

# Building recovery in communities:

A consultation for developing a  
recovery-orientated framework to  
replace Models of Care

Questionnaire

Deadline: 4 May 2011



*National Treatment Agency  
for Substance Misuse*

# Introduction

In the new drug strategy, the Government has set out a clear ambition for individuals to achieve recovery and support people to live a drug-free life. This vision recognises that people do not take drugs in isolation from what is happening in the rest of their lives. It acknowledges that the causes and drivers of drug and alcohol dependence are complex and personal. Thus it argues that the solutions need to be holistic and centred around each individual, with the expectation that full recovery is possible.

The strategy recognises the achievements of the treatment system in the past, by building capacity and bringing about substantial gains in both health and crime reduction. However, a fundamental difference is that it challenges the whole system to go much further in the future. It specifically rejects the emphasis of its predecessors on the harms caused by drug misuse, in favour of a new approach that offers every support for people to choose recovery as an achievable way out of dependency. Ministers have made clear their determination (over the next four years) to break the cycle of dependence on drugs and alcohol, and the wasted opportunities that result.

For the first time, the 2010 drug strategy seeks to bring together all aspects of substance misuse treatment. As well as treatment for dependence on illicit drugs, it covers alcohol, 'legal highs', and over-the-counter and prescribed medications. It also seeks to tackle drug treatment in all settings, whether community, in-patient, residential or prison. Our task, therefore, is to create an integrated system of recovery that not only effectively engages people in treatment and reduces harm, but also supports them to move through that system with the ultimate aim of overcoming their dependence for good.

The strategy pledges to consult on a new national framework for recovery. This will replace Models of Care for Treatment of Adult Drug Misusers (originally published in 2002 and updated in 2006) with an up-to-date evidence-based model to support local areas in increasing the recovery orientation of local systems. It could also replace the elements that focus on the treatment of dependence in Models of Care for Alcohol Misusers (2006).

The existing evidence base underpinning effective treatment interventions for substance misuse has been set out in influential publications including NICE guidance and the 2007 Clinical Guidelines. However, if the system is to be truly recovery-focused, we must now enter relatively uncharted territory. Learning from experience about what is effective to support people moving through the system, and gaining new evidence about how they sustain recovery after leaving treatment, will be essential.

The NTA now wishes to invite the drug and alcohol treatment field to participate in developing this new recovery-orientated framework. We will also canvass the views of other specialist agencies in relation to key recovery issues such as housing, employment and re-offending. The consultation will last 13 weeks, and interested parties will be offered a variety of opportunities to share their ideas and evidence. We want to encourage the widest possible participation, not only through formal responses to this document, but also via other communications channels and activities such as local focus groups hosted by the NTA.

# Note to respondents

We want as wide a response to this consultation as possible. You don't have to answer every question – answer as many or as few as you wish.

We have not put a limit on the number of words in your response, but it will help us to process the anticipated high volume of responses if you could be as brief and succinct as possible. In responding please do provide any evidence and/or examples of good practice that you may have either in your response or as an attachment when submitting your response. If you submit additional documents as an attachment please indicate clearly the question that the information corresponds to.

This consultation is anonymised and you do not need to give your name. However, to help us ensure we have a balanced response, it would be helpful if you could tell us a little about yourself. This information is optional, though, so please leave any part of it blank if you would prefer.

We plan to use extracts from responses when we report back on the consultation exercise. Please indicate if you would prefer us not to use any of your response. The deadline for responses is 4 May 2011.

If you have any queries, or require the questionnaire and/or supporting information in an alternative format, please email [yourviews@nta-nhs.org.uk](mailto:yourviews@nta-nhs.org.uk)

This questionnaire is available as an interactive document which you can save and email to [yourviews@nta-nhs.org.uk](mailto:yourviews@nta-nhs.org.uk) or it can be printed off, filled in manually and posted to Paul Hammond, NTA, Skipton House, 80 London Road, London SE1 6LH.

Job title (if any):

Organisation name (if any):

Region where you work/live:

Sector – drug treatment professional/alcohol treatment professional/drug and alcohol treatment professional/service user/family member or carer/criminal justice sector/other, please specify:

Do you consider yourself to be a keyworker?

yes  no

We plan to use extracts from responses when we report back on the consultation exercise. Are you happy for us to use extracts from your responses?

yes  no

# Widening the focus to consider dependence on all drugs

(HM Government Drug Strategy 2010)

For the first time, the 2010 drug strategy brings together all substance misuse treatment. This includes treatment for dependence on illicit drugs, alcohol, 'legal highs' and in all settings (community, in-patient/residential and prisons). The focus is on the individual, not the drugs they are using at any given time and to ensure that there is better continuity of care between prison and community-based treatment settings.

