Promoting Recovery from Substance Misuse through Engagement with Community Assets: Asset Based Community Engagement

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Promoting Recovery from Substance Misuse through Engagement with Community Assets: Asset Based Community Engagement

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ABSTRACT: Evidence shows that engagement with community resources can aid the process of recovery from substance misuse, yet systematic approaches to mapping resources and building bridges to these for recovery populations are limited. If done successfully, engagement with resources that are pro-social and afford access to meaningful activities not only provides a platform for personal development, but also has the ability to trigger a social contagion of positive behaviour and improve connectedness within communities. The current paper uses Asset Based Community Development (ABCD) as the basis for an enhanced version called Asset Based Community Engagement (ABCE). The work of ABCD has been pivotal in encouraging citizen-led, strengths-based approaches to community development, yet scientific support for it remains limited. While this approach has gained much traction, it has been subject to criticism for being too optimistic and unsystematic. In response to this, the new framework, ABCE, offers a more structured approach to mapping community resources. It does however advance previous work by acknowledging the need to identify current levels of community engagement and barriers to engagement, in order to support empowerment, maximise personal capital and address barriers to engagement. Identifying barriers to engagement should not draw ABCE away from its strengths-based focus but instead, provide a platform for person-centred, holistic support to be provided to those in recovery. To support the new framework, a workbook has been developed, offering a practical output that is intended to be used by the individual in recovery alongside a member of staff within a professional service supporting the individual.

KEYWORDS: recovery, substance misuse, community, engagement, assets, resources

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Recovery from substance misuse

Recovery from substance misuse remains a contested concept[1] however Best and Laudet[2] (p. 2) define this as 'a lived experience of improved quality of life and a sense of empowerment'. Contemporary ideas of recovery go beyond control over substance use, integrating global health and active participation in communities.[3–5] Central to the idea of recovery is recovery capital as the metric for measuring progress.[6] Recovery capital refers to 'the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol and other drug (AOD) problems' (p. 32).[7] Although there are multiple classificatory systems of recovery capital, the current paper categorises recovery capital into three components; personal, social and community capital,[2] which are seen as dynamically linked, and described below.

Personal capital, also referred to as human capital, includes the 'skills, positive health, aspirations and hopes and personal resources' an individual can draw upon to prosper.[2] Social capital includes access to information, social networks and mutual support through the development or maintenance of supportive relationships.[8,9] Cloud and Granfield[10] note the importance of social networks, highlighting how positive relationships can aid recovery. Part of this relates to the social psychology of groups. Jetten et al[11] have demonstrated that belonging to groups in which members have shared pro-social aspirations, benefit both wellbeing and physical health. However, Jetten's subsequent work[12] has shown that membership of marginalised and excluded groups does not confer the same wellbeing benefits and can indeed be a barrier to wellbeing. In contrast, pro-social networks can be associated with positive behaviour change whereas substance misusing social networks will generally have negative impacts on the wellbeing of group members, including further marginalisation.[13] If an individual is embedded in substance misusing networks, they will most likely have access to social groups with strong 'bonding capital',[14] such groups, through stigma and exclusion, will have limited access to positive social or community capital.

Community (or collective) capital can be understood in terms of community resources, such as activities and transport links; groups and facilities; recovery communities; as well as non-stigmatising attitudes within the community.[2] Within this model of recovery capital, cultural capital lies within community capital[15] and is described by Best and Laudet[2] (p. 4) as a form of capital that includes 'values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours'. In this paper, community and cultural capital are inter-related. While community capital can be understood in terms of the assets an individual is engaged with in the community, cultural capital can be understood in terms of individuals' beliefs towards becoming engaged within their communities, and their integration in the practices, processes and assets of the community.

By identifying and utilising micro-assets that exist within the local community we can both support individual social reintegration and successful community cohesion. When individuals early in addiction recovery are linked into positive

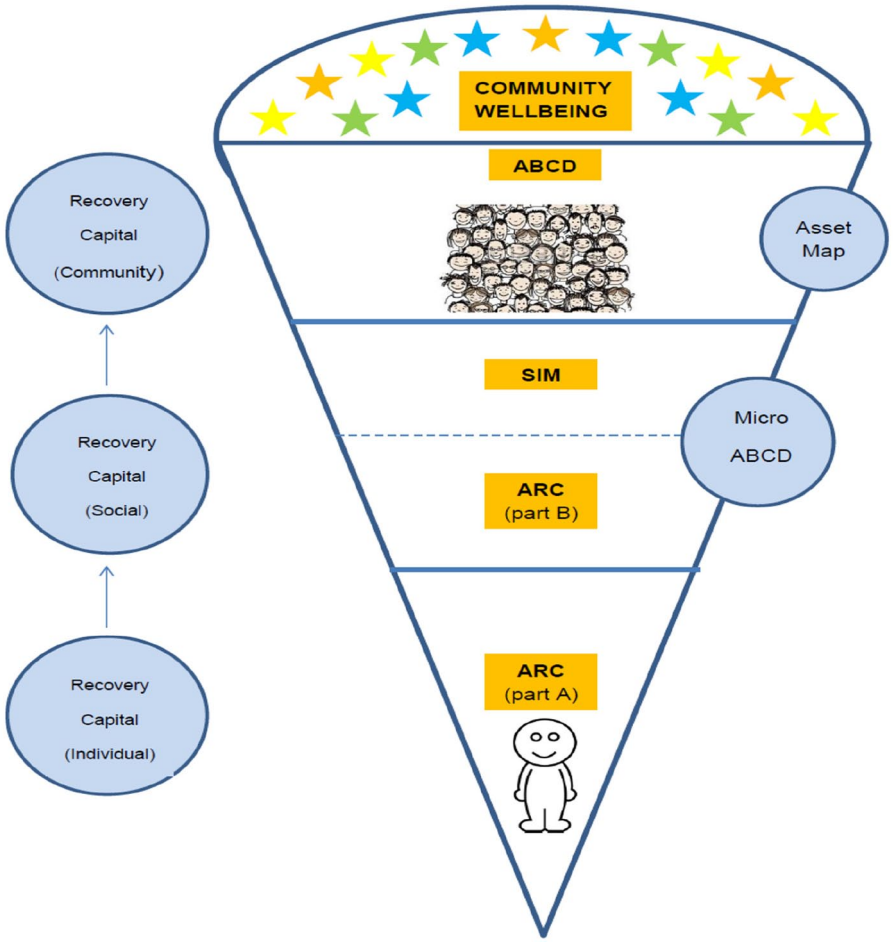

Figure 1. The 'ice cream cone': characterising recovery capital through layers of community engagement.[17]

community resources, it is anticipated that personal, social and community capital will grow as a result, and this can be framed within a model of recovery capital. Leamy et al,[16] identify the following themes as crucial for recovery, based on a review of the evidence from mental health recovery research: connectedness; hope; identity; meaning and empowerment (CHIME). Through a sense of CHIME, an individual's recovery capital will be enhanced. This mental health approach to recovery fits well with what is known about addiction recovery.

Characterising recovery capital through layers of community engagement: The ice cream cone

This approach to the symbiosis of recovery capital components has been detailed within the 'ice cream cone' which characterises recovery capital through layers of community engagement (see Figure 1).[17] The ice cream cone model highlights the strong dynamic relationship between the key components of recovery capital and represents a foundation for community and therapeutic level interventions for building recovery capital.

How does the ice cream cone model work?

