



CPH | CENTRE FOR
PUBLIC HEALTH
LIVERPOOL JOHN MOORES UNIVERSITY



Evaluation of Four Recovery Communities across England: Interim Report for the Give it Up project

Lindsay Eckley, Rebecca Harrison, Madeleine Cochrane, Marissa Pendlebury,
Harry Sumnall, Hannah Timpson

January 2016

Centre for Public Health, World Health Organization Collaborating Centre for Violence Prevention, Liverpool John Moores University, Henry Cotton Campus,
15-21 Webster Street, Liverpool, L3 2ET | 0151 231 4472 | r.harrison@ljamu.ac.uk | www.cph.org.uk | ISBN: 978-1-910725-25-2 (web)

ACKNOWLEDGEMENTS

There are a number of acknowledgements that the authors of the report would like to make, which are detailed below.

The Evaluation Advisory Group members: Mark Gilman – Discovering Health; James McVeigh – Centre for Public Health, Liverpool John Moores University (LJMU); Tim Leighton – Action on Addiction; Andrew MacDonald – Salford City Council; Alistair Sinclair – UK Recovery Foundation (UKRF); and Harry Sumnall – Centre for Public Health, Liverpool John Moores University.

The Give it Up Steering Group members: Kevin Cahill - Comic Relief; Gilly Green – Comic Relief; James Ohene-Djan – London Goldsmiths University; Noreen Oliver – Centre for Social Justice; Dominic Ruffy – Amy Winehouse Foundation; Chip Somers.

The staff, members and volunteers at Spitalfields Crypt Trust; CHANGES UK; The Hub – The Nelson Trust; and Clean & Sober Living The Cornforth Partnership who contributed to/took part in the evaluation.

Staff at the Centre for Public Health, LJMU: Jane Oyston for assistance with one of the focus groups; Laura Heeks for the report cover design; Gayle Whelan (Institute of Cultural Capital, LJMU) for proof reading and editing; Ellie McCoy for her involvement in the development of the project and logic model.

Ben Carpenter from Social Value UK who worked with us in a consultancy capacity to undertake a number of the focus groups and coordinate the Value Game.

Contents

1. Introduction	3
1.1 Background.....	3
1.2 Scope.....	3
1.3 Funding.....	4
1.4 Introduction to the four recovery communities	5
2. Setting the scene – the literature	8
2.1 Holistic approach to substance misuse	8
2.2 Recovery capital	9
2.3 The recovery process.....	9
2.4 Peer support mutual aid groups	9
2.5 Understanding the recovery experience	10
3. Methodology.....	10
3.1 Social Return on Investment	10
3.2 Methods for Clean and Sober Living – The Cornforth Partnership, Durham	14
3.3 Process evaluation.....	15
3.4 Analysis	16
4. Ethics	16
5. Findings.....	17
5.1 Process evaluation.....	17
5.2 Forecast SROI	23
5.3 Findings from Clean & Sober Living, Durham.....	32
6. Limitations	36
7. Conclusions and next steps.....	37
8. References.....	38
9. Appendices	41
Appendix 1 – Participant Information Sheet and Consent Form	41
Appendix 1.1 Participant information sheet	41

Appendix 1.2 Consent form.....	42
Appendix 2. Stakeholder analysis	43
Appendix 2.1 Stakeholder analysis for CHANGES UK, The Hub and Spitalfields Crypt Trust	43
Appendix 2.2 The Cornforth Partnership- Clean and Sober Living	46
Appendix 3. Discussion guides for SROI and process evaluation	48
Appendix 3.1 SROI engagement activities schedule of questions for all stakeholders .	48
Appendix 3.2 Discussion guide for the process evaluation.....	49
Appendix 4: Justification for financial proxies, deadweight and attribution measures ...	51
Appendix 4.1 The Hub, Gloucester, training programme and recovery cafe	51
Appendix 4.2 Choices and Progression, Spitalfields Crypt Trust, London	56
Appendix 4.3 Recovery Central – Peer led support and membership services, CHANGES UK, Birmingham	62

1. INTRODUCTION

1.1 Background

Definition of recovery:

“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, 2012, p.6).

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 supports the development of recovery communities in four geographical locations in England. It is expected that the recovery communities will be sustainable and continue to operate after the two years of funding is complete. The aim of this research is to evaluate the operational processes of the pilot programmes and better understand how they might contribute to ambitions of improved and sustained recovery.

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.

The large grants programme element of the Give it Up Fund is supporting the development of recovery communities in Durham, Birmingham, Gloucester and London by creating partnerships offering collaborative working with approaches that aim to sustain recovery.

This work explores how each of the projects contribute to recovery outcomes over time, and aims to embed processes to ensure that projects are able to measure and evidence their outcomes once the commissioned evaluation has finished.

Research question

How do recovery communities help people to maintain abstinence?

Aim

To understand the value created by the activities supported by the Give it Up Fund.

Objectives

1. Assess and value the impact of the recovery communities through the perspective of the stakeholders.
2. Explore the experiences of delivering and implementing the recovery communities.

1.2 Scope

Part one

This analysis is an evaluation of one year’s service delivery of:

- Recovery Central – peer led support and membership services - CHANGES UK, Birmingham;
- Clean & Sober Living – The Cornforth Partnership, Durham;
- The Hub – The Nelson Trust, Gloucester;
- Progression and Choices – Spitalfields Crypt Trust, London

Time and resource meant that analysis of service users' demographic information including personality type and past drug of choice were not possible in this analysis.

1.3 Funding

Funding of £20,000 was awarded by Comic Relief, Give it Up to the Centre for Public Health, LJMU to conduct the work over a two year period.

1.4 Introduction to the four recovery communities¹

Clean and Sober Living (The Cornforth Partnership, Durham)

Clean and 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. The staff members of Clean and Sober Living have over 30 years' 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.

In collaboration with the Cornforth Partnership and County Durham local authority, Clean and Sober Living provide an abstinence based recovery project for people engaged within drug and alcohol services in South West Durham. It 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 and 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 and 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.

<http://cornforthpartnership.wix.com/cornforthpartnership>

www.facebook.com/CleanSoberLivingDurham

¹ Please note that the descriptions provided were given by the recovery communities in their initial applications to Comic Relief.

Recovery Central – Peer-led support and membership services (CHANGES UK, Birmingham)

CHANGES UK is a user-led organisation 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.

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

<http://changes-uk.com/>

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. 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.

<http://www.sct.org.uk/>

The Hub (The Nelson Trust, Gloucester)

A community base to support the recovery community in Gloucestershire has been established in the form of The Hub. The community has been 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/plans 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

<http://www.nelsontrust.com/>

<http://www.recoveryhub.co.uk/>

2. SETTING THE SCENE – THE LITERATURE

2.1 Holistic approach to substance misuse

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 (DH, 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). Strategies to comprehensively tackle 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). Common amongst these strategies is the importance for services to consider a 'whole person' approach to recovery which focuses on more than drug use, abstinence and remission; but also helps the substance user achieve positive relationships, good health and wellbeing, secure employment and housing (ACMD, 2013). Without addressing the wider socio-ecological environment of recovery, biomedical approaches alone are likely to prove ineffective at promoting long-term positive outcomes for individuals affected by substance misuse (Deacon, 2013).

2.2 Recovery capital

Recovery capital has been described as the quantity and quality of resources that a person can draw on to initiate and sustain recovery from addiction (Granfield & 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 & Wacquant, 1992; Putnam, 1993; Teachman et al., 1997). Recovery capital comprises four primary components: physical and personal capital; cultural capital; human capital; social capital; and this conceptualisation considers the wider determinants of health, including socioeconomic status, health behaviours and experiences of stigma (Cloud & Granfield, 2008). Evidence has shown that individuals with a greater recovery capital are able to become more empowered in order to achieve their full potential and an optimal quality of life; during which they can positively contribute to and become actively involved in society (Laudet, White, & Cloud, 2008).

