

Recovery innovations in Yorkshire and Humberside

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ACT Research

Final report

Background

“The journey to recovery requires great fortitude and a supportive network. As we celebrate National Alcohol and Drug Addiction Recovery Month, we also express our appreciation for the family members, mutual aid groups, peer support programs, health professionals, and community leaders that provide compassion, care, and hope. Across America, we must spread the word that substance abuse is preventable, that addiction is treatable, and that recovery is possible”.

—Barack Obama, Presidential Proclamation, National Alcohol and Drug Addiction Recovery Month

At least in the US, as the above quotation suggests, the principles of recovery have entered the mainstream of thinking and recovery is accorded a place alongside treatment and prevention as core to policy and practice in addressing addiction issues, for both alcohol and illicit drugs. The importance of a recovery approach in the UK is acknowledged in the new strategy - in the 2010 strategy introduction, the Home Secretary, Teresa May MP, states that “A fundamental difference between this strategy and those that have gone before is that 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).

Yet there is a concern that strategy is significantly in advance of the evidence base and that the fundamental shift in policy and practice that a recovery model necessitates has not been matched by research at any of the levels of individual recovery, ‘what works’ in services supporting recovery, and in establishing wider systems of recovery facilitation – generally referred to as ‘recovery-oriented systems of care’. There is also a concern that local practice is also ahead of its evaluation and mapping, with recovery activity and innovation growing around the UK without adequate mapping or measurement of its success.

What the project in Yorkshire and Humberside enabled us to do was to assess what is currently going on in terms of innovation in the area. Following a selection process engaged in by the NTA

regional office, a total of eight projects were short-listed for inclusion in the review process. They are:

- System reconfiguration in Barnsley DAAT
- Recovery-oriented services in Halifax focused around the Basement
- DREAM in Doncaster
- Project 6 in Keighley
- Sheffield stuck and stable project
- MERLIN iron age village
- Bradford Bridge project development of NA awareness and integration
- North Lincs primary care and recovery programme

The model for the evaluation was to describe what the key elements of innovation were in each area and to start the process of assessing what is working and what the key ingredients of success were in each area. To do this, our analysis focused on three levels of recovery activity – the individual, the service and the wider system – referred to as a ‘recovery-oriented system of care’.

Our model for assessing projects was largely based on the Centre for Substance Abuse Treatment’s (2009) principles for recovery and principles for a recovery-oriented system of care which are set out below. The recovery principles are:

- There are many pathways to recovery
- Recovery is self-directed and empowering
- Recovery involves a personal recognition of the need for change and transformation
- Recovery is holistic
- Recovery has cultural dimensions
- Recovery exists on a continuum of improved health and wellbeing
- Recovery emerges from hope and gratitude
- Recovery involves a process of healing and self-redefinition
- Recovery involves addressing discrimination and transcending shame and stigma
- Recovery is supported by peers and allies

- Recovery involves rejoining and rebuilding a life in the community
- Recovery is a reality

The key features from this list are that there will be considerable variations in who programmes are targeting and how they go about supporting and enabling the personal and individual recovery journeys. As a consequence, the basic list of questions that we set about attempting to answer were the following:

1. **What the aims are and what principles of recovery the project addresses?**
2. **What the strengths and resources of the team are?**
3. **What challenges it faces?**
4. **How it fits into a recovery process / culture or system change?**
5. **What its goals can be and what its wider impact can be, in terms of generating communities of recovery and long-term sustainable change?**
6. **What the best methods of evaluating are or will be?**
7. **How we can support the next steps?**

From early on in the process, it became apparent to the research team that our role was as much about consultancy and support to each of the projects as providing anything that looked like traditional evaluation. The reason for this was twofold – first, that most of the projects had found that identifying sources of research, evaluation and guidance on both the establishment and monitoring of their projects was extremely difficult. Secondly, a major concern was that, even for the standalone projects, their success was largely determined by the active engagement of their commissioners and the wider treatment system and that the responsiveness of partners was a primary determinant of their success. From this, two key recovery lessons can be learned and these are the first recommendations of the project:

RECOMMENDATION #1: Innovative recovery projects will only succeed, irrespective of their own merits, if the overall treatment and support system can be moulded to accommodate them. To establish a recovery service that works requires the buy-in and cooperation of all local partners and this should be established in advance of the project being launched.

RECOMMENDATION #2: As a result, commissioners must ensure that clear pathways for referral are established to new recovery support services and that all referring agencies have the requisite targets added to their contracts to ensure that recovery services have suitable client flows, and are not stymied by resistance to change in other parts of the system.

We have divided the pilot projects into three groups – system change models, peer based approaches, and service delivery models. For each of these three categories (although there is some overlap between them), we have outlined some background information about that domain, the key findings from each of the pilot projects and then an overview of the key lessons and implications, with resulting recommendations.

1. RECOVERY SYSTEM CHANGE PILOT PROJECTS

In two areas the innovation was at a systems level, albeit addressed in different ways. The two areas involved were Barnsley, where there was a commitment to a new configuration of services within a recovery-oriented model, and Calderdale, where the appointment of a Recovery Coordinator was linked to the emergence of a series of recovery projects and activities in the area. Prior to describing the two pilots, a brief overview will be given about the implementation of ‘recovery-oriented systems of care’.

In 2009, CSAT defined a recovery-oriented system of care as “a coordinated network of community-based services and supports that is person-centred and builds on the strengths and resilience of individuals, families and communities to achieve abstinence and improved health, wellness and quality of life for those with or at risk of alcohol and drug problems”. The CSAT paper also defines an ROSC as relying on community-based services and supports, as involving collaborative decision-making, involving continuity of services and supports and having multiple stakeholder involvement.

However, such a model does not emerge overnight and there is a process of transition involving a wide range of stakeholders that is required. The Addiction Technology Transfer Centre (2010) cite a leading management theorist, John Kotter, suggesting key errors to be avoided if transformation of systems are not to fail. The key activities that he emphasises are:

- Establishing a great enough sense of urgency, and driving people out of their comfort zones
- Creating a sufficiently powerful guiding coalition who work together over time to effect change
- Creating a vision that sets the philosophy and direction of change
- Communicating that vision to all stakeholders consistently and regularly and generating buy-in
- Removing obstacles to the new vision, including worker attitudes and fears, and organisational structures and processes

- Systematically planning for and creating short-term wins to bolster confidence in the vision of change
- Not declaring victory too soon, and working with a plan for implementation that may take 5-10 years to complete
- Anchoring changes in the organisational culture

This is particularly difficult when there is not a single organisation involved and where some partners may feel threatened by the vision of change. The pilot projects in Barnsley and Calderdale are outlined below with the overall conclusions and recommendations outlined below:

1A. BARNSELEY SYSTEM RE-CONFIGURATION

What are the aims and principles addressed?

