer be called 'members' (becoming 'service users' or 'clients' again), but they also discussed how they would not have designated areas specifically for them under the new provider. This was reported to be of significant note as other service user groups (specifically the RAD) maintained their provision with limited changes (according to DRAW members).

Staff, interviewed within my research, often reported becoming surrogate parents or caregivers for individuals in recovery, therefore anything that detracted from staff being able to deliver this support potentially disrupted recovery. Therapists provide a safe base for vulnerable people to explore, separation from them can cause distress (Waters, Holttum and Perrin, 2014). Loss of trusted staff that service users had bonded with can result in the undertaking of risky behaviour (Jeal, Macleod, Salisbury and Turner, 2017). Thesis interviewees also described their concerns about the loss of staff and worried that losing that bond could set a recovery process back. Although participants seemed to understand that job insecurity might lead

staff to look for employment elsewhere, they still appeared upset to lose them.

Stress was also a reported issue for staff working in the recovery field, this manifested itself through various avenues; lack of management support, lack of resources, competing interests between linked providers (i.e. mental health and treatment services) and poor job security (brought about through commissioning changes) all impacted on the workforce (Sheridan, Barnard and Webster, 2011). The current context in which treatment services are commissioned has affected alcohol treatment numbers more than for other substances (Public Health England, 2018b). In part due to prioritisation of opioid substitute treatment, loss of focus on alcohol users specific needs and less effective referral pathways (Public Health England, 2018b).

Having a drinker or drug user in the family or amongst close friends also causes stress and a barrier to recovery (Neale and Stevenson, 2015, O'May, Whittaker, Black and Gill, 2017). In addition, family members and close social networks affected by an individual's drinking or drug use can also experience 'multiple stressors, coping dilemmas, lack of information and support and are at heightened risk of ill-health, at a cost to both personal health and public services' (O'May, Whittaker, Black and Gill, 2017 p.193).

Doing too much too soon?

Although doing too much too soon can be a barrier to recovery (Collins and McCamley, 2018, Duffy and Baldwin, 2013) (and thesis participants), boredom and loneliness was also reported as a trigger for a relapse (Ivers, Larkan and Barry, 2018). One participant in my research alluded to a phrase used in AA, HALT: Hungry, Angry, Lonely Tired, suggesting that routine and keeping yourself occupied was important with boredom being a risk to recovery (DM8). *The Recovery Book* (Mooney, Dold and Eisenberg, 2014) also talks about the need to consider how much effort is required to focus on recovery so taking on too much can lead to feelings of being overwhelmed. This was reiterated during my thesis interviews, most participants raised the aspiration for a return to employment, with some

already working or volunteering, although some also noted that they were taking one step at a time. One particular participant highlighted how he battled for an ESA payment to prevent him being forced along a path he was not yet ready to face, describing being forced to job seek when he still felt ill, was not conducive to successful recovery.

Service Changes

Amalgamating drug and alcohol services caused concerns for some of my thesis participants, particularly in the first round of interviews, interviewees described their anxiety at being placed in a service alongside individuals that attended for harm minimisation purposes (OST for example). The second round of participants were less concerned about amalgamation overall but did comment on the need for a client centred approach, which focused on what the individual wanted from treatment. Some participants noted that as long as everyone was in recovery (i.e. seeking abstinence) it did not really matter what their substance choice had been.

Some service user participants in my thesis research referred to a lack of a voice in the commissioning cycle; however, the service commissioner suggested that this was an area that was being addressed with the most recent provider operating in conjunction with a peer provider. The initiation of the Durham Recovery Forum provides an opportunity for service users to raise concerns, although as one interviewee suggested a range of voices needed to be heard not just those that spoke the loudest.

Some studies included in the systematic review (as discussed in Chapter 3), as well as the thesis participants reported that change is not always a barrier though; a change in provider can lead to inefficiencies and underperformance being targeted, and often the ‘new’ provider breaths fresh life into a previously dull provision. Nonetheless, generally service changes left some individuals feeling more vulnerable, suggesting that any changes in provision created yet another obstacle to the recovery process. However, some noted that it is not so much the change in provider that can cause concern it is how they change is dealt with, describing transparency and service user involvement as key to a successful transition. In addition, the impact of the change in provision varied

depending on where an individual is within their own recovery journey. Newcomers are least effected (having limited experience of the current provider anyway), those already in recovery, but in early stages are most affected (as they are building their recovery routine), with the impact on those in later stages of recovery being more limited (presumably as they are closer to being ready to move on anyway).

7.2.3 Overlapping Factors that can both Promote or Inhibit Recovery

Recovery from addiction is a complex process, therefore it is of little surprise that many areas of the recovery process and / or service delivery can both provide promotion of recovery principles as well as inhibit, depending on the occasion or individual. The following themes provide examples of factors that either support or hamper recovery.

Peer Support

Peer support is one element of social capital (the amount of support an individual can accrue from his / her relationships (Cloud and Granfield, 2008)). The benefits of having positive peer support whilst in recovery have been well documented (Cloud and Granfield, 2008, Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013, Neale, Tompkins and Strang, 2017, Duffy and Baldwin, 2013). Peers are often described as family both within the thesis research and systematic review papers (Neale and Stevenson, 2015, Lopez Gaston, Best, Day and White, 2010). Having support from others who understood the problems faced in recovery was especially important where other avenues of social capital were absent, for instance where actual family members lives still revolved around drinking. My thesis participants alluded to the importance of recovery peers in place of old friends or family members, often describing their peers as family.

Peers can influence the decisions of others in relation to reducing methadone use, often reminiscing about brutal, prolonged and previously unsuccessful withdrawal which may prevent others from attempting withdrawal (Neale, Nettleton and Pickering, 2013, Notley, Blyth, Maskrey, Pinto and Holland, 2015). Interviewees in my research described how the opinions of others could prevent attendance at a service, suggesting that if

one person receives a poor experience and tells others about it then word of mouth can prevent engagement.

On a positive note though, narratives of the experiences of a ‘wounded healer’ are often passed to others in the hope that they can learn from them (Irving, 2011 p.184). ‘This discourse is what McAdams (1993) called a “generative script” as it generates a gift to be given to the next generation’ (cited in (Irving, 2011 p.191)), the ability to pay it forward. Similarly other studies, as well as my thesis participants described the desire to give ‘something back’ (Duffy and Baldwin, 2013 p.5). Thesis participants described how shares prevented loneliness and isolation through knowing others have been in the same predicament and overcame. Furthermore, many mutual aid groups focus on the power of the ‘share’, where group members are actively encouraged to discuss the positives and negatives of their recovery journey (McPhee and Fenton, 2015). Although sometimes professionals believe clients would rather open up to staff rather than peers, suggesting that some are worried about discussing their lives in front of others that may still be using (Day, Wall, Choham and Seddon, 2015).

Groups run by service users or ex-service users help support those in recovery during times of ‘crisis points’ (Notley, Blyth, Maskrey, Pinto and Holland, 2015 p.235). Those in recovery were referred to as ‘an untapped pool of talent’ by one particular interviewee in my thesis research, who suggested they should be utilised further to provide support. People in long term recovery were utilised to an extent, as some of the staff working in the services were in recovery (recovery champions and / or ambassadors).The service commissioner and service manager in my thesis research described the importance of self-efficacy though, suggesting that service users need to take responsibility for sustaining their recovery, with the commissioner explaining that the Recovery Forum that runs within the county is delivered by people in recovery for people in recovery. Dealing with the problems of others in recovery, whilst battling their own struggles can create a situation of distress (Parkman and Lloyd, 2016). This was also described by my thesis participants who talked of their concerns for others in recovery who were facing difficult times or had

relapsed, but that their individual recovery needed to come first so although they would help if they could they needed to focus on getting well themselves before they could really help others. During the second phase of interviews (reported in Chapter 6), one participant described how as a ‘secondary’ (someone coming towards the end of the 12 week cycle in RAD) she often had to take responsibility for primaries (those new to the service), although she felt proud to be in a position to help, she also raised concerns suggesting that ‘baby-sitting’ others could jeopardise her own journey as this could prevent a focus on her own health.

Peer support among staff was also highlighted as fundamental to delivery, with a lack of support from managers undermining the effects of positive supervision and peer support, which can cause a greater level of stress than the challenges of working with clients (Sheridan, Barnard and Webster, 2011).

The visibility of recovery champions or peer mentors are important in driving recovery, these individuals, having a lived experience of the highs and lows of recovery provide valuable support (Neale, Tompkins and Strang, 2017, Best, Beswick, Hodgkins and Idle, 2016). However, a mentor suffering a relapse and returning to being a service users can create a challenge within services that utilise mentors as part of the provision (Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013). Although this impact can be reduced, or to an extent, protected against with mentors providing mentoring for each other in times of need (Tober, Raistrick, Crosby, Sweetman, Unsworth, Suna and Copello, 2013). Damagingly, where senior peers were viewed as hypocritical or biased in favouring other peers a negative effect occurred, whereby individuals were left feeling less motivated to engage with services (Neale, Tompkins and Strang, 2017).