2.3 The recovery process

Although there are no normative definitions, recovery can be defined as the process through which individuals, families and communities affected by severe substance misuse problems voluntarily take control of the problems associated to their substance misuse. They are also empowered to take on roles and responsibilities which enable them to lead healthy, productive and meaningful lives (White 2007; UK Drug Policy Commission 2012). Recovery may promote ways of seeking a more existential meaning in life including creating a new identity, restoring dignity, gaining self-acceptance and feeling a sense of community. 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 meaningful recovery is attributable to the collaborative actions of service users developing strong social networks and self-esteem via the services provided, which enables them to recognise the significant role they can play in their own recovery (Bracken et al., 2012; Kelly et al., 2009; Tew et al., 2012).

2.4 Peer support mutual aid groups

Evidence shows that positive social support networks can improve resilience to stress, increase self-efficacy for initiating or continuing abstinence, enhance quality of life, predict long-term reductions in substance use and improve subjective wellbeing among individuals

with substance misuse disorders, including those with comorbid psychiatric disorders (Laudet & Stanick, 2010; Mericle, 2014). Low levels of social support have been found to predict relapse, and it can sometimes be distressing for some individuals in recovery to realise that their friendships associated with previous drug networks tend to erode along their recovery journey (Granfield & Cloud, 2001; Laudet et al., 2006). One significant form of social support in recovery is that provided by peers, with research demonstrating that contact with positive peer support predicts reduced substance misuse and abstinence (Moos, 2008; White, 2009). Peer support also 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). 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).

2.5 Understanding the recovery experience

A systematic review of narrative studies highlighted that recovery processes involve hope, self-compassion, optimism, identity, meaning in life and empowerment (Leamy et al., 2011), however, such unique personal experiences make recovery hard to empirically define (Laudet, 2007; Knopf, 2011; Witbrodt et al., 2015) and it is hard to know what helps people give up substances in the first place (UK Drug Policy Commission 2012). 'Gold standard' research tools such as randomized control trials (RCTs) and other quantitative methods may be unsuitable for exploring the dynamics of complex social issues such as substance use, therefore mixed methods and qualitative research may be pertinent (Arnull, 2014).

3. METHODOLOGY

A mixed methods approach was used for the evaluation, which included undertaking forecast Social Return on Investment (SROI) analysis, to enable an evaluation of the outcomes and wider social value of the Give It Up pilot large grants programme. We also undertook a process evaluation to evidence the experiences and perceptions of key stakeholders involved in the delivery of the four recovery communities.

3.1 Social Return on Investment

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. Other approaches, such as an RCT or quasi-experimental designs were not considered to be appropriate, due to the difficulties in assigning individuals or communities to control or intervention groups.

SROI allows for the measurement and capture of outcomes that can be intangible and 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 approach 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.

For this first part of the evaluation (1st September 2014 to 31st August 2015) we undertook a forecast SROI with three out of the four recovery communities.² The forecast SROI is particularly useful at the start of an activity as it can demonstrate how investment can maximise impact, whilst also providing evidence of what needs to be measured throughout the duration of the project. The forecast SROI conducted explored how much social value will be created if each activity meets its objectives.

The SROI activities were organised in liaison with the recovery communities, who provided support to the research team in identifying key stakeholders and promoting the focus group events, helping to maximise the number of attendees. The data collection activities were held at a location from which the project activities were being delivered, and were supported by stakeholders.

SROI methods across the projects were standardised to ensure robustness in comparing values obtained from different groups of people. We approached the project using an open and objective framework, asking the stakeholders "what has changed for them" and "what are the most important changes". We also looked to identify and value negative and/or unintended outcomes (these unintended outcomes may be positive or negative).

3.1.1 The stages to carrying out a forecast SROI

1. Establishing scope & identifying key stakeholders (scoping activities to analyse and understanding why these have been chosen)

Over January and February 2015, the SROI scoping exercise was undertaken with key people from each recovery community. Attendees at the scoping meetings were asked to identify all the groups of people or organisations (stakeholder groups) that input into the specific activity or activities being evaluated. The scoping exercise also developed the inclusion and exclusion criteria³ for the SROI and also determined the purpose, audience, background, resources, activities, and the timescales to be captured.

Forecast SROI
Forecast, which predicts how much social value will be created if the activities meet their intended outcomes.
SROI Network (2012)

Over January and February 2015, the SROI scoping exercise was undertaken with key people from each recovery community. Attendees at the scoping meetings were asked to identify all the groups of people or organisations (stakeholder groups) that input into the specific activity or activities being evaluated. The scoping exercise also developed the inclusion and exclusion criteria³ for the SROI and also determined the purpose, audience, background, resources, activities, and the timescales to be captured.

² For the fourth recovery community (Clean and Sober Living, Durham) a different type of research evaluation was carried out. Details relating to this can be found later on in this Methodology section.

³ An initial decision on whether to include or exclude the stakeholder in the analysis was made based on the significance of the outcomes they brought about or experienced; their anticipated investment; experience of outcomes or value of outcomes.

For each recovery community, a specific activity or activities relating to abstinence-based recovery were identified as the area of focus for the SROI. Forecast SROI was used for the project activities at CHANGES UK, The Hub and Spitalfields Crypt Trust recovery communities. This involves considering outcomes which are expected to occur over a twelve month period. These outcomes are then mapped with values that result in a ratio of what value is expected to be created. The results from this forecast will also be used to establish the indicators, measurement tools, and data needed to support an evaluation SROI in 2016.

Stakeholders
People, organisations or entities that experience change, whether positive or negative, as a result of the activity that is being analysed.
 SROI Network (2012)

Please note: Stages 2-5 below were undertaken with all of the recovery communities with the exception of Clean & Sober Living, Durham. Further details relating the methodology and analysis of Clean & Sober Living can be found in the Methodology and Findings sections.

2. Mapping outcomes (stakeholder engagement and mapping outcomes)

Between June and July 2015 two focus groups were held with a selection of staff and service users/volunteers from each of the three recovery communities to establish what had changed for them already as a result of being part of the recovery community in general and taking part in the specific activity or activities that were being evaluated (see Appendix 3a for SROI engagement questionnaire for stakeholders). The focus groups also explored what participants thought might change for them over the next 12 months because of their involvement as a volunteer/service user.

Outcome(s)
The changes resulting from an activity. The main types of change from the perspective of stakeholders are unintended (unexpected) and intended (expected), positive and negative change.
 SROI Network (2012)

- The first focus group concentrated on the changes or expected changes with participants being encouraged to share their experiences of being part of this recovery community and specific activity/activities and how it had impacted their life.
- The second focus group concentrated on clarifying the key outcomes and deciding what indicators to use, attempting to value them and establishing proportions for deadweight and attribution.

Key outcomes were identified across the three recovery communities and these are detailed further in the Findings section.

3. Evidencing outcomes and giving them a value (proxy values and The Value Game)

Indicators and proxy values for the outcomes were informed through the focus groups as well as looking at proxy measures provided by a number of data sources.

The Value Game (<http://www.valuegame-online.org/>) was also used at one of the recovery communities (CHANGES UK). This game works to establish the relative market value of social intangible outcomes by comparing them to goods and services sold on the market. Due to

time and resources the value game was conducted in just this one recovery community. The types of questions that were asked included:

- What is the value of that specific outcome to you?
- What are you able to do differently or what can you do now that you couldn't before?
- If the project was not in place, what would you have to do to achieve the same level of change?
- What would you be willing to pay to achieve that outcome?