The drug strategy commits us to consult on whether it is desirable to replace Models of Care with a single recovery-focused framework that applies equally to drugs and alcohol dependence. The principles will apply to all settings.

Do you think the proposal to replace Models of Care with a new unified document is justified? If so, what are the key issues in bringing together all substance misuse treatment in a single framework?

yes  no

please list and describe key issues

What do you see as the advantages and disadvantages of bringing together Models of Care for Adult Drug Misusers (MoCDM) and the elements that focus on treatment of dependence in Models of Care for Alcohol Misusers (MoCAM) into a single recovery-orientated framework?

advantages

disadvantages

What, if any, are the areas of the framework that may be more difficult to implement in the context of prison-based treatment? Please list and describe any difficulties.

How do the systems promoting recovery need to reflect specific factors relating to ethnicity, gender, gender reassignment, disability, age, sexual orientation, religion/belief, pregnancy and maternity considerations? What proportionate measures could address those issues?

# Recovery can only be delivered by addressing the needs of the whole person (HM Government Drug Strategy 2010)

As set out in the new drug strategy, recovery involves three overarching principles – wellbeing, citizenship and freedom from dependence. We know that there are a wide range of changes that people may make in the course of a recovery journey and therefore recovery may be best defined by the outcomes that are achieved in the course of an individual's journey. A number of best practice outcomes have been identified in the new drug strategy. These include:

- Freedom from dependence on drugs or alcohol
- Prevention of drug-related deaths and blood borne viruses
- A reduction in crime and re-offending
- Sustained employment
- The ability to access and sustain suitable accommodation
- Improvement in mental and physical health, and well-being
- Improved relationships with family members, partners and friends
- The capacity to be a caring and effective parent.

These principles will help inform the development of the Payment by Results (PbR) for drugs recovery pilots, which aim to incentivise and reward providers that support individuals, to recover from their dependence, resulting in clear outcomes for the individual, their families and communities.

■ How do you think these best practice outcomes could be defined and measured?

please list each outcome domain – accompanied with a short paragraph indicating how they can be defined and measured

■ How can services that focus on reducing drug-related deaths and the spread of blood-borne viruses act as a platform for individuals to access structured, recovery-focused treatment?

# Recovery is an individual, person-centred journey as opposed to an end state and will mean different things to different people (HM Government Drug Strategy 2010)

The NTA proposes that the framework will support the development of a system where recovery is viewed as an achievable and realistic goal for the majority of service users and their families. This will require local areas to rebalance their systems to support multiple pathways to achieve recovery outcomes while continuing to be effective in reducing drug-related harm. Recovery is an individual person-centred journey with self-defined pathways that may include:

1. Abstinence from drug(s) of dependence
2. Abstinence from all drugs & alcohol
3. Controlled or low-risk use of alcohol
4. Medically assisted recovery using substitution or other medications

What are the key things that partnerships and service providers can do to increase the opportunity and access to a range of recovery pathways?

## We want to encourage people to take responsibility for their health, and support them to recover (HM Government Drug Strategy 2010)

We propose that the new framework promotes a shift in care-planning practice towards service user led recovery planning. We recognise that in a small minority of cases (and often at specific times in an individual's treatment journey) client identified goals may present issues of risk/harm for the user, their family and the community, or may appear unrealistic.

In the same way that we want to enable local treatment systems and providers to find their own innovative solutions to delivering a recovery-orientated system, we want to empower service users to be able to take greater responsibility for planning, delivering and sustaining their own recovery. A recovery plan could provide a tangible list of objectives, actions, and steps that the service user may undertake each day/week to accomplish their goal for a particular period. It aims to empower service users, helping them to recognise their ownership and ultimate responsibility for their recovery and rebuilding their lives. A recovery plan could also be explicit about the role of others.

Do you agree with the proposal to shift care-planning practice towards service user-led recovery planning?

What are the key components of recovery planning?

please list the key components and provide a description where necessary

How can the role of recovery planning be operationalised?

How can systems and services best ensure that recovery planning is sufficiently ambitious and challenging yet does not place the service user at unnecessary risk or set them up to fail?

