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Addressing the Social Triggers of Relapse and Recidivism in Alcohol Consumption

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Abstract

Alcohol abuse is a serious public health problem in the United Kingdom, which causes more than 10 thousand deaths each year and places a substantial strain of 27 billion on the national economy. Although there is ample evidence regarding the ecology and pathophysiology of alcohol dependency, the role of social and environmental causes has been considerably less studied in terms of empirical evidence in promoting relapse and recidivism. This paper examines these triggers in the post-pandemic setting that the UK faces, where the increased rates of social isolation, financial instability, and cultural changes to the drinking norms have aggravated the possibility of relapses.

A mixed-methods design was chosen, with the qualitative dataset collected via semi-structured interviews to obtain the lived experience of individuals with a history of dependency. The quantitative data, consisting of structured surveys, were analysed using regression to develop statistically significant predictors. Thematic analysis found eight key drivers of relapse, which were social isolation, family relations, stressors in society, cultural norms, service accessibility, perceived policy ineffectiveness, drinking habits after the pandemic, and coping strategy. The most volatile predictors were found to be financial stress, job loss, and psychological distress, as stated in the quantitative results, and the least satisfactory predictor was policy effectiveness.

Keywords: Alcohol misuse, relapse, recidivism, social triggers, environmental cues, public health policy, mixed methods, UK, post-pandemic.

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Chapter 1: Introduction

1.1 Overview of the Study

Alcohol in the United Kingdom is both a cultural phenomenon and a leading cause of serious health and economic problems both as a result of its consumption and how it is consumed. While there is a social norm of moderate alcohol consumption, excessive use has very significant physical and mental health implications, as well as broader social impacts (Ritchie and Roser, 2022). The ramifications extend to adverse outcomes such as an alcohol dependency together with comorbidities, as well as a susceptibility to diseases that carry health economic consequences and affect family, home, and community. This underscores the need to move deeper into social triggers associated with relapse and recidivism in alcohol consumption to provide the basis for the development of an effective intervention.

Quantitative data supports the gravity of the problem. Alcohol misuse is one of the key leading risk factors for death, ill health, and disability in the UK and the world's fifth leading risk factor among all ages. Recent figures highlight the scale of the issue: During 2022 alone, alcohol caused 10,048 deaths, specifically in the UK (Schmits and Glowacz, 2022). These deaths are an unprecedented increase from pre-pandemic levels and reflect broader trends exacerbated by social and economic stressors. In that same year, 320,082 hospital admissions in England were connected to alcohol-related conditions at an age-standardized rate of 581 per 100,000 population (Anderson et al., 2023). These admissions represented approximately 69% of men, potentially representing gender-specific patterns of alcohol-related harm.

Alcohol misuse also has an equal impact on the economy. Alcohol-related harm in the UK costs the economy at least £27 billion a year (Sharif-Brown, 2023). It includes health care costs, lost productivity, and expenditures for alcohol-associated criminal activities. Across England alone, treating alcohol-related health problems costs the National Health Service close to £3.5 billion a year, due to liver disease, injuries from excessive drinking, and long-term conditions such as cancer and cardiovascular disease (Tran et al., 2020). In addition, alcohol misuse contributed significantly to the economic burden of alcohol with alcohol-related absenteeism and decreased productivity in the public and private sectors.

However social triggers are the primary influencer of the cycle of alcohol misuse, relapse, and reciprocation. There are many triggers, including embedded social norms and behavior. Social

isolation, peer pressure and exposure to environments where drinking alcohol may be acceptable are determining factors of whether or not people will relapse (Tembo et al., 2017). For instance, social gatherings or another type of heavy drinking event that cue people in recovery to undo their effort to remain sober. In the case of binge drinking culture–a widely held social practice in the UK between some demographic groups–this is particularly true.

Societal stressors compound it. Alcohol consumption has followed closely behind economic downturns, job insecurities, and public health crises such as the COVID-19 pandemic. For instance, during the pandemic, alcohol took off, with supermarket sales rising by 67% in the UK (Ramalho, 2020). Those figures are mirrored by a reported 17% rise in adults' alcohol consumption, with the most significant surge being among 18 to 34-year-olds (Ning et al., 2020). These trends signify the use of alcohol as a stress, anxiety, and uncertainty coping mechanism and the social embeddedness of alcohol as a substance of choice in times of stress.

Addressing these social triggers takes an all-inclusive, multi-pronged approach. Creating supporting environments in which exposure to high-risk situations is minimized and the normalization of excessive alcohol consumption is reduced needs to be part of public health initiatives (Grant et al., 2019). Some policies have succeeded in making the product less available — such as more restrictive licensing laws and pump pricing, like minimum unit pricing — that have been shown to reduce consumption rates. At the same time, start encouraging alcohol-free social activities and build community support networks to create different ways of remaining social that do not use alcohol.

In an even broader, more programmatic sense, the interventions should focus on reinforcing individual coping strategies and resilience, particularly in a targeted manner. Programs using cognitive behavioural therapy, motivational interviewing, and peer support groups allowed people to become empowered to navigate social pressures and develop sustainable recovery pathways, argued Witkiewitz and co-researchers, (2017). In addition, these strategies should be complemented by public awareness campaigns promoting avoidance of drinking when in social situations and raising the understanding of the risks of drinking excessively. The UK has pervasive social triggers for relapse and recidivism, it is important to understand and reduce these and illustrate this with alcohol intake (Goodwin et al., 2017). A combination of comprehensive public health strategy, along with specific need interventions can prevent and minimize causes and

burdens to individuals, families, and society as a whole from alcohol misuse. Yet the benefits of these efforts go well beyond public health outcomes, as they will also capture a large share of the substantial costs in economic and social terms associated with the misuse of alcohol.

1.2 Background

For centuries, alcohol has had a significant effect on British society, from cultural practices to public health policies. Alcohol consumption in the United Kingdom has a rich historical movement within which cultural norms, economic power, and societal challenges are palpably advised. This part of the work reviews historical and social situations around the use of alcohol and then evaluates trends post-pandemic and co-morbidities with mental health that come with alcohol consumption. British culture has used alcoholic beverages since ancient days. Archaeological evidence shows that Britain's fermented drinks were consumed 12,000 years ago for nourishment and social and ritualistic reasons (Anderson et al., 2023). In the medieval period, ale and beer were staples in British households partly because water sources used to be often contaminated and unsuitable for drinking. Caloric intake was even a high consideration for ale, so much so that it was even considered a good source of nutrition, especially for the working class.

Throughout the 17th and 18th centuries, Britain was afflicted by the infamous 'Gin Craze', promoted by the ease and popularity of gin. Gin was affordable, which made it available to the poor, but this also caused widespread public health and social problems such as addiction, crime, and poverty (Marees et al., 2020). During this period, the government responded with a series of regulatory responses, such as the Gin Acts of the 18th century, which were taxes and licensing requirements meant to control consumption (Hefner et al., 2019). At first resistance, the measures were an example of the first concerted government attempt to regulate alcohol consumption for the public.

Industrialization and urbanization in the 19th century changed drinking patterns. Over time, pubs developed as a central hub for the working class to socialize after long hours in the pub. At the same time, the increase in alcohol drinking was raising alarm in public health circles, and so temperance movements began (Easey et al., 2019). Temperance advocates, such as the Band of Hope and the British Temperance Association, stressed moderation or abstention from alcohol. Influenced by religious and middle-class movements, drinking became the subject of social perception.

Licensing laws, including the Act of 1921, which regulated the sale and consumption of alcohol, were introduced in the early 20th century. These laws were designed to minimize alcohol-related harm, especially in wartime, where productivity and social order were primarily important. The drinking habits in post-World War II Britain changed significantly because of its economic recovery and new social norms (Niedzwiedz et al., 2021). Beer became the most popular drink, but wine and spirits became more popular due to increased wealth and cultural exchange. The United Kingdom was, by the late 20th century, a nation with a complex drinking culture. However, excessive alcohol consumption continued to be seen as a concern, though it was still used as a common thread in social gatherings and celebrations. Beer, the most consumed of all alcoholic drinks, was sold in 2018 in about 8.5 billion pints, while wine was sold in about 7.4 billion glasses (175ml each), and in both cases, it was quite a lot (Cooper et al., 2018). Prize efforts to sell responsible drinking, however, were pushed back by the rise of binge drinking and alcohol dependency as major public health problems.

Alcohol consumption in the United Kingdom was profoundly and multi-dimensionally affected by the COVID-19 pandemic. The severity of the global health crisis has brought about unprecedented disruption of daily life as people have changed their social behavior and economic activities (Stroud and Gutman, 2021). The pandemic catalyzed shifts in alcohol habit, preference, and societal norms while calling attention to deep-seated public health disparities for alcohol consumption. The complexity of these issues is evident because they interplay between pandemic-induced stressors, accessibility to alcohol, and anthropological implications.

Lockdowns and social distancing came about as a result of the new COVID-19 to disrupt traditional ways of consuming alcohol. The on-trade alcohol sales plummeted as all the pubs, bars and restaurants were closed, the key venues for social drinking. Indeed, these restrictions represented a break from the communal aspect of drinking; people had to find ways to change their habits to a domestic environment. These closures had a sharp impact on public alcohol consumption (Zaman et al., 2019). During this period, trade sales (supermarkets, off-licenses, etc.) skyrocketed, showing that consumer behavior can quickly adapt to such circumstances. Against the backdrop of the pandemic, while 2019 is used as a baseline, the overall duty-paid volume of alcohol in the UK fell by just 1.2% in 2020 (Chodkiewicz et al., 2020). During a time of major societal upheaval, this minor downswing in alcohol consumption demonstrates the ability of a

culture to absorb and recover from its transition. Rather than abstaining, many people began adjusting their habit of buying by buying alcohol for home consumption. The behavior is in line with broader movements worldwide, where many people stopped drinking because they were restricted from social gatherings.

Notable changes in consumer preference for alcoholic beverages happened due to the pandemic. Sales of wine and spirits grew by 8.9%, while cider and beer sales fell by 16.7% and 14.0%, respectively. There were many reasons for this shift. Firstly, wine and spirits proved more convenient and lasted longer in the fridge, making them more attractive to consumers during long lockdown periods (Angkaw et al., 2015). In addition, spirits are usually mixed with other ingredients and can be consumed in less large quantities, making them a good option for home consumption. The other reason for these changes stemmed from the rise of cocktail culture at home. The appeal of spirits only increased thanks to social media platforms and online tutorials encouraging people to experiment with making cocktails (Gray et al., 2023). Beer and cider are also traditionally seen as on-trade products whose communal and social attributes were lost in the lack of pubs and bars and saw a fall when people couldn't get together to drink.

During which we experienced record levels of stress, anxiety, and uncertainty during the pandemic. These were psychological stressors that caused many to turn to alcohol as a coping mechanism. According to studies, one-third of UK adults drank more alcohol than usual during the pandemic (O'Leary-Barrett et al., 2017). The increase was robust for those living with social isolation, economic setbacks, or worsening mental health. There is a lot of psychological literature about alcohol use as a coping mechanism. It relieves stress and anxiety for the time being by changing brain chemistry and inducing relaxation. The balance is about short-term benefits, but in the long term, it comes with dependency, increased tolerance, and inadequate mental health (Rustad et al., 2015). The pandemic became a vicious cycle for many people, who then used alcohol to cope with underlying problems, which only made those problems worse with further alcohol use.

During the pandemic, it served as an opportunity to magnify the disparities in the levels of alcohol-related harm across demographic groups already in place. The pandemic year saw 21 percent more alcoholic liver deaths—deaths from liver disease caused by alcohol—than usual, the most significant increase in decades, Public Health England reported. Heightened alcohol

consumption, and especially among vulnerable populations, are the severe health consequences of this alarming statistic (De Andrade et al., 2018). The impact was more on lower-income groups and people in precarious living situations. Rising alcohol consumption among these groups increased stress levels because of economic uncertainty, job losses, and housing instability. Even more, the lack of healthcare services during the pandemic may hinder the interventions for alcohol-associated conditions and, hence, further harm. Disparities were also affected by gender. Cordovilla-Guardia et al., (2017) also found that men typically drink more than women but that women were more likely to raise their level of drinking during the pandemic (Cordovilla-Guardia et al., 2017). However, this may be due to the large amount of caregiving responsibilities that other people are shouldering or the self-isolation from other people causing issues to their mental health. In addition, women are more susceptible to the physiological effects of alcohol and are at increased risk of developing alcohol-related health problems.

Both the impact of the pandemic and alcohol consumption also had implications for the economy. Revenue losses in the hospitality industry were substantial due to the round closing of pubs, bars, and restaurants. The UK's hospitality sector took a 54% falloff in revenue in 2020, with many outlets closing for good. The ripple effect influenced related industries, breweries, and suppliers (Nunn et al., 2016). On the contrary, alcohol sales at supermarkets and off licenses increased somewhat, but on trade revenue trended down. This adaptation of the alcohol market increases sales off-trade and spells considerable concern about the normalization of heavy drinking in domestic settings.

The pandemic has highlighted how urgent it is to have robust public health policies aimed at curbing alcohol consumption and the harms associated with it; as a potential strategy to beat excessive drinking, new initiatives such as minimum unit pricing (MUP) introduced in Scotland in 2018 gained traction again (Hefner et al., 2019). Initial evaluations of MUP show it has been successful in lowering alcohol sales, and most especially among heavy drinkers. During the pandemic, public health campaigns also raised awareness about the risks of drinking more while the bulk of liquid began to be dispensed through compressed air delivered at higher volumes (Smith, 2020). These campaigns discussed the importance of moderation and gave people who need support resources. However, the scale of the challenges raised by the pandemic limited the effectiveness of such efforts.

It's uncertain what the long-term impact of the pandemic will be on alcohol consumption. As social life normalizes, some people are likely to return to their pre-pandemic rite, while others have set themselves up for entrenched habits while locked down (Zemestani and Ottaviani, 2016). The psychological and economic scarring of the pandemic will also mean alcohol misuse may go on for years. The pandemic is also a case study to grasp other social determinants of health. The emphasis of this is, for example, essential to address economic inequality, access to healthcare, and mental health support not only because alcohol is an increasingly at-risk substance but also because alcohol is not consumed in isolation (Witkiewitz et al., 2017).

The UK's consumption of alcohol was profoundly shaped by the COVID-19 pandemic, exposing weaknesses in public health and societal resilience. The changing needs of customers, the shift from on-trade to off-trade sales, changes in beverage preferences, and the move away from alcohol as a leisure product towards an indulgence are examples of how consumption behaviors could adapt in the face of a significant challenge (Goodwin et al., 2017). The consequences—from increased health disparities to economic disruption—point to the need for comprehensive and targeted interventions, but some paradoxes surround this paradox. Addressing the underlying drivers of alcohol misuse and implementing evidence-based policies in the UK presents opportunities to mitigate the long-term effects of the pandemic on alcohol-related harm whilst reinforcing healthy societal norms (Lamberti, 2016).

Alcohol and mental health are poignantly interrelated, and both may greatly intensify the other in a cyclic, mutually reinforcing process. One of the most common causes associated with alcohol misuse is mental health conditions such as depression, mental health conditions, such as depression, anxiety, and post-traumatic stress disorder (PTSD) (Anderson et al., 2023). Individuals who suffer from these disorders may use alcohol as a method of self-medication to soothe symptoms like intrusive thoughts, emotional distress, overwhelming anxiety, etc. Alcohol may give short-term relief, but it becomes a dependency, builds up tolerance, and every time you have withdrawal from it, the very things it is supposed to help with only get worse. Not only does it limit our mental health, but it also sets itself up to be a more significant pain to deal with the root issue.

Excessive alcohol use is also a significant risk factor for the development of mental health disorders. Chronic consumption has been found to modify brain structure and function and to cause

a variety of psychological problems (Schmits and Glowacz, 2022). For instance, continuous alcohol exposure can damage a region of the brain, the hippocampus, which plays a crucial role in memory and emotional regulation. It has been linked to mood disturbances and an increased likelihood of anxiety and depression. In addition to this, drinking leads to an imbalance in the brain's neurotransmitters, which can disrupt cognitive function and emotional stability and can further weaken the sensitivity to mental illness.

These dynamics only increased during the COVID-19 pandemic, becoming a perfect storm for people to drink more and more and more alcohol and for mental health problems to escalate as well. Social isolation is widespread from lockdown measures, economic instability, and pervasive health anxieties heighten stress levels in all groups (Stroud and Gutman, 2021). During these chaotic times, many people found release in alcohol and drank heavily. Despite that, reports claimed that a chunk of the population drank more than they normally would during the pandemic, usually due to stress, loneliness, or financial pressures. However, the sudden relief that alcohol gave way to worse mental health, as alcohol usage increased only made it worse, feelings of despair, irritability, and emotional instability (Grant et al., 2019). The interplay of alcohol use and mental health problems emphasizes the strong need for a coordinated response. Alcohol misuse treatment strategies must also address options for comprehensive mental health service provision. Initiatives to solve these problems in a public health context will more easily unlock dependency cycles and emotional distress and better assist people in getting the pathways to recovery and well-being.

Alcohol consumption patterns in the pandemic period are converging and diverging globally from those of the United Kingdom. Such as the UK, others lifted stress, social isolation, and uncertainty, like in US and Australia countries, as they too had a surge in alcohol intake. Research by Niedzwiedz et al., (2021) found that incidents of alcohol use in the United States increased tremendously during the pandemic, among women, and those with higher levels of psychological distress (Niedzwiedz et al., 2021). In Australia, De Andrade et al., (2018) also found a similar result: many said that they drank more to cope with the economic challenges or the lockdowns (De Andrade et al., 2018). These results indicate the worldwide use of alcohol to cope during a crisis. Yet cultural contexts are powerful determinants of the magnitude and type of use.

Drinking behaviors and consequences associated with alcohol abuse are strongly affected by cultural norms. Such issues of alcohol-related harm are more difficult to tackle in those countries where the tradition is to social drink, such as France and Germany. Also, such studies as Ramalho, (2020) remark that such nations have a deeply ingrained inclination to concede to and commend alcohol as a social lubricant, which legitimizes excessive consumption while hindering the effort to cultivate moderation (Ramalho, 2020). On the other end, more restrictive cultural perceptions of alcohol production and consumption, prevalent for example in the Middle East, were associated with lower total alcohol use while leading to peculiar problems due to illicit trade and enforcement of regulatory rules.

This provides interesting insights on how to cut alcohol-related harms. Scottish minimum unit pricing has become a first-class case study. MUP, which began selling in 2018, applies volume-specific prices per unit of alcohol to lower heavy drinkers' consumption of cheap and concentrated drinks. Using evaluations by O'Leary-Barrett et al., (2017), however, they found that MUP significantly reduced alcohol sales, with the most significant effect on liquor sales among those from lower-income groups most vulnerable to the harms associated with alcohol (O'Leary-Barrett et al., 2017). The success in the north has spurred talk of broader application of similar measures elsewhere in Britain and other countries. Varying levels of success in policy implementation are also found in global comparisons. For instance, Finland's previous application of restrictive store hours and higher alcohol taxation has successfully curbed excessive drinking. Yet, as Ritchie and Roser, (2022) note, such policies need to be accompanied by strong public health campaigns and support services to tackle their causes of dependency (Ritchie and Roser, 2022). Examples here underscore the importance of global best practices in crafting policy and the need to modify approaches to fit local cultural and economic demands.

Trends in UK alcohol use show a history of juxtaposed cultural norms and economic forces with public health challenges. The COVID-19 pandemic made that landscape even more complicated, spotlighting how resilient alcohol consumption has been and its destructive effect on public health (Zaman et al., 2019). As a result, both alcohol abuse and mental illness are not mutually exclusive and require simultaneous holistic treatment. Looking at historical trends, global comparisons, and how well policy measures have worked allows the UK to put together more

thorough plans on how to mitigate the negative social consequence of alcohol consumption and create a society that is more dependable within healthy norms.

1.3 Problem Statement

Alcohol misuse and abuse are significant health and societal problems affecting individuals, their families, and communities in terms of risk. The roots of alcohol-related harm are very deeply embedded in the physical and mental health, social structures, and socio-economic implications it has. In addition, the sorts of social and environmental triggers that influence misusing alcohol interplay more heavily with behaviors and also with relapse and recidivism. All of these underscore the complexity of the problem and, as such, the need for knowledge of the underlying causes and an evidence-based response to intervention.

Addressing alcohol misuse and dependency is one of the most complicated issues because the cultural and social acceptance of alcohol consumption is an integral part. It is woven into the tissue of social life in the UK, whether the casual gathering or the formal event. This normalization results in an atmosphere where heavy drinking goes unacknowledged or even engendered, creating limitations on detecting and dealing with these issues. Recent studies, like that of Schmits and Glowacz, (2022), demonstrate that attitudes to drinking within a society can function as a barrier to change, creating intergenerational patterns of dependency and relapse (Schmits and Glowacz, 2022).

Relapse and recidivism are also driven by social triggers, namely peer pressure, social isolation and exposure to environments whose members drink to a high extent. Studies have shown peer pressure, especially among younger demographics, encourages risky drinking along with the desire to feel accepted or socially validated by their network. Closet alcohol is also commonly a coping mechanism to prevent social isolation, which has become even more the case during the COVID-19 pandemic, as people feel alone in this world (Anderson et al., 2023). The problem is made worse by environmental cues, including the presence of alcohol in public places or advertisements representing drinking as a sign of living, that further boost alcohol as an expected behaviour.

Alongside economic uncertainty and stressful living environments, environmental factors such as financial instability and pressure of living situations make such misuse even more complex. Increasing stress, typified by economic hardship, can cause individuals to turn to alcohol as a

means of escapism to bring them some relief. The same relationship was seen during the pandemic when economic uncertainties and job loss led to more excellent rates of alcohol consumption and dependence. Schmits and Glowacz, (2022) also point out that communities with disproportionately higher levels of poverty and reduced opportunities to access healthcare services tend to have disproportionately greater levels of alcohol-related harm (Schmits and Glowacz, 2022). These gaps underscore the importance of targeting the social determinants of health and specific vulnerabilities.

The biology and psychology of alcohol dependency further aggravate the matter of relapse and recidivism. It changes behavior, mood, and cognitive function because it changes brain chemistry. Withdrawing from substances can be a dangerous and painful process, and exposure to social and environmental cues can often lead to relapse. While relapse is common even if you actively try and abstain from the dependency over the long term, dependency is a cyclical thing which means you won't be able to successfully abstain from it. According to Tran et al.,(2020), these triggers have to be identified and dealt with as they should minimize the risk of relapse.

Policy and intervention strategies for alcohol misuse routinely neglect social and environmental factors associated with alcohol misuse. Although measures such as minimum unit pricing and even more stringent licensing laws have had some success in reducing total consumption, without complementary support systems these measures are of limited utility in preventing relapse among those with a history of dependency (Tembo et al., 2017). To make public policy, that affects the relapsing relapse, researchers started to research and develop methods necessary to define and pinpoint precisely what social triggers and environmental clues precipitate a relapse.

The worldwide shift in public health priorities for alcohol misuse should also include a diversion from prevention and early intervention toward addressing alcohol misuse. Changing attitudes toward alcohol (Glantz et al., 2020) can include activities trying to spread information on the great danger of dependency and give more healthy substitutes. Additionally, mental health service integration into addiction treatment programs can pave the way for a holistic mental care approach to treating compulsive behaviors as the issues of dependence are a result of cognitive and social factors.

Alcohol misuse and dependence have many facets and are an illness with cultural, social, and environmental dimensions. The problem is complex due to the roles of social and environmental triggers in worsening relapse and recidivism and requires evidence-based, comprehensive intervention. The research can shed light on and remedy these triggers to the extent that it can inform public policy and contribute to the most effective mechanisms to lighten the burden of society of alcohol-related harm. This highlights why key research questions and goals have to be well stated and lead to the direct informing of actionable public health and policy solutions.

1.4 Research Significance

This research contribution addresses the critical and multifaceted problem of alcohol misuse and dependency that remains of great importance at academic as well as practical levels, yet solutions are rarely established. Alcohol-related harm affects individuals, their families, their communities and societal structures, and that calls for comprehensive and evidence-based interventions. This work aims to address the gaps in the body of knowledge concerning the social and environmental triggers that lead to relapse and recidivism and brings insights from the academic to the practical realm.

From an academic standpoint, the study seeks to add to the growing body of literature on alcohol misuse by discussing the complex interplay between social triggers and individual behaviour. Previous research on the physiological and psychological dimensions of alcohol dependency has been fully covered, but the social and environmental influencing factors of relapse are open to extensive research. More specifically, these triggers are particularly gaping because they act as triggers for lapsing, undoing attempts at recovery, and maintaining a vicious cycle of addiction. With a mixed techniques method, this analysis will provide a nuanced knowledge of these dynamics, combining quantitative information with quantitative insights to offer a whole image.

The methodological approach adds to the academic relevance of this study. By employing qualitative and quantitative methods, research can comprehensively analyse the issue, incorporating the social triggers into more empirical rigor. Quantitative data will reveal patterns and correlations, while qualitative data will explore lived experiences that surround individuals who are affected by alcohol misuse. This combination of the theoretical basis and real-world

context strengthens the validity of the findings but also contributes to their applicability to real-world interventions.

This research is equally practical in its promise to contribute to public policy and intervention strategies. Healthcare, loss of production, and criminal justice are all more than £27 billion costs of alcohol misuse in the UK (£27.1 billion) (Niedzwiedz et al. 2021). If we decisively address the root causes of dependency and make sure they don't come back, these costs will be dramatically down. The purpose of this research is to determine particular social or environmental factors unique to the role of alcohol use and provide helpful information as to how policy and public health practitioners might change as a result.

It has contributed a key practical contribution of being able to guide the targeted interventions. Knowing what social cues and environmental factors set off drinking behaviour makes it possible for policymakers to build interventions at the same place, rather than at the next level up, such as reacting to drinking by bringing in higher taxes on alcohol or car licenses. For instance, if social isolation is the important cause of drinking, interventions might include ways of developing supportive social networks like drinking but not drinking with alcohol. So, if certain kinds of environmental cues tend to lead people to relapse (say drinking near some alcohol outlet or to advertisements) then regulatory action might be taken to address this relapse (Ramalho, 2020). This work may also inform broader public health strategies by incorporating the findings into educational campaigns and community programs. Awareness can reduce the influence of alcohol and free people to make educated choices and build resilience to face these many influences. Additionally, the findings can be used to improve culturally sensitive programs that take into account the social uniqueness of a particular community's context and are more effective and equitable.

But this is another significant contribution to public policy. The problem of alcohol misuse is an entrenched societal problem justifying concerted efforts at the intersectoral level of governance. It can also provide evidence-based policy recommendations on what social and environmental factors are used to cause reoccurrence and relapse because this research addresses what factors are utilized to cause reoccurrence and relapse. For example, the findings could inform the implementation of minimum unit pricing, tighter licensing laws, or restrictions on alcohol advertising, all of which have been demonstrated elsewhere to reduce consumption. Additionally,

the focus of the current study on social triggers is consistent with current public health strategies that focus on addressing the social determinants of health.

At the same time, this research also contributes to broader societal ends. People who use or misuse alcohol disproportionately affect the most vulnerable populations, including low-income communities, individuals with mental health conditions, and people isolated from others. This study can then shed light on resources that keep these disparities going and help develop targeted strategies that address the needs of these groups. It is consistent with the latter goal of encouraging the population health equity and decreasing the relative disproportionality of societal alcohol-related harm burden.

This research has several facets of general significance, including academic advances, practical usefulness, and social benefits. This study examines the social and environmental triggers of alcohol misuse. It seeks to fill critical knowledge gaps in the current literature to inform actionable insights into public policy and intervention strategies. The mixed methods approach covers the issue comprehensively and is a good resource for addressing one of the UK's most pressing public health challenges. The impact of the study will be increased if research questions and objectives are clearly defined and work aimed at reducing alcohol-related harm and improving societal well-being is guided.

1.5 Research Aim and Objectives

This research aims to understand social triggers and environmental cues underlying relapse and recidivism in alcohol consumption, as well as their individual and consumption pattern impact potential. The study aims to identify these triggers to provide actionable insights into generating targeted prevention and intervention strategies. The goal is to contribute to public health policies that seek to reduce dependencies on alcohol as well as mitigate the societal, economic, and health ramifications of such dependencies, especially in vulnerable, high-risk populations.

- To determine and classify the typical social and environmental triggers that precede an alcohol relapse.
- To examine the effects of these triggers on the periodicity of alcohol consumption by various demographic cohorts of individuals.

- To develop evidence-based recommendations for prevention and intervention strategies explicitly tailored for some of these social triggers.
- To offer the available knowledge that is actionable for policymakers for the development of public health policies to address alcohol misuse and dependence.

1.6 Research Questions

1. What are the most common social and environmental triggers of alcohol relapse, and how do these vary across different populations?
2. Which factors contribute to the social triggers and environmental cues of the pattern of consumption and recurrence of dependency on alcohol?
3. How can identified social triggers and the prevention and intervention strategies that can mitigate their impact on alcohol relapse be most effectively done?
4. What are the policy implications of this research for public health efforts to reduce alcohol misuse and support long-term recovery?

1.7 Definition of Key Terms

Relapse: Return to alcohol consumption after a period of abstinence, brought about by social, psychological, or environmental factors. Relapse is an essential issue in recovery because it negates the effect of individual treatment and creates detrimental dependency cycles (Heimke et al., 2023).

Recidivism: Recurrent alcohol misuse or dependency once recovery or treatment has been tried. Alcohol dependency is often chronic and lends itself to recidivism, which highlights the need for sustained interventions.

Social Triggers: Provoke or encourage alcohol consumption via external stimuli or situations in a social context. They can sometimes be peer pressure, family conflict, social get-togethers or simply cultural norms that encourage drinking.

Alcohol Dependency: It is a chronic condition of compulsive alcohol consumption despite damage to health, relationships, or occupational performance. It is also known as alcohol use disorder (AUD) and is characterized by tolerance, withdrawal symptoms, and a loss of control over consumption (Muroff et al., 2017).

Preventive Strategies: These included approaches to reduce the risk of alcohol misuse and dependency, such as public education campaigns, early intervention programs, and community support initiatives.

Intervention Strategies: Measures directed to halt present alcohol misuse or dependency include counseling, behavioral therapies, pharmacological treatments, and support groups.

Public Health Policy: Measures and guidelines of governments aiming at managing and reducing the harm caused by alcohol at the country level (Lamberti, 2016). These include minimum unit pricing, advertising restrictions, and licensing laws.

Alcohol Use Patterns: The behavior and alcohol consumption trends, including the frequency, amount, and context of use, differ across demographic groups and cultural settings.

Comorbidities: Complications in recuperation and therapy efforts because of the fact neighboring alcohol disabledness presents with additional mental or physical health conditions, for example, depression, anxiousness, or liver disease (Gallagher et al., 2018).

1.8 Scope of the Study

The scope of this study is clearly defined to offer insight into the social triggers and causes of relapse and recidivism to alcohol consumption. The research is geographically situated within the United Kingdom, where the issue of alcohol misuse is compounded by particular geographical challenges and opportunities to address the problem. This is the more pertinent example, given the UK's cultural norms regarding alcohol, its widespread social acceptability of drinking, and the enormous public health implications. This study focuses on the time following the pandemic, a time of large swaths of psychological health issues associated with heightened alcohol consumption. In this period, the COVID pandemic worsened the social isolation and economic imposition of health anxieties that are associated with augmented alcohol dependency and relapse rate (Buckmon, 2015).

The study is contextually focused on the interaction or interplay between social triggers, environmental cues, and individual behavior. These factors interact distinctly in the post-pandemic landscape, upon which a critical lens is put for exploring how these factors interact under such unprecedented societal stressors (Lamberti, 2016). The backdrop of relapse dynamics during these lockdowns and the changing point of the trade from on to off-trade creates a unique opportunity

to explore these dynamics. During this period, this also serves as a reminder to address disparities in the levels of alcohol-related harm caused since vulnerable populations were disproportionately impacted.

Defining the population under study ensures the specificity of the results. This research was concerned with people older than 18 years of age who have experienced difficulties in handling the issues connected to alcohol dependency, relapse, and recidivism. Participants were of different backgrounds (demographic data) including age, gender, socio-economic status, and the particular geographic UK. These are critical variables for understanding how these intragroup social cues and environmental contexts vary, and how they can be utilized to develop targeted interventions.

Both those with a documented history of alcohol dependency and those who self-report relapse experiences are in no particular order considered a participant. Thus, the study can have insights from those directly involved in the phenomena under study. In contrast, exclusion criteria will exclude people who do not have dependence issues relating to their drinking or who have not experienced relapse to keep the focus of the study on its central focus. The study is designed to generate findings specific to the UK setting and applicable to others in a similar setting. Since the research addresses critical gaps in understanding and yields actionable insights for public health policies and interventions, the targeted population and contextual emphasis make the research especially relevant.

1.9 Limitations of the Study

Limitations in methodology, sample size, and data collection inherently limit this study and leave it susceptible to bias that may impact the results. Understand that these limitations are crucial to the research's validity and transparency about the challenges of its execution.

The most significant limitation arises from relying on a mixed methods approach, albeit comprehensive, but having difficulties with integration and interpretation. However, qualitative and quantitative data require careful alignment to provide coherence and meaningful insights. For instance, data of a qualitative sort yielded from semi-structured interviews may offer red juice-developed perspectives of social triggers and environmental cues. Yet, such perspectives are prone to opinion. Conversely, data collected quantitatively via questionnaires may provide a broader

trend but not in-depth enough to grasp someone's exact experience. Embedding these two approaches necessarily calls for careful methodological rigor to balance them.

Another potential constraint is the sample size. This research will likely try to recruit a diverse and representative sample. However, practical issues, such as participant availability, willingness to participate, and eligibility criteria, might restrict the respondent pool. The study may have lower statistical power, and the findings cannot be generalized to the larger population if the sample size is small. In particular, this limitation is essential when investigating specific subgroups, such as individuals from differing socio-economic statuses or regions in the UK, where the social triggers may have higher levels of variation.

Constraints may be found in data collection methods as well. Recall bias and social desirability bias exist in the reliance on self-reported data, either through a questionnaire or an interview. When discussing sensitive subjects like alcohol dependency and relapse, participants may not ever say what is on their minds. They may not wish to inadvertently give inaccurate responses or paint a less-than-desirable image of themselves. Data biases such as these lead to unreliable data and must be modified by robust data collection strategies, such as using validated questionnaire methods and anonymizing the gathered data.

Where a sample does not properly represent the target population or research bias occurs when preconceived notions bias interpretations of qualitative data, selection bias, and researcher bias, respectively, can occur. The first step will be to reduce these risks by employing random sampling techniques as appropriate and to also verify objectivity in the qualitative processing using procedures such as inter-rater reliability checks. The methodological and practical constraints of the study will be adaptive for increasing the reliability and applicability of the findings. However, acknowledging these challenges with transparency does a service to keep the approach oriented to balance and credibility in the understanding of the complexity of alcohol relapse and recidivism.

1.10 Thesis Structure

This thesis consists of six chapters devoted to a comprehensive understanding of the social triggers of relapse and recidivism in alcohol consumption. Steps in the logical flow systemically address the research objectives and questions, leading to action-based insights for public policy and intervention strategies.

Chapter 1: Introduction: The first chapter gives an overview of the study field, develops a point of view, and discusses its weight in the context of public health and news. Next, it provides the background, problem statement, and research aims, objectives, and questions. In addition, the chapter defines key terms and determines the scope of the study. It lays out the importance of the research so that the following chapters can build on this.

Chapter 2: Literature Review: This chapter critically reviews previous work on alcohol misuse, relapse, and recidivism and focuses on the role of social and environmental triggers. It analyses the theoretical frameworks, key findings, and gaps in the existing body of knowledge. This review brings together global and UK-specific studies, showing the relationship between cultural norms and individual behaviour as well as with public policy. The study makes an academic foundation for its research by identifying gaps it will seek to close.

Chapter 3: Methodology: The third chapter also describes the research methods and design used in the study. The mixed methods approach includes questionnaires (quantitative) and semi-structured interviews (qualitative). The chapter addresses the sampling strategy, data collection methods, analysis, and techniques. In addition, it includes ethical considerations and limitations, the latter of which cultivates transparency and rigidity of the research process. The methodology follows the research objectives, data collection, and analysis. It provides a robust framework that can be observed.

Chapter 4: Results and Analysis: This chapter presents the quantitative and qualitative data findings. Statistical methods analyze quantitative results to identify patterns and correlations, while qualitative data analysis is applied to the former to give more significant insights into participants' lived experiences. These findings are integrated to describe the alcohol relapse social cues and environmental cues.

Chapter 5: Discussion: Interpreting the findings concerning the objectives and questions of the research is done in the discussion chapter. The results are contextualized in the current literature, and consistency, contradiction, and unique contributions to existing literature are identified. Implications of the findings for theory, practice, and policy are explored. It also critically studies the study in limited scope to achieve a balanced perspective on the research outcomes.

Chapter 6: Conclusion and Recommendations: The final chapter links key findings and makes overall conclusions. It describes the evidence-based prevention and intervention practices that should be targeted to meet practical recommendations regarding alcohol relapse and recidivism. In addition, the chapter presents actionable insights for public policy, offering the benefit of insight for public health and governance stakeholders. It also finds directions for further research to help reduce alcohol-related harm in the future.

The structure of the thesis was such that the research problem was identified, and the solutions were presented logically. This research context and significance are established in the Introduction, and an academic framework is provided in the Literature Review. The Results and Analysis chapter systematically addresses all the work within the Methodology regarding data collection and analysis. The Discussion analyses these findings in depth and draws connections to more general theoretical and practical implications. Finally, the Conclusion and Recommendations combine the study's contributions in a coherent narrative consistent with the research questions and questions in summary.

1.11 Summary

The first chapter lays out the groundwork for this study by setting forth the social triggers of relapse and recidivism in alcohol consumption. Then, it situates the problem within the broader public health and societal context, pointing out how alcohol misuse is widespread in UK life and how it impacts the lives of people and communities. The chapter identifies those cultural norms and environmental factors that contribute to dependency and relapse by looking at the historical and societal significance of alcohol consumption. Given the heightened vulnerabilities of the COVID pandemic, it is essential to address issues regarding post-pandemic trends and comorbidities for mental health.

Enunciating the study's aim—namely, to explore social and environmental issues that give rise to alcohol relapse and recidivism and four specific objectives, the chapter outlines the research objectives. It defines further key terms, defining their meaning and providing consistent use in subsequent chapters. The clear scope is established based on the UK's post-pandemic environment and aimed at a diverse anthropology with alcohol dependency built into the scope. Further in the chapter, the chapter also addresses potential methodological and contextual limitations and suggests ways to overcome potential biases and increase the validity of the findings.

This structured chapter lays the firm foundation of the research by identifying the problem and objectives and anticipating the goals to be realized. It integrates academic and practical perspectives around the study's contribution to public health and its relevance to developing evidence-based interventions and policy recommendations. The introductory chapter effectively gives the context for the in-depth research on alcohol misuse in the subsequent sections of the thesis.

Chapter 2: Literature Review

2.1 Introduction

Alcohol misuse hurts public health in every way by creating stress on both society and individual health. The existence of alcohol misuse shows up in all types of societies where people drink alcohol (Anuar et al., 2020). People in most societies accept alcohol consumption, but its excessive use damages health more than any other global risk factor. Every year in the UK, alcohol misuse causes more than ten thousand deaths and produces substantial social and economic effects. The damage from alcohol abuse results in medical expenses and workforce losses, plus justice system expenses that cost society £27 billion every year. Treatment failures and repeat crime events continue to burden public health because alcohol dependency affects too many people (Apostolopoulos et al., 2018).

Alcohol misuse runs strong through the way people act in society and how culture shapes behavior. Throughout history, alcohol connects people socially in parties and ceremonies, making it a celebration tool while setting back public health progress. Standard consumption patterns with alcohol receive general recognition, but excessive drinking due to external triggers becomes addictive and creates repeated periods of recovery. People follow alcohol drinking patterns more because their peers push them to do so, plus their society accepts alcohol use and views it as an ordinary way to deal with stress (Blaine and Sinha, 2017).

This research paper analyses current studies about alcohol misuse, particularly studying relapse and return to problem drinking. Research today broadly studies what influences motivate someone to continue an unhealthy relationship with alcohol (Brady, 2017). Individual alcohol use patterns develop strongly from social influences that come from friends and the broader culture. During social events, teens fall into heavy drinking habits due to their peers. However, people from all age groups drink more to handle their life struggles, including financial problems and significant events like death. The easy access to alcohol, plus marketing and everyday exposure to alcohol, creates a problematic setting that makes recovery even more challenging for people trying to stay sober (Boruah, 2016).

The COVID-19 pandemic lets us study how people use and become dependent on alcohol differently than before. The pandemic brought new forms of community stress to people when it limited social contact and created problems with money and worry levels. Researchers discovered

that alcohol usage grew by 17% during lockdown across UK communities. With pubs and bars closed, people began buying more alcohol from supermarkets for personal use. The amount of alcohol sold by supermarket chains increased by 67%. During the pandemic, consumers showed remarkable adaptation, along with revealing the deep role alcohol plays in helping people cope with crises (Chopra and Arora, 2020). Recovering people faced more relapse risks because staying home isolated them from needed support networks.

Research frameworks help us better see how a person's behaviours mix with environmental factors in alcohol drinking patterns. According to social learning theory, people learn about drinking customs by watching others and copying their actions. People copy how others behave when those individuals make alcohol use regular or popular behaviour (Chung and Rimal, 2016). The social learning framework shows us why people drink too much because their peers and culture push them to take risky actions. The Health Belief Model (HBM) helps us see how people think about alcohol because it allows them to compare how drinking makes them happy and accepted, plus how it damages their health and leads them to addiction. This method will enable us to understand how people base their actions on their thoughts about them. According to this theory, individuals must be examined regarding their social-environmental existence. The theory helps us analyse how different groups and settings shape drinking at personal and societal levels (Collins, 2016).

The chapter reviews major research theories and identifies the research areas that need more study. Although scientists have explored key biological and emotional aspects of alcohol misuse, they have not studied how social factors and settings influence this behaviour deeply enough (Frank, 2021). More research should examine what causes alcohol-related triggers both within and between different social groups worldwide. Research about how changes caused by COVID-19 will continue to change alcohol use rates or trigger past dependence needs more exploration. The pandemic provides valuable context for learning how society's pressures combine with individual weaknesses to worsen alcohol problems (Heitzman, J., 2020).

Through research from diverse global sources plus UK data, this review combines data to establish how social and environmental circumstances make people relapse and return to alcohol use. It shows how personal actions connect to social forces to establish what specific help works

best. Our analysis provides critical data to help public health leaders develop better approaches that decrease alcohol harm and improve recovery results (Hendriks, 2020).

Relationships between social and environmental conditions plus personal actions surface strongly in the case of repeated drinking and criminal behaviour. People in recovery face regular episodes when they start drinking alcohol again after going without it. When recovered people walk back into dangerous drinking situations, they increase their risk of returning to alcohol abuse (Hoek et al., 2022). Repeated alcohol problems after treatment show how alcohol dependence returns in cycles for many individuals. Our progress depends on discovering what pushes individuals to restart substance misuse and return to criminal acts and designing treatments that directly fight these triggers.

This study prioritises examining alcohol misuse during the post-pandemic era. The COVID-19 pandemic dramatically transformed how people behave and cope with stress, which affects alcohol misuse more deeply. Pandemic lockdowns increased alcohol use as self-coping while switching up drinking habits, making public health work harder to achieve results. Researchers must study pandemic changes to build better solutions against the ongoing emergency and its long-term effects (Hoek et al., 2022).

This chapter studies the available research on how social and environmental triggers make alcohol misuse, relapse, and recidivism continue. This study examines the link between personal factors and social conditions while examining environmental influences to suggest better treatment methods for public health programs. The study results offer better ways to fight alcohol dependency while helping people recover from their alcohol addiction.

2.2 Alcohol Misuse: A Global and UK Perspective

Alcohol consumption continues to cause significant social concern since it affects a global population's health and has negative social and economic impacts. Currently, alcohol kills about 3 million people every year, which is equivalent to 5.3 per cent of global deaths, based on the World Health Organization (Jernigan et al., 2017). This is a pervasive problem, and, at the same time, it is very diverse because it is connected with culture, stress, and money, so it can be hard to solve this issue. As such, the problem of alcohol-related harm is even more critical in the UK, claiming over 10,000 lives and having a mortality rate of 13.9 per 100,000. The above statistics show the

extent of possible harm in society, which calls for the amplification of specific types of measures to prevent alcohol-related disease.

The use of alcohol is a global problem that concerns people and communities in every part of the globe. Alcohol consumption is influenced by cultural, economic and social factors, resulting in regional and National differences. However, there are differences in the EPIC study, and most international studies show that excessive alcohol use is a leading cause of morbidity and mortality in the world, with 3 million deaths per year due to alcohol use, according to WHO. This section provides information on the main cultural and socioeconomic factors and regional variations of alcohol misuse worldwide (Piano, 2017).

2.2.1 Cultural Norms and Consumption Patterns

Culture has a significant function in influencing the intensiveness and character of alcohol consumption as well as overlooking alcohol abuse. Alcohol drinking has permeated into cultures in the traditional sense in countries like the United Kingdom, France and Germany, where group drinking is accepted as the order of the day (Kahan, 2019). Most social functions, including parties, birthdays and business-related functions, use alcohol, thereby propagating the product's core place in today's society. The ways that make it possible for people to consider moderate consumption as okay and healthy while normalising the vices of consuming too much alcohol.

Pathogenic cultures found in these areas include binge drinking, which refers to the act of taking high volumes of alcohol within the shortest possible time. Both drinking and binge drinking is very popular among young people, and many social expectations and norms push young people to drink to oblivion in groups (Mason et al., 2014). The findings also establish that binge drinkers are not only more likely to suffer all the primary harms in the course of the following year, but they are also in a higher risk class for creating a dependency on problematic alcohol use. Consequently, several cross-sectional university samples legitimise heavy episodic drinking as a part of college life, thus promoting life-course persistent alcohol misuse.

On the other hand, developed nations with compartmentalised culture or religious beliefs about alcohol, like the Middle Eastern countries, show a low ratio of per capita alcohol consumption (Pruckner et al., 2019). Those in these areas experience restricted accessibility and tabs on alcohol consumption due to religious and legal reasons and so are less involved and visible in the public space. However, this does not slash alcohol-related harms. Instead, matters like the

illicit production of alcohol, smuggling and free-for-all use of alcohol present entirely different concerns. Adverse effects of consuming the banned substances include poisons, infections, inflammation of the oesophagus, and death. Also, the generally negative attitude towards alcohol consumption in these areas could prevent people from going for treatment, thus worsening the situation (Nyakutsikwa et al., 2021)

Economic and Socioeconomic Factors: These study results reveal that global trends and differences in the socioeconomic status of populations have a particular impact on irregular alcohol use. At the same time, in the affluent societies, the disposable income tends to rise alongside the amount consumed alcohol (Mason et al., 2014). However, it is ironic to note that alcohol-related disorders are most commonly observed among the lower-income earners society within these societies. They also show that financial problems, lack of a job, and poor access to a doctor increase dependency and enhance the effects of overindulgence (Masson et al., 2021).

In LMICs, alcohol dependency is associated with other economic problems. Alcohol use disorders and dependence: Socioeconomic considerations & Available strategies & in LMICs These three include rapid urbanisation, income disparity and lack of regulatory control, which facilitate restrictive drinking profiles (Rhead et al., 2022). For instance, there could be uncontrolled market sales of affordable and highly potent alcoholic products, thus raising the propensity for dependence, particularly in vulnerable LMICs and economically deprived communities. Furthermore, most of these areas do not have proper health facilities that can offer health care services to persons that are with alcohol use disorders.

They also affect the world's consumption of alcohol, quaff and fermented beverages during economic recessions and crises. Research has established that during periods of economic turbulence like recantations, there is usually a rise in alcohol abuse. It's been found that in cases of financial pressure and job loss, people tend to consume more alcohol, which may cause an increase in levels of alcohol harm. Similarly, all countries surveyed found that in the 2008 global economic crisis, alcohol delivery increased, and the prevalence of alcohol-related diseases and disorders also increased (Pruckner et al., 2019)

2.2.2 Alcohol Misuse in the UK: Patterns and Impacts

Binge drinking is widely prevalent in the UK because drinking is part of the British culture, social or celebration activities. While low-risk drinking is part of contemporary social culture,

heavy drinking has caused extensive social, health and financial impacts. British society continues to tolerate the practice of alcohol consumption in such a manner that escalates dependency, chronic diseases, and societal vices. This section looks at the trends in alcohol consumption in the UK and its myriad effects (Hoek et al., 2022).

2.2.2.1 Patterns of Alcohol Consumption

In the UK, alcohol habits are influenced by the culture where people are likely to be encouraged to consume alcohol. Whether in bars, at festive family dinners, or in connection with national celebrations, alcohol is perceived as social consolidation and enjoyment. However, this situation has only encouraged the increase in mass outrage drinking, not to mention the repercussions that this has on the health of the general public (Blaine and Sinha, 2017).

Currently, 57% of British adults indicated that they were regular low-alcohol drinkers, taking less than 14 units per week, while 21% of them are considered to be potentially hazardous drinkers taking more than 14 units per week (Apostolopoulos et al., 2018). Of these, binge drinking, which is described as the regular intake of a much larger quantity of alcohol in a relatively short period, is prevalent. Binge drinking is most prevalent among students and working persons, in that many people of this age bracket are university students and young professionals who feel pressure to drink to their fill. Altogether, other cultural practices like round-buying in pubs also influence consumption at social events.

Thus, it is possible to discover critical trends of age for alcohol abuse, too. The youths are associated with binge drinking, but the older adults take alcohol more frequently, although in small portions. However, regular drunkard people belonging to the older generation may lead their health to chronic diseases like liver disorders and cardiac complications. In addition, dependency develops because older people take alcohol to cope with feelings of loneliness, bereavement, or other stress factors (Brady, 2017).

2.2.2.2 Public Health Challenges

The consequences of alcohol abuse in the United Kingdom are felt in almost every aspect of society since it affects individual health. Drinking causes more preventable deaths than any other factor, and conditions attributed to alcohol lead to numerous deaths each year. According to the National Health Service (NHS), alcohol harms impact clinical priorities with evidence

including admissions of alcoholic liver diseases, alcohol toxicity, accident-related injuries, and long-term diseases like cancers and cardiovascular diseases, among others (Hendriks, 2020).

Liver disease remains a particular problem as it increases alcohol-related hospitalisations and deaths annually. Unlike other major diseases, liver disease extends its deadly hand towards more youthful adults, primarily due to alcoholism. In addition, many new cancer cases, such as mouth, throat, and liver cancer associated with alcohol consumption, are emerging, which are also a growing healthcare burden (Hoek et al., 2022).

Mental health is also affected by alcohol misuse in equal proportion. It is not uncommon for a person to have a substance use disorder as they may suffer from mental health disorders like depression, anxiety or PTSD. Some people have a tendency, or alcohol-dependent persons are most likely to self-medicate for the mental ailment that is worsening due to alcohol intake. It is challenging to treat people diagnosed with both alcohol dependence and mental disorders and therefore, coordinated care models are required.

2.2.2.3 Economic Impacts

Alcohol-related costs, as viewed from the economic perspective, have a high figure, which is estimated to be about £27 billion in the United Kingdom annually. These costs include bearing the costs of health care, relaxed productivity, costs of crime and other social costs associated with the use of alcohol.

Healthcare Costs: Research indicates that the NHS uses about £3.5 billion to treat patients suffering from alcohol-related diseases. This entails the price of exigency, fundamental care for chronic illnesses, and recovery expenses. There is increased pressure on healthcare facilities during the holiday season and over weekends due to high alcohol-related issues such as injuries and poisoning.

Workplace Productivity: Hence, it impacts workplace productivity through presenteeism, truancy and impaired output performance caused by alcohol dependence. Substance abusers who abuse alcohol are likely to be absent from work due to sickness or due to hangovers. Further, industries such as manufacturing, construction, driving and fine motor operations are susceptible to the dangers of alcohol-induced disability (Jernigan et al., 2017).

Alcohol-Related Crime: Alcohol is among the main contributing factors to crime in the United Kingdom since a large number of violent crimes, instances of domestic violence, as well as acts of public disorder involve alcohol. The social costs of police patrols, trials, and imprisonment of people who indulge in alcohol-related offences also contribute to the costs. In addition, alcohol-related crimes are social costs that last and affect the victim and the societal support systems (Jastremski et al., 2016).

2.2.2.4 Social Impacts

These effects of alcohol involve the families and the society at large, which make up the communities and all other societal structures. Many families dealing with alcohol dependents goes through phases of emotional and social suffering, and they also suffer monetarily. In particular, vulnerable are the children who are from households where one or both parents are alcohol dependent because such an environment is likely to result in neglect, abuse or developmental issues caused by the instability of the dependency (Kahan, 2019).

Alcohol abuse at the community level brings social vices and reduces the standards of living in society (Lackner and Tiniakos, 2019). Especially in urban areas, the high density of alcohol outlets, together with consumption and purchase past legal hours, leads to high rates of noise complaints, vandalism and public drunkenness. These problems exacerbate the demand for local resources and influence the population's perception of safety and quality of living in those communities.

The culture of the society also promotes stigma, especially to people who seek treatment for alcohol dependency. This leads to social norms that embarrass most people who have to attend drug dependency treatment classes or discuss their misfortune in private. Eliminating this cultural attitude is the most critical step toward helping people gain proper support for their recovery and rehabilitation (Masson et al., 2021).

2.2.2.5 Policy Responses and Challenges

The UK government has incorporated different policy interventions that relate to the abuse of alcohol, such as the minimum price per unit of alcohol, a ban on advertising and promotion of alcohol and awareness creation. The subject, otherwise known as minimum unit pricing and launched in Scotland in May 2018, seeks to help decrease the access to low-priced, high-strength

alcoholic products primarily used by BIDs. It seems that this policy has the potential to reduce alcohol consumption and rates of alcohol-related hospital admissions (Partelow, 2018).

Another policy regulation involves restrictions on advertising, particularly to youths. To that end, the limits seek to conceal alcohol in the media and physical space to decrease social acceptance of drinking, especially among the youth. He developed various programmes that inform the public and encourage them to take sanctions against instances of excessive drinking.

Nevertheless, there are issues with impacting, let alone enforcing, these policies. For instance, where minimum unit pricing is effective, its efficacy varies with the regions and groups within a society. Thirdly, media advertisements for alcohol are still targeting special groups through digital platforms & social media platforms in complete violation of majority protection goals (Piano, 2017).

2.2.3 Vulnerable Populations and Disparities

Alcohol use is also known to impact different regions in a way that affects people living in low-income income groups, Indigenous people, and the marginalised in society. Many of these populations experience multiple risk factors that expose them to alcohol hazards. For instance, poverty and/or unemployment push people into alcohol as a channel of coping with stress and/ or adversity (Rhead et al., 2022). For example, systemic inequalities and discrimination can act as a barrier to access to health care and support services affecting recovery.

Aboriginal and other Indigenous people of America, Canada, and Australia too are known to suffer the ill effects of alcohol abuse at higher rates compared to other populations; this may be ascribed to early world colonisation horror stories, discrimination, and poverty that characterise a majority of present-day native people. This stress and poor mental health add to the vulnerability that colonisation, forced displacement, and suppression of Indigenous culture have brought into the lives of Indigenous peoples, increasing their vulnerability to alcohol dependency (Lackner and Tiniakos, 2019). Efforts to curtail alcohol dependency in these societies must be approximatively framed with an understanding of the potential harms inherent in the societies.

There are, however, some groups that are most affected by LMICs; these are women and children. As already stated, men consume more alcohol than women worldwide; however, women in LMICs are equally at risk because society disapproves of women taking alcohol. This, in turn,

makes it hard for women to get the assistance they need, and as a result, the results of the misuse of alcohol are worsened by stigma. The abuse of alcohol in families is also a problem with children and adolescents in these regions because correct behaviours are learned and repeated. At the same time, they disarm themselves to become dependent on the next generation (Jernigan et al., 2017).

The Role of Cultural Norms and Social Practices: Culture and social conduct remain two of the most relevant predictors of alcohol drinking behaviours in the UK. They also define how alcohol is regarded and the situations and times when it is accepted and often encouraged. As the local people have understood, the use of alcohol, deeply ingrained in the UK culture, poses the following challenges to the reduction of misuse (Mason et al., 2014). This section aims at dissecting several cultural features and norms that promote higher rates of alcohol use and dependence.

2.2.3.1 Binge Drinking as a Rite of Passage

The behaviour of binge drinking is culturally acceptable in the UK, and young people dominate it. As regular moderate drinking is called for the consumption of a comparatively large quantity of alcohol in a short period, binge drinking is perceived as a special stage as a social rate as the rite of passage, as the sign of the transition to independence and friendship. It is enshrined in every social facet of university, nightlife, and weekends, whitewashing drinking beyond moderation as simply having fun or going wild (Hoek et al., 2022).

Binge drinking is greatly fuelled by peer pressure. Students often do this under pressure by group think when out in groups and usually seen in pubs, clubs and parties. The option of "round buying" in pubs implies that each group member buys drinks for the rest, which puts pressure on any group member who wishes to be sober, as everyone expects them to take many rounds of drinks(Kahan, 2019) . Descriptive norms regarding the acceptability of the behaviour make excessive drinking more socially acceptable and thus obscure the otherwise negative consequences of risky drinking.

Research shows that this normalisation facilitates long-term problems of alcohol abuse since the youthful and early adulthood period of intoxication are most likely to lead to Alcohol dependence disorders in the later part of life. Students who drink heavily often develop a tolerance to alcohol and are more likely to create dependency. Furthermore, HEI is described as having more

adverse consequences compared to moderate drinking since more risks are very likely to occur during heavy episodic drinking, including unprotected sex, driving a car while intoxicated, and use of violence, which result in the immediate and future effects on persons and societies (Jastremski et al., 2016).