4. Establishing impact (deadweight and attribution)

To further establish the proportion of change (impact) that can be attributed to each of the recovery community projects, it was necessary to determine:

1. How likely it is the change would have happened anyway (deadweight); and

2. If any other projects/services/organisations/people helped to bring about the change (attribution).

When looking to establish deadweight and attribution, there are a number of aspects to consider:

- **Deadweight**

- How much has it changed by? (what was the level before the project, what is the level now?)
- What are the chances that the change would have happened anyway if the project was not in place?

- **Attribution**

- What other organisations/services/projects/people have helped bring about this change? How much have they contributed to the change?
- What proportion of the change is due to the project only?
- Did or will the contribution from other organisations/services/projects/people change with time? (this question is asked if the SROI is looking at more than one year)

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.

Impact

The difference between the outcome for participants, taking into account what would have happened anyway, the contribution of others and the length of time the outcomes last.

SROI Network (2012)

Deadweight

A measure of the amount of outcome that would have happened even if the activity had not taken place.

SROI Network (2012)

Attribution

An assessment of how much of the outcome was caused by the contribution of other organisations or people.

SROI Network (2012)

5. Impact map and calculating the SROI

The results of the engagement activities with each of the three recovery communities were brought together and input into an impact map – one for each recovery community. The impact map is a pre-prepared spreadsheet separated into the different stakeholder groups vertically, and the inputs and outcomes horizontally. Formulas are inserted into the spreadsheet to calculate the impact value for each indicator, taking into account quantity (the number of people experiencing the change) and impact (quantity times financial proxy, less deadweight and attribution). The impact value of each indicator for all stakeholder groups is totalled and the present value of the project determined. The present value is the current value of the cash flows discounted by the future value (3.5%).⁴ 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.

A sensitivity analysis was carried out where assumptions were made or discrepancies were found in order to assess the robustness of the impact map. This involves adjusting the variables under question and examining the effect on the overall SROI result. A large variation in the SROI result after variables are adjusted indicates uncertainty in the figure.

Sensitivity Analysis
Process by which the sensitivity of an SROI model to changes in different variables is assessed.

SROI Network (2012)

Financial information relating to each of the project activities was determined via email to establish the value of all the inputs covering the evaluation period.

When looking at the quantities used in the impact map, we used estimates derived from the engagement activities. We intend to use quantitative data to verify the numbers during the evaluative SROI analysis that will take place in Spring/Summer 2016.

3.2 Methods for Clean and Sober Living – The Cornforth Partnership, Durham

3.2.1 Outreach and advocacy work: focus group with service users

Two researchers facilitated a two-hour focus group with eight service users from Clean and Sober Living's outreach and advocacy work. The aim of the focus group was to explore the social value of Clean and Sober Living's outreach group and to establish what activities the service users engage in and if they have experienced a change in their mental health, wellbeing, housing, substance use and/or social relationships as a result of engaging in the activities. 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 and Sober Living and whether they thought any other organisations/people could have contributed to the changes they experienced. Data was recorded by hand during the focus group and subsequently analysed using thematic content analysis.

⁴ The recommended discount rate for public funds (HM Treasury, 2003. The Government Green Book).

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

Health professionals that attended a training day delivered by Clean and 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 and Sober Living:

1. My understanding of addiction is...
2. My ability to communicate with someone suffering with an addiction is...
3. My understanding of abstinence-based recovery is...
4. 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 was input and analysed using the statistical software SPSS.

3.3 Process evaluation⁵

The three SROIs and the evaluation of Clean and Sober Living were complemented with a process evaluation. Telephone interviews were conducted with those who were involved in the implementation and delivery of the recovery communities (see Appendix 3b for the discussion schedule). A total of ten staff/committee members took part during May and June 2015; with at least two representatives from each recovery community. The interviews were carried out in a private room and lasted between 20-45 minutes. The interviews were digitally recorded and subsequently transcribed. Two researchers independently analysed the content of the transcripts using thematic analysis.

This method aimed to gather insight from stakeholders involved in delivering the four projects to evidence their experiences and perceptions. Specifically, data was gathered regarding:

⁵ The process evaluation was carried out across all four recovery communities.

- understanding of recovery communities;
- experience of developing and delivering the recovery community, including any barriers;
- referral processes;
- amount and type of support that is offered and how this:
 - is determined
 - has affected their role and relationships with service users, wider groups such as families, friends, carers, health professionals and other organisations.

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

3.4 Analysis

The primary data collected through the SROI was analysed alongside any secondary data available to the research team.

The qualitative interviews were transcribed verbatim and analysed thematically in the context of the individual recovery community aims, objectives and activities, and in the context of the wider Give it Up programme objectives. Two researchers independently reviewed the interview notes and determined key themes arising from the data. The two researchers then agreed a final list of themes.

This approach to analysis enabled the evaluation to further evidence the elements of the recovery communities that are effective in sustaining recovery.

The secondary data, along with financial data regarding service spend, was compiled into an impact map in Microsoft Excel spreadsheet which includes formulae to calculate the input into the project (i.e. the input costs from Comic Relief, Give it Up to run the project; specific outcomes associated with the service users/volunteers and their families), which is then balanced with the associated social value created by outcomes as identified by stakeholders.

4. ETHICS

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 (see Appendix 1.1 and 1.2). 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.

5. FINDINGS

This findings section is split into three sections:

1. Summary of the findings of the process evaluation
2. Identification of key outcomes for the three recovery communities for which the forecast SROI was conducted; as well as individual level results from the impact map calculations
3. The findings for the evaluation of Clean & Sober Living, Durham

5.1 Process evaluation

5.1.1 Defining abstinence and recovery

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 are 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.

"Recovery isn't just about being abstinent; it's about participating in the community, being a kind of positive influence on those around you. Being active, responsible...it can be defined by progress, you know, people who are moving forward opposed to people who are kind of stuck." Participant 9: Recovery Community 4

5.1.2 Challenges and barriers to recovery

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 area, 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 can 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

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

5.1.3 Responses to challenges and barriers

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, it was identified that there was a need for support in the evening when normal services are closed as well as a need for support groups which are child friendly, services have been developed to meet these needs. A further example includes how opportunities are being tailor-made for service users who are 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 Russell 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

5.1.4 Increase 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

5.1.5 Developing relationships and sharing expertise and resources

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, 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

5.2 Forecast SROI

5.2.1 Scope & 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 may also include internal recovery community project management to inform decision making and other relevant audiences 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. Progression and Choices – Spitalfields Crypt Trust, London
4. Outreach and advocacy work and training- Clean and 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 an forecast SROI. Clean and 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 most appropriate.

Discussions during the scoping exercise and focus groups informed the stakeholders which 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 1. There were several other stakeholders identified by the recovery communities; reasons for their exclusion from the SROI are detailed in Appendices 2.1 and 2.2.