Through forming pro-social group memberships, an individual is able to increase their levels of personal capital, for example, resilience and self-efficacy, through social activities supportive of their sobriety and their personal wellbeing. This is demonstrated at the bottom layer of the ice cream cone at an individual level (see Figure 1), where the basic aim is the growth of personal capital. For individuals in recovery, developing personal capital alone is not achieved only through their efforts and attention must be paid to the accumulation of social (and community) capital, as a mechanism through which personal capital can be accrued. To sustain recovery, the individual must move away from groups whose norms are centred on substance use and move towards groups whose norms do not support heavy substance use, with resulting implications for their self-identity.[18]

The identification with multiple groups has been referred to by Jetten et al[11] as the 'social cure', acting as a psychological resource which in turn can protect an individual's wellbeing. Within the ice cream cone model, this is represented in the centre of the ice cream cone as the social world that informs and feeds personal wellbeing (the SIM of the model refers to Social Identity Mapping[18] which is a technique for mapping pro-social and pro-substance use groups in the person's social network). In the context of a recovery group, group memberships can provide an individual with psychological benefits, such as protection against emotional stress, as well as physical benefits, such as positive health outcomes associated with

group memberships. Litt et al[19] support this by highlighting how increased support for sobriety within a social network is associated with reduced risk for relapse. It is through positive social relations that individuals have an increased chance to gain access to resources that help their overall wellbeing and psychosocial functioning.[20]

At the upper level of the ice cream cone (see Figure 1) individuals benefit from 'improved pathways to social networks and supports and enhanced opportunities to engage with a range of community resources that are made more accessible through the process [community capital]' (p. 10).[17] Asset Based Community Development (ABCD) is recognised within the model at the upper level as a means to identify community resources. The new framework, ABCE, explored in greater depth later in the paper, builds on ABCD in the upper level of the ice cream cone model, and to show how such networks can be mobilised to increase inclusivity.

By maximising the resources available to the individual at each level, a growth in recovery capital can be noted. The 'sprinkles' on top of the ice cream cone are a result of improved community wellbeing and cohesion, fostered through engagement with the locale. The new framework, ABCE, endeavours to support engagement within the locale by identifying what assets are utilised by recovery communities and potential barriers to engagement. It is through this part of the model that communities themselves can benefit and grow. This in turn improves the likelihood of each subsequent generation of vulnerable individuals being supported to initiate and sustain recovery. This offers a strengths-based approach to community engagement and one that assumes a 'positive sum game' in that it is not only the marginalised individual who benefits, but the community itself is enriched as a consequence.

Those who engage positively and pro-actively within their local communities exert a positive force throughout the locale. In their discussion of the social contagion effects, Christakis and Fowler[21] refer to this contagion as the 'hyperdyadic spread' – the tendency of effects to spread from person to person, beyond an individual's direct social network. If recovery results in a ripple effect that generates community cohesion and community wellbeing and can be spread through a social contagion in communities, motivation to become more actively engaged within the local community also has the potential to spread in such a way. While we can presume recovery unfolds within therapeutic landscapes, further understanding can be developed regarding how, where and to what benefit these spaces have on promoting recovery, and how each individual success opens more doors and creates further links and connections.

Asset Based Community Development

Asset Based Community Development emerged as an approach to community building, highlighting that communities should not be built on their insufficiencies, rather on their capacities and assets of the people and the place.[22] The work of ABCD is innovative and over recent years has gained traction by offering techniques for identifying and promoting community development, through linking with local groups and activities (micro-assets) to support excluded groups.

Within the ABCD literature, emphasis is placed on communities driving their own agenda[23] with citizens having the knowledge and passion to mobilise assets within the locale. Integral to the ABCD approach is the process of asset mapping. Kretzmann et al[24] (p. 4) define assets as 'an item of value owned; a quality, condition or entity that serves as an advantage, support, resource, or source of strength', and defines mapping as 'to make a map of; to show or establish the features or details of, with clarity like that of a map; to make a survey of, or travel over for, as if for the purpose of making a map'. Asset mapping simply draws a map of what is valuable in communities, characterising communities as 'the wealth in people, things, services, and resources that exist' (p. 4).[24] ABCD has the ability to identify assets which otherwise may go unrecognised and underutilised. While asset mapping explores these resources, it also has the ability to highlight interconnections amongst assets – it is these interconnections that expose pathways to access assets. It is a combination of the accessibility and relations amongst assets that lead to successful community development.

McKnight and Block[25] argue that the interconnections amongst assets are integral to driving community development and, through the process of identification of assets, more individual and associational connections can be encouraged. Those with knowledge of the locale and passion to drive community development are key to the success of this process[25,26] and are referred to as community connectors.

Utilising assets through linkage processes

Once assets have been identified processes of 'assertive linkage'[27] hold great importance to connect individuals into the appropriate resources. Within the recovery literature it is noted that the work of professionals tends to be office based, as opposed to community-based, resulting in referrals to community resources often being passive, including the use of leaflets.[17] The effectiveness of this approach is limited, and assertive linkage can help to combat this.[28,29]

Manning et al[27] evidenced the value of assertive linkage with individuals from a residential AOD treatment setting who were actively linked into mutual aid meetings. Individuals were met by a peer who explained to them the purpose of the meeting, took them to the meeting and discussed it with them afterwards. Findings suggested those assertively linked through this process showed better attendance and following discharge showed lower levels of substance use. While specific to mutual aid groups, the same principles can be translated to other pro-social groups and activities.

White[29] outlines three aims for the linkage process for those in recovery. These are: to aid recovery initiation; to connect individuals with others 'with whom they can share experience,

strength and hope'[29] (p. 25); and to provide guidance throughout the recovery process. Findings from Moos and Moos[30] showed that 40% of those who left treatment did not engage with recovery supports or groups in the months after discharge, providing strong rationale for the need of assertive linkage for those early in recovery. Linking in with the ABCD literature, it would be the community connector whose role is to proactively link individuals into recovery groups and support them through this process.

Limitations of Asset Based Community Development

While ABCD has gained popularity, empowering citizens to drive their own local agenda and recognise the strengths of the locale, it has been subject to criticism. MacLeod and Emejulu[31] argue that the current model of ABCD is vague and unsystematic. While the underpinning of ABCD is innovative, it gives no real guidance as to how those wanting to adopt an ABCD approach go about doing so. While ABCD asserts the importance of mapping assets, it gives no structure to do so and it is acknowledged that mapping alone, simply creating a directory of assets, offers limited solutions. This is supported in later work by Blickem et al[32] who assert there is no methodological clarity to ABCD. Essentially, it has failed to generate empirical questions that have been adequately tested.

For socially excluded groups, including those in recovery from substance misuse, community engagement is challenging because of stigma, self-exclusion, lack of access, lack of social capital and unclear pathways into positive community groups. Community engagement is a key principle of ABCD however engagement itself has challenges, something ABCD fails to adequately address. Owing to this, mapping alone holds little value for socially excluded populations and current techniques to doing so must be more systematic. Communities cannot drive strengths-based community development work unless citizens are engaged. As identified by Blickem et al,[32] lack of engagement from socially excluded groups is a limitation of successful community development. If these groups can be better supported to become more engaged with local resources it is hoped in turn they will become empowered to drive community development. Owing to this, a new framework is needed to support ABCD, providing the rationale for the current paper.

We must first address levels of current engagement and barriers to engagement before progressing to ABCD, and then deploy techniques such as assertive linkage to help connect people to community assets most appropriate to their interests, with a focus on the needs and subsequent engagement of marginalised groups. The method proposed in this paper and outlined later, – ABCE, aims to advance this, through processes of connection building that augment community connectedness and inclusion.

MacLeod and Emejulu[31] further argue that ABCD unintentionally privatises public issues such as poverty, inequality and power relations, and one of the overt aims of the ABCE framework is to target marginalised groups for community engagement improvements through processes of inclusion and empowerment. By exploring barriers to community engagement at the therapeutic level, ABCE acknowledges social inequalities, while offering personalised pathways to community assets, and does not assume that professionals have no role to play, as will be explored in greater depth in the subsequent section.

