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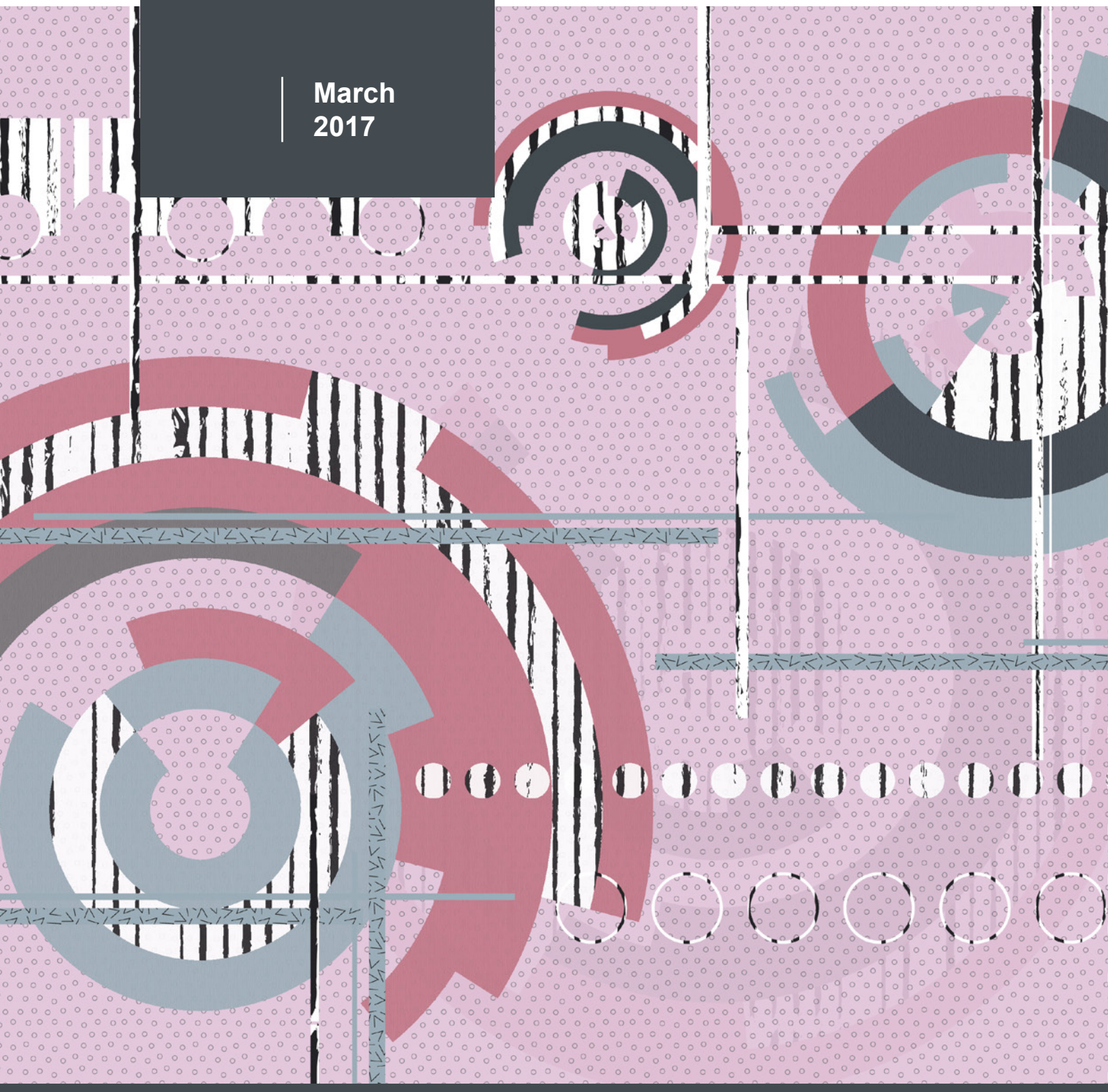

Evaluation of Four Recovery Communities across England: Final report for the Give it Up project

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1. EXECUTIVE SUMMARY

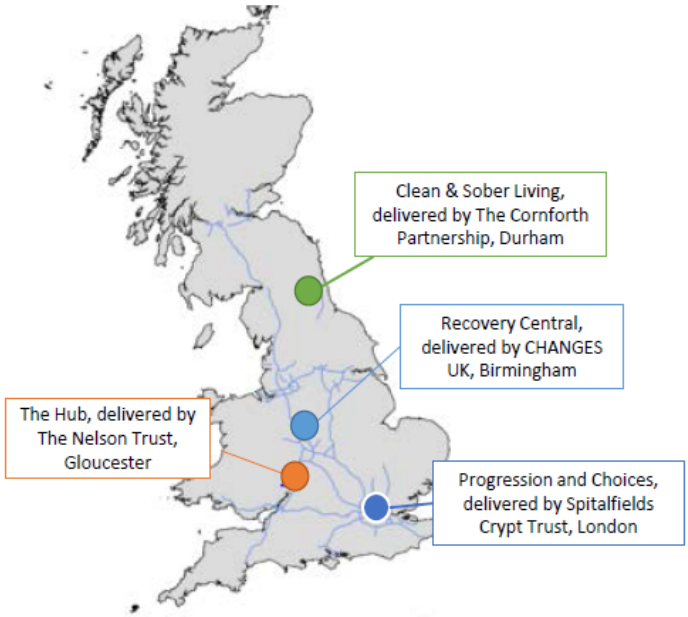
Introduction

Substance misuse is a key public health priority within the UK. Recent policy recommendations have highlighted the importance of providing services which focus on substance misuse recovery, not just treatment. Such support provides individuals with the skills and experiences they need to address key issues in their life which support their substance misuse recovery. It is hoped that this approach will help people to maintain abstinence and avoid relapse.

It has been recognised that the development of recovery capital is key to successful recovery. Recovery capital refers to the resources available to sustain recovery and refers to four key elements: human capital, social capital, physical and economic capital and cultural capital.

Current service provision is predominantly provided by NHS, Local Authority and voluntary sector organisations. Some substance misuse provision in the UK does include a recovery function, however, recovery communities have an important role to play in delivering a range of services to support the development of recovery capital.

The Comic Relief 'Give it Up' Fund is a programme that aims to develop and build abstinence-based recovery communities and learn more about their value. The Give it Up Fund was delivered between October 2014 and October 2016 to support the development of recovery communities in four geographical locations in England:



Purpose of research

In October 2014, the Public Health Institute (PHI) at Liverpool John Moores University was commissioned to undertake an evaluation of the Comic Relief Give it Up recovery communities. The evaluation aimed to understand the key outcomes generated by the recovery community, with reference to recovery capital outcomes. The primary research question for the evaluation was: **How do the recovery communities help people to maintain abstinence?**

The evaluation focused on the following objectives:

Exploration of key recovery outcomes and the impact each community has on the recovery of the people who use them
Exploration of how recovery communities help people to maintain abstinence
Evidence of the best ways of building personal and social capital to ensure people feel empowered and enabled to create change and improved health and life outcomes
Evidence of the social value that recovery communities create

Understandings of the delivery approach taken for each project and how they support recovery communities
Understanding of the organisations that need to be involved in delivering and supporting recovery communities
Understanding of how the partnerships, peer support, awareness raising and training of service providers within each project contribute towards recovery
Evidence of what recovery communities add to existing statutory service provision

Methodology

Personal experiences and outcomes of recovery can be difficult to capture. This evaluation used a mixed-methods approach to understand the impact of the recovery communities. A social value approach was taken to enable understanding of the social impact created by recovery communities; where possible, Social Return on Investment (SROI) analysis was used. This was accompanied by a process evaluation to explore the operation and delivery of each recovery community.

Forecast SROI

A forecast SROI is used towards the start of an activity and can demonstrate how investment can maximise impact and provide evidence of what needs to be measured throughout the duration of the project. The forecast SROI was undertaken at the start of the evaluation and aimed to explore how much social value would be created if each project activity met its objectives. Stakeholders were asked what would change for them and what would be the most important changes. The SROI also identified and valued negative and/or unintended outcomes. The SROI involved five stages: establishing the scope of the SROI and identifying key stakeholders, mapping outcomes, evidencing outcomes and giving them a value, establishing impact, and calculating the SROI.

One community (Clean & Sober Living) was not sufficiently developed for a forecast SROI to be undertaken; therefore an outcome evaluation that used a social value approach was delivered.

Evaluative SROI

The evaluative SROI took place towards the end of the research, during year 2. An evaluative SROI takes place retrospectively, and is based on actual outcomes that have already taken place. To do this, participants in each of the recovery communities were asked to confirm that the outcomes identified in the forecast SROI were still applicable. Additional outcome data were also collected: the *Warwick-Edinburgh Mental Wellbeing Scale* and the *Assessment of Recovery Capital Tool* were selected as the most appropriate and feasible tools. The measures provided evidence of the key outcomes identified in the forecast SROI, and are measures that recovery communities can continue to collect to help develop and understand the profile of the wellbeing and recovery capital of their members. To further

support the evaluative SROI, qualitative interviews were undertake with representatives from recovery communities, in order to further explore and validate outcomes.

Process evaluation

To complement the SROI research, process evaluations were undertaken across each recovery community. This method gathered insight from stakeholders involved in delivering the four communities about their experiences, perceptions, barriers and facilitators of project delivery. These process interviews also elicited perceptions of the programme, including issues regarding barriers and awareness.

In the case of Clean & Sober Living a second process evaluation was undertaken in year 2 of the evaluation due to a change in evaluation focus.

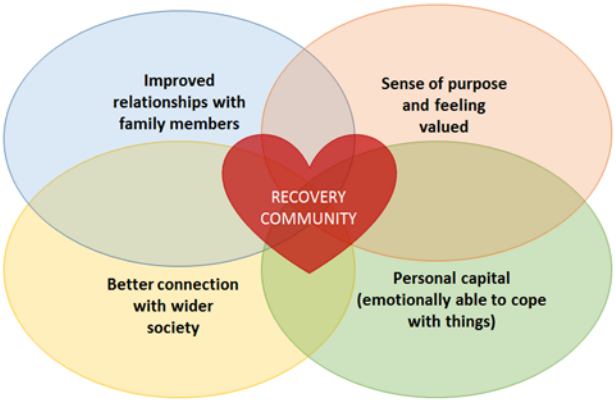
Findings

The key findings that may be taken from this evaluation are:

Key outcomes – achieving and maintaining abstinence

Four key inter-related recovery outcomes were identified across all of the recovery communities: a sense of purpose and feeling valued, personal capital (e.g. resilience, emotional stability, feeling responsible), improved relationships with family members and friends, and a feeling of being connected or belonging to wider society. All of these outcomes align to key elements of recovery capital. We know that in general, high levels of recovery capital enable individuals to cope and manage better with their lives, which in turn has implications for successful achievement and maintenance of abstinence. This research tells us more about which elements of recovery capital, namely personal and social capital, are important for abstinence and how recovery communities can support the activities that impact upon recovery community members.

Key recovery outcomes



How recovery communities support development of social capital – peer support

Peer support is important in helping people in recovery to manage addictions and maintain abstinence through the provision of emotional and practical support, and being part of a group and fostering social identity. Peer support was seen to be a key factor of each recovery community. This was achieved through the development of new social networks and activities within the communities; as

a result, recovery community members developed a strong sense of common purpose and meaning. People who were peer mentors were eager to have an opportunity to "give back" to the community themselves. These roles within the recovery community provided a foundation for developing skills that participants thought were vital for personal progression, maintenance of abstinence and the recovery journey.

How Give it Up recovery communities support development of cultural capital outcomes – reducing stigma

Stigma has been identified as a barrier to recovery, which impacts upon individuals' reintegration into society. Across the recovery communities, peer mentors acted as role-models for those who were less experienced and this was seen to reduce stigma by increasing visibility within and outside of the recovery communities of those in recovery from addiction.

Whilst this research did not look to measure stigma directly (due to the scale and scope of the research), the topic of stigma did arise through conversations with recovery community members. In order to try and tackle stigma that may stem from a lack of understanding, recovery communities provided training on addiction and recovery. Communities also delivered events for a range of professionals and organisations to further increase visibility. Participants in this evaluation described how activities of this type can reduce social and structural level stigma.

How Give it Up recovery communities support development of physical and economic capital outcomes – facilitation of education, training, volunteering and mentorship

The recovery communities developed and expanded opportunities for those in recovery by providing a number of opportunities to attend educational courses and training and carry out volunteering and mentorship. These opportunities aimed to help members to gain skills and qualifications to prepare for future employment and reintegration into society. The SROI results showed that these outcomes had been achieved by each recovery community.

How Give it Up recovery communities support development of human capital outcomes

This evaluation found that participants were more resilient as a result of engaging with the recovery communities. Members of the recovery community described how they were more emotionally able to cope, felt their lives had developed meaning, had improved relationships with family members and better connections with society. These outcomes demonstrate that the recovery communities support the development of human capital.

The role of abstinence in the recovery communities – differing definitions

Whilst all of the recovery communities focussed upon abstinence-based recovery, this was demonstrated in different ways. For example, one recovery community had clear guidance on substances that members were permitted to take, and this excluded use of some medicines such as antidepressants; whilst another incorporated a harm reduction approach for participants at the beginning of their recovery journey. On the whole, these differing approaches did not appear to impact upon the success of the projects under evaluation. This success was instead dependent upon a number of important delivery factors, which are detailed below.

Important delivery factors – cross-cutting regardless of geography

The most important factors central to a successful recovery community were shown to be cross-cutting between and within the abstinence-based recovery communities and their members, irrespective of the geographical location or the specific service that was under evaluation. These key

factors were: *person-centred recovery*; *flexible provision of services*; and *connections to education, employment and training*.

This has implications for service provision and effective delivery of abstinence-based recovery communities and related programmes across the UK.

The role of partnerships in delivering successful recovery communities – collaborative working and barriers

The value of the recovery communities is that they appeared to have freedom in their approach to service provision and delivery and were more responsive to change. Collaborative working was considered to be important in gaining the best possible outcomes for recovery community members and links were seen to have been made to government funded services such as housing providers, local colleges, businesses and third sector organisations. Communities described how tensions were present when attempts were made to develop relationships with statutory (and non-statutory) services promoting harm reduction due to differences in focus and approach to recovery. This has implications when looking at how best to integrate recovery community provision into overall substance misuse services.

It was also considered a barrier across the recovery communities to establish working relationships with 12-step programmes. Whilst many of the recovery community members accessed 12-step programmes (as well as other mutual aid groups within their recovery communities) and one of the recovery communities hosted 12-step recovery meetings in their building; 12-step programmes were seen as reluctant to engage with and promote other organisations who follow abstinence-based recovery. This may be due to the differing approaches to achieving and maintaining abstinence, but would benefit from further investigation as to how best to support collaborative working.

Social value – evidencing 'good' value

The SROI analysis carried out with three of the recovery communities placed a financial valuation upon the wider social value created by the recovery communities. All of the three recovery communities evidenced that the projects they are running (for which Give it Up funded) are 'good' value for money.

Data collected by evaluation participants indicated what may have happened if the recovery communities had not been available. People explained how a variety of issues may have arisen which would have impacted on their recovery. Specifically, people described how they would have a lack of structure, routine and direction; they may have poor or no relationship with family or friends; they may have poor accommodation; and they may be involved in criminal behaviour. Ultimately, people described how they may have poor mental health, they would be unable to cope, and they would either struggle to maintain their maintenance of substance misuse or relapse if abstinent.

In terms of valuation, the SROI analysis found that for every £1 spent, the following return was seen:[1]

	FORECAST SROI	EVALUATIVE SROI
SPITALFIELDS CRYPT TRUST	£6.61	£5.19
CHANGESUK	£9.24	£5.12
THE HUB	£5.17	£9.71

[1] An SROI was not completed for Clean & Sober Living

The figures from the forecast SROI represent the anticipated social value; this information is useful when predicting the potential value that could be created by the recovery communities. The evaluative SROI figures provide a reflection on the actual social value created by the communities. A decrease from forecast to evaluative SROI does not suggest a negative result, rather demonstrates how the actual outcomes compare to what may have been expected.

It is particularly important to note that SROI values cannot be compared across recovery communities. For each evaluation, ratios have been calculated based on the specific circumstances and experiences of each recovery community. Although experiences and outcomes for participants engaging in each recovery community were similar, they are also subjective to the demographic and geographic areas of each community, as well as the group of people who engaged with the research and those who completed the wellbeing and recovery measures. This is a recognised limitation of producing SROI valuations and is why the story of change (the outcomes and findings described here) are the most important findings from this evaluation.

Policy perspectives – models of delivery and sustainability of recovery communities

The recovery communities that took part in this evaluation were all third sector organisations that sit outside of traditional local authority and NHS organisation structures. Each recovery community was developed in order to meet the needs of the local community and support gaps in existing services. Each community provides different methods of delivery, whilst broadly tackling the same issues.

Given that current policy advocates the importance of providing recovery services alongside treatment services, communities such as those funded by Give It Up have a significant role to play. Results of this evaluation show that locally delivered recovery communities address the needs that other statutory services may not have capacity and/or resource to provide. Recovery communities provide a valuable role in supporting people to recovery and to maintain this recovery; this reduces the burden placed on statutory service provision. All of the recovery communities echoed that there is no 'one-approach fits all' for substance misuse treatment. Recovery communities described they had freedom to change delivery to meet the needs of their community and were able to be more responsive to change.

Many areas across the UK are seeing an increase in volunteer recovery champions (and this was evidenced in the recovery communities), but a decrease in salaried frontline staff and (expensive) specialists such as addiction psychiatrists. Recovery communities such as those included in this research, therefore provide a useful contribution to the overall service provision and contribute to improvements in recovery capital that have not traditionally been addressed by structured drug treatment.

All the recovery communities raised concerns regarding their sustainability, particularly in a climate with limit funding and budget constraints.

Conclusions

The Give it Up recovery communities clearly contributed to the development of recovery capital. This enabled individuals to cope and better manage their lives, which in turn had implications for successful achievement and maintenance of abstinence.

Each recovery community delivered a wide range of activities which were specific to the needs of their local community. Despite a breadth of activities being undertaken across each community, there were three common themes which applied to the delivery of each community: having a person-centred approach, being flexible in the provision of services, and having connections to education,

employment and training. These operational processes were evident regardless of demographic or geographic area, which suggests these factors are central to delivery of a successful recovery community.

This research suggests that activities related to the provision of peer support appear to be most strongly linked to key recovery outcomes. The development of social networks and activities contributed towards the development of self-confidence, resilience and structure; key elements associated with human capital. The social support also enabled people to attend medical appointments, obtain support regarding housing and debt and develop the resilience to maintain abstinence and their recovery journey. This research adds to our knowledge about social capital and suggests that it may be the most important for building and maintaining resilience.

Although UK drug policy emphasises the importance of recovery, there is a lack of evidence on effective approaches that support outcomes beyond those included in traditional drug treatment. 'Soft' outcomes that are difficult to empirically define are historically acknowledged as a challenge when looking to identify key predictors of what helps/maintains behaviour change and abstinence. It can also be hard to tease out what actual activity or service has helped someone to become abstinent. The mixed methods approach taken by this evaluation provides evidence about the outcomes that recovery communities can achieve. This evaluation also provides insight into the factors of delivery that are most important in ensuring these outcomes are achieved to maximum effect.

2. INTRODUCTION

2.1 Background

The number of drug-related deaths in England and Wales is increasing with levels at their highest since 1993 (Office for National Statistics, 2015). However, the proportion of people completing treatment for drugs is also increasing (HM Government, 2013). The health and socioeconomic impacts of substance misuse are widespread with far reaching effects on health, wellbeing, crime, families and the wider economy (Department of Health, 2015). Contemporary recovery-models of treatment for substance misuse now recognise the added value of community-based support systems that focus on developing individuals' strengths and quality of life (White, 2009). Interventions to address drug and alcohol-related problems and reintegrate individuals back into the community have been detailed in the Government's *2010 Drug Strategy*, the *2012 Social Justice Strategy* and the *Alcohol Strategy* (HM Government, 2010; 2012a; 2012b). Recommendations include the requirement to concentrate on a whole person approach, focusing on more than just drug use, abstinence and remission; but also helping the substance user achieve positive relationships, good health and wellbeing, secure employment and housing (ACMD, 2013).

The recovery process

Although there are no normative definitions, recovery has been described as "*A process of voluntary sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society*" (UK Drug Policy Commission, 2008, p.6). Successful recovery can be characterised by individuals, families and communities voluntarily taking control of the problems associated with substance misuse, and becoming empowered to take on roles and responsibilities which enable them to lead healthy, productive and meaningful lives (Best et al., 2012; White, 2007; UK Drug Policy Commission, 2012). Aside from individual motivation, behaviour change and stable alcohol recovery is also dependent on resilience-building motivators such as developing a strong sense of purpose by way of meaningful activities, strengthening supportive social networks, and having access to permanent supportive living accommodation and health care services (Best et al., 2012; 2015; 2016; Collins et al., 2016). Recovery can promote ways of seeking a more existential meaning in life including creating a new identity, improving relationships with family, restoring dignity, gaining self-acceptance and feeling a sense of community (Irving, 2011; Mawson et al., 2015; Wittouck et al., 2013). Positive recovery experiences may also incorporate aspects of spirituality that are associated with wellbeing more generally, such as gratitude, self-compassion and using personal experiences to help others (Kaskutas et al., 2014). There is increasing recognition that the development of strong social networks and self-esteem plays an important part in enabling individuals to recognise the significant role they can play in their own recovery (Bracken et al., 2012; Kelly et al., 2009; Tew et al., 2012).

Recovery capital

Recovery capital refers to the quantity and quality of resources that a person can draw on to initiate and sustain recovery from addiction (Granfield and Cloud, 1999). Originally founded on the concept of social capital, recovery capital embraces the ideas of several social scientists who have placed the function of a person's resources within the social structures to which they belong (Bourdieu and Wacquant, 1992; Putnam, 1993; Teachman et al., 1997). Recovery capital comprises of four primary

components, including; human capital, social capital, physical and economic capital and cultural capital. Specifically, these outcomes may include:

- Human capital (health and wellbeing) recovery outcomes, such as
    - Mental wellbeing
    - Nutrition
    - Hygiene
    - Living in deprivation or poverty
    - Exposure to violence
- Social capital outcomes, such as
    - Family
    - Friends
    - Carers
    - Communities
    - Benefits to organisations (such as service providers) as a result of collaborative working
- Physical and economic capital outcomes, such as
    - More appropriate housing options
    - Increased job opportunities
    - Reduction in substance-drive offending
- Cultural capital outcomes
    - Reduction in stigma and discrimination within communities

A key strength of this approach is its consideration of wider social and environmental determinants of health that support people in recovery to maintain long-term absenteeism. Research has shown that individuals who have a high level of recovery capital are more able to manage their circumstances and achieve their personal and professional goals, which enables them to achieve their full potential, allowing them to reach an optimal quality of life and positively contribute to society (Laudet, White, and Cloud, 2008).

Peer support mutual aid groups

There is strong evidence to suggest that positive social support networks help support people in recovery to manage their addictions and maintain abstinence (Litt et al., 2009; Stevens et al., 2010). In terms of recovery capital, the importance of peers and social networks has been found to be integral to the recovery process (Timpson, et al., 2016). Among various studies, high levels of social support has been associated with decreased levels of relapse (Granfield and Cloud, 2001; Laudet et al., 2006); improved resilience to stress, depression and anxiety (Best et al., 2015); enhanced subjective wellbeing; and improved quality of life among individuals with substance misuse disorders (Laudet and Stanick, 2010; Mericle, 2014). However, it is common for people in recovery to face isolation and limited social support following the loss and erosion of family relations (Dingle et al., 2015), and drug-network friendships along the course of the recovery process, which can be a distressing experience (Granfield et al, 2001; Laudet et al., 2006).

One significant form of social support in recovery is that provided by peers. Various studies have reported an inverse association between positive peer support networks and recovery relapse (Litt et al., 2009; Moos, 2008; Neale and Stevenson, 2015; Panebianco et al., 2016; White, 2009). Peer support offers opportunities to adopt more positive social norms that promote engagement in enjoyable sober activities and non-drug use, which override the norms of pro-drug use networks (Laudet et al., 2004; Longabaugh et al., 2010). Peers can also provide diverse forms of emotional and practical support,

including financial support, childcare, and a safe place to live (Neale, 2001; Neale et al., 2012). Moreover, there has been progressively increasing evidence to suggest that being part of a group and fostering a social identity is supportive for recovery (Best et al., 2010; Buckingham, Frings and Albery, 2013; Kaplan et al., 2010; Pagano, Post and Johnson, 2011; Pagano et al., 2013). Through engaging with others who have been through a similar experience, people in recovery are more able to overcome other accompanying addiction problems such as depression, isolation, and stigma (Best et al., 2015; Hester et al., 2013). In recent years, peer support recovery groups, such as the 12-step fellowships (such as Alcoholics and Narcotics Anonymous), that make up 98% of mutual aid recovery groups in the UK, have gained a new impetus as the relationships between substance users, peer mentors and recovery champions are being increasingly valued (NTA, 2013).

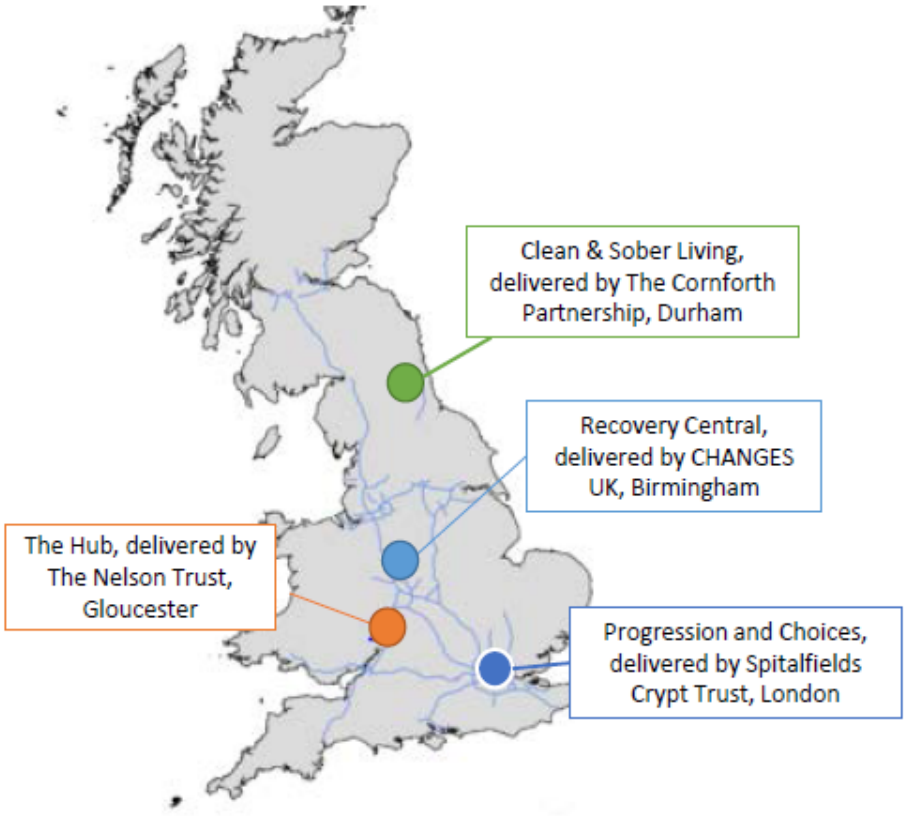
Understanding the recovery experience

Compared to the USA, recovery-orientated policies in the UK are less developed and the evidence base supporting the effectiveness of intervention programmes delivered in the UK are in their infancy (Humphreys and Lembke, 2014). The most recent systematic review on personal recovery in mental illness identified five key processes to recovery including empowerment, self-compassion identity, meaning in life, and hope and optimism (Leamy et al., 2011). However, such unique personal experiences are inherently difficult to empirically define (Laudet, 2007; Knopf, 2011; Witbrodt et al., 2015) which presents challenges to establishing key predictors to alcohol behaviour change and long-term abstinence, and effective community-based recovery approaches (Campbell et al., 2011). Quantitative approaches alone, such as randomized control trial studies, offer limited contextual understanding or insight into the underpinning factors that facilitate and/or restrict people in recovery from maintaining long-term behaviour change. Qualitative methodologies allow for perceptions, attitudes and the lived experience to be explored and can present an effective way of understanding the dynamics of complex social issues such as substance use and recovery (Arnull, 2014; Green and Thorogood, 2014). Further research is required to understand the role of recovery communities in supporting recovery and developing recovery capital.

