A realist inspired evaluation of a Salvation Army community programme for people with problematic alcohol use and cognitive impairment

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Declaration

I declare that none of the work contained within this thesis has been submitted for any other degree at any other university. This thesis is entirely my own work.

Jean A. Hannah

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To everyone, this is *our* PhD!

Contents

Abstract

People with experience of problematic alcohol use (PAU), cognitive impairment and alcohol-related brain damage (ARBD) seek help at Salvation Army community programmes. Realist evaluation, which inspired this research, encourages exploration of people's reasoning when resources are introduced into their lives. Realists anticipate varying intervention outcomes, expected and unexpected. Research findings may challenge but also provide evidence to create or strengthen interventions. This research sought evidence about '*what works for which people with PAU, cognitive impairment and ARBD in what circumstances in Salvation Army community programmes, how and why?'* Findings related to micro-actions and outcomes, small steps rather than giant leaps, creating opportunities for salutogenic flow in the midst of rippling complexities associated with PAU and cognitive impairment. Flow arose in the non-judgemental intervention context where people repeatedly accessed basic need resources. Their generalised resistance resources strengthened and recovery-orientated sense of coherence grew. As recovery resources to others, peer credence was given to those who had "*worn the T-shirt*". The Salvation Army crucially provided the physical and social context where individuals seeking help could access core resources, provided by peers, staff and volunteers whose approach extoled, '*Three strikes and you're welcome'*. People were offered realistic hope, with acknowledgement that though life's whirlpools could draw them back into PAU's depths, others could share experiences offering encouragement towards sustained recovery. Hope extended to people whose recovery seemed remote, their aspirations focusing on avoiding withdrawals and maintaining alcohol intake. Their hopes received daily fulfilment. Alcohol consumption continued through individual and peer group resourcefulness. Basic needs were met by staff, volunteers and peers offering stigma-free affirmation of worth. While not reaching the '*ease*' end of the salutogenic continuum, the pull of the '*dis-ease*' end precipice appeared held back. Supported by people to whom they mattered, those facing that precipice did not do so in isolation.

Lists of tables, figures, configurations and theories

List of tables

List of figures

List of candidate programme theories

Note also:

List of candidate programme theories refined

List of explanatory context, mechanism and outcome configurations

Note also:

List of evidence-informed programme theories

Note also:

List of Abbreviations

AA	Alcoholic Anonymous
A&E	Accident and Emergency
ABI	Alcohol Brief Intervention
ARBD	Alcohol-related brain damage
ARBI	Alcohol-related brain Injury
AUDIT	Alcohol Use Disorder Identification Test
CMO(s)	Context(s), mechanism(s), outcome(s)
CMOc(s)	Context(s), mechanism(s) and outcome(s) configuration(s)
CPT(s)	Candidate programme theory or theories
CPTR(s)	Candidate programme theory or theories refined. The numerical value at the end in brackets such as (4) refers to the original CPT source, such as CPTR1(4).
CRA	Community Reinforcement Approach
DASW(s)	Drug and Alcohol Support Worker(s)
GP	General Medical Practitioner
GRR(s)	Generalised resistance resource(s)
ISD	Information Services Department
Intervention (the)	Appointment and role of the DASWs in keeping with the strategy document, '*Time for Recovery*'
NA	Narcotics Anonymous
NHS	National Health Service
NICE	National Institute of Health and Clinical Excellence

Participant coding

- C at the end of a participant code indicates self-reported current PAU (Client-A1C)
- R at the end of a participant code indicates the person is in self-reported recovery (Staff-C1R)
- Where neither C nor R is present, there is no known history of PAU.

PAU	Problematic alcohol use
RCGP	Royal College of General Practitioners
Strategy (the)	The Salvation Army Scotland Drug and Alcohol Strategy Group document, '*Time for Recovery*'
Strategist(s)	Members of The Salvation Army Scotland Drug and Alcohol Strategy Group
Strategy Group	The Salvation Army Scotland Drug and Alcohol Strategy Group
SOC	Sense of coherence
TSA	The Salvation Army
THEAC	Territorial Health, Ethics Advisory Committee
TSO(s)	Third Sector Organisation(s)
WHO	World Health Organization

Chapter 1 Introduction

1.1 Introduction

Salutogenesis refers to the origin of health and wellbeing and contrasts with pathogenesis, associated with development of ill-health and disease. An important concept for all in society , it is more difficult to achieve or maintain for those with problematic alcohol use (PAU), a term used in this thesis for alcohol use creating personally recognised or unrecognised harm to self or others. PAU can have pathogenic effects on all bodily tissues increasing risks of a many conditions including liver cirrhosis, cancer and cardiovascular disease. A pathogenic impact less often highlighted is alcohol-related brain damage (ARBD), an umbrella term for various conditions affecting cognitive function including thinking, memory and decision making.

ARBD is particularly important because unlike other causes of cognitive impairment such as Alzheimer's disease, with early identification and support approximately 75% of those affected experience degrees of cognitive improvement. This reflects a positive shift along a personal pathogenic-salutogenic continuum. A challenge is that PAU and cognitive impairment may affect ability to make salutogenic choices and engage with statutory health and social care providers. People experiencing PAU can slip through traditional health and social care nets and turn to Third Sector Organisations (TSOs) including Salvation Army '*community programmes*' for support. In this thesis, community programmes refers to Salvation Army corps, citadels or churches and the activities, supports and services provided there.

The Salvation Army (TSA) originated more than a century before Antonovsky introduced the concept of salutogenesis. Nevertheless from its outset, community programme supports for people, including those with PAU, experiencing hardship had a salutogenic stance. In 2013, TSA through its Scotland Drug and Alcohol Strategy Group (Strategy Group) and strategy document, '*Time for Recovery*' (Scotland Drug and Alcohol Strategy Task Group 2011), launched a new Drug and Alcohol Support

Worker (DASW) intervention at community programmes in Scotland, replacing a former residential programme. At the research outset, a DASW had been appointed at each of three of four intervention sites, which subsequently became the three research fieldsites.

TSA joint funded this research with the University of Stirling to, '*address(ed) key gaps in scientific knowledge and provide(d) useful outcomes*' (Appendix 1 PhD Advertisement 2013) about '*what works and why*'(Scotland Drug and Alcohol Strategy Task Group 2011) for help-seekers with ARBD. This knowledge gap was particularly relevant because the Drug and Alcohol Support Workers (DASWs) were appointed to use principles of the Community Reinforcement Approach (CRA) (Meyers et al. 2011), which does not specifically focus on people with ARBD. Furthermore, when the fieldwork began, full CRA training was pending.

Inspired by realist evaluation and Zinberg's (1984) writing about drug, set, and setting, my research desire was to dig deeper into the important knowledge gaps identified by TSA and expand on TSA research question from a salutogenic stance. I wished to build programme theories supported by evidence about *what works in salutogenic terms, for whom with PAU, cognitive impairment and ARBD, in what circumstances, how and why in TSA 'Time for Recovery' community programmes.* As a realist inspired evaluation the research aimed to determine the *mechanisms* or reasoning and responses occurring and *outcomes* arising on introduction of resources into individuals' *contexts*. Data is from semi-structured interviews and focus groups with people accessing or providing community programme supports. It concludes by offering TSA recommendations about salutogenic approaches to supporting people with PAU, cognitive impairment and ARBD, relevant to other agencies working with people experiencing these issues.

This academic thesis aims to be a resource for people in TSA with its layout aiming to promote accessibility to a diverse readership.

1.2 Understanding the thesis structure

The thesis structure is influenced by realist review, evaluation and interview approaches. Chapters one to four present the background context, literature reviews and methodology of the study.

Literature reviews differ in approaches, aims (Grant and Booth 2009; Wong et al. 2013) and presentation styles depending on contexts and anticipated readership. Types include *systematic* and *narrative reviews* (Collins and Fauser 2005) and *realist reviews* or *syntheses* undertaken independently or as precursors to realist evaluation (Wong et al. 2013). To strengthen the research quality and in early stages refine the research aims, objectives and questions found in Chapter 3 (s.3.2.2.1), I reviewed the literature using two approaches. Firstly, I built knowledge and understanding about the issues being studied by undertaking a narrative-style background literature review (Chapters 1 and 2). Chapter 1 presents literature findings about PAU, cognitive impairment and ARBD on a personal and wider, particularly Scottish, contextual level (due to the community programme and research locations), information about TSA and introductions to the CRA and realist evaluation. Chapter 2 provides a background review about salutogenesis. Chapter 3 describes realist philosophy and methodology, review and evaluation, and begins the process of theory building which continues throughout the thesis as evidence is increasingly drawn from literature and participants' voices. Of importance to realist evaluation, it provides fieldsite contextual information.

Chapter 3 cements the background literature reviews in Chapters 1 and 2 to Chapter 4's deeper background review about the CRA then its focused realist inspired review about salutogenesis, PAU and ARBD. The advantage of realist over other forms of literature review is its use of '*grey literature'* (Adams et al. 2016), including TSA's website and policy document information important to this research. Chapter 4 explores the relevance of salutogenesis to help-seekers and to help-providers. Importantly the salutogenic nature or otherwise of the community programmes as workplaces may affect help-providers' ability to support help-seekers.

Chapter 5 presents findings from the DASWs Exploratory Focus Group about aspects of support the DASWs believed important for help-seekers with PAU, cognitive impairment and ARBD at the community programmes. DASWs' experiences about their roles and TSA community programmes as a salutogenic workplace are discussed.

Chapter 6 presents findings about participants' contexts, and examines *who knows what about associations between PAU, cognitive impairment and ARBD in what circumstances, how and why?* Explanations, beliefs and understanding about these issues are important to comprehensibility, meaningfulness and manageability in SOC and so to salutogenesis, both for help-seekers at the fieldsites and to help-providers in their workplaces.

Chapter 7 explores data from people with PAU, cognitive and ARBD experience. The chapter further demonstrates how findings help establish '*what works for whom, in what circumstances, how and why*'. It continues the process of theory building, confirmation and refinement.

Chapter 8 reflects on the research undertaken and evidence about a salutogenic framework in Salvation Army supports for people with PAU, cognitive impairment and ARBD. Discussion is presented about the relevance of the findings, highlighting where they support, challenge and add to existing literature. Recommendations are offered to TSA about the research findings, which it is argued offer learning to other people and organisations offering support to people with PAU and cognitive impairment.

A personal reflection is presented in Chapter 3 about undertaking the PhD and where aspects might have been undertaken differently. Suggestions are made in Chapter 8 about future research based on this study's achievements and research gaps identified.

1.3 Background literature review

Drawing on narrative approaches (Green et al. 2006; Bryman 2012, p. 102) and aligned to Ferrari's advice, Chapters 1 and 2 summarise existing publications to avoid inadvertent repetition of research and to support establishment of new research focuses (Ferrari 2015).

Chapters 1 and 2 searches used key topic-specific words firstly through Ovid Medline with restrictions to publications in English and for humans only. Stirgate and The Knowledge Network looked beyond Ovid Medline's medical emphasis. The Knowledge Network incorporated wider reference sources, including Ovid EMBASE, EBSCO CINAHL, EBSCO PSYCHINFO, government agencies and third sector organisations. It was particularly beneficial in identifying reports.

When search results highlighted high quantities of papers that made complete reading of each impractical, full text, reviews and latest update limitations were applied. Search period restrictions were set at a minimum of three years retrospectively from the search date. All paper titles were read then retained if relevant to the topic, this process subsequently repeated for abstracts with remaining papers used to support writing. Search templates and dates were recorded though My Workspace on Wolters Kluwer Health Ovid SP to enable re-running.

My personal knowledge of the topics started at low levels, which diminished risks of pursuing preconceived '*right answers'*. A University of Stirling librarian reviewed and confirmed my search techniques met required standards. GGCNHS (Greater Glasgow and Clyde NHS) and British Medical Association librarians kindly undertook searches to prevent omission of relevant documents. Finally while recognising potential bias in responses, I asked people working in the field to recommend literature.

Chapter 1 provides a background review of literature and governmental linked policy documents about PAU, cognitive impairment and ARBD on a personal and wider Scottish level. It describes complex factors contributing to and influencing TSA community programmes' wider contextual layers which potentially affect '*what works, for whom, in what circumstances, how and why*'.

Chapter 1 reviews evolving understanding about how and why alcohol creates harm. It considers theories of addiction and relapse and associated controversy, past and present, which may influence help-seekers, help-providers and support provision. Due to the research location, Scotland's attitudes to alcohol are examined, including those relating to faith and the Temperance Movement. Recent statistics demonstrate alcohol's continuing detrimental impacts on people living in Scotland, in this thesis

collectively called *Scots*. Terminology is explored about alcohol and problems associated with its use. This is followed by consideration of how and why alcohol use is important to brain health and cognitive function, the ramifications of development of ARBD, and governmental responses. Background information is provided about TSA and the CRA, of which TSA had experience elsewhere in the world.

Chapter 2 focuses on salutogenesis, fundamental to the research to follow. This includes its proposed suitability as a recovery service framework (Parkin 2016). Two original aspects of salutogenesis are focused on: sense of coherence (SOC) and generalised resistance resources (GRRs) (Antonovsky 1987). These have been chosen because of their perceived resonance with difficulties experienced by people with PAU. Sense of coherence relates to comprehensibility, meaningfulness and manageability in life when faced by stressors. PAU can arise in response to stressors and in itself create stress. Being able to access GRRs, ranging from financial to people who can be turned to for support, contribute to SOC.

Literature about salutogenesis in the workplace is then explored. This is of anticipated importance because comprehensibility, meaningfulness and manageability for help-providers in their roles has scope to impact on help-providers themselves, how they support help-seekers and so help-seekers' outcomes.

1.4 Problematic alcohol use

Many people enjoy consuming alcohol, including sometimes when associated with being drunk (Kelly and Barker 2016). However, alcohol-related harm is increasingly recognised especially for heavy drinkers who develop physical, psychological and potentially fatal consequences (Kelly and Barker 2016). Throughout history, individuals, cultures and religious groups have viewed alcohol use and impacts differently, including if consumption is problematic or not. Terminology has also changed, the World Health Organisation (WHO) and American Psychiatric Association (APA) guiding and benchmarking these changes (APA 2013; WHO 1992). As this thesis does not have a clinically diagnostic aim, broader terms of people experiencing alcohol problems or PAU are used to refer to people at risk of or experiencing alcohol

consumption associated difficulties. This is in keeping with terminology used by Scottish Government (Scottish Government 2012) and in the report, '*Monitoring and Evaluating Scotland's Alcohol Strategy*' (Beeston et al. 2014).

1.5 Theories of addiction past and present

Evolving theories about alcohol addiction contribute to understanding about why people believe what they do about PAU and recovery. Beliefs may shape people's attitudes, their accessing of or work in services, and their outcome expectations and aspirations. The 2013 Social Attitudes Survey (Sharp et al. 2014) demonstrates that attitudes towards alcohol and its consumption continue to change. Polarised views have included perceiving alcohol as a cheering, nutritious, integral part of life (Knapp 1988) and as creating fear through disease-based addiction (Rush 1819).

Hernen and Kemp (2016) proposed four periods of significant concept variation around alcohol consumption. Historically alcohol was seen as a normal, healthy aspect of life but became the perceived route to moral disorder (Levine 1978). A strengthening stance of a disease model of addiction followed (Jellinek 1960; Jellinek 1959). The current period is described as having a stronger recovery focus (Hernen and Kemp 2016). Generally, theorists advocating one main stance acknowledge relevance of other contributors.

Addiction theory development has been accompanied by escalating concern about alcohol's varying modes of action and wide-ranging impacts (Aaron and Musto 1981; Rush 1819). Rush (1819) referred to an alcohol-induced '*madness*', a '*terrible disease*' affecting hospital inpatients, some who might now be viewed as having ARBD. His disease model included warnings about, in today's terms, genetic factors (Aaron and Musto 1981; Rush 1819). He recommended complete abstinence as a cure, with an optional transitional phase of beer or wine substitution for spirits (Levine 1978). He hoped for '*permanent health of body and peace of mind*' (Rush 1819, p. 36).

Jellinek (1960), also prominent in disease model development, used terminology akin to medical approaches. He referred to '*alcohol addiction'* and '*chronic alcoholism*' with '*alcohol addicts*' experiencing four phases: pre-alcoholic symptomatic phase;

prodromal phase; crucial phase reflecting loss of control; and chronic phase with daytime and weekday intoxication (Jellinek 1960). Loss of control was described as either being unable to abstain for 24 hours or limit the amount ingested (Jellinek 1960), with complete abstinence the route to '*cure'* (Keller 1972, p. 164).

Jellinek (1959) attributed alcohol withdrawal states varying from gastric upset, seizures, delirium and hallucinations to death, to pharmacologically based physical dependence on alcohol, with vitamin and electrolyte deficiencies possibly contributing. He omitted Wernicke-Korsakoff syndrome, a frequent cause of cognitive impairment among people with alcohol use disorder and ARBD, recognised from the 1880s (Victor et al. 1971; Thomson et al. 2008; Kopelman et al. 2009). Jellinek did refer to Wellman's descriptions of presumed late withdrawal symptoms including '*irritability, depression, insomnia, fatigue, restlessness, a sense of aloneness and distractibility*' (Wellman 1954, p.361), with if severe, physical signs mimicking over-indulgence (Wellman 1954). At times '*dangerous depressions and confused states which have a schizoid colouring*' were noted and '*depressions are occasionally strongly paranoidal*', these findings attributed to physical changes accompanying continued excessive drinking (Wellman 1954, p. 361). However, abstinence-related improvement was witnessed and advised upon, with similarities in recovery periods to people now regarded as being affected by ARBD (Cox et al. 2004).

Zucker (1986) proposed a developmental-biopsychosocial systems formulation applying over a lifetime, with etiological typologies aimed at determining how people with specific characteristics would react in different situations. Four typologies emerged: antisocial, developmentally cumulative, developmentally limited, and negative affect alcoholism. Potential contributors to typology were thought to include individuals' psychopathological, genetic, behavioural, alcohol and family history, which encouraged wider thinking about treatment approaches and research methodology (Meyer et al. 1983; Zucker 1986).

Further classifications of alcoholism separated people into Type I and Type II (Cloninger et al. 1981; Cloninger et al. 1996) and later Type A and Type B alcoholics (Babor et al. 1992). Associated factors were sex, genetics, environmental factors, age of onset, duration and severity of drinking, family history, criminal behaviour, natural

remission likelihood and treatment service access levels (Babor et al. 1992; Cloninger et al. 1996; Tam et al. 2014).

1.5.1 Controversy about theories of addiction

Disease model of addiction controversy has continued over many years. Blaxter (1978) postulated using today's phraseology that the driver for the disease model of addiction was it offered a '*labelling process*'. '*Labelling*' enabled health providers to add a social diagnosis into medical diagnostic lists creating opportunities in population statistics, scientific developments and treatment guidance. However, Blaxter (1978) anticipated doctors' possible reluctance to use a disease classification if unaccompanied by defined medical treatment.

Another disease model controversy is that addiction reflects a transition from voluntary, controlled substance use to diminished levels of voluntary control (Keller 1972) over substance craving, seeking and use due to physiological changes in brain function (Leshner 1997). However, a seminal loss of control study did not show increased consumption by those with alcohol dependency primed with an alcoholic drink compared to controls (Marlatt et al. 1973). The results supported a learned theory, the alcohol expectancy theory (Jones et al. 2001), in which people with alcohol dependency learned to expect reinforcing effects from alcohol and so drank in anticipation, drinking more than social drinkers due to development of increased tolerance (Marlatt et al. 1973). This realisation stimulated thought about why people might drink more or relapse in specific settings, including situations potentially creating social anxiety (George et al. 2012).

1.5.2 Understanding relapse

Traditionally relapse following a period of abstinence in treatment programmes was regarded as an endstate or treatment failure (Larimer et al. 1999). Leshner (1997) viewed addiction, including to alcohol, as primarily a chronic, relapsing disorder. He described a psychobiological illness with biological, behavioural and social-context components, in which despite what appeared successful treatment, persistent or recurrent cravings and relapses could occur. He advised that each area needed addressed. Perceptions of a psychological, though multidimensional construct, to alcohol symptomology supported the importance of learning factors in problem

drinking development and continuance. The foundation was established for use of learning theory, alcohol expectancy theory and cognitive constructs in addictions aetiology (George et al. 2012).

Relapse is associated with significant psychological distress and influenced by craving, depression, education, age, marital status, employment, number of detoxifications and dependence duration (Engel et al. 2016). Prescribed medication cannot vanquish the many factors contributing to alcohol consumption at harmful levels (Miller et al. 2011), thus strong arguments exist against medical research separating substance abuse from its social, psychological, cultural, political, legal and environmental contexts (Heim 2014).

Zinberg's (1984) drug, set and setting, which considers interpretation, experience and societal impact of substances used, remains relevant today (Dalgarno and Shewan 2005). These factors influence relapse, a process originating before the individual begins drinking again after treatment. Treatment processes encouraged focus on relapse prevention with behavioural and learned intervention techniques to help people effectively anticipate and address possible relapse situations (Marlatt and George 1984). In the '*Cycle of Change*' (Davidson 2002; Prochaska and DiClemente 1983) which identified stages of change towards and maintaining recovery (Davidson 2002)[1], relapse was described as regression towards an earlier stage, such as pre-contemplation (Prochaska et al. 1992). Notably to the chronic, relapsing, loss-of-control disease model perspective are the 72% of people diagnosed with alcohol dependence who gained control in a few years without professional treatment in the NIAAA's National Epidemiological Study on Alcohol and Related Conditions (2001–2005) (Hasin et al. 2007). Furthermore, abstinence-based programme participants reported participating and choosing temporary abstinence to gain shelter and be with peers. Preferred recovery pathways involved fulfilling basic needs such as housing and harm reduction approaches (Collins et al. 2016).

[1] The stages described in the cycle of change in (Davidson 2002) Box 1 are: *precontemplation* or ignorance about or unwillingness to change problem behaviour; *contemplation* or serious thought about change and evaluation of the pros and cons of the problem behaviour; *preparation* or commitment to a change plan in the near future; *action* or behavioural change actually made; and *maintenance* or integration of behavioural change into the individual's lifestyle.

1.5.3 Reflection on theories of addiction

Understanding theories of addiction is important because they may influence and impact on individuals, those close to them, service providers and policy makers. Comprehensibility in this field may influence manageability, whether on an individual basis or on help-providers resource choices. In TSA context, psychosocial approaches and disease model components are of likely value to help-seekers.

Recommendations to people at risk of (or who already have) ARBD about alcohol consumption and, as correctly suggested by Jellinek (1959), the importance of vitamins to reduce alcohol's potential harm, may seem straightforward. However, addiction theory reveals that simplicity of approach is unlikely. Instead, the importance of each component of the realist evaluation question '*what works, for whom, in what circumstances in Salvation Army community programmes, how and why?*' is reinforced.

1.6 Scotland's attitudes towards alcohol

Scotland is the UK's '*constituent country with the highest rate of alcohol-related deaths in 2015*' despite the greatest decrease in these rates since a peak in the early 2000s (Office for National Statistics 2017, p. 2). Simultaneously, due to Scotland's whisky industry, connections between perceptions of '*Scottishness*' and alcohol are strong (Spracklen 2014).

Alcohol is associated with relaxation and social cohesion (Hanson 2013), violence and aggression (Bègue and Subra 2008; Hanson 2013). Historically thought healthier than contaminated water, it offered nutritional benefits and perceived supernatural properties (Rosso 2012; Vallee 1994). Strength and quantity increased with distillation and the agricultural revolution (Knapp 1988). The industrial revolution required workforce reliability, punctuality and efficiency, thus attitudes to alcohol and drunkenness changed (Hanson 2013). References to alcohol addiction began and the disease model was born (Levine 1978).

1.6.1 Alcohol, faith and the Temperance Movement

Unlike in Islamic tradition, Christians have mainly looked favourably on alcohol production and consumption (Sournia 1990). In biblical times, generally diluted wine was drunk (Hewitt 1980). In Psalm 104 verse 15, wine was seen, '*To gladden the heart of man*' (Hewitt 1980), though in Genesis chapter 9, verse 20, Noah is shamed for drunkenness. Some Christians resolved this dichotomy by stating that Jesus drank grape juice not wine and that wine (not grape juice) caused drunkenness (Hewitt 1980).

Ultimately, even moderate drinking became sinful. The Temperance Movement began (originating in the US and coming to the UK in 1817) and prohibition followed, aspiring to eradicate the majority of personal and societal ills: poverty, crime, violence, immorality, and marital disharmony (Hanson 2013; Hewitt 1980). Feeling at risk from the perceived highly destructive liquid, members throughout society were committed to supporting those described as '*habitual drunkards*' (Levine 1978, p. 45).

Outcomes unanticipated by the Temperance Movement occurred. Health issues related to illegal contaminated alcohol, increased organised crime, and increased heavy drinking when alcohol was available emerged (Hanson 2013). Hall (2010) argued that the 1920 to 1933 United States prohibition probably reduced alcohol related harm but that illegal trading and reductions in societal support lessened effects. He thought benefits could have been achieved by partial prohibition with a focus on taxation and stricter sales regulation.

Scotland's Temperance Movement formally began in 1829. Some people adopted total abstinence and others sobriety (Mullen 1989). Temperance tearooms offered opportunities to socialise in a sober manner (Yates and McIvor 2003, p. 151). Scottish Temperance and licensing legislation enabled community votes on local prohibition, creating '*wet'* or '*dry'* towns till beyond 1976 (Temperance (Scotland) Act 1913, Licensing (Scotland) Act 1959 and Licensing (Scotland) Act 1976, cited in Nicholls 2012, p. 1399). Kilmalcolm ended its 70 year '*dry town*' status when a public house opened only 20 years ago (Campsie 2016).

The first registered meetings of the Twelve Step organisation Alcoholics Anonymous (AA) began in Scotland in Glasgow and Edinburgh in 1949. Philip D., described as '*a loner from Campbeltown*', made the first links with AA (Alcoholics Anonymous Great Britain 2016a; Alcoholics Anonymous Great Britain 2016b). AA offers people opportunities to '*give back*' through peer support and mentoring, bringing benefit to mentors and those supported (Witbrodt and Kaskutas 2005)

The Licensing (Scotland) Act (2005, p.2) has been distinctive worldwide by incorporating '*protecting and improving public health*' to existing objectives of preventing crime and disorder, securing public safety, preventing public nuisance, and protecting children and young people from harm. Nevertheless, challenges exist in positioning decision making in local premises licensing boards towards reducing alcohol availability in Scotland (Fitzgerald et al. 2017) and in the dichotomy of promoting alcohol consumption against unenviably poor alcohol-related health statistics (Spracklen 2014).

1.6.2 Social attitudes in Scotland about alcohol

The 2013 Social Attitudes Survey (Sharp et al. 2014) provided insight into Scots' complex relationship with alcohol and its associated detrimental impacts (Bromley et al. 2005). Most thought drinking alcohol was important to socialising, 40% believing alcohol made nights out easier. Though most thought getting drunk was unacceptable and knew alcohol was harmful, stigma about not drinking was increasing. A considerable minority were unconcerned about binge and hazardous drinking, perhaps suggesting limited understanding of associated risks. Higher risk drinkers were more likely to perceive alcohol as a social lubricant, have stigmatising views of non-drinkers and be less concerned about drunkenness (Sharp et al. 2014). Importantly to this research are inconsistent recognition of alcohol related risks and the stigma held towards non-drinkers and to those who may benefit from help for PAU.

1.6.3 Recent macro Scottish perspectives on avoidance of alcohol related harm

Scottish policy makers and health and social care providers recognise daily living, health, mortality, social and wider societal consequences of Scots' drinking patterns (Bromley et al. 2005). Recent '*Scottish Health Survey*' (McLean et al. 2017) and '*MESAS*

Monitoring Report 2017' (Giles and Robinson 2017) findings about Scots drinking patterns are now presented.

1.6.3.1.1 *Alcohol sales*:

- Compared to 1980, in 2015 alcohol was 60% more affordable in the UK.
- In 2016, the equivalent of 20.2 units of alcohol per adult, per week were sold in Scotland, 17% higher than in England and Wales.

1.6.3.1.2 *Alcohol consumption*:

- Moderate weekly alcohol consumption is defined as no more than 14 units, with those exceeding this amount classified as hazardous or harmful drinkers.
- Men's hazardous or harmful drinking levels declined significantly from 47% in 2003 to 34% in 2013, remaining at similar levels thereafter
- Women's hazardous or harmful drinking levels were 23% in 2003 and 17% during 2014 to 2016.
- In 2015, 26% of adult Scots exceeded weekly drinking guidelines.
- In 2015 to 2016, men drank significantly more than women on their heaviest drinking day.
- In 2015, 4% of 13 year old and 17% of 15 year old Scots reported drinking alcohol in the past week.
- People over 75 drank less at one time but on more days.
- The lowest income group had the highest mean weekly consumption.

1.6.3.1.3 *Alcohol and deprivation*:

- In 2016, 26% of people in the most deprived area self-described as non-drinkers compared to 11% in the least deprived areas.
- People in the most deprived areas drank on fewer days per week than in the least deprived areas.
- Women in the least deprived areas drank more per week than in other areas.
- Alcohol-related death rates were six times higher in the most deprived areas than the least, and alcohol-related hospital stay rates were almost nine times higher.

1.6.3.1.4 Alcohol-related hospital stays and alcohol-related death

- Plateauing from 2012, in 2015, on average 22 Scots' deaths per week were alcohol-related, the rates being 47% higher than in 1981 and 54% higher than in England and Wales.
- Hospital stays remained 4.2 times higher than in the early 1980s.
- Men's death and hospital stay rates were more than twice women's rates.
- Death rates were highest in 55–64 year olds.

1.6.3.1.5 *Alcohol and imprisonment*:

- In 2015, 41% of prisoners reported being under alcohol's influence when arrested.

Of further concern is that 9% of adult Scots self-described as ex-drinkers in 2013 compared to 5% in 2003 (Gray and Leyland 2013). Yet based on AUDIT scores (Babor et al. 2001), 25% of men and 12% of women reported drinking at hazardous or

harmful levels or had possible alcohol dependence (Gray and Leyland 2013). The alcohol dependence prevalence of 3.1% in Scots over age of 16, of whom 23.1% were accessing treatment, was viewed an underestimate due to non-response rates from people living in deprived areas (Beeston et al. 2014; Gorman et al. 2014; Gorman et al. 2017).

1.7 Terminology about alcohol and problems associated with its use

Varying use and understanding of terminology can create communication barriers. From a salutogenic perspective, terminology and perceived meanings can affect comprehensibility, meaningfulness and manageability of PAU at individual, service provider and wider societal levels. Thus, understanding *how, why and in what context terminology about alcohol and problems associated with its use have changed over time* is helpful when talking to people about PAU and supports available or in development.

An important example is in the peer support group name '*Alcoholics Anonymous'*, though use of the word '*alcoholic'* is discouraged elsewhere. This then questions how individuals self-define in their contextual relationship with alcohol and its impacts compared to support providers (see s.3.4.4 paragraph 6 *CPT3: ARBD meaning and understanding*). '*Labelling*' is not always regarded as a positive approach (Simon 2000). In the case of '*alcohol use disorder*' (APA 2013, pp. 490-503), a subcategory of '*substance use disorder*' (APA 2013, p. 483), '*labelling'* can be accompanied by an attitude of blame in medical and social contexts (Gitto et al. 2016). However, it can create access to perhaps otherwise inaccessible support. Miller's words after four decades of addiction research are apt at this point:

> *I use the term addiction generically to refer to the full range of SUDs* (substance use disorders (APA 2013, pp. 481-584) *much as Jellinek* (1960) *used the term alcoholism.* (Miller 2016, p. 92)

Though aware of subcategories within them, Miller (2016, p. 92) and Jellinek (1960, p. 1341) opted for overarching terms of '*addiction'* and '*alcoholism*' respectively. Thus terminology can change, with differing uses and meanings of words held by different

people, perhaps showing enhancing insight, perceived or actual political correctness or stigmatising stances.

1.7.1 Current terminology and its background

Two main classification approaches to alcohol related diseases exist: the World Health Organization (WHO) International Classification of Diseases (WHO 1992, pp. 70-83) and the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorder (2013) or DSM-5 (APA 2013, pp. 490-503). In 1951, the WHO (1951) aimed to define '*alcoholism'* a word originating in the 1900's which focused on alcohol's physical impacts. In 1977, a more holistic terminology incorporated the psychological, physical and social impacts of excessive alcohol use. The '*alcohol dependence syndrome'* was described as existing in degrees, with contextual influences:

> *Its varied manifestations are influenced by modifying personal and environmental factors so as to give many different presentations….. Not all people manifesting alcohol-related disabilities are alcohol dependent…..* (Edwards et al. 1977, p. 17).

The term '*alcoholism'* was subsequently discouraged due to its lack of specificity (WHO Expert Committee 1980, pp. 17-18).

Harmful alcohol intake causes physical or mental problems often associated with adverse social consequences, alcohol dependence, and other psychiatric syndromes such as psychosis or delirium (WHO 1992, pp. 70-83). The transient '*acute intoxication'* phenomenon effects include disturbances in consciousness, cognition, perception, affect or behaviour disappearing as intoxication levels subside (WHO 1992, p. 73). Because of alcohol's effects in the brain, as consumption levels increase, people can become stimulated, agitated and aggressive, and ultimately sedated (WHO 1992, p. 74).

An '*alcohol dependence*' diagnosis (the term under which '*chronic alcoholism*' sits) depends on three from a number of criteria being present during the previous year. The criteria are: a strong desire or compulsion to drink; difficulties in controlling drinking behaviour; withdrawal or drinking to relieve or avoid this; tolerance; prioritisation of alcohol seeking behaviours including time for recovery over other aspects of life; and drinking pattern continuation despite evidence of harmful impacts including on mental, cognitive and physical wellbeing (WHO 1992, pp. 75-76). DSM-5

describes '*alcohol use disorder*' as comprising '*a problematic pattern of alcohol use leading to clinically significant impairment or distress*' with similar criteria requirements in a 12 month period (APA 2013, pp. 490-491).

Withdrawal affects people differently. Symptoms include anxiety, depression and sleep disorders. If more severe, '*delirium tremens'* may occur with impaired consciousness, hallucinations, and marked tremor. These are generally accompanied by delusions, agitation, insomnia and autonomic over-activity, and sometimes, seizures (WHO 1992, pp. 77-79).

O'Malley (2004) described '*problematic alcohol use'* (PAU) as either heavy drinking or drinking accompanied by unpleasant consequences, with increasing rates during late adolescence, highest levels occurring around age 22 and then reducing with age. Some have argued for simpler alcohol-related terminology, such as reference to, '*heavy use over time*' (Rehm et al. 2013, p. 633). However, this would depend on use and understanding of alcohol intake guidelines (Kerr and Stockwell 2012).

1.7.2 Scottish Government choices of alcohol-related terminology

The Scottish Executive (2002b, p. 7) referred to '*alcohol misuse'* as persisting alcohol use over safe levels, and as open to '*value judgements*'. '*Alcohol abuse'* was a stronger term for alcohol misuse, and '*harmful drinking'* as consumption levels causing physical and psychological harm (Scottish Executive 2002b). Elsewhere alcohol misuse has been called the '*common name'* (Cook et al. 1998, p. 318) for '*harmful alcohol use*' (WHO 1992, p. 74). It has been described on a scale from none, to hazardous, to harmful and then dependent, the latter having strongest links with problems associated with use (Raistrick et al. 2006).

More recently in '*Changing Scotland's relationship with alcohol: a framework for action'*, the Scottish Government referred to Scotland's '*problem with alcohol*' and individual's '*alcohol problems*' or '*problematic alcohol use'* (PAU) (Scottish Government 2012, pp. 1-5). Though lacking specific definitions, the document highlighted ramifications on individuals, families and society of PAU and aspirations about how these should be addressed by, '*reducing consumption; creating positive*

attitudes & choices; supporting families & communities; and providing effective support & treatment' (Scottish Government 2012, p. 1).

1.7.3 Reflection on use of alcohol-related terminology

People's word choices may affect conversation meanings and outcomes. The peer support group AA retained the same name, thus use of the term '*alcoholics'*, for many decades (Alcoholics Anonymous Great Britain 2016b). Meanwhile health and government guided alcohol-related terminology have evolved, with their accompanying increasing awareness of alcohol's holistic impacts, including from psychological and social perspectives. Yet according to ICD-10 and DSM-5, knowledge and experience of harms do not prevent people continuing to drink at harmful levels (APA 2013; WHO 1992, pp. 70-83). This raises two points relevant to the current study:

> *If health and governmental guidance is to use terms other than '*alcoholic' *yet this continues to be used in Alcoholics Anonymous, what terminology is used by people accessing and providing The Salvation Army community programme?*
>
> *If knowledge and awareness do not shape outcomes, what does, for whom, in what circumstances, how and why?*

This research did not have a diagnostic element, thus the umbrella term '*problematic alcohol use*' is used for study participants' descriptions of differing harmful and dependent drinking patterns (Chambers et al. 2017) and impacts. The term '*addiction'* will adhere to Miller's (2016) use, though where appropriate is clarified with additional words '*alcohol'* and/or '*drug'*. However, because literature uses varying terminology, wording will also follow that in cited articles (Cloninger et al. 1996).

1.8 Brain health, cognitive function and alcohol-related brain damage: why alcohol use matters

Alcohol, the social lubricant and anxiolytic many enjoy (NICE 2010), creates harm throughout the body (Seth et al. 2011; Bagnardi et al. 2015; Cao et al. 2015; Siva 2015). Alcohol causes approximately 3.3 million deaths worldwide annually (WHO 2014) mainly through injury, liver disease, heart disease, stroke, cancer, and gastrointestinal disease (Roerecke and Rehm 2013).

Alcohol's harmful impact on cognition is inconspicuous in health guidance. Contrary to Governmental reassurance (HM Government 2012) research has evidenced risk of harm at moderate alcohol intake levels (Topiwala et al. 2017; Welch 2017). Compared with abstinence, moderate alcohol intake reportedly increased risks of adverse brain outcomes and steeper cognitive decline (Topiwala et al. 2017). Former views about light drinking having potential protective effects may have been confounded by associations between increased alcohol and higher social class or IQ (Topiwala et al. 2017).

Mechanisms for alcohol consumption outcomes including brain damage are not entirely clear. It is known that alcohol as ethanol, the main psychoactive ingredient in alcoholic drinks, and its metabolite acetaldehyde are neurotoxic (Arendt et al. 1988). Other contributors to ARBD are thiamine and folate deficiency, recurrent head injuries, liver damage, and recurrent intoxication and withdrawal (Topiwala et al. 2017). If individuals stop drinking suddenly, withdrawal symptoms including delirium tremens and seizures may occur (Connor et al. 2016). The mortality rate associated with delirium tremens is up to 5% (Bodani et al. 2009). Rogawski (2005, p. 225) states that '*alcohol dependence results from compensatory* (brain) *changes during prolonged alcohol exposure'.*

People may have cognitive problems prior to, worsened by or as a result of PAU, all potentially impacting on individuals, those close to them and wider society. Cognitive problems may occur in some neurodevelopmental disorders (WHO 2001) and in conditions such as ARBD, Alzheimer's, long-term conditions including Parkinson's or multiple sclerosis, delirium, drugs and head injuries (APA 2013, pp. 591-643).

1.8.1 Alcohol-related brain damage

Terminology about alcohol's impact on brain structure and functioning continues to evolve. The term ARBD covers many alcohol-related cognitive and neurological syndromes. These include the acute condition Wernicke's encephalopathy, the more chronic Korsakoff's syndrome, alcohol-related dementia and less obvious impairments including due to frontal lobe damage (Schmidt et al. 2005; Hillbom et al. 2014; Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014). ARBD, the highest

prevalence of which is found in people under 65 years (MacRae and Cox 2003) with women affected at an earlier age than men (Cutting 1978), is referred to as alcohol-related brain injury by some authors (Brighton et al. 2013).

People may not necessarily realise they have PAU (Bonner et al. 2009), yet one in eight people can develop ARBD, identification of which is not straightforward (McCabe 2005). An important message to convey and act on is that people with ARBD can have a good outlook, contrary to cognitive impairment of other causes. Early identification and treatment within two years of onset can improve cognitive function in 75% of those affected (Smith and Hillman 1999). Thus ARBD identification and treatment, addressing causes of alcohol use disorders and offering supports to people affected are important (McMonagle et al. 2015; Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014; Siva 2015).

However, a grounded viewpoint is needed about help-seekers with ARBD. Of 41 people accessing a specialist ARBD service, about 10% relapsed into alcohol misuse and 10% died within an average 25 month follow-up period (Wilson et al. 2012). For some, long-term care is a recognised outcome, one publication reporting that 10-24% of the types of dementia in people living in nursing homes were alcohol-related (Ridley et al. 2013).

ARBD such as Korsakoff's may co-exist with and be difficult to distinguish from other forms of dementia. Victor, Adams and Collins (1971, p. 52) definition of Korsakoff's psychosis as '*a disproportionate affection of memory in an otherwise clear sensorium*' informed a further definition of '*an abnormal mental state in which memory and learning are affected out of all proportion to other cognitive functions in an otherwise alert and responsive patient*' (Kopelman et al. 2009, p. 149). 20% of people with Korsakoff's were reported to require long-term institutionalised care (Cook et al. 1998), with indications of why this support was needed:

> *Since the adaptation to every new situation required the formation of new memories and their integration with past experiences, it was largely this disorder of function that rendered the patient helpless in society and capable of performing only the most habitual and routine tasks.* (Victor et al. 1971, p. 53)

Malnutrition occurs in people with chronic PAU with poor gut absorption of vitamins, particularly thiamine (World et al. 1985). Thiamine transport genes may contribute to genetic susceptibility to Wernicke's encephalopathy and Korsakoff's psychosis (Guerrini et al. 2009). Without treatment, evidence shows that 20% of those with Wernicke's encephalopathy died (Harper et al. 1986; Kopelman et al. 2009; Galvin et al. 2010) and 85% of survivors developed Korsakoff's psychosis (Day et al. 2004). Wernicke's is fortunately reversible if appropriately treated with thiamine within 48-72 hours of onset (Thomson et al. 2002; Thomson et al. 2009). Post hospital admission for Wernicke's encephalopathy, 23 of 51 people died over a 2.3 to 8.1 year period, where known (18/23) due to infection, cancer, malnutrition and medical co-morbidity, and heart failure (Sanvisens et al. 2017). As only 10% of people present with Wernicke's complete triad of oculomotor abnormalities, ataxia and confusion (Harper et al. 1986), acute thiamine replacement therapy should be readily considered in those with a history of misusing alcohol. Dietary advice and prophylactic thiamine supplements reduce the likelihood of Korsakoff's developing (Latt and Dore 2014).

As more people live longer, more develop dementia-related cognitive impairment (WHO and Alzheimer's Disease International 2012; Prince et al. 2013; Scottish Government 2013). Older people may also have alcohol problems and ARBD (McCabe 2011; Ridley et al. 2013; Wadd et al. 2013). Approximately 10% of those under 65 years avoidably develop dementia because of alcohol (Harvey et al. 2003). Debate exists about whether alcohol-related dementia is due to ethanol toxicity, thiamine deficiency or multiple factors (Ridley et al. 2013).

Individualised, person-centred support is important for people with ARBD (Cox et al. 2004; McMonagle et al. 2015). Cognitive impairment presenting as memory and thinking difficulties affects everyday living with, depending on causation, progressive decline in independent ability to undertake activities and tasks and interact with others. Resources for people with alcohol-related brain injury emphasise risk reduction through abstinence, avoiding sudden withdrawal, nutrition, thiamine, hydration, falls risks and help-seeking (Alcohol Forum 2015a; Alcohol Forum 2015b; McMonagle 2015).

ARBD impacts depend on the area of brain affected (Staples and Mandyam 2016), with frontal cortex damage affecting executive function and decision making (Topiwala et al. 2017). Impaired insight into cognitive difficulties (anosognosia) may hamper individuals' recognition of needs and providers efforts to help (Steinmetz et al. 2014). Support and treatment engagement and outcomes can also be affected by difficulties in (Wilson 2015, p. 200 Table 12.1):

Concentrating
Learning new information (anterograde amnesia)
Reasoning, problem solving and explaining actions
Understanding complex information and concepts, including developing drink-refusal strategies
Moving from one theme of thought to another, this impacting on group work or discussions
Risk assessment, impulsivity and lack of awareness of ramifications of decisions
Organisational skills and ability to comply with treatments
Self-confidence
Relationships
Visioperception

Further confounding factors for help-seeking are stigma and encounter barriers, including knowledge gaps about services and supports, experiences of asking for but not getting help, and lack of trust in systems (Probst et al. 2015). Thus complexities for people with ARBD seeking, accessing and benefiting from supports cannot be underestimated.

1.8.2 Reflection on brain health, cognitive function and alcohol-related brain damage

Alcohol poses a serious risk to many people's brain health with risk exacerbated by incomplete recognition rates of ARBD and missed opportunities for treatment and support. Cognitive impacts complicate help-seeking and service engagement, diminishing recovery opportunities. This is particularly relevant to the current research because people accessing TSA supports are likely to experience additional life complexities, related or unrelated to alcohol. They may be affected by homelessness, time spent in prison, mental ill-health and substance misuse (Bramley et al. 2015; Fitzpatrick et al. 2011). The research offers opportunities to explore how alcohol use and cognitive impairment have contributed to TSA help-seekers' lives and to build

evidence-informed programme theories about their experiences of support and recovery.

1.8.3 Scotland and alcohol-related brain damage

Post mortem findings from almost 40000 people from differing countries reported alcohol-related brain changes in approximately 1.5% of the general population and 30% of heavy drinkers (Cook et al. 1998). The Scottish prevalence of ARBD is founded upon Chiang's work of 2002. This reported on a prevalence of 14.4 per 10000 in Inverclyde (Chiang 2002), an unknown general practice which established a prevalence of 7 per 10000 in Argyle and Clyde (MacRae and Cox 2003), and an unknown source in Greater Glasgow which confirmed 341 confirmed cases of ARBD in 2002 (MacRae and Cox 2003).

Scotland is not alone in its limited knowledge about ARBD prevalence (Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014; Emmerson and Smith 2015). However, the overarching view is that increasing numbers of people are being affected with particular risks in deprived areas (Ramayya and Jauhar 1997; Smith and Flanigan 2000; MacRae and Cox 2003; Cox et al. 2004; Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014; Emmerson and Smith 2015; McMonagle et al. 2015).

The West of Scotland is the Korsakoff's syndrome capital of Western Europe, with 7.34 per 10000 affected in Lanarkshire (Crome I.B. et al. 2015). A study of 266 Glasgow hostel dwellers showed four fifths had cognitive impairment and the majority were drinking hazardously (Gilchrist and Morrison 2005)2. However, diagnosis depends on appropriately skilled and qualified individuals who are not always available (Wilson 2011).

1.8.4 Scottish Executive and Governmental Actions

In 2002, the Scottish Executive (2002b) published a '*Plan for Action on Alcohol Problems*' then '*A Framework for Alcohol Supports and Treatment Services*,' (Scottish

[2] In comparison, a Welsh report stated that a conservative analysis of hospital admissions indicated that 241 Welsh residents (7.8 per 100,000) were diagnosed with ARBD in hospital in 2012, representing a 38.5 per cent increase from 2008 (Emmerson and Smith 2015).

Executive 2002a). Like elsewhere in the UK (Department of Health and National Treatment Agency for Substance Misuse 2006), a tiered intervention system brought together by Area Alcohol-Misuse Co-ordinating Committees was recommended involving statutory, independent and voluntary agencies. Unmet need and service gaps including for people with ARBD and those with co-existing alcohol and mental health problems were identified. Two subsequent reports confirmed these findings, '*A Fuller Life: Report of the Expert Group on Alcohol Related Brain Damage*' (Cox et al. 2004) and '*Mind the gaps: meeting the needs of people with co-occurring substance misuse and mental health problems*' (Scottish Advisory Committee on Drug Misuse and Scottish Advisory Committee on Alcohol Misuse 2003).

Recommendations from '*A Fuller Life*' (Cox et al. 2004) came under six headings: health promotion and prevention incorporating public and provider awareness raising including about risk factors, high risk groups and recovery potential; challenging stigma and discrimination; improving information available through Information and Statistics Division (ISD Scotland) to support planners and providers to assess need, plan and provide services for people with ARBD; plan and deliver better services; provider staff training in the care and management of people with ARBD; service standards for people living with ARBD in care homes, supported accommodation and hostels; and evaluation and research (Cox et al. 2004). The latter included guideline development for monitoring and evaluating services and interventions with, as possible, involvement of people with ARBD. Standards were provided in '*The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services'* (Scottish Government 2014). '*A Fuller Life'* also challenged researchers to improve the evidence base related to epidemiology and population needs assessment, early identification, rehabilitation, community living and care home provision (Cox et al. 2004).

'*Mind the gaps*' promoted understanding of individuals' dual experiences of mental ill-health and substance misuse (Scottish Advisory Committee on Drug Misuse and Scottish Advisory Committee on Alcohol Misuse 2003). USA data incorporated gave lifetime prevalence rates for those with a mental health disorder also having an alcohol disorder of 22%, and 37% for people with an alcohol disorder having a mental

health disorder (Regier et al. 1990). Those in prisons had the highest levels of comorbid addictive and severe mental disorders, particularly antisocial personality, schizophrenia and bipolar disorders (Regier et al. 1990). Such people had often experienced complex social situations including abuse or violence in childhood (Moncrieff et al. 1996), educational difficulties, unemployment, engagement with the criminal justice system (Singleton et al. 1998) and homelessness (Kershaw et al. 2003).

'*Mind the gaps'* highlighted statutory care and support provision gaps including lack of staff knowledge, skill and understanding of the complexities around dual diagnoses. Recommendations were made for improvements in social inclusion, levels of homelessness and housing support, employment opportunities and supports, equitable access to services, greater staff training and integrated working between services. This was set against a backdrop of some staff not wishing to work with people affected by these problems and being precipitous in referring on rather than firstly scoping issues themselves (Scottish Advisory Committee on Drug Misuse and Scottish Advisory Committee on Alcohol Misuse 2003).

Providers were reminded of the importance of politeness, listening, being respectful and thinking about basic needs such as food, warmth and housing. Recommendations were offered about active, early, community based interventions around which persuasion might be required. Although foundations for future work were weaker around service gaps and staff issues, the report gave an authoritative, positive steer for future improvements (Scottish Advisory Committee on Drug Misuse and Scottish Advisory Committee on Alcohol Misuse 2003).

The report highlighted Third Sector Organisations' (TSOs) extensive, successful approaches working with people unilaterally excluded from mainstream services because of complex and challenging needs (Scottish Advisory Committee on Drug Misuse and Scottish Advisory Committee on Alcohol Misuse 2003). '*Mind the gaps*' described levels four and five community and social response supports for people requiring specialist and highly specialist support due to concurrent problems. Based on the previous report statements, this group of people would have been at risk of exclusion from mainstream services thus potentially accessing TSOs' support.

'*Changing Scotland's Relationship with Alcohol: A Framework for Action*' (Scottish Government 2009) continued efforts to reduce Scotland's alcohol-related harm. Reduced alcohol cost and higher alcohol accessibility were acknowledged, and alcoholic liver disease added to Scotland's big killers list: heart disease, stroke and cancer. The need for the associated action framework to link into work addressing contributing factors to alcohol misuse at socio-economic, cultural, educational, community-based, health-related, and individual behaviour and choice level was recognised (Scottish Government 2009).

Alcohol brief interventions (O'Donnell et al. 2014) introduced into primary care, antenatal clinics and Accident and Emergency (Scottish Government 2009) offer a salutogenic prompt to individuals to think about drinking habits and effects, the potential impact of revising alcohol intakes, and supports available. On balance, they have been regarded positively (Kaner et al. 2009; Parkes et al. 2011; O'Donnell et al. 2014). '*The Early Years Framework*' focused on ensuring the futures of children with substance abuse, including alcohol, misusing families were not blighted (Scottish Government 2008; Scottish Government 2009). This is important not least because stressors associated with living in chaotic households with parental substance misuse can affect children's brain development (McEwen 2008; Scottish Government 2008).

The gauntlet was thrown down about alcohol minimum pricing, discounting and age of purchase (Scottish Government 2009). Subsequent legislative success was cautiously welcomed by some because of potential impacts on people dependent on alcohol (Holmes et al. 2018). However, concern remains about poor policy outcomes for this population related to illicit alcohol market growth, increased crime, prioritisation of income expenditure on alcohol over other aspects of life needs, and acute alcohol withdrawal consequences (Holmes et al. 2018).

Returning to '*A Fuller Life*' (Cox et al. 2004) it is surprising that the term ARBD has not been mentioned routinely in governmental and health related reports related to alcohol. However, as noted by Ridley and Draper (2015), although alcohol use disorders, alcohol dependence and depressive episodes secondary to heavy alcohol use are raised in the WHO status of alcohol and health report, ARBD is not (WHO 2014).

1.9 Reflection on Scotland, alcohol and ARBD

Many Scots have a problem with alcohol (which is at its lowest price since the 1980's) resulting in its Korsakoff's crown status. Complexities exist in determining the true extent of cognitive impairment associated with PAU, with little mention of ARBD in government associated publications. Deprivation, mental ill-health, homelessness and time spent in prison all have strong associations with drinking habits. Attitudes to alcohol are simultaneously celebratory and condemnatory, tolerance to drunken behaviour in others being most tolerated by people who drink at highest levels. Shifting societal attitudes to alcohol have involved faith beliefs, the Temperance Movement and peer support and 'giving back' including through Alcoholics Anonymous (Witbrodt and Kaskutas 2005). This research considers current day support offered through The Salvation Army, an organisation engaging with people likely to have slipped through statutory provider nets due to addiction, deprivation, mental ill-health, homelessness, and prison experiences, including those with or at risk of ARBD.

1.10 The Salvation Army

TSA is a Christian faith-based organisation with a strong social care arm founded in 1865 by William Booth (1829-1912). It provides services in response to specific local needs where these have existed for prolonged periods or at times of crisis. This includes opening community programmes, providing emergency relief at times of war or environmental disaster, supporting street dwellers and providing accommodation for people who are homeless, in need of supported accommodation or residential care. TSA's support to people with alcohol problems is core to its aims as reflected in Booth's last public address in 1912:

> *"While women weep, as they do now, I'll fight; while children go hungry, as they do now I'll fight; while men go to prison, in and out, in and out, as they do now, I'll fight; while there is a drunkard left, while there is a poor lost girl upon the streets, while there remains one dark soul without the light of God, I'll fight, I'll fight to the very end!"* (Smith 1949, pp. 123-124)

Although the reported wording's total accuracy has been queried (Merritt 2006, pp. 239-242), Booth's message has affected staff and volunteer perspectives and

aspirations within TSA ever since. Scotland's first Salvation Army community programme opened in 1879, the year TSA magazine '*The War Cry*' was first published, the uniform was introduced and the first Salvation Army community programme band established (Merritt 2006, p. *xx*). Like TSA worldwide, Scottish community programmes have supported generations of people who still fit Booth's descriptions of who he strived to help.

Current terminology for people described by Booth and more recently in TSA publication, '*The Seeds of Exclusion*' (Bonner et al. 2009), would be people affected by multiple exclusion homelessness (Fitzpatrick et al. 2011) or severe and multiple disadvantage (Bramley et al. 2015). These individuals excluded from society's norms have experiences including homelessness, time spent in prison, mental ill-health and substance misuse. TSA has and continues to provide support, accommodation and detoxification services for people with PAU and drug use in the UK.

1.11 Community Reinforcement Approach

Many cognitive behavioural therapies exist of which the Community Reinforcement Approach (CRA) is one.[3] Such therapies can be used alone or with medical approaches (APA 2018; National Collaborating Centre for Mental Health 2011). Programme contexts include health primary care or outpatient clinics, third sector premises (Ashton 1999) and residential settings such as Therapeutic Communities (Vanderplasschen et al. 2013).

The CRA (see s.4.3.1.2) is regarded as one of the most successful alcohol problem treatment programmes (Raistrick et al. 2006). "*Time for Recovery*" recommended that the DASWs worked using CRA principles (Scotland Drug and Alcohol Strategy Task Group 2011) which TSA had experience of in its New Zealand Bridge Project (Meyers et al. 2011; Patterson et al. 2015b). Described as a behavioural intervention based on operant conditioning theory (Hunt and Azrin 1973) and social learning theory (Azrin 1976), the CRA aims to eliminate positive reinforcement for substance misuse and

[3] Other cognitive behavioural therapies include coping and social skills training, social behaviour and network therapy, behavioural self-control, behaviour contracting, cognitive behavioural marital therapy, cue exposure, aversion therapy, relapse prevention therapy, and family interventions including Community Reinforcement and Family Training (CRAFT) (Marshall et al. 2010, p. 197-217).

enhance positive reinforcement for being free of alcohol or drugs of misuse. Such outcomes arise through building individuals' motivation to stop drinking, helping them to stop, supporting them to learn new coping strategies, and involving significant others in their recovery (Meyers et al. 2011).

1.12 Realist evaluation

Realist evaluation is a theory-driven evaluation (Pawson and Tilley 2004), used prior to this research to evaluate alcohol brief interventions in pregnancy (Doi et al. 2015) and a community-based drug and/or alcohol programme for urban Aboriginal people (Davey et al. 2014). When an intervention or programme is launched, developers generally have an idea it will work for specific reasons. This idea is described as a programme theory. In realist evaluation, the aim surpasses determining if a programme works or not (based upon hoped-for outcomes), rather determines who the intervention has or has not worked for, in what way, in what circumstances, how and why. Similarly to drug, set and setting (Zinberg 1984) it promotes retroductive thinking beyond what might first be considered.

Pawson encourages diagnostic approaches to evaluation to identify problems (Pawson 2017). For instance, not all people who drink alcohol develop PAU. Similarly, not all who do achieve and maintain recovery. People live in different contexts, can respond differently when presented with the same resources and so experience different outcomes. In terms of '*drug, set, and setting*' (Zinberg 1984), the drug could be seen a resource within the setting or context, the set of attitude and personality influencing reasoning and responses (mechanism) and the outcomes whatever arose thereafter, including use or not of the drug, and wider ramifications.

Realist evaluation aims to establish mechanisms or reasoning arising in different individuals in response to introduction of an intervention or programme into their context and the outcomes subsequently occurring. Contexts, mechanisms and outcomes can change, thus outcomes may become new contexts, and resources are sometimes viewed as being within contexts or as mechanisms. Contexts, mechanisms

and outcomes (CMOs) are important as they are used to build CMO configurations and so support programme theory construction.

Contexts are complex and layered. Complexity dimensions may include volitions, implementation, context, time, outcomes, rivalry and emergence (Pawson 2013, pp. 34-43). The layers are about individuals themselves, interpersonal relations, institutional settings, and infrastructure at wider socioeconomic and cultural settings (Pawson 2013, pp. 36-37). Similarly contexts, relationships and analysis are also referred to as occurring at micro, meso and macro levels (Cheyne et al. 2013; Lacouture et al. 2015; Wong et al. 2016). Of importance to realist evaluation is what happens inside the black box or space between the programme input and output in which mechanisms are anticipated to be found (Stame 2004; Astbury and Leeuw 2010). In this research, help-seeker mechanisms fired when staff and volunteer micro-actions occurred, as described at a Salvation Army training event. A '*micro-actions and outcomes'* example (see s.4.4.3.1.4) has similarities to Manzano's descriptions of micro events and processes (Manzano 2016). These ideas and use of realist evaluation in defining mechanisms, outcomes, contexts and programme theories are discussed more fully in Chapter 3 where I develop my methodology.

