Co-producing and re-connecting: a pilot study of recovery community engagement

EDWARDS, Michael <http://orcid.org/0000-0003-2866-9200>, SOUTER, Josie and BEST, David <http://orcid.org/0000-0002-6792-916X>

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Abstract

Purpose – This paper discusses the design and methodology of the REC-CONNECT project and whether a co-produced approach to research in this area between those with lived experience, those delivering recovery support, and those generating recovery evidence, supported greater project impact.

Design/methodology/approach – A co-productive approach was taken during project design, delivery, data collection and community connecting activity. Workshop evaluations (WEVAL) were collected at each training session related to worker/peer volunteer wellbeing, workshop efficacy and organisational factors. Community connectors used REC-CAP as a data instrument for evaluating improvements in clients' community engagement, as part of a systematic assessment of recovery capital.

Findings - Whilst co-production as a research approach broke down barriers between theory and practice and delivered a wider community asset map, a number of hurdles emerged: buy-in of all participants; culture/competing agendas; self-determining limitations of people in recovery; resources, tools and timescales of research requirements.

Research limitations/implications - This is a small pilot study in Sheffield. As such, data is limited. However, the implications for spread to other vulnerable groups in other areas is evidenced and the principles generated offer sustainability and partnership that go beyond time-limited projects.

Social implications – Co-production as an approach to research in the substance misuse field has a meaningful impact on the 'end-user' group of people in recovery through empowerment, better connected recovery pathways and evidence-to-practice based support models.

Originality/value - The project advanced the emerging principle of Reciprocal Asset Based Community Development and designed a co-produced model to create a team of professional, volunteer and peer community connectors to engage and connect individuals new to recovery with existing community assets, and who themselves emerged as a community asset through the project.

Key words: Recovery; co-production; Quality Action Research (QAR); Asset Based Community Development (ABCD); assertive linkage; community connections; peer support

Background

"There is no doubt that the idea of 'co-production' has arrived in the UK." (Boyle and Harris, 2009: 3). Beresford (2013) outlines two significant concerns in co-production: *who* gets to be involved and *how*. For this paper the *'who'* will focus on stakeholders involved within the substance misuse field (both drug and alcohol), including those with lived experience along with professionals from the voluntary, health, statutory and academic fields, working together on a research project called REC-CONNECT. All stakeholders brought their own agendas, responsibilities, perceptions and motivations for taking part; therefore the study's '*how'* examined their level of buy-in and engagement to a co-producing approach and what impact this had on the research outcomes.

Boyle and Harris (2009) point out that co-production has 'emerged as a critique of the way that professionals and users have been artificially divided', in part by managerial practices. This has resulted in co-production coming more naturally within some sectors, for example Public and Voluntary, rather than others, like the researcher/subject of Academia or doctor/patient in Health (Realpe and Wallace, 2010). Imperative to a co-production approach is the blurring of boundaries between the user and the professional (Nutbrown et al., 2015); therefore stakeholder buy-in and engagement with co-production can vary depending on a particular sector's culture of acknowledging the importance of the expert by experience. This dynamic is particularly relevant in the substance misuse field, where the principles for recovery care are undergoing a transition from 'expert-patient' relationship to one based on equal partnership, while acknowledging the importance of peer and lived experience (Sheedy and Whitter, 2009).

Co-production and the recovery community

Confronting the stigma of addiction is a significant hurdle for those who seek to embark on a recovery journey. A study in the US found that within the general population addiction was more stigmatised than smoking or obesity (Phillips and Shaw, 2013). Against this backdrop, Beresford (2013) talks about the most disadvantaged people often being excluded from co-production projects due to an unfair assumption that they are not able or interested in being involved. However, it could be argued that co-production has been embedded for some time in community-based addiction support, albeit restricted amongst people in recovery and described under different terms. The validity of the 'lived-experience' as an authority and the role of peers in co-producing social groups is well established in peer-based recovery communities and mutual aid groups like Alcoholics Anonymous. White (2004) chronicles as far back as the 1700s, where Native Americans were using group-based recovery 'circles' to achieve sobriety. Co-production in substance misuse as a method for reciprocity and mutuality is as relevant today as it was then. Valentine and colleagues (2007) assert that a core element of any vibrant Recovery Community Organisation is an authenticity of voice, in that "the voices of people who have experienced all forms of recovery are heard and embraced".

