LEARNING TO LIVE AGAIN: AN EXPLORATION OF AN EX-SERVICE USER LED PROJECT FOR ALCOHOL ADDICTION RECOVERY

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For my good friend Alex and my Auntie

Abstract

Background and rationale: This thesis explores the impact of attendance and participation at an ex-service user led project in Leeds for alcohol dependency. This thesis is important for two reasons. First, in the last few years, UK drug and alcohol policy has implemented a strategy that aims to facilitate full recovery from drug and alcohol dependency. Further research is needed to explore and understand the issues surrounding addiction recovery. Second, a scoping review of the literature found a significant lack of UK based studies exploring the impact of attendance and involvement at self-help groups for addiction recovery.

Methodology and Methods: A qualitative, ethnographic methodology was used to gain a holistic understanding of the Learning to Live Again project (hereafter LTLA). A convenience sample of service users, mentors and professional staff who attended or were involved with the project was recruited. Participant observation was conducted at the project in order to gain greater familiarity with the project, followed by semi-structured interviews with those involved with the project. Data were analysed through a thematic framework approach. The data were interpreted and explained based on the theoretical assumptions of symbolic interactionism.

Findings: The main finding was that the LTLA project provides service users with a recovery project that facilitates recovery on both an individual and collective level. The culture of abstinence and the peer support service users had access to, appeared to facilitate recovery by providing service users with a recovery project that is built on firsthand experience of addiction recovery. However, the data also demonstrated that some service users remain connected to their addiction through their 'over-involvement' with the LTLA project.

Conclusions: This thesis contributes to the understanding of how and why attendance at an ex-service user led project for alcohol dependency impacts on recovery, and contributes to the UK evidence base on research in this area. The themes identified in this thesis lay the foundation for future research and further contributes to the understanding of recovery in UK drug and alcohol policy.

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Authors declaration

I declare that I designed and conducted the research reported in this thesis and that it has not been submitted for a degree in this, or any other institution. To the best of my knowledge, this thesis does not contain material that has been published or written elsewhere by another person, except where acknowledgement and due reference is made in the text. With the exception of data collected and reported in this research, the views and opinions expressed in this thesis are my own and do not represent any other person or institution. Thomas James Parkman September 2013.

Chapter 1

Introduction

1.1 Why recovery?

After 25 years over which reducing harm has been the underlying guiding principle (Stimson, 2010), recovery has become a central focus for policy, research and practice (Home Office, 2010; Malloch & Yates, 2010). However, this recent *re*-emergence of recovery (Berridge, 2012; Measham, Moore & Welch, 2013) as an organising idea and ambition for national drug policy and the treatment of alcohol dependency (Roberts & Bell, 2013) is fraught with a number of complex, often contested issues. These are issues in which many people such as those in recovery, researchers, academics and policy makers, have great investment. Given this point, there is a need to understand how this central strategic drive is reflected and interpreted at the local level. This research examines the Learning to Live Again project (hereafter LTLA project), an *aftercare* program run by ex-service users to help service users maintain their commitment to abstinence in order to further their recovery from alcohol dependency (further context provided in section *1.2*). In the substance misuse field there is strong evidence to support the effectiveness of aftercare, as it is considered a key component of effective treatment (Ito & Donovan, 1986) and has been found to have a significant influence on long-term recovery outcomes (Moos, Finney & Cronkite, 1990). Some commentators however, argue that it remains a neglected component of drug treatment services (McLellan et al., 2000).

Presently, the evidence base that specifically evaluates the impact of recovery-focused interventions and their efficacy in terms of outcomes for different cohorts of service users is small (White, 2000; White et al., 2012; Yates & Malloch, 2010). There is a growing need to understand whether, how and why self-help groups (hereafter SHGs) impact on addiction recovery through qualitative methodologies (Advisory Council on the Misuse of Drugs, 2013

(hereafter ACMD); Neale, Nettleton & Pickering, 2013), as there is currently a lack of a nuanced understanding of how these alternate recovery paradigms operate and function (White, Kelly & Roth, 2012; ACMD, 2013). For example, in a literature review conducted by Measham, Moore and Welch (2013), the importance of associated recovery concepts such as 'recovery communities', 'recovery capital' and 'recovery identities' are highlighted as important domains of recovery and more research is needed to understand how and why these concepts impact on service users in recovery. In the UK, there is paucity of empirical (both quantitative and qualitative) and academic knowledge on the impact of SHGs for substance addiction and the use of peer-led support structures, as alternative, viable recovery paradigms (ACMD, 2012). Furthermore, there is a lack of empirical, academic research on how national drug policy shapes local drug services (Measham, Moore & Welch, 2013) and the extent to which service users actually engage with available recovery services (Ti, Tzemis & Buxton, 2012).

This thesis therefore, aims to address the gap in the evidence base and make a significant contribution to the understanding of an underdeveloped field (ACMD, 2012). The literature review (described in chapter *2*) highlighted the lack of qualitative research on SHGs for substance addiction, particularly in the UK. This study therefore, uses a qualitative methodology and methods to understand the LTLA project, a SHG for alcohol dependency and the impact it has on recovery. Examples of such impacts include the focus on abstinence and the effects this has on service users, as well as the use of 'mentors' (ex-service users) to run the LTLA project, both of which have implications for the current drug strategy (see section *1.4*). By doing so, it will be possible to examine how their recovery trajectories have been impacted on by their attendance at a recovery-orientated intervention. The use of symbolic interactionism in this thesis will explore 'self' and identity transformation in recovery and how such self-reflexive processes are impacted on by attendance at a recovery-orientated intervention. Furthermore, symbolic interactionism will provide a theoretical lens through which recovery and its associated concepts such as recovery communities, recovery capital and recovery identities can be understood. To the best of my

knowledge, this is the first piece of research that utilises the theoretical assumptions of symbolic interactionism to explore a recovery-orientated intervention in the UK. The LTLA project forms the focus of the study. It is important to outline the aims of this project in order to provide contextual detail for the study.

1.2 Local Context

The consequences surrounding the implementation of new drug policy are likely to be impacted on by the political, socio-economic and cultural climate in which drug policy is created (Monaghan, 2012). It is important therefore, to note that the LTLA project was conceptualised and implemented in a time of major global economic turmoil. In the UK, severe austerity and financial restraints were being implemented to combat a recession, which resulted in widespread and ongoing public sector budget cuts in the criminal justice system, health, welfare, social care and education sectors (Measham, Moore & Welch, 2013). This has arguably led to significant reforms in the structure and commissioning of drugs services across the UK (Home Office, 2010).

It should be stated up front that the rise in mutual aid groups is not the result of the current economic climate and implementation of severe austerity measures, but the product of a substantial scientific evidence base (NTA, 2013). The National Institute for Health and Care Excellence (hereafter NICE) and ACMD both found that mutual aid strengthens community integration, develops recovery capital and through peer support, provides individuals with meaningful relationships and positive social networks (NICE, 2012; ACMD, 2013). These are both reports built on the amalgamation of existing evidence on mutual aid. This is further discussed in section *1.4*, but it is important to state that the deployment of the LTLA project is one that is very much in line with not just drug policy, but empirical evidence also.

The LTLA project is situated at the Leeds Addiction Unit (hereafter LAU) in Leeds, a city in West Yorkshire with a population of 751,500 of whom 81% are White British (as of March 27th, 2011) (Office for National Statistics, 2012

(hereafter ONS). The LAU is part of the Leeds and York Partnerships NHS Foundation Trust (as of the 1st August 2007), a Trust that provides specialist mental health and learning disability services to people within Yorkshire. More specifically, the LAU works collaboratively with a large number of different stakeholders including service users, the Universities of Leeds and York, commissioners and both local and national service providers. The role of the LAU is to provide assessment, treatment and aftercare to those who misuse drugs and/or alcohol and have complex health and social care needs.

The LTLA project describes itself as an *aftercare* programme for people who have completed 'formal' treatment in the LAU and is run by ex-service users for current service users. The 'ex-service users' are referred to as 'mentors' and are akin to the 'community recovery champions' proposed by the Coalition's drug strategy (Home Office, 2010). They are people who have made considerable strides in their recovery, have long-since moved on from professional support and are now 'giving something back' in the form of peer support for those who still require support and advice in their recovery.

Whilst concerns have been raised about the use of ex-service users running mutual aid programs, primarily because it could place them in difficult positions or put them at a level beyond their skill set (Shapiro, 2012), this does not appear to be the case here. As it will become clear in the findings chapters (see chapter *5*, *6*, and *7*), the mentors are a group of people who not only run the project, but also benefit from it. The opportunity they have to support and provide advice to others appears to be an almost invaluable source of recovery capital for the mentors, which in turn, facilitates their own recovery.

Two clinical directors of the LAU first set up the LTLA project in 2008[1], based on the guiding principles of *co-production*. The National Institute for Health and Clinical Excellence (2008) (hereafter NICE) define 'co-production' as:

[1] Chapter *5* provides a more detailed description of the history of the LAU and the LTLA project and how service users are referred from the LAU to the LTLA project.

> *"the process whereby clients or service users work alongside professionals as partners to create and deliver services"* (NICE, 2008; p. 39).

The LTLA project is comprised of ex-service users (the mentors) who work with professional staff from the LAU to deliver an abstinence-based service. The aim of the LTLA project is to help people who have made a commitment to abstinence or who have achieved a level of control over their alcohol use and are ready to move on with their lives. The LTLA project is centred on getting people involved in leisure activities such as going to the gym, joining organised walks or day trips, or visiting places of local interest. The activities take place at any point during the week, including evening activities such as going to the opera or weekend activities such as 'Recoveryfest' (see section *5.4.4*). It is important to note that whilst the LTLA project is set up to help any individual with any substance misuse problem, in reality, it is primarily those suffering with alcohol dependency that attend the LTLA project. During this study, there were no individuals that joined the LTLA project who were recovering from a primary substance of misuse other than alcohol. As a result, this study focuses solely on those recovering from alcohol dependency and will be referred to as a project that aims to help those with 'alcohol dependency', as opposed to 'substance dependency'.

Given that the LTLA project was first set up in 2008, two years prior to the advent of the current drug strategy, the LTLA project preceded the recent wave of recovery projects that have appeared around the country (Roberts & Bell, 2013) and was considered by its founders to represent a project 'ahead of its time'. The LTLA project therefore, offers an example of a recovery project that has 'bedded in' and is less susceptible to the changes of aims, structure and personnel that are frequently associated with new initiatives. However, the LTLA project and its approach have not been evaluated and research is therefore needed to understand how the LTLA project has evolved since its inception, and how it may be impacting on 'recovery' of service users. In addition to local context, there is a need to explore issues surrounding the complex relationship between addiction and recovery, the definition of recovery, UK drug and alcohol

policy, as well as key concepts such as 'recovery communities', 'recovery capital' and 'recovery identities'.

1.3 Addiction, dependency, recovery and abstinence: The contestable nature of language

Before the complexities surrounding the definition of recovery can be explored, there is a need to briefly explore the concept of addiction and how it relates to the concept of recovery in this thesis. The American Society of Addiction Medicine (hereafter ASAM) define addiction as an:

> *"… inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response."* [ASAM, 2011]

There is no one clear way to define addiction. Understanding addiction is further complicated by its (incorrect) interchangeable use with the term 'dependency'. 'Addiction' for example, refers to a behavioural syndrome whereby the procurement of drugs dominates an individual's motivation (Booth Davis, 2007), whereas 'dependency' refers to a state whereby an individual is dependent on drug or alcohol for *normal* physiological functioning (Addiction Science, 2014). Furthermore, 'addiction', particularly 'alcohol addiction' and its associated language (for example, the term 'alcoholic'), is often laden with stigma and is considered by many in mainstream society to be a 'dirty word' (Dean & Poremba, 1983), which can have detrimental implications for those labelled 'alcoholic' in recovery.

Definitional and literary complexities surrounding 'addiction' can have implications for the relationship between addiction and recovery, as different substances are often attributed with different recovery interventions (Marlatt, Larimer & Witkiewitz, 2012). This thesis is concerned with alcohol. Given the extensive costs and consequences that surround alcohol dependency, interventions have historically focused on abstinence-orientated, intensive,

specialised treatment services for dependent individuals (Morse & Flavin, 1992; Willenbring, 2010). Abstinent-orientated interventions are further reinforced by the influence (that still exists today) of the disease model of (alcohol) addiction, which has its roots in Alcoholics Anonymous (Larimer et al., 2012; see also *chapter 2*). This model enforces the classical articulation that alcoholism is a lifelong disease that can only treated through the total abstention from alcohol (Larimer et al., 2012). Ultimately the language that surrounds 'addiction', 'dependency', 'recovery' and 'abstinence' (described below) are high contestable, therefore making it important to state exactly what is meant by terms used throughout this thesis.

This thesis is concerned with ***alcohol dependency***, as the mentors and service users encountered during this research stated am implicit need for alcohol in order to function 'normally'. The term *alcohol dependency* is also used (as opposed to 'alcohol addiction'), as it is a less stigmatised term and serves to reduce the impact of the disease model of addiction. As it has been alluded to, the concept of 'recovery and 'abstinence' are also contestable, even more so recently given their prominence in UK drug policy.

The rise of recovery is not necessarily a new emergence, but can be seen as a *re*-emergence of the concept (Berridge, 2012; Measham, Moore & Welch, 2013). Recovery is a concept that has been a central feature of many voluntary action schemes and mutual/peer support groups (Mold & Berridge, 2010) such as Alcoholics Anonymous (hereafter AA) and 12-step programmes, for over a century. Furthermore, Berridge (2012) writes, the concept of recovery has a long-standing history in relation to substance addiction with its prominence as a model of understanding often tied to the changing political, socio-economic and cultural climate of the time.

Recovery is increasingly being placed at the forefront of UK drug policy (Home Office, 2010). For many, abstinence is at the heart of this 'recovery revolution' (White, 2007), an approach which some have seen as a direct response to harm reductionism (McKeganey, 2012). This however, is a contested

view given that evidence suggests that specific harm reduction interventions have a place in the wider context of recovery (Measham, Moore & Welch, 2013). Despite this resurgence of recovery as a viable, sustainable approach to combating drug and alcohol addiction, the debate continues about what recovery is understood to *be* (Hacking, 1999). This debate is arguably the product of the resurgence in interest of recovery.

The Betty Ford Institute (2007) (hereafter BFI), a panel made up of those in recovery, addiction experts and policy makers, defined recovery as:

> *"voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship"* (BFI, 2007; p. 222).

They go on to define sobriety as *"abstinence from alcohol and all other nonprescribed drugs"* (BFI, 2007; p.222). This however, raises complex issues surrounding the concept of abstinence. As Measham, Moore and Welch (2013) explain, abstinence is a definitional *"can of worms"* (Measham, Moore & Welch, 2013; p. 10), as it could be desisting from *all* use of *all* psychoactive drugs and alcohol or it could mean abstention from just the primary problem drug. Furthermore, there are time implications that pose difficulties for abstinence, as recovery could be *"complete and enduring"* (White, 2007; p. 232) or *"sustained deceleration of the frequency and intensity of AOD* [alcohol and other drugs] *use"* (White, 2007; p. 232). In White's (2007) definition of recovery, abstinence incorporates both those who are completely abstinent, as well as those who maintain a decelerated, controllable level of use. White (2007) suggests that defining recovery requires more nuanced categories than 'abstinent' or 'not abstinent' and proposes that abstinence can be conceived as:

> *"…full recovery without secondary drug use, recovery with subclinical secondary drug use, and partial recovery marked by drug substitution"* [White, 2007; p. 233).

This definition of abstinence suggests therefore, that for some, 'total abstinence' is not always required for recovery, but that substitute prescription drugs or subclinical use (non-problematic use) should be considered as appropriate outcomes for abstinence and recovery. For example, an individual who is maintaining a controlled, non-problematic level of use and making strides toward social (re)integration would not be classified as 'in recovery' by the BFI (2007) definition, as they have not made a commitment to total abstinence, but would be classified as 'in recovery' based on White's (2007) definition. Abstinence like recovery therefore, is a much contested topic and viewing it as an absolute, as the BFI (2007) do, is perhaps short-sighted given the complexities and gradients which could be conceivably considered under the term 'abstinent'.

A definition of recovery that moves beyond abstinence is that prepared by the UK Drug Policy Commission (2008) (hereafter UKDPC), a board of senior figures from policing, policy makers and experts from the field of addiction research:

> *"The process of recovery from problematic substance use is characterised by voluntarily maintained control over substance use, which maximises health and well-being and participation in the responsibilities and benefits of society"* (UKDPC, 2008; p. 6)

In their definition, the UKDPC (2008) acknowledge that *control* is the key to recovery, as it is through control that one has power over the use of problematic substances. Granfield and Cloud (1999) state that 'control' implies non-problematic use and enables an individual to maintain stability and social integration (Granfield & Cloud, 2001). The UKDPC (2008) acknowledge that controlled use, as well as total abstinence are viable outcomes for recovery, thus eliminating any alienation of those who are aiming for non-problematic use in recovery, or those who are in medically-assisted recovery.

Importantly, like the BFI (2007), the UKDPC (2008) also acknowledges the importance of health, wellbeing and social (re)integration back into society. These concepts are important as both the BFI (2007) and the UKDPC (2008) understand that abstinence is not the only desirable outcome in recovery, but physical and psychological health and wellbeing and socially (re)integrating are also important outcomes in recovery.

Building on the UKDPC, the Home Office (2010) offer a definition of recovery as part of their drug and alcohol policy entitled *"Reducing demand, restricting supply, building recovery: supporting people to live a drug free life"* (Home Office, 2010). The Home Office (2010) define recovery as:

> *"Recovery involves three overarching principles – wellbeing, citizenship, and freedom from dependence. It is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people"* (Home Office, 2010; p. 18)

Like the UKDPC, the Home Office (2010) reinforce the importance of 'wellbeing', 'citizenship' and 'freedom from dependence' (akin to 'control'). Importantly, the Home Office (2010) explicitly acknowledges that 'freedom from dependence' can also include medically-assisted recovery and that for many, this is a viable route for recovery. The Home Office continued their push for a recovery-orientated approach in their latest policy paper entitled *"Putting Full Recovery First"* (Home Office, 2012). In it, they state that the Coalition government has set out its *"aspiration to challenge status quo and build a recovery-orientated society"* (Home Office, 2012; p. 3). They continue to state that:

> *"full recovery* [will] *improve outcomes for everyone* [and will] *shake up the status quo of heroin addiction… by achieving full recovery in many more cases will become the current norm* [and] *will not only save lives, reduce drug-related deaths, minimise harm and prevent blood borne viruses, but we will see people living in a stable families enjoying the personal freedom the majority of us experience"* (Home Office, 2012; p. 5)

The latest policy document outlined by the Coalition government has created a considerable amount of upset, particularly amongst harm reductionists. In response to 'Putting Full Recovery First', the UK Harm Reduction Alliance (2012) (hereafter UKHRA) provide a public statement in which, they provide a number of key arguments against 'full recovery'. First, the UKHRA (2012) propose that predetermined treatment goals such as 'full recovery' are arbitrary, unethical and ineffective, as recovery service provision should be *"client-led and empowering, not predetermined by policy document"* (UKHRA, 2012; p. 3). The UKHRA (2012) argue that by focusing on recovery, other outcomes are overlooked, as a *"one-size fits all abstinence goal"* (UKHRA, 2012; p. 3) is imposed on a vastly diverse population of people suffering with addiction problems. The UKHRA (2012) argue that putting 'full recovery' first implies all other goals are secondary. They site the evidence that supports the use of needle and syringe exchange programmes and opioid-substitution therapy (hereafter OST) as effective public health responses. They argue that this would threaten patient wellbeing, as alternative interventions that have proven to be effective would be overlooked. Finally, the UKHRA (2012) argue that focusing on recovery could waste scarce resources and become cost ineffective, especially if relapse rates rise due to the potentially unrealistic goal of abstinence being forced upon people.

In reality, 'putting full recovery first' is perhaps an unrealistic outcome for many with addiction problems. For many people battling severe and complex addiction problems that span an array of issues, such as overcoming dependency, physical and psychological health, unemployment, social wellbeing and homelessness for example, recovery is an outcome that not only seems unrealistic, but is likely to be unattainable.

It is important to note that whilst there may be differences between the selected recovery definitions presented here, there are also similarities. For example, all the definitions outlined above suggest a long-term concept best conceptualised as a *process* of overcoming alcohol and/or drug dependence, as

well as achieving improved health and wellbeing and aiming to become a part of society once again (ACMD, 2012). Nevertheless, recovery is an incredibly sensitive topic of debate, which has arguably become more contentious given its current prominence in policy. Recovery is an emotionally charged topic for many people who have become involved with the debate (and indeed all those in recovery), as they represent visible examples of people physically and psychologically living with their addiction and their recovery on a daily basis. It is also now a politically charged topic given its position at the heart of current drug and alcohol strategies. Recovery is therefore, a complex and often contested issue. Gaining a unified definition of what recovery is understood to *be* (Hacking, 1999) is a key focus for research and policy makers as it in turn, could shape which interventions are considered appropriate and effective (Measham, Moore & Welch, 2013). Understanding the contested nature of recovery (and abstinence) is vitally important for this thesis, as both have a central role in the LTLA project.

1.4 UK drug policy: *"Building recovery"*

As already outlined in section *1.1*, recovery has become a central organising idea and ambition for national UK drug and alcohol policy (Malloch & Yates, 2010; Roberts & Bell, 2013). Continuing on from section *1.3*, this section develops the concept of recovery in the context of UK drug policy, outlining the specific features of the Coalition government's drug strategy (2010) that are pertinent for this research. Roberts and Bell (2013) state that there has been a change in focus from harm reduction to recovery for three reasons.

First, there is a long history in the drugs and alcohol field of approaches to recovery being built on a foundation of lived experiences of people afflicted with addiction issues, and the ability of these people to provide support for one another. This suggests that recovery-orientated projects that are based on peer support can provide an alternative, viable route out of recovery. Second, the proliferation of methadone maintenance and OST led to many commentators and politicians (particularly the Conservatives) claiming that the drug strategy under New Labour may have been very effective at getting people into treatment, but

failed when moving them on from treatment (Roberts & Bell, 2013). A move away from hard reduction and toward recovery therefore, was seen as a way to help people move on from professional treatment and live a life free of addiction. Third, the focus on recovery has been supported by the notion of social (re)integration through housing and employment schemes, an approach which first came to light in the drug strategy proposed by Gordon Brown's New Labour party (Home Office, 2008). The Coalition's drug strategy develops the idea of social (re)integration, as well as highlighting the importance of addressing stigma and discrimination that flow from addiction, which could have a detrimental impact on 'recovery capital' (described below) and social (re)integration (Lloyd, 2010). Many commentators have welcomed the latest drug strategy, as it is deemed to provide a balanced vision that reflects consensus, particularly with its focus on recovery being a 'person centred journey' that will differ between individuals (Roberts & Bell, 2013).

Of particular importance for this research is the drug strategy's focus on 'recovery capital', a concept derived from the work of Cloud and Granfield (2008) and 'community recovery champions'. Both of these concepts make up key policy initiatives that are aimed at facilitating people to achieve and sustain abstinence and recovery. According to Cloud and Granfield (2008), there are four types of 'recovery capital': **social capital** (resources gained from a recovering individual's relationships, family and friends), **physical capital** (tangible resources such as property and money), **human capital** (personal resources such as skills, training or qualifications) and **cultural capital** (values, beliefs and attitudes relating more broadly to society and behaving in a way that is congruent with the societal norms in which they reside) (Cloud & Granfield, 2008; Home office, 2010).

'Community recovery champions' are defined in the strategy as being those already in recovery who are encouraged to help and support others in their recovery (Home Office, 2010). The re-emergence of recovery has seen a new role for both volunteer and peer mentors within drug and alcohol treatment services (National Treatment Agency for Substance Misuse, 2010) (hereafter

NTA). Peer led support is considered central to recovery-orientated interventions (Best et al., 2010), as its provides the opportunity for those more experienced in recovery to 'give something back' in the form of knowledge and experience (NTA, 2010) and offer visible examples of recovery (NTA, 2012). However, there are some who argue against the use of mentors, as it leads to a deprofessionalisation process that undermines and devalues existing professional staff (Best et al., 2010). Furthermore, there are ethical concerns surrounding the eligibility of potentially unqualified staff working with vulnerable people, despite their experience (Measham, Moore & Welch, 2013).

It is important to state that the aforementioned drug policy that focuses on recovery, recovery capital, the use of mutual aid programs and 'community recovery champions' is not political ideology, but an approach that is 'evidence-informed'. The term 'evidence-informed' has been used (as opposed to 'evidence-base'), as it allows for a degree flexibility when considering the evidence base upon which policy is produced (Toner et al., 2014). Unlike 'evidence-based' policy that is based on more rigid hierarchies of evidence rooted in formal, positivistic research (Williams & Glasby, 2010), 'evidence-informed' policy allows for guidelines to be produced based on broader research views (Nutley, Walter & Davies, 2007). This is in an important distinction, as the evidence that supports the 're-emergence' of recovery (Berridge, 2012; Measham, Moore & Welch, 2013), the value of recovery capital and mutual aid (see chapter 2), as well as the potential importance of 'community recovery champions' is not only based on quantitative research, but also a considerable amount of interpretivsitc knowledge that draws on experiential and interactional evidence (Toner et al., 2014). This is important as policy often crosses departmental boundaries[2], which evidence-based policy is less able to address, as it is usually aimed at targeting a specific research question set within a specific research context. There is no clear ruling on what constitutes sound evidence for policy making (Bennett & Holloway, 2010), but the evidence-informed approach that underpins

[2] For example, Toner et al., (2014) state that alcohol policy is relevant to the Department of Health, the Home Office, the Department of Culture, Media and Sport, the Department of Trade and Industry and the Treasury (and other government departments).

the current Coalition's drug strategy, implies a strong evidence base for the LTLA project.

Despite some of the concerns and criticisms that surround the latest drug and alcohol strategy (UKHRA, 2012), the LTLA project and their guiding principles appear to be very much in line with a number of key initiatives outlined in the Coalition drug strategy. Both identify the importance of recovery capital and consider recovery to be a person centred journey, which could mean different things to different people. The use of an inspirational workforce and the importance of building supportive social networks are evident in both national and the LTLA project's policy on recovery. Finally, both acknowledge the importance of not just overcoming dependence, but also the need to socially reintegrate into mainstream society. These are all findings reinforced by empirical evidence (ACMD, 2013).

When the wider recovery movement is considered, the LTLA project represents a group that was 'ahead of the (policy) curve'. This is best exemplified by the fact that the recent boom in recovery and the implementation of recovery-orientated services (Evans & White, 2013) did not take centre stage until 2010, with the LTLA project being implemented in 2008. Today, the number of mutual aid groups in the UK for substance dependency is rising, as they represent services that enable individuals to continue to practice their recovery (ACMD, 2013) and in the current economic climate, represent a cost effective way of continuing long-term recovery (Zarkin et al., 2005). This is a trend that has been seen in a number of other third sector areas, as the number of people volunteering across organisations increased by 6% between 2011 and 2012 (Cabinet Office, 2013).

Significant strides have been made since the publication of the Coalition governments drug strategy in 2010, with clinical dimensions of recovery being understood more fully (Roberts & Bell, 2013). The current focus on recovery in UK drug and alcohol policy provides a platform for future development of policy that is focused on recovery (Roberts & Bell, 2013). It provides a platform for the

continuing debate that pits abstinence against harm reduction, which could in turn, provide greater clarity to understand and define recovery (see section *1.3*).

Two important conclusions can be drawn from this section on UK drug policy. First, based on the LTLA project, it shows that national policy initiatives are being implemented on a local level. For example, the centrality of recovery and abstinence, the use of mentors and the desire of the LTLA project to facilitate the development of recovery capital for its service users by providing them with activities in mainstream society, all demonstrate national initiatives being implemented at a local level. This conclusion is further supported by research that has identified other recovery projects akin to LTLA that are being implemented across the county of Yorkshire (Best, Knowles & Morell, 2010). Second, given that the LTLA project was implemented in 2008 and the Coalition governments drug strategy was not published until 2010, it demonstrates that the LTLA project was actually implementing recovery-focused initiatives such as 'community recovery champions' prior to their appearance in national policy. This thesis therefore, affords the possibility of examining how some of the central tenets of current government policy play out in a project, which has had some time to mature.

1.5 Structure of this thesis

This thesis is presented in eight chapters; the first of which is this introduction. The second chapter is a literature review that explores the impact of SHGs for alcohol dependency. Whilst it primarily focuses on US based AA and associated 12-step programs, it does highlight a number of issues with the UK evidence-base on SHGs. In doing so, the relevance of this research is located in the context of the wider international literature and supports the main aim and objectives of this research. The third chapter outlines the theoretical framework that has been used to provide a lens through which to understand the LTLA project. This chapter includes an overview of the guiding principles of symbolic interactionism and how such a theoretical stance will be used to understand the culture of the LTLA project, as well as how the project impacts on individual identity.

Chapter four outlines the methodology and methods used to collect data in this research. There is an in-depth justification of the methodology adopted in this research, followed by a detailed description of the methods used to collect data, with a focus on sampling, data generation and data analysis. The focus of chapters five, six and seven are the findings. Chapter five looks specifically at the history of the LAU and the LTLA project, how service users get referred from the LAU to the LTLA project, the culture of the project, its goals, the name of the project and the activities. Chapter six explores the impact of the project on the individual. There is an exploration on the identity of the LAU and the LTLA project and how such an identity impacts on service users, how the project facilitates a 'normal' identity, the identity of recovery and the identity of being a mentor. Chapter seven explores the collective impact of the LTLA project and how being part of the project is beneficial to the individual, as well as the wider group. There is an exploration of the importance of firsthand experience in recovery, stigma and the non-stigmatising culture of the LTLA project as well as the importance of peer support and how the project addresses feelings of boredom and instils a sense of structure through the activities. There is also a discussion on power and how the project is set up in such a manner that may inadvertently induce power tensions.

Chapter eight provides further consideration of the findings of the research and discusses these in relation to other relevant literature. The contribution of this research from a theoretical and methodological point of view is also discussed. There is also a reflection on the strengths and limitations of the theory, methodology and methods used in this research, the implications this research has for policy and practice and suggestions for future research. There is a final concluding section.

Chapter 2

Self-help groups for alcohol addiction recovery: A scoping review

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2.1 Introduction

In this chapter, a detailed literature review of those studies that explored the impact of any SHG for alcohol addiction is given. Despite a considerable literature on SHGs for addiction recovery, the reason for focusing on SHGs for alcohol dependency is because the LTLA project deals primarily with those who are recovering from alcohol dependency (see section *1.2*). Before the methods and findings of this review can be outlined, there is a need to justify why this scoping review was undertaken, and why a scoping review was chosen over a systematic review.

2.1.1 Justification and rationale for this scoping review

The justification for this scoping review stems from the need to know more about the spread and impact of SHGs on alcohol addiction. Currently, there are reviews that have investigated key research findings specifically related to AA (Straussner & Byrne, 2009), the effectiveness of AA and other 12-step programmes in reducing alcohol intake (Ferri, Amato & Davoli, 2006), meta-analysis of the quality of studies that investigate AA outcomes and their statistical power (Tonigan, Toscova & Miller, 1996) and the effectiveness of 12-step programs for maintaining abstinence (Fiorentine, 1999). Furthermore, there are literature reviews that explore the spread of SHGs globally (Humprheys, 2004), the benefit of the social networks formed within SHGs for alcohol addiction recovery (Groh, Jason & Keys, 2008) and the need for SHGs for adolescents with alcohol addiction problems (Sussman, 2010), but no known, up-to-date review has investigated the impact of how and why all known SHGs might be beneficial for alcohol addiction recovery. There have been no known reviews that explore more broadly, the impact of SHGs on alcohol recovery. Such

a review is crucial to locate this thesis within the existing knowledge. A scoping review was chosen over a systematic review for several reasons.

Unlike systematic reviews, there is no set method for undertaking a scoping review (Arksey et al., 2002). One of the major reasons for conducting a scoping review is to 'map' the literature that currently exists in a given field (Mays, Roberts & Popay, 2001) and to identify gaps in existing evidence (Arksey & O'Malley, 2003) that will inform my research aims and objectives (see section *2.6.1*). Scoping reviews are typically used in cases where there are broad topics with many different study designs (Arksey & O'Malley, 2003). Given the large amount of data that is available in this area, in conjunction with the plethora of study designs used, conducting a scoping review made it possible to include a considerable breadth of information on the topic. A scoping review also allows for a more comprehensive overview of all the studies located during the search, regardless of study design. Thus, the present scoping review did not seek the 'best evidence' (Slavin, 1995), but instead all the relevant evidence that pertains to the efficacy of SHGs for alcohol addiction recovery, in order to provide the best 'map' possible to understand the existing literature, and how this thesis 'fits' within the existing knowledge base. A systematic review was not chosen for two reasons.

First, systematic reviews are concerned with reducing bias from included studies through the use of explicit methods to perform a comprehensive, critical appraisal of individual studies (Crowther, Lim & Crowther, 2010), and are typically concerned with quantitative evidence gained from randomised control trials (Littell, Corcoran & Pillai, 2008). Given that this review included qualitative studies and was not concerned with reducing bias of included studies, but more concerned with presenting the breadth of data that is available on alcohol addiction SHGs, a scoping review was more appropriate. Second, from an analytical point of view, systematic reviews synthesise all the data from identified studies in order to address a specific research question (Littell, Corcoran & Pillai, 2008). Given that this review does not attempt to synthesise the data from each study in order to answer a specific research question relating

the effectiveness of SHGs for alcohol addiction recovery, a systematic review was not the best approach. The nature of this scoping review meant that a more thematic analysis to the findings could be employed to interpret and report the study findings.

2.2 Methods

The main aim of this thesis is to address the following question: **What is known from the existing literature about the *impact* of SHGs for alcohol addiction recovery?**

Whilst this scoping review has not been 'systematic', a rigorous and comprehensive approach to identifying relevant studies has been undertaken in order to be as transparent and thorough as possible (Centre for Review and Dissemination, 2001; Mays, Roberts & Popay, 2001). Each stage of this review was fully documented in order to ensure it could be replicated by others, thus ensuring its methodological rigour (Mays, Roberts & Popay, 2001; Arksey & O'Malley, 2003). The remainder of this section will address four key areas:

1. Identifying relevant studies;
2. Inclusion and exclusion criteria;
3. Data extraction;
4. Analysis of the findings

2.2.1 Identifying relevant studies

In order to identify all the relevant studies for this scoping review, a threefold search strategy was used, each of which shall be explained in turn. All located papers were downloaded or entered into Endnote X6.0.1 ™ [3] according to pre-defined inclusion and exclusion criteria (outlined in section *2.2.2*). Due to the number of papers that were located within this review, Endnote X6.0.1 ™ facilitated a more effective management of the papers throughout the scoping review.

[3] Endnote is a computer software package that stores, manages, organises and searches bibliographic references.

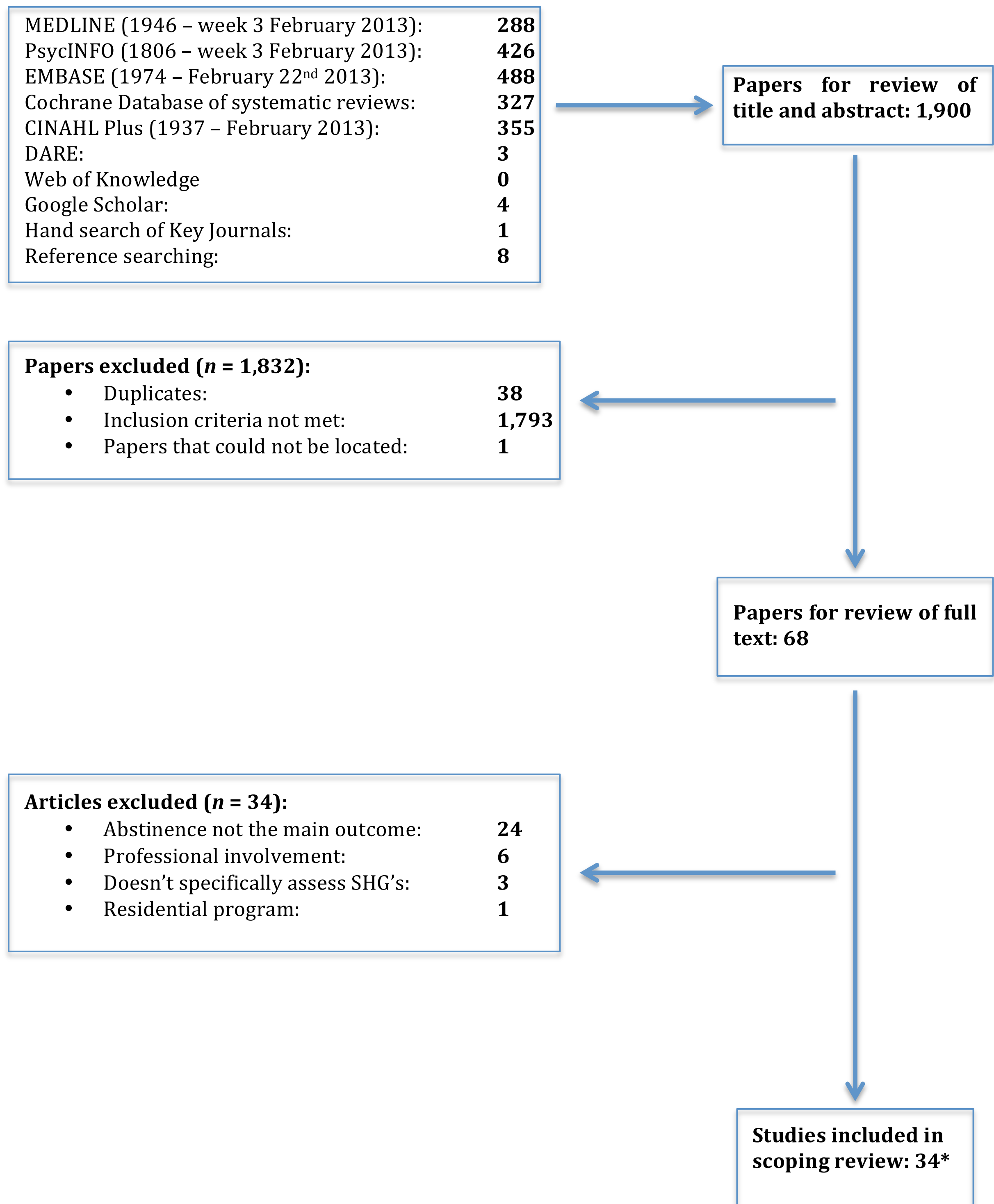
2.2.1.1 Search strategy

The first search strategy involved searching electronic databases. The electronic databases that were searched for this scoping review were:

- MEDLINE (1946 – February week 3, 2013);
- PsycINFO (1806 – February week 3, 2013);
- EMBASE (1974 – February 22nd, 2013);
- CINAHL Plus (1937 – February 2013);
- The Cochrane Database of Systematic Reviews;
- Database of Abstracts of Reviews of Effects (DARE);
- Web of Knowledge;
- Google Scholar (first 15 pages)

Prior to conducting the electronic database search, an information specialist in the NHS Centre for Reviews and Dissemination (hereafter CRD) at the University of York was consulted in order to ensure the search string used in this scoping review was comprehensive and inclusive enough to ensure as many relevant papers as possible were located (see appendix *1* for the complete search string used for each database). Figure *2.1* (see following page) represents a consort flow diagram of the search strategy in which, the number of papers collected via electronic databases can be seen.

Figure 2.1: A consort flow diagram of the search strategy



***See appendices *2*, *3*, *4* and *5* for full details**

The search strategy for electronic databases was restricted to three areas:

- Studies relating alcohol addiction SHGs only;
- Studies relating to abstinence only;
- Studies relating to SHGs

These three areas were selected based on the focus of this thesis. First, this scoping review focuses on alcohol addiction specifically as the LTLA project is an aftercare program that primarily addresses alcohol addiction. Whilst there is an extensive and very important literature on the impact of SHGs on illicit drug use, that literature will not be addressed here, as illicit drug use plays no part in this thesis. It is important to note that some of the studies explored in this review did investigate an impact of SHGs on illicit drug use, but this was provided as auxiliary information that supplemented the impact of SHGs on alcohol addiction. Information on illicit drug use will not be referred to. Second, focusing on studies that explored the impact of SHGs on abstinence is justified, as the LTLA project is an abstinence-based program. Like the literature on illicit drug use, there is an extensive literature that explores the impact of SHGs on other drinking-related outcomes such as moderated or controlled use. However, given that the LTLA project focuses solely on abstinence, the focus of this scoping review shall be on those studies that explore the effect of SHGs on abstinence as the primary outcome. Finally, the rationale for focusing on SHGs is because the LTLA project is run by ex-service users, not professional staff or any other individual who has not recovered from alcohol addiction, therefore any study investigating these aftercare programs would not be applicable for this scoping review. As figure *2.1* demonstrates, electronic databases yielded the majority of results (*n* = 1,891/1,900).

The second search strategy technique involved hand searching key journals. Whilst electronic databases offer a search avenue to a huge array of papers, they may be incomplete or potentially inaccurate (Arksey et al., 2002). As a result, hand searching of the following journals was undertaken:

- Addiction;
- Alcohol and Alcoholism;
- Journal of Substance Abuse Treatment;
- Drug and Alcohol Dependence;
- Alcoholism Treatment Quarterly.

These journals were selected as 'key journals' to search as they were the top five journals from which the majority of the papers identified from the database came. Each journal was searched back to 1980. The reason for searching back to 1980 is because the oldest paper located in the database search was Hoffman, Harrison and Belille (1983). This process generated one new study that had been missed during the search of the electronic database (see figure *2.1*). The final search strategy technique was hand searching the references and bibliographies of relevant studies.

Relevant studies were identified based on predefined inclusion and exclusion criteria (see section *2.2.2*) that were applied to all studies located via electronic databases or the hand searching of key journals. After applying these criteria, a total of 60 potentially relevant studies were located and downloaded/requested in full from the University of York's interlending library service. Each of these 60 studies reference lists and bibliographies were then checked to locate any further studies that may have been missed during the electronic database and key journal search. The reference list and bibliographies of any relevant systematic or scoping reviews located in the initial electronic database search were also searched (n = 4). This process did generate 8 new references (see figure *2.1*), although a saturation point was reached where no new references were being achieved. In total, 68 potentially relevant studies were identified. All studies identified via hand searching were added to Endnote X6.0.1 ™ and located in full.

2.2.2 Inclusion and exclusion criteria

Inclusion and exclusion criteria were applied to all 1,900 studies that were written in English that represented a 'best fit' (Arksey et al., 2002) with the central review question: **What is known from the existing literature about the *impact* of SHGs for alcohol addiction recovery?**

2.2.2.1 Inclusion Criteria:

- **Study Type:** empirical work (quantitative or qualitative) that explored the impact of SHGs for people suffering with alcohol addiction[4]. Any study design was included;
- **Intervention Type:** 12-step, SHG or any aftercare program that is led by recovering alcohol users/has no professional involvement;
- **Outcome:** only studies that assess abstinence from alcohol addiction as their primary outcome;
- **Recipient Group:** any individual of any age, race or ethnicity, in any geographical location that was attending a SHG for alcohol addiction.
- **Language:** only English studies were included

2.2.2.2 Exclusion Criteria:

- **Study Type:** any study that was not specifically assessing alcohol addiction as its primary outcome;
- **Outcome:** any study that did not assess abstinence as their primary outcome (such as harm reduction, controlled drinking or quality of life measures);
- **Nature of the reference:** policy papers, reviews (systematic or scoping) [5], theoretical papers, commentaries, dissertations and theses;
- **Language:** non-English studies were excluded.

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[4] Note: any study that compares SHGs with control groups or other cohorts of individuals are included, as they serve to show how recovery is impacted on by attendance at a SHG in comparison to other groups.

[5] As it was stated above, reviews were used for reference searching but were excluded from the current review.

After the inclusion and exclusion criteria were applied, 68 potentially relevant studies were obtained in full. Once the full reports were obtained and read, a further 34 studies were excluded as they did not meet the pre-defined inclusion criteria (see figure *2.1*). In total, 34 studies were therefore included in this scoping review (see appendices *2*, *3*, *4* and *5* for full details of the included studies in this scoping review). Having identified 34 relevant studies for this review, it was important to extract the data from each study.

2.2.3 Data extraction

The data extracted for each study could be separated into demographic and design information. Appendix *2* and *3* illustrate the demographic information for the quantitative and qualitative studies respectively. Demographic details include the following information:

- Authors (including year of publication);
- Study Location;
- Study sample (percentage of males and females);
- Mean age of the sample;
- Race/Ethnicity;
- Mean Marital Status;
- Mean Years in Education;
- Mean Employment Status;
- Substance of focus.

Appendix *4* and *5* illustrate the design information for the quantitative and qualitative studies. Design details include the following information:

- Sample size;
- Sample Origin;
- Research design (or 'Qualitative Approach' for the qualitative studies);
- Instrument of assessment.

Taking both types of information together, these data formed the basis of the analysis.

2.2.4 Analysis of the findings

A thematic analysis approach was employed to collate, interpret and report the data. Given the large amount of data that was gained from the studies, a thematic analysis approach provided the most robust and efficient process to analyse *all* of the data from the included studies. The 34 included studies were first separated by their methodological approach (quantitative or qualitative) and are reported on separately. Within the quantitative studies (n = 27), the studies were divided into two categories:

- Those that investigated 'AA and/or 12-step' SHGs (n = 25);
- Those that investigated 'non-AA, non-12-step affiliated' SHGs (n = 2).

It is important to state that throughout all the findings of this scoping review, only basic statistics such as mean values, total 'N', percentages and relevant 'p-values' and odds ratios are quoted to either demonstrate a statistically significant effect or not. However, a full report of statistical analyses of the papers are provided in appendix *6*.

The qualitative studies (n = 7) were analysed individually, and later compared and contrasted with one another, and the quantitative studies explored in the previous sections. Quotations are included from some of the papers to reinforce the points being made, which also allows for deeper analysis of the qualitative data. There is also an analysis section on those qualitative studies that were excluded, and their reason for exclusion. Having established how the studies were located, the type of data that was extracted and how the studies were analysed, the findings of the studies can be presented.

2.3 Findings of the scoping review

Table *2.1* (see following page) represents a schematic version of all the studies (both quantitative and qualitative) identified during this scoping review, the methodology they employed and the themes with which each study explores. Note that the 'study number' corresponds to the relevant study identified during this review in appendices *2* and *3*. The first part of the findings will explore the quantitative studies (n = 27), of which there are two parts. The first section will explore the studies that relate specifically to AA and/or 12-step programmes (n = 25). This section is further split into four sections: 'attendance', 'involvement', 'location' and 'composition of the social network', each of which will be discussed in turn. The second part of the quantitative findings will explore those studies that are categorised as 'non-AA, non-12-step affiliated' SHGs (n = 2). The final part of the findings will explore the qualitative studies identified during this scoping review (n = 7).

Table 2.1: The methodology and themes of studies in this scoping review

	Methodology		Primary Outcome Investigated				
Study Number	Quantitative	Qualitative	Attendance	Involvement	Location	Composition of social network	No effect
1	•					•	
2	•		•				
3	•		•				
4		•	•				
5		•				•	
6	•					•	
7	•		•				
8	•		•				
9		•		•			
10	•		•				
11		•	•				
12	•					•	
13	•		•			•	
14	•		•				
15	•			•			
16	•		•				
17		•	•				
18	•				•		
19	•				•		
20	•		•				
21	•		•				
22	•						•
23	•					•	
24	•		•				
25		•		•			
26	•			•			
27	•		•				
28	•		•				
29	•		•				
30		•				•	
31	•		•				
32	•		•				
33	•		•				
34	•					•	

2.3.1 The importance of AA and/or 12-step attendance

Of the 25 studies that make up this section on quantitative studies that investigate the impact of AA and/or 12-step programs, 64% (n = 16) investigate the impact of attendance on abstinence rates. As it will become apparent, 'attendance' across the studies often differs. Some studies (typically the earlier ones) investigate the impact of attendance verses non-attendance, whereas other studies typically employ a more sophisticated methodology to investigate attendance along different time periods (for example, attendance at 3 months

compared to at six, nine and twelve months). Given this methodological disparity between studies, the level of attendance will be reported for each study.

2.3.1.1 Attenders verses non-attenders: A straightforward association

The studies outlined in this section are some of the earliest studies that were found from this review. Through the use of fairly simple methodological designs, they demonstrate a basic association between attenders and non-attenders and its impact on abstinence. McBride (1991) found that continuous attendance at AA was positively correlated with more months of abstinence (n = 50; p < 0.001), and that the number of months since joining AA was also positively correlated with months of abstinence (p < 0.001). In the earliest study identified for this scoping review, Hoffman, Harrison and Belille (1983) found that frequency of attendance at AA and abstinence was found to be statistically significant (n = 900; p < 0.0001), suggesting that those who attend AA are more likely to maintain abstinence than those who do not. However, given the much larger sample size used in this study compared to McBride (1991), the findings perhaps carry more weight. Thurstin, Alfano and Nerviano (1987) found similar results but also found that frequency of attendance at AA was only significant at 18 months (n = 145; p < 0.05). These findings suggest that an individual must attend AA for a minimum of 18 months in order to experience positive effects related with attendance. However, given that the questionnaire used to collect data was devised by the authors, in conjunction with a sample that was amalgamated based on those who already attended AA, the results of the study are perhaps contentious.

It is important to note the limitations of these studies. Whilst these studies do demonstrate a positive association between attendance and abstinence, their methodological rigour and validity perhaps raises questions about the veracity of their findings. McBride (1991) and Hoffman, Harrison and Belille (1983) used self-designed questionnaires and Thurstin, Alfano and Nerviano (1987) did not report their method of data collection. The studies in the following section use a more detailed and rigorous methodology during their

investigation, and build upon the work outlined in this subsection by disaggregating attendance into more refined timeframes. This allows for a closer inspection of the different rates of attendance on abstinence.

2.3.1.2 A closer analysis of attendance on abstinence

The studies explored in this section continue on from those explored in the previous section by deconstructing attendance more intricately, and conducting more complex statistical analysis over a longer period of time, which offers further evidence for the association between attendance and abstinence. Cross et al. (1990) found that increased attendance at AA had beneficial outcomes on abstinence. Using a multiple stepwise regression, regular AA attendance was found to be a moderately significant predictor of the number of years of abstinence over a ten-year period of follow ups (n = 158; $p < 0.05$). Furthermore, 91% of those who remained sponsors (those who acted as primary forms of peer support to new service users) during the follow up period reported complete or stable remission, which suggests the importance of active involvement (discussed in section *2.3.2*). Snow, Prochaska and Rossi (1994) also found that frequency of AA attendance (low, medium or high) was found to be a moderately significant predictor of long-term abstinence (n = 191; $p < 0.05$). Gossop et al. (2003) found that those who attended AA on a weekly or more frequent basis reported drinking less frequently than those who attended less frequently or not at all (n = 150; weekly or more often: mean = 8.8 days; less than weekly: 17.3 days; not at all: 19.2 days; $p < 0.05$) and reported drinking in lower amounts (measured in single units of alcohol) ($p < 0.05$) during the 30 day period prior to follow up at six months. These studies demonstrate therefore that the impact of attendance on abstinence appears to be complex, and that different rates of attendance are associated with different rates of abstinence.

Tonigan and Beatty (2011) found in their investigation that there was a temporal relationship between 12-step attendance and subsequent substance use. They found that in a sample of 189 AA attenders that 81.5% (n = 154) attended a 12-step meeting between 0-3 months; 70.4% (n = 133) attended between 3-6 months; 61.9% (n = 116) attended between 6-9 months and 56.6%

(n = 106) were still attending AA after one year. During this time, reported alcohol use fell from 100% (n = 189) at baseline to 56.1% at 12 months (n = 106). Time-lagged hierarchical linear models also found that frequency of 12-step attendance significantly predicted reductions in percentage days of alcohol use ($p < 0.001$) and drinks per day ($p < 0.018$) over 12 months. Frequency of attendance also predicted alcohol abstinence ($p < 0.001$).

In the most recent study of this scoping review, Pagano et al. (2013), as part of the Project MATCH study, also confirmed that increased attendance at AA meetings was associated with reduced alcohol use (n = 226; $p < 0.01$). Interestingly they also found that attendance resulted in greater involvement in Alcoholics Anonymous helping activities, which was also found to have significant direct effects on substance use ($p < 0.05$). This is discussed in greater detail in section *2.3.2* but it indicates that those attending more often are more likely to actively participate in specific activities that facilitate recovery. This suggests that attendance is highly important, as it gives individuals the opportunity to participate compared to those who do not attend.

In their study investigating the longitudinal effects of different rates of SHG attendance on substance use, Kissin, McLeod and McKay (2003) found that SHG attendees could be divided into 5 categories: 'continuous attendees' (16%, n = 121) (those who met the criteria for attendance at baseline: 6 meetings per month at 6 months and endpoint); 'starters' (26%, n = 199) (those who did not meet criteria for attendance at baseline but did at endpoint); 'stoppers' (13%, n = 103) (those who met the criteria at baseline but not at endpoint); 'non-attendees' (19%, n = 146) (those who attended fewer than 6 meetings per month at baseline, 6 months and endpoint); and 'intermittent attendees' (26%, n = 203) (those who attended irregularly during the study period). 'Continuous attendees' and 'starters' were the only groups to significantly decrease their alcohol use at 6-month follow up (total n = 722 $p < 0.005$). This implicates the importance of starting a SHG immediately after inpatient treatment ('continuous attenders'), as well maintaining attendance over an extended period of time ('continuous

attenders’ and ‘starters’), as ‘stoppers’, ‘non-attendees’, and ‘intermittent attendees’ showed no significant sign of alcohol reduction.

Kaskutas et al. (2005) found that attendance rates could be subdivided into four categories: 'low' (n = 174), 'medium' (n = 63), 'high' (n = 71) and 'declining' (defined as those starting with high attendance but declined over the study period) (n = 41) based on their AA attendance at 1-year following treatment. A comparison of abstinence rates for the groups was significant (p < 0.0034). At the 5-year follow up, the 'low' group had significantly lower abstinence rates than the 'medium' group (p < 0.002), the 'declining' group (p < 0.003) and the 'high' group (p < 0.001). In a comparative longitudinal follow up study over seven years, Kaskutas, Bond and Ammon Avalos (2009) found that abstinence was lowest amongst the 'low AA group' (n = 371; averaging fewer than five meetings at each follow up point) and highest amongst the 'high AA group' (n = 58; averaging 200 meetings in year 1, then slowly declining over 7 years). Despite the steep decrease in AA in attendance in the 'descending AA group' (n = 67; 150 meetings in year 1, then declining steeply) and the gradual decrease in the 'high AA group', abstinence did not decline at the same rate, but remained fairly stable over the 7 years with approximately 75% of each group reporting abstinence in both of these groups. Only approximately 30% were abstinent at 7 years in the 'low AA group' and 60% in the 'medium AA group'. These two studies by Kaskutas and colleagues (2005; 2009) suggest therefore that those who attend AA more frequently, and for longer periods of time, are associated with better rates of abstinence than those who attend less frequently.

McKellar, Stewart and Humphreys (2007) found a significant effect of one-year AA involvement on 2-year alcohol problems (n = 2,319; p < 0.001) suggesting that more alcohol-related problems were the consequence of decreased AA attendance. This study suggests therefore, that more favourable outcomes are associated with increased attendance. Whilst it is difficult to state with any certainty a definitive causal link, the large sample size used in this study provides evidence that perhaps attendance at AA for one year does have positive outcomes for abstinence at two years.

In an international comparison of Swedish and US men and women attending AA, Witbrodt and Romelsjo (2010) found that in the Swedish and US samples, both male and female SHG attendance was positively correlated with abstinence (total n = 2,451; Sweden: $p < 0.0001$; USA: $p < 0.0001$). Similarly, Witbrodt and Delucchi (2011) found that greater AA attendance was associated with abstinence for both genders, but men were less likely to be abstinent overall (men verses women coefficient = -0.057; n = 926), which remained stable across the 7 year follow up periods. The final study in this section replicates previous findings but also raises an important point that has implications for interpreting rates of attendance.

Witbrodt et al. (2012) managed to divide their participants into six attendance trajectories: 'high' (n = 457) (continued high attendance); 'descending' (n = 220) (start with high attendance but descends during the study period); 'rising' (n = 93) (start with low attendance but rises over the study period); 'early-drop' (n = 291) (start with high attendance but rapidly drop over study period); 'low' (n = 154) (continual low attendance); and 'no' (n = 608) (never attend) attendance. Approximately 75% of those in the 'high' attendance group reported abstinence in the 30 days prior to each follow up. Those in the 'descending' (57%) and 'early-drop' (53%) attenders reported abstinence in the 30 days prior to follow up at 5, 7 and 9 years. Individuals in the 'high' attendance class had significantly better abstinence outcomes than all other attendance groups ($p < 0.003$). However, perhaps more importantly than these findings is the fact that Witbrodt et al. (2012) also found that the ‘high’ attendance groups had the lowest levels of ‘non problematic users’ compared to the ‘early drop’ and ‘no’ attendance groups ('early-drop' class = 11%, 14% and 12% with non-problematic use at 5, 7 and 9 years; 'no' = 13%, 12% and 11% with non-problematic use at 5, 7 and 9 years; 'high' = 2%, 3% and 3% with non-problematic use at 5, 7 and 9 years). This suggests therefore, that despite the ‘high’ attendance group having the most amount of problematic alcohol users, it still had the best abstinence outcomes, thus providing strong evidence of an association between attendance and abstinence. More broadly, the implications

of these findings are important for making inferences about the relationship between attendance and abstinence.

Whilst all the studies described in this section have demonstrated a positive impact of attendance on abstinence, there is one study that found no effect between these two variables. Mueller et al. (2007) set out to investigate if SHG attendance after alcohol detoxification enhanced rates of abstinence. Using participants from a placebo arm of a larger randomised control trial assessing the effects of various pharmaceutical interventions on alcohol use (participants were therefore not randomised or subjected to pharmaceutical medication), participants chose themselves to attend either AA or another 12-step programme once a week for six months, or no attendance at all. In total, 50 attended a SHG and 28 chose not to attend at all. With the exception of a slightly lower relapse rate after one month, there was no significant difference for abstinence rates between SHG attenders and non-SHG attenders after one year. However, the small sample size suggests that the results are less likely to be statistically significant. Whilst this study does not infer a positive effect of attendance on abstinence, the other studies described in this section represent a body of evidence that would suggest a positive relationship between SHG attendance and abstinence from alcohol. The next section to be explored is the impact of *involvement* on AA and/or 12-step SHGs and the impact that has on abstinence.

2.3.2 The impact of involvement

Of the 25 studies that explore the impact of AA and/or 12-step programmes on abstinence, 8% (*n* = 2) explore the impact of active involvement when at AA and/or a 12-step SHG for alcohol addiction. 'Involvement' relates specifically to actively getting involved when attending a SHG.

In a study by Sheeran (1988) investigating the relationship between relapse and involvement in AA, it was found that a number of specific activities were correlated with better outcomes. Sheeran (1988) divided the participants into two groups: those who reported less than 2 years continued abstinence

(group 1; n = 10) and those who reported more than 2 years continuous abstinence (group 2; n = 37) (participants from AA groups across Chicago). Group 2 scored better in all measures of involvement: 1) the number of AA meetings (mean = 4.32 verses 4.3); 2) working the steps of AA (mean = 4.43 verses 3.9); 3) using a sponsor (mean = 3.92 verses 2.8); 4) reaching out to AA members when in need of help (mean = 4.05 verses 2.9), 5) assisting others in 12-step work (mean = 3.43 verses 2.9); 6) involvement in meetings (mean = 4.62 verses 4.4) and 7) studying AA literature (mean = 4.14 verses 3.5). There was a statistically significant effect of having a sponsor ($p < 0.001$) and reaching out for help ($p < 0.05$). Furthermore, both groups were subdivided into two further subgroups: those involved with AA for 3-6 years and those involved for 7-10 years. Group 1 stated a shorter time of involvement (mean = 6.25 years verses 8.64 years for group 2). For the 3-6 year involvement in both groups, group 2 scored higher on all domains, with 'having a sponsor' and 'reaching out' both being significant. Group 1 scored higher on measures 1 (number of AA meetings attended), 2 (working the steps of AA), 5 (assisting others in 12-step work) and 6 (involvement in meetings) for the 7-10 year comparison but group 2 still significantly scored higher on measures 3 (using a sponsor) and 4 (reaching out to AA members for help).

These findings imply therefore that active involvement in the form of having a sponsor, reaching out for help and reading the literature correlate with significantly better outcomes. These findings however, should be interpreted with caution as they are based on retrospective self-report of service users, therefore meaning the data they report may be inaccurate, thus leading to potentially false or over-exaggerated findings. However, a counter to this argument is the replication of Sheeran's (1988) findings by Kingree and Thompson (2011). Kingree and Thompson (2011) found that for a sample of 268 participants, those who had a sponsor at three months were 2.69 times more likely to be abstinent than those without a sponsor. These findings have been confirmed elsewhere in specific investigations looking at the effect of having a sponsor in AA (Tonigan & Rice, 2010).

These studies demonstrate that participating in specific activities is associated with improved rates of abstinence and recovery. These are important studies as they implicate the importance of increased involvement in recovery. For those who continue to actively participate in specific activities in the form of being a sponsor, reading the literature, being involved in service work and calling other members for advice, a positive association is seen with rates of abstinence and recovery. Whilst many of the studies only show a positive association with attendance and abstinence, these studies arguably go one step further by suggesting that prolonged, active involvement is necessary to facilitate abstinence and recovery and that just attending is not enough. The third theme to be explored is the impact of AA and/or 12 step programme location, and the effect that proximity has on abstinence.

2.3.3 Location

Of the 25 studies that investigated the impact of AA and/or 12-step programmes on abstinence, 8% ($n = 2$) investigated the impact of AA or 12-step programmes locality in relation to abstinence rates. 'Location' refers specifically to the geographical location of AA and/or 12-step SHGs and how a closer proximity to an AA and/or 12-step SHG seems to produce more favourable recovery and abstinence outcomes. In a study of men attending AA in India, Kuruvilla, Vijayakumar and Jacob (2004) found that distance from AA ($n = 174$; $p < 0.030$) and the presence of a keyworker in the area ($p < 0.011$) were significant predictors of abstinence. Relative risk calculations also found that males who lived closer to the location where AA was conducted were 1.27 times more likely to be abstinent and 1.35 times more likely to be abstinent if a keyworker lived in their area.

A study conducted in the US (Laudet, Stanick & Sands, 2007) found similar results when comparing those who attended a 12-step group 'on-site' at the hospital where individuals received inpatient treatment compared to those who attended a 12-step program off-site. Laudet, Stanick and Sands (2007) found that the TSO clients (those who attended the 12-step group on-site) had significantly higher rates of attendance and higher rates of involvement at each

of the follow up points (n = 122; 3 months: 66% verses 45.1%, $p < 0.01$; 6 months: 50% verses 33.3%, $p < 0.05$; 12 months: 36.1% verses 24.6%, not significant) than the N-TSO participants (n = 97; those attending 12-step groups off-site). Furthermore, the TSO group had significantly higher rates of abstinence since their previous interview at all follow ups than N-TSO participants ($p < 0.001$). TSO participants were also 5.79 times more likely than the N-TSO group to have maintained abstinence for the entire year ($p < 0.001$). To conclude, whilst there are only two studies in this section, they do highlight the beneficial importance of easily accessible SHGs. Laudet, Stanick and Sands' (2007) study in particularly implicates the importance of having a SHG on the same site as inpatient treatment.

2.3.4 Composition of social network

Of the 25 studies that investigate the impact of AA and/or 12-programmes on abstinence, 24% (n = 6) investigated the composition of social networks on abstinence. This section explores specifically the influence of a recovering individual's social network and how having a social network comprised of individuals who encourage a reduction in drinking patterns, seems to facilitate more favourable recovery and abstinence outcomes. Social networks refer to the composition of an individual's entire social network that includes people from both inside SHGs, as well as non-addicted family members and friends.

Kaskutas, Bond and Humphreys (2002) investigated the mediating effect of social networks on AA members. They found through logistic regression that prior to follow-up, the likelihood of 30-day abstinence after AA involvement was 3.50 (n = 654; $p < 0.00001$), which went down to 2.94 ($p < 0.00001$) when social network influences were introduced, a consequence of their social networks being comprised of individuals who were still actively drinking. This is supported by their finding that pro-drinking influences in the social network significantly reduced the likelihood of abstinence ($p < 0.01$). Factoring in support from people they met at AA, each individual was 3.4 times likely to be abstinent at 30 days prior to the follow up ($p < 0.001$). At 90 days, 33% of people with no

support were abstinent, which went up to 45% with non-AA based support and 72% with support from AA members. These findings indicate that not only is support from non-drinking individuals important, but that support form those in recovery is the best mediator of subsequent abstinence.

Bond, Kaskutas and Weisner (2003) found that those who interacted with people who encouraged the individual to reduce their drinking were significantly associated with a 90-day-abstinence status (n = 655; $p < 0.01$) for both follow up periods (1 and 3 years). Those who had support from other AA members had proportionately higher abstinence rates (1-year: 36.6% verses 14.3%, $p < 0.001$; 3-years: 15.6% verses 5.8%, $p < 0.001$). Logistic regression found that for paired analysis (baseline and 1-year follow up and 1-year and 3-year follow up), increased attendance, those with fewer heavy drinkers in their social networks and those with proportionately more contacts who encourage a reduction in drinking were significantly more likely ($p < 0.001$) to be abstinent in the 90 days prior to follow up. For the baseline-1-year paired model, those with AA-based support were significantly more likely ($p < 0.03$) to be abstinent than those who had non-AA support. Statistically significant odds ratio's showed that those with less heavy drinkers ($p < 0.01$), more people who encouraged a reduction in drinking ($p < 0.01$) and AA-based support ($p < 0.05$) were more likely to be abstinent at both follow ups.

Referring back to Kaskutas et al. (2005) (see section *2.3.1.2*) they found that in a sample of 349 recovering drinkers, the number of heavy drinkers in the 'high' and 'medium' AA attendance groups were similar (approximately 1 person), for the 'low' group it was 2 heavy drinkers and for the 'declining' group it was 3 heavy drinkers in their social networks. At baseline, all four groups had a similar number of individuals who encouraged a reduction in drinking (3 or 4 persons) which increased at follow up to 7 people in the 'low' and 'declining group, 9 for the 'medium' group, and 12 for the 'high' group. These numbers declined in all groups at 5 years but the 'high' and 'medium' groups still had the most (approximately 4 people). Forty-six percent of the 'low' group reported abstinence in the 30 days prior to every follow up and 66% for the 'medium'

group across all follow-ups. These studies suggest therefore, that the composition of a recovering individuals social network plays a key mediating role in abstinence outcomes. Pagano et al. (2004) however, demonstrated that not only are the social composition of networks important, but that helping others when in the social network also plays a key contributing role to abstinence and recovery.

Pagano et al. (2004), using Project MATCH data found that at 3 months, 8% ($n = 120$) reported helping other problem drinkers through endorsement of the 12-step approach (82% of the 120) or being a sponsor (23% of the 120). Those who helped others prior to treatment were significantly related to helping others at the end of follow up ($p < 0.0001$). There was a positive correlation between the status of helping other problem drinkers and the total number of AA meetings attended ($p < 0.0001$). Using Kaplan-Meier survival analysis, those helping others at the end of treatment were significantly less likely to relapse in the 12 months following treatment than those who did not help others ($n = 120$; $p < 0.0001$) with 40% of helpers maintaining abstinence in the year following treatment (compared to 22% of non-helpers). Proportional hazard regression analysis also showed that the hazard of relapse for helpers was significantly less ($p < 0.009$) than those who did not help ($p < 0.126$ (not significant)).

The question that needs addressing; is what is it specifically about helping others that furthers one's own recovery? To answer this, Zemore, Kaskutas and Ammon (2004) found that helping others was positively correlated with sharing experiences of abstinence ($r = 0.24$), sharing experiences about other problems ($r = 0.18$), and giving moral support and encouragement ($r = 0.18$). Whilst a significant positive element of this study is that it begins to delve into the fact that helping others does seem to help the individual, there is still a paucity of knowledge on *why* and *how* helping others seems to help the individual. These are questions that could be addressed by qualitative research.

In addition to social networks being comprised of non-users or non-substance dependent individuals, Fiorentine and Millhouse (2000) also found

that having professional staff involved with social networks in conjunction with 12-step attendance produces the most favourable abstinence outcomes. Fiorentine and Millhouse (2000) found that the likelihood of abstinence from alcohol for those who completed less than 8 weeks of treatment and did not attend a 12-step program was 0.56, with non-abstinence being more likely (1.78). However, the odds of abstinence rose to 3.54 if they successfully completed 24 weeks of treatment with no 12-step involvement, which rose again to an individual being 8.09 times more likely to be abstinent if they completed 24 weeks treatment and attended 12-step meetings during this time. They concluded that this was the result of having a consistent member of professional staff in their social network that could address addiction-related issues that non-addicted family and friends could not.

To conclude, the composition of social networks for recovering individuals is important for recovery and abstinence outcomes, as the evidence suggests that having a social network comprised of people who actively promote abstinence and recovery results in these goals being met. This finding is consistent with a previous literature review that concluded the composition of an individual's social network plays a vitally important role in abstinence and recovery (Groh, Jason & Keys, 2008). The evidence in this section also suggests that those who have recovering individuals in their social network fair even better than those who do not.