1.13 Conclusion

Alcohol can have a potentially devastating impact on brain health as ARBD. However, ARBD is avoidable and for most has scope for recovery if identified and treated early. Addiction theories reflect contextual complexities experienced by people unable to readily walk away from alcohol's influences. Scots have longstanding conflicting yet simultaneous views about alcohol, culminating in stigma towards people with, or help-seeking for, PAU. Due to its immense health and societal impacts, the Scottish Government continues to endeavour to change Scotland's relationship with alcohol, including through minimum pricing. However, ARBD remains little mentioned despite recommendations in '*A Fuller Life*' (Cox et al. 2004).

For help-seekers with PAU, the presence of cognitive impairment and ARBD may affect salutogenic reasoning and influence engagement with and outcomes from support

and treatment. Third sector organisations such as TSA through its '*Time for Recovery*' strategy and community programmes (Scotland Drug and Alcohol Strategy Task Group 2011), offer help to people who may have slipped through health and social service nets. Of proposed importance to TSA help-providers are salutogenesis and SOC, as without comprehensibility, meaningfulness and manageability in their roles, they may struggle to understand why help-seekers present or behave as they do, including around engagement with the community programmes.

This introductory chapter endeavoured to provide the background to the research and literature reviews in this and subsequent chapters. It introduced key terms and understanding about PAU, cognitive impairment and ARBD with theories and evidence of how and why alcohol creates harm. The rationale for use of a realist inspired evaluation has been proposed, for in the absence of full CRA training, the actual community programme intervention and outcomes are unclear. Importantly to TSA community programmes is that they are not disease model focused, this being reflected by TSA's high regard for the CRA.

Within the research, programme theories are purposefully developed then iteratively reconsidered as data from different sources and participants adds to learning and understanding. Although "*evaluative knowledge is always partial knowledge*" (Pawson 2013d, p. 104), it is hoped the realist evaluation undertaken will enhance understanding of what works, for whom, in what circumstances, how and why for people with PAU, cognitive impairment and ARBD in TSA community programmes offering transferable knowledge from TSA context to that of other people and service providers.

The literature review in its entirety aims to identifying scientific knowledge gaps and form the evidence and knowledge base underpinning the realist inspired evaluation. Chapter 2 now provides the background review about salutogenesis. Chapter 3 provides information about realist philosophy, evaluation and review, and the methods adopted, including in the realist review in Chapter 4. Both Chapter 3 and 4 begin the process of building, confirming, refining and refuting programme theories integral to the remainder of the thesis. This culminates in development of evidence-informed programme theories in Chapter 8 about '*what works, for which people with*

PAU and cognitive impairment accessing Salvation Army community programmes, in what circumstances, how and why?'

Chapter 2 Salutogenesis

2.1 Introduction

Following its introduction in Chapter 1, discussion about the concept of salutogenesis is now expanded upon as understanding about it is critical to the thesis. The complexities associated with PAU, cognitive impairment and ARBD on an individual and wider societal level are vast. PAU is pathogenic in nature. In contrast it is proposed that recovery with associated improvements in holistic wellbeing is salutogenic. A literature review now provides explanatory reasoning about the rationale for the salutogenic focus to the research and within that on sense of coherence (SOC) and generalised resistance resources (GRRs). It explores why these concepts are important in explaining the findings presented about help-seekers with complex needs, including those related to ARBD and cognitive impairment, and community programme help-providers as they endeavour to support them.

The chapter is divided into 5 sections: the theory of salutogenesis, consideration of other potentially relevant theories, and rationale for the approaches used in this thesis, consideration of salutogenesis in the workplace, and a conclusion.

2.2 Theory of salutogenesis

Salutogenesis is described as an orientation, model, theory and an umbrella term. Antonovsky (1996) proposed the salutogenic model based on a theory of human health along a health ease/dis-ease continuum from studies of strengths and weaknesses of promotive, preventive, curative and rehabilitative ideas and practices. Salutogenesis, or the origin of health, (Antonovsky 1979) was a clear shift from a focus on risks, ill health, disease and pathogenesis to exploration of people's capacity to create health through problem solving and use of available resources (Lindström and Eriksson 2005). Crucial to this were what Antonovsky (1987) described as generalised resistance resources (GRRs) within an overarching sense of coherence (SOC). GRRs included money, ego strength, cultural stability and social supports, or indeed

anything contributing to how stressors could be opposed. The resources enabled individuals to address challenges or stressors in their lives, whether through aspects attributable to themselves, those around them or within a situation (Antonovsky 1996). An individual's response to a stressor had scope to cause movement on the health ease/dis-ease continuum.

Antonovsky (1996) described SOC as being comprised of meaningfulness, comprehensibility and manageability, that is, the desire and motivation to cope, belief that the challenge faced is understood and belief in availability of resources needed to cope. Individual variations in SOC were viewed as influencing personal thinking, being and actions, and in turn how people recognised, accessed, and benefitted from resources available to them (Lindström and Eriksson 2005). People vary in making sense of stressors and how they are able to respond to these (Korotkov 1998). The components of this standpoint can be aligned to contexts, mechanisms and outcomes of realist evaluation.

Antonovsky (1990) described stressors as requiring novel and sufficient responses as opposed to perhaps one off-the-shelf of previous life experiences and responses. Stressors include chronic life events and frustrations (Antonovsky 1990), tension creating conditions in which an individual needs to cope (Wong 1993), and for some a sense that life is meaningless and empty (Frankl 2004). Frankl (2004) viewed such feeling as contributing to a mass neurotic syndrome affecting younger people comprised of depression, aggression and addiction. Nevertheless, he noted some people's optimism despite their contexts of a '*tragic triad*' of pain, guilt and death (Frankl 2004, p.139). Older people were viewed as holding stronger positions despite their limited future opportunities. They had lived experience of actualising potentials, fulfilling meanings and realising values, shaping their outlook on the future (Frankl 2004). In realist terms they had experienced different contexts, resources, reasoning, decisions and actions leading to varying outcomes. These experiences then became resources when facing new stressors. Depending on style of tension management and individual use of GRRs, the result of encountering a stressor may be neutral, or indeed salutogenic, rather than pathogenic (Antonovsky 1987). However, memory deficits in

some people with PAU or drug use (Reith 1999) may diminish their life event memory bank including how they dealt with stressors, with erosion of GRRs and SOC.

Salutogenic perspectives have been used in research in varying fields. Sense of coherence has been demonstrated to affect mortality rates with a weaker SOC associated with higher all-cause mortality and not just deaths associated with mental ill-health (Super et al. 2014; Geulayov et al. 2015). The stressor of disability affects many people. Research revealed that in keeping with SOC and salutogenesis, the severity of disability and its functional impact were related to how individuals coped and adjusted (Lustig et al. 2000). Students adapting more readily to disability had lower psychological distress and functional limitations and higher reliance on problem-focused coping strategies, perceptions of greater frequency of personal control over health outcomes, higher quality of life, spiritual well-being and overall life satisfaction, (Livneh et al. 2004). Disengagement coping strategies with use of alcohol, drugs and attributing blame on self or others was associated with increased psychosocial distress (Livneh et al. 2004). This suggests limited tension management, diminished GRRs and a move towards dis-ease on the health ease/dis-ease continuum (Antonovsky 1987).

Further research studied SOC and alcohol use in older people facing age-related stressors (Midanik et al. 1992). High SOC was found to be associated with light drinking and low SOC with at least one alcohol problem in the previous year or one episode of being drunk. Older people's SOC was found to fortify despite diminishing health and social well-being in the latter stages of life (Silverstein and Heap 2015). In contrast, a study of SOC and sociodemographic variables, mental disorders, and mortality, did not show any difference in SOC between those with or without alcohol use disorder (Mattisson et al. 2014). However, study drop-outs were more likely to be unmarried men with a higher prevalence of alcohol use disorders. Comprehensibility was positively and alcohol use disorder negatively associated with longevity (Mattisson et al. 2014). The potential in this scenario is that cognitive impairment and ARBD contributed to diminished comprehensibility, and it is known that ARBD is associated with significant mortality rates (Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014).

This section explored the theory of salutogenesis and highlighted its relevance to people facing stressors in their lives. While some research has shown that high levels of SOC are associated with less PAU, questions remain, particularly about cognitive impairment and ARBD impacts. The current research aims to contribute to evidence in this field.

2.3 Salutogenic theory and other positive health approaches

Salutogenesis as a model of health has a '*dearth of academic writing in which there is a clear focus on a critique*' (Mittelmark et al. 2016, p. 45) though some can be found. Lindström and Eriksson (2010, p. 45) highlighted others' concerns, in particular that the SOC concept lacked psychometric clarity, that the theory was '*confounded with emotionality*', that other explanatory concepts for health existed and that there was insufficient evidence of stability over time. Early salutogenesis research was criticised for focusing on pathogenic as opposed to salutogenic outcomes such as wellbeing (Becker et al. 2010). Attitudes differed towards development of varying rather than uniform measurement tools, varying approaches to result interpretation (looking at one component of SOC as opposed to all), and the potential for changing rather than consistent results over time (Antonovsky 1987, Eriksson and Mittelmark 2016). The current research questions the expectation that SOC should be static over time in people with PAU, cognitive impairment and ARBD whose ability to think, remember and executive function can vary. This may impact on their comprehensibility, meaningfulness and management of stressors and their ability to access GRRs. Furthermore, in realist evaluation mechanisms (Lacouture et al. 2015), contexts and outcomes may comprise emotional elements. For some, PAU may have arisen through palliative use of alcohol when dealing with complex life issues (Kalimo and Mejman 1987) within which emotions and emotional responses and outcomes varied. In the current research of holistic salutogenic wellbeing, it is anticipated that emotional wellbeing or otherwise would be on a spectrum from GRR to generalised resistance deficit with subsequent influence on SOC related contexts, mechanisms and outcomes and vice versa, and individuals' relationships with alcohol.

Sound evidence has emerged for use of SOC new scales across many countries and languages, (Eriksson and Mittelmark 2016; Mittelmark et al, 2016) with scores for comprehensibility, meaningfulness and manageability looked at collectively or individually in specific research contexts, and scores categorised as opposed to remaining as individual numerical values alone (Eriksson and Mittelmark 2016). It was argued that the practical bent to tool development reflected oft needed health survey brevity (Eriksson and Mittelmark 2016).

Criticism has been made that despite salutogenesis offering significant opportunities in qualitative research (Apers et al. 2016), quantitative measurement of SOC has remained uppermost (García-Moya et al. 2013). This could include how people with PAU, cognitive impairment and ARBD react to stressors or in working towards or sustaining recovery. Of further relevance is the criticism that Antonovsky emphasised rational reasoning in his SOC theory rather than offering greater recognition to emotional responses to stressors (Geyer 1997), which might be turning to a resource of alcohol. Nevertheless Antonovsky (1996, p. 11) also advised thinking beyond existing boundaries, "*It is wise to see models, theories, constructs, hypotheses and even ideas as heuristic devices, not holy truths*." In keeping with this, Lindström (2018) recommends seizing the salutogenic opportunity and addressing perceived inadequacies of evidence-base in its use. The current research does not aim to adopt a quantitative, score-based approach to SOC, rather exploration of salutogenic orientation and the experiences of help-seekers with PAU, cognitive impairment and ARBD and TSA community programme help-providers. My rationale is that I wish the research to provide a deep and nuanced understanding from participants' verbal accounts about what is working, in what circumstances, how and why which would not be achievable through collation and interpretation of numerical values.

Salutogenesis is recognised as being more than SOC with developments including about assets, family, community and society, generalised and specific resistance resources, and positive psychology (Sagy 2016). Reflecting this, the salutogenic umbrella contents have expanded (Eriksson and Mittelmark 2016).

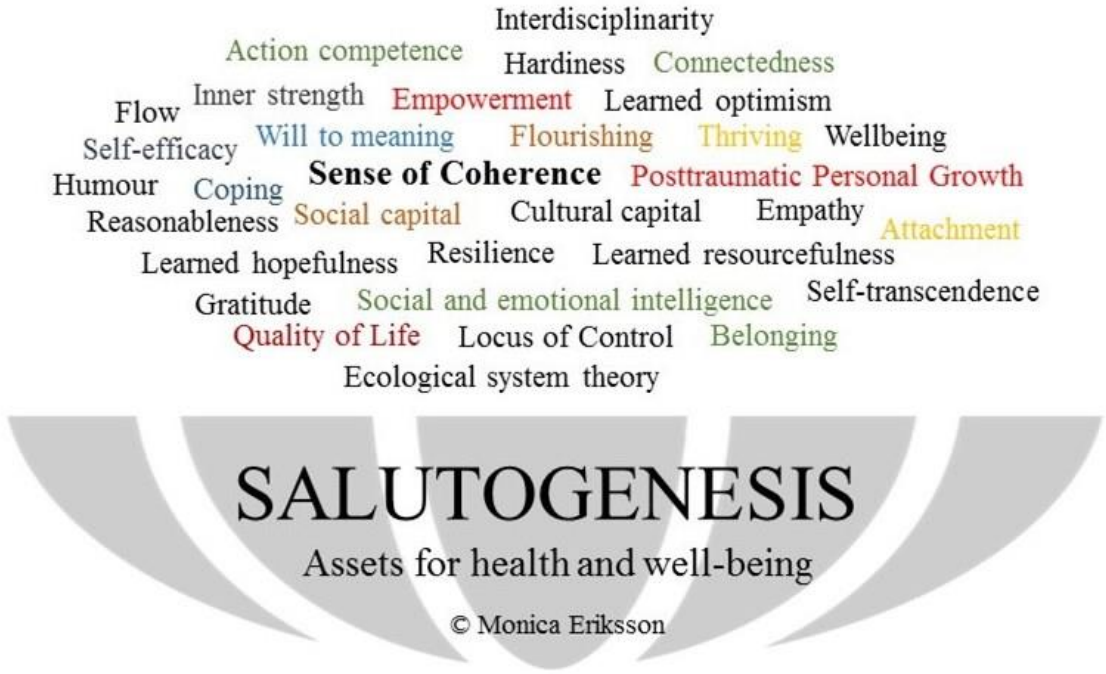

Figure 1The salutogenic umbrella (republished with permission (Eriksson and Mittelmark 2016, p. 103 Figure 12.4 The salutogenic umbrella, salutogenesis as an umbrella concept)

Other umbrella contents have relevance to people with PAU, cognitive impairment and ARBD and could have been the research focus rather than SOC and its associated GRRs. Alternatively fortigenesis, which refers to the origins of psychological strength in general, could have been considered (Strümpfer 1995). However, these areas can be complementary, may be or reflect the presence or otherwise of GRRs affecting an individual's ability to establish comprehensibility, meaningfulness and manageability in life, or be possible outcomes associated with movement on the ease/dis-ease salutogenesis continuum. Resources described as social (Baum and Ziersch 2003) or cultural capital (Bourdieu 1986; Abel 2008) affect alcohol consumption (Demant and Järvinen 2011), and though absent from the salutogenesis umbrella, recovery capital described in relation to substance misuse (Cloud and Granfield 2008) has kinship with social capital (Putnam 1995; Baum and Ziersch). Finding and fulfilling a meaning in life diminished risks of addiction, aggression, depression and potential suicide (Frankl 1972; Frankl 2004). From a pathogenic standpoint, Rutter (1985, p. 600) in writing about resilience described protective factors as '*modifying, ameliorating or altering an individual's response to an environmental hazard that predisposes to a maladaptive outcome*'. This can be likened to GRRs and SOC (Almedom 2005; Lindström 2018) in a

similar way to the complementary nature of wellbeing and salutogenesis (Diener et al. 1999; Becker et al. 2010).

Contrasting to the potentially grim pathogenic outlook for people with PAU, cognitive impairment and ARBD, this research seeks evidence of salutogenic contexts, mechanisms and outcomes in help-seekers accessing TSA community programmes. GRRs described as helping people view life events '*as patterned rather than chaotic, meaningful rather than nonsensical*' (Sullivan 1993, p. 1773) may be present in TSA fieldsites. However, co-exiting generalised resistance deficits may impinge on their potential impact on SOC. This may then impact on help-seekers' choices and the personal outcomes arising from community programme engagement.

2.4 Rationale to thesis approaches to salutogenesis

Individuals' associations with drug and alcohol use range from pleasure, to ambivalence (Kemp 2012) or suffering. Suffering may arise through bereavement (Alves et al. 2014), vulnerability, rejection, abuse, unemployment, disloyalty, isolation, homelessness, memory loss, fear (Oliveira 2015) and alienation (Seeman and Seeman 1992). Alienation can be about powerlessness, estrangement, discontent, hostility, isolation and meaninglessness (Finifter 1972, p. 3). In alcohol misuse disorders, crucial risks of alienation identified were exposure to stressors and high powerlessness, other components of alienation being self-esteem and social integration (Seeman and Seeman 1992). The authors recommended that a "*firmer theoretical grip on the microanalysis of situations could go a long way toward increasing our comprehension of the sometimes contradictory and frequently elusive personal and social conditions that generate the use and abuse of alcohol*" (Seeman and Seeman 1992, p. 204). This challenge is in keeping with the retroductive thinking and methodology of realist evaluation where individual responses or mechanisms may result in differing outcomes despite uniform contexts and resources.

The salutogenic model has been explored as a basis for a salutogenic framework for recovery from substance dependence (Parkin 2016). Parkin describes opportunities for people in defined drug using places and spaces, where perhaps disempowerment and

stressors feel diminished or more remote, to identify with others of similar perspectives away from and excluding wider society (Parkin 2016). A salutogenic framework and environment are believed to support a move towards a comprehensible, manageable and meaningful perspective with increased scope for recovery based upon GRRs and SOC (Parkin 2016). Though Parkin focused on drugs, the same arguments could be anticipated to apply in PAU with greater motivation to address issues, identify underlying challenges and believe in and utilise resources to aid recovery.

In this thesis, salutogenesis is used in a holistic manner encapsulating an individual's contextual health including physical, psychological, spiritual, social, workplace or environmental wellbeing. This challenges Antonovsky's (1979, p. 68) stance, for though he acknowledged other ease/dis-ease continuum rather than physical wellbeing alone, he warned of making the '*concept of health meaningless and impossible to study*'. However, PAU related health radiates far beyond physical health alone. To consider this in a lesser way would diminish the research potential. The research does focus on Antonovsky's SOC and GRRs, because this creates opportunities to establish what works (in terms of TSA resources) to enable help-seekers with PAU and ARBD to experience a shift towards or maintenance of recovery orientated comprehensibility, meaningfulness and management in their lives.

The term '*salutogenic flow*' is adopted to reflect movement along the ease/dis-ease continuum described by Antonovsky (1996). This contrasts with the psychological state referred to as '*flow*', when individuals concurrently experience happiness, motivation and cognitive efficiency (Massimini et al. 1987).

2.5 Salutogenesis in the workplace and in supporting others

Literature about salutogenesis in the workplace is important because the research is situated in the TSA community programmes that are workplaces for people in paid and voluntary roles, who may or may not have personal experience of PAU. Their SOC in their roles may vary as they interact with help-seekers and other help-providers, and they may have differing GRRs to access. TSA help-providers need to be able to

navigate through help-seeker complexities, including by being aware of potential prior alienating and stigmatising experiences and resulting coping mechanisms adopted (Isaacson 1991), to encourage engagement supportive of initiating and sustaining recovery.

Importantly to this study, employees and volunteers, their roles, training, support and workplaces may affect personal, organisational and help-seeker outcomes. Help-providers need to reconcile help-seekers' needs with policy and organisational drivers, which may diminish support for people most in need (Quirouette 2016). Help-providers can experience chaos, stress, burnout, compassion fatigue and search for meaningfulness when engaging with people with complex problems (Rokelle 2012). It has previously been shown across a wide range of occupations including social and health care that salutogenesis and SOC can act as buffers to occupational stressors (van der Westhuizen and Ramasodi 2016; Vogt et al 2016). However, alcohol is a resource to some people when facing occupational stress (Kalimo and Mejman 1987).

Volunteer staff may experience occupational stigma (Rokelle 2012) and have similar generalised resistance deficits and life pressures to help-seekers (Howard et al. 2016), including limited personal finance and welfare provision (The Salvation Army 2013). Help-providers may become dismissive and attribute blame or become blinkered towards help-seekers inner anguish, whilst reflecting on unwelcome aspects of their own lives (Oliveira 2015). They may perceive their roles devalued, such as through food and voucher distribution, because of help-seekers poor budgeting skills. Help-seekers may seem deserving or undeserving, inadequate and disorganised (Howard et al. 2016).

Such webs of complexity may diminish workplace comprehensibility and manageability. These have been hypothesised to be associated with pathogenic outcomes contrasting with meaningfulness in work and salutogenic workplaces (Jenny et al. 2016, pp. 201-202). SOC as a buffer to occupational stressors is reportedly important both for organisational commitment and community cohesion (Levy et al. 2012). It affects how individuals perceive, appraise and cope with what they encounter in their roles (Jenny et al. 2016, pp. 201-202). Job resources have been shown to predict SOC, in turn predicting work engagement with accompanying

reciprocal relationships between job resources and SOC proposed (Vogt et al. 2016). This implies that TSA staff and volunteers with a strong SOC would have more resources available to them in their roles, and that occupational resources would strengthen their SOC. However, of potential relevance to TSA help-providers is that key research excluded people working less than 20 hours per week or not aged 18 to 65 years (Vogt et al. 2016).

Sense of cohesion has also been found to help avoid burnout (Tartas et al. 2011) including through use of GRRs or more specific resistance resources (Wennerberg et al. 2016) and finding meaning amidst increasing pressures, risks, uncertainties and self-questioning (Stuhlmiller 2003). Social investment or investment in and commitment to adult social roles (Roberts et al. 2005) are important in work, volunteering, religion and families (Lodi-Smith and Roberts 2007). Despite role commitment being positively related to agreeableness, conscientiousness, emotional stability and low psychoticism, roles may lead to disillusionment and decreased emotional stability (Lodi-Smith and Roberts 2007). In these circumstances, establishing, sustaining or enhancing help-seeker or provider SOC may feel remote and unachievable with a sense of suffering potentially emerging.

When suffering, people have described loss of self in relation to objects, events and relationships. On losing the acts for which they were known, people felt they were no longer themselves (Cassell 1998). Lack of positive family relationships, childhood experiences and equitable health opportunities (McLeod and Shanahan 1993; Burns 2015) may have denied them adulthoods they might otherwise have had. Instead for some, intergenerational alienation and health inequality persisted with alcohol contributing to higher mortality rates from mid teenage years (Leyland et al. 2007). However, positive outcomes for help-seekers and help-providers exist. TSA help-providers retain opportunities to positively influence the self-perceptions of people with PAU and the recovery-orientated choices they make:

> *The experience of being met as a person is known subjectively and is visible to those who witness it. Caregivers who can respond with compassion and intelligence and who can support the intelligence and good sense of those who seek their care, however distressed and with whatever bewildering array of care-seeking behaviours, will experience the joy and pleasure of meeting and being met by a fellow human being. (McCluskey 2005)*

A Salvation Army centre manager described one man's experience of engagement with staff at a non-faith based centre compared to his understanding of Salvation Army perspectives:

> *People would not give him (a sex offender) the time of day and would say he doesn't 'deserve' support. A faith-based service offers Grace. We are often a 'last resort'. (Question 3, Response 1: manager and chaplain consultation process Scotland Drug and Alcohol Strategy Task Group 2011, p. 56)*

In contrast to not seeing help-seekers' anguish (Oliveira 2015), when help-providers perceived client suffering and infra-humanisation, burnout reduced and job satisfaction and organisational identification increased (Ferris et al. 2016). From a SOC stance, help-providers' acknowledgement of client suffering helped create meaning, strengthened and clarified organisational identification, and enhanced how the workplace operated. Context, mechanisms and outcomes are reflected in areas identified as contributing to comprehensibility (*"Suffering is why we are here"*), meaningfulness (*"Hard work is meaningful work"*) and manageability (*"We are in this together"*) (Ferris et al. 2016, pp. 9-10). Empathy exploration revealed reasoning about benefits of becoming hardened to others' experiences to prevent work from impacting on life outwith. This was captured as "*Being strong and remaining intact*" with accompanying realism about what individuals could do to help others, walking with them as opposed to telling them what to do, being supported themselves by colleagues and in supervision, and for some, seeking help through faith and their "*Higher Power*" (Ferris et al. 2016, pp. 10-11). Clients' suffering was a rallying call, motivating supportive action despite occupational low pay and stigma. Help-providers' own life priorities, self-awareness, humour, strong support, balance, clear values, sense of purpose, time for reflection and positive outlook to anticipated difficult situations (Rokelle 2012) also contributed to SOC and thus workplace functioning.

The jigsaw of personal and workplace resources contributing to help-providers' SOC have scope to significantly influence help-seeker engagement and thus programme outcomes. Appropriately resourced help-providers with strong workplace SOC could support help-seekers to achieve personal solutions rather than simply providing stop-gaps. Thus, salutogenic approaches could offer benefit to help-providers and help-seekers (Oliveira 2015) including in TSA settings. In the current research, realist

thinking will be used to explore the salutogenic nature of TSA fieldsites and the ramifications of this on both help-providers and help-seekers.

2.6 Conclusion

This research required a holistic approach to understand how and why help-seekers reach the outcomes they do in TSA fieldsites relating to PAU, cognitive impairment and ARBD. Simultaneously, for help-providers to offer optimal support to help-seekers there was an anticipation that they would need appropriate resources to fulfil their role requirements. The salutogenic umbrella demonstrates many areas that could have been studied. However, when considered for this realist inspired evaluation, SOC and its accompanying GRRs appeared to offer optimal opportunities in both aspects of the research. The research explores ideas and theories, looking for evidence to confirm, refine or refute them using context, mechanisms, outcome configurations. Reasoning is crucial to mechanisms, thus the importance of considering comprehensibility, meaningfulness and manageability of SOC. GRRs of salutogenesis offer encouragement to look beyond physical resources to psychosocial ones, including at a micro level. Finally, strength of help-providers' SOC and GRRs was of additional importance not just to them, but also to TSA and help-seekers to whom they were possible resources. Overall for the purposes of the research, there was a strong fit between use of salutogenic and realist evaluation thinking to the benefit of understanding initiation and sustainment of recovery in people with PAU, cognitive impairment and ARBD in TSA community programme settings. At the time of the research this was a novel approach.

Chapter 3 Methodology and methods

3.1 Introduction

The chapter has two parts: it begins by presenting the methodology and theoretical framework, the research aims objectives and questions, and a background to realist synthesis and evaluation. Discussion follows about the realist inspired evaluation methods used to determine *what works, for which people with PAU and cognitive impairment who access Salvation Army community programmes or those supporting them there, in what circumstances, how and why*. This chapter creates a foundation for the realist review in Chapter 4.

The rationale for the research methods adopted and how these affect theory building and refinement are explained. Realist literature reviews and evaluations challenge researchers to consider the *mechanisms* or reasoning that arise in people when programme resources enter their *contexts* and the *outcomes* which then arise. These contexts, mechanisms and outcomes (CMOs) are used to build, confirm, refine and refute programme theories. This iterative process involves revisiting of programme theories as CMOs are clarified by emerging data from different sources, including from literature and participants. Chapter 3 constructs realist evaluation strategic or initial candidate programme theories (CPTs) drawing on sources revealing Salvation Army aspirations including the strategy document, "*Time for Recovery*" (Scotland Drug and Alcohol Strategy Task Group 2011). It also uses information from literature about the CRA, as though not fully implemented, CRA aims and outcomes elsewhere influenced TSA intervention ideas and expectations. The process ultimately leads to development of evidence-informed programme theories found in Chapter 8.

A key sentence in '*Time for Recovery'* helped shape the conceptual and theoretical frameworks, methodology and methods adopted in the study:

> *'The SA's advocacy role in being a 'voice for the voiceless' will be strengthened and will provide a platform for the dissemination of The SA's key messages'* (Scotland Drug and Alcohol Strategy Task Group 2011).

Listening to people seeking or providing help for PAU and cognitive impairment in focus groups and interviews aimed using realist approaches to let their voices describe *what was working, for whom, in what circumstances, how and why.* Realist approaches provided a means of determining '*key messages*' from participants in the form of *evidence-informed programme theories* and recommendations for dissemination to TSA.

3.2 Part 1: Philosophy, methodology and theoretical framework

For purposes of clarity, '*methodology'* refers to the rationale and philosophy underpinning the design of a study and how it is carried out (Appleton 2009, pp. 16-29, Blaxter et al. 2010, pp. 59-63). The methodological orientation in this research is realism described by Pawson as a '*broad logic of inquiry that is grounded in the philosophy of science and social science*', a description influenced by the work of Bhaskar (1975) and others (Pawson 2006b, p. 17). Realist evaluation is increasingly recognised as suitable for use in complex settings such as community programmes. Brought to the fore by Pawson and Tilley (1994 and 1997), though it can be used in mixed methods research, the focus in this project is qualitative. Limitations of '*number crunching*' quantitative research have been long recognised with appreciation increasingly awarded to qualitative research either in isolation or to complement and add further depth and meaning to quantitative research (Greenhalgh and Taylor 1997). While quantitative data would have been interesting, the fieldsites lacked standardised, fully reliable methods of quantitative data collection.

Qualitative research has a holistic perspective acknowledging the complexities of human behaviour, situations and settings and is particularly advantageous when variables are unclear (Black 1994). In realist approaches, retroductive thinking about complexity is encouraged which requires thinking beyond what may be seen or found initially. The rich qualitative data this study sought and obtained allowed identification of CMOs for theory building.

Pawson and Tilley provide advice to people considering realist evaluation (Pawson and Tilley 1997). Mechanisms are described as '*the choices and capacities which lead to regular patterns of social behaviour*'; contexts as '*the spatial and institutional locations of social conditions together, crucially, with the norms, values, and interrelationships found in them*'; and outcomes as '*the key evidence for the realist evaluator in any recommendations to mount, monitor, modify or mothball a program*' (Pawson and Tilley 1997, pp. 216-217). However, the latter is also used to determine if hypothesised theories about mechanisms and contexts can be confirmed, refined or refuted. Thus many factors may contribute to individuals' contexts, but it is those aspects relevant to the mechanisms arising in response to interventions in those contexts that are important and may contribute to programmes being more beneficial for some people than others. With regard to TSA community programme, the current evaluation aims to follow Pawson and Tilley's recommendation to:

> *Anticipate the diversity of program mechanisms involved and ….. discover whether they have disabled or circumvented the mechanisms responsible for the original problem.* (Pawson and Tilley 1997, p. 216)

Intended and unintended intervention outcomes arise because of mechanisms or reasoning and responses of individuals to programme resources and contexts (Tilley 2004). Rather than identifying outcomes alone, theory-driven realist evaluation strives to gain understanding of the causes of outcome patterns.

In response to an email, experts in realist evaluation and synthesis described the '*fuzziness*' of the distinction between concepts and theories, including through an analogy about a tree (Jagosh and Westhorp 2017). The concept about TSA is that it is a resource to different people facing difficulties in their lives from where positive new experiences may emerge. However, there is a gap in knowledge detail about how this occurs: causality is missing. Furthermore, in a conceptual Salvation Army fruit tree, not all the blossom is pollinated, not all fruit develops and not all offspring fly from the nests built in its perceived safety. Theory building or theorising offers ideas about why this is the case, and why people accessing TSA resources have different outcomes. A benefit of realist theorising is that it is surpasses conceptualisation: it aims to establish causality. The use of a realist framework supports this aim by promoting research

methods enabling the questions of '*what works, for whom, in what circumstances, how and why*?' to be asked, and it is hoped, answered even if partially.

Concepts and thus conceptual frameworks can be drawn from TSA Founder, William Booth's, "*I'll fight*" speech (Smith 1949, pp. 123-124). This is based on concepts of exclusion, inequality, and unmet social and health needs, yet also on TSA determination to offer people routes away from such an existence to a new or renewed form of living. This concept is similarly found in Community Reinforcement Approach (Meyers et al. 2011; Scotland Drug and Alcohol Strategy Task Group 2011) descriptions, in which for those with PAU, achievement of a life without alcohol is conceived as being more fulfilling than one in which it continues.

Salutogenesis can be viewed as a concept, but in keeping with terminology '*fuzziness*', is also referred to as a theory. The salutogenic model of health theory, albeit with many expanding components, has two fundamental aspects: generalised resistance resources (GRRs) and sense of coherence (SOC) (Antonovsky 1996). Evidence for salutogenic approaches are sought in data gathered in this research. A realist inspired evaluation framework allows CMOs related to the origin and creation of health through access to TSA community programme supports to be scoped, with programme theories proposed, refined and refuted as data is scrutinised. The areas presented in this introduction are now more fully explored.

3.2.1 Philosophy

People undertake a PhD for different reasons, inquisitiveness about a topic, a desire to learn and enhance skills, or the challenge of a perceived research gap. Learning is about acquiring new knowledge and an understanding of the composition of that knowledge, the means and sources of its acquisition, its limitations including that associated with aspects of the learner, and its implications. Epistemology is a philosophical term relating to how an individual or wider group knows what they know, what constitutes knowledge and how knowledge can be advanced (Davies and Hughes 2014). The challenges of epistemology reflected in the international journal of epistemology, Logos and Episteme (Dima 2010), depending on perspectives might appear a Pandora's box or Aladdin's cave. Different doctrines have developed in epistemology. Positivism is primarily attributed to Auguste Comte (1798-1857) who

identified the importance of the associations and interactions of theory, practice and human understanding. In his view, although every theory must be founded on observed facts, without guidance of theories, facts could not be observed (Comte 1988, pp.1-2).

Since Comte's original work, positivism has further developed, with five key principles described (Bryman 2012). Phenomenalism states that knowledge and phenomena must be confirmed by the senses to be truly regarded as knowledge. Deductivism follows used theory to develop hypothesis which can then be tested, enabling explanations of laws to be evaluated. Inductivism reflects that when facts are gathered which provide the foundation of laws, knowledge is achieved. Objectivity is based on requirement that science is conducted in a means detached from values, assuming that this can be done. The final principle is clarity in the distinction between scientific and normative statements. Overall, this adheres to the view that in positivism, knowledge should be founded on what can be observed and measured, and diminishes the importance level of understanding of a subjective nature (Davies and Hughes 2014). Positivism has also been described as a means of offering explanations enabling control and predictability (Blaxter et al. 2010). It is therefore unsurprising it was subject to criticism and post-positivism was borne (Crossan 2003).

Post-positivists espoused the view that social reality can only be known imperfectly and probabilistically, and while retaining the ideal of objectivity supported increased use of qualitative techniques to ensure findings were valid (Blaxter et al. 2010). They interpreted positivists' views as epistemologically and ontologically unsound, whilst positivists regarded post-positivists as supporting subjectivism, reckless relativism and diminished standards, construing against undertaking proper research striving to improve the human condition (Patomäki and Wight 2000). Ontology refers to assumptions in social research and methods that the nature of social phenomena influences the process of research (Bryman 2012). The anti-positivism stance interpretivism based upon this premise is that there is no single means of understanding the world, as individuals have different experiences and viewpoints (Davies and Hughes 2014). This leads to researchers' desires to comprehend and clarify these differences and perspectives.

A further philosophical position sharing features of positivism is realism. Social science has two strands of realism: critical (Bhaskar 1975) and empirical (Pawson 1989) or scientific realism (Pawson 2006b, p. 19). Critical realism is greatly influenced by Bhaskar's (1975)[4]. Features of positivism common with realism are beliefs that social and natural science are able and ought to apply the same kind of approach to the collection of data and its explanation, and that there is an external reality to which scientists direct their attention (Bryman 2012). Critical realists extol the aim of recognising the reality of the natural order and all that is involved in the social world. Bhaskar's comments bring insight into his perceptions of the differences between the forms of realism with comparisons then made with Pawson's more empirical stance:

> *Critical realism: 'we will only be able to understand – and so change – the social world if we identify the structures at work that generate those events and discourses…. These structures are not spontaneously apparent in the observable pattern of events: they can only be identified through the practical and theoretical work of the social sciences'.* (Bhaskar 1989, p.2)

In Pawson's view, there will always be an excess of explanatory options, not all of which will be correct (Pawson 2006b, p. 19). This does not rest comfortably with Bhaskar's view of empirical realism's weakness that it:

> *….. fails to recognise that there are enduring structures and generative mechanisms underlying and producing observable phenomena and events.* (Bhaskar 1989, p. 2)

Pawson argued that though he benefitted from learning from Bhaskar about '*generative mechanism(s)'* thereafter Bhaskar's work was of diminishing value to him (Pawson 2011). Interventions in social settings are different to scientific laboratories as influences outwith interventions may affect outcomes, and so associated theories. Realism in the form of realist synthesis and evaluation calls on researchers to adjudicate or decide which of a range of programme theories is likely to fit best (Pawson 2013). However, evaluative knowledge is only partial knowledge: there may other theories and explanations yet to be considered and tested (Pawson 2013). Pawson likens scientific inquiry to bridge construction involving testing of rival hypotheses, with investigation starting mid construction (Pawson 2013, pp. 105-106).

[4] Bhaskar's 1975 book '*A Realist Theory of Science*' (Bhaskar 1975) was republished in 2008 with an introduction by Mervyn Hartwig (founding editor of the Journal of Critical Realism) as a result of ongoing appreciation and discussion about his work (Bhaskar 2008).

The concept of bridge building or bridging gaps when supporting help-seekers is important to TSA (Scotland Drug and Alcohol Strategy Task Group 2011; Patterson et al. 2015b; Salvation Army Housing Association 2017). In TSA planning for '*Time for Recovery'* bridge building, researchers drew on international Salvation Army experiences of interventions for people with PAU (Scotland Drug and Alcohol Strategy Task Group 2011). Encouragement and warnings in such a context are described as '*negotiating the difficult terrain linking, or separating, research from policy advice and the political process*', with recognition advised to contributions and constraints affecting everyone involved in social policy (Davies and Rowe 2014, p.35). In TSA Scotland Drug and Alcohol Strategy this includes practitioners, researchers and hierarchical layers, all stakeholders with a common goal of improving help-seekers' lives. Such an approach is more likely to result in effective attainment of intervention aims.

The '*investigation*' in this study, using Pawson's analogy, was mid construction: a strategy had been launched and service development was underway. The contexts had differing, pre-existing interventions each likely to have arisen when people developed and implemented what they believed a good '*idea'* or programme theory. This evaluation may help determine which aspects of '*Time for Recovery*' (Scotland Drug and Alcohol Strategy Task Group 2011) lead to positive outcomes for people with PAU and cognitive impairment.

3.2.2 Methodology and theoretical framework

The value of realism to this research is now described, beginning with its influence on consideration and development of research aims and questions.

3.2.2.1 Research aims, objectives and questions

In any project the methodology and methods or the approaches and techniques used to collect and analyse data (Maxwell 2012), need to be relevant to the research questions posed. Here, the research questions needed to address project funders' aims to explore and address gaps in services by examining the support offered to people with PAU and cognitive impairment in TSA fieldsites. TSA's main aims described (Appendix 1 PhD Advertisement 2013) were to:

- Ascertain levels and severity of cognitive impairment among services users accessing Salvation Army projects in Scotland
- Examine current use and experiences of services by people with cognitive impairment and alcohol problems and assess how well current services meet their specific needs
- Develop pathways to improve access and use of services.

TSA wanted the research to '*both address key gaps in scientific knowledge and provide useful outcomes to help the Salvation Army further develop their services*' (Appendix 1 PhD Advertisement 2013). As researcher, I then developed a specific research aim for the study. My aim was not to do a population study using cognitive assessment tools to formally assess levels and severity of cognitive impairment among service users. I am not qualified to undertake the battery of assessments that this would normally entail. Nor was the timing right to develop pathways for access to and use of services as the existing intervention was only partially implemented and evidence to support further change was lacking. My research aim was thus to obtain current evidence about support experiences from help-seekers with PAU and cognitive impairment and TSA help-providers to enable me to provide TSA with recommendations to strengthen future community programme supports. I aimed to complete a realist evaluation which took into account help-seeker and help-provider needs and views. The objectives established to achieve this were:

- using a salutogenic framework, identify how people can be supported towards wellbeing
- using realist approaches, obtain evidence about what works, for which people with PAU, cognitive impairment and ARBD accessing TSA community programme supports and those supporting them, in what circumstances, how and why
- when seeking and considering evidence, examine the DASWs' impact and also that of the wider fieldsite community in which people with PAU, cognitive impairment and ARBD are supported

The research questions developed incorporated reference to salutogenic outcomes, particularly SOC and GRRs. The rationale was that salutogenesis reflects creation of health, here from a holistic stance in people with PAU and cognitive impairment,

through problem solving and using available resources (Lindström and Eriksson 2005). The questions took into account TSA's research aims (Appendix 1 PhD Advertisement 2013). Thought was given to how levels and severity of cognitive impairment were recognised by help-seekers with PAU, cognitive impairment and ARBD and fieldsite help-providers. Help provided to clients in fieldsites and if this reflected the needs and aspirations of individuals from their perspectives was considered. Consideration was also given to what impacted on help-seeking, with subsequent development of recommendations about gaps and sharing of successful approaches in TSA with other providers.

Research questions:

1. Explanations, knowledge and experiences of PAU, cognitive impairment and ARBD:
   - what is known and understood about PAU, cognitive impairment and ARBD?
   - what contexts and mechanisms have led to this?

2. Living with PAU, cognitive impairment and ARBD:
   - what challenges are experienced within personal contexts?
   - what mechanisms fire and salutogenic outcomes occur when personal interventions are adopted to address these challenges?

3. Salutogenic experiences and impacts of The Salvation Army community programmes:
   - what salutogenic experiences and outcomes occur as a result of Salvation Army community programmes?
   - what contexts and mechanisms lead to these outcomes?

4. Current and future community programme support provision for people with PAU, cognitive impairment and ARBD:
   - what gaps currently exist within Salvation Army community programmes?
   - what programme theories can form recommendations for future community programme development?

Realist methodology and theoretical framework supported exploration of these questions and incorporated a diagnostic element (Pawson 2017). The choice of realist approaches aimed to optimise accuracy, recognition and meaningful interpretation of findings. This required appropriately gathered, fitting data from appropriate people or sources in or from suitable settings, with any researcher bias or personal influences addressed and taken into account. The rationale for a qualitative approach was the potential depth and richness of information about the services, providers and people served that qualitative data could offer.

3.2.2.2 Why realist review and evaluation inspired and influenced this research

Evidence-based practice evolved as a means to ensure diligent, unambiguous, and judicious use of best evidence in decision making around approaches to individualised support and care (Sackett et al. 1996). In complex health settings, absolute importance is given to care provision which recognises benefits or otherwise to each person with tailoring of approaches accordingly. The health evidence hierarchy awards strength to randomised controlled trials, though acknowledgment exists of accompanying limitations (Sackett et al. 1996). With regard to social research, Pawson and Tilley (1994) raised criticism against reliance of experimental approaches. They called on incorporation of a scientific realist strategy into evaluation to enable expression of causality and change occurring in social programmes.

Pawson (2013, pp. 3-12) sets the scene of realist evaluation by describing the '*Seven pillars of realist wisdom*': seven people who influenced development of realism and realist theory. Bhaskar (1975 and 1989) (see s.3.2) is recognised for work in the philosophy of science and the concept of generative mechanisms, and in contributions to social sciences and humanities. He proposed two types of scientific realism: transcendental realism for natural science such as chemistry or physics and critical realism for social science. Archer (1995) advised that interventions will always change due to collective choices and result in new social order developing. This brings complexity to evaluation and issues around change potentially perceived as threats rather than welcomed, especially when occurring unexpectedly.

The third pillar, Elster (2007), described social science's strength in explaining why we think we know things which in fact are not the case. That '*knowledge'* can underpin further misrepresentations of reality. However, establishing where and what our knowledge misbeliefs are can open new ways of approaching interventions (Elster 2007, p. 16).

Pawson's reflection (2013) on Merton's (1967) work is that programme theories tend to be unknowingly repeated recurrently by participants in their development and implementation. There is also acknowledgement that programmes superficially appearing disparate have, on the contrary, much in common from which shared

learning could occur. Popper (1992) wrote about science developing as explanation accumulates, instead of upon a foundation of observational facts. However, data contributing to explanations and perceived evidence-based policies (and outcome measures), lags behind problems arising. Thus it is important to recognise time-limitations of interventions, programmes and policies, and expect change will occur (Pawson 2013).

The penultimate pillar, Campbell (1988, p. 302 and p. 366), encouraged objectivity and the qualitative method. Emphasis is put on considered hypotheses, followed by the importance of sourcing wide-ranging data whether measurement, outcome and process, or quantitative or qualitative in nature. Thereafter inference can be made, with testing of these potentially recurrently with scope for inferences being strengthened or diminished (Pawson 2013).

The final pillar, Rossi, continues to cast shadows on providers' aspirations, in particular '*The Iron Law of Evaluation'* (Rossi 1987). Parry and colleagues took up the challenge of this '*law*' confirming many evaluation approaches often lead to a finding of no effect (Parry et al. 2013). They suggested evaluation be based on '*How and in what contexts does a new model work or can be amended to work?*' and supported by adoption of a formative, theory-driven, rapid-cycle evaluation approach with theory revision as initiatives develop.

Realist evaluation has a different emphasis of '*what is it about a programme that works for whom, in what circumstances, in what respects, over which duration and why'* (Pawson 2013, p. 15). Realist evaluation aims to determine the mechanisms and contexts explaining outcome patterns of programmes (Pawson 2013). Programmes are '*embedded*' because of locations in pre-existing social settings and '*active*' as intended effects work through the thinking or reasoning and choice of participants in response to intervention resources available to them. The outcomes created may vary from individual to individual, depending on their contexts. Finally, programmes are '*theories*': they begin as ideas amongst policymakers, are actioned by practitioners or providers, and can ultimately affect individuals' holistic wellbeing (Pawson and Tilley 2004, pp. 3-5).

The rationale for adopting a realist approach here is based on the thinking above. This research needed a methodology and framework suited to the complexity of the '*drug, set and setting*' (Zinberg 1984, p. 5) and the context, resources, reasoning and outcomes experienced by TSA help-seekers and help-providers. Furthermore, realist approaches offered a means of building learning and understanding from different perspectives using ideas, theories and evidence. Theory building and the evidence sources used are now described.

3.2.2.3 Theory development

Programme theories are important in realist literature reviews or synthesis, in realist evaluation and in choices of research methods. This research begins with TSA Strategy Group's idea or CPT that the introduction of DASWs working using the principles of the Community Reinforcement Approach (CRA) would result in the outcome that people with PAU would find life without alcohol more fulfilling than one with continued use (Gilson and Goldberg 2015). However, researchers elsewhere using the CRA acknowledged that a '*small subset*' continued to drink heavily (Smith JE et al. 1998) pp 548. These perspectives plus information about the CRA from Meyers et al. (2013) enabled creation of an initial candidate programme theory *CPT1: a life more fulfilled* (s.3.2.2.3) for this research:

CPT1: a life more fulfilled

> If the community programme offers Community Reinforcement Approach principled DASW led support for people with PAU, then some people living in local communities will develop and maintain a clean and sober lifestyle because this becomes more rewarding than one filled with substance misuse.

The word '*some'* reflects the complexities of hypothesising and developing programme theories for social interventions. The complex contexts in which programmes are set, the mechanisms occurring and the varying outcomes arising (Weiss 1997) can influence who becomes more fulfilled and in what way. This initial theory stimulates thought and questions akin to *what works, for whom, in what circumstances, how and why*? Of benefit is use of the scaffold of empirical science: clear conceptualisation and hypothesis making, use of critical comparisons, finding

empirical patterns, and monitoring the scope and extent of these patterns (Pawson 2006b, p. 19). Pawson also advised of benefits in the use of diagnostic approaches:

> *Most forms of synthesis, including RS, start with the interventions designed to deal with the problem. It makes more sense….. to begin with a thorough study of the problem. This is all within the technical scope of RS - basically one is asking for whom, in what circumstances, in what respects and why does the PROBLEM occur. This puts you in a better place to test the programme theories and the effectiveness of the responses.* (Pawson 2017)

This viewpoint is important here as desired research outcomes for TSA funders are recommendations about ways to improve the community intervention. Use of realist approaches requires inquisitiveness, and hypotheses not just for optimistic outcomes but also for those possibly regarded as unsuccessful. In an online seminar based on the work of Pawson and Tilley (1997), Jagosh (2017) succinctly provides key steps in realist methodology:

- identify the programme to be evaluated and establish the evaluation or review questions
- establish or construct CPTs if found helpful using an "if… then…" approach. Possible middle range theories may also be constructed
- develop protocols for data collection
- collect data then analyse it using **context-mechanism-outcome configurations**
- produce **evidence informed programme** or middle range **theories** to answer the questions of *what works, for whom, in what circumstances, how and why*

Here, the term *evidence-informed programme theory* (EIPT) is used. Thus the theory flow in the research begins with ideas (CPTs). Data is then gathered and analysed to test, refine and refute the CPTs, enabling subsequent creation of EIPTs.

Returning to Jagosh's (2017) recommendations, the intervention for evaluation was provided by DASWs at three community programmes as part of TSA Scotland Drug and Alcohol Strategy. Draft research questions were discussed at TSA Research Network Group, Trust Headquarters, London (May 2014). This revealed data gathering disparities between clients at Salvation Army services providing accommodation such as in '*The Seeds of Exclusion 2009*' (Bonner et al. 2009) and non-residential community programmes. In this research routine data about numbers of people attending and diagnostic categories were not accurately available.

Ongoing iterative reading and retroductive thinking about what I heard at Salvation Army events (The Salvation Army UK and the Republic of Ireland 2013; The Salvation Army UK and the Republic of Ireland 2014a; The Salvation Army UK and the Republic of Ireland 2014b) and the interactions I had with staff both there and at fieldsite introductory visits (April 2014) led me to believe that there was a '*bigger picture*' to be considered. This related to encouragement and support to people accessing services towards holistic wellbeing which was in keeping with the theory of salutogenesis, and in particular SOC and GRRs. Being free of alcohol alone did not mean that people would find purpose and meaning in their lives or be able to manage the complexities that they encountered. A further CPT was therefore hypothesised:

CPT2: holistic, salutogenic approaches

> If people with PAU and cognitive impairment access the community programme intervention then a more fulfilling life arises because of the acquisition of GRRs and enhanced SOC comprised of comprehensibility, meaningfulness and manageability which enables them to live without alcohol consumption.

However, evidential data needs gathered and examined to determine the accuracy of this or if indeed alternative theories might apply.

3.3 Reflection on philosophy, methodology and theoretical framework

This section provided overarching descriptions about how realist approaches to literature, evidence and evaluation have come to the fore and why they offer benefit to this research. From a philosophical standpoint there has been recognition that people do not always know what they do not know. Also sometimes what people believe to be true may not in fact be true. This combination means that without evaluating what is being carried out or provided, in this instance TSA intervention, it is difficult to tell what is or is not working. To use realist thinking, barriers exist to establishing what is working for whom in what circumstances, how and why. The risk then is interventions continue in manners believed by providers to offer benefits when this is not the case from help-seekers' perspectives. The programme outcomes may be enduring unmet needs and wasted resources.

Realist approaches in this research address these issues by looking at ideas or theories supporting the programme at its outset, creating CPTs. Evidence is then sought about these theories in real life fieldsite contexts and presented in context-mechanism-outcome configurations. The evidence may confirm, refine or refute CPTs or result in new theories developing. The aimed for research outcome is that data gathered will enable creation of EIPTs. These will then be used to support recommendations to TSA about ongoing programme provision for people with PAU and cognitive impairment.

Alternative approaches considered to realist evaluation were grounded theory and ethnography. Rather than testing or confirming existing theories, in grounded theory studies of social experiences or interactions, theory development occurs concurrently with analysis as data emerges (Lingard et al. 2008; Matthews and Ross 2010). Grounded theorists warn about researchers' preconceptions about what is relevant in theories and data gathering due to beliefs that this may subsequently impact on data that emerges (Glaser and Strauss 1967; Kelle 2005). This Salvation Army and University of Stirling partnership funded research conflicted with that stance as it was based on TSA's preconceptions about benefits of the CRA approach and of DASW appointments to community programmes (Scotland Drug and Alcohol Strategy Task Group 2011). Aware of this dichotomy, rather than grounded theory, I recognised benefits in a more focused method, with realist evaluation meeting that need.

Ethnography is an immersive approach in which researchers participate in the research context and collate data from personal observations (Hammersley and Atkinson 1983). My research focus however, unlike ethnographic research in which a researcher volunteered in a food programme (Garthwaite et al. 2015), was not about a specific site, and there was no particular place or activity for me to participate in. Instead, what was important was the range of stakeholders and their interactions plus how activities at community level linked with wider TSA management. Realist evaluation allowed exploration of links between contexts, mechanisms and outcomes crucial to understanding what was working (or not) for help-seekers with PAU, cognitive impairment and ARBD and TSA help-providers, in what circumstances, how and why. Thus while grounded theory and ethnographic approaches had strengths, realist evaluation was better suited to the objective of getting useful, relevant

information for TSA. Consideration of alternative approaches made me appreciate the importance of theory testing which realist evaluation offered in the practical, real world fieldsite settings.

3.4 Part 2: Research methods

Method, as opposed to methodology, relates to tools used to collect or analyse data (Blaxter et al. 2010). The approach adopted here was founded on a realist evaluation framework. It anticipated the setting would be complex, that people would reason and react differently in the intervention context and in response to available resources, and that differing outcomes were likely. In keeping with retroductive thinking, consideration of CMOs was important. Context is integral to any project and recognised as such rather than something to be controlled (Davidoff 2009). Most social programmes transform over time including due to changes in stakeholders with complex processes of actions, interactions, feedback and adaptation (Tilley 2009). In such evolving situations, difficulties arise identifying in simple experimental ways what has worked, where it has worked and what should be undertaken again in an expectation of replicating outcomes. Pawson (2013, p. 50) offers guidance on contextual layers requiring consideration in any intervention:

- individuals – the characteristics and capacities of people involved
- interpersonal relations – the relationships of stakeholders
- institutional settings – the programme's rules, norms and customs
- infrastructure – the wider social, economic and cultural setting

In critical realism, natural and social objects are regarded as having real underlying structures and have causal mechanisms responsible for producing events (de Souza 2014). Mechanisms, as agents of change, describe how resources in a programme influence participant thinking and behaviours (Pawson 2013, p. 115). In realist evaluation, a social programme can be viewed as the input that will reconfigure or in a differing way activate the underlying causal mechanisms sited in pre-existing social structures to produce change or a novel potential in the action context (de Souza 2013). In order to provide experiential data in the current research and iteratively build on it to support confirming, refining, refuting and creation of programme theories, primary data collection was undertaken in a staged way:

- 2014: Initial programme theories constructed from Salvation Army sources: Scotland Drug and Alcohol Strategy document and personal notes from Strategy launch, Salvation Army training events and meeting with Salvation Army staff
- December 2014: Exploratory Focus Group with DASWs from Fieldsites A, B and C
- January to March 2015: Individual semi-structured interviews with DASWs
- January to April 2015: Focus groups and semi-structured interviews with people accessing support (clients), volunteers and staff
- June 2015: Follow-up focus group with DASWs
- 2016 and 2017: Discussion about findings and theories with Salvation Army management and Drug and Alcohol Support Workers

Data came from different sources, the main one being from help-seekers with PAU and cognitive impairment and TSA help-providers at three Salvation Army community programme fieldsites. Qualitative data was sourced from semi-structured interviews and focus groups. Descriptive fieldsite data was gained from personal observation and DASW provided information. Personal notes from Salvation Army conferences recorded strategic level and training perspectives, with further data coming from the '*Time for recovery*' strategy document (Scotland Drug and Alcohol Strategy Task Group 2011), interviews with Salvation Army managers, and Salvation Army website information. I used an Excel spreadsheet to record dates of interviews and when I transcribed them.

Contextual fieldsite descriptions are now provided. This is followed by information and discussion about the focus groups and semi-structured interviews, data gathering and preparation, data analysis, ethical considerations and then reflexivity.

3.4.1 Fieldsites

The research context was in the period following TSA Scotland Drug and Alcohol Strategy launch in 2013. TSA identified the preferred community programme locations for the DASWs based on local community need, enthusiasm within individual community programmes, and availability of interagency partnership working. The research fieldsites were three Salvation Army community programmes (Fieldsite-A, B and C). Each provided differing contexts and opportunities to meet people with PAU and cognitive impairment and those offering support. Fieldsite access was agreed by TSA. Visits were agreed in advance with fieldsite managers and DASWs with flexible aims for each visit to reflect likely availability of research participants. By virtue of

going to fieldsites to collect data, the data collection is original or empirical (Blaxter et al. 2010).

The fieldsite all offered and hosted groups and activities for different age ranges accessed by people from the wider community. The buildings had worship rooms representing availability of faith-based resources for study participants. Community programmes originated from TSA's Christian foundations, focusing on the whole person, '*mind, body and soul*'. People with PAU could attend '*Recovery Church*' to engage with peers in a Christian worship setting. Additional rooms and facilities depended on the overall facility size and resources, though all fieldsites had catering kitchen and café facilities. All had meal programmes, one-to-one sessions and drop-ins (no appointments necessary) for people with PAU. Fieldsites B and C had on-site thrift shops. The fieldsites offered volunteering opportunities, including at Fieldsite-B and C, for people from local prisons during rehabilitative aspects of detention.

Fieldsite A was a large city centre building. One room had IMT facilities for training and education. DASW-AR previously worked with people who were homeless. He described establishing new recovery orientated services including a Recovery Café, drop in service, and one-to-one sessions.

Fieldsite B offered a general support group, parent and children craft and activity sessions, curry nights, and table tennis. It was closely connected to TSA Floating Support Service which offered support to people in recovery, particularly around housing (Care Inspectorate 2015). DASW-B previously worked at an alcohol rehabilitation residential setting. Her spouse was a chef in Fieldsite B and both were Salvationists.

Fieldsite C was comparably smaller. There was a fruit and vegetable garden plus a nearby furniture restoration project. DASW-C had previously worked in a drug and alcohol support service. Fieldsite-C had a Recovery Church and Café, and themed meal nights. Furthermore it hosted AA, NA and Signpost Recovery, a service for people with drug and/or alcohol problems.

3.4.2 Seeking participants' views

Qualitative interviews can be conducted in different ways including by telephone, through internet links, in group settings or on a one-to-one basis (Blaxter et al. 2010). In this study, focus groups and semi-structured interviews were undertaken, supported by topic guides and photographic prompts to gain information from participants about PAU, cognitive impairment and ARBD CMOs.

3.4.2.1 Focus groups

Focus groups are a widely used and highly regarded means of gathering qualitative research data (Sagoe 2012) providing research opportunities to obtain rich, experiential views from participants. They can offer a supportive, hospitable, open-minded environment augmenting opportunities to accumulate wide-ranging points of view not necessarily possible in interviews (Powell and Single 1996). They are used to develop new hypotheses or knowledge, which are valuable in realist research.

Each group normally involves between 5 and 8 participants (Twohig and Putnam 2002). Factors influencing focus group size include time availability, the questions or topics to be covered, the focus group session format and the research aims (Tang and Davis 1995). People with PAU or mental ill-health experience stigma from self and others thus a non-judgemental approach and welcoming environment is important (Schomerus et al. 2011a).

