Double Impact Academy Evaluation

University of Derby

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Acknowledgements

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A number of researchers worked alongside staff at Double Impact to assist the collection of data. We would like to acknowledge the following individuals for their involvement with the evaluation and recognise their contribution to the write up of the final report:

Professor David Best is Professor of Criminology at Sheffield Hallam University, Honorary Professor of Regulation and Global Governance at The Australian National University and Chair of the British Society of Criminology Prison Research Network. He is an experienced addictions researcher and a recovery champion. He has published more than 190 peer-reviewed journal papers and six books (both single-authored and edited).

Beth Collinson is an Associate Lecturer in Criminology and Doctoral Researcher at Sheffield Hallam University. Her research explores gender similarities and differences in pathways to recovery from problematic alcohol use, with a predominant focus on how community engagement aids recovery.

Lauren Hall is a Lecturer in Criminology at Lincoln University and a Doctoral Researcher at Sheffield Hallam University. Her research explores the social experiences of people who are both recovering from addiction and desisting from crime, with the aim of designing strengths-based strategies of support.

Nikki Dean Marshall is a Doctoral Researcher in Psychology at Sheffield Hallam University. Her current research aims to further understand the organisation of the bilingual lexicon by investigating how words belonging to different languages are stored and accessed. Nikki's other research interests are surrounding the topics of mental health, addiction, and motivated behaviour.

We would also like to acknowledgement the additional support received from the wider Sheffield Hallam research team: Dr Jamie Irving, Craig Wilkinson and Dr Anna Kawalek.

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Glossary

To increase the accessibility of the research, we have included a glossary below to support the clarification of terms utilised throughout this report.

Student (client): this is the term given to people in recovery who are accessing Double Impact

Recovery: living a well-round and balanced life, free from problematic substance and/or alcohol use

Desistance: a move away from life characterised by crime towards a happier and fulfilling life

Quantitative: data collection measures and results which utilise numbers to collect and present findings

Qualitative: data collection measures and results which depends on narrative, such as interviews, and uses more interpretative methods

SPSS: a quantitative data storage and analysis computer software

Convenience sampling: using easily available participants to collect data from

Statistical significance: a statistical convention that indicates where data deviate significantly from chance findings

NVivo: a qualitative data analysis computer software which supports the categorisation of data into themes

Thematic analysis: the categorisation of qualitative data into themes

Background, Aims and Objectives of Double Impact

Double Impact was founded by Tony Herbert in 1998 and so has been operational for around 20 years. It started as a partnership with a local community college (The People's College) to support recovering drug and alcohol users, and was initially based in the YMCA in Nottingham. By 2006, Double Impact was beginning to develop a national profile with a focus on identifying key factors in effective aftercare through the use of personal development plans for users of the various services. There has always been a focus on personal and individual pathways to recovery sustained by a model of vocational growth and personal development planning.

The growth of the organisation continued with the establishment of the Double Impact Volunteering Academy in 2011 and the first Recovery Academy in 2014, with the aim of developing peer mentoring across the county of Nottinghamshire. This is one of seventeen educational interventions or activities that Double Impact currently delivers. However, with the opening of Café Sobar, an alcohol-free café and social space in the centre of Nottingham, with offices and group rooms above the café, there is the emergence of a physical and visible hub for recovery.

The aims of the Double Impact Academy (identified on their website are):

• To connect people with themselves, each other and their local communities

• To raise aspiration and ambition

• To access key functional skills training where needed

• To access level 1 and 2 progression learning

• To coordinate volunteering and work experience opportunities

• To support students to be work ready and into employment

• To generate a Peer Support network

• To develop a service user involvement network

• To promote and champion recovery

Lincoln is one of the regional centres that Double Impact runs, sharing a building with Addaction and receiving most of the referrals from Addaction into the Recovery Academy.

The Evaluation

Sheffield Hallam were commissioned to conduct an outcomes evaluation of Double Impact, Lincoln. The detail of the evaluation design is detailed in the rest of this section. Data involved in the evaluation was collected between September 2016 and September 2019. The data were collected in two phases that overlap, and so what is presented below is a detailed analysis of implementation in Lincoln, followed by a more quantitative analysis of data collected across a wider time window and across multiple sites designed to assess implementation of the REC-CAP method and of positive change over time

Evaluation aims

The primary purpose of this evaluation was to identify the impact engagement with Double Impact had upon students' recovery and desistance journeys. The aim is to show their growth in wellbeing and recovery capital and to demonstrate how this is linked to the Recovery Academy and to the broader range of services and support provided by Double Impact.

For that reason the first part of the report focuses on the specific experiences of the Double Impact site in Lincoln, and then the second part looks at a more quantitative analysis of change across a number of Double Impact services.

Research questions

The research questions underpinning the evaluation are:

<u>Study 1: The Lincoln experience</u>

- To what extent is the Recovery Academy model delivered by Double Impact delivered in a way that is consistent with the research evidence base and that fulfils the requirements of implementation fidelity

- To assess the extent to which students are effectively engaged in the Recovery Academy approach and what variation there is in engagement and completion rates?

- What impact participation in the Recovery Academy has on recovery pathways and broader measures of wellbeing?

<u>Study 2: REC-CAP implementation and outcomes across DI</u>

- To what extent was the REC-CAP instrument successfully introduced and what norms did this establish around recovery capital in DI?
- What evidence is there that engagement with DI leads to significant reductions in barriers to recovery and significant improvements in recovery strengths?

Study 1: A mixed methods approach

The evaluation used a phased data collection approach, with data being collected between September 2017 and December 2018[1]. The data was gathered using the following four phases:

- Phase 1 - baseline REC-CAP and student interviews
- Phase 2 - follow up REC-CAP and student interviews
- Phase 3 - student focus group
- Phase 4 - staff focus group

As at least one qualitative data collection approach was combined with the one quantitative data collection approach, the evaluation used a mixed methods approach. Mixed methods approaches have gained popularity within evaluative research as it allows for a broader, more comprehensive understanding of the research question. Both qualitative and quantitative methods can be subject to criticism if used alone, so uniting these two approaches alleviates any potential research design limitations. This allows structured data to be interpreted in the context of subjective and experiential components of data collection that allow the voices of multiple stakeholders to be heard.

Each of the data collection approaches gathers different elements of learning associated with the research questions and evaluation aims. These are outlined in the table below:

Table 1: Data collection measure rationale

	Phase 1		Phase 2		Phase 3	Phase 4
Data collection instrument	REC-CAP	Interviews	REC-CAP	Interviews	Student focus group	Staff focus group
Qualitative		x		x	X	X
Quantitative	x		x			

[1] Not all of the REC-CAP completions in Study 2 have been incorporated into Study 1, as Study 1 was completed at a much earlier date

What this is used to show?	Baseline information of students' recovery capital	Exploring substance misuse and offending history, background to students and pathways into Double Impact	Follow up to track recovery capital trajectories	Follow up to explore student recovery and desistance progress	Group based discussion regarding impact of Double Impact of recovery and desistance	Group based discussion exploring progress of academy and challenges faced
Analytical strategy	SPSS	Thematic analysis, NVivo	SPSS	Thematic analysis, NVivo	Thematic analysis, NVivo	Thematic analysis, NVivo

The Lincoln study sample

As the evaluation was specific to the Lincoln Academy, all data was collected on site by staff or members of the research team. The sampling procedure differed for each phase of data collection. This is detailed below.

- Phase 1 - baseline REC-CAP questionnaires were completed by staff members with new students upon entry to the academy. All students were requested to complete the REC-CAP as part of the standard data collecting process for the service. During this phase of data collection, interviews were also conducted by one member of the research team. Students were recruited through a convenience sample.

- Phase 2 - follow up REC-CAP questionnaires were completed with students after 6 months. The research team were involved in collecting these follow ups, so students were still given the opportunity to complete a second questionnaire regardless of whether they remained engaged with the academy, in what is referred to as an 'intention to treat' design. The same member of the research team who conducted the

initial interviews followed students up on an ad hoc basis. All students who completed an interview in phase 1 were given the opportunity to participate in a second interview.

- Phase 3 - a focus group with students was conducted using a convenience sample. The focus group was hosted on the same day as a celebratory event held at the academy and all of those attending with given the opportunity to participate.

- Phase 4 – a focus group with staff was conducted

The total number of individuals who participated in each phase of data collection is listed below.

- Phase 1 - baseline REC-CAP and student interviews
- Phase 2 - follow up REC-CAP and student interviews
- Phase 3 - student focus group (8 students)
- Phase 4 - staff focus group (8 staff members)

Data collection instruments

Data collection consisted of four data collection instruments. These were as follows:

1) REC-CAP questionnaire (Best et al, 2017)

2) Student interviews

3) Student focus group

4) Staff focus group

From the data collection instruments listed above, two case studies were collated for students, one female and one male. These case students consisted of data being drawn together from the REC-CAP questionnaires and student interviews. Detail of each stage of the methodology and data collection instruments will be discussed in the subsequent subsections.

1.1 REC-CAP questionnaire (Best et al, 2017)

This aspect of data collection involved completion of the REC-CAP (Best et al, 2017) by students at DI at the start and approximately 6 months later, towards the end of their engagement with the academy. The REC-CAP measures key elements of personal, social and community capital and translates this into a summary of recovery strengths and barriers that can be used to support the ongoing recovery pathway and journey (Best et al., 2016). The REC-CAP is a systematic and simple way of quantifying recovery capital that can be used to chart progress as individuals proceed in his or her recovery journey. The REC-CAP has been approved for use in several prior and current projects (e.g. The Health Foundation, FARR, Intuitive Recovery), as is widely used in a range of research and clinical contexts.

Collected data were subject to statistical analysis in order to track individuals' levels of recovery capital in a quantitative method. The REC-CAP can be used to help services map client change (Best & Edwards, 2017). By tracking and mapping journeys, significant points in the process can be distinguished. Furthermore, factors which may facilitate and/ or hinder the accumulation of recovery capital can be distinguished and patterns within the data can be mapped. Examining differences in the subjective experiences of individuals across different demographics will help identify factors which may motivate recovery efforts and help individuals to realise the strengths they already possess. The primary focus of the evaluation report is to explore whether engagement with Double Impact impacts on an individual's accumulation of recovery capital, and so improves their quality of life and overall wellbeing.

The scales included in the questionnaire include: Demographic characteristics; quality of life and satisfaction; barriers to recovery; accommodation; service involvement; personal recovery capital; social recovery capital; involvement with recovery groups (which measures community recovery capital); commitment to sobriety; substance use; group membership; social support; and support groups. Although the REC-CAP is a measure orientated towards recovery, the measures of social recovery capital and social support, quality of life and satisfaction and accommodation are transferrable to those desisting from crime.

1.2 Interviews with students

16 interviews conducted with students across two timeframes were thematically analysed using NVivo 10: 10 at time one and 6 at time two. Initial interviews were conducted with students who were engaged with Double Impact, with follow up interviews being conducted 6 months later. Interviews were semi-structured and students were given the opportunity to discuss their recovery and desistance experience, exploring their pathways in and out of substance use and crime. Students discussed their social support networks and involvement in recovery orientated organisations external to Double Impact. Students also made reference

to their referral pathways into Double Impact and the impact involvement with Double Impact had on their recovery and desistance journeys.

