RSA

Action and Research Centre

Whole Community Recovery

The value of people, place and community

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Partners

The RSA (Royal Society for the Encouragement of Arts, Manufactures and Commerce) believes that everyone should have the freedom and power to turn their ideas into reality; we call this the Power to Create. Through our ideas, research and 27,000-strong Fellowship, we seek to realise a society where creative power is distributed, where concentrations of power are confronted, and where creative values are nurtured. The Whole Person Recovery project speaks to this mission and forms part of the RSA's Action and Research Centre, which combines practical experimentation with rigorous research to achieve these goals.

CRI is a leading charity that each year provides free treatment and support to around 120,000 people through their services in England and Wales. The organisation champions people who have faced hardships like abuse, homelessness and addiction, and empowers them to lead the lives they want, on their terms.

Foreword

In the UK, and in comparable countries across the world, a critical public policy question is how national and local welfare systems respond to the complexity of public need amid mounting fiscal pressures and institutional barriers to collaborative, preventative service design. Given the dynamic, multifaceted nature of substance misuse, drug and alcohol recovery services are often a case in point. Sunny Dhadley, manager of Wolverhampton Service User Involvement Team (SUIT), said at a recent RSA event on recovery that his organisation has recorded 57 types of need that people have presented with in terms of their addiction and wellbeing. As services are being asked to prepare for between 25 and 40 percent less funding, how will they continue to manage this challenging financial landscape and ensure sustainable outcomes for their clients, families and communities? Where there are innovative and cost effective practices, how can other public services learn from them and work more readily with the recovery sector.

Drug and alcohol abuse is often marginalised as a peripheral part of public health, which frequently overlaps with the wider 'troubled families' agenda and the criminal justice system. But substance misuse can be part of many people's efforts to manage the delicate balancing of personal wellbeing. As Susie Hayward FRSA, a clinical psychologist said at an RSA seminar on recovery: "Everyone has a void, it's how they choose to fill it." Similarly, at another recent RSA event, Geraldine Strathdee, clinical lead for mental health for NHS England reminded attendees that many of us use alcohol to manage stress and anxiety. Finding new models of effective healthcare, prevention and long term wellbeing is about all of us as people; individuals, families and communities. Public services – particularly those which are about supporting people back into a position where they can flourish and become masters of their own lives – need to have people at their heart.

Talk of 'people-centred' public services has been around for a while. In health, the idea of 'no decision about me, without me' has helped to rebalance the relationship between patient and clinician. However, many citizens' engagement with public services remains frustrated by a bouncing between institutions and agencies, where each deals with a particular symptom of a deeper, connected and complex set of causes. For example, of the estimated 188,000 people with a substance misuse problem, over 99,000 also have 'offending issues'.[1] People with mental health illnesses are three to four times more likely to have their utilities disconnected.[2] This isn't just a 'troubled families' problem, but a complex set of interlinking factors that can make life difficult for many of us.

The RSA's Whole Person Recovery approach blends clinical treatment,

1. Lankelly Chase Foundation (2015) *Hard Edges* www.lankellychase.org.uk/wp-content/uploads/2015/10/LANJ2803_Mapping_multiple_disadvantages_Summary_16.01.15_WEB.pdf

2. Jenkins R., Bhugra D., Bebbington P., Brugha T., Farrell M., Coid J., Fryers T., Singleton N., and Meltzer H. (2008) Mental disorder in people with debt in the general population. *Journal of Public Health Medicine.*

the building of recovery capital and peer support; helping people to sustain their recovery by drawing upon the knowledge and credibility of those who have a lived experience of addiction. This powerful combination has enriched the lives of people in recovery, peer support volunteers and the wider community in our pilot site in West Sussex and since in our three hubs in West Kent.

There we have worked with national treatment provider CRI to create a model based on three principles. First, that co-production is key for service users to own, and feel a valued part of, their personal recovery process. Second, that the services take a holistic, 'whole person' approach that enables services to encompass multiple dimensions of a person's recovery, increasing the likelihood of success (or sustained recovery) in the short and longer term. Third, the importance of social connectedness and transitioning networks, creating support and opportunities in the recovery community and beyond for people to enhance the sustainability of their recovery.

Over the last seven years, the RSA has been exploring how the role of social networks within communities can enhance the health and wellbeing of local residents. Our five-year Connected Communities project demonstrated the degree to which people and places can benefit – in a range of ways – from greater social connectedness. Similarly, we have more recently explored the variation in access to, and quality of, mental health services in England – highlighting the paucity of resources in primary care, where 80-90 percent of people first present for help.

This report marks the final phase of a four year relationship in West Kent, delivering our whole person approach in three towns in the area. We now look to begin further exploration of the social determinants of health and wellbeing, the systemic challenges in a current, often atomised model of care, and the opportunities of a new approach where public services are inherently people services.

Charlotte Alldritt
Director of Public Services and Communities, RSA

Executive Summary

Background

This report marks a milestone in the RSA's Whole Person Recovery programme with the completion of its four-year action and research project based in West Kent. The Whole Person Recovery concept originated in the RSA Commission on Illegal Drugs and its landmark report published in 2007.[3] The Commission proposed a 'whole person' approach to drug and alcohol misuse; one that emphasised the role that individuals can play in improving their own outcomes and strengthening sustainable recovery, based on the recognition that people often face a range of other challenges that can both drive and be symptoms of substance misuse. Policies and practices for drug and alcohol recovery have evolved since then; so too has the RSA's programme of work.

The project described in this report was set up to test the Whole Person Recovery model in practice, working as part of a commissioned recovery service programme in West Kent, with the explicit aim of enabling people to move away from problematic substance misuse and into recovery in a way that empowers the individual to tap into and make best use of their communities and their own capacity. While there is no absolute consensus on the definition of recovery – and some contention around whether abstinence-based recovery should always be the end goal – our focus, like much of the RSA's work, is on the extent to which a person or a community can be enabled to meet their own needs and aspirations.

This report reflects on what we have learned since 2007 and, in particular, through four years of working as part of a public service delivery contract, which explored what taking a whole person, place and community approach meant in practice.

3. RSA Commission (2007) *Drugs - the Facts*. London: RSA

- Nationally, over 300,000 adults accessed treatment services for support with their drug and/or alcohol use in the year 2013-14. [4,5]
- It is estimated that for every pound spent on interventions on those under 18, there is a future cost saving of between £5 to £8 and drug interventions delivered to adults are estimated to bring about a cost saving of £2.50 for every £1 invested.[6]
- The quality of drug and alcohol treatment and access to these services has improved significantly in England over the last 10 to 15 years. 98 percent of people are seen within three weeks and the rate of successful completions has risen significantly, although as services are left with many of the most complex cases, that progress has started to level off. [7]
- In 2013, Public Health England found that, in the UK, 45 percent of those in treatment that year completed treatment free of dependence. [8]
- Over half of those entering treatment do not leave free of dependence, leaving those people, as well as new people who might present to services, likely to need future support.[9]
- In 2013, Public Health England estimated that drug and alcohol misuse in the UK costs society £36.4bn every year.

Whole Person Recovery in practice

Since 2012, the RSA has been working as part of the West Kent Recovery Service in a consortium led by CRI, covering a large geographical area in three hubs – Gravesend, Maidstone and Tonbridge – within a payment by results framework. The objective was to test and develop the concept of 'recovery capital', the identifiable components that support individuals' progress, seeking to develop a partnership that placed the power of networks and the role of service users and communities at its core.[10] In practice, this has meant working with individuals, local services and the wider community to identify and mobilise the 'assets' – these could be physical, financial, individual or social – that can support recovery.

The programme was designed around three principles drawn from our earlier work in this area:

- **Co-production is key** for service users to own, and feel a valued part of, their personal recovery process.
- **Holistic, whole person approaches** enable services to encompass multiple dimensions of a person's recovery, increasing the likelihood of success in the short and longer-term.

4. Public Health England (2013) Adult Alcohol statistics from the National Drug Treatment Monitoring System. [Online] Available at: www.nta.nhs.uk/uploads/adult-alcohol-statistics-report-2013-14.pdf

5. Public Health England (2013) Adult Drug Statistics from the National Drug Treatment Monitoring System. [Online] Available at: www.nta.nhs.uk/uploads/adult-drug-statistics-from-the-national-drug-treatment-monitoring-system-2013-14.pdf

6. Department for Education (2010) Specialist drug and alcohol services for young people – a cost benefit analysis. [Online] Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/182312/DFE-RR087.pdf

7. Public Health England (2013) op cit.

8. Ibid.

9. Ibid.

10. Public Health England (2013) Why invest? How drug treatment and recovery services work for individuals, communities and society. [Online] Available at: www.nta.nhs.uk/uploads/whyinvest2final.pdf

- **Social connectedness** – within the recovery community and wider local community – creates a network of support and opportunities for individuals, enhancing the sustainability of recovery.

The Whole Person Recovery model has been in large parts experimental, with the CRI-RSA partnership allowing for the necessary freedom, support and financial resourcing to trial new ideas. Example innovations include:

- **The Small Sparks Scheme** introduced small grants to help recovering individuals overcome barriers that prevent them moving on to the 'next stage' of their recovery (Small Sparks), and slightly larger grants (Super Sparks) to enable members of the recovery community to try out ideas that would improve recovery capital at a community level, enabling co-production between service users and wider activists.
- **The Everyday Activities Programme** created free activities designed and mostly run by individuals in recovery. The programme was aimed at building recovery capital through the expansion of social networks and skills.
- **Community Events Programme** including Open Days and sponsored events that aimed to reach out to and integrate with the wider local community.
- **The Research and Innovation Team (RAIT)**, which provided opportunities for service users to get involved in the critique and scrutiny of Whole Person Recovery, the West Kent Recovery Service and the wider community recovery opportunities in the area.
- **The Recovery Alliance**, which aimed to establish a bridge between the recovery community and the vast resources of many other communities that exist in West Kent.
- **The Recovery and the Arts initiative**, a large-scale art exhibition was curated and showcased work done by the recovery communities across West Kent.

The whole person ethos has been widely adopted throughout the recovery sector in different ways. The culture of the programme has shifted: keys have been handed over to peer mentors and service users, so that the rooms – often empty – can be used for peer support groups, and other activities. With the aim of building and strengthening recovery communities, we have brokered relationships with third sector organisations, local businesses and a diverse range of community groups, as well as the RSA Fellowship, and this has provided the recovery community with access to the skills and social networks that were not immediately available before.

Perhaps the most significant factor in shaping this work – its challenges as well as benefits – has been the nature of the partnerships, with CRI but also beyond that with the system of central government and commissioners that frames what is possible locally. Our experience suggests that much more needs to be done early on to embed partnerships and secure local buy in and understanding about their value, data sharing and the extent to which the model of partnership working will impact on

replicating new approaches elsewhere.

This is also important in the context of co-production, stewarding the market, mixed provision (through consortia or otherwise) and is particularly relevant within health services as large providers partner with smaller organisations with the aim of bringing new approaches that can be scaled.

Treatment and recovery

The RSA entered into a four-year delivery partnership with CRI at a time when drug strategies and the treatment sector in the UK were deliberately shifting away from the view of treatment as primarily a means to reduce crime and disorder, towards a greater focus on health-based, recovery-oriented initiatives. This has been accompanied by a wider focus on wellbeing alongside reducing substance misuse.

This report concludes that, while we have largely moved away from the days of **treatment vs recovery,** there remains a lack of deeper understanding and ability to effectively operationalise approaches such as recovery capital and co-production. While our primary purpose has been to test ways of improving individual and collective capacity, this report seeks to draw out some of the lessons we learned from doing this work and some of the implications for commissioners, providers and policy makers. Reflecting on our work, some cross-cutting themes have emerged:

- The importance of embedded partnerships based on clear and open agreement on core aims, data sharing and securing buy in and understanding from contract through to delivery.
- The importance of peer support. The power and necessity of peers in co-production and in the continued development and delivery of innovation was a recurring theme.
- The importance of co-production with the local community. Working with local people and organisations is vital to make recovery better understood, prouder and more visible.
- The need for better understanding of co-production. National and local commissioning bodies need to better understand and accommodate the factors above in supporting recovery. This means being clearer about what is meant by recovery, the long-term nature of many people's progress and the importance of unlocking the assets that can be brought to bear in supporting and sustaining this.

This has profound implications for not just how these services are commissioned but also how they are measured. For example, within payment by results systems, such as the one the RSA has been working within in West Kent, this is done, to an extent, with banding that assesses how much money a service will get if an individual achieves the prescribed outcomes. We argue that currently these measurements are too narrow and short term; they struggle to reflect either the wider impacts that arise from a more expansive and flexible approach or the longer-term recovery journey beyond treatment.

There also remains a capacity issue. Too often we are using the tools of yesterday to try and solve what are now more complex and rapidly

changing problems. Commissioners and providers want their services to be creative; indeed current resource constraints demand this.

There is no shortage of people willing to be vocal about their recovery and support others. Likewise, we have shown that reaching out to the wider community can not only challenge stigma but also provide additional resources and skills and 'permission' to innovate. But the structures and resources to do this kind of work are often constrained.

The implementation of a whole person, place and community approach is not one that comes without direct financial cost, however the West Kent project demonstrates that relatively small investments can help build and strengthen recovery communities, adding significant value to the recovery experience and outcomes for many individuals. To this end, we recommend the following:

1. **The Department of Health should engage with Public Health England, NHS England, the professionals who deliver health and wellbeing services, and the recovery community to develop a shared and consistent understanding of recovery.** This should focus on recovery as the long-term shift to improved wellbeing that is embedded in the person, place and community. Outcomes should be measured in a way that reflects an individual and community recovery perspective, with key performance indicators being set around nourishing environments that support recovery.

   This concept of recovery also needs to be reflected in the metrics used to monitor recovery achievements. While current metrics in recovery are useful, research has demonstrated that risk of relapse is significantly higher for up to five years post treatment. This should be taken into account with a system that enables tracking throughout health services on a long-term basis and measures recovery capital (or wellbeing capital) in a holistic way.

   A shared measurement system is needed that combines subjective wellbeing indicators alongside service-based metrics (such as contact with wellbeing services and peer support) for at least five years after contact with recovery services. This should enable self-measurement of wellbeing indicators by an individual as well as by wellbeing services (such as NHS services, mental health, housing and employment).

2. To improve outcomes at a local level we recommend Public Health England drive the development of a **Creative Commissioning for Recovery approach** that would meet commissioners' aspiration for more creative and flexible procurement. Critically, as well as the 'skills for recovery' we identify here, commissioners could do more to emphasise the critical importance of partnerships, their nature and challenges. This could have a number of components but should be place-based and co-produced to ensure it is relevant to the communities it serves. Examples (including some used within the West Kent Recovery service) might include:

- **Define innovation capacity as a core competence for commissioners.** Review the skills, knowledge and tools available to commissioners, sending a clear message that innovation – alongside effective safeguards and evaluation – will be welcomed and rewarded.
- **Encourage asset mapping.** Explore the use of local recovery mapping that identifies the actual and potential assets within a community that can help sustain people's recovery.
- **Trial personal budgets.** The use of 'small sparks' – personal or small group budgets – can enable the building of recovery capital on a local level and allow targeted support for wider wellbeing.
- **Place peer support as a central component to recovery programmes.** Peer support should be recognised as a major component in recovery rather than marginal added value. This should include use of recovery **community-led Research and Innovation Teams (RAITs)** to explore the use of peer led insight and inquiry, enabling peers to undertake research with local partners and co-produce local responses to problems. **Recovery communities would benefit from greater sharing of learning and expertise.** Where possible, data should be collected to inform commissioners, researchers and other peer support groups about the value and use of peer support.
- **Encourage more than peer support, and invest in peer mentoring.** Emphasis should be placed not only on peers' current expertise through experience but their wider capacities and potential for employment progression. To this end, greater investment is needed in **coaching and upskilling recovery peers**, both in terms of commissioning models and investment in enabling treatment services.
- **Proactively engage with the local community.** Recovery communities should view themselves as a crucial link to wider recovery capital in the community. They should seek to develop implicit social contracts with community groups, transition networks and raise awareness of the value and skills of those in recovery in order to reduce the damaging stigmatisation that prevents the building of community recovery capital. In our experience, the appetite for change is there and we have observed the commitment and willingness among service users, local communities, providers and commissioners to embrace new approaches to recovery, including many of the ideas set out in this report.

