The transition to a recovery based service: exploring the perspectives and practices of staff

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Acknowledgements

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1. Introduction

Recovery based practice

The publication of the Drug strategy 2010 '*Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*' is part of a wider shift in drug and alcohol policy over the last 20 years from one in which an initial focus on harm reduction and engagement has moved through crime reduction and retention and on to one in which there is an 'expectation that full recovery is possible and desirable' (p.2). Whilst this is a new shift at the level of national policy, some organisations working with drug users have been operating to recovery based models for some time and arguably in work with alcohol users the emphasis has always been on recovery. The decision to shift the national policy framework in the direction of recovery appears to be essentially a philosophical and political one however since, as a recent review asserts, 'the UK evidence base is limited, and much of the evidence is based on alcohol research' (Scottish Government, 2010, p.24).

Recovery is a complex process which often endures for many years after stabilisation and/or abstinence has been achieved and some suggest it is a lifelong process which can never be completed. However, what most people agree is that recovery involves addressing issues in a number of life domains including drug and/or alcohol use, housing, relationships to families, friends and the wider community, employment, education and training opportunities, physical health, mental health and wellbeing. For some the concept of recovery is perhaps best encapsulated by the notion of a journey in which the emphasis is on movement towards recovery, although the routes that people may take to get there may be very different.

The dominant themes around recovery, relevant to this project, emerging from the review of the evidence undertaken by the Scottish Executive (2010) can be summarised as follows:

- There is considerable empirical support for family engagement in treatment with evidence of improved outcomes for the individual in treatment and improved functioning within the family. Positive results have also been shown for parenting training and for specialist interventions for pregnant drug users.
- Within a broad framework of developing recovery capital, there is clear support for the effective use of recovery housing, training and vocational support as parts of a recovery package of care.
- While there is some empirical support for integrated treatment, the evidence base around the co-morbidity of mental health and substance misuse and its impact on recovery remains limited.
- While there is some support for specific psychological or psychosocial interventions, there is increasing evidence that the context of treatment (in particular, the therapeutic alliance and the level of client engagement) is an equally important predictor of treatment outcomes, with worker motivation and efficacy central to this effect.

- Effective continuity of care is essential with an increasing international evidence base around the benefits of assertive linkage to aftercare and community support and for the use of recovery management check-ups.
- There is a strong and consistent evidence base around the benefits of engaging in mutual aid and ongoing support. This includes the importance of ongoing support after structured treatment, the positive outcomes associated with mutual aid and peer support in the community and the importance of assertive follow-up support.
- For criminal justice populations, there is international research support for the effectiveness of therapeutic communities in prison and continuity of care on release. UK studies have provided some support for quasi-coercive interventions, with effects varying depending on implementation and delivery factors.

This Project

The research team at the University of Central Lancashire (uclan) has been in discussions with Lancashire Drug and Alcohol Action Team (LDAAT) and Crime Reduction Interventions (CRI) for some time about the potential to develop a local evidence base around recovery based practice. Together we have applied for funding to support a Knowledge Transfer Partnership. In the first stage of the application process the Technology Strategy Board and the Economic and Social Research Council indicated a willingness to support the proposed project subject to the full application being approved. The full application was submitted in November 2010. In December 2010 the Technology Strategy Board changed its funding criteria and decided to retrospectively apply these new criteria to all existing applications. This has resulted in a significant delay in decisions and at the time of writing we are still awaiting the outcome.

In November 2010, representatives from LDAAT, CRI and uclan met to discuss the project and decided to pursue an initial research project which would underpin the future KTP and which could be undertaken whilst we waited for the decision about the KTP application. In these discussions colleagues reflected on the complexities of the transition to a new service and how this might have been experienced by staff and service users. It was decided that the focus of the initial programme of work should be to:

- gain a snap shot of how the TUPE process had been experienced by staff;
- gain a snap-shot of the views of staff about the changing culture involved in a recovery oriented service;
- provide baseline data against which the KTP could measure future progress on these subjects; and
- develop some initial thoughts about what a tool that measures recovery across the treatment population might look like.

The proposed outputs for this work were:
- A report.
- A series of recommendations for CRI and LDAAT about training and support needs of staff in relation to recovery models and communication and supervision processes across the integrated team during the transition period.
- To provide a foundation for the implementation of the KTP.

2. Methods

2.1 The sample

The plan for this research was to recruit and interview all CRI staff who were working with service users across the five sites. We managed to recruit and interview n=56 Inspire staff out of a possible 58 staff listed by the five managers. These staff described their locations as follows:

Table 1: Participant numbers by location
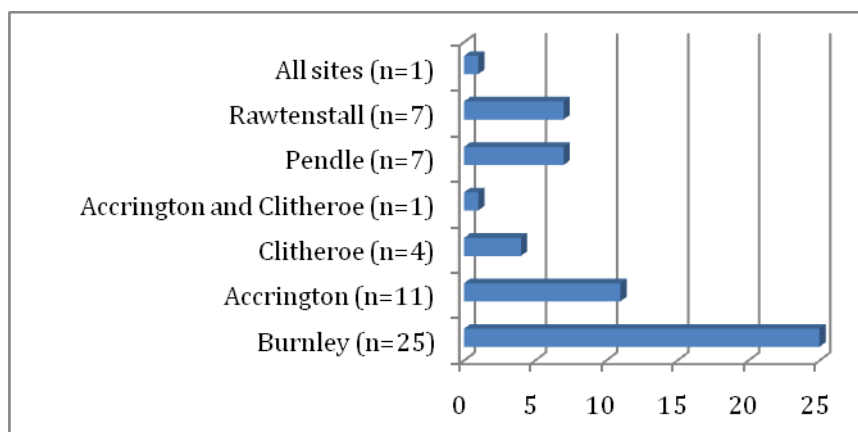
2.2 Method

The management group (comprising of representatives from CRI, LDAAT, the PCT and uclan) decided to use a semi-structured questionnaire. This method offered the possibility to explore a number of common themes across the staff group, but also allowed the latitude for participants to identify issues of particular interest or importance to them personally. The questionnaire used for the study was agreed with the group who all commented on it before it was used. The research team also conducted a mini-pilot of four interviews to test the tool. A copy of the tool is included in appendix 1. In all interviews contemporaneous notes were taken with interviewers taking care to feedback key points to participants during the discussion to ensure that the main points were grasped and understood correctly.

2.3 Analysis

A systematic qualitative thematic analysis of the interview data was undertaken to identify the key emergent concepts and the relationships between them (Ritchie, Spencer, and O'Connor 2005). This approach made it possible to: (i) report on a wide range of experiences and perceptions; (ii) identify areas of consensus and divergence, in particular differences between the data emerging from different occupational groups, those TUPED from different organisations and those working in different locations; and (iii) make recommendations on the way things might be altered to address the needs and perceptions identified by different groups.

2.4 Ethics

The research plans and methods for this project were reviewed and approved by the local Research and Development lead for NHS East Lancashire. All potential participants were provided with information about the focus of the study, details of the bounds of confidentiality and information about data protection in advance of interviews. Verbal consent was taken in all cases.

2.5 Limitations

The main limitations in this research are as follows: two staff were unavailable for interview due to long term sickness or suspension. Some respondents were quite careful to check out whether the interview was confidential before giving certain answers; and all staff new that the results of the research would be fed back to CRI and hence some may have been cautious about making criticisms. We used a structured questionnaire in order to allow for maximum comparison between participants. However this structure inevitably limited the latitude provided to participants and may have influenced the things they talked about. It was clear that some participants were more familiar with purpose and context of the interview beforehand than others.

3 Findings

3.1 The working histories of participants

The questionnaire asked staff a range of questions designed to elicit their history in the field of substance misuse and their organisational background. It was considered that organisational background may have helped to frame participant views expressed later in relation to recovery based work and the new organisational culture. Hence we asked people to identify their job title, their status in relation to the TUPE process, any previous organisations worked for and the length of time they had worked in the field.

3.1.1   Job Title

The n=56 participants described the following job titles:

Table 2: Job titles
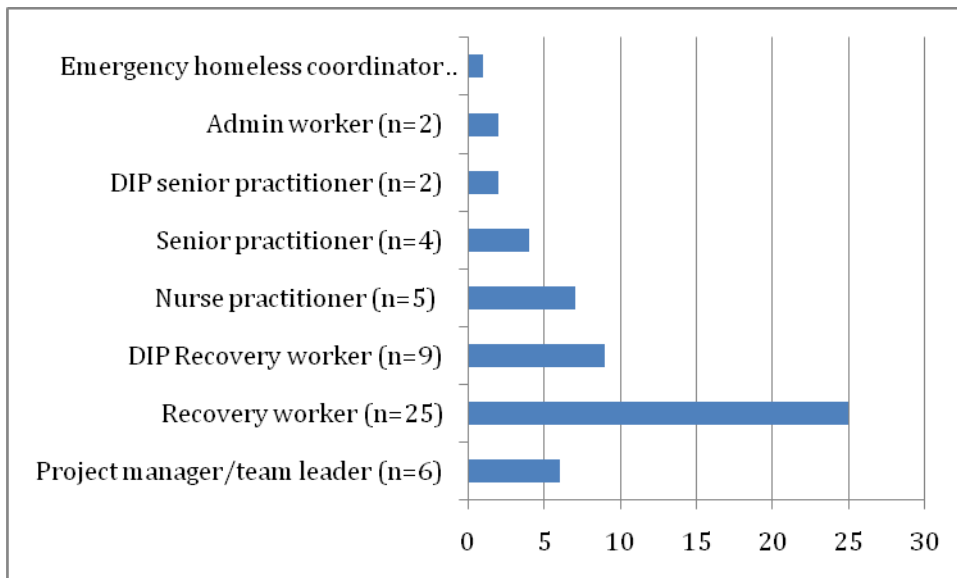
3.1.2 Proportion of staff TUPED

We asked all staff whether they had commenced employment with the service since for CRI since 1st April 2010 or whether they had been TUPED over from a different organisation.

Table 3: Proportion of staff TUPED
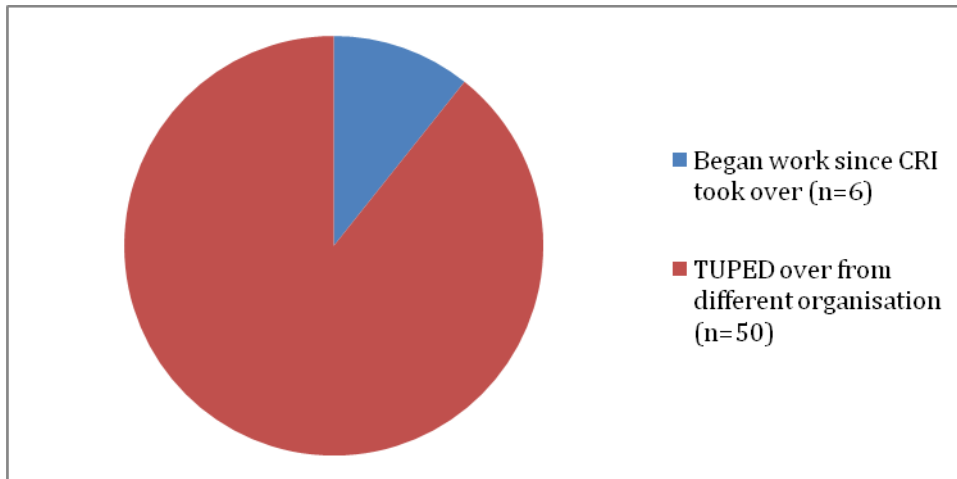
3.1.3 Previous employers of those TUPED

Those participants (n=50) who indicated that they had been TUPED in were asked to identify there previous employer.

Table 4: Previous employers of those TUPED
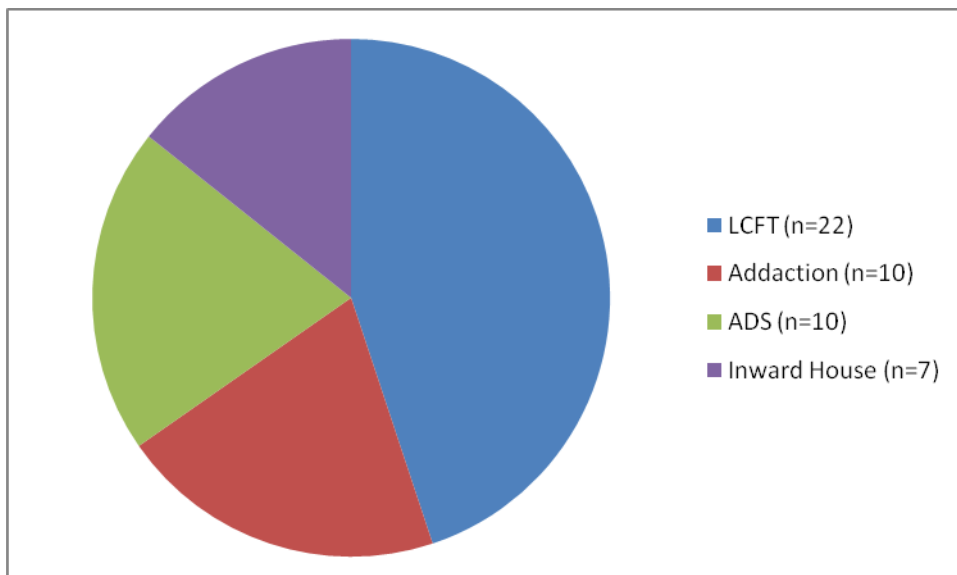
3.1.4   Number of years working for previous employer

Those participants (n=50) which indicated that they had been TUPED in were asked to identify the length of time they had worked for their previous employer.

