

Scottish Recovery Consortium

'Voices of Recovery' Workshop Report and Event Evaluation

March 2026

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1. Acknowledgement

SRC would like to express our thanks to Aberdeenshire ADP, the recovery communities across Aberdeenshire, and the many individuals with lived and living experience who contributed so openly and thoughtfully to this work. We are grateful to everyone who shared their time, insights, and experiences, and to the partners, volunteers, and facilitators who helped shape and support the Voices of Recovery event. Your commitment, honesty, and leadership are central to building a stronger, more inclusive recovery system for Aberdeenshire.

2. Background and Context

Scottish Recovery Consortium (SRC) is a national organisation that works with communities, organisations and partners across Scotland to support the development and implementation of Recovery-Oriented Systems of Care. Central to this work is ensuring that the voices of people and communities with lived and living experience are not only heard but also actively shape the locally needed pathways for recovery support, sustainable recovery communities and organisations.

SRC agreed to support Aberdeenshire Alcohol and Drug Partnership (AADP) in exploring and developing the needs of recovery communities across the area.

As part of that work, SRC agreed to facilitate and deliver a community engagement event. The planning, structure and focus for the event were co-produced by a planning group. The membership of that group included:

- Lived experience representation
- Scottish Recovery Consortium (SRC)
- Aberdeenshire Alcohol and Drug Partnership (AADP)

The group meet 4 times between November 2025 and January 2026.

This report has been developed by the Scottish Recovery Consortium (SRC) using feedback gathered at a community event. The information contained within it should not be shared, in full or in part, without the consent of SRC.

3. Purpose and Aim

Purpose

The *Voices of Recovery* event was designed to bring together people with lived and living experience of recovery, families, communities, and partners to shape local recovery priorities and inform the future direction of services and systems across Aberdeenshire. The overarching purpose was to:

- Provide a safe, inclusive, and enabling space for lived experience voices to influence strategy, service design, and system development.

- Align community perspectives with strategic priorities, including the forthcoming ADP five-year strategy (2026–2031) and the Scottish Government’s national drugs and alcohol strategy.
- Strengthen and embed recovery communities across Aberdeenshire as part of a Recovery Oriented System of Care (ROSC).
- Map recovery assets, service gaps, community priorities, and future opportunities – in collaboration with people in recovery, families, and communities themselves.

Aim

The event aimed to gather the priorities, insights, and experiences of people with lived and living experience of recovery, alongside families, communities, and partners, to shape the future recovery offer across Aberdeenshire. Specifically, the aims were to:

1. Centre and amplify lived and living experience, ensuring people in recovery, families, and communities directly influence local recovery development.
2. Map recovery strengths and gaps and identify priorities for future service and system improvements across Aberdeenshire.
3. Strengthen and connect recovery communities, particularly peer-led groups and networks across the north, central, and south of the region.
4. Align lived-experience contributions with strategic planning processes, including the ADP 2026–2031 strategy and relevant national policy frameworks.
5. Produce clear, community-informed recommendations (via SRC analysis) to support the ADP committee in developing a robust, inclusive ROSC.

4. Structure of this report

This report provides feedback from the Voices of Recovery event held on Monday, 29 January, in Aberdeen, focusing on two key areas:

- Workshop insights
- Overall event evaluation

Drawing on insights from people with lived and living experience, their families, local communities, and practitioners, the report outlines the feedback gathered during the workshops and the event evaluation. Together, the workshop insights and evaluation findings capture both what matters to participants and how effectively the event supported meaningful engagement—helping to strengthen future practice and partnership working.

5. Methodology of Analysis - Workshops

The information presented in this report was developed using a structured, repeatable approach. The methodology ensures that the findings reflect the perspectives of those who attended the

event and enable clear identification of patterns across the five workshop questions. This approach aligns with SRC’s commitment to evidence-based, recovery-oriented practice.

1. Collection of Participant Feedback

All participant contributions from the *Voices of Recovery* event were collected at workshop tables via Post-it notes. **Each comment was recorded verbatim, without interpretation or editing, to preserve the authenticity and integrity of each contribution.** All Post-it notes were fully documented before analysis.

2. Question-Level Thematic Coding

Responses to each of the five questions—gaps, barriers, assets, strategic priorities, and what good recovery-oriented care looks like—were reviewed individually. Similar ideas were grouped based on patterns identified in participant feedback. This produced a set of topics for each question, such as *Lack of Awareness, Funding Gaps, Bias and Stigma, Travel and Accessibility, Integration Issues*, and others.

3. Inclusion of Mentions Tables for Transparency and Accessibility

The findings include tables for each workshop question (Q1–Q5). These tables present:

- the total number of mentions per topic
- the percentage share of all mentions, and
- illustrative participant quotes drawn directly from participants’ feedback

This approach ensures that:

- readers can clearly see the relative importance of each topic
- the frequency of issues is visible at a glance
- the analysis stays demonstrably grounded in participants’ own words

By including both quantitative (counts, percentages) and qualitative (quotes) evidence, the mentions tables strengthen transparency while keeping lived experience at the centre of the analysis.

3. Cross-Question Comparison

The next stage involved examining all grouped responses across the five workshop questions. A cross-comparison grid was created to identify recurring feedback across multiple sections of the discussion. This analysis identified cross-cutting topics, including the centrality of lived and living experience; communication and awareness; transport and rural access; funding; stigma; system integration; evidence and learning; mental health and trauma needs; and community capacity.

4. Development of the FAIR Summary (Facts & Analysis Only)

Using the cross-cutting topics, the first two stages of the FAIR framework were completed:

- **Facts** – What participants said (verbatim-based findings)

- **Analysis** – What these findings mean for the recovery system

These columns were constructed entirely from the coded data and cross-cutting topics described above. No interpretation beyond topic-level information was applied. The report deliberately excludes the remaining FAIR elements—Identify (actions) and Review (monitoring)—because **these must be co-produced with people with lived and living experience, LEROs, ADP partners, and community organisations to align with the values and expectations expressed throughout the event.**

5. Opportunity for Co-Production

The methodology intentionally positions the findings as a foundation for co-producing the next stage of the FAIR model. By separating descriptive findings from solution generation, the report upholds the event's core values: partnership and community-led design.

6. Reflecting Participants' Experiences

Topics were not derived from assumptions or external interpretations; they emerged solely from participants' contributions. This process ensured the findings remained grounded in the experiences shared on the day.

6. Workshop Findings

Throughout the event, 33 participants (10 tables) were asked to discuss and explore several different questions: These questions were:

- What are the gaps in recovery and services across Aberdeenshire? (workshop 1)
- What are the barriers to recovery and treatment people face in Aberdeenshire (workshop 2)
- What are the recovery assets across Aberdeenshire? (workshop 3)
- What priorities should be considered in the ADP Strategy - "What does a good recovery-oriented care look like in Aberdeenshire? (workshop 4)

These discussions were split between the morning and afternoon. Each group collected discussions and feedback on post-it notes. The findings and topics that emerged across all groups constitute the first section of this report.

Question 1 - Gaps Identified in Aberdeenshire

During the Voices of Recovery event, participants highlighted a wide range of gaps affecting recovery support, system functioning, and lived experience involvement across Aberdeenshire. These gaps reflect barriers in daily life, challenges in accessing services, and broader issues across policy, infrastructure, and community development.

To ensure every participant's voice was heard, topics were included even when only a small number of individuals raised them. This will apply across every question.

The following information outlines the key topics identified by attendees.

Lack of Awareness

Participants described gaps in awareness, visibility, and communication about recovery supports and services across Aberdeenshire. They emphasised the need for clearer information pathways, consistent messaging, and proactive outreach from services.

Participant quotes:

- “We need Step-Ins and other organisations to invite people to community groups.”
- “Credible update information on what is going on in the shire and why.”
- “ABDH – any signposted dedicated route to access services.”
- “Statutory services – knowledge bank of contacts or places to go would be beneficial, GP’s surgery would be a great place to have contacts, consistency with support workers throughout early recovery.”
- “Getting referred, knowing what is available, info in one place, GP referrals, transport, better advertising.”
- “Making recovery visible.”
- “Monthly newspaper.”
- “Community magazine.”

Peer-Led and Lived and Living Experience Input

Participants expressed that peer-led approaches and lived-experience leadership are essential.

Participant quotes:

- “Peer-led groups – venues, accessible, affordable – funding to run groups.”
- “Lived experience.” “Peer-led groups is the only way forward.”
- “LLE should make all decisions on ADP budget.”
- “Peer-led groups.”
- “AB43 – more peer-led groups.”

ADP and Service Concerns

There were some concerns about trust, access, transparency, and how services—particularly Step Ins—currently operate.

Participant quotes:

- “Trust and mutual confidence between ADP support, HSCP and community organisations.”

- “Why follow other ADPs? Set a good example of LLE with representation on the board. Maybe all the other ADPs are not transparent.”
- “SACK THE ADP.”
- “Step-Ins are not working – Doors are locked, need to wait for someone to phone you back, some of the locations are not conducive to encourage people to ‘step in’, not enough staff to actually facilitate the Step-In.”
- “Step-Ins more accessible.”

Step-ins are ‘Step-in’ points across Aberdeenshire, where people can drop in without an appointment for same-day treatment. People do not need to be open to services to access these. They are currently open Monday to Friday (9 am to 5 pm). These were established in response to the Medication-Assisted Treatment (MAT) Requirements. There are currently 5 Step-in locations:

- Step in Banff, Seafield House
- Step in Central (Inverurie). Lumphart Cottage
- Step in Peterhead, 88 King Street
- Step in Stonehaven, Viewmount – these premises are not open to the public yet; however, phone number and email address for arrangements to be made to see the person at an appropriate venue (until premises are altered for people to attend)
- Step in Broch (Fraserburgh), Currently Faithlie Centre.

