COMMUNITY DRUG AND ALCOHOL RECOVERY SERVICES (CDARS)

THE EVALUATION OF THE WELLNESS AND RECOVERY PROGRAMME -- Preventing drug and alcohol relapse in Merton and Wandsworth

AUGUST 2016- AUGUST 2019

By

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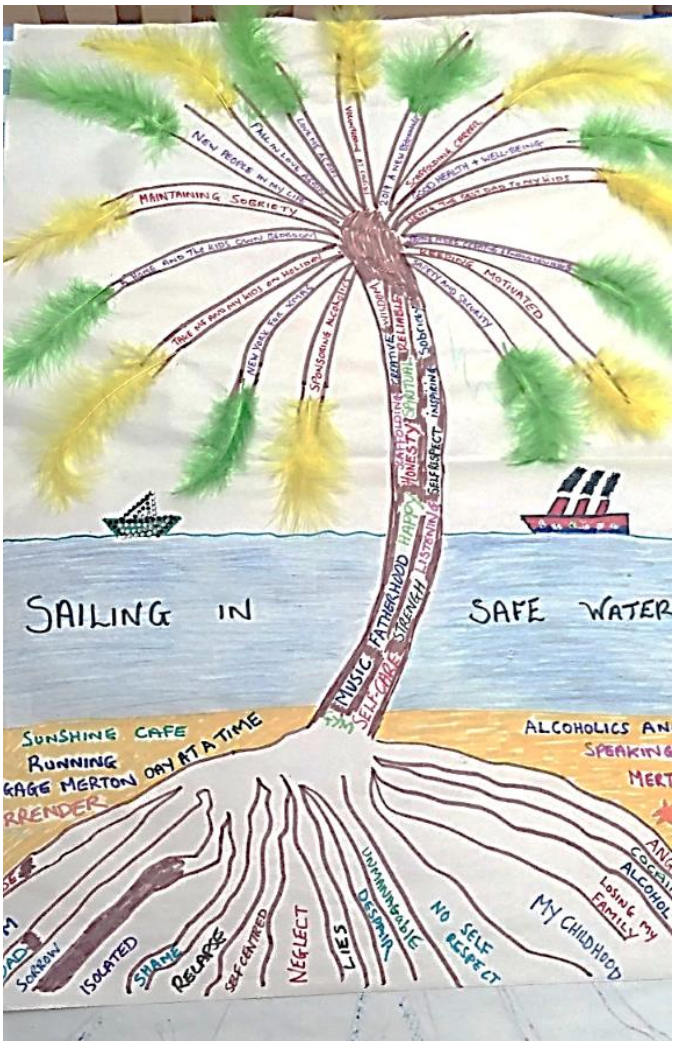

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EXECUTIVE SUMMARY

This report presents the findings and conclusions of an end of project evaluation for the Wellness and Recovery programme, a programme funded by the National Lottery Community Fund – Reaching Communities between August 2016 and August 2019. This programme, delivered by Community Drug and Alcohol Recovery Services (CDARS), aimed to deliver a comprehensive programme of holistic activities to help abstinent service users of CDARS maintain their recovery and avoid relapsing into substance misuse. The programme aimed to help participants improve their health and wellbeing and overall quality of life. The programme took place in the London Boroughs of Merton and Wandsworth.

The objective of this evaluation is to identify outcomes of the programme; to examine the effectiveness of the programme and to draw recommendations for future implementations of similar programmes. Using a range of methods including data collected from the programme team over the 3 years and data collected from a focus group created in the last quarter of the programme, the evaluation Consultant concluded that the programme had had positive outcomes on the participants' perceptions of health and other domains of health and wellbeing. It appeared to have been successful in helping participants improve their overall health; become more integrated socially and reduce relapsing rates. The programme enabled participants to build their recovery capital, which is essential to successful recovery.

A number of recommendations were made to help devise a best practice model and further improve future health and wellbeing programmes working with similar cohorts. It is to be noted that the cohort of this programme is very vulnerable and presents a range of complex, interrelated needs. A key recommendation is to deliver a holistic programme that is tailored to the needs of each individual rather than taking a one size fits all approach. As not all participants are initially motivated to engage in the programme, staff members need to use therapeutic motivational techniques to make sure the participants fully benefit from the programme.

The evaluation was carried out by an external Consultant from Consultancy and Development International. It was conducted in the period from 1st May 2019 to 15th August 2019.

PART 1: INTRODUCTION

Background

1.1 The Wellness and Recovery Programme (WRP) was funded by the National Lottery Community Fund 'Reaching Communities' in August 2016 for 3 years. It was based on the proposal submitted by CDARS reference 10265415 dated 27th May 2016.

1.2 The purpose of the Wellness and Recovery Programme was to deliver a comprehensive programme of holistic activities to help service users of CDARS who have reached abstinence form drug and/or alcohol misuse maintain their recovery and avoid relapsing. It was to help participants to improve their health and wellbeing and overall quality of life. A background note of substance misuse provided by CDARS is at **Appendix A.**

1.3 The programme was delivered from two of CDARS's centres in Merton and Wandsworth, and aimed to reach 360 people over 3 years – in cohorts of 15 participants per 12 week in each centre. All participants were either ex-substance misusers who had reached abstinence or people who had dual diagnosis (substance misuse combined with mental health issues).

