**Final report**

September 2017

# Innovating for Improvement

## REC-CONNECT: Building local pathways to community capital, social capital and connectedness to improve wellbeing outcomes: A pilot project to build professional networks in local communities

**Sheffield Health and Social Care NHS Foundation Trust**

The Health Foundation

## About the project

**Project title:** REC-CONNECT: *Building local pathways to community capital, social capital and connectedness to improve wellbeing outcomes: A pilot project to build professional networks in local communities*

**Lead organisation:** Sheffield Health and Social Care NHS Foundation Trust (SHSC)

**Partner organisation(s):** Sheffield Hallam University (SHU) and Safer and Sustainable Communities Partnership, Sheffield Drug and Alcohol Co-ordination Team (DACT)

**Project lead(s):**

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Prof David Best, Professor of Criminology, Project Research Lead (SHU)

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## Part 1: Abstract

Wellbeing is intrinsically linked to social capital and a sense of connectedness to supportive pro-social networks and more broadly to the community. This is particularly true for vulnerable and excluded populations - such as persons with alcohol and/or drug (AOD) misuse issues who are new to recovery - who may have limited access to positive supports and social capital (meaning access to resources and supports and the resulting feelings of wellbeing and belonging that come from active participation in the community). REC-CONNECT is about providing a mechanism to create connections and social capital for persons with AOD misuse issues to support their recovery journeys.

The project was innovative in bringing together three emerging methods - Asset Based Community Development (ABCD), Assertive Linkage (AL) and Social Identity Mapping (SIM).

REC-CONNECT's success was enabled by the strong existing recovery community in Sheffield and the partnership development between NHS and the voluntary sector services who came together in this project. A main challenge we faced was coordinating schedules between a cohort of 17 fragile participants and busy AOD workers, volunteers and peers.

REC-CONNECT has generated a wealth of data and a new network of engagements with pro-social assets in Sheffield and surrounding areas. It has also successfully trained over 40 AOD workers, volunteers and peers in ABCD, AL and SIM. Nearly 20 new to recovery service users have been connected through this group and the methods are being embedded into routine practice in both NHS and third-sector sites throughout the city.

## Part 2: Progress and outcomes

The model adopted for this project is based on a growing literature about community engagement and the importance of creating coalitions between professionals and communities as a means of identifying, working with and helping to grow community participation to support vulnerable populations but also to increase the overall capacity of communities. The project brought together three emerging theoretical and clinical concepts - ABCD (as the mechanism for identifying assets), AL (as the mechanism for engagement with those assets) and social identity theory as the underpinning model for building communities and individual engagement.

This project used AOD problems as a pilot to test the feasibility of this model for working with marginalised groups with limited access to community resources and began by improving local front-line professionals' capacity to support community engagement through active engagement with and participation in local communities. The aim was to establish a group of 'community connectors' (professionals and community members) who can act as the bridges to existing resources in the community (through the method of AL, defined as professional and peer support to enable vulnerable individuals to engage effectively and integrate with positive and pro-social groups in the community and to be supported to do so), and build partnerships with existing community groups and activities for those service users accessing AOD facilities in Sheffield.

The project had five phases:

1. Train community-based AOD workers in the principles of AL and how to build links with positive social groups that create and build community capital and connections. This training included principles of ABCD, which identifies community assets, AOD related or otherwise, and individuals who are identified as potential candidates for the community connectors group. This process both raises workers' and volunteers' awareness of local recovery resources and provides results from a local community asset mapping exercise.

2. Provide a Community Connector recruitment, training and support programme, based on the AL training model, which was delivered to this mixed professional, peer and community group of community connectors, to empower and skill them in techniques of recruitment, engagement and linkage. Community Connectors are respected and prominent members of local communities who are able to attract, engage and link vulnerable individuals with local community assets. Many had first-hand experience of AOD addictions, and so are credible and accessible to the target population.

3. Provide on-going support for the Community Connectors to engage with clients in drug/alcohol recovery in Sheffield, assertively linking them into local resources, pro-social groups and activities, increasing their social and community capital resources. This extends their role to that of peer navigators. We are creating a model to support them in this role, and to ensure that issues of governance and safety are managed effectively.

4. Evaluate the impact of the training provided and test if this model improves engagement in community groups and social capital in vulnerable populations such as those in early recovery from AOD problems (i.e. does it improve wellbeing and reduce engagement in harmful behaviours?).

5. Disseminate findings to local and national stakeholders, discuss replicability in different health settings and with different service user cohorts, and develop a tool kit for wider dissemination of good practice. This project is highly innovative and there are clearly lessons to learn from each phase of design, implementation and outcome monitoring. As part of this work we are also identifying opportunities for building the legacy of the work.

There were two significant adjustments to our original plan. First, we determined early to add third sector volunteers to the training cohort alongside the AOD workers. Second, due to recruitment delays, we reduced the data collection follow up times from 90 days to 60 or 30 days, depending on the date of baseline collection.

**Participant cohort and intervention appraisal**

We recruited 17 clients from 5 agencies: SASS (n=5), Phoenix Futures (n=5), SHSC (n=4), Drink Wise Age Well (n=2) and Addaction (n=1). All were white British - 5 female and 12 male. To quantitatively measure impact for the clients, we secured baseline REC-CAP evaluations for all recruits. The REC-CAP is a recovery capital measure created by David Best and colleagues (see Appendix 1). Analysis of the data shows varying levels of well-being and recovery capital (indicated in means with low to high scale ranges):

- wellbeing:  61.5 on a 0-100 scale
- personal recovery capital: 12.64 on a 0-25 scale
- social recovery capital: 12.76 on a 0-25 scale

Groups and services engagement was reported as:

- 8 engaged with 'other community recovery groups'
- 7 with peer support
- 5 with online groups
- 1 with 12-step groups
- 8 receiving drug treatment services
- 12 receiving alcohol treatment services
- 15 receiving primary healthcare services.

A full descriptive analysis is included in Appendix 1.

We were unable to secure follow up REC-CAP data for all recruits, as will be discussed below. However, case studies from several clients and their reports revealed significant change and strongly endorsed the intervention. Clients reported a positive impact on their social wellbeing and recovery. For some, it provided an opportunity to try new things and meet new people, which before working with their community connector had been difficult. From a social capital perspective, there was evidence of gains in both bonding capital (within the connectors group) and bridging capital (improved networks and engagement with a wider range of communities), and some of these bridges are sustainable beyond the life of the project. The full case studies are included in Appendix 1.

**Model and training appraisal**

The quantitative and qualitative data collected reflect broad community connector and participant support for the project and a general belief in its need and value.

To measure the quality of the training for drug and alcohol workers, we utilised a bespoke version of the Texas Christian University (TCU) Organizational Readiness for Change Workshop Evaluation form (WEVAL). Workshop evaluation data was collected at each stage of the project. In total, 63 total evaluations were received during the phase 1 and 2 (pre-launch) workshops; 13 were received from the connectors' launch event. The evaluations were compared. To summarise the findings from the pre-launch training sessions (n=63):

- Broadly positive responses to value of training, benefit to job and clients, and increased knowledge.
- Concerns around time and resources to utilise methods
- Key areas of learning were strongly endorsed with all domains scoring 3.5 or higher on a 1-5 scale, with 1 reflecting lower value and 5 higher value; only 'will not work' scored below 2

Within the TCU implementation science model, this suggests that there were substantial successes in engaging and training participants and building their competence and efficacy but anxieties about the actual implementation as a result of organisational factors.

The findings from the launch event were broadly similar to the findings from the pre-launch sessions but with some notable differences. To summarise:

- Launch event group generally more favourable to implementation of the training
- Both groups strongly endorsed the relevance, satisfaction and usefulness of the training
- Phase 1 & 2 group believed there would be fewer barriers to implementation, suggesting increased confidence about utilisation

- Launch event group scored slightly higher on key areas of learning and were more enthusiastic about the future of REC-CONNECT; they were, however, more concerned with workability of the method.

The WEVAL data strongly endorsed the value and quality of the training. This is evidenced in the tables included in Appendix 1, and would suggest that this approach can be delivered to a mixed group of professionals and peer volunteers, with high levels of engagement and positive building of a sense of community.

We were unable to secure all of the follow up workshop data we would have liked, as will be discussed further below, however there are qualitative data that reflect the feelings of participants. Training session participants provided feedback; themes identified included broadening of knowledge of opportunities available for those in AOD recovery and building a network of people and resources (Figure 1).

*'v[ery] good information of connectedness/belonging. All agencies/workers need to be working with this at the forefront of all their engagement with service'*

*'… It was particularly advantageous that so many people who attended shared their experiences in their posts/ volunteer status. Sort of networking experience of like-minded people in order to administer help care and wellbeing amongst a particularly stigmatised population of our society'*

*'…[I] found the possibilities and purpose very exciting. I'm kind of already connecting people through the different agencies that are currently helping me with my own recovery which makes this pilot so interesting for me'*

**Figure 1:** feedback received on training session

The awareness of the project in participating organisations also facilitated others, who did not take part as community connectors, to become more aware of these opportunities, which aided client recruitment.

With respect to outcome measures for the connectors and the asset mapping (ABCD) exercises, the ABCD mapping exercises generated a substantial body of data, with 22-35 community assets identified by workshop participants in 4 separate ABCD model domains, or some 140 overall community assets (Appendix 1, Figures 1-5). This asset directory is a living document and a core component of our sustainability plan (Appendix 1), as this is the foundation of a personalised pathways model to building recovery capital. This directory and related set of pathways represents a significant legacy of the project that can be built on.

