Inclusive Recovery Cities

A Civic Framework for Community Recovery

How places across the UK are rebuilding the social conditions that sustain recovery: Learning from Inclusive Recovery Cities across the UK.

Stephen Goodall

KTP Associate, Project Manager — Inclusive Recovery Cities

Recovery Connections / Leeds Trinity University / Innovate UK

Executive Summary

The Inclusive Recovery City (IRC) is a civic framework for deliberately building the community, relational, and civic conditions on which sustained recovery depends. It is not a service or a new layer of bureaucracy, it is a mechanism that brings lived experience leaders, local authorities, commissioners, employers, educators, and civic partners into coordinated relationship around a shared commitment to make recovery visible, valued, and sustainable. The model is distinguished by lived experience leadership at the centre of governance, cross-sector coordination of existing assets, active visibility to challenge stigma, and civic ownership of recovery as a shared responsibility.

Drawing on seven semi-structured interviews with strategic leaders across seven cities in England — spanning the North-East, Yorkshire, the East Midlands and the South Coast — this report sets out what an IRC is, what the cities currently engaged are achieving, and what the work requires of those who take it on. The reported outcomes operate at three connected and mutually reinforcing levels: individuals rebuild identity beyond addiction and progress into education, employment and leadership; fragmented services begin to function as a coordinated civic system; and sustained visibility shifts the public conversation from problem to contribution. The report also sets out the favourable conditions for IRCs develop from institutional support, aligned with lived experience leadership, realistic resourcing, distributed leadership and succession, to early engagement with the national network.

These findings are a research-evidenced mapping of developments, successes, and innovations rather than a critical evaluation of impact; the report adopts a strengths-based approach consistent with the model it examines, with limitations noted transparently in the methodology. The sample is small and drawn from strategic leaders involved in established sites across the UK. Within those limits, the evidence indicates that where lived experience leadership, institutional backing, and civic ambition are aligned, the IRC framework reaches well beyond the recovery sector into the wider civic fabric of a place. It is offered to local authorities, lived experience recovery organisations (LEROs), commissioners, and civic leaders considering whether the conditions are in place in their area to lead this work effectively.

Contents

1. Community-led recovery: a shared civic vision

Recovery from addiction is, fundamentally, a social process. The treatment that helps someone become well is one part of a longer journey — one that depends on the strength of the community they re-enter, the relationships they can rebuild, and the place they hold in the civic life around them (Best et al., 2026). Recovery is strongest when communities are equipped to welcome and support people: through genuine connection, purposeful opportunities, and a public culture that celebrates recovery as a civic asset (Best and Colman, 2019).This is the lived understanding of the recovery community itself, and it is increasingly supported by national policy — from the Dame Carol Black review's call for coordinated local action (Black, 2021), through Marmot principles on health equity (Marmot, 2010), to the maturing model of Recovery Oriented Systems of Care (Office for Health Improvement and Disparities, 2025). The evidence is increasingly clear; the opportunity is now to translate that understanding into a civic framework that enables coordinated local practice.

Across the UK areas already hold the key assets required for this work. People in recovery carry extraordinary lived expertise. LEROs and recovery organisations hold decades of community knowledge. There are local authorities, employers, faith groups, educators, and civic leaders who collectively can influence change but require a shared mechanism through which to do so. The capacity for change is present in almost every community. What has been needed is the framework that brings them into productive relationship.

The Inclusive Recovery City (IRC) is the social movement that can drive community led change. It is now in active development across a growing number of places in the UK, with international counterparts in Europe and beyond. More recently in England, all 12 local authority areas in the North-East have committed to becoming the first Inclusive Recovery Region, with 30 Inclusive Recovery Cities projected nationally by the end of 2026 (Best, 2025).The cities engaged are demonstrating that when these assets are coordinated under a shared civic vision, the results extend well beyond individual recovery — into family stability, community vitality, employer engagement, and reductions in drug-related harm at place level.

This report sets out what an Inclusive Recovery City is, what the cities currently engaged are achieving, and what is involved in becoming one. It is offered to local authorities, LEROs, commissioners, civic leaders, and partners seeking to understand whether the conditions are in place to lead this work effectively.

2. What is an Inclusive Recovery City?

An IRC is a civic framework through which a place commits to making recovery visible, valued, and sustainable. It brings together the people, organisations, and institutions of an area including lived experience leaders, local authorities, treatment providers, employers, educators, civic and community partners — under a shared commitment to build the social conditions in which recovery thrives.