1.4 In the CDARS proposal to the National Lottery Community Fund, the key aspects of the CDARS's Proposals were to achieve the following outcomes:

- Outcome 1. The health and wellbeing of the ex-users who have just completed treatment will be improved
- Outcome 2. Ex-users who have just completed treatment will improve their skills and employability
- Outcome 3. Ex-users who have just completed treatment will be more integrated socially
- Outcome 4. Ex-users who have just completed treatment will sustain their recovery.

1.5 Further details of these, plus Indicators, levels and means of reaching these objectives and their performance indicators are set out in Part 2 below.

1.6 The proposal also included an undertaking of this independent post-programme outcomes evaluation to:

a. Assess the degree to which the project objectives were achieved;
b. Document the lessons learned;
c. Provide recommendations for project development and improvement; and
d. Examine the changes that resulted from doing the project;
e. Devise a best practice model to implement a health and wellbeing programme for those who have completed treatment.

The Financial Aspects

1.7 The budget for this 3 year programme was £396,966 (£137,302 in year 1; £125,452 in year 2 and £134,212 in year 3). For each year, the total spend was within budget. The approximate cost the programme per participant is estimated to have been £834.

Those consulted and appreciation

1.8 Those consulted during this evaluation: the CDARS CEO, the Grants and Bids Manager and the Programme Manager as well as service users.

1.9 The consultant would like to thank those consulted for their help and advice and the documentation and other information provided.

PART 2: THE CONDUCT AND EVALUATION OF THE PROGRAMME

The Programme Overall

2.1 This programme was aimed at helping those who have just completed treatment to help them to sustain their recovery. It provided a comprehensive range of holistic activities which were delivered weekly with each participant attending weekly session for 12 weeks.

Activities included:

- Holistic activities around fitness, health and wellbeing, including yoga, kick boxing, mindfulness and nutrition
- Individual counselling sessions
- Group activities and social outings
- Employment training and education (ETE) and life skills training
- Peer mentoring sessions.

Appendices B and C give further details of these.

Organisation and Staffing

2.2 The programme was managed by the Bids and Grants Manager (under the direction of the CEO), and delivered by the Programme Manager. On the ground, the programme originally was managed by two Service Workers in Merton and Wandsworth. The worker in Wandsworth was promoted to Programme Manager in 2018 and managed both services in Wandsworth and Merton. She managed sessional workers who delivered specialist activities weekly and were experts on psychotherapy, mindfulness, nutrition, cooking skills and therapy. She was also responsible for managing data for the programme, whilst sessional workers were responsible for ensuring participants filled in feedback forms and questionnaires, and for providing their observations on the changes they witnessed in the recovery of the participants.

Demographic data of the participants

2.3 As participants joined the programme, they completed an assessment form which recorded basic demographic data such as: age; gender; ethnicity and sexual orientation. Some 476 participants engaged in the programme and the makeup was as follows: 251 were men; 225 were women. The programme was open to participants over 18 years of age - the overwhelming majority was aged between 25 and 64.

2.4 Key Personal Data:

- 16 % defined themselves as disabled
- 82% recorded as white and 18% were from a BAME background
- 10% were identified as homosexual or bisexual.

It should be noted that some of the participants may have identified themselves as disabled due to their mental health or substance misuse resulting in a long-term condition impacting on their health.

Evaluation purpose

2.5 This evaluation has been commissioned by Community Drug and Alcohol Recovery Services (CDARS) to understand the impact of the Wellness and Recovery Programme, to document the lessons learned from delivery of the programme and to draw recommendations for future implementations of similar programmes. The evaluation assesses whether participating in the Wellness and Recovery programme had an effect on the following outcomes:

- Reduced relapse rates
- Improved health and wellbeing
- Perceived improved quality of life
- Enrolment in education, training or employment
- Reduced isolation and better integration of the participants in their community.

Methods of Evaluation

2.6 The evaluation was commissioned by CDARS during the last quarter of the final year of the programme (May-August 2019). The evaluation of the outcomes is based on a mixed methods design - with both quantitative and qualitative data being collected. The evaluation analysed data for the duration of the programme overall as well as data from a focus group created during the last quarter of the programme. This helped to analyse the qualitative impact of the programme in more detail.

2.7 Each participant of the WRP was expected to engage in activities for a total of 12 weeks. Quantitative data was collected throughout the duration of the programme. The attendance of each participant at each session was recorded together with demographic profiles.

2.8 Qualitative data was collected at the baseline (T 1) at 6-week point (T2) and at discharge at week 12 (T3) via in-person sessions. These included measures asking questions about participants' health and wellbeing, social integration and motivation to stay sober.

2.9 The following tools were used to collect qualitative data, which was assessed for this evaluation:

- Feedback forms
- Questionnaires
- Surveys
- Quarterly focus group meetings, including the Programme managers, the Grants and Bids Manager and 4 participants.
- Staff and volunteer observation forms.

A copy of the questionnaire used and a summary of the data gathered are at **Appendix D.**

2.10 During the last quarter, a new focus group consisting of a cohort of 8 participants selected at random, to avoid bias, was created. The participants were from the last cohort

of the programme. Quantitative data was collected from this cohort at two time points: at baseline where they were introduced to the focus group and got a sense of what the group was about and then again after 10 weeks when their engagement was almost ended. Focus group discussions were facilitated by the evaluator without the presence of CDARS staff to maintain a degree of independence. Further details of these are given in **Appendix E.**

Project Proposed Outcomes and Delivery

2.11 In this section of the evaluation, details of the outcomes in the CDARS's proposals and the subsequent delivery are set out.