1.3 Focus group with students

A focus group with 8 students was run and later thematically analysed using NVivo 10. The focus group was semi-structured, with students being asked about the skills acquired through involvement with Double Impact, the environment fostered by Double Impact, social networks developed, pathways to external community resources, personal development and lifestyle improvements outside of Double Impact, hopes and aspirations for the future, areas for improvement for Double Impact as an organisation.

1.4 Case Studies

To further unpack the evaluation and merge together the quantitative and qualitative data, two case studies have been used; one male and one female. The case studies incorporate the REC-CAP questionnaire and student interview, with an analysis of how engagement with Double Impact has aided the individuals' recovery and desistance journeys.

1.5 Focus Group with Staff

A focus group with 8 staff members was run and later thematically analysed using NVivo 10. The focus group was semi-structured and conducted in December 2018. This allowed for staff members to reflect on the work and development of the academy and discuss challenges, past and present, which the academy faced.

Challenges and limitations

Difficulties arose at the follow up phase as students who had disengaged with Double Impact were hard to follow up. As a number of staff and researchers were in charge of completing REC-CAP questionnaires with students, some follow-ups were missed, resulting in data from only 10 individuals contributing to part of the analysis. However a more in-depth statistical analysis with a larger sample is presented from across the Double Impact sites in Study 2 below.

October 2016 - December 2018: Achievements at the Lincoln Academy

39 LEVEL 1 AWARD ACHIEVED

12 LEVEL 2 ACHIEVED

57 ACCESSING EDUCATION SKILLS

8 ACCESSING MAINSTREAM EDUCATION

103 ACCESSING ACREDITTED LEARNING

125 ACCESSING MUTUAL AID

14 INTO PAID EMPLOYMENT (35+ HOURS)

23 INTO PAID EMPLOYMENT (PART TIME)

14 INTO EXTERNAL VOLUNTEERING

Exploration of project objectives and outcomes

1.1 REC-CAP Analysis

While Study 2 provides the overall analysis of REC-CAP patterns and change, the analysis for the Lincoln study focuses at a lower level of granularity on changes in recovery capital and provides individual level detail on how these changes are managed. What is reported below is a series of individual case studies drawn from the Lincoln cohort about change:

Time 1 versus Time 2 (9 cases)

Individual Case Differences[2]

Name	Variable	Time 1	Time 2	Mean Difference (+ improved, - not improved)
Baker, S	**Quality of Life**	**74**	**79**	**5**
	Personal Recovery Capital	**22**	**20**	**2**
	Social Recovery Capital	21	18	-3
	Community Recovery Capital	**6**	**11**	**5**
	Commitment to Sobriety	30	29	-1
Volunteering (change): Baker was not volunteering in time 1; however, in time 2 they did begin to volunteer as a smart facilitator every Tuesday night (18:00-19:30).				
Work (no changes): Baker was not working full or part time in time 1 or time 2. There was involvement in education in both time 1 and time 2.				
Involvement with the criminal system (no changes): There was no involvement in offending, police in the last 90 days, community orders or parole in either time 1 and 2.				
Additional help from recovery groups: Baker expressed being involved in the mental health services and being satisfied; however, they would like additional help with these services. **Substance History (no changes):** While there was a history of alcohol and tobacco problem - there was no substance use in either time 1 and 2.				
Chaffon	Quality of life	unknown	91	…
	Personal Recovery Capital	25	25	0
	Social Recovery Capital	**19**	**25**	**6**
	Community Recovery Capital	5	5	0

[2] Bold numbers indicate where there is a positive change

	Commitment to Sobriety	30	30	0
Volunteering (change): Chaffon was not volunteering in time 1; however, in time 2 they did begin to volunteer as a countryside access volunteer in weekly walks for Lincolnshire country council.				
Work (change): Chaffon was not working full or part time in time 1 or time 2. However, there was involvement in education in time 2 compared to time 1.				
Involvement with the criminal system (no change): There was no involvement in offending, police in the last 90 days, community orders or parole in either time 1 and 2.				
Additional help from recovery groups: Did not want additional help with services. Was engaged in family relationships and primary healthcare services in time 1 but not in time 2. **Substance History (change):** There **was** substance use in the last 90 days in time 1 and Chaffon expressed that alcohol and tobacco was a problem. However positively, in time 2 there was **no** substance abuse.				
Challis	Quality of Life	60	75	15
	Personal Recovery Capital	Unknown		
	Social Recovery Capita			
	Community Recovery Capital			
	Commitment to Sobriety			
Volunteering: Challis was not volunteering in time 1; time 2 is unknown.				
Work: Challis in time 1 was not working part or full time or in education – time 2 is unknown.				
Involvement with the criminal system: There was no involvement in offending, police in the last 90 days, and community orders in time 1 but this is unknown in time 2. Challis was on parole in time 1, but time 2 is unknown.				
Additional help from recovery groups: In time 1, Challis was engaged in mental health services, family relationships, employment services, primary healthcare services, housing support, drug and alcohol treatment and was satisfied with the service. Time 2 is unknown. **Substance History:** There was no substance abuse in the last 90 days in time 1, but Challis did not disclose in time 2.				
	Quality of Life	**54**	**60**	**6**

Davis	Personal Recovery Capital	20	unknown	…
	Social Recovery Capital	19	15	-4
	Community Recovery Capital	**1**	**11**	**10**
	Commitment to Sobriety	30	30	0
Volunteering (change): In time 1 Davis was not volunteering; however, in time 2 he did begin to volunteer but did not specify what they did.				
Work (no change): Davis was working full time in both time 1 and time 2. There was no change in part-time work and education – not engaged with this.				
Involvement with the criminal system (no change): There was no involvement in offending, police in the last 90 days, community orders or parole in either time 1 or 2.				
Additional help from recovery groups: Was engaged in drug treatment and housing support services and was satisfied at time 1 and time 2. Does not want help with any services. **Substance History (change):** There was no substance abuse in time 1 but there was at time 2. Davis reported that heroin, crack cocaine and tobacco had been a problem but had not used these substances in time 2 or did not disclose. In time 1 Davis disclosed that prescribed methadone was a problem; however that it was not in time 2 - Davis had used prescribed methadone in the last 90 days in time 2.				
Durose	Quality of life	**77**	**87**	**10**
	Personal Recovery Capital	**8**	**21**	**13**
	Social Recovery Capital	**14**	**23**	**9**
	Community Recovery Capital	**6**	**12**	**6**
	Commitment to Sobriety	30	30	0
Volunteering (no change): Durose was not volunteering in time 1 or time 2.				
Work (change): In time 1 Durose was not working full or part-time and was not engaged in education; however, in time 2 they were engaged in part-time work and education.				

Involvement with the criminal system (no change): There was no involvement in offending, police in the last 90 days, and community orders in time 1 or time 2.				
Additional help from recovery groups: At time 1, Durose was engaged in drug treatment services and satisfied but not engaged in time 2. In time 1 engaged in housing support; however, this is unknown for time 2. Family relationships, employment and primary healthcare services were engaged and satisfied with in time 1 and 2. **Substance History (no change):** While there had previously been a problem with alcohol, heroin, cannabis, benzos prescribed and street, tobacco, methadone prescribed and street there was no substance abuse in the last 90 days in time 1 or time 2.				
Farrarr	Quality of life	82	73	-9
	Personal Recovery Capital	**22**	**25**	**3**
	Social Recovery Capital	**24**	**25**	**1**
	Community Recovery Capital	14	unknown	…
	Commitment to sobriety	30	30	0
Volunteering (no change): No volunteering in time 1 and did not disclose in time 2.				
Work (change): Farrarr was not working full-time and not engaged in education; however, in time 2 they were working full-time and engaged in education.				
Involvement with the criminal system (no change): There was no involvement in offending, police in the last 90 days, community orders or parole at either time 1 or 2.				
Additional help from recovery groups: Did not want help with any services at time 2. At time 1, Farrarr disclosed he wanted additional help in the areas of employment, alcohol, mental health, and housing support services. Farrarr was engaged in mental health services, primary healthcare, family relationships, other specialist (AA, DI), drug and alcohol treatment services, but either did not disclose or was not involved in the services in time 2. **Substance History (no change):** While Farrarr reported alcohol, heroin, and tobacco being a problem in the past; there was no substance use in the last 90 days in both time 1 and time 2.				
Kirkby	Quality of life	**61**	**67**	**6**
	Personal Recovery Capital	**15**	**18**	**3**

	Social Recovery Capital	19	19	0
	Community Recovery Capital	10	10	0
	Commitment to Sobriety	30	30	0
Volunteering (no change): Volunteering weekly in both time 1 and time 2 for Addaction with MAP groups.				
Work (no change): There was no change in full-time, part-time work and education – not engaged with this.				
Involvement with the criminal system (no change): There was no involvement in offending, police in the last 90 days, community orders or parole at either time 1 or 2.				
Additional help from recovery groups: Was engaged with other specialist services (not specified), employment services, mental health, drug and alcohol treatment services in time 1 but not at time 2. Engaged in primary health care services at time 2 (did not disclose for time 1). Reported that he wanted help in mental health and primary health care services and family relationships in time 1 but not at time 2. Expressed that he wanted help with employment services in time 2 (not in time 1). Engaged in family relationships in both time points, was not satisfied at time 1 but was at time 2. **Substance History (change):** Kirby did consume alcohol at time 1, but at time 2 there was no substances taken in the last 90 days. Has expressed that crack cocaine, cocaine powder, amphetamines, cannabis, methadone prescribed and street, benzo prescribed, and street was a previous problem.				
Stevens	Quality of life	**83**	**90**	**7**
	Personal Recovery Capital	**24**	**25**	**1**
	Social Recovery Capital	25	24	-1
	Community Recovery Capital	4	5	-1
	Commitment to sobriety	30	30	0
Volunteering (no change): No volunteering in time 1 or time 2.				
Work (no change): Stevens was working full time in both time 1 and time 2. There was no change in part-time work and education – not engaged with this.				

