Review of Local Lived Experience Mechanisms and the Effectiveness of the Recovery Support System in Sandwell – FINAL SUMMARY REPORT

Prepared by Linxs Consultancy Limited, Registered Office: 68 Kingshill Road, Manchester, M21 9HD, www.linxs.org.uk for Sandwell Council, 2023

Introduction

We were commissioned by Sandwell Council to undertake a Review of Lived Experience Mechanisms and their effectiveness in relation to substance misuse. We were also asked to review and to assess the current recovery support available.

The review has the aim of judging the level of involvement and recovery support that is available. This is especially within the context of the Government's most recent drug's strategy 'From Harm to Hope' which includes the desire to increase user involvement in services. In making an assessment of the current support available and involvement locally, comparative practice and models from elsewhere were also examined.

This report provides a summary of the issues raised in the review and culminates in a series of options and recommendations.

Methodology

As the central component of this research exercise we undertook a series of consultations with people with lived experiences of substance use. This related both to alcohol and drug use (the drug use included overuse of prescription drugs).

We consulted with a range of local stakeholders to gain their views on the current state of substance misuse provision in Sandwell and opportunities for development. We also spoke with representatives from organisations in a range of other areas identified from our literature review as having undertaken notable practice.

We thank all those individuals who took part in this exercise especially those who have experienced substance use; acknowledging their courage and openness in providing their experiences.

Local Situation

In relation to local provision and leadership Sandwell has a long established strategic partnership currently called the Sandwell Drug and Alcohol Partnership.

The commissioned specialist community substance misuse service in Sandwell is Cranstoun. This service covers a range of treatment options for both alcohol and drugs, along with recovery support. This recovery support includes a day programme, coffee mornings and peer support, along with providing links to the Kaleidoscope Plus programme. Clients can also be referred to West Bromwich Leisure Centre for a three month initial free pass. Cranstoun's contract was renewed from February 2023 including new requirements to deliver services, including recovery services, at locations across the Borough. This may ultimately include co-location delivery.

Education and training also form a part of the current offer for people who are recovering. For example people from the day programme at Cranstoun are offered the opportunity to undertake courses at Fircroft College. Fircroft College is a college specifically set up and designed to aid recovery. A variety of courses are available here and a number of those consulted had or were currently benefitting from them.

During 2022 a number of community based organisations (Cradley Heath Community Link, European Welfare Association, African French Speaking Community Support (AFSCS), Kaleidoscope Plus and West Bromwich Leisure Centre) were grant funded by Sandwell Council to provide additional recovery support.

The Blue Light Project is a Sandwell partnership initiative which includes Cranstoun, Sandwell Public Health, Police, Housing, voluntary sector organisations and NHS partners. It works with individuals who have failed to engage with alcohol and/or drug treatment and support and who place a high demand on public services.

The Alcohol Care Team at Sandwell and West Birmingham Hospitals Trust also provide treatment for patients within both Sandwell and City Hospitals who have alcohol issues. Once treated they then aim to refer patients to community based support, along with providing details of family support and of the various fellowships available.

There are also a number of other organisations who provide recovery support for individuals and their families. Many of these do not have this recovery support as their prime focus as they will incorporate responding to a variety of issues individuals who come to them have. These issues would include mental health, domestic abuse, homelessness/housing and employment and benefits.

Many statutory partners will also provide support as well; in addition to those outlined above these will include Adult and Children's Services and primary care.

The Probation Service also supervises a number of relevant orders from the courts. They supervise Drug Rehabilitation Requirements which are made at Court and form part of a Community Order or Suspended Sentence Order when it is assessed prior to Court that a person would benefit from support, and testing and/or substitute medication to help to rehabilitate them as part of a wider order.

They also supervise Alcohol Treatment Requirements which again can form part of a Court Order. These are targeted at people who appear in Court and have a dependency upon alcohol, locally an individual will have court enforceable appointments with Cranstoun to go alongside Probation appointments.

In the West Midlands they have also recently started working with CGL on an intervention, a Dependency and Recovery Order, which is designed to bridge the

gap between probation and community substance misuse services, offering psycho-social support and making referrals into community services where appropriate. The service is for men on a probation order or licence, who have some form of substance misuse, with the CGL worker supporting the individual at the Probation office.[1] It is a voluntary order but subject to sanctions for non-attendance.

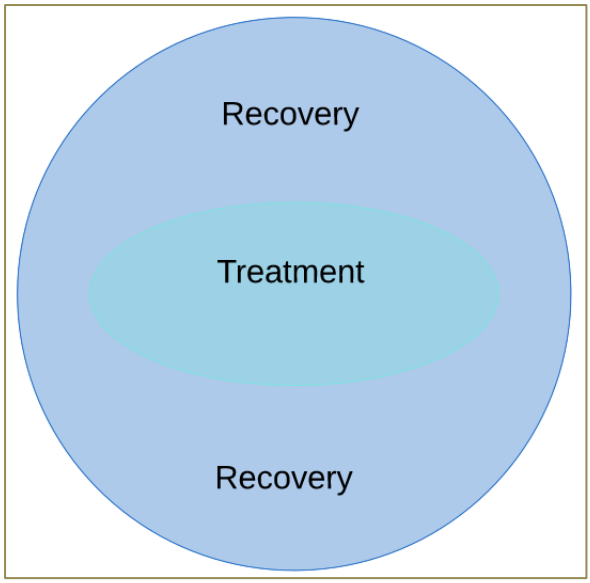
The Probation Service also has in place a peer mentors' scheme for suitable people on probation (not just those who have a history of substance misuse). If someone has a history of substance misuse they will need to be abstinent for a period of time to be deemed suitable. The role of a Peer Mentor is to offer support to a peer specifically around navigation within the Probation Service or wider community. At the time of the consultation, however, there were not any peer mentors in place at the West Bromwich office, a representative said this was partly due to the impact of Covid on recruitment.

[1] The Dependency and Recovery Pathway is provided via Black Country Women's Aid for females

Redefining Recovery

In order to examine the state of the recovery system in Sandwell, it is first necessary to provide a working definition of what 'recovery' actually means. There is a frequent assumption that recovery is simply the stage in an individual's journey that follows drug or alcohol treatment (or at least an intervention of some kind) – this is a gross over-simplification which leads to recovery becoming a poor relation to treatment within the substance misuse agenda, in policy decision-making and in commissioning. It also results in lip service being paid to the barriers which those with lived experience face at other stages of their journeys (including the point of first disclosure).

We would argue therefore that the relationship between treatment and recovery is not linear (see the diagram below). Rather, recovery is the entire journey that an individual undertakes to come to terms with their addictive behaviour(s), to reframe their sense of self identity and attempt to (re)connect with society. Treatment may play a part in this journey on one or multiple occasions, but it is not a requisite component. It is also about all agencies with any connection to the substance misuse agenda recognising that they are playing a role within recovery. For example, activity and leisure providers are vital components as boredom or the lack of daily routine can be massive factors behind relapse or delayed recovery.



Examining the Recovery Journey

A number of barriers and themes were identified especially from the consultations with those with lived experiences. These included the following:

Benefits of Peer Group Work

The vast majority of Cranstoun clients interviewed as part of this research were extremely positive about the value of the peer group recovery support that they had attended at the premises.

The attendees at the Cranstoun day group also described how they had created their own virtual WhatsApp community. This was felt to be particularly valuable during periods when group sessions were not available, most notably during holiday times.

It should be noted that this was also a particularly important dynamic because so many of the group had not found or been directed to any other source of recovery support, particularly in their own local communities. This is discussed further below.

A host of Cranstoun clients also stated that group attendance had given them the strength and desire to 'give something back' through volunteering or mentoring. It therefore represents a small but crucial first stage in the development of Sandwell's, and their, recovery capital.

West Bromwich Leisure Centre Pass

Through a Sandwell partnership initiative, a 12-week pass is available for Cranstoun clients to attend West Bromwich leisure centre for free as part of their recovery. Clients who had used the pass were interviewed and described the positive impact it had on them in terms of physical and mental well-being, as well as again helping to provide a structure to their daily regime.

Clients also made the vital point concerning societal reconnection as part of recovery, taking part in activities alongside other members of the population. Indeed, a representative from the West Bromwich Leisure Centre stressed the importance of the scheme in helping to reduce stigma for clients and staff alike.

There were other individuals interviewed, however, who were disappointed that they were unable to access the service due to their geographical location. They stressed the importance of exercise to their recovery, and felt it would be beneficial to extend the scheme to other leisure facilities across the local authority area.