While recent work from Kretzmann and Russell[33] highlights what is distinctive about ABCD, the current paper endeavours to act as an object of inquiry, attentive to the challenges associated with ABCD which in turn offers a more systematic and quantifiable approach to community engagement, with a focus on partnership working. The new framework, ABCE, shares similarities with ABCD however addresses the previous concerns and tries to augment the scientific rigour of the process by charting changes in active engagement with community assets and the accessibility and attractiveness of such assets.

Asset Based Community Engagement

The ABCE framework offers a more systematic approach to promoting recovery from substance misuse through community engagement and seeks to eliminate the 'blind spot' of ABCD, while adding to the empirical evidence base in this area. The new framework is intended to enhance ABCD by creating a bridge to individualised support for individuals lacking access to appropriate social supports and community assets. ABCE adds to this by offering a methodological approach to mapping community assets and gaining a deeper understanding of community engagement, with a particular focus on the inclusion of marginalised groups and populations.

To support the new framework, a workbook has been developed, offering a testable process that is intended to be used by two parties: the individual in recovery and a 'recovery navigator'. For example, this could be a peer or a support worker, key worker or drug and alcohol worker. The ABCE process is reliant on the individual in recovery and the recovery navigator forming a dyadic relationship to better manage community engagement. While reliance on the recovery navigator may raise concerns regarding an increased workload, this does help combat previous concerns which describes ABCD as 'neoliberalism with a community face' (p. 446).[31] As the recovery navigator can be a member of staff (and has been in the case study later presented), the professional organisation is reinstated in the process.

The workbook not only creates a platform to fuel conversation between the two parties but also allows the individual to engage in a process done with them, rather than done to or for them. It is intended that the workbook would be completed before individuals are linked into new community assets, and the group process of asset mapping outlined in Edwards et al[34] would be a complementary process. Within this study professionals and members of the recovery community mapped assets within the local community in a group based session. Following

this, they were jointly trained in the principles of assertive linkage and identified community connectors within the locale.[34]

The workbook will be explored in subsequent sections of the paper, providing rationale for each stage of the workbook and its' intended use and benefits within practice.

Community engagement

The new framework recognises the importance of community engagement and offers a systematic, practical approach to measuring community engagement to aid the recovery process. Community engagement can be defined as 'involvement in interpersonal interactions outside the home, including social, leisure, community activities and work' (p. 2).[35] Wong and Solomon[36] define community engagement for those experiencing mental ill health as a term that incorporates resource use, social interaction and psychological feelings of belonging. Similarly, literature highlighting the importance of resource use, social interaction and belonging is also noted within the recovery from substance misuse literature.[18]

Research commonly focuses on the use of resources and participation in community activities which limits the extent to which integration can be measured. Social integration is not only understood in terms of social interactions and relationships, but also in terms of social network size and quality.[37] The extent to which an individual feels a sense of connectedness and belonging within the community can be described as psychological integration. While ABCD focuses on what assets are utilised within the community, the ABCE framework goes above and beyond this, endeavouring to capture a holistic picture of social integration and its cumulative and positive impact on the community itself, and of how those resources can be deployed to support personalised pathways to reintegration and to active community engagement, through the use of assertive linkage techniques by established community connectors.

Six stages of ABCE

While the growth of recovery capital is predominantly an individual process, it is hypothesised that external factors, both social and community capital, create scaffolding for internal change, and that access to social support and community resources are essential components of the recovery journey, providing rationale for ABCE. Influenced by existing research which highlights the importance of social networks[11,18]; connection to others[38] and meaningful activity[17]; as well as barriers and enablers of community engagement,[39–41] ABCE is designed to give a clearer picture of assets utilised by marginalised groups.

Specific to recovery from substance misuse, the framework is mindful of the limitations of ABCD[31,32,42] and by acknowledging barriers to community engagement faced by the target population, provides a more holistic understanding of the engagement process. Identifying barriers should not draw the ABCE framework away from its strengths-based focus but instead, provide a platform for person-centred, holistic support to be provided to those in recovery from substance misuse.

ABCE has six key stages of partnership working. These are:

(1) Identify current levels of community engagement through asset mapping

(2) Exploration of assets (accessibility, affordability, connectedness and social networks)

(3) Explore the personal interests of the individual

(4) Identifying barriers to community engagement

(5) Highlighting the role of assertive linkage to the recovery navigator

(6) Assertive linkage and community engagement

Stages 1-4 of the framework (which form the ABCE workbook) are to be completed between the individual in recovery and recovery navigator. As stated in the ABCD literature[26] the community connector role is usually undertaken by citizens who are passionate and knowledgeable about their communities, but in ABCE they are primarily recovery navigators, and it does not matter whether they are professionals, peers or other members of the community. Figure 2 gives a visualisation of the roles involved within the ABCE process. Each role is explained in depth below (stages 5 and 6 [pages 20-22]).

ABCE workbook: Development and rationale

The workbook was coproduced with Sheffield Addiction Recovery Research Panel (ShARRP),[43] a public patient involvement panel and later piloted with a recovery group at Sheffield Alcohol Support Service (SASS), strengthening the ecological validity of the measure. This demonstrates ethical working and principles of coproduction in ensuring the participant group was included in the design of the model. The following sections break down each of the six stages of ABCE.

(1) Identify current levels of community engagement through asset mapping

This process is specific to each individual who engages with ABCE. The individual is encouraged to map only assets they are currently engaged with. By doing so, a holistic and personal understanding of the asset can be gained, enabling the recovery navigator to identify current levels of community engagement. Assets can be generic or recovery focused. For example, this could be a knitting group, AA group, or guitar tuition. It may be identified at this stage that individuals are already well connected with pro-social meaningful activities and have no interest in taking up new activities. The difference here with ABCD is that the process is person-centred. The asset mapping technique discussed in the ABCD literature involves communities

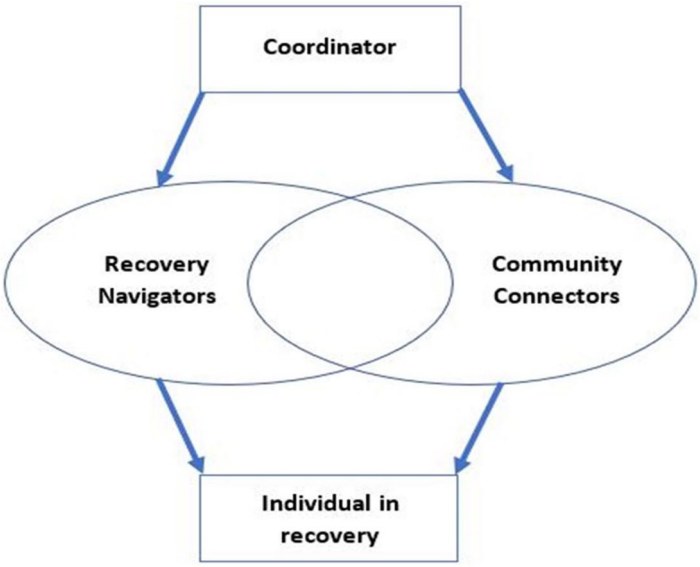

Figure 2. Roles involved in the ABCE process.

coming together to map the assets within their locale – both those they are engaged and those they are aware of. The person-centred approach adopted with ABCE allows the recovery navigator to work on a one to one basis with the individual in recovery to better understand their interests and skills.

Those engaged in ABCE are asked to map assets over four domains. These are: peers and mutual aid; sports, recreation and arts; professional services and education, employment and training. These domains are dependent on the context and others can be added, in line with the individual's needs and interests. A page would be designated for each domain in the ABCE workbook with individuals listing any groups, activities or organisations they are currently engaged with.

