

FINAL REPORT:

ADDICTS4ADDICTS & KEYRING RECOVERY NETWORK

DECEMBER 2015

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EXECUTIVE SUMMARY

The objective of the Recovery Network pilot was to evaluate the effectiveness of coupling trauma therapy with abstinence-based recovery when supporting individuals to live independently.

Over a three-year test cycle, the project consistently scrutinised feasibility and concept alignment; including regular evaluation of viability for alternative localities and demographics.

The pilot proved a successful and valuable undertaking; as positive outcomes were demonstrated – without exception- for all ‘members’ who participated. Findings provided a clear and consistent picture of marked improvements in health and psychological wellbeing; suggesting that the model can be effectively replicated in alternative contexts.

Notable improvements were evidenced across various areas of participants’ lives, including: wellbeing, retention of tenancy, attendance of mutual aid, engagement in meaningful activity, volunteering and ongoing abstinence.

All participants benefitted from the specialist trauma therapy element provided. The deeper layer of therapeutic support (in addition to bonding capital provided by group therapy) has shown to increase members’ ability to live independent and fulfilling lives.

The Recovery Network demonstrated a capacity to effectively enable -and sustain- recovery from substance misuse. Despite the challenges of piloting the project with participants who were managing complex mental and physical health difficulties, no illicit drug or alcohol use was reported by any members at point of post-project check-up.

This report provides a detailed overview of the concept in action and the chronology of the pilot as well as the shared learning of participants.

ACKNOWLEDGMENTS

Emerging Horizons would like to acknowledge the Board, Staff and Members of Addicts4Addicts (A4A), KeyRing, and the Recovery Network for contributing to this review. Further, we would like to thank Project Mentor Penny Snowball (A4A) and Suzy Pabla (KeyRing) for enabling the process with ongoing

support. Finally, Emerging Horizons would like to acknowledge a number of staff from other service local providers as well as commissioners who offered their time and views.

THE PROJECT

ADDICTS4ADDICTS

A4A is a non-profit, social enterprise registered in 2010 which began as a result of the personal experiences of the Founder, Penny Snowball, who is the Project Mentor of the Recovery Network. Its model emphasises the importance of quality and well-trained, experienced therapists who specialise in addiction, trauma and dual diagnosis casework combined; with experience of running groups and long term 1:1 therapeutic psychosocial interventions. The purpose of A4A is to provide quality therapeutic interventions for the many who do not have the financial means to get the quality and treatment they require for their ongoing recovery.

KEYRING

KeyRing (also known as KaeyRing Living Support Networks) is a UK based charity. Keyring's main focus is to support vulnerable adults to live independently. This is achieved by assisting integration in to a community, as well as teaching various life skills that promote self-management. KeyRing supports over 870 people across 100 UK networks.

THE RECOVERY NETWORK

The Recovery Network was born from a fusion of ideas between A4A and KeyRing. The pilot of the Recovery Network was to ascertain if there was value in coupling a therapeutic model of care alongside support for vulnerable adults to live independently, who have experienced substance misuse and addiction who are in the second stage of their recovery (6 -12 months of sobriety) and want to commit to being abstinent.

The Recovery Network combines housing, life skills, social and community support with a programme of individual and group therapy with a recovery orientation, focussing on relapse management. This is an abstinence program, stated at the outset by the Project Mentor, dealing with the underlying issues of trauma and secondary addictions. At maximum capacity the Network supports 12 individuals to abstain from alcohol and other drugs by providing individual 1:1 psychosocial interventions in conjunction with group therapy.

It also offers Members support with day to day living by providing a Community Living Volunteer (CLV) and other specialist support staff to enable Members to live an independent a life as possible. Support workers and therapists are also attached to the Network providing weekly 1:1 psychosocial interventions where recovery planning and risk management strategies are reviewed, and assist with coping strategies and reintegration into the community.

It supports individual recovery by developing a therapeutic network with multiple layers of support. The problems identified and specifically addressed by the model are:

- Availability of help when someone is in distress and therefore more likely to relapse
- Problems with obtaining and maintaining accommodation and social integration
- The need for ongoing therapeutic support
- Isolation and loneliness
- The increased risk of loss of accommodation increasing the severity and length of relapse

The Recovery Network in Oldham has flexibility built in and is based upon KeyRing's model of community focused support. This Network comprises of a number of individuals, living in ordinary properties, scattered around a defined geographic area. Both Members and the CLV live and work together to develop mutual support and community connections. The properties are rented by KeyRing via local councils and housing associations. Once the tenancy is agreed with the Network Member, she/he then becomes contractually responsible for it; if the CLV is provided with accommodation, KeyRing rents this. The CLV supports the members with practical support for day to day living.

The Recovery Network offers:

- Support from a volunteer who lives within the Network area
- Support to establish community connections
- Workers to provide support with tenancy and other issues
- Group and individual therapy which is appropriate to the individual's stage of recovery
- Facilitation of mutual support to help develop social skills, confidence, etc.
- Support to plan group social events

- Out-of-hours support when needed and the flexibility to respond to people should they experience a crisis

Flexible but structured support allows members to develop skills in preparation for moving into unsupported living or less supportive settings. Support is designed to encourage people to develop coping strategies and to re-integrate into their community in a planned way. It is therefore fundamentally about promoting independence. At the same time it acknowledges that the level of support offered to members will vary according to need. For example, support may need to be more intensive for some members when they join the Network or when they face a crisis. However, individual membership of the Recovery Network is designed to last for a maximum of three years with tapered support offered in the third year.