Signposting and Referral for Substance Misuse Support at Point of Disclosure

It was readily apparent within the consultations that opportunities are being missed by professionals to encourage and support the disclosure of substance

misuse appropriately. Multiple consultees related how they had spoken to their GP but had not received any advice on sources of substance misuse support, or indeed any coherent plan for addressing their addiction or level of intake.

Disclosure is often a difficult and traumatic event for those with lived experience, especially if there are associated complexities such as domestic abuse or family breakdown. It should be the first step in the recovery journey, but failure to handle disclosure appropriately may lead to the entrenchment or escalation of the substance misuse, and a number of respondents felt that their subsequent significant health problems were at least in part attributable to the failure of their GP to support them appropriately. Rather, individuals related GP responses such as being prescribed anti-anxiety medications, sleeping pills and in some cases dismissal that there was an issue.

Respondents also highlighted the fact that just being provided with contact details for Cranstoun still left the onus completely on them to make the call, resulting in significant delays in the recovery journey.

There was a shared perception amongst those consulted that there needed to be more specialist support within primary care settings, both in terms of information provision and the availability of staff with sufficient expertise to understand substance misuse and actively support the referral process.

To a lesser extent, episodes with West Midlands Police were noted as a missed opportunity to engaging in substance misuse support at an earlier stage. For those individuals also experiencing domestic abuse, the failure of the attending officer to respond appropriately compounded the situation.

Department of Work and Pensions (Job Centres)

Job centre interactions were also cited as potential barriers to recovery. One example was particularly stark, with that individual feeling that she was treated in an unacceptable manner in being escorted by security (due to her being on Probation), a sentiment exacerbated by the fact that she had her two small children in attendance with her at the time. She specifically stated in interview that the experience had left her very close to relapse, and it was only due to her strength of character that she had managed to maintain her recovery.

A number of other respondents described interactions which indicate that there is a lottery of inconsistency, with some staff being far less understanding or sympathetic as to the impact of substance misuse upon fitness to work.

The role of advocacy in relation to accessing benefits can be crucial in overcoming some of these issues.

Experience of Mental Health Services

Given the intrinsic relationship between substance misuse and mental health, it is crucial for the recovery journey that there are appropriate and accessible

pathways between associated services allowing individuals to access mental health support at the right time for them. Of paramount importance within this is the removal of barriers into mental health treatment for those experiencing substance addiction, and that the addiction/misuse is framed sensitively by the mental health professional during any sessions which take place. All of these points came to the fore during consultation with both the lived experience and stakeholder cohorts.

Accessing mental health support was seen as a fundamental component of recovery for a number of individuals consulted, and the inability to access it in a timely fashion was a source of frustration.

For those with chaotic lifestyles and/or multiple needs the tension between the strict policy of closing cases due to a failure to attend appointments and the need to make support available at the right point in that individual's recovery journey was raised by a couple of stakeholders.

The issue of many IAPT referrals not being accepted if the individual was not yet abstinent was also highlighted as an institutional barrier in failing to recognise that addiction and mental health are inextricably inter-related.

For those individuals with lived experience who had accessed Sandwell Healthy Minds, there was widespread dissatisfaction as to the quality of the support they had received. Indeed there were multiple references to feeling "patronised" or "judged" which had detrimentally impacted upon their well-being and recovery.

Need for Longer-term 1:1 and Community-based Support

A dominant theme amongst the vast majority of those consulted was the lack of community-based support and longer-term 1:1 peer opportunities. Whilst those individuals engaged with Cranstoun are clearly benefitting from the peer networking afforded through the various groups on offer (especially the day group) it was noted during interviews that there seemed to be no obvious route map for them to 'step-down' from their reliance on Cranstoun and access peer support closer to their own homes. It was physical 1:1 and peer relationships locally that were seen as being important and missing. Similarly amongst those consulted who were not engaged with Cranstoun, the theme of not being able to access local substance misuse peer/mentoring support was recurrent.

Many of those consulted had tried AA or similar groups. Continuing in these fellowships was not their preference, but clearly many others do value this peer support approach.

What was particularly striking was how those individuals who were accessing other forms of specialist services (e.g. for domestic abuse) had established a longer-term 1:1 relationship with key workers (effectively filling the peer support gap), and that crucially these relationships were seen as absolutely key to their substance misuse recovery journey. Examples of engagement include:

- Black Country Women's Aid Community and Safe Accommodation Services for survivors of domestic abuse;
- Black Country Women's Aid 'Ask Marc' service which is a recently introduced project which provides community-based support for male survivors of domestic abuse;
- The Mariposa Project. This project works with women in the criminal justice system across Sandwell, Dudley and Birmingham. It engages with clients released from prison and on probation to offer key worker support and educational programmes to help women to avoid reoffending (this helps to provide a continuum of recovery and to break the revolving door of custody);
- The Blue Light Project. The project offers more intensive 1:1 support for this client group than would otherwise be offered through Cranstoun, including assistance to attend appointments and community-based visits.

Consultation with representatives from the Mariposa project (which is part of a wider Women's Justice Service model) revealed that they had begun to offer drop-in sessions as a peer support route for clients. They noted that attendees frequently speak about the challenges of longer-term substance misuse recovery support.

Within this research process the sheer volume of individuals with lived experience who were wanting to "give something back" through volunteering or mentoring was very evident. The only obvious route for these available was to offer to volunteer within Cranstoun. Whilst this is commendable, this does nothing to address existing barriers of access and support. There is a latent recovery capital which remains untapped and uncoordinated.

Lack of Information Concerning a Wider Recovery Offer

Research participants also felt that there was a lack of information provision about other organisations or activities that those with lived experience of substance misuse could tap into to aid their recovery journey. This related to information provision at all levels, namely: (i) within community venues; (ii) in primary care settings; (iii) in Cranstoun; and (iv) in Local Authority communications, social media and website materials.

The experience of individuals spoken with illustrated that there is a lack of a recovery-orientated infrastructure in Sandwell. Individuals need to be able to map out their recovery needs and plan how they are going to spend their time to avoid relapse in their own community. Outside of a reliance on Cranstoun group support, such a system is simply not present.

The relationship with the Community Link Recovery Café in Cradley Heath is an example of the need to improve systematic linkages and information provision. There is now an arrangement in place for the café to receive referrals from Cranstoun to the resource, which is able to link together people with lived experience and provide opportunities for training and IT skills development. However, a representative from the Café stated that, at the time of the

consultation, they had only received 3 or 4 direct referrals from Cranstoun within the past 12 months.

Supported Housing Accommodation and Resettlement

The recent Sandwell Local Authority housing system redesign has seen the introduction of a complex needs hub (2022) based at Holly Grange in Smethwick. This offers 33 self-contained flats with complex case officers providing wraparound support for clients and staff based on site, bringing in additional support as necessary to help avoid relapse. It is essentially a 'toe in the water' towards supported accommodation for individuals with multiple needs including substance misuse. The model then is for clients to 'step down' to move on accommodation, which would usually be either hostel accommodation or The Gables in Smethwick depending on the level of ongoing support needs. This can be a barrier within Sandwell as the supported accommodation sector often sees demand outstrip capacity (within Sandwell the private sector is heavily regulated which reduces options, albeit for the right reasons).

Consultation with supported accommodation providers revealed they are clearly playing a role within the recovery journey, though all these representatives did not explicitly recognise that this was the case. In other words, they provided clear examples of working with substance misuse clients to help their reintegration into society (absolutely key to recovery) but consistently referred to Cranstoun as being the only organisation offering any kind of recovery support within the area. Their support was instead seen as 'other' facing. This emphatically demonstrates the lack of any vision of a multi-faceted and holistic recovery system within Sandwell. Whilst this may not be a specific barrier experienced by clients, it represents a systematic barrier which inhibits ownership of the substance misuse agenda and associated growth of Sandwell's recovery offer moving forward.

Another example of this lack of ownership was demonstrated by the fact that one provider indicated that they simply provided their substance misuse clients with details about Cranstoun and left them to self-refer. As noted in the section on first disclosure, individuals with lived experience of substance misuse may find that step into a service the most difficult one to take, and need support to understand and make contact with Cranstoun.

A number of providers expressed their concerns about the issue of resettlement, citing the fact that it can be a particularly challenging and isolating time where there is a sharp break in service and support. The absence of any offer for clients, particularly those without a mental health diagnosis was specifically noted. An example was given of one client who was given accommodation through Housing Solutions after just three months of being clean of drug misuse. He stated that she was left isolated and there was no communication with any agency about her addiction and support needs. She ended up relapsing and her drug misuse became worse than was previously the case.