Table 5: Length of time working for previous employer in years
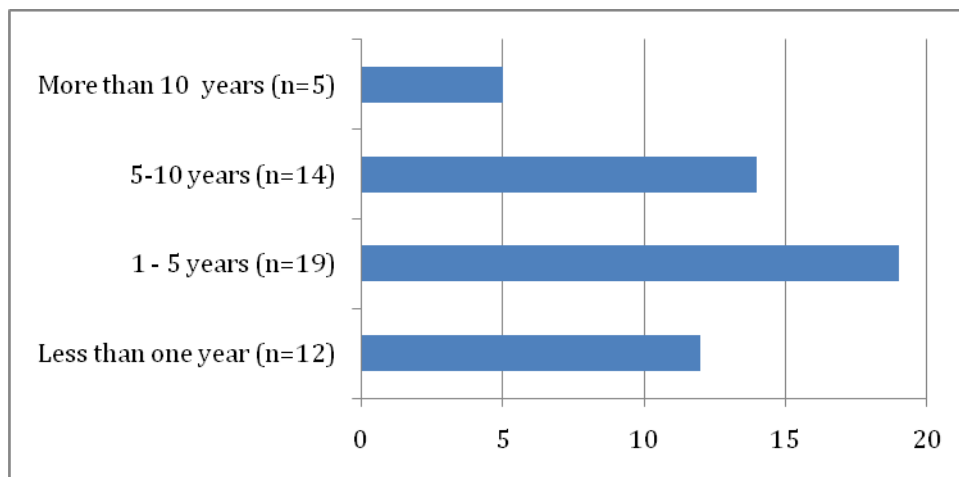
What is clear from the above data is that CRI has inherited a staff group with considerable experience. Many staff have worked in the substance misuse field for many years, but this experience has often been gained in different organisations which operated to quite different models and philosophies about addiction. This represents both an opportunity and a challenge to CRI. On the one hand, the experience that the workforce already has represents a huge asset that is there to be harnessed. On the other, there is a considerable challenge in bringing together workers from such different backgrounds, many of whom will have their own preferred philosophical frameworks, intervention strategies and will have different opinions about the new practice framework.

3.2 Staff definitions of recovery

After the initial set of questions which sought to establish people's working backgrounds, we asked everyone an open question which gave them the opportunity to offer their own definition of recovery. Excerpts from the responses to this question have been reproduced in full (**see appendix 3)** because we feel they offer rich material which may be of interest to those who commissioned the research and which may be important in helping the organisation move towards a shared view and vision. However, in the proceeding section we attempt to pull out some of the central themes emerging from these definitions. In analysing responses we have not merely considered what people have said, but have also cross referenced these data with the data presented in section 3.1. This allowed us to test the notion that people's definitions of recovery might be rooted in their working background or those of particular organisational cultures. The analysis revealed no clear pattern in

relation to these issues however and hence we have presented the data for this question in relation to the dominant conceptions of recovery evident within the staff team as a whole.

Some workers did seek to position their responses to this question in relation to the changed service structure, by either positively or negatively referring to the impact, or otherwise, of the new Inspire Service on provision as the following quotes highlight:

> *I think recovery is a good model. In ADS we worked in this model already. People came and we empowered them and they moved on. When CRI came in they [the drug service providers] were just handing out scripts and I found it really depressing. People were using on top and they still got scripts.*

> *I think CRI are dealing with semantics. For some people stability on a long-term methadone script is OK. This forced abstinence won't work.*

These two responses highlight a couple of important themes which appear in other sections of the report. The first is that there a range of views about the CRI-led Inspire Service which range from enthusiastic through to hostile. The second issue relates to an organisational split between those with a background in alcohol work and drug work, which in the research appeared to be felt and expressed most strongly by former alcohol workers.

Through a process of secondary analysis we sought to identify from people's responses what the most commonly recurring themes were. To make the process as robust as possible two different researchers undertook a thematic analysis of the quotes and then met to compare and agree the findings. Table six presents the results of this analysis.

Table 6: Emergent theme followed by the number of quotes which supported it

Emergent theme	Number of quotes
Achieving independence from services (n=1)	1
Not just handing out scripts (n=1)	1
Challenging thinking (n=1)	1
Getting off a script (n=1)	1
Can include being stable on a script (n=3)	3
Addressing priorities in order (Maslows hierarchy) (n=3)	3
A long-term process which should not be rushed (n=4)	4
In control of use (n=5)	5
Stability in life and control (n=9)	9
Any form of positive progress (n=9)	9
Can be different for different people (n=12)	12
Abstinence at least as a goal (n=13)	13
Predicated on accessing wider support, services and advocates (n=15)	15
Wider quality of life, relationships and reintegration issues (N=16)	16
Defining and meeting personal assets and goals (n=16)	16

The thematic analysis is interesting because it identifies a number of dominant issues emerging from people's definitions of recovery. The notion of 'defining and meeting personal assets and goals' mentioned in 16 responses, alongside the notion of 'any form of positive progress' mentioned in 9 responses, suggests many staff position recovery as a process rooted in defining objectives and identifying personal assets and external supports necessary to meet these.

Fifteen responses mentioned recovery as 'predicated on accessing wider support, services and advocates'. This demonstrates that many staff see the involvement of wider services and other forms of support (e.g. RAMP and SMARTER) as vital to improving the number of people who progress through the system. This was often supported in other sections of interviews, in which the majority of respondents viewed the availability of Acorn and Work Solutions as useful additions to the range of things people could be referred on to. This links to wider evidence emerging from the Scottish Executive (2010) which suggests that within a broad framework of developing recovery capital, there is clear support for the effective use of forms of support which meet wider needs as parts of a recovery package of care (p. 75).

The notion of recovery as related to 'wider quality of life, relationships and reintegration issues' mentioned in 16 responses emphasises that many staff agree recovery is only possible if other health, welfare and wellbeing issues are addressed alongside people's dependence. They also emphasise an understanding that addiction affects a wider group of people who have a stake and a role in supporting and being supported through recovery journeys. Three responses also mentioned Maslow's hierarchy of needs, a model which emphasises that dealing with issues related to self-actualisation (e.g. problem solving), esteem (e.g. respect of others) and belonging (e.g. friendship) is predicated on more basic and fundamental needs being met such as safety (e.g. decent housing) and physiological needs (e.g. food). What is interesting about this is that a small number of people (n=4) suggested that they felt a pressure to refer people onto groups, which they felt were not suitable in all circumstances. Some workers felt that some people just did not like being in groups, although one might ask how people can effectively integrate into society, education settings and workplaces without being able to function in groups to some degree. However, other workers suggested that attending groups could, in some cases, leave people feeling vulnerable. Some of the reasons identified in relation to this were that, people's confidentiality had been transgressed by other group members and that people smoked cannabis in break times between groups leaving some people feeling vulnerable and conflicted about other people's recovery motivations.

Abstinence emerges as an issue that people do not have a common view about. Some view an aspiration of abstinence as vital to recovery and some go further suggesting that people need to be abstinent from all drugs including methadone. Others seek to position the issue in terms of a relationship people have with a substance, with these responses tending to emphasise the need for people to be in control of their use. However, the picture is complex and there are at least four different groups as follows:

1. Some seek to distinguish between drugs and alcohol, seeing abstinence from drugs as necessary for recovery but control over drinking as possible within recovery.
2. Some seek to distinguish between cannabis and other drugs, seeing cannabis use as possible for some in recovery.
3. Some seek to distinguish between prescribed drugs (e.g. methadone) and street drugs, seeing use of certain prescribed drugs as – potentially at least – consistent with notions of recovery.
4. A final group feel that recovery involves a consistent movement towards total abstinence from all drugs.

Here is what one person said about these issues:

It is what each individual sees it to be. Some get off heroin and maintain a normal life on a low dose of methadone. This is recovery if they leave street drugs and chaos behind. For me it is a fairly broad range of interpretation. It is about recovery equilibrium and mental and physical health. If you are on 40 mls of methadone and you live an exemplary life then the notion that you are not recovered is daft.

Many people also sought to emphasise that recovery is an individual process that might mean and involve different things for different people. In some cases those who mentioned this issue sought to position the issues in relation to CRI. These individuals tended to see CRI's approach as rather fixed and instrumental, or as one person put it, 'like a sausage factory'.

Attempting to define measures of recovery is difficult. In order to measure recovery at a system level there is an enormous pressure to simplify issues in order to create measures so that they can be applied universally to all people in the system. This almost inevitably implies pre-determining some notion of what recovery looks like and then measuring clients against it which is at odds however with the development of measures that are individual and user defined. The difference is summed up neatly in these two quotes from respondents:

> *It is what each individual sees it to be*

> *It is a broad concept – it includes everything. Health, social, psychological...Externally it gets measured by social norms...having a house, working. But this might not be shared by the user.*

A key question for researchers, service managers and commissioners then, is the extent to which in trying to measure recovery we impose a value base on it which is at odds with the value base held by some staff and service users.

> *Users who think that recovery can mean continued use need to have their thinking challenged. This is the stark reality of it. Recovered users don't reflect back and say "that was a brilliant period of my life." They just don't.'*

3.3 CRI's definition of recovery

3.3.1 Introduction

We asked all participants whether they felt their own definition of recovery was the same as CRI's and then asked people to explain their answers. Just over half of respondents (n=29) thought that their own definition of recovery was the same as CRI's. A quarter (n=14) said that they did not know however. An eighth (n=7) said that they thought that they had a different view of recovery to CRI.

Table 7: Is CRI's definition of recovery the same as yours?
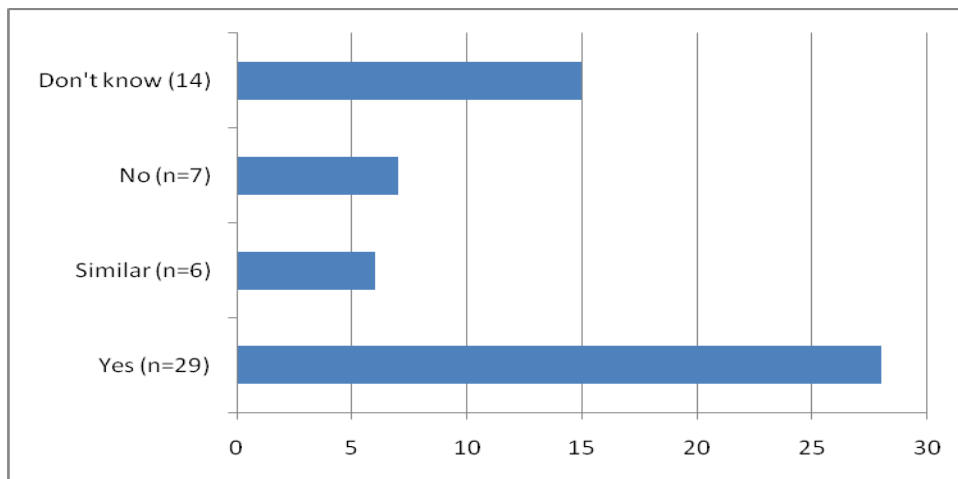
We conducted an analysis of these responses by comparing responses for new staff with those of staff who had been TUPED in from different organisations. The results of this analysis are presented in table 8. In all cases apart from staff TUPED in from ADS, most staff thought that their own definition of recovery was the same or similar to CRI's, with staff TUPED in from Inward House seeing the closest link.

Table 8: Analysis of responses by previous organisation
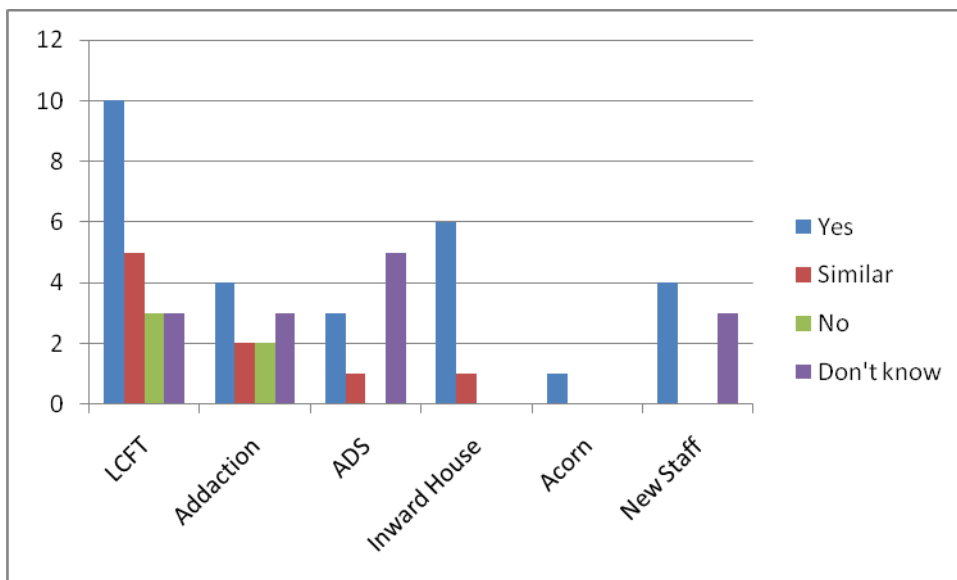
The responses to this question have been reproduced in full (**see appendix 4)** because we feel they offer rich material which may be of interest to those who commissioned the research. However, in the proceeding section we attempt to pull out some of the central themes emerging from the responses to this question and have also reproduced a small number of the quotes. These are organised under the four response types.

