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Substance Misuse Treatment Framework (SMTF)
Recovery Oriented Integrated Systems of Care

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Foreword

Recovery means different things to different people. It is a broad and complex journey that individuals must take, at their own pace. It is much wider than substance misuse alone and can take many forms including; reducing risk taking, overcoming dependence and improving health, improving quality of life and becoming personally fulfilled. Recovery Oriented Integrated Systems of Care (ROISC) provide choice and ensure that every effort is made to provide the right package of support in order to maximise each individual's chance of change and recovery.

In Wales we offer a wide range of evidence-based services and interventions in a number of settings throughout the substance misuse treatment system. The ROISC guidance sets out how providers can offer services and interventions to maximise the opportunity for service users to engage in appropriate support and treatment, thereby enabling them to make changes in their behaviour to improve their overall chances of recovery.

Ensuring that this guidance is based on robust evidence and expert advice is crucial and therefore it has been developed by a specialist sub group of the Advisory Panel on Substance Misuse (APoSM) and is underpinned by an extensive collaborative and consultative approach, ensuring that the voices of those who deliver and access services in Wales have genuinely shaped this framework.

Now is the time for a fundamental shift in the culture of substance misuse services in Wales. Area Planning Boards and their constituent service planners, commissioners and providers should embrace the Welsh Government's agreed definition of recovery by integrating recovery-based approaches into core substance misuse treatment services to meet the needs of all substance misuse service users attempting change in Wales.

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Minister for Health and Social Services

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1. Purpose

This document is a component module of the Welsh Government's Substance Misuse Treatment Framework. It reflects the philosophy of integrated care, where the needs of service users are considered from the time they engage with substance misuse services through to recovery.

It is intended to provide guidance for Area Planning Boards (APB) commissioners, planners, service providers and service users on establishing integrated systems of recovery oriented service provision which will inform practice and improve outcomes for service users by:

- Setting out a clear definition of recovery to be adopted across Wales.
- Providing a clear vision of 'Recovery Oriented Integrated Systems of Care' (ROISC).
- Setting out a framework that will embed recovery in the culture of treatment provision across Wales.
- Explaining what a workforce development initiative entails and what support will be required to deliver ROISC.
- Offering a guide to tools and interventions compatible with ROISC.
- Explaining systems of monitoring and measuring effectiveness and quality of ROISC.

An extensive collaborative and consultative approach underpins this document, ensuring that the views of those who deliver and access services in Wales have shaped this framework. This has included: services users, representatives of the recovery community and others with lived experience; service providers and managers; commissioners and policy makers.

2. Background

2.1 Background

This framework has been developed by a specialist sub group of the Advisory Panel on Substance Misuse (APoSM). The group consisted of a range of stakeholders including APoSM members, Public Health Wales, substance misuse providers, commissioners and Welsh Government officials. The aim of the specialist sub group was to develop a recovery framework which included a working definition of "recovery" that was inclusive and met the needs of all service users attempting change; and to advise on the integration of recovery-based approaches into core substance misuse treatment services.

Recovery Oriented care relies on service users feeling engaged and being active participants in the decision-making process in relation to their treatment options. The 'Service User Involvement' module of the substance misuse treatment framework sets out the principles, objectives and benefits of service user involvement regarding the planning, commissioning and delivery of services and should be used to support the development of ROISC.

2.2 Context

There has been and continues to be considerable discussion about recovery and recovery oriented services and interventions in the substance misuse field. However, there remains a lack of clear understanding about what recovery is and what it means to service users, service providers and commissioners.

The term 'recovery' has been increasingly discussed, debated and 'implemented' in UK substance misuse treatment systems in recent years. Despite this, confusion and inconsistency have, at times, distracted from the opportunities that recovery offers. Much of this has resulted from a lack of shared vision and meaningful communication between stakeholders. Differences in the underpinning philosophy of services and approach taken in different parts of the UK, for example abstinence from substance versus positive changes have exacerbated these difficulties, as well as the inherent change management issues that occur during any systemic change process.

Definition

Following extensive consultation, carried out between Area Planning Board members, commissioners, substance misuse treatment providers and service users throughout Wales, the Welsh Government has adopted the following definition of recovery:

> 'Recovery from problematic drug or alcohol use is defined as a process in which the difficulties associated with substance misuse are eliminated or significantly reduced, and the resulting personal improvement becomes sustainable.'

2.3 Philosophy and Culture

Creating a recovery culture requires all stakeholders to be willing to share views, experience and expertise in a meaningful way, as well as being open to change. This includes those who plan and commission services; policy makers; those who deliver services; those who use services; the peer-led recovery movement; advocates and researchers. Meaningful and practical service-user involvement must be at the core of this.