# Active promotion of mutual aid networks will be essential

(HM Government Drug Strategy 2010)

The terms mutual aid and peer support are often used interchangeably. While these two functions share some similarities, initial consultation suggests two different functions within a recovery-orientated system. These differences may be captured in the following descriptions:

**Mutual aid:** is used to refer to a defined relationship – underpinned by a structure, theoretical model or set of traditions or expectations – whereby the individual is both the donor and recipient of support based on shared life experiences. This is a completely voluntary relationship.

**Peer support:** is used to refer to a supportive relationship, where an individual who has experience of drug or alcohol problems may be specifically recruited on a paid or voluntary basis to provide support and guidance to peers. Peer support can also include less formal supportive arrangements where shared experience is the basis but generic support is the outcome (e.g. as a part of a social group).

■ How do you see the role of mutual aid in an integrated recovery-orientated system?

■ How do you see the role of peer support in an integrated recovery-orientated system?

# Recovery can be contagious. People tell us they are most motivated to start on their individual recovery journey by seeing the progress made by their peers (HM Government Drug Strategy 2010)

There are an increasing number of mutual aid and peer support networks becoming available within local communities. They can provide an important source of enduring support to service users and their families, both during and after the successful completion of treatment. These networks have been shown to reduce service users' dependence on formal services and empower people to take more control of their lives (Humphreys, 2004).

We propose that all service users have the opportunity to see what recovery looks like, what it offers and that it is a realistic and achievable ambition, by actively promoting recovery and through the development of active recovery communities. The new drug strategy encourages local areas to establish 'recovery champions' at three levels (strategic, therapeutic and community recovery champions).

How can the new framework best support the development of local systems in which mutual aid and peer support are well integrated and valued resources?

How can systems and services best implement the three levels of recovery champions as described in the drug strategy?

please address each level in turn

What are the key components of a recovery community?

How can the impact of a recovery community be demonstrated?

**Evidence shows that treatment is more likely to be effective, and recovery to be sustained, where families, partners and carers are closely involved** (HM Government Drug Strategy 2010)

Evidence indicates that treatment is more likely to be effective and recovery to be sustained where families, partners and carers are closely involved in service users' recovery. This can provide an important source of social support and helps the service user build crucial social capital.

The drug strategy acknowledges the need to encourage and support local areas in promoting a whole family approach to recovery; and also the need to provide support services for families and carers in their own right.

How can local systems and services better involve families, partners and carers in the treatment and recovery process?

What are the key sources of support that families, carers and partners need to enable them to participate in the service user's treatment and recovery?

please list and describe where necessary

How can the framework support local areas in strengthening the support that is available for carers, partners and family members?

# An integrated approach to support people to overcome their drug or alcohol dependence must be the priority

(HM Government Drugs Strategy 2010)

Parts of the recovery system need to become more joined up with greater continuity of care (for example, between prison and community based services including residential settings). Systems will need to be dynamic, integrated and flexible enough to meet the recovery needs of individual service users and their families. Models of Care (MoC) set out a national framework for the commissioning of adult substance misuse treatment, in effect, providing a blueprint for a standardised treatment system based around a four-tiered model of service delivery.

There is a possibility that the model of tiered treatment may have implied treatment was sequentially based, creating barriers to accessing particular interventions and settings (e.g. residential rehabilitation and injectable clinics). To support the development of a well integrated recovery-orientated system the NTA is considering moving away from a four-tier model to a model that places service users and their recovery journey at the heart of commissioning and service delivery, in an effort to break down some of the barriers that may have emerged as a consequence of the four-tier model.

How can the framework best support systems in developing greater continuity of care between prison and community services?

Do you consider that moving away from a four-tier model will be beneficial in supporting the development of integrated recovery-orientated systems?

yes  no  please explain your answer, providing the advantages and disadvantages

advantages	disadvantages

# Recovery is not just about tackling the symptoms and causes of dependence, but about enabling people to successfully reintegrate into their communities

(HM Government Drug Strategy 2010)

Systems will require a step-change in joint working between specialist treatment and mainstream services in order to address a greater emphasis on wider reintegration and recovery support. Support to gain employment and secure suitable housing play a crucial role for many in the development of personal and social resources that will help service users move through the treatment system and sustain recovery, and as such should be made available right from the start of the recovery journey. The new national drug strategy recognises that in the past a lack of effective employment and housing support has eroded for many individuals the benefits that treatment had offered them.

How can local systems best work with those in the employment and housing sectors to support successful reintegration into communities?