## Part 3: Cost impact

Statutory AOD services in Sheffield are commissioned by Local Authority and provided by Sheffield Health and Social Care NHS Foundation Trust (SHSC). Recovery support including residential rehabilitation detox facilities are provided by third sector organisations such as Sheffield Alcohol Support Service (SASS) and Phoenix Futures. Sheffield also has a thriving Recovery Community which is a supportive, voluntary-run community group.

The REC-CONNECT Project additionally includes Sheffield Hallam University (SHU) as evaluation partner.

SHSC, SHU and SASS are REC-CONNECT partners; grant funding is allocated to partners according to relative contribution outlined in the budget (see Appendix 2).

86% of the budget was proportioned to training delivery, statistical analysis, project management, and project leadership. The proportion of spend allocated to management and leadership was appropriate given the observational nature of the project, which was in essence a feasibility study.

Training delivered to community connectors and initial awareness-raising of the project, via advertising, and recruitment of clients were implementation costs incurred in Year 1. As an established project, REC-CONNECT project now has a cohort of trained connectors who do not require ongoing input and support directly from project staff. For project sustainability, bi-annual ad hoc refresher sessions can be arranged from within existing service provision in Sheffield, inexpensively or free of charge, and form part of the sustaining recovery strategy and offer for clients in AOD recovery in Sheffield.

We are confident that the REC-CONNECT project, and benefits realised thereof, can be sustained and accommodated by existing services in Sheffield, albeit without on-going evaluation of outcome measures in the robust and systematic manner that SHU has provided during the course of this project. The network of community connectors and partners may benefit from attending existing service-user focused forums where information on latest developments in the recovery community are shared or further social mapping with input from research organisations may be incorporated. This will help the project to be embedded within the recovery community in Sheffield.

REC-CONNECT is an asset for people in drug/alcohol recovery, treatment providers and the wider community in Sheffield. Although not in the scope of this project, clearer pathways to recovery and support in the community have the propensity to reduce relapse rates and may inadvertently contribute to national performance measures of treatment outcomes such as the Public Health England's Public Health Outcome Framework (PHOF) target. We have already realised the benefits of greater working between partner organisations and this has facilitated clients transitioning from treatment services into the recovery community. The project evaluation and learning made possible by this project

could be explored as an approach to aid networking and increasing social capital in other vulnerable cohorts in Sheffield.

## Part 4: Learning from your project

### Achievements

Whilst most of our goals were achieved and we rate our project successful, we did not achieve all goals. We recruited 17 clients against a target of 20. We had unexpected delays with NHS ethics approval resulting in some recruitment and participation delays with SHSC, contributing to us missing our client recruitment target. Any future project will propose that the NHS ethics process begins sooner to reduce impact on recruitment.

We exceeded our recruitment and training targets in the other two stages of our project. We recruited and trained 21 community connectors (target = 15), with-others requesting to join the scheme after the trainings concluded. We trained over 40 workers (target = 20), volunteers and peers in AL. We have demonstrated the viability of efficacy of the model, and it was primarily time and resource delays that affected client recruitment and outcome components of the project.

The NHS ethics delay also affected our ability to secure meaningful workshop follow up evaluations from drug and alcohol workers as that cohort was amongst the SHSC staff whose involvement was delayed. As a consequence, we were unable to assess their view of the workshop post-intervention with clients. However, the value of the workshops was uniformly endorsed at the WEVAL stage (see Appendix 1). Also, those peers and volunteers who engaged in the intervention for a measurable period uniformly endorsed the training informally.

The final area where we did not fully achieve our goal was in securing Social Identity Mapping (SIMs) and REC-CAP follow up evaluations from all clients. However, the feedback we received was that some recruits were not as willing to engage in these follow up activities because they perceived the research aspect i.e. REC-CAP survey, as interrupting their 'recovery time' as they were actively connecting and engaging with community assets. One recruit expressed that he 'just wants to get on with it', as reported by their connector. As the primary goal is to assist service users make connections to assets in the community, this 'failure' is so only insofar as the research is concerned, not, however, viewed from the perspective of the intention of the intervention. There are further implications for us in simplifying the process for social identity mapping to make this less intrusive for participants. It is worth noting that even with the challenges completing SIMs, we clearly established that SIMs can be readily completed by peers rather than clinicians.

In sum, the overarching goals of the project - educating workers and peers and connecting new to recovery service users - were uniformly accomplished, and our active engagement with communities and assets was highly successful.

### Enablers

The project's success was enabled by the existing recovery community in Sheffield, support of local government, and relationships formed among the agencies and their strong support for the project. Sheffield has a vibrant and

robust recovery community and many of the participants in our project are members of it. They were able to leverage their existing assets and relationships to promote, advance and sustain the project. This was facilitated by the strong online presence of the Sheffield Recovery Community. The project also benefited from the multidisciplinary Sheffield Addiction Recovery Research Group and public-patient involvement committee, Sheffield Addiction Recovery Research Panel.

The community connectors and representatives from SHSC, SHU and SASS met regularly once client recruitment was underway. This was an opportunity to share and reflect on experiences, receive project updates on timescales and recruitment progress and address any project challenges as they arose. The emerging network of community connectors is a major success of the project and their ongoing role in linking people new to recovery to community assets affords us a significant opportunity to build on the project successes.

We realised the importance of establishing an identity for the project. A REC-CONNECT logo was designed along with posters advertising the project (Appendix 1). These were shared in prospective-client recruitment organisations and online.

**Challenges**

Three main challenges were identified:

1. The greatest risk was an inability to recruit our cohort. Whilst governance delays, like ethics, are always a potential risk in a project of this nature, the length of the NHS delay was unexpected. However, we identified this early and attempted to mitigate it by securing additional recruitment partners and connectors. It is noteworthy that we had at least one recruit from every partner on the project and we have demonstrated that cross-agency working and partnerships between staff and volunteer can occur in the co-production of community assets and the emergence of a strong group for change and active community engagement.

2. Another challenge was the nature of the cohort; being new to recovery can itself be a barrier - indeed, the barrier the project was designed to remove. As Sheffield has an active recovery community, our research project was not, and did not seek to, introduce building recovery capital or networks as a new concept. However, the associated research aspect of it in the form of a survey and follow up and even introducing the clients to new connectors they had not met before, proved to be a barrier for some who felt supported by existing groups and individuals and did not see the added benefit of taking part in the research. This impacted on recruitment rates and we will need to work on more effective targeting and marketing of the project in future iterations.

3. Finally, as a co-production project, we made a suggested modification to the project design to have two connectors for each recruit. Whilst the merit to the modification is sound, the logistics proved challenging. Firstly, there was the inability for a portion of time to utilise SHSC connectors whilst awaiting ethics approval, and secondly, it was difficult to coordinate schedules between clients

and multiple connectors, many volunteers and in different agencies. We ultimately removed the additional connector component. Again, however, the model has merit and is worth re-evaluating.

**Reflections**

One reflection and unexpected challenge identified relates to identifying project recruiters i.e. community connectors. The project had volunteers from AOD service providers and the voluntary sector. Many, in particular the former group, were juggling project commitments, i.e. comprehensively surveying with clients, with their substantive roles. SHSC has an Ambassador Scheme, which provides volunteers an opportunity to support clients in their treatment and recovery journey. The Scheme cohort recruited at the start of the project graduated part way through; the timeframe of the project posed as a barrier to recruiting them to take part. Nonetheless, this group is a much richer seam of potential recruits for this kind of project than professionals, particularly those from statutory services.

This project encompassed the majority of AOD treatment and support services, statutory and non-statutory, in Sheffield. Recruitment was possible from a diverse cohort and we have been able to work across Sheffield. Expanding the project recruiters to third-sector organisations early in the project in particular greatly aided recruitment, engagement, retention and benefits realisation for community connectors and clients alike as well. Having representation from statutory, non-statutory and research partners fostered a collaborative design, implementation and evaluation project environments; each added value independently – scoping stakeholders in the planning stages has proved invaluable and is recommended for other projects. This will also give us a broader base for future developments and we know that it is possible to get entire sectors within a city to collaborate in this process. Although implementation was not as rapid as we would have wished, there are strong organisational foundations that have complemented the process of asset engagement - that will ensure the future effectiveness of roll-out of this work.

Other valuable feedback included the success of the project in connecting previously siloed agencies and organisations, and lowering of the separation between professional and peer-driven services is a project success that will be keyed on for sustainability. Some of the intervention successes have been due to Sheffield's existing recovery community and clear treatment provider pathways. In other areas of the U.K., AOD services are provided by a myriad of NHS and non-NHS organisations and the project approach used here may result in starker improvements in building networks and cross-working. The project evaluation and learning made possible by this project could be explored as an approach to aid networking and increasing social capital in other vulnerable cohorts in Sheffield. Sheffield is a 'resource-rich' city with significant potential for professional partnerships and active engagement with diverse communities and there is clear evidence that this approach could be extended to other vulnerable and marginalised groups such as those with physical or learning disabilities.