Pestoff and colleagues (2010) outline three key motivations for people willing to be involved in co-production: self-interest; civic obligation and belonging to a co-producing social group. What is significant about the substance misuse field is that all three of these motivations are already firmly embedded within the recovery community culture. For people with a history of substance related-harm, engaging in research activity that explores models to improve sustained recovery is not just altruistic but serves some form of self-interest, and fulfils a broader principle of 'giving back' that is seen as critical in mutual aid recovery groups. The recent UK Life in Recovery Survey (Best et al., 2015) highlighted that 79.4% of the 802 respondents felt a civic obligation to volunteer in community groups or civic groups and at least 70% had attended mutual aid groups.

Co-production and substance misuse treatment

On a UK policy level, the importance of the lived experience in substance misuse treatment has been acknowledged since Professor Strang's Recovery-Orientated Drug Treatment Report (2011) on behalf of the (former) National Treatment Agency. Peer-based approaches to both drug and alcohol treatment have subsequently become an expected part of more formal, medically-driven treatment pathways. With this focus has come a significant shift in the dynamics between service user and service provider, with the former considered an asset that can help shape the latter into agents of change rather than simply being deliverers of a service. However, on the ground, this redistribution of power can cause tensions within long-standing organisational hierarchical structures, posing challenges in terms of partnership working and co-production approaches that may be perceived as infringing on areas of clinical expertise and knowledge.

Co-production and research

The co-production of knowledge has an emphasis on the need to understand the research subject's experience and context (Pearce, 2008). Co-production in research has been described as facilitating empowerment and providing opportunities to learn and reflect on 'lived experience' – a move away from just a 'dialogical' approach between researcher and subject towards 'transformative research' (Durose et al., 2011). This directly challenges the positivist tradition in academia where truth is believed to only be found through objectivity and standing separate to the subject (Pearce, 2008). As with clinical expertise, co-production in research has implications on power dynamics as it asks the academic to relinquish their role as the creator of knowledge and value 'experiential expertise' (Porter, 2010).

REC-CONNECT

The subject of this paper, REC-CONNECT (recovery connections), is a research project that was not specifically focused on examining co-production within substance misuse research; rather it was about identifying and tapping into community resources for those early in their recovery journeys. Funded by the Health Foundation, REC-CONNECT is a pilot project to test if a recovery connector model improves the engagement of vulnerable populations in community groups, starting with a group in early recovery from alcohol and drug problems (McKnight and Block, 2010). Dennis and colleagues found that two-thirds of people seeking

recovery relapse within the first year (Dennis et al., 2007), but that this risk gradually reduces across the first five years of the recovery journey. There is clear evidence, for both alcohol and drug use, that changing social networks to those supportive of recovery and engaging in meaningful activities is highly protective of recovery from substance dependence (Longabaugh et al., 2010; Best et al., 2014, 2016a).

REC-CONNECT utilised people in recovery, as peer delivered support has shown to be a key evidence platform for effective recovery (Humphreys and Lembke, 2009). Engaging in such positive social networks has been associated with the development of coping skills necessary for long-term recovery (Moos, 2007, 2011). Furthermore, the value of connectedness is underscored by the 'CHIME' mental health recovery model that identifies Connections as one of the five core components of effective recovery support (along with Hope, Identity, Meaning and Empowerment; Leamy et al., 2011).

Asset Based Community Development and Assertive Linkage

Referred to as 'beyond co-production' (Russell, 2015), REC-CONNECT uses an emerging literature about Asset Based Community Development (ABCD) (Kretzmann and McKnight, 1993), specifically for alcohol and drug using populations (Best et al., 2013). The model, 'Reciprocal Community Development', was developed by one of the project team and piloted in partnership with the Salvation Army Eastern Division in Australia. The success of the Australia pilot has been published in a peer-review journal (Best et al., 2014), where the indicators of success included increased staff participation in community activities and greater partnership working between staff and service users.

Paper Aims

This paper aims to reflect on the co-production element of the wider REC-CONNECT research project. It will focus on the dynamics between the researchers, organisations involved and people in recovery during each stage of the project (design, delivery, data collection, analysis). The paper will reflect whether the project achieved increased staff participation in community activities, better partnership working between different fields and greater results through co-production, without compromising the integrity of the research design.