In delivering an integrated recovery-orientated system we would expect treatment systems and services to work in a more family-orientated way. How could the framework best support this?

What are the main barriers to individuals who are recovering in securing employment (including volunteering) and how could we best overcome them?

please list each barrier separately and indicate whether it is specific to paid or voluntary employment

What do you think are the best ways to get local employers to think of individuals in recovery as potential employees?

How can the framework support improved access to mental health services for individuals with a mental health dual diagnosis?

# Improving effective practices and integrated approaches to safeguarding the welfare of children (HM Government Drug Strategy 2010)

The new drug strategy acknowledges the need for drug treatment systems and services to do more to 'keep children safe and rebuild families'.

A third of the people accessing treatment have childcare responsibilities (NTA, 2009). This will, for some parents, encourage them to enter treatment, stabilise their lives and seek support. For some children it may lead to harm, abuse or neglect and others may take on inappropriate caring roles putting their education, health, well-being and future life chances at risk. Although some services have effective practices and integrated approaches to safeguarding and parenting support, the needs of the children of substance misusing parents are still too often invisible.

What can be done to ensure that services and staff are confident and competent to safeguard children and promote improved parenting capacity?

How can the framework support the development of systems and services that are integrated, identify and respond to the impact of parents behaviour on the child?

# Developing an inspirational recovery-orientated workforce; promoting a culture of ambition, and a belief in recovery (HM Government Drug Strategy 2010)

An integrated recovery-orientated treatment system will need a competent workforce, working in a collaborative effort to deliver positive outcomes. The range of competencies will need to be diverse and yet all working to a shared set of recovery-orientated values and principles.

Systems will need a full range of specialist and non-specialist medical competencies. This includes sufficient access to the specialist competencies required to provide direct clinical care for complex clients and provide clinical leadership, development and support for the local treatment system. It will need a workforce able to deliver a full range of evidence-based psychosocial interventions, harm-reduction interventions and effective key working. Systems will need to support and train those delivering peer support and have personnel competent to champion recovery in the system.

How can the new framework support systems in developing a competent and inspirational recovery-orientated workforce?

Which areas of competence do you think will need the most development?

please list and explain your answer

# Developing patient placement criteria to deliver better clinical outcomes, increase value for money, and most importantly to help individuals find the right treatment

(HM Government Drug Strategy 2010)

There is no effective 'one size fits all' approach to the treatment of drug and alcohol dependence. Dr David Best is currently chairing an independent cross-sector group of leading clinicians and academics to look at how we might better match individuals to packages of care that best meet their needs. These 'patient placement criteria' will be designed to indicate the most appropriate interventions and setting for an individual service user and also allow local commissioners to plan services depending on how their population 'segments' into different recovery categories.

The drug strategy 2010 suggests that local areas may wish to consider implementing a single assessment and referral processes. Such processes are being evaluated as part of the Payment by Results (PbR) pilots in the form of Local Area Single Assessment and Referral Systems (LASARS). While the LASARS may differ in detail across local areas, this service will provide triage, assessment and referral for all service users based on their individual needs.

We propose to develop a framework that supports the delivery of personalised packages of care, drawing on a menu of options. The system will need to understand an individual's problems, but also focus on their strengths and coping capacities, and what can be drawn upon (and strengthened) throughout their recovery journey.

How can the new framework best support a personalised patient placement model that includes scope to enable individuals to draw upon and develop their strengths and capabilities and address their needs?

How can the framework ensure that systems deliver a range of effective psychosocial interventions, delivered as the mainstay of treatment and enmeshed with prescribing interventions as appropriate?

How can we improve people's capacity to choose between residential and community based options?

How can the framework best support local areas in implementing single points of assessment and referral, and avoid repeated assessment?

# Encouraging offenders to seek treatment and recovery at every opportunity in their contact with the criminal justice system (CJS) (HM Government Drug Strategy 2010)

The link between substance misuse and crime is well understood, as is treatment's ability to facilitate significant reductions in offending and re-offending. An individual's clinical need is not affected by his or her legal status. The Integrated Drug Treatment System in prisons and the Drug Interventions Programme in the community have made real progress in the treatment of drug-dependent offenders, but there are still too many people whose treatment is interrupted in the transition between prison and the community.

What do you consider to be the key difficulties and opportunities in implementing a recovery-orientated framework in a prison setting?

please list key difficulties and opportunities separately

How can recovery services for drug and alcohol dependence be developed within prisons, building on the recent improvements in prison drug treatment?