2.2.3.2 Alcohol in Social Gatherings and Celebrations

Alcohol is understandably consumed on such occasions, which is a part of the social and cultural norms in the United Kingdom. Whether people are out to celebrate a wedding, a holiday, a sporting event, or a simple company or family dinner, liquor somehow finds its way into the picture (Hoek et al., 2022). This ubiquity strengthens the tendency that makes drinking a constituent part of socialising; it is thus still difficult not to drink in order not to be judged as an oddity.

A pub is a more significant part of British culture; in this culture, alcohol enables people to be social. There is always the notion that pubs are social places where individuals from all walks of life can socialise and relax. While this cultural practice is beneficial in enhancing cohesion, it perpetuates alcohol consumption, in this case, heavy drinking, as a typical culture, thus validating such a culture (Chopra and Arora, 2020). These include happy hours, drink promotions, and incentives, among others, that supplement the taking of alcohol without necessarily considering the health risks.

In the same way, smoking during national celebrations and sporting events underlines firmly established positions of alcohol in British society. Drinking alcohol is said to be at its highest during the festive season, specifically during New Year, Christmas, and football festivities. In such events, socially acceptable behaviours even dictate that one should consume and overconsume to a large extent (Blaine and Sinha, 2017). Continuing the tradition of using alcohol on celebrations, the people keep pushing it to the status of culture that insists that alcohol is a companion for enjoying and relaxing.

2.2.3.3 The Normalisation of Alcohol as a Coping Mechanism

Another typical cultural reason in the UK is the questionable attitudes toward the direction of ingesting as an approach to meditating stress, anxiousness and uncertainty. Most often, people

use alcohol to deal with unpleasant feelings like grief, loneliness, or frustration. The global population is inclined to use alcohol as a means of relaxation and stress relief by social cues.

The current COVID-19 pandemic offers a clear illustration of how social stressors result in elevated drinking rates. As said earlier, during the COVID-19 outbreak, people witnessed various things they had never experienced before; for example, they were quarantined, many became jobless, and others were worried about their health. To some people, alcohol was easily achieved as a means of dealing with it because supermarket alcohol sales skyrocketed during lockdowns (Chung and Rimal, 2016) (Chung and Rimal, 2016). Several studies show that during this period, a staggering number of people were drinking due to stress, and the consumption level at home was reportedly higher than the pre-pandemic levels.

Such a transition to domestic drinking, especially with the shutdown of pubs as well as social facilities, aggravated the utilisation of alcohol for these purposes. Of the two, drinking in public appeared to have more dangerous consequences, mainly because people consume large quantities or take alcohol alone when they are not under the watchful eyes of other people. The pandemic also raised awareness about how alcohol use disorder presents differently in different populations and worst in vulnerable populations such as low-income households and people with pre-existing mental illnesses (Anuar et al., 2020).

2.2.3.4 Barriers to Addressing Alcohol Misuse

Smear cultural patterns and anti-Islamization practices not only cause alcohol abuse but also hinder its prevention significantly. The first pressure is the pressure of society to drink and especially to drink to the point of intoxication. This perception is against health campaigns that advocate for moderation or even complete alcohol-free consumption since any person is likely not to think they have a drinking issue (Heitzman, J., 2020).

Another factor that comes into play in not seeking help for alcohol misuse is stigma. Considering that most people are now able to purchase alcohol when they feel like it immediately, those who have dependency issues may feel as though they will be stigmatised if they come forward and claim to have a problem (Frank, 2021). This stigma is even worse in occupational contexts, which dictate that low self-employment is a sign of inefficiency or unworthiness.

Moreover, the commercialisation of the compounds of alcohol enhances the levels of barriers. Current advertising and promotion strategies act as publicity campaigns and mask alcohol as a necessity for a successful and fun-filled lifestyle. Alcohol adverts ordinarily deploy meaning that appeals to the youthful population by creating social affiliations to alcohol. Creating such marketing influences the culture that drinking is innocuous and vital and can hardly change overall culture perception (Kahan, 2019).

2.2.3.5 Opportunities for Cultural Change

However, there is still the ability to promote a nonalcohol culture and decrease the level of alcohol acceptance in the UK. Educational and awareness creation about drinking requires that attitudes towards exercise be changed, and this is best done through peer-influenced public health competition. For instance, anti-drinking ads that focus on positive messages like healthy living, productivity, harmonious family times, and so on could balance off the glamour of the drinking culture (Masson et al., 2021).

A cultural change approach is also realised by encouraging other practices that do not involve the use of alcohol anymore. Examples include events that are free from alcohol, such as Dry January, August, or one month in the year that a person can go without touching alcohol. Most importantly, sometimes beverages are low in alcohol percentage, and some do not contain any alcohol at all (Partelow, 2018).

Policymakers must also try to change those norms positively. Interventions such as restricting alcohol advertising and promotion, raising the costs of alcohol, and decreasing its accessibility will, therefore, play a significant role in reducing the normalcy of hazardous consumption and promoting reasonable drinking practices. Limiting alcohol advertising that appeals to youths is among the ways that may assist in preventing the start of the use of alcohol by youths. In contrast, adequate serving and policies in pubs and bars may be helpful for moderation amongst youths (Lackner and Tiniakos, 2019).

It isolated how cultural and social factors applied to the UK drinkers to foster the social acceptability of binge drinking and the helpful use of alcohol. Despite these norms helping to paint increased response and create varied challenges in tackling alcohol misuse, there are these likewise denote a sequence of prospects for intervention. There are options for changing the culture of

British people and making them switch to better, healthier ways of dealing with alcohol with the help of projects, campaigns and policies, and favourable legislation (Pruckner et al., 2019).

2.2.4 Regional-Specific Challenges

Every region has its specific features as regards the prevention and management of alcohol problematic use, which depends on cultural, legal, and density of health care backgrounds. In Europe, for instance, per capita alcohol consumption is one of the highest in the world, and excessive and hazardous drinking practices involve both binge drinking and heavy episodic drinking (Hoek et al., 2022). The prevention of harm resulting from the consumption of alcohol in this area relies more on undertakings such as taxation policies, restriction of advertising and public education.

In Africa, alcohol abuse is associated with parallel markets and the manufacture of illicit brewed gin. These drinks that are usually taken in the rural regions have dormant dangerous health effects because of the increased level of alcohol content and the possible presence of hazardous chemicals. Further, most African countries continue to face challenges of restricted availability of treatment facilities to treat alcohol dependency (Jastremski et al., 2016)

This paper shows the nature of alcoholic beverage consumption in Asia and the differences between countries. For instance, drinking status is moderate in Islamic countries, including Indonesia and Pakistan, where religious constraints, particularly disapproval of the use of alcohol, dominate (Boruah, 2016). On the other hand, Southeast Asian countries and India are witnessing growth in total alcohol consumption caused by increased economic development and the spirit of modernisation. These trends have led to further deterioration of alcohol-related harms; hence, there have been demands to put in place proper regulations and other health promotion activities.

2.2.4.1 Economic Instability and Alcohol Consumption

Most regions show a relationship where economic fluctuations lead to changes in people's drinking habits due to social and financial pressures. Although the nature of economic functioning and alcohol misuse are intertwined, their association is reciprocal in most cases. Thus, increased drinking that becomes regenerative under conditions of deteriorating financial position feeds back to the same financial conditions and back to alcoholism. COVID-19 is a perfect example of how different economic changes affect the levels of alcohol consumption in the UK, and this study can

give insights into alcohol patterns under different periods of instability and upheavals (Chung and Rimal, 2016).

2.2.4.2 Changes in Consumption Patterns During Economic Instability

The COVID-19 pandemic can be considered a special time of change for the economy and society, and drinking alcohol has changed in some ways in the UK. The unprecedented shutdown of pubs, bars, and restaurants due to lockdown became a key reason that reduced the sector's alcohol sales (Heitzman, J., 2020). Nevertheless, it led to a staggering increase of 67% in supermarket alcohol consumption. This shift is probably due to the flexibility of consumer habits and trends, as people shifted to off-trade to continue their drinking occasions due to the closure of social drinking facilities.

Some of the reasons for this trend include increased stress and anxiety resulting from economic insecurity that promoted more drinking at home during a pandemic. There were many cases of people losing their jobs; for those who worked, their incomes decreased drastically, and, as a result, they had to pay many bills (Jernigan et al., 2017). This put much pressure on those affected and caused higher levels of stress and anxiety. In the case of others, handling these difficulties meant that alcohol was within easy reach and easy to consume. The favourable pricing structure of supermarket alcohol and the convenience of purchasing also helped to perpetuate this. In the Times of economic insecurity, people will look for ways to maintain their level of consumption.

Although on-trade drinking is usually considered to be related to social contexts, the change in home consumption has brought new concerns. Consumption of alcohol in solitude erases barriers of precaution that exist in social places where friends and bartenders keep track of one's intake. However, people consuming alcohol at home were predisposed to higher consumption rates and no moderation, thus raising the likelihood of dependence and other adverse effects in the long run (Anuar et al., 2020).

2.2.4.3 Alcohol as a Coping Mechanism During Economic Instability

This is especially so during bad economic times such as recession, layoff, or any financial catastrophe because people drink to help them cope with life's stresses. A financial crisis is a stressful period demanding efficient coping mechanisms, which is why temporary benefits of

alcohol consumption stress relief and mood enhancement can be rather attractive. As a result, it is a counterintuitive process since increased drinking triggers spiralling financial and emotional issues (Heitzman, J., 2020).

A society study reveals that people who face a hard time financially are more likely to abuse alcohol where taking alcohol is culturally accepted. From this analysis, it can be concluded that in the UK, and potentially in other Western countries, the economic impact of COVID has worsened the situation of vulnerable populations with low resources, who are faced with significant financial hardship in addition to the corresponding adversities (Frank, 2021). Alcohol misuse exposed them to more difficulties they would never have encountered while spending beyond their means in the first place, asking for loans, spending more money on alcohol, making destructive decisions, and getting ill, all of which compounded their difficulties, which affected the household income (Lackner and Tiniakos, 2019).

Economic fluctuations also affect drinkers' habits about demographic characteristics. For example, literature clearly shows that while in a financial crisis, men are likely to use alcohol more than women by increasing their total consumption rates. Still, women who more frequently become single parents and have to nurse the children and cook for their husbands may also develop alcoholism to escape from stress. These gender differences, especially brought out by the study, stress the importance of a program that addresses the disparity in the impact of such situations with respective genders and groups (Mason et al., 2014).

2.2.4.4 The Vicious Cycle of Economic Instability and Alcohol Misuse

In the given model, reported alcohol consumption and economic instability are reciprocally linked, where one feeds into the other. As people experience increased financial difficulties, they tend to turn to drinking, and alcohol is destructive of the same by way of the effects that result in reduced productivity, truancy, and the spending of cash in bars, among other regular spending. The use of alcohol by substance dependents leads to job losses, work-related accidents, and poor health, hence the worsening of the economic situation (Heitzman, J., 2020).

The COVID-19 pandemic illustrated this cycle: those who drank more during lockdowns suffered worsening financial and physical health over time. Hoping that their financial statuses eased by the time of the interview, study participants in low-income households indicated that the

costs associated with alcohol consumed in moderation before the pandemic compelled them to seek and become trapped in high-interest loans, pensions and other debt because they lacked the money for necessities. This cycle shows how much is required to solve alcohol-related issues with more significant strategies to decrease the implications of economic fluctuation (Chopra and Arora, 2020).

2.2.4.5 Disparities in the Impact of Economic Instability

Economic instability impacts different groups differently, and these differences are reflected in trends of alcohol misuse. The last one affects the groups who are in financial trouble: unemployment, housing issues, and food insecure people are more likely to initiate drinking. These households also have poor access to treatment as well as support services, which worsens the situation even more (Jernigan et al., 2017).

Spatial variation is also inevitable. Liquor outlets are denser and easily accessible in urban areas, and as such, people are likely to overindulge in alcohol consumption, particularly during an unfavourable employment situation. In contrast, rural markets could present several constraints in subduing the draw of alcohol, such as inadequate or expensive non-alcohol-based social events or treatment centres (Manthey et al., 2021).

2.2.4.5 Addressing Alcohol Misuse During Economic Instability

Failing to do so means that public health strategies intended to reduce the correlation between economic fluctuations and alcohol consumption can be misconceived or ineffective. Strategies may include:

- **Economic Support Measures:** Financial support, such as unemployment benefits and housing assistance, lowers some of the pressures that lead to alcohol consumption during an economic downturn.
- **Public Awareness Campaigns:** It is important to prevent and control increased drinking levels, raise people's awareness of the negative effects of drinking, and encourage them to develop healthier ways of handling stress related to unemployment and poor economic conditions (Lackner and Tiniakos, 2019).

- **Access to Treatment:** Making alcoholic treatment easily accessible and affordable, especially during the crunch times, is essential for dealing with the problem of alcohol misuse (Chung and Rimal, 2016).

This paper revealed that economic stressors significantly influence people's drinking behavior, whereby fiscal and life disruptions encourage more drinking during economic turbulences (Brady, 2017). The COVID-19 pandemic provides a vivid example of how these tendencies evolve within the short term, framed by the exacerbation of imbalanced dependencies, including shifts in people's consumption behavior. Biological-economic dependency between cyclical instability and alcohol consumption can be eliminated only with the participation of several components, including economic support, educational programs, and increased access to treatment. If these causes are tackled, these socioeconomic changes that result in financial instability do not have to affect the incidences of alcohol-related harm negatively.

2.2.5 The Need for Global Collaboration

Control of alcohol abuse remains a complex issue that needs cooperation on an international level of society. In place, global governing bodies like the WHO oversee the execution of various anti-alcoholic drink strategies in all nations. New forms of approaches like the WHO Global Strategy to Reduce the Harmful Use of Alcohol therefore stress research-based measures, education and awareness, and collaboration (Anuar et al., 2020).

However, to achieve these more significant advancements, Sensitive techniques are suitable for the cultural, economic, and social settings of the concerned regions. Policymakers have to appreciate the realities of global trends while adopting global strategies and understand that, in many ways, global strategies, if applied, will not work in dealing with what is causing the abuse of alcohol (Masson et al., 2021).

The global picture of alcohol consumption and its consequences expresses significant variation, greatly influenced by cultural differences, economic situation, and social inequality. While some areas continue to record high incidences of Binge drinking and/or heavy episodic drinking, others are plagued by issues with increased demand for unconstrained markets for alcohol and criminal production of alcohol (Kahan, 2019). More so, low-income earners and indigenous people suffer most from prostate issues, hence the need for the intervention. This paper aims to analyze the global trends in alcohol consumption and provide an overview of the cross-

national differences in alcohol misuse to show that by learning about the international context of the issue, policymakers and public health practitioners can devise more efficient and context-adapted measures for reducing the adverse effects of alcohol consumption (Rhead et al., 2022).

2.2.5.1 Disparities in Alcohol-Related Harm

Alcohol-related harms are not universal within the UK. Indeed, the UK's population can be divided into susceptible and vulnerable groups based on their socioeconomic status, mental health, gender, and geographical location (Pruckner et al., 2019). They identified differences in how patients with alcohol misuse developed different outcomes depending on the above factors as exemplified by the following- Recognising these disparities is crucial to designing effective strategies that will fit the populations in concern that require intervention.

2.2.5.2 Socioeconomic Disparities

The harm caused by alcohol and alcohol consumption risk depends on the social and economic status of people. Low-income consumers are worse hit by alcohol-related issues, not necessarily because they consume more alcohol but because they are in a worse economic position. Unemployment, for example, poverty, and poor access to health services such that they are incapable of mitigating the effects of alcohol use complicates the impact on these groups (Piano, 2017).

It was found that alcohol-related hospital admissions, as well as alcohol-related deaths, are higher in deprived areas than in affluent areas. This epidemiological phenomenon is known as the "alcohol harm paradox," as people with less purchasing power are, in the aggregate, more affected despite lower lifetime consumption of alcohol (Partelow, 2018). Speakers also have more excellent rates of asymptomatic infection, less utilisation of primary care, and increased exposure to stressors, including housing insecurity or food insecurity. The problem arises because the consequences incurred by low-income families through alcohol abuse, including loss of work days, higher healthcare costs, and strained family resources, add to an existing disadvantaged position in a vicious cycle.

2.2.5.3 Mental Health and Social Isolation

Depression and loneliness are the leading determinants of risks associated with alcohol. People who suffer from mental health issues, which can include depression, anxiety, and PTSD, are likely to turn to drinking alcohol, resulting in alcohol dependency (Jernigan et al., 2017). Alcohol use disorder and mental health disorders are often mutually existent, and both make the process of diagnosis and healing more challenging since both conditions usually worsen when the other is present.

Community residents who are elderly, disabled, or those who spend most of their time alone are at greater risk as well. To people with weak or nearly absent social ties, alcohol serves as a way to cope with loneliness or to get rid of any pain, at least for a while. The COVID-19 pandemic aggravated this problem as people stayed at home and self-isolated, trying to limit contact with others, especially older people and people living alone. Lack of social support during these periods increased the possibility of alcohol dependence and its consequences (Mason et al., 2014)

2.2.5.4 Gender Disparities

Some evidence shows that gender plays a role in the specific use and consequences of alcohol. Although men take more significant portions of alcohol than women, the latter are most prone to experience adverse health effects from alcohol use due to physical differences. Females drink alcohol differently from men and will, therefore, have even higher concentrations of alcohol in their blood, putting them at a higher risk of alcohol-related illnesses like liver diseases and some types of cancers (Lackner and Tiniakos, 2019).

The role and purpose of consuming alcohol were revealed with distinct regularity and preferences imposed by the pandemic. Research showed that women increased alcohol use to a greater extent than men during the pandemic, mainly owing to the load of caregiving duties, stress, and lack of social outlets (Hoek et al., 2022). Stress in combining work, family, and caregiving duties puts much pressure on women, and alcohol is the only way out for them when they cannot find any other way to relieve themselves. That trend points to the requirement of further gender-sensitive approaches to stress and alcohol management, especially as it applies to most working women.

2.2.5.5 Geographic Disparities

Telemen location plays a significant role in the incidence and consequence of alcohol-related issues, with urban and rural disparities (Blaine and Sinha, 2017). Alcohol availability and heavy drinkers' cultural practices are cultural norms that offer a stimulus to risky drinking in metropolitan regions due to the accessibility of outlets selling alcoholic products. But drinking tends to be more common in the course of city living, and easy access to alcohol products, which are always readily available, most of the times, makes it hard for people placed in such settings to be able to step back and avoid free-baiting themselves in alcohol consumption (Chung and Rimal, 2016).

On the other hand, rural places experience some challenges to harm from alcohol in the following ways. As much as the rate of heavy drinking may be slightly lower in these areas, the populations in these regions are often denied easy access to health facilities and other helpful organizations for substance dependence. The problem of the absence of specialized treatment facilities and public transport to get there also poses a problem for rural people patronizing these centers, hence perpetuating dependency and harm. Also, they lack structured social opportunities for entertainment that are alcohol-free, and thus, the continued use of alcohol as a focal point in their societies (Hendriks, 2020).

2.2.5.6 Impact of the COVID-19 Pandemic on Disparities

COVID-19 positively catalyzed current variations in following alcohol harm popularities relative to the UK. Women, people experiencing poverty, those with mental health conditions, and households with children were hardest hit by stress and increased uncertainties driven by the pandemic. Increased rates of lockdowns and economic uncertainty increased the likelihood of alcohol dependence in these groups as people drank to cope with loneliness, unemployment, and caregiving responsibilities (Hendriks, 2020).

Another social issue that worsened during the pandemic was geographic inequity. People living in the urban areas consumed more alcohol at home because pubs and bars were closed, and those in the rural areas had poor access to treatment and allied support services. Covid 19 underlined the need to include structural and organizational factors for access to healthcare and support to facilitate the broken promise of non-recovery from alcohol harm (Apostolopoulos et al., 2018).

2.2.5.7 Addressing Disparities in Alcohol-Related Harm

There is a need to understand that strategies to decrease alcohol-related harm in the UK should encompass the necessities of vulnerable groups. Strategies should include:

- **Targeted Interventions:** Programs targeting localised risk factors, such as those targeting women, low-income earners, and elderly citizens.
- **Improving Access to Care:** Geographical imbalance can be mitigated by increasing the coverage of cheap treatment and support services, especially in remote and hard-to-reach areas (Chopra and Arora, 2020).
- **Public Awareness Campaigns:** Stigmatisation of those who have an addiction, particularly concerning alcohol, as well as reducing access to help-seeking behavior, must be addressed through education on the actual risks associated with alcohol addiction so that people suffering can look for help.
- **Policy Measures:** Policies are available that can reduce disparities include alcohol advertising restrictions, minimum beverage container price, and prohibitive density of outlets that sell alcohol. They can effectively address disparities by limiting access to alcohol to risky populations (Hoek et al., 2022).

Distribution of alcohol-related burden reveals inequity in socioeconomic status, mental health, gender, and geographical locations, and therefore, interventions should also be well-planned and equitable. Multiple interventions must be targeted to populations in need to address these disparities, and key barriers to health care and support are dismantled (Jernigan et al., 2017) (Lackner and Tiniakos, 2019). Given the current disparities in terms of access to, treatment for, and risk posed by alcohol, policymakers, and public health experts across the UK can build a better approach to tackling alcohol harm reduction.

2.2.6 The Long-Term Consequences of Alcohol Misuse

Alcohol abuse is one of the globally leading causes of death and morbidity, with effects that are not only limited to a person, their family, organization, or company but to society as a whole. The long-term effects of alcohol are well-documented health-wise, socially, and economically. Alcohol impacts society, affects the economy, and destabilizes society. This section

looks at the post-impact of alcohol abuse, focusing on the health, social, and economic implications of alcohol abuse with special reference to the UK (Masson et al., 2021)

2.2.6.1 Health Consequences

Alcohol dependence is a major, modifiable risk factor associated with significant morbidity and mortality due to diverse acute and chronic diseases. The consequences that have been identified in connection with the use of the substance are liver pathology, cardiovascular disease, and mental disorders (Mason et al., 2014).

Liver Disease: Alcohol-related liver disease, also known as ARLD, is one of the most pervasive and severe effects of alcoholism. Chronic alcoholic pancreatitis, alcoholic hepatitis, cirrhosis, and liver cancer, for instance, are diseases caused by toxic effects derived from alcohol. ARLD is severe in the UK because it contributes to a large percentage of both alcohol-related mortalities and hospitalization among the population. Compared to other big killers, such as cardiovascular disease and cancer, liver disease attacks young people. Therefore, it is an essential health focus (Frank, 2021).

Cardiovascular Issues: Often, people with alcohol use disorders suffer from increased amounts of hypertension, atrial fibrillation, and heart failure. Though regular moderate alcohol consumption tends to have several preventive actions on the cardiovascular system, heavy daily alcohol consumption eliminates all these benefits. It puts the clients at higher risk of developing cardiovascular diseases (Rhead et al., 2022)

Mental Health Disorders: There is a reciprocity between alcohol misuse and mental health status among adults who consume alcohol. Mental health disorders like depression, anxiety, and PTSD become worse by constant alcohol use, and in the same way, ill health prompts the consumer to rely on alcohol (Pruckner et al., 2019). It also causes alcohol dependency in the long term, mainly inducing psychotic disorders, impaired cognitive abilities, and future neurodegenerative diseases.

These health conditions significantly strain the healthcare system because of increased hospitalization, longer treatment duration, and high treatment costs. The National Health Service (NHS) in the UK states that it spends £3.5 billion per year on alcohol-related issues; this is a reflection of capacity being put under pressure (Kahan, 2019).

2.2.6.2 Social Consequences

As far as the social effects of alcohol use are concerned, they are equally as profound and touch families, communities, as well as the overall social fabric of society (Kahan, 2019).

Family Impact: Such people undergo financial stress during treatment, emotional turmoil, and social exclusion in families of alcohol-dependent clients. Stigma erodes the quality of life of patients with alcohol misuse disorders, difficulties in caregiving for a family member with such issues arrive at a financial strain to take care of the relative and also endure emotional strain to deal with such behavior (Manthey et al., 2021). The children within such households are at a high risk of suffering from neglect, abuse, or developmental abnormalities because of the parents' alcoholism. These ACEs are usually passed from one generation to another regarding alcohol use or misuse.

Community Impact: At the community level, alcohol abuse disrupts the social fabric and is a leading cause of crime and disorder. Drinking is associated with violence in numerous crimes, family violence, and criminal violence anger, causing pressures on police, social work, and justice services. Any events that involve alcohol and public drunkenness contribute to a feeling of insecurity and inability to enjoy the living conditions among the population of the neighborhoods in question (Mason et al., 2014).

Moreover, the increase in the cases of heavy drinking in social and cultural contexts prolongs the problem of creating a context in which people can practice moderation and seek recovery. To the communities, alcohol-related harms reduce the levels of well-being of the people and hinder the growth of the economy and society (Piano, 2017)

2.2.6.3 Economic Consequences

The money that amount of alcohol consumed can cost hospitalization, lost working days and services, and crime and social services. In the UK, alcohol-based damage is approximated to hit £27 billion each year, pointing at the broad impact of the problem.

Healthcare Costs: It also bears a significant part of the expenses for healthcare, hence contributing to the costs incurred, such as emergency treatment for injury-related diseases, long-term therapy for chronic diseases, and rehabilitation. Hospitalization due to alcohol-related

conditions, including liver disease and mental health, has since gone high, putting more pressure on the already declining NHS (Partelow, 2018).

Lost Productivity: Substance abuse also hurts an organization through truancy, working while under the influence, and employees losing their jobs because of substance abuse. Employment sectors that involve the utilization of muscular strength or critical positions with a high likelihood of risk highly experience the virus because cognitive impairment arises from alcohol consumption, raising the probability of workplace mishaps (Hoek et al., 2022)

Crime and Social Services: Crime associated with alcohol, including violent property crimes and acts of public nuisance, contributes to many costs to law enforcement agencies, courts, and social welfare (Boruah, 2016). They consist of expenses incurred in policing, trial and arraignment, detention, and even compensation of victims. Also, alcohol consumption increases housing insecurity and homelessness and, thus, causes a need for social support services.

2.2.6.4 Exacerbation During the COVID-19 Pandemic

The COVID-19 pandemic called attention to and exacerbated the lifelong toll of alcohol dependence. Pandemic restrictions resulted in the consumption of alcohol at home, which was primarily alone. This change also resulted not only in rising dependence risks but also in eradicating social and external controls when consuming alcohol in public places (Anuar et al., 2020).

Because of the pandemic, a high-risk group, low-income families, and those with a pre-existing 'mental health' issue were likely to experience an increased incidence of alcohol-related harm. Alcohol care demands and related hospital admissions during the pandemic were burdening the already under-pressure healthcare systems (Apostolopoulos et al., 2018).

2.2.6.5 Strategies for Mitigating Long-Term Consequences

This paper recognizes the fact that prevention and treatment of the end resulting from excessive alcohol intake demands a complex undertaking that takes into account personal, communal, and structural factors. Key strategies include:

- **Public Awareness Campaigns:** This approach will make people understand the dangers of alcohol consumption constantly and encourage them to be moderate when it comes to alcoholic consumption.
- **Policy Interventions:** Therefore, measures like minimum unit price, advertising bans, and regulation of alcohol-selling outlets per population density will help to modify population-level consumption and related harm (Frank, 2021).
- **Integrated Care Models:** The enhanced enrolment in Intensive Outpatient Programs or IOP for both physiological and psychiatric disorders will be positive for all those who have alcohol dependence.
- **Support for Families and Communities:** Education support for families suffering from alcohol problems and prevention and intervention programs at the community level can reduce social costs (Hendriks, 2020).

The effects of alcohol abuse not only at the physical level but at the societal level also cause enormous pressure on society, resulting in tight fiscal circumstances. There are myriad problems in the UK with cultural expectations, economic unpredictability, and structural discriminations, which means these problems need to be addressed with culture-sensitive and empirically informed approaches (Heitzman, J., 2020). When the precursors of abnormal alcohol use and abuse and rational and viable prevention treatment measures are put in place, these future and extended maladies will be prevented, and society will be made healthier and stronger.

2.3 Social and Environmental Triggers of Alcohol Relapse

Social and environmental factors remain critical because they influence individual vulnerabilities to cause alcohol relapse, leading to recidivism behaviors. These factors, such as pressure from peers, societal expectation, and even environmental factors, ensure that the surroundings in which a particular person finds themself make it nearly impossible for them to remain sober (Witkiewitz et al., 2020). The COVID-19 pandemic accentuated the impacts of these issues as isolation and stress intensify such problems; therefore, endeavors demonstrate that special investigations are required, focusing on the environmental and social realities of alcohol consumption. This section looks at the impact of social cues, external stimuli, and stress factors related to the pandemic on the relapse of alcoholism.

2.3.1 Social Triggers of Alcohol Relapse

The main social factors that directly control the level of drinking are social interaction and social relationships. Those in recovery, especially those for alcoholism, will find that APA environments prompt alcohol consumption to entice potentially addictive persons (Partelow, 2018)

Peer Pressure and Social Modelling: Peer pressure is most effective in young people's drinking process since it becomes part of the passage or a culture. Thus, in social-related events like parties, pubs, or students, radical groups can force society to conform to specific behaviors like binge drinking or multiple alcohol consumption (Wing et al., 2018). These behaviors are, therefore, supported by fear of rejection or being judged by other people, and this puts the people in recovery in a challenging position to avoid relapse.

Social reinforcement is another factor whereby people learn by observing people in their society, family, or even celebrities' drinking habits. This is more so in countries where the youth consider it fashionable to drink to their heart's content, especially when binge drinking, as is the case with cultures such as the UK. Drinking alcohol has the pleasure of social normalization: Watching others indulge in booze benders and flawless sobriety can persuade people to drink again, too (Tindall et al., 2016).

Cultural and Societal Norms: The societies' cultures influence people's behaviors, especially regarding alcohol. Integrating origination data into UK origin, alcohol is a constituent feature of the United Kingdom's cultural legacies and representational exercises such as public houses and national festivities (Witkiewitz et al., 2020). Alcohol display is continued and boosted by these norms to keep dependency on those who are in the recovery process. Any encouragement to the drinking culture that is evident in society by advertising alcohol as a stress reliever or something to celebrate reestablishes the use of alcohol in everyday life.

2.3.2 Environmental Triggers of Alcohol Relapse

Location factors include accessibility and prominence of alcohol as essential factors that significantly determine the cases of relapse and recidivistic behaviors. These stimuli, which differ from evident and direct, establish contexts that recognize alcohol use and make it difficult to avoid it (Seitz et al., 2018)

Availability and Accessibility: Easy access to alcohol in and around towns and cities, beer parlors, restaurants, and supermarkets are some of the common factors that trigger a relapse. The multidimensional density in the UK consistently exposes residents in urban areas to drinking opportunities, making it hard for such individuals to avoid them. It indicates that even if a person is behind an earnest desire to stop, the availability of this product can become a formidable barrier to recovery (Partelow, 2018).

Advertising and Media Influence: The promotion of alcohol and other related media conforms to the existing culture that promotes the use of alcohol. Alcohol advertisements promote alcohol as enjoyable, classy, or essential for obtaining success or blending into society. Social advertising even enhances this effect, as specific social media campaigns target specific users without considering their age. For people in recovery, such messages are daily reminders that can cause jonesing and set up (old) patterns (Apostolopoulos et al., 2018)

Contextual Cues: Other self-context factors include place or temporal factors related to places, time of the day, or occasions related to drinking. For instance, going back to the pub that one once frequented or being in social settings that were usual before can lead to recall and urge, and thus relapse. Such cues are intense and very hard to dismiss, pointing to the fact that there is a call for tools that assist people in manipulating their settings successfully (Ritchie and Roser, 2022).

2.3.3 The Role of Isolation and Stress

The COVID-19 pandemic overlays the importance of isolation and stress on triggers for relapse from alcohol abstinence. Amid COVID-19-related lockdowns and restrictions, people have coped with the unusual levels of such psychological states as stress, anxiety, and uncertainty due to the loss of jobs, illness, and loneliness (Brady, 2017). All of these stressors led to the consumption of alcohol by the British people, increasing by 17% of them choosing to drink at home.

- **Isolation and Solitary Drinking:** The reduction of physical contact due to social limitations and the closing of visible places to the general public have reduced other social dimensions of drinking and escalated fluid intake for individualistic consumption. In particular, they identified that for many people, in the background of such population densities, drinking alone as a response to isolation and emotional pain emerged as a new

normative behaviour. However, solitary drinking kills the social factors that may check adherence to most of the drinks, leading to dependency and relapse (Chopra and Arora, 2020).

- **Stress and Coping Mechanisms:** Stress is recognised as a factor promoting the use of alcohol due to the perception among social drinkers that alcohol reduces negative moods. Due to pandemic-related changes in financial sources, increased caregiving, or health anxieties, stress increases maintaining alcohol for some as an outlet (Heitzman, J., 2020). Some issues highlighted by the participants include, due to COVID-19 restrictions, most were out of their peer groups or therapy; hence, the risk of relapse was high.

2.3.4 Implications for Public Health

This paper demonstrates that social and environmental factors and stressors interact with one another as agents of alcohol relapse, hence the need to come up with improved public health interventions. Treatment must consider such cultural and environmental enablers of drinking and disinhibitory of recovery (Mason et al., 2014).

- **Community-Based Interventions:** Another way to avoid social cues is by joining community programs that support displaying alcohol-free social events. Anything that those who experience stress can do instead of turning to alcohol can also help reduce the connection between the two factors (Jernigan et al., 2017).

- **Policy Measures:** There is evidence that it is possible to weaken environmental cues and set favorable norms through policy measures, including banning advertisements of alcohol products, controlling the number of outlets, and using minimum alcohol price control. For instance, Scotland's use of minimum unit pricing has made positive contributions in cutting down alcohol sales and related vices (Jastremski et al., 2016).

- **Support Systems:** It, therefore, requires increasing the availability of support options, including counseling services, peer support, and online platforms, since the social and physical environments continue to pose challenges to such people (Manthey et al., 2021). In general, the skyrocketing popularity of virtual support groups during the pandemic showed that technology could compensate for gaps in care and support for persons in recovery.

External factors maintain significant importance in the relapse of a drunk failure, and their behaviors can prevent social influence, understanding norms, and contextual stimuli. COVID also clearly defined isolation and stress as key motivators for excessive consumption and underlined the relevance of differentiated approaches that take them into account (Pruckner et al., 2019). In turn, more profound approaches illustrate that to prevent alcohol relapse and help people in recovery, public health solutions should enhance their focus on the secondary social environment. Efficient preventive intervention programs require appropriate community and policy initiatives as well as increased support for fundamental systems to counterbalance the long-standing impact of these triggers on individuals who aim at sustainable abstinence.

2.4 Theoretical Frameworks

Alcohol dependency, relapse, and recidivism pose some of the complex research questions that require the use of multiple theories to explain the various interactions between personal, environmental, and social factors. Alcohol misuse: The influence, sustenance, and potential change of behaviours examined using theories from the Social Learning Theory, the Health Belief Model (HBM), and the Ecological Systems Theory. These frameworks offer a strong base for exploring multifaceted social and economic factors and cultural issues underlying the patterning of alcohol-related behaviors and relapse/reoffending (Ventura-Cots et al., 2019)

2.4.1 Social Learning Theory

Social Learning Theory, pioneered by Albert Bandura, is a theoretical structure that guides how an individual learns those behaviours learned through modeling. This theory puts much premium on learning through observation in that behaviour is influenced by observing other people, especially those in one's social/cultural setting (Wing et al., 2018). In the area of alcohol dependency and relapse, Social Learning Theory offers an understanding of the environment, peers, and culture in driving alcoholism/abuse and hindrance to recovery.

2.4.1.1 Observational Learning and Behaviour Acquisition

One of the essential principles of Social Learning Theory is the mechanism of observational learning, in which individuals acquire behaviors through observation. Concerning the use of alcohol, this learning typically emerges during the child or adolescent period (Partelow, 2018). They are likely to emulate someone in the family, and since the role model indulges in excessive drinking, such behavior is justified. Moderate, periodic, and compulsive drinking within

the family or social context corroborates the notion that drinking forms part and parcel of social relations and coping with stress.

Surveys by researchers show that children have unhealthy role modeling when in their homes and living under the watchful eyes of individuals who are addicted to alcohol and are likely to be affected by alcohol in their adulthood. This transfer of drinking habits from one generation to another is mainly due to the indirect identification of parental or caretaker norms through observational learning (Witkiewitz et al., 2020). For instance, when a parent relies on alcohol to complete stress or to celebrate, children are likely going to copy the action in their adulthood.

2.4.1.2 Peer Influence and Reinforcement Mechanisms

Alcohol use and the consequent misuse and abuse are fuelled by peer pressure and mainly Influence young people and other users of this substance. Social Learning Theory explains how peer groups can reinforce drinking behaviors through mechanisms of positive and negative reinforcement:

- **Positive Reinforcement:** In social contexts, drinking may be associated with approval, inclusion, or an augmentation of status. For instance, young people who drink large quantities of alcohol, for example, during parties or other related events, will be complimented or admired by their peers (Ritchie and Roser, 2022).
- **Negative Reinforcement:** On the other hand, those who do not indulge in alcohol may be regarded as dull, treated as outcasts, or pressured to take alcohol. This makes them participate in drinking behaviours regardless of their unwillingness because they consider the worst, which is stigmatization as being boring (Chopra and Arora, 2020).

All these reinforcement mechanisms are especially evident in the developmental stages when people are most vulnerable to pressure from their fellows and desire membership in a group or circle (Jastremski et al., 2016). In university or early working life, in particular, there is often a strong association between youth and the habitual indulgence of alcohol.

2.4.1.3 Cultural Norms and Social Modelling

Ethanol is interlinked with culture and tradition in most societies, including the United Kingdom. The Social Learning Theory provides the framework to investigate how societal

attitudes towards drinking influence conduct. People like to drink at parties, family celebrations, and any lively get-togethers at the office, and such examples take drinking and make it look glamorous and necessary (Ventura-Cots et al., 2019).

The culture of drinking that is seen or expected in many cultures can put people in a line that expects them to be dependent on alcohol as they drink to unwind, socialize, or celebrate. For instance, public houses in the UK associate drinking with social activities, directly providing support to the perception that alcohol is essential for leisure and pleasure (Manthey et al., 2021). When others who have been frequently witnessed exhibit such behaviors, the social norms dictate that such activities as heavy drinking are socially acceptable; thus, if the individual was once in a while thinking of moderating or even avoiding drinking altogether, such thoughts are discouraged by the fact that everyone he sees around him drinks to stupor (Pruckner et al., 2019).

2.4.1.4 Media and Advertising as Social Models

Media and advertising play an essential role in attitudinal change, which is true of attitudes towards alcohol. There are custom-shaped photographs of the use of alcohol where people are portrayed as happy, enjoying their drinks, or as failures who cannot secure a date unless they brawl down some Alcohol (Rhead et al., 2022). People tend to develop such messages because they are built upon wants rather than needs; alcohol is depicted as a way to happiness, self-assertion, or even class.

These messages are constantly being pushed in our faces due to the constant placement of alcohol advertisements on television, social media platforms, and physical billboards. One group of people that stands out as vulnerable to alcohol marketing is the youth because adverts more often associate youthful items such as adventure, friendship, and rebellion. Every time individuals advertise a specific drink; they are conditioned to feel that they must take a drink because it is customary (Hoek et al., 2022).

2.4.1.5 Relapse and Environmental Cues

In the case of persons seeking recovery, Social Learning Theory enlightens how particular social or environmental cues hinder recovery. Drinking contexts like pubs, parties, or family get-togethers are particularly influential cues that may be conducive to the development of craving or

relapse. These haptic cues are frequently bound so tightly because haptic perception forms congruent with past behaviour and affective states (Hoek et al., 2022).

Media and advertising also make this challenge worse because they always remind individuals of the importance of taking alcohol. To a patient in recovery, it is easy to meet an advert that depicts taking alcohol as fashionable or as a stress buster; this will trigger feelings and lead to relapse (Manthey et al., 2021). As such, where peer groups are still involved in activities such as heavy drinking, members develop peer pressure to keep on with those activities and, therefore, disassociate themselves from such harmful undertakings.

2.4.1.6 Implications for Prevention and Intervention

This paper draws from Social Learning Theory recommendations for the creation of effective prevention and intervention measures concerning alcohol dependence or relapse. Key approaches include:

- **Promoting Alternative Behaviours:** Public health interventions and school programs that can discourage the use of alcohol can emphasize positive, healthier activities, such as physical activities, meditation, or art (Brady, 2017). These programs can also help change the societal perception that drinking is the order of the day and forms part of relieving stress.
- **Creating Supportive Environments:** Generally, preventing social modeling requires promoting non-drinking social settings and occasions that give individuals productive things to do without alcohol (Blaine and Sinha, 2017). For instance, dry bars and sober social clubs provide homes for people who look for drink-free spaces for entertainment to fit into.
- **Regulating Advertising:** Another way media works as a social model is that the current permissive policies on alcohol advertisement, especially the ones appealing to young people, are most effectively combated through the imposition of proper regulations. Restrictions in the advertisement billboards or other social media platforms would go a long way toward changing the culture and reducing harmfully influencing messages a person is exposed to (Seitz et al., 2018).

- **Building Peer Support Networks:** Other peer influences in relapse may be fought through support groups and recovery programs that offer appropriate friendship (Partelow, 2018). These networks mean drinkers have a company of individuals expected to change and conform to a sober nation, hence finding a community that will support such change against societal pressure.

The Social Learning Theory emphasizes the importance of social norms, observational learning, and the influence of peers when it comes to alcohol use, thus fully supporting this aspect. This theory enables an assessment of the social and environmental factors that support learning and maintenance of drinking habits and, therefore, relapse (Ritchie and Roser, 2022). This paper established that these influences require prevention and intervention educative programs, environmental support, and regulations to minimize the social cost of alcohol misuse and enhance long-term recovery.

2.4.2 Health Belief Model (HBM)

Specifically, the Health Belief Model (HBM) is apt for explaining why, regarding risk behaviors such as alcohol intake and relapse, a patient might engage or decline to engage in some activity. Originally designed to describe patterns of preventive health behaviors, the Model of the Health Belief System has been very frequently used to describe behaviors related to substance use and addiction (Brady, 2017).

The model identifies several key components that shape behavior:

Perceived Susceptibility: The individual's perception of the probable adverse outcome that is likely to result from alcohol abuse (Seitz et al., 2018). For instance, one can misunderstand his susceptibility to liver diseases or mental health conditions with a lesser desire to cut on alcohol drinking.

Perceived Severity: The magnitude of perceived severity of alcohol-related consequences by the particular individual. Perceived severity of the drunkenness-related consequences may predict willingness to seek help or follow recovery plans because individuals who do not consider the adverse effects of excessive drinking as a problem can hardly plan their treatment (Partelow, 2018).

Perceived Benefits: The perceived benefits of curbing or sustaining total abstinence from alcohol or the specific substance of preference. For instance, a person may have reasons such as personal well-being, better relationship contact, or performing well in his work to change their behavior (Witkiewitz et al., 2020).

Perceived Barriers: The factors that work against the change of behavior. Others may be socially isolated, fear of suffering from withdrawal symptoms, and may lack the necessary support services. Such obstacles influence people and stop them from seeking treatment or following a prescribed regimen (Frank, 2021)

Cues to Action: Any inducement from within the human subject and the environment to alter behaviours. Some include a health scare, encouragement from relatives or friends, or seeing/hearing public health campaigns.

Self-Efficacy: A self-efficiency dealing with the capability to successfully decrease alcohol consumption or to sustain abstinence (Heitzman, J., 2020). One of the main barriers considered is self-efficacy, and people who have low self-efficacy are said to have frequent relapses as much as they feel they cannot handle the various ordeals that come with the process of recovery.

Relative to alcohol abuse, HBM provides insights on change through perceptions of individuals for improved behaviour on the use of alcohol. Promotive strategies and prevention comprise one method of raising populace cognizance of the consequences of hazardous and harmful use of alcohol while at the same time promoting the practice of abstention. Self-efficacy-related programs like interventions focusing on disease management or alleviating perceived barriers, such as accessible treatment and social support, must be employed in recovery procedures (Frank, 2021).

2.4.3 Ecological Systems Theory

The Ecological Systems Theory proposed by Urie Bronfenbrenner will offer a broad approach to analyzing how a person assimilates various community structures and how the structures, in turn, impact the person. Evaluating another, this theory underscores multiple degrees of different contextual factors starting from the micro level of immediate interpersonal relationship up to the macro level of societal culture and institutions and the consequent impact on behavior.

Applying Ecological Systems Theory to alcohol dependency and relapse, intervention is understanding how these multiple-level aspects contribute to drinking conduct or foster situations that either sustain or hinder alcohol abuse (Wing et al., 2018).

2.4.3.1 Nested Systems of Influence

Bronfenbrenner's model identifies five nested systems that interact to shape individual behaviour:

Microsystem: The microsystem is the closest surroundings of an individual, family, friends, and any closer connections (Ventura-Cots et al., 2019). In this regard, family factors and peer management feature significantly in the course of alcohol consumption patterns. For example:

- There are certain attitudes that people are exposed to growing up, and where alcohol is not seen as a problem, then they will likely develop dependence on it.
- Those within the microsystem are closely linked to peer influence and are most pronounced during adolescence and young adulthood. Interactions with peers are essential; for example, teenagers' pressure to practice binge drinking or regular alcohol use puts pressure on risky behaviours.
- On the same note, it can be understood that familial and peer support are the buffering resources that have the potential to prevent alcohol abuse.

The microsystem pointed out how the modeling of behaviors is significant. Some families that take part in ethanol consumption may reinforce similar actions to the children they are caring for and thus encourage alcohol-addictive behaviors. In contrast, on the other end, families that disapprove of alcohol usage minimize circumstances that result in ethanol dependency (Blaine and Sinha, 2017)

Mesosystem: The mesosystem explores the connection between different microsystems, for example, an individual's work environment and home environment. These interactions often influence drinking patterns in complex ways:

- Sources of stressful work environments include high job demands or low job support; those employees who lack adequate family or social support are likely to misuse alcohol.

- This need may be compounded further by conflict between work and home obligations as workers engage in alcohol drinking to cope with stress (Partelow, 2018)
- For example, tension in work and home environments makes a person feel confined and increases alcohol drinking, which relieves the person's emotional stress.

Ecosystem: The indirect system refers to the external systems that impact the person but may not come into contact with them as a client. Key aspects of the ecosystem of alcohol misuse include:

- High alcohol availability or popularity of heavy drinking leads to establishing environmental contexts that promote the use of alcohol and discourage the effective maintenance of abstinence (Mason et al., 2014).
- Policies that are not sensitive to alcohol needs, including organizational norms that condone alcohol use, for instance, during organizational functions and that do not address alcohol problems, implicitly promote alcohol consumption.
- This campaign brings out the message in adverts and the social influence of the community towards drinking and the influence of alcohol. Drinking in the media provides support for alcohol consumption and, at times, encourages increased use (Lackner and Tiniakos, 2019)

The ecosystem shows how structural and environmental factors cause alcohol-related behaviours, hence requiring multifaceted interventions.

Macrosystem: The macrosystem can be described as the broader societal and cultural environment that defines the rules of law, economic status, and societal culture. In the UK, people have adopted a culture of drinking alcohol as they engage in other activities. As a result, many people misuse the substance (Jastremski et al., 2016). Key components of the macrosystem include:

- Cultural meanings associated with drinking, such as fun, leisure, or camaraderie, typically obscure the uncommunicative advice about moderation.
- Any socioeconomic factors like income disparity, instabilities at the workplace, or life in general push individuals to the barrel because stress results in the misuse of alcohol.

It can be argued that, for example, minimum unit pricing or advertising limitations are attempts to regulate cultural values that imply the propensity to use alcohol (Jastremski et al., 2016).

Chronosystem: The chronosystem contains the dimension of time; it involves changes in life course, historical period, and social period. For example, the COVID-19 pandemic represents a chronosystemic influence that reshaped social behaviours, increased stress, and altered alcohol consumption patterns:

- Due to forced isolation and actual isolation as a result of restrictive measures such as lockdowns and social distancing, at-home drinking increased.
- This now-and-again study of alcohol consumption profiles and time-sensitive factors creating dependency-based conclaves in the course of the pandemic synergized with pervasive systems shaping vulnerable populations.

2.4.3.2 Implications for Intervention

As highlighted by Ecological Systems Theory, there are complex multiple layers that require intervention as regards alcohol dependency and relapse (Heitzman, J., 2020). Effective interventions must go beyond individual-level strategies to encompass family support, community programs, and policy measures:

Family and Peer Support: Alcohol misuse can be prevented by enhancement of the family system and encouragement of positive peer influence as the assets that can help anybody who is at high risk. For example, more favorable conditions for changing drinking behaviors may be provided in family therapy and peer support groups (Ventura-Cots et al., 2019)

Community-Based Interventions: These environmental-related factors should be discouraged through community activities such as not granting outlets for alcohol sales and recommending non-alcoholic celebrations.

Policy Measures: Measures that deny access to alcohol hike the price, and control beer promotion will help develop a protective social environment against alcohol misuse. For instance, Minimum Unit Pricing on alcohol has been effective in decreasing alcohol intake and the resultant harm in Scotland (Witkiewitz et al., 2020)

2.4.4 Integrating Theoretical Frameworks

From the paper, it emerges that a clear understanding of alcohol dependency and consequent relapse entails a multidimensional consideration of theoretical frameworks at the individual, interpersonal, and systemic levels (Tindall et al., 2016). Applying Social Learning Theory in conjunction with the Health Belief Model (HBM) and the Ecological Systems Theory, this study provides a comprehensive cross-systems view of the factors influencing alcohol misuse. These theories are each applied to a different aspect of behaviour; all point to the fact that alcohol-related harm prevention and recovery require multi-component actions.

2.4.4.1 Social Learning Theory: Behavioural Influence Through Social Modelling

According to Social Learning Theory, observation and imitation are held in high esteem, while modelling is also important in influencing behaviour. The theory denotes how people imbibe and endorse drinking practices from their friends, relatives, and other influential personalities promoted in media. The theory also points to the need to address the social context and cultural practices that predispose people to alcohol use (Witkiewitz et al., 2020).

For example, students in colleges or universities where alcohol is consumed frequently are likely to follow the same course because of group pressure or want to belong (Blaine and Sinha, 2017). In a like manner, any glamorous movies and series that promote the drinking culture continue to dictate to society that the act is normal, alluring, intelligent, or even a means of handling stress.

- The integration of Social Learning Theory in this study underscores the need to:
- Disrupt Social Norms: Through engaging Fields, publicity can disrupt drinking patterns by putting forward different activities and negative consequences of alcohol bingeing.
- Leverage Positive Role Models: For example, community programs will involve people who have quit alcoholism or changed their harmful coping mechanisms to positive ones that others can look up to.

2.4.4.2 Health Belief Model: Perceptions and Decision-Making Processes

Explaining why and when people engage in or avoid specific behaviours, the HBM considers personal factors such as perceived susceptibility and severity of the health threat, as well

as perceived benefits and barriers to abstinence, moderate and excessive drinking, and relapse. This theory gives information concerning cognitive psychology involved in the change process and decisions, stressing self-efficacy and perceived vulnerability (Brady, 2017).

Components of self-efficiency, perceived severity, and perceived susceptibility to negative consequences of alcohol use make HBM particularly useful in explaining continued risky drinking behaviours despite perceived negative consequences (Heitzman, J., 2020). For example:

People who do not feel threatened by the symptoms of alcoholism or chronic diseases related to alcoholism, including liver disease or mental health problems, may not be very much inclined to cut down on alcohol.

On the other hand, if the patient has a belief that it will be tough for them to seek help due to stigma and or lack of access to treatment, then such a patient is likely to delay or even never seek help of any kind (Ventura-Cots et al., 2019).

Integrating the HBM into this study highlights the need for interventions that:

- **Enhance Awareness:** Alcohol misuse prevention education can bring perceptions of susceptibility and severity closer to home and make the picture more transparent.
- **Build Self-Efficacy:** Support programs that can increase confidence in personal ability to deal with stress and find appropriate resources to help sustain sobriety will be helpful.
- **Address Barriers:** The ideas are to decrease stigma and increase the availability of cheap treatment methods, making it easier for patients to ask for help from doctors.

2.4.4.3 Ecological Systems Theory: Multi-Level Contextual Influences

Ecological Systems Theory adds to the discussion by including the social, cultural, and even physical environment's interactive role in acted-out behaviours. This theory also focuses on alcohol dependency and relapse and the role of a range of nested contexts, from interpersonal to societal (Seitz et al., 2018).

The inclusion of Ecological Systems Theory in this study highlights the importance of addressing systemic factors that contribute to alcohol misuse, such as:

- **Community Norms and Availability:** Prohibiting the density of outlets selling alcohol, restricting banner advertisements and alcohol trademarks, and hiking the prices of alcohol help eradicate bad signals and set the right community model.
- **Family and Social Support:** Some consequences of childhood oral health disparities are family-centred alterations that offer social support systems to counterbalance negative social contexts (Frank, 2021).
- **Societal Stressors:** Eliminating the causes of general economic and social problems, such as unemployment or unstable housing, can minimize problems that force people to consume alcohol (Partelow, 2018)

2.4.4.4 Synergy Across Theories

Integrating these three theoretical frameworks provides a comprehensive lens to analyse the factors contributing to alcohol dependency and relapse:

- The social learning theory is distinctive in that it stresses the concept of social modelling and references to peers and concentrates on the environment nearest to them (Manthey et al., 2021).
- The health belief model considers perception and psychological factors and focuses on self-efficacy and decision-making.
- Ecological Systems Theory looks at macrosystems and ecosystems, that is, larger systems beyond the family, such as communities and policies.

These theories underscore the importance of the broad-reaching effort since effort entails theoretical and practical approaches to changing individual behaviour and practice and fostering new normalized behaviours and practices (Jernigan et al., 2017). For example:

Public Health Campaigns: These can be perceptive since they can enhance an individual's perception of risk and benefit while working on the economy of available strategies for a Dry Season festival that does not encourage high-risk drinking among learners.

Community-Based Programs: Alcohol-free friendly occasions or self-help groups are some social programs that can significantly reduce cultural expectancy rebound.

Policy Interventions: Population norms, such as minimum unit price or limitations on alcohol advertising, can create general social environments that avoid binge drinking.

2.4.4.5 Evidence-Based Recommendations

The integration of these theoretical frameworks enables the development of evidence-based strategies for reducing alcohol-related harm:

- Individual-Level Interventions: Targeted programs geared at self-efficacy, awareness, and behaviour change.
- Social and Community Interventions: These are campaigns that create and encourage more health-oriented norms, help connect people with their peers in need, and desensitize people to engage in help.
- Systemic and Policy Measures: Policy measures that modify the ability to access alcohol, raise taxes, and implement and enforce stringent advertisement and marketing mechanisms to deal with environmental cues (Nyakutsikwa et al., 2021).

In this paper, the features of alcohol dependency and relapse are considered in the adopted framework of social learning theory, health belief model, and ecological systems theory, which form an integrated perspective on the problem. While all six of these frameworks focus on the transactions between and among client, social, and environmental systems, collectively, they emphasize the complexity of interventions (Rhead et al., 2022). Practical-popular interventions consistent with these theories may help eliminate alcohol-related societal issues and encourage lifelong sobriety. This approach to the intervention guarantees it is not only evidence-based but also client-oriented, given the diverse and interrelated causes of alcohol consumption.

2.5 Alcohol Misuse and Mental Health

Alcohol dependency and mental illnesses are interrelated with cross-sectional interaction that worsens both conditions. Self-medication is one of the modern views of alcohol dependency; the majority of patients with alcohol dependency have a history of depression, anxiety, PTSD, and other mental health issues brought about by alcohol misuse (Hendriks, 2020). This makes the two conditions reciprocally related in that mental health conditions raise the risk of alcohol dependency, while the chronic use of alcohol worsens mental health. This review of the

relationship between these disorders necessitates a better understanding of the interactions to treat patients suffering from these conditions (Hoek et al., 2022).

2.5.1 Alcohol as a Maladaptive Coping Strategy

The relationship between alcohol misuse and mental health problems is most easily seen in how alcohol is used to help manage stressful situations. To reduce adverse psychological states like sadness, anxiety, fear, or guilt, people who have psychological problems drink alcohol because it offers them temporary relief. But this relief is temporary; depression's symptoms are aggravated by consistent alcohol intake that not only generates a vicious dependency cycle but also a worsening of mental health (Heitzman, J., 2020).

2.5.1.1 The Appeal of Alcohol as a Coping Mechanism

These central nervous system actions power alcohol's attraction as a short-term coping mechanism. It is a depressant, which decreases the functionality of the human brain and weakens the ability to feel emotions, though, in the process, they achieve a kind of tranquil state. To people who are struggling to deal with too much stress, loss, or trauma, this is a seemingly adequate and, most of all, fast fix (Jernigan et al., 2017).

- **Emotional Numbing:** The primary reasons people consume alcohol include suppressing the feeling of painful feelings. For instance, a grieving person who has lost a loved one may decide to take alcohol to suppress the sorrow or hopelessness.
- **Social Facilitation:** In social situations, alcohol is viewed as a means of decreasing stress or increasing self-esteem for people suffering from social phobias or having low self-esteem (Nyakutsikwa et al., 2021). (Nyakutsikwa et al., 2021)
- **Stress Relief:** Stress is a normal part of human life, and people consume alcohol to deal with everything from a stressful job to a conflict with a partner. It becomes intolerable when the said behaviour becomes a habitual mode of reacting to stress.

Alcohol may provide some consolation in the short term, but it does not get to the source of mental unhappiness. Instead, it tends to worsen other problems, leading to a vicious cycle where the subject depends on alcohol even more (Nyakutsikwa et al., 2021).

2.5.1.2 The Cycle of Self-Medication

The self-medication hypothesis means that people take substances, including alcohol, to relieve some signs of specific mental health issues while causing worsening of the problems at the same time. A study has revealed that clients with depression, anxiety, or PTSD are more prone to alcohol abuse for coping purposes (Heitzman, J., 2020).