3.3.2 Those who said CRIs definition of recovery was the same as their own

Many of those who suggested that their own definition of recovery was the same as CRI's suggested that they liked the notion of clients progressing through the system rather than being 'stuck' in treatment'.

> *I got my definition from CRI – I didn't know what recovery was before. I came from a criminal justice background. My practice has changed a lot. Now I say 'I don't want to see you in 6 months, 12 months, 5 years time, whatever'.*

> *It's about moving on – not being stuck in treatment. Not being a methadone car park.*

> *I agree with CRI that people need an impetus to move. I have a client who is 55 years old, on methadone and diazepam and temazepam, he is now on a reduction on temazepam and he is amazed at the changes and he is up and ready for it and he is getting his life back. He was the most difficult client because he was not up for changing*

> *CRI took over and it was 'recovery, recovery' it is about educating staff and clients. A lot of clients view methadone as a necessity, the system has let them think that and the methadone car park is banded about a lot. There needs to be an exit strategy. They want movement through the system and they don't want stagnation, they want aims and goals and clarity for clients and practitioners about exit from the system.*

> *Very similar yes. It is different from NHS. … they are very focused on the worker opening up options whereas the NHS was all about the script, clinical component and maintenance in treatment. It has changed a lot, things were stagnant before. Prescribing has changed.*

Others mentioned additional forms of structure or support that had been introduced to the system under CRI, such as Work Solutions or RAMP, although some criticised the fact that they were not available in all sites.

> *I like the way they are working and what they are offering as a service. The Service User and peer stuff and Work Solutions and abstinence groups and counselling in Acorn and aftercare under the same umbrella provides a much better range of options.*

> *Yes – we are singing off the same hymn sheet. Things like RAMP, DEAP and work solutions are good packages for recovery. DEAP and RAMP need to be developed across the piste however. They are not available in Clitheroe. Clients have to travel.*

> *CRI has put resources around them.*

Others described a changed emphasis or approach to treatment which had made a positive difference.

I think they have done well, the treatment side of things needed shifting for a while and they have changed a lot of things.

It starts as soon as people walk in through the door. This means changing the way people think, both clients and workers.

The same – bang on. I started out in harm minimization, but I have changed. Recovery starts as soon as you walk in the door.

Same ethos of looking beyond the script and looking at all that is going on for them.

In some cases staff sought to position themselves as positively aligned with CRI's ideals and described other staff as struggling with the changes. These individuals saw these staff as either rooted in outdated modes of practice or as having low expectations about client's potential for change.

It has not been easy for them – people did not want to change. A lot were TUPED over on large salaries and have never looked at discharges. This is a measure of what the service has to offer and whether the worker is doing what they are supposed to and the client is recovered. Lots of workers have no discharges, cause it is easy to keep them on and there is little proper work. CRI is changing this.

Some drug workers say they have no hope for the SUs and are just giving out a script – cynical.

I think so it is hard to say otherwise as I have not worked for other organizations. People here who have worked in the NHS have struggled with the changed agenda.

Some of those who described their own definitions as the same as CRI's still criticised what they saw as unhelpful elements of CRI's style of working. The main elements of criticism tended to be that CRI was focused on moving people through the system too quickly and/or that they did not view clients as individuals.

I do worry that the speed of what they expect us to do is too quick however. They want us to rush clients through.

Time limited treatment is not particularly realistic and I am not sure how it will work. That said I am very passionate that people should not be sat on a script for 20 years.

But they don't see clients as individuals, they are imposing time periods on treatment; for example, six interventions over twelve weeks for alcohol clients.

In a lot of ways yes, but I think CRI see things very black and white. Recovery is different for everyone. When people move from chaos to shared care that is a big step.

3.3.3 Those who said CRIs definition of recovery was similar to their own

Those who suggested that their own model of recovery was similar to CRI's tended to suggest that they liked the emphasis and direction of travel under CRI, but, like many of those above, were also

concerned about some elements such as a perceived pressure on staff and clients around time-limited treatment and/or a perceived failure to view people as individuals.

> *The emphasis for CRI is perhaps a bit too much on throughput. ...I like the model now. It is bounded, well-defined and time limited.*

> *Pretty similar, yes. But I have some concerns about the practice of it. ... It is OK to impose a new regime and new clients, but some of the older clients don't like it. ... Some of them feel they are being bull-dozed in to it. They are not ready.*

> *Sort of, CRI's stance would be about all the goals being achieved. It will be different for different people.*

> *Similar – but I do have some concerns about the speed with which people are moved through. ... we are sometimes pushing people on when they are not ready.*

> *Very similar. Not miles apart. But we all see the recovery differently as it is different for different people.*

3.3.4 Those who said CRIs definition of recovery was not the same as their own

Those who suggested that their own model of recovery was not the same as CRI's tended to criticise a number of different elements of the revised system. These included:

The speed with which CRI was intent on pushing people through the system feeling that this may be at odds with the needs of service users:

> *CRI have a time factor on recovery. This won't work. It should be individual.*

> *They sell it well in the training and it sounds like the way I want it to be. In the tender it is about budget and pressure to push people through too fast which is a different set of interests.*

> *CRI want people to come in on a limited timescale and to achieve recovery. People come in who have been using a long time and it is not acceptable. There is a lot of pressure to get people through the system*

The perception that pushing people through the system might result in more relapse and later readmissions:

> *Recovery to them is in the system and out of the system, but this just might manifest as a revolving door.*

A perception that CRI's main concern is meeting targets whereas workers are focused on individual needs of service users:

> *Their idea of recovery is about rushing people through making them fit our outcomes and this is not helpful. I know the government is leading this but it does*

not always help. Some can change quickly, but some people have had such awful experiences and are so traumatized.

Safer communities' healthy lives is the motto. We work for the individual hence it is difficult to define a system level agenda and workers are less interested in this. Unfortunately at the higher levels it is about numbers as that is how they get paid.

3.3.5 Those who answered 'don't know'

The most common response from those who answered 'don't know' to this question was to suggest that they did not know what CRI's definition of recovery was and/or that no one had explained it to them.

I don't know what CRI's view is. I am not clear how CRI views recovery ...

I don't know what their definition of recovery is.

Others were unsure because of what they saw as unhelpful elements of CRI's focus. The main uncertainties tended to include:

That CRI is too 'business oriented', fixed in its thinking and 'hard nosed', characteristics which are seen by some as inappropriate to the work.

I suppose it is a fairly good fit in terms of definitions but not always in terms of the best way of achieving things. My experience of CRI is that they are very business oriented, they would not have grown so quickly if they had not been. At times they seem quite hard nosed and that if people are not up to speed they get rid of them. That makes people feel they can't be honest about what they don't know.

In some respect yes, they have good ideas I would like to take forward. The expectation and what can be achieved are two different things. It's more about paper and statistics than the person.

I feel like people are products in the care industry and it is a sausage factory approach. They have a formula and some people don't fit it. I am looking at a unique individual whereas they pass people through the system more quickly in order to meet contract requirements.

That CRI altered its emphasis to suit the situation at hand.

... one minute they are a charity and the next a business. These are different modes of working.

That there is a lack of fit between how CRI describes its approach and what actually happens.

On the face of it is very black and white. It is presented to the outside world as being about becoming drug and alcohol free. But actually within the organization what

we do is very different. One thing I have heard is that we (the new service) are a lot less punitive (e.g. in terms of not stopping scripts) than we used to be (i.e. the old service). I think CRI is more focused on drugs than alcohol though.

That alcohol work is not on an equal footing to drug work in the new system.

My feeling is that Inspire is still a prescribing service and it does not feel as if alcohol is on an equal footing.

Alcohol workers feel added on to drug workers and the last 9 months have been quite frustrating ...

That there has been insufficient training about this issue.

We have not had that much training on the recovery model. The promised training has not been delivered. What is CRIs definition? The Key Workers are all frustrated with the lack of training

I don't know what their definition of recovery is. No one has explained it to me.

Perhaps it is not surprising given the context set out in 3.1 above that a number of tensions should have been expressed in relation to these issues. Workers have come together from different organisational backgrounds and with different levels of experience gained in different settings. There may be an on-going need around communication, training and supervision here. While there is evidence that change has occurred and that some staff are working in quite radically different ways to the ways in which they used to work, there is also evidence that not everyone shares the same view of recovery and that not everyone understands what CRI's view of recovery is. As will be explored further later, there are substantial concerns about the relationship between work with drug clients and alcohol clients and about the pressure that some workers feel that they are under to move clients through the system too quickly. The authors hope that it will be of use to CRI and LDAAT to understand the current dynamics and tensions within the team.

3.4 List the five most important things which support recovery

We asked all participants to list the five things which they felt were most important in supporting recovery journeys. Originally we had asked people to rank them in order of importance but people found this too difficult sometimes feeling several things were equally important. Also some people struggled to identify five and some people identified more than five, so we ended up allowing people latitude. As with earlier questions we have organised people's responses under certain themes to make the material more readable.

3.4.1 Service user characteristics, behaviours and beliefs

Many participants described recovery as a process of exchange between services, workers and service users. More than fifteen people mentioned issues related to the motivation, determination or willingness of the service user to engage and participate in their own treatment. Some responses seemed to position motivation as something that service users needed to possess themselves, with people making comments such as:

> *They need a motivation for change and willingness to engage.*

> *The client must be motivated and ready to change.*

> *They need a willingness to engage without coercion.*

Others (n=7) expressed similar ideas but in terms of a goal, objective or aspiration that a service user may have that could be used as a motive within the relationship. These respondents positioned recovery as a process in which workers helped service users to meet their own objectives.

> *The client must tell us what they want, it is their journey and they have to contribute to it.*

> *Clients need to learn to take responsibility for their own recovery.*

> *Having a goal to aim for, a carrot to keep you going, whether it's family or whatever.*

> *Identifying what they want out of treatment.*

Another group of responses (n=5) saw a sense of belief, self-worth or hope as either a prerequisite to recovery or something that might develop in the process of accessing support.

People often referred to the challenges involved in constructing a new life and a new identity outside of substance misuse. This involved an insight in substance using behaviour set in the context of wider lives. Respondents suggested that recovery required that people had or developed a sense of insight, acceptance and realism about their current behaviours and situations and the need to develop strategies, plans and structures to address these. Again, the issue of abstinence was something that there was no common agreement about. Some saw abstinence (or continuing moves towards it) as necessary to recovery, especially for drug users, whilst others thought that levels and types of use needed to be seen in the context of wider life issues. This is also discussed in section 3.2.

 A sense of self confidence, a growing assertiveness and the development of new routines were seen as key elements of building a new life.

> *Hope for the future, giving up drug use is not enough and they often get ghettoized,*

> *Having a routine, something to get up for and something to go to bed for.*

However some workers also sought to emphasize that, for a small group of drug clients exiting services, living without a script and integrating into society might be unrealistic goals at least in the short term. These workers were often concerned about the possible introduction of time-limited treatment which they felt might push people through the system too quickly leading to a revolving door syndrome.

> *We sell people lies, getting them through the system and clean is fine, but six months later if they are watching TV all day they go back to drugs.*

3.4.2 Wider family issues

Thirteen respondents directly mentioned family and/or friends as vital to recovery journeys, although many more said this in other sections of the questionnaire. The majority of these responses (n=10) identified the support provided by friends (especially non-using friends) and families as vital to people's stability and to the possibility of initiating and maintaining progress. One person identified this as something that many drug users needed help and support with as follows:

> *They need to integrate with communities and families, but lots don't know how to do it and are frightened.*

Three respondents referred to the support needs of friends and families who were seen to be engaged in their own parallel recovery journeys. One person suggested that within the Inspire Partnership, the support needs of families were there '*on paper'*, but in practice not currently well met.

3.4.3 Wider health and social issues

Wider health and social issues were mentioned by virtually all of the respondents in different ways as prerequisites for recovery. Fourteen people mentioned housing, accommodation or shelter, many suggesting that without this recovery was impractical at best. Others mentioned housing alongside other basic needs including, benefits, debt advice, welfare services, food and water.