It is not a service. It is not a programme to be commissioned. It is not a new layer of bureaucracy. It is the framework that allows the work already happening in a community to operate with greater coherence, visibility, and civic weight.

Four features distinguish the model.

Lived experience leadership

The model is built on the principle that people in recovery hold the knowledge and capability to shape the civic response to addiction. LEROs, recovery community members, and lived experience leaders are positioned at the centre of governance and decision-making as the people leading the work. This is what makes the framework distinctive from other forms of strategic coordination.

Cross-sector coordination

An IRC brings together actors who have rarely converged around recovery as a shared priority: local authorities, NHS commissioners, treatment providers, employers, universities and colleges, faith groups, criminal justice partners, housing providers, sports clubs, cultural institutions. Recovery has not typically been understood as a civic issue that touches and unites all of them, yet all are affected by and have a stake in it. The work is not to create new services but to align existing ones around a shared civic purpose, and to broaden the table to include the wider community institutions on which sustained recovery depends.

Visibility

Stigma operates by keeping recovery hidden. The IRC model reverses this — through public events, civic charters, recovery hubs and cafés, communications campaigns, Recovery Ally training, and the active presence of people in recovery in civic life. Visibility normalises recovery, allows role models to emerge, and shifts the public conversation from one of problem to one of contribution.

> *"That's the power of changing the narrative and flipping it."* — Participant F, LERO Chief Executive, established IRC

Civic ownership

The model's ambition is to reposition addiction and recovery as a shared civic responsibility that belongs to the whole community, not just to recovery services. This is why the framework includes employers, schools, sports clubs, and cultural institutions alongside the recovery sector itself. The point is to build a place in which recovery is supported by the entire civic fabric, not by a parallel system operating alongside it.

This frame also offers a practical governance consideration, in cases where those involved often bring different mandates and competing priorities, a key question emerged: "*Does this benefit the community?* (Participant D) as a practical discipline that keeps IRC activity tethered to civic purpose rather than organisational interest.

Momentum, conditions and coordinated action

The IRC model has emerged at a moment when the conditions for civic recovery work are unusually favourable. National policy is calling for coordinated local action across treatment, housing, employment, and criminal justice. The recovery community has matured into a confident civic actor with strong lived experience leadership. Local authorities are seeking frameworks that align with their statutory responsibilities while engaging the wider community. And there is a growing recognition that sustainable reductions in drug-related harm cannot be delivered by treatment services alone — they depend on the wider conditions IRCs are designed to build.

The framework is currently in active development across a growing number of places in the UK, with international counterparts across the world. The cities involved are not following a fixed template — each is adapting the model to local conditions, governance arrangements, and recovery ecosystems. They are united through a shared commitment to the principles above, and active participation in a network through which learning, infrastructure, and collective capacity are developed.

3. IRC outcomes and impact

The cities currently engaged in IRC development are producing outcomes that extend across three connected levels of community life — the individual, the institutional, and the civic. The model's distinctive value is that it works at all three simultaneously, with effects that compound across them. This section sets out what is being achieved at each level, drawing on evidence from the cities currently leading the work.

Individual outcomes: people rebuilding lives, identities, and futures

The most immediate outcomes of an IRC are visible in the lives of the people participating in the recovery community. The framework provides spaces in which individuals rebuild a sense of identity beyond their experience of addiction — recognising the strengths, skills, and contribution they hold. This identity shift is the foundation on which sustained recovery is built, and it maps directly onto the established CHIME framework of personal recovery (Leamy et al., 2011), in which Connectedness, Hope, Identity, Meaning, and Empowerment are recognised as the core dimensions through which people recover.

From this foundation, people re-engage with social and community life. They form relationships outside the recovery community itself. They take on volunteer and ambassador roles. They access training, education, and employment often beginning in lived experience capacities within LEROs and progressing into wider professional roles. They contribute to their families and communities in ways that recovery alone could not deliver, and that the wider civic life of an area could not sustain without them.

This is the strengths-based heart of the model. People in recovery are not the recipients of the work. They are its leaders, its evidence, and its primary source of civic contribution.

Institutional outcomes: systems working together with purpose

At the system level, IRCs are producing changes in how organisations engage with recovery and with each other. These are some of the most striking outcomes of the work and the ones most likely to be invisible to those outside the network.

