


Models of Recovery



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Executive Summary

Background

The government's 2010 drug strategy calls on the drug treatment system in England to concentrate more on helping and encouraging people with drug dependency problems to make a full recovery. It says: "instead of focusing primarily on reducing the harms caused by drug misuse, our approach will be to go much further and offer every support for people to choose recovery as an achievable way out of dependency" (Home Office, 2010, p2).

About this project

The Yorkshire and Humber Regional Recovery Forum was established in 2008 to identify and stimulate best practice recovery interventions across the region. The forum decided at an early stage to take a pragmatic, delivery based approach and focus on how everyday practice within treatment services might change to better facilitate recovery. The forum was keen to see if the strategic focus on recovery stimulated any innovative new models of treatment delivery that could be evaluated and ultimately shared with a wider audience looking to change established practice.

This summary is an attempt to assess the extent and effectiveness of some of the recovery work now happening in Yorkshire and the Humber, and suggest ideas that could be easily adapted for use in other locations. The full report can be found at <http://www.nta.nhs.uk/yandH-recovery-forum.aspx>

The review looked at eight projects which were chosen based on their level of innovation, the ease with which they could be replicated elsewhere and their cost effectiveness. In short, the forum agreed that the projects should be doing something different, be transferable and be cost effective. The chosen projects were:

- The whole system reconfiguration by Barnsley Drug and Alcohol Action Team
- Recovery-oriented services in Halifax focused around The Basement Recovery Project
- Doncaster DREAM peer support & mutual aid programme
- Project 6 accredited peer support in Keighley
- Sheffield specialist prescribing service 'Stuck and Stable' project

- Wakefield MERLIN iron age village.
- Bradford Bridge Project staff development of mutual aid awareness and integration
- North Lincolnshire primary care specialist recovery clinic.

Each project varied in their approach to supporting or facilitating user's recovery journeys, but the review asked each project the same questions, in order to identify common themes.

The questions were:

1. What are the aims of the project?
2. Which principles of recovery does it address?
3. What are the strengths and resources of the team?
4. What challenges does it face?
5. How does the project fit into a wider recovery culture or system change?
6. How does it generate communities of recovery and promote long-term change?
7. How does it evaluate outcomes?
8. How we can support the next steps?

These projects divided into three broad groups, although there was some overlap:

- 'System change models' requiring systemic reconfiguration by commissioners at a strategic level.
- 'Peer-based models' run by and for service users both independently of and embedded within treatment services.
- 'Service-delivery models' requiring treatment agencies to rethink their delivery of established core services.

From this process emerged a series of findings for local commissioners, would-be recovery projects and drug treatment staff to consider:

RECOVERY SYSTEM CHANGE PILOT PROJECTS

In two areas the innovation took place at a systems level. In Barnsley, commissioners created a new configuration of services within a recovery-oriented model. The system is underpinned by a Care and Recovery Navigation service created with the purpose of care co-ordinating service users on their entire recovery journey. In Calderdale, the appointment of a recovery coordinator at a strategic level to develop and co-ordinate recovery pathways for drug and alcohol users across health and social care provision, led to the emergence of the Basement Recovery Project and other recovery activities in the locality.

Finding 1: Recovery projects can succeed best where the wider treatment system accommodates them. Every local partner at both an operational and strategic level e.g. service providers, GPs, the police, Job Centre Plus, should all be encouraged to buy-in to the idea before the project is launched.

Finding 2: To help avoid resistance to change elsewhere in the treatment system, recovery projects need the backing of a 'recovery coalition'. Representatives from a wide range of bodies should oversee the communication of the broader recovery 'vision' and its fulfilment.

Finding 3: Commissioners should ensure there are clear referral pathways to recovery projects. Referring agencies should have contractual targets, to ensure recovery projects have a good flow of clients.

Finding 4: For a recovery system to involve the majority of substance users, joint working protocols are more effective if they ensure that treatment staff engage with recovery groups.

Finding 5: Audits of the opinions of service users, family members, staff and managers, along with case-file reviews on referrals and engagement with community groups, make up part of the growing evidence base for recovery.

"We are undoubtedly immature in our development of recovery oriented systems of care. Throughout the country we hear of models of best practice which are rarely evaluated objectively, making learning from area to area difficult. Contrary to popular practice, it is not as easy as replacing the word 'treatment' with that of 'recovery'. Innovation in our field is indeed a rarity which is why the importance of work such as this cannot be underestimated as we move forward in creating change"



PEER BASED APPROACHES

Project 6, Doncaster DREAM and Wakefield MERLIN, all represented models of innovation focused on peer models of support. Although the three projects are all at different stages, there has been significantly greater progress in making the peer mentoring programme at Project 6 a mainstream activity. This is largely due to the peer mentoring programme having Project 6 management structures and systems available as a 'parent' organisation to aid development.

