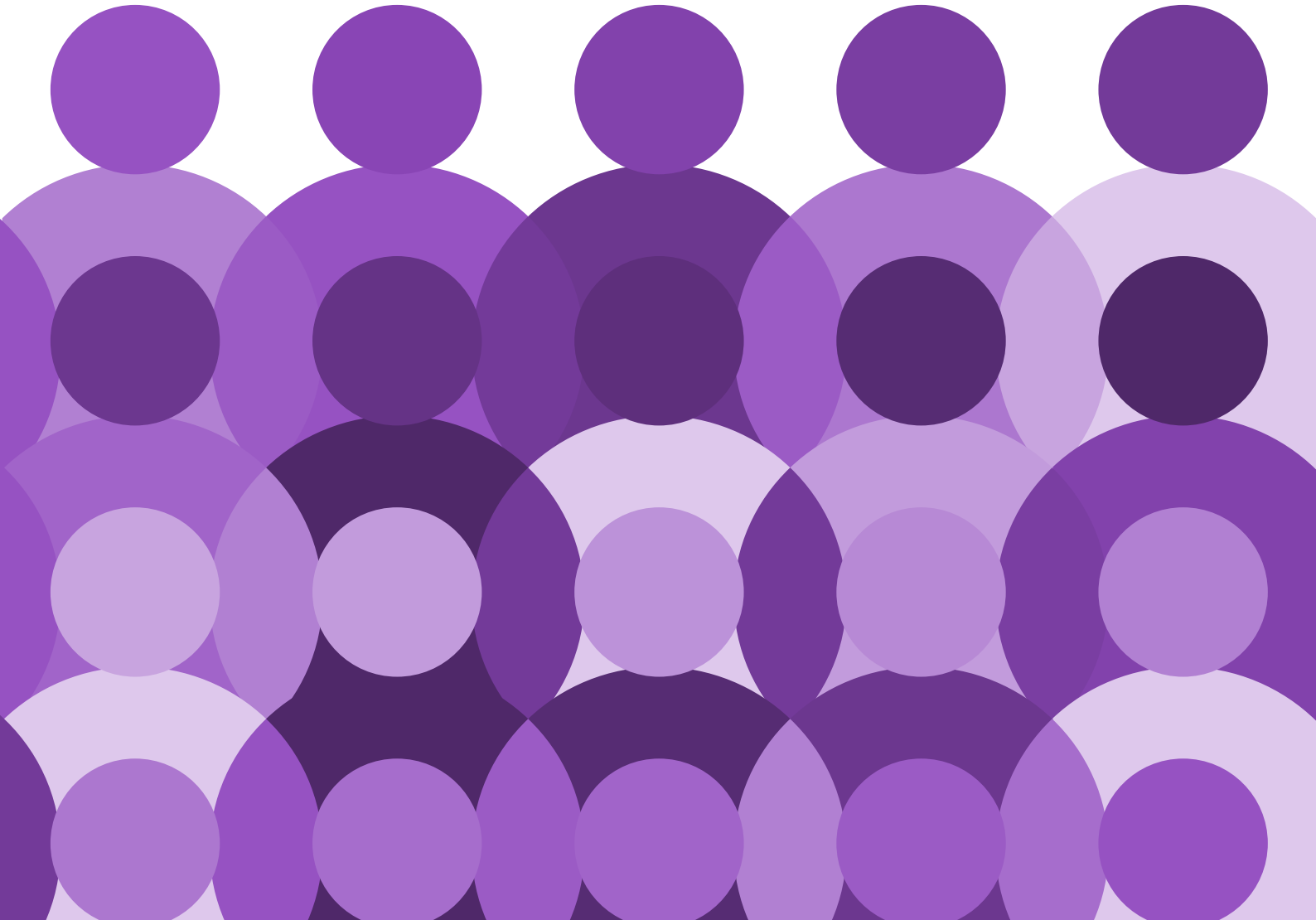
The barriers and facilitators to supporting, commissioning and working with Lived Experience Recovery Organisations in systems of care in England

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Conflict of interest statement

Prof John Strang is a clinician and academic who has worked with local, national and international government and non-government agencies to develop and test new approaches to tackling addiction and related problems. Through his employer (King's College London), he has received research and project grant support from a range of government and charitable research agencies and charitable organisations. Through the university, he has also worked with pharmaceutical and technology companies, from some of whom the university has received project grant support, honoraria and/or consultancy payments. In the past three years, these have included MundiPharma, Camurus AB, PneumoWave, Accord and Navamedic, alongside medication or device supply (PneumoWave, CMI and Catalent) to develop or study potentially improved formulations and devices. His employer (King's College London) has registered intellectual property for an innovative buccal naloxone formulation with which Prof Strang is involved, and he has been named as an inventor in a patent registration by a pharmaceutical company for a concentrated naloxone nasal spray. He is also named as a Patron of Addiction Family Support (formerly DrugFAM), a UK-based registered charity, and supported by the National Institute for Health and Care Research (NIHR) Biomedical Research Centre for Mental Health at South London and Maudsley NHS Foundation Trust and King's College London.

Since 2022, Prof Joanne Neale has received research funding from pharmaceutical companies Mundipharma and Camurus AB and honoraria from Indivior and Camurus AB for conference presentations and dissemination activities relating to drug treatment (including Buvidal) and recovery through her university (King's College London). She has also received honoraria from Addiction and the International Journal of Drug Policy for editorial work and from the Canadian Centre for Recovery Excellence for participating in an Expert Reference Group for a national survey of recovery from alcohol and other drug use.

Between 2019 and 2022, Prof Tim Millar was Chair of the Data Monitoring Committee for the investigator-led, industry-funded Extended-release Pharmacotherapy for Opioid Use Disorder (EXPO) Trial of depot buprenorphine preparation a (non-pecuniary) (EU Clinical Trials register 2018-004460-63).

As of December 2025, Dr Nicola Kalk is the Chief Investigator on the NIHR-funded, investigator-led research study BUILD2depot (NIHR206657), for which Camurus AB provides in-kind support to her employer.
The other authors of this report declare that they have no competing interests.

RAND Europe received sales data for quantitative analysis from Camurus AB in this project. This was non remunerated and Camurus AB did not receive early access to report methodology or findings.

Preface

This report is part of a wider RAND Europe evaluation of the former UK government's 10-year drug strategy investment in the Treatment and Recovery Portfolio in England (D-SITAR). As part of the Portfolio, and following Dame Carol Black's 2019–21 independent review of drugs, the Department of Health and Social Care (DHSC) has been providing additional funding to local authorities to improve treatment and recovery services for people who use alcohol and/or other drugs. In 2023, RAND Europe and partners King's College London, South London and Maudsley NHS Foundation Trust, the University of Manchester and the University of Queensland were awarded a grant by the National Institute for Health and Care Research (NIHR) to evaluate the implementation of the first three years of the investment.

This report presents the results of an evaluation of Lived Experience Recovery Organisations (LEROs). It is accompanied by four further evaluations of priority areas of the Portfolio, described in separate reports, focusing on the Housing Support Grant, the workforce transformation programme, mental and physical health service integration and the provision of depot buprenorphine, as well as a process evaluation of the first three years of implementation of the Treatment and Recovery Portfolio.

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Keywords: Lived Experience Recovery Organisations, peer-led recovery, drug strategy, recovery-oriented systems of care, drug and/or alcohol treatment and recovery services

Executive summary

Background

Lived Experience Recovery Organisations (LEROs) are peer-led groups run by individuals with lived experience of alcohol and/or other drug use, treatment or recovery. They offer direct support to people who use alcohol and/or other drugs or who are in recovery. They are distinct from peer-delivered services and are increasingly recognised in UK policy as vital components of recovery-oriented systems of care (ROSC). Despite this, at the time of data collection, only about one-third of local areas in England had a recognised LERO, although numbers have reportedly increased since study completion. There is limited evidence relating to their effectiveness and integration into treatment and recovery systems.

Study aims

This study aims to identify the **barriers and facilitators to supporting, commissioning and working with LEROs** in effective systems of care for people who use alcohol and/or other drugs. It addresses national policy priorities outlined in the former UK government's 10-year drug strategy as well as Dame Carol Black's independent review of drugs, which highlights the need to evidence peer-led recovery support services.

Methods

A formative process evaluation of the integration of LEROs into systems of care was conducted using the Consolidated Framework for Implementation Research (CFIR) and a systems perspective. In 2024–25, data was collected across three phases through: interviews and focus groups with commissioners, treatment provider leads and staff, as well as LERO leads and staff; a LEROs census mapping study and network analysis; and analysis of existing survey data. Qualitative data was thematically analysed to draw out key themes, and network and causal loop diagrams were used to visualise system dynamics.

Key findings

Confusion around what a LERO is impedes collaboration and support. Despite efforts by the Office for Health Improvement and Disparities (OHID), a unit within the Department of Health and Social Care (DHSC), and the College of Lived Experience Recovery Organisations (CLERO), there is no consistent understanding of what constitutes a LERO among stakeholders. CLERO standards are not universally known or accepted, particularly among more established LEROs. This has the potential to affect commissioning decisions, sector-wide legitimacy, and collaboration between services.

LEROs are emerging via different models, each presenting with unique facilitators and barriers to development. Our analysis identified four approaches to developing LEROs within local systems in England: areas that have not developed a LERO (Type 1), grassroots-led (Type 2), commissioner-initiated (Type 3), and treatment service-initiated (Type 4). Each model presents different challenges and requires tailored support strategies:

- Type 1 areas may report gaps in foundational recovery infrastructure and leadership or disinterest or distrust of the LERO approach.
- Type 2 LEROs, the common type, are embedded in the local community, but face risks of instability and over-reliance on individual founders.
- Type 3 LEROs benefit from more stable funding and strategic integration into local areas, but risk being perceived as top-down, and not fitting within the prevailing LERO definition.
- Type 4 LEROs leverage infrastructure and staffing support from treatment services but may struggle with independence and legitimacy if they have limited autonomy.

Funding models influence the sustainability and autonomy of LEROs. Direct commissioning and ring-fenced allocations were found to support LERO autonomy, visibility and strategic influence. In contrast, short-term funding cycles and fragmented grants led to LERO leads and treatment staff reporting instability and frequent shifts in service provision within LEROs; as a result, treatment providers report difficulty with consistent engagement. The subcontracting of services through treatment providers often obscured LERO contributions and limited access to commissioners. Competitive tendering processes were also reported to undermine collaboration.



Inclusion in local governance structures was helpful but often informal. LEROs that were embedded in local governance and decision-making structures (such as multi-agency forums, Combating Drugs Partnerships, and joint planning meetings) were more likely to influence funding priorities and strategic direction for their local area. However, access to these spaces was reported to be uneven. Personal support from commissioners could be valuable but reliance on individual actors was felt to be precarious, highlighting the need for formalised structures to ensure lived experience is embedded in local systems.



Differing views of recovery can undermine system cohesion. While LEROs and treatment providers share a common goal of supporting recovery, they often operate from fundamentally different philosophies. LEROs frequently adopt abstinence-based, peer-led approaches rooted in lived experience, while treatment services may follow medicalised models rooted in the clinical evidence hierarchy. These ideological differences can lead to tension, mistrust and misalignment in service delivery. However, in systems where diverse recovery approaches were accepted and clearly delineated, organisations were better able to work together effectively.

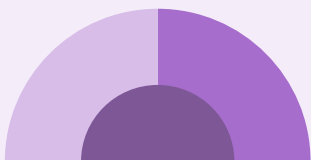


Compatibility of workplace culture shapes collaboration between LEROs and treatment providers. The degree to which LEROs and treatment providers can collaborate is strongly influenced by workplace culture. LEROs often prioritise flexibility, relational support and community engagement, while treatment services may emphasise adherence to established codes of conduct, risk management and formal procedures. These cultural differences can create friction, particularly around issues such as governance, boundaries and the appreciation of differing forms of expertise. Co-location was found to be a potential facilitator of collaboration, but only when accompanied by adequate space, shared values and mutual respect.

Recommendations



Central government should work with CLERO and existing LEROs to refine and disseminate clear messaging about what constitutes a LERO and what these organisations can contribute to the treatment and recovery system. This will help address any scepticism about the LERO model and the role and value of lived experience in treatment and recovery systems, promote a shared understanding across services and communities, and support more targeted and informed investment by commissioners.





Central government should continue to work with local authorities to design and implement targeted support for areas seeking to establish a grassroots LERO, including guidance on governance structures, access to start-up funding, and the provision of infrastructure and physical space. This may also involve CLERO as well as consideration of how to facilitate networking and support within the LERO community or to promote support from local voluntary and community sector organisations. This would help areas without a recovery community, or those with emerging LEROs, to build sustainable, locally rooted organisations.



Central government and local authorities should develop funding strategies to provide focused, longer-term investment in LEROs. This would solidify and emphasise top-down support and commitment to integrating LEROs into systems of care. Longer-term funding would also enable consistent service delivery, support staff retention, and build trust with commissioners and treatment providers – laying the foundation for deeper integration.



Local authorities should support the inclusion of LEROs in local governance and decision-making structures, ensuring that lived experience is embedded in strategic planning. This would reduce reliance on individual relationships and promote system-wide integration.



Local authorities should foster mutual respect and constructive collaboration between LEROs and treatment services, recognising the value of diverse organisational approaches to recovery. This could include supporting co-location arrangements with adequate space, and embedding LERO staff in local systems through – over time – physical placements in treatment services or integration into local planning structures. This approach would help build trust, improve collaboration and make LERO contributions more visible and valued.



LEROs should collect and share information about what they contribute to the treatment and recovery system. This could include qualitative measures such as collecting stories, testimonials or creative outputs (such as written, spoken or visual art pieces) from people who have been or are being supported by LEROs, thus illustrating how and why these organisations make a difference, as well as quantitative measures of impact that are relevant to their aims. This would help LEROs to demonstrate their impact and value in ways that are meaningful to their communities and accessible to commissioners and other stakeholders.

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Abbreviations

AA	Alcoholics Anonymous
CFIR	Consolidated Framework for Implementation Research
CHIME	Connectedness Hope Identity Meaning Empowerment
CLERO	College of Lived Experience Recovery Organisations
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
D-SITAR	Drug Strategy Investment in Treatment and Recovery
IMD	Index of multiple deprivation
KPI	Key Performance Indicator
LA	Local Authority
LERO	Lived Experience Recovery Organisation
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
OHID	Office for Health Improvement and Disparities
ROSC	Recovery-Oriented Systems of Care
RSS	Recovery Support Services
TSG	Twelve Step Group

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Chapter 1. **Introduction**

1.1. Dame Carol Black's independent review of drugs

Dame Carol Black's 2019–21 independent review of drugs recommended that the Department of Health and Social Care (DHSC) should 'support local areas to ensure that thriving communities of recovery are linked to every drug treatment system' in England (Black 2021). This is the central aim of the recovery communities programme, which is one of several initiatives within the Treatment and Recovery Portfolio (hereafter, the Portfolio) aiming to deliver against the priorities outlined in the 10-year drug strategy 'From Harm to Hope'. The programme is funded through the DHSC's £780 million investment in the Portfolio, and is focused on ensuring that recovery communities, peer-led initiatives and recovery support services are accessible in every drug and alcohol treatment system, helping more people to sustain long-term recovery.[1] In August 2023, when the evaluations of the Portfolio began, the DHSC had the following aims in this area:

1. Help treatment and recovery partnerships to understand the value of, and evidence for, recovery support services (RSS), particularly peer-based and peer-led options.
2. Support the sustainable growth of RSS provision, particularly involving services that are peer-based and peer-led.
3. Raise awareness of the different types of RSS and how such services, similarly to treatment services, are fundamental to recovery-oriented systems of care (ROSC).
4. Map the current provision of RSS in England.

Dame Carol Black's review identified a gap in the evidence on the effectiveness of peer-led interventions and how these can be encouraged and facilitated by the treatment system, as well as a need for the DHSC to work to produce standards on quality and governance (Black 2021). Peer-led interventions describe initiatives where 'people with lived experience independently lead activities, groups, events, projects, services or organisations' (OHID 2025a). They are distinct from peer-delivered initiatives that are provided by people with lived experience but are not specifically organised and led by them (e.g. when a treatment or other service provider employs peer support

1 Note that funds for alcohol and other drug treatment and recovery have since been consolidated into a single alcohol and other drug treatment and recovery improvement grant (DATRIG).

workers or volunteers with lived experience to deliver a service). Lived Experience Recovery Organisations (LEROs) are an example of a peer-led initiative.

1.2. The evidence for LEROs and other peer-led initiatives

LEROs are independent organisations led by people with lived experience of alcohol and/or other drug recovery. Unlike Twelve Step groups, which are mutual aid fellowships with a spiritual or abstinence-based orientation, LEROs are formal organisations that may combine mutual aid with wider community activities and advocacy. They also differ from peer workers embedded in treatment services, since LEROs operate independently of statutory providers and are collectively governed by people with lived experience (CLERO 2024). A LERO's activities may include a wide range of harm reduction interventions, peer support and recovery support, and providing help for people to access and engage in treatment and other support services (OHID 2025b).

While the concept of peer support in the treatment and recovery sector is well established, and some peer-led organisations have existed for 20 years (e.g. DATUS 2022; BAC-IN 2019; Build on Belief 2018), the term 'LERO' is relatively new. Coined in the UK by the College of Lived Experience Recovery Organisations (CLERO) in 2020, the term has since gained recognition through its inclusion in national policy documents such as Dame Carol Black's independent review of drugs (Black 2021), as well as guidance produced by the Office for Health Improvement and Disparities (OHID), which is a unit within the DHSC (OHID 2025b). With support from OHID, CLERO has produced a set of standards with the aim to define and support best practice for LEROs (see Box 1). These standards have a tighter interpretation of LEROs than OHID's broader definition, but are intended as guidelines for organisations to work towards rather than prescriptive requirements.

Box 1. What defines a LERO in the UK?

CLERO defines a LERO as:

> [A]n independent initiative led and delivered by and for people with lived experience offering direct support to people whose drug and alcohol use is problematic and those who identify as in recovery (which is self-defined). This support is typically free at the point of access, directed by and for local residents, time unlimited and provided regardless of treatment or recovery status (CLERO 2024).

As LERO support is directed by and for local residents, there is no single model for how LEROs fit within treatment and recovery systems. CLERO notes that LEROs can offer support regardless of treatment or recovery status and may act as a first point of contact, a harm reduction resource, or a long-term recovery support, depending on local needs and community context (CLERO 2024).