3. **Recovery service providers should enable capacity to support community focused skills and activities within services**. Our work recognises the intrinsic difficulty involved in bringing the capital and assets of recovery communities into their wider neighbourhoods and vice versa. Through this programme we have observed that community development can be highly challenging, but have found enormous value in having the capacity and resources and credibility to generate this. Skills such as

stakeholder engagement and management, the ability to lead on project and events management, and the capacity to effectively influence a community wide agenda. This role can be pivotal in encouraging reciprocity and enabling creative capacity from recovery communities.

1. The Context

- In 2013 there were 8,416 alcohol-related deaths registered in the UK; 66 percent of these were among males.[11]
- In England there was a 17 percent rise in the drug misuse mortality rate in 2014, up to 40 per million head of population; in Wales the rate fell by 16 percent to 39 deaths per million, the lowest since 2006. This represented 3,300 deaths in England and Wales, the highest figure since modern records began in 1993.[12]

It is no surprise then, that when individuals enter treatment for substance misuse they often present a range of other issues

The cost of alcohol and drug misuse

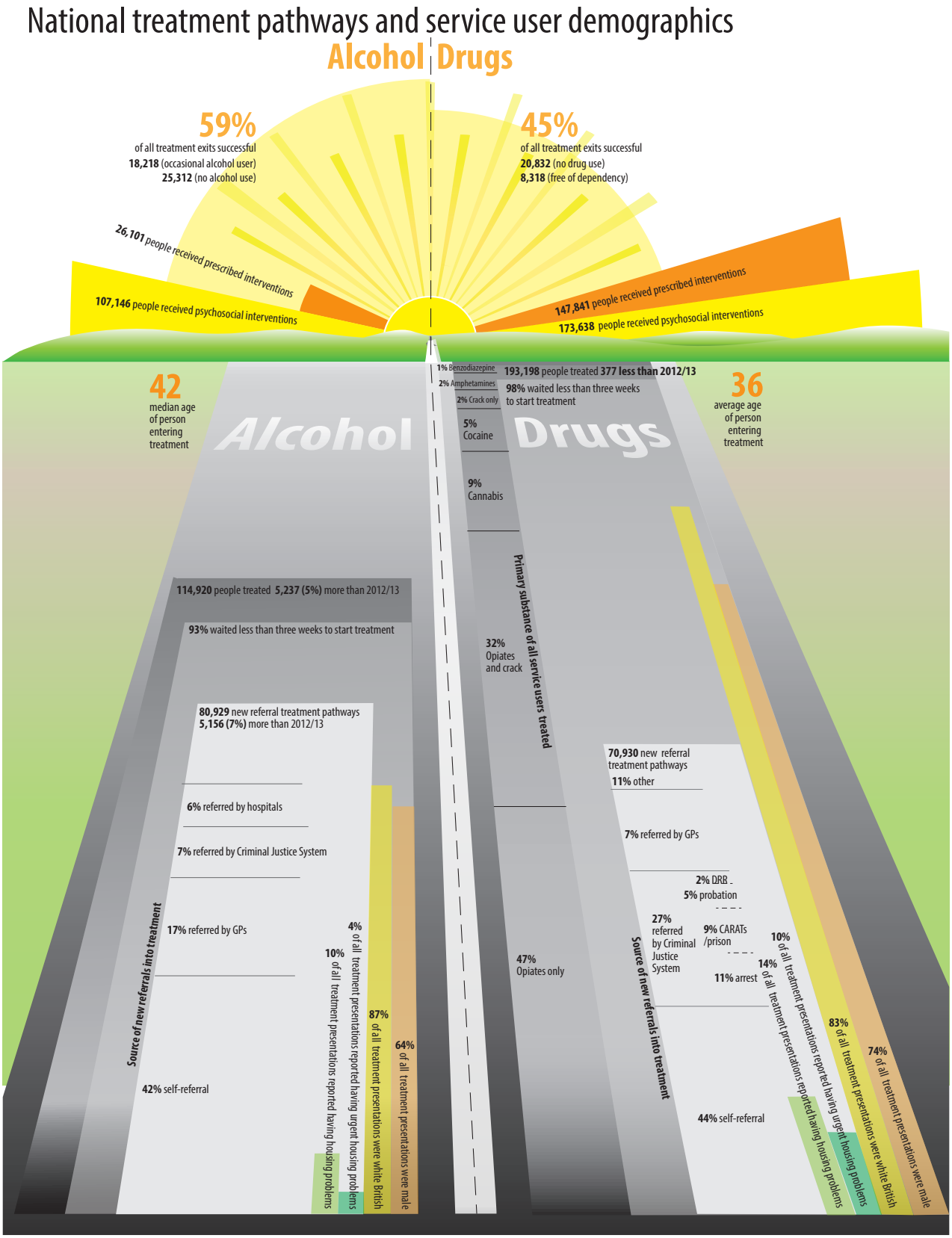
The human cost of misusing alcohol and drugs is not easy to measure. The damage extends well beyond the statistics and substance misuse and addiction are intrinsically linked to other social issues such as mental and physical health, housing, inequality, poverty and crime, and can have a much wider impact on people's relationships, employment and those around them.

It is no surprise then, that when individuals enter treatment for substance misuse they often present a range of other issues. The relationship between these is a *dynamic* one; disadvantages are compounded by, and often contribute to, substance misuse problems. In 2015, Lankelly Chase estimated that each year over 222,000 people in England have contact with at least two out of three of the homelessness, substance misuse and/or criminal justice systems, and that over 58,000 people have contact with all three.[13]

The recovery sector has been through a period of rapid change and alongside other public services is now facing an economic climate that can both drive need and reduce resources. The financial cost of drug and alcohol misuse is significant, with Public Health England estimating the total cost of alcohol-related harm alone at £21bn and the annual cost of drug addiction at £15.4bn.[14] While, in an ideal world, early intervention would prevent treatment service use, over 300,000 adults accessed treatment services for support with their drug and/or alcohol use in the year 2013-14.[15] The quality of drug and alcohol treatment and access to these services has improved significantly in England over the last 10 to 15 years. 98 percent of people are seen within three weeks[16] and the rate of successful completions has risen, although as services are left with many of the most complex cases, that progress has started to level off.[17]

11. Public Health England (2013) op cit.
12. *Deaths Related to Drug Poisoning in England and Wales, 2013*. Available at: www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/england-and-wales---2013/stb---deaths-related-to-drug-poisoning-in-england-and-wales--2013.html
13. Lankelly Chase (2015) op cit.
14. Public Health England (2013) op cit.
15. Public Health England (2013) op cit.
16. Adult Alcohol statistics from the National Drug Treatment Monitoring System, op cit.
17. Ibid.

Figure 1: The road to recovery – a national snapshot



This illustration is a snapshot showing demographic information taken from Public Health England's 2013-14 report 18 for all service users entering treatment and treatment outcomes in 2013/14

18. Public Health England [online]www.nta.nhs.uk/uploads/adult-drug-statistics-from-the-national-drug-treatment-monitoring-system-2013-14.pdf

It is estimated that for every pound spent on interventions on those under 18, there is a future cost saving of between five to eight pounds, and drug interventions delivered to adults are estimated to bring about a cost saving of £2.50 for every £1 invested.[19] However, the National Treatment Agency for Substance Misuse (NTA) measured re-presentation rates (people who have received treatment and then returned for further treatment) over a period of seven years and found that over two-thirds of people returned to treatment during this time.[20]

Promoting sustainable recovery

The criminal justice system rarely proves to be an effective way of deterring substance misuse, and indeed can exacerbate the issue. A 2010 report by the Prison Reform Trust found that 19 percent of heroin users who had been in prison reported their initial drug use was while serving their sentence[21] and 60 percent of those entering prison with an alcohol dependency will leave prison without successful treatment.[22] Although removing an offender from their community may temporarily reduce the negative impact on that community, a prison is less likely to offer the capacity to support that person with longer-term behaviour change, or offer the community a way to become more resilient in addressing and preventing problematic behaviour.

We must deal with the problem as it is. The ramifications of recovery not being sustainable have immediate impact on our collective financial resources and wellbeing, with drug and alcohol misuse in the UK costing society an estimated £36.4bn every year.[23] This figure takes into account factors such as lost productivity, the cost of treatment services, associated crime and the impact on other public services, including the NHS.

Defining recovery

> "We will create a recovery system that focuses not only on getting people into treatment and meeting process-driven targets, but getting them into full recovery and off drugs and alcohol for good. It is only through this permanent change that individuals will cease offending, stop harming themselves and their communities and successfully contribute to society."[24]
>
> **HM Government, Drug Strategy (2010)**

Since 2010 there has been political debate over what exactly constitutes recovery and whether total abstinence from substance use should be at

19. Department for Education (2010) Specialist drug and alcohol services for young people – a cost benefit analysis. [Online] Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/182312/DFE-RR087.pdf

20. National Treatment Agency for Substance Misues (2012) From access to recovery: Analysing six years of drug treatment data. [Online] Available at: www.nta.nhs.uk/uploads/six-yearstudy.pdf

21. Prison Reform Trust (2010) *Bromley Prisons Briefings Factfile*. London: Prison Reform Trust.

22. HM Inspectorate of Prisons (2010) *Thematic report, Alcohol services in prisons: an unmet need*. London.

23. Public Health England (2013) Why invest? How drug treatment and recovery services work for individuals, communities and society. op cit.

24. HM Government (2010) *Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug free life*. London: Stationary Office.

the core of government policy. This debate is still to be resolved. However, evidence, such as the second report of the Recovery Committee[25] and our experience in the sector, suggests that recovery is a long-term process that involves more than just resolution of substance use problems, and extends to building a productive and fulfilling life, with the individual taking ownership of what that means.

UK policy over the last five years has notably shifted towards a narrower definition of recovery. The government's increased focus on 'full recovery', while commendably ambitious in principle, is far from practical for many problematic users of drugs and alcohol, especially in the short term. This binary concept (of either full recovery or none) risks vilifying those who work hard to cut down use and reduce harm to themselves and others; and if people are seen and/or see themselves as failures, there is a further risk of reducing the incentive for them to begin their recovery journey and the possibility of 'full recovery', something that they may have aspired to over time.

This binary concept (of either full recovery or none) risks vilifying those who work hard to cut down use and reduce harm to themselves and others

The Advisory Council on the Misuse of Drugs[26] reflects on how difficult recovery can be. Supporters of harm reduction techniques say that substitute prescriptions, while not unproblematic, can help people to live more stable lives, reduce crime in communities and prevent some of the most harmful effects of street drugs that are more likely to lead to overdose, including blood-borne viruses and infections.

Drug and alcohol policy 2007-2015

While advocating that treatment should always be available for those who need it, the RSA's Whole Person Recovery project sought to pilot new ways of working locally to test approaches that focus the networks, services and capabilities – what we call 'recovery capital' – that sustain this. Ultimately, we share the aims of those we work with, to both increase long-term efficiency and reduce the volume of people needing to return to treatment. This reflects a wider shift within drug strategies and the treatment sector in the UK, where discourse has moved away from expanding treatment primarily as a means to reduce crime and disorder, towards a greater focus on health-based, recovery-oriented initiatives. This has been accompanied by a wider focus on wellbeing alongside reducing substance misuse. A representative from CRI, our partner organisation in West Kent, noted that as recently as 2007, many of the services were deemed to be "perfectly good",[27] whereas now the focus on building recovery capital is a core part of their model. There has since been a sea change in the way they operate; examples of this new approach include the uptake of the Whole Person Recovery model in West Kent and the greater emphasis on peer mentors and service user involvement.

25. Advisory Council on the Misuse of Drugs (2013) Second Report of the Recovery Committee: What recovery outcomes does the evidence tell us we can expect? [Online] Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/262629/Second_report_of_the_Recovery_Committee.pdf

26. Ibid.

27. To listen to this event please visit: https://www.thersa.org/events/2015/11/the-road-to-recovery/

This shift builds on the experience of US mental health services[28] in the early 2000s, and in the UK can be seen in a number of publications including the 2008 Scottish drug strategy, [29] and the UK government's strategy document *Drugs: protecting families and communities* (HM Government, 2008), in which the treatment section was entitled 'Delivering new approaches to drug treatment and social re-integration'.[30] Many of these ideas and emphases were picked up under the Conservative-led coalition in its publication *Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug free life*.[31] This signalled a move away from traditional service delivery towards a focus on recovery and more co-produced services and improved outcomes.[32] There is growing evidence that we can and should be ambitious about long term, sustainable recovery for everyone who comes into services.

> "Gone are the days when central government tells communities and the public what to do. We are setting out a clear and ambitious vision for the future direction of travel, and it will be for local areas to respond to this and design and commission services which meet the needs of all in the community."
>
> **Theresa May, Home Secretary (2010)**

The risk is that as austerity bites, it is the very things that support recovery – but may be harder to quantify and slower to take effect – that fall by the wayside

Shortly after Theresa May made this statement in the 2010 Drug Strategy, it was announced that the National Treatment Agency would be rolled into Public Health England. Local authorities were to be given much more control over how much they spent on services and their design, through commissioning processes. Treatment services across the country could now be more creative in their approach, with less prescriptive commissioning models. Change, however, has been slow.

While the shift towards a health-oriented approach to drug and alcohol misuse is welcome, it has not removed the wider impacts on communities, who experience the effects of acquisitive crime associated with drug use, alcohol-fueled violence and antisocial behaviour.

The change of emphasis in approach has also had wider implications for the skills and capacities needed and the way we measure impact. Our current system does not always provide people with the tools that they need to address their issues and sustain recovery post-treatment. The risk is that as austerity bites, it is the very things that support recovery – but may be harder to quantify and slower to take effect – that fall by the wayside. Rather, we need a collective response that looks further at how services are commissioned, resources are spent, and makes more of the

28. For further reading please see US Mental Health Commission (2002). Available at: www.recoverywithinreach.org/Recovery/sm_files/2002Presidentspercent20Newpercent20Freedompercent20Commissionpercent20Reportpercent200npercent20Mentalpercent20healthFinalReportpercent2001302013%2009.07.pdf

29. The Scottish Government (2008) *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*. Edinburgh, RR Donnelly.

30. HM Government (2008) *Drugs: protecting families and communities*. London: Stationary Office.

31. HM Government (2010) op cit.

32. Public Health England (2013) *Why invest? How drug treatment and recovery services work for individuals, communities and society,* op cit.

assets available in our communities.

This report argues that in accepting the challenge of increasing recovery rates, we need to ensure that more people, often the most difficult cases, have the opportunity to forge meaningful connections that enable them to sustain their recovery over the long term. In doing so we need to adopt those approaches that further involve and empower service users and local communities and identify the skills needed among service users, providers and commissioners. [33]

> "If people cannot overcome their drug or alcohol dependence, they should be encouraged to act responsibly and protect themselves and others from harm. Non-evidenced based approaches such as enforced detoxification should be discouraged as these will only lead to relapse."[34]
> **Advisory Council on the Misuse of Drugs (2013)**

There needs be a greater balance between treatment and recovery models; one that supports longer-term progress and does not simply mark the end of treatment. Our investigation into the use of Whole Person Recovery approaches suggests that the widespread adoption of these approaches, as outlined in this report, could generate the 'recovery capital' (see page 25) needed to sustain progress and enable people to achieve recovery goals.

Funding

Cuts to public spending have affected the resources available and the way in which they are managed. Funding for substance misuse was previously ring-fenced but the absorption of the National Treatment Agency into Public Health England has meant that funding is now allocated in line with other public health spending priorities. Cuts to the health budget have meant that services are being asked to prepare for between 25 and 40 percent less funding, as new contracts are being agreed and awarded.

Recently, many services have started to see cuts to their budgets and most expect this to continue over the next few years.[35] This will have a significant effect on the sector's ability to deliver high quality treatment using the same model, especially if the demand for treatment remains the same, increases, or changes with new drug trends requiring adaptable treatment models. As a result, the sector needs to look at longer-term sustainability in order to build resilience and reduce impact in the long term, by encouraging and enabling co-production and peer support to the fullest extent possible.