> *Housing. Pendle has poor housing situation –and many drug users are living in dives and it is hard to get a bond.*

> *Housing – dealing with housing. If you are a sofa surfer you are not going to engage.*

> *Accommodation – without this you have nothing.*

The other main issue mentioned by ten people was around physical and mental health issues and needs. People identified the availability of advice and screening and the need for assertive referral into other relevant services as necessary foundations to recovery journeys.
Ensuring that people's basic needs are met provides a necessary foundation for them to explore other elements of their lives and behaviors and two people specifically mentioned Maslow's Hierarchy of Needs. Four people mentioned the levels of isolation experienced by many drug and alcohol users, which has been reported in other research (Buchanan and Corby, 2005). These people

saw creating opportunities to reduce social isolation as vital to people moving forward and in particular to sustaining changes after disengaging from formal services.

3.4.4 Worker related issues

The worker related issues fell into four main themes: (i) the values and approach of the workers, (ii) care planning, (iii) regular contact with worker, and (iv) skills and knowledge.

(i) The values and approach of the workers

The values, characteristics and approach of workers were mentioned in 36 responses to this question. Some of the characteristics mentioned most frequently in these responses were: enthusiasm, motivation, support, empathy, congruence, flexibility, respect, openness and honesty. Most respondents placed great importance on the approach staff took with clients, although some also sought to criticize the behavior and attitudes of some colleagues who they saw as not treating service users with dignity and respect and/or having lost a belief in people's capacity to change. Some of the comments made in relation to this include:

> *Caring staff who are properly trained, using the right language.*
>
> *Motivated and enthusiastic key workers.*
>
> *Positive key workers who see them as people.*
>
> *The interaction between people and being able to get on a level*
>
> *Respect for client as a human being*
>
> *Treating them adult to adult not parent to child – respect*
>
> *Relationship with the worker and client – can be a spring board for change*

(ii) Skills and knowledge of workers

A small number of people explicitly referred to the skills and knowledge of workers as something which is key to recovery. Clearly this is not controversial in itself as it would be hard to find someone who didn't think that an appropriately skilled and knowledgeable workforce was important. The more interesting elements of these responses were how people positioned comments about this issue in relation to other concerns they had about the wider service structure. For example one person said '*Workers need the relevant skills and knowledge for working with different clients, for example, drug and alcohol clients*' and several other people mentioned this difference either in this section of the questionnaire or elsewhere. Whilst it will not be news to CRI, the merging of drug and alcohol workers into generic substance use workers has been controversial for some, perhaps in particular for those with a long history of working with clients who are primarily drug users or alcohol users. Some people presented this issue as something that had left them feeling deskilled or as something which might be dangerous because of the expertise involved in titrating a script for example.

In terms of promoting recovery a number of specific areas of skill and expertise were noted as being of particular importance. The first of these was the ability to hold hope and aspiration for the client and to be able to demonstrate an expectation of recovery from the outset. The second was about

the ability of the worker to help to motivate the client. The third was about the ability of the worker to empower the client and to encourage them to take an active part in their own recovery, as opposed to seeing treatment as something that would simply happen to them. The fourth was about the workers ability to challenge clients. This is embodied by the quote below:

> *It is important that workers can challenge clients. If someone has been coming for 5 sessions and nothing has changed, this needs to be tackled.   Clients need to be challenged about whether they are really ready. If they think that treatment is simply something that happens to them, they need to be challenged.   We need to sort out those who are motivated from those who aren't. We can say to those who are motivated – do this and do that and this will happen. And we can say that with some confidence because it does.*

Finally a number of people expressed the notion that workers needed to have the ability to work with recovery measures as *tools of intervention* as opposed to *pieces of paper* irrelevant to the work which were simply used for monitoring purposes. We will return to this point later in the report.

(iii) Regular contact with worker

Perhaps unsurprisingly a number of recovery workers mentioned the availability of regular one to one support as important to recovery journeys. Again this is not controversial in itself, as although the emphasis in the service is one of widening the range of support structures available to service users, the role of recovery workers is still important both in terms of providing support, care planning and as gatekeepers to other avenues of help. However, some people sought to emphasise this issue in relation to a feeling that CRI is increasingly squeezing the time people are able to spend with clients, either by limiting the number of sessions that clients could have, or as a result of the high caseloads that some workers said they were required to carry.

Two workers related the importance of contact with the worker to what they saw as cynical practice from a small number of colleagues who, they suggested, booked a large number of appointments in their diaries on some days in order that they might have a quiet day in the office on other days. In these cases they felt workers were not demonstrating an appropriate commitment to the clients.

3.4.5 Care planning

Many people suggested effective care planning was central to recovery and that this meant that the locus of control in care planning should remain with the client, with some suggesting that pushing people in a certain direction tends to be counterproductive. Poor care planning practice was described in terms of setting unrealistic or unachievable goals, or of the worker imposing their own ideals, values or objectives, or institutional ones, on the process.

> *Working out a regime that it suitable and review and adapt that regime to see if it is working.*
> *Care planning and listing goals with the client which they can take with them.*
> *A care plan that is drawn up with the client based on what they want.*
> *Small goals lead to success.*

Effective care planning was felt to be underpinned by the right values and approach. Good workers were seen as those who were flexible and open, who involved people in treatment decisions and had the skill to set realistic expectations or to avoid making false promises.

> *Flexibility – offering the client choices and giving them what they need.*
>
> *Having a relationship with your client where they can at least be honest with you.*
>
> *Working together on things (e.g. through ITEP).*
>
> *Skill and expertise not to make false promises.*
>
> *Not to have unrealistic expectations.*
>
> *Not to put your own expectations on them (e.g. drug free)*

3.4.6 Service related issues

A number of people mentioned the need for accessible services, meaning ones which are nearby, welcoming and easy to get into. In general terms, the opening of new sites meant that people felt that this was something which had improved under CRI and several staff mentioned this. However, the split between alcohol and drug clients resurfaced under this point as some staff sought to suggest that the clinical look of sites like Burnley House and its history as a place for drug clients had been off putting to some alcohol clients.

Many staff mentioned elements of service provision as particularly important (e.g. prescribing, psychosocial interventions or harm reduction) although there was no overall pattern to these responses excepting in relation to prescribing. In this case some identified prescribing as something they thought was important but perhaps less popular within the new regime.

A number of staff mentioned the notion of partnership and again for the majority of people this was an area of activity which had improved under CRI. In particular people mentioned Work Solutions, Acorn, RAMP and DEAP as useful things with clear and simple referral pathways. A handful of staff identified what they perceived as additional service needs including the availability of counselling and therapy.

3.4.7 Wider forms of structure and support including aftercare

There is strong recognition from the majority of staff that what happens within formal services is only part of the picture in recovery. This is an area in which the philosophies and ideals of CRI seem to be in-line with those of the vast majority of staff as more than 45 staff identified wider structures of support as prerequisites of good recovery journeys.

> *Drug users have a very busy life and stopping leads to a great big void.*
>
> *Meeting new non-drug-using peers and mending old relationships.*
>
> *Important that people attend groups or have access to a support network (e.g. people do a detox, think they are on track and it all goes wrong).*

Interestingly, more junior staff tended to mention wider forms of support and aftercare as particularly important at the end of formal treatment, whereas senior CRI staff have tended to

promote aftercare – or onward journeys – as notions they wish to include at the beginning of people's treatment journeys.

Aftercare support – keeping going, keeping stable – education and employment

This may be evidence of the need for ideas about recovery to have time and space to mature within the organisation. Some staff talked in terms of the value of a check-up system in which people who had left formal treatment might receive a call or a lower level of support for some time after they leave. This appears in line with the TOPS 4 which was intended to be used post-discharge but is not being used in East Lancashire. It would also be consistent with the evidence around the benefits of assertive linkage to aftercare and community support and for the use of recovery management check-ups.

However, as previously mentioned, some staff feel CRI is keen to move (at least some) service users through the system too quickly. The main things mentioned by people in relation to wider structures of support were Work Solutions, Acorn, RAMP, DEAP and the availability of peer mentors. Those who mentioned additional sources of support in their list of important recovery components cited their role in developing new skills and confidence, providing a structure for people's lives outside of addiction and widening social networks and developing new friendships. A smaller but still significant number of people also mentioned 12 step networks as significant sources of post-service support.

Then you need appropriate support for them which could be a mushroom of things – confidence building (RAMP), employment (work solutions) benefits advice etc

Things like RAMP and DEAP can help to under-pin the development of the skills people need (e.g. confidence and assertiveness).

Several people identified the referral systems for Work Solutions as simple and working well. Some staff mentioned that RAMP and DEAP are currently only operating in two of the five sites seeing this as a disincentive to those who lived in other areas due to the cost and/or inconvenience of travelling to access support.

3.4.8 Summary

The above discussion suggests that a measurement tool should focus on changes and outcomes in a number of areas including:

- measures of motivation and readiness for change;

- measures of inclusion and recovery capital;

- measures of staff competence and skill;

- measures of engagement in wider forms of support and with wider agencies; and

- measures of outcome in specific domains such as drug use, injecting behaviour, crime, mental health, physical health, housing, employment, education, training, family relationships and social networks.

These might be in addition to service measures such as numbers entering and in treatment; waiting times; retention; planned and unplanned discharges and successful referrals to partner agencies.

3.5   Recording recovery/progress

We asked all (bar one) participant whether they recorded recovery/progress as a regular part of their work. As table 9 indicates the vast majority answered yes to this question. We then asked people to expand on this answer by explaining how they recorded this information.

Table 9: Do you record recovery/ progress as a regular part of your work? (Yes/No/Don't know)
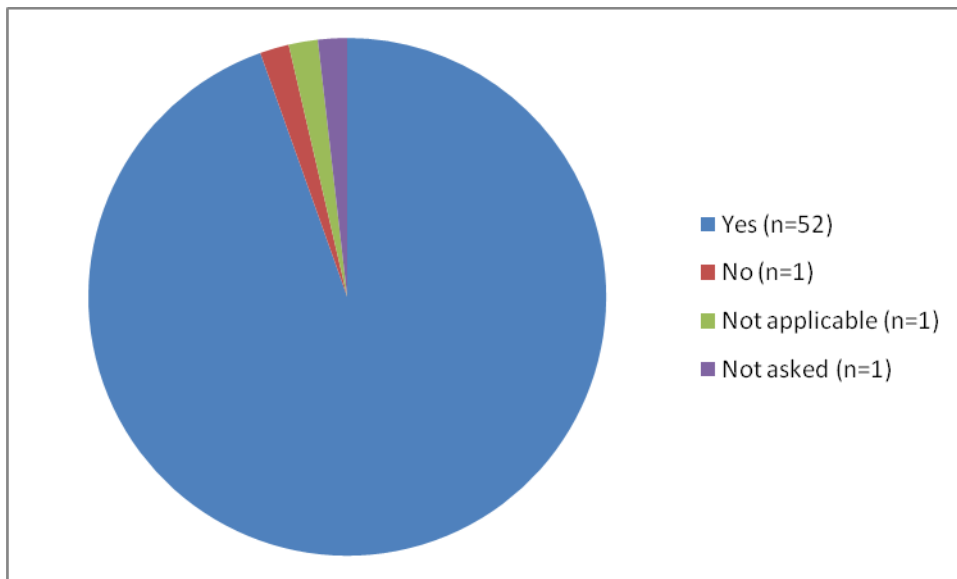
The vast majority of people mentioned more than one means of recording recovery/ progress. For example one person said:

> *Every session is documented. Whether it be a care plan or ITEP it involves update at the time and what has changed. As a CJ worker I see people weekly minimum. Over three months you will see reductions. Testing can be 2 x per week or 1 x per fortnight. I do a lot of free mapping with clients and do timelines and break down specific issues. My clients tend to be more chaotic and they see boxes and they switch off where as blank forms give more freedom. I use drink and drug diaries if working on a specific goal (e.g. not drinking in the day)*

Table 10 below shows the spread of responses. Care plans, TOPS, case notes and ITEP mapping were the most common ways that respondents said that they recorded recovery. The most common methods and pertinent issues relating to each is discussed below.

Table 10: How do you record recovery?
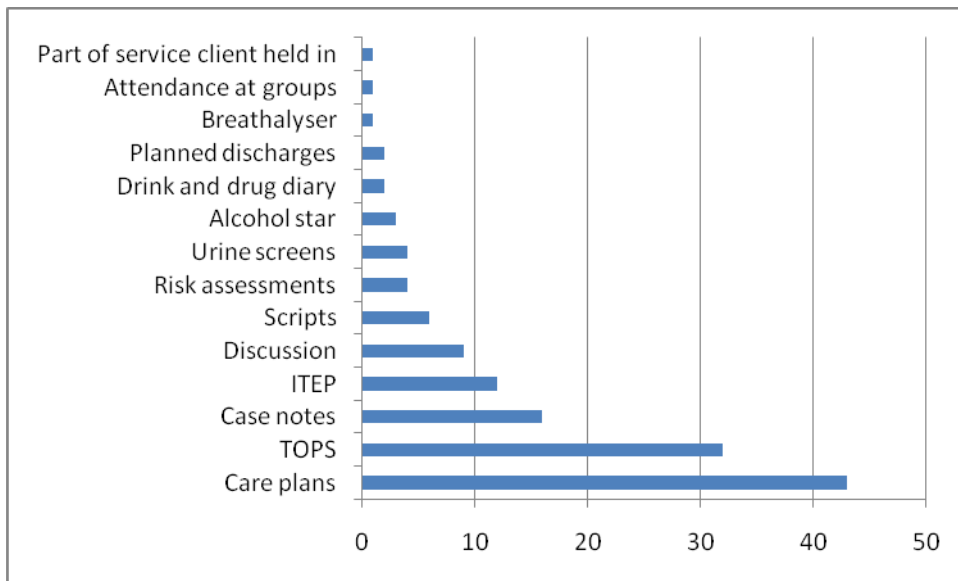
3.5.1 Care plans

Care plans were the most oft cited means of recording progress mentioned during the interviews and were discussed by N=43 people. In fact even the person who said they did not monitor recovery/ progress as a regular part of their work talked about using care plans.