As outlined in the standards for LERO community groups and providers co-produced by CLERO and OHID, a LERO should have or work towards the following members having lived experience:

- The provider leader, such as group leader, CEO or director
- More than half of the board of directors or trustees
- 90 per cent of frontline staff and volunteers.

The evidence base for LEROs is currently limited, which is partly due to the relatively recent recognition of this type of peer-led initiative. Looking more broadly at peer support services, rather than peer-led ones, there is some evidence of positive impacts from recovery support services providing peer support to people who use alcohol and/or other drugs.[2] Peer support engagement is associated with higher rates of abstinence and lower rates of relapse; reductions in cravings; improved housing stability; reductions in HIV and hepatitis C risk behaviours; reduced readmission to psychiatric hospitals in people with co-occurring mental health conditions; reductions in criminal behaviour; and enhanced treatment engagements and better social support (Miler et al. 2021; Tracy & Wallace 2016; Eddie et al. 2019; Orock & Nicette 2022; Stack et al. 2022; Mahon 2025). However, the limitations of this literature are widely recognised, particularly in terms of variable intervention definition and implementation; difficulty disentangling peer support effects from other interventions; the broad range of outcomes assessed; lack of controlled studies; and heterogeneous study populations (Miler et al. 2021; Tracy & Wallace 2016; Eddie et al. 2019; Orock & Nicette 2022; Stack et al. 2022).

The evidence that does exist regarding peer-led support suggests there may be benefits in areas such as emotional safety, wellbeing and access to mutual aid. One recent UK-based study of a LERO found perceived benefits in areas such as belonging, emotional safety and personal

2 While the Department of Health and Social Care tends to refer to 'drugs and alcohol', we have opted to use this term in keeping with the academic literature on the topic.

value among individuals affected by substance use and criminalisation (Buck et al. 2025). These findings were echoed in a study of another LERO in the UK, where participants reported feeling supported in recovery, feelings of self-worth, as well as gaining a sense of community and belonging (Humphreys & Finch 2025). Another study of a LERO that facilitated access to mutual aid found participation was associated with reduced distress, improved wellbeing and high rates of mutual aid attendance (Aslan et al. 2016). Similarly, a study of a peer-led organisation in Australia reported improvements in emotional resilience, self-care and skill development among family members and friends of individuals with substance use issues (Tari-Keresztes et al. 2023). However, this organisation was not a LERO and there is a lack of clarity in the paper as to whether the service was peer-led rather than peer-delivered. These studies were all qualitative and small in scale – each involving fewer than 20 participants – and lacked comparison groups, limiting the generalisability of their findings and the strength of conclusions about the effectiveness of LEROs or other peer-led models. A mixed-methods study of how one LERO identified and linked people to community resources drew on routinely collected data (including case management data, feedback forms and outcome data) to find that recovery communities can make positive impacts on people who use alcohol and/or other drugs in terms of decreased re-offending and demand on emergency departments and acute mental health services, as well as increased rates of abstinence, self-esteem, confidence and community involvement (Best et al. 2020). These evaluations, while hampered by opportunistic and incomplete data collection, provide indicative evidence that LEROs can contribute to building both individual recovery capital and wider community recovery capacity.

Recent theoretical work has also positioned LEROs as potentially powerful agents of community recovery, suggesting that they may generate residual benefits beyond individual recovery by building pathways to community assets and strengthening local recovery ecosystems (Best & Ivers 2021). This theory is rooted in the idea of 'recovery capital', which suggests that individuals' resources (including their relationships and the structures they engage with) are critical to success in recovery (Hennessy 2017). These resources, or personal capital, can be built through access to positive social networks of 'recovery-oriented' people (Best 2019). By providing positive social groups and community activities to engage in, and pathways to access these resources, LEROs can help individuals build their personal recovery capital while simultaneously participating in, and so contributing to the growth of, a community of recovery-oriented people. In this way, recovery becomes more visible, while connections to and the robustness of social networks of recovery increase, making LEROs centres of 'community hope and positive contagion' (Best & Ivers 2021).

There is limited evidence on the integration of LEROs into treatment and recovery systems, but related literature on peer support and mutual aid offers useful insights. A recent umbrella review of systematic reviews into the inclusion of lived experience and peer support workers in treatment and recovery services highlights several barriers to integration, including unclear role definition, lack of formal training for peer workers, and organisational stigma towards peer workers – challenges that may also apply to LERO workers (Mahon 2025). Research into the integration

of mutual aid organisations, such as Twelve Step groups (TSGs), into treatment and recovery systems has similarly identified tensions. While TSGs are not the same as LEROs, they share core features that make their integration into care systems a useful point of comparison. Both are mutual aid organisations, run collectively by people with lived experience of alcohol and/or other drug use, where members work together to identify needs and support one another. LEROs, like TSGs, often offer flexible, cost-free support which can focus on long-term recovery, and may have overlapping membership, shared origins or similar recovery philosophies. In the literature, it is noted that differing attitudes towards recovery among both treatment staff and people who use treatment and recovery services can act as a barrier. Staff may hold contrasting views on abstinence, spirituality and the value of group-based interventions, sometimes perceiving TSGs as unprofessional or incompatible with clinical care (Day et al. 2015). Meanwhile, individuals may be deterred by the perceived religious framing of some meetings, prior negative experiences, or difficulty identifying with group members (Lopez Gaston et al. 2010). These findings suggest that the integration of peer-led recovery models, whether mutual aid groups or LEROs, may be shaped by cultural, philosophical and structural tensions that require active navigation. In light of this, further research is warranted to explore the factors that influence the role and valuation of LEROs within systems of care for people who use alcohol and/or other drugs.

1.3. Drug strategy investment in LEROs

As part of the 10-year drug strategy investment, OHID is leading and/or supporting activities designed to encourage the incorporation of LEROs into treatment and recovery systems including:

- Producing and supporting the development of resources to map and track the extent of RSSs and LEROs in England.
- Providing guidance to ensure RSSs and LEROs form a fundamental part of recovery-oriented systems of care.
- Supporting partnerships to deliver and develop ROSCs which foster LEROs in line with best practice and evidence.

OHID continues to work with and support the National Recovery Champion and CLERO to cultivate these activities. CLERO, a UK-based membership body and advocacy organisation that supports and represents LEROs, was started in 2020 with the aim of providing guidance, resources and a platform for LEROs to share knowledge and influence policy (CLERO 2022). Some products have been completed and published already, such as the LERO standards (CLERO 2024) and the lived experience and recovery support services guidance (OHID 2025b). A LERO capacity-building project (CLERO 2025), commissioned by OHID in 2024 (DHSC 2024), also intends to support the development and sustainability of LEROs in England, and OHID and NIHR launched a research call in November 2023 on the effectiveness of LEROs, with a funded study due to begin in March 2026 (NIHR 2025). OHID has not prescribed a model for the involvement of LEROs in systems of care for people who use alcohol and/or other drugs; the appropriate

approach is determined at the local level. However, not all local authorities (LAs) in England have a LERO operating in their area. This suggests that further exploration of how LEROs can be successfully embedded in systems of care is needed.

1.4. Research question

To understand how LEROs can be successfully integrated into treatment and recovery systems, the research team conducted a formative process evaluation to address the overarching research question:



What are the barriers and facilitators to supporting, commissioning and working with LEROs in effective systems of care?

Chapter 2. **Methods**

2.1. Research overview and evaluation framework

An overview of this study's data collection methodology, mapped to its evaluation research question, is shown in Table 1.

Data were collected over three time periods: Phase 1 (January 2024–July 2024), Phase 2 (August 2024–June 2025) and Phase 3 (March 2025–June 2025). Phase 1 established a baseline picture of implementation, Phase 2 explored local system dynamics in depth, and Phase 3 revisited stakeholders and data sources to capture change over time, thereby linking early insights with longitudinal evidence. To understand how LEROs can be successfully integrated into treatment and recovery systems, we primarily utilised data collected in Phases 1 and 2. A full description of the methodology can be found in the Methods Report (Strang et al. 2026); this includes details on the number of participants in interviews and focus groups conducted for the D-SITAR evaluation, covering stakeholders engaged in planning, commissioning, delivering and utilising treatment and recovery services. Some of these data are not drawn on in this report.

Table 1. Methodology used for each aspect of the research question

Research question	Data collection method	Data type	Data origin	Data collection timepoint
1. Barriers and facilitators to **working with** LEROs in effective systems of care	Interviews	Semi-structured qualitative data	Head of treatment service	Phase 1
	Case studies: focus groups and interviews	Semi-structured qualitative data	Head of treatment services Other members of treatment/recovery service staff in service providers	Phase 2

Research question	Data collection method	Data type	Data origin	Data collection timepoint
2. Barriers and facilitators to **supporting** LEROs in effective systems of care	Desk research and follow-up interviews ('LERO census')	Structured desk research; semi-structured qualitative data	LERO leads	Phase 1 Phase 2
	Case studies: focus groups and interviews	Semi-structured qualitative data	LERO staff	Phase 2
3. Barriers and facilitators to **commissioning** LEROs in effective systems of care	Analysis of existing survey data	Structured survey	Commissioners (via OHID)	Phase 1
	Commissioner workshop	Semi-structured qualitative data	Commissioners	Phase 1 Phase 3
	Case studies: interviews	Semi-structured qualitative data	Commissioners	Phase 2

This evaluation takes a systems perspective, viewing organisational settings in which LEROs are implemented as complex systems (Luke et al. 2024). This facilitates explicit consideration of how LEROs interact with the wider treatment and recovery system, and the ways this may evolve and change over time (McGill et al. 2021). The Consolidated Framework for Implementation Research (CFIR) was used to facilitate this approach in terms of defining core concepts and formulating an Implementation Research Logic Model (IRLM; see Annex A) that was used in the development of data collection tools (Damschroder et al. 2022a, 2022b; Smith et al. 2020). This also supported the thematic analysis of the qualitative data (discussed further below) and the development of causal loop diagrams to understand the interaction of barriers and facilitators (van Beek et al. 2025; Kiekens et al. 2022; Uleman et al. 2024).

The study was informed by guidance from several advisory groups (Experts, Commissioners, Workforce and Public), along with regular input – during meetings with co-investigators – from patient and public involvement and engagement experts and team members with lived and living experience of treatment and recovery. We sought the involvement of these groups at multiple stages of the evaluation, including:

- **Characterising the intervention:** logic model review, including suggestions of missing items considered important to service providers and users.
- **Evaluation design/conduct:** review of data collection instruments (including participant information sheets and consent forms) and discussion of data collection and analysis protocols to ensure they are acceptable, appropriate and ethical.

- **Synthesis**: discussion of findings and possible interpretations of results in context.
- **Dissemination and impact**: development of plain English summaries for inclusion in reports and creative dissemination (with potential involvement of advisory group members if desired).

More information on the contribution of these groups is set out in Section 4 of the Methods Report.

2.2. Interview and focus group procedures

2.2.1. Recruitment

All participants were given a participant information sheet and written informed consent was obtained prior to data collection.

Phase 1

Participants included commissioners, treatment provider leads and LERO leads. As described comprehensively elsewhere (see Methods Report), **commissioners** from across England were recruited for workshops involving questions on all areas of the broader study, including one question on commissioning, supporting and working with the LEROs in systems of care.

For the **treatment provider leads**, a list of treatment providers by Integrated Care System (ICS) and LA was used by the study team to identify 15 treatment providers to recruit for interview that did not overlap with areas selected for Phase 2 data collection. Providers were purposively sampled to ensure a mix of NHS and third sector examples were included. Contact details for prospective participants were obtained via public websites and internal networks.

For the **LERO leads**, OHID initially scheduled an information session with LERO leads for the study team to introduce the project and provide contact details for those interested in participating. The study team also used a list of contacts retrieved from conducting a census of publicly available information online (see Section 2.3). All LERO leads for whom contact details could be identified were invited. As shown in Table 2, we conducted 42 interviews and one commissioner workshop in Phase 1. This included interviews with 27 LERO leads representing 25 LEROs.

Phase 2

Ten case study sites across England were selected that were diverse in relation to the funding received (in terms of amount and grants received), interventions delivered or planned, the population of people using the treatment and recovery services, and geography. Within each case study, **commissioners, treatment provider leads, treatment provider staff, LERO leads and LERO staff** (if a LERO was present) were recruited to interview and/or focus groups. LERO leads were identified by the primary contact at each case study site. As shown in Table 2, we conducted 84 interviews and 24 focus groups in Phase 2. A full account of the methods used can be found in the Methods Report.

Phase 3

As with the commissioner's workshop in Phase 1, **commissioners** from England were recruited for workshops and asked questions on all areas of the broader study. The Phase 3 workshops did not include a question specifically on LEROs, as the focus was on overall portfolio delivery, but commissioners raised the topic organically and so relevant data was collected. As shown in Table 2, we analysed data from five interviews and two commissioner workshops in Phase 3.

The findings from this report are based on 117 interviews involving 133 participants and 28 focus groups or workshops. Note that data collection did not include recruitment of families or carers who were interacting with treatment services or LEROs. This constrains the breadth of perspectives represented and means that it is not possible to draw conclusions about how LEROs are experienced by those they support, or about how relationships between LEROs and treatment services are perceived by those who use these services.

2.2.2. Data collection

Data collection was completed online for Phases 1 and 3, and both online and in-person for Phase 2. MS Teams was used for all online data collection. Interviews were recorded and transcribed verbatim by a professional transcription company where participants consented to this; in the few instances where they did not, a member of the research team took notes. The number of data collection activities by participant groups and phase is shown in Table 2.

Table 2. Data collection activities by participant group and data collection phase

	Phase 1		Phase 2		Phase 3	
	Interviews	Workshops	Interviews	Focus groups	Interviews	Workshops
Commissioners	0	2 (n=27)	20 (n=27)	0	5 (n=6)	2 (n=37)
Treatment provider leads	15 (n=16)	0	19 (n=23)	0	0	0
Treatment and recovery staff	0	0	25 (n=26)	19 (n=123)	0	0
LERO leads	25 (n=27)	0	8	0	0	0
LERO staff	0	0	0	5 (n=32)	0	0

Note: Number of participants in interviews and focus groups or workshops is shown in brackets.

2.2.3. Data analysis

For **Phase 1**, data was indexed deductively according to CFIR constructs and inductively according to themes that arose from it. For **Phase 2**, data was indexed deductively according to the research question and inductively building on themes that were developed in Phase 1. For **Phase 3**, data was indexed deductively according to research question 2 and inductively according to themes that built on those developed in Phases 1 and 2. For each phase, the study team chose one transcript to index separately. The study team then met to discuss their indexing line-by-line and harmonise understanding before proceeding with the rest of the transcripts. The study team reviewed all the text indexed to the research question to capture key themes and evidence. After multiple team discussions, the study team synthesised the key themes and subthemes emerging from the data. All analyses were conducted using the software programme MAXQDA.

2.3. LERO census procedures

We conducted a LERO census to characterise LEROs in England, providing a snapshot of the activities LEROs are engaged with and the degree to which they are aligned with the LERO standards. We identified LEROs based on OHID's list of LEROs operating in England and through discussions with the Recovery Champion (Ed Day, member of the Expert Advisory Group for this study). This census differs from the workforce census conducted regularly by OHID, which captures the workforce composition of LEROs rather than their activities and alignment with standards (NHS England 2024).

A structured template for the census was developed in collaboration with OHID, building on previous work from Recovery Champion Ed Day. A blank version of the structured template can be found in Annex B. The study team completed the structured template for each LERO through desk research using publicly available data from the LEROs' websites, the Charity Commission website, and Companies House. Interviews with LERO leads scheduled as part of Phase 1 data collection (see above) were used to supplement findings from the desk research. The study team shared the information gathered with the LERO lead prior to the interview, inviting them to correct errors or provide additional details either in the Phase 1 interview or over email.

2.3.1. Data analysis

The LERO census data was also used to create a map of LERO provision in England. Information from the census regarding whether LEROs worked together or supported each other was validated by sending a summary of identified links to LERO leads for review and correction. LERO leads were asked to confirm which other LEROs they worked with, supported or received support from. This information was used to develop a network visualisation of links between LEROs. The map and network analyses were constructed using R statistical software (R Core Team 2025) and the ggplot2 (Wickham 2016) and igraph packages (Csárdi & Nepusz, 2006; Csárdi et al. 2025).

2.4. Analysis of existing data: commissioner survey on recovery support services

A snapshot survey of Recovery Support Services (RSS) was conducted by OHID with input from the National Recovery Champion to understand the current national provision of RSS in England. This survey of local authority commissioners was intended to capture information on services that offer non-clinical (and clinical) support to people in recovery, including whether these services are directly commissioned by the LA and are provided by treatment providers or LEROs.

The survey was completed in June 2022, and the research team reviewed its data in February 2024. It provides an initial, LA-level mapping of knowledge of, and engagement with, LEROs, and the study team was able to cross-reference commissioners' understanding of LEROs in their area with the data gathered from the LERO census. The study team did not progress beyond this initial analysis for two important reasons: 1) the survey captured RSS more broadly, making it difficult to parse out LEROs from more general data; and 2) the comprehension of LEROs by commissioners appeared relatively low, which reduced our trust in the data.

2.5. Dissemination

We have worked with our advisory groups to develop dissemination and engagement strategies following NIHR dissemination guidance (National Institute of Health and Care Research 2019). While the plans are still being confirmed, we anticipate including the following as part of our dissemination activities for this report:

- Submission of academic papers for publication in high impact, policy-relevant journals such as *Addiction* or the *British Journal of Psychiatry*.
- Creation of dissemination tools including infographic summaries, slide decks, policy briefings, media interviews, blogs and podcasts/videos. These tools will be tailored for different stakeholder groups (for example, LERO staff members, staff in treatment providers, and commissioners).
- Presentation of key findings to specific audiences within DHSC and other local and central policy and practice stakeholders, including alcohol and drug commissioners in local government.
- Submission of abstracts to present findings at relevant conferences in the UK and abroad, including the Society for the Study of Addiction's annual conference.

Further information on our dissemination plans is provided in Section 7 of the Methods Report.

Chapter 3. **Results**

To understand how LEROs are supported in systems of care, we first discuss how actors within the system understand the concept of a LERO (Section 3.1), as well as the different ways in which LEROs may (or may not) emerge from local treatment and recovery systems given that they are intended to adapt to and reflect local needs (Section 3.2).