Difficulties in organising and running focus groups may limit potential impact on research outcomes. Greenbaum (2003) and Sagoe (2012) highlighted focus group strengths and limitation. A suitable venue is needed, though not all invited may attend. One or two participants may dominate. There may be reluctance to discuss sensitive topics, or ability to do so in a perceived '*safe'* setting with others holding shared experiences. Groups can be highly topic focused with output dynamically shaping research. Although output is not projectable, output consistency from different groups increases likelihood of it representing wider population outlooks (Greenbaum 2003; Sagoe 2012).

Focus group moderators aim to prevent or overcome difficulties. In non-biased manners, they encourage topic-focused discussion and ensure opportunities for

individual participation at appropriate levels, particularly when hesitancy or dominance of group members exists (Matthews and Ross 2010). Researchers may find participants prioritise unanticipated topic areas (Bryman 2012) prompting needs to adapt approaches. However, '*off topic'* discussions may offer valuable unanticipated information (Pawson 2006a).

Focus group data reports include individual group and cumulative participant numbers plus information about recruitment problems (Twohig and Putnam 2002) to support research limitation identification and discussion. Reassurance is needed that views expressed in groups are truly representative. Theoretical saturation is the stage in focus groups (or interviews) when no new concepts become apparent when data is reviewed, and more than 70% of interviews contain data about a certain category (Bowen 2008). General guidance is that 4 to 6 groups are required to reach this state (Morgan 1996).

3.4.2.2 Semi-structured interviews

Interview formats range from totally structured, pre-planned questions (Bryman 2012) to unstructured flow in response to participants' choice of direction (Holland and Ramazana 1994). Qualitative information from interviews may diminish in value if qualitative depth is lacking (Black 1994).

The semi-structured interview approach used in this project aimed to obtain rich and detailed answers (Arthur and Nazroo 2003) supported by topic guides (Appendix 2 and 3). It is important to give participants opportunities to share deep, quality information around topic guide themes (Bryman 2012). Topic guides aim to act as interview maps, with concurrent opportunities for relaxed welcome and differing routes to and exploration of areas of interest or importance to interviewee. Digression may need to be cautiously limited, as what may not initially appear relevant, may be greatly important to interviewee. This is the nub of semi-structured interviews, rather than interviewer beliefs. At times repeated participant interviews are needed to elicit further data, deepen existing data or address gaps in data analysed. Additional participants may be interviewed to increase data breadth, depth, adequacy and appropriateness (Morse et al. 2002). However, robust research methodology,

methods and implementation do not necessarily mean research outcomes will offer relevance or use (Morse et al. 2002).

Realist evaluators are encouraged to use realist interview techniques (Pawson 1996; Manzano 2016). However, this research demonstrates benefits in adapting interviews to styles suited to each individual and their cognitive ability. Based on a learner-teacher cycle, realist researchers adopt an approach of, "*I'll show you my theory if you show me yours*" (Pawson and Tilley 1997, p. 169) with interviewees as '*learners'* asked to comment on proposed researcher as '*teacher'* theories. Roles reverse when interviewees confirm, refine or refute the theories with teacher-learner cycles enabling mutual understanding to emerge (Pawson and Tilley 1997).

Realist interviews may involve a two or three-questions-in-one approach (Manzano 2016), potentially overwhelming for people with cognitive impairment or complex educational backgrounds. Participants try '*to respond to what they deem the interests of the interviewer*' (Pawson and Tilley 2004), creating similar concern to public responses to direct questions compared to more accurate private accounts if participants' conversation cues were followed (Cornwell 1984). Participants may be influenced by interactions with others elsewhere, such as paternalistic approaches by healthcare providers (Emanuel and Emanuel 1992). Furthermore, health professional and help-seeker honesty cannot be assumed (Palmieri and Stern 2009; Sokol 2014). People misled clinicians to enable access to hospital shelter, warmth and food (Sokol 2014) and reasons other than abstinence drove abstinence programme involvement (Collins et al. 2016).

To reduce the likelihood of people telling health providers what they think is wanted, clinicians like me are advised to ask open questions focusing on the individual (Chitnis et al. 2014) with caution expressed about formulaic approaches (Sanders 2016). Blanche and Bor (2009) recommend adapting communication styles to meet help-seekers' needs, including around cognitive or sensory difficulties.

A research challenge was therefore personal experience and training compared to Pawson's stance. Pawson (1989, p. 322) praises Mishler's interviewers or physicians for teaching respondents or patients limit responses *'to the information the physician*

considers relevant' (Mishler 1986, p. 54). Pawson (1989, p. 322) viewed '*teaching'* as the '*guiding metaphor'* for undertaking realist interviews.

In this research, some participants were anticipated to have had complex interactions with '*authority figures*' including when at school, through legal systems or in health or social care settings. I was also aware that I could be seen as a further authority figure because of my middle class, educated background. I therefore concluded that it was inappropriate when interviewing a vulnerable person to fully adopt the teacher style of realist interview. This had implications for realist methodologies. A realist PhD colleague (whose research involved people with dementia) (Berge 2017) and I received positive feedback when we co-presented on our responsiveness to vulnerable research participants' communication needs at an international realist conference (Berge and Hannah 2016).

3.4.2.3 Development of interview tools

I created topic guides to support interview and focus group processes, one for help-seekers and one for help-providers (Appendix 2 and 3). Literature highlights the unenviable stance of ARBD as an avoidable condition which for many offers scope for recovery if identified and treated early yet simultaneously is often not recognised or known about by individuals themselves or those who could help and support them (MacRae and Cox 2003). Recommendations in '*A Fuller Life*' (Cox et al. 2004) included the need for research about early recognition, rehabilitation and community living.

Questions began by clarifying help-seeker and help-provider knowledge and awareness of alcohol's relationship with cognitive impairment and ARBD. Without this, early recognition and opportunities for recovery support could be missed. Thereafter it was important to establish the kinds of issues in day-to-day life people with PAU, cognitive impairment and ARBD experienced or TSA help-providers witnessed in the fieldsites. The issues explored were guided by literature about difficulties for people with ARBD around nutrition, financial difficulties and associated ramifications, stigma, relationships with other people, and health (Cox et al. 2004). Without relevant knowledge and/or experience, rehabilitative approaches which could help people in TSA fieldsites might not be used. Finally, people accessing TSA

fieldsites lived in the local communities of which the fieldsites were part. A need thus existed to explore what people found helpful or unhelpful in TSA contexts in addressing immediate and recovery orientated needs to support recommendations to TSA about ways of improving their ARBD community supports.

I trialled the photographic prompts and topic guide at the Exploratory Focus Group with the DASWs. This confirmed the content relevance, but also emphasised the need for fluidity of approach with the topic guides functioning as live documents. I needed to be flexible about interview lengths and styles, taking into account alcohol's draw for some participants. Participants' alcohol needs in the first help-seeker focus group concluded the interview significantly earlier than anticipated. A conversational interview style was important to avoid perceptions of interviews being formal assessments. Interestingly, sometimes people did respond better to closed rather than open questions therefore I adapted approaches to individual participant needs. Overall my aim using a person specific conversation style was to encourage participants to speak about their experiences and perspectives, with significant openness on my part as researcher to learn from them.

3.4.3 Selection of participants

In realist studies, interviews are used to obtain data which is the '*evidence for real phenomena and processes (including mental phenomena and processes) that are not available for direct observation*' (Maxwell 2012, p. 103). It was therefore important in this research that participants selected were potential providers of such data. People were eligible if they were fieldsite help-seekers with experiences of PAU and cognitive impairment. Help-providers, that is, fieldsite staff and volunteers, were also eligible to participate.

Participants provided rich data in focus groups and interviews. They fell into different categories: people accessing Salvation Army services (help-seekers or 'clients'), and help-providers, that is, the DASWs, other Salvation Army staff, and volunteers with or without personal experience of drug and/or alcohol problems. Two participants were employed by other agencies. One volunteered at Fieldsite-A and another was based at Fieldsite-C twice weekly in her other agency drug and alcohol worker role. For clarity, '*client volunteers*' refers to people who were volunteering receiving DASW support,

whilst '*volunteers*' were people who may or may not have been clients in the past. Some volunteers described as '*placement volunteers*' were on placements from employment agencies or prison.

During the research it emerged that due to fieldsite contexts and resources, records were not routinely kept of the numbers of people with PAU and/or cognitive impairment accessing services. The community programme contexts varied markedly, including the duration of involvement in the new intervention. I was advised by TSA managers and staff that the numbers of people accessing the fieldsites varied.

To address these issues, '*purposeful sampling'* was used. In qualitative studies, often small numbers of people participate compared to in quantitative studies. Sampling in a purposeful manner enables inclusion of information-rich participants whose contributions lead to in-depth understanding of a topic (Patton 2002, p. 46). Patton's (2002, p. 46) argument of benefits of this approach in an evaluation to increase effectiveness of a programme for people in lower socioeconomic groups was relevant to the current study. Focusing in depth on the needs of a small number of information-rich people with PAU and cognitive impairment and those supporting them in the community programmes offered an opportunity for the research to '*illuminate the questions under study*'(Patton 2002, p. 46).

To raise awareness of the study, I undertook introductory fieldsite visits. The DASWs and senior staff I met all expressed interest in participation. They in turn introduced me to other staff, clients and volunteers. I provided posters and information leaflets about the research and how to get involved. The DASWs were gatekeepers in the recruitment process, discussing the research at the fieldsites, introducing people to me, and arranging space for interviews and focus groups. The research implication was potential bias towards people with stronger relationships with the DASWs and diminished representation of the wider population of help-seekers and providers. This may have created bias in the study results towards a more positive stance than otherwise. However, I also recruited participants independently, including help-seekers in the cafés and at a '*Winter Feeding Programme*', and bore the potential bias in mind during the analysis.

Recruitment was more straightforward in Fieldsites A and B, than in Fieldsite-C due to less hesitancy about involvement. The Fieldsite-C turning point was when a client engaged in conversation with me. He advised, "*Just go up and say to them, I'm Jean. I'm here to do research and it would be good to talk to you*". However, he chose not to participate as he felt he had already informally spoken to me a lot. A degree of suspicion remained, not apparent elsewhere. Furthermore, there were more people with experience of problematic drug rather than alcohol use. This provided an informative focus group opportunity when three close friends participated together. Two had experience of both PAU and drug use and the third drug use alone (Client-C9R). The different perspectives enlivened the conversation and provided dimensions to understanding of contexts, mechanisms and outcomes that might not otherwise have arisen.

In total, 57 people participated in focus groups and/or semi-structured interviews as presented in *Table 1* below. Two Salvation Managers and two DASWs also participated in individual discussion about the ultimate programme theories proposed.

Table 1 Number of participants in focus groups and semi-structured interviews

	Focus groups: 11 (FG)	**Semi-structured interviews: 33**	**Total number of participants**
	Number participants	**Number participants**	
Clients: People accessing services	8	13 (1 FG*)	20
Client volunteers: People accessing services and volunteer	2	3	5
Volunteers	8	4	12
Placement volunteers	3	2	5
DASWs	3	3 (3 FG*)	3
Salvation Army Staff	3	7	10
Staff from other agencies	1	1	2
Number participants	**28**	**33 (4 FG*)**	**57**

*number who participated in semi-structured interviews and focus groups

The participants in each focus group were according to group: DASW-AR, DASW-B and DASW-C; Client-A5C and Client-A6C; Client-A4R and Other-A1R; Staff-A3, Volunteer-A1, Volunteer-A2 and Volunteer-A3; Client-B4R and Client-B5R; Volunteer-B3,

Volunteer-B4 and Volunteer-B5; Client-C8R, Client-C9R and Client-C10R; CVolunteer-C1R and CVolunteer-C2R; Volunteer-C1R and Volunteer-C2; PVolunteer-C2 and PVolunteer-C3; and Staff-C2, Staff-C3 and Placement Volunteer-C4R.

The right to decline or to leave the project at any time was emphasised to all potential participants. This was important in what subsequently happened in focus groups and interviews which, despite forward planning, were unpredictable. Alcohol's draw influenced availability and was some participants' priority. As a result, one client completed the consent and AUDIT form, said he wished a cigarette, left and did not return. Two ended a focus group after 20 minutes as they wanted to go for a drink. Another consented verbally, but as alcohol drunk before he entered the building took effect, he went to sleep. In contrast, another who took prescribed methadone shortly prior to an interview appointment, initially had difficulty concentrating. The interview was therefore halted. He ate, had a hot drink, regained alertness, provided renewed informed consent and participated.

Clients regularly did not attend planned appointments because they forgot, including because of alcohol's influences. Thus if possible, they were undertaken as soon as possible after initial consent. This meant that interview contexts were not necessarily ideal, being adapted to available at times limited resources both in terms of physical setting and time availability for participants or settings. However, it meant following informed consent, conversations took place that might otherwise have been missed with accompanying loss of rich data.

3.4.4 Ethical issues

People accessing Salvation Army services and particularly those with PAU and/or cognitive impairment are a vulnerable group. People with PAU have a raised incidence of mental health issues (including cognitive impairment, Wernicke's encephalopathy and ARBD) and vice versa, with stigma impacting on support seeking behaviour (Glass et al. 2013). Multiple exclusion, homelessness and frailty are not unusual (Cornes et al. 2014; Salem et al. 2014). Substance misuse has been demonstrated to be highly associated with dyslexia (40%) which not only results in difficulties in reading, but also in attention and concentration (Yates 2013). These factors all had ethical implications and for the purposes of this study, informed consent.

For research purposes, I ensured familiarity with ethics guidance[5]: The project received approval from the Ethics Committee of the School of Applied Social Sciences, University of Stirling (Appendix 4) and TSA Territorial Health Ethics Advisory Committee (Appendix 5).

The most complex inclusion/exclusion criteria anticipated was around capacity to fully understand and retain knowledge about the study. The General Medical Council advises that some people with capacity may be vulnerable to pressure to take part in research, perhaps as a result of learning difficulties, mental illness or other health or social circumstances. This description is fitting to some people accessing TSA fieldsites, thus consent processes required initial enquiries to establish if additional help was needed to understand information or to decide whether to consent or not. In reality the process was straightforward because of DASWs' knowledge of clients, my own background in assessing capacity, and interview and focus group contexts. Inclusion only occurred following informed and written consent.

To ensure people were fully informed, I provided each with an information leaflet and consent form (Appendix 6), but also read the contents to potential participants, checking regularly to make sure they understood what was being said. I neither pressured nor coerced people to participate, instead recognised difficulties or hesitancies that can exist for people with PAU and/or cognitive impairment in discussing their experiences, fears and concerns.

An unanticipated aspect of the research project was the implication of drug use in conjunction with or instead of PAU in help-seekers, restricting recruitment opportunities. An amendment was thus submitted to and approved by the Ethical Committees to enable participation of people with PAU and drug use, though I endeavoured to continue to focus on people who had primarily experience of PAU (Appendix 4 and 5) in keeping with TSA aims (Appendix 1).

[5] I familiarised myself with the following ethics guidance: University of Stirling Code of Good Research Practice (University Research Ethics Committee); ESRC Framework for Research Ethics (FRE) 2010 (ESRC 2012); Adults with Incapacity (Scotland) Act 2000: Authority for Research (Adults with Incapacity (Scotland) Act 2000); and General Medical Council: Good practice in research and consent to research (General Medical Council 2013).

My choice of terminology in consent processes was to ensure fully informed consent and continued in focus groups and interviews, the accompanying rationale now explained. The Scottish Executive commissioned work in 2003 to examine the needs of people with ARBD (MacRae and Cox 2003). In keeping with this I hypothesised a new candidate programme theory *CPT3* about understanding about and use of terminology about ARBD:

CPT3: ARBD meaning and understanding

> If Scottish Executive backed document '*A Fuller Life*' (Cox et al. 2004) recommendations were embraced by government bodies and health, social care and third sector providers, then over 10 years later there would be an awareness of ARBD terminology and meaning among those affected, those at risk, and programme help-providers because help-provider training would result in their accurate information provision to help-seekers.

For this reason, during focus groups and interviews I asked about awareness of the overarching term '*alcohol-related brain damage*' as opposed to terms for more specific aspects of cognitive impairment which occur with PAU, such as Korsakoff's syndrome. In contrast when referring to cognitive impairment, I used additional explanatory wording of '*thinking or memory problems*' in case people were not familiar with clinical terminology.

During interviews and focus groups, if participants were hesitant about expressing views, I used photographic prompts about aspects of life potentially impacted by PAU or cognitive impairment. In the first focus group in which I used them, participants thought I was asking them to say what the pictures were of thus I ensured in subsequent use I clarified that this was not the case.

3.4.5 Data collection and preparation

The study used qualitative data from focus groups and semi-structured interviews which I digitally recorded. In qualitative research, there is encouragement to continue interviews or focus groups until data saturation is reached although clustering of sample sizes has been noted (Mason 2010). In this study, my approach was in keeping with purposeful sampling of information-rich participants (Patton 2002, p. 46) and the '*who'*, '*why'* and '*how'* of realist interview approaches (Manzano 2016). Based on an

awareness that in Pawson's (2013d) view evaluative knowledge is only partial knowledge, I was pragmatic about recruitment. Realist evaluation seeks information from different sources of which people are one, and people can choose or decline to participate in research. Thus my recruitment strategy was to include different people with different contexts, experiences and perspectives about of PAU and cognitive impairment, including help-seekers and help-providers. An important aspect of sampling was inclusion of people who were currently drinking and at varying stages in recovery, in order to gain insight about mechanisms which influenced their relationship with alcohol. Sampling ended when representation of people from these different alcohol-related contexts in the different fieldsites had been achieved.

I transcribed the recordings and used the computer software package, NVivo, repeatedly editing until confident participants' words were accurately presented. For anonymity purposes, I allocated each individual an individual code, examples provided Table 2 below:

Table 2 Participant coding

Participant code	Meaning
DASW-AR	Drug and Alcohol Support Worker, Fieldsite A, in recovery
Client-B2R	Second client participant from Fieldsite B, in recovery
CVolunteer-C1	First client volunteer participant from Fieldsite C
PVolunteer-B1	First placement volunteer participant from Fieldsite B
Volunteer-B2	Second volunteer participant from Fieldsite B
Staff-C3	Third staff member participant from Fieldsite C
Other-A1R	First staff participant from another agency at Fieldsite A

To gauge how much alcohol clients were drinking, I asked them complete an AUDIT questionnaire (Saunders et al. 1993). I read out the questions and potential response categories to ensure understanding. Nevertheless, accuracy of responses was not always clear. Client-C4C's response varied with clarification needed until he confirmed my understanding of his account was correct.

3.4.6 Data analysis

Data analysis in this research comprised cumulative theory building, each chapter drawing on its predecessors. Theory building required a dual approach of identifying themes and sub-themes while thinking in terms of contexts, mechanisms and outcomes, the building blocks of theories and the evidence to confirm, refine or refute them. Thus in terms of analysis, as *Figure 2 Theory development and approach to data analysis throughout thesis* below presents, I strove to be open throughout to emerging new contexts, mechanisms and outcome, configurations (CMOcs) and theories.

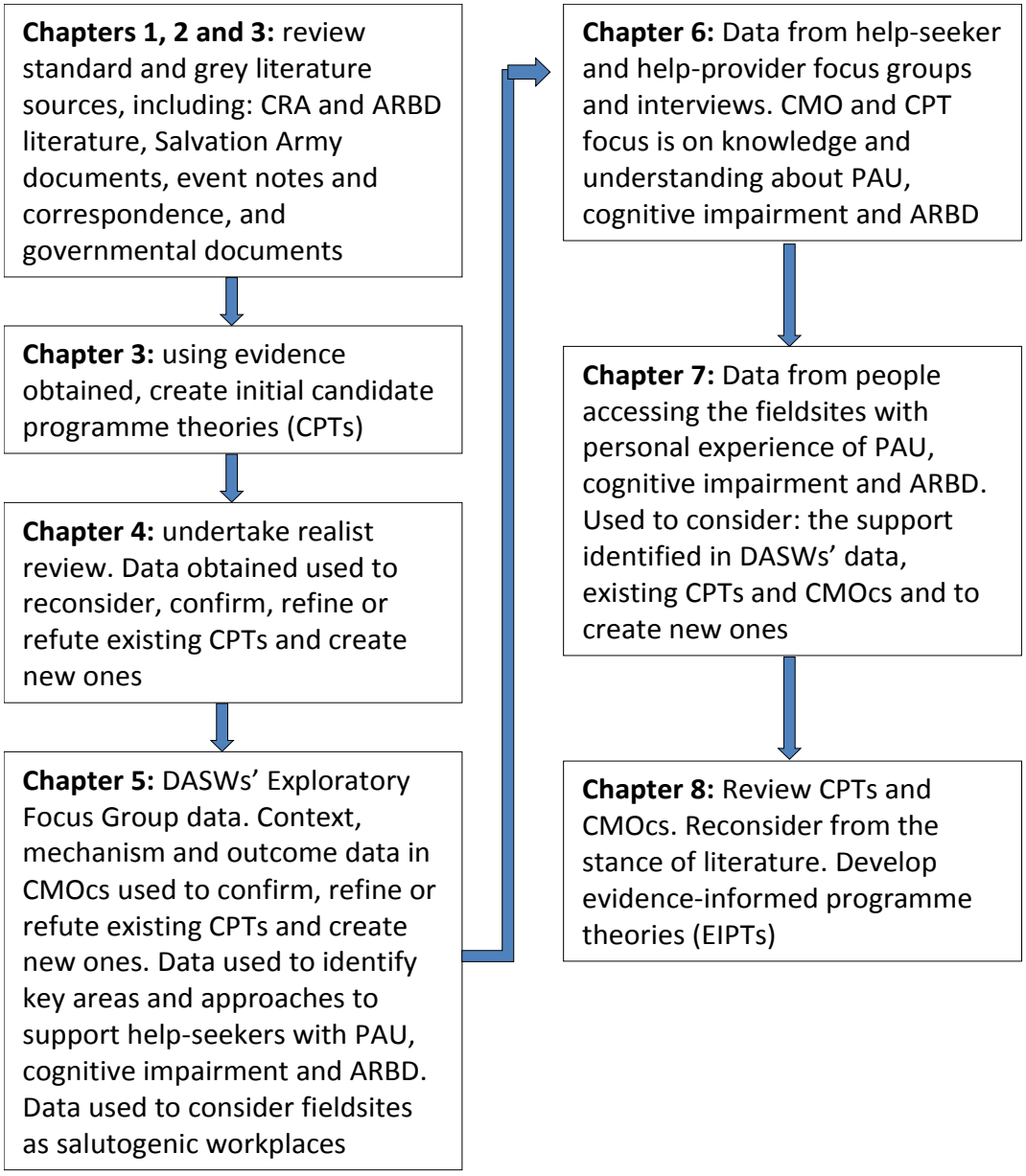

Figure 2 Theory development and approach to data analysis throughout thesis

At the ends of Chapters 3 to 8, summary flowcharts are provided about the approaches to data analysis and outcomes arising. Of note is CPTs may remain unconfirmed forming recommendations for future consideration by TSA as it continues service development.

Data analysis involved code and theme development (Braun and Clarke 2006; Clarke and Braun 2017) and iterative, retroductive realist thinking to develop CMOcs. NVivo supported thematic analysis incorporating data familiarisation; generation of initial coding; emerging themes; analysis and connecting themes; development and naming of each theme; and producing the report (Braun and Clarke 2006).

Variations exist in how realist researchers use NVivo (Lovell et al 2018). In my research, I used NVivo as a data repository in which I developed a coding frame founded on literature and reflections on the data collection processes. The first NVivo parent nodes were in keeping with the interview topic guides (s.3.4.2.3). They were about ARBD knowledge and understanding, Salvation Army services and supports, and the kinds of difficulties people experienced on a day-to-day basis due to alcohol-related cognitive impairment. Like others (Lovell et al 2018), I stored each interview or focus group transcript as an individual source, the first analysis of each guided by the initial parent nodes. The coding frame was expanded as new codes emerged in response to increasing recognition of GRRs and contexts, mechanisms and outcomes of relevance to salutogenesis.

I identified ten overarching themes from DASWs' Exploratory Focus Group data of general support and social engagement, support for memory problems and cognitive impairment, PAU and drug use, finance and housing, food and nutrition, health, clothing, education and learning support, volunteering, placement and employment, and the roles and engagement with other agencies. These reflected the original themes and DASWs' perceptions of help-seeker needs and experiences.

Ultimately, 50 parent nodes were created (plus a node template), each having a hierarchical structure with child nodes according to sub-themes. Sub-nodes were used for fieldsites (A, B and C) and participant grouping (client, client volunteer, placement volunteer, other volunteer, DASW, staff, staff from other agencies, and manager). This

is demonstrated in *Figure 3 Food parcels: an example of TSA services and supports and use of NVivo as a data repository*.

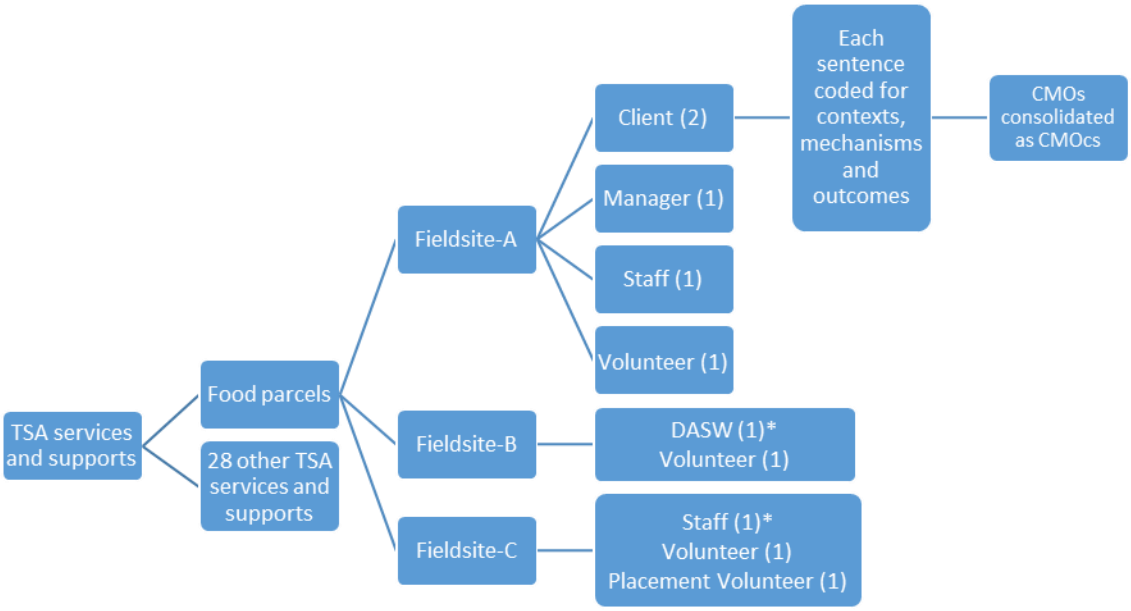

Figure 3 Food parcels: an example of TSA services and supports, and use of NVivo as a data repository

(* - The number adjacent to the group title refers to the number of participants who provided relevant data).

The TSA services and supports resources parent node had 29 child nodes, the number growing to this as people mentioned new sub-themes important to them. During analysis in keeping with Bryman (2012), some codes could be looked at under more general coding categories. Thus of those 29 codes, approximately half related to meeting basic needs around food (including food parcels), housing, clothing, hygiene, financial support and spending time with others. Others were about spirituality and church, including recovery church, meaningful activities such as band involvement, education and learning, volunteering and employment, peer support and influences, travel, and stigma.

An ARBD supports node had 10 child nodes, including about participant views, reasoning about what helped, what did not and what people thought might help people with PAU, cognitive impairment and ARBD, accompanied by participant explanations about why this might be the case and in what circumstances. Nodes incorporated how experiences of PAU, cognitive impairment and ARBD made people

feel, revealing experiences of stigma and in contrast unexpected happiness in recovery.

The NVivo filing system offered practical benefits in examination of topic-specific data from different participants' perspectives. However, I needed a layout style which helped me more readily undertake realist retroductive and iterative data consideration of contexts, mechanisms and outcomes in keeping with Pawson's (2006b) recommendations about juxtaposition, reconciliation, adjudication, consolidation and situating.

Helpful at this time was a diagrammatic representation of a CMOc framework (Figure 1 A CMOc framework in Dalkin et al. 2015, p. 5) and approaches used by Pearson and colleagues (Pearson et al. 2015, Additional Files 4 and 5) in considering and consolidating context, mechanism, and outcome data. While Pearson and colleagues adopted an, "if", "and" and "then" approach (Pearson et al. 2015, Additional File 5), I used "if" as context, "then" as outcome and "because" as mechanism. My approach was very practical. I retrieved all the data on a given topic from NVivo, transferred it to Excel and Word (in draft stages also used post-its and paper). As demonstrated below, I colour coded data from sentences from each participant source on that topic relevant to content, mechanisms and outcomes.

Client-A1C response when asked if he had heard of ARBD:

I haven't heard of it – context – knowledge resource gap
but I do feel it – mechanism – reasoning about his worsening memory on hearing about ARBD in the interview
I know it's happening – outcome - he concludes that he has ARBD

The knowledge resource gap was one of differing factors contributing to Client-A1C's context. He was attending NHS services for current PAU and accessing Fieldsite-A support. He knew others with PAU and marked cognitive impairment.

The approach to the analysis increased my familiarity with each participant's views and supported reasoning about data in keeping with Pawson's recommendations (Pawson 2006b, pp. 74-76). Juxtaposing evidence was considered including when one participant provided data which helped make sense of mechanisms or outcomes

described by another participant. When people offered contradictory data, there was a need to reconcile why this occurred and adjudicate about what had been said. Consolidation brought together contexts and mechanisms leading to the same or similar outcomes and involved consideration of potential rival explanations. Though recommended for realist synthesis, these approaches are applicable in evaluation:

> ….. *to think through studies and to make sense of their uniformities and discrepancies ….. embodies the real craft of systematic review.* (Pawson 2006b, p. 76)

The reasoning process supported my ability to confirm, refine and refute programme theories. The coding, theories and contexts, mechanisms and outcomes found in or developed through the data were considered relevant if they were within the data found to be novel, they challenged explanations in related accounts, added refinement, added to underlying explanatory accounts, were similar enough to other accounts offering consolidation options or required development of a new consolidated account or theory. Realist thinking and a salutogenic stance ultimately supported recognition and focusing on key themes of micro-actions, peer support and salutogenic flow and construction of evidence-informed programme theories.

To support validation processes, the findings, theories and recommendations were formally presented to a Salvation Army Scotland Drug and Alcohol Strategy Group senior manager (personal notes). He said the findings confirmed concerns arising within TSA about the roll-out of '*Time for Recovery*' (Scotland Drug and Alcohol Strategy Task Group 2011). He was unaware of the DASWs' innovation towards recognition of cognitive impairment in people with PAU and how they offered help. He reported back to TSA Scotland Drug and Alcohol Strategy Task Group members with recommendations for change. I had a telephone meeting (personal notes) with a second senior manager, with similar outcomes.

3.4.7 Reflection on research methods

In realist evaluation, CPTs are proposed then tested using chosen research methods. Here, primary testing comes from study participants' voices, whether help-seeking for the impacts of PAU and cognitive impairment or help-providing. The evidence sourced from focus groups and interviews will be presented in context-mechanism-outcome

configurations in Chapters 5, 6 and 7 and additional theories may be identified. This approach is supported by retroductive thinking and findings from literature as described in Chapter 4 and Chapter 8.

I was fortunate enough when presenting at the *2nd International Conference on Realist Evaluation and Synthesis: Advancing Principles, Strengthening Practice* in London (2016) to be able to speak directly to Ray Pawson about the project. He advised that I describe the research undertaken as a *partial realist evaluation* (personal research notes). The rationale for this is that the evaluation began before the new programme had been fully implemented, thus I was evaluating a '*work in progress*'.

3.5 Reflexivity

Reflexivity is a means used by researchers to consider and address their subjectivity, ensuring those accessing their research know about their perspectives (Morrow 2005; Cho and Trent 2006). The researcher's position is influenced by whether he/she has had similar experiences as participants, if the researcher during the research changes from a position of being an outsider to an insider, or if the research area is outwith the researcher's experience (Berger 2015). Researchers need to endeavour to glean advantage from or limit negative implications associated with their status (Berger 2015).

Various aspects about me could have detrimentally influenced the research process, particularly engagement with study participants, and therefore interview outcomes. As a middle class, educated, middle aged woman, I anticipated people would correctly assume that I did not share many participants' experiences with alcohol, cognitive impairment or multiple and deep exclusion. I purposefully only disclosed my occupation as a general medical practitioner to TSA management and DASWs to avoid adding to communication and experiential barriers. If participants asked what I did other than research, I said I had an office administration role. This concurs with a significant proportion of medical professionals' roles. I made this decision because participants' experiences of medical professionals might have influenced decisions

about participation and information sharing about themselves and their experiences. People often shape responses to medical professionals to what they believe '*right*' answers, including by scaling down drinking levels. Crucially, the research was about TSA, not about a medical model and I wished to avoid the interview focus slipping from the former to the latter.

As a PhD student, some people with PAU experience regarded me as a "*textbook candidate*" who had not "*worn the T-shirt*". My context lacked from their perspectives lived experience and thus ability to understand theirs. Their SOC and GRRs were influenced by alcohol and its impacts in ways mine were not. In these situations I acknowledged what participants said and described my hope to learn from them.

However, my life is similar to many others in Scotland, as alcohol or cognitive impairment may affect people we love and so indirectly ourselves. I was described by my medical appraiser as a "*feelings person*" and challenged about how this impacts on my work and dealing with complex scenarios and people. When asked about the hardest part of my PhD experience, I replied it was being silenced by a younger man with PAU, who sitting opposite me at a table smiled and asked where I was from. I could not speak. His eyes at that time were those of my artist cousin whose death at age 39 related to the tolls of over-prescribed diazepam and accompanying health issues. His was one of a family cluster of dependency related deaths. Those remaining live long with dementia frequently their companion.

A challenge in my PhD writing experience is now apparent, that is, not to let '*feelings*' overwhelm writing style and become self-indulgent. I have found difficulty '*letting go*' of participant accounts. They have been my teachers, my researcher responsibility being to ensure that my words convey their meanings in the way intended. Ettorre (2013) brings understanding of how undertaking research can affect researchers:

> *Although the transcripts make remembering easier, remembering is somewhat disturbing for me as my experiences were at times difficult and emotionally draining.* (Ettorre 2013)

Ettorre (2013), an autoethnographer, emphasised researchers' lack neutrality due to their contexts, cultural assumptions and interpretation, and because of their authority as researcher. Researcher mechanisms of reasoning and awareness of these factors

influenced what Ettorre described as recognising '*the problem of representation of 'the text"* (Ettorre 2013, p. 1382). The impact of this on the research was, I believe, that I did not progress through the research as quickly as others might have done. This meant I was slower in providing TSA with recommendations from it which may have affected their further programme planning and development.

Lack of neutrality may also have influenced my choice of realist evaluation as opposed to possible alternative approaches of grounded theory or ethnography. In my work, it is vital to consider with people coming for help or support what may or may not work for them, in what circumstances, how and why. Their contexts and resources influence their reasoning, comprehensibility, meaningfulness and manageability in life. Lack of recognition of the complexities in peoples' lives may undermine best intentions to help or support them. Thus the realist question and salutogenesis resonated strongly with me as opposed to other approaches. Perceptions of me as a '*textbook candidate*' affirmed to me that use of grounded theory or ethnography could have lessened the research potential compared to that achieved using realist thinking.

Finally, I am a Christian though have always questioned, questioned first rather than automatically believed. I feel extremely fortunate to have undertaken research in a Salvation Army context, an organisation of which I had no real prior knowledge.

3.6 Conclusion

This chapter described the philosophy behind the research methodology chosen and the methods adopted. The purposeful sampling used enabled the voices of 57 people with PAU experience and cognitive impairment or those helping them in TSA community programmes to be heard. Challenges associated with recruitment in part related to the chaotic lifestyles of some participants have been recognised. There is already an indication that others' personal experiences of PAU and cognitive impairment may influence the contexts, mechanisms and outcomes of help-seekers and who they regard as able to understand and support these needs. Three CPTs relating to a life more fulfilled, salutogenesis and shared understanding about ARBD have been developed which will be tested in subsequent chapters. Chapter 4 now uses

realist thinking as it builds up towards and presents a realist review on salutogenesis, PAU and recovery, while doing so, beginning the process of theory testing and new theory building.

3.7 Chapter 3 theory building synopsis

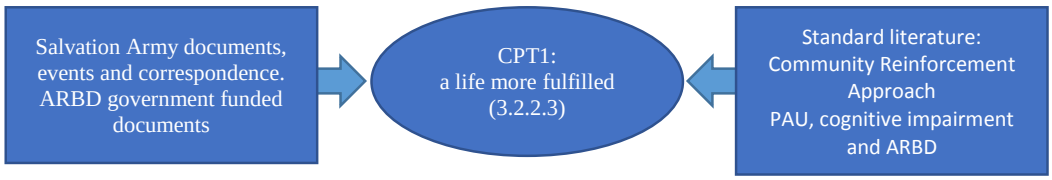

Figure 4 CPT1: a life more fulfilled

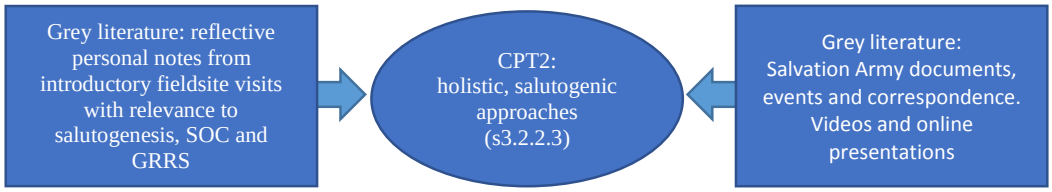

Figure 5 CPT2: holistic, salutogenic approaches

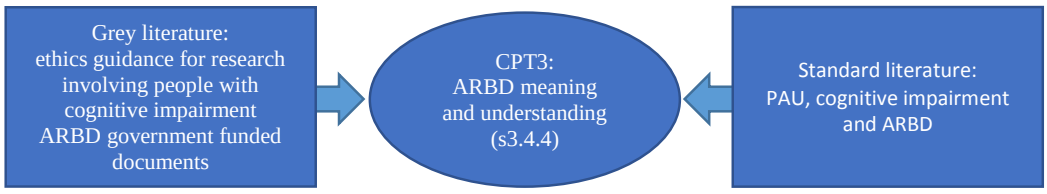

Figure 6 CPT3: ARBD meaning and understanding

Chapter 4 A realist inspired review of salutogenic approaches to supporting people with problematic alcohol use

4.1 Introduction

This chapter continues the process of stepping through literature. It includes a fuller background literature review about the Community Reinforcement Approach (CRA) due to its importance to TSA strategy, 'Time for Recovery' (Scotland Drug and Alcohol Strategy Task Group 2011). The realist lens is strengthened following explanations in Chapter 3 about realist philosophy and methodology and creation of initial candidate programme theories *CPT1*: *a life more fulfilled* (s.3.2.2.3), *CPT2*: *holistic, salutogenic approaches* (s.3.2.2.3) and *CPT3: ARBD meaning and understanding* (s.3.4.4). The steps in the realist review in this chapter draw on recommendations from Pawson and colleagues (Pawson et al. 2005; Wong et al. 2013). It considers the nature and content of the intervention, the circumstances for its use and the policy intentions. It considers the scope of the review and why a realist review is beneficial to the research. This is followed by a realist review of salutogenesis, PAU use and recovery.

The realist review incorporates searching for evidence in traditional and grey literature, which will be presented consecutively with explanations for this approach. It demonstrates an iterative process of evidence review. Apparent repetition demonstrates reflection on use of different data sources, meaning and explanation as evidence is appraised and data extracted. The evidence synthesised and conclusions drawn aid the process of theory building about *what works for which people with PAU and cognitive impairment in the community programmes, in what circumstances, how and why*. Evidence building from literature sources helps confirm, refine or refute the initial theories, and where appropriate create new ones. Further testing, building and creation of theories continues in Chapters 5 to 7, there using evidence from the participant data. The whole evaluation process continues until evidence-informed programme theories are presented in Chapter 8.

4.2 Stepping through the realist review

In a realist review, it is important to clarify the nature and content of the intervention. The review also requires information about the circumstances the intervention is used in, and the policy intentions and objectives of the intervention. The information about these areas is now provided.

4.2.1 Nature and content of the intervention

This research did not devise or implement an intervention, rather evaluated what was already in place, which was '*a product of its context*' (Pawson et al. 2005). From a TSA Scotland Drug and Alcohol Strategy perspective, the intervention was appointment of DASWs to community programmes to work using principles of the Community Reinforcement Approach (Scotland Drug and Alcohol Strategy Task Group 2011).

4.2.2 Circumstances or context for use of the intervention

The intervention circumstances related to closure of a Salvation Army residential programme in Scotland for people with PAU. This triggered TSA Scotland Drug and Alcohol Strategy Task Group review of services across Scotland. This led, as described above to the appointment of the DASWs to work using principles of the CRA (Meyers et al. 2013; Scotland Drug and Alcohol Strategy Task Group 2011). Additionally, TSA joint funded my post for this research with the University of Stirling to evaluate aspects of the community programme and make improvement recommendations if needed (The Salvation Army UK and the Republic of Ireland 2013).

4.2.3 Policy intentions or objectives of the intervention

'*Time for recovery*' is TSA strategy document policy underpinning the intervention (Scotland Drug and Alcohol Strategy Task Group 2011). In realist terms, it is a form of '*grey literature'*, information from it now contributing to the overall realist review. It presented two intervention strands relevant to this research. One related to community programme service development through appointment of the DASWs and the other to appointment of a researcher to assess services and make recommendations for future service development (The Salvation Army UK and the Republic of Ireland 2013).

'*Time for recovery*' defined policy intentions and objectives as '*charting a phased return to active involvement in the field of addiction recovery in Scotland*' (Scotland Drug and Alcohol Strategy Task Group 2011, p. 5). This was described as being based on Salvation Army '*robust research*' and '*fired by a passion to "fight" to alleviate the misery caused to so many by addiction to substances of abuse*' (Scotland Drug and Alcohol Strategy Task Group 2011, p. 5). The document wording reflected contexts and mechanisms accompanied by levels of comprehensibility, meaningfulness and manageability in supporting people in addiction recovery:

> *To be engaged in work with people with alcohol or drug problems is central to the social expression of The Salvation Army. The "*fight*" goes on in a different landscape from that facing early Salvation Army social work pioneers but belief in the intrinsic value of every person calls the movement to "*go and do something*". Serving the present age is a challenge to every generation and ScoDAST (The Salvation Army Scotland Drug and Alcohol Strategy Task Group) present this document as the framework in which that calling can be fulfilled.* (Scotland Drug and Alcohol Strategy Task Group 2011, p. 5)

TSA co-funded the research as an independent review of evidence about their supports for people with PAU use and cognitive impairment. The intention was to establish '*what was working and why*' with accompanying recommendations to this effect.

4.3 The scope of the review

Guided by steps in realist review, this has three sections: refining the review purpose, articulating key theories for exploration and identifying the review question (Pawson et al. 2005).

4.3.1 Refining the purpose of the realist literature review

The background literature review in Chapter 2 explored the complexity of alcohol use and harms and how these have changed over time, with an emphasis on Scottish perspectives. TSA community programme intervention was launched in this Scottish context. In keeping with other social programmes, the intervention outcomes were anticipated to be dependent on many factors, these factors also impacting on whether or not the programme might be replicable elsewhere.

4.3.1.1 The benefits of a realist review in a Salvation Army research context

Pawson advocates realist evaluation as a methodology for evaluating social programmes, as its approaches recognise the complexities found there (Pawson 2013d). A realist review aims to explain how and why an intervention or programme works, or indeed does not, presenting this in the form of a '*programme theory*' (Wong et al. 2013). It refines and offers benefit over the initial Salvation Army question about '*what was working and why?*' (Scotland Drug and Alcohol Strategy Task Group 2011) as realist approaches include '*for whom, in what circumstances, how and why*'. This strengthened the evaluation's potential to support meaningful recommendations to TSA about their supports to people with PAU and cognitive impairment.

In realist reviews and evaluations, intervention themselves are not the focus, rather the mechanisms leading to different outcomes in different contexts which can then be used to form context-mechanism-outcome configurations and patterns (Wong et al. 2013). These can be tested and refined, with benefits of using formal relevant theory while doing so. In this research the theory is about the support of people with PAU and cognitive impairment. A realist literature review offers opportunities for theory integrity to be assessed to determine if interventions work as anticipated and for theory adjudication to decide which theories are most applicable. Comparisons can be made for different groups in different programme contexts.

Reality testing, which is reflected in the current research context, is encouraged as policy level intended outcomes can differ from what actually happens. TSA research literature review for TSA Scotland Drug and Alcohol Strategy Task Group contributed to the DASWs' appointments in community programmes to work in keeping with CRA principles. When the fieldwork happened, the policy document remained in draft and not in general circulation. Thus '*theory integrity*' was difficult to determine. However, as TSA theorised that the CRA was likely to fit best in community programmes, CRA literature is now explored. Clearer understanding of the CRA will help clarify TSA aspirations, and so help refine the purpose of the realist review.

4.3.1.2 The Community Reinforcement Approach

The CRA as one of a number of means of offering support to people affected by PAU, was first introduced by Hunt and Azrin (1973). Subsequently, recognition of the importance of partners and families of those with PAU (Sisson and Azrin 1986) led to the development of Community Reinforcement and Family Training (CRAFT) (Meyers et al. 2013). These are based on learning theory, in particular operant conditioning as described in a personal communication from Meyers:

> *CRA & CRAFT - my family program - draw on operant conditioning. We use positive reinforcement, no punishment, no confrontation, no labelling, no judgements and use a "*happiness scale*" to let the client tell us what they want to work on. The theory is that anything they work on will promote more satisfaction and they always work on what they want to anyway. Why should any therapist think they know someone well enough to tell them what to do? Especially during the first month or two. I teach people to tell the client they don't have to do anything they don't want to do since they only do what they want to do anyway. And it relaxes clients so they don't drop out of treatment.* (Meyers 2015)

Meyers' words incorporate mechanisms and the outcomes that occur depending on contexts or '*environmental contingencies*' which can be highly influential in motivating or discouraging drinking (Smith JE et al. 1998). It uses social, recreational, familial and vocational '*carrots*' to help people to lower their alcohol consumption (Smith JE et al. 1998). Pertinent to TSA is that the CRA has been demonstrated to benefit people with PAU and psychiatric comorbidity (Meyers et al. 2011). Similarly it has benefitted people resistant to entering treatment, those with problematic drug use, and adolescents (Meyers et al. 2011). TSA context is according to '*The Seeds of Exclusion*' (Bonner et al. 2009) a place where people affected in such ways access support.

The CRA can be thought of in realist ways. Therapists endeavour to help clients determine mechanisms that fire in given contexts resulting in decisions to drink. Short term outcomes are explored including what people like about drinking or using drugs in certain setting or with particular people (Meyers et al. 2011). Short term benefits in terms of time of use, and pleasant thoughts, physical sensation and emotions are considered (Meyers et al. 2011). This is akin to Zinberg's work on drug, set and setting (Zinberg 1984, p. 5). Thus past experiential benefits of alcohol consumption may influence reasoning about alcohol consumption in current context. Consideration of

these thinking processes may be of value to help-providers, as aspects of alcohol consumption from the individuals' perspectives may lead towards what they perceive as the ease end of health continuum, such as avoiding withdrawals.

In the CRA, long-term negative consequences of PAU on interpersonal, physical, emotional, legal, employment, financial and other aspects of life are discussed (Meyers et al. 2011), all of which relate to GRRs. The conversations offer opportunities to explore people's thoughts about comprehensibility, meaningfulness and manageability in life and about PAU. This can be supplemented by sobriety sampling. Described as a '*gentle movement toward long-term abstinence*', an individual agrees to try abstaining for a specified period of time (Meyers et al. 2011). This may be more manageable to those daunted by concepts of stopping drinking forever, positive outcomes leading to greater confidence about future possibilities.

Community Reinforcement Plans encourage individuals to consider themselves in a holistic way, and to look at ways they can be happier in life. Clients are supported to develop behavioural training skills. They build abilities to look at problems as a number of components then work through these a step at a time. They are encouraged to develop positive interaction communication skill styles in which attributes including offering to help others or being empathetic can emerge. They are supported to recognise high risk of drinking contexts and assertiveness skills to decline alcohol (Meyers et al. 2011). Meaningful employment and support towards obtaining and keeping such a job, along with enjoying social and recreational activities not founded on alcohol are further key aspects (Meyers et al. 2011).

Comprehensibility and manageability of relapse and relapse prevention recognise the reality of contexts, reasoning mechanisms and outcomes that can occur in and for people with PAU. Daily reminders to '*be nice*' to partners are components of relationship counselling, accompanied by requests for '*small changes*' in each other (Meyers et al. 2011). Though the terms are not used, the approach helps individuals develop GRRs and SOC, with opportunities for salutogenic outcomes.

4.3.1.3 Reflection on the purpose of the realist literature review

The realist review is to support the partial realist evaluation undertaken which ultimately aims to obtain evidence to support recommendations to TSA about how to strengthen community programmes supports for people with PAU and ARBD (see s.3.2.2.1). In the absence of the programme's full implementation and in keeping with Pawson's recommendations, it is necessary to adjudicate or decide which of a range of programme theories is likely to fit an intervention best (Pawson 2013d).

The PAU recovery approaches described by Meyers (Meyers 2015) are in keeping with salutogenic thinking. In the theory of salutogenesis, people are described as having potential to move from the dis-ease to the ease end of a health continuum, based on comprehensibility, meaningfulness and manageability within their lives (Antonovsky 1996). The theory of salutogenesis also offers relevance to ARBD due to the significant scope for improvement in cognitive functioning on ceasing alcohol consumption (Kopelman et al. 2009; MacRae and Cox 2003; Victor et al. 1971).

The same salutogenic ethos is in '*Time for recovery*' (Scotland Drug and Alcohol Strategy Task Group 2011). In realist terms, the community programme could be a salutogenic resource enabling client recovery mechanisms to '*fire*'. In conjunction with my '*big picture*' impression of TSA at Salvation Army events (s.3.4 and s.4.4.3.1), these points support adoption of salutogenesis as the overarching review theory. Using a realist approach and focusing on people with PAU and cognitive impairment, the review aim becomes:

Realist review aim

To establish from literature and grey sources about Salvation Army community programmes, evidence of contexts, mechanisms and outcomes which enable salutogenic programme theory development of *what works, for which people with PAU and cognitive impairment accessing such programmes, in what circumstances, how and why*.

4.3.2 Identification of the review questions

Consideration of the realist review questions centres on the realist review aim, the research aim and questions (s.3.2.2.1), and TSA's aspirations of the research project to '*both address key gaps in scientific knowledge and provide useful outcomes to help the Salvation Army further develop their services*' (Appendix 1 PhD Advertisement 2013). The services referred to were community services for people with PAU and cognitive impairment. In the document, '*Time for Recovery*', an identified outcome for research and development was establishing '*what works and why?*' (Scotland Drug and Alcohol Strategy Task Group 2011). Three questions are now incorporated into the realist literature review, which also provides an opportunity to confirm, refine, refute and build on the candidate programme theories developed in Chapter 3, *CPT1: a life more fulfilled* (s.3.2.2.3)*, CPT2: holistic, salutogenic approaches* (s.3.2.2.3) and *CPT3: ARBD meaning and understanding* (s.3.4.4)*.*

Realist review questions

What are the contextual factors that enable mechanisms to '*fire'* to produce outcomes viewed as successful?

In what way do the realist review findings confirm, refine or refute *CPT1: a life more fulfilled* (s.3.2.2.3), *CPT2: holistic, salutogenic approaches* (s.3.2.2.3) and *CPT3: ARBD meaning and understanding* (s.3.4.4)?

What might other '*programme theories*' of Salvation Army community programme interventions to support of people with PAU and cognitive impairment be?

4.3.3 Development and articulation of key theories to be explored

Realist approaches involve retroductive thinking and thinking again. This enables articulation of which theories inspired by evidence or to explain evidence are to be explored in the realist inspired review and subsequent evaluation. It is recognised that not all may be identified and that they can change over time. Thus although *CPT1: a life more fulfilled* (s.3.2.2.3)*, CPT2: holistic, salutogenic approaches* (s.3.2.2.3) and *CPT3: ARBD meaning and understanding* (s.3.4.4), they may not be correct or dig deep enough into the intervention detail. More thought is required about TSA intervention context and resources known about at the research outset to enable focusing on relevant literature.

The textbook '*The Treatment of Drinking Problems. A Guide to the Helping Professions*' (Marshall et al. 2010, pp. 180-235) contains three consecutive chapters entitled, '*The basic work of treatment*', '*Specialist treatment*' and '*Alcoholics Anonymous and other mutual-help organizations*'. At the time of research, the intervention implementation was at early stages thus could not yet be in the '*specialist'* category. Nor was TSA a mutual-help organisation. Thus the most appropriate focus was '*the basic work of treatment*' or the '*helping*' process which includes factors relating to relationships, motivation, working with '*the patient*', the therapeutic work, the '*carrots*' associated with recovery, dealing positively with relapse, the use of therapeutic groups, scheduling of appointments, and duration and termination of treatment (Marshall et al. 2010, pp. 180-196). As '*treatment*' is a term readily associated with medical models, the option of '*the helping process*' appears more applicable.

A benefit of realist review processes is that sources other than traditional research literature sources can be used to develop theories. In this instance, opportunities arose through participation in a Salvation Army UK training event and at the launch day for the new Drug and Alcohol Strategy (Personal notes). The training event was for people working in Salvation Army community homelessness and addiction services, with speakers from different parts of the UK and the world. Sharing of experiences by people affected by PAU and drug use and those providing services provided opportunities for reflection at individual, local team and organisational levels in styles consistent with salutogenic thinking.

At the event, although this terminology was not used, comprehensibility, meaningfulness and manageability were explored in different ways involving thought about contexts, outcomes and mechanisms. There was a recurrent theme of '*bridging the gap*'. TSA was depicted as a bridge helping people move from difficult to more fulfilling times in their lives. This was supplemented by personal accounts of PAU and drug use experience. However, using realist thinking, it is apparent TSA is not the bridge, instead of importance are the mechanisms occurring in people in response to resources made available to them. It could be argued that these resources strengthen the individuals' pillars supporting the bridge walkway which they are then able to cross. This thinking supports *CPT2: holistic, salutogenic approaches* (s.3.2.2.3).

However, this does not offer the answer about why different outcomes arise, for whom and in what circumstances and with what help or resources. Further consideration offers the theory that in the fieldsite context, the DASW intervention may support salutogenic orientated mechanisms in people with PAU to '*fire*' resulting in a shift from the PAU dis-ease to recovery ease end of the health continuum. However, fieldsites incorporate other people and resources that may be contributing to recovery mechanisms firing. There is thus a need to search through literature and other existing evidence to identify other potential contributing factors.

4.3.4 Reflection on the scope of the review

So far in the theory building process to support the realist review, specific areas have been identified related to *'basic work in the helping process*', '*bridging the gap*', and the CRA, and the possibility that fieldsite impacts may be due to different resources, of which the DASWs are one. These have potential to be related to an overarching theory of salutogenesis which, building on *CPT2: holistic, salutogenic approaches* (s.3.2.2.3) becomes the main theory for exploration in this realist inspired review. The different components just described are presented in *CPT4* below.

CPT4: a helping organisation

> If The Salvation Army community programme uses salutogenic approaches in '*basic work in the helping process'*, then people with PAU and cognitive impairment achieve salutogenic outcomes because the resources accessed enable them to '*bridge the gap*' over periods of difficulty in their lives.

4.4 Searching for and appraising the evidence: what the data reveals

The search involves database and grey literature sources which are looked at separately.

4.4.1 Database searches and findings

A database search, as recorded in *Table 3* below, was undertaken to establish research evidence on approaches described by authors as salutogenic to supporting people with PAU towards recovery. Using the search term '*salutogen**' as opposed to

'*salutogenesis*' significantly increased the number of publications identified from 1720 to 4383. The search dates provided are the final dates on which they were undertaken.

Search terms: salutogen* AND alcohol* AND 'recovery OR rehabilitation'. Limit to English language.

Table 3 Realist review database search history

Database – all fields used	**Scopus**	**ASSIA**	**Web of Science**	**Zetoc**	**Stirgate**
Date	2017/06/06	2017/06/11	2017/06/11	2017/06/11	2017/06/14
Returned result years	1992-2017	1989-2017	1984-2017	1993-2017	1792-2017
Search terms and results: 'Salutogen*' AND 'Alcohol*' AND ('Recovery' OR 'Rehabilitation')	 4383 507 205	 382 67 32	 1004 22 3	 449 4 0	 12521 180 9
Limit to: English language	 186	 31	 3	 -	 4
Exclude: No abstract Title/Abstract not topic specific	 14 143	 1 22	 - 2	 - -	 3
Full paper review: Exclude – not topic specific Include	 18 11	 4 4	 1	 - 0	 1 0
Papers added following bibliography scoping	7		0	0	0

Database searches were undertaken at the widest levels, that is, '*All fields*' whenever possible. Twenty-three papers were ultimately included, seven of which following bibliography scoping. None included the term, '*The Salvation Army*'. Publications were excluded if there was no abstract or if they did not relate to the research topic. Important inclusion criteria related to alcohol, recovery or rehabilitation and perspectives on what the authors viewed as salutogenic. Some papers did not adhere to these specific criteria but due to their content offered information of potential relevance to alcohol and recovery in TSA context. Exclusions included research about children and adolescents, specific health conditions such as heart disease or cancer, and in the main part settings unlike that of the research including hospitals and prisons. Key findings on salutogenic aspects to recovery from PAU from the searches

above are now discussed. Grey literature processes and findings are presented in section s.4.3.3.

4.4.2 Salutogenesis and recovery from problematic alcohol use

In 1994, Mason recommended using salutogenesis as an organising structure for addictions nursing (Mason 1994). The context was a specialist outpatient clinic which adopted an approach based on salutogenic thinking for clients. The account emphasised staff perspectives and reflected on one client case study. A mechanism of staff reasoning was needed to enable a shift from a former disease to a health focus. This enabled recognition of the psychosocial impacts of '*alcoholism*' and that people did not present in clear cut manners of being '*sick*' or '*well*' (Mason 1994). When staff gained understanding (or comprehensibility) about individualised factors that helped clients move towards the health end of the dis-ease ease continuum, they were better able to help clients use their own resources. These were described as material, knowledge, self-identity, coping strategies, social supports, commitment, religion or life philosophy and preventative health orientation. From a realist perspective, depending on an individual's experiences, resource presence or deficiency may have been part of their context or alternatively mechanisms in addressing (or not) a stressor. The staff resource of access to tools to support discussions was viewed helpful in providing clients with comprehensive, holistic, individually unique support (Mason 1994).

Mason continued this theme in writing about salutogenic approaches to support for people with alcohol addiction in a specialised clinic using what was called solution based techniques (Mason et al. 1995). Staff recognised that fixed term regimented and standardised interventions with requirements for longer term involvement in AA resulted in some clients choosing not to engage. The clients were then labelled as '*treatment resistant*' and adversarial relationships developed between staff and clients. The account demonstrates how resources and reasoning (mechanisms) about the resources used by clients in different contexts led to different outcomes.