Method

Sharing many philosophical elements, Quality Action Research (QAR) provides a natural platform for designing co-production projects. Whilst defined more as a style rather than method of research, QAR is the term used for 'research in which the researchers work explicitly with and for people rather than undertake research on them' (Meyer, 2000, citing Reason and Rowan, 1981). Common elements to QAR are its participatory character, democratic impulse, critical reflection on both the process and the outcomes and parallel contribution to social science and social change reflecting the interface between research and practice development (Meyer, 2000). REC-CONNECT was in intent, design and structure consistent with the aims of QAR. The project adopted the view that co-production was less a

method for study and more a way of thinking in order to break down barriers (Walden et al., 2015).

What makes REC-CONNECT relevant to co-production practice is the bringing together of professional and recovery peers to jointly train in assertive linkage and ABCD mapping, supporting and growing a 'mixed' group of community connectors and assessing their impact on wellbeing of the target population. In other words, what is unique about this model and separates it from prior ABCD initiatives is that it has the goal of building community engagement in all participants (both professional and service user) - the research is applied and has a clear legacy. The experiential knowledge is found, not just in the lived experience of the service user or practice experience of the professional, but on the equal and shared experience of being a citizen of Sheffield. Thus, the method should not only improve outcomes for people in recovery but improve feelings of efficacy in staff, and through this increase wider community cohesion and wellbeing.

[INSERT FIGURE 1 ABOUT HERE]

Figure 1. Project phases and partner engagement

Phase 1: Design

A project lead group was formed with representation from academia, NHS, public and voluntary sector (see Figure 1). The project lead group agreed the purpose and process of the study, establishing context and methods for staff and service user (people in recovery) participation.

REC-CONNECT researchers consulted Sheffield Addiction Recovery Research Panel (ShARRP) to ensure Public and Patient Involvement (PPI) at design stage. ShARPP consists of people in recovery, carers and family members who learn about and review research projects that have a specific focus on addiction and/or recovery, and they have a key role in quality assuring and supporting the feasibility and application of addiction research projects in the city. Its observations and contributions informed the project's design throughout its stages.

Phase 2: Delivery

For service users (experts by experience) participation was fully voluntary and was planned for Phase 2 onwards.

Project delivery was segmented into 3 parts. The methodology is based on exposing both statutory, non-statutory organisations and those in the recovery community to both train and work together to improve the health and social capital outcomes for all, by:

- Training 20 alcohol/drug practitioners and service users in the principles of assertive linkage into communities and how to build links with positive social groups. Workshops included the mapping of community assets through co-production in order to:
    - establish as wide a map of assets as possible
    - raise awareness of local recovery resources
    - identify community connectors to support people new to recovery to engage in community groups and events that will build their personal and social recovery capital

- Facilitating community connector recruitment, training and support, based on the assertive linkage model, which was co-designed by a mixed group of practitioners and service users. It was imperative that this stage of delivery was guided by participants in order to establish ownership of the model and encourage cross-sector partnership working. This is consistent with the work of McKnight and Block (2010) who identified connectors as critical to the ABCD approach.

- Providing on-going support for 15 community connectors so they could engage with 20 people new to addiction recovery in Sheffield. The connectors assertively linked people into local resources and pro-social groups and activities, increasing their social and community capital resources, supporting them to engage with prosocial groups and to sustain their connections to maximise the benefits accrued. The aim was to map the growth in recovery capital in the new to recovery group to assess the benefits and impact of reciprocal community development work.

Phase 3: Data Collection

The project used two forms of data collection.

- During stage 1 and 2, data was collected related to worker/peer volunteer wellbeing, workshop efficacy and organisational factors using a bespoke evaluation form adapted from the Texas Christian University Organisational Readiness for Change (TCU ORC) workshop evaluation (WEVAL). Evaluations were collected at each of the training sessions. Additionally, the maps of community assets that emerged from the workshops constitute an additional source of 'data' for research and for application purposes (see Figure 2).

- During stage 3 the REC-CAP (Recovery Capital; Best et al., 2016b, 2016c) instrument was utilised as a way to establish baseline data at the point of connection with people in early recovery, and was administered by the community connectors to add to their ownership of the project. REC-CAP evaluated whether the REC-CONNECT model improved engagement in community groups and improves a range of recovery outcomes. The REC-CAP involves a series of questions designed to capture recovery capital, defined as 'the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drug] problems' (Cloud and Granfield, 2008). Best and Laudet (2010) identified recovery capital in three broad categories – personal, social and community resources - and the REC-CAP seeks to identify

what capital an individual possesses that acts as strengths to an individual's recovery. The community connector was responsible for working through the REC-CAP both at the baseline collection stage and 3-month follow-up.