We then discuss factors relating to how LEROs are commissioned, focusing first on the different approaches to funding LEROs (Section 3.3) and then exploring how strategic decisions about LEROs are shaped by commissioner relationships, governance structures and the availability of evidence (Section 3.4).

The final two sections explore key aspects of working with LEROs. This includes how differing views of recovery at the individual and organisational level influence collaboration between LEROs and treatment providers (Section 3.5), and how workplace culture and structural characteristics influence collaboration between LEROs and treatment providers, including the role of co-location, professional boundaries and perceptions of lived experience (Section 3.6).

3.1. LERO definitions

OHID and CLERO have made significant efforts to define and promote the concept of LEROs. Despite this, there does not appear to be a consistent understanding of what a LERO is, or should be, across the treatment and recovery sector. Lack of clarity has consequences for LERO creation, support and integration into the wider treatment and recovery system, and underpins the findings throughout the rest of this report.

3.1.1. (Dis)agreement over what constitutes a LERO

In 2022, at the start of the implementation of the Treatment and Recovery Portfolio funding, OHID with input from the National Recovery Champion conducted an internal snapshot survey to understand the national provision of RSS in England. While the survey did not explicitly ask commissioners about LEROs in their area, our subsequent analysis of its results focused on exploring whether commissioners had indicated knowledge of a LERO in their area. We compared the findings of this survey against data compiled by OHID and the research team about whether LEROs were operating in local authorities in England (the LERO census). We identified a limited

awareness among some commissioners about whether a LERO operated in their local treatment and recovery system or not. A substantial minority of commissioners surveyed (31; 41 per cent) incorrectly reported the LERO status in their area (compared to the LERO census): many (24; 32 per cent) reported there was a LERO in their area when there were none in operation and seven (9 per cent) reported the absence of a LERO when there was one in operation.

The current research study data was collected between 2024 and 2025. We found that commissioners from the case study sites had a good overall understanding of what a LERO was, even when they did not have one in their area: local leads from three of the four sites without a LERO were able to clearly differentiate LEROs from other voluntary or advocacy groups, emphasising their peer-led, independent nature. However, the commissioner from the final area conflated LEROs with broader voluntary peer-delivered rather than peer-led groups, and a commissioner who did have a LERO in their area seemed to deem any organisation involving people with lived experience to be a LERO. At some sites, treatment staff did not recognise the term LERO, were unaware of their local LERO or uncertain about how collaboration worked in practice. Others expressed strong support and pride in genuine co-production. This suggests that broad understanding of the term has not been reached.

Even among LEROs, there was debate around the definition of a LERO and whether certain activities would be contrary to the model. For example, there does not appear to be consensus within the LERO community on whether expansion beyond their original locality is desirable, or even compatible with the ethos of the 'home-grown' (LERO lead 9, Phase 1), grassroots model. Some LERO leads saw value in spreading their approach to new areas and had expanded operations, while others argued that the model must remain rooted in the community that gave rise to it. One LERO lead described their model as hard to replicate:

> Because we've been approached as an organisation to go and set LEROs up. You can't just like "Here's a hundred grand. Go and set a LERO up" you know what I mean? […W]e don't just work here, we live here, we play here, we eat here. Somebody's got a drug problem in the street they knock on my door, say "Our lad's here smoking crack. We can bring him in in the morning." We're trying to create a culture of recovery. (LERO lead 10, Phase 1)

3.1.2. CLERO standards do not necessarily facilitate development or recognition of a LERO

Many LERO leads described knowing and following CLERO standards for LEROs or were positive about the aims of CLERO, but there was some disagreement around the role of CLERO and the applicability of its definitions and support. Some LERO leads actively criticised the guidelines, although for a few this seemed to be because they felt their organisations were more well-established than the organisations the guidelines aim to support. One LERO lead noted the

requirement for boards to include more than 50 per cent people with lived experience was not feasible considering the scale of their operation:

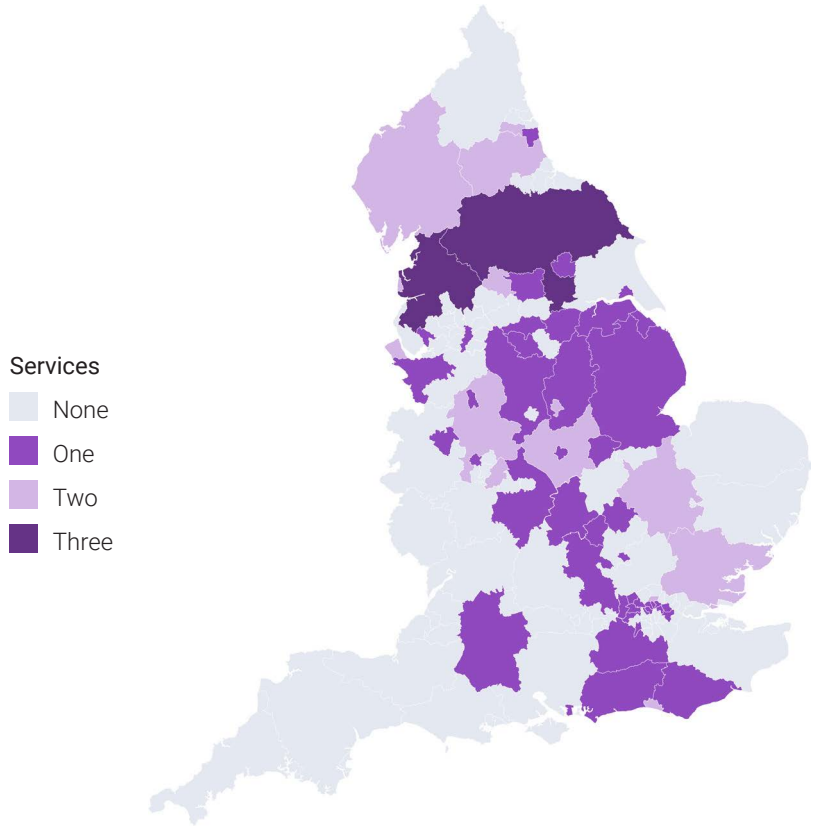
> So what I'll need from my board at £5 million a year turnover maybe supporting multiple thousands of people a year, is going to be very different. And it isn't always going to lend itself to being able to have a disproportionate weight into lived experience. Because what you need at that point is people with the technical expertise required to have oversight and governance of the key functions of the business. (LERO lead 4, Phase 1)

One LERO lead mentioned that they are currently not following the guidelines due to lack of resources rather than necessarily disagreeing with them, while other LERO leads simply had not known that the standards existed. This may be partially due to communication gaps (one LERO lead reported that it had 'only recently come to light' that there were standards (LERO lead 14, Phase 1). However, it may also be due to organisations viewing a structured approach as unnecessary: 'we just literally do what we do. There's been no need to formalise anything' (LERO lead 13, Phase 1). In contrast, another LERO lead described repeated unsuccessful attempts to be formally recognised by CLERO, despite feeling that they were operating in line with the ethos of the model.

3.2. Types of LERO development

In September 2024 the research team, following a structured census procedure, identified 52 LEROs operating in England. The majority of the 151 counties and unitary authorities in England (92; 61 per cent) did not appear to have a LERO in operation. Of the remaining counties and unitary authorities, 44 (29 per cent) had one LERO in operation and 16 (11 per cent) had two or more (Figure 1). There are more LEROs operating in the north of England, with 24 across counties and unitary authorities in the North East, North West, and Yorkshire and the Humber and many areas being served by more than one LERO. Conversely, there are very few LEROs operating in the south and west of England, particularly the South West region where only one LERO was identified. Yorkshire and the Humber and the East Midlands are the regions with the highest proportion of counties and unitary authorities with a LERO (82 and 75 per cent, respectively) and the South East, West Midlands and the South West have the lowest proportion (32, 31 and 7 per cent, respectively).

Figure 1. Map of LERO services in counties and unitary authorities of England



Source: RAND Europe.

This demonstrates that not all local-level treatment and recovery systems in England currently have access to a LERO. However, due to the funding and other recovery-oriented initiatives being implemented as part of the drug strategy, more LEROs are gradually emerging across England. We identified four ways in which LEROs have developed or become involved in local treatment and recovery systems. The first system is the absence of a LERO (**Type 1**) – we explore this system to understand factors that may make the development of a LERO challenging. The remaining models are:

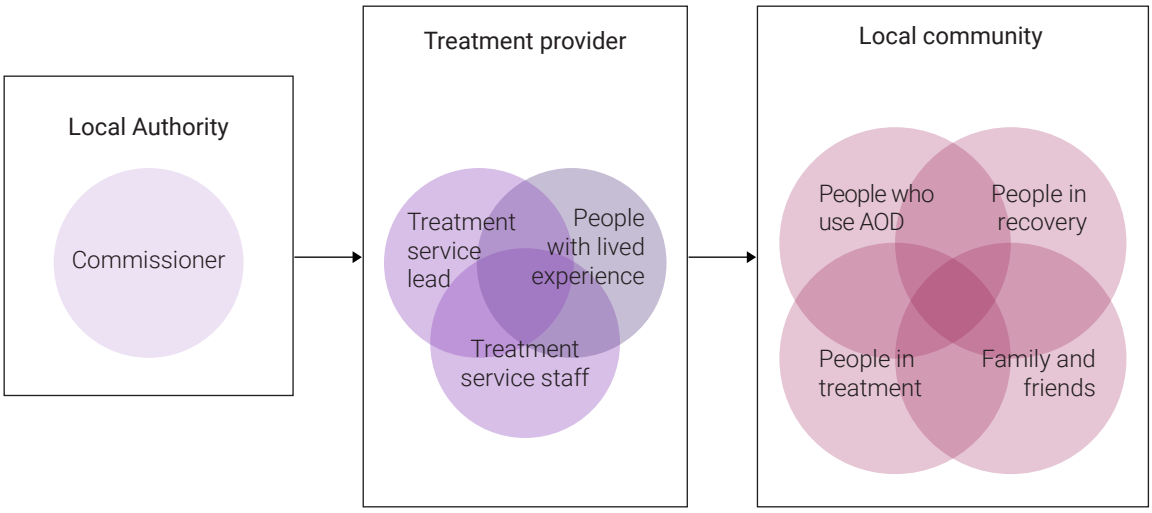
- **Type 2:** LEROs that emerged organically through grassroots-led development, initiated by individuals in recovery who mobilised local networks and resources to build more formal structures.
- **Type 3:** LEROs initiated through top-down efforts by commissioners and councils.
- **Type 4:** LEROs developed within a treatment service which may, or may not, strive to become independent.

These four types are not intended as fixed or exhaustive categories, but as a framework to help understanding of the diverse ways LEROs can emerge and operate. In practice, there are grey areas and overlaps between them, and local contexts often shape hybrid forms, while a small number of LEROs we engaged with did not seem to fit precisely into any of the categories. The different approaches do, however, have implications for how a LERO is integrated into treatment and recovery systems, as discussed later in this report. The four systems are outlined in more detail below.

3.2.1. Type 1 system – No LERO currently identified

Many treatment and recovery systems did not have a recognised LERO available locally, although they had people with lived experience working within the treatment service as staff, peer support workers or volunteers. These systems have simple, direct links: the local authority commissions the service, and the service then provides treatment and support to people in their local community (i.e. people who use alcohol and/or other drugs (Figure 2). Participants working in Type 1 systems, including treatment and recovery staff, treatment provider leads and commissioners, were asked if efforts had been made to stimulate the development of a LERO, and if so, what challenges they had faced.

Figure 2. Simplified map of a Type 1 treatment and recovery system



Source: RAND Europe.

Specific local resources are needed to create a LERO from the local recovery community

LEROs are typically defined as grassroots organisations, which are created, led and staffed by those who have lived experience of substance use and recovery. This foundational principle can prove a barrier to implementation: efforts by commissioners or treatment services to establish a LERO risk undermining the peer-led ethos that defines them by creating top-down, peer-delivered organisations. Treatment provider staff and commissioners in the majority of the case study sites without a LERO demonstrated awareness of this difficulty.

> The small charities are ones that have been started as LEROs, which often I find is tokenistic. In some areas, there's good recovery LERO movements, but in other areas… and they've got to come from the grass, that's got to come from the grassroots. No point [my colleague in the treatment service] said to me, "[…] let's start a LERO." We're not, you know, in recovery. That would just be starting another organisation that's going to try and recruit people to do whatever we want to do. That's not a LERO. (Treatment provider lead 1, Site 5, Phase 2)

It was emphasised that a pre-existing recovery community is a prerequisite to forming a LERO, and that such a community requires population and cultural resources, as well as infrastructure and investment. The absence of such a community was seen as a major barrier to LERO development by many treatment and recovery staff in sites without a LERO. Commissioners and staff also described the need for a recovery community that includes individuals with professional or organisational experience; has people willing and able to 'step up to the mantle' of leadership (Local lead 1, Site 5, Phase 3); and has a population that is able to stay in recovery and lead a LERO.

> [Y]ou need a core group of people to drive it, that are going through real challenges, to stay in recovery themselves and to stay well so it is hard. (Treatment provider staff 3, Site 5, Phase 2)

Some treatment provider staff and leads felt that the development of a recovery community depended on the availability of supportive infrastructure such as recovery housing, rehabilitation services and frequent mutual aid meetings, so that those in recovery had the opportunity to meet and develop networks. Additionally, good public transport and a culture of openness and mixing – rather than what staff described as a 'small town mentality' (Treatment and recovery staff focus group 3, Site 2, Phase 2) – were cited as important enablers by one commissioner, with reports of rural sites struggling to develop LEROs more than more urban areas. One commissioner attributed the lack of a local recovery community to the level of deprivation in their area. They felt that more affluent communities would be more likely to have a 'professional retired workforce' capable of supporting such initiatives.

> Just some areas are more affluent, maybe have a retired person who could, maybe has had a lot of business skills or whatever, or has been a chief executive of a charity before or something like that. Do you know what I mean? You have some areas probably more affluent, have probably more professional retired workforce that is interested in this kind of area […] because to set up a LERO, you do need to be… take risk. It's a kind of a bit of a business, isn't it? A bit of a charity-type business, if you saw what I mean. (Local lead 3, Site 3, Phase 3)

However, of the three most deprived case study sites visited (both within the sample and across England, according to their index of multiple deprivation [IMD] score), two sites had at least one LERO in their area, and some of the more affluent parts of the country have fewer LEROs. This indicates that affluence is not the only contributing factor. These findings suggest that the ability to develop a LERO is shaped by the underlying resources of an area, including its people, systems and geography. Enabling the development of a LERO which is in accordance with the original definition might therefore imply the need for a more substantial investment in the wider treatment and recovery system.

Financial constraints and competing demands in the treatment and recovery sector may impede the development of a LERO

A barrier to LERO development across several sites was the limited capacity of commissioners and of local treatment and recovery services to invest in supporting LERO initiatives. This included both financial constraints and competing operational demands. In some areas, the absence of a LERO was attributed to the lack of consistent funding for dedicated roles. For example, at one site, a few treatment staff wanted to support the development of a LERO but explained it required significant coordination and management, resources which they had initially 'underestimated' (Local lead 1, Site 5, Phase 2). There was a recovery lead within the service who was responsible for fostering a LERO, but their post was not renewed for the new financial year. Staff agreed that, despite feeling they were in a position of 'really going for' a LERO (Treatment and recovery staff 4, Site 5, Phase 2), the loss of this dedicated role would make any engagement activities more difficult.

> [I]t's a big task and it does need someone to coordinate it and it's a shame that that has gone and there's nothing we can do about it now, but yeah, I think if you asked everybody one thing, what do we need, it would be [the former recovery lead], absolutely, as an individual but also as a position. (Treatment and recovery staff 3, Site 5, Phase 2)

Similarly, attempts in that area to set up a group to be the 'voice of the living experience community' failed due to the instability of the funding available (Treatment and recovery staff 4, Site 5, Phase 2).

In other cases, the issue was not funding alone but the broader strain on local systems. The local lead at one site suggested that their energy and time was taken up with supporting their treatment service to try to meet government targets, including the number of people in treatment, so they were not able to invest in fostering a LERO:

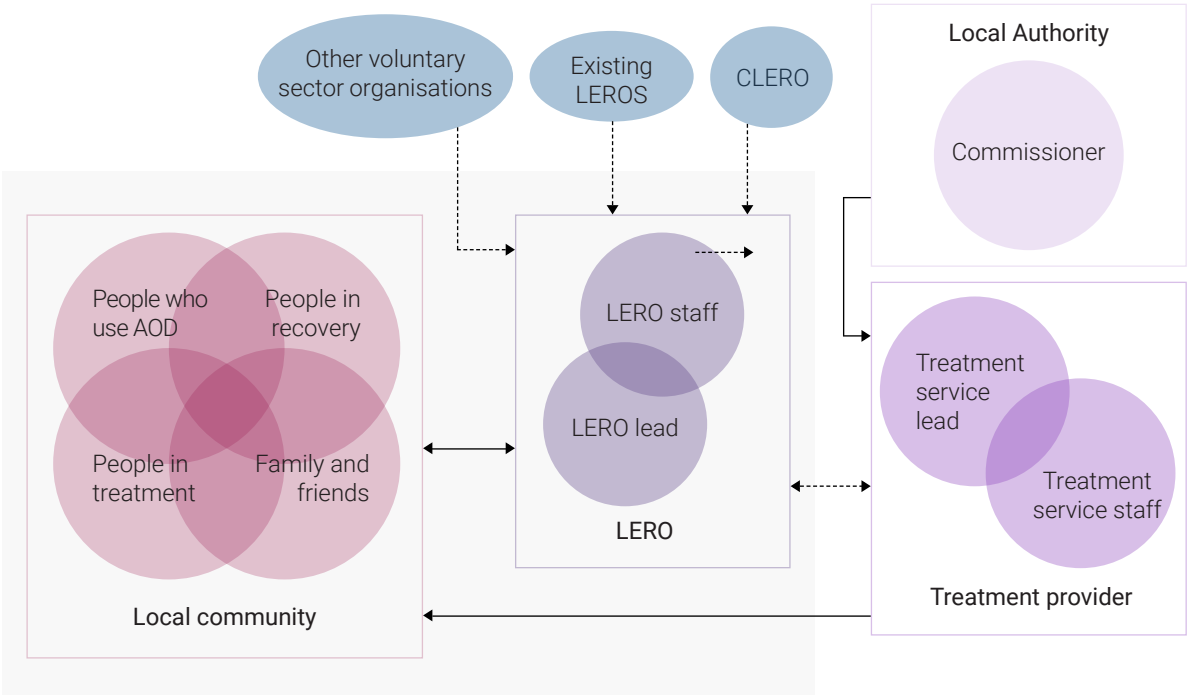
> If the provider was just passable and effective, we could have had a lot of energy in exploring the lived experience recovery groups, their impact on [the area], maybe cafes and all of those things that are nice to have that add the quality elements. We haven't had a chance to look at any of that stuff in great measure because we've been trying to drag the provider out of the gutter. (Local lead 1, Site 10, Phase 2)

This suggests that in areas that do not have a LERO, one potential barrier could be that the commissioner is focused on improving their treatment provider, highlighting that LERO development can be deprioritised in overstretched systems. Notably, a few LERO leads echoed the local lead quoted above in describing themselves as feeling treated as non-essential and an 'optional extra': something to consider only once core treatment services are functioning effectively (LERO lead 3, Phase 1). A different treatment provider lead was sceptical of the LERO model altogether, feeling concerned that the presence of a LERO may inadvertently undermine coproduction efforts within treatment services. In this view, the development of a LERO is not seen as complementary to the involvement of people with lived experience in service design and delivery, but as a competing activity that could divert attention from engagement efforts within the service. It is possible this conflation reflects uncertainty about the role of a LERO. These concerns, and the de-prioritisation of developing a LERO, may be exacerbated by what a few commissioners noted was a lack of evidence around the LERO model and what difference it makes to outcomes.