Payment by results

The economic context, combined with the longer-term challenge of measuring outcomes, has led commissioners to explore new models of efficiency. This has included attempts to find economies of scale, with larger treatment agencies being able to benefit from the efficiency measures that large contracts bring. This does, however, mean that more work needs to be done to understand and embed services into local

33. Advisory Council on the Misuse of Drugs (2013) op cit.
34. Ibid.
35. Drugscope (2014) State of the Sector. [Online] Available at: drugscopelegacysite.files.wordpress.com/2015/06/sosfinal2015.pdf

This does, however, mean that more work needs to be done to understand and embed services into local communities

communities.

It has also included trialling payment by results models, using mechanisms set out by the 2010 Drug Strategy to incentivise substance misuse treatment services to deliver to agreed and specific outcomes. The system means that a percentage of payments to providers are made from the commissioning service to the treatment service based on a financial tariff, according to evidence that service users had reached specific progress markers in their treatment. In April 2012, eight sites were chosen to pilot their treatment programmes using a payment by results approach; this included the West Kent Recovery service.

Before embarking on these pilots the UK Drug Policy Commission[36] identified a series of 'Issues and Challenges' that commissioners should consider when working within a payment by results model. These issues included: the effect it may have on harm reduction; perverse incentives; encouraging competition between services rather than collaboration; and providers gaming the system. Where possible, the pilot schemes sought to mitigate these risks.

In order to run a payment by results model, each service user entering treatment is assessed and awarded a banding, reflecting how complex and high risk their case is. The West Kent area, like a number of the other pilots, had a 'Local Area Single Assessment and Referral Service' (LASARS); an independent team that assigned the initial banding based on the commissioning criteria, and then re-assessed the case when submitted for review. Bandings fell under the headings: 'critical', 'substantial', 'moderate', 'low' or 'no need for structured treatment', depending on severity of need. As the service user moves through treatment, if the service is able to evidence that their case has met progression criteria, the service is awarded a payment according to a tariff. Progress is measured across two domains: freedom from dependency and health and wellbeing. In West Kent, there was a further bonus available if an overall target was met regarding reducing reoffending. Following a service user progressing through treatment and their case being closed, a further payment may be awarded, with another offered six months later if there was evidence that the person had been able to maintain their recovery.

In West Kent, the payment by results model accounted for a proportion of the overall service cost, with some fixed funding also being allocated.

The eight pilot sites were subject to an interim evaluation.[37] However it proved difficult to compare across many of the areas due to varying treatment structures; some practitioners reported that payment by results was having no impact on practice and some service users reported feeling pressured to move through treatment before they felt ready.[38] In terms of this report, perhaps the most notable of the interim findings was that some payment by results outcomes were dependent on factors beyond the

36. Roberts. M. (2011) By their fruits… Applying payment by results to drugs recovery. Available at : www.ukdpc.org.uk/wp-content/uploads/Evidencepercent20reviewpercent20-percent20By%20theirpercent20fruits...percent20Applyingpercent20paymentpercent20by%20resultspercent20topercent20drugs%20recovery.pdf

37. NDEC (2014) op cit.

38. Ibid.

control of treatment providers.

A central challenge that arises in using payment by results in a recovery system (and a number of other policy areas) is the sheer number of factors that could contribute to a 'good' outcome and the fact that many of these are outside the control of a single commissioned service. Conversely, it is important that contracts do not create barriers to achieving outcomes by introducing tick-box exercises that are not always applicable. In the case of recovery, there is not a simple cause and effect relationship where providers can treat symptoms and predict likely outcomes with any reasonable degree of certainty. Instead, recovery services are often required to identify and manage a complex array of interrelated factors, as well as navigate the multiple associated service areas and agencies – such as mental health providers, housing providers and other local authority services – to create real, sustainable change. Aside from other services, our work on recovery capital makes clear that recovery is not just or always about the absence of something (for example, drugs or alcohol) but the presence of other things . These other things are inherently difficult to measure.

In May 2013, DrugScope and the RSA brought together provider representatives from the pilot areas to discuss their experience. A common theme was the challenges brought by speed of implementation and the recommendations below need to be seen in this context:

- The transition to payment by results places significant burdens on service providers. Early performance may have been enhanced if these transitional challenges had been recognised at the design stage, with more support provided for implementation. One proposal was that payment by results could operate in 'shadow' form for an initial phase to support co-design, development and fine-tuning before operationalisation.
- The transition places additional burdens on commissioners, particularly during the design phase and, potentially, on service users. Effective mechanisms, including service user involvement in co-design and evaluation processes, are needed.
- Data requirements are more onerous in pilot areas with large numbers of targets. These costs should be taken into account in designing local payment by results systems; lower transitional and data costs were incurred where new arrangements had a manageable number of clear and 'easy to measure' outcomes.
- Local Area Single Assessment and Referrals Services (LASARS) and equivalents were a particular concern for service providers in the first 12 months and arrangements should be reviewed. One proposal was that providers should conduct assessments themselves, subject to an independent auditing process to address concerns about 'gaming'.
- A key issue was the level of understanding of payment by results within the workforce. Guidance and resources on how payment by results works, how it applies to recovery and what it means for day-to-day work with service users would help. This should take place alongside guidance for service managers on workforce issues around implementation, provision for staff training and the engagement of service users.
- The impact of negative perceptions and misplaced expectations from other local services was identified as an issue. Policy-makers, commissioners and providers should develop information and communication tools to inform/engage local stakeholders around payment by results.
- There is a particular need to review the approach to alcohol recovery in the payment by results pilots.
- Perhaps the biggest challenge to emerge was the need for local mechanisms and forums to support on-going co-design underwritten by constructive relationships between commissioners, providers and service users. Further consideration should be given to the relationship between tendering exercises and co-production with providers developing a 'learning culture' around payment by results.
- Providers wanted more support and training to equip them to work creatively with commissioners to develop opportunities in a payment by results framework, including innovation. This requires a 'letting go' by commissioners.
- There are limited opportunities for service providers in different payment by results areas to share their experiences, including exchanging ideas on good practice. Further support could be provided to support an on-going dialogue between service providers and dissemination of good practice.

Taken from DrugScope/The RSA 2013.[38]

39. Drug and Alcohol Recovery Payment by Results (PBR) Pilots – National Service Providers Summit.

The future of payment by results in the recovery sector remains unclear. While acknowledged to be working well in some areas (for example within the Work Programme)[40] and to an extent in relation to the government's Troubled Families Programme, the evidence gleaned from the Drug and Alcohol treatment pilots so far does not seem to support its continued use as it has not proved to be any more effective than traditional models. [41]

The National Drug Evidence Centre's 2014 evaluation of the pilot programme presented a mixed message.[42] It identified that payment by results had encouraged "greater emphasis on monitoring and progress review" and also focused on the use of Local Area Single Assessment and Referral Services (LASARS) and the impact that this has within treatment systems. However, there were other challenges that appeared more deeply entrenched, particularly the barriers to innovation and in enabling smaller entrants into the market.

Outcomes that are meaningful have to be based over the long-term and it is difficult to reconcile this with a system that emphasises relatively short-term objectives

Payment by results commissioning seems to be particularly difficult for the recovery sector. Outcomes that are meaningful have to be based over the long-term and it is difficult to reconcile this with a system that emphasises relatively short-term objectives. The way in which 'recovery' is measured is currently fairly crude, with a focus on non-problematic drug use rather than how an individual is coping, whether they feel their life has meaning or whether they feel connected to their community.

> "Six months of sustained recovery is a laudable achievement but evidence suggests that 'remission or recovery from addiction, like remission from cancer, be monitored for a minimum of five years following recovery initiation'."[43]
>
> **ACMD Recovery Committee (2013)**

Recovery is an individual experience. The measures in payment by results contracts focus on outcomes that are not applicable to each individual, but are necessary for services to monitor, as they will trigger a payment. This 'trigger' data is important to have but should not necessarily be the basis for services being paid for the work that they do, especially when, as discussed, over that six-month period there are so many contributory factors to an individual's recovery that a service has no control over. The government's own review across all commissioned services suggests that much more evidence is needed to prove that payment by results improve outcomes in any sector. [44]

40. National Audit Office (2015) Outcome-based payment schemes: government's use of payment by results. [Online] Available at: www.nao.org.uk/wp-content/uploads/2015/06/Outcome-based-payment-schemes-governments-use-of-payment-by-results.pdf
41. National Drug Evidence Centre (2014) Evaluation of the drugs and alcohol recovery payment by results programme – Interim Summary Report. [Online] Available at: www.population-health.manchester.ac.uk/epidemiology/NDEC/newsandevents/news/PbRDR_Summary.pdf
42. Ibid.
43. Advisory Council on the Misuse of Drugs (2013). op cit.
44. National Audit Office (2015) op cit.

2. The Whole Person Recovery Theory

Recovery capital

The concept of 'recovery capital' has been a key part of the RSA's Whole Person Recovery work and our partnership with CRI in West Kent. Put simply, people with high recovery capital – access to money, a good education, general good health, a supportive and stable family life – are still at risk of addiction, although less so, but have a much better chance of recovering naturally or with less support from treatment services or peer support. Our approach to recovery is therefore based on 'building' recovery capital for those with fewer resources to draw on; enabling people to identify and access the latent personal, social, community and cultural assets that can support their recovery.

Granfield and Cloud defined recovery capital as "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drug] problems".[45] They have since revisited this concept and explain recovery capital as being made up of the following four components as described by Best and Laudet. [46]

- Social capital is defined as the sum of resources that each person has as a result of their relationships, and includes both support from (and obligations to) groups to which they belong; thus, family membership provides support but will also entail commitments and obligations to the other family members.
- Physical capital is defined in terms of tangible assets such as property and money that may increase recovery options (for example, being able to move away from existing friends/networks or to afford an expensive detox service).
- Human capital includes skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital, and will help with some of the problem solving that is required on a recovery journey.
- Cultural capital includes the values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours.

Source: Best, D. and Laudet, A.B. (2010) *The Potential of Recovery Capital*. London. RSA.

45. Granfield, R. and Cloud, W. (1999) *Coming clean: Overcoming Addiction without treatment*. New York, New York University Press.
46. Best, D. and Laudet, A.B. (2010) *The Potential of Recovery Capital*. London. *RSA*.

The language of recovery is as individual as the person, and it is important to put the recovery journey into a context that the person feels ownership of

Granfield and Cloud[47] make clear that there are limitations to these four categories; while they serve as a useful framework for delivery, many situations could fit in more than one of these and there are cases to be made for introducing other categories, depending on the individual. The recovery capital themes we use in this report are, similarly, just examples of recovery capital. Not all of the examples will be applicable to everybody but are illustrative of what individuals might draw upon to contribute to positive recovery capital. The language of recovery is as individual as the person, and it is important to put the recovery journey into a context that the person feels ownership of.

> "Without the fundamentals in place: somewhere to live; good social networks; some money to buy food… how can we expect individuals to come out the other side and be perfect citizens? It's not going to happen… We need to ensure the right building blocks are in place so that ultimately those individuals can reach their potential."
> **CRI Recovery Worker (2015)**

Taken as a whole, the internal and external resources that make up recovery capital – in its negative or positive sense – boil down to the *realistic resources and opportunities* an individual can garner for a better life in the future if they overcome their dependence on drugs or alcohol. This is why poor physical health, a criminal record, a lack of friends or family who do not misuse substances, can impact recovery outcomes so strongly. People need to at least be able to hope that there is a better life around the corner that they might have some control over; without this there is no incentive to stop using. For many people, recovery is about a multitude of factors and a life without drugs that is still marred by poor physical and mental health, insecure housing and social isolation is not a satisfactory outcome. This seems obvious, but the outcomes that services are commissioned to deliver do not fully acknowledge this.

Dislocation

The work of Bruce Alexander has shown why some people become addicted to substances when many other people do not.[48] He argues that society in general (and this is a worldwide problem) has become more susceptible to addiction as a result of the fragmentation of families and communities. A renowned study of returning Vietnam War veterans showed that people are more likely to become addicted in stressful situations removed from their support networks. The study offered an extreme example of dislocation and what happens when it abruptly ends: the majority of soldiers who were addicted to heroin in Vietnam returned home and recovered naturally, with no support, other than returning to their normal lives with their old resources of friends and family.[49] In other

47. Cloud, W. and Granfield, R. (2009) Conceptualising recovery capital: Expansion of a theoretical construct. *Substance Use and Misuse,* 42 (12/13), 1971-1986.

48. Alexander, B. (2014) Rise and fall of the official view of addiction. (Online) Available at: www.brucekalexander.com/articles-speeches/dislocation-theory-addiction/241-rise-and-fall-of-the-official-view-of-addiction-5

49. Robins, L. N. et al (1973) Drug use by U.S. Army enlisted men in Vietnam: A follow-up on their return. *American Journal of Epidemiology*. 99 (4): 235-249.

words, they had high recovery capital.

Alexander's theory is that this is about dislocation, in a wider sense, from society and its demands, but also from people and communities. It begins to explain why and how recovery capital is so important. Addiction is not just caused by the drug; people with high recovery capital are much less likely to become addicted and when they do are then much more likely to overcome their addiction, so there must be something else that compulsive substance misuse is replacing in the lives of those with low recovery capital.

This theory also explains why services have moved towards 'recovery' rather than traditional 'treatment' over recent years. Harm reduction and medicalised treatment are important for many people, especially those unlikely to cease drug or alcohol use. But if services focus only on this then they are not promoting sustainable recovery. Most people that become addicted to drugs or alcohol recover naturally, without any access to treatment or recovery services, because they have enough recovery capital that they can harness to support this. But this means that those people who do need to enter treatment are usually the ones who are unable to build opportunities and resources without help.[50]

This is not an argument against treatment. Those who seek out this kind of support do so because the usual resources that individuals can draw on – their recovery capital – are either non-existent for them or have been exhausted. This is why entering structured treatment can be such an important step and why individual recovery capital should be looked at from the outset when developing recovery plans with clients and assessing the level of support needed. For example the recovery services, via the option of detoxes and titration, enable individuals to become free of their drug. This opens up the space for the rest of the work that goes on to build recovery capital. For some low risk users, this is all they need. A detox, and the reassurance that there is a friendly place and further support if necessary, will be enough to give them a fresh start and a chance to go out and live well. For others this is not enough, and it is the recovery services and the opportunities that they bring that will help them to build their recovery capital.

> "Treatment and recovery systems need to be designed to help people make progress, though multiple relapses are the norm: a recovery process can require long-term support over many years and systems should be designed to take a long term or 'extensive' approach – especially for the UK population of ageing heroin users."[51]
>
> **Advisory Council on the Misuse of Drugs (2013)**

A greater focus on recovery capital, and the evidence that supports its important contribution to thinking about how services are designed, has profound implications for how these services are commissioned and measured. For example, within payment by results systems, such as the one the West Kent Recovery service has been working with, this is done, to an extent, with banding that assesses how much money a service will

50. Ibid.
51. Advisory Council on the Misuse of Drugs (2013) op cit.

get if an individual achieves the prescribed outcomes. Not only do we argue that these outcomes are often inconsistent, we also argue that the *banding should be based on recovery capital*, taking into account when clients are referred. This could happen both in payment by results and non-payment by results services, and would need to be reviewed regularly with peer mentors or recovery workers and their clients to ensure that building recovery capital, alongside treating the disease, is at the heart of what is done in services.

Co-production

Treatment services can certainly help, in terms of building self-esteem and coping strategies, creating networks, assisting with skills and volunteering, but recovery is ultimately social and depends on a much wider group of actors

In recent years, many public services have been tasked with shifting from top-down delivery models to service user engagement and co-production. The practical approaches to building recovery capital are critically dependent on co-production; working with service users and wider communities in designing and delivering interventions. An individual will not have all of the resources to meet their own needs all of the time. It is important to be able to collectively identify and address gaps and opportunities to strengthen recovery assets. This approach is not consistent with predetermining people's needs and putting the onus on treatment services to *deliver* recovery for the people that come through their doors.

Treatment services can certainly help, in terms of building self-esteem and coping strategies, creating networks, assisting with skills and volunteering, but recovery is ultimately social and depends on a much wider group of actors. This might be something for other services, such as housing and employment, to take on, or it might be around creating strong networks of support, which can be done through mutual aid groups and community groups. Moreover it might be for individuals to work on relationships they have lost or to build more positive friendship groups, depending on the circumstances.

