Abstract:

Research highlights that recovery from substance use is a process facilitated by relational factors, resources and therapeutic practices embedded in places conducive to recovery. However, the accessibility of such resources for those with complex needs, and the therapeutic potential of peer-led spaces needs contextualising in both time and place. We examined the characteristics of a social space employing a non-interventionist peer-led approach for active alcohol users. Individuals prioritised the management of everyday life over recovery, especially abstinence. This space acted as a replacement 'jigsaw'; interrupting the temporal, spatial and social aspects of active use. Flexible approaches allowing choice in recovery pathways appear significant for this population.

MAIN TEXT INTRODUCTION:

Research evidence highlights that recovery from substance use is a gradual, discontinuous, process highly dependable on personal and contextual factors, often facilitated by treatment but not exclusively so (Kougiali, Fasulo, Needs & Van Laar, et al., 2017). Although treatment can contribute in many different ways towards recovery, the brief length of interventions and the frequent neglect and absence of aftercare (McLellan, Lewis, O'Brien & Kleber, 2000) often mean that recovery maintenance depends on individual planning, action and motivation. Historically, mutual aid, peer-led groups have been designed to run parallel and extend the provision of support pre-treatment, in treatment and post-treatment and assist individuals towards transition in community life (White, 2008). Attending peer support groups has been found to show higher rates of abstinence (Armitage, Lyons & Moore, 2010), improvements in quality of life (Barker & McGuire, 2017), increased psychological well-being (Kelly, Stout, Magill, Tonigan & Pagano, 2010) and significant reduction in relapse rates and return to homelessness

(Boisvert, Martin, Grosek & Clarie, 2008). Returning to high-risk environments after treatment in prison or the community significantly increase the possibilities of relapse and such alternatives.

There is strong evidence to suggest that involvement with recovery-focused peer groups and communities can contribute significantly towards the maintenance and achievement of long term recovery (Best, Day, Homayoun, Lenton, Moverley & Openshaw, 2008; Best, Gow, Knox, Taylor, Groshkova & White, 2012). Membership in such groups has been found to support the transition from a 'using' towards an emerging 'recovering' identity (Dingle, Stark, Cruwys & Best, 2014). Support provided by peers who share common experiences can present elements integral in the therapeutic relationship such as trust and therapeutic alliance, while peer mentors often act as the visualization of a future possible recovering self, to which active users can aim and aspire to (Author et al., 2019). Given the stigma and exclusion active users often encounter from mainstream society, peer mentors can transmit optimism about the prospects of recovery and be visible examples of communities where active users can belong. It can then be argued that recovery can be better understood as a social, rather than an individualized pathway.

Recovery capital '*the sum of one's total resources that can be brought to bear in an effort to overcome alcohol and drug dependency*' (Granfield & Cloud, 1999: 179), comprising of four forms; social, physical, human and cultural capital (Granfield & Cloud, 1999; 2001, Cloud & Granfield, 2004; 2008) has gained prominence in the area of recovery as it suggests that it is resources that are related to these four forms that facilitate recovery (Parkin, 2015). Social capital refers to the amount of support that can be accrued from relationships an individual may have (Cloud & Granfield, 2008) and the benefits emanating from participating in recovery-focused groups can be argued to be a factor that enhances social capital and have more positive effects than treatment (Panebianco, et al 2016). Although communities can provide resources that are supportive of recovery, it has been noted that not all communities are equally equipped to do so (Draine, Wolff, Jacoby, Hartwell & Duclos, 2005) while accessibility to such resources is not the same for all subgroups, such as individuals with complex needs, experiences of trauma and marginalization (Hennessy, 2017).