> *Care Plans are the best way*
>
> *Care plans. Make the focus where they want to be in 3-6 months and talk about all you will do with them and then review every three months or more often. It is a good means of reviewing progress and offering motivation.*
>
> *Care plans and case notes. Discuss treatment and future pathways. And it is about what they want to do. I get the client to do it and open up the parameters of the session. I get them to set down aims and objectives and put these on the care plan.*
>
> *A tool where you identify a problem and what you want to achieve which is done with the client – they agree and then you review – this is what we decided and it's their recovery.*
>
> *Care planning – but I don't like the CRIIS one. It is computer based so you can't do it with the client as we don't have computers in the rooms*

As discussed in section 3.3.5 above, workers had clear ideas about the use of care planning not just as a recovery measure but also as a recovery tool. Effective use of care planning was dependant on worker values and skills and on the involvement and ownership of the client.

3.5.2 TOPS

TOPS (identified by n=32 people) was the second most mentioned means of recording recovery progress. People expressed a range of views about the value of TOPS as a tool, some seeing it as simple to use and helpful and others seeing it as having no redeeming features at all. The

researchers used additional probing questions to try to encourage people to move beyond these initial expressions and to gain a more in depth understanding of the possible merits and drawbacks of TOPS.

Most staff thought that TOPS was of secondary use in comparison to care plans although a small number felt it was the most useful tool, one suggesting that it should be used with alcohol clients.

> *TOPS is second best to care plans.*

The main issues identified in relation to TOPS were:

(i)   **Scales of health**
The scales of physical and psychological health in section 4 of the form were viewed positively by the majority of people. However, some suggest that when working with those whose psychological health is subject to large and regular fluctuations, the scores can be quite inaccurate. Some also suggest that people tend to give the same score for each item.

… Depends on the mood they are in when the walk through the door. What they give a 5 one day they may give a 15 the following week.

(ii)   **Crime questions**
That the crime questions are of virtually no use because people are not honest about them. In fact, when questioned further on this issues, some staff were not clear about the circumstances in which they would be required to pass the information onto the police and two indicated that they would pass all information about crime onto the police.

… a lot of mine are not honest about crime activity. They may feel we pass the info on to the police and I am not sure when I have to pass info to the police; I guess I have my own scale.

I do know when I have to pass info on to police and clarify this at the outset.

One person also made the following comment:

… But crime is not picked up. Partly this is about confidentiality, but also it is about the kinds of crimes that we are asked to record. Sex work, fraud, purchasing drugs – these are all crimes. But they don't get picked up on the form.

Reference to the TOPS form however suggest that *fraud* is one of the areas of criminal activity which is asked about.

(iii)   **How the data is used**
Some also suggest confusion or suspicion – both from staff and service users - about how the data is used and who the information is for.

TOPS … there is a lot of emphasis on using this as a tool but it can tend to be used instrumentally. No honesty about the crime questions because people wonder where the info is going. The pressure to get data in is always there.

TOPS – this is for us [meaning service] not them [meaning service users].

(iv)   Questions about drug use

Three main areas of criticism emerged in relation to the questions about drug use: (1) that people tended to make the smallest estimate possible often due to denial, (2) that when people were reducing levels of use but not the number of days used the data did not tell this positive story and hence might de-motivate people, and (3) that people could often recall with some accuracy what they had used in the last seven days but not the last four weeks.

They give you the smallest estimate possible, often due to denial about how much they use. They see you fill it in in black and white and they feel worse about it than if it was just a conversation.

(v)   Cynical practice

Many staff have a preference for qualitative data sets and see these as abstract and decontextaulised. The pressure to complete TOPS data can lead to cynical practice in which people complete them without the client. Several people admitted to this taking place sometimes.

The data don't help tell a story of what is happening. People are under a lot of pressure to complete them and some make them up. But they are easy to use and they don't take long to complete and the system here is good for letting you know when something is due.

(vi)   A staff monitoring tool

Some staff feel TOPS is being used to monitor them.

TOPS – is a complete waste of time – it is a monitoring tool – it is used to monitor the key worker as much as the client.

(vii)   The value of TOPS as a practice tool

Some staff viewed it as a useful tool in working through issues with clients tending to work it into the session.

TOPS – very simple – clients OK with it

Others saw it as imposing an unwelcome agenda on the session which they saw as interrupting the natural flow of the relationship and leading to resentment from the clients.

TOPS – do use it but waste of time. You ask the same questions and get the same answers. Clients say oh no not this again and it is a rigmarole putting into the system again. I do

understand the need for it but it is very time consuming. From a national stats point of view it may be useful but from an individual asking questions level it just leads to antagonism and frustration in the treatment relationship.

Here it is a waste of time and an extra bit of paperwork that no one listens to.

Some do it on their own (i.e. without the client) when they forget.

3.5.3 Case notes

16 people also mentioned case or contact notes, often mentioning these alongside care plans or other means of monitoring.

Case notes – I list the main themes emerging from the ITEP mapping.

Care plan and case notes. These allow you to note small changes which can be significant.

Contact notes – if they have used illicitly, any alcohol problems, any illicit drugs on top, pregnancy, risks, hospital admissions, new partner, etc

In my day to day contacts I always comment on presentation, and script and urines.

Case notes and urine screens can be great; they provide visual evidence. I have been taught to focus on the positives and to record achievements. When things are going badly I can go back to the notes and say do you remember how you felt on that day.

Case notes now are on a computer so it to use them. Having a computer in the room would help.

3.5.4 ITEP

Twelve staff mentioned ITEP as an increasingly important means of monitoring progress, with some suggesting that they would extract the main points from an ITEP map and enter them into the case notes or care plan.

ITEP – recently worked on a detox – he can only come in late in the day because he works. He has quite a few health problems – we have done other sheets as a record – he gets the old forms out and see what has changed or not. You can get something down very quickly with this approach.

I am moving to ITEP which is more about them – when you are sat with a clipboard asking what do you think about MH it does not work.

3.5.5 In the discussion/ relationship

Nine people made reference to recording recovery or progress through the relationship, tending to see written or computer notes or monitoring frameworks as less important or useful:

I think the best measures are in talking to people.

Yes – through my knowledge of the client

It is much more about the relationship

3.5.6 The Alcohol Star

Very few people (n=3) mentioned the Alcohol Star and when asked about it in other parts of the questionnaire many were either not aware of it or had not received the training to use it. However, those who did use it liked its structure and focus and in particular the fact that it looked at a number of different life domains.

> *There is a new tool [the Alcohol Star] it allows you to identify a problems and give it a score on a scale of 1-7. Then you can set objectives.*

> *Alcohol star is quite good and looks at a number of life domains. It is quite different from TOPS which is not suitable for alcohol clients.*

3.5.7 Other means of recording recovery/ progress

Small numbers of people mentioned a range of other things, including: Monitoring of scripts (n=6); Risk assessments (n=4) which some saw a valuable when repeated; Urine screens (n=4), alcohol breathalyzers (n=1) and drink or drug diaries (n=2) which people suggested could provide excellent motivation; planned discharges (n=2) which people saw as a means of identifying people moving through the system; and measuring attendance at groups (n=1) which was seen as a means of identifying movements to inclusion.

3.5.8 Summary

From the point of view of developing recovery measures across the system as a whole, the data above tells us three clear things. Firstly, that most workers believe that they do measure and record recovery one way or another. Secondly, that the most commonly used method used by workers for measuring recovery is through care plans and care planning process. Thirdly, that TOPS, although widely used, is viewed very differently by different workers. Perhaps the controversy surrounding TOPS within CRI should not come as any surprise however, especially given the diametrically opposing views that have been expressed about it nationally and in wider forums (e.g. Addiction Today, May, June 2010). We will return to this discussion later.

3.6 CRI's approach to measuring recovery at a system level

Respondents were then asked about how they thought that CRI measured recovery at a system level. The results are set out in table 11 below. Most respondents (n=28 and n=26 respectively) thought that the main ways that CRI measured recovery was through the measurement of planned and unplanned discharges and TOPS.

Respondents were asked to comment on whether they felt that CRI's approach to measuring recovery was a good one and whether there were better ways of doing it. The results are set out in tables 12 and 13. Interestingly, in answering whether CRI's approach was a good one most (n=19) said that they did not know, closely followed by n=17 who said no.

People mentioned a lot of different issues in explaining their answers to this question and many took the opportunity to raise issues which had been discussed in other parts of the questionnaire. Some staff commented that they were currently unclear about what the service level targets and measures for recovery were.

> *There is a lot of work to be done on clarifying what the recovery based targets are. They may be clear about them but we don't know what they are.*

A dislike of quantitative data sets was mentioned by several people. Some disliked the data because they felt it could offer a skewed, partial or inaccurate picture of what had actually taken place in an intervention.

> *For example, being off a script is part of it but that is not the be all and end all. People can be off a script but still functioning poorly in other ways. … Engaging in the community could be as important but is not measured.*

> *It is quantitative not qualitative and things are missed. For example, someone can have an unplanned discharge but still have made progress.*

> *But the discharge summary is not a very honest way of measuring things. Someone may get identified as a failure even though they still achieved a number of things.*

> *Not sure – the problem with measuring attendance and drop out is that you may not know why the client did not attend and you may not be able to contact them to find out, though you do try.*

> *I suppose it is OK. It depends how well the data tell the story, but it is not always black and white – progress can be made and then there is an unplanned discharge and it looks bad. That's frustrating.*

> *There is a risk that you don't capture some of the good work that has been going on as it depends on the day and data can get skewed. I would say a client being referred to a rehab is a planned discharge as it is planned, but it wouldn't get recorded as such.*

Table 11: How do you think CRI measures its success in delivering recovery across the treatment system in East Lancashire?
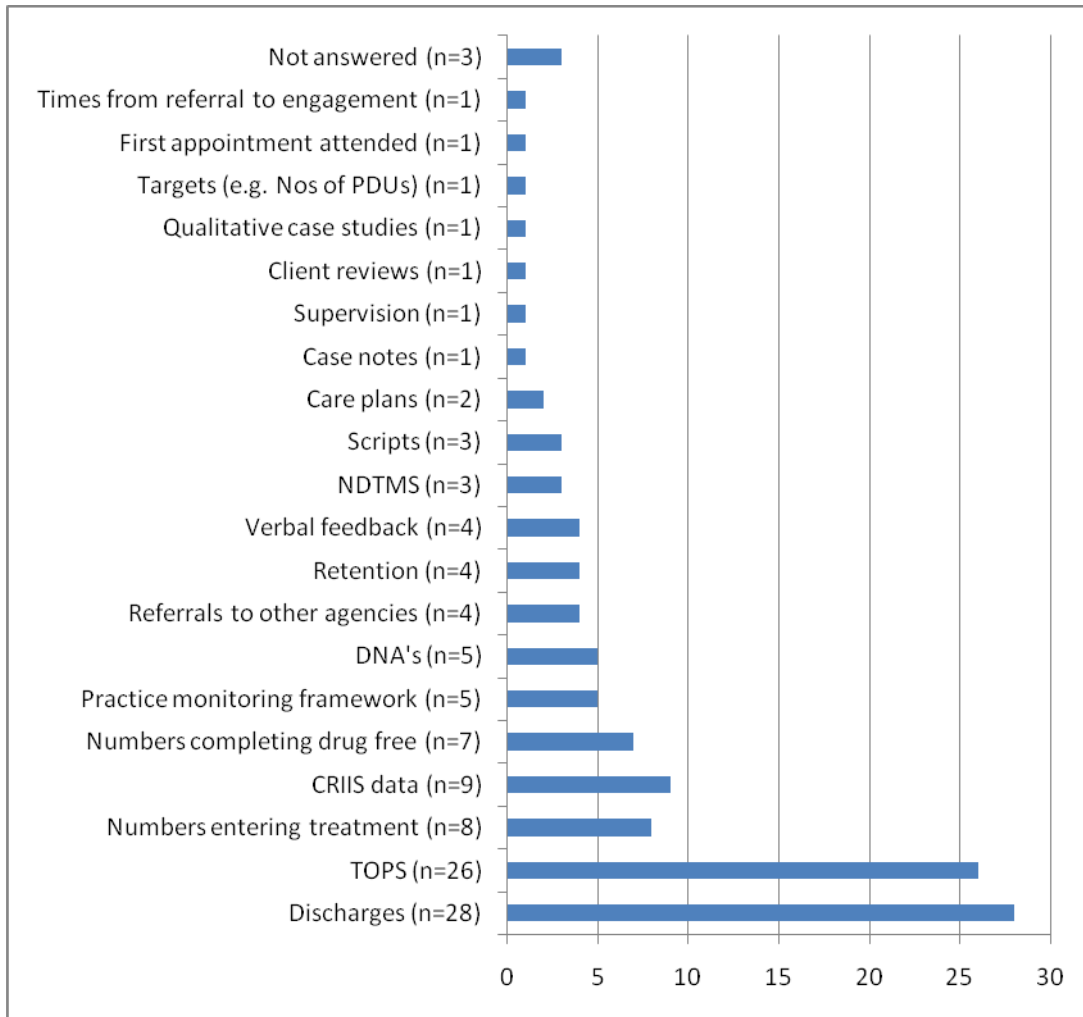