Across the cities engaged, IRCs are functioning as the mechanism through which fragmented services and stakeholders find a shared civic purpose. Local authorities, NHS commissioners, treatment providers, employers, universities, faith groups, and community organisations begin to operate as a coordinated civic system rather than a set of parallel services. This aligns with what Kania and Kramer (2011) identified as the conditions for *collective impact* — a shared agenda, mutually reinforcing activities, continuous communication, and alignment through coordination. IRCs provide exactly this infrastructure at place level.

The model also operationalises national policy locally. The Dame Carol Black review's emphasis on coordination across treatment, housing, employment, and criminal justice partners; Marmot principles on health equity; the development of Recovery Oriented Systems of Care — these are translated into coherent local practice through the IRC framework. This makes the work durable: it is

harder to deprioritise an initiative embedded in multiple existing strategies than one operating in isolation.

> *"A proper joined-up partnership approach between the different organisations, but widening the membership of those organisations."* — Participant E, Charity CEO, established IRC

Civic outcomes: places where recovery is part of the shared identity

The most ambitious outcomes of the IRC model operate at the civic level — at the scale of how a place understands itself and how it represents recovery to its own population and to the wider world.

The cities engaged in IRC development are challenging stigma actively and structurally. Recovery is being made visible through public events, civic charters, recovery walks, hubs and cafés, and the active presence of people in recovery in civic life. The public conversation begins to shift from one of problem to one of contribution. Communities that may previously have associated addiction with shame, deficit, or risk begin to associate recovery with strength, leadership, and civic value. This is not a marketing campaign — it is the cumulative effect of sustained visibility over time, led by people in recovery themselves.

This civic dimension echoes the principles of asset-based community development (Kretzmann and McKnight, 1996), in which communities are understood and engaged through the strengths and capacities they hold rather than the problems they face. IRCs apply this orientation specifically to recovery, building on the recovery capital framework (Cloud and Granfield, 2008; Best et al., 2026) which positions community resources, relationships, and civic engagement as the primary drivers of sustained recovery. The model is, in this sense, the practical operationalisation of a strengths-based theory of recovery at the scale of place.

The ripple effect

The outcomes described above do not operate in isolation. They reinforce one another, and their cumulative reach extends well beyond the recovery sector itself.

Individual recovery affects families. Stronger families strengthen communities. Strengthened communities reduce demand on health services, justice systems, social care, and employment support. Visible recovery shifts civic culture, which in turn changes the conditions under which the next person enters recovery. The model's outcomes compound across systems in ways that single-service interventions cannot replicate.

This is the strategic argument for IRC investment. The framework reaches across health and wellbeing, justice, social services, employment, education, and economic systems. Its benefits accrue not only to the people directly engaged in recovery, but to the whole civic fabric of the place in which the work takes hold.

> *"It's everybody's business because everybody benefits."* — Participant F, LERO Chief Executive, established IRC

The case for a new approach

The IRC model is, at its core, a civic response to drug-related harm and the loss of life it produces.

According to the Office for National Statistics (ONS, 2025), the rate of drug-related poisoning deaths in England and Wales has now doubled since 2012 and has risen every year since (46.5 to 93.0 deaths per million). These continual increases expose the limits of the current responses to the issue and require new innovative approaches. Sustained reductions in drug and alcohol-related deaths depend on the wider conditions IRCs are designed to build: the connected communities, supportive employers, engaged civic institutions, and shared cultural recognition that allow recovery to take hold and last.

What emerged from this research was the public health imperative to *"tackle head-on the number of drug-related deaths"* (Participant E). This is the test against which the work is ultimately measured - a clear reduction in drug and alcohol related deaths. It is a question that local authorities, commissioners, and civic leaders considering this work should hold themselves accountable to: *what would it take for our area to address drug-related harm not as an isolated service problem, but as a shared civic responsibility?*

4. Successes and innovations

The IRC framework is realised within the work of the people and organisations delivering it on the ground. Across the cities engaged in this report, participants described specific successes their areas have achieved and innovations they have developed in deploying the model. This section shares those examples directly, organised around the kinds of change that the initiative is producing. It is important to note that the IRC has not always created this work, but it has recognised, connected and amplified what was already happening.

The examples below are real, tangible, and provided by the participants in this research. They are provided to illustrate the possibilities when a place commits to this work, not intended as a template to be copied but to open up thinking on what could happen in other areas.