Volunteering Opportunities

It is widely recognised that volunteering following treatment and as part of the recovery process can be beneficial. 'Giving back'[2] is one of the 12 steps of various fellowships such as AA. However even when people recovering have not used this fellowship route, wanting to give their time and energies to assist others is seen as being valuable. This enables people recovering to inform others in a similar situation, or who were in a similar situation, of their experiences in the knowledge that information being provided is empirical. Being based on life experiences is seen as valuable by many. Volunteering also has the ability for people to gain confidence and repair self-esteem. It also can enable people to develop skills and be a springboard to future training and employment, whether that is in the organisation where they volunteer or elsewhere. However volunteering additionally has the benefit simply of enabling people to fill their time which may have previously centred on the use of substances.

In summary, managed appropriately and used at the right time in an individual's recovery journey, volunteering can and should have an important role to play - not least in enabling lived experiences to be shared with others. This would then further develop the local recovery capital.

(a) Current opportunities

At present there is the opportunity to volunteer within both Cranstoun and the Alcohol Care Team, although a representative from the Alcohol Care Team did state they had difficulty identifying appropriate volunteers. Volunteers are also used in a number of other settings and organisations that participated in the research. Examples include within Cradley Heath Community Link, AFSCS, supported housing providers and the European Welfare Association. However people recovering from substance use are not widely used, if at all, in all these wider examples.

The value of volunteering was highlighted by a number of individuals spoken with.

(b) Untapped potential

It has become apparent throughout the review, however, that there is untapped potential within specialist services, associated support providers and wider organisations to provide volunteering opportunities and pathways to development.

AFSCS, as an example, stated that they have a number of volunteers within their service who provide advocacy and deliver the white goods scheme used by those in substance misuse recovery. Yet none of these volunteers came from Cranstoun and this avenue had not yet been explored.

[2] Some consultees simply preferred the term 'giving' as they felt people did not have to 'give back'.

Similarly Cradley Heath Community Link had many volunteers in their service, most of whom were reported to have a range of complex issues, but a formal route between Cranstoun and themselves to encourage volunteering was not in place (indeed it was reported that only a handful of referrals had been made per se at the time of the consultation).

There is also a lack of knowledge of wider volunteering options in other organisations who could provide worthwhile activities to undertake. Such opportunities could be in food banks and charity shops but also, as will be seen later, as part of more formal programmes in leisure organisations or in gardening/landscaping based groups.

Developing these volunteering routes further is essential in order to ensure that the current untapped recovery capital is enhanced and built upon. Experience from other areas (covered later in this report) shows that this then has the potential to expand organically in the future.

For people to become volunteers it is necessary that they do so at the right stage in their recovery and for the right reason. They should be seeking to do so to provide others with an insight based on their experience, to share their real-life knowledge of the issues being faced, to gain confidence and learn new skills and to fill their time with worthwhile activities. It should not be used if they are trying to 'save' others or when their recovery process is still fragile.

(c) Overcoming stigma

The issue of stigma though is also relevant in another way and this is in relation to potential negative feelings of working alongside volunteers who are in recovery in organisations that are potentially providing these opportunities. As has been discussed elsewhere, a barrier to ongoing recovery is the stigma of having misused drugs or alcohol or the perceived stigma that this has in the eyes of members of the wider community. This also translates into people who work or volunteer in organisations where those in recovery may be placed. These people may be fearful of what they may encounter and have negative perceptions of what people in recovery are like. In turn this then can present a problem in that the leaders of these organisations could be reluctant to welcome individuals who are recovering.

However reducing and overcoming this stigma can actually be a goal in itself. The 'See Change' programme run in Birmingham by the DATUS LERO has set out to provide volunteering opportunities for people recovering in a variety of settings. These have included the Nature Centre in Birmingham, Lickey Hills Rangers, Birmingham University Museum, Canal and River Trust and Barber Institute and allotment associations. Whilst all of these organisations provide volunteering opportunities, and provide in many cases a 'reward' in return such as free tickets or a ride on a canal barge, a prime aim is also to overcome stigma. Here the people in these organisations work along the volunteers and can see that they are 'normal' people just like them.

Although in a slightly different context this was also seen for staff in West Bromwich Leisure Centre when the 12-week leisure pass was introduced. Although the people here were not volunteering ,the same sentiment was expressed by a representative of the service.

(d) Potential approaches

In order to overcome this barrier a first stage could be to map the potential volunteering opportunities available. This would help overcome the issues of not knowing what is available presently, and promote awareness of potential opportunities for those with lived experience of substance misuse within associated organisations. Following this initial stage work could then be undertaken to seek new organisations where opportunities could exist in the future if they knew that volunteering capital was available. This would likely involve, as the representative from DATUS stated, "literally knocking on people's doors as emails alone won't work". One stakeholder stated that this was an important step as:

> *"We need opportunities for the enrichment for people. The drug/alcohol use for is only a small part of what these people are; so we need to try and enrich their lives to aid recovery."*

There are options as to who could undertake this role; suggestions put forward in the consultation process included a volunteer themselves, a paid member of staff within the local authority or as part of a commissioned LERO/service provider package. Co-ordinating existing volunteering opportunities and publicising them to people as part of the recovery programme thus could be a relatively straightforward first stage. Later in this report the Sheffield model is highlighted, which takes volunteering opportunities to the next level by providing a formal rolling training and placement programme.

Once people commence volunteering and begin to see the personal and societal benefits of involvement they will potentially seek to progress further into more clearly defined peer support work. Mentoring and/or supervisory support may be required at this stage.

Creating a more defined and transparent volunteer pathway should in itself start to create a more defined notion of local recovery capital.

Lack of Education and Support for Families

The provision of support for families throughout the treatment and recovery journey is a crucial element within a holistic approach. Family members need to be empowered to support the individual in recovery, but they may also be deeply affected themselves, emotionally and physically, and need opportunities to reflect on their own needs, trauma and sense of self. Being in a position to assist with the recovery process will be of benefit to the individual concerned but this is often only possible if they have been supported and helped themselves. It

should never be understated that family members become 'damaged' themselves by the impact of the substance misuse and coping with a loved one in crisis. Family members may feel they do not need support or have become estranged from the individual concerned, but nevertheless it is important that viable support options are available and well publicised. Support can be especially powerful and seen as more credible if it is peer-based.

There is some limited support currently available for families and carers of those affected by substance misuse in Sandwell. Locally this comprises of the fortnightly families group at Cranstoun for families of clients in their service. The parents of a former drug user have also set-up Alternat-i-ves.org family support group; which is available via Zoom and is linked with the Alcohol Support Team. This group is accessed by families from elsewhere in the world as well as those locally. In addition national organisations such as Ad-fam and Al-anon are available for families to approach.

Many of those consulted, including individuals and parents themselves, felt there was insufficient support for families and also a lack of professional awareness of what is available. Consultations held showed the impact that the lack of family support can have: for example, one individual's recovery was clearly impacted by seeing the physical and emotional impact of her journey upon her mother. Further examples were provided where GPs had been unaware of family support services and had not signposted effectively. Specific support for children in alcohol dependent households was another area highlighted as being lacking.

The desire for greater support for families and friends and for the current support to be better publicised and signposted were seen as important priorities throughout the research process. Ideally this support would be provided by those with lived experiences of being parents, carers or friends of people who have used drugs and alcohol, but as important was that the tools and models being used were evidence-led. The development of recovery capital will be severely hampered without appropriate provision for families.

Culturally Based Support – Is a Faith Based Approach an Enabler or a Barrier?

Throughout the research process this question was one where differing opinions were provided by individuals consulted.

In terms of current provision services are available to all regardless of faith or culture. Efforts have been made to try and adapt provision locally to make it more inclusive. For example AA have a Cultural Liaison Officer in the West Midlands. This role is in place to try and ensure that AA services are relevant and inclusive for all, including to the South Asian population of which the West Midlands has a high concentration. One change this has resulted in is the instigation of a specific South Asian group that meets in a sports centre and not in a building linked to a place of worship, where many AA meetings occur (along with the availability of a dedicated Zoom meeting). Part of the remit of this role is also to look to address other barriers such as family structures within many

South Asian communities which can mitigate against seeking support, especially for females.

A separate company 'No More Pretending' has also been set up by the member of AA described above. This company aims to make alliances with other organisations, as AA itself cannot do so under one of its principles, and to try and encourage and promote cultural competency.

Cradley Heath Community Link is faith based being linked to St John's Church of England church. It has a weekly worship every Wednesday, though it has a non-judgemental philosophy and is available to all faiths and creeds.

From the consultations held with those individuals in recovery there were, though, differing viewpoints as to how linked, or not, recovery support should be to religious venues and organisations. The general view was that the important consideration was that support provided should be culturally aware and that those providing it should be culturally competent. This is not just in relation to South Asian communities highlighted above, but also for others including Eastern European communities where again family structures were said to play a (potentially negative) role particularly in relation to alcohol abuse. Support should be carefully designed to ensure that community and family structures do not dissuade people from seeking help and ongoing assistance.