Place has long been identified as an important element in the process of mental health (Parr, 2011; Doroud, Fossey & Fortune, 2018; Tucker, 2010) and addiction treatment and recovery (Wilton & Deverteuill, 2006; Deverteuill, Wilton & Klassen, 2007) conceptualized in notions such as restorative environments' (Hartig & Staats, 2003), therapeutic landscapes (Gesler, 1992) and enabling spaces (Duff, 2011; 2012). Doroud et al. (2018), highlight the way in which objective and subjective characteristics of place can enable recovery for people with mental health issues through mechanisms of 'being, doing and becoming', however, the resources afforded by places are not characterized by universal uniformity and consistency but are highly dependable on individual experience. Similarly, research in the area of substance use treatment has identified that spaces of recovery do not exist independently of their surroundings. Their therapeutic potential varies between neighborhoods, presenting challenges in creating safe spaces conducive to recovery when individuals are confronted with a return to high risk social and material realities (Wilton & Deverteuil, 2006; DeVerteuill et al. 2007).

Relevant research demonstrates that the strong social element involved in recovery from substance use and the idea that place and the associated resources afforded by communities are central in the recovery from addiction (Best & Laudet, 2010). Within this conceptual framework, the examination of contextualities afforded by particular spaces of recovery has become an emerging area of interest however, there has been less recognition of drug and alcohol consumption as assemblages of both spatial and temporal practices (Duff, 2014), while the therapeutic potential of different sites has not been contextualized in both time and place (DeVerteuill et al. 2007). Even less attention has been given to subgroups of individuals that might not have equal access due to marginalization (Henessy, 2017). Homeless people, more specifically, have been described as one of the most marginalised groups (Neale, 2008; Pleace, 2008) not only due to the lack of physical residence but because of complex needs that are often linked to past adversities such as histories of abuse (Koegel, Melamid & Burnam, 1995). Padgett and colleagues (2016) have proposed the term 'complex recovery' to capture the cumulative adversity and multiple co-occurring problems, such as mental health and substance use homeless people face; the multitude of these co-existing issues has also been found to affect the ways the different components of recovery capital can interact in complex ways (Neale & Stevenson; 2014, 2015).

In this study, we explore the impact of a service that employs a peer-led, non-interventionist ethos in an urban area that is characterized by ready access to drugs, limited resources for alternative activities and high crime rates. The individuals accessing the service were facing several difficulties along with substance use including but not limited to homelessness, mental health problems, very low or no physical and social resources, marginalization and isolation. We specifically examine the temporal and spatial functions of the site and their role in individuals' everyday life, substance use and recovery and within the context of their complex needs.

MATERIALS AND METHODS

Setting and participants

This paper was developed as part of a project which supported student involvement and training in conducting research with vulnerable populations. The students received in-depth training in qualitative methods as well as interviewing and conducting research in an ethical manner and with respect to individuals' vulnerabilities and pathways. The process was supervised throughout the duration of the project while analysis was facilitated by the first author and was conducted in a team setting where relevant themes were negotiated and agreed.

Participants were recruited from a mutual aid service in the South of England, open to individuals who are actively using drugs or alcohol. The service employed a non-interventionist ethos, did not promote any model of addiction or recovery and recognized users' freedom to choose their recovery pathways. The service ran on weekends when traditional treatment providers were usually closed. Recognizing issues such as isolation and lack of supportive social networks, the service used social interaction as their method and provided a safe space for times where individuals would have limited outlets. In line with the recognition that individuals have a choice in choosing their recovery pathways, there were no exclusion criteria and open to both abstinent and non-abstinent service users. Service users could progress to volunteers, and the only criterion for this was, in line with the rules for service users, that they are not under the

influence when attending or while volunteering at the service. Unlike other services, length of sobriety or 'clean time' was not used as a criterion for progression within the service.

Participants were included if they were English speaking, over 18 years and at the time of interview were free from all substances (self-report and verified via observations of trained interviewers), including alcohol (as is the general rule for using within the service). The final sample consisted of 12 participants; three volunteers (peers) and nine current service users. Three were female, seven white British, ages ranged from mid-'30s to 70 and seven were homeless (as defined by Twyman, Bonevski, Paul & Bryant, 2014), and the majority of those in accommodation lived alone. Participation was voluntary and recruitment was facilitated by leading members of the service.