Phase 4: Analysis

All data was entered and analysed by the researchers at Sheffield Hallam University. The WEVAL was summarised and shared with partners and community connectors. Completed REC-CAP questionnaires, both baseline and follow-up, were anonymised and sent to the researchers for quantitative analysis. In total, 63 workshop evaluations were received, which broadly endorsed the value of training, benefit to job and increased knowledge.

Findings

Co-production during design phase

The three non-academic, lead organisations were selected based on their expertise in the recovery field; their focus on the Sheffield community and representation of cross-sectors. Although partners were from different fields, all were members of the Sheffield Addiction Recovery Research Group (SARRG), a multi-agency/peer group which aims to support recovery-focused research activities; therefore, they had well-established relationships with each other and the researchers.

Senior representation was sought and provided, which facilitated strategic ownership to the approach and a commitment to sharing power/project decision making through co-production. Lead organisations were involved from the planning stages, which proved invaluable to helping to ensure aims were representative of all agenda's and a collective approach taken to project design.

Co-production during delivery phase

At each delivery stage, co-production was implemented to design subsequent stages.

- Information sessions - three sessions were held with 52 attendees, to introduce the project rationale, model and methods.

- Workshops - using the feedback from the information sessions, the research team subsequently designed workshops around ABCD and assertive linkage, delivering them to 41 workers and service users. Workshop participants completed ABCD maps and identified attributes of a community connector, thus co-designing the 'job description' for their role. At the conclusion of the training events, participants registered to become community connectors.

- Community connector training events - 30 connectors attended.

- Connector launch event - 20 connectors attended and completed the design of the project.

From the 21 community connectors who were ultimately recruited, 7 were NHS staff, 7 were voluntary sector staff and 7 were people in recovery (the recovery status of staff members was not investigated). Although evaluation feedback was quite positive, there was a significant withdrawal rate from practitioners who attended the information sessions to those signing up to become community connectors. This meant the aim of increasing staff participation in community activities was limited to the 14 staff who became connectors. However, accounting for repeated attendance of some of the participants, some 100 workers, volunteers and peers were exposed to the project's principles and methods over the course of the project. But better communication about research design, pre-training would have potentially led to more sustained buy-in from staff in some of the participating organisations.

There was very little evidence of stigma or exclusion between the professionals and service users. Challenges around stigma were more the self-determining limitations of people in recovery around their own identity, validity of voice and confidence. People in recovery tended to fall within two-groups: the gatekeepers (Pearce, 2008), who were very vocal throughout the project and wanted to do everything; and the passive consumers (Realpe and Wallace, 2010), who were looking to be told what their role and their usefulness was.

During the design phase much was discussed amongst the project leads about service user motivation and ensuring that the 'hard to reach' voices of people in recovery were included. What was overlooked was establishing buy-in from staff participants, with a 'presumed' motivation. Some were simply told a time and place to attend mandatory training, with little pre-information on the aims of the project or the co-producing nature. In particular, NHS staff appeared less motivated to participate as a result of going through a significant internal restructure. A few participants described feelings of 'suspicion' around the aims of the project and refused to complete the WEVAL evaluation (even though it was anonymous), as it asked for feedback on any organisational barriers to implementation. When planning the training sessions, researchers were unaware of these organisational challenges and the impact this would bring to levels of trust for the project. Equally, NHS professionals struggled with the project dynamics and reported a lack of clarity, feeling frustrated with the 'wooliness' of the co-production approach, the impact on their already-stretched time and a constant cycle of reflection on both the process and outcomes. This suggested that one of the major challenges and future questions is around how professionals can reconcile their professional roles and identities with partnership and participation in community engagement and co-production activities.

To this end, the voluntary sector staff were, on the whole, more comfortable with the user-led mechanism to planning, delivery and management. As a result, early on in the delivery phase (when service user recruitment was initially low), we were able to expand participation to additional voluntary sector organisations, which greatly aided connector recruitment, engagement and retention.

A main challenge faced was simply coordinating schedules between a fragile cohort of participants and extraordinarily busy staff and service users. The community connectors met regularly once client recruitment was underway and the meetings were pitched as the coming together of 'experts' to build focus on group skills to empower individual capability

and confidence. These meetings involved senior representatives from the lead partners, in addition to community connectors from various organisations. This was an invaluable opportunity to share and reflect on experiences, receive project updates on timescales and recruitment progress and address any project challenges as they arose.