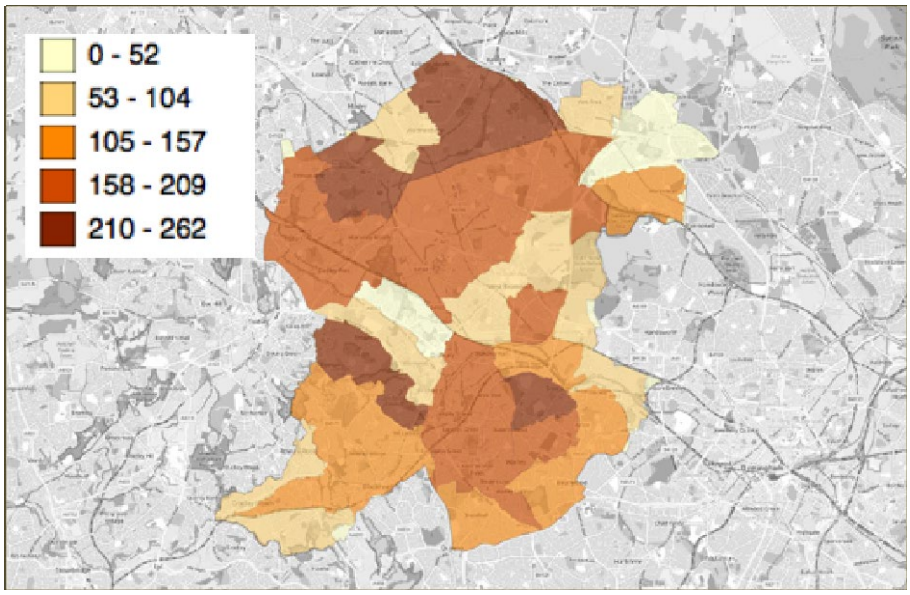
Neutral facilities and locations were felt, in some cases, to provide a safe space away from religion and from cultural pressures. The case of the AA meeting being held in a sports centre instead of the church hall provides an example of this. However, the promotion of support in cultural venues (such as temples) was seen by some consultees as being a viable and necessary measure. The need for greater visibility for recovery support (and treatment per se) for all ethnic and cultural groups was clearly recognised as being required.

Data Analysis

Cranstoun's centre for its recovery services is located in its Smethwick base, on the eastern boundary of the Local Authority area. In the absence of community-based delivery, both stakeholders and those with lived experience felt that geography was a likely barrier preventing some people from engaging (or at least fully engaging) in the current recovery offer.

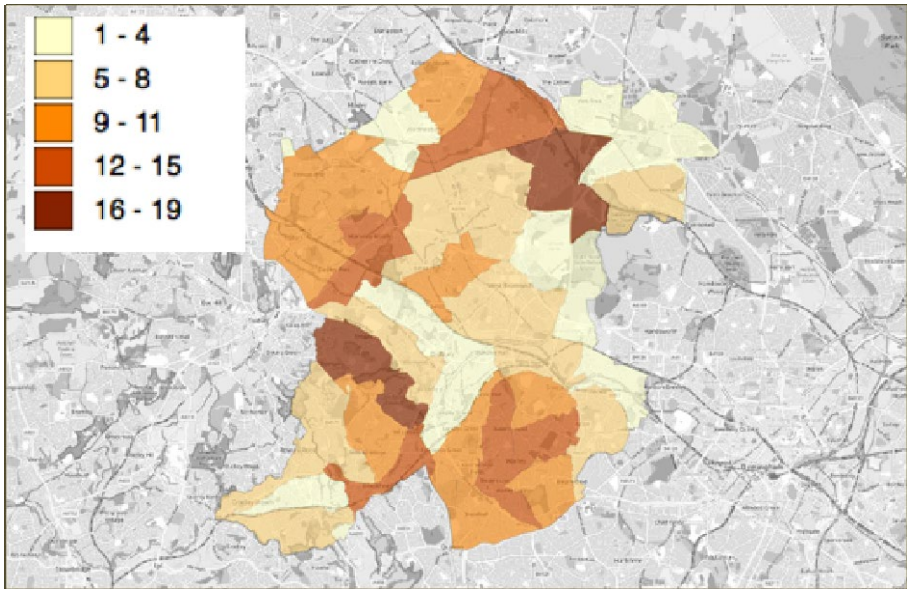
In order to examine these perceptions further, Cranstoun kindly provided service data since the start of 2020, which included demographic information and, crucially, attendance at recovery sessions. As a baseline for comparison, the following map shows the postcode sector of all Cranstoun clients in this period. The sector with the highest number of clients is shown to be B69 1 in Oldbury (262), followed by WS10 0 in Wednesbury (253), DY4 0 in Tipton (249), WS10 9 in Wednesbury (228) and B67 7 in Smethwick (221). These areas have the darkest shade on the map, with three of these sectors bordering each other at the northern end of the Borough.

Figure 1 - Cranstoun Clients by Postcode Sector (January 2020 - March 2023)



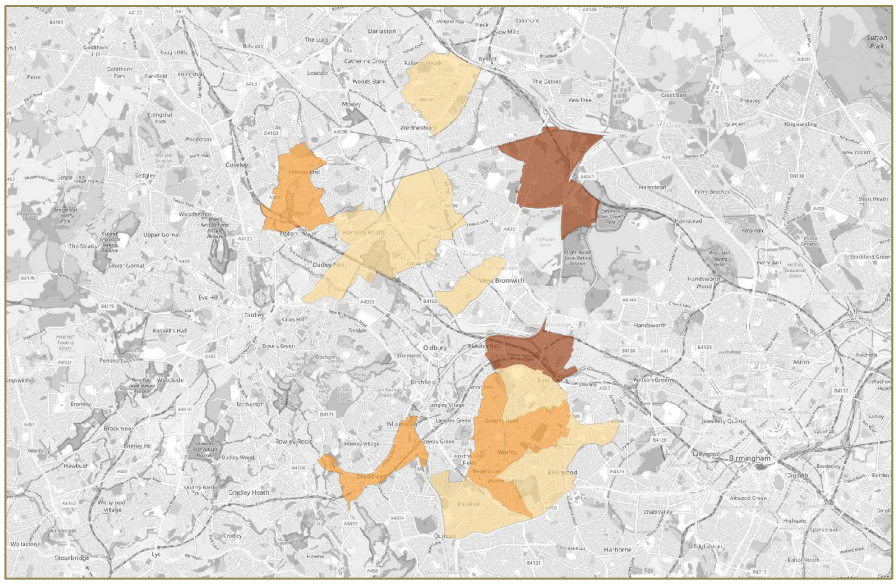
In figure 2, the focus is purely shifted to demonstrating the postcode sectors of those clients who had attended a recovery support group offer at Cranstoun. There may be some limitations in data collection techniques here so the actual numbers should be looked at with caution, but nevertheless the far lower numbers in attendance by postcode sector can be clearly observed vis-à-vis the overall number of clients, supporting the statement above, "they just come in for their 5 minute appointment and are gone." B71 3 towards the north-east of West Bromwich now emerges as the sector with the highest volume (19). There are noticeably fewer clients engaged in some areas of West Bromwich (Handsworth and Great Barr borders) as well as Rowley Regis in the south-west part of the Borough.

Figure 2 - Cranstoun Clients Attending Recovery Groups by Postcode Sector (January 2020 - March 2023)



The final map overleaf (figure 3) looks at patterns in recovery engagement further through the example of the day group. The map shows only postcode sectors from where at least 2 people have attended since 2020. B71 3 again features most prominently, with a notable cluster around Smethwick. However, there are areas that are absent from the map, including most of Rowley Regis.

Figure 3 - Cranstoun Day Group Attendance Showing Postcode Sectors with at least 2 Attendees (January 2020 - March 2023)



Demographic information relating to ethnicity, age and gender was also examined to understand any discrepancies in recovery group access. Figure 4 shows the ethnic category of all clients, those engaged in recovery groups and the relative census proportions respectively. There is a slight over-representation from the White-British population, which represents 65.8% of the Sandwell population but 69.0% of those who have attended a recovery

group. Most noticeable is the low proportion of all referred clients and recovery representation from the Pakistani and Bangladeshi communities, though the cultural taboo of substance misuse should be recognised as a factor here (making abstinence or the keeping of substance misuse hidden more likely).

