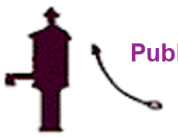
DERBYSHIRE County Council

Community-Based Drug and Alcohol Dependence Recovery Services: A Narrative Review



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1 EXECUTIVE SUMMARY

This narrative review sought to address 3 aims:

1) Explore critically appraised academic evidence underpinning community-based recovery services.
2) Describe delivery models for community-based recovery services.
3) Provide case studies of UK-based recovery services in the community that stand alone from drug treatment services – preferably in a shire county like Derbyshire.

This first aim was addressed by initially specifying what is meant by recovery. Although there is no one definition, various definitions do share common elements – including those that highlight the importance of social engagement and self-direction. These elements are seen in the individual processes involved in recovery. For instance, the CHIME (Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment) model of recovery proposed by Leamy *et al*. (2017) includes processes that involve rebuilding a sense of identity, rebuilding one's life, and receiving peer support. The constituents of this CHIME process model were echoed by a working group of strategic, therapeutic, and community stakeholders who described recovery as "a reality that grows from within and is supported by peers and allies" (Best *et al*., 2013, p.176).

Overall, the processes involved in recovery can be facilitated through recovery capital (RC) – i.e., the resources that individuals in recovery need, and gain throughout their recovery journey – which includes social (e.g., positive social networks), community (e.g., support groups), and personal (e.g., resilience) RC. Amongst this, social capital (e.g., strong family and friend relations) is especially important in the initiation of recovery, seeing as this part of the recovery process requires high levels of trust in others. Social RC can be gained through peer-support services, mutual aid support groups, as well as recovery residences (i.e., this describes community RC), and can also lead to positive outcomes (e.g., in mental health – i.e., personal RC) – highlighting the synergy that exists between social, community, and personal RC.

A way of facilitating this process of RC-building is through Asset Based Community Development (ABCD), which is the process in which community assets (e.g., support groups) are identified and mapped out, increasing their visibility and access pathways. Individuals can then be connected to resources that are appropriate to them via the process of assertive linkage. This process of mapping and linking of resources can be carried out in a more structured way through Asset-based Community Engagement (ABCE) – where a recovery navigator works in partnership with

the individual in recovery to identify resources that will be beneficial to them. “If done successfully, engagement with community resources that are pro-social and afford access to meaningful activities not only provides a platform for personal development and improvement, but also can trigger a social contagion of positive behaviour and improve connectedness within communities” (Collinson & Best, 2019, p10).

Creation and utilisation of these networks that serve to support recovery across communities can be seen in what are termed as Recovery-Oriented Systems of Care (ROSCs) – whose goal is to “sustain long-term recovery for individuals and families impacted by severe substance use disorders” (White, 2008, p.13). This addressed the second aim of this narrative review – where case studies were used to illustrate the function of ROSCs (which, in turn, addressed the third aim).

ROSCs have been shown to emerge through informal activities – for example, through the creation of working groups consisting of strategic (e.g., commissioners), therapeutic (e.g., staff in specialist services), and community (e.g., individuals in recovery) stakeholders. Partnership and links between these groups and professional services allows for an informed direction to be taken in identifying, creating, and promoting community resources and activities. This essentially creates a rich, effective, and accessible environment through which individuals can accrue RC – ultimately aiding and facilitating recovery across the community.

ROSCs can also involve more formal/’pre-built’ structures from their outset. For example, Recovery Community Centres/Hubs (RCCs) – which are run by peers (e.g., those in recovery, their friends, or family), offering recovery-related workshops, training, meetings, services, and social events. RCCs are also intentionally situated in visible and prominent locations within the community – which, in addition to providing the benefit of accessibility, places a positive identity on recovery and support services that support it.

As well as RCCs, ROSCs can also utilise the expertise and work of Recovery Community Organisations (RCOs) – which are independent organisations run by representatives from the local recovery community. RCOs may work with other organisations in engaging with individuals who are candidates for recovery or are already involved in the journey. This may be through “advocacy activities… recovery-focused community education and outreach programs, or… [by providing] peer-based recovery support services” (Valentine, White, & Taylor, 2007, p.1).

The multi-faceted support provided by the various elements that can make up ROSCs (e.g., training, social events, support groups, and workshops) mirror the multi-faceted aspects of recovery, as described by Dennis *et al*. (2007) (e.g., vocational engagement, peers associated with, and social support). Furthermore, this multi-dimensional quality of recovery is also seen in the various types and measures of recovery outcomes. For example, the case studies described in section 9.3 measured recovery across various domains including living status, mental health, and school/training enrolment.

Although these recovery measures can be quantified within these domains, and trends might be seen within them, the measures themselves should be interpreted with some caution. This is partly because short-term recovery (especially in the first three years) should not be used as a measure of long-term recovery (Dennis *et al*., 2007). Furthermore, it has been stated that one issue that community recovery services face "is that they frequently will not fare well on standard outcome indicators" (Best & Hennessy, 2021, p.5). "That is, because many of their clients will already have detoxed and overcome their acute problems with substance use, risk, offending and housing, there is a limiting 'ceiling effect' on the reduction of pathology relative to medication assisted treatments, intensive outpatient, and other acute clinical services" (Best & Hennessy, 2021, p.5).

RC as a measure of recovery might be a solution to this issue – as it "allows for regular monitoring of strengths and emerging capabilities that are associated with improvements in wellbeing and quality of life" (Best & Hennessy, 2021, p.5). Two such tools which have been shown to be effective are the Assessment of RC (ARC) and its briefer version, the BARC – which are both concerned with personal and social RC. In relation to community capital, another tool, REC-CAP, was recently developed, and "is… built on the ARC and several other recovery-oriented measures to create a strengths-based model for recovery care planning and community engagement" (Best & Hennessy, 2021, p.5; Cano *et al*. 2017). Furthermore, RC as a measure of recovery is not just useful as a proxy for measuring and identifying strengths and barriers to recovery. It can also act as a vehicle for "building trust [in the individual in recovery] through discussing growth and wellbeing rather than pathology and illness" (Best & Hennessy, 2021, p.5).

The benefits of RC, which can be facilitated by ROSCs, have been described above with regards to facilitating and measuring recovery. Indeed, "it is a combination of the accessibility and relations amongst assets that lead to successful community development" (Collinson & Best, 2019, p.3). However, the mobilisation of community resources and social networking involving ROSCs should be implemented cautiously, so-as-to avoid negative outcomes – both in the community and in individuals. In section 10, it is shown that ineffective implementation of a community-based

recovery service can lead to the creation of barriers to those support services, which in turn can lead to the "partitioning of a community into cliques, such that each person is tied to every other in his clique and to none outside" (Weston *et al*., 2017, p2). Therefore, "when developing services which facilitate recovery support networks, policy makers and commissioners should also take account of situational contexts and the potential within them for sustained and continued attentiveness to street-level capital that might hinder the development of RC" (Weston *et al*., 2017, p.9).

2 BACKGROUND

The Derbyshire Substance Misuse Recovery Team at Derbyshire County Council (DCC) is proposing to change the way the council procures its alcohol and drug dependency recovery services. Currently, grants are offered to organisations to run recovery projects across Derbyshire. Moving forward, the new proposal seeks to have one 5-year Community Recovery Service that would use the current recurring annual budget – as well as an already-budgeted-for one-off sum that will be allocated to a new recovery hub. This proposed service is an entirely community-based, separate from the treatment service.