Overall, the evidence discussed in this section on AA and/or 12-step groups provides a strong argument that increased attendance, combined with active involvement at an easily accessible SHG comprised of individuals who actively advocate recovery and abstinence results in significantly positive effects for recovery. However, it has been important to acknowledge some of the methodological issues surrounding the studies in this section as they have implications for the interpretation of the results. Whilst the studies only demonstrate an association between attendance, involvement, location and social network composition and abstinence, the overwhelming evidence suggests that such factors do directly result in better rates of abstinence. However, as it

has been alluded to throughout, there is a significant lack of a deeper understanding as to *why* and *how* such domains impact on recovery in the manner they do. It highlights the significant dearth of information available from a qualitative point of view (the focus of section *2.5*), which needs to be addressed in the future if recovery is to be understood fully. The second section of the quantitative findings discusses those studies that were found in the scoping review that are 'non-AA, non-12-step affiliated' SHGs.

2.4 'Non-AA and non-12-step affiliated' SHGs

Of the 27 quantitative studies, 7.4% (*n* = 2) explore a SHG that is neither AA nor 12-step affiliated. These SHGs explored in this section are 'Clubs of Alcoholics in Treatment' (Curzio et al. (2012) and 'Rational Recovery' (Galanter, Egelko & Edwards 1993). Due to their relative obscurity of these intervention types in comparison to AA and 12-step approaches, a brief description of each is given before exploring the implications of the study findings.

2.4.1 'Clubs of Alcoholics in Treatment'

Also known as 'Clubs of Treated Alcoholics' (hereafter CATs), CATs developed in the late 1970s as a result of collaboration between alcohol treatment professionals in Italy and the theoretical and methodological work of Vladimir Hudolin and colleagues from Eastern Europe (Humphreys, 2004; Curzio et al, 2012). Based on Hudolin's socio-ecological approach, CATs conceptualise alcoholism as a 'disease', which has resulted in CATs having no spiritual change component or broader personal and moral development beyond abstinence (Humphreys, 2004). They operate under the assumption that rehabilitation is not an individual journey, but a more holistic community-focused approach, which actively involves the family of the individual (Humphreys, 2004).

CATs meet one evening a week, and may be open all day at weekends (Sikic, Walker & Peterson, 1973). On top of the supportive group meetings, CATs often offer a range of social and recreational events for recovering individuals and their families to participate in (Humphreys, 2004). Extended family members are encouraged to attend as well as the problematic alcohol user, and

are typically asked to pledge a five-year commitment to the group (Humphreys, 2004). CATs are typically run by recovered problem drinkers (Bennett, 1985) and operate on the basis of long-term social support, social pressure, education, and at times, medication (Humphreys, 2004). Given that Hudolin was a strong proponent of the social environment being a mediator for alcohol use (Humphreys, 2004), CATs require that non-addicted family members actively abstain from alcohol use as well as the recovering individual (Hudolin, 1984). Most published articles on CATs were destroyed during the Balkan wars and the split up of Yugoslavia (Humphreys, 2004), but at present, there are considered to be approximately 2,200 CATs across 30 different countries (predominantly in Italy and Eastern European countries) (Curzio et al, 2012).

2.4.2 Rational Recovery

Rational Recovery (fully known as Rational Recovery Self-Help Network) can be traced back to *The Small Book* by Jack Trimpey (1988), a social worker who himself had overcome alcohol addiction (Humphreys, 2004). *The Small Book* strongly refutes the AA philosophy to recovery and promotes cognitive self-examination, rational analysis and self-control, three domains that stem from the rational-emotive therapy of Albert Ellis (Humphreys, 2004). Rational Recovery was initially set up with a 'for-profit' organisation run by professional addiction services, but this approach soon disbanded and in 1994, Rational Recovery split into two groups: one remained 'Rational Recovery' and the other became 'SMART Recovery' (Humphreys, 2004). The only known membership information stems from Galanter, Egelko and Edwards (1993; a study included in this scoping review), which found that most individuals who attended Rational Recovery were male (72%) and were in full time employment (60%). Given that Rational Recovery draws its members mainly from the well-educated, individualistic, Caucasian-American middle class, 81% of attendees were found to have at least a college education. Galanter, Egelko and Edwards (1993) also found that 47% were atheist relative to the US population, with nearly every member reporting alcohol abuse, 51% reporting cannabis addiction and 41% with cocaine addiction. The following section will explore the studies that have

been done that investigate the impact of CATs and Rational Recovery as SHG interventions for alcohol addiction.

2.4.3 The impact of CATs and Rational Recovery

Curzio et al. (2012) found that those who had extended attendance at CATs (> 3 years) were more likely to be abstinent than those with less than 3 years attendance (n = 7,522; $p < 0.0001$). Abstinence was shown to be statistically significantly affected by age, years of club attendance, the presence of other problems and employment. Being abstinent with a perceived better life was more likely for females and not having other problems. This study suggests therefore, that continued attendance at CATs is positively, and significantly associated with continued abstinence rates. This finding is reinforced by the large sample size it uses, thus suggesting a strong significant effect. Curzio et al. (2012) concluded that abstinence was significantly attributed to a change in lifestyle, which was in part, due to the involvement of family members. Following on from previous studies explored in this review, the composition of a recovering individuals social network therefore seems to be vitally important. However, it is important to state that this study adopted a cross-sectional research design (see appendix *4*), which suggests that whilst the data is positive, it contains no follow up data over time, so the results just reflect a 'snapshot' at one point in time.

Finally, Galanter, Egelko and Edwards (1993) explored the impact of Rational Recovery. They found that since joining Rational Recovery, 73% of 'engaged members' (those with an average of 8 months membership) were abstinent from all substances compared to 38% of 'recruits' (those who had only attended Rational Recovery for the first time in the past month). Of those who reported more than 6-month membership, 58% (n = 94) reported 6-month abstinence compared to 77% (n = 122) who reported 1-month abstinence for less than 6-month attendance. Those more engaged with Rational Recovery also had lower AA attendance scores in the past month ($p < 0.01$). Like CATs, attendance at Rational Recovery, a SHG with no AA affiliation does produce positive influences on abstinence rates.

However, a positive component of Rational Recovery in particular, is that it does not exclude those who have relapsed, and actively accepts those who may still be struggling with drink problems to attend Rational Recovery meetings, whereas AA dismisses such a status (Galanter, Egelko & Edwards, 1993). This is perhaps reflected in studies that have found relatively high attrition rates for AA (Makela, 1994). One such study found that of those attending AA, 68% had dropped out before completing ten meetings (Brandsma, Maultsby Jnr & Welsh, 1980), which suggests that the outright abstinence status required by AA results in aversive effects for membership. It is important to note that this was the only identifiable study on AA attrition rates and on its own, perhaps should not be considered an accurate representation of the wider literature on AA efficacy as a whole. However, it does illustrate the paucity of information that is readily available on AA attrition rates.

2.4.4 Methodological issues surrounding the quantitative studies

Having described the quantitative studies identified for this scoping review, there is a need to outline some of the methodological issues surrounding them. Appendix *4* illustrates that across the 27 quantitative studies, there were a plethora of different research designs and instruments of assessments used to assess the effectiveness of SHG interventions, which raises a number of key findings when interpreting the data. First, none of the studies used a randomised sample, meaning that the impacts of these studies could be erroneously attributed to the SHGs rather than the differences in samples (Balnaves & Caputi, 2007). This potentially means that for those studies that found a significant effect between abstinence and SHG attendance for example, the effect may not be the result of the SHG but other possibly unmeasured factors.

Second, all of the studies relied on self-report meaning that the responses may not be entirely honest and accurate. Adler and Adler (2003) state that for sensitive issues such as addiction, some respondents may be 'sensitive' or

‘secretive’ about their level of use, as they do not want others to know the full extent of their addiction problems. It is important to remember that issues surrounding addiction can be a highly emotive topic for some individuals, which may mean that they do not want to admit to the full extent the level of their drug and/or alcohol use to others, or maybe even researchers. This is arguably even more so the case if individuals are attending SHGs but continue to use secretly. Whilst there is no specific evidence supporting this claim, it is important to acknowledge that this could be a factor.

Third, all of the studies only demonstrate an association between SHGs and abstinence. This means it is not possible to definitively conclude that improved abstinence rates are the direct result of SHG attendance and involvement or that a lack of attendance and involvement is the direct cause of poorer rates of abstinence. However, the fact that all but one of the studies (Mueller et al. 2007) found a positive association, it is plausible to suggest that SHGs do cause a positive, direct effect on rates of abstinence. Finally, the fact that SHGs such as AA have always been historically marred with the problem of attrition (Makela, 1994) suggests that it is not possible to claim with any certainty if leaving SHGs is the direct cause of poorer abstinence rates, or if it is the result of existential factors that have not been accounted for. Whilst these are methodological points that need considering, the evidence, particularly the studies that used a detailed methodology and complex statistical analysis, the quantitative data demonstrates a positive association between SHGs and abstinence. Based on the quantitative findings, two important conclusions can be made.

First, the studies demonstrate that ‘non-AA, non-12-step’ programs are associated with positive impacts on those recovering from substance addiction. The reason for this is perhaps because they are comparatively quite ‘new’ interventions compared to AA and 12-step programs, which have only really emerged in the past 30 years. As a result, they are not steeped in a tradition that advocates a religious component to recovery, thus making them potentially more accessible to those who eschew religious-based recovery programs. This

conclusion however, is conjecture and is important to note that it is a conclusion based on just two quantitative studies identified for this review. More research of those who attend 'non-AA, non-12-step' programs is needed, in order to ascertain with greater certainty why these programs appear to facilitate recovery from alcohol dependency. Second, the studies highlight a significant dearth in research with regards to programs that are 'non-AA, non-12-step' based, and that these types of interventions need closer empirical inspection to ascertain why, and how such interventions appear to produce favourable outcomes. The final part of this section will explore the qualitative studies identified during this scoping review.

2.5 Qualitative studies located during this scoping review

Appendix *3* and *5* provide demographic and design information for the qualitative studies located during this scoping review. There have been fewer qualitative studies (n = 7) relevant to the focus for this thesis than quantitative studies. Despite this, the studies are important. These studies explore the experiences and views of those in SHGs for alcohol dependency, which from a thematic analysis point of view, sheds greater light on 'why' and 'how' SHGs seem to impact on recovery, rather than just demonstrating a statistical effect. The focus of this section is to elucidate what each qualitative study found and the implications they have for research in relation to addiction recovery. Whilst this section is restricted to qualitative studies, it is not restricted to intervention type (all types of SHG were included). Before the findings of the qualitative studies can be explored, a brief note is given to explain why some qualitative studies were excluded. Due to the small number of qualitative studies that were identified for this scoping review, it is important to outline that there were more 7 qualitative studies located, but that they were excluded based on their breach of the inclusion and exclusion criteria outlined in section *2.2.2*.

2.5.1 Excluded qualitative studies

In total, nine qualitative studies were excluded. Two qualitative studies (McIntosh & McKeganey, 2000; Yeh, Che & Wu, 2009) were omitted because they did not explore 'how' or 'why' SHG attendance and involvement impacted on

recovery, which meant much of the data did not explore the impact of the SHG on the individual. This resulted in studies exploring key concepts related to recovery such as identity transformation, but did not explore how SHG attendance and involvement impacted on such a transformation. One qualitative study (Wright, 2010) was excluded because he used the experiences of AA members to critique existing theoretical models relating to ideology and change processes, which upon deeper inspection, revealed very little about the impact of SHGs on the individual. Another study (Klaw & Humprheys, 2000) was excluded as it investigated Moderation Management, a SHG that advocates moderated alcohol use, as opposed to abstinence. Two qualitative studies (Strawbridge, 2007; Henges, 2008) were excluded as they were part of a larger dissertation, and one was excluded (Jahn et al., 2007) as it was in Portuguese. Finally, one study (Tonigan & Rice, 2010) was excluded, as its methodology was not wholly qualitative, but used structured questionnaires and surveys to collect data, which was then subject to statistical analysis. The studies explored in the following section were those located that best matched the inclusion criteria set out in section *2.2.2.1*. Like the quantitative studies, the qualitative studies are delineated based on those that investigate AA, and those that do not.

2.5.2 Findings of the qualitative studies investigating AA

Using a feminist ethnographic approach, Hall (1994) was interested in understanding the experiences of 35 lesbians in AA, as it was thought being a homosexual female in AA had implications for healthcare interaction and attendance at AA. Hall's (1994) main finding was that AA attendance was fraught with a tension for this group: the result of strain or unrest being imposed by the push and pull of opposing forces. Hall (1994) identified three areas of tension embedded in AA attendance: *assimilation* verses *differentiation*, *authority* verses *autonomy* and *false consciousness* verses *politicisation*. Hall (1994) stated these tensions manifested themselves as internal struggles involving both sides. The first tension, *assimilation* verses *differentiation*, refers to ones position in society. 'Assimilation' refers to integration with mainstream society, whereas 'differentiation' refers to maintaining separateness or uniqueness as a distinct subcultural group. The second tension, *authority* verses *autonomy*, reflects an

opinion on how best AA should be used. 'Authority' refers to those who believe AA is a specific 'blueprint' by which a recovering individual should live their life, whereas 'autonomy' refers to those who believe that recovery should be more self-directed. The final tension, *false consciousness* verses *politicisation* reflects the political ramifications of AA. 'False consciousness' reflects those who believe that ideologies or organisational tenets obscure political realities experienced by marginalised groups, whereas 'politicisation' is conjectured to have occurred when organisational participation heightened attention to power dynamics, oppressive conditions and liberating actions.

Hall (1994) concludes that such tensions impact on AA involvement as the tensions reveal fault lines among ideologies and experiences in lesbian communities. This study shows the depth to which different topics can be explored, but it also demonstrates the methodological issue of transferability from qualitative work. Hall (1994) focused on a lesbian sample, which means it is difficult to extrapolate her findings to other groups. This therefore, has potential implications for the transferability of her findings to other settings and that greater nuance is required in order to aid a deeper understanding.

Through the use of semi-structured, 'in-depth' interviewing with ten women, analysed through a phenomenological lens, Davis (1997) found a number of factors that impacted on women entering recovery and participating in AA. Firstly, Davis (1997) found that a lack of support from friends and family resulted in internal feelings of despair that seemed to prevent individuals from entering recovery as they felt they had no encouragement or support:

> *"The rest of my family was just vaguely aware of what was going on, and they were countersupportive. They talked about AA in a derogatory way"* (Davis, 1997; p. 156)

The women in this study articulated feelings of 'invisibility', as their drinking was largely unnoticed by partners, employers and professional staff, which Davis (1997) suggests this was the result of healthcare and criminal

justice systems being orientated to favour the recovery of men. As a result of such isolation, Davis (1997) found that women often initiated their own first steps in recovery (in the case of these ten women, that was entering AA). During recovery, Davis (1997) found that 'the process of recovery' had exerted more of an influence on their economic situation and their careers than the other way round. Many of the women reported a re-evaluation process of their jobs and careers based on the principles they were learning from their AA involvement. This actually resulted in them earning less money but a greater 'peace of mind'; a seemingly significant protective factor against relapse. Finally, Davis (1997) found that the experiences of men and women in recovery at AA are almost totally unique from one another, primarily due to societal expectations attributed to both genders. Davis (1997) locates her evidence in the literature on stigma and states that women often experience double forms of stigma, as society is bias against alcohol addiction and women. As a result, 90% (n = 9) of her sample found that all-female AA groups were of most support:

> *"It was a tremendous sigh of relief that I discovered a couple of all-women groups early in my sobriety… I reacquainted myself with my identity as a female"* (Davis, 1997; p. 163)

As a result of the support of other women and the experiences that others had, women were able to flourish under the protection and shelter of the all-female group. For some, this resulted in the re-establishment of an identity: who someone 'is'. This is a potentially pivotal moment in recovery, as it perhaps signifies a point in recovery whereby they are no longer fundamentally identified as an 'addict', part of 'them' and not 'us' (Link & Phelan, 2001), but are instead identified as a positive, strong individual who can be part of 'us'. This realisation could be a potentially important source of self-confidence, which in turn, fuels self-development and personal growth in recovery.

It is important to note that whilst this study does demonstrate some of the intricate factors that impact on female attendance at AA, the stories are referred to as *"outstanding success stories"* (Davis, 1997; p. 166). The findings

should perhaps be considered with caution therefore, as they only represent one side of the argument. The apparent 'exclusion' of stories that demonstrate AA to be less effective are not included, which could result in distorted interpretation of the findings. Furthermore, given that the interviews were short (a specific limitation suggested by Davis, 1997), with content being taken with *"explicit acceptance"* (Davis, 1997; p. 170) of their stories also raises questions of transferability and credibility of the study. However, whilst the women in Davis' (1997) study found a female-specific AA group to be more advantageous for their recovery, this is not always the case.

In a UK-based qualitative study, Dyson (2007) found that eight (total sample size) women in a more conventional, mixed AA group could benefit from AA. Through the use of a narrative method, Dyson (2007) found that AA was particularly helpful for two reasons. First, the stories that people heard at AA acted as a deterrent from further drinking:

> *"AA has put the fear of God in me. The stories I've heard..."* (Dyson, 2007; p. 213)

> *"You hear some terrible things at AA"* (Dyson, 2007; p. 213)

These narratives served to remind the individuals how life was without their need to resort to alcohol. Second, the supportive nature of AA was highly significant for recovery:

> *"Here was a bunch of people who really understood where I was coming from"* (Dyson, 2007; p. 213)

The supportive nature of the group was grounded in firsthand experience of alcohol addiction, and that the support gained from those who had experienced addiction and addiction recovery seemed invaluable for their own recovery. This study implicates a more fundamental role of AA: peer support. The importance of help, support and guidance form those who have experienced

addiction and addiction recovery seems invaluable for others in recovery, and AA should therefore perhaps not be overlooked due to the potential stigma that surrounds AA. This is a finding that supports the quantitative studies outlined in section *2.3.4*.

In another UK-based qualitative study, Whelan et al. (2009) further investigated the importance of peer support. In order to do this, they conducted interviews with 28 AA sponsors: people considered to be primary sources of peer support in AA recovery circles. Whelan et al. (2009) identified three main roles of the sponsor. First, they identified 'working the programme' as a key component of being a sponsor:

> *"The most important thing is taking* [sponsees] *through the steps, not telling them how to do them but what the meaning behind them is. This involves reading* [AA literature], *discussing and understanding"* (Whelan et al., 2009; p. 419)

Whelan et al. (2009) concluded that this was not only helpful to the individual as they receive advice and to the sponsor for giving the advice, but that it supports the culture of AA as a whole. Second, 'support' was a key part of being a sponsor, which they separated into two types: emotional and practical support. Emotional support encompasses offering advice during times of hardship:

> *"To offer empathy and support through difficult times, helping the person to know that they are not alone"* (Whelan et al., 2009; p. 419)

Practical support relates more to helping those with non-AA-related issues:

> *"I think its important to note that a skilful sponsor will also know when to recognise that a sponsee has problems outside their own sphere of existence"* (Whelan et al., 2009; p. 419)

Consistent with previous findings, Whelan et al. (2009) also found that the supporting nature of the sponsor not only helps the individual in their recovery, but also that it helps the sponsor, as it provides them with a source of 'giving back'. The final key component of being a sponsor, which is closely related to 'support' is 'carrying the message of AA', a goal achieved through advice giving. Whilst they provide no specific extracts for this, Whelan et al. (2009) concluded that advice should be delivered in a 'gentle' manner, and should not be aimed to control the service user. Consistent with the quantitative data, Whelan et al. (2009) found that having a sponsor is not only beneficial to the sponsee, but also to the sponsor themselves.

In the only qualitative study that compared SHG members with another cohort of individuals, Kubicek, Morgan and Morrison (2002) explored the experiences of seven AA members with six spontaneous remitters. Through the use of semi-structured interviews, they identified five key themes that were universal across both groups. These were the support from others; acceptance of a Higher Power; a genuine desire to recover; a reconstruction of the 'self' and remembering the negative consequences of their addiction. Kubicek, Morgan and Morrison (2002) made two important conclusions from their five identified themes. First, given that the themes were applicable to both AA members and spontaneous remitters, it highlights an overlap between two qualitatively different recovery trajectories. Their findings therefore implicate both the usefulness of AA to maintain recovery, as well the notion that AA is not the only way to recover. Second, and perhaps more importantly, is the fact that Kubicek, Morgan and Morrison (2002) acknowledge the importance of interviewing those in recovery, as they can provide useful information on how to sustain long-term sobriety and abstinence. They state that without qualitative research in areas such as these, knowledge of recovery cannot be fully understood, as researchers miss the opportunity to interview those actually in recovery. This provides strong support for this thesis, as it provides sound justification for the qualitative exploration of the LTLA project and how it impacts on recovery.

To conclude, the qualitative studies exploring the experiences of AA members elucidate that there are perceived negative effects surrounding AA membership. For example, whilst the quantitative data explored in section *2.3* perhaps presents an overly positive picture of AA and/or 12-step membership for recovery, as virtually all the quantitative studies demonstrate a positive effect, deeper inspection through a qualitative methodology actually found potential negatives surrounding AA membership. This is important as it demonstrates that qualitative research is just as important as quantitative research, as it facilitates a much deeper understanding of a given social phenomenon, as it enables questions relating to 'how' and 'why' to be addressed and answered. The next section explores the qualitative studies that do not specifically investigate AA and/or 12-step groups.

2.5.3 'Women for Sobriety' and 'First Steps'

Women for Sobriety (hereafter WFS) is a SHG that aims to tackle female specific issues in addiction (Kaskutas, 1989; 1994). Kirkpatrick (1977) states that the guilt a female problem drinker experiences results in deeply entrenched feelings of inadequacy, which is the result of societal bias towards female problem drinkers. This supposition supports the findings of Davis (1997). In order to address such guilt, an appropriately orientated program is needed that focuses on improving self-esteem and independence, as well as embracing female specific abilities in recovery (Kaskutas, 1994). WFS has considerable parallels with AA, as it operates a 13-step system comparable to that of AA, except with an additional step that advocates personal responsibility (Kaskutas, 1989; 1994). Whilst much of the Kaskutas (1989) study sets out the principles of WFS, the structure of the meetings and what goes on in the meetings (based on observational and interview data), the study illuminates why WFS may be more beneficial for some women.

In a sample of four women, Kaskutas (1989) found that WFS does not require the re-telling of tragic stories, does not 'compete' individuals against one another in terms of sobriety, does not require individuals to 'work the steps' and significantly downplays the role of a Higher Power. Kaskutas (1989) also found

that whilst alcohol addiction may bring them together, the social cohesion, which many experience in WFS keeps them together. Ultimately, Kaskutas (1989) found that WFS offers a potentially attractive alternative for those women who consider AA unpalatable.

The final qualitative study explores the experiences of homeless men, and how they use 12-step techniques to help them maintain sobriety without a formal place to live (Rayburn & Wright, 2010). Rayburn and Wright (2010) found through the use of semi-structured interviewing with homeless men (sample size not reported), 'First Steps' (the SHG they attend), uses three varieties of adaptations to the conventional AA program: 'excessive twelfth-stepping', 'aggregated religious and recovery principles' and ' unrealistic ideals'. The final step of AA is about 'giving something back' to other recovering problem drinkers and by spreading the practices and principles of AA. Rayburn and Wright (2010) found however, that homeless men in First Steps engage in 'excessive twelfth-stepping', a process whereby they want to help everyone around them. It is characterised by a strong sense of 'giving something back' to society, to do their part, to give instead of take and to become useful again:

> *"I wanna be able to help somebody. I wanna be able to start something. If I wanna go to the grocery story, and out of my pocket, buy lunchmeat, cheese, and a couple of cases of soda, go out on a Saturday, where people at, and just hand out food—I wanna be able to do that."* (Rayburn & Wright, 2010; p. 334)

Excessive 'twelfth-stepping' often manifested itself in quite extreme forms of altruism whereby the individual 'doing the excessive 'twelfth-stepping'' would often result in being worse off because of their kind nature continuously helping others. This is potentially very important, as it suggests that whilst helping others does help the individual (as the quantitative data in section *2.3.4* suggests), it is possible that helping in extreme forms comes at the detriment to personal development.

Rayburn and Wright (2010) found that none of the homeless men had a preference to one particular 'recovery theory', but that any theory that helped to combat their addiction was welcomed. This more universal approach represents a significant difference with AA that promotes its own 12-steps to recovery. Whereas those who attend AA are strongly urged to follow their guiding principles, Rayburn and Wright (2010) found that enabling an individual to adopt their own approach also facilitated their recovery. Finally Rayburn and Wright (2010) found that First Steps helped to encourage the men to aim for realistic goals and that *"going broke on perfection"* (Rayburn and Wright, 2010; p. 335) could result in a failure to realise a dream, a precursor to re-commencing their drinking.

The findings of this study suggest that attendance at First Steps does seem to help recovery, as it provides homeless men with the opportunity to 'give back' and to develop a plan of action that will facilitate the specific needs of their recovery. A potential methodological drawback of this study is that the homeless sample that Rayburn and Wright (2010) interviewed is very specific and perhaps not representative of many recovering from alcohol addiction. Therefore, their views and opinions are perhaps not generalisable to the wider population of recovering problem drinkers.

To conclude, the qualitative studies explored here arguably demonstrate a deeper understating of SHGs, as a qualitative methodology allows for more complex topics to be explored. Having analysed the qualitative studies, there are a number of key strengths that are apparent. First, given the fact that qualitative research is related to a number of different methods of data collection, analysis and interpretation, social entities such as SHGs can be interpreted from a number of different perspectives, thus potentially allowing for a greater, more holistic understanding of a social situation. Perhaps the key strength however, is that it allows an in-depth exploration of highly complex topic areas, such as the internal tensions explored in Hall (1994), which corroborates much of what the quantitative data suggests. Qualitative research therefore, enables a much

deeper understanding of *why* and *how* social processes and situations occur and play out.

2.6 Concluding comments

The purpose of this review was to address the following question: **What is known from the existing literature about the *impact* of SHGs for alcohol addiction recovery?**

Multiple studies explored in this review point to a positive impact of SHGs as a significant predictor of abstinence. Perhaps the most obvious finding of this review is that most of what is known about SHGs is based on studies of AA, despite studies of other recovery SHGs becoming more prominent in the past 25 years (Humphreys, 2004; White & Kurtz, 2006a). With regards to AA and/or 12-step SHGs and their impact on abstinence, increased levels of attendance were shown to have significantly better outcomes than those who attended intermittently or not at all. However, whilst attendance at AA and/or 12-step SHG was important, it was not the only mediating factor that improved recovery and abstinence outcomes. Increased involvement with AA and/or 12-step SHGs was found in some cases, to be more important than attendance.

The location of the SHG was found to be important with more convenient, accessible SHGs being better correlated with improved recovery and abstinence outcomes. Finally, the composition of a recovering individuals social network was proven to be important, as those with more individuals who encourage less drinking produced more favourable recovery and abstinent outcomes. In particular, those whose social networks were comprised of recovering individuals faired the best. It was concluded that this was because shared experience and the ability to provide moral support and advice from a position of experience seemed to facilitate recovery and abstinence to a greater extent.

The findings also demonstrate that 'non-AA, non-12-step' programs were also associated with abstinence and recovery. Studies investigating 'Clubs of Alcoholics in Treatment' and 'Rational Recovery' also found that increased

attendance was significantly correlated with more favourable abstinence rates. Whilst the quantitative studies found a positive effect of SHG and abstinence, they were considered in light of potential methodological limitations of quantitative research.

With regards to the qualitative studies, many explored specific areas of interest, which resulted in detailed, in-depth analysis of what impacts on individuals specifically getting involved with SHGs. The qualitative findings provided detailed, contextual knowledge that reinforced the quantitative data. Not only did the qualitative data demonstrate that attendance at a SHG seemed to have a beneficial impact on recovery, they elucidated themes that explored 'how' and 'why' SHGs facilitate recovery; an area that quantitative studies are less able to address.

As a result of these findings, there are a number of important conclusions that can be made form this scoping review. First, there is a great need to explore those SHGs that are not AA and/or 12-step related, as they have been proven to produce favourable outcomes with regards to abstinence and recovery. Clubs of Alcoholics in Treatment and Rational Recovery are just two examples of many SHGs that exist globally. The LTLA project is another example of such a project and there appears to be a real dearth in the literature with regards to empirical research on 'non-AA, non-12-step' related SHGs.

Second, the vast majority of quantitative and qualitative studies in this review were conducted in the US (see appendices *2* and *3*), which is most likely the result of the US being the birthplace of AA, thus making it the most widely sought source of help for alcohol problems in the US (Miller & McCrady, 1993). Research outside the US therefore, is needed to understand how SHGs facilitate recovery in different recovery contexts. This is supported by the ACMD (2012) who concluded that there is a need for more UK based evidence that considers key issues in the UK.

Third, not only is there a paucity of evidence-based knowledge with regards to addiction research in general in the UK, but there is a significant dearth of evidence with regards to informal peer support and other recovery communities in the UK (ACMD, 2012). It has been found that communities of recovery (such as the one that has evolved in the LTLA project) are beneficial for recovery, as they are replete with individuals who have firsthand experience of addiction and addiction recovery, and can therefore provide more in-depth support and advice based on personal experience (Zemore Kaskutas & Ammon, 2004). In-depth exploration and analysis is needed therefore, to understand how such communities of recovery impact on addiction recovery.

Finally, the scoping review highlights that in comparison to quantitative studies, there are very few qualitative studies that investigate the impact of SHGs on alcohol addiction recovery. Whilst quantitative studies are important to statistically and objectively highlight the importance of SHGs, qualitative studies are also important as they access the feelings, emotions and testimonies of people who have experienced firsthand what it is like to not only access SHGs, but also what it is like being in recovery more generally. As Neale, Nettleton & Pickering (2013) note, there is a need for further research that accesses the experiences of those in recovery, and particularly those in recovery at SHGs. This is because presently, there is a lack of nuanced understanding as to how and why alternative recovery paradigms such as the LTLA project operate and function (White, Kelly & Roth, 2012; ACMD, 2013; Neale, Nettleton & Pickering, 2013). Qualitative research addresses the gaps that are unable to be adequately filled by quantitative research: primarily questions relating to complex issues of *why* and *how* SHGs impact on the individual. For example, the quantitative findings in this literature review demonstrate that attendance and involvement at SHGs facilitates recovery, but the qualitative findings suggest a more complex story whereby attendance and involvement are often hinged on a number of complex issues based on gender (Davis, 1997) and ideology (Hall, 1994). Qualitative research is needed, as they access on a deeper level why and how attending a SHG may be important for recovery, and what aspects of SHGs hinder recovery.

2.6.1 Aims and objectives of this thesis

In light of the conclusions of this scoping review, the central aim of this thesis is:

To gain an in-depth and holistic understanding of the 'Learning to Live Again' project; a UK-based, ex-service user group that aims to facilitate recovery from alcohol dependency.

In order to meet this aim, several objectives will be undertaken to explore whether, how and why:

1. The structure and set up of the LTLA project impacts on recovery from alcohol dependency;
2. Whether having a project run by 'ex-service users' impacts on the recovery trajectories of service users of the LTLA project;
3. The social composition and environment of the LTLA project and its impact on individual transformation during recovery;
4. Whether how and why having pleasurable activities as the focus of the LTLA project impacts on the recovery trajectories of its service users and mentors.

Whilst these objectives are based on the findings of this scoping review, they are also theoretically informed based on the theoretical framework that runs throughout this thesis. Issues surrounding self and identity have surfaced throughout this scoping review, particularly when discussing the benefits of helping others in recovery. The focus of the next chapter therefore, takes a marked step away from the first two chapters to outline the theoretical framework that will be used to interpret the data collected for this thesis. Chapter *3* will apply the theoretical framework of symbolic interactionism to addiction recovery. This ensures that the theoretical framework used in this thesis is continuously made relevant by extrapolating its basic premises to the field of addiction recovery, thus facilitating a deeper understanding of how the theory will be used to interpret the findings of this research.

Chapter 3

The theoretical framework of symbolic interactionism

3.1 Introduction

This chapter describes the theoretical framework that will be used throughout the thesis, in order to explore and explain the LTLA project. Before the theoretical framework can be explored however, it is important to first understand *why* it is important to this thesis, and secondly *how* it will be used to explain the social entity under investigation in this research. Broadly speaking, theory and theoretical frameworks provoke individuals to think about *how* and *why* 'something' might happen, in order to produce an explanation for the 'something' under investigation. Given the fact that this research is exploring *how* and *why* recovery unfolds in the manner it does at the LTLA project, a theoretical framework becomes important. Theory frames how we ask, look at, and answer questions, provides conceptual clarity and a medium in which new knowledge obtained through data collection can be incorporated into the vast body of knowledge already known (DuPoy & Gitlin, 1998).

By having a theoretical framework in place, this will enable the data to be appropriately interpreted and explained, which will aid a more in-depth understanding and analysis of the data collected, as well as enabling the research to be located in the wider body of work on recovery. This research is qualitative and highly explorative, which places significant emphasis on a theoretical framework to explain why 'things happen'. Due to the subjective nature of this research, a theoretical framework is vital to enhance the 'story' of this thesis by explaining the social milieu in which the interactions and perceived identity transformations are occurring at a higher level of abstraction. Without a theoretical framework, there is the risk of a fragmented understanding of the data, which lacks continuity and depth resulting in a potential lack of quality. This leads on to the next question: *how* will the theoretical framework be used in

this thesis? The data collected will be explained using the theoretical framework outlined in this chapter. For example, the concept of identity is central to this thesis and as such, data will be thematically attributed to the concept of a changing identity as service users and mentors move through their recovery trajectory in the context of the LTLA project. The theoretical framework will be used to explain *how* the LTLA project can be understood from the viewpoint of a symbolic interactionist, which will in turn, offer explanations as to *why*, if at all, the LTLA project impacts on recovery in the manner it does. Before the theoretical framework used throughout this thesis can be explored, there is a need to understand what a theoretical framework actually refers to.

3.1.1 A theoretical framework

The theoretical framework used in this chapter is *symbolic interactionism*. Symbolic interactionism is considered a 'theoretical framework' as opposed to a 'theory', and in the interest of clarity, the distinction shall be briefly explored. Stryker (1981) explains the difference:

> *"The distinction is between a set of ideas intended as an explanation of some particular aspect of the empirical social world (theory) and the imagery, premises, and conceptualizations underlying that explanation (theoretical framework)"* (Stryker, 1981; p. 27)

A theoretical framework therefore, comes before theorisation and gives direction to a line of inquiry, without which the endless possibilities to interpret the empirical social world could leave a researcher bewildered with the range of possibilities (Stryker & Vryan, 2003). Symbolic interactionism has been chosen as the theoretical framework for a number of reasons. First, it pertains to philosophical assumptions, which 'I' as a researcher feel provide the most appropriate explanation for the social empirical world. Second, it addresses issues relating to the impact of an individual's location in patterned social settings, their relationships during social interactions, social constructions and social persons, the reciprocal nature and construction of social interaction, and individual's in their social settings (Stryker & Vryan, 2003), all of which have

important implications for recovery from substance addiction. Third, there are a number of specific, relevant symbolic interactionist theories that are drawn upon to explain the data, all of which have intellectual and philosophical affinity with one another given their foundations in symbolic interactionism (discussed in detail in this chapter). Fourth, its focus on the individual agent also makes it a highly pertinent theoretical framework when exploring and explaining the individual and their identity transformation during recovery. Finally, the methodological assumptions used in this research (see section *4.2*) have intellectual affinity with symbolic interactionism (Blumer 1969; Rock, 1979), which creates a harmonious relationship between the techniques used to collect and explain the data collected in this research.

The remainder of this chapter is split into four sections. The first section of this chapter will lay out the basic tenants of interactionism, a philosophical approach accredited primarily to the writings of George Herbert Mead. The areas discussed will be the origins of symbolic interactionism as a theoretical framework, which will lay the foundations for the subsequent section exploring the influences on Mead. The remainder of this section will explore the concept of 'self', with reference to three of its key constructs relevant in this research, namely the 'I', the 'me' and the 'generalised other'. The components of 'self' set out in Meadian philosophy are abstract and philosophical in nature, but this section will extrapolate Median ideas to tangible, everyday examples set in the recovery world. The second part of this chapter will explore the concept of culture and the symbolic interactionist concept of 'definition of the situation'. This is a vitally important section of the theory, as it lays the theoretical foundations to address the main aim of this research: to understand the culture of the LTLA project. The third section explores another key construct for this research: *identity*. The work of Erving Goffman will be explored, as his 'presentation of self in everyday life' is considered one of the most influential texts, not just in symbolic interactionist literature, but sociology on a more general level. Within this section on identity, the work of Sheldon Stryker and Peter Burke, two contemporary symbolic interaction theorists will also be explored. This is because they offer a more contemporary symbolic interactionist

conceptualisation of identity that incorporates both individual agency, and social structure under one theory. The final section will be concluding comments.

I acknowledge there are limitations surrounding symbolic interactionism. These however, shall be specifically addressed in chapter *8*, where I will discuss such limitations in the context of this research. This will ensure the limitations are addressed based on their specific impact on this research, as opposed to outlining the limitations surrounding symbolic interactionism more generally.

3.2 The origins of symbolic interactionism

Symbolic interactionism, or interactionism, is a major sociological perspective derived primarily from the Chicago tradition of Sociology (Hammersley, 1989; Plummer, 1991). Symbolic interactionism has its foundations set within American *pragmatism* (Plummer, 2005), which itself has a grounding in a neo-Hegelian philosophy that rejects the dualistic view of the mind in opposition to the body, the subjective in opposition to the objective, and the individual in opposition to the social (Maines, 2001). Furthermore, as it shall be explored in greater detail below, pragmatism has ties with social Darwinism and a behaviouristic emphasis on understanding, and reality as rooted in a persons' conduct (Stryker & Vryan, 2003). Interactionism owes much of its genesis to Charles Cooley (Cooley, 1902), W. I. Thomas and John Dewey (Archard, 1979; Deegan, 2007), but most importantly George Herbert Mead (1934). The term 'Symbolic Interactionism' (Coser, 1971) was devised by Herbert Blumer, a student of Mead, to explain the micro-scale interactions of humans and objects within our environments (Blumer, 1969; Plummer, 1991) and within a larger societal context (Blumer, 1966; 1969; Hammersley, 1989; Rose, 1962). Despite symbolic interactionism owing its name to Blumer, its basic tenants are grounded in Mead; widely considered to be the progenitor of symbolic interactionism. There is a need therefore, to briefly understand Mead's influences and how they shaped his explanation of symbolic interactionism, as these influences by virtue of the centrality of symbolic interactionism in this research, are pertinent throughout this thesis.

3.2.1 Mead's influences

Mead's influences can be broadly traced back to two philosophical perspectives; pragmatism and behaviourism and several influential philosophers, namely James, Dewey, Darwin, Hegel and Wundt. There are four basic tenants to pragmatism. First, what is real for us in the environment is very much dependent on our own active intervention, that is the world does not give us information, rather we learn it through interaction with it. Second, knowledge for each individual is constantly being tried in new situations and is judged by its usefulness, meaning if something works for us, we tend to stick to that method. Third, the objects we encounter in our world are defined based on the use we have for them, so that the meaning of objects in our environment is based on how we intend to use them. Fourth, the only true way to understand an individual is to understand how he or she acts, meaning our understanding of society is based on how we observe individuals behaviour (Charon, 1992). Behaviourism taught Mead to understand people in terms of their behaviour, not in terms of 'who they are' (Boakes, 1984); a concept that has significant parallels with the fourth tenant of pragmatism. Mead was a social behaviourist however, and did not adhere to the pure behaviourist approach that overlooked self and symbols in an individual's world. Mead states that it is imperative to understand self and symbols, as it unlocks how people interpret and define overt behaviour (Mead, 1934). Interpreting and defining others behaviour is a central component of interactionism as it allows each of us to adjust our behaviour appropriately given the social situation we are in (Atkinson & Housley, 2003). This process of understanding and interpreting others behaviour is based on the understanding of two key concepts of interactionism: *language* and *symbols* (discussed in section *3.2.2*).

James' social self theory (Charon, 2010), which conjectures that self is multifaceted and the product of a heterogeneously organised society, influenced Mead by suggesting that self in society is not singular but multiple. Dewey's theory of action, which predicates that action is the response to changed stimulus, influenced Mead by suggesting that stimuli are defined in the context of action and that only a change in stimuli can result in a change in self action

(Stryker, 1980). Darwin's work guided Mead to understand human interaction and societal life principally in three ways: firstly, humans are social creatures and as such, should be viewed as part of the social world in which they reside; secondly, due to the social nature of human language, people can symbolically interact with one another, thus enabling us to be active agents in our own world. Darwin's concept of time influenced Mead to view the social world as dynamic and ever-changing, a concept that is highly influential over his work on self (Charon, 1992). Mead was also influenced by the Hegelian philosophy that selves are not deterministic, but rather determined by what self makes of the world for *them*, as well as Wundt's philosophical assumptions that gestures are the mechanism through which mind, self, and society emerged from social interaction (Stryker & Vryan, 2003).

Meadian philosophy therefore, is a creative synthesis of his influences, which resulted in him producing a theoretical framework, which broadly speaking suggests that *we*, as humans, can manipulate symbols in our environment, respond to one*self* reflexively i.e. step outside our *self* to view us as objects, and can communicate with our *self* (Stryker & Vryan, 2003). Before Mead's view of *self* is explored, there are two more constituents that have significant influence over Meadian philosophy: *language* and *symbols*, both of which have significant meaning for addiction recovery.

3.2.2 Language and the symbol

For Mead, language is the most basic and crucial component of all social interaction (Mead, 1934). Language, according to Mead (1934), has the unrivalled power to unlock the world of human interactions, as without language we could not meaningfully communicate. Mead states that without language, we would not be able to discuss past or future events, convey emotions relating to past, future or hypothetical events, refer to any object, physical or abstract in our environments and would only be able to behaviourally respond to the immediate physical world around us (Atkinson & Housley, 2003). Language enables an individual to be an active agent in their own world as it allows them to interact with their world (Mead, 1934), which from the viewpoint of a recovering service

user is an important concept. It gives the individual autonomy in their recovery, as it enables them to act, and develop new social interactions with individuals that are more beneficial for their recovery. William White, a major advocate of the recovery movement describes the importance of language in recovery. White (2007) states that language has the immense power to shape peoples lives in a positive or negative manner as words can be positive or detrimental to an individual's sense of self and their identity. Stigmatising language such as "druggie", "junkie", "alchi" or "pot head" for example, serve to reinforce the stigma, thus alienating people further. Language in recovery therefore, is a vitally important component to consider, as language needs to be developed that promotes new identity and new people emerging successfully out of their addiction.

The most fundamental element of language is the *word*, as it is words, or *symbols* that make up language. Hertzler (1965) describes language as being culturally constructed and socially established based on standard, conventional symbols, which are used in societies to communicate socially meaningful expressions.

Symbols are essentially anything that can be referred to. They include physical objects like an umbrella or a chair, abstract concepts like recovery, philosophy, religion or liberty; natural objects like a cloud or a tree; animate objects like people and animals, or inanimate objects such as a piece of chalk or coal; groups of people such as doctors, recovering substance users and politicians or specific individuals such as the prime minister (Mead, 1934; Blumer, 1966; 1969). The meaning of symbols is not fixed or universal (Hammersley, 1989) and very much depends on the interaction one has with the thing, hence 'symbolic interaction'. The concept of symbols will become important in subsequent chapters as symbols, both positive and negative, can have an impact on recovery, as they have the potential to reinforce or reduce the social boundary between the recovering individual and 'normal' society (Becker, 1963). Language and symbols therefore, give each individual in any social interaction the ability to produce appropriate *definitions of the situation*

(discussed in section *3.3*) based on the behaviour of others, which enables the individual to adjust their behaviour to act appropriately.

Now the basic influences and elements of Mead's philosophy have been explored, it is time to turn the attention to understanding how Mead used the aforementioned concepts to develop his own theory of human interaction and behaviour. This section provides a précis of Mead's work relevant to this thesis. In relation to understanding how one acts, thinks, interacts and analyses the social situations they encounter from a Meadian point of view, there is one key concept that needs exploring – *self*.

3.2.3 Self: A brief introduction

The conceptualisation of self set out by early pragmatists such as Mead sees self as possessing agency embedded within everyday sociality (Jackson, 2010); a view radically disparate from the Enlightenment concept of the transcendent self standing outside the body (Holstein & Gubrium, 2000). More recently, the conceptualisation of Mead's self has become intertwined with late modern concepts of the self (Jackson, 2010) such as Anthony Giddens' (1984) 'project of the self' and Foucault's (1978) 'technologies of the self'. Despite Mead's interactionist approach to self possessing subtle nuances with postmodernist (Atkinson & Housley, 2003) and post-structuralist thinking (Sarup, 1993), interactionism from Mead's perspective differs from postmodernism and post-structuralism, as it views self as a process with rudimentary groundings in the lived actualities of everyday life (Jackson, 2010). This implicates the conceptualisation of not just self, but also *time*, as one is able to reflect back on him/herself and project forward into anticipating others responses to our actions (Jackson, 2010). This is important as the temporality of self enables individuals to reflexively think back which, in turn, allows us to plan ahead; a concept that will be explored in greater depth later on. The most important parts of the self are Mead's highly abstract *'I'*, the *'me'*, and the *'generalised other'* (Mead, 1934).

3.2.4. The 'I' and the 'me'

Charles Cooley, with significant influence from William James (Coser, 1971) developed the concept of the 'I' and 'me', which subsequently inspired Mead to develop his own cognitive basis to explain the self (Cooley, 1902; Mead, 1934; Jenkins, 2008). The concept of the 'I' and the 'me' is a difficult and often convoluted notion to grasp due to its abstract nature. It needs explaining early on that the "I" and the "me" are purely theoretical, abstract concepts that have no known physical basis. Trying to envisage the 'I' and the 'me' as having a physical basis lodged within our brain complicates the matter, as the function of the 'I' and the 'me' is related to the overarching concept of *self*, an entity that transcends the physical. The 'I' and the 'me' is an abstract relationship between two structures that depend on one another, introduced by Mead and interactionism to explain how an individual's self, their source of consciousness, guides their behaviour, interactions and thoughts over time, in relation to the social mores of society they are part of. Atkinson & Housley (2003) explain Mead's self as a tension between two characters: the 'I' refers to the creative impulse, whereas the 'me' refers to the *"socialized internalization of social mores"* (Atkinson & Housley, 2003; p. 7). Joas (1985) describes the relationship as the 'me' being the object of consciousness and the 'I' as the consciousness of the individual, and Jenkins (2008) describes the 'I' not being directly available in experience, as that is based on the historical 'me'. Perhaps a more accessible description of the 'I' and the 'me' is from McCall and Simmons (1966):

> *"The "me" is best thought of, not as the antagonist in a dialogue with the "I," but as an* ***audience*** [authors italics]*, all the people in a* ***multiperson discussion*** [authors italics] *who are temporarily silent while the "I" holds the floor. But though they are politely silent, they are evaluating and criticizing all the while that the "I" is talking. Each has a somewhat different reaction, corresponding to his unique perspective, and, when the "I" has finished and relinquished the floor, so to speak, every member of this metaphorical audience strives to inform him of his own personal reaction to what was said."* (McCall & Simmons, 1966; p. 55-56)

From this description, the 'I' is the behaviour of the individual from the viewpoint of the individual performing the behaviour. The 'me' is the social self that arises during interaction, the 'one' the actor communicates toward, directs, judges, identifies and analyses interactions with others (Charon, 1992). In this respect, the 'me' reflects the social mores of society by which each individual should abide. McCall and Simmons' (1966) description of the 'I' and the 'me' is apt, as it draws parallels with Goffman's (1959) dramaturgical depiction of the self; another hugely influential interactionist conceptualisation of self. Mead (1934) explicitly states that when referring to the 'I' or the 'me' he is not raising metaphysical questions appertaining to how a person can be both, but he is trying to demarcate the two. The 'me' reflects the organised cognitive frames of reference which our mind uses to appraise, evaluate and monitor ongoing thought and the actions of its own person, the 'I' (McCall & Simmons, 1966). The 'me' gives depth to the 'I' and keeps individual agency bound within the structure of the wider community. The "I-me" dialectic therefore, is a part of self that is continually reacting to 'significant others' in society, thus making self a continually emerging construct rooted in social interaction. However, as it has been alluded to, the self includes a further construct that the 'I-me' dialectic interacts with; the *'generalised other'* (Mead, 1934).

3.2.5 The 'generalised other'

Like the 'I' and the 'me', the 'generalised other' is a purely theoretical entity with no physical basis, developed by Mead to explain how individuals come to understand other individuals acts, beliefs and intentions during social interaction. The 'generalised other' essentially reflects an individual knowing their position in relation to other individual's 'generalised other's' (Mead, 1934). Mead (1934) states that the 'generalised other' is inherent in every individual and reflects a process whereby the self of each individual is able to understand and interpret the 'selfs' of others. By interpreting and defining others 'selfs', we as individuals are able to understand *their* rules and *their* norms (Mead, 1934) and they are able to reciprocate this process with our 'self'. Mead (1934) states that the 'generalised other' is the process whereby we as individuals come to

learn about society as we build up our own rules, norms, beliefs and values based on our 'selfs' interpretation of others 'selfs'. The 'generalised other' enables the individual to take the role of others into their own 'generalised other', thus enabling the individual to become socially aware of the social milieu in which another individual is placed (Atkinson & Housley, 2003). Mead (1934) states that the 'generalised other' relates to the 'I' and the 'me' as he states a complete sense of self is developed through interactions with others in society as mediated by the 'generalised other' and the internal dialect between the 'I' and the 'me'.

Through possession of self as a holistic structure, *we* as individuals are able to perform a number of internal processes such as *self-communication*, *self-conception*, *self-direction* and *self-control*. Self-communication is reflecting on our own actions and inferring emotions in the same manner as we would speak to others, except this type of communication is internalised within us. This process of *self-communication* is a key constituent of Mead's self, as it relates to a process of being able to make judgements about our *self* and our actions and ultimately see our *self*, as others do, across time and different contexts (Rosenberg, 1979); a process that contributes to *self-conception* (Mead, 1934). Self-conception has ties with identity as it ultimately relates to a perceived location of the individual in relation to others. Therefore, in one situation an individual might be a mother, whereas in another, they may be a drug user.

We are also able to perform behaviours such as *self-direction* and *self-control*, which direct and control our actions based on our own morals, beliefs and values. Self-direction and self-control have significant implications for recovery, especially as the recovery of an individual is ultimately determined by the self-control and direction of the individual. If an individual is part of a recovery group then they will be able to align their actions with the beliefs and values of the group, thus influencing their behaviour. This exemplifies how affiliation with recovery groups is often highly beneficial for recovery (Humphreys, 2004). Up to this point, the explanation of *self* has been quite abstract with little mention of how it relates to this thesis. The following section

outlines how symbolic interactionism can be used as a theoretical framework to explain the emergence of culture within a group.

3.3 Culture and 'definition of the situation'

It is difficult to argue that one single 'thing' best encapsulates 'recovery', hence its difficulty in defining. Recovery is arguably best visualised as a culture, a 'way of life' (Finlayson, 2002) whereby individuals develop a 'shared meaning' with significant others of the goals, values, beliefs, norms and behavioural expectations that are associated with the culture of recovery. Becker (1982) states:

> *"A group finds itself sharing a common situation and common problems. Various members of the group experiment with possible solutions to those problems and report their experiences to their fellows. In the course of the collective discussion, the members of the group arrive at a definition of the situation, its problems and possibilities and develop a consensus as to the most appropriate and efficient ways of behaving. This consensus thenceforth constrains the activities of individual members of the group, who will probably act on it, given the opportunity"* (Becker, 1982; p. 520)

In this context, 'culture' therefore means 'consensus' of the group with a shared understanding of language, knowledge and values that make up the culture of the group, which in turn, constrains the actions of group members. Culture therefore, can be conceptualised as a frame of reference through which we understand how and why people think and act in the manner they do (Shibutani, 1955). In a similar way that symbolic interactionism is a theoretical framework or perspective that offers underlying explanations of the social world, culture too, can be considered a perspective as it offers a social lens through which the social world can be understood (Charon, 2010). Depending on the social lens that an individual adopts to 'observe' and interpret culture, different explanations will arise. In the interest of theoretical congruity, the social lens adopted in this research to understand and explain culture is symbolic interactionism.

The first point to note is that culture is not just a perspective, but a *shared* perspective that enables each of us to understand another's place as well as our own place in social interaction (Warriner, 1970). Based on communication and a shared understanding of the situation, culture can develop, as it enables further shared experiences to develop (Strauss, 1959). The 'shared understanding' of a given culture stems from the Meadian construct 'the generalised other' (see section *3.2.5*). To recap, the 'generalised other' is the socially created conscience of self that contains the 'laws' that are supposed to be obeyed within a group, as well as the values, morals, beliefs and behavioural expectations of the group. The 'generalised other' enables individual self-control and self-direction of behaviour so that it is consistent with the actions of others. Not only does it guide *our* own behaviour, but it also allows us to understand the actions of others and the social rules that *they* abide by. William Thomas (1923), a forerunner to Mead referred to this as *definition of the situation*.

Definition of the situation predicates that individuals in a given social situation have a collective agreement of the situation, and therefore each knows how to act and react in such a situation (Thomas, 1923). This is the direct result of 'self' being a social construct that can be objectively assessed from the viewpoint of the individual, so that individuals can appraise their own behaviour in light of the interactional context. Each member in the collective group will strive to take the role of the other, which Mead states would establish a shared understanding of what is going on and how the situation should proceed (Scott, 2006). Group life continues therefore, at least in part because individuals possess a shared understanding of the culture on which to 'define the situation' and their own behaviour (Meltzer, 1972). Extrapolating this to SHGs, the culture of recovery and its associated values, norms and behavioural expectations that are possessed by members of the SHG and reinforced through social interaction enable members to continually 'define the situation' so that their behaviour matches the culture of the project. Mead (1934) states that society and self are two sides of the same coin, intrinsically linked so that society influences self and vice versa. This suggests therefore that the recovery culture of the SHG

influences the self of each individual, which in turn, reinforces the recovery culture of the SHG.

Thomas (1923) also argued that through continual 'definition of the situation' from each individual group member, moral codes and norms are established in collective groups (Thomas, 1923). This is particularly important for abstinence based SHGs such as the LTLA project, as it offers an explanation as to why the individuals who attend the project, do so abstinent. Their 'definition of the situation' infers to each service user that abstinence is the socially accepted behaviour and that attending whilst under the influence of alcohol could result in social persecution. Alfred Schutz stated that through continual 'definition of the situation', actors within the situation have background knowledge and 'typifications' that contribute to order and predictability of social encounters, resulting in every individual of the group following the unspoken rules (Wagner, 1983).

Culture therefore, seems to operate in a manner that minimises obedience and group conformity by force, in favour of promoting commitment to the shared culture of the group (Shibutani, 1955). The 'rules' that are embodied by the 'generalised other' which influences an individuals 'definition of the situation' are important as they impose order (Charon, 2010). Given that social interaction is an ever-evolving process, culture is an ever-changing process that adjusts to maintain the stability and order of a group. The culture of recovery that subsumes the project therefore, is the product of individuals socially interacting with the shared intention of continuing their recovery trajectories. This in turn, becomes a shared perspective adopted by each individual in the group and each new individual who joins the group, which will in turn guide their behaviour so that it mirrors the overarching culture of recovery that subsumes the group. Based on the seemingly strong culture or recovery that subsumes the project, the same culture fosters and reinforces ongoing social interaction.

Up to this point, the theoretical framework of symbolic interactionism and its associated constructs have been discussed along with the concept of culture. The subsequent theories discussed in this chapter all use 'self' as the focus of individual action and perceived identity transformations in recovery. Furthermore, all theories discussed in the remainder of this chapter and the findings chapters will utilise 'self' as a complete, holistic structure, as it is this conceptualisation of self that is directly testable in research[6]. Whilst the exploration of the individual components that make up symbolic interactionism as a theoretical framework may not be directly referred to (based on the fact that they are not directly testable constructs), they are vitally important to understand the basic assumptions held by symbolic interactionists and their theories. All of the theories discussed in the remainder of this chapter and throughout the results section utilise 'self' and self-related processes as a complete structure, and are grounded in the assumptions of symbolic interactionism as a theoretical framework.

3.4 Identity

Identity first emerged as a focus of empirical enquiry in the 1940's, with Erik Erikson commonly cited as the main protagonist for its introduction to theoretical and empirical efforts in the social world (Stone, 1962; Vryan, Adler & Adler, 2003). The purpose of this section is to set out the conception of identity from the theoretical perspective of symbolic interactionism. Gregory Stone's (1962) definition is considered one of the most useful working conceptions of identity (Vryan, Adler & Adler, 2003):

> *"Almost all writers using the term imply that identity establishes* ***what*** [emphasis in original] *and* ***where*** [emphasis in original] *the person is in social terms. It is not a substitute word for "self". Instead, when one has identity, he is* ***situated*** [emphasis in original] – *that is, cast in the shape of a social object by the acknowledgement of his participation or membership*

[6] The individual components (the 'I', 'me' and 'the generalised other') that make up self relate more to the fundamental philosophies of symbolic interactionism as a theoretical framework, and should be assumed to function throughout the self-related processes explicitly discussed throughout this thesis.

in social relations. One's identity is established when others ***place*** [emphasis in original] *him as a social object by assigning him the same words of identity that he appropriates for himself or* ***announces*** [emphasis in original]*. It is in the coincidence of placements and announcements that identity becomes a meaning of the self"* (Stone, 1962; p. 93)

Unlike the individually focused self and self-concept explored above from a Meadian perspective, identity is a much more social construct as it indicates a specific spatial and temporal location within a social structure. Furthermore, given that identity is considered a wholly social construct (Nettleton, 2006), identity is only established and confirmed through social interaction with others. The first part of this chapter will discuss identity from the perspective of Erving Goffman, followed by a second section that explores the work of two contemporary interactionist theorists, Sheldon Stryker and Peter Burke, who incorporate social structure into a traditionally agency-focused view of self and identity.

3.4.1 Identity: Goffman's perspective

The rationale for exploring identity specifically from a Goffmanian perspective, is because Erving Goffman is considered unrivalled when it comes to the social interpretation of everyday interactions and identity (Jenkins, 2008). Furthermore, Goffman's theoretical explanation of identity and presentation of self in everyday life provides an in-depth general framework upon which future theories of identity have evolved (Vryan, Adler & Adler, 2003)[7]. Whilst Goffman was not the first to explore the idea that identity is *situational*, Goffman's explanation of a situational identity is arguably the most influential (Smith, 2006).

Goffman's (1959) seminal book *The Presentation of Self in Everyday Life* sets out his conception of identity grounded in dramaturgical analysis. Goffman

[7] In a similar way that symbolic interactionism can be considered a general framework as it provides a set of ideas on how best to explain the social empirical world, as opposed to providing more specific, testable theories.

argued that identity was ultimately carved out during the flow of information that occurred during face-to-face interactions (Vryan, Adler & Adler, 2003), which he demonstrated through a dramaturgical metaphor. There are three basic parts to Goffman's dramaturgical scene: *the performance*, *the front stage* and the *back stage* (Goffman, 1959). The performance is the overt behaviour that other people witness; the front stage is the 'area' where the public view the performance and make judgements about behaviour; and the back stage is the domain of the self image where one can be 'removed' from public scrutiny (Goffman, 1959), a place physically and mentally out of view. The core of his dramaturgical metaphor is suggested to be 'the performance' (Leary, 1996) (see section *3.4.2*). Goffman argued that identities are carved out through *impression management*, as this process dictates the information that is passed during face-to-face interactions (Leary, 1996). Thus in face-to-face interaction, two processes seem to occur. First, an individual is able to guide what others might think of them by amending their appearance or manner based on their continual 'definition of the situation', whilst at the same time, the individual is forming and obtaining information about the individual they are interacting with (Leary, 1996). 'Definition of the situation' is an important component of Goffman's identity perspective, as it highlights that an individual can be a performer and an audience members simultaneously (Leary, 1996).

Goffman (1959) also explained how identity has an impact on behaviour. Goffman stated that when identities are threatened, our own behaviour, as well as others' behaviour, engage in cooperative efforts to re-establish our own, and others' situational identities (Vryan, Adler & Adler, 2003). For example, if an individual at a formal dinner (a social situation where one is trying to present themselves as dignified and elegant) trips, those nearby are likely to enact inattention and tact so as to establish a working consensus in situ (Vryan, Adler & Adler, 2003).

Relating this to addiction, those 'around' the addicted individual may 'turn a blind eye' to their addiction to avoid having to directly face the consequences of addiction, which arguably reinforces problematic substance use

as such use goes 'unnoticed'. It is only when addiction becomes so problematic that inattention to such drinking patterns cannot be overlooked. This point demonstrates how individual identity is not just shaped by the individual, but also by others that they socially interact with. Furthermore, Goffman (1959) states that the identity performance we enact for others impacts on how we view ourselves, as self-conception is consistent with the performances we enact. As such, identity is the synthesis of the individual internalising their own individual performance, as well as their social and situational identity in reference to their audience (Vryan, Adler & Adler, 2003). This point is important as it illustrates how Goffman acknowledged that identity was also impacted on by the social structure of the group in which the individual was located (Stone, 1962), which produced arguably a more refined view of identity than that of earlier interaction theorists such as Mead and Blumer. Based on his dramaturgical approach to conceptualising identity, Goffman proposed two 'types' of identity an individual can 'be': the *virtual and/or actual social identity*.

3.4.2 The 'virtual social identity' and the 'actual social identity'

Returning to look at 'the performance' in closer detail, Goffman (1959) defines it as:

> *"A 'performance' may be defined as all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants"* (Goffman, 1959; p. 26)

'The performance' of others is important as it allows for *us* to assume a set of personal and structural attributes about an individual in first encounters ('honesty' is an example of a personal characteristic, and 'occupation' represents structural characteristics) that make up their 'social identity' (Goffman, 1963). However, until assumptions have been verified, the characters *we* impute about an individual are made 'in effect' (Goffman's (1963) term). A characterisation made 'in effect', Goffman explains, is the *virtual social identity*. He contrasts this with a construct he terms the *actual social identity*; attributes the individual actually proves to posses (Goffman, 1963). Based on the type of discrepancy

between the virtual and actual social identity (for example, a good or bad discrepancy), an individual can move up or down in other individuals estimations. A good discrepancy, Goffman (1963) explains, is one that necessitates that an individual be 'reclassified' from one socially accepted category to a different, more reputable category. On the other hand, a bad discrepancy can result in the individual being discredited, as their personal and structural attributes impose a less desirable conception of the individual from the view of others (Goffman, 1963). This latter discrepancy is the result of *stigma* (Goffman, 1963).

3.4.3 Stigmatisation, stereotyping and symbolisation

Goffman's (1963) book *Stigma: Notes on the Management of Spoiled Identity* is one of the biggest contributors to understanding the concept of stigmatisation in the last fifty years and as such; will form the basis of the discussion on stigma here. Goffman (1963) states that a stigma is essentially anything that discredits an individual in anyway. Goffman (1963) states that stigmatisation ultimately results in individuals being stereotyped under one identity. Goffman (1963) cites the account of a blind individual:

> *"For some, there may be a hesitancy about touching or steering the blind, while for others, the perceived failure to see may be generalised into a gestalt of disability, so that the individual shouts at the blind as if they were deaf or attempts to lift them as if they were crippled. Those confronting the blind may have a whole range of belief that is anchored in the stereotype"* (Gowman, 1957, cited in Goffman (1963).

In this scenario, the blind man is treated as if his blindness has resulted in multiple disabilities; *"shouts at the blind as if they were deaf...* [or] *crippled"* resulting in the blind individual being treated under the larger label of "disabled". Goffman (1963) identified three different types of stigma. Firstly, there are those stigmatised as a result of a physical abnormality; secondly, there are those socially stigmatised due to their individual character, for example, the weak-willed, the mentally ill and substance addicts; and thirdly, those

stigmatised due to their race, religion or national origin. Of particular interest for this research is the second group of stigmatised individuals, as it pertains to those with substance addictions. Falk (2001), another highly influential sociologist to have written about stigma, stated that deviancy (and therefore substance addiction) is an *achieved stigma* as the individuals have significantly contributed to their own 'spoiled identity' (Goffman, 1963) through their actions of continued substance misuse. Although Falk's (2001) concept of 'achieved stigma' is perhaps accurate, it is important to remember that stigma is a social creation attributed to an individual through face-to-face interaction with those who consider an action to be deviant from the norm (Goffman, 1963). Therefore, an individual can only 'achieve' their stigma, if their behaviour is classified as stigmatising by others in interaction in the first instance.

A final point to note with regards to stigma is the strengthening effect it can have for those who are stigmatised. Goffman (1963) states that the stigmatised can avoid stigmatisation if a group of those who possess the same stigma form a group. Lloyd (2010) provides interesting insights into this with regards to drug use. In his paper for the UKDPC, Lloyd (2010) suggests that if drug users who possess the same stigma form a group, stigma is alleviated. In other words, by the very nature that everyone possesses the same stigma, no one possesses it. This is a potentially very important part of SHGs, as it serves to address sources of stigma through each members understanding of what it is like to face such stigma. This in turn, could act as a strong source of commitment to SHGs, as members feel they a sense relief that they will not be persecuted for the addiction.

The concept of stigma allows 'normal' individuals to label others with an unwanted set of characteristics resulting in a *stereotype* (Goffman, 1963). Goffman (1963) states that stereotyping is a process whereby those without the stigma *"impute a wide range of imperfections on the basis of the original one"* (Goffman, 1963; p. 5). Goffman (1963) refers to these character traits as *symbols*, which, in this example due to their potentially stigmatising nature, are referred to more specifically as *stigma symbols*. Goffman (1963) states that 'symbols'

convey social information to others, about the individual who is conveying the symbol. The 'track marks' of a heroin addict, the worn septum of a chronic cocaine user, the discoloured fingers of a chronic smoker or the smell of a chronic alcohol user are all 'stigma symbols' that people 'use' to stereotype the individual as 'a junkie', 'a coke head', 'a smoker' or 'an alcoholic' respectively. All of which serve to reinforce the 'spoiled identity' (Goffman, 1963) of the individual; thus creating further problems for the labelled, as they face social problems due to their stigmatised identity. All of these examples are examples of another process known as *symbolisation* (Cohen, 1972).

Cohen (1972) found in his acclaimed ethnographic study on 'Mods' and 'Rockers' at British seaside resorts that there are three processes to symbolisation. Firstly, Cohen (1972) states the initial step of symbolisation is 'a word'; for example 'Mod' or 'Rocker' which, over time, becomes symbolic of a certain status i.e. deviancy. This leads on to the second phase relating objects or 'things' to the word, which in Cohen's (1972) research were objects such as hairstyles and clothing synonymous with the 'Mod' or 'Rocker' appearance. This subsequently results in the object or 'thing' becoming symbolic of the status; the third stage in the symbolisation process. To extrapolate this to SHGs, if 'recovery' symbolises the group, then over time, 'things' related to recovery, such as abstinence, will begin to become 'symbolic' of those who attend the project. To reiterate, identity is a wholly social process where others ultimately determine the identity of an individual in social interaction based on the behaviour of the individual (Nettleton, 2006). If an individual therefore, acts in a recovery-orientated manner, and continues such behaviour over time, their identity is likely to become one that symbolises positive traits associated with recovery, and not negative traits associated with the stigma and stereotypes of addiction.

The second part of this section on identity discusses the work principally of two influential contemporary interaction theorists: Sheldon Stryker and Peter Burke. Together, they further the integration of social structure into a traditionally agency-focused symbolic interactionist perspective (Stryker & Burke, 2000).

3.5 A structural symbolic interactionist approach: A brief introduction

The term 'structural symbolic interactionism' is one that serves to marry two closely related views of identity (Stryker, 1980). Both views are instantiations of a theoretical and research program whose goal it is to understand and explain how social structures affect self and how self affects social behaviours (Stryker, 1980; Stryker & Burke, 2000). The rationale for focusing on the work of Stryker and Burke both independent of one another and together is because they have produced a theory that attempts to marry the linkages of social structure with identity. Based on a paper they wrote together (Stryker & Burke, 2000), Stryker advocates that the relationship between social structures and identity influences self-verification, whereas Burke proposes that the process of self-verification creates and sustains social structure. When synthesised, they produce an elegant theory whereby the individual and social provide contexts for one another (Stryker & Burke, 2000), thus serving to address the criticism that symbolic interactionism favours agency over structure (Gouldner, 1970). In order to understand the synthesised theory completely, the individual parts must first be understood. This starts with the work of Sheldon Stryker.