Table 1: Stakeholder groups included in the SROI and reasons behind 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

5.2.2 Mapping outcomes (stakeholder engagement and mapping outcomes)

There were a number of commonalities identified between the three recovery communities that were experienced by those in recovery on four levels:

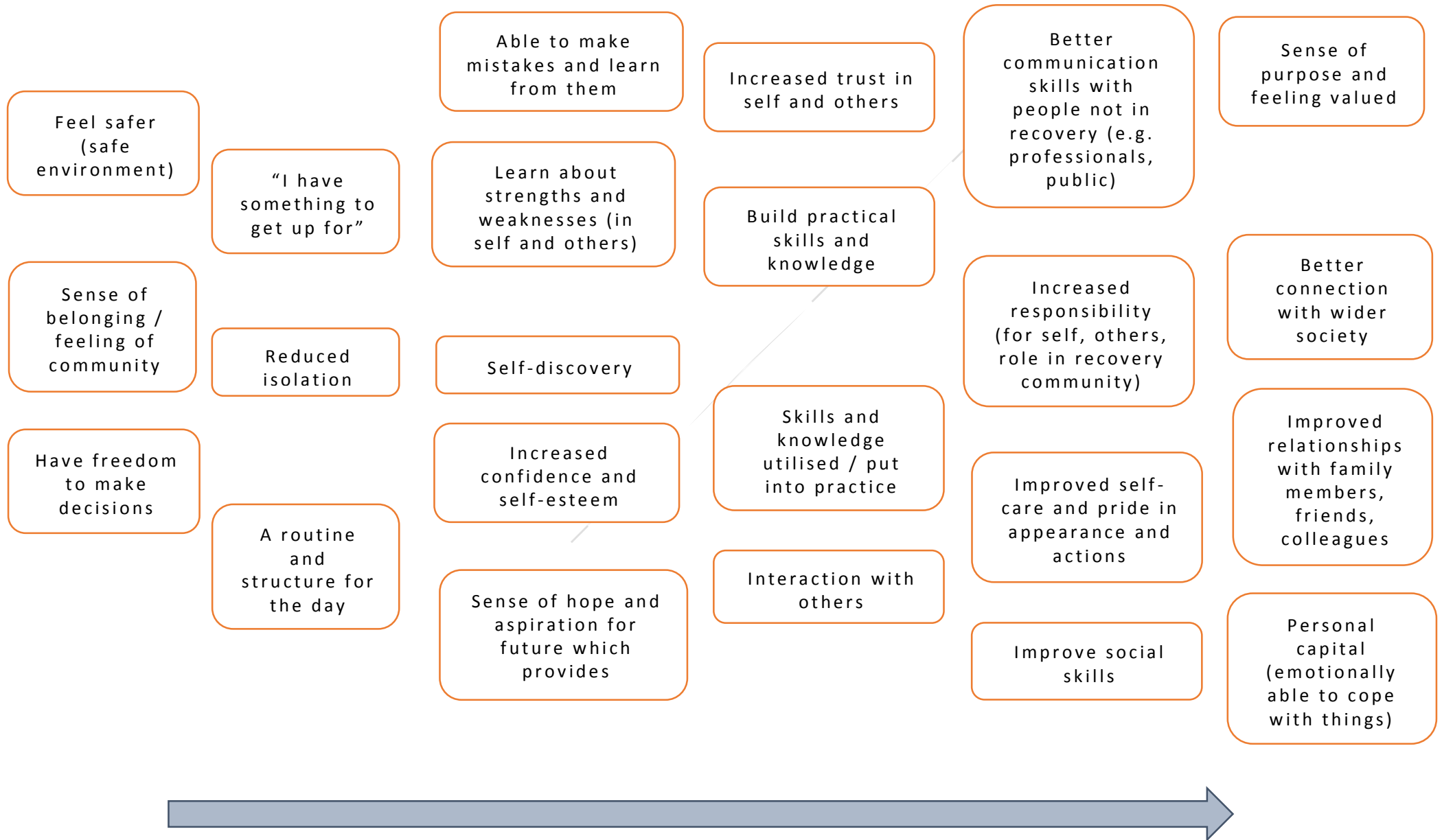
- A connection with themselves – learning about their assets and deficiencies, a process of self-discovery, building self-confidence and resilience, developing practical skills and knowledge and taking on responsibilities;
- A connection with peers – social interaction, making new friends, building trust 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 have 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 and a chain of events was developed that depicted the common experience of abstinence-based recovery (Figure 1). Participants were then asked to identify the most important outcomes for maintaining abstinence and recovery. Shared outcomes experienced by the participants from the three focus groups were then mapped.

Overall the outcomes that we 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 inclusion criteria for outcomes which would be used in the analysis was those which were of greatest value, quantity, duration and causality as reported by the service users.

Figure 1: Shared chain of events



The second focus group concentrated on clarifying the key outcomes and deciding which indicators to use, attempting to value them and establishing proportions for deadweight and attribution. Participants were able to refine the identified changes and outcomes and order them into a chain of events which would depict the common experience of abstinence-based recovery.

Four key outcomes were independently identified by two recovery communities and placed in the same rank order (ordered from most to least important): (Figure 2)

- 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 (Figure 3) and the ordering revealed the relative value of the outcomes.

Figure 2: Independently identified outcomes

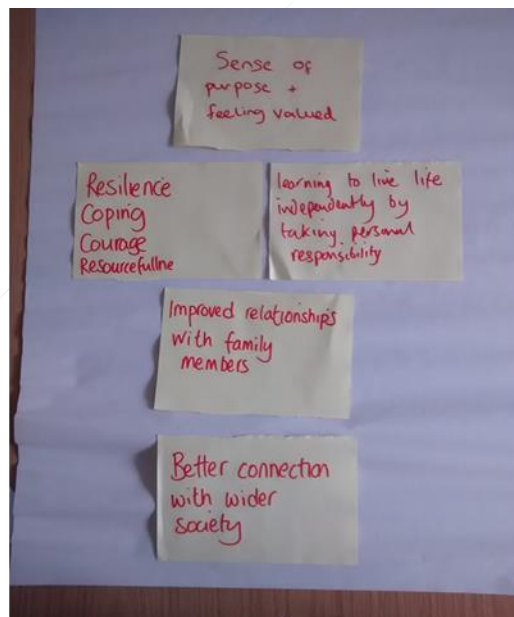
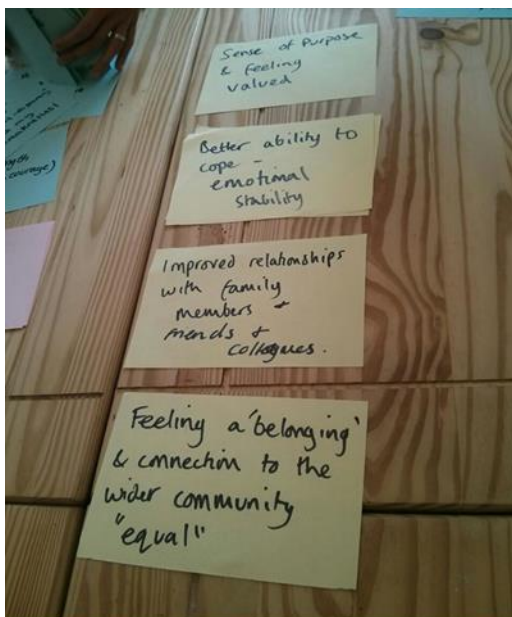
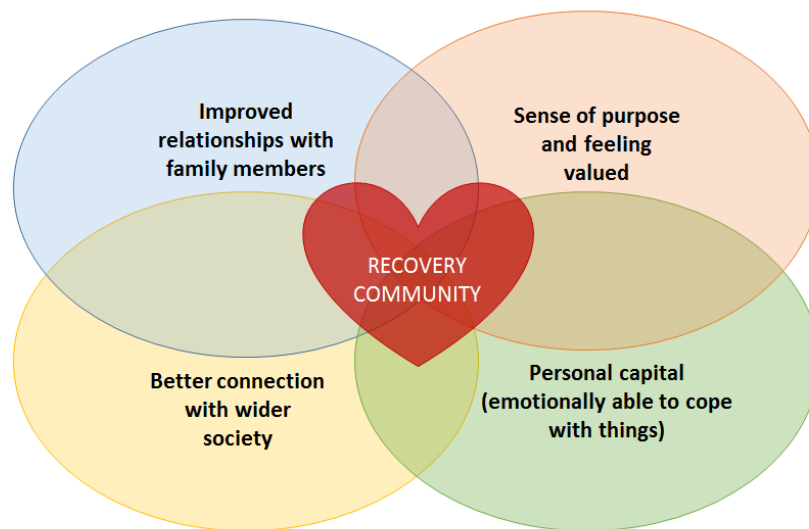


Figure 3: Shared outcomes



The focus groups and telephone interviews also identified a number of contextual factors, which contribute 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

5.2.3 Evidencing outcomes and giving them a value (proxy values and The Value Game)

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 4 for further details on the proxy values used for each of the four outcomes and justification for their use).