The positives of social relationships have been covered earlier, however, there is also a ‘dark side’ to social capital that needs to be considered when examining relationships (Weston, Honor and Best, 2018 p.3). Where social networks focus on intense ‘bonding’ capital, social isolation can occur as ‘high walls’ exclude members who do not meet the criteria

(Putnam, 2000 cited in (Weston, Honor and Best, 2018 p.3)). While building social relationships can create a shared sense of identity, they can also 'promote homogeneity leading to the fostering of group boundaries, self-interest and the emergence of an exclusive social capital that can be detrimental to both the group and "outsiders"' (Weston, Honor and Best, 2018 p.3). This was also described in my thesis research, SU2 explained how some service users were 'cold shouldered' if they did not pledge to the 'common goal'. Participants in a systematic review study also reported feeling like an 'outsider' among peers (Lopez Gaston, Best, Day and White, 2010). Sometimes others impacted so negatively on individuals that they were described as 'enemies', these individuals often caused acute distress, presenting intolerable behaviour for others accessing the service (Neale and Stevenson, 2015). One particular participant in my thesis research described such a dislike for a 'fantasist' he encountered in the service, he actively avoided being in his proximity (SU2). The sharing of personal or communal spaces could exasperate the irritation caused by others and ultimately effect recovery capital in a number of complex ways. In a study of homeless people suffering from dependence on drugs or alcohol it was noted that:

> having to share rooms and communal spaces (lack of physical capital) disrupted social networks and undermined relationships by creating interpersonal stresses and tensions. This, in turn, resulted in some individuals going without food (which could compromise health or human capital) or depriving themselves of hostel facilities, including computer rooms (which could have boosted human capital via education and training).
> Relationships with peers often encouraged drug taking and law breaking (so affecting cultural capital), whilst relationship breakdown negatively affected mental health (so reducing human capital) (Neale and Stevenson, 2015p. 481-482).

This quote highlights how components of recovery capital interlink and how one aspect (negative social relationships) can create a barrier to recovery.

A further 'dark side' to social capital relates to issues leaving existing social networks behind, these relationships supported drug use and provided access to drugs and alcohol, providing 'dense and bonding

capital' that can hinder routes to recovery (Weston, Honor and Best, 2018 p.3). Participants in my thesis study also reported the difficulties of leaving old friends behind, and that coming across them in the waiting rooms of treatment services (where those entering the recovery facility are mixed with those collecting methadone prescriptions), often presented uncomfortable feelings, on one hand they want the previous associate to see that recovery is possible by seeing them well, but on the other it reminds them of the world they left behind.

Relapse

Relapse or unplanned exits from services can cause considerable problems for substance treatment services (Harris, 2015, Aslan, 2015). With debates in the literature about which groups of service / ex-service users are more successful in their recovery journeys – those that drop out or those that remain to finish the programmes (Aslan, 2015). Thoughts towards relapse are often linked to the consideration that recovery is an on-going and often difficult process, where the potential for relapse loomed in the background creating conflicting thoughts about striving for abstinence and the desire to return to use (Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016, Ivers, Larkan and Barry, 2018, Harris, 2015). One particular interviewee in my thesis research suggested that 'it is as much to do with …how you learn good habits you can relearn bad ones' (SU4), suggesting that those in recovery are always striving to keep the addiction at bay (certainly in early stages). Reasons for relapse range from re-engaging with old friends to environmental triggers (Notley, Blyth, Maskrey, Pinto and Holland, 2015, Weston, Honor and Best, 2018, Shortt, Rhynas and Holloway, 2017, Day, Wall, Choham and Seddon, 2015, Irving, 2011). Fears, stressed by thesis participants, relating to coming across 'old friends' has already been alluded to above.

Similarly the fear of withdrawal can leave individuals trapped in the cycle of use (Notley, Blyth, Maskrey, Pinto and Holland, 2015), a shift from maintenance of drug use (usually an opiate substitution programme) to abstinence through detoxification can create an 'abstinence phobia', creating an over-reaction to withdrawal symptoms and / or the societal expectations of socially acceptable behaviour (Hall, 1984, cited in

(Kondoni and Kouimtsidis, 2017 p.233)). Being fearful of detoxification can lead to apprehension and worrying about relapse, especially where OST had helped them stabilise their lives (Kondoni and Kouimtsidis, 2017). To this extent the individual would need to consider what recovery meant to them, is a stable life (on opiate substitution) what is desired or to be totally drug free (completely abstinent).

There is however, learning to be taken from relapse, participants in my thesis research described hearing how others talked about relapse had provided them with valuable knowledge. This is reminiscent of the 'wounded healer' and 'generative script' discussed above. Participants in other studies also described how the recovery – (re)lapse – recovery process provided possibilities for learning that reinforced recovery and played an important role in the eventual success (Ivers, Larkan and Barry, 2018, Irving, 2011). Although for some the guilt felt from a relapse risked a return to full substance use (Ivers, Larkan and Barry, 2018).

Service Rules

Rules governing service provision also received a mixed view from participants, both in the systematic review and my qualitative work. Having a no visitor policy left residents feeling lonely and isolated, as it effected their access to outside family and friends (Neale and Stevenson, 2015). Participants in the second phase of interviews (who attended the semi-residential section of RAD) also raised similar frustrations, having to reduce or remove contact with the 'outside world' whilst attending the service. Some residential services also conducted breath-analysis tests on residents, this was seen as displaying a lack of trust by some, whereas others thought that it helped keep trouble away (Neale and Stevenson, 2015). Similarly, my interviewees who attended the RAD described how they had to hand over their mobile phones to the staff when attending the service (those in the residential section had no personal phones at all), although the majority stated this was viewed as for the benefit of all in the service (removing contact to previous users / dealers and helping keep service users safe), others felt slightly patronised by it, suggesting a liberty had been removed. At the time of the second round of interviews the process relating to the removal of personal phones was under review.

Participants in my thesis research described how having to complete paperwork effected their motivation. Others talked of the dislike of having to be 'buzzed' into centres instead of having a more open access. Although others noted how most services had this and it was to keep those inside safe. Residential recovery centres possess a number of fairly stringent rules, presumably focused to keep their clients safe, conditions such as no phone, not leaving the centre alone and only going outside to smoke in certain places, in view of staff, were all described by participants who attended the RAD or those from DRAW that had visited the RAD. Centre rules require clients to 'buy into' what the service is trying to achieve, some of the participants understood why the rules were in place for others it restricted them or made them feel untrusted.

7.3 The Wider Research Context

> 'A review of qualitative studies of changes in unhealthy behaviours, including substance use, concluded that successful behaviour change was not primarily the result of specific treatments or life events. The key moment leading to behaviour change was rather self-appraisal, prompted by distressing accumulated evidence that revealed an intolerable conflict between continued use and personal values and goals…Studies of individuals in treatment have identified a reduction in quality of life and a lack of control, family influences, and detachments from a substance-user identity as primary reasons for their choice to abstain' (Petterson, Landheim, Skeie, Biong, Brodahl, Benson and Davidson, 2018 p.1).

The importance of supportive social networks have been widely identified as supporting recovery, often resulting in better treatment outcomes (Best and Laudet, 2010, Panebianco, Gallupe, Carrington and Colozzi, 2016, Birtel, Wood and Kempa, 2017, Best, McKitterick, Beswick and Savic, 2015). However, the types of social support provided are of particular importance if recovery is to be supported (Brooks, Magana Lopez, Ranucci, Krumlauf and Wallen, 2017, Boeri, Gardner, Gerken, Ross and Wheeler, 2016). Supportive social networks foster a positive sense of identity, enhance social connectedness, sustain motivation for change, provide meaningful activities and help prevent relapse (Best, McKitterick, Beswick and Savic, 2015).

The notion of a ‘cliff edge’ to services discussed in this chapter has also been noted in addiction services in the USA; with research suggesting more needs to be done to support the transition period between residential services and establishing access to stable housing and employment, supportive social networks and aftercare services (Manuel, Yuan, Herman, Svikis, Nichols, Palmer and Deren, 2017). The length of stay in recovery provision (residential in particular) should be long enough for the individual to establish meaningful activities and address barriers to accruing recovery capital, as well as removing ‘negative recovery capital’ (Cano, Best, Edwards and Lehman, 2017 p. 16).

Stigma or perceived stigma can be associated with higher levels of depression and anxiety, lower self-esteem and poorer quality of sleep (Birtel, Wood and Kempa, 2017). Stigma and negative attitudes of health care professionals can contribute towards suboptimal provision for individuals suffering from substance addiction (Van Boekel, Brouwers, Van Weeghel and Garretsen, 2013).

Recovery means a variety of things to different people, terming addiction alone is difficult (McPhee and Fenton, 2015) so considering what life away from dependency is and requires, naturally creates ambiguity. Government polices describe recovery as ‘drug free’, (Scottish Government, 2018, Home Office, 2010, HM Government, 2017) the term hence becoming synonymous with abstinence, although in Scotland the vision includes providing support ‘within communities to find *their own* type of recovery’ (Scottish Government, 2018 p.4), which may indicate an acknowledgement that not one type fits all. Economically, it may be that abstinence is viewed as being more cost-effective than a programme focusing on maintenance by providing a substitute. So where does this leave those on substitute programmes? On the one hand they are often stable and gathering recovery capital (the OST assisting them in holding down employment and relationships), however, on the other they still require a drug to normalise their lives, leaving some in limbo. The notion of being ‘recovered’ also creates ambiguity, for some this means they now feel they have the tools to prevent relapse, having developed healthy coping mechanisms to difficult times. For some recovery is a lifelong

commitment, accepting that they can never use alcohol or drugs again 'one drink is never enough', but for others saying never again was just a 'step too far'.

It was over a decade ago when Laudet stated 'Recovery is a ubiquitous concept but remains poorly understood and ill defined, hindering the development of assessment tools necessary to evaluate treatment effectiveness' (Laudet, 2007 p.1). Although there is now a more varied answer to 'what does recovery mean to you?' there is still work to do in service provision to ensure an individualised route is provided. Not everyone entering treatment seeks to abstain, just as not everyone wishes to reduce their consumption or switch an illegal drug for a prescribed one. A greater focus on the *individual* need of a person entering treatment / recovery is required, what this thesis presents is how complex barriers and facilitators to recovery can be, what appears to support one individual can pose as a barrier to another.