Table 12: Is CRI's approach to measuring recovery a good one?
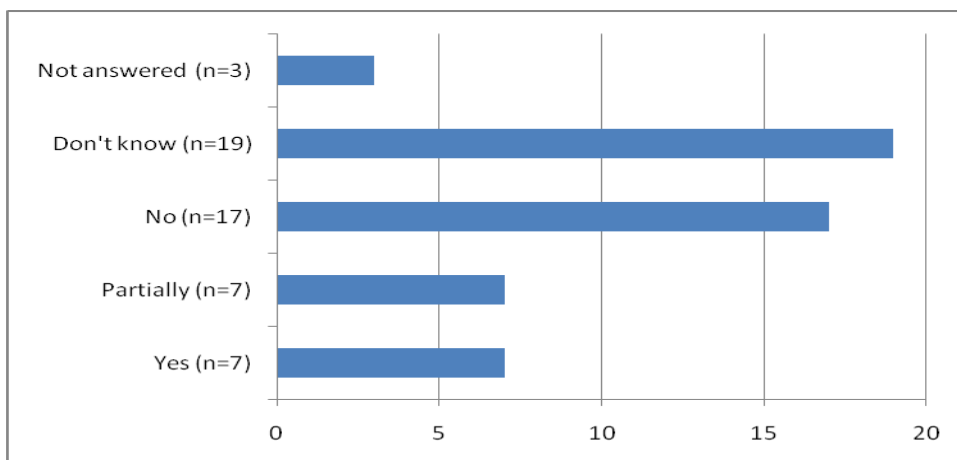
Some felt that much of the data collected –particularly in TOPS - is neither reliable not valid and hence regardless of the sample sizes is not useful.

> *With any data it depends whether it is accurate at the point of recording. There are issues of honesty and issues of timing especially with TOPS.*

Others felt that these data sets (especially TOPS) addressed the issues and concerns of the NTA and the DAAT rather than service users and workers. Some added to these comments suggesting that the data which staff complete tends to disappear into a black hole with little or no reporting back to staff on relevant issues.

> *Quite focused on DAAT and CRI views and modes and not clients.*

> *Its driven by a business model which is about retaining and winning contracts. This drives their agenda not the recovery or otherwise of clients.*

> *No – it is not the client's perspective. It is not the client's view. It is a different agenda.*

> *Numbers wise it works. But a lot more could be focused on the client views and benefits. In the end client outcomes are qualitative.*

> *I do use TOPS and it should show changes but it doesn't always work like that. It is just a monitoring tool for the NTA, as all these things are in my care plan already.*

Several people made reference to the seemingly endless pressure to keep up to date with monitoring and data collection tasks and a number of people commented that paper work had increased as a proportion of the working week. What a number of people suggested that they resented about this was that a lot of the communication happened by e-mail rather than face-to-face and that people were named and shamed and/or treated like school children.

> *… there is a lot of pressure. After six weeks if you haven't done your care planning the system turns orange. But you might only see some clients every 4-6 weeks.*

> *It is all very new and they certainly like treating us like school children and making comparisons of one group against the other and sending them by e—mail.*

> *There is a lot of pressure. You get lots of requests for figures. I understand why there are targets etc, but sometimes filling in all the forms and responding to all the e-mails gets in the way of you actually doing the work. I suppose so, but I do not feel there is enough face to face input from this. Everything is done by e-mail, from the project manager and if you miss a deadline you will be told that you will be named and shamed. Talking face to face will be better.*

> *Paperwork – I have never had so much paperwork since they took over and it is the demands and threats when it is due that get me down.*

Some suggested that the pressure to complete data collection tasks could lead to various forms of cynical practice from staff.

> It is not a realistic way. … I was told to change the information on TOPS forms.

> I think they massage the figures to make them look better. The data gets manipulated. You need to look at how many times people pass around the system in multiple ways and times.

> We skew the figures to fit things. If I discharge someone who has stopped heroin use and detoxed off methadone but uses cannabis I should not put drug free but I will.

Finally, a number of people mentioned what happens once people leave formal treatment as a critical period which current data sets don't manage to capture useful information about.

> For me the danger signs are than we get lost in discharges. The real question is what happens later and no one is measuring that.

> The need to focus on aftercare is vital.

Table 13: Are there better ways of recording recovery progress than those currently available?
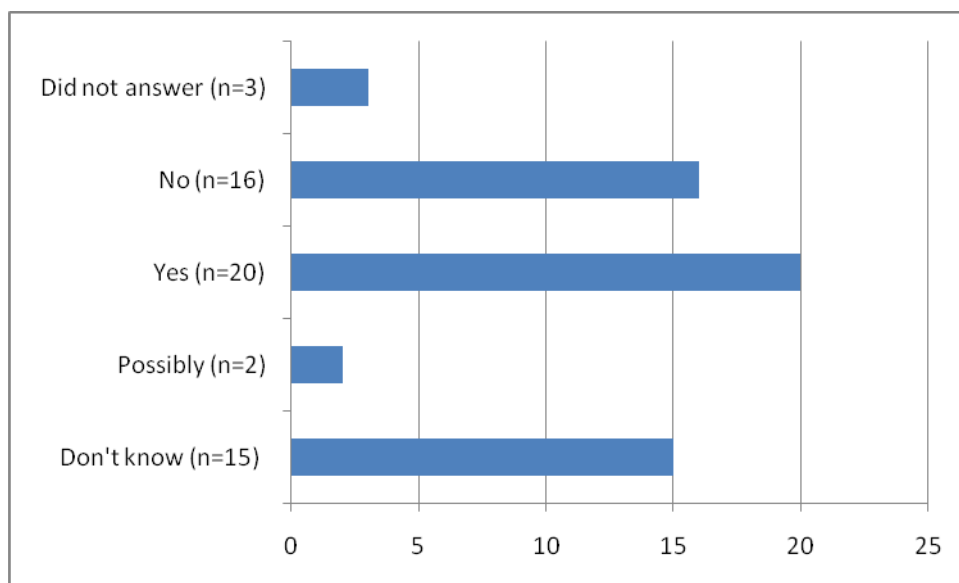
In answering the question about whether there were better ways of recording recovery, responses were fairly evenly split between those who answered yes (n=20), those who answered no (n=16) and those who said that they did not know (n=15).

3.6.1 The responses of those who answered 'yes'

Those who answered in this way mentioned a lot of different issues in explaining their answers. However, for many who answered yes the fundamental issues were to do with a dislike of capturing data in ways they felt lacked relevance to the work they were doing with clients. People often

reported that tools such as TOPS felt like one-sided exercises that were done to clients rather than with them. People articulated a need for tools which explored the clients perspective, the clients level of motivation and level of treatment engagement, and which explored a number of life domains (e.g. the alcohol star). One team manager made the following comment:

> *I say we have to tow the line because they (the DAAT) pay our salaries. There have been discussions about measuring through case studies. We have not hit the nail on the head yet. … It needs a balance of quantitative and qualitative data. Drug workers have never been concerned about figures and it is hard to translate it into good working.*

This comment appeared to capture a number of important issues mentioned by other people including: a frustration from workers about forms of data which they felt did not capture the work they were doing with clients and a general dislike amongst many workers for quantitative data which many felt lacked context. Some examples of others comments which addressed the same issues include:

> *If it were me I would ditch TOPS and do client questionnaires every three months: do you feel you get a good service? Standard of care etc.*

> *We tend to review on our target driven objectives and these can be less relevant to clients and workers feel like pawns.*

Some who communicated a preference for these forms of data suggested that they could sometimes capture small issues, missed by tools such as TOPS, which could be central to an individual's recovery journey.

> *Measures should be based more on the recovery plans and the little things that people achieve should count for more. Something like attending an appointment on time or having a shower might be major things for some people.*

> *Not just numbers through the door and completed, measure individual movement and progress with treatment across a range of life domains.*

> *It would be good to have something that is more sensitive and can pick up on the little things that people achieve. For example, if someone is taking their vitamins or has had a liver function test. If someone takes less drugs on just one day that may be significant for them, but you would lose that if you just average everything out. You need to tell the story behind the figures.*

However, some who communicated a preference for forms of recording such as care plans also recognized that these were of limited use at a system level.

> *I like the care plans. But these only show things at an individual level. TOPS is not realistic because the data gets tweaked.*

> *Case notes are about a lot of things and are quite dense.*

Care plans – but they need simplifying.

One person suggested that an important form of monitoring could include workers diaries, making the following comment:

> *Measure how many clients people see in a day. Some people have 20 clients in their diary for a day and then have a nice quiet day in the office afterwards. People who do not discharge complain that they have high case loads but they are just handing out scripts.*

3.6.2 The responses of those who answered 'no'

No was the second most common answer to this question. Many of those who answered no suggested they were relatively happy with what was currently available, several following this up with a response which indicated a preference for care plans and contact sheets over TOPS.

> *I think what is available is alright*
>
> *Care plan and CRIIS system; it is centred around the client and it seems to work well for clients and workers.*
>
> *I am happy with Care Plan and Contacts and prescriptions sheets and urines*
>
> *But not with TOPS.*
>
> *What we are using works for me and people are recovering.*

Some said that they were happy with TOPS and others suggested that the general criticism of TOPS is unjustified. These people felt that major problems with this tool results from the way in which it is used by workers rather than any specific flaws in its design.

> *I am happy with TOPS and care plan. TOPS takes 5-10 mins and it is really good way of sharing with the client what progress they have made.*
>
> *TOPS is not too bad, it's not the questions, it is because of how literally it is used.*
>
> *TOPS minus the crime questions and minus the name will help.*

A final group commented on the general level of paperwork involved in the role suggesting that it is increasing.

> *The tools are good and the CRIIS system is intense and you do record things on a daily basis and you have to do that to cover yourself. Quite a lot of paperwork – although it is for a reason and it is about line management … 40-50% of working week is paperwork.*

One interesting suggestion from someone who answered no to this question was the use of photos as a form of motivation.

But I would like to use photos – they are thin and dirty and then six months later you see a huge physical change. We don't take that into consideration and people forget how bad they looked.

3.6.3 The responses of those who answered 'Don't know'

The third most common answer to this question was 'don't know'. Those who answered in this way were often concerned about the inevitable tensions between collecting data and delivering work with clients. Some chose to position workers as those committed to service users and managers and commissioners as those committed to figures, seeing TOPS as the embodiment of managerial rather than client concerns.

Don't know. I just work for my clients. If CRI wants to introduce something they need to listen to workers to check if their ideas will work.

I don't know whether introducing more forms is useful. You can get all the TOPS forms out of the last 12 months and they (service users) don't care.

You need to know what is going on behind the figures.

The care plan is the most important because it tells the story of progress. TOPS is a useless bit of paper.

Other responses indicate a belief that monitoring systems can serve as a means to monitor and make judgments about workers.

You don't want a scoring system that set clients competing against each other, or workers either. Just because worker X has 10 clients who have recovered and worker Y only has two doesn't mean that worker Y is not doing their job. They may have clients at different stages of the change cycle.

However, in common with some of the answers above, some suggested that the main problems with TOPS related to the way in which it was used by workers rather than flaws in its design.

Recovery is about how people have changed inside. TOPS is good if it used as a reflective tool. The trouble is TOPS tends not to get used in this way. If you use TOPS as the basis of a conversation and as something that you can discuss and challenge where you think there are tensions or conflicts then it can be really good. For example, I had a client who scored their well-being quite high when they were using nearly every day. The next time, they scored their well-being quite low when they were hardly using at all. I picked this up and used this as the basis of our session. If TOPS gets used for this sort of reflective practice it is good. I think that people need training in how to use TOPS as an intervention tool, rather than a monitoring tool.

What matters is that the client identifies with it. Scoring systems are good, otherwise it is too descriptive. You can add some narrative to the score.

Some others suggested that they liked TOPS because it was simple, quick to compete and easy to use.

> *TOPS form has potential – the rating scales are an easy way to work. That's all I've been used to. You want something that's not too complicated – clients want to be gone.*

Some who answered in this way felt that tools such as the alcohol star were more useful than TOPS, but suggested that this also needs using as an intervention tool rather than a monitoring tool if it is to be useful.

> *The Alcohol star could also be transferred to drug users. But again, this needs to be used as a tool to prompt discussion and not just as an assessment form. You need the 'softer side' of interventions for any of these things to work. I think there are a number of barriers that stop workers using tools in this way, such as confidence and being unsure of what they are doing and why.*

3.7 How important are measures of recovery to service users?

We asked all staff the above question asking them to score responses on a 5 point Likert type scale. The responses are presented in table 14.