The recovery approach relies on building upon strengths and assets, both for the individual's journey and system transformation. Creating this culture requires the involvement of groups of recovering people and their families, the use of recovery language and fundamental beliefs that people will, and do, recover from substance misuse problems in Wales. Hope, encouragement and empowerment must be at the heart of the culture to ensure the way in which services are developed and delivered, are recovery focused, adaptable and transparent. The recovery approach builds independence and skills over time, ensuring people 'own' their own journey towards sustained self-management and freedom.

Recovery will mean different things to different people and the Welsh Government's definition of recovery allows this flexibility. Service users need to be supported to define what their goals and aspirations are. Every recovery pathway must be equally respected and validated. Individuals should be encouraged to look beyond solely their substance misuse and be helped to address underlying issues while developing long-term life goals beyond treatment.

Abstinence and non-abstinence based recovery is a reality. It is important not to develop 'hierarchies of recovery' but to maintain a pragmatic, meaningful and service-user oriented approach. This means that service providers and others may need to put aside personal beliefs and ideologies for the benefit of those using substance misuse services.

To create a successful treatment system, it is essential that those who deliver and manage services recognise and fully embrace being part of a 'bigger picture'. It is the treatment system as a whole that can best meet the needs of a diverse group of people at different stages of their recovery journey. It is likely that no single service will be able to provide all the support needed by an individual. Specialist services and specific philosophical approaches can maintain their individuality while still embedding the principles of recovery focused practices into the ways in which they deliver their services.

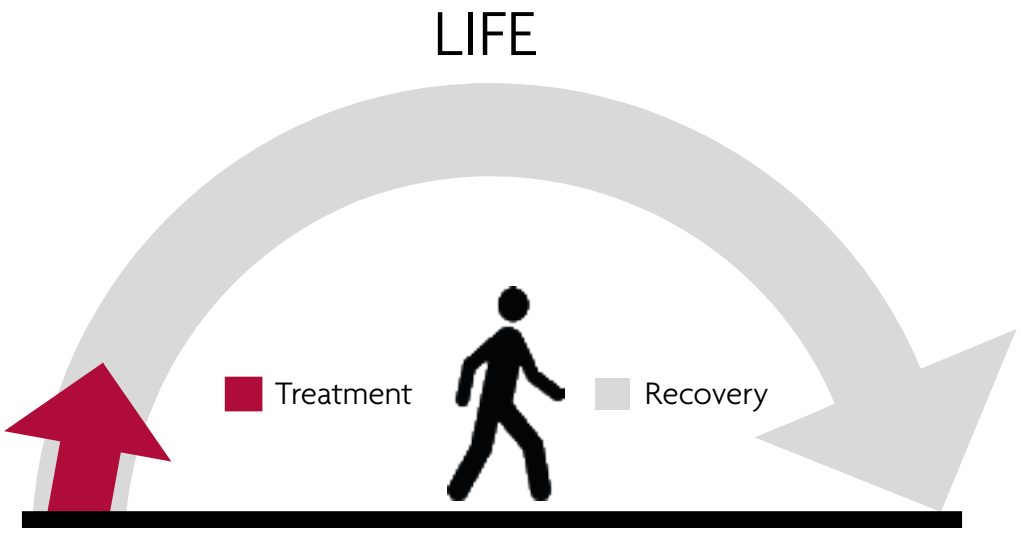
2.4 Evidence Base

The evidence base to support recovery based approaches is growing, demonstrating that recovery oriented approaches can augment and enhance treatment interventions and maximise wider benefits to families and communities. There is little UK-based research on recovery and the international evidence base is limited. However, Best et al (2009)[1] makes key conclusions as follows:

- Sustained recovery is the norm, although the time to recover and the pathways involved are unique to the individual. For this reason, the evidence suggests that a narrow diagnostic definition of recovery is not advisable.
- There are a wide range of pathways to recovery and the evidence illustrates the importance of individuals discovering their own path. Recovery stabilisation does not happen quickly and will depend on the individual and their circumstances and motivation.
- The best predictor of the likelihood of sustained recovery is the extent of recovery capital. This includes the personal and psychological resources a person has, the social supports that are available to them and the basic foundations of quality of life (i.e. a safe place to live, meaningful activities and a role in their community, however they define this).
- Barriers to recovery include psychological problems, significant physical health problems (including blood-borne virus infection), social isolation and on-going chaotic substance misuse. Strengths (recovery capital) are a better predictor of long-term recovery than the symptoms of substance misuse.
- While structured treatment has a key role to play in an individual's recovery, it is only part of the support that most people will need to recover from their drug use. On-going support in the community is essential for maintaining and continuing the recovery journey. It is also important to provide on-going support to individuals following structured treatment and to reinforce the positive outcomes associated with mutual aid and peer support in the community.
- Recovery is not just about the individual. The evidence shows that when recovery is sustained beyond treatment, it can have a positive impact on the psychological health of the children of parents in recovery; and there are grounds for suggesting that this will be a mediating factor to aspirations and achievements in young people.