To those ends, this narrative review was requested with the goal of addressing the following aims:

1) Explore critically appraised academic evidence underpinning community-based recovery services.
2) Describe delivery models for community-based recovery services.
3) Provide case studies of UK-based recovery services in the community that stand alone from drug treatment services – preferably in a shire county like Derbyshire.

3 MATERIALS AND METHODS

To address the three aims mentioned above, the following steps were taken in producing this narrative review.

3.1 Understanding Information Needs

After meeting with the Substance Misuse Recovery Team who commissioned this review, the following topics and areas were identified as being of particular interest (in relation to community-based recovery services) to the DCC Substance Misuse Recovery Team:

- Acceptability/Kickback
- Delivery models (e.g., recovery through nature, mutual aid, Recovery-oriented Systems of Care (ROSCs), and Lived Experience Recovery Organisation (LEROs).

- Effectiveness
- Measuring recovery outcomes
- Recovery capital
- Similar services in the UK - standing alone from treatment services.
- Strengths and limitations

3.2 Gathering Literature

14/38 of the publications analysed in this this narrative review were provided by Professor David Best (University of Derby, 2022), a leading academic in the field of addiction recovery.

11/38 of the papers used was retrieved from performing a literature search on the MEDLINE and PSYCINFO bibliographic databases using the following terms (as well as the thesaurus function of the aforementioned databases) with the date range 2007 - 2022:

- communit*
- recover*
- drug* OR cocaine OR hallucinogen* OR methamphetamine* OR opiate* OR opiod* OR marijuana OR heroin OR alcohol* OR drink* OR substanc* OR addict*
- service* OR model* OR intervention* OR program*

All results were initially assessed for relevancy (i.e., application of an inclusion/exclusion criteria) against the topics/areas of interest listed in section 3.1 based on result titles, and then abstracts/summaries.

Furthermore, a separate grey literature search was also performed using the Google search engine, the Recovery Research Institute (2022) website, and the website of research consultant William White (White, 2022) (another leading researcher in this field). This yielded 6 of the 38 analysed results.

The remaining 7/38 publications were identified through citation analysis.

3.3 Appraisal and Write-up

Literature provided by Professor David Best was considered to have already been critically appraised. Empirical studies retrieved from the literature searches described above were critically appraised using guidance from corresponding CASP checklists. Non-empirical literature was also critically appraised, but without the use of any guidelines.

4 THE CONCEPT OF RECOVERY

“Addiction [to drugs and alcohol] has been framed as a chronic, debilitating disease, with remission or recovery used to describe one’s healing from it” (Best & Hennessy, 2021, p.3). However, ‘recovery’ itself “is a contentious concept, and there exist a number of different definitions” of it (Weston *et al*., 2017, p.3). These “definitions range from the vague and nebulous (e.g., ‘recovery is what each individual wants it to mean’), to the highly prescriptive (e.g., ‘recovery means abstinence from all substance use’) (Neale *et al*., 2014, p.26).

Furthermore, even outside of the debate on a set definition, “many in the addiction and recovery field question whether anyone has the authority to define ‘‘recovery’’, as it signifies such a profound and personal experience” (Kelly & Hoeppner, 2014, p.2). Nonetheless, “several working definitions of recovery from various organizations have been proposed” (Kelly & Hoeppner, 2014, p.2).

For example, the UK Drug Policy Commission ([UKDPC], 2012) has described it as a “voluntarily-sustained control over substance use, which maximizes health and wellbeing and participation in the rights, roles and responsibilities of society” (p.123). In the USA, the Substance Abuse and Mental Health Services Administration ([SAMHSA], 2012) similarly defines it as “a process of change, through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (p.3). On a smaller scale, a focus group of individuals with personal and lived experiences of recovery in the UK has described it as “a reality that grows from within and is supported by peers and allies” (Best *et al*., 2013, p.176).

Although separate, various definitions such as these share common elements – such as mention of social engagement, health, and/or self-direction. This commonality of themes is also encompassed in a general viewpoint of recovery put forward by Dennis *et al*. (2007), who described and categorised aspects of recovery as including positive changes in abstinence, health state, state of mental health, coping responses, legal involvement, vocational engagement, housing, peers associated with, and social support. This viewpoint will be used in this narrative review as a reference point of what recovery means.

In addition to categorisation into constituent areas, recovery has also been categorised as a process on a timeline. For example, the Betty Ford Institute Consensus Group (2007) has described recovery as consisting of 3 stages: ““early recovery” (<1 year), “sustained recovery” (1–

5 years) and “stable recovery” (>5 years), with the implication that recovery is more robust as the individual progresses through these stages” (Best *et al*., 2021, p.2).

5 MECHANISMS OF RECOVERY

In terms of how recovery comes to be, initiation and maintenance of it is positively influenced and facilitated by mechanisms that act as “active interventions (like participation in treatment or mutual aid groups) or changes in individuals’ lives (Vanderplasschen & Best, 2021, p. 385).

These mechanisms have been described from different perspectives – including through the construct of social identity, as posited by Best *et al*. (2015) in their social identity model of recovery (SIMOR). SIMOR describes mechanisms of recovery as relating to a “process of social identity change, in which a person’s most salient identity shifts from being defined by membership of a group whose norms and values revolve around substance abuse to being defined by membership of a group whose norms and values encourage recovery” (Best *et al*., 2015, p.3).

From a different perspective, recovery has also been described as a set of behavioural mechanisms, which include: 12-step mutual aid support; support from other peer-based groups; residential and therapeutic community treatment; specialist outpatient (maintenance and abstinence-oriented) treatment; and natural recovery (Best *et al*., 2018, p.14; Vanderplasschen & Best, 2021).

Although multiple mechanisms can contribute towards recovery as described by this behavioural model, it should be noted that “no single mechanism is likely to account for recovery by itself – as the availability of mechanisms may change over time, and different mechanisms may be involved in initiating and maintaining recovery” (Vanderplasschen & Best, 2021, p. 385). This is illustrated in a conceptual model of personal recovery developed by Leamy *et al*. (2011), which integrates the myriad of processes which might be involved in the overall recovery process (Table 1).

Category	Recovery Processes	
Connectedness	- Peer support and support groups - Relationships	- Support from others - Being part of the community
Hope and optimism about the future	- Belief in possibility of recovery - Motivation to change - Hope-inspiring relationships	- Positive thinking and valuing success - Having dreams and aspirations
Identity	- Dimensions of identity - Rebuilding/redefining positive sense of identity	- Overcoming stigma
Meaning in life	- Meaning of mental illness experiences - Spirituality - Quality of life	- Meaningful life and social roles - Rebuilding life
Empowerment	- Personal responsibility - Control over life	- Focusing upon strengths

Table 1. Processes of personal recovery (Leamy et al., 2011, p.448)

This model describes how positive connections can create hope – through the observation of "successful transitions and [through] the recognition that recovery is possible" (Best, 2019a, p.182-183). Connectedness to "positive and pro-social groups" also offers a sense of belonging and a subsequent identity change (Best, 2019a, p.183; Best *et al*., 2015), as described above in the SIMOR model (Best *et al*., 2015). Furthermore, active participation in these social groups provides the opportunity for engagement in meaningful activities – which further reinforces "changes in identity" (Best, 2019a, p.183). The personal benefits - and awareness of those benefits - gained from active participation in positive social groups, better access to community resources, and positive identity changes, ultimately serve to empower the individual (Best, 2019a).