What would help promote recovery for offenders being released from prison?

# Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification (HM Government Drug Strategy 2010)

As the new drug strategy acknowledges, prescribing interventions play an invaluable role in the treatment system. Opioid substitution therapy – when allied with psychosocial interventions – is among the best evidenced treatment that we have. While it is clear how substitute prescribing can be recovery-orientated (e.g. White 2010) there is a common consensus that in some cases more could be done to help people move on after a period of prescribing stabilisation.

It is accepted that no one should be on opioid substitute medication, whether high or a low dose, without the offer of help to detoxify as soon as they wish. There are, of course, some people who will have a genuine need to be on a prescription for a long period of time, but a system of regular, time-bound reviews should ensure that no one will be in this position unless it is really clinically necessary.

Professor John Strang is currently chairing an independent cross-sector group on this topic and we would like to be able to feed your views into this process through the questions below:

How can we ensure that substitute prescribing is recovery-focused, and provided as part of a wider package of care that assists the service user in achieving recovery outcomes (for example, recovery-orientated methadone maintenance or medically assisted recovery)?

What can be done to ensure that service users with genuine needs for long-term treatment continue to be supported in a recovery-orientated system?

# We need to become much more ambitious for individuals to leave treatment free of their drug or alcohol dependence so they can recover fully (HM Government Drug Strategy 2010)

Getting people in to treatment and engaging them long enough to derive benefit from treatment is important but too many people drop out before successfully completing. We know that people who successfully complete treatment have a better chance of sustaining recovery than those who leave in an unplanned way (NTA, 2010).

Our task is to create a system of recovery that focuses not only on effectively engaging people in treatment but also supporting them in moving through that system, successfully completing treatment and ultimately overcoming their dependence for good.

How can the framework best support local areas in optimising the number of people who move through the system and successfully complete treatment?

What do you think are the key factors that prevent individuals successfully completing treatment? How can the framework best support local areas to overcome these?

please list each factor – with a description of how the framework can support local areas in overcoming them

What are the key interventions and support that people need to assist them in sustaining long-term recovery following the successful completion of treatment?

please provide examples, where appropriate

## We are committed to continuing to review new evidence on what works in other countries and what we can learn from it (HM Government Drugs Strategy 2010)

We know that drug treatment works. Outcome studies from the UK and abroad, regardless of methodological or definitional differences, consistently show that people's lives improve markedly on a whole range of domains once they enter treatment.

However, nearly all the evidence concentrates on changes in behaviour while people are in treatment rather than after they leave. There are understandable concerns about the limitations of a slowly emerging evidence base (Best, 2010) and what sort of treatment works best for which sort of person, and how to work with people to give them the best chance of recovery in the long-term.

The past ten years has seen a significant increase in the availability and choice of treatment services. To a large extent, we have now implemented, through the old Models of Care frameworks, what we know to be effective. If the system is to be truly recovery-focused we must now enter territory that is relatively uncharted in terms of what is effective after people leave treatment – learning from experience and gaining new evidence as we progress.

What are the key points that need to be incorporated into the framework to support partnerships in continuing to develop a balanced treatment system i.e. placing a greater emphasis on moving people through the system and into sustained recovery while maintaining the improvements that have been achieved in terms of waiting times, access and retention?

What are the key gaps in the recovery evidence base and how do you think they could best be filled?

Please provide evidence to support your response, where possible

## We need to respond to new and emerging evidence, to respond flexibly to the changing nature of the drugs trade and the outcomes being achieved (HM Government Drugs Strategy 2010)

Around 70,000 people every year access psychosocial-only treatment (i.e. with no prescribing component to their care). This has been a big change for the drugs field, and it probably reflects the large increase in cocaine powder and cannabis use during the past decade. Alcohol services have always worked predominantly with the provision of psychosocial support and there may be opportunities this presents in local systems of care.

Services also need to be able to address new patterns of drug misuse. 'Legal highs' are becoming more prevalent and this is bound to be reflected among the people entering drug treatment. Providers and commissioners need to be alive to these emerging needs.

The drug strategy also gives a new focus on over-the-counter and prescription medicines. Again, this presents new challenges to a field that has traditionally focused on heroin, crack cocaine and alcohol.

What are the main challenges for the field in moving to treat a wider range of substance abuse problems?

please list main challenges

What are the key challenges in developing and implementing a single framework that deals with drug and alcohol dependence together?

please list main challenges

How can these challenges best be overcome?

Thank you for taking the time to complete this consultation.