7.4 Utilising NPT, and Delivery and Commissioning of Addiction Services

'Normalisation Process Theory (NPT) rests on the analysis of peoples' investments in *agentic contributions* – the things that they do – as they interact with the things that they work with, with each other, and with dynamic elements of their environments' (May, Sibley and Hunt, 2014 p.291). The relationships that individuals can build with their environment can be fundamental to successful recovery (as described in the facilitators to recovery section above).

> Over the past decade, NPT has been developed in three phases or iterations…objects, agents, and contexts – of social life…Objects are the focus of agency. They are the ensembles of practices and things that are enacted by agents, and the constraints on their workability and integration that are experienced by agents when they do so…Here, agents' contributions are made in reciprocal relationship with the emergent *capability* that they find on the objects – the ensembles of behavioural and cognitive practices – that they enact. These capabilities are governed by objects, and the extent to which they can be made workable and integrated in practice as they are mobilised… Agents are the people

> implicated in the implementation process and *agency* is expressed when they make things happen…Here, investments of social structural and social cognitive resources are expressed as emergent *contributions* to social action through set of generative mechanisms… Contexts: Social systems and networks are the locus of agency, and thus forms relational *contexts* in which structural and cognitive resources are distributed through relational networks and their social systems…Here dynamic elements of social contexts are experienced by agents as *capacity* (the social structural resources, that they possess, including informational and material resources, and social norms and roles) and *potential* (the social cognitive resources that they possess, including knowledge and beliefs, and individual intentions and shared commitments). These resources are mobilised by agents when they invest in the ensembles of practices that are the objects of implementation (May, Sibley and Hunt, 2014 p.291)

Contexts in this thesis relates to service provision for those suffering from drug or alcohol dependency, *agents* are those attending services or those delivering the service and *objects* relate to the practices that are conducted during the recovery or treatment process. When considering addictions in terms of NPT, there must be consideration given for the fact that individuals start the process at different levels and under different circumstances. Some service users view dependence differently, often believing treatment is for when ‘you’re really, really ill’, this can mean attending a service is delayed as individuals believe they have not reached that point (Gilbert, Drummond and Sinclair, 2015 p.447). In terms of NPT this can refer to pre-contemplation or early coherence, individuals may be in denial of their issue or are not ready for health promotion programs, appearing resistant to change. However, an alternative explanation is that traditional health promotion programs were not ready for such individuals and were not motivated to match their needs (Prochaska, Redding and Evers, 2015). These hard to reach groups of individuals can become lost to services or feel excluded due to specific characteristics they pose (as covered above in relation to barriers to provision). When considering recovery many individuals refer to a ‘turning point’ or crisis point in their lives (Timpson, Eckley, Sumnall, Pendlebury and Hay, 2016 p.32); For others a perceived lack of control over

consumption drives them to seek help (Gilbert, Drummond and Sinclair, 2015). Highlighting, motivations for change differ; therefore not everyone enters the process at the same starting point. In addition, the conflict of identity or construction of identity varies among individuals. In terms of NPT this would refer to differentiation or internalisation, feeling 'different' to society as a whole as an addict, or indeed starting to feel 'different' in recovery as opposed to in active drug or alcohol use; Internalising is born out of the individual making sense of the notion of recovery and deciding to engage.

Those suffering from dependency must train their brains to normalise recovery (Mooney, Dold and Eisenberg, 2014), this requires de-normalising the addict lifestyle; a further challenge posed to this process stems from the availability of addictive substances, alcohol in particular is so widely obtainable that its use is very much a norm within society. To endure this aspect of society requires further commitment from the individual to identify with their own community (those in recovery or seeking to reduce – depending on the chosen path), enrol in what this support network will provide and to continue to drive forward their recovery and enact the processes required to sustain.

Considering NPT in studies of addiction highlights the cyclical process of recovery, individuals do not move through the components of NPT in a linear fashion but flow between the components, back and forth and / or in a recurrent manner and service provision must be able to move randomly to meet the needs of the individual. The main issue of using NPT to look at addiction studies or commissioning processes lies in the inevitability of changes to the service delivery; this means the reflexive monitoring components can be difficult to examine long term. Aspects such as appraising the service received, suggesting what works (individually and communally) can be provided but not from a long term perspective. For example an individual (service user or staff member) cannot describe how the service was embedded or used for the journey to stable recovery (a journey that may take approximately five years) as the current commissioning cycle in Durham is two plus one year (meaning a maximum

of three years unless the contract is awarded for another period – which as of yet has not occurred in Durham).

Change within organisations is of course nothing new, 'the process of continually renewing organisation's direction, structure, and capabilities to serve the ever-changing needs of an external and internal customers' (Moran and Brightman, 2000, cited in (Gwaka, Gidion, Mayianda and Damaris, 2016 p.1)) will always be a requirement of an ever changing world. Similarly to NPT a particular model of change developed by Bullock and Batten (1985), (cited in (Gwaka, Gidion, Mayianda and Damaris, 2016)) highlights four stages (amended to demonstrate NPT): Exploration (Coherence), Planning (Cognitive Participation), Action (Collective Action) and Integration (Reflexive Monitoring). Although this model is more common in business change it nevertheless demonstrates similarities in the process to NPT, describing first a thinking phase, then a planning phase, an action phase and finally a bedding in or reflection phase.

Service delivery in health settings must seek to align itself with the ever changing needs of the societies they serve (as described in the recommendations section below). Local authorities commissioning these services need to ensure that the providers meet these demands, within the pre-set financial budget whilst also meeting the values and aims of the organisation (the local authority). Conflict can occur when the *perceived* needs of potential service users do not correlate with the *actual* needs of these individuals. It is at this point reflexive monitoring can play the largest part, providing individuals with a voice to impact change within the service for the benefit of others in similar situations provides not just the service with lived experience but also provides the service user with an opportunity to 'pay it back' or 'pay it forward' an aspect useful to ongoing recovery (as mentioned above). The provision of a voice should not belong to those that shout the loudest but should incorporate all voices, from different walks of life and groups to ensure that provision meets the needs of all potential users not just those most active at speaking.

NPT has been utilised in this thesis as a heuristic framework to understand the complex process of recovery and to map out how each

individual works through the stages involved with buying into what recovery can bring them. NPT provided a conceptual context by which to examine barriers and facilitators to implementing the recovery process. In essence, people in recovery broadly understand the notion of recovery (coherence), but that translating how recovery could be brought into practice in their lives (cognitive participation) created many complexities. These complications then shaped how the individual (and the staff working with them) operationalised aspects of recovery into their lives (collective action). Preparing to leave treatment created a sense of 'what next', often presenting a 'cliff edge', individuals were then able to appraise what they needed to do to continue to maintain abstinence and provide support for those embarking on their journeys (reflexive monitoring).

In summary, addiction recovery services can become disposed to normalisation when:

a) Those delivering the service and those attending understand the requirements of recovery. For the staff (especially those with no lived experience of recovery) this requires an understanding that recovery is non-linear, complex and requires a holistic support package to address addiction issues. Staff must balance this with commissioning priorities and service delivery policies. For those in recovery this requires initially an understanding of what recovery will mean to them, what it will need from them and how the service they are attending can support this.
b) Those in recovery decipher how life in recovery differentiates from the previous life under addiction or when the service staff accept how the delivery of the newly commissioned service differs from the previous.
c) Access to recovery capital is established, positive social networks evolve and aftercare to treatment is considered.
d) Professionals and those in recovery can complement each other's voices in the establishment and delivery of recovery provision.

The thesis will now move to the final chapter, where key findings will be reiterated and conclusions provided.

Chapter 8: Discussion

8.1 Chapter Introduction

The first section of this final chapter draws together a summary of key findings, returning to the research objectives as described in the introduction. The chapter will then define the contributions to research that this thesis provides, before moving onto strengths and limitations and suggestions for future research.

8.2 Summary of Findings

The aim of this research was to explore factors that may inhibit or promote recovery from addiction within local authority commissioned addiction recovery services. In addition, because of the circumstances in the field at the time, it looked at how the commissioning and subsequent re-commissioning of services can impact on those attending the service as well as those working within them.

Chapter 3, the systematic review, examined literature from the UK and the Republic of Ireland which focused on the opinions of both those attending and those working within addiction recovery services. The review identified factors that promoted or inhibited the development of recovery capital. The thematic synthesis of the included studies identified the following topics: Motivation for change / Help seeking behaviour, Abstinence / Harm minimisation, Hard to reach / specific group dynamics, Gender focused delivery / differences, Identity change / Self-image, Commitment / 'Buying into delivery / Driving change, Community / Peer support / Negative aspects of peers or relationships, Barriers and Facilitators.

Chapter 5 reported the findings from the first phase of qualitative interviews (those conducted with 8 DRAW members and 3 members of DRAW staff). Chapter 6 described the findings from phase two of the research (interviews conducted with 7 service users from Lifeline, Change-Grow-Live and RAD, as well as a service manager and the service commissioner). The findings reported in Chapters 5 and 6 were derived using NPT as a framework for analysis and so the findings were described

in terms of Coherence (what is recovery?), Cognitive Participation (engaging in recovery), Collective Action (in recovery) and Reflexive Monitoring (reflecting on recovery).

Chapter 7 provided a synthesis of the findings from Chapters 3, 5 and 6, whereby themes were collated under factors that promote recovery, factors that inhibit recovery and those factors that can either promote or inhibit (depending on differing circumstances). Factors that promote recovery are: understanding recovery, having an optimal treatment time and aftercare, meaningful activates being present, a reconstructed identity (for those who wish to create one), having a sense of hope, value and pride and learning successful coping mechanisms. Factors that inhibit recovery relate to: an inability to identify with others (within the recovery community), experiencing shame, guilt and stigmatisation, worrying about the treatment 'cliff edge' (end of service provision), feelings of stress, insecurity and uncertainty, doing too much too soon (in the recovery journey) and service changes. Peer support, relapse and service rules were all factors that could promote or hamper recovery depending on the circumstances.