## Part 5: Sustainability and spread

The intervention will be sustained beyond the funding period. The principles underlying the model have begun to be embedded in the partner organisations' practices. Also, the partners have agreed a continuing professional development programme which includes SHU providing periodic training in AL, ABCD and SIM to project partners' staff and volunteers. Support for this continuation was gained through the cooperative relationships the partners developed over the course of this project and we think these milestones will assist in embedding the work started by this project. One of the outputs, the asset directory, is a living document and its development and dissemination will continue post-research project. To summarise, the project has produced three clear levels of asset:

1. access to a cohort of community assets that can be mobilised to support recovery pathways and that represent a major resource, and that can be built on and developed through the commitment of a range of stakeholders

2. a strong organisational partnership with NHS and third sector organisations linked to a university department with a strong record for collaboration and who are committed to future iterations of the project. This provides a core platform for a range of future co-production activities

3. a strong and enthusiastic team of community connectors who now have established links to community assets and a strong commitment to the values of the project. This group is key to the development and enhancement of the project.

Our project received significant external interest and recognition, including:

**Conference presentations**

- SASS's 6th annual national *Recovery in the Community* conference (9 November 2016)
- SHSC's Qu*ality Improvement - Your Contribution Counts* conference (1 July 2016)
- SHU's Sheffield Institute for Policy Studies' *Engaging Marginalised Populations Within Inclusive Communities* event (5 April 2017)
- SHU's Helena Kennedy Centre for International Justice's *Social Justice Week/Desistance and Recovery* event (7 April 2017)
- Gothenburg, Sweden Social Resources Management's *Recovery Cities* conference (27 April 2017)
- WHO NGASS supplementary event in Vienna (March 2017) - this project was cited as a recovery innovation

- Irish Drug Strategy Launch (Trinity College, Dublin, 8th April, 2017) - project was cited as a key form of recovery innovation

**Print media**

- The project launch on 1 March 2017 received extensive publicity (Recovering addicts can REC-CONNECT with community), with articles appearing on the SHU media center, SHSC website and in 5 regional newspapers

**Radio coverage**

- The project launch on 1 March 2017 was reported on Hallam FM radio (no link available)

- The project was discussed during an interview on BBC Sheffield Radio's Toby Foster at Breakfast Show on 6 September 2017 (You can listen to the interview from 01:23:56)

Members of the project team have authored a paper exploring the co-production element of the project and have submitted to a peer-reviewed journal for publication consideration. The article has received an initial favourable review and has been forwarded for additional review.

Reflecting on possible reasons why our project has received diverse interest, we think that the project affirms existing work in the community and contribute positively to potentially improving outcomes for vulnerable hard-to-reach individuals in society. Innovative approaches to supporting this aim resonates with commissioners, service providers, clients in recovery and the wider community in general. As the project draws to a close, for us, it is becoming apparent that this project is an example of collaboration between individuals who can sustain the networks created with or without the associated research aspect.

The project evaluation and learning made possible by this project could now be explored as an approach to aid networking and increasing social capital in other vulnerable cohorts in Sheffield and further, or in other cities where drug and alcohol provision models differ.

Indeed, on 18 September 2017 the research lead was contacted by a staff member at Department of Work and Pensions (DWP) who had heard about the REC-CONNECT project. The DWP expressed an interest in developing the project model for people with physical disabilities, reflecting the ready transferability of the model to other vulnerable, marginalised and / or isolated groups. A meeting is being organised to present REC-CONNECT to the DWP. Both connectors and clients from the project will be invited to share their experience with the project.

An event has been planned in Sheffield for 13 November 2017 to celebrate the project's success, acknowledge the connectors, and affirm the partners' and participants' commitment to sustaining the project.

## Appendix 1: Resources and appendices

- Case studies
- REC-CAP descriptive data report
- Workshop Evaluation (WEVAL) data
- Asset Based Community Development (ABCD) maps and data
- Asset directory (latest)
- REC-CONNECT poster
- Media coverage
- Electronic attachments to Appendix 1
    - REC-CAP survey

REC-CONNECT REC-CAP.pdf

    - WEVAL survey

THF WEVAL.Launch.doc

    - Asset directory

Sheffield Community Connector Assets Dir

- Case studies

**Case 1**
Female, aged 27
First seen: 03/04/17

Susan* walked in to local service the Alcohol Recovery Community (ARC) without an appointment. She had previously had support through the SHSC treatment service when she had issues with other substances, but now felt she was compensating with alcohol and had started to lose control of her drinking.

At first she didn't show much motivation to make any changes to her alcohol use but after reviewing her recovery capital with an ARC Support Worker, it came to light that she really struggled during the evening, when a lot of services were closed. The ARC Worker suggested that she access some support groups in the evening, which is when she had the most trouble with urges and worries. Susan was very anxious about going to a meeting on her own, especially one she had never been to before and when offered a subscription to

online support group Soberista's as an alternative, she didn't feel comfortable enough with computers to get any benefit. This is when the worker thought REC-CONNECT might work.

The Community Connector based with the ARC team sat down and went through the REC-CAP, identifying what type of meeting would be most helpful for her to attend. The Connector already had links in this area so was able to initiate a meeting with a female member of AA who the connector trusted and made sure that Susan would feel welcome.

Susan met the AA member, who has now become her sponsor and is taking her through a program of recovery in an environment that Susan feels is friendly and safe. She continues to maintain her recovery and she can't quite believe the changes she has made to her life and continues to make in her recovery.

**Case 2**
Male, aged 38
First Seen: 17/03/17

John* was struggling to keep his house tidy but was spending long periods of time at home on his own. He described the isolation and unpleasant environment as significant factors to his drinking; using alcohol as a way to help reduce his anxiety and help him socialise. He felt that finding some form of hobby that would get him out of the house and meeting people in a non-drinking environment would help him to reduce his drinking. He was particularly interested in walking.

The Community Connector helped John to make contact with a local walking group in Sheffield. However, John wasn't able to make the scheduled group walks but has maintained an interest and contact with the group leader. In the meantime, the Community Connector linked John into a local recovery upcycling activity called Rags to Riches that refurbishes furniture and household items. This has been perfect for John as there is a focus to the activity but also the opportunity to socialize in a less pressured way. He has reduced his alcohol use by half and appears to be less nervous around others. He has also used his new-found enthusiasm for upcycling to tackle his own home.

**Case 3**
Female, aged 55
REC-CAP baseline date: 29/03/17

Charlotte* suffers serious physical limitations as a result of her misuse of alcohol. She was hospitalised for 7 weeks a few years ago and hasn't used alcohol since. However, she struggled because of her physical limitations. She uses a wheelchair or standing frame to get around, was essentially home-bound, and was socially isolated. She was approached by a worker from Drink Wise Age Well (DWAW) about visiting their programme. DWAW staff picked her up and took her to meetings where she met her Community Connector. She was unconvinced about completing the REC-CAP initially, but then began getting involved with activities and by the time she completed her follow up, she was feeling 100% better and enthusiastic.

Charlotte said she 'feels better,' enjoys the 'different atmosphere' of her recovery group, who she described as 'like family'. She has a loving, caring son but needed connections. She attends meetings and does team work - putting together puzzles, making jewellery and candles and other crafts. Even with her physical limitations, she went on a group visit to an aquarium and was booked to visit a safari park the day after our talk but had to cancel due to her dog being seriously ill.

She goes to DWAW fortnightly and said as good as her son is to her, she thinks she could pack a bag and live there. With a hearty laugh, Charlotte said, 'when I go down there [DWAW], I just let loose'!

*names have been changed at the request of the participant

Descriptive Analyses
(17 Respondents)

## Descriptive Analyses

### 1. Socio-demographics

The sample was composed of 17 White British people: 5 females, 12 males. The average age of participants was 43.76 years (SD = 11.63), which ranged from 29 to 68 (men: M = 41.64, SD = 10.72; women: M = 47.80, SD = 14.79).

The number of people engaged with "other community recovery groups" is 8 people out of 15 who replied, followed by engagement with peer support (7 people out of 16 who replied) and engagement with online groups (5 people out of 15 who replied). One person (out of 15) was engaged with 12 steps groups.

### 2. Wellbeing

The mean of total wellbeing (scale range: 0-100) in the sample was 61.50 (SD = 18.43), which ranged from 32 to 83.

## Strengths analyses

### 1. Recovery capital

The mean raw score for personal and social recovery capital were, respectively 13.42 (SD = 4.72) (minimum 6, maximum 24) and 13.42 (SD = 6.26) (minimum 1, maximum 22). Both have scale ranges of 0-25.

### 2. Group engagement (RGPS)

The mean of group engagement (scale range: 0-14) in the sample was 3.71 (SD = 3.42), which ranged from 0 to 11.