Procedure

Semi-structured, open-ended interview guides were developed focusing on questions exploring user's experiences regarding their engagement with the service with further focus on personal or contextual factors that might have had an impact on their recovery pathway. Questions were developed in consultation with the service to ensure consistency and relevance. Topic areas in relation to both service users' and volunteers' experiences of the service were covered in the interviews, while participants were asked to expand on areas that they felt were important. The topic areas explored reasons for involvement with the service, levels of support, effects on individual recovery including any additional impact on employment and social inclusion. Volunteers were asked the same questions, given their initial status as service users but were also encouraged to elaborate on their views with regards to future goals and personal development. As such interviews were participant-led, allowing individuals to express their experiences in their own terms (Burgess, 1984). Avoiding overly prescriptive questions and agendas of the researchers (Strauss & Corbin, 1998) was the preferred methodological approach employed during data collection, allowing more opportunities for genuine expression, minimising disruption and attempting to reduce the power connotations and perceptions of mistrust that might be encountered during interviews with participants potentially involved in the criminal justice or mental health system (Kvale, 2006).

Upon recruitment and following informed consent, interviews were conducted individually face-to-face in a designated quiet room on the premises, during service hours (Saturday or Sunday). All interviews were audio-recorded and lasted between 20-40 mins, followed by a full debrief. Participants volunteered their time and were not compensated in any way. All interviews were later transcribed verbatim, and anonymized during transcription, with all records erased to protect participants' identity. The research received full ethical approval by the host University's Ethics committee.

Analysis

Thematic analysis (TA) in line with the method proposed by Braun and Clarke (2006) was conducted on all transcribed interviews to identify both surface level and interpretative themes. TA was deemed most appropriate as it offers theoretical flexibility, appropriate when the research is inductively oriented, and, yet, is a highly rigorous research method adequate for scientific enquiry (Braun & Clarke, 2006). It allows for an extensive and thorough identification of themes, essential for this study, given the limited literature on this unique approach to alcohol addiction. Thus, TA allows for a rich, comprehensive analysis of themes across the whole data sample (Braun & Clarke, 2006). Following a critical-realist stance (Bhaskar, 1978), the analysis of this paper attempted to capture the ways individuals make meaning of their experiences of recovery within their life trajectories and the way these are situated within a broader social context. Particular attention is paid to underlying mechanisms and processes involved in individual's lives within social systems and institutions (Danermark, Ekstrom & Jakobson 2005).

The analysis involved the five stages of familiarization of data, identifying a thematic framework, indexing, charting and mapping and interpretation (Pope, Ziebland & Mays, 2000). All interview transcripts were shared amongst the research team and thus familiarization of the data involving recalling the interviews and re-reading the transcripts identifying any initial ideas about the concepts and observations (Willig, 2013). Initial analysis then commenced with line-by-line coding on the descriptive surface level data, and initial themes proposed amongst the

research team. Subsequently, the researchers performed a second thorough analysis of the entire data set reading and re-reading each transcript, recoding (Saldana, 2009) and systematically identifying interpretative codes. Codes were identified inductively because the outcomes were not initially hypothesized (Braun & Clarke, 2006; Willig, 2013). Coding was facilitated by QSR NVivo 11 data analysis software. Initial themes were then discussed and negotiated with the research team until consensus around theoretical concepts was achieved. While seeking theoretical saturation which, according to Sadelowski is reached when '*properties and dimensions of the conceptual relationships selected to render the target event are fully described*' (2008:257); this definition was operationalised in a way that was consistent with the research questions (Saunders et al, 2017). The research team, therefore, explored the research questions in relation to processes of 'how and why', while taking into account life trajectories and contextual factors that would affect recovery pathways generating categories that were connected together and contextualised in a broader social context.