Barnsley Treatment System was until this year (2010) a system that was designed to provide rapid access to treatment via GP 'shared care' and central prescribing via the PCT, supplemented by voluntary sector provision of psychosocial interventions and structured day care. This system was effective in terms of outputs, with low waiting times to access treatment and good retention. However many service users perceived that they were 'stuck'; organisations working in isolation and competitively and long-term outcomes were poor. A decision was then made in 2009 after a comprehensive option appraisal that the whole system should go out to open tender, with a view that 'recovery' should underpin the new system. A third sector provider was awarded the contract in partnership with the PCT who are to provide prescribing cover as sub contractors.

The successful partnership proposed a '**Care Navigators**' approach who would sit independently of the treatment system, providing central assessment and recovery planning for each service user. Importantly the care navigator stays with the service user throughout the journey to improve the likelihood of effective engagement. However, the care navigators can have caseloads of up to 100, and there is a lack of a clear recovery vision across the system. There is also considerable work to do to change organisational and professional cultures, and to identify and implement successes.

Strengths and resources of the team

The drive to implement the recovery approach has been driven centrally by the commissioning team. There is drive and dedication to making the system work from the lead commissioner and their team, and from the managers of the lead provider. There is not however a sense that from a

partnership level that there is active support for the change. The evaluation team attended a recovery launch event in Barnsley which was extremely positive and suggested widespread support for the recovery model but some anxieties about feasibility and considerable nervousness about jobs and careers. There is a significant communication issue and the need for early 'wins' to be used to generate buy-in and clarify mission and goals.

Challenges

The partnership has undergone a radical change in the way treatment is delivered. There are new structures and new partnerships, and this has provoked anxieties about change. This is exacerbated by needing to maintain traditional performance monitoring which do not necessarily complement a recovery approach and perceived inconsistencies about targets and goals in the new system. Trying to nurture and empower recovery networks is going to require a significant change in the approach of workers and providers, and there is a clear need for both a strategic vision of recovery that can be 'owned' by multiple stakeholders and a clear plan for implementation and monitoring of that vision. One of the major challenges of generating a recovery-oriented system is identifying 'early adopters' or 'recovery champions' and enabling and empowering them to become change agents in overcoming the obstacles and the resistances to recovery models and processes.

How it fits into a recovery process / culture or system change

The launch event suggested that there is a strong and growing peer group that may well represent a bottom-up capability to match the 'top-down' commissioning model but it remains early days for the vision of a recovery system and it is evident that there is a lot of work to do. Part of that process involves a series of recovery workshops for professionals early in 2011, and the attempt to identify and support a group of active champions for recovery who will work to develop a vision and a plan for implementing recovery process. Part of this will involve a community asset audit, to provide links to other key activities in the local community and to generate a model for the co-production of community supports and resources. At present, there is limited availability of some forms of mutual aid and some evidence of a 'two worlds' model where professionals are not actively engaging with community resources and groups and that will be one of the major culture change challenges in the area.

What are the goals? Communities of recovery and long-term change

This is a hugely ambitious undertaking at a time of financial cutback and the problems that are faced in Barnsley are largely about safeguarding the treatment access and quality issues while at the same time managing a fundamental shift in philosophy and approach. For Barnsley, as with many other

places, this raises questions of how the philosophy of recovery (which few people now object to) can be reconciled with practical actions that do not cause a risk to clients and ensure that the gains made by acute treatment are not lost. The lesson that has been learned in Barnsley which will apply in other areas are that this is a time-consuming process (as outlined above by Kotter) and that, as ATTC (2010) have argued, there are basic requirements:

1. That there is some form of Recovery Advisory Board to guide the transformation process and that this includes people in recovery
2. There is a process of orientation for all board members, staff and peers around the principles and evidence of recovery
3. There is an internal service process of assessing the compatibility of treatment practice with recovery process
4. That there are effective protocols for assertive linkage to local communities of recovery
5. There is a programme for post-treatment monitoring and, where necessary, early re-engagement

(ATTC, 2010, p.420)

Methods of evaluation

There are three levels of analysis for evaluation for a systems change model:

1. Treatment service clients and people in recovery
2. Workers and service activity
3. Communities

One of the challenges is to retain quality measures for acute treatment – such as waiting times, retention, discharge reasons – with quality of life and expectancies of people in and out of treatment. There are items in the TOP form that can act as proxy recovery indicators for treatment populations, and these should be supplemented by assessments of wellbeing in community and recovery groups.

The second level which is more akin to process measures is assessed by staff attitudes to recovery and their engagement with recovery groups, and that points 2-5 of the above ATTC guidelines are adequately addressed by treatment services.

At the final level, of communities, there are baskets of wellbeing indicators for the community that have been summarised in the Wellbeing And Resilience Measure (WARM, Young Foundation, 2010). As with the three tier model of recovery capital proposed by Best and Laudet (2010), so the WARM

approach suggests that community resource be considered at three levels – ‘self’, ‘support’ and ‘system and structure’ – as indicated in Table 3 below:

Self	Support	System and structure
Income/ wealth	Strong and stable families	Buoyant local economy
Health	Networks of friends	Low crime
Education	One to one services	Effective public services
Life satisfaction		

WARM analysis of wellbeing

The “Taking the Temperature” report also provides an overview of key data sources for measuring community wellbeing that include factors listed:

Source	Information type
DH	Hospital Episode Statistics
DH	Life expectancy at birth
DWP benefits	Jobseekers allowance / incapacity benefit
NHS HSCIC	Synthetic estimates of healthy lifestyle behaviours
DCLG	Dwelling stock by tenure and condition
Police	Crime data – notifiable offences
DfES	Pupils eligible for school meals
DfES	Unauthorised pupil absences
Connexions	16-18 year olds not in education, training or employment

Sources of data about community functioning

The purpose of this information is twofold – first to establish what contextual information is needed to provide a map of community recovery capital – and second to map the bridges between this and the attributable links to substance using populations and treatment.

Lessons learned and next steps

The most important lessons from the Barnsley experience are:

1. That system transformation is not an overnight process, and requires both a vision and an implementation plan
2. There needs to be a strong supporting coalition of champions including people in recovery to enable and drive the change
3. Culture change is a core part of the change in system functioning
4. Establishing clear goals for a recovery model and delivering quick wins are essential

In terms of the next steps, Barnsley is currently undertaking staff awareness training and champion recruitment. This will lead to the development of a recovery vision that will be communicated as part of the evolution of a recovery system implementation plan involving the establishment of meaningful local metrics.