ABCD mapping exercises

The ABCD mapping exercises generated a substantial body of data creating an asset directory identifying 134 community assets. The mix of sectors and professional/service user participants provided broad range of knowledge and networks of city assets. These were classified into four domains – education, training and employment; sport and leisure; mutual aid and recovery; and peer and community participation - with 22-35 community assets identified per domain (see Figure 2, Peer and Community Support domain example). That directory is a living document and a core component of the project learning sustainability within substance misuse services and groups in Sheffield.

[INSERT FIGURE 2 ABOUT HERE]

Figure 2. Peer and Community Support

Co-production during data collection

The original research design had to evolve due to the co-produced approach to data collection. The research goal of achieving REC-CAP follow up evaluations from all service users was not fully met, partly because of the challenge of reconciling quantitative methods within a co-production process where some connectors felt uneasy about the amount of data collection. The REC-CAP was designed, not just as a research instrument, but a tool with practical applicability in peer treatment and recovery settings (Best et al., 2016b, 2016c). However, feedback from some connectors was that the REC-CAP was quite lengthy when conducted in conjunction with the other outcome monitoring and assessment requirements already embedded within individual agencies. This led to recruits not being as willing to engage in these follow up activities because they perceived the research aspect, i.e. REC-CAP survey, as interrupting their 'recovery time' as they were actively connecting and engaging with community assets. One service user expressed the sentiment by stating that he 'just wants to get on with it', as reported by his connector. With the primary goal being to assist people in recovery to make connections to community assets, this 'failure' is only insofar as the research is concerned.

Co-production during analysis

Broadly speaking, there was an element of co-production in some of the data analysis as the connectors analysed and collated the community assets identified during the ABCD mapping exercises. However, Phase 4 was the only stage of the project that didn't involve any substantive form of co-production, with university researchers being responsible for

analysis and then sharing findings with participants. A requirement of the grant funding was completing the project within a 15-month timeframe that practically wouldn't allow for training non-academics in research techniques. Consequently, this did add some form of separation between connecting theory with practice for wider participants. It also raises questions about relinquishing power and academic authority in the co-production of knowledge (Porter, 2010). However, participants were involved in a project ending celebration event and dissemination strategy discussion, along with assisting the project team in making contacts for project spread.

Discussion

Co-production as a research method

The project was hugely successful and accomplished its goals of educating workers and peers and connecting people new to recovery services. The project developed a large and engaged cohort of great connectors, an extensive network of community assets to link into, and a strong organisational partnership between the local government, third sector and academic communities. Hindsight tells us that the project could have been transformative if participants had been involved from the beginning through to the analysis stage, for example designing simplified data collection mechanisms or training non-research participants in data analysis techniques. This raises challenges around resources and timescales, but nevertheless is an important barrier to consider. One of the key successes of the project was the university becoming a visible and accessible resources that vulnerable populations could access without fear.

The project benefited from the presence in Sheffield of the multidisciplinary SARRG and the PPI ShARRP. The formation of SARRG and ShARRP reflects that both higher education institutions in Sheffield (Sheffield Hallam University and University of Sheffield) have a commitment and acknowledgement of the usefulness of interactive knowledge production in the field of substance misuse research. Universities and research departments should consider implementing similar structures to widen potential audiences of their research findings in their specialist field of research to facilitate co-production and encourage the change processes needed for progress in our societies.

Breaking down barriers

Valuable feedback from participants included the success of the project in connecting previously siloed agencies and organisations. The relationships formed or enhanced within the project team and the lowering of the separation between researcher, professional and peer-driven services is a project success that will be key for sustainability. What the project has done is create a partnership for co-production that involves statutory organisation and NGO's, with a local university at a strategic level and engaged a range of individuals who are both professionals and volunteers to work together to generate and link to community resources. The project demonstrated as well how the university is a valuable physical community resource and provides a venue for breaking down barriers.

Sheffield is fortunate to have a vibrant and robust recovery community that was able to leverage their existing assets and relationships to promote, advance and sustain the project. This was facilitated by the strong online presence of the Sheffield Recovery Community, and its active Facebook page. What the project added to this was the generation of both a network of cross-sector connectors (bringing with them existing social resources) and a clear collective purpose that included training and team-building to develop a visible and meaningful identity and presence in the city.

In other areas of the U.K., drug and alcohol services are provided by a myriad of NHS and non-NHS organisations and the project approach used in Sheffield may result in starker improvements in building networks and cross-working. Having the collective purpose of researching new recovery models can break down barriers between sectors, with Universities acting as a catalyst in the bringing together of interested parties. The project evaluation and learning could also be explored as an approach to aid networking and increasing social capital in other vulnerable cohorts.