A range of options are available when people are ready to move on from the Recovery Network and many will be able to live without support, or less intensive support directly from this setting. Conversely, others in the Network, particularly those with enduring mental health problems may require longer term support in order to stabilise and then reintegrate within their own community.

A4A and KeyRing have proposed a unique support service that recognises the crucial role of social networks in an individual's personal growth and development and believes this is affected by the recovery environment which they live in.

The proposal is based on KeyRing's model of support which was studied by Care Service Efficiency Delivery (CSED) in November 2009; this report concluded that "many thousands of people could contribute to and benefit from being Members of Living Support Networks".

This report presents the key findings of previous reports in addition to gathering the views on the development of the Network post Years 1 and 2.

The Interim Review (June 2014) considered aspects of service provision when the service had been operational for 12 months, and looked at the pathways and processes in place for referrals; confidence amongst a range of external stakeholders; and offered suggestions regarding strategic direction at a crucial stage in the Recovery Network's development, asserting recommendations.

The report on the data collected by July 2015 suggested that the network had grown to close its original project capacity. The summary report will consider how the service has developed to date and offer a closing statement.

PROCEDURE

This organisational review has been commissioned by A4A and KeyRing in order to explore how far their model is effective in delivering the intended outcomes objectives and provide a picture of the impact of the service on the lives of service users.

A4A and KeyRing have a stated philosophy and rationale, which outlines the approach that the service aims for and describes the outcomes that the programme hopes to facilitate. In order to understand the extent to which A4A and KeyRing are achieving this approach and stated outcomes, the methodology employed takes a cohort approach looking at the people that the service is attempting to support and considers how and the extent to which the Recovery Network has impacted on their journeys.

This final report aims to review the following:

- Aspects of service provision, interventions used and their effectiveness
- The pathways and processes in place, including areas of duplication or inefficient practise and referral pathways to and from services
- Confidence amongst a range of external stakeholders regarding both the maturity and determination of the organisation to build for the future

PILOT REVIEW

At the time of this review (December 2015), the service has been in operational practice for 2.5 years with many Network Member changes. The pilot was required to review its scope and reach once it went live. The local variables influenced aspects of the model such as continuity of staff and Members and adjustments were incorporated.

In that context some findings should be treated with caution and conclusions viewed as areas for further development of the service. The review comes at a time when the UK, and in particular Oldham are experiencing reduced funding and questions are being raised as to how best to support vulnerable adults in a time of reduction in public funds.

RESEARCH

The research was undertaken by experienced researchers, commissioned by Emerging Horizons to carry out the review, comprising of Trish McKitterick, Stuart Honor and Professor David Best.

The methods is a mixed methods approach to the client interviews with a series of standardised measures of recovery supplemented by open ended questions to assess personal and subjective views of their experiences of the Recovery Network. Staff structured interviews included volunteers, support staff and managers, the two free-lance therapists and the Project Mentor. Stakeholders represented community and statutory organisations and their interviews were intended to both measure recovery awareness and activity of the Recovery Network.

The review was conducted between January 2014 and December 2015. Methods consisted of two stages:

- analysis of strategies, plans and policies and procedures; from both desktop and a series of meetings
- a series of semi-structured interviews with people from the following groups:
KeyRing management and staff, including therapists, A4A Founder and Project Mentor, current and former Recovery Network Members, commissioning representatives, partner organisations including ADS, Acorn and Ramp

A4A and KeyRing provided Emerging Horizons with a range of documentation, including policies and procedures in addition to monitoring data.

A total of 45 interviews were conducted as follows:

- 11 staff interviews examining attitudes to the Recovery Network (Therapists and Project Mentor - Times 1 and 2, Network Lead and Network Manager - Time 1, Support Workers and the CLV - Time 1)
- 17 network members interviews assessing recovery capital and wellbeing amongst clients engaged in the Network at 6 monthly intervals dependent on the duration of an individual's exposure to the Recovery Network (Time 1, Time 2 and Time 3)
- 7 partnership stakeholders and commissioning representatives interviews examining their beliefs and expectations in relation to the Recovery Network pilot in Oldham

Interviewees were sampled from across Oldham services to gain a range of views and sampling was conducted opportunistically. The review was promoted by fieldworkers and staff within the settings and all Member participants were requested to give their views in a semi-structured interview. Interviews were conducted at a range of locations and interviewees were asked for their consent to participation after being given an explanation of the purpose of the review, assurances of confidentiality and informed that they could decline to answer any question without explanation. All information was recorded, stored and used in accordance with data protection legislation, and Interim and Data reports were disseminated in June 2014 and July 2015 respectively.

INTERVIEWS: RECOVERY NETWORK MEMBERS

STAFF INTERVIEW

Staff were asked a range of qualitative questions to ascertain their understanding and attitudes towards the Recovery Network; how well it is being utilised and the impact of the Recovery Network within Oldham, in addition to the benefits they perceive it has on clients' behaviour. Staff and volunteers were also asked for their reflections on the service and their comments and observations appear throughout the report.

STAKEHOLDER INTERVIEW

Again a range of qualitative questions were posed to ascertain perceptions of the Network, such as how far the Network could be embedded within the treatment system and what, if any, benefits a Recovery Network could bring for its Members within the immediate setting of Oldham.

RECOVERY NETWORK INTERVIEW

Rationale: The method is a simple one - of the clients engaged at the baseline (n=17), attempts at assessing change were undertaken using a mixed methods approach in two populations, primarily the self-reported behaviour of the clients themselves but also among the staff. This reports primarily on the client sample, which is based on a total of 38 structured interviews - 17 at baseline, 12 at follow-up and 8 at second follow-up (where a time 3 interview was done but there was no time 2 interview, it was treated as a time 2 interview).