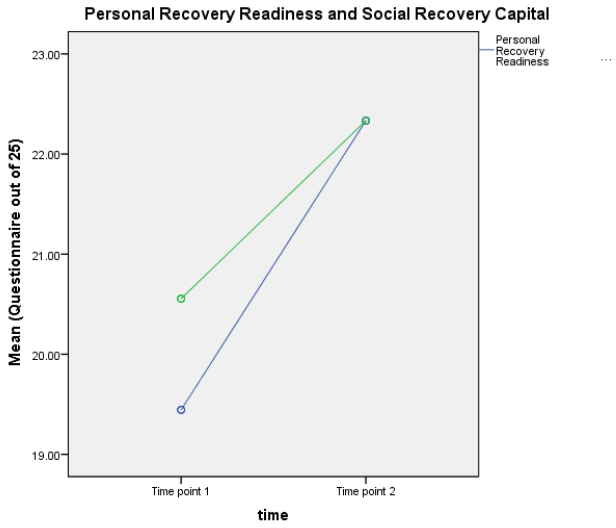
<table>
<tr><td colspan="5">Involvement with the criminal system (no change): There was no involvement in offending, police in the last 90 days, community orders or parole in either time 1 or 2.</td></tr>
<tr><td colspan="5">Additional help from recovery groups: Was engaged and satisfied with alcohol treatment and primary healthcare services at time 1 but not at time 2. Does not want help with services.
Substance History (no change): While Stevens expressed alcohol being a problem in the past, there was no substance use in the last 90 days in both time 1 and time 2.</td></tr>
<tr><td rowspan="5">Young</td><td>Quality of life</td><td>53</td><td>88</td><td>35</td></tr>
<tr><td>Personal Recovery Capital</td><td>14</td><td>unknown</td><td>…</td></tr>
<tr><td>Social Recovery Capital</td><td>20</td><td>21</td><td>1</td></tr>
<tr><td>Community Recovery Capital</td><td>9</td><td>9</td><td>0</td></tr>
<tr><td>Commitment to Sobriety</td><td>30</td><td>30</td><td>0</td></tr>
<tr><td colspan="5">Volunteering (no change): No volunteering in time 1 or time 2.</td></tr>
<tr><td colspan="5">Work (change): Young was not working full time at time 1 but was at time 2. There was no change in part-time work and education – not engaged with this.</td></tr>
<tr><td colspan="5">Involvement with the criminal system (no change): There was no involvement in offending, police in the last 90 days, community orders or parole in either time 1 or 2.</td></tr>
<tr><td colspan="5">Additional help from recovery groups:
Was engaged in alcohol treatment services, family relationships, primary health care services, and housing support at both time 1 and time 2 and was satisfied with this service. At time 1, Young was engaged in mental health and employment services but not at time 2. Does not want help with services.
Substance History (no change): While Young reported alcohol and tobacco being a problem in the past, there was no substance use in the last 90 days at both time 1 and time 2.</td></tr>
</table>

Demographics

The following section will discuss the comparisons between time 1 and time 2 for a total of 10 individuals, of which 7 were males and were 2 females (missing for the remaining person). There was a mean age of 48.22 (SD=12.66) in time 1 and 49.11 (SD=12.74) in time 2. A total of 8 people identified as white British and 1 as British.

Personal Recovery Readiness and Social Recovery Capital

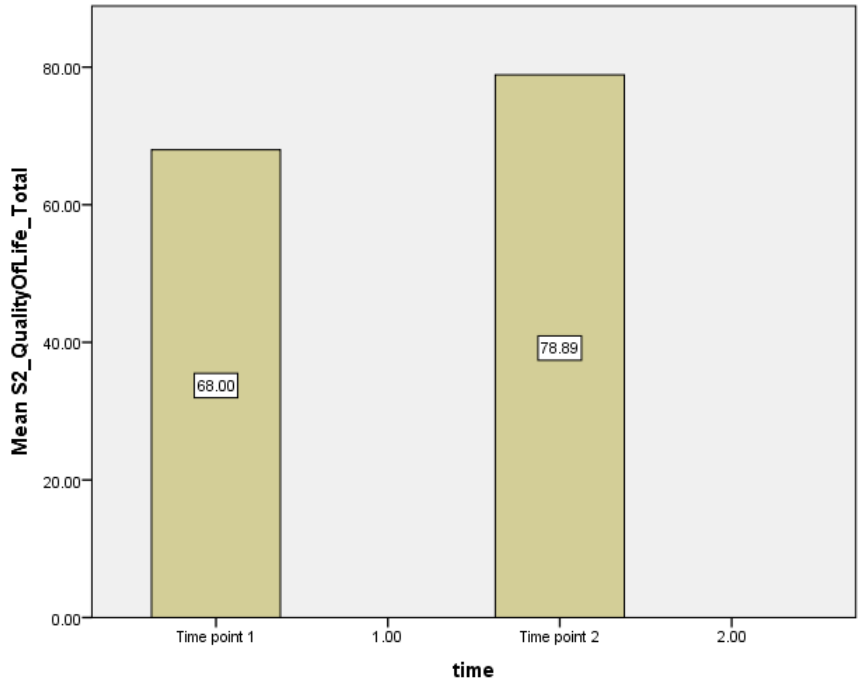
In the graph below it is clear that personal recovery readiness and social recovery capital both increased in time 2.



However, while you can see differences between the time points, this is not supported in the independent t-tests (a statistical method for assessing differences in averages between groups), probably as a result of low statistical power because of the small sample size. There were no significant differences between time 1 (M= 19.44, SD=5.88) and time 2 (M= 22.33, SD=3.43) for personal recovery readiness (t (13) = 1.10, p = .292; See Appendix for t-test SPSS output). Thus, although it had increased, the growth was not enough to make the difference significant on a statistical level. There were also no significant differences between time 1 (M= 20.56, SD=3.43) and time 2 (M=21.50, SD= 3.65) in social recovery capital (t (15) = .40, p = .692), although again the mean had gone in a positive (increasing) direction. According to the G*Power calculation programme based on priori analysis, to obtain a power size of .8 and a medium effect size (.5), a total of 128 participants would be required. Therefore, more participants are needed to finalise conclusions. However, it is also evident that there are generally positive gains in recovery capital for those included.

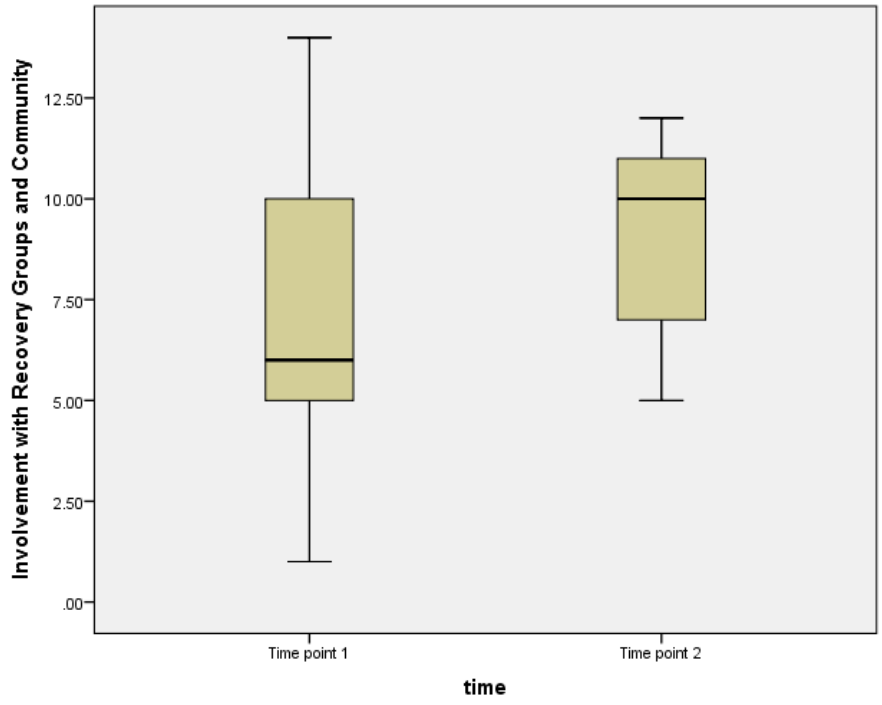
Quality of Life and Satisfaction

Similarly, while the bar chart below shows a marginal increase in the mean (also shown in the bar chart) in quality of life and satisfaction in time 2 compared to time 1, this is not supported by the independent t-tests which show no significant effects (t (15) = 1.92, p = .074), but again this is likely to be because the test is under-powered from a statistical perspective, and the consistency of positive effects – as reported again in study 2 – are positive grounds for regarding this as an effect of engagement in the services.



Involvement in Recovery Groups and Community, and Commitment

According to the boxplots below, involvement in recovery groups did appear to increase in time 2 (M=9.00, SD=2.89) compared to time 1 (M=7.44, SD=4.13), however this again was not significant in the independent t-tests conducted (t (14) = .85, p = .412).



Looking at the means for commitment to sobriety between time 1 (M=28.89, SD= 3.33) and time 2 (M=29.88, SD=.35), it is unsurprising that there were no significant differences in the t-tests (t (15) = .83, p = .420) as commitment to sobriety did not appear to change drastically between the time points. However, as the maximum score on this measure is 30, there is what we refer to as a 'ceiling effect' – in other words, where the baseline score is near the maximum for motivation, there is no place for motivation to grow!

The overall profile of Lincoln clients at baseline

There were 64 participants (Mean age = 41.66, SD = 10.66), 33 male and 31 female. The sample ethnicity was predominantly white British (57.8% **or** 37/64), followed by British (28.1% **or** 18/64) and 1.6% (1/64) stated they were British Irish, Irish and British mixed race. A total of 6 people did not disclose their ethnicity.

Offending

Out of 64 participants, there were only 2 individuals who disclosed being *involved in offending* in the last 90 days. There was a total of four individuals who disclosed being *involved with the police* in the last 90 days. In relation to *community orders,* one person did not disclose an answer, 62 did not have a community order and one currently did. Likewise, for *parole in the last 90 days*, one person did not disclose an answer, 59 were not on parole and four individuals disclosed being on parole.

Work

Out of 64 participants, 56 individuals were not currently *working full time*, while six were. There were two individuals *working part time* while 10 individuals disclosed being involved. Lastly, there were 11 people who stated they were currently *volunteering*.

Services Accessed (Time 1)

Drug Treatment

27 people (42.2%) were currently *engaged in drug treatment*, and in terms of satisfaction, 27 people were *satisfied* with the drug treatment services (42.2%), two were not (3.1%; 19 or 29.7% not applicable, 16 or 25% not disclosed). Five individuals (7.8%) stated that they wanted further help on this (30 stated no (46.9%), 10 not applicable (15.6%) and 19 did not disclose (29.7%)).

Alcohol Treatment

24 people (37.5%) were currently *engaged in alcohol treatment*, 23 (35.9%) people were *satisfied* with the alcohol treatment services, 8 were not (12.5%; 33 or 51.6% not applicable or did not disclosed). Six individuals (9.4%) stated that they wanted further help on this service.

Mental Health Services

23 people (35.9%) were currently *engaged in mental health services*, of whom 11 people were *satisfied* with the mental health services (17.2%), 12 were not (18.8%; 41 (64.1%) stated this was not applicable or did not disclosed). 15 individuals (23.4%) stated that they wanted further help on this service.

Housing Support

14 people (21.9%) were currently *engaged in housing support*, 12 people were *satisfied* with the housing support services (18.8%), seven were not (10.9%; 45 or 70.3% not applicable or did not disclosed). Six individuals (9.4%) stated that they wanted further help on this service.

Employment Services

12 people (18.8%) were currently *engaged in employment services*, 12 people were *satisfied* with the employment services (18.8%), eight were not (12.5%; 44 or 68.8% not applicable or did not disclosed). Five individuals (7.8%) stated that they wanted further help on this service.

Primary Healthcare Services

39 people (60.9%) were currently *engaged in primary healthcare services*, of whom 30 people were *satisfied* with the primary healthcare services (46.9%), five were not (7.8%; 29 or 45.3% not applicable or did not disclosed). Five individuals (7.8%) stated that they wanted further help on this service.

Family relationships

30 people (46.9%) were currently *engaged in family relationships*, of whom 19 were *satisfied* with the service (29.7%), 8 were not (12.5%; 37 or 57.8% not applicable or did not disclosed). Six individuals (9.4%) stated that they wanted further help on this service.