By making the mapping process person-centred and tailored to the needs and interests of the individual, ABCE becomes more engaging. The mapping technique implemented within ABCE has been influenced by the Social Identity Mapping (SIM) tool.[18] The SIM is a psychometrically validated instrument designed to provide a comprehensive overview of a person's social world. While ABCE has not yet been standardised, the principles of the framework are in line with the SIM tool. The SIM aims to identify levels of social capital and so work out who is in need of the most immediate linkage to prosocial groups and what they need to be linked to. Similarly, the mapping technique implemented in ABCE aims to help the navigator identify who is most in need of linkage to new activities. For example, individuals who list no assets may need assertively linking to pro-social community resources which in turn, will promote positive health and wellbeing. Unlike the SIM tool, ABCE not only aims to identify levels of social capital but provide a clearer understanding of community capital too. It can be presumed that those who list more assets, evidencing a level of connection to their community, will possess higher levels of community capital.

Similarly to the SIM tool,[18] this stage of asset mapping involves individuals constructing a visual map, categorising these assets dependent on the domain they fall under: professional services; sport, recreation and art; mutual aid and education, employment and training. The asset mapping technique implemented within ABCE aims to map assets by adopting a more systematic and innovative approach,[17] and the key challenge is to keep this live and vibrant. The ABCE workbook created offers a practical resource to be used in practice.

This is a dyadic process and relies on the recovery navigator to initiate conversation with the individual regarding their personal skills, interests and hobbies. This links to a later process (stage 3) of the ABCE framework which focuses on the interests of the individual. A single parent who works full time may be less engaged within the community due to time and family constraints however may be just as satisfied with their level of community engagement as an unemployed single person who has much more free time to participant in community groups and activities.

(2) *Exploration of assets* (accessibility, affordability, connectedness and social networks)

How each asset is explored?

Once assets have been identified, ABCE explores strengths and limitations of these assets. This stage of ABCE adds another dimension to this by exploring each asset over the following categories: affordability, accessibility (location and transport links), connectedness and social networks (see Figure 3). Each asset is explored using a traffic light system (see Figure 4). This approach to assessing assets was recommended by both the Sheffield Addiction Recovery Research Panel (ShARRP) and a recovery group at SASS. This demonstrates coproduction within the design of the model but also supports the practical use of the workbook.

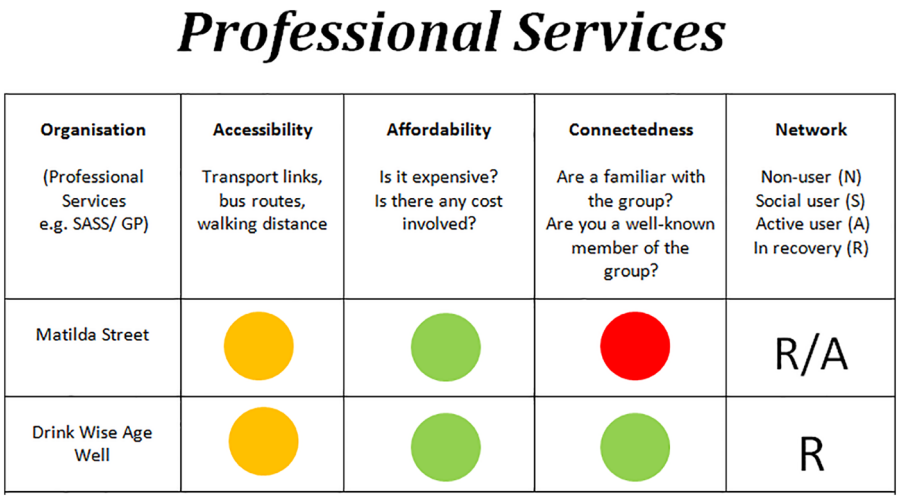

Figure 3. Example of assets listed in one domain of workbook, Professional Services.

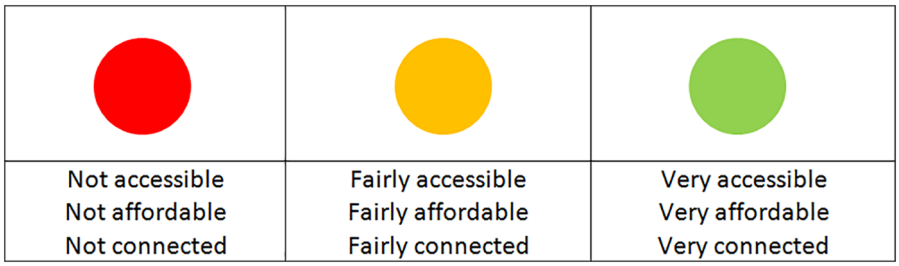

Figure 4. Traffic light system used to assess each asset.

The traffic light system is user friendly and allows individuals to give each asset listed a visualised rating: red, amber or green. Red dots are given to those assets the individual perceives as not affordable, not accessible and those they do not feel connected to. Amber dots are given to those assets that are fairly affordable, fairly accessible and those assets they feel fairly connected to, whereas assets given green dots are perceived as being very accessible, very affordable or very connected to. While it could be argued this technique is subjective, its simplicity makes it understandable and easy to interpret by the individual and implement within practice. Likewise, if assets mapped are recommended to others in recovery by the individual in recovery or recovery navigator, information can be shared and interpreted easily.

Rationale for four domains

Existing literature has provided the rationale for including these four components, with barriers to community engagement commonly noted within the literature including accessibility,[40] affordability[44] and contemporary research conceptualising recovery emphasising the importance of connectedness and meaningful activities.[16,17] Likewise, research further highlights the importance of network ties that are supportive of sobriety.[18,45] This is the first time this approach has been combined with the asset mapping technique, offering an enhancement of the ABCD mapping process.

Benefits for the individual in recovery and for the recovery navigator

Through mapping assets, the process allows time for self-reflection, enabling the individual in recovery to reflect on how and why they feel connected to certain assets. Through this process, the individual can discuss with the recovery navigator why they identify with specific groups and what benefits they offer. By doing so, the recovery navigator can become more aware of what assets individuals connect with and for what reason and this increases the recovery navigator's own levels of community knowledge and allows them to signpost others to appropriate assets.

Benefits for wider recovery community

Building on the social ecological theory,[46] Wong and Soloman[36] identify factors that help or hinder an individual's integration. For marginalised groups, the therapeutic value of non-judgemental and non-threatening landscapes[47] that individuals can access to socially interact with others can help to combat their social isolation and in turn, help to promote recovery. Exploring the landscapes in which recovery unfolds while identifying potential barriers to community integration and engagement has influenced the design of the new framework. Through a more holistic view of community engagement, ABCE aims to shed light on the potential of local assets and contribute to the

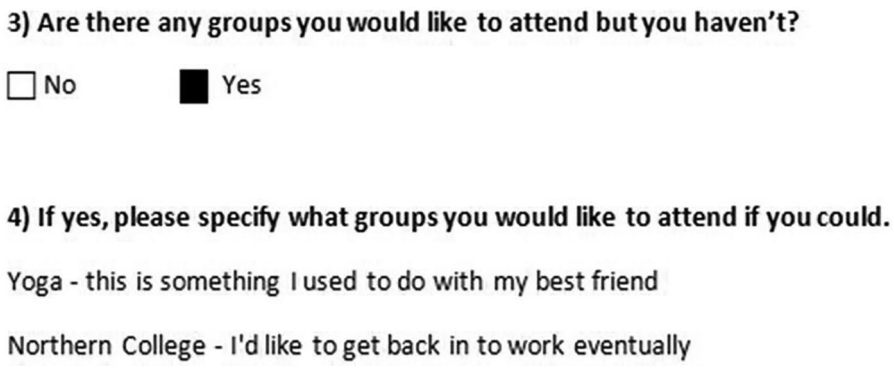

Figure 5. Exploring the personal interests of the individual within the ABCE workbook.

understanding of how assertive linkage into specific assets would be beneficial for others in recovery.