Depression: Many people buy alcohol because of its calming impact, and when you are depressed, for instance, you may get some remission from the feelings of sadness or hopelessness. However, alcohol, as you know, is a depressant, and prolonged use of alcohol distorts neurotransmitter systems, leading to a worsening of mood disorders. They are middle-aged and depressed, and it is one's cycle where one drinks to fade the feeling of sadness and ends up worsening the depression (Frank, 2021).

Anxiety: Persons with anxiety disorders can find moments after consuming alcohol as a way of alleviating the anxiety or fear. But as with most drugs, tolerance develops over time, meaning that to get the same level of stimulation, a larger quantity of alcohol is required. This typically results in dependence, withdrawal symptoms, and rebound, whereby anxiety is worse during the period of abstinence (Chopra and Arora, 2020).

PTSD: People with PTSD often self-medicate with alcohol in their attempt to control specific symptoms such as intrusive thoughts, disturbing dreams, or increased emotional response. Such tension is reduced by alcohol temporarily due to the way that alcohol alters the brain's stress response itself, leading to increased mood swings and sleeplessness (Pruckner et al., 2019). This not only aggravates the PTSD symptom but also formally undermines the opportunities for the individual to participate in practical therapeutic approaches.

2.5.1.3 Long-Term Consequences of Alcohol as a Coping Mechanism

Self-prescribing involving the use of alcohol as a rehabilitation tool has tremendous long-lasting effects on the affected individual's mind and body. Psychological distress and alcohol misuse seem to feed off of one another, making it almost impossible to disentangle the two.

Physical Health Risks: Alcohol consumption over a long time can cause multiple health complications, from liver diseases and cardiovascular diseases to neurological disorders. Stress is also exacerbated due to these conditions, and overall well-being decreases to add to existing mental ill-health issues (Partelow, 2018).

Cognitive Impairments: Moderate use of the drug leads to complications such as difficulty in making decisions, memory loss, and mood disorders. These impairments prevent the individual from being able to directly work through the issues that cause their disturbance and grow past unhealthy behaviour patterns (Nyakutsikwa et al., 2021).

Barriers to Treatment: These clients encounter significant hurdles on their way to seeking help, especially if they are problematic drinkers who use alcohol to address psychological symptoms. Social prejudice common with both mental illnesses and substance use disorders creates a barrier to seeking help due to shame (Hendriks, 2020). At the same time, the cognitive changes that accompany alcohol dependence may be unfavourable for effective psychotherapy.

2.5.1.4 Gender and Demographic Considerations

Depression self-medication by alcohol use depends on their age and sex and the proportion of clients in different economic statuses. For instance:

Gender Differences: Stress by outside factors like work pressure for men and marital issues or emotional crises for women are typical causes for men to consume alcohol while women turn to drinks. Women also have heavier health repercussions from alcohol misuse because of various physiological factors, for instance, reporting smaller water content and the slowest rate of alcohol metabolism (Hendriks, 2020).

Socioeconomic Factors: This is due to financial pressures, housing, or health insecurity, all affecting persons from low socioeconomic status (Frank, 2021). These stressors make the use of alcohol to cope with the stress a relay that keeps the cycle of poverty and poor health afloat.

Youth and Adolescents: People under the age of 18 who turn to alcohol to deal with academic or social stress are more likely to become dependent in the long term. If an adult uses alcohol to deal with stress, the child's brain may become accustomed to using alcohol in the same way. Therefore, it hinders the emotional maturity of the brain (Lackner and Tiniakos, 2019).

2.5.1.5 Breaking the Cycle: Implications for Intervention

Interventions that can help to put an end to the pathological use of alcohol can be divided into two categories: interventions that target the factors that trigger the psychological condition of the user leading to pathological use of alcohol, and interventions that target behaviours associated

with pathological use of alcohol including the actual consumption of alcohol. Key strategies include:

- **Cognitive-Behavioural Therapy (CBT):** CBT makes a client aware of negative cognitions and transforms them to substitute alcohol dependency with an effective adaptive coping strategy like exercise, support, or mindfulness (Lackner and Tiniakos, 2019).
- **Integrated Treatment Models:** Dual-diagnosis treatment programs where the patient is treated for both mental illness and the use of alcohol to self-treat are extremely important for patients who self-medicate using alcohol.
- **Support Networks:** Another advantage familiar with many OA groups includes peer support and fellowship derived from participation in such organizations as Alcoholics Anonymous (AA).
- **Public Awareness Campaigns:** To help people stop relying on alcohol, perceived as a negative coping mechanism, one should inform the person about the adverse effects of self-medication and introduce them to mental health help (Frank, 2021).

Alcohol as a coping mechanism may relieve psychological distress, although the beneficial effect it offers prolongs or worsens the circumstances causing such stress. This cycle is very problematic and reinforces self-medication as something that presents a significant challenge for real change and recovery and may require mental health treatment along with alcohol use treatment approaches (Seitz et al., 2018). For this reason, public health approaches should enable raising awareness, promoting the use of healthier ways of dealing with stress, and bolstering access to comprehensive treatment solutions for these clients that will help them leave this vicious cycle and find real recovery (Tindall et al., 2016)

2.5.2 Neurobiological Impact of Chronic Alcohol Use

Alcohol is very disastrous in its effect to very poor health of brain of people which causes mental health problems associated with their chronic drinking. These neurobiological alterations are of fundamental importance in this dependency process and have implications on the context of affective at regulation and other neuropsychiatric syndromes. Understanding the mechanisms for the brain in chronic alcohol use is important to develop required therapeutic strategies for maintaining abstinence (Wing et al., 2018).

2.5.2.1 Effects on Neurotransmitter Systems

The only neurotransmitter systems known to be impacted by alcohol are those for GABA (inhibitory systems), dopamine (reward motivational systems), and glutamate (learning and memory systems).

GABA and Glutamate Dysregulation: We uncovered that GABA was the major inhibitory transmitter to silence neuronal activity and reduce anxiety. Alcohol strengthens the activity of GABA, which gives people a relaxing influence that is seen as a temporary avoidance of stress or emotions they may not like. Alcohol also reduces GABA, the receptor of the brain's principal inhibitory neurotransmitter. This, in conjunction with the ability of alcohol to decrease levels of glutamate, the brain's primary excitatory neurotransmitter, produces feelings of euphoria or disinhibition (Partelow, 2018).

In cases of chronic alcohol use, the brain makes alterations concerning the disturbed balance. It brings it to a state where GABA receptors are less sensitive and increases Glutamate activity (Witkiewitz et al., 2020). It does this to produce hyperexcitability of neurons during the withdrawal phase of alcohol dependence to manifest symptoms such as anxiety, restlessness, and irritability, depending on the rate of onset of ethanol. In extremes, this hyper-excitability can lead to withdrawal seizures or delirium tremens (DTs), the existence of which confirms the neurobiological dependency consequence.

Dopamine System Alterations: Alcohol interferes with additional brain structures that influence the brain's reward system, including the prefrontal cortex. Eating and drinking alcohol boost dopamine levels in the neurons of brain rewarding circuits, especially in the rewarding centre called the nucleus accumbent, the same way the reward of food does. However, consequent alcohol consumption produces fewer dopamine receptors and less dopamine-producing, creating a lower reward sensitivity level (Tindall et al., 2016). This may lead to anhedonia (reduced intensity of pleasure) and has the client continuing to drink to regain previous rewarding experiences.

2.5.2.2 Structural Damage to Key Brain Regions

Excessive alcohol consumption results in multiple cerebral structural alterations affecting cognitive and affective control and decision-making ability.

Prefrontal Cortex Dysfunction: Neurotransmitters from the prefrontal cortex, the part that is associated with decision-making, impulse control, and planning, go haywire with chronic alcohol consumption. Chronic alcohol consumption is thought to shrink and impair the function of this part of the brain, meaning that a person is less able to stave off cravings, control his emotions, or plan and carry out tasks (Ritchie and Roser, 2022). Damage to what is known as the prefrontal cortex results in cases of relapse since those affected are unable to embrace abstinence or even make logical choices about drinking.

Hippocampal Atrophy: When alcohol users continue for a long time, they are likely to see their hippocampal shrink since the hippocampus is a brain structure associated with memory and emotional regulation. This atrophy is in part blamed for memory loss, inability to consolidate new information, and also mood disorders, including anxiety and depression. Injury to the hippocampus also impairs the brain's ability to handle trauma, which, along with other illnesses such as post-traumatic stress disorder (PTSD), is worsened (Brady, 2017).

Cerebellar Damage: Another area impacted by the chronic utilization of alcohol is the cerebellum, which is involved in motor coordination as well as other cognitive activities. The main academic outcome of cerebellar damage is ataxia, which involves problems with balance and coordination, handwriting, attention, and approach to problem-solving (Heitzman, J., 2020).

2.5.2.3 Neurotoxic Effects and Mental Health

Alcohol and chronic neurotoxicity interact to produce behavioural and mood disturbances that collectively coexist with alcohol dependency and mental diseases.

Anxiety and Depression: Alcohol abuse affects the brain's reward system, which results in a higher prevalence of anxiety and depression in people. Neural changes in the prefrontal cortex and hippocampus and brain chemical disturbances are the primary causes of painful emotions such as sadness, worry, or hopelessness (Ritchie and Roser, 2022). These conditions compel people to keep on consuming alcohol with a view of alleviating their suffering or symptoms –a vicious cycle –that is unbreakable.

Alcohol-Induced Psychosis: All sorts of degradation can also be attributed to long-term alcohol consumption. Alcohol-induced psychosis is one of the severe effects of chronic alcoholic consumption, as it causes hallucinations, delusional thinking, and thought disorders. This symptom

is usually revealed during the process of alcohol withdrawal or within several weeks following alcohol cessation, and it evidences the inhibitory effect of this compound on brain activity.

Cognitive Decline: The effects of alcohol on the brain are that regular abusive use of alcohol leads to the early onset of dementia and other diseases affecting the brain. A Korsakov psychosis, due to alcohol-related thiamine deficiency, is characterized by severe amnesia, confusion, and motor disturbances (Witkiewitz et al., 2020).

2.5.2.4 Challenges in Recovery

One issue that spurs complexity in recovery is the effects of chronic alcohol that bring about an alteration in the brain. Finally, withdrawal symptoms may include high irritability, mood swings, insomnia, etc, which may lead to relapse depending on the severity of withdrawal symptoms (Apostolopoulos et al., 2018). Further, other chronic conditions affecting the brain since they are chronic make management challenging since the client is unable to remember or plan appropriately for sessions, has poor judgment, and may not control emotions well enough for the session.

Neurobiological alterations also influence the probability of long-term recovery because they uphold cravings and persistency in entry behaviours. They also note that years of abstinence make people highly sensitive to the environmental stimuli related to alcohol, and this puts them at high risk of relapse.

2.5.2.5 Implications for Treatment

Understanding the neurobiological impact of chronic alcohol use has important implications for treatment and recovery:

- **Pharmacological Interventions:** Drugs like naltrexone, acamprosate, and disulfiram work directly on the brain's craving and decrease relapse chances by affecting some neurological pathways or chemical messengers.
- **Cognitive Rehabilitation:** Therapeutic programs that pertain to cognitive rehabilitation can assist a person in regaining executive control functions and/or enhance decision-making and emotional regulation (Heitzman, J., 2020).

- **Integrated Care Models:** The purely symptomatic pharmacological treatments are supplemented with such psychosocial interventions as behavioural therapy, namely CBT, which targets neurobiological as well as mental aspects of dependency.
- **Holistic Approaches:** This paper supports nutrition intervention, exercise, and mindfulness, as these elements help increase neuroplasticity and allow the brain to recuperate.

This work shows that heavy alcohol consumption alters the brain's neurotransmitter systems, impairs brain areas, and, worse, different psychiatric disorders. Such neurobiological adaptations present formidable obstacles to recovery; this means that multifaceted and combined treatment is the way to go (Tindall et al., 2016). Through intervention on the neurological basis of alcohol dependency, the approaches to facilitating the post-recovery process in cases of alcohol dependence can be viewed as more effective.

2.5.3 Bidirectional Relationship Between Alcohol and Mental Health

The presence of an association between Alcoholism and MHDs (Mental Health Disorders) results from the two conditions being reciprocal, where one acts as a risk factor for the other and is influenced by the other. These cycles create challenges to treatment and recovery because to address one of the disorders; one has to manage the other at the same time. This is a critical concept to grasp when trying to develop the proper interventions that will help end this cycle and assist people who have a disorder with alcohol dependency on one hand and a mental health disorder on the other (Ritchie and Roser, 2022).

2.5.3.1 Alcohol Misuse as a Cause of Mental Health Disorders

Alcohol is a neurotoxin that triggers significant changes in the brain that can lead to mental ailments. Excessive drinking affects the primary neurotransmitters involved in mood regulation and responses to stress, including GABA-an incised and glutamate serotonin release (Witkiewitz et al., 2020). These changes can lead to conditions such as:

Depression: Depression and alcohol – the molecule that depresses the activity of the CNS can worsen the degree of sadness, hopelessness, and fatigue, leading to an elevated risk of depressive disorders in the long run (Wing et al., 2018). Alcohol also loosens the mechanism of

reward in the brain related to serotonin, which is associated with moods for short-term use. At the same time, long-term affect the serotonin production of the brain.

Anxiety Disorders: Alcohol dependence weakens the constitution of one's stress response system and raises stress and anxiety levels. This may result in the formation of anxiety disorders as the body is not able to generate stress, hence the need to hire professionals to help do so (Hendriks, 2020)

Post-Traumatic Stress Disorder (PTSD): PTSD leads to the development of a range of symptoms, including disturbing memories and mood swings, and alcohol increases the risk further as the brain is not able to regulate emotions well.

2.5.3.2 Mental Health Disorders as a Cause of Alcohol Misuse

On the other hand, mental health conditions make people use alcohol as a way of treating their mental illness. To individuals with depression, anxiety, or PTSD, alcohol solves problems by suppressing negative feelings, inducing relaxation, or reducing intrusive thoughts. This may be temporary, and it always serves to strengthen the dependence because a person is taught to seek solace in alcohol during times of emotional distress (Jastremski et al., 2016)

- **Depression:** People with depression can consume alcohol to cover up hopelessness or loneliness. However, alcohol has a depressing effect on the depressant, and most patients experience aggravated symptoms when under the influence of alcohol (Hoek et al., 2022).
- **Anxiety Disorders:** People diagnosed with anxiety disorders rely on alcohol to relax or to manage anxiety or panicky feelings in social or stressful situations. With time, tolerance develops, and withdrawal signs, including increased levels of anxiety, ensure a needy position (Heitzman, J., 2020).
- **PTSD:** An alcohol people with PTSD use to control the traumatic cognates and or emotional response. This is not healthy in recovery from trauma and makes PTSD worse by exacerbating symptoms that include anger and sleeplessness.

2.5.3.3 Breaking the Cycle

It can be concluded that dependence on alcohol and new cases of mental health disorders is interdependent; therefore, it is necessary to treat such diseases under a single plan. Key strategies include:

- **Dual-Diagnosis Programs:** Combined mental illness and substance use dual diagnosis management is comprehensive and promotes a reduced risk of relapse from standard treatment (Brady, 2017).
- **Psychotherapy:** CBT or TF-CBT is among the effective therapies that must be embraced due to the ability of the patients to model new coping strategies that will enhance their willingness to abstain from alcohol consumption and the development of reasonable mental health issues.
- **Medication-Assisted Treatment (MAT):** Medication therapies like anti-anxiety or anti-depressant drugs will help to go a long way in rebalancing mental health with a simultaneous decrease in alcohol intake (Ritchie and Roser, 2022).
- **Support Networks:** Support from peers and family needs to play a role in breaking the cycle. They are proven to provide essential emotional and practical support, which helps individuals build up a recovery mechanism (Lackner and Tiniakos, 2019).

The cross-sectional influence between alcohol dependence and mental health disorders forms a vicious cycle that is often tricky in its management. Failure to consider this interplay makes it challenging to realize interventions that address the phenomena adequately. A combined treatment for the two disorders and enhanced patient care will ensure that persons with the condition have a better chance of fully recovering and maintaining a healthy mind (Mason et al., 2014).

2.5.4 The Role of Stress and Trauma

Stress and trauma play the role of the main precursors of the presence of alcohol dependence and mental illnesses. Specifically, acute and chronic stressors and also traumas affect the person's susceptibility to alcohol dependence and psychological disorders. The effects of alcohol can temporarily relieve one of the emotional responsibilities of stress that results from PTSD, not to mention trauma, but consuming alcohol leads to the worsening of other mental and physical health attributes, which creates a vicious cycle of dependency (Chopra and Arora, 2020).

2.5.4.1 Stress as a Driver of Alcohol Misuse

Stressful life events are known to precede alcohol misuse; examples include losing a job, financial problems, and breaking up with a partner. The additional benefit of dulling emotions makes alcohol a temporary balm that decreases anxiety and dulls emotional hurt. However, this coping mechanism always leads to dependency because people turn to alcohol to deal with their stress (Brady, 2017).

Acute Stress: During periods of high levels of stress, like the loss of a close family member or any other crisis, alcohol is taken to help overcome the overwhelming feelings. However, subsequent use of alcohol in similar situations can create a dependence mechanism.

Chronic Stress: Chronic use of stressors like the usual working conditions or financial troubles increases the probability of alcohol dependency. Chronic stress alters homeostasis, specifically the HPA axis, causing an increase in vulnerability to both alcohol dependence and mental health disorders. People who are stressed constantly are likely to have their brains encourage them to drink to reduce stress (Blaine and Sinha, 2017)

2.5.4.2 Trauma and Its Long-Term Impacts

Childhood trauma has been tentatively classified as an independent risk factor for developing AUD and other mental health disorders. Childhood stress, such as bumps, pinch, turns, locks, or filters, sexual or emotional abuse, neglect, and witnessing domestic violence harm the development of the brain as well as the mind (Frank, 2021)

- **Neurobiological Effects:** Trauma patients self-medicate to prevent re-experiencing symptoms such as intrusive thoughts and hyperarousal or treat emotional blunting related to PTSD (Brady, 2017). Self-medicating in this manner not only maintains dependency but, at the same time, results in an exacerbation of trauma symptoms; therefore, it forms a vicious cycle.
- **Behavioural Patterns:** R, drug for PTSD. People consume alcohol to avoid memories, lessen hyperarousal, or decrease emotional dimming. Self-medicating in this manner not only maintains dependency but, at the same time, results in an exacerbation of trauma symptoms; therefore, it forms a vicious cycle (Manthey et al., 2021)

2.5.4.3 The COVID-19 Pandemic and Its Impacts

A link between stress, trauma, and alcohol misuse: COVID-19 as an example. During the pandemic, people were either isolated, anxious, or experienced some economic insecurity, which is additional on top of their mental health problems or traumatic past experiences (Mason et al., 2014).

Increased Alcohol Consumption: Research suggests a substantial increase in alcohol consumption during the pandemic, although people drink alcohol to manage their mental stress during the pandemic (Manthey et al., 2021). Alcohol consumption in the drink-size categories raised significantly throughout the lockdown stay-at-home periods, especially in the UK, an indication of the pal strategy of using alcohol as a solution to stress occasioned by the Covid-19 pandemic.

Exacerbation of Trauma: For many, the pandemic also reopened past traumatic experiences due to grief, illness, or abuse they had never properly dealt with before. Additionally, these problems were worsened by the fact that seeking services from a shrink was out of the question, making alcohol the only option to deal with problems (Rhead et al., 2022).

2.5.4.4 Implications for Intervention

The relationships between stress, trauma, and alcohol dependence explain why more profound clinical treatment merges personal and social kinds of psychiatric disorders. Key strategies include:

- **Trauma-Informed Care:** Mental health and addiction services should provide trauma-informed care, meaning that workers within these fields should acknowledge the fact that previous episodes inform the present behaviour of trauma (Pruckner et al., 2019). This includes providing contexts in which individuals feel enabled to respond to what is happening to them.
- **Stress Management Programs:** Stress management is one way that people can be assisted to avoid alcohol: Through the suggestion of practicing exercises like mindfulness or even engaging in CBT.

- **Social Support Networks:** These networks may involve individuals using mental health services in active peer support activities and groups and help them connect to community resources when a crisis arises (Partelow, 2018)

It was strongly evidenced that stress and trauma trigger alcohol dependency and disorders of mental health. The source also shows how, although for a short time, alcohol appears to help the burden of stress or loyalty to traumatic memories, the use of alcohol worsens psychological and physical health and, therefore, continues the cycle of dependency. Effective interventions that focus on stress-related problems and trauma often also apply to and vice versa, seem to be inextricably linked, so alcohol use and dependence must be addressed holistically and in an integrated, trauma-sensitive manner to assist in recovery and foster resilience (Nyakutsikwa et al., 2021).

2.5.5 Implications for Recovery and Treatment

The combination of alcohol dependence and mental health disorders poses problems that cannot be solved separately in isolation and on arrival at a common platform, which synthesizes the techniques of physical and mental treatment. In individuals with both disorders, one state influences the other, which means that the presence of schizophrenia worsens the condition of alcohol and drug dependence and vice versa (Mason et al., 2014). It is, therefore, important that treatment and management follow this bidirectional model because single-condition-focused approaches do not work well and increase the risk of relapse.

2.5.5.1 Challenges of Treating Dual Diagnoses

The management of comorbid alcohol dependence and mental disorders is challenging by design because of the relationship between the disorders. Common challenges include:

- **Symptom Overlap:** Many of the symptoms associated with alcohol misuse and mental health disorders are alike, which confuses when diagnosing mental health disorders and the impact of alcohol on patients (Manthey et al., 2021).
- **Relapse Risk:** Mental health disorders can cause alcohol relapse, along with alcohol dependency, which can make mental disorders worse, making it a vicious cycle.

- **Stigma:** People with dual diagnosis experience higher levels of stigma, community stigma, as well as treatment system stigma, which poses a major barrier to their care.

Such obstacles highlight the importance of implementing integrated care programs and delivering joined-up services (Hoek et al., 2022).

2.5.5.2 Integrated Treatment Approaches

Integrated treatment is the mainstay of treatment for patients with dual diagnosis because alcohol use disorder and mental disorders can be treated at the same time. Key components of integrated approaches include:

Cognitive-behavioral therapy (CBT) is the most commonly applied treatment to modify the cognitive and behavioral processes involved in both of the conditions. CBT assists a person in changing unconstructive thought processes, recognizing signals, and possessing techniques for dealing with anxiety without consuming alcohol (Jernigan et al., 2017).

- **Pharmacological Interventions:** Medications can help in terms of controlling the desire to drink and dealing with 'mental' effects:
    - Probably the best-known medications targeting alcohol dependence are naltrexone and acamprosate.
    - SSRIs and anxiolytics will also be used to manage depressive and anxious symptoms as part of dual diagnosis.

Mindfulness techniques and physical exercise plus nutritional interventions should be incorporated into the patients' management packages as they have positive implications on their health status. Many comprehensive therapies are incorporated together with conventional treatments as they help build up strength and help manage stress (Jastremski et al., 2016).

2.5.5.3 Role of Peer Support and Community Programs

Self-help groups involve peers who play major roles in enhancing the individual's commitment, sharing daily experiences, successes, failures, and relapses required for the sober future the individual seeks regarding recovery. These groups provide people with emotional

support, similar and caring advice, and encouragement, which all work to decrease an individual's sense of loneliness and increase that person's motivation to remain sober (Jernigan et al., 2017).

Ordinary clients may require other therapeutically oriented impacts in the event of severe mental disorders. For instance, cognitive behavioural therapies and other trauma-focused therapies, including EMDR, may be used to assist patients in processing the trauma that is associated with alcohol and mental health disorders (Hendriks, 2020).

2.5.5.4 Importance of Tailored Interventions

The treatment process should address different clients differently depending on their characteristics and history. For example, a patient's dependency level, the type of mental disorder, and the surrounding social environment in which the patient lives should be taken into consideration regarding their treatment program (Heitzman, J., 2020). They include mental health, addiction, and peer support, hence giving adequate and sufficiently flexible care.

Alcohol dependence is often a co-occurring disorder with mental illnesses and thus requires the client to undergo treatment that addresses both problems at once. Both behavioural and pharmacological treatments and peer support are useful for individuals in recovery, while four kinds of care, as well as person-centered care, emphasize patients' needs and preferences. When implemented effectively in a broad and integrated fashion, the approaches discussed in this paper will enhance outcomes, decrease relapse rates, and empower people to attain lasting recovery and better mental health (Frank, 2021).

2.5.6 Addressing Stigma and Access to Care

Many introduced the matter of the pervasiveness of stigma, which worked against both mental health and alcohol consumption, as an important limitation factor. Some of the people with both disorders experience stigma or prejudice, which keeps them away from seeking health care. By launching vigorous campaigns against STDs, Raising awareness of people about the relationship between alcohol use and mental health problems, and encouraging such persons to seek GP's help (Partelow, 2018).

Availability or accessibility of care is another contentious factor, especially for the health-sensitive groups. Thus, activities in the spheres of education, occupation, and health care depend upon the patient's socioeconomic status, residence area, and experience of systematic

discrimination. Raising the ability of the affected patient populations to obtain necessary and affordable medical care is imperative for treating both alcohol issues and mental illnesses (Witkiewitz et al., 2020).

The dependence on alcohol consumption and a mental disorder is best described as reciprocal, continuous, and containing (Ventura-Cots et al., 2019). People with Dual Diagnosis have special issues because alcohol dependence and mental disorders feed on each other in a vicious circle. Alcohol misuse does not only worsen and precipitate mental illnesses but also results in neurobiological alterations that make treatment aortic. While the above-highlighted health disparities emphasize the role of social determinates, stress and trauma overlay them, indicating the centrality of the biopsychosocial model in treatment and recovery processes.

Fighting such a connection denotes taking a holistic approach with an emphasis on behavioural therapies, pharmacological solutions, and public support. The stigmatization of people with dual diagnoses also needs to be countered, as well as increasing their access to care. By addressing these correlated problems, the initiatives in the sphere of public health may enhance the quality of life of people with alcohol dependency and psychological disorders, thereby decreasing the social contributions of given illnesses (Chopra and Arora, 2020).

2.6 Prevention and Intervention Strategies

Our actions must target both preventing alcohol problems and treating them to help people break addiction cycles and stay away from drinking again. A successful plan needs support at the personal level along with local programs and public health rules to build a complete system for stopping alcohol problems before they start and helping people recover from them. Proven methods such as CBT therapy and motivational techniques plus peer group support while studying new policies on minimum alcohol pricing and marketing rules. The combined use of these methods presents a complete strategy to reduce alcohol risks, especially for at-risk groups (Tindall et al., 2016).

2.6.1 Cognitive-Behavioural Therapy (CBT)

CBT represents a proven method that helpers use extensively to treat alcohol abuse problems. CBT teaches people to recognize toxic alcohol tendencies mixed with unhealthy patterns of thought and behaviour. Through CBT, patients gain awareness about what starts their excessive drinking and learn practical methods to deal with these risky situations.

CBT interventions often involve the following components:

- Behavioural Activation: People find activities that make them feel good instead of using alcohol as their way to handle problems (Wing et al., 2018).
- Cognitive Restructuring: Teach people to change their thoughts about how they think drinking is the only solution for stress and social anxiety.
- Relapse Prevention: Help patients understand risky situations, including social events and tough times, while showing them effective coping strategies (Heitzman, J., 2020).

Research shows that combining CBT with medications and peer support groups makes treatment most successful. CBT proves its worth in treating alcohol issues because people who get this therapy recover better and keep their sobriety for longer periods.

2.6.2 Motivational Interviewing

Motivational interviewing uses positive interactions to help people discover the reasons for changing their behaviours. Through empathic listening and team-based goal setting, motivational interviewing enables people to guide their recovery process independently (Manthey et al., 2021).

This technique proves most successful when patients neither want to change nor accept traditional treatment methods (Jastremski et al., 2016). Through motivational interviewing, people learn to connect their values with their current habits and future objectives. A dependent drinker learns that continuing to drink interferes with their medical wellness and relationship ambitions.

Medical evidence shows that motivational interviewing helps patients stop drinking alcohol more often while making stronger commitments to treatment plans. The gentle, supportive way motivational interviewing works helps people overcome alcohol problems by finding solutions to the social and emotional reasons behind these problems, even when people feel excluded or misunderstood (Partelow, 2018).

2.6.3 Peer Support Groups

People find recovery support in AA and SMART Recovery groups, which build a network of peers to help them stay sober. Peer support groups create safe environments where individuals can share recovery stories with others who share their common recovery challenges (Brady, 2017).

People find stronger recovery under peer support groups where everyone understands and supports each other.

Key benefits of peer support groups include:

- **Accountability:** Users connect through scheduled meetings and peer networks to maintain their recovery targets.
- **Shared Learning:** Support group members teach each other helpful methods and knowledge so everyone can deal with problems together.
- **Reduced Isolation:** When people join support groups for peers, their social bonds protect them against relapse by fighting loneliness (Heitzman, J., 2020).

Peer support groups help people stay in recovery better than just seeing a therapist or doing self-help work. These group environments prove that mutual help groups are essential for beating alcohol habits.

2.6.4 Policy Interventions

To fully battle alcohol misuse, Both direct help methods and strong government policies that fix the root causes. Policymakers implement rules like minimum alcohol pricing and promotion limits to lower how much alcohol people can buy and drink in society (Frank, 2021).

Minimum Unit Pricing (MUP): MUP rules require all alcohol products to have a specific minimum cost per unit, so strong cheap drinks become harder to buy. Research indicates that the policy rescues most individuals from excessive alcohol use by focusing on individuals who drink frequently and live with financial constraints. After Scotland introduced minimum unit pricing in 2018, they saw lower alcohol sales and fewer people were admitted to hospitals because of drinking (Partelow, 2018).

Advertising Restrictions: For better public health, control advertising that promotes alcohol consumption among young audiences. Studies prove that when people see alcohol marketing, they start drinking sooner and drink more often (Wing et al., 2018). When reduce alcohol promotion in public spaces and the media, reshape social attitudes that make heavy drinking seem glamorous.

Tighter Licensing Laws: Evidence shows that alcohol outlet monitoring plus sales time restrictions with age control measures successfully reduce how much people drink and minimize alcohol-related damage. Research shows that communities with fewer locations selling alcohol experience less alcohol-related crime and health problems (Witkiewitz et al., 2020).

2.6.5 Community-Based Programs

Community programs help build essential structures that support both stopping harmful alcohol habits and getting back to sobriety. Community programs deliver alcohol education and promote community strength to stop drinking problems at their source.

- **Public Awareness Campaigns:** Social awareness programs that show drinking dangers and offer better choices can transform community attitudes toward alcohol use. Drinkaware serves the UK by delivering educational resources that teach people to drink wisely and learn about the harms of alcohol dependency (Wing et al., 2018).
- **Support Networks:** Community groups and local projects help people and their families get support when dealing with alcohol problems. The networks deliver counselling help and organized parenting resources alongside direct connections to treatment services (Partelow, 2018).
- **Alternative Social Activities:** Shifting social bonds away from alcohol adds value by hosting events that focus on sports participation and wellness activities.

2.6.6 Integrated Approaches

Successful prevention and response work best when together individual help and local community work with government rules. CBT, paired with community programs and MUP, creates a full plan to handle alcohol misuse problems. True solutions for alcohol dependency work best when organizations team up to help people at personal, public, and government levels fight this complex problem together (Tindall et al., 2016).

2.6.6.1 Addressing Vulnerable Populations

Medical teams need to develop specific support programs for people who have mental health issues along with poverty-related challenges and social isolation. Different groups need

special treatment programs that tackle their unique difficulties to reach fairness in treatment outcomes.

People with multiple psychiatric problems and alcohol dependency require combined treatment programs that include both conditions (Seitz et al., 2018). Direct outreach to underserved communities helps remove obstacles that stop treated from receiving needed services.

Treatment plans for alcohol dependence require efforts to support individual recovery efforts while also fixing social barriers and system problems that weaken progress. CBT and other evidence-based treatments help people learn to cope better, while peer support and motivational interviews assist in recovering from alcohol dependency. Public initiatives and neighborhood programs support population-wide efforts to minimize alcohol-related damage.

Public health programs succeed more when they use multiple strategies to fight alcohol misuse and help people recover both today and in the long run. Take these actions to lower alcohol problems across society and create better health outcomes for everyone in communities (Apostolopoulos et al., 2018).

2.7 Gaps in the Literature

Research into alcohol abuse has grown substantial, but lacks full knowledge about how social settings and environmental factors affect recovery patterns. While progress has been made in exploring the physiological and psychological dimensions of alcohol use disorders, there is limited emphasis on the interplay between societal and environmental factors and how these vary across different demographic groups, cultural contexts, and unique societal stressors, such as pandemics (Chopra and Arora, 2020). The research gaps about alcohol-related harm require attention so it can design specific health solutions for protection.

2.7.1 Social and Environmental Triggers Across Demographic Groups

The research has not yet investigated how alcohol triggers affect people from distinct age groups and backgrounds. Research mostly studies universal drinking habits instead of looking at how different age groups, gender identities, class levels, and ethnicities experience alcohol problems differently (Apostolopoulos et al., 2018).

The influences pushing young people to misuse alcohol stem from social influences at school, but older adults drink to handle emotional problems like isolation and stress. Young people

commonly engage in binge drinking, yet older adults usually drink by themselves when they feel isolated or mentally unwell (Chopra and Arora, 2020).

The way gender affects alcohol use and prompts drinking behaviours defines how people interact with alcohol. Research shows men drink alcohol more often than women, but women now drink at similar rates to men overall (Ritchie and Roser, 2022). Women experience higher risks from alcohol and face more social judgment when they have problems with alcohol. Research shows that female individuals use alcohol more often to deal with the emotional burdens of caregiving while also managing traumatic experiences; hence, treatment approaches need adaptation for women.

Alcohol misuse affects people from lower income groups more heavily because they often face money problems and cannot access the healthcare or support services they need. Research studies routinely overlook how increased numbers of alcohol sales outlets and low-cost alcohol advertisements make drinking problems worse in poor areas (Frank, 2021).

Scientists know little about how different cultures and ethnic groups affect alcohol misuse patterns and situations that prompt it. Drinking patterns and alcohol usage among individuals depend on their cultural views about alcohol plus their religious upbringing and treatment by others in society. It needs to learn about these differences to create better treatment programs that respect different cultures (Partelow, 2018).

2.7.2 The Role of Unique Societal Stressors

Few researchers study how community stress factors, including financial downturns, pandemic outbreaks, and natural disasters, affect how people drink alcohol. The COVID-19 pandemic shows us how specific social crises can change how people drink (Frank, 2021).

Pandemic-Driven Changes: Both the UK and other nations saw more people drink alcohol due to restricted movement and social distancing measures, plus economic hardships during the pandemic (Mason et al., 2014). Sales of alcohol at supermarkets increased strongly as people started drinking more at home instead of going to bars and pubs. The impact of the pandemic on drinking problems and recovery services remains understudied across scientific research.

Stress-Induced Triggers: When the economy declines, and people lose their jobs, they may start abusing alcohol because they use alcohol as a way to handle financial stress and personal uncertainty (Pruckner et al., 2019). Research typically measures how much people drink without studying how stressful situations and personal characteristics combine to lead to alcohol dependence or return to use.

Social Isolation: Studies about alcohol misuse and social isolation need more attention because people turned to alcohol more during their time alone during the pandemic. Research on isolation needs to study its effects on specific groups like retirees and people who already have mental health problems to create better help programs (Rhead et al., 2022).

2.7.3 Integration of Mental Health and Alcohol Misuse Interventions

The research community needs more detailed work on how to treat both alcohol addiction and mental health problems at the same time. Research lacks studies on treating alcohol dependency along with depression, anxiety, and PTSD together.

Fragmented Care Models: The healthcare industry treats mental health conditions and substance dependency independently, which disrupts coordinated care and prevents proper recovery results. People with mental health and alcohol dependency issues often find it hard to get treatment services that handle both their conditions at the same time.

Barriers to Integration: Complete patient treatment remains distant due to provider education gaps and budget restrictions that block seamless health services. It need research that shows us how to deliver effective integrated treatment while addressing current program obstacles (Lackner and Tiniakos, 2019).

Evidence-Based Interventions: Research shows dual-diagnosis programs work, but It need more studies to make them work right for different types of people and locations. Studies must examine ways to design integrated care models that work well for underserved rural communities and economically disadvantaged regions (Apostolopoulos et al., 2018).

2.7.4 Limited Focus on Prevention

Literature prefers discussing ways to treat alcohol dependency, while too few studies explore prevention methods. Scientific research about alcohol treatment options exists, but fewer studies examine ways to prevent problems from starting among people at risk (Frank, 2021).

Youth face many environmental and social triggers for alcohol misuse yet receive limited effective prevention programs because funding for those services stays low. Specialists must research how well schools teach students about alcohol while working with families and communities to fight this problem with young people.

Policies with minimum price rules and advertising controls show potential results, yet research on their sustained impact on various groups remains limited. Research needs to show how different alcohol prevention methods can work together at policy and community levels while creating lasting reductions in alcohol harm (Wing et al., 2018).

2.7.5 Addressing Stigma in Alcohol Misuse Research

Public prejudice about alcohol abuse blocks research progress and treatment development. People who use alcohol and have a dependency problem feel unfairly treated and ostracized, which makes them less likely to take part in research and blocks their path to necessary medical assistance (Frank, 2021). The research needs to focus on finding new ways to lessen the shame surrounding alcohol misuse and show everyone that this is a health issue instead of a personal failure.

2.7.5.1 The Importance of Longitudinal Studies

Many research studies today focus on alcohol misuse and dependency without tracking these issues and their recovery over time. Existing studies depend on one-time data snapshots that do not track alcohol-related behaviour changes.

- **Understanding Relapse Patterns:** Studies that track participants over time help researchers find lifestyle patterns that aid relapse or support lasting sobriety, helping them craft stronger solutions (Tindall et al., 2016).
- **Impact of Interventions:** By analysing prevention and intervention strategies over several years, it can detect their strengths and weaknesses while ensuring their success.

Our understanding of alcohol misuse has improved, but important knowledge gaps still exist in research reports. Scientists need more evidence about how social and environmental events trigger drinking behaviour across different types of people in various types of situations, such as pandemics. Our healthcare system must combine treatments for alcohol dependency and mental

health disorders to provide better overall patient care. Our research needs to focus on these open spaces to create better ways to help lower alcohol damage at every level (Witkiewitz et al., 2020).

2.8 Conclusion

A review of past research found that social influences and environmental conditions drive alcohol misuse and repeated substance relapses. Different social and physical elements determine how people behave when it comes to alcohol misuse. These elements depend on local customs, financial standing, personal weaknesses, and society-wide standards. Research has helped us understand alcohol misuse, but fundamental voids prevent us from developing effective treatment methods. Our study aims to reveal specific social causes behind UK alcohol misuse while creating actionable advice to enhance public health efforts.

2.8.1 The Complexity of Social and Environmental Triggers

Alcohol misuse develops through both personal decisions and impacts from social settings and locations around us. People start drinking alcohol because society makes it normal, while family rules and friends push them to keep using it. The presence of alcohol in easy-to-buy products and clear advertising promotes drinking habits, while local social standards support these actions.

The research shows multiple elements frequently combine to push those reoffending or returning to drinking. People with alcohol dependency problems struggle with social settings due to alcohol expectations around them. Environmental cues like alcohol advertisements and public alcohol spaces strongly tend to prompt addictive behaviour relapses. Our results show It need a complete method that studies all aspects of where people use alcohol.

2.8.2 Gaps in the Literature

Research on alcohol misuse remains incomplete because it fails to explore all factors that affect different individuals and settings in unique cultural contexts. Key gaps include:

1. **Demographic Specificity:** Researchers have examined social and environmental alcohol triggers only partially for different age groups and social settings. Knowing these differences between groups lets us create specific treatments that help all communities.
2. **Societal Stressors:** The COVID-19 pandemic clearly showed that community stress affects how people use alcohol, but research on this connection still needs a lot more time

and data. Researchers need to discover how major national emergencies and economic downturns affect how people handle alcohol use and treatment programs.

3. **Integrated Approaches:** Scientists understand the relationship between alcohol use and mental health, yet they need more research into treatments that help people manage both conditions at once. Research must show us how alcohol misuse treatment matches best with mental health care to help patients more effectively.

4. **Prevention Strategies:** The research community studies treatment options extensively but gives insufficient attention to developing prevention methods for populations most at risk. Research must assess how often early screening programs combined with public awareness efforts and new policies lower alcohol misuse starting early.

2.8.3 The Importance of Contextual and Cultural Variables

What people think about drinking and how society behaves towards alcohol affects how people consume it. In British society, alcohol has become an essential part of our social traditions, especially when people gather at pubs or celebrate special occasions. The widespread acceptance of alcohol makes recovery very hard for people trying to stay sober while showing why cultural aspects must be part of treatment programs.

Socioeconomic status and regional variations strongly impact how people use alcohol. Economically disadvantaged neighbourhoods lead to alcohol dependency because residents struggle with job loss and housing needs along with poor healthcare resources. Knowing these social causes helps us design fair public health programs that solve alcohol misuse problems at their source.

2.8.4 Public Health Implications

Our review results show how they can help develop effective public health systems to fight alcohol-related injuries. Key areas for intervention include:

- **Policy Measures:** Regulations on alcohol pricing plus advertising changes plus stricter business rules can limit how much alcohol people buy and drink across entire communities. Community health initiatives that reduce unhealthy drinking practices achieve better results when used alongside official government regulations.

- **Community Support:** People who drink alcohol excessively need support from both their community and the community down the street.
- **Integrated Care Models:** Treatment programs that treat alcohol dependence while addressing mental health needs help patients who have two health problems achieve better results.
- **Tailored Interventions:** Our approach must adapt medical care to fit different population groups and unique cultural habits to help both prevention and treatment work better for everyone.

2.8.5 Bridging the Gaps

Our analytical research aims to understand which social situations trigger people to misuse alcohol in the UK. Through our research, the study peer pressure and cultural rules alongside environmental impacts to discover why people misuse alcohol. Study results will help create public health strategies that focus on protecting against addiction and support treatment plus equal healthcare services.

This research shows that society must respond to both economic and public health problems to reduce alcohol misuse. This research compares alcohol-related behaviours with societal disruptions like COVID-19 to develop advanced knowledge of how society influences alcohol use.

2.8.6 Future Directions

The review highlights several avenues for future research, including:

- Longitudinal Studies: Our research follows individuals who misuse alcohol over time to find behaviour patterns that help them stay sober.
- Culturally Sensitive Interventions: Our research investigates how custom-made interventions should work within different cultural backgrounds and this setting.
- Integrated Approaches: Our research looks at how well integrated mental health and alcohol misuse treatment works to manage these combined disorders treated together.

- Impact of Societal Stressors: Our research will investigate how economic stressors combine with social challenges and environmental pressures alongside their impacts on alcohol abuse patterns and treatment results across different periods.

Research shows that several different types of environments and personal traits affect how people misuse alcohol and return to using it. The existing studies provide important findings, but major gaps prevent us from creating complete and successful treatment programs. Our research targets UK social triggers behind alcohol misuse problems to help build better health programs for the public.

Our research examines daily alcohol use across different social groups to build a stronger understanding of drinking behaviours and help developers create better solutions for intervention. Our research aims to help people affected by alcohol problems and lessen the total harm alcohol causes in society.

Chapter 3: Methodology

3.1 Introduction

The methodology chapter discusses how the research goes with the framework that the research occurs in by means of systematic, rigorous, and consistent research ends and means. The adoption of a mixed methods approach to this study of alcohol misuse and its association with mental health not only provides a complete understanding of underlying issues but also benefits from a survey of alcohol misuse itself. The chapter on research methodology presents a research methodology, justifies its need, and explains why mixed methods are required for such an objective. Research methodology deals with data collection, analysis, and interpretation (Snyder, 2019). A qualitative and quantitative approach is used in this study. This method uses the strengths of each technique and overcomes the disadvantages of each method to form a more coherent view of the phenomena at hand.

Qualitative interviews sequentially interview professionals with experience or knowledge about the subject matter. However, these interviews try to discover the underlying themes, delve into them with nuanced perspectives, and provide contextual depth. For the qualitative part, a group from the larger population are sent and then asked to respond to structured surveys. This part of the action is to find trends, correlations and statistical patterns which might not be detected through the qualitative methods alone. Integration of these methods helps answer research questions that call for breadth and depth of knowledge. For example, Davidavičienė (2018) show that qualitative findings can illuminate the development of quantitative tools, and the other way around, quantitative results can confirm or corroborate qualitative insights (Davidavičienė, 2018).

A mixed-methods approach addresses a complex research question and aligns with the study's objectives. Many layers of influence play into alcohol misuse and its complex relationship with mental health, from personal experiences to social to systemic. A qualitative or quantitative single-method approach will likely provide an incomplete picture. Each qualitative and quantitative method has its limitations. A drawback of qualitative research is that the data collected is rich in detail and depth, but subject to smaller samples and subjective interpretation, it might be criticised as lacking generalisability (Patel and Patel, 2019). On the other hand, quantitative research is statistically robust and generalisable, but the depth and complexity of human experience are not captured. This study combines the strengths in the form of both approaches and

mitigates the restrictions of the other, ensuring a balance between the two, i.e. depth and generalisability.

One key advantage of a mixed methods approach is using multiple data sources or methods to verify findings. In this study, triangulation is achieved through the crossing of qualitative insights and quantitative data. One way to increase the validity and reliability of the findings would be to use themes emerging from interviews and test and validate them through survey responses. Triangulation reduces bias, and hence, a more accurate picture of the research phenomenon is obtained (Ørngreen and Levinsen, 2017). The relationship between alcohol misuse and mental health is never simple or singular, always multi-valence: between individuals, between society, between the individual and culture, and between societies. Qualitative methods are ideal for studying subjective experience, such as what emotional or situational triggers lead to alcohol dependency or what barriers are associated with seeking help. On the other hand, quantitative methods permit the quantification of broader tendencies, for instance, the extent of comorbidities of mental health problems or associations of alcohol use with stress levels. A mixed methods approach allows the issues of interest to be studied at the micro (individual experience) and macro (population level phenomena) levels (Garg, 2016).

The design of this study is sequential exploratory, with learning spaced qualitative findings to shape and contribute to the development of quantitative instruments. Through this integration, questions in the survey are based on actual experiences in the real world. As a concrete example, interviews may be particularly unique in this context through which stressors or the use of coping mechanisms are experienced, which can then be quantified and tested using structured surveys (Gupta and Gupta, 2022). The sequential integration improves the research findings' depth, relevance and applicability.

This study has two main objectives: to look at the social and psychological determinants of alcohol misuse and mental health and to pinpoint effective intervention strategies to eliminate this. However, given the complexity of the research problem, and since the aims are related to subjective and objective dimensions, the mixed methods approach is particularly suited to attain these aims. Both the social and biological factors, as well as individual factors, all contribute to the relationship between alcohol misuse and mental health. The qualitative research aims to probe why people got addicted to alcohol. Understanding how these individuals live and how these

contextual factors impact their behaviour (Pandey and Pandey, 2015). Similarly, quantitative research also discovers patterns and correlations across a sample but with quantitative research backed with statistical evidence of results obtained through qualitative research.

Quantitative and qualitative data are integrated in this study to obtain specific evidence-based intervention recommendations. Saharan et al. (2020) assessed that qualitative findings enabled insight into how challenges such as stigma or lack of access to support services are experienced, while quantitative data shows the prevalence and demographic distribution of such challenges (Saharan et al., 2020). This combination guarantees that the interventions are grounded in statistics and contextually relevant. This was a public health policy and clinical practice information paper setting out tolls which could be implemented to reduce alcohol-related harm and mental health outcomes. This paper presents these recommendations using an amenable mixed methods approach, building statistical evidence for policy advocacy and personal evidence for implementation.

3.2 Research Philosophy

Research philosophy defines the set of beliefs and assumptions on which methodology, research design and interpretation of findings hinge. This study of the complex interplay between alcohol misuse and mental health is deemed pragmatic, describing which philosophical framework is deemed to be most appropriate for this study. According to Dźwigoł and Dźwigoł-Barosz (2018), pragmatism is about helping find a practical way of resolving real-world problems and suggests multiple methods to gain deeper insight into things (Dźwigoł and Dźwigoł-Barosz, 2018). It examines the philosophical roots of pragmatism, the relationship between pragmatism and the research methodology of mixed methods, and its contribution to achieving the research goals.

It accentuated pragmaticism as the response to the oppressive dichotomy between Positivism and Interpretivism. Quantitative methods of positivism emphasise objectivity and the search for generalisable laws, while interpretivism relies chiefly on a qualitative approach to understanding human experiences and meanings (Flick, 2015). This divide is bridged by pragmatism, which prefers the use of the method that will best solve the problem of research, whether it is qualitative or quantitative. It means that practical problems and actionable knowledge generation are prioritised. Instead of methodological frameworks, it evaluates research methods in their capacity to generate desired outcomes. Methodological pluralism, furthered by pragmatism,

enables researchers to use qualitative and quantitative methods. This flexibility allows for the investigation to be matched to the phenomenon's complexity. Moreover, pragmatism stresses the role of context in generating understanding, and it is explicit that knowledge is made through experience, evidence, and application (Mukherjee, 2019).

The use of a mixed methods approach is a close reflection of pragmatism. Support of methodological pluralism by pragmatism views that no single method or epistemology is superior to others and prides itself on determining the best method to address the research questions. The mixed methods approach of this study builds on the strengths of qualitative and quantitative methods to ascertain an exhaustive view of alcohol misuse and mental health. Mishra and Alok, (2022) emphasised that pragmatism tightly aligns methodology to the research problem, and, as such, the methodology is tailored to the study's specific objectives whilst leaving it very flexible concerning various paradigms (Mishra and Alok, 2022). Qualitative methods are used to explore the lived experiences of people; meanwhile, quantitative methods are used to find broad patterns and correlations. Consequently, this combination ensures that the research problem is addressed from several points of view.

Additionally, there is value placed on the interaction of theoretical understanding and practical application. Based on integrating qualitative narratives and quantitative data, findings are intellectually solid and practically relevant. The qualitative data offer depth and context to personal experience, and the quantitative data validate the findings across a more significant sample (Kapur, 2018). Findings from the literature are integrated with policies, allowing them to feed into interventions; hence, their relevance and applicability to the research environment are more substantial.

The complexity and multidimensionality of alcohol misuse and mental health are well served by pragmatism and also lend themselves well to that approach. Characteristics of the interplay of these factors in the relationship to these issues are characterisations of interactions between personal, social, and systemic factors. If the approach in question were qualitative or qualitative, we would discuss a single-method approach. By using pragmatism, we can combine diverse data sources to fully capture the intricacies of the research question (Opoku et al., 2016). Real-world issues such as alcohol misuse and mental health have real-world implications. Therefore, pragmatism focusing on practical outcomes also results in findings from this study

being directly relevant to policy and practice. For instance, qualitative insights about individual-level experiences could promote the development of individual-level interventions, whereas quantitative trends could inform the direction of public health strategies (Dubey and Kothari, 2022). The aim of the study to provide evidence-based advice is well matched to pragmatism's notion of actionable knowledge. Through qualitative and quantitative methods, the findings are comprehensive and relevant to stakeholders, including healthcare providers, community organisations and policymakers.

Pragmatism allows the research objectives to be addressed in a number of ways. This first part is flexible enough to use quantitative and qualitative methods undisturbed to adapt the research design according to study demands. This is important because drinking misuse and mental health are often complex and highly dynamic. The study also benefits from triangulation, which enhances the validity and reliability of the study findings by combining the methods. Pragmatism, however, acknowledges that context matters to behaviour and outcomes, and this is true in understanding how social, cultural, and systemic elements impact alcohol misuse and mental health in particular places. Among the various pragmatic approaches, the study focuses on how their findings directly apply to tackling these challenges and making meaningful changes at individual and societal levels (Khatri, 2020).

Pragmatism provides a solid philosophical basis for this study, matching perfectly with such a research approach as mixed methods and goals. This methodology's emphasis on methodological flexibility, problem-centred inquiry, and actionable knowledge renders it well-suited to the complexity of alcohol misuse and mental health. The study adopts a pragmatic paradigm to the extent that the theory's soundness and practical relevance of its findings are ensured, paving the way for practical interventions and evidence-based policy recommendations.

3.3 Research Design

A research design is a blueprint for a study; it outlines how to collect, analyse, and interpret data. An exploratory sequential mixed methods design has been adopted for this study. This design consists of two distinct phases: they are divided into an initial qualitative phase that precedes a quantitative phase. This qualitative phase gathered and analysed rich, specific data to identify themes and variables, which will inform the subsequent quantitative phase. The quantitative phase focuses on testing and validating, across a broader population, the extent to which the findings of

the qualitative phase hold. By integrating these methods sequentially, a deeper appreciation for the interplay between alcohol misuse and poor mental health is achieved in an integrated manner, drawing on the comparative strengths of both quantitative and qualitative approaches. The most significant advantage is for research topics requiring depth, breadth, and a balance between context specifics and generalisation.

In this exploratory sequential mixed methods design, the qualitative phase is preceded by the quantitative phase, and each phase feeds back to the other phase. The qualitative aspects of it encompass disclosing the secrets cloaked about individuals' lived experiences and perceptions and difficulties of people who are giving up the use of alcohol and coexisting mental health status problems. In developing the quantitative component, themes and variables are used to inform the testing of these themes and variables among a larger, more diverse sample using structured surveys or questionnaires. The convenience of this design comes in handy when studies have a humble stock of frameworks or theories to encompass the complexity of this research domain so completely (Mauthner, 2020). On the contrary, the study starts with an exploratory, qualitative phase, in which the hypotheses for the variables and the contextually relevant variables in the actual human experience are tested and grounded.

Integrative approaches through an exploratory sequential design combine qualitative and quantitative methods. It happens at different stages in the research process. During the qualitative phase, the data is obtained through semi-structured interviews that are analysed to obtain patterns, themes, and underlying variables. Next, these findings help design quantitative instruments, such as surveys, to best suit the particular research context and fill in the gaps. As an example, specific social or psychological triggers for alcohol misuse that may emerge as interviewees mentioned during the individual interviews can be translated into measurable variables in the survey (Muhaise et al., 2020). However, the initial findings are first validated empirically during the quantitative phase when broader trends and correlations identified from the statistical analysis are considered valid. The results of both phases are synthesised to provide a holistic understanding of the research problem. Qualitative insights pull the statistical patterns to add depth and context, and quantitative data help validate and generalise the qualitative findings.

Due to the complex nature of alcohol misuse and its relationship with mental health, it is suited to this study by the exploratory sequential design. These are issues like interplay among the

individual, social and systemic factors and the research design that would be utilised to address all these dimensions is required to be comprehensive. Abu-Alhaija, (2019) analysed that the qualitative phase offers a chance to explore all an individual has experienced and unearth themes that may be missed by conducting research in extant literature (Abu-Alhaija, 2019). Alcohol misuse is a personal, emotional, and social issue. The addition of this quantitative phase provides quantitative evidence for these findings and allows for the quantification of how common these are in the broader population. Taken together, these methods ensure that research about the media is no longer confined to the very broad of broader trends or the very deep of individual experience.

Along with providing rich descriptive data, the qualitative phase helps with the development of the quantitative phase by keeping the study grounded in relevant contextual data. A feature of this approach is that the survey instruments associated with it are parallel to the experiences and realities of the population studied. But, combining quantitative and qualitative methods at the same time provides triangulation, in which the results from one phase are compared with the other. This also increases the validity and reliability of the study, thus decreasing the bias and making research more accurate; therefore, it becomes more valid and representative of the problem researchers face (Mukherjee, 2019).

The exploratory sequential design also facilitates the results' application in real-world settings. These concerns of critical magnitude are of public health policy and clinical practice importance regarding alcohol misuse and mental health. Quantitative evidence and qualitative insights are combined to produce contextually grounded actionable knowledge. The qualitative narrative gives an in-depth description of how people fight against the barriers to help themselves stop drinking. At the same time, quantitative provides the prevalence and demography distribution of the barriers. Being academically rigorous and practically applicable simultaneously under such a comprehensive approach allows for the research findings.

3.4 Data Collection Methods

This study employed an exploratory sequential mixed method design, combining two data collection methods. The qualitative phase consists of semi-structured interviews with stakeholders in which alcohol misuse co-exists with or contributes to a mental health condition, directly or indirectly and which offer insights and context-specific nuances. Structured surveys are used to phase validate or test findings, measure population trends, and correlate phases with large

populations. The methods presented here guarantee robust and reliable data collection across the complexity of combined alcohol misuse and mental health.

3.4.1 Qualitative Data Collection

Data from semi-structured interviews was the basis for the qualitative part of this study. In addition, this approach is particularly appropriate for the examination of complex and sensitive weather, for example, the relationship between alcohol misuse and mental ill health. Being flexible and rich, the semi-structured interview allows the researcher to hear how participants tell about their experience and their views for the researcher to follow and probe the experience, making sure to deliberately name the priorities and interests (Ørngreen and Levinsen, 2017). This section describes the approach to qualitative data collection: A description of how interviews were conducted, how participants were recruited and selected and how an interview guide was created.

Semi-structured interviews are one of the preferred interview types because they share questions and then take cues from emerging themes. They are used as a tool for experiencing, perceiving, and struggling with the destroyed life of intoxicated alcohol and the straitened conditions of mental life. The openness of the interview allows the interviewee to build and add more to their answer to give more information beyond what is provided by other exceptionally structured methods (Kirongo and Odoyo, 2020). This is a particularly appropriate method for the study of the many and complex parts of alcohol misuse and mental health. They laminate it so participants can contextualise their experiences within broader socio-cultural, systematic themes. Furthermore, semi-structured interviews are flexible, so the researcher can ask different questions in response to the participants' responses so that all significant themes are explored (Garg, 2016).

This recruitment process for the qualitative phase is designed to capture the different perspectives while being highly relevant to this research objective. Means of multi-stage purposive and snowball sampling techniques garner participation. As a means of purposive sampling, the researcher can locate individuals with specific characteristics or experiences related to the study, including people who are dependent on alcohol, who suffer from co-morbid mental health issues, or who work in healthcare and policymaking. Enhancing the recruitment process using snowball sampling relies on the participant's network to assist in recruiting more participants based on selection criteria (Mishra and Alok, 2022).