Other Specialist support

12 people (18.8%) were currently *engaged in other specialist services*, with nine people were *satisfied* with other specialist services (14.1%), nine were not (14.1%; 46 or 71.9% not applicable or did not disclosed). Four individuals (6.3%) stated that they wanted further help on this service.

Four people stated that they would like help with the following: Christians Against Poverty, AA and AA meetings, Probation, Bernandos (person became looked after in 2014), liver consultant, transport issues (having negative consequences on their engagement with services as they cannot attend).

1.2 Qualitative Data Analysis for the Lincoln Academy

Analysis of student interviews and focus group

The themes identified through the interviews and focus group shared similarities and therefore the results are discussed collectively. Remarks made in the interviews were supported in the focus group, highlighting these elements were recognised at a group level.

Themes identified within the transcripts are broken down in subsequent sections, with quotations being used where appropriate to provide a richer understanding of how engagement with Double Impact has aided students' recovery and desistance journeys.

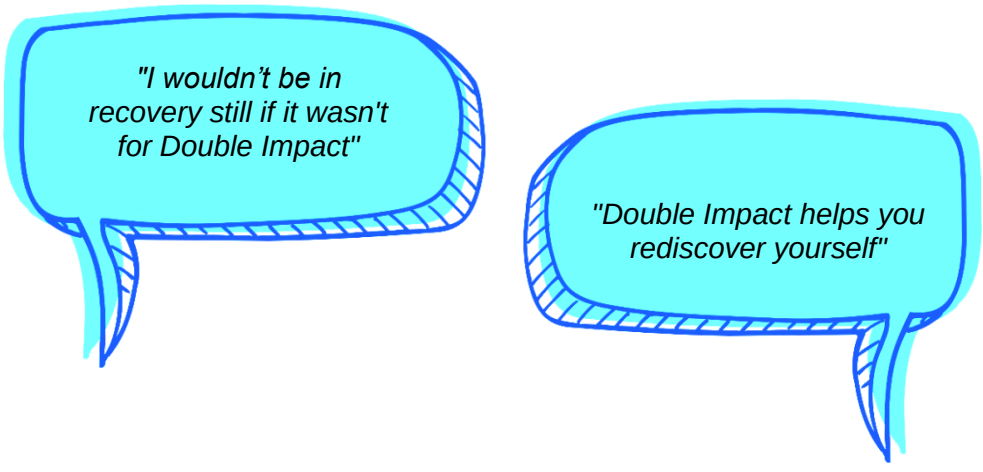
Engagement with Double Impact

Students made reference to the following referral pathways into Double Impact:

- Addaction
- Probation
- Other Double Impact academies

Addaction was the most commonly noted referral pathway, demonstrating multi-agency work between the two services. Students also made reference to other Double Impact academies and services they were familiar with, including Double Impact Nottingham and Café Sobar. Through these experiences, awareness of other Double Impact academies had been raised, with pathways to the Lincoln academy becoming more accessible. As a result of engagement with the academy, some students had relocated to Lincoln, as explained by one student, "I thought I might have to move however I didn't because Double Impact was here". This is of importance due to the tangible benefits a visible recovery community can have for individuals attempting to begin or maintain their recovery journeys.

Students within the focus group discussed how invaluable engagement with Double Impact had been on their recovery and desistance journeys with remarks such as, "I wouldn't have been able to do it without this place".



Double Impact Staff

Students commented on the continuous support from DI staff and the positive impact this had on their recovery and desistance journeys. As supported by one student:

"There's no black or white with the staff, there are lots of grey areas in this field and I think they understand that so their experiences, whether personal or learnt, they understand there are lots of grey areas in recovery and it helps."

Within the focus group, students discussed the non-hierarchal structure of the academy, stating how welcome they were made to feel by staff. As supported by one student who stated, "You're made to feel welcome by everyone, even the people above you i.e. the mentors and tutors and people who work here, we're always on each other's level - there's no hierarchy when you walk through that door". Other students in the group agreed with this comment, expressing how comfortable they felt around staff and mentors and how they saw themselves as "not being a number (…) you're valued". Through the formation of these non-hierarchal relationships, students in the focus group expressed how this lead to them being more open and honest with staff. One student discussed how as a result of their mental ill health they were unable to attend for two weeks but spoke about how tutors welcomed them back in - "the door was still open (…) this was early in recovery so that's really important to know that if you've got an issue I don't have to lie, I felt I could be honest, I can just call up and say this is what's happening".

Encouragement and enthusiasm from staff was commented on as a significant factor for the success of the academy. As highlighted by one student, "it's saying 'I understand, we're here, and you're doing brilliantly' and that's the key (…) which builds self-confidence and has that knock on effect"; "they're supportive which is the main thing and will bend over backwards, within reason, to cater for any difficulties you may have". Students commented on the welcoming environment fostered by staff members and how this, coupled with the informal setting implemented within the learning environment, "it's more informal than a lecture hall"; "it's so welcoming", increases engagement with the academy. As supported by one student, "the staff and the groups are equally as crucial".

In terms of the understanding of staff, those with personal experience of recovery and desistance acted as a crucial component of support for students. As stated by one student, "they are run by people who have been through it before, I think that makes a massive difference". Another student stated, "it's a breath of fresh air being around people that have similar experiences and the staff definitely don't judge you and genuinely want to help you".

Double Impact Groups

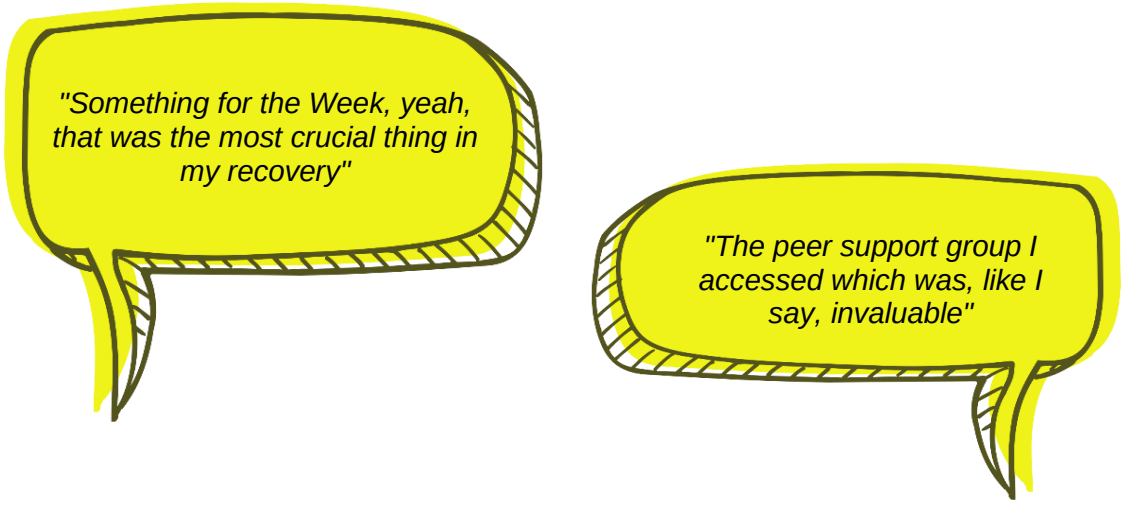
All students spoke highly of the range of groups and educational courses offered by Double Impact. Those frequently mentioned were: "Something for the Week", "Something for the Weekend", the peer support group and a range of Level 1 and Level 2 educational courses.

Coupled together, these groups provided opportunities for personal growth as well as a therapeutic environment conducive to students' recovery and desistance. Educational courses offered a platform for employability skills to be developed and new knowledge to be learned, "I'm learning again and I absolutely love it"; "I went straight onto the Level 2 – I loved doing it and got a lot out of it". As a result of this, students discussed a number of opportunities that had become available to them since completing educational courses. These opportunities include paid and voluntary work, both internally and externally to Double Impact. As previously mentioned, staff fostered a friendly and comfortable environment for students to learn, advantageous to the students' development and engagement with the academy.

Additionally, students recognised other groups at Double Impact as offering invaluable support for their recovery and desistance journeys. As stated by one student, "the talking, the group work and stuff, well money can't buy that (…) you can't just say, "oh I want to do a personal growth course' - it doesn't work like that". A group environment allowed students to associate themselves with others who were supportive of their recovery and desistance.

It was evident that engagement with Double Impact groups lead to a contagion of wider engagement (this is the well-established recovery pathway from 'bonding social capital' (that exists within a group) to 'bridging and linking social capital' (connecting effectively with other groups). Through pro-social networks formed, individuals frequently started to access other groups at Double Impact and encourage one another to try out new groups and activities. As a result of this growth of engagement, opportunities externally to Double Impact became visible for students.

Similarly to remarks made about the educational courses being more informal, students commented on other groups run by Double Impact being similar, as stated by one student, “[The groups] are kind of informal so it’s just relaxed which is better than other groups”. Students spoken about groups external to Double Impact comparatively, discussing the significant impact Double Impact had on their recovery and desistance.



Opportunities

All students commented on the opportunities that had been available to them as a result of engagement with Double Impact. These were both internally at Double Impact - opportunities to study, volunteer, and work, and externally - with opportunities to work and engage in local activities and services. As explained by one student, "giving up substances just takes you to the base of the mountain and then you've got the rest of the mountain to climb to actually get you to where you need to be". Students in the focus group discussed how Double Impact provided them the opportunity to engage within an educational environment which felt safe and comfortable. One student spoke about how they wanted to go into education however due to these past problematic substance use, felt they were "not ready to go to normal college or

go into a normal job". Following this, students discussed collectively how Double Impact was a "perfect stepping-stone between the two".

Through personal development and the accumulation of self-confidence, self-esteem and newly formed trusting relationships, students expressed that they were optimistic in regards to new opportunities arising. When coupled with ongoing support from Double Impact staff, students presented with higher levels of self-worth and self-belief, “they are giving me that confidence in myself and just give me the signposting and the guidance and pointing little bits and pieces out, like, look into this, look into that, and being very supportive”.

Students remarked on how staff were encouraging engagement in voluntary work amongst students and supporting them throughout the process. As demonstrated by one student, “I can’t say enough good things about it, [the staff] really pushed me to go for this volunteer position and are pushing me to go for something else at the end of next month. The staff are brilliant, really supportive”.

Students spoke about support from staff encouraging them to undertake new courses and opportunities. Students made comments such as “[staff member] has given me the gee up to start looking (…) so it’s given me that boost”. Through the success of staff support coupled with the courses and groups available at Double Impact, students were given a platform to develop in a number of areas, promoting successful recovery and desistance. Through these opportunities, students were presented with responsibility which helped to sustain motivation to maintain recovery and desistance. As stated by one student, "if you started to go away and drink again you would lose your job. Everything would go downhill and I don't want that".