2.12 **Outcome 1**. The health and wellbeing of Ex-users who have just completed treatment will be improved.

a. PROPOSAL: The health and wellbeing of ex-users will be improved: better diet; better fitness levels; better general health.

b. DELIVERY:

Diet and nutrition

The questionnaires first asked the following questions:

- How healthy do you think your diet is?
- How often do you eat fruit and vegetable?
- How often do you cook your food from scratch?

At baseline (T1)	At week 6 (T3)	At the end of the programme (T3)
3%	38%	69%

Table 1: Number of people who report a good diet

The results evidence improved diet, which can be attributed to a clear focus of the programme on healthy living including mindful eating and mindful shopping. Nutrition classes were very well attended throughout the 3 years of the programme, and proved very popular. The Programme Manager reported that the participants were more interested in practical sessions as opposed to theoretical sessions around nutrition.

Mindful eating sessions

Fitness

The questionnaires asked how often participants took part in physical activities and whether they improved their fitness level.

At baseline (T1)	At week 6 (T3)	At the end of the programme (T3)
10%	31%	64%

Table 2: Number of people who report good fitness

The result of the questionnaire found a continual increase in the perceived improved fitness levels that the participants reported on at the end of the programme compared to their perceived fitness levels at baseline and halfway through their engagement. The programme considers fitness activity to include any activity that encourages participants to move and to use energy. The programme offered a range of activities including yoga, kickboxing, walking, and tennis that the participants took part in regardless of their baseline fitness level.

General health

The questionnaire also asked participants how healthy they felt in general, not only physically but also mentally, emotionally and spiritually.

At baseline (T1)	At week 6 (T2)	At the end of the programme (T3)
5%	45%	72%

Table 3: Number of people who report feeling healthy

It is interesting to note that the levels of perceived health were higher than the perceived levels of fitness and diet/nutrition. One can assume that participants do not segment their health but define it as a general state. This indicator is particularly positive and shows the most continual increase over the duration of the programme.

2.13 **Outcome 2:** Ex-users will improve their skills and employability:

a. PROPOSAL: Ex-users will have more confidence and better skills to find employment, to enroll in education, professional training or work experience; to become volunteers at CDARS.

b. DELIVERY

Education, training and employment (ETE)

Participants were asked if they felt they had the skills and confidence to get into employment, training or back into education. They also asked if they were employed when they started the programme and at the end of their engagement in it.

At baseline (T1)	At week 6 (T2)	At the end of the programme (T3)
7%	29%	53%

Table 4: Number of people who felt confident to get into ETE

At baseline (T1)	At week 6 (T2)	At the end of the programme (T3)
1%	10%	33%

Table 5: Number of people who were employed

Over half of participants felt more confident to get back into work and indeed over a third of them found a job by the time they completed the programme. The questionnaire was limited in that it did not ask what kind of contract the participants got (I.e full-time, part-time; permanent or temporary). This indicator is significant to evaluate the impact of the programme on the social integration of the participants. This cohort faces particular challenges to get back into work due to external discrimination and very low levels of self-esteem.

It is also worth noting that a number of participants enrolled in peer-mentoring schemes and became peer mentors. This scheme became an important element of the programme from the second year of the programme, with very positive feedback.

Tree of Life (life skills) session

2.14 **Outcome 3:** Ex-users will be more integrated socially.

a. PROPOSAL: Number of Ex-users who get better accommodation; who will participate in new social activities, make new friends; will feel less isolated.

b. DELIVERY:

<u>Better social integration</u>

At baseline (T1)	At week 6 (T2)	At the end of the programme (T3)
12%	43%	67%

Table 6: Number of people who feel less isolated

Many of the activities proposed in the programme involved group activities, which led to the participants creating social networks. It is to be noted here that the participants filled their questionnaires at the end of an activity and therefore their level of confidence and feeling of belonging to a group could have been higher at that moment than it would have

been at another moment of the same week. Nonetheless the outcome on levels of social integration are very positive.

Arts and crafts workshop

2.15. **Outcome. 4.** Ex-users who have just completed treatment will sustain their recovery

a. PROPOSALS: Number engaged in relapse prevention groups; number feeling positive and motivated about their recovery.

b. DELIVERY

Data shows that 42 participants (9% of participants) relapsed during their engagement in the programme, with the majority having to start treatment again. It is estimated that through traditional treatment, 40 to 60% of patients relapse after treatment.

The In-Programme monitoring by the Funder

2.16 Throughout the programme regular monitoring was undertaken every 6 months by the Funder and CDARS also provided regular feedback every 12 months during the project. A copy of the report covering the period between August 2018 to July 2019 is attached as an example In **Appendix F.** An overall summary of the monitoring of the programme over 3 years is in **Appendix G**. This gives details of the statistics of the outcomes.

Testimonials and Qualitative Feedback

2.17 During the focus group sessions, 8 participants were able to give their feedback on what they felt the programme did well and where improvements should be made. All the participants were very positive about their engagement in the programme and stressed that by committing to the programme fully and consistently they made a lot of changes to their overall health. Two key subjects dominated the discussions: nutrition and discovery of new skills. They stressed that the programme enabled them to pay attention to things they took for granted and to educate themselves about food.

'I used to drink a can of lager for breakfast. I never thought about eating a banana for breakfast until I went on the programme.'

'You never know what you are capable of. You learn new things about yourself'.