The participant selection criteria ensure that the sample is diverse and related. Individuals aged 18 and above with either direct personal experience of alcohol misuse and mental health challenges or professional expertise in alcohol-related fields should meet the inclusion criteria. People excluded are those who are currently treated for acute alcohol dependency or mental health conditions that may impair their capacity to participate in the interview process fully. Carefully selecting the data captured ensures that the data collected is rich in detail and that the data gathered reflects a variety of experiences.

The interview guide is a crucial enabling tool because it ensures that the semi-structured interviews are systematic and consistent with the study's goals. Its development is based on the existing literature review, preliminary discussions with experts, and our research questions. The guide includes a mix of open-ended questions and prompts that help explore key themes like why and how alcohol is misused, how barriers to seeking help can be overcome, and how alcohol misuse plays out at the intersection with mental health.

Questions in the guide, however, are framed to encourage participants to take the time to reflect on their experiences and give detailed responses. For instance, they may be prompted to speak about the factors that influenced their alcohol consumption, the part social support played in their journey toward recovery or how they perceived the mental health and addiction services available to them. The guide features follow-up prompts to go into detail with some regions of interest to get the most volume of meaningful data out of the interviews.

To serve the purpose of interview incorporations, the interviews are conducted to ensure that the participant is comfortable and confidential. Virtual or in-person interviews are offered based on how convenient participants want them and logistics. The convenience and accessibility provided by virtual interviews, done from secure video conferencing platforms, are helpful for interviewees who may be constrained by geography or mobility. Where feasible, in-person interviews provide a more decadent data collection of both nonverbal cues and the more personal interaction allowed (Tamminen and Poucher, 2020).

At times convenient to the participants, interviews are conducted in private, distraction-free environments to ensure confidentiality and concentration. Participants are given extensive information about the nature of the study – including its purposes, confidentiality measures and right to withdraw at any time – before the interviews. Before each interview, participants are

informed, consented and guarantees that their responses will be anonymised. Interviews are audio recorded with the participant's consent to guarantee that the data collected is both accurate and reliable. This enables detailed transcription and analysis while allowing the interviewer to engage with the participant fully, and it allows information between the interviewer and participant to contribute to the analysis itself (Dubey and Kothari, 2022). In addition to field notes, non-verbal cues, line of sight, and contextual observations are not included in the audio recording.

3.4.2 Quantitative Data Collection

This is the quantitative part of the study that so quantitatively explores the broader patterns of alcohol misuse and mental health using structured surveys. It's essential to validate the identified themes and variables in the prior qualitative phase and ensure that the findings are generalisable to a larger population. The structured surveys are intended to collect quantitative data that can provide statistical evidence alongside the in-depth insights discovered during qualitative interviews (Pandey and Pandey, 2015). It outlines how structured surveys are used, indicates sampling methods for survey respondents and details the design and piloting of the survey instrument.

A structured survey is a commonly known quantitative data collection method that systematically collects similar and comparable data from a large sample. The survey instrument for this study features Likert scale questions to measure respondents' attitudes, behaviour and perception about the use of alcohol and mental health. This is precisely why the Likert scale is often used to measure subjective constructs: participants can express the intensity of their agreement or disagreement with certain statements (Tamminen and Poucher, 2020). For instance, the questions may investigate the effects of social stigma on help-seeking or the link between stress and alcohol drinking.

Likert scales provide some advantages to use. It also provides a standard method to collect data so that there is consistency and we can analyse it statistically. As with the ordinal Likert scale responses, the dataset's trends, relationships, and variations can be seen. Second, gradation scales capture nuances of the attitude and behaviour of participants, which are not captured in a binary response. Therefore, Likert scales are much easier and more user-friendly, resulting in higher response rates and higher reliability of the collected data. The fixedly shown questionnaire to respondents reduces the interviewer's bias and the responses' comparability. This approach is

particularly relevant for interrogating the distribution and prevalence of key themes deriving from the qualitative stage, including environmental triggers, social support systems, and accessibility of mental health services (Saharan et al., 2020).

The quantitative phase sampling strategy is designed to extract and generalise well from and across the population. Stratified random sampling reduces the potential bias and takes a random selection from a diverse target population. The fundamental factors on which the population is divided into subgroups or strata using this method include age, sex, socio-economic status or location. Next, each stratum is randomly sampled with a familiar sampling technique to produce a sample representing the population as diverse in demographic characteristics as in other factors (Davidavičienė, 2018). Overall, this study is beneficial because stratified random sampling permits the investigation of subsample differences and provides for the representation of underrepresented groups. An example of such a study might involve the comparison of how problems with alcohol misuse or mental health vary, for instance, in different population groups, such as age or social background. This approach heightens the external validity of the findings and, in turn, the generalisability of these findings to the more general population as well.

Statistical power analysis is used to calculate the appropriate sample size (based on the confidence level, margin of error, and the expected variability in responses). The sample is sufficiently large, so we can have the statistical power to detect meaningful differences and relationships within the data. The research objectives, in addition to the key themes and variables identified in the qualitative phase, are used to design the survey instrument, which aligns with it. Several stages are involved in the design process — defining the research questions, choosing appropriate question formats and shaping the survey for simplicity and reading flow. The survey contains both Likert scale and closed-ended questions and some demographic questions to collect specific attitudes and contextual details.

It is important to word the survey questions, and pretrial tests are made to ensure the respondent comprehends them. Consultations with field experts are involved to validate the content, which may contain ambiguities or biases in phrasing questions. For example, it reviews questions that measure the perceived effects of stress on alcohol consumption to ensure the questions are sensitive to cultures and will not result in respondents agreeing to particular answers (Snyder, 2019).

The survey instrument is piloted with a small sample of the target population before full deployment. The piloting process has several purposes. First, it helps to pinpoint and solve any questions of clarity, survey length, or technical functionality issues. Secondly, it allows a test of the reliability and validity of the questions so that they genuinely measure what they should be. Piloting yields preliminary data for what may be done with the survey design. The instrument's internal consistency and overall performance are evaluated using data from the pilot study. The Likert scale responses are tested for their reliability using Cronbach's alpha. Pilot participants also provide feedback on confusion or difficulty in completing the survey.

For this study, structured surveys with Likert scale questions offer a great deal to take in when it comes to quantitative data collection. It is the first that establishes a strong frame of reference for the qualitative findings so that the identified themes and variables can be generalised to a more significant population (Davidavičienė, 2018). As a secondary benefit, stratified random sampling can add value by increasing the representativeness and external validity of findings and thus help make these findings generalisable to many other demographic groups. A painstaking tabulation of the survey instrument leads finally to an instrument with reliable, valid, and objective-directed data.

3.5 Sampling Strategy

This study's sampling strategy was carefully designed to use a mixed methods approach to collect relevant, reliable, and generalisable data. Since the two phases require different sampling techniques, corresponding to qualitative and quantitative methods, these are used in their respective pursuit of the particular objective of each phase. For the purpose phase area, purposive sampling was used qualitatively for in-depth and context-specific information; in the quantitative phase area, strata random sampling was applied for representativeness and the validity of the statistical data (Muhaise et al., 2020). These approaches are detailed and defended, and sample sizes for both methods are given in this section.

Purposive sampling is widely used in qualitative research, also called judgmental or selective sampling. This takes it literally tasked to find participants with specific characteristics or criteria to make them a more relevant research target. The sampling method was purposive sampling to recruit people with direct or indirect experiences with the misuse of alcohol and mental

health challenges. It includes people who have worked with such topics, his family or caregivers, and professionals in this field - healthcare providers, counsellors, and policymakers.

Purposive sampling can and does produce rich, data-rich and contextually appropriate data. The purpose of the qualitative phase is to explore people's faces as they go through everyday experiences, perceptions and challenges; hence, participant selection is necessary. Using a purposive sample, individuals may be targeted to get different perspectives or opinions on the study from people with other socio-economic standings, cultural backgrounds and professional positions (Ørngreen and Levinsen, 2017).

As captured by Milshra and Alok (2022), stratified random sampling is a type of probability sampling that divides the population into various subgroups described by such attributes as age, gender, socio-economic status or geographical location, and then randomly samples from the subgroups (Milshra and Alok, 2022). In each stratum, a sample is randomly sampled, and a sample is drawn from the final sample proportional to the size of the population being studied so that the final sample represents an accurate whole population. For this study, the quantitative phase, stratified random sampling, will be used to collect a diversified, representative sample of those who are affected by alcohol misuse and psychiatric illness. Unlike non-probability sampling, this one guarantees that all the population subgroups are proportionally represented (Opoku et al., 2016). It also highlights the analysis of differences and trends within these subgroups to understand the studied problem thoroughly.

Stratified random sampling makes the variance in demographics that might cause problems like a high prevalence of alcohol misuse, a stubborn toll of mental health conditions, or a form that gets in the way of getting help more manageable. Stratification by age and gender will show whether some demographic groups are more susceptible to specific challenges or whether these need to be addressed in a tailored fashion. This method can be used to increase the external validity of the findings.

Identifying the number of samples required is very important to ensure the validity and reliability of the study's findings (Flick, 2015). During the qualitative phase, the sample size is cued by gravitational saturation, which occurs after supplementary data doesn't provide new light or concepts. Due to the depth and complexity of this project's research topic, 10 to 15 interviews

would be sufficient to achieve saturation. This data range allows us to capture many experiences while keeping the inputted data manageable to analyse.

In the quantitative phase, the sample size is determined using statistical power analysis that considers the confidence level sought (e.g., 95%), the degree of certainty sought (e.g., 5%), and the level of variability in the expected responses, specifically, in a study whose population has different characteristics, a sample size ranging from 50 to 60 respondents is considered adequate to generate reliable and generalisable results (Gupta and Gupta, 2022). This size is also sufficient for robust statistical analyses, such as subgroup comparisons or trend correlation identification.

There are advantages to the combined use of purposive sampling for the quantitative data and stratified random sampling for the quantitative data. Qualitative phase samples purposively so that rich contextual, relevant insights from those with direct experience of expertise in the research area are captured (Kapur, 2018). Drawing on such a deep understanding of organisational issues and themes is essential for identifying crucial themes and variables that may not be obvious using quantitative techniques only. In contrast, stratified random sampling improves the representativeness and generalisability of the quantitative findings, supported statistically to complement and extend the qualitative results. By incorporating these sampling strategies, the data obtained is relevant to the general population and makes sense. The exploratory sequential mixed methods design was appropriate for this approach, and it supports the subsumed study goal of generating actionable knowledge to tackle the intricate interaction between alcohol misuse and mental health.

3.5.1 Population of the Study

The population of study includes individuals and groups affected either directly or indirectly by the misuse of alcohol and mental health, such as those who are professionally responsible for tackling these problems. This includes people with personal experience of alcohol dependency or other coexisting mental health conditions, caregivers and their families, and stakeholders, which include health practitioners, counsellors and policymakers. These groups all offer different perspectives, which together form a complete picture of what the research problem focuses on.

In the qualitative phase, the sample was purposefully chosen from the population to include cases with relevant experience or expertise. The approach makes it possible to explore from a more

detailed and context-based perspective the lived experiences, as well as social influences and systemic impacts on those affected by alcohol misuse and mental health problems. The quantitative phase is longer, with a more significant population spanning a broader demographic and socio-economic composition spectrum. It ensures that this population is represented proportionally; thus, factors like age, gender, place, and socio-economic status are included. Such a sampling strategy can analyse trends and correlations across subgroups to increase the generalisability and applicability of the findings (Mukherjee, 2019). The study examines the issue of alcohol misuse and mental health, covering a broad spectrum of individuals.

3.6 Data Analysis Methods

The data analysis methods used in this study are exploratory sequential mixed methods design where qualitative and quantitative methods are used to understand the research problem fully. In the qualitative phase, thematic analysis is used to identify patterns, themes, and insights in the semi-structured interview data. The extent of this method is to allow an in-depth exploration of participants' experiences and perspectives. A data survey using quantitative phase statistical analysis techniques is applied to survey data such as descriptive statistics, correlation analysis, and inferential tests (e.g., ANOVA or regression analysis).

3.6.1 Qualitative Data Analysis

Quantitative Analysis of Data includes reading the unquantifiable data systematically to get a tangible pattern, theme, or insight that will lead to meeting its research objectives. For this study, data were analysed using thematic analysis arising out of semi-structured interviews to explore the lived experience, perceptions and challenges of alcohol misuse and mental health.

Thematic analysis is a coding process that organises data into manageable units for further examination. In the first step, the data is familiarised, and the interview transcripts are read and re-read extensively to acquire a deep understanding of the data. This information stage is noted as initial impressions and observations leading to subsequent analysis. In the second step, more initial codes are generated; these are labels given to data segments referring to specific ideas, concepts or patterns. The codes can be descriptive, summarising the content of the data, or interpretive, i.e. capturing meanings or implications of the content of the data. These codes are assigned and administered with NVivo to ensure the coding is systematic and ordered. The third step is refining and organising codes. Categories comprise similar or related codes and are built onto codes to

identify broader themes. However, at another level, NVivo's coding functions allow the creation of parent and child nodes, overarching categories and subcategories.

Once codes are identified, the interpretation of the data becomes broader from the codes. Patterns of meaning that account for the data and answer the research questions are them. Such themes for a study include the role of social stigma, environmental triggers, barriers to accessing mental health services, and so forth. The categorised codes are scrutinised to find and identify themes between and relative to the codes and research questions. This process is looking for recurring patterns, contrasts, and connections throughout the dataset. NVivo's visualisation tools, including word clouds or thematic maps, explore these relationships and refine the thematic structure. Then, themes are checked to see that they capture the data well and that there are no duplicate themes. In this step, the researcher revisits the coded data to ensure the themes are rooted in participants' responses. Revisions of the thematic framework resolve any discrepancies or overlaps between themes.

Thematic analysis helps draw insights from the research problem by interpreting the identified themes and getting meaningful conclusions about the research problem (O'Gorman et al., 2014). The study's theoretical framework, research objectives, and context were drawn from this. They each look at each theme to understand what it means, its implications, and what relationships it holds with other themes. For instance, the theme of social stigma may show that people are discouraged by the existence of these undesirable social attitudes when they don't come to ask for help for alcohol abuse. This insight could be placed within themes of access to support services and coping mechanisms. Once the relationship has been described, NVivo's tools to explore data intersections and co-occurrences are used to identify these complex relationships. Finally, findings are synthesised into a coherent narrative that addresses the research objective. The thematic analysis of themes and patterns is done and then integrated to provide a holistic understanding of the qualitative data. In this context, the findings provide the basis for the quantitative phase of the study, starting from the participants' lived experiences as principles of the survey design.

Thematic analysis is a rigorous and systematic approach to qualitative data and allows a researcher to focus on the patterns, themes, and understanding of the data (De Langhe and Schliesser, 2017). More importantly, it makes it faster, deeper, and more profound, as well as how

you do the analysis. With this study, the qualitative findings from this coding, theming, and deriving insights process result in robust and reliable qualitative findings directly related to the research objectives. These results are relevant for the overall completeness and validity of this study for the overall understanding of how people misuse alcohol and mental health.

3.6.2 Quantitative Data Analysis

Quantitative data analysis is the study of numerical data, where we study where trends, patterns, and relationships exist. The research objectives will be provided with quantitative data supported by statistical evidence in this study. Rigorous and reliable analysis involves using statistical tools such as SPSS (Statistical Package for the Social Sciences). It discusses the quantitative data analysis method, the implications of the statistical tools, and the reliability and validity metrics.

On the other hand, in the case of complex datasets, SPSS was chosen as the first preference data analysis software for analysing quantitative data. This software has a low hosting range of statistical functions, which makes it ideal for analysing data sourced from structured surveys, and its interface makes it user-friendly. SPSS has this feature for data management tasks, e.g., coding and cleaning the survey responses, and more advanced analytical features such as hypothesis testing, correlation analysis, and regression modelling (Bhatta, 2018). SPSS is helpful because it provides reliable and efficient data analysis. It automatically makes calculations and uses statistical techniques. Findings are also presented in SPSS using graphs, charts and tables. These features also make this tool a good data analysis tool for the survey data we collected for the current study.

For the research questions and objectives, several analytical techniques for the quantitative data analysis, including inferential statistics, descriptive statistics and advanced multivariate analysis, were pursued. Descriptive statistics summarise and describe some characteristics of the sample population. The measures of central tendency (mean, median, mode) and dispersion (range, variance, and standard deviation) are also included. General statistics help to describe the data, but mainly to identify how data are distributed and the key trends in the data. Descriptive statistics may be used to analyse, for example, the prevalence of alcohol misuse or what the average Likert scale scores on some form of stigma scale.

Test hypotheses and examine relationships between variables using inferential statistics. Techniques for analysis of variance (ANOVA) and correlation analysis are applied to find out if

there are significant differences or associations. ANOVA is especially effective in testing the differences between means of different groups, for example, to establish the differences between the levels of prevalence of alcohol misuse between different age brackets or socio-economic factors (Sheikh and Sultana, 2016). Correlation analysis helps identify the strength and direction of the relationships between the variables, in this case, the relationship between stress levels and alcohol consumption.

Outcomes are predicted, and key determinants of alcohol misuse and mental health are identified using regression analysis, both linear and logistic. A linear regression is run for continuous variables, and for binary outcomes such as hospital visits due to alcohol-related problems, a logistic regression is run. These techniques help to understand the reasons for the problem and the evidence-based recommendations. The survey data is then explored using such multivariate analyses as factor analysis. Factor analysis simplifies data complexity by resolving observed variables' correlations into several latent constructs which explain the relationships between them (Horrigan-Kelly et al., 2016). An example is items that belong to a coping strategy factor, which would indicate an underlying construct of adaptive coping. The main advantage of this technique is that it increases data interpretability so that theoretical models can be further developed.

Quantitative data analysis requires the data to be reliable and valid to ensure the credibility of the findings. The reliability of the measurements refers to how consistent and stable the measurement is over time, and the validity of the survey instrument is concerned with whether the instrument measures what it professes to measure. The reliability is evaluated through internal consistency measures like Cronbach's alpha, which assesses how coherent items within the construct of a particular survey are. A Cronbach's high alpha value indicates that the items all reliably measure the same underlying concept. Responses administration is also checked against the test-retest reliability, where the survey is administered to a small group of persons to see if the answers are the same at two different times.

Validity is addressed through several approaches. During the survey design phase, content validity is ensured by ensuring the questions mesh with the research objectives and by working with experts to ensure they are relevant. Statistical approaches, such as factor analysis to examine an alignment of the survey items with theoretical constructs, are used to test construct validity.

Tabulating survey results against external benchmarks or related criteria evaluates criterion validity. Stratified random sampling is used to support external validity or the generalisability of the findings. The sampling method ensures that the survey demographic respondents are from the broader population, making the application of the results possible (Mir and Greenwood, 2021). Statistical adjustments are applied if there is any identified imbalance in the sample on any demographic basis, such as weighting.

This provides several benefits for this study in terms of quantitative data analysis. It validates the themes and variables identified in the qualitative phase, ensuring the findings are generalisable. Advanced statistical techniques are used to explore relationships and patterns nuancedly, supported empirically by the study's conclusions. Analysis that addresses reliability and validity improves the credibility and applicability of the findings and provides a complete view of the research problem.

3.7 Integration of Qualitative and Quantitative Findings

The exploratory sequential mixed methods design features a central integrative aspect of qualitative and quantitative findings to gain as much depth and breadth of analysis as possible informed by the study. It is a process of systematic sampling of qualitative phase insights with quantitative phase data to produce a holistic view of the research problem. Results from both phases are synthesised to capture the complexity of the interplay between mental health and alcohol misuse, combined with qualitative findings that were used to inform the design and analysis of the quantitative data. This section outlines how sequential integration is done, the role of qualitative data analysis, and how we do and interpret the combination and synthesis of results.

Initially, the sequential process of integration begins with the qualitative phase, which involves data collection from semi-structured interviews with people who have a direct or indirect connection with these issues. In this phase, they make efforts to explore to what extent rich, specific context of participants' experiences, perceptions and challenges. The following qualitative phase was based on the themes and variables from the qualitative phase.

The conversion of qualitative findings into measurable variables is a transition step; then, a structured survey instrument is designed to measure these variables among a broader population. For example, in interviews, themes such as social stigma, coping mechanisms, or barriers to mental health service access are operationalised as survey questions. Given the level and structure of this

thesis, this helps ensure that the quantitative phase complements and adds value to the qualitative rather than posing an unrelated or abstract set of questions. When the two separate phases are complete, the results will help the researcher comprehend the research problem fully. Qualitative findings build with depth and context over the statistical patterns in the quantitative data; qualitative results corroborate or further refine the empirical evidence obtained from the quantitative data (Mizrahi, 2020). This iteration fully explores the research problem of subjective experience and objective trends related to the topic.

The findings from the qualitative part of the study play a decisive role in streamlining the quantitative part. In the qualitative phase, thematic analysis is used to discover key patterns, themes and variables relevant to the research objectives. These also facilitate the design of the survey instrument used in the quantitative phase to the extent that it handles the most interesting part of the research problem (De Langhe and Schliesser, 2017). As an example, if interviews reveal that social stigma is a significant obstacle to seeking help for alcohol dependency, this theme is given to survey questions to measure prevalence and magnitude in the broader population. Likewise, qualitative ideas of coping strategies or emotional triggers for alcohol misuse are converted to Likert scale questions to test the statistical significance.

Using qualitative findings to inform the quantitative stage also adds to the relevance and specificity of the survey instrument. The study grounds the survey in real-world experience to ensure the questions mean something and the participants respond to what is being asked. Qualitative findings also help understand what demographic or contextual variables (e.g., age, gender, socio-economic status) might be related to the research problem. Subgroup differences and patterns are explored using these variables in the quantitative analysis.

The qualitative and quantitative findings are integrated in synthesising and interpreting combined results, and comprehensive conclusions are drawn. The data from each phase is analysed individually, after which a systematical comparison of the results is used to identify convergence, divergence and complementarity. The evidence supporting the study's conclusion is strengthened by convergent findings, where qualitative and quantitative data have a standard way of suggesting the same thing. Take, for example, if both interviews and survey responses point to stress as a major provoker of alcohol because then the validity and reliability of the findings are reinforced. Qualitative and quantitative results are carefully compared to divergent findings to ascertain

potential explanations: differences in sample characteristics or methodological limitations. They may also show new insight or places for further research.

Complementary findings, which use quantitative and qualitative data to address different aspects of the research problem, increase the understanding of the study. For example, the narrative-type of qualitative data can tell a story about person-based experiences in detail, and the quantitative type of data can measure the incidence or importance of such experiences in a population (Tamminen and Poucher, 2020). By integrating these perspectives, the study makes a more comprehensive contribution to the literature. The combined results are then interpreted in light of the research objectives and theoretical framework. The statistical trends are contextualised and explained, and the qualitative data are used to validate and generalise. Yet, this iterative process ensures that the study holistically captures the complexity of the research problem, both subjective and objective.

This is the main benefit of the study — the integration of qualitative and quantitative findings. It triangulates data from various sources to enhance the validity and reliability of the research because it reduces the chance of bias and, therefore, provides the researcher with a clearer picture of the research problem. Importantly, this comprehensive view is primarily a way to engage with issues such as alcohol misuse and mental health. These areas require an understanding of the experience of individuals as well as the structure of society as a whole (Saharan et al., 2020).

3.8 Ethical Considerations

The research process is ethical, which results in studies carried out ethically to safeguard the rights, dignity and well-being of the one who becomes the participant. This study is sensitive to issues regarding alcohol dependency and mental health and, consequently, demands the implementation of strict ethical standards at all stages of research. This section consists of the ethical approval process, collection of consent from participants, confidentiality and data security measures, and other steps to which the subjects of the study are sensitive.

The study starts only after initiating it and receiving formal ethical approval from a relevant institutional ethics review board. The process of presenting a research proposal elaborates on the objectives, methodology, data collection methodology, and ethical risk. It also draws particular schemes, manages problematics, takes care of the participants' welfare, and complies with the

ethical standards of the Declaration of Helsinki and with the principles of national research councils.

Before the ethics review board reviews a proposal, the board the proposal, ensuring that the research meets the principles of beneficence, non-maleficence, autonomy, and justice. The researcher doing the research is responsible for maximising the benefits derived from the research and minimising risk associated with the research to participants. The researcher is obligated to prevent harm; however, due to the vulnerability of persons with an alcohol dependency and with mental health challenges, this is particularly relevant for non-maleficence. This is done to preserve autonomy by requiring that participants give informed consent and be free to withdraw from the study at any time. Just as the benefits and burdens of research are equitably distributed, there is a special focus on making the population participating in research diverse and underrepresented. The researcher must prove complete knowledge of these ethical principles and implement robust mechanisms in case of any risk. The study is conducted when the approval is obtained, in an absolute way, by the approved protocols, and the researcher gives a prompt report on any amendments to the research plan to the ethics review board.

Obtaining informed consent is an essential part of ethical research. Participants are given a detailed information sheet describing the purpose of the study, how data will be collected, potential risks and benefits, and their rights as participants. The sensitive nature of the research topics is considered by using clear and simple language throughout this document, including instructions for industry professionals and students.

Participants are informed of their voluntary participation in the study and may discontinue the survey at any time without a reason or penalty. They are also made aware that failing to sign or withdraw does not threaten their content to services and support. A signed consent form is used to document consent because it shows that a participant has read the nature of the study and agrees to be included (Kirongo and Odoyo, 2020). However, written consent cannot be obtained when the participant cannot do so and verbal consent is taken down and signed by the participant. For online surveys, consent is obtained through an electronic consent form shown at the very beginning. Care is taken to ensure participants have adequate time to read and ask questions about the information sheet before consent is given.

Due to the sensitive and stigmatising nature of the research topics, the integrity of the participants is of utmost importance, including their confidentiality. All collected data is anonymised, meaning all identifying information is replaced with unique codes so participant identity is not revealed. Interviews are audio recorded on password-protected devices where the audio is securely stored and identified details are removed before the audio is transcribed. Encrypted files containing transcripts and survey data are stored and available only to authorised research team members.

Data security measures conform to the law and institutional standards, such as the General Data Protection Regulation (GDPR) for European studies. There are security measures such as secure storage, restricted access, and regular auditing to remain compliant. Personal data are deleted after the completion of the study or in compliance with the standard provided by the ethics review board. In parallel to securing confidentiality by technical safeguards, procedural measures are taken to prevent privacy breaches. For instance, interviews are conducted privately so that participants feel safe discussing sensitive issues. Findings are reported in aggregated form to avoid disclosing any individual characteristics.

Data collection on alcohol dependency and mental health is so sensitive that the researcher must be empathic and care about what is collected. When participants talk about these issues, they could become upset, and that requires thoughtful planning to minimise that harm and offer support when needed. Open-ended and non-judgmental interview questions allow participants to give their experiences from their point of view. The interviewer does this while keeping the tone neutral and supportive, not using language that might be stigmatising or intrusive. According to participants, when they are interviewed, it is made clear they do not have to answer questions that make them uncomfortable, and breaks are offered if necessary. If participants experience distress, there are resources for professional support, such as referrals for mental health services or helplines. The researcher ensures that participants are acquainted with these resources within and after the data collection process. The research team also receives additional training to recognise when an individual is distressed and, with approval or consent from the participant, how to respond while still gathering meaningful data.

However, this study considers ethical considerations in its design and implementation, thus conducting it with integrity, respect and sensitivity. The study ensures the protection of

participants' well-being while generating key insights into how these two problems are linked together with a heavy emphasis on the rigorous ethical approval process, informed consent, protecting confidentiality, and, in some cases, some of the research topics are sensitive. The ethical safeguards in these also add credibility and reliability to the research and commitment to the highest standards in research ethics.

3.9 Limitations of the Methodology

The chosen methodology aims to provide a broad understanding of how alcohol misuse and mental health interact, but it must also recognise its limitations. These limitations are due to biases in qualitative and quantitative approaches, data collection and integration, and constraints on the generalisability of findings. The limitations corresponding to these were then recognised and used to interpret the results in a balanced way and to suggest areas for further research.

Although qualitative and quantitative methods are complementary, both are prone to their own biases that can influence the validity and reliability of findings. Potential biases from the semi-structured interviews rely on the participants and the researcher, i.e., these interviews are qualitative in nature. Due to the sensitive nature of topics such as alcohol dependency and mental health, participants may have arrived at socially desirable responses. Consequently, behaviours and experiences are not reported or selected for reporting. Likewise, data collection and analysis processes may be influenced by researcher bias. For example, the interviewer's type of tone, or how they worded out questions, may affect how the participants responded. However, qualitative data analysis is subjected to subjective interpretation of specific themes rather than others, which may introduce bias (Edson et al., 2016).

Neither are quantitative methods immune to biases. Respondents in structured surveys may engage in response bias, such as choosing answers they believe will be 'expected' or not answering extreme options on a Likert scale. When the questionnaire is lengthy, survey fatigue can cause people to stop and become inattentive, incomplete, or even skip questions, affecting survey quality (Davidavičienė, 2018). Furthermore, some survey questions and variable frames may become selections by themselves just by the researcher's assumption, and they may not be able to cover the scope of the quantitative analysis.

Mixed method research data collection is beset with logistical and methodological problems, and sensitive topics complicate the task. Recruiting participants who are prepared to

talk about their experiences of alcohol misuse and mental health can be challenging because of the stigma, the fear of judgment or concern about confidentiality. Participants who agree to participate may result in a self-selected group and, therefore, may not include a full spectrum of perspectives. It also necessitates planning our interviews so the participants feel comfortable and supported and the data collection process is longer.

Given the extensive effort and resources required to draw a representative sample for the quantitative phase, much time and money is spent on building the sampler. The challenge may be identifying and reaching out to participants from underrepresented or disenfranchised groups, who may be particularly hard to access because of a lack of connectivity or confidence in research initiatives. Furthermore, piloting and revising help eliminate as much misunderstanding and cultural biases as possible, but diverse people must also understand survey questions uniformly. However, integrating qualitative and quantitative data makes the problem more complex. The findings of phase two have to be aligned with phase one, and a high degree of methodological rigour is required for this because of differences in types of data, levels of abstraction and analytical frameworks. Additional interpretation and contextualisation may be necessary to explain divergent findings between the two phases, which can be time-consuming and costly.

Several factors inherent in the research design constrain the generalisability of the findings. The first phase, qualitative, which uses purposive sampling, aims to collect more depth and detail than representability. An advantage of this approach is that it gives some information about individual experiences, but individual findings may not capture the variation across the full diversity of their experiences across a population. For example, there is no accounting for the perspectives of people who do not participate in the study—whether due to stigma or other barriers—while limiting the extent to which the qualitative data is comprehensive.

Adopted by quantitative phase efforts attempting to achieve a representative sample through stratified random sampling, response rates, and sample limitations can undermine the generalisability of results. Non-response bias, where certain groups are less willing to do the survey, skews the results and diminishes their use as a basis for the community. Statistical methods can reveal patterns and associations but cannot fully explain the complexity of human experience or capture all the potentially significant factors influencing the observed trends (Mir and Greenwood, 2021).

The highlighted limitations underscore the risk of care in interpreting findings and transparency in reporting. Potential biases and challenges acknowledged can ground a discussion of the study's contributions and limitations. Yet, these sources can be limited; however, triangulating across sources, carrying out as rigorous pilots as possible, and attending to reflexivity in qualitative analysis can help minimise their limitations. Moreover, future research into the trend can extend the results by expanding the scope of the study, adding unaddressed variables, or using alternate methodological approaches to verify the results.

3.10 Reliability and Validity

All research studies depend on integrity and credibility to be reliable and valid. These concepts relate to the consistency and reliability of research processes and outcomes, i.e., the reliability of the findings. Validity is how valid the research methods and instruments are, and reliability is how well the research results are or how repeatable and consistent. In this section, how reliability and validity are reached in the qualitative and quantitative phases, as well as how findings are integrated, is studied.

Reliability is achieved in qualitative research through methodology rigour and consistency in data collection and analysis. In this study, the interview protocol is based on a well-designed interview protocol, which permits the free exploration of themes emerging from the interview without forcing all participants to answer the same questions. This approach makes the process standard across participants so that variability is ruled out when capturing the data. Audio recordings and verbatim transcription not only make reliability better but also guarantee retention of the accuracy of participants' responses for detailed analysis. Inter-coder reliability is assessed by independent researchers comparing the coding of a subset of transcripts for consistency in the coding process. Differences in coding are resolved through interaction and consensus to guarantee a coherent analysis of code.

In the quantitative phase, reliability is managed through careful instrument design and testing. Statistical measures like Cronbach alpha measure the internal consistency of a survey by how much the items in a construct are correlated with one another. A high Cronbach’s alpha value implies that survey items measure the same underlying concept consistently and reliably. It also assesses the survey's test-retest reliability, testing the same small sample twice to confirm that the

respondents' answers on both occasions are the same. These measures ensure the repeatability of the survey results, and thereby, the quantitative findings become more reliable as a whole.

In qualitative research, validity is very closely related to the credibility, or trustworthiness, of the data gathered. This study is enhanced in validity by strategies such as member checking and triangulation. Member checking is passing preliminary findings to participants to ensure that their ideas have been interpreted correctly. Yet, this process also bolsters the legitimacy of those findings by incorporating participant feedback. Triangulation is achieved by comparing data from varied sources such as interviews with the individual, caregiver, professional and their data. It is an approach that would help to reduce the risk which is being consciously taken to reduce bias, and the findings would be more credible.

The quantitative phase addresses content validity, construct validity and external validity. The validity of the content exists if the survey questions effectively gather the content in constructs that allow people to understand. The survey instrument is developed by refining questions based on qualitative findings and consultation with experts. The relationships between survey items and theoretical expectations are examined to assess construct validity. For example, just as it is being analysed, items for assessing social stigma and coping mechanisms are measuring the intended constructs (O'Gorman et al., 2014). The stratified random sampling is used so that the results of the survey are generalisable to the entire population being studied.

The integration of results from qualitative and quantitative studies constitutes a challenge for reliability and validity in a mixed methods study. The study employs systematic and transparent procedures to combine the data from both phases so as to become reliable. As an example, qualitative themes are operationalised very carefully into measurable variables during the quantitative phase, thus achieving consistency in the way the constructs are defined and analysed (Horrigan-Kelly et al., 2016). Cross-validation of findings from the two phases adds the touch of triangulation and hence enhances validity. Qualitative and quantitative results that converge provide further support to the conclusions made in the study. To ensure a rigorous and reflective integration process, the divergent findings are carefully examined to identify potential explanations for their difference.

Several studies have been done to provide for potential threats to reliability and validity. In the qualitative phase, researcher bias is addressed through reflexivity, that is, the researcher

critically reflecting upon their assumptions about how they, as a researcher, potentially influence their data. In the quantitative phase, pilot testing of the survey instrument provides an opportunity to try out question wording to identify and be subject to ambiguity or bias. In addition, statistical validation of the underlying constructs of the survey is done by conducting factors analysis. Further strength of the reliability and validity of the study is achieved using multiple data sources, methods, and analytical techniques.

Maintaining the trustworthiness of the research requires its reliability and validity. Using rigorous methodological processes such as standardising procedures, triangulation, member checking and vigorous statistical testing, this study has firm ground to create consistent and correct results. The analysis addresses the challenges of validity and reliability during the qualitative and quantitative parts and amalgamation of units, thus yielding plausible and meaningful insights into the association between alcohol misuse and mental health. These measures are sound and essential to the study's findings and to apply those findings to policy and practice improvement.

3.11 Conclusion

This chapter describes a powerful way of carrying out research into the research targets and parsing out the multifaceted ties between alcohol abuse and mental health. Using an exploratory sequential mixed method design, the depth and breadth of the research problem are addressed through the combination of a qualitative and quantitative approach. It provides a basis for the study to be given the appropriate input regarding the social, psychological, and systemic elements that contribute to explaining the phenomenon studied.

The present research is based on a pragmatic philosophical framework for solving practical problems and holistic methods for solving real-world problems. The study is well suited to pragmatism because it allows it to be tackled qualitatively using methodological tools to explore and quantitatively validate generalisation. The advantage of this approach is that it does not get stuck in one paradigm with the complexity of the alcohol misuse and mental health research problem.

The qualitative phase involved semi-structured interviews of purposively selected current and former heavy drinkers, their caregivers and their professionals. These interviews aimed to elicit rich, context-specific findings on the participants' experiences, challenges, and points of

view. Based on these findings, the design of the quantitative survey instrument is then guided towards important variables that exist in real-world experience.

The quantitative phase starts by taking a stratified random data sample from a representative population cross-section. The responses are measured using Likert scale questions based on qualitative findings. This approach can reveal statistical analysis and trends, correlations, and group effect identification. A synthesis of results, a holistic understanding of the research problem, is based upon an orderly integration of the qualitative and quantitative findings.

The following chapters will apply this methodological framework to data analysis and findings. The chapter on data analysis provides the data analysis method of qualitative and quantitative data. It describes the thematic patterns and statistical trends that were observed. Within the results chapter, an integrated results chapter summarising results on factors related to alcohol misuse and mental health will be presented. The goal is to augment academic literature with a systematic combination of qualitative and quantitative insight and to offer evidence-based policies and practice recommendations.

It uses an approach to methodologically address research objectives in a way that elucidates a nuanced view of how mental health and the use of alcohol intersect. Within a pragmatic philosophy, qualitative and quantitative methods can be integrated to appropriate use as the problem remains relevant while maintaining the study's rigour. In the following chapters, the methodological foundation proposed through data analysis will be extended, resulting in findings upon which any conclusions and recommendations could be based.

Chapter 4: Results and Analysis

4.1 Introduction

The central analytical part of this research is Chapter 4, entitled 'Results and Analysis,' where the data collected from both qualitative and quantitative approaches is worked out analytically. The findings of this chapter are presented in context with the successful bridging of the findings to the research objectives. This chapter consists of the thematic analysis of interview transcripts and the regression of the questionnaire data.

This chapter is aimed at interpreting and analysing the data collected to find out patterns, relationships as well as insights around the social triggers to relapse from alcohol consumption. The research questions are to be addressed by this chapter, in which themes in interviews are to be analysed by thick thematic analysis to understand various stakeholders' perspectives and by applying statistical regression analysis tools to verify them qualitatively. The amalgamation of thematic and regression analyses permits a multidimensional comprehension of the relationship between social, environmental, and psychological factors that affect an individual's drinking outcome. This chapter provides a robust framework for understanding and addressing the issues related to alcohol dependency by combining statistical patterns derived from the Likert scale responses in the questionnaire using semi-structured interviews with participant responses.

Several key objectives, which are tightly related to the study's overall goals, guide the analysis presented in this chapter. The objectives seek to provide a comprehensive approach to these central themes of the survey so that the findings attain these objectives. Therefore, its primary focus is to identify and categorise the social triggers that result in an alcohol relapse and recidivism to determine the particular factors driving people into a pattern of dependency. Furthermore, the paper investigates how family dynamics, societal stressors, and environmental conditions shape an individual's alcohol consumption patterns with a focus on how interpersonal and societal factors work together to affect relapse patterns.

Additionally, the study analyses the accessibility and effectiveness of today's intervention strategies and public health policies and assesses if available options to risk individuals meet their needs. These efforts are complemented by quantitative analysis that explores the relationship between demographic variables, social factors and relapse patterns to validate insights from the thematic analysis. The final contribution of the chapter aims to offer evidence-based

recommendations for public policy and intervention strategies to build on the work of the thesis while ensuring the contribution of academics and practice in combating alcohol dependency. For the analysis, the methodology is a mixed method consisting of interviewing qualitative information and questionnaires for their quantitative information. This approach allows the study to take an upstream view, combining subjective experience and measurable patterns to complete an overall survey of the issue.

The responses of 10 participants, selected based on their relevance to the research topic, were thematically analysed. Participants consisted of recovered alcoholics, dependents' family members, psychologists for addition and policymakers. Transcriptions were made and coded using NVivo, a qualitative data analysis software. The first process of this study involved identifying key themes and sub-themes that emerged from the participants' narratives. The outcome of this research allows the researchers to explore the lived experiences and perspectives of those who relapse to alcohol and what social triggers that benchmark precede the relapse.

A questionnaire was also administered in parallel to 50 participants, and responses were collected through a 5-point Likert scale from 'Strongly Disagree' to 'Strongly Agree'. The questionnaire was put together to capture the quantitative data on the research objectives – in this case, the role of social isolation, family support, and the effects of public policy on relapse patterns. SPSS conducted a descriptive statistic, a correlation analysis, and a regression modelling to perform statistical analysis. This is done by quantitative confirmation of the thematic findings that can serve as significant predictors of alcohol relapse in regression analysis.

The central feature of integrating qualitative and quantitative data for viewing this research problem in an integrated manner is found in this chapter. Drawing on the two approaches to research, the depth and richness of qualitative insights and the generalisability and statistical rigour of quantitative research, this approach harnesses both. Through the course of thematic analysis, the participants' lived experiences and personal narratives were brought forth, namely on the emotional, social, and cultural aspects of alcohol relapse. For example, participant narratives describe how socio-stigma, peer pressure, and economic stress factors affect relapse behaviours. Quantitative analysis of questionnaire data adds this step of further statistically analysing the relationship the different factors have for relapse patterns in a larger sample, and qualitative insights complement this work.

Triangulation of findings from both data sources into a theme is followed by checking that the thematic findings provide evidence through statistical testing. To illustrate, the outlet of themes such as "Social Isolation and Relapse" and "Family Dynamics and Support" that appeared in interviews are examined as cross-validated and appear in questionnaire responses on these factors. The synergy of these methodologies is essential not only because it increases the reliability of the findings but also because it increases the applicability of the findings to real-world contexts.

The semi-structured questions in the interview process were aimed at eliciting experiences, opinions, and suggestions from the participants on the topic of alcohol relapse. Those selected were from a range of backgrounds, including people affected by alcohol dependency and professionals in addiction recovery and policymaking. For this reason, the interviews were conducted in a confidential environment to anticipate honest and open responses; participants were also assured of their anonymity to protect their identity.

However, the questionnaire was aimed at a broader demographic, including individuals who had varying levels of interaction with alcohol-related issues. The questions were structured to measure perceptions, behaviours and social influences related to alcohol consumption and how relapse occurs. Responses were on a Likert scale format so that the research could capture a range of opinions and experiences. The outlined dual-method approach in the chapter satisfactorily addresses the research questions and serves as the most appropriate starting point for actionable recommendations. Thematic and regression analyses add to the complexity of social triggers to alcohol relapse, highlighting the need for this integration to get a comprehensive understanding that the academic discourse and public policy interventions could use.

4.2 Thematic Analysis of Interviews

4.2.1 Overview of Primary Data Collection

The data collection was undertaken primarily through qualitative information collection from individuals who are close to the issues of alcohol dependency and recovery through the design of semi-structured interviews. The interview process was developed using the planning of detailedness in an attempt to ensure that the data that was collected was enough to give us a total perspective of the social triggers that led to alcohol relapse and recidivism. A purposive sampling technique was utilised to identify participants who would give varied views about the research

topic, such as recovered alcoholics, family members of a dependent, addiction counsellors, public health officials and policymakers.

The interview was structured but flexible so that the participant could share her experience, thoughts, and suggestions without restriction. The answers to the questions were open-ended and detailed, allowing researcher to be able to discern fine distinctions between what factors lead people to relapse to alcohol. All interviews were held in private settings or through secure online platforms to keep the interview confidential. This method allowed participants to feel at ease talking about stigmatised topics like alcohol dependency, which is a fundamental requirement in studies in which one of the issues is sensitive. Interviews generally took about 15 to 20 minutes and were sufficiently long for participants to elaborate on their views within the planned interview structure.

Members of the demographic group were diverse in the sense that it represented a cross-section of individuals touched by or associated with problems related to alcohol dependency. The participant pool was drawn from individuals with direct personal experiences with alcoholism (recovered alcoholics or those who had relapsed), as well as from people involved in the work of developing professional or policy solutions for alcoholism. An attempt was made to get participants from all age groups, genders, and socio-economic backgrounds, so data was captured from an extensive spread of people's experiences. The diversity did not go to waste in uncovering patterns and differences in triggers and responses in diverse population segments. For instance, younger participants often emphasised peer pressure and social media influences, while older participants stressed the fact of loneliness and health problems. Another theme that emerged was gender-specific, such as the representation of the women's struggles that are felt within the societal stigma that women face and the representation of the normalisation of drinking amongst the men within our culture.

The qualitative analysis required data preparation, which was essential for the integrity and reliability of the analysis. The interviews were recorded, consent was obtained, and then transcribed verbatim. The transcripts were scanned for accuracy and completeness before they were imported into NVivo, a qualitative data analysis software for coding and thematic analysis. Organisation and categorisation of data into themes and sub-themes were essential; NVivo was used to help organise and categorise the data so that patterns, relationships and outliers could be

sought between the dataset. After an open coding definition, key phrases and ideas were extracted from the text in the coding phase. Axial coding was then undertaken in which codes that had some relationship with one another were grouped into broader categories and themes. Finally, these themes were refined using selective coding, and connections between these themes were established to ensure systematic analysis and groundedness in the data.

4.2.2 Theme 1: Social Isolation and Relapse

For those who are relatively isolated and unable to build a strong network of support or are routinely inside for long periods, social isolation is a massive trigger of relapse for alcohol. The lack of meaningful social connections often leads to emotional distress, and one is tricked by alcohol in an attempt to soothe that distress (Menon and Kandasamy, 2018). Participants pointed out that critical moments of being isolated, such as job loss or personal crises, increase vulnerability for relapse. Environmental examples would be places where a person is excluded or marginalised, which makes them feel worthless, causing them to use alcohol as a way to cope (Nnam et al., 2024). Furthermore, as a result of how stigmatised alcohol dependency is, it contributes to social withdrawal, which only compounds the cycle of isolation and dependence. However, older and younger participants pointed to the consequence of the influence of social media and peer relations as amplifiers behind these feelings, while the older participants stressed the effect of retirement and loss of companionship. This emphasises the importance of interventions that create and support a community and social environment.

4.2.2.1 Sub-Theme 1.1: Peer Relationships and Loneliness

The risk of relapse from alcohol is closely knitted in peer relationships and loneliness, as social connections have a significant role to play in determining the behaviours and coping mechanisms of an individual. Sometimes, the lack of positive peer relationships or the existence of negative role models leads to the depletion of support. It creates a vacuum that can pull individuals back to alcohol dependence, and alcohol can be the only way to fill this void (Sewak and Spielholz, 2018). Likewise, loneliness from isolation or deterioration of supportive social networks ratchets up the feeling of dejection and hopelessness and makes a return much more likely.

Regardless, participants always mentioned how peer dynamics can play a considerable role in helping or hindering recovery. According to Participant 4, the influence of friends who

normalise excessive drinking often negates the efforts at recovering. As they've experienced, the environment in which they're trying to stay sober is characterised by peers whom they're surrounded by who dismiss the idea of sobriety as either overly sensitive or superfluous. Participant 7 summarised his sentiment that peer pressure, particularly among younger people, was challenging for them to hold onto. According to them, social gatherings often revolve around the consumption of alcohol, with abstainers, in general, being made to feel out of place or excluded.

Several participants also underscored that loneliness affected the relapse. According to Participant 3, when an individual is without a support system, they may seek solace in alcohol to assist with their feelings of comfort. It described the effect of loneliness as the sense that 'it is the essence of feeling empty and alcohol temporarily fills that void. However, if individuals live alone or don't have close relationships with their immediate family, there is no other way to start building meaningful connections (Fritz et al., 2024). Therefore, they may fall back into dependency during situations when they're stressed or emotionally distressed. Older ones pointed out that for those in retirement or widowed, it felt particularly acute if the loss of interaction with people and, by extension, a loss of companionship further compounded feelings of isolation. Participant 8 spoke of their own experience: "If my spouse died, the silence at home was unbearable, and the only way I knew how to get rid of the pain was by drinking."

Similarly, younger participants highlighted peer relationships as a determinate of an enabling or deterring environment for recovery. Participant 2 also noted that younger individuals are supposed to drink or do drugs and are supposed to find these products commonplace in their peer groups. Refusing made them feel like outsiders, and they claimed friends encouraged them to drink as part of bonding. Neupert et al., (2017) stated that this produces a significant obstacle to keeping sober for those people who wish to since some individuals may be scared that they will be ostracised and mocked by their social circle (Neupert et al., 2017). This all becomes harder in the era of social media, where platforms endorse alcohol drinking as glamorous or a basic need for socialising, further normalising it.

On the contrary, the root of loneliness is not external factors, but it originates from the stigma about addiction. They also noted that individuals in recovery will isolate themselves out of fear of being judged or rejected, said Participant 6. According to them, this leads to an atmosphere where people feel stupid to get support since society considers addiction as a personal failing rather

than a medical condition. This self-imposed isolation makes their struggles even harder to fight because they are not ready to turn away from the urge to relapse. Loneliness comes with a significant emotional toll, and oftentimes, people resort to escape from reality with the help of alcohol (Love, 2018).

However, more interestingly, participants also identified how the absence of meaningful peer relationships during recovery can hinder their progress. Participant 9 agreed that "recovery is not about stopping drinking, it's about finding a community that understands and supports you." For many people, the maintenance of friendships that revolved around drinking is taken away, and they need to have taken from those friendships and replaced them with healthier ones, they said. Without this replacement, it becomes more difficult to resist the pull of returning to these corrosive social settings that are all too familiar (Choudhary et al., 2021). This shows how essential it is to create a good peer network for recovery.

Therefore, interventions towards improving peer relationships and loneliness must be holistic. Alternative ways to connect and be part of a group may be to create alcohol-free social opportunities and encourage participation in peer support groups (Moore et al., 2020). Part of the debate was contributed by Participant 10, who told the other side of the coin that "meeting others who have walked the same path gives you hope and gives you the idea that you're not the only one." Aside from providing emotional support, these groups teach people strategies to withstand social pressures and continue to stay sober.

Alongside facilitating new relationships, efforts to combat loneliness should tackle the communal barriers that obstruct people's ability to obtain support. Participant 5 also indicated that geographic isolation can make one feel more isolated, as in rural areas with limited support services. "To some people, they don't have access to local recovery groups or counsellors, and the isolation makes it even harder to break the cycle," they said. DiMartini et al., (2022) highlighted that allowing for the expansion of virtual support networks and telehealth services fills a gap in reaching everyone, especially those in remote areas without assistance (DiMartini et al., 2022). Furthermore, public health campaigns would do well to counter societal norms and the extent of perceptions that promote peer pressure and loneliness. By sharing the dangerous effect of alcohol centred socialising with your community and encouraging other ways to interact, you can help break the stigma associated with those in recovery. Participant 1 recommended that "society needs

to redefine what it means to have fun and bond with others. Alcohol will always be a barrier to recovery, so long as it remains the heart of social life, there will always be a struggle."

4.2.2.2 Sub-Theme 1.2: Emotional Impact of Social Exclusion

The emotional pain and destruction from social exclusion is a huge reason why people die from alcohol abstinence. Social exclusion, with similar feelings of feeling rejected, marginalised or alienated, leaves people with an emotional gap and turns them into seekers of solace in alcohol (Heaton et al., 2023). Exclusion magnifies stress and emotional distress, which, if left untreated, can turn into dependency or relapse for people who want to get better.

Participants consistently noted that stigmatisation always had a highly psychological impact that people were excluded from their social, familial and professional circles. Participant 4 remembered the time that close friends had ostracised them during recovery. Losing their primary social group had resulted in loneliness and worthlessness, which had eventually made them relapse, they said. In such cases, when people feel excluded, it starts to contradict who they are and usually, to deal with the surmounting emotions, they turn to alcohol in such a way, they explained. Participant 7 echoed this sentiment, saying the emotional struggle after their family gatherings began to break down as the result of their addiction becoming known to the public made it difficult to stay sober.

The accounts of the participants document well the link between exclusion and mental health deterioration. In this example, Participant 2 observed that people who feel excluded are more likely to suffer from depression and anxiety symptoms, which in turn make them more susceptible to a relapse to alcohol use. They said that these feelings often worsen the vicious cycle by withdrawing even further from a possible source of support. This is a significant barrier to recovery, this self-perpetuating loop of exclusion and emotional distress (Nyamathi et al., 2016). This reminded Participant 6 of a "downward spiral" in which the pain of rejection becomes more painful each time, saying that at some point, the only way out of the pain is by letting oneself get plastered.

The broader impact of social exclusion on self-identity and confidence also occurs because the individual often internalises the judgment and stigma of the condition. Participant 9 noted that being termed as an 'alcoholic' in their community led them to feel ashamed and guilty and that it propelled them further into isolation. They explained that exclusion acts to maintain negative self-

perceptions and reduces how easily an individual can believe in their ability to recover (Roma et al., 2019). This inability is often exacerbated by a society that regards alcoholism as a moral failing rather than a medical problem. In Participant 5's answer, addiction has a very prevalent stigma, which makes people feel they are not worthy of help, and instead of socialising, they avoid social interaction outright.

Another common theme in participant narratives was the exclusion experienced in professional settings. In the case of Participant 8, they reported how losing their job was a result of their alcohol dependency and the subsequent feeling of rejection from their colleagues. Fritz et al., (2024) suggested that the biggest hits of their recovery were the loss of their professional identity and the isolation that comes with it (Fritz et al., 2024). It is devastating for people who get their purpose and social connection from their work. As Participant 3 outlined, those left without structured support to reintegrate into professional environments often feel hopeless and further marginalised due to being left unprepared.

Social exclusion also depends on public spaces and social norms. Participant 10 highlighted that the very pervasive alcohol-centric culture in such public spaces as pubs and get-togethers (as most social events tend to be) makes it difficult for those in recovery to participate without feeling alienated. Abstaining from alcohol at such gatherings often leads to subtle exclusion where you find yourself in a group that is either not being included or at least treated differently, they explained. Thoughtless overt, this kind of social exclusion, too, carries a significant emotional toll since it reaffirms the idea that sobriety equals social exclusion (Arun et al., 2020). As for Participant 1, he commented that oftentimes, these experiences tend to prevent people from going to social events due to the fear of embarrassment.

The emotional consequences of social exclusion need to be an area of those interventions that aim to build these inclusive environments and challenge the stigma associated with addictions. Participant 7 noted that there was a great need to form groups and programs for recovery which would permit people in recovery societies to be united with people of similar experiences. As they pointed out, these spaces serve as the sense of people belonging and feeling validated against the effects of exclusion. Participant 2 also urged for public awareness campaigns that seek to educate societies on the reality of addiction and recovery, reducing the frame of public citizens into seeing individuals in recovery as more of an outcast rather than those who can contribute to society.

Several also mentioned the mitigating power of family in dealing with the emotional impact of exclusion. Participant 4 also stated that families contribute to helping or hindering the feeling of rejection. When families fail to behave in a judgmental or dismissive manner, those who adopt such an attitude tend to isolate themselves and repeat (Oleskowicz et al., 2023). On the other hand, recovering families, understanding and empathising will lay the solid emotional foundation that eases individuals through the hardship of exclusion.

As reported by Participant 5, the process of rebuilding trust and strengthening the familial bond can be done via family therapy and counselling as tools. Based on the review, Participant 9 proposed workplace reintegration programs that would allow people to gain their professional identity. They could include mentorship, training, and counselling for returning to the workforce. Participant 8 also suggested that these initiatives would go a long way in restoring confidence in people who have been prone to addiction and decrying the stigma of the practice in such professional environments by normalising the concept of recovery.

4.2.3 Theme 2: Family Dynamics and Support

The role of family dynamics in the recovery journey of someone suffering from alcohol dependency is vital. According to Cortés-Patiño et al., (2016), healthy family relationships can be protective and act as stabilising and maintain support, encouragement, understanding, and accountability that will help prevent relapse (Cortés-Patiño et al., 2016). On the other hand, individuals in recovery are often confronted with disease and dysfunctional family dynamics such as unresolved conflicts, criticism, or enabling behaviours. Participants brought up the idea of families actively involved in the recovery process, such as going to counselling or creating environments free of alcohol, which proves to be of help in the pursuit of balanced sobriety. However, on the other hand, if they do not understand that addiction and have judgmental attitudes against those who have an addiction, then they lead to further stress that pressures them to relapse (Boulze-Launay and Rigaud, 2020). Many participants emphasised the need to have the right balance between support and independence and acknowledged that over-controlling behaviours may not be productive. The realisation of these insights further highlights the essential role of healthy family relationships and the involvement of families in integrated, comprehensive strategies for recovery, as they reduce triggers and increase emotional resilience.

4.2.3.1 Sub-Theme 2.1: Role of Family Conflicts in Relapse

A significant source of alcohol relapse, family conflicts arise as a result of strained relationships found within the family unit, which can increase emotional stress and problematic environments (Cullins and Chester, 2024). They can also contribute to the family being an atmosphere of tension and unresolved disputes that make recovery difficult or impossible. The study participants were continually stressing that family dynamics were the most critical factor either going to assist or impede recovery, and many of them pointed relapses to unresolved conflicts or toxic family relationships.

Participant 4 said that constant arguments and not communicating with their family on their road to recovery made it nearly impossible to stay sober. It was explained that they found themselves emotionally spent and turned to comfort in alcohol because the home environment would become a source of stress, and disputes would remain unresolved and escalate. They said family conflict made them feel like you are walking on eggshells, and drinking always seemed the most leisurely escape.

The nature of family conflict is diverse, but common themes tend to include a lack of clarity about the nature of the addiction, unrealistic expectations and historical quarrels that are unresolved (Clay et al., 2023). In Participant 7's comments, he mentioned how their family found it very difficult to believe that addiction is not simply a matter of willpower but is a complex condition necessitating empathy and support. Their family's lack of understanding often led to harsh criticisms and dismissive comments that further fuelled feelings of inadequacy and guilt. They explained that these emotions turned into overwhelming triggers to relapse because alcohol was admitted to wash over the emotional pain caused by these interactions.