An important outcome was the recognition by staff of the need to change the way the service was operating (Mason et al. 1995). They recognised benefits of brief interventions, which for some clients resulted in recovery with little service input, and

wider resources availability beyond 12 step approaches. The salutogenic context staff aimed for involved partnership and facilitative approaches. Clients were encouraged to choose what they wished to do, for example reduce or stop alcohol consumption, and supported in using resources available to them to develop solutions to tensions and stressors they faced. Staff expectations of clients not to drink on clinic days was described as for safety reasons as most drove cars.

The approach was optimistic as opposed to adversarial, with a focus on strengths, resources and abilities to promote health. Clients set goals, received contextually tailored compliments (including about small accomplishments), were less likely to drop out, experienced optimism, empowerment and felt better when leaving the clinic (Mason et al. 1995). The descriptions were similar to the case study in the previous paper (Mason 1994) about a man who had experienced PAU, his own violence towards his partner and time spent in prison. Small achievements about tension management were recognised along with positive links to quality of life, motivation for further change and acceptance of own responsibility for change. It was important that goals were manageable and meaningful, with positive outcomes associated with increased self-confidence.

These papers are supported from both a realist and salutogenic perspective by research findings about alcohol brief interventions in an acute hospital setting (McQueen et al. 2017). Although the research setting was not comparable to TSA, it was included because it used realist underpinning and because of the increasing evidence of benefits from alcohol brief interventions (s.1.8.3 and s.1.12). It provided a source of contexts, mechanisms and outcomes identifiable in the findings from interviews from 10 people who had participated in alcohol brief interventions and who had subsequently reduced their alcohol consumption.

The outcomes for all included reduced alcohol intake (McQueen et al. 2017). One participant's context included a bereavement and lack of understanding by others about his use of alcohol as a coping resource. He judgementally viewed himself as weak, and though recognised alcohol's negative impact on his relationships, continued to do drink. The acute hospital admission for him and others affected by emotional and psychological pain offered a context in which resources of time and someone to

talk to were available. Resources and mechanisms included place and space where people could see, and for some fear, the physical impact alcohol was having on their health and those of other people, and reflection on the impact they saw of their alcohol related issues on others. Opportunities in alcohol brief interventions gave people '*permission*' to review their alcohol habits and undertake social and psychological cost-benefit analysis, supporting enhancement of motivation for change (McQueen et al. 2017).

Positive feedback was a motivation to initiate and sustain change. A mechanism for sustaining change was planning ahead for a structured future with less alcohol and potentially employment. However, there was recognition of the fragility of recovery (McQueen et al. 2017) with concerns expressed about those who were more socially isolated without past alcohol related companions who did not necessarily support their abstinence. Coping strategies included salutogenic thinking about comprehensibility, meaningfulness and manageability, reflected in one individual's strategy of telling himself to "*give it 24 hours*" when facing a stressor to which he would normally have turned to alcohol to help him manage (McQueen et al. 2017). Managing boredom, a risk for alcohol use, was acknowledged as part of a new approach to life:

> *For many of the participants in this study, sustaining the changes they had made appeared to depend on finding something to take the place of alcohol.* (McQueen et al. 2017)

Feigin and Sapir (Feigin and Sapir 2005) studied the relationship between SOC and attribution of responsibility for problems and their solutions, and cessation of substance abuse over time. They mentioned alcohol only in terms of adaptation of an alcohol related tool for purposes of the study and in the context of participants' family history of drugs, alcohol or gambling addiction. However, the research was of interest to the current study and the papers just discussed (Mason 1994; Mason et al. 1995; McQueen et al. 2017) due to its salutogenic orientation. It recommended that attention should be placed more on '*factors of success than those of failure*' with growth in understanding of '*what enables people to cope more effectively with the*

process of recovery from drug addiction and succeed in abstaining from drug use over time' (Feigin and Sapir 2005, p. 72).

SOC as a buffer was found to contribute to coping in the context of stressful stimuli during the recovery process. Short term abstainers had lower and long term abstainers similar SOC compared to levels in the general population. Feigin and Sapir recommended consideration of rehabilitation motivational triggers (Feigin and Sapir 2005), including seeing the impact of others' addiction (in this case family members). Alternatively or in conjunction with that, high SOC was proposed as motivating people to adopt and sustain rehabilitative lifestyles (Feigin and Sapir 2005). Once motivation is developing in people with PAU, some need significant support while others enter recovery naturally without formal help. In these instances it is proposed that in keeping with salutogenesis, both resources (such a social supports) and stressors are important (Bischof et al. 2003).

People may experience concurrent PAU and mental ill-health. People accessing out-patient support for dual diagnosis were asked about their priorities. The response was accessing care that aided them to '*strengthen their own identity as well as find a new intention and stability in everyday life*', this being in keeping with a salutogenic approach and not with perhaps staff anticipated priorities about psychosis and substance misuse (Cruce et al. 2012, p. 667). Themes described by participating clients about recovery-orientated care included entirety, stability, symptom control, mindfulness, dignity, participation, reciprocal relations and autonomy (Cruce et al. 2012). Recovery-orientated care supported client mechanisms of seeing themselves as individuals, being able to choose, reflect on meaningfulness and empowerment. Outcomes were enhanced feelings of hope, self-worth, awareness about spiritual issues, strengthening of self-confidence, reduction in the potential impact of psychological distress, increased motivation and increased capacity to take part in recovery (Cruce et al. 2012).

These findings are in keeping with descriptions of salutogenic recovery from mental ill-health (which included alcohol dependence) which incorporate alleviation of mental ill-health and promotion of positive mental health (Provencher and Keyes 2011). Factors regarded as contributing to complete mental wellbeing were: positive affect,

quality of life, self-acceptance, personal growth, purpose in life, environmental mastery, autonomy, positive relations with others, social acceptance, belief in the potential of people, groups and society to evolve or grow positively, feels useful and valued by others, finds meaningful, comprehensible interest and engagement with others, and feels integrated in society (Provencher and Keyes 2011).

The database search identified a paper about a mental health self-help organisation, *Recovery, Inc.* (Murray 1996). Though the paper focused on general mental ill-health issues as opposed to alcohol related issues, AA was mentioned as a comparable group. *Recovery, Inc.* was a context in which the method:

> *'… intentionally avoids distinctions based on diagnosis and promotes effective coping with the fears, stigma, and everyday stressors common to most people with mental illness, it can help people with a broad range of dysfunctions - if they choose to "walk through the door"'.* (Murray 1996, p. 1379)

Recovery, Inc. aimed to support people towards optimal health with individuals assuming responsibility for their failures or successes. Mechanisms adopted included learning to recognise:

> *'….. self-defeating and illness-promoting thoughts and impulses and counter them with self-endorsing thoughts and wellness-promoting actions'.* (Murray 1996, p. 1378)

The sessions involved formal and informal components in a non-judgemental context, in the presence of peers, with approaches enhancing comprehensibility, meaningfulness and manageability in keeping with salutogenesis. Hearing from others, gaining insight and understanding about life, and sharing successful experiences of health promoting thinking and behaviour, demonstrated that life was comprehensible, meaningful and manageable. Social skills were enhanced, overly clinical speech discouraged, helping others in turn benefitted the helper, and hopelessness was replaced by hope in a new social context (Murray 1996).

Recovery cafés, though in the article focusing on drug dependence, were described as offering a salutogenic place and space to support recovery (Parkin 2016). The cafés were reported to provide informal activities in supportive settings that encouraged building of social networks and occupational skills. People in recovery often had leadership roles. Parkin aligned the findings to Lindström and Eriksson's (2006)

interpretation of the value of salutogenic approaches to health promotion: focusing on a solution based approach; identifying GRRs to assist in moving towards the health end of the disease ease health continuum; and SOC as the integral mechanism within the process of change. Salutogenesis was recommended framework for recovery services and supports (Parkin 2016).

The adoption of a salutogenic approach was in keeping with recommendations to use '*non-stigmatizing and autonomy-supportive language when seeking to 'treat' addicts*' (Johansen et al. 2013b, p. 539). Engagement and communication with clients was recommended to take place in a relaxed, open-minded, empathic context supporting people to create solutions to the difficulties they were facing (Johansen et al. 2013b). The term '*unconditional positive regard*' used in this article came from the work of Carl Rogers:

> *….. an acceptance of this other individual as a separate person, a respect for the other as having worth in his or her own right. It is a basic trust—a belief that this other person is somehow fundamentally trustworthy* (Rogers 1980, p. 271).

Of importance also is psychosocial integration, particularly as views of individuals of themselves and by others can change depending on their relationship with alcohol status (Johansen et al. 2013b). As a result of my interest in the authors' work (Johansen et al. 2013b), I identified a further paper outwith the realist search undertaken which had potential value to the study (Johansen et al. 2013a). Clients with drug addiction issues were asked about their views of support being offered. They responded that supports were ineffective if power imbalances existed between the sponsor and client, or if despite high emotional availability, there was a lack of practical support and goal setting. Clients valued sponsors addressing power imbalances and their own experiences of reaching a stage when they themselves felt of use by being able to assist others (Johansen et al. 2013a). However, while people with PAU experience may benefit others by offering peer support and guidance, they may be vulnerable if unsupported in their roles (Conchar and Repper 2014).

Establishing what was important to individuals was described as shaping supports and not confining them to disease model options, which perhaps aimed solely for abstinence (O'Leary and Kane 1999). In realist terms, the emphasis was the offer of

support that enabled salutogenic mechanisms to fire with an accompanying shift to the holistic health end of the dis-ease/ease continuum. Though not focusing on the support of people with PAU, a paper endeavoured to examine links with blood markers, salutogenic effects of social support, and income (Vitaliano et al. 2001). Pertinent to this research was that emotional supports were salutogenic for people with low as opposed to higher incomes. People with lower incomes, which would be anticipated to be in keeping with those accessing TSA community programmes, '*may derive benefits from social supports that go beyond tangible assistance*' such as food or physical resources (Vitaliano et al. 2001).

Biederman and Forlan wrote about women affected by homelessness (Biederman and Forlan 2016). This group are known to be at greater risk than other women of higher alcohol use and substance misuse to '*mitigate sadness, loneliness and anger and to create a feeling of normality in the midst of their life experiences*' (3137 Patterson, M.L. 2015a; Biederman and Forlan 2016, p. 196). The women identified that of importance to their future was resolving homeless situations and being '*connected, significant, independent, safe and fulfilled*' (Biederman and Forlan 2016, p. 198). In terms of the homelessness service being accessed, connectedness and significance came about because of welcoming staff, provision of resources to meet basic needs, and gaining purpose such as having opportunities to '*give back*' through volunteering. Being safe and fulfilled involved ideas of having their own house and having a '*normal life*' like paying rent, having a dog or looking the same as everyone else (Biederman and Forlan 2016, p. 199).

A paper identified in the search because '*salutogenesis'* was in the reference list and '*alcohol'* in the text with regard to spirituality and alcohol abuse, asked the question, '*Does religion cause health?*' (Oman and Thoresen 2002). The paper was relevant to this research in its discussions about mechanisms which included, '*well established factors such as social support and improved health behaviors*' and '*enhanced positive psychological states (e.g. faith, hope, inner peace) acting through'* psychobiological pathways (Oman and Thoresen 2002, p. 365). Questions were asked about religion '*offering psychological strength for acquiring or maintaining positive health behaviors*' and '*causally influencing health by distant healing or intercessory prayer*' (Oman and

Thoresen 2002, p. 365). Park (2007) hypothesised about numerous pathways or mechanisms linking religiousness and spiritualty to health, with mention included of alcohol consumption and abuse in the context of health problems. These included: beliefs, motives and goals; meaning in life, social support, body sanctification, health locus of control, gratitude, hope, optimism and compassion; health behaviours and lifestyle; and positive and negative affect and stress.

Following a literature trail from reference lists (Oman and Thoresen 2002; Park 2007) resulted in a return to Miller (2016).Religiousness was reported to predict lower risk of current and future substance use disorders and spiritual changes linked with recovery from addiction (Miller 2016). However, Miller also referred to an earlier study which demonstrated that spiritual direction in a recovery programme was not found to increase spiritual measure scores or be associated with reduced substance use. The priority to participants was meeting basic needs of food, housing and safety (Miller et al. 2008).

At this juncture, it is recognised that few relevant papers were identified and found to be of suitable relevance to the research topic. However, they did convey evidence of salutogenic approaches offering benefits to people with PAU. There was evidence also of the relevance of contexts, mechanisms and outcomes. This included the finding through reading Johansen and colleagues work (Johansen et al. 2013a), a review paper on a mechanism of social network and support in the effectiveness of AA (Groh et al. 2008). The authors stated that involvement in AA resulted in people having more positive friendship resources and larger social networks including others in recovery offering recovery support for abstinence (Groh 2008). It was argued that people with harmful social networks supportive of drinking benefitted the most from AA involvement (Groh et al. 2008).

However, other research hypothesising that increases in abstinence-based social networks would be explained by the association between having a sponsor and increased abstinence (Rynes and Tonigan 2012) challenged the findings. The results showed that having a sponsor early in 12-step recovery predicted duration of abstinence from alcohol. However, predictions related to sponsorship and changes in the abstinence-based social network or of abstinence-based social network and

abstinence from alcohol did not occur. Furthermore a link between early sponsorship and later abstinent days was not facilitated by changes in the abstinence-based social network (Rynes and Tonigan 2012). Two explanations were proposed about the early benefits of improved drinking outcomes in those in receipt of sponsorship in 12-step organisations: the scope for a close, supportive, trusting, mentoring relationship and increased motivation and engagement in supports offered and 12-step principles in those with sponsors (Rynes and Tonigan 2012). A further consideration in AA (and in TSA) is the role of prayer. This was found to reduce self-reported craving, and using brain scanning, with concomitant engagement of parts of the brain (through neural mechanisms) linked with control of attention and emotion (Galanter et al. 2017). In realist terms, this provides opportunities for further thinking and research about what is working, for whom, in what circumstances and why amongst people accessing AA and other 12-step programmes.

Detail has now emerged of potential aspects relevant to the candidate programme theories about TSA community programme and how and why it might work for whom and in what circumstances. Resources included practical support, equitable and non-judgemental relationships, place and space, peer support and flow to a position of being able to help others, acceptance and trust. Furthermore, depending on context, for some the resources may be outcomes or mechanisms.

4.4.2.1 Limitations of database search and findings outcomes with actions then taken

A limitation was that none of the articles found discussed ARBD. As result I undertook database searches (Scopus, ASSIA, Web of Science (includes Medline and Embase), Zetoc and Stirgate on 13 05 2017) using the search terms '*Community Reinforcement Approach*' and '*alcohol-related brain damage OR alcohol-related brain injury*' revealed no results relevant to the current study when additional search terms of '*Salvation Army*', '*salutogen**', '*sense of coherence*' or '*generali* resistance resource**' were included.

Further searches on 05 08 2017 returned one ASSIA result for '*Community Reinforcement Approach*' AND '*Salvation Army*'. This related primarily to community

participation and mental health in people prior to their entry into a treatment programmes for alcohol or other substance addictions (McGaffin et al. 2017). The results demonstrated that informal social connectedness and civic engagement were significant predictors of mental health status. The results were perceived as being in keeping with community participation approaches such as the CRA. The authors viewed TSA as suitably positioned to support development in participants' social networks and civic engagement through spiritual connections or volunteering. As part of the support, hope was described as being offered to people who did not believe that recovery was possible (McGaffin et al. 2017). Importantly for this research, McGaffin, Deane and Kelly identified TSA as a context where social connectedness, civil engagement, volunteering and spiritual connections had a role to play. This is a further situation in which these components could for different people be part of their contexts, GRR and SOC, mechanisms or outcomes.

4.4.2.1.1 Reflection on database search findings

The realist review to this point has confirmed the potential applicability of *CPT1: a life more fulfilled* (s.3.2.2.3), *CPT2: holistic, salutogenic approaches* (s.3.2.2.3) and *CPT4: a helping organisation* (s.4.3.4), though testing using participant data is needed to confirm this in the fieldsite settings. Resources identified in literature contributing to study participants' desired salutogenic outcomes were to meet basic needs, and to support futures incorporating hope, purpose and meaning, experience of being welcomed and valued by others, and an opportunity to '*give back*' through peer support. From the many choices of words used by participants and authors of papers, there can be focusing down to access to appropriate GRR and individuals' experiencing meaningfulness, manageability and comprehensibility in their lives. In that context, new CPTs are not presently indicated.

4.4.3 Grey literature findings: The Salvation Army

Grey literature is a recognised information source for realist reviews (Wong et al. 2013). Grey literature findings are presented here separately to the database founded review above as grey literature has been accessed iteratively throughout the research.

The wide-ranging style of literature [6] is important because TSA does not routinely report or publish findings in peer-reviewed journals. Grey literature includes speeches, presentations, and information on websites (Adams et al. 2016).

Grey literature found in each thesis chapter to this point is now added to and not re-iterated. The grey literature used incorporates: governmental publications, email communications, personal notes taken at presentations and Salvation Army events, books, meeting minutes, TSO publications including on websites, and videos on the internet. In 2015, I undertook internet searches combining search terms of *'salutogenesis'* and '*alcohol-related brain damage/injury*' which gave no results. The same was true of *'salutogenesis'* or '*alcohol-related brain damage/injury*' in combination with '*Salvation Army*' or '*Community Reinforcement Approach'*.

Realist synthesis incorporates use of literature which is relevant, of rigour and offers benefit to the research. The searches demonstrated a dearth of information about salutogenesis in combination with ARBD, TSA and the CRA. The grey literature and accompanying findings now presented offer valuable contributions to the realist review. They are categorised as '*Salvation Army events*', '*The Salvation Army and the Community Reinforcement Approach*', '*Videos and presentations*' and '*Third Sector Organisation grey literature*'. Whenever appropriate to do so and in keeping with realist review and evaluation, preceding CPTs will be confirmed, refined or refuted, and new programme theories developed.

4.4.3.1 Salvation Army events

Attendance at Salvation Army events, listed in *Table 4* below, was an immense source of information and insight which shaped my thinking and direction of the research.

[6] Types and formats of grey literature: bibliographies, discussion papers, newsletters, PowerPoint presentations, program evaluation reports, technical notes, governmental agencies publications, reports to funding agencies, unpublished reports, dissertations, policy documents, webinars, rejected manuscripts, un-submitted manuscripts, conference abstracts, book chapters, personal correspondence, newsletters, informal communications, census data, pre-prints, standards, patents, reports on websites, publications from NGOs and consulting firms, videos, Wiki articles, emails, blogs and social media, data sets, committee reports, working papers, company reports, catalogues and speeches (Adams et al. 2016).

Table 4 Salvation Army events attended during research

Event	Date	Description	Location
1	2013, July	Launch event of TSA's Drug and Alcohol Strategy in Scotland	Stirling
2	2014, March	United Kingdom and Republic of Ireland Social Services Conference. Key theme discussed: '*bridging the gap*'	Swanwick
3	2014, March	All Scotland Community Information Day: various topics including the Scotland Drug and Alcohol Strategy, ARBD and nutrition	Perth
4	2015, May	All Scotland Community Information Day: *What Would The Founder Say?*	Falkirk

4.4.3.1.1 Event 1 Launch event of The Salvation Army's Drug and Alcohol Strategy in Scotland

In keeping with *CPT1: a life more fulfilled* (s.3.2.2.3) at Event 1, it was revealed the new Drug and Alcohol Strategy aimed to support people with PAU and drug use in community rather than residential settings using principles of the CRA (Meyers et al. 2013). The invitation included context details and hoped for outcomes at fieldsites where the DASWs worked: '*Salvation Army premises already tackling social problems in deprived communities blighted by alcohol abuse*' (Dixon 2013). The desired intervention context was one in which Salvation Army founding principles were retained and which enabled partnership working, with emphasis on with other agencies.

Expectations were that addressing a resource gap through DASWs' appointments would allow the community programme to develop and increase the practical support offered to help-seekers. The invitation wording choices are noteworthy: '*alongside those in need*' suggests a supportive rather than paternalistic approach; '*ministering*' holds religious connotations but can be interpreted as attending to others' needs; and '*marginalised*' raises queries about who the people are that the community programme was designed for and their contexts, mechanisms and outcomes. Key points from the invitation and '*Time for Recovery*' (Scotland Drug and Alcohol Strategy Task Group 2011) are now drawn together to hypothesise *CPT5: Booth's footsteps and partnership working*:

CPT5: Booth's footsteps and partnership working

If DASW are appointed to the community programmes then the programme will:

- be able to continue working and ministering as William Booth did
- alongside those in need - the marginalised of many communities.
- but in a more modern way in partnerships with other agencies

because the extra capacity brought by the DASW will enhance the community programme work and the practical support offered.

4.4.3.1.2 Event 2 United Kingdom and Republic of Ireland Social Services Conference

In writing about salutogenesis, Antonovsky referred to the river of life, and risks, experiences and influences found when swimming in it (Antonovsky 1996). At the 2014 Social Services conference (The Salvation Army UK and the Republic of Ireland 2014b), Salvation Army resources were described as '*bridging the gap*' for people experiencing difficulties in their lives. The resources aimed at bridging the gap over what in the salutogenic metaphor are potential difficulties and dangers in the river till individuals reached times of greater wellbeing. Such an experience was described by a Salvation Army member of staff at the event (personal notes). When young, he began misusing drugs and alcohol to the extent he dropped out and "*lost twenty years of my life*". He said with Salvation Army support he entered recovery, began volunteering then was employed in a drug rehabilitation programme. He had purpose and meaning in his life and felt, and was, valued by those with whom he worked. His account was not of sudden transformation but small steps, set-backs and ultimately life which without drugs and alcohol was better than one in which they were present.

Although salutogenesis was not mentioned, the presentations and personal story offered were in keeping with an initial programme theory incorporating SOC and GRRs. Furthermore, in light of the staff member's transformative account above, it is viewed appropriate to incorporate the idea of scope for cognitive improvement in the '*Time for Recovery*' intervention (Scotland Drug and Alcohol Strategy Task Group 2011). *CPT6: salutogenic cognitive benefits* now hypothesised reflects on those reaching and sustaining recovery, and others whose lives are positively impacted by the resources accessed and their responses to them.

CPT6: salutogenic cognitive benefits

If the community programme is offered to people with PAU and drug use then they will:

- be more likely to enter or sustain recovery
- be less likely in the case of PAU to develop ARBD
- when ARBD already exists, have greater opportunities for cognitive improvement

because they will:

- develop greater GRRs
- experience an increased SOC
- find life to more fulfilled without rather than with substance misuse
- have opportunities for improvements in brain function

For this to hold true, and in light of the staff member's account, it is hypothesised that the fieldsite workplace would promote comprehensibility, manageability and meaningfulness or SOC in those working there. To enable this to happen, staff and volunteers would require access to GRRs. In keeping with this, *CPT7: a salutogenic workplace* is hypothesised:

CPT7: a salutogenic workplace

If the community programme is a salutogenic workplace, then those working there will be able to fulfil '*Time for Recovery*' (Scotland Drug and Alcohol Strategy Task Group 2011) expectations because the organisation ensures staff and volunteers:

- are involved and collaborate with others
- have access to GRRs (personal, social and environmental)
- have comprehensible, manageable and meaningful (coherent) working experiences
- are encouraged to develop and use their capacities

4.4.3.1.3 Event 3 All Scotland Community Information Day: Scotland Drug and Alcohol Strategy, ARBD, nutrition and other topics

Salvation Army awareness of ARBD was reflected in '*Time for Recovery*' (Scotland Drug and Alcohol Strategy Task Group 2011) through recognition of the association between PAU and nutritional deficiencies:

> *Nutritional deficiencies can have severe and permanent effects on brain function. Specifically, thiamine deficiencies, often seen in alcoholics, can cause severe neurological problems such as impaired movement and memory.* (Scotland Drug and Alcohol Strategy Task Group 2011, p. 49)

A dietician colleague (Alison Molyneux, NHS Greater Glasgow and Clyde) and I presented at Event 3 about ARBD and nutrition. An informal questionnaire circulated

by Alison prior to her presentation demonstrated marked Salvation Army staff basic knowledge gaps about nutrition. While the presentations addressed these topics, as nutrition was not the focus of this research, a recommendation in Chapter 8 is that research be undertaken in this field. The suggested focus would be on formally identifying staff knowledge gaps particularly about recognising and meeting the nutritional needs of people accessing community programmes. However, a barrier to this might be people not wishing healthy options.

4.4.3.1.4 Event 4 All Scotland Community Information Day: What Would The Founder Say?

This event (The Salvation Army UK and the Republic of Ireland 2015) contained presentations and discussion about Integrated Mission, which referred to different parts of TSA working together rather than separately (The Salvation Army 2015). This included the Floating Support Service and adjacent community programme and DASW. The account is drawn from my personal notes from the event.

At Event 4, during a presentation and discussion about the author Morisy's work (1997 and 2009), a theme emerged about engaging with people feeling overwhelmed by different stressors through '*micro-actions*' (Morisy 2009, p. 26). This is a term not readily found in literature though examples are found in education (Kim 2014). Micro-actions were described as including small acts of generosity, communication and hospitality. Outcomes of relationships, connections, neighbourhood and flow were described, the relating to being spurred to be creative in approaches.. An illustration of successful micro-actions was provided by a Salvationist in the following account:

> *A man arrived at a Salvation Army community programme in a deprived area of the city. He was welcomed and offered a meal. He sat, ate and left without speaking. This continued for a year, till one day when finished eating, he said to a member of staff, "*That was a good meal*" and left. (From personal notes based on an account given by a Salvation Army member of staff)*

In the account, Salvation Army staff and volunteers demonstrated micro-actions of repeated, non-judgemental welcome with an accompanying meal provision and no expectations of the man. The message shared was about how Salvationists should act in a love founded approach towards someone in need. Their view of love came from a Christian stance of loving neighbours as yourself (Mark 12:30-31, Bible, New International Version).

At Event 4, the Salvationists spoke of their lives including in the workplace as '*Belief in action*'. Their manner was not proselytising. They saw their role in people coming to faith as demonstrating personal Christian faith through their lives and prayer. To love others and "*See them through the eyes of Christ*" was crucial despite not necessarily liking the life choices people might make. They wished using positive, '*soft eyes*' conveying lack of fear, to build trusting relationships.

Participants stated that PAU and drug use "*can happen to anybody*" and that knowledge of others' lives is only partial. They believed the first interaction with someone who might need support was crucial. An initial response from someone to, "*How are you?*" might be "*Fine*" but with a sense of feeling valued, time and trusting relationships their experience was that clients were more able to open up and access help they needed. However, some Event 4 participants said they did not see themselves and the resources they had access to as necessarily the supports people needed. They recommended prayer and waiting to see the outcome of, "*who God sends into their life*".

Without using the terms, participants demonstrated salutogenic attitudes towards others and their own SOC and access to GRRs. A personal resource impacting on their workplace SOC was their relationship with God and the role of Integrated Mission in TSA (The Salvation Army 2015):

> *We are taking micro-actions, as you are doing so, being connected to the mission of God.*
>
> *Join in the mission of God to create connectivity and flow. (Both quotes taken from personal notes at Event 4)*

For those present, *CPT7: a salutogenic workplace* (s.4.4.3.1.2) was confirmed.

4.4.3.1.5 Reflection on Salvation Army events

My overwhelming experience was one of welcome and gratitude to those who had invited me. More importantly, from a realist evaluation perspective, it created iterative and retroductive thinking opportunities. Event 4 approximately coincided with completion of the focus groups and interviews which were yet to be transcribed and analysed. Using explanation and understanding drawn from it and using personal notes from Event 4, refinement of *CPT4:* a *helping organisation* (s.4.3.4) is undertaken:

If TSA community programme, in which many staff base their SOC on spiritual beliefs, offers micro-action resource provision in its '*basic work in the helping process'*, then people with PAU and cognitive impairment will achieve micro then sustained outcomes as they '*bridge the gap*' over difficult periods in their lives.

In total, seven CPTs have now been developed and confirmation and refinement are underway. These will continue to be considered with the remaining grey literature.

4.4.3.1.5.1 The Salvation Army and the Community Reinforcement Approach

A Google Scholar alert (2016) highlighted a document about Community Reinforcement Approach by TSA in New Zealand (Patterson et al. 2015b). TSA appointed a research team to evaluate '*The Bridge Programme's Model of Treatment*' which incorporated residential and community approaches to supporting people with PAU or drug use (Patterson et al. 2015b). The programme was based on four components described as '*Partnership, Community Reinforcement Approach, the 12 Step Recovery Journey, and The Salvation Army aspect*' (Patterson et al. 2015b). The report stated that completion of an at minimum, four week intervention was associated with: reduced or discontinued harmful substance use; improved real-world functional outcomes related to health, social and vocational functioning, quality of life, activity increase, and decrease in criminal offending; and impacted on changeable personal factors related to good treatment outcome including increased motivation for treatment, self-efficacy and internal locus of control (Patterson et al. 2015b).

'*The Bridge Programme*' intervention involved: building motivation; relationship counselling with family and/or close friends; group sessions and activities; Alcoholics or Narcotics Anonymous meetings; Recovery Church[7]; health assessment and access to health care professionals; and follow up plans. Each participant had an Individual counsellor who coordinated supports. This person was described as someone who would adopt '*the role of partner, advocate, negotiator, listener, teacher, advisor, and/or cultural support, and facilitates a personal treatment plan*' (Patterson et al.

[7] The description of Recovery Church is from The Salvation Army New Zealand, Fiji & Tonga Territory: '*The emphasis at Recovery Church is on honesty and acceptance. The only requirement is that people are 'clean and sober on the day'. Doubts and questions are welcomed. People can hold alternative beliefs, or no beliefs. The Recovery Church motto is: 'A place to belong, before you believe.''* (The Salvation Army New Zealand, Fiji & Tonga Territory 2018)

2015b). This support and treatment planning provided flexible and individualised opportunities for sobriety sampling, functional analysis, positive reinforcement, behavioural rehearsal, and involvement of significant others (Patterson et al. 2015b).

4.4.3.1.5.2 Videos and online presentations

Videos can be a valuable information source, including of former Chief Medical Officer Sir Harry Burns, introducing salutogenesis and its Scottish relevance (Burns 25 July 2014). It refers to impacts of deprivation, alienation, lack of work, chaotic lives and lack of purpose and in contrast benefits of experiencing a life that is comprehensible, meaningful and manageable. He supported salutogenic, without use of the terms, micro-actions which can have cumulative holistic micro-outcome health benefits. He emphasised through quoting words of others, the salutogenic impact of small, kind gestures, particularly to those with complex lives (Burns 19 November 2015).

A valuable information source for this research was a Salvation Army video '*Greenock Drug and Alcohol Work - The Salvation Army*' (2013). The output from its review from a realist stance was core to a book chapter on use of realist approaches in TSOs (Hannah 2018). A chapter section is presented below. To distinguish it from the main thesis text, it is in Times New Roman font. It is included because it incorporates use of realist evaluation approaches, with salutogenic recovery outcomes demonstrated of in two Salvation Army clients:

> *"Things are going quite nicely for me at the moment ..... I've got no major hiccoughs in my life that are going to make me want to go back to drink." (Chris)*

They describe transformation in their lives through engagement with the Salvation Army community programme and Floating Support Service. Willy described aspects of his past life and experiences (context), his current situation (outcomes) and what has enabled the changes to occur (mechanisms). A synopsis configuration of rippling context-mechanisms-outcomes (CMOs) is portrayed below:

Table 5 Willy's context, mechanisms and outcomes

Willy's context	Mechanisms	Outcomes
Traumatic childhood Self-harmed and attempted suicide Problematic drug and alcohol use from young age Lacked confidence Unable to face other people, get involved in groups or work with others Past help from other agencies	Resources: supports from community programme and Floating Support Service Reasoning: supported by people he could trust and rely on Inclusion: opportunity and support to work in café Positive experiential reasoning: increased confidence associated with working in café, and increased confidence made him feel more able to interact with other.	Alcohol and drug free Self-esteem increased: A lot of confidence Employment: Working in cafe Relationships: Able to work with other people and participate in groups Belonging: Feeling of being in a family Trust: Someone to rely on, day in day out, no matter what

Trust, self-esteem, feelings of belonging, purpose, fulfilment and knowing reliable people to turn to at any time of need were instrumental to the outcomes here and incentifying ongoing engagement. They contributed to enhancement of Willy's sense of coherence and generalised resistance resources (Antonovsky 1996). Willy and Chris both spoke of having reached a time in life when life without alcohol was much better than with it.

Table 6 Chris's context, mechanisms and outcomes

Chris's context	*Mechanisms*	*Outcomes*
Traumatic personal events Developed problematic alcohol use Broken family relationships Unemployed Poor health Did not like leaving house	Resources: Salvation Army community programme and Floating Support Service Reasoning: free support available Responding to incentives: opportunities provided were things he wanted to get involved in. He chose to leave the house to take part.	Alcohol free Relationships: Re-establishing family relationships Social capital: Went out of house for positive purposes Education: Undertook college courses Employment: Hoping to return to work Optimism: Life's good - nothing to make him want to go back to drink

The culmination for Chris was moving from a complex time in life (context) to one with optimism for the future based on positive experiences (outcome) through choosing to access and engage with freely available, accessible resources (mechanism). (The Salvation Army UK with the Republic of Ireland 2013)

The video provides contextual information about the community programme, confirming descriptions of Fieldsite-B (s.3.4.1) and showing it is not set in an affluent area. The building has a large informal '*Welcome*' sign. Christian beliefs are

demonstrated through the Drug and Alcohol Support Worker's words and a biblical quotation on a whiteboard:

> *We do not lose heart…. our spirits are being renewed 2 Corinthians 4:16*

Chris and Willy have accessed supports elsewhere, but it is the connection and help from the community programme that has made the difference. The frustration that others are not accessing the same resource is clear, though the need to be "*ready*" is recognised (The Salvation Army UK with the Republic of Ireland 2013). The DASW spoke of measuring success, though not in terms of an assessment tool:

> *How do I measure success? By seeing a change in a life. By seeing someone unloved, uncared for to becoming someone who is more confident in themselves, who is able to make friendships and make relationships. (Lesley)* (The Salvation Army UK with the Republic of Ireland 2013)

This connected to a quotation identified for this research, referred to in *Figure 10 CPT11: the right track* (s.6.3):

> *Something that provided a person with a set of life experiences involving feedback, sending messages like: Here is the right track; you can handle things; you are of worth.* (Antonovsky 1990, p. 78)

4.4.3.1.5.3 Reflection on videos and presentations

Videos offer advantage when searching for literature as the physical voices of people who have accessed supports can be heard. Videos also enable specialists to convey their knowledge by spoken as opposed to printed word and tailor this to their target audience. The former can give an appreciation of context not necessarily achievable through printed word, and the latter promote accessibility to complex concepts. An example of the latter was my access of an interview with Frankl (s.2.3) (Frankl 1972). The presentations and videos have confirmed the benefit of realist evaluation and the theory of salutogenesis in this research. They have demonstrated how salutogenic approaches and experiences can support people towards happier, healthier and more fulfilled live, confirming *CPT2: holistic, salutogenic approaches* (s.3.2.2.3).

4.4.3.1.5.4 Third Sector Organisation contributions to grey literature

Alcohol Forum in Ireland has produced publications for professionals and for families about supporting people with ARBD (McMonagle 2015; McMonagle et al. 2015). Of value are descriptions about why people affected by ARBD present as they do in

different situations, which may reflect coping strategies. TSA participated in the Expert Working Group for '*A Fuller Life: Report of the Expert Group on Alcohol Related Brain Damage*' (Cox et al. 2004). This document emphasised the importance of multi-agency working, including with third sector organisations (TSOs). The role of TSOs included acting as the client's advocate, reflecting the contexts of help-seekers. The need of an advocate may indicate a lack of a significant other to support individual's confidence or ability to represent him or herself. Yet clients recognised that staff in the range of sectors supporting them needed access to ARBD training and education. The ARBD recovery process is described (Cox et al. 2004) from perspectives of people with experience of ARBD, or those supporting them, as involving hope and disappointment, positive recognition and exclusion, devotion and heartbreak. While these documents do not change existing or create new CPTs, they reinforce the life complexities experienced by people with ARBD and in turn the resources and responses which many be needed from help-providers.

4.5 Conclusion

This review aimed to establish from literature and grey sources about Salvation Army community programmes, evidence of contexts, mechanisms and outcomes which enable programme theory development of *what works, for which people with PAU and cognitive impairment accessing such programmes, in what circumstances, how and why*. There was very little literature about the combined specific topics being studied.

In realist reviews, reference is made to synthesising evidence prior to drawing conclusions. This chapter has synthesised evidence from traditional research and grey literature sources to continue to build, confirm and refine a total of now seven CPTs. To recap, the CPTs identified relate to: a life more fulfilled; holistic, salutogenic approaches; cognitive benefits and workplace; TSA as a helping organisation, working in partnership with others and following in William Booth's footsteps; and use of terminology. *CPT4: a helping organisation* (s.4.3.4) has been refined to *CPTR1(4): a helping organisation* (s.4.4.3.1.5) which now includes micro-actions. No original CPTs has been refuted, though this is possible as Chapter 5 to 7 explore participant findings.

Many factors and people influence what actually happens when an intervention is implemented (Pawson et al. 2005). In the chapters to follow, the findings will be interesting in part because they have occurred during the implementation. There are thus opportunities for diagnostic elements to the evaluation, diagnostic approaches being in this instance for both intended and unintended outcomes with accompanying exploration of the mechanisms and contexts related to these. An email from Pawson to the RAMESES Group members is relevant at this point:

> *"I've being banging on for a while about the need for 'realist diagnostic evaluation'. Most forms of synthesis, including RS, start with the interventions designed to deal with the problem. It makes more sense ….. to begin with a thorough study of the problem. This is all within the technical scope of RS - basically one is asking for whom, in what circumstances, in what respects and why does the PROBLEM occur. This puts you in a better place to test the programme theories and the effectiveness of the responses."* (Pawson 2017)

This chapter has provided a platform on which the evaluation will follow in Chapters 5 to 7 by beginning to answer the question, '*Within Salvation Army community programme contexts, what works, for which people with PAU and cognitive impairment, in what circumstances, how and why?*'. TSA, Community Reinforcement Approach and other sources have demonstrated the importance of relationships, community, small steps or '*micro-actions'* (Morisy 2009, p. 26) and outcomes, time, comprehensibility, meaningfulness and manageability in addressing PAU. There are indications that the micro-actions and outcomes can have ripple effects in the lives of individuals and those close to them. Outcomes related to coming back for more support, developing trusting relationships, having hope for the future, employment, reduction in legal issues, improved relationships, feeling of belonging and reductions in or cessation of alcohol consumption. Although the literature and evidence in this realist review did not bring ARBD to the fore, it is known when alcohol consumption ceases, that for many people cognitive function improves.

Chapters 5 to 7 will now enable the voices of people accessing and providing support, including those whose experience is that they have *'been there, worn the t-shirt and out the other side'* (Crossley and Gyngell 2012) to be heard. Chapter 5 findings are from an Exploratory Focus Group with the DASWs, Chapter 6 from focus groups and interviews with people accessing and providing help, and Chapter 7 from people who

have in the main part had personal experiences of PAU. This approach will support the transition where appropriate of *candidate* to *evidence-informed programme theories* and determine the value of use of realist evaluation in the complex social community based intervention in this research.

4.6 Chapter 4 theory building synopsis

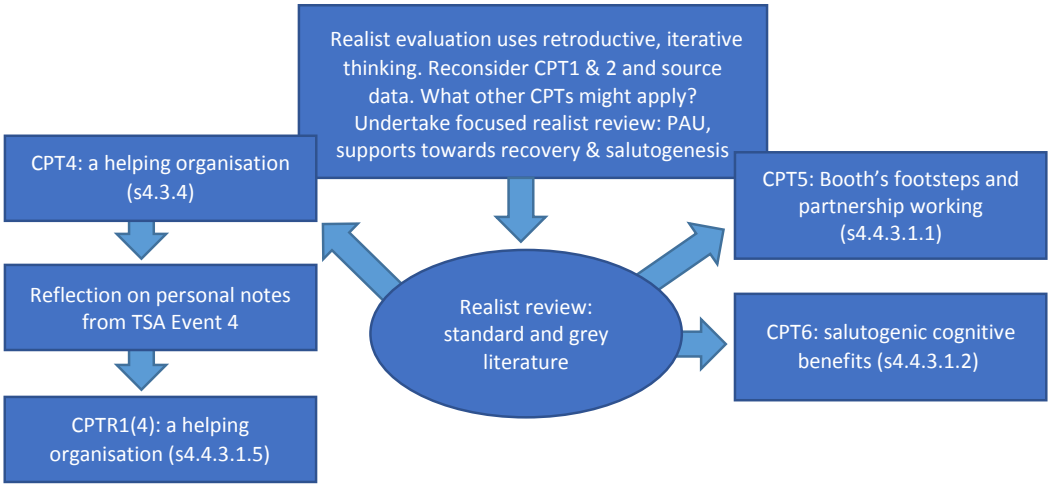

Figure 7 CPT4: a helping organisation, CPTR1(4): a helping organisation, CPT5: Booth's footsteps and partnership working and CPT6: salutogenic cognitive benefits

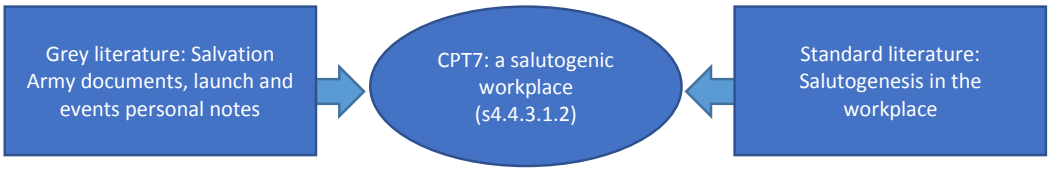

Figure 8 CPT7: a salutogenic workplace

Chapter 5 Exploratory Focus Group testing and generation of programme theories

5.1 Introduction

In keeping with realist evaluation, this theory-driven chapter aims to contribute to evidence-informed theory building about *what works, for which people with PAU and cognitive impairment, in what circumstances and why in TSA community programmes*. Data from the DASWs' Exploratory Focus Group provides evidence to confirm, refine or refute candidate programme theories (CPTs) hypothesised in previous chapters (Pawson and Tilley 1997). Findings are presented in context, mechanism, outcome configuration(s) (CMOc(s)) and when appropriate, new CPTs developed.

This chapter brings insight into why realist evaluation includes considering people in different organisational or wider societal contextual layers, including strategists, practitioners and help-seekers. In this instance, the Strategy Group developed an intervention proposal for people with PAU and drug use in specified community programmes. The DASWs had practitioner level responsibility, and at another level, people received help. Layers are not necessarily static structures. Thus CMOc consideration needs to include findings from people overlapping or transitioning from one to another.

The initial focus is *CPT7: a salutogenic workplace* (s.4.4.3.1.2). This hypothesises that such a workplace would enable the DASWs to fulfil TSA Scotland Drug and Alcohol Strategy Group expectations of them in their intervention role, working with people with PAU and cognitive impairment. The chapter then moves to explanations and understanding about how the DASWs engaged with people with PAU and cognitive impairment, creating a context and resources for client uptake of supports.

TSA Integrated Mission programme which influenced the DASWs' workplaces, aspired to have people throughout all organisational, group or individual levels working

together to benefit help-seekers (The Salvation Army 2015). Anyone accessing the community programme could influence how the intervention operated and its outcomes. In this research, seeking explanations and understanding from wide-ranging individuals helped test and develop theories about the intervention.

5.2 Background to programme theories testing and development by the DASWs

Appointed to fill a resource gap and in keeping with *CPT5: Booth's footsteps and partnership working* (s.4.4.3.1.1), the DASWs were seen as crucial to the community programme's outcomes. The Exploratory Focus Group was their first joint meeting, despite DASW-AR being in post for 10 months, DASW-B over 2 years and DASW-C 20 months. They saw the service and their roles as new. *CPT7: a salutogenic workplace* (s.4.4.3.1.2) is considered in this context. The rationale for doing so is anticipation that Strategists would ensure new staff in a new service would receive salutogenic support through GRR provision to maintain and enhance work-related SOC.

The DASWs described their Strategy launch experiences and their fieldsite and wider Salvation Army roles. The findings were examined '*using a realist lens*', that is, in an iterative, retroductive and diagnostic manner to establish DASW views about '*what works (or does not), for whom, in what circumstances, how and why'*. A '*salutogenic lens*' was also used to gain understanding about the GRRs and SOC contexts, mechanisms and outcomes of the DASWs and those they worked with or helped. Potential DASW intervention related outcomes were through direct interactions with help-seekers or indirectly through their role and influence with volunteers, staff and the wider community.

5.3 Consideration of CPT7: a salutogenic workplace

DASWs' descriptions of their workplace experiences helped review *CPT7: a salutogenic workplace* (s.4.4.3.1.2), create explanatory *CMO configurations* and develop new CPTs. Key aspects identified by the DASW were about the vision for and implementation of the intervention, education and training about supporting people

with PAU and ARBD, Integrated Mission, communication and hierarchical barriers to Strategy and intervention implementation, community programme volunteers and staff, and measurement of '*success*' and occupational meaningfulness.

5.4 Vision for and implementation of the intervention

At the focus group outset, DASWs' SOC in their role appeared strong. DASW-AR spoke positively, emphasising the importance of promoting the new service, including its ability to accept referrals from other agencies:

> *Where I work we're proud of - we're a new service up there ….. So it's trying to get referrals coming in 'cause we don't have any route of referral or we didn't. We've got plenty of organisations now that know about us. (DASW-AR)*

DASW-B thought outcomes experienced of positive feedback from local people about TSA's "*good work*" was important.

These outcomes reflected changed community and personal GRRs resulting in self-referrals and increased DASW scope to support more people and families. They suggest a reciprocal relationship between SOC and job resources. However, the context was complex with challenges in helping support certain clients. DASWs' reasoning about this included their wish to help people who might have ARBD and lacked cognitive resources in day-to-day living:

> *There seems to be a barrier no matter what you think up to aid the person….. in a lot of cases it's just the damage that's done to them mentally, because they can remember some things ….. the things that's really important to them - about payday for Jimmy, 'cause go down and get drink. For that's all familiar….. but it's the things that they have to look at about themselves. They don't seem to give them much prevalence in their memory, as seeing that as important. (DASW-AR)*

Chinks in the salutogenic workplace profile then emerged:

The Strategy implementation was viewed as lacking planning and organisation with responsibility falling to the DASWs to build the programme as opposed to a wider organisational approach (DASW-C). Despite this DASW-C described successfully navigating difficult engagement processes with another agency till relationships strengthened. The agency's perception of TSA as a "*Mickey Mouse service*" changed to that of a permanent, "*huge service*" (DASW-C).Thus despite workplace gaps refuting

CPT7: a salutogenic workplace (s.4.4.3.1.2), the DASWs confirmed *CPT5: Booth's footsteps and partnership working* (s.4.4.3.1.1).

A shared vision deficit for the intervention was described across organisational layers, that is, the Strategy Group, community programme managers, the DASWs and some people for whom the intervention was established to support. In the DASWs' opinion, the original high profile of and albeit disjointed vision for the intervention disappeared, the Strategy Group and managers' residual vision lacking clarity, detail and clear outcome aims. It was suggested, in reference to the Floating Support Service, of a "*me too*" approach to the intervention roll out without consideration of the practical implications including where clients would come from for DASWs to work with and help (DASW-AR).

DASW-AR felt some people who might benefit from the intervention had historically influenced visions of its purpose:

> *There's a suspicion that maybe this is about getting people to church. So you've got to try and break that and say, "No, that's not my job. My job is exactly what I'm telling you." And I think for some of the clients …. there's a worry going back to the old days, sing for your supper and all this - that they still have this image of this is what this is about. An' I think it's about trying to change that image. (DASW-AR)*

The DASWs reflected on personal responsibilities and how management changes and managers lack of understanding about the programme had detrimentally impacted on them (DASW-B). Overall, from the DASWs' perspectives, *CPT7: a salutogenic workplace* (s.4.4.3.1.2) is refuted with evidence now presented as explanatory CMO configuration, *CMOc1: DASWs, Strategy vision and sense of support*. A CMOc describes outcomes arising in response to the reasoning or responses which occur when a resource or resource deficit is introduced into individuals' contexts.

CMOc1: DASWs, Strategy vision and sense of support

In the months following the Strategy launch, changes in management and managers': • Strategy knowledge, understanding and consistency and clarity of vision resource gap (institutional force) • hindered DASWs' ability to develop services Resulted in DASWs' outcomes of: • generalised resistance deficits • not knowing what the community programme or Strategy Group expected of them • self-doubt and self-blame about slow service development with ultimate consideration that this was a management responsibility • diminished sense of support and SOC Additional wider outcome: slowing of service development.

From a salutogenic perspective, this represented a potential shift towards the dis-ease end of the ease/dis-ease workplace holistic wellbeing continuum. However, as now follows, the DASWs looked beyond their roles to organisational layers and contexts to seek understanding and explanations for what was occurring.

5.5 Supervision, education and training about supporting people with PAU and alcohol related brain damage

The DASWs' job satisfaction driver was knowledge they had spent the day productively, positively impacting on and making a difference to others' lives (DASW-AR).They wanted to know they were doing the job well to an agreed standard. However, their experiences of induction, training and supervision concerned them. DASW-C described lacking an induction package but "*hit*(ting) *the ground running*" and "*being a rabbit in the headlights.*" Because of help-seekers' complex needs and DASWs' varying knowledge levels and ability to understand, constant opportunities for updating knowledge were viewed important (DASW-B). They believed this would mean that the information and advice they gave help-seekers would be accurate (DASW-All).

Instead, the DASWs' felt vulnerable and isolated. They recommended the resource of group learning incorporating peer support to address knowledge gaps and practitioner isolation. They aspired to increase manageability through shared learning about

managing complexities and project ideas. Concern existed about sole learning, online learning and accompanying learning standards (DASW-All).

While noting managers' complex contexts the DASWs expressed concern about their own and managers' knowledge about supporting people (including some volunteers) with PAU and ARBD:

> *You have to be doing supervision with people (volunteers and staff) with brain injuries who are maybe not as quick on the uptake an' you've got to be very clear with them. (DASW-AR)*

Despite concerns about managers' skill sets, they were keen for supervision, an interpretation about which was that it made them feel valued and supported. They wished assurance they were doing their jobs well at agreed standards (DASW-All). Training on peer and volunteer supervision was viewed as beneficial to DASWs, volunteers and fieldsite managers including, it was hoped, by freeing up managers' time for other work (DASW-AR).

Some improvements in support representing a positive salutogenic workplace shift had subsequently occurred with experiences of officers being "*great*", supportive, listening to ideas, being keen on supervision and engaging with the DASWs to clarify the community programme vision (DASW-B and DASW-C). However, the DASWs all described continuing experience of working in isolation, only DASW-B having regular, formal supervision. Furthermore, DASW-C said when the community programme officers were away:

> *I'm in charge of everything. So it's a lot of responsibility. (DASW-C)*

The learning process and readiness to change proposed to best meet help-seekers' needs reflected positively on the DASWs' inherent SOC. Their outlook was salutogenic: it demonstrated the importance of meaningfulness, comprehensibility in the complexities of the lives of the clients they were supporting, and manageability in so doing. However, there simultaneously appeared a need to justify their roles to themselves and others.

Although the terminology of micro-actions (Morisy 2009) and outcomes used at Event 4 (s.4.4.3.1.4) was not used, DASWs' descriptions of making a difference to someone's life were in keeping with this:

> *Did you make somebody feel better? Even by just giving that cuppa tea, saying, "Sit down for ten minutes". (DASW-B)*

DASW-AR described less fulfilling days:

> *When you go home and think, "Well all I did was sit in the office, didn't do very much," then to me it doesn't make me feel very good about what I'm supposed to do. (DASW-AR)*

This negative self-reflection highlights the importance of meaningfulness, SOC and feeling of worth in the workplace.

The DASWs' experiences of induction, education, training, support and supervision are now brought together as *CMOc2: a workplace shift towards dis-ease*.

CMOc2: a workplace shift towards dis-ease

The DASWs had different occupational backgrounds and comprehension levels about complexities faced by people with PAU and drug use. In:

- the presence of generalised resistance deficits including an absence of induction, agreed training and education, clear supervision and support, and a perception of lack of Strategy Group planning and organisation
- at times absence of the officer
- and varying resources at different community programmes
- DASWs tried to reason what was expected of them, not knowing if they were doing a good job at an agreed standard

This resulted in DASWs' outcomes of feeling:

- confused, fearful, isolated and unsupported
- concerned about the accuracy of information and advice they offered clients
- a high sense of responsibility with generalised resistance deficits
- with resulting reduced SOC.

Next, findings related to factors driving the DASWs in their roles, their need for meaningful activity, training, support and supervision are presented in explanatory *CMOc3: meaningful work and doing the job well*.

CMOc3: meaningful work and doing the job well

In the outcome context of *CMOc2: a workplace shift towards dis-ease* (s.5.5), DASW:

- retained a personal vision for their job: "*It's about making people's lives better"*
- used reflective practice approaches to examine "*Did I make a difference to anybody's life today*?" and how this was done
- explored knowledge gaps which impacted on their ability to fulfil their role
- reasoned about peer support benefits especially at times of difficulty
- reasoned about their personal financial value to the community programme

Resulting in outcomes that DASWs individually identified days when they did:

- "*make somebody feel better*" or when primarily office based, felt they had underachieved in their role
- justify their pay

But deficits remained in this context reinforcing the DASW:

- identified need of standardised training and supervision
- need for formal guidance on if they were undertaking the role as expected of them in an approved, consistent approach and having proof to support this
- need for assurances that they were doing a good job

With mechanism of:

- DASW as peers exploring and discussing learning resource deficits and how these could be addressed

Creating new *CPT8: salutogenic workplace, personal development and support* as below.

Creation now of *CPT8: salutogenic workplace, personal development and support* reflects ongoing changes that occur in the complex context of a social intervention. People and their thoughts and actions often change rather than stand still in response to what is happening around or to them.

CPT8: salutogenic workplace, personal development and support

If there is an agreed induction, supervision, training and education plan with consistency of vision, implementation, aims and objectives with managers and peers

- regular joint learning with peers including case and service development scenarios

Then:

- their practise and approaches would be up-to-date
- the community programme salutogenic workplace status would be enhanced

Because the DASW would be more self-confident about their knowledge, skills and abilities, with opportunities to be listened to and contribute, have a greater sense and experience of support and learning, and overall increased GRRs and SOC.

CMOc3: meaningful work and doing the job well (s.5.5) leading into *CPT8: salutogenic workplace, personal development and support* (s.5.5) demonstrates the changing

context that occurs when people have the resource of place and space to talk and support one another in the workplace. The findings are also in keeping with the realist inspired review of TSA video (The Salvation Army UK with the Republic of Ireland 2013). The DASW wished to make a difference to people's lives and to offer and be offered the assurance as described by Antonovsky of being on the right track (Antonovsky 1990).

Meaningfulness in the workplace is associated with use of GRRs. *CMOc4: innovation and foundation building* demonstrates how the DASWs used their resources to create positive outcomes which occurred despite the previously described complexities.

CMOc4: innovation and foundation building

In the early months of the intervention when meeting people with misconceptions about The Salvation Army community programme and:

- in the absence of induction package and clear supervision and support
- DASWs used individual abilities and experiences to reason what work was needed
- provided information and raised awareness to potential clients and other agencies
- endeavoured to build foundations for trusting relationships

This resulted in the outcomes of:

- community programme development beginning
- establishment of an interagency relationship based on accurate knowledge about the community programme extent and permanency
- potential clients got to know the DASWs and the supports that could be offered if they wished to access them – early relationships established
- positive impact on GRRs and SOC

Although this data refuted *CPT7: a salutogenic workplace* (s.4.4.3.1.2), it demonstrated the DASWs approach to managing complex situations was to look for solutions. In this instance they wished training to effectively and consistently supervise volunteers. They believed this would benefit volunteers and release managers' time for other matters. They similarly saw benefits in peer support and supervision.

5.5.1 Reflections on the community programme as a salutogenic workplace

DASWs' explanations and theory building about the community programme as a salutogenic workplace reflect the context complexity, their reasoning within this and the outcomes that arose. Despite the negative impact of salutogenic workplace gaps,

all described proactive approaches endeavouring to build trusting relationships, promote available services, engage with clients, and being mindful of the needs of managers, volunteers and others in the community programme layers. They expressed enthusiasm about preferred learning methods to supplement online learning they had been scoping individually.

When supervision had arisen, they spoke positively about managers and the complexities of their roles. The contrast between the isolation, lack of confidence and the "*rabbit in the headlights*" (DASW-C) fearfulness described when supervision was not forthcoming was stark compared to when available. The DASWs then felt supported and valued. Yet it was primarily in the former context the DASWs were expected and wished to knowledgably recognise, engage with and support people with PAU, including those with cognitive impairment. With this awareness, data about DASW views and experiences of wider engagement with the community programme as they have tried to develop services for people with PAU is presented.

5.6 Integrated Mission: engagement between the Strategy intervention and the wider community programme

The Strategy aimed to build on existing community programme interventions in which Integrated Mission was a core development area (The Salvation Army 2015). The Integrated Mission agenda encouraged, "*….. engaging every aspect of our movement in our Integrated Mission of physical, emotional and spiritual health for every person*" (The Salvation Army 2015). Some people primarily attended the community programme for Christian worship in keeping with spiritual health and had limited wider engagement. The Strategy created change which had potential, from an Integrated Mission perspective, to affect worshippers or others with differing organisational affiliations. Ideas about change in response to the intervention introduction in an Integrated Mission context are now presented as *CPT9: Integrated Mission, salutogenic workplace and change*:

CPT9: Integrated Mission, salutogenic workplace and change

If a new intervention including the appointment of staff occurs in a salutogenic workplace in which Integrated Mission is a key component, then existing and new people in the context will positively adapt to change because they have been provided with resources to do so in a comprehensible, manageable and meaningful way.

DASW-B believed the foundation for the new intervention in the wider community programme was regarded positively because of TSA's "long established social service record." However, the DASWs identified generalised resistance deficits in information provision, learning and wider community programme engagement about PAU and its impacts and the DASWs' roles. DASW-B saw opportunities to address this via the Integrated Mission developments (The Salvation Army 2015):

> *It's about encouraging people who don't understand the work of the DASW to get on board. It's like the people who attend the Corp - to understand more about what the issues are wi' people who have drug and alcohol problems and not to just….. pooh-poohing and say(ing), "Don't want to know" or "It's their own fault because they're drinking." But to understand that it's not somebody's own fault. (DASW-B)*

DASW-AR described personal proactive, innovative, "*thinking outside the box*" and "*sell(ing) it to the people behind us*" to address the need for wider organisation buy in and support in order for ideas and plans to succeed. In workplace salutogenic terms, the DASWs demonstrated drawing meaning from the Integrated Mission. However, they viewed complexities such as wider fieldsite lack of understanding about or stigma towards people with PAU as hindering potential benefits of the new intervention. They used innovative thinking to support manageability of what they were trying to achieve: help-seekers with PAU engaging with people in the wider community programme and vice versa. The findings are now presented as *CMOc5: solution seeking through Integrated Mission*.

CMOc5: solution seeking through Integrated Mission

TSA Integrated Mission intervention aims to strengthen engagement between people accessing the community programme regardless of reason. However, some people may not wish to engage with people with PAU because they believe, "*It's their own fault because they're drinking*".