Successes: what cities are achieving

Making recovery visible and productive in everyday life

Across the cities engaged, IRCs have built a tangible, productive recovery presence in shared civic space as a civic contribution. Across several areas, LEROs have used a coffee bike to offer free coffee as a low barrier point of community contact. In one area, IRC partners have launched a co-branded coffee bike under a single unified campaign, alongside a recovery sculpture installed in a prominent area of the city as a public symbol of hope and encouragement (Participant C). In another, recovery cafés operate as visible high-street presences that both generate income and improve local public space (Participant F). In a third, a city-wide walking group emerged from IRC partnership meetings and is now self-sustaining, drawing in residents who are not themselves in recovery (Participant G). Litter-picking initiatives in another IRC make recovery visible through environmental contribution, with people in recovery being physically present in the community "carrying a message of hope" (Participant A).

What unites these examples is a deliberate reframing, separating recovery from its association with addiction and presenting it as something communities gain by embracing. Recovery should not be considered as a problem, but the solution. When recovery is visible and shifts community beliefs regarding what is possible hope spreads through proximity. The kinds of community building activities mentioned can generate the social contagion of recovery (Best and Ivers, 2022), enabling the conditions for recovery to be supported for the benefit of all.

Shifting how major institutions think and act

Several IRCs are producing change in the institutional partners around them by making the case so visibly that institutions begin to act differently. In one early-adopter area, the NHS has begun to redirect resources from treatment toward recovery support, with the local NHS population health team now asking the IRC directly how to invest in recovery (Participant E). In the same area, education providers are delivering accredited courses in community recovery settings rather than only in formal institutions (which are often perceived as exclusionary by those in recovery) and meeting people where they are, producing routes into mainstream learning.

In another city, the IRC became the vehicle through which Public Health England recovery priorities were operationalised locally (Participant G). Elsewhere, the IRC has been formally embedded within the local authority's Marmot principles work, locking recovery into the health equity agenda (Participant D). Civic leaders are being drawn into the work through cultural activity. Art galleries and cultural venues are emerging as effective sites of engagement, carrying civic weight, while reducing the distance between those in recovery and those that make decisions. In one area, an art exhibition created by people in recovery engaged council leaders and commissioners directly, building relationships that would have been unlikely in more conventional engagements (Participant D).

Transforming workplaces and employer culture

IRCs are reshaping how employers relate to addiction and recovery, with concrete results inside specific organisations. Working with an engineering business, one LERO has demonstrated how Recovery Ally training shifts workplace culture from punitive to supportive and gives employees permission to ask for help. In one organisation that signed up to the work, the first two people to come forward asking for support were managers, an outcome that illustrates the scale of hidden recovery need within ordinary workforces (Participant F). The same IRC supported national health and beauty retailer to fundamentally reframe its response to shoplifting moving from a punitive stance toward an attempt to understand the underlying factors of addiction in the people involved (Participant F). Across multiple cities, Recovery Ally training is being delivered to private, public, and third-sector employers as a CPD-accredited package, opening conversations about recovery across sectors that would not otherwise engage with the topic (Participants F and G).

> **What is Recovery Ally Training?**
>
> Recovery Ally training is a CPD accredited workshop designed to equip people with the knowledge and confidence to support those impacted by addiction. Delivered by people with lived experience of drug and alcohol addiction, challenging common perceptions, and explaining the realities of a successful recovery journey.

Growing lived experience leadership and workforce

In one early-adopter area, a lived experience drug and alcohol team has grown from 2.5 staff to 20 over the course of the IRCs development — a concrete illustration of how civic visibility translates over time into structural change in commissioning (Participant E). The same area has built a Recovery Hub in which the principle is explicit: no one is employed or volunteers in the hub who is not themselves in recovery (Participant E). In another city, hope ambassadors recruited from the recovery community move from voluntary contribution into recognised roles, with the IRC actively framed as an opportunity provider rather than a service (Participant A). Across the network, IRCs are providing the platform for those in the recovery community to take up genuine civic leadership positions, with real influence over long-term change and decision making. This is an important distinction as multiple participants identified tokenistic inclusion as a persistent risk and a lived experience of prior engagement. IRC governance aims to make lived experience leadership a normality, rather than an exception.

Innovations: how cities are deploying the framework

Participants also described innovations in how the IRC framework is deployed — distinctive ways of working that demonstrate the creative range of the model. As one participant observed, what counts as innovation is context-dependent: practice that is standard in one setting may be genuinely novel in another. The examples below are offered in that spirit.

A bottom-up citizen pledge model

Rather than framing the IRC as a civic charter signed by leaders at the top, one IRC has built it as a campaign in which every citizen, business, and group can pledge support. The approach inverts the conventional hierarchy and builds legitimacy from the ground up. As Participant B described it: *"flipping it on its head — rather than someone at the top pledges, everyone gets the opportunity to pledge."* This is paired with an online recovery directory and a public-facing IRC toolkit — a low-cost, scalable set of fact sheets and guidance that turns the IRC framework into practical resources residents can use directly.