3.2.2. Type 2 system – LERO developed from local recovery community

The majority of LEROs included in this study developed organically from a community of people in recovery, sometimes driven by one individual who had a strong 'vision' for the organisation and stepped into a leadership role (LERO lead 1 and LERO lead 2, Site 3, Phase 2). The development of these LEROs was often supported by the local treatment provider and/or other organisations external to the local treatment and recovery system, but was not initiated by them (see Figure 3). In these systems, LEROs generally (but not always) work with the treatment provider to provide recovery support to the local community. The relationship between the LERO and local authority varies, depending partly on the funding model implemented (see Sections 3.3 and 3.4). This system was the most common model of LERO origination and was found both in long-running established LEROs, who had presence in multiple areas, and in LEROs that were only months old at the time of interview.

Figure 3. Simplified map of a Type 2 treatment and recovery system



Note: The grey shaded box indicates the origin of the LERO; solid arrows indicate consistently observed links; dotted arrows indicate links observed for some LEROs in this type of system. Source: RAND Europe.

The presence of a thriving recovery community, with access to resources such as multiple TSGs and residential rehabilitation centres, may be important to grassroots LERO growth and development. Such resources not only provide LEROs with opportunities to expand their membership and build connections but also offer individuals' knowledge and conceptual understanding of mutual aid approaches. Many LEROs reported having strong connections to local TSGs, often signposting or accompanying people to TSG meetings, and noting that many members first engaged with the LERO through TSGs. A small number of LERO leads described shaping their organisational model around TSG philosophies and practices or using them as a conceptual starting point – although the extent to which they adhered to the model, or conceived of their LERO as a distinct alternative to it, varied. For a small number of LERO staff, mutual aid appeared almost synonymous with the Twelve Step framework; it was a common reference point that helped LERO leads and staff conceptualise and illustrate what mutual aid could look like in practice. For example, one LERO staff member felt the LERO aimed to create a 'community of like-minded people' or 'a community of the same to AA (Alcoholics Anonymous)' (LERO staff 1, Site 9, Phase 2). Residential rehabilitation centres were also highlighted as key elements of recovery infrastructure. Some LERO leads noted that connections formed within rehabilitation often led to new members, volunteers or staff joining the LERO.

While a strong recovery community is likely an enabling factor for organic LERO development and growth, at least one LERO lead reported that when their LERO began their area did not have an

'organic recovery community' (LERO lead 10, Phase 1). The founder rented a space in which to hold a social club and multiple mutual aid meetings. People in recovery began engaging with the space and forming a community. This developed, however, over many years.

The primary challenges for this form of LERO appear to be finding stable sources of funding and the resources and guidance to constitute themselves as legal organisations with a governance structure and clear policies. LEROs in this type of system were sometimes self-financed in the initial stages: LERO leads noted instances where founders contributed personal funds to cover rental costs for meeting spaces, and where LEROs relied on participant donations to finance rent and telephone expenses. These LEROs also very often involved significant input by volunteers (noted by over half of LERO leads interviewed). Funding primarily came from multiple small grants while LEROs were in their early stages, with the National Lottery mentioned multiple times by many LERO leads as a key funding stream. A few of these LEROs were subsequently directly commissioned by their local authority or entered a consortium with a treatment provider in which they were subcontracted to deliver recovery support.

While these were all independent LEROs, support from and coordination with treatment providers was a key facilitator for aiding growth. Services provided help with writing funding applications, provided spaces without charge, and referred or otherwise promoted the work of the LERO to people who use treatment services. A few LERO leads reported that they had received advice or support from other voluntary sector organisations within their area but outside of the treatment and recovery sector, while several others described receiving support and advice from other LEROs. Notably, more than one LERO was started by people with lived experience who had experience working within, or were at the time employed by, drug treatment services, although these initiatives were conducted external to the service.

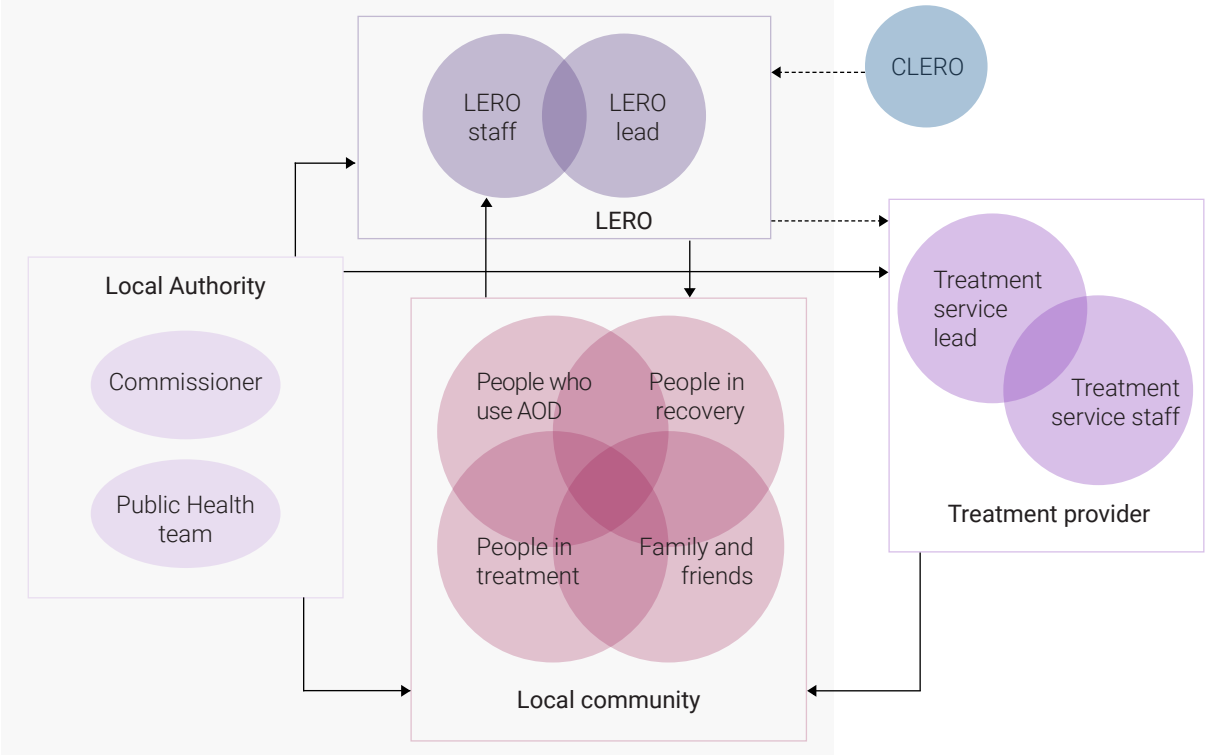
3.2.3. Type 3 system – LERO creation stimulated by the local authority

Some LEROs were created from the efforts of a commissioner or council (see Figure 4). In these instances, someone from the council (for example the Alcohol and Drug commissioner or a member of the Public Health team) approached an individual or group of people in recovery about setting up a LERO or recovery organisation.

> [W]e were approached by [the council] and it was as easy as "Who wants to set up a LERO?" and I put my hand up! (LERO lead 22, Phase 1)

From the data, it is not always clear how the founders were initially identified by their local authority, but at least one was already working within the sector services and took on the creation of the LERO in their own time. Two of the LEROs interviewed that fall into this type of model were created within a few months of data collection taking place, and so they were likely to have been started at least partially in response to the work of OHID to promote LERO's integration into systems of care. Their LAs had strong policy mandates and strategic priorities to develop LEROs given the Portfolio funding.

Figure 4. Simplified map of a Type 3 treatment and recovery system



Note: The grey shaded box indicates the origin of the LERO; solid arrows indicate consistently observed links; dotted arrows indicate links observed for some LEROs in this type of system. Source: RAND Europe.

As these LEROs tended to be newer, challenges were not yet reported to have become apparent, although some commissioners who did not pursue this option described their decision as being rooted in fears that the LERO created would be too top-down, and not fit within the LERO ethos. However, it is clear that the commissioner in each instance needed a strong recovery community to approach to start a LERO, with a few LERO leads mentioning the presence and support of mutual aid meetings as key facilitators to their growth and success. By design, these LEROs all had relationships with the local authority but also worked with the local recovery community to develop the organisation, retaining the spirit of the conceptualisation of a LERO as a grass-roots creation. They worked with the treatment provider to deliver recovery services but may also have been supported by them during their development.

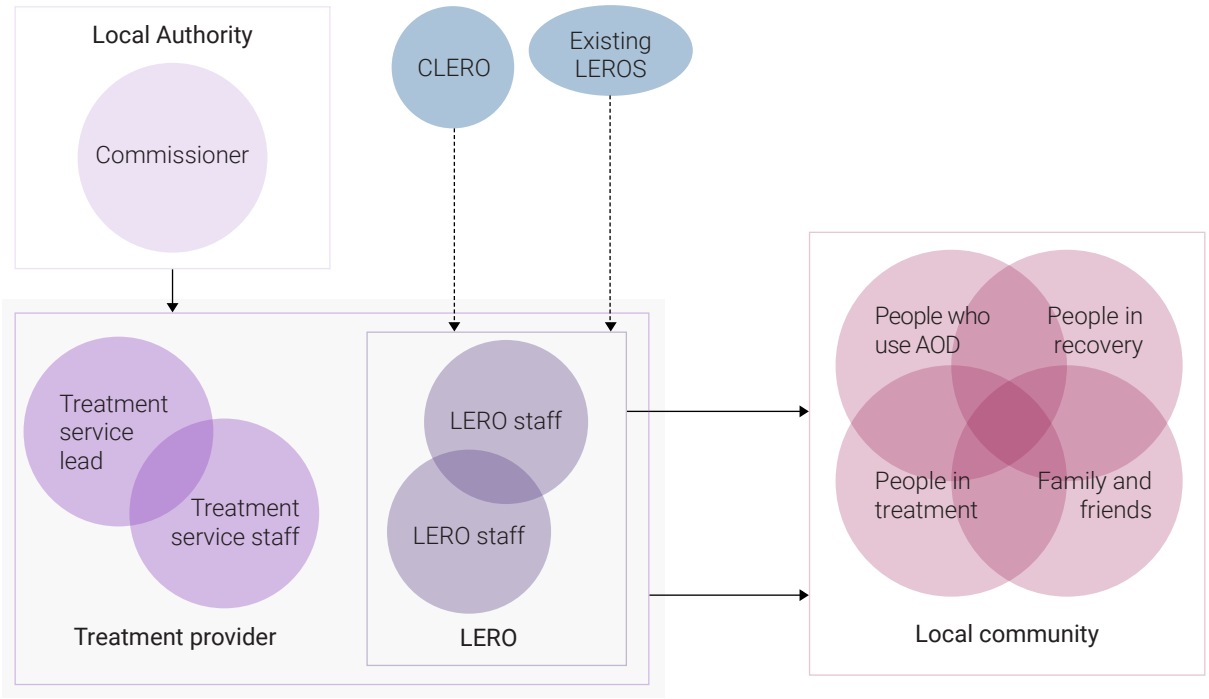
For LEROs created by the efforts and stimulus of a commissioner, the funding source varied. While several LEROs were given initial funding from what was Public Health England (the health improvement functions of which transferred into OHID in 2021), others were partnered with a treatment service by the council to receive funding through them or were given funds by other third sector organisations. Unlike the organically developed LEROs, only one of these LEROs

described struggles with accessing stable funds, and this instability was connected to uncertainty around the longevity of their subcontract with a treatment provider, rather than difficulty finding any resources. The other LEROs, if not still funded by the council, became subcontracted to a treatment service, or transitioned into a social enterprise with a wide base of potential funding streams in addition to funding from the council.

3.2.4. Type 4 system – LERO creation stimulated by local treatment service

A few LEROs were formed by or within a treatment service and have made, or are making, attempts to become independent organisations. They work closely with the treatment provider to deliver services to the local community but may not have a direct relationship with the local commissioner (see Figure 5). Some of these LEROs had close ties to TSGs but were clearly distinct from them; several LERO leads described sharing a building with, or even facilitating, TSG groups, but were clear that the LERO was separate from both the TSG and from the treatment service also located in the same building.

Figure 5. Simplified map of a Type 4 treatment and recovery system



Note: The grey shaded box indicates the origin of the LERO; solid arrows indicate consistently observed links; dotted arrows indicate links observed for some LEROs in this type of system. Source: RAND Europe.

One LERO lead emphasised that gaining independence from the treatment service is important for these organisations in order to be recognised as a LERO. Attempts to develop into independent organisations were often reported to receive external support or intervention and were met in some cases by strong resistance from treatment services. This resistance to the LERO becoming a separate, independent organisation was attributed by LERO leads to a lack of trust.

> We were still seen as ex-offenders, ex-addicts, no capability of managing a budget and no professional experience that's going to enable us to run a project, run a programme of activity, run a service…. (LERO lead 4, Phase 1)

> [I]t's trust, it's power, yeah, it's many things, but trust and power, there's a power relationship in all this, isn't there, there's a power dynamic that has to change and I think it's very slow at changing. (LERO lead 11, Phase 1)

This lack of trust in the ability of LERO staff to run their own organisation may be partially due to LERO leads lacking specific experience or qualifications (see Section 3.6). For one LERO, hiring a non-executive director with business experience helped convince the council that the organisation could function independently, but they still described facing stigma when working with treatment providers who were said to view people with lived experience as 'a risk':

> And the NHS Trust got rid of all the lived experience volunteers when they got the contract because they saw them as a risk. So we inherited people that were disgruntled by being cut out from the incumbent provider to the new provider, the NHS Trust, and no longer good enough because they've got lived experience. (LERO lead 4, Phase 1)

Another LERO, however, suggested that as 'ex-clients, ex-customers of the service provider', transitioning themselves into equals with staffs was difficult (LERO lead 11, Phase 1). Resource constraints within the service were also identified as a barrier to independence due to the LERO being de-prioritised, as well as a hesitancy from both the council and the treatment provider to 'cut the apron strings', inhibiting the investment needed to become self-sustaining (LERO lead 11, Phase 1).

For one LERO that began as an initiative within a treatment service, knowledge gained from CLERO inspired them to develop into an independent LERO. In another area, a treatment provider hired an established LERO to develop a new LERO local to the area. The new LERO is still financially under the umbrella of the originating LERO (and thus not independent) but has a plan to become constituted and independent. This suggests that CLERO and more established LEROs can play a role in creating new LEROs and helping guide them to independence.

Finally, several LEROs that began within treatment services reported that they were reluctant to become independent. One LERO lead noted:

> I'm not a fan of that idea, because we get so much support from [the treatment service]. (LERO lead 16, Phase 1)

This status would not meet other organisations' definition of a LERO. In another LERO, some of the staff were not convinced by the LERO model set out by CLERO, and the decision to become independent prompted multiple members of the committee to resign, with only a core group of strongly committed individuals able to push the change through:

> [P]eople resigned off the committee because they were not happy with the – they just fundamentally did not think it was the right thing. (LERO lead 11, Phase 1)

3.3. Funding models

Many participants, from LERO and treatment service staff to treatment leads and commissioners, identified the broader funding landscape as a significant challenge to commissioning, supporting and working with LEROs in systems of care.

3.3.1. The commissioning model significantly influences the extent to which LEROs can participate meaningfully in service delivery and system design

LERO leads described multiple strategies for funding their organisations, with some directly commissioned by a council, and many subcontracted to treatment providers. Other LEROs are sustained by grant funding alone, while several LERO leads reported more creative sources of income including renting out buildings and providing training services.

Commissioners ring-fencing funding within main contracts to be explicitly allocated to a LERO, or releasing smaller tenders aimed at directly contracting LEROs, were both felt by some LERO leads to facilitate the sustainment and independence of LEROs. Direct commissioning was valued by some LERO leads for preserving their independence and enabling them to act as a critical friend to treatment services. However, direct commissioning was felt to be inefficient by a few commissioners, one of whom noted it had a high administrative burden and could create 'an absolute mess' of opposing views at planning meetings (Local lead 1, Site 3, Phase 2). Other commissioning models could act as barriers to LERO integration and growth: where LEROs were subcontracted to treatment providers but did not have direct access to commissioners, LERO visibility and influence was felt to suffer by one LERO lead.

Fixed-term funding also impacted regional commissioning capacity. At one site, the loss of commissioners due to fixed-term contracts was felt to limit their area's ability to create more innovative contracts and funding models that might support LERO creation. In another area, the public health team experienced staff turnover and struggled to recruit due to funding insecurity. However, their staffing challenges were somewhat mitigated by the area knowledge held by one commissioner, who had previously been involved in a needs assessment and direct engagement with people who use alcohol and/or other drugs. This enabled them to take a strategic approach to supporting LERO development, which ultimately led to a direct award to a LERO. This example illustrates that commissioning capacity is not solely determined by current staffing or funding levels; it also depends on whether the system has access to strategic insight, evidence

and meaningful engagement with lived experience at the right time. The role of individual commissioners and evidence needs are further explored in Section 3.4.