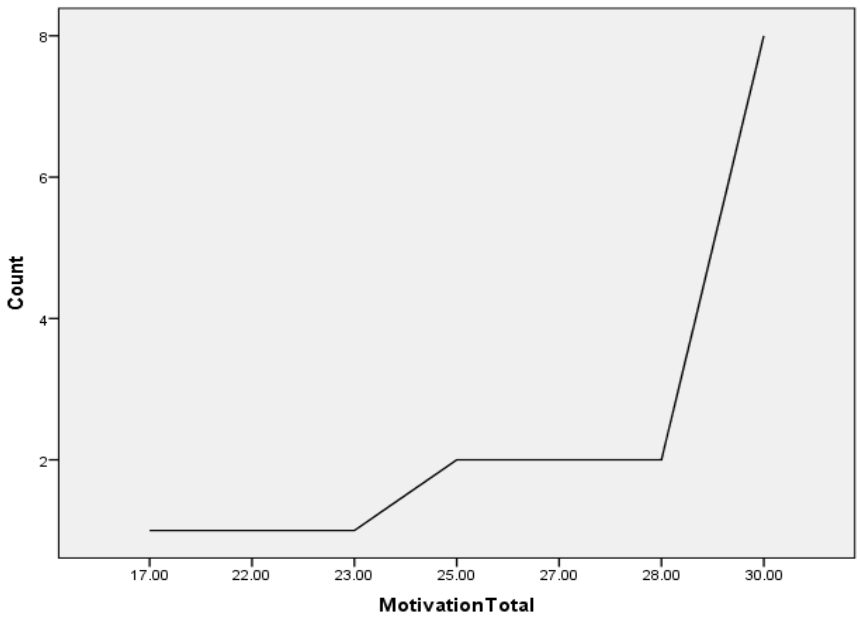
### 3. Social support

The mean of total social support (scale range: 1-28) in the sample was 16.87 (SD = 6.42), which ranged from 4 to 28 and was normally distributed. That is, the majority of the people's scores were close to the mean of the group.

### 4. Commitment to sobriety (CSS)

On the sample, the most frequent value for commitment to sobriety (scale range: 1-30) in all the subscales was the highest score possible, with eight residents reporting the highest value across all dimensions (Image 1). The mean of motivation in the sample was 27.18 (SD = 3.73).

Image 1




## Barriers analyses

### 1. Accommodation

The predominant patterns for accommodation were a) risk of eviction (Image 2) for 5 people, no risk for 4 people and 8 people who did not report information on this; b) housing problems (Image 3) for 6 people, with 3 without problems and nine who did not report information; c) 3 people reported debt issues, 12 did not face such risk and 3 did not reply.

Image 2

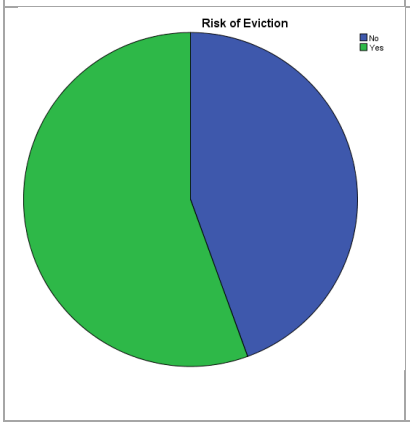



Image 3

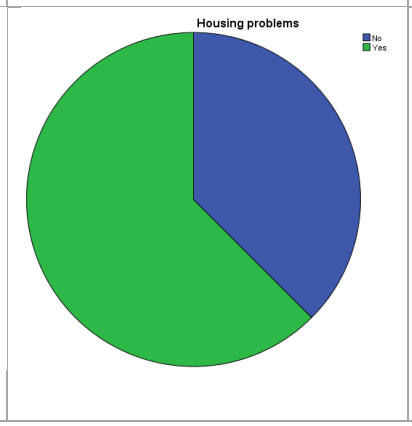
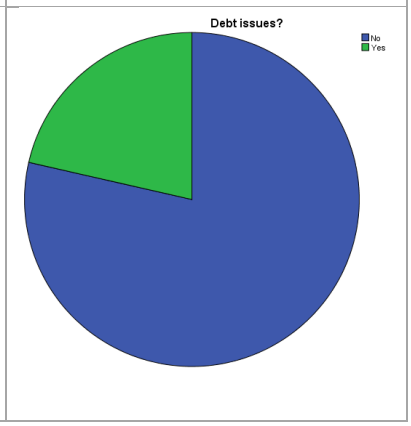



Image 4



### 2. Substance use

On the sample, 11 residents reported not having used legal or illegal substances in the last 90 days. Among the 6 individuals who did use, the most problematic substance were alcohol and tobacco (6 people), followed by and cannabis and reported by 3 residents.

### 3. Criminal justice involvement

Ongoing criminal justice involvement was low with 3 people on probation and nobody reporting being on parole; 1 person reported recent offending and 1 reported police involvement in the last 3 months.

### 4. Lack of meaningful activities

On the sample, none of the residents reported being currently working full time; two were working part time, while nobody being volunteering or enrolled at college/education.

## Needs analyses

### Specialist needs

The predominant patterns for reported needs and services engagement can be found in Image 5.

Image 5

**Specialist needs**

| | Are you currently engaged? | | Are you satisfied? | | Do you need more help? | |
|---|---|---|---|---|---|---|
| | No | Yes | No | Yes | No | Yes |
| Drug treatment services | 7 | 8 | -- | 9 | 6 | 1 |
| Alcohol treatment services | 4 | 13 | 2 | 12 | 7 | 5 |
| Mental health services | 11 | 5 | 4 | 3 | 5 | 3 |
| Housing support | 5 | 11 | -- | 11 | 6 | 5 |
| Employment services | 15 | 1 | 3 | -- | 2 | 1 |
| Primary healthcare services | -- | 16 | 3 | 12 | 12 | 3 |
| Family relationships | 8 | 8 | 2 | 7 | 7 | 1 |
| Other specialist help or support | 9 | -- | -- | -- | -- | -- |

## Bivariate Analyses

### *A. Relationship between strengths and wellbeing*

#### 1. Recovery capital

All other things being equal, in this sample neither personal nor social recovery capital was significantly associated with wellbeing.

#### 2. Group engagement (RGPS)

In this sample, all other things being equal, group engagement was marginally predictive of wellbeing ($p = .059$). That is, the higher group engagement, the greater the score in wellbeing; yet this effect is not large enough to be considered significant.

#### 3. Social support

All other things being equal, in this sample social support was marginally predictive of wellbeing ($p = .062$). That is, the higher social support, the greater the score in wellbeing; yet this effect is not large enough to be considered significant.

#### 4. Commitment

All other things being equal, in this sample commitment to sobriety was not significantly associated with wellbeing.

### *B. Relationship between barriers and wellbeing and recovery capital*

#### 1. Accommodation

In this sample, none of the accommodation barriers (risk of eviction, housing problems, debt issues) was associated with differences in the mean score of wellbeing or recovery capital.

#### 2. Substance use

In this sample, substance used in the last 90 days was not associated with wellbeing. However, all other things being equal, predicted recovery capital for people who had used in the last 90 days compared to people who had not was 10.030 units lower (see Image 6).

Image 6

**Coefficients[a]**

| Model | | Unstandardized Coefficients | | Standardized Coefficients | | | 95.0% Confidence Interval for B | |
|---|---|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | t | Sig. | Lower Bound | Upper Bound |
| 1 | (Constant) | 30.364 | 2.898 | | 10.477 | .000 | 24.186 | 36.541 |
| | Substance use in the last 90 days? | -10.030 | 4.878 | -.469 | -2.056 | .058 | -20.428 | .368 |

a. Dependent Variable: Total Capital

#### 3. Criminal justice involvement

Only 1 person reported involvement with the CJS or the police, and therefore no bivariate analyses were conducted.

#### 4. Lack of meaningful activities

All other things being equal, in this sample the lack of meaningful activities was not significantly associated with wellbeing or with recovery capital.

***C. Relationship between unmet needs (those where more is help required) and wellbeing and recovery capital***

All other things being equal, in this sample none of the unmet needs was significantly associated with wellbeing or recovery capital.

- Workshop Evaluation (WEVAL) data

**Tables 1-3**

(pre-launch workshops)