The participants explained how the programme enabled them to change their mindset and to become open about trying new things they never knew they would enjoy doing.

'When I come to CDARS I remove all barriers'.

Moreover the programme enabled them to make new friends and to socialise again. Meeting new people was one of the highlights of the programme.

'With substance misuse, you lose your social skills. The groups help get back to socialise'.

Case studies of two participants are also given at **Appendix G.**

PART 3: CONCLUSIONS AND RECOMMENDATIONS

Conclusions

3.1 Considering the results of the questionnaires presented in this evaluation, it appears that the Wellness and Recovery programme has had very good outcomes on various domains encompassing health and wellbeing, with the most notable being perception of general health, improved diet and access to employment. Drawing on the evidence from the project's monitoring and evaluation tools, the programme has successfully improved the participants' health both physically, through improved dietary habits and increased physical activity, and mentally, through better social integration and improved life skills. The variety of data sources used to gather evidence suggests this is an objective and reliable conclusion.

3.2 The programme has been successful at maintaining overall relapse rates considerably low. One can therefore assume that improving prospects of employability, skills-building and improved general health are key determinants to reducing relapse rates. The Wellness and Recovery programme aimed to build the participants' recovery capital to help them maintain their recovery and it appears to have succeeded in this outcome.

3. 3 CDARS was able to tap into its own resources to add value to the Wellness and Recovery programme by enabling the participants to benefit from other services and activities available within CDARS, notably the Sunshine Recovery Café, a mental health recovery café based in Wimbledon Chase. It is possible that the outcomes demonstrated above are a result of the Wellness and Recovery programme as well as other services provided to the participants during the same period of time.

Recommendations

Throughout the duration of the programme, the participants have been asked regularly to provide their feedback through surveys, questionnaires, feedback forms as well as a small group of participants involved in a focus group. The participants were asked to give their opinion on what worked well, what they felt did not work very well and what could be done differently to improve the programme. Programme staff have considered these feedback very carefully and have aimed to act upon suggestions promptly in order to improve the programme.

A number of key recommendations for implementing a health and wellbeing programme for people in recovery from drug and alcohol misuse and/ or with dual diagnosis were drawn.

3.4 All participants are in different stages of recovery, with different levels of complex needs. The programme should therefore not take a one size fits all approach but rather offer a flexible approach and deliver a programme tailored to the needs of each individual. Some participants may require more time not only to improve their overall health, but also to become motivated to participate in some of the activities. Members of staff will therefore require to be trained to work with this cohort and use motivational techniques to support their engagement, especially at the beginning. The programme should offer a wide range of holistic activities which are appealing to a wide range of individuals with different interests and different levels of fitness/ general health.

3.5 Many of the participants are not used to looking after themselves and their own health and therefore a sudden focus on their own quality of life did not come naturally to them. A lot of it is due to the fact that they do not feel self-worth and do not feel they deserve to live a good life. A lot of therapeutic work needs to be done to improve self-perception and get them to understand that it is important for them to look after themselves.

3.6 The participants expressed a keen interest to get involved in activities as opposed to being taught theory, be it around health or nutrition. They enjoyed practical sessions enabling them to learn new skills but were reluctant to learn more theoretical life skills.

3.7 A recommendation was made to make the timetables more inclusive for people with learning disabilities or dyslexia. A request was made to print the timetables each month to make the planning of the programme more visual.

3.8 Many participants felt the programme was too short and that they would have benefited more if it lasted longer. Currently the programme was lasting 12 weeks and participants were not expected to participate for a longer period of time. A recommendation would be to extend the duration of the programme for this cohort due to their complex needs. Staff members suggested that a 6 months programme would have a more sustainable impact.

3.9 The participants also commented that the sessions are too short. When a session lasts 1.5 hour they take a large proportion of this time to ‘check in’, where everyone is expected to say how they are feeling that day. This is an essential element of the programme but it takes a lot of time away from the activity. It was suggested that the sessions last 3 hours each or that they do sessions in the morning, followed by a lunch break, and then again in the afternoon.

3.10 Although the programme has relied on collaborations with other organisations, more can be done to encourage the participants to engage in other activities within their community. A recommendation was made to attend organisations’ open days as a group to break down barriers.

3.11 From year 2 onwards some of the activities were delivered from the Sunshine Recovery Café, which is open from 6pm to 11pm every evening and during weekends. This was an important development as some participants who had succeeded to get

back into work suddenly had struggled to attend activities during the day. The programme therefore needs to offer some flexibility to be accessible by people at various stages of their recovery, including those who are back in employment.

Best practice model

3.12 Health and Wellbeing programmes designed for people experiencing substance misuse and /or dual diagnosis should be offering interventions and activities tailored to the needs of each individual and take a flexible approach to work at the pace that is right for the service user in their recovery journey. This cohort has a range of complex problems therefore health and wellbeing programmes would have better outcomes if they run over 6 months rather than 12 weeks. In addition, in order to make the programme more inclusive the activities on offer should be made available at different times of the day in order not to impede people from attending due to their personal circumstances.

APPENDICES

APPENDIX A: NOTE BY CDARS ON SUBSTANCE MISUSE AND THE NEED FOR THE PROGRAMME – PLUS REFERENCES

Background of the programme

Substance misuse can be the cause and consequence of poor quality of life, such as poor social and physical well-being and psychological distress. Here we consider quality of life as per the World Health Organization's definition, focusing on four domains: how satisfied an individual is around their current physical health, mental health, social relationships, and environment. Importantly, quality of life plays a key role in recovery from substance misuse (Ashley E. Muller, Svetlana Skurtveit, Thomas Clausen, 2016)(1). Improving the domains of quality of life through a range of activities that can help improve mental and physical health is essential to maintaining abstinence and recovery.