1B. THE BASEMENT

Aims and principles addressed

Halifax has a central treatment system based on 10 shared care services coordinated from a specialist treatment provision. At any given time, there are around 850 people in contact with the prescribing service. In terms of recovery culture change, all of the mainstream service staff are ITEP trained and all clients receive mapping interventions. The specialist prescribing service also runs recovery groups and has a life coach involved. The clients on prescription are also offered access to employment and training opportunities, and around half of the discharges are described as leaving drug-free by the service manager. Calderdale appointed a recovery coordinator who has attempted to generate a range of recovery activities in the local area.

The Basement project has evolved out of a breakfast club linked to a service users' group that is held in the centre of the town and is an open access event for all kinds of people with substance use and related issues. To date, more than 1,350 people have attended and the site now hosts a recovery programme. The Basement programme has three primary strands:

1. Recovery services – moving from pre-recovery groups, through detox to abstinence, and then on to sober living and aftercare support
2. Breakfast drop-in including advice and signposting, family support, social rehabilitation and mutual aid access
3. Volunteering opportunities – including user involvement, becoming a recovery champion, training and education and community volunteering

The Basement also has strong links with sober living housing and with Project Colt providing volunteering and training opportunities based on a social enterprise model. In essence, the Basement is the hub for a network of more and less structured recovery opportunities and activities in Halifax. The project is about establishing a recovery culture and to improve the opportunities for individuals to sustain recovery by effective community engagement. The key principle is around creating belief that recovery is possible and providing the foundations for building personal and social capital based on a strong foundation of communities of recovery.

Strengths and resources of the team

The Basement has identified and supported three recovery champions each with a separate area of specialism. These champions are active in the local community and have become integrated not only with those engaged in active recovery but a wide cross-section of users in Halifax.

In addition to the high level of recorded activity around the breakfast club, the Basement has some documentary evidence that at least 90 people have achieved sustained recovery in the first 18 months of its operations. This has created a network of graduates and there is some evidence that it has generated a community of recovery. There is also the benefit of having as recovery coordinator an experienced researcher who has worked extensively with out of treatment and recovery populations. The local commissioner appears to be committed to the recovery model and there is a solid foundation of recovery housing and recovery social enterprise that provides the basic building blocks for supporting stable recovery pathways and journeys.

Challenges

There are system issues with marked differences in philosophy and perceptions between the prescribing service and the Basement, and clear tensions around the merits and appropriateness of abstinence-oriented interventions. There are also residual concerns that the 12-step focus of the recovery services are not suited to the needs of all clients, and there may be barriers to referral from the statutory service because of perceptions that this is an abstinence-oriented service. There are

clear tensions about the definition of recovery and related issues around 'maintained recovery' and what this might mean in a recovery model.

As a result of these issues, movement between the mainstream prescribing service and the recovery communities is limited, and there is little evidence of culture change within the acute services or significant changes in the delivery of the treatment system. While there is some evidence of 'recovery contagion' across the local community, there is a danger that engagement with recovery is opportunistic and that those engaged in prescribing do not have the same opportunities for engagement.

Fitting into a recovery culture

In contrast to Barnsley, there is a real 'grass roots' quality to the recovery movement in Calderdale and a resulting concern that it is not having the desired impact on professional practices or systems, and there is some scepticism among professionals about the viability and the reality of this recovery model. There is currently a significant disparity between the statutory services and the emerging recovery groups in terms of both the meaning of recovery and the role of what are often two 'elephants in the room'

- Mutual aid
- Methadone maintenance prescribing

The challenge for a recovery model at a system level is reconciling acute care interventions with recovery approaches that will precede treatment engagement through assertive outreach, work in parallel versus engagement in recovery groups and communities and linking to opportunities for meaningful activities and provide the post-treatment care that includes ongoing peer support and recovery management check-ups.

What are the goals relating to communities of recovery and long-term change?

The primary objective is to enable the shoots of a recovery movement – albeit one that has significant impact and activity since its initiation – to become mainstreamed and to develop a more effective working relationship ultimately with a view to developing a ground-up recovery oriented system of care. Specifically, there are core objectives around both sustainability and growth of:

- Social enterprise
- Sober living housing
- Post-treatment recovery management and support
- Early engagement in recovery groups and assertive linkage work

Methods of evaluation

In Calderdale, among the most important hard measures that will be indicative of success are:

1. Assessing changes in specialist staff attitudes towards a recovery philosophy and specifically towards the recovery groups in the area
2. This can be measured in part by staff attendance at recovery meetings, groups, etc and the engagement of the recovery groups within specialist services
3. Levels of awareness of recovery activity and expectancies of personal recovery among clients engaged in treatment services
4. Movement from specialist services to recovery and subsequent engagement in recovery groups
5. Ongoing growth in the number of recovery champions and the range and diversity of recovery activities and groups available in Calderdale
6. The emergence of a system-wide vision of recovery that has commitment and sign-up from all of the key parties
7. Quantifying the successes of each of the key components of the recovery system and accessing sustainable funding

Next steps

The key challenge is to quantify and map success – including a map of the recovery groups and communities and the related map of recovery champions in community settings. Linked to this is the identification of candidate champions – there is currently a risk that the recovery movement in Calderdale is driven by a couple of strong individuals and so generating sustainability and the related financial bases is essential.

Overall conclusions and recommendations in relation to recovery-oriented systems of care

Although the two approaches are very different in that Calderdale is a bottom-up approach based on establishing a series of recovery activities from a hub (the Basement) and through the endeavours of a coordinator, while Barnsley is an attempt at a top-down system change approach, there are considerable similarities in the issues faced.

The first is the recognition that, while the vision and support of the DAAT is essential, it is not sufficient and there has to be a development of a recovery group that includes representation from a wide range of bodies including peers in recovery.

RECOMMENDATION #3: The establishment of a recovery oriented system of care involves the establishment of a 'recovery coalition' who will oversee and support the communication of a recovery vision and the steps needed for its implementation

In the UK in particular, where there is a long tradition of long-term treatment retention based around substitute prescribing, the transition to a recovery system requires integrated recovery modelling for staff in specialist services to be informed about and become engaged with recovery community activities

RECOMMENDATION #4: For a recovery system to become a reality in the UK, and not to involve only the minority of substance users who are highly motivated, it is essential that joint working protocols are established and monitored to ensure that treatment staff have regular engagement with recovery groups and that treatment effectiveness measurement includes community engagement during and after the formal treatment process

To bring these two recommendations together, it is essential that senior managers in all services contribute to the Recovery Coalition and identify champions in their own services who will drive the agenda forward and who will be the leaders in culture change.