To support Integrated Mission, DASW described current and aspired approaches of:

- innovative thinking and approaches
- to encourage and promote
- information provision and understanding of issues experienced by people who have PAU by people in the community programme, including staff

Resulting in outcomes of increased GRRs and SOC reflected by:

- less dismissiveness, less attribution of blame and greater understanding by community programme attendees of issues experienced by people with PAU
- more integration of people throughout the community programme

For Integrated Mission to be successful with regard to '*Time for Recovery*' (Scotland Drug and Alcohol Strategy Task Group 2011) good communication between all involved would be anticipated. However, the DASWs described communication and hierarchical barriers to implementing and developing the new intervention for people with PAU, reflecting workplace SOC gaps and generalised resistance deficits (DASW-All) creating confusion and disappointment. Yet DASWs' strength of meaningfulness in their jobs is also revealed in the words below and *CMOc6: communication and community programme development* which follows

> *It's about being courageous. Then you've got to sell it to these people (TSA managers) and these people's sometimes stuck in the old ideas, in the old ways, "It's always done this way". You're in a bit of a battle. (DASW-AR)*

CMOc6: communication and community programme development

In the 'Time for Recovery' fieldsite context, DASWs described experiences of:

- generalised resistance deficits in communication processes and support in service development
- diminished SOC: feelings of confusion, unpredictable communication processes when they introduced proposals with concerns proposals were lost

This resulting in outcomes of DASW describing:

- being courageous despite confusion
- conveying positive impact ("*selling*") of proposal to managers
- using personal resources and SOC to positively influence change

5.6.1 Reflection on Integrated Mission

In keeping with realist thinking, the contexts, mechanisms and outcomes have shown potentially unexpected outcomes. Antonovsky wrote of the ability of some people and not others to overcome deeply complex life experiences, attributing survivor outcomes to their SOC and the GRRs available to them (Antonovsky et al. 1971; Antonovsky 1990). In this instance, the DASWs have not walked away from challenges. Instead a key study finding is that due to the meaningfulness they experienced in endeavouring to support people with PAU and cognitive impairment, the DASWs have drawn on their SOC and personal GRRs to challenge the status quo. The DASWs' awareness of community programme challenges now focuses on the roles, support and engagement with other groups or levels in the community programmes: staff and volunteers.

5.7 DASWs' views: volunteers and staff

Relevant to this section are the CPTs and CMOcs related to a salutogenic workplace, training and support, and Integrated Mission. Early in this chapter, the importance of considering organisational layers when developing or testing theories about an intervention was discussed. Mention was made of the fact that not everyone in the community programme fitted neatly into '*a layer*'. As described in *Participants' Selection* (s.3.4.3), participants were at different stages of current PAU or recovery, with support needs relevant to their ongoing relationship with alcohol and presence or absence of cognitive impairment. Some staff and volunteers had no personal PAU or cognitive impairment experience.

The DASWs' experiences of the Strategy implementation in relation to volunteers, for whom they had support and supervision responsibilities, were in keeping with the complexity of social interventions (Pawson 2013d). They viewed volunteers as crucial to community programme developments as "*no one person can do it*" (DASW-AR). However, Strategy group and management thinking ahead about sources of volunteers was recommended. Surprise that people from the community programmes' "*own ranks*" (DASW-AR) did not volunteer was followed by explanatory reasoning about this:

> *….. the congregation ….. are quite aged, elderly and they have done their duty…. I s'pose it's unfair of me to expect, "Well, you can come and do a bit more". Some … they've got lots of health problems. And I find that's been a barrier to setting up new things. (DASW-AR)*

The DASWs thought a lack of volunteers affected integration of help-seekers for PAU with people in the wider community programme and vice versa (DASW-All). They were concerned about volunteers' knowledge about PAU and its impact. Furthermore, lack of employed staff was viewed as detrimental to volunteer retention:

> *Some people* (including clients) *have got posts, jobs in the café volunteering, and some of them have done OK. But you know after a few times, it's just they haven't come back. There must be the (paid) café staff because that's a bit of a community. (DASW-AR)*

The resource of paid staff was seen as potentially creating a key outcome of community in which people felt they were valued, supported and belonged, this positively impacting on self-worth. The DASWs described the importance of providing weekly structure for volunteers with PAU and ARBD, taking into account their mental health, cognitive issues and their ability to cope with current or additional volunteering sessions (DASW-B).The DASWs agreed client volunteers could not run services or activities in isolation because at times they were likely not to come:

> *They're gonnae have issues where they're gonnae have to take a long time off. So you can't have (services) just run by….. I need to have a core of people who are reliable but can also work alongside those who are unreliable without being judgemental. (DASW-B)*

This was described as a "*really tricky situation*" (DASW-B) with associated risks:

> *There's a risk when you're bringing people in as well because some of them have very colourful pasts - thieving and whatever. So I mean you've got to try and get that balance right. (DASW-AR)*

A balance sought involved not "*putting temptation in someone's way*" (DASW-B) while simultaneously:

> *….. not judgin' them either. It's about giving them that space to move on with their lives. (DASW-AR)*

Explanatory *CMOc7: volunteering in a salutogenic workplace* now presented is based on successful DASW experiences of working with volunteers as part of the community programme development:

CMOc7: volunteering in a salutogenic workplace

If mechanisms promoting GRRs and SOC in the form of:

- staff and volunteers non-judgementally working alongside client volunteers
- DASWs' use of knowledge of and relationship with client volunteers to understand if they were coping with the role, including around their mental health
- use of caution to ensure client volunteers were not overburdened
- flexibility and getting balance right between client volunteers, volunteers and staff in service provision in knowledge of inconsistent client volunteer participation
- clients use of volunteering "*space*" in their complex lives

In a context incorporating:

- a core of reliable staff, some of whom are paid
- a consistent, structured weekly plan for client volunteers
- an awareness of "*colourful pasts*" of some client volunteers
- recognition that client volunteers may not always come, due to PAU

Then outcomes described were:

- individual client volunteer structured weekly plan responsive to wellbeing
- some clients volunteered successfully and moved on with their lives
- some client volunteers stopped coming after a few times
- although some clients volunteered successfully, inconsistencies in engagement by others confirmed need to have staff and volunteers who are not clients
- getting the balance right for individuals and the service
- service community created and enhanced, with volunteers experiencing feeling of being supported, valued, belonging and enhanced self-worth

Overall, the outcomes arose because of the comprehensibility, manageability and meaningfulness of the programme to volunteers and the GRRs available to them.

5.7.1 Reflection on DASWs views of community programme volunteers and staff

Interesting contrasts exist in this data about the salutogenic workplace experiences of the DASWs on a personal level compared to those they endeavoured to promote for others. DASWs' innovation aimed to enhance supports and services for people with PAU, including offering clients volunteering opportunities thought to help them "*move on with their lives*".

DASWs' service initiatives relied on input from others, especially volunteers. They described the community programme population as people who were older, "*have done their duty*" and had health problems affecting their ability to volunteer. In this context, DASW reasoned it unfair to expect these people to do more but simultaneously experienced under-resourcing limiting innovation.

CMOc7: volunteering in a salutogenic workplace (s.5.7) demonstrates points relevant to realist thinking. It reveals the differing outcomes that may occur for different people from an intervention occurring in what may be initially seen as a single context. The flow of people from clients to client volunteer status does not necessarily result in a clear cut outcome "*success*". However, the outcome success or otherwise depends on how these are interpreted and by whom as will be considered below.

5.8 Cumulative reflections about CPTs and CMOcs presented so far

The DASWs in the main refuted *CPT7: a salutogenic workplace* (s.4.4.3.1.2) this theory though did speak of partial improvements in support and supervision. Despite the DASWs' personal experiences, they endeavoured to make it a salutogenic workplace for themselves and others as in *CMOc7: volunteering in a salutogenic workplace* (s.5.7). This was in keeping their desire to have comprehensibility, manageability and meaningfulness in their roles.

The DASWs drew on personal SOC and GRRs to address community programme requirements. This confirmed *CPT5: Booth's footsteps and partnership working* (s.4.4.3.1.1) that they were a resource bringing extra capacity to the community programme work and the practical support offered, plus enhancing interagency working.

There are indications as yet unconfirmed by clients that *CPT1: a life more fulfilled* (s.3.2.2.3) may be true for some clients through their transition to volunteer or staff status. Similar unconfirmed indications apply for *CPT6: salutogenic cognitive benefits* (s.4.4.3.1.2) as if people are volunteering, it suggests their alcohol consumption and cognitive function levels enable them to do so. In ARBD, reductions in alcohol intake would lessen likelihood of worsening cognitive function and open doors to cognitive improvement.

5.9 PAU, cognitive impairment and engaging with the community programme

People with PAU and cognitive impairment may have greater opportunities for recovery if they have opportunities to engage with services in keeping with their needs. Engagement resources in this thesis refer to things or approaches that support people to engage with the community programme and so increase likelihood of them asking for and receiving help. A potential barrier to this is cognitive impairment. This chapter section examines how, in the DASWs perspectives, they determine who they think might have cognitive impairment, the factors which might contribute to presence or appearances of cognitive impairment, and how they optimise the likelihood of engagement and thus supporting help-seekers needs. It then examines how they helped people engage with, access and choose to accept help available. It offers a summary in *Table 7: bridging the gap* (s.5.11) of the resources and approaches to support the DASWs thought important.

5.9.1 Determining who might have cognitive impairment: DASWs' practitioner nous

CPT1: a life more fulfilled (s.3.2.2.3) specifies the DASWs' centrality to the intervention in helping people adopt a rewarding lifestyle free of PAU. In keeping with *CPT6: salutogenic cognitive benefits* (s.4.4.3.1.2), this lifestyle had potential to create opportunities for cognitive improvements and avoidance of ARBD. DASWs' relationships with individuals or other agencies were similarly regarded as important to optimise intervention success (*CPT5: Booth's footsteps and partnership working* (s.4.4.3.1.1)). To strengthen confirmation of these CPTs, the DASWs needed understanding of PAU, cognitive impairment and ARBD and their management. However, as presented in *CMOc2: a workplace shift towards dis-ease* (s.5.5), generalised resistance deficits were identified in DASW training, education and supervision. Furthermore, the DASWs were not appointed to formally assess people with PAU for co-existent cognitive impairment. Evidence was sought from Exploratory Focus Group data to create explanatory CMOcs about how DASWs determined who they thought had cognitive impairment.

Of relevance are *CPT3: ARBD meaning and understanding* (s.3.4.4) and *CPTR1(4): a helping organisation* (s.4.4.3.1.5). When communicating with help-seekers, it would be anticipated that shared meaning and understanding of terminology would aid communication. Sometimes during the research the DASWs specifically used the term ARBD. Their use of '*cognitive impairment*' implied impairment might have different causes and generally referred to memory difficulties rather than other forms of cognitive impairment (DASW-All).

Unlike statutory health and social sector staff, DASWS could not access client health or social care records. They thus lacked formal information on diagnoses and health and social care and support recommendations. However, ideas, knowledge and understanding come in different ways, including as the practical nous of people delivering or accessing intervention supports (Pawson and Tilley 1995). Practitioner nous is important because of their '*first-hand experience, practical nous, and familiarity with the craft skills of social care'* (Pawson et al. 2003, p. 3). DASWs' nous in recognising and helping people with PAU and cognitive impairment is used to develop *CPT10: practitioner nous*:

CPT10: practitioner nous

If DASWs lack formal community programme training, then they will use pre-existing skill sets and ongoing work experience (GRRs and SOC) to develop practitioner nous about what works, for whom, in what circumstances and why, because "*It's about making people's lives better*".

In the absence of formal cognitive assessments, DASWs' mechanisms involved gleaning information about client cognitive function through conversations with them or witnessing events or interactions in the fieldsites. The areas the DASWs highlighted as suggestive of cognitive impairment are now presented, followed by a reflection on the findings.

5.9.2 People thought particularly at risk of cognitive impairment

DASW-AR believed he encountered people with cognitive impairment in addition to PAU every day, with those described as "*street drinkers*" most likely to be dually affected. He felt he could "*quite quickly identify*" people dually affected. He observed

individuals' facial expressions, some of which he thought suggested cognitive difficulties:

> *When you look at them and they've got a blank stare and ….. there's a difficulty cognitively trying to recall something. (DASW-AR)*

DASW-C viewed homeless clients as most affected. DASW-B knew people with cognitive impairment and current or past PAU accessing help or volunteering who were neither homeless nor street drinkers. A challenge was determining if cognitive impairment presenting as memory difficulties was due to alcohol or other causes. In some instances, clients spontaneously told their DASW about their memory concerns (DASW-AR).

Sometimes memory loss was attributed to alcohol intake the night before and included what was viewed as alcohol-related blackouts (DASW-AR). However, some clients said they had been alcohol-free for days to years yet retained memory impairment (DASW-AR, DASW-C). Other factors viewed as possible contributors to cognitive impairment were head injuries (whether alcohol related or not) and concomitant use of drugs and alcohol (DASW-All), with dual addiction thought to cause very severe memory loss (DASW-C).

Concern was raised that cognitive impairment might be attributed to alcohol when there was a "*hidden element*" (DASW-AR) such as attention deficit hyperactivity disorder (ADHD), dyslexia and dyspraxia (DASW-All). However, regardless of the cognitive impairment cause, PAU was thought likely to negatively affect cognitive function (DASW-AR).

Remembering and keeping appointments were seen as core identifiers of potential cognitive impairment (DASW-All). This included forgetting appointments or retaining partial information such as time but the wrong day (DASW-All). Appointment absences which could result in homelessness or financial difficulties raised particular concern and potentially reflected cognitive impairment severity:

> *When it's turning up is going to benefit them for instance keeping their home or whatever, you'd think, well, surely you would turn up but because sometimes they don't… they've said, "I've forgot, I've forgot all about it." (DASW-AR)*

The difficulty with appointments was further complicated for some clients with ARBD who found it hard to make telephone calls:

> *They've got tae psych themselves up, even just to 'phone the doctor up. Tae remember how to speak on the phone 'cause they go blank and they panic. (DASW-C)*

DASWs were concerned that clients had cognitive impairment when they repeated questions, including about the day of the week, and if forgetfulness and concentration difficulties affected abilities in volunteering roles (DASW-AR):

> *They go to do something ….. get distracted and ….. forget what they are doing and ….. can't go back to what they were doing. They end up doing something else. (DASW-B)*

This affected individuals and other volunteers who did not understand why this happened and sometimes relationships between them, particularly when clients lacked insight into their cognitive impairment (DASW-B and DASW-C). Some clients appeared fearful of the cause of their memory problems or unaware of alcohol's potential association:

> *He wouldn't have been stupid man so he would have known ….. there was something not right but I think it's the fear that you're gonnae go and be told that you've got dementia. They may not tie the two together – alcohol and dementia – the same way as addicts don't tie together using drugs and using alcohol is also a drug. (DASW-AR)*

5.9.3 Reflection on who might have cognitive impairment and why

The DASWs explained what made them think that someone with PAU also had cognitive impairment. They demonstrated increasing comprehensibility of PAU's effect on cognition, manageability in developing a '*practitioner nous*' based means of client assessment, and reinforced their perspectives of meaningfulness in their roles. This is now developed into explanatory *CMOc8: practitioner nous*, confirming *CPT10: practitioner nous* (s.5.9.1):

CMOc8: practitioner nous

The DASWs were concerned clients, including those with PAU, potentially had cognitive impairment issues. The DASWs:

- in the absence of formal training in use of cognitive assessment tools (generalised resistance deficit)
- innovated
- using pre-existing GRRs, SOC, problem solving abilities and work experience based skills incorporating conversation and observation when engaging with clients with PAU who might have cognitive impairment

Resulted in outcomes of the DASWs:

- establishing identifiers, risk factors and severity indicators they believed associated with cognitive impairment and PAU in the client population
- using these identifiers as an informal assessment process
- recognising people they believed had cognitive impairment in addition to PAU
- recognising an individual's cognitive impairment may be multifactorial in origin and not necessarily alcohol related
- enhancing their own GRRs and SOC

Overall, the DASWS recognised indicators of PAU associated cognitive impairment. Their next step was establishing what needs and supports such clients might have.

5.10 Helping people with cognitive impairment and PAU engage with and uptake supports

To fulfil *CPT5: Booth's footsteps and partnership working* (s.4.4.3.1.1) that DASWs would enhance supports for people with PAU, they required skill sets, roles and opportunities enabling recognition of needs, and access to resources to enable offers of appropriate help. Their role as a client resource had potential to support '*firing*' of client reasoning to seek, access and accept help.

The DASWs described client led, on-request, first contact opportunities arising to help people with their self-identified areas of need. Prompt DASW responses were emphasised, as opportunities to provide support might otherwise be missed. Scope existed to offer alternative appointments, but people with memory impairment were found likely to forget to return. Such support opportunities were described as "*one off hits*":

> *They're coming in. They've got some issue. They're maybe not keeping appointments and purely because they're forgetting to go and these appointments is now leading to, "You're now going to be evicted." So they're hiding, they're burying their heads in the sand. It's about, at that time dealing with that issue there and then because if you let them, if they go and you make another appointment, they may not come back. (DASW-AR)*

After the "*instant gratification*" of a need being met, Fieldsite-A clients tended not to return until facing a further crisis (DASW-AR), possibly relating to food, benefits, bills, clothes or support in the community. DASW-AR said all of these could be addressed in or through Fieldsite-A, though other agencies offered similar supports. What might happen at a subsequent crisis was described:

> *It'll be something different and I think they're creatures of habit. If they get a good relationship wi' you and you obviously meet their need they will come to you rather than go to another agency but they may go to another agency for different stuff ….. which can sometimes clash with what you're doing ….. it's about looking and dealing with what's there and then. (DASW-AR)*

The account reflects rivalry, with different interventions occurring simultaneously and lack of clarity about which creates outcomes occurring (Pawson 2013d). Realist approaches use retroductive thinking to try to establish which mechanisms associated with interventions create outcomes. This may reveal that mechanisms firing in individuals in one context may or may not fire in the same way in another.

This was the DASWs' first mention of the importance of establishing good relationships with clients in order to help them. Furthermore DASW-AR's words (above) reflected the need for an open door approach to people experiencing continuing crises in their lives. DASW-B agreed about offering immediate help, describing TSA as "unique" compared to other organisations because of abilities to "deal with issues instantly" The provision of nutritional support was given as an example, not as an end point, rather part of an overall presentation of wider need, including respite from life's daily challenges:

> *Sometimes they come in and what they're looking for initially is something to eat, a cup of tea, cup of coffee and somewhere to just get themselves into some semblance of order ….. get themselves just a wee sort of time out. (DASW-B)*

The relationship between the DASW and clients with ARBD was emphasised as a supportive mechanism to enable access to other agencies:

> *If we can get them to come back an' start building up that relationship then we can offer an awful lot more. We can offer advice, medical advice whether it be supporting them to their appointments, whether it be having the doctors and nurses coming in, podiatrists, people coming in tae actually offer to look after them. (DASW-B)*

The severity of the clients' overall health and support needs was reflected by DASW-B's choice of wording, "*people coming in tae actually offer to look after them.*" The implication of this was of unmet need. This included in clients the DASWs believed had ARBD, as opposed to cognitive impairment of other causes, who were struggling to live independently or in their current support context. This gap triggered seeking fieldsite assistance. DASW-B described aims of helping people:

> *…back into as normal a lifestyle as they can, in sobriety, so that if we can stop the progression of the damage that they've already caused, if we could manage to kinda halt that or not make it you know any worse. (DASW-B)*

This statement backs *CPT1: a life more fulfilled* (s.3.2.2.3), *CPT5: Booth's footsteps and partnership working* (s.4.4.3.1.1) and *CPT6: salutogenic cognitive benefits* (s.4.4.3.1.2), with notable wording chosen. There is recognition that "*normality*" of lifestyle might differ from what others in society aimed for or expected. The aspiration of sobriety as a component of "*normality*" and preventing progression of ARBD was recognised. The community programme role in helping people access volunteering or employment opportunities when they are "*able to*" as part of the transition to "*normality*" is highlighted. The implication included clients' differing needs and abilities at different times which impacted on when or if they could take up such opportunities. The DASWs' emphasis then returned to their relationships with clients:

> *It's all these kinds of things that we can offer but it's all …. built on relationship really and about val.. (valuing them), allowing them to build up their trust with us so that we can do it. (DASW-B)*

This highlights further complexity. DASWs recognise "*instant gratification*" (DASW-AR) sought by some clients, with limited opportunity for engagement at the time and sporadic contact thereafter. They identified the need to establish longer term, trusting relationships in order to offer help and engagement opportunities in activities reflecting and contributing to a "*normal*" lifestyle, part of which is based on sobriety and enhancing self-esteem.

5.10.1 Flexibility and the extra mile

An important context and mechanism to support such transition was time, with the community programmes viewed as time rich compared to other agencies. DASW-C said of other agencies, *"…they're maybe restricted to say half an hour or 45 minutes because they've got such a high case load*", contrasting to weekly support DASW-C offered a working client:

> *He was a heavy drinker, so I would be there from 5 o'clock to maybe half seven ….. going through absolutely everything ….. for about 10 months ….. With the services we've got at the moment we've got that time, time to speak. (DASW-C)*

This salutogenic approach recognised aspects of the client's life contributing to his SOC and GRRs. DASW-B concurred with this view and built upon it, again demonstrating salutogenic drivers:

> *It's about going that extra mile sometimes for people….. letting them know you care about them….. they are an individual person who's important. And you're taking the time no matter how busy things are ….. and if you can't take that time, make sure that you've got a reason and let them know. (DASW-B)*

Specific appointment times were viewed of limited value due to non-attendance:

> *It's really about when he needs it as opposed to me sort of saying, "I need you to come on …" You know he won't or he'll come up (on a different day)….. He knows that I'm going to be there a certain day, so when he's feeling (he needs to speak to the DASW) that's the day he comes. (DASW-B)*

Thus consistent, set day, DASW-B availability supported client help-seeking for self-identified needs and development of trusting relationships with DASW-B. In this context, communication skills were viewed important resources affecting engagement with supports and outcomes. DASWs thought listening was a positive attribute which reduced clients' anxiety and ensured needs were accurately identified and met:

> *….. We're all continuously assessing the person ….. if you address the issue they've come with, then they see, "Right OK you're listening." That lowers the anxiety but then you may identify maybe there's ….. something else going on ….. so it's about continuously trying to see and then when ….. I've done that, I think, "Right, what is it that you maybe need else for me to do today?" (DASW-AR)*

The description of DASWs' client-centred communication skills was different to their workplace communication experiences. However, the descriptions confirmed their

endeavours to use personal resources and SOC to positively influence change (*CMOc4: innovation and foundation building* (s.5.5)).

Sometimes clients asked for one kind of support when in the DASW's view, another area unrecognised by clients was of greater priority. DASW-C spoke of a man attending for food despite a head injury requiring hospital attention. However, the DASWs recognised client choice to accept help or not. DASW-AR spoke of experiences with people who had ARBD:

> *The homeless doctor, "I'll go down with you, we can register, we can try and do these things". Some of them will and again some of them are just, "No I'll be all right, I'll do it myself," and ….. there's no point in trying to force them. (DASW-AR)*

The DASWs' focus was being person-centred, with knowledge of the client and their relationship with them influencing conversation approaches:

> *It's a personal choice for people whether they want that support and as we say, timing is essential. It's about assessing, an' about timing, and about knowing when the client speaks to you, "Right, will I go any further ….. or is this as far as we're going today?" Because, person centred approaches, what's important to them - it's all about them and how we move forward with them. (DASW-B)*

Honesty was deemed important to enable appropriate help to be offered and sought, even if DASWs did not concur with client hopes for support (DASW-B):

> *….. as long as you're honest….. that's what they see wi' The Salvation Army. You say it as it is ….. not like another service that ….. flower up or "I'll sort that for you tomorrow" ….. I will do it there and then…… if I don't know something I'll say, "Well I don't know that but I'll certainly go and find out," instead of the flannelling them wi' rubbish that they'll pick up anyway. (DASW-C)*

Help-seeker familiarity with help-providers' attitudinal and environmental contexts were viewed important (DASW-C). Familiarity and trust had scope to support salutogenic client interagency flow, diminishing risks of possible stigmatising experiences in other contexts The DASWs thought help-seekers' perceptions of honesty in community programme relationships created anticipations of similar approaches by other hosted agencies.

This created a ripple effect: the outcome of a decision to come to the fieldsite to meet a particular need could open doors to others.

5.10.2 Reflection on helping people with PAU and cognitive impairment uptake supports

The DASWs' engagement resources reflect positively on them as they try to engage with and help help-seekers. Their words reflect their GRR and SOC as they move forward "*with*" clients (DASW-B). They wish to build supportive rather than leading or controlling relationships, trying to help clients create contexts encouraging choice making towards a lifestyle removed from alcohol's dominance. The engagement resource findings are presented in explanatory *CMOc9: relationship building and opening doors to help* below.

CMOc9: relationship building and opening doors to help

Context: Help-seekers experiencing PAU, cognitive impairment or ARBD who:
- attend at times of crisis
- lack insight into their needs other than those at crisis points
- decline support for DASW identified need
- forget appointments and attend sporadically

DASW: lack of formal information about clients' health and social care support backgrounds
- crisis management

Mechanisms used by DASW:
- relationship building based on caring, compassionate and non-judgemental approaches
- listening and honesty
- being person-centred and looking beyond presentation
- responding promptly to client identified need using fieldsite biopsychosocial resources and recognising importance of client choices
- availability of DASW at times and durations to suit client on a recurrent or sporadic basis according to client perception of need
- keep doors open to future opportunities to support people again
- awaiting and identifying the time when client likely to be able to engage with new supports or coping strategies

Outcomes:
- immediate need addressed fully or partially
- more likelihood of help-seeker returning though may access another agency
- successful trusting relationship building
- recognition of the right time to optimise client receptiveness to support
- further needs identified both by the client and DASW, then explored and addressed
- the preceding outcomes may contribute to an outcome spectrum of DASW self-perceptions of achievement in their role

Overall, this configuration confirms that DASW aims and approaches are in keeping with Strategy aims. They use micro-actions, with hopes for micro-outcomes such as people returning and being receptive to help. *CMOc9: relationship building and opening doors to help* (s.5.10.2) most strongly links with *CPT10: practitioner nous* (s.5.9.1), with indicators suggestive, but yet to be confirmed, from clients and others of client orientated candidate programme theories *CPT1: a life more fulfilled* (s.3.2.2.3), *CPT2: holistic, salutogenic approaches* (s.3.2.2.3), *CPTR1(4): a helping organisation*, *CPT5: Booth's footsteps and partnership working* (s.4.4.3.1.1) and *CPT6: salutogenic cognitive benefits* (s.4.4.3.1.2).

5.11 Clients, DASWs and bridging the gap

Table 7 Bridging the gap which follows, collates DASW identified contexts, biopsychosocial resources and supports offered to help-seekers with PAU and cognitive impairment and mechanisms and outcomes that may emerge in their presence. These are considered further in Chapter 7 perspectives of people with PAU experience.

Table 7 Bridging the gap: biopsychosocial resources and supports, contexts, mechanisms and outcomes

<table>
<tr>
<td rowspan="3">General support and social engagement
If we can get them to come back an' start building up that relationship then we can offer an awful lot more.
Come in and sit and have a chat
Time to be listened to – listening, have some time, at time client wishes to come which is often a crisis point.
Create a comfortable, warm, safe environment where clients are not judged in any way.
Reduce anxiety.
Treat client as a normal person.
Sense of belonging: come in and be part of our group.
Support clients in lack of confidence issues.
Let them know you care. They are important.
DASW honesty and fulfil what say will do.
Boundary setting at fieldsites: I don't care what you're on as long as you're not drinking when you come in.
Providing structure to week but don't put on too much pressure.
Walking group.</td>
<td rowspan="2">Support for memory problems and cognitive impairment
Repeat same information in conversation as requested. Write information down.
Appointment prompts: write notes, mobile phone text reminder or enter in phone diary.
Accompany or take to appointments.
Make phone calls for clients.
Read letters or forms with clients.
Provide support to client around something they wish to in the community.</td>
<td>PAU and drug use
Alcohol advice including sober though not necessarily alcohol free lifestyle to stop progression of alcohol-related damage.
Group work
Support clients in family relationships</td>
</tr>
<tr>
<td>Finance and housing
Eviction avoidance
Bankruptcy support.
Benefits – Employment Support Allowance and sanctions
Bills, electricity</td>
</tr>
<tr>
<td>Food and nutrition
Even by just giving that cuppa tea, saying sit down for ten minutes
Initially cup of tea, invitation to community meal, curry night.
Something to eat, roll and slice, somewhere to get into some semblance of order, get a wee sort of time out.
Something to eat before clients go to computing class.</td>
<td>Health
Injuries – take to hospital
Identifying physical and mental ill-health and encouragement of health seeking behaviours
Enabling access or taking to their appointments, with doctors, nurses, podiatrists and people coming in to look after them.</td>
</tr>
<tr>
<td>Clothing
Provision of clothing. Washing and drying facilities</td>
</tr>
<tr>
<td>Support for education and learning support
Adult learning class, reading, writing, and computing: classes at fieldsites or supported to access elsewhere by DASW. Education and learning about alcohol and its impact – includes supporting volunteers working with people with PAU and cognitive impairment</td>
<td>Volunteering, placements and employment
Helping client and other people working with client, support groups (Feelings Group)
Within roles, avoid putting temptation in someone's way
Within roles, do not judge people – give them space to move on with their lives.</td>
<td>Other agencies
Services and agencies accessed or hosted at fieldsites: Health (GP, nurse, and podiatry), Shelter, Signpost, homeless worker, Addiction Support and Counselling (ASC).
Engagement with external agencies: benefits, employment agencies.</td>
</tr>
</table>

From a salutogenic standpoint, the table sections relate to enhancing GRRs and SOC. Subsequent chapters explore if clients, volunteers and other staff share the DASWs' viewpoints or if their stances are different. The iterative process will continue and challenge the portrayal of the community programme intervention and impacts developed till this point.

5.12 Conclusion

This chapter has challenged programme theories in preceding chapters and created novel ones, reflecting on both the importance of different organisational levels and dimensions of complexity. DASWs' data refuted that the community programme was a salutogenic workplace in the months following the Strategy launch. Complexities and gaps in induction, clarity of role, change of management and programme vision negatively impacted on DASWs' SOC. However latterly, there is an indication of improvements in their support. They described using personal GRRs including *practitioner nous* to aid recognition of cognitive impairment of varying causes, including ARBD, and to respond to and address client needs. This reflected individualised DASW contexts, mechanisms and outcomes influencing and influenced by SOC and the GRRs available to them. Of note were perceived variations in knowledge and understanding about PAU and cognitive impairment and how that influenced their workplace SOC. Interestingly, the Exploratory Focus Group itself was a resource to the DASWs. It provided a forum which they valued for meeting, discussion, reasoning and shaping viewpoints previously done independently of each other.

The DASWs did not speak of sudden transformational processes occurring as they supported clients, rather micro outcomes arising as a result of micro-actions, with for some clients, salutogenic personal growth. The DASWs' data portrays support for the client orientated CPTs, with early indicators both of crisis management but also client supported achievement of a life more rewarding without rather than with alcohol.

Chapter 6 now examines the understanding of other study participants about cognitive impairment, including as ARBD, in people with PAU how and its implications in and for recovery.

5.13 Chapter 5 theory building synopsis

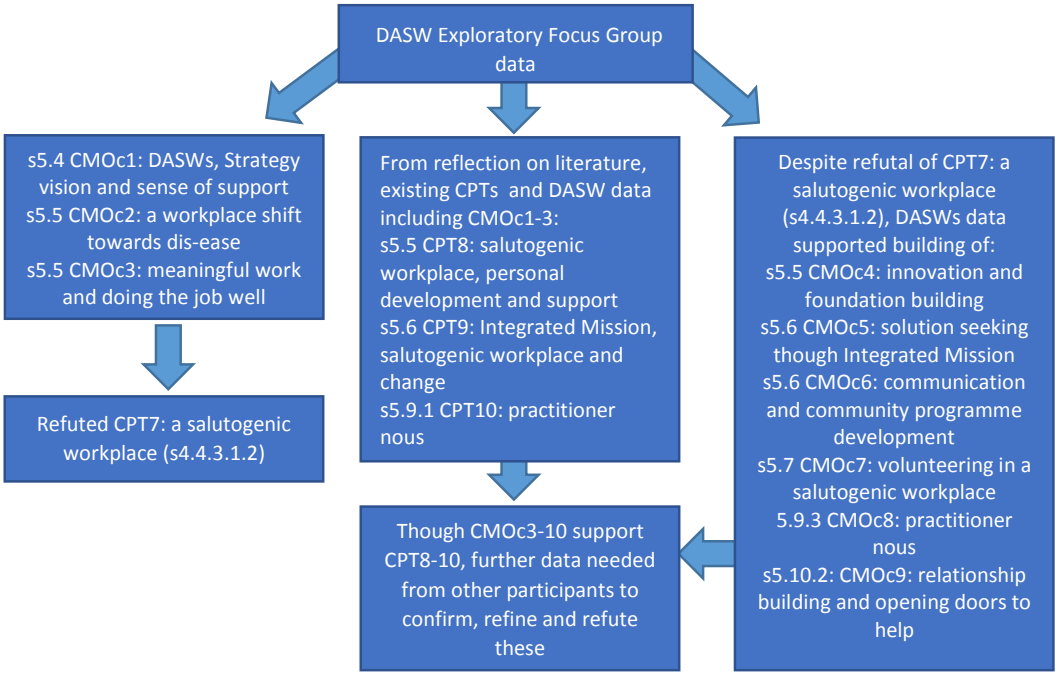

Figure 9 Theory building summary from DASWs' Exploratory Focus Group

Chapter 6 Explanations and understanding about problematic alcohol use, cognitive impairment and ARBD

6.1 Introduction

Either experiencing or supporting someone with PAU and cognitive impairment can be complex, and using Antonovsky's choice of term, a stressor (Antonovsky 1996). When faced with stressors, people with a strong sense of coherence (SOC) wish and are motivated to cope (meaningfulness), believing they understand the challenge (comprehensibility) and that they have resources available to deal with challenges being faced (manageability) (Antonovsky 1996). Based on this thinking, knowledge and understanding through effects on meaningfulness, comprehensibility and manageability may affect salutogenesis.

This chapter builds on epistemology foundations about how individuals or wider groups know what they know, what constitutes knowledge and how knowledge can be advanced (Davies and Hughes 2014). A twist to the standard realist question considers '*who knows what about associations between PAU, cognitive impairment and ARBD, in what circumstances, how and why?*' The hypothesis *CPT6: salutogenic cognitive benefits* (s.4.4.3.1.2) proposed that people with PAU offered the fieldsite intervention would be less likely to develop ARBD, or if this was already present, that they would have opportunities to improve brain function. For this to be true, it is anticipated key contexts and mechanisms would prevail. These include comprehensibility in help-seekers and help-providers about PAU, cognitive impairment and ARBD, meaningfulness in processes and outcomes, and manageability in the context enabling achievement of recovery outcomes. Gaps in these areas could detrimentally affect intervention outcomes. However, in realist thinking, outcomes can be expected or unexpected. It would seem important for help-seekers at risk of or

with ARBD and their help-providers to be aware of links between PAU and cognitive impairment. However, whether this knowledge would instigate moves towards reducing or stopping drinking is questionable, particularly as sites of ARBD have been linked to aspects of cognition function which could alter recovery-orientated reasoning (Le Berre et al. 2013).

Complex contextual factors can influence reasoning and decision making. These include hazardous drinking's association with difficulty coping and low SOC (Neuner et al. 2006) and cognitive impairment's impact on learning (Wilson 2015, p. 200 Table 12.1). Learning new coping strategies is important in achieving non-alcohol dependent fulfilment in life (Miller et al. 1999). Presence of alcohol-related cognitive deficits including impaired ability to abstract, problem solve and learn new information (Wilkinson and Sanchez-Craig 1981) may hinder such achievements. "*Learning-in-treatment*" (Wilkinson and Sanchez-Craig 1981) may be compromised because people may forget what they have learned. Engagement difficulties may arise, requiring understanding by support providers. The DASWs expressed views about gaps in their own, staff and volunteer training and education about PAU and ARBD. These perceived gaps had potential to affect their collective client support.

This chapter considers knowledge, knowledge gaps and learning needs identified by clients, staff and volunteers. Wider relevance of *CPT10: practitioner nous* (s.5.9.1) beyond the DASWs to other participants is explored, along with the latter's views on PAU, cognitive impairment and ARBD. A new CPT presents client, volunteer and staff recommendations for future information provision, learning and support (*Figure 10 CPT11: the right track,* s.6.3*)*.

6.2 Chapter guide

The chapter follows a pattern of participant contribution in keeping with community programme layers of clients, clients in recovery, volunteers and staff. This allows data from people individually or in context similar groups to contribute to theory consideration and building. Each section begins with participant group contextual information. AUDIT scores are provided for clients and clients self-described as in

recovery to gauge their current drinking practises (Babor et al. 2001). The participant group order provides opportunities to demonstrate salutogenic flow, including in ARBD's presence.

Participants preferred terminology when referring to PAU, cognitive impairment and ARBD is presented. Their understanding about cognitive impairment and ARBD is explained. This can relate to understanding of experiences in their own or others day-to-day lives, or to what they believe factually or scientifically accurate. As the research is not based about a medical model, understanding and experiences about thiamine and complexities associated with its use including engagement with health supports are included in a recommendation for further research in the concluding thesis chapter.

6.3 A pause for reflection

Realist approaches challenge researchers to think in a retroductive and iterative manner, building theories as new hypotheses, explanations and understanding arise. A pause is now taken to reflect on the intervention context and those it aimed to serve. The importance of so doing lies in realist thinking about complexity, as to think of knowledge and understanding in an isolated rather than contextual manner would diminish its relevance, meaningfulness and implications. The discussion which follows is inspired by Antonovsky (1990, p. 74) and supported by *Figure 10 CPT11: the right track* (s.6.3) and Salvation Army grey literature (documents, video material, presentations and individual's personal accounts at events).

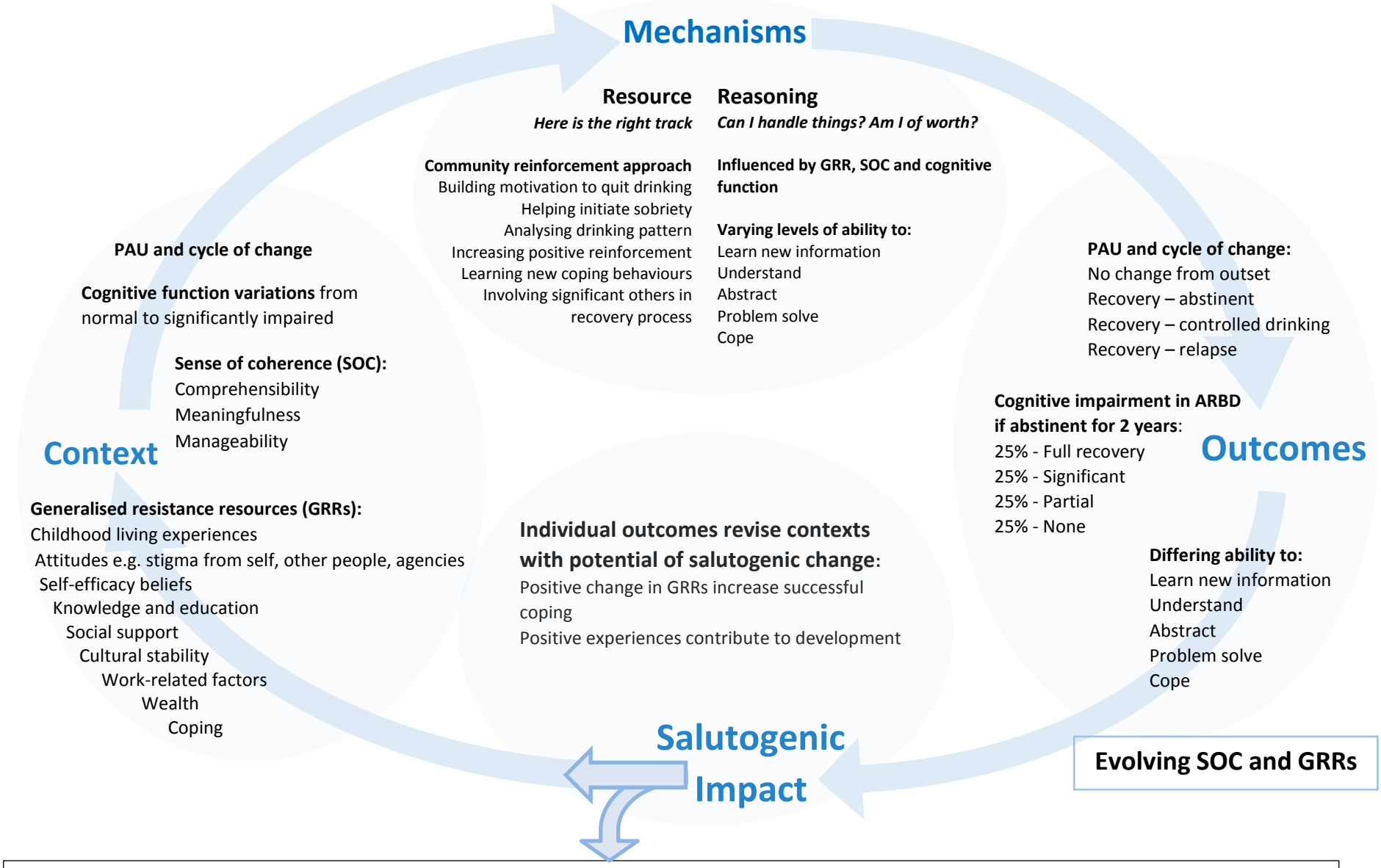

Figure 10 CPT11: the right track

To TSA, the Community Reinforcement Approach (Miller et al. 1999) principles were viewed as offering benefits to the fieldsite intervention. Though the intervention implementation was incomplete when the research occurred, the CRA principles have been included in *Figure 10 CPT11: the right track* (s.6.3). Mechanisms are proposed that the community programme offered resources guiding people towards "*the right track*" in recovery from PAU and ARBD. It is hypothesised resources such as those in the CRA (Miller et al. 1999) can support people in reasoning about manageability, meaningfulness and self-worth enabling them to reach and stay on "*the right track*". However, reasoning mechanisms are influenced by individuals' GRRs, SOC, cognitive function and wider context. Contexts incorporate individuals' experiences of PAU and cognitive impairment, and their position on the cycle of change. It is therefore hypothesised that outcomes are beyond solely learning. Knowledge and understanding may subsequently be relevant resources in a cyclical or spiralling manner, helping build and strengthen SOC. For some these evolving and strengthening resources may prompt recovery orientated change. Thus contexts, mechanisms and outcomes can change, with outcomes contributing to subsequent contexts. Resources may pre-exist in, or be added to, individuals' contexts via a resource mechanism including through the intervention (Dalkin et al. 2015), family supports or other agencies.

It is hypothesised when key mechanisms fire in salutogenic contexts supportive of recovery, individuals may reach a set and setting of belief that they are on the right track, they can handle their PAU and recovery maintenance, and they are of worth so the challenges they face are in turn worth overcoming. Furthermore it is proposed in salutogenic circumstances the cycle of change focus incorporates not just alcohol-related change but also aspects, opportunities and consequences of change in cognitive function which may or may not arise. However, in keeping with realist thinking, ultimate outcomes may not be a single version of "*the right track*" (Antonovsky 1990, p. 74) but a "*complex signature*" of planned, clear, puzzling or unanticipated outcomes for different individuals or groups (Pawson and Tilley 2004).

Following *Figure 10 CPT11: the right track* (s.6.3) there is a refocusing on participant knowledge and understanding and the question: *what explanations about knowledge*

and understanding about associations between PAU, cognitive impairment and ARBD exist in what circumstances, for whom, how and why?

6.4 Contextual factors for clients with current PAU

Table 8 Clients: aspects of context below presents summarised contextual information about clients with current PAU, all of whom were unemployed men aged 28 to 58 years.

Table 8 Clients: aspects of context

Client	Age	AUDIT score	Childhood and when started drinking	Criminal history	Cognition and diagnoses (formal or self)	Medication	Work history	Where lives
C4R	28	40	Not known	Prison	Schizophrenia. History consistent with cognitive impairment. Seizures and suicide attempts	Schizophrenia medication. Uses diazepam and cannabis	Either in prison or unfit due to mental ill-health	At aunt's
A7C	35	39	Not known	Prison	History consistent with cognitive impairment	Not known	Not known	Homeless. Street drinker
A5C	39	32	Not known	Prison	History consistent with cognitive impairment though does not think ARBD	Not known	Fishing industry	Homeless. Street drinker
C1C	41	40	22 – PAU from age 28. Both parents physically and verbally abused him.	Said police repeatedly stop and search him	History consistent with cognitive impairment and marked ARBD. Loss of sensation in fingers. Hallucinations.	Does not wish medication to help him stop drinking. Uses cannabis	Hotel work Caddy Played guitar. Bodybuilder Begging	Homeless. Street drinker
B1C	47	40	16 – PAU from age 21 when grandmother died	Prison	History consistent with cognitive impairment. Depression, seizures, self-harm	Anti-epileptic drugs and antidepressants	Employment agency schemes. Security agencies	Flat
A1C	49	40	Complex life-long relationships with father. Due to PAU, no longer seeing own son (age 6)	Shoplifting	History consistent with cognitive impairment. Thinks has ARBD. Previous drug use and suicidal thoughts. Seizures	Not known	Owned hotels, restaurants, two businesses	Flat. Homelessness experience
A3C	54	39	Not known	Prison	History consistent with cognitive impairment. Back pain	Thiamine. Analgesics	Oil rigs, building trade, driver	Flat
A6C	55	40	Not known	Prison	History consistent with cognitive impairment and ARBD: *"I'm away wi' the budgies"*	Not known	Professional sport	Sofa-surfing, homeless, street drinker
C7C	58	20	10 – does not think he has PAU. Others thought PAU from age 21	Not known	Forgetfulness he attributes to senile dementia and age. Walks with stick and back problems	Not known	Roofer, steel erector, labourer: *"You name it, I've done it"*	Flat

As shown in the AUDIT scores, most of which were 40, drinking levels were akin to probable alcohol dependency (Babor et al. 2001). Clients' alcohol consumption began from age 10 to age 22. Almost all referred to "*alcoholics*" and "*alcoholism*" to describe their own or others' PAU. Client-A6A described being diagnosed with ARBD and all except one recounted experiences in keeping with cognitive impairment. Client-C7A described minor levels of forgetfulness such as forgetting his keys or bus pass.

6.4.1 Severe and multiple disadvantage

All clients had experienced lives of multiple and severe disadvantage at the dis-ease end of the health continuum. Two clients described difficult childhood relationships with parents, one being physically abused. Encounters with prison services, courts or police were the norm. Four lived in rented accommodation, four were homeless and one lived with an aunt. Most had past prolonged employment in varying roles, with workplace drinking culture influences (Client-A1A).

6.4.2 Mental and physical wellbeing

PAU and co-existing physical and mental ill-health affected ability to work, but did not necessarily diminish expressed desire to work:

> *Ah've worked a' ma life an' Ah dinnae want tae go tae job centres ….. I want tae make a wage. (Client-C1A)*

Client-A3A described seeking employment which supported his ability to access alcohol all day and unemployment consequences including loneliness:

> *If ye're nae workin', whit are ye ginnae dae? Sit in the hoose a' day bored? No, you'll either go oot or welcome dafties into yer hoose who don't give a shit as long as they've got a place to sit an' drink. (Client-A3A)*

Three clients experienced seizures, one described self-harm and another, suicide attempts. Client-B3A described self-medicating using alcohol and prescribed painkillers. Others described past or current drug misuse. Client-C1C wished to avoid medication to help him stop drinking.

6.4.3 Thoughts about recovery in the community programme context

Clients' SOC and GRRs were evident, though focused on sustaining alcohol intake thus strengthening their place at the dis-ease end of the salutogenic continuum. There was experience and understanding of alcohol-related loneliness and isolation, with peer

connections primarily meeting alcohol rather than friendship needs. For some, there were peer friendships, companionship and mutual support in the presence of ARBD

Clients' SOC and GRRs were low with regard to addressing PAU and associated cognitive impairment. However, fieldsites were resources, places clients had established relationships and went and returned to at times of need or want. Peer support in joint attendance was a resource for some, and all except Client-C7A had established relationships with the fieldsites. This offers early confirmation of *CMOc9: relationship building and opening doors to help* (s.5.10.2).

6.5 Clients with current PAU: explanations and understanding about PAU, cognitive impairment and ARBD

The aim of this and similar sections for remaining participants is to build explanations and understanding about what knowledge different participants had about associations and impacts of PAU, cognitive impairment and ARBD. This supports explanatory CMO development and CPT review.

6.5.1 Sources of explanations, knowledge and understanding

Main resources and contextual factors influencing client explanations, knowledge and understanding about PAU and cognitive impairment were personal experiences. Some participants knew people with presentations in keeping with cognitive impairment and PAU (Clients-A5C, A6C and B1C) and other people with thinking or memory difficulties unrelated to alcohol (Clients-B1C and C4C).

Information provision as a resource mechanism had been provided or accessed in different ways. This included via the Integrated Alcohol Service and NHS, AA, television and conversation. During focus groups and interviews, some participants demonstrated reasoning and evolving understanding and perceptions about ARBD.

Witnessing effects and reasoning about cognitive impairment in others affected explanations and understanding about alcohol, its impact on the brain, and possibilities of different causes of cognitive impairment including head injuries,

Parkinson's disease and what was described as senile dementia. However, as indicated by comments made by Clients-A1C, A3C, A5C and A6C, individual's knowledge varied in type. Two clients were more comfortable thinking of their cognitive impairment as due to "*sickness*" (Client-A5A) and old age or dementia (Client-C7A) rather than alcohol.

6.5.2 Scope of explanations, knowledge and understanding

Client knowledge about cognitive impairment and PAU varied, including awareness of ARBD. Client-C4C was unaware of PAU's association with cognitive impairment. When asked about any experience of memory problems, his response reflected the complexity of his mental ill-health

> *It's all bad memories. Every time I sit an' think about a memory, makes me tick, tick, tick, an' Ah go, boom. (Client-C4C)*

The outcome was a strong desire to seek and drink alcohol, creating risk of ARBD. However, others were aware of ARBD. Two drinking friends highlighted how similar contexts and mechanisms led to different knowledge and understanding outcomes. Describing themselves as alcoholics, they were often together witnessing each other's alcohol and cognitive problems. They attended the same psychiatric hospital due to PAU, and while not guaranteed, were probably provided with similar advice about PAU and cognitive impairment. Client-A6C believed he had ARBD caused by his alcohol intake:

> *I'm no' happy about it ….. But it's what I'm daein' to myself. Naebody else is forcin' me to drink. (Client-A6C)*

Client-A5C conversely, did not think he had ARBD despite experiencing memory and thinking difficulties:

> *Of course I have ….. but I'm not saying it's a brain damage ….. I see it like a sickness because you always coming back to the same square. (Client-A5C)*

Returning to the same square alluded to reasoning on recovery and anticipated inevitable return to "*sickness*". Client-A6C disagreed with Client-A5C who then conceded he perhaps had ARBD. This combination of resource and reasoning mechanisms were apparent in conversations with Client-A1C and Client-A3C. Client-A1C had not heard of ARBD but said he had felt it and knew it was happening.

Mechanisms were feelings associated with cognitive impairment, knowledge gaps around ARBD, and reasoning about his own experiences on hearing the term ARBD. When asked about its meaning, he immediately replied the cause was alcohol "*killing brain cells*".

6.5.3 Awareness of liver damage and recovery: comparisons to the brain

Statutory agency information on alcohol harm and recovery was described as focusing on the liver with little on the brain. Three clients referred to liver damage caused by alcohol and two to its potential to "heal" if alcohol was stopped. Client-C1C believed his brain had similar recovery potential, but was more concerned about his liver. Although Client-B1C remembered the Integrated Alcohol Service's advice about potential liver recovery, he did not remember equivalent information about his brain. His interpretation of a hospital specialist's comments about his brain and alcohol withdrawal seizures was:

> *When I take these seizures he says that's ma brain shuttin' down. An' if Ah stop ma drinkin' as he says, "That's your brain opening up again". (Client-B1C)*

6.5.4 Client summary

Client information provided on contexts and explanations and understanding about PAU and cognitive impairment supports *Figure 2 CPT11: the right track* (s.6.3). It demonstrates complexities of client contexts with intertwining of factors relating to PAU, cognitive function, SOC, and GRRs. This affected '*firing*' of mechanisms in response to resources influencing explanations and understanding. Knowledge gaps about ARBD were clear implying missed opportunities for informed decision making reducing risk of cognitive harm. Furthermore, presence of knowledge about associations between PAU and cognitive impairment, including when diagnosed as ARBD, did not demonstrate a move on the cycle of change to reducing or stopping drinking. Clients were at the dis-ease end of the salutogenic health continuum. However, in their context, the community programme was a platform offering safety, strengthening of resources and access to opportunities for ongoing support.

6.6 Contextual factors for clients in recovery

Table 9 Clients in recovery: aspects of context on the next page gives summarised data about eleven men in self-reported recovery from PAU for 4 months to 28 years, aged 37 to 73 years who participated. One said he had*:*

> *Conquered ma drinking now …. I'm on the straight and narrow road ….. I don't think about drink. (Client-C5R)*

Overall salutogenic status, GRRs and SOC were stronger than when drinking with the fieldsites resources to the men from twice daily to every few weeks. Fieldsite-C's importance to Client-C5R was reflected in the sixteen mile, public transport round trip he chose to make to access it a few times a week.

Clients in recovery described complex life experiences in keeping with severe and multiple disadvantage. Five had been in prison and two others described circumstances of avoiding anticipated incarceration. Prison resulted in Client-A4R reasoning about benefits in stopping drinking:

> *If you forget your last drink an' where it took you, then you're gonnae go back on it again. Ma last drink took me in to lookin' at 4 to 5 years in jail. (Client-A4R)*

Client-B5R was fearful about his future as his father and grandfather were in care homes totally dependent on others due to ARBD. Like others, alcohol was part of life from a young age. This included exposure to parental PAU and drinking themselves from age 8 or 9 years. Client-B4R's father died when he was 13 years old. Despite being abused by him, he was saddened by not knowing his father. The context he viewed as being where he could have done so was the pub, *" just tae see what he'd be like." (Client-B4R)*

Most clients in recovery abstained from alcohol, though two had AUDIT scores of 9 and 16 respectively suggesting possible need for ongoing support (Babor et al. 2001). None were homeless but two required Salvation Army support to maintain tenancies, one stayed in a residential care home and five received family support in their daily lives. Client-C2R and C3R owned their own homes, Client-C3 describing himself as being a "*hobo*" when he was a teenager, homeless and sometimes living in Salvation Army homelessness accommodation.

Table 9 Clients in recovery: aspects of context

Client	Age	Recovery in years	AUDIT score	Childhood and when started drinking	Criminal history	Cognition and diagnoses (formal or self)	Medication	Work history	Where lives
B3R	37	4	0	15	Prison	Mental ill-health, forgetful, hallucinations	Disulfiram, diuretic, gabapentin, methadone	Not known	Lives at family member's home
B5R	39	0.7	0	13. Father and grandfather have ARBD	Not known	ARBD – diagnosed	Thiamine, antidepressant	Would like to be a counsellor	Permanent home
B4R	41	0.3	0	Young age. Abused by alcoholic father	Not known	ARBD – diagnosed	Thiamine	Gardening, floor laying	Permanent home
B2R	46	6	0	In AA since age 16	Not known	Head injury, depression, memory problems	Amitriptyline, diazepam, dihydrocodeine, pregabalin	Not known	Permanent home
C8R	46	1	16	Not known. Also problematic drug use	Not known	Previous alcohol-related blackouts. Forgetfulness	Suboxone	Building trade	Permanent home
C10R	54	1	9	Not known. Also problematic drug use	Prison	ARBD by description	None	Hotel	Permanent home. Past homelessness
A4R	56	34	0	"*Drinking was in general a thing to be good at. As a young kid I can always mind ma dad being drunk ….. ma mama being drunk*"	Prison	Head injury	Not known	Soldier Air Defence. Studying at university	Permanent home
C5R	60	20	0	Not known	Not known	Mental ill-health	Not known	Railways, miner, forestry, councillor	Care home
A2R*	66	14	0	*"I was working at 15 and I just thought it was my right after work that I could go and have a drink. An' some of ma pals used to drink and we used to get older people to buy the drink*"	Prison	Cognitive impairment: told by GP memory loss due to alcohol	Not known	Building trade, post office, machine assistant in mill, printers	Permanent home
C2R*	68	23	0	*"I wasn't brought up bad. I was brought up in a good Christian Catholic home, but alcohol taken ma whole personality. I could be singing an' somebody would say something tae me an' I'd go aff ma heid"*	Prison	*"It's called Korsakoff's or wet brain syndrome ….. I've got some of that plus the (head injury)". Memory problems. Anxiety, depression, arthritis, post-traumatic stress disorder*	Amitriptyline, diazepam, dihydrocodeine, venlafaxine	Army	Bought house
C3R*	73	28	0	*"I was born in the middle of the big war in about 1942. Drink was a goin' thing and the expression was, "the rich got rich an' the poor got drunk""*	Not known	Memory problems. Aortic aneurysm, encephalomyelitis, myocardial infarction, peripheral neuropathy, prostate cancer	Morphine plus long-term condition and prostate cancer medication	Carnivals, caddy	Bought house. Past homelessness
C9R	49	3	6	Problematic drug use	Prison	Not known	Diazepam, methadone	Kitchen, building and hotel work	Permanent home

*Table notes: * indicates those who are retired, the rest being unemployed*

As a group, previous PAU was not an isolated issue. Proximity to the dis-ease end of the health continuum was reflected by differing general and mental ill-health and/or significant head injury, prescribed medication and current or past drug misuse. Two diagnosed with ARBD were taking thiamine.

Client-B3R's account reflected help-seeker context complexity and the ripple effects on others. His sister who he lived with supported him every day. He described forgetfulness and mental ill-health issues, including hallucinations. He took methadone for drug dependency, sometimes a neighbour's medication for a "*cage fighting*" injury, and previously medication to discourage alcohol consumption. His account and those of people with head injury, dual addiction and dyslexia histories concurred with DASW discussions about help-seekers' potential multi-factorial cognitive impairment.

6.6.1 Employment

Three clients in recovery were of retirement age, though ill-health prevented employment pre-retirement. Unemployment and financial reliance on government benefits was normal. Two had been in the military. Like prior client group descriptions, importance was placed on occupations enabling access to alcohol or incorporating drinking cultures (Client-A2R). Client-A2R worked for most of his life despite PAU and cognitive impairment. Employment agencies were supporting Client-B4R who had ARBD to get landscape gardening work. Client-B5R had been assessed as unfit for work due to ARBD, which he found demeaning, distressing and incomprehensible.

6.6.2 Access to learning resources

Of importance to acquiring new knowledge and understanding were findings demonstrating seven clients in recovery had taken up educational opportunities ranging from home cooking to university courses. Home cooking courses helped people address ARDB associated salutogenic decline. Cooking skills and thus nutritional opportunities had been lost with diminishing cognitive function, the former then potentially exacerbating the latter and worsening salutogenic continuum status.