In many ways the concept of recovery capital speaks to the current emphasis on 'active citizenship', whether articulated in terms of personal responsibility or the now rather out of fashion 'Big Society' narrative that characterised the UK Prime Minister, David Cameron's, early leadership. In this vein the RSA argues here, and elsewhere[52] for design-led services that are able to empower and harness the latent energy of individuals and their social networks. By enhancing capacity for, and confidence in, people's sense of agency, we create the conditions for more socially productive citizens and services. [53]

52. Rowson, J. Broome, S. and Jones, A.(2010) C*onnected Communities How social networks power and sustain the Big Society*. London: RSA.

53. Schifferes, J. (2014) *Developing Socially Productive Places*. London: RSA. [Online] Available at: www.thersa.org/discover/publications-and-articles/reports/developing-socially-productive-places/

Whole Community Recovery

> "Whole Person Recovery gives people a real focus, and a real future. It brings fun into recovery, which is needed, the celebration. You have to work to make life without drugs better than life with drugs. Peer support is invaluable. It is something unique; if it's used in the right way. Our service users find it inspirational, empowering, to know someone has been where you were, and to see how they have worked recovery, you can't replicate that. But we also need to take this further. People need to understand that peers aren't limited to people who are in recovery. Your peers are your community, and you have to seek and embrace the support there as well. That's what I think you are trying to help with here."
> **CRI Recovery Worker (2015)**

In simple terms, a community's power to create positive change is greater than an individual's

In the time between entering and leaving treatment, and then hopefully sustaining recovery, individuals need support from their immediate social networks, peer support groups and wider communities. A local community that feels welcoming and non-judgmental gives someone with often severe and multiple disadvantages another chance at rebuilding their lives. But how do we go about creating a community that looks like this?

The RSA has long argued the benefits of personalised recovery services, based around the needs of the individual. Here we go a step further, making the case for a 'Whole Community' model of recovery, where support networks within *and beyond* the immediate recovery community are integral to achieving successful recovery outcomes for people over the long-term. As discussed in the original *Whole Person Recovery* report, the 'Recovery sub-system' is based around a positive reinforcing loop in which routines are broken, informal and formal recovery capital is accessed (including treatment), plans are made to sustain recovery, and individuals begin to see a new, alternative future.[54]

William White's research[55] suggests that recovery 'durability' (where the likelihood of experiencing active addiction falls to below 15 percent) is reached at around four to five years after seeking interventions. Given this, it is important that eventually – and we would emphasise that this is an individual process – a person transitions away from services, into the recovery community and into everyday life that includes positive and high quality social networks.

Communities have a responsibility as a collective to each individual and vice versa. Although the recovery community shares the commonality of a history of addiction, it involves individuals, and as a result has a wide variety of experiences and skills. Enabling people to build on this diversity of knowledge in turn builds on their capacity to help others. By combining individuals into a group that can create networked support, the capability then becomes greater. In simple terms, a community's power to create positive change is greater than an individual's.

54. Daddow, R. and Broome, S. (2010) *Whole Person Recovery: A user-centered systems approach*. London: RSA.

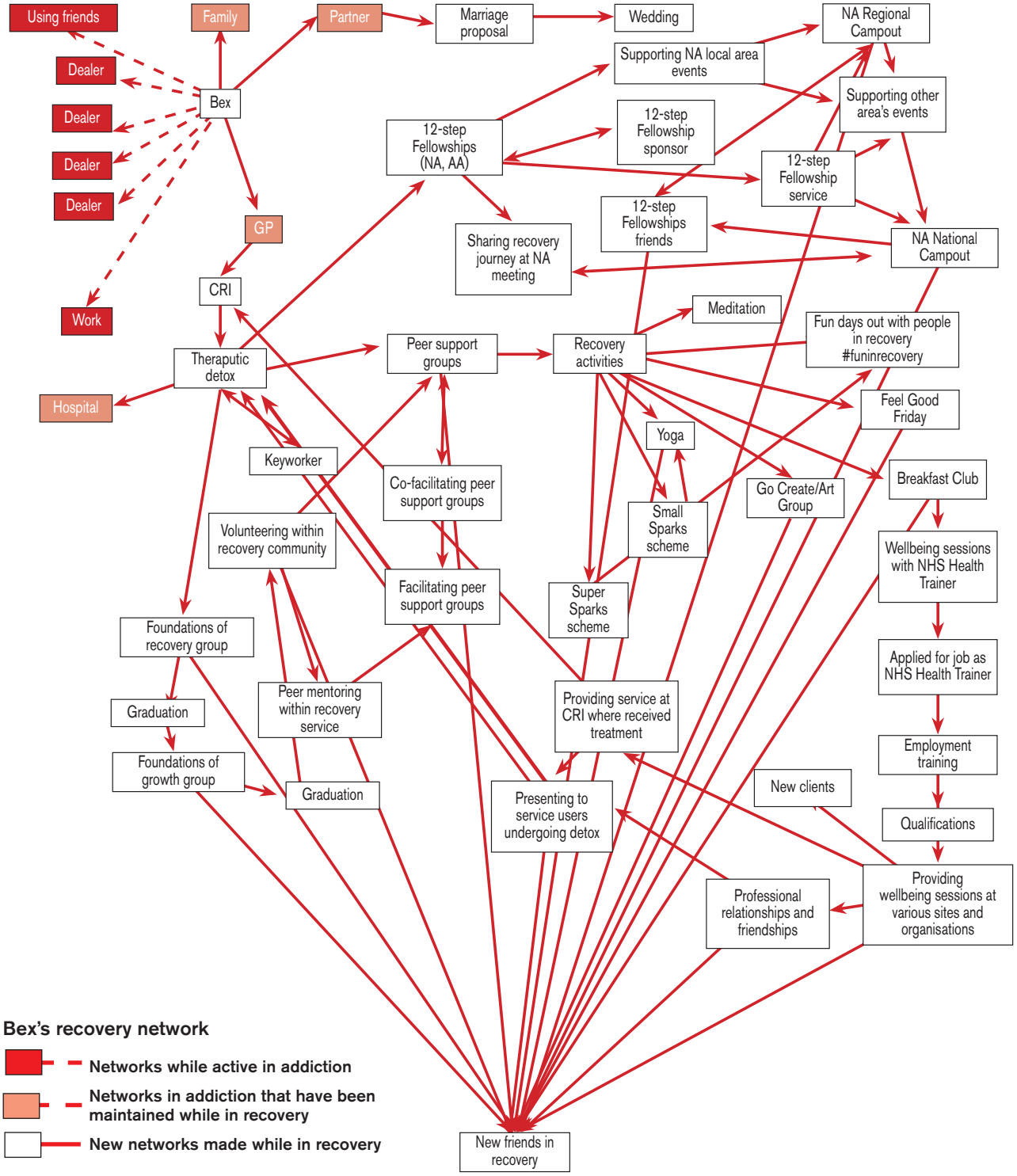
55. White, B. (2013) *Recovery Durability: The 5-Year Set Point*. Selected Papers of William L. White, 31 July [Blog]Available at: www.williamwhitepapers.com/blog/2013/07/recovery-durability-the-5-year-set-point.html

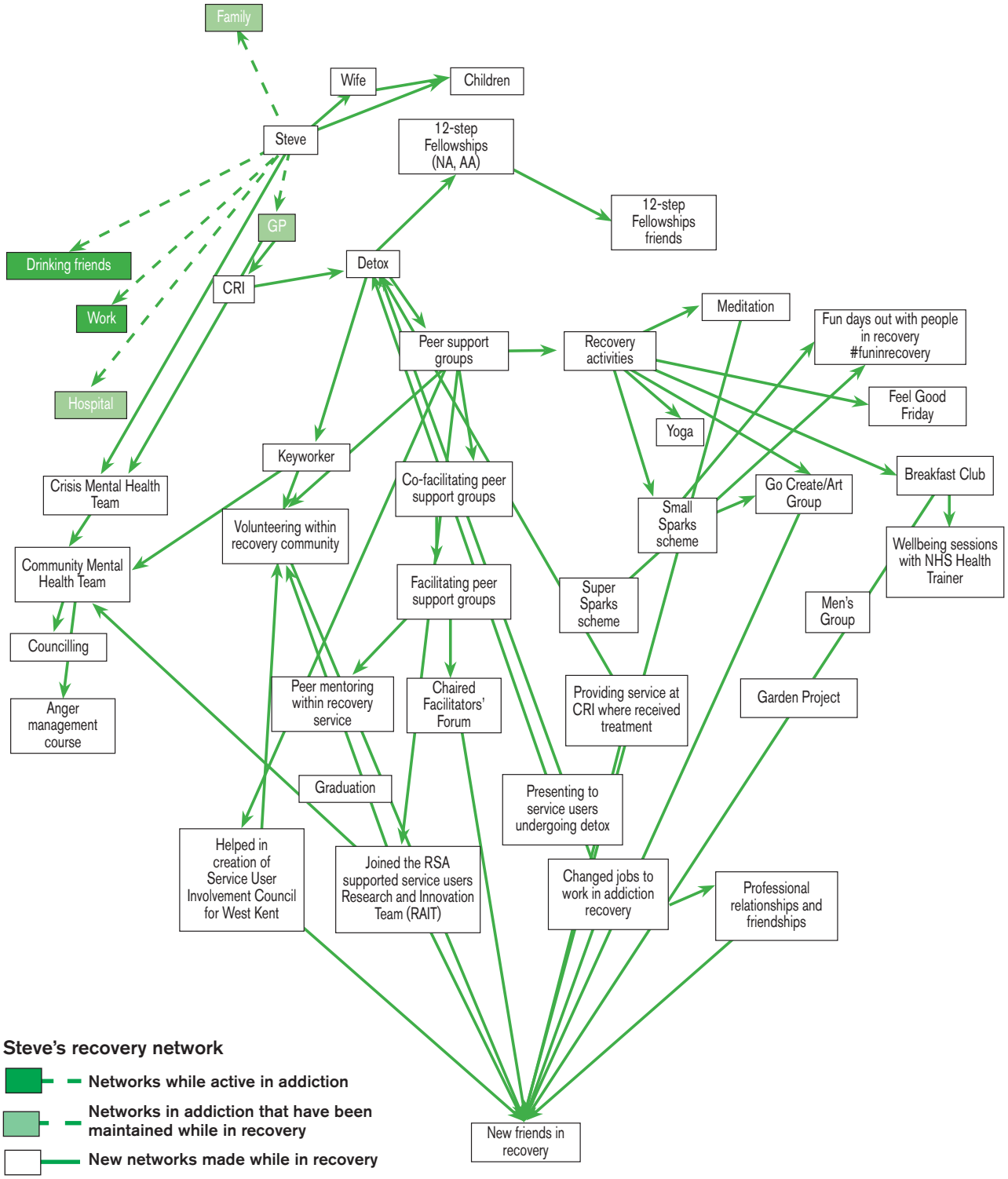
A crucial facet of any recovery community is that its members are experts by experience. They have a knowledge and credibility that it is impossible to have without a lived experience of addiction. This appears to be a well-established route into volunteering and employment, with many members of the recovery community opting to remain as volunteers within treatment services or peer mentor organisations, and often becoming good candidates for paid roles in the future. However, there is a case for generating robust links into other sectors in order to build integration and collective development. The breadth of skills and experience that individuals in recovery have to offer should be able to help shape and positively impact other services and sectors.

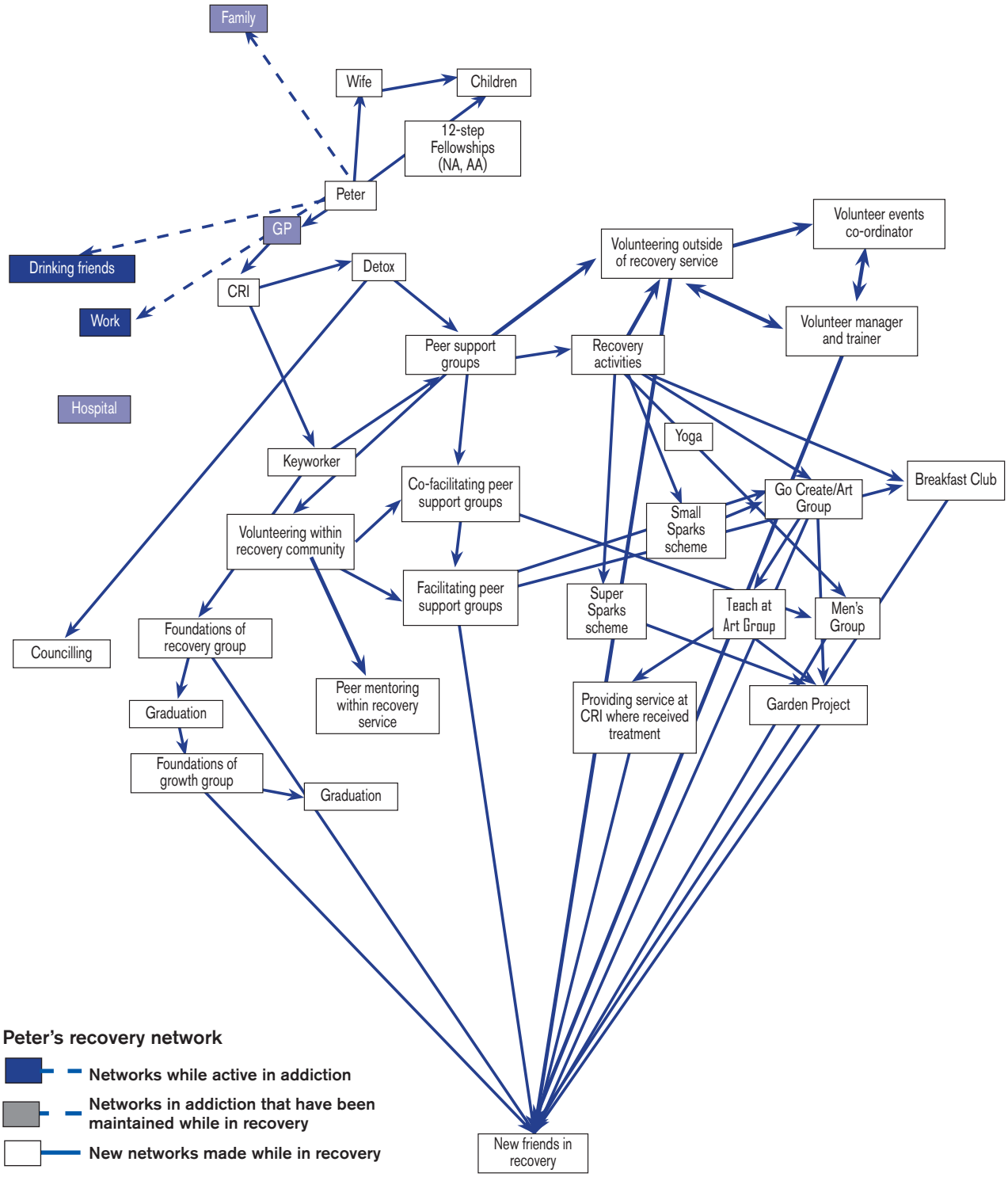
In addition to employment, the recovery sector has an abundance of knowledge that can be shared with other sectors with regard to mutual support and long-term health management. Lived experience of the transition from being unmotivated to self-motivating, having an understanding of behaviour change, resilience, determination and how to manage long-term conditions, are all skills that are developed through sustained recovery.

Figure 2. The power of building recovery networks

Figure 2 shows examples of how three service user's social networks broadened following entering treatment and engaging with the recovery communities in West Kent.