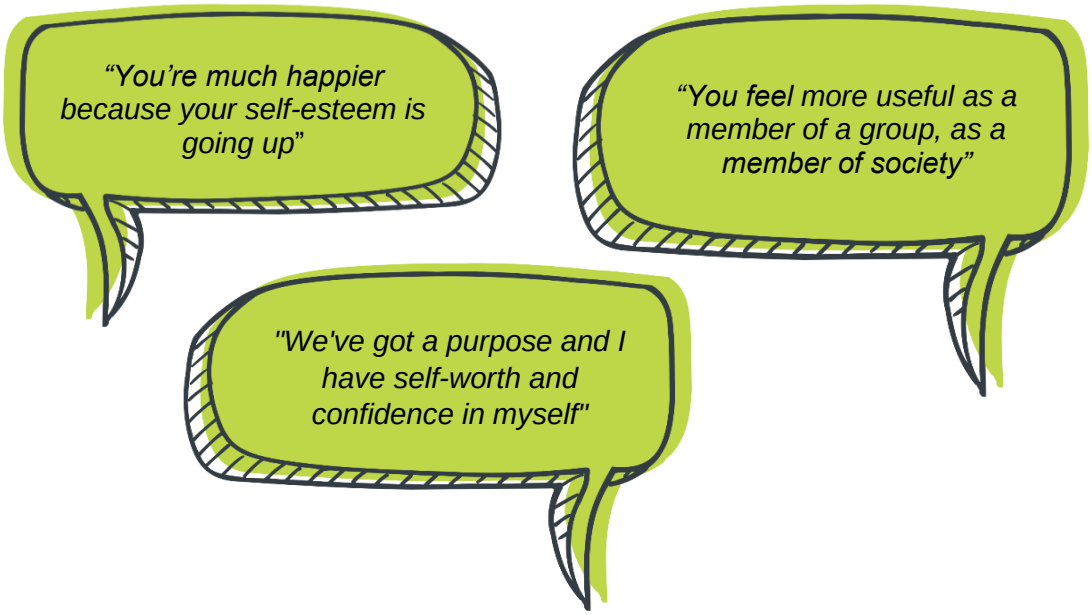
Personal Development

Students discussed how through problematic substance use, confidence had been lost, both in themselves and in others. As supported by one student who stated, "Your self-esteem gets so, so low [during addiction]". Students also discussed how before engagement with Double Impact, they lacked trustworthy and supportive relationships. As evidenced by one student who said, “I was totally untrustworthy and I wasn’t moralistic in my addiction but I believe that I am becoming more moralistic and more trustworthy”.

Through engagement with Double Impact, all students within the focus group noted a growth in confidence, expressed how satisfied they were with their lives since becoming involved with the academy. Students used phrases to describe their life satisfaction as being "off the scale" and "having a life now instead of just existence".

Students reflected on their past selves, “you can’t be who you are [whilst using] and that chips away at your confidence and self-esteem" and talked about how engagement with Double Impact and newly formed relationships with staff and peers helped to rebuild trust and contributed to personal development. As one student expressed, "it's really good to be able to come to Double Impact and be able to find trust in people in the room". This was further supported in the focus group, with students acknowledging that throughout their recovery and desistance journeys they could begin to become "true to themselves". Students all expressed how aware they were of the stigma associated with problematic substance use and this had lead them to "go through life lying because you don't want to be honest or confess how things are because there's so much stigma surrounding addiction". Reflecting on their newly forming identities however, students showed confidence in the progress they were making. As one student described, "the outside to me doesn't really need to know anything about me or my story or my past, they just need to know me from how they see me moving forward and I'm really sure that I can do that. I feel confident in being able to do that now".

While not immediate, the growth of a number of factors over their time with Double Impact had helped aid student's recovery and desistance journeys and over time, lead them to better themselves - "you can be honest and have openness with people". A number of other factors including: self-confidence, self-esteem and self-worth were developed through engagement with peers, staff, support groups and educational courses at Double Impact. As one student remarked, "the whole personal growth thing (…) well money can't buy that", "Double Impact gives you self-worth and a bit of purpose about your life".



Health and Wellbeing

Notable improvements were made in students' physical and psychological health and wellbeing. While causal effect cannot be attributed directly to involvement with Double Impact, students expressed the belief that continuous engagement with Double Impact, leading to openness to change, willingness to learn and pro-social social networks, in turn lead to improved health and wellbeing.

Students expressed that as well as noticing improvements in their own health and wellbeing, others had remarked on this, reinforcing motivation to stay sober and clean. As stated by one student in regard to the support offered by Double Impact, "people are being supportive and being really positive and saying, I can see you've changed, you look so much better".

Students frequently referred to their past, using identities, addressing issues of low self-esteem and confidence. When follow up interviews were conducted, students then reflected on their new self, marking remarks such as, "people just say I'm happier and nicer and cleaner". Noted within this was openness to change, as stated by one student, "it makes it easier to open up about your feelings and what's happened to you and accept it". Students attributed this to engagement with individuals at Double Impact who could relate to their own life experiences.

Social Networks

Social networks can have a strong impact on recovery and desistance pathways. Networks associated with deviant, substance misusing behaviour can be detrimental to those in recovery or desisting, as supported by one student, "it was being around negative people [group external to Double Impact] and that is what made me go back to the drink". Students in the focus group shared experiences of having to distance themselves from old peers who were not supportive of their sobriety. As one student stated, "I had to deter myself from anyone and everyone in the lifestyle I used to live in before in order to help myself move forward".

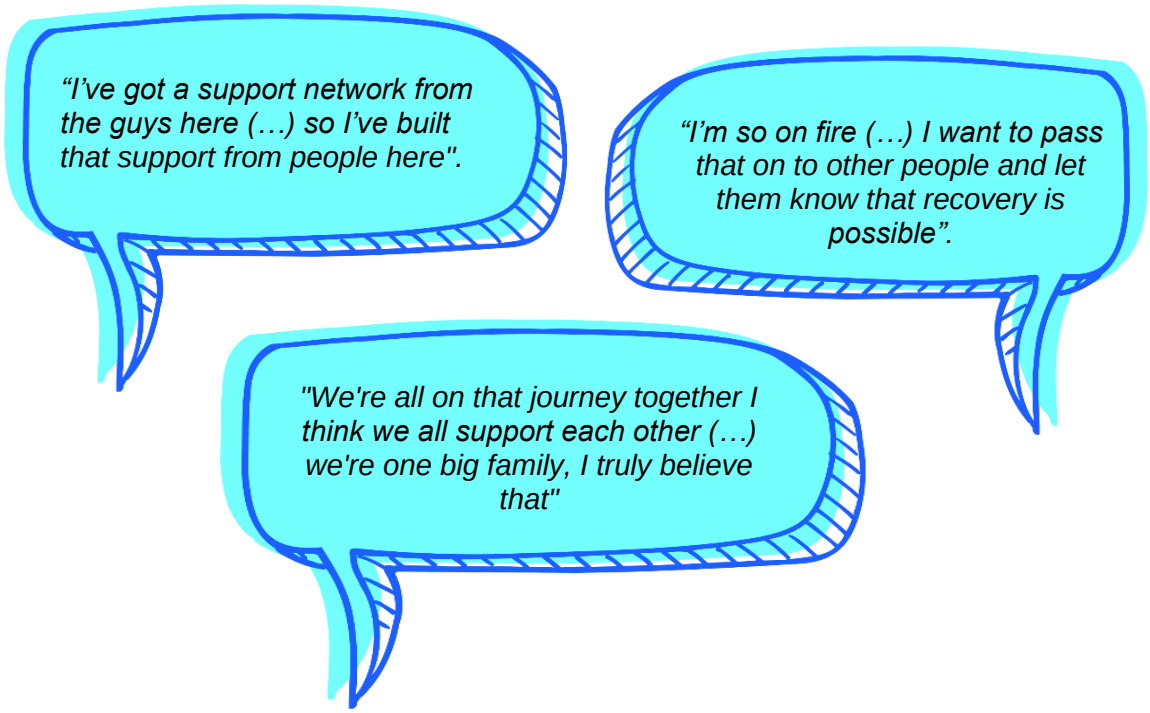
Double Impact allowed students to meet and interact with others with shared experienced which proved to be invaluable for students as these networks were supportive of their recovery and desistance, "the friends that I've made in groups here have been helpful", "you are in a building and doing activities with people who have actually been where you've been".

Engagement with Double Impact provided a platform for students to receive peer support whilst forming new social networks. While these interactions provided immediate support for students, they often resulted in lasting friendships, as explained by one student, "you make new friends, that's just the way it is", "we're friends here, really close, good friends who I won't forget. I was not in a good place when I first came; I remember how different I was a year ago so I've really changed".

Students highlighted that being around others who had been through similar experiences had powerful implications - allowing students to feel comfortable and safe and share their own

stories in a non-judgemental environment. As stated by one student, “it gave me an environment in which I was around people who’ve got shared experiences and that was absolutely crucial, you feel safe (…) you know that people will understand”.

Within this, a contagion of recovery and desistance became prominent, with students passing on messages of hope to others who were not as far on in their own recovery and desistance journey. One student stated, “When there’s somebody who’s in a bad place its saying look what I’ve come through, it’s doable”. This also reflects the research literature emphasising the importance of both a sense of belonging and camaraderie and also how important positive role models and informal social control can be in the recovery journey.



Past and Future Selves

Throughout the interviews, students often reflected on their past selves, noting how far they had come in their recovery and desistance journeys and the significant changes that had happened throughout the process. During their engagement with Double Impact, students gained confidence and self-esteem, showed signs of improved health and wellbeing and evidenced an uptake of new pro-social activities including volunteering, work and educational courses.

Through this, Double Impact provided a platform for individuals to promote the success of their own recovery and desistance and given the determination and commitment, showed others

this was achievable. As supported by one student, “I saw there could be light at the end of the tunnel and that I could get back into normal society again and work”.

Students were open about their past, "it's saying that is the past and this is who I am now and moving on", and then reflecting on their futures, “for all that bad that you’ve done, they then see the fact you’re now turning a corner and actually starting to do something that is positive and proactive”. Student spoke positively and shared their aspirations for the future. These included things such as: "I want to open my own gym and be helping people", "I want to own my own rehab" and "I would love to work within recovery services in the future".

1.3 Analysis of staff focus group

In December 2018 a focus group was conducted with eight members of staff. Conducting this towards the end of the evaluation allowed for staff to reflect on the work of Double Impact and how the academy has developed over the course of the evaluation.

Employment pathways: from service user to staff

Out of those staff members who attended the focus group, three had previously been students within the academy and over the course of their time spent with Double Impact had progressed in to paid roles. During this transition, many had volunteered with Double Impact or other organisations within a similar field of work, including voluntary work in rehabs and hostels. This creates an important visibility of progression and provides extremely strong role modelling opportunities for those who engage with the Academy.

Staff members who had previously been students with Double Impact reflected in the focus group on their experiences within the Academy and their transition from student to staff member. Staff members noted how experiencing this transition had helped them within the role as they were able to relate with the experiences of new students. As explained by three individuals, “I’ve lived it and now deliver it so it’s been a wholly positive experience for me”; ““I just like the model, how people who have been through it are then able to help other people and get experience and move forward in their life to whatever it is that they're going to do”; “having experienced it personally – the wonderful thing with it is to see other people going through that process and trying to encourage them to get out of it what we have”. Staff members engaged in discussion about the progression and development of the academy and how it was the only thing of its kind within the local area.