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). The members of the recovery community were then asked if they were able to have these items over twelve months where they would place them in relation to the four outcomes that had been identified. In this instance, all of the items in the calibration list were placed below the outcomes, thus inferring that the outcomes were more valuable to the members of the recovery community than the material items. This informed the proxy values we sought from existing data sources

as we knew the value of the outcomes based upon the results of the Value Game were at least £8,000.

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 difference between these proxies is reflected in the final value ratios detailed in Section 5.2.5.

5.2.4 Establishing impact (deadweight and attribution)

The researchers considered how much of the impact the recovery communities could claim. 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 (-ve)
- 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 that 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.

5.2.5 Impact map and calculating the SROI

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, in a focus group of seven people; a representative sample from the 100 participating from the specific 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). Therefore for each response reported in the focus group, the aggregated number was 14. So 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).

Table 2 shows the approximate proportion of participants from the focus group who indicated that they had experienced each 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.

Table 2: Approximate number of individuals within the three recovery communities who have experienced an outcome

Outcome	Approximate number of people in the focus group experiencing the outcome			Approximate number of people in the recovery community experiencing the outcome		
	<i>The Hub</i>	<i>Choices and Progression</i>	<i>Recovery Central – peer led support and membership services</i>	<i>The Hub</i>	<i>Choices and progression</i>	<i>Recovery Central – peer led support and membership services</i>
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

Figures for each component were 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.

SROI result

CHANGES UK

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

Spitalfields Crypt Trust

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

The Hub

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

It is important to note with each of these analyses that this is a forecast SROI and therefore additional beneficiaries/stakeholders and intended/unintended outcomes may not have been identified.

Please see Appendix 4 for further details of proxies, deadweight and attribution justification for the three recovery communities detailed above.

The Value Game

When the recovery communities' financial proxies were adjusted to alternative proxies which were AT LEAST £8,000, in order to meet the proxy values generated from the Value Game, the valuations were high and produced high returns on investment. This may be because the valuation technique (the Value Game) is relatively new. As the technique was only applied at one recovery community (CHANGES UK) there were no comparison groups to check for the technique's reliability. In order to limit the risk associated with the Value Game being used on this population where all the social outcomes were valued as higher than the ten items which are available on the market, the £8,000 was not used to inform the proxy values. Instead lower value proxies from national databases were preferred as they gave more reliable returns on investment.

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 inform 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 14% 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.

5.3 Findings from Clean & Sober Living, Durham

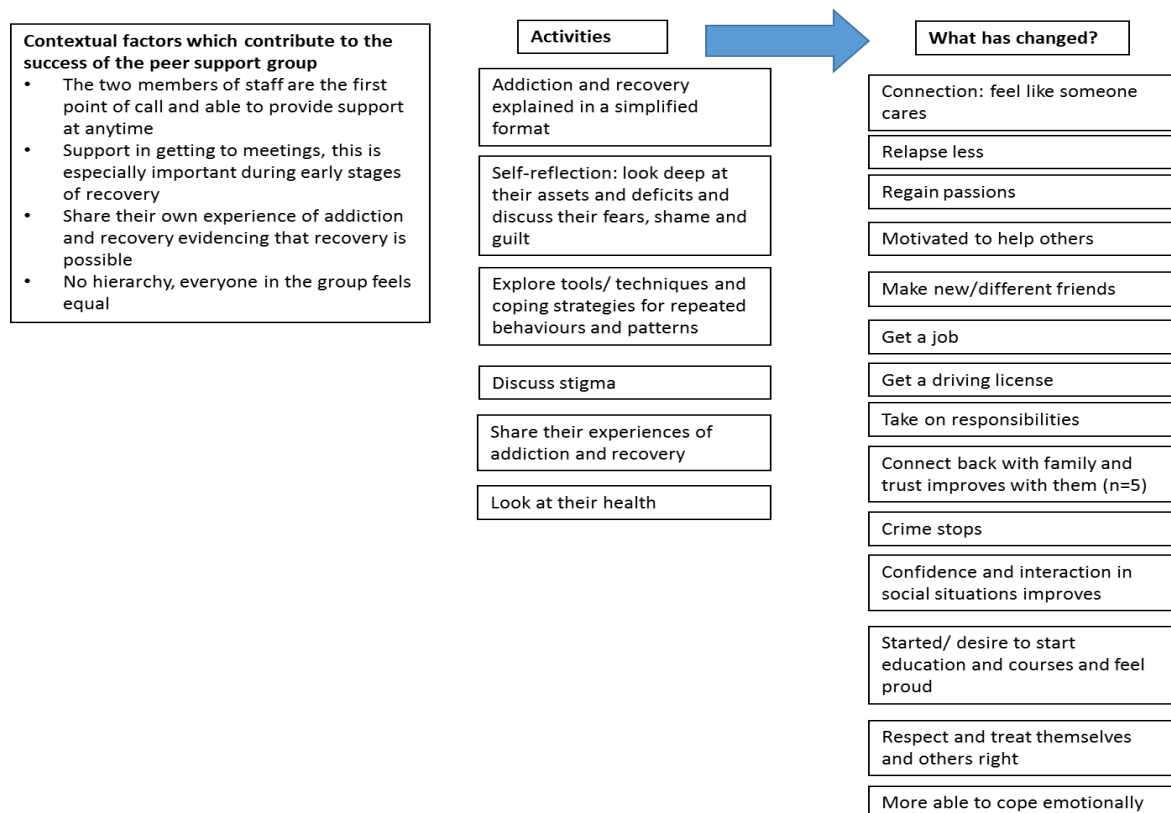
5.3.1 Outreach peer support group

The participants in the therapeutic peer support group meet weekly and learn about their addiction and tools/ coping strategies for it. Although the group works together to find solutions for their addiction, there are two members of staff from Clean & Sober Living who lead the group. 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. Moreover, as Durham is a large county with limited transport links, it was reported that the Clean and 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. 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. 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 4 shows the activities delivered by Clean and Sober living and the contextual 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 4: Chain of events for the service users of Clean and Sober Living’s outreach group



Deadweight and attribution

The participants were asked what would have happened if they did not receive the support from Clean and Sober Living. There was a general consensus across the group that the outcomes could be predominantly negative, such as they would still be using the substance they were addicted to and 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.

5.3.2 Training

Pre- and post- training questionnaire

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. For the pre-and follow up questionnaire the median value was generated for each of the four first questions (Table 3). The difference in median value between the pre and follow up questionnaire showed that the median value had increased for all of the questions, this corresponds with the percentage increase reported for the post questionnaire. Both the post and follow up questionnaires indicate 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.