3.5.1 Sheldon Stryker's identity theory

One of the biggest issues with Mead's framework of self and identity is that it fails to produce a testable theory of identity, conjectured to be the result of ambiguity of his central concepts (Meltzer, 1972). There is a need therefore to specify and make researchable the concepts of self and society based on Meadian philosophy, and to organise these explanations to demonstrate how they impact on *behaviour*, the ultimate focus of sociological research (Stryker, 1968). Stryker (1980) states that Mead's theoretical propositions are adequate to deal with the emergence of the social person but not adequate to deal with the complexities of 'society', hence his desire to depart from Mead in this respect. Stryker (1968) therefore was keen to show that:

"... society is seen as a mosaic of relatively durable patterned interactions and relationships, differentiated yet organized, embedded in an array of groups, organizations, communities and institutions, and intersected by crosscutting boundaries of class, ethnicity, age, gender, religion, and other variables. In addition, persons are seen as living their lives in relatively small and specialized networks of social relationships, through roles that support their participation in such networks. The embeddedness of patterned interactions and relationships implies a structural symbolic interactionist argument." (Stryker & Burke, 2000; p. 285)

Stryker therefore, became interested in why people chose to behave the way they did in a given social situation, and why in a particular social setting, the behaviour chosen to perform was decided upon (Stryker, 1968). Stryker's (1968) paper is suggested to be one of the most significant theoretical accomplishments of the decade as it reasserted symbolic interactionist ideas within mainstream sociology (Smith-Lovin, 2007). Stryker's (1968) paper reasserted the ability of the symbolic interactionism principle: that society shapes self, which in turn shapes social behaviour (Stryker, 1968; Smith-Lovin, 2007). The basic premise of Stryker's identity theory can be traced back to James' theory that self is multifaceted, with each person possessing different selves based on the social group in which they are participating (Stryker & Burke, 2000). In Stryker's identity theory however, he fuses the concept of identity with role (Vryan, Adler & Adler, 2003), so that different social roles are associated with specific behavioural expectations depending on the position occupied by the individual in the social group, with identity being an *internalisation* of the role expectations (Stryker, 1968; Stryker & Burke, 2000). Stryker's theory therefore, posits that role choices are a function of identity, and that identities within self are arranged with more important identities existing at the top of the *salience hierarchy* (Stryker, 1968).

Salience hierarchy refers to the idea that the more important the identity to the individual, the higher up the hierarchy it will be 'placed', and the more

likely it will be evoked than those identities lower down the hierarchy (Stryker, 1968; Vryan, Adler & Adler, 2003). The salience hierarchy, Stryker (1968) explains, determines which identities are invoked as people enact their roles and interpret the roles of others. The more salient an identity, the more meaning it has for an individual, thus resulting in the individual trying to perform such a role and its associated behavioural expectations more often. For example, if 'recovery' becomes a salient identity for the service users at the LTLA project, such an identity will be performed more often in different social contexts, as it possesses inherent 'value' to the individual. The more an identity is performed, the more consistently they are associated with it. However, in order to build a more holistic identity theory, specification of the concept of 'society' is needed (Stryker & Burke, 2000). Stryker (1968) conceptualised his salience hierarchy proposition through a construct he termed *commitment*.

'Commitment' refers to the notion that individuals designate varying degrees of dependence to relationships based on the others *being* a certain type of identity (Vryan, Adler & Adler, 2003), with greater salience reflecting a greater degree of commitment and meaning to that role (Stryker & Burke, 2000). Stryker and Serpe (1982) demonstrated this conceptualisation during their investigation of religious identities. They found that the salience of a religious identity predicted the time spent 'doing' religious activities, and that the salience of the religious identity predicted increased commitment of the individual to the role of religion and its associated meaning and relationships. Serpe and Stryker (1987) also found that identity salience and commitment to salient identities is potentially stable across time. They found in a quantitative study of new university students that they seek to find relationships (by joining various groups and societies) that provide them with the opportunity to behave in a manner that is congruent with their more salient identities. They concluded that self-structure was stable over time, as they were able to perform roles that were congruent with their identity (Serpe & Stryker, 1987; Wells & Stryker, 1988).

A final implication of Stryker's identity theory is that it also explains how emotional responses impact on identity (Serpe & Stryker, 1987). For behaviours

that are positively reinforced by others, the commitment to such an identity will be strengthened, thus promoting it further up the salience hierarchy. This in turn will enhance feelings such as self-worth, self-confidence, and self-esteem further enhancing one's commitment to the identity. Subsequently, the probability of performing such role expectations in the future is increased (Serpe & Stryker, 1987). In contrast, if role expectation (behaviour) is judged as negative based on cultural norms of the social structure and 'definition of the situation' in which an individual is located, negative feedback from others through social interaction will be conveyed. As a result, feelings of anger, shame and guilt are likely to be self-conveyed (Serpe & Stryker, 1987). In this latter scenario, an individual can improve their role performance so as to '(re)-define the situation', which if it is not possible, the identity will move lower down the salience hierarchy, thus making it less likely the identity and its role expectations will performed in future situations. Thus Stryker states that emotions are *markers of adequacy*, with positive emotions reflecting adequate role behaviours, and negative emotions reflecting inadequate behaviour (Serpe & Stryker, 1987).

To conclude, Stryker and colleagues research states therefore, that social structures affect the structure of self, as an individuals position in a social structure will dictate what role is performed, but also that the structure of self and how salient and committed an individual is to a particular identity, influences social behaviour (Stryker & Burke, 2000). However, his identity theory fails to fully acknowledge the internal dynamics of self-processes and how identities operate within the contexts in which they were held (Stryker & Burke, 2000), a shortcoming that is addressed through the work of Burke and colleagues.

3.5.2 Peter Burke's identity theory

Burke and colleagues identity theory is essentially based on traditional symbolic interactionist views that identities are self-meanings and that self-meanings evolve in the context of roles and counter-roles (Burke & Tully, 1977; Burke, 1980; Stryker & Burke, 2000). A second important feature of Burke's identity theory is that the link between behaviour and identity is through the

meanings they share (Burke & Reitzes, 1981). In order to demonstrate the intrinsic importance of *meaning* as a connection between identity with behaviour, Burke and Reitzes (1981) needed a method to measure both identity and behaviour (Stryker & Burke, 2000). The empirical measure they used was *semantic differential measurement* developed by Osgood and colleagues (1957), a positivistic method that measures meaning as internal responses to stimuli. Following research conducted by Burke and Tully (1977) who adopted the semantic differential measurement technique, which demonstrated that self-meanings are reflexive responses to self-in-role, Burke and Reitzes (1981) were able to show that identities predicted behaviour only when the *meaning* of identity corresponded to the meaning of behaviour. To use recovery as an example, a recovering individual's self-view of continued substance use would not predict recovery, as continued drinking and recovery do not share the same meaning. In contrast, a recovering individual's self-view of abstinence is likely to predict recovery, given the shared meaning between the behaviour of abstinence and the identity of recovery.

This led Burke and Reitzes (1991) to develop a model of identity, which states that behaviour serves to organise and change where necessary, perceived symbolic self-meanings of a situation so that they agree with the *identity standard*. The 'identity standard' is the set of culturally prescribed meanings held by an individual, which define their role in a given situation (Burke & Reitzes, 1991; Stryker & Burke, 2000). For example, the 'identity standard' of an individual at the LTLA project could be comprised of meanings that are culturally relevant to the project, for example, the meaning of abstinence and recovery for each service user. Burke and Reitzes (1991) refer to this process of behavioural change as *self-verification*, a process that demonstrates how behaviour can be amended or used to create a new situation so as to ensure perceived self-relevant meanings match their identity (Stryker & Burke, 2000). To use recovery as an example once more, if a recovering service user values their 'recovery identity' highly, abstinence, a behavioural trait of recovery, is likely to be enacted by ensuring their situation matches the meaning of a recovery and abstinent

identity, for example, not going to locations that promote alcohol and/or drug use.

Burke and Reitzes (1991) cognitive concept of *behavioural change* is key, as it demonstrates the potential connection with Stryker's more structural theory. Unlike Stryker (1968) who demonstrated the ability of social structure to impact on *behaviour*, Burke and Reitzes (1991) identity conception demonstrates how the individual agent impacts on *behaviour*. Before the synthesis of the two theories is discussed, two final points need mentioning with regards to the implications of Burke and Reitzes' (1991) model. Firstly, it instils agency to the individual, as *their* behaviour is able to change the situation in order to make congruent the meanings held in the situation by the individual and *their* standard identity (Burke & Gray, 1999). Secondly, like Stryker's model, Burke's conception of identity also takes into account emotional responses (Burke & Stets, 1999). For example, in situations where identities are verified by the responses of others, individuals will experience positive emotional feedback, thus enhancing feelings of self-worth, self-confidence and self-esteem. Conversely, where others do not verify identities, individuals will experience negative emotions such as guilt, shame and anger (Burke & Stets, 1999). The parallels with Stryker's model are evident through different strands that seem to relate to behaviour, meaning and emotion. The next section discusses how Stryker and Burke's theories can be combined to produce a theory of identity that incorporates both agency and structure into its make up.

3.5.3 Combining the two theories

As it has already been suggested, the two theories primarily link through *behaviour* (Stryker & Burke, 2000). Stryker's structural theory emphasises the impact of social structures on identities and the relationship between identities, and explains *behaviour* through the process of an individual moving from social structures to commitment to relationships through the resulting salience and meaning of identity to behaviour (Stryker & Burke, 2000). Burke's cognitive theory emphasises the internalised process of self-verification, an internalised mechanism that verifies or indicates discrepancy between the perceived self-

meaning of a situation and the identity standard, and explains *behaviour* by stating an individual amends their behaviour to address any discrepancy between the two (Stryker & Burke, 2000).

There is added cohesiveness between the two theories given the fact that they are built on philosophical and sociological foundations cemented in a symbolic interactionist framework. Stryker and Burke (2000) offer several points of connection. First, both theories understand identity to be different from self, with self being made up of multiple identities and second, they both connect identity with behaviour through meaning. Third, individual roles and role expectations are located within different social contexts and groups that provide different expectations based on the context. As a result, they claim their theory takes into account individual roles within social structures, which can explain different social groups. Adjunct to this is the notion of commitment and the number of others that an individual is connected to through a particular identity (Stryker, 1980). The more 'ties' there are to a particular identity in a social structure, the more salient that identity becomes therefore making it more likely to be performed (Stryker, 1980). This has particular relevance for SHGs as the 'identity of recovery' could mean that a 'recovery identity' becomes more salient for the individual, as they are all connected through the 'identity of recovery', thus facilitating individual recovery trajectories.

Fourth, they state that interaction of persons in a common situation will verify the identity and commitment to that identity for each individual (Burke & Stets, 1999; Stryker & Burke, 2000). This again has implications for SHGs, as it suggests that the common meaning of recovery that subsumes the project, in which interactions take place, reinforces the 'identity of recovery' for each individual. Finally they state that their model enables individuals with identities in a specific situation to manipulate symbols and resources to obtain goals (Freese & Burke, 1994). Freese and Burke (1994) found that manipulation of resources creates *value* for a given identity, which in turn, increases the level of commitment to groups that underlie the identity, and increases salience of the identity so it is more likely to be performed in future situations. This too has

implications for SHGs. If service users are able to manipulate and utilise the resources offered by SHGs to their advantage, the value of their 'recovery identity' may take on greater meaning and salience, thus making it potentially more likely that the role expectations associated with a 'recovery identity' will be performed in future situations. The final part of this chapter will explore the identity of 'space' and how important such a concept could be for recovery.

3.6 The identity of 'space'

In the context of this research, 'space' refers to the physical location in which something is set. Understanding physical space and the perceived identities it is associated with is important, as it is suggested that socio-spatial relations have important implications for the construction of identity, as both space and identity are considered mutually constitutive (Bondi & Rose, 2003): identity shapes space, just as space shapes identity. For example, a church is an iconic religious edifice that principally symbolises, and is identified with, strong Christian values based on the religious scriptures of the Bible. This in turn, has the effect of identifying those who attend church as possessing strong Christian beliefs. In the modern world in which we live however, the church is often associated with pejorative traits such as corruption and allegations of sexual abuse, but this nevertheless further implicates the relationship between identity and space. Whatever one's view of the church, either good or bad, it represents the importance of a locations identity and the traits we impute onto those who occupy that space.

In order to explain the identity of space and its impact on identity formation, structural symbolic interactionism shall be drawn upon. The reason for overlooking Goffman's theorisation of identity is because the very feature that has made Goffman's work so iconic in the field of sociology is also the feature that restricts its use here. Through a highly detailed, microsociological analysis of identity and group relations, Goffman produced a dramaturgical account of the actor in their broader social context that is still used in many domains of sociology and deviance today; a testament to the analytical rigour with which he interpreted an unexplored area of social thought. However,

Goffman's microsociological analysis and dramaturgical study of self and identity limits the possibility of applying it to activities in the larger social world, and therefore provides at best, a cursory explanation of larger institutions and processes of society. Whilst structural symbolic interactionism does not provide a complete solution to understanding the identity of space and its impact on identity transformation, it does provide a tangible approach to conceptualise how the identity of space may impact on identity formation. That tangible approach is through 'commitment' and a 'common meaning' (Stryker & Burke, 2000).

Structural symbolic interactionism suggests that through interaction in a common space or situation, the common meaning of that space would shape the identity of the individual occupying that space. The more one commits to the identity of the space they occupy, the more reinforced the identity becomes in the individual. Returning to the church analogy, if an individual attends church on a regular basis, they will begin to develop an identity based on the identity of the church. The more an individual attends church, the more reinforced the meaning of church will have for the individual. Given that the socio-spatial relationship is mutually constitutive, those who attend church will in turn, reinforce the identity of the church. It is important to remember that identity is multi-dimensional (Jenkins, 2008), which means that the identity of a churchgoer is likely to be just one identity they possess. The salience of the identity will depend on how high up their salience hierarchy the identity is located (see section *3.5.1*) (Stryker & Burke, 2000). The relationship between the identity of space and identity formation plays a potentially important role in recovery from substance addiction. For example, if an individual attends, and continues to attend a SHG for addiction recovery, an identity is likely to develop based on the identity of the SHG. If that identity is one of abstinence, an individual is likely to develop an identity based on the guiding principles of abstinence. The more an individual attends the SHG, the more salient their recovery identity is likely to become.

3.7 Concluding comments

This chapter has provided an overview of symbolic interactionism as a theoretical framework, and the subsequent interactionist theories of identity that will be utilised in this research. The first section explored the theoretical influences on Mead, and how he used such influences to produce a detailed cognitive explanation of how self interacts with society. The second section explored the concept of identity, first with an overview of identity from a Goffmanian perspective, which introduced the idea of 'the performance', virtual and actual social identities, stigma, stereotyping and symbolisation. The second part of the identity section explored two more contemporary theories that served to fuse agency and structure into the same identity theory through their individual explanations of behaviour, which led them to a revised version of Mead's formula: *"commitment shapes identity salience shapes role choice behaviour"* (Stryker & Burke, 2000; p. 286). Finally, there was an exploration of the mutually constitutive relationship between space and identity.

To conclude, the constructs in this chapter relating to self and identity have been explained ultimately from a theoretical point of view. This chapter develops the story of this thesis as it explicitly sets out the theoretical assumptions that are to be used to explain and frame the data with existing evidence in the literature. An advantage of using symbolic interactionism as a theoretical framework is that it possesses a number of *applicable* theories that can be extrapolated to many social arenas. Whilst theory is important, the application of theory is arguably even more important. Highly complex, detailed theory that has little application to the social environment is arguably of little value, as such theory will likely offer little by way of a coherent explanation of the social world. The theoretical framework explored in this chapter has already been used to explain a significant number of social environments, many in the field of deviancy, a social domain with many ties to this research, thus making the theories highly applicable to this thesis.

The focus of the next chapter is to outline the methodology and methods used in this research. This will demonstrate the methodological assumptions that were adopted during data collection, which will in turn, justify why the specific methods of participant observation and semi-structured interviewing were used.

Chapter 4

Methodology and Methods

4.1 Introduction

This chapter outlines the methodology and methods deployed in this research. In the interest of methodological pluralism, it is important to explicitly set out the methodology and methods used in this research, as it demonstrates an affinity between the specific technical practices adopted to physically collect, analyse and report the data (methods) and the more holistic, conceptual framework that 'I' - as a researcher - have adhered to (Payne & Payne, 2006). A case study design using the methodological approach of ethnography, and deploying the methods of participant observation and semi-structured interviews, was considered the most appropriate framework to address the research aims and objectives (see section *2.6.1*). To recap, the main aim is to gain an in-depth and holistic understanding of the Learning to Live Again project, an 'ex-service user' led group that attempts to facilitate the recovery of those suffering with alcohol dependency. This aim is addressed through objectives that explore the structure and organisation of the LTLA project and its location at the Leeds Addiction Unit. Other objectives include exploring whether, how and why the project impacts on recovery and how attendance at the LTLA project may impact on issues surrounding identity and sense of self.

This chapter is split into four sections. First, in order to address the research aims and objectives, a discussion of the methodological assumptions of this research are discussed. This includes a discussion on why a qualitative approach was adopted to explore the LTLA project, ethnography and the case study design used in this research. The second section discusses the research tools used to collect the data: participant observation and semi-structured interviews. Third, the credibility and trustworthiness of this research are discussed (Guba & Lincoln, 1981); two concepts that had significant influence

over my research. Finally, there is a detailed description of how the data were analysed.

4.2 Methodology: a brief introduction

Presenting the methodology is important as it sets out the theoretical assumptions of the researcher. The term 'methodology' refers to *"the science of methods"* (Payne & Payne, 2006) and sets out the governing standards for the appropriate selection and application of the chosen research tools in this research. The appropriate methodology goes above and beyond the research tools and refers to a higher level, more ubiquitous set of methodological assumptions. Given that I wanted to understand the respondent's life as a whole and how their recovery has been impacted on by the LTLA project, this supported an ethnographic approach so that I could explore the LTLA project's culture in great detail (Hughes, 1990). There are three parts to my methodology: why I chose qualitative methods, ethnography and the case study design adopted for this research.

4.2.1 A qualitative approach

The rationale for using qualitative methodology is fivefold. First, the flexibility of qualitative methodology allowed me to gain a complete, holistic understanding of the project in its original setting (Janesick, 1994), through the use of observations and semi-structured interviewing to explore the theoretical framework, interactions and views and perceptions of the individual service users, mentors and professional staff who utilise or work at the projects (Ambert et al., 1995). Second, a qualitative methodology allowed me to explore how relationships are formed between the service users, mentors and professional staff and the complexities of how and why 'things happen' (for example, relapse) (Huberman & Miles, 1994); thus shedding insight on how and why recovery from substance dependency is perceived to unfold in light of the LTLA project. Third, a qualitative methodology provided me with the opportunity to understand and make sense of the social realities of the recovering service users that utilise the project (Denzin & Lincoln, 2008); thus allowing me to gain insight into how salient a role the project plays in the recovering user's lives. Fourth, in keeping

with my theoretical perspective of symbolic interactionism, a qualitative methodology ensured the story behind why and how the LTLA project was set up could be explored, as well as how it operates; thus giving me firsthand knowledge of an unexplored social entity (Blumer, 1969). Finally, using a qualitative methodology was the best way to address the aims and objectives of this research. Under the pervasive term of 'qualitative research' there are a number of different conceptual frameworks, such as grounded theory or phenomenology a researcher can adopt to address their research aims and objectives. The most appropriate conceptual approach for this research was *ethnography*.

4.2.2 An ethnographic approach

As the research aims and objectives state (see section *2.6.1*), I am interested in exploring the culture of the LTLA project, as well as the service users who make up the LTLA project. Ethnography is principally aimed at understanding a culture, whatever the social setting, making it most appropriate for this research. Ethnography means *"describing a culture"* (Spradley, 1980; p. 3) with the central aim to *"learn from people"* (Spradley, 1980; p. 3). Ethnography is fundamentally about understanding a given research setting through close, first-hand inspection (Atkinson et al., 2007), which allows for a deep, context rich understanding of any given social culture (Spradley, 1979). In the case of this research, that culture is to understand how recovery from substance addiction is impacted on by the LTLA project. Ethnography is specifically aimed at understanding the *culture*, knowledge and system of meanings that guide the life of a defined group (Geertz, 1973); thus making it a highly appropriate research methodology to understand the culture of recovery.

Ethnography not only aims to shed light on any given culture under exploration, but it also aims to locate the culture in the wider social context in which it is produced (Spradley, 1979; Atkinson et al., 2007). Understanding the wider social context is a key aim of this research as locating the culture of the project in the wider social context enables not just the area of investigation to be understood, but it also allows for a much deeper understanding of how the

culture impacts on, and is impacted by, the wider social environment in which it is situated (Barbour, 2008). With specific reference to this research, using ethnography as the central epistemological approach allowed for highly detailed, context rich, firsthand information on the impact of the LTLA project on recovery through extensive fieldwork (Silverman, 2005; Hammersley & Atkinson, 2007).

There are two further justifications for the use of ethnography in this research. First, ethnography has intellectual affinity with symbolic interactionism (Rock, 1979); the underlying theory adopted in this thesis. Blumer (1969), one of the founding fathers of symbolic interactionism (Hart, 2010), states that in order to truly understand any given social world, its problems, conceptions, relationships and interactions, one must have firsthand knowledge of the social world. Blumer (1969) also states that a research scholar must have intimate familiarity with their chosen field of research, as it gives much greater insight, and therefore more in-depth interpretation, into the social world under investigation. Without this familiarity, one may misinterpret or miss key interactions that may occur, which shed light on how and why the social world operates the way it does. Blumer writes extensively about this topic and has demonstrated significant parallels between ethnography and symbolic interactionism, which creates a balanced dynamic between the theory and research methodology (Blumer, 1969). The second justification is the extensive use of ethnography in the study of deviance. Highly influential studies of deviancy such as Laud Humphrey's 'tea-room trade', Howard Becker's exploration of marijuana users and Goffman's work on psychiatric institutions all utilised ethnographic techniques to explore their chosen line of inquiry (Hobbs, 2007). Given the relationship between deviancy and addiction, and therefore addiction recovery, the use of ethnography is methodologically (and historically) justified.

4.2.3 Research design

A *case study* design has been adopted. The case study can be considered a part of the methodology, as it is a type of qualitative design as well as being a product of the inquiry (Cresswell, 2007). Case study is an approach that can

explore a bounded system (a case) or multiple bounded systems (cases) over time, with the use of detailed data collection techniques (discussed below) (Cresswell, 2007). The case study approach is commonly associated with ethnography and qualitative methods more generally due to the inductive nature of qualitative research (Payne & Payne, 2006). Yin (2009) states that the case study approach should be thought of as two parts that make an all-encompassing method. The first part relates to the scope of the case study approach:

> *"A case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident"* (Yin, 2009; p. 18)

Based on this and the aims of my research, the case study approach was appropriate to explore the LTLA project. A case study is a detailed study of a social unit, usually representative of many cases that make up the social unit (Payne & Payne, 2006; Yin, 2009). There was one social unit under investigation during this research. I wanted to understand the culture within the LTLA project and how it shapes the trajectories and social interactions of those recovering from substance addiction. The history of the LTLA project and how it has evolved to shape the recovery of its service users and mentors was also an important feature of this research. A major strength of the case study approach is its ability to provide insight into complex social phenomena such as the LTLA project hence its use for this study (Keen & Packwood, 2000). The second feature relates to data analysis and collection:

> *"The case study inquiry copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result benefits from the prior development of theoretical propositions to guide data collection and analysis"* (Yin, 2009; p. 18)

As it shall be discussed later on (see section *4.5*), triangulation of data and methods is a key feature of this research, as it enhanced the credibility of the data collection and analysis. Triangulation of methods was used in this study to gain different perspectives of the LTLA project (Keen & Packwood, 1995), resulting in a holistic, complete and contextual account of the project (Lewis, 2003).

It is important to recognise that there are a number of different case study designs that exist (Yin, 2009). Case studies can be differentiated by single or multiple cases (for example, looking at one or more hospitals) or by units of analysis – holistic or embedded (Yin, 2009). Holistic analysis looks at the global nature of the organisation, whereas embedded analysis looks at the individual units within the organisation (Yin, 2009). Thus it is possible to deploy four different types: single case study (holistic), single case study (embedded), multiple case study (holistic) or multiple case study (embedded).

This research is exploring the views of different personnel involved within one project (the professional staff, mentors and service users). Therefore, a *single case study (embedded)* design is used. The advantage of using this type of design is that it enables extensive, in-depth analysis with enhanced insights of a single case, as the individual units of analysis can be combined to create a more sophisticated understanding of the case under investigation (Yin, 2009). However, a potential pitfall of the embedded design is that the holistic nature of the case study can be overlooked as the individual units are given too much attention (Keen & Packwood, 2000). This pitfall will be addressed by continually relating the different forms of data back to the overarching culture of the project, as well as identifying how the data from the different sources compares and contrasts with one another. The implications of the case study design in this research will be critiqued in chapter *8*.

4.3 Methods

The methods used for data collection included *participant observation* and *semi-structured interviewing*. Participant observation came before the semi-structured interview stage for three reasons. First, going on and participating in the activities and attending the mentor committee meetings allowed me to observe how the service users, mentors and professional staff interact with one another. This provided a 'firsthand' insight of the LTLA project and how it functioned. Second, the data gained from the observational period helped to shape my topic guide for the interview stage. Finally, attending the activities and the mentor committee meetings allowed me to meet the service users and mentors on numerous occasions in a social setting where they were comfortable, thus allowing a good rapport to be built. This meant when it came to the interview stage each participant had already met me several times, thus reducing any perceived anxiety that either the service user or myself had about the interview. The methods used in this research will now be discussed in turn.

4.3.1 Participant observation: the rationale

Considerable amounts of work have been afforded to explaining when and how to use participant observation (McCall & Simmons, 1969), and have been used in some of the most influential pieces of sociological work to date. Of particular importance is the use of participant observation in research on deviance (Hobbs, 2007). The use of participant observation by researchers studying deviance allowed them to gain close and intimate familiarity with their participants (Hammersley & Atkinson, 1995), which enabled them to base their conclusions on firsthand, highly detailed, contextual accounts of different areas of deviance. From their respective studies, a number of highly influential theories have been devised to explain how deviance might start, how it is sustained and how it can be addressed, all of which still have significant influence today.

Participant observation promotes the researcher to witness the reality of an individual's actions in their social context (Silverman, 1985). Participant

observation in the field gave me intimate and close familiarity with the action as it actually unfolded (Grbich, 1999), and allowed me to understand the experiences of the people and the meanings they attributed to them (Bowling, 2009). It enabled me to witness the intricate details of the activities that the LTLA project provided for their service users, as well as the interactions between the service users, mentors and professional staff. Participant observation also enabled a greater understanding of how the activities operated; for example, how and where they met, transport to the activity and how the activity was run, the role the service users, mentors and professional staff, how they interacted and what sorts of activities were provided. Furthermore, by sitting in on numerous mentor committee meetings, I was able to gain knowledge of how the project operated. For example, understanding how the activities were decided upon, who would 'take the lead' on each activity and any other issues that needed discussing. This significantly contributed to the development of my topic guide for the subsequent interview stage, as personal experience of the project was able to be drawn upon. For example, one of the activities I attended was bowling, so in order to be a 'complete participant' (Spradley, 1980), I fully participated and went bowling.

Complete participation involves the highest level of involvement (Spradley, 1980), which had two significant impacts on my research: first, complete participant observation helped me to 'blend in', which downplayed my role as a researcher (Payne & Payne, 2006), as it demonstrated authenticity on my part and a genuine enthusiasm to 'get to know the project'. Second, it enabled me to interact with the service users and mentors, which developed and strengthened my understanding of the group's values, norms and beliefs through enhancing my emotional commitment from a secure and unthreatened position (Ashworth, 1995; Grbich, 1999).

It is important to state however, that I was very careful to ensure I did not 'go native' (Hammersley & Atkinson, 1995). 'Going native' refers to being so immersed in a group that that a lack of distance is maintained from the social entity under exploration (Lobo, 1990), thus resulting in the research agenda

being lost (Hammersley & Atkinson, 1995; Mays & Pope, 1995). To ensure this did not happen, I adopted a 'marginal native' position (Freilich, 1970). A 'marginal native' position refers to being *"part-insider and part-outsider"* (Lobo, 1990; p. 127) thus facilitating in-depth analysis to be made whilst maintaining a critical and objective edge (Freilich, 1970).

4.3.2 Structure of the observations

The observations were structured in such a way as to ensure that my research aims and objectives were addressed. The main areas of interest during each observation were:

- The role the mentor played. Did they assume a position of power, and if so, did the service users react to such a position?
- The role of the professional staff (if one was present during the activity) and how the service users and mentors reacted to such a position.
- How the service users interacted with one another during the activity.
- How the service users interacted with the mentors during the activity.
- How the mentors and service users interacted with a professional member of staff if they were present during the activity.
- How the service users interacted with the environment of the activities settings, and were they nervous or did they interact with others in the 'real world' as if any individual would?
- How the service users, mentors and professional staff interacted with me during the activities; did they treat me as they did when we were not on an activity? Or did they treat me differently because I was an 'outsider' imposing on their project?

4.3.3 My role in the participant observation

Considerable thought was given to how I would present myself on the activities, as it is a factor that may influence the dynamic of the group during the activity. Everyone who attended the activities wore their own clothes (typically jeans, a t-shirt and trainers) and acted in a very relaxed manner. In order to

'blend in' I too wore casual clothing, which had the benefit of alleviating my role as a researcher and helped me to develop close ties and rapport between myself and the participants (Kleinman & Copp, 1993). The service users and mentors typically only encountered professional staff in formal attire at the project, a role I did not want to be associated with, as it may have the effect of creating boundaries between me and the participants if they saw me as another member of professional staff. Furthermore, from a personal point of view, dressing in casual attire to mirror the service users and mentors attire made me feel much more integrated and part of the group; something I feel would not have been achieved if I wore formal attire whilst in the field.

4.3.4 Taking field notes

Another hurdle I faced was how to take field notes. A fundamental tension arose between me wanting to be a complete participant with a high degree of involvement and the need to keep detailed field notes. Keeping detailed field notes of exactly what happens in the field is one of the most important aspects of participant observation (Jorgensen, 1989; Grbich, 1999) and is something that must be done in order to maintain a high level of trustworthiness and credibility (see section *4.5*).

I decided to overcome this tension by not taking notes at all whilst in the field, but instead, to take notes after the activity had finished, out of view of the participants. This was principally for three reasons. First, it was not practical to take notes whilst actually doing the activities; for example, it would have proved very difficult to take notes and bowl at the same time. Second, taking notes in such a social setting could have alienated me from the group and would almost certainly have impacted on the rapport I had managed to build with the service users and mentors who attended the activities. Finally, overt note taking could have impacted on the dynamic of the group perhaps causing the participants to not act as they normally would, which would result in my field notes not being a true representation of how the service users and mentors normally interact. Taking notes after the activity had finished meant I overcame the aforementioned points, and could reflect more deeply on what had happened

during the activity (Payne & Payne, 2006). Furthermore, taking notes after the activities was feasible as the duration of the activities were not too long.

In the field notes I included everything that happened from the start of the activity until the end. I noted who attended the activities (via the use of consent forms), what time the activity started, what the activity was and how long it lasted for. During the activity I noted how the service users interacted with the mentors and professional staff (if one was present) and how these interactions developed during the course of the activity. I also noted how the participants acted with me and how they treated me. I noted how 'involved' I felt I was and also any thoughts or feelings I had with regards to any part of the activity. By documenting not just what happened but also my thoughts and feelings and how they changed over time, I addressed the issues of credibility (validity) and dependability (reliability) (both discussed in more depth in section *4.5*) though *self introspection* and *interactive introspection* with my academic supervisors (Denzin & Lincoln, 1994; Grbich, 1999) (see appendix *7* for a detailed example of field notes that were taken during an observation).

4.3.5 Sampling for observations

The sampling strategy adopted was that of a convenience sample as I was interested in how the activities operated, and had no say in who attended the activities. As I had no say in who attended the activities, the sample was based on whoever turned up for each activity, therefore making it a convenience sample. As a result, the sample for each observation varied each time. Table *4.1* (see following page) illustrates basic information pertaining to each activity attended during the observational period. Whilst these were the activities I attended, appendix *8* provides a detailed description of all the activities that were available to service users during my data collection period.

Table 4.1: Descriptive data of those who attended the activities

Activity	Date of the activity	Description of the activity	Length of activity	Who attended the activity
1	On-going throughout the data collection period. Attended approximately 25 meetings	Mentor committee meetings	1.5 hours (each meeting)	The mentor team (which varied in number and personnel throughout my data collection) and professional staff who were involved with the project.
2	24th November 2011	Women's day: A walk in Skipton	5 hours	1 mentor, 4 service users, 1 professional staff
3	12th January 2012	Opera at the Grand Theatre, Leeds	4 hours	1 mentor, 3 service users, 0 professional staff
4	27th January 2012	Bowling	1 hour	1 mentor, 6 service users, 0 professional staff
5	9th March 2012	Bowling	1 hour	1 mentor, 6 service users, 0 professional staff

Participant consent (appendix *9*) and information sheets (appendix *10*) were given out at the start of each activity I attended for observation.

4.3.6 The Hawthorne Effect

The Hawthorne effect is the modification of an individual's behaviour if they know they are being observed. Payne and Payne (2006) describe the Hawthorne effect as:

> *"...the tendency, particularly in social experiments, for people to modify their behaviour because they know they are being studied, and so to distort (usually unwittingly) the research findings"* (Payne & Payne, 2006)

The Hawthorne effect was addressed by attending a number of mentor committee meetings prior to the first observation. This enabled a good rapport with the mentors and professional staff to be built up, who then introduced me

to the service users at the weekly “meet ‘n’ greet” sessions. These meetings also had the added benefit of me being able to acclimatise and orientate myself to the recovering service users I would encounter during the data collection period; a group of individuals I had previously never encountered before. The Hawthorne effect is a phenomenon that can never be totally eradicated, as it is never possible to know how much others are modifying their behaviour. However, I felt every effort was made by the service users and mentors to integrate me into each activity as best as possible.

4.3.7 The interview stage: the rationale

The interviews were conducted after the observational period and there were a number of reasons for the use of interview methods in this research. First, interviews occur largely as an adjunct to participant observation, as a researcher is able to probe areas of interest on a more intimate level (Grbich, 1999). Second, interviewing allowed me to gain empirical data about the social world under exploration by asking people to talk about their lives (Holstein & Gubrium, 2003). The semi-structured nature of the interview enabled me to direct the conversation with questions designed to open up a conversation about recovery but it also gave flexibility to the respondent to elaborate and tell their story (Wengraf, 2001; Rapley, 2004). Third, individual interviews are arguably the best means of obtaining authentic accounts of subjective experiences (Rubin & Rubin, 1995; Miller & Glassner, 2004) and are considered by many to be the ‘gold standard’ of qualitative research (Barbour, 2008).

Interviews therefore gave me the chance to understand individuals’ feelings and opinions of the project, how it related to other areas of their life, how salient a role the project plays in their life and how the project has impacted on their recovery and (re) integration back into society. By listening to the reconstructed accounts of the individual interviewees, I was able to build up an intellectual understanding across time, race, gender, class and demographic divisions of the activities (Rubin & Rubin, 1995) and how their recovery trajectory had developed. Furthermore, face-to-face interviews enabled non-verbal cues to be interpreted, such as body position and how something was

said, all of which served to provide additional context to my subjective interpretation of the interview transcript (Fontana & Frey, 2008). As an iterative approach was adopted during this research, I was able to open up new lines of inquiry as research progressed (Payne & Payne, 2006). Although the rapport that was built with the interviewees was beneficial for putting the interviewee and myself at ease, this strong rapport could impact on analysis in the form of bias. In order to ensure I minimised bias, I was very careful to be as transparent and reflexive as possible, two concepts that ensure qualitative work is of a high quality (discussed in section *4.5*). Adopting a more semi-structured approach to the interviews meant I was able to freely and actively probe new lines of inquiry that surfaced during the interview (Payne & Payne, 2006). Despite the benefits of including semi-structured interviewing as part of my data collection, there were three caveats that needed considering when interviewing.

First, the ability of the interviewee to accurately recall and articulate insight into their own experiences (Mason, 2002) may cause inaccuracies. This is especially problematic with a cohort of participants who have suffered from years of substance abuse, as it is well documented prolonged exposure to illicit substances has detrimental effects on memory (Ruiz, Strain & Langrod 2007). Second, it must be recognised that interviewing is context dependent and what is said during an interview is a social construction based on the interaction between the interviewer and interviewee (Miller & Glassner, 2004). This is a radical form of social constructionism but must be considered, as it takes into account the context of the interview, which will impact on analysis (Rapley, 2004). Third, the relationship between the behaviour of the interviewee and their desire to be seen in a good light may result in the respondent giving socially desirable answers as opposed to real facts (Coffey & Atkinson, 1996). Taking these points into account is important as they impacted on how I conducted, interpreted and analysed the interview.

4.3.8 Developing the topic guide

The topic guides (appendix *11, 12* and *13*) were developed from the theoretical framework, the research aims and objectives, the observational period and discussion with my academic supervisors. It was important that the theoretical framework was prominent in the topic guides to explore concepts such as identity change, stigma and social interactions with the service users and mentors, and how the project impacted on such concepts. The topic guides covered a breadth of questions ranging from the history and set up of the projects (aimed at the professional staff) through to subjective experiences of the activities from the viewpoint of the service user, mentor and professional staff. It was important to structure the topic guides in this manner, as it yielded diverse responses from a host of different topic areas relating to the project. The first few interviews were considered pilot interviews but these were still analysed and used because important information was gained from them. After the first three interviews had been conducted, I transcribed and sent them to my supervisors. We had a meeting to discuss my interview style and further areas to probe in subsequent interviews. No amendments were made.

4.3.9 Sampling for interviews

There were three sets of interviews: those with professional staff, and those with the service users and mentors. Appendix *14* provides the consent form for the interview stage. All interviewees were given participant information sheets (appendix *15* and *16*). The order of the interviews were as follows:

- **The professional interviews:** The first interview was on the 16th March 2012. The final interview was on the 27th June 2012. I interviewed all three professional staff who were directly involved with the project and three professional staff who worked in the LAU but directly referred to the LTLA project. This was so contextual information that related to the project such as its history and how people got referred to the LTLA project from the LAU could be gained. Appendix *11* illustrates the topic guide used for the professional staff.

- **The service user and mentor interviews:** The first interview was on the 16th March 2012. The final interview was conducted on the 26th October 2012. I interviewed a total of five mentors (which at the time of interviewing was all of the mentor team) and thirteen service users (of approximately nineteen service users at the time of interviewing). During these interviews I was interested in understanding their addiction, how they came into contact with the LAU and how their recovery is unfolding in the context of the LTLA project. Appendix *12* and *13* illustrate the topic guides used for the service users and mentors respectively.

Due to the small size of the project, I interviewed as many of the service users, mentors and professional staff associated with the project as possible (see appendix *17* for detailed biographies of the service users interviewed). Table *4.2* (see following page) lists those that were interviewed at the project, the date and length of each interview and the amount of time they had been attending the LTLA project at the time of the interview. Professional staff and mentors were not given pseudonyms for anonymity reasons. Furthermore, their gender and length of time at the project is omitted from table *4.2* so as to reduce the risk of identification (see section *4.4*). There were other service users that I encountered that feature in subsequent results sections, but are only referred to either in observational notes or interview transcripts. The reason for not interviewing these participants was because they were not present on days I was conducting the interviews, had left the project by the time I commenced my interview stage or were admin staff that work as part of the LAU (for example as a receptionist). I provide a list of these individuals (also given pseudonyms) at the end of Appendix *17*. I have not included a biography of the professional staff or mentors, as this would provide information that would make them easily identifiable. I was in constant communication with my academic supervisors throughout the interviews to consult them on any queries or issues that were raised during data collection. One interview was excluded from the results for confidentiality reasons.

Table 4.2: Demographic data of interviewees

Participant	Date of the interview	Length of the interview	Gender	Length of time at the project (at time of the interview)
Clinician ♯1	16th March 2012	31m 22s	Not reported	N/A
Mentor ♯1	16th March 2012	49m 15s	Not reported	Not reported
Mentor ♯2	23rd March 2012	47m 24s	Not reported	Not reported
Mentor ♯3	23rd March 2012	41m 47s	Not reported	Not reported
Mentor ♯4	30th March 2012	53m 26s	Not reported	Not reported
Coordinator	13th April 2012	39m 41s	Not reported	N/A
Clive (SU)	20th April 2012	20m 28s	Male	14 months
Kevin (SU)	20th April 2012	30m 38s	Male	2 years
Barbara (SU)	25th April 2012	48m 02s	Female	4 months
Alison (SU)	25th April 2012	20m 37s	Female	3 years
Chloe (SU)	27th April 2012	29m 52s	Female	15 months
William (SU)	27th April 2012	18m 05s	Male	17 months
Kirsty (SU)	27th April 2012	33m 57s	Female	6 months
Clinician ♯2	14th May 2012	51m 51s	Not reported	N/A
James (SU)	18th May 2012	38m 22s	Male	9 months
Jayne (SU)	25th May 2012	29m 32s	Female	11 months
Christopher (SU)	1st June 2012	19m 41s	Male	2 years
Peter (SU)	1st June 2012	14m 50s	Male	1 month
Angela (SU)	13th June 2012	29m 00s	Female	3 months
Catherine (SU)	13th June 2012	36m 52s	Female	2 months
Clinician ♯3	27th June 2012	13m 52s	Not reported	N/A
Clinician ♯4	27th June 2012	22m 03s	Not reported	N/A
Clinician ♯5	27th June 2012	15m 25s	Not reported	N/A
Mentor ♯5	26th October 2012	31m 35s	Not reported	Not reported

4.3.10 Conducting the interviews

All the interviews were conducted on site at the LTLA project. Whilst I tried to interview the professional staff and mentors before the service users, this was not possible due to the busy schedules of the professional staff. As a result, there were four professional staff interviews that were conducted alongside the service user interviews (see table *4.2*). The interview room was a comfortable room on site and in a place away from disturbances. The duration of the interviews ranged between 13 minutes 52 seconds and 53 minutes 26 seconds. All interviews were audio recorded and transcribed verbatim by myself at the same time as data collection was being carried out.

By transcribing the interviews I had the opportunity to familiarise myself with the data and emerging themes, as well as plan for further probing and exploration of areas of interest that came up in the interviews (Kvale, 1996). This meant I was able to initiate the interview with open questions so as to get the respondent talking and to put the respondent at ease. For example, with all the professional staff I commenced the interview with the question *"tell me about the history of the project and why it was set up"*. With the mentors I commenced the interview with the question *"tell me why you wanted to become a mentor and how you became a mentor"* and with the service users I asked *"tell me about the story of you becoming involved with the project"*. This enabled conversation to flow and I found that many areas of interest were brought up naturally and inadvertently by the interviewees. When this happened, I continued to probe such areas. If an area of interest came up that I had not previously considered, I made a mental note of the point and brought it up at a later point in the interview. Where this happened, I incorporated the question into subsequent topic guides to ask future interviewees. The next section discusses the potential ethical issues that could have arisen during the research and how they were minimised.

4.4 Ethical considerations for this research[8]

There were a number of ethical issues that were considered. First, gaining informed consent, providing participant information sheet and assuring confidentiality were all interrelated ethical issues that were carefully managed throughout the research. Prior to consent being gained, participant information sheets were handed out to each individual on the activity and at interview, regardless if they had received an information sheet before. This was to ensure that at each stage of data collection, each individual was given the chance to (re) read exactly why I was there and what I was planning to do. It was made clear to every individual, what they said to me would be made anonymous and no one could trace what they had said. After the participants were given the chance to read the participant information sheets, consent was requested. Throughout the observational and interview period, no individual refused to sign the consent form and consent was gained on every activity by every individual, even if they had previously signed a consent form for a previous activity.

An ethical concern for the observational period was the dilemma of a service user turning up unexpected or questioned my presence. Service users were only allowed to attend activities if they had previously indicated they were attending prior to the activity starting. I informed the mentors of the activities I would be attending so they could relay this to the service users when they indicated they wanted to attend the activity I would be present on. At no point was my presence questioned on any of the activities, as all the service users had been notified about my presence prior to the activity commencing.

With regards to the interview period, a number of ethical considerations were considered. First, a major ethical point was the potential vulnerability of the participant causing the individual to become overwhelmed by the interview. This was minimised by making it clear to the interviewee they could stop at any point and did not have to continue if they did not want to. Second, there was the potential to repeat a comment made to me during the observational period or

[8] Ethical consent was gained from the NHS Leeds West ethical committee (see appendix *18*).

other interviews that might identify an individual. I minimised this by making sure I had a thorough and well thought out topic guide that included any specific points individuals made to me as general comments. Third, there were issues surrounding anonymity. This was an issue discussed at great length with my academic supervisors in order to devise a way to minimise identification of participants.

This was particularly pertinent for the professional staff and mentors involved with the LTLA project, as they are potentially identifiable given that the name and location of the project are used. It was considered that the name of the project would not be used, but given the importance of language in this thesis; this was not an ideal solution. Having consulted the professional staff and mentors at the project with this potential solution, they encouraged me to use the name of the project, as it was a central part of what the project represents. I made it clear to the professional staff that using the name of the project could result in identification of them and the mentors, which they acknowledged and accepted. I made it explicitly clear to the mentors and professional staff prior to each of their interviews that there was a possibility that they may be identifiable. However, I also explained to each of the mentors and professional staff that they would not be identified by a name, but by their role in the project (for example, 'clinician', 'coordinator' or 'mentor') in order to reduce the risk of identification. Their gender and length of time at the project was also omitted to further reduce the possibility of identification through these channels. All of the mentors and professional staff acknowledged the potential for being identified. They all gave written consent to continue with the interview.

It is important to note that all of the mentors have conducted numerous interviews about the LTLA project prior to my research and are experienced when talking about the project. The mentors and professional staff often showed great enthusiasm for my research, as it was a way of publicising the LTLA project and the work they do. Furthermore, many of them articulated that they wanted to 'tell their story' so they could demonstrate to other people that recovery is achievable and the positive impact that the LTLA project has had on their

recoveries. With regards to the service user interviews, pseudonyms were used to reduce the possibility of identification. Pseudonyms were decided upon for the service users, as it is very difficult to identify anyone by a pseudonym given that they are not directly linked to the LAU or the LTLA project. All of the service users in my data collection were white British in origin; therefore the pseudonyms were selected at random based on common white British names. I ensured each participant had their own unique name so as to avoid confusion (for example, there are not two participants called 'James') and gave all the female participants a female name, and all the male participants a male name. Finally, there was the ethical issue surrounding the location of the interview. I decided that the interview was to take place on site at the project for three reasons.

First, each participant was familiar with the location of the project thus reducing the risk of the interviewee becoming overwhelmed, as might be the case if the interview was conducted in novel surroundings. Second, if the interviewee was to become distressed, professional help was immediately available to deal with any situation. This had the effect of putting the interviewee's minds at ease, as they knew professional, familiar help was immediately available if they required it. Finally, conducting the interview at the LAU was financially and logistically the most suitable option for me as many of the service users live considerable distances from one another so to travel would have resulted in the interview process taking much longer than necessary.

4.5 Promoting credibility and trustworthiness

A considerable hurdle that qualitative researchers face when collecting and presenting their data is demonstrating the research is credible and trustworthy (Guba & Lincoln, 1981). In quantitative language, this refers to the validity (both internal and external), reliability and objectivity of research. However, in qualitative research there is often a tension that arises between those who argue for and against the need for quality criteria. On the one hand, some dispute the need for subjecting individual interpretation (*verstehen*) to objective measures of quality as it contravenes the fundamental philosophy of

qualitative work (Emden and Sandelowski, 1999). Whereas on the other hand, there are those who argue qualitative research needs quality criteria to measure facets like reliability and validity, in an attempt to bridge the artificial schism that separates qualitative from quantitative research (Goodwin & Goodwin, 1984). In order to ensure this research is of a highly credible and trustworthy nature, there are several criteria, first proposed by Guba and Lincoln (1981), that can be used. The criteria are *credibility*, *transferability*, *dependability*, *confirmability*, *reflexivity*, *transparency*, *triangulation* and the use of an *iterative process*.

Credibility refers to how 'truthful' or valid the data is, and how accurately participants can build the same experiences and observations as the researcher does. *Transferability* refers to how generalisable the research is, and how easily it can be extrapolated to other social settings. *Dependability* refers to reliable and consistent the data is, with *confirmability* referring to how accurately another individual could confirm the data. *Reflexivity* refers to understanding the researcher as part of the research process, and can therefore impact on how data is collected. *Transparency* refers to how 'visible' the method and procedure of data collection is, and if someone else could replicate what a researcher has done. *Triangulation* refers more specifically to data collection techniques. It advocates the use of gaining data from multiple sources (triangulation of data) and from a number of different sources (triangulation of methods). Finally, an *iterative process* refers to data collection and analysis occurring concurrently with one another, so as to ensure new lines of inquiry that become illuminated during data collection, can be added into new lines of inquiry (Guba & Lincoln, 1981). Each of these criteria will be evaluated in the discussion chapter (section *8.5.2*) to demonstrate the overall credibility and trustworthiness of this research.

4.6 Method of Analysis

In this section the data analysis process is described, an important part of any credible qualitative research (Silverman, 2010). There is a multitude of different ways to analyse qualitative data (Bernard & Ryan, 2010) but the method used in this thesis was Miles and Huberman's (1994) *thematic*

framework approach. Whilst they outline twelve points that make up their thematic framework analysis, many of these points were conducted simultaneously. The following outlines how I conducted the analysis of the data, making specific reference where relevant to Miles and Huberman's (1994) points to outline how I used their thematic framework in the context of this research.

First, in order to gain a more complete and holistic understanding of the data collected during this research, I read and re-read the participant observation notes and interview transcripts several times. This facilitated preliminary themes to be conceptualised that ran throughout the data (refers to *noting patterns and themes* and *clustering*, the first and third steps of thematic framework analysis). I made very brief notes on the transcripts of the types of themes that were occurring as well as the salience of each one. I also re-read the reflexive journals I had made during data collection to identify if any of the themes located in the data related to my reflexive thoughts. As it was stated in section *4.5*, data analysis was conducted concurrently with data collection, which meant the data was fresh in my mind during analysis, thus facilitating contextual information relevant to the data (such as the emotions conveyed during interview) to be recalled more readily. Table *4.3* represents the initial themes that came out of the data. Many of these themes were expected as the topic guides were constructed in order to explicitly explore these themes.

Table 4.3: Codes for preliminary analysis

History of the projects
Identity and identity change during recovery
Stigma/being labelled
Sense of self
Individual change during recovery
Normality

As I continued to read and re-read each transcript, I was constantly addressing my research aims and objectives, field notes and reflective journals in order to ensure any new themes I identified were added to the coding framework (Brewer, 2000), and to ensure the themes I was identifying were

plausible themes rooted in the data (refers to *seeing plausibility*, the second point of thematic framework analysis). As new themes continued to surface, I went back over each transcript to code the data where relevant for the new themes. This ensured my data analysis was open and inductive, two features salient in ethnographic research (Bryman, 2001). This also ensured I could cluster different parts of participants interview transcripts under relevant themes, for example, all those who mentioned the importance of 'firsthand experience' in recovery (*clustering*). Adopting this approach meant I gained close and intimate familiarity with the data through multiple readings, thus ensuring I had a comprehensive knowledge of my own data. At this point I had a multitude of themes at different conceptual levels. Some were more descriptive such as the history of the project, while others were more analytical such as themes relating to identity and self.

At this point, it was necessary to 'tidy up' the data by logically combining or eliminating codes (relates to *making contrasts and comparisons*, *partitioning the variables*, *subsuming particles into the general* and *factoring*, four independent stages of thematic framework analysis). In order to do this, I used different writing techniques as an analytical tool in order to develop a 'journey-style' analogy as one goes through their recovery (Wolcott, 1994). I 'tidied' the data up by going back through each transcript and noting down all the themes that were evident in the transcript. Having completed this for each transcript, it was evident that all the themes could be condensed into eight major themes, each with their own subthemes (*subsuming the particles into the general*). I produced separate word documents for each major theme that contained all the quotes from each transcript relating to that theme. As I re-read the transcripts in order to 'clean up' the themes, I re-ordered the themes into a coherent format, which resulted in two overarching concepts: the individual impact of the LTLA project (chapter *6*) and the collective impact of the project (chapter *7*) (refers to *building a logical chain of evidence*, the final stage of thematic framework analysis). Table *4.4* (see following page) provides an overview of which themes belong to each concept.

Table 4.4: Overview of the themes

The impact of the project on the individual (chapter *6*)	The collective-social impact of the project (chapter *7*)
The identity of the LAU and the LTLA project	*Firsthand experience*
The identity of 'being' normal	*A non-stigmatising culture*
The identity of recovery	*Peer Support*
The identity of the mentor role	*The activities*
	Power

Whilst these were the two overarching concepts, many of the themes related with one another, regardless of the overarching concept in which they were located (*noting relations between variables*, point ten of thematic framework analysis). These themes featured prominently throughout the transcripts and were often expressed with considerable emphasis and emotion. Although each theme is more attributable to one of the concepts, they are by no means mutually exclusive to that concept. For example, the theme 'a non-stigmatising culture' came under the wider theme of the collective impact of the project but by having a 'non-stigmatising culture' in which a recovering individual can practice their recovery, it impacts positively on their identity, a theme that has been attributed to individual impacts of the project. I decided upon having two overarching concepts as it made understanding the data more manageable and it provided me with a coherent manner in which to structure the write up of the results. As I selected quotes from themes, I read and re-listened to the quote in the context of the interview in order to gain a sense of the emotion behind what was said and to ensure what I was reporting was authentic and consistent.

The main issue I faced when reporting the data was finding a balance between reporting the data as objective truth and taking a relativistic position (Alvesson, 2002). I acknowledge from the outset that I cannot report some information as objective truth as the methods used to collect the data prevents me from doing so, as much of it is based on personal interpretation. However,

there was some information such as age and their main substance of addiction that have been reported as factual. Elsewhere I adopted a more subtle approach where methodological context had an impact on the data being collected, scenarios where individuals want to convey themselves in a particular light and alternative explanations.

As it was stated in section *4.4*, relevant terms (clinician, coordinator or mentor) or pseudonyms were used to anonymise the participant's true identity. A detailed description of each service user is in appendix *17*. The biography of each service user (based on information gained during interview) outlines basic demographic details along with a brief history of their addiction, how they came into contact with the LAU and subsequently the LTLA project and how long they have been a member of the project. Throughout the data, the themes discussed relate to a significant number of the participants. To avoid 'quantifying' the data, I use the word 'some' to refer to fewer than half of the participants, 'many' means between half and three-quarters or 'most' for more than three-quarters of the participants. In the interest of contextual richness, I often provide long extracts so as not to present data out of context.

Overall, Miles and Huberman's (1994) thematic framework analysis proved an exceptionally useful tool to collate and analyse the data. Whilst most of the twelve points were used, techniques such as *counting* and *making metaphors* were used more sparingly, as I was keen to not overweight certain themes based on their prevalence (a potential result of *counting*) and did not want to over-complicate or over-exaggerate points through the use of metaphors (*making metaphors*).

4.7 Summary of methodology and methods

In this chapter the methodological approach and techniques used in this study to explore the LTLA project have been described. This is complex task, potentially involving the exploration of a variety of social phenomena, for which qualitative research is ideal, as it allows the researcher to gain sufficient depth and contextual understanding. Participant observation of the activities were first used to explore how the activities operated, the number of mentors, service

users and professional staff that attended each activity and how they interacted with one another and with mainstream society. Interviews were then conducted with a convenience sample of service users, mentors and professional staff to explore themes such as how the project has impacted on recovery (themes explored from mentor and service user interviews) and how and why the project was set up (themes explored from professional staff interviews). Details of how the credibility and trustworthiness of this study were promoted, as well as how the data were analysed was also included in this chapter.

The following three chapters explore the findings of this research. Chapter *5* explores the history of the LAU and how people are referred from the LAU to the LTLA project. There is also a detailed explanation of the LTLA project, its culture of abstinence, the goals of the project, how its name was derived and the activities offered by the project. Chapter *6* explores the impact of the project on the individual. Within this section the concept of identity and self are explored, and how such constructs seem to have been impacted on by the project. Finally, chapter *7* explores the collective impact of the project on the service users and mentors and how being part of a collective also has implications for individual recovery trajectories.

The findings will be framed in light on the theoretical framework and theories outlined in the chapter *3*, as well as drawing on existing evidence and literature. The reason for drawing upon evidence and literature alongside the theory and the data is twofold. First, it will provide evidence from 'what has already been found', which will second, contextualise the data with the wider evidence and literature base, allowing for a more holistic understanding of how this data fits into the wider body of existing evidence. In the interest of clarity, the term 'symbolic interaction' will refer to the more classical theoretical perspectives of Mead and Goffman, whereas 'structural symbolic interaction' will refer to the identity theories attributed to Stryker and Burke.

Chapter 5

The culture of the LAU and the LTLA project

5.1 Introduction

The aim of this chapter will be to set out the history, structure and culture that underpins the LAU and the LTLA project. The focus on culture is important for two reasons. First, understanding the culture of the LAU and the LTLA project will provide a deeper understanding of *how* and *why* the project impacts on recovery in the manner it does, the overarching aim of this research (see section *2.6.1*). Second, understanding the culture of the project will provide rich contextual information that is of great importance, as it locates recovery within the relevant social system (Miles & Huberman, 1994). 'Culture' does not just relate to the artefacts, tools or the tangible cultural elements of a given social group or society, but to how the members of the group interpret, use and perceive the cultural elements of the group (Banks & McGee Banks, 2010). Mishler (1979) stated that in-depth understanding of contextual information gives a true understanding of the meaning of events, as meaning is always within context, and contexts incorporate meaning. Therefore, understanding the background of the LAU and the LTLA project will serve to facilitate an understanding of *why* and *how* recovery unfolds in the context of the LTLA project, and will lend further information to the local context set out in section *1.2*. The first section will explore the culture of the LAU and how one gets 'referred' from the LAU to the LTLA project, followed by a section on the history, structure, culture, goals, name and activities of the LTLA project.

5.2 The history of the LAU

As it was explained in section *1.2*, the LTLA project operates directly out of the LAU. Given this point, the current set up of the LAU is important as it has implications for the set up of the LTLA project. In order to understand the LAU more completely, there is a need to understand its historical context. The LAU

was first established in 1979 as the first alcohol service in Leeds to specifically deal with the rapidly growing prevalence of alcoholism across the city centre. As clinician ♯2 explains, in 1984, the focus of the LAU shifted to tackle the rapidly expanding problem of AIDS spreading through injecting drug use. This shift in the LAU's treatment goals that was symptomatic of wider UK drug policy at the time (Stevens, 2010). This resulted in the LAU becoming an alcohol and drug service:

> *"The organisation continued to expand from the point of view of staff and the number of people who came to it and in 1984, there was money coming for drug services to address the problem for AIDS and the service then became an alcohol and drug service in 1984"* [Clinician ♯2; co-clinical lead of the LTLA project]

During the 1980s and 1990s, the LAU went on receiving significant funding from the government to tackle the entire spectrum of problematic drug and alcohol use that was growing across the city of Leeds. As a result of such funding, the project continued to grow in size until it reached its peak in 2004:

> *"I think by 2004 the organisation was at its absolute biggest. We had two sites, we had a harm reduction site in town where we would see people who are on criminal justice orders, we had a big community service doing umm, drugs and alcohol in shared care with general practitioners umm, and we had the base unit here providing outpatient detoxification for drugs and alcohol and follow up with psychosocial interventions. We developed the pregnancy and parenting service and we were starting to specialise more with dual diagnosis."* [Clinician ♯2; co-clinical lead of the LTLA project]

In 2005, clinician ♯2 explained that financial cuts resulted in their harm reduction site being closed, which resulted in a significant reduction to their overall caseload. Despite the harm reduction site being closed, the LAU did not abandon harm reduction as a treatment option. To this day the LAU has continued to offer a 'dual approach' to recovery with abstinence typically being

the main approach for problematic drug users and a harm reduction and controlled drinking the typical approach for problem drinkers. Clinician ♯2 explained throughout her interview that this 'dual approach' is typically the result of 'what has worked best' with service users during the LAU's history. Despite this approach, clinician ♯2 was keen to stress that individual service users are involved in their recovery process and recovery outcomes are determined based on what the individual is thought to be able to achieve. In other words, if a problem drinker wants to achieve abstinence, then treatment is tailored to meet such ends.

Whilst the budget cuts resulted in the project being downsized to one site (the site it is currently on), it had the effect of making the LAU a more specialist site that deals with the most complex cases of substance dependency:

> *"So we became a smaller organisation focusing on complex cases, with complexity with dual diagnosis with physical illness, with psychiatric problems and with pregnancy and parenting"* [Clinician ♯2; co-clinical lead of the LTLA project]

Currently, two clinical directors; a consultant psychologist and a consultant psychiatrist run the LAU. The LAU is subdivided into three clinical teams: the *hospital in-reach team*, which includes professional staff who go into hospitals across the city to find those who are struggling with substance dependency, the *dual diagnosis team*, who concentrate on those suffering with comorbid addiction and mental health issues and the *pregnancy and parenting team*, who help pregnant women and those with young children combat addiction. Clinical managers run each clinical team and all the staff at the LAU fall into one of these three categories. Whilst each staff member has their own specific caseload within their clinical team, each of the professional staff has one afternoon a week whereby they see individuals new to the LAU. These individuals are then added to the existing caseload of the individual professional staff. Of the service users that the professional staff encounter, each has to make a decision about 'referral' to the LTLA project, the focus of the next section.

5.3 'Referral' from the LAU to the LTLA project

The only method of 'referral' to the LTLA project is via the LAU:

> **Me: Service users have to come through the LAU?** *"They do, yes. That's the natural restriction at the moment... there's a natural restriction of numbers coz there's only ever going to be, you know a finite number of people who come to this agency and of those, who want to join in with them"* [Clinician ♯2; co-clinical lead of the LTLA project]

Clinician ♯2 explained that this allowed for the effective management of 'referral rates' to ensure the service can deliver and secondly, it is a natural control on who has access to the LTLA project. Whilst the word 'referral' has been used to depict the process of professional staff informing the service users of the LTLA project, 'referral' is perhaps too formal. Each of the professional staff explained that it is not a formal referral process, but more a case of just mentioning the project to the service user so as to make them aware of the different forms of help after professional treatment. This informal mentioning of the LTLA project to service users is what is meant by 'referral' throughout this section. The word 'referral' is typically used in medical settings whereby patients are professionally referred to medical specialists in order to treat an ailment, which is supported by the fact that codes of ethical conduct surrounding professional referral are explicitly mentioned in the guide for medical practitioners (Medical Council, 2009).

This may seem like a minor point relating to language, but its implications are that it perhaps represents a subtle partition from the medical world, in favour of a 'referral' process that gives autonomy to service users in recovery. Informal referral of this kind suggests that service users have control over their own recovery and 'how' they recover, and are not being forced to attend the LTLA project. Allowing service users to make their own decisions on whether to attend the LTLA project or not, represents the first steps in taking control over their life once again, a feature that many articulated was lost during their addiction.

Once the service user has been allocated a keyworker at the LAU in the relevant clinical area, the keyworker can mention the LTLA project at any stage. More often than not, this appears to be quite early on in treatment:

> **Me: How long would it typically be before you start to think about maybe referring to the LTLA project?** *"Personally, from assessment you know, I'm thinking already down the line, so it's always on the forefront of my mind in terms of what options this person has. What things we know works for people and what things umm, other clients have said, they did this, this is a good period of change so I'm already thinking… this* [the project] *would be a good thing"* [Clinician ♯4, a keyworker at the LAU]

> *"It can be really early, because you got to bear in mind that the screening kind of meeting we have with people when their in hospital although we hope to draw people into treatment that may be the last time we see them. You know, people may not engage very well with us so if they fall into a kind of criteria that indicates LTLA might be appropriate at some stage, not necessarily immediately then I don't think it does any harm to flag up the treatment options that are available to people"* [Clinician ♯3, a keyworker at the LAU]

The professional staff are aware that in some cases, the individuals they encounter during treatment may not decide to come again for a host of different reasons. This prompts the professional staff to mention the LTLA project early on in treatment so the service user is aware that once their time in professional treatment officially comes to an end[9], they have an *aftercare* programme they can become a part of. Mentioning the project early ensures that the momentum gained during their recovery can be maintained and service users know that there is on-going help; albeit of a different form, available to them after professional treatment. The individuals who are typically referred to the LTLA

[9] Whilst the professional treatment may officially end after three months, the service users are made aware that if they need professional help in the future, they are able to return to their keyworker for further support.

project are those that have suffered with severe substance dependency and want peer support or to help with feelings of boredom:

> *"I guess a fairly common trigger that people say about continued use or past, you know past relapses is boredom, lack of structure or umm, if their if their meeting up regularly with other drinkers or drug users and so your already thinking this* [the LTLA project] *might be quite beneficial to that person, this could tailor their needs quite well."* [Clinician ♯4, a keyworker at the LAU]

> *"Or people might want to say 'right I don't want to talk about my drink or drug use, I want a sort of social network to support' so it would be LTLA."* [Clinician ♯5, a keyworker at LAU]

> *"People who are abstinent, who have poor social support, they have to be in need of social support and, just generally as a relapse prevention measure."* [Clinician ♯3, a keyworker from LAU]

There are no set criteria that professional staff are obliged to abide by when referring and it is based solely on subjective interpretation of an individual's situation. Whilst referral is subjective, the professional staff have weekly meetings where they discuss each of their cases with others. This ensures that each professional staff member becomes familiar with others' caseloads and the meet-ups are a place where they can seek the professional opinion of others.

It is important to note that not all service users get referred to the LTLA project. The professional staff have a duty of care to not refer those who may disrupt the LTLA project, even if it might be good for that individual. For example, those who have not committed to abstinence and are still actively drinking are not likely to be referred:

> *"If I thought, well if they're drinking or if I thought there was a risk of people drinking."* [Clinician ♯3, a keyworker from LAU]

There are others who may not get referred because the mental state of the individual may disrupt the group:

> *"Because of their mental illness they, they can make not inappropriate relationships but they can become very dependent on some relationships and I'm very aware that LTLA is a peer support group, and I wouldn't want to put any of the mentors or other members of the group in a position where they felt responsible for someone else. That job is a professional's job not a peer support* [group]*... There are specialised services so during my assessment and work with somebody I was doing, it became apparent that was an issue then I would refer to a personality disorder service"* [Clinician ♯5, a keyworker at the LAU]

There are also those who may not get referred because the discretion of the professional, based on what they are told during treatment, decides that they have a busy life outside of their professional treatment and the LTLA project may not add anything meaningful to their life:

> *"With other people I don't recommend it* [the LTLA project] *but some people have very busy family lives. Or have got rather insular family lives which is just as it is in the general population, some people go out, some people don't go out, some people don't go out ever so I gauge what their sort of natural socialising is like."* [Clinician ♯2; co-clinical lead of the LTLA project]

All the professional staff were keen to mention that they always err on the side of mentioning the project, as they feel that most people they encounter are looking for a peer support network to continue their recovery beyond professional help. An important point to note is that the professional treatment the service users receive is very much centred around motivational interviewing and changing thought patterns from maladaptive thinking processes to forward looking, positively focused thought processes that help people succeed in life.

Involving the service user in this process actively ensures the service user is thinking ahead and planning what they want to achieve from recovery. This implicates the importance of 'self' in recovery, as it is through 'self' that internal processes such as 'self-reflection' of their identity, and 'self-communication' about what behaviours *they* deem are acceptable, thus resulting in 'self-direction' and 'self-control' of *their* own behaviour (Blumer, 1969). These internal processes in turn facilitate an individual to guide their own behaviour in accordance with the goals they set themselves, a key component of recovery. By having the LAU as sole provider of the LTLA project, there appears to be a harmony that runs throughout all aspects of the service user's recovery; from the start of professional treatment through to those who have been members of the LTLA project for years and no longer receive professional help, such as the mentors. It seems plausible that this may contribute to stability in recovery, as the goals are immutable, positively orientated and individually focused. The following section discusses the themes that are specifically relevant to the LTLA project, starting with a discussion of its history and structure.

5.4 The LTLA project: Its history and current structure

Given that the project was only founded in 2008, its history is short. As it was stated in section *1.2*, the LTLA project is set up based on the guiding principles of co-production, a process whereby service users work along side professional staff to deliver treatment (NICE, 2008). The project was initially devised as a collaborative effort between the LAU and the University of Leeds, but due to irreconcilable differences that essentially stemmed from what each party wanted to achieve with such a project, the directors of the LAU severed ties with the University and decided to implement the project alone. The clinical directors at the LAU were keen to set up a project that developed *aftercare* after professional treatment had come to an end. The clinical directors and an administrative member of staff from the LAU, in collaboration with a small group of recovering service users (soon to become the 'mentor team') decided that a cohort of ex-service users would run the LTLA project:

"What we wanted to do was to set up with service users, a service...an ex-service user led aftercare program, this was the thing that we thought this is what this project will be useful for... We sort of think of them as people who are an example to other people and the example they give is there's life after addiction, its about giving people hope, its about giving people a role model, I can you know, I can be like that, I can you know go about my life like that so its those sort of things and in that sense they are mentors and ex-service users" [Clinician ♯2; co-clinical lead of the LTLA project]

It is important to highlight that at the time of the LTLA projects inception, this 'ex-service user' led approach very much represented a novel and innovative approach to recovery. It is only in the past five years or so that the concept of recovery has really gained momentum within addiction research (White, 2011), and was not until 2010 that UK drug policy explicitly mentioned the use of 'community recovery champions' as an *"inspirational workforce"* (Home Office, 2010; p. 20) to disseminate advice and support in recovery. This suggests that the LTLA project not only preceded drug policy, but that an 'ex-service user' led structure is a viable and sustainable approach given that the LTLA project is still contributing to the recovery of its service users five years after its inception.

In the context of the LTLA project, the mentor team are effectively a team of 'recovery champions' who have firsthand knowledge and experience of what it is like to tackle addiction and commit to recovery. The current structure of the LTLA project is one that has three groups: the service users, the mentors and the professional staff from the LAU involved with the project (the implications of which are discussed in section *7.6*).