A for-profit social enterprise driver

In one area, a LERO operating within the IRC has developed a profit-for-purpose social enterprise model, working alongside a treatment provider to generate sustainable income in support of recovery-focused community activity. This LERO is generating an income, employing people in recovery, and reducing dependence on commissioned funding. The enterprise has produced a tangible consumer product and used inventive public-facing campaigns to drive visibility, including a high-profile product tour. The same participant is now developing a national LERO accelerator model to support other organisations to build similar financial sustainability (Participant A).

Locking value-based rules into commissioned services

In another area, the development of the local Recovery Hub has been used to embed structural principles into commissioned provision including the requirement that all staff and volunteers within the hub are themselves in recovery. The same approach has also been used in prison-leaving services, utilising people with experience of leaving prison. This is a distinctive innovation that uses the IRC infrastructure to lock value-based commitments at the design stage of developing statutory services (Participant E).

Recovery Ally training as a shared network asset

Recovery Ally training was developed within one IRC and has been shared at low cost across LEROs and IRCs nationally. It is now functioning as both a door-opener for engaging sectors that might not otherwise come to the table, and as a piece of shared infrastructure that strengthens the work across all participating cities. This is one of the clearest examples of the IRC network operating as a collective rather than a set of parallel initiatives as innovative practices are shared rather than protected (Participants F and G).

Small-scale, high-trust visibility

Some of the most generative innovations are the simplest. In one area, the first IRC event was a community coffee morning at which free coffee was donated by independent local shops — generosity that larger providers would not have offered, and that gave the initiative goodwill from its inception (Participant D). This points to a wider pattern: small, locally rooted IRC activity often generates the kind of community trust that larger, better-resourced initiatives struggle to access.

Unique, distinctive and place-based contributions

These successes and innovations are not solely down to the IRC framework, they are the achievements of the people, organisations, and communities who have committed to the work in partnership. They demonstrate what becomes possible when lived experience leadership, institutional backing, and civic ambition are brought into alignment.

They also illustrate that no two IRCs look the same. The framework provides the civic infrastructure; what each city builds within that infrastructure reflects its own assets, ambitions, and creativity. This is one of the most generative features of the model. Across the network cities were not adopting an imposed and rigid framework, but an adaptable model with a relational approach that supports distinct, localised work that each area is ready to undertake.

5. The conditions that enable IRCs to thrive

IRCs are consequential, demanding and long-term civic commitments. Challenging civic work succeeds when the conditions for it are built in deliberately from the beginning. It is also important to note that they sit within a crowded macro-environment, with local authorities, statutory and voluntary sector partners operating in a post-austerity climate navigating funding pressures and multiple competing priorities with limited resources (Clifford, 2017; Clifford and Morphet, 2023). What the existing network demonstrates however is these pressures should not be prohibitive. While the cities leading IRC development have not avoided challenges, they are unique in that they are sustained through community relationships and not wholly dependent upon any single institutional commitment. They have recognised what the work requires, prepared accordingly, and built the conditions for sustained progress into the foundation of their initiatives.

The research underpinning this report has identified enabling conditions which enable the model to develop and thrive.

Institutional backing alongside lived experience leadership

The strongest IRCs combine two sources of legitimacy: the community authority of lived experience leadership, and the strategic backing of commissioners, local authorities, and senior civic partners. Neither operates well in isolation. Lived experience leadership without institutional backing struggles to access the resources, partnerships, and platforms that civic work requires. Institutional backing without lived experience leadership produces coordination but loses the distinctive contribution of the model.

What the most effective IRCs have done is align these two sources of authority from the start — establishing clear lived experience leadership at the centre, with active commissioner and civic leadership support around it. This alignment is the single strongest predictor of pace and reach in the cities currently engaged.

For areas considering the model, this is one of the most useful early conversations to have. Securing the institutional backing of commissioners and civic leaders early, alongside the leadership of LEROs and recovery community members, creates the conditions in which everything else becomes possible.

Honest resourcing for the work involved

IRCs are often described as low-cost relative to commissioning a new service — and in one sense this is accurate, because the model does not require new service infrastructure. But this description can understate the real resource needed to sustain civic mobilisation across multiple organisations.