**Table 1**

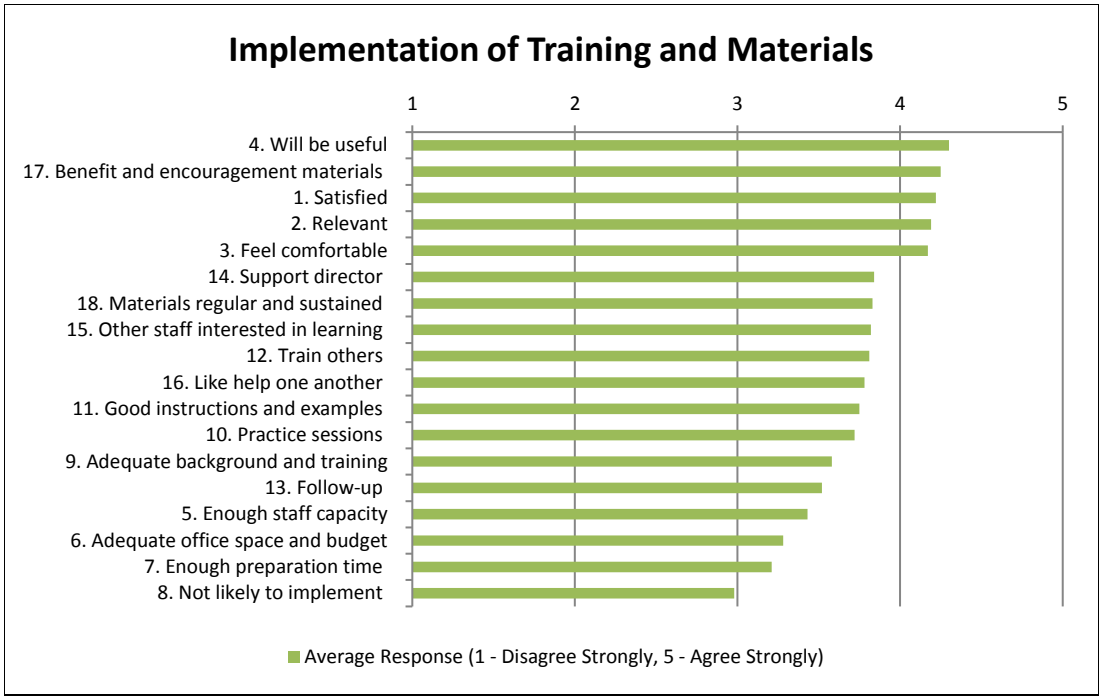


**Table 2**

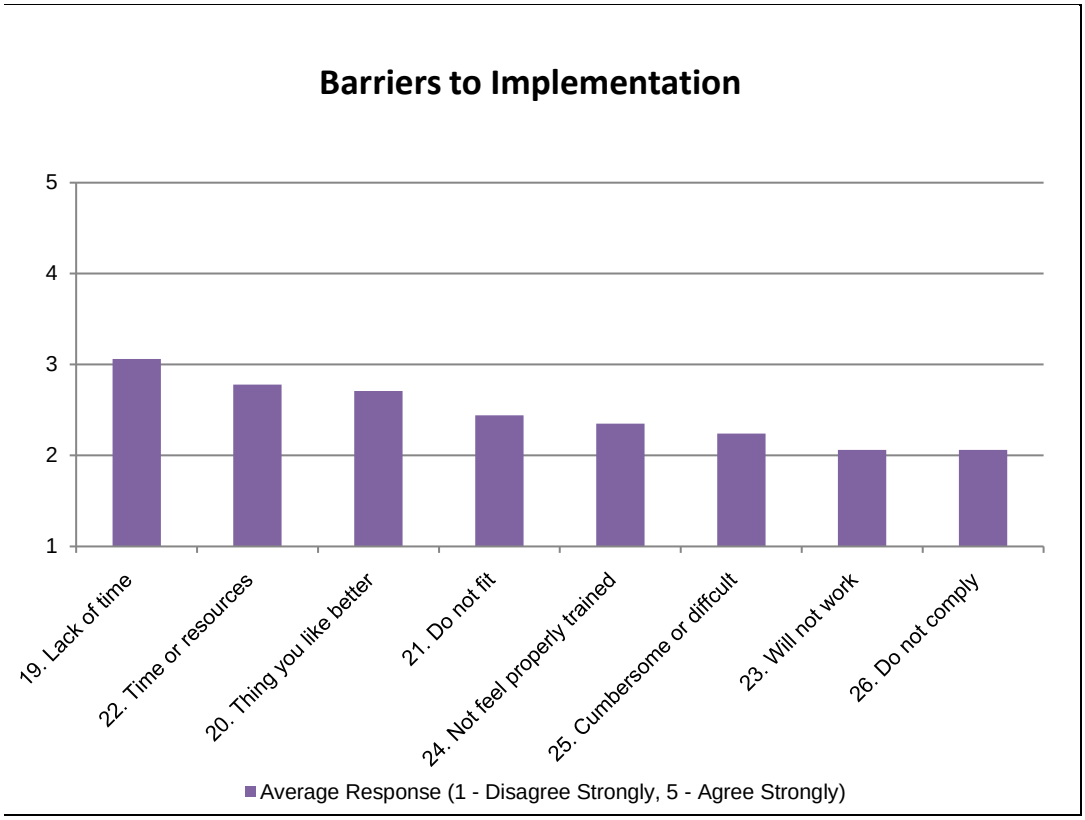
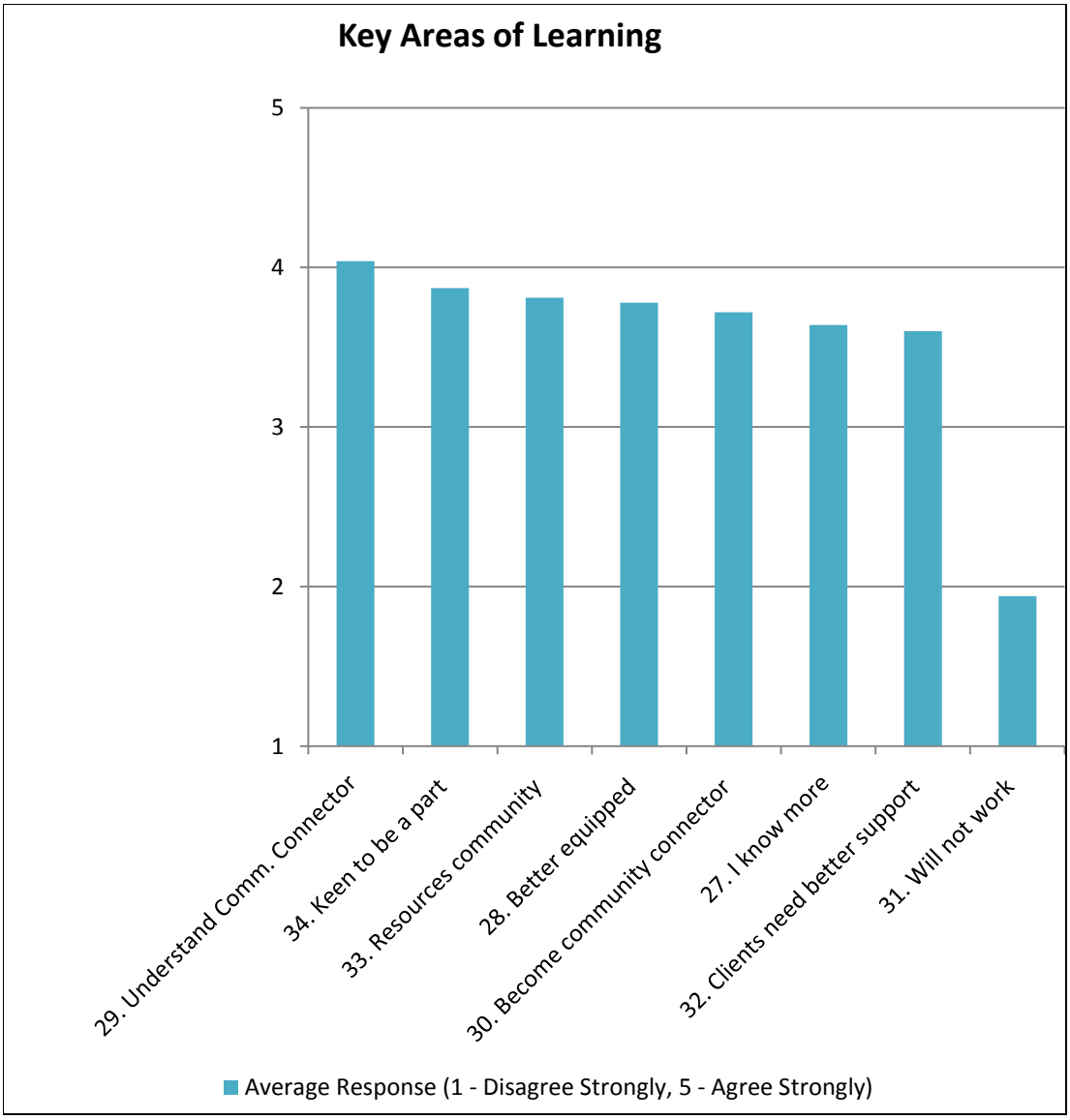



**Table 3**


Key Areas of Learning
5
4
3
2
1
29. Understand Comm. Connector
34. Keen to be a part
33. Resources community
28. Better equipped
30. Become community connector
27. I know more
32. Clients need better support
31. Will not work
Average Response (1 - Disagree Strongly, 5 - Agree Strongly)