The professional staff and mentors involved with the LTLA project refer to themselves as an 'ex-service user led' project:

"…ex-service user led, ex-service users and um, its not peers in that the people who become the mentors, and we tried in the group to define this so many times. The people who, who become the mentors, have really moved

on from an active phase of treatment… they've sort of moved away from, sometimes people with addictions problems have ideas that you know, I can have one [an addiction] *and nobody will know or, I can, I'm alright now so I can have one and people do tend to get into difficulty with those sort of tings so its moving on from that sort of thinking. So their ex-service users in that sense, it's not, I know its not very clear um, their not needing, their not needing the sort of um, regular support for themselves… we sort of think of them as people who are an example to other people and the example they give is there's life after addiction. It's about giving people hope, its about giving people a role model, 'I can you know, I can be like that, I can you know, go about my life like that' so its those sort of things and in that sense they are mentors and ex-service users"* [Clinician ♯2; co-clinical lead of the LTLA project]

This is important to mention as 'ex-service user group' is a rather different descriptor to those self-help groups discussed in chapter *2*. On the one hand, the term 'ex-service user group' downplays the role of 'self' in 'self help' to produce a taxonomy that is less centred on individualistic connotations surrounding 'self', and more centred on ex-service users helping others directly through advice-giving. On the other hand however, the term 'ex-service user' perhaps imposes a social stratification whereby ex-service users are seen as 'above' active service users. This could potentially result in power tensions, as service users may perceive the mentors as having power over them. This is explored in greater detail in section *7.6*.

5.4.1 Culture

Clinician ♯2 explained that the mentors decided at the projects inception that it would be an abstinence-focused project, as it was thought this was the only approach that could conceivably work long-term:

"But we did think that it involved a changed way of thinking and first of all a commitment to abstinence, abstinence is the only thing that worked in the group so we've had a couple of people in the past as mentors who thought

'well I got this sort of problem so drinking's not a problem so I can do controlled drinking' that hasn't worked. I don't think its ever been the other way round you know, 'I've got a problem with alcohol therefore, I can use drugs' I don't think that's happened but umm, abstinence works well, its clear and I'm not saying that coz I think its the right course of action but in this group, in this agency, that deals with people at the severe end of addiction problems its nearly invariably the case that abstinence is the proper treatment goal to be going for" [Clinician ♯2; co-clinical lead of the LTLA project]

Given the definitional complexities surrounding abstinence (see section *1.3*), it is important to state that in the context of the LTLA project, abstinence is defined by the total abstention from *all* psychoactive drugs and alcohol. The mentors chose this 'rule' at the time of the LTLA project's inception. Whilst the implications of this will be discussed in greater detail in section *7.6*, it demonstrates that a select few service users who were selected at the start of the project have decided upon the entire culture of the group. Whilst this may seem like a pivotal moment in the implementation of the LTLA project, the abstinence approach the project adopted was considered the only approach by the mentors it could opt for. Based on observational and interview data, those who attend the LTLA project have suffered with addiction problems to such a severe extent that any other approach apart from abstinence seems likely to result in a project that is much harder to maintain.

It is important to acknowledge that abstinence is perhaps a much more common and straightforward goal for those recovering from alcohol dependency, as there is no substitute drug to control alcohol use. Those recovering from opiate abuse for example, are often prescribed substitute drugs such as methadone or buprenorphine to control their opiate use, which would make abstinence a much more difficult 'rule' to enforce. Given the success with which abstinence has worked throughout the LTLA project, the mentor's decision to enforce abstinence has been vindicated. However, it does suggest that those recovering from opiate dependency for example, where recovery

trajectories most likely take a different path, require a project that cater to the specific needs of opiate addiction recovery. This suggests therefore, that the LTLA project should remain a project that specifically helps those recovering alcohol dependency. This is supported by findings that suggest the needs of those recovering from opiate or alcohol dependency are often quite different (McIntosh & McKeganey, 2002), therefore implicating the need for substance-specific groups in recovery.

As well as the culture of abstinence, there also seems to be a culture of 'normality' that runs throughout the project. Raymond Williams, an influential sociological commentator on culture suggests that culture should be conceptualised as 'ordinary', as this view incorporates the value of 'everyday experience' and common behaviour, and does not dismiss 'everyday experiences' as worthless beside some of the influential, elitist conceptions of culture advocated by Arnold, Bourdieu and Gramsci (Aldridge, 2006). Conceptualising culture as 'ordinary' and placing emphasis on the importance of 'everyday experiences' and common behaviour is a potentially powerful conception of the LTLA project's culture.

It suggests that the LTLA project attempts to facilitate reintegration back into society by providing the opportunity for service users to enact behaviours that are considered culturally 'common' (or 'normal') by mainstream society. The LTLA project facilitates 'everyday experiences' through their activities such as going bowling or going on day trips (see section *5.4.4*). This is a potentially powerful facilitator for recovery, as 'everyday experiences' and behaving in a manner that is considered culturally 'normal' or 'ordinary' by mainstream society could serve to increase their shared meaning and 'agreement' with 'normal' society through cultural connections. The LTLA project therefore, through its regime of leisure activities, becomes a potential source of 'cultural capital', as societal norms and values are gained through 'everyday experiences'. Referring to the LTLA projects culture as 'ordinary' is not a criticism of the project. It demonstrates that the LTLA project accepts that overcoming addiction is not attributable to a single solution, but more to a continuous process of

reducing their addict identity and facilitating a culturally 'normal', 'ordinary' identity that will help them reintegrate back into 'normal' society.

5.4.2 The LTLA project's goal

The LTLA project ultimately has one main goal: to help those who have suffered from substance dependency, commit to abstinence and reintegrate back into 'normal society'. The project attempts to do this by providing service users with activities that are not only deemed pleasurable, but to also teach them important life skills that were detrimentally impacted on by addiction. As clinician ♯1 and clinician ♯2 explain:

> *"Because it's a bit scary, I think if you haven't been absorbed in a world of taking drugs or drinking and remember a lot of people have done that all their lives, so that they have never really, you know a lot of people have missed out on growing up and forming normal relationships, they don't know, they know surprisingly they know how to score cocaine on the street, but they don't know how to shop in Sainsbury's. So it's a slow learning process"* [Clinician ♯1; co-clinical lead of the LTLA project]

> *"Learning to do things you have difficulty doing like going to the post office or the bank or the housing department or learning alternative sources of enjoyment of pleasurable activities and that was, that's what we were very keen on developing and we wanted to get on and develop it* [the project]*"* [Clinician ♯2; co-clinical lead of the LTLA project]

The projects goal is in keeping with the abstinent and 'ordinary' culture of the project. Through the provision of pleasurable, albeit culturally 'normal' activities, service users are given the opportunity to gain 'everyday experiences' such as shopping at Sainsbury's or going to the post office. This in turn, helps to facilitate a sense of feeling 'normal' and a part of mainstream society. In this sense, the project is perhaps best conceptualised as a conduit between the seemingly protective nature of professional support and the potentially exposed nature of mainstream society:

"Well I think it's a bridge. People can come to LTLA activities and that they don't have to explain themselves, they don't have to explain their drinking or their drug taking, people know about that. It's taken for red so you just get on with whatever the activities might be and it's a sort of transition from that into going it alone. [Clinician ♯1; co-clinical lead of the LTLA project]

The project then, seems to act as a social environment whereby each service user can 'practice' their recovery and build up self-confidence within the protective nature of the project to tackle mainstream society without the need to resort back to the project. However, as it will become apparent throughout the findings chapters, the protective nature of the project almost creates a social environment that becomes too attractive for some service users, which perhaps results in some becoming over-involved with the LTLA project. This results in some living their life almost within the context of the project. The implications of this are further discussed in section *8.3.1* but the data suggests that over-involvement with the project serves to keep an individual connected with their recovery and therefore their addiction.

5.4.3 The name: 'Learning to Live Again'

One of the main reasons for having a mentor team is because they personify that addiction is beatable and that there is a life after addiction. Based on such a culture, the name of the project became important, as it needed to reflect the cultural values of the group. Finlayson (2002) states that culture is not external to what we are doing or being, but is best thought of as *"the very air that we breathe"* (Finlayson, 2002; p. 152). This point provides a good description for the name of the project, as the name needed to reflect the very essence of what the project was striving for. The professional staff, in collaboration with the mentor team were very keen to have a name that embodied the cultural values of the project:

"It was one of the service users who has now left. We were thinking what to call the group umm, and then this service user said 'what about Learning to Live Again?' and everyone thought it was such a good idea and we just called it that ever since..." [Coordinator, professional staff at the LAU]

Given the importance of language in both symbolic interactionist and addiction literature, the 'language of the project' became significantly important, as it has the potential to *em*power an individual to be an active, autonomous agent in their own social world. 'Learning to Live Again' embodies the cultural essence of the project: learning to live life after addiction. William White is a major figure in the field of addiction recovery and has written extensively on the importance of language in the field of addiction and recovery. Language reflects the cultural values of a group (White, 2009) and can be a highly positive tool in the field of recovery, as it empowers the individual agent to embrace their own recovery (White, 2007) (see section *7.6.2*). White (2001) suggests that recovery language should promote positivity and challenge the stigmatising stereotype embodied by the phrase 'once an addict, always an addict'. The name *'Learning to Live Again'* captures the essence of White's (2001) argument, as well as demonstrating the influence that language can have over those in society by challenging negative stereotypes. Whilst the name 'Learning to Live Again' is a good reflection of the culture that subsumes the project, a slight tension perhaps arises between the name and its main goal (see section *5.4.2*).

As it will become apparent in the following findings chapters, there are some who seem to become 'over-involved' with the LTLA project, thus resulting in the project becoming the central component of their life. This in turn, results in their recovery, and therefore their recovery identity, becoming a central part of their life, thus keeping them constantly connected with their addiction. Given that the goal and the name of the project imply 'learning to live (life) again *after* addiction', 'over-involvement' by some to the LTLA project implies that they only 'learn to live again' *within* the context of the project. The tension therein lies between the projects aim to move people on from their addiction, and the fact that some seem to exhibit a dependency on the project. The concept of 'over-

involvement' to the project resurfaces throughout the findings chapters and is explored extensively in the discussion chapter (see section *8.3.1*).

5.4.4 The activities

As it has been alluded to throughout the findings chapters so far, the LTLA project provides activities for service users to participate in. Based on observational data, the activities can be broken down into three different categories. *Frequent activities* are those that occur on a weekly or two-weekly basis (except *Zumba* which occurs once a month), *infrequent activities* are those that occur approximately every two months and *novel activities* are those that are put on for specific events such as the Diamond Jubilee. The activities outlined below are all those that occurred during the data collection period (January 2012 to December 2012). They represent a wide range of activities that cover those that have been running since the project's implementation and those that have been introduced as the project has evolved. Due to the poor financial state of most of the service users, the activities offered by the LTLA project are either free, subsidised by the project, or cost a small amount (typically no more than £3-5). For those service users that travel by public transport to attend the project's activities, travel expenses are reimbursed to ensure that no service users are put under financial pressure as a result of attending the project. Mentors receive a weekly fee of £15 (plus travel expenses) for their contribution to the running of the project and its activities. For a detailed description of the activities, see appendix *8*. The activities offered were:

Frequent Activities:

- The Friday "meet 'n' greet"
- Bowling
- The allotment
- Cinema visits
- Reiki
- The Women's day
- The Gym

- The Inkwell Café
- Parents and Toddlers Group
- Zumba

Infrequent Activities:

- Theatre Trips
- Canal Trips
- Day trips out on the minibus
- The Jamie Oliver eight week cooking course

Novel Activities:

- The Diamond Jubilee
- 'Recoveryfest'

5.5 Concluding Comments

Understanding the history and structure of the LAU is important, as it has influenced how the LTLA project was set up and the goals it aspires to achieve. The abstinence culture that envelopes the LTLA project is one that was decided on by the founding service users, as they decided that such a program could not work if service users were not totally abstinent when interacting within the confines of the LTLA project. As a result, the LTLA project is an ex-service user led group that promotes abstinence. 'Learning to Live Again' is a name that has been chosen as it reflects the abstinent culture and main goals of the project. Participation in leisure activities not only attempts to reinvigorate a positive outlook on life, but it also seems to (re)-teach service users certain life skills that have been lost during their substance dependency.

To conclude this chapter, the LTLA project is perhaps best conceptualised as being a *community* of people who are recovering from substance dependency. The concept of community is closely linked with culture as a community is considered, at the very least to be a group of individuals interacting with one another over a sustained period of time based on a shared, common culture (Finlayson, 2002). In the interest of conciseness, the term 'community' must be further defined, as it is a term that continues to resurface throughout the

findings chapters. The LTLA project seems to be most representative of a 'community of recovery', a term first proposed by Ernest Kurtz (1999), to suggest that there is not one, but multiple recovery communities that people can access (White, 2002), which take into account the growing varieties of recovery experience (Kurtz, 1999). Within a 'community of recovery', members of that community will often experience 'reciprocity of fit' with other members (White, 2002), as there is a shared identity, culture and mutual support for those within the community.

This 'reciprocity of fit' can be explained through the 'density of (social) ties' at the project. Structural symbolic interactionism (Stryker & Burke, 2000) suggests that the more 'ties' there are in a given social group to a particular identity, the more salient that identity becomes for the individual, meaning each individual is more likely to self-verify their role expectations associated with their identity standard. As it will continue to be explored in the subsequent findings chapters, each member of the LTLA project seems to experience this reciprocity of 'fit' with other members due to the cultural identity that subsumes the group, the shared activities they participate in, the firsthand experience each has of addiction which allows them to understand another and the peer support they provide for one another. It is important to remember that abstinence is only enforced *within* the project and does not extend beyond the LTLA project. This would suggest therefore, that the identity of recovery each service user may develop during their time at the LTLA project therefore, is contextually and situationally specific to the project. Conceptualising the LTLA project as a 'community of recovery' will resurface in the final discussion chapter, as there are potential implications for such a conceptualisation (see section *8.4.1*). The next findings chapter discusses the impact of the project on the identity of the individual, and how being a part of the LTLA project seems to facilitate a sense of *being* 'normal'.

Chapter 6

The LTLA project: An Individual Impact

6.1 Introduction

The focus of this chapter is to understand the concept of *identity* and how the identity of those who attend the LTLA project is impacted on by the project. To recap, symbolic interactionism theorises that identity is a human capacity rooted in language to know 'who's who' and hence 'what's what' (Jenkins, 2008). *Identity* is a multi-dimensional *process* of understanding the human world and our place in it as individuals or members of collective groups (Ashton, Deaux & McLaughlin-Volpe, 2004). Based on the data collected during this research, there are four key themes that relate to identity, each of which shall be explored in this chapter. It is important to remember that the culture of abstinence and normality described in section *5.4.1* will resurface throughout this chapter, as it is through these two cultures that identity in the context of the LTLA project is impacted upon.

The first section will develop the identity of space and how the LAU and LTLA project serve to shape the identity of the service users and mentors. This provides a natural continuation from themes explored in the previous chapter, and provides further context from which subsequent themes relating to identity can be explored. The second section will explore the identity of *being* 'normal' through the process of socialisation. This subsection is split into two further themes: *normal functioning* and *employment*. The third section of this chapter will explore the identity of recovery and why most of the mentors and service users consider themselves to be *recovering* as opposed to *recovered*. Within this section is also a theme titled *reaffirmation of self*, which essentially explores if service users and mentors desire 'their old self back' or 'a new self'. The final section will explore the identity of being a mentor and if being labelled a mentor seems to benefit recovery. This subsection is split into four themes: *the mentor label*, *the benefits if being a mentor*, *the supporting role of the mentor* and finally

over-representation of females in the mentor team The final section is concluding comments.

6.2 The identity of the LAU and the LTLA project

The need to explore and understand the identity of the LAU and the LTLA project is because the subsequent themes relating to identity explored in this chapter are all discussed within the context of the LAU and the LTLA project. Furthermore, there is a need to explore the activities and how having the activities in a 'space' that is identified as 'normal' (locations across Yorkshire), facilitates a 'normal' identity to develop in each of the service users. This section is split into two parts. The first explores the 'space' of the LAU and the LTLA project and the implications this has for the individual identities of the service users and mentors. The second section discusses how individual identities during addiction were for many, drastically different to their present identity that has developed in the LTLA project.

Understanding the 'space' of the LAU and the LTLA project and their perceived identities is important, as it is suggested that socio-spatial relations have important implications for the construction of social identities with both identity and space being mutually constitutive (Bondi & Rose, 2003), so that identity shapes space, just as space shapes identity. This is particularly pertinent for the LTLA project. From a situational point of view, the LTLA project itself has no 'real', tangible properties of space; its identity is often linked with that of the LAU. For example, the mentor committee meetings, the weekly 'meet 'n' greet' sessions and some of the activities all operate directly out of the LAU. This was evident as many service users used the terms *"the LAU"* or the *"LTLA project"* synonymously when referring to the LTLA project, which implies that the identity of the LAU shapes, or at least contributes to the identity of the LTLA project.

A synonymous identity with the LAU could be problematic for some service users, as the LAU is, and has always been a service that professionally treats addiction (see section *5.2*), which could result in the LTLA project being

seen as a professionally led service. For some this may not be an issue, but for others it could prove to be problematic. An extended literature review by McLaughlin and Long (2008) found that many service users were reluctant to attend professionally led addiction services because of the perceived negative, and often stigmatising attitudes held by professional clinicians that resulted in unsatisfactory and unsafe care (McLaughlin & Long, 2008). If the LTLA project's identity is perceived as synonymous with the identity of the LAU therefore, it could result in service users not utilising the project through fear of being subjected to such negative views. However, based on observational data and informal conversations with many of the service users, close proximity to the professional staff was considered a positive component of the LTLA project, as they knew that professional support with familiar keyworkers was close at hand if they ever required it.

A second important point to note with regards to the identity-space relationship is the fact that many of the activities the LTLA project offers take place in the context of mainstream society:

> *"Accessing things that are going on in the city is much better from the service users point of view, in that it sort of normalises their life so, so that they are not going to an addiction unit or a mental illness clinic to do their, to do their gym, or their cooking, or, or watching movies, they are going like everyone else in Leeds to their local cinema, or the local gym or whatever."* [Clinician ♯1; co-clinical lead at the LTLA project]

> *"You can facilitate new experience with people you know so that they have the experience of going to the cinema together and they notice that people interact with them perfectly normally. They don't move away from them, they don't you know, they don't, they don't treat them badly. When their doing these things, people treat them like normal human beings… coz they don't see people treating them badly"* [Clinician ♯2; co-clinical lead at the LTLA project]

Provision of the activities across local public sites in Leeds is a potentially powerful contributor to recovery. Given the reciprocal nature of space and identity, going to the local gym to exercise or the local cinema to watch a movie, the service users are interacting with space that is also occupied by 'normal' members of the public, thus allowing for *their* self to potentially develop under circumstances that are less related to recovery, and more related to 'normal', mainstream society. This means that service users not only get the opportunity to socially interact with 'normal' others in society, thus demonstrating to each service user they are treated like 'anyone else', but that their bodies also become part of the space (Malins, Fitzgerald & Threadgold, 2006). The implication being that if the space they are *in* is considered 'normal', this has the potential to infer a 'normal' identity within each service user. From a cultural point of view, going to the gym or the cinema serves to give each service user and mentor a tangible connection with culturally 'normal life', thus allowing them to socially engage with mainstream society and experience *being* 'normal' (explored in section *6.3*). This in turn, allows the service users and mentors to 'learn' what is 'required' of them by society through the continual processes of engagement and interaction (Coffey, 2006). By having the opportunity to participate in activities set in the context of the general social milieu of Leeds city centre helps the service users and mentors 're-create' themselves, as Angela explains:

> *"We've all said this and I certainly feel it that you feel like your personality's coming back, you sort of lost your personality back then and like, umm, your personality starts to come back and things that used to make you laugh make you laugh now. I don't know we might say 'o have you had your hair done' or… everyday things in recovery and everyday things, so its not all sort of 'woe is me and I felt terrible' it's more, sort of well they say learning to live again, just sort of getting yourself back, your old self back, not necessarily your old self, but its like a new you, like as you've got older like your new personality coming through and things so yeah it really does help"*
> [Angela; service user]

Corrigan and colleagues (2002; 2006) suggest that one of the most effective strategies to reduce the stigma attached to addiction is to increase interpersonal contact with mainstream citizens, as it facilitates normal interaction and highlights to the recovering service user that they are not seen by others as 'abnormal', 'deviant' or an 'alcoholic'. Having the activities take place in the wider context of 'mainstream' society therefore, serves to help individuals construct a sense of self and an identity based on the normal interactions they encounter with members of 'mainstream' society. This in turn, reinforces the LTLA project's 'space' as positive, hopeful and recovery-focused. Whilst Corrigan's (2002) conjecture is arguably an accurate one, it is perhaps only half the story.

Many in mainstream society actively shun individuals with addiction problems, which often results in profound, detrimental impacts on self-worth for those with addiction problems (Lloyd, 2010). Whilst there may be some who uphold negative stereotypes associated with addiction, many of the service users and mentors at the LTLA project managed their addiction by concealing their drinking habits from others. Based on Goffman's ideology, the service users and mentors in this scenario are considered *discreditable*, as their plight is neither known about nor perceivable by others (Goffman, 1963). Interacting in mainstream society therefore, is perhaps not just an opportunity for the service users and mentors to experience that others do not necessarily 'see' them as deviant or abnormal as Corrigan (2002) and Corrigan, Watson & Barr (2006) suggest, but also an opportunity for mainstream society to 'see' that not all recovering problem drinkers are inherently bad people.

Given the popularity of many of the activities, in conjunction with the opportunity to socially interact with others at the project, the identity of the LTLA project seems to have become an identity of hope and a positive belief that addiction can be overcome:

> *"Starting a new life, starting again… I'm a lot more outgoing, I'm a lot more confident with recovery. Its built my confidence up so much from you know,*

from when I first started going to the group, obviously at first you're a bit nervous you know, there's a whole room of people but its just made me so much confident and its given me something to do, given me something to focus on, rather than just having myself or my problems or whatever to focus on. Its given me something, something positive… it is so positive coz not only are you working on staying away from your addiction, being aware of why you're there and being aware of you're problems you know what I mean? Its just really, really is a positive thing, a positive place." [Chloe; service user]

Structural symbolic interactionism would suggest that though interaction in a common situation or space such as the LTLA project, the common meaning of abstinence that envelopes the group would also subsume the identity of the individual. This would suggest that the commitment of each service user to the LTLA project and the role expectations of recovery would in turn, reinforce the recovery identity of the LTLA project. As a result, the mentors and service users seem to construct a 'recovery-focused' identity based on the LTLA project's abstinent culture. The more time the mentors and service users spend 'recovering' at the LTLA project, the more cemented the relationship becomes between the LTLA project's space and their identity. However, it is important to remember that this identity is culturally and contextually specific to the LTLA project, as the culture of abstinence is not enforced on the service users and mentors outside the project. However, most of the service users and mentors articulated that abstinence is their end-goal to recovery, which would suggest that the culture of abstinence is being internalised by most of the service users and mentors.

This is in stark contrast to the mentors and service users identities during their addiction. Many saw themselves then as the stereotypical 'alcoholic':

Me: Did you consider yourself an alcoholic? *"Yeah, I might have well been laid int streets with bottle of cider in a paper bag, that's how bad I*

were. Yeah because I needed to drink before anything." [William; service user]

This raises two interesting points. First, William, like many of the service users, fully accepted that they were alcohol dependent at the time of their addiction, which brings into question the commonly held view that alcohol dependent people are in a state of denial about their drinking (Dyson, 2007). William explained that whilst he fully accepted his problem, he prevented disclosure to others through fear of persecution or being judged. This finding suggests therefore, that there may be some who fully accept their alcohol dependency, but are afraid to confront the problem through fear of the stigma surrounding their addiction. This problem, Corrigan (2002) writes, is most likely to be addressed through greater public awareness of addiction.

The second point of interest to note is that William refers to his 'alcoholic' identity in the past tense, which suggests that in the present, he no longer sees himself as an 'alcoholic'. This is a powerful point as it provides evidence that attending the LAU for professional treatment followed by attendance at the LTLA project does have positive impacts on identity from the point of view that in the present, he no longer sees himself as an 'alcoholic':

> **Me: How do you see yourself now?** *"Back to how I was, just getting on with people, socialising and being alright with people, a lot more happy, a lot happier"* **Me: How has the project helped?** *"Its helped me alot because I'm going on the activities, I got me confidence back and I can see how it helps other people. It's a good project coz it gives people their lives back"* [William; service user]

For William, the LTLA project has facilitated an identity transformation back to how he was, a point in time when he seemed content with himself. William explained in his interview that he had been totally abstinent for eighteen months, which provides strong evidence that the culture of the project is being internalised and adopted as an approach to recovery outside the confines of the

project. For William, his recovery identity seems to have been partly moulded by the culture of the project, which not only embodies abstinence, but the associated feelings of self-confidence and personal development also. Through a commitment to abstinence and participation in the activities, William's self-conception has shifted from being an 'alcoholic' to a person he is content with. It is important to note that the LTLA project is not the sole reason for such an identity transformation, as many of the service users mentioned, but all were keen to explain that the project seemed to be the catalyst for personal development and a commitment to abstinence and recovery. Unlike William, there were some who were reluctant to accept the 'alcoholic' identity:

> *"Because when you say 'alcoholic' to anyone, to anybody, there seems to be a tag on it you know. There seems to be a, its umm, you know somebody being like a tramp or you know"* [Catherine; service user]

The historically embedded discursive identity of an 'alcoholic' is a particularly powerful and negative one, often associated with William and Catherine's 'tramp on a bench' analogy. William like many of the other interviewees, built a sense of self and an identity that was constructed on the pejorative citations of an 'alcoholic'. 'Alcoholic' is a term that has traditionally always been considered a 'dirty word' laden with stigma (Dean & Poremba, 1983). Many therefore view alcoholism as a psychosocial and moral problem, which has resulted in it becoming one of the most rejected stereotypes in many societies (Schomerus et al., 2011). However, Catherine continued to explain that because of the stereotypical 'alcoholic' being associated with negative traits, 'problem drinker' was a preferred identity:

> *"I got two books actually, I brought two books. One is umm, one is called umm 'learning to stay off the drink' or something like that its about alcohol and stuff. And it says in there that these days in this time and, in these modern times, people don't say 'alcoholic', they just say umm that you're a 'problem drinker' or you 'have problems with drink' and things and it's*

[alcoholic] *is an old fashioned word"* **Me: So did you see yourself as a problem drinker than?** *"Yes, yeah"* [Catherine; service user]

Through the use of language, Catherine has constructed a more 'favourable' sense of self when discussing her addiction past; one that she feels is less stigmatising and more representative of her addiction. The language associated with being an 'alcoholic' is that of inherent deviance, being dirty and dangerous and long-lasting (White, 2007); all traits of which Catherine strongly refused to accept. The language associated with 'problem drinker' however, implies that it was a 'problem' that did not define Catherine, and that it was a problem that could be overcome. Furthermore, the word 'problem' arguably reduces the impact of her problematic drinking past to reflect a self-conception whereby her drinking was not the result of weak-will, but was the product of her life circumstances (primarily the death of her husband). Whereas an 'alcoholic' identity perhaps implies that addiction is a problem fundamentally *in the person* (Link & Phelan, 2001), making *them* fundamentally different from *us* (non-problem drinkers), 'problem drinking' implies that an individual is still one of *us*, just beset with a problem of drinking. A 'problem drinking' identity arguably serves to prevent such an identity becoming internalised as part of an individuals self-conception. It is important to note that denial of the 'alcoholic' identity is perhaps not a denial of their drinking habits, but a denial constructed to avoid the identity of an 'alcoholic', and therefore avoid becoming associated with the substantial stigma that consumes the 'alcoholic' stereotype.

Catherine's extract highlights the importance of language in recovery. Malins, Fitzgerald and Threadgold (2006) state that the discursive repertoire in addiction, particularly for women to draw upon to narratively construct a sense of self is limited, and often results in negative stigmatisation and stereotypes being used as a foundation for identity construction. Terms such as 'alcoholic' perpetuate unproductive identities, as they form a negative foundation when individuals construct their sense of self. Language in recovery therefore needs to be developed to contest the negative stereotypes that are historically embedded across societies, in order to promote narratives that enable more positive

identities to be constructed that may facilitate recovery from addiction (White, 2007).

To conclude this section, an important caveat that needs mentioning with regards to the 'identity-space' relationship is that one can become contiguous with/or indistinguishable from the space (Malins, Fitzgerald & Threadgold, 2006). Based on observational data, it became apparent that whilst the activities that attempt to facilitate a 'normal identity' through 'normal' interaction with mainstream society take place *in* mainstream society, they all take place *within* the confines of the LTLA project's safety. This potentially means that whilst the service users have the opportunity to interact *with* mainstream society, they are not necessarily interacting *within* mainstream society. For those who engage with mainstream society outside the project and maintain a 'healthy' balance between their life inside the project as well as outside (see section *7.4.3*), this is not necessarily problematic, as they continue to 'practice' socialisation outside of the LTLA project.

For those who become over-involved with the LTLA project such as James and Clive (see section *7.4.2*) however, there was a tendency for them to only engage with mainstream society in the context of the LTLA project. This is potentially detrimental for recovery, as it perhaps limits the extent to which an individual can *be* 'normal', as their socialisation primarily takes place *within* a project that ultimately deals with those who are considered not normal given their addiction pasts. This could limit a service users 'self' development as they are continually constructing and reconstructing self within the same social community of the LTLA project, a theme that continues throughout the findings chapters.

At present, the LTLA project has no separate physical basis and remains a recovery project that operates out of the LAU. Given the mutually constitutive relationship between identity and space, if the project was to expand and new grounds were required, careful consideration should be given to its location. Throughout this subsection it has been have argued that socio-spatial

assemblages not only have the potential to shape the identity of others, but are also shaped by the people who use the space. Malins, Fitzgerald and Threadgold, (2006) argue that future services for drug treatment centres should have multiple capabilities such as a health clinic, public library, housing referral services and community art spaces etc. Whilst these are only suggestions and may not be wholly applicable for the LTLA project, it sets out the importance of considering space when setting up treatment services, as these services may have future impacts on how people begin to re-define their identity after addiction. As it is explored in the following section, the LTLA project seems to be a space that attempts to facilitate a 'normal' identity by providing activities set within 'normal', mainstream society. The question that needs answering therefore, is what is *being* normal, and how is it achieved?

6.3 The identity of *being* 'normal'

Being or *doing* 'normal' things could relate to a huge spectrum of activities, some of which are considered 'normal' by most in society, for example going to work, whereas other activities such as chronic substance use may only be considered 'normal' by the minority of individuals who chronically use substances. 'Normal' in the context of this research relates to two themes: *normal functioning* and *employment*. An important concept that relates to the identity of normality is the process of *socialisation*.

Socialisation is a process of *being* or *becoming* a member of society of a cultural group (Coffey, 2006). From a symbolic interactionist's perspective, the process of *being* or *becoming* allows for personal biographies and social identities to be actively constructed and reconstructed, as we 'learn' the new roles and nuances of a culture in which an individual is located (Coffey, 2006). As it shall become apparent, socialisation and the process of *being* will feature throughout this chapter and beyond, as *being* does not just relate to 'being normal', but also to traits such as 'being in recovery' and 'being a mentor'. Whereas the above section explored how having activities take place in the general milieu of 'normal' society facilitates a sense of 'normal' interaction with

mainstream society, this section explores how 'being' and 'doing' normal things facilitates recovery.

6.3.1 *'Being'* normal

The first part of this section will discuss how the LTLA project has helped individuals to develop a 'normal' identity, followed by a section on how 'normal functioning' appears to be a product of entering into recovery. During addiction, many individuals behave in ways that are often shunned by 'normal society':

> *"You musn't forget that people have done things in public that they, they very often behave badly in public, you would perceive it, I would perceive it you know, being abusive to people umm, staggering about the place all that sort of thing and you know. In some cases, maybe stealing and all sorts of things so they become as I, as I said earlier, people you know, you know their still in the same body so they encounter other people, they expect people to judge them negatively umm, which is why people are so reluctant to disclose a history of addiction because they just expect people to think badly of them"* [Clinician ♯2; co-clinical lead at the LTLA project]

As a result, many service users missed out on developing 'normal' relationships with others as well as missing out on how to function normally in society:

> *"I think if you haven't been absorbed in a world of taking drugs or drinking and remember alot of people have done that all their lives, so that they have never really you know, alot of people have missed out on growing up and forming normal relationships. They don't know, they know surprisingly how to score cocaine on the street but they don't know how to shop in Sainsbury's so it, it's a slow learning process, and picking up many of those things that, that they didn't get when they were in their teens or their early twenties"* [Clinician ♯1; co-clinical lead at the LTLA project]

During some of the service users and mentors addiction pasts, socialisation was minimal as they drank alone whereas for others, socialisation was primarily limited to others who also drank or used drugs problematically. The reason some drank alone or limited their interactions to others who drank, is arguably to prevent the process of stigmatisation taking effect. Stigmatisation takes effect when the mark or stigma becomes the focal point of the self-concept (Jones et al., 1984), and at some level accepts the social meaning of *their* stigma. This in turn, results in associated feelings of rejection, as the stigma is now a central component of their sense of self (Lloyd, 2010). This process of stigmatisation is arguably accelerated when interacting with those who do not possess the stigma of alcohol addiction, as *we* (those without the stigma) generate a stigma theory, an ideology to explain *their* (those with addiction problems for example) inferiority, which is imputed onto the stigmatised through social interaction (Goffman, 1963). As a result, many drank alone to minimise the process of stigmatisation taking place from others. Ultimately however, all the service users and mentors *became* 'addicts'. The LTLA project however, through participation in pleasurable activities in mainstream society, in conjunction with their culture of abstinence attempts to challenge the perceived negative identity built up during addiction, and tries to facilitate a reconstruction of a 'normal' self through interaction with 'normal', mainstream society.

This point highlights that *being* is perhaps reliant on *doing*. Coffey (2006) states that socialisation is based on a process of *being*, which is perhaps only half an explanation, as it implies that one can almost spontaneously just *be* or *become* an identity. For an individual to *be* a certain identity, they must theoretically '*do*' and continually '*do*' behaviours over time that are indicative of that specific identity. The service users were only considered to *be* addicts based on them '*doing*' behaviours that were representative of *being* an addict over an extended period of time. The concept of time is important, as continual repetition of behaviour reinforces the extent to which someone *is* an identity. The service users only *became* addicts over time; it was not an identity that commenced immediately when they first started drinking. The same is true of recovery and

being ‘normal’. For an individual to *be* considered ‘normal’, they must ‘*do*’ behaviours that are reflective of a ‘normal’ identity over an extended period of time. Given the length of time that recovery from addiction often takes, the process of *doing* is likely to be a continual process over many years. During this time however, the continual process of *doing* ‘normal things’, will continue to facilitate a sense of *being* considered ‘normal’.

Developing a ‘normal’ identity not only serves to reduce the social distance that was once evident between their former addiction identity and their new ‘normal’ identity, but it also perhaps serves to increase the distance with the former addiction pasts. ‘*Doing* social interaction’ in mainstream society therefore, not only facilitates a perceived ‘normal’ identity to develop as the interaction is based on the culture of ‘normal’, mainstream society, but it is also likely to alleviate the sources of stigma that are perceived to exist in mainstream society from the viewpoint of the individual service user. It is also likely to have the effect of challenging stigma about mainstream society from the viewpoint of the service users.

6.3.2 Normal functioning

Most of the mentors and service users expressed a desire to regain *normal functioning*. At an individual level, this related to regaining normal cognitive function:

> *“Me brain weren’t functioning as it should have been, I were dry, I wasn’t drinking but I was still in a mental state of confusion… I only live ten mile away and I remember feeling so proud of myself that day that I had driven myself here and found it without getting lost. That’s how long it took me brain to get back to normal, so I’m a really coherent sort of a guy, I know what’s going off, but I weren’t at the time”* [Mentor ♯2]

Regaining normal cognitive function meant that mentor ♯2 was now able to start doing ‘normal’ things again such as driving. On a physiological level, socialisation plays a less central role as ‘normal functioning’ is based on internal

bodily processes physically re-addressing the effects of chronic alcohol dependency. For others, 'normal functioning' related to effective management of their finances, an aspect of their life that was significantly impacted on during their period of substance dependency:

> *"Managed to do all me bills, sorted all me bills out... when I were drinking, if a bill come in I just put it in bin. I just didn't care."* [Jayne; service user]

> *"Just getting back to normality and same with like when your bills come in, I used to hide them all over house, I can sit now and work things out you know"* [Barbara; service user]

It has been reported in the literature that addiction is often accompanied by major financial problems, as money is primarily used to purchase alcohol and/or drugs (Hamilton & Potenza, 2012). Regaining control of one's finances can therefore serve to facilitate recovery, as it re-instils a sense of stability back in their life and provides them with a financial structure upon which they can live. '*Doing* the bills' is symptomatic of mainstream society, as most in society often have to undertake tasks such as organising finances. Referring back to the process of *doing*, whilst financial organisation may seem trivial to those who have not suffered with substance dependency, it facilitates a sense of *being* normal. Referring back to Raymond Williams' 'ordinary' conceptualisation of culture, '*doing* the bills' is arguably apart of mainstream 'normal' culture, so continued socialisation and engagement with such a culture perhaps serves to reconstruct the service user's identities based on this 'normal culture'. 'Normal functioning' also related to 'normal' chores and hobbies that are indicative of everyday life:

> *"There were a lot of things in the house you know, where I needed stuff mending and I were letting them all go to one side coz me mind weren't settled on it and now I seem to be getting me home in ship shape again you know... I'm usually pretty busy till about six o clock. Teas been made, washed up and then sit down and relax and watch tele. I got quite back into*

reading and knitting and stuff like that. I like it when me husband and granddaughter, me granddaughter lives with me, she's 19, when they've gone to bed because I like to tidy round, I don't mean tidying round, washing floors, I just mean tidying cushions up, making sure there aint any washing to get up to in morning, and I love to get, then I love to get up in a morning and the house is still tidy from the night before and I class that as my, my, my… quality time, when they've all gone to bed and I just got, if its only half an hour to me myself, tidy round and everything. Last thing I think about is having a drink and I go to bed and I like to read, I usually read for about it can, can be 10 minutes maybe an hour" [Barbara; service user]

For Barbara, keeping her house neat and tidy is perhaps a narrative articulation of 'who she *is*' as a person. During her addiction, Barbara's house began to deteriorate as a result of her drinking, a symbolic representation of how her life was also beginning to deteriorate. During her recovery however, her house is now clean, tidy and how she wants it. Barbara now takes pride in her homes appearance, which is perhaps symbolic of her recovery. In many cultures, the family home is a socially constructed place that contributes in particular to a women's self-esteem and emotional well being as they are able to exercise certain 'rights' and autonomy (Curtis, 2010), which in Barbara's case it did. Barbara's pride in her home therefore, is perhaps not just an extension of her 'new' self in recovery, but also a source of empowerment as she re-gains control over her home. Re-gaining control over her homes appearance perhaps serves to facilitate a grander 're-gaining of control' over her life, a sense of control that she did not have during her addiction. It is widely reported throughout the literature that addiction is often accompanied by feelings of total powerlessness (Ronel & Claridge, 2003), so regaining control over any aspect of one's life is a potentially valuable source of recovery capital, no matter how trivial it may seem. Furthermore, Davidson (2003) explains that the home is *"the heart of many of our life-worlds and provides a relatively stable base for us to orient ourselves"* (Davidson, 2003; p. 653). This which would suggest that having a sense of control over ones home would also provide stability on which to build a new sense of self. Maintaining a nice home is similar to 'doing the bills'; it provides

Barbara with culturally comparable connections to those in 'normal' society, as most in 'normal' society like to keep a nice home.

The important point to note is that 'doing normal things' such as maintaining finances, doing chores around the house and participating in activities and hobbies all serve to facilitate a sense of *becoming* normal. Through the action of 'doing something normal' that most in mainstream society do, they have a tangible connection with such a society, thus serving to help a 'normal' identity develop. This is supported by a recent report written by Measham, Moore and Welch (2013) who found that being 'normal' and becoming a part of 'normal' society was the driving force behind most people's recovery.

The narratives used in this section have come from those who utilise the project in a manner whereby they strike a good balance between their life inside the project, as well as their life outside the project. As it is was stated above and explored in greater depth in section *7.4*, there are some who become over-involved with the LTLA project, which is potentially detrimental for recovery. The reason it is perhaps detrimental is because their main form of social interaction is limited to those within the project, which restricts their socialisation to one group, thus having an impact on identity. Symbolic interactionism dictates that identity is a social creation based on interactions with other people and cultures in a society (Jenkins, 2008), which if restricted to one group (such as the LTLA project) means identity will only be shaped by socialisation within that group.

6.3.3 Employment

A theme that continued to resurface throughout the data and was heavily linked with the concept of 'normality' was *employment*. Many of the service users explained that they had been out of work for some time and that a goal of theirs was to regain employment:

> *"I used to work a few years ago and umm I haven't worked for about five years and I'd like to umm, get back into work. Maybe part time at first umm,*

to sort of work up to sort of more hours but you know sort of start off, I'm quite interested in umm, going to college part time as well too. I used to work in a school and because it's been a few years since I've worked there I need to like do a refresher, sort of get back into the new things and everything so I'd like to get back into that" [Angela; service user]

"It'd be worthwhile employment, if it was going to be something I wanted to do and my quality of life would improve and me son would have more, it's, I think its setting out the correct, the, the correct way to be for your children that they see me go out to work rather than they see me sit at home because I want to do a voluntary group and so that'd be the wrong choice. If it was possible I'd try and still be involved in another way if there was activities or things like that but if it wasn't, then that would be the you know, that would be the end of my involvement with it [the project] *coz I need to work."* [Mentor ♯3]

At a social level, gaining employment was a common narrative that was articulated, as it would not only help with their financial situation but it would also be a further step away from many of their unemployed, addiction pasts to their recovery focused future. It is well documented in the literature that one of the biggest challenges for recovering problem alcohol and/or drug users is finding employment, as many businesses do not want to employ those with previous histories of addiction (UKDPC, 2008). It was estimated in 2006/2007 that the Department for Work and Pensions (hereafter DWP) paid out an estimated £40 million for those on disability allowance whose main condition was recorded as problem drug use (DWP, 2007), illustrating the problem that arises as a result of an unwillingness to employ former drug and/or alcohol users. Gaining employment however, has been found to aid the development of an individuals 'recovery capital' (Cloud & Granfield, 2008), improve self-esteem and self confidence (UKDPC, 2008), enhance social functioning (NTA, 2010a) as well as providing significant social and economic benefits for the employee and their families (Black, 2008), all of which are likely to improve the recovery of the individual.

Employment does not just help with their financial situation but it portrays *"setting out the correct... way to be for your children"* [mentor ♯3]. Structural symbolic interactionism suggests that roles and role expectations are located in different contexts. If an individual is able to gain employment therefore, it will provide them with a further context upon which to build an identity that is considered 'normal'. Societal convention dictates that employment is a normal component of life and as such, those who do not work, especially those dependent on the benefits system come under scrutiny. As a result, those receiving benefits are often associated with the stigma of receiving benefits; another factor that potentially hinders them being regarded as 'normal'. Employment however would not only diminish the stigma associated with being on benefits, but it would also provide them with another role: an employee.

At an individual level, employment is likely to significantly contribute to their recovery capital. As section *1.*4 sets out, the four components of recovery capital are *social*, *physical*, *human* and *cultural* capital (Cloud & Granfield, 2008; Home Office, 2010), all of which are likely to be positively impacted on by employment. Social capital is likely to be enhanced through new social networks made at work, physical capital will likely increase as a result of their increased financial earnings, human capital may increase through the acquisition of new knowledge and skills required for their work which is also conjectured to contribute to mental stability, and cultural capital will likely increase as employment reflects social norms within our societal culture (Cloud & Granfield, 2008). It is important to note that this is conjecture and that in reality jobs can vary significantly, which may result in employment contributing to one form of capital more than another, but employment in general is likely to fuel personal development in recovery in a fairly holistic manner. From a structural symbolic interactionist's perspective, employment would also instil another role to occupy (Scott, 2006), they would *be* an employee, which would provide them with a different culture upon which they could construct and reconstruct their personal biography and social identity (Goffman, 1959).

It is important to note that whilst employment was a recovery goal for many of the service users and some of the mentors, employment was also a significant reason some of the service users remained in the grips of their addiction:

> **Me: Some people say when they are drinking or when they are in the grips of the addiction, they don't feel normal, is that something you felt?** *"No because I was working full time Tom… they didn't, they never even knew, I don't know how I got away with it to be honest. I were training girls, I worked for* [a supermarket] *and I worked part time in the cash office and then the rest of the time training girls from other stores, umm yeah I were functioning normal"* [Alison; service user]
>
> *"No, I was in denial about it* [her addiction]*. I didn't because I was working and holding a full time job down and doing a you know, pretty decent job and umm, but when I look back I must have been"* [Barbara; service user]

Cloud and Granfield (2008) state that certain factors such as young age, being female, mental health and incarceration can result in negative recovery capital, as they hinder recovery trajectories. Based on the data collected in this research, *employment* is also another domain that in some cases could hinder recovery, as the capital they gain from work actually serves to keep them rooted in their addiction. It would seem that being in employment counter intuitively reinforced addiction, as it meant they saw themselves, and were seen by others to be *doing*, and maintaining a routine that was considered 'normal', thus allowing for the 'alcoholic' identity to be avoided. It enabled concealment of their drinking habits, which in turn, prevented the stigma of their addiction becoming the focal point of their self-conception (Jones et al., 1984). Furthermore, the financial capital they gained during their addiction would have also enabled their problematic drinking to continue fairly freely for as long as their funds permitted. Cloud & Granfield (2008) state this is because they have capital that enables their addiction to be maintained. Paradoxically therefore, the very recovery capital that facilitates problematic substance use cessation for many, is

also for others a barrier that can insulate others from attempting to stop their use. Furthermore, seeking employment and failing in such an endeavour could result in a return to drink in order to deal with failure:

> *"Yeah, I mean like I, I gone all out trying to find work, which I have had follow up interviews, I've applied for god knows how many jobs and its just not worked and its knocked me down every time. I know I were advised last time to maybe wanna take a step back from doing it, driving yourself into ground when there's nowt there. I mean I crashed and burned [relapsed] a few week ago"* [Kevin; service user]

In Kevin's case, finding work became so central to his recovery that it actually resulted in relapse when he was not able to gain employment. Employment therefore, whilst it is likely to contribute to recovery should be considered with caution. It could provide them with the necessary funds to re-commence their alcohol use and could also have the effect of making an individual feel like they had 'recovered', thus making them complacent and thinking they can return to alcohol use. As mentor ♯4 explained she got *"a bit too clever"* ultimately because the recovery capital she had built up over her thirteen-year period of abstinence made her feel she could do controlled drinking, an outcome that resulted in a second period of addiction. Furthermore, placing employment as a main recovery goal and failing to achieve such a goal could result in relapse, as it makes individuals feel like they have failed, thus impacting on their self-esteem and self-confidence. Gaining employment, especially in the current economical climate is an exceptionally difficult task even for those without a history of addiction, and for some, perhaps should not be made a central goal of recovery.

Throughout this section, the concept of *being* normal through a process of *doing* 'normal' actions has been explored. It was argued that *being* normal is achieved through socialisation with 'normal' actions such as doing the bills, maintenance of one's home, taking up hobbies or employment. By *being* normal and experiencing the positive implications of *being* normal, commitment to such

an identity is increased, thus moving it further up an individual's salience hierarchy and increasing the likelihood of such an identity being maintained and enacted in future situations. As it is explored in greater detail in the following section of this chapter, identity is never a fixed some*thing* that *is* (Jenkins, 2008). From a symbolic interactionist's perspective, identity is a continually evolving process of *being* or *becoming*, which suggests that an individual in recovery, as well as any individual in mainstream society can never just *be* normal, as this suggests a finite state of normality. *Being* normal through the process of socialisation therefore, should be conceptualised as a continuous process of an evolving 'self' based on the 'normal' social interactions and tangible connections a recovering individual has with 'normal' life.

6.4 The identity of recovery

This section is split into two parts. The first subsection will explore the identity of *recovering* or *recovered*, followed by a subsection referred to as *reaffirmation of self*. The rationale for exploring the first subsection stems principally from the debate about how best to model addiction. Due to the lack of consensus that surrounds which is the best model to understand addiction, it is difficult to determine recovery outcomes. Whilst there are several models to understand and explain addiction (West, 2006), the prevailing model, especially within the AA field appears to be the disease (or medical) model of addiction. The rudimentary premise of this model is that addiction is a chronic, progressive illness (or disease) like any other ailment, for example, type II diabetes or cardiovascular disease (Clark, 2006). Based on this model, addiction is seen as a lifelong, chronic condition that can never be 'cured' (Alcoholics Anonymous, 2010), therefore an individual is never 'recovered' but always 'recovering'. It is this model of addiction that is upheld by support groups such as AA, NA and the Minnesota 12-step approach and is the model that is ultimately responsible for the 'once an addict, always an addict' philosophy.

Opponents of this model however, argue that viewing addiction as a lifelong illness serves to keep the individual connected with their addiction, reinforces stigma (Tatarsky, 2011), prevents individuals from developing self-

control techniques as they explain their addiction as an illness that 'experts' must treat and impedes social reintegration (Clark, 2006). The reasons for this opposition are primarily born out of the view that conceding addiction as a lifelong illness serves to reinforce a lifelong addiction, regardless of the amount of time an individual may have been abstinent (Clark, 2006). Hence opponents of the disease model feel that 'recovered' is a more viable treatment outcome. The second subsection stems principally from the fact that throughout the data, there was very little articulation of physical recovery but many references to a 'regaining of an old self' or a 'regaining of a new self' that had been lost during addiction; hence the term *reaffirmation of self*.

6.4.1 'Recovering' or 'recovered'?

A recurrent theme in understanding SHGs, or more accurately mutual aid groups, where one's self identity is a project to be worked on, is the personal identification with being 'in recovery' or 'recovering' or having 'recovered' (Measham, Moore & Welch, 2013). Of the eighteen service users and mentors interviewed during this research, seventeen identified themselves as *recovering* and only one as *recovered*. Given such a stark contrast in how individuals identified themselves, there is a need to understand why all but one – mentor ♯3 - identified themselves as *recovering*. The first subsection will explore the *recovering* identity from the viewpoint of the mentor and also from that of the service users. The second subsection will adopt a specific case study approach with mentor ♯3 as the sole focus to understand a *recovered* identity.

6.4.1.1 A *recovering* identity: The mentors

Mentor ♯1, mentor ♯2, mentor ♯4 and mentor ♯5 were the four mentors who identified themselves as *recovering*. They did so because they expressed throughout their interviews the view that no matter how long one has been in recovery, addiction is always a potential threat:

> *"I don't think you can ever say recovered, I think it always has to be recovering but I don't on a day to day basis think of myself as… somebody*

who has an alcohol problem. In the past and I'm very aware that has happened to me and thirteen years it can happen again but I don't go by the AA philosophy of you know, lock your doors and don't go in a pub. It, it you know, I didn't do it the first time and I wouldn't do it this time it's my problem, not everybody else's umm, and I don't see it as a problem that I don't drink now. I've got a friend who well over thirty years has never drunk just coz she doesn't like it so to me I can just say well I don't drink, she does. Nobody questions her its just coz I don't drink, I don't like it so I sort of base me a bit with her" [Mentor ♯4]

"I'm not gonna say curing myself from my addiction coz your never cured but, I've got over it and come through the tunnel at the other end you know" [Mentor ♯2]

Me: Do you class yourself as recovering or recovered? *"Recovering… I don't, its strange aint it. Coz I don't think you can be too confident saying that you recovered"* [Mentor ♯5]

However, White who has written extensively on the importance of language in recovery defines recovery in the following way: *"recovered provides a means of designating those who have achieved stable sobriety and better conveys the real hope for a permanent resolution of alcohol and other drug problems"* (White, 2002; p. 29). This would suggest that, by his definition, mentor ♯1, mentor ♯2, mentor ♯4 and mentor ♯5 are therefore *recovered*. The question remains therefore, why do they consider themselves recovering rather than recovered? Their reluctance to accept a 'recovered' labelled arguably stems from their firsthand experience of the power of addiction:

Me: So you mentioned eighteen years ago you had an alcohol problem? *"Yeah well it will be 16, 18 years now coz I had 13 years dry… and then I had 2 years I'd drank.* **Me: What triggered your relapse after 13 years dry?** *"There were lots, coz I don't think you can ever say anything. I think it was boredom, I think it was, well I got a bit too clever is my honest*

answer that I thought right I'm 15 years older, didn't have the money problems that I had when I drank for the first time, didn't have the social problems that I was experiencing then, I'd done a course in psychotherapy, I'd trained as an addictions counsellor and thought 'I can do controlled drinking' and it lasted about two months and I was back to hiding vodka behind the wardrobe and you know, just went downhill very quickly" [Mentor ♯4]

Symbolic interactionism suggests that we learn through experience and that through experience, we can interpret and modify our meaning of things (Blumer, 1969). In the case of mentor ♯4, despite thirteen years of abstinence, her controlled drinking very quickly ended in relapse, which demonstrated to mentor ♯4 that abstinence was the only viable goal for her. From an individual point of view, the intensely negative feelings mentor ♯4 experienced when she relapsed were the result of her behaviour being deplored by herself and by significant others in her social environment, which resulted in intensely negative feelings being self-verified (Burke & Stets, 1999). From a more structural point of view, her *actual* role expectations as an 'addict' were radically disparate from the role expectations she was expected to perform as a mother or a wife in her social structure (Stryker, 1980). As a result, mentor ♯4 drastically altered her behaviour and entered into recovery. During her recovery, the positive feedback from others in the project and from her friends and family enhanced her commitment to her 'new' recovery identity, which increased the identities salience for her.

However, it is important to note that whilst mentor ♯4 may consider herself to be *recovering* when asked to respond directly to the question *"do you see yourself as recovered or recovering?"* it does not mean she fundamentally identifies herself as a *recovering problem drinker*, as mentor ♯4 continued to explain throughout her interview. Mentor ♯4 now identifies herself as an individual that does not drink simply because of the taste, not because she has been alcohol dependent in the past. Whilst mentor ♯4 is aware of her past addiction and considers herself to be *recovering*, her addiction, and indeed her

recovery no longer define who she is as a person and states that she openly contests the *"AA philosophy of you know, lock your doors and don't go in a pub"* [mentor ♯4]. It is perhaps more accurate to suggest therefore that in the context of recovery, mentor ♯4 is a *recovering* problem drinker, but in the context of her general life, mentor ♯4 very much seems to be *'passively recovering'*. I use the term *'passively recovering'* to demonstrate that whilst mentor ♯4 may always consider herself to be *recovering*, it is not an identity status that *actively* defines who she is. *'Passive recovery'* reflects a *subordinate identity* (Hughes, 1984), which in most social contexts is not an identity mentor ♯4 is commonly associated with, as 'recovery' seems to have become almost 'second nature'.

6.4.1.2 A *recovering* identity: The service users

The same is perhaps not true of the service users who identified themselves as *recovering.* There were a variety of reasons that the service users regarded themselves as *recovering,* but most were grounded in a lack of self-confidence to control their alcohol use:

> **Me: So would class yourself as recovering or recovered?** *"I would say I'm still recovering coz I'm still not as strong umm, as strong a confident person as I was before"* [James; service user]

> **Me: Do you class yourself as recovered or recovering?** *"Recovering coz I still fancy a drink now. I need to have a word with* [his keyworker] *coz I'm getting cravings for alcohol again. I've had these cravings for about a week"* [Christopher; service user]

> **Me: Would you class yourself as recovered or recovering?** *"That's a hard question to answer, recovering. I don't think I'll, I'll say a good two years as a I feel now before I feel confident you know, to, to not drink. I mean I go socialising, I got out with my family now and I'm quite contented to have a glass of juice or something but then again I'm on the Antabuse. How I feel when that* [taking Antabuse] *stops because I don't know, it, it is*

still early days for me yet but I am getting stronger each day and I do know what I want from my life you know" [Barbara; service user]

James, Christopher and Barbara like most of the other service users are still consciously battling issues directly related to drinking, which perhaps reminds each of them that addiction is still a very real threat and *actively* impacts on their daily lives. As it is explored in section *7.6.2*, most of the service users expressed a feeling of powerlessness against their addiction that often left them feeling as if recovery simply was not possible. Whilst they have perhaps regained some of this power through their participation at the LTLA project, drinking still seems to *actively* impact on service users on a daily basis, an impact, which requires conscious cognitive efforts to not return to drink.

The difference between the *recovering* status of the mentors (excluding mentor ♯3) and the *recovering* status of the service users is that whilst the mentors may be considered to be *'passively recovering'*, it is a *recovering status* that is almost 'second nature' and something that requires little conscious effort to maintain. On the other hand, the service users are *'actively recovering'* from their substance dependency, as their addiction still seems to be a fairly central component of their life, a component they have to *actively* manage in order to facilitate their recovery. Clinician ♯2 clarified this point by suggesting that some of the service users still require active professional support for their addiction, suggesting that their addiction is still an active component of their identity. As a result, their status as a *recovering* service user perhaps relates more to a *master status* (Becker, 1963); a prominent identity amongst their multiple identities as a whole. As each of the service users recovery trajectories unfold over time (Becker, 1963), their *recovering* status, like the mentors, may become less of a master status, and more of a subordinate status if they continue their commitment to recovery. The concept of 'passive' and 'active' recovery are addressed more broadly in section *8.3.2*, where they are used as a basis for the 'stages of recovery' model proposed by this thesis.

6.4.1.3 A *recovered* case study

As it was stated in the introduction, mentor ♯3 was the only individual who defined herself as *recovered*, which meant there were a number of idiosyncrasies that are not necessarily applicable to the wider context of recovery, but do highlight potentially important theoretical points. Fry, Ketteridge and Marshall (1999) state that case studies are good reporting tools to use as they can describe complex cases, which give an insight into the context of a problem. Whilst the story of mentor ♯3 may be one that has specific biographical points relating to her addiction past therefore, there are a number of points that are pertinent to common concepts in recovery such as stigma. As it will become apparent, mentor ♯3 defines herself as *recovered*, but given the nature of her interview, it is perhaps plausible to argue that mentor ♯3 is still *recovering*.

6.4.1.4 The story of mentor ♯3: Truly *recovered*?

Mentor ♯3 ultimately considered herself to be *recovered* based on the premise that she no longer craves alcohol:

> **Me: So would classify yourself as recovered or recovering?** *"Recovered. Because I don't crave, I mean I don't crave. Well for example I, I thought that me job were gonna be made permanent, that were quite a crushing blow, four weeks after an appraisal when everything was going right and I were still on the week to week contract. The area manager had the power to change it if she wanted to and it turned out she did, coz somebody was having a problem somewhere else. The solution - I was easy to get rid of so she solved a problem at my expense. I could have used that as an excuse coz I'd done everything right and it didn't enter me head 'o, shall I go and have a drink – no' it was 'o damn, I lost me job'"* [Mentor ♯3]

However, whilst this was mentor ♯3s response to being asked about her recovery status, her narrative is interwoven with discourse that would suggest her *recovered* status is not as reinforced as mentor ♯3 initially claims. The manner in which mentor ♯3 articulates and presents herself during her

interview suggests that her addiction past and the different sources of stigma associated with her addiction continue to impact on her present circumstances.

First, not only was addiction a source of stigma, but so was being a mother with an addiction problem. Mentor ♯3 continually referred to her son, whom for a period of time while mentor ♯3 was still substance dependent, was taken into protective care:

> *"Its beneficial for him* [her son] *because its normal. I suppose, I don't know coz I suppose its still quite isolating at times and there's still the, still the, there's still the element that you, I still feel like someone who's quite a misfit. I don't get overly close to sort of any of the mums and stuff at school coz I'm different,* [her son] *spent a few years away from me* [in care] *and that's a part of me past that I don't disclose to people. And again people, people judge so that's, so I suppose that does isolate you quite a bit because they, I don't, I don't mix with the people I used to mix with but then you don't just get a new social network that, it takes time. I just sort of fill me days and I accept it coz I cant change that. But then if I were really open about me difficult few years, there'd, there'd be people who shun you coz they don't know ya, you know… when there's children involved you know, it, its umm and it doesn't sound nice and if someone hasn't come into contact with addiction why should they understand?"* [Mentor ♯3]

Being judged as a mother, as well as being judged as an individual who is alcohol dependent, resulted in mentor ♯3 experiencing *double stigma*, a social construct that is apparent in a number of social scenarios. For example, Faye (2005) describes those who suffer with mental illness as well as belonging to an ethnic minority group as experiencing double stigma, as they are confronted by prejudice and discrimination because of their ethnic group affiliation, as well as suffering the stigma of mental illness. The social role and cultural expectation of motherhood seems to result in highly specific stigma and negative stereotyping of those mothers that fail to meet the socially expected role of a 'good mother'. Mentor ♯3, as well as some other mothers explained they felt judged as an

alcohol dependent mother, a role antithetical to ideals of femininity and especially motherhood (Boyd, 1999). The decision made by mentor ♯3 to not *"get overly close to sort of any of the mums and stuff at school"* therefore, is perhaps her way of reducing the impact of her addiction past and the associated stigma on her present, primary role of a mother. Goffman (1961) describes how stigmatised people often isolate themselves so as to avoid ratifying any interaction that presses a reciprocal role upon themselves, thus rendering them vulnerable to see themselves through the eyes of others. If mentor ♯3s addiction past became public knowledge to other mothers therefore, her identity or self as a mother is likely to evolve based on the stigma of addiction; an identity she can avoid through limiting social contact with others (Canfield, 1990).

Second, during her interview mentor ♯3 also disclosed the fact she had criminal convictions as a direct result of her addiction, a further source of potential stigma. Those who are found guilty of committing a crime are often burdened with the stigma of committing a crime, which often results in a deviant identity that has significant social consequences for the labelled (Thomas, 1928). This is particularly problematic for women, as they are not only stigmatised for committing the crime, but also for not conforming to the conventional role of the women in society (Falk, 2001). This often results in limited economic and social opportunities in life (UKDPC, 2008), which in mentor ♯3s case, it did:

> *"For me its harder coz I got convictions and because I got some periods of time out of work. I would want to work not because, not because I been through the LAU and being in rehab. I'd want to work coz I used to work and umm, I should work coz I got children to provide for and I don't want to be on benefits… it's much more difficult to get a job with a conviction than not having one… I suppose it's still quite isolating at times and there's still the, still the, there's still the element that you, I still feel like someone who's quite a misfit. I don't get overly close to sort of any of the mums and stuff at school coz I'm different… I don't mix with the people I used to mix with but then you don't just get a new social network, its takes time and I just sort of fill me days"* [Mentor ♯3]

Third, given the fact that mentor ♯3 was unemployed, she felt burdened by the potential stigma associated with dependence on the benefits system for income:

> **Me: What do you mean by normal?** *"Normal functioning as a normal person, not as someone with an addiction… Well yeah its functioning, it's structure to your day, it, its, living on benefits is not the highlife you know I would prefer you know, to me that is quite normal wanting to work"* [Mentor ♯3]

The perceived stigma that is associated with the benefits system serves to highlight she is perhaps 'not normal'. Many of those at the bottom of the social strata such as those with addiction problems, or 'benefit scroungers' existing in 'broken communities (Tyler, 2013) are deemed socially unacceptable and are therefore stigmatised or 'othered' (Lloyd, 2010; 2013). The 'othered' are 'revolting subjects' (Tyler, 2013) who do not conform to the citizen-consumer ideal-type identities required by today's consumer capitalist society (Young, 2007). In mentor ♯3s case, whilst her dependence on the benefits system for an income is genuine, it is still a situation that affiliates her with the potential stigma that is associated with being on benefits, a stigma that appears to reinforce the disparity between her situation and what mentor ♯3 considers 'normal'. Furthermore, the emphasis that mentor ♯3 places on 'normal functioning' - to be employed and to have a daily structure as a result of being employed and not living off benefits, seems to result in a perceived sense of personal failure (see section *6.3.3*).

A further problem that mentor ♯3 seemed to experience is a lack of different identities. It is important to remember that identity is multi-dimensional, both singular and plural and is ultimately never a settled matter (Jenkins, 2008). Jenkins (2008) continues to state that identification is a process of understanding who we are, and who other people are given a situational context. Throughout her interview mentor ♯3 only seemed to articulate two

prominent identities: her role as a mother and her role as a mentor (the latter of which is an identity that keeps her connected with her addiction indirectly through her recovery, the former of which she feels judged for). Merton (1968) states that individuals rarely occupy one role and that between roles, contradictions can occur between the expectations of roles. Given the fact that mentor ♯3 has few roles, most of which are likely to be significantly contradicted by her former role as an 'addict', mentor ♯3 may experience significant role conflict between her primary roles as a mother and a mentor. To compound matters further, the identity of mentor ♯3 as a former substance dependent individual is perhaps still an identity that seems to impact on her present recovery. Mentor ♯3 explained that she did not socialise with many outside the project as *"I don't want* [them] *to know that side of me"* [mentor ♯3], a statement that would suggest she still feels her addiction past is still a part of her current identity. As a result of having 'few strings to her identity bow', her former identity as an individual with alcohol dependency appears to still actively play a part in 'who she *is*', which may limit the extent to which she can *be* normal.

Finally, mentor ♯3 still seems to have connections with her addiction past through her son's father, a prominent feature in both her life as an addict, and her current life in recovery:

> *"Why should I expect somebody to understand the difficulties of my past? I mean* [her son's] *dad were a drug dealer, people have problems with that you know. They used to be, its, there's a lot of things I couldn't you know, it wouldn't be the type of thing I disclose to people and I, I, because you understand that people may make a judgement you know. Having your mum in rehab and your dad in prison is not a good you know, not a good start and* [her son] *had two or three* [years] *he were shipped out here, there and everywhere you know, it's not ideal."* [Mentor ♯3]

Despite her desire to move on with her new life, mentor ♯3 is continuously connected with her old addiction lifestyle as she continues to have contact with her son's father, a former drug dealer who perhaps personifies her

negative, addiction past. Such a connection with her addiction lifestyle through her continued contact with her son's father is perhaps the reason she feels *"a misfit"* [mentor ♯3], as she is not able to prevent her addiction past encroaching on her recovery-orientated present and future. This has had the effect of making mentor ♯3 experience feelings of not 'fitting in':

> *"Yeah, o no I see myself as I'm not scared. I think I been sober for nearly three years so in that respect its different but the fact all the things from me past and it's just like with me kids and stuff. I just think it makes your life quite different umm, and so it's, it is difficult coz where do you fit in? You don't fit in with your old lifestyle but then me new lifestyle that's different, and that's what I meant by low key; it's just much quieter. It's still not the type of thing where I'd open up and tell somebody about, you know, being in rehab its something that I keep quiet about… I don't want her to know that side of me"* [Mentor ♯3]

The lack of placement that mentor ♯3 feels in society is arguably the result of being in a 'social limbo', trapped between her old life as alcohol dependent and her new life in recovery. An interesting point to note with regards to the interview of mentor ♯3 is not just what she said during interview, but also what she did not say:

Throughout the interview she was more on edge than the other mentors. She seemed to have a much more pessimistic outlook on life (in comparison to other mentor responses) and to me I think this is because she has a lot less going for her in her life. After the interview, mentor ♯3 said to me if I thought it was weird her not telling other people about her past. I replied 'I guess it depends on the individual doesn't it?' But she said she is very aware that she thinks people judge her which leads to 'social exclusion' (mentor ♯3 used the words 'social exclusion') and made the comment that if other people not from an addictions background found out she had been in rehab twice and her son's father in prison due to drug dealing they would "hardly want her round for tea" (her words). Mentor ♯3 made the comment that she thought her past and her ex partners past were very taboo

subjects and that she didn't want people knowing, as she would feel judged and persecuted for putting her son through such circumstances.

This perhaps suggests mentor ♯3 is not only ashamed of her past but she wants to forget it; but cant. Mentor ♯3 seems to be restricted by her past despite being abstinent for three years. The vast majority of her laughter in the interview was nervous (in my opinion) and it was the first time I was very apparent I was being viewed as an outside researcher. Up until now, I had felt totally part of the group and people were very friendly and warm with me, mentor ♯3 seemed quite reserved. It almost came across as if she felt I was judging her hence her not totally opening up, as the previous respondents seemed to have. (Reflexive thought after the interview with mentor ♯3: 23rd March 2012).

This would suggest that not only is mentor ♯3 cautious of what she says to people with regards to her addiction past, but also by its very nature, is cautious of what she does not disclose to people. Despite her present and future commitment to recovery, mentor ♯3 is still fearful of 'social exclusion' as a result of her past. This demonstrates that the destructive power of addiction can still impact on people despite years of abstinence and commitment to recovery. Taking the points raised above with regards to the recovery of mentor ♯3, whilst she may no longer crave alcohol or use alcohol during difficult times in her life suggesting she is *recovered*, mentor ♯3 is perhaps not recovered when taking into account the wider implications of recovery in addiction. White (2002) states that recovery from addiction also embodies a total transformation of personal identity and character, and to be content and happy with one's life after substance use; a domain of recovery, which based on her narrative, mentor ♯3 perhaps does not fit.

Whilst the story of mentor ♯3 may be idiosyncratic, it does raise a number of complex issues that surround recovery from addiction, such as criminal convictions and being a mother with a history of addiction that are applicable to many others in recovery. The story of mentor ♯3, in conjunction with the *recovering* identities of the mentors and service users that were discussed at the

beginning of this section highlight the complexities surrounding recovery and how it is defined and measured (see section *1.3*).