Method: The structured interview was based on contemporary thinking about recovery as a process that takes place over time and with a strong relational focus. This meant that there was a focus on the measurement of strengths rather than pathologies, and on socially focused activities and community

engagement. However, ongoing chronic health problems were measured in the form of the Maudsley Addiction Profile (Marsden et al, 1998) sub-scales of symptoms in the domains of physical health, anxiety and depression. The qualitative focus was based on the subjective experiences and needs of the participants.

The primary focus of the current reporting is around client change over time in the key domains of the intervention provided by A4A and KeyRing.

BEHAVIOUR CHANGE

The Recovery Network began in January 2013 and by first baseline interview in January 2014 there were 6 members. By December 2014 there were 13 individuals who had accessed the Recovery Network, however 3 left the Network in a planned way, leaving a total of 10 for year-end 2014. In 2015 the Network has seen 4 new members join and 3 leave the Network, with a total of 11 members by December 2015. Over the pilot duration 2 Members geographically moved out of Oldham. 4 Members relapsed and were supported by KeyRing into alternative Oldham Networks such as the Barker Street, Littlemoor and Royton Networks and 1 member is currently attending a 12 Step residential rehab. Member changes should be viewed within the fledgling nature of the Recovery Network and the procedural changes applied post year 1.

New Members introduced to the Network largely came from the community via mutual aid attendance and discussions therein, or having already been previously exposed to a KeyRing Network, few referrals of the total 17 entering the Recovery Network came from local stakeholders.

FINDINGS

This section will be split into two parts. The first part will describe more fully the actual members within the Network at present and their journey whilst the second will focus on the organisational effectiveness of the Recovery Network incorporating the views of staff, members and stakeholders.

GENDER

By December 2015 there were 11 members of the Network. All 11 had been engaging for 6 months or more, with a total of 3 participant's remaining in the Network since the initial baseline interviews held in January 2014.

Male	58.3% (n7)
Female	33.3% (n4)

The next question asked who the Members lived with and the responses indicate social isolation, in terms of living alone, and reflect similar previous isolation findings of Members not being physically located near to each other. The issues surrounding appropriate referrals, leading to the expansion of the catchment area beyond the original remit of St Mary's, being the consequence of piloting a new concept.

This should be contextualised with the fact that 100% of Members reported a reduction in social isolation due to accessing group therapy, attending Network meetings and Network social events, in addition to the 1:1 individual therapeutic support and ongoing support from staff.

SUBSTANCE USE

The 11 Network members at time of writing consist predominantly of primary alcohol users (n=9) with the other 2 Members of the group being other drug users. Since joining the Network, none of the current Members reported recent alcohol and other drug use.

The question asked respondents to report any drug or alcohol use over the last 90 days. One person reported daily use of a prescribed opioid for pain management and at Time 3 one person reported daily use of prescription benzodiazepines. In 2014/15 data shows that 5 out of 16 members relapsed with 2 members re-engaging with the service, whereas 2015/16 data reports a significant reduction i.e. that 2 out of 11 Members relapsed, with 1 re-engaging with the service. It is a remarkable achievement that there is no illicit drug or alcohol use reported at either Time 2 or at Time 3. Given the complex circumstances of the client group and their cumulative and multiple disadvantage, this is a huge testament to the Recovery Network for supporting and ensuring sobriety and non-engagement in illicit drug use.

This factor illustrates the proactive approach management and staff put in place with Member consultation. Members were taken out of the Recovery Network post relapse, offered specialist 1:1

support with a therapist for 4 weeks focussing on reasons for lapse and individual plans were agreed to allow for successful reintegration into the Network.

This successfully employed strategy is reflected in the comments from both therapists, the Project Mentor and staff; *“I believe the creation of the policy that was made with the involvement of Members, gave us clear boundaries and guidelines and in effect made the group safer.”*

Members also echo similar sentiments, *“People thought it was funny to use until they (STAFF) said that we would be out of the group therapy and if we didn’t stop we would lose the one to ones.” “It now feels more stable, we know where we stand now.”*

These comments show the progress and learning that all those connected with the Recovery Network have undergone from baseline to present, and mirrors monitoring documentation re-engagement post relapse.

REASONS FOR SOBRIETY - GROUP AND MUTUAL AID INVOLVEMENT

The method for measuring involvement in recovery support groups (including but not restricted to 12-step groups like AA and NA) is the scale Recovery Group Participation Scale (Groshkova, Best and White, 2011). This scale ranges from 0-14 with higher scores indicating greater involvement in recovery support groups. Although this does not increase from baseline to follow-up (the mean score is 8 out of 17 at both baseline and Time 2), this represents incredibly high participation in recovery support - and only two people at baseline and one at follow-up reported no involvement in recovery support. This is critical as we know from the evidence base that recovery group participation is associated with building and sustaining motivation for sobriety, for creating pro-recovery social networks and for allowing people to learn and copy recovery techniques (Moos, 2007).

This is supported in the qualitative comments and case studies prepared by KeyRing - with most of those involved in the follow-up interviews reporting that they attend a combination of AA and NA groups, both in Oldham and Rochdale, with people typically attending two or three times a week, and the more recent Members stating that they were approached in fellowship meetings about joining the Network. By November 2015 100% of Members engaged in mutual aid and have been actively supported by staff and each other to do so.