8.2.1 Research Objectives

This section will return to the research questions as set out in the introduction to remind the reader of how they have been achieved.

Research Objective One: What does the literature, both from the UK and the Republic of Ireland tell us about the perspectives of service users and staff working within the addiction treatment and recovery arena?

The systematic review described in Chapter 3 reported what the current literature tells us about the opinions of service users and staff from within the addiction recovery field in the UK and the Republic of Ireland.

Research Objective Two: What are the barriers and facilitators for service users in accessing alcohol and drug treatment / recovery and for the staff working within them?

Chapters 3, 5 and 6 reported factors that promote or impede recovery. Chapter 7 provided a synthesis of these barriers and facilitators for service users and staff.

Research Objective Three: Does Normalisation Process Theory (NPT) provide a useful model to understand how clients and service delivery staff operate in community based North East service(s) for treating alcohol misuse?

Chapters 5 and 6 reported the findings from the qualitative interviews conducted with those using or working in the recovery centres, this data was analysed, as described above, using NPT as a framework.

Chapter 7 highlighted the value of using NPT, demonstrating how each of the components can be used to understand the process of recovery, albeit it can be difficult to truly examine normalisation in the ever changing environment of commissioning.

Research Objective Four: What are the recommendations for future commissioning of drug and alcohol services?

The findings from Chapters 3, 5, 6 and 7 were collated and the recommendations below were produced.

8.3 Recommendations for Service Delivery

The recommendations as collated through the findings from chapters 3, 5, 6 and 7 are presented below, these have been grouped under relevance for service commissioners or service delivery, although it is recognised that there may be an overlap between the two.

8.3.1 Recommendations for Service Commissioning

Service Location

Although it is unrealistic to imagine services could be located in 'alcohol free areas' with the availability of alcohol being so widely dispersed, locating a service away from as many triggers as possible should be considered. Individuals in recovery struggle with the retail environment of alcohol, especially on vulnerable days when dealing with other stresses (Shortt, Rhynas and Holloway, 2017). Research conducted by DeVerteuil *et al* 2007, examining neighbourhood settings, has concluded that 'both social and built environments matter with environmental risks presented including ready access to drugs and alcohol and the strong links between

social network and former spaces of drug and alcohol consumption' (Shortt, Rhynas and Holloway, 2017 p.148).

Aftercare

Studies describe the need for aftercare to be provided (Notley, Blyth, Maskrey, Pinto and Holland, 2015, Parkman and Lloyd, 2016, Colley and Blackwell-Young, 2012, Duffy and Baldwin, 2013), this correlated with findings from my thesis interviews. 'Aftercare services have been shown to reduce substance use, delay relapse, lower stress and improve quality of life' (Duffy and Baldwin, 2013 p.2). Even following release from prison, the continuity of care is important so that where the recovery process was initiated in prison it could be continued in the community (Powis, Walton and Randhawa, 2014).

Establishment Support and the Commissioning Cycle

Staff and managers need to receive support from senior managers and hierarchy in order to effectively and successfully implement provision to encourage recovery (Sheridan, Barnard and Webster, 2011, Powis, Walton and Randhawa, 2014, Public Health England, 2018b). The commissioning cycle also needs to consider the impact of staff turn-over, for both the benefit of the service users and the staff involved. Recovery champions or mentors should be utilised as much as possible, but the effect that mentoring may have on the mentor also needs to be considered, with the mentor also receiving peer support. Service users require a voice in the commissioning and service delivery processes, this will encourage their involvement by providing them with a vested interest.

'The concept of recovery capital may also be one of the keys to understanding how individuals maintain momentum throughout their recovery journey' (Best, McKitterick, Beswick and Savic, 2015 p.271). Addiction services need to provide comprehensive pathways from referral to aftercare that supports all avenues of building recovery capital.

8.3.2 Recommendations for Service Delivery

Non-Stigmatised Approaches and Varied Routes of Referral and Delivery

Offering an alcohol specific pathway, which includes alcohol treatment expertise among staff would assist engagement from those suffering alcohol dependence (Public Health England, 2018b). In addition, a service that focuses on detoxification and abstinence can drive some potential help seekers away (both in relation to alcohol and drugs) (Gilbert, Drummond and Sinclair, 2015), therefore provision must be centralised around what each individual wants, with options for harm minimisation as well as abstinence based routes. Staff should provide a non-judgemental approach to individuals accessing services, and discuss thoroughly with each person what their concept of a healthy future involves.

Providing a holistic approach to treatment which includes talking therapies will drive forward recovery, delving into what brought about addiction facilitates self-reflection and understanding which supports the creation of a non-addict identity (Gilbert, Drummond and Sinclair, 2015). Furthermore, offering a selection of different approaches to recovery support can facilitate recovery, treatment staff should signpost service users to mutual help groups such as 12-steps and / or SMART recovery, and consider attending themselves to understand what is delivered. Service provision can and should be delivered alongside mutual-help groups (Day, Wall, Choham and Seddon, 2015). Service opening times should also, where possible operate beyond the usual 9 till 5 to support access for those who are still in work or have childcare to consider.

Provision for specific group identities should also be considered, sessions for individuals with particular needs or lived experience (for example veterans, people from minority groups, victims of domestic abuse, sex workers, single parents) as their specific requirements may create a barrier to normal provision (Kiernan, Osbourne, McGill, Greaves, Wilson and Hill, 2018, Jeal, Macleod, Salisbury and Turner, 2017).

Provision of ‘Meaningful’ Activities

A range of services need to be provided in order for service users to embed the culture of recovery, this includes access to facilities or support that allows them time to relax and address their issues internally. Mindfulness has been suggested to reduce chronic pain and stress related disorders (Harris, 2015). Asset based approaches to building social capital such as indulging in nature, museum visits or involvement with sport can also develop social relationships and improve confidence, which supports recovery (Morse, Thomson, Brown and Chatterjee, 2015, Morton, O'Reilly and O'Brien, 2016, Aslan, 2016).

Family and Social Network Support

Provision that supports the family and close friends of individuals suffering alcohol or drug dependence also require support ‘in their own right’, although this has become a rising priority in policy and practice (O'May, Whittaker, Black and Gill, 2017 p.193), it needs to be considered at delivery level.

8.4 Contributions to research

This research supports the statement that: ‘Overcoming addiction requires some degree of self-change, and for this to happen, facilitating opportunities are required’ (Landale and Roderick, 2014 p.25).Highlighting that aspects, such as building social or recovery capital can support recovery by encouraging individuals to behave in a certain way. The provision of meaningful activities and the forming or rebuilding of relationships and the development of a shared sense of identity supports the ‘structure’ side of a structure versus agency debate, suggesting individuals possess a need to be ‘included’ and feel a belonging to the social domain. However, the notion of agency or free will cannot be overlooked in terms of recovery either. This research described various reasons to seek help and find motivation to change, for some participants changing for others was not enough alone (i.e. conforming to society norms), there had to be an internal drive to change for themselves too. In NPT terms, elements of recovery require individuals to consider what recovery means for them specifically. In addition, many participants

described having to put their own needs and recovery first, highlighting a degree of freedom, which supports the agency element of the debate. Although it must be noted that in relation to addiction recovery, the structure agency debate is a complex one, with various elements linking and / or representing both sides of the argument: the notion of identity alone can be viewed from a structure side ('shared identity' mentioned above, influenced by factors found to have in common – i.e. religion or belief in AA, gender or group dynamics) but also from an agency level (the capacity to act independently to change their self-image). 'Choice alone without structures of support, or the offering of support alone absent of a decision to desist, however inchoate, seems destined to fail' (Sampson and Laub, 2005 p.43). Although Sampson and Laubs' work focused on the desistence of crime the same principle could be suggested with regards to desisting in substance use, provision and support is one element to a recovery journey but there must also be a drive from the individual to instigate the recovery journey and maintain motivation to sustain.

This research provided an in-depth overview of facilitators and barriers to recovery from the perspective of service users, service staff, and service commissioning, as well as a summary of what the literature from the UK and the Republic of Ireland tells us about factors that promote or inhibit recovery.

The research highlighted a potential dislocation caused by service redesign, the commissioning cycle being shorter than the average recovery journey (being around five years to 'stable' recovery and the commissioning process usually being between two to four years), meaning that an individual attending a service for the initial stages of recovery are likely to undergo at least one service redesign (change ironically becoming the only constant feature).

Recommendations for service delivery from the viewpoint of service users and service staff were provided in this research, these are transferable to other addiction services in other areas of the country and many of the recommendations can be transferred to similar services (mental health provision for example).

Although this research aimed to provide a rich and in-depth overview for a specific setting rather than necessarily generalise to all recovery provision, it does provide a comprehensive overview of potential barriers and facilitators to service provision, which could not only be applicable to other UK recovery services but also similar health provisions internationally. Many of the issues raised in this research would assist in preventing barriers nationally and internationally, for example the need for aftercare and meaningful activities as well as non-stigmatised approaches to provision are just as likely to be applicable worldwide as they are in the North East of England. In addition, as the research was conducted at a unique time (during service changes) it provided a first-hand view of how these changes effected individuals as it actually occurred, which again could be relevant and pertinent to service changes that occur both nationally and internationally.

In addition, the thesis explored how aspects of recovery can be viewed through the lens of NPT, with NPT providing a useful context to examining how facilitators and barriers present during the recovery process.

8.5 Strengths and Limitations

The research provided an in-depth examination of a specific local authority addiction recovery service provision. The qualitative focus placed the service user (and to a lesser extent staff working in the provision) at the heart of the research, demonstrating how patient involvement in service based or evaluation research is key.