Family
Wife
Children
Steve
12-step Fellowships (NA, AA)
12-step Fellowships friends
GP
Drinking friends
Detox
CRI
Work
Hospital
Peer support groups
Recovery activities
Meditation
Fun days out with people in recovery #funinrecovery
Feel Good Friday
Yoga
Keyworker
Co-facilitating peer support groups
Breakfast Club
Crisis Mental Health Team
Volunteering within recovery community
Small Sparks scheme
Go Create/Art Group
Community Mental Health Team
Facilitating peer support groups
Super Sparks scheme
Wellbeing sessions with NHS Health Trainer
Men's Group
Councilling
Peer mentoring within recovery service
Chaired Facilitators' Forum
Providing service at CRI where received treatment
Garden Project
Anger management course
Graduation
Presenting to service users undergoing detox
Helped in creation of Service User Involvement Council for West Kent
Joined the RSA supported service users Research and Innovation Team (RAIT)
Changed jobs to work in addiction recovery
Professional relationships and friendships
New friends in recovery
Steve's recovery network
Networks while active in addiction
Networks in addiction that have been maintained while in recovery
New networks made while in recovery

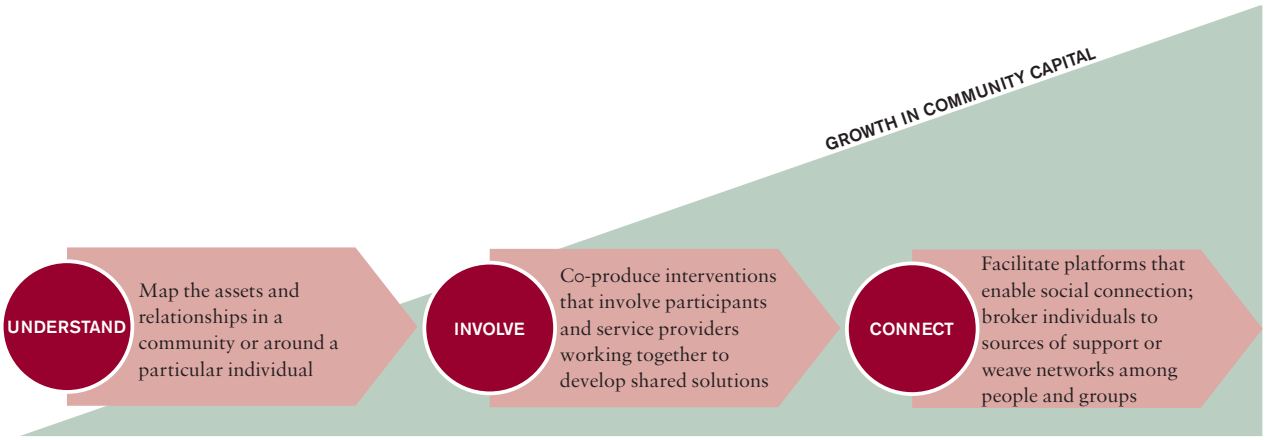

Family
Wife
Children
12-step Fellowships (NA, AA)
Peter
GP
Drinking friends
Work
Hospital
CRI
Detox
Volunteering outside of recovery service
Volunteer events co-ordinator
Volunteer manager and trainer
Peer support groups
Recovery activities
Yoga
Keyworker
Co-facilitating peer support groups
Breakfast Club
Go Create/Art Group
Small Sparks scheme
Volunteering within recovery community
Facilitating peer support groups
Super Sparks scheme
Teach at Art Group
Men's Group
Councilling
Foundations of recovery group
Peer mentoring within recovery service
Graduation
Foundations of growth group
Graduation
Providing service at CRI where received treatment
Garden Project
New friends in recovery
Peter's recovery network
Networks while active in addiction
Networks in addiction that have been maintained while in recovery
New networks made while in recovery

Community capital

> "The development of recovery 'champions' as charismatic and connected community figures who are visible examples of success provides not only the opportunity for 'social learning' for those who claim that recovery is not possible, but also increases the waves of impact within local communities for recovery spread." [56]
>
> **Best & Laudet (2010)**

Expanding on thinking from Putnam and Bourdieu, the RSA has developed the term 'community capital', the sum of assets and benefits derived from the relationships within a community.[57] Community capital can be seen as one important part of recovery capital as it extends beyond personal resources and assets and encompasses the resources that are available in local areas and wider communities. An environment that enables and encourages recovery capital provides a means for disparate assets to come together and become much more than the sum of their parts. These kind of strong, networked relationships help foster more vibrant and inclusive communities as a whole. The recovery community is an important part of this and accessing their networks is both beneficial for wider community groups and for the recovery community.

Figure 3: Theory of change for growing community capital, Parsfield et al (2015)



System change

The RSA's Whole Person Recovery work is influenced by the capability approach, pioneered by thinkers such as Amartya Sen and Martha Nussbaum.[58] The core characteristic of this approach is its focus on what is feasible for people to do given the multiple factors that shape their lives. This contrasts with philosophical approaches that concentrate on people's happiness or desire-fulfilment, or on theoretical and practical

56. Best, D. and Laudet, A.B. (2010) op cit.
57. Parsfield et al (2015) *Community Capital: The Value of Connected Communities.* London: RSA
58. Nussbaum, M. (2003) Capabilities as Fundamental Entitlements: Sen and Social Justice. *Feminist Economics* 9(2–3), 33 – 59. www.philpapers.org/archive/NUSCAF.pdf

approaches that concentrate on income, expenditures, consumption or basic needs fulfilment. It thus places a much greater emphasis on understanding how people's capabilities are shaped by the systems within which they operate, the choices they have within these and the role that other agents play in defining these.

As the psychologist Bruce Alexander argues, addiction is only a small corner of the addiction problem and is more social than individual.[59] He argued that when socially integrated societies are fragmented by internal or external forces, different forms of addiction increase, becoming almost universal in extremely fragmented societies. Within this model, addiction is a form of adaptation, not a disease that can be cured nor a moral error that can be corrected by punishment and education.

While these theories are not uncontested or uncontroversial they have acquired considerable recognition and speak to the lived experience of those who experience addiction and to the RSA's work in this area. They suggest that in understanding and responding to addiction, profound social change is needed; a humanistic approach that values approaches that promote dignity, belonging and attachment, nourishing relationships, and individual meaning and purpose.

Recovery is ultimately social, requiring co-production of a wide range of actors. The aim of recovery services should be to enable people to realise their potential with all the roles, rights and responsibilities that this implies. While recovery capital is important, its value comes from thinking about recovery capital in the systems of addiction, transition, and recovery that constitute the Whole Person Recovery model, and the corresponding commissioning/service model. This approach reveals the extent to which recovery capital can only be mobilised and translated into recovery activity through social and community spheres, with all the components and dynamics that make these up. This is not how we view recovery currently but is critical if we are to understand how different forms of recovery capital (or their absence) interact with the whole person in context.

59. Alexander, B. (2014) op cit.

3. The Whole Person Recovery Project

The RSA's Whole Person Recovery project aims to help people to move away from problematic substance misuse and into recovery in a way that empowers the individual and their communities to tap into and make best use of their own capacity. While there is no absolute consensus on the definition of recovery – and some contention around whether abstinence-based recovery should always be the end goal – our focus is on the extent to which a person and collective can be enabled to meet their own needs and aspirations.

This report marks a milestone in the project, which has its roots in the RSA Commission on Illegal Drugs and its landmark report published in 2007.[60] This proposed a 'whole person' approach to drug and alcohol misuse; one that emphasised the role that individuals can play in improving their own outcomes and on sustainable recovery, based on the recognition that people often face a range of other challenges that can both drive and be symptoms of substance misuse.

Sector policies and practices have evolved since then, and so too has the RSA's programme of work which has been designed to develop and test in practice our whole person model for sustainable recovery. The project, and our model, has developed through earlier work, drawing on the latest evidence and practical implementation.

West Sussex

The RSA's Whole Person Recovery Project was piloted initially in West Sussex, with drug and alcohol users firmly at the centre of a programme of innovation and inquiry aimed at building recovery capital.[60]

The West Sussex Whole Person Recovery pilot project successfully demonstrated that people with drug and alcohol problems could play a central role in improving services and working with the wider community to increase the recovery capital of both individuals with drug problems and the community as a whole.

However, the project also identified a number of obstacles, particularly the issue of the stigma associated with drug problems and the associated 'invisibility' of recovery. It also remained to be established how transferable the findings were to other geographical areas and how the user-centred approach could fit within a rigid commissioning framework and emerging funding models including payment by results.

60. RSA Commission (2007) op cit.
61. Daddow, R. and Broome, S. (2010) op cit.

The emphasis is on taking a whole person, place and community approach and on building 'recovery capital' – the identifiable components that support individuals' progress – through the power of networks, with a model that places the service user and community at its core and orients around this. At the heart of this approach is co-production; defined by the New Economics Foundation (NEF) as "The delivery of public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours."[62] More broadly, as the phrase suggests, co-production emphasises approaches that enable services and citizens to make better use of each other's assets, expertise and resources to achieve better outcomes.

Whole Person Recovery in West Kent

The project has been testing this model, at scale within a payment by results framework in West Kent over the last four years, where a dedicated RSA team has been working with individuals, clinical and psychosocial treatment specialists, families and community groups in three sites: Gravesend, Maidstone and Tonbridge. This has involved working in partnership with the West Kent Recovery Service, a consortium led by CRI, which covers a large geographical area, with the work done by the partner organisations and the wider recovery community spanning numerous towns.

Figure 4. West Kent Area Map

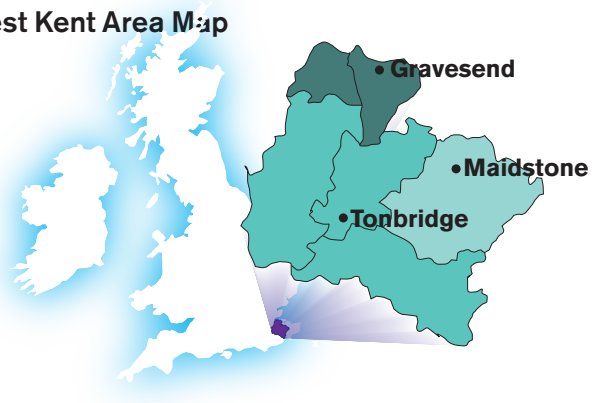


Figure 4 shows the West Kent area covered by the three hubs, separated by Local Authority

The primary objective of the four-year programme was to further test and develop the concept of 'recovery capital' as defined in the RSA paper *The Potential of Recovery Capital*.[63] We have explored how co-production of services and community interventions supports sustainable recovery at a local level, within the pilot payment by results framework. In practice, this has meant working with individuals, local services and the wider community to identify and mobilise the 'assets' – these could

62. New economics foundation. (2008) Co-production: A manifesto for growing the core economy. [Online] Available at: www.neweconomics.org/publications/entry/co-production
63. Best, D. and Laudet, A. B. (2010) op cit.

be physical, financial, individual or social – that can support recovery. Some are obvious: local services and the experiences and skills of staff and clients, for example. Others can be latent or even hidden, such as identifying the 'small sparks' that can aid recovery, or creating local champions and networks of mutual support.

In each of the three West Kent hubs, and the wider areas they support, we sought to create an environment in which people could co-define and work towards meaningful and sustainable recovery goals. To achieve this, the programme was based on three main principles emerging from our work in West Sussex:

- **Co-production** is key for service users to own, and feel a valued part of, their personal recovery process.
- **A holistic, 'whole person'** approach enables services to encompass multiple dimensions of a person's recovery, increasing the likelihood of success in the short and longer term.
- **Social connectedness** – within the recovery community and wider local community – creates a network of support and opportunities for individuals, enhancing the sustainability of recovery.

Applying these three principles meant that each of the three sites grew to look quite different from one another. Despite sharing the same Whole Person Recovery approach, each co-produced their activities and initiatives around their specific needs and capabilities.

The first year of the CRI-RSA partnership involved major organisational change in the area as we took over a cohort of smaller, individual services that had previously provided treatment in different areas of West Kent. Unsurprisingly perhaps, the early transition period was challenging, as the partnership sought to maintain high-quality services for users as well as ensuring staff TUPE (the transfer of employees from roles with previous providers to CRI) and adaptation to new payment by results procedures. Thus, much of the first year was focused on establishing a trusting partnership and service delivery model, with subsequent years consolidating and developing this to improve outcomes. The Whole Person Recovery model has been in large parts experimental, with the CRI-RSA partnership allowing for the necessary freedom, support and financial resourcing to trial new ideas. Example innovations include:

- **Personalisation.** The Small Sparks Scheme introduced individual grants to help recovering individuals overcome barriers that prevent them moving on to the 'next stage' of their recovery (Small Sparks), and slightly larger grants (Super Sparks) to enable members of the recovery community to try out ideas that would improve recovery capital at a community level, enabling co-production between service users and wider activists.
- **Peer support.** The Everyday Activities Programme created free activities aimed at building recovery capital through the expansion of social networks and skills. These activities are, for the most part, designed and run by individuals in recovery, although occasionally a paid staff member will step in for continuity if a

peer mentor is unavailable to ensure continuity of opportunities.

- **Community Events Programme.** For example, Open Days and sponsored events that aimed to reach out to and integrate with the wider local community.
- **Creativity.** Through our Recovery and the Arts initiative, a large-scale art exhibition was curated, showcasing work done by the recovery communities and opened by Her Royal Highness The Princess Royal, RSA President. Creativity has remained a key theme in each of the hubs, with coproduced groups making and creating in different ways. Each of the hubs' work will be drawn together for a final showcase exhibition in January 2016.
- **Drawing on our assets.** Throughout the project, Fellows of the RSA have engaged on a number of levels, from being part of panels judging the efficacy of grant applications, to attending events, to delivering skills workshops. This has been of value not only by having a bank of external skills and input to draw on, but also as a conduit for showcasing recovery.

Everyday activities programme

This has been the crux of the Whole Person Recovery project and involved a series of social activities aimed at providing networking, creativity and upskilling opportunities. Crucially, the programme is open to anyone who is part of the recovery community, and usually much wider than this, and has provided an opportunity for people at any stage of recovery to network. There is a tendency within formal treatment settings to group people by the 'stage' of their recovery (ie those who are still using drugs or alcohol, those who are not and those who are very stable in recovery). The Everyday Activities Programme is built upon the premise that recovery is contagious,[64] and that people at any stage of recovery have a valid stake in the recovery community and are able to offer skills and their personal experience. It has been the platform for much of the co-production and has been used as a forum for ideas generation, as well as for collecting feedback and testing new initiatives.

The Everyday Activities Programme was originally set up with some 'stock' activities such as breakfast clubs in each of the hubs, and grew from there according to local interest and expertise. The breakfast clubs, in particular, proved to be an opportunity for scrutiny from our service users. Feedback was generally given in a very open and transparent way, and this meant that other members of the network could also feed into developing an environment that fostered solutions and was creative.

The open nature of the activities did not come without issues. Over time, group rules and agreements had to be developed to establish an environment that was inclusive but that was as safe as possible for those who were in early recovery. The nature of having to meet these challenges gave an opportunity for the recovery community to start to build resilience and problem solve as a collective.

64. Best, D. and Laudet, A. B. (2010) op cit.

Small Sparks Scheme

The Small Sparks Scheme is a grant-giving scheme for people who are in recovery or are working hard towards it. Grants of up to £200 were made available on a rolling monthly basis, to enable individuals to purchase services or products (determined by them and agreed by a panel) that would facilitate their ongoing recovery. From its inception this component of the project has been a key tool for recovery workers and peer mentors to offer a different kind of support with personalisation at the heart; it enables people to create their own solutions to support their longer-term recovery.

The scheme was advertised around the hubs, and initially most of the applicants were referred by recovery workers or peer mentors, who would support the applications. In time, applicants heard about it through their recovery networks. In a sector where many of the individuals are managing with very little money while at the same time attempting to overcome their addiction, recovery workers often find that their hands are tied in terms of creating new opportunities. The scheme enabled people to use their local gym or exercise classes (often after engaging with the health trainer scheme), get a bicycle if they couldn't afford public transport, or to access courses with the adult education service. The Small Sparks Scheme is an alternative to personal budgets that allows a more person-centred, whole life approach to recovery compared to traditional treatment systems alone, and gives the opportunity to understand the wide variety of things outside of traditional services that might support recovery.

The scheme draws on knowledge of behavioural science and what it tells us about reducing the 'scarcity effect'. That is, when you have insufficient resources (for example, money or time) to cover all your requirements, it becomes necessary to make trade-offs, which is particularly mentally taxing. So, if for example an individual does not have enough money to pay all of their bills and buy new shoes for their children, they have to decide whether rent, electricity, water, food, or the shoes get priority. Eldar Shafir and Sendhil Mullainathan examine this idea in their book *Scarcity*.[65] They argue that when people lack sufficient resources they tend to 'tunnel', which means they focus all their mental energy on solving the most immediate problem. In this case that is unlikely to be an individual's recovery, so whatever can be done to reduce the effects that scarcity has will bolster an individual's recovery capital, and thus the likelihood of them sustaining their recovery over the long term.