6 RECOVERY CAPITAL

The individual processes described in the CHIME model of recovery above can be enabled – and also measured – through what is referred to as recovery capital (RC). This term characterises resources that can be accumulated as recovery progresses and as abstinence is sustained – and refers to personal RC (e.g., "health, mental health, housing, being crime-free, employment, life satisfaction"), social RC (e.g., "strong family and social relations"), and/or community RC ("resources and assets available to individuals in their communities") (Best, 2019b, p.7; Dennis *et al*., 2007, p.568).

This essentially purports a “strengths-based model of recovery – building hope in that, even in those with low levels of resource, access to resources and assets available in their communities (i.e., community RC) can be supported through… guidance and assistance [from] individuals or groups who can be professionals, peers, family members or employers, neighbours or friends (i.e., social RC)’ (Best, 2019b, p.7).

This idea of the cumulative nature of RC was also supported by van Melick *et al*. (2013), who found that there were “positive correlations between recovery-functioning scales (especially on overall quality of life) and length of time in recovery” (p.196). How correlations between recovery and RC can be utilised as a measure and indicator of recovery are discussed in greater detail in section 9.3

6.1 Social Recovery Capital as an Enabler of Recovery

As an enabler and facilitator of recovery, Weston *et al*. (2017, p.1) reinforced the notion that “those who have access to RC have a greater capacity to terminate substance misuse than those who do not”. Among enablers of recovery, social RC is especially key. Indeed, “the initiation of recovery generally requires high levels of trust, which is acquired through the establishment of dense social networks and the norm of reciprocity around help-seeking and help-giving” (Weston *et al*., 2017, p.8). This highlights the significance of ‘connectedness’ processes, as described in the CHIME model shown in section 5.

Social capital also facilitates recovery later in its process – as social capital has been shown to be correlated to better outcomes (Eddie & Kelly, 2017). This could be through “reducing individuals’ exposure to substances and related conditioned cues, facilitating the acquisition of recovery coping skills and learning of new non-substance use related recreational activities, and strengthening of abstinence self-efficacy” (Eddie & Kelly, 2017, p.246)

The mechanism of action behind social capital as enabler and facilitator of recovery was further elucidated by Eddie & Kelly (2017), who sought to” examine the relative influence of number of high-risk and low-risk friends, and the amount time spent with these friends, on substance use outcomes (measured by percentage days abstinent)” (p.246). Some of the findings from that examination were that “a greater number of, and more time spent with high-risk friends was associated with poorer substance use outcomes, while greater number of, and more time spent with low-risk friends were associated with better outcomes” (Eddie & Kelly, 2017, p.251). In other

words, “there is more to social capital than the existence of relationships alone, and not all relationships result in positive consequences” (Weston *et al*., 2017 p.2).

In general, positive social capital and recovery can be built upon in multiple ways. Three common interventions which capitalise on the central role of peers in recovery, and which have been shown to be effective are mutual aid support groups, peer-based support, and recovery housing (Humphreys & Lembke, 2013).

6.1.1 Peer-support Recovery Services

“Peer-based recovery support services are defined as the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from substance use disorders” (Bassuk *et al*., 2016, p.1). The support provided is by “individuals with lived experience of addiction and recovery” – which can be “informal, involving ad-hoc support from one individual to another; and/or formal, with peers trained to offer support in a structured way” (Miler *et al*., 2020, p.2).

In terms of how peer-support facilitates recovery, it has been shown that those in recovery typically go to others in recovery for emotional support (van Merlick *et al*., 2013) – a process which could be enhanced and enabled by the availability of peer-based support interventions. Furthermore, helping others also helps the helper – in that, peer support not only strengthens the helper’s own social network, but also provides them with a model of successful commitment to live a sober lifestyle (van Melick *et al*., 2013).

Despite these beneficial aspects of peer-support services, a review by Miler *et al*. (2020) “identified challenges that peer workers commonly face in their roles, including [issues around]: vulnerability; authenticity; boundaries; stigma; and having their involvement valued” (p.13). Miler *et al*. (2020) went on to draw out guidelines on how these challenges can be overcome, and on how peers can be embedded in services more effectively. These are show in Table 2.

Category	Guideline
Role description	- Clear description of role/job needed to prevent peers from assuming extra responsibilities beyond their contractual tasks, overworking, and burning out.
Compensation	- Transparency must be ensured in terms of compensation for the service provided so that peers can make informed choices regarding their terms of engagement. - Recognition of the complexity regarding compensation, and social welfare/security issues is needed. - Low-waged roles should be challenged, especially where peer roles are demanding and complex.
Support	- Support services must be available so that peers feel emotionally supported given the difficult nature of their roles.
Development	- Training and development opportunities must be available to ensure career progression.
Value	- Value and recognition of peers must be ensured. - Peers should feel welcome and included in their workplace and by other colleagues.
Accommodations	- Workplace accommodation should be in place as required by each individual.

Table 2. Proposed guidelines for embedding peers in services (Miler et al., 2020, p.14)

6.1.2 Mutual Aid Groups

"In contrast to peer-support services, mutual aid modalities of peer support are typically provided in the context of 12-step groups, such as Alcoholics Anonymous - presenting a single pathway for recovery as defined by the mutual aid group model" (Bassuk *et al*., 2016, p.2). Furthermore, "mutual aid is informal, does not require training, and is deeply rooted in bi-directional relationships of mutual support (Bassuk *et al*., 2016, p.2) – unlike peer-support services.

"The extent to which support received through [mutual aid groups] shapes recovery pathways of people in drug addiction recovery" was investigated by Martinelli *et al*. (2020, p.2). One finding from that investigation was that those who had been members of a mutual-aid group at some point in their life displayed greater participation and positive changes in their social network and RC in general, compared to those that had not (Martinelli *et al*., 2020).

6.1.3 Recovery Residences

Finally, there are recovery residences. These are “operated by and for people with substance use disorders, with an emphasis on peer-driven, abstinence-oriented recovery” (Humphreys & Lembke, 2013, p.15). One example of such housing is the Oxford House model – where residents are expected to adhere to the House’s self-determined rules, pay rent, and stay abstinent from drugs and alcohol (Majer, Beers, & Jason, 2014).

The effectiveness of recovery residences was shown in a study by Cano *et al*. (2017), who found that “time in residence resulted in significantly increased number of meaningful activities” (e.g., employment), “decreased barriers to recovery” (e.g., substance use), and a subsequent decrease in the “number of unmet needs” (e.g., relationships with family) (p.12).

7 ASSET-BASED COMMUNITY DEVELOPMENT AND ENGAGEMENT

7.1 Recovery Capital: Interconnected

Although social capital is such a vital component in initiating and maintaining recovery, it does not achieve this by itself. Section 6 describes how community capital (e.g., community resources such as mutual aid or peer support groups) can act to facilitate the acquisition of social capital (e.g., positive social networks). In other words, “different aspects of RC work together and possibly synergistically to support recovery” (Best & Hennesy, 2021, p.4).