- Switching to a recovery model may require a fundamental change in culture and attitudes by many professionals and communities.

Therefore, we need to recognise the invaluable contribution that treatment services make to some people's recovery journey, while also acknowledging that the time people spend accessing services is, and should, be only one small part of the individual's wider recovery journey. Treatment should be an episode in an individual's life, after which they continue to make and maintain positive changes and live fulfilled lives in the community. This will mean different things for different people and may include continued access in other service provision and the recovery community. For others, they will never again need or want to be involved in substance misuse or support services.



(Drug Aid 2013)

2.5 Recovery Capital

Recovery capital refers to the internal and external resources an individual has to achieve and sustain behavioural change and recovery. Recovery capital recognises that each individual has different life areas, which can support or jeopardise recovery. These can be categorised into: social networks, physical (e.g. money, somewhere to live), human (e.g. skills, health, employment), cultural (e.g. values, beliefs) and community (e.g. availability/quality of services) issues.

The need for, and availability of, recovery capital differs from individual to individual, and differs within the same individual at multiple points in time. Problem severity will also shape the intensity or level of care one needs in terms of professional treatment, and the intensity and duration of post-treatment recovery support services. Substance misuse treatment services should aim to educate and support individuals to recognise their recovery capital in an asset-based approach, assisting individuals to identify existing resources and build new recovery capital. This should be an integral part of every interaction with service users and can range from introducing the concept and language to completing recovery planning resources.

2.5.1 Assessing Recovery Capital (ARC)

The use of Assessment of Recovery Capital (Best, 2009)[1] is a measure of wellbeing where higher scores represent better levels of overall functioning. Best et al (2010)[2] states "one of the key objectives of the transition to a recovery model, and one of the main objectives of recovery interventions, is to focus on enabling clients to build their own recovery capital, and to develop the resources that will not only enable them to become substance free but also to develop and grow".

Best and Laudet (2010)[3] have argued that there are three parts to recovery capital:

- Personal recovery capital: the personal skills and resources available (competencies, coping skills, self-esteem, self-efficacy, and a positive identity).
- Social recovery capital: consisting not only of the social network and the individual's resulting engagement with them and their commitment to normative values.
- Community recovery capital: that there is a contextual component to the resources available for the recovery journey that is about available recovery champions, clear roads to recovery supports from treatment and the underlying community resources such as houses and job opportunities to enable and sustain recovery pathways.

This echoes Best et al work on Recovery Capital (2010)[2], which breaks recovery down into ten component personal and pro-social areas of capital that can be measured across a client's long-term recovery journey.

Key component aspects of inherent client capital are as follows:

- Substance misuse and sobriety
- Psychological health
- Physical health
- Community involvement
- Social support
- Meaningful activities
- Risk taking
- Housing and safety
- Recovery experience

ARC as a tool enables assessment and ongoing collaborative work between the service user and substance misuse worker to enhance each area of recovery capital. It is therefore suggested that APBs should ensure services use this tool to enhance recovery within drug treatment services.

Further evidence in respect to the recovery process and the use of the Assessment of Recovery Capital (ARC) is included at Appendix 1.

2.6. Recovery Champions, Community Groups and Mutual-aid Groups

An integral part of commissioning substance misuse treatment and recovery services will be to develop and use networks of support and other assets within the community such as mutual aid, peer support, community groups and recovery communities.

Service users have reported that they would welcome more support from people who have been through a recovery journey themselves and are willing to be open about it. Providers also need to be aware of the need to ensure boundaries are in place to enable groups to do this in a positive manner. These services need to form part of the support and therapeutic packages in formal treatment services.

The terms "mutual aid" and "peer support" are often used interchangeably. While these two functions share some similarities, they are two different functions within a ROISC.

"Mutual aid" is used to refer to a defined relationship, whereby the individual is both the donor and recipient of support based on shared life experiences. This is a completely voluntary relationship. APBs need to build links with mutual-aid groups ensuring that all individual services have the relevant pathways in place. These resources should be encouraged at all stages of the treatment journey and be sufficiently publicised. Where these resources are not currently available, commissioners and planners should seek to support their growth.

"Peer support" is used to refer to a supportive relationship, where an individual who has experience of drug or alcohol issues, may be specifically recruited on a paid or voluntary basis to provide support and guidance to peers. Clarity is needed about what mutual aid and peer support mean in terms of treatment service and in the community. They may often be the same but it is important that individuals understand what is offered and have realistic expectations. The value of peer support can also be integrated into the ways in which professionally-led interventions are delivered.

Service providers should consider the ways in which they keep in touch with people who have exited their services. People are often willing to share their experiences with others and to use their experiences of treatment and recovery to support and encourage others. These people are an invaluable resource for service providers to embed peer support within their services.

It should be noted that mutual aid and peer support are not the same as service user involvement, although they can support one another.

Recovery community and mutual-aid resources should also form an integral part of structured and less structured aftercare and open-ended on-going support.