The cities furthest along the work have approached resourcing honestly from the outset. They have funded the staff time required to convene partnerships, organise civic events, build communications, and hold governance together. They have recognised that the lived experience leaders, LEROs, and partner organisations doing this work are providing significant resources and have built the financial conditions that allow that contribution to be sustained.

This is a learnable lesson for new cities. Costing the work honestly from the start and securing the modest but real resourcing it requires is what allows IRCs to operate as serious civic initiatives rather than goodwill projects sustained by the people least able to absorb the cost. It is also worth noting that this does not and while financial investment helps implementing the initiative should not require large-scale investment from the outset (such as the coffee morning referenced in the previous section). Most IRC initiatives have started small and developed with purpose, this can enable the resourcing to grow in line with impact.

Distributed leadership and active succession

The IRC model is designed to distribute responsibility for recovery across a wide civic base. In practice, this is a discipline that needs to be built actively into how the work is organised.

The cities leading IRC development should seek to share responsibility across multiple individuals at each level, central coordination, local delivery, and community participation rather than allowing the work to concentrate in a small number of people. It is vital to invest in succession planning, in the documentation of relationships and knowledge as collective assets, and in the deliberate development of new leaders at all levels of the recovery community.

This is one of the network's clearest strengths, as the IRC model is built on the leadership of people in recovery, the active development of that leadership is a primary consideration of the work. It has the potential to become one of the most generative aspects of the model: every IRC develops the next generation of civic leaders from within the recovery community it serves.

Visibility infrastructure

The IRC model depends on visibility making recovery present, valued, and recognisable in civic life. The cities furthest along the work have built the communications and visibility infrastructure that this requires: shared messaging, public-facing events, recovery directories, civic charters, and consistent presence across digital and physical channels.

A practical learning from established sites is the value of engaging institutional partners — local authorities, NHS trusts, universities and employers — not just as stakeholders but as communications channels. These organisations carry reach that LEROs cannot easily replicate and while it can be challenging to compete for space via their communications channels, building relationships that allow partners to carry the message can extend visibility into networks and audiences outside of the reach of one organisation alone. The national network can support new cities in developing their presence, sharing learning from sites that have encountered similar previous challenges and provide materials that support enhanced visibility of recovery in new settings.

Engaging with the network from the start

The IRC movement now spans multiple cities in the UK and internationally. Most challenges new cities encounter have been navigated elsewhere, often within the past two years. Participants consistently

described the value of attending events in other cities, sharing learning across sites, and contributing to the collective picture of how the model is developing.

For new cities, this is more than peer support. The national network is the mechanism through which the model itself is maturing — refining what works, identifying what does not, and developing the shared infrastructure no single city can build alone. New cities benefit from this work, and they should expect to contribute to it as they develop. The network is not a resource to consume; it is a collective project to participate in.

6. Future direction of the IRC movement

The Inclusive Recovery City movement is at one of its most exciting moments. In just a few years, the model has moved from a single city to a growing national and international network. The pace of development is visible in concrete ways including the author's participation in a Knowledge Transfer Partnership currently underway between Recovery Connections, Leeds Trinity University, and Innovate UK, dedicated to advancing the development and sustainability of Inclusive Recovery Cities across the North-East (Leeds Trinity University, 2024). The involvement of university research capacity and national innovation funding signals a transformation in the initiative from a grassroots civic initiative into an evidence generating approach with potential for systematic development and replication.

The cities engaged in this research are demonstrating what becomes possible when societal actors unite around the cause of recovery. Emerging peer reviewed research is beginning to document the pattern. A study of Middlesbrough as a model IRC showcases measurable growth in recovery community assets, substantial increases in digital visibility and rising participation in public facing events (Best et al., 2025). This report has brought to the surface the transformations that can occur on an individual level, rebuilding identity, re-engaging with society and sustaining recovery through access to opportunities and employment. On an institutional level, it is responsible for coordinating often fragmented systems and enhancing partnership working. On the societal level the work is reframing the narrative around recovery, tackling stigma and positions recovery as a solution to a significant public health issue.

This report is evidences the work of lived experience leaders, LEROs, local authorities, commissioners and civic partners developing and refining the IRC model over time. The national network is operating collectively, sharing what works, supporting newer cities and developing the empirical base of the model.

Several opportunities are now opening for those engaged in the network:

Broadening employment and enterprise pathways

Cities are working to open routes into mainstream professions, self-employment, and careers that may once have seemed out of reach for people in recovery. This is one of the areas where partnership between IRCs, employers, education providers, and enterprise infrastructure has the greatest potential, and where collective work across the network is likely to yield more significant results than any single city can achieve alone.