While a key component of ABCD is to map assets, the approach outlined in ABCE allows a more holistic picture of each asset to be created. User ratings given to assets using the traffic light rating scale can be later used in a larger community project and can help shed light on the local area's sum of community capital. The user ratings can further be shared with others, and in a 'Trip-Advisor' manner, can be used as a method to recommend local community assets to others with shared interests, and can help to build confidence and accessibility. This makes the ABCE process appealing as individuals can be linked into assets on a basis of recommendation from peers with first-hand experience (stage 6 of ABCE). As a result, the product becomes a useful tool for practitioners, volunteers, individuals in recovery and a live, up to date resource. While some assets mapped may be recovery specific, other local assets will be mapped not specific to these populations.

(3) Explore the personal interests of the individual

The next process is at the dyadic level between the individual in recovery and the recovery navigator and aims to explore the individual's interests and skills; this is both person-centred and strengths-based. Following the initial process of exploring current levels of community engagement, this stage looks at supporting the individual to engage in new meaningful activities, if desired. It is at this stage that the individual may list groups and activities which relate to their personal interests and skills. The relationship between recovery navigator and the individual is important here and must enable the individual to take ownership of mapping assets they wish to become engaged with. Figure 5 provides an example of how this would look in the ABCE workbook

For those early in recovery this process provides a sense of empowerment, allowing individuals to reflect on their personal interests and previous passions, and helps to build a strength and trust-based relationship with the recovery navigator. This shares similarities with the underpinning of ABCD which asserts that individuals must realise their own potential. What however is different here is that ABCE provides a platform within the workbook for individuals to reflect on their skills and interests by writing these down. While this may have been forgotten through periods of heavy drinking or drug use, the ABCE framework recognises that everyone has skills, passions and enthusiasms, and a strengths-based, relational approach draws these out, and enhances the working alliance as a consequence. This process aims to strengthen an individual's personal and cultural capital by facilitating conversations about their interests, and providing links to the community assets where these can be explored and enacted most effectively. This is an individualistic process and through exploration of the individual's personal and cultural capital seeks to develop an individual's social capital in a way which best suits them.

This stage of the ABCE workbook holds value for the recovery navigator as they can develop an understanding of the community resources the individual wishes to become engaged with and to work with the person to identify and engage with those groups or activities. Through combining this stage of the workbook with the next stage, *Identifying barriers to community engagement*, the recovery navigator can better understand how best to support the individual through the process of assertive linkage.

(4) Identifying barriers to community engagement

The final section of the ABCE workbook identifies barriers that may hinder willingness to engage with community resources (see Figure 6). Here, the recovery navigator must acknowledge that any groups the individual may have listed at the previous stage, *Exploring the personal interests of the individual*, cannot be perceived as an asset, or be deemed accessible, until barriers to engagement are understood and addressed. The ice cream cone model (Figure 1) emphasises the dynamic link between the three components of recovery capital and ABCE allows for disparities in capital to be identified, especially for marginalised populations, which in turn can contribute to the development of appropriate supports to build capital.[10,15] This forms part of a personalised assertive linkage approach (stage 5 and 6), relying on recovery navigators linking individuals to effective community connectors or acting as connectors themselves. Community connectors are

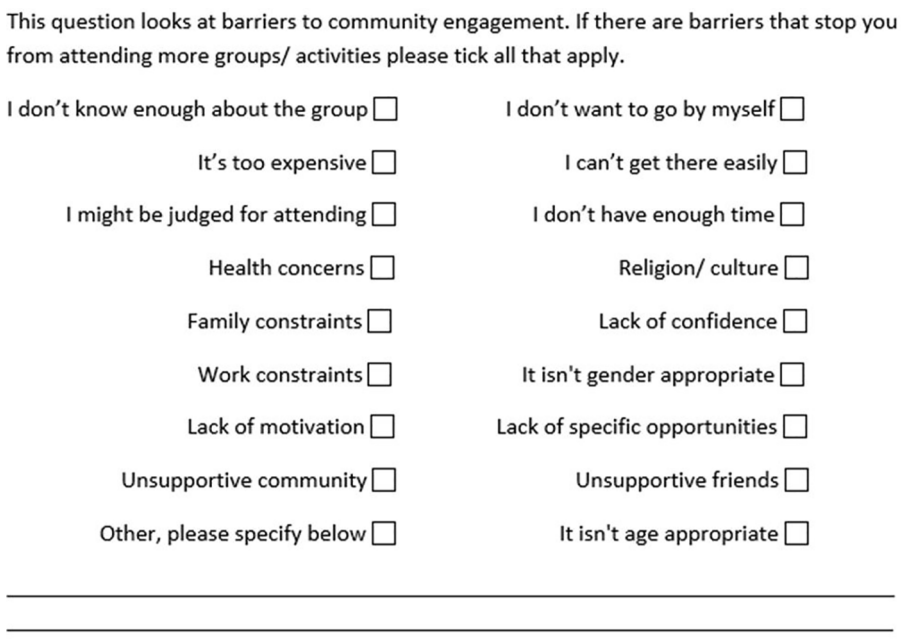

Figure 6. Exploring barriers to community engagement in the ABCE workbook.

experts of the locale and provide pathways into community assets, subsequently assisting the process of linkage. The role of the community connector will be explored in stage 5 and 6.

Acknowledging barriers to community engagement is a unique aspect of ABCE and barriers incorporated in the ABCE workbook (listed in Figure 6) are based on existing literature, with barriers noted at a micro, meso and macro level. Those commonly noted include illness and/or disability, loss of contact to social connections, an absence of a supportive community, and unavailability of transport,[40] absence of appropriate social opportunities, finances, confidence and opportunities that support preferred identities.[39,41] Furthermore, Goll et al[35] also found that fears of social rejection and fear of losing valued aspects of identity were also seen as barriers to community engagement. Those in recovery often report feelings of stigma and marginalisation associated with their 'using' identities.[48,49] Owing to this, the fear of social rejection may be exacerbated by those in recovery as a barrier to wider community engagement. ABCE aims to build bridges that will assist in overcoming barriers. The role of the recovery navigator is vital here to support the individual through this process. It is noted that marginalised populations often face a multitude of stigmas, contributing to the array of barriers to community engagement. Owing to this, those involved in ABCE must be realistic and note that it will not be feasible to overcome all barriers listed, but the role of the recovery navigator is to generate pathways and support groups to overcome as many of the barriers as possible and to build personal capital in doing this. Through facilitating community engagement within the wider community (explored in stage 5 and 6), individuals will be able to endeavour to live fulfilling lives and contribute positively to society, while lowering the demand of costly health and human services. Once engagement within the wider community can be successfully encouraged, structural barriers will be challenged and subsequently broken down. This process is reliant on community responsibility, outlined as a key component of ABCD.[26]

It is acknowledged that this element of the workbook may be deemed needs-based, however when combined with the other elements of the ABCE workbook aims to enable the individual to be supported in a person-centred way. The strength here is the dyad and the relationally-based, future and community focused endeavours of the partnership. While working with marginalised groups may require additional work, the relationships formed, and opportunities opened to individuals are essential as they can support individuals, provide a buffer against pressure and exclusion, and promote recovery. For example, the social interactions between individuals in recovery with new peers will help individuals make sense of their newly forming identities and provide support mechanisms which will promote positive change. Social skills learned through this process will provide a buffer against stress and increase resilience, and practical skills learned will help individuals increase self-efficacy. It is these types of interactions which will increase motivation and open opportunities for individuals to volunteer or gain work. By focusing on inclusion of marginalised groups, the process makes a commitment to community-level processes of social justice and social inclusion.

(5) Highlighting the role of assertive linkage to the recovery navigator

Stages 1-4 are all of importance if we are to assertively link those in recovery into new assets at a later date. Assertive linkage stands as a key component of ABCE as it provides the process through which individuals are encouraged, prepared

and supported to participate in community assets. It is impossible to know whether assertive linkage to assets will be suitable for specific individuals if our understanding of the asset is limited to begin with, providing the rationale for stages 1 and 2 of the workbook.