RESULTS

Findings suggest that individuals with low physical, human and social recovery capital might not aim to seek long term recovery and instead prioritize short term goals that allow the management of everyday life within the difficulties presented by addiction, mental health difficulties or homelessness. The peer-led service we observed for the aims of this study did not attempt to enforce change via formal interventions. However, it afforded varying degrees of resources that could be considered therapeutic in their contribution towards recovery via a flexible and non-interventionist approach. This approach facilitated the 'opening-up' of service users' social space and the interruption of active use acting as a temporal and spatial alternative to addictive routines and contributed to the gradual cultivation of social skills that were absent due to isolation, withdrawal or attitudes of mistrust that were the outcome of traumatic pasts.

Through an in-depth analysis of the data, we identified four themes which address the ways in which the peer-led service functioned in relation to service users' experiences: 1) as a physical

and affective spatial alternative to places and mental states that enabled use, 2) as a temporal marker that interrupted the routine of active use and acted as a 'test of sobriety', and 3) as a means to open up the, otherwise restricted and narrow, social experience of addiction. The three themes covered service users' experiences in the way these assisted the management of day to day life in active use and early recovery. In the fourth theme, 'Plateau', we discuss the views of volunteers and their experiences outside the urgency presented by service users.

1) *Somewhere to be: Physical and metaphorical spatial alternatives*

1a) Physical spatial markers

Participants reported experiences of homelessness and problems associated with their material survival alongside difficulties with mental health or substance use problems that could have pre-existed but were exacerbated by homelessness. Highlighting the link between space or lack thereof and identity, Vandemark (2007) notes that homelessness does not merely consist of the absence of a physical domicile but, strongly linked with identity, manifests in the diminished sense of belonging and connectedness to a social space of action.

Lydia, below, refers to the absence of several material resources, poor mental and physical health before and after her involvement with the service:

Lydia: what brought me here coz I was feeling really ill at the time, very down, like I had no money for food, no home, it's brought me up the hill, picked me up a bit, coz at least there's something, if there's homeless people you have something to eat, ain't a lot but it's here, you can have a cup of tea, there's someone always here you can talk to if you need to, so, yeah, it does help, it does help (Lydia, Service User, Lives in hostel)

Lydia's experience is characterized by the co-referentiality of terms that indicate the complete absence of essential resources (no money, no home) and those that indicate the appearance of a new substituting resource (something, someone). The quote suggests a 'floating' relational and

physical experience reflected in the initial lack of references to people and places that would allow her to engage and participate in the social world. The subsequent use of indefinite pronouns serves as an identification of spatial markers which could indicate a more 'fixed' point of reference, with the addition of material (something) and social (someone) elements. These new resources are restricted to the essentials (a cup of tea), yet they are evaluated as helpful in the way they occupy the previously void in the social and material sphere.

Jacob, below, also had experienced homelessness in the past, but he did not classify his current needs as urgent compared to other service users.

Jacob: Of course, of course, y'know 'cause me I come here out of choice, but some people come here because, they've got nowhere to go, d'you know what I mean so as I said, yeah I wouldn't be without the place, d'you know, as I said I come here out of choice people come here because they genuinely need to come somewhere 'cause they ain't got nowhere to go (Jacob, Volunteer, Lives alone)

With the use of antithetical terms 'nowhere' and somewhere', Jacob suggests the need for the identification of a new spatial marker that opposes the way inhabited space is perceived within homelessness. The notion of 'place' has been recently explored by human geographers, not as a static entity but in the ways they provide a sense of security, connectedness and belonging (Mallet, 2004). Here, Jacob discusses this need by referring to the 'non-spatial' elements of homelessness, expressed in the absence of directionality as well as attachment to a specific space (nowhere). The urgent need for connectedness is expressed in the phrase ' I wouldn't *be* without the place', whereby Jacob suggests that many of the elements that lead to a reduced spatial experience in the streets are now found and linked with the service.