Although the changes in provision throughout the lifetime of the research created unforeseen delays and restructuring of the research plan, it did however, provide me with the ability explore the views of the participants in a dynamic environment of service provision, reflecting the real challenges facing those in addiction and those working in the field.

In addition, a further strength of the research was in the utilisation of an explicit theoretical framework (i.e. NPT). NPT provides the opportunity to

investigate how an ever changing environment such as service provision / service re-commissioning can become normalised and embedded.

The constructs of NPT were particularly useful in explaining the processes involved in recovery, although recovery journeys are not specifically linear they adopt a pattern in that before participating in recovery or actioning recovery occurs there requires a stage of thinking about recovery (coherence in NPT terms). Highlighting that thought is a precursor to doing. NPT mechanisms can be non-linear, they can interrelate dynamically, similarly in recovery individuals can move back and forth between thinking about recovery, undertaking recovery, striving to maintain recovery and reflecting on recovery. The interviews with participants each naturally created a recovery story which could be plotted into sections such as: what led to seeking help for the addiction (*Coherence*); how recovery was instigated (*Cognitive Participation*); what being in recovery meant (*Collective Action*); and considering what works in recovery (*Reflective Monitoring*).

Although, the research does not investigate whether other theoretical models would have found similar results, which is a limitation.

Limitations of the research also include the restriction of conducting the study in just one local authority, which may reduce the transferability of findings to other areas. Furthermore, as all the participants interviewed were all following a path of abstinence, no one attending a service for a harm minimisation (such as OST) was interviewed. If those following different paths were interviewed there may have been a wider scope of barriers and facilitators to provision uncovered. A further limitation arose from not having a direct comparison for DRAW either in the local authority examined for this research or regionally. The DRAW model was born out of a community asset based model, whereas the subsequent models (Lifeline and CGL) both appeared more clinical in their direction, this was potentially as a direct result of the remodelling of provision that combined drugs and alcohol and abstinence and harm reduction. Additionally, it was not possible to follow-up the first round of participants as they had moved on from provision once DRAW closed, the study may have been enhanced

by re-interviewing them at a later date to establish how the closure of DRAW had impacted on their recovery journeys. Although three participants in the second phase had also attended DRAW, they had not been interviewed in the first phase.

The wider impact of service budgets and the implications for service delivery was not considered as part of this research, although what the research does show is that services can still deliver (even if on a reduced capacity) despite very difficult circumstances.

There is also my background to consider, as a trained licensing practitioner (alcohol and gambling) with a background in criminology and analysis I had a wealth of knowledge around the harms caused by alcohol (and to a lesser extent drug use) prior to commencing the research, albeit for a particular standpoint. Although as much as my background was a strength it may also have provided a weakness in that I may have been unknowingly subjective, having viewed the harms caused by alcohol and drugs (and associated criminality) first hand operationally.

While it is worth considering that researchers conducting interviews can create a bias (often un-knowingly), the observational periods helped to reduce this bias through building relationships and breaking down barriers between the researcher and participants. The observations were aimed at scoping the service and generally getting a feel for DRAW, rather than observing in the clinical research sense, therefore it was not felt that those being observed consciously or unconsciously altered the way they acted to any great extent. In addition, conversations with the DRAW staff reiterated that the members generally conversed with one another in the manner observed.

8.6 Suggestions for Future Research

This research focused solely on qualitative aspects, providing the ‘why’, however, this work has not looked to establish whether there were any losses or gains by changing the mode of delivery, the relative effectiveness. Future research may wish to examine how efficacious the interventions delivered were, clearly some people get better (in that they progress along the recovery journey), but how many do overall, and how

many would have got well without the interventions. This would require a rigorous experiment or quasi-experimental design (like an interrupted time series for example), however, as my research highlights, the dynamic changes in service configuration may mean that standard research designs may be unlikely to work.

Broader research into the commissioning process and effects on provision is still needed, perhaps examining representation rates or potentially following up previous service users or staff who have moved on from recovery provision. The impact on staff was touched upon in this thesis; however, more specific research into the effects of commissioning processes on staff morale may uncover further concerns.

8.7 Conclusion

Overall, the research provided a comprehensive synthesis of factors that facilitate or create barriers to recovery capital development, highlighting that some factors can either support or hinder recovery, depending on the individual or the context in which the factor arises. Recommendations for service delivery were born out of these findings and presented within this thesis. A focus on a client centred approach, that helps reduce stress and anxiety for the individuals attending is required, after all those attending are at pinnacle points in their recovery (usually early stages), whereby adjusting to a different way of life, away from the chaos of drink or drug use, needs to take precedence so any factors adding to the stress they are already under is detrimental. Those in recovery are already undergoing dramatic changes to their way of life; any further changes (for example service delivery, staffing, location of provision) need to be considered where at all possible to reduce further harm to the individual. Economically, a successful treatment journey not only provides the individual with better outcomes, but is also more financially viable for the local authority and society as a whole (potentially reducing re-presentation rates, reducing harms to health and supporting the individual back into the workplace).

In addition, the research demonstrated how NPT can provide a map of recovery journeys, describing how each construct and sub-construct of

NPT can be understood in terms of elements of recovery and how each individual looks to overcome addiction, how they de-normalise their once addict lifestyle and accept the new ‘normal’ of recovery. NPT provides a useful model to understand this complex journey and to examine facilitators and barriers to the process.

Although within the interviews conducted for this research, there appeared a general acceptance of the commissioning cycle it has to be noted that commissioning and re-commissioning also bears a cost to the local authority, change is not a free entity. The process of commissioning may well open up market principles, whereby ‘bidders’ can propose better outcomes and more streamlined approaches but ensuring delivery remains motivated on a population focused approach must remain at the heart of every successful bid.

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Appendices

Appendix A: The 12-Steps

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Appendix B: Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist

Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (Y= Yes / N= No)										
Reference	**Screening Questions**		**Detailed Questions**							
	Was there a clear statement of the aims of the research?	**Is a qualitative methodology appropriate?**	**Was the research design appropriate to address the aims of the research?**	**Was the recruitment strategy appropriate to the aims of the research?**	**Was the data collected in a way that addressed the research issue?**	**Has the relationship between researcher and participants been adequately considered?**	**Have ethical issues been taken into consideration?**	**Was the data analysis sufficiently rigorous?**	**Is there a clear statement of findings?**	**How valuable is the research?**
Aslan (2015)	Y	Y	Y	Y	Y	Y	Y	N	Y	Potential / High
Aslan (2016)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
Best *et al* (2016)	Y	Y	Y	C	Y	N	N	N	Y	Potential
Bliuc *et al* (2017)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential
Chambers *et al* (2017)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
Colley, E. and J. Blackwell-Young (2012)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential
Collins and McCamley (2018)	Y	Y	Y	Y	Y	C	Y	Y	Y	Potential / High
Day *et al* (2015)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
Duffy and Baldwin (2013)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
Gilburt *et al* (2015)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
Harris (2015)	Y	Y	Y	Y	Y	N	N	Y	Y	Potential

Irving (2011)	Y	Y	Y	Y	Y	N	N	Y	Y	Potential
Ivers *et al* (2018)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
Jeal *et al* (2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Potential / High
Kiernan *et al* (2018)	Y	Y	Y	Y	Y	N	Y	N	Y	Potential / High
Kondoni and Kouimtsidis (2017)	Y	Y	Y	Y	Y	N	C	Y	Y	Potential / High
Lopez Gaston *et al* 2010	Y	Y	Y	C	Y	N	Y	Y	Y	Potential
McIntosh, J. and N. McKeganey (2000)	Y	Y	C	Y	Y	N	N	C	Y	Potential
McPhee and Fenton. (2015)	Y	Y	Y	Y	Y	N	Y	C	Y	Potential
Morse *et al* (2015)	Y	Y	Y	Y	N	N	N	Y	Y	Potential / Limited
Morton *et al* (2016)	Y	Y	C	Y	Y	N	Y	Y	Y	Potential / Limited
Neale *et al (*2012)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
Neale *et al* (2017)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential
Neale, J. and C. Stevenson (2015)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential
NOMS, (2014)	Y	Y	C	C	Y	N	Y	Y	Y	Potential / High
Notley *et al*, (2015)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
O'May *et al* (2017)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
Parkman and Lloyd.(2016)	Y	Y	Y	Y	Y	N	N	Y	Y	Potential / High
PHE, (2018)	Y	Y	Y	Y	C	N	N	C	Y	Potential
Radcliffe, P. and A. Stevens (2008)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / High
Sheridan, *et al*. (2011)	Y	Y	C	Y	Y	N	Y	Y	Y	Potential / High
Shortt *et al* (2017)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential / Limited
Timpson *et al* (2016)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential
Tober *et al* (2013)	Y	Y	Y	C	Y	N	N	Y	Y	Potential
Waters *et al* (2014)	Y	Y	Y	Y	Y	N	Y	Y	Y	Potential
Weston *et al* (2018)	Y	Y	Y	Y	Y	Y	N	Y	Y	Potential / High

Appendix C COREQ (COnsolidated criteria for REporting Qualitative research)

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	95
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	95
Occupation	3	What was their occupation at the time of the study?	264
Gender	4	Was the researcher male or female?	N/A
Experience and training	5	What experience or training did the researcher have?	264
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	98
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	98
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	99
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	87
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	101
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	101
Sample size	12	How many participants were in the study?	101
Non-participation	13	How many people refused to participate or dropped out? Reasons?	105
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	104
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	104
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	137 & 173
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	100
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	102
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	105
Field notes	20	Were field notes made during and/or after the inter view or focus group?	99
Duration	21	What was the duration of the inter views or focus group?	105
Data saturation	22	Was data saturation discussed?	105
Transcripts returned	23	Were transcripts returned to participants for comment and/or	118

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	119
Description of the coding tree	25	Did authors provide a description of the coding tree?	119
Derivation of themes	26	Were themes identified in advance or derived from the data?	119
Software	27	What software, if applicable, was used to manage the data?	119
Participant checking	28	Did participants provide feedback on the findings?	118
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Chapters 5&6
Data and findings consistent	30	Was there consistency between the data presented and the findings?	Chapters 5&6
Clarity of major themes	31	Were major themes clearly presented in the findings?	Chapters 5&6
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	Chs. 5,6&7

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Appendix D: Phase One Information Leaflet

Thank You.....