2.2 Introduction to the Comic Relief Give it Up Fund and the four recovery communities

The Comic Relief Give it Up Fund

The Comic Relief: Give it Up Fund is a programme that aims to develop and build abstinence-based recovery communities and learn more about their value. The Give it Up Fund was delivered between October 2014 and October 2016 to support the development of recovery communities in four geographical locations in England.



Abstinence-based recovery communities aim to ensure that people with addictions are supported to meet their personal, social and economic needs in order to enable long-term recovery and reintegration back into society. Abstinence-based recovery complements the UK Drug Strategy (2010) objective of supporting people to live abstinence-based, 'drug-free' lives. It is expected that the recovery communities will be sustainable and continue to operate after the two years of funding is complete. Details about the purpose and delivery of each recovery community are presented here alongside contextual information regarding the characteristics of each setting; the specific information about each project has been provided by a representative from each community.

Recovery Central (delivered by CHANGES UK, Birmingham)

CHANGES UK is a user-led organisation based in Birmingham that aims to support people to maintain their recovery from addiction through an abstinence-based model; as well as identifying and addressing those behaviours that prevent individuals from stopping any criminal activity they may be involved in.

Compared to the national average Birmingham has higher rates of: deaths by drug misuse, hospital stays for alcohol-related harm, homelessness and long term unemployment (Public Health England, 2016). Over recent years Birmingham has seen an increase in illicit drug use, specifically marijuana and novel psychoactive substances (also known as 'legal highs'). Alongside these trends it is estimated that there are around 22,000 dependent drinkers in Birmingham with an even higher proportion of people classed as harmful or hazardous drinkers (Kilgallon, 2013).

Drug and alcohol treatment services have traditionally been set up to support opiate and crack users. As Birmingham has experienced an increase in alcohol clients accessing treatment there has been a need to re-design its services. Especially as treatment completion rates have reduced by 8% for opiate clients and are reportedly low for alcohol clients (Kilagallon, 2013). It is claimed Birmingham's treatment services are outdated and need to integrate a recovery focus. Birmingham City Council support the recovery agenda and aim to commission services which employ holistic approaches focusing on wellbeing, citizenship and freedom from dependence (Birmingham City Council, 2013). Since March 2015 Birmingham's Drug and Alcohol Services have been delivered by Change Grow Live (CGL) formerly known as Crime Reduction Initiative (CRI), a social care and health charity.

CHANGES UK was established to develop a recovery community from the foundations of good quality, abstinence-based, single sex housing. This was to provide a safe and substance-free environment where people were able to support one another from a shared experience. Those living in the accommodation are required to engage in the recovery community through fellowship support or mutual aid groups; and to gradually become actively involved in the local mainstream community and develop the skills to move closer to the job market.

Peer support is considered to be a fundamental building block within the CHANGES UK recovery community, and this is underpinned by a network of volunteer peer mentors (Recovery Coaches). Volunteering opportunities include central support functions to front-line delivery, to give people confidence and employability skills. Recruitment, induction, training and supervision programmes are available for CHANGES UK volunteers; and volunteers are also encouraged to apply for roles within the organisation.

Current activities provided by CHANGES UK for people maintaining abstinence include:

- A detox unit (Clarity House);
- Supported housing including women-only and 'move-on';
- Group-work and workshops to address key life and personal skills, positive decision making, coping strategies, mindfulness;
- Practical support towards independent living;
- Volunteering opportunities;
- Access to education, employment and training.

Recovery Central has recently been developed in partnership with others to jointly tackle ingrained issues, including drug and alcohol misuse, mental health issues, offending behaviour and homelessness.

Problematic drug and alcohol users need a holistic and comprehensive package of support that is delivered in the community to maintain their recovery and reduce the risk of re-offending. Instead of signposting service users to provisions elsewhere, CHANGES UK aims to provide those services directly and, by housing other service providers in order to remove the barriers to accessing those services.

The Hub (delivered by The Nelson Trust, Gloucester)

A community base to support the recovery community in Gloucestershire has been established in the form of The Hub. Latest figures show that rates for long term unemployment and hospital stays for alcohol-related harm are significantly higher in Gloucester than the national average (Public Health England, 2016). Around a quarter of people in Gloucestershire are estimated to be consuming more

alcohol per week than recommended guidelines and in 2012-14 there were 3,934 hospital admissions recorded where alcohol had played a main factor. In addition, n 2013-14 1,495 adults were recorded as accessing drug treatment in Gloucestershire (Gloucestershire County Council, 2015).

Gloucestershire County Council commission prevention, harm reduction, treatment and recovery services. In 2012, the area underwent a major change in the way its drug and alcohol support services are commissioned, the main community service is now delivered by one service provider called Turning Point, who deal with both drugs and alcohol, in 2013-14 over 2,000 people engaged with the service (Gloucestershire County Council, 2015).

The Hub was developed to engage and involve the local recovery community and is run voluntarily by people in recovery – staff, ex-clients and others. The aim is to grow The Hub into a self-sustaining independent project employing and managed by people in recovery.

The Hub aims to educate the public about recovery, making recovery more visible and accessible to those struggling in addiction; as well as providing recovery awareness training to educate frontline professionals, journalists and the general public about recovery and its benefits. The Hub has a recovery café in its base (for on- and off- site catering), which offers vocational training in catering and customer service and will recruit volunteers and recovery champions to deliver training and advocacy. The project also offers or hasplans to offer the following activities:

- Physical health: sports teams and events, healthy cooking on a budget clubs, exercise classes.
- Emotional wellbeing and social support: The Hub will be used by local fellowships and other self-help groups as well as being a venue for people in recovery to start their own groups, arrange events and recreational activities.
- Education, training and employment: NVQ qualifications will be offered in catering and customer service delivered through the operating recovery café.
- A hub for recovery- an informal setting where keyworkers, mentors, advocates and support workers can spend time with their clients outside of the treatment environment in a safe and relaxed place which the centre could offer.
- A shop front for 12-step literature, self-help books, “recovery birthday” cards and gifts.
- Off-site and outreach events and activities across the county from The Hub base.

Choices and Progression (Spitalfields Crypt Trust, London)

Spitalfields Crypt Trust provides high-quality support, rehabilitation and training services for people facing problems of addiction, homelessness and social isolation. Both Hackney and Tower Hamlets have problems with homelessness and long term unemployment rates. Specifically Hackney which has significantly higher rates of homelessness than the national average (Public Health England, 2016). Tower Hamlets is home to a large street and hostel based homelessness population who have substance misuse problems (Tower Hamlets Council, 2011).

Out of all the boroughs in London, Tower Hamlets has seen the greatest number of residents accessing specialist drug and alcohol treatment. In 2014/15 there were 2,274 residents accessing treatment (Tower Hamlets Council, 2016). During the same period, a similar number of residents accessed treatment in Hackney (n=2,172) (Hackney Council, 2016).

Hackney has an older drug and alcohol treatment population compared to the national average with a high proportion of service users their 40's and 50's. It is perceived that this could indicate that there is a need for earlier intervention if individuals are accessing support at a later age. Services in Hackney are recovery-focused and help individuals reintegrate back into the community by offering additional support services including support with education and employment (Hackney Council, 2016).

Tower Hamlets latest drug strategy draft outlines the council's ambition to focus on 'hard to reach' groups such as street drinkers. The strategy also reports that local drug and alcohol treatment services in Tower Hamlets have been redesigned so as they are better integrated, recovery focused and include greater service user involvement (Tower Hamlets Council, 2016).

There are a number of key aims to help people on their pathway to recovery. These are:

- Becoming drink/drug free and making real life changes.
- Attempting new things and developing the personal confidence and social skills that facilitate wholeness and healing.
- Breaking the negative patterns that can lead back into addiction.

There are a number of activities that are provided by Spitalfields Crypt Trust to help individuals maintain abstinence and these include:

- A 16-bed residential 12-step recovery house - Acorn House.
- Four semi-independent move-on houses that provide longer term accommodation for 29 men.
- A holistic day programme (New Hanbury Project) for people in abstinence-based recovery, which provides activities and courses that respond to people's social, creative, educational, employment and therapeutic needs.
- A number of fledgling social enterprises for people in abstinent recovery - Paper & Cup coffee shops, YourTime Decorating firm and Restoration Station Furniture Restoring firm.
- A Friday evening support group and social venue for people in abstinence-based recovery (Choices).

A number of new activities are being /have been introduced that aim to provide constructive and creative support for people leaving primary/residential abstinence-based treatment.

Spitalfields Crypt Trust are currently in the process of further developing a number of areas to offer abstinence-based recreational activities that will help bring together people in all stages of recovery, including families. These areas of development include:

- The engagement and training of recovery champions.
- Employment and training opportunities (through its social enterprises).
- Evening and weekend social and recreational activities run and facilitated by people in recovery.
- Pioneering evenings at Paper&Cup as a 'Recovery cafe', where people in recovery can create a supportive community.
- A broadening of the people Spitalfields Crypt Trust have previously engaged and partnered with; families, the local community, local services, local businesses and anyone who is willing to make a contribution to their recovery community.

Clean & Sober Living, delivered by The Cornforth Partnership, Durham

In collaboration with the Cornforth Partnership and County Durham local authority, Clean & Sober Living provide an abstinence based recovery project for people engaged within drug and alcohol services in South West Durham. Clean & Sober Living is a new community organisation, led and managed by people with lived experience of drug addiction, alcoholism, acquisitive crime and long-term abstinence-based recovery. Compared to the national average Durham has higher rates of: deaths by drug misuse, hospital stays for alcohol-related harm and long term unemployment (Public Health England, 2016). Similarly, compared to the national average fewer people in Durham are completing drug and alcohol treatment. Moreover, the proportion of people completing alcohol treatment has declined in the area (Durham County Council, 2016). Reducing alcohol consumption is a priority for tackling inequalities, between 2006/07 and 2010/11 there was a 52.5 % and 47.4% increase in alcohol-specific hospital admissions for men and women in Durham (respectively). This is approximately double the increase seen nationally for men and women (17.7% and 26.2% respectively) (Durham County Council, 2013).

In 2013 Durham began mapping their drug and alcohol services and reviewing ways in which they can be better integrated. A consultation event with stakeholders was held in 2014 which identified the needs of the local people and best practice. There were a number of key findings from the consultation: abstinence base programmes and mutual aid groups have had an important role in increasing the visibility of recovery in some areas in Durham; there is a need to focus more on people's recovery capital and work better with both families and mutual aid networks (Durham County Council, 2014). Since April 2015 Durham's Drug and Alcohol Services have been delivered by a charity called Lifeline (Durham County Council, 2015).

The staff members of Clean & Sober Living have over 30 years of personal and professional experience in supporting those addicted to alcohol and/or drugs to fully recover and go on to become responsible, productive members of society. The culture philosophy and activities are centred in abstinence-based recovery and are underpinned by a peer-led approach.

Clean & Sober Living is a user-led organisation whose members are in abstinence-based recovery. The project helps participants to achieve and maintain abstinence by supporting them through their detoxification, delivering support groups and facilitating mutual aid involvement. The project offers advice, guidance and education, surrounding addictions and acquisitive crime, to families and stakeholders.

Clean & Sober Living aims to make a difference around recovery in County Durham by helping more people achieve and sustain abstinence-based recovery. Additionally, it looks to identify and redress any systemic and cultural barriers that impede the development and growth of the recovery community, such as stigma, prejudice and ignorance through delivering training with key stakeholders.

Clean & Sober Living also aims to help families and communities to recover from the impact of addiction and to help people in recovery to flourish in areas such as; relationships, education, employment and community reintegration. For those in recovery this includes the development of an abstinence-based housing and recovery support program, which will provide sober housing; and a recovery support team and access to additional wrap around services such as:

- Education, employment and volunteering, and family and community reintegration

- Facilitation into abstinence-based mutual aid groups; and
- County wide training and education programme surrounding abstinence-based recovery communities. This incorporates awareness training delivered to frontline professionals about addiction and abstinence-based recovery.

2.3 Evaluation

In October 2014, the Public Health Institute (PHI) at Liverpool John Moores University was commissioned to undertake an evaluation of the Comic Relief: Give it Up recovery communities. The evaluation aimed to understand the key outcomes generated by the recovery community, with reference to recovery capital outcomes and those described in relevant policy, recovery strategies and wider literature.

The primary research question for the evaluation was:

How do the recovery communities help people to maintain abstinence?

The evaluation focused on the following objectives:

Exploration of key recovery outcomes and the impact each community has on the recovery of the people who use them
Exploration of how recovery communities help people to maintain abstinence
Evidence of the best ways of building personal and social capital to ensure people feel empowered and enabled to create change and improved health and life outcomes
Evidence of the social value that recovery communities create

Understandings of the delivery approach taken for each project and how they support recovery communities
Understanding of the organisations that need to be involved in delivering and supporting recovery communities
Understanding of how the partnerships, peer support, awareness raising and training of service providers within each project contribute towards recovery
Evidence of what recovery communities add to existing statutory service provision

3. METHODOLODGY

Given that personal experiences and outcomes of recovery can be difficult to capture (Laudet, 2007; Knopf, 2011; Witbrodt et al., 2015), the research used social value methods to capture evidence of outcomes related to recovery capital. Specifically, Social Return on Investment (SROI) analysis was used to understand the social value of each recovery community.

A process evaluation was also undertaken. This method provided understanding of the delivery approach used by each recovery community and the key characteristics needed to make a recovery community successful.

Social Return on Investment (SROI)

SROI is a framework to assess evidence of value and impact by measuring and accounting for improvements in wellbeing by incorporating social, environmental and economic costs and benefits.

SROI allows for the measurement and capture of outcomes that can be hard to measure, and is therefore useful for the evidencing of recovery capital outcomes. This method also enables consideration of the wider impacts of community projects on the areas they thrive in.

The SROI process involves identifying changes as a direct result of an individual's engagement with a project. This enables stakeholders and service users to draw on the changes that have happened to them as a direct and indirect result of engaging with the project, and the impacts this has on mental health, wellbeing and behaviour change. The analysis uses a combination of qualitative, quantitative and financial information to estimate the amount of 'value' created by each of the recovery communities. The nature of SROI requires stakeholders to be involved in the development of the evaluation framework from the start of the process.

Forecast and Evaluative SROI

A 'forecast' SROI can be undertaken at the start of a project, to predict how much social value will be created if the activities meet their intended outcomes. An 'evaluative' SROI can be undertaken at the end of a project, or after a project has been established for a period of time, to explore the actual value created (SROI Network, 2012).

In order to establish and track evidence over the life of the funding, we proposed to undertake a forecast and evaluative SROI for each project. A forecast SROI is used towards the start of an activity, and can demonstrate how investment can maximise impact, and provide evidence of what needs to be measured throughout the duration of the project. The forecast SROI aimed to explore how much social value would be created if each project activity met its objectives. The evaluative SROI then explored the actual social value created by the projects, based on the actual outcomes that have taken place.

One project (Clean & Sober Living) was not developed to a point where a forecast SROI could be undertaken at the beginning of the research, therefore a process evaluation was undertaken at the beginning and a forecast evaluation was undertaken towards the end of the research (see Table 2 for details of which research methods were used with each project and when).

Process evaluation

To complement the SROI research, process evaluations were undertaken across each recovery community. This method gathered insight from stakeholders involved in delivering the four Projects about their experiences, perceptions, barriers and facilitators of project delivery.

3.1 Methods

The evaluation was undertaken between October 2014 and October 2016. Research activities were centered around undertaking a process and forecast evaluation upon project initiation (during year 1) and an evaluative SROI towards the end of the funding period (during year 2).

Due to limitations with project implementation, Clean & Sober Living did not have the resources in place to undertake a forecast evaluation during year 1. Instead, a process and outcome evaluation was undertaken which focused on their advocacy and training during year 1, and a forecast SROI alongside analysis of outcome measures was undertaken during year 2. A full SROI analysis was undertaken, however, value calculations were not completed, as Clean & Sober Housing ceased to run.

Table 1 provides details of which research methods were undertaken with each project, and when.

Table 1: Research methods used across each research community

	Year 1			Year 2		
	Process evaluation	Forecast SROI	Outcome evaluation (in place of forecast SROI)	Process evaluation	Evaluative SROI	Forecast SROI and analysis of outcomes data
Recovery Central	√	√			√	
The Hub	√	√			√	
Choices and Progression	√	√			√	
Clean & Sober Living	√		√	√		√

Ethical approval was granted by the LJMU Research Ethics Committee (reference 14/EHC/082). All participants who agreed to take part in the evaluation (whether the process evaluation or service user/volunteer focus groups) were provided with a participant information sheet explaining the purpose of the process evaluation/taking part in the focus group. Verbal consent was gained over the telephone or in person before the interview/focus group commenced. Participants were assured of their voluntary participation, confidentiality and it was explained to them that they could avoid answering questions they were not comfortable with as well as withdraw their consent at any time.

The methods employed for each research approach are described in detail below.

3.1.1 How the forecast SROI was carried out

A forecast SROI was undertaken with all recovery communities. SROI methods across the projects were standardised to ensure robustness in comparing values obtained from different groups of people. The project used an open and objective framework, asking the stakeholders "what has changed for them" and "what are the most important changes". The SROI also identified and valued negative and/or unintended outcomes (these unintended outcomes may be positive or negative). The SROI involved five stages:

Stage 1. Establishing the scope of the SROI and identifying key stakeholders

A scoping exercise was undertaken with key people from each recovery community. These stakeholders identified activities within their recovery community to be included in the evaluation. This determined inclusion and exclusion criteria for the SROI. Information about data already collected by each community was also obtained. This informed the research team about gaps in data and additional data needed for the SROI. The information was captured in the form of a logic model.

Stage 2. Mapping outcomes

To understand anticipated outcomes, focus groups were held with stakeholders from each recovery community. Participants were asked about what had changed for them already as a result of being involved in the recovery community. The focus groups also explored expected changes over the forthcoming 12 months. Participants attended two focus groups:

- *Focus group 1 explored changes and expected changes as well as identifying what they contributed to the projects and whether a monetary value could be attached to this 'input'*
- *Focus group 2 asked participants to identify which were the key outcomes and collected other information to establish impact about: if the change would have happened without the recovery community, the likelihood of these changes happening anyway, what other services or people might have contributed to this change and how long the change would last.*

Stage 3. Evidencing outcomes and giving them a value

As part of SROI, the key outcomes identified by participants need to be valued. The Value Game was conducted with one of the recovery communities (CHANGES UK) to monetise the outcomes. Here, participants were asked to develop a list of items they would like to receive as gifts (calibration list). The list of eight items ranged in value from £150 (a meal out for four people) to £8,000 (the price of a luxury holiday for 4 people). It was not possible, however, to conduct the Value Game with members of the recovery communities at Spitalfields Crypt Trust and The Hub due to time and resources. With this in mind the researchers did not feel it was appropriate to use the proxies provided by the Value Game that was conducted at CHANGES UK across these two recovery communities and therefore additional proxies were sought. These proxies were also applied to the CHANGES UK recovery community.

The data sources used in the valuation of the outcomes included a recent SROI report, the HACT social value bank (www.hact.org.uk/social-value-bank) and New Economy Working Papers (See Appendix 3 for further details on the proxy values used for each of the four outcomes and justification for their use).

Stage 4. Establishing impact
To understand the amount of change that could be attributed to recovery communities, it was important to understand:

- *How likely it was the change would have happened anyway (deadweight); and*
- *If any other projects/services/organisations/people helped to bring about the change (attribution).*

Deadweight is the level of change that would occur and whether it would happen without the project. Attribution considers whether other organisations/services/projects/people contributed to the change.

Levels of *deadweight* were collected from a number of national and regional data sources, while levels of *attribution* were collected through discussion with the service users/volunteers during the focus groups.

Stage 5. The Impact Map: Calculating the SROI
Findings from the engagement activities were brought together into an 'impact map'. This is a pre-prepared Excel spreadsheet. Project inputs, outputs and values are input onto the spreadsheet, alongside details of the number of people experiencing change, the deadweight and the attribution. The impact map calculates the value of each outcome for each stakeholder and determines the present value of the project. The SROI is conducted by calculating the ratio of return by dividing the present value of the project impact (the total value of the benefits) by the total value of investment.

3.1.2 How the outcome evaluation was carried out (for Clean & Sober Living, in place of a forecast SROI)

It was initially planned to carry out forecast SROIs with all four recovery communities, during the early phases of the project funding. However, due to the design of the projects, one community (Clean & Sober Living) was not sufficiently developed for a forecast SROI to be undertaken. In collaboration with members of the Give it Up fund and Clean & Sober Living, it was decided that an outcome evaluation would be more appropriate during this time, which used a social value approach, and focused on two specific elements of this project: outreach and advocacy work and training with professional services. Research methods for each element are detailed below.

Outreach and advocacy work: focus group with service users

A two-hour focus group was undertaken with eight service users from Clean & Sober Living's outreach and advocacy work. The aim of the focus group was to explore the social value of the outreach group and establish what activities service users engaged in and the outcomes they experienced. In addition, the researchers sought to explore how important the outcomes were and whether they were all positive. Participants were also asked whether the outcomes would have taken place without Clean & Sober Living and whether they thought any other organisations/ people could have contributed to the changes they experienced. Data were recorded by hand during the focus group and subsequently analysed using thematic content analysis.

Training with professional services: attitude and behaviour questionnaire (pre, post and follow up)

Health professionals that attended a training day delivered by Clean & Sober Living in August 2015 were invited to complete a questionnaire about their understanding of addiction at three time points: pre, post and follow-up. The pre-questionnaire was distributed immediately before the training and the post questionnaire was completed immediately after the training, while the follow-up questionnaire was converted into an online survey and circulated via email to the training attendees, six weeks after the training. The online follow-up questionnaire ran for one week and included questions about whether the training received was perceived to have impacted their personal and professional lives.

The pre and follow-up questionnaire asked the participants to respond to the following four statements and to rate their understanding and knowledge on addiction on a scale of 1-6, where 1 represented 'not good' and 6 represented 'very good'. The questionnaire was designed by Clean & Sober Living:

- My understanding of addiction is…
- My ability to communicate with someone suffering with an addiction is…
- My understanding of abstinence-based recovery is…
- My awareness of stigma and prejudice towards people with addiction is…
- Additionally the follow-up questionnaire asked participants how they thought the training had impacted on them personally and professionally.

Drawing on the same four questions as the pre and follow-up questionnaire, the post questionnaire asked the participants to select by what percentage they believed their knowledge and skills had improved by. Each question also had a comments box for the participants to explain their chosen percentage. All data were input and analysed using the statistical software SPSS.

3.1.3 How the evaluative SROI was carried out

The evaluative SROI took place towards the end of the research, during year 2. An evaluative SROI takes place retrospectively, and is based on actual outcomes that have already taken place. The SROI followed steps 2-5 as described in the forecast SROI. Step 1 was not included as establishing scope and identifying stakeholders had already been completed during the forecast SROI. Each of the recovery communities was also asked to confirm that the outcomes identified in phase 1 were still applicable.

As part of the forecast SROI, information was gathered regarding existing data collected by recovery communities. This process enabled the identification of research gaps. As a result, all four recovery communities were asked to embed two additional measures into their data collection processes, with the aim of providing robust data on which to base the evaluative SROI.

The *Warwick-Edinburgh Mental Wellbeing Scale* and the *Assessment of Recovery Capital Tool* were selected as the most appropriate and feasible approaches for recovery communities to embed.

The measures provided evidence of the key outcomes identified in the forecast SROI, and are measures that recovery communities can continue to collect to help develop and understand the profile of the wellbeing and recovery capital of their members.

To further support the evaluative SROI, qualitative interviews were undertake with representatives from recovery communities, in order to further explore and validate outcomes.

(A note on Clean & Sober Living)

Due to the delays in implementation, a full evaluative SROI was not undertaken for Clean & Sober Living. It was anticipated that a forecast SROI evaluation would be undertaken when other recovery communities received their evaluative SROI, however, this did not take place as the housing run by Clean & Sober Living ceased to run. This recovery community did, however, implement the outcome tools, as described below. This provided Clean & Sober Living with an assessment of outcomes, and a social value framed evaluation, despite not having the resources to undertake a full evaluative SROI.

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

The WEMWBS provided an overview of wellbeing within and between the recovery communities. Measuring wellbeing enables us to see how people feel (emotions) and how they function (competence and connectedness) on both a personal and social level, providing a subjective overview of their lives at a given point in time (Michaelson, Mahony and Schiffres, 2012).

WEMWBS has been developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. This tool has been validated for use in face-to-face interviews and showed good content validity (Tennant et al., 2007).

WEMWBS comprises a 14 item scale with five response categories, summed to provide a single score ranging from 14-70. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing (Appendix 1.1). More details about WEMWBS can be found at:

http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/

Assessment of Recovery Capital (ARC) tool

To complement the WEMWBS data, methods were included to capture factors relating to recovery capital. The ARC was chosen as the most appropriate method to do this. The tool addresses ten key factors of recovery capital (Figure 1; Groshkova, Best and White, 2012). Within each of these ten factors, participants using the tool are asked five sub-questions to which they are required to tick only the boxes for statements that they agree with and that describe their experience on the day of assessment (Appendix 1.2). Their responses to these statements relate to their experience on the day the measure is taken. A score between 0 and 5 can be reached for each sub-scale within the overall recovery domain. The overall score is calculated by totalling the scores for each sub-scale (this can range from 0 to 50), with a higher ARC score indicating higher recovery capital.

Figure 1: The ten key factors of recovery capital (Groshkova, Best and White, 2012)

Descriptive analysis of the WEMWBS and ARC Recovery tool data as well as the additional indicator data (where provided) was carried out for each of the recovery communities using SPSS and Excel. This looked to identify, where possible, changes occurring over time in these measures.

It was initially hoped that it would be possible to carry out further statistical analysis (e.g., calculations of statistical significance) on the WEMWBS and ARC data, however, the sample sizes for the data across each of the four recovery communities were too small. Given the size and nature of the recovery communities, this was an anticipated outcome; the data are still valid for the purposes of the social value evaluation.