However, and what is likely to be the critical success elements is that this is not the sole form of support with almost all of the follow-up interviews citing both the one-to-one psychosocial and the group sessions provided by the Recovery Network. The support from the Recovery Network staff is a

key part of the establishment of a therapeutic landscape of recovery and this is illustrated in the following quotations (all taken from follow-up interviews):

When asked what the Recovery Network did for them, one respondent replied "*Regular contact with Philly, and we meet up and phone each other*". This individual support and ongoing contact is also reported by a second person talking about what is good about the Network, "*One-to-ones and groups. I see a few of the group members at meetings. Philly is my support worker and friend*". Here it is the combination of the personal touch and the link to activities and support that has made the difference.

The combination of activities has been particularly valued by participants with one respondent saying that the vital ingredients were "*meeting like-minded people; going to the theatre; one-to-ones and groups*". However, there are also the diverse range of life supports that are valued as indicated in the assertion that the Recovery Network "*keeps you motivated. It has helped get my life back on track and has been a great help with health and financial issues*".

This proactive positive approach can be summed up in the following Member case study comment, "*Since joining the KeyRing network I have found it helpful and now feel that I have a sense of direction to further my recovery. I have obtained my own flat and furthered my mental health treatment to try and stabilise my illnesses to improve my lifestyle towards a full recovery. I have also received a lot of help with organising and paying bills and help with old debts I had been avoiding. I have also received help obtaining necessities in order to organise my life*". Prior to joining the Recovery Network this Member had been isolating whilst living with his parents, undergone 4 detoxes and various treatment and hospitalisation episodes. He now enjoys an independent life in his own flat. This and all other case studies demonstrate the value of coupling a therapeutic model of care alongside support for vulnerable adults and this mirrors monitoring documentation demonstrating that 91% of Members were now enjoying their own tenancy and 100% have sustained their own tenancy.

HEALTH AND WELLBEING

In order to explore perceptions of health and wellbeing we asked people how satisfied were they with their health and how would they rate their quality of life.

Figure 1 depicts the changes across the three health domains from Time 1 to Time 2, and shows consistent improvements in all three domains with the physical health domain, previously mentioned, showing a statistically significant difference. The improvement in anxiety is close to significance and,

although the depression effect is not significant, this is a clear and consistent picture showing marked improvements in health and psychological wellbeing from the baseline to the follow-up point.

This is particularly impressive considering what a complex population this is. The raw scores (improvements in symptom scores from 20 to 14 and to around 8 for both depression and anxiety) would suggest that there are still residual symptoms in both areas and so work remains to be done in this area, but the trajectory of change is very clear.

There is some indication of further improvements in anxiety and depression at time 3 (to mean scores of 6.5 and 6 respectively), but an increase in mean physical health symptoms (to a mean score of 18), however the small numbers involved would suggest that this cannot be interpreted as a reliable change.

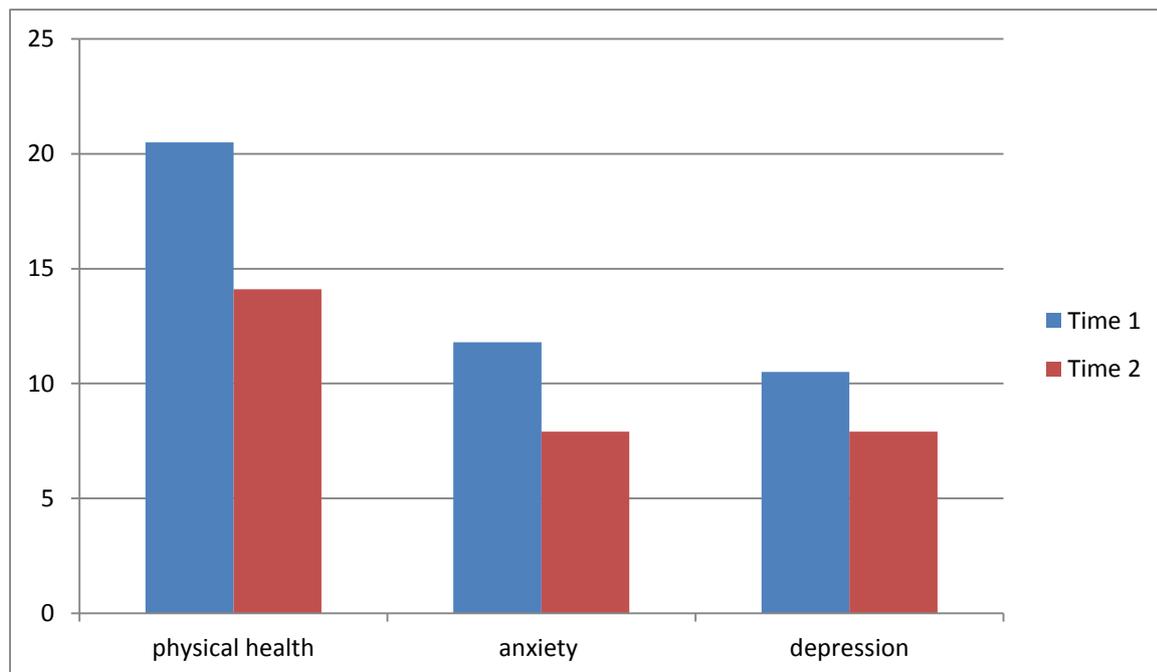


Figure 1: Health and psychological health symptom reductions from baseline to follow-up

Thus, in the first domain of health, there is a clear indication of robust positive change in the Recovery Network population in spite of the relatively small sample, as the results achieve statistical significance (it is much harder to get statistically reliable differences with small samples).

It is interesting to note that 82% of Members are now beginning to build positive identities through voluntary work and or education and training, seeing recovery from substance misuse as a daily reprieve contingent upon meaningful connections with others in their therapeutic community.