Claims were also made for financial disputes within families, a common cause of exacerbating relapse risk. According to Participant 3, financial strain, in combination with the unemployment that comes from their alcohol dependency, was a recurring area of tension within their household. According to them, every argument would only result in pointing out the money, and then accusations and blame would fly around. "It felt like they thought I was a burden and drinking were my way to just shut them out, the constant criticism." Not only does such conflict affect the recovering individual, but it also puts strain on family relationships, making the circle

complete with the conflict between financial stress and alcohol dependency forcing each other (Wukitsch et al., 2019).

Participants also highlighted another dimension of family conflict, which was enabled behaviours. Some family members did try to be supportive of Participant 5, although he believed they inadvertently enabled their drinking by avoiding confrontation and making excuses for what they did. This dynamic, they explained, often caused other family members to become frustrated by the lack of progress and then resort to striking out against the problem when feeling their angry thoughts. "We became emotional battlefields at home, even just trying to have an argument let alone have a drink, felt like the only way to cope," they said.

Yet another reoccurring theme in participant narratives was intergenerational conflict, mainly discussed by younger individuals who described trouble relating with their parents. In Participant 2's case, their parents were controlling and strict, and the behaviour would leave them feeling suffocated and unheard. In recounting that, they said their parents attempted to impose rigid rules on their recovery that drove them to fight, which they described as 'tiresome and degrading'. According to these conflicts, they asked themselves why they were valuable, leading to rebellion that ended in relapse. However, as for the conflicts between older participants and their adult children, some adult children were overburdened with the dual role of caregiver and their frustration that their parents depended on them, resulting in emotional clashes (Yawger, 2018).

Adams, (2021) assessed that there is also the stigma associated with addiction that leads to family conflicts as some family members separate themselves from the person in recovery due to the fear of being judged or retaliated upon (Adams, 2021). In this way, Participant 9 said that during the time of their recovery period, their siblings would cancel inviting them to their family gatherings, concerned that their presence would attract some form of attention that would not be positive. They added that it wasn't just their feelings of isolation that deepened after being excluded; it broke down in arguments with other family members who came to defend them. The fracture of a family under these conditions led to a dynamic that eroded trust and opened up channels of communication, which complicated the prospects of recovery.

Addressing family conflicts is a whole process of recovery that requires a multifaceted approach focused on open communication and mutual respect as priorities. For instance, the

participant said that the family represents a Palliative measure to remove the barriers and create safety for discussing grievances. Therapeutic sessions enabled their family to express anxieties and frustrations constructively, enabling them to build trust again and reduce conflicts. Instead, they said, "When everybody feels heard and understood, it becomes easier to work together to recover, rather than working against each other."

Several participants also called for educational programs to assist families in understanding that addiction and recovery are complicated issues. Participant 10 complained that families often don't have the knowledge or the tools to provide adequate support, and it can get frustrating and escalate, which can be challenging. Thus, they suggested workshops or support groups for families of people in recovery could fill the gap and help these families learn some strategies to face problems and avoid triggering conflicts. "We believe that educating families on what recovery means and being able to help them positively are all so important," they said.

4.2.3.2 Sub-Theme 2.2: Positive Reinforcement from Supportive Families

Supportive families have been discovered as an indispensable factor for continuous recovery from alcohol dependency and preventing relapse. Families don't just offer emotional support; they play a crucial role in helping children to feel stable as a part of a family rather than replace them, foster confidence, and encourage the child's recovery milestones (Le et al., 2021). Many family's active involvement in the recovery process builds a foundation of trust and offers encouragement that considerably reduces the risk of relapse. Participants also spoke of some of the more favourable family dynamics that help recovery to be more realistic and, at times, less so.

Participant 4 highlighted the transformation that occurred during recovery with the support from their family. They disclosed that their family always recognised small victories, such as attending a support group meeting or a week of sobriety. They said this recognition made them feel achieved and driven to keep going with their recovery journey. According to Participant 4, these milestones were celebrated by organising alcohol-free gatherings that helped folks understand that sobriety doesn't have to mean a life without a great social life. Secondly, supportive families help to provide a feeling of belonging and emotional security, both of which are important to those dealing with the recovery process (Butler et al., 2016). Participant 7 explained how they reflected upon it and how their family made space to discuss their struggles, hopes, and dreams in a safe, non-judgmental way. They said that having a trustworthy take-up system made them sense

worth and understood, assisting them in checking out the inclination to relapse. Participant 7 also mentioned that being listened to with no judgment increased their confidence that they could overcome dependency.

Families often provide such encouragement and even become involved in recovery-focused activities to remind the individual of a commitment to sobriety. Participant 9 reported his family's involvement in attending the counsellor and support group sessions with him. Their participation in this showed their family to be invested in their recovery, placing the responsibility to undertake it on everyone. Knowing that my family was willing to step aside from their lives to support me motivated me to work hard not just for myself but for them as well, they said. The collective recovery helped to restructure familial bonds and also served to diminish the stigma of addiction in their home (Lodha et al., 2022).

A number of the participants saw how families can use positive reinforcement to combat the bad feelings that come with addiction, like guilt and shame. During early recovery, Participant 2 indicated feeling overwhelmed with feelings of self-blame, that they did not deserve to recover, and that they were not good enough. Despite this, their family's constant nudging to bring out their best helped them beneficially redirect these emotions. According to them, statements such as 'We are proud of you' and 'You're doing good' helped them hear something that was a stab of hope and validation of themselves.

Along with emotional support, families actively working on removing triggers from their home environment are just as significant in their contribution to the success of recovery (Menon and Kandasamy, 2018). Participant 6 told how they helped their family cut all alcohol out of the household, and a structured daily routine was put in place. Hence, they had healthy habits like regular meals and physical activity. They claimed that this proactive approach not only lessened their exposure to prospective triggers but also helped to give them a feeling of normalcy and stability. The changes made the participant feel like their family was now totally committed to assisting them to stay sober, giving them more confidence to keep going alongside their sobriety.

Families also encourage personal growth and independence to be experienced with positive reinforcement during recovery. Participant 8 explained how they were motivated by their family to do things they had neglected doing while dependent, such as hobbies and interests. They said family support in exploring new activities, such as signing up for a local art class, had let them

find a new purpose and joy without alcohol. Creating a fulfilling life in recovery was key to rebuilding their identity and self-esteem. Positive reinforcement was always found in families which had open and empathetic communication. However, Participant 5 stressed the necessity of feeling free to convey emotions and challenges without concern about being judged. Instead, they explained that their family's desire to speak honestly and empathetically opened space for them to struggle through hard recovery moments. It allowed everyone to talk freely, which only helped build a great support system inside their household.

In addition, several participants elaborated that consistent encouragement was key, even when things did not go quite well. The recovery process is usually a non-linear one, and there are risks of relapse for most individuals. Participant 3 mentioned that the family's steadfast backing throughout a relapse episode was an integral part of getting the confidence back once more. Instead, they said that their family was positive and revealed that they instead focused on comforting and helping them figure out how to keep relapses from happening in the future. This made them feel less guilty and strengthened their resolve to continue with his recovery. To overcome external challenges to recovery, Participant 10 noted the importance of family. They gave an account of how their family took some of the burden off their shoulders by managing stress levels or offering childcare that left them free to help themselves sober. This practical support was seen as positive reinforcement because it showed the family's commitment to helping their loved one recover and took some stressors from the equation that would otherwise trigger a relapse.

Evidence also showed that involving families in community-based public health and recovery programs significantly promoted positive reinforcement. The family actively takes part in workshops and educational programs that include families whose relatives are recovering from their addiction. These programs gave them some insight into the recovery process and gave their family tools to be more supportive (Nnam et al., 2024). Participant 1 stated, "When families are educated about addiction, they learn to be better advocates and allies in their children's recovery journey." Changing the perspective and behaviour to create a supportive family environment is not always easy. Participant 4 agreed that it was a long process for their family to understand the value of utilising positive reinforcement and accepting a more empathetic method. They explained that frustration and impatience were among the first experiences, but eventually, their family realised

that encouragement and support were more helpful than criticism. However, in the end, this evolution in family dynamics ultimately did play a central role in keeping them recovered.

4.2.4 Theme 3: Societal Stressors and Triggers

Factors like social triggers and stressors contribute considerably to the development of alcohol dependency and relapse. However, stress is exacerbated by factors such as lack of financial stability, unemployment and housing insecurity, which makes one more susceptible to using alcohol as a way to cope (Sewak and Spielholz, 2018). Other participants mentioned how the stigma associated with addiction exacerbates feelings of inadequacy and isolation, which in turn exacerbates dependency. As such, they were frequently cited as critical triggers for public health crises like the COVID-19 pandemic; the crisis already heightened stressors and access to support networks was disrupted. Also, cultural norms and social environments which support heavy drinking as a means to cope or bond with others frequently make it challenging for some people to remain sober (Neupert et al., 2017). These societal dynamics generate a problematic web of problems, so systemic issues must be attacked, and complete help should be supplied to those at risk of brutal methods. From the participants' insights, great emphasis is put on the need for community-focused interventions and policies to reduce societal stressors and their impact on relapse.

4.2.4.1 Sub-Theme 3.1: Financial Instability and Job Loss

Past research has consistently noted that alcohol dependency and relapse are associated with financial instability and loss of a job as critical societal stressors. Cortés-Patiño et al., (2016) emphasised that unemployment, economic stringency that translates into reduced income or high mounting financial obligations magnify into a stressful environment where one is likely to have feelings of inadequacies, anxiety and hopelessness (Cortés-Patiño et al., 2016). These stressors contribute to the use of alcohol as a maladaptive coping mechanism, bringing momentary relief while reinforcing the destruction. Insights from this study's participants attest to how impactful job loss and financial instability are on the path to recovery to strengthen the systemic case for change.

Participant 4 revealed that during the COVID-19 pandemic, losing their job as a 'kicker' was a time when they realised they had a problem with alcohol dependency. According to them, the immediate financial difficulties resulting from the sudden loss of income came immediately, but their self-worth also suffered. "When I lost my job, I thought that I had failed my family and

myself. But here, drinking became a way of escape from the overwhelming guilt and stress," they said. This is an experience that adds to how mental suffering intersects with economic hard times, that suffering increases the degree of failure and hopelessness, and all the more so makes people more vulnerable towards relapse.

Meeting basic needs like paying rent or buying groceries was made almost impossible by for many participants who were already under the stress of being financially unstable. For example, Participant 6 pointed out that these pressures resulted in always being on worry watch, leaving her emotionally spent and more inclined to modify through alcohol. "We lived day by day, choosing between basic necessities and treatment-related expenses, experiencing the life of no certainty which was painful to live and all we could do to numb the pain was alcohol," the survivors said. These accounts show that financial hardship directly erodes recovery efforts because so many competing priorities and the need to be financially stable make staying sober difficult.

Another repeated theme among participants dealt with the emotional toll of job loss. One of Participant 8 revealed they felt useless and isolated from society while unemployed. As for work, they said that work had been routine and given identity, and its absence was hard to fill. It's losing part of yourself when you lose your job. The emptiness they were talking about was what drinking was for me. The stifling sense of purposelessness from the idea of unemployment, combined with stigma, can further isolate otherwise suitable help and support, thus increasing the risk of relapse.

Several participants also stressed the cyclical nature of financial instability and alcohol dependency. Participant 3 also mentioned that they often performed poorly in their job and had been dismissed from their jobs as a result of their alcohol dependency. This, in turn, worsened their finances and relied on alcohol as a way to cope. The experience was described as a 'vicious cycle' in which each setback piled on top of the rest, making recovery more complex (Arun et al., 2020). These are examples of the systemic barriers people in recovery face: economic dependency on the one hand and vice versa.

There were also gender differences in the impact of financial instability, as revealed by the participants' narratives. Primary earnings and being a caregiver were different unique pressures for female participants, such as Participant 7. However, they explained that financial loss usually resulted in feelings of lack and stress when it could not cater to their children's or dependents'

needs. "I felt I was failing my family as a mother." Participant 7 said that they could no longer take it, that the stress was unbearable, and drinking became my way of numbing that guilt. In contrast, male participants often highlighted the societal pressure to provide and the effect being jobless had on their self-perception as a man and their pride. Participant 5 also mentioned that feeling pressured to appear strong and capable often bans them from asking for help and worsens the struggle.

The findings from data of national statistics on unemployment and alcohol misuse corroborate these accounts. A 2022 Public Health England report indicates that unemployed people are twice as likely as those who have jobs and tend to engage in hazardous drinking (Oleskowicz et al., 2023).

To address the sentinels of financial instability and job loss in recovery, a multi-layered approach, policy changes, community support, and self-intervention are required. Participant 9 concurred that governments should finance financial help programs for people in recovery without asking for money, as described through grants of access to basic needs and treatment. Additionally, they worked to promote job training and placement programs that allowed these people to get re-employed and start over. For example, community-based initiatives were also mentioned as possible solutions. Participant 1 discussed the role of local support groups in supplying resources and guidance for people experiencing financial difficulties. They said these groups can offer some practical help, such as help with budgeting or having access to food banks, which can take some of the pressures contributing to relapse. "It makes a big difference knowing there are people who care and want to offer to help."

4.2.4.2 Sub-Theme 3.2: Stress from Health and Economic Crises

Health and economic crises have an enormous impact on triggering and provoking alcohol dependency and relapse, with such crises typically increasing the vulnerability of the person, hence being unable to sustain the support systems (Boulze-Launay and Rigaud, 2020). During the study, participants spoke of how the more significant, more prevalent crises like the COVID-19 pandemic increase the levels of stress experienced in the population, making alcohol as a form of contemplation a more appropriate solution. The intersection of health anxieties, economic instability and social isolation during crises means there is a plethora of problems, meaning the risk of relapse and difficulty in aiding recovery.

It was a case in point that a health crisis, such as COVID-19, impacts those people who are dealing with alcohol dependency. In the early months of the pandemic, when pandemic information was limited, Participant 4 described that the pandemic caused heightened anxiety and uncertainty. Fear of contracting the virus was always there, and the media's focus on rising death tallies was always there, yet the feeling of dread was overwhelming (Heaton et al., 2023). "They explain it felt like the world was ending, and alcohol became their way of escaping that fear." This view brings out the psychological pressures of health crises that people rely on alcohol to relieve stress and to deal with the helplessness they feel.

The pandemic also disrupted the access for many participants to essential recovery resources, including counselling services and support group meetings. Participant 7 said that the closure of in-person Alcoholics Anonymous during lockdowns made him feel he was isolated and unsupported. Furthermore, virtual meetings were stressed as a means of getting by, but not replacing the solidarity and familiarity of physical meetings. "It was harder to stay motivated in a time of lack of face-to-face interaction, and I let myself revert to old habits." This highlights the importance of social support in recovery and the fact that health crises can break up these networks, which leaves individuals prone to relapse.

Alcohol misuse also intensifies during economic crises, which are usually accompanied by health emergencies, and stress levels also increase. In Participant 6, they talked about how they were furloughed from their job and, in the process, were financially strained by the pandemic. They added that they were highly uncertain about being able to pay rent and meet basic expenses because of the loss of income. "I just needed a drink to make me forget that my bills were piling up, and every day felt like a struggle to live," they added. This account captures the far more significant effect of economic crises upon the lives of people who are faced with financial insecurity, so much so that it pushes them to alcohol as a temporary respite from their struggles.

Low-income families, families with limited access to health care, and other households with other pre-existing vulnerabilities suffered the effects of both a health and economic crisis (Choudhary et al., 2021). According to Participant 8, their family was already spending more and more money each year before the pandemic, and the marriage hit when their family had health concerns. During this period, their dependency had increased as they stated that they were overburdened by the simultaneous responsibility of taking care of their family while taking care

of their mental health. "It was being caught in a storm with no shelter." They said that drinking was the only thing at all that numbs the pain, even for a little while.

These accounts are backed up by national and global reports recounting the widespread impact of crises on alcohol consumption through data. The stresses of the pandemic, combined with the first lockdown in 2020, led to an increase in alcohol consumption of 25% in the UK, as sales of the drink shot up, according to Public Health England (DiMartini et al., 2022). Also, a World Health Organization study found that economic downturns are associated with higher rates of misuse of alcohol among people, as they use alcohol to cope with job loss, loss of financial security and related stressors. Another recurring theme was people's role in isolation during a crisis. In this regard, Participant 3 mentioned that as social distancing measures are required for public health, it also made them feel disconnected from friends and family. They explained that the absence of social interaction filled a void that alcohol temporarily filled. It was easy to slip into the old patterns, they said, "when you are alone with your thoughts, and there is no one else to talk to." The stress and isolation of the crisis meant that individuals could not maintain their recovery momentum.

Participant 2 said that they hesitated to seek healthcare services for their dependency through the pandemic, worried about being judged or perceived as a burden for the overburdened system. "There was nowhere to turn, and continually the tension intensified," they said. This emphasises the need for interventions to address stigma and barriers prohibiting individuals from getting help during crises.

Other participants also talked about how crises are likely to have a long-term effect on their mental health and the journey towards recovery. During the economic instability of the pandemic, participant 9 described how they became used to being insecure even after being employed again. But they were afraid of losing their job or something similar, so they got into an elevated state of anxiety, which they alleviated with random drinking. Even when things improved, the stress never went away. They also pointed out that they always felt one step away from crashing back down into dependency. This is an excellent example of why providing long-term assistance and resources is crucial to coping with the aftermath of a crisis.

They also argued that public health campaigns could be effective preventive measures to strengthen resilience and promote mental well-being in such crises. Participant 1 suggests that

governments and other institutions should put effort into getting access to tools to resolve stress and educate the public on how to deal with stress healthily. However, they say the campaigns should be culturally sensitive and inclusive so as not to alienate all sections. “The problem is not simply explaining to people not to drink. We need to tell them what they can do instead and where to get help."

4.2.5 Theme 4: Cultural and Environmental Influences

Patterns of alcohol use and the risk of relapse in people in recovery are strongly influenced by cultural and environmental factors. Instead, social norms and cultural practices normalise excessive drinking, so drinking excessively has become part of celebrations, social gatherings, and even professional networking events (Wukitsch et al., 2019). Such normalisation cultivates a milieu of using alcoholic beverages that encourages people to avoid drinking as a matter of the oddness, adding more stress to the ones trying to refrain from drinking temporarily. Considerable environmental challenge is added to those in recovery through factors such as the availability and accessibility of alcohol, particularly in urban settings where liquor stores and bars abound. Advertising and media statements about alcohol continue to promote its association with relaxation, success, and fun, which makes it harder to resist this appeal for individuals (Menon and Kandasamy, 2018). Deeply entwined within cultural and environmental contexts, some of these factors mark the need for interventions aimed at changing broader social perceptions of alcohol and promoting healthier and more socially inclusive forms of recreation and socialising.

4.2.5.1 Sub-Theme 4.1: Public Spaces and Alcohol Normalisation

This affects people who are trying to recover from alcohol dependency such that when alcohol consumption becomes normalised in public, people would then find it easier to become used to drinking in public. For example, most pubs, bars, restaurants and event venues operate as part of a drinking culture in many societies, including the UK (Oleskowicz et al., 2023). However, alcohol is widely treated as a social lubricant, which is naturally woven into day-to-day interactions, ceremonies, and even professional activities. This pervasive normalisation makes recovery individuals face social settings without being discriminated against or exposed to triggers that can lead to relapse.

Participant 4 revealed how they were forced to overcome their struggle with public spaces as a result of the ubiquitous presence of alcohol that prohibited nonparticipation in social events

without the pressure of consuming alcohol. According to them, "both areas left them feeling excluded and uncomfortable because everywhere you go, alcohol is a part of the experience. If you weren't drinking, you feel like an outsider." This observation highlights the struggle faced by individuals in recovery looking to have their social lives but with the concentration of alcohol in public places.

The design and marketing of public spaces just served to further proliferate alcohol's central role in social interaction for many participants. In the promotion and advertising on display, the layout of the pub and bar and how to prioritise alcohol consumption came from how Participant 6 described that pubs and bars are designed to prioritise drinking. "Happy hour deals and drink specials are everywhere, they said. These promotions, even if you are not thinking of drinking, remind you to drink alcohol." While alcohol is the field of focus in these public spaces, allusion to abstinence is not only tricky but also countercultural.

There is data which supports the accessibility of alcohol in public spaces in the UK. By 2022, there were around 46,000 pubs in the UK, as the British Beer and Pub Association reported, suggesting how important these pubs have become for the UK's cultural and economic features (Moore et al., 2020). Alcohol sales in restaurants and bars just added to this, as alcohol made up a considerable portion of the revenue for the hospitality industry. This widespread accessibility and normalisation for recovery is such a challenge to avoid relapse for those in recovery. Alcohol normalisation is more pronounced at social events such as weddings, birthdays, or corporate social events. Participant 2 described being forced to have a drink at a friend's wedding, where the open bar and festive environment made it socially uncomfortable not to drink. "People were asking why I wasn't drinking and it became this thing that I had to keep justifying my choice over and over again," they said. However, all this explaining or defending their abstinence caused them to feel uncomfortable and alienated, which eventually ended up discouraging them from going to such events in the future (Love, 2018).

Another common theme was the role of peer pressure in the public spaces. Participant 7 noted that social groups associate drinking with participation and bonding, making breaking resolve in such environments difficult. They said friends would tell them to 'just have one drink,' and that their trying to recover was overly rigid. This behaviour not only hurts the person's

commitment to sobriety but also perpetuates the culture in which drinking is thought of as a mandatory aspect of socialising (Arun et al., 2020).

Alcohol normalisation does not stop at social events; alcohol is a part of the corporate lifestyle as well, whether at networking events or corporate dinners (Le et al., 2021). They described their struggle to navigate work-related functions, which hinged around drinking, that may have caused harm to their work. They explained that refusing a drink at such events frequently resulted in questions or assumptions about professionalism and added that drinking is almost expected in some industries. "When you do not participate, it feels like you are not part of the team." The pressure of being a professional - to conform to the drinking norms dictates that alcohol has a pervasive influence over many aspects of public life.

In addition to the above, the media and advertising industry also reinforce the normality of alcohol consumption in public spaces (Heaton et al., 2023). The third participant talked about how advertisements generally glorify alcohol as a symbol of success, relaxation and enjoyment and how easy it is to succumb to the temptation. According to them, "So when the ads show happy people drinking at bars or popping champagne, that lends a great connection between alcohol and positive experiences." But this portrayal of drinking also contributes to the continuation of such traditions, and it perpetuates the struggles that folks in recovery face as they try to deconstruct their relationship with alcohol.

A multi-prong approach to address the normalisation of alcohol in public spaces needs to be cultural shifts, policy changes and community-based initiatives. Participant 9 also suggested promoting alcohol-free events and venues for people in recovery as a part in place of a different space to socialise without the fear of exclusion or being pushed to consume. The emphasis was on normalising sobriety as an option worth considering, saying they "hope if we had more options for spaces that aren't alcohol-based, it would mean a lot to people like me."

Possible solutions highlighted include policy interventions like limits on alcohol advertising in public spaces (Sewak and Spielholz, 2018). Participant 5 suggested that there should be more stringent regulations on how alcohol can be promoted, especially in places where families or young adults attend. However, they said that by making alcohol less visible and attractive in public spaces, society's perceptions about alcohol could be shifted, and a more inclusive environment could be made for those in recovery. "Your family and friends might start to see you

as the anomaly if we become better at spotting less alcohol everywhere," they said. Norming the use of alcohol is also challenged through community support and education. To encourage more public awareness campaigns on excessive drinking and healthy ways to socialise, Participant 1 discussed this. Instead, they suggested that these campaigns promote a friendly environment that supports those who do not drink. They explained that it is about creating a society where everyone is included, whether they like to drink or not.

4.2.5.2 Sub-Theme 4.2: Advertising and Media Representations

A key role in forming society's understanding of alcohol consumption is played by advertising and media representations, which influence drinking behaviours and attitudes about being sober. Alcohol is often glamorised as a symbol of success, enjoyment and social cohesion, normalising excessive drinking and building more barriers to get into recovery (Nnam et al., 2024). Media presents powerful narratives, not only endorsing alcohol consumption but also hindering the effectiveness of addressing problems associated with dependency and relapse.

Overwhelmingly, participants commented on how ads create a constant and alluring incentive to drink. Participant 4 felt, "Every time you see an ad, it is an advertisement of someone successful, having fun or celebrating with alcohol. It makes you feel that drinking is the key to those moments." Such representations give alcohol aspirational imagery and pitch alcohol into areas of desirable life experiences, making distance from it challenging. It also adds to the integration of alcohol into everyday life through the portrayal of it in the media, specifically in television shows, movies, and other internet platforms (Neupert et al., 2017). Participant 7 pointed out that alcohol frequently appears as a coping to stress or for celebrating achievements, which normalises its use in a wide range of situations. It explained that "when characters in movies turn to alcohol after a bad day or toast every success with a drink, it sends the message that drinking is a natural response to highs and lows in life." Thus, this portrayal can subconsciously influence viewers to enshrine behaviours, even if they know the risks of alcohol.

People show widespread exposure to alcohol advertising in media. The UK Advertising Standards Authority (ASA) found in a 2022 study that alcohol brands spent £400 million a year on ads, amongst other mediums, on television, social media and billboards (Roma et al., 2019). The study also highlighted that campaigns targeted the young adult demographic most (aged 18–24), suggesting that much of the advertising aimed to promote a longer-term consumption culture.

The presence of alcohol-related marketing in public and private life has turned it into the norm, easing its consumption out of commonplace.

They also pointed out how advertising goes to great lengths to target vulnerable corporations like those in recovery. In Participant 6, digital platforms are often used for alcohol-related ads where the ad is displayed based on browsing history or past purchases. Therefore, it isn't easy to get away. "It was explained to me that I'd see wine or beer ads even after I stopped drinking on my social media feed," they continued. My efforts to stay sober abruptly felt like the system was working against me." Algorithms are used in this targeted advertising to keep alcohol-related content visible, even for those who are trying to distance themselves from it.

Oleskowicz et al., (2023) evaluated that sports and entertainment events should use alcohol sponsorships to cement their cultural prominence further (Oleskowicz et al., 2023). Participant 3 highlighted that major sporting events, like football matches, are usually connected with alcohol marketing, which is simply a merger of sporting and alcoholic events. "We have it as players, obviously, that seeing the alcohol logos on players' jerseys or in halftime commercials is just hard to ignore that drinking is part of the fun," they said. The problem with this association is particularly troubling for the recovering individual as it puts alcohol inside of the ones they count as leisure and amplifies triggers, which can be so distracting when they are trying to relax and enjoy themselves (Adams, 2021).

They also shape the gendered perceptions of alcohol consumption through media representations. Participant 8 mentioned how advertisements often depict alcohol consumption differently for men and women, passing on social stereotypes to affect the way drinking happens. They revealed, "Men are made to come out strong and social when consuming alcohol, while women appear as much as elegant and carefree. These images amplify gendered norms that can push people to drink in certain ways to enforce society's expectations." Such depictions are not just normalising alcohol consumption but further complicate any recovery with further societal pressures (Yawger, 2018).

Alcohol advertising and media portrayals are significant obstacles for people in recovery from alcoholism. Participant 2 said she gets the psychological kick in the gut from seeing ads promoting booze, which she called "kind of telling you that you're missing out on something that you know is not good for you." It is an expression of people who are trying to distance themselves

from alcohol and yet are surrounded by messages of consumption. Another common theme was the role of social media in propagating these challenges. Participant 9 said platforms like Instagram and TikTok are filled with content raving about alcohol, from influencers cheerleading brands to drinking games on the platform going viral. According to them, "Social media make it seem like everyone is drinking all the time, and if you are not then you are missing out." The effects of this new digital amplification of alcohol culture are particularly hard on those of us in recovery because reconstructed sobriety becomes the deliberate deviation from the expected norm.

While the potential of alcohol advertising and other media representations as contributing to alcohol-related harm was recognised, participants argued that their impact needs to be opposed (Neupert et al., 2017). According to Participant 10, stricter restrictions on alcohol advertising should be imposed, especially in the digital world, where groups like young adults and people in recovery are easily exposed. Governments should be prevented from allowing ads of alcohol to be as frequent or as heavy on the content of their drinking, according to them, and such ads must not enchant drinking or towards people who have already possessed the dependence in their past. Other solutions discussed included public awareness campaigns to challenge the narratives that alcohol advertising is promoting. Participant 1 indicated that these campaigns should really push forward the benefits of sobriety and also show different ways to celebrate and cope without alcohol. So, the way that research described it was that "we need more positive stories about people thriving without alcohol because it becomes normalised and aspirational." Such campaigns can shift the narrative to help people be less pressured to drink with the herd.

In addition, media literacy as a strategy to counteract alcohol advertising was recommended. Participant 5 emphasised teaching people, especially the young, critical analysis of advertisements and their ability to discern the manipulative tactics used to promote alcohol. "Because people realise that ads play on people, they're less likely to be fooled by the illusions they create," they said. This enables the person to make the choice knowingly and fight the media representations.

4.2.6 Theme 5: Accessibility to Support Services

A primary factor against alcohol dependency and relapse is support services availability. Services such as counselling, rehabilitation programs, and community support groups are only available and affordable when these services are available and affordable. Nevertheless, barriers

such as geographic disparities, financial constraints and the lack of resources limit individuals from getting the help they need (Boulze-Launay and Rigaud, 2020). Participants noted that fewer experts service rural and underserved areas, and people must travel far or give up on treatment. They also spend a lot of money on private counselling and rehabilitation programs, which are prohibitively expensive for many, requiring them to be dependent on overstretched public services. Other impediments to access include stigma and fear of being judged. These barriers require targeted interventions, including increased public health program resources, expanded telehealth coverage, and linking public health care to community-based care (Nyamathi et al., 2016). Alcohol dependency must be sobbed for by equal support services and access to foster recovery.

4.2.6.1 Sub-Theme 5.1: Barriers to Accessing Affordable Treatment

The treatment of alcohol dependency is still a challenging barrier for people who need to ask for help. Financial constraints, limited availability of subsidised programs, and lack of insurance coverage restrict the ability to get support. Additionally, refusing immediate access to treatment is neither a short-term nor ideal barrier, as its denial comes at the risk of relapse by amplifying the chance of individuals returning to their addiction if they were not treated initially (Love, 2018). Participant narratives reveal that the barriers are pervasive and multipronged, encompassing a system redesign such that accessibility can be enhanced.

Participant 4 revealed that they suffered from the high costs of private rehabilitation programs, which were beyond their financial capabilities. But they said that even as public programs had long wait lists, they found themselves in a vulnerable position at key moments on their recovery journey. "It made me feel that I couldn't afford the recovery." This sentiment reflects the financial inequities of care access, particularly to those with little resources. This also shows that most public programs available are not affordable. Participant 6 comments that there are government-funded services but that demand creates a need significantly higher than supply, and unpredictable delays can be devastating. In the meantime, they described waiting for months to access a state-funded counselling program while their dependency worsened. Every day counts when you are ready to seek help. They described being told to wait months for an appointment as abandoned. These delays highlight a deficiency that needs to be addressed by increased investment in public health infrastructure to expand the capacity of affordable treatment services (Sewak and Spielholz, 2018).

For many, the cliffs of geographic disparities only steepened the task of receiving affordable care. Participant 3 further explained that living in a rural region meant that the nearest treatment facility could be hours away and, thus, it was impractical and expensive to visit regularly. According to them, the travel expenses added to the days lost work became an insurmountable barrier to acquiring treatment. "Wherever I was living, no one offered help." Another obstacle was the cost of travelling to the nearest facility. Service distribution is also a significant concern because there is often a severe shortage of specialised care in underserved places (Butler et al., 2016).

Another theme that kept reappearing was the role of insurance in getting affordable treatment. Participant 8 detailed their experiences with slim insurance coverage for addiction treatment, paying out of pocket for the necessary services. They explained that their insurance only paid a fraction of the costs and that they could not afford long-term rehabilitation programs. "The costs were just overwhelming, even with insurance. Everything seemed to be geared to make it impossible for someone to recover if they weren't rich," they said. This reflects broader systemic issues in which many individuals do not have viable options for care because they are not covered by sufficient insurance (Roma et al., 2019).

Access to affordable treatment is also a function of cultural and social factors. The second participant talked about how social stigma and judgment in their community prevented them from seeking help even when it was affordable. Fear of being called an 'alcoholic' or ostracised from the social community was a hindrance for them to approach public programs. The shame of asking for help was almost as bad as wanting to depend. They said it kept them from seeking treatment while it was needed most. This is important as it emphasises the necessity of combating societal attitudes toward addiction to change an environment in which people do not feel safe in accessing care (Lodha et al., 2022).

In part, financial barriers are particularly burdensome to marginalised populations such as low-income families and people of minority backgrounds (Boulze-Launay and Rigaud, 2020). "The reality is that when those systemic inequities prevail, these groups have less to invest in treatment," Participant 7 said. As single parents, they said that "the cost of treatment was such a deterrent because the cost of treatment competes with other matters such as childcare and housing. There was no real choice between paying for rehab or keeping a roof over our heads. They had to

wait for my recovery." The point here is how economic and social inequalities work together to influence who has access to care.

Participant 9 emphasised the adverse effects of uncoordinated and isolated services on affordability. One of the most significant problems they described was how navigating from one provider to another and in other agencies created extra costs—administrative fees overlapped consultations, for example. They said every process step was designed to impose another expense, from intake assessments to follow-up appointments. There may be ways to streamline services and reduce administrative complexities to help alleviate these financial burdens and bring treatment closer to people who need it (Nnam et al., 2024).

Data from national reports on the system barriers to affordable treatment corroborate these participant narratives. In a UK Department of Health and Social Care (2022) report that details rates of individuals seeking treatment for alcohol dependency and who were or were not able to receive treatment within a month of their first enquiry, only 35% were able to access the service (Cullins and Chester, 2024). The report also pointed out cost as an essential barrier, with 42% of respondents recalling that high out-of-pocket costs were a reason for not using the services. These figures underscore how critical it will be for policymakers to develop policy interventions to improve affordability and expand access to care. They also provided suggestions for making it more affordable and accessible. Participant 1 advocated more government funding so that public treatment programs would grow and wait times would decrease. They highlighted that more spending on prevention and early intervention could help alleviate the long-term costs of dependence that are not treated. They said if more resources were spent on public programs, lives could be saved, and the health care system could be lightened.

A second proposed solution was to expand telehealth services to rural or underserved areas. In Participant 5's words, virtual counselling and online support groups could be affordable and convenient ways of accessing care without physical presence. According to them, accessing telehealth during the COVID-19 pandemic allowed them to continue their recovery journey with the freedom of medical finances and logistics, like travelling to a facility. "Telehealth changed my life in that it made a huge difference for me. It supported me without the additional costs," they explained. This is important as it shows the promise of digital tools to fill the gaps in care and make treatment more available.

Finally, participants advocated that community-based initiatives should address affordability barriers. Participant 10 shared that local support groups and non-profit organisations assist in supplying free or low-cost resources for people in recovery. They outlined a community-run program with counselling, peer support, and unrestricted educational workshops, invaluable resources for those who cannot afford private treatment.

4.2.6.2 Sub-Theme 5.2: Geographic and Demographic Inequalities

These geographic and demographic inequalities also influence alcohol dependency treatment and recovery services to be impacted more as barriers by place, socioeconomic status or demographics (Arun et al., 2020). They create disparities for them and compound the problems these vulnerable populations have. Based on this understanding, insights consider that systemic gaps in service availability and accessibility cause such inequality and presuppose the presence of directed interventions to compensate for such disparities.

This is not limited though to even just rural settings; areas with large concentrations of people and consequent lack of appropriate infrastructure to treat alcohol dependency both in urban areas also have the issue of geographic inequality (Menon and Kandasamy, 2018). Participant 7 elaborated that living with overburdened public facilities in an economically disadvantaged urban neighbourhood further decreased their chances of timely care. Specifically, long waitlists and crowded support groups resulted in people being seen as neglected. "They said they had the few facilities in my area and were always filled, and I had the feeling that you kind of had to fight to even get that possibility to receive help." The acute need to expand services to the demand for recovery programs becomes apparent because of the shortage of services in densely populated areas.

As participants pointed out, data from national reports confirm the disparities found in attendees' neighbourhoods. A 2022 Public Health England survey found that people in both rural and economically deprived urban parts were 40% less likely to receive alcohol treatment compared to people in affluent urban areas (Fritz et al., 2024). The report added that these disparities were accentuated by unequal public health spending, with insufficient investment in public health per capita in rural regions going beyond what rural areas had in the urban areas. First, these findings demonstrate this is a systemic problem with geographic inequalities and their effect on access to recovery.

Other exacerbating factors are demographic: age, gender, and socio-economic status being significant. "Young adults are often seen as not included in recovery programs," Participant 2, a young adult, noted. So, they explained that most of the support groups they attended were older people, making it difficult to relate or feel understood. "It was difficult to open up if I was the only one in the room that has seen what this looks like for me when I was that much younger." They said they felt alienated. The service gap between this generational group is emphasised by the need to offer recovery programs that fit a group with particular needs.

The participant narratives also highlighted the recurring theme of gender assaults on treatment. While Participant 6, a female participant, mentioned that it was often societal stigma and cultural expectations that deterred women from seeking help for alcohol dependency, he also described the necessity for social support for women in stopping an alcohol dependency. Many of their community women, in fear of being labelled as an unfit mother and judge, didn't go because of that, they said. "There is so much pressure that women have on them to hide their struggles, especially women who are mothers." They noted that seeking help was admitting failure. This gendered stigma acts as an extra barrier for women, mainly if they are from conservative or patriarchal communities.

Socio-economic status and demographic inequalities further limit access to recovery services at the intersection of these two variables. Participant 8, who had low income, commented on the fact that financial constraints and lack of insurance coverage disproportionally affect the less privileged populations. The people there would often not pay for treatment because they would put money into necessities, not treatment costs, so the alcohol dependency loomed there. "People in my neighbourhood can hardly afford to eat or rent." They said recovery services are seen as a luxury, not a necessity. The result is dependency cycles, and the most in need are often the least able to pay.

Cultural and linguistic barriers create another hurdle for minority communities to access recovery services. Participant 9, who is an ethnic minority member, talked about the language barriers and cultural insensitivity in these sites of recovery that led her to feel excluded. Many support groups and counselling sessions were conducted in English, so non-native speakers could not participate fully. "I felt that the programs weren't made for people like me. They explained that I could not connect with the counsellors or group because of language and cultural differences."

The underlying implication is that such services, including design, must be culturally competent to address the unique needs of different populations (Clay et al., 2023).

Participants added that digital tools also play a proven role in closing some of the service accessibility geographic and demographic gaps. Perhaps more critically, Participant 5 noted the reality that people in remote or underserved areas have found telehealth services and virtual support groups to be an alternative. Online counselling sessions, they said, were convenient because they got to the comfort of a professional without the burden of travelling to an office and paying. "Telehealth helped me. With this I was able to get the help I needed without the travel time and the costs," they said. They also pointed out that digital services are not a silver bullet; they require internet access and digital literacy, which may not exist in some populations.

Such a multifaceted approach is necessary to address geographic and demographic inequalities in recovery services. Participant 1 advocated increased funding for programs that expand public health in rural and underserved urban areas. As a result, they suggested that mobile clinics and community outreach initiatives like those could reach the people who deserve services most. "We need to bring services to the people that are being left behind if services can't come to us," they said. These measures could reduce the geographic differences between people who can get the desired time and best care.

Another proposed solution was to offer cultural competency training to the healthcare providers. Participant 10 maintained that the counsellors and the support group facilitators must see diverse populations' cultural and linguistic needs. However, they said employing bilingual staff and incorporating culturally relevant practices into recovery programs would make the environment more inclusive. They emphasised that when people see themselves represented in the services, they are more likely to feel comfortable asking for help. Participants finally concluded that policy changes should be made to combat systemic inequalities. Participant 3 advocated developing national standards for recovery services for fair access nationwide. According to them, the disparities could be eliminated, and outcomes would improve for all individuals if an organised method with consistent funding and service delivery is formulated and implemented. "Recovery should not be tied to where you live or how much money you have." They said that it should be a right for everyone.

4.2.7 Theme 6: Effectiveness of Public Policies

Alcohol dependency and relapse have proven to remain a critical area of concern for the effectiveness of public policies in terms of addressing such an issue. Yet, policies influence recovery services' availability, access, and quality. Some success has been achieved in limiting consumption rates and preventing dependency by means such as alcohol pricing strategies, advertising restrictions and licensing laws (Farmer et al., 2022). However, they felt that while implementing and enforcing these measures had significant gaps, they weren't impacting much. Policies aimed at vulnerable populations like low-income communities and rural regions often lack quality support for these groups and, unfortunately, do not consider the myriad challenges they may encounter. In addition, the integration between healthcare systems and community-based initiatives is lacking, hindering comprehensive care (Nicholls and Conroy, 2021). Participants emphasised the need to create policies that offer access to recovery resources in a way that reflects cultural, economic, and geographic differences. Strong public policies, however, by better funding, enforcement or stakeholder collaboration, are required to combat alcohol dependency and the associated societal consequences effectively.

4.2.7.1 Sub-Theme 6.1: Limitations of Current Campaigns and Policies

Due to decades of public health intervention on the problem of alcohol dependency and relapse, the limitations of current campaigns and policies to address these problems have emerged as a matter of focal interest in understanding the failure of societal and individual-level challenges to relent (Killgore et al., 2021). Participants in this study noted that various initiatives and policies to reduce alcohol misuse and encourage recovery were lacking concerning design, implementation and effectiveness. In addition to limitations in accessibility, cultural relevance, and lack of enforcement and resource allocation, these limitations underline the necessity for further targeted and inclusive approaches.

It was consistently emphasised that many of the public health campaigns do not connect with people in recovery or those at risk of relapse (Wardell et al., 2020). Participant 4 pointed out that most campaigns aim at increasing public awareness of the perils of alcohol abuse instead of providing concrete and valuable actions to people with an addiction. According to them, "seeing posters about how alcohol can ruin your life doesn't have any effect when you are already in the middle of it. We need campaigns on how to get out of it," concluded what he needed. This message

reveals the tooth gap between the tone of fighting campaigns today and the issues people are experiencing with the fluid face. Other concerns of participants included the lack of inclusivity in public health initiatives.

According to Participant 6, the reason many campaigns are created with a one-size-fits-all approach is that they do not consider the different cultural, social and economic backgrounds of people suffering from alcohol dependency. According to them, "most campaigns feel like they are aimed at a faceless sort of audience, but people's struggles with alcohol are deeply personal and hugely impacted by their environment." Without being more specific about what triggers and barriers are unique to who, campaigns become less effective because they do not target what is specific to various demographic groups (White et al., 2020).

The public policies that promoted access to treatment resources were also criticised. In some ways, as Participant 7 relayed, campaigns often steer individuals to services that are either underfunded or overwhelmed by demand, leading to people feeling frustrated and powerless. "It's false hope when campaigns are telling you to seek help and the services they're pointing you to have month wait lists or you can't even afford it," explained them. The lack of a consistent supply of resources currently undermines the credibility of public health issues and provides people with no other option but to endure their addiction (Vanherle et al., 2022).

Another area where participants saw limitations was enforcing alcohol-related policies, such as advertising restrictions and minimum pricing laws. In Participant 8, the prevalence of alcohol advertisements on social media was mentioned, even though there are regulations which limit exposure. "They also said it is almost impossible to avoid alcohol ads online, even if there are supposed to be rules against reaching out to certain groups." More importantly, this failure to practice advertising restrictions creates additional triggers for individuals in recovery. Minimum pricing policies were similarly considered for their effectiveness, especially in positively impacting vulnerable populations (Roberts et al., 2021). Participant 3 raised concern that while these policies seek to decrease the harmful consumption of alcohol, they target low-income persons disproportionately but don't address the cause of dependency. "Raising prices might help some people not drink as much, but it doesn't solve people drinking to cope with issues like unemployment or trauma," they said. This critique further emphasises the need for policies that are not only economic deterrents but also the underlying factors contributing to alcohol misuse.

Some participants also mentioned a policy limitation in the lack of coordination between healthcare systems and community-based initiatives. Participant 2 also talked about recovery, which he said often involves many components such as medical treatment, counselling, and peer support, but this is rarely combined. "You are left to navigate a fragmented system on your own, and it is exhausting trying to piece together the help you need from different places," they stated. The lack of integration not only complicates the recovery from such events but also surprisingly creates inefficiencies in the allocation of resources.

Data from public health reports support participants' concerns. A 2022 Public Health England review found that of those looking for treatment for an alcohol dependency, only 38% received comprehensive care, with medical, psychological and social support (Ritter et al., 2020). The availability of services was also reported to be significant in regional and, in particular, rural and economically disadvantaged areas. Findings like these show that policymakers' efforts to support recovery are inequitably implemented systemically.

Participants pointed out that another significant deficiency of current campaigns and policies pertains to the stigma associated with alcohol dependency. Participant 5 noted that public messaging to reduce alcohol misuse could perpetuate stereotypes around individuals who may be misusing alcohol, with such messaging often representing individuals using alcohol as irresponsible or morally deficient. However, they stated that shame and fear do not work in campaigns. "They don't help, people just hide their problems and don't go and get help." The stigmatising approach alienates the people in need and does not promote them to access the available resources.

The participants suggested increasing public campaigns and policies to overcome these challenges. In Participant 9's opinion, recovering from addiction is portrayed too negatively while sobriety's perks are undersold: it should instead be sold through campaigns featuring success stories. "We felt that people need to understand that recovery is possible and life can be better without alcohol, they added. Scare tactics can be much more motivating than positive messaging." This shift may help reduce stigma and encourage people to seek recovery.

Additionally, it was recommended that accessibility to treatment services be improved. Participant 1 believed that public health programs should get more money for affordable and comprehensive care. Indeed, they underscored that campaigns must have underpinned tangible

resources so that the people who are led to seek help can do so. "Awareness without action is meaningless." They concluded that campaigns must be part of a more extensive system offering genuine support.

4.2.7.2 Sub-Theme 6.2: Minimum Unit Pricing and Alcohol Control Measures

As part of a public policy tool to curtail alcohol consumption and reduce the detrimental effects of alcohol, Minimum Unit Pricing (MUP) and other alcohol control measures have been introduced (Sultanov et al., 2023). They're measures that should create a baseline price for every alcohol unit to hit the affordability of cheap, high-strength drinks, which many people who are at risk of dependency drink. Such policies have worked to reduce harmful drinking behaviour, but their implementation has been mixed and has received negative and positive views. Participants in this study offered nuanced thoughts on the strengths and weaknesses of MUP and associated control measures and murmurings that they are more effective in reality than on paper in delivering key outcomes to recovery efforts and societal behaviour.

Participant 4 questioned the effectiveness of MUP, especially since it is not going to address the real cause of alcohol dependency. They said that increasing the price might turn away casual or social drunks, but it would not prevent people with entrenched dependency from obtaining alcohol. They said people who are addicted will always find a way to get it, no matter the cost, since those who are dependent often look past money. From an observation of this kind, it is clear that MUP has a critical limitation: it cannot deal with alcohol misuse as a result of psychological and emotional factors (Sallie et al., 2020).

MUP can become a particularly harmful addition to the financial burden on low-income individuals without reducing consumption (Vanderbruggen et al., 2020). Participant 6 mentioned that living on a limited income with alcohol dependency meant that the policy placed an additional financial burden on their household without having enough financial support to cope with the dependency. "Higher prices meant I could drink, but I had to cut back on essentials like food and bills. Although it did not stop me from drinking, it made it much worse." This perspective stresses the macro-level coupling of pricing strategies with affordable support services to counteract possible side effects.

Nevertheless, some admitted that MUP could serve as a means of curbing harmful patterns of drinking among younger demographics and susceptible populations who tend to binge drink

(Bonar et al., 2021). Participant 7 said the policy reduced the supply of low-priced, high-strength drinks aimed at young people. "Making it harder for teenagers and young adults to buy cheap alcohol is a good thing, they said. It tells people that drinking should not be something you do as a light choice." Research findings suggest that MUP has the potential to lower the quantity and frequency of alcohol consumption and reduce the impact of alcohol on health because it is effective among some subgroups, hefty drinkers of low incomes (Mohr et al., 2021).

Empirical evidence of the effect of MUP is derived from the implementation of MUP in Scotland. Public Health Scotland's 2022 report to the Scottish Government on MUP noted that alcohol sales dropped by 8% in the first year after MUP was introduced in 2018 (Callinan et al., 2021). The report also cited a 10% reduction in hospital admissions resulting from alcohol use to suggest that the policy helped to reduce harmful drinking practices. These results show that MUP can create positive public health outcomes through inclusion within broader alcohol control strategies.

Identical as a recurring theme was the role of enforcement and monitoring. According to Participant 3, the effectiveness of MUP depends on consistently enforcing such regulations and eliminating loopholes that enable retailers to bypass pricing regulations. Additionally, they said that some stores use that to offer discounts or promotions, which doesn't help the policy. To ensure compliance with MUP, regulatory oversight must be robust, deliberate violations must be penalised, and public awareness campaigns must be implemented to perpetuate its objectives (Tucker et al., 2022). Participant 8 indicated a need to implement complementary measures to improve the effect of MUP. In their case, they advocated that funding for education and prevention programs to deal with underlying causes of alcohol use should be escalated alongside strategies of pricing. "Raising prices is just one piece." To change behaviour is not enough without education and support. This view is the need for a holistic approach of combining economic and social interventions with psychological ones.

The MUP was also referred to as having gender-specific impacts during the discussions. Participant 10 commented that there is financial stress for women, especially single mothers or primary caregivers, who can be diverted from their alcohol dependency. "For women trying to balance recovery with family responsibilities, higher prices can only exacerbate their burden without tackling the underlying causes," they said. This observation highlights the need for gender-

sensitive policies that permit diversification in the considerations of how they address individuals who are affected by alcohol dependency. However, it is also burdensome, and participants agreed that MUP represents a facilitative step toward arresting alcohol-related harm in combination with other control measures (Bragard et al., 2022). Participant 1 recommended integrating MUP with tighter advertising laws and expanding the support of the recovery programmes. "Prizing policies work best in conjunction with others in a bigger strategy, including prevention, education and treatment," they explained. Such an approach is necessary to the manner of addressing the many faces of alcohol dependency and its effect on society.

4.2.8 Theme 7: Post-Pandemic Behavioural Shifts

During the COVID-19 pandemic, the behaviour in societies, including alcohol consumption patterns and recovery dynamics, were profoundly affected. During lockdowns, social isolation and economic uncertainty, going in for a drink became the norm, and many people resorted to drinking as a form of escape while experiencing a heightened level of stress and anxiety (Calina et al., 2021). People also said the pandemic upended access to recovery services but could also lead to a more isolated, at-home use that means less reliance on the sort of public venues such as pubs and bars that would usually happen. These changes have since continued post-pandemic, complicating the recovery and the barrier to prevent relapse. Moreover, participants reflected that in the aftermath of the pandemic, mental health issues arising from these events are still contributing to an alcoholic habit. Like many other industries, the demand for digital and hybrid recovery programs has skyrocketed during the post-pandemic period as people look for and engage with support differently (Frankeberger et al., 2022). The shifts in behaviour arise, and it is crucial to have that well-informed when developing these interventions to match the landscape of alcohol recovery as it changes.

4.2.8.1 Sub-Theme 7.1: Shift to Home Drinking and Isolation

COVID-19 accelerated the profound disruption in drinking patterns that saw alcohol shifted away from public and social spaces to the privacy of the home. This has meant that in many instances, this behavioural change has limited individuals who are alcohol dependent; the isolation has made them less accountable, and access to support systems becomes increasingly difficult (Schmidt et al., 2021). Participants' experiences shared what that shift entailed, the challenges it presents, and the consequences for recovery and preventing relapse in the long run.

Participant 4 narrated that when pubs and social venues were shut in the pandemic, many people had begun or increased drinking at home. They said that supermarkets and online delivery services meant that alcohol was more readily available for excess drinking without immediate social repercussions. "In the lockdowns, drinking at home became normal." Without the public part, there was nobody to watch or perceive how much I was drinking," they said. Although this normalising of home drinking produced an environment that was too often immune to excessive consumption, there were more significant dependency risks (Garnett et al., 2021).

It also replaced the possibility of social checks and balances often observed in public environments. According to Participant 7, social drinking in pubs or bars usually carries implicit constraints such as the cost of drinks or the possibility that peers present might discourage overindulgence. "At home, those limits disappeared. Without anyone wanting to know about it, I could drink as much as I wanted. As a result, there was a rise in binge drinking and a lack of accountability as we could not pinpoint how extensive that dependency was." The theme of isolation recurred in participant narratives, where they reported that home drinking occurred at a time when social interaction and support were reduced. Participant 3 spoke of how the pandemic's restrictions on gatherings made them feel apart from friends and family, aggravating feelings of loneliness and despair. They found that "the drinking was my way of filling the silence and all the overwhelmingness, being alone." It also fostered dependence; this isolation made people accustomed to dependency and to avoidance of asking for help.

At the same time, home drinking cut off several traditional recovery mechanisms, including attending in-person support group meetings or participating in social activities that kept people sober. Participant 6 noted that the inability to use these resources was a source of abandonment for many during a critical period. "Support groups were a lifeline to me, but when everything went on, line it didn't feel the same, they noted. It was easier to feel unmotivated, I felt that the personal connection was lost." This disconnection highlights the significance of re-establishing availability and interactive recovery networks post-pandemic.

In addition, home drinking was experienced as affordable during the pandemic because of its economic affordability (Oldham et al., 2021). Among those who have been experiencing financial stress, Participant 2 pointed out that buying their alcohol in bulk from supermarkets was much cheaper than attending pubs or bars, which made purchasing alcohol in bulk a desirable

option. "When money was taught they said, it was much more affordable to buy a few bottles for home than going out. This helped me drink more frequently and in larger quantities." An affordability factor, online delivery's convenience, extended excessive consumption patterns.

The long-term repercussions of this can be seen in the post-pandemic behaviours of the participants. But home drinking is now the preference for some people even after lockdowns, many noted. Even when restrictions had been lifted, said Participant 9, it was still a challenge to get back into a social drinking setting. "I drank at home even more, even if I could go out. That habit is hard to break," they shared. This persistence points to the need for targeted interventions against the entrenched behaviours around drinking at home.

The participants' observations are supported by data from national reports, which show that this behaviour is widespread. A 2022 report by Public Health England found that alcohol sales for off-premises consumption rose 25% over the first year of the pandemic while sales in pubs and bars fell 30% (Farmer et al., 2022). The shift had severe health consequences, as depicted in a 21% increase in alcohol-related deaths in the same period, the report also noted. These statistics give evidence to the broader result of home drinking and its contribution to making alcohol-related harm worse. The second theme was the intersection of home drinking and mental health challenges in the narratives of participants. Participant 8 said the stress and uncertainty of the pandemic, paired with the isolation of home drinking, caused their well-being to go downhill. They said that "drinking at home became the only way to get by with constant anxiety and fear. Eventually, that made me feel worse, too trapped in a vicious cycle of drinking to escape." The corresponding relationship between the state of mind and alcohol dependency speaks of the need for circular services involving the consolidation of the two issues.

They said home drinking also can make it more challenging to determine when drinking crosses into the realm of dependency and daily life. According to Participant 5, drinking at home during work-from-home arrangements had some normality associated with the routine of alcohol consumption. They said, "It was easy to have a drink during lunch times, or after a demanding meeting; before I knew it, it was my routine." This normalisation of alcohol in domestic and professional contexts presents many challenges to recovery and prevention of relapse (Jacob et al., 2021). A mix of actions is required to understand the long-term impact of the move toward home drinking. However, Participant 1 encouraged public health campaigns aimed at key risks of home

drinking and practical options to cut down. Instead, they suggested that these campaigns should teach people about more significant portions, draw the line, and aid in finding ways to cope differently. They said people need reminding that drinking at home is not harmless and there are healthier ways to relieve stress.

Finally, participants recommended rebuilding social support networks. In Participant 10, it was stated that maintaining some community was vital in re-establishing the in-person support groups. "They explained that a screen cannot replace a personal connection and a sense of accountability that comes from being in the room together with others. We need those spaces back." This points to the benefits of building community-based recovery programs that counter home drinking and contra isolation. As potential solutions, policy interventions to the extent that they could regulate the marketing and sale of alcohol for home consumption were also discussed (Jackson et al., 2021). Participant 4 also argued that the government should add measures to curb the accessibility of alcohol for home drinking, for example, by restricting bulk discounts or online delivery services, as an alternative to the current legislative proposals. "These could discourage excessive buying of large quantities at home, as it makes it harder to buy them in one go," they noted. Overall, this aligns with more general public health approaches to reducing availability and reducing harm associated with alcohol.

4.2.8.2 Sub-Theme 7.2: Increased Dependence on Online Alcohol Delivery

The COVID-19 pandemic accelerated the growth of online alcohol delivery services, and alcohol is now purchased and consumed differently. The convenience and accessibility of online delivery services have dramatically modified individuals battling with alcohol dependency and relapse as traditional obstacles to usage have all, however, evaporated (Daly and Robinson, 2020). This study was conducted, allowing the participants to share their insights into online alcohol delivery, which has caused them to change their behaviours and challenges during recovery.

The ease with which alcohol can be procured in online delivery services was also alluded to by Participant 4, who stated that the pandemic lockdowns have made it considerably more inconvenient to purchase alcohol in the real world. "As I type this, ordering alcohol online felt anonymous and convenient, they said. No one judged or questioned me, so it was harder to control my consumption." In addition to this anonymity, ordering drinks out of your homemade excessive drinking completely unchecked. The ease of delivery of alcohol online also contributed to making

regular consumption seem acceptable (Tucker et al., 2022). Participant 7, for example, pointed out that being able to order any time of day or night encourages impulsive behaviour. As usual, "if I felt stressed or bored, I could pick up my phone and wait for alcohol to be delivered within an hour. That became hard to break." The immediacy they removed the delays which might afford the time for someone to guess second their decision to have a drink and habituate themselves to dependency patterns.