Qualitative Interviews

To support the quantitative data collected for the evaluative SROI, a number of interviews were undertaken to elicit in-depth views, experiences and perceptions regarding the impact of engagement with the recovery communities.

Each recovery community was asked to recruit a maximum of three family/friends of recovery community members. The purpose of this initially was to explore their perceptions of:

- what impact attendance at the recovery community has had on the member of their family/friend;
- what has changed for them as a result of their family/friend attending the recovery community.

For The Hub a telephone interview was conducted with a family member of one of the recovery community members. Whilst for Spitalfields Crypt Trust one family member completed a written version of the interview schedule. Due to the small numbers of respondents and in the case of CHANGES UK and Clean & Sober Living it was not possible to engage with family members/friends; the responses gained were used to validate, where applicable/appropriate, outcomes identified in phase 1 of the evaluation.

Members of the recovery community

For Clean & Sober Living, Durham where a forecast evaluation was being conducted, interviews were carried out over the telephone with three of the Clean & Sober recovery community members to identify what outcomes they are currently experiencing/might expect to experience over the next twelve months.

Re-confirmation of outcomes

Following on from the identification of the four key outcomes in phase 1 of the evaluation, CHANGES UK, The Hub and Spitalfields Crypt Trust were asked to re-confirm/re-validate these outcomes and identify any potential new outcomes. This was done through the lead person(s) at each recovery community consulting with members of their recovery community and feeding back any discussions to the evaluation group.

Evaluative SROI: Impact maps calculation

The information collected from WEMWBS and ARC were used to inform the content of the impact map.

Researchers used the information collected from the WEMWBS and ARC data to estimate the numbers of people in recovery communities experiencing each outcome. To do this, questions/key topic areas in each tool were categorised into one of the four key outcome themes that emerged from the SROI interviews (See Appendix 1.1 and 1.2). These were:

- Sense of purpose and feeling valued
- Improved relationships with family members
- Personal capital (emotionally able to cope with things)
- Better connection with wider society

This analysis approach allowed for the identification of subtle changes experienced by the recovery members; this information would not have emerged through simple exploration of overall total numbers of recovery community members who had shown an improvement across each measure.

The researchers then looked at where positive changes had been observed via the WEMWBS and ARC data and used this to inform the quantities of recovery community members from each community who had experienced each of the four key outcomes. This information was then used to inform the SROI impact map and calculate the social return on investment ratio.

3.1.4 How the process evaluation was carried out

A process evaluation was undertaken with each recovery community in year 1 of the evaluation. It was anticipated to undertake telephone interviews with ten people involved in the implementation and delivery of the recovery communities, with at least two representatives per recovery community. Interviews lasted between 20-45 minutes and discussed the following topics:

- understanding of recovery communities overall (locally/nationally) – what contributes to the success of recovery; what are the main challenges/ barriers to recovery
- working relationships - with other partners/organisations/agencies/local communities; how do recovery communities support 12-step fellowships;
- experience of developing and delivering the recovery community including: how do recovery communities define abstinence and recovery; referral processes; barriers to the recovery communities; how the recovery communities empower their service users and tackle stigma; engagement with social media.;

These process interviews also elicited perceptions of how the programme is received by service users, including issues regarding barriers and awareness.

In the case of Clean & Sober Living a second process evaluation was undertaken in year 2 of the evaluation due to a change in focus from outreach and advocacy work and training with professional services to recovery housing.

Interviews were audio recorded and transcribed verbatim. Two researchers independently analysed the content of the transcripts using thematic analysis.

4. FINDINGS

4.1 Forecast SROI Findings

Scope and key stakeholders for each recovery community

The scoping exercise confirmed that the primary audience for the analyses would be the Comic Relief Give it Up funders and steering group. However, key audiences would possibly also include internal recovery community project management to inform decision making and other relevant partners such as local commissioners, policy and local authority departments.

The scoping exercise established that the following activities within each recovery community (which offered several types of activity) would be the focus of this evaluation:

1. Recovery Central: peer-led support and membership services - CHANGES UK, Birmingham
2. The Hub: The Nelson Trust, Gloucester
3. Choices and Progression: Spitalfields Crypt Trust, London
4. Outreach and advocacy work and training: Clean & Sober Living

Changes UK, The Hub (Nelson Trust) and Spitalfields Crypt Trust had already implemented recovery community activities, which meant it was possible to carry out a forecast SROI. Clean & Sober Living's recovery community was still in development and so there was a consensus amongst the recovery community staff and researchers that a development evaluation would be more appropriate.

Discussions during the scoping exercise and focus groups informed which stakeholders would be included in the forecast SROI. The key stakeholders were the same across the three recovery communities. These included: the members of the recovery community, the members' family members and Comic Relief. The reasons for why these stakeholders were included are described in Table 2. There were several other stakeholders identified by the recovery communities, who were excluded from the forecast SROI. Reasons for their exclusion included: stakeholder groups where material changes were unlikely to be evidenced within the time frame in the scope of this SROI (e.g., wider community/wider recovery community); stakeholder groups where although material changes may be evident they were not identified as a key outcome during the stakeholder engagement (e.g., Hospital/NHS/health services; criminal justice system); and stakeholders who only provide inputs (e.g., Public Health England). Further details can be found in Appendices 2.1 and 2.2.

Table 2: Stakeholder groups included in the SROI and reasons for their inclusion

Stakeholder group	**Reason**
Members of the recovery community (service users and volunteers)	Main beneficiary who will experience key material outcomes. As well as providing an important input, they would also experience material changes as a result of their volunteering activities
Family members and friends	Beneficiary who will experience possible material outcomes. They would possibly experience material changes as a result of improved relationships with members of the recovery community
Comic Relief	Financial contributors

Recovery outcomes

The stakeholder engagement and focus group activities asked people to describe and discuss the outcomes they had and thought they would experience as a result of being involved with the recovery community. The same outcomes were found across all three recovery communities involved in the forecast SROI (and also reflected in the research undertaken with Clean & Sober Living):

- A connection with themselves – learning about their assets and deficiencies, a process of self-discovery, building self-confidence and resilience, developing practical skills and knowledge and taking on responsibilities;
- A connection with peers – social interaction, making new friends, building trust in others, learning appropriate social skills;
- A connection with family members – becoming responsible, building trust, re-establishing positive relationships;
- A connection with those not in recovery and society – communication skills, feeling of equality and reduced stigma.

By sharing their stories with the researchers during the first focus group, it became apparent that many of the participants experienced similar changes and outcomes as a result of engaging with their recovery community. At the focus groups, participants shared their stories with the researchers. The stakeholder engagement and focus group findings were used to develop a chain of events that illustrated key activities and common outcomes associated with each recovery community; this information depicted the common experiences of abstinence-based recovery (Figure 2).

Overall the outcomes that were most valuable to the service users were positive, with very few service users reporting they had relapsed since engaging with the recovery communities' activities. The outcomes included in the SROI analysis were those which had the greatest value, quantity, duration and causality (as described by the service users).

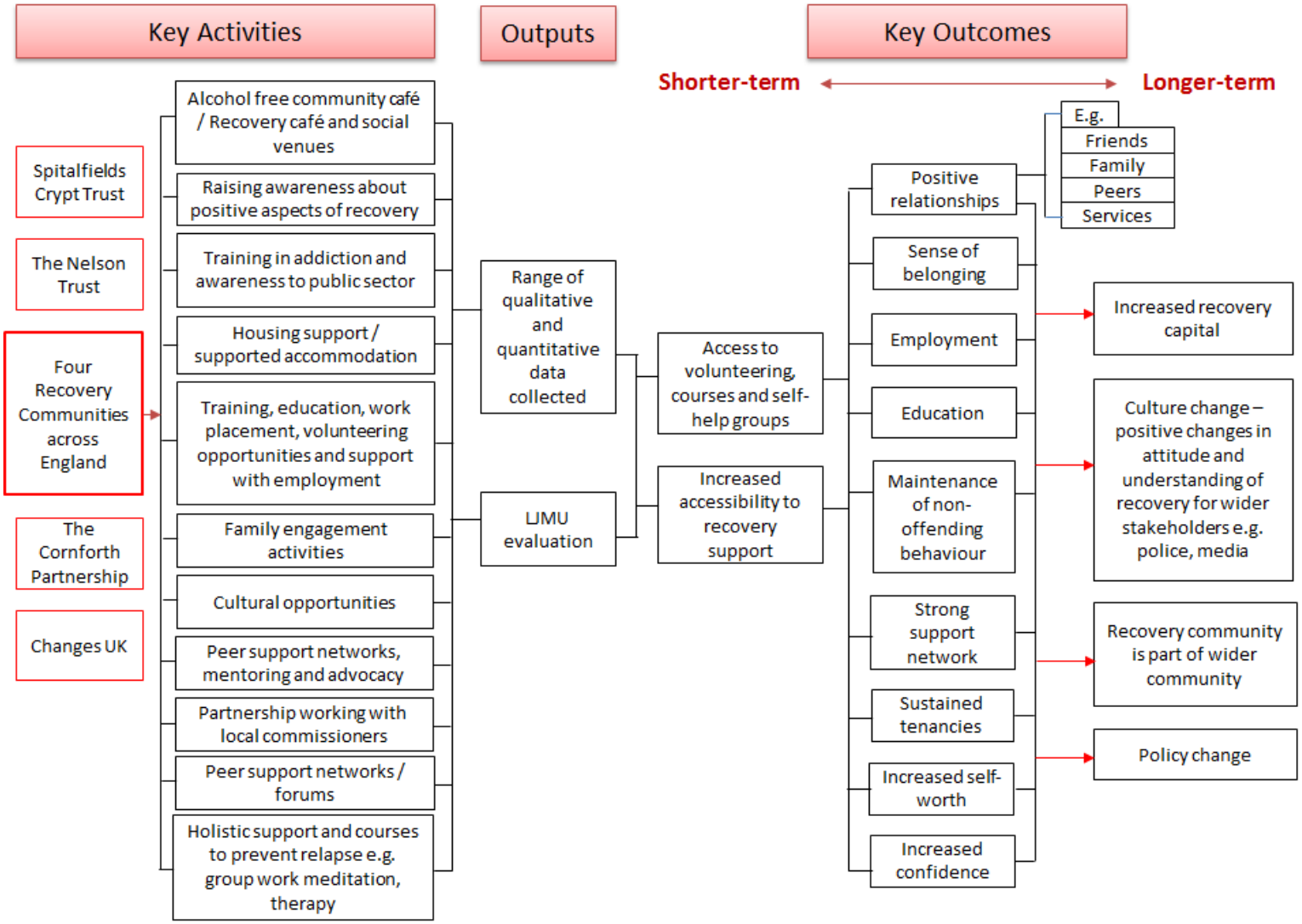


Figure 2: Chain of events for recovery communities

The second focus group clarified key outcomes and agreed what information would be used for the forecast SROI by attempting to value them and establishing proportions for deadweight and attribution. Participants were asked to refine the identified changes and outcomes and order them to show the most common experience of abstinence-based recovery. Four key outcomes were independently identified and placed in the same rank order (ordered from most to least important) revealing the relative value of the outcomes (Figure 3):

- Sense of purpose and feeling valued
- Personal capital (emotionally able to cope with things)
- Improved relationships with family, friends and colleagues
- Better connection with wider society

These four outcomes were considered to be inter-related so that they were very much connected in a way that each outcome has an effect on or depends on the other.

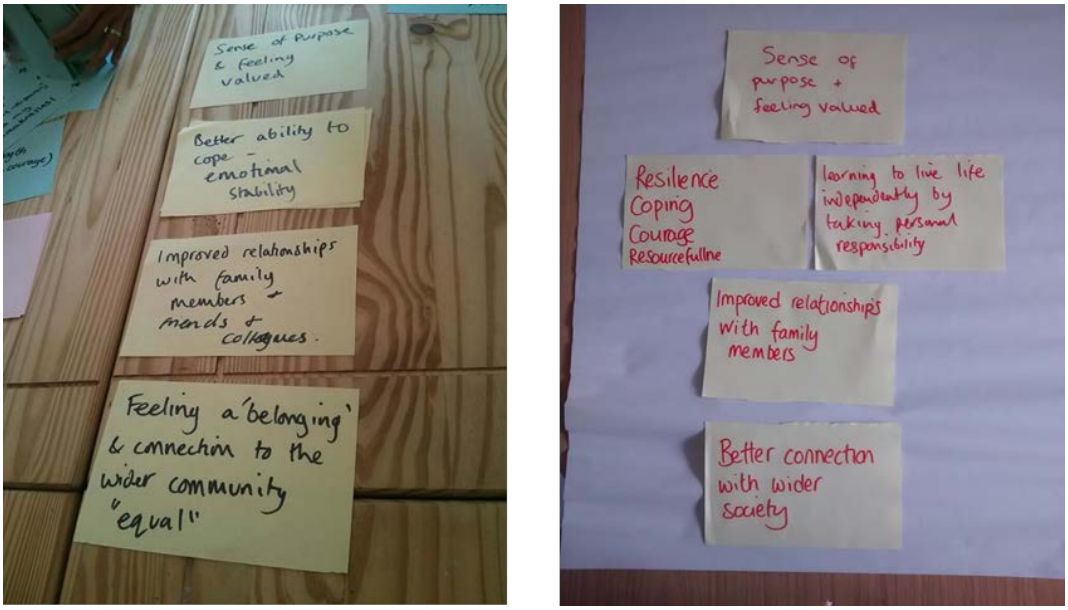


Figure 3: Focus group session 2 - Independently identified outcomes from two of the recovery communities

The focus groups and telephone interviews also found that recovery community users identified a number of contextual factors as being central to the delivery of an effective recovery community:

- Fostering a community (belonging and space)
- Peer support
- Options/choices
- Routine and structure
- Sense of fun
- Person centred
- Not Monday-Friday 9am-5pm

Placing a financial value on the outcomes

Once the key recovery outcomes had been determined, the next stage of the forecast SROI involved placing a value on these. The data sources used in the valuation of the outcomes included a recent SROI report (Goodspeed, 2014), the Housing Associations Charitable Trust (HACT) social value bank (www.hact.org.uk/social-value-bank) and New Economy Working Papers (See Appendix 3 for further details on the proxy values used for each of the four outcomes and justification for their use).

For example the outcome of 'sense of purpose and feeling valued' was defined as 'positive functioning - autonomy, meaning and purpose' from the national accounts of wellbeing model (Cox et al., 2012), which was a similar outcome to that described at the focus groups with the members of the recovery community; valued as £1,056/annum. Whilst the outcome of 'improved relationships with family, friends and colleagues' was defined as 'improved/ supportive relationships or reduced isolation' from the national accounts of wellbeing model (Cox et al., 2012). Again, this was considered similar to the outcome described at the focus group; valued at £2,640/annum.

What would happen without the recovery communities?

Once the values of the outcomes had been determined, the researchers needed to determine how much of the impact could be due to each recovery community. This was done by establishing levels of deadweight and attribution. Existing data sources for the general population were used to inform on the likelihood of the four outcomes happening without the recovery communities. However, upon discussion with the recovery communities during the focus groups it was believed that those without the support of a recovery community were much less likely to achieve the four outcomes.

Participants from one of the recovery communities described what would have happened to them if they had not attended their recovery community's activities. This included:

- offending/substance misuse - prison cycle
- poor mental health
- maintenance of substance misuse
- maintenance of friendship groups (negative influences)
- relapse
- morbidity/mortality
- poor/lack of relationships with family
- lack of structure, routine and direction
- no housing
- interactions can be narrowed; challenge to changing relationships;
- unable to cope/deal with change

In a similar way, the process evaluation component suggested what other projects/services/ organisations/people could contribute to the outcomes. The majority of participants felt that there was a lack of abstinence-based recovery in their area, however, all recovery communities identified that some of their service users also attended 12-step fellowships.

Calculating the forecast SROI figure

In order to establish how many people in each recovery community had experienced the identified outcomes, the proportion of participants who agreed that they had experienced a particular outcome during the focus groups was aggregated up to the number of people who had engaged in the recovery community's activities over the one year period.

For example, a focus group of seven people provided representation for 100 members of that particular recovery community. Therefore each focus group member represented the voices of approximately 14 individuals (100 recovery community members divided by 7 as a representative sample = approx. 14). For each response reported in the focus group, the aggregated number was 14. Therefore if 5 out of 7 people in the focus groups reported improved relationships with family, friends and colleagues, this was calculated as being 71 members of the recovery community (5x14=71 – rounded up to nearest whole number).

Please see Appendix 4 for full details of the approximate number of individuals within the three recovery communities who experienced an outcome. This proportion was then used to produce an aggregated number of individuals experiencing each outcome in relation to the total number of members found within each specific recovery community. These figures were then inserted into the impact map, including the number of people experiencing the outcomes, the percentages for the deadweight and attribution and the value awarded to each recovery community by Comic Relief.

Checking the robustness of the findings

In order to check the SROI findings, a sensitivity analysis was carried out. This involved changing the outcomes and values in the impact map and examining the effect on the overall SROI ratio. A large variation in the SROI result after variables are adjusted indicates uncertainty in the figure. At the time of undertaking the SROI analysis, the existing data sources which related to the outcomes experienced by this population group (those in recovery) were limited and so it may be possible that there are limitations in the robustness of the proxy values and deadweight used in this forecast SROI. Nonetheless, the current analysis gives an indication that the three recovery communities' activities are moving in the right direction of creating social value.

Details of the sensitivity analysis for the forecast SROI can be found in Appendix 5.1

Forecast SROI result

It is important to note that SROI outcomes cannot be compared. The ratios have been calculated based upon the specific circumstances and experiences of each recovery community. The process, outcomes and theory of change are central to understanding differences and similarities between communities.

For each of the forecast SROI analyses it is important to note that additional beneficiaries/stakeholders and intended/unintended outcomes may not have been identified.

ChangesUK - The ChangesUK peer led support and membership service was shown to have the potential to create **£9.24** of social value for every £1 invested.

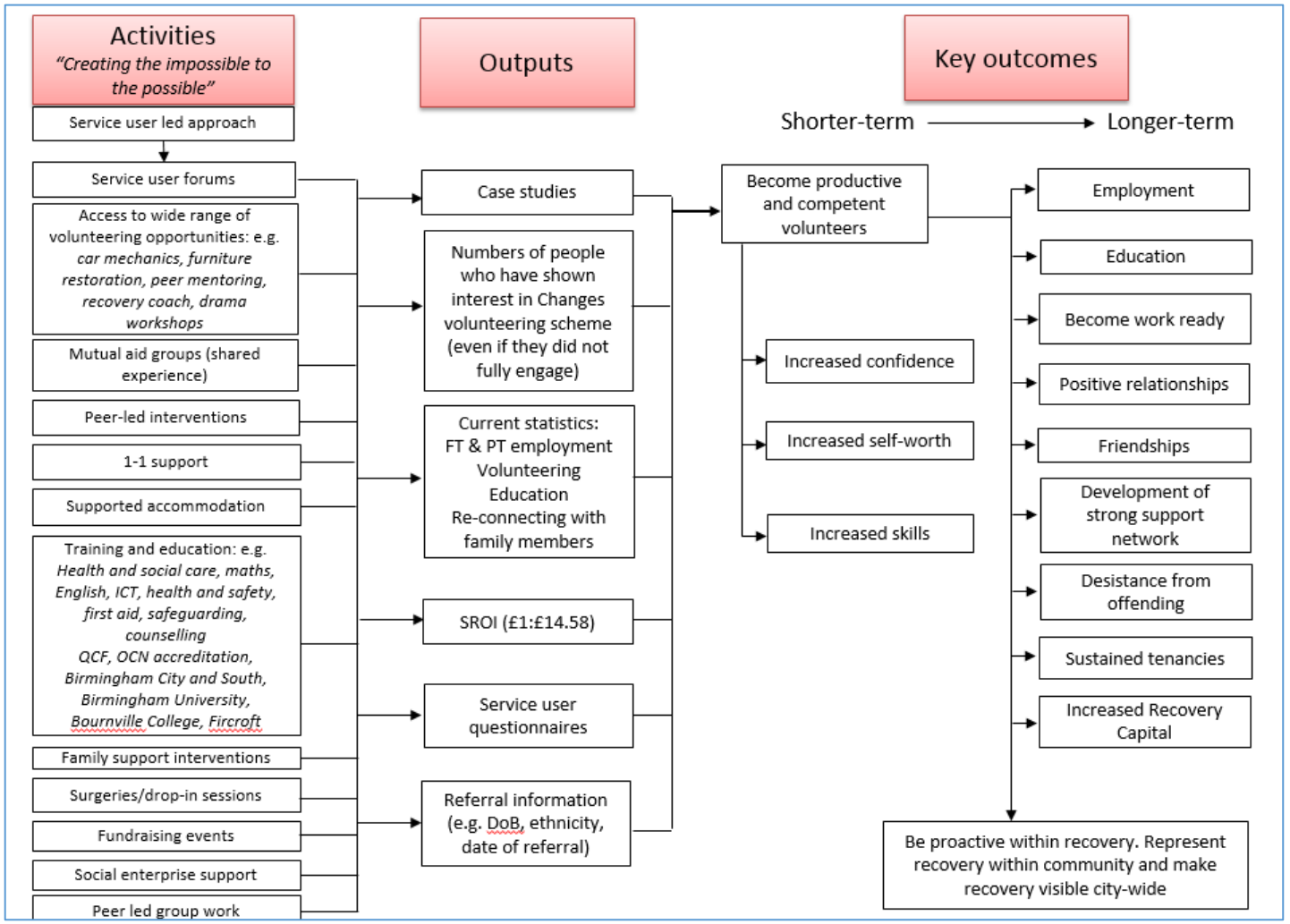


Figure 4: Key activities, outputs and outcomes identified for ChangesUK at the forecast SROI

Spitalfields Crypt Trust - Choices and Progression was shown to have the potential to create **£6.61** of social value for every £1 invested.

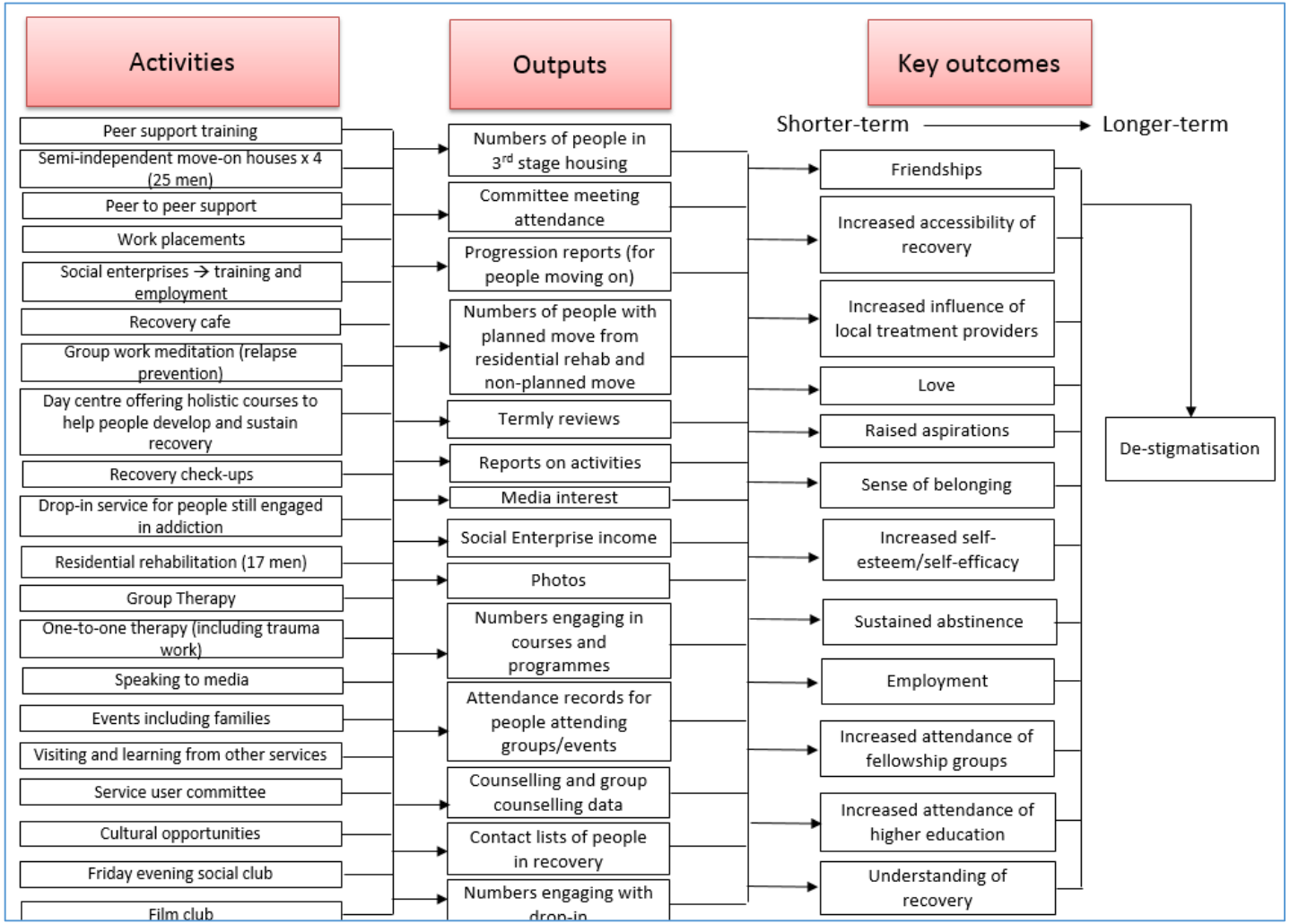


Figure 5: Key activities, outputs and outcomes identified for Spitalfields Crypt Trust at the forecast SROI

The Hub - The Hub was shown to have the potential to create **£5.17** of social value for every £1 invested.