**Tables 4-6**
(launch event)

**Table 4**

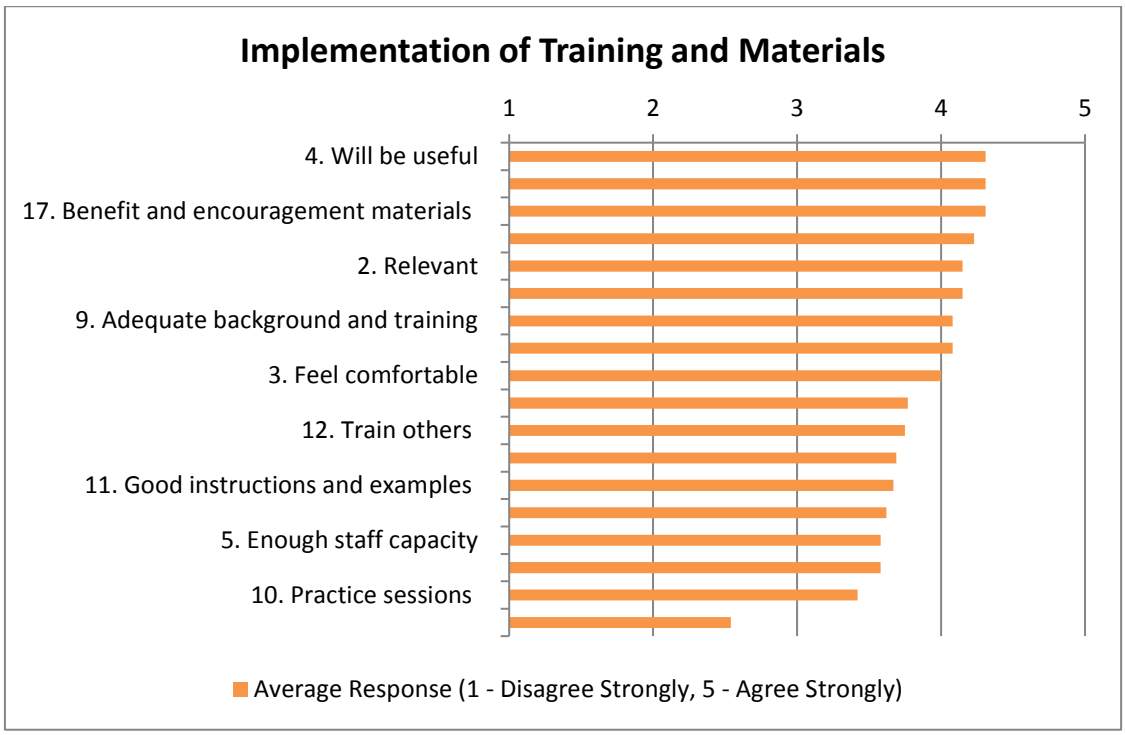



**Table 5**

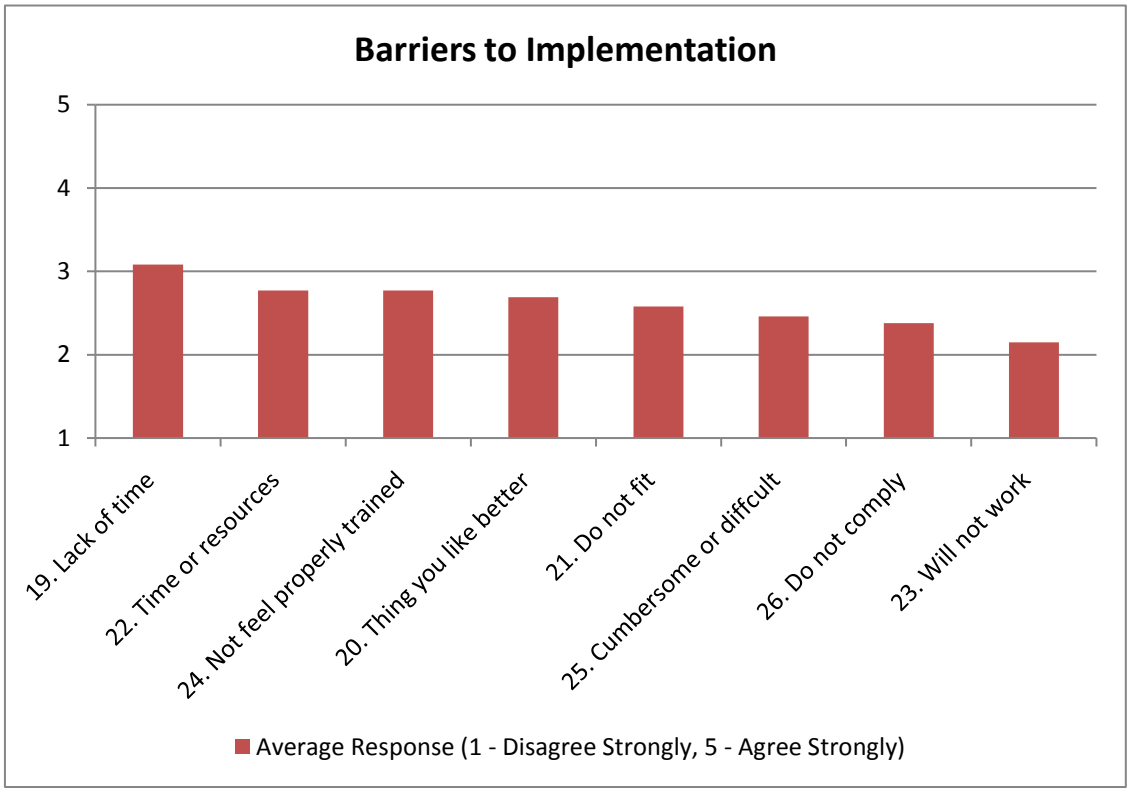
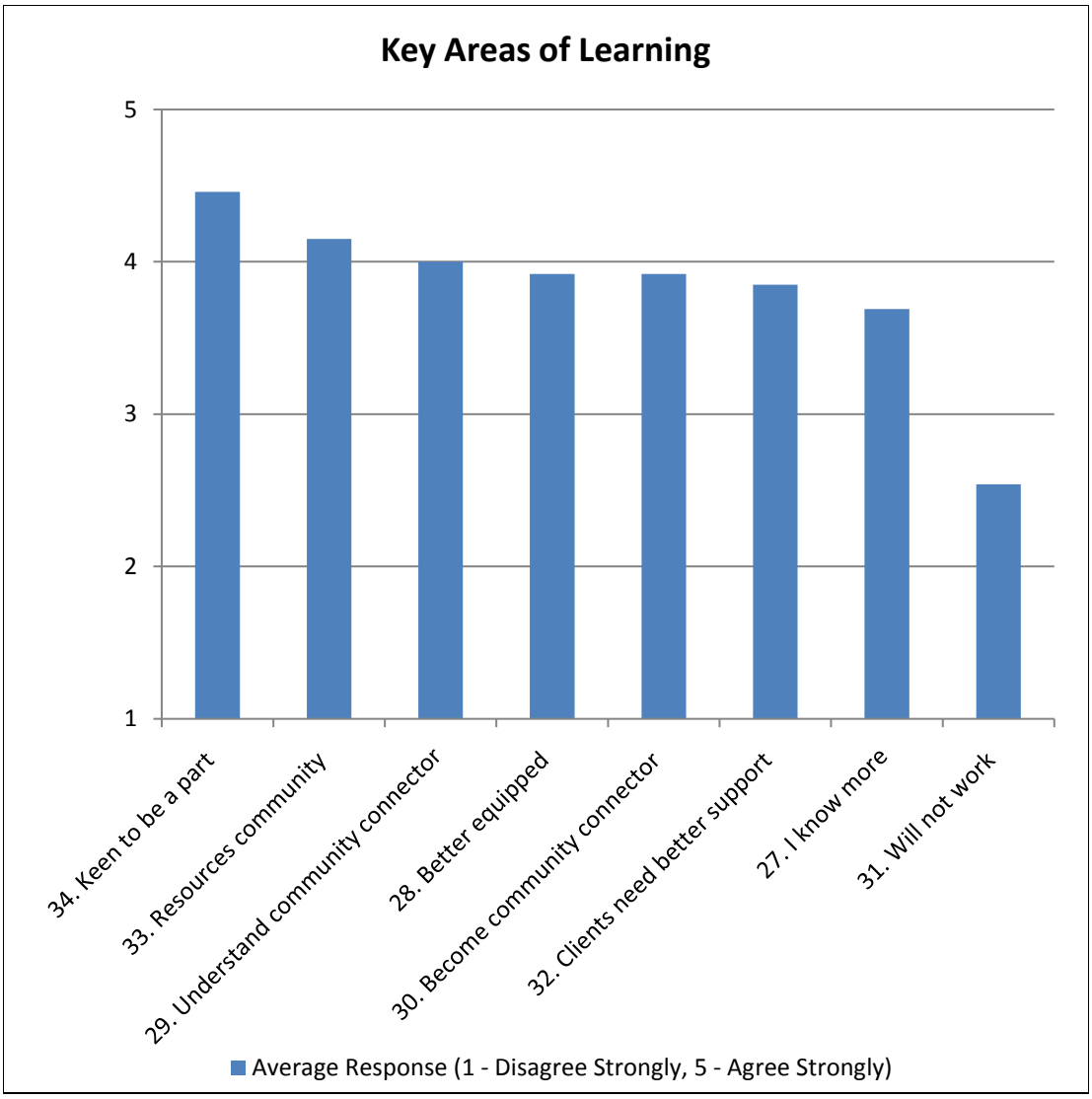
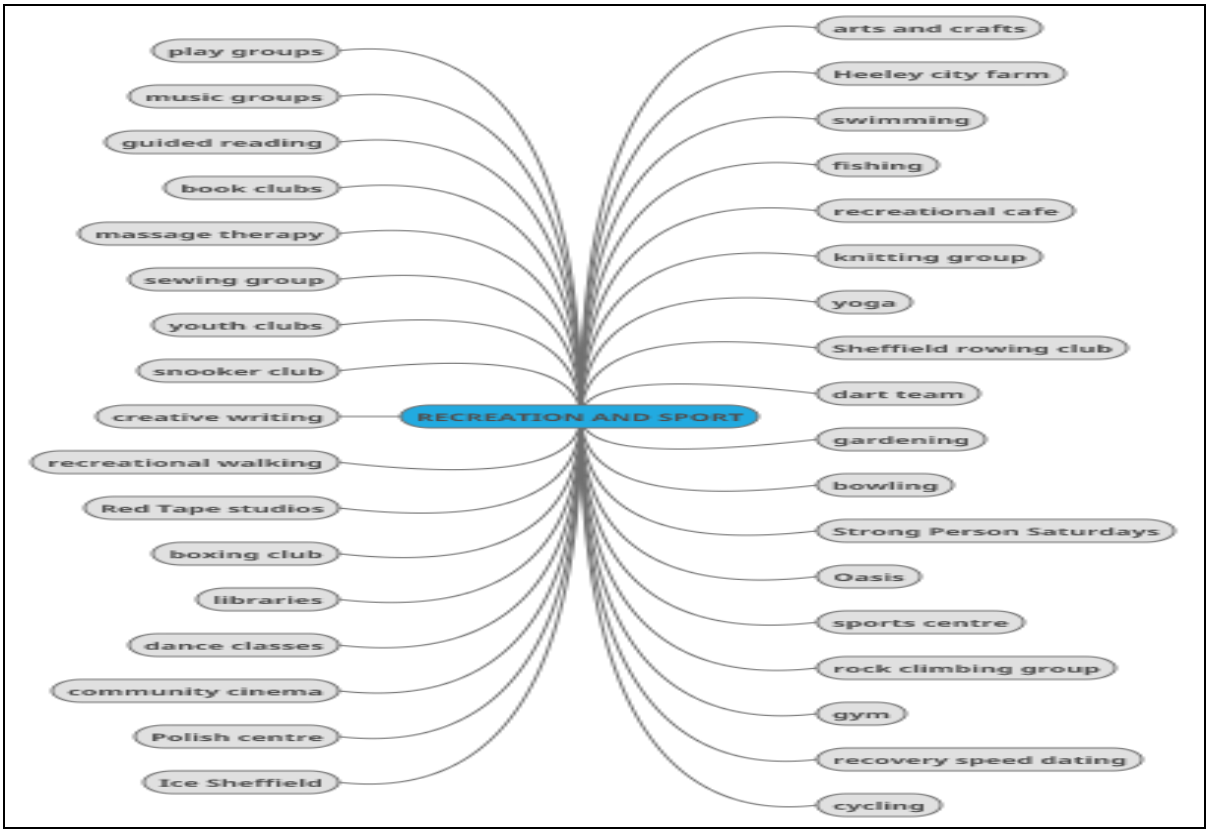