SOCIAL SUPPORT AND RECOVERY CAPITAL

Two further standardised measures were used to capture the 'relatedness' components of recovery - a measure of social support and the Assessment of Recovery Capital (Groshkova, Best and White, 2013). In both of these measures higher scores represent better functioning in each of these domains.

Among the people who completed both baseline and follow-up interviews, there was a slight mean increase in social support from a mean score of 56 at the baseline interview to 58.5 at the follow-up with a slight further rise among those who completed the third interview. On all three occasions, the levels of social support are extremely strong, suggesting that Members remain well connected and supported throughout their time within the Recovery Network.

This change in social networks is reflected in Table 1 in the changes from baseline to Time 2 in the composition of the social network

	Users in the network	People in recovery in the network	Non-users in the network
Baseline	0.8	10.8	2.9
Time 2	0.8	16.0	3.9

Table 1: Network members at baseline and follow-up

Although none of these differences were significant what is clear from this is that there is a completely successful moving away from using networks and into recovery networks with Members averaging under one user in their network at each time point and continuing to grow their recovery network, averaging 16 people in their recovery network at the follow-up point. This is in contrast to baseline figures in January 2014 when 3 of the 6 original Network members had between 1-5 people still using in their social network; therefore they had not completely cut themselves off from others still using substances.

We can see that the current members attending mutual aid external to the group therapy has significantly increased from a baseline of 50% to almost three quarters of the network i.e. 8 members. It is therefore optimistic that 72% of the current Network regularly attend mutual aid groups. This figure, when contextualised with the fact that not everyone will be able to access mutual aid due to the nature of the trauma work they are doing and may be too vulnerable to make connections external to the group therapy, is indicative of the Network meeting its aim of social connectivity.

Two crucial indicators in increasing individual recovery capital are higher levels of exposure to people who have never had drug or alcohol issues and inevitably report more attendance at recovery oriented

support groups. Certainly in the policy field the importance of positive peer supports and networks has become central to support models. Public Health England's latest commissioning guidance states that systems should ensure:

"That all individual services have pathways to mutual aid groups".

It is therefore encouraging news that that the Facilitating Access to Mutual Aid documents (Improving Access to Mutual Aid – PHE publications gateway number: 2014015) have been utilised and considered within the service provision. This is reflected in Network documentation and in Members increasing attendance in mutual aid in the community, with 100% of Members having tried some form of community mutual aid, in addition to the CLV being in recovery and thus supporting and promoting attendance.

There is much less growth in the non-user network, with an increase from an average of 3 to 4 people, but the social network pleasingly remains dominated by recovery. This is very good for maintaining sobriety and supporting recovery, but the lack of non-recovery people may suggest a lack of 'bridging capital' into groups who have access to community resources and assets. This bridging capital would be advantageous for A4A and KeyRing's future developments into the recovery arena and also assist to embed the Network within Oldham's therapeutic landscape.

The Network Members qualitative responses indicate over the last 12 months high levels of 'bonding capital', "*We have started to phone each other and meet up*", "*The best part of my week is the group, I worry when members don't turn up*". These comments are in contrast to Members baseline perceptions, when reports were that they there was no connectivity outside of the group therapy. Regardless of the challenges concerning the changes in Network membership, the Members have bonded, again reported by a therapist's comment, "*Members are a strength to each other*".

The findings create an emergent picture of the Network Members and suggest that conversations with this group about their resources and conditions have taken into account a backdrop that includes problematic substance misuse and ageing impacting upon health and well-being. Moreover, the respondents' comments also allude to possible effects of either negative social networks or social isolation, illustrated in the following comment taken from the November 2015 data, "*My anxiety kicked in and I just wanted to stay at home, I stopped going to AA*". Again, these finding should be appreciated within the realms of the mental health and deteriorating physical health symptoms, and the specific and complex needs reported by the Network Members. These conditions include anxiety, agoraphobia, hearing voices, self-harm, panic attacks, OCD, depression and suicidal ideation. It is

pleasing to note that everyone has someone who is in recovery in their social network outside of the Network.

There are very gradual increases in the recovery capital scale (which is scored from 0-50 with higher scores representing better recovery capital). The baseline score of 36.7 is already quite high, and this increases slightly to 37.1 at Time 2 and 38.5 at Time 3, although neither of these increases is statistically significant.

What is interesting about this is that, at Time 2, there is a strong relationship between recovery capital score and perceived social support, and there is a strong relationship between recovery group participation at baseline and recovery capital at follow-up, suggesting that those who engage in recovery groups early in their journey have higher recovery capital at follow-up. There is also a significant relationship between better recovery capital and lower levels of reported depression.

ORGANISATIONAL EFFECTIVENESS

The semi-structured interviews used a number of questions to gather views on the organisational effectiveness of the Recovery Network. The questionnaires for each of the three groups: staff, Members and stakeholders contained a core set of similar questions, with a small number of different questions for each group to reflect the differing roles. The analysis of the three groups' data where the same questions were asked is presented together to avoid repetition and where questions differed for the three groups, analysis is presented separately. Data was analysed inductively; responses within each group were codified and emergent themes from across responses collated, where appropriate. These comments represent views held post 2014 in an attempt to prevent duplication whilst remaining consistent with the overall findings.

ROLES/CONNECTIONS AND UTILISATION

All three groups were asked the same initial question: *What is your role/connection to KeyRing?*

Within the staff group, there was a mix of roles and organisational levels, from senior management through to volunteers. Time working at the service ranged from the newly inducted CLV replacement, to 8 years as a senior member of staff, coupled with 2 freelance roles working on average 10 hours a week, in addition to the Project Mentor working 3 hours a month. The stakeholder respondents all worked for local providers or the commissioning team and had experience of either referring in or

receiving referrals from KeyRing. Two stakeholders' organisations were interviewed again post July 2015, in addition to both therapists, the Project Mentor, the CLV and the Network Members.