1b) Emotional spatial separations and connections

Participants identified their limited attachment to a physical spatial marker, as a result of the complex interaction between homelessness and substance use. Most of the participants, not only

those that had no physical residence, highlighted an additional spatial separation from others, expressed in feelings of loneliness. Literature suggests that those experiencing distress also face multiple spatial exclusions that can exacerbate isolation and loneliness, pointing to the importance of the relational context of recovery (Muir & McGrath, 2018).

Feelings of loneliness are significant throughout the course of alcohol abuse and recovery in the way they both contribute to the continuation of abuse, but also hinder attempts to abstain, indicating profound and enduring negative perceptions of one's self (Åkerlind and Hörnquist, 1992). Social relationships, participating in group activities has been, therefore, suggested as of paramount importance to recovery.

The participant below, who chose the pseudonym 'Shovel Hands', describes how loneliness affected his substance and alcohol use:

> *I: And you mentioned it keeps you out of trouble. What sort of trouble are we talking, [Shovel Hands]?*
>
> *SH: No, it's not even trouble. I meant like, to me, I said trouble, like you are lonely, you are forced to buy a can of beer. You get lonely; somebody says, "Hey, I've got crack, let's go". And you just, let's go. That's the kind of trouble I'm trying to stay out of. Not like trouble, I go and thief, stab somebody or something. No. So that's trouble for me. That's very important actually (Shovel Hands, Service User, Homeless)*

In the above extract, the participant does not attribute his use to cravings but as an inevitable act resulting from loneliness. In this context, substance use is portrayed as one, if not the only, option that could counteract the absence of other meaningful emotional and social ties. Expressed in the phrases *'forced'* 'and you *just,* let's go', loneliness is framed as a strong driver that makes using inevitable, a situation which the participant has ranked as of high importance in the danger it poses for relapse.

Michael, below adds to the notion of loneliness, but in a framework that highlights the function of physical residence, in contrast to other participants who were currently homeless:

Michael: Because when you're on your own and thinking, it's a dangerous place. But you come here to interact with others so, you know. Just somewhere to be innit, as I said you know I'm in here to clear me head, I mean I'm in a room now, and I wake up and as I said it's it's… and like it's a very small room d'y know so it's like I'm there all day I'm there all night… so, I just need to get out, so it's a good place it's it's a good place to come when you just wanna, d'you know what I mean I come here personally to get me head together, it's still a safer, situation to be in like if I'm , is I'll rather be here with my thoughts , then alone with my thoughts d'you know what I mean (Michael, Service User, Living in supported accommodation)

McGrath et al (2018) report the overwhelming and 'prison-like' experiences of those in the lowest rungs of the housing ladder that occupy and are confined in small and isolated homes that can intensify the experience of distress and, in turn, lead to seeking escape routes such as homelessness. Michael, above, suggests that a physical residence can also be a space of exclusion. Attributing spatial characteristics to his thoughts, he describes that solitary thinking can also be a 'dangerous place'. Similar to other participants, he adds the need to be 'somewhere', perhaps due to the reduced emotional resources afforded by his residence. His description resembles those of confinement, whereby occupying a space appears restrictive and devoid of any sense of belonging or connectedness.

2) Something to do: Temporal alternatives

Time in active substance and /or alcohol use is constructed around a tight time frame that appears to include mostly the present, with a fragmented memory of the past and a short expansion in the future without these dimensions being interconnected (Kougiali, 2015). Daily life is characterized by circularity and repetition and activities are constructed around the need to use. The analysis of the previous theme supported the fact that spatial movement and lived space are restricted; this 'narrowness' was also reflected in the similarity in which temporal structure was described by participants. Daily activities were structured around use and, most often, this occupied the temporal spectrum in its entirety. Participants reported that the service had several temporal functions in the way their visits replaced using/drinking with sober time which was, in

turn, evaluated as an indication of the ability to achieve some 'dry' time. Being in the service interrupted active use both in real time and retrospectively as it provided service users with a structure and routine which acted as an incentive to avoid drinking.