Staff members further discussed the ethos of the academy and how “connecting yourself with the wider community, volunteering and training” is what makes Double Impact unique – the staffing team discussed the progression and development of the academy and how it was the only thing of its kind within the local area. Throughout this discussion, staff members reflected on how privileged they felt to be able to assist students within the transition from the academy to the wider community and how through this process they were able to “give students the confidence to move into society”. As explained by a another staff member, Double Impact strives to provide a holistic package of support –

> “it really is the whole package because it isn't just about Level 1 and Level 2, it's so, so much more than that and to try and push that across to people, not push it but encourage them to see it as they go through it's just amazing because we've had some fantastic results here. I mean I can't speak highly enough”.

Similarly, staff members discussed the supportive and safe environment that Double Impact fosters, allowing individuals “room to develop in a very supportive way”, conducive to their recovery and desistance. For those staff members who were previously students at Double Impact, the support they had previously received enabled them to build confidence and progress in their own recovery and desistance journeys. At the point of being a student, becoming a member of the staff team seemed unimaginable – “I think it’s amazing, in the two years that I’ve been here I’ve gone from service user to volunteer to a paid part time position and then a full time position which is absolutely amazing as far as I’m concerned”; “Two years ago I would never, ever have imagined that I'd be teaching the courses that I was doing”.

Those who had previously been students spoke highly of the opportunities available to progress to paid employment within the Academy and reflected on how giving back to others earlier in their recovery or desistance journeys had helped their own personal development -

“It’s given me my life back basically, or my sense of purpose and my self-respect and dignity back again”. Individuals reflected on “seeing two sides” to Double Impact, having previously been students but expressed how valuable it was to be able to “give the same opportunity for people who want to change (…) stopping the drugs or alcohol is one thing but to build a life for a service user can be a daunting thing so the fact Double Impact are in the business of helping people move forward is a fantastic thing and I feel very privileged to be part of that”. This is known as the Helper Principle (Reissman, 1965) and is based on the idea that helping others increases feelings of connectedness, self-worth and self-efficacy.

Empowerment

Staff members honoured being able to help others and expressed how this gave themselves a purpose within their own recovery journeys. As stated by one staff member –

> “I've got a purpose in life and I'm helping other alcoholics and addicts. I think for me to see people that I've had a direct influence on now multiple months or even over a year in sobriety is an amazing thing. I still can't believe that I can be instrumental in some people’s lives in that way”.

Others supported this statement, stating -

> “It's only when someone will say to me just out of the blue, 'well, it was only because you did that', that takes me back to realise that - even though I know that's what my role is it's sometimes just getting that affirmation sometimes just makes you realise how important the role is”.

> “From a personal perspective when a student turns round and throws their arms around you sobbing and crying because their kids want to get in touch with them for the first time in years and said 'you've done that, you're my role model’”.

Future of the Project

Staff spoke optimistically about the future of Double Impact, sharing their visions for academy developing and expressing excitement to be part of the staffing team whilst the academy grows – “For the future we've got some really good things happening and as a whole it's a really great place to work for”.

During the focus group, staff were given the opportunity to express their vision for Double Impact and where they would like to see the academy going. Recommendations included:

- A one stop shop (“treatment, drug workers being all together, support services, housing etc.”). As explained by the staff member, this would offer continuity and visible progress for students.

- The Lincoln Academy acting as a pivotal point for the other hubs in the country ("This is the pivotal link between the recovery, if you can get people in to groups to begin with or vice versa because we do get people in to the academy who we can then get in to groups because they've been reticent about it before so for me I would like to see those grow and develop and be self-sustaining as much as we can here").
- Delivering interventions throughout the entire recovery journey. One member of staff stated that they thought the academy would be favourable to deliver such interventions because of the way in which the staff work, "we work very forward focussed, we don't look at people's past where people dwell on. I think it would make a massive difference".

Supportive Environment

Staff members all discussed a supportive working environment within the academy. When reflecting on previous job roles, staff spoke highly about the flexibility within the working approach at Double Impact and how team members often "thought outside of the box", adding to the Academy's value and ability to cater to the needs of students. Staff all agreed that the Academy's approach to work was "person orientated", with the academy supporting professional development, "As far as training's concerned, they're really open to learning and learning more and building yourself"; "You've got loads of opportunities".

Individuals spoke about the staffing team feeling like a "family" and showed great enthusiasm to be part of the team: "it's a really great place to work for", "the team we've got now is fantastic". The working, inclusive environment fostered by the staffing team was important for them and individuals used phrases such as "feeling part of something". This was beneficial for their own productivity and individuals expressed how this enhanced motivation. As stated by one staff member, "It's like a family. It's lovely and there's nothing better than to get up in a morning and want to come to work and love it".

Growth of the Academy

Staff members discussed the work of the Academy being unique in its nature and the flexibility of the working approach allowed the Academy to "be responsive rather than a system". Through the development and growth of the Academy, staff members discussed having to "change and adapt" and through being responsive, the academy as an organisation was "open to change". One staff member used to the analogy of a recovery journey to describe Double Impact, explaining how it has blossomed over the years.

Staff members discussed the reflective nature of the focus group and how having the opportunity to discuss the progress and work of academy allowed individuals to realise how alike their own journeys have been. As described by one staff member -

> "It's only when we all sit together that I realise how like your journeys mine is and how like your journey yours is. They're all individual but there's a thread that runs through and the thread that seems to run through is what we do and I think that is wonderful to see that".

Impact on the wider community

Staff reflected on the growth of the recovery community and recovery presence within Lincoln. In line with the contagion of recovery evident amongst students, staff had also noted a growth in the visibility of recovery within Lincoln.

Staff discussed the recovery community within Nottingham and how this had been around for "such a long time", compared to Lincoln which "had never had one" in previous years. One staff member disclosed the growth of this recovery presence had been a highlight of their career with the Lincoln academy stating, "and to see that in Lincoln now building and growing out towards Lincolnshire and seeing people representing the recovery community I think it's massive highlight for me".

Staff discussed how through the development of new recovery groups and opportunities for students, the recovery community was forever growing. Within this discussion, staff acknowledged how "recovery can only be contagious if there's enough people around to go and make it contagious". During the initial set up of the Lincoln academy, this proved to be challenging but as the academy has grown and developed over the years, Lincoln's recovery community has grown which in turn has created a visible recovery presence within the town.

As explained by one staff member –

> "If you live in a very rural area and you're one of the three heroin users in that village and you get on your bus and you come to pick your script up and eventually the script goes and then you go back to your little village again, that's it, there aren't going to be AA meetings for two people in the middle of nowhere".

Being mindful of this challenge and the geographical challenges posed in Lincolnshire, staff discussed how they had undertaken outreach work to the more rural local areas to make pathways to the Lincoln academy more accessible for those who otherwise would be unable to attend and engage with the service.

Challenges and responses: Staff perceptions

A real challenge for the community is that people that have a low baseline of recovery and challenges. One staff member reported: “The challenge is for convincing people that there is a recovery community and them to buy in to that and for me that's a challenge.” Another commented that: “In a rehab environment you can point something out and go 'that behaviour will get you in trouble my friend.' In the community you can't be as direct as that because people have to go home, you don't know that they're safe when they go home so we have to find creative ways to create a space where people can put their [emotional] stuff in and then we can box it up nicely and push it back in again and then go home. So for me that is always a challenge, always a challenge.”

Another staff member said that “I think we do need something that get them to really look at themselves, get the service users to really look at themselves… but the fact of the matter is it's a life and death situation isn't it? Addiction's a serious business and I think, you know, you've said it really Steven, it's about getting them to a place where they're looking at themselves and want to change the way they are. It's how we do that in a loving way ultimately isn't it?”

Standardise the expanding recovery group format, and creating a wraparound suite of support options such as groups and qualifications for people to access together as opposed to accessing one or the other: “Well, if you think six months ago we'd only got something for the week and weekend so within six months we've introduced a lot more recovery groups haven't we, so that's now something that we can work on to standardise and to look at and to make sure that we deliver our programme holistically rather than separate accreditation and then recovery group, so we want to make it as one package, one programme that people do, not just dib in and out of one thing and another for their good.” *vocalised agreement from other group members*

This can help to forge clear pathways into the academy: by including students who are undertaking accredited programmes in groups bridging capital is created, which can help to inspire support group members to explore the academy route: “By doing the groups they grow with confidence because when they come they've got very low self-esteem, very low confidence but by doing the groups they're building confidence and then eventually they think, oh, I might be interested in that, you know, then that's the next stage.”

Teaching people that recovery is most frequently an ongoing and longitudinal process which continues to require hard work can be a challenge: “Yeah, so then when they get to us and we're sort of saying in a nice way this is where it starts, not where it finishes my friend. It's

hard isn't it because people, they've stopped drinking, they're quite depleted, they're battered and bruised."

Overall, staff have shown good awareness of challenges they have faced and approaches that need to be adopted to overcome problems that remain.

1.4 Case Studies

1.4.1 Eve[3]

Eve had a traumatic childhood, characterised by abuse and isolation. She started using drugs from a young age, and eventually began dealing drugs. She lost custody of her daughter and was incarcerated on more than one occasion. Whilst waiting on remand in prison to be sentenced again, she realised that one more charge would result in much more serious prison sentences, and she did not want to miss out on her daughter growing up, and so found somewhere to live and detoxed herself. She cut off existing social connections and began to make contact with Addaction. From there she learned about Double Impact and began to attend to the social support groups. She became involved in volunteer work with recovery services and probation, and began spending more structured time with her daughter. She is now in recovery and desisting from crime. She has a partner, who is in prison, but who she describes having an open trusting relationship with. She spends structured time with her daughter and has come off her Subutex script since joining Double Impact.

Eve	Quality of Life	**61**	**67**	**6**
	Personal Recovery Capital	**15**	**18**	**3**
	Social Recovery Capital	19	19	0
	Community Recovery Capital	10	10	0
	Commitment to Sobriety	30	30	0
Volunteering (no change): Volunteering weekly in both time 1 and time 2 for addaction with MAP groups.				

[3] Pseudonyms have been used for case studies

1.4.2 George

George has developed appositive social identity which is anchored in Double Impact and is used to inspire others

Well, I guess for me because I've been through the services, both treatment and recovery, I want to – I guess because I'm so on fire about it I want to pass that on to other people, other service users and let them know that recovery is possible because, you know, from my perspective I'd never saw a way out, I never saw people in recovery and didn't realise that was even a possibility. Obviously coming through the academy, my life has just changed, it's gone 180 degrees. Yeah, I'm just really enthused and want others to feel that. I think I'm quite compassionate towards other people and I've got empathy because I've been on the fringes of society, I want to include everybody and I try and do that in my job as best I can. I just like to draw people in I guess and that's what I'd like to do as much as possible. As far as my colleagues, as time' s going on I'm feeling more and more a part of a team and Double Impact as well, you know, part of that organisation and actually I reflect the organisation as well which is interesting, that's a concept that I haven't quite understood fully but I'm just starting to in the last couple of weeks.

* What do you mean? Could you explain that?

M Well, in terms of – I am Double Impact and that's something that maybe I've – Because of where I've come from I've found it probably difficult to understand. Because I've been separate from everything and everyone, I've separated myself, I've probably found it difficult to be part of something but actually I'm realising that I'm not just the face of something. What I bring to work on a daily basis is what is making Double Impact what it is I guess I'm trying to say.