In the ABCD literature those who assertively link others into community assets are known as community connectors.[26] In the ABCE framework this is done by the recovery navigator as they will have already formed a trusting relationship with the individual and have a good understanding of their interests. It is thought that each organisation who adopts ABCE will have a pool of recovery navigators internal to the organisation. There may also however be a pool of external community connectors who are knowledgeable about the locale and well connected (see Figure 2). If the individual wishes to be linked into a community resource the recovery navigator has little knowledge of, a community connector already linked with the specific resource may be asked to support the process of assertive linkage.

It is the role of the coordinator (Figure 2) to oversee this and ensure if the recovery navigator does not have expertise in a specific resource, they are aware of which community connector to contact to support the process. It is intended the coordinator will be internal to the organisation adopting ABCE and will work with the pool of recovery navigators to understand their areas of expertise. For example, each recovery navigator may be a specialist in one of the domains listed within the ABCE workbook (peers and mutual aid; professional services; sports, recreation and art; or education, employment and training).

The role of the recovery navigator and/or community connector is vital to support the process of assertive linkage. In a similar programme of work with recovery residences in the US, this role was undertaken successfully by peer champions[5] – those who have been through the recovery process. For individuals in recovery, giving back to their communities may be a significant milestone in their journey, with research showing that finding a proactive role to play in society and helping others acts as a powerful form of reconnection to the world,[50] and this is one potential source of connectors, and can provide a community alternative to professional connectors. For persons following the 12 Step model of recovery, an emphasis is placed upon helping others; it is an encouraged practice and is argued to have positive therapeutic and spiritual effects[51]; and more generically there is evidence for the benefits of what is known as the 'helper principle'.[52] Evidence suggests this does happen, with a clear increase in individuals in stable employment from 37% in the first year of recovery, to 60% in the period of sustained recovery (*Life in Recovery*).[9]

Findings from *Life in Recovery*[9] also show that 79.4% of individuals in stable recovery report volunteering in community or civic groups since the start of their recovery journey, in comparison to 42% of the general public. What this shows is that with the correct support, individuals in recovery do successfully act as not only recipients but also as full contributors. Findings from Zemore et al[53] further support this, demonstrating that longer periods of sustained recovery predicted significantly more time spent on community helping. While increasing exposure to opportunities can develop a greater sum of recovery capital, community engagement has also been evidenced to have positive effects for overall wellbeing and recovery.[11,17]

(6) Assertive linkage and community engagement

It is the role of the recovery navigator to support the individual to engage with resources listed in stage 3 of the workbook, *Explore the personal interests of the individual* through assertive linkage. It may be that the recovery navigators have different expertise and therefore cover different domains (professional services; mutual aid; sport, recreation and art; and education, employment and training), dependent on their knowledge. If an individual wishes to be linked to a community asset which falls outside of the recovery navigators expertise then the appropriate community connector will be contacted to support this process.

Research by Edwards et al[34] show that this method using the community connectors model is effective for promoting community engagement for those in recovery from substance misuse. The work of Edwards et al[34] further details how community connectors could be supported through this process with appropriate training given. In the ABCE model it would be the role of the coordinator to oversee the pool of recovery navigators and community connectors and support them with appropriate training.

If done successfully, engagement with community resources that are pro-social and afford access to meaningful activities not only provides a platform for personal development and improvement, but also can trigger a social contagion of positive behaviour and improve connectedness within communities. Through wider engagement with both recovery-orientated and non-recovery orientated resources, individuals' levels of personal, social and community capital will be enhanced, conducive to the individuals recovery journey.

Once the ABCE workbooks have been completed across a cohort, a practical output of the accumulated data is to map available assets in the local area. This practical resource will in turn help the recovery navigators to assertively link others in recovery into community resources, promoting successful community engagement.

Putting the ABCE framework into practice: A case study

For this paper, a case study has been conducted using ABCE, in which a 33-year-old white British female, A, completed the ABCE workbook while conversations between herself and the

recovery navigator were audio recorded. The purpose of the case study was to highlight the use of the ABCE workbook in practice. Conversations were audio recorded to highlight the importance of community engagement to aid recovery from substance misuse. The audio recording was thematically analysed, as defined by Braun and Clarke[54] (p. 79) as 'a method for analysing and reporting patterns (themes) within data'. The data presented in the subsequent sections has been lifted from the case study with A. A had been engaged with a local Sheffield charity, SASS, for three months and was an expecting mother. While new to SASS, A had been in recovery for 13 months. Through completion of the workbook, several assets were listed, both internal and external to SASS.

Identify current levels of community engagement through asset mapping

A listed eight assets within the local community she was engaged with; six internal to SASS and two were external. Within the four different domains, no assets were listed under Education, Employment and Training but A did show willingness to become more engaged following the birth of her child. While several assets were listed, the extent to which this engagement stretched into the wider community was somewhat limited, and so her engagement is largely linked to the alcohol support service. The barriers which can be seen to hinder the community engagement of A will be later discussed.

Explore the personal interests of the individual

A expressed interest in becoming more engaged with numerous activities within the wider community. These included: art groups; cooking classes; sporting activities including netball and rounders; hair and beauty courses and Northern College to support her training and education needs. While enthused to participate in activities aforementioned, a number of barriers were listed.

Identifying barriers to community engagement

Figure 7 highlights the barriers to community engagement listed. Two barriers listed were affordability (it's too expensive) and accessibility (I can't get there easily), two components assessed in the user ratings. Not knowing enough about the groups was also listed as an additional barrier. This is supportive of the rationale of ABCE, as while the groups listed within the *Explore the personal interests of the individual* section of the workbook do already exist within the local community, a systematic process of mapping which provides further details of these resources would be later used to link A and others with shared interests into these resources. Through the dyadic relationship involved in ABCE mapping, additional information regarding listed assets can be learned by the recovery navigator and subsequently shared with others who engage with ABCE. This highlights the need for outreach work between local agencies to promote assets. While undoubtedly beneficial for individuals in recovery, this multi-agency outreach work would also prove beneficial for professionals working in the field – sharing local knowledge of what exists within the community and supporting one another. This is part of a broader aim of using dyadic level pairings as part of a process of building connections and networks across the community.

Thematic analysis of the audio recording with A

Theme 1: The challenges of recovery capital

An analysis of the audio recording highlighted the importance of ABCE and outlined a number of challenges faced by A when seeking recovery. As the ice cream cone model[17] (Figure 1) highlights, there is a dynamic link between the three components of recovery capital, and if challenges exist at any of these points, then community engagement conducive to both the individual and the community cannot be achieved.

At the bottom of the ice cream cone model[17] personal determination and commitment to recovery is essential, alongside the mobilisation of existing personal resources and passions, if barriers to engagement exist at this initial stage then pro-social networks cannot be formed and isolation experienced is exacerbated. This is supported by A who states, 'my main issue is the isolation (. . .) it took me until about three months ago until I actually came to SASS'. Social isolation can often initiate heavy drinking[55] and stands alone as a vital reason for why community engagement is so important.[56,57] If the ABCE framework can help to identify commonly noted barriers to engagement at a personal level, then professionals, peers and those involved in the framework as recovery navigators or community connectors can help to overcome these barriers in a person-centred manner. A states, 'Lewis* who works here, he knows it's a struggle going out, so anytime he sees something that he thinks might be worth my while he mentions it to me, because I did used to struggle in groups and things like that and I would refuse to go to them'. This highlights the role of the recovery navigator who is able to understand A's interests and help create personalised pathways in to community assets.

In line with Lloyd[58] who states individuals struggle to regain self-respect if they are continuously stigmatised within society, A expresses apprehension at joining the local baby groups. To help combat this, A suggests 'if I go whilst I'm pregnant I might make friends sooner and it will make it easier to go to (. . .) because everyone likes babies. If you see someone pregnant and then you find out that they had a baby you want to meet that baby, so I feel like it might help in getting me going there'. This supports previous concerns that ABCD is too optimistic, and for socially excluded groups, engagement within the wider community is challenging because of self-stigma. This highlights the need for individuals to be assertively linked into community assets and supported throughout the process by the recovery navigator.