Yet unemployment rates amongst substance misusers are high, and so is isolation and marginalisation so opportunities to engage in recreational or holistic activities are limited for them. A greater number of people with substance misuse come from deprived backgrounds, with little to no aspirations in their lives (DrugWise)(2). This not only makes treatment difficult for them but maintaining recovery if they become abstinent even more challenging.

Becoming abstinent from drug or alcohol misuse is only one part of a long and complex recovery process. The individual's environment needs to be taken into account and improved as substance misuse usually impacts on their whole life including their jobs, housing situation, health, family life and social integration. To increase their chance of maintaining sobriety, treatment should address the needs of the whole person, not only the substance misuse. To increase chances of treatment success, changing deeply rooted behaviours is essential (National Institute on Drug Abuse, July 2018)(3). Once treatment is completed, aftercare is essential to ensure the individual does not relapse. Aftercare should involve a range of complimentary holistic activities that support the whole person.

Need for the programme

The UK Drug Policy Commission defines recovery as "voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society". According to this, recovery involves wellbeing and quality of life, some measure of community engagement or citizenship, and some measure of sobriety. Recovery is therefore the process by which an individual can attain better quality of life (David Best and Alexandre B. Laudet) (4).

The RSA outlines three key areas of recovery capital (I.e. the resources that enable an individual to initiate and sustain recovery):

1. Personal recovery capital:

- safe and secure accommodation
- physical and mental wellbeing

- purposeful activity

2. Social recovery capital:

- Peer support
- Supportive friends and family

3. Community recovery capital:

- Supportive and non-stigmatising attitudes in the broader community
- Community resources (for instance activities and transport links)
- Recovery communities.

Relapsing is often an outcome following treatment, and it is estimated that 40 to 60% of patients relapse (National Institute on Drug Abuse, January 2018)(5). It is therefore imperative to build recovery capital to provide all the tools for individuals not to relapse.

References

1. Ashley E. Muller, Svetlana Skurtveit, Thomas Clausen (2016) *Many correlates of poor quality of life among substance users entering treatment are not addiction - specific* https://www.researchgate.net/publication/296691584_Many_correlates_of_poor_quality_of_life_among_substance_users_entering_treatment_are_not_addiction-specific
2. https://www.drugwise.org.uk/is-drug-use-mainly-in-deprived-areas/
3. https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery
4. David Best and Alexandre Laudet (2014) *The Potential of Recovery Capital* http://www.recoverystories.info/the-potential-of-recovery-capital-by-david-best-and-alexandre-laudet/
5. National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)* (January 2018)

APPENDIX B: AN EXAMPLE OF THE ABSTINENCE, HEALTH AND WELLNESS TIMETABLE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
2- 3pm	2 – 3pm	2 – 3pm	2 – 3pm	2 – 3pm
	Mindfulness	Auricular Acupuncture/ Reflexology	ETE/ Benefits/ Housing Support	
3:30 -	3:30 – 4:30pm	3:30 – 4:30pm	3:30 – 4:30pm	3:30 – 4:30pm
Growth and wellbeing	Arts and Crafts activities		Basic skills/	Fitness
Group / Mindful cooking / eating			ITC / life skills	/ Yoga
6.30 -7.30pm	6.30 -7.30pm	6.30 -7.30pm	6.30 -7.30pm	6.30 -7.30pm
	Arts and crafts actvities		Kickboxing	General health / Sexual health

APPENDIX C: AN EXAMPLE OF THE 'SEEDS OF CHANGE' AND 'TREE OF LIFE' SOCIAL ACTIVITIES

'Seeds of Change' in Wandsworth and 'Tree of Life' in Merton offered sessions based on a person-centred, holistic and non-directive approach, with the purpose to enable service users to explore their life, social and employment skills. The modules used a life-coaching approach and provided a wide range of learning tools such as group exercises, visual aids, open questions, group discussion and reflection, relaxation techniques and social outings together with tailored one-to-one support for employment, education, welfare benefits, housing and debts issues.

'Seeds of change' – Social activities 2017/2018:

August 2017	Thames River trip – Westminster, Greenwich and Thames Barrier
September 2017	1. "Lady Wimbledon" inspirational talk at EngageMerton, Wimbledon Chase 2. "The Mermaid" Play by Open Stage CIC at Theatre Peckham
October 2017	"Inside" Koestler foundation exhibition in Southbank with lunch at Borough Market
November 2017	Visit to Kew Gardens
December 2017	"Scrooge and the seven dwarves" Pantomime at Theatre 503 - Battersea
January 2018	Visit to Science Museum – South Kensington
February 2018	Visit to Kew Gardens – Orchid festival (cancelled due to cold weather/snow)
March 2018	1. "Moving Hearts" workshop at South Bank University with lunch at "Mercato Metropolitano" Borough. 2. Visit to Kew Gardens
April 2018	Visit to Tate modern with lunch at Borough Market
May 2018	Visit to Kew Gardens
June 2018	Visit to the Buddhapadipa Thai Temple in Wimbledon Common
July 2018	"Tea and little sympathy" Play by Open Stage CIC at Tara Theatre Earlsfield