Before *reaffirmation of* self is explored, a final word shall be awarded to the identity of recovery. Jenkins (2008) states that the biggest mistake scholars make when discussing identity is that identity is some*thing* that simply *is*. Jenkins (2008) continues to state that careless reification of identity results in insufficient attention being given to the social construction of identity in interaction and institutionally, and that identity should be fundamentally understood as a process of *being* or *becoming* that is a never settled matter. This raises the question: can the identity of *recovered* truly exist? A *recovered* identity suggests a finite identity that is no longer *being* or *becoming*; it has arguably reached a point where it can develop no further; it has become a settled matter. *Recovering* on the other hand reflects an identity that is not immutable, and is continually adapting to the temporal and spatial context in which the *recovering* individual is located. Individuals in society are forever adapting to their surroundings; in one instance they may be identified as an employee at work whereas in the next instance, they may be socialising with friends; two identities which are likely to differ and are forever adapting to their social environment; they are never fixed (Jenkins, 2008). This explanation of identity is one that serves to support the disease model of addiction, which suggests that an individual is forever *recovering*.

It is important to state this forever adapting identity of continuous recovery is based on the data collected in this research, which is specifically located in the context of the LTLA project, and depending on one's philosophical interpretation of identity, may be one that is refuted. However, given the fact that nearly all the participants in this research identified themselves as *recovering*, it is a conjecture that is plausible. On a more general level, the concept of recovery is a ubiquitous term that can include almost any trait that helps an individual recover from addiction. Yet the very nature that makes 'recovery' ubiquitous, also makes it highly subjective, as what works for one individual in recovery may not work for another. As a result, it is very difficult to define and perhaps even

harder to measure. Most traits that 'make up' recovery relate to concepts of inherent well-being, abstinence, identity transformation and life satisfaction; traits which are not easily and definitively measurable.

6.4.2 Reaffirmation of Self

Reaffirmation of self refers to the 'regaining of an old self' or the 'gaining of a new self', both of which have potentially different implications and will be explored in this subsection. For most of the service users interviewed, one of their main goals seemed to be about regaining their old sense of self; what they were like before their drinking became problematic:

> *"I'd like me old self back, maybe I'll never get to that stage again, how I was but only time will tell"* [James; service user]

> **Me: How do you define yourself now?** *"Well back to my old self before I started drinking, carrying on doing normal things"* **Me: Which is?** *"Well just sociable, working and you know doing what you normally do in your family"* [Kirsty; service user]

In James' case, despite the strides he has made during his time at the project, he still feels like he has some way to go in his recovery until he regains a sense of 'who he was' before he started drinking. This is most likely the reason he classifies himself as *recovering*, as he perhaps still feels he is not the same person he was before he started drinking, thus making him feel his addiction is still an issue. For others such as Kirsty who have a strong network of family and friends in conjunction with the various forms recovery capital she alluded to throughout her interview, such as being employed, reaffirmation of self seemed to be a more rapid process. Drawing on William White (2002) once more, he states that recovery is the process of regaining something that one used to posses which was lost during addiction. White (2002) relates this to a number of domains such as regaining health, self-esteem, relationships, financial and social status and so on, but in this research it relates to a regaining of self and a regaining of a socially accepted identity. The LTLA project aims to facilitate this

reaffirmation of self by providing the service users and mentors with the opportunity to actively participate in recreating their lives through the activities. By socially interacting with others in the project, and with mainstream society during the activities, they are actively rebuilding *themselves* (Charmaz, 1987) and therefore creating new, 'reconstituted identities' (Nettleton, 2006). This begs the question: are the 'selfs' each service user is developing in recovery really a 'regaining of an old self' or is it more a case of a 'new self' being created?

Clive for example, used the phrase *"I'm born again"*, which suggests that instead of regaining the 'self' he was before his addiction, a totally 'new self' has been born out of his addiction recovery. Clive was the only interviewee to describe himself as being an active Christian, a religious role that he claimed simultaneously developed with his recovery. The role and discourse of religion in recovery is pervasive throughout the literature, with many influential recovery support programs, such as the twelve-step approach adopted by AA (in particular, steps three, seven and eleven), actively promoting the need to yield to a Higher Power (Sussman et al., 2011). There is much ambiguity as to why religion works for some in recovery with reasons ranging from it being a service that provides the opportunity to socialise with other church-goers (in this respect it is similar to the LTLA project) through to a new, enlightened meaning of life (Borras et al., 2010).

The historical context of religion in recovery is also a potentially influential explanation as to why religion 'works' for some in recovery. The global temperance movements that have existed over the centuries have all heavily advocated religion and spirituality as a viable escape from suffering, which has led many millions of people over the years to believe in its transformational power (White, 1992). For Clive, this transformational power took the form of being able to help others:

> *"I'm Christian… I like to help others really, to, to try and help others, people who are new, they aint got not idea and says 'look just because your a new face you know'. They says* [other service users] *'you know, why do you fetch*

all these cakes?' and I do say because, as daft as it may seem, I'm a kind hearted person" [Clive, service user]

Clive believes that the morals and values instilled in him through religion have given him the power to help others in their recovery, and it is through this ability to help others that he feels a personal transformation in recovery. The founding of AA was a pivotal milestone in the spiritual approach to recovery. Its spiritually-orientated approach, which focuses on 'ego-surrender' to a higher power and moral reconstruction of one's self through self-inventory, confession, restitution and service has, and still does, influence the philosophical premises of addiction recovery (White, 1992). As a result of AA's global reach, many different religious and spiritually based programs have emerged, which continue to reinforce the deep-seated importance of religion in recovery.

From a symbolic interactionist's viewpoint, religion perhaps provides fundamentally new, positively orientated experiences upon which an individual can build an identity. Just as Clive's addict identity was born out of negative, stigmatising social interactions with others, he is continuing to develop a positive identity based on his 'good' Christian values and morals. For Clive, the 'good-Christian values' and culture that surround his faith, have come to underpin who he is as a person, which has allowed him to build an identity based on such a culture. It is important to state that whilst some may find religion useful in recovery, religion is itself a potential source of stigma as some may link religion, especially in today's society, with extremist views and that for many, the rules one has to follow in order to be considered a good religious character could be detrimental to recovery (White, 1992).

Angela also explained that she felt like a 'new' type of person:

"I feel like umm, my actual mind and body is in like a better, like in a better place… just sort of getting yourself back, your old self back, not necessarily your old self, but its like a new you, like as you've got older like your new personality coming through and things" [Angela; service user]

Angela's extract implies that instead of regaining who she once was as a person, she is becoming a new individual. This potentially reflects a deeper level of self-development, as it demonstrates that Angela is perhaps more aware that returning to 'who she was' before her drinking became problematic is perhaps not the most appropriate goal for self-development. It begs the question: if an individual wants to regain what they were like before their drinking, is this not a potential precursor for relapse as the very self they desire, was the self that ultimately resulted in their problematic drinking in the first place? Angela's recognition that *"a new you"*, or a new 'self' is desired in recovery arguably takes into account that she does not want to return to what she once was, but instead, wants to become a new, better person. Recovery in this context is perhaps more a process of *discovery*.

Fundamentally *discovery* appears to relate to being perceived as an individual who is no longer an 'addict' through the *discovery* of 'who they really are' without the shackles of addiction restricting personal growth. It includes the *re-discovery* of emotion, feelings, personality and residual strengths they once possessed before their addiction that will benefit the development of their newly discovered self. It includes the discovery of new skills and hobbies and discovering that life is manageable without the need to resort to substance use. *Discovery* arguably also includes that an individual *discovers* the pain they put their loved ones through during addiction and that now they have made a concerted effort to commit to abstinence, they can make amends for their previous actions. *Discovery*, like the concept of *recovery* explored in the previous section is a ubiquitous term that could feasibly relate to a host of different traits, some of which are shared with others, and some of which are more subjective. Whilst this discussion on *discovery* is theoretical, the important point to note is that *discovery* relates to finding out who someone really '*is*' without the physical, psychological and social manacles of addiction supressing personal growth and development. It also raises important issues with regards to language in recovery and that for some; *discovery* of a new self is a more meaningful goal, rather than recovery of an old self. The final section of this chapter will explore

the identity of being a mentor and how such an identity may actually facilitate recovery.

6.5 The identity of a mentor: Does it benefit recovery?

The re-emergence and reorientation toward recovery has brought about a change in the role both the volunteer and the 'recovery champions' within treatment services (NTA, 2010). Central to this change and recovery support systems such as the LTLA project are the use of community based, ex-service users to provide support for others (Best et al., 2010). Within the LTLA project, the mentor team are a group of ex-service users who run the LTLA project on a daily basis, as well as provide support and advice for the service users who attend the project. Clinician ♯1 and clinician ♯2 explain:

> *"The people who, who become the mentors have really moved on from an active phase of treatment… We sort of think of them as people who are an example to other people and the example they give is there's life after addiction. It's about giving people hope, it's about giving people a role model, I can you know, I can be like that, I can you know, go about my life like that so its those sort of things and in that sense they are mentors and ex-service users"* [Clinician ♯2; co-clinical lead at the LTLA project]

> *"I think the qualities we look for in the mentor are, are several. It will be about being good with people, being able to engage with people. It's about their own individual stability in terms of drinking and drugs and umm well really those two things. I think also some, some if they could bring something else like particular interests if you had somebody that was a football coach for example that wanted to bring along a football team, umm that would be great so I guess that would be a bonus"* [Clinician ♯1; co-clinical lead at the LTLA project]

The 'mentors' then, seem to have a distinct *role* within the LTLA project that encompasses a different set of behaviours to that of the 'service user' role. The mentors at the project appear to have two roles. Based on observational

data, their first role embodies the practical responsibilities that the mentor team perform. Their practical responsibility is to ensure the running and operation of the LTLA project on a day-to-day basis, which is primarily achieved by each mentor ensuring the activity they are in charge of, runs smoothly and consistently. Their secondary practical responsibility is to collaborate with one another and the professional staff involved with the project to discuss the project at the mentor committee meeting. During this meeting (typically an informal, 'fun' atmosphere), the activities from the week before are discussed, which includes a summary of how many attended, how people enjoyed the activity and when the next activity will run. If certain activities are not performing as well as they initially thought, the mentors in conjunction with the professional staff offer ways to improve the activity[10]. Also within this meeting the mentors and professional staff discuss 'project-related' matters that are not specific to the activities. During data collection, such matters have primarily included how to gain 'charity status', how to gain further funding and how best to advertise the project. Appendix *19* is an example of the 'minutes' sheet that is drawn up for each meeting. The final practical responsibility of the mentors is to offer peer support to the service users at the project (discussed in greater depth in section *6.5.3*). The mentors are the primary pillars of peer support and the service users are fully aware that any problem they encounter, a mentor is the first point of contact.

Their second role at the project relates more to mentors exemplifying what can be achieved in recovery, and offer visible examples of recovery. Continuing on from section *5.4.1*, the mentors are akin to 'recovery champions' (Home Office, 2010), a cohort of individuals who have made considerable strides in recovery and exemplify what can be achieved in recovery. In the context of the LTLA project, the mentors exemplify life after recovery:

> *"We sort of think of them as people who are an example to other people and the example they give is there's life after addiction. It's about giving people*

[10] Whilst it did not happen during data collection, clinician ♯1 explained that in a minority of cases, activities are withdrawn if they consistently demonstrate that they are not popular amongst the service users.

hope, it's about giving people a role model; I can you know, I can be like that, I can you know, go about my life like that, so it's those sort of things and in that sense they are mentors" [Clinician ♯2; co-clinical lead at the LTLA project]

They embody hope and empowerment over addiction and fundamentally that one can maintain steady recovery from addiction. Having spent considerable time with the mentors and service users, it became apparent that the mentors seem to be considerably further along in their recovery trajectories than the service users, even those service users who have been at the project a similar amount of time to some of the mentors. This begs the question: do the practical responsibilities and their identity as a mentor facilitate recovery? The remainder of this section will draw on data from this research and the wider literature to answer this question. First, the 'mentor' label is addressed.

6.5.1 The 'mentor' label

As it was stated in section *3.2.2*, language plays a fundamental role in symbolic interactionism, as the theory states it has the power to unlock our social worlds (Atkinson & Housley, 2003). This therefore, brings significant importance to the 'mentor' label, as it becomes symbolic of a number of role traits that have the potential to facilitate recovery. If an individual is labelled a 'mentor' and continues to act in a manner that is indicative of the 'mentor' label (which in the case of the LTLA project is behaviour linked with long-term, sustained recovery), then such an identity could become apart of the individuals self-conception. The more the label is reinforced by others in social interaction, the more likely the positive 'mentor' label will become internalised as part of who they are.

This brings into play the mentors social position in the project; seemingly one that is higher than that of the service users, and arguably more on par with some of the professional staff at the project. Stryker (1968), one of the influential protagonists to incorporate structure with symbolic interactionism was keen to demonstrate that social structure shapes self, which in turn shapes social

behaviour (Stryker, 1968; Smith-Lovin, 2007). To recap, Stryker theorised that within a social group there are different social roles that are associated with different behavioural expectations, and that given the salience and commitment of an individual to a particular social role, the increased likelihood that the associated behavioural expectations to that role will be maintained and performed in future situations (Stryker, 1968; Stryker & Burke, 2000). Given that each mentor articulated with great fervour their commitment to their role as a mentor, the identity of *being* a mentor is held with great commitment and salience *within* individuals, thus suggesting it is an identity that is strongly *internalised* within their self-conception. This instils a great sense of perceived *meaning* for each of their mentor identities, thus suggesting it is an identity that remains stable over time (Serpe & Stryker, 1987); a plausible reason as to why the mentor team members remain consistent over extended periods of time. Their role as mentors who exemplify 'successful' recovery in the social group therefore, shapes *their* self to be recovery-orientated, which in turn shapes their behaviour to maintain behavioural expectations that epitomise successful recovery.

Furthermore, drawing on the process of socialisation and *'being'* discussed in earlier sections of this chapter (see section *6.3.1*), *being* a mentor implies that it is a social role attributed with different traits to that of *being* a service user. Based on observational data and interviews with the professional staff, *being* a 'service user' is an identity that is associated with still needing active support in order to maintain their commitment to abstinence and recovery. *Being* a mentor however, is attributed with more positive traits such as 'successful' recovery and overcoming addiction to *be* a 'normal' person once again (see section *6.3*). Given that identity is reinforced through social interaction, the mentor and service user roles and their associated traits become relatively stable across time. The social position of the mentors within the LTLA project therefore, results in their role being attributed with *status*, which in the context of this research is an 'achieved status' (Linton, 1936), as it is one earned through their commitment to recovery.

As a result of their status, the mentors at the LTLA project might be considered *elites* (Scott, 2006). Weber referred to 'elites' as having high social honour and standing amongst the communal sphere in which they are located (Mommsen, 1992), which results in a social stratification with the elites at the top (Scott, 1990). In the context of the LTLA project, the mentors, given that the label they have been awarded which exemplifies 'successful' recovery, may be considered as 'elites of recovery', as they have gained perceived higher social standing amongst their peers as a result of their recovery efforts.

Whilst the mentor team can arguably be theoretically defined as 'elite' given their social standing in the group, some do not seem to perceive themselves as 'elite', as mentor ♯2 explains:

> *"Well being a mentor to be perfectly honest with you Tom, I didn't agree with calling ourselves mentors coz to me, umm, a mentor is somebody who I would look up to and admire if you know what I mean and I didn't really think, I didn't expect anybody to look up to me and admire me coz I don't think I have done anything that's very admirable. It's, it's a name as good as any I suppose. Umm to me, a mentor is, a mentor is somebody who's succeeded in whatever they been doing and, and I suppose I'm gonna contradict myself here and shoot myself in foot a little bit I suppose, but I suppose in the same way I have been successful in* [recovery]*, I'm not gonna say curing myself from my addiction coz your never cured but I've got over it and come through the tunnel at the other end you know. So in a way I guess I have been successful of that umm, that's my idea of a mentor anyway"* [Mentor ♯2]

Despite successfully overcoming addiction and making significant strides in recovery, mentor ♯2 articulates that such a feat is not admirable. This perhaps stems from the fact that addiction in mainstream society is often shunned and not 'seen' as 'admirable', and therefore overcoming addiction is not perceived as admirable or 'elite'. However, within the context of addiction and amongst a circle of people who know just how difficult it is to overcome addiction, the

progression of mentor ♯2 in recovery, along with the other mentors recovery trajectories appear to be revered by many of the service users. Many stated that they considered the mentors to be inspirational, not just because of their advice giving, but because they personify a position they aspire to achieve. Therefore, their 'social honour' and standing within the LTLA project seems to be raised to a higher plain than that of the service users.

A word of caution must be made therefore with regards to the culture of the project. Whilst the culture of the LTLA project is one of abstinence and recovery, the same cultural system defines the mentors and service users differently. The rights and obligations marked out by the 'mentor' label relate to a seemingly more positive role and set of behaviours and traits than the 'service user' label, which seems to facilitate recovery. Through a self-fulfilling prophecy, the 'mentor' label encompasses a role that embodies a perceived identity that is more positive, which in turn, has more positive impacts on recovery trajectories for those labelled 'mentors'.

6.5.2 The benefits of *being* a mentor

Based on observational data, there are several benefits the mentor team receive as a direct result of being labelled a mentor. First, each mentor receives an official 'mentor card' that includes photographic identification, their name and their role as a mentor. This 'mentor card' is very similar to the identification card the professional staff at the LAU posses. This has two potential implications. First, the 'mentor card' *physically* and *socially* identifies themselves as 'mentors' to others, which ensures they are not identified as a service user at the LAU or the LTLA project. Second, the 'official' nature of the identification card serves to liken the mentors to the professional staff of the LAU. Taken together, the 'mentor card' further delineates their mentor status from service users and increases their association with professional staff. Being 'likened' to professional staff is a potentially powerful facilitator for recovery, as it potentially reduces the social distance between being a mentor and the professional staff, a cohort of individuals considered 'normal' and held with high regard by many in society.

The second benefit is access to restricted areas in the LAU. The mentor committee meetings take place in a meeting room on the first floor of the LAU, a part of the building that service users are not permitted to enter. Not only does this socially reinforce the mentor identity, as they receive benefits that service users do not, it also physically demarcates the mentor identity from that of the service user identity, as they have access to areas that are only permissible by professional staff. The first floor of the LAU has, until the inception of the LTLA project, been an area restricted to professional staff, meaning its socio-spatial identity has traditionally always been one that reflects the professional staff who occupy the first floor space. Now the mentors are permitted access to this area, they gain further similarities to professional staff at the LAU, especially when this is combined with their 'mentor card'.

The final benefit is the resources the mentors have access to. Financially each mentor benefits as they receive a small fee of £15 per week (plus travel expenses) for their role as a mentor. Furthermore, they receive training on how to be a mentor, as well as having the power and responsibility to dictate what activities are offered, when they are offered and how the project operates on a daily basis and potential future candidates to be a mentor:

> *"It's for everyone to decide so it's not just me who can get the blame* [laughs] *for not getting the ideal candidate. So it's everyone and as you know from the previous meetings we have talked about particular mentors but because we are such a close group I guess if you got the wrong mentor it could change everything you know, the atmosphere… they do get peer mentoring training which covers confidentiality, boundaries and then one of the teachers here, she's just done a half day peer mentoring training course which covers it further umm, for the details so they do get training."* [Coordinator; professional staff at the LTLA project]

Taking these points together, there is the potential for the mentor team to assume a position of power over the service users (discussed in greater detail in section *7.6*). Simpson and Mayr (2010) state that power is born out of privileged

access to social resources such as education, wealth and knowledge; three domains the mentor team have access to. Combining this with language such as the label 'the mentor team' perhaps creates a social boundary between the mentors and the service users (Young, 2008) that impact on the social milieu of the project, a point explored in greater depth under the section *7.6*. The final component of the mentor role to be discussed is their role as the primary pillars of support for service users.

6.5.3 The supporting role of the mentor

As it was referred to above, one of the active roles of the mentor team is to offer peer support and where necessary, advice to help service users of the LTLA project. All the mentors expressed how their personal development in recovery has benefitted as a direct result of helping others and 'giving back':

> **Me: So what is then about being a mentor that you like so much?** *"Because it helps others and it also helps me"* **Me: In what way?** *"To umm, stay sober, and not to drink and umm, coz if I'm a mentor and I'm trying to pass all these things on to other people, I cant go drinking myself so it gives me that extra strength… support"* [Mentor ♯5]

> *"The feeling of satisfaction you get when you do have a successful you know, you do, you see somebody pull through from being bad to good, the feeling of satisfaction you get is brilliant. I mean one of the AA principles, I mean the main principle of joining AA is the desire to stop drinking and the other main is to help other people, alcoholics into recovery. Help of others is part of your recovery, I think so anyway."* [Mentor ♯2]

Experiencing such positive feelings of self-worth, self-satisfaction and self-confidence through helping others appears to facilitate recovery as positive feelings of self-worth serve to empower the individual to commit to recovery and overcome their addiction (see section *7.6*). This finding supports previous literature that implicates the importance of 'giving something back' in recovery (NTA, 2010; Measham, Moore & Welch, 2013) and makes a further contribution

by suggesting that 'giving something back' facilitates personal development in recovery by actively engaging self-reflexive processes that induce positive feelings of self-worth and self-confidence. Most of the mentors explained that not only do they get a positive feeling from helping others, they also see it as a way to repay the debt they owe the LAU for helping them with their addiction:

> *"Well I bet if you ask them, well you have asked them coz I'm last one you're interviewing aren't ya. I'd say that umm, the giving back. They're really pleased that LTLA, addictions unit helped them so I think they're giving back and a lot of people like* [mentor ♯2] *and* [mentor ♯4] *have got a lot of time on their hands coz their not working umm, I promised I'd come back coz I left for a bit, coz I were looking after* [her son] *but he's in full time school now so. We all like to think we can pass on umm, what we've been through and then its not all been done in vein has it? Something good's come out of it. And also it keeps you going as well, it makes you realise, how bad it can be. Its just a good feeling to be able to pass knowledge on what you've got to people"* [Mentor ♯5]

Experiencing such positive feelings of self-development in conjunction with 'giving something back' by helping others is a potentially powerful facilitator of recovery, as it reinforces their own recovery, as well as increases the social distance with their former addiction pasts. As it is explored in the next chapter, peer support provides a good medium through which to elevate personal social capital that facilitates recovery. In the context of recovery, social capital relates to the sum of the relationships that one is able to build in recovery with strong, varying social bonds contributing to greater levels of recovery capital (Cloud & Granfield, 2008). As one of the major roles of the mentor is to offer peer support to others, it provides a robust, continuous source of social capital for the mentors. Observational data would suggest that whilst the service users are also encouraged to help one another, service users are encouraged to talk with mentors for support rather than potentially burden other service users who are likely to be more mentally fragile. This suggests that whilst the mentors are primarily setting out to help others in recovery, they are likely to be

benefitting more in terms of their own recovery from their role as 'advice givers' and peer support.

As a result of their supporting role and perceived 'expertise' in recovery, most of the service users view the mentors as examples of successful recovery:

> **Me: So how do you see the mentors?** *"Examples of recovery yeah, like long term recovery yeah, long term recovery yeah… its like the you know, you can see the success, like the long term success that they've achieved and it gives you something to umm, well sort of look upto but something to sort of aspire to, yeah so that's how I see it"* [Angela; service user]

In the more general use of the word 'role', being seen as 'role models' is a potential powerful source of social capital. Being a visible source of recovery to service users is perhaps a social platform for them being almost idolised, a facet that is likely to further enhance the positive feelings of self-worth and self-satisfaction for each mentor. In general society, individuals of a higher social status such as sports stars, musicians, actors and so on, are often idolised by individuals who aspire to be a sportsman, a musician or an actor, as it is the pinnacle of such an identity. The same is potentially true of the mentors: they have achieved a status that epitomises long-term recovery and are at a stage in life that many service users wish they could achieve.

There is one caveat that needs mentioning with regards to the supporting role of the mentor. Given that peer support is dependent on the activism of mentors to continually engage with their past experiences of addiction in order to boost their credentials as 'healers' (Measham, Moore & Welch, 2013), such engagement with their past addict identity could place them in potentially problematic positions of responsibility, or at a level beyond their capabilities (Shapiro, 2012). White (2000a) likens this situation to the mythological curse of Icarus. White (2000a) conjectures that those who have conquered addiction and become mentors can become so intoxicated by the throes of their new position, that such intoxication can lead them to *"fly to close to the sun and then plummet*

to their demise, sometimes taking their movement with them" (White, 2000a; p. 30). White (2000a) states that this can be guarded against by provision of adequate support systems, the implementation of new leaders and careful planning, all measures of which are taken in the LTLA project. The continual involvement of clinician ♯1 and clinician ♯2 ensure the mentors have continual access to professional support and advice, as well as clinician ♯1 and clinician ♯2 overseeing the planning and implementation of the project and its activities. Furthermore, based on observational data, the mentor group is very much based on a democracy whereby every individual has an equal say, thus ensuring every individual is a 'leader' within the mentor team. The final point to explore is why there are so many more female than male mentors.

6.5.4 Over representation of females in the mentor team

At the time of data collection, there were five female mentors and one male mentor, which subsequently grew to seven female mentors and one male mentor after the data collection period for this research had finished. The mentor team are those who have come through the LTLA project, demonstrated a commitment to abstinence and recovery and are therefore rewarded with the chance to become a mentor. This begs the question: why are there more female mentors? The answer lies in two areas: *the identity of motherhood* and *a perceived female orientation*.

6.5.4.1 The identity of motherhood

Whilst women in Western society now have far greater equality in general society than they once did, there is still a culturally and socially pervasive view that women should first and foremost, conform to the role of motherhood (Ragone & Twine, 2000). Furthermore, the apparent social identity of motherhood in western culture is a central component of the notion of possessing a moral self (Liamputtong, 2006), with those considered 'bad mothers' not possessing a moral self (May, 2008). As a result, any mother who problematically uses substances, is seen as a 'bad mother' and considered antithetical to the ideals of femininity and motherhood (Boyd, 1999), which often results in greater stigmatisation than their male counterparts (Bancroft,

2009). Feeling judged as a mother had significant impact for many of the female mentors and service users, as mentor ♯5 explains:

> **Me: You felt judged as a mum?** *"Yeah"* **Me: In what way?** *"I don't know, I just didn't feel like I were doing it as well as everybody else even though I were doing a good job I still felt like under-confident because of me drinking. Like I weren't going out to mum's and tots group blottoed or things like that but I still felt really, really embarrassed about it. Everybody could tell that I had a problem even though they probably couldn't so it made me paranoid… The thing what made me stop was I knew I would end up losing children and they'd be living with somebody else and not me. And I just thought to myself what right have I got to bring four kids into world and their mums like this. That's how I felt… coz you got to be there for your kids haven't ya. I mean when I were younger I had a really good role model as a mum and that's what I think my kids deserve. A good role model as a mum."* [Mentor ♯5]

The fear of losing her children to social services and feeling judged as a poor role model for her children was a significant 'turning point' in mentor ♯5s life and caused her to re-evaluate her alcohol use and re-define who she was by seeking help for her dependency. Whilst it is argued that 'turning points' are considered a classic narrative of realist discourse for example, overcoming difficult odds to find one's true self (Gill, 1996), mentor ♯5, as well as some of the other female mentors and service users that were interviewed linked their recovery with their role as a mother. As a result, they are not only serving to address their own identity problems that have arisen as a result of their substance dependency, but are also constructing a new identity that portrays them as 'good' mothers (Radcliffe, 2011), a perceived identity that many women are still measured against (Jacobsen, 2007).

The role of *being* a mother is entrenched in a history of culturally relevant, behavioural expectations that are akin to protection and nurturing of children. Any behaviours therefore that actively impede such historical and

cultural behaviours, such as addiction, are likely to be highly contentious and potentially stigmatised. As a result, many women in this research articulated that addressing such stigma was a significant factor to entering recovery.

Whilst it was not the sole factor for the female mentors entering recovery in the first place, it did appear to be a significant factor. Mentor ♯5 explained that if she didn't have children, she would probably have continued drinking in the same manner, as she ultimately had no responsibility to anyone else. The obligation many women feel towards their children is often the reason many enter into recovery in the first place, and remains the continued reason why many women remain abstinent (Radcliffe, 2011). Having such an obligation and *"another reason to stay sober, for kids"* [mentor ♯5], is arguably the reason why there are more female mentors; they progress quicker in their recovery as they have another fundamental reason (other than their own recovery) to recover. It is important to note the data are not suggesting all women who are mothers will recover at a 'faster rate', as there were two female mentors interviewed who did not have children, or that males with children can not make the same strides in recovery. However based on the data collected, *being* a mother and addressing the stigma associated with *being* a 'bad mother', certainly had an impact on many of the female mentors and service users recovery trajectories.

6.5.4.2 A perceived female orientation

Whilst it is argued throughout the findings chapters that the project appeared to significantly facilitate recovery for *all* the service users and mentors, it is evident that the project is perhaps set up in a female orientated manner. For example, one of the positive points about the project is that it provides a host of activities that the service users can participate in, but several of these activities are female specific (Zumba, the women's day and the parents and toddlers group[11]). The women's day out in particular is the most attended activity out of all the activities with it regularly receiving on average six to twelve service users

[11] Whilst the parents and toddlers group is for both males and females, it is an activity that has only ever been attended by women and is an activity that is considerably more advertised to women (based on my observations).

and often, more than one female mentor. The women's day happens on average, every two weeks with most starting with a group session prior to the activity. Whilst I was not allowed to attend this session (as I would have not only been an observer that may have impacted on the groups dynamics, but also the fact I am male would have further impacted on an all female group), the coordinator informed me that the sessions provide the opportunity for the women attending to 'open up' about any issue they are having and can receive support from the other women. Whilst it is only conjecture, it is possible that having a gender-specific group in collaboration with female specific activities serves to facilitate the recovery of the female cohort who attend the project.

This is consistent with evidence from the literature that has found single-gendered groups result in better recovery outcomes than mixed-gendered groups. Greenfield et al., (2007) conducted a randomised control trial to investigate the difference in substance use therapy and recovery outcomes between a Women's Recovery Group (hereafter WRG) and a mixed-gender Group Drug Counselling (hereafter GDC). Greenfield et al., (2007) found that after six months of counselling in the respective groups, women in the WRG expressed significantly greater levels of self-satisfaction than women in the GDC and had sustained improvements in all substance abuse treatment outcomes (physically tested by urine samples), whereas the women in the GDC not only did not sustain their improvements, but their post-treatment outcomes worsened from baseline in three out of four assessments. Davis and Jason (2005) also found that women benefit more from social support than their male counterparts and that female social support is linked with increased levels of abstinence and self-efficacy. Furthermore, strong social support with others (as exemplified by the women's group) has been found to have protective and health-enhancing influences (Orford, 1992), as well as providing a 'buffer' for negative life events by involving individuals who are supportive of abstinence and recovery (Longabaugh et al., 1998). Whilst this final point is likely to benefit everyone who attends the project, the firsthand experience of being a woman in addiction is likely to create stronger social bonds between the women of the group. Just as the more general firsthand experience of addiction creates a strong

peer support network amongst those at the LTLA project as a whole (discussed in the following chapter), the same can arguably be said of women in addiction.

This would suggest therefore, that having a female specific group where problems can be discussed with other women significantly contributes to the recovery of the female cohort who attend the women's group at the LTLA project. The specific social support network seems to help women with their female specific addiction and recovery issues, as well as enhancing female ingroup membership (Aronson, Wilson & Akert, 2005; 2009), which will in turn, likely enhance the companionship and camaraderie of the female service users and mentors. Furthermore, the women who attend the LTLA project also have access to more activities, as they are either unisex or female specific activities, which arguably further orientates the projects benefits towards females.

This is perhaps also a reflection that for certain activities such as Zumba, women are more likely to feel insecure and potentially embarrassed when exercising, especially in front of male participants. This is perhaps not just specific to the LTLA project and relates to women in society on a more general scale. Gyms for example offer female specific classes in order to cater for those who do not want to exercise in front of men, 'weight-watcher' classes are often gender specific as are gender specific swimming sessions. Nevertheless, the increased number of activities that females are able to attend perhaps does give females a greater chance to develop in recovery thus making them more eligible for potential mentor candidacy. It is important to note that the data does not advocate that the LTLA project 'favours' female recovery, as that suggests that men are unhappy with how the project operates. It is perhaps more accurate to claim that there are gender differences and sensitivities that exist within the LTLA project and within wider concept of recovery that need considering and managing appropriately.

Based on the data presented in these sections, it appears that the LTLA project seems to be more successful at engaging women in recovery than their male counterparts. When considering this in relation to the wider literature, the

situation that appears to have arisen at the LTLA project is perhaps at odds with the other services. It is well known that women face different barriers (such as increased social disapproval, and the 'invisibility of women in recovery) to men when seeking help from treatment services (Thom & Green, 1996; Raine, 2001) and that in many cases, female-specific needs often go unnoticed (Coomber et al., 2013). This has been found to have detrimental impacts in terms of women with drug and alcohol problems engaging with treatment services (Thom & Green, 1996). Even when women are engaged in treatment, they often face greater financial costs, stigma, job-related and family costs (Beckman & Amaro, 1984), in particular, the danger of losing children to social services.

In order to address these challenges, Thom and Edmundson (1989) suggested that specialist services for women should be implemented. The literature review (see section *2.5.2*) supports these findings as Kaskutas (1989), Hall (1994) and Davis (1997) all found that female specific recovery groups seemed to be more beneficial to meet the needs of woman in recovery. Whilst the LTLA project is not female specific, the female specific activities such as the 'women's day out' (preceded by a group session) and the 'mum's and tot's' group help to address the needs of women at the project, which in turn, seems to facilitate their recovery to a greater extent than their male counterparts. This is consistent with recent findings, which suggest that gender-sensitive, parent-friendly services could have potentially positive impacts for woman attempting recovery from substance use (Measham, Williams & Aldridge, 2011).

In this section the data explored the mentor group at the LTLA project. Based on the data collected, it is plausible to argue that being labelled 'a mentor' does seem to elevate an individual to a social position that is more favourable for recovery. Those labelled as mentors are instantly associated with more positive traits, have access to benefits that other service users do not have access to and have the opportunity to facilitate their own personal development in recovery by actively being a pillar of support for others. A resulting feature of being a mentor therefore, is having a perceived sense of power over those who are not labelled mentors i.e. service users (explored in greater detail in chapter *7*). The mentor

team appears to be comprised more of female mentors as the role of being mother and the apparent orientation of the project towards female service users. Despite these points, the mentor team are widely regarded as the fundamental component of the LTLA project because without them, the project would not be able to function. Whilst the support they provide helps their own development, most of the service users explicitly made the point that their support is vital and the project would not function without them.

Having mentors run the project is a way of ensuring that active service users can visibly see that recovering is not only attainable, but also sustainable. Measham, Moore and Welch (2013) found that visible examples of recovery was a powerful facilitator for others recovery, as it inspired individuals to take an active role in their own recovery. Therefore, whilst the mentors may benefit due to their roles as mentors, the service users of the project also benefit by having a project to go to where they can practice their recovery and have the opportunity to be inspired by others in recovery.

6.6 Concluding comments

This chapter has explored the concept of identity and how identity is shaped given ones social positioning at the project. The first section explored that the abstinent identity of the LTLA project in conjunction with the activities operating in the social milieu of mainstream society seems to influence the identity of the service users. The abstinent and recovery-orientated culture that subsumes the LTLA project also comes to subsume the individual identities of those who occupy the LTLA project space. Given the mutually constitutive relationship between identity and space, the culture that subsumes the identity of each individual is also reinforced by each individual who attends the project; it seems to have become a self-fulfilling prophecy. It was also suggested in this section that the safe environment in which service users can interact and socialise becomes too safe, and that for some service users who perhaps have little life outside the project, it comes to define their identity, as their interactions are limited to the project. This is a theme that continues to resurface throughout the next chapter.

It was argued in the second section that the process of socialisation with others who are considered to *be* 'normal' in mainstream society, facilitates *being* normal. This is again facilitated by the activities take place in the social milieu of mainstream society. This ensures each service user has the opportunity to experience firsthand that mainstream society does not shun them for their past addictions, thus allowing them to potentially strengthen their affiliation with those considered to *be* normal. However, it was also argued that whilst the activities take place in mainstream society, they do so *within* the safety of the project. For those who continue to practice socialisation with general society outside of the project, this is not necessarily problematic, yet for those who seem to become over-involved with the LTLA project (explored in greater depth in the following chapter), restricted socialisation of this sort can be detrimental for identity transformation in recovery as it is a potential connection with their addiction.

The third section explored the identity of recovery with all but mentor ♯3 identifying themselves as *recovering*. For the mentors who defined themselves as *recovering*, they did so not because addiction was still a daily, conscious problem, but because they were aware of the threat of addiction. It was suggested that the identity of *recovering* prevents one from becoming too confident with their recovery thus making them think they can attempt controlled drinking. It was concluded that the service users primarily identified themselves as *recovering* as addiction was still a daily problem, one that they had to actively 'manage' in order to continue their recovery. Using mentor ♯3 as an example, it was shown that a *recovered* identity pertains to more than physical abstinence and no longer craving alcohol. The psychological problems mentor ♯3s experience with regards to the stigma of being a bad mother and her continued connection with her addiction demonstrate that the psychological effects of addiction can often outlast the physical, and that in many cases, addiction can take years to successfully overcome. The concept of *discovery* was proposed to suggest that perhaps recovery is a process of not regaining an 'old self', but discovering a new 'self.

The final section explored the identity of the mentor and how being labelled a mentor perhaps facilitates recovery based on being physically and socially demarcated from service users, the benefits they receive for being a mentor, the peer support they offer, which in turn, facilitates their own recovery and their more transcendent role as personifying successful recovery. It was also suggested that there are more female mentors due to their desire to address the stigma associated with being a bad mother, the apparent female-orientated nature of the project offering more activities for women to participate in and the individual differences between men and women which perhaps promote female recovery over males.

To conclude this chapter, the LTLA project seems to facilitate an identity transformation through the process of inducing normality. By offering 'normal' activities to service users that were perhaps once void during their addiction, they gain a sense of connection with 'normal' society once again. Through such a connection, part of their addiction identity diminishes and part of their 'normal' identity begins to develop.

Chapter 7

The LTLA project: A Collective Impact

7.1 Introduction

The focus of this chapter is to explore the *collective* impact of the project on its mentors and service users. 'Collective representation' was a term first introduced by Durkheim to refer to the *shared* beliefs, values, ideas, symbols and expectations that form the way individuals think and feel in a particular society or social group (Durkheim, 1898). The idea of such collective representation being *shared* is important as this relates to the concept of culture. Such collective representations are socially constructed concepts that operate in relation to the natural world and other people they encounter, which make up the fundamental constituents of any given culture (Scott, 2006). Within the LTLA project, each group member appears to have the same recovery culture, which is one of abstinence and to enhance the cohesiveness of not just the group members, but also the cultural identity of the group. It will become clear that the culture of the LTLA project appears to shape the recovery trajectories of its service users and mentors based on the recovery culture of the project.

The need to explore and understand the collective impact of the LTLA project is important, as it will not only elucidate the positive components of an ex-service user led project, but also the complexities surrounding such a project. The five themes covered in this chapter are *firsthand experience*, *the story of stigma*, *peer support*, *the activities* and *power*, each of which shall now be explored in turn.

7.2 Firsthand experience

All of the service users and mentors expressed the value of interacting with other service users and mentors who had firsthand experience of addiction and recovery:

"The other people that go and umm and the mentors as well, they really understand how you've been feeling, not just physically but mentally umm, they understand that like the place you been in and can relate to it. Nobody judges anybody else, everybody takes everybody face value umm and everybody's just so easy to talk to… you feel like they're somebody that understand and when you come to the group you can, you can say 'I've had a bad day, I've had a bad day, I've felt really down and I've felt like I wanted a drink, but didn't't' and part of the reason I didn't was because I know I was coming here. I got support and people to talk to who understand how you feel umm and if you're feeling good about yourself well I've not had a drink and I've not even thought about having a drink you know. It sort of 'oh yeah that's really good' but whereas like your family might say 'that's really good' like supporting ya, I just feel that they, the people in the group understand how you feel coz they've been there so it's a different, it's a different sort of support, it's a more umm…" [Angela; service user]

Me: Would you say a more genuine support? *"Well yeah I'm not saying family members aren't genuine but I don't think they understand when you say 'I've had a bad day' they understand how you feel umm and that you've not actually turned to think 'well I'm gonna turn and walk up to local shop and buy a bottle of wine' or something like that you know, and you've actually like said, thought in your mind 'I'm not gonna do it, I'm not gonna do it and going to group on Friday'"* [Angela; service user]

Angela expresses the value of firsthand experience when discussing *"a bad day"* for someone who is attempting recovery from substance dependency. Although Angela values the support of her friends and family and the encouragement they give her when she tackles *"a bad day"* without resorting to drink, Angela feels they do not truly understand how significant that achievement is for her recovery.

In the past, Angela's primary behaviour to deal with *"a bad day"* has been drinking; a behaviour that became self-destructive, and was heavily reinforced

through seven years of addiction. A *"bad day"* for an individual 'in recovery' is not just contending with the actual series of events that make it a *"bad day"*, but also contending with the deep-seated urge to resort to alcohol to deal with *"a bad day"*. For Angela, overcoming such an urge to resort to alcohol use is a significantly positive step as it reflects a self-control and self-direction indicative of recovery: *"'I'm not gonna do it, I'm not gonna do it and going to group on Friday"'*. This is a step that her friends and family who have not suffered with addiction problems cannot fully comprehend.

Chloe explains that the firsthand experiences of those who attend the project make them truly aware of what others are going through:

> *"Well for one, everyone understands you because with a lot of the times with anything like alcoholism and all that, there's an underlying thing like anxiety, depression, there's all things. So it's like I know if I feel anxious I could talk to someone in there* [the project] *and I'd know that they are proper sound and know that they would understand. And if I got up suddenly out of the room and leave I know that they'd, they'd understand, they wouldn't be like 'god what's wrong with her' you know"* **Me: And can you not do that with your family?** *"I can and I will I'm not bothered about crying in front of anyone. Its not that because everyone's here for the same thing and nobody in my family has ever had a problem with addictions or anything so as far as they can empathise, or sympathise or whatever but they can't, they can't really understand. Not the emotions like obviously they feel emotions but not because of you know, drinking or whatever or drugs or anything"* [Chloe]

Chloe and Angela's extracts explain that the support they receive from their family and friends, whilst genuine, is not deep enough to truly understand what they are going through. The firsthand experiences of the complex feelings of emotions such as the *"anxiety, depression, there's all* [sorts of] *things"* that accompany 'being in recovery' are only truly understood by those who have been through it according to Angela and Chloe. Overcoming the urge to resort to

alcohol to deal with these emotions or *"a bad day"* therefore is a significantly important step in recovery, one that appears to be only fundamentally understood by other service users.

There were others who continued this theme by stating that they feel professional staff do not have access to fundamental feelings of being 'in recovery' (assuming the professional staff has not experienced recovery themselves), despite their professional expertise:

> *"No disrespect to yourself Tom, or to* [the professional staff who oversee the project] *coz I got the greatest of respect for them, but if you've never been, if you've never been through it* [addiction]*, there's no words that can explain just what its like and I wouldn't, I wouldn't wish it on my worst enemy. So I suppose I've gotta just, a natural, I feel sorry for people in that situation and would do everything I could, everything in my power to help them out you know. I don't know whether that's the sort of fall out from going through it myself and knowing, I suppose it is, so its not, I don't do it* [help others] *for any personal gain – no. I do it just because I know what it's like"* [Mentor ♯2]

These extracts support the qualitative findings of the literature review (see section *2.5*), as Dyson (2007) also found that the firsthand experience of others in recovery was an invaluable component of their own recovery. Nettleton (2006) suggests that those in self-help groups often develop considerable expertise and knowledge in their given areas, which may surpass that of the experts in the medical profession; a point that would support mentor ♯2s extract. Thomasina Borkman (1976), a sociologist, suggested that self-help groups represent 'experiential knowledge', a source of knowledge grounded in pragmatic, concrete, lived experiences. 'Experiential knowledge' differs from 'lay knowledge', which relates more to common sense ideas, folk knowledge, pop culture beliefs and 'recipe knowledge' (Berger & Luckmann, 1967) as well as differing from 'professional knowledge' that is derived from analytical, theoretical and scientific principles (Humphreys, 2004). The LTLA project

therefore, given the firsthand knowledge that each service user and mentor possesses about addiction makes it a different type of support based on 'experiential knowledge' than that offered by professional staff and friends and family. For the service users and mentors, peer support based on firsthand experience appears to be important for recovery, as peers grasp firsthand what another service user 'in recovery' is experiencing:

> *"The young girl who were me doctor, I probably saw her on and off for two year, maybe even a bit longer than two year and OK, she obviously qualified in her job but I felt she didn't do anything for me. She came to the doctors once a week, she went round the different surgeries and she saw me as a one to one, but if started getting upset over what I were getting upset over, she'd say to me like umm 'o if its upsetting you don't talk about it' and I just felt well why am I coming I'd, I'd literally go out of that doctors surgery and I'd go straight in first supermarket* [to buy alcohol] *coz she made me feel like I'd just wasted me time"* [Barbara; service user]

> *"I'd sought help before that, I'd never gone to the, I'd never gone to the group so I'd a few like, what do you call it like little starts and then not gone through with it* [commitment to abstinence]*. But this time because of the group I'd like made that step to go into the group and, and how supportive they are and umm that's what really helped me…. It has, it has been to me, more than talking to doctors, more than them giving you medication"* [Angela; service user]

According to Barbara, the professional help she received from her doctor actually caused her to drink more, as her perceived feelings about the lack of awareness of her alcohol addiction made her feel she was wasting her time with professional services. A number of other service users articulated that the professional help they have received outside of the LAU has had minimal impact on their drinking. Furthermore, some of the service users explained that the lack of support from professional staff outside the LAU actually resulted in relapse:

"I had umm, a short spell in St Anne's [detoxification clinic] *a few years ago and umm, I got* [out] *from there umm, nobody told me where to go or what to do after, I were just sent home, I relapsed and then I ended up hospital"* [Alison; service user]

Such views however, do not necessarily show that peer support was fundamentally a better form of support. The service users and mentors may understand firsthand the feelings and experiences of addiction and recovery, but this does not necessarily make them a better form of support. Furthermore, while all the service users and mentors appear to value peer support as the best form of support, it is perhaps not entirely possible to claim other forms of support (such as professional or family and friends) are not beneficial as they do not have firsthand experience of addiction, as has been suggested. It is perhaps more a case of peers over-identifying with other service users so that they understand other recovering service users feelings and experiences more, but it does not necessarily follow that this results in a better form of support.

It may be true that close friends and family and professional staff do not have direct experience of suffering from substance dependency, but they do have firsthand experience of what it is like to live or cope with someone who has suffered from addiction problems. They will have firsthand experience of what it is like to cope with a loved one who suffers from addiction problems and although they may not know fundamentally firsthand what addiction 'feels like', their knowledge is arguably comparable to firsthand experience of addiction as they witnessed *firsthand* the destructive nature of addiction on their loved one. Similarly, professional staff may not fundamentally grasp what addiction 'feels like', but their expertise and experience in the field and in clinical practice will give them an experience base that stems from a different perspective. This suggests therefore, that whilst the LTLA project may reflect a source 'experiential knowledge' on addiction, it is not necessarily the best form of support for all.

7.2.1 Gaining perspective and trust

Whilst it has been argued that different forms of support, other than peer support rooted in firsthand experience should not be devalued, there is no escaping the fact that the data collected in this research strongly conveys the importance of firsthand experience for peer support. The question remains therefore, why does firsthand experience of addiction and recovery appear to elevate peer support to a higher level than support from other sources? It has been suggested that firsthand experience gives *perspective* on others situations, which, in turn, builds *trust* between ingroup members. 'Perspective-taking' is defined as *"the active consideration of another's point of view, imagining what the person's life and situation are like, walking a mile in the other person's shoes"* (Galinsky & Ku, 2004; p. 596). Having perspective on another's situation has been found to enhance ingroup membership, as it enhances the interaction between self of each individual and self of another (Turner, 1987), thus allowing for each individual to fundamentally understand the experiences of another.

This fundamental understanding of another's self is built upon shared knowledge of an experience. Shared knowledge of an experience allows each individual in a common social situation to access the emotions and experiences they possess to understand another. In the case of this research, each service user and mentor can access their own knowledge of addiction and recovery to understand the contextual, spatial, temporal and cognitive elements of another's experience, regardless of the fact each of their pasts possess potential commonalities and differences within their addiction careers. Despite each service user and mentor possessing considerable differences in terms of life experience, the nature of alcohol and substance dependency still results in commonalities, such as experiencing stigma and a powerlessness over their addiction. In this case, the differences in their life circumstances are arguably not of central importance, as it is the commonality of experience, in terms of the experience of addiction that enables another's addiction past to be understood.

For example, Angela felt *"a different person"* during her addiction. Based on the premise that her 'addict identity' and its associated behaviours are very

disparate from her desired identity as a non-addict, Angela articulates such an identity as being *"a different person"*. This creates an internalised situation whereby Angela is perhaps creating social distance with such a negative identity and arguably even shifting blame onto this 'different person'. Feeling like a 'different person' during addiction was a common narrative in the data and would suggest that only those with firsthand experience of substance dependency could truly understand the 'different person' metaphor. For those who have not suffered with substance dependency or experienced knowing someone with addiction, such behaviour is sometimes not comprehendible as they perhaps lack the experience to understand 'what addiction does to a person'.

Understanding the self of another in addiction therefore, appears to reinforce ingroup membership as they are bound by shared experience, which has also been shown to reduce prejudice and stereotyping among ingroup members (Galinsky & Moskowitz, 2000), as a level of *trust* is built up between ingroup members. Firsthand knowledge of addiction appears to result in each service user and mentor having a deeper understanding of the behaviours and motivations of other service users, which, in turn, allows them to contextually understand each other on a deeper level than those who have not suffered with substance dependency. This appears to create a strong social bond between ingroup members of the LTLA project, as they feel understood as a human being, not as an addict. This is a feature of life that extends to a vast array of social situations.

There are self-help support groups for bereavement, gambling, cancer, mental health, diabetes, disability, bullying, racism, domestic violence, homosexuality, sexual abuse, infertility, miscarriage, suicide, eating disorders, AIDS, sleep disorders, congenital disorders and so on, all of which cover a huge array of issues. In theory, a self-help group could be implemented to deal with any issue on which people need support. At an individual level they offer emotional support, which could be invaluable in the earlier stages of recovery, whereas at the collective level, self-help perhaps facilitate recovery by providing

a positive identity for those who are at the project, as well as a sense of solidarity between the group members (Nettleton, 2006).

Possession of firsthand experience of a situation through understanding another's perspective builds *trust*, a concept that is built up through social interaction and physical contact with ingroup members of the LTLA project, as Barbara explains:

> *"But if it does, I been told it can happen* [relapse] *but I can come and get the back up I need here and it might just be a bit of a blip in me life I can go forward again… to know that if I do have a you know a little hiccup as you call it. I can come and I won't, you will feel failure coz you let yourself and your family down and everything but you know you can come and they gonna say 'ok, you've had it, you realised its something you don't want again' and go forward again."* [Barbara; service user]

Trust is built upon a foundation of each service user knowing firsthand what it is like to experience prejudice and stigma, which, in turn, means they do not judge or stigmatise against others. It is not necessarily a trust that is indicative of 'everyday trust scenarios' such as 'trusting someone not to steal' or 'trusting someone in a relationship', but a trust that appears to transcend these domains to a level where they implicitly trust each other not to judge them as a human being if they falter during their recovery. Firsthand experience appears to operate by allowing each service user to tap into the experiences and emotions of another, even if they have no prior knowledge of their addiction, by accessing their own emotions and experiences of addiction. This enables each service user and mentor to gain a psychological understanding of another person's addiction, as they can imagine firsthand the complexities surrounding their own addiction and recovery, thus creating strong social bonds between them.

7.2.2 A collective social conscience

The firsthand experience and trust that is built up between the LTLA project's members contributes to the idea of the project being a safe, social community. It is a community built upon a recovery-orientated culture, which from a *firsthand experience* point of view, is maintained through the perceived socialisation of all its members (Scott, 2006), as they understand what it is like to combat addiction and commit to recovery. Durkheim's work on 'collective conscience' and 'societal solidarity' is pertinent here, as it provides an explanation as to why the LTLA project's perceived community is maintained and has survived the passage of time. Durkheim explained that collective representations are comprised of a 'collective' or 'social conscience'; something that is 'external' to the individuals in society: it pre-exists them and persists after they have left the collective (Durkheim, 1898). This 'collective conscience' refers to the internalised, moral commitment and obligations that each member of the collective experiences, which, in turn, constrains the actions of the groups individuals and the relationships they build with others (Scott, 2006). Mediated by social interaction, the externality of the collective conscience is shared within the group (Scott, 2006), thus meaning the overarching cultural morality that subsumes a social group becomes internalised in each group member and subsequent new members. Moral codes and norms are established through successive *definitions of the situation* by each member, which dictates that social order is maintained through the collective mechanisms (Thomas, 1923). There is a sense of moral 'policing' required by each member to check any individual behaviour that contravenes the projects culture.

Through this collective conscience, 'social solidarity' between group members is maintained and reinforced. Durkheim explains that small communities (such as the LTLA project) tend to be based on 'mechanical solidarity'; a cohesive process that integrates community members based on the homogeneity of the individuals i.e. people feel connected due to similar beliefs, norms, values and morals (Durkheim, 1898). Durkheim continues to explain that from the perspective of mechanical solidarity, individuals in a community are influenced primarily by the culture of the community (Durkheim, 1898), which

in the context of the LTLA is a recovery-orientated culture. New members that join the group will gain support from existing members who have *firsthand experience* of what it is like to commit to recovery and enter such a group, which will not only instil the projects culture on the newcomer, but will also increase solidarity between the new and existing members as their values, norms and beliefs become congruent. Furthermore, solidarity of this kind also acts as a moral 'force' that checks individualism and upholds the collective representation of the group (Etzioni, 1996; Crow, 2002), thus allowing for the LTLA project to continue. Solidarity of this nature is a cultural phenomenon that is instilled *within* people as they share common values that are reinforced through behaviour (Crow, 2002). The question that remains then, is such a community beneficial for recovery?

The LTLA project's community and solidarity might be helpful in recovery, as it provides them with a safe social place in which they can interact, but it may also result in 'ingroup favouritism'. Ingroup membership dictates that those within the group have a common trait that intrinsically connects group members and shuns any individual who does not 'fit in' with ingroup norms (Aronson, Wilson & Akert, 2005). For ingroup members, companionship, values, norms and beliefs become strongly reinforced through social interaction, as they are all linked by a common trait (their firsthand experience of addiction and their commitment to recovery). This has the potential to result in 'ingroup favouritism', a phenomenon that occurs when affinity to ingroup members outweighs obligations to outgroup members (Aronson, Wilson & Akert, 2009). This is potentially detrimental to recovery, as it may result in individuals' socialisation becoming restricted to the small community of the LTLA project. As it was explored in section *6.3*, socialisation is a process of *being* or *becoming* a member of society or a cultural group through interacting with others and participating in daily routines of life (Coffey, 2006). If this socialisation is primarily restricted to the LTLA project, it may mean that not only do they forgo the opportunity to interact with others in mainstream society thus facilitating their transition back into 'general life', but it may also keep them continuously

connected with their addiction and recovery identity, thus preventing them from 'learning to live again'.

This is an interesting finding as it provides an alternative argument to section *2.3.4* of the literature review. Section *2.3.4* suggests that for those who have a social network comprised of more people in recovery or those who do not drink problematically, abstinence and recovery are better maintained. However, the findings of this research suggest that if an individual has a social network comprised of too many people in recovery, their social interactions are restricted to those in recovery, which in turn, keeps them connected to their addiction.

7.3 The story of stigma

All of those interviewed during this research articulated experiencing stigma of some form. The first sub-section explores how the stigma of alcohol addiction impacted on the individuals interviewed in this research. The second sub-section introduces the stigma of recovery, and that in some cases, despite making efforts to maintain recovery and commit to abstinence, a perceived sense of stigma was still experienced due to their recovery status. The final section explores how the LTLA project appears to have created a non-stigmatising culture, which in turn, appears to contribute to promising steps being made in recovery.

7.3.1 Experiencing stigma

Every service user and mentor expressed feelings of being judged by others and even by themselves. Kevin explains that his parents do not understand the difficulties of combating substance dependency:

> **Me: Who would be your first port of call [for help]?** *"Not me mum and dad coz they don't understand it now, I don't think they ever will"* **Me: What do you mean?** *"Well to me dad, everything's black and white, you either drink or you don't drink, there's no middle bit, there's no grey area or owt like that. But somebody who's done it, who's been through it to understand*

> *that, so I've usually got a few people I can phone if I need to…. me phone is full of people, I got more friends on me phone than I have family, and all from here* [the project]*, or from groups"* [Kevin; service user]

An interesting reflexive point made after the interview with Kevin however was that he disclosed to me that his father did not drink but was a heavy chain smoker. Kevin's father had been hospitalised because of the extent of his smoking, yet despite this, still continued to smoke. Catherine articulated the difference between chronic alcohol use and chronic smoking:

> **Me: Do you think people do judge?** *"Yeah they do yeah"* **Me: In what way?** *"Well the thing is, the thing is when people smoke a lot you know, they want to stop smoking and they umm, people don't judge 'em for it you know. But with alcohol the people judge ya."* **Me: Why do you think that is?** *"I think it's because umm there's a stigma to it ain't there – alcohol. And they think 'o she's gonna show me up' or something like that you know. I'd never ever shown anybody up when I been drinking, I have been a drinker but I done it in me own house in private. I've never gone out and showed myself up or anything like that"* [Catherine; service user]

Catherine feels that people are often more judgemental of drinkers than smokers thus resulting in more damaging effects on personal identity. Others based on the stereotype of 'an alcoholic' judged her against the stereotype, despite her actions not conforming to the stereotype. Thus, she is still attributed with many of the negative traits that are subsumed by the 'alcoholic' label (Link & Phelan, 2001). From a Goffmanian perspective, Catherine's perceived feelings of stigma demonstrate the intricate relationship between *attribute* and *stereotype* (Goffman, 1963). At the social level of face-to-face encounters, Goffman (1972) states that stigma is the result of discrepancies between the 'virtual social identity' – the *stereotyped* imputations we make in everyday life, and the 'actual social identity' – the *attributes* an individual actually possesses (Goffman, 1963; Nettleton, 2006). Stigma is a wholly social process generated, sustained and reproduced in the context of social inequality, and the reaction of

others (i.e. those likely to not be stigmatised), 'spoiling' the normal identity of the stigmatised (Nettleton, 2006). In the context of alcohol and drug addiction, 'addicts' are often shunned by others in mainstream society, as addiction is not indicative of the 'virtual social identity' that general society demands, as exemplified by Catherine's extract above.

In contrast however, there is no such perceived identity for a smoker. The stigma associated with '*being* a smoker' is negligible in comparison to '*being* an alcoholic'. From a structural symbolic interactionist perspective, the behavioural expectations and position of 'the smoker role' in society is arguably subject to less public scrutiny than 'the alcoholic role'. This is based on the premise that alcoholism is associated with more obvious, immediate impacts such as aberrant social behaviour, problems with employment and violence, which are not often associated with 'the smoker role'. Given the UK's perhaps lessened preoccupation towards smoking in comparison to alcohol use, those who do smoke are rarely subject to public scrutiny, and therefore far less likely to experience stigma. This is perhaps the reason why self-help groups for nicotine dependency such as Nicotine Anonymous are considerably less common and lower profile across the globe (Humphreys, 2004). An 'alcoholic' on the other hand, is arguably one of the most well known stereotypes, meaning any individual who has suffered from alcohol dependency will likely be judged in light of the stereotype: *"somebody being like a tramp you know"* [Catherine]. Judgement from others is not the only source of persecution, as Christopher explains:

> **Me: Do you class yourself as recovered or recovering?** *"Recovering coz I still fancy a drink now. I need to have a word with* [his keyworker] *coz I'm getting cravings for alcohol again. I've had these* [cravings] *for about a week"* **Me: And how does that make you feel? [Having these cravings]** *"Pissed off with myself, knowing that you know, I should be strong enough to cope with it"* [Christopher; service user]

From the viewpoint of Goffman (1963), Christopher's self-stigma is arguably the result of social interactions he participates in at the LTLA project. Goffman (1963) states that stigma can only exist in interaction and cannot come from within, therefore implicating the social nature of stigma (Nettleton, 2006). Given that Christopher envisages the responses of others and sees how well some of the other service users are progressing in their recovery, his desire to still drink in comparison, results in feelings of shame and self-stigma. Christopher's desire to drink and be in recovery at the same time has resulted in a tension that acts as a source of self-stigma.

This perceived awareness of 'what they have become' seemed to manifest itself throughout the data, as many participants explained that they often drank alone, out of view of the others:

> *"I have been a drinker but I done it in me own house in private. I've never gone out and showed myself up or anything like that"* [Catherine; service user]

> *"I didn't really mix with I of people, I used to do me drinking at home on me own so I didn't really mix with people"* [Kevin; service user]

Avoiding others, Goffman (1961) states, is a tactic that is deployed by stigmatised individuals in order to avoid ratifying social interaction that presses a reciprocal role on themselves. They become consciously aware of what they have become in the eyes of others (Goffman, 1961). Just as others shun the stigmatised individual based on the stigma that surrounds their perceived addict identity, the stigmatised individuals begin to shun themselves as a result of the same stigma, which induces feelings of self-loathing as Christopher experienced. This is then reinforced internally by the stigmatised, as a result of a self-fulfilling prophecy; negative stereotypes associated with substance dependency such as being weak-willed and being unable to quit contribute to those very outcomes (Schomerus et al., 2011). This can, in turn, have the effect of reinforcing the social boundary that divides substance dependent individuals from others, thus

potentially keeping them entrenched in the stereotype (Phelan, Link & Dovidio, 2008). The social division between 'them' (the stigmatised) and 'us' (the stigmatisers) has become an internalised feature of their self.

Social boundaries that separate 'them' from 'us' are upheld by the very nature of the labels; incumbents are thought to fundamentally *be* the thing they are labelled (Estroff, 1989). Link and Phelan (2001) use mental illness as an example. They state that people are referred to as 'epileptics' or 'schizophrenics', or in the case of this research people are referred to as 'alcoholics', not as people who *have* epilepsy, *have* schizophrenia or *have* alcohol dependency. For someone who *has* cancer or *has* heart disease, they are seen as a person who is one of 'us' but is just beset with serious illness. 'Epileptics', 'schizophrenics' and 'alcoholics' on the other hand, are labels that suggest someone *is* 'epileptic', *is* 'schizophrenic' or *is* 'alcoholic'; it is fundamentally *in the person* (Link & Phelan, 2001), which underlines the difference between 'us', and 'them' as undesirable outsiders.

7.3.2 The stigma of recovery

So far, this section has explored the stigma that is often related to addiction, a theme that is pervasive throughout the literature. However, an important theme that came out of this data was the perceived sense of stigma that was attached to being in recovery. Many of the service users explained that outside the confines of the LTLA project, they still feel as if they would be judged not only for their addiction pasts, but also for their present and future commitment to recovery:

> *"People did start questioning 'why you just having a lemonade Jayne?' I went 'oh I'm getting up int morning, got to take* [my son] *to school, for 6.30, he's got a cricket match' blah blah blah. And it weren't that I wanted a drink, it were just I felt like I were lying to them and I didn't like that. But I didn't want to tell 'em, it's none of their business"* **Me: Do you think you would have felt like they would have judged you?** *"Yeah, umm now I've started getting lemonade and lime and I don't get as much comments coz it looks like wine and lemonade so"* [Jayne; service user]

> **Me: Do you feel people do judge?** *"Yeah"* **Me: Do you still feel that?** *"At times yeah, I had me bit of pressure, like there's pressure on you know, if I go in a pub or what have you and somebody sees you drinking a coke or lemonade and its like 'why aren't you drinking' sort of thing you know, I say 'on medication, I cant' you know"* [Christopher; service user]

In Jayne's case, the fear of being perceived to be judged if people were to discover her previous history of substance dependency has forced her into *"getting lemonade and lime… coz it looks like wine and lemonade"*. Similarly for Christopher, he makes excuses for not drinking; *"I say 'on medication, I cant' you know"* for the same reason that Jayne makes excuses; through fear of being judged if their addiction pasts were to become public knowledge. Both Jayne and Christopher explained that during their addiction, their alcohol consumption had become so problematic that they no longer felt 'normal' and often felt ostracised from 'normal' social functioning. In order to regain a sense of 'normality' and control once again in their lives and to feel a part of society once again, they addressed their excessive drinking and made commitments to recovery. Paradoxically however, drinking in modern society is almost synonymous with social convention, as commercialisation of alcohol and alcohol-related products has become ubiquitous worldwide, that for many, alcohol has become a significant component of their social lives. Thus Jayne and Christopher have felt stigmatised because they have *not* drunk alcohol. Whilst addiction therefore, is often associated with stigma and discrimination, recovery too, seems to have a perceived sense of stigma attached also.

Being 'legitimate' and acting 'normally' is part of the cultural fabric of society, with people acting in specific ways due to social constraints of society (Williams, 1986), which in the case of Jayne and Christopher means 'mimicking' drinking. From a Goffmanian perspective, face-to-face encounters help to stage personal identity, which are shaped by social norms, external and internal resources and culture (Goffman, 1972). Pretending to drink therefore, is Jayne and Christopher's way of ensuring their personal identities fall within the

boundaries of social convention. The one behaviour (drinking) both Jayne and Christopher are combating during their recovery, has now become the one behaviour they are having to mimic in order to avoid the stigma of their recovery from those already considered socially 'normal' and be seen as 'legitimate' members of society.

Whilst the LTLA project appears to provide a safe place for service users to socially interact without being stigmatised (see section *7.3.3*), it cannot prevent public judgement and stigmatisation. Dealing with such judgement and stigma might seem fairly straightforward for those who have not suffered with substance dependency, but for those who have, dealing with such feelings without resorting to alcohol use is potentially very difficult.

7.3.3 The LTLA project: A non-stigmatising culture

The LTLA project seems to be built on a foundation of firsthand experience of what it is like to be stigmatised. This seems to have resulted in each member of the project not stigmatising others. I witnessed this non-judgemental attitude during my first observation, a day trip to Skipton:

When I first arrived it was 9.50am and I was the first of the group to arrive. I was greeted by the receptionist and told that [LTLA coordinator] *would not be too long. The next person to arrive was mentor #4 who greeted me and was very friendly. We had met several times before so I was happy to see a familiar face. The next person to arrive was Rachel – a woman of approximately 50 years of age who was friendly to me after introducing myself and we sat in the LAU reception and chatted. Rachel explained to me that she had not been on a trip like this with other people for 14 years as she did not like to leave her father alone and was also very nervous of going out generally with other people she does not know. Approximately 10 minutes later, mentor #4 said to* [the coordinator] *that she thought she could smell alcohol on Rachel's breath and they both then asked me as I had been sitting next to her whilst chatting about her holiday. I said I couldn't but very quickly commented that I am perhaps very naïve with this and that they shouldn't take my word. Between Mentor #4 and* [the coordinator] *they decided to breathalyse*

Rachel. After a short debate it was decided that [the coordinator] *would take her into a room and say "we smell alcohol on you can you please take a breath test". The rule is that one cannot come on the activities if one is not sober* [it was about 10.25am at this point]*.* [The coordinator] *went outside and asked if she could just have a quick word with Rachel in the interview room to which Rachel obliged.*

When [the coordinator] *and Rachel came out of the room they both went through to the back office where* [the coordinator] *breathalysed Rachel. When they came back* [the coordinator] *said that Rachel was twice the drink drive limit, to which mentor #4 said she had definitely been drinking that morning.* [The coordinator] *and mentor #4 had a conversation and* [the coordinator] *said that Rachel really wanted to come on the trip. It was decided that* [the coordinator] *would ask the group and if they agreed she should come then Rachel would be allowed. I thought at this point that despite contravening their own rules, it was a democracy and that others had a say in others actions – perhaps because they were sympathetic. Rachel was allowed to come on the trip.* [Observation 1: 24th November 2011]

This observation raises two potentially contradictory points. First, it is a good example of both the firsthand experience and non-judgemental attitudes of the service users. They were all aware it was Rachel's first trip out without her father for a considerable amount of time, and they were all sensitive to the fact that she was very nervous. Each service user understood firsthand how challenging attending the project and its activities can be which made them accommodating of the fact she had consumed alcohol to deal with her nerves. At no point during the day out did they seem to judge her and interacted with her normally. On the other hand however, breathalysing a service user to determine if they have been drinking is a potentially powerful source of judgement. Breathalysing Rachel not only overtly raised the fact she may have been drinking to others, but it also served as a potential source of stigma and distrust as she is still drinking.