3.3.2. Diverse funding sources can protect independence but can also create service instability

A small number of LERO leads described their success with adopting a trialling approach: securing funding through national pilot schemes of grants to enable them to enact an initiative and create a proof of concept that could then be sold to their local authority. However, some national money came with limitations. For instance, people who used their services needed to meet specific criteria to qualify to receive support from the LERO, and this was felt to be 'strict', and to not recognise the overall complexity of the people who use services (LERO staff focus group, Site 1, Phase 2).

Frequent changes or instability in funding streams were reported by many LERO leads to contribute to rapid changes in the services offered by LEROs, often as funding for specific activities finished or resources to launch something new were acquired. Treatment provider staff within one site noted that this created barriers to working with their local LERO:

> I'm not sure if that were a pot of money that started and stopped or didn't get utilised quick enough or you never really know, [the service within the LERO] just pops up and disappears again. (Treatment and recovery staff focus group 1, Site 7, Phase 2)

Unsure of the support and services on offer from the LERO, some treatment staff reported struggling to know how to engage with the LERO or refer people who use their service to the LERO appropriately.

Multiple LERO leads described the importance of diversifying funding to ensure stability and longevity, enable independence from the local authority and allow LEROs to make decisions in line with their values and beliefs, which might be prohibited were they solely reliant on a treatment service. For example, one LERO lead described being able to uplift their staff wages to be closer to the NHS equivalent by drawing on multiple funding streams outside of a contract, including income from philanthropic donations, grants, social enterprise and providing supported housing. It was felt that this would not have been possible were they relying only on their core contract. Another LERO lead described deciding to no longer be commissioned by a large treatment provider in their area after their offer of funding to the LERO to provide recovery support was halved. This amount was felt neither to be financially viable, nor to enable the LERO to provide a service in line with their 'values and beliefs' (LERO lead 1, Site 3, Phase 2). Instead, they sought funding elsewhere to stay afloat. However, receiving funding from many small pots was also considered unstable by many LERO leads, and a few described a desire to be directly commissioned by their local authority.

3.3.3. The competitive tendering process can impede good working relationships within the treatment and recovery system

The competitive nature of the tendering process was criticised by both treatment provider and LERO leads. Concerns were raised that it might not always foster the development of good working relationships within systems of care, or that the design of the system was not favourable to smaller and grassroots LEROs securing funding. One LERO lead described feeling like an 'afterthought' in a commissioning process so arduous that the LERO did not have the resources to engage with it without support from a larger treatment service as a partner (LERO lead 23, Phase 1). Another LERO described being unable to bid for anything bigger than a third of their annual income and thus feeling 'stuck with subcontracting' to a larger organisation (LERO lead 10, Phase 1). A treatment provider lead also agreed that tenders privileged large treatment providers, who could 'pay the lowest wages' which smaller organisations and LEROs could not compete with; this difficulty was felt to partially explain the lack of a LERO in their area (Treatment provider lead 1, Site 5, Phase 2).

Some participants – both LERO and treatment provider leads – described LEROs and treatment services in competition for the same tenders. One LERO lead noted that this could damage working relationships between LEROs and treatment services:

> What damages the third sector the most at times is when tenders come up because all of a sudden, you're in competition and then a year later you're expected to work right alongside […] it's a big ask when you're pitched against one another, then in the next breath now work alongside one another. (LERO lead 2, Site 7, Phase 2)

However, in this instance, the friction was effectively managed by the LERO and the treatment service. The LERO had been in the area for many years and had long-standing relationships with treatment staff and a history of working collaboratively. This was felt to help absorb the stress caused during periods of competition and allow for a generally positive relationship to be maintained.

Finally, flexible definitions of what constitutes a LERO, combined with competition for resources and a national strategic priority to develop LEROs, have led to concerns that some organisations are incorporating LEROs in a superficial way in an effort to win funding. Several LERO leads described the funding they have received as 'tokenistic' (LERO leads 13, 20 and 23, Phase 1), with one raising doubts about commissioner understanding of coproduction:

> I don't think they do [understand coproduction], or if they do, they don't really want it. (LERO lead 17, Phase 1)

Staff from a different LERO focus group felt that some treatment providers view LEROs as 'bid candy':

> R6: And what's very, very frustrating is when you get the areas where you've got a massive treatment provider and they're like "Oh, they can see which way

> the wind is blowing from the strategy" and they're "Oh, right, lived experience and recovery, we've got a..." So they go about kind of "Oh, right how can we kind of make what we do look as though it's lived experience" and they kind of do these tokenistic scrabbling around to try and build and tag on and paste on some lived experience so that they can win all the contracts [...].

> R2: I do think it's, you know, they used to call it "bid candy" didn't they, back in the day where they'd have sort of lived experience levered in so your bid looks good. (LERO staff focus group, Site 3, Phase 2)

Concerns were raised by some LERO leads that treatment providers may superficially adopt the language of LEROs primarily to access funding, sometimes committing to engaging with a LERO model while offering only minimal practical support. Others noted that smaller organisations may rebrand as peer-led because it's 'trendy' and improves their likelihood of accessing funding (LERO lead 20, Phase 1). One LERO lead noted that:

> [I]f a few quid comes out for LEROs, millions, [then] everybody's a LERO. (LERO lead 10, Phase 1)

3.4. Strategic integration

3.4.1. The degree to which commissioners understand the value and needs of LEROs emerged as a key facilitator or barrier to effective system integration

Strong relationships with commissioners were commonly described as a contributor to LERO success by LERO leads. At nearly all case study sites, LERO leads reported positive relationships with their commissioners. These relationships were characterised by: flexible financial support, such as commissioners easing policy requirements or providing informal financial backing to enable early stage development; direct access and frequent contact, facilitated by regular joint meetings alongside the treatment provider, or in one instance frequent co-location, with the commissioner often working from the LERO office; and advocacy and protection, with commissioners actively promoting LERO involvement with treatment providers and shielding them from opposition within the system.

> The commissioners especially are very good at encouraging other services to work alongside us. [...] It's the commissioners that keep plugging away and really keep fighting our corner, is what I'd say. (LERO lead 2, Site 7, Phase 2)

Such relationships resulted in LERO leads reporting that their organisations were understood, supported and in some instances embedded in local decision-making processes. A few LERO leads described contributing to decisions about service design and funding allocations across

the sector, and providing advice to their commissioner on the needs of the local area. Notably, however, one LERO lead did feel that the role of the commissioner was less important than the lateral relationships formed by staff across LEROs and treatment services:

> The thing is that's been achieved because of the people in the room. The force of personality; that hasn't come from commissioners. Who is going to put this; this is us forcing it, sort of getting people to trust, believe, to respect if you like. (LERO staff focus group, Site 3, Phase 2)

Equally, positive relational connections with individual commissioners could be a fragile source of support for the LERO. Many LERO leads noted that funding and support for LEROs could be overly reliant on personal relationships with an individual commissioner, rather than system-wide strategies or formalised structures. Moreover, several treatment provider staff reported commissioners telling treatment services to work with LEROs or recovery communities. While this appears to help encourage outreach by treatment services, it was reported to also breed resentment among treatment service leads who felt commissioners were too involved, and too partial towards LEROs.

> We're not able to run the service how we choose or how we see it. It's how the commissioners see and there is some…. There's some bias towards the LEROs. […The LERO is] protected and prioritised from our commissioning team's perspective. (Treatment provider lead 1, Site 1, Phase 2)

In contrast, some LERO leads described negative relationships with their commissioners. These leads felt they were seen as unprofessional or irresponsible by commissioners, or that commissioner engagement was more procedural than sincere or supportive. One LERO lead said:

> I contacted the alcohol and drug commissioner and, frankly, I was shocked by her receipt of me […] I was irresponsible because I was potentially steering people away from statutory services; I was unprofessional because I haven't been trained by the statutory service; and I was dangerous because the same thing again – I was diverting people away from the statutory service. (LERO lead 7, Phase 1)

This was felt to be exacerbated when the LERO lead had limited contact with the commissioner; when turnover meant they had to get used to a new commissioner; and when commissioner metrics of success were felt to rely too heavily on quantitative measures which were not appropriate to capture the impact of LERO activities. How commissioners assess LERO activity was also a concern for some LERO staff in one area who felt their commissioner could play a larger role in 'examining what's happening and setting targets' that would ensure LEROs were resourced to substantively deliver on aims, rather than being only shallowly included by organisations paying 'lip service' to the importance of lived experience (LERO staff focus group, Site 3, Phase 2).

3.4.2. Evidence for the effectiveness of LEROs may support an understanding of the value of lived experience, but gathering it may be challenging

In local systems of care, the visibility and influence of LEROs in decision making may hinge on the type of evidence commissioners consider valid and actionable.

Several LERO leads noted concerns with the evidence that commissioners used to judge the effectiveness of LEROs. They felt that some quantitative measures, such as those based around data captured by the National Drug Treatment Monitoring System (NDTMS), could not capture the effectiveness of much of the engagement LEROs have with people in the community. In particular, LERO leads noted that any preventative work (with those who would not pass the thresholds to be seen by treatment services) was not able to be captured using current monitoring frameworks. One LERO lead also commented on the difficulty in determining what success for a person in recovery might look like:

> [I]t's sometimes quite hard to measure – how can we prove that anyone's clean? There's no such thing as "clean" and we can forget about them. The endpoints are slightly nebulous. (LERO lead 17, Phase 1)

Moreover, some LERO leads were hesitant to capture data that would allow for quantitative evaluation, due to a desire to avoid becoming 'KPI-driven'[3] (LERO lead, Site 1, Phase Two and LERO lead 10, Phase 1), to avoid prioritising 'rattling off numbers' and meeting targets over more time-consuming work tailored to the individual needs of people who use their services (LERO staff focus group 4, Site 4, Phase 2), or because they felt the lack of surveillance within the LERO, supported by a decision not to keep records, was seen as a key attraction for people who use their services. One LERO lead described how this flexibility around collecting data reassured people:

> They know that we'll help them without getting – listen, I'm not bothered if you fill a form in. I don't care. Still going to help you. Don't even need to fill a form in. I'm not bothered. If you don't want to collect any data on you, if you don't want to be the data subject, I'm alright with s**t like that. I'm all right. We'll help you anyway, mate. (LERO lead 10, Phase 1)

Some LERO leads did describe themselves, however, as being interested in and open to engaging in evidence-gathering activities. Two LEROs described the positive impact of collecting basic information on the population who utilised their service. For example, counting the numbers of individuals and contacts their service had, as well as people's ethnicity, allowed one LERO to demonstrate that they had a much more diverse population than comparative services. This brought them legitimacy and funding opportunities. More commonly, however, LERO leads described engaging in forms of evidence collection that were more qualitative. The value of peer researchers in conducting comprehensive needs assessments, asset-mapping local areas, and evaluating current services was mentioned by several LERO leads. An action research approach and a developmental evaluation lens, with LEROs

3 Key Performance Indicator.

being given time to experiment and learn from those experiments, were also raised as positive methods by others. A few LERO leads also mentioned the benefits of drawing on academic theories and models to legitimise and ground their work: the Connectedness Hope Identity Meaning and Empowerment (CHIME) model (Leamy et al. 2011) and the concept of recovery capital (Best 2019) were both seen as useful to draw on and give the LERO approach credibility. Finally, some LERO leads expressed a desire for support with collecting evidence, including guidance on what to collect and financial support to conduct evaluations. One noted:

> [N]obody's sitting with us to say "This is the data that we would benefit from you collating." So the sort of different places that the statutory services would report back to nationally, we may have no awareness of. So it would be good if there was that sort of joined up approach there where it was like "OK, are you collecting this data? Do you know how to collect this data? Have you got somebody or the infrastructure that allows you to do that?" Because I think a good part of the funding would have been even just a small allowance for lived experience organisations to have somebody to collate that data for them. (LERO lead 13, Phase 1)

Inclusion in governance and decision-making structures

In several areas, LEROs were included in local governance and decision-making structures, which helped foster integration and mutual understanding. Such inclusion provided LEROs with direct access to forums where strategic decisions were made, enabling them to advocate for recovery-oriented approaches. Examples of local governance inclusion include LERO leads being invited to multi-agency forums and Combating Drugs Partnerships, as well as to meetings between treatment providers and commissioners. In one instance this involved the LERO being included in joint financial decision making for the area.

Some LERO leads saw this inclusion as critical, with a few noting the typical inaccessibility of these groups for LEROs:

> It's a bit like a cartel that you can't get in. (LERO lead 25, Phase 1)

In another area, for example, the treatment provider lead described struggling to get the LERO lead's attendance at a Combating Drugs Partnership accepted, as they were not a directly commissioned service.

Notably, there were a small number of LERO leads whose organisations were run primarily by and for minoritised ethnic groups and these individuals reported having faced particular challenges integrating into their local systems of governance. One LERO lead expressed some distrust in how commissioners were scrutinising their LERO, as well as dissatisfaction with the proportion of their local area's drug strategy funding they received:

> I've seen services in the voluntary sector that were Black organisations, like ourselves, getting de-commissioned. They were getting de-commissioned

> and sometimes that was, again for me, inequalities in commission or systematic, I feel anyway. It was systematic, saving money from the Black organisations, the mental health or whatever were getting less of the cake than everyone else was and I seen what flaws they used. The biggest flaw they used was governance, due diligence and safeguarding but then I did see a lot of organisations that lacked that as well […] but if you say am I happy with what we're getting, I say no because if it's a £4 million contract and I'm getting about £250,000 from it and 47 per cent on the census in [the local area] is diverse, then no. (LERO lead 2, Site 3, Phase 2)

Similarly, another LERO lead expressed dissatisfaction with how commissioner decisions were being made around allocation of funding, but focused more on a perceived inadequacy of evidence gathering:

> The service specs did not reflect the need of the whole population. The service spec every three years was a rehash of the three years before that kind of built and designed for the white British population of [the local area] – Caucasian – white British population. It wasn't designed for the multicultural [local area], a multidiverse community, you know, the needs and how to respond to those needs was absent. (LERO lead 20, Phase 1)

The same LERO lead described their service facing opposition in its local area:

> And we, as an ethnic minority led, as a BAME-led LERO, we've had lots of challenges from the commissioners, from local partners, from the treatment system, from the harm reduction sector, especially our approach as an ethnic minority LERO that incorporates faith, culture and spirituality into our framework of recovery. (LERO lead 20, Phase 1)

However, they also noted that much progress had been made in 'educating commissioners, service managers' over the years of their activity, which was echoed by the other LERO lead too. They also commented on a third LERO 'facing the same challenges we've been facing over twenty years ago'; that specific LERO lead did describe significant challenges to being recognised in their local area, and felt that this was not equitable:

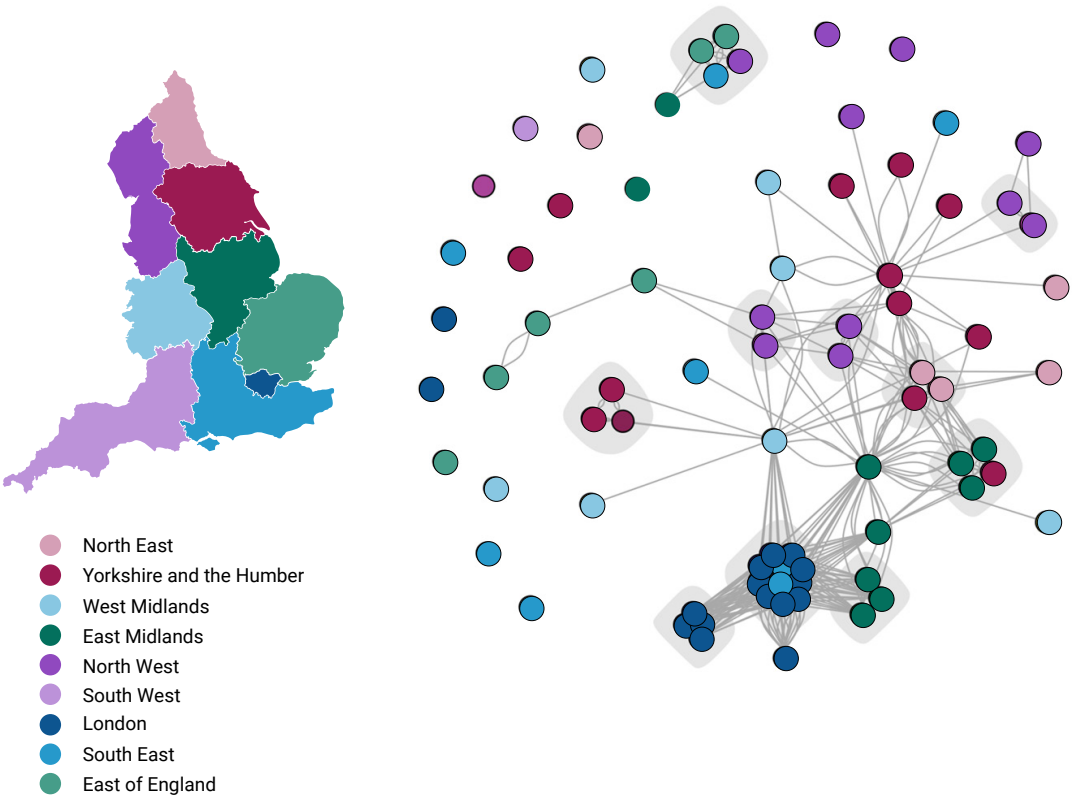
> I realised that it was – especially in this area – going to be exceedingly difficult to get any kind of fair equitable position within the local landscape or a voice or in terms of funding. (LERO lead 7, Phase 1)

However, this LERO lead did not specifically mention ethnicity as a factor.

3.4.4. Lateral relationships between LEROs can allow for peer support, although access to networks is uneven

As discussed in Section 3.2, newly emergent LEROs often receive support (in conceptualising their remit, finding funding, or setting up governance structures) from other more established LEROs. Lateral relationships between LEROs also serve as informal channels for sharing strategic intelligence, influencing local decisions through collective advocacy and knowledge exchange. Networks of information sharing, however, are concentrated amongst only a proportion of LEROs. Almost two thirds (32; 64 per cent) of the LEROs we identified are part of a large network of LEROs, encompassing most regions of England, that work together or support each other (see Figure 6).

Figure 6. Network analysis of LEROs in England



Note: Each dot in the network represents a LERO service in a particular county or unitary authority area in England. Some LEROs operate in more than one area; these are indicated by multiple dots within a grey envelope. Dot colours indicate the larger region of England the service is based in, as shown in the inset map. Links between LEROs are based on information on organisation websites, and interviews and survey data from LERO staff regarding whether LEROs have worked together or have helped each other in some way. Source: RAND Europe.