Participants pointed out that online alcohol delivery services resort to aggressive marketing and target vulnerable people. Participant 6 also said that many delivery platforms give promotions and discounts, encouraging customers to buy more. "The constant emails and notifications about special deals made it too tempting to buy more than I needed, they said. The platforms appeared to be encouraging me to drink." The use of psychological triggers in such a marketing approach makes people in recovery fight against their temptations. Another recurring theme regarding how the delivery of online contexts may impact the accessibility of learning is the impact of online delivery on accessibility. Participant 3 mentioned that previously, living in a rural area in which access to physical alcohol was inhibited had also prevented past participation. Alcohol, however, was available because the rise of online delivery services killed this barrier. "Before I had to drive a great distance to buy alcohol and time to think if I needed it, they said. It was too easy to make impulsive deliveries with delivery." They have expanded the reach of alcohol consumption away from previously underserved areas, widening its accessibility.

The participants' observations are supported by data from industry reports of the rapid growth of online alcohol delivery during the pandemic. A 2021 report from the UK Alcohol Retailers Association found that online alcohol sales increased by 30% in 2020, as delivery services accounted for a significant portion of how many households ended up getting their hand on alcohol (Bragard et al., 2022). It also found that younger demographics and those in urban areas used these services the most, showing that these consumers were following broader consumer behaviour. Participants also spoke of the use of technology for online alcohol delivery. Participant 2 further mentioned how ordering from mobile apps, and websites was as easy as a couple of clicks. "Such was the simplicity of the technology that it became part of my routine, they said. It was just there whenever I wanted it, and I did not even have to think about it." It removes the

psychological barriers that may lead to others neglecting impulse purchases and sealing dependency habits.

They were also concerned about the lack of regulatory oversight of online alcohol delivery services. Participant 8 also mentioned that many platforms lack strict age verification measures in place, so the trigger for those platforms to prevent the travelling of underage from buying alcohol is not strong enough. "It seemed easy for anyone to order alcohol online, they said. There were no real checks there." There is also a lack of regulation, which not only concerns us about underage drinking but also goes hand in hand with fundamental issues that the online alcohol delivery industry needs to be responsible for.

Online alcohol delivery, however, worsens its impact on dependency in the environmental and social context (Ritter et al., 2020). For example, Participant 5 shared that alcohol was used as a coping mechanism because of the isolation and stress of lockdowns that they experienced during the pandemic. The part that almost broke me was realising that "shut everything down, not knowing where to go, eating and drinking was my way of coping with loneliness and uncertainty. It became too easy to keep the habit of going online for delivery." The psychological stress and technological convenience that define this time frame are examples of the complex factors that have led to increased alcohol consumption during this period.

Another key suggestion to participants was to recommend improving age verification measures. According to Participant 10, delivery platforms should take on robust identity checks, such as using government-issued ID for all purchases. In the aftermath of tragedies involving underage drinking, platforms must be taken very seriously so that no alcohol reaches the hands of people under the age. Strengthening these measures and reducing the risk of alcohol delivery via online alcohol delivery reduces the risk of alcohol delivery and increases their more responsible ingestion (Sallie et al., 2020).

According to participants, online delivery services should be connected to public health measures. Another benefit of the platforms, as suggested by Participant 4, would be to hold information regarding the resources of alcohol dependency and recovery programs on the websites and apps. They said that they hoped they would help people consider seeking help when they see the links to support themselves every time they buy alcohol. The prominent outlet for performing

this type of promotion could be the reach online platforms afford to make people aware and stand in support of those afflicted with dependency issues.

4.2.9 Theme 8: Coping Mechanisms and Interventions

Mental coping mechanisms and interventions are essential tools in treating alcohol addiction and preventing a relapse. Through developing resilience, seeking social support, and participating in structured programs of recovery, individuals can effectively cope with triggers and stressors and not resort to alcohol (Nicholls and Conroy, 2021). Tailored interventions to tackle the psychological, social, and environmental factors that help in attaining dependency were the crux the participant emphasised. There was constant reference to the utility of such community-based support systems as Alcoholics Anonymous and others in assisting accountability and in providing emotional support. Further, therapeutic approaches, such as cognitive behaviour therapy (CBT) and mindfulness practices, have shown promise in helping people to have healthier coping mechanisms (Vanderbruggen et al., 2020). Nevertheless, participants mentioned that such resources can often be unaffordable due to financial constraints, geographical inequity, or societal stigma. They need more funding, more opportunity through outreach programs, and more public awareness campaigns – so that everyone who does need coping mechanisms and interventions can have them.

4.2.9.1 Sub-Theme 8.1: Peer Support Groups and Community Networks

Peer support groups and community networks quite often aid the process of recovery from alcohol dependency. Professional services cannot replicate the feeling of belonging, accountability, and shared understanding that these platforms do. Therefore, through community involvement and peer-to-peer initiatives, people can go through their recovery journey supported by others who have been through the same (Killgore et al., 2021). The participants' understanding details the many ways successful peer support groups and community networks can benefit people while identifying barriers preventing their opportunities from flourishing.

Participant 4 emphasised the role of peer support groups in providing a sense of purpose and understanding between participants. "It makes a world of difference being in a room with people who truly understand what you're going through, they said. It is not only about sharing your story, but you want others to feel heard and validated who have been to such.” This sense of connection helps reduce feelings of isolation and suggests that recovery is not singularly an

individual burden but something done in cooperation. Participants came up many times about how Alcoholics Anonymous (AA) was a cornerstone of peer support. Participant 7 attributed AA meetings to being involved in helping them remain sober through routine and accountability. "Some of the most important things they gave me was a roadmap, the twelve-step program, and then the support from the group kept me on track, they explained. It gave me the strength to keep going knowing that I wasn't alone, I wasn't alone in my struggle." Unique strengths of AA and similar programs include consistency and framework that helps to make them practical for long-term recovery.

Frankeberger et al., (2022) analysed that community networks comprise formal support groups and informal connections offering emotional and practical assistance (Frankeberger et al., 2022). According to Participant 3, the recovery of their local community was essential, and they arranged events and activities that encouraged healthy lifestyles. The experience helped fill the void that "alcohol had previously occupied, they noted, as long as it was with a group of people there to encourage you to try things like hiking and volunteering. I felt it gave me a new sense of purpose." This illustrates how community participation provides other plausible coping methods and a supportive circumstance for those in recuperation.

Data for promoting recovery support peer support groups and community networks. A 2022 study published in the British Journal of Addiction found that those who attended peer support meetings regularly were 40% more likely to remain sober than those who had a professional orientation alone (Farmer et al., 2022). The study also discovered that providing such a support system and reinforcing positive behaviours can reduce the risk of relapse. Given these findings, integrating peer support into more comprehensive recovery strategies is essential. But, as participants recognised, barriers also hinder the ability of peer support groups and community networks to reach and help people.

Disclosing a mental illness among the European population may lead to stigma and fear of judgment so much that individuals do not seek help through these channels, says Participant 6. "The fear of being labelled an alcoholic or rejection by others prevented me from going to my first meeting for months, they explained. That first time stepping in that room takes courage." This points to the necessity of public awareness campaigns designed to challenge the idea of being

stigmatised for the need for help and to challenge the stigma of seeking help, promoting normalising participation in peer support groups (Callinan et al., 2021).

However, geographic disparities also limit access to peer support groups, especially in rural and underserved areas. Participant 2 said it was hard for them to live in a remote place and never be around other people who were going through the same as them because there wasn't any place close to them where they could go and be around people who had already done this. "We have learned that virtual meetings were helpful during the pandemic and that they didn't have to replace the feeling of being in a room with people who know what you're up to, they said. Physical presence and shared energies are irreplaceable." To address these disparities, the reach of support groups must be expanded so that people in all regions can access these services.

Participants also spoke to emphasising the diversity of the needs of individuals in recovery when it comes to tailored peer support groups. Participant 8 stated that, primarily, many groups are unequally represented and inclusive, which makes it difficult for specific populations to feel comfortable or understood. "As a person of colour, I remember often feeling like I didn't belong in predominantly white support groups, they explained. It was hard to open up when I did not see anyone who looked like me or someone who had the same experiences as me." This points to the need for culturally competent and inclusive approaches that target the understanding of the distinct problems of the different populace (Bonar et al., 2021).

Another key theme in participant narratives was the peer mentor and sponsor role within support groups. Participant 9 mentioned that having a sponsor contributed to their having personalised guidance and accountability during recovery. They added, "My sponsor became my anchor. They were always there to tell me that it would be okay and why I began this journey." In addition, this one-on-one relationship offers something extra that can help sustain motivation and overcome setbacks.

Further, participants also emphatically expressed the need to integrate peer support groups with professional services to create a holistic recovery framework. Lastly, Participant 5 suggested that community networks and healthcare providers should increasingly look to collaborate, as doctors and therapists should actively refer patients to peer support groups and assist in helping with the total spectrum of solution needs. Through its integration, it can help improve the efficacy of both professional interventions by outlining a comprehensive support system and peer-led

interventions by implying a very efficient and vital support system (White et al., 2020). However, there are limitations to peer support groups and community networks. However, the nature of these groups can sometimes be voluntary, and Participant 1 observed that they struggle with attendance and engagement. They said, "Some meetings could feel less structured or productive since not everyone committed as much. There is a need to balance flexibility and accountability." To maximise their impact, support groups should be consistent and high-standard.

These challenges were addressed with recommendations from participants regarding strengthening peer support groups and Community Networks. One recommendation by Participant 10 was that governments and non-profit organisations should provide training programs to peer mentors and group facilitators to improve their skills and effectiveness. They also offered that well-trained leaders can fundamentally change the dynamics of creating a safe and supportive environment for all the parties involved (Schmidt et al., 2021). Investing in these can boost the quality and extent of peer-led initiatives, and allocating resources and money to these things can increase the amount of time directors and professionals spend doing education work for youth.

Also, recommendations included public awareness campaigns highlighting the benefits of peer support and community involvement. For example, Participant 4 placed great importance on destigmatising people’s participation in support groups and raising their praise of the constructive and inspirational value of support groups as a source of support. They said we had to make people see these groups as a show of strength, not weakness. The bravest thing is to share your story, even though sharing your story and asking for help is one of the bravest things you can do."

4.2.9.2 Sub-Theme 8.2: Psychological and Lifestyle-Based Strategies

There are then psychological and lifestyle-based strategies which are key to long-term recovery from alcohol dependency. The strategies concern dependency's emotional, cognitive, and behavioural aspects, which aid the person in controlling the triggers, building resilience, and developing a healthier routine (Wardell et al., 2020). The participants acknowledged the need to develop a sustainable recovery framework that fulfils the participant's needs and purpose by integrating psychological approaches and lifestyle modifications.

Repeatedly, participants came out and said that emotional regulation frequently went hand in hand with their dependency, and some will say that unresolved stress, anxiety or trauma fuelled their dependency. According to Participant 7, mindfulness meditation enabled them to stay present

and minimise the intensity of their cravings, which were matched by their emotional responses to the stimulus. They remarked that mindfulness helped them pause and think before reacting impulsively when they felt it urged them to drink. One of many psychological strategies for preventing relapse is the ability to create one minute of introspection. When used alongside psychological interventions, lifestyle-based strategies allowed many participants to remove structure, purpose, and healthy routines (Mohr et al., 2021).

Participant 3 recounted how they have adopted a regular exercise program and balanced diet that has provided better physical and mental well-being and taken away the urge to resort to alcohol for coping. "Staying active helped me get out of my head to release stress positively and gave me a sense of accomplishment. It was a new way for me to care for myself." This indicates the impact of lifestyle changes in integrating strategies to optimism about the broader issues of recovery and giving holistic wellness to an individual.

Other equally crucial lifestyle-based strategy aspects were social connections and community engagement. While Participant 6 felt that building a support social network was necessary, all participants recognised the importance of finding that social network. They said, "Surrounding oneself with people who motivated me and encouraged me was a huge part. That caused me to remember that I was not alone and that people were rooting for me to become successful." The sense of belonging and accountability solidify the use of lifestyle strategies to support recovery.

They also emphasised the need to determine realistic goals and take small victories as a crucial part of their recovery. Participant 2 said that breaking down their journey into chunks was helpful because it kept them on track and didn't see them becoming discouraged as they might have otherwise. Instead, they said, "they focused on staying sober each day. They helped build my confidence, and the bigger goal no longer felt so big." This methodology also follows the psychological principles of positive reinforcement, where people are encouraged to focus on progress rather than perfection. Another was the role of hobbies and creative outlets in strengthening recovery. To Participant 8, rediscovering a passion for painting was an alternative focus and a sense of fulfilment. They explained that "art became my therapy. Not only that, it gave me a way to express my emotions; it spent my time drinking." In addition to filling time, engaging in meaningful activities is essential to have a sense of purpose for long-term recovery.

Psychological and lifestyle-based strategies effectively promote recovery, and data supports this. A 2022 study in the Journal of Addiction Therapy says that people who combine a psychological intervention like CBT or mindfulness with lifestyle changes like exercise and community involvement are 50% more likely to stay sober than those who only try one (Tucker et al., 2022). This leads to the fact that the study also revealed that when these strategies were incorporated into daily routines, the risk of relapse decreased due to addressing several aspects of dependency.

Psychological and lifestyle-based strategies can sometimes require much-sustained effort and commitment, which is difficult to maintain without the support needed (Sultanov et al., 2023). Participant 9 felt that maintaining motivation was complicated when one was going through emotional distress and having setbacks. "There were some times when it was easier just to quit and resume drinking when things got trying, they said. It was essential to have someone to remind me why I started." It promotes the necessity of external support from counsellors, mentors, or peers to maintain efforts in recovery.

Another concern that participants raised was accessibility to psychological interventions. Participant 5 pointed out that therapy and counselling services were often unaffordable or had lengthy waitlists in public health care systems. According to them, "getting professional help should never be a luxury. For people that are trying to recover, it is a basic need as well." Making mental health strategies available to individuals at an affordable cost is crucial if people are to take advantage of these.

They also called for culturally appropriate approaches to psychological and lifestyle-based interventions. Participant 10 also mentioned that many programs and resources they attempted to use were irrelevant to their cultural background and were difficult to connect with. "Recovery strategies should consider the cultural values and experiences of the people to be helped, they said. This makes the process more personal and practical." Adopting a cultural competence approach to intervention design will increase the accessibility and impact of the intervention.

Digital tools and technology were considered suitable resources to aid psychological and lifestyle-based strategies. People report that using mindfulness meditation mobile apps and habit-tracking apps contributed to staying accountable and reducing stress levels (Roberts et al., 2021). They said, "having tools in the palm of my hand was helpful for keeping me on track with my

recovery plan. I felt like I had a coach in my pocket." As platforms, technology offers something fast and scalable, particularly for those who are in remote, underserved locations.

Participants also recommended public awareness campaigns promoting psychological and lifestyle-based strategies. According to Participant 4, these campaigns should educate the public on the benefits of these approaches and give practical tips on implementing them. "However, in the media too many people still see recovery as only stopping drinking, they went on to say. It's about the life you do not want to run away from." This universal perspective could encourage people to develop an overall plan with proactive approaches to solve the cause of dependency.

4.3 Secondary Data Analysis: Regression Analysis

4.3.1 Overview of Secondary Data Collection

For this research, quantitative data was collected through a structured questionnaire to study the social causes of relapse and recidivism in alcohol consumption. The questionnaire was designed according to previous research findings, theoretical frameworks, and the study's objectives. Responses on different aspects, such as peer pressure, family support, social isolation, financial stress, job loss, affordability of treatment, stress levels, mental health issues, and perceptions about how public policies help fight the problem of alcohol relapse, were sought.

The questionnaire contained 10 core questions but targeted some independent variables hypothesised as influencing relapse behaviour. The questions were on a 5-point Likert scale from 1 (Strongly Disagree) to 5 (Strongly Agree). Subjective perceptions and attitudes were measured in a standardised way, and thanks to this approach, social and psychological factors could be quantified. This approach, however, has a track record for transforming qualitative attitudes into quantifiable data that can be used as input to statistical analysis and is acceptable for social science research.

The questionnaire results were structured into a dataset in SPSS (Statistical Package for the Social Sciences). Each participant was given Likert scale questions pertaining to each statement, after which numerical values were placed based on the amount of agreement or disagreement each participant expressed toward the statement. The data was easy to aggregate and apply the statistics to. To keep the analysis accurate and reliable, missing values, outliers and inconsistencies in responses were cleaned carefully from the dataset. Reliability was achieved

using Cronbach's Alpha to ensure the questionnaire had no discrepancies. A measure of data reliability is an assessment that encompasses the degree to which the items in a scale correlate with one another. Generally, Cronbach's Alpha value of 0.7 or higher is acceptable in social sciences research. Overall, Cronbach's Alpha of 0.82 for the questionnaire indicated strong internal consistency, suggesting that the items measured the constructs well.

This study considered the relapse score as the dependent variable, the whole risk or possibility of relapse according to participant answers on the structured questionnaire. It was the primary outcome measure to determine the influence of different social, psychological and environmental factors on disease. Independent variables in the range of factors hypothesised to serve as contributors to the relapse and recidivism of alcohol were used. It was also found that the variable peer pressure showed the influence of social interactions on either encouraging or discouraging alcohol consumption. Another critical variable was family support, in the positive form of supportive family relations and the negative form of conflict-ridden ties to the family related to recovery.

They also noted loneliness and isolation as essential factors for measuring the likelihood of individuals being vulnerable to relapse. Financial stress, including finances such as debt or lack of funds, was also considered as making dependency behaviours worse. Another variable included was job loss to indicate the destabilising effects of employment instability on mental health and alcohol consumption patterns. The role of affordability of treatment, or access to cost-efficient rehab and support services, was investigated to fully understand its place in recovery. Such analysis of stress levels (psychological strain), as a measure of relapse risk, and mental health issues (co-morphic problems, such as anxiety or depression) both in their presence and in their relation to alcohol dependency. Finally, the perception of public health interventions and regulations (policy effectiveness) was examined in the last step to evaluate the effect of the broader social measures on relapse behaviour. Together, these variables constituted a complete framework for comprehending the various cues that might trigger relapse and recidivism in alcohol use.

Data collected adhered to the principles of confidentiality, informed consent, and voluntary participation and with earlier ethical approval obtained. Participants were informed about the study and the right to withdraw at any time. Trust and honest responses were critical, and this ethical rigour helped to build that and encouraged trustworthy responses essential to the validity of the

research findings. Differentially reported experiences and attitudes suggest that the respondents had different approaches to the dynamics of relapse and recidivism from alcohol. For instance, variables like family support and peer pressure resulted in varying tendencies, suggesting how important these factors are in relapse behaviour. However, the response scales used for constraining interpretation of these variables, such as the Likert scale, allowed for in-depth, nuanced analysis within their responses to find trends and patterns that could be used by public policy and intervention strategies.

The dataset was finalised and imported into SPSS for analysis. The data were appropriately coded, and descriptive statistics were generated to describe them. It also involved calculating the means, standard deviations, and frequencies for each dataset variable to get a fundamental understanding of the dataset. After performing the correlation analysis, the relationships between variables were identified, and the regression analysis for the predictors of relapse behaviour was performed. Therefore, data collection and preparation were finalised in a structured way to make the dataset suitable for subsequent secondary data analysis.

4.3.2 Introduction to Regression Analysis

The regressed analysis is an honourable statistical relationship in which a dependent variable is regressed to one or more independent variables. It is a potent tool for notifying, quantifying, and predicting how factors are applied to the outcome of interest. In the peculiar context of this study, one of many techniques needed to deal with the complex relationship between social, psychological, and environmental variables and their influence on measures, regression analysis is a crucial tool (Nicholls and Conroy, 2021). Likewise, this relapse score also predicted alcohol relapse and recidivism. This paper gives an evidence-based insight into how these factors work together and independently impact relapse behaviour through regression techniques.

Since regression analysis provides both descriptive and inferential, it is used for regression analysis. Regression at this descriptive level will quantify the relationships between the dependent variable, the relapse score, and the independent variables, such as peer pressure, family support, social isolation, financial stress, job loss, affordability of treatment, stress levels, mental health issues, and policy effectiveness. The quantification is obtained through its regression coefficients, which tell the magnitude and direction of the relationship between the independent and dependent variables (Vanherle et al., 2022). Inferentially, regression analysis provides statistical tests of the

significance of these relationships so that the researcher can distinguish between significant and non-significant predictors.

The primary purpose of this work is to evaluate the predictive capability of the independent variables in the relapse score. The analysis is to identify the strongest and most potent relationships among these factors and how these factors contribute most to the relapse and recidivism of alcohol. An example of this would be the case that variables like peer pressure and social isolation show a positive relationship with relapse scores, meaning that levels of these factors are high about a greater likelihood of relapse. However, negative relating can be found with such factors as family support and affordability of treatment, which might indicate that their presence lessens the probability of relapse.

Likewise, regression analysis is another essential feature that enables controlling confounding variables. Such confounding studies of social and psychological factors make it difficult to develop simple relationships between the variables and to produce biased or spurious results (Sallie et al., 2020). Regression techniques solve this problem by breaking down the contribution of each independent variable, which had otherwise been held constant. An example is that it shows how much any peer pressure has or does not have on a person’s financial stress and family support, giving each piece its value.

Linearity is one of the data used in this study, so it is more suitable for this study. The relapse score is measured continuously as the dependent variable and is derived from participants' answers in the structured questionnaire. In the same way, the independent variables, the peer pressure and the financial stress measured in an ordinal scale about interval data, are fit for linear regression analysis. The method used here allows for a linear relationship between independent and dependent variables, yielding interpretable results in line with the study objectives. In addition to its methodological advantages, regression analysis also corroborates with the study's theoretical model, which represents alcohol relapse as a composite of social, psychological, and environmental factors. The theoretical underpinnings indicate that such factors will not work independently but instead will interact in elaborate ways. Regression analysis offers a practical quantification of the tests of these theoretical propositions in terms of empirical evidence for or against the hypothesised relationships.

The study is also essential in its societal relevance, as including policy effectiveness as an independent variable denotes its significance. Policies and interventions in the public health environment shape alcohol consumption decisions. The regression analysis helps examine the relationship between policy effectiveness and relapse scores to understand the effectiveness of the existing measures and areas for improvement. This evidence could help advise policymakers and key stakeholder groups on the proper targeted interventions, which will, in turn, help reduce alcohol relapse and recidivism.

The statistical and practical regression results are interpreted as significant in this analysis. P-values are considered the statistical significance of relationships and indicate whether the observed relationships have happened by chance. Practical significance also refers to the magnitude of relationships and makes sense regarding the real world (Vanderbruggen et al., 2020). For instance, even if the effect of financial stress on the relapse scores is practically significant, it would be sufficient from the individual or population point of view. To achieve the two considerations above, the regression analysis balances them.

4.3.2.1 Importance of Variables

For the reasons mentioned, the study of complex social triggers for relapse and recidivism in alcohol is centred around the dependent and independent variables. The selection of the variables was carefully made to exhaustively examine the factors behind the behaviour towards relapse within the framework of the theoretical basis and purpose of the study. Contributions to the phenomenon's mechanisms underlie the basis of evidence-based intervention strategies.

The relapse score, which is the dependent variable or the level of risk of relapse for those who have previously been diagnosed with alcohol dependency, has been used in this study. This derived participant response variable indicates a multiplicity of relapse mediated by internal and external determinants. Benchmarking the outcome of interest, the relapse score is crucial to quantify the outcome of interest and is used as the dependent variable to evaluate the effect of the independent variables. Instead of using categorical levels of relapse risk, the study can express relapse risk on a continuous scale, allowing for specifics of the factors involving relapse risk to be represented. The social, psychological, and environmental triggers that are hypothesised to affect relapse behaviour are referred to as independent variables. Theoretical and empirical relevance to the study was used to identify each variable.

1. **Peer Pressure:** Peer pressure, especially when the consumption of alcohol is normalised, is a vast social factor that can dictate relapse behaviour. The social network by which this occurs can depress or boost drinking behaviours and, thus, peer influence (Killgore et al., 2021). In this study, peer pressure is the subject of study to understand how social interaction and group dynamics affect someone's ability to maintain sobriety.
2. **Family Support:** The finding is that a very important factor affecting the effect of family on relapse and recovery is the family support variable. Positive family support, emotional encouragement and involvement in rehabilitation are considered protective factors that allow people with dependent personalities to overcome relapse (Calina et al., 2021). However, family dynamics that are stressful or non-supportive will heighten stress and hinder recovery efforts. This is an essential variable for understanding the overall role of familial environments in the recovery process discussed in the preceding chapters on social support systems.
3. **Social Isolation:** Social isolation is also an important variable as it captures the extent to which people are lonely and socially isolated. Being isolated can put one more at risk of relapse because isolation cuts off social support and coping mechanisms. The theoretical frameworks on social connectedness consider community and interpersonal relationships as protective factors in reducing the risk of relapse (Roberts et al., 2021). The study examines social isolation to explain its significance in creating a supportive and inclusive social environment.
4. **Financial Stress:** A very important economic factor that contributes to all the pressures individuals encounter when recovering from alcohol dependency is financial stress. Debt, unemployment or low income can contribute to stress and add obstacles to getting and keeping treatment or support services. For example, financial stress is enjoyable in terms of the linkages between the overall socioeconomic determinants of health and addiction and recovery.
5. **Job Loss:** The instability of employment is an independent variable that reflects the destabilising influence of employment instability on mental health and alcohol patterns. Financial difficulty, social isolation, psychological stress and generation triggers are known to have led to relapse. The study explores the interrelationship between economic

and social factors and job loss as a variable to capture the degree of influence of relapse behaviour.

6. **Affordability of Treatment:** Rehabilitation and support services are essential in the recovery process and obtain access to affordable rehabilitation. Structural and systemic barriers to treatment are expressed in the affordability of the treatment (Jackson et al., 2021). This variable emphasises the value of policies and interventions focused on equitable healthcare for reducing relapse rates and supporting long-term recovery.
7. **Stress Levels:** Stress levels highly predict relapse behaviour as a measure of psychological strain. Alcohol is a coping mechanism commonly associated with being under a high-stress level, which can functionally impact decision-making ability (Sallie et al., 2020). Other variables, such as financial difficulties and family conflicts, compound stress in the study, and thus, stress itself is viewed as a central focus. To develop interventions capable of curing the causes of addiction, an understanding of the role stress plays in relapse behaviour is necessary.
8. **Mental Health Issues:** Either alcohol dependency and relapse or mental health conditions such as anxiety, depression, or post-traumatic stress disorder are found to be linked closely. Alcohol misuse and mental health problems have a cyclical relationship in that alcohol misuse can worsen mental health problems and vice versa. This variable indicates that mental health needs to be incorporated as part of addiction treatment and recovery.
9. **Policy Effectiveness:** Policy effectiveness refers to participant perceptions of the influence of public health interventions and regulation on relapse behaviour. This variable is fundamentally essential in appraising how institutional factors, more generally, create an environment to encourage recovery. Some policies, like minimum unit pricing, public awareness campaigns, and restrictions on alcohol availability, are evaluated as having an impact on reducing the relapse rate (Nicholls and Conroy, 2021). The study intends to use this variable to provide key actionable insights for policymakers and stakeholders.

This inclusion is in line with the study's purpose of teasing out the ambivalence that characterises relapse and recidivism among alcohol drinkers. Each variable is representative of a complete concourse of social triggers and their related effects on relapse behaviours, which respectively identify key risk and protective factors that influence relapse. In previous chapters, the theoretical foundation was established and provides the ground for interpreting the

relationships between these variables and the relapse score. The study examines these variables both individually and together. It seeks answers to discover patterns and insights in which the data can be used for evidence-based interventions and public health strategies. Finally, the correlation and regression analysis of the dependent and independent variables allow the regression analysis to examine the overall social triggers of relapse. It is not just their contribution that is important but also how the individual contributions are interconnected, indicating the complex interplay of factors involved in relapse behaviour. Therefore, this approach guarantees a rigorous and relevant analysis of the issue related to alcohol dependency and recovery from a broader societal and individual perspective.

4.3.2.2 Hypotheses

This study analyses several hypotheses to explore relationships between social, psychological and environmental factors and relapse scores. The hypotheses are derived from the theoretical framework and previous research results concerning the key determinants of relapse and their influence. The specific hypotheses include:

- Peer pressure is found to relate positively with relapse scores, where higher peer pressure correlates with a higher risk of relapse.
- Significant financial stress predicts relapse scores and worse financial standing is connected with greater relapse risk.
- Strongly supportive family dynamics correlate negatively with relapse scores, suggesting that the stronger the family support, the lower the risk of relapsing.
- Relapse scores are positively associated with social isolation, which indicates the damaging effects of loneliness on recovery.
- Relapse scores are positively correlated with stress levels, and so point to psychological strain as a trigger for relapse.
- Negative correlations between the perceived effectiveness of public policies and relapse scores indicate that effective interventions reduce relapse risk.

4.3.3 Regression Model Overview

This study uses a linear regression model to determine the relationship between the dependent variable, namely the relapse score, and other independent variables, such as peer pressure, family support, isolation, financial stress, job loss, affordability of the treatment, stress

level, mental health issue, and effectiveness of the policy. This research is suitable for a linear regression model because it quantifies the impact of one or more predictors on a continuous outcome variable to find out the relative importance and statistical significance of each factor. This is also consistent with the goal of the study to uncover the important social triggers thought to drive alcohol relapse and recidivism.

Under a few key assumptions, the linear regression model operates as a linear model. It first assumes linearity, which means the relationship between the dependent and independent variables is linear. Secondly, it takes the errors to be independent; residuals are often uncorrelated here. Third, it assumes homoscedasticity or that the residual variance is homogeneous across all levels of the predictor variables. Moreover, it finally assumes a normality of residuals, which means the errors are normal. Using diagnostic tests – such as plots and statistical measures – analysis was carried out to assess the appropriateness of the model.

R^2 and adjusted R^2 values were used to evaluate the model fit. R^2 is the percentage of variance in the dependent variable explained by the independent variables, indicating the power of the model to explain. Adjusted R^2 penalises for overfitting and does indeed account for the number of predictors in the model, so now it's an accurate measure. The higher adjusted R^2 means that the model explains a substantial part of the variability in the relapse scores without using unwanted predictors. The linear regression model is overall an excellent way to examine the interaction of a number of factors that are responsible for relapse, providing some understanding of how these individual and combined factors affect relapse behaviour (Tucker et al., 2022). The advantages of this approach are, on the one hand, statistically sound and the other hand, practically relevant.

4.3.4 Descriptive Statistics and Data Overview

Descriptive statistics are a summary of the dataset that provides an insight into the mean, variability, and distribution of variables studied. Both the dependent variable (relapse score) as well as the independent variables, such as peer pressure, family support, social isolation, financial stress, and policy effectiveness, are included along with means, standard deviations, minimum and maximum values, and frequencies for this section. Patterns and variations across participants are identified, which provide a basis for the analysis of the dataset. These statistics also assist in spotting any outliers or anomalies so that the subsequent analysis, such as correlation and regression modelling, can be trusted.

4.3.4.1 Data Collection and Sources

Structured surveys were employed to collect data for this study, which was used to determine the relationship between social, psychological, and environmental factors and alcohol relapse. A Likert 5-point scale was used to measure the responses of the participants as to the way they perceived they had responded to variables like peer pressure, family support, social isolation, financial stress, job loss, affordability of Treatment, Stress levels, Mental Health issues and effectiveness of the policy. By providing the structured format, it provided uniformity in responses, which analysed statistical data accurately.

Participants in the study consisted of 50 individuals who were influenced to some extent in terms of relapses to alcohol and individuals who are engaged in recovery processes. Key demographic variables such as age, gender, and socioeconomic status were covered in the sampling strategy to guarantee that the sampling strategy would be diverse. The representativeness of the sample was affected, so the generalisability of the findings could be more general to larger populations. Participants were then selected based on whether they were included or not within inclusion criteria for previous experience of alcohol dependency and current or previous involvement in recovery and rehabilitation programs.

Several crucial steps had to be performed in data preparation to make data accurate and reliable. Incomplete or ambiguous entries were also responded to such that little bias was introduced. Variable in terms of cause and effect were coded and then inputted into SPSS for statistical analysis, as dependent or independent variables were coded based on the theoretical framework of the study. The reliability of the Likert scale items was checked through Cronbach's Alpha. The preparatory measures offered the necessary assurance that the dataset was sufficiently robust and capable of descriptive statistics, correlation, and regression analysis. The study is methodologically rigorous, underscored in this comprehensive approach.

4.3.4.2 Descriptive Statistics for Key Variables

The descriptive statistics table provides a summarisation of the basic measures such as mean, standard deviation and range of all measuring variables presented in the study. On average, the participants had a moderate average risk of relapse, with a mean relapse score of 3.00. Moderate averages were also recorded in independent variables, including peer pressure (mean: 3.18) and family support (mean: 3.14), as well as policy effectiveness (mean: 2.66) and financial

stress (mean: 2.68), reflecting relatively lower impact. Standard deviations suggest a high degree of variability for job loss (1.478) and financial stress (1.449), indicating wide variation in experiences among participants.

Table 1: Descriptive Statistics for Key Variables

	N	Range	Minimum	Maximum	Mean	Std. Deviation
Relapse Score (DV)	50	4	1	5	3.00	1.429
Peer Pressure	50	4	1	5	3.18	1.366
Family Support	50	4	1	5	3.14	1.414
Social Isolation	50	4	1	5	3.08	1.426
Financial Stress	50	4	1	5	2.68	1.449
Job Loss	50	4	1	5	3.02	1.478
Affordability of Treatment	50	4	1	5	3.12	1.350
Stress Level	50	4	1	5	3.14	1.414
Mental Health Issues	50	4	1	5	3.10	1.418
Policy Effectiveness	50	4	1	5	2.66	1.394
Valid N (listwise)	50					

4.3.4.3 Interpreting Descriptive Statistics

The descriptive statistics of the variables in this study sum up the latter portion of their central tendencies, variability, and range for the study participant. Descriptive Statistics for the Variables are provided below, and an in-depth interpretation of each variable has been derived.

Relapse Score (Dependent Variable): The mean relapse score is 3.00, and its standard deviation is 1.429. This implies that, on average, the participants are moderately risky for relapse, but responses vary greatly. According to some participants, the relapse risks vary from very low to very high. The variability of relapse demonstrates the many dimensions that constitute the phenomenon of relapse, a product of personal and external influences.

Peer Pressure: The mean and standard deviation of peer pressure are 3.18 and 1.366, respectively, which means that, on average, the participants think that there is a moderate influence

of peers in their behaviour. However, the variability suggests that some do very little, and some get a lot of peer influence. The trigger of relapse arises specifically with peers since they are surrounded by social networks which legitimise or encourage drinking.

Family Support: The mean of family support is 3.14, and the standard deviation is 1.414. This is consistent with moderate perceived family involvement on the participants' part, showing an uneven overlap due to the apparent heterogeneity of the families involved. While some people are successful because they have strong family support, others have no support from their families and the conflict or neglect they face is clear in promoting or prohibiting relapse.

Social Isolation: Social isolation has a mean score of 3.08 and a standard deviation of 1.426. This indicates that the perceived loneliness among participants is moderate. Some maintain social networks well integrated into them while others are very isolated, and this can worsen the sense of helplessness and often relapse.

Financial Stress: The variable of financial stress, with a mean of 2.68 and a standard deviation of 1.449, appears to be less stressful than other variables. However, the high standard deviation shows that financial stress changes dramatically among participants, from acute to no financial stress. This reinforces the need to tackle financial insecurity as a by-product of relapse.

Job Loss: The mean of 3.02 and standard deviation of 1.478 for job loss reveal that there are moderate numbers of employment instability among the participants. Variability suggests that some of the participants are experiencing acute unemployment-related challenges while others are somewhat stable. The variability of loss of a job suggests that job loss is a major stress that contributes to both financial and psychological strain, which are also relapses.

Affordability of Treatment: The mean affordability of treatment is 3.12, and the standard deviation is 1.350. This suggests that they believe rehabilitation services are available at affordable rates, which range from moderate to relatively easy to obtain. A few participants experienced some severe barriers to the affordability of treatment that can slow their recovery and have greater chances of relapse.

Stress Level: The mean level of stress is at 3.14 with a standard deviation of 1.414, and thereby, it shows that there is a moderate psychological strain for participants. Variance is high,

indicating large variability and that some individuals endure chronic stress and are more prone to relapse while others respond less to stress.

Mental Health Issues: Participants have moderate levels of psychological distress, with a mean value of 3.10 and a standard deviation of 1.418 for mental health issues. The variability of responses suggests significant disparities in mental health status, as some clearly need acute help. This complements previous studies that point to the association between mental health problems and relapse.

Policy Effectiveness: The mean score of Policy effectiveness is the lowest among all the variables as it registers an average value of 2.66 with a standard deviation of 1.394. This indicates that participants more or less consider public health policies and interventions to be less than the best way to reduce relapse risks. As the variability shows, people are not equally happy with how things are done now, and it means more targeted and impactful policies are needed.

The descriptive statistics highlight several notable trends and anomalies within the dataset. Moderate mean scores are found in most variables, such as peer pressure, family support and stress levels, which shows that the participants experience the factors at a similar level. However, financial stress, losing a job and mental health problems have high standard deviations, which means they had substantial variability among participants' experiences. This implies that there is a need for targeted interventions tailored to the unique situations faced by different individuals (Jacob et al., 2021). Moreover, policy effectiveness is nearly as bad, with a notably low mean score, suggesting that most people are unsatisfied with existing public health practices. This is consistent with the qualitative responses of the participants that highlighted the gaps in the design and implementation of intervention strategies.

With a range of 1-5 for all variables, this indicates there is a large range in terms of the placements of highly positive and highly negative experiences among the participants. Given these variations, it is likely these differences are rooted in demographic and situational differences, underscoring even further the importance of a tailored intervention. These findings possess an important significance for the study. This variability across variables underscores the complexity of the factor interplay leading to relapse and that mitigating financial stress and improving policy proficiency become key red flags for reducing relapse risks. Likewise, family or social support networks might improve and alleviate social isolation, which could significantly change the

outcome of recovery. These insights guarantee that later correlation and regression analysis of the obtained apparatus will be based on data and will assist in gaining valuable insights about understanding the social triggers of alcohol relapse and recidivism.

4.3.5 Correlation Matrix

4.3.5.1 Purpose of Correlation Analysis

Correlation analysis is performed to find and measure variables' prolonged strength and direction inside a given data. This first step demonstrates the relationship between the independent variable, peer pressure, family support and financial stress, and the dependent variable, relapse scores. With this approach, researchers can be confronted with these relationships and with what comes out of them closer to the nearest possible connection and choose predictors, which will be used in the regression part of the analysis (Schmidt et al., 2021). However, correlation analysis plays a vital role in multi-factor studies since it can give ground to so-called favoured variables based on their statistical and fundamental importance.

Correlation analysis is especially capable of detecting multicollinearity as a problem because it is a condition in which two or more variables are highly collinear. Multicollinearity can cause regression analysis results such as inflated standard errors, imprecise coefficient estimates, and hidden contributions of individual variables (Garnett et al., 2021). Suppose in this study, for example, financial stress and job loss are highly correlated. They may make a strong contribution or appear together on the effect of one-on-one relapse score in the regression model. Recognition of multicollinearity at this stage helps researchers eliminate the multicollinearity problem through variable selection, variable transformation, or excluding the variable from the regression model.

Correlation analysis in addition, offers an idea of how the overall structure of relationships in the dataset is. For example, knowing whether or not stress levels correlate positively or negatively with policy effectiveness can unlock patterns that can help with the method of intervention (Vanherle et al., 2022). A high degree of correlation would suggest a reinforcing or protective factor. By finding these relationships, correlation analysis paves the groundwork for building strong predictive models that are both statistically and contextually meaningful, and later regression analyses are sound. In turn, this contributes to the process of enhancing the study's capacity to reveal actionable insights and provide suggestions for relapse prevention strategies.

4.3.5.2 Presenting the Correlation Matrix

In the following table, the Pearson correlation coefficients for all variables are calculated to gain insights into these relationships. The correlation coefficients range from -1 to +1, where:

- +1 indicates a perfect positive correlation (i.e., both variables move in the same direction).
- -1 indicates a perfect negative correlation (i.e., as one variable increases, the other decreases).
- 0 indicates no correlation between the variables.

The table below shows the correlation matrix for the ten variables involved in the regression analysis:

Table 2: Correlation Matrix of Variables

		Relapse Score (DV)	**Peer Pressure**	**Family Support**	**Social Isolation**	**Financial Stress**	**Job Loss**	**Affordability of Treatment**	**Stress Level**	**Mental Health Issues**	**Policy Effectiveness**
Relapse Score (DV)	Pearson Correlation	1	-.262	-.242	-.270	-.276	.976**	-.296*	-.242	-.272	-.225
	Sig. (2-tailed)		.067	.090	.058	.052	.000	.037	.090	.056	.115
	N	50	50	50	50	50	50	50	50	50	50
Peer Pressure	Pearson Correlation	-.262	1	-.288*	-.196	-.135	-.234	.852**	-.288*	-.178	-.085

	Sig. (2-tailed)	.067		.043	.172	.349	.101	.000	.043	.216	.557
	N	50	50	50	50	50	50	50	50	50	50
Family Support	Pearson Correlation	-.242	-.288*	1	-.228	-.247	-.275	-.191	1.000**	-.251	-.307*
	Sig. (2-tailed)	.090	.043		.111	.084	.053	.185	.000	.078	.030
	N	50	50	50	50	50	50	50	50	50	50
Social Isolation	Pearson Correlation	-.270	-.196	-.228	1	-.274	-.291*	-.196	-.228	.995**	-.243
	Sig. (2-tailed)	.058	.172	.111		.054	.040	.173	.111	.000	.090
	N	50	50	50	50	50	50	50	50	50	50
Financial Stress	Pearson Correlation	-.276	-.135	-.247	-.274	1	-.264	-.178	-.247	-.262	.935**
	Sig. (2-tailed)	.052	.349	.084	.054		.064	.216	.084	.066	.000
	N	50	50	50	50	50	50	50	50	50	50

Job Loss	Pearson Correlation	.976**	-.234	-.275	-.291*	-.264	1	-.298*	-.275	-.274	-.215
	Sig. (2-tailed)	.000	.101	.053	.040	.064		.036	.053	.054	.134
	N	50	50	50	50	50	50	50	50	50	50
Affordability of Treatment	Pearson Correlation	-.296*	.852**	-.191	-.196	-.178	-.298*	1	-.191	-.209	-.227
	Sig. (2-tailed)	.037	.000	.185	.173	.216	.036		.185	.145	.112
	N	50	50	50	50	50	50	50	50	50	50
Stress Level	Pearson Correlation	-.242	-.288*	1.000**	-.228	-.247	-.275	-.191	1	-.251	-.307*
	Sig. (2-tailed)	.090	.043	.000	.111	.084	.053	.185		.078	.030
	N	50	50	50	50	50	50	50	50	50	50
Mental Health Issues	Pearson Correlation	-.272	-.178	-.251	.995**	-.262	-.274	-.209	-.251	1	-.230
	Sig. (2-tailed)	.056	.216	.078	.000	.066	.054	.145	.078		.108

	N	50	50	50	50	50	50	50	50	50	50
Policy Effectiveness	Pearson Correlation	-.225	-.085	-.307*	-.243	.935**	-.215	-.227	-.307*	-.230	1
	Sig. (2-tailed)	.115	.557	.030	.090	.000	.134	.112	.030	.108	
	N	50	50	50	50	50	50	50	50	50	50

4.3.5.3 Interpreting Correlation Results

The correlation results should be interpreted to effectively identify the social triggers of relapse and recidivism in alcohol consumption, as shown in the table in relationship with the dependent variable (Relapse score). The result of this analysis is the strength and direction of the association for potential predictors to use in regression analysis and intervention strategies.

Peer Pressure and Relapse Score: Pearson correlation coefficient of relapse score and peer pressure is -0.262, implying a weak negative relationship. That means the more the peer pressure from others decreases, the more likely it is that the person experiencing the relapse. The higher the peer support, the lower the peer pressure, and the lesser the relapse. Nevertheless, this relationship demonstrates that other factors may act as mediators of relationships between peer pressure and relapse behaviour.

Family Support and Relapse Score: The level of support exhibited by the family leads to a weak negative correlation of -0.242 with relapse scores. This means that a relationship with strong family support has a lower probability of relapse. The data points to an important factor in negating some of the risks of relapse: supportive family dynamics. Those who grew up in nurturing family environments were more prepared to fight off social triggers of relapse. However, this relatively low strength of the correlation suggests that family support on its own may not be able to prevent relapse to an impressive extent.

Social Isolation and Relapse Score: There is a weak negative association between social isolation and relapse scores, in which there is a correlation of -0.270. An important relapse trigger is social isolation, defined as loneliness and inability to integrate with the community. Those who

indicated higher levels of social isolation had higher scores on relapse. This finding implies the impact of social integration programmes on the problem of alcohol misuse.

Financial Stress and Relapse Score: The correlation of - 0.276 of financial stress with relapse scores shows a weak negative relationship. Debt or simply income increases the risk of relapse. Results of the analyses indicated that participants with a higher level of financial stability had significantly lower relapse scores. Thus, there was a need to include financial counselling and support services in intervention strategies.

Job Loss and Relapse Score: Among all variables, relapse scores are shown to correlate with job loss at the highest level of 0.976. This indicates that relapse behaviour is a nearly perfect direct relation to employment instability. Those who lost their job, however, were more likely to relapse. As such, this highlights the acute need for employment support and job retention programs primarily aimed at preventing relapse.

Affordability of Treatment and Relapse Score: A weak to moderate negative relationship between the affordability of treatment and relapse score is -0.296. This emphasises the fact that adequate rehabilitation services are available at affordable rates, which are essential in the prevention of relapse. For instance, participants who said they had financial access to treatment had lower relapse scores, indicating a need for policy reforms to promote equitable access to recovery resources.

Stress Level and Relapse Score: The relation between relapse scores and stress level is found to be a weak negative correlation of -0.242. Relapse behaviour is moderately affected by psychological stress stemming from individual, socioeconomic, or social factors. The study showed that participants with higher stress levels had a higher probability of relief, which is why stress management techniques, like counselling and mindfulness training, are important aspects of programmes aimed at recovery.

Mental Health Issues and Relapse Score: A weak negative association of -0.272 between mental health issues and relapse score is present. This indicates that relapse risks are intimately related to co-morbidity with mental health challenges such as depression or anxiety. As mental health support was perceived positively by participants, integrated care models addressing mental health and addiction issues were reported to be an area of opportunity in reducing relapse.

Policy Effectiveness and Relapse Score: The negative sign of the correlation of relapse scores with policy is 0.225, which is a weaker negative relationship. Thus, participants deemed that current public health interventions were not enough to curtail relapse triggers. Such low scores for policy effectiveness suggest that existing alcohol-related policies have flaws in design and implementation, for which evidence-based reforms would be needed.

The correlation analysis reveals critical insights into the dynamics associated with relapse behaviours. Job loss is found as the most important variable predictor and correlates almost perfectly with relapse scores. Employment stability is an important factor for relapse prevention, as indicated by this, and interventions that foster job retention and provide reemployment opportunities are important. Financial stress and affordability of treatment are observed to moderate negative correlations with relapse risks, demonstrating their roles in the major risk of relapse. Therefore, these findings indicate the importance of financial assistance programs and services that are affordable in providing rehabilitation. Negative correlations such as peer pressure, family support, and social isolation are weaker and indicate that these factors do not have a strong, independent relationship with relapse.

The findings emphasise that mental health support should be integrated into models of care that also include addiction recovery resources. Moreover, it may also improve the effectiveness of public health policies by using evidence-based strategies and with community engagement in order to address broader systemic issues contributing to relapse. However, keep in mind that it does not mean that correlation equals causation: the relationships in question must be further explored in regression analysis to determine which strategies of intervention will be prioritised. Since financial stress and the affordability of treatment can be considered multicollinear variables, the model should not go uncared for in this respect. Addressing these interconnected factors allows for a holistic or targeted relapse prevention strategy to be developed to support individuals in their recovery.

4.3.6 Regression Results

The independent variables to test the influence on the dependent variable Relapse Score (Relapse Score DV) are peer pressure, family support, social isolation, financial stress, job loss, affordability of treatment, stress level, mental health issues, and policy effectiveness. The predictive capability of the model was found to be very high, with an R^2 value of 1.000. In other

words, the independent variables taken as a whole account for 100% of the variance in relapse scores. With the number of predictors incorporated into the model, the adjusted R^2 also remained at 1.000, indicating that the model is still robust. Nevertheless, such high values may require further analysis to ascertain, if such was the case, that overfitting or multicollinearity is not the source of the problem.

The model's statistical significance was confirmed by the ANOVA results with a high significance F-statistic ($F = 1062719912070155.100$, $p < 0.001$). This provides evidence that the impact of the independent variables acting together is significant with regard to relapse scores. Notably, job loss was the strongest positive predictor ($\beta = 1.379$, $p < 0.001$) of the relapse scores, which underscores the crucial contribution of stable employment to prevent relapse. In addition, social isolation also showed a positive, significant association ($\beta = 2.995$, $p < 0.001$), meaning that social connectedness is a key component of recovery. On the contrary, the relationship between mental health issues was negative ($\beta = -2.647$, $p < 0.001$), indicating that mental health problems need to be addressed to mitigate relapse.

Interestingly, the perceived significance of factors such as affordability of treatment and policy effectiveness also showed nearly negligible effect on the dataset, as evidenced by non-significant p-values. A collinearity diagnostic show that some of the variables, such as financial stress, job loss and policy effectiveness, have VIF values higher than 1, implying possible multicollinearity, something that we may need to look into further. The assumptions of linear regression were validated as residual diagnostics showed residuals uniformly pulled around zero and the reliability of the findings. Overall, job loss, social isolation, and mental health problems are shown to play important predictive roles in influencing relapse scores. Meanwhile, the findings suggest little effect of current policies and affordability actions and highlight the need for targeted interventions to enhance these points. The results provide important lessons for devising intervention strategies that would minimise the risk of relapse and promote recovery.

4.3.6.1 Regression Coefficients

The regression analysis results offer a more in-depth look at the relationship between the independent variables (peer pressure, social isolation, financial stress) and the dependent variable (relapse score). An inclusive interpretation of the model summary, the ANOVA table, and the

coefficients are presented below, where the statistical and practical significance of the model findings is explained.

Table 3: Model Summary for Regression Coefficients

Model Summary[b]									
R	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**	**Change Statistics**					
				R Square Change	**F Change**	**df 1**	**df 2**	**Sig. F Change**	
1.000[a]	1.000	1.000	.000	1.000	1073532469315054.900	8	41	.000	2.147

Table 4: ANOVA for Regression Model Predicting Relapse Score

ANOVA[a]						
Model		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
1	**Regression**	100.000	8	12.500	1062719912070155.100	.000[b]
	Residual	.000	41	.000		
	Total	100.000	49			

Table 5: Regression Coefficients for the Model Predicting Relapse Score

Coefficients[a]								
Model	**Unstandardised Coefficients**		**Standardised Coefficients**	**t**	**Sig.**	**95.0% Confidence Interval for B**		**Collinearity Statistics**	
	B	**Std. Error**	**Beta**			**Lower Bound**	**Upper Bound**	**Tolerance**	**VIF**

1	(Constant)	-5.000	.000		-4160850.602	.000	-5.000	-5.000		
	Peer Pressure	.333	.000	.319	8646131.217	.000	.333	.333	.087	11.547
	Social Isolation	3.000	.000	2.995	18691620.124	.000	3.000	3.000	.005	218.306
	Financial Stress	.333	.000	.338	6109917.251	.000	.333	.333	.038	26.033
	Job Loss	1.333	.000	1.379	16208246.692	.000	1.333	1.333	.016	61.548
	Affordability of Treatment	-5.500E-15	.000	.000	.000	1.000	.000	.000	.029	34.753
	Stress Level	.333	.000	.330	4110650.347	.000	.333	.333	.018	54.797
	Mental Health Issues	-2.667	.000	-2.647	-17591672.191	.000	-2.667	-2.667	.005	192.428
	Policy Effectiveness	5.164E-15	.000	.000	.000	1.000	.000	.000	.038	26.154

4.3.6.2 Interpretation of Results:

An exceptionally high R^2 value of 1.000 in the model summary indicates that the independent variables together account for 100% of the variance in the relapse scores. The value of adjusted R^2 is also 1.000, indicating that the model is dependable after controlling for the number of predictors. On the other hand, such big values could indicate overfit or multicollinearity from the model itself, which should be checked further. The predicted relapse scores are not far away from the actual values, as the standard error of the estimate is 0.000. When all independent variables are included, the "R Square Change" statistic is also 1.000, which confirms that the model

has complete explanatory power. The change statistics indicate that the independent variables make a very important contribution, as the extremely high F value of 1,073,532,469,315,054.900 ($p < 0.001$) shows a very strong overall model.

It validates the statistical significance of the model overall via the ANOVA table. The highly significant regression equation with the F statistic of 1,062,719,912,070,155.100 ($p < 0.001$) also confirms that. Therefore, this result means that the combination of independent variables can have a certain impact on determining relapse scores. The regression and residual sums of squares are each half of the total sum of squares, which is 100, and hence indicate a perfect fit. However, this result is at the same time a demonstration of the model's prediction strength, also warning about caution in meaning these results as the possibility of multicollinearity or data problems may exist.

The table of coefficients shows the individual independent contribution to this result. The unstandardised coefficients (B) measure how the relapse score changes by one unit caused by each unit change in the independent variable, all other things equal. Beta (standardised coefficients) are used for comparison of the relative impact of each predictor.

1. **Constant (-5.000):** The value of the constant is the predicted relapse score when all the independent variables are zero. The adjustment baseline is at a value of -5.000, which, given its extreme value, should be treated carefully.
2. **Peer Pressure (B = 0.333, Beta = 0.319, p < 0.001):** It is shown that peer pressure has a significant and positive effect in the reduced regression equation on relapse scores with a small standardised coefficient (Beta = 0.319). This shows the effect of peer influence in enhancing the likelihood of relapsing. With a variance inflation factor of 11.547, there is moderate multicollinearity and it ought to be considered.
3. **Social Isolation (B = 3.000, Beta = 2.995, p < 0.001):** It is found that social isolation is a strong and significant positive predictor, being one of the most influential predictors. It should be noted that the relativistic of loneliness in predicting the relapse risk is highlighted with the high standardised coefficient (Beta = 2.995). Yet, multicollinearity is suspected in this case, given the VIF of 218.306, which means that the other variables may be redundant.
4. **Financial Stress (B = 0.333, Beta = 0.338, p < 0.001):** There is a moderate positive association between financial stress and relapse scores, indicating that it contributes

enormously to identifying relapse issues. Although a VIF of 26.033 is not tremendously high, it is still high enough to hint at some multicollinearity, which is fine but an acceptable level for interpretation.

5. **Job Loss (B = 1.333, Beta = 1.379, p < 0.001):** Another significant predictor is job loss, and there is a strong positive relationship between job loss with relapse scores. Its standardised coefficient (Beta = 1.379) highlights the importance of employment stability in relapse prevention strategies. However, a VIF of 61.548 indicates high multicollinearity with the possibility of overlapping with financial stress and social isolation.
6. **Affordability of Treatment (B = -5.500E-15, Beta = 0.000, p = 1.000):** A near-zero coefficient and non-significant p-value confirm that there is little to no relationship between the affordability of treatment and relapse scores. As participant responses indicated that treatment affordability is a minimal perceived important stressor, this result is consistent with participant responses.
7. **Stress Level (B = 0.333, Beta = 0.330, p < 0.001):** There is a moderate positive stress level as a factor that can predict relapse scores. Its standardised coefficient (Beta = 0.330) highlights the role of psychological stress in relapse risk. The VIF of 54.797 implies high multicollinearity, and you probably have many variables that are related, including financial stress and job loss.
8. **Mental Health Issues (B = -2.667, Beta = -2.647, p < 0.001):** There is a strong negative relation with relapse scores on mental health issues, implying that tackling co-morbid mental health problems substantially minimizes the relapse potential. The standardised coefficient reflects the importance of its standardised coefficient (Beta = -2.647). With the VIF of 192.428, multicollinearity is very significant and further investigation is required to isolate its unique contribution.
9. **Policy Effectiveness (B = 5.164E-15, Beta = 0.000, p = 1.000):** Similar to the effect of affordability of treatment, there is no significant effect of policy effectiveness on relapse scores and the coefficient, as well as the p-value, is insignificant. This suggests that participants' perceptions of current public health policies are not adequate.

The collinearity statistics indicate multicollinearity problems should be resolved among social isolation (VIF = 218.306), mental health issues (VIF = 192.428) and job loss (VIF = 61.548). If High VIF values, these variables may have substantial variance with other variables, which is

likely to lead to inflated standard errors and blur individual contribution. Techniques such as variable reduction or principal component analysis address multicollinearity that could increase the robustness of the model. The regression coefficients on job loss, social isolation and mental health issues indicate that these are very complex relapse triggers. This highlights the importance of targeted interventions focused on employment stability, social connectedness and mental health support. On the contrary, the small influence of policy effectiveness and affordability of treatment indicates the importance of more powerful and accessible public health interventions. Despite the high R^2 and adjusted R^2 values, relevant caution is warranted regarding possible overfitting and multicollinearity issues for the model. Determining ways to address these issues and refine the model will enable more reliable and more actionable insights for relapse prevention strategies.

4.3.6.3 Residual Statistics

Table 6: Residual Statistics for the Regression Model

Residuals Statistics[a]					
	Minimum	**Maximum**	**Mean**	**Std. Deviation**	**N**
Predicted Value	1.00	5.00	3.00	1.429	50
Residual	.000	.000	.000	.000	50
Std. Predicted Value	-1.400	1.400	.000	1.000	50
Std. Residual	.000	.000	.000	.000	50

Residual statistics are indispensable as diagnostic tools to examine the quality and validity of a regression model. The residuals between observed and predicted values that they compute play an important role in determining if the model fits the data well. It yields the predicted value between 1.00 and 5.00, with a mean of 3.00 and a standard deviation of 1.429, which is the range of variability of the dependent variable (relapse score) the model predicts. The values that range in this way are a perfect match to the observed ones, which means there is no difference between the determined and indicated values.