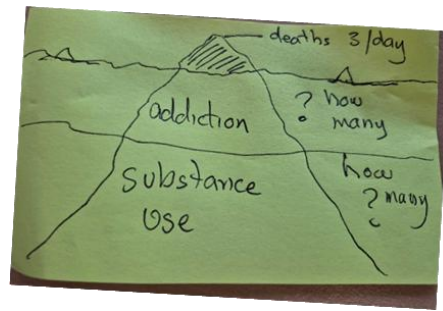
All of these venues also provide wider services, including Harm reduction equipment, testing, and advice.

Research, Policy and System Gaps

Participants highlighted a lack of consistent data, coherent strategy, and system learning.

Participant quotes:

- “We need more data – how many people have an addiction... how many use substances... cannot find a solution if there is no data on the problem.”
- “A structured approach to review and learning from all drug-related deaths (including DUI and violence) and an equivalent process for alcohol deaths.”
- “AB54 – any coherent referral process between services and community groups.”
- “Any structured and credible needs analysis published at intermediate zone level for Aberdeenshire.”
- “Focus on prevention and avoidance of relapse.”
- “Establish a credible, robust evidence base for the shire and publish regularly.”
- “Aberdeenshire strategy and ADP strategy do not align.”



These gaps reflect a desire for system improvement, accountability, and consistency.

Funding Gaps

Concerns were raised about a lack of adequate, trauma-informed spaces and insufficient funding for third-sector organisations.

Participant quotes:

- "Funding!!!! More choice in 3rd sector."
- "AB45, AB10, AB22, AS44 – secure building (funding) – trauma-informed, welcoming, safe."

Lack of Throughcare and Pathways (Prison, Rehab, Community)

Participants described weak connections between services and poor reintegration pathways for those leaving prison or rehab.

Participant quotes:

- "Break down barriers between community and prison."
- "Throughcare opportunities for prison officers."
- "Maintain relationships with prison/rehab to return to communities."
- "AB42 – HMP Grampian gaps."

Lack of Specific Opportunities and Service Provision

Participants highlighted the absence of support, insufficient group services, and limited access to specialised services.

Participant quotes:

- "More groups, help practical skills."
- "Life skills groups."
- "Wellbeing and healthy living."
- "Better access to trauma therapy."
- "Support."
- "More training opportunities."

- “AB422 – more local recovery community groups.”
- “People in crisis – nowhere to go... referrals take long... mental health services difficult to access.”

Travel and Accessibility

Participants described physical and transport barriers that restricted access to services and events.

Participant quotes:

- “The accessibility to this event is a disgrace, stairs, locked door, no instruction that front door was closed!”
- “Easier travel (support) getting to and from apps and events.”

Working Together and Networking Gaps

Participants want more collaboration, communication, and shared working across services and communities.

Participant quotes:

- “Everyone singing off the same page – LLE – professionals.”
- “More opportunities to work with professionals and different areas.”
- “Better communication with organisations and groups.”
- “Mainstreaming services.”
- “All under one roof – end competition with services.”

Table: Mentions per Topic – Question 1

To give a clear picture of how strongly each issue featured in the discussion, all responses were grouped, and the number of mentions within each topic was counted.

Topic	Total Mentions	Percentage	Illustrative Quotes
Lack of Awareness	8	16.7%	“We need Step-Ins and other organisations to invite people...”; “Credible update information...”; “ABDH – any signposted route...”
Lack of Peer-Led & LLE Input	7	14.6%	“Peer-led groups is the only way forward”; “LLE should make all decisions on ADP budget”; “AB43 – more peer-led groups”

ADP and Service Concerns	5	10.4%	"Trust and mutual confidence..."; "SACK THE ADP"; "Step-Ins are not working..."
Research, Policy & System Gaps	7	14.6%	"We need more data..."; "Structured approach to drug-related deaths..."; "Strategies do not align"
Funding Gaps	2	4.2%	"Funding!!!! More choice in 3rd sector"; "Secure building – trauma informed, safe"
Lack of Throughcare & Pathways	4	8.3%	"Break down barriers between community and prison"; "Maintain relationships with prison/rehab"
Lack of Specific Opportunities & Service Provision	8	16.7%	"More groups, practical skills"; "Better access to trauma therapy"; "People in crisis – nowhere to go..."
Travel & Accessibility	2	4.2%	"Accessibility to this event is a disgrace..."; "Easier travel for apps and events"
Working Together & Networking Gaps	5	10.4%	"Everyone singing off the same page"; "Better communication with organisations"

Question 2 – What barriers do people face in Aberdeenshire?

Participants identified a wide range of barriers affecting access to recovery support, participation in community groups, and engagement with services across Aberdeenshire. This information reflects challenges in funding, stigma, awareness, transport, service organisation, and wider system culture.

The information below highlights feedback:

Funding and Opportunities

Participants highlighted challenges around funding, particularly for community-based recovery, LLE-led groups, and premises.

Participant quotes:

- "Difficulty in accessing adequate funding to support community development."
- "Treatment-focused service and funding mindset – based on MAT reporting and insufficient services blocks investment in the 3rd sector and community."
- "Fluid career pathways valuing LLE within a well-funded 3rd sector and community groups."
- "Help with funding to get premises."
- "Broken funding system."
- "Lack of funding."

Bias and Stigma

Stigma was raised as a barrier, experienced across systems, communities, and service settings. Participants described how stigma undermines confidence, participation, and opportunities for leadership.

Participant quotes:

- "LLE, ASP, chasm, clinical knowledge, stigma, knowledge."
- "Groups are not people-friendly and very stigmatised."
- "Stereotyping of people with LLE as illiterate, uninformed and stupid."
- "Stereotyping people with an addiction are poor and incapable of participating as leaders."
- Stigmatised at every turn."

Lack of Awareness

Participants described challenges in finding clear, accessible information about recovery opportunities, groups, and local activities.

Participant quotes:

- "Lack of information."
- "Lack of info."
- "Information about recovery things and things available beyond recovery to do in my local area."
- "Communication."

Travel and Accessibility

Transport was one of the most widely reported barriers, particularly for people living in rural areas. Challenges spanned bus timetables, access to online support, affordability, and limited rural routes.

Participant quotes:

- "Bus times not the best at night."
- "Lack of transport."
- "Free online services – difficulty – timing issues."
- "Links between the city and the shire."
- "Bring more opportunities to local communities."
- "Support with travel to events and appointments needed."
- "Barriers are transport and lack of info."
- "Location/rural – transport."
- "Transport communication."

- “Transport in rural areas.”
- “Affordable barrier – public transport which actually links rural communities.”
- “Public transport – rural areas are cut off from services.”
- “Problems getting bus passes.”
- “Available bus service are unknown.”

Service Provision

Participants described fragmentation, lack of integration, and issues with system culture. Step-Ins, in particular, were frequently criticised for inaccessibility and lack of trauma-informed practice.

Participant quotes:

- “Lack of integrated services.”
- “Poor health, population needs interactive approach i.e. recovery.”
- “Communication.”
- “Lack of staff in the Step-Ins.”
- “Step-In in Banff not trauma informed – door closed for a while, ring a phone, now have to push buzzer because no receptionist.”
- “No choice.”
- “Poor mental health support.”
- “ADP is a dictatorship not a partnership.”
- “Breakdown in services/community relationship since 2023.”
- “Groups are few and far between.”
- “Bureaucracy.”
- “NHS/HSCP organisation model based on ARI/Cornhill and specific closed offices.”
- “Lack of support to volunteer by services.”

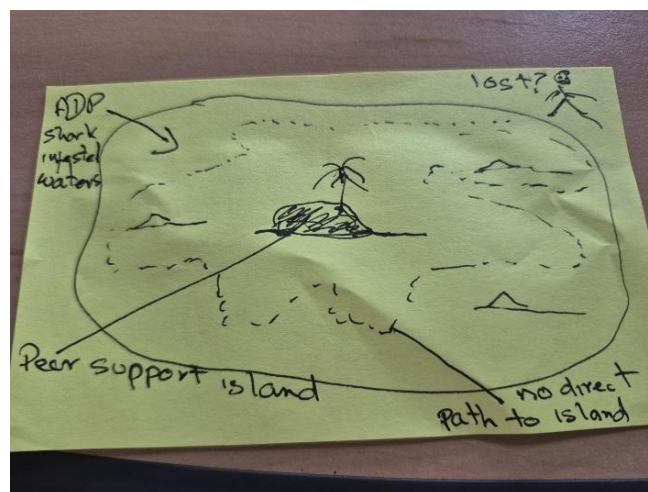
Table: Mentions per Topic – Question 2

To give a clear picture of how strongly each issue featured in the discussion, all responses were grouped, and the number of mentions within each topic was counted.

Topic	Total Mentions	Percentage	Illustrative Quotes
Funding and Opportunities	9	20.0%	“Difficulty in accessing adequate funding...”; “Broken funding system”; “Funding, Funding, Funding”

Bias and Stigma	7	15.6%	"Groups are not people friendly and very stigmatised"; "Stigmatised at every turn"; "Stereotyping of people with LLE..."
Lack of Awareness	4	8.9%	"Lack of information"; "Information about recovery things..."; "Communication"
Travel and Accessibility	14	31.1%	"Bus times not the best at night"; "Lack of transport"; "Public transport – rural areas are cut off..."
Service Provision and Organisation Concerns	11	24.4%	"Lack of integrated services"; "Step-In in Banff not trauma-informed"; "ADP is a dictatorship not a partnership"

"The LLE community offers an island of hope surrounded by a sea of services which are disconnected. The services often create barriers for the LLE community and can be antagonistic toward peer-led community groups. It is difficult for people to find the LLE community group."