Table 3: Median value for the pre and follow up questionnaire and the percentage increase in knowledge and skills for the post questionnaire

Questions	Pre (n=18)	Post (n=18)	Follow-up (n=7)
My understanding of addiction is...	3	70%	5
My ability to communicate with someone suffering with an addiction is...	3	60%	5
My understanding of abstinence-based recovery is...	2	80%	5
My awareness of stigma and prejudice towards people with addiction is...	4	70%	5

In the post questionnaire participants commented on why they felt their knowledge and skills around addiction and recovery had increased by a specific percentage. 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 behavioural/process addiction. All participants felt their ability to communicate with someone suffering with an addiction had improved as a result of the training, 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)

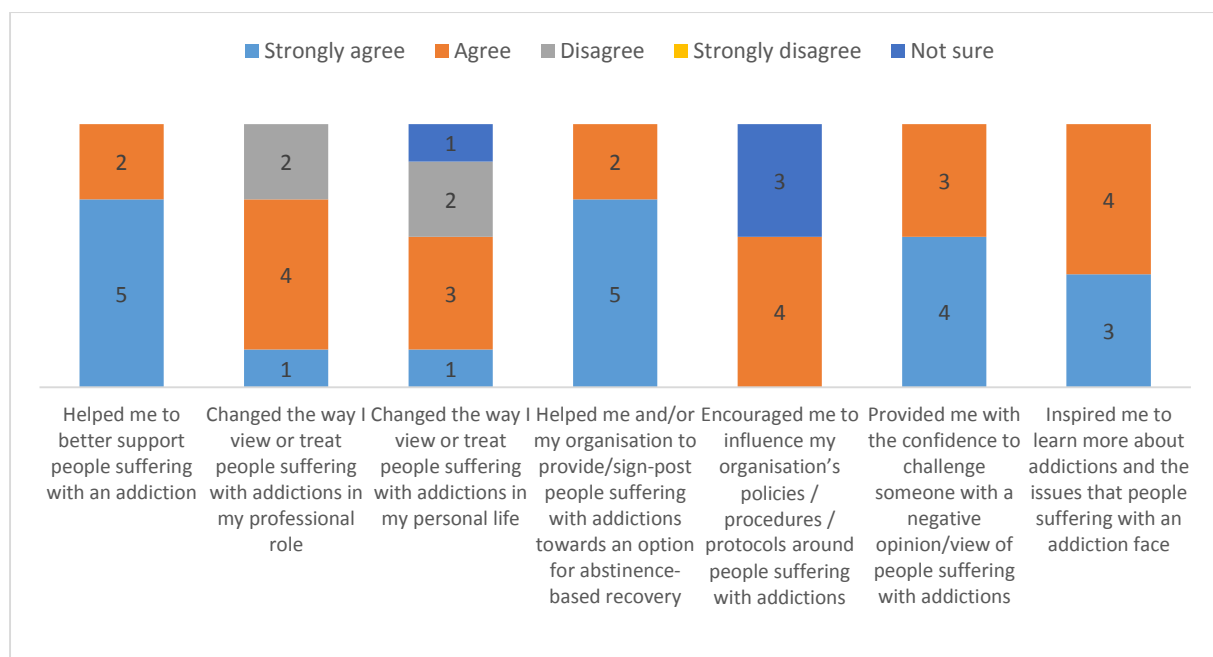
claimed they were already aware of the stigma and prejudice towards people with addiction and reported having seen it in their workplace or across society, however, a couple of participants (11%, n=2/18) felt the training reinforced the importance of how it can impact on people and their engagement with 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 5 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 in addiction, and both felt the training had encouraged them to find out more or discuss with others about the local support services.

Participants identified which parties they have 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.

Figure 5: Examples of how the participants feel the training has impacted on their job role and personal life



6. LIMITATIONS

As the value created by each recovery community as a whole was not analysed, there may have been overlap if service users were accessing multiple activities/services. 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.

The findings from this evaluation aim to explore the impact and value of the projects over a two year period (this interim report highlighting the findings of the first 12 months' evaluation from 1st September 2014 to 31st August 2015). However, research has suggested that drug and alcohol recovery outcomes can only be reliably judged after at least five years (White 2012 quoted in the ACMD 2013 report). Our end research will explore outcomes across the two year period, and will employ methods to embed processes of continual monitoring to enable each project to assess outcomes over the longer-term.

Our evaluation approach aims 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 will be feasible within the scope of this study; this approach would be less robust than an SROI focusing on one specific project. The scope of the SROIs will also depend upon the geographical locations of each.

It is important to acknowledge that comparison of findings between projects in the 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 three SROI ratios in this evaluation be compared. For the purposes of this interim report, 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.

More in-depth work is needed for the final evaluative SROI report, which will take into account all stakeholders' engagement and financial commitments, some of which were outside the scope of this interim report. The research team will now work with commissioners to further refine which stakeholders to include and engage with as part of the final evaluative SROI reports.

7. CONCLUSIONS AND NEXT STEPS

Across all focus groups participants agreed that once they had become abstinent, it was important to become engaged in positive activities to combat social isolation and return to “normality”. Recovery from substance misuse is a continual journey in which the person rebuilds their life and interaction with the world around them. Even though the recovery journey is an individual experience, there are shared stories. Recovery communities provide a non-judgemental, safe environment and the freedom in which to build necessary social and practical skills. Peer support is essential for recovery and those further along the recovery journey act as role-models for those less experienced. Nearly everyone in recovery want the opportunity to “give back” to the community. Therefore, members of recovery communities tend to engage in voluntary and mentoring roles. These roles provide a foundation for developing skills that are vital for personal progression, maintenance of abstinence and the recovery journey.

Following on from this evaluation, the evaluation team at LJMU will work in consultation with the recovery communities to embed continual and longer-term monitoring and evaluation processes at each recovery community in order to measure the key outcomes identified. It is anticipated that these measures will include:

- The use of a recovery measure, for example, the Recovery Star or the David Best – Recovery Capital Measurement Tool
- The use of a wellbeing measure, for example, the Warwick-Edinburgh Mental Well-being scale (WEMWBS). This scale was 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. It is envisaged that the full 14 item scale WEBWBS will be used. Each item on the scale has five response categories, summed to provide a single score ranging from 14-70.

In order to explore further the impact of the recovery communities upon the wider community and family members as stakeholders, it is also possible that additional data collection tools such as questionnaires and interviews may be implemented by the recovery communities.

Specifically for Clean and Sober Living we would recommend that they continue to collect monitoring data on their training in addition to embedding the above measurement and monitoring tools into their systems to measure the four outcomes identified through the work with Spitalfields Crypt Trust, CHANGES UK and The Hub in relation to their housing programme.

The evaluation team at the Centre for Public Health, LJMU will carry out a second evaluation in Spring/Summer 2016 that will look at the second years’ service delivery from 1st September 2015 to 31st August 2016. This will be an evaluative SROI, which will investigate the actual changes that have occurred for each stakeholder group over the year. It will look to evaluate indicators that have been put in place to measure specific outcomes as identified in part one and explore the actual value created by each of the recovery communities based on the actual outcomes that have taken place; thus helping to determine the value of abstinence-based recovery.

8. REFERENCES

ACMD (Advisory Council on the Misuse of Drugs) (2013). *Advisory Council on the Misuse of Drugs (ACMD) Recovery Committee: second report*. London: Advisory Council on the Misuse of Drugs.

Arnall, E. (2014). *Understanding Substance Use: Policy and Practice*. Northwich: Critical Publishing.

Bourdieu, P. & Wacquant, L. (1992). *An invitation to reflexive sociology*. Chicago, IL: University of Chicago Press.

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C, et al. (2012). Psychiatry beyond the current paradigm. *British Journal of Psychiatry*, 201, 430-434.

Cloud, W., & Granfield, R. (2008). Natural recovery from dependency. *Journal of Social Work Practice in the Addictions*, 1(1), 83-104.

Deacon, B.J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review*, 33, 846-861.