Clustering did appear to have some geographical basis (e.g. LEROs from the North West, North East, and Yorkshire and the Humber working together), but this was not the case for all segments of the network. One other small network involved two LEROs and there were no identified linkages for the remaining 16 LEROs. This indicates that a substantial minority of LEROs may be operating in isolation in terms of direct support or collaboration with individual LEROs; however, these LEROs may still have connections with CLERO. There did not seem to be any association between geographical area served and lack of linkage to the network.

There are some LEROs that operate across multiple sites, and in some instances these sites are not all in the same geographical area of England. In most cases they do operate across geographically contiguous areas, and it is plausible that 'locally grown' LEROs could be expanding in response to need in nearby areas. However, a few have quite diverse sites (e.g. operating services in the South East, East of England, and the North West).

While many LEROs benefit from peer support and are embedded in a large, cross-regional network, a substantial minority remain isolated from these lateral working and supportive relationships. This fragmentation suggests uneven access to shared learning, resources and mutual support across the sector. The lack of connection between geography and network inclusion implies that isolation is not simply a function of location but may reflect deeper structural or relational barriers. This has implications for how commissioning bodies and national stakeholders (like CLERO) might better facilitate inclusive networking and capacity-building across all LEROs, especially those operating independently.

3.5. Mission alignment across services

Although treatment providers and LEROs both aim to support people to achieve and sustain recovery, treatment and LERO staff often held divergent views around what their support was intended to achieve for people using their service, which could create friction. Staff in treatment and LERO services described following different philosophies of recovery, with some subscribing to person-centred, Twelve Step, spiritual or abstinence-based approaches, while others followed a medical model rooted in the clinical evidence hierarchy, and emphasised diagnosis, pharmacological treatment and harm reduction, as well as measurable outcomes as defined within formal healthcare systems. While some staff felt that varying viewpoints did not prevent collaboration and mutual respect, others described clashes from differing opinions. Note that differences in opinion were not constrained to LEROs only, nor did all LEROs have the same approach to recovery. An accompanying report – Wadsworth et al. 2026 – explores tensions among staff in more detail; this section, however, will focus specifically on how differing perspectives affect collaboration between LERO and treatment staff.

3.5.1. Conflicting views on recovery between LEROs and treatment services may challenge collaboration

Multiple views and approaches to recovery were reported by LERO and treatment staff. However, where LEROs took an abstinence-based approach and worked with service providers rooted in a

medical model which focused on harm reduction and prescribing of opioid substitution treatment, conflict could arise. Across both LEROs and providers, there were a small number of actors who at times expressed negative language around the approach with which they disagreed.

Some LERO staff and leads who described themselves as working in abstinence-based organisations felt that this approach was not well understood or accepted by individuals within their local treatment services. One staff member with lived experience, working within a treatment service (not a LERO), observed a divide between their colleagues in the treatment service who had lived experience, who generally supported abstinence and had strong interpersonal ties to the LERO, formed through attendance at TSG meetings and other recovery events, and those did not have lived experience and were less in favour of abstinence, and who struggled to work with or form lateral connections to the LERO staff.

LERO leads also thought that some staff from treatment services viewed mutual aid groups such as AA and Narcotics Anonymous (NA) with suspicion: one described their local treatment service as 'steering people away from local mutual aid meetings' (LERO lead 7, Phase 1). In an area where they had struggled to build a LERO due to lack of recovery community, a treatment lead noted:

> The actual recovery worker explicitly, said, you know, in front of people, "no, AA is a cult." (Treatment provider lead 1, Site 5, Phase 2)

Other LERO leads felt that some treatment service staff seemed to view all abstinence-based work with suspicion: the view that abstinence was 'a bit cultish' was said by LERO staff to be held by treatment provider staff in an area with a LERO (LERO staff focus group, Site 3, Phase 2), while another LERO lead noted that, for treatment service management in their area:

> [If] abstinence-based recovery had spirituality, faith and culture attached to it then it was a cult. We were literally called a cult. (LERO lead 20, Phase 1)

On the other hand, several LERO staff and leads who were proponents of abstinence described feeling sceptical about their treatment services' medicalised approach to recovery, and reported strongly negative views around prescribing practices and the perceived limitations of medication-based support. One LERO lead described the offer from treatment services as a 'methadone mill':

> And so I started working in the drugs field […] all I did see was that what – without being crass like – but is the "methadone mill" and that people stuck in that "methadone mill" and my thing was always how do we change this, how do we? […W]e came to it with that sort of life experience of drug and alcohol and methadone and realising that actually so many of my friends and family ended up going into drug services to get help and then finding themselves given a methadone prescription and for some of them given a lifelong sentence to addiction. (LERO lead 24, Phase 1)

Similarly, other LERO staff felt that having people receive opioid substitution prescriptions was 'limiting them' (LERO staff focus group, Site 3, Phase 2). They felt that treatment service staff were partially in favour of the prescribing model, not due to belief, but due to the restrictions of their employment:

> [T]hey believe that people deserve more but they're stuck in that job. (LERO staff focus group, Site 3, Phase 2)

Other LERO staff from the same area, however, attributed the approach to risk aversion:

> If they're abstinent for a while then relapse, they're more at risk of overdosing and death, and that was the predominant thing. It was like well if something happens to them… to the point, I remember one time, a guy came in and I think he'd stopped using and it was like it was bad news. (LERO staff focus group, Site 3, Phase 2)

3.5.2. Clearly delineating the role of LEROs and treatment providers can help organisations and their staff to work together effectively, despite different perspectives on recovery

Many LERO and treatment provider staff held different views about recovery, but these differences did not always preclude them working well together. In an area where LERO workers disagreed with the medicalised approach and felt abstinent LERO workers were sometimes viewed as 'walking talking miracles […] a bit of a one-off', the LERO was heavily integrated into the service, and staff from both organisations worked together very frequently (LERO staff focus group, Site 3, Phase 2). Similarly, in another area, the treatment service lead felt that you would be 'labelling yourself' by still referring to yourself as in recovery even many years after sobriety; but they acknowledged that this approach was successful for some people and having a LERO which offers a service for them is useful (Treatment provider lead 2, Site 4, Phase 2). Other treatment staff in the same area felt that, while everyone had different opinions and approaches, they were 'quite respectful of that' and it did not prevent them working together (Treatment and recovery staff 3, Site 4, Phase 2). An important dimension was the LERO's clearly defined remit, which was seen as separate to the treatment service; this enabled the organisations to work together, but did prevent significant integration or lateral relationships forming between LERO and treatment staff.

> It's very much a us and them. Like they're separate. And there's quite a lot of corridor comments around kind of like, "oh, they'll do their thing, we'll do ours," or just disagreements over certain things that, yeah, I think people take quite personally. And I think both services deliver a really good service, but I don't necessarily think they're cohesive across the two. It doesn't feel like it's one service delivering two parts, it definitely feels like it's two separate services. (Treatment and recovery staff focus group 3, Site 4, Phase 2)

This sentiment was echoed by staff at other sites, who felt that respect for others' roles would be improved by an increased effort by management to explain different staff remits:

> I actually think that actually there should be kind of more effort made mainly by management to explain kind of what each services roles are and their particular remit within the service. (Treatment and recovery staff focus group 2, Site 9, Phase 2)

On the other hand, individual workers within LEROs and treatment services can continue to disagree even when their organisational approaches appear to be aligned. For example, in one area, while the LERO lead felt that treatment and LERO philosophies aligned, staff on the ground noted instances of individual disagreement. In those cases, LERO staff reported that treatment staff did not give additional support to people the LERO felt needed it, while the treatment lead felt LERO staff were encouraging people to come to the service inappropriately.

3.6. Workplace culture

3.6.1. Staff from treatment providers expressed a range of views about the value of lived experience and how it affects the provision of treatment and recovery support

Many treatment staff noted the benefits of having colleagues with lived experience, whether or not they were part of a LERO. Some noted that people who used their services appreciated or even preferred working with a support worker who had lived experience. Similarly, a few treatment staff described gaining a unique perspective on how to approach care in specific cases when consulting their colleagues with lived experience. It was even felt that the presence of a LERO was 'lucky' for the treatment service (Treatment and recovery staff focus group 1, Site 7, Phase 2), and that maintaining a good 'balance' of workers with learned and lived experience was important for effective services (Treatment and recovery staff focus group 1, Site 3, Phase 2).

However, other staff, many within the same areas, felt that lived experience workers were more likely to cause challenges. One such challenge raised by several treatment leads and staff was the logistical difficulty of hiring people with lived experience, who may require more support if moving into employment for the first time or after a long break. People with lived experience may not pass the vetting processes required in, for example, hospitals or criminal justice settings. Individual workers' personal histories were also raised by some LERO staff, who recognised the difficulty some LERO workers had integrating within the treatment and recovery system as a staff member if they had had a negative experience with the service before they were in recovery. Some practitioners and clinical staff were also noted to struggle to adjust to seeing people who had previously used treatment services as colleagues.

The concerns of some treatment staff, however, lay in doubts about the appropriateness of support given by those with lived experience. They expressed reservations about LERO staff sharing their own lived experiences with people who use their services and noted that emphasising lived experience might diminish the perceived value of the skills and expertise of

staff *without* direct lived experience. These treatment service staff felt that lived experience was only important if accompanied by the right skills.

> "I've got lived experience" means s**t to me, okay? So, whenever I had a service user moaning that their worker doesn't have a clue, they only learned it from a book, always the same analogy I use when, if you break your wrist, you go to hospital, and the surgeon says, "I'm a doctor, so I'm going to fix your wrist." "Have you broke your wrist before, doctor?" "No." "So, do you trust them?" "Well, yes, but in a doctor, it's different." (Treatment and recovery staff focus group 3, Site 5, Phase 2)

The scepticism and concern felt by treatment service staff impacted some LERO staff, who observed that a distinction was made between formal education and lived experience when discussing treatment staff's recognition of their abilities. One LERO staff member noted that treatment staff sometimes placed a higher value on educational qualifications, and that this led to LERO staff feeling excluded:

> [I]t's like your opinion doesn't count for much because you haven't got to where you've got to by going through X, Y, Z of education. (LERO staff focus group 4, Site 4, Phase 2)

Equally, some LERO staff did feel that their lived experience made them more effective and empathetic workers, and they held a critical view of co-workers whose learning was primarily academic:

> You might have, say, a professional that's just coming straight from a book, that's no good. What you want is somebody, ideally, who's been through it. (LERO staff focus group 1, Site 8, Phase 2)

3.6.2. Cultural differences between treatment services and LEROs can undermine joint working efforts

Staff from treatment services and LEROs expressed some differing views on the value of professionalism, which reportedly created tension. While a few treatment service staff valued a 'professional attitude' as essential for credibility and integration (Treatment provider lead 2, Site 4, Phase 2 and Treatment provider lead 1, Site 1, Phase 2), some LERO staff members actively sought to 'de-professionalise' their approach to emphasise relatability and shared identity with the people using their services (LERO staff focus group, Site 8, Phase 2). This relatability was seen by LERO staff as central to their effectiveness but could be viewed by treatment services as a lack of rigour.

A small number of LERO leads expressed frustration that treatment provider staff assumed they would not be professional, which was felt to be 'demeaning' (LERO lead 4, Phase 1). There were also differences raised between treatment and LERO staff regarding professional boundaries. Some treatment service staff emphasised the importance of maintaining professional

boundaries, viewing their roles as structured and time-limited, with clear separation between work and personal life. For others, organisational policies prevented self-disclosure of lived experience, which reinforced these boundaries. In contrast, many LERO staff saw their willingness to be available outside of formal hours as a strength, rooted in personal commitment and shared experience with the people using treatment and recovery services. This divergence in ethos led some LERO staff to perceive treatment services as lacking 'dedication' (LERO lead 2, Site 7, Phase 2) or to view treatment staff as overly 'clinical' and 'rigid', to the detriment of the people who use their services (LERO staff focus group, Site 1, Phase 2). One LERO lead observed:

> [A]ll the staff and volunteers go an extra mile. Quite often, we're the one organisation that's open the longest over the holiday period. Volunteers and staff will come in on Christmas Eve unpaid. Out of that extended family comes a dedication, I think, that a lot of other services lack. (LERO lead 2, Site 7, Phase 2)

Tensions between LEROs and treatment services were further exacerbated by differing operational cultures. LERO leads and staff reported often prioritising flexibility and person-centred approaches, sometimes avoiding formal procedures such as risk assessments in favour of relational judgement.

> It's quite a beautiful thing about being a LERO, we can say, "just do it. Let's not risk assess it. I'll risk assess it. Hold up, I know you." (LERO staff focus group, Site 8, Phase 2)

This clashed with the governance-focused, risk-averse culture reported by LERO staff to be occurring at treatment providers, leading to frustration when LEROs were expected to conform to systems that felt at odds with their values.

> Everyone has a different, yes, policies and statutory stuff they have to abide by. But we're a lot more flexible, so it's fitting our flex into their systems isn't that easy, because we want to keep independent and flexible as well as be part of that system. (LERO lead 1, Site 1, Phase 2)

This feeling was further heightened in some instances where LEROs were subcontracted to the treatment provider and had to operate within their systems. For example, one LERO described making the decision not to continue partnering with their local treatment service, when the funding allocated to the LERO decreased to the point that they felt they could no longer operate in accordance with their values:

> But we had to walk away. We'd been pushed down a road that was too far away from our values and beliefs and it didn't feel right. A LERO at some point has to make that decision, otherwise you're no longer a LERO. (LERO lead 1, Site 3, Phase 2)

In other instances, treatment service staff expressed frustrations with LERO staff not using formal systems for recording case notes, which led to gaps in information and concerns about accountability. The responsibility, and liability, that treatment services have in terms of the Care Quality Commission (CQC) was also raised by both treatment and LERO leads as a source of tension. One treatment lead felt that their 'ultimate responsibility in terms of CQC' meant that, rather than their local LERO having control over its activities, it should be led by the service (Treatment provider lead 1, Site 1, Phase 2). The LERO lead in that area described this mindset as 'fearful' and felt negatively about treatment providers' ability to be flexible.

> Everything's fear driven. It's all driven by fear of CQC. It's all driven by fear of making a mistake. They're frightened of making a mistake. They cannot be creative because it's all process, process, process, process, process. (LERO lead 10, Phase 1)

Similarly, treatment staff from one focus group expressed concern that their LERO colleagues were overpromising to people who use their services, such as by suggesting access to rehabilitation services that were not realistically available due to budget constraints.

3.6.3. Sharing physical space can support lateral relationship creation if there is adequate space, a clear role for the LERO, and cultural alignment

Many staff members – from both LEROs and treatment providers – felt that communication across organisations was simple and easy when they shared a building, and at one site co-location enabled informal communication and trust-building. A treatment staff member described how working from the LERO's office helped them build strong relationships:

> I work in their offices alongside their staff. I've been doing that for about two and a half years now, so I've got really good […] I probably know them better than a lot of my own official colleagues, because I work with these guys on a daily basis. (Treatment and recovery staff 1, Site 7, Phase 2)

Proximity also enabled real-time referrals and simplified communication, as reported by one treatment provider lead:

> The pathways are quite straightforward in that you're physically with each other and you can refer there and then. (Treatment provider lead 2, Site 7, Phase 2)

Similarly, in two other areas, co-location was described by LERO staff as enabling communication and integration, although some cultural tensions and disagreement around how to approach recovery remained. In one of these areas, shared space contributed to a highly integrated model, with treatment staff noting that LERO staff were indistinguishable from treatment staff, wearing the same lanyards, and working under various teams across the treatment system. However,

LERO staff from that area did note that this level of integration was only achieved over many years, and after overcoming initial resistance:

> It was like a war zone […] people who I knew previously were just like hysterical with the changes, that we were in their building. (LERO staff focus group, Site 3, Phase 2)

Some LERO staff felt that sharing physical space could facilitate a cultural shift amongst treatment service staff – towards appreciating the presence of a LERO – because physical co-location made it easier to demonstrate their value. This transformation was achieved through persistent advocacy, with LERO staff placing themselves in clinical spaces to visibly model their impact. The positive and spontaneous reactions of people who used their services helped shift perceptions at a grassroots level. It was also achieved by establishing their work as part of a larger theoretical framework, to raise credibility, and by engaging in strategic reflection on how LERO staff could progress professionally and be recognised as legitimate members of the workforce.

Despite its benefits being reported by both LERO and treatment service staff, co-location was not universally welcomed. In some instances, some LERO and treatment provider staff reported that sharing physical space did not enable relational connections to be formed through exposure, but instead generated disputes over appropriate use of the space, sometimes rooted in a cultural misalignment between treatment and recovery approaches.

Several LERO leads described power imbalances in shared spaces: one described being unable to contest the small site of the space they were moved into after a refurbishment, as they did not pay rent. Other LERO leads reported being unable to access their shared building outside of treatment service hours without a treatment service staff member present, preventing them from organising activities flexibly and reinforcing a sense of mistrust. LERO and treatment staff from more than one site described the LERO and treatment staff present in the same building as divided into opposing sides. Another LERO lead described a 'culture clash' when working in medicalised treatment spaces, preferring their own building where they could 'grow and flourish' (LERO lead 8, Phase 1).

While co-location can support integration, several LERO leads warned that it can also erode autonomy. In one area, while the LERO lead was enthusiastic about the impacts of integration, LERO staff described how their identity was being 'eroded through partnerships', despite formal equality (LERO focus group 1, Site 3, Phase 2). In another area, the LERO lead expressed concern that being too integrated with the treatment provider would risk the LERO losing its distinctiveness and ability to challenge the system. In another area, some LERO staff expressed a preference for a separate space to help maintain a distinct community identity, with one wanting this despite the enthusiasm of their commissioner for a co-located space.

Chapter 4. **Discussion**

The barriers and facilitators to supporting, commissioning and working with LEROs in effective systems of care are diverse and encompass the definition and understanding of what a LERO is and does; the ways in which funding is made available to LEROs and to the wider treatment and recovery system; different approaches to supporting people in recovery; and variation in how lived experience is perceived and valued. At the beginning of the data collection period, only about a third of local areas in England had a recognised LERO in operation, although through discussions with OHID we now know that numbers have increased since then. Treatment and recovery systems are still adapting to the drug strategy stimuli designed to promote the development and inclusion of LEROs. However, we have identified key opportunities that could be capitalised upon to further encourage the integration of LEROs into systems of care.