Figure 4 – Ethnic Profile of Cranstoun Clients (January 2020 – March 2023)

Ethnicity	All Referred	Recovery Groups	Census
White - British	67.8%	69.0%	65.8%
White: Irish	0.8%	1.2%	0.7%
White: Other White	3.0%	2.1%	3.4%
Mixed/multiple ethnic groups: White and Black Caribbean	3.4%	3.1%	2.0%
Mixed/multiple ethnic groups: White and Black African	0.2%	0.6%	0.2%
Mixed/multiple ethnic groups: White and Asian	0.7%	1.2%	0.7%
Mixed/multiple ethnic groups: Other Mixed	1.1%	1.5%	0.5%
Asian/Asian British: Indian	12.7%	10.4%	10.2%
Asian/Asian British: Pakistani	1.8%	1.8%	4.5%
Asian/Asian British: Bangladeshi	0.6%	0.6%	2.1%
Asian/Asian British: Other Asian	2.6%	2.1%	2.4%
Black/African/Caribbean/Black British: African	0.6%	0.9%	1.4%
Black/African/Caribbean/Black British: Caribbean	2.1%	3.4%	3.7%
Black/African/Caribbean/Black British: Other Black	1.2%	1.5%	0.8%
Other ethnic group	1.4%	0.3%	1.6%

Finally, the table below (figure 5) demonstrates the age and gender profile. For both males and females it is noticeable that the age profile of recovery groups is older than the corresponding all clients figure, with higher proportions in all age categories above the age of 35.

Figure 5 – Age and Gender Profile of Cranstoun Clients (January 2020 – March 2023)

	All		Males		Females	
Age Bracket	Referrals	Recovery Groups	Referrals	Recovery Groups	Referrals	Recovery Groups
0-18	0.2%	0.0%	0.3%	0.0%	0.1%	0.0%
19-24	5.6%	3.3%	5.3%	3.0%	6.7%	3.9%
25-34	23.2%	19.4%	23.7%	21.4%	21.7%	15.6%
35-44	34.1%	36.1%	34.4%	37.3%	33.6%	34.4%
45-54	21.7%	25.2%	22.1%	25.4%	20.3%	25.0%
55-64	11.0%	13.9%	10.3%	11.9%	12.9%	17.2%
65-74	4.2%	2.1%	4.0%	1.0%	4.8%	3.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Mapping the Current State of the Recovery Sector in Sandwell

The following table draws from the consultation exercise with those with lived experience of substance misuse and wider stakeholders, in order to provide a digest of agencies and institutions that are playing a role within the recovery sector in Sandwell. The preceding analysis shows that for a number of those listed, there is variation in practice at an operational level that needs to be addressed, leading to barriers rather than support. It should also be noted that some are unaware that they are part of the recovery agenda – some of the supported accommodation providers are a clear example of this. This list is relatively small, and should be considered a reflection of the disconnection inherent in the recovery system and the clear testimonies of those interviewed who frequently alluded to the lack of other recovery opportunities conveyed to them.

Substance Misuse Services	Community Services	Statutory/ Commissioned Services	Leisure and Education
Cranstoun	Community Links Recovery Cafe	West Midlands Police	Fircroft College
Alcoholics Anonymous	European Welfare Association	GP Surgeries	Libraries
Al-Anon	African French Speaking	Job Centres/DWP	West Bromwich Leisure Centre
Alcohol Care Team	Sikh Helpline	Mental Health/ 'Healthy Minds'	Parks/Open Spaces
Cocaine Anonymous	Food Banks	Housing Solutions	Shaw Trust
Narcotics Anonymous	Dorothy Parkes Centre	BCWA (Refuge)	BBO Bridges (Walsall)
Kaleidoscope Plus	West Bromwich BID	BCWA (Community Services)	Recovery College
Alternat-i-ves-org		BCWA (Justice Services)	SUITS (Wolverhampton)
SMART Recovery		Ask Marc	
		P3	
		Midland Heart	
		Green Square	
		Trident Reach	
		YMCA	
		Sharp	
		Chadd	
		Phoenix House	

(Note there are no SMART recovery sites currently in Sandwell, the nearest being run out of CGL bases in Walsall and Dudley).

Lived Experience Involvement in the Recovery System in Sandwell

There are perhaps two distinct aspects by which those with lived experience can become involved in enhancing recovery support, these being peer involvement in services/support and a wider involvement in service and policy design. These are taken in turn below in relation to the situation in Sandwell.

Peer involvement in services is seen as a key aspect of recovery capital in that it both provides the opportunity for people to give 'back' along with sharing with others the benefit of their lived experiences. Such peer involvement can take a range of forms such as mentoring support, being involved in service panels to consult on current and future provision, providing training and delivery of aspects of recovery programmes (with appropriate training and supervision) and advocacy. Peer, mutual, support in itself is a fundamental aspect too of the fellowships such as AA and NA.

In Sandwell most of these types of peer support and involvement are in place; however, in general, the reach of its utilisation is not huge. In other words there is a tendency for peer involvement to be insular and silo-based, with those with lived experience becoming involved and staying with the one organisation that has supported them. This is largely restricted to treatment providers. There is little semblance of networking between organisations and external progression for those engaged in peer support. This is a fundamental restriction on the growth of Sandwell's recovery capital.

Cranstoun do have peer involvement in a range of aspects of their work with volunteers and former users embedded within their organisation. They also have a newly developed peer panel, the SCORE team, who also are involved in the delivery of the needle exchange and naloxone programme and providing mentoring support.

The Alcohol Care Team at West Birmingham and Sandwell Hospitals Trust has involvement of peers in their service. In this case they provide mentoring support and advice, especially when patients are awaiting treatment, with their presence reported to being welcomed, as outlined in the volunteering section earlier.

AA, and similar, also has peer involvement as a fundamental aspect of their operation. A representative from AA locally felt that the ability to draw on these lived experiences and enable people to relate with them was felt to be an important, and unique, aspect of AA.

However outside of these organisations there is more limited peer involvement in service provision especially in terms of those who are in recovery (as opposed to other issues individuals have faced). Cradley Heath Community Link does have broad spectrum peer involvement that is tailored to the wishes and capabilities of the individuals concerned. This involvement covers a range of aspects from cleaning and pricing up stock through to Barista training and management. As a wider community asset, this is not designed to be dedicated to

those from the recovery community. The options though are there for potential greater involvement in the future. The same can also be said for AFSCS and some of the supported housing providers consulted (P3 and Green Square Accord for example) where non-subject specific peer support plays a part in the provision residents receive.

In relation to the potential for involvement in wider service, system and policy design the picture locally is even more limited. At present any involvement is not system wide and is silo focussed within individual organisations, for example Cranstoun's user panel and SCORE team (as well as other organisational user panels). In the following comment, a representative from Cranstoun describes the importance and positive impact of this involvement within their own organisation, but also recognises its limitations in terms of its impact upon the Borough-wide substance misuse agenda:

"It has made them sit up and listen to those actively in treatment or entrenched in behaviour. It has helped us shape things in a practical sense with issues such as event timings and structure. I feel it is motivating for staff as well as they get something different and it allows service users to show something different. It is a break out from the 'groundhog day' of service.

We would like to have a panel that can formally consult locally which is not organisationally focussed. We have moved towards that with the SCORE group but there is a long way to go... We are super keen to have links to Lived Experience processes from other services."

This section (alongside the earlier ones on peer support and volunteering) demonstrate that there is unfulfilled potential in Sandwell to develop peer involvement. This can be seen is in relation to restricted volunteering options, peer support networks and opportunities to inform decision-making and strategic priorities. There is no, or certainly very limited, networking available between different organisations on this agenda meaning that overall empowerment to make a difference is also fundamentally limited.

At present this could be seen as a missed opportunity to develop greater community and personal recovery capital to build on the desire of so many to give.

An overall vision for developing responsive services could thus be seen as enabling individuals and their families, regardless of access points, to be well-informed and empowered to reach their full potential, to access appropriate recovery options, and to help promote recovery opportunities within their own communities.

Comparative Practice in Lived Experience Involvement

This section contains examples from elsewhere which address the barriers already outlined, especially in developing models of operation which have development of recovery capital at their heart.

(i) Sheffield

Sheffield was identified within this research as a local authority area which has invested significantly in the recovery agenda in recent years, and sought to enhance significantly the level of lived experience involvement. In 2017 the Rec-Connect (Recovery Connections) research project was launched which combined elements of co-production, community engagement and community asset mapping through a recovery connector model. A combination of substance misuse stakeholders and individuals with lived experience of substance misuse were trained to map assets linked to the recovery agenda, and also tasked to raise awareness of these resources. Further 'community connectors' were identified and trained through the project, who provided assertive outreach to help engage those who were new to addiction recovery into these local resources. The mapping exercise identified 134 community assets across the area, which is a stark contrast to those known to be involved in Sandwell.