**Table 6**

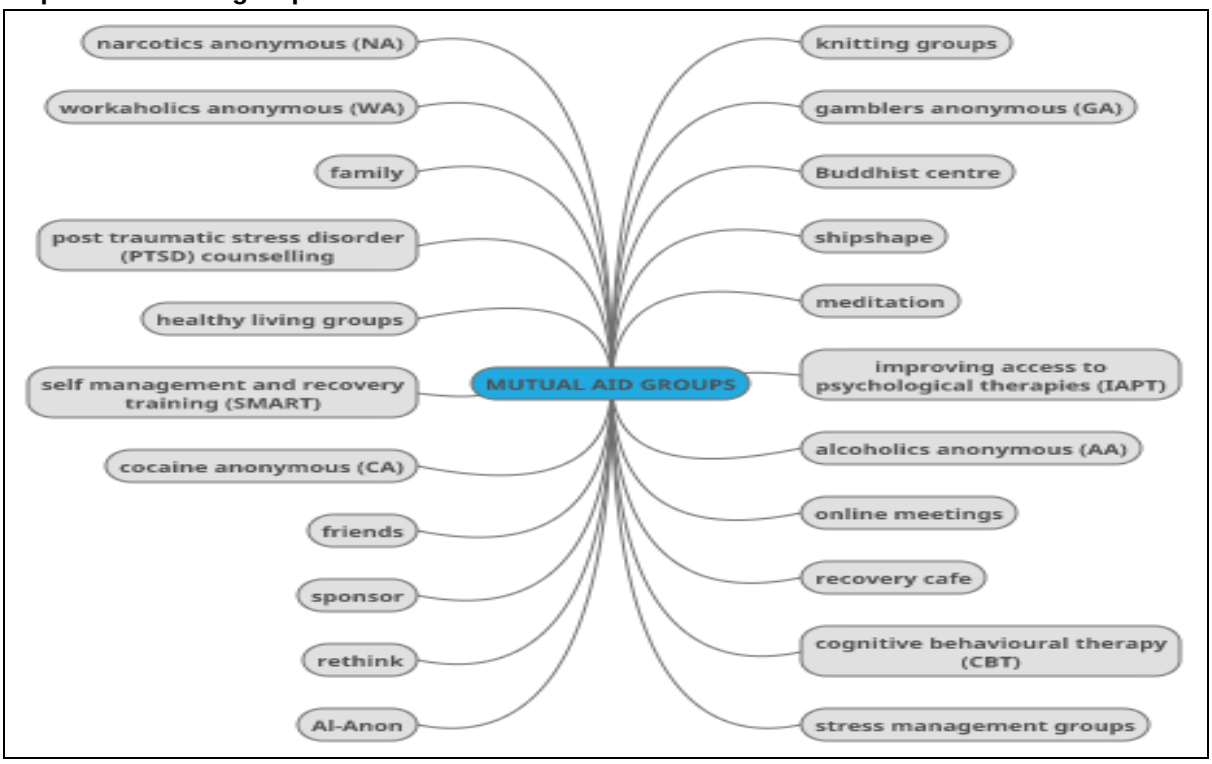

Key Areas of Learning
5
4
3
2
1
34. Keen to be a part
33. Resources community
29. Understand community connector
28. Better equipped
30. Become community connector
32. Clients need better support
27. I know more
31. Will not work
Average Response (1 - Disagree Strongly, 5 - Agree Strongly)