4.1. Adapting support strategies to different LERO models

This evaluation found significant variation in how LEROs are emerging and operating across England. This heterogeneity reflects both the adaptability of the LERO model and the complexity of the systems in which they exist. Many LEROs developed organically in response to local need, often led by individuals in recovery who mobilised networks and resources to build sustainable support structures. This grassroots model aligns most closely with CLERO's definition of a LERO and is the most widely understood form of LERO creation. However, other LEROs were initiated by commissioners or emerged from within treatment services, sometimes with the intention of becoming independent, and sometimes without.

This adaptability can be a strength, enabling organisations to respond to local contexts and needs; however, the differing models all come with their own challenges, which can make it difficult to develop a universal strategy for supporting LERO creation or integration. Each model has its own unique barriers and facilitators to development:

1. **Type 1. Areas without a LERO** often lack the conditions for one to emerge, such as a visible recovery community, mutual aid infrastructure, or individuals with lived experience identified to take on leadership roles. While there was often interest in developing a LERO, efforts were constrained by limited resources and competing priorities. Additionally, some commissioners and treatment leads were unconvinced by the model due to concerns about undermining coproduction efforts (where services are

designed and delivered in partnership with the people who use them) within treatment services, or due to lack of evidence for LEROs. These areas may benefit most from upstream support: investment in recovery infrastructure, leadership development, and guidance on supporting grassroots mobilisation without instituting top-down structures.

2. **Type 2. The grassroots model** often faced funding instability and services could rely heavily on a single founder who may lack experience in setting up formal structures, policies or legal entities. Without this knowledge, and appropriate support, grassroots LEROs may risk being unsustainable in the long term, as suggested by Best & Ivers (2021). These LEROs may particularly benefit from support in governance, leadership development and sustainable funding.

3. **Type 3. Commissioner-initiated models**, by contrast, tended to be better resourced and more quickly integrated into local systems. However, some stakeholders expressed reluctance to pursue this model due to concerns that it might be top-down or tokenistic, particularly if it lacked visible roots in the local recovery community. These LEROs may benefit from support in community engagement and legitimacy-building, to ensure they are not seen as imposed or inauthentic.

4. **Type 4. LEROs emerging from within treatment services** faced perhaps the most complex transition. While they may benefit from infrastructure and staffing support through the treatment service, they often struggled to gain independence. Internal conflict, power dynamics and resistance from treatment providers often slowed or stalled their development. These LEROs may benefit most from external facilitation, mentoring from independent LEROs, and clear pathways to autonomy.

As evidenced by the variety of needs each model is likely to generate, a one-size-fits-all approach to supporting LEROs is unlikely to be equally effective in all areas. Instead, support strategies must be tailored to the specific challenges and trajectories of each model – recognising that the same flexibility that enables LEROs to emerge in diverse ways also demands a flexible and responsive policy and commissioning environment. OHID's recently commissioned LERO capacity-building project presents an opportunity to deepen understanding of, and develop support strategies for, the unique needs of each LERO model.

Moreover, just as there is variation in how LEROs develop, there are differences in how they are understood across the treatment and recovery system, despite efforts by OHID and CLERO to define and promote a model. Confusion persists among commissioners, treatment providers and even LEROs themselves, with some conflating LEROs with any organisation involving lived experience, and others questioning whether certain models fit the ethos of a LERO. This reflects a broader tension between the importance that the national strategy places on lived experience, and local variation in how LEROs are understood and supported. It may also simply reflect the relative recency of the term. The flexibility of the LERO definition may make it difficult to identify what constitutes a genuine LERO, or to agree on what one should be. This raises questions around how commissioners and providers can distinguish between performative and authentic engagement with lived experience,

and highlights the need for clearer definitions, stronger accountability and more robust support mechanisms if LEROs are to be meaningfully embedded in local systems of care.

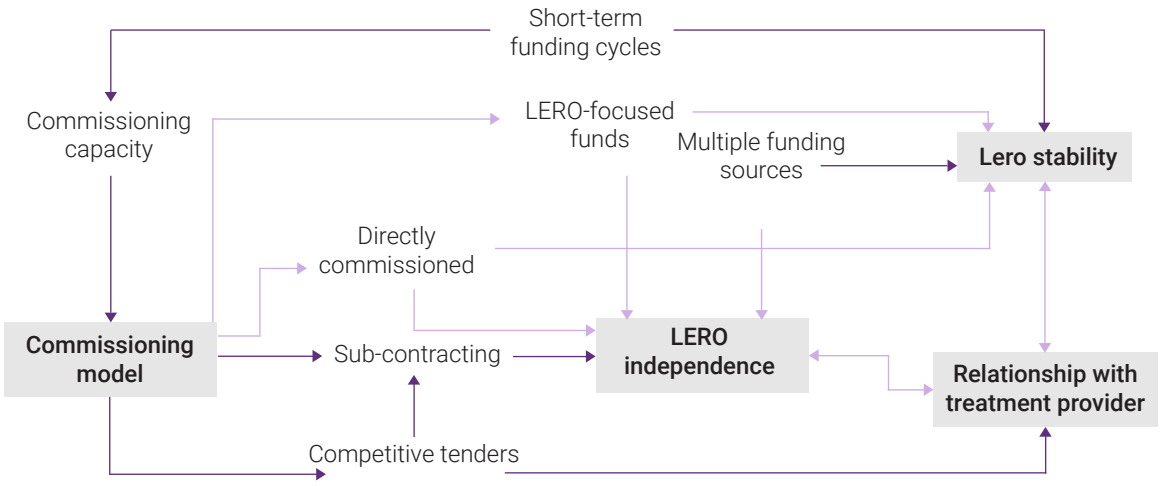
While CLERO standards aim to provide a unifying framework, they are not universally known or seen as applicable, particularly among larger or more established LEROs. Without a shared definition, commissioners may struggle to know how they should support or commission LEROs, and without understanding of the appropriate role or aim of a LERO, interpersonal friction with services can develop. While ongoing efforts to clarify and promote the LERO model are gradually improving sector-wide understanding, this suggests that as the treatment and recovery system adapts to the more widespread inclusion of LEROS, further work to reach an agreed definition is needed.

4.2. Strategic approach to commissioning LEROs in local treatment and recovery systems

This evaluation found that the viability of LEROs is not tied to a single funding model. Instead, the effectiveness of a commissioning approach depends on the quality of relationships between commissioners and providers, the capacity of commissioning teams to manage multiple contracts, and the local system's openness to shared leadership and co-production.

The simplified causal loop diagram in Figure 7 illustrates how funding approaches can reinforce or undermine LERO integration. For example, LEROs that are directly commissioned tend to enjoy greater independence, which in turn strengthens their relationships with treatment providers. Similarly, LEROs with stable funding are better able to maintain consistent service delivery, which fosters trust and collaboration across the system. These reinforcing loops suggest that strategic investment in LERO autonomy and sustainability can yield broader system benefits. However, the evaluation also identified negative feedback loops. Competitive tendering processes, short-term funding cycles and ambiguous definitions of what constitutes a LERO can all undermine integration. When LEROs are subcontracted through treatment providers without direct access to commissioners, their visibility and influence can suffer. When funding is unstable, services shift rapidly, making it difficult for treatment staff to engage meaningfully. And when LEROs are included superficially in bids – a participant in our study used the phrase 'bid candy' – without genuine co-production, trust between organisations erodes.

Figure 7. Simplified causal loop diagram of funding approaches



Note: Dark purple arrows indicate negative links, light purple arrows indicate positive links. Source: RAND Europe.

National guidance suggests that LEROs should be formally involved in local commissioning and governance. The Commissioning Quality Standard (OHID 2022) and the drugs strategy guidance for local delivery partners (Home Office 2024) both consider LEROs as organisations to be included in strategic and commissioning partnerships, and as representatives in Combating Drugs Partnerships. In practice, however, many LEROs rely heavily on the support of individual commissioners who champion their work, offer flexible funding and promote their inclusion in local systems. While this support can be critical, it is also fragile. Commissioner turnover is reportedly common, and when a key advocate leaves, LEROs may lose access, connections or funding. This fragility has prompted some LEROs to diversify their funding streams (through grants, adopting social enterprise models, or partnering with other organisations) in an effort to reduce reliance on any single individual or institution. Others have partnered with treatment services to secure subcontracted funding, but this was felt to come at the cost of autonomy. LEROs in these arrangements often report limited access to commissioners, reduced visibility in strategic decision making and difficulty obtaining the information needed to plan and advocate effectively.

These challenges are compounded by the difficulty many LEROs face in evidencing their impact. While some are actively collecting data or commissioning evaluations, others are hesitant to adopt formal monitoring practices, fearing that key performance indicators (KPIs) and a culture of what can feel like surveillance may undermine their ethos or alienate people from engaging in support. This reluctance by some LEROs to collect or present data can limit the visibility of LERO contributions in formal decision-making spaces, where commissioners often rely on measurable outcomes to justify funding and strategic inclusion. Taken together, these findings suggest that LEROs need more than ad hoc support or informal recognition. A strategic approach to integration must include mechanisms for formal recognition that are not dependent on individual

relationships and must be underpinned by a shared understanding of the value of lived experience – even if that value is expressed through theory or qualitative evidence rather than conventional metrics. Without this, LEROs risk being marginalised, misunderstood or excluded from the systems they are meant to help transform.

4.3. Understanding how values and beliefs regarding lived experience and approaches to recovery influence working with LEROs

The integration of LEROs into treatment and recovery systems is shaped not just by structural or financial systems. This evaluation found that relational connections between staff across LEROs, treatment services and commissioning bodies are among the most critical indicators of successful integration. While physical co-location can support integration of LEROs into systems of care, success depends on a combination of adequate space, mutual respect and understanding between organisational cultures, and clear boundaries. Where these conditions are met, co-location can foster strong lateral relationships and improve service integration. Where they are absent, it can reinforce mistrust, limit flexibility and undermine the LERO's core ethos.

Where staff across organisations shared a clear understanding of the LERO's role and viewed lived experience as a legitimate and complementary form of expertise, collaboration was more likely to succeed, regardless of physical co-location. However, even in areas with strong commissioner support, integration faltered when treatment staff were sceptical of the LERO model, or when LERO staff felt marginalised or misunderstood. This suggests that buy-in must occur at every level: individual champions are important, but sustainable integration requires investment in time to build understanding and relationships across entire teams.

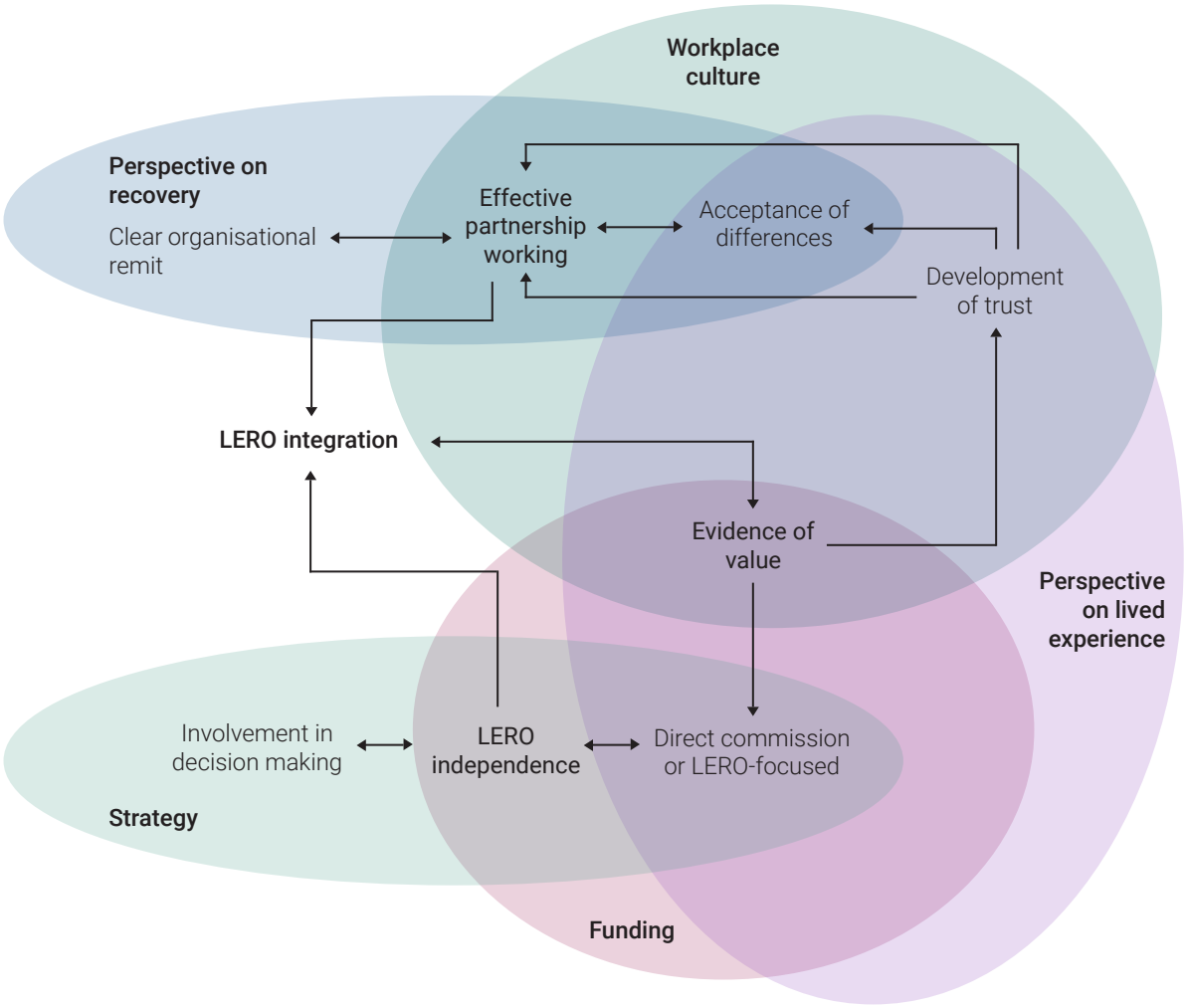
Equally, clarity of role and remit emerged as a key facilitator. This builds on the wider literature on peer support workers embedded within treatment services, which suggest that their integration into these environments can be hampered by unclear job descriptions and roles (du Plessis et al. 2020; Mahon 2025; Bell, Hagaman, et al. 2025; Bell, Tillson, et al. 2025) and that there is a widespread lack of understanding of the role of peers within the sector (Piatkowski et al. 2025). Our findings suggest that this clarity is important at an organisational and not just individual level: LEROs that maintained a distinct identity (even when co-located with treatment services or deeply embedded in service delivery) were better able to navigate tensions and assert their value. Where boundaries blurred too far, LERO staff reported feeling subsumed or tokenised, undermining their ethos and autonomy. Equally, it is important to recognise that some members of the workforce experience conflict regarding their colleagues' understanding of and approach to treatment and recovery. The positioning of harm reduction and abstinence as opposing philosophies has been explored in the literature (Kalk et al. 2018), as has the contestation of the concept of 'recovery' – which might be interpreted as open-ended and self-determined, or more narrowly equated with abstinence (Neale et al. 2015; Paylor et al. 2012; Neale et al. 2014). This oppositional view is present in reports from some participants: where multiple approaches to recovery exist in one

area and these differing approaches were not recognised as equally valid, lateral relationships were unlikely to form, and stigma and mistrust were evident.

These findings suggest that integration is not simply a structural or strategic challenge, but a relational one. Systems that invest in building shared understanding, clarifying roles and fostering mutual respect are more likely to create collaborative environments where LEROs can contribute meaningfully.

4.4. Key facilitators for supporting, commissioning and working with LEROs in effective systems of care

Figure 8: Simplified causal loop diagram highlighting key positive links that support integration of LEROs with local treatment and recovery systems



Source: RAND Europe.

Across diverse systems and models, several facilitators emerged that supported the meaningful involvement of LEROs in treatment and recovery systems. As Figure 8 illustrates, these facilitators can interact and reinforce each other, with improvements in one area potentially generating momentum across the system.

Clarity around the remit and role of LEROs has helped reduce friction and support joint working. When staff at treatment providers and LEROs understood each other's purpose and boundaries, they were better able to collaborate – even when their philosophies of recovery differed. This clarity would also help commissioners distinguish authentic LEROs from organisations adopting the label for strategic gain, support more targeted funding decisions, and enable areas to invest in creating a LERO that would be accepted as legitimate. In areas without a LERO, commissioners and treatment providers often expressed uncertainty about how to support the development of one, particularly when the peer-led ethos conflicted with top-down approaches. Clear guidance on governance, infrastructure and start-up support was identified as a potential enabler.

Ring-fenced allocations for LEROs and direct commissioning both enabled LEROs to maintain autonomy and stability in local areas. While enabling LEROs to diversify their funding streams could also be useful, the process of finding and applying for grants could stretch LERO staff capacity and skills and cause frequent changes in the activities being offered by the LERO. More stable funding, on the other hand, enabled more consistent service delivery, which in turn, built trust with treatment providers and commissioners, which could support further integration and investment in the future.

Strategic involvement of LEROs in governance and decision-making structures enabled system-wide integration. Where LEROs had direct access to commissioners, were included in multi-agency forums, or participated in joint planning, they were more likely to influence service design and funding priorities. This was more likely to be possible when the LERO was directly funded, or had been given ring-fenced funding, by the commissioner. Otherwise, relationships between LEROs and commissioners were often strong, but tended to rely on individuals who could leave their role, highlighting the need for formalised structures to embed lived experience in local systems.

Recognition and appreciation for diverse organisational values between LEROs and treatment services supported collaboration, particularly when organisations shared physical space. Co-location was most effective when accompanied by mutual respect, adequate space and shared values. In these cases, informal communication and real-time referrals were easier, and staff described stronger relationships. Where LERO staff were embedded in local systems over time, their contributions became more visible and valued. Long-standing relationships were often key to overcoming initial scepticism and building trust.

Evidence for the value of LEROs in effective systems of care for people who use alcohol and/or other drugs may help LEROs to develop further and improve engagement with treatment providers and commissioners. Some LEROs reported that collecting data on their work was beneficial for supporting their organisation, but others were hesitant to engage in formal data collection activities. This is partly due to concerns that doing so may impede engagement with people who use their services, but also to a lack of support and guidance in terms of how to conduct monitoring and evaluation work.