Throughout the scheme there has been concern from staff that the money given out could be misused and represent an unnecessary temptation to someone who is vulnerable. A comprehensive review in the second year by the Research and Innovation Team (RAIT, see below) highlighted that on a few occasions the grants had not been spent as intended (one applicant used it to pay bills rather than for a gym membership for example). We sought to mitigate these risks by working with recipients to make sure they received the money in a way that did

65. Mullainathan, S. and Shafir, E. (2013) *Scarcity: Why having too little means so much*. London. Penguin.

not put them at risk. For many people this might mean someone would accompany them to purchase what they applied for, or the money might be placed in the care of a trusted friend or family member. The awarding of grants was overseen by a panel of stakeholders, which included recovery staff, peer mentors, community members, RSA Fellows and previous grant applicants.

Public Events Programme

The public events programme offered an opportunity for the local communities around the hubs to attend a series of talks on wellness and wellbeing themes. The idea behind this was to initiate conversation on these topics with community members and invite them to find out about the project as well as form an interest-based network. These events were marketed openly through the West Kent Recovery Service's existing networks and were free to attend. This was often the first step for a service user in introducing their family and friends to the project, and so began to widen local awareness. The majority of people who attended were interested professionals that had been aware of the project's existence but had not had a broad understanding of the work. Contact details were collected with permission, and these were used as a platform for updating people about how the project was developing through newsletters and campaigns.

Research and Innovation Team (RAIT)

The Research and Innovation team was initiated to provide opportunities for service users to get involved in the critique and scrutiny of Whole Person Recovery, the West Kent Recovery Service and the wider community recovery opportunities in the area. The team was recruited on a rolling basis for much of the project duration. Recruitment criteria were based on stability and suitability for the role, and recommendation was sought by the service user's recovery worker, in the same way as a reference for a job application would be sought. Training was offered to cohorts of members in social research methods, research ethics and data protection.

The team initially completed projects to feedback into the development of the Whole Person Recovery programme – providing the RSA team with an 'in motion evaluation' on elements of the project such as the efficacy of the Small Sparks Scheme. RAIT team members conducted a series of interviews with previous applicants, and produced a list of recommendations for improvement of the scheme, which were then implemented. This led to a larger-scale RAIT project being undertaken, involving a survey of more than 100 members of the recovery community about 'local recovery' which was reviewed through a series of focus groups to explore the themes which arose from it. The team is now self-sustaining and is due to publish a series of outputs and recommendations in early 2016.

The Recovery Alliance

As noted in the RSA's Connected Communities report, a lack of diversity in groups can be damaging.[66] A homogenous group might be made up of those with similar life experiences, social networks and skills that can lead

66. Parsfield et al (2015) op cit.

to isolation as a group. The recovery community is particularly vulnerable to isolation and so bridging the gap between the recovery community and the wider local community is vital.

A key part of the RSA's work in West Kent was an attempt to build a recovery alliance in the local areas. The aim was to establish a bridge between the recovery community and the vast resources of many other communities that exist in West Kent. Through the Recovery Alliance approach, we have built relationships with other third sector organisations, local businesses and a diverse range of community groups. The Alliance has provided the recovery community with access to the skills and social networks that were not immediately available, helping with employment, funding applications for projects, and making sure that efforts and best practice in one sector can be shared across another. A great example of this has been our work with a local branch of Mind (a leading mental health charity), that has allowed collaboration on resources and ideas to deliver substantially more support than would have been possible individually. A key part of the development of the Recovery Alliances has been support from and collaboration with the RSA's Fellowship. This has provided access to people in West Kent and beyond who have provided their expertise, time and networking opportunities to the project and the recovery communities across the area. This has included one-to-one mentoring, running workshops in and outside services, and involvement in our community grant-giving scheme, Super Sparks.

Over the three-and-a-half-years, the service has evolved significantly. The Alliances have had significant investment, and in the case of Gravesend, two new buildings. Purpose-designed spaces for group activities such as art, yoga, meditation and breakfast clubs have meant significant areas being been turned over for use by the recovery community in West Kent.

Since 2012, the culture of the hubs has been transformed. The keys have been handed over to peer mentors and service users, so that the rooms – often empty, especially during the evenings and at the weekend – can be used for peer support groups, CV clinics and a Saturday club, which has helped to bridge the gap for people at a time they feel most vulnerable, and reinforce that recovery does not only occur 9-5 on weekdays.

Who we worked with

- The CRI-RSA partnership worked with up to 1,861 service users each year between 2012 to 2015, 70 percent of whom were male and 30 percent female. Their needs were variously assessed as critical, substantial, moderate and low.
- In 2012/13, 544 people were males and 246 females classed as having 'moderate' substance misuse problems. This rose to 718 and 301 respectively in 2013/14 and 759 and 323 respectively in 2014/15 but remained a relatively stable percentage of the overall clients.
- The number of people deemed to have critical substance misuse problems remained relatively stable over the two years: 52 males and 15 females in 2012/13, 56 and 21 respectively in 2013/14 and 65 and 30 respectively in 2014/15. This reflects a relatively stable percentage of the overall clients.

- The bulk of clients were between the age of 25 and 54 (85 percent), with the highest percentage (32 percent) between the ages of 35 and 44.
- In total the number of exits (when people were no longer working with the service) was 2654. Of these, 37.6 percent did not complete treatment, 16.3 percent were transferred to another service and 46.1 percent completed treatment.
- Not surprisingly perhaps, when looked at in terms of those who had critical or substantial needs, 41.3 percent did not complete treatment, 21.4 percent were transferred to another service and 37.3 percent completed treatment.
- Of those classed as having moderate to low needs 36.3 percent did not complete treatment, 15 percent were transferred to another service and 48.7 percent completed treatment.
- Funding for the West Kent Recovery Service was 75 percent core funding in year one, with 25 percent of funding based on performance indicators being met in regards to the payment by results criteria. The payment by results element rose to 30 percent of funding in years two and three. Over the course of the three years, the project achieved full contract value, meeting each of the criteria year on year.

Impact

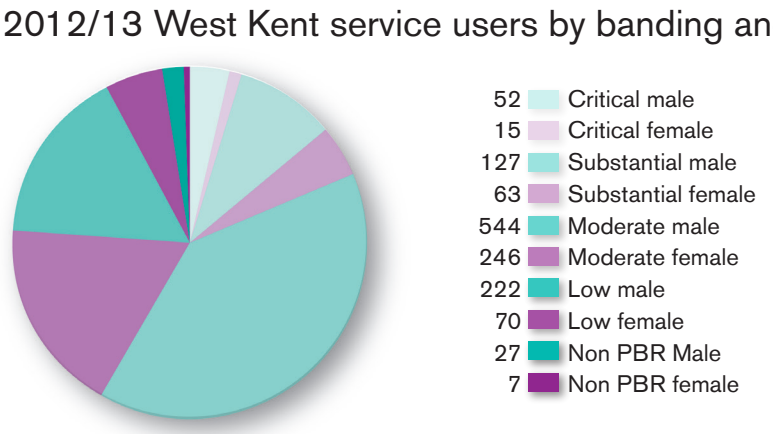
The CRI-RSA partnership in Kent grounded its activity within the RSA's Whole Person approach, where social networks and the communities within a geographical area are seen as fundamental to high quality service design and outcomes. In West Kent, the relationship between the recovery service delivery partners and the project commissioners, KDAAT, has been both supportive and critically constructive. The project benefited from having a commissioning team which encouraged experimentation and acknowledged the benefits of enabling recovery communities to co-produce and try out new ideas without requiring constant and exhaustive evaluation.

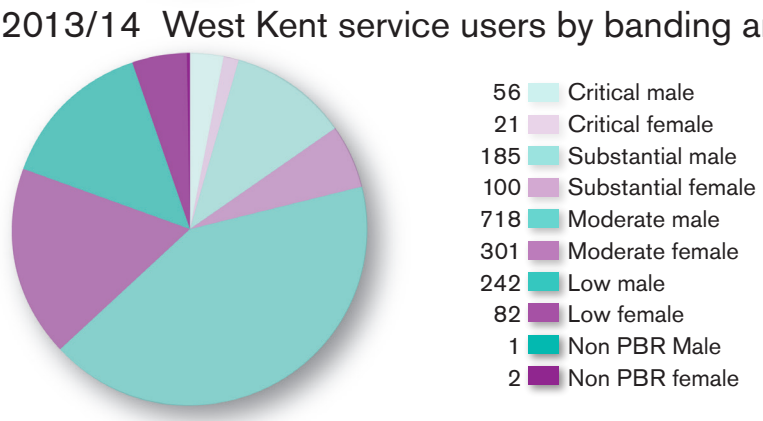
Over the last four years, we have observed that the Whole Person ethos has been widely adopted locally throughout the recovery sector in different ways. Our conversations with wider recovery stakeholders suggest that the quality of treatment experience, degree of peer support, strength of social networks and wider community integration all play a pivotal role in facilitating sustainable recovery.

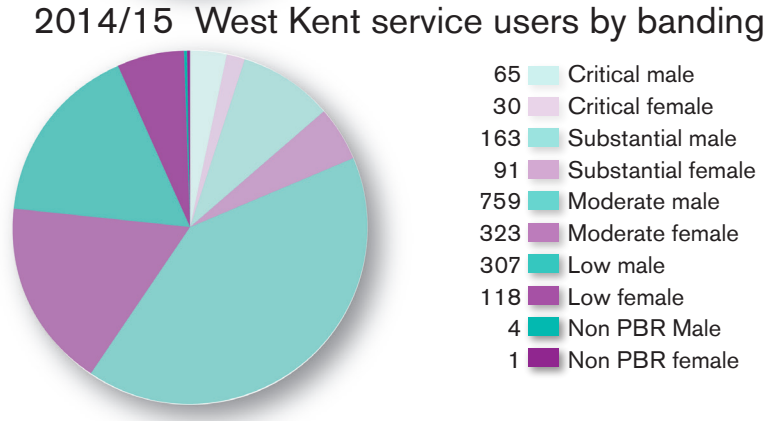
The project has demonstrated – through a range of activities aimed at engaging individuals in supportive social networks – that a Whole Person approach can build and strengthen recovery communities. Each of the three hub sites have offered a number of 'stock' activities, and, as the recovery communities have grown, this has led to other activities that have been co-produced according to the skills, needs, interests and capabilities of the people involved.

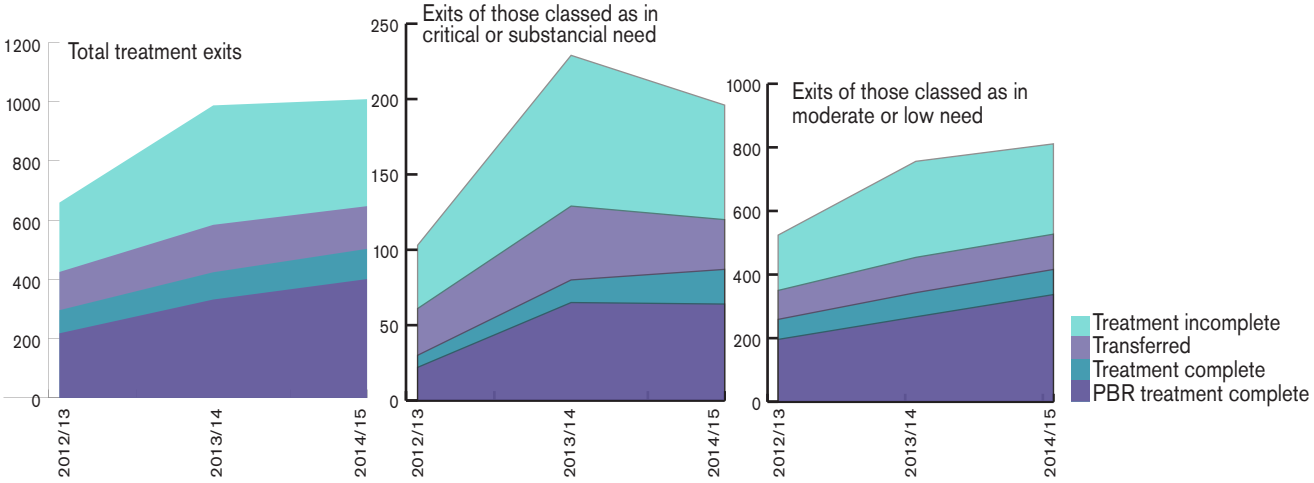
The RSA West Kent pilot comes to a close in March 2016. Having fostered and empowered recovery communities to create local environments that nourish recovery, the next step is to look at the mechanisms by which this occurs; helping services to map individuals' personal social networks and understand and build meaningful recovery capital alongside building the power of communities.

Figure 5: West Kent Recovery Service treatment demographics for the first 3 years of the project





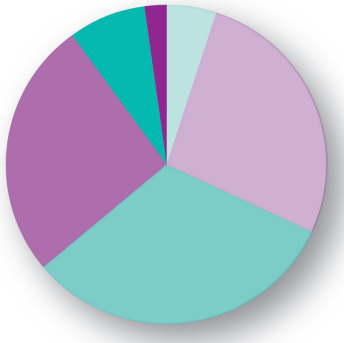




Source: CRI

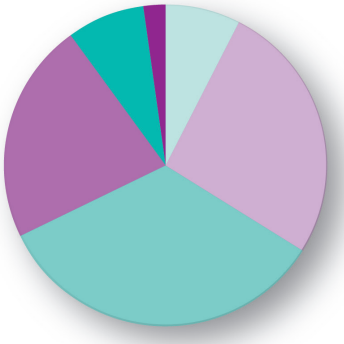
Figure 6: West Kent Recovery Service demographics compared to national figures for 2013 – 14

West Kent service users by age



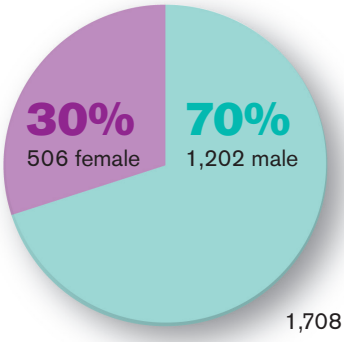
5% 18-24
29% 25-34
31% 35-44
25% 45-54
8% 55-64
2% 65+

National average by age



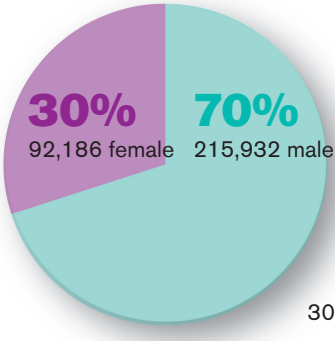
8% 18-24
29% 25-34
34% 35-44
21% 45-54
7% 55-64
1% 65+

West Kent service users by gender



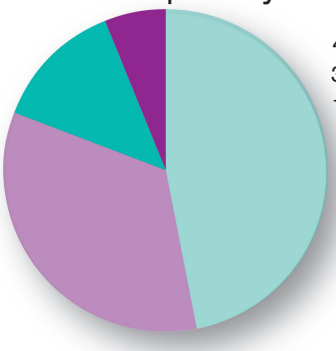
1,708 total

National average by gender



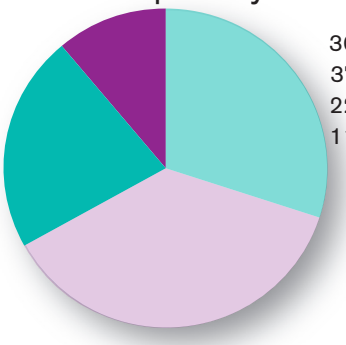
308,118 total

West Kent primary substance



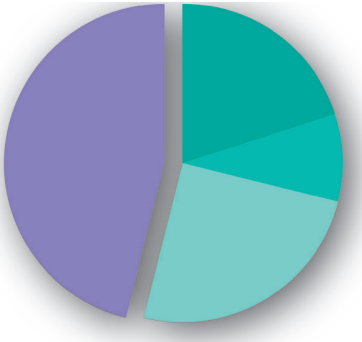
47% Opiate only 810
34% Alcohol only 584
13% Non-opiate and alcohol 215
6% Other drugs 99
Total clients 1,708

National primary substance



30% Opiate only 91,560
37% Alcohol only 114,920
22% Other drugs 67,401
11% Alcohol and other drug 34,237
Total clients 308,118

West Kent treatment exits

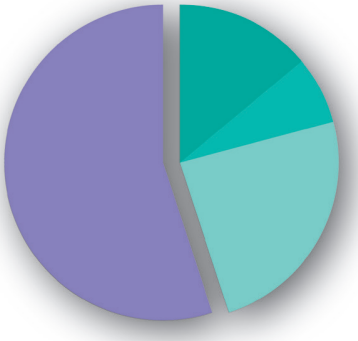


987 treatment exits 58% of all individuals in treatment

25% 424 Treatment complete
9% 160 Transferred either in or out of custody
24% 403 Individuals dropped out, moved away, or died, treatment withdrawn
42% 721 Retained in treatment

Source: CRI and Public Health England[67]

National treatment exits



138,563 treatment exits 45% of all individuals in treatment

24% 72,680Treatment complete
7% 21,916 Transferred either in or out of custody
14% 43,967 Individual dropped out, moved away, or died, treatment withdrawn
55% 169,555 Retained in treatment

67. Public Health England reports [online] http://www.nta.nhs.uk/uploads/drug-treatment-statistical-bulletin-2013-14.pdf. http://www.nta.nhs.uk/uploads/adult-alcohol-statistics-report-2013-14.pdfw

4. Lessons Learned

The experience of working within the West Kent Recovery Service (and previous RSA Whole Person Recovery work) has given us a clearer understanding of some of the key priorities that need to be included when trying to translate the theory into practice and learn from the best evidence available. The challenge for the RSA and others working in this area is that our aim is to both argue for a flexible approach based on co-production, adaptation to specific individuals, localities, their economies, communities and service contexts and to develop a replicable model of provision. This report does not argue that what worked in West Kent can be 'packaged up' and replicated in West London or West Lothian, but tries to extract from our work the broader lessons that can be brought to bear elsewhere.