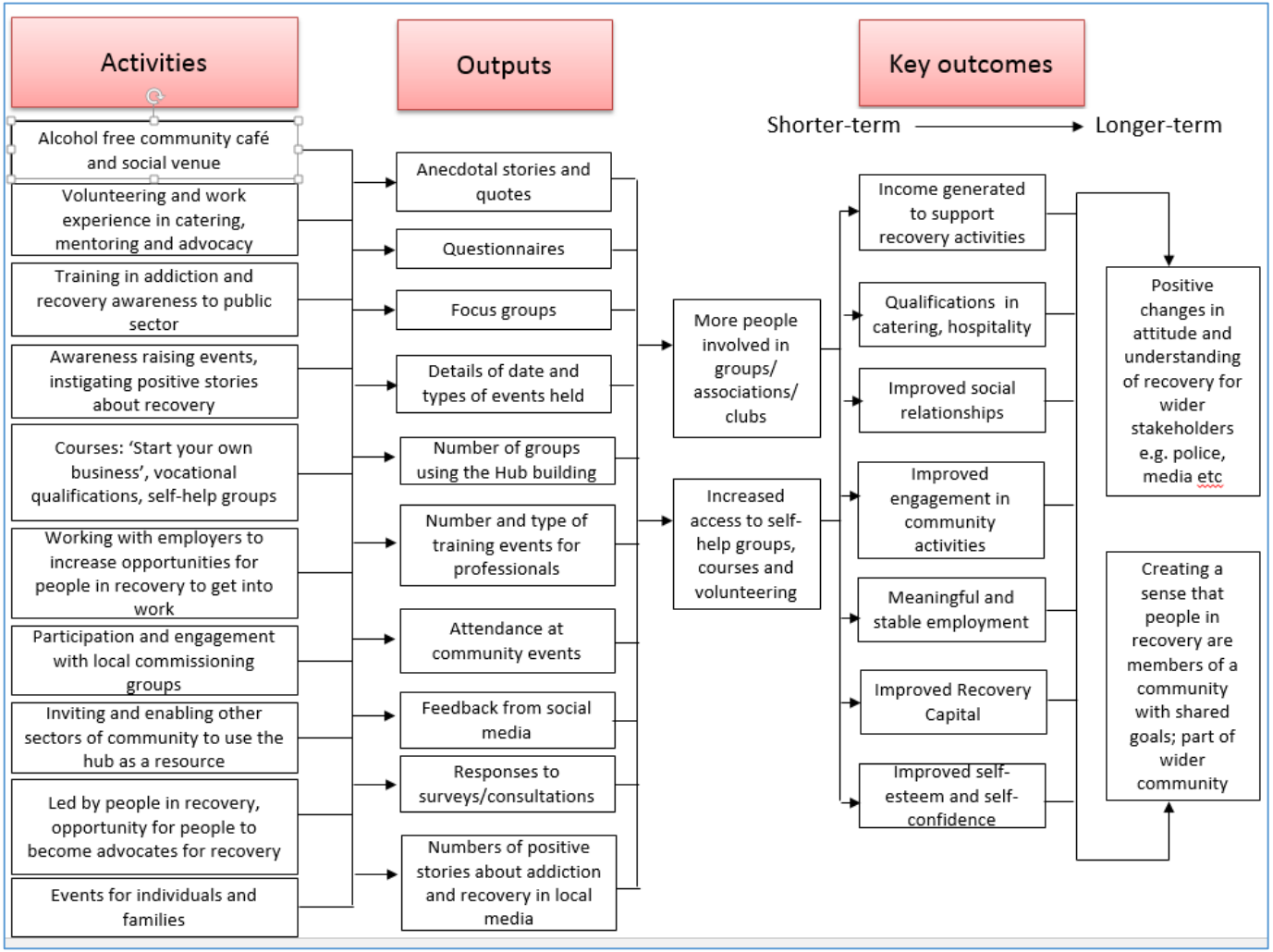


Figure 6: Key activities, outputs and outcomes identified for The Hub at the forecast SROI

Clean & Sober Living

In place of a forecast SROI that was undertaken with the other three recovery communities in year 1 of the evaluation, an outcome evaluation was undertaken with Clean & Sober Living which focused on outreach peer support and their training elements; findings are described below.

Outreach peer support group

The therapeutic peer support group met weekly, with the purpose of discussing and learning about their addiction and tools/coping strategies for it. Two members of staff from Clean & Sober Living led the group. Outcomes echoed those found within the forecast SROIs undertaken with the three other recovery communities and centred around:

- Fostering a community: as Durham is a large county with limited transport links, it was reported that the Clean & Sober Living staff provided additional support such as driving members of the group to and from the sessions and being contactable throughout the week for 24/7 support and care.
- Peer support: The participants believed the staff's own experience of addiction and recovery meant that they had the appropriate level of knowledge and understanding to effectively engage and inspire them.
- Routine and structure: The participants described the staff as being a first point of call when they were struggling with their addiction and the staff therefore had an important role during the early stages of some service users' recovery by encouraging them to attend the peer support groups.
- Being Person centred: The participants felt that the group was open and friendly and that everyone was treated equally because there was no hierarchy within the group.

What has changed for the service users?

Figure 7 shows the activities delivered by Clean & Sober Living and the factors which contribute to the success of the activities as reported by the participants. The figure also reports what the participants described has changed for them as a result of engaging in the activities. This included feeling better connected to family, friends and others, gaining the motivation and confidence to take on responsibilities, start a job and/or education, improved ability to cope emotionally and reducing the likelihood of them relapsing and/or engaging in crime.

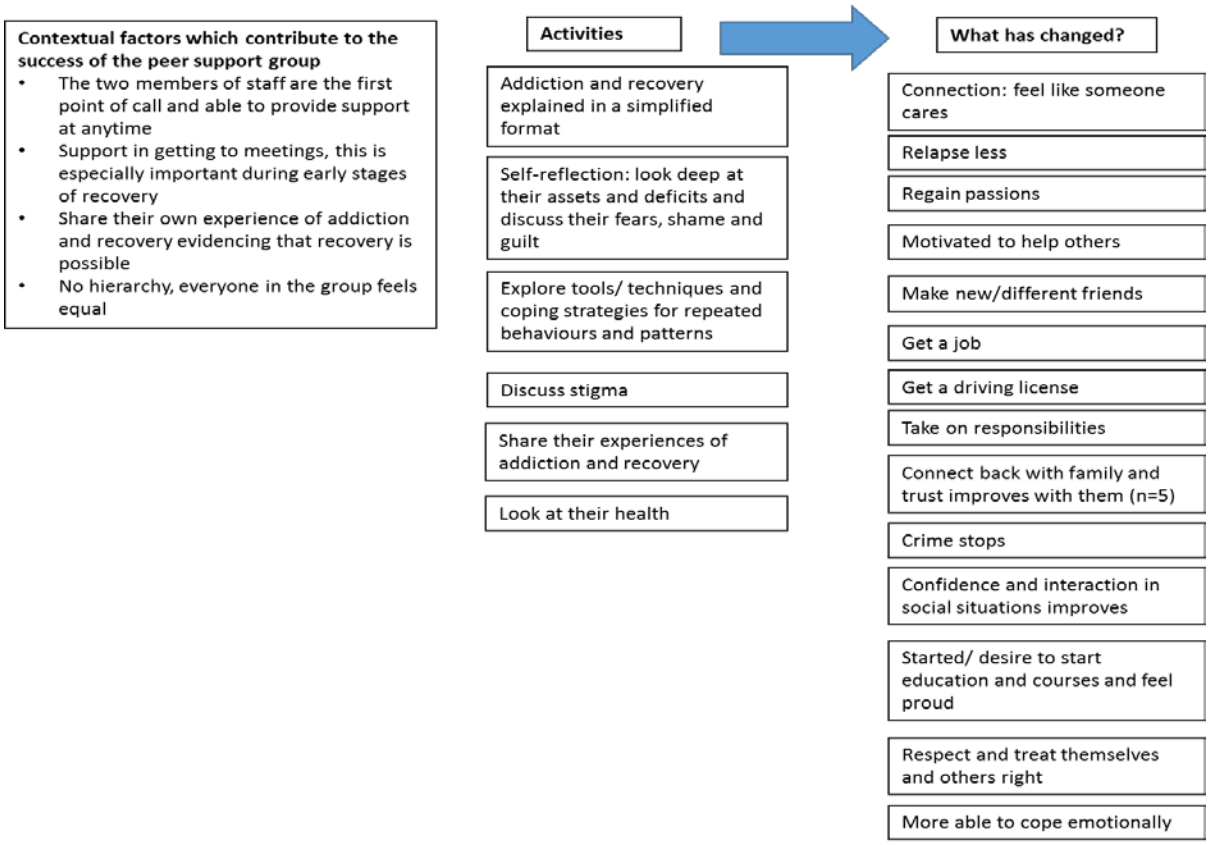


Figure 7: Chain of events for the service users of Clean & Sober Living's outreach group

What would happen if Clean & Sober Living were not there?

The participants accessing the outreach and peer support services were asked what would have happened if they did not receive the support from Clean & Sober Living. There was a general consensus across the group that the outcomes could be predominantly negative, such as continued use of the substance they were addicted to and an increased chance that they would be in jail, a mental institution, a hospital or even dead. When the participants were asked whether there were any other groups in the area for recovery, a number of them named the 12-step fellowships and said they regularly attended the meetings ran by them. Two other agencies were named for recovery in the local area. This included the statutory service Lifeline.

Training

The other element of Clean & Sober Living that was explored in place of the forecast SROI was the training delivered to statutory services such as police and probation services; charities and social enterprises.

All staff who attended the training completed the pre-and post-training questionnaire and seven participants went on to complete the follow up questionnaire. Of the 18 participants who completed the pre-and post-questionnaire, nearly three quarters were female (72%, n=13) and just over half (56%, n=10) were from statutory services, with the remainder coming from charities and social enterprises. Both the post and follow up questionnaires indicated that the participants felt that their understanding of addiction, recovery and their ability to communicate with someone suffering with

an addiction had improved as well as their awareness of stigma and prejudice towards people with an addiction.

In the post questionnaire participants commented on why they felt their knowledge and skills around addiction and recovery had increased. Just under two-thirds of the participants (61%, n=11/18) stated that hearing about addiction from the perspective of those in recovery, in particular, hearing about their experience and history, had improved their understanding of addiction and abstinence-based recovery. In particular, participants (61%, n=11/18) appreciated learning about how the 12-step fellowship works. Three participants (17%, n=3/18) felt the training had broadened their view on what addiction is, as they felt previously they had had limited knowledge on the behavioural/process of addiction. All participants felt their ability to communicate with someone suffering with an addiction had improved as a result of the training; and several participants (39%, n=7/18) claimed they intended to now work more with the person by trying to understand their perspective. Participants from the police acknowledged their skills for dealing with those in addiction had improved, however, three of the four participants from the police believed that due to the nature of their job, there will always be a barrier in communication. Just under half of the participants (44%, n= 8/18) claimed they were already aware of the stigma and prejudice towards people with addiction and reported having seen it in their workplace or across society, however, a couple of participants (11%, n=2/18) felt the training reinforced the importance of how it can impact on people and their engagement with services.

Follow-up questionnaire

All participants who completed the follow up questionnaire agreed (strongly agree n=5, agreed n=2) that the training had helped them in their job. Figure 8 details further how the participants felt the training had positively impacted on both their job role and personal life. Some participants provided examples of the impact of the training. For example, two participants stated the training had helped them be more empathetic towards people in addiction, one of whom also went on to explain how it had encouraged them to focus more on rehabilitation rather than just prosecution. Similarly, another participant felt that hearing the lived experiences of addiction had helped them appreciate what those in addiction face. Two participants felt they were more confident to talk/offer advice to people experiencing addiction. Both felt the training had encouraged them to find out more or discuss with others about the local support services.

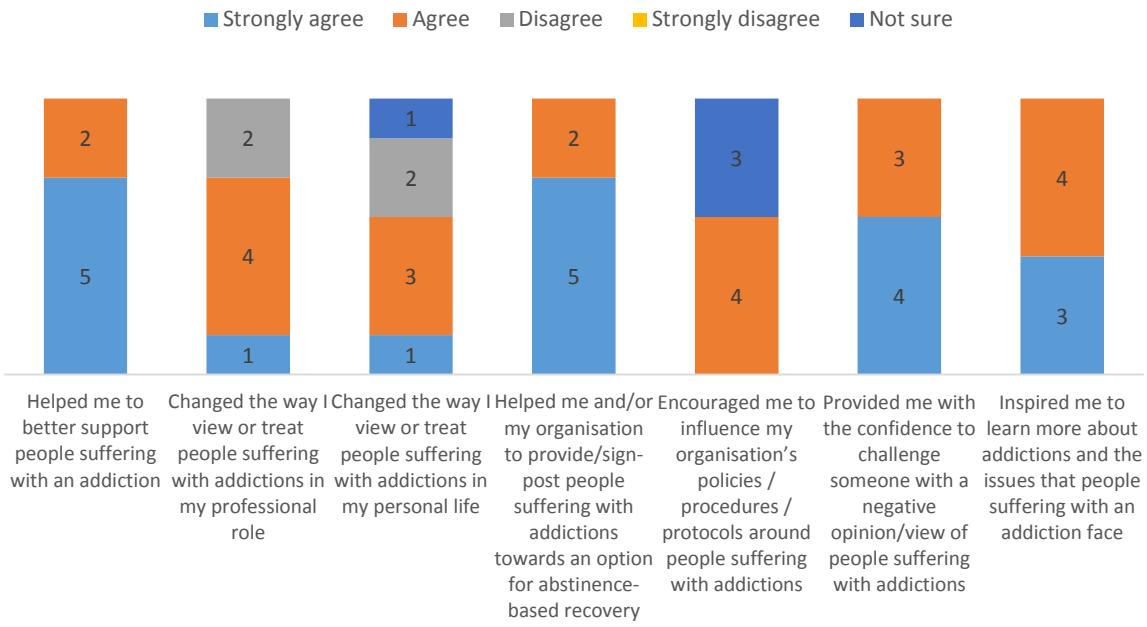


Figure 8: Examples of how the participants felt the training impacted upon their job role and personal life

Participants identified which parties they had discussed their training with. At least five participants reported discussing what they had learnt about addiction, stigma/prejudice (towards those in addiction) and abstinence-based recovery with their colleagues (this included both colleagues who had and had not attended the training). Similarly, more than half (n=4) of the participants discussed their understanding of addiction and stigma/prejudice (towards those in addiction) with the person they lived with/ spouse, however they were less likely to discuss abstinence based recovery with them. Four participants discussed stigma and prejudice towards those in addiction with their friends, while only two discussed addiction and abstinence-based recovery with their friends.

4.2 Evaluative SROI Findings

Evaluative SROI: CHANGES UK

Quantitative data analysis

Characteristics of participants

The first stage of data collection was completed for the WEMWBS and ARC tool at the start of April 2016 and the second stage was collected at the start of July (approximately three months later). Both before and after data were gathered for ten service users: seven males and three females. Nine participants were White British, one was Black Caribbean. The age of the service users ranged between 25-48 years with the majority (n=7/10) under the age of 40. All service users had been a member of the ChangesUK's recovery community for approximately three months at the point of the first data collection.

Employment, education and training status

At the start of March 2016 data were collected for 36 service users. Four months later at the start of July the same information was collected for 50 service users.[2] Data showed that at both time points all participants for whom data were collected for had a housing problem, were in receipt of Employment Support Allowance and unable to work. Despite being unable to work 75% (n=27/36) of service users were doing unpaid voluntary work at the start of March and 82% (n=41/50) were doing it at the start of July. The type of voluntary work varied, examples including: receptionist, administrator, social media, gardening, catering, event management, retail and support work.

Parental status

At the first stage of data collection, a third (n=12/36) of service users did not have children under the age of 18 living with them, similarly a third did not have a child under the age of 18, and for the other third the parental status was unknown. At the second stage of data collection, just under half (n=24/50) of service users reported not being a parent of a child under the age of 18. For the other categories the frequencies remained similar, with no service users reporting they had a child under the age of 18 living with them.

Engagement in recovery activities

All service users attended activities ran by ChangesUK, such as the mutual aid groups, Recovery Football, Tournaments and Recovery Conventions. At both the first and second stage of data collection, the majority (24/36 and 41/50 respectively) of service users regularly attended (at least once a month) local organised activities (which were not run by the recovery community), which included the Gym, Football, Performing Arts, Acupuncture, Equine Therapy, Music, Art.

WEMWBS

Responses were given for all questions except for one by one participant; in this case the median was used to replace the missing value. The range for the WEMWBS score improved between the first and second stages of data collection. In April WEMWBS scores ranged from 21-42, while in July scores

[2] For the purpose of the calculation of the evaluative SROI the lower figure of 36 was taken to illustrate the size of the recovery community so not to over claim – this is a key social value principle.

ranged from 38-57. As the data contained outliers and so was not normally distributed, the median was used instead of the mean to describe the measure of central tendency for the ten participants.[3] Over the two stages the median improved by 16 points from 29 to 45 on the WEMWBS tool. As the sample size was less than 50 it was not deemed appropriate to carry out a statistical analysis of the results. Nearly all (n=9/10) service users had an improved WEMWBS score of 8-26 points, whilst one service users score remained the same at 42. For comparison, the national England mean was 52.3 (NHS Health Scotland, 2016).

ARC recovery tool

For the ARC tool, the range for the second stage of data collection (26-46) was notably higher than the first stage (5-26). As the data contained outliers and so was not normally distributed the median was used instead of the mean to describe the measure of central tendency for the ten participants.[4] The median of 14.5 at the first stage of data collection improved over time to 38. An individual analysis of the participants showed all service users scores improved by between 11-31 points. The researchers who designed the tool calculated that a sample size of at least 31 participants would be needed for a test-retest analysis (Groshkova, Best and White, 2012). Due to the small sample size no further analysis was conducted.

ChangesUK - The evaluative SROI found that CHANGES UK peer led support and membership service was shown to have the potential to create £5.12 of social value for every £1 invested.

[3] Not normally distributed data may be expected due to the small sample size.
[4] Not normally distributed data may be expected due to the small sample size.

Quantitative data analysis

Characteristics of the participants

Data were collected at two time points for all participants. The first stage of data collection took place between March and August 2016, with the second stage from July to September 2016. Data were collected for 27 service users at the first stage of data collection and for 12 during the second stage. During the first and second stage there were a similar number of males and females (n=15 and n=12, and n=6 and n=6 respectively). Similarly, at both the first and second stage around half (n=15/27 and n=5/12 respectively) of the participants were aged 40-59 whilst the rest were aged 21-39. At both stages of data collection there was one participant aged 20 or under. Of the 14 participants for whom ethnicity was reported the majority (n=11/14 during the first stage and n=10/12 at the second stage) were White British. Data on accommodation status, employment, education and training status, parental status and engagement was collected for all 27 participants.

Accommodation status

The findings for both the first and second stage of data collection showed that the majority (n=25/27 and n=9/12 respectively) of service users at the Hub did not have a housing problem. At both stages only one service user had a housing problem and only one was living in a Dry House. Similarly, at both the first and second stage of data collection over half (n=14/27 and n=8/12 respectively) of the service users where in unpaid voluntary work. Type of unpaid volunteer work was described for five service users (at the second stage of data collection) these included working at the Hub (front and/or back of house), a Peer Mentor at a Drug and Alcohol service, a Verger and a book keeping/accounts. Of the 14 from the first stage of data collection who were doing unpaid volunteer work three had a long term sickness/disability, one was seeking employment and one was a student.

Employment, education and training status

At the first stage of data collection it was reported that just less than half (n=10) of the 27 service users were in regular employment, and a similar percentage (n=5/12) were in regular employment at the second stage of data collection. Two service users from the first stage of data collection reported they were not employed nor were they looking for work; further detail on this was not available. Types of regular employment were described for four service users (at the first stage of data collection), which included two who worked at the Hub (one of which was working in the front of the house at the Hub), a Recovery Worker and an Admissions Worker.

Parental status

At both the first and second stage of data collection just over half (n=15/27 and n=7/12 respectively) service users were not a parent of a child under 18, and over a quarter (n=7/27 and n=4/12 respectively) had at least one child under the age of 18 living with them. The rest of the service users (n=5/27 and n=1/12 respectively) had a child under the age of 18 but the child did not live with them.

Engagement in recovery activities

Seventeen service users out of 27 attended engagement activities within the Hub on a monthly or more basis during the first stage of data collection; during the second stage five out of 12 service users

regularly took part in engagement activities organised by the Hub. Eight out of 27 service users during the first stage of the data collection said they attended activities in the local community which were not ran by the Hub on a monthly or more frequent basis. Examples of these activities included: 12 Step Fellowship (AA) aftercare, Church, meetings and conventions. During the second stage of data collection eight individuals out of 12 reported attending activities external to the Hub, examples included: the Gym, Family Fun Days, 12 Step Fellowship meetings and aftercare (NA and AA), SMART recovery, Turning Point, a Recovery Skills Programme, football and Church.

Joined the recovery community

Data on how long someone had been a member of the Hub recovery community was provided for approximately half (14 of the 27) participants. Four participants had been members before the start of the Give it Up funded project, five participants joined during the first year the Hub was in receipt of funding from Give it up and another five joined during the second year. In the comparison analysis data on time at the recovery community was available for 11 out of 12 participants: three participants had been members before the start of the Give it Up funded project, four had been members since the first year of the funding and another four since the second year.

WEMWBS

The range for the WEMWBS score improved slightly between the first and second stages of data collection. Data were missing for one individual on one of the questions, as the data were normally distributed the mean was taken. As data from the first stage of data collection was normally distributed the mean was used to describe the measure of central tendency for the 27 participants, the mean was 52.56, values ranged from 30-70.

When making a comparison of the data from the first and second stage only the 12 participants who had data from both time periods was compared. The range from the first round of data collection was 40-70, whilst by the second stage this slightly decreased from 35-70. As the data contained outliers and so was not normally distributed the median was used instead of the mean to describe the measure of central tendency for the twelve participants.[5] The average score from the 12 participants from the first stage of data collection was 52, while at the second stage it was 52.25. For comparison, the national England mean was 52.3 (NHS Health Scotland, 2016). As the sample size was less than 50 it was not deemed appropriate to carry out a statistical analysis of the results.

Half (n=6/12) of the service users had an improved WEMWBS score of 5-12 points, one service user's score remained the same at 70 and five service users had a decrease in score of -3 to -13 points. Participants who had been accessing the Hub for 12 months or more were more likely to have an improved score, whilst participants who had been members for less than six months were more likely to have a worse score. However, as the numbers were small it is not possible to make any clear interpretation with this. Due to the small sample size no statistical analysis was conducted.

ARC recovery tool

For the ARC tool data were missing for two individuals (four questions for one individual and one for the other); as the data for each question was not normally distributed the median was taken.[6] As data

[5] Not normally distributed data may be expected due to the small sample size.
[6] Not normally distributed data may be expected due to the small sample size.

from the first stage of data collection was normally distributed the mean was used to describe the measure of central tendency for the 27 participants, the mean was 38.26, values ranged from 10-60.

When making a comparison of the data from the first and second stage only the 12 participants who had data from both time periods was compared. The range for the first set of data were 20-50, while for the second it was 12-50. As the data contained outliers and so was not normally distributed the median was used instead of the mean to describe the measure of central tendency for the twelve participants. The median of 43 at the first stage of data collection stayed constant over time. An individual analysis of the participants showed four service users' scores improved by between 4-8 points however, five service users scored between -4 to -8 points whilst three service users' scores remained constant over time. The researchers who designed the tool calculated that a sample size of at least 31 participants would be needed for a test-retest analysis (Groshkova, Best and White, 2012). There was no clear trend between date joined the recovery community and increase or decrease in ARC score. Due to the small sample size no further analysis was conducted.

Qualitative analysis

One family member was successfully recruited. The family member's daughter had a voluntary post in the Hub café three times a week which the participant believed their daughter enjoyed as the baking duties involved with the post closely aligned with their daughter's interests. The family member felt that the working relationships and environment in the Hub, and the nature of the voluntary post were beneficial to their daughter as at the Hub her daughter did not experience the stress associated with working under pressure and making mistakes in the workplace.

> *"She's met customers and deals with customers, she works alongside the people in the kitchens really well, I mean there isn't anybody she doesn't get on with… so she has had a positive feedback with relationships which is good because she used to struggle with relationships"*

According to the family member the voluntary post played a pivotal role in increasing their daughter's self-esteem and independence, especially as it led to her feeling confident in her ability to take on paid work in the near future. This was highlighted as being important for two main reasons: their daughter had felt like she was a nuisance for her family and was not contributing to the community; the family member recognised the difficulties individuals in recovery face when trying to gain employment. The family member believed that their daughter had not experienced any negative outcomes from being involved with the Hub.

> *"one of [name]'s main problems was why should she be here, she adds nothing to the community, she's nothing but a nuisance to everybody in the family, look what she has done to the family and she shouldn't be here and now you know she feels it's a bit of payback time and it's a really contribution she can make herself feel good about herself which I think a lot of people in her position don't like themselves and so it's the only thing that will make her feel good about herself and it's fantastic"*

As well as the Hub, their daughter attended Narcotics Anonymous (NA) meetings, groups delivered by the Nelson Trust and counselling sessions. The participant felt that other activities such as the groups

delivered from the Nelson Trust and NA meetings had attributed to some of the outcomes their family member had experienced. For instance, it was felt that approximately half of the 'improved family relationships' outcome could be attributed to the counselling sessions. The family member explained how they lived over two miles away from the Nelson Trust and the Hub, but started using the services because they felt that there was no such service provision in their local area.

The Hub - The evaluative SROI found that The Hub has been shown to have the potential to create £9.71 of social value for every £1 invested.

Quantitative analysis

Characteristics of the participants

Data were collected at two time points for all participants. The first stage of data collection took place in May 2016 and the second stage in October 2016. WEMWBS and ARC Recovery Tool data were collected for 20 service users across these two points in time from 11 females and nine males. The majority of these service users were aged between 27 and 36 (n=14/20) and the remaining service users being aged between 45 and 56. The majority of the service users were White British (n=16).

Additional data

Data were also collected on accommodation status, employment, education and training status, parental status and engagement across both stages of data collection. These data were presented as total numbers:

- accommodation status information was provided for 21 service users across both data collection periods
- data were collected for 78 and 76 service users for employment, education and training status (first and second data collection respectively)
- parental status information was provided for 23 service users in the first data collection phase and 21 in the second

Accommodation status

The findings for both the first and second stage of data collection showed that the majority of service users for whom data were collected did not have a housing problem (n=19/21 and n=20/21 respectively).

Employment, education and training status

Employment, education and training status data collected was very similar across the two data collection periods. Data were not known for 13 and 14 service users respectively. Similar numbers of service users were seen to be undertaking unpaid voluntary work at the first and second stage of data collection (n=16/78 and n=13/76 respectively). At the first stage of data collection it was reported that four service users were in regular employment, whilst five were employed when the second data measure was collected. Thirteen service users were recorded to be unemployed and seeking work, 21 service users were a pupil/student and two were retired from work. Similar numbers of service users were shown to be in receipt of benefits across both data collection periods.

Parental status

At both the first and second stage of data collection 16 service users reported not being a parent. A small number of service users stated that they had at least one child under 18 living with them (5/23 and 3/21 respectively) across the data collection period. Two service users stated that they had a child under the age of 18 but the child did not live with them.

Engagement with other activities

When looking at the numbers of service users who attended local groups/locally organised activities not run by the recovery community (at least once per month for at least two months) 15 service users and 17 service users were reported at the first and second data collection respectively.

WEMWBS

The range for the WEMWBS score general seemed to improve between the first and second stages of data collection. In May WEMWBS scores ranged from 35-49, in October scores ranged from 23-59.

As the data contained outliers and so was not normally distributed the median was used instead of the mean to describe the measure of central tendency for the twenty participants.[7] Over the two stages the median improved by seven points (43.5 to 50.5) on the WEMWBS tool. Three quarters (n=15/20) of the service users completing the WEMWBS had an improved WEMWBS score, whilst the remaining service users (n=5) had a decrease in score.

As the sample size was less than 50 it was not deemed appropriate to carry out a statistical analysis of the results. For comparison, the national England mean was 52.3 (NHS Health Scotland, 2016).

ARC recovery tool

As previously detailed the ARC Recovery tool measure looks at a series of 50 questions and requires a 'yes' or 'no' answer, where 'yes' is recorded as a score of 1 and 'no' as a score of 0 giving the participant a score out of a potential 50. In the case of Spitalfields Crypt Trust, however, each question was scored using a Likert Scale of 1 to 5 (None of the time -1; Rarely -2; Some of the time – 3; Often – 4; All of the time - 5), therefore giving an overall possible score of 250. The researchers decided to interpret the data as it had been presented as it was still possible to establish whether there had been a change in score over time for each service user who had completed the measure.[8]

For the ARC tool, the range for the second stage of data collection (182-220) was similar to the first stage (178-211). As the data were not normally distributed the median was used to describe the measure of central tendency for the 20 participants.[9] The median increased from 192 to 204 over the two stages of the data collection. An individual analysis of the participants showed that 18 service users had experienced an increase in their score,[10] whilst one had experienced a decrease and one had stayed the same.