Table 14: How important are measures of recovery to service users?
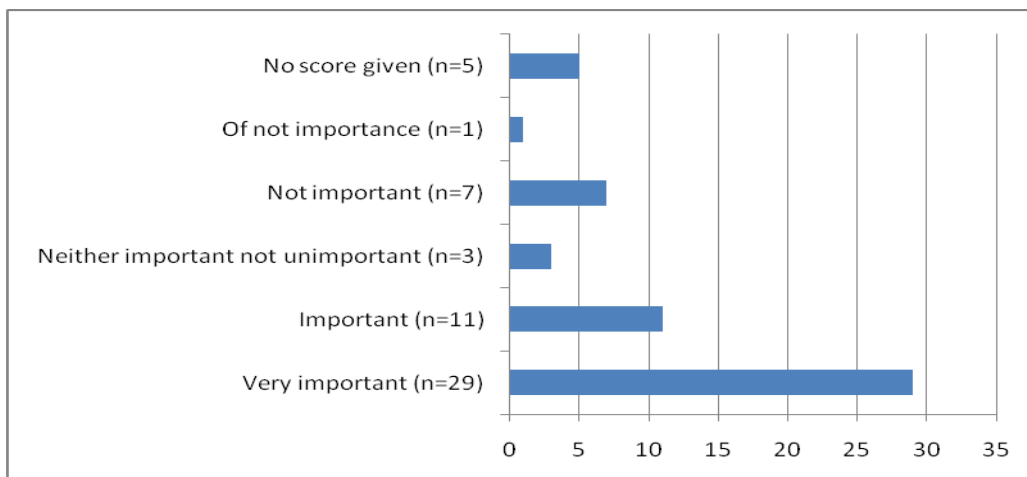
Most respondents (n=40) thought that recovery measures were either important or very important to service users.

We asked people to explain the reasons for their score. Some of the things people said are listed under each of the six possible responses.

3.7.1 Very Important or important

Many of those who scored measures of recovery as important made links to people's personal journeys in their explanations tending to suggest that measures of progress/recovery were central to the notion that they were making progress

> *They have to have some notion of their own recovery and of what they want to achieve.*

> *Should be classified as a journey and people should have boundaries and benchmarks of what should be achieved. ITEP can be used to indicate aims and goals – set a time frame and order by priority. If not achieved then it is looking at why.*

> *If you can't see that you are making progress then it is disheartening and sometimes even with small things if it is not recorded it is missed (e.g. picked up script every day - steps to contact family).*

> *It shows them how well they are doing. They can be really proud of the urine screens. It tells a story of how they are progressing. Our knowledge of them is significantly important to their recovery plan and if not given appropriate support their progress is hindered. They do come here for help. Some people think along script lines but I have been in the field a long time and I know desperation is desperation and giving people hope can be powerful.*

People also described how measures could provide encouragement and suggested they were strongly linked to tentative improvements in self-esteem.

> *Even the smallest improvement can be a big deal. If someone gets a clean sample I want them to feel my enthusiasm*

> *To see how far they are progressing. They have low self-esteem and don't get many people telling them they are doing well.*

> *People don't realize how far they have come. It is only at review that they realize. It allows positive feedback.*

> *So they can map progress because they don't remember and may have a negative outlook and thinking so they don't see. Useful even if stagnant and not getting anywhere.*

However, a few people who scored measures highly sought to distinguish between the sorts of measures that had meaning to clients and workers – mainly qualitative and life based issues - and those which had meaning to commissioners – mainly quantitative data sets.

> *Important – but only if you measure the right things.   A bunch of figures won't mean anything to them. I am not sure that the right things get measured. Are we measuring what they think is important?*

If you have something clear to bring back to the table. But sometimes a conversation does this just as well reminding them of a feeling they had before and how they feel now. The measures often feel like an exercise for the system rather than for the individual. Feels like a hamster on a wheel you don't get anywhere besides constant movement.

A small number linked the need for and strength of measures either to the problems with the old maintenance model or to workers they saw as lacking ambition for clients.

In the past, some of the key workers under the old system just kept people on maintenance. Some of these clients have been passed to me now. They don't always know how far they have come. I can say to them, look you scored a 4 on your mental health, but now you are up to 16.

3.7.2 Neither important nor unimportant

Those who scored this issue in the middle suggested that the importance of this issue can vary significantly by service user.

Difficult one – it depends on the service user. It is important for some, but not for others. Not all are interested.

One person mentioned that the way the system measures outcomes means that some elements staff deem to be – at least partially – successful are recorded as failures. For example the following worker gave the example of someone on a DRR who complied with the order for several months but did not complete it.

For service users to know they have achieved something is very important. But if they are on a DRR and they stay on it for 3/6 months and then commit a crime this is not measured as a success but the police would say it is.

3.7.3 Not important or of no importance

8 people thought that recovery measures were of low importance. They tended tended to position the issue in terms of what they saw as the differing needs and priorities of commissioners and service users.

More important for commissioners. Clients know where they are. It doesn't really tell them anything they don't know. They are living it.

Measures are too formal and clinical. They respond better to a bit of praise. You look well.

They are not concerned about measures but with how they feel; negotiated goals are better than quantitative scores.

If I sit with someone I have seen for 2-3 years I say look back and see what you were like then, take a snap shot, why do you present better. It is not quantifiable but a notion of progress.

Some saw measures as just one more bad news story for those who were not making progress and sought to assert that some clients will need to be in treatment for the rest of their lives.

> *But for some, it is not important. They will be in treatment for life. Not all want to or can change.*

3.8 Most useful and least useful means of monitoring recovery

We began this section by asking people to list the data sets they were required to complete as a regular part of their work (responses set out in table 14). Then we asked all participants to describe which data sets they found least useful and most useful in recording recovery progress and then asked people to explain the reasons. We also reviewed that data sets that respondents referred to so that we could form our own view about the usefulness of these to measuring recovery.

The quantitative responses to these questions are set out in tables 15 and 16 below; the explanations have been set out in themes staring on page 48.

Table 14: Which data sets are you required to complete as a regular part of your work?
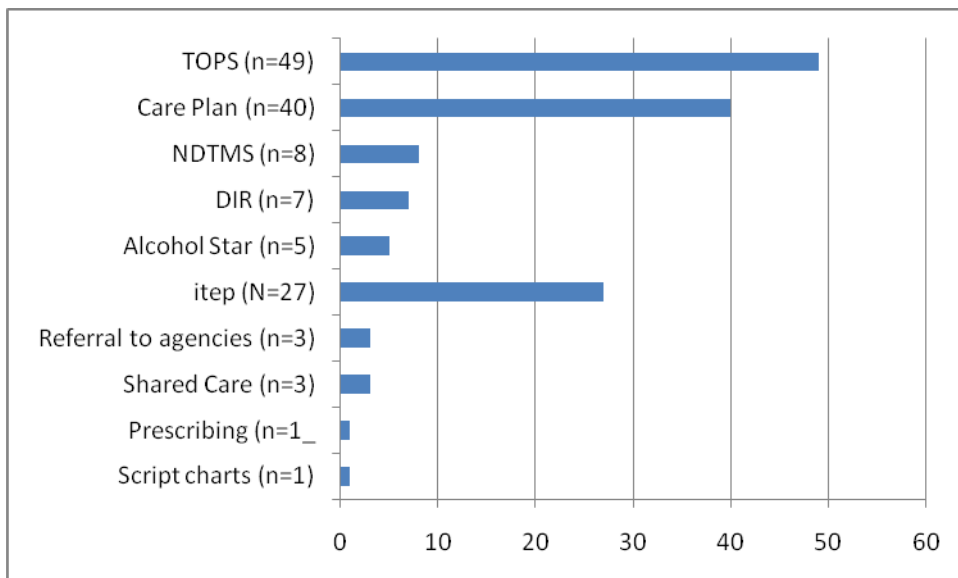
Table 15: Which forms do you find most useful for monitoring recovery?
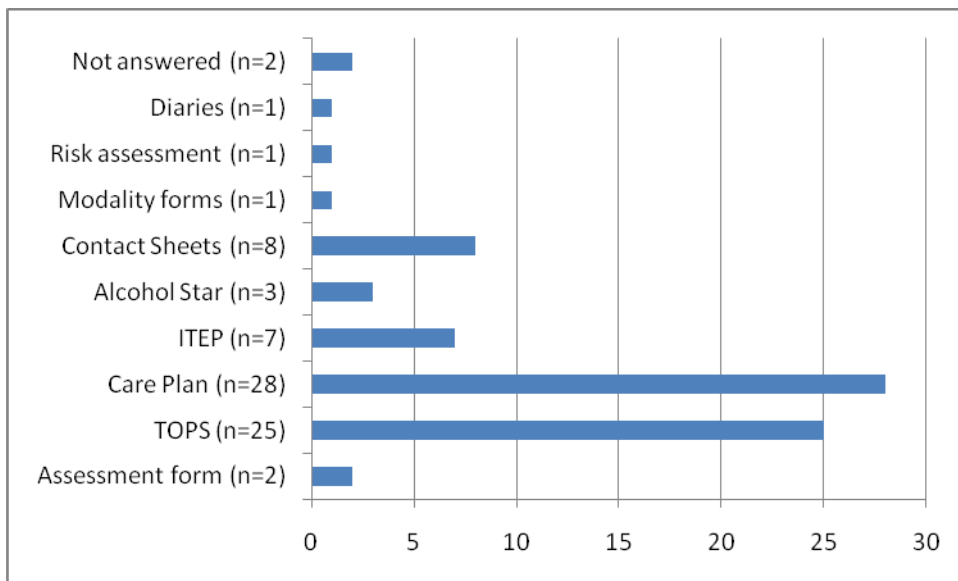
Table 16: Which forms do you find least useful for monitoring recovery?
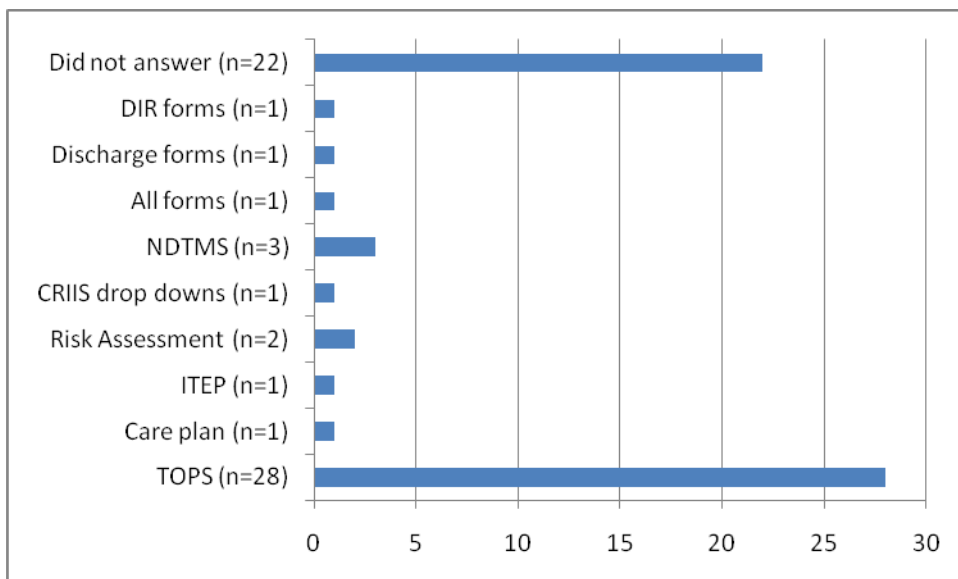
3.8.1 Care planning

Care planning was mentioned most frequently (n=28) as the most useful tool in recording recovery based work; some also mentioned case notes often making similar points. The things that people said they liked about care plans included that fact that it involved the service user and the worker setting appropriate goals which could be reviewed together. Some workers preferred these to the externally imposed questions within TOPS.

Care Plan can look at individual goals.

Care plans – you talk about it to the client and there are lots of good sections and it gives them what they want. It plots progress and problems and solutions.

People like the fact that care plans set targets and objectives in the wider context of the case, feeling that this makes them relevant. Another perceived advantage of care plans is that the information makes sense to other workers who may have to see someone as a duty case or in covering sick leave.

Because it is individual if I am off sick people can read it and see what is going on.

In a few cases we asked people who made comments such as this how likely it was that workers would look at the file in advance of seeing a duty case and most suggested it was unlikely.

People often mentioned other tools which could be used as a part of care planning. A popular example was ITEP mapping which was felt to brought the client into the exchange and people liked the freedom and imaginative capacity that this visual approach offered.

Some disliked the computerized care plans (although not all agreed and some sought to emphasize that the computerized system was a key strength of CRIs model in comparison to those of previous organizations) criticizing elements of the format (e.g. the fact that things are on different pages) and the fact that you can't share them with clients as there are no computers in the meeting rooms. One person added that this means clients cannot check that they agree with data which has been entered.