RECOMMENDATION #5: Annual audits of the perceptions of clients, family members, staff and managers linked to audits of casefiles around referrals and engagement with community groups constitute part of the growing evidence base of merging acute and recovery evaluation and evidence approaches.

2. PEER-BASED APPROACHES

The three projects in this section are Project 6, Doncaster DREAM and MERLIN, all representing models of innovation that are focused on peer models of support. Again, each project will be considered individually before overall implications and recommendations are outlined.

2A. Project 6: Keighley, West Yorkshire

Aims and principles

Project 6 is a harm reduction service in West Yorkshire that offers a range of services including needle exchange, structured treatment, complementary therapy, specialist provision (including an Asian community project) and an aftercare team. Through their aftercare service, Project 6 have set up an accredited Peer Support training course available to all service users in recovery, especially those who have come through the aftercare programme. The course is supported by the Open College Network and runs for 6 weeks and is a bridge to accessing volunteering options with Project 6. A recovery group is also being set up to be led by one of the peer trainers, so there is a community echo from the peer training project.

The peer project links with other key components of the Project 6 programme – particularly the aftercare service, the integrated family support service and the Moving On group – to fulfil some of the key requirements for community recovery programmes. Additionally, the structured day care programme uses a 12-week programme to support ongoing recovery and links to ongoing community supports. They include the development of groups of accessible peers providing more and less structured support for clients both in treatment and at the end of their treatment period.

Among the goals specified for the peer mentoring project as part of this larger community integration and continuity of care model are:

- The ability to track people better after they have received the peer training
- To offer a wider range of placements (at present half come from the alcohol service)
- To measure and improve on community impact.

One of the key challenges of the programme is to integrate recovery-oriented processes and practices in Project 6 within a service that has a commitment to a harm reduction philosophy and operates a needle exchange from their central site.

Strengths and resources

According to the half-yearly report for 2010/11, 21 individuals have received the peer support training and this has opened doors to mainstream education for a number of the graduates of the programme. Two of the Peer Supporters have achieved accreditation and there is a growing network of contacts and links made by the programme and by those who have participated in it. Thus there are initial signs of the emergence of community recovery champions, supplemented by a staff team with a strong vision of recovery support from early engagement through to effective reintegration in the community. This link includes engagement with the volunteer centre in Keighley and a strong

treatment base that can act as the hub for a recovery system. The local commissioners are also committed to enabling and supporting recovery models across the Bradford area.

Challenges

One of the main challenges with peer programmes is that, while respecting individual choices and needs, that some graduates are empowered to remain visible and active as recovery champions and that the peer mentoring process is not simply seen as a stepping stone to a job or to other opportunities for personal development. This will require both tailoring of the structured day programme to provide appropriate ongoing links and supports and clear support pathways to personal development – including those explored currently with education and development. As with the system change models, there is also an element of time and maturation in a recovery system with the gradual transition of staff and peer thinking about the nature of support and the gradual emergence of a peer network that are linked to a range of community supports, including those involving sober living housing, education, training and employment and ongoing volunteering and community recovery activities. This will also involve some overlap with mutual aid provision and early reintegration to treatment where this is required.

Fitting into a recovery culture

Although the language is new, and can cause unease with some professionals, much of the peer initiative is consistent with the organisational culture in Project 6. However, there is a systemic issue about dedicating sufficient resources to ensuring that day programmes and aftercare provision is central to organisational functioning and that clear goals of:

- Sustaining recovery journeys in those who complete treatment
- Rapid re-engagement of those who lapse

Are both measured and accounted for as part of the peer process. This is why in many recovery models, assertive outreach is the mechanism for ‘completing the circle’ in that graduating peers become both the front end and the back end of the recovery process. The other major challenge is about ensuring that the service is ‘permeable’ – in other words, there is no real end point to ensure ongoing support and continuity of care, and that the professional support is embedded in and meaningfully integrated with a diverse range of community activities.

What are the goals relating to communities of recovery and long-term change?

According to William White's evidence review (White, 2009), more than 50% of clients discharged from treatment will return to some use in the next year – 80% of these in the first 90 days. White also cites findings from Simpson et al (2002) who reported that 25-35% of those completing addiction treatment are re-admitted within one year; 50% within 2-5 years. This is not to suggest that treatment is ineffective, but that there is a strong evidence-based case for ongoing support consistent with the timeframes of a recovery journey typically being 4-5 years for alcohol, and 5-7 years for opiates, after the last use of the primary substance. Aftercare is often regarded as an afterthought: yet we know that post-discharge care can enhance recovery outcomes (Dennis et al, 2003) but only around 1 in 10 of those who access treatment in the US (SAMHSA, 2005) receive this form of support. There is little 'science' of what works in aftercare but what we do know suggests that it is programmes that offer continuity of care; that involve engagement and integration with peers and that provide an opportunity to 'give something back'. What that means in practice for an initiative like the peer mentoring project is that it will be most effective when it is run by a network of peers and is linked in to a wide range of community support organisations and recovery groups.

Methods of evaluation

The most basic measures to start with are process indicators:

- Staff attitudes and support for the peer initiative
- Activity rates and completion
- Ratings of participant satisfaction and changes in recovery capital over the course of the programme
- Referral rates from different referral agencies
- Ongoing engagement and involvement in continuing care and recovery group participation
- Graduate engagement in linked support and ongoing training programmes

In the first instance, this is about establishing the need for the programme and its credibility – only the client measures of changes in functioning and recovery capital would represent an 'outcome' indicator. As the programme evolves, the most important success indicators will be around mapping sustained recovery and community impact, the latter of which is likely to involve the peer groups and graduates' engagement in 'co-produced' services and activities in Keighley and more widely in Bradford. However, this will require a programme of ongoing support and development for graduates of the peer mentoring scheme.

Next steps

There are system issues about ensuring the continuity of funding and support for this project to enable the growth outlined above and to develop a cohort of linked and supportive peer champions who can enable and facilitate the process. This is partly to do with the identification of quick wins and the recognition of the community and individual benefits of sustaining recovery and the process of enabling recovery to become contagious through peer groups. In the first instance, the key is to establish a meaningful evidence base of activity and perceived impact and to use this as a foundation for establishing long-term outcomes linked to individuals, families and recovery communities based on peer networks of recovery.

2B. Doncaster DREAM

Aims and principles

DREAM is a service user led group of people in recovery. The group has been meeting for about a year. The group has just agreed its constitution as a group, and is about to open a bank account. The group are still agreeing their focus, ideas vary from starting a 'Serenity Cafe' to providing a mini bus to support a wider geographic area. The current members are all abstinent, but they see their group as able to support people still using drugs, as long as they do not present as being under the influence. The group has been involved in the production of a DVD called "Wasted Years" which has been highly influential and has been used by the NTA and has been cited on Wired In.