Department of Health (2015). 2010 to 2015 Government policy: drug misuse and dependency. Available from: <https://www.gov.uk/government/publications/2010-to-2015-government-policy-drug-misuse-and-dependency/2010-to-2015-government-policy-drug-misuse-and-dependency> [Accessed 28th April 2015].

Granfield, R., & Cloud, W. (2001). Social context and “natural recovery”: The role of social capital in the resolution of drug-associated problems. *Substance Use & Misuse*, 36(11), 1543-1570.

HM Government. (2010). Drug Strategy 2010 - Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life. Available from: <http://mhfe.org.uk/content/drug-strategy-2010-reducing-demand-restricting-supply-building-recovery-supporting-people-live> [Accessed 28th April 2015].

HM Government. (2012a). Social Justice: transforming lives. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49515/social-justice-transforming-lives.pdf [Accessed 28th April 2015].

HM Government. (2012b). The government's alcohol strategy. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf [Accessed 28th April 2015]

Home Office (2013). *Drug Strategy Annual Review: Delivery within a New Landscape*. London: The Stationery Office.

Kaskutas, L. A., Borkman, T. J., Laudet, A., Ritter, L. A., Witbrodt, W., Subbaraman, M. S., Stunz, A., & Bond, J. (2014). Elements that define recovery: the experiential perspective. *Journal of Studies on Alcohol and Drugs*, 75(6), 999-1010.

Kelly, J. F., Magill, M., & Stout, R. L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behaviour change in Alcoholics Anonymous. *Addiction Research and Theory*, 17(3), 236-259.

Knopf, A. (2011). Definition of recovery is vague, measures elusive, even as taxpayers fund services. *Alcoholism and Drug Abuse Weekly*, 23(18). Available from: https://www.med.upenn.edu/psych/documents/ADAW_050911.pdf [Accessed 28th April 2015]

Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse and Treatment*, 33(3), 243-256.

Laudet, A. B., Morgen, K., & White, A. L. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug problems. *Alcohol Treatment Quarterly*, 24 (1-2), 33-73.

Laudet, A. B., Cleland, C. M., Magura, S. Vogel, H. S., & Knight, E. L. (2004). Social support mediates the effects of dual-focus mutual-aid groups on abstinence from substance use. *American Journal of Community Psychology*, 43, 175-185.

Laudet, A. B., & Stanick, V. (2010). Predictors of motivation for abstinence at the end of outpatient substance abuse treatment. *Journal of Substance abuse treatment*, 38, 317-327.

Laudet, W. L., White, M. A., & Cloud, W. (2008). Recovery Capital: A primer for addictions professionals. *Counselor*, 9(5), 22-27.

Leamy, M., Bird, V., Boutillier, Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, 199(6), 445-452.

Mericle, A.A. (2014). The role of social networks in recovery from alcohol and drug abuse. *The American Journal of Drug and Alcohol Abuse*, 40(3),179-180.

Moos, R. H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, 103(3), 387-396

Office for National Statistics (ONS) (2013). Deaths related to drug poisoning in England and Wales, 2012. Available from: <http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2012/stb---deaths-related-to-drug-poisoning-2012.html> [Accessed 5th November 2015].

Office for National Statistics (2015). Deaths-related to drug poisoning in England and Wales 2014 registrations. Available from: <http://www.ons.gov.uk/ons/rel/subnational-health3/deaths->

[related-to-drug-poisoning/england-and-wales---2014/deaths-related-to-drug-poisoning-in-england-and-wales--2014-registrations.html](#) [Accessed 24th November 2015].

Putnam, R. (1993). *Making democracy work: Civic tradition in modern Italy*. Princeton, NJ: Princeton University Press.

SROI Network (2012). The Guide to Social Return on Investment. Available from: http://socialvalueuk.org/publications/publications/cat_view/29-the-guide-to-social-return-on-investment [Accessed 24th November, 2015].

Teachman, J., Paasch, K., & Carver, K. (1997). Social capital and the generation of human capital. *Social Forces*, 75(4), 1343-1359.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. *British Journal of Social Work*, 42, 443-460.

UK Drug Policy Commission. (2012). A Fresh Approach to Drugs. Available from <http://www.ukdpc.org.uk/wp-content/uploads/a-fresh-approach-to-drugs-the-final-report-of-the-uk-drug-policy-commission.pdf> [Accessed 28th April 2015].

Witbrodt, J., Kaskutas, L. A., & Grella, C. E. (2015). How do recovery definitions distinguish recovering individuals? Five typologies. *Drug and Alcohol Dependence*, 148(1), 109-117.

White, W. (2007). The new recovery advocacy movement in America. *Addiction*, 102, 696-703.

White, W. (2008). *Recovery management and recovery-orientated systems of care (Vol.6)*. Chicago: Great Lakes Addiction Technology Transfer Center, Northeast Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. (2009). The mobilisation of community resources to support long-term addiction recovery, *Journal of Substance Abuse Treatment*, 36, 146-158.

9. APPENDICES

Appendix 1 – Participant Information Sheet and Consent Form

Appendix 1.1 Participant information sheet



Evaluation of [name of Project] as part of the Give it Up fund



Dr Lindsay Eckley, Mrs Rebecca Harrison, Miss Madeleine Cochrane
Centre for Public Health, Liverpool John Moores University

Invitation to take part in a research study

Why have I been given this sheet?

We would like to invite you to take part in a research study that is exploring the effectiveness of [name of Project] being undertaken by researchers from the Centre for Public Health at Liverpool John Moores University. As someone who is involved in delivering [name of Project], we would like to gather your views on the implementation, delivery and impact of the recovery project.

Do I have to take part?

No. Taking part is voluntary; please take the time to decide. However, only those aged 17 and over can take part. If you do decide to take part and change your mind during the research or feel uncomfortable answering questions, you can leave at any time or choose not to answer the question. A decision to leave will not affect your rights or access to current or future services.

How will the information I provide be used?

The information you give us will be very important to understand if and how [name of Project] has achieved its objectives, and how it has benefitted those in recovery. The information will be used to improve the project to make it better for you and others. It is also hoped that the information will be used more widely to improve other recovery communities and to inform policy.

What will happen to me if I take part?

You will be asked to discuss your views with an experienced researcher from Liverpool John Moores University either in a one-to-one interview or a telephone interview. The interview will last approximately one hour and will be private – the interview/ focus group it will take place in a private room at xxx, if the interview is over the telephone the researcher will call from a dedicated interview room with no-one else present. A suitable date and time will be decided in advance. It will be necessary to take your phone number; however, this will be confidential and not shared with anyone else.

Are there any risks / benefits involved?

There are no risks by being involved in this research and there are no direct benefits.

Will my information or things I say be kept confidential?

Yes, we take confidentiality very seriously. You will not be asked for any personal information such as names or address. The researcher may take notes from the discussion, but personal information (e.g. names) will not appear on any notes or materials. Interviews may be tape recorded, the recording will be stored on a password protect computer and destroyed from the recording machine. Quotations from the interview may be used in the study report, but they will be anonymised.

This study has received ethical approval from LJMU's Research Ethics Committee (14/EHC/082, January 2015)

If you any concerns regarding your involvement in this research, please discuss these with the researcher in the first instance (contact details can be found on the next page). If you wish to make a complaint, please contact researchethics@ljmu.ac.uk and your communication will be re-directed to an independent person as appropriate.