Strengthening collective capacity

From this research it was clear that when a city hosts an event or opens its doors to peers, more cities are drawn in, a contagion effect that reflects how the IRC movement spreads. Established IRCs are increasingly mentoring newer ones, sharing templates and resources, and contributing to practical guidance in areas just beginning on the journey. This collective capacity is further strengthened through complementary networks such as the College of Lived Experience Recovery Organisations

(CLERO) and Collegiate Recovery networks. This collective capacity is a significant advantage of the network that further develops when new cities get on board.

Deepening evaluation and shared learning

Work is developing across the network to build shared evaluation frameworks, longitudinal evidence of outcomes, and the kind of impact narrative that supports continued investment from commissioners, funders, and civic leaders. This is collective infrastructure that benefits every city engaged.

Expanding partnership working and enabling new approaches

The model continues to engage new partners: employers, educators, faith groups, cultural institutions, sports clubs, criminal justice partners. Each new sector that joins broadens the civic foundation on which recovery rests, and each city that engages the work brings new perspectives, new ideas, and new partnerships into the wider movement.

The continued growth and development of the movement upon depends upon both new cities, with fresh commitment and local energy while established cities continue to drive their community focused approach, extending partnerships and contributing new learning to the collective. These are parallel and mutually reinforcing streams of work and are essential to building the movement.

For those reading this report, whether part of an established IRC, an area considering implementing an IRC approach, or a friend, family or community member exploring community driven recovery models, the conditions have rarely been more favourable. The IRC model is maturing, evidence is building, and the network continues to expand.

7. Methodology

This report is based on seven semi-structured interviews with individuals involved in the development or delivery of Inclusive Recovery Cities across England. Participants were purposively selected for their strategic involvement in IRC implementation, governance, or delivery. Given the small number of cities currently engaged with the model in England, the identities and locations of participating cities have been anonymised, and participants are referred to throughout as Participants A–G.

The sample reflected the principal organisational settings involved in IRC development: four leaders within LEROs; two local authority roles (one commissioning, one strategic lead for IRC development); and one representative of a charitable organisation supporting communities affected by addiction with a lived experience function. Most participants held senior leadership positions, including three Chief Executives. This was a purposive sample of selected leaders throughout the network and spanned seven cities across the North-East, Yorkshire, East Midlands and South Coast and selected for their close involvement in the strategic implementation of the IRC model. It was also balanced by gender, with four male and three female participants.

Interviews were structured around a consistent set of themes — origins and catalysts, governance and leadership, intended outcomes, sustainability and risk, and advice for emerging cities — while allowing participants to develop their own framing. Analysis was thematic, with findings organised across the three levels — individual, organisational and system, civic and cultural which emerged consistently across the dataset. Where participants described their own organisational work in response to questions about IRCs, this material was retained where it contributed to the broader civic, cross-sector, or visibility-related dimensions of the IRC framework. This reflects a structural reality in most IRC contexts: the IRC is rarely a standalone entity, but a coordinating framework layered within an existing recovery ecosystem.

Scope and limitations

Three limitations should be noted. First, the sample is small and reflects the early stage of IRC development in the UK; the findings should be read as a foundational mapping rather than a comprehensive evaluation of impact. Second, the sample is concentrated among strategic leaders — the perspectives of community members, people in recovery participating in IRC activity, employers, and civic actors outside IRC governance are not represented and remain a clear priority for subsequent research. Third, the participating cities are predominantly in established or maturing IRC contexts; the experience of cities at the earliest stages, or those that considered the model and chose not to adopt it, is not captured here. Finally, the author is directly involved in the implementation of IRCs and

recognises that their proximity to this work may shape interpretation and has been actively mitigated through reflexive analysis. It is also important to note that the report is intended to set out research backed developments, successes and innovations across the cities engaged in IRC implementation. It is not intended as a critical evaluation but adopts a strengths-based approach consistent with the model it examines.

Participants engaged voluntarily, were informed of the purpose and scope of the research and consented based on anonymised reporting. Quotations have been edited for clarity where necessary without altering meaning. Material that could compromise anonymity has been generalised or omitted.

8. Acknowledgements

Finally, this report would not exist without the generosity of the anonymised participants who gave their time, shared their experiences and spoke with honesty about the challenges and possibilities of Inclusive Recovery Cities. They provided the insight upon which this report has been built.