The mission statement asserts that *"Doncaster Recovery Empowerment and Mentoring meet to offer emotional and practical support for people looking to make changes from problematic drug use in a safe non-judgemental environment. D.R.E.A.M promotes the belief that a life without drugs is possible by providing a sense of safety and relief provided by individuals who have had similar experiences and overcome similar problems"*. The aim is to provide comprehensive peer and recovery support services across Doncaster across the course of the recovery journey and to enable the growth of personal and social capital by developing and delivering a range of peer-selected and run activities.

Strengths and resources

There is strong support from the commissioners for the project and the group are very committed to recovery, and as a group are keen to develop voluntary opportunities. However, this group consists of only 4-5 people and the group has not grown as had been hoped or anticipated. There are strong and positive links with the Tier 2 service in Mexborough and with the DIP team, and there are some

ongoing forms of peer activities such as a football team and a peer mentoring scheme, in which 11 of 16 individuals completed the scheme.

Challenges

The challenge for the group is to agree its role and function within Doncaster, agree its strengths and how to develop. Although a range of activities have been undertaken there has not been a significant growth in membership and none of the activities undertaken has successfully engaged and retained candidates to be new 'recovery champions'. This problem has been compounded by a lack of funding that has led to uncertainty of activities and that has prevented the establishment of long-term programmes or posts to support the recovery programme. A funding bid has been submitted to the Big Lottery. The success of the peer mentoring scheme, the establishment of a regular group on a Saturday morning and the "Wasted Years" DVD does provide some hope that there is both the creative energy and the commitment to establish sustainability.

Fitting into a recovery process

DREAM is an important grass root development for Doncaster. Other than support from the DAT they are working in isolation. Despite this they are still maintaining their own recovery, and actively looking within the local community to develop voluntary opportunities.

Thus one of the key challenges, and where support from the DAT would be extremely useful, would be in developing effective linkages with formal treatment services to enable access to services through peer-based outreach, access to recovery support groups for those actively engaged in treatment services and continuity of support for those exiting treatment – by providing peer support systems and by linkage to community champions of recovery. The core objectives should be:

- Recovery champion recruitment (starting with the recovery event at the end of February 2011) to increase the pool of champions, including professionals rather than relying solely on peers
- Establishing a balanced programme of fixed and flexible support systems – this includes groups providing structured activities of various kinds and recovery system development options such as Recovery Management Check-up supports
- Building on existing links with DAT and local services to act as a bridge between services and the in-treatment and recovery communities and in doing so take on community-focused service user group roles

What are the goals in terms of communities of recovery and long-term change?

The major challenge for DREAM is to become embedded within a recovery system that is actively engaging for specialist services and where they can operate around the treatment system. The small core of recovery champions with strong links to the DAT is an extremely positive start but is hampered by a lack of engagement with other mutual aid and community groups in the area and no formal links to specialist treatment. The goal is to establish a set of community based activities that provide bridges into treatment for those using chaotically and those who relapse and links to community groups for those already engaged with treatment and those exiting the treatment system. Only by creating this 'system' model are they likely to identify a core purpose and role and to generate the level of activity and throughput that will allow champions to emerge and a core role in the recovery community and the wider community in Doncaster to emerge.

Methods of evaluation

As with Project 6, the first level of evaluation is around activity, acceptability and throughput. Thus, the same basic model of assessing core activity is the first step:

- Staff attitudes and support for the peer initiative
- Activity rates and completion
- Ratings of participant satisfaction and changes in recovery capital over the course of the programme
- Referral rates from different referral agencies
- Ongoing engagement and involvement in continuing care and recovery group participation
- Graduate engagement in linked support and ongoing training programmes

Once this has been established for a core set of activities and programmes – particularly the recovery group and the peer mentoring, it will be possible to develop community impact and results-based outcome measures.

RECOMMENDATION #6: The NTA regionally should work with the DATs in the relevant area to generate a bank of basic monitoring and mapping instruments for a diverse group of community-based recovery programmes relating to the items listed above

Next steps

For Doncaster DREAM, the first core step is the establishment of secure funding and a clear role within the treatment and recovery system, whether this is about assertive outreach and recovery

management or is about programme provision and structured support. It is critical that a key focus of activity is created around continuity of recovery and acting as a bridge to community groups.

Merlin Roundhouse Village

Aims and principles

The project is designed to build a community based on past industrial skills by creating an Iron Age village in West Yorkshire. The aim is to:

- Help engage people in community processes
- Give participants a sense of purpose through team activities
- Challenge stigma and barriers in the local community
- Provide an educational resource that extends beyond addiction
- Improve wellbeing and develop a spiritual component

Strengths and resources

This is a service user project which allocates tasks to people on the basis of their strengths and skills. The early achievements include the establishment of a company and developing appropriate partnership supports.

This is a community driven project that has a clear product while the process is about developing practical skills and generating self- and group-efficacy and a sense of purpose. The outcome will be a contribution to community life that will challenge stigma and stereotypes about addict populations.

Challenges

The primary problems will be around resources, matching the skills mix to the requirements of the task and the coordination of partners in this ambitious project. This is a hugely ambitious project, particularly at a time of economic recession, and one of the challenges that this project faces, which is common across recovery activities is to convince commissioners and partner agencies that recovery is not 'an expensive luxury' that involves large amounts of money for relatively few people to reap the benefits.

The challenge that is hidden within this concern is about how to measure the benefit – that it is not restricted to the direct recipients and participants in the project but that it has wider effects. As Best

and Gilman (2010) have argued, benefits from enacting recovery activity should be manifest in terms of:

1. Gains for the families of those involved, including reduced harms to children and greater family stabilities
2. The generation of visible recovery communities that provide supports to both those actively in recovery and those considering the start of a recovery journey
3. Giving back to the local community and in so doing challenging stigma and discrimination by making a direct contribution to community life
4. Altering the local environment in such a way that the community's attitudes to alcohol and drug use shift

The massive challenge here is that these are very difficult things to capture and, even if they can be demonstrated, the time line to change is not known and the attribution of success is problematic.

Fitting into a recovery process

This is a project that is at the centre of the recovery endeavour in that its focus is on activities in the community that establish recovery as a shared and social activity that is transformative for individuals embedded in their families and their communities.

What is the evidence base?

The most obvious benefit will be the tangible one of the construction of the village but there are also individual level outcomes and outputs in terms of the number of people in recovery engaged in the process, the impact on their own recovery journeys and the resulting recovery outcomes – increased engagement in training and volunteering, engagement in part-time and full-time employment, and the generation of recovery support groups and activities that emanate from this hub.

What are the goals – communities of recovery and long-term change?