- Asset Based Community Development (ABCD) maps and data

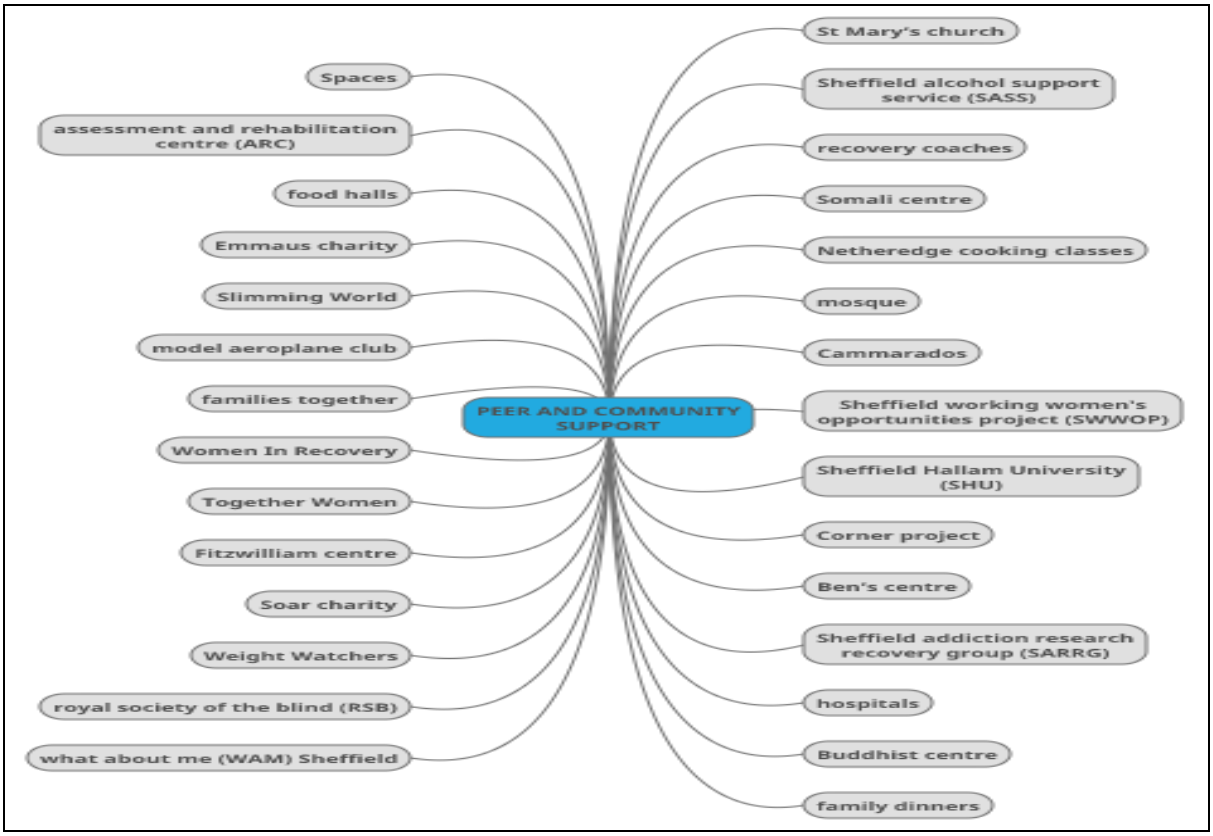
**Map 1. Recreation and sport assets**



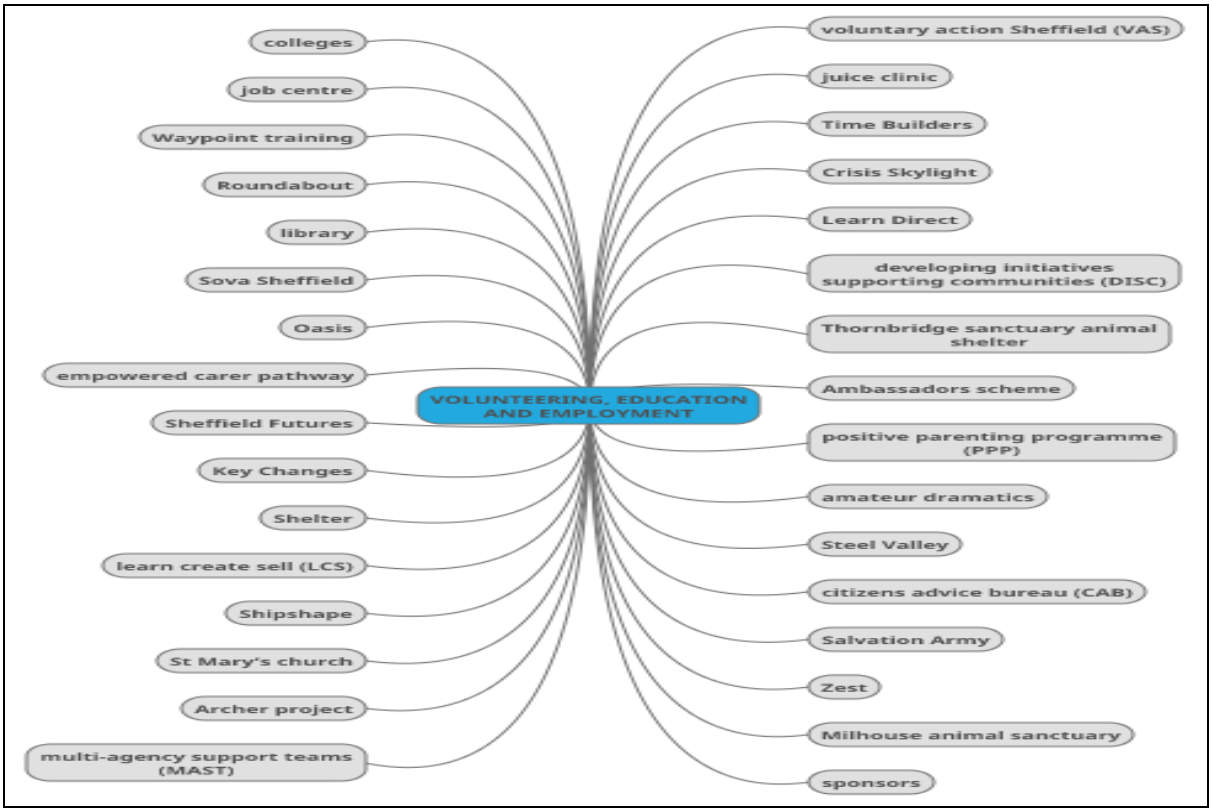
**Map 2. Mutual aid groups assets**



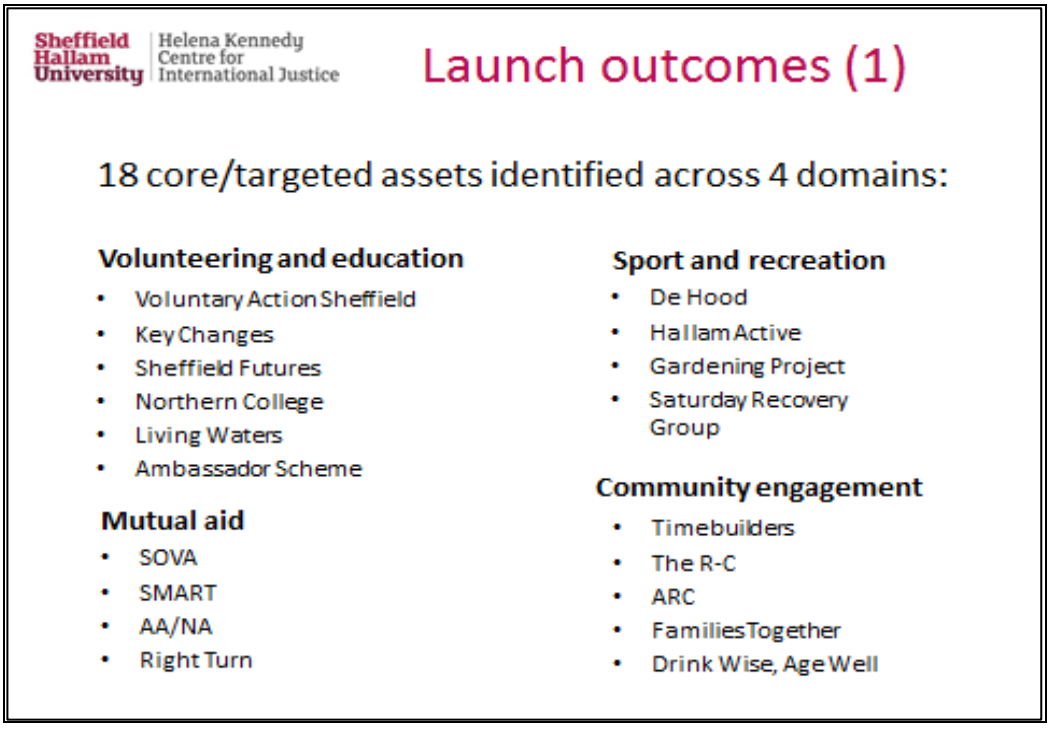

**Map 3. Peer and community assets**



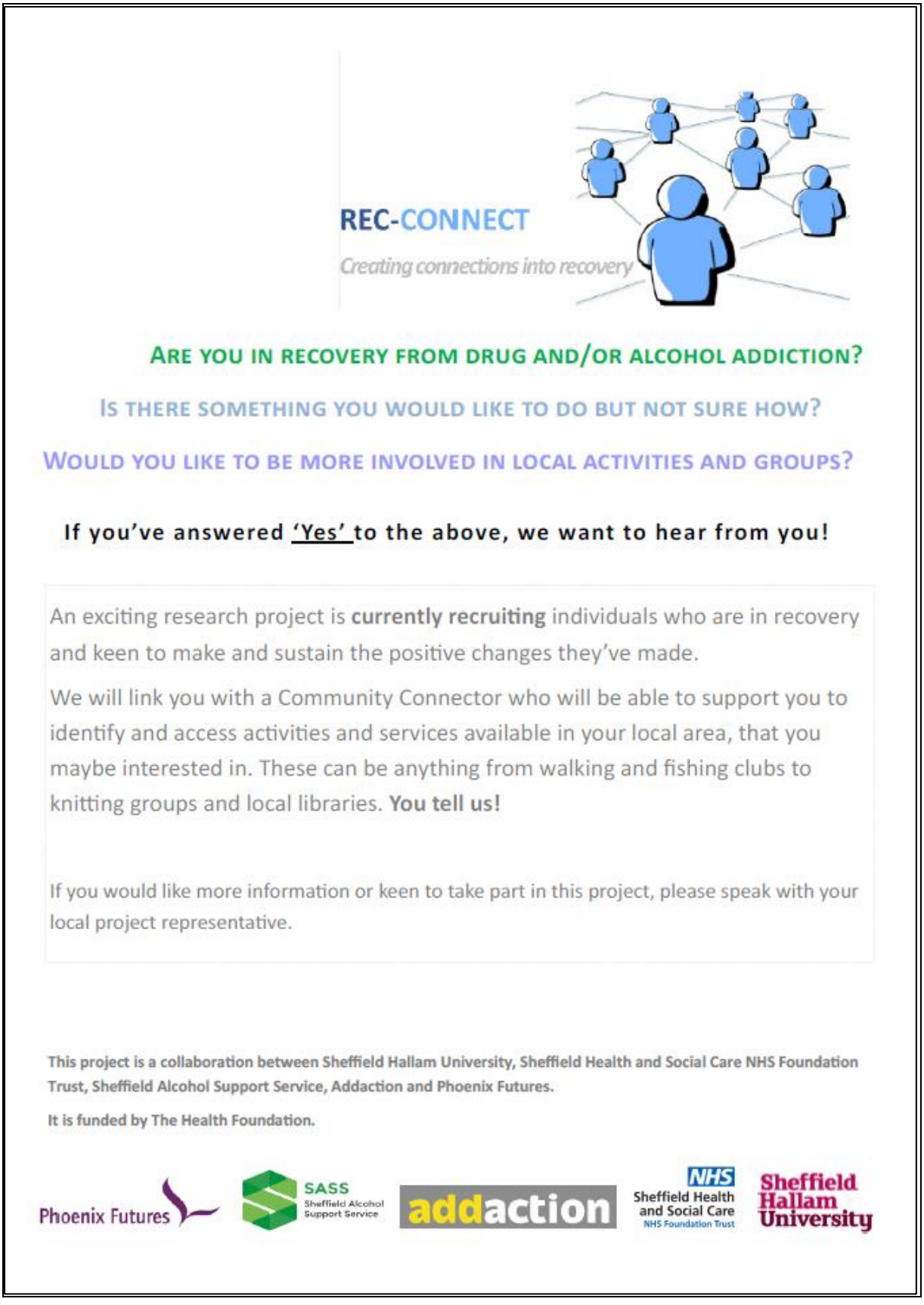
**Map 4. Volunteering, education and employment assets**




**ABCD Figure 1. Core/targeted assets**



## REC-CONNECT poster



- Media coverage

  http://www.thestar.co.uk/our-towns-and-cities/sheffield/recovering-drug-and-alcohol-addicts-can-rec-connect-with-sheffield-community-1-8423190

  https://www.shefnews.co.uk/2017/03/09/sheffield-launches-project-to-rec-connect-recovering-addicts-with-the-community/

  https://www.uk-rehab.com/blog/rehab/what-happens-after-treatment-in-drug-and-alcohol-rehab-clinics/

  https://www.sanctuarylodge.com/blog/project-helping-build-links-recovering-alcoholics-community/

  http://www4.shu.ac.uk/mediacentre/recovering-addicts-can-rec-connect-community

  https://shsc.nhs.uk/news/rec-connect-workshop-and-launch-01-march-2017/