Appendix 1.2 Consent form



Evaluation of [name of Project] as part of the Give it Up fund

Dr Lindsay Eckley, Mrs Rebecca Harrison, Miss Madeleine Cochrane
Centre for Public Health, Liverpool John Moores University



By signing this consent form you are agreeing to take part in the above research and are happy with the following:

- I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights.
- I understand that any personal information collected during the study will be anonymised and remain confidential
- I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised
- (If applicable) I understand that the interview will be audio recorded and I am happy to proceed
- I agree to take part in the above study

Initials or name of participant Date Signature

Name of Researcher Date Signature

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 input 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, they will unlikely 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	The Hub

		to be material within the time frame in the scope of this SROI.	
--	--	---	--

Appendix 2.2 The Cornforth Partnership- Clean and 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.	<ul style="list-style-type: none"> • Maintained abstinence • Involved in positive and meaningful activity • Better physical and/or mental health
Clean and Sober Living staff	Time and resources	The build their skills and experience and feel satisfied in their role. At the same time, it contributes to their own recovery.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Enter pre-contemplative stage of recovery (develop willingness to change)
People in recovery		They sustain their recovery and continue to work to becoming a responsible and productive member of society	<ul style="list-style-type: none"> • 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

<p>Families, friends and significant relationships</p>		<p>They learn more about addiction and recovery.</p>	<ul style="list-style-type: none"> • 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
<p>Drug and alcohol treatment organisations and their staff</p>		<p>They learn more about addiction and recovery from a user led perspective</p>	<ul style="list-style-type: none"> • 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
<p>Wider organisations and their staff (e.g criminal justice services, social services, schools and educators and third sector organisations)</p>		<p>They learn more about addiction and recovery from a user led perspective</p>	<ul style="list-style-type: none"> • 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
<p>The wider community and the environment (e.g local shops and businesses and the landscape -how places look and feel)</p>		<p>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.</p>	<ul style="list-style-type: none"> • 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. Discussion guides for SROI and process evaluation

Appendix 3.1 SROI engagement activities schedule of questions for all stakeholders

SROI engagement activities schedule of questions for all stakeholders

Inputs

What do you contribute to the Project? (time, capital investment, office space etc)
How would you value this input? (how much is the input worth in monetary terms?)

Outcomes/changes

What has changed for you during x time?
What do you do differently because of this change?
What does this change mean to you?

Which outcomes are the most important to you?

Stakeholders will be asked to order outcomes by importance (most to least) and identify the key outcomes

Valuing outcomes

A tool called the Value Game will be used here <http://www.valuegame-online.org/>. This tool allows participants to place a monetary value on the non-financial outcomes they have experienced by revealing their preference compared to products/service that can be bought on the market.

Establishing impact

What would have happened if the Project was not available?
How likely is it that the outcome/s you experienced would have happened anyway?

What other people or services have contributed to the outcome/s?
How much of the change is down to the Project?

How long will the outcome last if the Project was not available or you stopped engaging?

Appendix 3.2 Discussion guide for the process evaluation



Process Evaluation: Give it Up Recovery Communities Evaluation, Comic Relief

Discussion Guide: Staff from each recovery community (to be used as a semi structured guide for both interviews/focus groups)

"Hi [name of participant], my name is [name of interviewer] and I am a researcher from the Centre for Public Health at Liverpool John Moores University. First of all thank you for agreeing to meet with me; I really appreciate the time you have given. We have been asked by Comic Relief to speak to staff involved in the implementation and delivery of the four Give it Up recovery communities. We want to have an informal open discussion with you today. If you are not comfortable answering a question, please let me know and I shall move on. If you would like to stop the interview at any time, this is OK. You can withdraw from the study and it will not affect your rights. What we discuss and anything you say is in confidence, I will not take any personal information and no-one will know what you have said. If it is OK I would like to tape record the conversation because I would like to give you my full attention and I cannot write fast enough to take notes. After the interview I shall summarise our conversation using notes, this will be saved on a password protected computer, no-one but the research team will have access to it. After this I shall delete the original recording. I may use the odd quote from our conversation in the report, but your name will not appear next to it. Would you still like to participate in the study?"

Opportunities for questions about research/consent/confidentiality. If participant/s agrees, ask them to sign a consent form or provide verbal consent over the telephone, give them a copy of this along with the participant information sheet pointing out the contact information.

Questions should be asked in relation to abstinence and recovery locally and nationally and specifically about the staff member's recovery community

Context

- How does your recovery community define abstinence?
- How does your recovery community define recovery?
- What do you think are the main challenges or barriers for recovery locally and/or nationally?
- Are there any factors or circumstances that you think contribute to the success of recovery locally and/or nationally?
- What structures and/or activities already exist for abstinence-based recovery in your area?
 - How is your recovery community different?

Working relationships

- How does your recovery community work with other partners, organisations and/or agencies, including commissioners, treatment services and statutory organisations?

- How has the GIU fund helped you develop this?
- Please describe the relationship between your recovery community and the local community?
 - Prompts: local employers/business, local recovery community, local public
 - How has the GIU fund helped you develop this?
- In what ways does your recovery community support 12 step fellowships?

Development and delivery of recovery community

- Have you experienced any challenges or barriers throughout the implementation/development of your recovery community? How did you overcome these challenges or barriers?
- In your opinion, how effective do you think your recovery community is at involving and empowering service users? In particular, its effectiveness in:
 - Creating a safe environment, building a sense of trust and strengthening relationships
 - Improving the knowledge, skills and expertise of service users
 - Enabling the application of knowledge into practice
 - Encouraging engagement and collaborative problem solving
- Can you describe the ways in which your recovery community has been trying to tackle stigma towards those in recovery and encourage a culture change within the local community?
 - How effective do you think your recovery community has been at bringing about such a change in attitudes and/or behaviour?
 - How has the GIU fund helped this?
- Has your recovery community been able to engage with social media and in what ways?
 - How has the GIU fund helped this?
- What has the GIU fund helped you to achieve so far?

Thank you for your time, is there anything you would like to add?

Appendix 4: Justification for financial proxies, deadweight and attribution measures

Appendix 4.1 The Hub, Gloucester, training programme and recovery cafe

Appendix 4.1.1 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 them 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 proportion of members	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: 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	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 4.1.2 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% 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 4.1.3 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 4.2 Choices and Progression, Spitalfields Crypt Trust, London

Appendix 4.2.1 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 to cope with things)	Number of people in focus group agreeing with this aggregated to the proportion of members	60	£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	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 wellbeing 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 4.2.2 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	
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 4.2.3 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* 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' 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 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	<p>Daily 12-step fellowship meetings daily meetings: attended by some service users*</p> <p>SMART Recovery*</p> <p>Lifeline refer people to Spitalfields (statutory service, not abstinence only) provided a small pot of funding to support Spitalfields activities</p> <p>Other activities ran by Spitalfields*</p> <p>Clean Break (service which works with those who have been in prison)</p> <p>Island Drug Programme (structured abstinence-based programme)</p> <p>Crisis (drug testing and other services)</p> <p>St. Mungo's (first stage treatment centre)</p>	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 4.3 Recovery Central – Peer led support and membership services, CHANGES UK, Birmingham

Appendix 4.3.1 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.	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.
					HACT. 2015. Social Value Bank: Secure Job for outside London 25-29. £12,164.		
	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.	This is higher than the £8,000 from the value game	
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.							
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.	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.	
				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 proportion of members	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 was worth more than the £8,000 for an exotic holiday for two people.	This was not as ranked as highly as the other outcomes and so will be lower.	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).
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	<p>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.</p> <p>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.</p>	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 proportion of members	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 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	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 4.3.2 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% 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 4.3.3 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*	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.

		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*		
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	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%	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. Signposting to the 12-step fellowship means Changes UK can claim for this.



CPH | CENTRE FOR
PUBLIC HEALTH
LIVERPOOL JOHN MOORES UNIVERSITY