Finding 1: The NTA should work with local areas to monitor and map the work and progress of all community-based recovery projects

Finding 2: Whilst peer projects don't have to be embedded in specialist treatment services, those that work best have a 'parent organisation' that helps help with structure, management and on-going development.

Finding 3: Service users find it useful to have a clear programme that does not rely on a single provider. Programmes are more successful if they offer a broad range of meaningful continuity options that enable development of skills and effective linkage to wider community assets such as education, training and volunteering.

Finding 4: Projects should consider encouraging on-going engagement or volunteering options within the project. Give those individuals graduating from peer projects an incentive to remain engaged.

Finding 5: A region-wide set of criteria is needed to evaluate community and peer programmes. The criteria should start by measuring activity and processes within services, and then look at service user's individual growth in personal and social recovery capital.

"Some of the best training I ever had, NA was a mystery for me until today."

"Listening to people share how they'd recovered the 'NA way' was the most powerful part of the day".

"The workshops gave me some useful tools to help clients overcome some of the barriers they have to attending NA"

"I feel much better equipped to help talk to my clients about how NA may play a role in their recovery"



SERVICE DELIVERY MODELS

Three projects focused on improving recovery-based activity within existing structured drug treatment services. The Bridge project in Bradford attempted to develop positive staff attitudes to and engagement with, Narcotics Anonymous to increase client engagement in mutual aid. In North Lincolnshire, the shared-care programme used evidence-based psychosocial interventions to develop recovery-focused treatment clinic for a more stable cohort. In Sheffield the specialist prescribing service adopted a similar approach, where a consultant psychiatrist led a treatment team in delivering a recovery-orientated programme based on the Texas Christian University Treatment Effectiveness model.

Finding 1: To sustain their impact, projects need to have a clear, written strategy for developing the skills and knowledge of staff, and for ensuring recovery initiatives become part of mainstream treatment and the wider community.

Finding 2: Service user ownership of recovery initiatives is essential, as is the development of peer and volunteer components. These should have strong links to wider communities of recovery to maximise their impact.

D.R.E.A.M peer support was great for me as I was relatively early in my recovery and gave me somewhere to go on a Saturday with people in the same boat as me; I even did the cooking for lunch as I am a trained chef. There is a growing recovery community in Doncaster that has evolved from D.R.E.A.M and I have made some close friends that are also involved in SMART and mentoring that I met there.



CHALLENGES

All services were found to face common challenges in delivering the recovery agenda:

1. Integration with and influencing established orthodox specialist treatment provision, especially those prescribing treatments for long-term service users.
2. Increasing the throughput of service users from prescribing services, and developing recovery graduates who can then actively engage with other users accessing specialist services.
3. Enabling culture and attitude change in service staff and commissioners.
4. Enabling continuity of funding for recovery initiatives and the resulting stability to build effective programmes and the essential links in the community
5. Scoring 'quick wins' in terms of inspiring and engaging clients who may have a more passive view of 'treatment'
6. Identifying recovery champions from both service users and staff to create the drive and motivation while assuring safety nets and supports that enable recovery.
7. Ensuring that the recovery champions' influence is sufficiently widespread that the recovery innovations gain system - wide, on-going support for people who exit treatment successfully.
8. Establishing credible measures and evaluation mechanisms for early process aspects of delivery and linking these to recovery-focused outcomes such as training, volunteering and employment.
9. Creating a range of services that build personal and social capital for all service users and provide the safety net of a conspicuous, supportive recovery community.

"Peer support training and peer mentoring has helped me in many ways and given me an insight into other people and their recovery. It has helped me build my confidence and fine tune my people skills. I have gained further understanding of recovery and the knowledge behind it. The training has given me a good foundation to start a course in Health and Social Care and the experience I have gained has created a pathway for me to work towards an advocacy role."



These are the nine key areas that all drug treatment projects may need to address if they are to become truly recovery focused. By addressing these areas projects will also be able to measure their success within local treatment systems whilst generating and supporting long term sustainable recovery.

"If nothing changes, nothing changes"

Earnie Larsen

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Alcoholics Anonymous	www.alcoholics-anonymous.org.uk
Narcotics Anonymous	www.ukna.org
SMART Recovery UK	www.smartrecovery.org.uk/

And people in recovery everywhere.