Chapter 5.
Strengths and weaknesses

5.1. Strengths

This study is part of the first independent evaluation of the Treatment and Recovery Portfolio funding – a comprehensive large-scale project which involved a large amount of data collection, including the perspectives of a wide range of stakeholders.

Variation amongst the ten case study sites selected across England – in dimensions that include level of funding and grants received, geography, level of deprivation, types of interventions delivered (including both LERO presence and absence) and provider type (with both NHS and a range of third sector organisations included) – enabled us to capture a broad spectrum of experiences and implementation contexts.

This is also a study of a truly under-researched area of the treatment and recovery system in England and provides the first evaluation of the integration and creation of LEROs in systems of care.

5.2. Weaknesses

The ten areas that agreed to be case study sites in Phase 2 may not be typical of other areas who were not approached or declined the offer to be part of the research.

In Phase 1, OHID and the study team invited all LEROs for which contact details were available to participate in the research. The 25 LEROs that were interviewed represent all those that responded, but their views may not be representative of all LEROs in England. Moreover, by November 2025 OHID was aware of 60 LEROs. This increase is partly due to greater knowledge of existing LERO provision and partly to new LEROs emerging. We can conclude that some existing LEROs were not approached to participate in this research.

The LERO census undertaken to inform this evaluation was based on publicly available information and supplemented by interviews with LERO leads. While this approach enabled a broad mapping of LERO activity across England, it had several limitations. Firstly, the census relied on the availability of contact details and online presence, which may have excluded smaller or less formalised LEROs. Secondly, the accuracy of the data depended on LERO leads' willingness and ability to validate the information provided. Not all LERO leads responded to requests for validation, and some may have interpreted questions differently, leading to

inconsistencies in the data. As such, the census may not fully capture the diversity or scope of LERO activity in England.

The network analysis of LERO-to-LERO relationships was constructed using data from websites, interviews and survey responses. While this provided valuable insights into patterns of collaboration and support, the analysis is limited by incomplete validation. Not all LERO leads confirmed their connections, and informal or ad hoc relationships may not have been captured. The network map therefore reflects formal or publicly acknowledged relationships, rather than the full extent of peer support or strategic collaboration. Additionally, the absence of connections in the network should not be interpreted as isolation, as some LEROs may engage in informal support or participate in broader networks not captured by this methodology.

More individuals in leadership positions within LEROs were interviewed than LERO staff members, particularly in Phase 1 which focused on engaging a breadth of LERO leads. These voices may not be representative of the wider membership, which may limit our ability to assess whether positive accounts of LEROs' integration into local treatment and recovery systems are shared more broadly.

Chapter 6.
Recommendations

- **Central government should work with CLERO and existing LEROs to refine and disseminate clear messaging about what constitutes a LERO and what these organisations can contribute to the treatment and recovery system.** This will help address scepticism about the LERO model and the role and value of lived experience in treatment and recovery systems, promote a shared understanding across services and communities, and support more targeted and informed investment by commissioners.
- **Central government should continue to work with local authorities to design and implement targeted support for areas seeking to establish a grassroots LERO, including guidance on governance structures, access to start-up funding, and provision of infrastructure and physical space**. This may also involve CLERO as well as consideration of how to facilitate networking and support within the LERO community, or to promote support from local voluntary and community sector organisations. This would help areas without a recovery community, or those with emerging LEROs, to build sustainable, locally rooted organisations.
- **Central government and local authorities should develop funding strategies to provide focused, longer-term investment in LEROs.** This would solidify and emphasise top-down support and commitment to integrating LEROs into systems of care. Longer-term funding would also enable consistent service delivery, support staff retention, and build trust with commissioners and treatment providers – laying the foundation for deeper integration.
- **Local authorities should support the inclusion of LEROs in local governance and decision-making structures, ensuring that lived experience is embedded in strategic planning.** This would reduce reliance on individual relationships and promote system-wide integration.

- **Local authorities should foster mutual respect and constructive collaboration between LEROs and treatment services, recognising the value of diverse organisational approaches to recovery.** This could include supporting co-location arrangements with adequate space, and embedding LERO staff in local systems through – over time – physical placements in treatment services or integration into local planning structures. This approach would help build trust, improve collaboration, and make LERO contributions more visible and valued.
- **LEROs should collect and share information about what they contribute to the treatment and recovery system.** This could include qualitative measures such as collecting stories, testimonials or creative outputs (such as written, spoken or visual art pieces) from people who have been or are being supported by LEROs, thus illustrating how and why these organisations make a difference, as well as quantitative measures of impact that are relevant to their aims. This would help LEROs to demonstrate their impact and value in ways that are meaningful to their communities and accessible to commissioners and other stakeholders.

References

Aslan, Laura, Thomas James Parkman & Nina Skagerlind. 2016. 'An Evaluation of the Mutual Aid Facilitation Sessions Pilot Program, "You Do the MAFS".' *Journal of Groups in Addiction & Recovery* 11(2): 109–24. doi: 10.1080/1556035X.2016.1153441

BAC-IN. 2019. 'About.' BAC-IN 2Life Recovery. As of 10 March 2026: https://www.bac-in.org/about

Beek, Alexandra van, Janya McCalman & Vicki Saunders. 2025. 'Making Systems Thinking Accessible for Qualitative Researchers: A Primer on Systems Thinking and Introducing Inductive Systemic Analysis.' *International Journal of Qualitative Methods* 24(June). doi: 10.1177/16094069251348546

Bell, Justin S., Angela Hagaman, Justin Beattey, Gina Fears, William L. White & Dennis P. Watson. 2025. 'Advancing Peer Support Workforce Research: Insights and Recommendations through the Lens of Professionalization.' *Journal of Substance Use and Addiction Treatment* 170(March): 209612. doi: 10.1016/j.josat.2024.209612

Bell, Justin S., Martha Tillson, Morgan S. Anvari, Daniel M. Blonigen, Mark McGovern & Jessica F. Magidson. 2025. 'Implementation Factors Influencing Peer-Delivered Behavioral Evidence-Based Interventions for Substance Use Disorders: A Scoping Review.' *Administration and Policy in Mental Health and Mental Health Services Research.* doi: 10.1007/s10488-025-01470-x

Best, David. 2019. 'What We Know about Recovery, Desistance and Reintegration.' In *Pathways to Recovery and Desistance: The Role of the Social Contagion of Hope*. Bristol University Press. doi: 10.2307/j.ctvpwhfpp.6

Best, David, David Higham, Ged Pickersgill, Kerrie Higham, Richard Hancock & Theresa Critchlow. 2020. 'Building Recovery Capital through Community Engagement: A Hub and Spoke Model for Peer-Based Recovery Support Services in England.' *Alcoholism Treatment Quarterly* 39(1): 3–15.

Best, David, & Jo-Hanna Ivers. 2021. 'Inkspots and Ice Cream Cones: A Model of Recovery Contagion and Growth.' *Addiction Research & Theory* 30(3): 155–61.

Black, Carol. 2021. *Review of Drugs Part Two: Prevention, Treatment, and Recovery*. HM Government, Home Office. As of 10 March 2026: https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

Buck, Gillian, Emma Pratt, Peter Yarwood, Victoria Arnold & Sarah O'Mara. 2025. 'Coproducing Recovery with People Affected by Substance Use and Criminalization.' *British Journal of Social Work* 55(3): 1015–40. doi: 10.1093/bjsw/bcae167

Build on Belief. 2018. 'A History of Build on Belief.' As of 10 March 2026: https://www.buildonbelief.org.uk/Pages/Category/our-story

CLERO. 2022. 'About the College of Lived Experience Recovery Organisations.' As of 10 March 2026: https://www.clero.co.uk

———. 2024. 'National LERO Standards.' As of 10 March 2026: https://www.clero.co.uk/post/clero-standards

———. 2025. 'LERO Masterclasses.' As of 10 March 2026: https://www.clero.co.uk/lero-masterclasses

Csárdi, G., & T. Nepusz. 2026. 'The Igraph Software Package for Complex Network Research.' *InterJournal, Complex Systems* 1695 (2006). As of 10 March 2026: https://igraph.org

Csárdi, G., T. Nepusz, V. Traag, et al. 2025. *Igraph: Network Analysis and Visualization in R.* V. 2.1.4. Released.

Damschroder, Laura J., Caitlin M. Reardon, Marilla A. Opra Widerquist & Julie Lowery. 2022a. 'Conceptualizing Outcomes for Use with the Consolidated Framework for Implementation Research (CFIR): The CFIR Outcomes Addendum.' *Implementation Science* 17(1): 7. doi: 10.1186/s13012-021-01181-5

Damschroder, Laura J., Caitlin M. Reardon, Marilla A. Opra Widerquist & Julie Lowery. 2022b. 'The Updated Consolidated Framework for Implementation Research Based on User Feedback.' *Implementation Science* 17(1): 75. doi: 10.1186/s13012-022-01245-0

DATUS (Home page). 2022. As of 10 March 2026: https://www.datus.org.uk/

Day, Ed, Rosemary Wall, Gagandeep Chohan & Jennifer Seddon. 2015. 'Perceptions of Professional Drug Treatment Staff in England about Client Barriers to Narcotics Anonymous Attendance.' *Addiction Research & Theory* 23(3): 223–30. doi: 10.3109/16066359.2014.976205

DHSC. 2024. 'Tender: DHSC:OHID:LERO Capacity-Building.' Find a Tender, 8 May. As of 10 March 2026: https://www.find-tender.service.gov.uk/Notice/017472-2024

Eddie, David, Lauren Hoffman, Corrie Vilsaint, et al. 2019. 'Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching.' *Frontiers in Psychology* 10. As of 10 March 2026: https://www.frontiersin.org/articles/10.3389/fpsyg.2019.01052

Hennessy, Emily A. 2017. 'Recovery Capital: A Systematic Review of the Literature.' *Addiction Research & Theory* 25(5): 349–60. doi: 10.1080/16066359.2017.1297990

Home Office. 2024. *Guidance for Local Delivery Partners (Accessible Version).* As of 10 March 2026: https://www.gov.uk/government/publications/drugs-strategy-guidance-for-local-delivery-partners/guidance-for-local-delivery-partners-accessible-version

Humphreys, Gabrielle, & Natalie Finch. 2025. 'Experiences of a Lived Experience Recovery Organisation for Those in Abstinence-Based Substance Use Recovery: A Thematic Analysis.' *Substance Abuse Treatment, Prevention, and Policy* 20(1): 41. doi: 10.1186/s13011-025-00671-9

Kalk, Nicola J., J. Roy Robertson, Brian Kidd, et al. 2018. 'Treatment and Intervention for Opiate Dependence in the United Kingdom: Lessons from Triumph and Failure.' *European Journal on Criminal Policy and Research* 24(2): 183–200. doi: 10.1007/s10610-017-9364-z

Kiekens, Anneleen, Bernadette Dierckx de Casterlé & Anne-Mieke Vandamme. 2022. 'Qualitative Systems Mapping for Complex Public Health Problems: A Practical Guide.' *PLoS ONE* 17(2). doi: 10.1371/journal.pone.0264463

Leamy, Mary, Victoria Bird, Clair Le Boutillier, Julie Williams & Mike Slade. 2011. 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis.' *British Journal of Psychiatry* 199(6): 445–52. doi: 10.1192/bjp.bp.110.083733

Lopez Gaston, Romina S., David Best, Ed Day & William White. 2010. 'Perceptions of 12-Step Interventions Among UK Substance-Misuse Patients Attending Residential Inpatient Treatment in a UK Treatment Setting.' *Journal of Groups in Addiction & Recovery* 5(3–4): 306–23. doi: 10.1080/1556035X.2010.523371

Luke, Douglas A., Byron J. Powell & Alejandra Paniagua-Avila. 2024. 'Bridges and Mechanisms: Integrating Systems Science Thinking into Implementation Research.' *Annual Review of Public Health* 45(1): 7–25. doi: 10.1146/annurev-publhealth-060922-040205

Mahon, Daryl. 2025. 'Umbrella Review of Systematic Reviews of Peer Support in Substance Use Settings.' *Mental Health and Social Inclusion.* doi: 10.1108/MHSI-01-2025-0002

McGill, Elizabeth, Vanessa Er, Tarra Penney, et al. 2021. 'Evaluation of Public Health Interventions from a Complex Systems Perspective: A Research Methods Review.' *Social Science & Medicine* 272(March): 113697. doi: 10.1016/j.socscimed.2021.113697

Miler, Joanna Astrid, Hannah Carver, Wendy Masterton, et al. 2021. 'What Treatment and Services Are Effective for People Who Are Homeless and Use Drugs? A Systematic "Review of Reviews".' *PLoS ONE* 16(7): e0254729. doi: 10.1371/journal.pone.0254729

Neale, Joanne, Emily Finch, John Marsden, et al. 2014. 'How Should We Measure Addiction Recovery? Analysis of Service Provider Perspectives Using Online Delphi Groups.' *Drugs: Education, Prevention and Policy* 21(4): 310–23. doi: 10.3109/09687637.2014.918089

Neale, Joanne, Charlotte Tompkins, Carly Wheeler, et al. 2015. '"You're All Going to Hate the Word 'Recovery' by the End of This": Service Users' Views of Measuring Addiction Recovery.' *Drugs: Education, Prevention and Policy* 22(1): 26–34. doi: 10.3109/09687637.2014.947564

NHS England. 2024. 'Drug and Alcohol Treatment and Recovery Services Workforce Census.' As of 10 March 2026: https://www.hee.nhs.uk/our-work/mental-health/drug-alcohol-treatment-recovery-workforce-programme/drug-alcohol-treatment-recovery-services-workforce-census

NIHR. 2019. 'How to Disseminate Your Research.' As of 10 March 2026: https://arc-swp.nihr.ac.uk/uploads/attachments/NIHR%20Dissemination%20Guidance.pdf

NIHR. 2025. 'Mapping and Realist Evaluation of Lived Experience Recovery Organisations as Part of the Drug and Alcohol Treatment and Recovery System in England (LEROS).' NIHR Funding and Awards. As of 10 March 2026: https://www.fundingawards.nihr.ac.uk/award/NIHR174454

OHID. 2022. *Commissioning Quality Standard: Alcohol and Drug Treatment and Recovery Guidance*. England. As of 10 March 2026: https://www.gov.uk/government/publications/commissioning-quality-standard-alcohol-and-drug-services/commissioning-quality-standard-alcohol-and-drug-treatment-and-recovery-guidance

OHID. 2025a. 'Part 4: Glossary and Resources.' In *Recovery Support Services and Lived Experience Initiatives*. As of 10 March 2026: https://www.gov.uk/government/publications/recovery-support-services-and-lived-experience-initiatives/part-4-glossary-and-resources

OHID. 2025b. *Recovery Support Services and Lived Experience Initiatives.* As of 10 March 2026: https://www.gov.uk/government/publications/recovery-support-services-and-lived-experience-initiatives

Orock, Ayuk Nyakpo, & Georges Nicette. 2022. 'A Review of Literature of Peer-Based Recovery Support in Substance Abuse and the Implications for Effective Implementation in Seychelles.' *Journal of Substance Use* 27(2): 115–21. doi: 10.1080/14659891.2021.1912201

Paylor, Ian, Fiona Measham & Alison Wilson. 2012. *Social Work and Drug Use*. McGraw-Hill Education.

Piatkowski, Timothy, Emma Kill, Cameron Duff, Kailas Jenkins & Kyra Hamilton. 2025. 'Mapping the Risk Environment for Peers with Lived-Living Experience Working in the Alcohol and Other Drugs Sector in Queensland.' *International Journal of Drug Policy* 137(March): 104725. doi: 10.1016/j.drugpo.2025.104725

Plessis, Courtney du, Louise Whitaker & John Hurley. 2020. 'Peer Support Workers in Substance Abuse Treatment Services: A Systematic Review of the Literature.' *Journal of Substance Use* 25(3): 225–30. doi: 10.1080/14659891.2019.1677794

R Core Team. 2025. *R: The R Project for Statistical Computing*. R Foundation for Statistical Computing. As of 10 March 2026: https://www.r-project.org/

Smith, Justin D., Dennis H. Li & Miriam R. Rafferty. 2020. 'The Implementation Research Logic Model: A Method for Planning, Executing, Reporting, and Synthesizing Implementation Projects.' *Implementation Science* 15(1): 84. doi: 10.1186/s13012-020-01041-8

Stack, Erin, Christi Hildebran, Gillian Leichtling, et al. 2022. 'Peer Recovery Support Services Across the Continuum: In Community, Hospital, Corrections, and Treatment and Recovery Agency Settings – A Narrative Review.' *Journal of Addiction Medicine* 16(1): 93. doi: 10.1097/ADM.0000000000000810

Strang, Lucy, Katherine Morley, Beth Muldrew, et al. 2026. D-SITAR Methods Report. Santa Monica, Calif.: RAND Corporation. RR-A4735-7. As of 23 April 2026: https://www.rand.org/pubs/research_reports/RRA4735-7

Tari-Keresztes, Noemi, Noelene Armstrong, James A. Smith, Himanshu Gupta, Sam Goding & Sal-Amanda Endemann. 2023. '"You Don't Get That from Professionals": A Consumer-Led Peer Recovery Program for Families and Friends of Individuals with Alcohol and Other Drugs Use Issues in Darwin.' *International Journal of Environmental Research and Public Health* 20(8): 8. doi: 10.3390/ijerph20085514

Tracy, Kathlene, & Samantha P. Wallace. 2016. 'Benefits of Peer Support Groups in the Treatment of Addiction.' *Substance Abuse and Rehabilitation* 7(December): 143–54. doi: 10.2147/SAR.S81535

Uleman, Jeroen F., Karien Stronks, Harry Rutter, Onyebuchi A. Arah & Naja Hulvej Rod. 2024. 'Mapping Complex Public Health Problems with Causal Loop Diagrams.' *International Journal of Epidemiology* 53(4): dyae091. doi: 10.1093/ije/dyae091

Wadsworth, Elle, Maggie Bradford, Emily Hutton, et al. 2026. *Factors that influence employees' perceptions and experiences of working within the treatment and recovery sector in England.* Santa Monica, Calif.: RAND Corporation. RR-A4735-3. As of 10 March 2026: http://www.rand.org/pubs/research_reports/RRA4735-3

Wickham, H. 2016. *ggplot2: Elegant Graphics for Data Analysis*. Springer-Verlag. As of 10 March 2026: https://ggplot2.tidyverse.org