Client-C2R described mixed salutogenic changes in recovery. A head injury prevented civil engineering educational and employment ambitions. However, he established and participated in an AA group. Cognitive decline now created difficulty in his chairmanship of the local community council. This account demonstrated a shift to the ease end of the salutogenic continuum, the resource Client-C2R had become and created for others, and more recent cognitive decline creating a dis-ease shift. Nevertheless he retained resources including the community programme that without recovery he would not have had. Intermittently assisting in Fieldsite-B tasks, Client-B3R also demonstrated salutogenic flow.

Overall to clients in recovery, fieldsites were important resources supporting shifts towards salutogenic ease and fulfilment levels surpassing those prior to recovery. Clients in recovery spoke in manners consistent with choosing "*the right path*" though this was not necessarily being alcohol free. As demonstrated by durations of recovery and ongoing resources clients in recovery chose to access, this was not a "*quick fix*". In keeping with *Figure 2 CPT11: the right track* (s.6.3), the community programme was one of a number of resources contributing to and sustaining recovery. Notably achievements occurred in personal contexts in which PAU and cognitive impairment were merely two complexities.

6.7 Clients in recovery explanations and understanding about PAU, cognitive impairment and ARBD

Clients in self-reported recovery shared sources of explanations, knowledge and understanding with clients who were currently drinking. Main resource and contextual factors related to personal experience. Some were actively involved in AA and NA including as mentors providing information and support to others. This highlighted the need for accuracy of shared knowledge and understanding and demonstrated positive salutogenic shifts in which increased comprehensibility aided meaningfulness and manageability of PAU and ARBD.

Seven clients had heard of ARBD, though four usually referred to "*wet brain*" and/or Korsakoff's, and another, "*brain freeze*". Client-C8R had not heard of ARBD but like

Client-C7R and Client-C13R knew that people could “forget about things an’ that” in association with alcohol. Nine clients in recovery referred to people with PAU as “*alcoholics*”, four of these also referring to “*alcoholism*”. Client-C3R described people as being allergic to alcohol and preferred medical terminology which to him emphasised a state of illness though opted for terms peers used:

> *Ah keep usin' the word alcoholic 'cause Ah've got tae view it fae the people that's roon' aboot me, ma peers an' that. (Client-C3R)*

Three clients referred to themselves or others “*drinking*” implying this was at problematic levels. Two spoke of alcohol “*addiction*” and that some people with problematic drug use began drinking alcohol hoping it would help them stop drugs. Client-B5R challenged what he perceived as inequitable access to opportunities for people labelled as having had alcohol or drug addictions compared to others. Some described PAU and ARBD as hereditary illnesses based on genetic abnormalities. Three generations in Client-B5R’s family had ARBD. Client-B2R said the drug ethanol rather than alcohol was craved.

Alcohol’s power and influence was described but also strength in resisting it:

> *This alcohol has got no barriers. It can take anybody an' it'll take the skin off yer back. An' it's the only illness I know that tells you you've no' got it. It's powerful, it's cunning, baffling, but it's also patient. It'll wait till ye're having a bad time: it'll go like, "Hae a drink. Hae just one." Ah've had that a thousand times, but Ah've no' took a drink. (Client-C2R)*

Inability to resist was associated with belief about alcohol-related early death, because of knowledge of a “*phenomenal amount of people*” (Client-C10R) who had died and an understanding of why some with ARBD opted for suicide (Client-B5R):

> *One way to explain it is you have a murderer running about in your head speakin' to you in your own voice, tellin' you it's OK to use alcohol an' drugs, even though you know long term it's gonnae kill you….. You have a disease that tells you that you don't have the disease. (Client-C10R)*

It was in this context that ARBD could occur, potentially rapidly and dramatically:

> *If they realised in a year's time, six months’ time, if they keep drinking the way they do, they'll maybe not remember their own name. (Client-B4R)*

Alcohol was described as killing brain cells without replenishment, with varying viewpoints on permanency of memory loss (Client-B5R) in Korsakoff's or wet brain syndrome (Client-C2R).

The impact was loss of confidence in future cognitive function:

> *Since Ah came aff the drink, I feel that ma memory is gettin' a lot, lot worse ….. so Ah'm livin' in the unsurity - is ma memory gonnae get worse? (Client-B5R)*

Yet for some there was a glimmer of hope:

> *The wet brain guys, none of them recovered ….. Some of them like H.C., he wasnae so wet - he wasnae compus mentus - an' he could deal wi' wee problems after a while (in recovery). (Client-C3R)*

Client-C10R's understanding that improvement in cognitive function took time was based on personal experience and knowledge acquired through NA:

> *It's said that it takes a month for every year (of PAU or drug use) tae have a normal thought process. (Client-C10R)*

6.7.1 Relevance of ARBD to clients in recovery to self and others

Client-B3R gave no indication he had been diagnosed with ARBD, but his presentation was suggestive of cognitive impairment. In recovery from PAU and drug use, he had mental ill-health issues, was on methadone and had slow, slurred speech:

> *Ma mind's gone….. Ah could be talkin' aboot something an' next minute Ah'm lookin' at the person, "Whit was Ah sayin' there?" ….. It just stops for some reason, an' Ah'm feeling like a pure idiot. Ah'm like, "Sorry. Ah don't know what Ah was talkin' aboot." (Client-B3R)*

Four clients had been diagnosed or believed they had ARBD. Two diagnosed with ARBD and two others thought their cognitive problems were due to something else. Client-A2R attributed forgetfulness and difficulty constructing sentences to old age or dementia. Client-B2R attributed memory difficulties to "*all the years of drinking an' everything else building up*". He believed a drug and car accident related head injury not PAU triggered cognitive issues as he had not noticed prior difficulties and had been sober since.

Client-B5R talked about his ARBD diagnosis, yet repeatedly asked that someone explain what was happening to him. His account of provision of general and

personalised information about ARBD by statutory health providers is demonstrated in *Figure 11 CMOc10: Client-B5R ARBD knowledge and understanding*.

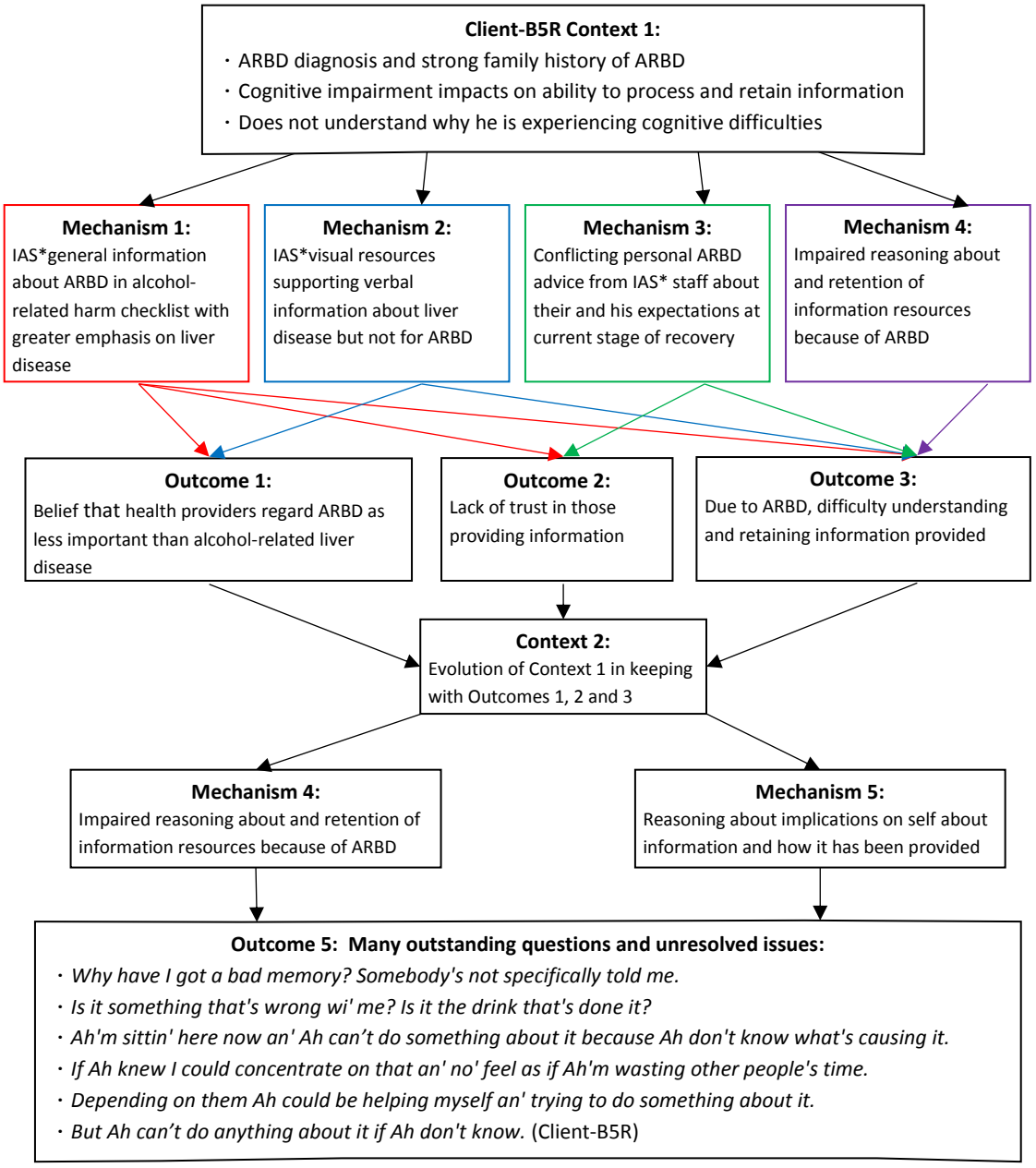

Figure 11 CMOc10: Client-B5R ARBD knowledge and understanding

*IAS - Integrated Alcohol Service

Client-B5R's comments reflected personal turmoil, suffering (Cassell 1998) and diminished GRRs. Furthermore they indicated a lack of comprehensibility, manageability and meaningfulness, all crucial to his SOC and salutogenic make up. He could not follow in his father's footsteps in ways he aspired to:

He was really high up - worked wi' social work, carried two jobs. He always supported an' looked after us. But he always carried the drink problem as well, but he was a functioning alcoholic. (Client-B5R)

Client-C10R had a clearer outlook. He attributed his cognitive impairment to PAU and drug use, but explained knowing about alcohol's harmful effects did not necessarily alter behaviour:

I was aware that alcohol damages the brain but once you're so active in alcoholism, all reason goes out the window. (Client-C10R)

With DASW-C's help, he took ownership of his recovery and his cognitive function gradually improved:

I'm just coming round from alcohol an' heroin. I call it brain freeze. Two years ago I could barely walk and I lost the gift of speech through alcohol an' drugs combined. So I'm in the process now of retraining my mind. (Client-C10R)

Client-B4R described trying to improve his cognitive function after regressing to what he regarded as equivalent to infancy:

It's as if you've just come out your mother's womb an' you're tryin' tae learn everything all over again. (Client-B4R)

Client-B5R and Client- B4R, who had ARBD, contrasted understanding about recovery in ARBD to other alcohol-related conditions based on information from health providers. They viewed ARBD as unimportant to specialists compared to liver disease:

They'll show you photos ….. that's cirrhosis of the liver or ….. a picture o' a swollen belly, an' then turn roon' an say, "You can also develop Korsakoff's". Full stop. No pictures. No nothing. (Client-B5R)

They things can be fixed, but when ye loss yer brain, there's nae comin' back. (Client-B5R)

A sense of stigma arose, that people with ARBD were undervalued compared to those with liver disease. This was compounded by an ongoing sense of cognitive decline, in keeping with Client-A2R whose memory had improved after going into recovery but was worsening again despite abstinence.

6.7.2 Client in recovery summary

Clients in recovery described PAU as an allergy to alcohol and a disease or illness influenced by genetics. Alcohol was craved and seen as a powerful, living, deceptive

being. Most were aware of associations between PAU and cognitive impairment, terminology used being "*wet brain*", "*Korsakoff's*", "*brain freeze*" and "*ARBD*". They referred to people with PAU as "*alcoholics*" and "*addicts*". PAU was seen as potentially leading in 6 months to a year to an individual being unable to remember their name. Alcohol was believed to kill brain cells without replenishment. Knowledge of alcohol's potential impact on cognition did not necessarily lead to reduced alcohol intake because of alcohol's impact on reasoning. In recovery, cognitive improvements were believed slow and limited, if occurring at all due to ARBD's perceived permanency. Yet Client-C10R demonstrated marked improvements could occur. PAU and ARBD were associated with early death. In life associations were with confusion, fear, embarrassment, feelings of idiocy, stigma, inadequacy, and diminished SOC.

Diagnosis of ARBD, or belief by clients their cognitive impairment was due to PAU, did not preclude some attributing it at least in part to other causes including age, dementia, drugs and head injuries. Mechanisms supporting acquisition of knowledge and understanding were influenced by the accuracy of that held by those providing it and by levels of cognitive impairment of those in receipt. This finding is relevant to *Figure 11 CMOc10: Client-B5R ARBD knowledge and understanding* (s.6.7.1) as with time, cognitive impairment may improve to differing levels. Understanding and retention may thus improve along with other skill sets, with potential impact of GRRs and SOC. In contrast, negative effects on GRRs may occur when emphasis is on alcohol-related liver disease with little mention of ARBD.

6.8 Contextual factors for community programme volunteers

In contrast with the all-male client and clients in recovery groups, two thirds of the twenty-one volunteers were women. The total group has been subdivided into three. Five were client volunteers who volunteered but were also clients in receipt of ongoing Fieldsite support. Five were placement volunteers. Eleven are described as "other volunteers", and were neither clients nor on placements. Only one volunteer also had a current paid job. While some had no personal PAU experience others

demonstrated salutogenic flow from client to client in recovery to client volunteer and ultimately to volunteer. The contexts of these transitions involved TSA and other agencies.

Client and placement volunteers were all under 55 years of age with two men and three women in each group. One was a Salvationist. All had experienced PAU or drug use. Three worked in fieldsite kitchens and cafés, two in the shops, three volunteered in peer support groups, one was a gardener and another, a hairstylist. Two placement volunteers were doing work experience linked to benefits payments from employment agencies. Three came from prison as part of community re-engagement.

Eleven other volunteers comprised three men and eight women, two with past and none with current PAU. All but one were close to or, as most were, over age 60. Seven worked in the kitchens or cafés, three were receptionists and one supported spiritual activities. Three were Salvationists and one an adherent for decades. One Salvationist had not revealed his past PAU in the community programme, whilst another had. The former attended literacy lessons to support his Sunday school teacher role. Another described non-alcohol related experiences suggestive of cognitive impairment, again not shared with others.

6.8.1 Wider contextual information

PVolunteer-C1R lived in homelessness accommodation, the rest having permanent housing. Three had previously lived in homelessness settings. Relocation did not necessarily help PAU:

> *Changin' the scenery doesn't change the problem. I got drunk, I was wild ….. And then Ah got put in a bedsit so then Ah gained a whole other set o' problems tae deal with ….. Stuff like taking cocaine, amphetamines, smokin' dope, an' still drinkin'. (PVolunteer-C1R)*

Two other volunteers had experienced mental ill-health described by them as bipolar and depression. Three described significant physical health issues. Some volunteers had similar difficult childhood experiences to clients, including proximity to relatives with PAU. Some linked drinking onsets to complex childhoods. One described physical abuse resulting in moving into care, and another, domestic violence.

Salvationist CVolunteer-A1R described being "*unhappy*" when growing up. He found TSA and band involvement "*not enough*" opting at age 18 for life changes precipitating decades of PAU. He attributed stopping drinking to community programme help, including re-engagement with the band. He felt strongly about his volunteering role and ability to support others because of his experiences. Life complexities remained he said because of a life-limiting cancer diagnosis. However, DASW-AR was concerned about relapse due to his recent absences and an apparent smell of alcohol. Volunteer-A1 brought a different perspective, describing her brother's alcohol-related significant memory loss as primarily "*selfishness*".

6.8.2 Summary of contextual factors for community programme volunteers

Unlike the client groups, most volunteers were women. All except one had permanent housing and only one was in paid employment. The '*other volunteers*' were mainly older and in contrast to client and placement volunteers, only two had personal PAU experience and none problematic drug use. Similarly although volunteers described physical and mental ill-health, this was less than for clients. In salutogenic terms, volunteers were more towards the ease end of the health continuum than clients.

6.9 Volunteers' explanations and understanding about PAU, cognitive impairment and ARBD

There are two components to explanations, knowledge and understanding to be considered for volunteers and staff. One relates to the disease-model aspects of PAU, cognitive impairment and ARBD. The other focuses on psychosocial aspects, for if volunteers and staff lack skills and abilities to engage with clients, hoped-for outcomes may not arise. These areas will be discussed more fully initially for volunteers and then for staff after their contexts are presented.

6.9.1 Sources of explanations, knowledge and understanding and their contexts

Having "*worn the T-shirt*" of PAU or drug use positively influenced lived experience knowledge and understanding. Seven of the 21 volunteers (3 client, 2 placement and 2 other volunteers) had had some form of education about PAU and its impacts. Knowledge and understanding was also influenced by involvement in AA, prison run

courses, Signpost and Alcohol Counselling Services rather than the community programme. Three were undertaking courses to help them support others with PAU in NHS or other settings. Another was doing a counselling course in prison. Volunteer-A3 received training while working in a psychiatric hospital and alcohol rehabilitation unit.

PVolunteer-C1R had heard of ARBD but not Korsakoff's. Differing terminology used for ARBD, its potential long-term impact and varying causes of cognitive impairment were raised by CVolunteer-B2R when speaking of his experiences:

> *I always believed it's what they first called Korsakoff's disease, wet brain. I always thought I was brain damaged but it was explained to me it could be a number of things - forgetfulness an' just dementia. It's like senile dementia, things like that. Some come in different categories if that's the right term. (CVolunteer-B2R)*

Volunteer-C2 wished to help others. Her ex-partner and mother-in-law had PAU with accompanying cognitive impairment. She thought as a volunteer her knowledge and awareness of PAU and its impact had grown:

> *I love the communication and building a lot of trust. An' people now, when they trust you, open up to you. I learned a lot I didn't know - a lot about judgements I had made wrongly about people in situations that they were dependent upon things. I've got a lot to learn. (Volunteer-C2)*

DASW-C and Staff-C1 referred to Volunteer-C2 as "*dangerous*". They thought she lacked knowledge and understanding about PAU, and could inappropriately "*stick her oar in*" with some clients. She demonstrated learning about the importance of communication and trusting relationships, but lacked specific expertise in helping people with PAU. Insight was offered by Volunteer-A3:

> *I remember sayin' to somebody, "Oh, they were a bit uncanny, they were a bit oot of their mind" (with the reply), "You should be able to deal with that." But we've had nae training as such to deal with people that's got a difficult problem. We're just kindly, welcoming people that do our best. (Volunteer-A3)*

Volunteer-A1 encountered difficulties engaging with clients, often regarding food parcels and. She described hurdles in recognising cognitive impairment:

> *If someone comes in and they're very drunk, it's hard to know what they're thinking - or if they're thinking. I think I'd have to be in it a lot of years to be able to just snap my fingers and think "That one's definitely got memory problems" or "That one (hasn't)". A lot of it as well is when you choose to lose your memory. (Volunteer-A1)*

A contextual factor regarded as beneficial by clients and volunteers who had experienced PAU was shared experiences with the person they were talking to:

> *I get people now that likes a drink, that come an' talk to me in the town. That's why they come to me because they sit back, "You've done it. You've been there. An' you've wore the T-shirt." (CVolunteer-A1R)*

Client volunteers felt more able to address complex situations with clients than volunteers without personal PAU experience including because sometimes they could:

> *….. be a wee bit harder on (Clients) 'cause they can see through manipulation as well. (CVolunteer-C2R)*

Information sources, understanding and knowledge varied, most originating outwith the community programme. Some '*other volunteers*' were vulnerable due to lack of training and life experience, thus their volunteering experience did not fully support *CPT7: a salutogenic workplace* (s.4.4.3.1.2) or *CMOc7: volunteering in a salutogenic workplace* (s.5.7). It demonstrates benefits in *CPT8: salutogenic workplace, personal development and support* (s.5.5), as DASW personal development and planning would strengthen their ability to train and support other staff and volunteers in PAU, cognitive impairment and ARBD.

6.9.2 Scope of explanations, knowledge and understanding

All volunteers used the terms "*alcoholic*" and "*alcoholism*" routinely. Unless stated, the explanations, knowledge and understanding outcomes now presented are cumulative for the group.

The brain was described as "*a complicated bit of kit*", a computer and a muscle. PAU was said to stop parts of the brain working and potentially affect brains of unborn children, damage presenting at birth. Alcohol's impact was viewed as variable depending on luck, nutrition, physical activity and individual reaction of the body to it.

PAU was stated as causing seizures, brain haemorrhages and dementia, and linked to falls and head injuries which in turn could cause brain damage. Although some clients were "*lovely*" and "*loved*", people with PAU and cognitive impairment were also understood to present with a range of issues. These included a memory that was "*not good*"; forgetfulness; concentration difficulties; not completing tasks; self-described

"*warped*" or circular thinking; anxiety; mood changes; aggression; violence; self-neglect; inability to manage money; drinking to forget; and homelessness.

Approaches to support, treatment and recovery were discussed. Participants raised questions about obtaining a diagnosis and availability and access to treatment. They lacked clarity about medication's value, and expressed views about limitations when individuals did not want available help. Contrasting beliefs about likelihood of recovery included that cognitive function could improve over a couple of years, that it would never be 100% again, and that with early intervention it might improve.

Some volunteers without a history of PAU or drug use said they tried not to categorise help-seekers or:

> *….. put them intae slots an' pigeon holes. (Volunteer-B3)*

Though a formal diagnosis was deemed unnecessary (Volunteer-B4) concern existed that lack of awareness of issues behind individuals' presentations might be detrimental to communication and support offered (Volunteer-B3, B4 and B5).

6.9.3 Volunteers' summary

From a salutogenic perspective, knowledge and understanding gaps impacted on GRRs and SOC, particularly around aetiology of ARBD and its outlook. Furthermore, volunteer support and supervision were not evident in clearly defined ways despite their engagement with people with complex, and at times distressing, lives. Formal education, training and supervision remained as unmet or partially met aspects of workplace salutogenesis. Only one volunteer outwith client and placement volunteer groups had training or education in PAU and cognitive impairment. The findings support DASWs' concerns about volunteers' knowledge and understanding gaps, and their own gaps in volunteer supervision and support training. This leads to a refinement of *CPT8: salutogenic workplace, personal development and support* (s.5.5) to include all staff and volunteers, with an aspiration of strengthening outcomes associated with the client orientated CPTs.

If there were:

- agreed induction, supervision, training, education and development plans for all staff and volunteers
- including joint learning with others

Then there would be:

- consistency of vision, implementation, aims and objectives with managers and peers
- up-to-date practice and approaches
- enhancement of the community programme salutogenic workplace status
- greater likelihood of the needs of people with PAU and cognitive impairment being recognised and met

Because staff and volunteers would:

- be more self-confident about their knowledge, skills and abilities
- have opportunities to be listened to and contribute
- have a greater sense and experience of support and learning
- overall have increased workplace GRRs and SOC.

6.10 Staff explanations and understanding about PAU, cognitive impairment and ARBD

In keeping with the preceding volunteer section, explanations and understanding about PAU, cognitive impairment and ARBD are considered from disease-model and psychosocial aspects.

6.10.1 Sources of explanations, knowledge and understanding and their contexts

Nine staff members participated, seven women and two men. All staff had permanent accommodation. Four were Salvationists. Their ages ranged from thirties upwards, with two in their seventies. A community programme lead (described in the research as “Manager”) was interviewed at each fieldsite. Fieldsite-B differed with the Manager and DASW-B as the only employed staff, though they worked closely with TSA Floating Support Service. Fieldsites-A and C had additional staff, with three research participants at each. In Fieldsite-A, Staff-A1 worked in the kitchen and Staff-A2 and A3 as café supervisors. In Fieldsite-C, Staff-C2 worked in the shop and Staff-C3 at the recycling centre and furniture store. The cook and kitchen co-ordinator (Staff-C1R) was the only staff member (other than DASW-AR) with personal PAU experience.

Manager-A had been a social worker and Manager-B1 a psychiatric nurse. Staff-A1 had worked in bars and Staff-A2 in services for adults and children with learning disabilities. Staff-C3 began on a Furniture Project community placement progressing to a permanent role. Despite working, Staff-C2 described personal financial struggles similar to some clients, with "*totally awful, totally disgusting*" experiences in homelessness accommodation when pregnant and penniless.

Staff drew on personal, family and occupational (paid and voluntary) sources in their awareness of PAU's association with cognitive impairment and ARBD. Staff-A2 described traumatic childhood experiences, witnessing events involving people with PAU near her home. Manager-B1 mentioned her brother's alcohol-related death. Staff-A2 and Manager-C described people they knew with dementia, Staff-A2 expressing concerns she might be "*going the same way*".

Staff-C1R, from a military background, had suffered post-traumatic stress. He described receiving support through AA, from the doctor who did surgeries at Fieldsite-C and a post-traumatic stress specialist. During recovery he began volunteering at Fieldsite-C, later being employed there:

> *Alcohol, drugs don't play a part in ma life any more, they don't enter ma head at all. I don't need them. (Staff-C1R)*

Staff-C1R organised AA meetings and was highly respected by clients. He was in a happy, fulfilled relationship, planning his forthcoming wedding. A Fieldsite-C manager was to be his best man, reflecting their strong, trusting relationship.

6.10.2 Scope of explanations, knowledge and understanding

The Staff group approaches to terminology differed to other participant groups. Although Fieldsite-C staff used the term "*alcoholic*", those from other fieldsites did not. Manager-A referred to "*alcohol overuse*", "*addictions*", and "*abuse with alcohol and drugs*". Manager-B1 spoke of "*long-term alcohol issue*" and its impact:

> *If it's been someone ….. who's had contact with alcohol over a number of years, it has actually affected them. (Manager-B1)*

Expressions used by Fieldsite-A staff were "*a problem with alcohol*", "*ill with alcohol*" and "*under the influence of alcohol*".

Four of nine staff had heard of ARBD and another knew of Korsakoff's syndrome and alcoholic psychosis:

> *It's a disease where they've no' got a great memory retention due to the damage done wi' alcohol, an' you could have the same conversation for a week an' no' remember havin' it yesterday. (Staff-C1)*

Some staff knew of physical but not cognitive impacts of alcohol, describing shock and naivety that this was the case:

> *When I started working here I couldn't believe how alcohol was such a big problem. I mean that quite shocked me when I came here - to see how many people are on drugs, how many people drank. (Staff-C2)*

Those aware of ARBD described it as a disease where memory was impaired due to brain damage caused by alcohol, in which people could become forgetful, confused and retained politeness, or became aggressive, frustrated and in the context of change, stressed. It was believed people could present with difficulties with time-keeping, speech or chronic behavioural presentations associated with psychosis.

Views varied about relative ease or difficulty in determining if someone had alcohol-related cognitive impairment. Mechanisms contributing to this were resources of long rather than short relationships providing time for observation, reasoning and establishment of help-seeker trust and confidence in sharing their problems and experiences with help-providers. Reasoning based upon physical appearance alone was thought potentially deceptive as this did not necessarily reflect cognitive function. Staff described conditions presenting similarly to PAU, cognitive impairment and ARBD as Alzheimer's disease, dementia, multiple sclerosis, learning difficulties and diabetes. Observing drinking patterns aided reasoning about causation of cognitive impairment.

6.10.3 Impact of knowledge and understanding

Limited understanding about alcohol-related cognitive difficulties and their presentations in certain clients created exasperation among staff and volunteers. However, staff and volunteers reflected about why people presented as they did, trying thereafter to be more patient and understanding. This was in keeping with *CPT10: practitioner nous* (s.5.9.1). Furthermore, practitioner nous helped them consider the role of PAU and ARBD when witnessing people experiencing difficulties

including with hygiene and self-care, shopping, nutrition, housing, financial matters, health, relationships, family and work environments.

Despite staff knowing clients with PAU and ARBD with improved well-being, mixed levels of optimism about recovery existed. Some clients they knew saw prison as a positive option. Others deteriorated, ultimately needing care home care. Staff described premature aging in people with PAU and expressed concern for older clients. However, they also noted developments of recovery based peer support. As they encountered clients and gained understanding through this about PAU and ARBD, some staff recognised their own, at times, stigmatising views. This perception then created change in keeping with practitioner nous and helped them to more ably engage with people affected.

6.10.4 Staff summary

Some staff demonstrated significant knowledge and understanding both from the '*disease model*' and psychosocial aspects of PAU, cognitive impairment and ARBD, but for others this was not the case. Staff at Fieldsites A and B opted to use words other that '*alcoholic'* or '*alcoholism'*, perhaps because of concerns about stigma. Staff admissions of lack of knowledge and exasperation supported the DASWs' recommendations for staff development and training plans (*CPTR2(8) salutogenic workplace, personal development and support*, s.6.9.3). However, staff approaches were also in keeping with *CPT10: practitioner nous* (s.5.9.1) in that they were acquiring experiential knowledge through undertaking their jobs.

6.11 Summary of participants' explanations, knowledge and understanding about PAU, cognitive impairment and ARBD

The main contexts, mechanisms and outcomes across all participant groups are demonstrated in *Table 10 CMOc11: knowledge and understanding contexts, mechanisms and outcomes* as follows.

Table 10 CMOc11 knowledge and understanding contexts, mechanisms and outcomes

Contexts		Mechanisms		Outcomes	
C1	Current PAU	M1	Feeling/experiencing cognitive impairment: symptoms static, improving or worsening	O1	Not heard of ARBD
C2	Past PAU	M2	Knowledge and information gap	O2	Heard of ARBD including as wet brain syndrome, Korsakoff's
C3	No PAU	M3	Information from NHS	O3	Knows/believes has ARBD
C4	Current or past problematic drug use	M4	Information from AA and TSOs	O4	Self or others have PAU and cognitive impairment but does not think ARBD or wonders if something else could be causing it – age, dementia
C5	Thinking or memory difficulties past or current	M5	Information from media	O5	Believes own drinking behaviour has created cognitive impairment
C6	No thinking or memory difficulties	M6	General knowledge from or reasoning about own or others experience of impact of alcohol, DTs, hallucinations, PAU, background to drinking	O6	Knowledge and concerns about alcohol and cognitive impairment impacts – DTs, hallucinations, death, hereditary
C7	Known people with ARBD or possible indications of this	M7	Reasoning about and witnessing impact of cognitive impairment (or lack of in PAU) on others	O7	Knowledge of ARBD cause, treatment, prognosis and recovery
C8	Known people with thinking or memory difficulties – not alcohol-related	M8	Reasoning about why cognitive impairment happening (or not) in self	O8	Knowledge and awareness of cognitive impairment of other causes and its impact
C9	Known people with PAU but not with thinking or memory difficulties	M9	Reasoning about ARBD cause, treatment, prognosis and recovery	O9	Recommendation or actual providing of information to self or others
C10	Does note know anyone with thinking or memory difficulties of ant cause	M10	Reasoning about ARBD following its mentioning in interview	O10	Increased knowledge and understanding of PAU and its impact: if personally or others known to them affected
C11	Some knowledge of ARBD, treatment and recovery	M11	Reasoning about lack of knowledge of others about cognitive impairment and/or alcohol, drugs, head injuries	O11	Unable to do job: impact on self-esteem: questioning by others about why could not do job. Change of job
C12	Unsure what PAU and its impact are	M12	Job changed: could not remember how to do it: memory blanks	O12	Feeling unhappy, hurt, wishing dead, grateful, happy, scared, what is normal, wasting people's time
C13	Some knowledge about link between alcohol, thinking and memory problems			O13	Views of agencies and providers – presence of understanding
C14	Head injury			O14	Views of agencies and providers – lack of understanding
C15	Mental ill-health			O15	View that liver disease prioritised
C16	Workplace learning acquiring skills to do job				

A number of different contextual factors, mechanisms and outcomes may be relevant to the same individual. Thus, Client-A5C had current PAU and was experiencing thinking and memory problems, as had his drinking companion. He was given information through a hospital clinic about ARBD yet when he reasoned about why he had memory issues attributed it to "*sickness*" rather than ARBD which he said he had not heard of.

Most spoke of "*alcoholics*" and "*alcoholism*" when referring to people with PAU. Most (29/51) knew of the term ARBD although seven opted for "*Korsakoff's*", a couple spoke of "*wet brain*" and one of "*brain freeze*". Of the remaining 22, 15 had not heard of ARBD. Due to the nature of individual interviews, seven were not specifically asked about familiarity with ARBD though were asked about experience or awareness of associations between PAU and thinking or memory problems. The vast majority who were or had been clients were aware of ARBD, though some referred to "*Korsakoff's*" or "*wet brain*". This was also true of placement volunteers but in contrast, more than half of the other volunteers were not. Even though some people had not heard of ARBD, most had either personal or witnessed experience in others suggestive of PAU and cognitive impairment. Presence of a formal diagnosis of ARBD did not prevent some people considering other causes such as age, dementia and head injuries.

When describing understandings about ARBD, or associations between PAU and cognitive impairment, people said alcohol killed brain cells, some mentioning an association with poor nutrition. Little optimism was expressed for recovery, though some improvement was noted by individuals themselves and in others when they stopped drinking. A spectrum of impact was described from a "*functioning alcoholic*"

to rapid deterioration over 6 months with an individual's inability to remember their name, to being totally dependent on others in a care home setting, and death.

When volunteers and staff had not undertaken training, most had noticed presentations suggestive of cognitive impairment, which concurred with client experiences. However, volunteer and staff reports of ease of recognition of these presentations varied.

6.12 Participant recommendations about enhancing knowledge and understanding about PAU, cognitive impairment and ARBD

Most, though not all, participants thought they would benefit from further information, support and training about PAU, cognitive impairment and ARBD. Their recommendations about this are presented in *Figure 12* CPT12*: enhancing understanding about PAU, cognitive impairment and ARBD* (s.6.12) which draws on *Figure 2 CPT11: the right track* (s.6.3). The rationale is that regardless of people's status in the fieldsites, Antonovsky's view on being on the right track, being able to handle things and feeling of worth should apply (Antonovsky 1990). Its cyclical core reflects requirements for individual ongoing learning and support and the needs of the changing population whatever their role in the community programme.

Context:

Gaps in knowledge and understanding at level of:
Individual
Community programme staff and volunteers
About and between agencies

About: PAU and ARBD
Cause, impact and stigma
Recognition
Support and treatment
Nutrition
Outlook and recovery
Roles, responsibilities and where to get help

Sense of coherence

Generalised resistance resources
Childhood living experiences
Wealth
Attitudes e.g. stigma (self, others, agencies)
Self-efficacy beliefs and coping
Knowledge and education
Social support and cultural stability
Work-related factors

Outcome

We are on the right track, we can handle things, we are of worth

Mechanisms:

Participant recommended resources:
One-to-one support and learning
Peer groups
In-house and external training for Staff and Volunteers
Spoken word: experiences shared by Clients in Staff and Volunteer training sessions
Written word: information leaflets
Visual presentations: posters
Interagency learning
Practical skills: cooking, completion of forms

Reasoning: If I understand things better: I'll have more confidence and trust in my choices and actions and those of others.

Influenced by GRR, SOC and cognitive function
Varying levels of ability to: learn new information, understand, abstract, problem solve, cope

Revised Individual, community programme staff and volunteers and interagency contexts: potential for salutogenic change:

Positive change in GRRs enhance coping

Positive experiences enhance development of SOC with trusting, confident life attitude

Potential outcomes:

PAU and cycle of change:
Understanding and recognition
Timely seeking or offer of appropriate help
Reduced stigma: about self, others and between agencies
Increased skill sets including engaging with others
Trusting relationships
Enhanced optimism for future

Community Reinforcement Approach:
Building motivation to quit drinking
Helping initiate sobriety
Analysing drinking pattern
Increasing positive reinforcement
Learning new coping behaviours
Significant others in the recovery process.

Cognitive impairment in ARBD:
Earlier recognition
Earlier seeking or provision of appropriate support
Increased likelihood of cognitive improvement
Enhanced optimism for future

Ongoing varying levels of ability to:
Learn new information
Understand, abstract, problem solve, cope

What is the impact on SOC and GRR?

Figure 12 CPT12: enhancing understanding about PAU, cognitive impairment and ARBD

6.13 Chapter Summary

Findings were from data from 52 participants (31 men and 21 women). While most clients (past or current) were male, most volunteers and staff were female. Most clients met criteria for severe and multiple disadvantage, thus would be anticipated to make weaker progress in the community programme than less complex groups (Bramley et al. 2015). They attended on a prolonged or sporadic basis. Salutogenic flow to more positive contexts (including homelessness to permanent accommodation, sobriety and improvements in cognitive function) was demonstrated by help-seekers. Some ultimately become volunteers and staff. This created a demarcation between those who had "*been there, done that, wore the T-shirt*" (CVolunteer-A1R) and others. Only Staff-C1R besides DASW-AR had personal PAU experience. Others had experienced homelessness, family experience of ARBD or personal concerns about cognitive impairment.

People with personal PAU, cognitive impairment and ARBD experience believed they could positively contribute to the support, learning and understanding of others in ways those without could not. They were more likely to have accessed learning and support through AA and other agencies. However, help-seekers were mainly supported by people without PAU experience. They had varying knowledge, understanding and confidence levels and practitioner nous, with fairly informal support from other staff and volunteers. Generally their means of learning had not included formal training, though this was recommended of future benefit.

Most participants used the terms "*alcoholic*" and "*alcoholism*". Staff from Fieldsites B and C instead used terms including "*alcohol overuse*" and "*contact with alcohol over a number of years*". Some staff and volunteers did not wish to diagnostically categorise people, preferring to support them in their presenting contexts.

Findings revealed salutogenic experiences reflecting increased GRRs around learning and coping, with ripple effects on SOC. However, gaps remained with complexities around retention of knowledge and understanding for those with cognitive difficulties. There was recognition that PAU could cause ARBD, but that different aetiologies such

as dementia and brain injuries could also cause cognitive difficulties. Formal learning gaps were partially overcome through life experience and observations of day-to-day impacts of PAU, cognitive impairment and ARBD on people affected. People prescribed thiamine were not convinced of its benefits and were off-put by side-effects.

Although some people experienced cognitive improvement when in recovery, there was also a belief about irreversibility of brain cell damage. However, the interview process created opportunities for thought, including realisation about nutrition's importance or why people known to participants behaved or presented as they did. Creation of opportunities to discuss concerns and learn about PAU, cognitive impairment and ARBD are of salutogenic importance to community programme's future impacts.

6.14 Chapter 6 theory building synopsis

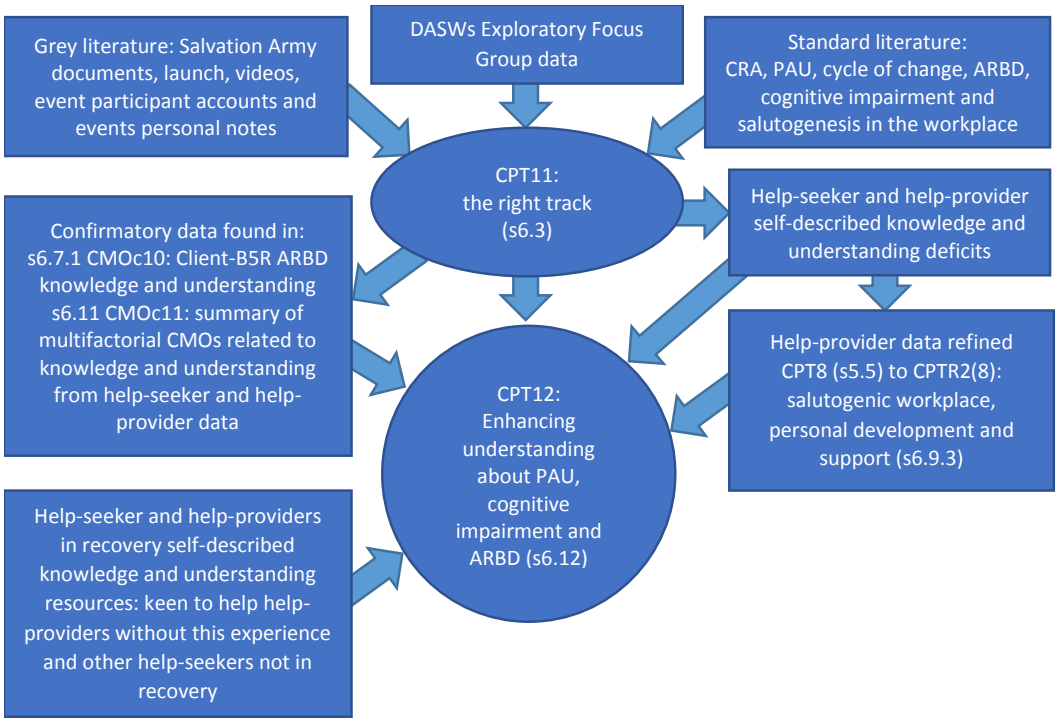

Figure 13 CPT11: the right track and CPT12: enhancing understanding about PAU, cognitive impairment and ARBD

Chapter 7 Salutogenic micro-outcomes, peer support and flow as contributors to recovery

7.1 Introduction

Mechanisms are important in realist thinking, whether physical, such as resources added to an intervention, or psychological reasoning and responses of people accessing it. This research focuses on a Salvation Army community programme intervention for people with PAU, cognitive impairment and ARBD. In keeping with Figure 2 *CPT11:* the *right track* (s.6.3), it is hypothesised that TSA intervention is of salutogenic nature (Antonovsky 1990), as such surpassing physical resources and practical supports.

Table 7 Bridging the gap (s.5.11) highlighted resources the DASWs thought important to engagement with and support of clients with PAU, cognitive impairment and ARBD. Of a practical, physical and psychosocial nature, they suggested the intervention offered resources and life experiences to people who could then reason about their primarily alcohol use, set and setting (Zinberg 1984). If so desired, this could be about individualised versions of "*Here is the right track; you can handle things; you are of worth*" (Antonovsky 1990, p. 78). This depended on their context and what needed to work, how and why to enable them to reach their desired outcomes, whether this be continuing, reducing or stopping drinking.

DASW identified resources are now considered mainly using data from clients, volunteers or staff with PAU experience. This enables focused consideration of existing and new CPTs and CMOcs from the perspectives of people with lived experience of the issues addressed. Themes arising are about meeting basic needs, help for cognitive impairment, health issues, the "*right time*" and challenges of recovery, learning and education, and salutogenic flow through volunteering, placement and employment opportunities. Guided by prominent data findings, three

overarching areas arose: *micro-actions and outcomes*, *peer interactions and support* and *salutogenic flow*. Rather than stand-alone concepts, supports for PAU, cognitive impairment and ARBD were interwoven, with outcomes demonstrating movement along the salutogenic continuum.

7.2 Meeting basic needs: The Salvation Army as a helping organisation

CPTR1(4) a helping organisation (s.4.4.3.1.5) refers to micro-actions and outcomes at the fieldsites supporting people with PAU in or towards recovery. *Table 7: bridging the gap: biopsychosocial resources and supports, contexts, mechanisms and outcome* (s.5.11) collated DASW descriptions of micro-actions and resources, revealing some outcomes they believed occurred when these were available. This chapter section explores perspectives of people with PAU, cognitive impairment and ARBD to confirm, refine or refute the DASWs' views. The DASWs emphasised the importance of communication styles and resources to meet basic needs plus development of trusting relationships. They believed this incentivized help-seeker fieldsite attendance and supported awareness-raising of wider resources, including around recovery, volunteering and employment.

7.2.1 Meeting basic needs: general support and social engagement

People with PAU experience seeking help with basic needs described positive engagement at fieldsites incorporating micro-actions and outcomes. They identified beneficial DASWs' personal resources as approachability, accessibility, listening to others, being easy to talk to and supportive of innovation beneficial to those accessing the programme. These personal resources were especially important to clients embarrassed by difficulties in following conversations.

The non-stigmatising fieldsite context offered a place for acceptance by others with peer interactions and support. Shared peer experiences of cognitive difficulties created amused relief (Client-B3R), humour being a coping mechanism:

> *Ah says to ma wife, "Ah'm gettin' very forgetful." She says, "Are you takin' anything for it?" Ah says, "Ah'm Ah takin' anything fur what?" See? (Client-C3R)*

PVolunteer-C1R said the DASWs' approach style was helpful in early recovery because of client difficulty trying to cope with new emotions previously dealt with by drinking or walking away from demanding life situations. Client-A2R decades into recovery said this still applied:

> *We're still alcoholic, an' I've still got tae tell ma brain ….. we can still be upset and things like that. I think now we think we've got a different lifestyle, (every)thing should be hunky-dory but it's nae. We've still got to remember it. Anything might upset us, might put us tae drink. (Client-A2R)*

Clients particularly valued speaking to people with PAU experience such as DASW-AR and Staff-C1R. They were viewed as knowledgeable resources and role models, their lives demonstrating salutogenic flow.

7.2.1.1 General support and social engagement: reflection on CPTs and CMOcs

The findings confirm the first part of explanatory *CMOc9: relationship building and opening doors to help* (s.5.10.2) and are a salutogenic match with DASWs' general support and social engagement aspirations (*Table 7 Bridging the gap* (s.5.11)). The importance of micro-actions and outcomes, peer support and salutogenic flow is evident.

7.2.2 Meeting basic needs: food, clothing and hygiene resource provision

Staff and volunteers viewed Client-C1C's context as reflecting worsening wellbeing, unmet need and increasing support requirements:

> *He's not getting supported enough. He ….. needs to be supported on a daily basis, to have somebody go round there every morning, get him up ….. out of bed, show him how to clean….. His personal hygiene's really bad…. Sometimes he's come in an' he's weed himself. (Staff-C2)*

Client-C1C and other clients confirmed accessing GRRs of showers, clothing and washing facilities. Barriers to accessing support were lack of awareness of poor state of hygiene (Client-B5R) and a lack of and inability to retain knowledge about how to use facilities (Client-C1C).

For those deep in current PAU, food was not a priority:

> *The drink becomes first and you can't be arsed. You haven't got time because you need to get to the shop (to shoplift alcohol)….. And after four days you think, oh God, I've got to eat something. (Client-A1C)*

Drinking was described as associated with loss of appetite (Client-A3C), and marked cognitive impairment with loss of knowledge about needing to eat (Client-C10R) thus available food was sometimes uneaten (Client-C9R). Alcohol acted as a mechanism driving behaviour and decision making, with hunger ultimately similarly being a force to seek food though this was not always available. Sometimes "*easy*" sandwich or noodle options were made and eaten (Volunteer-B2, Client-B5R), creating risk of nutritional deficits associated with ARBD.

The physical and psychosocial outcomes associated with fieldsite food provision were wide. Free food parcel resources did not always bring aspired benefits. Physical impairments (Client-B3R, Client-C1C) and lack of facilities due to homelessness and unpaid bills (Client-C6) prevented cooking. People with cognitive impairment described forgetting how to cook (Client-B5R, Client-C10R). Others burned food creating fire safety concerns (Client-C2R, Client-C3R, CVolunteer-B2R). Client-A1A was upset and Client-B5R baffled by skill losses including cooking family meals, leaving them feeling disempowered as fathers. Some described lacking confidence, self-trust, willpower and energy to cook (Client-C9, Client-B5R, Client-B3R). Client-B5R's memory difficulties made shopping overwhelming.

Most clients and clients in recovery accessed programme meal resources, some twice daily. For a time, Client-C10R thought he would have committed suicide or died without this sole source of food. In recovery, he described "*reprogramming*" to realise he needed food. In contrast PVolunteer-C1R reasoned "*more luck than judgement*" occupational nutritional and exercise resources prevented ARBD developing.

Micro-outcomes occurring through meal resources were structure, stability, enjoyable social engagement and daily purpose (Client-C4C, Staff-C1R, Client-A3C, Client-C5R, Client-C10R). Client-C3R enjoyed making the "*audience*" laugh. Others appreciated the "*good meal(s)*" (Client-C1C, Client-C5R) and sitting at a table when eating (Client-C6). After eating a community programme meal with street-drinking peers, Client-A1C said:

> *Everybody's different….. I love some of these boys 'cause they've been through a lot more than me (tearful) all their lives. (Client-A1C)*

There was a sense staff and volunteers were "*looking out for you*" (Client-C5R). However, Client-C4A felt ignored and stigmatised as "*another waste of space*" by Staff-C1R possibly because he often arrived drunk. The café was financially accessible in contrast to a fieldsite café open to the general public (Client-A3C).

Seeking washing and hygiene support could be embarrassing as peers witnessed resources being accessed (Client-C1C). However, peer help was also described:

> *Ah had a shower….. wi' another guy ……. The place (café) was packed….. He was washin' ma back….. When we came oot, they were a' lookin' at us as if, God! (Client-C1C)*

Some street drinkers shared knowledge (Client-A2R) about free food resources. Peers were aware others with PAU accessed food resources (Client-C4C), and reassured those experiencing difficulties were eating (Client-C8R, Client-C2R, Staff-C1R). However, Client-A2R acknowledged it was not always possible to help those who did not want it.

Contrasting to TSA's "*right reason, to make sure they're fed*", clients described peers using "*the place for the wrong reasons*" (Client-C2R), "*begging for free meals*" (Client-C3R) "*like it's owed to them*" (Client-C10R), "*grabbing everything….. so they can have full cupboards*", rather than from need. Food resource released money for alcohol (Client-A1C and Client-A3C). Client-A3C described regularly accessing food parcels giving away unneeded items, saving money and encouraging peers to do likewise. He thought this offered daily structure with meaningful, resourceful activity instead of watching television.

While "*lots*" were "*genuinely grateful*" (Client-C2R) others complained about meals (Client-C9R and Client-C10R) with concern this reflected state reliance and independent living skills deficits (Client-C10R). Opinions varied about making financial contributions for food. On balance Volunteer-C1R thought it possibly beneficial to ask for even a token payment for meals to encourage self-sufficiency:

> *If you take everything away from them, they just think we go through life an' get everything for nothing. But ….. I'm different to the others ….. old fashioned views. (Volunteer-C1R)*

7.2.2.1 Salutogenic flow

The findings have looked beyond historical perspectives of TSA providing food after someone "*sang for his supper*" (Client-A2R). Clothing, hygiene facilities, food parcels and meals were physical GRRs meeting basic needs and incentification mechanisms with associated salutogenic micro-actions and outcomes. Some recognised food's importance to holistic wellbeing when drinking, reasoning about its role in maintaining and preventing deteriorating physical and mental health (Client-C10R, Client-C9R, Client-C8R, PVolunteer-C1R, and Client-A1C).

Food-related coping strategies varied. Client-B4R attended cooking classes, relearning skills and more confident than when alone. Lessons added weekly structure, enabling social engagement and peer support through shared positive experiences and inclusive class discussions. Others relied on family for shopping and cooking, then microwaving meals, with families influencing their choices (Client-B3R, Client-C2R). Pride limited help seeking (Client-A2R), and some felt cooking pointless due to solitude and anticipated failure (Client-C7C, Client-B5R, Client-C9R).

The café contexts revealed findings that what others in society might take for granted brought happiness and a sense of mattering to others. PVolunteer-C4R had achieved much at the programme despite her complex life and was highly regarded by managers. Her affect was bright when engaging with clients:

> *The Salvation Army….. it'll go for another long time because their guys ….. take care o' their business happily. Not, "This is a chore." (Client-C3R)*

Micro-actions was similarly taken by Staff-C2 when asking if Client-C1C, who staff and volunteers viewed as "*sweet*", "*always polite*" and "*a lovely man to talk to*", wanted tea or coffee, addressing him by name and repeatedly being "*really, really nice*" to him (Client-C1C).Client-C1C felt respected and of worth, unlike stigmatising experiences when begging.

Though dependency culture concerns existed (Volunteer-C1R), in the cafés, clients saw peers' lives changing, with employment, happy relationships and optimism. People experienced or witnessed evolving self-confidence set against lack of self-worth and embarrassment. Resourcefulness previously used to ensure alcohol supply continuity

was instead used in peer support, volunteering, employment and financial self-determination. When generalised resistance deficits were addressed, enhancement of SOC and pride occurred with, for some, peer affirmation of achievements (Staff-C1R, Client-C9R, CVolunteer-B2R, Client-B4R, Client-C10R, and CVolunteer-A1R). Participants saw peers regain control over alcohol with meaning and meaningfulness in their lives. They saw setbacks and offered support, including by meeting again at the cafés and recovery meetings. Peers, staff and volunteers innovated about new ideas for the fieldsites. Furthermore there was peer determination of acceptable behaviour, including through intimidatory family connections (Client-C3R).

A key outcome of incentification mechanisms of meeting basic needs was facilitation of trusting, relationship building. Sometimes people attended for one need and DASWs, staff and volunteers identified and met another (Client-A1C, Client-A7C). Some attending for food were dishevelled and encouraged to recognise their need for and accept offers of showers and clean clothes (PVolunteer-C4R and Staff-C2). At these points, micro-actions of staff and volunteers conveying acceptance and non-judgemental kindness minimised potential client embarrassment (Client-A1C). Such approaches resulted in help-seeker openness to further engagement (Client-A1C, Client-A7C), confirming explanatory *CMOc9: relationship building and opening doors to help* (s.5.10.2).

The findings have also confirmed *CPTR1(4): a helping organisation* (s.4.4.3.1.5). With new GRRs, help-seekers managed previously unmanageable aspects of life. However, true self sufficiency was an unlikely outcome for those with more severe ARBD for whom the programme was a primary resource for meeting basic needs. Individual contexts were also, for some, associated with prolonged self-consciousness, fear of ridicule and diminished motivation to seek help. The programme offered a supportive structure, purpose, meaning and manageability in their lives. PVolunteer-C4R described her approach with such people:

> *It's no' nice, for them to see them slippin'….. they feel uncomfy theirselves ….. Some of them dinnae want tae come in here because they feel ashamed which is wrong, because we're no' here tae judge. We're here tae basically open our arms an' say, "Come in. We're here tae help, no' judge." (PVolunteer-C4R)*

This reflects aspects of the programme's salutogenic context, as a resource to people with PAU experience supporting PAU manageability and consequences for which in other contexts they could have been turned away. Thus whilst in part controversial, particularly where participants' money was spent on alcohol instead of food or clothing, the overarching outcome of basic resource provision was salutogenic.

7.2.2.2 Reflection on meeting basic needs

Staff-C1R emphasised the historical and current contextual importance of providing basic help to people in need:

> *William Booth('s)….. philosophy was "Feed the - the three S's basically - soup, soap an' salvation". 'Cause there's nae use in speakin' to somebody if they're hungry or dirty. (Staff-C1R)*

The message was clear: to engage successfully with clients, basic needs should be addressed first. The anticipated outcome of food, clothing and hygiene facility resources might relate to hunger, warmth and cleanliness. However, mechanisms in response to resources created physical and psychosocial outcomes. The findings confirm *Figure 2 CPT11: the right track* (s.6.3) that basic need resources added to the GRRs of people with PAU experience and supported opportunities to enhance SOC.

7.3 Support for memory problems and cognitive impairment

Some people with PAU experience described memory problems, cognitive impairment, "*warped*" thinking (CVolunteer-C1) and a "*mixed up head*" (Volunteer-C1R). Practical implications were difficulties making and keeping appointments, completing forms and dealing with information which had wide implications including on health, financial management and housing.

Help-seekers adopted different means of managing awareness of dates, appointments and information with mixed outcomes associated. Some used calendars and mobile telephones to record appointments. Others used set appointments including AA meetings as weekly benchmarks. Issues existed in writing ability and remembering to look at visual prompts (Client-C9R). Client-C3R successfully used a large piece of

scarlet paper to put appointment information on as without it, "*Ah'd probably just see bits o' paper there*".

Contrasting to when drinking on wakening, Client-C10R determined which day it was. This represented increasing life manageability with meaningfulness he linked to AA approaches, supports and ethos.

> *When I get up, I don't know what day it is. Coming fae active alcoholism an' addiction, probably most people don't really care what day it is either. (Client-C10R)*

Client-B1C's attitudes to appointments varied, missed dental ones mattering due to non-attendance fines. In contrast, Client-B5R's GP wrote advising that further missed appointments would result in exclusion. Despite his alcohol-free lifestyle and daily ARBD supporting living calls, true life structure was remote. He had difficulty understanding and retaining information, low self-esteem and struggled with his view of life. The letter implied incomplete GP recognition of Client-B5R's ARBD severity and was detrimental to his wellbeing by threatening to erode his GRRs and thus SOC.

Help-seekers confirmed family, community programme and other agency support increased attendance at appointments they might otherwise have been fearful about or have forgotten, sometimes intentionally:

> I'd say, "Look, can you come wi' me to an appointment ….. an' help me get through this?" An' they did. (Volunteer-C1R)

The outcome was confidence he had people to rely on when afraid. Fear extended to letters possibly containing bills, Volunteer-C1R's reasoning leading to tearing up unopened envelopes and drinking. In contrast, Client-C3R described AA's spiritual component helping him overcome such issues:

> *The spiritual part is ….. you can talk tae people after a while in Alcoholics Anonymous, you've got the courage tae face the things you can ….. Ah could phone fur an appointment, do it maself. (Client-C3R)*

Client-C3R's account reflected a series of micro steps and outcomes enhancing his GRRs and SOC. Deciding to attend a meeting gradually resulted in developing trusting relationships and self-confidence to "*face the things you can*" rather than all life's complexities simultaneously. As part of clients' GRRs, the DASWs were similarly

described, contributing to clients' SOC in complex or intimidating situations including appointments supporting recovery (PVolunteer-C2).

ARBD impacts meant that Client-C1A had difficulty understanding forms, and alcohol related physical disability limited writing. Client-C3R's advice to a "*formophobic*" peer enhanced comprehensibility about and manageability of form completion:

> *"Start at the very first question….. Don't go tae the back ae your forms ….." An' then all of a sudden he could dae it. (Client-C3R)*

The outcome was positive for Client-C3R, the help-seeker, and witnesses of change. Attitudes to seeking similar DASW help varied from Volunteer-B2R thinking DASW-B too busy, to Client-B2R giving DASW-B all his forms due to personal impatience. This reflects differing reasoning about the same resources with different outcomes arising.

7.3.1 Money and housing

When drinking, most participants with PAU experience financially prioritised alcohol over personal, family and home life. Financial decisions were potentially influenced by the presence of certain cognitive impairments, ARBD or raised blood alcohol levels. Volunteer-C1R experienced PAU associated fear and forgetfulness resulting in financial benefit sanctions as he avoided or forgot appointments and telephone calls. He believed benefits agency staff lacked understanding of challenges faced by people like him, including about communication approaches.

Income streams were varyingly supplemented and though Client-B1C described opening a Credit Union account, alcohol-related debt occurred commonly including as debt to drinking peers:

> *They get their benefits one day an' it's gone the next '….. they're borrowin' aff a' people. By the time it comes round to gettin' their next benefit cheque, it's either owed all over or they do the same again, drink it all. (Client-A3C)*

Individual and peer group strategies, GRRs and SOC focused on maintaining alcohol flow, some requiring planning and organisation. Some peers receiving benefit payments on different days developed payment day alcohol purchasing circles. Pooled, staggered income was reasoned to offer continuity of financial resources to buy the group alcohol. However, Volunteer-B2R and Client-B1C felt taken advantage

of, peers speaking to them primarily when they had money and Client-A3C's flat became a peer drinking den.