George	Quality of Life	**77**	**87**	**10**
	Personal Recovery Capital	**8**	**21**	**13**
	Social Recovery Capital	**14**	**23**	**9**
	Community Recovery Capital	**6**	**12**	**6**
	Commitment to Sobriety	30	30	0

Work (change): In time 1 George was not working full or part-time and was not engaged in education; however, in time 2 they were engaged in part-time work and education.
Involvement with the criminal system (no change): There was no involvement in offending, police in the last 90 days, and community orders in time 1 or time 2.
Additional help from recovery groups: In time 1, was engaged in drug treatment services and satisfied but not engaged in time 2. In time 1 engaged in housing support; however this is unknown for time 2. Family relationships, employment and primary healthcare services were engaged and satisfied with in time 1 and 2. **Substance History (no change):** While there had previously been a problem with alcohol, heroin, cannabis, benzos prescribed and street, tobacco, methadone prescribed and street there was no substance abuse in the last 90 days in time 1 or time 2.

Study 2: REC-CAP data from across multiple sites

2.1 Introduction

This chapter presents data from multiple Double Impact sites to show the strengths of the client base at the service. The primary measurement tool used is the REC-CAP which is a composite measure of strengths that is described in the methods section below, originally developed by Cano et al (2017), and is embedded into the multi-method approach reported above. The REC-CAP is sensitive to change and so can be used at the individual client level of support their recovery care, and at the group level to assess the effectiveness of teams or services in supporting their clients to build sustainable recovery resources.

This section is the core quantitative component of the evaluation project and is a critical part of the project and of recovery capital work. Double Impact is the first UK community agency to fully pilot the REC-CAP and this is highly significant in the development of the tool, and in supporting its implementation in applied recovery settings. The data below will allow us to generate norms for recovery capital to support future research and treatment processes.

The results presented here will also allow us to assess whether the findings for Lincoln reported in Study 1 is likely to be anomalous and, if not to identify baseline norms for recovery capital strengths and barriers that can be applied across the Academy sites.

2.2 Method

The REC-CAP is a composite measure that assesses the following core areas:

1. Barriers to recovery
2. Unmet support and treatment needs
3. Global wellbeing
4. Personal and social recovery capital
5. Recovery Group participation
6. Social Support
7. Commitment to sobriety

The model is based on the assumption that to build positive recovery capital, the individual has to overcome acute barriers and to have unmet needs addressed. Once the tool is completed, a profile of recovery wellbeing arises that can be used to directly and scientifically inform the recovery care planning process, and in doing so reconciling subjective and evidence-based recovery goals and objectives.

The instrument was completed as part of routine clinical practice, either by clients on their own or with the support of their workers. The overall profile of strengths scores are used to inform recovery care planning.

2.3 Results

The results are divided into three sections, based on the fact that the 115 completed REC-CAPs of whom 27 have completed the form on two or more occasions. Some of these have been included in the data in Study 1 but in this section it is only recovery capital data that are reported.

There will therefore be three sections to the results:

1. Overall presentation of the score profile
2. Comparison of the recovery capital profiles in Lincoln and Mansfield
3. Analysis of change for those with more than one form complete

2.3.1: Overall pattern of recovery capital among DI clients

A total of 115 REC-CAP forms were completed – with the breakdown as shown in Table 1 below:

Table 2.1: Recording of locations in sample

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Missing data	10	8.7	8.7	8.7
	Boston	4	3.5	3.5	12.2
	DI	1	.9	.9	13.0
	Gainsborough	1	.9	.9	13.9
	Grantham	1	.9	.9	14.8
	Lincoln	55	47.8	47.8	62.6
	Mansfield	40	34.8	34.8	97.4
	Sleaford	1	.9	.9	98.3
	Spalding	2	1.7	1.7	100.0
	Total	115	100.0	100.0	

There were 10 missing cases and a further case that just stated “Double Impact” but the majority of cases were either from Lincoln (47.8%) or Mansfield (34.8%), with Lincoln making up just under half of this new and enlarged database. The combination has two benefits – an overall profile of DI clients and the opportunity to compare the profile of those from the two locations, which account for 95 out of the 115 cases.

The mean of the sample was 43.8 years but with a range of 19-77 years. The majority of participants were female (52.2%) and the majority described themselves as either British or White British (86.1%) with the remaining participants describing themselves as Dutch, mixed race, white European or white Irish.

Quality of life and wellbeing

The REC-CAP provides five measures of quality of life with scores out of 20 for each with higher scores representing better quality of life, as shown in Table 2 below:

Table 2.2: Overall wellbeing profile

Physical wellbeing	Psychological wellbeing	Quality of life	Quality of accommodation	Quality of relationships
11.62	12.31	12.63	14.75	14.82

These scores suggest relative low functioning around physical and psychological health and quality of life, but much better ratings on satisfaction with accommodation and with relationships.

There were strong associations between scores on these variables suggesting a common theme – in particular:

- Psychological health and social support ($r=0.42$, $p<0.001$)
- Psychological health and quality of life ($r=0.81$, $p<0.001$)
- Social support and quality of life ($r=0.51$, $p<0.001$)

This justified the creation of an overall wellbeing index, rated out of 100. The mean overall score was 65.5 although there was significant variability with individual scores ranging from 27 to 92. Although men had slightly higher average overall wellbeing scores than women (66.4 compared to 64.8) this difference was not statistically significant. There was no relationship between overall wellbeing and age.

Barriers to recovery

1. Housing: A small number of participants (10, 9.3%) reported that they were at risk of eviction at the time of the assessment. A slightly larger number (13, 12.1%) described themselves as having acute housing problems
2. Substance use: around one third of the sample (n=40, 35.4%), with the most common substance use being alcohol which was reported as having been used by 34 people (29.6% of the sample) in the previous 90 days. There was much less frequent use of illicit substances with 3 people reporting any use of heroin in the last 90 days, five people reporting crack cocaine use, one person using amphetamines and 14 reporting cannabis use. In terms of prescription drugs, six people were prescribed methadone, six buprenorphine, five were prescribed benzodiazepines and two more had used illicit benzodiazepines.
3. Injecting and risk: Three people reported that they had injected drugs in the previous 90 days but just one person reported sharing injecting equipment
4. Crime and justice involvement: Four people reported that they had committed offences in the last ninety days and eight that they had had contact with the police in the same period.
5. Meaningful activities: There were very low levels of employment in the sample with five people reporting that they had worked full-time in the last 90 days and five that they had worked part-time. However, 19 participants reported that they were studying and 23 people reported that they had been volunteering in the course of the previous 90 days.

So in terms of barriers to recovery, there is relatively little unstable housing or crime involvement and virtually no risky injecting behaviour. On the other hand, around one-third of the sample are using alcohol and the rates of meaningful activities are low – but with some positive signs of community engagement.

It was possible to create an overall total of barriers to recovery, using seven indicators (one of which reversed the questions). The seven indicators were:

- At risk of eviction
- Acute housing problems
- Substance use in the last 90 days
- Injecting in the last 90 days
- Crime in the last 90 days
- Justice involvement in the last 90 days
- No meaningful activities (ie the person had not worked, studied or volunteered in the last 90 days).

This yielded a range of 0-7 barriers and the mean number of barriers was 1.3 with a range of 0-7. On every one of our strengths measures, there were strong and consistent negative correlations as shown below:

- Overall wellbeing score (r = -0.21, ns)
- Personal recovery capital (r = -0.30, p<0.01)
- Social recovery capital (r=-0.30, p<0.01)
- Recovery group participation (r = -0.18, ns)
- Social support (r = -0.28, p<0.08)
- Commitment to sobriety (r = -0.17, ns)

In other words, there is clear evidence from this, that where there are ongoing recovery barriers, it is difficult to build recovery capital, although not all results are statistically significant and we should be wary about inferring causality from cross-sectional results.

Unmet needs: The next section of the instrument assesses service engagement and unmet needs. Across a number of domains, participants are asked to identify whether they have a need in a particular area and, if they are already engaged with services, whether they are satisfied that this engagement meets their needs.

This complements the acute barriers section by identifying where participants do not have enough support from a range of other agencies that would be essential for a holistic recovery process, as outlined in Table 3 below:

Table 2.3: Overall profile of unmet needs

	Are you currently engaged with services?	Are you satisfied?	Do you need additional help in this area?
Drug services	33.3%	89.7%	17.6%
Alcohol services	41.3%	81.1%	23.7%
Mental health	42.3%	50.0%	42.6%
Housing services	18.3%	58.6%	19.5%
Employment services	21.6%	61.8%	17.4%
Primary care	64.2%	85.9%	16.7%
Family relationship support	51.4%	74.5%	22.2%

What this table indicates is that a number of DI clients are already actively engaged in other services but with variable levels of satisfaction and unmet needs. The key areas where there are clearly identified group needs for additional support are around alcohol treatment and mental health services. However, there are a diverse range of unmet needs in the group and this is important as meeting these basic functioning needs is likely to be necessary to support enduring and successful recovery careers. Recovery is generally regarded as multi-dimensional and that progress across a number of domains should continue over long periods of time.

Strengths measurement

Assessment of Recovery Capital: The measure that is used to assess this is the Assessment of Recovery Capital (Groshkova, Best and White, 2012). This is a 50-item scale half of which assesses personal recovery capital (25 items) and the other half social recovery capital (25 items).

1. Personal Recovery Capital: Is a measure of the personal resources that an individual has available to support their recovery journey including resilience and coping skills. The mean score for personal recovery was 17.35 (out of 25) suggesting reasonably strong personal recovery capital in this cohort. However there was marked variability with a range of personal recovery capital scores of 2 – 25 suggesting marked variability across the population.
2. Social Recovery Capital: Is measured in the same way out of 25 with higher scores indicating greater perceptions of positive social supports for recovery. In the current sample, the mean score was 17.64 (out of 25). As with personal recovery capital, there was marked variability with a range of 5-25 again indicated considerable variation in social engagement and support in this group at the start of the process.

There is a very high association between the two types of recovery capital with a positive correlation value of 0.84 ($p<0.001$) consistent with the theory that there is a strong dynamic and generative relationship between social resources and support and growing personal capital. Both types of recovery capital were also strongly related to the overall wellbeing score – for personal capital the correlation was 0.50 (<0.001) and for social capital 0.47 ($p<0.001$).

Recovery Group Participation: Is measured using the Recovery Group Participation Scale (Groshkova, Best and White, 2011) a 14-item questionnaire that is designed to assess engagement in a range of peer based recovery activities, including formal groups such as

AA, NA and SMART Recovery. Higher scores indicate greater involvement in the recovery community. The mean score in the current sample was 6.45 (with a range of 0-14) suggesting a moderately high level of recovery group participation in the cohort, although six participants reported no involvement at all in recovery groups.

The level of involvement in recovery groups was positively associated with:

- Personal recovery capital ($r = 0.44$, $r < 0.001$)
- Social recovery capital ($r = 0.41$, $p<0.001$)
- Overall wellbeing ($r = 0.32$, $p<0.01$)

There are two other measures used to measure strengths – a measure of social support taken from work on social identity by Haslam and colleagues (2013) and a measure of commitment to sobriety taken from the work of John Kelly in the US.

Social support: The scale ranges from 4 to 28 with higher scores indicative of more perceived social support. The mean score for social support was 19.5 with a range of 4-28 suggesting generally positive perceptions of the availability of social support.