2a) Interrupting substance using time: a test of sobriety

'Shovel Hands' (SH), below, describes the hours spent within the service as a period that disrupts the circularity of active use, at least until the centre is closed 'and then we go out again'. SH, along with other participants who shared a similar approach, views the hours spent in the service as discounted from the time that would be otherwise spent drinking or using. This rupture in the, otherwise, homogenous temporal order of active use appeared to function as a measure of the ability to tolerate the urges and withdrawals, as a tool of self-awareness but also as an indication that sobriety could be an achievable goal, even if only for a short period.

SH: The way I look at it, it's like, you're here until four o'clock sometimes. All the time you are not (drinking). It's not accepted here to drink, so you're not drinking. And you notice later on how strong you are. If you are a really shaky one, or cravy one. Lots of categories of knowing yourself actually (...) I know some people who finish here and then go again. And it goes around and around. But on Saturday and Sundays you have some sort of limit, sort of a couple of hours abstinent. The main thing is that I'm away from the streets. Main, main, main, main thing. And then the other thing is, at least, you know yourself how much you can drink, you know? The four, five hours, six hours, without alcohol (...) But it's only during the weekend time, keeping away from the streets, the park, for a few hours.

Interviewer: And do you think that's the same for the other people who come here?

SH: Yeah. I can see them, they are here, talking with me. And then we go out again. Like I said, four o'clock – boom- and we go again — same habit. (Shovel Hands, Service User, Homeless)

These short bouts of sobriety followed the opening days and hours of the service, indicating an alteration in the using habits which would normally occupy the entire day, their replacement with dry/clean time and the development of a structure that acted as a real-time harm reduction tool

that paused the sequence of using time. Space, here, provides an opportunity to break the circular temporality of using, normally embedded in the space of the streets and part of the coping mechanism for homelessness or poor quality housing.

2b) Structure as a replacement of future using time

Cloud and Granfield (2004) highlight the importance of creating and maintaining new practices and activities and suggest that facilitates the cultivation of a new identity that is incompatible with that of a user. Involvement in alternative routines, such as volunteering, art or education can ‘‘represent avenues to new meanings and epistemologies through which an individual can compose a self that is incompatible with excessive alcohol and drug use’’ (p. 191). Participants in our sample have described daily routines that consisted mostly of active use and isolation and identified loneliness and boredom as critical triggers for relapse. The spacetime within the service appeared to contribute towards the creation of a daily structure that acted as a goal that prevented or ‘paused’ excessive use.

Interviewer: and do you think this has helped your recovery?

Kate: Massively, yeah massively I mean yeah I still drink, I have got no problem with drugs but I still drink but I have not got a severe problem with it. I can put it down and put it down but I know that am going to come here, Fridays it’s like early to bed and early to rise you know weekends are a lot of mischiefs comes out you know so I want to be here, I don’t want to come here under the influence of alcohol and whatever, it will not look good, it will not look good in front of you know, it won’t look good. (Kate, Service User, Lives alone in council flat)

In the above extract, Kate describes how the difference in her daily routine, acts as a way to regulate her drinking the night before. Acting as a replacement space, being in the service provides a way for service users to replace the spacetime of the streets with the spacetime of the service. This ‘jigsaw’ like function, allows users to ‘slot in’ time in the space of the service during the most vulnerable and high-risk points of their week. Instead of an externally performed intervention or imposed requirement (e.g. abstinence), the service can be used as a tool to modify and modulate their overall experience.

3) Always someone there: Occupying and opening up social space

Research into the lived experience of addiction has highlighted the narrow social space of an addicted individual's world. Living space is restricted, and so is social space not only in the limited contact with others but, often, reflected in withdrawal from the world (Kemp, 2011). While long-term recovery can be maintained by engagement in recovery focused peer groups (Best et al, 2008; 2012), early attempts in sobriety are often marked by a gradual broadening of the social environment (author, 2015). However, initial engagement with services has been often found to be problematic due to high levels of mistrust amongst homeless (Kryda & Compton, 2009), as well as substance using populations, often accentuated by stigmatization (Reyre et al., 2014). Our participants identified a significantly narrow network of social relationships and difficulties in their ability to engage in basic social interactions due to isolation or prior experiences of trauma.