Following on from Rec-Connect, Sheffield has now launched a Facebook Recovery Community. This initiative is totally separate from the treatment provider, and acts as a mechanism for advice/awareness on recovery-focused activities, as well as providing a virtual peer networking resource. For further information see https://www.facebook.com/sheffieldrecoverycommunity.

As a particular innovation, Sheffield now provides a Recovery Ambassador Scheme. This is a training and volunteering opportunity which is open to applicants in recovery from substance misuse. The scheme is commissioned by the Drug and Alcohol Coordination Team (DACT) at the local authority and delivered by the NHS Sheffield Treatment and Recovery Team (START). 24 individuals a year (in two tranches) receive weekly training sessions over a 6 month period. This is followed by a 6 month volunteer placement within a recovery asset. The intention is that the ambassadors serve as role models, not just by giving help and advice to other individuals struggling with addiction, but also by providing a lived experience perspective to the agency or service in which they are placed, enabling that service to be more responsive to addiction moving forward.

In terms of enhancing peer group support, Sheffield DACT has supported the development of a Smart Recovery Network across the city. They have a partnership agreement and licence with UK Smart Recovery, enabling them to nominate staff and volunteers to undertake Smart Recovery Facilitator training and subsequently to run groups within communities.

Key Learning Points:

- Historically individuals with lived experience have been used in Sheffield to map and promote recovery community assets;
- A Recovery Ambassador Scheme runs twice yearly, providing training and volunteer placements in recovery assets for individuals with lived experience;
- Sheffield Recovery Community is an active Facebook page providing information, awareness and peer support. In association with a published daily timetable, awareness of the recovery offer in Sheffield is maximised; and
- A Smart Recovery Network has been established in communities across the local authority as a viable route for peer group support at a local level.

(ii) Milton Keynes

SAMAS (The Support Advocacy Mentoring and Advice Service) is run by Community Led Initiatives in Milton Keynes. It is a distinct recovery service that is independent from the treatment provider, although good working relationships and pathways have been established. The commissioners of the service frequently use SAMAS as a means of providing ongoing feedback in relation to the treatment service.

Of particular interest in relation to the SAMAS model is the focus on long-term recovery. The organisation recruits a range of mentors that includes both volunteers and paid staff. Whilst lived experience of substance misuse is common amongst the mentoring cohort, experience is not absolutely necessary, with mentors paired based on assessment of interests and need. The support is community-based, with mentors arranging to meet individuals at local venues. Typically support includes relationship building, financial advice, advocacy and emotional well-being.

Key Learning Points:

- Preference for separate treatment and recovery providers to maintain independence;
- A longer-term 1:1 mentor in the community focus established as the modus operandi; and
- Group work is now also being implemented using the Smart Recovery Model.

(iii) The LERO Model – DATUS and Changes UK in Birmingham

In the course of the research representatives from two Birmingham-based LEROs were consulted; these being DATUS and Changes UK. Key elements of their approach and possible transferable lessons are outlined below.

DATUS

DATUS started in Birmingham 18 years ago and was developed by service users. The foundation came from the then legal requirement from Health and Social Care Act to have user involvement; however it then turned into a delivery arm,

including becoming an advocacy organisation. They deliver group work within the treatment system that is available at any stage of the journey and for as long as the individual wishes to access it. DATUS only employs peers, with 50% of the board and 100% of the volunteers having lived experience.

The group work philosophy is evidence-based, especially drawing upon the ACT psychological matrix designed by Kevin Polk in the United States. The focus is on longer-term recovery, using the matrix to enable those in recovery to notice where their behaviours are taking them to/from and how this is aligned with their priorities.[3] Mutual aid is also a cornerstone of the DATUS approach. Importantly, DATUS also have a family support group believing that this aspect is often ignored within recovery models.

An initiative which has been developed relatively recently is See Change, the idea being that those in recovery work as volunteers at an attraction or similar, and will then get something back in return such as free tickets or the use of an attraction. Groups worked with include the Nature Centre in Birmingham, allotment associations, Lickey Hills Rangers, Birmingham University Museum, Canal and River Trust and the Barber Institute. See Change is about challenging stigma and giving those in recovery some reward for their efforts locally. They have found that people need accompanying into the setting at first, but once engaged in volunteering they are confident to proceed alone.

A DATUS representative stated that a key benefit of having a LERO in the area is that it is "value based and is not there to make money." The recovery organisation also needs a good relationship with the local treatment provider along with a commissioner who understands the nuances of the relationship between treatment and recovery and can help to develop the organisational co-existence. Indeed, it was stated that the LERO needs to be 'stitched into' the treatment service in so far as it is like a 'golden thread' being visible throughout people's journeys, even if that is only being there 1 hour a week at a day programme. Having access to the LERO, however brief, at the start of treatment is critical so that the individual knows about them and can seamlessly become more involved over time.

Key Learning Points:

- A key factor is having local people to set up, implement and ultimately run the LERO;
- Having only peers with lived experience and a Board with 50% lived experience representation ensures that the LERO is a motivated and co-produced service 'for' people in recovery;
- A flexible and evidence-based approach to peer support is required. It is also crucial that it is not time-limited and made available to the individual from day one of their journey;

[3] DATUS is currently establishing a training portal to accredit individuals to deliver ACT matrix sessions, linked to the ACT academy in the USA.

- A close working relationship between commissioner, treatment provider and the LERO is essential;
- Offering advocacy means that barriers to recovery can be dealt with directly; and
- Developing a network of volunteering opportunities is a fundamental means of challenging stigma and promoting social (re)integration.

Changes UK

Changes UK offers abstinence-based LERO in Birmingham and Solihull. They were formally solely a supported accommodation provider, and now offer different stages of accommodation depending on the recovery needs of the individual.

Alongside the housing model, there is a Recovery Academy Programme providing accredited training for participants and peer support/volunteering opportunities. They currently have 48 staff members, 92% of which are in abstinence based recovery (including all front line staff), with a perpetual cycle of people coming into the service proceeding to volunteer, mentor and become members of staff.

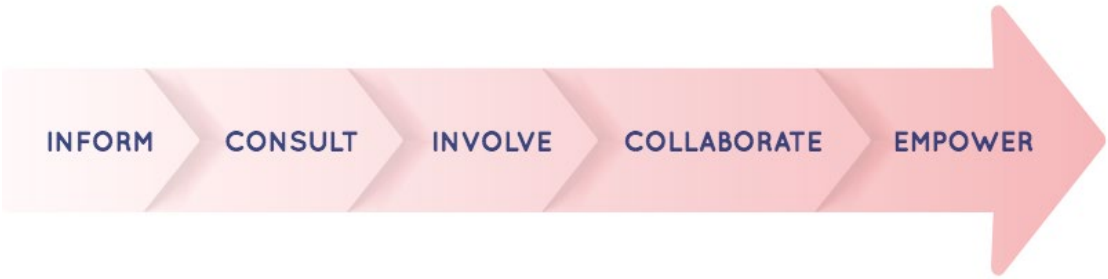
The organisation has expanded its offer further by developing a network of small businesses that provide vocational opportunities for clients, which have been developed based on the skills and interests of those in recovery. This includes a safe space landscape gardening business, a coffee shop, charity shops and IT businesses.

Key Learning Points:

- Having front life staff with lived experience is a core component of the organisational model;
- Clients are expected to engage in 1:1 support and volunteering; and
- Development of structured volunteering and vocational opportunities is a key facet in mobilising recovery capital.

Lived Experience Shaping Strategy and Design

As an emerging concept, co-production is often cited as being the 'gold standard' in terms of how to engage those with lived experience in shaping strategy and design. If we consider a ladder of engagement model, most activity locally tends to fall within the bottom two rungs: service users are either informed about changes which are to occur, or at best are consulted through surveys or groups as to proposed developments. The top end of the ladder is tangibly different. At this level those with lived experienced are empowered by not just being heard, but by participating alongside professionals in the design and delivery of public services, and areas of high influence.



Research suggests however that there is an inherent danger of tokenism if co-production is attempted but not delivered effectively. It may do more harm than good, particularly in relation to the mental health and wellbeing of those who have given their time to be involved.