This feedback reinforces the value of peer-led recovery, even when system structures create challenges around visibility and access.

Question 3 - What Are the Assets Within Aberdeenshire?

Participants identified a wide range of strengths, resources, skills, and community assets that support recovery across Aberdeenshire. These assets reflect both formal and informal supports, as well as the qualities and contributions of people with lived and living experience and the broader recovery community. The feedback is summarised below under each topic.

Specific Organisations, Services, and Groups

Participants highlighted the breadth of organisations, groups, and services that play a vital role in supporting recovery across Aberdeenshire.

Participant quotes:

- “Aberdeenshire Community Recovery”
- “Active peer support groups”
- “Family and peer support groups”
- “Aberdeenshire Recovery Forum”
- “Strong residential recovery network – built up during the previous ADP framework”
“Our community groups like Talking Point etc”
- “New ADP”
- “ADP – experienced recovery activists, well networked to national and regional issues”
- “HMP Grampian”
- “Recovery specific officers HMP Grampian”
- “Having our group at AIR drop-in 7 days per week”
- “Groups/events/organisations/professionals”
- “Voluntary organisations bringing lived experience”
- “Step In services”
- “Women’s groups”
- “The available peer groups are excellent”
- “LEROs”
- “LLE and ADP”
- “The LLE community offers an island of hope surrounded by a sea of services which are disconnected... services are often a barrier to the LLE community and can be antagonistic... difficult to find the LLE community group.”

Resources and Opportunities

Participants identified a range of resources, activities, and opportunities that support personal growth, skill development, volunteering, connection, and recovery across the region.

Participant quotes:

- “Community organised training courses”
- “Website and social media”
- “Training we’ve had so far”
- “We’ve had the opportunity to voice our opinions like this event today”

- “Opportunities we’ve had to go to events like Recovery Connects and Recovery Walk”
- “Training opportunities”
- “Potential employment”
- “Volunteering and helping others”
- “Being heard and validated”
- “Feeling seen/heard”
- “Funding is available to services”
- “Services are accessible and successfully help people”
- “Organised events like the annual Recovery Walk”
- “Facilitators”
- “Training that is available”
- “Volunteering opportunities”
- “Availability of funding and support”
- “Community groups that are not exclusive”
- “Sharing experience”
- “All other opportunities that become available”

Qualities and Skills

Participants emphasised the strengths, resilience, and collective expertise of people within Aberdeenshire’s recovery communities.

Participant quotes:

- “Trained and knowledgeable peer supporters outwith services”
- “Compassion”
- “Freedom of speech outwith ACC/NHS constraints”
- “Wisdom – lived experience”
- “Building good health”
- “Expertise”
- “Peer-to-peer support”
- “Every person we meet on our journey”
- “Support and relationships – AB42 2YY”
- “Can do attitudes”
- “Getting into a good routine”

- “Airing out problems/feelings”
- “Learning new techniques”
- “Peer support”

Table: Mentions per Topic – Question 3

To give a clear picture of how strongly each issue featured in the discussion, all responses were grouped, and the number of mentions within each topic was counted.

Topic	Total Mentions	% of All Mentions	Illustrative Items from Participants
Specific Organisations, Services & Groups	19	35.8%	Aberdeenshire Community Recovery; HMP Grampian (incl. recovery-specific officers); LEROs; Aberdeenshire Recovery Forum; AIR drop-in 7 days; women’s groups; “The available peer groups are excellent”; “LLE and ADP”; “ <i>The LLE community offers an island of hope...</i> ”
Resources & Opportunities	20	37.7%	Community-organised training; websites & social media; Recovery Walk/Recovery Connects; volunteering; employment pathways; “Being heard and validated”; accessible services; facilitators; “Availability of funding and support”; non-exclusive community groups
Qualities & Skills	14	26.4%	Trained peer supporters; compassion; freedom of speech (outwith ACC/NHS); lived-experience wisdom; peer-to-peer support; “Support and relationships – AB42 2YY”; can-do attitudes; routines; learning new techniques

Question 4 – What Priorities Should Be Considered in the Upcoming ADP Strategy?

Participants identified a range of priorities that they believe should shape Aberdeenshire ADP’s forthcoming strategy. These priorities reflect values, system improvements, service needs, and the importance of lived and living experience. The feedback below is grouped into topics exactly as participants expressed them.

Workforce

Participants emphasised that a values-driven system—**respectful, safe, and grounded in understanding**—is essential for trust and engagement. Concerns were raised about inconsistent attitudes from professionals.

Participant quotes:

- “More understanding with older professionals.”
- “Confidential safe environment.”
- “More understanding in professionals.”

Reduce Stigma

Stigma continues to affect access to care, confidence, and willingness to seek help. Participants highlighted the value of creating genuine opportunities for listening and understanding across communities.

Participant quotes:

- “Opportunities to let others who haven’t had addictions listen to people who have had substance use issues to help combat stigma.”
- “Less stigma around help.”
- “Understand fears around names, i.e. social worker.”

Travel and Accessibility

Transport barriers and access issues were highlighted, affecting group participation, appointments, and social connections.

Participant quotes:

- “Look more into how we move to travel for appointments, social, etc.”
- “Travel bus pass.”
- “Groups and one-to-ones must be open and accessible.”
- “Easy access facilities.”

Service Provision

Participants highlighted gaps in one-to-one support, access to mental health services, psychological services, and advocacy. Community infrastructure and LERO-led initiatives were described as vital.

Participant quotes:

- “One-to-one support.”
- “Better access for mental health.”
- “Drug education within schools.”
- “Community building development.”
- “Reinvest in the community forums with true lived experience central.”

- “LERO.”
- “Psychological services and advocacy.”

Systems and Policy

Participants want a strategy that is responsive, aligned to national policy, evidence-based, and focused on early intervention and prevention.

Participant quotes:

- “Getting the right support on the day.”
- “ADP strategy must align to National Policy.”
- “Integrated service design and interactive approach to prevention.”
- “ADP strategy must be evidence-based with early intervention and prevention strategies.”

Raising Awareness and Communication

Clear, consistent communication was described as essential for navigating the system and understanding available support.

Participant quotes:

- “More communication – same page.”
- “More knowledge of support.”

Funding Opportunities and Support

Participants emphasised the need for secure funding for essential supports that enable recovery and stability in daily life.

Participant quotes:

- “Funding support.”
- “Keeping the support going.”
- “ADP fund fundamentals of activities of daily living, e.g. housing support, finance advice, therapy, legal advice, advocacy.”

Increased LLE Focus

LLE representation was consistently highlighted as a priority, particularly in leadership, strategy, and peer-led approaches.

Participant quotes:

- “AB43 – more lived experience.”
- “More lived experience on ADP.”

Increased Training Opportunities

Training was viewed as essential for building confidence, skills, and organisational capacity across LEROs and the wider recovery community.

Participant quotes:

- “More training for LEROs.”
- “More training and courses.”
- “Training for advocacy.”
- “More training support for LEROs and support.”

Table: Mentions per Topic – Question 4

To give a clear picture of how strongly each issue featured in the discussion, all responses were grouped, and the number of mentions within each topic was counted.

Topic	Total Mentions	Percentage	Illustrative Quotes
Values	3	9.1%	“More understanding with older professionals”; “Confidential safe environment”; “More understanding in professionals”
Reduce Stigma	3	9.1%	“Opportunities to let others who haven’t had addictions listen...”; “Less stigma around help”; “Understand fears around names i.e. social worker”
Travel & Accessibility	4	12.1%	“Look more into how we move to travel...”; “Travel bus pass”; “Groups and one-to-ones must be open and accessible”; “Easy access facilities”
Specific Service Provision	7	21.2%	“One-to-one support”; “Better access for mental health”; “Drug education within schools”; “Reinvest in community forums...”; “LERO”; “Psychological services and advocacy”
Systems & Policy	4	12.1%	“Getting the right support on the day”; “ADP strategy must align to National Policy”; “Integrated service design...”; “Early intervention and prevention strategies”
Raising Awareness & Communication	2	6.1%	“More communication – same page”; “More knowledge of support”

Funding Opportunities & Support	3	9.1%	"Funding support"; "Keeping the support going"; "ADP fund fundamentals of daily living..."
Increased LLE Focus	2	6.1%	"AB43 – more lived experience"; "More lived experience on ADP"
Increased Training Opportunities	4	12.1%	"More training for LEROs"; "More training and courses"; "Training for advocacy"; "More training support for LEROs and support"

Question 5 – What does a good recovery-oriented care look like in Aberdeenshire?

Participants described a vision of recovery support in Aberdeenshire that is personalised, locally rooted, evidence-based, compassionate, and driven by lived experience. Below is information highlighted by participants.

Personalised, Needs-Led Support

Participants emphasised that recovery support must adapt to the individual, not the system.

Participant quotes:

- "Individual care needs."
- "Opportunities for other things other than groups."
- "Medical intervention as last resort and proportionate."
- "Visible, inviting, choice, proactive."

Efficient, Evidence-Based and Not Top-Down

People want a system that works well.

Participant quotes:

- "Efficient."
- "Evidence-based."
- "Not top down."

Strong Advocacy at Every Stage

Advocacy was highlighted as essential to navigating the system and ensuring rights.

Participant quotes:

- "Advocacy, advocacy, advocacy."

Peer-Informed and Peer-Delivered

Peer support was described as fundamental to recovery, belonging, and hope.

Participant quotes:

- “Peer informed.”
- “Peer support from ACR.”
- “Given opportunities from ACR and involved in volunteering.”

Locally Delivered, Accessible Support

Care close to home and easy to access was considered essential.

Participant quotes:

- “Locally delivered.”