This is also supported by Collinson & Best (2019) who state that “when individuals early in addiction recovery are linked into positive community resources, personal, social and community capital are all anticipated to grow as a result” (p.1). This is illustrated in the ice cream cone model below, which characterises the building of RC through “layers of community engagement” (Collinson & Best, 2019, p.2).

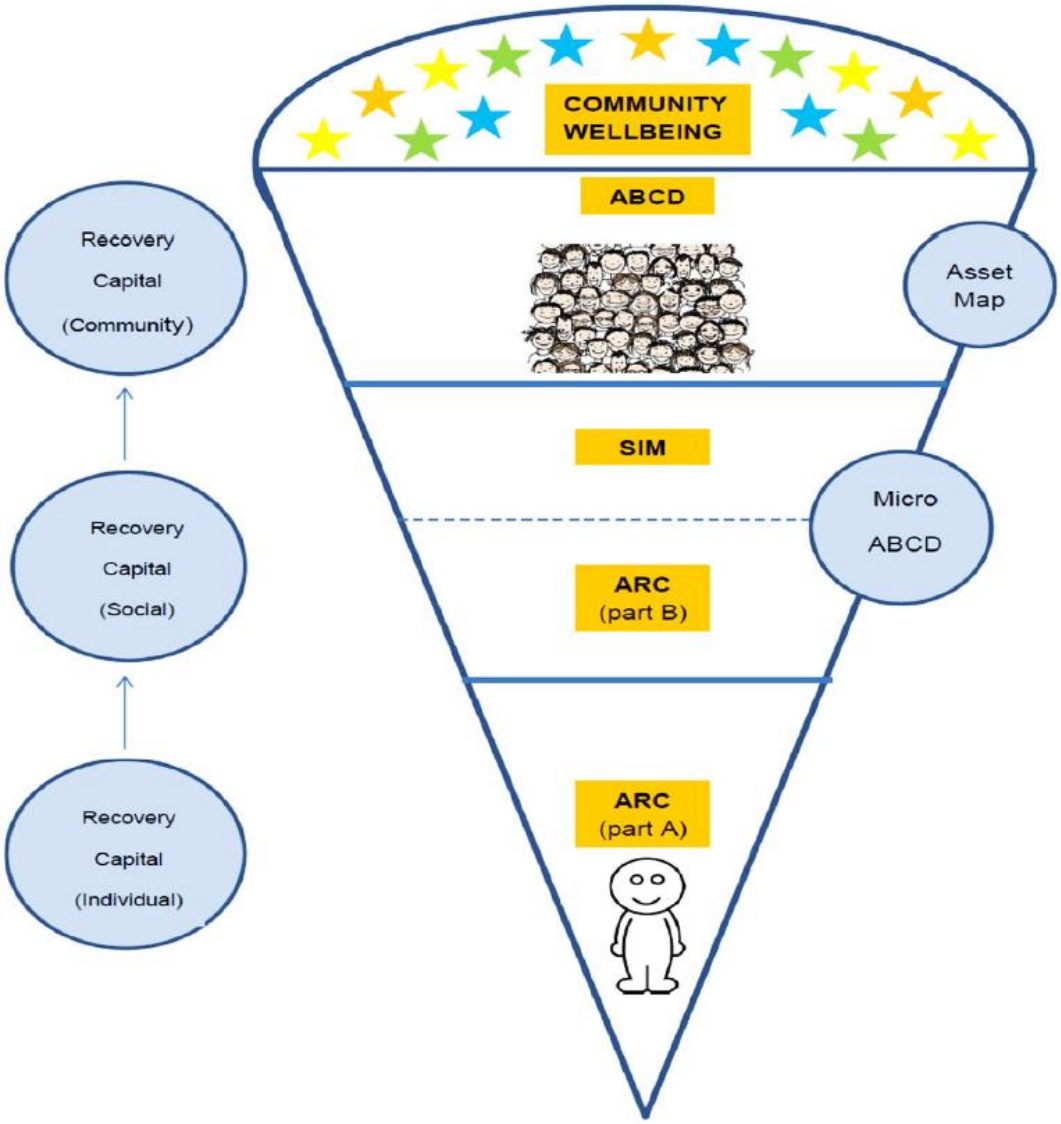

Figure 1. The 'ice cream cone': Characterising RC through layers of community engagement (Collinson & Best, 2019, p.2) (ARC = Assessment RC, and SIM = Social Identity Mapping).

The bottom layer represents how an individual in the early stages of their recovery journey can increase their RC (personal RC, such as resilience) by forming positive social group memberships and being involved in social activities that support their sobriety (Collinson & Best, 2019). (Note: "ARC" in this diagram refers to a tool used to measure RC. For reference, ARC is discussed further in section 9.3).

The middle of the cone shows how identification with multiple groups can act as a resource that can protect an individual's wellbeing (e.g., psychological wellbeing, through protection against emotional stress) (Collinson & Best, 2019). This idea is related to Section 5, which described how one mechanism of recovery is the shifting of one's social identity from "being defined by membership of a group whose norms and values revolve around substance abuse to being defined by membership of a group whose norms and values encourage recovery" (Best *et al*. 2015, p.3). That is seen in this middle part of the ice cream cone model – where contact with pro-

recovery groups influences changes to the individual's social identity in a process that is facilitated by utilisation of "micro-assets that exist within the local community" (Collinson & Best, 2019, p.1). In this context, an asset refers to "an item of value owned; a quality, condition or entity that serves as an advantage, support, resource, or source of strength' (Collinson & Best, 2019, p.4) – i.e., social groups in this context. (Note: "SIM" in this diagram refers to Social Identity Mapping, "which is a technique for mapping pro-social and pro-substance use groups in [a] person's social network" (Collinson & Best, 2019, p.2)).

At the upper level of the ice cream cone, individuals benefit from "improved pathways to social networks and support, and enhanced opportunities to engage with a range of community resources that are made more accessible through the process [community capital]" (Best *et al*., 2016, Collinson & Best, 2019, p.3).

7.2 Asset-based Community Development

Increasing the visibility and knowledge of assets not only benefits the individual – but can also increase the capacity that a service, system, or community has in supporting those in recovery. This can be achieved via Asset Based Community Development (ABCD) – which is illustrated in the upper level of the ice cream cone.

ABCD refers to the mapping of assets that individuals in recovery can use to accrue RC (Collinson & Best, 2019). Mapping out of these assets allows for the characterisation of "communities as 'the wealth in people, things, services, and resources that exist'" within it – helping unrecognised or underutilised assets to be identified (Collinson & Best, 2019, p.4). This also then allows for interconnections between assets to be exposed, revealing pathways to accessing them (Collinson & Best, 2019) by individuals in recovery. (One approach towards ABCD in practice is described later in sections 8.1.1).

After this mapping, ABCD can then be supplemented with "'assertive linkage' – which holds great importance in connecting individuals to the appropriate resources" (Best *et al*., 2016; Collinson & Best, 2021, p.4) such as recovery-oriented groups. (An example of how assertive linkage can be used in conjunction with ABCD can be seen in the case study described in section 8.3.1).

7.3 Asset-based Community Engagement

"While ABCD asserts the importance of mapping assets, it gives no structure [on how] to do so"; additionally, "it is acknowledged that mapping alone, simply creating a directory of assets, offers limited solutions" (Collinson & Best, 2019, p.4). Furthermore, as seen in the paragraph immediately above, linking individuals to relevant assets is carried out separately to ABCD – not as part of the same process.