Figure 7. Barriers to community engagement listed in ABCE workbook by A.

Theme 2: The power of shared experience

Further analysis of the audio recording with A uncovered the power of shared experience, highlighting the importance of community engagement as a means to form new social networks supportive of an individual's recovery attempts. These shared experiences act as an instrumental form of support, as A explains, 'if it's something surrounding like mental health or addiction then you want people there that have got either mental health issues or people who are recovering, because then you've got that peer support, you've got people that are in the same boat as you'. The experiences shared of those within SASS share characteristics of a therapeutic landscape, a place in which health, healing and place coincide[59] and members of the in group can manage potential feelings of shame and guilt.

As recovery unfolds within this therapeutic landscape, the tendency of emotions and attitudes to transmit from person to person, also known as a hyperdyadic spread becomes evident.[21] Through this contagion of hope and opportunity,[60] these environments further provide both a source of social learning, 'coming to places like SASS and seeing people not react in a bad way to what I'm saying makes me come here more' as well as access to social support, 'coming here and talking to people from different walks of life, obviously we all got the same sort of issues'. It is through this window of opportunity that individuals come together, share together and heal together, regardless of the situation, as stated by A, 'I mean I could sit there knitting, it's not about that, knitting is not something that I would actively go and look to do, it's about the people that are there'. By surrounding individuals with recovery-orientated support networks, individuals are provided with a greater chance of envisaging their identity change and working towards it. Once an individual is able to reflect on their past self, 'I used to wear full on goth gear and I used to stomp through town' and note visible improvements in their health and wellbeing, 'my mental health is the best it's ever been, whereas before I would always describe it as flat (. . .) but now I will say it's good because I am getting out, I am doing stuff, not brooding on things', motivation can be sustained through a hope for a better life.[61]

Summary

Wacquant[62] explain how marginalised groups and communities have become distanced from society on a physical, spatial and economic level. As a result of this, structural barriers to full citizenship become more prominent, termed 'urban marginality'.[63] This results in huge differences between the physical and mental health of the richest and poorest in society.[64] In order to reduce health inequalities and support the needs of disadvantaged groups we must endeavour to create and develop healthy and sustainable communities.[65] This was outlined by the World Health Organization[66] as one of their four priority areas for policy action and Marmot et al[65] highlighted the importance of communities utilising their local assets to maximise health and wellbeing outcomes for the locale.

Attentive to the challenges of ABCD, the newly proposed framework, ABCE, acknowledges the need for a more systematic approach to promoting recovery from substance misuse through community engagement. Drawing on the origins of ABCD, the new framework ties in theoretical components from the social identity model of recovery[18] and CHIME[16] and through the development of the ABCE workbook, endeavours to provide a more holistic understanding of community engagement amongst recovery populations.

To be successful, recovery navigators involved in the process must understand the benefits of both frameworks, ABCE and ABCD, working alongside one another. ABCE must be considered prior to ABCD in order to explore an individual's current levels of community engagement and barriers to engagement, before assertive linkage into new community assets can be achieved in an appropriate manner to support empowerment and maximise personal capital. It is the role of the recovery navigator who must also act as or in concert with

the community connector to appropriately support the individual through this process and to subsequently work towards overcoming barriers to engagement by linking individuals into appropriate supports. Once the ABCE workbook has been completed, stage 5 and 6 of the framework lends itself to the work of ABCD.

The ABCE workbook is still in the developmental stage and while piloted with ShARRP, further developments may still be made. The workbooks functionality is replicable, and its practical application may be transferable to other marginalised populations, while minor changes may need be considered. Further research would need to be undertaken to explore its application and transferability to other populations. While the recovery navigator helps to guide the process of asset mapping and assertively link individuals in recovery into new resources, ABCE is led by the individual at the heart of the process and its outputs for recovery communities are sustainable, allowing local knowledge regarding assets to be shared between others in recovery, recovery navigators and community connectors.

ABCE does indeed still face its own challenges and with the development of the new framework remaining in its preliminary stage, further work must be done to strengthen its robustness.

Author Contributions

BC and DB had explored Asset Based Community Development approaches in a previous body of research. Through other exploratory work, BC developed the idea of Asset Based Community Engagement (ABCE) and undertook data collection for her doctorate thesis. BC wrote the first draft and DB provided expert opinion. The data collection undertaken for the doctorate thesis of BC fed into the case study outlined in the paper. DB assisted in the redraft and suggested the visualisation of the roles within the ABCE model and BC created this visualisation for the paper.

Authors' Note

*All names have been changed for purposes of confidentiality and anonymity.

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REFERENCES

1. White WL. Addiction recovery: its definition and conceptual boundaries. *J Subst Abuse Treat*. 2007;33(3):229–241.
2. Best D, Laudet A. *The Potential of Recovery Capital*. London: RSA; 2010.
3. Betty Ford Institute Consensus Panel. What is recovery? A working definition from the Betty Ford Institute. *J Subst Abuse Treat*. 2007;33:221–228.
4. UK Drug Policy and Commission. *The UK drug policy commission recovery consensus group: a vision of recovery*. Policy report, 2008. London: Kings Place.
5. Cano I, Best D, Edwards M, Lehman J. Recovery capital pathways: mapping the components of recovery wellbeing. *Drug Alcohol Depend*. 2017;181:11–19.
6. Granfield R, Cloud W. Social context and "natural recovery": the role of social capital in the resolution of drug-associated problems. *Subst Use Misuse*. 2001;36(11):1543–1570.
7. Granfield R, Cloud W. *Coming Clean: Overcoming Addiction Without Treatment*. New York: New York University Press; 1999.
8. Ruiu ML. The social capital of cohousing communities. *Sociology*. 2016;50(2):400–415.
9. Best D, Albertson J, Irving J, Lightowlers C, Mama-Rudd A, Chaggar A. *Life in Recovery Survey*. Sheffield: Sheffield Hallam University; 2015.
10. Cloud W, Granfield R. A life course perspective on exiting addiction: the relevance of recovery capital in treatment. *NAD Publication*. 2008;44:185–202.
11. Jetten J, Haslam A, Haslam C. *The Social Cure: Identity, Health and Wellbeing*. Hove, East Sussex: Psychology Press; 2012.
12. Johnstone M, Jetten J, Dingle GA, Parsell C, Walter ZC. Discrimination and well-being amongst the homeless: the role of multiple group membership. *Front Psychol*. 2015;6(739):1–9.
13. Mehrabi M, Eskandarieh S, Khodadost M, Sadeghi M, Nikfarjam A, Hajebi A. The impact of social structures on deviant behaviors: the study of 402 high risk street drug users in Iran. *J Addict*. 2016;2016:6891751.
14. Putnam RD. Bowling alone: America's declining social capital. In: Crothers L, Lockhart C (eds) *Culture and Politics*. New York: Palgrave Macmillan; 2000.
15. White W, Cloud W. Recovery capital: a primer for addictions professionals. *Counselor*. 2008;9(5):22–27.
16. Leamy M, Bird VJ, Le Boutillier L, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry*. 2011;199:445–452.
17. Best D, Irving J, Collinson B, Andersson C, Edwards M. Recovery networks and community connections: identifying connection needs and community linkage opportunities in early recovery populations. *Alcohol Treat Q*. 2017;35(1):2–15.
18. Best D, Beckwith M, Haslam C, et al. Overcoming alcohol and other drug addiction as a process of social identity transition: the social identity model of recovery (SIMOR). *Addict Res Theory*. 2016;24(2):111–123.
19. Litt MD, Kadden RM, Kabela-Cormier E, Petry NM. Changing network support for drinking: network support project 2-year follow-up. *J Consult Clin Psychol*. 2009;77(2):229.
20. Wolff N, Draine J. Dynamics of social capital of prisoners and community reentry: ties that bind? *J Correct Health Care*. 2004;10(3):457–490.
21. Christakis NA, Fowler J. *Connected: The Amazing Power of Social Networks and How They Shape Our Lives*. London: HarperCollins; 2010.
22. McKnight J, Kretzmann J. *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. Evanston, IL: Center for Urban Affairs and Policy Research, Northwestern University; 1993.
23. Kretzmann JP, McKnight J. Asset based community development. *Natl Civ Rev*. 1996;85(4):23–29.
24. Kretzmansn JP, McKnight J, Puntenney D. *Discovering Community Power: A Guide to Mobilizing Local Assets and Your Organization's Capacity*. Evanston, IL: Asset-Based Community Development Institute, School of Education and Social Policy, Northwestern University; 2005.
25. McKnight J, Block P. *The Abundant Community: Awakening the Power of Families and Neighbourhoods*. San Francisco: Berrett-Koehler Publishers Inc.; 2010.
26. Nuture Development. Welcome to Nurture Development. https://www.nurturedevelopment.org/. Accessed August 31, 2019.
27. Manning V, Best D, Faulkner N, et al. Does active referral by a doctor or 12-Step peer improve 12-Step meeting attendance? Results from a pilot randomised control trial. *Drug Alcohol Depend*. 2012;126(1–2):131–137.
28. Weiss RD, Griffin ML, Gallop R, et al. Self-help group attendance and participation among cocaine dependent patients. *Drug Alcohol Depend*. 2000;60(2):169–177.
29. White W, Kurtz E. Recovery. *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counsellors and Recovery Coaches*. Pittsburgh, PA: Ireta; 2006.
30. Moos RH, Moos BS. Paths of entry into alcoholics anonymous: consequences for participation and remission. *Alcohol Clin Exp Res*. 2005;29(10):1858–1868.
31. MacLeod MA, Emejulu A. Neoliberalism with a community face? A critical analysis of asset-based community development in Scotland. *J Community Pract*. 2014;22(4):430–450.
32. Blickem C, Dawson S, Kirk S, et al. What is asset-based community development and how might it improve the health of people with long-term conditions? A realist synthesis. *SAGE Open*. 2018;8:1–13.
33. Kretzmann JP, Russel C. The four essential elements of an asset-based community development process. What is distinctive about an asset-based community development process? ABCD Institute. *Nuture Development*; 2018. https://www.nurturedevelopment.org/wp-content/uploads/2018/09/4_Essential_Elements_of_ABCD_Process.pdf
34. Edwards M, Soutar J, Best D. Co-producing and re-connecting: a pilot study of recovery community engagement. *Drugs Alcohol Today*. 2018;18(1):39–50.
35. Goll JC, Charlesworth G, Scior K, Stott J. Barriers to social participation among lonely older adults: the influence of social fears and identity. *PloS One*. 2015;10(2):e0116664.
36. Wong YLI, Solomon PL. Community integration of persons with psychiatric disabilities in supportive independent housing: a conceptual model and methodological considerations. *Ment Health Serv Res*. 2002;4(1):13–28.