[7] Not normally distributed data may be expected due to the small sample size.

[8]The researchers considered asking the recovery community to recollect the data, however, this was not possible due to resource constraints. Re-coding the data that had been provided was also another option that was considered. This would have involved re-coding the Likert Scale scores of 1 and 2 (none of the time; rarely) so that they represented a '0 – no' score; and the Likert Scale scores of 3 to 5 (some of the time; often; all of the time) represented a '1-yes' score. However, it was felt that this may provide an unrepresentative picture of the recovery community members experiences as the researchers would have been placing their own assumptions upon the data.

[9] Not normally distributed data may be expected due to the small sample size.

[10] For those service users who had experienced a positive change in score across the two data collection methods, 10 servicers users had a change of between 2 and 10 points, seven service users had a change of between 13 and 22 points and one service user had a change of 63 points.

Qualitative analysis

> *"She was diagnosed with social anxiety which made it very difficult to talk with anyone she didn't know, especially in groups. This change means she is now able to talk about problems she is experiencing and get help before things get too difficult."*

One of the family members completed a written version of the outcomes questions. Their daughter was involved with Choices as both as service user and committee member and attended two to three days a week. There were a number of changes that they felt their family member had experienced as a result of engaging with Spitalfields Crypt Trust and the Choices programme. These were felt to be positive, yet unexpected changes and were ranked as follows: 1) long term sobriety; 2) better/improved mental health; 3) ability to support others; 4) increased self-confidence, self-assertion and decision-making skills; 5) Ability to talk to people about herself; 6) getting married.

> *"..being part of the committee has helped her feel part of the community. [It] Means she is able to evaluate what is good for her and make decisions based on this instead of people-pleasing."*

The family member also considered that all of these changes were as a direct result of being involved in Spitalfields Crypt Trust and that without being a member of the Spitalfields recovery community she may well have relapsed.

When the family member was asked about the changes they had experienced, it was clear that the relationship between themselves and the recovery community member had improved/strengthened and that there was reduced concern/worrying by the family member.

> *"X nowadays is more calm, not so anxiety and speaks correctly with the family members and out guests too. She tells [us] willingly about her life, we make food together and have fun time with her, we really enjoy her visits. Earlier when she visited us, she was distressed, didn't want to tell about herself or what was happening to her. Quite soon she wanted to open a bottle of wine and did not stop drinking even I wanted her to be sober."*

Spitalifields Crypt Trust - The evaluation SROI found that Choices and Progression was shown to have the potential to create £5.19 of social value for every £1 invested.

Forecast SROI Clean & Sober Living

As noted previously, it was not possible to conduct a forecast SROI evaluation for Clean & Sober Living in year 1 of the evaluation. Data, however, were collected in year 2 to inform a forecast SROI.

Quantitative data analysis

Characteristics of participants

The first stage of data collection was completed for the WEMWBS, ARC and additional indicators tools at the start of April 2016 and the second stage was completed in May (approximately five weeks later). However, the additional indictors were not collected during the second stage of data collection stage. Both before and after data were gathered for eleven service users: eight males and three females. All participants were White British. The age of the service users ranged between 19-55 years with the majority (n=9/11) aged 26- 49 years.

Additional indicators

The majority (n=10) of service users engaged in education or employment activities which were supported by Clean & Sober Living. Ten service users also attended events externally to Clean & Sober Living such as 12-step fellowship meetings. A minority (n=2) of service users had children under the age of 18 living with them.

Joined the recovery community

Three participants were already members of Clean & Sober Living prior to the organisation receiving the GIU funding (members for over 18 months), another three participants became members during the first year of the GIU funding (members for 12-18 months) and a further five became members during the second year (members for less than 12 months).

WEMWBS

The range for the WEMWBS score improved between the first and second stages of data collection. In April WEMWBS scores ranged from 22-42, in May scores ranged from 34- 64. As the data contained outliers and so was not normally distributed the median was used instead of the mean to describe the measure of central tendency for the eleven participants. Over the two stages the median improved by one point (38 to 39) on the WEMWBS tool. As the difference over time was small and the sample size was less than 50 it was not deemed appropriate to carry out a statistical analysis of the results. Nonetheless, both scores indicated the service users' mental wellbeing was below England's national average (52.3) (NHS Health Scotland, 2016). Nearly all (n=9/11) service users had an improved WEMWBS score, a minority (n=2) had a decrease in score. One observation from the data is that those who became members of Clean & Sober Living during the second year of the GIU funding tended to have higher scores at both time points.

ARC recovery tool

For the ARC tool, the range for the second stage of data collection (24-50) was similar to the first stage (25-50). As the data were normally distributed (despite the small sample size) the mean was used to describe the measure of central tendency for the eleven participants. The mean increased marginally from 41.64 to 41.82 over the two stages of the data collection. An individual analysis of the

participants showed mixed results: 4 out of 11 participants improved their score by 1-3 points, 3 out of 11 decreased their score by 1 or 3 points and 4 out of 11 had the same score between the first and second data collection period. The researchers who designed the tool calculated that a sample size of at least 31 participants would be needed for a test-retest analysis (Groshkova, Best and White, 2012). Due to the small sample size no further analysis was conducted.

Qualitative analysis

Interviews with recovery community members

Interviews with two of the recovery community members from Clean & Sober Living identified that there were a number of common outcomes that had been experienced (Figure 9). There were three initial areas that were identified across the two recovery community members and these related to relationships with family, friends and recovery community members; taking responsibility; and relationship with self. Within these three areas, the only aspects both recovery community members had experienced were gaining genuine friendship and experience of peer mentoring. There were, however, three longer-term overarching outcomes that were identified all of which echoed those evidenced in the other three recovery communities:

1) improved relationships with family, friends and recovery community members
2) sense of purpose
3) emotional stability

It is important to note that this was a very small sample size of recovery community members. It was not possible to generalise these findings to the wider recovery community members, however, it is important to note that the outcomes identified were similar to those identified by the three of the recovery communities in phase one of the evaluation. It was also not possible to confirm the value of these outcomes (from lease to most important) due to issues with the overall recovery community and a number of members relapsing and leaving the recovery community, and so an SROI was not calculated.

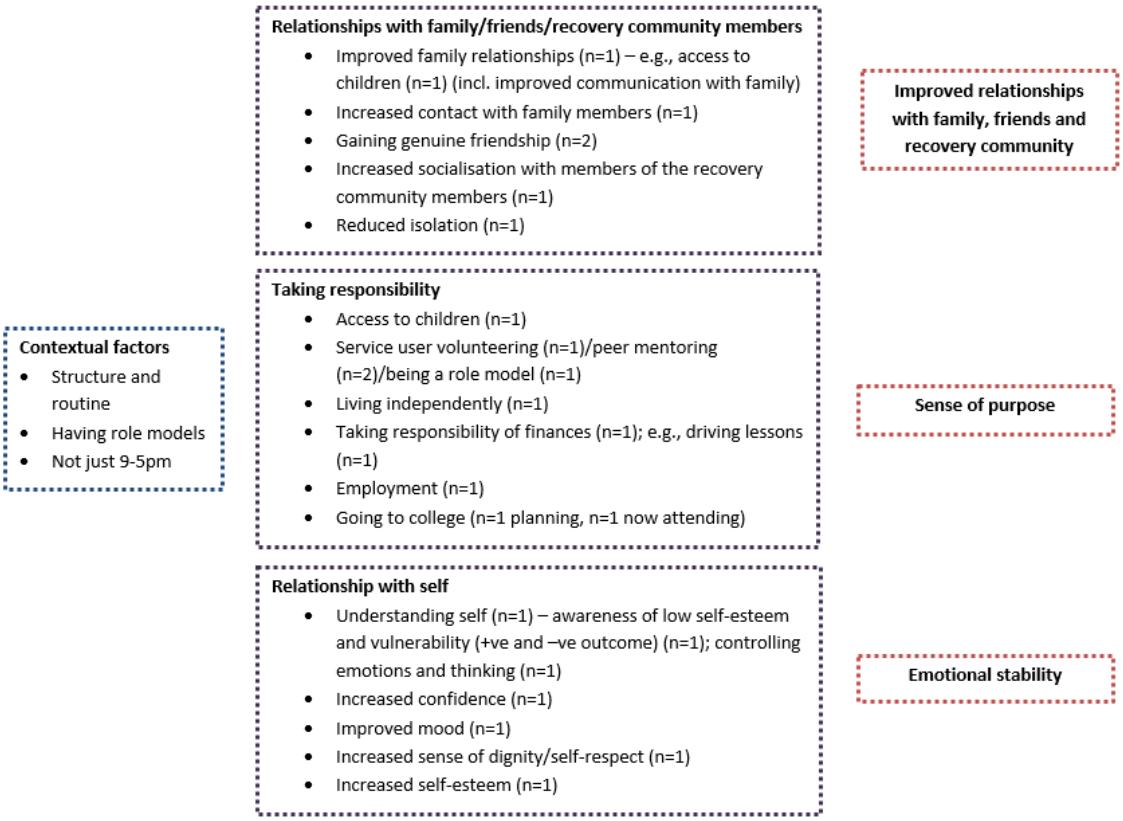


Figure 9: Outcomes identified by two Clean & Sober recovery community members

Checking the robustness of the SROI findings

As with the forecast SROI carried out in phase one of the evaluation, sensitivity analysis was again carried out on the analyses for ChangesUK. The Hub and Spitalfields Crypt Trust. This aimed to check the assumptions made by the researchers and assess the robustness of the impact map and involved changing the variables under question and examining the effect on the overall SROI ratio. A large variation in the SROI result after variables are adjusted indicates uncertainty in the figure – this was, however, not shown in any of the recovery community's calculations.

The data available to inform exactly how many people in the recovery community had experienced each outcome, came from the WEMWBS and ARC Recovery tool measures. The proportion of those recovery community members who completed the wellbeing and recovery tool measures were then aggregated up to denote the proportion of people in the whole recovery community who may be experiencing a positive outcome or change. It is important to note that due to the small sample sizes of the data collected for the outcome measures, it may be possible that there are limitations in robustness. The proxy values identified for each recovery community in phase one of the evaluation are still considered to be appropriate.

Details of the sensitivity analysis that was conducted for the evaluative SROI can be found in Appendix 5.2.

Details of the financial proxy indicators used as well as the deadweight and attribution justifications can be found in Appendix 3. Financial proxy indicators and values remained the same over the duration

of the forecast and evaluative SROI, with the 'n', number of recovery community members being amended in line with the data collected. The justification for deadweight and attribution values also remained the same.

4.3 What Makes the Recovery Communities Work?

Findings from the process evaluations undertaken across each recovery community in year one of the evaluation have been analysed and presented collectively. A number of key themes emerged from the thematic analysis: defining abstinence and recovery, challenges and barriers to recovery, responses to challenges and barriers, increased visibility of recovery to those in recovery and addiction, and developing relationships and sharing expertise and resources. A discussion of each theme is presented below.

4.3.1 Abstinence as a focus for recovery communities:

Abstinence was defined by all communities as not using drugs or alcohol. There were some differences in opinions between and within the communities, as to whether abstinence also included abstaining from prescribed drugs. In some communities there was a requirement for committee members and volunteers to be abstinent for six months. All recovery communities explained how recovery was not just about maintaining abstinence, but the ability to be proactive, make progress in their recovery and to help others to recover. Members of the community were often at different stages in their recovery, but all can make progress by engaging in meetings and activities which are meaningful to them. It was expected that such engagement will help them to live independently and reintegrate back into their local community. A number of participants explained how moving from street drugs to prescribed drugs was also recognised as a level of progress and went on to explain how individuals don't have to be abstinent to be a part of their recovery community.

> *"I know people that are in recovery that do drink alcohol although it's not abstinence, they've changed their way of life, and for them it works, so I think recovery as far as the Hub is concerned is about moving towards abstinence, but we're also really aware that we don't want to sort of differentiate or marginalise people that may still be that's on a methadone script because someone whose stopped using heroin on the street, and is stable on the methadone script, is a level of recovery, it's not abstinence, but it's a level of recovery…our kind of focus is towards abstinence, but we're all mindful of the effect that it can have if we are saying to people 'well you're not in recovery because you're on a metha script', no, that's not helpful we don't believe" (Participant 10: Recovery Community 4)*

4.3.2 What the recovery communities add:

Although the 2010 Drug strategy advocates for abstinence-based recovery, a number of participants felt the majority of treatment and recovery services focus on harm reduction approaches and claimed that there were tensions between those services which are based on different models.

The majority of participants stated there were no other abstinence-based recovery communities in their areas, apart from the 12-step fellowships. It was reported by some that the 12-step fellowships held daily meetings in their area, however, one participant felt this was not enough for someone in

addiction as they can have the impulsion to take the substance they are addicted to at any time of the day. All recovery communities felt there was a need for more abstinence-based activities. However, participants felt that there was a lack of funding and resources locally and nationally to support this. A number of participants explained that when individuals came out of treatment or prison they struggled to live independently, find employment or training opportunities; this could be especially true for those with a criminal record as they struggle to obtain their DBS check and may not have the skills or confidence to enter the workforce. A further barrier to gaining access to employment and educational opportunities was the cycle of poor socio-economic and housing outcomes experiences by those in recovery.

Three of the communities discussed how society's cultural norms are not supportive of those in recovery. Access to street drugs locally and recreational drug and alcohol use in the workplace and social housing were described as making it difficult for individuals in recovery to abstain from substance use. The participants identified that there was therefore a need for somewhere individuals could go in the evenings where they felt safe and supported in their abstinence-based recovery. A further need included meetings which are child friendly.

"Generally services are 9-5 so you know, if somebody needed you know, support then, obviously you know, after 5 o'clock you know, they might struggle. 12 step fellowships have people that will do a 12 step call if somebody is in trouble, but you know, a lot of people won't want to make that call and go 'you know, will you help me?', whereas just coming to a coffee shop they can do, you know, independently without making too much fuss, and you know, they'll be people around who they can have a chat with if they want to. So it's a kind of little bit more informal and less threatening I suppose for people… the aim of the alcohol free venue is this it's going to be open at 8 in the morning till 11 o'clock at night." Participant 9: Recovery Community 4

"I've had experience of hearing other people, they don't know what they're doing when they've come out of treatment or they've come out of prison into treatment and then they are back out and then they are left to do nothing, well obviously there's meetings but meetings on their own doesn't hold people, there needs to be some sort of pastoral, a caring sort of workforce" Participant 7: Recovery Community 3

The recovery communities described how there was a lack of understanding of and training on addiction, recovery and the challenges associated with it for both the general public and those in professional services. Recovery can be a full time, long term process as it takes time to establish healthy habits, however, the participants reported that staff in professional services believe recovery should be a quicker process. Stigma was described by all communities as being a barrier for recovery. One community felt abstinence-based recovery was misunderstood; and that it was this lack of understanding made recruitment to the recovery community difficult. The participants believed that the general public were interested in the recovery community and one community found that a café ran by the recovery community would not put people off going, but instead customers reported preferring to spend their money on a business which had a social goal.

"I think one of the main things that stands in the way of recovery is the stigma towards people in recovery a profound lack of understanding in not only in general in society, also in the medical field as well there doesn't seem to be enough training and understanding of what addiction is and what is required for recovery. There's the kind of mind-set that people go off for three months go to rehab and get well as if some, as if people were going off and trying to mend a broken leg and once that's healed it's ok. There seems to be often that attitude. That this is an ongoing lifelong challenge for some people and then it can take years to ingrain healthy habits… I think there's a profound lack of understanding." Participant 8: Recovery Community 3

4.3.3 Key characteristics needed to support improvement of long-term abstinence outcomes:

Two recovery communities stated that they helped the service users find out what recovery programme works best for them. The non-judgmental support from other service users was highlighted as being a key contributor to the success of recovery. It was felt that those in recovery could empathise effectively with other service users, having been through similar experiences themselves. One participant claimed that the user led aspect of their recovery community made it unique to other recovery models.

Another element which featured across all recovery communities was the involvement of the service users in problem-solving and decision-making. One community claimed that their service users provided ideas on what activities, skills and opportunities were needed and wanted. Another explained how their committee was purposively made up of service users from various stages of recovery so as it was representative of all service users. Moreover, one recovery community planned their service users to be included in the social media strategy and for the social media content to be user generated. As a result of the service users becoming service providers and this helping its sustainability, one participant described how those at the recovery community were starting to believe they had ownership over the recovery community.

"I think a network, a support network in whatever shape or form is essential, it is an essential key part, whatever the shape or form the recovery takes … a support network, you have peers and people to sort of like spend time with, or construct activities to get involved with … we're here to sort of facilitate getting people in touch with what works for them … I don't know anybody that has really managed to sustain a happy and fulfilling life in recovery on their own." Participant 10: Recovery Community 4

All recovery communities felt it was important to have activities and opportunities set up for those who come out of formal treatment. The Give it Up Fund was being used to pay to develop or expand opportunities for those in recovery. For example, training, volunteering, mentorship, employment confidence building sessions, social outings, life drawing as well provision of holistic services such as support for accessing accommodation. All of these activities aimed to help individuals gain skills and qualifications in order to prepare them for future employment and integration back into the wider community.

Two recovery communities explained how their aftercare made them stand out from other recovery communities as they provided an aftercare service and/or activities which were tailor-made to match the needs of the service user. For example, where it was identified that there was a need for support in the evening when normal services were closed as well as a need for support groups which were child friendly, services have been developed to meet these needs. A further example includes how opportunities were tailor-made for service users who were keen to volunteer however, because of their offending history their DBS check can take months to obtain. As a result, the recovery communities provide volunteering and educational opportunities where a DBS is not needed, such as gardening, fundraising, marketing and training courses. In addition, one recovery community reported that they were building up a rapport with businesses with whom they hope in the future which employ their service users.

"Our aim as an organisation is to support people from dependence to independence and ultimately I think everybody knows that if you're going to achieve long term recovery or if you're really going to reduce long term unemployment you need accommodation, we provide that… our artist and resident was here yesterday and he runs an art class on a Monday and something like that it's really simple and straight forward but it's really well attended and it's led onto other things so there's the photography project as well which has now grown out of the photoshoot that we did for the website so there's a lot of potential there and it all effectively relates back to Comic Relief to be honest because you can start to think about ideas without having to worry about whether you can afford it or not and it all fits." Participant 3: Recovery Community 1

Reducing stigma by raising awareness was described as being important. It was felt this could be achieved by demonstrating to the wider community that recovery works and that those in recovery have a significant role to play in society. It was believed by the participants that the world of addiction needs to become increasingly visible to the public to reduce the prejudice attached to it. The interviewees suggested that this had worked for other groups that have been subjected to endemic stigma such as homosexuality and mental health. All of the communities described projects, events or training which they had set up to help members of their recovery community interact with the local public and for the public to be increasingly exposed to positive images of recovery. Examples of these projects and events included a voluntary gardening project, family fun days, and alcohol free venue/cafes. Nonetheless, one community described how in their area recovery was still hidden from the general public. Two recovery communities described that by having their recovery community in a visible location, such as on the high street, the public and other businesses were aware and supportive of them. Media platforms which were being used to increase the visibility of recovery to the local community included a magazine, the creation of a film on addiction and recovery, and engaging with social media. Twitter was highlighted by all communities as a useful way to engage with businesses. Two recovery communities explained how they were using the Give it Up Fund to develop a social media strategy so they could expand their engagement with service users as well as businesses on Facebook and Twitter.

"I mean the main thing it's getting people into our recovery café which isn't, we deliberately made it not exclusively recovery you know for recovery people… we've tried to build on what we do with the social enterprise which is to make it integrated, to make it a place where regular members of the public and people in recovery mix." Participant 6: Recovery Community 3

Two of the recovery communities stated that the funding was being used to pay for a member of staff whose role had included changing people's views of addiction and recovery. Training was being delivered to a range of organisations including: voluntary sector partners, the police, staff from the local authority and drug treatment staff. The recovery communities reported receiving feedback on how the training had changed people's opinions and views on recovery and how they intended to carry out their practice with a more informed understanding of the experiences of those in addiction. One of the communities was using the Give it Up Fund to pay for the publication of a magazine they were producing. The magazine portrays a proactive image of those in recovery and has been distributed to businesses and services in the local community which is expected to challenge stigma towards those in recovery. Another community was using some of their funding to design and promote a logo for their alcohol free venue, with the intention of showing that their venue is a professional business of good quality. Two of the recovery communities explained how they were situated within a network of businesses which are supportive of the recovery community. Moreover, being funded by a high profile celebrity and well-established funder such as Russell Brand and Comic Relief was identified as an important contributing factor to the success of recovery. In particular, one participant believes that Russel Brand's advocacy for abstinence-based recovery has helped recovery communities nationally feel more self-assured in their work. However, it was cautioned that high profile situations need to be managed well so that the right message is delivered to the public.

"I think what [name] does on the training I think there's a real need, there's a lot of stigma and prejudice I think within, even people who don't see themselves as being prejudice, you know we've had comments of things like, the youth offending service and people have said oh I see things in a different view now and I'm going to change how I'll do my practice which is great." Participant 5: Recovery Community 2

4.3.4 Increased visibility of recovery to those in recovery and addiction

Exposure to role models who are having a positive experience in recovery was seen as being important for both those in addiction and recovery. More specifically, one participant described how recovery needs to be more visible so that individuals in addiction can see what recovery looks like and know that it's an achievable alternative to taking prescribed drugs or prison. By contrast, a participant from another recovery community felt that in some cases exposure to recovery does not always lead to engagement.

"Something that is really important is being around positive people who are doing well in their recovery and you know, that's so important because of course, you know, addiction is quite an isolating thing." Participant 9: Recovery Community 4

Some of the recovery communities discussed facing few difficulties in getting those in recovery to attend events and meetings at their recovery community. Similarly, one recovery community

explained how they had difficulties in retaining volunteers. However, these challenges were overcome by reminding people by text and on Facebook about upcoming events, inviting individuals for dinner before meetings and setting up a formal volunteering process so volunteers feel supported. In particular, Facebook was seen as an advantageous platform to engage with service users as many of them were familiar with it. One recovery community was planning to set up an App for service users to find out about events.

> *"Working with volunteers can be challenging. We've had a couple of people come along and they've signed up as volunteers they've done a hard day's work and we've not seen them again, which you know, we expect that with volunteers and the thing about volunteering is it's a much lesser commitment. We're currently working on like setting up all of our volunteer processes and all of our policies and procedures and systems and training courses and stuff to make sure volunteers feel supported and are well trained and are well resourced to do what they're trying to do." Participant 9: Recovery Community 4*

4.3.5 How do partnerships contribute towards recovery?

The recovery communities referred users both to other services as well as having users referred to their services. This included links with government-funded services, counselling services and housing providers. The recovery communities also reported having links with local colleges, businesses and third sector organisations in the area who are providing/will provide courses and training to the service users, some of which are delivered free of cost. Examples of training and courses included health and social care and social media training, meditation, life drawing and jewellery making classes. One of the recovery communities had links with a theatre and film and a new media company who were helping the service users put on a performance to the local community. Collaborative work with partners along with training and sharing of resources, meeting rooms, best practice and standards were described by the recovery communities as a way in which they worked with others. It was hoped that links with local employers would lead to local businesses employing people from the recovery community.

> *"Local people are coming in to run [classes/groups] for the people in recovery so there's a charity who's going to do meditation classes, there's an arts group that are going to come in and do life drawing and jewellery making … Some of it we've had to pay for but some of it we've managed to talk people into coming in and doing it for free, we're always looking for freebies but we also wanted it to be good quality so for instance for tutoring, we're getting a life drawing tutor and a life drawing model because we wanted it to be really good, we didn't want it to be sort of second rates so the Comic Relief funding is paying for that yeah." Participant 8: Recovery Community 3*

One recovery community, however, highlighted that whilst they had been proactive in trying to engage with local business and service, but this had been met with limited success.

"We're trying as part of the comic relief funding to engage more with the local services but, to be honest with limited success really… I dunno, we've kind of gone to other services, told them what we're about, told them that you know this is what we do, I guess because without, I'm not judging other services, I think because everyone is really busy and has got a lot on" Participant 8: Recovery Community 3

All of the recovery communities explained how the 12-step fellowship did not associate with any other organisation, however, some claimed to be connected to the 12-step fellowships due to some of their service users attending the meetings. In particular, two of the recovery communities said they signposted individuals to the 12-step fellowships. Two of the recovery communities reported that the 12-step fellowships use their rooms to hold their meetings.

"Well we're very much involved within that I mean we kind of go hand in hand erm so that erm our all of the people that we associate with are all actively involved within the 12-step programme… yeah everybody that's in recovery, staff, service users, residents, volunteers, everybody's actively involved within the programme if you like." Participant 3: Recovery Community 1

Two of the recovery communities described how they were working with commissioners by keeping them informed on the progress of projects. Partners and potential investors were being invited to various social events so that they can visit the recovery community and see how it works. Two of the recovery communities explained how they were situated within a network of businesses which are supportive of the recovery community, with some businesses engaging with them on social media sites such as Twitter. Nonetheless, some recovery communities described having difficulties engaging with other organisations. One attributed this to services being too busy with their own activities. Another participant felt it was due to the tensions between the abstinence and harm reduction models.

"When it comes to commissioners itself what we like to do is very much keep them informed about exactly how we are getting involved and how we are evolving as a project… speaking to them, saying look, these are our barriers, these are what we are facing, these are the things that we are struggling with, is there any way that we can help, after that we are showing them actually this is what the success is, thanks for what you guys have given to us, and things like that, so keeping very you know, discussing it with everyone really." Participant 1: Recovery Community 1

4.4 Clean & Sober Living (Year 2)

In the case of Clean & Sober Living it was necessary to carry out a second process evaluation due to the changing focus of their evaluation.

Give it Up funding

Predominantly, the Give it Up fund for 2015/16 had been used to fund the salary of one staff member at Clean & Sober Living: a Senior Support Worker. This member of staff delivered Clean & Sober Living's supported housing project and provided therapeutic support to service users. The supported housing project provided houses located within the local community for those in drug and alcohol

recovery. Clean & Sober Living is comprised of a team of seven staff members, four of which were volunteers.

Identifying individuals in need of Clean & Sober Living's Housing

The 12-step fellowship meetings enabled Clean & Sober Living to identify people who may benefit from their housing project. However, recruitment to the recovery houses via the 12-step fellowship meetings was done informally. Other places where those in need of housing were recruited included hostels and on the streets. Facebook was perceived by one staff member as a useful means for getting people referred to their service.

Relationship with other organisations

Similar to the previous year (2014/2015), Clean & Sober Living experienced ongoing implementation challenges. The challenges were attributed to the decision-making processes made at the local authority: funding that had originally been allocated for Clean & Sober Living's housing project was redistribute to other services. Nonetheless, Clean & Sober Living received support from another organisation to set up their housing project and has received continual admin and capital support from the Cornforth Partnership.