For taking the time to read this leaflet. Please feel free to contact me if you have any questions about the research. If you decide to take part please keep this leaflet for future reference.

Any suggestions or complaints regarding the study or how you were treated, will be dealt with, in writing within 7 days. They should be made in writing to Prof. Luke Vale at:

Institute of Health and Society,

Newcastle University,

Baddiley-Clark Building,

Richardson Road,

Newcastle Upon Tyne,

NE24AX

Samantha Level

Researcher

Samantha Level

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Room 3.77 Baddiley-Clark Building

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Newcastle University

Richardson Road

Newcastle Upon Tyne NE2 4AX

Tel: 0191 222 7400

Email: s.level@newcastle.ac.uk

Newcastle University

An Evaluation of County Durham Alcohol Recovery Service

Research Information Leaflet

Research Information Leaflet V0.4 9/12/2014

What is the purpose of the study?

The research is part of my PhD at the Institute of Health and Society at Newcastle University. The purpose of the research is to examine what the Durham Recovery and Well-being Centre (DRAW) offers, how members are supported through their recovery journey and whether there are any barriers present. It offers an opportunity to express your views in a confidential manner regarding the service – what you liked, what you would change etc. DRAW members, DRAW staff and staff from CAS are being invited to take part.

Do I have to take part?

Taking part in the research is **entirely voluntary: it is up to you to decide whether to join the study.** If you agree to participate, confidentiality would be discussed and I will then ask you to sign a consent form. **You are free to withdraw at any time**, without providing a reason and without your legal rights being affected.

What will happen if I take part?

If you decide to take part, a single (one-to-one) interview will take place at a time, date and location convenient for you between January and March 2015. I will conduct the interview in a face-to-face situation and it will last no longer than two hours for DRAW members, an hour for staff. Questions around your feelings towards the service, what it offered and how recovery is supported will be asked. For DRAW members information about your recovery journey will be asked. DRAW members will be offered a £10 voucher for their time.

Who will have access to my information?

All information given will be treated as confidential (providing there is no risk to yourself or another person mentioned). Your details will be anonymised and only the researcher and one member of the supervisor team will have access. The interview will be audio-recorded but none of your personal details will be identified. The recording will then be transcribed to allow analysis at a later date. All information will be stored on a password protected computer. Data will be kept for 10 years within the University, according to the rules of the Data Protection Act. After 10 years, the data will be destroyed securely.

Could I be at risk by taking part?

I'm confident you will not experience any harm by taking part. However, if it is proven you are harmed as a result of the researcher's lack of care, you may have grounds for legal action against Newcastle University. You may have to pay for your own legal costs.

Who is funding the research?

The PhD is funded by Durham Primary Care Trust.

What happens to the results of the research?

The research will count towards my doctorate degree and may be printed in academic journals and presented at conferences. You will not be identified in any of the information written about the study.

Will the research help me?

I cannot promise the research will help you directly. However, it will offer you a chance to share your opinions and feelings towards the service and may help in the development of future services.

Appendix E: Phase Two Information Leaflet

Thank You.....

For taking the time to read this leaflet. Please feel free to contact me if you have any questions about the research. If you decide to take part please keep this leaflet for future reference.

Service users who take part in the study will receive a £10 gift voucher.

Any suggestions or complaints regarding the study or how you were treated, will be dealt with, in writing within 7 days. They should be made in writing to Prof Luke Vale at:

Institute of Health and Society,
Newcastle University,
Baddiley-Clark Building,
Richardson Road,
Newcastle Upon Tyne,
NE24AX

Samantha Level

Researcher

Samantha Level
FUSE (The Centre for Translational Research in Public Health)
Baddiley-Clark Building
Institute of Health and Society
Newcastle University
Richardson Road
Newcastle Upon Tyne NE2 4AX

Tel: 0191 202 3203
Email: s.level@newcastle.ac.uk

Newcastle University

An Evaluation of County Durham Recovery Services: The Impact of Change on Service Users

Research Information Leaflet

Research Information Leaflet V4: 22/12/2017

What is the purpose of the study?

The research is part of my PhD at the Institute of Health and Society at Newcastle University. The purpose of the research is to examine what recovery services offer, how members are supported through their recovery journey and whether there are any barriers present. In addition, how the changes in service provider effects recovery. It offers an opportunity to express your views in a confidential manner regarding the services – what you liked, what you would change etc. Those in recovery and those working in the field of recovery in County Durham are invited to take part.

Do I have to take part?

Taking part in the research is **entirely voluntary**: **it is up to you to decide whether to join the study.** If you agree to participate, confidentiality would be discussed and I will then ask you to sign a consent form. **You are free to withdraw at any time**, without providing a reason and without your legal rights being affected.

What will happen if I take part?

If you decide to take part, a single (one-to-one) interview will take place at a recovery hub at a date and time convenient for you between November 2017 and June 2018. I will conduct the interview in a face-to-face situation and it will last no longer than two hours for recovery members, an hour for staff. Questions around your feelings towards the services, what was offered, how recovery is supported and how changes to services effected you or those you work with will be asked. For recovery members information about your recovery journey will be asked.

Who will have access to my information?

All information given will be treat as confidential (providing there is no risk to yourself or another person mentioned). Your details will be annonymised and only the researcher and one member of the supervisor team will have access. The interview will be audio-recorded but none of your personal details will be identified. The recording will then be transcribed to allow analysis at a later date. All information will be stored on a password protected computer. Data will be kept for 10 years within Newcastle University according to the rules of the Data Protection Act. After 10 years, the data will be destroyed securely.

Could I be at risk by taking part?

I'm confident you will not experience any harm by taking part. However, if it is proven you are harmed as a result of the researcher's lack of care, you may have grounds for legal action against Newcastle University. You may have to pay for your own legal costs.

Who is funding the research?

The PhD is funded by Durham County Council.

What happens to the results of the research?

The research will count towards my doctorate degree and may be printed in academic journals and presented at conferences. You will not be identified in any of the information written about the study.

Will the research help me?

I cannot promise the research will help you directly. However, it will offer you a chance to share your opinions and feelings towards the services and may help in the development of future services.

Appendix F: Participant Consent Form – Phase One

An Evaluation of County Durham Alcohol Recovery Service (DRAW)

Please tick the appropriate boxes:

I have read and understood the project information sheet dated 9/12/2014	☐
I have been given the opportunity to consider the information, ask questions, and have had these answered satisfactorily.	☐
I understand that my taking part is voluntary; I can withdraw from the study at any time, without giving reason and without my legal rights being affected. I understand that if I withdraw, that information already collected with my consent will be retained and used in the study.	☐
I understand that my personal details will not be revealed to people outside the project.	☐
I understand that the confidentiality of the information collected will be maintained, it will be stored securely in locked university offices and computer files will be password protected.	☐
I understand that, during the course of the study, should any unprofessional, or unethical, or unsafe practices be identified, the researcher has a duty to inform the relevant authorities.	☐
I consent to the use of audio taping, with the possible use of anonymous direct quotes in the study report.	☐
I have read and understood the information and I agree to take part in this study.	☐

_____ _____ _____

Name of Participant *Signature* *Date*

_____ _____ _____

Name of Researcher *Signature* *Date*

Appendix G: Participant Consent Form – Phase Two

An Evaluation of County Durham Alcohol Recovery Service (DRAW)

Please tick the appropriate boxes:

I have read and understood the project information sheet dated 22/12/2017	☐
I have been given the opportunity to consider the information, ask questions, and have had these answered satisfactorily.	☐
I understand that my taking part is voluntary; I can withdraw from the study at any time, without giving reason and without my legal rights being affected. I understand that if I withdraw, that information already collected with my consent will be retained and used in the study.	☐
I understand that my personal details will not be revealed to people outside the project.	☐
I understand that the confidentiality of the information collected will be maintained, it will be stored securely in locked university offices and computer files will be password protected.	☐
I understand that, during the course of the study, should any unprofessional, or unethical, or unsafe practices be identified, the researcher has a duty to inform the relevant authorities.	☐
I consent to the use of audio taping, with the possible use of anonymous direct quotes in the study report.	☐
I have read and understood the information and I agree to take part in this study.	☐

_____ _____ _____

Name of Participant *Signature* *Date*

_____ _____ _____

Name of Researcher *Signature* *Date*

Appendix H: Participant Demographic Sheet

An Evaluation of County Durham Alcohol Recovery Service (DRAW)

Cover Sheet

Participant Number.....

Please circle as applicable

Gender	Male / Female
Age range	18-25, 26-35, 36-45, 46-55, 56-65, 65+
Time in treatment **prior** to attending DRAW	0-6months, 6months-1 year, 1-2 years, 2-3 years, 3-4 years, 4-5 years, 5-7 years, 7 Years plus
Time attending DRAW	0-6months, 6months-1 year, 1-2 years, 2-3 years,

Appendix I: Interview Schedule – Phase One – DRAW Members

An Evaluation of County Durham Alcohol Recovery Service (DRAW)

Interview Schedule for DRAW Members:

Notes to Interviewer

Introduction and Thank You; provide them with the research information sheet and talk them through the information provided – ensuring it is fully understood.

Advise participant that the interview should last approximately 2 hours. They will not be identified in the report; however I would prefer to record the interview as this helps us to capture exactly what is said. Check that they are comfortable with that.

Ensure the consent form is signed and ask if they have any questions before I start.

Section 1: Background to Attendance at the Community Alcohol Service (CAS) Or Other Treatment Centre		
Question	**Points to Cover**	**Prompt**
Could you explain how you came to seek help for your drinking? What led you to seek change?	Drinking levels? Reasons for drinking – avoid pain / seek pleasure? Time consuming at that level? Been in recovery before? If yes – what changed?	Background
What level of peer or home support did you have then (during treatment / prior to DRAW)	Support network? What led to seeking help / behaviour change? Peer network? Support of a peer mentor?	
Section 2: Service delivery at CAS		
Could you describe the alcohol treatment service you received before DRAW? *Or below*	Correct level of support? Peer support? Visible peer mentor? Attend a local service or prefer to travel? Feelings towards the staff there? Location / venue - Specific to alcohol misuse? Importance of all these aspects? Treatment tailored to individual needs? Family and friends	

	involvement	
Could you explain how you came to attend DRAW?	Time in treatment. Abstinence the focus?	
Can you tell me how your individual recovery pathway was planned for during your treatment stage / CAS?	DRAW introduced ? Attended? AA etc.? Were you given options? (12 steps / SMART etc.) What did you understand of 'recovery'? (empowerment / freedom etc.) . Involved in the planning?	
Was DRAW mentioned to you at CAS? If yes at what point?	Ready for the move? Your choice to attend DRAW? Did it feel like a punishment or gradual progression to move to DRAW? What was it about the notion of DRAW that appealed to you?	Process into recovery
Section 3: Attendance at DRAW / Service Delivery at DRAW		
Can you tell me about your time at DRAW?	Time attending? How often you attend? Location suitable? Peer support – how important is this to you? Presence of a recovery champion? Abstinent throughout time at DRAW?	How is recovery measured? How did your behaviour and attitudes change? Most important part of DRAW for you?
What is it specifically that DRAW offers?	Goal / target setting discussed early in process? Re-visited? Behaviour attitude changing techniques used? Employment opportunities / training How was the training delivered? (useful – ie issues - online courses) Skills developed? Members led / individual involvement? How is your progress tracked / monitored? Training / peer support levels correct? Importance of DRAW being specific to alcohol recovery (i.e. not mixed with drug recovery)?	
Was there anything you felt was missing from the DRAW program?	Anything you would have changed? Location suitable? Attendance at another recovery centre while at DRAW? – If yes – why needed? Out of hours support? (I.e. sponsor?) Social media used?	
Section 4: Current Status / Summing up		
Altogether what would you say recovery means to you?	Recovery mean something different now? (Empowerment / freedom etc.). At what stage would you define 'stable recovery' as? Journey more difficult without DRAW? Involved yourself now as a peer mentor?	Concept of recovery Complete recovery possible?
Can you tell me if you felt there are any barriers present	Was recovery supported right through process from referral to CAS to present day? Travel an	

to recovery in the current CAS / DRAW process?	issue? Services joined up enough? Staff aware enough of concepts of recovery? Individual process catered for?
Have you re-presented (returned) to CAS following attendance at DRAW?	If yes how many times? What happened? Why do thing it happened? Maintained abstinence since? What mechanisms do you now use in times of stress etc.? (Behaviour change / Cognitive thinking process?)
Were you previously involved in any crime prior to attending CAS / DRAW?	If yes have you since? Reasons why there has been no return to crime? Involvement with offender management unit? (positive experience?)
Can you tell me about your employment prior to CAS / DRAW?	Returned to work? New job prospects? Training due to DRAW support?
Could you tell me about you previous education level prior to CAS / DRAW?	Improved through DRAW?
Are you generally positive and hopeful about the future?	If yes - DRAW increased positivity – why? What do you want to do next? (peer mentor / community?)
Is there anything you would like to add?	Or anything you feel is relevant to an evaluation of the service that I haven't asked?

Finally: Thank participant for their time. Remind them how material will be used:

- Once we have completed our interviews with DRAW members, DRAW and CAS staff, the findings will be analysed to identify key issues / research themes. This data will inform a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced. Participants will receive a summary of the findings after the final report has been disseminated if they wish.
- All quotes / opinions will be anonymised – any direct quotation will be attributed to a participant number (e.g. "Participant 1") or a pseudonym will be given.
- Ensure I have the consent form.

Appendix J: Interview Schedule – Phase One – DRAW Staff

An Evaluation of County Durham Alcohol Recovery Service (DRAW)

Interview Schedule for DRAW Staff

Notes to Interviewer

Introduction and Thank You; provide them with the research information sheet and talk them through the information provided – ensuring it is fully understood.

Advise participant that the interview should last approximately 1 hour. They will not be identified in the report; however I would prefer to record the interview as this helps us to capture exactly what is said. Check that they are comfortable with that.

Ensure the consent form is signed and ask if they have any questions before I start.

Section 1: Position at DRAW / referral process		
Question	**Points to Cover**	
Can you tell me about your role at DRAW?	Position held? Role involve? Recovery champion (been in recovery?)	
Can you explain the process of how members arrive at DRAW?	Self-referral accepted? How do you know they are ready to be abstinent? Readiness to change assessment – explain. DRAW available for all? How is confidentiality between CAS and DRAW managed?	
Section 2: DRAW Facilities		

Can you describe what DRAW offers? What techniques are used to encourage behaviour change?	How recovery is supported? Training – education and employment skills? Types of classes? Peer support? Tools used? Sponsors? Out of hours needs? Use of social media	Education skills? Employment opportunities
What do you feel are the most important aspects to recovery?	How does DRAW support these aspects? Empowerment?	
How do you feel DRAW differs from other recovery groups?	What does it offer that is different to say AA? 12 steps used? If not why not? Members encouraged to attend other groups? AA etc. – if yes why is DRAW alone not enough?	AA etc.
Section 3: Members Attendance at DRAW		
Can you describe how members progress at DRAW?	Arrive with clear recovery goals? Knowledge of recovery on arrival? Recovery goals set? Tools used? Social media? Recorded? Goals revisited? If yes how often? Members benefit from attending? Skills developed – educational and employment opportunities Recovery Star / scale?	Recovery star / scale Readiness to change measured how?
How do you know they are progressing / ready to change? How are members that are stuck assisted?		
What level of involvement do members have in devising the program of recovery?	Members led? Group discussion? Tailored to individual needs? How is the balance measured between meeting individual needs and ensuring centre is members led?	
Is there anything you would like to see added to the process?	Any training missing etc.?	
How important is peer support to the recovery process?	Why? How does DRAW enhance this? Importance of visible recovery champion / peer mentor?	Recovery champion presence?
How important do you think it is for the members to be all alcohol only abstinent – rather than mixed with	What issues do you feel may arise from mixing those in recovery?	

those in drug recovery?		
Can you describe the process if a DRAW member returns to alcohol while attending the centre?	Returned to CAS? Supported internally?	
Section 4: Summing up / Barriers		
Do you feel recovery is supported throughout the entire process?	Through CAS and DRAW?	
Do you feel there are any barriers to recovery present within the healthcare system? Do you feel you are trained to deal with all issues that arise in recovery? I.e. Mental Health	If yes where and how could this be improved? Issues regarding service being under review / changing?	
Is there anything else you would like to add?	Any aspects import to recovery or an evaluation of recovery services that I have not mentioned?	

Finally: Thank participant for their time. Remind them how material will be used:

- Once we have completed our interviews with DRAW members, DRAW and CAS staff, the findings will be analysed to identify key issues / research themes. This data will inform a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced. Participants will receive a summary of the findings after the final report has been disseminated if they wish.
- All quotes / opinions will be anonymised – any direct quotation will be attributed to a participant number (e.g. "Participant 1") or a pseudonym will be given.
- Ensure I have the consent form.

Appendix K: Interview Schedule – Phase Two – Service Users

The Service Provision and the Impact of Change on Service User

Interview Schedule for Service User

Notes to Interviewer

Introduction and Thank You; provide them with the research information sheet and talk them through the information provided – ensuring it is fully understood.

Advise participant that the interview should last approximately 2 hours. They will not be identified in the report; however I would prefer to record the interview as this helps us to capture exactly what is said. Check that they are comfortable with that.

Ensure the consent form is signed and ask if they have any questions before I start.

Overarching Question	Sub Questions	Prompt(s)
Can you tell me a bit about the treatment and recovery services you have attended	How does the current service differ to others you have attended?	Attended many services?
	How are ideas of recovery built into the service?	Recovery capital?
	Can you explain how this differs from other services you have used?	Policies / Procedures?
	Do you feel the priorities set by commissioners / service delivery plan matches the needs of people experiencing recovery?	Any issues around the changing of services?

What sort of activities are offered within the service?	What specific activities or ways of treating people are offered within the service? How clear were the interventions to you? How easy do you feel the service delivery plan / tasks / interventions are to adhere to? What value do you feel they offer to the recovery program overall? Are you required to attend all the sessions suggested to you or are you 'free' to drop into as many / as few as you want? Are the interventions delivered within a time frame / or at times suitable to you? How valuable are the interventions? **Do you feel staff are trained efficiently** in what they deliver? Do you feel they believe in what they say? Are recovery champions visible in the centre? How important are these to your everyday life? How do these assist in driving recovery? Do you feel staff have a good enough understanding of recovery to support you fully?	Types of interventions? Set process? Agreement? Guidance? Flexible? Structured? Meaningful? Types of training? Specialist? I.e. Mental health Value of recovery champions
How is recovery progress tracked in services?	How are recovery goals set within the service? How involved were you in setting out your goals?	Flexible – defined by service users? Tools used?

	How are concepts of recovery built into every day delivery of the service? Do you feel this works? Are service users given the opportunity to request what they need from a recovery service? How are recovery goals re-examined / refreshed? What tools do you use to assist with the recording of recovery practices (i.e. alcohol recovery star) How effective is this tool / easy to use? Do staff record your progress? If yes how? What is your understanding of the tool? If you don't feel something is working at the centre do you feel able to make the changes? Are the processes fairly fluid or rigid?	Recovery capital growth Understanding of tool? Usefulness? Flexible? Structured? Offered a voice?
How do you relate to others at the centre – both staff and other service members?	Do staff and other centre members share your ideas regarding recovery? Do you feel staff are involved in setting the service priorities? Do you feel other service users 'buy into' what is being delivered? Do staff have enough time to spend with you? What sort of things do they discuss with you?	Target driven?

Can you tell me what recovery means to you?	What other support do you have / need to sustain recovery? How will you utilise practices developed at the centre in everyday life to continue on your recovery path? What techniques to encourage growth in recovery capital were employed at the centre? How useful were these Are you able to reflect on what has worked / what hasn't at the centre? Do you remain in contact with other service users? What will you hope to achieve from this? What do you hope to achieve in the future? Has the service helped prepare you for that? If yes what specific parts What does recovery mean to you? Is the prospect of 'being recovered' possible?	Visible? Skills developed / coping mechanisms Future? Terminology around recovery
Can you tell me how changes in the service provision affected your recovery?	How did changes to service affect you personally? What impact did this have on our recovery? How has changes in service provision effected you? Impact on recovery Do you feel commissioners / service managers value the importance of peer support / recovery champions? How was information about the changes in service described to service users?	Shared ethos of service? Impact on recovery Offered a voice?

	What involvement were you asked to provide? Are you and other service users asked for regular feedback about what the centre delivers? Do you feel this feedback is taken on board? Are you asked your opinions about the commissioning process and what a recovery service should look like? What would you change if you could?	

Finally: Thank participant for their time. Remind them how material will be used:

- Once we have completed our interviews, the findings will be analysed to identify key issues / research themes. This data will inform a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced. Participants will receive a summary of the findings after the final report has been disseminated if they wish.
- All quotes / opinions will be anonymised – any direct quotation will be attributed to a participant number (e.g. "Participant 1") or a pseudonym will be given.
- Ensure I have the consent form.

Appendix L: Interview Schedule – Phase Two – Service Manager

The Service Provision and the Impact of Change on Service User

Interview Schedule for Service Manager

Notes to Interviewer

Introduction and Thank You; provide them with the research information sheet and talk them through the information provided – ensuring it is fully understood.

Advise participant that the interview should last approximately 1 hour. They will not be identified in the report; however I would prefer to record the interview as this helps us to capture exactly what is said. Check that they are comfortable with that.

Ensure the consent form is signed and ask if they have any questions before I start.

Overarching Question	Sub Questions	Prompt(s)
Can you tell me a bit about the treatment and recovery services you have worked at	How does the current service differ to others you have worked in? How are ideas of recovery built into the service? Can you explain how this differs from other services you have worked in? Do you feel the priorities set by commissioners / service delivery plan matches the needs of people experiencing recovery?	Attended many services? Recovery capital? Policies / Procedures? Any issues around the changing of services?
What sort of activities are offered within the	What specific activities or ways of treating people are offered within the service?	Types of interventions?

service?	How clear do you feel the interventions are for service users? How easy do you feel the service delivery plan / tasks / interventions are to deliver? What value do you feel they offer to the recovery program overall? Are service users required to attend all the sessions suggested or are they 'free' to drop into as many / as few as they need? Are the interventions delivered within a time frame / or at times suitable to service users? How valuable are the interventions? **Do you feel staff are trained efficiently** in what they deliver? Do you feel they believe in what they say? Are recovery champions visible in the centre? How important are these to recovery? Do you feel staff have a good enough understanding of recovery?	Set process? Agreement? Guidance? Flexible? Structured? Meaningful? Types of training? Specialist? I.e. Mental health Value of recovery champions
How is recovery progress tracked in services?	How are recovery goals set within the service? How involved are service users in setting goals? How are concepts of recovery built into every day delivery of the service? Do you feel this works?	Flexible – defined by service users? Tools used? Recovery capital growth

	Are service users given the opportunity to request what they need from a recovery service? How are recovery goals re-examined / refreshed? What tools do you use to assist with the recording of recovery practices (i.e. alcohol recovery star) How effective is this tool / easy to use? Do staff record progress? If yes how? What is your understanding of the tool? If you don't feel something is working at the centre do you feel able to make the changes? Are the processes fairly fluid or rigid?	Understanding of tool? Usefulness? Flexible? Structured? Offered a voice?
How do you relate to others at the centre – both staff and other service members?	Do staff and other centre members share your ideas regarding recovery? Do you feel staff are involved in setting the service priorities? Do you feel other service users 'buy into' what is being delivered? Do staff have enough time to spend with service users?	Target driven?
Can you tell me what recovery means to you?	What other support do you feel is needed to sustain recovery? What techniques to encourage growth in recovery capital were employed at the centre? How useful were these	Visible? Skills developed / coping mechanisms

	Are you able to reflect on what has worked / what hasn't at the centre? What does recovery mean to you? Is the prospect of 'being recovered' possible?	Future? Terminology around recovery
Can you tell me how changes in the service provision may have affected the recovery of service users?	How did changes to service affect you personally? What impact did this have on job security How has changes in service provision effected you? Do you feel commissioners / service managers value the importance of peer support / recovery champions? How was information about the changes in service described to service users? What involvement were you asked to provide? Are you and other staff members asked for regular feedback about what the centre delivers? Do you feel this feedback is taken on board? Are you asked your opinions about the commissioning process and what a recovery service should look like? What would you change if you could?	Shared ethos of service? Impact on recovery Offered a voice?

Finally: Thank participant for their time. Remind them how material will be used:

- Once we have completed our interviews, the findings will be analysed to identify key issues / research themes. This data will inform a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced. Participants will receive a summary of the findings after the final report has been disseminated if they wish.
- All quotes / opinions will be anonymised – any direct quotation will be attributed to a participant number (e.g. "Participant 1") or a pseudonym will be given.
- Ensure I have the consent form.

Appendix M: Interview Schedule – Phase Two – Service Commissioner

The Service Provision and the Impact of Change on Service User

Interview Schedule for Service Commissioner

Notes to Interviewer

Introduction and Thank You; provide them with the research information sheet and talk them through the information provided – ensuring it is fully understood.

Advise participant that the interview should last approximately 1 hour. They will not be identified in the report; however I would prefer to record the interview as this helps us to capture exactly what is said. Check that they are comfortable with that.

Ensure the consent form is signed and ask if they have any questions before I start.

Overarching Question	Sub Questions
Can you tell me a bit about your background – prior to becoming a service commissioner?	How did the services you worked in differ (if relevant)? What models of treatment / recovery did you experience within these services? How were service users guided through the services?
Could you talk me through the commissioning service process?	What aspects do you consider most important in a service provision bid? What threads need to run through any recovery service provided? I.e. in a constant change of flux is there a model in the middle that remains?

	How are ideas of recovery built and embedded into the service? Encouraged within the service? Did you feel the priorities set by commissioners / service delivery plan matches the needs of people experiencing recovery?
What mechanisms do you feel are important to instigate change?	What were the ingredients to encourage change within the previous models commissioned (Lifeline) What do you think went wrong in the Lifeline model? I.e. model for change / service provision worked but economics didn't? What are the ingredients to encourage change in the current model?
Can you tell me what recovery means to you?	What other support do you feel is needed to sustain recovery? What techniques to encourage growth in recovery capital do you feel should be considered? Are you able to reflect on what has worked / what hasn't in previous services? What does recovery mean to you? Is the prospect of 'being recovered' possible?

Finally: Thank participant for their time. Remind them how material will be used:

- Once we have completed our interviews, the findings will be analysed to identify key issues / research themes. This data will inform a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced. Participants will receive a summary of the findings after the final report has been disseminated if they wish.

- All quotes / opinions will be anonymised – any direct quotation will be attributed to a participant number (e.g. “Participant 1”) or a pseudonym will be given.
- Ensure I have the consent form.

Appendix N: Participant Debrief Sheet

An Evaluation of County Durham Alcohol Recovery Service (DRAW)

Debrief Sheet

Chief Investigator: Samantha Level

I would like to take this opportunity to once again thank you for your participation and to reiterate a few aspects from the introduction.

The purpose of the study is to examine what DRAW has offered each individual in terms of assisting in their recovery journey – basically what DRAW has offered you. Staff - Or how you feel recovery is supported within the treatment / recovery pathway and what barriers exist

What if there is a problem?

If you have a concern about any aspect of the study, you should contact me and I will do my best to answer your questions. Contact details are provided at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this via writing to Prof Luke Vale at the Institute of Health and Society, Newcastle University, Baddiley-Clark Building, Richardson Road, Newcastle, NE24AX

Confidentiality Your involvement in this study is confidential – all the information you have given me will be recorded as interview 001 for example – your name will not be associated with the data. For some of the writing a pseudonym may be used for narrative purposes.

The results of the research study will be used to form part of my Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University.

If you would like feedback from the interview than I will be happy to send you a synopsis once all the data has been analysed.

How can I get further information?

If you would like any further information, please do not hesitate to contact me:

Samantha Level
FUSE (The Centre for Translational Research in Public Health)

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Appendix O: Transcription Guide

Transcription Guide

Verbatim transcription used which includes repeated words and phrases such as ‘er’

Lines of transcription were numbered in chronological order

Interviewer = I

Participant = IV / R

Each transcription included date of transcription and participant number (as stated by researcher at the beginning of recording)

And concluded with End of transcription / audio