Compassionate and Inclusive

Participants stressed the importance of a service culture that sees people, not problems.

Participant quotes:

- “Compassionate.”
- “Inclusion in all aspects of recovery care/support.”
- “Visible, inviting, choice, proactive.”

Prevention and Recovery

Participants highlighted that prevention and recovery should be understood as interconnected rather than separate.

Participant quotes:

- “Prevention and recovery looped focus.”

Recovery Infrastructure

Recovery needs to be understood as broader than treatment—rooted in community assets and LEROs.

Participant quotes:

- “Put social, economic, and LERO support at the front of the ROSC model and funding priorities to reflect this.”

Access to Specialised Services

Specialist psychological and therapeutic support was highlighted as essential.

Participant quotes:

- “Access to counselling and psychotherapy.”

Table: Mentions per Topic – Question 5

To give a clear picture of how strongly each issue featured in the discussion, all responses were grouped, and the number of mentions within each topic was counted.

Topic	Total Mentions	Percentage	Illustrative Quotes
1. Personalised, Needs-Led Support	4	23.5%	“Individual care needs”; “Opportunities for other things other than groups”; “Medical intervention as last resort and proportionate”; “Visible, inviting, choice, proactive”
2. Efficient, Evidence-Based and Not Top-Down	3	17.6%	“Efficient”; “Evidence-based”; “Not top down”
3. Strong Advocacy at Every Stage	1	5.9%	“Advocacy, advocacy, advocacy”
4. Peer Informed and Peer Delivered	3	17.6%	“Peer informed”; “Peer support from ACR”; “Given opportunities from ACR and involved in volunteering”
5. Locally Delivered, Accessible Support	1	5.9%	“Locally delivered”
6. Compassionate and Inclusive Culture	2	11.8%	“Compassionate”; “Inclusion in all aspects of recovery care/support”; “Visible, inviting, choice, proactive”
7. Prevention and Recovery as a Connected Loop	1	5.9%	“Prevention and recovery looped focus”
8. Social, Economic, and LERO-Led Infrastructure	1	5.9%	“Put social, economic, and LERO support at the front of the ROSC model...”
9. Access to Counselling and Psychotherapy	1	5.9%	“Access to counselling and psychotherapy”

A Recovery-Oriented System of Care (ROSC) in Aberdeenshire should provide individuals with a **coordinated, compassionate, and person-centred network of support that recognises recovery as a long-term, non-linear journey.** A working ROSC places lived and living experience at its

heart, ensuring that people have real choice, easy access to help, and appropriate support at the right time. It should provide clear pathways into treatment, rehabilitation, peer support, and community-based opportunities, while ensuring follow-up support so no one “slips through the cracks.”

A strong ROSC enables people to move smoothly between services, be signposted to wider opportunities, and access training, volunteering, advocacy, and community connection. It balances clinical care with peer-led and psychosocial supports, building confidence, hope, skills, and long-term well-being. Ultimately, a high-quality ROSC should empower people not only to stabilise and recover but also to thrive, with **recovery communities, statutory services, and third-sector partners working together to make recovery visible, sustainable, and achievable for everyone.**

Participant’s personal case study of their journey through a working ROSC model in Aberdeenshire

“The initial support I received was fantastic. I was also offered follow-up support to ensure I didn’t slip through the cracks. I went to a rehab centre and then had after-care with the rehab centre and with Penumbra (a non-profit organisation in Aberdeen). Through the aftercare, I was signposted to further services. Then training opportunities were made available to me, and some excellent ongoing opportunities continue to appear”.

7. Cross-cutting topics across (Workshop Questions 1–5)

Understanding the cross-cutting topics that emerged across all five workshop questions is essential for building a coherent, effective, and genuinely recovery-oriented system of care in Aberdeenshire. While each question explored a different aspect of people’s experiences—gaps, barriers, assets, priorities, and what good recovery-oriented care should look like—the discussions circled back to a shared set of concerns, values, and aspirations. These recurring topics reveal not only what participants find challenging, but also what they believe is possible when recovery is adequately supported.

By examining this collectively, we can see what shape people’s everyday experiences take: the need for accessible, locally delivered services; robust, transparent communication; meaningful investment in peer-led and lived-experience-driven approaches; improved transport and rural access; stigma-free environments; sustainable funding; and a more integrated, person-centred system. Highlighting these cross-cutting elements strengthens the change that will have the most significant impact across Aberdeenshire’s recovery landscape.

Crosscutting Topics

1. Lived & Living Experience (LLE) and Peer-Led Practice as Central

LLE voices and peer-led groups are consistently positioned as essential: from gaps (insufficient peer-led provision and influence), to barriers (stigma and marginalisation of LLE), to assets (strong peer networks, LEROs, ACR), to strategic priorities (more LLE on ADP;

reinvestment in community forums), and to “what good looks like” (peer-informed, inclusive ROSC).

2. **Information, Awareness & Communication**

A need for clear, credible, and visible information: gaps in service awareness; barriers due to (poor communication); assets such as (websites/social media and events); strategic priorities calling for (“same-page” communication); good care being visible, inviting, and proactively communicated.

3. **Access, Travel & Local Delivery (Rurality)**

Transport and geographic barriers recur throughout: identified as gaps (access/venue issues), as barriers (public transport limitations, bus passes, rural isolation), as priorities (travel solutions and easy-access facilities), and as features of reasonable care (locally delivered support).

4. **Funding & Infrastructure for Community and LEROs**

Funding shortfalls are both a gap and a barrier; assets include the availability of some funding and supportive events; **priorities urge funding for fundamentals (housing, finance, advocacy);** and the vision of good care places social, economic, and LERO support at the front of the ROSC—backed by funding.

5. **Integrated, Person-Centred, Non-Top-Down System (ROSC)**

Cross-cutting calls for **integrated, trauma-informed, person-centred, and non-hierarchical services.** Gaps highlight fragmentation; barriers include a lack of integration and bureaucracy; assets include **multi-actor networks and recovery forums;** priorities call for an integrated, evidence-based strategy; and **reasonable care is collaborative** rather than top-down.

6. **Stigma, Values & Culture of Care**

Stigma is a barrier and a target for strategic action; assets include compassion and validating spaces; values prioritise safety, confidentiality, and understanding; **good care is dignified, inclusive, and advocacy-rich.**

7. **Evidence, Data & Learning**

A recurring need for **robust data and continuous learning;** gaps call out missing prevalence data, needs assessments, and death reviews; priorities insist on evidence-based planning and alignment to national policy; good care emphasises evidence-based approaches.

8. **Pathways, Throughcare & “Right Support on the Day”**

Gaps and barriers cite **weak transitions (prison/rehab/community) and crisis response;** priorities emphasise same-day/right-day support; **good care joins prevention with recovery** and ensures timely, proportionate help (with medical care as a last resort).

9. **Mental Health, Trauma & Psychosocial Supports**

Across questions, people seek better **access to mental health services, trauma therapy, counselling/psychotherapy, and practical life skills**—areas that appear as gaps, priorities, and defining elements of reasonable care.

10. **Community Capacity: Training, Volunteering, Skills & Employment**

Assets include training, volunteering, and feeling “heard/seen”; priorities include expanded training (esp. for LEROs and advocacy); good care includes **opportunities beyond groups**, volunteering routes via ACR, and life skills development.

8. **Summary of Workshop Findings**

The *Voices of Recovery* event generated rich experiences, reflections and insights from people with lived and living experience, families, communities, practitioners, and partners across Aberdeenshire. These findings highlight what is working well, where barriers persist, and what is needed to build a strong Recovery-Oriented System of Care (ROSC) locally.

Across all five workshop questions, participants consistently emphasised several recurring issues:

1. **Lived & Living Experience Must Be Central**

Participants highlighted the need for meaningful lived experience in decision-making, service design, peer support, and ADP governance. Participants identified strong peer-led groups as a core asset, but also highlighted gaps in influence, sustainability, and visibility.

2. **Information, Communication & Awareness Gaps**

There is a lack of clear, accessible, and up-to-date information about available services, pathways, rights, and supports. Poor communication was identified as both a gap and a barrier, calling for consistent messaging, credible information, and greater visibility of recovery efforts across localities. Opportunity to highlight and share information about recovery networks, supports and positive assets available across Aberdeenshire.

3. **Travel, Transport & Rural Accessibility**

Transport barriers—particularly in rural areas—were cited as an obstacle. Lack of bus services, affordability barriers, poor links between the Shire and the city, and venue accessibility issues all affect people’s ability to access support. Locally delivered services were seen as essential.

4. **Funding & Infrastructure Challenges**

Sustained, adequate, and flexible funding is needed for peer-led organisations, LEROs, community groups, and trauma-informed spaces. Participants described the funding system as short-term or insufficient, limiting community capacity and innovation.

5. **Need for Integrated, Trauma-Informed, Person-Centred Services**

Fragmentation across services, inconsistent staffing, unclear referral pathways, and gaps in throughcare (prisons, rehabilitation facilities, community transitions) were raised.

6. **Stigma & Values-Based Culture of Care**

Stigma—structural, social, and interpersonal—remains a barrier to accessing support and participating fully in community life. Participants emphasised the need for respect, dignity, confidentiality, and understanding across all systems and services.

7. Evidence, Data & Continuous Learning

Highlighted need for clearer evidence base and data to inform strategy, service planning, and prevention.

8. Pathways, Throughcare & “Right Support on the Day”

Highlighted gaps and opportunities to link pathways, communities, and recovery networks at critical transition points

9. Mental Health, Trauma & Psychosocial Support Needs

There is a lack of access to trauma therapy, counselling, mental health support, crisis response, and preventive interventions. All of these play a crucial role in long-term recovery.