In the previous process evaluation a staff member had reported that a consultant had been hired to design Clean & Sober Living's website, however the staff member reported in this process evaluation that it had not been good value for money. Efforts to establish further working partnerships over the past year have been unsuccessful. One staff member described how they had approached another drug and alcohol treatment provider who they were aware had a waiting list for clients. Clean & Sober Living offered to provide support to those on the waiting list, however, they stated that their offer was refused by the provider:

> *"You've got 25 people on a waiting list, it might be 6 or 7 months, some people could die in that time, why don't we just, why don't we all work together, maybe I was naïve and that, but I was really surprised when they were reluctant to do it" Staff Member 2*

The staff member anticipated that they were reluctant because they saw Clean & Sober Living as competition. It was explained that such providers receive funding for every client they take on, and so it is advantageous for them to have people on their waiting list, especially as there is a high turnover of clients in drug and alcohol recovery.

Similarly, working with the 12-step fellowship groups was seen to have been met with limited success. This was considered to be because the 12-step fellowship do not affiliate themselves with other organisations. According to one staff member treatment centres do not inform those in need of drug and alcohol support about the 12-step fellowship meetings. Staff from Clean & Sober Living have addressed this concern by taking their service users to 12-step fellowship meetings.

Relationship with service users

It was perceived that around three quarters of the cohort who were recruited by these methods were less likely to be interested in fully engaging with Clean & Sober Living's programme of activities. This has been a barrier to building a positive relationship between the staff and service users:

> *"What's happened here we had a community of people, where we all worked together and worked through groups and did some really good stuff together. And we said why don't we open a place and Comic Relief helped us to do that. And then we found that when we were getting people in it became an us and them sort of thing, and this was not we were wanting, we tried one way of letting them have what they want and that ended in disaster everyone ended up taking drugs and relapsing so we said right we're going to have to have some rules, and then we became like prison officers really" Staff Member 2*

Relationship with the local community

The recovery houses were purposefully located within the community, Clean & Sober Living held a consultation event to raise awareness to the public about the individuals who will be living in the houses and about the stigma they face. Both staff members felt awareness had been raised, however, they still felt the recovery communities were stigmatised:

> *"in the village that we're in it's alright, but say if there's a burglary or something like that straight away they'd think it was the guys in the houses" Staff Member 2.*

Effectiveness of the Clean & Sober Living Model

Overall, in the short term the housing project was seen as a success, however relapsing was common amongst both service users and staff in the long term. A number of possible explanations for this were provided: the therapeutic sessions were too challenging; there is a lack of local support in the area; some of the Clean & Sober Living staff had not long been in recovery themselves:

> *"It's been really effective and empowering but most of them have relapsed and gone so it has been one side helping them address their addiction but on the other side you could say that the concept is crashed and burned at the moment… It might be the therapeutic angle that has been a bit hard for people I don't know. It's just a different take on it" Staff member 1*

The 12-step fellowship model was seen as a good model for overcoming the staff and service user conflict as service users were not obliged to participate in activities if they did not want to. Nonetheless, it was explained that even within this model, there is a high turnover, with around 70% of people discontinuing to engage with the 12-step fellowship meetings. It was explained that some people do not build up trust with anyone. One staff member felt Facebook was the cause for many relapses, they felt that the 'Likes' function on Facebook meant people seek approval from others and

moreover, for some it was a reminder of their old friends and behaviour meaning it was hard to move on.

Future plans for Clean & Sober Living, included ending the housing project and focussing upon providing informal support across the county. This will include both one-to-one and group counselling, advice, guidance.

5. DISCUSSION

Recovery is a unique and personal experience (Witbrodt et al., 2015), which means that it is a difficult process to study using standard research methodologies. There is also no normative definition of recovery, which often makes it difficult to compare outcomes across studies of different types of recovery activity. The two-year nature of this evaluation enabled researchers to explore predicted and actual outcomes using a range of quantitative and qualitative methods.

The first year of the evaluation found that although recovery communities were in their early stages, many outcomes were already evident. In this first year, all focus group participants agreed that once they had become abstinent, it was important to become engaged in positive activities to combat social isolation and to support return to "normality" and the maintenance of abstinence. For these participants, recovery from substance use was a continual journey in which the person rebuilds their life and their interaction with the world around them. Even though the recovery journey is an individual experience, there were shared stories and participants believed that the recovery communities provided a non-judgemental and safe environment that provided them with the freedom in which to build necessary social and practical skills. Support and skills helped them in their recovery journey to remain abstinent. These findings, and similar research of this type, highlight the important role of peers and social networks within the recovery process (Timpson et al., 2016). This element of recovery capital is arguably the most important and predictive in terms of effective and sustainable recovery.

Recovery outcomes

This section addresses the following evaluation questions:

- What are the key recovery outcomes?
- What is the impact each community has on the recovery of the people who use them?
- How do recovery communities help people to maintain abstinence?
- What is the evidence of the best ways of building personal and social capital to ensure people feel empowered to create change and improve health and life outcomes?

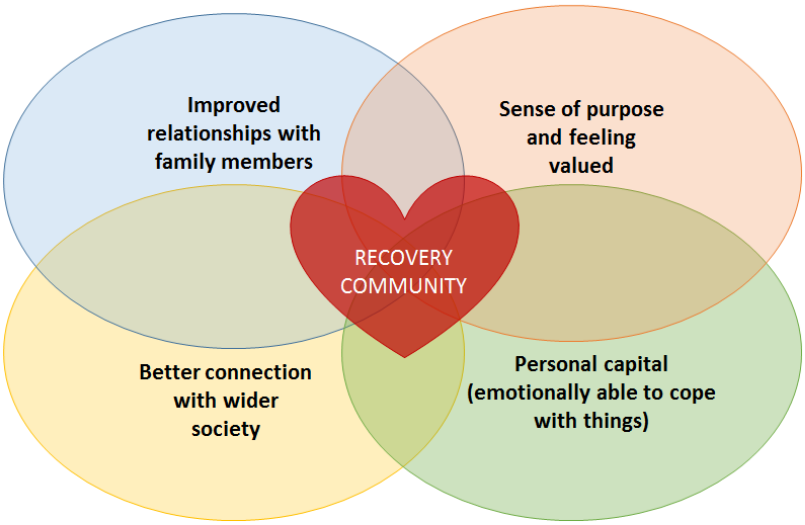
Each recovery community approached the design and delivery of their activities individually, in order to meet the needs of the local community environment. Despite these different approaches, each recovery community provided support in the same key areas: peer support (e.g. service user forums, mutual aid, peer-led interventions), volunteering, training and education opportunities, accommodation support, family support interventions and social enterprise work. Similar outcomes were achieved by each recovery community.

Key outcomes

It was clear that there were a number of common experiences that were identified by those in recovery which contribute towards positive recovery experiences and the maintenance of abstinence. These involved those in recovery having a connection with themselves, peers, family members and those not in recovery and wider society. Four key inter-related recovery outcomes were also identified across the recovery communities by recovery community members: a sense of purpose and feeling valued, personal capital (e.g. resilience, emotional stability, feeling responsible), improved relationships with family members and friends, and a feeling of being connected or belonging to wider society. It was also evident (though from a very small sample) that these outcomes were validated by family members of those who were in recovery; and that family members were additional

beneficiaries who experienced positive outcomes as a result of their family member attending the recovery community.

Key recovery outcomes



All of these outcomes align to key elements of recovery capital. We know that in general, high levels of recovery capital enable individuals to cope and manage better with their lives (Laudet et al., 2008), which in turn has implications for successful achievement and maintenance of abstinence.

The Advisory Council on the Misuse of Drugs (ACMD) (2013) highlights that good treatment outcomes are more than just recovery and abstinence, and include the development and growth of wider recovery capital including achieving positive relationships, good health and wellbeing, and securing housing and employment. Recovery capital comprises four key elements: social capital, human capital, physical and economic capital and cultural capital. It is clear from this two-year evaluation that the recovery communities all deliver outcomes which contribute to the development of recovery capital.

How Give it Up recovery communities support development of social capital

Peer support has been identified as important in helping people in recovery to manage addictions and maintain abstinence (Litt et al., 2009, Stevens et al., 2010); providing emotional and practical support (Neale 2001, Neale et al 2012); and being part of a group and fostering social identity (Best et al., 2010; Buckingham, Frings and Albery 2013; Pagano et al., 2013). Peer support was a key factor of each recovery communities; this was achieved through development of new social networks and activities within the communities, so that recovery community members developed a strong sense of common purpose (Best et al., 2012; 2015; 2016; Collins et al., 2016) and meaning (Cloud and Granfield, 2008; Laudet and White, 2010). People who were peer mentors were eager to have an opportunity to "give back" to the community themselves. These roles within the recovery community provided a foundation for developing skills that participants thought were vital for personal progression, maintenance of abstinence and the recovery journey. This evaluation suggests that social capital may be integral to the development and maintenance of other elements of recovery capital, influencing the development of human capital, physical and economic capital and cultural capital.

How Give it Up recovery communities support development of cultural capital outcomes

In the recovery communities, peer mentors acted as role-models for those who were less experienced and this was seen to reduce stigma by increasing visibility of those in recovery from addiction. Stigma has been identified as a barrier to recovery, which impacts upon individuals' reintegration into society; for example their ability to gain employment and access education and training (UK Drug Policy Commission, 2008).

Stigma can stem from a lack of understanding; in light of this, recovery communities provided training on addiction, recovery and associated challenges. Increased visibility promoted by the recovery communities was also evidenced through community events and training delivered to a range of professionals and organisations by the recovery communities, which have been evidenced to reduce social and structural level stigma (Livingstone et al., 2012).

How Give it Up recovery communities support development of physical and economic capital outcomes

The recovery communities were seen to develop and expand opportunities for those in recovery by providing opportunities to attend training, carry out volunteering and mentorship to help members to gain skills and qualifications to prepare for future employment and reintegration into society.

How Give it Up recovery communities support development of human capital outcomes

In general, high levels of recovery capital enable individuals to cope and manage better with their lives (Laudet et al., 2008), which in turn has implications for successful achievement and maintenance of abstinence. This was also evidenced in one of the key outcomes identified by the recovery community members "personal capital – emotionally able to cope". Through participation in the recovery communities, members developed existential meaning in their lives and were able to evidence improved relationships with family members, and better connections with society (Irving, 2011, Maswon et al., 2015; Wittouck et al., 2013). The involvement of recovery community members in problem-solving and decision making processes was also seen to help the sustainability of recovery communities.

Characteristics of recovery communities

This section addresses the following evaluation questions:

- Who are the organisations that need to be involved in delivering and supporting recovery communities?

- How do partnerships, peer support, awareness raising and training of service provider within each project contribute towards recovery?

Geographical location and service type varied amongst recovery communities, with two being based in much larger UK cities (Birmingham and London) compared to the third and fourth recovery community, which were based in Gloucester and Durham. The nature of the projects under evaluation also varied: a public cafe, which was predominantly (if not solely) staffed by individuals in recovery - this café also housed recovery/support group meetings; a support group and social venue that ran social and recreational facilities along with the development of employment and training opportunities; and a peer-led support and membership services. The focus of the fourth recovery community based in Durham changed over the duration of the project from outreach and advocacy work and training with professional services to recovery housing. This illustrated that whilst very

different services were being offered, the key elements identified as integral to the delivery of a successful recovery community programme were echoed across the recovery communities.

The role of abstinence in the recovery communities

Whilst all of the recovery communities focussed upon abstinence-based recovery, this was demonstrated in different ways. For example, one recovery community had clear guidance on substances that members were permitted to take, and this excluded use of some medicines such as antidepressants; whilst another incorporated a harm reduction approach for participants at the beginning of their recovery journey. On the whole, these differing approaches did not appear to impact upon the success of the projects under evaluation. This success was instead dependent upon a number of important delivery factors.

Service use

Although each recovery community involved different services and activities, they all provided support in similar ways. In terms of people using the service, we know that across two of the recovery communities, those recovery community members completing the wellbeing and recovery measures were predominantly male (approximately 3:1); whilst one of the recovery communities had similar numbers of males and females. Those in the recovery communities were aged between 21 and 59 years and were predominantly White British. Recovery community members were also reported to engage with education and training and employment activities (including unpaid voluntary work) as well as attend meetings external to their recovery community such as mutual aid/12-step meetings and locally organised activities.

Important delivery factors

The process evaluation explored the delivery of the communities. The most important factors identified as central to a successful recovery community are described here. These were shown to be cross-cutting between and within the abstinence-based recovery communities and their members irrespective of the geographical location or the specific service that was under evaluation. This has implications for service provision and effective delivery of abstinence-based recovery communities and related programmes across the UK.

Person-centred recovery: This evaluation found that that recovery communities provided their members with options, choice and holistic support. This approach also helped foster a sense of community, both in terms of individuals having a sense of belonging with each other and within the space. Having fun was also cited as an important part of supporting recovery, and one which the recovery communities fostered through their members.

Peer support: The provision of peer support was also seen to be vital. The recovery community leads considered societal cultural norms to be unsupportive of those in recovery with street drugs being easily available as well as recreational drugs and alcohol being available in the workplace; thus making it difficult to abstain.

Flexible provision: Providing support that did not just focus upon Monday to Friday 9am to 5pm provision was seen as a key factor. This also set the recovery communities apart from more traditionally accessible services.

Connections to education, employment and training: providing a range of opportunities was important. The flexible delivery of these activities was also important, to ensure that people were able to attend.

The role of partnerships in delivering successful recovery communities

As voluntary organisations and social enterprises, the value of the recovery communities is that they appeared to have much more freedom in their approach to service provision and delivery and were more responsive to change. The importance of collaborative working in gaining the best possible outcomes for recovery community members was discussed. Links were seen to have been made to government funded services such as housing providers, local colleges, businesses and third sector organisations. However, it was clear that tensions were present when attempts were made develop relationships with statutory (and non-statutory) services promoting harm reduction. This has implications going forward when looking at whether the integration of recovery community provision into overall substance misuse is appropriate.

It was also considered a barrier across the recovery communities to establish working relationships with 12-step programmes. Whilst many of the recovery community members accessed 12-step programmes (as well as other mutual aid groups within their recovery communities) and one of the recovery communities hosted 12-step recovery meetings in their building; 12-step programmes were seen as reluctant to engage with and promote other organisations who follow abstinence-based recovery. This may be due to the differing approaches to achieving and maintaining abstinence, but would benefit from further investigation as to how best to support collaborative working.

How do the recovery communities add value?

This section addresses the following questions:

- What social value do the recovery communities create?
- What do the recovery communities add to existing statutory service provision?

Social value

The SROI analysis explored the wider social value created by the recovery communities. Two of the recovery communities experienced a decrease in their social value ratio between the first forecast SROI and the second evaluative SROI (Spitalfields Crypt Trust £6.61 to £5.19 and ChangesUK £9.24 to £5.12), whilst one experienced an increase (The Hub £5.17 to £9.71). However, all of these recovery communities are still evidencing good value for money. It is important to note that the original forecast SROI aimed to look at the potential value for money created by the recovery communities. For the evaluative SROI the impact map calculations were informed by the total numbers of recovery community members reported (in all cases these numbers changed across the two evaluations) as well as the evidence collected from the WEMWBS and ARC Recovery tool measurements.

Data collected by evaluation participants indicated what may have happened if the recovery communities had not been available. People explained how a variety of issues may have arisen which would have impacted on their recovery. Specifically, people described how they would have a lack of structure, routine and direction, they may have poor or no relationship with family or friends, they may have poor accommodation and they may be involved in criminal behaviour. Ultimately, people described how they may have poor mental health, they would be unable to cope, and they would either struggle to maintain their maintenance of substance misuse or relapse if abstinent.

Policy perspectives

There is currently no agreed national model for the local commissioning and delivery of drug and alcohol services. However, the importance of recovery services is recognised as being integral to the

development and maintenance of recovery capital. There is no 'one-approach fits all' for substance misuse treatment, and this was echoed across the recovery communities.

Drug and alcohol service provision are predominantly provided by NHS, local authority and voluntary sector organisations with a small presence from private sector provision. The recovery communities that took part in this evaluation were all third sector organisations (including social enterprises), some of which are registered as charitable organisations, and so sat outside of traditional local authority and NHS organisation structures. A key aim of a number of recovery communities is self-sustainability, which is especially pertinent in current times of reductions in NHS and local authority budgets (PHE, 2014). All of the recovery communities highlighted the impact of lack of funding and resources available in their local areas to support those with substance misuse issues to achieve abstinence-based recovery. In light of this, recovery communities such as these have an important role to play, especially in areas where local authorities have limited budgets to provide structured treatment. Many areas across the UK are seeing an increase in volunteer recovery champions (and this was evidenced in the recovery communities), but a decrease in salaried frontline staff and (expensive) specialists such as addiction psychiatrists. Recovery communities such as those included in this research, therefore provide a key contribution to the overall service provision and contribute to improvements in recovery capital that have not traditionally been addressed by structured drug treatment.

Whilst recovery communities provide an integral service, they should not be viewed as a cost-efficient solution to limited budgets for statutory provision. This is particularly pertinent due to the diversity found in drug using populations, where certain cohorts of individuals may not be best served by these types of voluntary organisations. This approach has the potential to place unnecessary burden on recovery communities who may be expected to 'fill the gap' in local provision. This research did not seek to identify the key substances to which recovery community members were in recovery from; however, it was clear that the substances included covered the spectrum of both alcohol and drugs (for example, cocaine and heroin). It was also evident that very similar outcomes were experienced regardless of whether recovery community members were in recovery from alcohol or drug misuse. Further investigation would be needed to identify whether the recovery communities under evaluation such as these are suitable for all types of drug user.

The recovery communities funded by the Give it Up fund were located in areas where indicators such as deaths by drug misuse, hospital stays for alcohol-related harm as well as associated indicators such as long term unemployment and homelessness were higher than the national average (PHE, 2016). This highlights the fact that recovery communities were providing a service which tackled problematic issues within their local area. Local policy in the areas where these recovery communities are placed showed a focus upon recovery (Durham County Council, 2015; Hackney Council, 2016; Kilagallon, 2013). However, one of the barriers acknowledged by lead members of the recovery communities was that locally available treatment and recovery services predominantly (and in some cases solely) appeared to focus upon harm reduction, despite local and national policy advocating otherwise. It was also highlighted that there was a lack of abstinence based recovery communities apart from traditional 12-steps.

This evaluation suggests that, whilst most local authority areas have some form of recovery provision, individuals can still be isolated in terms of geography and access to available services. This seems to particularly be the case for abstinence based recovery programmes.

Strengths and limitations of the research

We acknowledge that recovery capital outcomes are often intangible and hard to measure (Arnull, 2014). In light of this, the mixed-methods approach used in this evaluation was the best way in which to identify relevant outcomes, assess (likely) effectiveness of the project approaches and explore the value of each of the recovery communities. This research adds valuable findings to the knowledge that is available around the outcomes experienced by those in recovery, specific to abstinence-based recovery communities; and what key factors contribute to a 'successful' recovery community.

The nature of social value methodology requires stakeholders to be involved in the development of the evaluation framework from the start of the process. The researchers engaged with key stakeholders from the inception of the research ensuring that they were involved in key aspects of research design.

SROI provides an ideal method to assess evidence of effectiveness and impact by measuring and accounting for improvements in wellbeing by incorporating social, environmental and economic costs and benefits. This approach allowed for the measurement and capture of outcomes that can be intangible and hard to measure. These 'softer' but nevertheless important outcomes that those in recovery experienced provides vital evidence around those changes that help individuals to achieve and sustain their abstinence. SROI also enabled this evaluation to begin to consider the wider impacts of the recovery communities have upon the areas they thrive in.

In order to establish and track evidence over the life of the funding for each recovery community project the researchers undertook forecast and evaluative SROIs. The forecast SROI was deemed particularly useful as it is used towards the start of an activity (in this case the programmes under evaluation being funded by Give it Up), and demonstrated how investment can maximise impact as well as providing evidence of what needs to be measured throughout the duration of the projects to evidence the changes experienced. The evaluative SROI built upon this by exploring the actual social value created by the recovery community projects, based on the actual outcomes that had taken place.

Other approaches, such as a randomised-controlled trial or quasi-experimental design were not appropriate, due to the feasibility of assigning individuals or communities to control or intervention groups within the scope of this study.

There were, however, a number of limitations that were acknowledged over the duration of the research project:

- For the purpose of this evaluation, we have also only looked at key beneficiaries, i.e., those who are directly affected by the activities/services being funded by the Comic Relief Give it Up Fund. Future research may look to explore actual impact on other beneficiaries.
- Our evaluation approach aimed to explore the four projects to elicit evidence of the most effective models for recovery communities, key characteristics required, and an understanding of the key organisations and activities involved. A broad exploration of forecast and evaluative SROIs was feasible within the scope of the study; however, this may not have been as robust a process as an SROI focusing on one specific project.
- It is important to acknowledge that comparison of findings between projects in the Give it Up programme will be difficult and is dependent on factors such as the degree of comparability and difference between projects (such as aims, objectives, size, and characteristics of service

users, e.g. pre-existing recovery capital, indicators of substance use and dependency), malleability of selected indicators, and availability of secondary data.

- Under no circumstances should the forecast and evaluative SROI ratios in this evaluation be compared across the recovery communities. For each part of the evaluation, ratios have been calculated based on the specific circumstances and experiences of each recovery community. Considering differences in demographic and geographical areas, while the experiences for many engaging the research were similar, they were also subjective to the group engaging with the research on that day (for those taking part in the focus groups); and those willing to complete the wellbeing and recovery measures.
- Only a sample of individuals from each recovery community were engaged with, therefore when calculating the SROI analysis for the wellbeing and recovery measures, the small sample sizes may have produced an unrepresentative numbers when figures were aggregated.
- In a number of instances the data collected were not normally distributed and therefore the median (central tendency) rather than the mean (average) was used. This not normal distribution, however, may be anticipated due to the small sample sizes from which the data were collected. The advantage of using the median is that it is not usually distorted by outliers/skewed data; however, it does not take into account the precise value of each observation and hence does not use all information available in the data.

6. CONCLUSIONS, RECOMMENDATIONS AND FUTURE RESEARCH

Although UK drug policy emphasises the importance of recovery, there is a lack of evidence base on effective approaches that support outcomes beyond those included in traditional drug treatment (Humphreys and Lembke, 2014). Soft outcomes that are difficult to empirically define (Knopf, 2011; Witbrodt et al., 2015) are historically acknowledged as being challenging when looking to evidence key predictors of what helps/maintains behaviour change and abstinence (Campbell et al., 2011). It can also be hard to tease out what actual activity or service has helped someone to become abstinent (UK Drug Policy Commission, 2012).

There are a wide range of negative impacts associated with substance misuse: personal (physical and mental health and wellbeing), social, economic costs of substance misuse (Home Office 2012; Public Health England, 2013a; The Centre for Social Justice, 2013; JCMPH, 2013). Recovery communities have a valuable role to play in providing support for those in recovery. This has the potential to impact upon costs experienced by NHS, social care services, employers, and the economy as a whole; but also importantly the softer, harder to measure outcomes looking at the impacts of recovery upon those in recovery, family friends and wider society.

This research demonstrates some of the key common processes that recovery communities undertake and how these contribute to and have impact upon an individual's recovery journey and maintenance of abstinence. It also highlights the need for further research in order to evidence and increase understanding of the wider-role that recovery communities such as these have in abstinence-based recovery.

6.1 Recommendations

Outcomes measurement

The findings from this evaluation aimed to explore the impact and value of the projects over a two year period (1st September 2014 to 31st August 2016). However, research has suggested that drug and alcohol recovery outcomes can only be reliably judged after at least five years (White, 2012, cited in ACMD report, 2013). Based upon this evidence, the continuing recovery communities involved in this evaluation should look to embed processes of continual monitoring to enable them to assess the outcomes identified (and any additional outcomes that may be identified in the future) over the longer-term.

The recovery communities developed and expanded opportunities for those in recovery by providing a number of opportunities to attend educational courses and training and carry out volunteering and mentorship. Recovery communities may look to ensure that they track the life course of their members in terms of the skills and qualifications they may gain to help them to prepare for future employment and reintegration into society; as well as any employment that may have been gained as a result of this.

Barriers to data collection

The recovery communities were provided with wellbeing and recovery measures that were considered appropriate to evidence the four identified outcomes; however, it was acknowledged that there are inherent barriers to collecting these data. Recovery was seen to be a process of development and self-reflection, throughout which wellbeing was considered to fluctuate from moment to moment

depending on an individual's circumstances. It was felt that using wellbeing and recovery measures to evidence change may deter people (funders, individuals looking to access the recovery community) where poor measurement results are shown and therefore some reluctance was present in employing the measures. In order to evidence change across recovery communities, validated measurement tools should be used to demonstrate this change. As part of social value measurement this should include showing whether this change had been positive or negative (intended or unintended). Additional, individual level information could be taken in conjunction with the wellbeing and recovery measure data that would look at an individual's circumstances at a given point in time. This may go some way to provide supporting evidence of the reasons for an individual's change in wellbeing or recovery measure over time.

Whilst all of the four recovery communities succeeded in collecting some data, in three out of four instances, this did not cover the whole cohort of recovery community members involved with the specific programme under evaluation. Data should be collected from all recovery community members where possible. If this is not possible, data should be collected from a sample of 50 people (this figure of 50 recovery community members would allow for key statistical analysis to be carried out); however, this is dependent on the size of the recovery community. Where it is not possible, data should be collected from at least 50% of recovery community members to ensure that the data collected provides a more representative sample of the recovery community members outcomes (depending on the size of the recovery community).

Although the key leads at the recovery communities recognised the importance of collecting data to evidence change, anecdotal evidence identified some barriers to data collection. These were mainly rooted in aspects such as acknowledged weaknesses in administration, issues with recovery community infrastructures, and the association of forms with clinical assessment. Time and resources were also considered to be barriers to data collection. Research communities felt it would be beneficial to have members of the research team collect data; it was felt that this would help data to be generated more quickly and effectively. It was also suggested that the data collection could be undertaken as an 'event' where recovery community members feel that it is something that they need to attend and engage with. However, a main component of the research approach was to encourage recovery communities to collect their own data, to allow them to evidence their outcomes post-evaluation. In light of this, and informed by the resources available for the research, research staff decided to continue as planned in having recovery communities collect their own data, with support and instructions from the research team.

Discussion was also had regarding the use of other data collection methods, such as e-mail and online survey tools to try and access a greater number of recovery community members. Consensus across all of the recovery communities was that whilst an online survey would be something that could be readily and independently accessed, many of the service users are not computer literate. Some but not all of the recovery community leads suggested that face-to-face interaction was very important. For future evaluations the recovery communities should give consideration to employing a specific member of staff to carry out data collection and that this can be built into any funding that is applied for. Data collection methods should be tailored to meet the needs of recovery community members and other beneficiaries for whom the research is aiming to target.

Social value measurement

As highlighted above, two indicators (the wellbeing and recovery tool measures) were put in place to measure the change being experienced by members of each recovery community. This evidence in turn was used to inform the calculation of the SROI ratio. This ratio is important as it evidences whether services are providing 'good value for money'; however, it should never be used in isolation and should always be supported with qualitative data and what comes from that in terms of evidencing individual and group journeys of recovery.