Vulnerable subjects

Purely viewing the people in recovery as the 'vulnerable subjects' was a significant oversight of the planning stage. The project relied on staff being motivated to make a difference or bring about change, which Pearce (2008) outlines can have the opposite effect if participants feel it is meaningless or they are focused on 'survival'. Staff don't operate in a vacuum and there were challenges around the timing of the project. Nationally the NHS interest in co-production has coincided with significant internal changes and new models of health services as a response to the consequences of modern lifestyle (Realpe and Wallace, 2010). Co-production requires the redistribution of power between all stakeholders involved. In the pursuit of ensuring the experience was meaningful and non-tokenistic to people in recovery, the project failed to nurture similar feelings of empowerment in staff (pre-delivery) causing tensions from the outset. This demonstrates that when determining the 'vulnerable subjects' within the researched, researchers may need to look beyond assumptions of disadvantaged groups and consider objective conditions, competing agenda's, sector cultures, funding regimes and other factors.

Another learning point from the design phase regards the non-inclusion of people in recovery. It could be argued that power was delegated to this group through seeking feedback and approval of project design through ShARRP. However, certain challenges faced during delivery and data collection phases may have been identified earlier if those with lived experience had been part of the project lead group during the design phase. Lead organisations found that motivation for engagement in the project amongst users of their service was high. It was therefore determined early, following a project team meeting, to include service users in the training cohort to join the alcohol and drug workers targeted in the model.

Sustainability

The REC-CONNECT project, partnership and produced resources could be sustained and accommodated by existing services in Sheffield, albeit without on-going evaluation of

outcome measures in the robust and systematic manner that Sheffield Hallam University has provided during the course of this project. The network of community connectors and partners may benefit from attending existing service-user focused forums where information on latest developments in the recovery community are shared or further social mapping with input from research organisations maybe incorporated. This will help the project to be embedded within the Sheffield recovery community. The project has created a vibrant network of connectors through a process of co-production and social network building and this is a hugely valuable resource that could be applied in a wide range of areas.

Summary

The project has highlighted the opportunities for partnerships to generate co-production by building existing networks and challenging partners to design and contribute to new ways of working together to support the recovery journeys of vulnerable populations. In the paper we have shown how a model designed to train and support community connectors has generated a diverse network of community assets and has created opportunities for a consortium of volunteers, peers and professionals to contribute to recovery by building networks, generating community and social capital and creating a model for supporting community growth.

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Figure 1

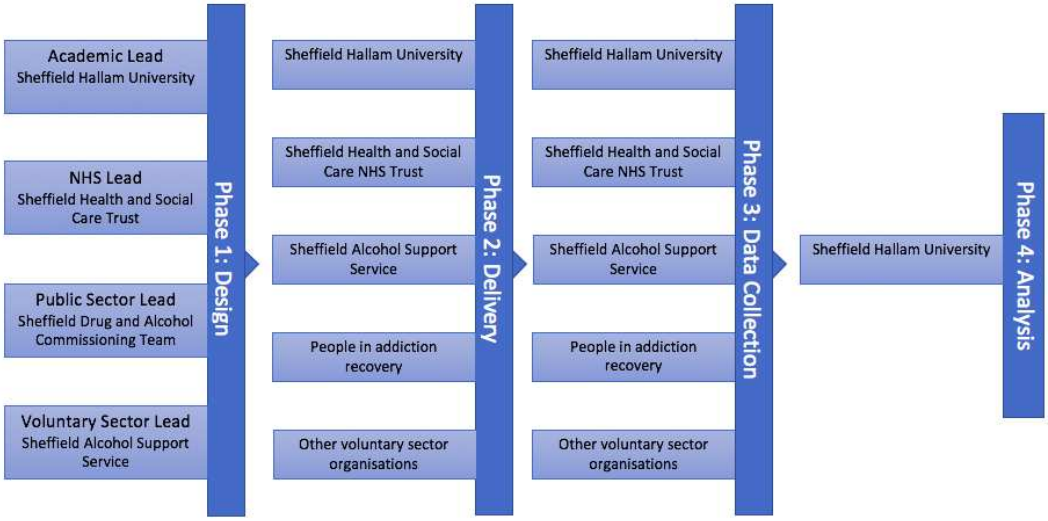

Figure 2