Lee, below, describes how traumatic experiences during, or because of, homelessness have led him to avoid engaging with other people. Recalling his initial visit to the centre, he recounts his hesitation to enter the premises due to his unwillingness to talk to others, a result of 'losing faith' in people.

Lee: When I was homeless, I gave up faith in people, because I was still traumatized by the events of my homelessness. I completely shut off talking to people, so coming here has opened me up socially. I remember the first time I came here there was a woman called Sharon, a volunteer here, and I remember standing outside and she said to me "We don't bite" or something like that, because I didn't want to talk to people, because of my faith in them ya know. (Name of service) has helped it's helped. cos a lot of people they don't know how to conversate, you know they don't know how to communicate with other people (Lee, Service user, Lives in supported accomodation)

Lindsey, below adds a thought shared by many participants: the perception of normality and the ways service users felt that they did not meet the criteria required to engage in social interactions. Frequenting the service, appeared to ease these perceptions and restore a sense of normality. This was achieved via simple interactions that were performed at the participants' own pace.

Lindsey: Coz before I wouldn't, I wouldn't know how to act normal, was always miserable, always unhappy, but here, you know you can come out you gonna have a laugh with someone, there's always someone round here (Lydia, Service User, Lives in hostel)

While recovery focused networks have been found to be contributing greatly towards the maintenance of recovery, often, via the establishment of strong bonds of trust between their members, such strong bonded recovery groups, however, might limit or prevent access to members who do not fulfil strict definitions of recovery, such as abstinence (Weston, Honor & Best, 2018). Our research suggests that users with complex needs, might prioritize the management of everyday life and not seek abstinence. Due to the narrowness of the lived experience in terms of spatial, temporal and social factors, such users might benefit from approaches that do not require intense social interaction and act as gradual cultivation of social skills.

4) Plateau

For most peer mentors, volunteering meant that they had made some progress in their recovery and being of service to others was unanimously evaluated as a rewarding exercise and a source of empowerment and gratitude, in line with previous literature (Repper & Carter, 2011). Volunteers' experiences differed in that there was a distinct distancing from the old 'using self', their lives did not present the urgency described by service users while their social world appeared to be more diverse and not exclusively occupied by active use or drug/drink related activities. This difference indicated that for some volunteers, there was a cycle of progression within the service and a point whereby transition to alternative activities could be encouraged.

Brian: Like you sit there and check in and check out, it's the same process every week. And it's kinda… I get bored of things when I keep repeating again and again. Not like, when I was

working years ago, I'd be working all over the place and one day I'd be desk fitting or console fitting, and security, working all around. So working one place for so long. [Indistinct] So, well it's only part-time, if it was full-time, I don't know. It's just staying here. Because I haven't worked for so long, see how I can get back in employment. I haven't got a reference. I've done my [Qualifications], so it's something to fall back on. (Brian, Volunteer, Housed)

Brian describes the feelings of stagnation, lack of variation, goals and opportunities within the service as well as his plans to move towards paid employment. Considering the service users' descriptions at the beginning of their involvement with the service, it appears that while the existence of a safe space can interrupt the temporal, spatial and social aspects of active use, as individuals get more stable in their recovery, there is a need for further progression and personal development for peers and who are further in their recovery. In their initial involvement, the service appeared to interrupt the repetition and cyclical nature of addiction with the input of new markers that enriched the social and emotional world. Brian describes a different kind of repetition that could indicate the need for a transition towards a pathway that could add to the personal growth and professional development of volunteers (peers).