To evidence aspects of social value, SROI does not always need to be included. When looking to evaluate the impact and value of recovery communities and the programmes that run within them in the future, recovery communities should aim to follow more general social value principles. This includes ensuring that any evaluation:

1) identifies and involves key stakeholder groups throughout;
2) identifies key outcomes or changes being experienced by these key stakeholder groups (these can be positive, negative, intended and unintended);
3) puts indicators/measures in place, where they are not already present, that evidence these outcomes or changes;
4) does not over claim for the role that the recovery community is playing in the recovery journey of individuals (including the maintenance of abstinence);
5) attributes the outcomes or changes being experienced (where applicable) to other programmes, resources, interventions etc. that individuals are accessing. This may be within the recovery community but not specifically related to the programme under evaluation; or external to the recovery community.

Developing relationships/collaborations

As an outcome of this research, relationships have been forged and developed between the recovery communities. This has enabled the communities to discuss how their projects are running as well as use each other as a sounding board, for example, to express concerns and highlight barriers to the implementation of their projects. Where possible these relationships should be maintained so that this continued support is available and best practices can be shared.

A number of the recovery communities highlighted established collaborative relationships that they had in place with organisations external to their own. In some instances, barriers were evident when trying to develop relationships with statutory and non-statutory services promoting harm reduction as well as 12-step programmes. This should be investigated further to identify exactly what issues/barriers are present and whether the integration of recovery community provision into overall substance misuse provision is appropriate or is required.

Infrastructure support

Three of the recovery communities that took part in the evaluation were large and well established. Spitalfields Crypt Trust had been running for 50 years whilst ChangesUK had been running for approximately 10 years. The Hub was also supported by The Nelson Trust, which had been established for 30 years. It may be suggested that longevity of these organisations, as well as their clearly defined

aims and objectives, may have impacted upon the success of the projects under evaluation due to established infrastructures and support being in place. These recovery communities had active service user/peer involvement in committees and these individuals also had responsibility for driving forward agendas within these recovery communities. In contrast to this, Clean & Sober Living was a much smaller, newly established recovery community (established in October 2014), with one key individual who appeared as the driving force. For newly established recovery communities (or those recovery communities in the process of being established) lessons may be learned from others as to how service user involvement and a strong support network are essential to successfully drive forward services for those in abstinence-based recovery. It is important to recognise that this infrastructure can take time to embed, and to ensure time is factored in for implementation before outcomes may be evidenced.

6.2 Future research

Other beneficiaries of the recovery communities

Phase two of this research looked to try and engage with friends and family of those in each of the recovery communities, however, this was met with limited success. It was possible for the researchers to contact two family members (one each from Spitalfields Crypt Trust and The Hub respectively). These family members were able to produce verification of the outcomes that had been identified and experienced by their family member as a result of attending the specific recovery community. These outcomes included: improved relationships with family and increased confidence and self-esteem. One of the family members also identified a long-term outcome of employment that the recovery community member wanted to achieve, whilst the second identified outcomes that they had experienced themselves e.g., reduced worrying about and improved relationships with their family member. Future research may look at how we might engage more successfully with other beneficiaries (family, friends, wider community) of the recovery communities identified in the scoping phase of this evaluation to identify the wider impact and outcomes experienced by wider community/society.

Outcomes measurement tools

When looking at the WEMWBS and ARC Recovery Tool measures it was apparent that the majority of recovery community members completing the measures had experienced positive changes (i.e., an increase in their wellbeing and recovery) over the periods of time that the data were collected. All of the recovery communities left a minimum of five weeks between when the measures were initially taken and when they were repeated, with one recovery community leaving approximately 20 weeks. It may be suggested that the period of time in recovery might have impacted upon the responses given; for example, the results shown by one of the recovery communities suggested that those who had been in the recovery community longer were more likely to show improved scores across the measures. However, the reverse was shown in a second recovery community (i.e., those who had been in the recovery community for less time showed more positive scores). This data were not collected across all of the recovery communities, however, and where it was collected only small sample sizes were achieved so it was not possible to infer any relationship between length of time in recovery community and improvements in wellbeing and recovery measure scores. Future research should look to investigate more closely any potential differences in outcomes experienced by those new to recovery and those in long-term recovery. This could initially be done through the exploration of some case study work across the different recovery communities to look at common experiences,

processes etc undertaken by individuals at different points in their recovery journey. It may also look to investigate evidence of best practice across recovery communities and what this looks like.

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8. APPENDICES

Appendix 1 Outcome indicators

Appendix 1.1 WEMWBS 14 item scale

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time	Attributed outcome measure
I've been feeling optimistic about the future	1	2	3	4	5	Sense of purpose and feeling valued
I've been feeling useful	1	2	3	4	5	Sense of purpose and feeling valued
I've been feeling relaxed	1	2	3	4	5	Personal capital
I've been feeling interested in other people	1	2	3	4	5	Improved relationships with family members
I've had energy to spare	1	2	3	4	5	Personal capital
I've been dealing with problems well	1	2	3	4	5	Personal capital
I've been thinking clearly	1	2	3	4	5	Personal capital
I've been feeling good about myself	1	2	3	4	5	Sense of purpose and feeling valued
I've been feeling close to other people	1	2	3	4	5	Improved relationships with family members
I've been feeling confident	1	2	3	4	5	Personal capital
I've been able to make up my own mind about things	1	2	3	4	5	Personal capital
I've been feeling loved	1	2	3	4	5	Improved relationships with family members
I've been interested in new things	1	2	3	4	5	Sense of purpose and feeling valued
I've been feeling cheerful	1	2	3	4	5	Personal capital

Appendix 1.2 Key factors and sub-questions for the ARC Recovery tool

Key factor	Sub-questions	Tick if agree	Attributed outcome measure
SUBSTANCE USE & SOBRIETY	I am currently completely sober		**Personal capital**
	I feel I am in control of my substance use		
	I have had no 'near things' about relapsing (Regarding this question, we have been in contact with the author of the tool Dr David Best for clarification of the wording of this statement and he said that this means 'I haven't had any situations where I've nearly relapsed')		
	I have had no recent periods of substance intoxication		
	There are more important things to me in life than using substances		
GLOBAL HEALTH (PSYCHOLOGICAL)	I am able to concentrate when I need to		**Personal capital**
	I am coping with the stresses in my life		
	I am happy with my appearance		
	In general I am happy with my life		
	What happens to me in the future mostly depends on me		
	I cope well with everyday tasks		

GLOBAL HEALTH (PHYSICAL)	I feel physically well enough to work		**Personal capital**
	I have enough energy to complete the tasks I set myself		
	I have no problems getting around		
	I sleep well most nights		
CITIZENSHIP /COMMUNITY INVOLVEMENT	I am proud of the community I live in and feel part of it – sense of belonging		**Better connection with wider society**
	It is important for me to contribute to society and/or be involved in activities that contribute to my community		
	It is important for me to do what I can to help other people		
	It is important for me that I make a contribution to society		
	My personal identity does not revolve around drug use or drinking		
SOCIAL SUPPORT	I am happy with my personal life		**Improved relationships**
	I am satisfied with my involvement with my family		
	I get lots of support from friends		
	I get the emotional help and support I need from my family		
	I have a special person that I can share my joys and sorrows with		

MEANINGFUL ACTIVITIES	I am actively involved in leisure and sport activities		**Sense of purpose and feeling valued**
	I am actively engaged in efforts to improve myself (training, education and /or self-awareness)		
	I engage in activities that I find enjoyable and fulfilling		
	I have access to opportunities for career development (job opportunities, volunteering or apprenticeships)		
	I regard my life as challenging and fulfilling without the need for using drugs or alcohol		
HOUSING AND SAFETY	I am proud of my home		**Personal capital**
	I am free of threat or harm when I am at home		
	I feel safe and protected where I live		
	I feel that I am free to shape my own destiny		
	My living space has helped to drive my recovery journey		
RISK TAKING	I am free from worries about money		
	I have the personal resources I need to make decisions about my future		
	I have the privacy I need		

	I make sure I do nothing that hurts or damages other people		**Personal capital**
	I take full responsibility for my actions		
COPING AND LIFE FUNCTIONING	I am happy dealing with a range of professional people		**Personal capital**
	I do not let other people down		
	I eat regularly and have a balanced diet		
	I look after my health and wellbeing		
	I meet all of my obligations promptly		
RECOVERY EXPERIENCE	Having a sense of purpose in life is important to my recovery journey		**Sense of purpose and feeling valued**
	I am making good progress on my recovery journey		
	I engage in activities and events that support my recovery		
	I have a network of people I can rely on to support my recovery		
	When I think of the future I feel optimistic		

Appendix 2. Stakeholder analysis

Appendix 2.1 Stakeholder analysis for CHANGES UK, The Hub and Spitalfields Crypt Trust

Stakeholder group	**Include/ Exclude**	**Reason**	**Recovery community**
Recovery community members	Include	Key beneficiary who will experience key material outcomes. As well as providing an important input, they would also experience material changes as a result of their volunteering activities	All
Family members, friends and colleagues	Include	This group experience a material outcome such as client gaining deeper understanding of the value and importance of relationships. Changing behaviour and attitude towards their loved ones.	All
Comic Relief	Include	As inputs only	All
Birmingham City Council	Exclude but consider for inclusion in evaluative SROI	As inputs only – providing monetary investment	CHANGES UK
Public Health England	Exclude but consider for inclusion in evaluative SROI	As inputs only – providing monetary investment	CHANGES UK; The Hub
Wider community	Exclude but consider for inclusion in evaluative SROI	Although there may be changes to this stakeholder group, it is unlikely to be material within the time frame in the scope of this SROI	All
Local businesses	Exclude but consider for inclusion in evaluative SROI	Experience changes in clientele/customers due to café being open. Local cafes could also experience negative outcome by losing customers	The Hub Spitalfields Crypt Trust

Criminal Justice System (e.g. Probation Service, Prisons - HMP Birmingham (DART), HMP Oakwood)	Exclude	Material change through changes in offending of clients - less time dealing with offenders and avoided prison sentences. During the focus groups with the members physical health did not come out as a key outcome.	All
Hospitals/NHS/health services	Exclude	Material change through reduction in service provision due to better physical/mental health of key stakeholder group (clients). During the focus groups with the members physical health did not come out as a key outcome.	All
Professionals – GPs, key workers, volunteers	Exclude	They would not experience a material change as individuals and they will be captured as part of another stakeholder group (NHS/health services)	CHANGES UK
Wider recovery community	Exclude	Although there may be changes to this stakeholder group, it is unlikely to be material within the time frame in the scope of this SROI	CHANGES UK
People affected by substance misuse but not currently in recovery/abstinent/seeking services	Exclude	Although there may be changes to this stakeholder group, it is unlikely to be material within the time frame in the scope of this SROI. There would also be limited ways in which this stakeholder could be consulted	CHANGES UK; The Hub
Referral pathways/Treatment Centres – Gloucester House, Livingstone House	Exclude	Although they refer clients to Changes UK, it is unlikely they will be experiencing material outcomes	CHANGES UK
Security staff- Prison staff	Exclude	Unlikely to experience material changes	CHANGES UK

Further education establishments	Exclude	Unlikely to experience material changes	CHANGES UK Spitalfields Crypt Trust
Local employers (providing jobs for people in recovery)	Exclude	This stakeholder group would not experience material changes; however, they are key to providing outcomes for the key stakeholder group. This group could be included as an indicator (i.e. number of local employers willing to provide people in recovery with jobs as an indicator of reduced stigma against those in recovery from substance misuse)	The Hub Spitalfields Crypt Trust
Colleagues of training attendees	Exclude	Although there may be changes to this stakeholder group, it is unlikely to be material within the time frame in the scope of this SROI. There would also be limited ways in which this stakeholder could be consulted	All
Staff members – recovery communities	Exclude	As inputs only – providing building and staff/ volunteer investments. These staff members are employed with money provided by Comic Relief	All
Gloucester drug and alcohol commissioner	Exclude	Although there may be changes to this stakeholder group, it is unlikely to be material within the time frame in the scope of this SROI.	The Hub

Appendix 2.2 The Cornforth Partnership- Clean & Sober Living

Stakeholder group	What do they invest?	How are they affected?	Please list the key outcomes/changes likely to be experienced
Recovery Champions	Time (in kind/as a volunteer) Recovery experience	Build skills in mentoring and community outreach; maintain their own recovery journey including meaningful activity, avoiding relapses.	• Maintained abstinence • Involved in positive and meaningful activity • Better physical and/or mental health
Clean & Sober Living staff	Time and resources	They build their skills and experience and feel satisfied in their role. At the same time, it contributes to their own recovery.	• Improved employability levels • Become more skilled and experienced • Improved communication skills • Improved confidence and self esteem • Become more self-reliant and financially stable
People seeking recovery		Gain a sense of hope and inspiration	• Enter pre-contemplative stage of recovery (develop willingness to change)
People in recovery		They sustain their recovery and continue to work towards becoming a responsible and productive member of society	• Improved physical and psychological health • Stop committing crime • Re-engage with families and communities • Improved social skills • Re–enter education / volunteering / work • Improved housing circumstances
Families, friends and significant relationships		They learn more about addiction and recovery.	• Improved ability to communicate with addicted people and recovering people • Improved ability to set new and healthier boundaries with addicted or recovering people • Improved psychological and emotional health

Drug and alcohol treatment organisations and their staff		They learn more about addiction and recovery from a user led perspective	• Changed perspectives and attitudes and behaviours towards addicted and/or recovering people (stigma and prejudice) • Improved abstinence-based outputs and outcomes • Improved relationships with recovery communities and the people in them
Wider organisations and their staff (e.g. criminal justice services, social services, schools and educators and third sector organisations)		They learn more about addiction and recovery from a user led perspective	• Changed perspectives and attitudes and behaviours towards addicted and/or recovering people (stigma &prejudice) • Improved abstinence-based outputs and outcomes • Improved relationships with recovery communities and the people in them
The wider community and the environment (e.g. local shops and businesses and the landscape - how places look and feel)		Some see recovering people for the first time, and as a result, their attitudes and beliefs change. Also, they feel happier, healthier and safer in their community.	• Changed in attitudes and behaviour (stigma and prejudice) • Less drug litter etc. • Less shoplifting and theft (improved business) • The wider community appears healthier and safer

Appendix 3: Justification for financial proxies, deadweight and attribution measures

Appendix 3.1 The Hub, Gloucester, training programme and recovery cafe

Appendix 3.1.1 Financial proxies

Stakeholder	Outcome	Indicator	N	Value	Financial proxy and source	Justification for value	Alternatives and justification
Members of the recovery community	**Sense of purpose and feeling valued**	Number of people in focus group agreeing with this aggregated to the proportion of members	50	£1,056	Positive functioning from the national accounts of well-being model. The value was £1,056/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was defined as autonomy, meaning and purpose which was similar outcome described at the focus groups with the members of the recovery community.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: it was much higher than the £8,000 for an exotic holiday for two people
							HACT. 2015. Social Value Bank: Secure Job for outside London, unknown age. £12,083
	Personal capital (emotionally able to cope with things)	Number of people in focus group agreeing with this aggregated to the proportion of members	42	£1,056	Increase in confidence/self-esteem from the national accounts of well-being model. The value was £1,056/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers. -> Due to value game personal capital was worth more than £8,000 and so we will not use this value.	This was defined as resilience and self-esteem which was similar outcome described at the focus groups with the members of the recovery community.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: personal capital was worth more than the £8,000 for an exotic holiday for two people
							Equating wellbeing with mental health to get a value of overall wellbeing which includes personal and social wellbeing outcomes, the sum of these is £10,560. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers
	Improved relationships with family, friends or colleagues	Number of people in focus group agreeing with this aggregated to the	35	£2,640	Improved/ supportive relationships or reduced isolation from the national accounts of wellbeing model. The value is £2,640/annum. Source: Cox et al. 2012. Social Value:	This was defined as: this was defined as supportive relationships which was similar outcome described at the focus groups with	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: it was much higher than the £8,000 for an exotic holiday for two people

		proportion of members			Understanding the wider value of public policy interventions. New Economy Working Papers.	the members of the recovery community.	A similar outcome improve relationships with family and friends was identified in a recent assured SROI report, Turning Point, 2014. The value was £15,500 and came from the British Household Panel Survey data 1997-2003 as analysed by Nattavudh Powdthavee (2008) Putting a price tag on friends, relatives, and neighbours. Journal of Socio Economics 37 (4) 1459 –80
	Better connection with wider society	Number of people in focus group agreeing with this aggregated to the proportion of members	21	£2,640	Trust and belonging. Drawn from the national accounts of well-being model. The value is £2,064/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was defined as autonomy, meaning and purpose which was similar outcome described at the focus groups with the members of the recovery community.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: personal capital was worth more than the £8,000 for an exotic holiday for two people.
							The outcome was similar to the outcome (a sense of being a functioning member of society) reported in the Turning Point Report. Goodspeed. 2014. The report draws on the wellbeing valuation for relief from depression and anxiety (HACT, social value bank). The value was £36,827.
Family and friends of the members of the recovery community	**Improved relationships with family, friend or colleague who is a member of the recovery community**	Number of people in focus groups who said they had improved relationships with a least one family, friend or colleagues, this was aggregated to the proportion of members	35	£2,640	Improved family relationships, taken from wellbeing valuation model. The value is £2,640/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was specifically applied to improved community wellbeing. During the focus groups, more than half (n=5) of the participants said they had improved relationships with family, friends and/or colleagues.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: personal capital was worth more than the £8,000 for an exotic holiday for two people.

Appendix 3.1.2 Deadweight

Outcome	Deadweight %	Indicators for justification	Benchmark	Source	Location
Sense of purpose and feeling valued	20%	Participation in volunteering at least once a month. Looking at both the formal and informal volunteering, as both involved giving unpaid help through groups, clubs or organisations.	2014/15:Informal volunteering=34% Formal volunteering=27%	Community Life Survey England 2014-15, Cabinet Office, 2015. Statistical bulletin.	National
		Proportion of people involved in social action at least once a year in 2014/15; the figure (18%) was the same for 2013/14. Social action was defined as people coming together to deliver a community project in their local area.	2014/15: 18% 2013/14: 18% 2012/13: 23%	Community Life Survey England 2014-15, Cabinet Office, 2015. Statistical bulletin.	
		Treatment outcomes at six months review for clients with substance misuse who are in treatment. Percentage of those who are in employment and education.	Employment: 2013/14: 23% Education: 2013/14: 4%	NDTMS. 2014. Drug treatment activity in England 2013/14: http://www.nta.nhs.uk/statistics.aspx	
		Percentage of those who feel that the things that they do in their lives are 'completely' worthwhile. This is the percentage of those rating the highest levels (9-10 on a scale of 0-10).	Worthwhile: 2014/15: 35.6% Life satisfaction: 2014/15: 29.7%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	Regional
Personal capital (emotionally able to cope with things)	20%	Percentage of those reporting that they have very low anxiety yesterday (0-1 on a scale of 0-10, where 0 is not at all).	South West: 2014/15: 40.3% National: 2014/15: 40.9% 2013/14: 39.4%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	Regional & National

		Percentage of those who rated their happiness yesterday was very high.	South West: 2014/15: 34.8% National: 2014/15: 34.1% 2013/14: 32.6%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	
Improved relationships with family, friends and/or colleagues	50%	The majority of people in the UK report that they have someone to rely on if they have a serious problem	2010/11: 87%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	National
		The majority of people in the UK have one or more friends that they can confide in, support them or escape with/have fun with	Confide in: 2011/12: 93% Support them: 2011/12: 92% Escape/have fun with: 2011/12: 90%	Measuring National Well-being: Our Relationships, 2015 http://www.ons.gov.uk/ons/dcp171766_394187.pdf	National
		Just under two thirds of people in the UK reported having a good or very good relationship between themselves and their managers	2011: 64%	Measuring National Well-being: Our Relationships, 2015 http://www.ons.gov.uk/ons/dcp171766_394187.pdf	National
Better connection with wider society	40%	Sense of belonging to their neighbourhood. Community cohesion where it is felt people from different backgrounds get on well together. Borrowing and exchange favours with neighbours. Chatting to neighbours at least once a month, more than just to say hello. People pull together to improve their neighbourhood.	Belonging: 2014/15: 72% 2013/14: 70% Cohesion: 2014/15: 86% 2013/14: 85% Borrowing and favours: 2014/15: 45% 2013/14: 44% Chatting: 2014/15: 79%	Community Life Survey England 2014-15, Cabinet Office, 2015 statistical bulletin. Accessed online on 03.11.15, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/447010/Community_Life_Survey_2014-15_Bulletin.pdf	National

			2013/14: 75% 2012/13: 80% Pull together: 2014/15: 63% 2013/14: 60% 2012/13: 62%		

Appendix 3.1.3 Attribution

Stakeholder	Outcome	Services and organisations which may have contributed to the outcomes	Attribution %	Justification
Members of the recovery community	**Sense of purpose and feeling valued**	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery* Links with colleges for training courses* Turning Point (local drug and alcohol service) Other activities ran by the Nelson Trust* Local mental health and health and wellbeing service The Magistrates training- service users delivering it helps with feeling valued*	30%	Attendance at 12-step fellowship and/or SMART recovery meetings will have an impact for some service users. The other services and organisations might have had some impact but it is likely this will not be a substantial amount.
	Personal capital (emotionally able to cope with things)	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery* Links with colleges for training courses* Links with housing providers in the area signposting* Turning Point (local drug and alcohol service) Other activities ran by the Nelson Trust* Local mental health and health and wellbeing service The Magistrates training- service users delivering it helps their personal capital*	30%	Attendance at 12-step fellowship and/or SMART recovery meetings will have an impact for some service users. The other services and organisations might have had some impact but it is likely this will not be a substantial amount. Only a few members will have delivered the magistrates training. Signposting to the 12-step fellowship means the Hub can claim for this.
	Improved relationships with family, friends and/or colleagues	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery* Turning Point (local drug and alcohol service) Other activities ran by the Nelson Trust* Local mental health and health and wellbeing service	20%	Attendance at 12-step fellowship and/or SMART recovery meetings will have an impact for some service users. The other services and organisations might have had some impact but it is likely this will not be a substantial amount. Signposting to the 12-step fellowship means the Hub can claim for this.

	Better connection with wider society	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery* Links with colleges for training courses* Links with housing providers- signposting/referrals* The Magistrates training- service users delivering it helps them have a better connection with wider society* Local media- interviews	10%	The training courses delivered by the college will have some impact on helping the members integrate back into society as they attend courses with those who are not in recovery. Only a few members will have delivered the magistrates training. Signposting to the 12-step fellowship means the Hub can claim for this.
Family and friends of the members of the recovery community	**Improved relationships with family, friend or colleague who is a member of the recovery community**	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery* Links with colleges for training courses* Links with housing providers in the area signposting* Turning Point (local drug and alcohol service) Other activities ran by the Nelson Trust* Local mental health and health and wellbeing service The Magistrates training- service users delivering it helps their personal capital*	20%	By the recovery community member attending the 12-step fellowship and/or SMART recovery meetings will have an impact for some service users. The other services and organisations might have had some impact but it is likely this will not be a substantial amount. Only a few members will have delivered the magistrates training. Signposting to the 12-step fellowship means the Hub can claim for this.

Appendix 3.2 Choices and Progression, Spitalfields Crypt Trust, London

Appendix 3.2.1 Financial proxies

Stakeholder	Outcome	Indicator	N	Value	Financial proxy and source	Justification for value	Alternatives
Members of the recovery community	**Sense of purpose and feeling valued**	Number of people in focus group agreeing with this aggregated to them proportion of members	70	£1,056	Positive functioning from the national accounts of well-being model. The value was £1,056/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was defined as autonomy, meaning and purpose which was similar outcome described at the focus groups with the members of the recovery community.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: it was much higher than the £8,000 for an exotic holiday for two people HACT. 2015. Social Value Bank: Secure Job for outside London, unknown age. £12,083
	Personal capital (emotionally able	Number of people in focus group agreeing with this	60	£1,056	Increase in confidence/self-esteem from the national accounts of well-being model. The value was	This was defined as resilience and self-esteem which was similar outcome	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: personal

	to cope with things)	aggregated to the proportion of members			£1,056/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers. -> Due to value game personal capital was worth more than £8,000 and so we will not use this value.	described at the focus groups with the members of the recovery community.	capital was worth more than the £8,000 for an exotic holiday for two people Equating wellbeing with mental health to get a value of overall wellbeing which includes personal and social wellbeing outcomes, the sum of these is £10,560. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers
	Improved relationships with family, friends or colleagues	Number of people in focus group agreeing with this aggregated to the proportion of members	40	£2,640	Improved/ supportive relationships or reduced isolation from the national accounts of wellbeing model. The value is £2,640/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was defined as: this was defined as supportive relationships which was similar outcome described at the focus groups with the members of the recovery community.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: it was much higher than the £8,000 for an exotic holiday for two people A similar outcome improve relationships with family and friends was identified in a recent assured SROI report, Turning Point, 2014. The value was £15,500 and came from the British Household Panel Survey data 1997-2003 as analysed by Nattavudh Powdthavee (2008) Putting a price tag on friends, relatives, and neighbours. Journal of Socio Economics 37 (4) 1459 –80
	Better connection with wider society	Number of people in focus group agreeing with this aggregated to the proportion of members	30	£2,640	Trust and belonging. Drawn from the national accounts of well-being model. The value is £2,064/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was defined as autonomy, meaning and purpose which was similar outcome described at the focus groups with the members of the recovery community.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: personal capital was worth more than the £8,000 for an exotic holiday for two people. The outcome was similar to the outcome (a sense of being a functioning member of society) reported in the Turning Point Report. Goodspeed. 2014. The report draws on the wellbeing valuation for relief from

							depression and anxiety (HACT, social value bank). The value was £36,827.
Family and friends of the members of the recovery community	**Improved relationships with family, friend or colleague who is a member of the recovery community**	Number of people in focus groups who said they had improved relationships with a least one family, friend or colleagues, this was aggregated to the proportion of members	40	£2,640	Improved family relationships, taken from wellbeing valuation model. The value is £2,640/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was specifically applied to improved community wellbeing. During the focus groups, more than half (n=5) of the participants said they had improved relationships with family, friends and/or colleagues.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: personal capital was worth more than the £8,000 for an exotic holiday for two people.

Appendix 3.2.2 Deadweight

Outcome	**Deadweight %**	**Indicators for justification**	**Benchmark**	**Source**	**Location**
Sense of purpose and feeling valued	20%	Participation in volunteering at least once a month. Looking at both the formal and informal volunteering, as both involved giving unpaid help through groups, clubs or organisations.	2014/15:Informal volunteering=34% Formal volunteering=27%	Community Life Survey England 2014-15, Cabinet Office, 2015. Statistical bulletin.	National
		Proportion of people involved in social action at least once a year in 2014/15, the figure (18%) was the same for 2013/14. Social action was defined as people coming together to deliver a community project in their local area.	2014/15: 18% 2013/14: 18% 2012/13: 23%	Community Life Survey England 2014-15, Cabinet Office, 2015. Statistical bulletin.	