In recovery, alcohol expenditure ceased, affecting financial and home contexts, attitudes towards monetary use and life experiences. Budgeting independently strengthened or was supported by trusted others (CVolunteer-B2R), including the DASWs. Client-A2R's wanted to be more financially independent but did not manage because of lack of financial confidence. Some prioritised expenditure using lists and established direct debits. Client-B3R described "*hiding money away*" to buy his child "*good things*". Volunteer-C1R valued divorcing his first wife, leaving "*her*" debts. Changing his financial and housing priorities contributed to his being, "*more happier now than I ever was*".

Though not always debt free, Client-C8R said he planned ahead, paying bills, debts and for basic need items, then prioritised dog food and tobacco. His financial driver was caring for his dog, a priority recognised and respected by peers. In contrast, despite daily ARBD assistance, Client-C5R's high fuel bills continued as he forgot to turn off the fire.

Findings about finance and housing emphasise the complexities of contexts and how both intertwine with alcohol rather than being stand-alone issues. Reasoning mechanisms about financial and housing decisions and planning were influenced by alcohol use, peers and others. Some coping mechanisms, including peer influences, adopted when drinking continued into recovery. Client-B1C's ultimate housing outcome arose through reasoning about wanting to stay near AA and residential rehabilitation peers with shared life experiences. Drinking less than previously, Client-A3C's tone was of discovery about his self-sufficiency:

> *I tend not tae ask anybody for any help, financially or anything. I never borrow money aff anybody….. I've actually started learning how to budget ma money. (Client-A3C)*

CVolunteer-B2R's housing resource provided salutogenic opportunities for micro-actions and outcomes enhancing his GRRs and SOC:

> *(My flat has) helped me in a lot o' things. It's gied me settled ….. peace o' mind ….. confidence ….. a lot of responsibility. It's just changed my life. (CVolunteer-B2R)*

Client-C3R and Client-C2R's recovery based successful financial undertakings included buying, adapting and selling houses in response to changing, complicated family experiences, ability to do so drawing on available GRRs and SOC.

7.3.2 Reflection on support for memory problems and cognitive impairment

People with PAU, cognitive impairment and ARBD struggled with aspects of daily life. Coping strategies included avoidance and drinking, and failure to engage was sometimes due to cognitive difficulties or fear. Key micro-actions in addressing generalised resistance deficits were attending supportive settings such as the fieldsites or AA, or approaching peers or family members and being shown or asking about coping strategies. For some in recovery and with improving cognitive function, new or renewed levels of independence were achieved as GRRs and comprehensibility, meaningfulness and manageability grew. For others, long-term support was required due to ongoing PAU, cognitive impairment and ARBD impinging on true independence. Fieldsite resources and inclusive, accepting and supportive approaches meant people were more likely to be identified by others to need help. . This section has confirmed explanatory *CMOc9: relationship building and opening doors to help* (s.5.10.2) and recognised the importance of peers and family members as GRRs. It also demonstrated the positive impacts when *CPT6: salutogenic cognitive benefits* (s.4.4.3.1.2) is fulfilled.

Support around memory problems and cognitive impairment had ripple effects on approaches to and support for health issues. PAU and cognitive impairment impacted on people remembering health information, appointments and taking medication. Death, suicide and suicidal thoughts were not remote concepts. People described stigmatising experiences, difficulty engaging with and avoiding health providers, or adopting desperate measures to open doors to support. Reasoning identified as necessary to minimise personal health risks was belief in alcohol-related harm, and a level of self-worth that made living desirable and worth fighting for, as opposed to hopelessness and suicidal thoughts. Participants perceived limited health provider understanding about PAU and ARBD impacts and resulting complexities arising when trying to access support. When participants spoke of fieldsites and health, this was mainly about nutritional, mental wellbeing and PAU support, including via peers. Peer

support contributed to health and wellbeing, from encouraging others to access food programmes, to providing shelter in their own homes, encouraging involvement in peer support groups and looking out for each other. This enhanced GRRs and supported a shift to recovery orientated SOC, with accompanying refinement of *CPT11: the right track* (s.6.3) to *CPTR3(11): the right track and the importance of peers*, with specific recognition of the importance of peers in recovery to contexts and as resources to help-seekers.

7.4 The '*right time and place*' and addressing challenges of recovery

The '*right time and place*' to address PAU was multifactorial with varying contextual and reasoning influences. Staff-C1R spoke as someone who had '*worn the T-shirt*' and now provided support:

> *It's all right gettin' somebody sayin', "Right ….. Ah want tae stop drinkin' ….. an' they're in an' out ….. I don't persecute, judge or whatever because they'll nae get it till it's their time, till they're ready ….. I didn't get the drink, the drugs first time ….. Ah was in an' out o' AA like a wheelie bin tae the penny finally dropped. You've just got tae be in the right place before you can even attempt it. You've got to genuinely want it. (Staff-C1R)*

Volunteer-C1R described his '*right time*' as including reasoning about advancing age, a new, loving relationship, and bridge building with people he felt he had previously let down. He enjoyed giving back to others because of prolonged help he received. Explanations about factors for others including spirituality, family influences, angels, demons and hope, the community programme as a self-discovery resource, and peer support and recovery are now discussed.

7.4.1 Family influences on recovery and their consequences

Volunteer-B2R initiated recovery when his then wife issued him with a carrot or stick ultimatum to stop drinking or lose his family. This created rippling outcomes for him and others. He entered and maintained recovery though his marriage ended. Unlike CVolunteer-A1R, he described PAU as, "*Something that I'm not proud of*". For both participants, the fieldsite was a recovery resource. They encouraged others to seek DASW support:

One chap ….. said to me about alcohol an' I said, "Yeah, you want to talk to DASW-B ….. Don't leave it any longer. Go up there straight away," and I phoned DASW-B and the bloke went up there. Really good. (Volunteer-B2)

Volunteer-B2R's micro-actions were listening to someone seeking help, suggesting where support was available, and recommending prompt action. He viewed the key resource as conversations with DASW-B, a similar resource to those described by Client-C3R at AA. Volunteer-B2R strengthened the resource available by direct communication with DASW-B ensuring the man received a knowledgeable welcome. The encounter was "*really good*" for the new client and enhanced Volunteer-B2R's SOC: he wanted to help others, this evidencing he had. Making a difference in others' lives created meaningfulness in his. However, PAU recovery did not necessarily mean family relationships improved. PVolunteer-C1R hoped to rebuild relationships with his younger children which had been unachievable with older ones.

7.4.2 Angels, demons and the community programme as a resource of hope

Others' recovery contexts and experiences included self-detoxification and becoming abstinent in prison. PAU struggles were likened to conflicting influences of angels and demons, the latter either inside them saying it was safe to drink, or on their shoulder trying to undermine them (Client-C10R, Client-C9R, Client-C8R, Client-C4C). This feeling could remain years into recovery:

Ah'm no' gettin' away. Ah've still got the demon inside me. (Client-B3)

To combat this, a desire to stop drinking or using drugs, listening to others' advice, and being headstrong in recovery were viewed important. Without these mechanisms, supports offered were likely to be ineffectual (Client-C9R). Volunteer-C1R avoided places where alcohol was available. However, for some, drinking was easier than stopping. Client-A1C found seizure risk manageability, shoplifting and broken family relationships easier than abstinence. In salutogenic terms, he was rooted at the dis-ease end of the health continuum. His SOC and GRRs were governed by alcohol need and avoiding withdrawal:

Ma heid's scrambled an' Ah'm just goin' tae leave here, go up the toon, drink the wee bit cider Ah've got, an' Ah'm just goin' tae sit in a doorstep, put the bag doon, an' try an' get a wee bit money fae alcohol fur in the mornin' so Ah'm no' shakin' an' that. Ah know that sounds bad. It's human nature. (Client-C1C)

In contrast, for CVolunteer-A1R, Fieldsite-A involvement created salutogenic outcomes:

> *I've started working voluntary with The Salvation Army, I come to services, I play in the band. That's my brain activated again. I manage to sit and talk to people where at one time I used to shy away. (CVolunteer-A1R)*

Clients experienced intentional and unintentional fieldsite social engagement. Seeing and meeting people in recovery created scope for hopeful reasoning:

> *There's not a lot of people maybe see people in recovery an' it's to let them again have that wee bit of hope that people can do it an' there they are ….. an' give them a bit of time. (CVolunteer-C2R)*

These accounts demonstrated complexities in continuing or stopping drinking. Yet peers demonstrated what was achievable, in turn offering others hope.

7.4.3 The community programme: a self-discovery resource

People with PAU experience, cognitive impairment and ARBD viewed recovery as a time of multifaceted discovery but also vulnerability:

> *It's no' that long ago ….. I got asked that question, "Who are ye?" ….. I couldn't even answer it. (PVolunteer-C1R)*

The programme's salutogenic context and resources contributed to people thinking about who they and others perceived them to be. People described perceptions changing when drinking and in recovery (CVolunteer-B2R). In recovery, for some, self-understanding related to childhood experiences impacting long into adulthood. When very young, DASW-AR lived in a care home. With unrecognised dyslexia and dyspraxia, he grew up believing he was stupid. Aged 14 he began drinking heavily, developing PAU:

> *If the building blocks in life of childhood, if they're not fully developed where you feel secure ….. loved ….. accepted, then if that isn't put right ….. you're drawn to subcultures ….. to places, to people who probably aren't gonna be good for you, because they're giving you acceptance ….. "You're like us." ….. And that can lead on to doing things that you wouldn't do ….. an' the unacceptable becomes acceptable. (DASW-AR)*

The peer subculture context offered pathogenic acceptability as opposed to the fieldsites' salutogenic lifestyle potential. Twenty years sober, DASW-AR reasoned that his understanding and experiences could help others with PAU.

It's when you look back at the feelings, an' the emotions, the reasons for the fear, the lack of hope, that these guys feel is what I felt in my days of alcoholism. An' I can bring that to the party when we talk. (DASW-AR)

DASW-AR was happier, healthier and more fulfilled, yet had unanswered questions about how differing factors affected his cognition. Nevertheless his manner reflected comprehensibility, manageability and meaningfulness:

The damage of alcohol it's a very wide topic because a lot of it's to do with feelings an' emotions an' lack of development in childhood. A lack of worth in yourself ….. It's just not as simple as somebody goes an' buys drink an' gets drunk an' wanders about the day aimlessly. There is a whole lot of factors ….. going on for years that ….. led up to this ….. It's never just as simple as some people make it out to be ….. "Just stop drinking. Problem solved." If it was that easy, then we wouldn't need any self-help groups. (DASW-AR)

DASW-AR referred to "*undiagnosed damage through early years of drinking*" of importance to brain and psychological development in teenage years:

The evidence ….. is my own alcohol addiction. When I was got sober at 32, realised I was immature. I was mentally ….. the age of 14, 15 an' I believe that's when my heavy drinkin' started. (DASW-AR)

His views were confirmed by similar experiences of peers at self-help groups. Thus phases of teenage salutogenic discovery of GRRs and SOC may be detrimentally affected by alcohol. The fieldsite context and resources recognised and accepted that development of adult self may be postponed till recovery, out of synchrony with and understanding of similarly aged people without such issues. Causes of persisting cognitive impairment may be unclear, requiring coping strategies. DASW-AR's strategies involved daily structure and organisation in, for him, mainly salutogenic employment:

When I talk to people, I like to give them hope. That if I can do this, they can do it. (DASW-AR)

His approach and experiences were valued by others with PAU experience seeking support or volunteering (CVolunteer-A1R, Client-A1C, Client-A2R).

7.4.4 Peer support and recovery

Although sometimes pathogenic, peer support was generally described positively. Peers encountered each other in fieldsites, street drinking communities, recovery and other church services, at other agencies and support groups. Fieldsites peer

conversations supported individual and group reasoning to attend the Feelings Group and AA. The fieldsite context provided opportunities to share experiences, recognise others' achievement, create opportunities for positive feedback and offer advice to others:

> *I can sit doon ….. talk tae a few folk that Ah know, I get on well wi' them. Or if I've got any problems, I could sit doon in here an' talk tae DASW-B. (Client-B1C)*

These coping strategies reduced Client-B1C's likelihood of drinking alcohol then becoming depressed and aggressive, instead remaining "*brand new*". The fieldsite, people he knew there and DASW-B were part of his GRRs. This strengthened his comprehension of alcohol's pathogenic potential and his manageability of problems, bringing new levels of meaningfulness and feelings of self-worth.

Although some were encouraged by peers to re-start substance use, peers were seen as being able to offer support that others could not:

> *Another person (in recovery) ….. can say, "I've been like that before as well." ….. It gives them a little bit of hope that maybe they can be like that in the future. (CVolunteer-C2R)*

Peers offering personal accounts at meetings and in conversations were particularly valued:

> *I listened tae aither people sharin' their experience, strength and hope. Somebody at the face front. (Client-A4R)*

Retroductive thinking offers benefits when considering actions and outcomes of speaking, listening and being listened to. All were associated with people reasoning that they were valued. By being listened to, they felt their lives and experiences were given credence by others: "*You are of worth*" (Antonovsky 1990, p. 78). As listening resources to others, they likewise felt of worth. Participants confirmed Fieldsite-C Feelings Group as a valuable resource for people with PAU or drug use experience because of its peer led status and open communication. Realisation about shared experiences created mutual acceptance overcoming prior stigma.

Client-C3R's described the reaction of a man with prolonged PAU who he eventually successfully encouraged to attend AA:

> *He ….. cannae get enough meetin's an' Ah'm drivin' him here an' there, then Ah've got other guys tae kinda help me an' take him, so he was well liked. But he'd a hang up about how people treated him, "They should have known that I was sufferin' from alcoholism." But nobody knows that. (Client-C3R)*

This emphasised AA members' prioritisation of providing and maintaining peer support. Client-C10R similarly attended as many meetings as he could to provide stability and daily routine:

> *….. even if it's only just for one hour a day, an' that keeps me focused on the time an' place (Client-C10R)*

CVolunteer-C1R gave insight into how "*not right*" thinking and reasoning changed in recovery, highlighting the contribution of recovery meeting attendance:

> *When you come in tae AA you've got tae process what's happened to you first….. You're away wi' the fairies when you first come in 'cause your head's a' oooooh. You're just gettin' to meetin's an' that's a' that you're doin'. An' then you get a bit of clarity an' a' bit ae social awakening when you think, "I've been sleepin' for 20 year." (Laughs loudly) An' a spiritual awakening almost. It's amazing! It really is amazing! (CVolunteer-C1R)*

Emerging clarity of thought enabled development of comprehensibility and meaningfulness in life, with peer support to develop abilities to manage challenges associated with PAU, then achieving and sustaining recovery. Client-C10 succinctly described how peers could help one another:

> *The most powerful tool for an addict is another recovering addict. There's an understandin' between them. (Client-C10)*

Both DASW-AR and Staff-C1R fell into this category though said help-seekers sought support about financial or family difficulties, not underlying PAU. They purposefully shared PAU experiences including Staff-C1R's "*choice*" rather than "*slip*" to drink "*taking him right back*" and his subsequent achievements in recovery. Alcohol and its impact remained influences in their reasoning and lives. However, they had reached salutogenic outcomes, looking forward in their current context with purpose, meaning and optimism in supporting clients.

7.4.5 Reflections on the '*right time and place'* and addressing challenges of recovery

Most with PAU experience described alcohol support varyingly coming from AA, the NHS, other local agencies and peers rather than from the fieldsites. Their experiences of help from, engagement with and contribution to the fieldsites depended on their aspirations, stage of PAU and cognitive function. Peers were a recovery resource, encouraging fieldsite and AA attendance. Their lived experiences, GRRs and SOC were resources to others impacted by PAU:

> *He said, "If that was anybody else spoke to me like that I wouldn't have listened." So I said, "Why did you listen to me?" "'Cause you've been there, and done it and wear the T-shirt. You've been through it," he says "….. and got into sobriety". (CVolunteer-A1R)*

The fieldsites were salutogenic resources. Individuals experienced changed contexts and GRRs creating opportunities for recovery orientated mechanisms to evolve and fire, supporting the '*right time*' to enter and maintain recovery. Some valued spiritual resources and others development of meaningful, non-judgemental relationships. There were opportunities to witness and engage with people offering hope and evidence that recovery was an achievable outcome.

Individual outcomes depended on contexts and resources for mechanisms '*firing'*. Outcomes ranged from lessening potential alcohol-related harm to providing people with paid employment, supporting their comprehensibility, meaningfulness and manageability of PAU issues in their own and others' lives.

7.5 Activities, learning and education

GRRs supporting recovery increased as participants joined in DASW organised activities at the fieldsites and elsewhere. Fieldsite community meal nights, walking, craft and women's groups offered shared, enjoyable experiences. A women's group outcome was men requesting an equivalent men's group.

Ripple effects of fieldsite engagement were demonstrated. Some took up opportunities for education and learning, such as computer classes. Client-C8R initially attended for free food, then companionship. This created a context where DASW-C

and peers encouraged him to develop new skills beyond personal confidence zones. Client-C8R used computing classes and life story writing to reason about past difficulties, this supporting him in his recovery orientated future:

> *I'm writing, but that's helping ….. my recovery. It gives me something to focus on. Fair enough it's got me thinking aboot the past….. but I've got tae get all them things out….. an' Ah find it helps like. (Client-C8R)*

However, ARBD hindered new learning which in turn did not necessarily increase employability:

> (The employment agency) *said I'm unemployable….. I want to know a reason why they're singlin' me oot ….. (Client-B5R)*

Thus when cognition allowed, learning enhanced resources and SOC but a similar outcome was not necessarily shared by those with ARBD. Nevertheless people with PAU experience and ARBD felt strongly that they could actively contribute to others' learning in the fieldsites. This is presented below as a candidate programme theory:

CPT11: 'wearing the T-shirt', peer support and salutogenesis

If people who '*wear the T-shirt*' of PAU, cognitive impairment and ARBD experience have a fieldsite context to share their experiences and offer recommendations on improving supports and services Then they will enhance others' and their own GRRs and SOC thus strengthen fieldsite engagement with and support for people with PAU, cognitive impairment and ARBD because *For others*: they will raise awareness and understanding of the challenges, impacts and road to recovery of PAU, cognitive impairment and ARBD based on personal experience and the learning they have received from elsewhere *For self*: enhance personal GRRs and SOC through sense of purpose, achievement and benefitting others.

7.5.1 Reflections on activities, learning and education

GRRs supporting recovery increased as participants partook in DASW organised activities and educational groups at the fieldsites and elsewhere. The resources were enhanced by peer support, participants' positive feedback and recommendations, and peer recognition of achievements. Though ARBD for Client-B5R hindered employment, he achieved stepped positive outcomes of class participation and course completion, demonstrating comprehensibility and manageability in a complex context. Learning

and participation in activities was not seen as a one way street. People wished to contribute to development of activities and contribute to others' learning, including about PAU, cognitive impairment and ARBD for those in the fieldsite without such personal experience.

7.6 Community programme volunteering, placement and employment opportunities

People with PAU experience were on placements, volunteered and worked in the fieldsites, with some outcomes demonstrating salutogenic flow and others reflecting complexities. When receiving daily ARBD support, Client-B4R volunteered to garden, a previously loved occupation:

> *I've messed up, haven't I? I'm back an' forward like a yoyo an' I've no' done it when I was meant tae do it. An' that's me feeling as if I've let somebody down as well ….. Makes me unhappy. (Client-B4R)*

He and Client-B5R spoke in distressed tones about ARBD impacts on employability and how they and others perceived them as their GRRs and SOC diminished. Client-B4R's response to this context was to reason about patience in recovery.

Volunteering did not suit everyone. Client-A4R found it difficult "*associating with people*". In contrast others experienced benefits:

> *This place has done everything for me. I used to work in here an' everything. (Client-C9R)*

Ill-health and physical disability limited employment options. However, volunteering enhanced Volunteer-B2R's SOC and contributed to achieving a self-prioritised outcome of happiness. Volunteer-B2R highlighted DASW-B's support in his role, ensuring no detrimental health impacts occurred.

Volunteering enabled PVolunteer-C4R to reflect on past alcohol issues and to look forward with newly acquired positive experiences:

> *I didn't dae great at school an' (alcohol's) obviously stopped me growin' because I got myself into trouble….. which stopped me puttin' in for jobs because people were just, "Seen you oot in the street. You're an idiot," ….. An' it's just like well, I've changed. (PVolunteer-C4)*

PVolunteer-C1R described his gardening role as "*a lifeline*". He viewed aspects of repetitiveness in gardening and teamwork opportunities as being beneficial supports to others:

> *Like any other working environment. You have your strengths an' your weaknesses an' it doesn't matter what your mental level is or what people presume you are. It's no' just about you - it's about the people roon' about you. (PVolunteer-C1R)*

Fieldsite-B's second-hand shop successfully operated by two volunteers supervised by DASW-B demonstrated this viewpoint. CVolunteer-B1R had a history of problematic drug use, low self-esteem and low self-confidence, and CVolunteer-B2R had ARBD. It offered both GRRs and enhanced their SOC, CVolunteer-B2R specifically identifying his volunteering role as a cornerstone in recovery maintenance. It created purpose and structure in his week and enhanced his self-confidence. It was opposite to what he described as his worst experiences of ARBD, when people were disinterested and brushed off his concerns about forgetfulness.

Recovery for Staff-C1R led to permanent fieldsite employment. He described engagement with people he met there:

> *We treat each individual client to whatever needs he needs at the time….. we don't try tae make an issue of any of the problems they've got. (Staff-C1R)*

Although clients did not always confide in staff, with time and trusting relationships this changed and advice was sought (Staff-C1R). People he supported shared Staff-C1R's view that peer support including at AA offered more benefit than support from people without personal PAU experiences. Besides being kitchen co-ordinator, Staff-C1R had roles in the recovery church, AA and NA where part of his approach was straight talking:

> *I just say, "Ah'll help you as much as I can but dinnae take the mince." ….. Once they come an' speak to me, generally they're genuinely wantin' tae dae something about it. 'Cause they know Ah dinnae mess about. (Staff-C1R)*

Despite enthusiasm about the current context, PVolunteer-C1R worried his reasoning about dealing with pressures, including related to volunteering, might repeat previous life outcomes. He had walked and drunk away from people, troubles and pressures,

metaphorically putting concerns in boxes with lids tied down. He lacked confidence the boxes would remain closed:

> *….. all the wee (emotional) boxes that Ah've shut again, some of them keep flapping…. in the wind. (PVolunteer-C1R)*

In the wind of contextual complexity and early PAU recovery, PVolunteer-C1R hoped that having Staff-C1R as a resource of someone he could turn to for advice, would prevent history being repeated and that outcomes would be different.

7.6.1 Spiritual influences on place and timing of recovery

For CVolunteer-A1R, Volunteer-B2R and Client-B5R, previously involved in or '*uniformed*' in TSA, the right place and time included re-engagement with TSA:

> *I got stopped outside the front door. I just felt a hand grab me. Nobody behind me. Nobody in front of me. I just felt this hand grab me and walked me straight through the front doors. (CVolunteer-A1R)*

His reasoning was of a miracle, God having "let go" of him then getting him back into TSA. Mechanisms occurred surrounding meeting a past band member "*mate*" with accompanying positive memories associated with musical peers, friendship, meaningfulness, comprehensibility and manageability. He recounted his friend's reasoning and welcome:

> *"God's seen you go through enough so He's just brought you back." (CVolunteer-A1R)*

According to his beliefs, CVolunteer-A1R experienced acceptance on human and deity levels and entered recovery:

> *I've never looked back on it wi' disgust an' been ashamed. I've looked at it as a relief. (CVolunteer-A1R)*

Spiritual wellbeing from a Christian perspective was mentioned by some others as contributing to and sustaining them in recovery. Some described this similarly to CVolunteer-A1R and others a gradual process through hearing about the Higher Power mentioned at AA or reading the bible. For these people, spiritual beliefs were part of their GRRs, SOC and place on the salutogenic continuum.

7.6.2 Reflection on community programme volunteering, placement and employment opportunities

Findings from people with PAU experience confirmed *CMOc7: volunteering in a salutogenic workplace* (s.5.7) and accompanying salutogenic flow. The fieldsite context contained opportunities and threats for volunteering and employment. However, resources including the DASWs and approachable, knowledgeable peers offering support and guidance had potential to help people develop occupational GRRs and SOC.

Wider volunteer comments confirmed DASW and workplace salutogenic approaches. Prison placement volunteers with mixed experiences of PAU and drug use described previously unknown sense of purpose and belonging:

> *PVolunteer-C2's got so much love for this place ….. It's such a good place an' I would like to ….. have ties here fur when Ah dae get oot. (PVolunteer-C3)*

They experienced acceptance, lack of judgement, feelings of positively contributing to the community programme, and created new dimensions to how they and others perceived them, with hope for continuing meaningful and manageable lives.

7.7 Conclusion

Findings evidenced that TSA community programme for people with PAU, cognitive impairment and ARBD experience was salutogenic enhancing GRRs and SOC. Salutogenic reasoning mechanisms fired in response to contextual changes as physical, practical, and psychosocial resources were introduced. Salutogenic engagement and flow contributed to PAU recovery, with people evidencing transitions from daily attendance for food to employed status.

Micro-actions and outcomes occurred in response to reasoning about micro resources. Depending on GRRs and SOC, people used solution focused reasoning about desired individual and peer group outcomes, whether alcohol or recovery orientated. Help-seekers' contexts included barriers to accessing governmental financial benefit entitlements, health supports and housing. These existed due to literacy and computing knowledge gaps, skills deficits in form completion, lack of

permanent address, and not attending or forgetting appointments. Reasoning mechanisms were influenced by alcohol-related generalised resistance deficits, hopelessness, lack of self-worth, stigma and fear.

Salutogenic outcomes arose in personally intended and unintended ways. Whether drinking or in recovery, experiences of help from, involvement in and contribution to the fieldsites relied on individuals' wishes, their relationship with alcohol and cognitive function. Those with current PAU drew on alcohol focused individual and peer group GRRs and SOC to achieve constancy of alcohol supply and withdrawal avoidance outcomes. Alcohol as a mechanistic force drove thinking and behaviour with reasoning about activities including shoplifting and begging to achieve goals. This mechanistic force resulted in ripple effect generalised resistance deficits in meeting basic needs, securing housing, employment, and damaged relationships with family members. However, it also created a context of alcohol-related peer awareness, mutual support and friendship.

Accessing programme '*carrot'* incentives including food released personal resources to secure alcohol consumption and avoid withdrawal '*sticks'*. Fieldsite basic need associated mechanisms and outcomes included reasoning about ongoing access to food, feeling sustained, being warm and clean, and having company and conversation before seeking alcohol. Conversations included those between peers with shared purpose, people in or supportive of recovery, and the wider fieldsite community.

Fieldsites were generally non-judgemental, welcoming contexts with opportunities for salutogenic GRRs and SOC growth including individuals feeling of worth to others. At this stage to help-seekers, GRRs salutogenic impacts beyond meeting basic needs were indirect outcomes, yet for some had occurred. People did not describe salutogenic leaps, rather micro outcomes. While continuing to drink, overall, people had found GRRs addressing basic needs and a forum of acceptance enhancing self-worth and SOC. This confirms *CPTR1(4): a helping organisation* (s.4.4.3.1.5).

Though outcomes for people in recovery confirmed *CPT6: salutogenic cognitive benefits* (s.4.4.3.1.2), continued cognitive decline was also evidenced albeit that basic support uptake may have lessened its rate. A refinement to *CMOc9: relationship*

building and opening doors to help (s.5.10.2) is inclusion of other staff and volunteers. Their "*really nice*" approaches encouraged re-attendance so addressing "*social dislocation and isolation*" (Yates 2017). This contrasted to peer cultures with alcohol consumption focused GRRs and SOC.

The fieldsites as recovery contexts and resources incorporated the people present, resources available and reasoning about and approaches to engagement with people with PAU and ARBD. Salutogenic AA and peer support were most often mentioned for PAU with other support from families, the NHS, other local agencies and the fieldsites. The programme context supported individuals' salutogenic recovery orientated GRRs and SOC development preceding and when it was "*their time*" (Staff-C1R) to reach a more fulfilling alcohol-free status. People were helped to build self-esteem and find and retain purpose, manageability and meaning in life, while managing alcohol's remaining influences on them. Increased financial security and stronger health orientated behaviours developed. They were knowledgeable about PAU through personal and others' experiences, successfully addressing this on an individual basis and endeavouring as peer recovery role models to help others. This included by raising awareness of recovery groups at fieldsites and elsewhere, and planning with and motivating others to attend.

They recognised personal traits in providers which increased the likelihood of client engagement and help-seeking behaviours. Some saw themselves as an educational resource to others, in addition to accessing education. They identified personal lived-experience resources, their ability to listen to others and benefits of sharing what worked for them, culminating in strengthening contexts of achievement and hope. Hope was also a mechanism supported by growing GRRs and SOC, initially in reasoning about future recovery, then recovery, then potentially recovery following relapse. Thus people, some of whom had been decades in recovery, with PAU experience, cognitive impairment and ARBD were fieldsite salutogenic resources. Seeking café food resources gave accompanying beneficial psychosocial outcomes and access to wider DASW support including about housing. Some individuals in recovery were experiencing cognitive deterioration potentially due to past PAU or other causes.

For some, engagement or re-engagement in spiritual aspects of the community programmes enhanced recovery orientated GRRs and SOC. It addition to supporting reasoning about comprehensibility, meaningfulness and manageability in life, it enabled relationship building outwith alcohol related circles and attainment of band and Sunday school roles. DASW volunteering support enhanced subsequent potential paid employment opportunities. A stepping stone to formal volunteering proudly described (Client-B3) was informally undertaking small fieldsite tasks. Individuals again became aware they were resources to others, enhancing recovery orientated SOC, including in those with cognitive impairment and ARBD. Sobriety and ARBD cognitive improvement opened volunteering and employment opportunities reflecting positive salutogenic flow from dis-ease towards ease on the salutogenic continuum.

In comparison, small steps in engagement with other agencies were difficult for people with ARBD due to diminished reasoning and recollection about appointments. Individuals valued TSA Army daily telephone reminders, walk-in support and individualised appointments at times aligned with other activities. Support came from trusted others, which for some with ARBD was an anticipated long-term need.

Overall, the findings confirm the hypothesis presented in *Figure 2 CPTR3(11): the right track and the importance of peers.* The fieldsites provided a context where at whatever level and type of resources being accessed, there were salutogenic impacts and outcomes. This ranged from staff micro-actions resulting in people momentarily then recurrently feeling of worth, through to permanent employment. The fieldsites provided a context where individuals' potentials and strengths were recognised with supportive building and development of these. In contrast to prior experiences of exclusion, stigma and sense of worthlessness, the majority endeavoured to develop positive relationships, and supported a view of the future incorporating hope, comprehensibility, meaningfulness and manageability. The outcomes reflected salutogenic flow, which will be discussed further in Chapter 8.

7.8 Chapter 7 theory building synopsis

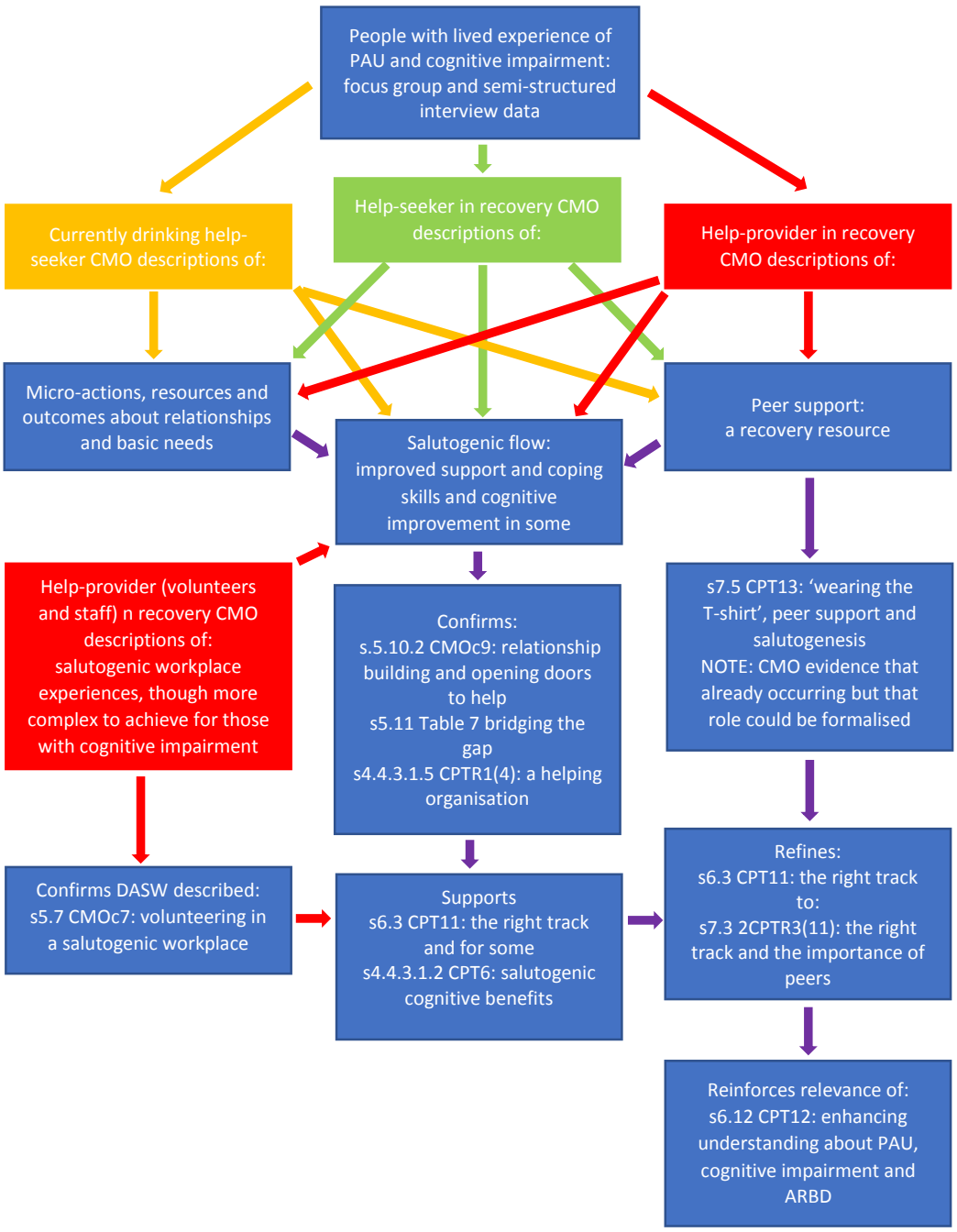

Figure 14 Salutogenic micro-outcomes, peer support and flow as contributors to recovery

CPTs supported by evidence could be re-labelled as EIPTs. However, in keeping with theory adjudication and refinement, the CPTs and CMOs are scrutinised further in Chapter 8 in conjunction with relevant review of literature to support conclusive EIPT development.

Chapter 8 Discussion

8.1 Introduction

Core UK guidance about supporting people with ARBD focuses on statutory health and social care models (Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014). The guidance encourages referral in particular to the third sector organisation, Headway, despite a lack of information about ARBD on its website (Headway 2018). In contrast, The Salvation Army funded this research to benefit people with ARBD recognised to be accessing its community programmes (Scotland Drug and Alcohol Strategy Task Group 2011). Though not mentioned in the above guidance, Salvation Army recognition of the importance of this field also was reflected by its previous involvement in '*A Fuller Life: Report of the Expert Group on Alcohol Related Brain Damage*' (Cox et al. 2004). This research continued their commitment to better serve this group.

The research extended academic knowledge and addressed research gaps about what works, for whom, in what circumstances, how and why for people with PAU and cognitive impairment and did this outside statutory health and social care settings, instead within TSA community programmes. Findings were from the perspectives of people with personal experience of PAU, cognitive impairment and ARBD and TSA help-providers. The research confirmed that TSA community programme and its biopsychosocial intervention worked for people in contexts of exclusion from society's norms. Importantly participants described difficulties engaging with statutory providers which impacted on adherence to recommended steps to support and recovery (Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014). For them, TSA successfully provided supports in ways other organisations did not. Importantly the research revealed Salvation Army salutogenic approaches and outcomes predating Parkin's (2016) recommendation for use of a salutogenic framework for recovery services and supports and the concept of salutogenesis itself.

As the research used the realist question *what works, for whom, in what circumstance, how and why,* implications of TSA findings radiate far beyond the fieldsites. Currently major political and financial uncertainty exists, with accompanying pressures on individuals, those close to them and service providers including the NHS for whom alcohol-related challenges may seem overwhelming (Bardsley et al. 2017; Giles and Robinson 2017). Conversely, the research answers in TSA context lie in micro-actions and resources which enabled help-seekers to experience salutogenic recovery-orientated outcomes, with peer resources particularly important to generalised resistance resources, sense of coherence and salutogenic flow.

Furthermore, though normally regarded as core to Therapeutic Communities (De Leon and Wexler 2009, p. 169), this chapter argues that TSA fieldsites have their own *community as method,* offering learning to other organisations. Important to this were volunteering and occupational opportunities. This research adds to literature (Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014) by providing insight into the complexities and benefits of people with PAU and cognitive impairment workings in TSA setting. People achieved personal outcomes and through their peer role model status helped others, their lives demonstrating salutogenic flow.

My novel research combined realist approaches and salutogenic theory to explore how people with PAU and cognitive impairment, reasoned about and responded to resources available to them in TSA community programmes. I identified contexts, mechanisms and outcome experiences from help-seeker and help-providers' perspectives. The salutogenesis focus was on GRRs and SOC, the latter incorporating the desire and motivation to cope (*meaningfulness*), belief that challenges faced are understood (*comprehensibility*) and belief in availability of resources needed to cope (*manageability*) (Antonovsky 1996).

Realist evaluation recognises that co-existing factors in intervention contexts can influence outcomes. Here, the DASW '*intervention'* partial implementation alone was not assumed instrumental in client response mechanisms and outcomes. I used retroductive and iterative thinking commended in realist evaluation and synthesis, going back and forward, looking and listening anew, and exploring *what worked, for*

which people with PAU and cognitive impairment accessing the wider Salvation Army community programmes, in what circumstances, how and why.

Realist evaluation has theory building using contexts, mechanisms and outcomes at its core using data from wide-ranging sources, in this instance beginning with literature. However, as previously described (s.4.4.3), there was a dearth of information in literature about salutogenesis in combination with ARBD, TSA and the CRA. To avoid limiting the research to testing of one or two literature-based candidate programme theories (CPTs), I sought learning from participants as my teachers, allowing new theories to emerge. Participant data was used to test initial CPTs and create new ones, with ultimate development of the evidence-informed programme theories (EIPTs) in this chapter. This overall approach deepened my understanding of TSA fieldsites as communities and their places within local neighbourhoods. The study celebrates the real world of TSA, reflecting the dynamic, complex nature of fieldsite supports and the people and wider communities served.

TSA salutogenic context involved buildings, people and resources for help-seekers with PAU, cognitive impairment and ARBD. The research reveals positive salutogenic outcomes in such individuals, but perhaps unexpected ones about workplace salutogenesis. Three aspects of help for people with PAU experienced became increasingly prominent during the research: *micro-actions, peer support* and *salutogenic flow*. This combination sent help-seekers a message of inclusion and hope, contrasting with experiences elsewhere of "*three strikes an' yer out" (DASW-AR)*.

Though this chapter describes research limitations, the findings independently and when compared to literature offer benefit to TSA, those they help and more widely to other organisations supporting similar populations. Recommendations are offered about improvements to help-provider support which in turn will enhance scope to assist help-seekers. The chapter ends with recommendations for further research and closing remarks.

8.2 The research approach to theory building

Theory building approaches (s.3.4.6 including *Figure 1 Theory development and approach to data analysis throughout thesis*) considered salutogenic theory and using realist approaches, revealed evidence of *what worked for which people with PAU and cognitive impairment accessing TSA community programmes in what circumstances, how and why.* The process demonstrates the value of developing and examining theories from wide-ranging literature sources and included here, research focus group and semi-structured interview participant data. NVivo use supported transcribed data management and the realist based analysis. Following consideration of existing CPTs, refined CPTs and CMOcs, EIPTs developed in this chapter form the theory building pinnacle of this study. CMOcs, CPTs and EIPTs underpin recommendations to TSA about its community programmes and future research. *Table 11* lists the CPTs, CMOcs and EIPTs developed during the research with accompanying codes, titles and section numbers.

Table 11 Theory building reference table

Category	Title	Section
CPT1:	a life more fulfilled	3.2.2.3
CPT2:	holistic, salutogenic approaches	3.2.2.3
CPT3:	ARBD meaning and understanding	3.4.4
CPT4:	a helping organisation	4.3.4
CPT5:	Booth's footsteps and partnership working	4.4.3.1.1
CPT6:	salutogenic cognitive benefits	4.4.3.1.2
CPT7:	a salutogenic workplace	4.4.3.1.2
CPTR1(4):	a helping organisation	4.4.3.1.5
CMOc1:	DASWs, Strategy vision and sense of support	5.4
CMOc2:	a workplace shift towards dis-ease	5.5
CMOc3:	meaningful work and doing the job well	5.5
CPT8:	salutogenic workplace, personal development and support	5.5
CMOc4:	innovation and foundation building	5.5
CPT9:	Integrated Mission, salutogenic workplace and change	5.6
CMOc5:	solution seeking through Integrated Mission	5.6
CMOc6:	communication and community programme development	5.6
CMOc7:	volunteering in a salutogenic workplace	5.7
CPT10:	practitioner nous	5.9.1
CMOc8:	practitioner nous	5.9.3

CMOc9:	relationship building and opening doors to help	5.10.2
Figure 2. CPT11:	the right track	6.3
Figure 11. CMOc10:	Client-B5R ARBD knowledge and understanding	6.7.1
CPTR2(8):	salutogenic workplace, personal development and support	6.9.3
Table 10 CMOc11	knowledge and understanding contexts, mechanisms and outcomes	6.11
Figure 12. CPT12:	enhancing understanding about PAU, cognitive impairment and ARBD	6.12
CPTR3(11)	the right track and the importance of peers	7.3.2
CPT13:	'wearing the T-shirt', peer support and salutogenesis	7.5
EIPT1:	Booth's footsteps and partnership working	8.4.1
Figure 15. CMOc12:	Client-A6C reasoning about food and engagement	8.4.2
EIPT2:	a helping organisation	8.4.2
Figure 16. EIPT3:	ripple effects and salutogenic flow	8.4.3
EIPT4:	community as method	8.4.5

8.3 Evidence-informed programme theories

Realist approaches were used to identify contexts and mechanisms leading to salutogenic outcome experiences in people with PAU and cognitive impairment accessing TSA fieldsites. This involved considering GRRs and SOC from help-seekers and help-providers perspectives. Findings are now aligned to research question headings, with consideration in each of the main research findings about how peer support and micro-actions created salutogenic growth and flow in people who were often "square pegs" to statutory providers "round holes".

8.3.1 Explanations, knowledge and experiences of PAU, cognitive impairment and ARBD

Participant findings of inconsistent understanding or knowledge about ARBD refuted *CPT3: ARBD meaning and understanding* (s.3.4.4). All participant groups revealed learning needs. However, TSA micro-actions and resources of welcome, inclusion and meeting basic needs created learning opportunities. These GRRs were incentifying mechanisms supporting people's desires to return and so develop and strengthen relationships with others. They confirmed *CPT5: Booth's footsteps and partnership working* (s.4.4.3.1.1) with refinement as below to *EIPT1: Booth's footsteps and partnership* working. *CPT5* (s.4.4.3.1.1) emphasised partnership working with other

agencies (Scotland Drug and Alcohol Strategy Task Group 2011). This research highlighted peers' importance as a resource '*agency*', the referring here to people who on an individual or group basis could offer help to others with PAU and cognitive impairment.

EIPT1: Booth's footsteps and partnership working

The DASWs appointed to the community programmes enabled TSA:

- to continue working and ministering as William Booth did
- alongside those in need - the marginalised of many communities
- in partnerships with hosted agencies, other local agencies, and individuals and peers coming to the community programmes

because the extra capacity brought by the DASWs enhanced the community programme's layered GRRs and SOC in helping people with PAU, cognitive impairment and ARBD.

In TSA context, peer agency grew as peers offered what others could not. They shared lived experience based explanations and knowledge about PAU, cognitive impairment and ARBD with others in AA, in TSA peer support groups and informally in TSA café settings. They spoke of addiction, alcoholism and alcoholics, unlike some help-providers' keen to avoid potentially stigmatising terms. Help-seekers thought particularly statutory and private agency providers lacked understanding of the immense challenges help-seekers faced:

> *It's a'right ….. getting them sober an' then saying, "OK you can go now". An' what are they gonnae dae? Exactly the same thing they did the day before. (Client-A4R)*

Peers' approaches were different. Through personal experiences of recovery-based salutogenic flow, they became salutogenic resources for others still drinking or in recovery. Their micro-actions were of listening, being there, and acknowledging and giving credible understanding to issues others were facing. As mentors and role models, they advised about recovery approaches they and others they knew had adopted, including when things went wrong. Though not judging, they challenged, encouraging people to use their SOC and GRRs to problem solve:

> *Relapsing again, you say, "Why are you going wrong?" ….. the point's not on you to find a solution, the plan is then on that person to look at he'sel an' say, "Well, I didn't, I did that, I never did that". (Client-A4R)*

Peer wording choices of being alcoholics reflected alcohol's holistically damaging impact on their lives, accompanying depths of despair and the enormity of achievements towards and sustaining recovery. That is why '*wearing the T-shirt*' of having been there and done that was important to individuals and to those for whom they were resources (CVolunteer-A1R).

Comprehensibility about links between PAU and cognitive impairment is reflected in *Table 10 CMOc11: knowledge and understanding* (s.6.11). Drawing lines from individuals' co-existing contextual factors to varying mechanisms and sometimes contradictory outcomes creates cats' cradles of CMOcs. Cognitive impairment was a potentially evolving contextual factor which impacted on SOC and GRRs, including comprehensibility about PAU and its impact on cognitive function (s.6.7.1, *Figure 11 CMOc10: Client-B5R ARBD knowledge and understanding*). In TSA context, evidence of DASW and peer supported recovery experience with improving cognition and strengthening GRRs and SOC (Client-C10R) supported *CPT6: salutogenic cognitive benefits* (s.4.4.3.1.2).

Importantly people with PAU experience wanted to be information and education resources for TSA, offering future scope for individual and organisational salutogenic flow. As presented in *Figure 12 CPT12: enhancing understanding about PAU, cognitive impairment and ARBD* (s.6.12) this offers opportunities for all involved in TSA community programmes who wish to do so, to reach a stage of feeling of being on the right track, being able to handle things, and being of worth (Antonovsky 1990).

8.3.2 Living with PAU, cognitive impairment and ARBD

The research confirms literature findings about PAU (Bonner et al. 2009; Bramley et al. 2015; Fitzpatrick et al. 2011), cognitive impairment and ARBD (McMonagle 2015; McMonagle et al. 2015; Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014; Wilson 2015) impacts on daily life. Though peers backgrounds varied, when in TSA fieldsites they shared alcohol-related experiences and outcomes. Whether drinking or in recovery they innovated, finding solutions towards sustaining alcohol consumption or recovery flow. In both contexts, people sought and established GRRs including TSA fieldsite support in meeting basic needs and peer encouragement to attend. These

were reflected in experiences of people like Client-A6C who had ARBD. *Figure 15 CMOc12: Client-A6C client reasoning about food and engagement* demonstrates his reasoning towards resources available to him through his partner, a peer and the community programme. Notably his peer, Client-A5C, was a resource throughout.

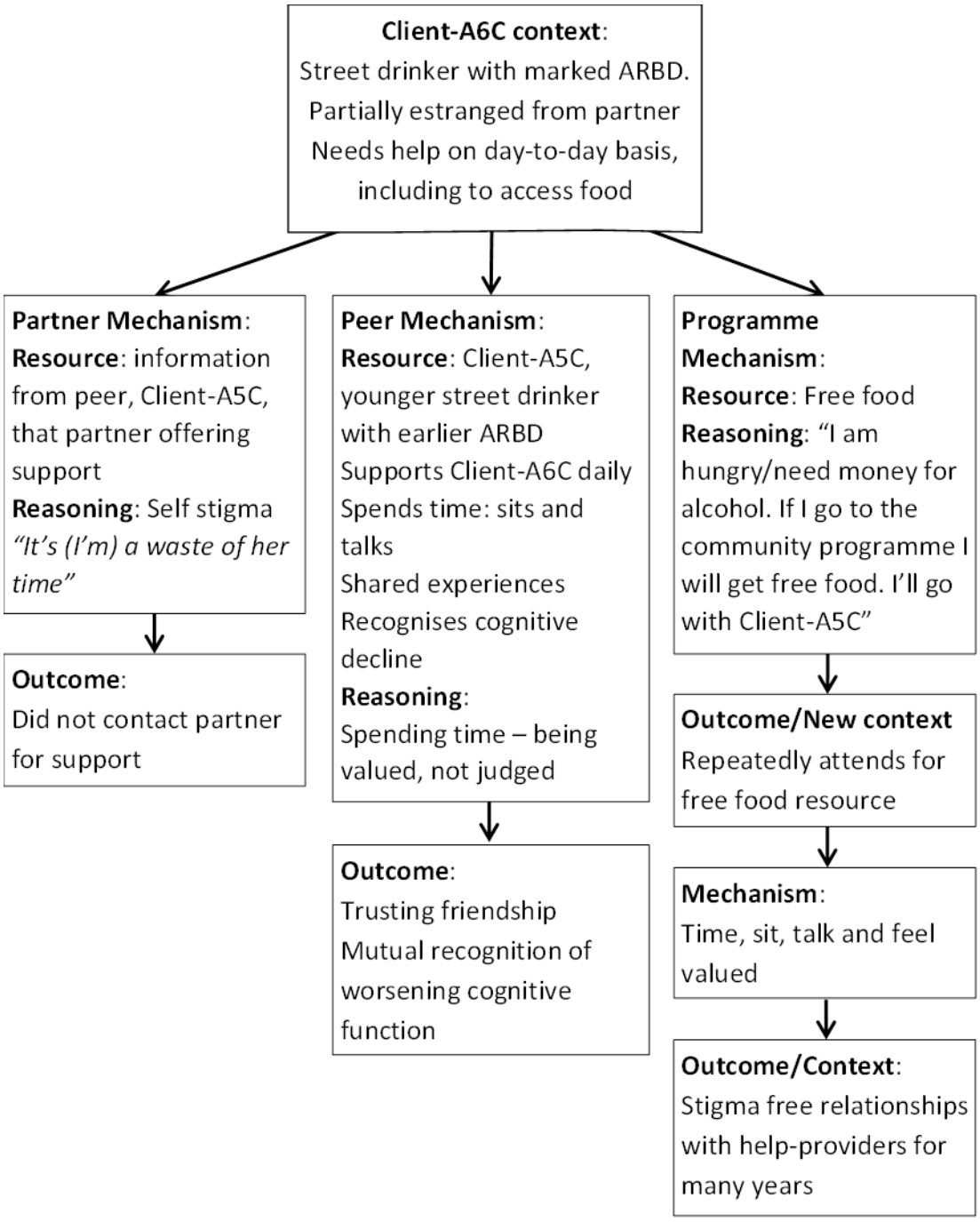

Figure 15 CMOc12: Client-A6C reasoning about food and engagement

This confirms TSA community programmes became GRRs for people with ARBD when facing basic need life stressors. It enables refinement of *CPTR1(4): a helping*

organisation (s.4.4.3.1.5) to *EIPT2: a helping organisation* below. The findings confirm that it was not TSA DASW intervention alone that created impact. Different resources including peers, staff and volunteers were influential in engagement and thus outcomes, whether about continued drinking or recovery.

EIPT2: a helping organisation

People with PAU and cognitive impairment choosing to access community programme '*basic work in the helping process'* micro-action resources provided by TSA staff (many of whose SOC has spiritual foundations), achieved micro then sustained outcomes as they '*bridged the gap*' over difficult periods in their lives due to enhancement of their GRRs and thus SOC.

Peers were also mutually motivating resources encouraging Recovery Church or AA attendance. Like the DASWs, peers supported and advised on where to access help about stressors, including by highlighting TSA resources. Living with PAU, cognitive impairment and ARBD was made more manageable and meaningful by peer micro-actions. The resulting salutogenic flow might have remained dormant without TSA community programme context and resources.

8.3.3 Salutogenic experiences and impacts of TSA community programmes

In this thesis, salutogenesis refers to creation of holistic biopsychosocial health and wellbeing, the opposite of PAU's pathogenic pull. People with current or past PAU knew of alcohol's harmful impacts on relationships, employment, housing and physical and mental health. Peers had died, sometimes through suicide. Despite this awareness, participant accounts were not necessarily of recovery. At the dis-ease end of the salutogenic continuum, Client-A6C who had ARBD said, "*I know exactly what I'm daein' to myself*". It could be argued that he and similar others were accessing Salvation Army long-term condition palliative help but the context included hope and evidence of recovery should they choose to reduce and/or stop drinking. In fieldsites they witnessed precipices beckoning peers who somehow instead successfully developed recovery-orientated GRRs and SOC, in so doing attaining a fulfilled life. The idea of long-term condition palliative help is proposed as a future research topic (s.8.7).

Salutogenic experiences were in the form of micro-actions, resources and outcomes. Help-seekers attended frequently for many years to only once or twice. Their belief mechanisms fired on realising that TSA resources could help them cope with life's stressors. In TSA context, manageability rose on gaining GRRs to meet basic needs of food, clothing and hygiene. Sometimes fieldsites were places of humility: shared shower facilities with one peer washing another's back. They were not stigmatised by staff or volunteers, and were offered support by peers. Daily purpose arose. Help-seekers had somewhere to go to enjoy a meal or talk to non-judgemental others.

Desire or motivation to cope emerged to varying levels in different people with focuses on recovery, continued drinking or shifts on the cycle of change when the time was right. Some experienced a spiritual awakening or renewal, with respect for a Higher Power, others and self. People felt valued, with recognition by self and others of abilities to contribute in the community programme. Opportunities arose for involvement in groups organised by the wider community programme, groups specifically for people with PAU and drug use, and hosted organisations. The resources all contributed to living with differing levels of help and support, which ebbed and flowed according to need.

Demonstrated below, Figure16 EIPT3: ripple effects and salutogenic flow was constructed using data from people with PAU experience with salutogenic flow contributing to recovery. EIPT2: a helping organisation (s.8.4.2) highlighted the importance of micro-actions and resources in helping people 'bridge the gap' over difficult periods in their lives. In Figure 16 EIPT3: ripple effects and salutogenic flow, micro-actions, resources and outcomes have been pulled into wider headings of GRRs, SOC and salutogenic outcomes. The ripple effect CMOc demonstrates how micro-actions, resources and outcomes contributed to salutogenic flow. Data confirmed flow from dis-ease levels of PAU through recovery to outcomes including cognitive improvement, employment, a permanent home and happy, fulfilling relationships with others. Peers exemplified that life without, as opposed to with, alcohol was more fulfilling. They recognised achievements of others, were concerned if peers appeared to be struggling and 'gave back' through fieldsite peer support and in mutual support organisations. SOC and GRRs were no longer driven by overwhelming need of alcohol.

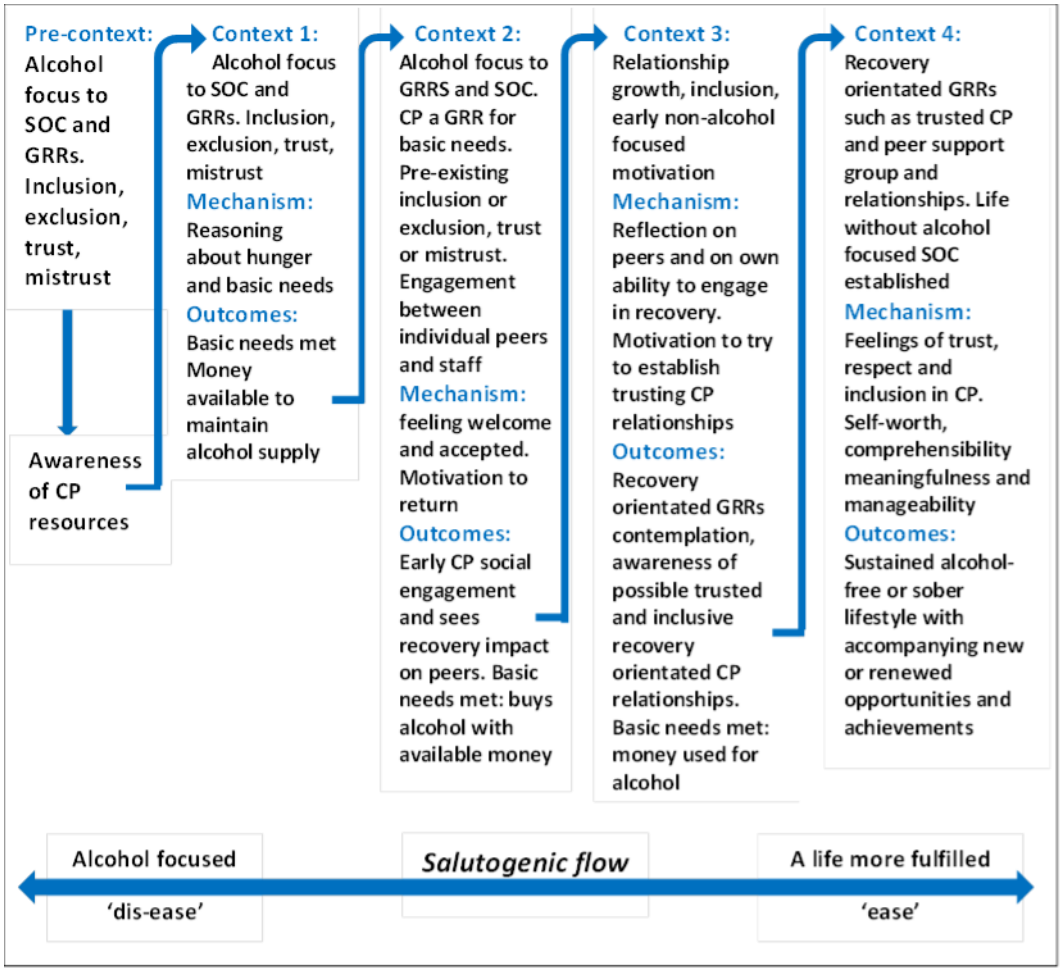

Figure 16 EIPT3: ripple effects and salutogenic flow (CP: community programme)

Mechanisms centred on reasoning related to SOC and GRR changes. As generalised resistance deficits were replaced by resources, participants experienced feelings of trust, self-esteem, self-confidence, connectedness and belonging, safety, knowledge, skills and hope. With support, they gained knowledge and understanding about PAU and cognitive impairment, the impacts of these in their lives and coping strategies.

Although *Figure 16 EIPT3: ripple effects and salutogenic flow* reflects positive experiences associated with recovery through transition from one context to another, the situation was complex and not automatic. Some remained "*in the grips*" of alcohol (Client-C10R), "*slipped*" or "*chose*" (Staff-C1R) to drink again. Alcohol's continued pull could worsen health and cognitive function. Choice influenced where '*home*' (including rough-sleeping) was and whether to beg or shoplift for an income. Lives incorporated varying levels of trust or mistrust, inclusion and exclusion. Inclusion could be pathogenic with encouragement of harmful alcohol use. Individuals were

excluded from their homes or by people or services who could offer help. Simultaneously, TSA fieldsite micro-action conveyance to help-seekers that they mattered encouraged a sense of dignity and self- respect.