This peer led project has ambitious goals, by building a roundhouse village it is believed that the project has the potential to integrate those involved and build a sense of community. It is hoped that this will be achieved by providing both work opportunities and developing life skills such as confidence building, self esteem, team work - essential for supporting those who want to re-integrate themselves back into society. As such it could offer something extremely beneficial to clients of drug treatment services, and result in genuine community cohesion in the process. The project could be educational in its scope, but also perhaps uniquely each roundhouse can be built on a modular basis so that people can learn new skills with each house built.

Methods of evaluation

As the Project is currently in its 1st stage of development the outcomes have been focussed on governance, developing literature, and funding with service users supporting this process rather than on evaluating the effectiveness or impact of the project. It is timely though to remind projects of the importance of incorporating evaluation into a project as early as possible into the process. Methods of evaluation can be wide ranging and it would be useful to begin identifying core processes now to aid the development of evaluating the project in the future.

Next steps

The project have submitted a request to another organisation that commissioners supported a number of years ago who are discussing a request from MERLIN at their Board to utilise a piece of land to start the actual construction. In terms of next steps in terms of recovery the challenge is to ensure that MERLIN becomes part of the local recovery movement and is seen as being valid and relevant to the local services. How does MERLIN integrate into local provision and provide meaningful opportunities?

Overview of peer-based projects

Although the three projects are at different stages, one of the first conclusions is that there has been significantly greater progress in mainstreaming the peer mentoring programme at Project 6. Part of the reason for this is related to the structures and systems available where there is a larger 'parent' organisation for the peer project to be based within.

RECOMMENDATION #7: While there is no requirement that peer projects have to be embedded within specialist treatment services, for peer organisations to be successful there is strong justification for them having a 'parent' organisation who can assist with development, structure and management

When issues of structure are identified, there are issues to address about managing programme provision linked to assertive activities in the community. Clarity of purpose is crucial to peer programmes and to ensure that it does not simply become another time-limited, programme without continuity or community impact. This means:

RECOMMENDATION #8: There needs to be a clear programme for accessing participants that does not rely solely on a single provider. The programme has to offer meaningful continuity options at the end to enable development of skills and effective linkage to a range of community alternatives

RECOMMENDATION #9: This links to the issue of sustainability and the need to have an ongoing engagement or volunteering component so that those graduating from the peer projects have an incentive to remain engaged

There is also a need for a framework for evaluation that is common to all of the programmes as regional commissioners. This is the need for locally agreed markers of impact that will start with process measures of engagement, completion and satisfaction and will then evolve into outcome focused analysis that measure growth of personal and social recovery capital

RECOMMENDATION #10: The development of a region-wide set of evaluation criteria and instruments for community and peer programmes that are developmental in that they start with measures of activity and process, before evolving into results-focused measures of growth in personal and social recovery capital.

3. Service delivery recovery models

The final set of innovation projects considered in the review were three initiatives linked to improvement of recovery-focused service activity. In the Bridge project in Bradford, this took the form of attempting to improve staff attitudes to and engagement with Narcotics Anonymous to improve client engagement in mutual aid. In North Lincs, the shared care programme developed a recovery focus through the endeavours of two team members using evidence-based psychosocial interventions to develop recovery approaches to treatment. A similar approach was adopted by the team in Sheffield where a consultant psychiatrist led a treatment team in delivering a recovery oriented programme based on the TCU Treatment Effectiveness model. As above, each of the programmes is considered separately before an overall analysis is presented.

3A. NA engagement at the Bridge, Bradford

Aims and principles

Day et al (2006) and Gaston et al (2010) have both demonstrated that there are staff and client anxieties about engaging with 12-step services particularly in statutory services. However, this is at odds with the evidence (eg Humphreys 2004) which shows that, for those who engage actively in 12-step groups, the outcomes are positive. Humphreys has also gone on to show that the key ingredients from engaging in 12 steps are:

- That it improves active coping
- That it increases motivation for abstinence
- That it improves friendship quality
- That friendship support for abstinence increases

In the UK, Best et al (2001) showed that there was considerable openness to the idea of mutual aid among many drug users who had not previously attended meetings and there is some evidence that the number of meetings of AA, NA and CA has risen in recent years in the UK (Leighton, 2010, personal communication). Yet, staff resistance to 12-step remains a problem, with little active engagement in mutual aid from workers and low levels of knowledge and support for client attendance.

The aim of the initiative was to raise awareness among staff at the Bridge about 12-step and to encourage them to attend at least one meeting, with a longer-term aim of encouraging clients to become actively involved in NA as part of their recovery process. The underlying principles are a belief that there is nothing incompatible about structured treatment and mutual aid groups and that, while not all clients will want to become actively engaged, for those who attend and engage it is likely to provide a significant added value to their treatment. The cultural change component of recovery systems relates to a wider recognition that recovery is 'co-produced' and that staff at some point must empower clients to continue their recovery journeys in their families and communities and that the process of change is intrinsically linked to embedding social and personal capital in a long-term model of change.

Strengths and resources

The senior management team at the Bridge has a strong commitment to both recovery and to treatment innovation and they were involved in establishing the ITEP project. The Bridge is also a well-run and effective provider of a wide range of treatment services and there is growing staff interest in and support for recovery. Although willingness to engage with mutual aid is low, the staff have a strong commitment to their clients and there is a culture of openness to change that is consistent with the culture change component of recovery-oriented approaches to drug treatment.

There has also been clear and effective communication of the programme of change that is an essential part of the implementation process of recovery.

Challenges

In the initial phase of the project, there was considerable staff resistance to attending mutual aid groups, although at the end of the year 6 of 38 staff members had attended at least one open meeting. There is an entrenched 'professional' culture which is both client-centred and counselling focused and so a major challenge is for workers to recognise the need for wider culture changes and system developments. Thus engagement with 12-step is seen as both engagement with something that is seen as contradicting professional practices and something about which many of the workers have negative and stereotyped views – these typically include the idea that NA is all about God, is a 'cult' and so on. It is also seen as representing an abstinence promoting tradition that is seen as inimical to the harm reduction culture that many UK substance workers are accustomed to and adherents of.

Additionally, there is no clear indication that a community recovery peer group is emerging in the area, as has been the experience with Project 6 and DREAM. Thus, there is little indication that the demand for mutual aid and community activity is driven by service users and one of the challenges of a peer-based model is raising awareness, energy and engagement on the part of service users whose views of treatment service may be much more consistent with a 'patient' role. Thus, one of the main challenges facing this approach is the question of identifying and supporting emerging recovery champions who are empowered and supported to promote the NA group and meetings to their peers and can act as part of the process of worker attitude change through changing beliefs and expectations. There are structural challenges as well in bringing mutual aid groups into structured treatment services around issues of safety and governance, and shifts in expectations about the relationship between peers and professionals.