Taking the wider context of the LTLA project into account, their main rule is that all service users and mentors cannot be intoxicated with any illegal substance whilst attending the activities. For those who appear under the influence of alcohol, the only way to quickly and objectively test the individual is to breathalyse them. Whilst this may seem somewhat authoritarian, it could be argued that this is the only way to preserve the fundamental rule upon which the LTLA project is built. If they were to overlook episodes of drinking such as Rachel's, it may indicate to others that drinking is not going to be addressed, thus resulting in others turning up to activities intoxicated. However, the coordinator's actions not only ensure that Rachel's drinking was addressed, which preserves the integrity of the project but it also demonstrates that the LTLA project accept that recovery is difficult and that in many instances, service users may relapse. This serves to uphold the non-stigmatising culture that has come to embrace the project. Barbara explains that every individual who attends the project is not judgmental about others:

> *"I do enjoy* [coming to the] *LTLA for the friends I've met there and the activities we do and what's good about it is nobody looks at ya as though you got two heads you know. You felt a person, you feel a person you know, you've got a problem you're not, you're not an alchi or a druggie or whatever people say you are… yeah nobodies gonna judge me. But the thought of going in a strange place and doing it, I don't think I could do it, even now but I could do it with the people I've met now* [from LTLA] *coz I got so much confidence in them. I know I'm not gonna be judged, I'm not gonna be looked at so I'm a bad person coz I done these things so, yeah. It took me, it took me really somebody to give me a kick up the backside and say you need to get involved more if you want to help yourself and that was yeah, it has been the turning point"* [Barbara; service user]

Barbara feels that those who attend the project treat her like a human being accepting she has made a mistake with her addiction, but not judging her because of this. Across many societies, alcohol dependence is seen as a psychosocial and moral problem and is one of the most rejected public

stereotypes (Schomerus et al., 2011). Therefore, many who have suffered with alcohol dependence like Barbara, often feel rejected by society, as they are viewed as weak-willed and judged as a *"bad person"* [Barbara]. However, Barbara feels that those at the LTLA project do not see her as *"an alchi or a druggie or whatever people say you are"* [Barbara] and treat her as a person who has had addiction problems in the past, but that is not who she *is* as a person. Goffman (1963) suggests that the stigmatised are able to avoid stigmatisation if a group of those who possess the stigma form a group. This is because by the very nature of everyone possessing the same stigma, the stigma itself is eradicated (Lloyd, 2010) or in other words, if everyone possesses the stigma, it has no effect. It is well documented that those who feel judged or stigmatised experience depressive symptoms, low self-esteem and low self-efficacy as a direct result of such judgement and stigma (Corrigan, Watson & Barr, 2006). Socialising in an environment therefore, where judgement and stigma are not present seems to have the opposite effect and enhances confidence, as they know they will not be judged (which many of the service users explained).

There is one caveat to this subsection that needs highlighting: I did not interview everyone at the LTLA project and there may have been those who do experience feelings of judgement from other service users and mentors. Even though each service user claimed they never felt judged by others at the project, it is impossible to know if this is truly what they feel. Due to the support all of the service users and mentors gained from the project, they may not want to portray the project in a bad light, thus resulting in them giving wholly positive opinions.

Continuing on from the discussion raised in earlier sections, the perceived non-stigmatising culture of the LTLA project, in comparison to the potentially stigmatising nature of mainstream society appears to reinforce the service users affiliation to the LTLA project's community. Such a culture is upheld by the projects members, as they have firsthand experience of what is like to feel stigmatised, hence appearing to not stigmatise others in the group. As it was explained in the above section, this transcending culture of recovery that embraces traits such as firsthand experience and a non-stigmatising attitude

towards others is shared between group members through social interaction. This makes socialisation within the LTLA project an attractive alternative to socialisation outside of the LTLA project, as they have the conscious knowledge that each service user knows they will not be judged, discriminated or persecuted. As Coffey (2006) explains, there are no books on 'how to become' a gothic punk or a train spotter, just like there are no books on 'how to become a member of mainstream society'; they are all identities that are learnt through social interaction with other gothic punks, train spotters and members of mainstream society. Continued engagement and socialisation with the LTLA project therefore, means their social interaction will primarily only be with other recovering service users and are less likely to learn 'how to be' a member of mainstream society. This finding suggests therefore, that there are potential limitations to having a social network comprised of too many people in recovery, an alternative finding made by the quantitative studies in section *2.3.4* of the literature review.

7.4 Peer Support

The LTLA project was set up to act as a component of recovery that aims to help service users 'learn to live again'. Clinician ♯2, one of the founding professional staff that helped set up the project explains:

> *"I think it tries to help that transformation… By giving people a new life, a new perspective on life. I mean it's not a new life, that's grandiose but, new components to their life, things they can do, feel good about themselves. And the transformation is bigger for some people than it is for other people depending on how much their addiction has overwhelmed their lives but by the time they get here* [the LAU and the project]*, its overwhelmed their lives really. And it helps them, its more of a sort of contributing components to the life, their going to have without their substance use. People* [members of 'normal' society] *perceive them* [service users] *differently, when they've given up drinking or taking drugs, its part of it, its only a part of, of what people do with their own social networks, their own families, their own jobs if they have them, their own voluntary work, it's* [the project] *a component*

of it, it's never more than a component of it. It's a contributory component." [Clinician ♯2; co-clinical lead of the LTLA project]

The LTLA project has been set up in a way so that service users and mentors are able to help one another in their recovery, which, when combined with participating in leisure activities that require them to re-learn life skills such as money management, planning and 'normal' social interaction, they 'learn how to live again'. Within this section the concept of *peer support* is explored, and how under-engagement or over-involvement with the LTLA project appears to be detrimental for recovery.

'Rates of recovery' is a concept that resurfaces throughout this section. Determining an empirically based method of measuring the rate of recovery is difficult, as the concept of recovery has no objective definition (West, 2006). Even assessing an individuals progress based on their goals is fraught with complexity, as goals will likely vary considerably between service users and also in terms of the amount of time different goals may take to complete. This thesis is less concerned with 'how fast' one recovers whilst at the LTLA project, and more concerned with the subtle nuances and intricacies of how, and why recovery unfolds the way it does within the LTLA project. Based on this premise, the 'rates of recovery' referred to in this subsection are based entirely on subjective interpretation of how I think each service user is developing as a person. This subjective method of assessing rates of recovery will be discussed in my discussion section. This subsection on peer support is broken down into three themes: *under-engagement with the project*, *over-involvement with the project* and a group I have termed *the goldilocks group*.

7.4.1 Under-engagement with the LTLA project

There are a select few at the LTLA project whom, based on my data appear to under-engage with the LTLA project for support. Christopher is one such example:

"Yeah just, I don't know you know. I get mixed up and this, I can say how I'm doing, 'I'm doing alright, had a bit of a wobble' and what have ya, I, I, feel a bit hard, you don't wanna put pressure on other people… bit of a loner really" [Christopher; service user]

Christopher's extract refers to his inability to confide in other service users and mentors with any problems he is experiencing in his life, as he does not want to put additional pressure on others. Christopher is experiencing cravings for alcohol once again:

Me: Do you see the Antabuse as a safety net? *"Yeah, without a doubt…"* **Me: So what stops you drinking?** *"The Antabuse, top and bottom of it, the Antabuse"* **Me: So if you weren't on the Antabuse do you think you would be drinking?** *"Yes, without a doubt"* **Me: Even if you were coming to the project?** *"How do you mean?"* **Me: So say for example the Antabuse didn't exist….** *"Yeah"* **Me: And you were coming to the project…** [Christopher interrupts] *"I wouldn't come"* **Me: You wouldn't come?** *"Coz I'd be having a drink"* **Me: Ok, so would you still say that you have a problem with drinking?** *"Yeah"* [Christopher; service user]

Despite two and half years attending the project where he has regular access to support to discuss these cravings, he still refrains from doing so. Christopher's under-engagement with the project appears to have resulted in him not getting the peer support that many of the other service users have access to, as he seems almost reluctant to socially interact with others. According to Christopher, as a direct result of his under-engagement with the project for social support, he relies on physical support in the form of Antabuse; an alcohol antagonist drug that makes the individual very sick if they consume alcohol on top of it. This raises an important question: is living a life on Antabuse necessarily a bad outcome if it prevents a return to chronic drinking habits? From a biomedical point of view, Antabuse has minimal side effects (as it is explained in the extract below) and is active in the body for seven days. Mentor ♯5 explains that she still takes two Antabuse pills a week:

"I take Antabuse, yeah. I take two a week... you're supposed to take them daily when you first come off it. But two a week just keeps me, coz I know its in me system without over doing it coz you got to come off for a full week before you drink." **Me: How long have you been doing that for?** *"I been doing it quite a while, since I stopped drinking. Yeah and umm, I had a word with clinician ♯1 about it to see if its ok to do that and he said yeah its fine, there's hardly no side effects from it. Sometimes I just forget to take it and as soon as I get that thought, I take it but sometimes I can, I can forget for a full week and coz I'm that busy it doesn't enter me mind. But even now when I've forgot, that thought still goes into me mind, "oh I could have a drink now" and as soon as I've thought that I take me tablet straight away. They work wonders for me do Antabuse"* **Me: So how does it stop you drinking?** *"It takes that choice away. So like if you're not on Antabuse you can sit there and you can be thinking right I really need a drink, do I need a drink? Should I have a drink? Shouldn't I have a drink? And even though you know it would be disastrous to do it, you still battling with that. Whereas I take me Antabuse and it cuts all that out, you know. You don't have that choice which works wonders for me."* [Mentor ♯5]

Similar to Christopher, mentor ♯5s extract suggests that taking Antabuse is a viable outcome for recovery as it stops her drinking and *"takes that choice away"*. Despite both taking Antabuse, mentor ♯5 seems to have 'taken the next step' in recovery to a stage whereby her psychological thought processes are no longer centred on the acquisition and consumption of alcohol. In her situation, prolonged use of Antabuse is perhaps a successful recovery outcome as Antabuse is not the sole reason for her abstinence. Instead Antabuse plays a more subordinate, supporting role in her recovery with the main reason for her commitment to recovery being her role as a mother (see section *6.5.4.1*). Christopher on the other hand appears to have not taken that next 'psychological step' and actively relies on Antabuse as his primary form of support for recovery. Whilst Antabuse may have virtually no side effects, Christopher's 'Antabuse-based' recovery is perhaps detrimental to his future recovery, as it seems to

hinder him addressing the underlying psychological issues and cravings he experiences. Whilst Christopher may have been abstinent for nearly thirty months, a time period considerably longer than most at the project, he has arguably made little progress in his recovery. Christopher's abstinent behaviour is perhaps a 'pseudo-abstinence', a state whereby his abstinence is perhaps not founded on underlying feelings of recovery, but perceived feelings of what he feels he should be experiencing.

Furthermore, the prolonged use of Antabuse, whilst it may stop him drinking, keeps him psychologically connected with his drinking, as he is implicitly aware that the only protection he has from succumbing to his cravings is the Antabuse. For some however, Antabuse is an important part of early recovery:

> **Me: Do you feel for the entire time you're on the Antabuse you will be fine but the big test is when you come off the Antabuse?** *"I would think so yes, because I know in my head, even though I feel alright at the moment, you still know that that you can* [have] *a little relapse or a little temptation. I'd pay the consequences for it from taking the tablet.... its like riding a bike without stabilisers, you know what mean? You get used to it don't ya and you think, can I trust myself without* them [the Antabuse]*, so I've still got yet to try and challenge myself with that"* **Me: Do you think the test comes when you come off the Antabuse in November?** *"Yeah"* **Me: Will that be a big step for you?** *"Oh god that will be fantastic yes. I hope then that's when I will have achieved it. I will be a recovering one* [alcoholic] *or recovered, you can't say that. Until I have actually done it myself without help, I mean help with the tablets"* [Kirsty; service user]

Kirsty realises that recovery is a long-term process that requires practice and that in some situations such as hers, physical support is required. However, the difference between her and Christopher is that Kirsty is aware that Antabuse should not be the only form of support for her recovery. Comparing Christopher as an individual with others who fully engage with others at the project, his

development appears to be stunted in comparison. For example, mentor ♯1 has been at the project approximately the same amount of time as Christopher, and by her own admissions, was quite shy when she first came to the project:

> *"For a few weeks I came and stuck to* [mentor ♯4s] *side like a little limpet... I remember one week* [mentor ♯4] *had told me she wouldn't be here and I still came and I did make the effort. There was a mentor then who was a little bit like an over excited puppy umm, but I made the effort to go and speak to her and I remember there was, there were two guys and I actually remember making the effort to go over and say "Hi I'm* [mentor ♯1]*, I'm quite new here, have you been coming long" and strike up a somewhat stilted conversation."* [Mentor ♯1]

However, in her time at the project, mentor ♯1 has not been on medication for nearly the entire time she has been at the project, become a mentor, found a house to live in and re-gained employment. Whilst it may not be every service user's goal to become a mentor or to get back into employment, the progress mentor ♯1 has made in comparison to Christopher is considerable. Based on observational data, it would appear that those who are less capable of socially interacting with others do seem to have a reduced rate of recovery. An under-engagement with the project not only results in service users missing out on potentially valuable peer support, but they also forgo the opportunity to socially interact and develop companionship and camaraderie with others at the project. This suggests they remain somewhat isolated in their own recovery and end up having to tackle recovery from addiction with very little support.

7.4.2 Over-involvement with the LTLA project

Whilst under-engagement with the project seems to result in a 'reduced rate' of recovery, over-involvement with the project also possesses its own problems. Over-involvement appears to be the product of having little else to focus on outside the project, as James explains:

"I mean I do get lonely, I'll be quite, quite honest but how I feel at the moment, I'd sooner stick with loneliness and not have a trust in somebody I'm with" [James; service user]

For many of the service users, boredom and loneliness outside of the project, appears to have resulted in over-involvement with the project, as it becomes their main social environment in which they seem to live their lives:

Me: How long do you see yourself coming to the project? *"All the time, constantly as long as I possibly can… Well I look forward to going out on trips with them umm, I been on barge trip four times, this is gonna be me fourth time on the 30th of this month"* [Clive; service user]

In James' case, his life events have led him to have little in the way of social life as he has trust issues with people he meets, except those he interacts with at the project. Clive on the other hand, has had to take early retirement due to his disability, which has meant he no longer has employment as a second component of his life to focus on. As it has been explored throughout this chapter, over-involvement with the project not just for peer support, but for a social life in general, can result in the project seeing to become the central component of their lives. Both James and Clive explained that they view the project as the main element in their lives that keeps them from drinking. The pleasure they both articulated from attending the LTLA project's activities and socialising with others at the project appears to be significantly positive for both of their recoveries. Based on this premise, over-involvement with the LTLA project for a social life is perhaps not as damaging to recovery as it may first seem.

However, if the project was to disappear (for whatever reason), those who rely on the project as their main form of social support would suddenly experience considerable life difficulties, as the one stable aspect of their life that prevented them drinking would be removed. It has been shown in the literature that consistent, stable social support contributes to the social capital each

individual possesses (Granfield & Cloud, 1996), which contributes to successful recovery (Bischof et al., 2007). If the LTLA project was to cease to exist, the risk of relapse for service users such as James and Clive is likely to increase, as their sole reliance on the project for support and a social life would be removed thus leaving them with very little. This is supported by section *2.3.4* of the literature review that found those with less support have a higher rate of relapse and a lower rate of abstinence. Furthermore, over-involvement with the project is perhaps detrimental to recovery as it restricts them moving on as clinician ♯4, a keyworker at the LAU explains:

> *"I think to some extent there's something going on which is bit of a double-edged sword to some extent that umm, because its based here at LAU and its not actually run by clinicians but there is some kind of close contact with the clinical side, I mean I know the two clinical directors attend meetings with the LTLA mentors, there's a certain sense of it being kept in the family as it were where people feel umm it's, it's something of a safe haven, people still feel they've got one kind of foot in the treatment camp. And what I mean by a double-edged sword, you do wonder sometimes if that at some point during their stay with LTLA, it can kind of stop people moving on and they get kind of stuck… it comes to define their life, that they are in this treatment, this treatment ghetto almost whereas from my own, my own view would be the idea is to ideally get people to have left all treatment behind if at all possible… feels a bit to me that there's like another step beyond LTLA you know, a kind of core treatment with us then move into LTLA for more prolonged period but perhaps there's another step beyond that where people just leave their previous life within addictions behind them….."* **Me: Just draw a line totally?** *"Yeah, I mean you break your leg in a car accident you on an orthopaedic ward, you don't stay an orthopaedic patient forever do you? It's something that happens to you in the past that isn't forgotten about but umm, life moves on"* [Clinician ♯4]

The extract of clinician ♯4 is a good example of the project almost making life too comfortable for service users. On the one hand, the culture created by the

project appears to be a significantly important factor for most of the service users to begin and practice being 'in recovery'. On the other hand, the project becomes very familiar for service users, thus preventing some of them from moving on; it is a *"double-edged sword"*. In this sense, the LTLA project is a victim of its own success as service users *"kind of get stuck… it comes to define their life"*. In *Asylums*, Goffman (1961) explains that the self-conception each inmate takes of their 'self' is governed, in part, by the institutional establishment in which they occupy, i.e. they are defined as mentally ill because they are in a psychiatric institution. A similar point can be made here; for those who continually interact in the social setting of the project, their 'self' is likely to become defined by the project, as opposed to being defined by other aspects of life that are less associated with their addiction. Ironically, one of the goals of the project is to help service users move on and socially reintegrate back into the wider community; a goal, which in my observation is not always achieved.

This notion of 'over-involvement' with the LTLA project provides a counter argument to section *2.3.2* in the literature review. Section *2.3.2* found that those who become actively involved in SHGs benefit more in their recovery, as they are being an active part of their own recovery. However, this research found that those who become 'over-involved' with a SHG actually seem to fair worse in recovery as they become reliant on the project for support. This finding is further explored in chapter *8* but is important to raise here, as it implicates the importance of not over-engaging with SHGs in addiction recovery. Based on what has been discussed so far in this subsection on peer support, it would suggest that those who maintain an equilibrium that is 'just right' profit most from the LTLA project: the *'goldilocks group'*.

7.4.3 The 'Goldilocks group'

The service users discussed in this section are a cohort of individuals who utilise the project as it was intended when it was first set up; *"a component of it* [life]*, it's never more than a component of it"* [clinician ♯2]. I have collectively referred to these service users as the *'goldilocks group'* as they manage to maintain a stable balance between their commitments and obligations to life

outside the project, and their commitment to the project. They seem to maintain an equilibrium, which includes peer support that is 'just right' for recovery. Barbara, a service user retired from work explains:

> *"I've always had a great relationship with my family, my two daughters. I got two daughters and two sons - good relationship with them all but, more so with your daughters, which you do have don't ya. I mean, we've always, I see 'em everyday, if I don't see 'em everyday, I speak to them and we've always been a loving family, we don't see each other and leave each other without giving each other a kiss and we're very emotional family"* [Barbara; service user]

Barbara, like some of the other service users and mentors have strong social support outside the project from friends and family, as well as the support they get from the service users, mentors and professional staff at the project. Barbara continues to explain that she likes to keep her life in the project separate from life outside the project:

> *"I don't want to get involved with people outside work* [the project] *at the moment yet. I want it to stay in here"* **Me: Why do you think that is?** *"Because I want, at the moment, I want top keep my family life separate… I don't at the moment, I don't want to feel like you know somebodies invited my up to their house for the day and then I might have to invite them back to mine, I don't want to get in that situation at the moment. Because I want to keep it separate, I want to keep this separate to me life outside maybe in time you know, you will have friends that you know are gonna be friends for life but at the moment I want to keep it on a separate"* [Barbara; service user]

Barbara's desire to keep her life separate reflects a state whereby she almost compartmentalises her recovery so it does not encroach on her life outside the project. This process of compartmentalisation is perhaps a way to not only keep the project as only one component of her life, but her recovery

also. In the wider context, the LTLA project represents a group that helps recovery from substance addiction, a part of their lives all the service users want to move on from. By compartmentalising the group, Barbara ensures she is not primarily identified as 'in recovery' as that automatically connects her back with her addiction. Compartmentalising her life so recovery is only a part of 'who she is' serves to facilitate a redefining of self as mentor ♯4 ♯explains:

> *"I don't think of myself as somebody who has an alcohol problem in the past. I'm very aware that has happened to me and thirteen years it can happen again but I don't go by the AA philosophy of you know "lock your doors and don't go in a pub" you know. I didn't do it the first time and I wouldn't do it this time it's my problem, not everybody else's umm and I don't see it as a problem. I don't drink now, I've got a friend who well over thirty years has never drunk just coz she doesn't like it so to me, I can just say well I don't drink, she does, nobody questions her. It's just coz I don't drink, I don't like it"* [Mentor ♯4]

Mentor ♯4 accepts that she suffered from alcohol dependency during her past, but she no longer defines her 'self' by those actions. Furthermore, mentor ♯4 no longer seems to define her 'self' by her recovery status either but rather as someone who simply does not like to drink; arguably a more advanced stage than Barbara. Mentor ♯4 now defines her 'self' in the same capacity as her friend who has never suffered with substance dependency, an identity that is comparable to what is considered socially 'normal'. Mentor ♯4 has a healthy social life outside of the project and during her time at the project, has used the support from other service users and mentors, as well as the professional staff to get her into the position she is today. By no longer defining her 'self' by her addiction or her recovery, mentor ♯4s 'new' self is reaffirmed through face-to-face interactions she has with significant others, such as her friend who does not drink. Whilst Barbara and mentor ♯4 have both benefited from peer support within the project, they have not over or under-relied on it as their only form of support. They are aware that other forms of support such as their family and

friends outside the project also play an important part in their recovery, which arguably gives them a more holistic form of support.

Considering peer support in a general capacity, it is perhaps a source of social capital for the service users and mentors. Putnam (2000), one of the leading thinkers on social capital, states that close social ties (such as the ones exhibited by the LTLA project) are made possible though 'bonding social capital', a type of social capital which is reliant on close social ties such as the ones exhibited by many of the service users and mentors. Putnam (2000) has also argued that communities thrive when social capital within the community is high. This would suggest that peer support not only offers a source of individual social capital by providing the opportunity to help others and be helped by others[12], but the collective social capital of each service user and mentor is perhaps what drives the LTLA project to continue. As a result of this perceived collective social capital, solidarity of group members is arguably strengthened, as there is increased social cohesion due to the homogeneity of the group's members (Durkheim, 1898). Georg Simmel also points out that solidarity is at its most intense when there is a heightened sense of interdependence between group members (Wolff, 1964). Whilst the service users and mentors may not totally depend on one another for support, the peer support within the LTLA project is perceived by many to be better than all other forms of support (see section *7.2*). Whilst this is only conjecture as it impossible to 'know' how much social capital an individual possesses given its difficulty to measure, it is a plausible argument to explain the continuation of the project.

There is one caveat that needs to be made with regards to this section on *peer support*. All the data used in this section has come from those who were active members of the project (either mentors or service users) at the time of interview and not from any individuals who have left the project. As I have not been able to conduct any follow up interviews with individuals who have left the LTLA project, it is difficult to claim with any certainty that any of the groups

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[12] One of the primary roles of the mentor is to provide advice and support to others where necessary. As a result, they have increased opportunities to gain social capital and further their own recovery. This is discussed in section *6.5.3*.

explored in this section are 'good or bad' for recovery. There are some I know have left for good reasons (for example, mentor ♯1) but there are some who have left for unknown reasons. Based on the data collected, the service users and mentors could be subdivided into the three explored groups, but this is based solely on my interpretation of their recovery trajectories and what they said to me during interview. Due to a lack of follow up interviews, the overarching terms of *under-engagement*, *over-involvement* and *the 'goldilocks group'* used to categorise participants in this research should be regarded as experimental or suggestive and worthy of further research attention.

7.5 The activities: Addressing boredom and providing structure

Due to the regularity of the LTLA project's activities, feelings of boredom are addressed, as well as providing the service users with a sense of structure, around which, they can organise their time. When each service user entered into recovery at the LAU and then the LTLA project, they found themselves with vast amounts of spare time, to which they were not accustomed. Whilst this spare time is a direct result of their commitment to abstinence, a positive step in their recovery, the spare time for many often resulted in boredom, a potential trigger for relapse:

> *"The biggest problem you've got from stopping away from drinking is kicking it to start with but its even harder not go back to it"* **Me: Maintaining it?** *"Yeah maintaining it, and one of the biggest obstacles that we come across is boredom coz I mean most of these guys have lost their job, or they never had a job or you know umm, they don't know what to do with themselves from morning until night"* [Mentor ♯2]

Many of the service users explained that boredom was arguably the biggest trigger for relapse as it meant they had significant amounts of time to fill. For some, this time was filled by their jobs, but for others who were retired or did not have a job, boredom became a significant risk factor for relapse. The

reason boredom is a risk factor for relapse is because it appears to induce other associated negative feelings such as loneliness, as James explains:

> *"It gives me something to look forward to during week. At least it gets to middle of week and umm, I can get a bit fed up bit, bit of a downer* [and] *I think 'well I got their* [the project] *to go on Friday'"* [James; service user]

This finding is consistent with the literature. Preston and Epstein (2011) found in their study that negative feelings such as boredom, loneliness and tiredness had a statistically significant association with feelings of ongoing stress (background stress not necessarily associated with a specific event) and a negative association with feelings of happiness and relaxation. This in turn, has been found to significantly increase the motivation to return to substance use as a way of dealing with such negative feelings (Newton et al., 2009). The project addresses feelings of boredom by providing service users with activities that run on a weekly basis, and sometimes at weekends, as mentor ♯3 explains:

> *"Well a structure, people look at* [the project] *if they come in on Wednesday to the women's group* [one of the activities] *that's the, its the structure to the day on the Wednesday and they might want to then go on to the cinema in the afternoon on a Friday; it's two afternoons where they are doing something. The majority of people are not working when they, they first come to us so when you've had seven days a week and your completely out of it through one substance or another to having seven days a week where you got a lot of time to fill. So getting involved with an aftercare program, meeting up and getting involved you know, getting involved with life again and umm actually doing things. Just to sit at home and be completely isolated is that you know, that in itself is god you know. It's, it's own problem and at some point you need to take that step and get involved with doing something umm, to function again"* [Mentor ♯3]

Having a project to structure their week around appears to facilitate recovery as it gives them a positive focus to the week and reduces their

propensity to return to alcohol and/or drug use. The recovery-orientated, time-filling activities are substituted for their former alcohol and/or drug use, meaning that each service user can structure their week around the time-filling activities, thus reducing the impact of boredom.

Furthermore, having something positive to focus on each week serves to keep the momentum of their recovery going and reduces periods of spare time where they might get bored. Kevin explains that he looks forward to Friday afternoon's "meet 'n' greet" as he sees it as a positive focus in his weekly schedule:

> *"Its always here, there's always something you can do, or there's activities and things. And you know you come Friday... you might be going to the cinema or you might be off on a trip, they might meet up on a Sunday and go for a walk or something you know, it's, it's, it keeps you focused I think"* [Kevin; service user]

All the service users explain that they receive genuine enjoyment from participating in the activities:

> *"I come to the ladies meeting at LTLA, which I really, really enjoy coz the ladies I've met have just been so brilliant. We do certain things, this, this week we're going for our nails doing, been ont boat trips, going to the theatre and some of us afterwards we go for a coffee in town and go our separate ways but I really enjoy that"* [Barbara; service user]

> *"Yeah, so I been coming for some considerable and I really enjoy it, it's something to look forward* [to]*. On a Friday, I love Fridays and coming on the trips and even ten pin bowling, it's fantastic"* [Clive; service user]

The genuine pleasure that the service users appear to get from socially interacting with others whilst participating in the activities is potentially quite a powerful concept. For many of the service users, despite committing to recovery,

their addiction past is still very much a part of their present and appears to still impact on their lives on an almost daily basis. Therefore, having pleasurable activities to focus on and attend throughout the week provides them with some respite from dealing with the social and physical fallout of their addiction. The activities provide the service users and mentors with the opportunity to try new, novel activities that potentially broaden the mind as my second observation at the opera in Leeds highlights:

My initial thoughts of the service users going to the opera were in retrospect quite narrow-minded, as I did not think they would enjoy it. To me, going to the opera is not something I would do in my spare time and thought the same might be the case with the service users as it was maybe too cultured and quite frankly, boring. I thought to myself that the opera is quite an acquired taste and so for a recovering service user who have otherwise led fairly chaotic lives, to sit down and watch a two and a half hour opera is not something that would appeal to the service users and ultimately it did not appeal to me… I went and sat down – I was on the end of the row next to Ryan, a recovering problem drinker. I sat down and said "have you been to the opera before" and he replied "no" but it is something he was interested in as it was different to what he might normally do which I agreed with… At the end of the performance, I was standing outside the theatre with mentor #1, Ryan and James and we had a brief discussion on what we thought of the play. James made the comment that he was going to initially come as he had never done it and thought the opera was not something he would like, as it was 'upmarket'. He continued to say however, that he really enjoyed it, much more than he thought he would and that given the troubles he had been having with his ex-wife over house payments, he found the opera a great release as it had opened his eyes up to something he never knew he would like. [Observation 2: 12th January 2012]

James and Clive also explained to me that they liked the variety of the activities that the project offers as it has 'opened their eyes' to activities they would never have tried, and therefore never discovered they enjoyed:

> *"It opens your eyes to different aspects and stuff like that you know, it's nice to have a day out like* [the] *canal trip, that's a nice day out just sat on a barge chatting and that, it's great yeah"* [James; service user]

> *"Yeah, as well as umm, finding more information about different things in life, such as* [the] *picture house you know, going down there, then the cinemas, going* [on] *away trips"* [Clive; service user]

By 'broadening the mind', one becomes more aware of activities they enjoy doing which they previously would perhaps never have considered. 'Broadening the mind' serves to not only induce positive feelings, but also consequential personal resources such as mindful attention, self-acceptance, positive relations with others and good physical health (Fredrickson et al., 2008). Such personal resources are likely to contribute significantly to the 'recovery capital' proposed by Cloud and Granfield (2008) that dictates recovery will be more effective, the more recovery capital they have access to. The project is not just a positive focus for those who are unemployed or retired, as Kirsty explains:

> *"Well I'm busy at work all the time and yes, I do enjoy coming here and it's just nice. Like meeting up with friends, you don't feel as though you're coming somewhere what's helping you, just like a coffee morning with friends, that's how its become... It's just chit chat and if you wanna mention something like this 'o god remember in this situation I'd have been like that' you know so, its, even if it might come up in conversation. No it's just general talking, what you would do if just like meeting somebody in a cafe, your neighbours or weekly coffee mornings or something"* [Kirsty; service user]

Kirsty's extract is indicative of all those who are either in employment or are retired. Kirsty sees the project as a social meeting place indicative of any coffee shop 'normal' people in public might meet up with friends. Kirsty, like a minority of others who have busy lives outside of the project, perhaps view the

project as a way to relax and interact with friends. Not only does the project seem to provide the service users with a sense of social stability, it perhaps transcends this to act almost like a *protective* community where they know they will not be persecuted for their addiction pasts. This has two diametrically opposed implications. On the one hand, the protective nature of the project allows for social interaction to occur without fear of persecution or discrimination from others. This will provide a stable foundation for a new self and positive identity to be built upon which will further delineate their addiction pasts from their recovery futures.

On the other hand, the protective nature of the project could serve to keep individuals entrenched in the group, as it becomes a seemingly more attractive alternative to reintegrating back into mainstream society where they are exposed to numerous sources of stigma that may significantly hinder recovery trajectories. Furthermore, remaining within the safety of the LTLA project may serve to alienate the very community that the LTLA project is trying to help reintegrate people back into i.e. mainstream society. In this context, mainstream society becomes the 'outsider' (Becker, 1963). They are considered 'outsiders' principally because they have never suffered with an addiction and are therefore not eligible for LTLA project membership, thus rendering them 'outgroup' members (Aronson, Wilson & Akert, 2005). Stigmatised groups often engage in stigma-related processes with regards to those who are not stigmatised (Link & Phelan, 2001), thus making mainstream society a perceived stigmatised group from the viewpoint of those in the project. Combining this with the projects community solidarity, strong 'ingroup favouritism', social stability and a social platform to interact without fear of stigmatisation, prolonged attachment to the LTLA project is a possibility. The final section to be explored is *power*.

7.6 Power

The rationale for exploring the concept of *power* is because it is a collective property of societies or social groups of cooperating 'actors' who collectively empower and discipline others (Scott, 2001; 2006). Foucault argued that power generally operates through processes of socialisation and community

building that produce individuals as subjects with specific mental orientations and actions (Foucault, 1982); a feature that has particular resonance within the LTLA project. Furthermore, some of the most effective forms of power are exercised by those individuals who have managed to exercise self-discipline over their behaviour, and conform without the need for any direct action from others (Scott, 2001; 2006), for example, those in recovery from addiction. In its most general capacity:

> *"… social power is an agent's intentional use of causal powers to affect the conduct of other agents… one of who is the 'principal'… and the other is the 'subaltern'… the principal exercises power, while the subaltern is affected by the power of the principal"* (Scott, 2006; p. 127).

Taking these points into consideration, it is plausible to suggest that the LTLA project may involve power relations that occur as a result of a perceived hierarchy that includes the mentors, service users and, perhaps, the professional staff. This could produce a social situation comprising of 'principals' (the professional staff and mentors) and 'subalterns' (the service users). Alison articulated something similar:

> **Me: Do you think there is a barrier [between service users and mentor]?** *"Yeah, although they have been in the same boat as us, I think there's a line there, somewhere. An example is I just met a lady today who I haven't seen here* [at the LTLA project] *for absolutely ages and she hasn't been for nearly a year because she came on a Friday and nobody spoke to her, not even a mentor and that's not good is it… yeah, so maybe there is* [a line] *but I suppose not with everyone because the mentors are everybody's friends as well."* [Alison; service user]

The 'line' that Alison refers to is arguably a reference to the 'mentor role', a role that demarcates their status from that of the service users. Referring back to section *5.4.1*, the mentors were the cohort of individuals who originally decided on the LTLA project being abstinence orientated. Discussed in an earlier

section (see section *6.5.1*) the ‘mentor’ label creates a different social role to that of the service users, which given the power it instils in each mentor to overcome their addiction, it also potentially gives them power over those who are not labelled ‘mentors’, for example, the service users. Furthermore, the committee meeting that takes place between the mentors and professional staff every Friday afternoon to discuss the project is referred to as the ‘mentor committee meeting’, as opposed to a more neutral title such as ‘the LTLA project meeting’. The ‘mentor committee meeting’ title arguably reinforces the social position of the mentors above that of the service users thus serving to reinforce their potential position of power in the project.

The ‘mentor’ label potentially does this through a type of power called *persuasive influence* (Scott, 2001; 2006). *Persuasive influence* is defined as:

> *“… the rhetorical use of arguments, appeals and reasons that will lead subalterns, by virtue of their socialisation, to believe that is appropriate to act in one way rather than another”* (Scott, 2006; p. 129).

It includes four main forms of power, the first two of which are *expertise* and *command*; two discursive processes which Weber referred to as ‘domination by virtue of authority’ (Schluchter, 1989). *Expertise* and *command* are structures of authority that influence others through commitment, loyalty and trust (Scott, 2001; 2006), which in the context of the LTLA project is evident throughout many of the narratives.

The commitment each service user has not just to recovery, but to the LTLA project also, combined with the loyalty and trust (discussed in section *7.2.1*) that service users seem to feel toward mentors instils a perceived sense of ‘mentor power’. This was captured during one of the mentor committee meetings:

An example of the mentors power was overheard during one the mentor committee meetings. I was informed by [the coordinator] *and mentor #4 that they*

had been on a day outing to Bridlington to have a wander around the beach and to get some fish and chips and ice cream. However, [the coordinator] *mentioned to me that half way to Bridlington in the car, one of the service users mentioned to another service user that they had been drinking. This service user was new to the group and the activities so informed* [the coordinator] *and mentor #4 of what the man had said.* [The coordinator] *said to me that she and mentor #4 immediately confronted the man who admitted to having a bottle of wine in his bag.* [The coordinator] *said that mentor #4 made it abundantly clear that the rule was abstinence and that he would have to get the bus home once they got to Bridlington. Mentor #4 told me that as soon as they got to Bridlington, they went to the bus stop and found which bus he needed to take back to Leeds. This was possible as the man had enough money to catch the bus.* [The coordinator] *explained to me that this was an isolated incident and that at no point in the past had any individual actively been drinking on the activities.* [Mentor committee meeting; participant observation: 9th August 2013]

Whilst the mentors may only overtly exercise their powers fleetingly (for example, preventing a service user attending an activity if they are intoxicated, or asking a service user to leave an activity if found to be intoxicated), they are still in possession of potential power over the service users, as a result of their role as a mentor in the project. Whilst the above extract demonstrates an example of the mentors 'intentional' (see Scott (2006) definition above) use of power, in reality this does not occur often as those who attend the LTLA project abide by the rule of abstinence. This suggests that whilst they have been 'given' power with their mentor identity, it is rarely exercised. It is important to note that fundamentally the LTLA project is an aftercare service designed to provide individuals with the chance to help each other, and whilst the mentors do potentially have power over service users, it is very much a democratic group[13].

The remaining two forms of persuasive influence are *signification* and *legitimation*; discursive processes that operate through shared meaning (Scott,

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[13] For example, the service users provide ideas for future activities in conjunction with the mentors suggestions. They are then debated within the mentor committee meeting.

2001; 2006), which in the context of the LTLA project is a shared meaning of abstinence and recovery. Through the socialisation that takes place between the service users and mentors at the project, the culture of abstinence and recovery is negotiated through social interaction, as they each seem to personify that very culture. Signification and legitimation work throughout the LTLA project as each service user and mentor articulated a fundamental belief in the culture of abstinence. This is important as it not only demonstrates the power that it instils in mentors (as there is a shared view amongst the service users that mentors are examples of recovery) but also the perceived power it potentially instils in the service users. Each member's 'moral obligation' to uphold the project's culture serves to empower each member as a type of 'moral police officer' which keeps other peoples actions congruent with the culture of the group.

From a symbolic interactionist's perspective, the moral codes and cultural norms of the LTLA project's social community are upheld by successive 'definition(s) of the situation' made by the project's members which establishes socially acceptable behaviour in the group (Thomas, 1923) i.e. abstinence. From a structural symbolic interactionist perspective, the shared *meaning* between the identity of recovery and behaviour serves to empower each individual as a type of 'moral police office', as they are each able to reflexively verify *their* self-in-role (Burke & Reitzes, 1981). Having such autonomy over *their* own actions instils a sense of power *within* each individual, as they can self-control and self-direct *their* own behaviour to align with the recovery culture that subsumes the group. Whilst the LTLA project is considered an 'ex-service user led' project, the question that remains is to what extent is it 'ex-service user led'?

7.6.1 A professional influence

Clinician ♯2 explained during her interview that she and clinician ♯1 have the power to shut the project down in extreme circumstances:

> *"I suppose you know if things were looking as if they were going horribly wrong and they* [the mentors] *were making horribly really bad decisions, if*

things went really wrong, it would be my responsibility to, I would feel it my responsibility even to go as far as calling it a day" [Clinician ♯2]

This suggests that whilst the mentors run the LTLA project on a daily basis, the overall power lies with clinician ♯1 and clinician ♯2, which does raise questions as to the extent it is an 'ex-service user' led project. The answer appears to be twofold. On the one hand, the daily operation and running of the project, the activities they offered and the actual 'hands on' contact with the service users were most definitely the domain of the mentors. The service users who were part of the LTLA project had virtually no contact with clinician ♯1 or clinician ♯2, unless they were their designated members of professional staff they encountered during professional treatment. This was corroborated by the fact that in many of the mentor committee meetings, both clinician ♯1 and clinician ♯2 were unaware of how many service users attended the LTLA project and were seemingly not aware of who each service user was. From this viewpoint, the LTLA project can be considered an 'ex-service user' led project. On the other hand, the power that clinician ♯1 and clinician ♯2 both have to close the project down implies that the overall power lay in professional hands.

Based on observations at the project, the LTLA project most likely works as well because of the 'behind the scenes' input from clinician ♯1 and clinician ♯2. Whilst the mentors run the project on a daily basis, they receive guidance from the professional staff in areas that are perhaps unfamiliar to them. Furthermore, given the fact that the LTLA project operates directly out of the LAU, the professional staff have to ensure that the project is operating to the appropriate standards of the LAU. In this respect, the professional staff have to be involved. The final subsection to be explored is the idea of individuals feeling empowered by the project to fight their addiction.

7.6.2 'Counter-addiction'

The second type of power, which has more resonance for recovery, refers to one that is not necessarily between project members or between the mentors and service users, but against addiction. Researchers of power have long

emphasised that power is often met with resistance, which in itself, is a form of power (Lukes, 1974). It is known as *counteraction* and is considered power from below, rather than above and derives its significance from united subalterns (Scott, 2001; 2006). In general power research, counteraction often manifests itself through protest against pressure groups; for example the protest march of students against the coalition governments policy to raise university tuition fees in 2010. In this research however, counteraction takes on a different manifestation: counteraction against addiction, which I will term *counter-addiction*. 'Counter-addiction' is different to pressure groups in traditional power research, as they typically take physical form such as governments or repressive religions, whereas in this scenario addiction, a ubiquitous term that has psychological and social connotations (as well as physical) is the pressure group.

Many of the participants referred to a sense of powerlessness against their addiction:

> *"People say you control yourself in drink. I totally disagree with that, I were totally out of my head. I didn't even know what I were doing"* [Barbara; service user]

Throughout the literature, expression of powerlessness against addiction is a common discourse that many addicts and recovering addicts articulate. Based on this premise, a perceived (unintentional) function of the LTLA project that has seemingly developed, as a result of social cohesion, is collective 'counter-addiction'. Scott (2006) states that counteraction is most important when done in a collective group, which in the case of this research is the collective group of the service users and mentors of the LTLA project. The 'pressure group' in this scenario is addiction and the 'protest group' is the LTLA project. Rather than the source of power coming from 'below', it comes from *within*. Not just from *within* the social interactions of the group, but from *within* the individuals self. The individual members of the LTLA project unite together through peer support, which is founded on a non-stigmatising culture of firsthand experience, which empowers each individual to tackle addiction. This

was articulated throughout many of the narratives in the form of enhanced self-confidence, a trait, which stems from a rebuilding of self. Mentor ♯1 explains:

> *"I asked* [her old boss at the theatre] *if I could get some dress rehearsal tickets and umm, he said yeah… I had to face the company manager to collect the tickets and I had to, I had to see people I used to work with and by the end I was drinking alot at work umm, quite noticeably I think. But umm, but gradually I've been able to, I've been able to stop and chat to people and look them in the eye"* [Mentor ♯1]

The ability of mentor ♯1 to confront those she encountered during her addiction is potentially quite a strong source of empowerment, as it provides her with the ability to actively participate in her own recovery (White, 2002). From a Goffmanian perspective, it relates to her presentation of self. To recap, Goffman saw self as two interacting regions; the 'frontstage' where behaviour is publically visible to other social agents and the 'backstage' where behaviours can be performed out of view of public scrutiny. Implicit in the idea of 'backstage' is the notion of a 'true', 'authentic' self that is rarely expressed publically (Goffman, 1959). During her addiction, mentor ♯1 explained that she tried to conceal her excessive drinking, as she did not want others becoming aware, which meant she would drink alone, or conceal her drinking under the guise of 'not drinking':

> *"During the last couple of years at work I mean I had a Volvic bottle, but a Volvic bottle of vodka in it and you know… I had an office"* [Mentor ♯1]

From the viewpoint of self, the private self, the 'I', is the focus of autonomous agency, an entity distinct from any role played publically. Such autonomous agency enables an individual to make decisions and choices on which impressions are managed or manipulated in role performance (Goffman, 1959) i.e. *we* choose which 'self's' to present to other people (Elias, 1994). Goffman used this concept to suggest that individuals can seek distance between roles which must be enacted but do not wish to be identified by others (Goffman, 1959). For Mentor ♯1, she concealed her alcohol dependency, as she did not want

to be identified as an 'addict' by others. In this instance it reduced her propensity to have to manage self as concealment from society arguably reduces the impact of the 'me' (the moral and social norms learned through interaction), thus making their autonomous, 'drinking-focused' 'I' the dominant force of self. As a result, her role as 'an addict' remained hidden from public scrutiny. However, as her addiction worsened, mentor ♯1s 'backstage' addiction began to spill out onto the 'frontstage':

> *"Then I started just thinking, you know coz I had an office, just half a bottle of vodka in my handbag and didn't even bother decanting it... in those last few weeks I was falling to pieces"* [Mentor ♯1]

As a result, mentor ♯1s addiction became public knowledge, which not only alienated herself to stigmatisation but also served to render her powerless against her addiction. The publication of her addiction readdressed the balance of her 'self' (the 'power' of the autonomous, impulsive 'I' over the social 'me' that infers appropriate social and moral conduct weakened), which rendered her power and control over her addiction void, as she no longer had control over her addiction or over those who knew about it. Her true 'backstage' self, which reflected problematic drinking was no longer private and people came to see her 'for who she *really* was'.

During her recovery at the LTLA project however, mentor ♯1 began to build a new sense of self, founded on moral codes and norms of recovery and abstinence; a sense of self, which, during her time at the project not only enhanced her confidence but also became her fundamental self seen by others. Referring back to the idea that counteraction against addiction comes from *within*, the LTLA project appears to help loosen the power of addiction over people by providing a collective support structure in a non-stigmatising environment, that empowers individuals in their recovery by rebuilding a 'new' sense of self founded on a culture of abstinence and recovery. As a new sense of self develops over time, domains such as self-confidence begin to develop, as there is a harmony between the fundamental actions and impulses of the

individual, the "I", and their moral codes and norms they have built up through reflexive awareness and social interaction with significant others, the "me". As each member of the LTLA project is arguably going through this same process of rebuilding a new sense of self and identity, solidarity is maintained between group members as they are all striving for the same goal: to beat addiction. This has the effect if coordinating collective action (Scott, 2006), which serves to empower the LTLA project and its group members.

It is important to note that the story of mentor ♯1 is very much an example of successful recovery, a story that for many, may not be achieved. In reality, addiction can be so severe so some people that achieving a sense of stable recovery is not only unthinkable, but likely unattainable. The purpose of this subsection was to demonstrate that through the collective nature of the group and the supporting nature of others, a sense of power or 'counter-addiction' can be achieved for some.

7.7 Concluding comments

Throughout this section, many of the data demonstrate the benefits of the LTLA project to facilitating recovery from addiction. The firsthand experience of 'what it is exactly like to recover from substance-dependency' makes the LTLA project a source of 'experiential knowledge', which differs from that of lay knowledge and professional knowledge of addiction. Firsthand experience enables each service user and mentor to take the *perspective* of another, which builds *trust*, thus allowing each of them to 'understand' others addiction pasts despite having no direct experience with the individual. In many cases, this appeared to have significant benefits for recovery: more so than friends and family and professional support. The data also highlight that firsthand experience of addiction and recovering from addiction seems to make the service users of the project non-judgemental to others and that each service user is taken at face-value and not judged on their past. Whilst this is true, it was also explained that this finding must be taken with some degree of caution. It may be true that the general culture of the LTLA project is socially equal and non-judgemental, but it is not possible to claim that the service users and mentors

feel they are not judged at all within the LTLA project. The importance of addressing the stigma of recovery was also raised as there were some who felt judged for their commitment to recovery.

The peer support that all the service users and mentors receive from one another appears to be almost invaluable for recovery development, as the support is based on shared experience of being substance dependent and what it takes to 'recover'. Those with a more holistic support structure from friends, family and where necessary, professional support (the 'goldilocks group') appear to make more greater progress in their recovery trajectories than those who under-engage or over-involve with the project, as they do not rely on the LTLA project as their only form of support. The fourth section argued that the regularity and consistency of the activities helps to alleviate feelings of boredom, and instils a sense of structure around which service users can organise their time effectively. Furthermore, it was argued, social stability in conjunction with the firsthand experience, non-judgemental culture and peer support of others provides 'protection' from others outside the project who do not grasp the culture and meaning of the project.

It became apparent during data collection and analysis that the LTLA project breeds a culture of not just having a group of recovering service users and mentors who are passive recipients of support, but also providers of that support; an element of many self-help support groups (Stacey, 1988). The final section explored the potential power relations that may arise as a result of the differentiation between the mentor role and the service user role. It is important to reiterate that whilst these power relations may be evident at times, it does not seem to be a common trait of the mentors and only do they exercise their power to preserve the culture of the group. It was also conjectured that the LTLA project in itself empowers individuals in their recovery by providing them with a social platform upon which they can rebuild a sense of self that enables them to not only enhance internal traits such as self-confidence, but to also counteract against the power of their addiction, a process I termed 'counter-addiction'.

Whilst it has been argued throughout the findings chapters that the LTLA project is beneficial for recovery as it provides a 'safe' social place for individuals to 'practice' their recovery', it has also argued that the project appears to hinder some individuals' reintegration back into mainstream society. The LTLA project ultimately provides its service users with a place to 'practice' recovery in a socially safe place. Individuals who repeatedly relapse are often those who have poor social support, social relations and social functioning, as they are significantly less likely to have stability during their recovery attempts (Hibbert & Best, 2011). The project provides each of these domains through its activity program, which is perhaps the reason why those at the project seem to benefit so much from the project. Whilst it has been argued that this may serve to keep them permanently connected with being 'in recovery', and therefore constantly connected with their addiction, if living a life grounded in the LTLA project prevents them from returning to substance use, is this such a bad outcome? Whilst there may be benefits for living a life in the context of the LTLA project, it perhaps restricts personal growth beyond recovery, which could become detrimental for life progression and could even be a risk factor for relapse as individuals experience feelings of un-fulfilment in life.

Identification with specific social groups serves to form the basis of networks of social interaction (Scott, 2006). Being a member of a book club, a political party, a sports team, a band, a fraternity, a religion or a recovery project all serve to provide specific, distinctive social interactions in the context of their social network. For those in society who participate in a variety of social groups, *their* identity will be shaped across the social interactions that take place within the group. Diverse, yet distinct affiliation with a variety of social networks is likely to become a source of holistic, personal growth as continual reconstruction of *their* social role in the context of the social situation in which they are engaging establishes a sense of social order and stability (Scott, 2006), which arguably fuels personal growth. Prolonged engagement and socialisation within the LTLA project arguably restricts personal growth as one's social role is continually reconstructed within the context of the project. This would arguably

have the effect of reinforcing not just their position within the project but also their identification being primarily rooted in recovery from addiction.

Furthermore, Coffey (2006) argues that we learn new skills and knowledge through socialisation, which if it is rooted in a recovery project, not only does one restrict their knowledge and skills to recovery, but they do not learn how to interact in mainstream society. Part of learning how to interact with mainstream society is learning how to deal with stigma and discrimination present in everyday life, something from which the LTLA project seems to shield its service users and mentors. In this respect, the community set up within the LTLA project is perhaps not representative of mainstream communities as it perhaps lacks comparable features. Taking these points together, prolonged engagement not only potentially restricts personal growth beyond recovery, but it could also be a potential source of relapse, as individuals experience a lack of fulfilment in life as they are confined to a small recovery project.

Whilst there are potential drawbacks of the LTLA project's recovery culture and community, it is important to reiterate that the LTLA project seems to be a successful 'method' of recovery. Throughout the data collection period, the benefits of the LTLA project were witnessed on a regular basis. The constant support that each service user receives from others who attend the project seems to be more beneficial to recovery than recognised professional treatment, as it is a support system based on shared, non-stigmatising, firsthand experience of addiction recovery.

Chapter 8

Discussion

8.1 Introduction

This chapter develops the thesis by discussing and interpreting the research findings and their contribution to wider literature and policy and developing knowledge of recovery and SHGs. This is achieved by examining the use of symbolic interactionism and its associated theories used for this exploratory study of recovery. A detailed examination of the methodology and methods used will provide a transparent account of how this research was conducted, which will in turn, provide an argument for its trustworthiness and credibility. A detailed analysis of the research findings in relation to developing knowledge and contributing to practice and policy supports the contribution of this work. Finally, areas for future research are suggested, to build from this study, alongside concluding comments.

8.2 Contribution of this thesis

This thesis supports the positive impact of the LTLA project for people recovering from alcohol dependency. In doing so, the processes of the LTLA project that produce this 'recovery' are presented and discussed in relation to relevant theory. This is the first exploratory study of a recovery project like this in the UK, thus demonstrating the original contribution of this research.

An extensive scoping review of the literature (presented in chapter *2*) found there was a gap in the evidence base with regards to qualitative research on self-help groups (akin to that of the LTLA project). The review also found a significant gap in the literature with regards to UK-based studies on self-help groups (either qualitative or quantitative), a gap also identified in a report from the ACMD (2012). Furthermore, the paradigmatic shift in policy over the past decade from conceptualising addiction as a crime problem to a recovery-focused

approach (White, 2004; White, 2007a; White & Cloud, 2008) supports the need for empirical research to understand the impact of SHGs on recovery from addiction. In conjunction with the lack of research on SHGs for substance addiction and the centrality of recovery in current policy, the concept of recovery, and how to define it is contested (Amering & Schmolke, 2009). This study takes an important step in addressing these gaps. By exploring the concept of recovery in an applied setting such as the LTLA project, this thesis represents an important contribution in an area where research is lacking but much needed to inform policy and practice (see section *8.6*).

8.3 Interpretation of the findings

The findings were presented in three chapters: the set up of the LAU and the LTLA project (chapter *5*), the impact of the project on the individual (see chapter *6*) and the collective impact of the project (chapter *7*).

From the viewpoint of the individual, the culture of abstinence and 'everyday experience' (chapter *5*) that envelops the LTLA project appears to contribute to the production of a 'normal' identity in many of the service users and mentors (chapter *6*). The LTLA project promotes this through the provision of 'normal', leisure activities taking place in mainstream society, which appears to facilitate a sense of social reintegration amongst service users (a recurrent theme throughout this chapter). By experiencing feelings of '*being* normal' and realising they can interact with 'normal' society without the need to resort to alcohol use, the service users' recovery and commitment to abstinence was described as being reinforced.

However, as it was suggested in section *6.2*, this sense of 'normal' social interaction with mainstream society is mediated through the LTLA project, so that whilst interaction is taking place *in* mainstream society, it is still taking place *within* the protective confines of the LTLA project. It was proposed in section *6.2* that this is not necessarily problematic for service users who continue to interact with mainstream society *outside* of the LTLA project, but can be problematic for those who become over-involved with the LTLA project. This is because whilst

service users may be 'doing' normal activities in mainstream society, they are continually doing so with a cohort of people who are perhaps considered not 'normal'. This could restrict identity transformation in recovery, as it leads to an identity built on continual socialisation with those in recovery, which in turn, keeps them connected with their addiction. This lends an alternative interpretation to the findings of section *2.3.4* in the literature review. These quantitative suggest that the more individuals in recovery one has in one's social network, the more positive impact this has for recovery trajectories. However, this research suggests that if an individual's social network consists only of recovering individuals, or is comprised of mainly those in recovery, then recovery is restricted. This confines social interaction to those who are in recovery, many of whom are likely to be experiencing complicated addiction issues themselves. This could have two consequences.

First, having a social network and relying on peer support from others in recovery could place greater burden on those from whom they seek support; a situation that could impact detrimentally on the recovery of these service users. This is a situation that was found in this research, as there was one service user who articulated that she felt 'under pressure' to be able to lend constructive and helpful support, in order to reciprocate the support she received. Experiencing such pressure could lead to pernicious effects such as an increased preoccupation with alcohol, or worse, relapse. Second, based on the theoretical premise that identity is a wholly social process (Nettleton, 2006; Jenkins, 2008), continual social interaction with those in recovery will likely result in an identity based on such interactions. This could lead to their primary identity being one defined by their recovery, which in turn, keeps them indirectly connected with their previous 'addict identity'. It should be noted therefore, that whilst the LTLA project makes contributions to social capital by providing a social network that participates in pleasurable activities within mainstream society, its impact on identity is always likely to be limited. This is because the extent to which the LTLA project contributes to a 'normal identity' will always be restricted by the fact it is fundamentally a recovery project that deals with people considered 'un-normal'.

From a methodological point of view, this finding implicates the importance of both quantitative and qualitative research. Whilst the quantitative research demonstrated the importance of the composition of a recovering individuals social network, it was the qualitative research used in this thesis that highlighted the potential dangers of having too many recovering users in their social network.

Chapter 6 suggests that the LTLA project effectively 'favours' the recovery of its mentors, as it provides them with greater sources of recovery capital (Cloud & Granfield, 2008), in particular, the chance to provide support and advice to others. For mentors, the notion of 'giving something back' was readily apparent, and was articulated as one of the greatest facilitators for their own recovery. This appeared to be because the 'mentor' role provided them with a source of self-satisfaction and a sense of 'righting the wrongs' they caused during their addiction. Whilst a 'non-addict' identity appeared to be magnified in the mentor group, service users also seemed to benefit by having access to a project that facilitates recovery, as well as having access to a potentially vital network of peer support. Most of the service users explicitly mentioned the importance of the mentor team for their commitment to running the LTLA project and for the peer support they provide. The implications of using a team of mentors to run the LTLA project are discussed in section *8.6.6* when exploring the impact of this research on UK drug policy.

Chapter *7* addressed the collective impact of the LTLA project. It was found that the LTLA project appeared to be a safe, non-stigmatising, social environment of peer support in which service users could practice their recovery. This was instilled through the activities that the LTLA project provided, as it decreased feelings of boredom, provided a sense of structure to their week, gave service users and mentors 'something to do', and provided them with a space where they can practice their recovery. This in turn, appeared to facilitate individual self-development in recovery, as service users believed that they would not be judged for their addiction pasts, or even potential relapses in

their recovery. Of particular importance for many of the service users recoveries was the peer support from the mentors and the social network of the LTLA project. Taken together, these findings suggest that the LTLA project is a significant source of social capital, as it provides each service user with supportive relationships and a source of social interaction that seems to benefit recovery.

However, continuing on from points raised above with regards to social network, it is important to state that the social network of the LTLA project is situational. It is situational in the sense that the impact of the LTLA project is likely to have little impact on service users lives outside of the project. This was exemplified by one service user who explained that when he was in the company of certain individuals who drank, he too drank. When asked during the interview what his goal in recovery was, he stated total abstinence despite disclosing that he sometimes drank outside of the LTLA project. This suggests therefore, that whilst the LTLA project may provide a positive source of social capital through peer support and a recovering social network, this is likely to be limited to the LTLA project. It thus differs from a residential rehabilitation intervention where service users have access to support and care at all times (NTA, 2012a). It is an ex-service user group that only operates within specific hours meaning that outside of those hours, the influence of the LTLA project is likely to play a lesser role in the context of service users' lives. Nonetheless, the LTLA project provided activities most days during the week, which often lasted several hours. Compared with formal addiction treatment, this represents a very high level of contact.

For those who placed great emphasis on the LTLA project for their recovery, the findings also appear to suggest that the social environment of the LTLA project leads some to become over-involved. Given the potential implications of this finding, closer scrutiny of this interpretation is warranted.

8.3.1 An over-involvement to the LTLA project

As a result of the LTLA project producing a safe, social environment where individuals can interact with others without fear of being stigmatised over considerable periods of their free time, some seem to 'over-involve' with the LTLA project. 'Over-involvement with the project' refers to those who have been a member for some time and are showing no signs of moving on from the project, and involve themselves with as many of the activities as possible. This is an empirical finding that can be interpreted through the theory of 'positive' and 'negative' recovery identities (White & Kurtz, 2006).

White & Kurtz (2006) suggest that a 'recovery positive identity' is one whereby an individual openly acknowledges a lifelong status of recovery, whereas a 'recovery negative identity' is one whereby an individual conceals their recovery status so as to prevent others sharing any perceived sense of shame. However, the 'recovery positive identity' is founded on a continual identification with a problematic experience and may make it difficult to move on from their addiction past (Koski-Jannes, 2002). This could result in the identity of a 'saved sinner', or from the viewpoint of those who provide support (such as the mentors) as a 'wounded healer' (White, 2000a). In either case, the individual defines their 'self' by their addiction, thus preventing the potential development of other more positive identities and greater social (re)integration (Measham, Moore & Welch, 2013). These cases were evident at the LTLA project. For those who became over-involved with the project, an identity appeared to develop based on social interaction with other recovering service users. Whilst this does not necessarily result in a 'saved sinner' or 'wounded healer' identity (White, 2000a), it does result in continual identification with those who symbolise and personify problematic past experiences surrounding addiction. This in turn keeps individuals who over-involve with the LTLA project connected to their addiction via their social interactions in recovery, thus potentially impacting on wider social (re)integration.

This finding provides a more nuanced argument to section *2.3.2* of the literature review. The quantitative studies described there point to the importance of active involvement when present at a SHG, as it is through active

involvement that an individual benefits more that just attending a recovery SHG (see section *2.3.1*). This research however, suggests that whilst involvement is an important component of recovery, 'over-involvement' appears to have detrimental effects on recovery. Like the discussion on the composition of social networks discussed in section *8.3*, 'over-involvement' with a recovery SHG such as the LTLA project serves to keep one continually connected to their recovery, thus hindering personal development in recovery. This interpretation is hypothetical, as it is impossible to state (based on this research) if 'over-involvement' in the LTLA project actually results in 'under-involvement' with mainstream society outside of the LTLA project. However, given that some of the service users attending many of the LTLA project's activities reported having very few social networks and interests outside of the LTLA project, this is an issue demanding further exploration.

The implications of this are that service users may be held back from moving on from their recovery, which could restrict their 'self-development' and in certain cases, could be a precursor to relapse. This is a potential weakness of 'communities of recovery', as they serve as a potential source of connection with their addiction past, and could prevent people from 'moving on'. Ironically therefore, whilst the goal of the LTLA project (see section *5.4.2*) is to help people move on from their addiction pasts, for some who have very little outside of the LTLA project and therefore become 'over-involved' in order to fill the apparent void in their life, involvement may represent a more positive form of dependency. This conjecture requires further clarification.

Whilst there seems to be very little research on dependency on SHGs in the addiction world, research in the mental health arena does provide some parallel insights. In his work investigating dependent personality disorder (hereafter DPD), Bornstein (1993) states that many with DPD often exhibit signs of alcohol dependency. Furthermore, with regards to treatment for DPD, Bornstein (2005) also found that those with feelings of dependency (such as those exhibited by problematic alcohol users) often become over-reliant on their therapist for support. Harrison (2011) corroborated this finding when she found

that those with feelings of dependency often referred to their therapeutic relationship with their counsellor as *"fundamental"*, *"essential"* and *"the bedrock"* of their support (Harrison, 2011; p. 147).

Bornstein (2005) writes that 'dependency' in the context of DPD pertains to issues surrounding a need for support from others, perceiving oneself as powerless and a tendency to becoming anxious when asked to function autonomously. The data collected for this study suggests that many experienced a sense of powerlessness in their addiction, resulting in a need for ongoing support from other members of the LTLA project. It is therefore plausible that some could become dependent on the LTLA project. Based on the notion of 'over-involvement' (particularly section *7.4.2*), I propose a 'stages of recovery' model, which identifies where on the recovery spectrum a service user could be conceivably placed.

8.3.2 The 'stages of recovery'

'Over-involvement', in the context of this research, reflects the reality that for many in the early stages of recovery, greater support is needed. The 'stages of recovery' model proposed here may help to delineate recovery more effectively, thus making it easier to identify the needs of individuals at each stage. Despite this research being cross-sectional, the interviews were conducted with service users and mentors who spanned the spectrum of recovery (see table *4.2* in section *4.3.9*). Interviews were conducted with service users who had just come into the LTLA project, as well as with service users and mentors who had been attending the project for some time. As a result, the 'stages of recovery' model presented below is based on data that comes from participants who span the recovery spectrum. Based on the findings of this research, I propose that recovery be viewed in three distinct stages:

- **Stage 1: Active recovery**
- **Stage 2: Sustained recovery**
- **Stage 3: Passive recovery**

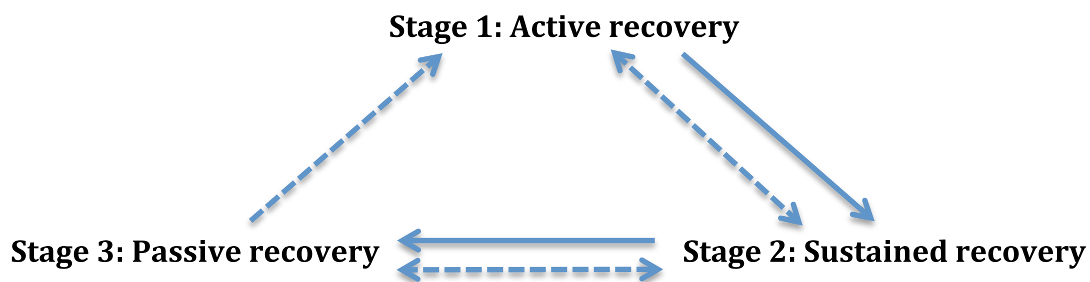
'Active recovery' relates to those who are in recovery and making a commitment to abstinence but are still consciously managing their addiction on a daily basis. Whilst they are making conscious efforts to remain in recovery, service users in the 'active recovery' stage are still beset by the thought of alcohol and drug use. The service users most indicative of this 'active recovery' phase are presented in section *6.4.1.2*, *7.4.1* and *7.4.2*. They represent those who despite efforts to maintain their recovery still require professional support and peer support from the LTLA project to actively manage their desire to drink. Interestingly, whilst many who fell into this 'active recovery' stage were at the start of their recovery journey, there were some who had been 'in recovery' for quite some time and shown a commitment to abstinence, but were still consciously preoccupied with alcohol. This suggests therefore, that the 'active recovery' stage is not restricted to those who have just entered recovery (although this cohort are most likely to be in this stage), but it includes any individual who still has a preoccupation with drink, and managing their addiction.

The second stage relates to 'sustained recovery', a stage characterised by sustained abstinence and a reduced preoccupation with alcohol or drug taking, and actively attaining personal goals to contribute to their recovery capital that an individual has built up during their recovery. Section *7.4.3* represent those most indicative of this stage. The data in this section demonstrates that positive steps in recovery are being made, but that the perceived threat of alcohol or relapse requires support from the LTLA project in order to maintain their recovery. This stage represents those who are managing to maintain a good balance between their recovery and their life outside the LTLA project, which together, facilitate abstinence and recovery to be sustained. It is perhaps a stage marked best by the fact that service users are heading in the right direction, but still require some support and need to demonstrate further commitment in terms of time to their recovery before they can move onto the 'passive recovery' stage.

The final stage relates to 'passive recovery' (for example, the mentors), a stage whereby individuals no longer consciously think about their recovery and are at a stage in their life where recovery no longer defines their actions or thoughts. This final stage is different to the first two as it represents a stage in recovery whereby recovery itself is no longer a conscious thought process. Section *6.4.1.1* represents those who are most like this. In the context of this research, this final stage of 'passive recovery' is primarily reserved for the mentor team, as they have demonstrated years of commitment to abstinence, and in most cases, are not consciously aware of their recovery.

It is important to state that the 'stages of recovery' model presented here is not always a linear process. Figure *8.1* schematically represents how the 'stages of recovery' model should be conceived.

Figure 8.1: The 'stages of recovery model'



The solid blue line represents what might be conceived as an ideological recovery trajectory. It represents a service user that makes a linear transition from active to sustained to passive recovery without regression to previous stages. Given the complex issues surrounding addiction recovery and relapse however, the dotted lines represent a more realistic, non-linear pathway in recovery. The dotted lines represent that it is possible to move forward or backward in recovery depending on the state of the individual. When considering relapse, the impact of how relapse might impact on the individual is dependent on the extent and severity of the relapse period. For example, if an individual in 'sustained' or 'passive' recovery relapses, but immediately recognises the implications of their actions and makes concerted efforts to

rectify their relapse, they do not necessarily regress a stage. However, if the relapse persists and is continued over an extended period of time, it perhaps demonstrates that an individual requires additional support to help rectify and facilitate their recovery, thus meaning the do regress to an earlier stage. As mentor 4 explained in section *6.4.1.1*, she was abstinent for thirteen years but relapsed for approximately three months, which resulted in her needing professional intervention to help combat her relapse. It is important to note that this model represents just one potential way to conceptualise how people might differ in recovery and the needs they require in order to progress further in their recovery. Further research is needed to provide more evidence on the applicability and usefulness of this model.

The only other known model that appears comparable to this proposed recovery model is Prochaska and DiClemente's (1985) transtheoretical model of change, a model which to date, has received great praise for its conceptualisation of recovery on a cognitive level (West, 2006). Whilst they propose six stages, only stages four and five map onto the proposed 'stages of recovery' in this thesis. Stage four is their 'action stage', a stage marked by a focus on overcoming addiction and making real behavioural changes to meet such an end. This stage would map onto my 'active recovery stage' as it reflects a change in thought process to enable 'active recovery'. The fifth stage of their model is the 'maintenance stage', a stage marked by remaining abstinent in the face of potential life stressors. They also state that this stage is marked by new ways of thinking so that substance use is not the first response when faced with difficulty. This stage maps onto my 'sustained recovery' stage principally because they both advocate that abstinence is being maintained, but that an individual is still 'practicing' their recovery. Prochaska and DiClemente's (1985) model offers no stage comparable to my 'passive recovery' stage, but I propose this as the stage beyond their fifth stage.

It is important to note that the 'stages of recovery' proposed here are not a replication of the transtheoretical model. The transtheoretical model specifically relates to the cognitive stages an individual goes through when

approaching and attempting recovery. The 'stages of recovery' proposed here, pertain more to socio-cultural stages and should be considered more broadly relating to different stages *of* recovery, as opposed to individual changes whilst *in* recovery. It should also be noted that the 'stages of recovery' proposed here are based on the current view of recovery which places abstinence at its centre (White, 2007a; McKeganey, 2012). Those who advocate moderated outcomes may take issue with the 'stages of recovery' model. Whilst this thesis offers only the start in terms of empirical work to support each stage of the proposed 'stages of recovery' (but therefore an opportunity for future research – discussed in section *8.7*), the data does suggest that there are those who can be attributed to the different stages. Breaking down recovery into more 'manageable' and potentially empirically testable components may make it easier to produce a definition of recovery which to date, has remained a fairly elusive prospect (Amering & Schmolke, 2009). The implications of this 'stages of recovery' model for policy is addressed in section *8.6*.1.

Overall the implications of these findings are that recovery should perhaps not be conceptualised as one 'entity', but a series of different stages. The study data stem from a cohort of individuals who span an array of different points in recovery, all of whom seem to require different forms of help. For example, those at the beginning of their recovery may require greater professional help, whereas those in the latter stages of recovery may require less professional intervention and more help seeking employment for example. This thesis provides a conceptual model of the stages of recovery from which the idea can be empirically developed and tested. Having interpreted the main findings of this research, the next section addresses points relating to the use symbolic interactionism as the theoretical framework for this research.

8.4 Theoretical engagement

This section critically evaluates the theoretical framework used in this thesis: symbolic interactionism. Theoretical frameworks give direction to a line of inquiry, without which, there is a vast array of possibilities to interpret the social world (Stryker & Vryan, 2003). The use of symbolic interactionism as a

theoretical framework provided this research with a structure for understanding and explaining the social world, and thus to analyse and interpret the data based on a guiding set of principles.

There are some commentators who criticise symbolic interactionism for being 'untestable', as it only offers explanations of the social world as opposed to directly testable theories (Stryker & Vryan, 2003). However, it can be argued that theoretical frameworks can be tested by their ability to *produce* empirically testable theories rather than by their ability to be directly tested themselves (Stryker & Vryan, 2003). Given that there were a number of 'symbolic interactionist-derived' theories used throughout this research relating to 'self', 'identity', 'social interaction' 'culture' and 'community', the use of symbolic interactionism in this research is justified. Its use is further substantiated by its use in a wealth of previous research areas comparable to this thesis, for example, the highly influential studies of deviancy that can be traced back to symbolic interactionists such as Becker, Goffman, Liewbow, Whyte, Cohen and Laud Humphreys (Hobbs, 2007). These studies provide historical and theoretical justification for symbolic interactionism in this research, given the affinity between deviancy and addiction, and therefore addiction recovery.

Symbolic interactionism has supported understanding and explanation of the impact of the LTLA project on recovery; a previously unexplored social entity. In particular, it has enabled an in-depth understanding of how 'self' (for the service users and mentors) changes in the context of the project, and how processes of socialisation in 'normal' social environments seem to facilitate a 'normal' identity to develop through the ability of the reflexive 'self'. It has also enabled a detailed interpretation of the LTLA project's *culture*, and how the culture of the project impacts on both the individual and the collective group, as well as providing an interpretation of the LTLA project as a 'community of recovery' (see section *8.4.1*). To the best of my knowledge, this is the first study to utilise symbolic interactionism, its underlying premises and its associated theories to understand UK-based, addiction-related peer support programs.

From a methodological point of view, a key facet of symbolic interactionism is its natural propensity to give an authentic 'voice' to research participants through focusing on the particularities of their definitions and interpretations (Harris, 2001). Given that well conducted qualitative research is also concerned with providing 'authentic' representations of the social phenomenon under investigation (Silverman, 2010), there is a harmonious relationship that runs throughout this thesis with regards to data collection, analysis, theoretical interpretation and reporting of the data. This is further supported by the intellectual affinity that exists between symbolic interactionism and ethnography (Rock, 1979; Hobbs, 2007), as both advocate total immersion in the selected field of research interest.

It is important to address the criticism that symbolic interactionism tends to focus on small subunits of social interaction within specified groups (Charon, 2010), which has led some to state that it does not consider wider social structure (Gouldner, 1970). The narrow focus of symbolic interaction theoretically restricts explanation of the LTLA project's culture in relation to the larger, overarching system of human culture that limits or influences the choices available to *us* as autonomous individuals (Gouldner, 1970). However, its narrow focus has facilitated an in-depth, detailed analysis of the LTLA project's culture, and how it has influenced the individual members of the group, which in turn, has facilitated a greater understanding of how the LTLA project impacts on recovery, the central aim of this thesis. This claim is supported by the breadth and depth of data that were collected and reported in this thesis. Perhaps more fundamentally, the use of *structural symbolic interactionism* addresses the criticism that agency is favoured over structure.

Structural symbolic interactionism, as Stryker and Burke (2000) write, incorporates the traditional ideas of symbolic interactionism that advocate the fluidity and openness of social interaction, self-direction and human agency with inherent aspects of membership in society (Stryker, 1980). It attempts to provide a theory whereby the individual and the social provide contexts for one another, both of which are mediated by *behaviour* (Stryker & Burke, 2000). The

notion of *role* in the theory is central, as it posits that through the individual roles that we adhere to and perform in society, the individual can be located within social structure. The concept of 'role' facilitates a marriage between the more traditional views of symbolic interactionism and the more contemporary theoretical ideas of an individuals 'role' in society.

The importance of 'role' is evident throughout this research. For example, section *6.5* explored the role of the mentor within the LTLA project and how 'their' role was socially defined by a set of rights, duties, expectations, norms and behaviours that encompass that role. This in turn, locates 'the mentor' role within the social structure of the LTLA project, as it defined *their* social position. It is through the 'role of the mentor' and the associated behaviours of a mentor that *they* gain status, which in the context of this research is an achieved status (Linton, 1936): as it reflects a status that is earned through their commitment to recovery. The same is true of the 'role of the service user' or the 'role of the professional staff': all are socially defined and it is possible to locate their relative positions within the larger social system. Building 'down' to the social person in this manner, and building 'up' to unit of social organisation, a bridge can be built between society and the individual (Stryker & Burke, 2000). This addresses the criticism that symbolic interactionism favours agency over structure (Gouldner, 1970). However, there is an additional consideration with regards to structural symbolic interactionism that needs addressing within the context of this study.

A key component of structural symbolic interactionism is that increased commitment to, and salience of, an identity results in that identity becoming reinforced, thus making it more likely that an individual 'portrays' that identity to others (Stryker & Burke, 2000). Stryker and Burke's (2000) theory is very much located in a theoretical context whereby they offer a way to combine social structure with symbolic interactionism, but offer little by way of application. Whilst they do offer some applicable contexts for their theory, the overpowering theoretical context of the paper comes at the detriment to evaluation of the model. As such, it is perhaps not surprising that their paper overlooks the implications of certain aspects of the model such as 'commitment'.

This is not a criticism of Stryker and Burke's (2000) theory, as it makes theoretical sense that the more one commits to an identity, the more likely they are to be recognised by that identity. However, this study indicates that the implications of commitment and 'over-commitment' to an identity need addressing. The purpose of the next section is to demonstrate how the theoretical framework of symbolic interactionism has been interpreted to provide a potential explanation of the LTLA project's 'community of recovery' and how it fits into the wider 'recovery community'.

8.4.1 The LTLA project: A 'community of recovery' within the 'imagined recovery community'

It was suggested in chapter *5* that the LTLA project represents a 'community of recovery', a term devised by Ernest Kurtz (1999) to suggest that there are multiple communities of recovery to which recovering individuals can be introduced. The firsthand experience and peer support set within the non-stigmatising culture of the LTLA project reflects Kurtz's (1999) 'reciprocity of fit' hypothesis, a term that suggests individuals within the group will experience commonalities with others, thus reinforcing group cohesion. In addition to the 'community of recovery' concept is the idea of a 'recovery community', a term that represents the larger shared identity and mutual support of those in the recovering social world (White, 2002). However, these two terms are clearly not mutually exclusive (White & Kurtz, 2006a). Thus, the LTLA project is best conceptualised as one specific 'community of recovery' set within the wider 'recovery community'. In order to conceptualise this point further, Benedict Anderson's *imagined communities* and Charles Taylor's (2004) *social imaginaries* concepts will be drawn upon.

Anderson's (1991; 2006) 'imagined communities' concept stems from his explanation of individual nations and the political community and ideologies that represent each nation. Anderson (2006) states that nations are *imagined* because even in the smallest nation, each member will never meet, hear or know all other members, yet in the minds of each individual lives the image of communion. It is

important to note that 'imagined' does not refer to being 'false' or 'made up' but to being 'perceived' by those within a community. In other words, *imagined* relates to those who perceive themselves to be a part of the community through an assumed, shared mental affinity and values. Furthermore, Anderson (2006) states that nations are *communities* regardless of the actual inequalities and exploitation that may exist in certain nations, because the nation is always conceived as a deep, horizontal comradeship underpinned by fraternal values. Putting aside Anderson's political ideologies and his use of 'imagined communities' to explain nationalism, the crux of his theory can be used to understand the LTLA project's community of recovery located within the recovery community.

The 'recovery community' can be conceptualised as an 'imagined community', as it explains the perceived, but unknowable community of recovery-orientated people. Charles Taylor's (2004) 'social imaginaries' hypothesis offers a potential explanation to understand why individuals in recovery might behave in similar ways. Taylor (2004) states that people imagine their social existence, how they fit with one another, how people interact with their fellows, the expectations that are normally met, and the deep-seated, normative notions that underlie these expectations. In other words, people 'fit' together based on a shared meaning of *their* social existence, meaning that individuals in recovery have an underlying set of 'recovery expectations' they abide by. His 'social imaginaries' hypothesis provides a conceptually congruent way to understand how and why people in the recovery community behave and act toward themselves and recovery in the manner they do.

From the viewpoint of symbolic interactionism, Anderson's 'mental affinity' or Taylor's 'social imaginaries' concepts are akin to culture, or a 'shared perspective'. To briefly recap, symbolic interactionism advocates that culture is a *shared perspective* that creates continuity over time, and guides the actions of individual project members in culturally congruent ways (Shibutani, 1955). In this sense, culture from the viewpoint of symbolic interactionism, mental affinity or 'social imaginaries' all broadly advocate a perceived sense of communion and

how to act between community members, despite not knowing one another. In the context of addiction recovery, the 'recovery community' is based on the 'shared perspective' or culture of addiction recovery. In this sense, the recovery community can be considered an 'imagined recovery community', as there are many millions of people in recovery across the world who will never meet or know about each other, but their mental affinity to recovery is what connects each of them to the 'imagined recovery community'.

In contrast to the 'imagined recovery community' is the 'community of recovery'. 'Communities of recovery' should be conceptualised as smaller groups of recovering service users who provide support for one another (Kurtz, 1999). In contrast to the 'imagined recovery community', which is based on the perception of every single individual in the recovery community across the globe, 'communities of recovery' represent smaller, visible groups of individuals in recovery in the community. The LTLA project represents one example of a 'community of recovery', just as individual AA groups or SMART recovery meetings represent others. Within each of these 'communities of recovery', will be their own cultural approach to recovery. For example, the LTLA project advocates abstinence, Moderation Management groups advocate moderated substance use and AA and 12-step groups advocate the use of the 12 steps and 12 traditions to achieve and maintain recovery. The important point to note is that taking all the individual 'communities of recovery' as one, they make up the 'imagined recovery community'.

This thesis suggests therefore, that the LTLA project can be potentially conceptualised as a *(real) community of recovery* located within the *imagined recovery community*. This definition of 'what the LTLA project is', arguably provides a theoretical explanation to understand that the individual LTLA project (and indeed any individual 'community of recovery') is a *physical* entity bound within the ubiquitous 'imagined recovery community'.

To my knowledge this is the first time the concept of imagined communities has been used to conceptualise and understand how recovery

might be conceived. This is a potentially significant idea, as it provides a way to conceptualise how the individual recovery communities might fit together to create the overarching (imagined) recovery community. From a research point of view, further understanding of individual communities of recovery would shed light on how they each frame their own identity in relation to other communities of recovery and how communication exists between the various communities of recovery. Furthermore, as it has been suggested throughout this thesis, identity is never quite fixed, nor an absolute (Anderson, 2006; Jenkins, 2008), thus demonstrating that identity, and indeed the identity of recovery is a flexible, non-essentialised construct. Extrapolating Anderson's (2006) idea to this research, acknowledging that the identity of the LTLA and indeed, the identity of recovery are fluid processes sensitive to context, new areas of research are opened up. This thesis offers the beginnings of this research, as it explored how people construct their recovery identity in relation to engagement with others in recovery, and also those in mainstream society. Further work is needed however, to further explore how the proposed 'imagined recovery community' concept set out by this thesis impacts on the identity of recovery, and how this impacts on recovery from substance addiction.

To conclude this section on theoretical engagement and implications, it is clear that whilst there are potential criticisms of both symbolic interactionism and structural symbolic interactionism, the strengths provided by both approaches has resulted in an in-depth, detailed theoretical explanation of the LTLA project. They have facilitated a detailed understanding and interpretation of the LTLA project, how it operates and how it impacts on the recovery trajectories of the service users and mentors who attend the project.

8.5 Methodological engagement

The exploratory nature of this research necessitated a qualitative methodology with a specific use of ethnography and its guiding principles. Participant observation of the project's activities and mentor committee meetings and semi-structured interviews with the service users, mentors and professional staff were the two methods of data collection. The underlying

premises of qualitative research and the use of ethnography more specifically meant that it was crucial I immersed myself in the LTLA project to gain intimate familiarity with all aspects of the project. It enabled me to gain a holistic understanding of how the project operated on a daily basis, with a specific focus on the activities and mentor committee meetings. It also enabled an in-depth exploration of the feelings and experiences of the service users, mentors and professional staff involved with the LTLA project This immersion enabled me to address the central aim of this thesis: whether how and why the LTLA project impacts on recovery from alcohol dependency.

The methodology also facilitated my understanding of a sense of time within the data. Whilst this research was cross-sectional, analysing the project at one point in time, the data collected from the service users and mentors provided a sense of change over time enabling a 'stages of recovery' model to be developed (see section *8.3.2*). A sense of time was achieved by asking service users to recount their addiction pasts: how it happened, why it happened and the associated feelings that accompanied being alcohol dependent, in conjunction with their feelings now, and where they would like to be in the future. Furthermore, as a result of being able to interview most of the service users and mentors at the LTLA project, all of whom spanned the spectrum of recovery (see table *4.2* in section *4.3.9*), a sense of time was also achieved through the collection of experiences and feelings of different service users and mentors at different points on the 'recovery spectrum'.

Study participants comprised a convenience sample of those attending the LTLA project at the time of study. Whilst a convenience sample is accompanied by certain flaws, such as a lack of control over the representativeness of the sample, thus impacting on the generalisability of the findings (Silverman, 2010), this research was not specifically aimed at producing findings that could be extrapolated to other social contexts. It was aimed at specifically exploring the impact of attendance at the LTLA project on recovery, meaning that a convenience sample of those attending the LTLA project was not methodologically problematic. As section *8.5.2.2* explains, whilst this research is

located specifically within the LTLA project, the theoretical conclusions made from this research are generalisable to other recovery populations. The convenience sample therefore, has not limited theoretical generalisation. Furthermore, despite a convenience sample being used, the range of those involved in this research is diverse. As table *4.2* (see section *4.3.9*) demonstrates, the range of people who attended the LTLA project spanned from those at the start of their recovery through to those who had been in recovery for many years. This meant the data collected in this research and the conclusions and interpretations made from the data were based on a diverse cohort of people in recovery, thus lending weight to the generalisability of the study's findings.

There is one methodological limitation that needs addressing. It was not possible to interview those service users and mentors who have left the LTLA project: this point was considered in section *7.4*. The lack of opportunity to interview people who had left the LTLA project means that it is very difficult to determine if under-engagement or over-involvement with the LTLA project was actually detrimental to recovery. For example, there could have been those who left the project who under-engaged or became over-involved with the LTLA project, but are actually doing well in their recovery. Similarly, there may be those that left, who maintained a good balance whilst attending the project, but are now struggling in their recovery. Whilst this thesis claims therefore, that some can under-engage or become over-involved with the LTLA project, this claim is restricted to the data collected in this research.

The implications of this cohort of individuals who have left the LTLA project, or indeed those who never join a SHG raise interesting questions with regards to the proposed 'imagined recovery community' concept. Due to a lack of affiliation with a SHG, it could be argued that they are not part of the imagined recovery community. However if they continue to maintain recovery without any form of recognised help, these service users would seem to be part of a more elusive recovery community: natural recoverers. This concept stems from the work of Dan Waldorf and Patrick Biernacki (1981) who investigated those who recover from opiate addiction without any recognised form of help. I would

argue that, despite receiving no recognised form of treatment, they do represent a different, albeit more elusive, community of recovery, thus making them a part of the 'imagined recovery community'. This conclusion is based on the premise that those in natural recovery identify themselves as belonging to the 'imagined recovery community'. For those who do not identify with the 'imagined recovery community' for whatever reason, their inclusion as part of the ubiquitous 'imagined recovery community' is debatable.

Why and how natural recovery works for some is still relatively poorly understood, when compared to knowledge on how AA works (for example). This is likely to be because the recruitment of those in natural recovery represents some of the most difficult people to access, which is further compounded by the economic and temporal costs to locate such a cohort (Carballo et al., 2009). Carballo et al. (2009) concluded that identifying 'self-changers' is one of the greatest obstacles facing studies that set out to analyse natural recovery. Despite these difficulties, locating and identifying individuals who leave SHGs or never join one to start with, offer an important line of future inquiry, as the reasons behind how and why some are able to recover without officially recognised help would shed greater light on the different pathways in recovery.

8.5.1 Being a 'complete participant'

'Complete participant' in the context of this research refers to being open about my presence at the LTLA project and participating in all the activities I attended during my participant observation period There are two methodological issues surrounding the fact that I was a 'complete participant' during data collection that are worthy of consideration. The first pertains to failing to understand the perspectives of the participants correctly, primarily because it is not possible to check interpretations within the social arena of data collection (Hammersley & Atkinson, 1995). This is a potential problem for participant observers when collecting data, as it could lead to fabricated or over-exaggerated notes being taken that could lead to skewed interpretation of the data, which would impact on the credibility of the research. To overcome this, interpretations made about the data were presented to the mentor team and

professional staff involved with the LTLA project (discussed in greater depth in section *8.5.2.1*).

The second issue relates to the 'outsider-insider' problem, a term defined by an outside researcher attempting to become an insider of the culture or society that they are investigating (Lobo, 1990). This can be addressed in three ways, two of which are problematic. First, one can be a 'privileged stranger', but this results in one being so far removed from the culture that it is not understood fully (Lobo, 1990). This stance was decided against during this research, as it would have impacted on the depth to which I would have understood the LTLA project, which in turn, would have had detrimental impacts on the quality of the data. On the other extreme, one can 'go native' (Hammersley & Atkinson, 1995). However, the issue surrounding 'going native', is that it refers to being so immersed in a group or culture that 'over-rapport' (Hammersley & Atkinson, 1995) results in a lack of sufficient distance to observe the culture (Lobo, 1990) thus resulting in the research agenda being lost (Hammersley & Atkinson, 1995; Mays & Pope, 1995). In between these two extremes lies the 'marginal native' position (Freilich, 1970), a point explored in greater detail below.

Given the positivity with which so many of the service users, mentors and professional staff described the LTLA project, it is important to demonstrate that I did not 'go native' during this research. I am confident in making this claim as despite the broad positivity with which the LTLA project was reported, I identified a number of drawbacks that principally stemmed from service user 'over-involvement' with the LTLA project. Whilst I did gain intimate familiarity with those at the LTLA project, I maintained a critical edge from a marginal position, which minimised the dangers of 'over-rapport' (Hammersley & Atkinson, 1995). This was achieved by being transparent about what occurred during data collection, my thoughts toward data collection and how my experiences and opinions changed as I gained further intimacy with the LTLA project (see section *8.5.2.4*).

It is still possible to gain creative insight into a social area from a marginal position (Lofland, 1971), primarily because the researcher is intellectually poised between familiarity and strangeness, or in the case of being a 'complete participant', poised between being a stranger and a friend (Everatt, 1977). In the case of this research, despite research relationships being made, a critical and objective analytical stance was maintained through my 'marginal native' position (Freilich, 1970). 'Marginal native' refers to being *"part-insider and part-outsider"* (Lobo, 1990; p. 127), a position which allows in-depth analysis to be conducted, whilst maintaining a critical and objective edge (Freilich, 1970). Whilst I adopted an overt 'complete participant' position in terms of 'how' I conducted the participant observation period, the marginal native approach ensured I maintained sufficient distance to prevent 'going native'. The depth and breadth of data achieved in this research is a testament to this approach, all of which are the product of the guiding principles of qualitative and ethnographic research.

8.5.2 Reflections on the quality of this research

Section *4.5* sets out a series of quality criteria in order to explicitly present how this research would be conducted in such a manner so as to ensure it is a trustworthy, credible piece of qualitative research (Guba & Lincoln, 1981). The criteria were *credibility*, *transferability*, *dependability* (and the use of an *iterative process*), *confirmability*, *transparency*, *reflexivity* and *triangulation*. Having completed the research, the exploration of these criteria in this chapter moves beyond the hypothetical, to the practical ways in which they were met. In this section there will also be a section reflexively outlining points surrounding the method of analysis used in this research.

8.5.2.1 Credibility and reflexivity

Credibility (or internal validity) is essentially how 'truthful', or valid the data are (Silverman, 2010) and is centred on whether the social actors under study can build the same experiences and observations of their social reality as the researcher does (Archard, 1979). Given the importance of this point, the mentor team and professional staff were consulted after the data had been collected and analysed to present them with the main findings. Having outlined

the main points of this research, the mentor team and professional staff were in agreement that I had not fabricated or manipulated the data in any way, and that what I was reporting was an accurate and fair representation of the LTLA project.

Credibility was promoted through prolonged engagement with the participants, persistent observations in the field and researcher reflexivity (Morrow, 2005). Reflexivity is essentially understanding *"the human as an instrument"* (Guba & Lincoln, 2000; p. 210) and recognises the influence of the researcher on the research process (Mays & Pope, 2006; Kuper, Lingard & Levinson, 2008). Reflexivity is a process whereby the researcher is consciously aware that his or her own beliefs are socially constructed, and will have a natural impact on the interactions and interpretations of the research setting (Grbich, 1999). Reflexivity enables a researcher to continually improve their research processes and outcomes, as it encourages researchers to critically examine the strengths and limitations of what they are doing in light of their methodological orientation (Hammersley & Atkinson, 1995; 2002). Marcus (1994) states that in order to be reflexive, a researcher must be self critical of their own experience in order to maintain objectivity and to transcend the differences that may exist in terms of power, culture or class (Grbich, 1999).

Credibility and reflexivity were promoted through extensive observational periods and comprehensive sampling for participant interviews (within the timeframe of this PhD), which ensured prolonged engagement. From a more practical standpoint, details such as the length, date, time and number of people present for each observation and interview were recorded. Reflexive journals, which outlined any thoughts I had about anything related to the research, were kept (Denzin & Lincoln, 1994), alongside the interactions I encountered during data collection, analysis and write up. Where relevant, these reflections were incorporated and presented if they impacted on any part of my data collection, analysis or write up (see section *6.4.1.4*). This ensures that the reader is able to judge any possible bias I may have introduced at any stage throughout the research process.

8.5.2.2 Transferability

Transferability or generalisability, assumes that the data collected in qualitative work can be translated to other sociocultural settings (Lincoln & Guba, 1985). Given that this research adopted a single case study approach, transferability became important (Gomm, Hammersley & Foster, 2009). Whilst this research did focus on recovering problem drinkers, therefore perhaps making it non-transferrable to other projects that support problematic drug users for instance, there are a huge array of empirical studies that focus on one substance of misuse (see chapter *2*). Although my data collection was restricted to the LTLA project, it addresses the much wider and diverse concept of recovery from alcohol addiction. As a case study research design was adopted, my thesis will not necessarily be directly transferable to other samples or projects, but theoretically, the conclusions made from this research will be testable in other recovery contexts (Yin, 2009). This ensures my research can be located in the wider literature, thus making it transferable to the wider understanding of recovering from substance dependency. For example, the importance of peer support, 'stages of recovery' and 'over-involvement' with the LTLA project are all examples of theorising that are transferrable to other recovery projects.

8.5.2.3 Dependability and an iterative approach

Dependability essentially reflects how consistent the data is, with more reliable, consistent data reflecting greater quality (Silverman, 2010). Reliability from the stance of ethnography and symbolic interactionism is achieved by *inspection* and *exploration* rather than statistical techniques. Inspection is the total immersion of the researcher in the social world under investigation. In the case of this research, reiteration and triangulation were used to totally immerse myself in the activities and interview transcripts; thus enabling me to expand and deepen my awareness and knowledge of the project, and gain firsthand, reliable knowledge of the social phenomenon under investigation (Blumer, 1969). Furthermore, immersion in the activities enabled me to keep audit trails of activities and document how my own interpretation influenced data collection

and analysis, which further ensured reliability through researcher reflexivity and transparency (Denzin & Lincoln, 1994; Morrow, 2005).

Exploration, Blumer (1969) explains, enables two objectives to be achieved. First, it enables a researcher to gain closeness and comprehensive acquaintance with a social world that one is otherwise unfamiliar with; something that was achieved in this research. Second, it enables the development and precision of the researcher's line of inquiry, data, analytical relations and interpretations to remain firmly grounded in the empirical life under study. Exploration is a dynamic concept, meaning that if new information arises that contravenes or shifts the line of inquiry in a new direction then the researcher has the right to shift their focus in accordance with the new information (Blumer, 1969). This is an *iterative process*. An iterative approach refers to data collection and analysis being conducted concurrently with one another so new lines of inquiry that were elicited from the analysis could be explored in the follow-up interview stage (Kuper, Lingard & Levinson, 2008). Throughout my observation and interview stages, I transcribed and reflected on the information I had observed and subjected it to initial analysis to discover 'what is going on', then using the new information that had been gained from analysis in subsequent data collection (Grbich, 1999).

Throughout the data collection period, new lines of inquiry were probed in later interviews to ensure any new areas of interest that arose from the data were incorporated. For example, it was not initially considered that there would be a divide that exists between the mentors and service users until one service user mentioned that she perceived there to be a definite divide between the two cohorts. As a result, the concept of 'power' was incorporated into future questioning, which led to the emergence of section *7.6*. This ensured new points that were not previously considered were addressed. The quality of the data reported in this thesis is a result of all the different techniques used to ensure the research was credible.

Dependability, from the stance of qualitative research, also refers to the researcher noting the ever-changing context within which the research occurs. In my research I was continuously noting in reflexive journals how the situational circumstances and context changed during the data collection and how my views changed as the context did. This ensured that dependability, as well as transparency was maintained, as it is clear to see through inspection of my reflexive journals just how the context changed over time.

8.5.2.4 Confirmability and transparency

Confirmability essentially refers to how accurately another individual can corroborate or confirm the data (Lincoln & Guba, 1985). Since social interactions in a given social setting are unique, it is possible to achieve confirmability through *transparency*. Hakim (1987) states that transparency relates to making the methods and procedures for data collection visible, so that the overall research design can be assessed. I kept journals of how the observation 'played out' so any independent reader can see exactly what happened during the observation and at what time it occurred. This ensured that I kept an audit trail of everything that occurred during data collection, and how my feelings and experiences related to the events that unfolded during data collection. I was also very careful to note as much as possible in a logical and methodical manner so at the end of my analysis, I could refer back to the data audit to identify any potential areas of bias or distortion that may have occurred. In any situation where an individual is making mental notes of how interactions 'play out', an element of reporting bias will surface. In order to counteract any reporting bias, I was extremely careful to note down also, exactly what I thought about a given situation and how my presence as a researcher may have influenced the situation. This ensures any reader can observe my thought processes as the data collection unfolded, thus adding to the confirmability and transparency of this research.

8.5.2.5 Triangulation

Triangulation involves the comparison of results from two or more different methods of data collection (triangulation of methods) or, more simply,

from two or more data sources (triangulation of data) (Mays & Pope, 2006). I used participant observation and semi-structured interviews to achieve as accurate picture as possible of the social world under investigation by using different techniques to observe it (triangulation of methods) and through the collection of interview data from different sources (professional staff, mentors and service users), triangulation of data was achieved (Silverman, 2010). This enabled me to discover multiple aspects of a single empirical reality (Denzin, 1978). The use of two different data collecting techniques provided me with comprehensive knowledge about a reality or process (Miller & Fox, 2004) and corroboratory data from different techniques deployed in different contexts (Silverman, 2005). Participant observation provided me with a holistic conceptualisation of how the activities operated and how the individuals interacted with one another, whereas the interviews enabled me to probe whether, how and why the activities and the LTLA project promoted their recovery trajectory or not. By using both participant observation and interviewing, a balance between quantity and quality of data was ensured. The next section reflexively evaluates the method of analysis used in this research: Miles and Huberman's (1994) thematic framework.

8.5.2.6 Reflections on the method of analysis

There were two main reasons for adopting the thematic framework set out by Miles and Huberman (1994). First, it was a logical, comprehensive method that allowed me to manipulate large amounts of data in the simplest and most practical way possible. It also ensured that each concept discussed in the results section is the product of the entire data set being analysed and not a reflection of a few responses chosen to reflect the entire data set. This means that every theme and concept discussed in the results section is the product of analysis from *all* the data. Second, it enabled me to extrapolate and incorporate the data I collected with the overarching theoretical framework of symbolic interactionism and identity I set out in the theoretical framework chapter. This method of analysis therefore enabled the specific findings of this study to be incorporated into the overarching, generalised, existing theory of *whether*, how and why recovery from substance addiction unfolds at ex-service user led projects.

Miles and Huberman (1994) designed their method of data analysis to be conducted in a fairly chronological order of analytical events, starting with 'noting patterns, themes' through to 'building a logical chain of evidence'. The reason for conducting the research in this manner is because it is thought that as a researcher continues down the method of analysis, one moves from lower-level intuitive processing of the data to more in-depth, analytical inductive techniques. The method has been designed so that a researcher can both manage and analyse their data set in a complete, in-depth and detailed manner. However, reflecting upon the analysis stage, it became clear that many of the points relating to their thematic analysis approach (see section *4.6*) were conducted simultaneously over an extended period of time that included both data collection and analysis. The analysis of the data did not just occur in what might be referred to as 'the analysis phase', it transcended this to cover the entire process of data collection, analysis and write up. I did not conduct the analysis starting with noting themes and ending with a chain of events. Based on my aims, objectives and theoretical framework, I was able to analyse the data in a manner that merged many of the above points. There were certain techniques such as 'clustering', 'subsuming particles into the general' and 'factoring' that I used more than others ('counting'), but this was just the natural way that made most analytical sense for the study. Overall, the processes adopted for the study have addressed the 'quality criteria' and support the proposition that this research is of high quality, credible and trustworthy (Guba & Lincoln, 1981).

8.6 Implications of this research for policy and practice

The focus of this section on policy and practice is to propose ways in which this work may inform existing alcohol and drug policy, alongside the implications this research may have for future projects, and the field of addiction recovery more broadly. Sections *1.3* and *1.4* outlined the current Coalition stance on drug and alcohol policy. To recap, the drug policy states that:

> *"Recovery involves three overarching principles – wellbeing, citizenship, and freedom from dependence. It is an individual, person-centred journey"* (Home Office, 2010; p. 18)

The drug strategy also emphasises the importance of 'recovery capital' in the field of addiction, and how such capital can be the driving force behind recovery attempts; and the need for 'community recovery champions' to deliver support and guidance to those attempting recovery (Home Office, 2010). This research shall now be evaluated against its contribution to understanding recovery and the policy principles outlined above in order to demonstrate the implications of this research for current and future policy and practice.

8.6.1 Understanding recovery: Staged recovery?

Section *1.3* explored the difficulties surrounding a definition of recovery, which in turn, impacts on our understanding of recovery. A recurrent tension that continues to complicate our understanding of recovery is whether one is always in a state of being 'in recovery' or whether one can become 'recovered' (Measham, Moore & Welch, 2013). Being forever 'in recovery' refers to a never-ending state whereby an individual must maintain abstinence in order to control the irreversible effects of their addiction (Clark, 2006). 'Recovered' however, implies an end-state that people can reach, beyond which they are no longer afflicted or identified as a 'recovering substance user' (Clark, 2006). Both of these outcomes were articulated by service users and mentors in this study (see section *6.4.1*). Based on the findings of this research, I have proposed a conceptualisation of recovery that goes beyond the dichotomy that pits being 'in recovery' against 'recovered', to produce a conceptualisation that encompasses aspects of both. It is called *staged recovery.*

Section *8.3.2* outlined that recovery can be conceivably delineated into three stages: active, sustained and passive recovery. 'Active recovery' refers to those who are still preoccupied with their addiction and have to actively manage it on a daily basis. Those service users that fall within this stage represent those who are clearly still 'in recovery', as their addiction and cravings consciously

preoccupy their cognitive processes; traits indicative of being ‘in recovery’. Those in ‘sustained recovery’ are making the transition from being ‘in recovery’ to being ‘recovered’, as they are making positive steps toward their recovery, collecting recovery capital and are having a reduced preoccupation with alcohol and their former addiction. As one makes the transition from ‘sustained’ to ‘passive recovery’ (which could take a number of years), the individual begins to become ‘recovered’, as they no longer consciously consider their addiction, or even their recovery as a key trait of ‘who they are’. The longer one spends in ‘passive recovery’, the more their ‘recovered’ identity is likely to be reinforced.

The implications of this conceptualisation of recovery for practice is that it could help to provide greater insight into what service users require at each stage of recovery. Those in active recovery are likely to need significant amounts of professional and peer support in order to alleviate conscious thoughts of substance use. As one makes the transition to sustained recovery, professional support may reduce and peer support from others in recovery may be more valuable as they represent to one another the strides they have made in recovery. It is at this stage that resources relating to employment, skill acquisition or housing for example, may become more valuable in order to help the service user continue to progress in recovery. Those in ‘passive recovery’ are not likely to need any form of professional support and may find mentoring and ‘giving back’ a valuable source of continued self-development. Others may want a clean break from their past so mentoring may not be an option, but it is at this point the notion of being ‘in recovery’ is arguably more of a hindrance than a help.

Whilst this conceptualisation of recovery may be contested, it does provide a platform from which it can be further tested. To date, the debate between being ‘in recovery’ or ‘recovered’ has continued for many years, so perhaps a new tact is needed. This thesis contributes to the understanding of recovery in UK drug policy by suggesting that recovery is a multi-staged process, as opposed to being either ‘in recovery’ or ‘recovered’, whereby each stage is characterised by different recovery service demands.

8.6.2 Wellbeing

The lack of a definition of 'wellbeing' in the Coalition strategy makes it difficult to apply the concept in the LTLA project. Having explored the literature for a possible definition of 'wellbeing', the most applicable appears to be one proposed by William White (2007). As part of a wider definition of recovery, White (2007) refers to the need for a *"healthy, productive and meaningful life"* (White, 2007; p. 236), a phrase, which for the purpose of defining 'wellbeing', will be used as a conceptual platform. White (2007) states that the term 'healthy' incorporates physical and emotional health, as well as the enhancement of social relationships to support being healthy. 'Productive', White (2007) writes, refers to behavioural modification so that others in their social network and the wider community are helped rather than negatively affected, and finally, 'meaningful life' refers to the idea that their life has been saved and that they have a second chance to make a meaningful contribution to life (White, 2007). Extrapolating this definition to this research, the LTLA project does appear to make contributions to 'wellbeing'.

The underlying culture of abstinence, in conjunction with health promoting activities such as 'going to the gym', 'zumba' and 'going on walks' (see section *5.4.4*) all contributed to improving the physical wellbeing of the service users and mentors who attend the LTLA project. The research also found that peer support provided service users and mentors with the opportunity to receive and give advice, which in turn appeared to facilitate recovery, as it appeared to instil a sense of cohesiveness within the group. This appeared to contribute to social and psychological wellbeing as service users develop friendships within the LTLA project based on *their* shared goal of overcoming addiction and making a commitment to abstinence. However, not everyone at the LTLA project perhaps felt a sense of increased 'wellbeing'. As section *7.6* points out, there was one who came and subsequently left the LTLA project, as she did not feel engaged by those at the project. Furthermore, there were some who attended the LTLA project but continued to experience cravings for alcohol (see section *7.4.1*). These examples are visible reminders that for some, their life problems can be so complex that no amount of project work will simply address

all their problems. These findings suggest therefore, that the LTLA project cannot fully address 'wellbeing' for all, and should be considered as just one source of wellbeing.

The practical implications of this research are that the LTLA project is not just about the enjoyment of leisure activities, but for some it can facilitate deeper processes that underlie personal transformation in recovery. Narratives of improved physical, social and psychological wellbeing are apparent throughout the data, thus supporting the claim that the LTLA project does improve the wellbeing of the service users and mentors that encounter the project. This finding however, should be treated with caution, as there may be some who fail to engage with the LTLA project fully, thus impacting detrimentally on the extent to which their sense of 'wellbeing' is positively affected.

8.6.3 Citizenship

'Citizenship' can be seen as related to two key points. First, as the BFI (2007) state, 'citizenship' relates to *"living with regard and respect for those around you"* (BFI, 2007; p. 222). By this definition, the LTLA project does appear to help service users gain a sense of 'citizenship'. Many mentors and service users articulated that since joining the LTLA project, they have taken considerable steps toward repairing the relationships they damaged during their addiction and are taking strides to becoming a 'better person'; traits indicative of 'citizenship'. However, to claim that the LTLA project is the sole reason for this sense of 'citizenship' would be naive. Whilst the LTLA project may have been the catalyst for this transformation, and indeed service users may exhibit a sense of 'citizenship' within the LTLA project, it is impossible to know with any certainty (based on this research) if any of the service users 'live with respect for those around them' outside of the LTLA project. In order to make this claim, interviews with family and friends of service users would be required to ascertain from their point of view, if 'citizenship' (according to the BFI (2007) definition) is being met. The BFI (2007) definition however, is somewhat limited. It suggests 'citizenship' involves just those in the immediate social vicinity of the service user and overlooks the importance of wider social (re)integration. The second

point regarding 'citizenship' therefore, is the extent to which the LTLA project helps service users socially (re)integrate into the wider community.

Section *5.4.2* states that the LTLA project attempts to act as a conduit between the service users former world of addiction and mainstream society. The LTLA project attempts to (re)-teach the service users skills such as 'going to the shops' or 'going to the gym' that were lost during their addiction. All these 'skills' arguably fall under the umbrella term 'social (re)integration', and it is through social (re)integration that service users demonstrate a respect for those around them. This provides a greater argument for the LTLA project's impact on 'citizenship', as it teaches them skills that are necessary for social (re)integration, thus making it more plausible to suggest that the LTLA project does continue to have an impact on service users 'citizenship' outside of the project. This research does go some way to supporting the notion that recovery-orientated programmes such as the LTLA project do contribute to a sense of 'citizenship' and social (re)integration, as advocated by the UK drug policy, but that the findings should be interpreted with caution. The lack of data regarding their lives outside the LTLA project make it difficult to know just how socially (re)integrated service users are becoming with mainstream society.

8.6.4 Freedom from dependence

'Freedom from dependence' can mean a number of outcomes that range from total abstinence, through to moderated, non-dependent drinking. In the context of this research given the severity of the addictions that many portrayed, abstinence was thought to be the only goal, but for others with less serious or complex addiction problems, 'moderated drinking' could also be an example of 'freedom from dependence'.

Enforcing an 'abstinence' rule has enabled the LTLA project to run efficiently, as the service users are aware that attending under the influence of alcohol will result in them being turned away for that activity. Two findings from this research demonstrate this. First, section *7.3.3* explains that there was one service user who turned up to an activity having had a drink that morning. It was

acknowledged however, that this was the first activity this service user had ever attended and was the first time they were having any prolonged form of social contact with mainstream society for years. The second, more serious incident (see section *7.6*) was a service user who brought a bottle of wine with him on the activity. In this incident the service user was sent home from the activity due to such a serious breach of the 'abstinence only' rule. In the first example, the accommodating nature of the LTLA project is demonstrated, as they realise that for many, committing to recovery is a daunting and challenging prospect, which many need support and help with in the early stages. In the latter example, such a serious violation left the mentors and professional staff with very little choice but to send the service user home in order to ensure the safety of others on the trip. These examples demonstrate that the LTLA project's 'rule' of abstinence is an approach that allows for the effective running of a recovery-orientated project. Whilst the 'rule' is abstinence, the LTLA project still acknowledge that recovery is very difficult and that in some cases leniency and discretion is required (the first example), whereas in others (the second example), the rule must be enforced.

The implications of this research for policy therefore, are that, at least for service users with severe dependency issues freedom from dependence is an achievable end goal (as proposed by the Coalition governments drug strategy). However, it needs to be acknowledged that for many, freedom from dependence is likely to be a very difficult journey, requiring some flexibility and significant amounts of support from others. Moreover, the main focus of this research has been on alcohol dependency. Achieving abstinence from chronic opiate addiction for example, will pose its own difficulties and dangers, all of which must be considered if a project for opiate addiction was to be set up based on 'freedom from dependence'.

A final point to note with regards to the Coalition's focus on 'freedom from dependence' is the potential stigma surrounding recovery. It was found in this research (see section *7.3.2*) that there were some who felt a perceived sense of stigma for making a commitment to abstinence. It was concluded that this was

because alcohol plays such a central role in Western societies that the 'norm' is to drink; therefore any individual who does not drink is perhaps considered 'not normal' and contravening social convention. The implications of this are that some feel the need to conceal their recovery, which could in turn, place greater (unnecessary) pressure on steps being taken to conceal their recovery; a potential situation for relapse. This research suggests therefore, that whilst this research supports 'freedom from dependence' as advocated by the UK drug strategy, policy should also take into account the potential sources of stigma attached to abstinence and being in recovery.

8.6.5 Recovery capital

To recap, four types of 'recovery capital' have been identified: *social*, *physical*, *human* and *cultural* (see section *1.4*) (Cloud & Granfield, 2008; Home Office, 2010). It is important to note that many of the service users and mentors possessed varying levels of recovery capital, ranging from those who possessed very little to those who possessed much more. Whilst it is difficult to quantify how much recovery capital an individual has or how much the LTLA project contributes to existing levels of recovery capital, it is possible to state that the project does make some contributions.

The LTLA project does not really contribute to *physical* capital, as this domain relates more to the physical assets one has access to. However, this research found that the LTLA project does seem to be a source of human, social and cultural capital for a number of reasons. First, the skills the service users learn such as 'gardening' 'arts and crafts' and 'how to use the gym' all contribute to human capital. Whilst these skills may seem low level to someone who takes these skills for granted, it is not the actual task itself that should be judged, but the contribution they make to 'recovery capital'. Cloud and Granfield (2008) state that recovery capital relates to the internal and external assets that enable recovery to initiated and sustained. Learning how to garden or how to use the gym correctly therefore, should be conceptualised as new sources of internal self-confidence and self-esteem that can be used to facilitate self-improvement in other areas. The renewed self-confidence that many service users referred to

appeared to be a direct result of experiencing firsthand that they could learn new tasks and interact with the world without the need to resort to alcohol use.

Second, the friendships and relationships that service users and mentors develop at the project are an important source of social capital, which was reinforced by the sense of obligation that service users and mentors appeared to have for the LTLA project. With regards to 'cultural capital', the abstinence approach, in conjunction with the project providing the opportunity to participate in 'everyday experiences' seems to facilitate an identity transformation based on the culture of everyday experiences. It enabled service users and mentors to behave in ways that are considered culturally congruent with the rest of society, which in turn, further provided them with a source of cultural capital. It is important to note that whilst the LTLA project is a potential source of social and cultural capital, this should be considered as being situationally defined. In other words, whilst this research suggests that the LTLA project is a good source of social and cultural capital *in* the project, it is difficult to state with any certainty if service users 'use' this source of capital *outside* the project. Whilst it is perhaps possible to conjecture that service users do try to maintain abstinence, their friendship networks and 'recovery beliefs' outside the project, this thesis makes no claim of this.

8.6.6 Community recovery champions

The mentors appeared to personify the Coalition government's 'community recovery champions' (Home Office, 2010). The mentors at the LTLA project should be considered the central part of the LTLA project, as without them, the project could not operate. They ensure the activities run smoothly, ensure the delivery of a variety of activities in which service users can participate and they provide peer support and advice for others at earlier stages in their recovery. Their motivation for doing so stems from wanting 'to give something back', thus supporting the 'ex-service user led' model and the use of community recovery champions proposed by the drug strategy. This finding supports previous literature that implicates the role that peer support has to play in the 'recovery age' (Best et al., 2010).

The practical implications of an ex-service user led approach are that the LTLA project offers a promising model upon which future projects could build. The weekly 'mentor committee meetings' reflect a certain level of professionalism, allowing weekly communication with professional staff that help direct the LTLA project. Furthermore, given that all the mentors help run the project in their own time, it represents a model whereby a project can be sustained at very low expense over a long period of time.

Given that the LTLA project is set up based on the guiding principles of co-production (see section *1.2*), the mentors had close contact with professional staff at the LAU. This ensured that any concerns or issues that arose, professional advice was at hand to tackle the problem. This was evident in a number of mentor committee meetings when mentors asked for advice on how to improve the popularity of certain activities, how to improve certain activities or for retrospective clarification of how to deal with difficult situations. An example of this final point can be seen in section *7.6* when a man brought a bottle of wine to an activity. The mentors dealt with it as they thought most appropriate, which they then reported to the professional staff involved with the LTLA project. On this occasion the professional staff commended the actions of the individual. Considering this structure more generally, the professional staff act as point of advice for mentors. Measham, Moore and Welch (2013) explain that some commentators argue against the use of ex-service users in recovery-orientated programs, as it undermines the role of the professional. This research however, provides an alternative argument to such claims, as there appeared to be value to both the mentors and professional staff involved with the LTLA project. It should be pointed out however, that co-production is perhaps not a scenario that can replicated easily. Where it is achievable however, the benefits of both ex-service user and professional staff involvement appear to have positive effects for the implementation of such projects.

To conclude, this research found that the LTLA project reflected many of the central themes contained within the Coalition government's drug strategy.

Evidence of the LTLA project's impact on recovery also argues for the relevance and worth of this national strategy – or those aspects covered here. This research provides evidence that projects such as LTLA provide recovering service users not only with pleasurable activities in which to participate, but are also a good form of human, social and cultural capital.

8.7 Future research

Throughout this thesis a number of important future areas of research have been identified. With regards to methodology, chapter *2* identified a need for more UK-based studies on SHGs, from both a qualitative and quantitative perspective. With regards to the LTLA project, further qualitative research is needed to ascertain the reasons why some service users and mentors left the project. This would shed greater light on the varying levels of commitment to the LTLA project suggested by this research (see section *7.4*), as it would provide further empirical evidence that supports the idea that those who under-engage or become over-involved with the LTLA project do fair worse in their recovery. Quantitative study of the LTLA project would also provide empirical evidence from a different perspective. For example, it would be able to explain rates of attendance and participation and how these domains correlate with abstinence. Taken together, both qualitative and quantitative seem to cover each other's weaknesses, whilst at the same time, compliment each other's strengths. This suggests the need for a mixed-methods approach to understand not just the LTLA project, but recovery support groups more generally.

Another avenue for future research would be to evaluate the cost effectiveness of the LTLA project (and indeed other UK-based SHGs), as this would shed light on how it compares to other SHGs, such as AA. Cost effectiveness studies would be able to evaluate the outcomes of the LTLA project (those who recover and move on from the LTLA project) in comparison to what it costs to run the LTLA project.

With regards to research more generally, there is a greater need for both qualitative and quantitative research into UK-based SHGs for addiction. First, the

LTLA project could be compared and contrasted with other projects in order to determine the similarities and differences between the projects and if these are associated with different outcomes for recovery trajectories. Future research should also look to investigate projects that encounter different types of substance use such as opiate addiction. These findings could then be compared and contrasted with the LTLA project to determine if there are any differences that exist between such projects, and if the differences are the result of the project, or the result of the substance of dependence. Furthermore, by exploring other projects, the 'stages of recovery' proposed in section *8.3.2* could be explored in different recovery contexts. Future research should also aim to investigate if over-representation of females in the mentor team that was observed in the LTLA project is specific to the project, or if it is a more universal trait of 'ex-service user led' projects. Given that a number of men in this research explicitly articulated a desire to become a mentor, this latter point raises interesting lines of inquiry surrounding the ability of women to recover at a greater rate than their male counterparts. This would not only shed light on potential areas of recovery that may facilitate women in recovery, but would also illuminate potential areas where men are perhaps held back in their recovery. As it was suggested in section *8.5*, identifying and locating 'natural recoverers' would provide an excellent opportunity for future research, as it would illuminate reasons behind their recovery. This in turn, could be compared and contrasted with those who do attend SHGs to see if the traits are similar, or if there are stark differences between SHG attenders and natural recoverers.

Other areas of future research should include further exploration of the different communities of recovery, and to focus on communities of recovery that are more obscure such as those explored in section *2.4* of the literature review. This would hopefully begin to address the dearth of information on SHGs other than AA and/or 12-step programmes. There is also a need for further research to understand the proposed 'imagined recovery community' concept, as it is through this that the individual identities of the communities of recovery can be understood, as well as the more ubiquitous 'identity of recovery', and how drug and alcohol policy impacts on the individual communities of recovery.

Furthermore, as it was suggested in section *8.3.1*, there seems to be a dearth of information regarding dependency on recovery support programs for addiction. The data collected in this research suggests that there may be some who do become 'over-involved' with the LTLA project; an area that needs more research to elucidate if this finding is specific to this data set, or if it is potentially a wider problem for the field of recovery. Overall, the main focus of future research should be to address the apparent gap of investigations of UK-based recovery support programs. Any relevant, well-conducted research into this area would be welcome, as it could illuminate a number of new themes that have a potential impact on future projects and benefit for those in recovery.

8.8 Concluding comments

This thesis is centred on addressing the following aim:

To gain an in-depth and holistic understanding of the 'Learning to Live Again' project; a UK-based, ex-service user group that aims to facilitate recovery from alcohol addiction.

This research has addressed this aim by providing an in-depth view of the LAU and the LTLA project. It has addressed the set-up and implementation of the LTLA project, as well as discussing how the LTLA project impacts on a deeper conceptual level pertaining to the transformation of 'self' and identity in recovery. This has illuminated the ways in which the LTLA project impacts on recovery trajectories, as well as highlighting the key strengths and limitations of the LTLA project. This thesis also highlights that the LTLA project may restrict recovery by providing an environment that is potentially attractive to some service users, thus resulting in 'over-involvement' with the LTLA project at the detriment to social reintegration back into mainstream society. Furthermore, the 'stages of recovery' proposed by this thesis has offered a potentially new way to conceptualise recovery, which can be explored in other recovery contexts.

My claim to originality lies in the breadth and depth of this research. This started with a literature review that found a significant lack of qualitative

evidence in UK based SHGs. Theoretically, this thesis uses a well established set of guiding principles and theoretically congruent theories to understand a previously unexplored social entity, which not only shed light on this entity, but also the concept of recovery, and the role and importance of UK-based SHGs in recovery.

The paradigmatic shift in UK drug and alcohol policy towards a recovery-focused approach, has been accompanied by an explosion of debate on recovery and how best to define and understand it more fully. There is a great need for more empirical work on the concept of recovery, which can contribute to such debates and future policy in this area. The 'stages of recovery' model proposed by this thesis, along with the notion of 'over-involvement' with SHGs, addressing the stigma of recovery and the 'imagined recovery community' concept offer new avenues through which to explore recovery, all of which could have implications for future drug and alcohol policy, as well as research opportunities.

Appendices

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Appendix 1: Search string for electronic databases

1. exp Alcohol-related disorders/
2. exp Drinking Behaviour/
3. amphetamine-related disorders/ or cocaine-related disorders/ or marijuana related disorders/ or exp opioid-related disorders/ or phencyclidine-related disorders/ or substance abuse, intravenous/
4. Drug users/
5. ((narcotic* or heroin or opiate* or opioid* or opium or cocaine* or cannabis* or marijuana or marihuana or hash* or phencyclidine or PCP or benzodiaz* or barbiturate* or amphetamine* or methamphetamine* or MDMA or ecstasy or hallucinogen* or Ketamine or LSD or inhalant* or substance*) adj (abuse* or misuse* or use* or problem* or depend* or addict* or disorder*)).ti,ab
6. legal high.ti,ab
7. or/1-6
8. self help groups/
9. self help group*.ti, ab
10. (ex-service user* or ex service user*).ti,ab
11. (peer-led or peer led).ti,ab
12. (twelve step facilitation or TSF or 12 step facilitation).ti,ab.
13. Alcoholics Anonymous/
14. Alcoholics anonymous.ti,ab
15. Abstainers club.ti,ab
16. Al-anon family group.ti,ab
17. All Nippon Sobriety Association.ti,ab
18. The sobriety friends society.ti,ab
19. Clubs of treated alcoholics.ti,ab
20. Double trouble in recovery.ti,ab
21. Jewish alcoholics, chemically dependent persons and significant others.ti,ab
22. Moderation management.ti,ab
23. Narcotics anonymous.ti,ab
24. Oxford houses.ti,ab
25. Rational recovery.ti,ab
26. Self management and recovery training.ti,ab
27. Secular organisation for sobriety.ti,ab
28. Save our selves.ti,ab
29. Life ring secular recovery.ti,ab
30. Women for sobriety.ti,ab
31. Non-al-anon-affiliated adult children of alcoholics.ti,ab
32. Alcoholics victorious.ti,ab
33. The caritas lok heep club.ti,ab
34. Circle of friends.ti,ab

35. Free one recovery.ti,ab
36. Kreuzbund.ti,ab
37. (Marijuana anonymous or marihuana anonymous).ti,ab
38. Methadone anonymous.ti,ab
39. 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38
40. abstinence/
41. abstinence.ti,ab.
42. Abstain*.ti,ab.
43. 40 or 41 or 42
44. 39 AND 43
45. 7 AND 44

Appendix 2: Demographic information for quantitative studies

Study Number	Authors	Study Location	Gender	Mean age (years)	Race/Ethnicity	Mean Marital Status	Mean Years in Education	Employment Status
1	Bond, Kaskutas & Weisner (2003)	California, USA	56% male (*n* = 367)	38	60% White; 27% Black; 7% Hispanic	66% single/divorced	82% had a high school degree	Not reported
2	Cross et al. (1990)	Georgia, USA	64% male	48	Not reported	Not reported	Not reported	Not reported
3	Curzio et al. (2012)	Florence, Italy	76% male	53.2	Not reported	55.4% married; 24.6% single; 13.3% separated/divorced	74.2% with 'low' education; 23.2% with 'medium' education; 2.7% with 'high education'	48% had regular employment
6	Fiorentine & Hillhouse (2000)	California, USA	33% male	42.1	45% African American; 28% European American; 23% Latino; 4% Asian	58% married/in a committed relationship	11.8	26% employed
7	Galanter, Egelko & Edwards (1993)	USA (across 19 different states)	72% male (*n* = 313)	45.1	Not reported	Not reported	81% (*n* = 345) had attended college	60% (*n* = 253) in full time employment
8	Gossop et al. (2003)	London, UK	74.7% male (*n* = 112)	Not reported	Not reported	25% married/cohabiting; 39% single; 36% divorced/separated/widowed	Not reported	80% unemployed; 16% employed; 4% retired

Appendix 2: Demographic information for quantitative studies (continued)

Study Number	Authors	Study Location	Gender	Mean age (years)	Race/Ethnicity	Mean Marital Status	Mean Years in Education	Employment Status
10	Hoffman, Harrison & Belille (1983)	Minneapolis, USA	65% male	39	96% White	Not reported	73% completed high school; <10% had a college degree	Not reported
12	Kaskutas, Bond & Humphreys (2002)	California, USA	58% male	38	67% African American	50% single/divorced	83% high school graduates	51% full time employment
13	Kaskutas et al. (2005)	California, USA	65% male	39.8	54% White; 34% Black; 4% Hispanic; 7% Other	30% married/cohabiting	80% had a high school education or more	Not reported
14	Kaskutas, Bond & Amman Avalos, (2009)	California, USA	67% male	39	54% white American; 31% black American; 6% Hispanic; 9% Other	30% married/living together	25% had no high school education	Not reported
15	Kingree & Thompson (2011)	South Carolina, USA	46% male (n = 96)	35	14% reported as 'minority race'	Not reported	Not reported	Not reported
16	Kissin, McLeod & McKay (2003)	Ohio, USA	55% male	35.8	75% African American; 1% Hispanic	83% unmarried	51% had a high school diploma	76% unemployed

Appendix 2: Demographic information for quantitative studies (continued)

Study Number	Authors	Study Location	Gender	Mean age (years)	Race/Ethnicity	Mean Marital Status	Mean Years in Education	Employment Status
18	Kuruvilla, Vijayakumar & Jacob (2004)	India	100% male	Not reported	100% Asian	90.8% married (*n* = 158)	Not reported	Not reported
19	Laudet, Stanick & Sands (2007)	New York, USA	55.3% male (*n* = 122)	39.4	62.6% African American; 33.9% Hispanic/Latino	Not reported	10.6	5.6% employment; 77.1% government assistance
20	McBride (1991)	Florida and Georgia, USA	66% male	43	100% White	70% married	11 did not complete high school; 52% reported education above high school	58% employed
21	McKellar, Stewart & Humphreys (2003)	USA (no specific city location given)	100% male	43.5	42.3% African American; 52.3% non-Hispanic Caucasian	86% not married/single	Not reported	77% unemployed
22	Mueller et al. (2007)	Germany	Not reported	42.1	Not reported	Not reported	Not reported	Not reported
23	Pagano et al. (2004)	USA (no specific city location given)	76% male (*n* = 1,141)	40.2	83% Non-Hispanic Whites	65% married	13.3	51% full time employment

Appendix 2: Demographic information for quantitative studies (continued)

Study Number	Authors	Study Location	Gender	Mean age (years)	Race/Ethnicity	Mean Marital Status	Mean Years in Education	Employment Status
24	Pagano et al. (2013)	USA (Albuquerque, Buffalo, Farmington, Milwaukee and West Haven	66% male (*n* = 148)	33.1	48% Caucasian (*n* = 71); 51% Hispanic (*n* = 75)	24% married	12.7	44% full time employment (*n* = 65)
26	Sheeran (1988)	Chicago, USA	50.8% male (*n* = 30)	Not reported	Not reported	Reported as 'most were married'	100% high school graduate or more	Reported as 'most were employed'
27	Snow, Prochaska & Rossi (1994)	Rhode Island, USA	61% male	44.1	97.8% White	53% married	13.8	Not reported
28	Thurstin, Alfano & Nerviano (1987)	Alabama, USA	Not reported	44	86% White; 14% Black	30% married; 11% separated, 6% widow; 42% divorced, 10% never married	12	Not reported
29	Tonigan & Beatty (2011)	USA (no specific city location given)	67% male (*n* = 127)	39.1	64% Hispanic	Not reported	12.9	65% (*n* = 123) unemployed

Appendix 2: Demographic information for quantitative studies (continued)

Study Number	Authors	Study Location	Gender	Mean age (years)	Race/Ethnicity	Mean Marital Status	Mean Years in Education	Employment Status
31	Witbrodt & Delucchi (2011)	California, USA	<30 = 16% male, 21% female; 30-44 = 56% male, 57% female; 45+ = 28% male, 22% female	39 (male); 38 (female)	Male: 48% white; 36% Black; 16% Other. Female: 64% White; 26% Black; 10% Other	29% married (male); 33% married (female)	Male: 24% < high school; 50% high school education; 27% > high school. Female: 20% < high school; 53% high school education; 27% > high school	Not reported for either male or female cohorts
32	Witbrodt et al. (2012)	California, USA	63% male	37	74% White	45% married/cohabiting	< High school = 14%; High school education = 48%; > High School = 38%	60% full-time/part-time employment
33	Witbrodt & Romelsjo (2010)	Stockholm, Sweden and California, USA	Sweden: 73.7% (male); USA: 61.1% (male)	Sweden: 43; USA: 39	Not reported	Sweden: Male = 20% married/cohabiting; female = 30% married/cohabiting; USA: Male = 29%; female = 33% married/cohabiting	Sweden: <high school = 37%, high school = 45%, >high school = 18%. USA: <high school = 22%, high school education = 51%, >high school = 27%	Not reported
34	Zemore, Kaskutas and Ammon (2004)	California, USA	58% male	41	51% white; 37% black; 9% Hispanic; 3% other	Not reported	Not reported	Not reported

Appendix 3: Demographic information for qualitative studies

Study Number	Authors	Study Location	Gender	Mean age (years)	Race/Ethnicity	Mean Marital Status	Mean Years in Education	Employment Status
4	Davis (1997)	USA (no specific city location given)	100% female	40.7	100% White	50% divorced; 20% separated; 30% married	2 PhD graduates; 1 Masters graduate; 2 BA graduates; 5 high school graduates	80% employed; 20% unemployed
5	Dyson (2007)	UK (no specific city given)	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
9	Hall (1994)	San Fransisco, USA	100% female	37	68% Euro-Americans; 17% African American; 9% Latino; 3% Asian-Pacific Islander; 3% Native American	46% with a partner	All had completed high school	100% employed
11	Kaskutas (1989)	Maryville, USA	100% female	Not reported	100% White	Not reported	Not reported	Not reported

Appendix 3: Demographic information for qualitative studies (continued)

Study Number	Authors	Study Location	Gender	Mean age (years)	Race/Ethnicity	Mean Marital Status	Mean Years in Education	Employment Status
17	Kubicek, Morgan & Morrison (2002)	USA (no specific city location given)	38.5% female	46.9	Not reported	Single females: 15.4%; married females: 23.1%; divorced females: 23.1%; married males: 30.8%; divorced males: 15.4%	Not reported	Not reported
25	Rayburn & Wright (2010)	Florida, USA	100% male	Not reported	Not reported	Not reported	Not reported	Not reported
30	Whelan et al. (2009)	London, UK	86% male	43	68% British; 25% non-white British/white non-British	Not reported	Not reported	85.7% employed; 10% retired; 4.3% unemployed

Appendix 4: Design information for quantitative studies

Study Number	Authors	Sample Size	Sample Origin	Research Design	Instrument of Assessment
1	Bond, Kaskutas & Weisner (2003)	655	Public and private alcohol treatment centres in a Northern California County, USA	Longitudinal (follow up at 1 and 3 years)	Questionnaire created by authors
2	Cross et al. (1990)	158	Willingway Hospital, Georgia, USA	Longitudinal (10 year follow up)	Questionnaire created by authors
3	Curzio et al. (2012)	7,522	DATACLUB Project, Florence, Italy	Cross-sectional	Self-administered questionnaire assessing lifestyle and alcohol consumption.
6	Fiorentine & Hillhouse (2000)	356	The Target Cities Project	Longitudinal (follow up at 8 months)	UCLA Client Needs Outcome Questionnaire
7	Galanter, Egelko & Edwards (1993)	425	Rational Recovery Programs across 19 states in the USA	Cross-sectional	Self report questionnaire; Substance Abuse Severity Index; Group Cohesiveness Scale; RR Belief Scale; Neurotic Distress Scale
8	Gossop et al. (2003)	150	South London specialist, short-stay, inpatient unit.	Longitudinal (follow up at 6 months)	Semi-structured interviews; The Alcoholics Problem Questionnaire; The Severity of Alcohol Dependence; The Symptoms Checklist; Life Situation Survey
10	Hoffman, Harrison & Belille (1983)	900	The Chemical Abuse/Addiction Treatment Outcome Registry (CATROR), Minneapolis, USA	Longitudinal (follow up at 6 months)	Questionnaire created by authors

Appendix 4: Design information for quantitative studies (continued)

Study Number	Authors	Sample Size	Sample Origin	Research Design	Instrument of Assessment
12	Kaskutas, Bond & Humphreys (2002)	927	Northern California County, USA	Longitudinal (follow up at 1 year)	Questionnaire created by authors
13	Kaskutas et al. (2005)	349	Recruited from 10 public and private treatment programs in a Northern California County, USA	Longitudinal (follow up at 1, 3 and 5 years)	Questionnaire created by authors
14	Kaskutas, Bond & Amman Avalos, (2009)	926	North Californian County	Longitudinal (follow up at 1, 3, 5 and 7 years)	Addiction Severity Index; questions from the Diagnostic Interview Schedule for Psychoactive Substance Dependence; questions from AA Affiliation Scale/Religious Beliefs and Behaviours Scale
15	Kingree & Thompson (2011)	268	South Carolina, USA	Longitudinal (follow up at 3 and 6 months)	Drug Use Frequency Questionnaire; Alcoholics Anonymous Affiliation Scale
16	Kissin, McLeod & McKay (2003)	722	Cuyahoga County, Ohio, USA	Longitudinal (follow up at 6, 30 months)	Computer Assisted Central Intake Assessment Instrument-Cleveland (CIAI-C)
18	Kuruvilla, Vijayakumar & Jacob (2004)	174	India	Longitudinal (follow up at 1 year)	Questionnaire created by authors
19	Laudet, Stanick & Sands (2007)	219	Two Programs in New York, USA	Longitudinal (follow up at 3, 6 and 12 months)	Lifetime Non-alcohol Psychoactive Substance Use Disorders subscale of the Mini International Neuropsychiatric Interview Addiction Severity Index

Appendix 4: Design information for quantitative studies (continued)

Study Number	Authors	Sample Size	Sample Origin	Research Design	Instrument of Assessment
20	McBride (1991)	50	Florida and Georgia, USA	Cross-sectional	Questionnaire created by author
21	McKellar, Stewart & Humphreys (2003)	2,319	Located at 15 VA treatment centres in USA. No reference to specific location	Longitudinal (follow up at 1 and 2 years)	Health and Daily Living Form; Problems From Substance Use Scale; Stages of Change Readiness and Treatment Eagerness Scale
22	Mueller et al. (2007)	78	13 alcohol treatment centres in Germany (part of a larger randomised, placebo-controlled pharmacological study)	Longitudinal (follow up at 3, 6 and 12 months)	Munich Alcoholism Test; Hamilton Depression Scale; Social Functioning Questionnaire;
23	Pagano et al. (2004)	1,501	Project MATCH, USA	Longitudinal (follow up at 3, 6, 9, 12 and 15 months)	Form 90; Alcoholics Anonymous Involvement Scale
24	Pagano et al. (2013)	226	Project MATCH, USA	Longitudinal (follow up at 3, 15. 39 and 120 months)	Alcoholics Anonymous Involvement questionnaire; Form 90
26	Sheeran (1988)	59	5 AA groups in the Chicago metropolitan area, USA	Cross-sectional	Likert Scale assessing AA involvement and abstinence
27	Snow, Prochaska & Rossi (1994)	191	Newspaper articles/local Rhode Island council, USA	Cross-sectional	Process and Change Questionnaire; The Self-Efficacy Questionnaire

Appendix 4: Design information for quantitative studies (continued)

Study Number	Authors	Sample Size	Sample Origin	Research Design	Instrument of Assessment
28	Thurstin, Alfano & Nerviano (1987)	145	Tuscaloosa VA Medical Centre, Alabama, USA	Longitudinal (follow up at 6, 12 and 18 months) Longitudinal (follow up at 3, 6, 9, 12, 18 and 24 months)	Not reported
29	Tonigan & Beatty (2011)	189	Community-based AA and outpatient treatment programs, USA (no specific mention of metropolitan area)	Longitudinal (follow up at 1, 3, 5 and 7 years)	Form 90; iCassette Drug Screen-4 Panel Test; Stages of Change Readiness and Treatment Eagerness Scale
31	Witbrodt & Delucchi (2011)	926	10 public and private treatment programs in Northern California, USA	Longitudinal (follow up at 1, 5, 7 and 9 years)	Social Network Assessment; Addiction Severity Indices; Graduated Frequency Scale
32	Witbrodt et al. (2012)	1,825	Kaiser Permanente Chemical Dependency Recovery Program (CDRP), Sacramento, California, USA	Longitudinal (follow up at 1 year)	Addiction Severity Indices; self-assessed questionnaires
33	Witbrodt & Romelsjo (2010)	2,451	Stockholm county health-based system and social-welfare based system. California: public and private treatment programs.	Longitudinal (follow up at 6 months)	Addiction Severity Indices; self-assessed questionnaires
34	Zemore, Kaskutas and Ammon (2004)	279	Three mixed-gender sites from Northern California, USA	Longitudinal (follow up at 6 months)	Questionnaire created by authors

Appendix 5: Design information for qualitative studies

Study Number	Authors	Sample Size	Sample Origin	Qualitative Approach	Instrument of Assessment
4	Davis (1997)	4	The Maryville group for Women for Sobriety (WFS)	Not reported	Participant observation of one WFS meeting a week for 4 months; semi-structured interviews
5	Dyson (2007)	35	Alcoholics Anonymous groups in San Francisco, USA	A feminist ethnographic study	Semi-structured interviews
9	Hall (1994)	10	Alcoholics Anonymous groups	Not reported	Semi-structured interviews
11	Kaskutas (1989)	13	Alcoholics Anonymous groups	Thematic Analysis	Semi-structured interviews
17	Kubicek, Morgan & Morrison (2002)	8	Alcoholics Anonymous groups	Narrative method	Semi-structured interviews
25	Rayburn & Wright (2010)	28	Alcoholics Anonymous groups	Not reported	Semi-structured interviews
30	Whelan et al. (2009)	Not reported	First Steps: a shelter for homeless males in Florida	Not reported	Semi-structured interviews

Appendix 6: Detailed statistics of quantitative studies

Study Number	Authors	Detailed statistics
1	**Bond, Kaskutas & Weisner (2003)**	Abstinence for 90 days was significantly associated with increased AA attendance ($p < 0.01$), more sponsors ($p < 0.01$), more reading of AA literature ($p < 0.01$) and more AA service ($p < 0.01$) in the 12 months prior to each follow up. Those who interacted with people who encouraged the individual to reduce their drinking were significantly associated with 90 day-abstinence status ($x^2 = 6.4$, $p < 0.01$) for both follow up periods. Those who had support from other AA members had proportionately higher abstinence rates (1-year: 36.6% verses 14.3%, $p < 0.001$; 3-years: 15.6% verses 5.8%, $p < 0.001$). Logistic regression found that for paired analysis (baseline and 1-year follow up and 1-year and 3-year follow up), increased participation, those with fewer heavy drinkers in their social networks and those with proportionately more contacts who encourage a reduction in drinking were significantly more likely ($p < 0.001$) to be abstinent in the 90 days prior to follow up. For the baseline-1-year paired model, those with AA-based support were significantly more likely ($p < 0.03$) to be abstinent than those who had non-AA support. OR's showed that those with less heavy drinkers (OR = 0.84 (0.77 - 0.91); 95% CI; $p < 0.01$), more people who encouraged a reduction in drinking (OR = 1.00 (0.99 - 1.01); 95% CI; $p < 0.01$) and AA-based support (OR = 1.58 (1.13 - 1.98); 95% CI; $p < 0.05$) were more likely to be abstinent at both follow ups.
2	**Cross et al. (1990)**	61% of those who had attended the self-help group during treatment, followed by regular AA attendance were either in complete or stable remission. Using a multiple stepwise regression, regular AA involvement was found to be a significant predictor of the number of years of sobriety ($p = 0.05$). Furthermore, 91% of those who remained sponsors during the follow up period reported complete or stable remission. AA scores for complete remission were significantly higher ($p < 0.05$ (ANOVA and Newman-Keuls Test)) than the other categories (stable remission, intermittent abuse and chronic abuse).
3	**Curzio et al. (2012)**	Those who had extended attendance at CAT's (> 3 years) were more likely to be abstinent than those < 3 years ($r = 1303.206$, $p < 0.0001$). Abstinence was affected by age (OR = 1.023, 95% CI = 1.1016-1.030), years of club attendance (OR = 1.199, 95% CI = 1.175-1.222), the presence of other problems (OR = 2.565, 95% CI = 2.090-3.147) and employment (OR = 1.176, 95% CI = 1.009-1.371). Being abstinent with a perceived better life was more likely for females and not having other problems (OR = 3.190, 95% CI = 2.555-3.984).
6	**Fiorentine & Hillhouse (2000)**	Completed professional treatment in conjunction with 12-step attendance over 24 weeks had higher rates of abstinence (odds ratio = 3.54) than those who participated in one or the other (odds ratio = 1.78).