An example of an integrated methodology for mapping assets and appropriately linking individuals to them is Asset-based Community Engagement (ABCE). ABCE "refers to an evidence-based framework that is intended to support practitioners to identify a service users' current levels of community engagement and barriers to engagement, whilst also mapping community resources and identifying pathways into these resources" (Collinson & Hall, 2021, p.434). This effectively provides a structured and systematic approach towards the mapping as well as utilisation of appropriate assets in the community.

The benefits of this can be seen when considering gender-specific mechanisms of recovery. Section 5 described how recovery involves an identity change, where the new identity is "defined more by membership of a group whose norms and values encourage recovery" (Best *et al*., 2015, p.3). In women, it has been found that recovery identities are only one aspect of their experience; in that, although recovery helped to initiate identity growth and change in women, they frequently went on to redefine their identity to centre on other aspects of their lives (Collinson & Hall, 2021).

To help facilitate this process of developing a more balanced identity (i.e., one not solely centred on recovery), ABCE could be of help – especially in supporting women who report an absence of pro-social networks and involvement in such activities (Collinson & Hall, 2021). In other words, ABCE could allow women to better identify and engage with resources that are appropriate for their circumstances and personal recovery journey. This would also apply to other populations with complex recovery support needs.

An ABCE workbook has been used to pilot practical implementation of the ABCE framework (Collinson & Best, 2019); although, it does not appear to have been published at the time of producing this narrative review. However, in their paper, Collinson & Best (2019, p.5-6) did provide an overview of the key stages of partnership working [between a recovery navigator and the individual in recovery] in ABCE (with steps 1-4 forming the workbook):

1) Identify current levels of community engagement through asset mapping:
    - This is done in the following domains: peers and mutual aid; sports, recreation and arts; professional services and education; and employment and training. These domains are dependent on the individual context, and other domains can be added – depending on the individual's needs and interests.
2) Exploration of assets (accessibility, affordability, connectedness and social networks):
    - This makes use of a traffic light system – which, although subjective and simplistic, allows for the individual in recovery to understand, interpret, and apply to their own lives.
3) Explore the personal interests of the individual:
    - This allows the individual to develop their RC in a way that individually suits them.
4) Identifying barriers to community engagement:
    - Barriers might include a lack of specific opportunities, family constraints, or a lack of confidence, for example. Their identification is key in them being broken down.
5) Highlighting the role of assertive linkage to the recovery navigator:
    - Here, the recovery navigator, who has already built a trusting relationship with the individual receiving support identifies assets which might be beneficial – with the help of a recovery connector (i.e., an individual with expertise/a connection to a particular resource) if needed.
6) Assertive linkage and community engagement.

As well as being beneficial to individuals, "once the ABCE workbooks have been completed across a cohort, a practical output of the accumulated data is to map available assets in the local area (Collinson & Best, 2019, p.10). This practical resource will in turn help the recovery navigators to assertively link others in recovery into community resources, promoting successful community engagement" (Collinson & Best, 2019, p.10).

8 COMMUNITY-BASED RECOVERY SERVICES

Sections 3-5 above provide an overview of what recovery is, its mechanisms of action, as well as its facilitators. In practice, these concepts and ideas feature heavily in what are termed "Recovery-Oriented Systems of Care" (ROSCs) – through which community-based recovery services can be delivered.

8.1 Recovery-Oriented Systems of Care

ROSCs "are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders" (White,

2008, p.13). That is not to say a different system with more short-term objectives is necessarily worse or better in addressing addiction than a ROSC – but rather, different systems have different advantages and disadvantages depending on their objectives.

8.1.1 Case Study: Barnsley, England

For instance, in Barnsley, up until 2010, the "treatment system in use was designed to provide rapid access to treatment via general practice shared care and central prescribing via the Primary Care Trust, supplemented by non-statutory sector provision of psychosocial interventions and structured day care" (Best *et al*., 2013, p.172). However, although "this model engaged clients in treatment, it did little to help them progress beyond acute care to better quality of life and community involvement" (Best *et al*., 2013, p.172).

This assertion is supported by Dennis *et al*., (2007), who investigated the association between various aspects of recovery (e.g., abstinence and mental health) over an 8-year period and found that the initial period in recovery "does not fully represent changes associated with long-term recovery" (p.607). This suggests that there is a need to move away from focusing on acute episodes of treatment, and more towards strategies and programs that support long-term management of recovery (Dennis *et al*. 2007) if the objective is to support sustained recovery from addiction.

In Barnsley, this sentiment led towards the creation of a new vision "for working toward a system and professional culture that would support recovery" (Best *et al*., 2013, p.173). In attempting to establish such a system, the South Yorkshire Drug and Alcohol Action Team sought to implement a model of recovery champions in Barnsley (Best *et al*., 2013). The "idea of recovery champions was introduced in the 2010 English Drug Strategy (HM Government, 2010) through the concept of "recovery networks" – which is based on the assumption of the social contagion of recovery via a network of champions" (Best *et al*., 2013, p.170). Although the term 'recovery champion' was not defined, the English Drug Strategy did describe recovery champions as potentially existing at three different levels: "strategic (i.e., leaders - such as service commissioners and managers), therapeutic (typically workers in specialist services), and community (people already in recovery who mentor and support others in their local communities)" (Best *et al*., 2013, p.170; HM Government, 2010).

Implementation of the recovery-oriented vision in Barnsley initially began with the identification and recruitment of potential champions from the local community, as well as from specialist workers in Barnsley addiction services (Best *et al*., 2013). Participants were then distributed amongst three

working groups (i.e., 'strategic', 'therapeutic', and 'community') during meetings and workshops – where they could discuss how to best work together to promote recovery in Barnsley (Best *et al*., 2013) at these levels.

From the first meeting, one outcome was the identification of various recovery assets and resources in Barnsley – as shown in Table 1 below – which was an activity inspired by the concept of Asset-Based Community Development (ABCD) (Best *et al*., 2013), where community resources are mapped, as described above in section 6.2.

Specialist Provider	**Recovery Community Groups**	**Mutual Aid and Communities**	**Link Services and Supports**
- Phoenix Resettlement Team - Addaction - Swanswell - Substance Misuse Team	- Barnsley Alcohol and Drug Advisory Service (BADAS) - Combat Academy - Recovery Forum - Women in Recovery - Arts project - STORM (peer community organisation)	- Self-Management and Recovery Training (SMART) - Alcoholics Anonymous - Narcotics Anonymous	- Church Project Street Pastors - Reach Out Barnsley - Sure Start - MIND (mental health support organisation). - Society of Voluntary Associations (SOVA). - Leisure Centres - Community Centres - YMCA - Northern College

Table 3. Recovery assets and resources identified in Barnsley (Best et al., 2013, p.177).

Building from initial meetings and workshops, the newly created champion network – consisting of growing and linked-up 'strategic', 'therapeutic', and 'community' groups – mobilised itself in an active attempt to advance recovery in Barnsley (Best *et al*., 2013). This was through the production of a recovery strategy directly linked to the Barnsley Drug and Alcohol Action Team; engagement with local activities; and "development of bridges to treatment and worker engagement in recovery events and processes (i.e., professional training and development)". (Best *et al*., 2013, p.176).