The following analysis remains as indications to the pilot's development. A local stakeholder stated *"Now that they are beginning to understand recovery I've heard members who have popped in say that they are happier"*. One of the therapists offered the following; *"KeyRing learning the recovery culture has worked. We are looking at 80% attendance for each group session"*. These observations highlight the steep learning curve that the pilot has undergone and is testimony to A4A and KeyRing's response and reaction to previous reports. The particular references to the appreciation and awareness of recovery are very encouraging.

There still remains work to be done with local partners, as previously evidenced, in terms of embedding the Recovery Network within Oldham. Referrals for later additions to the Network have come via word-of-mouth and through mutual aid. Stakeholders were asked *what differences they had seen in the Network within the last 12 months*. Responses were positive and recognised the move towards abstinence for Members. However, there remained uncertainty as to what the Network offered other than a duplication of the other KeyRing networks available in Oldham.

Therapists reported that the Network *"took a long time to build up, recruitment should have happened sooner. If we had 12 from the start it would have been ideal."* Staff have offered reasons for the blockages to full membership referencing Local Authority budget cuts impacting the ability of partners to co-produce an outcome, with Members being referred from other services having complex multiple needs which other services could not meet. At time of writing the Network remains at almost near full capacity, with a complex set of individuals. That said, reflections clearly show lessons learnt and how to best utilise the Recovery Network for future roll out.

IMPACT

This question was asked to staff and stakeholders only, *How would you describe the impact of the Network locally?*

The responses to this question have migrated from previous reports, again highlighting the learning that the Network has undergone. Staff are aware of the implications of the Network not having a CLV for the first 12 months being a huge miss and replaced the original CLV with someone with the lived experience of recovery. This has had a positive impact, affording the creation of social events and connectivity central to recovery.

To report that the current Members are not using substances is a major achievement and should be viewed against the backdrop of both A4A and KeyRing having worked tirelessly to improve outcomes and impact and is illustrated in the following therapist's comment, *"The Network can offer stability in lives for example, "How do I pay bills, how do I make contact with people" and the CLV helps with practicalities and the Members are now forming communities with each other, friendships etc."*

To test areas for improvement and highlight things that the Network is doing well we asked for staff and all interviewees reflections, including Members: *What are the strengths of the Recovery Network?* Responses focussed on the culture of recovery being embedded into the service post interim report and staff going the extra mile. Members viewed the Recovery Network positively, *"I would not be where I am today without them. I am loving life"*. The majority of staff and Member responses were positive and strongly indicated that Recovery Network staff are perceived as supportive, caring and passionate about their work.

CHANGES/IMPROVEMENTS TO THE SERVICE

Both staff and stakeholders were asked the question: *What aspects of the service would benefit from changes and what would those changes look like, and what has happened in the Network in the last 12 months*. This was to profile a set of suggestions for future roll out, and dominant themes emerged around the structure and promotion of the Recovery Network.

Staff members commented that *"KeyRing were new to recovery – it's about the learning process which applies to recovery"*, this can be viewed in the light of lessons learnt consistent with a pilot and being proactive in implementing changes, with particular reference to new recovery procedures put in place after Year 1 and greater inclusion of the A4A's Project Mentor.

Again, comments highlight a need for clarity around the Recovery Network's role in Oldham and whom it intends to support, and staff are fully aware of the need to promote and possibly rebrand the service to avoid the stakeholders' perceptions that the Network caters for *"those that need more support than our programs give them; the difficult clients"*. This links to the issues around pathways and for catchment and recruitment. Given the original remit of the catchment being within a particular area, i.e. St Mary's, the lack of referrals and recruitment of Members has meant that the catchment has had to be expanded to fill capacity, and this obviously has an impact on Members connectivity. This sentiment was echoed by a staff member reflecting that more needs to be done to create bonding capital within the Network.

EXPECTATIONS

Members were asked a question around expectations to explore what knowledge people had prior to beginning programmes: *What were you expecting the service to help with?*

Responses indicated that those entering the Network did not have a clear sense of what to expect prior to starting, with the majority of answers focussing on aspects of support other than recovery.

“Not sure. Would like to get a flat, emotional support.” “KeyRing offered me support. They helped me sort my bills, visited twice a week, told me about the cell and support workers”. “I was told in an AA meeting that they would help with everything.”

Whilst acknowledging that these are responses from a small network, these comments can perhaps be interpreted in the context of previous staff and stakeholder comments, indicating a lack of knowledge about the Recovery Network and that communication can be misinterpreted. Recovery Network staff have subsequently worked hard to prepare the Members for recovery, and demonstrate awareness of the importance of preparing people for the experience of the Network and full recovery. It is positive to note, all Members stated that the Recovery Network experience had gone above expectations with positive comments from all 11 of the current Members, indicative of the passion and support its employees; *“Yes. It builds my self-esteem and confidence.” “More than met my expectations. I can’t say a wrong word about them”, “They go above and beyond”.*

SUPPORT

Recognising that many people using the Recovery Network will also be in contact with other services we asked Members: *What did/does the project offer you?* This question also aimed to explore further the question asked to stakeholders considering what the Recovery Network brought to local provision.