Commitment to sobriety: The scale ranges from 5 to 30 with higher scores indicative of greater motivation to sober living. The mean score was 28.8 with a range of 20-30 suggesting that there was exceptionally strong and consistent recovery motivation in the group.

Perhaps because of the generally high mean scores, there were no associations between commitment to sobriety self-ratings and any of the other strengths measures. In contrast, social support was strongly associated with all of the other strengths measures and was particularly strongly linked to both personal ($r=0.57$, $p<0.001$) and social ($r = 0.61$, $p<0.001$) recovery capital.

Overall patterns of strengths and barriers

The final analysis in this section looks at normal patterns of resources for Double Impact in relation to future use of the tools.

What we have used to do this is to create a semi-interquartile range for each variable to show what is atypical for DI clients:

Table 2.4: Establishing normative patterns for strengths in Double Impact clients

	Mean	25th percentile	75th percentile
Overall wellbeing	65.5	57.0	78.0
Personal recovery capital	17.4	14.0	21.75
Social recovery capital	17.6	14.5	22.0
Recovery group participation	6.4	3.0	11.0
Social Support	19.5	16.0	24.0
Commitment to Sobriety	28.8	29.0	30.0

The point of doing this is to establish what can be thought of as a 'normal' range for DI clients for each of the key 'strengths' markers. Thus, a client who is scoring less than 57 on overall wellbeing should be thought of as unusually low in this dimension and if they are scoring more than 78, they should be thought of as unusually high in this area. Between the two percentiles is 'normal' – and this is a good guide to what can be considered areas that need clinical attention and areas that can be regarded as strengths to be mobilised to support the individual on their recovery journey. In effect, when the client does not have their own prior scores to compare against, this provides a range for what can be considered typical.

2.4 Comparison of recovery strengths in Mansfield and Lincoln

Although there were multiple locations that participants were drawn from, the only two sites with sufficient participants to permit analysis were Lincoln and Mansfield and so in the analysis presented below, location is clustered in three groups – Lincoln, Mansfield and 'other locations'. In the section below participants are compared in three areas – demographic characteristics, barriers and unmet needs, and recovery strengths

2.4a. Demographic characteristics

There were no significant age differences between the locations with the mean age of the participants from Mansfield being 45.3 years; from Lincoln, 41.3 years and from other locations 46.0 years. Around two-thirds of the participants from both Mansfield (55.0%) and

other locations (66.7%) were female but only around half of the participants from Lincoln were female (45.0%) these differences were not statistically significant. At least on demographic characteristics, the samples were broadly similar and this is unlikely to have skewed the results below, although we are not in a position to comment on the severity or extensity of their alcohol and drug problems given the data available.

2.4b. Recovery strengths

To compare results, the total scores for each of the strengths measures is compared in Table 5 below in which the mean scores for each location (on each of the recovery factors) are compared with the final column presenting the statistical analysis to show whether differences in mean are significant.

Table 2.5: Differences in strength factors by location on the REC-CAP

	Mansfield	Lincoln	Other locations	F value, significance
Overall wellbeing	64.6	66.7	70.6	0.50, ns
Personal recovery capital	17.9	16.2	18.1	0.86, ns
Social recovery capital	16.4	17.9	18.3	1.52, ns
Recovery Group Participation	7.1	5.3	6.4	0.63, ns
Social Support	19.9	17.9	19.4	1.31, ns
Commitment to sobriety	28.7	28.9	28.3	0.61, ns

Although some of the differences in strengths may be of interest to the service – such as the lower ratings for recovery group participation in Lincoln or the higher level of social support reported in the other locations – none of these differences were statistically significant, suggesting that the improvements shown are consistent across the Double Impact locations and that the general level or recovery wellbeing is relatively high in each of these groups.

2.4c Differences by site in barriers to recovery

There were no differences in the housing factors although participants from Mansfield reported slightly higher rates of acute housing problems than in the other locations (18.4% compared to 8.2% in Lincoln and none in the other locations).

Ongoing substance use was highest in Mansfield at 40.0% reported some form of drug or alcohol use in the previous 90 days followed by Lincoln with 37.7% and the other locations was lowest at 22.2%. Again there were no statistically significant differences in this nor were there differences in rates of injecting or injection-related risk taking (which had a very low prevalence in all three locations).

There were also no differences in offending or involvement with the justice system with the highest rates of each reported in Lincoln where 5.5% of participants reported involvement in offending in the last three months and 9.3% some engagement with the police. The respective figures were 0 and 5.0% for Mansfield and zero for each barrier for participants from other locations.

While 7.5% of the Lincoln participants were working full-time, none of the Mansfield clients nor those from other locations were in full-time employment. With regard to part-time employment, 5.0% of Mansfield clients, 3.9% of Lincoln clients and none of the clients from other locations were in part-time employment. There were higher rates of education involvement in Mansfield (25.0%) and the other locations (22.2%) than from Lincoln (9.3%), but none of these criminal justice or educational differences were statistically significant. There were also no differences in the rates of volunteering with around 20% of participants in each location involved in volunteering.

There was also no overall significant difference in barriers to recovery although the mean number of barriers was slightly lower among clients in Mansfield (mean = 1.3) than in Lincoln (mean = 1.4) but slightly higher than in other locations (mean = 1.0).

2.4d Differences by site in unmet needs

Because of the low numbers with each of these presenting problems, data in this section are reported by raw numbers rather than percentages.

Drugs: Three people in Lincoln, three in Mansfield and two in the other locations expressed the need for additional help with drug problems.

Alcohol: Eight people in Mansfield, five in Lincoln and one in other locations expressed the need for additional help with alcohol problems.

Mental health: Fourteen people in Mansfield, six people in Lincoln and two people in other locations expressed the need for additional help with mental health problems, suggesting

that this is a common barrier to building recovery capital across multiple locations, but a particular issue for clients in Lincoln although the difference was not statistically significant.

Housing support: Two participants in Mansfield, six in Lincoln and none in the other locations reported the need for additional housing support.

Employment support: One person from Mansfield, two from other locations and four participants from Lincoln expressed the need for additional support in seeking work.

Primary care: Four participants from Mansfield, four participants from Lincoln and one participant from other locations expressed the need for additional support around their primary healthcare.

Family relationships: A total of ten participants requested additional support around family relationships – 4 from Mansfield, 5 from Lincoln and one from other locations.

Thus, overall, there is little indication of differences in population patterns or in patterns of strengths across the different settings. The only areas where there do appear to be some differences are around unmet needs with greater needs for alcohol services in Mansfield, and greater need for mental health and employment support in Lincoln. The pattern is consistent in showing reasonably positive patterns of strengths across locations.

Thus, overall, while there were some minor differences between sites, particularly in the areas of unmet needs, the barriers and strengths profile is reasonably consistent across the participating areas. This means that we can:

(a) Be confident that the norms can be applied to any site to identify atypical recovery strengths and recovery barriers for individual clients
(b) Generalise many of the qualitative findings from Chapter 1 to the other Academy sites

2.5 Repeated measures – indicators of positive change

This is a key part of the analysis but unfortunately there was a relatively low rate of completion of more than one form, and there are likely to be some biases around attrition and satisfaction in those who were willing to complete the forms on multiple occasions. Also, there were very low numbers where more than two forms were completed so this analysis relates only to clients who have at least two successfully completed REC-CAP forms. This does allow us to look at change over time and to assess trajectories of change in clients.

There were 27 individuals where it was possible to clearly identify a matched pair of cases, in some cases because of missing identifiers. It is also important to note that for some of the

pairs there are gaps of up to 18 months between the first and second completion suggesting that this may not be part of the same treatment episode.

In spite of this, Table 6 shows changes in the overall wellbeing indicators from baseline to follow-up

Table 2.6: Matched pair changes on overall wellbeing indicators

	Time 1	**Time 2**	**T value, significance**
Psychological health	11.7	13.7	T=2.63, p<0.05
Physical health	11.5	12.8	T=1.40, ns
Quality of life	12.8	14.4	T=1.63, ns
Quality of accommodation	15.3	17.1	T=1.98, p=0.06
Network support	14.7	16.8	T=2.96, p<0.01
Overall wellbeing	63.2	74.8	T=2.79, p<0.05

Although the numbers are too small to find statistically significant differences (with the exception of recovery group participation) there is a clear and consistent pattern of improvement across multiple domains. There is a statistically significant improvement in psychological health and in network support and also in the overall wellbeing score which rises from 63.2 (out of 100) to a mean of 74.8 – which is highly statistically significant.

For all of the other recovery strengths indicators, a similar analysis is reported in Table 7 below:

Table 2.7: Matched pair changes on other recovery strength indicators

	Time 1	**Time 2**	**T value, significance**
Personal recovery capital	19.4	20.1	T=0.60, ns
Social recovery capital	19.4	19.5	T=0.08, ns
Recovery group participation	7.0	7.9	T=0.83, ns
Social support	21.0	22.9	T=1.89, ns

Commitment to sobriety	28.9	29.5	T=0.83, ns

There are small improvements in the mean scores on all five of the recovery strengths indicators but none of these achieve statistical significance. This is likely to be a result of the low follow-up sample or that the wellbeing changes reported above are more sensitive to short-term changes over time.

2.6 Overall conclusions

The first and most important conclusion is that there is a strong organisational culture that allows completion of a recovery tool and a commitment on the part of the client group to be involved in this task. The qualitative experiences of clients' journey from Study 1 are particularly important in allowing us to make sense of these findings and to show that staff generally welcome a tool that builds on strengths and allows progress to be tracked and shared with the client.

In terms of the quantitative data, there are moderate levels of recovery capital reported at the baseline data collection point and evidence of a number of ongoing barriers and unmet need that are, with one or two variations (around mental health and alcohol treatment) consistent across locations.

There is tantalising evidence that there are significant improvements in strength in spite of the small sample and the uncertainties about treatment episode. In particular, there are clear improvements in the wellbeing indicators with marked improvements in psychological health and social support, and a clear overall indication of improvement in wellbeing. Although the differences do not attain statistical significance in all cases, there is a clear pattern of growth in wellbeing across multiple domains.

There is also consistent positive and supportive qualitative feedback from participants in the Academy programme in Lincoln that was reported in the in-depth findings of Study 1. There are four emerging positive themes from the qualitative data – that the Academy helps to support and preserve recovery and generates hope; that involvement allows participants to discover themselves and develop their self-worth; that the staff are supportive and generate a sense of trust; and the importance of peer communities. This is consistent with an evidence base that emphasises the five core components of recovery support services – connectedness; hope; identity; meaning and empowerment.

In spite of these limitations, we can confidently state that there is a trend to both significant growth in strengths over time and to a slight reduction in barriers to recovery.

This is an extremely positive set of pilot findings for a new measure that speaks well of the structure and management of the services and the commitment to recovery-oriented, shared and strengths-based approaches to supporting clients.

More broadly, while engagement with the academy was highlighted to aid the recovery and desistance journeys of all students for whom data was collected, referral pathways into the academy are limited. Spreading awareness of the academy amongst the wider community would prove to be beneficial and may bring in a new cohort of students. The REC-CAP will not remove barriers to recovery but will provide an essential tool that is not too resource intensive and that has started to show how Double Impact positively supports change in the client group.