8.2 Recovery Community Centres

These activities in Barnsley show how a ROSC can emerge through engagement with public and professional communities and stakeholders. However, ROSCs can also involve structures that are defined from the outset. One such “major organizing structure for the provision of some of… peer-delivered support within the context of recovery-oriented systems of care… is that of the recovery community centre (RCC)” – which is a peer-led initiative (Haberle *et al*., 2014, p.258).

The Connecticut Community for Addiction Recovery (CCAR) – who apparently developed the first RCC – describe the RCC model as “a recovery-oriented sanctuary anchored in the heart of the community” (CCAR, 2006 as quoted by Haberle *et al*., 2014, p.259). Situating RCCs in “the heart of the community” has been important for several reasons: firstly, this makes it easier for people to drop in and seek support; and secondly, this visibility in a prominent location also increases the prominence of a positive recovery vision in the community – showing that that addiction is nothing to be ashamed of or to hide, and that help is readily available, and that recovery is possible” (CCAR, 2006,= as cited by Haberle *et al*., 2014, p.259).

In terms of the key features of a RCC, these are described below in Table 4 – which also includes the structured activities a RCC might engage in.

A recovery community centre…
Is a recovery-oriented sanctuary anchored in the heart of a community
Is visible so local communities of recovery can actively put a face on recovery
Serves as a physical location for organising the local recovery community's ability to care, specifically through the provision of a variety of recovery support services
Provides peer-based recovery support services using a volunteer force to deliver a vast majority of these services
Attracts people in recovery, family members, friends, and allies to serve as volunteers, who in turn help those coming up behind them
Fosters the inherent nature of the recovery community (people in recovery, family members, friends, and allies) to give back
Functions as a recovery resource for the local community
Is a location where, sometimes, people still struggling with addiction will enter and will be assisted in navigating the local behavioural health system
Is a place to find workshops, training, and educational sessions to enhance one's own recovery
Maintains a structured schedule of recovery-related workshops, training, meetings, services, and social events
Hosts and promotes recovery social events

Table 4. Key features of Recovery Community Centres (Haberle et al., 2014, p.259)

8.2.1 Case Study: Pennsylvania, USA

In practice, "one robust example of RCCs serving as hubs for an ROSC is provided by the city of Philadelphia and Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT), a grassroots advocacy and recovery project sponsored by The Council of Southeast Pennsylvania, whose mission is educating its constituency and mobilizing its members to advocate for the recovery community in the greater Philadelphia area and nationally" (Haberle *et al*., 2014, p.261)

"These services comprise a comprehensive matrix of integrated recovery and support services that respond to each stage of the recovery process… from engagement and increasing readiness to stabilizing recovery and sustaining and growing recovery" (Haberle *et al*., 2014, p.261). These services are described in Table 5 below – illustrating services available in relation to stages of the recovery journey (left to right).

Engagement	Increasing Readiness	Stabilising Recovery		Sustaining and Growing Recovery
Recovery Initiation	**RC Assessment**	**Stabilisation and Recovery Skill Building**		**Ongoing Recovery Support**
Increased recovery awareness	Development of a customised recovery plan	Access to treatment and recovery support	Recovery coaching	Recovery coaching
Screen/need for detox	Match with recovery coach	Warm hand off referrals	Life skills	Relapse prevention/early intervention
Help navigating health care system	Provide evidence of hope and encouragement for change	Mutual support	Education support	Community inclusion
Support individuals on waiting lists	Increase personal responsibility and willingness to accept help and support	Sober social networks	Vocational support	Growing RC
Meet with certified recovery coach	Population-specific peer recovery groups	Faith-based support	Health and wellness	Telephonic recovery support
Motivational interviewing	Recovery resources and access to treatment	Developing a sense of belonging and purpose	Job readiness support	Career development
Orientation to recovery options	Legal system navigation and support	Reduction of shame and guilt	Telephonic recovery support	Volunteer opportunities
Strength-based approach to	Resume development	Increased self-respect	Recovery-oriented resources	

resource identification and linkage			
Increasing engagement and recovery support	Increased volunteer opportunities	Volunteer opportunities	Parenting resources
24/7 telephonic recovery support			
Volunteer opportunities			

Table 5. Recovery support integration model (Haberle et al., 2014, p.262).

8.3 Recovery Community Organisations

In addition to RCCs, ROSCs may also achieve their function through the work of Recovery Community Organisations (RCOs). These are “independent, non-profit organisations that are entirely led and governed by representatives of local communities of recovery” (Ashford, Brown, *et al*., 2019; Valentine, White, & Taylor, 2007, p.1). “RCOs organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services – with the sole mission of mobilising resources within and outside of the recovery community in order to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction” (Valentine, White, & Taylor, 2007, p.1).

8.3.1 Case Study: The Well, North-West, England

An example of a ROC in practice is The Well, which is a peer recovery organisation operating under a community engagement model that engages and assists programme participants with recovery (Best *et al*., 2020). The organisation attempts to achieve this via an Asset-Based Community Development (ABCD) approach such as the one seen in Barnsley in section 8.1.1, as well as through assertive linkage through peer leaders – helping build RC in programme participants (Best *et al*., 2020).

Best *et al*. (2020) described the workings of this model using 3 case studies. One case study was a partnership between The Well and an acute hospital – which was an early engagement project

that sought to engage those with acute substance-related harm issues (Best *et al*., 2020). This approach made use of staff with lived experiences in the form of a “Dual Diagnosis Team” within a hospital (Best *et al*., 2020). Following an initial assessment, staff and volunteers from The Well were able to build support links and personalise support plans in a co-produced way – e.g., through engaging individuals with clinical services, or linking individuals to community initiatives and activities (Best *et al*., 2020).

Another case study of The Well was a 28-bed peer-led recovery residence program in Cumbria – typically lasting 6-12 months - that was linked to individuals identified as being at high-risk (Best *et al*., 2020). The programme then attempted to link those individuals to community recovery hubs (Best *et al*., 2020) (i.e., recovery community centres). At the start of the programme, clients were expected to fully engage in a structured programme, involving a 12-step recovery programme, daily-living activities, budgeting, and exercise (Best *et al*., 2020). Further on in the programme, there was a drive to address barriers to individuals being in “meaningful” employment by encouraging them to engage in voluntary work, training, and education (Best *et al*., 2020).

The final case study presented by Best *et al*. (2020) was a partnership established between The Well and a prison service, seeking to “effectively reengage individuals leaving prison with Behavioural Health Companions and community resources” (p.7). The initiative itself consisted of two phases: a pre-release phase, where support included access to two support groups, and one-to-one support from The Well staff (Best *et al*., 2020, p.11). The second phase, supporting individuals’ transition from prison and into the community, included access to a “group that delivers over 18 sessions, in addition to a robust abstinence-based 12-step groupwork program (which aimed to develop and maintain recovery motivation and personal resilience, increase 12-step mutual aid affiliation within the prison estate, and also on release into the community)” (Best *et al*., 2020, p.11).

Although the three projects differed in setting, common across all of them was a “short-term aim to attract and engage vulnerable individuals into personalized and sustainable recovery pathways (Best *et al*., 2020, p.12); and a longer-term objective to build sufficient community capital (through partnerships and the growth of a visible recovery community) to make the ground more fertile for each new generation of addicts seeking to start on their recovery journeys” (Best *et al*., 2020, p.12; White, 2009).