Whilst the majority of service users are aware of other networks of support such as mutual aid, peer support, community groups and recovery communities, it is imperative that local areas develop a directory of services outlining all relevant services available.

Lastly, service providers should utilise recovery champions as they play an important role in articulating ambition, championing routes to recovery, supporting individuals in treatment, and challenging partnerships and services to retain a recovery focus at all stages of a service user's journey.

3. A Framework For Effective Recovery Oriented Integrated Systems of Care

3.1 The role of Area Planning Boards

Substance Misuse Area Planning Boards (APBs) are responsible for the planning and commissioning of substance misuse services. To make commissioning decisions that reflect the needs, priorities and aspirations of the local population, APBs need to engage with the public and actively seek the views of substance misusers, their families and carers, and the wider community to shape services and improve substance misuse treatment, reintegration and recovery outcomes. This relationship should be long-term, inclusive and forged through a sustained effort and commitment on the part of planners and commissioners.

The successful implementation of personalised recovery oriented practice goes beyond the confines of the current substance misuse treatment system and involves consideration of front-line practice, organisational learning and development, and system-wide commissioning and partnership activity. In order to assist in delivering effective recovery-based treatment, commissioners need to reduce barriers to accessing and completing treatment by ensuring:

- Local treatment services maximise the number of people who overcome addictions and sustain long-term recovery.
- Substance misusers have access to employment, education and housing and that they become inclusive and contributing members of society.
- Services meet the needs of substance misusers and offer timely, appropriate and accessible evidence-based treatment in community, residential and criminal justice settings.
- The transition from children's to adult services is easily managed.
- Local partnerships promote access to relevant mutual aid networks and on-going peer-led community support which include self-help and mutual aid.
- Substance misuse treatment systems have competent staff, good systems of clinical governance and provide good value for money.
- There is clear communication and joint working between services across the system.
- Services are monitored on the basis of meaningful outcomes with the service-user experience and goals at the centre of this.
- Opportunities for innovation.
- There is something for individuals to move onto post-treatment.

3.2 Monitoring the Implementation of ROISC

Area Planning Boards will be responsible for ensuring delivery of the guidance. The following arrangements need to be in place in each APB area:

- Recovery oriented integrated systems of care should be embedded within commissioning strategies.
- Recovery oriented systems of care should form part of annual monitoring of substance misuse services by APBs and commissioners.
- An integrated system should be in place that provides access to recovery support (e.g. housing, employment, education) and that partnership efforts are oriented on harnessing local job and housing options as key building blocks to maximise recovery.
- Service Level Agreements (SLAs) should specify required workforce activities that evidence that induction, individual staff development plans, trainee/volunteer schemes and provision for undertaking competency-based training and continuing professional development are being carried out.
- Welsh Government Core standards on Substance Misuse should be met.
- Performance management systems should be in place (please refer to sections 4.3 and 4.4).

3.3. Workforce Development

The successful implementation of psychosocial interventions in treatment and support services relies heavily on the skill set of front-line workers. Guidance documents and toolkits have already been widely published to support this and a comprehensive overview can be found in Pilling et al (2010)[6]. Although it is acknowledged that there are a large number of different psychosocial approaches available, with varying levels of intensity, they share many common elements. By focusing on the common elements between approaches, Welsh support agencies can ensure that front-line workers have a solid base of skills from which to meaningfully engage this client group. Considerable investment in building the skills of practitioners has already been made across Wales and it is recognised that many professionals are well practised in delivering interventions effectively, for such services this may offer an opportunity for fine-tuning the skills of their workforce.

The value of going back to basics should not be underestimated, even for the most experienced practitioners. Appendix 2 provides a useful aide memoire on what skills the workforce should ensure are integral to practice.

Continuous improvement of the capacity and effectiveness of adult substance misuse treatment depends upon sustained commitment to workforce development. Effective treatment requires a skilled workforce capable of delivering a care-planned and coordinated range of interventions. They need to be able to negotiate this treatment journey with service users/carers to enable them to achieve stability, recovery and reintegration into full community life.

Service Level Agreements (SLAs) should specify required workforce activities that evidence that induction, individual staff development plans, trainee/volunteer schemes and provision for undertaking competency-based training and continuing professional development are being carried out.

Developing a recovery oriented workforce is beyond training but needs to ensure efficacy and evidence-based interventions and that learning is embedded into practice. Practitioners, when working with drug/alcohol users need to establish which therapeutic techniques, interpersonal styles or attributes work best with whom and in which situations. They should work to improve their practice based on research and service-user feedback.

Workforce development is an essential and integral part of realising a truly recovery oriented system. This not only applies to traditional approaches involving training but also involves a broader outlook incorporating organisational development, change management, evidence based knowledge transfer and skill development. This involves embedding the philosophy and culture of recovery into the recruitment, supervision and performance management process, as well as providing psychosocial tools for practitioners to work with.