In the final section of this report, page 58, we conclude with recommendations that focus on building a stronger culture and capacities for boosting current approaches to recovery; many of these focus around the skills needed at all levels. In this penultimate chapter the aim is to first draw out our broader learning, focusing on key priorities and insights that can inform not just our own work but the continued work in West Kent and the many recovery initiatives around the UK. Three fundamental issues stand out:

- **Co-production** is key for service users to own, and feel a valued part of their personal recovery process. By developing mechanisms by which people feel empowered to be involved, not only in building their own recovery capital but in fostering it for their peers, capacity is built within the system and beyond. A major theme that emerged during the West Kent project was the power of peers in co-production and also in the continued development and delivery of innovation. A further theme was the importance of co-production with the local community and striving to make recovery better understood; louder, prouder and more visible.
- **A holistic, 'whole person' approach** enables services to encompass multiple dimensions of a person's recovery, increasing the likelihood of success in the short and longer term. Public services are by no means able to 'personalise' around every individual. The best that can be offered as a top down approach is a menu of options. By embracing co-production, service users are able to not only orient the direction of travel around their own needs but also around their individual experience.
- **Social connectedness** – within the recovery community and wider local community – creates a network of support and

> opportunities for individuals, enhancing the sustainability of recovery. By enabling people to exit treatment with a meaningful network of support – the difference between those people who are in their lives because of friendship, shared experience and reciprocity rather than a service provider to service user relationship – connections are enabled that allow recovery to flourish.

This work has highlighted the need for national and local commissioning to be able to better understand and accommodate the factors above in supporting recovery, so that procurement processes and associated impact measurements – whether payment by results or not – empower local providers to be genuinely creative in unlocking these vital assets that form a central component of recovery capital.

i) The power of peers

> "Bored out of your brain on a Saturday night? That's where friends and your community should come in. We can't be expected to be open 24/7 and we don't want people to be dependent on services anyway. I'm there to help them focus and move forward. That's the first step to getting the life that they want but it is only a step. The rest has to come too, but that's not the stuff you get in treatment, it has to be out there."
> **CRI Recovery Worker (2015)**

Peer support in recovery operates at many levels, and across most facets of the recovery system, including: prisons, with inmates forming support groups as well as external support visits; detox centres; residential rehabilitation units; community treatment services and the wider community. Becoming a peer worker can often be an important first step in building community capital and provides people with key social, practical or emotional help when they need it. This kind of support is generally more formal than recovery community activities, although there is clearly overlap, but it is less formal than the support from recovery services, with the key premise being that peers share lived experiences of addiction and recovery. Peer supporters are often trained and supervised by recovery services, or are part of voluntary organisations.

In the UK, peer support might involve a small, local group of people who have experience of addiction offering support, a large network of groups such as Narcotics Anonymous or an umbrella organisation such as the UK Recovery Federation, who advocate and champion recovery networks. Characterised by a culture of mutual giving and reciprocity of resources, peer support is widely acknowledged to be an important asset in helping people to improve their recovery capital through the power of networks. Alcoholics Anonymous (AA) is perhaps the most well-known service for those with a substance misuse problem. Founded in 1935, it is thought to operate in 175 countries around the world, and AA estimates that 97,568 support groups are run under its name internationally. [68]

68. AA Fact File Introduction. Alcoholics Anonymous [Online] Available at: www.alcoholics-anonymous.org.uk/About-AA/Membership accessed 16/10/2015

The level of peer support in UK recovery services is difficult to estimate given its tendency towards anonymity and informal volunteering arrangements. Peer supporters often do not have to sign up or commit to attending activities regularly. The anonymous nature of many activities, some of which might be funded by peer support workers themselves, only compounds the difficulty in collecting complete and accurate data, and it is often only the formally funded activities that require reporting records, which are generally not cross-matched with any other services or verified.

Public Health England refers to the 'extra effect' of peer-to-peer productivity and recognises its value alongside structured treatment:

> "Health behaviours are determined by a complex web of factors including influences from those around us. Community engagement and outreach are often a vital component of behaviour change interventions and the support from peers who share similar life experiences can be a powerful tool for improving and maintaining health." [69]
>
> **Public Health England (2015)**

This has further-reaching effects than simply offering additional support and recovery capital building for people on recovery journeys. In doing so, it is likely to be supporting public services by reducing demand on resources for treatment.

Peer support is a valuable community asset that helps to improve individual recovery capital and the associated community capital it generates. With this in mind, it is important to note the role that both traditional services and peer support groups can have in encouraging and supporting their respective participants in accessing each other's services.

Peer support after treatment

The National Institute for Clinical Excellence (NICE) has recommended that those achieving abstinence through a detox be supported for a further six months.[70] For some this is enough, and given what is likely to be widespread and significant funding reductions it might be difficult to deliver more than this in the foreseeable future. Local formal and informal peer support will therefore be critical to ensuring people have the opportunity to maintain their level of engagement after treatment, building their personal recovery capital and helping others to do similarly through contagion effects.[71]

> "Traditional peer-support like AA/NA had many benefits like having a sense of belonging but didn't point me in any new direction, or give opportunities to do things outside of the meetings."
>
> **West Kent Service User (2015)**

69. Public Health England (2015) Improving mutual aid engagement: A professional development resource. [Online] Available at:www.nta.nhs.uk/uploads/improving-mutual-aid-engagement-a-professional-development-resource-feb-2015.pdf

70. National Institute for Health and Clinical Excellence (2012) Draft quality standard for drug use disorders. [Online] Available at: www.nice.org.uk/guidance/qs23/documents/drug-use-disorders3

71. For further details see: Best, D. and Laudet, A.B. (2010) op cit.

Post treatment, there still remains a higher risk of future problematic drug or alcohol use until, as mentioned earlier, the risk plateaus at around five years of abstinence.[72] Peer support is integral in bridging the gap between leaving treatment and everything else. A participant in the RSA's West Sussex project explained their experience of leaving treatment as being like "falling off a cliff".[73] To sustain recovery capital and ensure dependence free outcomes over the long term, it is vital that ending treatment does not result in a sudden or significant drop in recovery capital. Bridging these 'cliffs' in the journey over the initial five years post-treatment makes for a more comfortable, stable and productive recovery journey, that people can undertake with less anxiety about what happens next.

Challenges to organising peer-support

Our work in delivering the Whole Person Recovery project has highlighted some of the inherent challenges for those co-producing peer support on a local scale. Perhaps the most significant of these challenges is sustainability. We have seen peer groups develop strong local offers, only to have to be scaled back because those championing them, providing the all-important volunteering hours and inspiration, are ready to move into paid work.

There can also be a tension between some peer support, which is largely offered by volunteers, and formally commissioned treatment services. Treatment and recovery services have targets and outcomes to meet, robust risk assessment, business management considerations and operational guidance to adhere to. In a formal service, the balance of power is strongly influenced by those who are able to formally manage others' behaviour or have the professional skills to deliver clinical interventions.

In contrast, peer support is based on an equality dynamic, where everyone is an expert in their own situation. The inherent differences can be challenging, leading to conflict in terms of the 'right way' to encourage and support recovery, despite the general acceptance that a combination of both formal treatment and peer participation is most likely to support people to move forward on their recovery journey. In addition, peer support schemes are generally expected to operate on much scarcer resources than formal treatment, and in operating outside a regulated system, are also likely to be more creative in their genesis and development; peer schemes often deliberately look to help people explore their sense of identity and connection beyond their addiction, which by nature may not be quantifiable by pre-determined outcomes.

> "When we first started everyone thought you must be crazy. You can't let them run their own service. Certainly not at weekends, and because ours aren't abstinence-based anyone can come in. It was no, no, it's a waste of money, it's dangerous. Ten years later almost all tenders coming out in London insist on having a weekend service."
>
> **Tim Sampey, Build on Belief (2015)**

72. NDEC (2014) op cit.
73. Daddow, R. and Broome, S. (2010) op cit.

Continued support within the recovery community has significant positive impact on sustained recovery but individuals also need to ensure that they connect with the wider community and do not become solely dependent on what might be a relatively isolated group.

In overcoming these barriers and more, we have identified from our work in West Kent and elsewhere, a best practice framework. While this may iron out issues in many contexts, our experience suggests that while there could be much better learning between peer support groups, small, localised approaches are a key part of their success. Attempts to scale up, while sometimes successful (such as the network approach of AA or NA), can prevent peer support from doing what it does best, building place-based connection and recovery capital, and creating positive social impact for the group members and the wider local community.

Groups that are able to work more responsively and flexibly are likely to be able to co-produce more effectively to address local need, and there is an increased scope in the ways in which a reciprocal relationship is built

While there has been an emerging rise in other large-scale models, particularly SMART Recovery, effective peer-based support will continue to rely heavily on place-based groups and organisations that are responsive to their communities' different needs. Top down approaches such as those from larger-scale peer support organisations have a tendency to stick to a pre-determined formula or ethos. This leaves less room for recognising the value of the skills that each individual may be able to contribute to the collective capacity in the room. Groups that are able to work more responsively and flexibly are likely to be able to co-produce more effectively to address local need, and there is an increased scope in the ways in which a reciprocal relationship is built. Rather than having pre-determined roles and responsibilities within peer support, this flexibility provides the opportunity for anyone's skills to be utilised.

> "People have different skills and different ideas. I'm a recovery worker. I know my limitations. I can't do for people what their neighbour might be able to do, because when I go home at night I have my family, my neighbours and my community to sort out. Am I best placed to help them outside of treatment? No."
>
> **CRI Recovery Worker (2015)**

Peer support should be as locally responsive as possible and may be improved by light touch oversight, if requested. However, we also recommend greater sharing of learning, so that peer support groups can benefit from the experiences and insights of others. There are myriad situations and safeguarding procedures that are likely to be applicable in any peer support group and there are organisations in existence that have already identified the best ways to approach these operational challenges.

Greater attention needs to be given to the factors that encourage (or discourage) members of the recovery community to become what are commonly known as recovery 'champions': people who can have influence and who are connected to people in their area who can 'get things done'. In particular, there needs to be stronger emphasis, alongside learning from people's 'expertise through experience', on empowering individuals in recovery through coaching and upskilling, enabling them to access the skills needed to support newer members of the recovery community. Such an approach should not only help to create a 'ripple effect', being an important role model to others, but also as CRI has shown, providing

important employment and professional development for those individuals who aspire to work in the sector.

We suggest that much could be gained from creating an online platform for ongoing learning, development and networking between those who are involved in peer support. This could include a toolkit with practical advice about becoming involved in peer support as well as being a repository for skills, experience, practical innovation and evaluation. There are many organisations with the capacity to host this kind of platform (indeed some initiatives already exist in different guises) and that already have good links with the peer support community and treatment services. However, it is important that a resource such as this is not owned (in terms of intellectual property) by the platform organisation but developed by and for those with experience of offering peer support as an open resource.

Best practice

Our experience in building the Whole Person Recovery project, as well as numerous conversations and interviews with peer participants, professionals and wider stakeholders, has highlighted what we would consider to be best practice in promoting peer support.

- **Position local peer support** as part of the core offer within a community, rather than added value.
- **Champion peer activity:** building strong relationships with the recovery community within formal services to promote local peer activity. This promotes the 'contagion effect' of recovery and informs people about the recovery opportunities outside of services.
- **Share resources:** treatment services often have plenty of available space, especially during the evening and at weekends, when many people feel they most need support. Services should ensure that, where possible, publicly funded space is available to peer support groups. We recognise that handing over the keys can be difficult; volunteers often need to go through disclosure and barring checks and clinical services rely upon secure access to sensitive personal information. However, we have seen this work extremely well in West Kent and there are countless other examples across the country. The sharing of marketing, social media presence and having shared local campaigns and objectives is important in bringing together a vision for the local community.
- **Access to high quality information:** through online and traditional marketing material, helping to raise awareness of local services and their benefits. Information needs to be up to date and readily understandable. This will help to inform service users, recovery workers, peer mentors and group leaders about available options in their area.
- **A shoulder to lean on:** where necessary and appropriate it can be helpful for people new to peer support-based recovery if someone they trust can go along with them. Recovery workers should be encouraged, where appropriate, to attend peer support with their service users so that they can better understand what is available locally. Peer support should extend, where possible, to the service user's friends and family to develop the widest networks and to enable others to go on the recovery journey with the service user.
- **Proportionate risk management:** treatment services undertake disclosure and barring checks, risk assessments and offer ongoing supervision to their volunteers who are in positions of responsibility. This should not preclude someone from setting up a peer support activity on the same site. It should be understood, agreed and supported by commissioners that peer support is distinct from clinical service provision but can operate in a safe and responsible way.
- **Connect to the wider community:** peer support can and should be used as a resource to contribute to community solutions on a wider level. While usually set up as a front line resource, the capacity within the sheer number and commitment of these volunteers could be utilised to address wider community challenges, such as skills and employability, public health, and wellbeing.

The limitations of peer support

While the Whole Person Recovery model aims to help people build their recovery capital at every stage of treatment and recovery, it is important to recognise that there is a distinct group of people within treatment services (and indeed, some who never access treatment) who do not feel ready or able to make significant changes. For this group, who struggle most with making movements towards long term recovery – people who are very traumatised, have extremely low recovery capital, co-morbidity, entrenched behaviour, or are treatment resistant – helping them to manage their own high risk behaviour is hugely important. A focus on recovery should never stigmatise or minimise the value of harm reduction initiatives that save lives, such as needle exchange programmes, hepatitis and HIV management, testing and regular monitoring, which reduce harm, both to individuals and the community.

There are numerous individuals that fit into the above categories who have still attended Whole Person Recovery initiatives in the West Kent Recovery Service. In one particular site, an individual remarked that being able to attend activities for a few hours in the day made him feel safe and for that few hours, he chose not to use drugs. For him, this was a significant change in behaviour, and it may be something that he feels able to build on in the future.