		Treatment outcomes at six months review for clients with substance misuse who are in treatment. Percentage of those who are in employment and education.	Employment: 2013/14: 23% Education: 2013/14: 4%	NDTMS. 2014. Drug treatment activity in England 2013/14: http://www.nta.nhs.uk/statistics.aspx	
		Percentage of those who feel that the things that they do in their lives are 'completely' worthwhile. This is the percentage of those rating the highest levels (9-10 on a scale of 0-10).	Worthwhile: 2014/15: 31.8% Life satisfaction: 2014/15: 25.4%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	Regional
Personal capital (emotionally able to cope with things)	20%	Percentage of those reporting that they have very low anxiety yesterday (0-1 on a scale of 0-10, where 0 is not at all).	London: 2014/15: 36.2% National: 2014/15: 40.9% 2013/14: 39.4%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	Regional & National
		Percentage of those who rated their happiness yesterday was very high.	London: 2014/15: 31.2% National: 2014/15: 34.1% 2013/14: 32.6%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	
Improved relationships with family, friends and/or colleagues	50%	The majority of people in the UK report that they have someone to rely on if they have a serious problem	2010/11: 87%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	National
		The majority of people in the UK have one or more friends that they can confide in, support them or escape with/have fun with	Confide in: 2011/12: 93% Support them: 2011/12: 92% Escape/have fun with: 2011/12: 90%	Measuring National Well-being: Our Relationships, 2015 http://www.ons.gov.uk/ons/dcp171766_394187.pdf	National

		Just under two thirds of people in the UK reported having a good or very good relationship between themselves and their managers	2011: 64%	Measuring National Well-being: Our Relationships, 2015 http://www.ons.gov.uk/ons/dcp171766_394187.pdf	National
Better connection with wider society	40%	Sense of belonging to their neighbourhood. Community cohesion where it is felt people from different backgrounds get on well together. Borrowing and exchange favours with neighbours. Chatting to neighbours at least once a month, more than just to say hello. People pull together to improve their neighbourhood.	Belonging: 2014/15: 72% 2013/14: 70% Cohesion: 2014/15: 86% 2013/14: 85% Borrowing and favours: 2014/15: 45% 2013/14: 44% Chatting: 2014/15: 79% 2013/14: 75% 2012/13: 80% Pull together: 2014/15: 63% 2013/14: 60% 2012/13: 62%	Community Life Survey England 2014-15, Cabinet Office, 2015 statistical bulletin. Accessed online on 03.11.15, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/447010/Community_Life_Survey_2014-15_Bulletin.pdf	National

Appendix 3.2.3 Attribution

Stakeholder	Outcome	Services and organisations which may have contributed to the outcomes	Attribution %	Justification
Members of the recovery community	**Sense of purpose and feeling valued**	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery*	30%	Attendance at 12-step fellowship and SMART recovery meetings will have an impact for some service users' sense of purpose and feeling valued. Spitalfields staff signpost some members to 12-step fellowship meetings and so can claim for the referrals/signposting they do. The other services and organisations might have had some impact but it is likely this will not be a

		Lifeline refer people to Spitalfields (statutory service, not abstinence only) provided a small pot of funding to support Spitalfields activities Other activities ran by Spitalfields* Clean Break (service which works with those who have been in prison) Island Drug Programme (structured abstinence-based programme) Crisis (drug testing and other services) St. Mungo's (first stage treatment centre)		substantial amount. Lifeline have funded some of the activities ran by Spitalfields and so can claim for some of this.
	Personal capital (emotionally able to cope with things)	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery* Lifeline refer people to Spitalfields (statutory service, not abstinence only) provided a small pot of funding to support Spitalfields activities Other activities ran by Spitalfields* Clean Break (service which works with those who have been in prison) Island Drug Programme (structured abstinence-based programme) Crisis (drug testing and other services) St. Mungo's (first stage treatment centre)	30%	Attendance at 12-step fellowship and SMART recovery meetings will have an impact for some service users' personal capital. Spitalfields staff signpost some members to 12-step fellowship meetings and so can claim for the referrals/signposting they do. The other services and organisations might have had some impact but it is likely this will not be a substantial amount. Lifeline have funded some of the activities ran by Spitalfields and so can claim for some of this.
	Improved relationships with family, friends and/or colleagues	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery* Lifeline refer people to Spitalfields (statutory service, not abstinence only) provided a small pot of funding to support Spitalfields activities Other activities ran by Spitalfields* Clean Break (service which works with those who have been in prison) Island Drug Programme (structured abstinence-based programme) Crisis (drug testing and other services) St. Mungo's (first stage treatment centre)	20%	Attendance at 12-step fellowship and SMART recovery meetings will have an impact for some service users' improved relationships. Spitalfields staff signpost some members to 12-step fellowship meetings and so can claim for the referrals/signposting they do. The other services and organisations might have had some impact but it is likely this will not be a substantial amount. Lifeline have funded some of the activities ran by Spitalfields and so can claim for some of this.
	Better connection with wider society	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery* Launch party and social events attended by businesses and the local community to raise awareness of Spitalfields activities* Other activities ran by Spitalfields*	10%	The launch party and social events attended by the public and businesses will have some impact on helping the members integrate back into society however these are ran by Spitalfields so they can claim for this. Only a few members will have delivered the events. Attendance at 12-step fellowship and SMART recovery meetings will have an impact for some service users' better connection with society. Spitalfields staff signpost some members to

		Lifeline refer people to Spitalfields (statutory service, not abstinence only) provided a small pot of funding to support Spitalfields activities		12-step fellowship meetings and so can claim for the referrals/signposting they do. The other services and organisations might have had some impact but it is likely this will not be a substantial amount. Lifeline have funded some of the activities ran by Spitalfields and so can claim for some of this.
Family and friends of the members of the recovery community	**Improved relationships with family, friend or colleague who is a member of the recovery community**	Daily 12-step fellowship meetings daily meetings: attended by some service users* SMART Recovery* Lifeline refer people to Spitalfields (statutory service, not abstinence only) provided a small pot of funding to support Spitalfields activities Other activities ran by Spitalfields* Clean Break (service which works with those who have been in prison) Island Drug Programme (structured abstinence-based programme) Crisis (drug testing and other services) St. Mungo's (first stage treatment centre)	20%	By the recovery community member attending the 12-step fellowship and/or SMART recovery meetings this will have an impact on some close relationships. Spitalfields staff signpost some members to 12-step fellowship meetings and so can claim for the referrals/signposting they do. The other services and organisations might have had some impact but it is likely this will not be a substantial amount. Lifeline have funded some of the activities ran by Spitalfields and so can claim for some of this.

Appendix 3.3 Recovery Central – Peer led support and membership services, CHANGES UK, Birmingham

Appendix 3.3.1 Financial proxies.

Higher values based on the Value Game

Stakeholder	Outcome	Indicator	N	Value	Financial proxy and source	Justification for value	Alternatives and justification
Members of the recovery community	**Sense of purpose and feeling valued**	Number of people in focus group agreeing with this aggregated to proportion of members	100	£10,082	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point, it was much higher than the £8,000 for an exotic holiday for two people. HACT. 2015. Social Value Bank: Secure Job for outside London 25-29. £12,164.	This is the half way point between stakeholder informed valuation (£8,000) from the value game and the value from the HACT social value bank (£12,164)	Positive functioning: this was defined as autonomy, meaning and purpose. The value was £1,056/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.

	Personal capital (emotionally able to cope with things)	Number of people in focus group agreeing with this aggregated to proportion of members	71	£10,560	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point, personal capital was worth more than the £8,000 for an exotic holiday for two people. Equating wellbeing with mental health to get a value of overall wellbeing which includes personal and social wellbeing. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This is higher than the £8,000 from the value game	Increase in confidence/self-esteem: from the national accounts of well-being model, defined as resilience and self-esteem. The value was £1,056/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers. -> Due to value game personal capital was worth more than £8,000 and so we will not use this value.
	Improved relationships with family members	Number of people in focus group agreeing with this aggregated to proportion of members	57	£11,750	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: it was much higher than the £8,000 for an exotic holiday for two people. A similar outcome improve relationships with family and friends was identified in a recent assured SROI report, Turning Point, 2014. The value was £15,500 and came from the British Household Panel Survey data 1997-2003 as analysed by Nattavudh Powdthavee (2008) Putting a price tag on friends, relatives, and neighbours. Journal of Socio Economics 37 (4) 1459 –80.	Mid-point between stakeholders informed valuation (£8,000) and proxy for same outcome in recent assured SROI report, Turning Point, 2014.	Reduced isolation: this was defined as supportive relationships from the national accounts of wellbeing model. The value was £2,640/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.
	Better connection with wider society	Number of people in focus group agreeing with this aggregated to	43	£8,000	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: personal capital	This was not ranked as highly as the other	The outcome was similar to the outcome (a sense of being a functioning member of society) reported in the Turning Point Report (Goodspeed, 2014). The report draws on the wellbeing valuation for relief

		proportion of members			was worth more than the £8,000 for an exotic holiday for two people.	outcomes and so will be lower.	from depression and anxiety (HACT, social value bank).
Family and friends of the members of the recovery community	**Improved relationship with a member of the recovery community**	Number of people in focus groups who said they had improved relationships with a least one family, friend or colleagues; this was aggregated to the proportion of members	57	£11,750	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point: it was much higher than the £8,000 for an exotic holiday for two people. A similar outcome improve relationships with family and friends was identified in a recent assured SROI report, Turning Point, 2014. The value was £15,500 and came from the British Household Panel Survey data 1997-2003 as analysed by Nattavudh Powdthavee (2008) Putting a price tag on friends, relatives, and neighbours. Journal of Socio Economics 37 (4) 1459 –80.	Mid-point between stakeholders informed valuation (£8,000) and proxy for same outcome in recent assured SROI report, Turning Point, 2014.	Reduced isolation: this was defined as supportive relationships from the national accounts of wellbeing model. The value was £2,640/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.

Lower values

Stakeholder	**Outcome**	**Indicator**	**N**	**Value**	**Financial proxy and source**	**Justification for value**	**Alternatives**
Members of the recovery community	**Sense of purpose and feeling valued**	Number of people in focus group agreeing with this aggregated to them proportion of members	100	£1,056	Positive functioning from the national accounts of well-being model. The value was £1,056/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was defined as autonomy, meaning and purpose which was similar outcome described at the focus groups with the members of the recovery community.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point, it was much higher than the £8,000 for an exotic holiday for two people HACT. 2015. Social Value Bank: Secure Job for outside London, unknown age. £12,083

	Personal capital (emotionally able to cope with things)	Number of people in focus group agreeing with this aggregated to the proportion of members	71	£1,056	Increase in confidence/self-esteem from the national accounts of well-being model. The value was £1,056/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers. -> Due to value game personal capital was worth more than £8,000 and so we will not use this value.	This was defined as resilience and self-esteem which was similar outcome described at the focus groups with the members of the recovery community.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point, personal capital was worth more than the £8,000 for an exotic holiday for two people Equating wellbeing with mental health to get a value of overall wellbeing which includes personal and social wellbeing outcomes, the sum of these is £10,560. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers
	Improved relationships with family, friends or colleagues	Number of people in focus group agreeing with this aggregated to the proportion of members	57	£2,640	Improved/ supportive relationships or reduced isolation from the national accounts of wellbeing model. The value is £2,640/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was defined as: this was defined as supportive relationships which was similar outcome described at the focus groups with the members of the recovery community.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point, it was much higher than the £8,000 for an exotic holiday for two people A similar outcome improve relationships with family and friends was identified in a recent assured SROI report, Turning Point, 2014. The value was £15,500 and came from the British Household Panel Survey data 1997-2003 as analysed by Nattavudh Powdthavee (2008) Putting a price tag on friends, relatives, and neighbours. Journal of Socio Economics 37 (4) 1459 –80
	Better connection with wider society	Number of people in focus group agreeing with this aggregated to the	43	£2,640	Trust and belonging. Drawn from the national accounts of well-being model. The value is £2,064/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of	This was defined as autonomy, meaning and purpose which was similar outcome described at the focus groups with the	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point, personal capital was worth more than the £8,000 for an exotic holiday for two people.

		proportion of members			public policy interventions. New Economy Working Papers.	members of the recovery community.	The outcome was similar to the outcome (a sense of being a functioning member of society) reported in the Turning Point Report. Goodspeed. 2014. The report draws on the wellbeing valuation for relief from depression and anxiety (HACT, social value bank). The value was £36,827.
Family and friends of the members of the recovery community	**Improved relationships with family, friend or colleague who is a member of the recovery community**	Number of people in focus groups who said they had improved relationships with a least one family, friend or colleagues, this was aggregated to the proportion of members	50	£2,640	Improved family relationships, taken from wellbeing valuation model. The value is £2,640/annum. Source: Cox et al. 2012. Social Value: Understanding the wider value of public policy interventions. New Economy Working Papers.	This was specifically applied to improved community wellbeing. During the focus groups, more than half (n=5) of the participants said they had improved relationships with family, friends and/or colleagues.	During the value game with another recovery community, we played with the terms social and material outcome to get to a tipping point, personal capital was worth more than the £8,000 for an exotic holiday for two people.

Appendix 3.3.2 Deadweight

Outcome	**Deadweight %**	**Indicators for justification**	**Benchmark**	**Source**	**Location**
Sense of purpose and feeling valued	20%	Participation in volunteering at least once a month. Looking at both the formal and informal volunteering, as both involved giving unpaid help through groups, clubs or organisations.	2014/15:Informal volunteering=34% Formal volunteering=27%	Community Life Survey England 2014-15, Cabinet Office, 2015. Statistical bulletin.	National
		Proportion of people involved in social action at least once a year in 2014/15, the figure (18%) was the same for 2013/14. Social action was defined as people coming together to deliver a community project in their local area.	2014/15: 18% 2013/14: 18% 2012/13: 23%	Community Life Survey England 2014-15, Cabinet Office, 2015. Statistical bulletin.	

		Treatment outcomes at six months review for clients with substance misuse who are in treatment. Percentage of those who are in employment and education.	Employment: 2013/14: 23% Education: 2013/14: 4%	NDTMS. 2014. Drug treatment activity in England 2013/14: http://www.nta.nhs.uk/statistics.aspx	
		Percentage of those who feel that the things that they do in their lives are 'completely' worthwhile. This is the percentage of those rating the highest levels (9-10 on a scale of 0-10).	Worthwhile: 2014/15: 32.2% Life satisfaction: 2014/15: 27.0%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	Regional
Personal capital (emotionally able to cope with things)	20%	Percentage of those reporting that they have very low anxiety yesterday (0-1 on a scale of 0-10, where 0 is not at all).	West Midlands: 2014/15: 45.9% National: 2014/15: 40.9% 2013/14: 39.4%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	Regional & National
		Percentage of those who rated their happiness yesterday was very high.	West Midlands: 2014/15: 32.1% National: 2014/15: 34.1% 2013/14: 32.6%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	

Improved relationships with family, friends and/or colleagues	50%	The majority of people in the UK report that they have someone to rely on if they have a serious problem	2010/11: 87%	ONS. 2015. Personal Well-being in the UK 2014/15: Personal well-being in the English regions. Accessed online on 03.11.15, at: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2014-15/stb-personal-well-being-in-the-uk--2014-15.html	National
		The majority of people in the UK have one or more friends that they can confide in, support them or escape with/have fun with	Confide in: 2011/12: 93% Support them: 2011/12: 92% Escape/have fun with: 2011/12: 90%	Measuring National Well-being: Our Relationships, 2015 http://www.ons.gov.uk/ons/dcp171766_394187.pdf	National
		Just under two thirds of people in the UK reported having a good or very good relationship between themselves and their managers	2011: 64%	Measuring National Well-being: Our Relationships, 2015 http://www.ons.gov.uk/ons/dcp171766_394187.pdf	National
Better connection with wider society	40%	Sense of belonging to their neighbourhood. Community cohesion where it is felt people from different backgrounds get on well together. Borrowing and exchange favours with neighbours. Chatting to neighbours at least once a month, more than just to say hello. People pull together to improve their neighbourhood.	Belonging: 2014/15: 72% 2013/14: 70% Cohesion: 2014/15: 86% 2013/14: 85% Borrowing and favours: 2014/15: 45% 2013/14: 44%	Community Life Survey England 2014-15, Cabinet Office, 2015 statistical bulletin. Accessed online on 03.11.15, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/447010/Community_Life_Survey_2014-15_Bulletin.pdf	National

			Chatting: 2014/15: 79% 2013/14: 75% 2012/13: 80% Pull together: 2014/15: 63% 2013/14: 60% 2012/13: 62%		

Appendix 3.3.3 Attribution

Stakeholder	Outcome	Services and organisations which may have contributed to the outcomes	Attribution %	Justification
Members of the recovery community	**Sense of purpose and feeling valued**	12 step fellowship* SMART recovery* Harm reduction service Treatment services Counselling service* Links with two colleges for training courses* Links with housing provider- signposting/referrals* Engaging with social enterprises and businesses* Real Access (community focussed film and new media company, putting on film at theatre in Birmingham which explores addiction and recovery)* Citizen Click, website and social media training for service users (funded by Changes UK)* Canvassing with the local community- positive feedback that some of the public said they would rather use a service which has a social goal- helps service users' feel valued*	30%	Attendance at 12-step fellowship and/or SMART recovery meetings will have an impact for some service users. The other services and organisations might have had some impact but it is likely this will not be a substantial amount.

	Personal capital (emotionally able to cope with things)	12 step fellowship* SMART recovery* Harm reduction service Treatment services Counselling service* Links with two colleges for training courses* Links with housing provider- signposting/referrals* Engaging with social enterprises and businesses* Real Access (community focussed film and new media company, putting on film at theatre in Birmingham which explores addiction and recovery)* Citizen Click, website and social media training for service users (funded by Changes UK)* Canvassing with the local community- positive feedback that some of the public said they would rather use a service which has a social goal- helps service users' personal capital*	30%	Attendance at 12-step fellowship and/or SMART recovery meetings will have an impact for some service users. The other services and organisations might have had some impact but it is likely this will not be a substantial amount. Only a few members will have engaged with the businesses or done the canvassing with local community. Signposting to the 12-step fellowship means Changes UK can claim for this.
	Improved relationships with family, friends and/or colleagues	12 step fellowship* SMART recovery* Harm reduction service Treatment services Counselling service* Links with two colleges for training courses* Links with housing provider- signposting/referrals*	20%	Attendance at 12-step fellowship and/or SMART recovery meetings will have an impact for some service users. The other services and organisations might have had some impact but it is likely this will not be a substantial amount. Signposting to the 12-step fellowship means Changes UK can claim for this.
	Better connection with wider society	12 step fellowship* SMART recovery* Harm reduction service Treatment services Counselling service* Links with two colleges for training courses* Links with housing provider- signposting/referrals* Engaging with social enterprises and businesses* Real Access (community focussed film and new media company, putting on film at theatre in Birmingham which explores addiction and recovery)* Citizen Click, website and social media training for service users (funded by Changes UK)* Canvassing with the local community- positive feedback that some of the public said they would rather use a service which has a social goal- helps service users' personal capital*	10%	The training courses delivered by the college will have some impact on helping the members integrate back into society. Only a few members will have engaged with the businesses or done the canvassing with local community. Signposting to the 12-step fellowship means ChangesUK can claim for this.
Family and friends of the members of the recovery community	**Improved relationships with family, friend or colleague who is a**	12 step fellowship* SMART recovery* Harm reduction service Treatment services Counselling service*	20%	By the recovery community member attending the 12-step fellowship and/or SMART recovery meetings will have an impact for some service users. The other services and organisations might have had some impact but it is likely this will not

	member of the recovery community	Links with two colleges for training courses* Links with housing provider- signposting/referrals*		be a substantial amount. Signposting to the 12-step fellowship means Changes UK can claim for this.

Appendix 4 – Impact map calculations – approximate number of individuals within each recovery community experiencing outcomes

Appendix 4.1 Forecast SROI

Approximate number of individuals within the three recovery communities who have experienced an outcome

	Approximate number of people in the focus group experiencing the outcome			**Approximate number of people in the recovery community experiencing the outcome**		
Outcome	*The Hub*	*Choices and Progression*	*Recovery Central – peer led support and membership services*	*The Hub*	*Choices and progression*	*Recovery Central – peer led support and membership services*
Sense of purpose and feeling valued	7/7	7/7	7/7	50/ 50	70/70	100/100
Personal capital (emotionally able to cope with things)	6/7	6/7	5/7	42/ 50	60/70	71/100

Improved relationships with family, friends and colleagues	5/7	4/7	4/7	35/50	40/70	57/100
Better connection with wider society	3/7	3/7	3/7	21/ 50	30/70	43/100
Improved relationships with recovery community member	5/7	4/7	4/7	35/50	40/70	57/100

Appendix 4.2 Evaluative SROI

For example: For CHANGES UK, a total of ten individuals completed the WEMWBS and ARC Recovery tool measures. When looking at the outcome of 'improved relationships with family members', across WEMWBS, 9 out of 10 individuals showed positive change; whilst 10 out of 10 individuals showed positive change for this outcome for the ARC Recovery Tool. An average was then taken i.e., 9.5/10, rounded down to 9 out of 10 so as not to over claim (which is a key principle in SROI research). As this number of 10 was only a sample of the total number of individuals accessing the peer led services, the total number of individuals accessing the recovery community peer led services was then used to calculate a quantity of service users experiencing this outcome. Across the point in time that the wellbeing and recovery measurements were taken, the number of individuals accessing the peer led service fluctuated between 36 and 50. The lower figure of 36 was taken (again not to over claim) and multiplied by 0.9 (the proportion of individuals completing the measures who had experienced a positive change over time), which gave an estimated quantity of 32 individuals who had experienced this outcome (rounded down from a figure of 32.4.

This process was applied across all of the outcome measures for each of the three recovery communities.

Approximate number of individuals within the three recovery communities who have experienced an outcome

	Approximate number of individuals completing data measures experiencing the outcome			**Approximate number of people in the recovery community experiencing the outcome**		
Recovery Community	CHANGES UK – peer led support	The Hub	Spitalfields – Choices and Progression	CHANGES UK – peer led support	The Hub	Spitalfields – Choices and Progression
Outcome						
Sense of purpose and feeling valued	9/10	4/12	14/20	32/36	33/100	43/62

Personal capital (emotionally able to cope with things)	9/10	6/12	15/20	32/36	50/100	46/62
Improved relationships with family, friends and colleagues	9/10	6/12	9/20	32/36	50/100	28/62
Better connection with wider society	10/10	12/12	11/20	36/36	100	34/62
Improved relationships with recovery community members (as experienced by family and friends as a key beneficiary)	9/10	6/12	9/20	32/36	50/100	28/62

Appendix 5: Sensitivity analysis

Appendix 5.1 Forecast SROI sensitivity analysis

Sensitivity analysis was carried out on all three analyses. This aimed to check the assumptions made by the researchers and assess the robustness of the impact map. This involved changing the variables under question and examining the effect on the overall SROI ratio. A large variation in the SROI result after variables are adjusted indicates uncertainty in the figure. At present the existing data sources which related to the outcomes experienced by this population group (those in recovery) were limited and so it may be possible that there are limitations in the robustness of the proxy values and deadweight used in this forecast SROI. Nonetheless, the current analysis gives an indication that the three recovery communities' activities are moving in the right direction of creating social value.

Definitive data was not available to indicate exactly how many people in the recovery community had experienced each outcome; therefore the seven members at the focus group carried out at each recovery community were used. The proportion of the focus group who self-reported that they had experienced an outcome was aggregated up to denote the proportion of people in the whole recovery community who may be experiencing an outcome. To ensure the ratio was not too dependent on an individual in the focus group, the quantity for all for recovery communities was reduced by at least one individual, which was equivalent to approximately 10% of members from the recovery community. For ChangesUK, Spitalfields and the Hub when the SROI ratio was adjusted in this way, the ratio did not change by more than 7%, £0.66 (7%), £0.46 (7%) and £0.33 (6%) respectively, indicating that the ratio was not too sensitive to the quantity variable.

When the deadweight variable was tested at 50% for all outcomes (in the same calculation), the ratio still indicated that it is likely (more than 50% likely) that at least £7.66 (83%), £5.44 (82%) and £4.34 (84%) of the social value created would not have happened without Changes UK, Spitalfields and the Hub respectively. National and regional data sources and research on the limited opportunities for those who are in recovery suggest that it is likely that the outcomes would not have happened anyway, i.e. without the support of a recovery community.

The attribution variable was also tested at 50% for all outcomes (in the same calculation) and indicated that even when half of the claim was attributed to other activities which may be taking place in the area, Changes UK, Spitalfields and the Hub could still claim for 64% of the social value their recovery community created (£5.93, £4.26 and £3.32 respectively). As the focus groups and process evaluation indicated that there are not many other services in the recovery communities' local areas which provide structured support for those in recovery, which is ongoing and person centred, then it is likely that less than 50% of the outcomes can be attributable to other services. Moreover, as the recovery communities' refer and signpost their members to external services and organisations then the social value created through the engagement with the services can be partly attributed to the recovery community.

Appendix 5.2 Evaluative SROI sensitivity analysis

As with the forecast SROI carried out in phase one of the evaluation, sensitivity analysis was again carried out on the analyses for ChangesUK, The Hub and Spitalfields Crypt Trust. This aimed to check the assumptions made by the researchers and assess the robustness of the impact map. This involved changing the variables under question and examining the effect on the overall SROI ratio. A large variation in the SROI result after variables are adjusted indicates uncertainty in the figure, however, this was not shown in any of the recovery community's calculations.

The data available to inform exactly how many people in the recovery community had experienced each outcome, came from the WEMWBS and ARC Recovery tool measures. The proportion of those recovery community members who completed the wellbeing and recovery tool measures were then aggregated up to denote the proportion of people in the whole recovery community who may be experiencing a positive outcome or change. It is important to note that due to the small sample sizes of the data collected for the outcome measures, it may be possible that there are limitations in robustness. The proxy values identified for each recovery community in phase one of the evaluation are still considered to be appropriate.

To ensure the ratio was not too dependent on any one individual responding to the wellbeing and recovery tools, the quantity for all for recovery communities was reduced by approximately 10% of members from the recovery community. For Changes UK when the SROI ratio was adjusted in this way (10% of the population of 36 = 3 individuals), the ratio changed by less than 3% (£4.98-£5.06) indicating that the ratio was not too sensitive to the quantity variable. The same was true for The Hub (10% of the population of 100 = 10 individuals); this ratio changed by less than 5% (£9.24-£9.51). For Spitalfields Crypt Trust Choices and Progression when the SROI was adjusted this way (10% of the population of 62 = 6 individuals), this ratio changed by less than 10% (£4.91-£5.07)

When the deadweight variable was tested at 50% for all outcomes (in the same calculation), the ratio still indicated that it is likely (more than 50% likely) that at least £4.38 (86%), £4.29 (83%) and £8.33 (86%) of the social value created would not have happened without Changes UK, Spitalfields and The Hub respectively. National and regional data sources and research on the limited opportunities for those who are in recovery suggest that it is likely that the outcomes would not have happened anyway, i.e. without the support of a recovery community.

The attribution variable was also tested at 50% for all outcomes (in the same calculation). It indicated that even when half of the claim was attributed to other activities which may be taking place in the area, Changes UK could claim for 62% (£3.19) of the social value created by their recovery community. The figures for Spitalfields and the Hub were 64% (£3.33) and 56% (£5.49) respectively.

As previously highlighted in phase one of the evaluation, there are not many other services in the recovery communities' local areas providing structured support for those in recovery, which is ongoing and person centred. It is therefore unlikely that more than 50% of the outcomes would be attributable to other services.

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