APPENDIX D: QUESTIONNAIRES – EXAMPLE AND SUMMARIES

Questionnaires

- How healthy do you feel? (i.e. mental, physical, emotional, spiritual)? 1 to 10
- How healthy do you think your diet is? 1 to 10
- How often do you eat fruit and vegetables? Never, rarely, sometimes, usually, always
- How often do you cook your food from scratch? Never, rarely, sometimes, usually, always
- How often do you take part in physical activities? (I.e. gym, walking, swimming, jogging?) Never, rarely, sometimes, usually, always
- Activities...
- If your answer is never, is there a reason for this?
- Are you currently involved in education, training or employment?
- If not, do you feel confident to get back to work?
- Do you sometimes feel isolated? Never, rarely, sometimes, usually, always

Feedback forms

Did the 12 weeks Health and wellbeing programme meet your expectations?

1	2	3	4	5	6	7	8	9	10

Not at all *Completely*

Please tell us what you think using the scale below. Check the response that best fits the statement.

	Strongly agree	Agree	Disagree	Strongly disagree
I was given a warm welcome				
I was treated with dignity and respect				
I improved my diet and eat healthier food				
I improved my fitness level				
I feel more confident in my skills to find employment				
I enrolled in education or professional training				
I am attending the peer mentoring training				
I feel less isolated				
My housing situation has improved				
I engaged in relapse prevention groups				
I feel more positive and motivated about my recovery				

What did you like most about the Health and Wellbeing programme?

What did you not find useful?

If you were going to make any changes to complement the programme, what would they be?

Is there anything else that you'd like to tell us?

APPENDIX E. DETAILS OF THE FOCUS GROUP

- Do you feel the health and wellbeing programme helped you in your recovery? How?
- What do you think was a key success to the programme?
- What should be done differently in future programmes?
- How could the programme be improved?
- Do you feel your overall health has improved with the programme?
- What will you do differently now?
- Any comments?

APPENDIX F: COPY OF CDARS REPORT TO THE FOUNDER COVERING THE PERIOD BETWEEN AUGUST 2018 AND JULY 2019

Project monitoring

Reporting period: August 2018 to July 2019

1. Project overview

Provide a brief overview of the project and what it has achieved in the reporting period.

The types of things we want to know about are

- Whether you have completed all of your key activities for the year
- About project governance, leadership and project management
- External context: e.g.; other delivery organisations, funding environment, policy environment
- Evidence of strong relationships locally, with other providers, funders, stakeholders
- Extent to which the work has been / continues to be informed by the community / service users
- Management of risk
- Organisational financial situation and potential impact on project

This year the programme worked with 120 participants in Merton and Wandsworth. Out of these, 101 engaged for 12 weeks as anticipated and 10 relapsed during the programme. Almost all our clients have dual diagnosis: a combination of substance misuse with mental illness, including anxiety, depression, sleep deprivation or a drug-induced psychotic episode. All experience a range of interrelated needs which contribute to their dual diagnosis.

Each participant is expected to engage for a duration of 12 weeks. However we have learnt that 12 weeks is not enough to change habits (in this case substance misuse). They require more time to substitute their unhealthy routine with positive choices. Moreover for many, the options available in the programme are totally new to them: the majority did not engage in any fitness activities at all before joining the programme for instance, so they require more time to embrace these positive changes. But we have seen extremely good outcomes for the participants who have enrolled in various activities, often new to them.

This year we have offered a range of complementary holistic activities, including:

- Physical exercise including yoga, kickboxing, walks, stretching and tennis at the AELTC. As a result of engaging in our tennis programme, a number of participants have enrolled independently as members of the AELTC community grounds tennis courses.
- Nutrition: mindful shopping/ eating with a particular focus on switching to a low sugar diet. One of our ex-service users who is a trained Nutritionist ran a series of nutrition classes which were very popular.
- Creative activities: creative writing, art therapy, jewellery-making, drawing, arts and crafts and music.

- New techniques for wellbeing to ease pain, ease cravings and manage anxiety and depression: emotional freedom techniques, massage, acupuncture, mindfulness and CBT.
- Individual counselling for those with serious issues- we also signposted some participants to local specialist organisations in sexual violence, bereavement and family support services.
- Group activities and workshops to reinforce the belief that change is possible and encourage social engagement, including social outings.
- For life skills sessions we referred participants to specialist programmes such as St Mungos' programme, the Recovery College and Hillcroft College.

In order to manage risk, we have robust safeguarding policies in place, to protect not only our clients but also our members of staff. Most importantly our employees are not to work alone as some of our service users can display aggressive behaviours. To protect the safety of our participants we work closely with social services for support in case of risky behaviour. We also work closely with Probation Officers when risky behaviour is disclosed: for instance, one of our participants disclosed that he had hit his child. We therefore completed a MASH report for social services. As we work with people experiencing mental health crisis, we also have to be alert to risks of suicide. In case of concern, we contact our client's GP and work closely with the Samaritans and the ambulance services if needed. However it is to be noted that in June 2019 we received funding from the Henry Smith Charity for a suicide prevention programme to be delivered at the Sunshine Recovery Cafe.

We have continued to involve our service users in the ongoing development of the programme. We have asked them to take surveys regularly; they have filled in feedback forms and some of them have been part of our focus group alongside the Programme Manager and the Grants Manager. A key learning that came out of our customer feedback was the positive impact of peer mentors and peer-led groups. Service users highlighted the importance of giving back to their peers. General feedback was also the fact that 12 weeks is too short to sustain recovery long-term and to transform unhealthy habits into healthy ones.

After a challenging year in 2018, CDARS has successfully implemented our fundraising strategy and has continued to diversify our funding sources. We have had a number of key fundraising successes which will enable us to build our strategic objectives, such as the suicide prevention programme as mentioned above, as well as our programme funded by the Wimbledon Foundation to make our services more inclusive and culturally diverse. Our focus currently is to build sustainability rather than grow as an organisation.

2. Project progress

Please provide progress to date this year on each outcome, ideally including numbers achieved against yearly/end of project targets for outcomes and indicators.

Project Outcome 1: The health and wellbeing of ex-users who have just completed treatment will be improved

Change indicators: **If you've achieved more or less change than you planned, explain why you think this is.**	**What amount of change do you want to see?**
No of ex-users who report having improved their diet and eating more healthily	**Progress to date:** 95 out of 120
No of ex-users who report better fitness levels	**Progress to date:** 90 out of 120
No of ex-users who report better general health	98 out of 120

Project outcome 2: Ex-users who have just completed treatment will improve their skills and employability

Change indicators: **If you've achieved more or less change than you planned, explain why you think this is.**	**What amount of change do you want to see?**
No of ex-users who report more confidence and better skills to find employment.	**Progress to date:** 95 out of 120
No of ex-users who become employed, enroll in education, or professional training/ work experience	**Progress to date:** 65 out of 120
Number of ex-users who become volunteers at CDARS or similar orgs	**Progress to date:** 26 out of 120

Project outcome 3: Ex-users who have just completed treatment will be more integrated socially

Change indicators: **If you've achieved more or less change than you planned, explain why you think this is.**	**What amount of change do you want to see?**
No of ex-users who get better accommodation	**Progress to date:** 25 out of 120 Most participants were already in accommodation.
No of ex-users who participate in new social activities and make new friends	**Progress to date:** 95 out of 120
No of ex-users who report feeling less isolated	**Progress to date:** 95 out of 120

Project outcome 4: Ex-users who have just completed treatment will sustain their recovery

Change indicators: **If you've achieved more or less change than you planned, explain why you think this is.**	**What amount of change do you want to see?**
No of ex-users engaged in relapse prevention groups (incl. AA etc)	**Progress to date:** 88 out of 120
No of ex-users who report feeling positive and motivated about their recovery	**Progress to date:** 95 out of 120

3. Monitoring and evaluation techniques - and how you'll use or share what you've learned from your own monitoring or evaluation

We have recorded each interaction and engagement of our participants on our database. This has enabled us to keep track of our progress against the set KPIs. We have also tracked the demographics of our participants. In order to understand the qualitative impact of our work we have asked service users to fill in questionnaires at baseline and then regularly until the end of their engagement in the programme. They also filled in feedback forms. These enabled us to analyse the outcomes of the programme and the satisfaction/ expected changes for the programme. We also created a focus group (including the Programme Manager, Support Worker, Grants Manager, and some service user representatives) who met quarterly to discuss progress of the project and to evaluate what worked or did not work and establish recommendations for improvement. These recommendations were implemented, which enabled us to improve the programme outcomes. The focus group also informed each end of year report submitted to the National Lottery Community Fund.

CDARS is currently evaluating the programme over its 3 years duration.

4. How well did you reach everyone who could benefit from your project?

How many and who you have been able to support and how does this align with the people you had intended to support?

Describe what you've done to make sure everyone who could benefit from your project knew about it and was able to get involved. If your project hasn't been as effective as you'd have liked, explain what you'll do differently in the future.

As mentioned above, we had 120 participants this year across Merton and Wandsworth. We are able to refer participants internally from our other programmes such as the Day Programme in Wandsworth and our recovery café. We also got referrals from other voluntary and statutory organisations with whom we work closely such as social services, Probation, social prescribers and local hospitals. We have provided marketing material within GP surgeries however we realise the uptake from these is quite low so we need to keep building rapports with GPs to improve this.

The 120 participants had substance misuse, mental health issues and dual diagnosis as anticipated.

5. Overall lessons learned

What has worked particularly well?
What has not worked as you had planned?
Any plans to build on learning to date; sharing learning?

A key learning for us is that our beneficiaries are willing to engage in health and wellbeing activities and are keen to make changes in their lives. However recovery is a long journey and people react and respond differently to aftercare depending on personal life issues, personalities and life experience. We can provide holistic activities that tap beyond recovery however there is no magic formula and aftercare needs to be provided over a longer period to improve chances of sustained recovery.

Peer mentors offer a great opportunity to lead by example and to improve their own self-empowerment. However they need to be given the opportunity at the right time in their recovery journey. They also require adequate regular supervision so that they do not feel under pressure.

In effect, the health and wellbeing programme has aimed to empower individuals. A longer programme, over 6 months, would enable individuals to make the necessary changes without feeling extra pressure.

Should we be successful in delivering a continuation of the programme we would offer a 6 months programme and we would further strengthen our community network for additional support.

6. End of project review

Please provide a full budget breakdown for project year (please complete excel spreadsheet sent with this document)

Please explain any significant differences between the amounts you've received and spent and how this may affect your project.

Is there any overspend/underspend at the end of project?

Has your project brought about the changes you expected it to?

What have you done to ensure the benefits of your project have a lasting impact after the funding from The National Lottery Community Fund ends?

The programme outcomes were very positive so CDARS considers the wellness and recovery programme to be a real success. Since year 2 we were able to broaden the reach of the programme and to open it to people with substance misuse and mental health issues. The rate of relapsing has been very low within this programme, evidencing the benefits of the holistic activities on the participants' recovery.

All our activities have been delivered with a focus on delivering long-term benefits. In particular we have focussed on enabling individuals to make positive lifestyle choices and effecting positive changes in their routine. Although most of the activities were enjoyable and recreational they went further in empowering individuals to make the right choices to improve their quality of life. The fact that 31% of the participants enrolled in employment or education as a result of the programme demonstrates the potential to have an impact on the participants' lives, as well as their dependents.

APPENDIX G: DETAILS OF THE MONITORING BY THE FUNDER

Outcomes	Target Year 1	Actual Year 1	Target Year 2	Actual Year 2	Target Year 3	Actual Year 3
Number of ex-users who report having improved their diet and eating more healthily	90	117	90	118	90	95
Number of ex-users who report better fitness levels	90	109	90	105	90	90
Number of ex-users who report better general health	90	125	90	121	90	98
Number of ex-users who report more confidence and better skills to find employment	90	76	90	82	90	95
Number of ex-users who become employed, enrol in education or professional training/	60	49	60	46	60	65
Number of ex-users who become volunteers at CDARS	25	31	25	16	25	26
Number of ex-users who get better accommodation	30	28	30	28	30	25
Number of ex-users who participate in new social activities and make new friends	90	104	90	99	90	95
Number of ex-users who report feeling less isolated	90	114	90	112	90	95
Number of ex-users who engage in relapse prevention groups	60	95	60	101	60	88
Number of ex-users who report feeling positive and motivated about their recovery	90	122	90	124	90	95

APPENDIX H: CASE STUDIES

Lloyd's story

Lloyd's difficult childhood led him to start drinking aged 16. Within 10 years, his drinking worsened and he began to use cocaine and cannabis regularly. However he was a high functioning addict with a good job, family and house until he lost everything when he was imprisoned aged 49.

Lloyd underwent a detox programme in prison. CRC referred him to CDARS' 12 weeks Health and Wellbeing programme when he was released into the community. He had been abstinent for six months. The programme consisted of a comprehensive range of holistic activities including keyworking, care planning, Relapse Prevention, Personal Development around fitness, healthy eating, life skills and mindfulness.

Lloyd's attendance was consistent and he engaged positively with the programme, working very well with the other clients.

He successfully completed the 12 weeks programme, improving his life skills and resilience, which led him to enroll into a gardening course and a peer-mentoring scheme with a partner organization. His goal is now to become a drug and alcohol worker.

Kelly's story

Kelly, 34 years old, was referred from the Family Recovery Project to the 12 weeks Health and Wellbeing programme as a result of Social Services involvement, and her two children being placed in a Child Protection Plan for neglect.

She is the eldest of 5 children, 3 brothers and 1 sister. Her parents split up when she was 9 years old due to her mother being an alcoholic. Kelly witnessed domestic violence between her mum and dad since she was 5 years old and, later on, between her mother and step dad. Kelly was physically abused by her mum's sister from the age of 5. She struggled with dyslexia and was moved to different schools as a "problem child". She also experienced bullying at school. Between the age of 9 and 10, she was repeatedly sexually abused by a family friend.

Kelly started to use alcohol when she was 17 years old and went out clubbing with girls.

She had a stillborn daughter at the age of 19. At the age of 20 she had her first son. She separated from her partner when the child was 18 months old and by the age of 24 she started using cocaine and alcohol with her youngest brother and ex-partner.

In 2007 she had her second son who was born with cerebral palsy and is severely disabled. Kelly did not accept any support offered by local services. She attempted suicide one year after the birth of her second child and was diagnosed with anxiety, depression and aggressive behavior induced by substance misuse.

In the past 10 years Kelly occasionally worked with her dad who owns a painting and decorating business and also volunteered in activities for special needs children.

Until her referral to the health and wellbeing programme, Kelly's longest period of abstinence from drugs was 3 weeks.

Kelly attended a comprehensive assessment and was accepted into the health and wellbeing programme consisting of relapse prevention, personal development, gender specific groups, nutrition, life coaching, mindfulness & focusing, yoga classes and complementary therapies, social outings and ETE- life skills. The programme lasted for 12 weeks and included key working sessions and care planning. Kelly's attendance was consistent, she showed willingness to learn and participate to all activities and motivation for change. She also attended NA meetings.

After the successful completion of the 12 weeks daily programme, Kelly started counselling sessions and moved onto CDARS' voluntary aftercare evening groups, which is there to offer continued support for as long as she wishes to attend. She has also taken responsibility for recovery liaison peer-to-peer meetings on Wednesday morning and has been referred to a painting and decorating NVQ course with the view of starting her own business soon.

Kelly said that she is now spending quality time with her children and learning to listen to them rather than rushing them through their daily routine. As a result of her lifestyle change and Kelly testing negative for drugs and alcohol, her children have now been placed in a Child in Need plan.

Using Kelly's words: "The programme at CDARS gave me the opportunity to regain the Inspiration and strength I had lost along the way. Having a good support network is vitally important to me. I learned not to be too hard or critical on myself when a bad day does come along and that asking for help when you need it is to me NOT a sign of weakness".