10. Community Capacity: Skills, Volunteering, Employment & Training

Participants recognised Aberdeenshire’s strengths—peer skills, volunteering culture, events, and training opportunities—but emphasised the need for further training for LEROs, advocacy capacity, life skills development, and employment pathways.

9. FAIR Model – Facts, Analysis, Identify, and Review

The findings presented in this section are drawn directly from the contributions gathered at the *Voices of Recovery* event. They represent the **Facts** – what participants shared about gaps, barriers, strengths, priorities, and what good recovery-oriented care should look like – and the **Analysis** of what these findings mean for Aberdeenshire’s developing Recovery-Oriented System of Care (ROSC).

The report intentionally excludes the latter elements of the FAIR model—**Identify (what needs to be done) and Review (how progress will be monitored)**. This is a deliberate decision. The event generated strong evidence about what people are experiencing and what matters to them; however, **designing actions and accountability mechanisms must not be done unilaterally.**

In keeping with the values expressed throughout the event—particularly the call for meaningful, central involvement of people with lived and living experience in all decisions—the next steps of the FAIR model should be **co-produced**. This reflects participants’ repeated emphasis on:

- the need for peer-led and community-led decision-making,
- greater transparency and shared ownership, and
- building a system that is not top-down but shaped together with those directly affected.

Developing actions (“what needs to happen”) and defining review processes (“how we will know it is happening”) without co-production would undermine the very principles highlighted during the event – including dignity, respect, and leadership from lived and living experience. Therefore, these elements should be developed with, not *for*, the community, ADP partners, and recovery organisations.

The Facts and Analysis presented here form the foundation for that co-production. They ensure that future decisions are grounded in evidence, aligned with the lived realities of people in Aberdeenshire, and consistent with the commitment to build a recovery system that is inclusive, transparent, and genuinely community-led.

Topic	F – Facts (what participants said/experienced)	A – Analysis (what it means/why it matters)
1) Lived & Living Experience (LLE) must be central	Participants want meaningful LLE involvement in decision-making, service design, peer support, and ADP governance. Strong peer-led groups exist but lack influence, sustainability, and visibility.	System decisions risk being misaligned with real needs if LLE is not embedded; under-resourced LEROs are constrained as a core asset of the ROSC.
2) Information, communication & awareness gaps	Lack of clear, up-to-date information on services, pathways, and rights; poor communication cited as both a gap and a barrier; call for consistent messaging and visibility across localities.	People can't reach support they can't find; fragmented information increases access inequality and delays help.
3) Travel, transport & rural accessibility	Transport is a persistent obstacle: limited/broken links, affordability, bus pass issues, and venue accessibility problems. Locally delivered services are viewed as essential.	Rurality compounds exclusion: without travel solutions and local delivery, inequity persists.
4) Funding & infrastructure challenges	Need sustained, flexible funding for LEROs, peer groups, trauma-informed spaces; current funding seen as short-term/insufficient; premises gaps in several postcodes.	Short-termism undermines continuity, capacity and trust; safe premises are prerequisites for trauma-informed ROSC delivery.
5) Integrated, trauma-informed, person-centred services	Fragmentation, inconsistent staffing, unclear referral pathways, and weak throughcare (prison/rehab/community) were key concerns.	People need the right support on the right day; fragmentation creates drop-off points and harms outcomes.

6) Stigma & values-based culture of care	Stigma (structural/social/interpersonal) persists; participants called for respect, dignity, confidentiality and understanding.	Stigma suppresses help-seeking and leadership by people with LLE; values shape outcomes.
7) Evidence, data & continuous learning	Gaps in local data, needs assessment, and review/learning systems; desire for an evidence base to guide strategy and prevention.	Without shared data, planning is reactive; learning loops are essential for improvement and accountability.
8) Mental health, trauma & psychosocial support needs	Insufficient access to trauma therapy, counselling, MH support, crisis response, and prevention.	Co-occurring MH issues are common; unmet MH/trauma needs derail recovery and increase crisis use.
9) Community capacity: skills, volunteering, employment & training	Strong peer skills, volunteering, events, and training exist; however, there is a need for more LERO training, advocacy capacity, life skills development, and employment pathways.	Building community capacity multiplies recovery capital, strengthens networks, and sustains ROSC.

By linking each topic to its source, we demonstrate that the findings are grounded directly in what people told us—not in assumptions or interpretive bias. It ensures that participants' feedback is visible within the analysis, and that future actions, recommendations, and funding decisions can be traced directly to what participants identified as most important.

Topic	F – Facts (what participants said/experienced)	A – Analysis (what it means/why it matters)	Where the Topic Appears (Q1–Q5)
1) Lived & Living Experience (LLE) must be central	Participants want meaningful LLE involvement in decision-making, service design, peer support, and ADP governance. Strong peer-led groups exist but lack influence, sustainability, and visibility.	System decisions risk being misaligned with real needs if LLE is not embedded; under-resourced LEROs constrain a core asset of the ROSC.	Q1: Need more peer-led approaches; LLE decision-making. Q2: Stigma and marginalisation of LLE. Q3: Peer groups, LEROs, ACR as assets. Q4: LLE on ADP; reinvest in community forums. Q5: Peer-

			informed, non-top-down services.
2) Information, communication & awareness gaps	Lack of clear, up-to-date information on services, pathways, rights; poor communication cited as both a gap and a barrier; calls for consistent messaging and visibility.	People cannot access support they cannot find; fragmented information drives inequality, and delays help.	Q1: Lack of info, poor navigation. Q2: Communication problems. Q3: Websites, social media, events as assets. Q4: "More communication," shared messaging. Q5: Visible, proactive services.
3) Travel, transport & rural accessibility	Transport barriers: limited/broken links, affordability, bus-pass issues, venue access challenges; local delivery essential.	Rurality compounds exclusion: without travel solutions and decentralised services, inequity persists.	Q1: Access/venue issues. Q2: Transport, rural isolation. Q4: Travel pass; easy access. Q5: Locally delivered care.
4) Funding & infrastructure challenges	Need sustained, flexible funding for LEROs, peer-led groups, trauma-informed spaces; current funding is viewed as short-term or insufficient.	Short-termism undermines continuity and stability; safe spaces are critical to trauma-informed practice.	Q1: Trauma-informed premises needed. Q2: Repeated "Funding." Q3: Funding/support as assets. Q4: Funding fundamentals (housing, therapy, etc.). Q5: Resource LERO-fronted ROSC.
5) Integrated, trauma-informed, person-centred services	Fragmented services, inconsistent staffing, unclear referrals, and weak throughcare between prison, rehab, and community.	Fragmentation leads to drop-off points; people need the right support at the right time.	Q1: Fragmentation. Q2: Lack of integration. Q3: Multi-actor networks. Q4: Integrated, evidence-based strategy. Q5: Non-top-down, collaborative care.
6) Stigma & values-based culture of care	Stigma persists at structural, social, and interpersonal levels;	Stigma suppresses help-seeking and discourages	Q2: Stigma as a significant barrier. Q3: Compassion/validation

	strong calls for respect, dignity, confidentiality, and understanding.	leadership from people with LLE; culture shapes outcomes.	n as assets. Q4: Anti-stigma priorities. Q5: Compassion, inclusion, advocacy.
7) Evidence, data & continuous learning	Gaps in local data, needs assessments, and system learning; desire for stronger evidence base.	Without data, planning is reactive; learning loops drive quality improvement and accountability.	Q1: Need for prevalence data, needs assessment. Q4: Evidence-based, policy-aligned strategy. Q5: Evidence-based care approaches.
8) Mental health, trauma & psychosocial support needs	Insufficient access to trauma therapy, counselling, MH support, crisis response, and prevention.	Co-occurring MH issues are common; unmet needs disrupt recovery and increase crisis.	Q1: Trauma therapy gap. Q2: Poor MH support. Q4: MH access; psychological services. Q5: Counselling/psychotherapy is central to good care.
9) Community capacity: skills, volunteering, employment & training	Strong peer skills, volunteering, and training exist; however, additional LERO training, advocacy skills, life skills, and employment pathways are needed.	Building community capacity strengthens recovery capital and ROSC's sustainability.	Q3: Training & volunteering as assets. Q4: Training for LEROs/advocacy. Q5: Opportunities beyond groups; ACR volunteering.

10. Event Evaluation Findings (Question 1 – 9)

This section highlights how participants evaluated the Voices of Recovery event, drawing directly on feedback from –the on-the-day paper evaluation forms completed by attendees. Two data collection methods were offered (paper and QR code), but 100% of participants chose paper forms. A total of **22** participants submitted evaluation responses, representing **68.75%** of those who took part in the event. The evaluation information captures participants' motivations for attending, their expectations, what they valued most, and what they felt could be improved. It also highlights the extent to which the event fostered connection, inspiration, and hope, as well as practical considerations such as accessibility, travel, and barriers to participation. By analysing this

feedback, the section aims to present a clear account of how the event was experienced by those who attended.

Understanding participant perspectives is essential to ensuring that future recovery-focused events—and the wider development of a Recovery-Oriented System of Care across Aberdeenshire—are shaped by the voices of those most directly affected.

Methodology – Event Evaluation

The methodology in this section mirrors the approach used in the workshop analysis to ensure consistency in how participant feedback was captured, managed, and interpreted. As with the workshop data, responses were primarily qualitative, generated through open-ended questions that allowed participants to describe their motivations, experiences, learning, and reflections in their own words.

To preserve accuracy and maintain the integrity of participants' voices, all paper evaluation forms were transcribed verbatim into SurveyMonkey before analysis. Where quantitative responses were provided—such as scaled or multiple-choice questions—they are presented as frequencies and proportions to offer a clear and accessible summary of participant feedback.