In order to fully integrate recovery oriented principles into the substance misuse sector across Wales, this must apply to professionals at all levels, in all disciplines. This applies to front-line workers, directors and executives of treatment and support organisations, as well as those responsible for commissioning and strategic delivery. Furthermore, the role of the wider workforce must be acknowledged, which incorporates volunteers, mentors, health professionals, criminal justice agencies and many other partners.

There is a considerable body of evidence to confirm that incorporating psychosocial elements into substance misuse treatment has substantial benefits for service users. These may take many different forms ranging from harm reduction advice and brief interventions, through to node link mapping techniques, motivational interviewing and cognitive behavioural therapy. When delivered effectively, these interventions fully support the delivery of a recovery oriented system and the realisation of self-defined goals.

In order for practitioners to fully integrate psychosocial interventions into every day practice, time and resources must be set aside for training, qualifications and suitable supervision. These skills must become fully embedded into the culture of the organisation to be effective.

APBs should ensure that:

- Staff new to the sector are fully trained on the principles of recovery at the point of induction and this is then consolidated throughout their supervision and personal development plans (PDPs).
- Existing staff, many of whom already demonstrate good practice in a range of recovery oriented areas, receive training on what the recovery movement means for Wales.
- Recovery community members are invited to participate in the delivery of training and briefings to professionals. They should be fully supported throughout and provided with the skills needed to participate meaningfully.

- Services should review their care planning arrangements to ensure that the recovery principles have been fully adopted and to question if this process is truly service user-led.
- Services self-audit, using the checklist provided, and identify potential development areas within their own workforce.
- Professionals delivering services increase their awareness of community resources in their local area and ensure that service users know how to access them.

It is essential that partner agencies take ownership of what this process means for them and develop service specific implementation plans based on the recommendations outlined within this framework.

Organisations need to have in place strategies to ensure they have a diverse workforce recognising the unique benefits and risks different types of workers bring to the table and have appropriate training, supervision and support.

4. Developing Recovery Oriented Integrated Systems of Care

4.1. Integrated Care Pathways

In order to deliver against all treatment actions outlined in the Welsh Government 10 year Substance Misuse Strategy 'Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-18'[4] and associated Substance Misuse Delivery Plan 2013-15, APBs need to recognise that recovery is the bedrock of all commissioning decisions. Parts of the recovery system need to become more joined up, with greater continuity of care (for example, between prison and community-based services).

APBs need to ensure that services are commissioned based on the needs of the population and have a whole systems approach including a wide range of treatment and aftercare options available. This will incorporate abstinence based services, including traditional residential rehabilitation, and also parallel or integrated support towards reintegration and recovery for those service users who are not ready, or may not wish to access full abstinence-oriented service provision.

Service user aspirations should be regularly checked at individual care plan review stages and opportunities maximised as they present throughout a client's journey.

Commissioners and providers – through their APB – need to ensure that there is an integrated system that provides access to recovery support (e.g. housing, employment, education) in the community and prisons; and that partnership efforts are oriented on harnessing local job and housing options as key building blocks to maximise recovery. Commissioners should have a written pathway to increase service users' access to education, training and employment. Joint protocols are also needed to ensure all key partners have shared definitions, objectives and outcomes. APBs also need to build in opportunities for families and carers to positively impact on the service user experience of treatment and to assist with getting their lives back on track.

Additionally, APBs will be aware of the need to pay significant attention to how service users exit treatment, whether through community-based structured day services, via residential rehabilitation services, or grass roots support groups. Building on annual needs assessments and service user views, planned exits and recovery opportunities are likely to be key building blocks in an ever-improving effective treatment system.

4.2. Recovery Oriented Care Planning

> "The process should be a detailed and collaborative exploration of resources, goals, strategies, options, benefits and risks" (Strang 2012)[5]

Care planning has become an integral part of delivering interventions for substance misuse for many years and there is a wealth of resources available to demonstrate that the care planning process can be a very effective psychosocial intervention in its own right.

The care plan should outline the goals of the service user while addressing the main issues identified during the assessment process. Since the introduction of node link mapping techniques, care planning has become more interactive and engaging for clients and practitioners in many services. The care plan should be developed collaboratively in a style that suits the learning preference of the service user. Creative methods are encouraged to engage the person seeking support throughout the entire process. The International Treatment Effectiveness Project (ITEP) manuals offer a useful starting point for those who wish to explore this further (see useful links section). However, practitioners should refrain from using manuals prescriptively and focus their attention on engaging the person they are supporting. The client owns this process and has the right to dictate its design.

There is a delicate balance to be found between satisfying audit criteria to ensure that care plans in Welsh substance misuse services meet best practice standards, while at the same time empowering the service user to take full ownership of the process. This balance is possible as long as audit criteria for care plans are available and clear. The main point to emphasise is that a good care plan is not 'completed' and then reviewed, it is built and evolves over time alongside the clients' journey. The care plan should be an active demonstration of how recovery principles are applied in practice and make clear how recovery capital will be developed. The care plan need not be based around a specific paper template or map, but can include other media such as video files, board games and other creative methods.