37. Chan DV, Helfrich CA, Hursh NC, Rogers ES, Gopal S. Measuring community integration using Geographic Information Systems (GIS) and participatory mapping for people who were once homeless. *Health Place*. 2014;27:92–101.
38. Seppala E, Rossomando T, Doty JR. Social connection and compassion: important predictors of health and well-being. *Soc Res Int Q*. 2013;80(2):411–430.
39. Rozanova J, Keating N, Eales J. Unequal social engagement for older adults: constraints on choice. *Can J Aging*. 2012;31(1):25–36.
40. Victor CR, Scambler SJ, Bowling ANN, Bond J. The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain. *Ageing Soc*. 2005;25(6):357–375.
41. Walker RB, Hiller JE. Places and health: a qualitative study to explore how older women living alone perceive the social and physical dimensions of their neighbourhoods. *Soc Sci Med*. 2007;65(6):1154–1165.
42. Emejulu A. Searching for the state and the market in American community development: reflections on editing Community Development in the Steel City. *Community Dev J*. 2013;48(1):158–162.
43. University of Sheffield. School of Health and Related Research. Sheffield Addiction Recovery Research Panel (ShARRP). https://www.sheffield.ac.uk/scharr/ppi/sharrp. Accessed November 1, 2018.
44. Bukov A, Maas I, Lampert T. Social participation in very old age: cross-sectional and longitudinal findings from BASE. *J Gerontol B Psychol Sci Soc Sci*. 2002;57(6):510–517.
45. Cruwys T, Steffens NK, Haslam SA, Haslam C, Jetten J, Dingle GA. Social Identity Mapping: a procedure for visual representation and assessment of subjective multiple group memberships. *Brit J Soc Psychol*. 2016;55(4):613–642.
46. Moos RH. *Evaluation Treatment Environments: A Social Ecological Approach*. New York, NY: Wiley; 1974.
47. Bell SL, Foley R, Houghton F, Maddrell A, Williams AM. From therapeutic landscapes to healthy spaces, places and practices: a scoping review. *Soc Sci Med*. 2018;196:123–130.
48. Corrigan PW, Kuwabara SA, O'Shaughnessy J. The public stigma of mental illness and drug addiction: findings from a stratified random sample. *J Soc Work*. 2009;9(2):139–147.
49. Kelly JF, Saitz R, Wakeman S. Language, substance use disorders, and policy: the need to reach consensus on an "addiction-ary". *Alcohol Treat Q*. 2016;34(1):116–123.
50. Jacobson N, Greenley D. What is recovery? A conceptual model and explication. *Psychiatr Serv*. 2001;52(4):482–485.
51. Smith AR (2007) *The Social World of Alcoholics Anonymous*. Lincoln, NE: iUniverse.
52. Riessman F. The "helper" therapy principle. *Soc Work*. 1965;10(2):27–32.
53. Zemore SE, Kaskutas LA, Ammon LN. In 12-step groups, helping helps the helper. *Addiction*. 2004;99(8):1015–1023.
54. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101.
55. Juárez J, Vázquez-Cortés C. Alcohol intake in social housing and in isolation before puberty and its effects on voluntary alcohol consumption in adulthood. *Dev Psychobiol*. 2003;43(3):200–207.
56. Putnam RD. Tuning in, tuning out: the strange disappearance of social capital in America. *PS Political Sci Politics*. 1995;28(4):664–683.
57. Victor C, Grenade L, Boldy D. Measuring loneliness in later life: a comparison of differing measures. *Rev Clin Gerontol*. 2005;15(1):63–70.
58. Lloyd C. The stigmatization of problem drug users: a narrative literature review. *Drugs Educ Prev Polic*. 2013;20(2):89–95.
59. Gesler WM. *Healing Places*. Lanham, MD: Rowman and Littlefield; 2003.
60. Wilton R, DeVerteuil G. Spaces of sobriety/sites of power: examining social model alcohol recovery programs as therapeutic landscapes. *Soc Sci Med*. 2006;63(3):649–661.
61. McKay JR. Making the hard work of recovery more attractive for those with substance use disorders. *Addiction*. 2017;112(5):751–757.
62. Wacquant L. *Urban Outcasts: A Comparative Sociology of Advanced Marginality*. Cambridge: Polity; 2008.
63. Cummins I. Wacquant, urban marginality, territorial stigmatization and social work. *ANZSW*. 2016;28(2):75–83.
64. Pickett KE, Wilkinson RG. Inequality: an underacknowledged source of mental illness and distress. *Br J Psychiatry*. 2010;197(6):426–428.
65. Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M. *Fair Society, Healthy Lives*. London: The Marmot Review; 2010:14.
66. World Health Organization. *Health 2020 Priority Area Four: Creating Supportive Environments and Resilient Communities*. World Health Organization; 2018.