The workshops that are set for the end of January will provide an opportunity for linking the NA initiative into a broader model of introducing recovery philosophy and practices and the aim with this approach is, as with the idea of recovery contagion in clients, that a similar dissemination of recovery approach and values can be achieved with workers.

Fitting into a recovery culture

There are a number of fundamental changes in moving from an acute treatment to a recovery model including the following core issues:

1. The worker does not have the solutions and is not the expert – the person in recovery is central and the worker has a crucial but time-limited role
2. Recovery will primarily happen in the family and the wider community and the journey will continue long after the end of treatment
3. Developing recovery peer networks is a critical component of establishing the long-term recovery capital needed to sustain a recovery journey
4. 12-step offers a well-evidenced support and belief system for those who are willing to engage, and one that is available when most treatment services are shut
5. 12-step is likely to be of particular benefit to those who have low existing social capital and little family support
6. Giving something back is at the heart of both 12 steps and the larger recovery philosophy

As with the Treatment Effectiveness agenda (Simpson et al, 2009; Best et al, 2009) it is critical that there is a gradual process of evolution towards professional culture change that must start with early professional champions but also must involve a recognition of the different model and mechanisms in 12-step.

This requires a core component of the recovery systems model – that not only do professionals have to leave their specialist services to gain an understanding of the approach and the mutuality of 12-step groups, but also the specialist services have to open their doors to community and mutual aid groups so that there is shared development and growth within a recovery system.

What are the goals – communities of recovery and long-term change?

Pathways to recovery will attempt to identify the barriers between the professional community and NA, and will subsequently develop strategies for closer integration and cooperation with the aim of increasing the number of services users accessing NA. There are potentially three staged objectives in terms of generating a community of recovery:

1. Addressing negative worker perceptions about NA, encouraging them to attend at least one open meeting, with the aim of improving the rate of ‘assertive linkage’ by workers for clients into NA groups
2. As a result, increased attendance and engagement by clients both during and after treatment to increase the social capital of clients and their rates of ongoing abstinence and active coping
3. That this forms part of a wider recovery community where NA attendance is central too but not the only manifestation of recovery activity in the community

Methods of evaluation

This study has been planned as an evaluation intervention and so the structure of the evaluation has already been established and has focused on creating baseline and follow-up measures of worker attitudes and expectations about NA as the basic change mechanism for the training and awareness sessions to be held.

Most of the early stage evaluation measures will be process measures of activity – level of attendance at mutual aid groups by first workers and then clients and then indicators of assertive linkage and engagement by clients.

The evolution of the more ambitious measures of recovery culture and change should be developed only once the initial measures have been developed, and the initial results collated.

Next steps

In Bradford, there are both the local activities in the Bridge project where staff awareness sessions are being run in January and this will be evaluated as the basis for promoting active linkage and engagement to NA.

The more ambitious objectives relating to the wider development of recovery cultures and systems are being supported by the Bradford DAT's facilitation of management support and training through the CoLab event. The focus on system change and commitment to improving education, training and employment, families and children and housing are entirely consistent with a recovery model.

Thus, there is a significant opportunity for synergy of developments within the Bridge and the wider development of a recovery model – with the challenge of systematic assessment of assessing both granular and overall effectiveness of the models.

3B. North Lincolnshire

The aims are and principles

The North Lincs Shared Care Team started in November 2009. It is a self directed approach led by two workers committed to recovery as a concept after they attended a training course on recovery. The two workers then negotiated with a practice manager within their local shared care scheme to have the use of a room one day a week, and the support of the GPs. Their focus is on supporting the

people attending the 'recovery' clinic to achieve their goals. The team use ITEP as a tool to facilitate this.

The local NA/AA groups are still in their infancy, whilst a local Baptist church also have a recovery group. These groups (including the shared care recovery clinics) appear to work pretty much in isolation with no communication/sharing of resources going on between the groups.

It is the intention of the two lead workers to develop the 'recovery clinic' and approach across the system. The focus is on providing 1:1 sessions for people interested in recovery. Beyond this there is no sense of how recovery could or should be rolled out, or how the project as it is will be sustainable as it seems to be developing and driven very much by two individual workers.

The service users were extremely positive about the work being completed, and had a very good understanding of recovery and keen to take on 'recovery champions' roles.

Strengths and resources of the team

The service is driven by two workers with support from their managers and GPs. They are obviously passionate about their work and utilise the tools they have picked up attending training courses. They describe a 'groundswell' of interest in recovery but there did not seem to be a clear operational or strategic plan on how recovery could be expanded or how it would work. They are providing 'recovery clinics' and have adopted the approaches learnt through training, but it is unclear how sustainable this approach is as it is very much personality driven.

Challenges

The challenge for North Lincs is how to make sure this service can be initially sustained, and then expanded across the treatment system. There is managerial support for the approach, but there does not appear to be a senior manager or commissioner who is firmly behind this approach to develop and support the approach. Because of this there is little or no financial investment. To increase the likelihood of attracting funding it would be useful to implement an outcome framework which would hopefully demonstrate the effectiveness of this approach. Currently they are reliant on feedback from the people using the service rather than a consistent outcome monitoring framework.

Fitting into a recovery process / culture

This project demonstrates that individuals with a passion and belief can make significant changes in the way that a system works. It is the beginning of a groundswell of opinion in support of recovery. There is little idea how to make sure that the principles that the workers use are maintained as the service grows.

What are the goals – communities of recovery and long-term change?

Since the evaluation of this project started there has been a need to re-define the project locally and consider how best to incorporate the learning from the project to influence the wider treatment system. It is therefore difficult to ascertain with any certainty what the goals are currently for this particular project whilst a wider service review is being undertaken. However, it is appropriate to say that because the lessons from the early work undertaken are being used as part of the review, it will in effect influence the development of long term change at a service and system level. It is perhaps useful to reflect that 'recovery' needs to be integrated within the treatment system so that specialist services and shared care/primary care services can all develop and encourage the development of a recovery approach and the infrastructure required. This also requires local commissioners to be involved in the development of the overall strategic direction for treatment system development.

Methods of evaluation

There has not been a formal evaluation of this project. A note has been kept identifying the outputs achieved, for instance numbers of people attended, and numbers of people completing treatment etc. However there was little work completed on evaluating outcomes resulting from the project. One of the areas that needs to be considered when developing a more systemic approach to recovery is identifying the evaluation framework in order to be able to demonstrate the effectiveness (or not) of this approach. There are a number of readily available approaches to evaluation as mentioned elsewhere in this report and consideration should be given to adopting an approach as part of the development of projects.