Question 1 – Why did you attend the event

Number of respondents = 22

Question 1 was open-ended, allowing participants to describe in their own words what they enjoyed most about the event. Participants' responses are highlighted below:

Desire to Influence Change and Shape Local Strategy

A significant proportion of participants attended with the explicit intention of contributing to change across Aberdeenshire's recovery system. Responses referenced wanting to:

- "help make change"
- "put ideas forward and try to change something even a little bit"
- "voice my opinions on ADP strategy"
- "attempt to influence Aberdeenshire strategy in light of the real experience of people of LLE"

Commitment to Sharing Lived and Living Experience

Many participants attended to share their lived or living experience, contribute insights, and ensure their perspectives were "heard," "validated," and "acted upon." Comments included:

- "to give my experience"
- "to have my voice heard"
- "to support friends and listen to what is going on"

Wish to Learn, Build Knowledge, and Improve Understanding

Several attendees expressed a desire to gain knowledge about recovery, services, or community activities:

- “to further my understanding of the recovery world”
- “to get more information about recovery”
- “interest in personal development and knowledge building”

Motivation to Connect with Peers and the Recovery Community

Participants highlighted community connection, meeting new people, and engaging with others in recovery as key motivations:

- “to meet others in recovery and find out more about how we can move forward”
- “to see what everyone else has to say”

Hope for ADP Engagement and System Responsiveness

A number of responses reflected explicit hopes that the ADP would listen, engage, and take action:

- “to hope the ADP would listen to the community”
- “to be involved in the future of recovery in Aberdeenshire”

Curiosity and Openness Without Clear Expectations

A smaller number of respondents attended without specific expectations, expressing curiosity or attending because invited:

- “I didn’t have any expectations”
- “not sure”
- “I was invited”

Overall Summary

The reasons for attending revealed a motivated community seeking:

- Influence over local decisions
- Opportunities to share lived experience
- Knowledge and information
- Connection, belonging, and collective voice
- Assurance that services and strategic partners will listen and respond

These insights affirm the importance of sustained, accessible, and co-produced engagement spaces where lived and living experience is valued and central.

Question 2 – What were your expectations of the day?

Number of respondents = 22

Question 2 was designed as an open-ended question, allowing participants to describe in their own words what they enjoyed most about the event.

Participants highlighted a wide range of expectations before attending the Voices of Recovery event:

Low or No Expectations Prior to Attending

A noticeable number of participants stated they arrived with minimal or no expectations, sharing comments such as:

- “I didn't have any expectations”
- “None”
- “no expectations... excited to be part of it”
- “not sure”

Expectation of Open Discussion, Shared Learning, and Honest Conversation

Many participants expected opportunities for conversation, listening, and shared experience, using phrases such as:

- “further my knowledge”
- “free and open discussion of issues in a respectful environment”
- “to hear what changes they want to see happening”
- “to get more information about recovery”

Hope for ADP Engagement, Responsiveness, and Visibility

Several responses reflected a desire for the ADP to be present, engaged, and listening:

- “that the ADP support team would mingle with the community and listen”
- “hopeful my comments contributed well”

Expectation of Personal or Professional Growth

Participants expressed hope for learning, insight, and development:

- “further my knowledge and understanding”
- “interest in personal development and knowledge building”
- “to learn about addiction”

Desire for Community Connection and Networking

Several people expected a supportive, positive experience with others in recovery:

- “positive networking”
- “talking on mental health”
- “see everyone working together finding solutions”

Expectation of Larger Attendance or More Diverse Representation

One participant specifically noted:

- “*thought there would be more people*”

Overall Summary

Some participants attended with few expectations, however those who did express expectations hoped for:

- open conversation and shared learning
- community connection and support
- meaningful engagement with ADP
- opportunities to contribute to change

This feedback highlights that for most, there is a desire for constructive, collaborative, and recovery-affirming spaces.

Question 3 – Did the event meet your expectations?

Number of respondents = 21 (1 skipped)

For Question 3, participants were asked to rate the extent to which the event met their expectations on a five-point scale, ranging from “Fell short of my expectations” at the lowest to “Greatly exceeded my expectations” at the highest. This scale allowed respondents to indicate not only whether the event met their expectations but also the extent to which it exceeded or fell short of those expectations.

The scale was presented as follows:

1. Fell short of expectations
2. *(No label – lower-mid rating)*
3. Met expectations
4. *(No label – upper-mid rating)*
5. Greatly exceeded expectations

Below is a table of the rating categories and corresponding responses for Question 3, based directly on the SurveyMonkey results provided. All data is cited from the evaluation.

Rating Category	Description	% of Responses	Number (n)
1 – Fell short of expectations	Lowest rating	4.76%	1
2 – Lower-mid rating (<i>no label</i>)	Slightly below expectations	4.76%	1
3 – Met expectations	Event met expectations	38.10%	8
4 – Upper-mid rating (<i>no label</i>)	Exceeded expectations modestly	23.81%	5
5 – Greatly exceeded expectations	Highest rating	28.57%	6
Total		100%	21

The responses to Question 3 demonstrate a strongly positive overall evaluation of the event. Using a five-point scale from “Fell short of expectations” to “Greatly exceeded expectations,” participants’ ratings indicate that the event generally met or exceeded expectations.

More than **90%** of respondents rated the event 3 (Met expectations) or higher, and over half indicated that the event exceeded their expectations to some degree. Only 2 respondents (9.52%) indicated that the event fell short of expectations.

The most common response was “Met expectations” (38.10%, n=8), followed by the two highest categories combined— “Upper mid rating” and “Greatly exceeded expectations”—representing 52.38% of all responses (n=11). This pattern is reflected in the weighted average score of 3.67, which sits between “*Met expectations*” and “*Exceeded expectations.*”

Overall, the feedback indicates that the event was well received, with participants broadly satisfied and many reporting that the experience exceeded their expectations.

Question 4 – Have you enjoyed today’s event?

Number of respondents = 22

For Question 4, participants were asked to rate how much they enjoyed the event on a ten-point scale, ranging from “Not at all” at the lowest to “Really enjoyed” at the highest. This scale allowed respondents to express their level of enjoyment with greater nuance than a simple “yes/no” response, capturing subtle differences in the degree to which they experienced the event positively.

Participants selected a rating from 1 to 10, where:

- 1 represented - *Not at all enjoyable*
- 10 represented - *Really enjoyed the event*

- Ratings 3–9 reflected varying degrees of enjoyment without explicit labels, allowing individuals to position their experience more precisely along the continuum.

This approach provided a detailed picture of participant satisfaction. The resulting average rating of 7.9 indicates a strong positive response across the group, with most participants rating the event toward the higher end of the scale.

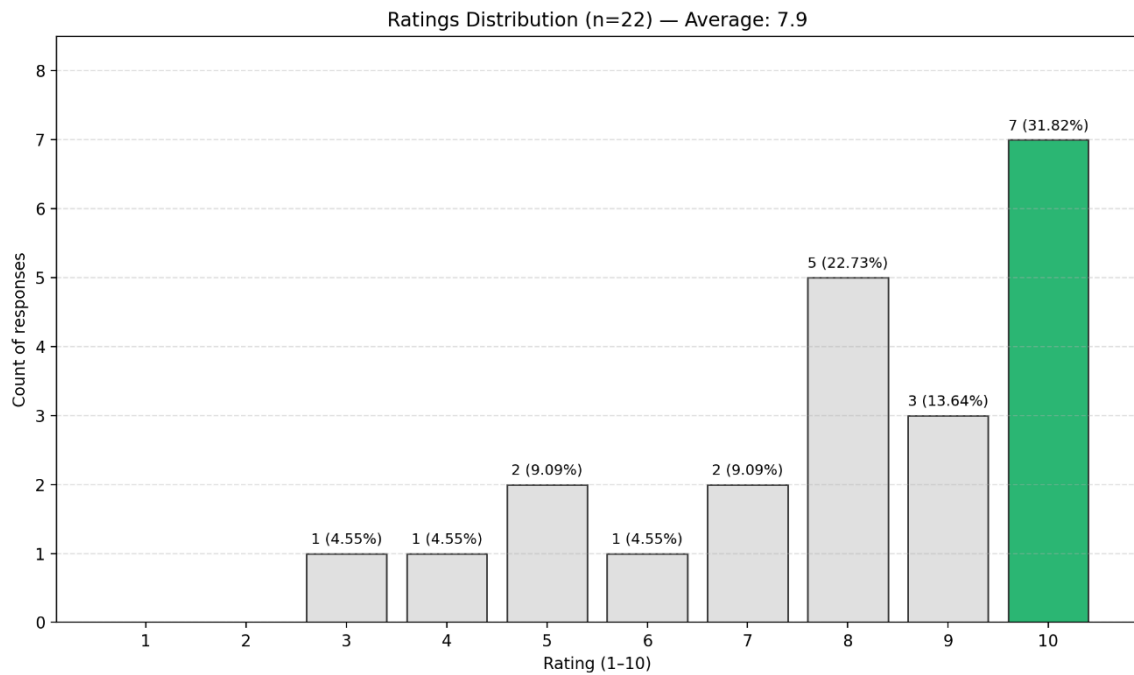
Below is a table with all ratings, count and percentages:

Rating	Count	Percentage
1	0	0.00%
2	0	0.00%
3	1	4.55%
4	1	4.55%
5	2	9.09%
6	1	4.55%
7	2	9.09%
8	5	22.73%
9	3	13.64%
10	7	31.82%
Total	22	100%

The table below shows the distribution of ratings from 1 to 10. This allows readers to quickly see how many participants selected each score and the percentage share of total responses, providing a transparent and accessible overview of the feedback.

Ratings Distribution (n=22, average 7.9)

Each bar shows the **count**, with the **percentage** labelled above.