Members reported positively focussing on help with finances, housing, and education in addition to seeing a therapist. Members were also asked how connected they felt to their community. It is pleasing to note that Members reported connection to other group members through the group therapy. Members now enjoy attending the group and bonding capital is strong, so much so that they are considering ways to continue to meet post pilot.

Although the participants report a strong bond to the staff of the Recovery Network, to the other Members they meet in group and through the range of activities that the Network support, there are a number of follow-up clients who report ongoing challenges. The most dramatic limitation in terms

of the recovery journey of the participants is that only one of the sample was involved in any paid employment. That said, 100% of Members are involved in volunteering and or ongoing education. This reflects the positive experiences reported qualitatively by participants, around quality of life and meaningful activities, and given the complex nature of the Members this is a staggering achievement.

We also looked at how people in the Network spent their time and explored whether people displayed skills or resources that may not have emerged under previous questions. It is recognised that meaningful activity can be viewed as much wider than simply education and employment and people were also asked what activities filled their daily lives. Network Members *reported “I am getting out and about now, doing voluntary work and studying for a computer course and an English course.”*, in addition to *“I am loving life, working in the day and getting out and about at night with my friends, sometimes going to a meeting”*. The latter comments identify the use of positive social networks for support, with Members utilising a range of community and mutual aid groups. They highlight the possibilities of meaningful networking to influence Network Members in the early stage of their recovery journeys. It is also pertinent to note that throughout the pilot review all Members, at differing periods of time, have engaged in various forms of volunteering and or education and training.

CONCLUSION

The Recovery Network has evidenced an ability to enable -and sustain- recovery from substance use; evidenced not least by the fact that no illicit drug use or drinking was reported by participants at points of follow-up. Since joining the network, all have sustained their tenancies and no members have required emergency services; a particularly pertinent development in the case of one participant who, prior to the pilot, would routinely call an ambulance on average 11 times per week.

Findings from the pilot have served to further support an established evidence-based model of linking engagement with other people in recovery alongside meaningful activity (Best et al, 2011). Thus, participants not only value the structured activities and supports, but also there is a strong commitment to the group and particularly to the staff members.

The pilot also demonstrated the positive impact than attendance of 12-step support groups can have on increased wellbeing. There are clear indications of strong and stable recovery capital and social support in this group, and the evidence here would suggest that more active engagement in recovery groups at baseline predicts better recovery capital at follow-up.

This is reflected in staff learning, *“The idea is a massive strength, and with greater input from Penny we are now aware of the importance of abstinence prior to joining the Network”*, and again reflected in the appointment of the CLV being in recovery. However, this is a complex population with ongoing needs around mental health and the need for continued active engagement in volunteering and employment.

The promotion of the Recovery Network’s purpose and aim both internally and to a lesser extent externally, has eradicated any perceived confusion regarding pathways for its members. New Members have been introduced via the new CLV promoting the service through her own mutual aid networks, evidenced previously and again in the following comments *“I was in AA and I heard about what KeyRing offers and was told it might benefit me”*, *“Referrals came from word of mouth and from other Members”*.

Findings showed little to no impact in improving perceptions about the Recovery Network as a result of staff promoting and marketing the service by visiting local stakeholders. It remains largely viewed as a support service for vulnerable people. That said, KeyRing’s reputation in Oldham is exceptional for the work they do with vulnerable people, reflected in the following testimonies from stakeholders, *“I have referred many service users I have been supporting over to Keyring and achieved positive outcomes for them. KeyRing are fantastic in helping people move forward with their life’s with very professional staff & dedicated volunteers.”* to *“After leaving our service X has enrolled on courses on our Recovery hub and X’s attendance was 100%”*.

The recommendation for an abstinence network has now been fully embedded in to KeyRing’s offer of intention. Clear guidelines asserted by the Project Mentor on inception have been established and protocols have been followed with regards to potential relapse. This has completely eradicated any confusion around what was considered acceptable in terms of substance misuse.

These guidelines have also served to support those joining the Recovery Network during the last 12 months by setting a clear precedent. The introduction and implementation of Members being removed from the network for 4 weeks post-relapse has impacted positively and Members are now beginning to utilise the Network for its intended purpose i.e. recovery and relapse management, in addition to daily living support.

The appointment of the new CLV has assisted and actively promoted not only Members’ engagement in mutual aid but also attendance at social functions. Having a lived experience of addiction and recovery the CLV has had a positive impact on the members by recovery being visible and viewed as a reality. To date, 8 of the current members regularly attend fellowship meetings in addition to weekly

group therapy sessions and monthly Network meetings. The CLV has also benefited from attending various training sessions to improve knowledge of working with vulnerable people in a professional capacity.

A shared sense of belonging and connection is evident amongst those in the Recovery Network; with members cooking meals for each other and engaging in wider social activities such as trips to the theatre. Members look forward to taking part in social activities outside of service provision. This has clearly strengthened bonds and improved relationships within the network. When Members do not attend the social events there remains a keen sense of empathy and belonging, illustrated in the following comment, *“I don’t like the theatre so I don’t go, but I am happy for the others who do like it.”* This sense of coproduction and this connectivity has obviously had an undoubtably positive impact on health and wellbeing.

Network roles have clearly been defined for all involved in staffing the provision. Regular meetings currently take place between the Project Mentor, Therapists and KeyRing staff; which has in turn helped secure partnership working protocols. This is reflected in the introduction of a Therapists Handbook, coordinated by the Mentor for utilisation within the service. The Handbook supports therapists by providing understanding around clear lines of communication, awareness of expectations and job roles. Further, the Project Mentor is being utilised more fully, playing a greater role in the partnership by sharing her expert experience and wealth of knowledge of trauma, addiction and recovery.