To the wider network of those in recovery, lived experience leaders, LERO staff, commissioners, civic partners and volunteers this report reflects your collective efforts in driving transformational change in communities. The evidence base is building and beginning to demonstrate what you have known for some time: that recovery happens in communities. The IRC movement provides the framework, network, and the visibility to turn that knowledge and shape the future direction of the field.

References

Best, D. (2025) 'Introduction', in *UK Inclusive Recovery Cities Newsletter #6*. Newsletter no. 6, November. Available at: https://sheffieldrecoverydirectory.co.uk/wp-content/uploads/2026/04/IRC-Newsletter-April-2026.pdf Accessed: 14 May 2026).

Best, D., & Colman, C. (2019). 'Let's celebrate recovery. Inclusive Cities working together to support social cohesion'. *Addiction Research & Theory*, *27*(1), 55–64. Available at: https://doi.org/10.1080/16066359

Best, D., Bryson, J., Petson, A., Smith, D., Stephenson, M., Jackson, P., Duffy, S., & Bowden, J. (2025). 'Becoming the Model Inclusive Recovery City: Building Recovery in Middlesbrough'. *Alcoholism Treatment Quarterly*, pp. 1–10. Available at: https://doi.org/10.1080/07347324

Best, D., Duffy, S., Smith, D., Bryson, J., & White, B. (2026). 'An "outside in" model of recovery capital growth: building personal and social recovery capital from community resources'. *Addiction Research & Theory*, *34*(1), pp. 1–11. https://doi.org/10.1080/16066359.2025.2523825

Best, D., & Ivers, J.H. (2022). 'Inkspots and ice cream cones: a model of recovery contagion and growth'. *Addiction Research & Theory*, *30*(3), pp. 155–161. Available at: https://doi.org/10.1080/16066359

Black, C. (2021) *Review of drugs: phase two report*. Available at: https://www.gov.uk/government/publications/review-of-drugs-phase-two-report (Accessed: 8 May 2026).

Clifford, B., & Morphet, J. (2023). 'Local authorities doing it for themselves: austerity, the direct provision of housing and changing central-local relations in England'. *Local Government Studies*, *49*(6), pp. 1218–1240. https://doi.org/10.1080/03003930.2022.2033227

Clifford, D. (2017) 'Charitable organisations, the Great Recession and the age of austerity: longitudinal evidence for England and Wales', *Journal of Social Policy*, 46(1), pp. 1–30. Available at: https://doi.org/10.1017/S0047279416000325.

Cloud, W., & Granfield, R. (2008). 'Conceptualizing Recovery Capital: Expansion of a Theoretical Construct'. *Substance Use & Misuse*, *43*(12–13), pp. 1971–1986. https://doi.org/10.1080/10826080

Kania, J. & Kramer, M. (2011) 'Collective Impact'. *Stanford social innovation review*. 9 (1), pp. 36–41. Available at: Collective Impact (Accessed: 14 May 2026)

Kretzmann, J. and McKnight, J.P. (1996) 'Assets-based community development', *National Civic Review*, 85(4), pp. 23–29. Available at: https://doi.org/10.1002/ncr.4100850405.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. and Slade, M. (2011) 'Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis', *British Journal of Psychiatry*, 199(6), pp. 445–452. https://doi:10.1192/bjp.bp.110.083733

Leeds Trinity University (2024) *University secures funding for first Knowledge Transfer Partnership with addiction recovery charity*. Available at: https://www.leedstrinity.ac.uk/news/university-secures-funding-for-first-knowledge-transfer-partnership-with-addiction-recovery-charity/ (Accessed: 15 May 2026).

Marmot, M. (2010) *Fair society, healthy lives: the Marmot Review*. Available at: https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review (Accessed: 8 May 2026).

Office for Health Improvement and Disparities (2025) *Part 3: how to develop systems of care that support recovery*. Available at: https://www.gov.uk/government/publications/recovery-support-services-and-lived-experience-initiatives/part-3-how-to-develop-systems-of-care-that-support-recovery (Accessed: 8 May 2026).

Office for National Statistics (2025) *Deaths related to drug poisoning in England and Wales: 2024 registrations*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2024registrations (Accessed: 18 May 2026).

Russell, C. (2020) *Rekindling democracy: a professional's guide to working in citizen space*. Eugene, Oregon: Cascade Books. [online]. Available from: https://ebookcentral.proquest.com/lib/leedstrinity/detail.action?docID=6318547.

Recovery Connections (2023) *Building an Inclusive Recovery City in Middlesbrough*. Available at: https://recoveryconnections.org.uk/inclusive-recovery-city/ (Accessed: 8 May 2026).