The three projects run by The Well, described above, show how ABCD and assertive linkage can be used to engage with individuals at different points of their recovery journey.

9 RECOVERY OUTCOMES

9.1 Measuring Recovery in Practice

After the initiation of recovery, its outcomes can be measured in various ways – and at various levels.

9.1.1 The Well, North-West, England

As stated in section 3, recovery has been described to include aspects of abstinence, health state, state of mental health, coping responses, legal involvement, vocational engagement, housing, peers associated with, and social support (Dennis *et al*., 2007). However, the "definitional ambiguity of recovery" (Neale *et al*., 2014, p.27) as illustrated by the multi-faceted nature of recovery described by Dennis *et al*. (2007), "renders the pragmatics of measuring recovery outcomes particularly complex" (Neale *et al*., 2014, p.27). At The Well, although outcomes were contained across the recovery domains outlined by Dennis *et al*. (2007) above, they did differ between projects/settings.

In its early-engagement program (where The Well worked in partnership with an acute hospital), outcomes achieved were measured at a system level, with focus being placed on the burden the hospital service was under. Specifically, outcomes were measured with regards to changes in: demand on A&E and Ambulance service 999/111 for mental health crisis; admissions to Acute Mental Health wards; and in numbers of alcohol-related harm presentations to Emergency Department or Liaison services where a Mental Health issue is a comorbidity (Best *et al*., 2020).

In another setting, in the recovery residence programme run by The Well, progress and outcomes were focused on clients as a group, as quantified by the percentage of: clients no longer using substances, those in voluntary work, and those in employment – where snapshots of these percentages were taken for clients spending 3, 6, and 12 months in the programme (Best *et al*., 2020).

In the prison service partnership programme with The Well, outcome data were collected at individual client-level using the Outcome Star (2022), where baseline pre-release scores were taken across the domains of "offending, accommodation, connection to community, and physical health" (Best *et al*., 2020, p. 11).

9.1.2 Pennsylvania, USA

Outcome data were captured through the "a standard Government Performance and Reporting Act (GPRA) survey tool issued by the federal SAMHSA – which collected data from a subset of

RCC participants in the following six domains: (a) alcohol and other drug use; (b) family and living conditions; (c) education, employment, and income; (d) crime and criminal justice status; (e) mental and physical health problems and treatment/recovery; and (f) social connectedness" (Haberle *et al*., 2014, p.262). This also presents outcomes of client recovery outcome measures at a group level.

		Baseline	**6 Months**
Substance Use	No alcohol use	93%	92%
	No drug use	93%	95%
Living conditions	Own/Rent	30%	53%
	Recovery house	54%	34%
	Shelter	5%	4%
	Residential treatment	5%	3%
	Someone else's home	8%	10%
	Institution	4%	3%
Enrolled School or Training	Not enrolled	81%	77%
	Enrolled part-time	10%	11%
	Enrolled full-time	8%	11%
Employment Status	Employed full-time	10%	22%
	Employed part-time	11%	16%
	Unemployed, looking	43%	32%
	Unemployed, disabled	11%	13%
	Unemployed, volunteer	6%	3%
	Unemployed, retired	1%	1%
	Unemployed, not looking	17%	11%
Sources of Income	Wages	21%	41%
	Public assistance	51%	45%
	Parole/Probation		
	On parole or probation	25%	22%
Mental Health Symptoms Not Related to Substance Use (in previous 30 days)	No depression	60%	64%
	No anxiety	50%	56%
	No hallucination	96%	97%
	No difficulties with cognition or memory	66%	73%
	No trouble controlling violent behaviour	90%	90%
	No attempted suicide	99%	100%

Table 6. Selected GPRA domain changes from baseline to 6-month follow-up (Haberle et al., 2014, p.266).

9.2 Considerations to be Made When Measuring Recovery Outcomes

9.2.1 When to Measure Outcomes?

Although the outcome measures described in section 9.1 above are presented quantitatively, measures such as these should be analysed with some caution. For example, "in the absence of a randomized design, many factors may have influenced changes" in the domains described immediately in the RCC case study above and might not all "be directly attributed to the recovery support services received at the RCCs" (Haberle *et al*., 2014, p.263-264).

Another consideration to make when measuring recovery outcomes is the drawing of conclusions from trends. In an 8-year study by Dennis *et al*. (2007, p.607), it was found that the "risk of relapse is particularly problematic in the first three years of abstinence and never completely goes away". This suggests that initial recovery should not be used as an indicator for long-term recovery – especially in the first three years.

Furthermore, Dennis *et al*., (2007) also found that the "duration of abstinence is related to changes in other aspects of recovery but at different rates and times" (p.603). This suggests that the state of recovery can be quantified differently, depending on what aspect of recovery is being examined at the time (Best & Hennessy, 2021). For instance, it has been found that the "use of coping mechanisms starts out high and decreases as the number of years of abstinence increases, suggesting that the high rates of these coping strategies may actually be a characteristic of early abstinence" (Dennis *et al*., 2007, p.604). This perhaps highlights the need for recovery outcomes to be measured and monitored in a multi-faceted way.

9.2.2 Context Matters

In addition to the potential importance of multi-faceted measuring of recovery outcomes, recovery outcomes should also not be interpreted in a vacuum – but should be deciphered through the lens of context. Indeed, in a study by Neale *et al*. (2014) involving focus groups of participants who had been in long-term recovery, they "highlighted examples of measures that might seem positive but had dangers attached" (p.29). For instance, it was "reported that various suggested outcomes, such as having confidence, feeling in control, experiencing self-belief, were important to a point, but beyond that point could result in individuals becoming complacent, thus increasing the chances that they would 'let their guard down' and relapse" (Neale *et al*., 2014, p.29).

"Contrasting with these points, focus group discussions also revealed how some apparently negative recovery outcomes, such as tiredness, being anxious, and feeling shame and guilt, could

be positive, in that: if people in recovery did not experience tiredness or feel anxious, shame or guilt, they were probably not 'working at their recovery' and 'did not care'" (Neale *et al*., 2014, p.29).

9.3 Recovery Capital as a Measure of Recovery Outcomes

In addition to these challenges in accurately measuring recovery outcomes, "one of the major challenges for community recovery services (e.g., RCOs) is that they frequently will not fare well on standard outcome indicators" (Best & Hennessy, 2021, p.5). "That is, because many of their clients will already have detoxed and overcome their acute problems with substance use, risk, offending and housing, there is a limiting 'ceiling effect' on the reduction of pathology relative to medication assisted treatments, intensive outpatient, and other acute clinical services" (Best & Hennessy, 2021, p.5). "In this regard, the assessment of RC allows for regular monitoring of strengths and emerging capabilities that are associated with improvements in wellbeing and quality of life" (Best & Hennessy, 2021, p.5).

According to Best & Hennessey (2021), "six tools have been developed to measure RC. To date the most widely used are the 50-item Assessment of RC (ARC; (27)) and its briefer (10-item) version (BARC;(28)), both of which have been used in a range of recovery support settings and across different populations" (Best & Hennessy, 2021, p.4). ARC is "an instrument designed to measure both strengths and barriers (across ten domains of personal and social RC)" (Best *et al*., 2021, p.2; Groshkova *et al.*, 2013). The effectiveness of ARC was demonstrated by Hennessy (2017, p.355) who showed that ARC score to be significantly correlated with four of six World Health Organization Quality of Life Assessment Instrument domains among a recovery sample" (Hennessy, 2017, p.355).