Limitations

Whilst the current findings contribute to the literature on the social space provided by such peer-led services, which allow flexible and individual choice in recovery, the findings are not without their limitations. It needs to be acknowledged that the findings may have been impacted by social desirability bias and might not generalisable beyond this research sample. Findings are drawn from participants from one service within Southern England, and from service users of which alcohol was their main drug of dependence. Individuals with different dependencies and more complex needs and indeed from service users who were not frequently attending, had moved on or dropped out may indicate different views. Additionally, whilst the researchers were transparent in the data collection and analysis, with themes negotiated and agreed, no other forms of methodological triangulation was used.

DISCUSSION/CONCLUSION

In this study, we explored ways in which a peer-led recovery service could afford resources that support recovery in individuals with complex needs. The service was of special interest as it did not employ any specific recovery model, allowing and recognizing individual recovery pathways, and did not restrict access or progression based on abstinence measured recovery.

The findings suggest that individuals with complex needs and lacking essential resources, as seen with many marginalized groups, might not prioritize abstinence, as doing so could potentially remove their main coping strategy in view of everyday difficulties. The absence of other resources and, in the case of our participants, prolonged isolation and social withdrawal, can lead to a gradual loss of social skills, further inhibiting motivation to initiate involvement in more organized, dense recovery social networks. As noted by Weston, Honor & Best (2017), although the strong bonds and trust between members of such groups can be essential components in maintaining recovery, these can also be elements that discourage membership and prolong ambivalence. Approaches that are deficit-based and take a punitive attitude towards relapse might not be appealing to everyone, on the other hand, approaches that allow individual choice, do not require abstinence might appear as more inviting to those who might be dealing with more complex issues. For the participants with the least available resources, the management of day-to-day life was of greater importance than the maintenance or even initiation of recovery. The service we explored, appeared to afford various resources valuable for the initiation of recovery by employing an indirect approach which prioritized social support without demanding change or abstinence and functioned as a positive input which, in turn, contributed in the gradual enrichment of social capital.

Within the provision of a safe space and by the adoption of a non-interventionist approach, the service appeared to function in a pre-therapeutic manner, preparing individuals to progress in their recovery journeys acting via an inclusive and open approach. Doroud et al. (2018) highlight that while there is no universal formula that would make a place promoting of recovery, some characteristics such as openness, familiarity, accessibility can facilitate healing and recovery.

Gesler, in his initial paper on therapeutic landscapes notes:

Most alcoholics have low self-esteem, in part because they feel no identity with particular places. Often places represent failure, threats, or feelings of not being wanted. Therapy for alcoholics might usefully include establishment of refuges, places with positive images, where identity could be established (1992:p.738).

In agreement with Doroud's study on the link between mental health and place, this study demonstrates the ways in which place can extend beyond objective physical contexts. A social space, such as the service examined here, is defined by a dynamic interplay between adopted inclusive practices that encourage climates of trust, openness and support, collective activity, shared experience and interaction. Relatedness and belonging were reinforced by the organic cycle of progression within the service, which acted as a source of empowerment for volunteers and awarded visibility and attainability of recovery for service users. Of significant importance was the recognition of choice in recovery and the availability of resources to be used without requirements.

It has been previously argued that relapse might be linked to the lack of post-treatment access to environments of support (Molloy & White, 2009). Individuals with substance use histories facing homelessness or life post-incarceration might be particularly vulnerable to relapse when systems of support are not in place (Polcin & Henderson, 2008). Community based recovery homes, such as Oxford Houses, which operate democratically and follow a social model recovery philosophy (Kaskutas, 1999) emphasizing peer support, have been found to both help develop a strong sense of bonding with similar others who share recovery goals as well reduce the risk of relapse (Jason, Ferrari, Davis & Olson, 2006).

Although social spaces providing peer support as described in this paper appear to afford significant resources for individuals in early recovery, not least because progression and goals are clearer, more research is needed to address the needs of those in sustained recovery. Current research has identified the gap between treatment and aftercare, but less is known in terms of the progression, personal and professional development of peer mentors. Finally, and given the importance of relational factors in recovery, more research is needed into the factors that obstruct or facilitate group membership and access to spaces that can afford resources for recovery.

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