The Whole Person Recovery approach advocates as many peer support approaches as possible. This allows room for groups who may exclude by default such as Alcoholics Anonymous (for those who have a desire to stop drinking), or abstinence-based groups (who would not allow someone who is currently using drugs or alcohol to attend). Exclusion is often in order to create a space where people feel more comfortable or to allow for people to bond through their similar experiences (having a problem with alcohol for example). Where these types of groups exist, it is essential that there are also open activities or groups that allow for inclusion, where people can attend as long as they are able to abide by rules around their own behaviour (not bringing drugs or alcohol onto the premises for example). These types of groups allow for a more open response to the developing world of drug use in particular, where the widespread heroin epidemic is far less prevalent than it used to be, and where a rise in the use of Novel Psychoactive Substances (also known as 'legal highs') has presented a challenge for services. Where there are mechanisms for all and any individuals to 'get involved' in peer support, everyone is able to contribute by way of their own experience.

ii) Visibility and stigma

> "The stigmatisation of people with drug problems has serious consequences for government policy. Key policies seeking greater reintegration and recovery, moving people from benefits into work, and a focus on public health will not succeed while stigmatising attitudes are pervasive. If people with drug problems are seen as 'junkie scum' and 'once a junkie always a junkie', people will be reluctant to acknowledge their problems and seek treatment, employers will not want to give them jobs, landlords will be reluctant to give them tenancies and communities will resist the establishment of treatment centres. As a result, drug problems will remain entrenched rather than overcome."[74]
>
> **UKDPC (2010)**

Additional challenges face those in recovery; in particular forms of stigmatisation and fear. This is felt in wider society, but often it is the case that those with addictions feel that healthcare professionals, landlords or housing providers, employers and employment services and aspects of the criminal justice system also hold unfair prejudices about them that reinforce stigma and makes recovery more difficult.[75]

Figure 7: Examples of negative reporting towards the local recovery community

Recovery services have faced a backlash from local residents in recent years reflecting the stigmatisation of recovery.

74. Source: UKDPC (2010) Getting Serious about Stigma: the problem with stigmatising drug users. [Online] Available at: www.ukdpc.org.uk/publication/getting-serious-about-stigma-problem-stigmatising-drug-users/

75. Ibid.

The fragmented ways in which some public services are commissioned, particularly in the drug and alcohol sector, has meant the formation of highly specialised recovery services that are removed somewhat from everyday 'public' spaces. This invisibilisation of recovery contributes to the stigmatisation of vulnerable groups such as people with drug and alcohol misuse issues. The problem of stigma not only becomes a very real obstacle for the many people with addiction issues who are working on their recovery, but also a barrier to those helping people change their behaviour. The result can be that the isolation, rejection and the subsequent difficulties this can bring, means much of the good work by treatment services occurring behind closed doors is hidden from the wider community. The risk of this is that many of those needing help may not approach services for fear of stigmatisation.

Rather than 'hiding' services behind closed doors, we have been trying in West Kent to highlight recovery in local communities. The project has initiated and taken part in community activities, such as dragon boat races, art exhibitions, volunteering days and picnics. These activities provide the recovery community with an opportunity to speak to people who are interested in the service and what it offers. Forging better links with voluntary services, for example, can give recovery workers the opportunity to include visible interventions in people's recovery plans, and in turn, encourage both service users and the wider community to take pride in what can be achieved. On a national scale there is work going on such as the UK Recovery Walk,[76] but it is important to build local, place-based profiles for recovery. While West Kent is by no means unique in terms of community development, this should be seen as a key priority in commissioned services where embedding into the community is intrinsically linked to recovery capital opportunities.

As our experience in West Kent showed, there is no shortage of people prepared to be vocal about the positive benefits that recovery can bring to individuals, their loved ones and the broader community. But there are not always the structures in place to allow this to happen. Our hope is that other drug and alcohol services and, where appropriate, peer support groups will do the same and that this is supported in commissioning discussions. A more visible approach to recovery in the community can provide a powerful way to overcome this and is essential to the concept of Whole Person Recovery.

> "What makes aspire2be special is that it's run by people who have joined it when they were at their very bottom and through it they've found hope. They've regained their lives and they are there to be a beacon of hope for people who come in and watch that take place, seeing someone coming in at their lowest and be inspirational to them so they find a new life and then can pass that on to other people, that's the real magic of aspire2be."
>
> **Dr Marcus Colman, aspire2Be (2015)**

Recovery is grounded in the community; achieving a valuable level of understanding and co-production between recovery groups and the wider community – that may feel disjointed and disparate – is a significant

76. For more information see: www.facesandvoicesofrecoveryuk.org/

challenge but one that can create a virtuous loop, fostering more understanding and more space to innovate and engage. The rhetoric placing more responsibility with individuals and communities to stand up and meet their local challenges is welcome but needs to be accompanied by strategies, investment and the skills for engagement.

iii) Commissioning for recovery capital

The government and public service reform agenda has placed emphasis on localism and devolving more decision making to the regional and local level, most recently expressed in its Northern Powerhouse plan, as well as increased emphasis on devolution with that most centralised of public services, prisons. Although the Big Society narrative that dominated the early years of the previous coalition government has cooled in recent years, there remains a greater interest in establishing mechanisms that help communities to create their own solutions in response to the challenges that they face.

> "The key ingredients to achieve the desired outcomes are good relationships and a sense of shared responsibility and purpose between commissioners, providers and stakeholders whilst keeping service users and significant others at the heart of everything we do."
> **Gaby Price, Previous KDAAT Commissioner (2015)**

In theory, commissioning should be reflecting these wider shifts; specifying, securing and monitoring services to meet people's needs at a strategic level. The reality for many services however, is a trend towards tightly specified contracts and these may take little account of local links, knowledge and resources. For example, geographical location can be a specific challenge for many people in the recovery community. This was the case in West Kent where costly bus fares and inadequate public transport meant that many of the groups and activities were difficult to access. Working in rural areas often makes it more difficult to deliver the same opportunities to individuals as you might find in cities and the economies of scale are much smaller. Consideration should be given for a greater per capita budget in areas outside of big cities, or to encourage more thinking about where spend might be appropriately managed to help overcome these types of barriers, for example brokering local public transport agreements.

Too often services are procured under tight timescales in line with strict contract and procurement regulations, with commissioners and service providers facing political and financial pressures and fearing legal challenges. Positive and close working between commissioners, service providers, and any related organisations – as we saw in Kent – developed a shared vision, which translated into better practice and more innovation. For them, the challenge is to ensure the right level of expertise, leadership, workforce development, governance arrangements and a commitment to ongoing innovation, ensuring that services present value for money while meeting the needs of the population.

Place plays an important role in the development of community recovery opportunities and needs to take into account the physical geography, assets, culture and people. Some interventions work

effectively in vibrant cities where recovery communities are more concentrated: recovery colleges are a notable example of this. Smaller towns, and treatment services that cover large, rural areas need to be much more creative about how to engage with service users, where place (especially physical location) can be a barrier as well as an asset. Interventions need to be designed in response to local need that takes advantage of local opportunities.

More radically, there is a need for commissioners to 'catch up' with the evidence and rhetoric around recovery and the sea change in approaches that are taking place in many areas (such as Essex as well as Kent). This means reconnecting and supporting innovation on the ground, particularly in relation to the role of peers and local communities in supporting recovery locally. This could involve, for example, ensuring that supporting peer-led recovery and community engagement initiatives becomes an integral part of the commissioning process alongside treatment, recognising that treatment providers themselves may not be in the best position to support this work. This might include small pots of funding or the creation of service level agreements for treatment services to facilitate and fund peer support and/or create new community networks or events.

There is also a need to develop a national evidence base for peer support around recovery. Commissioners are in a unique place to support this type of work; mapping the local peer support resources and supporting the collection of data, while recognising the challenge of data collection within informal environments. The development of local peer-led Research and Innovation Teams (RAITs), gives a unique opportunity to gain insight into local practice.

Measuring recovery

> "Commissioning of drug and alcohol services should be outcome based and make use of available data and information."[77]
>
> **Joint Commissioning Panel for Mental Health (2013)**

Definitions matter as they drive strategy and impact frameworks. Policy changes tend to err towards measuring things that are familiar, absolute and can be quantified in the short term. But statistics belie a more complex set of issues especially for those individuals that are hardest to reach and have low recovery capital.

A greater focus on recovery capital and the mainstreaming of peer work, and a more community facing approach to support this, brings with it other challenges, including the need to be clearer and more expansive about the impact that services are expected to make.

Yet, as we have said, the field of addiction treatment lacks a universally accepted and unambiguously defined clinical definition of recovery. The increased focus on personalisation and a switch in focus from treatment to recovery has not seen any widely applied change in

77. Joint Commissioning Panel for Mental Health (2013) *Guidance for Commissioning Public Mental Health Services.* [Online] Available at: www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf

metrics. It is not then surprising that measuring success in addiction remains a huge challenge. The most widely used measurement tool, the Treatment Outcomes Profile (TOP) makes some very basic benchmarking assessments of wellbeing. The completion of a recovery measurement tool such as the TOP form may be widely influenced by individual practitioner and treatment service culture around expectations for recovery. If the recovery paradigm is blurred then how can we measure recovery? We need a better and agreed understanding of what recovery is and how it becomes sustainable over the long term.

William White defines 'recovery' as: "The experience (a process and sustained status) through which individuals, families and communities impacted by severe alcoholism and other drug problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by alcohol and other drug-related problems, and develop a healthy, meaningful and productive life."[78] The challenge then is to assess all of these factors to create a comprehensive and objective 'picture' of recovery (a huge and time-consuming task). Although the metrics of health and productivity can be assessed through wellbeing and economic indicators, ultimately the person best placed to define and assess the extent of meaningfulness and value of their life is the individual to whom it belongs.

We suggest that key performance indicators for measuring recovery be set around nourishing environments that support recovery capital. It is important that this work is not seen as supplementary or 'added value', but the core of what all of the work in the recovery sector is trying to achieve.

Drug and alcohol services should be monitored in part by the achievable outcomes that individuals in recovery have helped to co-produce (alongside overall treatment outcomes) with local communities contributing to discussions about local priorities; a shared measurement system for all wellbeing services – including mental health and housing services – should be explored, in order to work towards services and support collective impact for the many individuals these services work with that face multiple disadvantages. We would argue that the amount of focus and effort put into 'care planning' during treatment should be translated into a measure that allows the person to plan for recovery and score against self-defined metrics.

78. White, W. (2007) Addiction Recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33(3) 229-241.

5. Building the Skills for Recovery

> "Recovery from addiction isn't the modern scarlet letter. It's a badge of honor, and I keep mine pinned to my chest because we need to illuminate the solution just as frequently as we broadcast the problem."[79]
> **Carly Keyes, Michigan Daily (2015)**

While our primary purpose has been to test ways of improving individual and collective capacity, as this report concludes, this has implications for commissioners, providers and policy makers; in particular the culture and skills needed to support recovery. We have largely moved away from the days of *treatment vs recovery* but there remains a lack of deeper understanding and ability to effectively operationalise approaches such as recovery capital and co-production. Being clearer about what we mean by recovery, the long term nature of many people's progress and the importance of recovery capital in supporting this would go some way to bridge the gap between theory and practice, rhetoric and implementation, including what we measure.

There remains a capacity issue. Too often we are using the simpler tools of yesterday to try and solve what are now more complex and rapidly changing problems. This can leave recovery services with a *Catch 22*; we intuitively know that the mounting evidence of positive peer effects is worth listening to and acting upon. We understand that alcohol and drug misuse is a problem, that requires the community to be more engaged – be they service users, the families or local communities – bringing not only important untapped assets to the table but also providing more 'space' to take risks and innovate. Commissioners want their local services to be creative; indeed current resource constraints demand this, but they can struggle to understand what creative commissioning looks like having got used to highly structured and prescriptive impact measurements and contracting processes.

Since the RSA's Whole Person Recovery work began some eight years ago, we have been part of a wider shift in thinking, towards a more health-based approach to substance misuse, and growing acceptance of the need to see recovery as a complex and nuanced process, linked to

79. Keyes, C. (2015) Viewpoint: Recovery is a Reality. *The Michigan Daily*. [Online] 22nd September 2015. Available from: www.michigandaily.com/section/viewpoints/viewpoint-recovery-reality.

people's wider internal and external resources; their recovery capital, including their access and engagement with treatment. In the areas we have worked, it is clear that there is a desire for innovative ways of working and – most critically – a deep commitment to improving the lives of those who experience addiction or drug and alcohol misuse and those of their families and communities.

In times of economic austerity, we are acutely aware of the futility of simply demanding more public resources; although this is a factor facing local recovery services and partner organisations. The implementation of a whole person, place and community approach is not one that comes without direct financial cost, however the West Kent project demonstrates the opportunity to help build and strengthen recovery communities, adding significant value to the recovery experience and local recovery outcomes.

To this end, we recommend the following:

1. **The Department of Health should engage with Public Health England, NHS England and the professionals that deliver health and wellbeing services and the recovery community to develop a shared and consistent understanding of recovery.** This should focus on recovery as the long-term shift to improved wellbeing that is embedded in the person, place and community. Outcomes should be measured in a way that reflects an individual and community recovery perspective, with key performance indicators being set around nourishing environments that support recovery.

   This concept of recovery also needs to be reflected in the metrics used to monitor recovery achievements. Whilst current metrics in recovery are useful, research has demonstrated that risk of relapse is significantly higher for up to five years post treatment. This should be taken into account with a system that enables tracking throughout health services on a long-term basis and measures recovery capital (or wellbeing capital) in a holistic way.

   A shared measurement system is needed that combines subjective wellbeing indicators alongside service-based metrics (such as contact with wellbeing services and peer support) for at least five years after contact with recovery services. This should enable self-measurement of wellbeing indicators by an individual as well as by wellbeing services (such as NHS services, mental health, housing and employment).

2. To improve outcomes at a local level we recommend Public Health England drive the **development of a Creative Commissioning for Recovery** approach that would meet commissioners' aspiration for more creative and flexible procurement. This could have a number of components but should be place-based and co-produced to ensure they are relevant to the communities they serve. Examples (including some used within the West Kent Recovery service) might include:

- **Define innovation capacity as a core competence for commissioners.** Review the skills, knowledge and tools available to commissioners, sending a clear message that innovation – alongside effective safeguards and evaluation – will be welcomed and rewarded.
- **Encourage asset mapping.** Explore the use of local recovery mapping that identifies the actual and potential assets within a community that can help sustain people's recovery.
- **Trial personal budgets.** The use of 'small sparks' – personal or small group budgets – can enable the building of recovery capital on a local level and allow targeted support for wider wellbeing.
- **Place peer support as a central component to recovery programmes**. Peer support should be recognised as a major component in recovery rather than marginal added value. This should include use of recovery **community-led Research and Innovation Teams (RAITs)** to explore the use of peer led insight and inquiry, enabling peers to undertake research with local partners and co-produce local responses to problems. **Recovery communities would benefit from greater sharing of learning and expertise.** Where possible, data should be collected to inform commissioners, researchers and other peer support groups about the value and use of peer support.
- **Encourage more than peer support, and invest in peer mentoring.** Emphasis should be placed not only on peers' current expertise through experience but their wider capacities and potential for employment progression. To this end, greater investment is needed in **coaching and upskilling recovery peers,** both in terms of commissioning models and investment of enablement from treatment services.
- **Proactively engage with the local community.** Recovery communities should view themselves as a crucial link to wider recovery capital in the community. They should seek to develop implicit social contracts with community groups, to transition networks and raise awareness of the value and skills of those in recovery in order to reduce the damaging stigmatisation that prevents the building of community recovery capital. In our experience, the appetite for change is there and we have observed the commitment and willingness amongst service users, local communities, providers and commissioners to embrace new approaches to recovery, including many of the ideas set out in this report.

3. **Recovery service providers should enable capacity to support community focused skills and activities within services**. Our work recognises the intrinsic difficulty involved in bringing the capital and assets of recovery communities into their wider neighbourhoods and vice versa. Through this programme we have observed that community development can be highly challenging, but have found enormous value in having the capacity and resources and credibility to generate this. Skills

such as stakeholder engagement and management, the ability to lead on project and events management, and the capacity to effectively influence a community wide agenda. This role can be pivotal in encouraging reciprocity and enabling creative capacity from recovery communities.

There has been a sea change in thinking about recovery and we have argued here that this needs to be reflected in the way that services are designed, funded, commissioned and measured and suggested some ways this could be done. This work chimes with other practice and research done elsewhere, in particular with people who experience multiple needs and social exclusion. Ultimately what much of this work highlights is the need for profound systemic changes based on better understanding of people's capabilities and how these are supported or constrained by their social and individual context. This requires that we see addiction, not as an individual 'battle' that people can win or lose, but part of a much wider social issue that requires a much wider social response. We hope this report makes a small contribution towards that end.

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