Although ARC has shown such good prediction of recovery, it does only measure RC across the personal and social domains – not community. In response to ARC (and its briefer version, BARC) "primarily assessing aspects of human and social RC, the REC-CAP was recently developed" (Best & Hennessy, 2021, p.5). It is a tool built on the ARC and several other recovery-oriented measures to create a strengths-based model for recovery care planning and community engagement" (Best & Hennessy, 2021, p.5; Cano *et al*. 2017).

Similarly, also building on the notion of RC as a strengths-based description of recovery, Best *et al*. (2021) recently developed the Strengths And Barriers Recovery Scale (SABRS) – which was shown to clearly demonstrate "changes in recovery strengths and barriers from active addiction to recovery as an indicator of positive and negative RC" (p.7).

Using RC as a means of measuring recovery outcomes also "has the positive psychological benefit of generating trust through discussing growth and wellbeing rather than pathology and illness, and challenging stigma by building on personal and social capabilities" (Best & Hennessy, 2021, p.5). This benefit of using RC measuring processes might be especially useful in the early stage of recovery, where high levels of trust (e.g., through "the norm of reciprocity around help-seeking and help-giving" as stated by Weston *et al*., (2017, p.8)) are required to initiate recovery.

Furthermore, RC may also address another challenge that service-providers might face when supporting individuals later in their recovery journey: managing expectations. If expectations are set too high, service providers risk the possibility of further excluding marginalized individuals; conversely, if expectations set too low, those in recovery will likely find little satisfaction in making progress (Neale *et al*., 2014). RC might be able to address this by allowing individuals to identify and quantify their starting point in recovery, which might also inform the setting of realistic expectations as they move forward in their recovery journey.

10 POTENTIAL PITFALLS OF COMMUNITY-BASED RECOVERY SERVICES

The case studies described in section 8 provide insight into how the social networking can be facilitated by ROSCs and RCOs in helping participants build social capital (e.g., by linking individuals to community recovery hubs, reengaging participants with community resources, and providing access to recovery groups). However, something that should be avoided in facilitating these processes is the inadvertent "partitioning of a community into cliques, such that each person is tied to every other in his clique and to none outside" (Weston *et al*., 2017, p2).

10.1 Case Study: 'North/South Town', England

An example of this was seen in an English town consisting of anonymised and unspecified 'North' and 'South' localities. "Both North and South Town had similar provision of one-to-one psycho-social support, prescribing services, and structured day programmes" (Weston *et al*., 2017, p.3). However, provision for residential services and support groups were slightly different. "While residential rehabilitation and detoxification were available to residents of both North and South Town, the location of these services was in North Town" (Weston *et al*., 2017, p.3). Furthermore, access to the county's main recovery community network was only available to those who "abstained from all drugs and graduated from this service" (Weston *et al*., 2017, p.3), which might serve to limit the reach of the main recovery network.

In that particular study by Weston *et al*. (2017), “in the absence of local support groups and active recovery networks that do not insist on abstinence, many of [the] study’s participants had very little social RC to draw on, although they were generally aware of the recovery community that was out of reach (p.8). As a result, “not only were they unable to escape their previous bonding capital” (i.e., connections that already exist within a group) “with drug-using friends but neither could they establish new bridging capital” (i.e., connections with new and dissimilar individuals) because of the absence of support networks that would help to generate these types of contacts” (Weston *et al*., 2017, p.8-9). This highlights the importance of making community recovery services as accessible as possible.

11 LIMITATIONS

This narrative review has several limitations, which should be considered when generalising the review’s findings. One of these limitations can be seen in the initial step of gathering literature.

Although publications on theoretical aspects of areas such as RC, ABCD, and ABCE were readily available, the same could not be said about case studies on ROSCs and community-based recovery services. These systems and services surely exist throughout the country – however, their operational details and outcomes are not necessarily published.

This is reflected in the case studies included in this review – which all should preferably have been based in English shire counties (i.e., non-metropolitan geographies without a major city – where travel across the region can be time-consuming). Of the case studies covered, only one was located in a shire county (Barnsley in South Yorkshire). Furthermore, the characteristics of Barnsley, a market town, might be similar to some market towns in Derbyshire (e.g., Chesterfield) – suggesting at least some generalisability of findings.

The location of case study based in ‘North/South’ Town was not specified – however, it does share similarities to Derbyshire, in that residents needed to travel from one side of the region to the other, in order to access service. The location of The Well case studies was also not specified – aside from being the “North-West”. However, The Well does share similarities to Derbyshire in that services run by the Well involved engaging with communities across the county (e.g., individuals being released from prison into the community, and early engagement with individuals with acute substance-related harm issues identified from a hospital service) – and linking them to multiple services in the community, such as a recovery hub.

The least similar location was seen in the RCC case study, which was based in Pennsylvania, USA. Particularly ungeneralisable, are the recovery outcome measures used by the RCC – which were from a USA-government issued tool. However, the tool does illustrate what recovery outcomes might be used in practice by RCCs.

12 CONCLUSION

This narrative review has shown that the definition, mechanisms, development, facilitation, and outcome measurement of recovery are all interconnected – through the idea of RC.

Definition: As previously described, there is no single definition of recovery – however, several definitions describe personal RC (e.g., resilience), social RC (e.g., positive social networks), community RC (e.g., membership of social groups) in some way.

Mechanisms: As an overall journey, the *CHIME* model (section 5) describes the groups of processes involved in recovery, i.e.: how *C*onnectedness to others in recovery (social and community RC) builds *H*ope in that recovery can be achieved (personal RC) and how it also contributes towards the creation of a new recovery-oriented **I**dentity (personal RC), which positively adds to *M*eaning in life (personal RC), and *E*mpowerment of oneself (personal RC).

Development: These processes described by the CHIME model can be facilitated through layers of community engagement (section 7) that one might traverse through as part of their overall recovery journey: from building personal RC through engagement with positive social groups; to building social RC through joining pro-social groups; and community RC in the form of better access to improved pathways to social networks and supports, and enhanced opportunities to engage with a range of community resources.

Facilitation: ROSCs (e.g., in the form of informal networks, RCCs, or work with RCOs) are able to facilitate this community engagement through increasing accessibility and visibility of activities such as mutual aid groups, peer-based support services, training and voluntary opportunities (section 8).

Outcome measurement: Service providers are able to measure the effectiveness of their services at various levels. At client-level, multiple tools have been used to measure recovery through RC – including the Assessment Recovery Capital (ARC) (personal and social RC) and REC-CAP (community RC) tools.

In closing, RC describes a strengths-based approach recovery (i.e., greater access to RC, means greater capacity of terminating substance misuse), one which service-providers can use for both planning, monitoring, and facilitating recovery. However, service-providers should also be mindful not to inadvertently create barriers-to-entry to their services, which might exclude those in need of those services. Indeed, “where a recovery community has developed as a result of one particular pathway ([e.g., based… on a therapeutic community or 12-step philosophy]) and where that pathway may not be appropriate or available for all, then that community may be perceived by others as ‘gated’ whereby the potentially protective factors offered by membership are only available to a privileged few” (Weston *et al*., 2017, p.8). This highlights the need for maximising access and inclusivity of community-based recovery services, for them to – in turn – maximise their reach and impact.

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