Help-providers micro-actions influenced client reasoning and responses and whether salutogenic relationships developed. The way a help-seeker spoke when asking a help-seeker if he wanted a cup of tea mattered. In those few words, he knew that to her, he mattered. When begging, others ignored him or regarded him with disdain. Staff saw beyond his outer dishevelled, overwhelmed by PAU and ARBD, homeless appearance to a "*sweet*", "*always polite*" and "*lovely man to talk to*" (Staff-C2). They repeatedly welcomed him, giving him resources they anticipated would vanish. Recovery was not on this man's horizon, yet each fieldsite micro-action and resource stalled his journey towards the pathogenic end of the salutogenic continuum.

Noticeably, most fieldsite help-seekers and all the study clients and clients in recovery were men. Three female client volunteers hesitantly participated, mothers with caring responsibilities for children or other family members. Though left unasked, I felt I was a barrier to their research engagement: a working, middle-class mum, never unable to care for her children. However, TSA café's predominately male, sometimes fairly noisy client group context may have diminished female attendance. Some people had "colourful pasts" (DASW-AR) with time in prison common. Fieldsites were part of local neighbourhoods. People knew or knew of each other, and family connections potentially created dis-incentives for women to come. However, these women demonstrated salutogenic flow. Two successfully ran Fieldsite-C's Feelings Group and were training to be peer support workers in NHS settings. Becoming friends at the fieldsite, they mutually supported each other in recovery, in fieldsite engagement, and as resources to others.

8.3.4 The Salvation Army as a salutogenic workplace

CPTs anticipated that TSA would be salutogenic workplaces for the DASWs and other help-providers. Although there were indicators of improvement described at the Exploratory Focus Group, the DASWs revealed detrimental workplace impacts on their wellbeing. Thus, using evidence from *CMOc1: DASWs, Strategy vision and sense of support* (s.5.4) and *CMOc2: a workplace shift towards dis-ease* (s.5.5), *CPT7: a*

salutogenic workplace (s.4.4.3.1.2) was refuted. Nevertheless the DASWs demonstrated use of practitioner nous and personal GRRs and SOC to improve and develop services, with *CMOc8: practitioner nous* (s.5.9.3) confirming *CPT10: practitioner nous* (s.5.9.1). This occurred on an individual client level, when supporting other help-providers, and when successfully developing interagency relationships.

Despite the concerns raised above, the DASWs conversations evidenced growing SOC in their roles as reflected in *CMOc4: innovation and foundation building* (s.5.5). Lacking formal assessment tools, each developed a mental checklist of presentations they thought suggested cognitive impairment. Micro-actions and outcomes then came to the fore, such as happy readiness to support a café client volunteer with ARBD when he repeatedly forgot who he was taking a cup of tea to. To them, this was about *CMOc3: meaningful work and doing the job well* (s.5.5) and reflected growth in workplace GRRs and SOC. This evidence confirms *CPT5* (s.4.4.3.1.1), which now becomes *EIPT1: Booths' footsteps and partnership working*).

The DASWs identified needs for regular workplace support, development plans and training through their own experiences and when supporting other help-providers,. Their ideas as found in *CPTR2(8): salutogenic workplace, personal development and support* (s.6.9.3) were confirmed as helpful by other staff and most volunteers. Many participants wished to learn about ARBD and PAU. People with lived experience recommended specific training materials plus their voices in explaining to people without equivalent experiences about their own. This mattered because knowledge and understanding gaps created pathogenic engagement risks. Volunteer-B3 became irritable because CVolunteer-B2R who had ARBD left tasks incomplete. Volunteer-C2's knowledge gaps resulted in Staff-C1R and DASW-C calling her '*dangerous*'. These accounts reflect how different contextual factors including cognitive impairment may influence levels of understanding and the relevance of *Figure 12 CPT12: enhancing understanding about PAU, cognitive impairment and ARBD* (s.6.12). These would then need considered within *CPTR2(8): salutogenic workplace personal development and support* (s.6.9.3) for each individual.

Though not about TSA, and putting training gap concerns aside, the quotation below reflects help-seeker approaches:

Be thorough; there is no substitute for quality; judge not; be welcoming and warm, but be persistent; like people and they will like you; cooperation gets the job done; help yourself by helping others; know what you should be doing, do it, and do it well; explain clearly what you are up to and why; have and give confidence that together you can make things better; assume nothing. Perhaps above all – timing: catch people at the cusp of change, or somehow get them there….. the rest of the journey may be bumpy and long, but it will be downhill. (Ashton 1999)

8.4 Research contribution to literature

This study extends current understanding of TSA third sector organisation support for people with PAU, cognitive impairment and ARBD through application of realist methodologies within a salutogenic framework. Figure 17 provides headline findings in relation to literature and described fully in subsequent sections. The ultimate finding is of TSA fieldsites demonstrating community as method in which micro-actions and resources and peers contribute to recovery-orientated salutogenic flow outcomes. The study findings about methodological implications of interviews approaches with vulnerable people are found in s3.4.2.2.

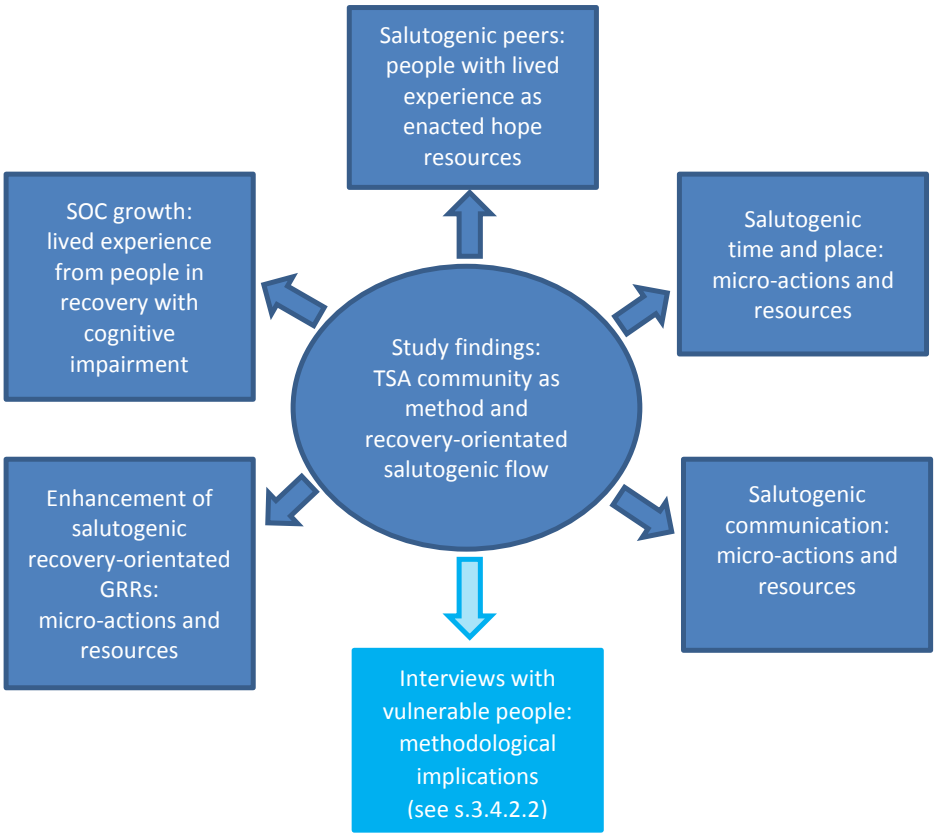

Figure 17 Study headline contributions to literature

8.4.1 Salutogenic time and place

This timely research addresses the Substance Misuse Management Good Practice call "*to strengthen the patient voice in alcohol and other drug services*" (SMMGP 2018) and ARBD. Participants described difficulties around diagnosis, stigma, multiple disadvantage, statutory health and social care service provision complexities, and difficulties people with PAU, cognitive impairment and ARBD experience face, as elsewhere in literature (Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014; Craig and Watson 2018). Parkin (2016, p. 21) advocated a salutogenic, recovery framework contrasting to, "*the State's more structurally-focused treatment options that may not fully appreciate the influence of agency (and the role of place) in attempts to garner recovery capital."* TSOs may lack resources available to statutory organisations, but TSA has resources of help-seekers and help-providers with lived experience of PAU and cognitive impairment which statutory agencies may lack.

This PAU and cognitive impairment study extends understanding about Parkin's (2016) suggestion and about the importance of local communities and SOC (Maass 2017). This study revealed TSA salutogenic supports and their local context for help-seekers pre-date Parkin's recommendation. According to health providers, people with PAU missed 36.9% new and 18.9% review appointments, reflecting complexities in accessing health service (Mitchell 2007). TSA located community programmes with primarily open-door access arrangements in neighbourhoods with demonstrated need in places readily accessible to people in terms of their alcohol consumption patterns, their prevailing mind-set and where they were living, all important factors in Zinberg's drug, set and setting (1984). The intervention sites were part of the community, used by many people with or without PAU experience.

Help-providers welcoming approach was a repeated micro-action which became a GRR for people with PAU and cognitive impairment. Help-seekers knew they had a place to go to which would not exclude them, despite potentially very poor states of individual wellbeing. The timing of accessing support depended on individual contexts, but generally reflected significant need requiring a prompt response rather than a waiting list place that was experienced with other services. Similarly to

elsewhere (Collins et al. 2016) (s.3.4.2.2), help-seekers had individual and not necessarily recovery-orientated reasons for accessing TSA support. Like Meyers (2015), TSA's primary initial focus was on help-seeker self-identified need. This evaluation demonstrated that TSA community programme peers and help-providers specifically created favourable conditions for active engagement by people with PAU, cognitive impairment and ARBD. Opportunities for and actual recovery-orientated experiences then arose, strengthening individuals' recovery resources. TSA successfully offered local longevity and continuity of support to individuals towards or in recovery over many years, with evidence of help-seekers taking up opportunities to become involved in the wider Integrated Mission community (The Salvation Army 2015).

8.4.2 Salutogenic communication: micro-actions and resources

An important contribution of the study findings to literature is that it adds to understanding about salutogenesis (Antonovsky 1987) in people who as a result of ARBD have difficulties in learning new information, decision making and executive function (Steinmetz et al. 2014; Wilson 2015; Staples and Mandyam 2016; Topiwala et al. 2017). Communication micro-actions and resources adopted by TSA help-providers created salutogenic opportunities, particularly important to people with ARBD for whom communication was at times difficult. They adapted their communication styles in order to meet each individual help-seeker as a person (McCluskey 2005) (s2.5). This contrasted to help-seekers stigmatising experiences in other, including health, settings (Brondani et al 2017; Schomerus et al 2011b; Sleeper and Bochain 2013; van Boekel et al. 2013).

Relationship resources emerged through repeated micro-actions of respectful engagement and welcome and meeting basic needs in an environment supporting relaxation, humour and "*a wee time out*" (DASW-B). Relationships were the foundations for future engagement and outcomes, including access to other services. Crucially, with reference to 'treatment, not just care' (Craig and Watson 2018), this research demonstrated increased access to statutory provider 'treatment' because of salutogenic, caring micro-actions and resources of DASWs, peers and others at the fieldsites. This was because of help-provider micro-actions as they made help-seeker-

centred arrangements (often in keeping with the stage of PAU or level of cognitive impairment) rather than ones simplest for the organisation. If services for people with PAU and cognitive impairment are developed without constant recognition of ARBD impacts on help-seeker engagement, endless frustrations may arise.

8.4.3 Enhancement of salutogenic recovery-orientated GRRs: micro-actions and resources

A community-based substance addiction programme comprising weekly counselling sessions and access to co-located services (Davey et al. 2014) reported mechanisms of a treatment programme for clients' need, trusting relationship with caseworkers, belief in a holistic ways of healing, willingness, self-efficacy and self-awareness. Reduced alcohol consumption or sobriety, renewed relationships, cultural reconnection and improvements in mental health occurred. The current study extended knowledge in this field by its specific focus on concurrent PAU and cognitive impairment, not recorded in the aforementioned research (Davey et al. 2014). It also dug under the described mechanisms to what created them. In TSA's less formally structured programme these were salutogenic micro-actions, resources and outcomes to which peers contributed, resulting in salutogenic flow.

The concepts of GRR and SOC enabled a more nuanced understanding of how support provided in TSA context works for people with PAU and cognitive impairment, and how through evolving contexts and mechanisms, more positive outcomes emerged. TSA help-providers recognised a mum's particular challenges just before Christmas. Their micro-actions and resources ensured she had food and gifts for her to give to her children, with a family Christmas celebration then possible. In recovery and a resource in TSA, that mum was supporting other women in similar situations highlighting the importance of welcome, time, acceptance, and informal settings in which peers could relax, talk and share without judgement. Women who are parents describe the highest levels of PAU-related stigmatising experience (Stringer 2018). This finding demonstrates how help-provider micro-actions and resources resulted in a peer led, Salvation Army based, successful approach to supporting women with PAU, including with cognitive impairment.

Further small but significant aspects of interventions for people with PAU and ARBD exist. Micro-actions and resources should anticipate help-seekers' likely forgetfulness about plans made, reminders arranged and how to do things. Letter reminders were often unhelpful as post could create fear. Encouraging telephone prompts and face-to-face reminders worked better. Non-judgemental, repeated support across aspects of social engagement, meeting of basic needs and daily activities created incentives for continuing engagement and cumulative salutogenic outcomes. Successful peer recovery-orientated GRRs were mutual prompting, joint planning about and joint recovery group attendance, with use of a common language of language.

8.4.4 SOC growth: lived experience from people in recovery with cognitive impairment

The study specifically challenges beliefs and contributes to discussion about changes in or the static nature of SOC over time (Antonovsky 1987) (Hakanen 2007). The prevailing view has been that SOC stays stable over time or is subject to little change, a dismal outlook for people in this study whose lives often comprised of deprivation, exclusion, homelessness and traumatic experiences. In contrast this study revealed that TSA created a context of enacted hope (s.4.4.3.1.4) for people whose life experiences had been perceived by self and others as failures, but whose recovery-orientated GRRs and SOC grew in TSA context. Many years into recovery with partially improved cognitive function, CVolunteer-B2R's with help successfully maintained a flat, had a successful relationship, volunteered in TSA programme and felt fulfilled. Other people with ARBD similarly demonstrated salutogenic flow in TSA context despite ARBD's complex impact on readiness to change (Le Berre et al. 2013) and alcohol-related behaviours (Kelly and Barker 2016).

8.4.5 Salutogenic peers: people with lived experience as enacted hope resources

The concept of, "*You've done it. You've been there. An' you've wore the T-shirt*" (CVolunteer-A1R), was a highly regarded badge of honour and extends knowledge about supporting people with PAU and cognitive impairment. Peers sharing of experiences became a GRR to others. TSA context enabled them to organise GRRs supportive of achieving and maintaining recovery and supporting others to do likewise, such as recovery meeting attendance. Peer support and personal experience

enhanced individuals' understanding about how and why the recovery resources worked.

TSA's community resources included intergenerational examples of "*enacted hope*" (Morisy 2009, p. 26) (s4.4.3.1.4) due to salutogenic flow outcomes. Help-seekers continuing to drink or in early recovery saw peers with similar PAU experiences in long-term recovery, volunteering or in paid employment in the fieldsites, with happy, fulfilled relationships and permanent housing. This offered them hope for their own future. The results support evidence about the value to recovery of service work in peer communities, support of sponsors, and social networks with non-drinkers and people encouraging recovery (Witbrodt and Kaskutas 2005).

8.4.6 TSA community as method and recovery-orientated salutogenic flow

As people experienced cumulative micro-resources, actions and outcomes, their GRRs and SOC grew, and their ability to engage with TSA staff, volunteers and peers rose. Positive changes were sometimes accompanied by cognitive improvements. Recovery voices were strong, whether remaining as help-seekers, as volunteers or as staff demonstrating comprehensibility, meaningfulness and manageability in their lives. Looking to literature, the DASWs were working in a '*calling'* occupation where meaningfulness, including related to the social and cultural status of TSA, and being of value influenced job engagement and wellbeing (Antonovsky 1987; Jenny et al. 2016). Data from help-providers with experience of PAU and cognitive impairment in this study conveyed the same findings. Individuals' recovery-orientated SOC included a desire built on lived experience to '*give back*' in-so-doing making a difference to others' and their own lives. The findings primarily adhered to the CRA goal '*to help people discover and adopt a pleasurable and healthy lifestyle that is more rewarding than a lifestyle filled with using alcohol or drugs*' (Meyers et al. 2011, p. 380).

Without full DASW CRA training, help-seekers confirmed DASWs' support on interpersonal, physical, emotional, legal, employment, financial, housing and recovery aspects of life. Boundaries were set with positive peer influences on respectful attitudes to others as opposed to formal behavioural training. Approaches were similar to Meyers' (2015) CRA synopsis. TSA, which pre-dates the CRA by over 100 years, was a place of positive reinforcement, punishment in the form of exclusion

occurring rarely, straight talking but not confrontation, no labelling and no judgements. Support was about client perceived priorities, small steps, and in time for some, recovery. Continued drinking findings were in keeping with CRA research (Smith JE et al. 1998, pp 548).

These findings made me return to realist retroductive and iterative thinking, and to literature. Local communities are known to have salutogenic (or pathogenic) impacts (Maass 2017) which is relevant to Zinberg's (1984) *'Drug, set and setting*' and TSA's choices of community programme settings (Scotland Drug and Alcohol Strategy Task Group 2011) made in response to local need. I reflected on the importance of TSA community, and sought further evidence about what might be working, for whom, in what circumstances in TSA fieldsites, how and why. Christian community is defined as:

> *….. a body in which every member has a given place and function….. made of living stones, not coerced and forced into place, but drawn and called together in the Holy Spirit….. a loving and caring family of many brothers and sisters. (The Salvation Army 2015, p. 18)*

TSA called on its members to engage in a:

> *….. programme of practical action to serve the community, to help those who are suffering and in need, and to speak out against social injustice. (The Salvation Army 2015, p. 4)*

I reconsidered community biopsychosocial approaches to supporting people with PAU then re- explored Therapeutic Communities which offer '*value and efficacy to a range of people with problems of social dislocation and isolation'* (Yates 2017, p. 56). Like TSA fieldsites, they are developed outwith traditional medical, mental health and scientific settings because of unmet needs (De Leon and Wexler 2009). In Therapeutic Communities, '*community as method*' (De Leon and Wexler 2009, p. 169) refers to the psychosocial approaches used and individual's engagement with the community activities and peers. A hierarchical peer based model is used. Peer influence as a resource supports individuals to determine what social norms are and enhance social skills (Malivert et al. 2012). Progressing in recovery, responsibility levels increase and people transition through three hierarchical levels (Malivert et al. 2012). This offers similarities to TSA salutogenic flow from client, to recovery, to volunteer and to staff levels.

TSA intervention lacked Therapeutic Communities' organisational structures. Yet Demosthenes' words of "*Small opportunities are often the beginning of great enterprises*" as quoted by Barbieri et al. (2016, p. 381) about Therapeutic Communities, offer similarities to micro-actions, resources and outcomes in this research. Therapeutic Community associations between social supports, sense of community, and work engagement on positive attitudes during recovery from 'pathological addiction' (Barbieri et al. 2016) are akin to salutogenic processes of increasing recovery-orientated hope, GRRs and SOC. A difference between most Therapeutic Communities (De Leon 2010; Vanderplasschen et al. 2013), statutory agency services and TSA, was the open-door approach and absence of limits in engagement duration offered by TSA.

An NHS study (Macleod 2016) examining moving on from a homelessness community offers an interesting comparison. The project motivators were the immense individual and societal costs of homelessness, difficulties experienced by people and staff helping them to move on, and a desire for greater integration into mainstream services. By contrast, TSA fieldsites were already part of the community without limits to or reasons for engagement. Through community programme supported help-seeker salutogenic flow, improvements in family relationships, health, wellbeing, employment, and housing issues are anticipated to have created wider community benefit. Some clients and people in recovery attended TSA for many years. For men in particular, fieldsite engagement provided an alternative means of relaxing, socialising and maintaining male friendships, all described in literature as motivators for drinking (Parkes et al. 2018). The fieldsites were part of their community, GRRs, SOC and lives, which while different to Therapeutic Communities and the CRA, reflected a Salvation Army resource of 'community as method' (De Leon and Wexler 2009, p. 169).

This thesis section demonstrated benefits of realist iterative and retroductive thinking, with and recognition that knowledge and understanding changes as new evidence emerges. The evidence enables refinement of *CPT1 a life more fulfilled* (s.3.2.2.3) n conjunction with *CPT2: holistic, salutogenic approaches* (s.3.2.2.3) to create EIPT4:

EIPT4: community as method

Some people with PAU seeking help at their local TSA community programmes, through its salutogenic DASW and community as method intervention experienced growth in their recovery-orientated GRRs and SOC, with development and maintenance of a clean and sober lifestyle, because this became more holistically fulfilling than one of continuing PAU.

This research extends understanding about local resources for the development of a strong SOC specifically for people whose SOC and GRRs are undermined by PAU and cognitive impairment. Salutogenic outcomes can arise in people with PAU and cognitive impairment, particularly when provided by people who understand their issues and in particular, peers.

What works? Repeated micro-actions and resources, peer support and support towards holistic salutogenic flow, without limitation of period of engagement.

For who? People with PAU, cognitive impairment and ARBD

In what circumstances? People's contexts included PAU, cognitive impairment and ARBD related complexities in statutory service engagement, multiple exclusion and wide-ranging stigmatising experiences. They then accessed locally accessible multi-purpose, faith-based, third sector organisation resources, with or without continued family and statutory provider supports.

How and why? TSA low and frequently no-cost resources were locally accessible to help-seekers. The resources were what people said they needed, beginning with the basics of life. The non-judgemental peers and other help-providers became resources to individuals. They experienced encouragement to return, with cumulative opportunities to access new GRRs particularly as when and if their cognitive function improved, so did their awareness of what was available to them.

Leading to what outcomes? The recovery orientated salutogenic outcomes arose as help-seekers experienced growth in predictable GRRs. This repeated, sustained over time experience created individual contexts in which people could better deal with daily challenges, for which previously alcohol was a salve. The changes reflected strengthening of SOC with an accompanying spectrum of PAU and cognitive impairment related outcomes from lessening of risks through access to nutrition to

recovery, employment and previously unattainable positive life experiences and happiness.

8.5 Research limitations

I anticipated the research was to evaluate a new but established DASW service using CRA principles on outcomes for people with PAU and cognitive impairment in three Salvation Army fieldsites. However, the DASWs had not all met till the Exploratory Focus Group. Unclear about their roles, they felt isolated and unsupported. Their impressions of TSA as an employer in their current roles was not good, with poor organisational communication, supervision and training highlighted.

The main '*what went well*' arose for the same reason as my focus widened beyond TSA DASWs' appointment '*intervention*' to think deeply about fieldsite resources accessed by people with PAU and cognitive impairment. I needed to consider what resources in addition to the DASWs were influencing outcomes, what mechanisms were '*firing*' in help-seekers and what outcomes were then arising.

A research limitation was its positioning at a particular point in time, rather than on a longitudinal basis. The findings are primarily based on what participants said in single recorded conversations with me and how they reasoned and reflected on their experiences. This in turn was dependent upon my communication skills and barriers to engagement:

> *Whether findings are to be truthful, credible, or effective is mainly determined by the empirical data gathered. (Cho and Trent 2006)*

There were few female help-seekers with experience of PAU at TSA fieldsites. I was concerned that it might be harder for them to speak to me than the men, fearing a judgemental approach. This topic is later highlighted (s8.7) as a proposed future research area.

Quantitative data in the research was restricted to AUDIT scores. These had a descriptive, contextual purpose relating to clients and clients in recovery, with significantly higher scores in the former group. Figures relied on participant ability to remember and accurate information provision. Of relevance to quantitative data was

that the fieldsites were not set or expected to meet targets as often occurs in statutory agencies. A standardised approach to attendance recording across the fieldsites was not in place, thus any references to frequency or duration of engagement was provided by participants.

8.6 Recommendations about helping people with PAU, cognitive impairment and ARBD

The main recommendation to TSA is to keep building on existing strengths which address gaps unmet by statutory providers supporting people with PAU, cognitive impairment and ARBD. However, intervention launches need accompanying fieldsite, help-seeker and help-provider engagement, with accessible, user-friendly information sources both printed and on websites.

A raft of CPTs and CMOs emerged about TSA provision of a salutogenic workplace. *CPTR2(8): salutogenic workplace personal development and support* (s.6.9.3) is of highest priority. All help-providers need inductions, training and supervision, supported by management structures and staff who understand help-seeker and help-provider contexts. This includes potential PAU, cognitive impairment and ARBD experiences. Practitioner nous is valuable but should not be the intervention cornerstone. The research reveals TSA has immense overall SOC and GRRs. However, TSA management needs to ensure this translates into help-provider SOC and GRRs, with ripple effects to those they serve. Examples of good practice such as Fieldsite-C's peer led Feelings Group should be shared and encouraged, with provision of opportunities for clients and voices of recovery to actively influence service development.

From my biased 35 years NHS employment stance, clear Salvation Army intervention visions are needed. By not being a statutory agency, TSA has strength to independently address local community needs according to its core values. This strength would potentially diminish if TSA transitioned to a '*statutory service*'. People I met sought help from TSA because they had either slipped through the nets of or been excluded from statutory services. TSA was meeting needs that other agencies were

not. Again this puts TSA in a position of strength to positively influence wider provider and societal approaches and attitudes, in so doing remedying their non-inclusion status in guideline development groups (Royal College of Psychiatrists, Royal College of Physicians of London, Royal College of General Practitioners and Association of Neurologists 2014).

8.7 Recommendations for future research

Unsurprisingly, questions arose during the research (Pawson 2013d). Notably the research did not attract women with PAU experience. Barriers described in literature to women seeking treatment include social stigma, fear of losing children, primary care physicians' reluctance to refer women, and service access complexities (Small et al. 2010). Women have described more PAU-related stigma than men (Gomberg 1988). Attending medical services more often than men (Wang et al. 2013) they may have more exposure to reported stigmatising attitudes of some health professionals (van Boekel et al. 2013; van Boekel et al. 2014). Research focusing on women accessing Salvation Army supports around PAU and drug use might encourage more female participation. This could reveal more insight into what works, for which women, in what circumstances, how and why in TSA services, with subsequent developments according to findings.

Not all help-seekers entered recovery, but positive micro-outcomes occurred. Proposed research is to formally measure SOC and record GRR shifts which support people to tackle PAU. In keeping with some long-term conditions, research about palliative approaches focusing on supporting help-seekers whose lives appear time limited to have the highest quality of life they can would be valuable. This should not be confused with end of life care, though the fragility of help-seekers' lives means premature death is in fact not unexpected. A specific aspect of nutritional and health support related to PAU, cognitive impairment and ARBD warranting research is thiamine. This research evidences that people with cognitive impairment have difficulty remembering to take it. There are wider knowledge gaps about its benefits, concern about side-effects experienced and reasoning not to take it. TSA fieldsites in

conjunction with health providers might offer innovative approaches to this therapeutic issue.

8.8 Conclusion

This partial realist evaluation is about people with experience of PAU, cognitive impairment and ARBD and those helping them in Salvation Army community programmes in Scotland. It used realist evaluation approaches to explore and gain understanding of people's thinking and reasoning when resources were introduced into the contexts of their lives. The iterative and retroductive thinking used reinforced that knowledge is partial, and drove me to keep searching, looking and listening to evidence from wide-ranging sources to reveal greater accuracy and understanding of the topics explored.

Realist thinking encourages expectations that outcomes will differ for different people, potentially in unanticipated ways. Realist researchers are curious about, *"What works, for whom, in what circumstances, how and why?"* Answers may challenge those involved but also provide evidence to create or strengthen interventions for help-seekers or help-providers in comprehensible, meaningful and manageable ways. In this research, help-seeker and help-providers data from fieldsite focus groups and semi-structured interviews helped explore *what works, for which people with PAU, cognitive impairment and ARBD, in what circumstances in TSA community programmes, how and why?*

The CPTs began by hypothesising about a life more fulfilled, holistic and salutogenic approaches, and about TSA as a helping organisation following in Booth's footsteps. Theories were proposed about participant understanding about ARBD and potential salutogenic cognitive benefits of intervention engagement. From a different perspective a hypothesis emerged about the community programmes as a salutogenic workplace.

Unexpectedly the DASWs Exploratory Focus Group revealed conflicting findings about the high profile intervention launch and subsequent events. The DASWs' appointments were celebrated, yet the foundations to support them were

inadequate. Lacking clarity about what they had to do, who with and how, they felt isolated, inadequately trained to meet help-seekers' complex needs, and fearful about whether they were doing the right things. The emergent outcome was perhaps unexpected. They did not walk away. Instead drawing on their own as opposed to workplace SOC and GRRs, they focused on the needs of people seeking help.

Each day, the DASWs wanted to know in themselves (in the lack of supervisory support) that they had helped someone and made a difference to their life. They innovated, developing individualised mental checklists to assess whether help-seekers had indicators of cognitive impairment. They prioritised meeting basic needs and relationship building, thereafter encouraging and keeping doors open to help for PAU, supporting resource access in TSA fieldsites and beyond. They pursued relationships with other agencies including health, housing, employment, legal, drug and alcohol services, education and spiritual. They supported people whether currently drinking or in recovery, the latter being offered and given volunteering opportunities. Volunteering was at a person-specific level and scale, responsibilities taking cognitive impairment into account.

I explored beyond DASW impacts, as the intervention implementation was incomplete. Participant responses revealed micro-actions, resources and outcomes, small steps rather than giant leaps, creating opportunities for salutogenic flow amidst rippling complexities associated with PAU and cognitive impairment. In TSA non-judgemental community programme context, people repeatedly accessed resources to meet basic needs. Peers present demonstrated that fulfilled lives without alcohol were achievable. As GRRs strengthened, SOC grew. People spoke of life changes reflecting increasing comprehensibility, meaningfulness and manageability, though ARBD could impinge on this. People became and wanted to be resources to others, with particular peer credence given to those who had "*wore the T-shirt*" (CVolunteer-A1R).

Some of the fieldsites approaches and outcomes mirrored those of the CRA. Perhaps, however, of greater interest is learning from Therapeutic Communities. While TSA intervention is community based, Therapeutic Communities mainly offer residential programmes. It is suggested in this thesis, however, that the Therapeutic Community

term '*community as method*' (De Leon and Wexler 2009, p. 169) is what worked for people with PAU and cognitive impairment accessing participating Salvation Army fieldsites.

TSA's crucial contribution was that it provided the resources and context that enabled a community to develop. Recovery could be witnessed, supported by peers and DASWs, and importantly, experienced. People met to eat, seeing peers working as staff and volunteers, engaging happily and productively with others lacking personal knowledge of PAU and cognitive impairment. As people chatted, peer planning to support and maintain recovery took place. The predominate approach throughout was, "*Three strikes and you're welcome*".

8.9 Closing remarks

Returning to 'Time for Recovery' I hope that this thesis has been a 'voice for the voiceless' (Scotland Drug and Alcohol Strategy Task Group 2011). The days of sleeping at warm air vents or in hedgerows are past for Volunteer-C1R and he is now inspiring others as they contemplate or engage in recovery:

> *What I've achieved in the 4 years I've been off the drink….. I'd never have done it with drink. So many good things have happened to me since I gave up drinking, it's unbelievable. And I'd like it to happen to other people, but they've got to know that it can happen….. An' I still have issues but I deal with it now….. And it's only because of services and aids that I've been to in the last three years. I'm at a lovely place. I'm at a lovely area of my life. (Volunteer-C1R)*

8.10 Chapter 8 theory building synopsis

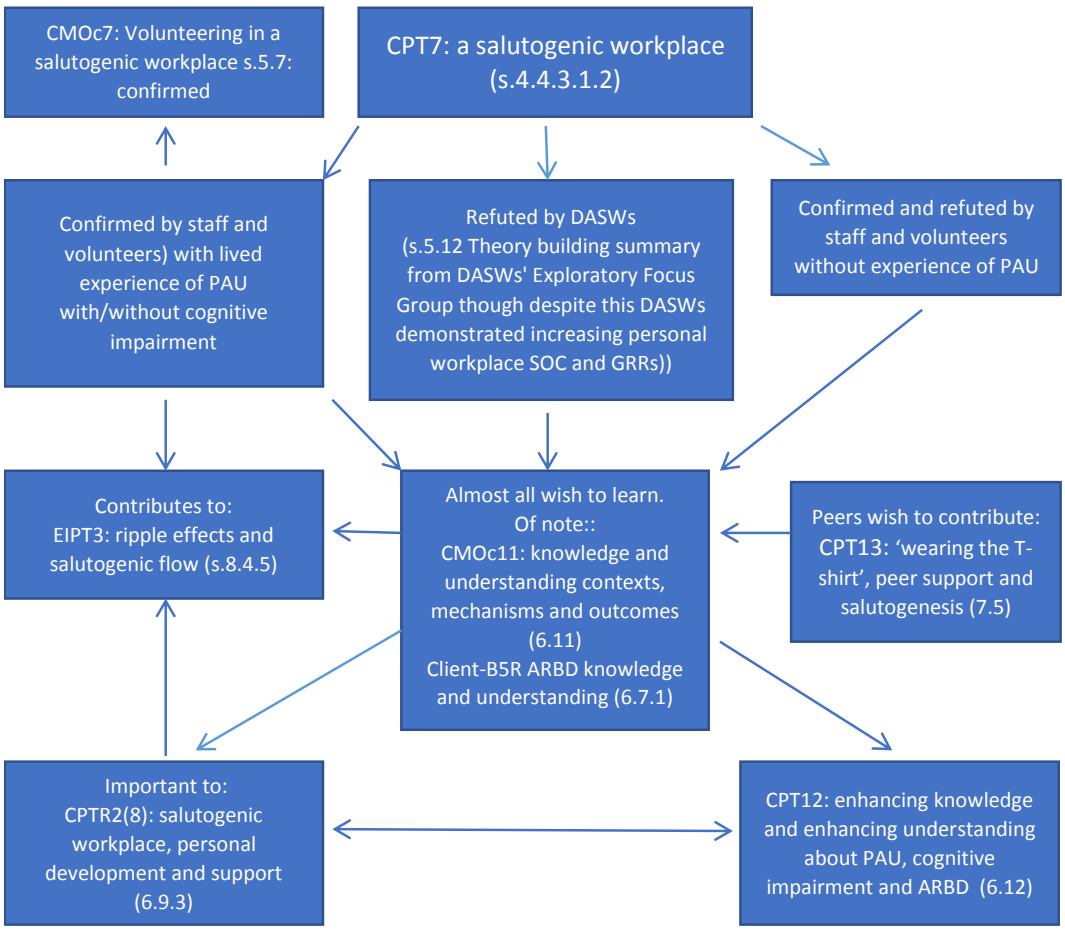

Figure 18 Salutogenic workplace: a web of complexity

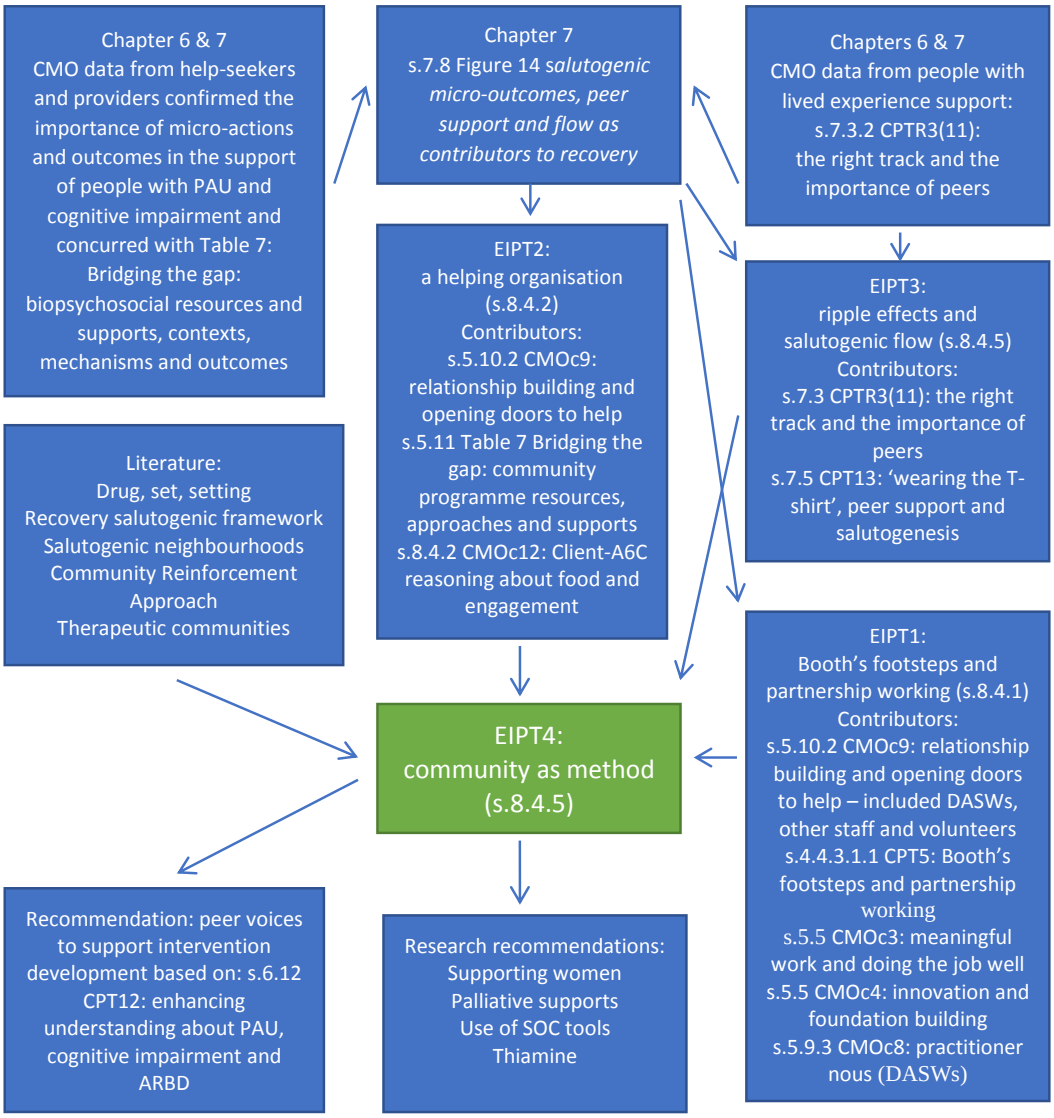

Figure 19 Culmination of theory building - EIPT4: community as method

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Appendix 1 - PhD Advertisement 2013

A fully funded PhD studentship is available to investigate services and support for people with alcohol related brain damage. The student will work closely with the School of Applied Social Science at the University of Stirling and with the Salvation Army. The project is titled: 'Understanding the experiences and support needs of people with cognitive impairment and alcohol problems among users of Salvation Army services in Scotland.'

Understanding the experiences and support needs of people with cognitive impairment and alcohol problems among users of Salvation Army services in Scotland

There is increasing recognition of cognitive impairment caused or exacerbated by the misuse of alcohol.

In Scotland the term alcohol related brain damage (ARBD) is used to describe a condition whereby people develop long term cognitive impairment due to the effects of alcohol use on the brain. There are strong indicators that the numbers of people with ARBD are increasing and the age of people with the condition is going down alongside an increase in the number of women with the condition. ARBD is strongly associated with deprivation and poor nutrition and so people who are homeless or living chaotic lives due to alcohol problems are more susceptible to this condition. A Glasgow study found around one in five hostel dwellers had some form of ARBD (Gilchrist and Morrison 2006). This suggests that among the users of Salvation Army homeless and addiction services there is likely to be a high prevalence of ARBD.

One of the key problems faced by people with ARBD and those working to support them is that traditionally services have not been set up to meet the dual needs of these individuals, services either focus on supporting people with alcohol problems or people with dementia and other forms of cognitive impairment. There are a small but significant group of specialist ARBD services established in Scotland that meet the needs of this group in specific areas from which lessons can be learnt but there is still much to be learnt about meeting the needs of people with ARBD in more generic settings.

This project aims to explore and address the gap in services by examining the current support offered to people with cognitive impairment within Salvation Army projects in Scotland.

The main aims of the project are to:

- Ascertain levels and severity of cognitive impairment among services users accessing Salvation Army projects in Scotland
- Examine current use and experiences of services by people with cognitive impairment and alcohol problems and assess how well current services meet their specific needs
- Develop pathways to improve access and use of services.

Thus the project will both address key gaps in scientific knowledge and provide useful outcomes to help the Salvation Army further develop their services.

The research will involve a mixed-methods approach with the collection and analysis of qualitative and quantitative data. Methods will include quantitative analysis of data collected on each service user by the Salvation Army as well as in-depth interviews and focus groups with staff and users of Salvation Army services both in the community and in residential settings.

Combining quantitative and qualitative approaches within the project will provide a broad picture of Salvation Army services illustrated with detailed portraits of individuals and specific services to draw conclusions about the efficacy of services at organisational and individual levels and to find routes to improve services from individual and organisational perspectives.

Number of awards

Value

Deadline

How to apply

Apply for a Research Degree in Dementia Studies here.

Contact

Project supervisor: Dr Louise McCabe

Partner Organisation: The Salvation Army

Appendix 2 – Topic guide for people accessing services

Topic guide for focus groups and semi-structured interviews (conversations) for people accessing Salvation Army services

Introduction: note to self: Introduce focus group/semi-structured interviews through reflection/reminder about information sheets and contents

Discussion: approx. 10 mins per topic

I'd like to start by giving everyone the opportunity to discuss what is called Alcohol Related Brain Damage or ARBD.

Has anyone heard of this?
Does anyone have any idea of what it is? Can you explain?
Do you know how people with brain damage caused by alcohol might be affected?

Now, we are going to think about the kinds of difficulties people with ARBD might face.

To help with discussions, there are photographs of different things we all have to deal with on a day-to-day basis. We've talked about how alcohol can make it harder for people to remember things or to make decisions or how to work out how to do something. It may be that some of the photographs remind you of difficulties you (or someone you know) have experienced.
Prompts:
Looking after self: nutrition, personal care, cooking, washing clothes, alcohol, drugs, gambling
Looking after the home: cleaning, furnishing, maintenance **Shopping:** food, food banks, clothing
Transport: public, driver's license **Employment:** getting, maintaining
Finance: managing money, rent and other bills, savings, debt **Legal issues**
Relationships and dependents: family, friends, children, work **Hobbies and interests**: maintaining, starting
Health: appointments at doctor/dentist/hospital, getting and taking medicine, managing health problems including mental health **Spirituality and faith**: loss, maintaining, rekindling, new
View of self: self-worth, impact of memory/thinking problems on top of alcohol, stigma, embarrassment, hope
Is there anything we have missed?

The next step is to talk about things that can be helpful for people with ARBD.

What has been helpful for you and why?
Prompts: tie these into Prompts for 2 above in context of **people, groups, services, personal strategies, medication, activities etc.**
Has there been anything that has not been helpful – or perhaps has been detrimental? And why?
Prompts: tie these into Prompts for 2 above in context of **people, groups, services, personal strategies, medication, activities etc.**

Which of these might be helpful for (other) people with ARBD?

The Salvation Army and how they help people with ARBD

If someone was getting forgetful or having difficulties with their thinking, who in The Salvation Army might notice?

Who do you approach for help or advice within the SA?

Prompts: tie these into Prompts for 2 above in context of **why, when, what type of help sought and received, and any examples – explore further if problem was related to memory/cognition**

What kind of help or advice turned out to be no use and why?

Recommendations/suggestions for the future

How could the support you receive from the SA be improved?

What do you think The Salvation Army should do to help people with ARBD?

Can you think of anything that might stop people getting this help?

If you could choose one thing that would really help, what would it be?

Close Thank you so much for all your help. Is there anything you would like to add? Thank you again for taking part in this discussion. Each of your contributions has been invaluable (provide option for sending more comments later) My thanks to …….. for hosting this discussion group. Thank you.

Appendix 3 – Topic guide staff and volunteers

Topic guide for focus groups and semi-structured interviews (conversations) for Salvation Army staff and volunteers

Identifying people with alcohol problems and memory or thinking difficulties
How often do people with alcohol problems come to the services you provide?
How many of these people do you think also have thinking or memory difficulties?
What makes you think they have thinking or memory difficulties?
Do the individuals recognise these difficulties themselves?
Can you give examples of when people have recognised their own difficulties?

Current supports and services to people with alcohol problems and memory or thinking difficulties
What kinds of supports and services are offered to these individuals?
What works well? What changes occur to make you think this is the case?
Why do you think the changes occur?
What supports and services don't help these individuals?
Why do you think this is the case?

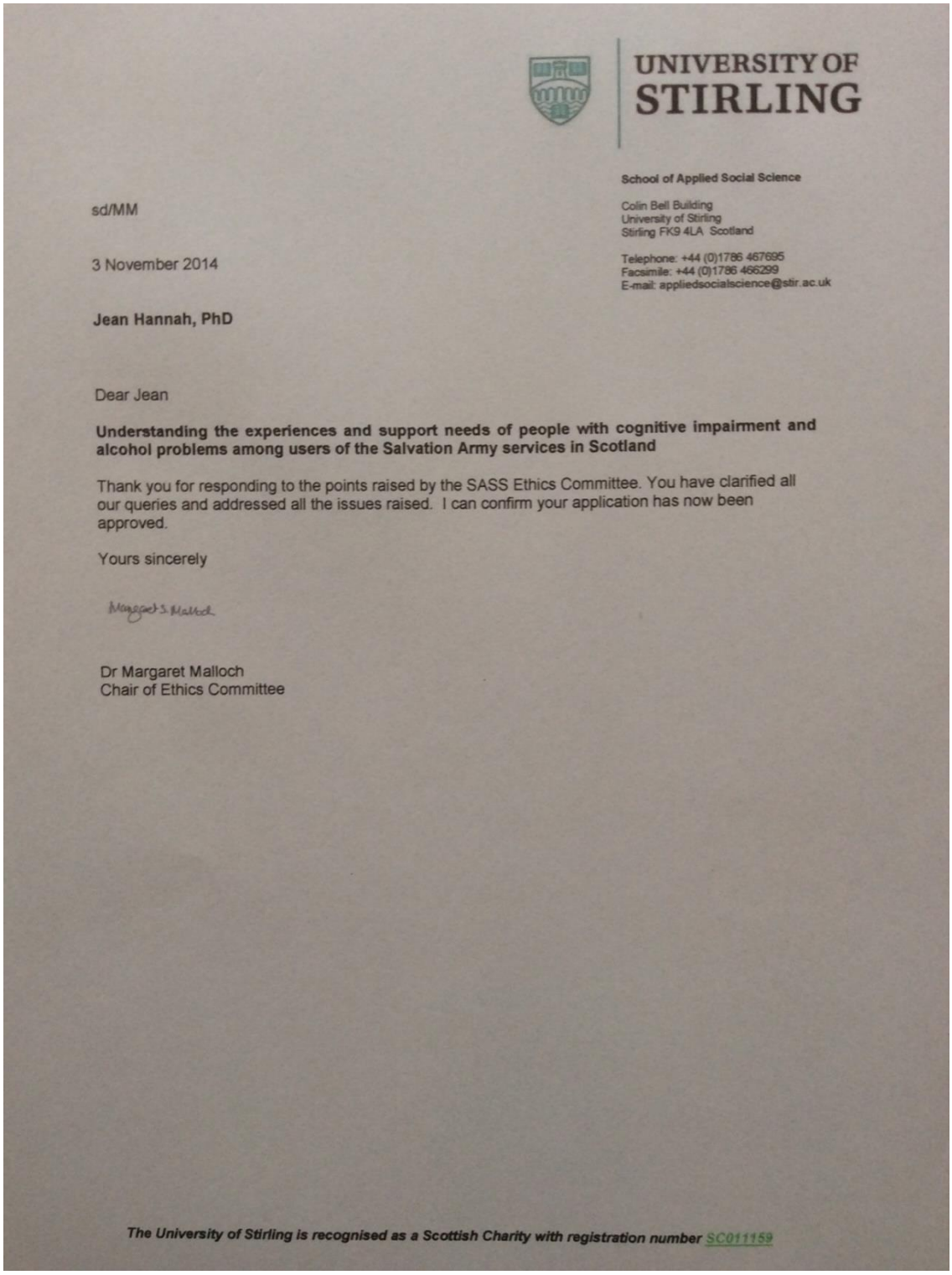
Choosing supports and services for people with alcohol problems and memory or thinking difficulties
How do you decide what approaches, supports and services to offer?
How do you know if what you are offering is about what the individual thinks is important?

Your recommendations
What would your top recommendation be to improve the services and supports offered to people with alcohol, memory and thinking problems?
Why have you recommended that in particular?
What changes would your recommendation bring?

Supporting you
Is there anything that would help you as an individual to improve the support and services you offer to people with alcohol, memory and thinking problems?
How would this change affect you and the supports and services you provide?

Appendix 4 – University of Stirling SASS ethics approval

University of Stirling SASS Ethics Committee letter of 03 11 2014



UNIVERSITY OF STIRLING

School of Applied Social Science

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University of Stirling
Stirling FK9 4LA Scotland

Telephone: +44 (0)1786 467695
Facsimile: +44 (0)1786 466299
E-mail: appliedsocialscience@stir.ac.uk

sd/MM

3 November 2014

Jean Hannah, PhD

Dear Jean

Understanding the experiences and support needs of people with cognitive impairment and alcohol problems among users of the Salvation Army services in Scotland

Thank you for responding to the points raised by the SASS Ethics Committee. You have clarified all our queries and addressed all the issues raised. I can confirm your application has now been approved.

Yours sincerely

Margaret S. Malloch

Dr Margaret Malloch
Chair of Ethics Committee

University of Stirling SASS Ethics Committee approval email 27 04 2015

From: Margaret Malloch
Sent: Monday, April 27, 2015 11:57 AM
To: Jean Hannah
Cc: Sharon Day
Subject: RE: Ethics Committee and Salvation Army project

Hi Jean

Thank you for bringing your proposed changes to the attention of the SASS Ethics Committee. I have had an opportunity to review the changes you would like to make and am happy to approve via Chair's Action.

I would make one small suggestion which relates to the consent form – it may be useful to move the point you propose to add (currently numbered 7) to go before point 5 – to ensure that the participant is aware that the notes will also be kept confidential and anonymised. I assume you mean this, but as it is stated the participant may be concerned that information written about them is kept for so long – you could also note that the participant could see those notes, in which case you might want to refer to this in the information sheet - if they wish (if that is the case), given that you are telling them they will be in existence for 10 years.

I hope the study is going well and it would be good to hear how things are progressing!

All the best
Margaret

Dr Margaret Malloch
Chair of SASS Research Ethics Committee
University of Stirling
FK9 4LA
T: 01786 467723

Appendix 5 – The Salvation Army THEAC ethics approval

The Salvation Army THEAC approval email 15 12 2014

RE: Ethics committee submission

Gayle.Munro@salvationarmy.org.uk [Gayle.Munro@salvationarmy.org.uk]

Sent: Monday, December 15, 2014 11:44 AM

To: Jean Hannah

Cc: Adrian.Bonner@salvationarmy.org.uk

Dear Jean,

Further to your application to THEAC, I am pleased to inform you that the group has approved your research proposal.

I wish you well with your study and look forward to receiving an update on progress in due course.

All the best,

Gayle.

Gayle Munro
Research Manager

The Salvation Army
Research and Development
101 Newington Causeway
London SE1 6BN
0207 367 4850
07889755580

The Salvation Army THEAC acknowledgement of amended document 27 04 2015

From: Adrian.Bonner@salvationarmy.org.uk [Adrian.Bonner@salvationarmy.org.uk]
Sent: Monday, April 27, 2015 9:42 AM
To: Jean Hannah
Subject: Re: Ethics committee submission

Hi Jean

Thank you for the amended document.

I discussed a possible presentation of your interim data with David Burns, chairman of the SDAS Strategy committee. He thinks that this will be very helpful. The next meeting is on Friday 19th June, I hope that you are available on that day (10.00-15.00).

It would be helpful to have a preliminary paper so that David will be able to determine where this should fit into the agenda.

It was good to note your progress at the meeting last Thursday. I hope that the visit to Greenock was worthwhile.

Best wishes

Adrian

From: Jean Hannah <jean.hannah@stir.ac.uk>
To: "Gayle.Munro@salvationarmy.org.uk" <Gayle.Munro@salvationarmy.org.uk>
Cc: "Adrian.Bonner@Salvationarmy.org.uk" <Adrian.Bonner@Salvationarmy.org.uk>, Louise McCabe <louise.mccabe@stir.ac.uk>, Rowdy Yates <p.r.yates@stir.ac.uk>
Date: 25/04/2015 13:21
Subject: Ethics committee submission

Dear Gayle -

Understanding the experiences and support needs of people with cognitive impairment and alcohol problems among users of Salvation Army services in Scotland

I would be grateful if the following amendments to the information sheet and consent form relating to accessing anonymous ISD health data about people accessing Salvation Army services could be considered by THEAC.

During recent months at the fieldsites (now 3 as opposed to 4 due to staff changes at one), it has been apparent that it will be extremely difficult to seek support for this aspect of the research from people with experience of alcohol problems alone as opposed to either or both drug and alcohol problems. It has also become apparent that memory or thinking difficulties exist, they may be due to other causes.

As this aspect of the research aims to determine whether or not the process of accessing anonymous ISD-based group health information can be successful, I wish to widen the group which I can approach for help. I have checked the wording in the study protocol and this does not need changed to accomodate this approach, as the wording used is 'people accessing Salvation Army services'. However the participant information sheet and consent form do.
I have therefore attached these just now, with the key amendments highlighted in blue on pages 1, 2 and 4.

My thanks to both you and the Committee for your consideration of these amendments,

Kind regards, Jean
PhD student

Appendix 6 – Participant information sheets and consent form

Information sheet for **people accessing Salvation Army services** about **focus groups** and **interviews**

UNIVERSITY OF STIRLING

Understanding the experiences and support needs of people with cognitive impairment and alcohol problems among users of Salvation Army services in Scotland

I am a student from Stirling University working with The Salvation Army in Scotland. My research is about how The Salvation Army can best help people with thinking or memory difficulties who also have experience of alcohol problems. At the end of the research I will report back to The Salvation Army with the findings so they can follow up on any recommendations made. This research will help The Salvation Army improve their services where this is needed.

To make sure the research is of value, it is important to involve people using Salvation Army services who have experiences of thinking, memory and alcohol problems. I would like to invite you to take part in this research. You are being invited to take part because you access Salvation Army services in one of three Salvation Army centres supporting this research. This information sheet provides further details about what would be expected from you if you agree to take part in the project.

The project aims to learn about your views and experiences of thinking, memory and alcohol problems. It is important to hear about the ways in which individuals face and deal with such difficulties. There is also great interest in your opinion about how The Salvation Army helps or could help people with thinking, memory and alcohol problems. Your ideas on how to make Salvation Army service better are welcomed.

You can help in two different ways:

1. Join a small discussion group:

You are invited to join about 6 or 7 other people who have experienced difficulties with memory or thinking and who also have alcohol problems to discuss these issues as a group. The group will meet at a Salvation Army centre in your area.

2. Individual conversations:

Individual conversations can be arranged for people who would like to help but would rather speak to the researcher on their own or cannot manage to the group discussion.

It is important as part of this research to understand how much alcohol individuals are drinking who access Salvation Army services and the impact this is having on them. If you agree to take part in the study, you will be asked to help with this by answering some questions about your own alcohol drinking pattern. The information you provide will be anonymous.

If you agree to take part in the project I will arrange to meet with you either to join a small discussion group or for an individual conversation depending on which you prefer. These will be held in your local Salvation Army centre and will last about one hour.

Your participation in this project is voluntary and you are free to withdraw at any time without providing reasons.

The services and support you may currently receive will not be affected, whether or not you take part in the study.

What will happen to the information I give?

All information collected during group discussion, individual conversations and about alcohol intake will be treated in confidence, and accessed only by me. I will write a report on the findings and may like to quote you to illustrate the points made. I will ensure that no-one will be identified in any written report.

Will the research benefit me?

I cannot promise that the research will benefit you directly, but I hope the findings will inform the delivery of services for people with thinking or memory problems in Scottish Salvation Army services.

Further information

Should you wish to discuss the study further prior to making a decision I can be contacted via e-mail or telephone:

Jean Hannah: jean.hannah@stir.ac.uk Tel: 07843 950855

For your information, as part of my University of Stirling PhD studentship, I receive supervision and support from:

Louise McCabe, Senior Lecturer in Dementia Studies, School of Applied Social Science, University of Stirling and PhD Student Supervisor for this project.

Professor Adrian Bonner, The Salvation Army and the University of Stirling

Rowdy Yates, Senior Research Fellow, Scottish Addiction Studies School of Applied Social Science, University of Stirling.

If at any time you have any concerns or issues regarding the research which you do not think are suitable to discuss with me the research student, you can discuss these with:

Louise McCabe, Senior Lecturer in Dementia Studies, School of Applied Social Science, University of Stirling and PhD Student Supervisor for this project. Contact: louise.mccabe@stir.ac.uk Tel: 01786 466317

Thank you for taking the time to read this information sheet. If you are happy to take part in this research I will discuss the main points again when I meet with you. I will ask you to sign a consent form and at this time will ask you a few questions about your alcohol intake.

Information sheet for **volunteers and staff** providing Salvation Army services about **focus groups** and **interviews**

UNIVERSITY OF STIRLING

Understanding the experiences and support needs of people with cognitive impairment and alcohol problems among users of Salvation Army services in Scotland

I am a student from Stirling University working with The Salvation Army in Scotland. My research is about how The Salvation Army can best help people with thinking or memory difficulties who also have alcohol problems. At the end of the research I will report back to The Salvation Army with the findings so they can follow up on any recommendations made. This research will help The Salvation Army improve their services where this is needed.

This information sheet provides further details about what would be expected from you if you agree to take part in the project.

To make sure the research is of value, it is important to involve volunteers and staff working in Salvation Army services supporting people with thinking or memory difficulties who also have alcohol problems. It is important to learn what makes you think someone with alcohol problems also has thinking and memory problems and about the supports they are offered. Your opinions about how The Salvation Army can best help people affected in such ways will be appreciated.

I would like to invite you to take part in this research as you are a member of staff or a volunteer working in Salvation Army services. You can do this in two different ways:

1. Join a small discussion group:

You are invited to join about 7 other Salvation Army staff and volunteers to discuss these issues as a group in your local Salvation Army centre.

The remainder of this information sheet is the same as that above for people accessing Salvation Army services thus is not duplicated here

Consent form for focus groups and interviews

UNIVERSITY OF STIRLING

Consent form – Understanding the experiences and support needs of people with cognitive impairment and alcohol problems among users of Salvation Army services in Scotland: **focus groups and interviews**

1. I confirm that I have read and understand the information sheet for the above project.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
3. I agree to take part in the above project.	
4. I understand that information provided will be kept confidential and anonymised.	
5. I understand that all information will be accessed only by the researcher.	
6. I give consent for the interview to be audio-recorded. Notes will be taken from audio-recordings, and recordings will be deleted upon completion of the study. Notes pertaining to interviews may be kept for ten years in line with data protection requirements then destroyed.	

Researcher name: J Hannah Signature: Date:

Participant name: Signature: Date: