Director-General Health & Social Care and
Chief Executive NHSScotland
Caroline Lamb

T: 0131-244 2790
E: dghsc@gov.scot

Scottish Government
Riaghaltas na h-Alba

Richard Leonard MSP
Convener
Public Audit Committee
The Scottish Parliament

6 February 2025

Dear Richard,

Thank you for your letter dated 15 January 2025. Please find the responses to your additional questions and follow-up promised in the committee session below.

Question 1

We have begun work on a refreshed strategy that will set out our intended approach following on from the National Mission and ensure the long-term sustainability of alcohol and drug services.

The strategy will cover both drug and alcohol related harms and deaths and be underpinned by a set of clear and deliverable actions. Our priority is to ensure it is evidence based and will address the next steps across treatment, whole systems, and harm reduction, as well as long term preventive measures to support those most vulnerable to substance abuse and harms.

The strategy will complement the Population Health Framework which will set out the Scottish Government's 10-year strategy on how we plan to tackle population health-based challenges.

Financially, the Scottish Government remains committed to supporting vital drug and alcohol related services. Despite the tight fiscal position, we have protected our investment in residential rehabilitation for 2025-26 and maintained record levels of funding for Alcohol and Drugs Partnerships (ADPs). For 2025/26 onwards we have increased the amount of baselined funding ADPs get by £19 million providing further stability. We will continue to take an evidence-based approach to future funding decisions, particularly using the PHS evaluation to support our decision-making.

Question 2

With regard to accessing drug and alcohol services and the implementation of the Medication Assisted Treatment (MAT) standards, there are unique challenges faced by remote and rural areas. These are not limited to, but include lack of prescribing capacity, the logistics of same day prescribing, lack of GP shared care and workforce pressures.

The Public Health Scotland based MAT Implementation Support Team (MIST), continue to provide support and assistance to remote and rural areas in order to share best practice and aid them in mitigating against barriers faced.

Through MIST we understand that areas are overcoming the challenges of rurality by using different approaches and of which include: high use of self-referral and telephone, 'tele-health' technology such as NEAR ME; wide use of bus passes, taxis, and third sector to take people to appointments; offering a choice of venues to be seen at, such as a GP practice, home and community hubs, as well as settings to deliver care when weather disrupted usual access.

A strength in many areas is also the utilisation of informal local networks and relationships to respond to urgent presentations even when no formal arrangements are in place.

Question 3

A) Data on the size and scale of recovery communities

Scottish Recovery Consortium commissioned a report on recovery communities, which was completed in August 2024. The full report has been provided as a separate attachment to this letter.

The research was designed to:

- to get a better understanding of what a recovery community is, how recovery communities and Lived Experience Recovery Organisations (LERO) define themselves, what support they provide to people affected /harmed by alcohol and drug use, and some of the challenges being faced across Scotland
- to ensure SRC are responsive to the changing needs and of recovery communities and Lived Experience Organisations (LEROs)
- to incorporate these findings into the SRC strategy 2025-2028 to ensure alignment of local need and national policy

The SRC research involved engaging with a range of recovery communities, Lived Experience Recovery Organisations and ADPs over several months in 2024. In total 50 recovery communities were contacted and 41 responded. A video explainer with more details on the research can be found here: https://youtu.be/bGxRUQr78v0

It is clear from this research that recovery communities, Lived Experience Recovery Organisations (LEROs) and broader community groups that support and /or engage with people affected and /or harmed by problematic substance use are diverse, both in nature and size. These groups take on many forms including un-constituted, constituted groups, recovery communities attached to other charities and independent lived experience organisations.

In terms of key highlights, the research found that there are 389 volunteers involved in the design or delivery of recovery programmes, carrying out a total of 2,789 hours of volunteering per week. It also found that 2,174 people were supported each week by recovery communities. The summary report has been provided alongside the follow-up response to the committee. The research also identified gaps in relation to women only recovery support. SRC have now completed a Rapid Evidence Assessment of the research evidence base on women affected by addiction and the role of recovery and they are currently mapping/exploring directly with women in recovery what is needed in Scotland.

SRC are now directly engaging with a research group in Dundee University made up of academics with lived experience to further explore in detail the broader impact volunteers are having in support local people with alcohol and drug issues, the reduction of drug deaths and the National Mission.

SRC are working in every prison in Scotland and currently completing a baseline of all recovery activities /support being delivered across the Scottish Prison service. SRC also consulted with over 30 recovery organisations / LEROs are part of SG pre-budget scrutiny consultation with a specific focus on third sector / local partners.

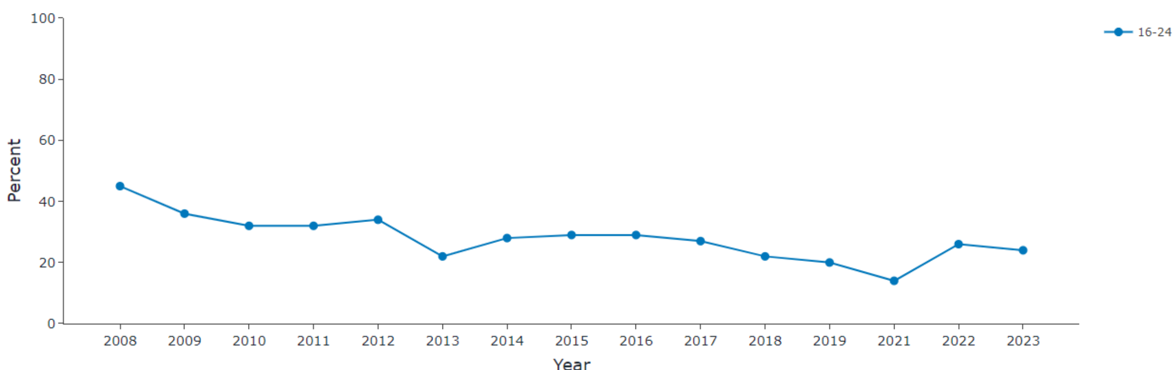
B) Capacity of residential rehab

Since 2021, there has been a rise of 21% in residential rehabilitation bed capacity in Scotland. An official statistics report published on 26 November 2024 showed that there has been a rise in residential rehabilitation capacity from an estimated 425 beds in 2021 to a maximum of 513 in 2024. Whilst we know there is still more to do, this report provides a useful snapshot of progress as we continue to expand access to residential rehabilitation across the country. Since November 2021, we have made £38m available between eight projects across Scotland to add at least 140 more beds to our 2021 baseline by 2026.

C) Data relating young people and alcohol

The Scottish Health Survey provides information on young people and alcohol consumption.

In 2023, 24% of those aged 16-24 years reported consuming harmful or hazardous levels of alcohol. This was a small decrease on 2022 (26%). The proportion of 16–24-year-olds who reported consuming hazardous/harmful levels of alcohol has decreased over time.



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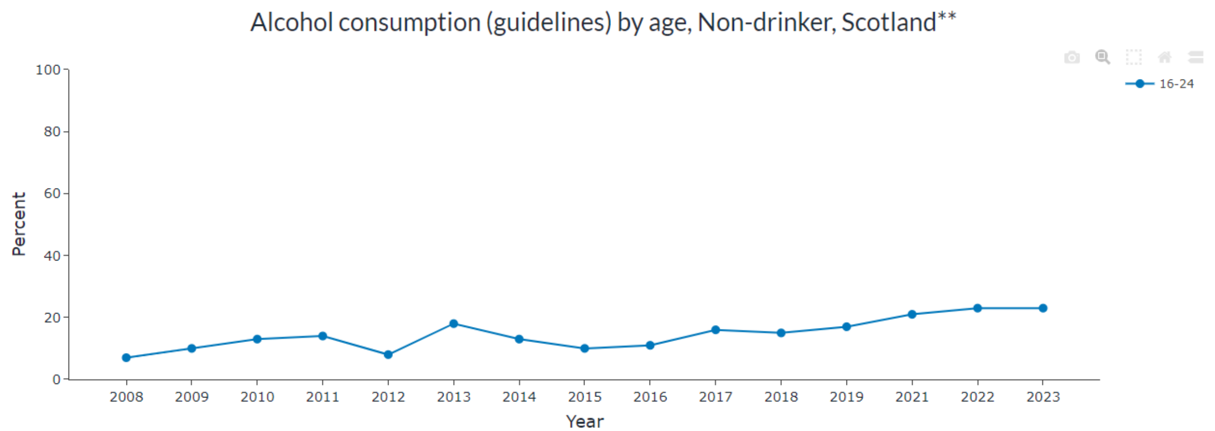
There has been a steady increase in the proportion of 16–24-year-olds reporting that they are non-drinkers (7% in 2008 rising to 23% in 2023).



Source: Scottish Health Survey 2023, Scottish Government, November 2024.

Yours sincerely,

Caroline Lamb (she/her)
Chief Executive of NHS Scotland and Director General for Health & Social Care

iconic consulting

Recovery Communities

Research

Summary Report

August 2024

Scottish Recovery Consortium

Introduction

This concise report summarises the findings of research on recovery communities in Scotland. Iconic Consulting carried out the research on behalf of the Scottish Recovery Consortium (SRC). The research gathered information on recovery communities, the issues they are facing, and how SRC could support them in the future.

A mixed methods approach was adopted for the research which involved:

- A survey of recovery communities known to SRC. Iconic and SRC co-developed a questionnaire which was available online and, on request, as a Word document. SRC distributed the survey link to over 50 recovery communities they had some previous contact with. The online survey was accessible from mid-January to early March 2024. In total, 41 recovery communities responded.
- A survey of Alcohol and Drug Partnerships (ADP). As above, Iconic and SRC co-developed a questionnaire which was available online and as a Word document. SRC distributed the survey link to all ADPs in Scotland which was accessible from mid-February to early April 2024. In total, 8 ADPs responded.
- In-depth research in four case study areas chosen to include island, rural and urban recovery communities across Scotland. Consultations took place with recovery community staff, volunteers, and beneficiaries, and ADP staff between May and August 2024.

The recovery communities and ADP surveys provided valuable information on recovery communities in Scotland. It is important to note this is a snapshot and the findings should be regarded as indicative rather than fully representative of recovery communities in Scotland.

What is a recovery community?

Recovery communities and ADPs were asked to describe a recovery community in their own words, with the question stressing there was no right or wrong answer. There was a positivity to the responses which emphasised the support provided by a group of people with lived and living experience of substance use that aimed to aid their recovery and the recovery of others. Responses highlighted that recovery communities provide emotional and practical support, social interaction, and activities for people in recovery. They can also link people to support provided by other organisations for substance use and related issues such as health, housing, finances, and employability. Recovery communities were described as a safe place where everyone was welcome.

> "A recovery community is a group of people who are involved in addiction recovery. It should be a supportive and non-judgmental environment where people can meet others who have went through similar situations and share their experiences, struggles, and successes. It is a place where people can access a variety of harm reduction pathways and other interventions such as employment and job training, recreational activities and a host of other services designed to help people in, or seeking, recovery from substance use". (Recovery community staff).

> "A recovery community should provide a range of supports that will change and grow with the individuals accessing the supports. Holistic therapies, training, education, group work, one-to-one support, peer support and signposting to other treatment and recovery services. Providing tools to build up confidence and allow individuals to volunteer at a pace that suits them". (ADP staff).

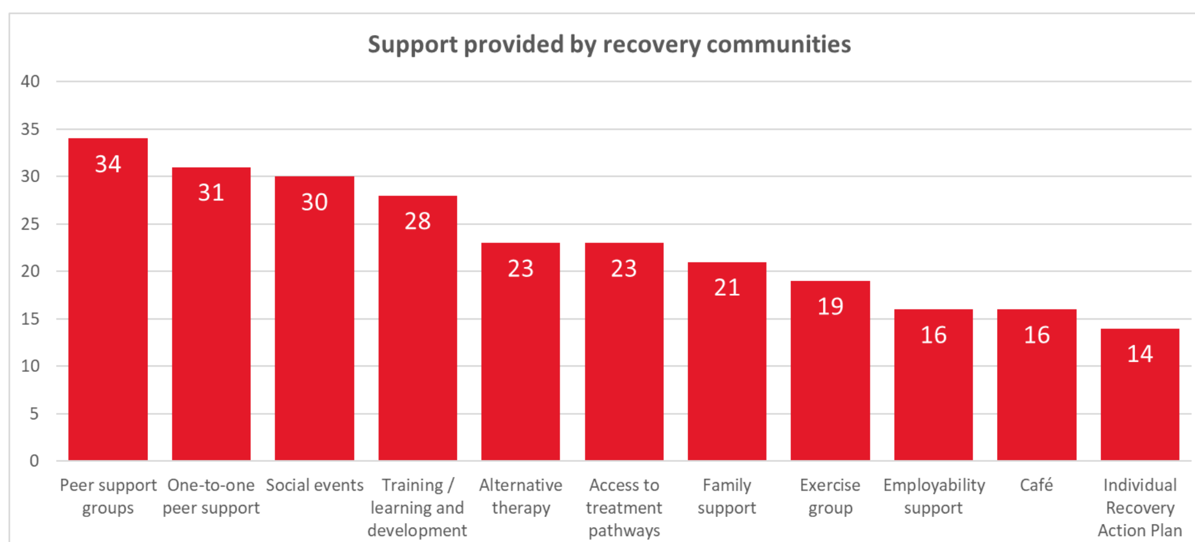
Organisational structures

Just over a third of the recovery communities taking part in the survey were an independent charity in their own right. Just under a third reported they were a service or part of another charitable/third sector organisation; the charitable focus of these organisations included substance use, homelessness, health & wellbeing, and children, young people & families. Around a fifth were constituted groups or in the process of becoming a constituted group. Others reported they were a service operated by the local ADP, an informal or unconstituted group, or a Community Interest Company (CIC).

Support and activities

In total, 2,174 people were supported each week by the 39 recovery communities that provided information in the survey. Totals at individual recovery communities ranged from four to approximately 300. The average was 56 beneficiaries per week.

Recovery communities in Scotland provide a wide range of support. The most common were peer support groups, one-to-one support, and social events which were provided by at least three quarters of the recovery communities surveyed. Over half of all recovery communities also provided training/learning & development, alternative therapy, access to treatment pathways and family support. Individual Recovery Action Plans were provided by the fewest recovery communities, however, this was still part of the support available in more than a third of those surveyed.



One of the recovery communities in the case study areas had a comprehensive programme of groups and activities throughout the week, which included sessions specifically for women, men, LGBTQ+, veterans, and family members. It also hosted AA and CA meetings which provide connections and help familiarise potential beneficiaries with the venue. Another recovery community, in a rural area, was part of a wellbeing hub that supported people with mental health issues, socially isolated people, and older people, as well as those in recovery. It also had a series of groups and activities throughout the week. In another area, the recovery community had no set programme with staff arranging activities at meetings that took place in different localities on different days throughout the week. These activities includes music, a mobile cinema, meditation and sports. In addition, beneficiaries explained they regularly take part in outdoor activities together on days of the week when they were not attending the recovery community. Staff were initially

involved in setting up these additional activities although the beneficiaries have since taken on the responsibility. Hot food was available at one of the recovery communities and beneficiaries reported it helped attract people in recovery who were struggling with the cost of living or had limited cooking skills. There were fewer activities at the recovery community in the island case study area.

Recovery communities role in recovery pathways

Approximately 40% of the surveyed recovery communities reported they have a structured/comprehensive pathway in place to support people at different stages of their recovery. The pathways varied from signposting and linking into other providers, to integrated support provided by the recovery community and others organisations. Three quarters of recovery communities reported that other organisations provide some support to their community. The support cover a variety of issues including recovery, health and wellbeing, advice, advocacy, employability, housing and homelessness. In addition, a fifth of recovery communities reported they received organisational support such as staff training and funding advice from external providers.

The value of outreach by support services was evident in one of the case studies. Housing and nursing staff regularly attended the recovery community and beneficiaries reported it helped engage people who may not seek out that support themselves. For example, one beneficiary reported they had lost trust in their GP but found the nurses to be helpful and very good at phoning back with information. They also reported that the nurses had picked up health issues with most of the beneficiaries. Staff at another recovery community, in a rural area, reported that services do not utilise the venue to reach people in recovery. They added that there were few local services which meant people often had to travel over 20 miles to access services and for some this involved two bus journeys.

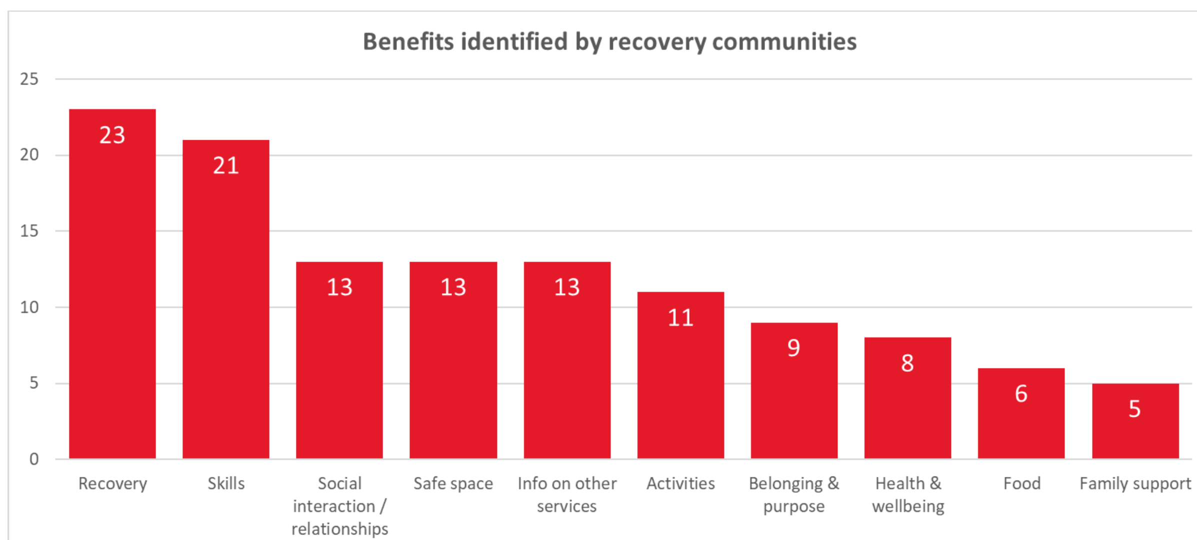
Staff and volunteers

Almost three quarters of recovery communities reported they had paid staff. There were marked variation in terms of staff roles and hours worked. In total there were 129 posts in 29 recovery communities working in roles that could be broadly categorised as manager/co-ordinators, recovery workers, and support staff.

Approximately 70% of recovery communities reported they have volunteers. The 27 recovery communities that provided information, estimated that 398 volunteers delivered 2,789 hours of volunteering per week. Volunteers roles included peer support, groupwork, family support, promotion, meet & greet, set up, cooking, admin and trustees. Some of the recovery communities in the case study areas had clear pathways for beneficiaries to progress into volunteer roles. Most of the volunteers who took part in the research had come through this route. They reported the training and support they received was very good, with some gaining qualifications. They added that being a volunteer helped their self-confidence, gave them new skills, and was an added motivation in their recovery.

Benefits and impact

Recovery communities identified a wide range of benefits for those attending. The main benefit, not surprisingly, was ongoing support with recovery from substance use. Skills development, social interaction, having a safe space to attend, and information on other services were among the other benefits identified in the survey.



> "Our participants tell us that attending gives them a sense of purpose, it helps with social isolation, and confidence. Although participants are people in recovery, the project (community) is about them as people and our participants always say that they like that recovery isn't really spoken about but that attending definitely helps with their recovery". (Recovery community staff).

ADPs were asked about the impact that recovery communities have. Their responses were overwhelmingly positive emphasising the vital support they provide for individuals in recovery. "Lifesaving", "life changing" and "invaluable" were some of the words used to describe their impact. ADPs' also stressed that recovery communities provide hope as well as practical support for people in recovery. The importance of mutual aid groups, complementing treatment and service, and reducing stigma were also mentioned.

It was striking how many of the beneficiaries in the case study areas attended the recovery communities very regularly including several who attended every session. They emphasised that attending regularly was important in maintaining their recovery. They also highlighted friendships, social interaction and activities as benefits. Several commented that they would be lost without the recovery community. While this shows the benefits of recovery communities it also suggests a level of dependency which could be problematic if the communities do not exist in the future.

> "I am in every day. I do all the groups. It was the only thing that got me out the house. If I didn't have this place I'd be fucked cos for months and months and months it was the only thing I was looking forward to. If I sit in the house I just crumble. I'm getting more comfortable in my own flat now. My mood will dip on a Friday afternoon because I know it's shut at the weekend and I can't come back until Monday". (Recovery community beneficiary).

"The people here are unbelievable, they're like angels. I can talk to them like I couldn't talk to others. I feel free when I'm here. I've been coming for a few years, it helps with my routine". (Recovery community beneficiary).

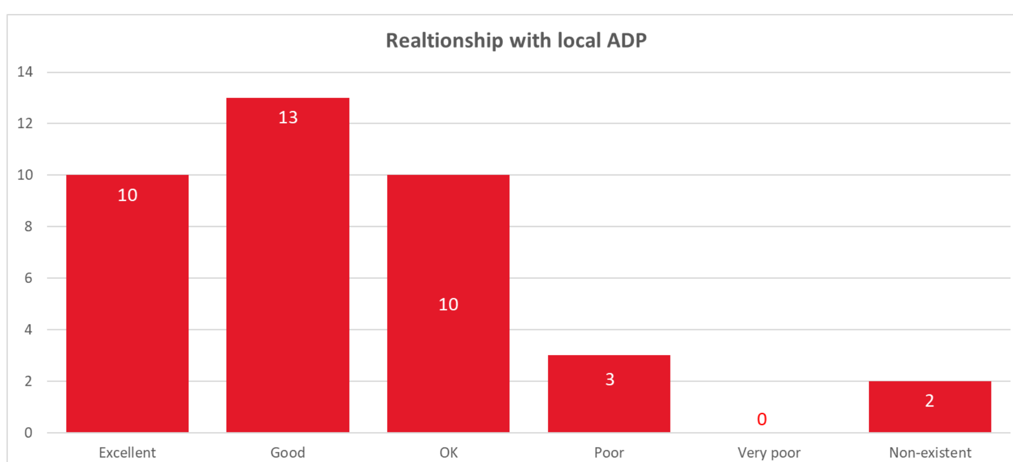
Funding and targets

Recovery communities' funders include ADPs, Health and Social Care Partnerships (HSCP), Scottish Government, Corra Foundation[1], National Lottery Community Fund, local authorities and charitable trusts. From the information provided in the surveys, annual funding for recovery communities ranged from £225,000 to £2,000. Just over half of the recovery communities received ADP funding which ranged from £175,000 to £2,000. Two recovery communities reported the ADP was their only funder.

Just over half of the surveyed recovery communities have targets or outcomes set by a funder or another organisation that they have to try to meet. The majority of the targets were set by the Corra Foundation (which could refer to the Scottish Government National Drugs Mission Funds) and ADPs. The targets primarily related to engaging people in recovery and providing support, activities, events, and training. However, some recovery communities had other targets such as "Introduce and follow the MAT standards", "Make recovery more visible in the local area", and "Enhanced joint work between treatment provision and community support services, with improved pathways and reduction in 'revolving door' support".

Contact and relationship between ADPs and recovery communities

Overall, 90% of recovery communities reported they have some contact with the local ADP. This tended to involve: regular meetings and support, often with a named contact in the ADP; membership of ADP forums or groups; invitations to participate in specific events or consultations; financial assistance; and access to training. Almost two thirds of recovery communities rated their relationship with the local ADP positively as either "Excellent" and or "Good". A handful of recovery communities rated the relationship as "Poor" or "Non-existent".



"We are incredibly lucky to have an excellent relationship with the ADP. [ADP Officer] has been an absolute hero to the community, investing time, funds and knowledge

[1] The Corra Foundation administer a number of funds on behalf of other organisations including five Scottish Government funds collectively known as the National Drugs Mission Funds.

and supporting our decisions throughout. They are part of our steering group, have attended many of our groups and outings and are invested in the recovery community". (Recovery community staff).

"We have very little contact. It is usually us contacting them to ask for answers. Their website information is poor and communication isn't great. They tend to exclude us from things and favour particular organisations. Their processes are not transparent either". (Recovery community staff).

For their part, ADPs reported they have strong relationships with recovery communities. The majority of the ADP survey respondents rated the relationship as "Excellent" or "Good". They explained that recovery communities are involved in ADP groups, forums, networks and meetings. However, the extent of this involvement varied from informal attendance at meetings to formal membership of ADP groups. It was noteworthy that the more formal involvement in groups tended to be limited to a handful of recovery communities that were members of several groups. In most cases it was recovery community staff who were involved in these groups, however, in some volunteers and/or participants were involved. Recovery communities reported they supported volunteers and participants where they were representing the community. Some ADPs have commissioned third sector organisations to develop recovery communities. This raises some interesting questions about their role and sustainability. In addition to funding, ADPs supported recovery communities in other ways such as training and organisational development.

Role of recovery communities in the recovery pathway

In the survey, most recovery communities reported that local services signpost or refer people to them and they signpost or refer people to local service or treatment providers. Reassuringly the majority of referrals to recovery communities were appropriate and where this was not the case recovery communities emphasised they still try to support people in some way.

ADPs regard recovery communities as having a vital role in the recovery pathway. They suggested recovery communities complement statutory and third sector services and there is a symbiotic relationship with people in recovery moving between recovery communities and services throughout their recovery journey.

In the four case study areas, most beneficiaries first heard about recovery community by word of mouth. This tended to involve someone who was already attending the recovery community or a mutual aid group telling them about it. Some beneficiaries had heard about the recovery community from substance use services however others, as well as some staff and volunteers, reported awareness of recovery communities was patchy among substance use staff.

"I've been coming here for nearly two years and my addiction worker had no clue about it, I was handing her leaflets to give to people, that was only a few months ago. It is madness. It's daunting when you first come, I was ready to run out the door. That's when you need your addiction worker to come with you to the first meeting as a wee bit of back up. I have seen some workers do that". (Recovery community beneficiary).

One of the ADPs added there was an onus on all parties to improve if signposting from substance use services to recovery communities was not routine.

> "I am not sure just how well those pathways are there for somebody that has been discharged from statutory services or they are more stable or they are ready to link them into recovery communities, I am not sure that is happening so well. It might be and the ADP just doesn't know about it but we haven't seen the evidence of that. I do think staff at statutory services are aware of the recovery communities but the signposting and referrals might not be happening as much". (ADP staff).

Issues facing recovery communities

Recovery communities identified the issues facing the sector. Funding was identified by almost half of recovery communities surveyed and was the most frequently mentioned issue. The second issue raised was the challenge of working with other organisations from the public and third sector and, for some, specifically the challenge of embedding a Recovery Orientated System of Care (ROSC). Stigma was also an issue. The other issues mentioned in smaller numbers can be separated into those that related to recovery communities and those that related directly to people in recovery. The former included concerns about recovery communities' capacity and resource levels, recruiting/retaining staff and volunteers (including board members), engaging participants, location (including challenges in rural areas), finding suitable venues, providing childcare for participants, and supporting family members. The issues directly related to people in recovery were the effects of the cost of living crisis including benefits, housing problems, drug related issues (new drugs and long-term methadone prescriptions) and support for mental health problems.

> "Recovery communities can be worth their weight in gold compared with other service providers. They provide help when it is needed not when it's convenient to service providers' needs. We need national recognition of this and equitable funding which will support this when funds are being allocated". (Recovery community staff).

ADPs were also asked about the issues facing recovery communities. Funding was again prominent, as was the issue of understanding/recognition. Practical challenges such as accessibility, resources and premises were also identified. There was an interesting comment from one ADP on the challenge recovery community representatives can face in terms of their confidence interacting with ADPs. Another interesting comment highlighted the challenge recovery communities face in balancing their role supporting people in recovery and meeting the demands/expectations of funders or services.

Issues facing ADPs in supporting recovery communities

ADPs were asked to identify the main issues/challenges they faced in supporting recovery communities. Not surprisingly funding, particularly sustainable funding, was identified by several ADPs with one commenting that recovery communities were particularly vulnerable when budget cuts were being considered. Several ADPs suggested there was limited recognition of the significance of recovery communities at both the national level and within ADPs (where staff tended to come from a local service provider background). There was also a view that ADPs could be unclear on the support needs of recovery communities, which could be exacerbated by the diverse nature of the sector.

> "Lack of focus nationally especially now the Scottish Government has forgotten about the concept (of recovery) and all the staff who remember it have moved on. There

> are no targets around recovery, no measurement of it in individual treatment journeys, very little attention on alcohol compared to ORT etc". (ADP staff)

SRC support for ADPs

The research highlighted a number of ways SRC could, potentially, support ADPs in the future with regards to recovery communities. The support is summarised below.

Championing recovery and Recovery Orientated System of Care (ROSC)

ADPs suggested that recovery and the ROSC approach had become less of a strategic priority, nationally and locally, over recent years and SRC was seen as a key organisation in re-prioritising it. There was a view that the Scottish Government's focus on reducing drugs deaths and implementing the MAT standards had reduced the focus on recovery and ROSC. In turn, ADPs were focused on delivery the National Mission, partly at the expense of recovery and ROSC. One ADP suggested SRC as a national organisation had more contact with the Scottish Government than individual ADPs and was therefore ideally placed to champion recovery and ROSC nationally and take forward the Scottish Government's ambitions locally with ADPs and providers. It was also suggested that SRC's championing of recovery and ROSC should include the championing of a rights-based approach.

> "I feel that the whole Recovery Orientated Systems of Care and recovery orientated ways of working has fallen off the radar because of the MAT standards and resi rehab. There are some services, statutory, that are just so set in their ways and pushing back on the charter of rights and a rights-based approach. By not doing these things they are taking people's rights away and it wouldn't happen in any other part of the healthcare system. It's coming and we would be best placed to get them in place now. It would helpful if SRC could help get that buy-in. This is not optional. We are removing that choice and not giving people that choice and therefore taking their rights away. Ultimately, it is institutional stigma, it's systemic. You hear comments like: these people don't know what they want. What do they mean 'these people'? It is up to services to set out the choices in terms of their treatment and care and what is open to them in terms of recovery. So some work (from SRC) on embedding that. It has kind of dipped off the radar". (ADP staff).

Several consultees suggested SRC could champion recovery by organising networking events across Scotland for recovery communities. The events would allow recovery communities to share experiences, ideas, learning, good news stories, and celebrate recovery. ADPs reported they would welcome this, and would be interested in linking in to local events. There was also some interest in SRC convening an ADP-only event focused on recovery, ROSC and recovery communities.

Strengthening recovery communities role in ADP structures

ADPs reported SRC could have a role in helping strengthen the voice of recovery in ADP structures. As described in this report, recovery communities and/or people with lived and living experience are part of ADP structures in different ways depending on the area. However, there was a view that they could be more prominent, with a stronger voice, and play a more active role in ADP structures and meetings. ADPs explained that representatives of recovery communities may not have the skills and experiences of other representatives and this limited their input. SRC could help strengthen their role through tailored support and training for individuals and the organisations they are representing. There was also a suggestion that recovery communities were quite insular and could be better integrated into local third sector structures such as local forums and the Third Sector

Interface. Doing so could help strengthen them and their role in ADP structures. It was suggested SRC could encourage and help recovery communities to engage with the third sector locally.

Broaden recovery communities remit

One ADP would like to see the local recovery communities broaden their remit as wellbeing communities. They suggested SRC could had a role to play in supporting the process.

SRC support for recovery communities

The research highlighted a number of ways SRC could, potentially, directly support recovery communities in the future. The support is summarised below.

Networking

As referenced above, there was very strong support for SRC to help recovery communities connect and share good practice. This included networking events to meet each other, share experiences and learn about what is working well in other areas. It also included sharing good practice on SRC's website, social media and by producing publications, as well as a directory of recovery communities on SRC's website. There was also a suggestion that SRC could use the networking events to explain to recovery communities what they can do for them. There was specific interest in a networking session for recovery communities in island and rural areas. Recovery communities acknowledged that there was an onus on them to improve links with SRC. This could, for example, involve recovery communities inviting SRC to their events or meetings.

> "The Consortium have been very quiet and not as visible as they have been in the past. I feel it is vital that people know they support recovery communities and don't just organise one major event per year then disappear". (Recovery community staff).

Developing more activities and support

Recovery communities would welcome SRC's help in developing more activities and the support available to beneficiaries. This included help developing weekend activities including 'clean' social events given the relative lack of such provision at present and the challenges weekends can create for people in recovery. Other specific suggestions included help with volunteering development, back to work programmes, gym sessions/passes, and overcoming transport barriers. One small way SRC could help is by showcasing examples of good practice. ADPs also reported they would welcome SRC helping recovery communities to develop more activities including social events. Recovery communities would also welcome SRC's help in broadening the support provided by other organisations to the beneficiaries. They highlighted support on housing, benefits/welfare advice, budgeting, and learning opportunities which could be provided on an outreach basis by other organisations.

Raising awareness and improving signposting from services

The research found that links between recovery communities and service providers vary markedly from area to area and service to service. It also showed that the number of people attending some of the recovery community sessions was quite low. There is therefore a potentially significant role for SRC in raising awareness and improving links between recovery communities and providers. One suggestion was that SRC could facilitate local workshops bringing organisations together. There may also be a role in helping recovery communities to build positive relationships with services including communication skills as some representatives could be perceived as difficult to work with.

Engaging people not in treatment

There was a suggestion from one ADP that recovery communities could have a role in reaching people who were not in treatment. SRC could, potentially, support recovery communities do so by showcasing good practice, producing guidance or supporting the development of a pilot. However, the suggestion is an ambitious one, in our view, and would need careful consideration by all parties if it were to be progressed. People in recovery often distance themselves from those still using alcohol and drugs so may not be in contact with them. Also, asking them to do so may put their own recovery at risk.

Engaging women

Based on the evidence gathered during this research, recovery communities – as they currently stand – are primarily male-orientated spaces. For example, one recovery community reported that two thirds of their beneficiaries are male rising to about 90% when talking about those taking part in activities. The basic premise of a recovery community is tailored more towards men than women given the venues, the opening times, and the activities. It was encouraging to see most recovery communities have a dedicated women's group and some work with organisations such as Women's Aid. It was also encouraging to hear that one recovery community was planning to introduce a Women's Day one day a week, an idea which they had seen operating in another area. We would encourage SRC to examine this issue in more detail and consider what a recovery community could look like for women in recovery.

Rural and island recovery communities

Rural and island recovery communities felt they were not a priority for SRC and more broadly Scottish Government. From SRC they would welcome more contact to better understand their areas and needs, as well as specific initiatives or actions designed to support recovery communities in rural and island areas and promote awareness of them in the community. They felt SRC could help highlight the challenges faced by people in recovery and recovery communities in rural and island areas, including stigma and community shaming. There was also a suggestion that SRC could help promote services that work such as assertive outreach in a rural area delivered by the third sector.

Funding and becoming more sustainable

Inevitably funding was a major concern for recovery communities and an area they would welcome SRC's support. Suggestions included sharing details of funding opportunities with all recovery communities, showcasing examples of recovery communities that have improved their sustainability for example through volunteer development, and linking recovery communities with organisations that can help them source and apply for funding.

Training

SRC already provide training and support for recovery communities which is highly regarded. Recovery communities are very keen that this continues. There is a particular need to support small or newly established recovery communities that are still susceptible to challenges or do not have access to in-house training programmes. There may also be an opportunity to provide leadership training or mentoring for relevant individuals, drawing on the experience of the strong leaders that are in place in some of the recovery communities. The training may also benefit representative of recovery communities who are involved in ADP structures. There was also a suggestion that SRC could share information on training with recovery communities, although this could potentially be a time-consuming task in our opinion.