Within the staff group, suggestions were given as to how to overcome certain barriers, *“I would have liked time to go and market the project...I feel that I am in a position to do so now”, “That drug and alcohol services were suspicious of the pilot and possibly felt threatened. More work to be done to demonstrate that this service is part of the pathway and a move on option which is currently not being offered.”*

These comments highlight an awareness of what could be done to support future roll-outs in order to fully utilise the service in Oldham, in addition to other networks, in the form of *“the psychotherapy input alongside the practical and social support is a very powerful offer for people”*.

CLOSING STATEMENT & RECOMENDATIONS

The original proposal has undergone considerable modification, exemplified by various first-hand reports such as; *“the two sides have finally come together; recovery therapy and the community living aspects”* to *“the original concept is a massive strength and it is invaluable to support those who need trauma therapy”*.

The original vision for the service came from Penny Snowball’s realisation that individuals leaving residential and community rehabilitation centres could not access appropriate support for secondary conditions (e.g. PTSD, depression, anxiety), or other forms of addiction that may have only become explicit in recovery (e.g. sex addiction, eating disorders). Having addressed their substance misuse issues (and been seen by others to have recovered) these individuals often relapsed nonetheless. With this in mind, the current model can therefore be seen as a substitute for secondary and tertiary residential rehabilitation support and/or ongoing recovery support for those leaving community drug and alcohol services. As Oldham already has an existing residential provision that includes move-on recovery housing at enhanced housing benefit rates, the model could not be adequately evaluated against more expensive provision.

In Oldham, Acorn referred only clients who were unlikely to benefit from secondary and move-on recovery housing. We suggest that the model is evaluated with a more representative client profile (i.e. less multiple dependencies and complexities) as we believe that it may improve the long-term outcomes of those leaving both residential and community treatment. It could also provide an alternative to residential treatment services and be more closely aligned with a ‘Housing First’ model.

This pilot has evidenced how trauma therapy and increased connection can play a significant role in improving the health and wellbeing of individuals with multiple and highly complex needs. The element of specialist support has enabled these individuals to lead more meaningful and independent lives; evidenced in limited relapse rates amongst participants. Further, the financial support required to maintain the service can be considered against a lesser reliance on other statutory services.

Community connectivity such as integration into mutual aid and social activities, coupled with collective reliance and mutual accountability has nurtured a greater confidence to volunteer and contribute to society amongst participants.

There is a significant opportunity for A4A and KeyRing to build upon existing assets, resources and the shared learning to improve the treatment and recovery experiences of substance users and their family members in Oldham and beyond.

APPENDIX

INTERVIEW DESIGN

MEMBERS: The survey instrument included a number of domains. Demographic information collected included age, gender, ethnicity, relationship status, living situation, employment status and days in full time work in the last month. Substance use was measured using two items; 1) any substance use in the past three months, and 2) the number of days of substance use in the past three months. Each of the substance use items were segmented by substance type.

Perceived quality of life was measured using the first two items from the World Health Organization Quality of Life Brief Scale (WHOQOL-BREF): 1) How would you rate the quality of your life? 2) How satisfied are you with your health? (Skevington, Lotfy, & O'Connell, 2004). Both of these general items illustrate good face validity, and Item one is strongly associated with the psychological and environment domains of the WHOQOL-BREF, while item two is strongly associated with the physical health domain (Skevington, Lotfy, & O'Connell, 2004).

Recovery capital was measured using the 50-item Assessment of Recovery Capital (Groshkova, Best and White, 2012). The Assessment of Recovery Capital has 10 subscales including: substance use and sobriety, global health (psychological), global health (physical), citizenship/community involvement, social support, meaningful activities, housing and safety, risk taking, coping and life-functioning, and recovery experience. Factor loadings on each of the subscales have been found to range between 0.54 and 0.78 and the instrument has demonstrated good concurrent validity (Groshkova, Best and White, 2012).

The 14-item Recovery Group Participation Scale (Groshkova, Best and White, 2011) was used to measure the extent of recovery group participation. The scale is not limited to a particular kind of recovery group and thus provides an overall picture of recovery group participation.

Psychological health was measured using the 10-item Maudsley Addiction Profile (MAP) psychological health symptoms subscale and physical health was measured using the 10-item MAP physical health symptom subscale (Marsden et al. 1998). Both scales ask about symptoms experienced in the past 30 days and have been found to have good internal reliability, test-retest reliability and correlate well with other measures (Marsden et al. 1998).

STAKEHOLDERS AND STAFF: A series of semi-structured interviews ascertaining attitudes, beliefs and expectations in relation to the Network were posed. Example qualitative questions appear below.

All three groups (Stakeholders; Staff; Members) were asked the same initial question: *What is your role/connection to KeyRing?*

Stakeholders only were asked: *What does KeyRing bring to the local area in terms of provision?*

This question was asked to both staff and stakeholders, with slight variation on the wording: *Is the service you offer utilised as well as it could be? [staff] / How far is this provision utilized by the local system? [stakeholders]*

Again this question was asked to staff and stakeholders only: *How would you describe the impact of KeyRing locally?*

To test areas for improvement and highlight things that KR do well we asked all interviewees including Members: *What are the strengths of KeyRing?*

Both staff and stakeholders were asked the question *What aspects of the service would benefit from changes and what would those changes look like?* This was to profile a set of suggestions for the next phase (Year 2).

This question was also asked to stakeholders and discussed at the focus group: *How effective are pathways into and out of KeyRing?*

Staff were asked: *How would you describe KeyRing as an employer to a prospective worker?*

All responses were input into software, including SPSS and Word, allowing for analysis.