Next steps

The next steps for this project are being determined outside of the control of the project itself. Therefore the important elements that need to be retained are a commitment to recovery within the treatment system and an agreed vision that is commonly held and which all partners agree to work towards. There needs to be thought given to how existing recovery groups can be involved in this process and consensus on what outcomes are needed to demonstrate an effective system is in place.

3C. Sheffield ITEP mapping training

Aims and principles

The aim of 'some say stable, some say stuck' is to provide 6 sessions with a psychiatrist and a drugs worker, based on delivery of ITEP (International Treatment Effectiveness Project) to clients who are perceived to be stable in treatment. This is a crucial project in that it attempts to provide an evidence-based group and support service to clients who have successfully stabilised their substance use but have not managed to move on from this point.

The target population is clients who have been stable in treatment for at least two years and who are not currently engaged in active substance use. The target group is both those who actively want to move on and those who are satisfied with where they are in treatment. The project also aims to provide ongoing support after completion of the group programme

Activities to date

Eight clients recruited to date and the format and model developed for the intervention. Materials developed based on the node link mapping model utilised by Simpson and colleagues within the Treatment Process Model (TPM, Simpson, 2004).

Strengths and resources

The recruitment of a team involving a peer recovery champion, a drug worker and a consultant psychiatrist and the development of a model that is evidence-based, and that targets a key population who are not frequently targeted in recovery models. It is crucial that recovery thinking is not restricted to new clients or those clients in treatment who are sufficiently motivated to enable and sustain their own recovery journeys.

Challenges

An early problem of this project has been the infra-structure and sustainability of the group and they are not currently running at the time of writing. This may be related to resources or to client or staff engagement in the process – and suggests the problem of developing an initiative that is recovery-focused where the awareness of both client and staff groups, and the organisation, may not have an overall recovery culture and model.

As with all service-based recovery initiatives, there are also the issues of effective linkage to ongoing and sustainable recovery supports – in other words, if the sessions and groups successfully raise client awareness about recovery, what are the ongoing links to communities of recovery and to the supports and resources (particularly around employment and housing) that will be essential components of successful recovery journeys.

Fitting into a recovery process

This project is essential in developing a coherent recovery model that is inclusive and participative. To avoid a silo system in which recovery is done by small numbers of clients who then disappear into 'conventional society', it is critical that the long-term treatment population are actively supported in recovery process.

What are the goals – communities of recovery and long-term change?

It has not been possible to update this element of the report. In the initial stages of preparing this report the focus for the project was very much about trying to facilitate change in service users who were perceived to be ready to move into recovery. There was little contact with a wider recovery community, nor were service users able to self select. However it has not been possible to establish if this approach has been modified.

Methods of evaluation

It has not been possible to establish formally the evaluation of this project. However initially the project was using Tops, and readiness to change questionnaires as a basis for evaluating their work.

Next steps

It has not been possible to establish what the next steps are for this project.

Conclusions and recommendations about service-based recovery models

Perhaps the greatest risk to these initiatives is that they can come to rely on the commitment and goodwill of individual workers and may have relatively little impact on the overall organisational culture. Although the Bradford Bridge initiative had the specific objective of changing staff culture and attitudes, all of these programmes require an organisational commitment to their sustainability and a mechanism for learning from and generalising successes, so that neither is recovery seen as the responsibility of a sub-group of workers nor is the programme seen as an 'add-on'.

RECOMMENDATION #11: For recovery initiatives to have sustainable impact, there must be a clear dissemination strategy, and a mechanism for developing organisational learning and change to ensure that the initiatives are mainstreamed and linked to the activities of all workers

One of the key risks for embedding recovery focused activities within treatment services is that they become 'professionalised' and detached from the cultures and communities in which recovery occurs. It is critical that programmes are empowering to clients who engage in them and that they have a stake in the development of the programmes and that they are linked effectively to ongoing activities in peer and community settings

RECOMMENDATION #12: Service user ownership of the initiatives is essential and the development of peer and volunteer components is an essential developmental process. Similarly, the process must be linked to wider aspects of communities of recovery and there must be strong links to other groups for community recovery to maximise their impact.

Particularly for the two Treatment Effectiveness programmes there is also an additional issue around ensuring that there is appropriate continuity of care and ongoing support for clients at the end of the programme. Although there is a strong evidence base in favour of the mapping methods and manuals for them to deliver effective interventions they need to be linked into ongoing programmes without a discrete end point, so that they are seen as a part of an ongoing programme of care and support for recovery. There is also a need for the interventions to be specifically focused on recovery and the growth of personal and social capital.

Overall conclusions and challenges

If the projects are grouped together. There are two system change recovery models:

- Calderdale Recovery Partnership – based around the Basement recovery service, but also linked to sober living housing, long-term social enterprise and employment and training opportunities and the growth of a community of recovery champions
- Barnsley Recovery-Oriented System of Care to develop a system of outcome and recovery focused services built on the principle of growing social recovery capital

Three programmes address the recovery challenge of attempting to initiate recovery process from within structured treatment services:

- Bridge: by attempting to create effective links to NA
- Sheffield Health and Social Care: by providing psychosocial group support for 'stuck' clients
- North Lincs Primary Care Trust providing a 'recovery clinic' for those interested in recovery

Finally, there are three peer projects:

- DREAM: Peer support system including therapeutic interventions, support group and a service user newsletter
- Project 6: Peer support training and linked recovery group
- Merlin: Peer based community project to construct an Iron Age village

However, there are common challenges they all face:

- 1. Integrating effectively with and influencing specialist treatment provision, especially prescribing treatments for long-term clients**
- 2. As a result, having a throughput of clients from acute care services and having graduates who can actively engage with clients accessing specialist services**
- 3. Enabling culture and attitude change in service staff and commissioners**
- 4. Establishing continuity of funding and the resulting stability to build effective programmes and the essential links in the community**
- 5. Initial steps that are 'quick wins' in terms of inspiring and engaging clients who may have a more passive view of 'treatment'**
- 6. Identifying recovery champions from service users and from staff and creating the drive and motivation, along with the safety nets and supports, to enable recovery**
- 7. To ensure that their zone of impact is sufficiently widespread that the innovations can enable system wide**
 - **Early and assertive engagement to recovery supports**
 - **Ongoing support and care to people who exit treatment**
- 8. Establishing credible measures and evaluation mechanisms for both early process aspects of delivery and then linking these to recovery-focused outcomes**
- 9. Creating a range of services that build personal and social capital across a range of clients and that provide the safety net of collective or community recovery capital**

It is these nine key areas that the programmes attempt to address and that provide the foundation for mapping their traction in local treatment systems and their ability to generate and support long-term recovery.