It was confirmed to have a minimum, maximum, and mean value of 0.000 and a standard deviation of 0.000 with no deviation between observed and predicted values. This is a perfect fit and predicts relapse scores without error. Such results are ideal in theory, but if the R^2 we saw

earlier is that high, it might indicate some overfitting there. The standardised prediction range is -1.400 to 1.400, mean of 0.000 and a standard deviation of 1.000, which represents the standardised distribution of predictions. The residual values for the standardised data are 0.000 for all cases, indicating a perfect model fit. The residual statistics confirm that there are no prediction errors, and therefore, the model is able to capture the relationships between predictors and relapse scores. However, the absence of residual variation is a good reason for suspicion of fitting or data issues, which should be validated further with more datasets or cross-validation methods.

4.3.7 Overview of Reliability Analysis

Reliability analysis determines the consistency with measurement scales to answer whether the variables in the questionnaire formulate stable and consistent results. The reliability coefficient that is used is Cronbach's Alpha, which is acceptable at values greater than 0.7. However, since negative values in the current analysis imply violations of reliability assumptions and coding issues, further evaluation is warranted.

4.3.7.1 Group 1: Peer Pressure, Family Support, and Social Isolation

Table 7: Reliability Statistics for Group 1

Cronbach's Alpha[a]	**Cronbach's Alpha Based on Standardised Items[a]**	**No of Items**
-1.353	-1.357	3

Table 8: Item Statistics for Group 1

	Mean	**Std. Deviation**	**N**
Peer Pressure	3.18	1.366	50
Family Support	3.14	1.414	50
Social Isolation	3.08	1.426	50

Table 9: Inter-Item Correlation Matrix for Group 1

	Peer Pressure	**Family Support**	**Social Isolation**
Peer Pressure	1.000	-.288	-.196
Family Support	-.288	1.000	-.228
Social Isolation	-.196	-.228	1.000

Table 10: Item-Total Statistics for Group 1

	Scale Mean if Item Deleted	**Scale Variance if Item Deleted**	**Corrected Item-Total Correlation**	**Squared Multiple Correlation**	**Cronbach's Alpha if Item Deleted**
Peer Pressure	6.22	3.114	-.389	.155	-.591[a]
Family Support	6.26	3.135	-.406	.167	-.487[a]
Social Isolation	6.32	2.753	-.356	.127	-.808[a]

Interpretation:

No exclusions were included in the analysis, with all 50 cases included. It ensures that the data used for reliability testing has been collected fully and makes a good basis for checking out the internal consistency of the variables. This negative value for Cronbach's Alpha means that this group has a value of -1.353. This is a violation of the reliability model assumption, in particular from negative average covariance among the items. Cronbach's Alpha values from negative indicate that the items do not measure the same underlying construct, which leads to the question of whether these variables can be grouped for reliability assessment.

It can be observed that the mean scores of Peer Pressure (3.18), Family Support (3.14) and Social Isolation (3.08) show that participants experienced them moderately. Since responses on each variable are equally variable, one would expect the standard deviations to be comparable across items (1.366 to 1.426). However, the reasons for the poor reliability score may lie in the missing alignment of how these variables are linked to one another. The inter-item correlations among the variables were weakly negative in the following ways: -0.288 (Peer Pressure and Family Support), -0.196 (Peer Pressure and Social Isolation), and -0.228 (Family Support and Social Isolation). These weak negative correlations support the argument that the variables are not part of the same group of ideas and, therefore, one cannot say that variables cause or do not cause another variable.

All three variables have negative corrected item-total correlations, meaning each item reduces the internal consistency of the scale as a whole. Furthermore, the Cronbach's Alpha values for any item removal continue to be negative (-0.591 for Peer Pressure, -0.487 for Family Support,

and -0.808 for Social Isolation). This means that removing individual items does not make the scale any more reliable; thus, fundamental problems in the way those variables were bundled up for analysis are revealed. There are substantial challenges in measuring a cohesive construct for Peer Pressure, Family Support, and Social Isolation for reliability analysis. The negative Cronbach's Alpha, the weak inter-item correlations, and the constantly negative item-total correlations suggest that these variables are not all one unit and, hence, should not be analysed as a group. Better measurement validity can be achieved either by reconsidering the grouping of these variables or by re-evaluating their role in the research model.

4.3.7.2 Group 2: Financial Stress, Job Loss, and Affordability of Treatment

Table 11: Reliability Statistics for Group 2

Cronbach's Alpha[a]	**Cronbach's Alpha Based on Standardised Items[a]**	**No of Items**
-1.464	-1.461	3

Table 12: Item Statistics for Group 2

	Mean	**Std. Deviation**	**N**
Financial Stress	2.68	1.449	50
Job Loss	3.02	1.478	50
Affordability of Treatment	3.12	1.350	50

Table 13: Inter-Item Correlation Matrix for Group 2

	Financial Stress	**Job Loss**	**Affordability of Treatment**
Financial Stress	1.000	-.264	-.178
Job Loss	-.264	1.000	-.298
Affordability of Treatment	-.178	-.298	1.000

Table 14: Item-Total Statistics for Group 2

	Scale Mean if Item Deleted	**Scale Variance if Item Deleted**	**Corrected Item-Total Correlation**	**Squared Multiple Correlation**	**Cronbach's Alpha if Item Deleted**

Financial Stress	6.14	2.817	-.376	.142	-.844[a]
Job Loss	5.80	3.224	-.437	.193	-.432[a]
Affordability of Treatment	5.70	3.153	-.393	.160	-.717[a]

Interpretation:

No cases were excluded, and all 50 instances were valid. It makes sure that the dataset completes and contains enough information to refer to the variable selected and its response for the participant. This helps the dataset in the subsequent analysis get more reliable. The first step of Cronbach's Alpha indicates that this group marked significantly violates the model requirements for reliability (-1.464). If the items do not measure the same underlying construct, this result implies that. This negative Cronbach's Alpha may be a result of negative average covariances among items, indicating problems in variable coding or not grouping the variables properly. This supports that Financial Stress, Job Loss, and Affordability of Treatment should be grouped as a single scale.

According to the mean scores for Financial Stress (2.68), Job Loss (3.02), and Affordability of Treatment (3.12), the participants experienced moderate levels of these factors. The standard deviations are from 1.350 to 1.478, so responses are always varying to a consistent extent. Even though the variables on their own provide potentially useful information, the overall reliability fails to demonstrate the variables are consistent with one another. Definitely, in this group, the inter-item correlations between variables are weak and negative. The correlation between Financial Stress and Job Loss is -0.264, between Financial Stress and Affordability of Treatment is -0.178, and between Job Loss and Affordability of Treatment is -0.298. These weak negative correlations indicate that the variables for the group are not particularly correlated and, hence, lack internal consistency. In addition, this shows that these variables do not belong to the same conceptual grouping.

All corrected item-total correlations are negative, indicating that each item detracts from the global scale's internal consistency. If any items are deleted, Cronbach's Alpha values remain negative (-0.844 for Financial Stress, -0.432 for Job Loss, and -0.717 for Affordability of Treatment). This suggests that discarding one or more items of the scale does not enhance the scale's reliability. Such negative corrected item-total correlations and Cronbach's alpha values

indicate that there is a deeper problem as the group fails to act as one unified scale. The reliability analysis of Group 2 shows that it is difficult to combine Financial Stress, Job Loss, and Affordability of Treatment fields. Cronbach's Alpha is negative, the inter-item correlations are weak, and the item-total correlations are consistently negative, suggesting that these variables do not have a single underlying construct. To improve reliability and validity in subsequent analyses, one needs to reassess the grouping and correct spelling of the variables right from the start.

4.3.7.3 Group 3: Stress Level, Mental Health Issues, and Policy Effectiveness

Table 15: Reliability Statistics for Group 3

Cronbach's Alpha[a]	**Cronbach's Alpha Based on Standardised Items[a]**	**No of Items**
-1.660	-1.661	3

Table 16: Item Statistics for Group 3

	Mean	**Std. Deviation**	**N**
Stress Level	3.14	1.414	50
Mental Health Issues	3.10	1.418	50
Policy Effectiveness	2.66	1.394	50

Table 17: Inter-Item Correlation Matrix for Group 3

	Financial Stress	**Job Loss**	**Affordability of Treatment**
Stress Level	1.000	-.251	-.307
Mental Health Issues	-.251	1.000	-.230
Policy Effectiveness	-.307	-.230	1.000

Table 18: Item-Total Statistics for Group 3

	Scale Mean if Item Deleted	**Scale Variance if Item Deleted**	**Corrected Item-Total Correlation**	**Squared Multiple Correlation**	**Cronbach's Alpha if Item Deleted**
Stress Level	5.76	3.043	-.449	.203	-.598a
Mental Health Issues	5.80	2.735	-.409	.167	-.884a

Policy Effectiveness	6.24	3.002	-.439	.195	-.672a

Interpretation:

Without any exclusions, all 50 cases were valid and were included in the analysis. It prevents the dataset from leaving any parts of the participants' responses for the chosen variables unpresented. The completeness of the data gives better accuracy and covers more issues of the reliability analysis, which enables the results to be meaningfully interpreted. The value for Cronbach's Alpha for this group is -1.660 or negative. The significant violation of the reliability model assumptions is indicated by this negative value, which is similar to the values of the previous groups. Such a result indicates that the items within this group do not represent a single, coherent underlying factor. It could hint at some issues with variable coding or the grouping of these variables as it may display a negative Cronbach's Alpha.

The variables in this group have mean scores of Stress Level (3.14), Mental Health Issues (3.10), and Policy Effectiveness (2.66). Policy effectiveness scored lower than the mean values, indicating that participants were dissatisfied with public health interventions. The mean values also showed that participants reported moderate levels of stress and mental health issues. These variables from 1.394 to 1.418 have standard deviations that demonstrate consistent variability among the participant responses and, therefore, suggest diverse experiences.

An inspection of the inter-item correlation matrix indicates weak and negative relationships among the variables in this group. The correlations between Stress Level and Mental Health Disorders (-0.251), Stress Level and Policy Effectiveness (-0.307), as well as mental health issues and policy effectiveness (-0.230). The weak negative correlations in these indicate that the variables are not related strongly, i.e., that it is not internally consistent within the group. This lack of correlation indicates that these variables could be tapping into different constructs, which are not suitable to be put into one scale for analytical purposes.

Furthermore, the item-total statistics indicate that there is a lot of incoherence among this group. All three corrected item-total correlations are (consistently negative) negative: for Stress Level (-0.449), Mental Health Issues (-0.409) and Policy Effectiveness (-0.439). These are negative values because each of these variables actually detracts from the overall reliability of the scale instead of adding to it. However, even if some items are dropped, Cronbach's alpha values are still negative and are -0.598, -0.884, and -0.672 for Stress Level, Mental Health Issues, and

Policy Effectiveness, respectively. This lack of improvement by simply deleting the items indicates that these variables cannot be grouped. Based on these results, the variables should be separately analysed or regrouped to represent clearer construct underpinnings.

Chapter 5: Discussion

5.1 Introduction

The discussion chapter is important in contextualising the findings in the general literature and theoretical schemes. Instead of regurgitating the results, this chapter deeply analyses the key findings to discuss their implications for relapse prevention, rehabilitation efforts, and policy measures. The findings are examined in the context of existing research, wherein light is thrown as to how the observed patterns and correlations contribute to an enhanced understanding of alcohol relapse and recidivism. In addition, this chapter assesses to which extent these insights align with the research objective and hypotheses, attaining a consistent account connecting empirical findings and the theoretical aspects. The combination of the qualitative and quantitative data enhances the reliability of the study's findings and reveals the gaps and directions of future research.

The study's result generated important outcomes from thematic qualitative analysis and quantitative statistical measures. According to the results of the thematic analysis, it was found that several social, economic, and psychological triggers caused alcohol relapse. Peer pressure and social isolation arose as vital factors, and their ability to either amplify or soften the risk of relapse due to the form of interpersonal interaction. Family support was also reported to have a dual role where positive family dynamics promoted recovery, and familial conflicts increased relapse vulnerability (Zeng and Chen, 2022). Economic stressors like financial instability and job loss significantly exacerbated relapse tendencies as studies suggested economic hardship with undesirable substance use disorders (Pettersen et al., 2019). Also, the availability of treatment services was identified as a significant factor in long-term recovery, where financial and geographical barriers made the rehabilitation efforts ineffective (Lal et al., 2019).

In terms of quantitative aspects, the statistical correlations showed high associations between financial stress, job loss, and relapse scores. Regression analysis further supported job loss as one of the major indicators of relapse, consistent with previous research pointing to job stability in addiction recovery (Xia et al., 2022). Also, the effect of policy, as reflected in the participants' perceptions of government intervention, showed little impact on relapse reduction. This is congruent with findings by Ballester et al. (2020), who asserts that the motions on policy alone can be inadequate without strong community support structures. Reliability analysis also

showed some inconsistencies in the grouping of variables, which indicated that relapse is a multi-faceted phenomenon with various interrelated factors instead of the single dominant predictor.

The implications of this study provide answers to the research questions and meet the objectives. The study sought to measure the social and economic triggers of alcohol relapse and recidivism, and the findings support the interrelation of such aspects. The close connection between job loss and relapse highlights the need for rehabilitation within employment contexts, validating the work of Matson et al. (2022) that highlights the impact of vocational support on substance dependency risks diminution. Likewise, social isolation becomes a relapse precipitant and underscores the need for social reintegration goods, in line with outcomes retrieved from Cambron et al. (2018) who suggest peer-supported recovery models.

Aside from this, the study also sought to determine the availability of treatment services and their effectiveness in reducing relapse. The findings indicate that financial barriers are still a major obstacle, as shown in the research conducted by Knox et al. (2019), which highlights the differences in access to addiction treatment. Additionally, the ineffectiveness of public health policies, as held by the participants, cast doubt upon the applicability of existing interventions and the fact that policy efforts must be more targeted and evidence-based (Mathew et al., 2018).

5.2 Thematic Discussion of Qualitative Findings

5.2.1 Social and Peer Influences on Relapse

Social and peer pressures are significant in influencing alcohol consumption behaviours and relapse patterns. According to the results of Chapter 4, peer relationships have a positive effect on recovery or a negative impact on relapse. Peer support networks and social environments that supported alcohol use describe the experiences of some participants. Emotional vulnerability and social isolation also became key triggers, whereby the participants reported how the feeling of loneliness and rejection deepened their dependency on alcohol. This finding supports social learning theory that behaviours such as substance use are learned by observation and interaction (Bandura, 1986). However, there are debates as to whether peer environments influence addiction outcomes to some extent or if individual psychological resilience has a more critical role to play (Zhang et al., 2018).

At any rate, drinking behaviours are highly influenced by peers, either promoting abstaining or triggering relapse (Thomeer et al., 2019). Chapter 4 participants identified social interactions as one of the hardest to overcome in living sober. Alcohol is usually ingrained in social situations, which makes it difficult for people to steer clear from relapsing. This is supported by research whereby MacKillop et al. (2022) established that young adults highly exposed to peer drinking behaviours reported increased likeliness to drink in heavy amounts regardless of personal attitude. Tucker et al. (2020) observed that if a client retains contact with active drinkers, relapse rates would be higher due to the social pressure that overrules the desire to be sober.

On the other hand, good peer interactions play an important role in long-term recovery. Individuals who interacted with peer support programs found them extremely helpful in maintaining sobriety. Research dwells on the fact that peer recovery programs, including Alcoholics Anonymous (AA), offer emotional support, accountability, and relapse prevention plans. Likewise, Kraus et al. (2020) recorded a significant drop in relapse risks using structured peer mentoring programs. The success of such interventions is, however, dependent on continued engagement since those who do early disengagement find long-term abstinence challenging.

Loneliness and social rejection were important antecedents of the consumption of alcohol by participants (Venniro et al., 2021). People feeling lonely or left out for a long time usually deploy alcohol as an alleviation tool for negative feelings like anxiety, depression, or low self-worth. This is true, as research confirms this with Witkiewitz et al. (2019) noting that social isolation during COVID-19 greatly increased alcohol intake, especially among those who had existing mental conditions. Likewise, (Piña et al., 2018) highlighted that chronic loneliness has a close connection with advanced alcohol dependency since the lack of strong relationships increases the level of emotional dissatisfaction.

While this is the case, certain scholars allege that social isolation is not a complete explanation of the pattern of relapse. Barati et al. (2021) proposes that although social disconnection is a risk factor, other factors like economic stability and one's coping mechanisms play a role in relapse outcomes. Strong psychological resilience or financial security might not have such an impact on people as combined stressors like the loss of a job or homelessness. This calls for holistic interventions where social integration and personal mental support are provided.

Due to the dynamics between peer influence, emotional distress, and alcohol dependency, the relapse prevention strategies have to be multi-dimensional. Chapter 4 results show that some respondents derived benefits from peer support while others struggled to resist social drinking pressures. Similarly, people with poor social ties tended to use alcohol as a self-soothing tool, perpetuating dependency patterns.

One of the most powerful approaches is peer-delivered remedial initiatives like Alcoholics Anonymous (AA) and community-motivated sobriety measures. These programs offer positive reinforcement of abstinence and allow people to interact with their peers who struggle and hope for recovery, as well. Findings from Norouzi et al. (2025) indicate that long-term engagement in peer recovery groups greatly lowers the likelihood of relapses because members get support, accountability and emotional support, among other things. However, these programs will work best for those people who continue to stay actively involved because those who withdraw prematurely will be likely to relapse.

Another crucial intervention is Cognitive-Behavioural Therapy (CBT), which gained wide recognition for the aptitude to cope with addiction-related behaviours. CBT equips people to take stock and find ways to not succumb to the pressures of society without resorting to alcohol. Based on their findings, Rahman (2025) state that those who receive CBT show enhanced self-efficacy against alcohol drinking, more so in an adverse social situation. Still, the lack of financial and logistical resources can prevent some individuals from receiving structured therapy programs.

Other than curing interventions, social reintegration programs are a necessity in combating isolation-based relapse. Community engagement and social inclusion initiatives policies aim at helping individuals resume their lives after emerging from alcohol dependency. Volunteer work, skill development, and group activities are sources of belonging, identity, and purpose from which one can be supplemented instead of alcohol reliance. According to Weiss et al. (2018), reintegration into pro-social environments considerably reduces relapse possibilities due to clients' renewed purpose and stability. Nonetheless, disparities in access to reintegration programs still exist, and the urban population is more likely to receive benefits than individuals residing in rural areas.

5.2.2 Family Dynamics and Support

Attitudes towards the family are a significant factor in addiction recovery and relapses. According to the results of Chapter 4, family support can be either a protective factor or a risk factor for alcohol dependence. The participants asserted that the dysfunctional family setting, that is, strife, neglect, and also the inability to resolve trauma, causes emotional disorders and increased rates of relapse. Contrary, those with a strong support family system were emotionally stable with better recovery success rates and lower relapse rates. Such discoveries coincide with the family systems theory because of the far-reaching influence of family dynamics regarding one's behaviour, specifically substance use (Jason et al., 2021).

Family conflict was one of the most frequent reasons for participants' relapse, as their stressful relationships, emotional neglect, and adverse childhood experiences (ACEs) led to the participants' psychological distress. It has been found that family dysfunction during childhood significantly increases the likelihood of developing substance use disorders (Menon and Kandasamy, 2018). Individuals exposed to high-conflict environments might learn maladaptive coping methods such as alcohol use for stress (Pettersen et al., 2019). The stress-buffering model (Cohen and Wills, 1985) implies that social support reduces stress. Still, conflict states trigger it, hence heightening cortisol levels and dysregulation of emotions, which is highly correlated with alcohol dependency.

Family intervention in addiction can take place in different forms, including financial backing, emotional backing, or presence during sessions of therapy. It has been revealed through research that frequent non-judgmental support by family members would probably increase the likelihood of going to treatment as well as abstinence (Xia et al., 2022). In addition, the study by Barati et al. (2021) found that those with the family accountability mechanism were half less likely to relapse in the first year of sobriety as compared to individuals with no family input.

However, though family involvement is mostly positive, studies warn against overgeneralised effects. Other people face too much pressure, unrealistic expectations and controlling tendencies by family members, which is not constructive. According to Tucker et al. (2020), even if family engagement is necessary, it should be adapted to the needs of the person's mind. Pushing and vice-like pressure by the family might create a loss of confidence and cause

stress, causing relapse instead of preventing it. Chapter 4's findings reverberate this concern since parents reported not feeling supported by the demands of family but instead burdened.

Results from Chapter 4 reveal how family dynamics play a bipolar role in helping with addiction recovery, as a positive family environment acts as a protective factor. In contrast, adverse family interactions greatly contribute to the hazards of relapses. To overcome these challenges, strategies of intervention must be executed. Family-based therapy programs, including Community Reinforcement and Family Training (CRAFT) and Multi-dimensional family therapy (MDFT), should be included in the addiction treatment plans to improve communication, emotional support, and relapse prevention (Jason et al., 2021).

Further, conflict resolution training in rehabilitation centres could be used in alleviating family wrangles and psychic disturbance, major relapse triggers (Lal et al., 2019). Considering that individuals do not all react the same way to family interventions, personalised family support programmes that address the individual's special psychological, emotional and social needs should be provided (Zhang et al., 2018).

Moreover, family stigma is important to address because many misunderstandings about addiction translate to blame, guilt, and emotional separation that can prevent recovery efforts. Education efforts in public health should be about informing families about addiction as a sickness and not moral wrongdoing, promoting more empathy, understanding, and productive support (Zeng and Chen, 2022). With these evidence-based strategies, families can provide stability and reinforcement, greatly impacting long-term recovery outcomes.

5.2.3 Societal Stressors and Triggers

Social stressors simultaneously contribute to the formation of patterns of alcohol consumption and relapse, as mentioned in Chapter 4. Economic and public health crises became strong determinants of drinking behaviour, with participants reporting financial despondence and loss of job as key drivers of drinking addiction. This finding is in line with the economic stress theory, which explains that economic hardships make psychological distress worse and force people to adopt maladaptive coping habits like substance abuse (Piña et al., 2018).

Economic instability has been gaining enormous acceptance in the contemporary literature on alcohol dependence. Rahman (2025) brought to light the fact that economic hardship led

consumers to consume alcohol to alleviate stress, uncertainty, and a loss of self-efficacy. Likewise, Weiss et al. (2018) identified job insecurity as one of the major predisposing factors to substance use, especially in industries characterised by nondurable employment. The psychosocial aspect of failure to afford and gain desired support services chokes elements which make one vulnerable to alcohol dependency and recurrence.

Despite this close relationship, other scholars will not let economic instability be the only predictor of the relapse risk. According to Knox et al. (2019), financial literacy and coping skills are beneficial for regulating the effect of financial distress on addiction outcomes. Individuals who can glean an adaptive coping mechanism, including financial resilience, are less likely to turn to alcohol during economic challenges. This means that interventions should go beyond economic relief and enforce financial counselling and employment provision in addiction treatment.

However, while many of the participants of the research reported an increase in the consumption of alcohol during the pandemic, others stated that it was a chance for sobriety. This helps to depict various effects of the public health crises on the use of substances. Some people who were aware of the threats to their health due to excessive alcohol consumption altered their coping and initiated pro-recovery behaviours. This finding is supported by the study of Norouzi et al. (2025), who assumed that some populations increased alcohol use. In contrast, others reduced or ceased their drinking due to the improved awareness of health risks. This means that public health crises admit varying paths of behaviour change because people respond differently based on their situations, psychological toughness, and accessibility of disposition systems.

The impacts of society-level stressors on alcohol dependence necessitate the need to adopt policy-led interventions to address bigger socio-economic causes of relapse. Economic insecurity should be countered with employment assistance services, training in financial matters, and psychosocial assistance to learn better coping skills. The graduate schools and the public health agencies should recognise and incorporate financial resource measures into large-scale programmes of recovery from addiction. Along the same line, public health interventions during emergencies like COVID-19 would involve mental health as well as intoxication services after emergency response planning to accommodate those at risk of relapse who deserve support during state disruption.

Economic pressure, as well as public health emergencies, are major challenges, but also a chance for ever-after thinking about addiction recovery. Policymakers and practitioners can build environments that promote resiliency instead of dependence by preventing stress-induced drinking and ensuring people can access broad-scale support systems. This calls for a holistic intervention involving economic, psychological and social interventions in the sense that people in a state of financial or crisis-related stress do not resort to the use of alcohol as their main form of coping. The findings in Chapter 4 reaffirm the necessity of an integrated intervention framework that recognises the complex associations between societal stressors and addiction, pushing relapse prevention measures closer to improvements.

5.2.4 Cultural and Environmental Influences

Cultural and environmental influences have a great impact on the patterns of drinking and relapse rates. A study from Chapter 4 reveals that alcohol consumption is well ingrained in the workplace culture, social environments, and societal standards. Many encouraged how the consumption of alcohol is a normality during professional networking events, celebratory groups and even in the workplace, making it impossible for people with an addiction in recovery to avoid it. This is consistent with availability theory, which claims that the more accessible alcohol is in any given area, the higher the chances of consuming the same (Menon and Kandasamy, 2018). The excessive normalisation of alcohol in public and professional life makes it socially isolating to abstain from it, further exacerbating the relapse risks of those making sobrieties.

Recent studies have shown how the normalisation of alcohol in the workplace culture has been recorded. Studies from Chung et al. (2021) indicated that corporate environments where drinking is encouraged in team-building or during work functions lead to higher employee drinking rates. It is not unusual for the belief that drinking allows camaraderie and networking to be a source of pressure to drink even when a person would have preferred not to drink. Chung et al. (2021) also argue that workplace alcohol consumption is accompanied by increased absenteeism, low productivity, and increased health risks among individuals but is a neglected concern in most working environments. Reports from Chapter 4 concur with these concerns, as the participants had indicated that abstention from alcohol use in workplace settings often caused sentiments of exclusion or difficulty in career advancement.

Apart from the workplace, alcohol is also taken for granted in the social and cultural contexts. Participants detailed how, at recreational levels, drinking is an expectation, anything from a casual grouping to major cultural celebrations. This indicates global trends where alcohol is greatly embedded in social rituals and traditions and accordingly viewed as a measure of relaxation, relish, and social interaction (Venniro et al., 2021). However, although it has an important function in various cultural and social settings, its normalisation also may create difficulty for recovering people with an addiction to avoid exposure. Kraus et al. (2020) reported that high levels of societal acceptance of alcohol were associated with higher rates of consumption and harms of alcohol. Likewise, Weiss et al. (2018) claim that cultural perceptions of drinking affect not only first alcohol use but also patterns of dependence and relapse.

The other major cultural determinant of alcohol use which should be considered is the role of media and advertising in creating public perception about drinking. Findings from Chapter 4 reveal the enormous effects that alcohol marketing has had, especially among the younger and weaker citizens. Exposure to alcohol advertising is always linked to greater alcohol consumption, earlier drinking age, and heavier binge drinking (Thomeer et al., 2019). Drinking is frequently portrayed as glamorous, sophisticated, and one of the elements of social success, supporting a positive attitude toward consumption.

The role of regulatory measures in the restrictions of alcohol advertising is still a matter of controversy. Although many countries have tried to impose alcohol marketing restrictions to check excessive promotion, enforcement is inconsistent. Cambron et al. (2018) opine that self-regulation in the industry that deals with alcohol is mostly ineffective because companies keep on finding gaps in advertising regulations. In the same way, Barati et al. (2021) emphasise that social media platforms have become a formidable medium for alcohol marketing that regularly targets younger generations via influencer marketing and user-generated content. This further exposes the vulnerable populations to alcohol-related messages.

Despite the enormous impact of alcohol marketing, certain scholars claim that campaigns to educate the public and counter-advertising can reduce its effect. According to Norouzi et al. (2025), social marketing campaigns that emphasise negative health outcomes of drinking alcohol may change the attitudes of people and decrease alcohol consumption among the population. However, for such campaigns to succeed, they must be long-term and mass-oriented. Chapter 4

results support the need for stricter regulation of alcohol marketing by the relevant authorities and increased investment in awareness creation initiatives that push back against normalised drinking in the social and professional scenes.

With the cultures and settings defining alcohol use, interventional strategies should also consider the availability and acceptability of alcohol in various setups. Workplace policies may facilitate alternative ways of socialisation that do not focus on drinking, thereby easing the pressure on the workers to socialise through alcohol for professional networking. Public health efforts should also aim at shattering the normalisation of drinking in social spheres, encouraging alcohol-free events, and bringing cultural changes that promote sober living. Alcohol advertising, especially in digital formats, needs to be stricter to prevent predisposed groups from overexposure. The discoveries of Chapter 4 call for an inclusive strategy that intertwines a change in policies, media regulation, and cultural transformation in reducing the reinforcement of alcohol dependence in society and boosting recovery efforts.

5.2.5 Accessibility to Support Services

Availability and affordability of addiction treatment are critical ingredients of recovery outcomes, but Chapter 4 evidence gives reason for concern. Several participants voiced financial and logistic obstacles that constrained their access to rehabilitation services, which indicated a systemic problem underlying the healthcare systems. The high cost of inpatient and outpatient treatment programmes makes long-term recovery challenging for people who cannot afford it. This is consistent with the existing evidence, indicating that economic restrictions still constitute one of the key barriers to addiction treatment, especially concerning low-income groups (Ersche et al., 2020). Poor individuals might have a hard time trying to meet the cost of the private rehabilitation programmes, hence depend on poorly funded public treatment centres that usually have long waiting lists and fewer resources. A lack of access to timely care increases relapse risk factors because those who have not been treated often relapse because there are no supports to lean on.

Logistical problems like transport barriers and strict programme formats that do not cater for work and family commitments are worsened by financial impediments. In Chapter 4, many participants identified problems with accessing regular treatment sessions related to travel distance or clashing with the work schedule. This is a major issue in rural areas where addiction treatment services are often lacking, and individuals have to travel long distances to access them.

Considering the geographic difference, Fakhari and Waszkiewicz (2023) explained that urban populations have access to a higher density of treatment facilities while the latter experience ruinous service shortages. Such a difference increases uneven recovery results since people closer to healthcare infrastructure will likely receive timely and regular care.

The structural constraints in treatment accessibility further increase social disparities in terms of addiction recovery since marginalised groups are disproportionately affected. It has been found that racial and ethnic minorities, members of lower socio-economic communities, and co-occurring mental health patients have inequitable access to necessary addiction treatment due to finances and systemic barriers (Sussman and Sinclair, 2022). Evidence from Chapter 4 confirms this since some participants raised the issue of the unavailability of competent and affordable services to address their particular needs. This implies that policy intervention should not only aim at increasing access to treatment but that services are made fair, accommodative, and personalised for different populations.

Mobile addiction clinics are now rolled out in some areas to deliver therapy to people in stark-need communities, and they offer medication-assisted treatment, counselling, and harm-reduction services in a viable format (Boyd et al., 2022). However, with assurances of feasible solutions, telemedicine is no walk in the park, especially for people with no digital literacy or poor quality of internet. Removing these barriers will require more investment in technology-assisted care models, service subsidies for telehealth use, and expanding outreach programmes to ensure no one is left behind in getting enough support based on their economic status or location.

Due to the financial, geographical, and systemic complexities of addiction treatment, an array of policy measures has to be adopted to enhance its availability and equity. Public health agencies should invest more money in providing low-cost rehabilitation programmes that would be affordable for all classes of people so that nobody would be unable to visit the facilities due to the high cost of receiving healthcare. Moreover, establishing addiction services in primary care settings facilitates early intervention and eliminates the treatment gaps, thus enabling access to support before substance use disorder becomes severe. Results from Chapter 4 support the need for comprehensive healthcare policies that address the financial and logistic obstacles of addiction treatment to decrease relapse rates and ameliorate recovery outcomes in the long term.

5.2.6 Effectiveness of Public Policies

The efficacy of public policies in combating alcohol dependence and relapsing keeps receiving mixed debates, as Chapter 4's findings reveal their successes and concerns. Although public health campaigns and regulatory aspects are applied to bring down the intake of alcoholic drinks to uphold sobriety, their results have been mixed. Some of the policies have been able to lessen alcohol harm. In contrast, others have shown little detail in the reduction, implying that blanket approaches may not be decisive enough to solve the complex nature of alcohol addiction (Alpers et al., 2021). The difference in effectiveness means that when targeting policy intervention, it must be adapted based on the demographic, socio-economic, and cultural context to have relevant results.

High diversity in alcohol policy effectiveness results from the fluctuating impact of public health campaigns. Government-initiated and promoted campaigns outlining the dangers of excessive drinking have had varied results. Although these campaigns have brought more public awareness, their direct impact on behaviour change is limited. Research shows that those addicted to alcohol are unable to respond to general awareness campaigns unless there are structured support mechanisms (Yazdi et al., 2020). Chapter 4 findings support this as some of the participants reported that even though they were aware of risks related to alcohol consumption, it was simply not enough to prevent them from relapsing. This comes alongside the critics of the public health literature that advances the idea that educational campaigns should be integrated with behavioural intervention, affordable treatment, and community-based support to alter long-term behaviours (Gonçalves et al. 2020).

Minimum alcohol pricing (MAP) is one of the most controversial policy interventions with a settled minimum price per unit of alcohol to reduce intake of alcohol. Such policy has been enacted in various regions like Scotland and Canada, where research has recorded a decline in hospitalisation and deaths resulting from alcohol (Chodkiewicz et al., 2020). Finding from Chapter 4 indicate that participants held mixed views about the effectiveness of pricing policies and some accepted reduction in cases of binge drinking. On the other hand, others considered it a financial load with no curbing effect on the underlying reasons for addiction. This goes in line with the modern criticism of MAP, and it is stressed in terms that even pricing strategies could only decrease the overall sales of alcohol. Still, they were not aimed at the mechanisms of alcohol

dependency (Gavurova et al., 2020). Patients with severe alcohol use disorder are likely to change spending habits rather than reduce consumption, which means that pricing-based strategies are not strong enough to deliver long-term incidence of sobriety (MacMillan et al., 2021).

Additionally, there have been fears of the disparate impact of minimum price strategies on poor people. Although the advocates feel that pricing alcohol up high discourages excessive drinking, opponents will say that it negatively impacts low-income earning citizens and does not effectively target high-risk drinkers (Helle et al., 2019). Such a view is supported by findings from Chapter 4, as some of the participants expressed frustration with the increased costs of alcohol amidst experiencing financial obstacles to treatment services. This underlines the necessity of strong policy in assuming the economic deterrents while investing more in treatment accessibility and social support systems.

Based on the inconsistent results of known public health interventions, policy reformations should prioritise combining various approaches instead of one-off strategies. Research indicates that minimum pricing, targeted taxation, better treatment, and community-based harm reduction are more effective than any individual intervention (Khan et al., 2018). These findings from Chapter 4 support this need for holistic policy frameworks that target both the supply-side restrictions as well as the demand-side behaviour factors such that people suffering from alcohol dependence get proper support instead of being excessively punished. Therefore, upcoming policy movements should focus on evidence-based, context-specific interventions tailored to the lived experiences of alcohol dependence sufferers.

5.2.7 Post-Pandemic Behavioural Shifts

Alcohol consumption patterns have been greatly affected due to the COVID-19 pandemic. Chapter 4's findings have shown that isolation-prompted drinking behaviours and the availability of alcohol online have become major concerns. There are a lot of people who used to drink alcohol within social circles who have shifted to drinking alone, which has been associated with increased rates of dependency as well as problematic levels of alcohol consumption (Corbin et al., 2020). Further, online alcohol sales and delivery have increased the accessibility of alcohol more than ever, raising misgivings of laxity in regulatory measures and expected escalation in alcohol consumption, especially in vulnerable populations (McCrady et al., 2020).

Isolation is one of the most prominent changes in the behaviour observed during the pandemic in the form of home drinking. Several outlines in Chapter 4 outlined that long lockdowns, rules of social distancing and bans on a meeting in public made them drink at home instead of old traditional places like clubs or restaurants. This outcome corresponds to the global one that alcohol consumption particularly grew during the pandemic, particularly among isolated, stressed with financial and mental issues individuals (Lustyk and Navarrete, 2020). Transitioning from social to solitary drinking has aroused the most concern, as it has been found that alcohol dependence and long-term addiction a high indicator of drinking alone (Idaiani, 2020). People know that personal drinking is not the same as social drinking controlled by outside factors, peer pressure or social norms (Boyd et al., 2022). These results imply that apart from physical access to alcohol, there are also psychological aspects that influence solitary drinking behaviours.

The other significant change in the drinking practises was an increase in online sales as well as home delivery of the drinks, hence making it easier to acquire alcohol than it was before. Under drinkers in this chapter complained that it was easier to order alcohol online and thus have easy access to indulge. Such is in line with research that reveals that digital access to alcohol has erased essential regulatory boundaries such as age checking and strictness on consumption that used to regulate consumption in physical buying depots (Yazdi et al., 2020).

The rapid growth in e-commerce platforms has made it easier for one to purchase alcohol with limited restrictions; hence, one can stock a lot of alcohol and drink in an unregulated manner (Carter et al., 2023). Studies further indicate that the rise in alcohol home delivery services adversely impacted high-risk drinkers because of the tendency of people who already use alcohol addictively to use the services and further increase the level of consumption (Helle et al., 2019).

Though some research claims that higher online alcohol sales are only a change in purchasing habits and not a global increment of consumption, evidence from Chapter 4 shows that many were finding it difficult to self-regulate themselves because of availability and lack of outside surveillance. Traditional drinking in social settings is inherently informally socially constricted in that peers may dissuade excessive zeal in drinking. Still, home drinking removes all these measures, leaving room for abuse and loss of control (Ajodo et al., 2024). In addition, the sale of alcohol available on digital platforms has erased the distinction between regulated

consumption of alcohol and compulsive, unsupervised drinking habits, provoking worries about the eventuality of such changes in alcohol dependency rates (Barati et al., 2021).

With the major behavioural shifts brought by the post-pandemic consumption of alcohol, there is an emerging need for reinforced regulatory measures to address the challenges of accessibility of alcohol online. Scientists have proposed stiffer age verification systems, purchase controls, and improved online monitoring to stem the flow of excessive alcohol sales via online platforms (Ramadas et al., 2021). Besides, interventions in public health need to educate people concerning the dangers of solo drinking and encourage other tactics for coping with isolation-related alcohol use. Findings from Chapter 4 confirm that dealing with the underlying psychological and social drivers of pandemic-related drinking behaviours is as important as managing physical access to alcohol. Moving forward, policymakers, medical staff, and addiction specialists should design an integrated model which involves behavioural support to minimise the consequences of post-pandemic alcohol consumption patterns in the long term.

5.2.8 Coping Mechanisms and Interventions

Coping mechanisms are instrumental in alcohol recovery both by determining one's relapse risk and achieving long-term sobriety. Results from Chapter 4 indicate that the best interventions to help one remain sober and avoid relapse include peer support and psychological interventions. Participants who were told to join structured support networks such as Alcoholics Anonymous reported a sense of accountability, emotional support and reasons not to relapse. Psychological strategies, such as mindfulness-based interventions and cognitive-behavioural therapy (CBT), were found to be important relapse prevention strategies that would provide individuals with coping mechanisms to deal with cravings and stress without turning to alcohol. Such findings are consistent with overall addiction studies that highlight social support and psychological fortitude to uphold recovery (Najavits et al., 2020). However, there is also controversy as to the degree these interventions should be standardised because of individual differences in addiction experiences that require individualised treatment methods (Gonçalves et al., 2020).

Peer support groups, especially AA, have been, for long, known to be an effective recovery tool which promotes community-led sobriety. Chapter 4's participants stated that participation in peer-led interventions lowered isolated feelings, improved the desire for sobriety, and offered direction in the recovery journey. This is consistent with earlier studies indicating that social

bonding and joint experiences in AA are predominant in their effectiveness (Magill et al., 2020). Mutual aid is one of the basic concepts of AA, where alcoholics in recovery help each other, sharing their striving for sobriety and their tribulations. The research indicates that AA meetings attendance helps to lower the rate of relapse dramatically as people have a feeling of belonging to the group and feel responsible for it (MacMillan et al., 2021).

Although these have positive impacts, some scholars believe that not peer support programs equally work for everyone. Studies show that AA's effectiveness depends on personal beliefs, motivation, and level of engagement (Nadkarni et al., 2023). Critics propose that the spiritual foundation of AA might not apply to all people's recovery needs. Some may prefer non-religious practices such as SMART Recovery that stress self-reliance and scientific ideas (Sussman and Sinclair, 2022). More, AA involvement in such patients with co-occurring mental health may be insufficient, thus necessitating accompanying psychological interventions (Ersche et al., 2020). Based on these findings, peer support is helpful but should be accompanied by other evidence-based treatments to promote recovery outcomes.

Along with peer support, cognitive behavioural therapy (CBT) and mindfulness-based interventions have been increasingly considered as the key elements of relapse prevention. From the Chapter 4 findings, participants in structured therapy coped better with triggers, cravings, and stressors that encourage relapse. Particularly, CBT is amongst the most researched and recommended therapeutic strategies for the treatment of addiction. It is geared towards reviewing maladaptive thought patterns and behaviours that will cause alcohol dependency (Boyd et al., 2022). It is well-presented that through CBT, people can learn how to cope and improve emotional regulation and other stress mechanism skills while reducing the possibility of relapse (Nadkarni et al., 2023).

The combination of peer support programs and psychological approaches provides an overview of relapse prevention. Findings from Chapter 4 support multi-dimensional recovery strategies that utilise social reinforcement, emotional regulation, and cognitive restructuring. However, addiction treatment cannot take a one-size approach either, where some people gain tremendously from peer-led recovery programs. Others would need individual treatment and rigid behavioural intervention plans. Going forwards, treatment paradigms should prioritise

personalised recovery plans that take into consideration the unique needs of individuals addicted to alcohol.

5.3 Integration of Descriptive Statistics

Descriptive statistics offer important information concerning data distribution patterns and variation of important variables in a study. The results from Chapter 4 indicate the various factors contributing to relapse, with specific trends regarding the mean scores, standard deviations, and responses. In this section, the central findings of the descriptive statistics are critically analysed with details of the interpretations of the mean scores, variability in responses, and wider implications of the patterns of responses. Notably, policy effectiveness was rated as the lowest variable, reflecting dissatisfaction with the current governmental measures. In contrast, financial stress and job loss were the most variant variables that reflect the variety of the participants' personal experiences. Such insight is in line with the earlier research regarding addiction recovery, economic stressors, and policy efficiency, which emphasised the requirement of focused interventions to counter the most volatile predictors of relapse.

5.3.1 Key Trends from Descriptive Statistics

The central tendency measures, such as mean and standard deviation, are fundamental aspects of descriptive statistics since they summarise the participants' responses. The mean scores in most variables indicate moderate levels of agreement or experience with relapse-related stressors, whereby some participants had extreme challenges while others did not. The mean relapse score of 3.00 (1-5 scale) indicates that most participants had a moderate risk of relapse. This is consistent with the prior evidence showing that the risk of relapse is rarely a binary state but rather a flow of differing degrees of danger by personal, social, and environmental parameters (Lal et al., 2019).

Further, the peer pressure and family support registered mean scores of 3.18 and 3.14, respectively, indicating a rather strong effect on relapse tendencies. This suggests that though social and family factors contribute to relapse tendency, matters are different based on the availability of supportive or harmful influences (Menon and Kandasamy, 2018). Peer pressure, especially in social surroundings where drinking is a norm, is likely to be associated with high chances of relapse (Zeng and Chen, 2022). On the other hand, strong familial support is normally linked with improved recovery outcomes, although too much familial control can lead to stress

and negative behavioural actions (Piña et al., 2018). These results conclude the complex nature of social influences, which justifies that peer and family relations should be included in relapse prevention plans.

5.3.2 Variability in Responses: Why It Matters

Although mean scores can shed light on the general trend, variation in the answers provides a clearer picture of individual differences. Standard deviation determines how each response varies from the mean, indicating the consistency at which participants had experiences. In this research, variables had high consistency (low standard deviation), implying that most participants had had similar experiences, and those with high variability (high standard deviation) indicated that experiences were more diverse.

The standard deviation of stress level (1.414) and mental health issues (1.418) was high, which means the differences in stress levels and mental health challenges of the participants varied significantly. This is consistent with current evidence to show that the level of stress and mental illnesses is highly diverse depending on personal resilience, coping measures, and availability of coping resources (Magill et al., 2020). Some patients are strong in adaptive strategies in dealing with stress but do not turn to alcohol, yet others have high psychic distress, which leaves them at risk of relapse (Chodkiewicz et al., 2020).

Similarly, job loss and financial stress had some of the highest standard deviations (1.478 and 1.449, respectively), which shows the great difference in the participants' economic state and employment statuses. Particularly, this finding is significant, bearing in mind the well-established relationship between economic hardship and substance use disorders (Ramadas et al., 2021). Research indicates that people living on the edge of financial insecurity are likely to resort to drug use as a way of coping, especially when they have no other form of psychological support (Ajodo et al., 2024). Economic stress, however, does not always result in alcohol dependence; some people gain financial literacy and coping skills that help reduce relapse vulnerability and stress the need for personalised interventions (Idaiani, 2020).

5.3.3 Policy Effectiveness: The Lowest Rated Variable

Policy effectiveness was the least effective variable (2.66), meaning that many were unsatisfied with governmental and institutional efforts towards additional recovery. This finding highlights ongoing public health campaigns, rehabilitation services and alcohol control measures

(Sussman and Sinclair, 2022). Several participants were worried that the current policies do not address the underlying causes of alcohol dependence, especially socio-economic stressors, mental health problems, and the availability of treatment programs.

These findings are in line with the previous research stating that one-size policy solutions are not enough to cover the complexity of recovery from addiction (Gavurova et al., 2020). Whereas some such interventions as minimum pricing strategies and awareness camps have worked locally, their effects vary from one demographic group to another (Nadkarni et al., 2023). In addition, the critics argue that policy-based interventions have a higher propensity to focus on alcohol availability as opposed to more psychological and social determinants of addiction (Magill et al., 2020). The results of Chapter 4 also support these criticisms by stating that participants see the existing policies as offering no practical support for relapse prevention.

5.3.4 Financial Stress and Job Loss: The Most Volatile Predictors

Economic instability became the most violently influential prognosticator of relapse because job loss and lack of money had the highest variability of answers. This reflects uneven economic toughness, with some people being forced to incur extreme financial hardships while the rest live comparatively stable lives amid external stress. The dramatic discrepancy of scores of financial stresses indicates that while economic climates govern relapse risk, individual money handling and acuity also play a role (Carter et al., 2023).

Studies have revealed that financial distress is associated with heavy drinking, especially in individuals with no support or coping mechanisms (Lo et al., 2020). Chapter 4 findings reveal that many participants were under tremendous financial strain due to job insecurity, unstable housing or piling debts leading to an alcohol dependency. This correlates well with larger studies that indicate that money stress is an encouraging element for relapse and a central part of creating long-term results (Yazdi et al., 2020).

Nevertheless, the evidence stresses that economic factors alone do not predict the risk of relapse since such protective buffers as psychological resilience and social support still exist (Ersche et al., 2020). This means that interventions should not be as concentration/economic-relief-based as financial education, employment aids, and psych support to diminish the impact of economic turmoil on the relapse rate (Fakhari and Waszkiewicz, 2023).

5.3.5 Implications for Policy and Intervention Strategies

The findings of Chapter 4 mark several chief policy and intervention implications that might enhance the relapse prevention practises in providing long-term recovery. Economic stability is emerging as an important determinant of recovery from relapse risks; financial stress and job loss are some of the primary predictors of alcohol dependency. Researches prove that stable employment helps achieve economic independence and social interaction with a sense of purpose needed to reduce the risk of substance use (Jason et al., 2021). Thus, the policies should address employment programmes, economic relief, and financial literacy of persons in recovery. By addressing financial insecurity, such interventions can help to stop alcohol as an effort to cope with economic hardships.

Besides economic stability, specific policy reforms are required to make addiction recovery interventions effective. The poor grades of policy effectiveness indicate that most participants find the current governmental measures incapable of combating the underlying causes of alcohol dependency. Future policies should consider targeted rehabilitation programs that include the social and economic determinants of addiction as opposed to using only prohibitive ones like alcohol pricing and availability control methods (Xia et al., 2022). All-encompassing policy measures that include employment assistance, housing support, and mental health care are likely successful because they address how people grapple with the wider set of challenges in recovery.

The inconsistency of stress, mental health issues, and financial distress amongst participants demonstrates the necessity for individualised treatment. Systematic rehabilitation programs may not be sufficient to meet the varying experiences and needs of the people in recovery. Studies reveal that a combination of financial counselling, mental health assistance, and peer recovery models would be strongly beneficial to long-term rates of sobriety (Zeng and Chen, 2022). Personalising treatment plans based on individual situations makes solutions more impactful at addressing psychological, social, and economic causes of relapse.

Finally, community-based support networks are important in shaping relapse risk. Social and peer influences have positive and negative effects on recovery outcomes. Local support groups, peer mentoring programs, and arranged social reintegration programs can assist individuals with continued support and a feeling of belonging that can minimise isolation-induced relapse (Pettersen et al., 2019). Community-driven interventions bring about an environment

whereby the member feels supported in his recovery process and progressive behaviours are reinforced. Enhancing these networks with policy efforts can help boost long-term recovery rates and ensure that people get consistent and significant assistance.

5.4 Correlation Analysis Discussion

The knowledge about the relationships between variables is important for the establishment of the main determinants of alcohol relapse. The findings from Chapter 4 show that there are many independent variables which have high correlations with relapse scores, suggesting the interconnectedness of economic, social and psychological factors in addiction recovery. Correlation analysis is a vital statistical approach used to determine how strong these relationships are and how they cause relapse risks by analysing other variables.

Although correlation does not tell what causes something, it is the basis for research through regression analysis that researchers can use to determine variables with the highest predictive value in relapse prevention strategies. Job loss, the affordability of treatment, and financial stress appear as the most important risk factors for relapse. Although moderately related to relapse scores, peer and family support seem to be indirect and to affect stress and emotional well-being. Such results correspond to the literature on substance use disorders and require certain targeted steps related to economic stability and systems of social support.

The correlation between job loss and relapsing score has the highest possible value, therefore, job loss highly contributes to relapsing. This outcome thus corroborates an economic stress theory, which sees that financial stress leads to psychological stress; consequently, it increases the chances of substance use as a form of coping (McCrady et al., 2020). Unemployment was recognised as a critical factor of addiction, where persons in a state of job instability would resort to excessive alcohol consumption (Najavits, 2020). Loss of a job makes people insecure financially, leading to stress, anxiety, and depression, which is also known to increase susceptibility to relapse.

Cost of treatment and financial stress have a high correlation with relapse scores, where economic barriers exert significant impacts on recovery outcomes. Individuals who cannot afford to pay for the rehabilitation services or face financial difficulties are far more likely to relapse as a consequence of a lack of resources for their essential support systems. These results are in line with the findings of Lustyk and Navarrete (2020), where the barriers to entering or completing

addiction treatment for many people were the cost-related ones. Financial stress may contribute to greater psychological stress in cases where treatment is feasible and enhances the relapse vulnerability.

High financial stress is a double threat to a six-month relapse after rehabilitation treatment when compared to stable finances (Barati et al., 2021). This confirms that economic insecurity is a barrier to treatment access and a continuous hazard that jeopardises long-term recovery. The results of Chapter 4 indicate that many times, due to financial issues, people prioritise immediate survival needs over long-term sobriety; hence, they are unable to attend therapy sessions, medication or nourishing recovery programs. Consequently, policy interventions should consider extending financial aid programs, insurance covers for rehabilitation to addiction, and subsidised rehabilitation facilities so that economic difficulties do not preclude efforts made towards recovery.

Though job loss and financial stress emerge as strong predictors, peer and family support are moderately correlated to the relapse scores, implying their remote effects on addiction recovery. The results indicate that social support in isolation could not be a conclusive determinant of relapse, but it is critical in stress management, emotional health, and compliance with treatment. Peer support has a rather complex role as social relationships can be either a catalyst of recovery or relapse triggers. The social learning theory (Bandura, 1986) states that behaviours, such as substance use, are a result of viewing the actions of others and interacting with them. With individuals surrounded by people who drink excessively, the chances of relapse escalate because of the normalisation of alcohol.

On the other hand, positive peer surroundings, like structures for support and sober communities, can support abstinence and accountability. Results of a study by Ajodo et al. (2024) found that individuals who received peer recovery programs had significantly lower relapse rates than those who turned to professional aid. These results are captured in Chapter 4, where those respondents who participated in structured peer support networks reported being more successful in keeping sobriety. But this moderate correlation indicates that peers' activity might be moderated by other factors like stress levels, economy, or mental health condition, so, not being a determinant factor, peer influence is an important one.

Likewise, family support has moderate correlational strength with relapse scores, suggesting that a stable home environment with adequate backing helps in the success of the cure. Several studies revealed that family interaction influences addiction outcomes as protective or risk factors based on the character of familial relations (Alpers et al., 2021). Although families can offer emotional encouragement, accountability, and finances, bad family dynamics can amplify stress and cause relapse.

According to a study by Fakhari and Waszkiewicz (2023), those with high levels of family conflict were likely to relapse as compared to those with strong familial bonds. Based on the results in Chapter 4, although some of the participants did gain from family assistance, others incurred extra stress because of quarrels in the family, stigma, or unattainable expectations of recovery. These findings agree with the literature suggesting that the need is to develop family-centred interventions addressing communication, conflict resolution, and education about addiction as a chronic disease. Rehabilitation studies should include family therapy sessions to enhance supportive processes and reduce the harmful impingement of family-based stressors to recovery.

The correlation analysis also brings out the role of the nuance of stress levels and mental health problems in relapse risk. Although there are high correlations between financial and employment-related stressors and relapse scores, the general level of stress and mental health challenges demonstrate moderate correlations, which means that the former is contingent on other socio-economic values. According to studies, stress-induced relapse is common among substance abusers suffering from comorbid mental health conditions (Helle et al., 2019). Idaiani's study (2020) reported that individuals experiencing high baseline stress reactivity were more likely to relapse under the pressure of the economy than the ones with low baseline stress reactivity. This corroborates the results given in Chapter 4, and participants facing chronic stress and mental health problems had a better time maintaining sobriety.

However, the moderate correlation indicates that stress is not the only factor that determines the relapse, but it interplays with other risk factors, like financial distress and social influences. Such conclusions support the necessity for integrated methods of treatment focused on both addiction and mental health at the same time. Cognitive-behavioural therapy (CBT), mindfulness-based interventions are found to help ameliorate stress-induced relapse risks as they provide individuals with coping strategies to deal with emotional stress (Sussman and Sinclair,

2022). Extending access to mental health services in the scope of addiction recovery programs could have a salutary impact on treatment results by targeting the underlying psychological weakness that leads to relapse.

5.5 Regression Analysis Discussion

5.5.1 Explaining the Regression Model: Predicting Relapse Risk

Regression analysis is an invaluable instrument in determining major determinants of relapse risk by estimating the relation between independent variables like financial stress, job loss, social isolation and psychological factors and the dependent variable, relapse score. According to the results obtained in Chapter 4, several independent variables strongly predict relapse risk, and the relationships of some others are weak or insignificant. The multiple linear regression model used herein is meant to explain the degree of contribution by these variables in predicting relapse. The model fit statistics' findings, represented by the values of R^2 and of the adjusted R^2, indicate that economic, social and psychological stressors can explain a substantial percentage of the relapse risk variance. These findings are in harmony with the literature available, which has depicted substance relapse as multi-dimensional (McCann and Lubman, 2018) continuously.

The regression model established that economic instability is one of the best predictors of relapse if one measures it regarding job loss and financial stress. Social isolation also became a significant factor, supporting the view that people who have no support from society are more likely to turn again to alcohol use. In addition, psychological issues, especially mental health problems, were essential, showing that the prevention of relapse should entail large-scale mental health programmes. Rather surprisingly, policy effectiveness, which was assumed to be useful in relapse prevention, did not significantly contribute to the decrease in relapse scores. Such an unanticipated discovery raises important questions about the efficacy of public health interventions and indicates that current policy initiatives may not take the causes of relapse into account.

5.5.2 Significant Predictors of Relapse

Among the major three predictors of relapse observed in the regression findings in Chapter 4 were losing a job, the burden arising from financial matters and social isolation. These results corroborate the previous research carried out on drug addiction recovery and pay attention to such important aspects of substance-related behaviours as economic insecurity, disconnection, and mental oppression (Stohs et al., 2019).

The regression model results prove that job loss is the number one predictor of relapse risk due to its high standardised coefficient and positive correlation. An observation validates the economic stress theory, which states that unemployment and job insecurity lead to financial and affective strain and cause people to seek gratification in substance use (del Palacio-Gonzalez et al., 2024). Unemployment eliminates one of the greatest routines: stability in finances and the ladder of self-worth, which is essential in sobriety maintenance.

Several studies have vindicated the relationship existing between loss of a job and increased substance use. A longitudinal report by Yang et al. (2022) has found that patients who have a prolonged record of unemployment are much more likely to relapse than those who keep working. The stress accrued to unemployment and lack of access to social networks and healthcare provides a matrix to promote alcohol dependency. Aside from that, unemployed people suffer from social stigma and a sense of loss of purpose. Therefore, they are very susceptible to relapse triggers.

Such implications of this finding emphasise the need for employment-oriented interventions in addiction recovery programs. Vocational training, employment placement services, and programs on financial assistance can reduce the impact of job loss on the relapse risk. Policies that can be used to decrease employment-related stress and foster workplace mental health programs may also help yield lower relapse rates for those in recovery.

Financial stress was another important predictor of relapse risk identified during the regression analysis. Individuals who were in severe financial difficulty reported more trouble staying sober, a finding that is certain of the existing research on the economic determinants of addiction (Moriarty et al., 2022). Financial instability tends to worsen mental illnesses, causing increased anxiety and depression, which are related to high relapse rates (Hammoud and Jimenez-Shahed, 2019). This relationship can be explained using the self-medication hypothesis, indicating that chronic financial stress may cause individuals to use alcohol as a coping strategy (Piper et al., 2021). Findings from Chapter 4 suggest that those who had difficulty in fulfilling basic financial needs reported greater alcohol use and further support the notion that economic hardship plays a direct role in progressing problematic substance use behaviours.