In order to engage those with lived experience in an effective and meaningful co-production model requires ensuring that the following key factors are taken into account:

- Genuine Relationship Building (Co-production should not be seen as short-term. It needs longevity to be effective. Participants need time and opportunity to build the relationships that will lead to richer conversations).
- Clarity About Influence/Expectation Management (As in the Swedish research above participants may become frustrated at any seeming lack of influence of the created structure or process. Having a clear plan as to how influence will occur and what constraints exist is essential).
- Feedback (Aligned to the issues of influence and expectation, any co-production process needs to ensure that participants are routinely informed as to any developments that have been implemented or being considered. Those engaged will have signed up to make a difference and therefore need to be fully cognisant of the status of change).
- Addressing Power Imbalances (The process will involve a combination of those with lived experience alongside professionals. There is a need for careful handling and some initial strong leadership to broker democracy and a healthy group dynamic: a mutual

understanding that views have equal weight. There is no space for professional privilege in an effective model).
- Support (Consider what support those with lived experience need to become effective participants within the process. This is likely to include capacity building such as bespoke training sessions on subject knowledge and personal development, as well as risk assessments and safeguarding to minimise the risk of traumatisation.[4]

(i) Brisbane (Australia) Peer Participation in Mental Health Services

In April 2016 the Peer Participation in Mental Health Services Network (PPIMS) was established as a mechanism for peer networking, development opportunities to expand workforce potential and co-design processes. It includes individuals and carers with lived experience of substance misuse, mental health and suicide. PPIMS now has a membership base of more than 300 people, with monthly meetings attended by around 25-35 individuals. PPIMS is not a legal entity; rather it has established as a network with a set of guiding principles and objectives as to its purpose. It is coordinated by one individual who is the Project Officer for Lived Experience Networks within the Brisbane North PHN (Primary Health Networks).

Progress and achievements to date have been notable, including:

- Rapidly growing membership with an associated Facebook page that has representation from a range of high-level strategic committees at a regional, state and national level.
- Regular capacity building initiatives for participants: This includes scholarships to undertake accreditation (e.g. Certificate IV in Mental Health Peer Work). Other training opportunities provided include first aid training and 'Speaking the Truth' which is a module about power brokerage and how individuals can effectively share their experiences with professionals.
- Use of the network to provide submissions to government on policy issues.
- Co-design processes. Two examples of this are (i) involvement in the creation of the 'Planning for Wellbeing' regional strategy and oversight over implementation of the lived experience element of the strategy; and (ii) working with the Police to consider the effectiveness and sensitivity of first responders.
- Promotion of paid job opportunities amongst partner organisations.
- Some participants have also developed their own peer network meetings or Community Interest Companies within the sector.
- Guest speaker sessions.

[4] University of Melbourne: *The Family Violence Experts by Experience Framework* (2020)

Key Learning Points:

- PPIMS serves as both a peer network and a vehicle for co-production.
- The PPIMS network meets the research criteria for effective co-production, including capacity building for its members, genuine relationship building, dealing with power imbalances, expectation management and feedback.
- Resource implications are minimal. The network is administered by one Primary Health member of staff with a pot of funding for hosting events and catering.

(ii) Sheffield Co-Design Approach

In Sheffield co-production activity has come via the Changing Futures Programme[5] which is a national programme funded by the Department of Levelling Up, Housing and Communities and the National Lottery; there are 16 sites across the country. The aim of the programme is to develop learning and service change to improve services for multiple disadvantages of which substance misuse is one. Sheffield's work is a follow-up to the Fulfilling Lives Programme that was previously in place in the city and it has used learning from that programme. Principally this learning was that it is hard to change a service if all the funding resource is in the 3rd sector as you need to get buy-in from statutory sector to make changes. For this reason the programme is located in Public Health and is embedded within the statutory sector.

There are 2 elements to the programme:

1. Operational: at present there are 81 adults in a cohort and they have a multi-disciplinary team working with them. These are particularly vulnerable and disadvantaged individuals;
2. System change: System mapping to look at what works, identify needs and opportunities to modify approaches.

Co-production is a key cornerstone of programme. Part of the process has involved investing in 20 co-production associates who are trained to take part in elements of work such as strategy reviews, acting on evaluation panels for services, aiding with design specifications, sitting on recruitment panels and providing ad-hoc consultancy. The associates also go out to community groups to obtain feedback and strengthen the lived experience voice in the city.

A large element of the programme is also data driven. Through a robust service mapping process they have brought together a range of different datasets and cross-refer them to inform delivery. For example cuckooing was not recorded in Sheffield but anecdotally was highlighted as a problem during consultation exercises. They searched records across datasets and talked to victims of cuckooing to enable them to inform the work, thus combining data analysis with a lived experience approach.

[5] www.changingfuturesheffield.info

In relation to recovery, the Changing Futures programme also serves to champion Social Connections, echoing the previous work delivered in Sheffield on the Rec-Connect agenda. Sector mapping has provided details of over 300 groups that those in recovery could access free of charge, and discovered the stigmas that prevented individuals from attending.

Key Learning Points

- Developing co-production takes a lot of work and setup time to do properly. However, once embedded, it becomes seen as part of the usual way of operating;
- Co-production associates need to be drawn from a range of agencies and not the 'usual suspects';
- Training is a key not just for the co-production associates but also from partnership members to create equity;
- Mapping of services needs to be detailed to uncover real need; and
- The role of 'social connections' in recovery is important, revealing who can help and supporting their capacity to do so.

(iii) St Helens Domestic Abuse Forum

A further example from a different sector concerns the Domestic Abuse Forum in St Helens. This was established in 2021/22 as a mechanism through which to enhance lived experience involvement in information gathering, priority setting and strategic input. 30 survivors were recruited through multiple agencies, with each applicant undertaking a risk assessment and interview as part of the selection process focusing on understanding where they were on their recovery journey, what triggers for trauma existed, and what they could offer and wanted to achieve through involvement in the forum. The process is supported by just one member of staff within the local authority, who describes herself as an "authentic voice coordinator." She has enhanced the forum's capital by delivering a bespoke training package for all participants based on SafeLives materials. A representative from the forum now also sits on the St Helens Domestic Abuse Strategic Partnership.

Key Learning Points:

- Recruitment of survivors from multiple agencies to ensure a breadth of experience and previous sector engagement;
- A robust recruitment process including interview, risk assessment and training to enhance the benefit of participation;
- Forum representation at the Strategic Partnership; and
- The need for full strategic buy-in to mitigate against tokenism.

Recommendations

Outlined here are a range of recommendations that are based on the issues and themes outlined above. These recommendations are in two parts; firstly there are a number of options and service reconfiguration options that could be selected as a way of moving Sandwell along the ladder of engagement. These options are not mutually exclusive and could also be implemented as incremental steps towards the end goal of achieving full empowerment. Secondly there are a number of 'hygiene' recommendations that should be considered no matter which option or model is examined further. Primarily these are intended to reduce the barriers to recovery that have been encountered by those with lived experience. These are taken in turn below.

Possible Reconfiguration Options

At present the level of lived experience engagement in the substance misuse agenda is at the bottom end of the engagement ladder spectrum. Participation is restricted to silos – i.e. volunteering within the treatment organisation that the individual has attended. There are also no coordinated opportunities for those with lived experience to establish their own community peer groups, and no real possibilities for them to influence wider policy making and strategy.

To increase participation towards 'involve' on the ladder requires focusing on two key areas. Firstly consideration should be given to how best to tap into the large number of individuals who want to give 'something back' and want to introduce locally based peer support. The initial step would be to identify and consult with this cohort to examine such issues as:

- What would the group model look like?
- How can geographical coverage be ensured?
- What are the training needs?
- Does it need a constitution?

In the comparative practice review it was noted that Sheffield have used the SMART Recovery model as their 'off the shelf' approach to developing a peer support network. They have a partnership agreement and licence with UK Smart Recovery as means by which to facilitate online training for volunteers to prepare them to run their own groups. A similar approach could be adopted in Sandwell.

The second element is the development of volunteering opportunities and of mapping activities for people to use. Both of these enable people to fill their time and provide a focus to their ongoing recovery. Volunteering also provides people with the prospect of giving their time to help others. However to make this process happen the following steps are required:

- Identification of volunteering opportunities. Some of these will be with associated organisations (consider for example the African French Speaking Community Support link which is not currently being exploited). To find others, a more proactive approach would be required;
- Coordination of volunteering, both in terms of ensuring people can be matched with an appropriate opportunity but also that they remain current and up to date. Making sure that appropriate support and, if necessary, training is provided also would be required;
- The mapping of activities should be constantly refreshed and be available for workers within the treatment/support providers but also for individuals and possible referrers themselves to access. The use of a Facebook group, or similar, as in Sheffield should thus be a consideration to be implemented. A further creative idea would actually be to engage those with lived experience themselves to undertake the mapping process as an aspect of volunteering.

There are also options on how and who manages and delivers this co-ordination function. These in themselves could place the activity at different points of the ladder. One option, as is used in Sheffield, would be for the employment of a staff member within the local authority (or partner agency) to undertake this role. This could be under the supervision of existent staff. A further option would be that a volunteer themselves could undertake this role which could also then provide a springboard towards employment at some point in the future. This function also could be within the remit of a specific recovery organisation such as a LERO (this function could also be implemented in the interim prior to developing the LERO model).