It is essential that care plans are owned by the service users and have specific measurable goals identified. Service managers and commissioners should complete audits of care plans to ensure these are working documents, which are collaborative in nature and regularly reviewed.

4.3. Recovery Oriented Outcomes and Performance Management

Organisations need to be clear about recovery, the ultimate outcome sought and the method of measuring whether they have been successful. They also need a method to articulate and deliver that vision. Substance misuse service delivery should have recovery oriented outcomes and meaningful partnerships between service users and staff at their core.

Commissioners need to build the recovery oriented outcomes and activity indicators into service specifications and performance monitoring. Realistic outcomes in relation to the service user's aspirations and abilities must also be developed in partnership with their key worker.

Commissioned services may only be able to play a part in promoting or contributing to the attainment of the actual meaningful outcomes for individual service users. That is accessing:

- Meaningful relationships
- Appropriate and settled accommodation
- Access to education and employment
- Financial stability
- Engagement in meaningful activity
- Good physical health
- Mental well-being

Welsh Government monitors activity and measures effectiveness of the treatment of substance misuse through its National Key Performance Indicators which include the Treatment Outcome Profile (TOP). TOP is the outcome tool adopted by Welsh Government to monitor outcomes in treatment. It offers a core set of outcome measures to assess the effectiveness of treatment by measuring improvements in both physical and mental well being. However it is recognised that the TOP can also be used in conjunction with other monitoring tools.

4.4 Audit

Mechanisms need to be in place to measure how effectively the contents of this framework are embedded into working practices. To support this, an audit checklist is enclosed at Appendix 3. This should not be seen as another checklist to complete, but as a tool to facilitate cultural and operational change.

Service users and the recovery community should be part of monitoring the performance of services. Service users want to know how well their service is performing and they are very keen to know that outcomes monitoring is not about ticking boxes. Commissioners and service providers need to communicate how they measure success and foster service user involvement in identifying issues and improving practice across the treatment system.

It is recognised that when monitoring and assessing peer-based, mutual-aid and recovery community services, there is a need to ensure any system is relevant and meaningful and needs to be undertaken carefully so as not to put in place reporting mechanisms which are burdensome.

References and research

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10. Thomas, S (2011) The Introduction of the Assessment of Recovery Capital Within a Residential Alcohol Rehabilitation Facility – An Exploration of its Influence on Client and Therapist Experience.

11. Hills, R (2011) An Investigation Into The process of Recovery When Substance Misusers are Attempting Desistance, Phd Thesis, University of South Wales.

Useful Links

Pilling et al 2010

www.nta.nhs.uk/uploads/psychosocial_toolkit_june10.pdf

NICE Clinical Guideline 51 July 2007

www.nice.org.uk/nicemedia/live/11812/35973/35973.pdf

Resources for Motivational Interviewing

www.motivationalinterview.org/

Node Link Mapping Techniques (ITEP & BTEI)

www.nta.nhs.uk/uploads/itep_routes_to_recovery_part1_120309.pdf

www.nta.nhs.uk/uploads/itep_routes_to_recovery_part2_180209.pdf

www.nta.nhs.uk/uploads/itep_routes_to_recovery_part3_120309.pdf

www.nta.nhs.uk/uploads/itep_routes_to_recovery_part4_240309.pdf

www.nta.nhs.uk/uploads/itep_routes_to_recovery_part5_240309.pdf

www.nta.nhs.uk/uploads/itep_routes_to_recovery_part6_240309.pdf

www.ibr.tcu.edu/

Care Planning

www.nta.nhs.uk/uploads/nta_care_planning_practice_guide_2006_cpg1.pdf

Also see ITEP manuals listed above.

Glossary

APB	Area Planning Board
APoSM	Advisory Panel on Substance Misuse
ARC	Assessing Recovery Capital
BTEI	Birmingham Treatment Effectiveness Initiative
ITEP	International Treatment Effectiveness Project
ORS	Outcome Rating Scales
PDP	Personal Development Plans
RBA	Result Based Accountability
ROISC	Recovery Orientated Integrated System of Care
SLA	Service Level Agreements
SMTF	Substance Misuse Treatment Framework
SRS	Session Rating Scales
TOP	Treatment Outcome Profile

Appendix 1

Supporting literature for the recovery process and the use of Assessment of Recovery Capital (ARC)

This appendix provides additional sources of information which go into more depth on the evidence base behind the recovery process, the definition of recovery capital and the use of the Assessment of Recovery Capital (ARC). Within the recovery model, recovery refers to a sense of hope, a sense of purpose, a sense of belonging and a positive identity (Best, 2012)[7]. The model does not assume that people will have to be abstinent to achieve recovery and recognises that 'you are in recovery if you say you are'. At the heart of this model is the assumption that recovery is a developmental process (Hser et al, 2007a, b) [8, 9] in which there are trajectories and turning points and the aim of treatment, and specifically the aim of the therapeutic relationship is to act as a 'turning point' in an addiction career. In this approach (Best, 2012)[7] recovery is seen as accruing enough 'recovery capital' so that a window of opportunity for lasting change can be achieved.