Question 5 – What did you enjoy the most?

Number of responses = 20 (2 skipped)

Question 5 was designed as an open-ended question, allowing participants to describe in their own words what they enjoyed most about the event.

1. "hearing different ideas"
2. "the personal stories and filling out our post it notes"
3. "providing feedback, filling out post it notes"
4. "listening to people's life stories and meeting new people"
5. "different conversations"
6. "group discussions"
7. "warm friendly atmosphere and sharing LLE. Listening to the voices that see what is happening around their communities or themselves."
8. "catching up with the peers"
9. "meeting the recovery community"
10. "people coming together discussing important issues gives me hope – encouraging seeing how things can progressed"
11. "sharing experiences and having my voice heard"
12. "hearing everyone fight for what they believe in, hear their passion"
13. "hearing others"

14. "the collaboration of everyone from different backgrounds working together"
15. "The amount of information regarding support services that are available and finding out how to access those"
16. "the discussions"
17. "all"
18. "the general chat"
19. "shared experience and knowledge"
20. "the conversations at the table"

Question 6 – What, if anything, have you learned today?

Number of responses = 20 (2 skipped)

Question 6 was designed as an open-ended question. allowing participants to describe in their own words what they enjoyed most about the event.

1. "what SRC is about"
2. "learned alot about what we want to change in the recovery community"
3. "what is happening so far to help"
4. "learned a lot about what the future has to hold in the recovery world"
5. "not a lot"
6. "The tail still wags the dog"
7. "ADP have not helped by cutting funding for some groups"
8. "there needs to be a change in the system to support prevention/recovery. Better spent"
9. "the ADP committee don't care partially attendance from them"
10. "strategy does not match services"
11. "that our community is quite small – I knew most of the people who attended"
12. "reinforces the message – RECOVERY HAPPENS"
13. "recovery is possible"
14. "reminded me"
15. "I have learned so much today – it has been fantastic"
16. "service are still fragmented"
17. "lots of things to think about"
18. "more about addiction treatment"

19. "it's great to see the organisations coming together with LLE and working together"

20. "that there are bigger gaps between the community and the ADP than I had realised"

Question 7 – Have the discussions at today's event inspired you or given hope for the future?

Number of responses = 21 (1 skipped)

Question 7 was designed as an open-ended question, allowing participants to describe in their own words what they enjoyed most about the event.

1. "Yes"

2. "yes"

3. "yes definitely"

4. "It certainly has and there is so much understanding out there and it's very inspiring"

5. "some of it"

6. "they have clarified my view on the way forward for LEROS"

7. "some of them"

8. "hopefully"

9. "hope in the community stepping up and supporting each other. Not from ADP"

10. "no"

11. "yes"

12. "very much"

13. "yes"

14. "not sure I'm tired"

15. "yes they gave me a fresh outlook of changes I could make within the prison I work"

16. "Most Definitely"

17. "Always hopeful"

18. "YES"

19. "Both"

20. "today's event has shown me hope for people coming into recovery, it's not perfect, but everyone working together shows, we're all on the same page"

21. "yes - the community need more community support"

Question 8 – Did you build connections with event attendees today?

Total Responses = 20 (2 skipped)

Question 8 asked participants whether they had built connections with other attendees during the event. This question used a fixed-choice response format, requiring participants to select one of three predefined options: Yes, Somewhat, or No. This closed-ended question design allowed for a clear, quantifiable measure of the extent to which the event facilitated relationship-building and networking among participants. All responses were recorded on paper evaluation forms and later entered into the online system for analysis.

Answer Choice	% of Responses	Number (n)
No	5.00%	1
Somewhat	20.00%	4
Yes	75.00%	15
Total	100%	20

Key Findings

- 75% (n=15) of participants responded “Yes”, indicating they successfully built connections.
- 20% (n=4) selected “Somewhat”, suggesting partial or limited opportunities to connect.
- Only 5% (n=1) reported “No”, indicating they did not make any new connections.

The overwhelmingly positive responses (95% selecting “Yes” or “Somewhat”) demonstrate that the event provided a platform for networking amongst participants. This suggests that the event’s structure and facilitation effectively supported relationship-building and peer exchange.

Overall, the feedback indicates that the event successfully fostered new connections, with clear evidence that most participants engaged meaningfully with others.

Question 9 – Any other comments about today’s event?

Total responses = 11 (11 skipped)

Question 11 was designed as an open-ended question, allowing participants to describe in their own words what they enjoyed most about the event.

1. “I have just found it an inspiration “
2. “Interesting”
3. “The polarity was wrong, to elicit a report to the ADP rather than co-producing a better ROSC. What was the purpose of recovery shares since 80% if audience was in recovery”
4. “Speakers from LLE - really appreciate the share and hope they are supported after the event from a trigger point of view”

5. "disgusting behaviour from chair and also project manager (non-attendance)"
6. "It was very open and honest, not a sales pitch"
7. "a follow up event is organised before the information is opened to the ADP strategy"
8. "no/good for myself - very good day, thank you"
9. "no"
10. "No - other than it was great to see everyone coming together, sharing experiences, strategies on how to help the awareness of issues and share positive outcomes"
11. "no discussions regarding early intervention, drug education, prevention strategies"

11. Summary of Evaluation Findings

1. Why Participants Attended

Most attendees came with motivations centred on influencing change, sharing lived and living experiences, learning more about recovery, connecting with peers, and seeking meaningful engagement with the ADP. This reflects a community seeking voice, impact, and connection.

2. Expectations of the Day

Expectations varied: some had no clear expectations, while others anticipated open discussion, learning, ADP visibility, or professional/personal growth. A few expected broader representations. Overall, people hoped for honest dialogue and meaningful engagement.

3. Did the Event Meet Expectations?

More than **90%** felt the event met or exceeded their expectations. Only two participants felt it fell short. The weighted average score of 3.67/5 indicates strong satisfaction with how the day was delivered.

4. Enjoyment of the Event

Participants rated their enjoyment at an average of 7.9/10, with most scores clustered at the high end. This demonstrates that attendees found the event positive, engaging, and enjoyable.

5. What Participants Enjoyed Most

People most valued storytelling, group discussions, a supportive atmosphere, peer connection, opportunities to share lived experience, and access to service information. Conversation and community were central to enjoyment.

6. What Participants Learned

Participants gained insight into SRC's role, local system needs, service gaps, future recovery developments, and differences between strategy and lived experience. Some also highlighted fragmentation across services. A few reported limited new learning.

7. Inspiration and Hope for the Future

Most respondents felt inspired or hopeful following the event, though a few reported mixed or tired responses. Many expressed hope rooted in the community itself, but less confidence in the wider ADP system.

8. Building Connections

A strong majority—75%—built new connections, with a further 20% building some. Only one person made none. This demonstrates that the event successfully fostered peer support and community relationships.

Overall Summary

The event was broadly well-received overall and created a positive, inclusive space that fostered connection, hope, and shared learning. Participants valued being heard, contributing to change, and meeting others. However, the findings also highlight ongoing developments needed to strengthen co-production, clarify communication, and promote visible lived-experience leadership.

12. Additional Travel Findings (Question 10 – 14)

As part of the evaluation, the ADP sought to gain a clearer understanding of attendees' travel experiences, particularly the challenges they face when relying on public transport. This was an important focus given the wide geographical spread of participants and the known transport barriers across both rural and urban areas. Question 10, therefore, asked individuals where they had travelled from, providing insight into the distances covered, the diversity of starting points, and the extent to which transport—especially public transport—may influence people's ability to attend recovery events and access ongoing support opportunities.

Question 10 – Where have you travelled from today?

Total responses = 22

Question 10 asked participants where they had travelled from to attend the event. All **22** respondents provided an answer, offering a useful snapshot of the geographical spread of attendees. The responses show a wide distribution across Aberdeenshire and Aberdeen City, with some participants travelling from rural and more remote areas.

Location	Count
Aberdeen	3
Banff	3
Macduff	2
Fraserburgh	1
Portsoy	1
AB54 Forgue	1

AB44	1
Banchory	1
Cruden Bay	1
Westhill	1
Stonehaven – Aberdeen	1
Kincorth	1
HMP Grampian	1
Fettercairn	1
Lumsden Huntley	1
Bridge of Don	1
North	1
Total	22

Question 11 – What was your means of travel to get to the event?

Total responses = 22

Question 11 asked participants to describe their mode of travel to the event in an open-ended text box. This allowed respondents to detail their specific mode of transport rather than selecting from predefined options, providing a clearer picture of how people actually travelled.

Topics	Description	Count	Examples from Responses
Car Use	Participants driving themselves or sharing car transport	13	Car, Car, Driving, Car shared, own car (drive), "I drove and collected another person"
Bus Transport	Public buses, hired buses, ADP/LLE-funded buses	8	bus, hired bus, private bus, bus provided by ADP/LLE
Passenger (non-driver)	Participant travelled in someone else's vehicle	1	Passenger

Summary of Topics

- Car travel was by far the most common method, with *over half* of attendees using a personal vehicle or sharing a lift.
- Buses (public, private, or ADP-supported) accounted for just over a third of responses.
- Only one participant travelled as a passenger without driving.

Question 12 – What were the barriers to you attending today, or accessing future recovery opportunities?

Total responses = 18 (4 skipped)

Question 12 provided participants with an open-ended text box to identify any barriers they faced in attending the event or accessing future recovery opportunities.

Responses	Count
No	10
having to travel	1
the stairs	1
public transport – lack of facilities	1
stairs and bad communication on where to enter building	1
travel confusion (main door closed, unclear directions, stairs to room)	1
work	1
would have been late without car share	1
weather – snow/rain	1
Total	18

Question 13 – Could you suggest anything that could make gaining access to recovery opportunities more accessible?