Appendix 6: Detailed statistics of quantitative studies (continued)

Study Number	Authors	Detailed statistics
7	**Galanter, Egelko & Edwards (1993)**	97% of participants had used alcohol; 52% had used cannabis; 31% had used tranquilisers/depressants; 41% had used cocaine and 12% had used heroin in the month prior to participation. Since joining Rational Recovery, 73% of 'engaged members' (those with an average of 8 months membership) were abstinent from all substances compared to 38% of 'recruits' (those who had only attended RR for the first time in the past month). Of those who reported 6+ month membership, 58% (*n* = 94) reported 6 month abstinence and 77% (*n* = 122) reported 1 month abstinence. 'Engaged members' also had a lower score on the Neurotic Distress Scale (14.5 verses 18.3; x^2 (d.f. 129, $t = 4.14$, $p < 0.05$)), a greater sense of cohesiveness (30.7 verses 26.9; x^2 (d.f. 112; $t = 4.86$, $p < 0.01$)) and were more involved with RR (31.8 verses 15.8 x^2 (d.f. 327; $t = 2.41$, $p < 0.05$)). Those more engaged with RR also had lower AA attendance scores in the past month (1.5 verses 4.0; x^2 (d.f. 155; $t = 4.06$, $p < 0.01$)).
8	**Gossop et al. (2003)**	40% (*n* = 48) attended AA after inpatient treatment during the follow-up period. Those attending AA during the follow up reported drinking less frequently than non-AA-attenders at follow-up (AA attenders: mean = 31 drinking days, non-attenders = 53; drinking days: $t = 3.9$; d.f. 110.6; $p < 0.01$). Those who attended AA on a weekly or more frequent basis reported drinking less frequently than those who attended less frequently or not at all (weekly or more often: mean = 8.8 days; less than weekly: 17.3 days; not at all: 19.2 days; F = 4.4 (d.f. 119), $p < 0.05$) and in lower amounts (measure in single units of alcohol) (weekly/more often: mean = 6.0; less than weekly: 20.1; not at all: 22.3; $F = 4.2$ (d.f. 117), $p < 0.05$) during the 30 day period prior to follow up.
10	**Hoffman, Harrison & Belille (1983)**	The relationship between frequency of attendance at AA and abstinence was found to be statistically significant beyond $p < 0.0001$. Of those who attended weekly for 6 months after inpatient treatment, 73% remained abstinent. 69% remained abstinent of they attended 3 times a month, 43% remained abstinent if they attended once a month and only 33% remained abstinent if they did not attend AA at all. There was no statistical significant difference between weekly attenders and several times a month but there was a significant difference between these two groups and those who attend once a month or not at all ($p < 0.001$). They also found that those who attended AA weekly tended to group together (48%, *n* = 428), and those who did not attend also grouped together (33%, *n* = 300).

Appendix 6: Detailed statistics of quantitative studies (continued)

Study Number	Authors	Detailed statistics
12	**Kaskutas, Bond & Humphreys (2002)**	Four groups: 'low' (*n* = 174), 'medium' (*n* = 63), 'high' (*n* = 71) and 'declining' (*n* = 41) based on their AA attendance at 1-year following treatment. At baseline, the number of heavy drinkers in the 'high' and 'medium' groups were similar (approximately 1 person), for the 'low' group it was 2 heavy drinkers and for the 'declining' group - 3 heavy drinkers or drug users in their social networks. At baseline, all four groups had a similar number of individuals who encouraged a reduction in drinking (3 or 4 persons) which increased at follow up to 7 people in the 'low' and 'declining group, 9 for the 'medium' group, and 12 for the 'high' group. 46% of the 'low' group reported abstinence in the 30 days prior to every follow up and 66% for the 'medium' group across all follow-ups. For the 'declining' group, 1-year abstinence rates fell from 79% to less than two-thirds at each follow up. For the 'high' group, abstinence at 1-year went from 66% to 86% at 3 years and 79% at 5 years. A comparison of abstinence rates for the groups was significant (x^2 = 13.47, 3 d.f., $p < 0.0034$). At the 5-year follow up, the 'low' group had significantly lower abstinence rates than the 'medium' group ($p < 0.002$), the 'declining' group ($p < 0.003$) and the 'high' group ($p < 0.001$).
13	**Kaskutas et al. (2005)**	They found three measures of AA involvement that were significantly higher at follow up: number of AA meetings (106.8 meetings at follow up compared to 34.6 at baseline ($p < 0.005$)); those who have sponsors (26% at follow up compared to 14% at baseline ($p < 0.005$)) and those who are sponsors (4.5% at follow up compared to 0.5% at baseline ($p < 0.005$)). Furthermore, using logistic regression, AA involvement as a predictor of 30 day abstinence prior to the follow up was 3.50 ($p < 0.00001$), which went down to 2.94 ($p < 0.00001$) when social network influences were introduced. They also found that pro-drinking influences in the social network significantly reduced the likelihood of abstinence (OR = 0.70, $p < 0.01$). Factoring in support from people they met at AA, each individual was 3.4 times the odds of being abstinent at 30 days prior to the follow up ($p < 0.001$). At 90 days, 33% of people with no support were abstinent, which went up to 45% with non-AA based support and 72% with support from AA members.
14	**Kaskutas, Bond & Amman Avalos, (2009)**	There were 4 identifiable groups: 1) low AA group (*n* = 370); 2) medium AA group (*n* = 90); 3) descending AA group (*n* = 67); 4) high AA group (*n* = 58). All of these groups had treatment at baseline but treatment in the 12 months prior to the 1, 3, 5 and 7-year follow ups declined. Abstinence was lowest amongst the 'low AA group' and highest amongst the 'high AA group'. Approximately 30% were abstinent at 7 years in the 'low AA group' and 60% in the 'medium AA group'.

Appendix 6: Detailed statistics of quantitative studies (continued)

Study Number	Authors	Detailed statistics
15	**Kingree & Thompson (2011)**	Abstinence from alcohol and drugs were significant at baseline (phi = 0.32, $p < 0.001$) and at 6 months (phi = 0.32, $p < 0.001$). Abstinence form alcohol (x^2 (d.f. = 1, n = 205) = 15.8, $p < 0.001$) and abstinence from alcohol and drugs (x^2 (1, n = 205) = 6.90, $p < 0.001$) increased significantly from baseline and 6 months. They found that baseline abstinence from alcohol and baseline abstinence from drugs (OR for alcohol = 7.69; OR for drugs = 8.23) increased the odds that participants would be abstinent at 6 months. Furthermore, those who had a sponsor at 3 months, the odds of them being abstinent from alcohol at 6 months was greater (OR = 2.69). Similarly, for those with a sponsor at 3 months, the odds of them being abstinent from drugs at 6 months was greater (OR = 1.66).
16	**Kissin, McLeod & McKay (2003)**	SH group attendees could be divided into 5 categories: 'continuous attendees' (16%, n = 121); 'starters' (26%, n = 199); 'stoppers' (13%, n = 103); 'non-attendees' (19%, n = 146); 'intermittent attendees' (26%, n = 203) At baseline, 31% (n = 238) reported having attended at least 6 self-help group in the previous 6 months. Of the 238 self-help attendees, 18% reported lifetime attendance of at least 6 years. Between baseline and 6 month follow up, self-help attendance increased from 31% to 71% (of the sample), which finished at 43% at 36 months. Of the 5 groups, 'continuous attendees' attended the most meetings at 36 months (63.7%, $p < 0.001$). Baseline self-help attendance was associated with less alcohol use (6 months: t = -0.10, $p < 0.01$; 30 months: t = -0.25, $p < 0.01$ (Kendall's tau-b test)) and drug use (6 months: t = -0.10, $p < 0.01$; 30 months: t = -0.18, $p < 0.001$ (Kendall's tau-b test)) at both follow up points. More self-help days at 6 months were associated with less alcohol (Pearson r = -0.09, $p < 0.05$) and drug use (Pearson r = 0.06) at 6 months and more treatment at the endpoint was also correlated with less alcohol use at that point (Pearson r = -0.17, $p < 0.001$). Self-help group attendance showed significantly decreased alcohol use for all groups with 'starters' 'intermittent' and 'continuous' showing the greatest decline between baseline and 6 months. The same applied to drug use.
18	**Kuruvilla, Vijayakumar & Jacob (2004)**	Educational status of the individual (x^2 = 3.90, 1 d.f., $p < 0.048$), distance from AA (x^2 = 4.72, 1 d.f., $p < 0.030$) and the presence of a keyworker in the area (x^2 = 6.54, 1 d.f., $p < 0.011$) were significant predictors of abstinence. Relative risk calculations also showed that those with higher educational status were 0.75 (95% CI; 0.61 - 0.92) times more likely to be abstinent at follow up, 1.27 (95% CI; 1.01 - 1.60) times more likely to be abstinent if they lived closer to the AA centre and 1.35 (95% CI; 1.05 - 1.73) times more likely to be abstinent if a keyworker lived in their area.

Appendix 6: Detailed statistics of quantitative studies (continued)

Study Number	Authors	Detailed statistics
19	**Laudet, Stanick & Sands (2007)**	55% or fewer reported no drug use since the prior interview and only 21.5% reported sustained abstinence over the one-year. 54.3% attended 12-step meetings at baseline, which declined to 29.7% at the 12-month follow up, and only 16.7% reported continuous 12-step attendance. The TSO clients (those who attended the 12-step group on-site) had significantly higher rates of participation and higher rates of involvement at each of the follow up points (3 months: 66% verses 45.1%, $p < 0.01$; 6 months: 50% verses 33.3%, $p < 0.05$%; 12 months: 36.1% verses 24.6%, not significant). Furthermore, the TSO group had significantly higher rates of abstinence since their previous interview at all follow ups than N-TSO (those attending 12-step groups off-site) (TSO = 33.3% verses N-TSO = 12.2%, $x^2 = 13$, $p < 0.001$). TSO clients were also 5.79 times more likely than the N-TSO to have maintained abstinence for the entire year (B = 1.75, $p < 0.001$; 95% CI = 2.32-14.5).
20	**McBride (1991)**	Continuous attendance at AA was positively correlated with months of abstinence (Pearson's $r = 0.71$, $p < 0.001$). Furthermore, the number of months since joining AA was also positively correlated with months of abstinence (Pearson's $r = 0.59$, $p < 0.001$).
21	**McKellar, Stewart & Humphreys (2003)**	46.6% of participants stated they had attended 1-10 AA meetings in the 3 months prior to baseline with only 9.2% reporting 10+ meetings. In the three months prior to the 1-year follow up, 56% reported attending 1-10 meetings, with 23.3% reporting more than 10 meetings. In the 3 months prior to the 2-year follow up, 48.6% reported attending 1-10 meetings with 19.8% reporting 10+ meetings. They also found that AA involvement significantly predicts subsequent alcohol problems, but alcohol problems do not significantly predict AA involvement.
22	**Mueller et al. (2007)**	Those in the self-help group had better social functioning outcomes than those who did not attend a SHG at baseline (t (76) = 2.51), $p < 0.037$). Kaplan-Meier survival analysis showed that over the year (of those who completed the one-year follow up), 37.9% of SHG ($n = 11/29$) and 41.2% ($n = 7/17$) had relapsed. At 1-year, both groups improved on social functioning scores ($F(2, 84) = 7.61$, $p < 0.001$) suggesting that time, not group allocation was the most important factor.
23	**Pagano et al. (2004)**	Those who helped others prior to treatment were significantly related to helping others at the end of follow up ($x^2 = 8.9$, 3d.f. $p < 0.0001$). Helping others was positively correlated with the number of AA meetings attended ($r = 0.27$, $p < 0.0001$). Helping others was linked with less chance of relapse (Wilcoxon $x^2 = 16.9$, 1 d.f., $p < 0.0001$) with 40% of helpers maintaining abstinence in the year following treatment (compared to 22% of non-helpers).

Appendix 6: Detailed statistics of quantitative studies (continued)

Study Number	Authors	Detailed statistics
24	**Pagano et al. (2013)**	A significant effect of 10-year attendance was found on percentage of days abstinent (F = 40.15, p < 0.0001) but not for other outcomes (measured by the Beck Depression Inventory) (F = 2.11, p < 0.15). Significant fluctuations on AA meeting attendance were observed over time (F = 10.82, p < 0.0001). The average number of steps completed over the 10-year period remained low (F = 2.01, p < 0.11), but those who worked at least one step during index treatment continued to progress in step-work over time (F = 10.21, p < 0.0001). Those who helped in AA also remained stable over time (F = 2.62, p < 0.06) (approx. 9-10%). During the 3-month treatment period, twelve-step facilitation (TSF) recipients had greater participation in AA-helping (15% verses 6%; x^2 = 5.17; p < 0.05), step-work (1+ steps worked: 68% verses 29% x^2 = 29.90, p < 0.0001) and percentage of days attending AA meetings in treatment period (MTG) (mean = 23.73 verses 5.93; F = 38.81; p < 0.0001) at any time point. These results were replicated at 15 months. There were positive effects of MTG (p < 0.01) and AA-helping (p < 0.05) on percentage of days abstinent (MTG: p < 0.05; AA-helping: p < 0.05)
26	**Sheeran (1988)**	Participants were grouped into 2 groups: (group 1) and those who reported more than 2 years continuous abstinence (group 2). Group 2 scored better in all 7 domains: 1) AA meetings (mean = 4.32 verses 4.3); 2) working the steps of AA (mean = 4.43 verses 3.9); 3) using a sponsor (mean = 3.92 verses 2.8); 4) reaching out to AA members when in need of help (mean = 4.05 verses 2.9), 5) assisting others in 12-step work (mean = 3.43 verses 2.9); 6) participation in meetings (mean = 4.62 verses 4.4) and 7) studying AA literature (mean = 4.14 verses 3.5). Of particular importance are having a sponsor (p < 0.001) and reaching out for help (p < 0.05) as they were both significant differences between group 1and 2. With regards to AA involvement, both groups were subdivided into 2 subgroups: those involved with AA for 3-6 years and those involved for 7-10 years. Group 1 stated a shorter time of involvement (mean = 6.25 years verses 8.64 years for group 2). For the 3-6 year involvement in both groups, group 2 scored higher on all domains, with 'having a sponsor' and 'reaching out' both being significant. Group 1 scored higher on domains 1, 2, 5 and 6 for the 7-10 year comparison but group 2 still significantly scored higher on domains 3 and 4.
27	**Snow, Prochaska & Rossi (1994)**	Frequency of AA attendance (low, medium or high) was a significant predictor of long-term abstinence (x^2 (2, 89) = 5.55, p < 0.05). Frequency of attendance was associated with behavioural change (F(2, 86) = 6.46, p < 0.01) with medium and high frequency attendance reporting greater behavioural change than low frequency AA attendance. The length of abstinence was also a significant predictor of increased self-efficacy (F(2, 63) = 3.60, p < 0.05).
28	**Thurstin, Alfano & Nerviano (1987)**	Only frequency of attendance at AA produced a significant result for 18-month abstinence (x^2 = 4.32 (1 d.f.), p < 0.05).

Appendix 6: Detailed statistics of quantitative studies (continued)

Study Number	Authors	Detailed statistics
29	**Tonigan & Beatty (2011)**	Between 0-3 months, 81.5% (n = 154) attended a 12-step meeting; at 3-6 months, 70.4% (n = 133); at 6-9 months, 61.9% (n = 61.9%) and at 12 months 56.6% (n = 106) were attending 12-step groups. During this time, reported alcohol use fell from 100% (n = 189) at baseline (0 months) to 56.1% at 12 months (n = 106). Similarly, drug use fell from 68.3% (n = 129) at baseline to 45.5% (n = 86) at 12 months. At 6 months, the percentage of days alcohol use and drinks acquired per day were significantly correlated ($r(189) = 0.458$, $p < 0.001$), as were the same values at 12 months ($r(181) = 0.359$, $p < 0.001$). For percentage of days illicit drug use and alcohol use, 6 month follow up was significant ($r(189) = 0.215$, $p < 0.003$) as was 12 month follow up ($r(181) = 0.177$, $p < 0.017$). Time-lagged hierarchical linear models found that frequency of 12-step attendance significantly predicted reductions in percentage days of alcohol use ($b = 0.15$; $t = -3.84$, $p < 0.001$) and drinks per day ($b = -0.03$, $t = -2.38$, $p < 0.018$) over 12 months. Frequency also predicted alcohol abstinence ($b = 0.02$; $t = 4.11$, $p < 0.001$) and drug abstinence ($b = 0.01$; $t = 2.81$, $p < 0.006$). More frequent illicit drug use predicted lower probability of alcohol abstinence (% days illicit drug use: $b = -0.011$; $t = -3.17$, $p < 0.002$; inclusive % days illicit drug use: $b = -0.008$; $t = -3.23$, $p < 0.002$). Reporting drug use did not significantly predict percentage days alcohol use or drinks per day. Higher values of inclusive percentage days illicit drug use significantly predicted reductions in drinks per day ($b = -1.42$; $t = -2.00$, $p < 0.045$) which was strongest between baseline and 3-month follow up. Of those who completed 12-step attendance over 12 months (n = 107), reporting drug use significantly predicted later alcohol use ($b = 0.89$; $t = 2.80$, $p < 0.006$), whereby alcohol use was 2.4 times more likely with prior drug use, with less drug use significantly predicting less alcohol use ($b = 0.01$; $t = 2.26$; $p < 0.024$).
31	**Witbrodt & Delucchi (2011)**	Regression analyses showed that for both genders, greater AA involvement was associated with abstinence (male coef = 0.294; female coef: 0.251), but men were less likely to be abstinent overall (men verses women coef = -0.057), which remained stable across the 7 year follow up periods.
32	**Witbrodt et al. (2012)**	Determined 6 attendance trajectories: 'high' (n = 457), 'descending' (n = 220), 'rising' (n = 93), 'early-drop' (n = 291), 'low' (n = 154) and 'no' (n = 608) attendance. Those in the 'high' trajectory reported approximately 75% abstinence in the 30 days prior to each follow up. Those in the 'descending (57%)' and 'early-drop' (53%) trajectories reported abstinence in the 30 days prior to follow up at 5, 7 and 9 years. Abstinence was lowest in the 'rising class' in year 1 (46%) which did increase to 60% at year 5 and 65% at year 9.. Individuals in the 'high' attendance class had significantly better abstinence outcomes than all other trajectories ($p < 0.003$). Furthermore, those in the 'high' trajectory had significantly lower ASI scores over time ($p < 0.003$) than all other trajectories. Found low attendance trajectories had higher levels of 'non problematic use' than high attendance classes ('early-drop' class = 11%, 14% and 12% at 5, 7 and 9 years; 'no' = 13%, 12%and 11% at 5, 7 and 9 years; 'high' = 2%, 3% and 3% at 5, 7 and 9 years).

Appendix 6: Detailed statistics of quantitative studies (continued)

Study Number	Authors	Detailed statistics
33	**Witbrodt & Romelsjo (2010)**	Swedish men and women reported mutual-help group attendance at similar lifetime rates (60% and 58% respectively, as did men and women in the US (88% and 86% respectively). There were no gender differences at 1-year follow up. Swedish sample: for both genders, follow up mutual-help group participation was positively correlated with abstinence (OR = 2.0; $p < 0.0001$). US sample: mutual-help attendance was also significantly correlated with abstinence (OR = 2.3; $p < 0.0001$). For women in the US sample (not men), alcohol and drug dependency predicted follow up attendance (OR = 3.8; $p < 0.014$). For the US sample, of the 72% who attended mutual-help groups in the year after treatment, 51% only attended AA, 7% attended only NA/Cocaine Anonymous, 2% attended 'unspecified' groups and 40% a combination. Data not available for the Swedish sample.
34	**Zemore, Kaskutas and Ammon (2004)**	Helping others during treatment predicted 12-step involvement at follow up positively and significantly. Involvement was correlated with sharing experiences of abstinence ($r = 0.24$), sharing experiences about other problems ($r = 0.18$), and giving moral support and encouragement ($r = 0.18$).

Appendix 7: A detailed example of field notes

Observation 1
Date: 24th November 2011
Location: Skipton
Activity: Walk around the town
Time span of activity: 10am until 15.30pm
Time notes were written up: 16.00pm on 24th November 2011

When I first arrived it was 9.50am and I was the first of the group to arrive. I was greeted by the receptionist and told that Adele would not be too long. The next person to arrive was Julie (mentor) who greeted me and was very friendly; we had met several times before so was happy to see a familiar face. I did feel slightly apprehensive before meeting everyone as this is something I have never done before and is a world that is very alien to me. The next person to arrive was Christine – a woman of approximately 50 years of age who was friendly to me after introducing myself and we sat in the LAU reception and chatted. (At this point Julie had gone outside for a cigarette and Adele had quickly popped to her desk to check for messages). Christine explained to me that she had not been on a trip like this with other people for 14 years as she did not like to leave her father (a man of 84) alone and was also very nervous of going out generally with other people she does not know. She said whenever they went somewhere, they always went together – even abroad on holidays to Spain. She was telling me about how she and her father went to Magaluf this year and how her father was a big hit with the ladies. At this point I felt much more at ease as she approached me and was chatty with me from the start.

At this point (about 10.20am) the rest of the ladies going on the trip had turned up – Diane, Sally, Frances and Jim the driver. They were all (including Christine) standing outside having a cigarette except myself, Adele, Julie and Ann the receptionist. Julie said to Adele that she thought she could smell alcohol on Christine's breath and they both then asked me as I had been sitting next to her whilst chatting about her holiday. I said I couldn't but very quickly commented that I am perhaps very naïve with this and that they shouldn't take my word. Between Julie, Ann and Adele they decided to breathalyse Christine – after a short debate it was decided that Adele would take her into a room and say we smell alcohol on you can you please take a breath test. The rule is that one cannot come on the activities if they are not sober (it was about 10.25am at this point). Adele went outside and asked if she could just have a quick word with Christine in the interview room to which Christine obliged. They were in there for about 2 minutes. Meanwhile myself and Julie were standing outside in the reception and Julie was explaining to me that with recovering alcoholics, they often just 'top up' which is why they don't look or appear drunk but still are drunk.

At this point I thought to myself that Julie (a recovering alcoholic) was quite cynical – perhaps because she used to do it which a) highlighted to my I was quite naïve and b) Julie just knew Christine had been drinking. Julie was quick to say to me however that I may be right. I was sceptical about my naivety. When Adele and Christine came out of the room they both went through to the

back office where Adele breathalysed Christine. When they came back Adele said that Christine was twice the drink drive limit, to which Julie said she had definitely been drinking that morning. Adele and Ann the receptionist made a comment that one time when they both came to work they had been out the night before, come into work, breathalysed themselves and found they were still under the drink drive limit. This confirmed to Julie that Christine definitely had been drinking that morning. Adele and Julie had a conversation and Adele said that Christine really wanted to come on the trip. It was decided that Adele would ask the group and if they agreed she should come then Christine was allowed. I thought at this point that despite contravening their own rules, it was a democracy and that others had a say in others actions – perhaps because they were sympathetic. Christine was allowed to come on the trip, at which point we all left the LAU and got onto the bus. Just before we got on, Adele made a quick comment, this is Tom, he wants to use part of the project for his dissertation. I was surprised as no one seemed to take much notice and were very welcoming of me.

We got on the minibus at about 10.40am and set off for Skipton. Sally, the youngest member of the group was quite loud (in a good way) and was very chatty just saying how she didn't like buses but was going to get through it. She made a comment 'I deserve a medal for this' and I immediately thought she meant because of the journey but Sally then said "coming from what I was earlier this year – all yellow and 6 million stone I deserve at least something" (to quote her). Adele and Julie both said you have done so well and really reassured her the bus journey would be fine. I thought at this point that Julie and Adele were there only for 2 reasons – 1) to organise what to do on the walk (a role any group would have) and 2) to act as reaffirmation to people that they are doing well just by coming on the activities.

At first I was a little nervous, despite being well received as I did not want there to be awkward silences or for them to see me as intruding. Within seconds however, my nerves were calmed as Diane (my favourite) immediately struck up conversation with me about where I live and was pointing out to me places along Kirkstall Road like where she lived and went swimming etc. Christine sat in the back and for nearly the entire journey (unless she was asked a question) was silent. I thought this was perhaps because she had been caught drinking and perhaps felt a bit embarrassed and wanted to keep a low profile. The journey took around an hour as we got stuck in traffic going through Ilkley but the entire journey people were just chatting as normal. Were asking each other what they were doing at the weekend and were asking Adele about her holiday to the Maldives. They engaged me conversation just as if I was one of their own and at no point did I ever feel out of place or that I was unwelcome. Along the route, what I found interesting was that they pointed out some of the pubs they used to go to. This was interesting for me as I had the thought that they would try and avoid attention to such places as it might bring back bad memories but that was not the case. They were talking about how lovely some of the pubs were which was a real surprise to me as they just talked about alcohol and alcohol related topics freely. Diane, Frances and Julie were even talking to me about the clothes they had brought to go on a night out in Leeds to a retro 70's bar called Revival

on the 3rd December. Diane made a joke that it was just going to be a tonic water night. About half way through the journey, I had them sign the consent forms – I did this as I did not want to shove the forms in their faces form the off which seemed to really work. Adele said to them all – would you mind just signing this for Tom. I said to Diane, its something I just have to do and she said not to worry and that they all totally understand.

As the journey went on, I was just still so surprised by how 'normal' they all were and said to myself if I didn't know they were recovering alcoholics, I would never would have guessed as they just seemed so down to earth, friendly and welcoming of me. I did feel like they enjoyed me being there as a younger person and felt like they almost acted as my mum, which I think they enjoyed as they liked talking to me about things.

After a traffic jam in Ilkeley, we arrived in Skipton at about 12 noon. We all got out the car and decided that we would just wonder around until we found somewhere for some lunch. We stopped in a few shops and the service users led the way – Julie, myself, Adele and Jim just took a back seat and followed the others into whatever shop they went. I thought at this point they were given more freedom than I imagined but was nice to see the ladies just pottering around. I had a good conversation with Jim and it was only him the entire day who asked me what I do, what it was in, and anything related to my course and where I live. As we wondered along the service users led the way and were able to go into shops as they pleased. Fran and I were talking about some candle holders she had purchased at the German Market in Leeds for £18. She saw similar ones in a small shop we walked past and pointed them out to me that the candle holders she had purchased were exactly like these and made a comment on how these ones were cheaper. Although this seems like a mundane event, it was nice for me as I thought that they really are treating me as if I was just a normal person coming on a walk with them and not someone coming from the outside to research their project. I felt like I was really fitting in and it was an event such as this that made me feel I was getting good firsthand knowledge of how they acted with one another and just what they like doing – in this case just pottering around. Many of the projects activities are like this (so I am told) which from the outside makes me think that the project is not there to perform miracles but instead to simply instil a sense of normality back in the lives of service users who once had previously chaotic lives.

At about 12.20 we found a little coffee shop we all went in except Sally – she said she wanted to go get a pork pie for her dad and she was free to wonder as she pleased. Again I found this interesting as they were awarded the freedom and given the trust not to go to a pub. Christine was watched more closely and was not left alone in case she did do this as she did admit she was nervous about coming on an outing like this for the first time in 14 years.

We all ordered lunch and the conversation amongst everyone was just a normal conversation as any group of friends would have. Sally returned about 15 minutes later but did not eat food. I talked to Jim the driver mostly and he told me how he did the same sort of job for the Leeds Mental Health clinic as well. We discussed general topics like the NHS and what we thought of the project and I

told him about how it was hard for me be as objective as possible and not put my own feelings on my write up. Jim was sympathetic to this and we just talked a little about the project. Jim said to me he thought the project was great as it was giving back a sense of being normal to people who have not lived normal lives for some time we he said he thought was very valuable. At this point it was nice to hear that as that was my view on the project – it was nothing extravagant just a way of instilling normality and routine back into the lives of people where conventional normality has been absent for some time. During the lunch they were also talking about some of the other trips they have been on to the coast and were talking about a great fish and chip shop they went to in Bridlington. All the service users were discussing how they really enjoyed going on the trips as it gave them something to do and look forward to. Again my pre conception is that the project was there to act as means of giving users something to do so was nice to have my preconception confirmed independently by them.

We finished the meal around 13.20 and decided that we needed to be back for 15.00pm so decided to have a little more of a wonder around Skipton. We went to a sweet shop were something interesting happened. Christine dropped change on the floor, I bent down to pick it up for her and as I stood up I got a very strong smell of alcohol on her breath. Something which I did not smell earlier. I thought to myself I don't know if it was because I knew she had been drinking that I smelt it or because she had actually drank during the trip but either way I felt obliged to tell Adele. Adele took it calmly and said she may have a drink in her bag which she was swigging from and to me it felt like quite a relaxed approach as I would have perhaps checked her bag. But then I did think the project does try to treat the service users with respect so asking to search someones bag is not showing them respect so can understand why Christine was not checked. We wondered back to the minibus, I was talking with Adele just about the activities and I said they seem to love her and wanted to go on the night out they had planned on the 3rd December. Adele laughed and said it was a Saturday and that she didn't want to use her spare time doing things like that as much as she loved the project, to which I agreed.

We returned to the bus (at about 14.30pm) and the journey home was a lot quieter. I myself was quite tired from wondering around and the others were too. When we returned to the LAU at around 15.30pm, Christine said how much she enjoyed it and Julie said she was really glad she came and that she just wanted her to get better. Christine said she knew she had work to do and they all hugged each other goodbye – something which I thought was really nice as it showed a genuine support system to help those in need of it. I left shortly after this and wrote everything down on the train journey home – less than 30 minutes after leaving the group. I thought to myself I had a lovely time seeing how they work and interact and also found that remembering events was easy enough for me not to have to take notes.

General Reflections

The interaction amongst the service users, mentor, professional staff and myself was very relaxed and very friendly. I did have the preconception that Julie or Adele might take charge slightly but in fact it was the service users who led

the way. The only reason Adele and Julie were there was to simply keep track of time and to have a figure perhaps leading the group. However, in my experience every group develops an individual who directs others and Julie and Adele took the same stance. At no point did either try and take charge and were just happy to wonder. The whole feel of the group was very relaxed and just felt like a normal trip out as any friendship group might. To me this was really nice as it was creating friendship bonds and values based on abstinence and doing activities like this really seemed to reinforce this way of life for them.

I was really well received and at no point (apart from by Jim) was I asked why I was there or what I was doing. I immediately felt comfortable and at ease and I never felt like I was being viewed as an observer. This may be because they already knew as I had met them once before but they were all very welcoming of me and really felt like I was a part of their group and had been a part of their group for some time. I was really glad that the first activity I went on was a social one as others include going to the cinema or opera, a setting where it is difficult to see how the individuals act as their behaviour is restricted by the setting. The next activity is yet to be decided but is most likely to be the Christmas bash at some point in December. I am attending the mentor committee meeting on 2nd December to finalise more activities.

Appendix 8: Detailed overview of the activities

Frequent activities

The Friday "meet 'n' greet"

The Friday "meet 'n' greet" has been in operation since the project's implementation. It runs out of a common room at the LAU and occurs between 12.45 and 2.30pm every Friday. It is a chance for any service user and mentor of the project to attend, and is also where new service users are introduced to the group (it was at the Friday "meet 'n' greet" that I was first introduced to the service users). On average fifteen to twenty service users attend each week, as well as several mentors. It is a very informal, sociable and friendly atmosphere that gives the chance for service users and mentors to chat and 'catch up' on what they have been doing. From what I have observed, a positive aspect of this "meet 'n' greet" is that the mentors are present to welcome new, often very nervous service users into the group. The role of the mentors is to engage new service users in conversation, introduce them to other existing service users and explain what the project does and how the activities operate. From what I have observed, this method of social integration appears to work well as it ensures any new service user is immediately engaged and not left on their own in a potentially intimidating social environment During my numerous visits to the "meet 'n' greet", introducing newcomers to existing service users appears to facilitate social integration as they are engaged immediately with an existing member of the group. It is important to note that this does not happen during one visit, but occurs over several weeks of continued attendance of the new service user. The more they attend the "meet 'n' greet" in conjunction with attending the activities, friendships are developed through social interaction.

Bowling

Bowling takes place at a local bowling centre in Leeds every other Friday. The service users sign up for bowling at the Friday "meet 'n' greet" and then go after the "meet 'n' greet" has finished. Typically between five and ten service users go bowling accompanied by a mentor. Due to the early time that the service users go bowling (approximately 3pm), they receive discounted rates and are able to have one game of bowling for £1.99. If the service users want to, they are able to pay an extra £1 and have two games of bowling.

The allotment

The LTLA project rent an allotment that is approximately ten minutes drive from the LAU. Visiting the allotment is conditional on the weather, which means over the winter months, it is not an activity that is available to service users. However, during the months where the weather is nice, the allotment is visited twice a month on alternate Friday's to the bowling. This ensures anyone who wants to go to the allotment and bowling is able to do so. Unlike bowling, the allotment is a much more niche activity and typically only gets two or three service users. However, this small number appears to work well as it is only a small allotment, meaning groups any larger would perhaps be impractical. There is no fee to attend the allotment.

Cinema Visits

This is an activity that takes place at a local cinema in Leeds. It occurs at lunchtime every other Wednesday. The LTLA project takes advantage of the "early bird" deal so tickets are discounted for each of the service users. Typically each service user pays less than £5 to go and see any movie that is currently out at the cinema. Approximately three to five service users attend this activity, along with one mentor.

Reiki

Reiki is a "technique commonly called *palm healing* or *hands on healing* as a form of complementary therapy and is sometimes classified as *oriental medicine* by some professional medical bodies. Through the use of this technique, practitioners believe that they are transferring universal energy (i.e. Reiki) in the form of "qi" (pronounced: "*ki*") through the palms, which allows for self-healing and a state of equilibrium" (Wikipedia, 2012). The service user lies down on a massage bed as the "Reiki specialist" performs the calming ritual by running their palms close to the surface of the service users body. Reiki takes place every other Wednesday between 5.30 and 7.30pm with each session lasting 30 minutes per service user (i.e. a total of four service users for every two hour slot). Reiki is a new activity that was introduced at the start of 2012 but has become very popular amongst the service users, which, as a result, it has to be signed up for several weeks in advance. In the interest of fairness, time slots are allocated equally, so those who have just participated in the activity are not allowed to go again until it is back to their turn or unless a session is under-subscribed. There is no fee to attend a Reiki session.

Women's day

The women's day occurs every other Wednesday and is split into two parts. Firstly, there is a group session where the women who attend can discuss any issues they are having to other female service users and mentors. It is similar to the Friday "meet 'n' greet" but is more formal and focused on supporting one another as opposed to 'chatting and catching up". This initial part takes place at 11am. After this support session, those that want to, participate in the activity. Whilst the overall activity is called "the women's day", the specific activity itself varies. For example, they may go to a manicurist one Wednesday, whereas on another day, they may go for a coffee or a walk around a place of interest, for example Skipton (this was my first observation). The specific activity is decided amongst the group several weeks prior to the activity date. The price will depend on the activity that is decided upon, but in many instances, the cost comes to less than £10 each.

The "women's day" is the most popular activity as it regularly has between eight and twelve female service users attend every time. Having a female specific activity raises interesting points with regards to the project perhaps favoring their female cohort. Whilst this remains conjecture, many of the women who attend the project do seem to be in a more stable state of recovery. This is based on the language they use, the optimism they appeared to possess about their recovery and how they conducted themselves during the interview. I accept this is based on my interpretation and could be the result of

several existential factors such as better family support or the fundamental differences between genders in recovery. I am not advocating that having a female specific activity dramatically improves the recovery of female service users in comparison to the male population but it does beg several questions such as why have female specific activities? And why not have a male specific activity?

The Gym

The LTLA project obtains free passes from a local gym. Each pass lasts for ten weeks and entitles any individual to attend the gym during that time for free. The project are given a number of passes approximately three times a year for service users to continue their training. This is a particularly beneficial activity for recovery, as physical recovery appears to be an important aspect of the overarching concept of recovery, as my data will demonstrate in subsequent chapters.

The Inkwell Café

This activity is a visit to a local crafts café where service users are able to socialise with others and if the want to, can participate in making a host of different things such as cards and small gifts. The activity runs every Thursday between 3-5pm and is attended by one service user. There is no fee for this activity (except any cost they incur at the café) and approximately three to five service users attend each week.

Mum's and Toddlers Group

This is an activity that is aimed at those service users who have little children. It takes place every Wednesday between 1-2pm at a local children's centre. It is run by one mentor who has a toddler, making her adept at understanding the complications other parents with young children may be experiencing. It is a place where parents with toddlers are able to go with their children to socialise with others and discuss any issues they may be having as they combat their addiction whilst having little children to care for. There is no fee for this activity.

Zumba

'Zumba' is a type of aerobic exercise set to music and dance routines and is primarily aimed at a female cohort. It takes place in the group room (also where the Friday "meet 'n' greet" takes place) at the LAU once a month and is taken by a 'Zumba instructor'. It is female specific and costs 50p to attend each time and is typically attended by five to seven service users. The reason for it being female specific is because it was decided amongst the group that the women like the idea of Zumba but did not want to do it in front of male company. Furthermore, there was no male interest in Zumba hence it being female specific.

Infrequent activities

Theatre trips

Over the course of my data collection, there was the option for service users to attend seven different plays: Giulio Cesare, Norma, Madam Butterfly, Carousel, Makropoulus Case, Don Giovanni and Faust. Tickets for theatre

productions are free as one of the mentors used to be employed by the theatre and is given as many tickets as required to watch the production on the same night as it is reviewed by journalists (typically the night before being opened to the public). On average, five service users and one mentor attends the theatre each time, however, this number depends on the play being shown. For more popular plays, more service users mentors and professional staff attend.

Canal trips

There are approximately four canal trips along Mirfield canal per annum. Due to limited capacity on the canal boat, only a total of twelve service users, mentors and professional staff can attend during each trip. Typically one service user and one professional staff go in the canal boat each time. Given the popularity of this activity, those service users who are yet to participate in this activity or have not participated for some time are awarded first refusal. Any unsubscribed places are then awarded to those who express a desire to go on the canal trip. Operating in this manner maintains a fair approach as it is not an activity that happens regularly and gives every service user the opportunity to attend at least once over the course of the year. The canal trip costs each member £2, which will then contribute to the price of the train ticket to Mirfield (£5.30). The remainder of the train ticket cost is paid by project funds.

Day trips out on the minibus

One of the mentors possesses a driving license that enables them to drive a minibus. The minibus is paid for out of the LTLA charity fund and can seat a total of fifteen people. Typically, there are approximately ten service users, two mentors and one professional staff who attend the day trip. This year the LTLA project has visited Scarborough, York, Whitby, Bridlington and the Castleford 'Xscape' (an indoor ski dome that hosts an array of shops and restaurants to look around). A small fee is paid by service users to attend the activity (the fee will depend on the daytrip but it never exceeds £5), which is collected before the day of the activity. Whilst on the activity, the service users have complete autonomy about what they want to do and where they want to go. They are not required to stay within the confines of the group and are allowed to do what they want as long as they are back at the meeting point when they have all decided they are leaving. To ensure each service user is contactable at all times, each service user gives their mobile number to either the mentor or professional staff on the trip.

The Jamie Oliver eight-week cooking course

This is an activity that teaches individuals how to prepare and cook cheap and nice tasting meals. It is open to the public and takes place at Kirkgate Market in Leeds. It runs over an eight-week period and service users are able to attend a 'taster lesson' before signing up. In total, there are fifteen different courses each service user has the option to attend. There is no fee for this course.

Novel activities

The Diamond Jubilee

During the Diamond Jubilee the LTLA project offered the service users the chance to go and watch the procession on a big screen in Millennium Square in

Leeds. Four service users, one mentor and one professional staff attended the activity.

"Recovery Fest"

'Recover Fest' takes place once a year and it is a small festival to celebrate being in recovery. It takes place at Roundhay Park in Leeds and is open to any individual who has suffered with an addiction of any kind. The festival includes live music, stalls, games, activities and various competitions for individuals to participate in. It took place on the 15th September 2012 and it was the first year it operated in Leeds. One mentor and five service users attended the festival.

Appendix 9: Consent form for the observational period

THE UNIVERSITY *of York*

CONSENT FORM FOR PARTICIPANT: OBSERVATIONAL PERIOD

User perspectives: experiences of how user-led support groups have impacted on recovery

Names of Researchers: Tom Parkman

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my legal rights being affected. ☐
3. I understand that information I provide to the researchers is confidential to the research team and any such material used in reports or other outputs from the project will be anonymised. ☐
4. I agree to take part in the above study. ☐
5. I agree to observational notes being recorded and transcribed. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 10: Participant information sheet for the observational period

THE UNIVERSITY of York

The Department of Health Sciences

A study of the recovery and social integration of service users attending peer-led support groups.

Information Sheet for service users and mentors

You are being invited to take part in a research project about how the peer-led support group you attend has impacted on your recovery from substance use. The reason for this leaflet is to outline the research and explain what will happen if you decide to take part.

What is the project about?

This research aims to explore how peer-led support groups have helped in the recovery of people with substance use problems. I am particularly interested in what recovery means to you and how the project you visit helps you. I am also interested in how the project combines with any other help you may be receiving and other things going on in your life.

Why is the research being done?

I am doing this research for my PhD. It will be conducted from late 2011 to late 2012. I am planning to come along on some of the activity days to see what activities you all enjoy doing the most and why they are your favourites. It is also a chance for me to get to know you all so you can ask me questions you like with regards to the research.

Why have I been chosen?

This research project is taking place within your project. I am planning to come along on your activity days to see what sorts of activities you take part in and which ones you like. Your involvement in the research is your choice and anything you say will be kept confidential. If you choose to take part, but change your mind, you can quit at any time without reason. Again, we would like to reassure you that taking part is completely confidential.

What would be involved?

I will be coming along on around three of your activities to see the different things you do. It will give me a chance to talk to you about what you think of the activities and which ones you like the most and why. It will also give you a chance to get to know me and you are welcome to ask me any questions you like about my research. After me coming on some of the activity days, there will be a chance for you to express your opinions further in an interview. It must be stated – you do not have to

do the interview if you do not want to and anything you say to me on the activity days will be kept totally confidential. If you decide you want to be interviewed, there is another sheet like this that outlines the interview process more fully which the mentor team can provide you with.

Anything you tell me would be confidential to me, and anything you say, or ideas from you I wish to use in project reports would be made anonymous.

I will not share anything you have told us with staff, or anyone else, without your permission. However, during the activities you may mention something which suggests that an individual has been, or is, at risk of harm. If so, I will suggest sources of support, but may also have to inform the appropriate authorities after discussing this with you.

What will happen to the findings from the project?

I will be analysing all the information collected and will write a thesis to report the findings. I will be giving a short summary of the findings to the project so you can see what is happening. I will try to publicise and raise awareness of the findings of the study by writing journal articles and contributing to relevant conferences and workshops.

Who is doing the study and how is it funded?

The study is being carried out by Tom Parkman based at the University of York and is funded by National Institute for Health Research (NIHR) CLAHRC collaboration for Leeds, York and Bradford. I am being supported by my supervisor, Charlie Lloyd, a senior lecturer in the Health Sciences Department at the University of York.

What do I do next?

If you are willing for me take part in the activities as described above please just let one of the mentor team, Duncan, Gillian or Adele know so they can pass it on to me.

Tom Parkman,
Department of Health Sciences,
University of York,
Heslington,
York,
YO10 5DD,
Tel: 01904 320000
Email: tjp507@york.ac.uk

Patient Advice & Liaison Service (PALS),
The PALS Office,
Therapy Suite,
The Becklin
Alma Street,
Leeds
LS9 7BE

Tel: 0800 0525 790 **Email: pals.lpft@nhs.net**

Appendix 11: Topic guide for the professional staff interviews

Introduction:

- Thank you for taking the time to speak to me for this interview, it will take between 30 minutes and an hour but you can stop at any point if you want to.
- There are no right or wrong answers, I am just interested in your own thoughts and opinions. If you do not want to answer a question you don't have to and we can move on. Anything you say will be kept absolutely private and no one, except me will know what you have said so you are free to be as honest as possible.

Housekeeping points

- The interview will be audio recorded and transcribed verbatim i.e. exactly what you say.
- Direct quotes may be used but will be entirely anonymous
- Do you have any questions before we start?
- Are you happy to sign the consent form and continue? (Get them to sign the consent form)

Contextual Information

Probe the following:

- Tell me about the projects history to date and why it was set up.
- Why is it called [insert name]?
- How would you classify the project and why? (i.e. is it a peer-led group, self-help group etc)
- How is it funded?
- What is its position in the wider community (i.e. LTLA is part of the LAU)
- What is your role in the project?
- What are the goals of the project?
- How does the project 'link' with other services such as employment/housing?

Identity and recovery

Probe the following:

- Why/how do you think the project helps recovery?
- Do you think the project facilitates identity transformation? – Why?
- Is the project aimed at changing attitudes to substance use?

Future of the project

Probe the following:

- How has the project developed in relation to your own perceptions from its inception? i.e. has it developed faster/slower or remained steady in its development? [explain why you think this is]
- How do you see the project developing in the future?
- What are the limitations [if any] of the project?
- What would be your dream scenario for the 'end goal' of the project?
- Do you see the project reaching that 'end goal'? [explain if yes or no]?

Appendix 12: Topic guide for the service users interviews

Introduction:

- Thank you for taking the time to speak to me for this interview, it will take between 30 minutes and an hour but you can stop at any point if you want to.
- There are no right or wrong answers, I am just interested in your own thoughts and opinions. If you do not want to answer a question you don't have to and we can move on. Anything you say will be kept absolutely private and no one, except me will know what you have said so you are free to be as honest as possible.

Housekeeping points

- The interview will be audio recorded and transcribed verbatim i.e. exactly what you say.
- Direct quotes may be used but will be entirely anonymous
- Do you have any questions before we start?

Contextual Information

Probe the following:

- Tell me about your substance using past
- How long were you/have been addicted?
- When did you realise you needed help?
- How did you come into contact with the project?
- How long have you been coming to the project
- What do you think of the project?
- What other services do you attend? How do they compare to this project?

Identity and recovery

Probe the following:

- What does recovery mean to you?
- What is your 'end goal' of recovery?
- What impact has the project had on your substance use?
- How has the project helped in reaching that goal?
- Why do you think the project has helped?
- Why is the project important to you?
- Is being reintegrated into society part of your recovery? If yes – how has the project helped with that?

The future

Probe the following:

- How long do you see yourself coming to the project?
- Why do you feel you need to come for that long?
- How would you change the project to improve your recovery?

Appendix 13: Topic guide for the mentor interviews

Introduction:

- Thank you for taking the time to speak to me for this interview, it will take between 30 minutes and an hour but you can stop at any point if you want to.
- There are no right or wrong answers, I am just interested in your own thoughts and opinions. If you do not want to answer a question you don't have to and we can move on. Anything you say will be kept absolutely private and no one, except me will know what you have said so you are free to be as honest as possible.

Housekeeping points

- The interview will be audio recorded and transcribed verbatim i.e. exactly what you say.
- Direct quotes may be used but will be entirely anonymous
- Do you have any questions before we start?

Contextual Information

Probe the following:

- Tell me about your substance using past
- How long were you addicted?
- When did you realise you needed help?
- How did you come into contact with the project?
- How/why did you become a mentor?
- Why do you like being a mentor?

Identity and recovery

Probe the following:

- What does 'recovery' mean for you?
- How has the project helped your recovery? Why do you think this is?
- Has it helped to re-shape 'who you are'?
- How has the project fitted in with other aspects of you life? i.e. employment
- Why do you feel the project helps in recovery?
- Does being a mentor put pressure on you to remain clean? [explain]
- Do you feel the project helps reintegration back into society? [explain]
- Would you say the project provides activities to make services users feel 'normal'? [explain]

The future

Probe the following:

- How long do you see yourself being a mentor?
- Do you have plans to leave the project?
- How would you develop the project?
- How (if at all) is the project better than other projects like AA or NA?

Appendix 14: Consent form for the interviews

THE UNIVERSITY of York

CONSENT FORM FOR PARTICIPANT: INTERVIEWS

User perspectives: experiences of how user-led support groups have impacted on recovery

Names of Researchers: Tom Parkman

Please initial box

6. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
7. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my legal rights being affected. ☐
8. I understand that information I provide to the researchers is confidential to the research team and any such material used in reports or other outputs from the project will be anonymised. ☐
9. I agree to take part in the above study. ☐
10. I agree to the interview being tape recorded and transcribed. ☐

....

Name of Participant   Date   Signature

....

Name of Person taking consent   Date   Signature

Appendix 15: Participant information sheet for professional staff interviews

THE UNIVERSITY of York

The Department of Health Sciences

A study of the recovery and social integration of service users attending peer-led support groups

Information Sheet for professional staff

You are being invited to participate in a research project about how the peer-led support group you are involved with has impacted the recovery and social integration of service users. The purpose of this leaflet is to outline the research and explain what will happen if you decide to take part.

What is the project about?

This research is concerned with exploring how peer-led support groups have impacted on the recovery of individuals with chronic substance use problems. I am particularly interested in what recovery means to service users and how the project helps to aid their view of recovery. I am also interested in the history of the project and how it is run on a daily basis and how it fits in with other organisations to help the service users.

Why is the research being done?

I am doing this research for my PhD. It will be conducted from late 2011 to late 2012. I am recruiting participants to interview from three different projects across Yorkshire to explore how these projects are set up to help service users. I am interested in three different sites to see how they differ and how these differences impact on the recovery and social integration of service users.

Why have I been chosen?

Your project is one of the three projects I am researching. I am interviewing professional staff who work at the projects to gain an insight into how the project is run and how the professional staff interact with the service users to help them on their recovery pathways. Your involvement in the research interview is completely voluntary and confidential. If you choose to be involved, but change your mind, you can withdraw at any time without reason. We would like to reassure you that anything you say within the interview is completely confidential.

What would be involved?

I would like to talk to you for between 30 minutes and an hour. I would like to ask you generally about your involvement with the project and how it has developed since it started. General questions will be asked about the logistics of the projects (who runs it, funding etc) and how you feel it impacts on service users outcomes.

Anything you tell us would be confidential to me, and any comments or ideas from you we wish to use in project reports would be made anonymous. We would like to record and transcribe the interview if you agree; transcripts would be anonymised and kept securely. You can have a copy of the transcript if you wish.

I will not share anything you have told us with other staff, or anyone else, without your permission. However, during the interview you may mention something which suggests that an individual has been, or is, at risk of harm. If so, I will suggest sources of support, but may also have to inform the appropriate authorities after discussing this with you.

What will happen to the findings from the project?

I will be analysing all the information collected and will write a thesis for my PhD. I will report back to each of the projects with short summaries discussing the main findings ensuring anonymity is maintained at all times. I will publicise and raise awareness of the findings of the study by writing journal articles also contributing to relevant conferences and workshops.

Who is doing the study and how is it funded?

The study is being carried out by Tom Parkman based at the University of York and is funded by National Institute for Health Research (NIHR) CLAHRC collaboration for Leeds, York and Bradford. I am being supported by my supervisor, Charlie Lloyd, a senior lecturer in the Health Sciences Department at the University of York.

What do I do next?

If you are willing to take part in an interview as described above please contact us directly. Our contact details are provided below.

Further Information

If you are interested and you would like further information on the study, please contact:

Tom Parkman,
Department of Health Sciences,
University of York,
Heslington,
York,
YO10 5DD,
Tel: 01904 320000
Email: tjp507@york.ac.uk

Patient Advice & Liaison Service (PALS),
The PALS Office,
Therapy Suite,
The Becklin
Alma Street,
Leeds
LS9 7BE

Tel: 0800 0525 790 **Email: pals.lpft@nhs.net**

Appendix 16: Participant information sheet for service user and mentor interviews

THE UNIVERSITY of York

The Department of Health Sciences

A study of the recovery and social integration of service users attending peer-led support groups.

Information Sheet for service users and mentors

You are being invited to take part in a research project about how the peer-led support group you attend has impacted on your recovery from substance use. The reason for this leaflet is to outline the research and explain what will happen if you decide to take part.

What is the project about?

This research aims to explore how peer-led support groups have helped in the recovery of people with substance use problems. I am particularly interested in what recovery means to you and how the project you visit helps you. I am also interested in how the project combines with any other help you may be receiving and other things going on in your life.

Why is the research being done?

I am doing this research for my PhD. It will be conducted from late 2011 to late 2012. I am getting participants to interview from three different projects across Yorkshire to explore how these projects help service users and how they help your recovery.

Why have I been chosen?

This research project is taking place within your project. I am interviewing people who attend the project about what recovery means to them and how they feel the project is helping them. Your involvement in the research interview is your choice and anything you say will be kept confidential. If you choose to take part, but change your mind, you can quit at any time without reason. Again, we would like to reassure you that taking part is completely confidential.

What would be involved?

I would like to talk to you for between 30 minutes and an hour. I would like to ask you generally about your history of substance abuse and what has led you to the project. You will be asked to say what you feel recovery is for you and how the project has helped in your life.

Anything you tell us would be confidential to me, and anything you say, or ideas from you we wish to use in project reports would be made anonymous. We would like to record and write out the interview if you agree; copies of what you say will be kept anonymous and kept safe. You can have a copy of what you say if you wish.

I will not share anything you have told us with staff, or anyone else, without your permission. However, during the interview you may mention something which suggests that an individual has been, or is, at risk of harm. If so, I will suggest sources of support, but may also have to inform the appropriate authorities after discussing this with you.

What will happen to the findings from the project?

I will be analysing all the information collected and will write a thesis to report the findings. I will be giving a short summary of the findings to each project so you can see what is happening. I will try to publicise and raise awareness of the findings of the study by writing journal articles and contributing to relevant conferences and workshops.

Who is doing the study and how is it funded?

The study is being carried out by Tom Parkman based at the University of York and is funded by National Institute for Health Research (NIHR) CLAHRC collaboration for Leeds, York and Bradford. I am being supported by my supervisor, Charlie Lloyd, a senior lecturer in the Health Sciences Department at the University of York.

What do I do next?

If you are willing to take part in an interview as described above please contact us directly. Our contact details are provided below.

Further Information

If you are interested and you would like further information on the study, please contact:

Tom Parkman,
Department of Health Sciences,
University of York,
Heslington,
York,
YO10 5DD,
Tel: 01904 320000
Email: tjp507@york.ac.uk

Patient Advice & Liaison Service (PALS),
The PALS Office,
Therapy Suite,
The Becklin
Alma Street,
Leeds
LS9 7BE

Tel: 0800 0525 790 **Email: pals.lpft@nhs.net**

Appendix 17: Detailed biographies of the service users

Alison

Alison is a 55-year-old recovering problem drinker who is retired from work for physical disability reasons. Alison suffered with addiction for over five years and was regularly admitted to hospital for health complications that arose as a direct result of her drinking. Alison was referred to a keyworker at the LAU by her gastrointestinal doctor from the hospital in 2009 and has been abstinent for the past two and a half years. Alison did have a brief time being a mentor but decided she did not like it as she felt it detracted from her ability and willingness to help other service users. Alison is still an active member of the LTLA project.

Angela

Angela is a recovering problem drinker who is currently unemployed. Angela was alcohol dependent for nearly eight years before she attended the LTLA project in February 2012. Angela's substance dependency began as a result of the depression she developed from the death of her mother. During her addiction, Angela attempted recovery at various different professional organisations, one of which was the LAU, but each time she relapsed. It was not until she started attending the LTLA project that she has managed to maintain her recovery for any extended period of time. At present, Angela is still an active member of the LTLA project and has started looking for work.

Barbara

Barbara is a recovering problem drinker who is retired from work, but has a busy social life and family commitments outside of the project. Barbara has enjoyed a drink throughout her life but claimed it only became problematic in 2007, with it being particularly bad in the final 2 years of her addiction. Barbara's drinking during the early stages of her addiction followed a different pattern to the others described in this section. Whereas the others used to drink on a daily basis, Barbara was able to go approximately ten days without drinking, but would then drink heavily for several days at a time i.e. she used to 'binge drink'. However, Barbara claims that as her addiction worsened, her time between drinking periods got smaller and by the end of her addiction, she was drinking daily. Barbara was referred by a keyworker she met at her GP surgery to ADS and the LAU in January 2011. Barbara left the project in August 2012, the reasons for which are unknown.

Catherine

Catherine is a 63-year-old recovering problem drinker who is currently unemployed. Catherine explained that she had enjoyed a drink all her life but that it only became problematic after her husbands funeral in October 2011. Like some of the other service users, Catherine developed depression, which significantly contributed to her alcohol dependency. Her sister took Catherine to the hospital in March 2012, where she was referred to the LAU. At the time of interview, Catherine had only been attending the LTLA project for approximately ten weeks and still remains an active service user of the project. In conjunction to the LTLA project, Catherine was also attending a bereavement counsellor in

Wakefield to help her with the death of her husband. Catherine is currently looking seeking employment.

Chloe

Chloe is a recovering problem drinker. Chloe's problematic drinking started approximately 4 years ago, which lasted for one year before she successfully managed an 18-month period of abstinence. Chloe began drinking again in 2010, which resulted in her being hospitalised in April 2011 with liver failure. Chloe was visited by a keyworker from the LAU during her time in hospital, who referred her to the LAU. Chloe began attending the project in September 2011. During her time at the project, Chloe made considerable strides with her recovery, which culminated in her becoming a mentor in August 2012. Chloe is still an active member of the mentor team.

Christopher

Christopher is a 41-year-old recovering problem drinker who is currently unemployed. Christopher has been drinking since he was 16-years-old and claims that his alcohol dependency continued to get more problematic the older he got. Christopher relapsed several times from professional treatment and has had several attempts at medically assisted abstinence (i.e. he takes Antabuse). Christopher has also suffered with depression in the past and has spent time in a day care centre that caters for those with mental difficulties. Christopher first started attending ADS, which did not stop his excessive drinking and was subsequently referred to the LAU and the LTLA project approximately two years ago. He has been abstinent for the past 18 months but relies heavily on Antabuse for his recovery. Christopher left the LTLA project in the summer of 2012 for unknown reasons, but stated explicitly to me during the interview that he was having strong cravings for alcohol.

Clive

Clive is a recovering problem drinker who is retired from work for physical disability reasons. Clive first came to the LAU in February 2011 after he was seen by a keyworker from the LAU whilst he was in hospital. Clive had been admitted to hospital with life-threatening health complications that were a direct result of his drinking. Clive was drinking heavily since 1989, but stated he became alcohol dependent in 2004 until his hospital admission in 2011. During Clive's addiction, he suffered with depression; a condition, which he claimed, was a direct result of the death of his two brothers. Clive remained abstinent until he left the project shortly after his interview in June 2012. The reason for him leaving is unknown.

James

James is a recovering problem drinker who is currently unemployed. James has enjoyed a drink for the vast majority of his life but claims it only became problematic after the breakdown of his marriage. James drank everyday for several years up until September 2011. During his substance dependency, James suffered with depression, which led his GP to refer him to St Anne's, a rehabilitation clinic for those suffering with comorbid alcohol and mental health problems in September 2011. James was referred to the LAU in January 2012

and was introduced to the LTLA one month later, and has been attending ever since. James has initially set himself the goal of controlled drinking as he feels his alcohol dependency was the direct result of his marital breakdown, a component of his life he has since rectified. James does not attend any other recovery project.

Judith

Judith is a recovering problem drinker who is currently looking for employment. Judith has drunk alcohol for most of her life but claimed that it only became problematic in the summer of 2011, a time that coincided with her marital breakdown. Judith was referred to the LAU by her GP in September 2011, and she left the project in June 2012. Within this time, Judith completed two detoxification treatments at the LAU as she relapsed in March 2012. The reasons why Judith left the project are unknown. Judith, like James considers her alcohol dependency to be the product of her life circumstances and claims that the goal for her is not abstinence but controlled drinking.

Kevin

Kevin is a recovering problem drinker who is currently unemployed. Kevin has been drinking since he was 16-years-old but it only became problematic in 2003. Kevin remained alcohol dependent for seven years until he was referred by his GP to the LAU in 2010. He was immediately introduced to the LTLA project and after five months became a mentor. During his time as a mentor he relapsed and made the decision that being a mentor was too much for him to cope with so decided to remain as a service user of the project. During 2011 he relapsed once again as he put himself under too much pressure to find work and in March of 2012 he relapsed once again as a result of being diagnosed with depression. In conjunction with attending the LTLA project, Kevin also attended ADS and SMART (Self Management And Recovery Training) to help with his recovery. In July 2012, Kevin left the project for unknown reasons.

Kirsty

Kirsty is a 53-year-old recovering problem drinker. Kirsty is in full time employment and up until the age of 45 had never had a drink of alcohol in her life. Kirsty became alcohol dependent at the age of 49 and was dependent for 4 years. Kirsty came to the project in November 2011 and has managed to remain abstinent from alcohol since (she was on a course of Antabuse to combat the addiction, but that ended in November 2012). Kirsty suffers with a form of bipolar disorder that makes her depressed, a condition she sees a psychiatrist for. Kirsty's psychiatrist referred her to the LAU where she was seen by a keyworker and told about the LTLA project. Due to Kirsty's work commitments, she does not have the opportunity to attend as regularly as some other service users but she still very much sees herself as part of the project and attends those activities she is able to. Kirsty does not attend any other recovery project and is still an active member of the LTLA project.

Peter

Peter is a 38-year-old recovering problem drinker who has recently commenced employment. Peter claims he has been drinking heavily for the past eighteen years with it becoming particularly problematic in the past two years. Peter's brother contacted the LAU directly in February 2012 to address his alcohol dependency and was introduced to the project one month later. Peter claims that during the peak of this alcohol dependency, he was consuming on average, a large bottle of vodka or whiskey on a daily basis. In April 2012, Peter entered into full-time employment meaning he can only attend the project when he does not have work commitments. Peter is currently on a course of Antabuse and also attends ADS to help with his recovery.

William

William is a recovering problem drinker who is currently unemployed. William has enjoyed a drink for most of his life but claims it became problematic in 2006 for four and half years up until December 2010. During his alcohol dependency, he confessed to consuming on average, two to three bottles of whiskey a day and also smoked cannabis daily. William sought help from his local GP who referred him straight to the LAU in January 2011. William has been attending the project since February 2011 and is still an active member of the project. He has remained abstinent throughout his entire time at the LTLA project and does not attend any other recovery project.

Those referred to but not interviewed

Laura - a receptionist at the LAU

Louise – former mentor. Tried to contact for an interview but she was not contactable.

Christine – former service user. Had left the project by the time I commenced interviewing.

Ryan - former service user. Had left the project by the time I commenced interviewing.

Charlotte - former service user. Had left the project by the time I commenced interviewing.

Appendix 18: NHS ethical acceptance form

National Research Ethics Service

NRES Committee Yorkshire & The Humber - Leeds West
First Floor
Millside
Mill Pond Lane
Leeds
LS6 4RA

Telephone: 0113 3050108
Facsimile:

19 September 2011

Mr Tom Parkman
17 Wheatlands Road
Harrogate
North Yorkshire
HG2 8BB

Dear Mr Parkman

Study title: **A study of the recovery and social integration of service users attending peer-led support groups**
REC reference: **11/YH/0318**

The Research Ethics Committee reviewed the above application at the meeting held on 09 September 2011. Thank you for attending to discuss the study.

Ethical opinion

The Committee congratulated the researcher for a very well put together proposal.

The issue of the observation part of the study not being included within the Participant Information Sheet was raised. You explained the service users will attend the meeting and be told about the observation; they will then be given the Participant Information Sheet a few weeks before the observation so they can ask any questions in the meantime. Members queried what would happen if one person in each group doesn't want to be observed. You advised that it is his understanding that service users are enthusiastic about being observed to convey what they are doing.

Members questioned the interviews taking place in offices or facilities and whether this would pose a threat on confidentiality. You explained that this was the best option rather than going out to individuals homes. This way participants are already aware of the offices and will have no apprehensions as it is familiar to them; the psychologist will also be readily available on site at all times.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Appendix 19: Example of the minutes sheet

Date of meeting: **Friday 10th May 2013**	**Present**	Date of next meeting: **Friday 17th May 2013**
	Apologies	**Action**
[mentor] AGREED to attend the Newsam Centre, Ward 5 on Tuesday 4 June to talk about recovery/LTLA to service users. Details to be confirmed		[mentors] to check their diaries
[mentor] AGREED to continue with the Parents and Toddlers get together but will no longer be able to attend the meetings. [mentors] to help out		
LTLA Activity programme –		
Parents and Toddlers get together – [mentors] to visit St James's NAS clinic alternate Tuesdays,10.30 – 12.00. Quarry Mount Children's Centre - room available Wednesday, 1.00pm – 2.00pm		
Women's get together [mentors] - 15 service users attended **Slimming club, 50p**		
Games club [mentors] - Every Sunday between 1 – 4pm at the Mount, starting Sunday 19 May		Mentors to inform service users
Bowling, 1st Bowl, Leeds [mentors] - Friday 10 May at 1.30pm		Mentors to inform service users
Gym [mentors] - ongoing		Mentors to inform service users
Allotment, Inkwell [mentors] - Friday 10 May at 1.45pm		Mentors to inform service users
Vue Cinema, The Light [mentors] - Wednesday 15 May. Film to be confirmed		Film to be discussed with service users. Find out if Johnny can take lead
Reiki (Alternate Wednesdays 4.45 – 6.45 half hour slots) - Next session Wednesday 15 May		Mentors to inform service users
The Grand Hotel Scarborough - Depart from LAU on Monday 13 May at 9.00am returning Tuesday 14 May at 5.30pm in Leeds City Centre. £12.00 bed and breakfast, £5 minibus plus spends. 5 service users have paid		Fully booked
Roundhay Park – Monday 27 May. Meet at Vicar Lane bus stop at 10.30 to catch the 10.52 bus. Everyone to take a packed lunch		Mentors to inform service users
Canal boat – 24 June and 16 September 2013. 12 places available.- £2 deposit which we be refunded on the day. Meet at train station at 9.45am (train ticket £5.60 return)		
Ministry of Food - 10 week course held at Kirkgate Market/Armley. 9 FREE x 8 week courses left. Service users to attend a taster session prior to being given an application form. Next taster sessions available in June		Mentors to inform service users

List of Abbreviations

AA	Alcoholics Anonymous
ACMD	Advisory Council on the Misuses of Drugs
AIDS	Acquired immunodeficiency syndrome
BFI	Betty Ford Institute
CATs	Clubs of Alcoholics in Treatment
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CRD	Centre for Reviews and Dissemination
DPD	Dependent Personality Disorder
DWP	Department for Work and Pensions
GDC	Group Drug Counselling
HIV	Human immunodeficiency virus
LAU	Leeds Addiction Unit
LTLA	Learning to Live Again
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NTA	National Treatment Agency for Substance Misuse
N-TSO	Non-Twelve-step onsite
ONS	Office for National Statistics
OST	Opioid substitution therapy
SHG	Self-help group
SMART	Self-Management and Recovery Training
TSO	Twelve-step onsite
UKDPC	UK Drug Policy Commission
UKHRA	UK Harm Reduction Alliance
UK	United Kingdom
US	United States of America
WFS	Women for Sobriety
WHO	World Health Organisation

WRG	Women's Recovery Group

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