Published in January 2011, *The Introduction of the Assessment of Recovery Capital Within a Residential Alcohol Rehabilitation Facility – An Exploration of its Influence on Client and Therapist Experience* (Thomas, 2011)[10] had two main findings and recommendations; firstly, on a positive note this pictorial representation of client recovery journeys served to empower the client and place him/her at the centre of their own recovery journey. However, a need was also identified to better train professionals in the ethos and rationale behind the ARC so as to avoid mistrust and devaluation of the tool.

Hills (2011)[11] undertook an investigation into the process of recovery when substance misusers are attempting desistance. Qualitative interviews of a semi-structured nature were carried out over a one year timeframe. The purpose of the interviews was to explore periods of drug use and desistance and to investigate the processes involved each time a respondent desisted from drug use or resumed their use. Treatment can be viewed as an episode in the recovery process. The research showed that although abstinence is a goal for respondents, the achievement of it is not without difficulties and can take time. Hence the process of recovery is not straightforward but can prove difficult to achieve and be lengthy in its process. The main reason people resume drug use is not in relation to the drugs themselves but instead seems to be due to extraneous factors which have overwhelming influences on the respondent. This raises the importance of individuals having a robust package of care that deals with not only the substance and the withdrawals from that substance but with a wider remit surrounding their everyday lives, namely recovery capital. Recovery should not be viewed as a stand-alone intervention based around treatment, but should encompass the holistic needs of the individual, taking into account all aspects of an individual's life in order to facilitate the wider process of change. Hence evaluating Recovery Capital and evaluating strengths and weaknesses in order to build on these areas will enable service users to build meaningful activities and relationships to enable them to make positive progress with regards to their substance misuse.

Getting the basics right – workforce development skills integral to practice

Communication: Many psychosocial approaches depend largely on key but very basic communication skills. The value of using open questions effectively and being able to communicate understanding to a service user is absolutely essential in the delivery of any psychosocial intervention. Utilising basic communication skills is an essential component for gathering information during assessment and helping the service user to identify where they want to start in their recovery journey. The communication style of front of house staff must also be taken into consideration and is as essential as the style of the person offering support.

Collaboration: The relationship between the person giving support and the person seeking support should be collaborative, empathetic, non-confrontational and empowering. An essential part of changing the culture in treatment services across Wales is to move away from practitioner-led care and towards a model which is truly client-led.

Knowledge: All practitioners should have a solid basic knowledge of substance misuse and related issues, including mental health. This is important so that the right questions can be asked when delivering psychosocial interventions. Practitioners must also feel confident in their own knowledge levels to enable them to pass on information to service users. All practitioners should have a healthy knowledge and respect for appropriate professional boundaries in line with the policies of their service. Any gaps in knowledge regarding community resources outside of the treatment and support system should be addressed as a matter of priority if practitioners are to meaningfully facilitate the development of recovery capital. Service users need to know what they can expect to move on to after they have achieved their immediate goals in treatment or support.

Partnership working: The evidence is very clear that meaningful partnership working increases the likelihood of positive outcomes for people in treatment and allows organisations to allocate their resources more effectively. It is essential that service users are presented with a wider range of options and practitioners promote other services as passionately as they promote their own. This is the basis of genuine choice and genuine partnership. It is highly recommended that practitioners collaborate with their colleagues from different agencies in the planning and delivery of intervention, guided by their service user.

Hope: It is well documented that the attitude of the practitioner has an impact on the success of the person receiving psychosocial interventions. If the practitioner believes that their client has the ability to achieve the goals that they set for themselves then their outcomes may be more positive. This must be balanced with realism and the practitioner has a responsibility to act as a guide throughout the process to help the service user find the most appropriate route to recovery for them.

Ownership: It is paramount that service users have ownership over their treatment. The issues about communication, collaboration, knowledge, partnership working and hope are essential in order for service users to feel empowered and engage fully in treatment.