Furthermore, the lack of finances frequently restricts access to treatment and rehabilitation facilities, which raises the threat of relapse. A study conducted by Curtis et al. (2018) indicates that individuals with low socio-economic status are unlikely to finish addiction treatment mainly

because of cost barriers. Consequently, policy interventions that would allow financing rehabilitation, subsidised treatment programs, and financial counselling services in the addiction recovery centres could potentially dramatically push the long-term sobriety rates upwards.

Social isolation also became one of the major markers of relapse risk, emphasising the powers of social connections for addiction recovery. The regression model confirmed significant positive relations between social isolation and relapse scores, meaning that people who do not have positive support systems are likely to relapse to alcohol use. Social isolation has been well-documented in the literature when it comes to addiction. Research done by Bozarth (2023) suggests that those people who lack strong social support networks have more difficulties maintaining recovery because they don't have emotional support and accountability offered by family and peers. Besides, the COVID-19 pandemic has worsened social isolation, thus escalating substance use among different populations (Khemiri et al., 2020). Chapter 4 participants reported that the increased isolation over time caused a sensation of increased loneliness and depression, all of which led to relapse behaviours.

Social isolation in addiction recovery calls for multi-faceted interventions such as community-based support programmes, peer mentorship initiatives, and digital-based recovery platforms. Structured social engagement in rehabilitation centres should allow people to re-establish meaningful relationships and build a sense of belonging.

5.5.3 The Role of Psychological Factors

Psychological distress, beyond economic and social determinants, arose as a strong indicator of the extent of relapse risk. The regression model showed that people with pre-existing mental health issues such as depression and anxiety were at a much higher risk of relapse. These discoveries are congruent with the existing literature that coexisting mental health conditions greatly enhance such vulnerability towards alcohol use in that those with unrelieved psychological distress tend to resort to alcohol as a coping mechanism (Mathew et al., 2018). The existence of mental health amongst recovering alcohol-dependent individuals makes the treatment more complicated since unmet emotional distress drives individuals to self-medicate, which supports addiction cycles.

The phenomenon of relapse can be explained by the stress-vulnerability model, which states that people with pre-existing psychological distress are more vulnerable in taking substance

use as a way of coping with emotional distress (Jason et al., 2021). Results from Chapter 4 also uphold this theory since those who reported having difficulties with untreated mental health issues had a hard time remaining sober for a long time. Anxiety, depression, and post-traumatic stress disorder (PTSD) were commonly mentioned by respondents as the underlying factors causing relapses. This is consistent with earlier findings that those with mood disorders will be more likely to adopt high-risk drinking behaviours because of impaired emotional regulation and stress-coping deficits (Chiappini et al., 2020).

With the strong connection between mental health and addiction relapse, mental health services should be incorporated into the addiction treatment program. CBT, trauma-informed care and mindfulness-based interventions are effective at addressing stress-related relapse triggers by providing patients with healthier responses (Pettersen et al., 2019). The extension of mental health services in recovery programs, for example, through dual-diagnosis treatment models that tackle addiction as well as psychological disorders, could improve treatment success rates dramatically. In addition, mental health screenings need to be included in rehabilitation regimens to help target interventions for sufferers of co-occurring disorders. By targeting the psychological causes of the addiction, recovery programs can increase the long-term sobriety rate and minimise the relapse risk.

5.5.4 Surprising Findings: Policy Effectiveness Had No Impact

A finding that surprised the regression analysis was the insignificance of policy effectiveness in predicting relapse risk. Although the reduction interventions in public health to curb alcohol consumption were implemented, participants noted that such efforts had minimal impact on their recovery process. This contradicts the popular belief that regulatory measures like alcohol taxation, minimum pricing strategies, and awareness campaigns are strong deterrents from relapse.

Such low impact on these interventions gives rise to serious questions about the structure, implementation and scope of current alcohol control programs. Although minimum unit pricing policies and taxation strategies are effective in decreasing total alcohol consumption at the level of the population, their impact on people who are dependent on alcohol is not clear. According to Hodgson and Stockwell (2023), research shows that while higher prices of alcohol deter excessive drinking in the general population, it does not inhibit the actual drivers of addiction (financial

distress, social isolation, psychic comorbidities). Along the same lines, awareness campaigns about alcohol-related harms tend to miss the mark on people who already depend on alcohol because such campaigns rarely suggest how to prevent relapses (Witkiewitz et al., 2019).

The results of Chapter 4 show that individuals in recovery need more personalised and focused interventions rather than general regulatory step-ups. Rather than focusing only on policies restricting alcohol, future policy initiatives should include economic, psychological and social support systems. For example, policies that increase the availability of low-cost rehabilitation services, availability of mental health care, and availability of financial aid, such as loan programs for recovery people, can create greater and more permanent results in relapse prevention. Unless the causes of addiction are addressed, then regulatory measures will not lead to a significant reduction in relapse rates. As such, policymakers need to rethink the existing strategies and adopt a broader and more evidence-based approach to treat and recover from alcohol addiction.

5.5.5 Implications for Targeted Interventions

From the regression results, there is a need for individual recovery measures that target the risk factors leading to relapse. A standardised system of alcohol addiction recovery may not work since people have their own different social, economic and psychological challenges. Rather, the intervention efforts should be oriented at targeted support mechanisms that compensate for the most important relapse predictors in the analysis.

The urgently needed measures include widening economic support programs to alleviate stress about finance and job instability, among the most powerful antecedents of relapse. Unemployment and financial hardships appear from studies to increase the risk of alcohol dependence and relapse as the substance becomes a coping mechanism among people with low incomes in uncertain economic times (Religa et al., 2024). Increasing efforts in employment assistance programs, vocational training, and financial relief programs can bring stability to individuals in recovery and keep them sober. Policies allowing job placement to the population recovering from addiction (especially in contexts of well-being and structured social support) can dramatically lower relapse rates (Ilhan and Yapar, 2020).

Additionally, integrated mental health services should be included during addiction recovery programs in that psychological distress usually accompanies alcohol dependency. Regression findings reinforce the role of mental health issues in the relapse risk, echoing the

previous studies which emphasise the association between emotional distress and substance intake (Babor et al., 2022). Proper intervention strategies should include mental health counselling, cognitive-behavioural therapy, and trauma-informed care in rehabilitation. Making mental health services easy to access in addiction treatment centres will ensure that every person gets all-rounded care as they address both the substance abuse and the underlying psychological factors that cause addiction.

Community-based social support networks also play a critical role in averting a relapse-especially in those at risk of isolation-induced dependence on alcohol. It is found that social isolation significantly contributes to the likelihood of relapse, which in turn reaffirms the need to boost peer recovery programmes and social reintegration initiatives. Community-based interventions, including Alcoholics Anonymous (AA), peer mentoring, and local support groups, have proven useful in providing vital emotional support, accountability, and encouragement towards long-term sobriety (MacKillop et al., 2022). Extending access to these support systems, especially in remote and under-served tracts, may close the gap between those in recovery and the networks that aid their progress.

Lastly, individualised approaches to rehabilitation need to supplant non-specific policies to enable people to access treatments designed for their unique levels of relapse propensity. Today's rehabilitation paradigms utilise similar procedures to patient populations whose experiences, economic situations, and status within their minds could not differ more, resulting in varied recovery results. A transition towards a more individualised orientation – in which the mental health history, financial situation and social environment will be considered – will make the treatment more effective. Research indicates that intervention programs tailored to economic relief, mental health treatment, and social support lead to better long-term recovery than standardised ones (Witkiewitz et al., 2019).

Overall, the results confirm the significance of integrative recovery strategies whereby economic unrest, mental health, and social support form the major approach to dealing with addiction. The individuals are still prone to relapse despite the regulatory policies laid that attempt to control the consumption of alcohol. Therefore, future recovery programs should pay attention to economic security and mental health care, which is incorporated into the community-based support network to make it a viable and lasting structure for addiction recovery.

5.6 Reliability Analysis Discussion

5.6.1 Overview of Reliability Tests (Cronbach's Alpha)

Reliability analysis will prove fruitful for assessing the level of internal consistency of observation scales in quantitative data. Cronbach's Alpha is one of the most famous calculations of reliability, and it is used to determine to what extent a collection of items corresponds to a single underlying construct (Van Ingelgom and Didone, 2019). If Cronbach's Alpha (> 0.7) is high, it implies high internal consistency, whereas a low or negative value indicates low reliability and a problem with item grouping. In the present study, the outcomes of the reliability tests were not the ones that were expected, as some groups of variables indicated a negative Cronbach's Alpha value, which meant that the chosen items did not measure the same construct in the same way.

From the findings, it is revealed that the chosen variables are not theoretically nor empirically compatible; this causes discrepancies in measurement. This lack of internal consistency conveys doubts about the suitability of combining some of the variables into one analysis. Negative Cronbach's Alpha values indicate that some items are inversely related or have low inter-item correlations; thus, they fail to make a cohesive scale (Smith, 2021). The significance of reliability in validating the research outcomes presents the need for a thorough re-examination of the process through which the variables were classified and quantified. For the sake of various variable groups, three reliability tests were done.

1. Group 1: Peer Pressure, Family Support, and Social Isolation
2. Group 2: Financial Stress, Job Loss, and Affordability of Treatment
3. Group 3: Stress Level, Mental Health Issues, and Policy Effectiveness

All these groups presented low or negative Cronbach's Alpha values, showing that the variables were not generally associated. These findings imply crucial consequences for the measurement of risk factors for relapse. The two constructs should be measured separately or reassembled according to empirical grounds. Consequent sections detail the findings for each group, explaining the potential reasons for the low reliability and implications for further studies.

5.6.2 Group 1: Peer Pressure, Family Support, and Social Isolation

The first variable group of peer pressure, family support, and social isolation gave a negative Cronbach's Alpha (-1.353), indicating poor internal consistency. This implies that these

three variables fail to cluster together. Thus, they can be psychological and social phenomena instead of a unitary dimension of relapse risk.

One of the explanations for the mentioned results may be that peer pressure, support from family, and social isolation influence people very differently, so it is significant to combine them into a single, internally consistent scale. Peer pressure is usually linked with external social influences that promote or discourage substance use, while family support refers to emotional and instrumental support which could protect against the addictions. At the same time, social isolation refers to the lack of social contacts, which may result in increased levels of substance abuse as a coping mechanism. Given how these variables function, their weak or negative inter-item correlations are unsurprising (Fairbairn and Kang, 2025).

Empirical research also confirms the idea that peer pressure, family support, and social isolation serve as independent predictors of addiction outcomes and not the elements of one construct. Peer influence among the young populations is reported to be more influential than family support in long-term recovery stability (Calina et al., 2021). In the meantime, social isolation has been associated with addiction by various psychological routes, including stress, depression, and loneliness (Room, 2020). Future research should consider these variables in isolation or households along different consolidations that capture their distinctive differences in relapse risk.

5.6.3 Group 2: Financial Stress, Job Loss, and Affordability of Treatment

The second group – financial stress, job loss, and affordability of treatment also had a negative Cronbach's Alpha (-1.464), meaning that the inter-item correlations were low and there was no internal consistency. This means these variables are not measuring a single construct but rather unique economic stressors to addiction in varied ways.

One of the main reasons for low reliability in this group could be that financial stress and job loss are highly associated with psychological distress. At the same time, accessibility of treatment is mainly an issue of affordability. Financial strain and job loss have been strongly established as significant precipitants of substance use because economic insecurity intensifies anxiety, depression, and despair, which contribute to elevating the risk for relapse (Mathew et al., 2018). On the other hand, affordability of treatment refers to structural and policy-related

challenges of access to rehabilitation, which can be detrimental to government regulations, insurance policies, and healthcare setup than any individual monetary situation.

The second concern is that treatment being affordable can not necessarily mean financial stress or lack of a job. Some people may be employed but cannot receive affordable rehabilitation services because of unavailability, insurance problems, and distances (Zhang et al., 2018). On the other hand, not all people undergoing financial duress or job loss seek addiction treatment, so cost concerns may not be equally relevant for the sample.

Such findings indicate that financial stress, job loss, and affordability of treatment should be studied individually or reorganised depending on the theoretical frameworks that recognise their different routes to relapse. Future research could examine other models of economic stress that distinguish psychological stress related to financial disarray and structural impediments to healthcare access.

5.6.4 Group 3: Stress Level, Mental Health Issues, and Policy Effectiveness

Stress level, mental health issues, and policy effectiveness comprised the third group, with the lowest Cronbach's Alpha figures (-1.660), thus showing extreme inconsistency in measurements. This implies that these variables are different constructs altogether and should not be categorised together in future analysis.

One of the probable reasons for this result is that mental health issues and stress levels are closely connected to perceptual coordinates. At the same time, policy effectiveness is not a direct projection of a person's emotional or cognitive condition. Stress and mental health issues are well-recognised predictors of substance use because people are likely to use alcohol to cope with anxiety, depression, or trauma-induced anguish (Le Berre, 2019). In contrast, policy effectiveness reflects the perceptions of government interventions dependent on external socio-political influences as opposed to personal psychological experiences (Meier et al., 2018).

The second point worth discourse is that it is possible for policy effectiveness to influence addiction victims' population disparately. Some participants might consider government interventions ineffective because of personal examples, and some do not know about the existing policies. Additionally, there are cases when some individuals may relapse under the influence of

personal stressors and mental health struggles, thus further preventing the formation of inter-item correlation within a group.

Taking all this into consideration, it is clear that stress levels and mental health problems should be analysed under psychological vulnerability models, while policy effectiveness should be discussed aside in the context of the bigger public health structures. Research should look to apply multi-level models that distinguish between psychological predictors at the individual level and influences on addiction from higher-order policies.

5.6.5 Implications for Measurement and Future Research

From the reliability analysis findings, some of the groupings of variables in this study were inconsistent with the theoretical assumptions. The negative Cronbach's Alpha values indicate that the chosen constructs do not form a latent factor and need reassessment for further studies.

One of the most important implications is for researchers who should perform preliminary factor analysis to decide if certain variables load on the same factor before their aggregation in reliability tests. As an option, Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA) may be utilised to determine if particular variables have high correlations and shared variance, creating more conceptually consistent scales (Khemiri et al., 2020).

Additionally, future research should examine alternative grouping of variables based on empiricism instead of assumptions. The findings from the present study indicate that financial stress, job loss, and affordability of treatment are to be studied separately since they are different aspects of economic hardship. Likewise, peer pressure, family support, and social isolation should be investigated as separate predictors, with their unique socio-psychological consequences for the risk of addiction.

Lastly, additional research requires measurement refinement to have accurate and meaningful results. Future work in this area should focus on building more specific scales to reflect the actual relapse risk factors, including both the psychological and structural forces driving the addiction outcomes. Through these measurement issues, the researchers can increase the validity and reliability of their study, thus enhancing better policy and intervention strategies for relapse prevention.

5.7 Integration with Existing Literature

5.7.1 How Findings Align with Previous Research

Results from this study offer a strong correspondence with other literature on addiction, relapse, and the larger socio-economic and psychological factors that affect substance use. Work on addiction has always articulated that relapse is not an individual's failing but an interaction of psychological, social, economic as well as policy issues (del Palacio-Gonzalez et al., 2024). The findings from Chapter 4 support these multi-faceted aspects, and findings indicate that job loss, financial burden, social isolation, and mental illness are the major predictors of relapse, as in previous addiction vulnerability studies (Piper et al., 2021).

5.7.1.1 Social and Peer Influences on Relapse

The literature shows evidence of the role of peer influence in addiction and relapses. The findings of this study confirm the research, which sees social networks as both protecting and favourable for increasing risk in recovery from addiction (Stohs et al., 2019). Social learning theory states that people tend to emulate behaviours in their social landscape, such as peer support in recovery programmes and exposure to heavy-drinking peer groups (Bandura, 1986). Hodgson and Stockwell (2023) researches bear out that strong social group ties that promote drinking could put an individual at relapse risk.

Similarly, results from this study are consistent with the self-medication hypothesis, whereby people utilise substances such as alcohol to alleviate emotional ordeals (Moriarty et al., 2022). A study by Meier et al. (2018) established that those with poor social support networks are likely to turn to alcohol to relieve stress, a phenomenon evident in the current study participants who associated social rejection and isolation as cues for relapse. The conformity of these findings with previous research indicates that intervention measures should involve community-triggered support systems to prevent social isolation as a relapse factor.

5.7.1.2 Economic Stress and Addiction Vulnerability

Financial stressors are well-studied as risk factors for substance use disorders, being directly linked to greater relapse risks (McCann and Lubman, 2018). These findings agree with those made in this study which indicate that job loss and financial pressure were some of the best predictors of relapse. This is congruent with investigations that raise financial instability as a

significant factor for mental health issues that intensify substance use as a comfort strategy (Stohs et al., 2019).

A study by Curtis et al. (2018) demonstrates that economic empowerment and financial literacy programmes severely reduce addiction relapse rates, indicating that there is no automatic association between financial stress and relapse if the correct tools are available. This reinforces the need to implement economic rehabilitation and financial planning programmes in addiction treatment that have been shown to increase long-term sobriety rates (Religa et al., 2024).

5.7.1.3 Mental Health and Psychological Vulnerability

The mental health in addiction has been researched thoroughly, and there is an agreement that co-occurring conditions of mental health increase relapse odds significantly (Babor et al., 2022). The outcome of this study supports this body of research; they say that anxiety, depression, and untreated mental health were among some of the best predictors of relapses. The stress-vulnerability model presents that pre-existing psychological distress estimates the greater likelihood that people will use alcohol as emotional regulation (Hammoud and Jimenez-Shahed, 2019). This is evidenced by findings that reveal that including mental health services in addiction recovery programs enhances better outcomes (Khemiri et al., 2020).

However, the study also goes alongside the arguments that contend that mental health is not the only predictor of relapse. For example, Van Ingelgom and Didone (2019) revealed that individual coping mechanisms and social resources moderate the mental health impact on substance use outcomes. This means that though psychological distress is a significant risk factor, structural and social support systems can lessen its effects, thus emphasising the required comprehensive, multi-dimensional treatment approaches.

5.7.1.4 Public Policy and Relapse Prevention

The findings of the study also agree with literature that has been focusing on the effectiveness of public policies in addressing addiction to alcohol. Although pricing policies and regulatory controls in alcohol sales have been successful in curbing rates of consumption, the findings of this study support those indicating that the measures are not adequate in combating relapse (MacKillop et al., 2022). Minimum pricing of alcohol lowers overall drinking, but it is not linked directly to long-term recovery outcomes unless it comes with holistic support interventions

(Chiappini et al., 2020). This substantiates that policy strategies must acknowledge economic and psychological support systems and not just exist on restrictive measures.

5.7.2 Contradictions and Unexpected Findings

Although many findings of this study agree with previous research, some contradict already established theories and point out the aspects that need further research. The most surprising findings were the little effect of policy effectiveness on relapse rates as well as the relationship between family support and relapse prevention. These findings are contrary to previous studies that have focused on government interventions and support from the family to give a solution to addiction, but this suggests the other aspects influencing relapse are more complex than thought.

One of the most surprising findings was that policy effectiveness had no significant effect on relapse risk. This goes against previous studies indicating that a strong public health policy, including alcohol taxation, minimum pricing, and public campaigns to raise awareness about addiction, can curtail addiction rates (Thomeer et al., 2019). It was hoped that the policies to limit alcohol availability and increase the cost of consumption would lead to the prevention of relapses. However, the results of the regression analysis showed that policy measures had minimal to no effect on participants' risks of relapse, which brings critical questions regarding the practicality of regulatory measures in addiction recovery.

Perhaps the reason why such a contradiction is possible is that public health policies focus mainly on societal-level alcohol consumption. At the same time, personal, financial, and psychological stressors cause individual relapses. Public health initiatives proposed by Witkiewitz et al. (2019) are useful for preventing the initial use of alcohol, but they do not address the difficulties of sustaining recovery. This result highlights some of the pitfalls of general policy-oriented interventions and points to the fact that more one-size-fits-all support systems are needed in the future, including economic aid programs, mental health services, and peer-driven recovery efforts.

The other unforeseen result was the low correlation between family support and relapse prevention. The previous studies have strongly advocated for the substance of familial encouragement in addiction recovery to the extent of stating that strong families serve to offer emotional stability, accountability, and drive to continue sobriety (Xia et al., 2022). Nevertheless, the results of this study imply that family support alone is not a critical aspect when preventing

relapses. This goes against the popular assumption that family members play a beneficial role in the recovery from addiction.

One of the possible explanations for this surprising outcome is that all family interactions need not necessarily be positive. Family member pressure, a feeling of being judged and unrealistic expectations were reported as reasons that led to emotional distress, leading to increased chances of relapsing. The argument is supported by the research conducted by Rahman (2025), whereby it is noted that family dynamics can sometimes act as a stressor instead of being a protective unit. If, in any case, the expectations of the family add more pressure on the people in recovery, the supportive role of the family may be neutralised by stress-induced relapse triggers. This implies that interventions based on families should be well customised to ensure that they encourage without coercion. Instead of merely presuming all family interactions are healthy, rehab programs should consider distinct family setups and construct interventions that enhance healthy communication, conflict resolution and emotional support.

Such contradictions demonstrate the necessity of reconsidering the common assumption in drug research and policy-making. Although public health intervention and family support are no doubt essential, they might not entirely suffice in protecting from relapse. Rather, holistic intervention models incorporating economic aid, mental health provision, and individual recovery programs could potentially be useful for the multifaceted nature of relapsing in addiction. Future researchers should continue examining these contradictions to create more sophisticated, evidence-based solutions that consider the intricate relationship between individual, social, and structural elements in addiction recovery.

5.7.3 Theoretical Contributions to the Field

The results of this study bring great contributions to the existing theories about addiction and relapse, particularly in detailing the understanding of how several risk factors interact to create relapse. Both biological predispositions and social and environmental triggers are the main areas of emphasis for the traditional models of addiction. Nevertheless, the results highlight the complexity of addiction relapse and imply that the combination of psychological distress, economic strains, and social forces increase an individual's likelihood of relapse. These findings are consistent and elaborative of several important theoretical frameworks in addiction research.

The results of this study support the stress-vulnerability model (Volkow et al., 2019) regarding the findings that economic and social stressors play a crucial role in increasing the relapse risk. The findings indicate that relapse is not just an individual matter of willpower or predestination but is the product of socioeconomic stress, job insecurity and lack of monetary stability. Since financial distress and job loss became two of the most powerful risk predictors for relapse, this highlights the need to incorporate stress-reducing interventions into addiction therapy to combat such risks to a sufficient degree.

On the same note, the study results corroborate the social learning theory (Bandura, 1986), where peer influences are important in addiction behaviours. Participants who were connected with active drinkers in social networks had more difficulties in maintaining sobriety. Supplementary, the findings also indicate that peer-recovery groups with some structure can counter the negative social influence, which helps support the sum effect of interventions like AA and peer-mentoring programs. This is an addition to an increasing literature that suggests social reinforcement can be used as a protective force in terms of addiction recovery instead of always being a relapse trigger.

Additionally, the self-medication hypothesis (Blaine and Sinha, 2017) is also supported by the findings of the study, which shows that psychological distress leads to substance abuse as a way to cope. Those who experienced untreated mental health challenges, such as anxiety and depression, were much more likely to relapse, stressing the need for mental health care to be integrated into addiction treatment. This is the same argument as Bozarth (2023), which indicates that mindfulness-based and cognitive-behavioural therapies efficiently manage stress-related relapse risks.

Apart from refining addiction theories, the discoveries contradict policy-centric approaches to fighting addiction that mainly involve minimum pricing strategies, alcohol taxation and public awareness in addressing substance use. Results imply that economic and psychological interventions are more important than general regulatory practices in relapse prevention. Although social-level policies aimed at monitoring the intake of alcohol may minimise the first use of alcohol, it does not guarantee to address the root causes of addiction or prevent alcohol relapse among the recovering (McCann and Lubman, 2018). This highlights the need for a more comprehensive public health model which focuses on individualised recovery support, financial

stability programs and mental health interventions in preference to exclusive use of restrictive alcohol regulations.

Considering the shocking results of policies' effectiveness and family support, further research should focus on alternative intervention models that combine the financial, social and psychological support systems for addiction recovery. Also, longitudinal studies are required to examine the changes in relapse patterns over time, specifically about economic stance, mental illness interventions, and peer networks. Inequalities in research gaps can be resolved, and in the future, better strategies for relapse prevention and longevity in sobriety can be applied, by extension, advancing the field of addiction studies.

5.8 Summary

Chapter 5 is a deep analysis of the study's main findings, combining the qualitative and quantitative results to locate the relapse risk factors in the existing literature and the theoretical framework of studies. The chapter identifies social, economic, psychological, and policy-related determinants of alcohol relapse, providing an understanding of how these factors affect recovery outcomes.

Social and peer pressures in the context of drinking behaviours are one of the major themes in the discussion. The findings show that although peer support can improve recovery, drinking networks increase the risk of relapse. Social isolation was also identified as a great trigger, which supports the self-medication hypothesis, which states that people use alcohol to alleviate emotional stress. These insights highlight the need for organised peer recovery and social reintegration programs.

Family dynamics developed as a protective and risk factor in preventing relapse. A positive family environment increased treatment adherence, while disrupted familial relations worsened stress, increasing relapse susceptibility. This double effect indicates that the family-type interventions would need to be customised to incorporate hope without creating pressure and stigma.

Economic pressures, especially financial uncertainty and unemployment, were some of the most powerful predictors of fallout. The presence of economic hardships was accompanied by increased stress and the inability to access treatment, with more chances of alcohol dependence.

The findings are consistent with the monetary stress theory, which associates financial distress with greater use of substances. Consequently, employment support programs, financial literacy measures, and economic relief programs are recommended to prevent such risks.

Another of the primary findings was the impact of mental health issues as a relapse predictor. Co-morbid anxiety, depression, or trauma-related conditions placed individuals at a greater risk of substance abuse. This is compatible with the stress-vulnerability model, which focuses on the interaction of psychological stress with the use of substances. The study proposes to adopt integrated mental health services in the context of addiction recovery interventions, such as cognitive-behavioural therapy and trauma-informed care, to better the treatment outcomes.

The chapter also discusses the efficacy of public policies in reducing relapse risk. Strikingly, the effectiveness of policies appears to have only a limited impact on rates of relapse, overriding the belief that regulatory policies like minimum pricing and taxation are enough to stop the reoccurrence of addiction. From the findings, it is evident that policy interventions need to transcend the alcohol control strategies and implement comprehensive economic, social, and mental health systems to yield meaningful outcomes of recovery.

Finally, the reliability of the measurement scales used by the study is discussed. The reliability analysis showed the inconsistency in grouping some variables, which means some constructs should be re-evaluated for further research. According to the findings, the economic, social, and psychological risk factors were to be evaluated individually to enhance measurement accuracy.

Chapter 5 focuses on a multi-dimensional approach to relapse prevention, addressing economic stability, mental health care, peer and family support, and evidence-based policy changes. Findings indicate weaknesses in today's addiction recovery systems and suggest more individualised and holistic strategies in intervention to tackle the complexities of alcohol relapse. Research for the future should explore the long-term effects of these risk factors and measure the impact of individualised intervention plans on recovery results.

Chapter 6: Conclusion

6.1 Introduction

Alcohol relapse is an obscure problem of public health, and some socio-economic, psychological, social, and environmental factors stimulate this issue. The main aim of the work under analysis was to talk about the social predictors of relapse and recidivism in alcohol use, the possible determinants and some of the factors that motivate long-term sobriety. Specifically, it offered peer pressure and family support, as well as financial pressures, loss of a job, and mental health issues, which were influenced by the intervention of the policies. Most individuals are concerned with addiction recovery, and therefore, it is essential to study these factors to enhance their prevention and intervention methods.

The research question in the proposed study arose as a result of the extent of relapses that occur among persons recovering from alcoholism. It has already been determined that relapse leading to rejection in individuals attempting to recover is 40-60 %, and social and environmental stress factors play a significant role in it (Menon and Kandasamy, 2018). The instruments of addiction treatment are also associated with biology and psychology, but it is essential to take care of the higher society determinants, which might lead to relapse (Zgierska et al., 2019). The current study aimed to fill this gap by examining the role played by external stressors, such as economic instability, social exclusion, and ineffective policy measures, in the relapse pattern. The necessity of this study is due to the need to incorporate a socioeconomic and psychological approach to the framework of addiction treatment and ensure that rehabilitation attempts also respond to the non-biological causes of addiction to add its piece to the puzzle of recovery or the lack thereof.

The researchers employed both qualitative and quantitative methodologies in this study to provide a comprehensive picture of the triggers of relapse. The study used thematic analysis in examining qualitative data gathered using semi-structured interviews to come up with essential themes regarding social stressors and relapse addiction. Furthermore, descriptive statistics, correlation analyses, and regression modelling techniques were applied to establish relationships among variables and to assess the predictive ability of the greater relapse factors. Cronbach's Alpha was used to determine the reliability of the survey through the internal consistency of the instruments, assuming that the variables used were valid and reliable. A combination of such

methodologies enabled a more detailed view of relapse risk that proved helpful in both theoretical and practical fields of addiction studies.

The importance of the research findings extends beyond academic rhetoric, providing policymakers, medical practitioners, and drug rehabilitation initiatives with well-informed knowledge. The main results of this study were the high correlation between the financial stress factor and the risk of relapse, indicating the necessity of economic stability in maintaining long-term recovery. In addition, peer influence was also noted as both a protective and a risk factor, suggesting that organised peer support programs could serve as a barrier to negative peer pressures. The other unexpected answer was the doubt about the effectiveness of public policy measures, specifically the current regulatory measures, such as taxation and lower prices for alcohol consumption, in addressing the leading causes of relapse. The novel findings substantiate the notion of more targeted, multidimensional intervention solutions which would bear in mind the individual risk factors, as well as the structural drivers of the addiction.

This paper is a critical assessment of the causes of alcohol relapse, focusing on how psychological, financial and social factors interact. A more detailed picture of the addiction recovery process may be provided in this study, as it utilises theoretical concepts such as the stress-vulnerability model (Volkow et al., 2019) and social learning theory (Bandura, 1986). The implications of this study will be significant in improving treatment regimens, informing government policy, and enhancing understanding of addiction and relapse prevention theory.

6.2 Summary of Key Findings

This paper has examined social antecedents of relapse and recidivism of alcohol drinking as applied to different psychological, social and economic characteristics. The results provide a clear understanding of the various factors that influence relapse risk, which were identified through theme analysis, statistical analysis, and theoretical discussions. The findings impart that relapse is not entirely an individual mental disorder but is a multidimensional, well-informed problem related to outside stress and interpersonal and structural adversities.

6.2.1 Key Insights from Thematic Analysis

Thematic analysis, which assisted in unveiling the qualitative findings, emphasised the critical roles played by social relationships, economic stress, and policy efficacy in the literacy of

the relapse risk. The issues of the participants outlined the finer points of the process of being cured of addiction because they elaborated on how external settings enhance or trigger relapse.

The effect of peer relationships came out as the second strongest theme. Some participants recognised that peer support was critical to their recovery, whereas others cited peer influence as one of the primary sources of triggering a relapse. The results showed that people with social networks with active drinkers had difficulties remaining sober because drinking was normalised in their social groups. In contrast, participants who used more organised peer support groups, i.e., Alcoholics Anonymous, gave higher relapse prevention results. Family dynamics is another critical theme that had a two-fold impact on the risk of relapse. The subjects who had a conflictual family history reported an increased level of psychological stress that, in most cases, resulted in a relapse as a coping strategy (Tabugan et al., 2025). Conversely, positive family support served as a protective factor, strengthening recovery and providing emotional stability. Nevertheless, others indicated that family members pressured them to stay sober in one way or another, which was yet another stressor that led to a relapse in some people.

One of the strongest indicators of relapse was economic pressure. Those who experienced financial hardships such as job loss, housing instability, and financial insecurity were also the most likely to mention financial crisis as a common cause of relapse into drinking. The results helped prove that financial stability is a significant factor in the prevention of relapse because most people undergoing financial difficulties resort to alcohol as a means of dealing with stress and anxiety. The paper also considered the role of accessibility to treatment services. Qualitative results showed that most participants faced significant financial and logistical challenges when pursuing rehabilitation programs. The treatment facilities were more accessible to the urban population, while the rural population faced healthcare limitations and transportation issues. In addition, others indicated that the cost of treatment was prohibitive at some level, which served as a discouraging factor in accessing treatment by professionals (Fairbairn and Kang, 2025).

The last thematic category examined the effectiveness of public policies aimed at reducing relapse rates. The results found that although interventions like public awareness programs, to a certain extent, increased consciousness regarding the harmful effects of alcohol, this study did not identify interventions to assist those at risk of a relapse. The respondents complained about the perceived ineffectiveness of government policies and the necessity of more formalised efforts,

such as economic assistance programs, mental health care, and community-based recovery programs.

6.2.2 Insights from Statistical Analysis

In addition to the qualitative themes, quantitative analysis revealed vital information on links between various variables and the risk of relapse. Regression analysis, correlation analysis, and reliability testing were employed to assess the statistical significance of multiple predictors.

Regressions also confirmed that job loss, financial stress and social isolation were the best predictors of relapses. People with unstable employment were also at a much greater risk of a relapse, which proves the significance of economic stability in substance abuse recovery. In the same way, financial stress has been identified as one of the key risk factors, with participants who experienced persistent economic instability presenting an increased inclination toward alcohol relapse.

Another major factor that determined relapse was the issue of mental health. The regression model underlined the influence of a more profound psychological distress, constructs of anxiety and depression, on alcohol dependency. People with mental problems could not maintain long sobriety, tending to resort to alcohol as a tool of emotional relief. Interestingly, policy effectiveness does not qualify as a factor in the occurrence of relapse. The alcohol taxation, minimum pricing, and other regulatory measures did not seem to directly affect the reduction of relapse risk even though the interventions were implemented (Bach et al., 2025). This result implies the need to view the individual determinants of addiction recovery through more disparate and personalised approaches rather than casting them within the context of general policy frameworks.

The correlation analysis further proved the validity of the relations among key variables. Job loss had the most positive correlation with the relapse scores, and so employment raggedness also played a pivotal role. In the same way, financial stress displayed an impressive connection to relapse risk, strengthening the case of economic support systems in approaches to addiction.

The moderates were peer pressure and family support associated with the probability of relapse risk. Social interactions affected behaviours in the use of alcohol, but the impact may have been moderated by other stressing factors like economic insecurity and issues related to mental health. This observation implies that although social relationships are also crucial, they are not

isolated, as they interact with surrounding structural and psychological determinants. Among the most outstanding findings of the correlation analysis is the weak relationship between policy effect and relapse risk (Litman, 2023). Results showed that the current public health-based interventions, including taxation policy and awareness campaigns, do not significantly influence the outcomes of relapse. It concurs with the thematic results as the participants showed scepticism on the effectiveness of government interventions.

The Cronbach reliability analysis revealed inconsistencies in how key variables are grouped, suggesting that some components of the relapse risk may be independent and not a summary of coherent entities. The first category, comprising peer pressure, family support, and social isolation, had a negative Cronbach's Alpha score, which demonstrated that these variables are not considered a unified social determinant. Generally, the same applied to financial stress, loss of job, and ability to afford treatment, which exhibited low Cronbach alphas, meaning that, despite sharing links to economic stability, they cannot be part of the same construct and, thus, must be addressed differently. Finally, the clustering of stress, mental health concerns, and policy performance were not consistent, and this finding implies that stress and government decrees are distinct effects and not connected aspects of relapse vulnerability.

6.2.3 Connecting Findings to Research Questions and Objectives

The main results of this research are relevant to the original research aims and objectives. The main goal was to determine the key social stimuli contributing to alcohol relapse and evaluate how they influence the results of the recovery. The thematic and statistical results demonstrated that such predictors of relapse, such as job loss, financial stress, and social isolation, were the most prominent factors that directly answered the central research question of external stressors and addiction vulnerability.

The other aim was to determine the effectiveness of the policy in preventing relapse. The results show that, although there are policy interventions, they do not directly affect the relapse risk of individuals, implying that more significant changes in public health strategies need to be reconsidered to handle problems in addiction recovery. The paper also attempted to analyse the effect of peer and family support on patterns of relapse. Findings showed that although there is an effect of social relationships on recovery, it is usually indirect through other stressors like financial unsteadiness and mental issues. This calls upon the existence of integrated recovery programs,

which will involve interventions to social support mechanisms as well as economic and psychological interventions (Karriker-Jaffe et al., 2020).

Finally, the results give functional implications on many intertwining factors that comprise alcohol relapse. The paper establishes the fact that in treating relapse, one needs a comprehensive intervention that focuses not only on personal behaviour but also on exogenous socioeconomic-psychological factors. The outcomes reinforced the necessity of more specific evidence-based interventions, which assist in treating the causes of addiction instead of standard regulations.

This study combines qualitative data and quantitative analysis to provide a whole picture of the relapse risk and contribute to finding more effective strategies for treating addictions. The study reinforces the importance of economic stability, mental well-being support, and team recovery programs in reducing the likelihood of relapse, highlighting an area for future research and policy development.

6.3 Implications for Policy and Practice

The findings of the current research have several critical implications for public health policy, rehabilitation treatment, and broader societal issues, particularly regarding the issue of indulgence. The relapse risk complexity fact, as stated in the research, means that the required intervention must go beyond the established patterns according to only the alcohol restriction patterns. Instead, it requires a multi-pronged approach that incorporates aspects of economic stability, mental well-being promotion, peer-based interventions, and policy reform to enhance recovery (Brown et al., 2020). The work denotes the need for well-organised, available and personalised methods of addiction recovery that may be able to overcome all triggers of the addiction like financial crisis, nervous tension and social aspects.

6.3.1 Implications for Public Health Policies

According to the study results, the ongoing public health program for the reduction of alcohol consumption cannot be sufficient in preventing a relapse. The classical policy instruments of taxation, minimum pricing, and bans on advertising will help reduce the initial relapse but cannot cover the multifactoral and multidimensional origins of relapse (Bowen et al., 2021). The results show that the losses on finances, loss of job, and anxiety emerge to be superior variances on relapse as compared to the structural availability of alcohol. Consequently, the programs of the

public health sphere need to be more comprehensive and integrate the issues of healthcare, finances, and employment into the addiction control plan.

In addition, people at high risk should be effectively reached by targeting and evidence-based interventions aimed at streamlining public health campaigns. The campaign will be better aimed at the at-risk groups instead of the general and broad unified warning messages on alcohol dangers. At-risk groups will include those people with financial problems, those with untreated mental disorders, or those who have been victims of social isolation in the past. The educational needs of the community must include making information on relapse prevention, support networks, and mental health easily accessible (Saunders and Allsop, 2023).

Additionally, policies must promote more interactions among healthcare providers, addiction experts, and social services organisations so that individuals in recovery can access comprehensive care. Comprehensive care strategies where addiction treatment is integrated with financial counselling sessions, job training, and psychological services may be effective in meeting the needs of individuals who are prone to relapse. The orientations of data-driven policy reforms should also be presented in the work of public health agencies and constantly evaluated in terms of success rates concerning addiction interventions, with strategies adjusted accordingly (Jason et al., 2021).

6.3.2 Recommendations for Rehabilitation and Intervention Programs

Rehabilitation efforts need to move away from the traditional uniformity framework to personalised, evidence-based interventions that take into consideration the individual needs of individuals undergoing recovery. It was concluded that relapse risk prevalence is mainly related to economic stability, mental health, and peer support and that treatment programs should target these three aspects (Guenzel and McChargue, 2019).

First, the rehabilitation services should have economic stability programs. Vocational training, financial counselling, and employment services need to be offered to people going through recovery to help them have the monetary means to make themselves stable, hence preventing relapse (Stohs et al., 2019). As job loss has proven to be a significant determinant of relapse, financial security should be an essential part of ongoing recovery.

Second, the mental health support must be integrated into the rehabilitation services. A significant percentage of substance use disorder patients experience comorbid psychiatric disorders, including depression, anxiety, and PTSD. In the absence of proper psychological attention, people in recovery might resort to alcohol as an escape strategy, doubling the chances of relapse as such, addiction treatment programs should provide cognitive-behavioural therapy (CBT), trauma-informed, and mindfulness-based approaches as a way of teaching people practical coping skills (Yazdi et al., 2020).

6.3.3 Addressing Barriers to Treatment Access

The study identified several main issues, including unequal access to medical services, which is influenced by socioeconomic and geographical factors. Most people who have problems with substance abuse are not able to get appropriate forms of treatment as they cannot afford medical care, rehabilitation centres and treatment. Policies must aim at building up rehabilitation by developing mobile treatment units and stimulating tele-based programs to support the management of addiction (Sliedrecht et al., 2021).

One of the most serious issues is also the geographical variance in access to treatment. Special treatment or addiction services are also unavailable to persons in rural or underserved areas. To remedy this situation, medical services would need to invest in telehealth options, which would enable people to receive counselling, therapy, and even peer support remotely without the need for a long trip (Ray et al., 2019). The distance can also be bridged through mobile recovery units and outreach programs that would offer addiction treatment services to communities with fewer resources.

Besides, stigma is still a potent inhibition to the treatment of addictions. All these factors make many people avoid seeking help due to fear of judgment, discrimination, or social repercussions. It should be aimed at making the treatment of addiction common and normal, and people should seek professional help without feeling humiliated (Gibson et al., 2018). Healthcare workers should also train on how to prevent stigma during medical practice, so that people recuperating can be treated with mercy and without judgment.

6.3.4 Socioeconomic Factors and Addiction Recovery

The paper emphasises the essentiality of socioeconomic issues in the recovery of people with an addiction. The results show that financial strain, job insecurity, and social turmoil play an

essential role in the relapse risks. Hence, these socioeconomic factors are critical to offering effective addiction recovery programs.

The most significant protective factor of relapse is employment stability. People with stable jobs are most likely to have a structured routine and financial and social activities, which decreases their tendency to use alcohol as a coping mechanism (Khan et al., 2018). Consequently, workforce reintegration programs shall also be initiated to enable the recovering people to access employment opportunities. Local businesses can collaborate with rehabilitation centres to provide opportunities to advance the individuals who have tamed down drug addiction by placing them in employment.

Addiction recovery programs should also be incorporated with financial literacy programs. Financial pressure caused by either previous debts, job loss, or inconsistent wages plagues many individuals with substance use disorders. Financial counselling may also provide individuals with budget planning skills, the skills of managing debt, and schemes of savings, which, will also eliminate the financial strain that might lead to relapse (Kraus et al., 2020).

Social reintegration is crucial when recovering from addiction, besides monetary problems. When individuals leave rehabilitation, they face hardship in re-entry into society due to ruined relationships, socio-stigma, or failure to have a support system. Return to community programs need to focus on rebuilding social relations, developing healthy relationships, and giving them a chance to play a critical role in society (Zaidi, 2020). Support groups, mentorship, and community service can help individuals re-engage with their communities.

6.4 Theoretical Contributions

The findings of this study can bring meaningful contributions to the existing knowledge on addiction and relapse. They will present a fresh concept regarding the complex nature of psychological, social, and economic processes. The research study enhances existing theoretical propositions and methods for determining them, aiming to improve knowledge of relapse and the roles of factors such as unemployment, financial pressure, mental health status, social integration, and policy effectiveness. The results indicate that it is necessary to have a comprehensive image with a focus on psychological stability, financial sustainability, and specific intervention actions.

6.4.1 Contribution to Addiction and Relapse Theories

In the past, theories of addiction and relapse have attempted to formulate why individuals fail to adhere to sobriety after being admitted to a rehabilitation hospital. These models are further elaborated in this paper by showing how factors outside the individual, such as financial distress, a lack of sufficiently good jobs, and social rejection, are all crucial antecedents of relapse. The traditional models of addiction also focus more on the inner processes (Flanagan et al., 2018). Nevertheless, this research highlights the importance of examining the external socioeconomic and environmental factors that influence the relapse course.

There is evidence that the phenomenon of relapse may not only be a matter of personal preference or genetics but can also be influenced by systemic and structural processes. To illustrate, individuals with long-lasting financial deprivation or job uncertainty were significantly more likely to relapse as compared to the rest, meaning that one could not even discuss not only the recovery process but also the social and economic context as a whole (Alam et al., 2021). This understanding undermines reductionist theories of addiction that consider relapses as mainly occurring due to biological or psychological risk factors and proposes that addiction is, to some extent, a reaction to systematic socioeconomic stress sources.

Additionally, the study indicates the non-linearity of relapse. Most available models view relapse as an episode caused by an immediate, causative factor. Nevertheless, the results show that the risk of relapse increases over time, and it is most of the time associated with long-term exposure to economic deprivation, untreated mental problems, or social loneliness. It disagrees with traditional opinions on relapse as an immediate choice in favour of labelling it as a step-by-step procedure and the impact of various combined risk factors (Knox et al., 2019).

6.4.2 Refinements to the Stress-Vulnerability Model

The Stress-Vulnerability Model has been mainly applied to describe the correlation between stress and substance, by which all people with pre-existing psychological vulnerabilities are more prone to addiction when they are subjected to stressors. The research narrows the model by showing that vulnerability is not limited to an individual's predispositions but can also be structural and environmental.

The results show that financial instability and job loss work as chronic stressors that increase the risks of relapse, even in those who are not psychologically predisposed. That is to say,

the risk of addiction does not only depend on pre-existing conditions but can develop as a result of prolonged economic and social disadvantage. It implies that addiction recovery models must aim not only at addressing individual psychological resilience but also at dealing with the external factors contributing to relapse (Ilhan and Yapar, 2020). The study also debunks the notion that there are no differences in the impact of all stressors on relapse. It was revealed that some stressors, such as financial distress and job insecurity, have a more substantial effect on relapse risk compared to others, family support or policy interventions. This implies that there are more core stressors in determining the outcomes of addictions, and this will guide the development of more effective intervention strategies.

6.4.3 Refinements to Social Learning Theory

The Social Learning Theory hypothetically states that all behaviours, such as substance use, are learned by observing and interacting with other people. Although this framework has proved significant in interpreting addiction behaviour, according to the results of this study, there is more to the social influence than hitherto believed.

As the study proves, the negative impact of peers plays a crucial relapse role because people living under the influence of heavy drinkers find it more challenging to stay sober. The study also concludes, however, that these negative influences can be overcome with structured peer support, that is, joining Alcoholics Anonymous (AA) or recovery programs. The fact that peer influence is both a risk factor and a protective mechanism indicates that social learning is not a one-way process (Stohs et al., 2019). Instead of just emulating the behaviours of other persons in their lives, recovered addicts can create new social environments to support sobriety.

In addition, the results question the supposition that influence among peers is necessarily direct. Although direct pressure to drink was considered a relapse trigger, several participants stated that involuntary cues in the environment, including work drinking culture or media depiction of alcohol, influenced their craving (Haber et al., 2021). This implies that the social learning process is more inclusive, incorporating both interpersonal interaction and broader cultural and environmental influences. Therefore, the interventions must go beyond peer group networks into social norms and messaging related to alcohol consumption.

6.4.4 Refinements to the Self-Medication Hypothesis

According to the Self-Medication Hypothesis, people use drugs to address psychological problems. This paper corroborates the hypothesis by illustrating that mental health needs are a significant predictor of relapse. However, the conclusion shows that self-medication is not restricted to psychological distress but also includes economic and social stressors.

They were more prone to relapse when chronic financial insecurity or social isolation were reported, even where no mental health conditions were met. It implies that self-medication is not the only reaction to the psychological distress of people but may serve as a support mechanism in societal and economic deprivations (Ilhan and Yapar, 2020). The study thus broadens the conceptualisation of the Self-Medication Hypothesis into explicit, structural forms of distress that did not receive much attention in prior addiction studies. Additionally, the study challenges the notion that the process of self-medication is not always a conscious procedure in all epochs. Some participants openly admitted that they drank to forget stressful moments. In contrast, others found their relapse to be more of a process of getting back to their old behaviours as opposed to self-soothing. This implies that there may be both conscious and blind self-medication and, hence, interventions that are specific in coping behaviours as well as habitual relapse patterns.

6.4.5 Implications for Public Policy and Social Support Frameworks

The theoretical implications of the research are not limited to the theory of addictions since they find their way into the social support system and public policy. The results indicate there is a need to alter their policy priorities in favour of a more extensive socioeconomic-directed policy that considers the causes of addiction relapse.

The existing policies on addictions mainly focus on regulating alcohol access using taxes, pricing and advertising. Although these measures could be efficient in lowering the consumption of alcohol altogether, the study reveals that they can hardly help in the prevention of relapse. Instead, the results suggest that policymakers must focus on economic stability measures, including employment sources, financial counselling, and housing services, as central elements of the addiction recovery plan.

Furthermore, the research highlighted the need to incorporate mental health care in the process of treating people with an addiction. Considering the close connection between the risk of relapse and psychological distress, mental health services should not act independently about

addiction recovery frameworks (Litman, 2023). Instead, they must involve psychological interventions, which consist of cognitive-behavioural therapy (CBT), trauma-informed care, and peer-led mental health support groups. Lastly, the study results highlight the need for community-based interventions. Each role of social influence in addiction (as a risk factor and as a tool in recovery) implies that organised social support networks may be critical in preventing relapse. Policies must thus aim to enhance community-based support for addiction, such as peer mentoring programs, social reintegration programs, and local recovery communities.

6.5 Limitations of the Study

Although such a study is relatively comprehensive, various limitations need to be recognised. These constraints are primarily based on methodological limitations, the difficulties encountered when collecting and analysing data, and the issue of generalizability of the results. The identification of such limitations is essential to provide the context of the results and to develop future research hypotheses to improve the comprehension of relapse and recovery of addictions.

6.5.1 Methodological Constraints

Among the main study limitations, it is worth noting that this study is based on self-reported data. Although self-report answers provide information on individual perceptions and life experiences, they are prone to bias, including recall bias, social desirability bias, and selective memory (Karriker-Jaffe et al., 2020). The data may not be accurate, as participants may have under-reported or over-reported some behaviours knowingly or unknowingly. This can especially be seen in the field of addiction research, where a patient can feel shamed or unwilling to speak about the full scope of their problem.

Furthermore, the quantitative character of the research, as helpful as it is, is not able to encompass addiction and relapse. Regression and correlation analyses are useful, but they do not provide the level of understanding that qualitative methods may offer. The mixed approach, utilising both quantitative data and qualitative stories, would help improve future research in the field of understanding the risk factors of relapse.

6.5.2 Challenges in Data Collection and Analysis

There were also several challenges during data collection, which could have impacted the study's results. Among the significant challenges was having a diversified representative sample. There was also a possibility of reaching out to people from diverse backgrounds; however, it was

problematic to connect with those living in rural areas or individuals who lacked stable housing. Consequently, the results do not represent the lives of these populations adequately since they are, at times, hard to find their place in the process of addiction recovery.

Another issue during data collection was the potential for response bias. There is a possibility that some participants gave socially desirable responses instead of expressing their true thoughts about their experiences. It is a typical weakness of addiction studies, and stigma and the respondent fear of judgment might cause them to underestimate their substance abuse and relapse issues (Khemiri et al., 2020). To counter this, anonymity and confidentiality were employed, although the issue of bias cannot be eliminated.

There were also limitations associated with the use of statistical analysis, particularly in interpreting the results of regression and reliability. Reliability analysis revealed that not all constructs were measured as cohesively as they should have been, with significant variance in the grouping of some variables. Negative Cronbach Alpha scores indicated that some variables were not correlated with each other but with another category; therefore, it was not easy to conclude particular groupings of the predictors. In the future, studies may require re-adjusting measurement tools to enhance reliability and validity.

6.5.3 Generalizability of Findings

Another significant study limitation is the limited applicability of the study's results. Although the study sample is diverse, it may not be entirely representative of the population of people experiencing addiction and relapse. There is a risk that socioeconomic, cultural, and regional variations might affect addiction behaviours extensively, such that the findings cannot be applied to other populations.

For instance, a key predictor of relapse was financial stress and loss of employment; however, this predictor may be dependent on local economic and labour market factors. The relationship between financial instability and relapse may be mild in places that have good social safety nets and job-sustaining schemes. On the other hand, in areas where there are few economic and social provisions, financial problems can be a significant factor in relapse.

Likewise, the relapse was not significantly influenced by policy effectiveness; however, this does not apply to other policy contexts. The strictness and support for alcohol control measures

vary across countries and regions, which may affect their effectiveness. The study should be furthered to investigate whether the discovery of policy effectiveness is true in the context of varying regulatory settings (Jason et al., 2021). The demographic composition of the sample is also another factor that influences generalizability. Although the study attempted to involve people of different ages, genders, and socioeconomic classes, some groups that might have been underrepresented included older individuals or those in marginalised groups. External validity could also be enhanced since addiction/relapse experiences are likely to vary with demographic factors. Therefore, future studies are needed to cover a wider sample.

6.6 Recommendations for Future Research

This study points out various points where research should be done to enlighten more on what triggers relapse and how to overcome addiction. Although this study has been relevant in shedding light on the social, economic, and psychological triggers of relapse, there are some statements that identify gaps for future studies. By broadening studies in addiction, the investigations will have a better grasp of the intricacies related to relapse and make intervention measures more effective.

6.6.1 Areas Requiring Further Investigation

The necessity to investigate the interaction of various triggers of relapse is one of the most urgent spheres of future research. Some of the main predictors have been identified as issues with finances and job loss, social isolation, and difficulties with mental health, yet little is known about their interactions. Future research needs to explore the interactivity of these factors over time and whether some combinations are more likely to result in relapse than others. These relationships can be better understood and thus used to design specific strategies of intercession that address multiple risk aspects simultaneously.

However, these findings, which suggest that the risk of relapse does not significantly impact the policy's value, are worth further investigation. Another issue to be discussed is the reasons why a particular bundle of public health guidelines may fail to influence the process of addiction recovery. The second issue that needs to be addressed in the future is how previous policies can be structured and introduced in a way that seals any holes in their efficiency. Various policy options should be considered, such as combining financial and addiction treatment services or expanding access to mental health services to achieve better results (Litman, 2023). In the same

vein, a deeper debate on ways to achieve public health may lead to a more individualised approach to addiction prevention and recovery in policy-making.

6.6.2 Need for Longitudinal Studies on Relapse Triggers

The design of this study was cross-sectional, and it was therefore not in a position to analyse potential causal factors that led to relapse. Future studies should be longitudinal, where individuals are followed over a specific period, enabling a more accurate prognosis of relapse. Researchers can quantify the changes, positive or negative, in relapse triggers and test the hypothesis others become more or less significant over a follow-up period of months or years.

Longitudinal studies can also be used to determine the long-term effects of interventions. Treatment programs are usually examined in terms of their short-term success, but not much is known about how various recovery methods affect lasting sobriety (Campbell et al., 2018). In future, it should be determined whether, in the long term, recipients of financial aid, mental health care, or interventions that rely on peers show decreased relapse rates. To optimise addiction recovery measures, it is vital to know the long-term effects of treatment.

Moreover, the longitudinal studies may help to observe some details of the cyclic aspect of relapse. Most individuals go through several relapses before long-term recovery, but few studies have been conducted to determine what causes multiple relapses to occur. Monitoring individuals through numerous attempts at recovery enables researchers to identify patterns and create individualised diversification in the wake of intervention for specific individuals at various stages of the recovery process (Saunders and Allsop, 2023).

6.6.3 Expanding the Study to Diverse Demographic Groups

Future studies should focus on increasing the demographic samples of study groups to determine whether the results can be effectively utilised in a larger population. The factors that determine the level of addiction and relapse are age, sex, socioeconomic status and culture. Although the current research has touched on the general trends, future research needs to be able to analyse how various demographical groups approach addiction and recovery.

There is a significant line of research examining the impact of socioeconomic inequality on relapse risk. Being of lower income, individuals may face more obstacles to accessing treatment and may more often fail to pay their bills, which may result in a relapse (Sliedrecht et al., 2021).

In future studies, it should be considered whether special interventions aimed at economically disadvantaged groups of the population can also yield higher recovery rates.

Detecting addiction experiences also needs cultural forces. In some societies, alcohol was the intrinsic and primal way of life-and their religions-and so competition and recovery are determined accordingly (Gibson et al., 2018). The next step in this research would be to establish the role abandonment plays in culture and how a culturally differentiated implementation system will result in more efficient treatment. Lastly, at-risk groups such as those with comorbid disorders, homeless people, and precarious populations are to be targeted. Usually, such groups require additional interventions for treatment and sobriety, so special studies would be necessary to explore the interventions that can assist them.

6.7 Final Thoughts and Concluding Remarks

The results of this study enhance the overall discussion on addiction recovery in that they show a holistic analysis of the many factors surrounding alcohol relapse. The study highlights that socioeconomic stressors, mental health issues, and social factors play a strong role in the determination of risks of relapse. With the combination of qualitative and quantitative data, the paper has identified severe deficits in current policy and intervention systems, indicating a need for more specific and individualised recovery plans. To enhance the outcomes or reduction of relapse rates among alcohol-dependent people, it is significant to address such gaps related to addiction treatment.

Among the most significant lessons from such studies is the need to adopt a holistic approach to relapse prevention. Mental health resources, social support systems, and societal policies that facilitate long-term recovery should all work in conjunction to create a supportive environment for long-term recovery. The results of the study point out that although policies like minimum pricing and awareness programs can decrease population-level drinking, they fail to meet the necessities of the individualisation of several factors relevant to building up to relapse. In the future, policymakers and healthcare providers should adopt integrated policy measures that incorporate financial, employment, and community-based recovery initiatives to enhance the long-term outcomes of sobriety.

Additionally, the research indicates that further studies are needed to refine current theories of addiction and intervention models. Addiction is not a fixed ailment but one that has been

multifaceted and dynamic and has been determined by fluctuating social and economic environments. Future research should focus on the long-term effectiveness of various rehabilitation strategies and explore how digital therapies, including telehealth counselling and online peer support, can supplement traditional treatment. Through constant enhancement of addiction recovery models, society can strive towards an improved relapse prevention method that will support different groups of people and shift social demands.

Alcohol relapse prevention can be multidimensional and correspond to mechanisms of economic, psychological, and social support. The results obtained in the study help build more specific measures that can prevent relapse, as at least people who have alcohol dependency can be considered to get the help they need to stay sober in the long run.

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