Total responses = 18 (4 skipped)

Question 13 invited participants to share their suggestions in an open text box for improving access to recovery opportunities.

Suggestion
making opportunities more visible
make sure travel cost are given, which was given to us
providing childcare, using venues in the shire
transport
schedule events at weekend or evening and with crèche facilities in an accessible venue
lift or no stairs
Transport costs – rural area transport – less availability

one website with all groups listed; 3rd sector services promoting recovery groups
take recovery to communities
mainstreaming services; simplify the process
transport for everyone
being made aware
more literature
/
open the door listen to people's thoughts
no
more signposting to groups/activities/events from local organisations
bus pass

Question 14 – Any other comments?

Total response = 10 (12 skipped)

Question 14 included an open-text box for participants to share any additional comments about the event.

Comment
no
had to organise it ourselves
the scheduling of the event blocked folk with jobs or kids
This room was not accessible no lift had to go up stairs DISGUSTING!!
n/a
a note of the available car park – the closest one was labelled for councillors so I wasn't sure if I could park there
none
was a safe, good driver
Bus travel in Aberdeen is good
A number of our community members couldn't get to the bus provided because of the rural areas they live in – they can't get to the main towns.

13. Summary of Additional Travel Findings

The additional findings from Questions 10–14 provide valuable insights into the practical and environmental factors that shape people’s ability to attend recovery events and access ongoing support. Responses showed that attendees travelled from across Aberdeenshire and Aberdeen City, including several rural and remote areas. This highlights both the event’s regional reach and the significant commitment required of individuals who travelled long distances.

Travel patterns indicate a strong reliance on cars—either driving independently or sharing lifts—with buses (public, private, or ADP-supported) also playing an important role. Only one participant travelled solely as a passenger. These findings underscore the continued importance of accessible, reliable, and affordable transportation options, particularly for rural residents.

Several people highlighted challenges, including long travel distances, limited public transport, accessibility issues at the venue (particularly stairs and unclear entry points), weather conditions, and work commitments. These factors demonstrate how environmental and logistical barriers can intersect to limit participation.

Responses to how access to recovery opportunities could be improved reflected a broad range of practical suggestions, including better transport options, clearer information and signposting, increased visibility of recovery opportunities, childcare provision, more accessible venues, and taking recovery activities into communities.

Finally, additional comments reinforced these topics: some participants described positive experiences, while others highlighted issues with event scheduling, room accessibility, parking uncertainty, and the difficulties rural residents face when using centralised transport options.

Overall, the findings emphasise that transport, accessibility, communication, and venue design remain critical factors in ensuring equitable access to recovery opportunities across diverse communities.

FAIR Table – Additional Travel Findings (Questions 10–14)

Topic	F – Facts (What Participants Said / Experienced)	A – Analysis (What It Means / Why It Matters)
Wide geographical spread and long-distance travel	Participants travelled from 22 different locations across Aberdeenshire and Aberdeen City, including rural and remote areas (e.g. Banff, Macduff, Forgue, Fettercairn, Cruden Bay, Lumsden, Fraserburgh)	The widespread shows strong commitment but highlights geographical inequity in access. Rural participants face the greatest burden, reinforcing the need for local delivery, decentralised support, and improved rural transport.

<p>Heavy reliance on cars</p>	<p>13 out of 22 attendees travelled by car (driving themselves or sharing lifts). This was the most common travel mode</p>	<p>Car dependency suggests insufficient public transport and indicates that those without access to a vehicle may face systematic exclusion from recovery opportunities.</p>
<p>Significant use of buses, including ADP-supported transport</p>	<p>8 participants used buses (public, hired, or ADP/LLE-supported)</p>	<p>Reliance on buses—especially special/hired transport—shows that public transport alone is not meeting needs, particularly for rural areas. ADP-supported transport appears to be a stopgap rather than a sustainable solution.</p>
<p>Very limited options for non-drivers</p>	<p>Only 1 person travelled as a passenger without driving themselves</p>	<p>This indicates barriers for people who cannot drive (due to cost, health, or licence issues), raising concerns about equity and accessibility.</p>
<p>Mixed but notable transport-related barriers</p>	<p>Although 10 participants reported no barriers, others cited: long distances, lack of public transport, venue accessibility issues (stairs, unclear entry), weather, work constraints, and confusion around building access</p>	<p>Even when people reported “no barriers,” structural issues still affect others. The venue access challenges highlight the need for fully accessible event locations, while the travel issues reinforce transport as a major structural barrier.</p>
<p>Transport affordability, rurality, and availability issues</p>	<p>Participants referenced lack of facilities, low availability of rural transport, the need for travel cost coverage, and specific requests like bus passes</p>	<p>The cost and availability of transportation disproportionately affect people in rural and economically disadvantaged communities, limiting their consistent access to recovery opportunities.</p>
<p>Venue accessibility challenges</p>	<p>Participants noted stairs, no lift, closed main doors, unclear entry instructions, and an</p>	<p>Poor venue accessibility can exclude disabled people, people with mobility</p>

	<p>unwelcoming access experience. Comments included “This room was not accessible ... DISGUSTING!!”</p>	<p>challenges, or those with anxiety. This undermines our duties to promote equality and requires urgent improvement for future recovery events.</p>
<p>Event scheduling barriers</p>	<p>One comment noted that the event timing “blocked folk with jobs or kids” and limited participation</p>	<p>Event timing needs to be more inclusive. Daytime events can exclude working people, parents, and carers, reducing representativeness and community reach.</p>
<p>Need for clearer communication and signposting.</p>	<p>Suggestions included: making opportunities more visible, one website listing all groups, more literature, better signposting, and improved communication about venue access</p>	<p>Poor communication creates avoidable access barriers. Clearer signposting and simple communication improvements could significantly increase engagement.</p>
<p>Community desire for localised recovery opportunities</p>	<p>Multiple participants said recovery should be “taken to communities” rather than requiring long travel distances to central hubs</p>	<p>This reinforces the need for community-based, decentralised recovery support, which aligns with ROSC principles and addresses rural inequalities.</p>
<p>Positive reflections mixed with accessibility frustrations</p>	<p>Comments included praise (“safe good driver”, “bus travel in Aberdeen is good”) alongside strong criticisms of venue access and transport gaps</p>	<p>This mixed feedback suggests the event experience was positive for some but inaccessible to others—indicating inequitable participation.</p>
<p>Rural communities are unable to access ADP-provided buses</p>	<p>One comment: “community members couldn’t get to the bus provided because of the rural areas they live in—can’t get into main towns”</p>	<p>Even supportive measures (such as ADP buses) are ineffective for people in remote rural areas, underscoring the need for flexible, localised transport solutions.</p>

14. Report Summary

The *Voices of Recovery* event brought together people with lived and living experience, families, communities, practitioners, and partners to shape the future of recovery support across Aberdeenshire. The combined insights from the workshop and evaluation feedback highlight the strengths, priorities, and aspirations of local recovery communities, as well as the challenges they continue to face.

Across all discussions, participants emphasised the importance of lived-experience leadership, accessible, locally delivered support, improved transport, clear information, and better-integrated, trauma-informed services. The event was widely valued for creating an inclusive space that fostered connection, hope, shared learning, and open conversation. Participants also reflected on areas where relationships and communication with statutory partners could be strengthened, signalling opportunities for deeper collaboration and more regular dialogue.

Overall, the findings provide a robust evidence base for developing a Recovery-Oriented System of Care that is person-centred, community-led, and grounded in the lived realities of people across Aberdeenshire. They form a strong foundation for the next stage of the FAIR model—co-producing actions and accountability measures with lived and living experience at the heart of the process.

15. Next steps

The evidence gathered at the *Voices of Recovery* event provides a strong foundation for the next stage of development of Aberdeenshire's emerging Recovery-Oriented System of Care (ROSC).

Whilst local solutions must always be developed jointly and collaboratively, it is important that the learning generated through this process is carried forward into the next stage of planning. In line with our role, SRC has outlined potential ways forward that emerge directly from what participants shared on the day. These suggestions are offered as a resource to support continued dialogue and co-production. **It remains for the ADP, in mutual partnership with lived and living experience and community organisations, to determine how this learning is translated into action** and integrated into strategic planning and development.

1. Co-produce the remaining FAIR stages

Using the Facts and Analysis already presented, the next stages—Identify (what needs to happen) and Review (how progress will be monitored)—should be developed collaboratively with people with lived and living experience, LEROs, community groups, and ADP partners.

2. Hold a follow-up engagement session (SRC to facilitate)

Participants requested further engagement before submitting information to the ADP strategy process. A follow-up session would provide an opportunity for SRC to share the report's findings.

3. Strengthen communication and visibility

Develop clear communication pathways to ensure people can:

- see how their contributions are being used
- track progress on actions

- access accurate, up-to-date information about services, groups, and opportunities

4. Begin joint work on priority topics

Several cross-cutting topics emerged consistently (LLE leadership, transport, communication, funding, trauma-informed practice, integration). Establishing small, focused working groups—each co-led by lived and living experience—would enable immediate shared problem-solving.

5. Review accessibility and participation barriers

Transportation, venue access, event timing, and information sharing all shaped participation. A practical accessibility plan should be developed to facilitate engagement with future events and recovery opportunities across rural and urban areas.

6. Share the report

Distribute the report to:

- participants who attended the event
- recovery communities and lived experience organisations
- third sector partners
- service providers
- ADP committee

7. Integrate learning into ADP strategic planning

Ensure the evidence, topics, and lived-experience insights directly inform the ADP's 2026–2031 strategy and align with the national commitment to person-centred, community-led recovery.

Tracey McFall

Scottish Recovery Consortium

March 2026