Recovery Oriented Integrated Systems of Care (ROISC) Audit Checklist for Substance Misuse Service Providers

	Yes	No	Partially	Suggested evidence
Role of the practitioner: a partnership approach, an expert guide, a coach				– Presence of service user, volunteer, recovery champion or peer mentor – Statement of philosophy – Service user feedback – experience within the service, attitude of staff, reflection following a period of exit – Service user advocates and complaints procedure advertised and feedback mechanisms in place to demonstrate when they are used – Welcome booklet – Service Charter – commitment/expectations – Job description – Supervision/360degree reflections – Quality framework/case audit – Observed practice – Evidence of what model you have been using and for how long – are latest evidence based approaches being implemented? – Is there evidence of flexibility – Mystery shoppers

	Yes	No	Partially	Suggested evidence
The clinician moves from being "the expert" to a coaching role, working alongside the client				– Coaching principles embedded in supervision – Service user feedback mechanism – Welcome booklet – Service Charter – commitment/expectations – Observed practice
Implementation of self-directed building of recovery capital from day one				– Referral information – Assessment and recovery oriented care planning tools – Is Assessment of Recovery Capital (ARC) being used? – Welcome information – Service user contract – Is recovery capital explained? – Service user feedback – Are free resources available in the community – Directory of Services outlining community based options
Recovery built into supervision and appraisal sessions				– Supervision policy/template – Training needs analysis – Opportunities for peer/group supervision – Observed practice by peer or volunteer – Staff feedback

	Yes	No	Partially	Suggested evidence
Language: Developing a common, strengths based, recovery oriented language				– Promotional material/service information – Website – Case file audits – Worker feedback – Service user feedback – Service user and volunteers involved in developing materials and language used – Training/induction material
Treatment tools, e.g. node link mapping, recovery plans, assessment maps				– Case file audit – Staff development/training – Assessment, recovery oriented care planning tools – Evidence of use of tools – Service user feedback – Flexibility in tools used depending on desires of the client

	Yes	No	Partially	Suggested evidence
Workforce development, e.g. the recovery approach, beliefs and attitudes				– Training/workforce development policy – Training received/personal development plans (PDP) – Treatment and recovery tools – Statement of Ethos – Recovery tools training – Exposure to service user groups – Recovery tools
Psychosocial and medical approaches not in isolation				– Service description – Service Level Agreements/contracts – Commissioning plans and Integrated Care Pathways developed and communicated – Communication channels between services – Service user involvement in strategic groups and Area Planning Boards
Recovery champions and service users involved in formal treatment services				– Evidence of service users involvement – Recovery champions – Peer support groups in house – Mutual-aid and community resources advertised and referral routes

	Yes	No	Partially	Suggested evidence
Knowledge of and partnership working with other services within the Integrated Care Pathways				– Directory of services, whats offered and contact details – organised by APBs – Each service provided information to the directory – In depth website for each area with the above information – Service user feedback – DAN 24/7 advertised – Service information – Case file audit – Performance management e.g. referral on and referral routes – Partner feedback
Family and carer involvement				– Carer feedback collected – Information for carers available – Mentioned in welcome booklet – Recovery oriented care planning including family or carer – tools and case audits – Service user feedback

	Yes	No	Partially	Suggested evidence
Assertive linkage to the recovery community and community-based supports				– Community resources booklet – Advertising mutual-aid and recovery community – Peer support groups available – Establishment of peer/recovery champions
Aftercare provision				– Embedded and supported within care pathways – Referral routes – Through care and aftercare planning – case audits – Service user feedback – Service information – Service user information – SLA contracts
Early re-intervention				– Embedded and supported within care pathways – Service user feedback
Care coordination				– Case file audits – Evidence of partnership work – Service user feedback – Guidance from APB and written into SLAs

	Yes	No	Partially	Suggested evidence
The environment in which treatment is held				– Estates review – Service users feedback – Mystery shoppers
Flexibility in approaches to engagement, assessment and care planning				– Service SLA/contract – Supervision – Observed practice – Case file audit – Use of recovery champions and peer supports to encourage people to attend – Working hours – Responding to need – Out of hours sign posting – Appropriate self disclosure
Flexibility in admin systems – letters, text, phone calls				– Evidence of letters used – Use of text and phone – Are service users asked their preferred communication method? – Use of recovery champions and peer supports to encourage people to attend – Service user feedback

	Yes	No	Partially	Suggested evidence
Outcomes and data collection approaches				– Use of TOP – Use of Outcome Rating Scales/Session Rating Scale (ORS/SRS) – Result based accountability (RBA) score cards – Assessment of Recovery Capital (ARC) – APB annual service reviews – published – Closure and exit reporting
The recovery approach supported by management				– Annual reports – Service reports – Stated philosophy – Team meeting minutes – Staff feedback – Staff development programme/workforce development policy – Core standards – APB Commissioning strategies – Annual monitoring meetings
Embedding the contribution of those with lived experience in services				– Access to the recovery communities – Access to recovery champions and peer mentors within service

	Yes	No	Partially	Suggested evidence
Service user involvement				– Are there 'in house' service user groups – Are service users included in design and review meetings – Service user surveys – Service user representation on interview panels – Service user groups advertised – Involved in design of services – Involved in performance management
Communication				– APB Communication strategies – Service information available in a variety of ways e.g. website leaflets, face book, twitter.