In terms of volunteering opportunities, the Recovery Ambassador Scheme used by Sheffield is an example that takes engagement further up the ladder towards collaboration. The scheme embeds volunteering within a committed partnership network, ensuring that valuable opportunities are provided to reach peers in many parallel sectors, including housing, employment and family support. Further, the provision of a lived experience perspective to the service in which the individual is placed enables the service to be more responsive to addiction and recovery needs moving forward. The Recovery Ambassador Scheme is a

long-term rolling programme with two tranches per year, which includes an extensive training regime. Consideration could be given as to whether a similar scheme could be established in Sandwell.

As was seen earlier in the report, especially in the section focussed on lived experience involvement locally, a key gap in Sandwell is in relation to a user panel or forum. From the consultations held there would appear to be a willingness locally to instigate this function and thus it is recommended that this option be explored. Such a panel could be used in a variety of ways such as being used to consult on local policy and strategic priorities, being involved in partnership activity, involvement in service developments and being a conduit for enabling user voices to be heard.

If this was instigated then learning from comparative practice suggests there a range of facets that should be considered. These include:

- The need for strategic buy-in to the panel and the feedback provided;
- Ensuring a breadth of experience is included and a variety of representation;
- Representatives should be refreshed to enable progression for those involved, enable others to become involved and to reduce the likelihood of people becoming seen as being part of the 'establishment';
- Training should be provided both for the individuals themselves and the members of the strategic partnership so that principles such as mutual respect can be embedded. The recruitment process used should aim also to be inclusive across all relevant services;
- Having a peer network, such as that in Brisbane, is also a potential way of organising this function. Such a network would have the advantage of being both flexible but also peer led; and
- To be truly at the empower end of the spectrum the approach should facilitate full co-production of services based on the following key principles:
    - Genuine relationship building and a long term commitment;
    - Clarity about the influence being afforded;
    - Routine feedback on developments made due to co-production processes;
    - Ensuring that power imbalances are addressed; and
    - Comprehensive support for participants.

Developing a local LERO is the ultimate model for achieving empowerment. If this were to be considered then resources would need to be identified to support

and deliver this model of operation. Based on the DATUS model outlined earlier this organisation would have a number of elements within it. These would include:

- Mutual aid group work – based on evidence-led methods;
- Experiential volunteering programme such as the See Change model outlined earlier. Here volunteering opportunities are provided in exchange for a 'reward' whilst tackling stigmatisation; and
- Advocacy – people receive 1-to-1 support again being peer-led to respond to any issue that is a barrier to an individual's ongoing recovery.

The recovery organisation would need to have a close relationship with the treatment provider and be visible throughout the treatment process such as the day programme. It is likely that it would take approximately 6 months to commence some aspects of this model. This would enable participants to be identified and a work plan including volunteering opportunities to be developed.

Recommendations for Service Improvement

After outlining these possible options there now follows a series of recommendations that can be implemented regardless of which reconfiguration options are progressed:

A Community-Based Recovery Offer

There is clearly a need to ensure that recovery support is available across Sandwell and its towns. This means not only developing a network of community-based support, but also actively and systematically promoting the awareness of recovery provision to all partner agencies and through social media. This would inextricably link to the reconfiguration option of developing local peer-led groups, and Cranstoun's move towards locality-based working will also be beneficial. However the need is greater than these facets alone. Far too many respondents stated that they had no option for support in their own community, and had not been signposted to other activities. Increasing knowledge of available activities such as leisure, crafts, sport, education etc. is crucial. This also means promoting awareness amongst the organisations and groups themselves, as well as potential referrers (e.g. GPs), that they can play an important role within the recovery nexus.

West Bromwich Leisure Pass

Linked to this point several people consulted with valued the availability of the leisure pass at West Bromwich leisure centre. This was seen both as a way to undertake meaningful activities to fill their time but also as a way to integrate themselves back into wider society. This scheme should be continued if funding allows, but consideration should also be given to whether it could be expanded to other leisure centres/facilities elsewhere in the borough to promote uniform accessibility across the six towns.

Appropriate Response in Primary Care Settings

GPs can play a vital role in identifying signs of substance misuse and then referring people on to services. However there were many cases highlighted, including those depicted in the journey maps, where the GP contact was a lottery. In some cases a knowledgeable and approachable GP did make a difference in commencing the treatment and recovery process, however in many others this was not the case. This included examples provided where families approached the GP for assistance. This lottery of first contact should not be the case especially given the NHS's Make Every Contact Count initiative in place along with a number of screening and brief intervention tools available.[6]

The IRIS programme in relation to domestic abuse is successful nationally and locally in Sandwell in training GPs, and other primary care staff, in recognising the signs of domestic abuse and then providing knowledge of how to respond appropriately. A similar programme, or at least one incorporating the key aspects of it, should be considered for substance use to assist raising awareness and access to available services and support.

First Responder Responsibilities

Although the lottery of contact was reported in more cases in relation to GPs, it was also seen for other first responders to incidents including West Midlands Police. Similar awareness raising programmes covering assessment and brief intervention tools, the use of appropriate language, and also knowledge of available support, should also be considered. Crucially, this would stress the responsibility of first responders to take advantage of windows of opportunity that present themselves to help people to commence their recovery journey.

Accessing Mental Health Support

A common theme in many of the consultations held with both representatives from organisations and those with lived experience was in relation to issues faced gaining appropriate mental health support. Whilst, as with many services, mental health services are under pressure with the volume of caseloads better pathways for people with substance misuse issues into mental services should be explored. The testimonies of a number of individuals who highlighted a perceived inappropriate response also requires further investigation.

1:1 Longer-Term Recovery Support

A host of individuals spoken with highlighted their desire to have ongoing and longer-term one-to-one support alongside that received from the groups. Indeed there were numerous examples provided where individuals had received this one-to-one support from other non-substance misuse specialist agencies such as Black Country Women's Aid. They frequently stressed how the dedicated

[6] These include the locally produced Sandwell Complex Risk Assessment Tools and Sandwell Brief Intervention Tools that have been developed for both alcohol and drugs. These can be accessed by anyone, including professionals, from: www.ourguideto.co.uk

support offered had been a pivotal period in their recovery journeys. Measures to increase the availability of some form of longer-term one-to-one support should therefore be considered. Whilst peer mentoring could be part of the reconfiguration models outlined above, the need for added service flexibility to provide this level of personal support as an aid to ongoing recovery and crisis prevention should be examined in any case. This could, for example, take the form of an enhanced floating support offer for individuals exiting substance misuse or partner services (consider for example how representatives from the Blue Light Project, Mariposa Project and supported accommodation providers highlighted the vulnerability of clients to relapse after ending their periods of intensive support).

Substance Misuse Support within Supported Accommodation

Representatives from supported accommodation providers consulted with highlighted the need for greater integration between substance misuse and housing provision. One practical way in which this could be achieved would be by having a specialist treatment worker available to undertake outreach sessions at the various properties concerned. This would have the benefit of delivering some services locally, reducing the need to travel and reducing the barrier of access and the potential for 'no shows'. However it would also integrate these providers more into the treatment/recovery process. Having a worker on site even on a rota of one day a week would increase the visibility of the service and the staff within the properties could build a greater relationship with them.

Availability of Family Support

Providing support for family members is key to strengthening the individual's recovery journey and resilience to relapse. Families can be a key source of support, but can also face significant emotional and physical toil in caring for a loved one affected by substance misuse. Current support that is available for family members in Sandwell is limited. Moreover, knowledge about how to access it is not easy to find, and a number of individuals' recovery journeys were compromised by the difficulties in finding support for family members. Efforts to improve the visibility of current services and enhance the support available should be considered. If an enhanced recovery offer is developed via one of the models above, family support should be seen as an essential component.

Recovery Support Regardless of Cultural Background

Current services in Sandwell are available to all residents regardless of culture or ethnicity. Ensuring that people are confident in accessing the support available and are knowledgeable about it is an ongoing challenge. The data analysis earlier in the document regarding the ethnicity of clients at Cranstoun accessing recovery support also showed those of Pakistani and Bangladeshi heritage were under-represented; other ethnic groups were largely similar to Census data. Different views were expressed as to how linked support should be to religious organisations and venues. However, what should be of key importance is that all services should be culturally competent. This would mean that they seek to

ensure on a continuous basis that they are truly accessible for all and that there are no barriers in place that would prevent people seeking support.

This is not to say that services do not do this at present; indeed examples were provided of where they do. It is merely stating that they, and the individuals within them, should continue all efforts to ensure anyone who wishes to gain support knows about services or groups and feels comfortable accessing them. This must necessarily be tied to greater publicity of the recovery offer.