3.8.2 TOPS

TOPS was the second most popular choice as a useful tool (n=25) and the most popular choice as the least useful tool (n=28). These data indicate that opinions about TOPS are polarized within the team as a whole some seeing it as a very useful tool and others seeing it as having no useful features. The comments made about TOPS in this section are very similar to those made in other sections of the questionnaire. The common themes include:

- TOPS is a useful tool if used properly. Staff who view it most positively report that they use it as a part of a wider discussion rather than using it instrumentally. Some also suggest that the TOPS form can provide a useful structure for discussions and sometimes reminds you to discuss things that you might otherwise have overlooked. Those who view it most negatively view it as lacking relevance to the work they are undertaking, as an imposition from commissioners and/or the NTA, as something that service users often resent having to complete, and as something that they complete as quickly as possible. It is clear from the level of polarization in the views expressed that people have quite different experiences of using this tool. We would speculate that some staff at the most negative end of the continuum, in terms of opinions expressed, might be reflecting their own prejudices in relation to this tool rather than simply reflecting their experience of using it.

- The small number of people whose opinions about TOPS were in the middle range tended to see it as a tool with distinct strengths and weaknesses. The main strengths tended to be seen as section 4 which asked about psychological health, although some also suggested this was subject to wide variation depending on the day it was completed. The main criticisms related to section 3 on crime which that vast majority of people – even those who viewed the tool as generally useful – viewed as waste of time. Section 1 tended to receive mixed reviews, with the main criticisms being that people cannot realistically recall drug use over a 4 week period, that many tend to offer low estimates of use and that when people are reducing amounts used rather than days used the data will not reflect this as a positive picture.
- TOPS data are often chased within CRI and the CRIIS system has a traffic light warning system which in some cases is followed by telephone chasing. Some people appreciate the reminders and use them as an aide memoire and others resent some elements of this system.
- Some people with a background in alcohol work described how they had used the tool with alcohol clients in the past and had found it useful. It is now not being used with alcohol clients in East Lancashire, we assume because of wider debates about the process of validating the tool undertaken by the NTA which did not include alcohol clients.
- Two workers observed that there is no space to record sex work which can reduce its relevance in working with this group of clients.
- Finally, some people observed that the TOPS form was not designed to measure recovery.

3.8.3 Alcohol star

Although only mentioned by a small number of people the Alcohol Star seems worth mentioning. It is currently being used by a very small number of people but is due for a wider role out across the system. The vast majority of those who have used it seem to view it positively. People suggest that what they like about this tool is that fact that it looks at a number of domains of life and that it provides guidance about how things should be scored which provides clarity and benchmarking.

3.9 Perception and importance of TOPS

3.9.1 How important is TOPS to CRI?

Nearly all respondents (n=48/56; 85%) recognized that TOPS was very important to CRI (see table 16). This recognition stemmed from an acknowledgement of the link between TOPS compliance and funding and the emphasis placed on TOPS centrally by the NTA. Typical explanations for ranking included:

It goes off to the NTA. We get measured on it.

That's how they (CRI) get their money.

Because of commissioner demands.

The importance of TOPS to CRI was underlined for staff the by internal procedures that alerted workers to when TOPS forms were not completed.

Case loads go red when they are overdue.

You are named and shamed.

It comes across they are constantly looking for this to be complete to fulfil the contract.

Table 16: How important is TOPS to CRI?
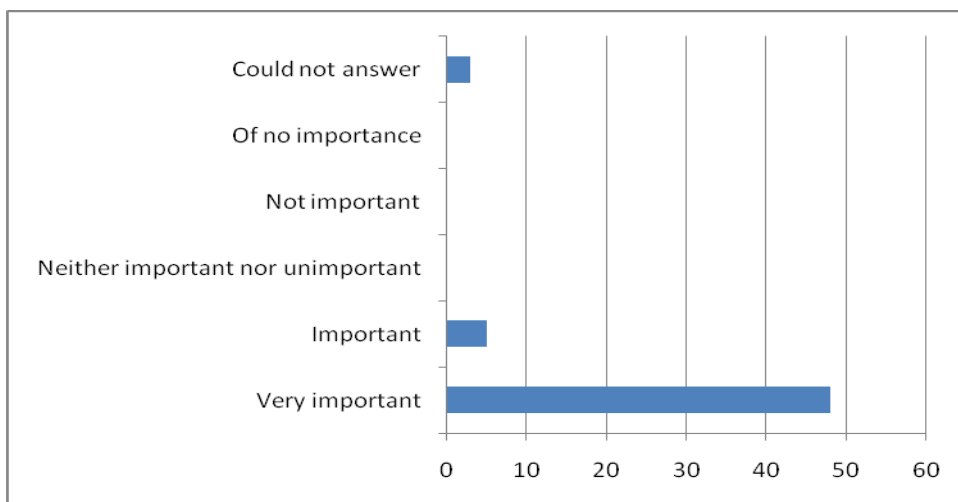
3.9.2 How important is TOPS to you in relation to your own practice?

Significantly less people rated TOPS as important or very important to their own practice than rated TOPS as very important or important to CRI (see table 17). While 44% (n=22) of respondents reported that TOPS was either very important or important to them as practitioners, 32% (n=18) reported that TOPS was either not important or of no importance. A fifth of respondents (n=11) said that TOPS was neither important nor unimportant to them.

Table 17: How important is TOPS to you in relation to your own practice?
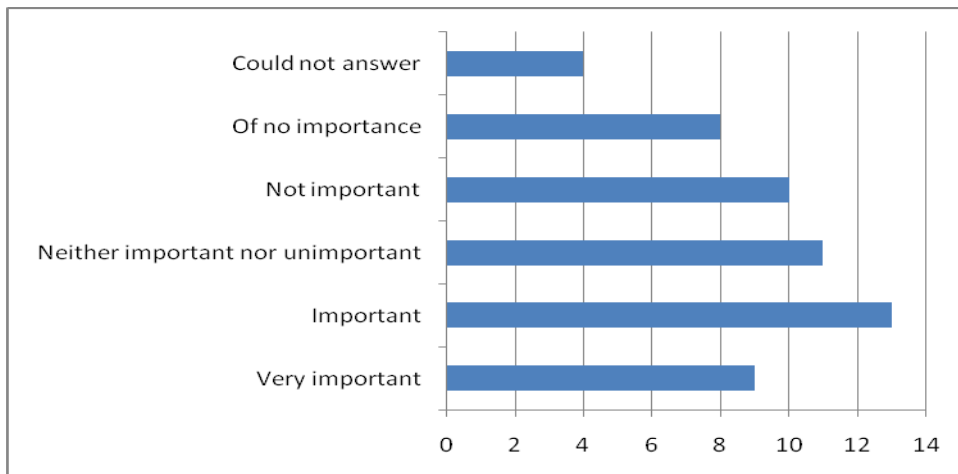
Staff TUPED in from Addaction were most likely to view TOPS as important or very important to themselves as practitioners (5 out of 8 or 62.5%) followed by staff from Lancashire Care Trust (11 out of 23 or 48%). Perhaps this is not surprising given what some staff from Addaction reported:

> *Addaction were up on TOPS and I am used to it.*

As table 18 suggests, staff TUPED in from ADS were the least likely to rate TOPS as 'important' or 'very important' to themselves as practitioners (3 out of 11 or 27%). This is shown in table 18 below.

Table 18: Perceived important is TOPS by organisation TUPED in from
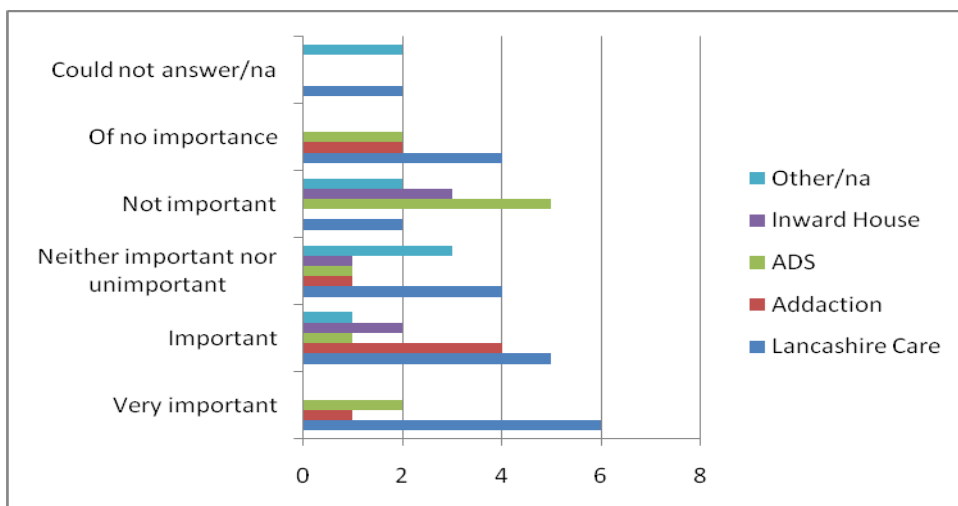
Those people who viewed TOPS is unimportant to their own practice gave different reasons. Some had not used for the tool because, for example, they worked with alcohol clients with whom they were not required to use the TOPS form.

> *It is not important to me as we don't use it with alcohol clients.*

Others were overtly critical of the tool however, saying that it either told them nothing new, that it was misleading or that it positively got in the way of more meaningful work with clients.

> *It tells me nothing new.*

> *It does not tell me things that I cannot gauge from the interaction.*

> *People score their health as 18 when they are losing a leg!*

> *The data gets "tweaked".*

> *The focus for workers is the relationship. People get frustrated getting asked the same questions again and again.*

> *It can halt a session. Lot's of bits of the form I can fill in myself based on the conversation that we have, but some bits you end up having to say "hang on, I need to ask you this before you go".*

> *It antagonises clients.*

A number of those who saw TOPS as either very important or important to their own practice said it was important because they saw it as a central part of their own relationship with CRI.

> *I want to meet the requirements of the job.*

> *It has some limitations, but it is still a useful tool and my job is on the line.*

Interestingly enough, this was the same as one of the reasons given by a number of other practitioners who saw TOPS as not important or of no importance for their own ranking. They too accepted that TOPS was critical to their relationship with CRI and to their job security, but for them, that was all TOPS was about:

> *I will do it because I know it is important to CRI.*

> *I do it because I have to.*

A number of criticisms of TOPS were shared by staff, whatever their views of TOPS as a measurement of outcome might have been. Even those who viewed TOPS positively were not uncritical of it. They recognized the limitations of some bits of the form, particularly around the crime data, as well as issues around client priorities that may make it difficult to complete the form in a timely manner.

> *The mental and physical health questions are good, but I would be wary of the crime section. The drug question is hard to fill in as it goes back 3-4 weeks which people find hard. You may not always get a true picture.*

The crime measures are false though. People don't tell us…Some of the figures for drug use are not sensitive enough.

It is alright every six months, but not every three months. In shared care you may only see the client every 4-6 weeks.

You can't always do it as the clients may come to you with a crisis which is more important than filling in the form.

In general there was most support for the scaling questions around mental and physical well-being.

It is good for tracking psychological functioning.

From a therapeutic point of view I don't place much importance on it apart from the last three questions.

However, a number of respondents felt that the validity of TOPS data even in this respect could be undermined depending on when it was administered:

The scaling bit is useful, but it depends on the day that you do it.

I do like it. It is a good tool, but it depends on when you do it.

In the short-term it is up and down too much.

A number of workers of all persuasions had views about how the use of TOPS could best be promoted and made more useful. Many thought that it was important that workers used it as part of their practice, rather than as a monitoring too.

If used properly like the alcohol star and as part of an action plan then it could be really good. It needs to be an integral part of practice however.

It can help you monitor how people perceive themselves, but you need to ask why people have scored as they have and pick up on any conflict between what they say and you think.

If the client has participated fully and answers the questions honestly then it can be positive.

It is a good tool with a client that is being honest. You can see a big change in three months. I would take the earlier one out to show them.

I would use the scores to discuss so it is about how use it in the session. Other people seem to do it after the session and not with the client.' 'I use it as an intervention tool. It is something to promote a discussion.

For some workers it is just another piece of paper.

Several suggested that it should be extended for use with alcohol clients.

We should use it for alcohol clients too. You can use it to measure moods and to have a discussion around the main points.

A number of workers complained that in order to be able to use TOPS as an intervention tool they would need to be given more time to work with their clients. Several complained that they had high case loads and did not really have time to work with clients therapeutically.

It can be helpful, but there is not enough time to use it.

Others felt that the TOPS data needed to be supplemented by other forms of information.

It is too driven by stats. It does not tell the story behind these or the individual progress. Lots of things that are central to recovery do not feature.

'You need some form of narrative explanation to understand what is going on and why and to identify gaps and needs.'

A number of workers felt that they needed more explanation about how TOPS got used:

I am not clear how it gets used and why.

I am not really clear how the information gets used.

There is too much emphasis on TOPS as a commissioning tool. I have never had any feedback.

3.10 Responses to the open question

At the end of the interview we offered respondents the opportunity to discuss anything else about delivering recovery based work which they wanted to tell us about but which had not been covered anywhere else in the questionnaire. Perhaps unsurprisingly, given the open nature of the question, a variety of responses were elicited. These have been grouped thematically in table 19 below, which also gives an indication of how many times each theme was mentioned.

Table 19: Issues raised in response to the open question
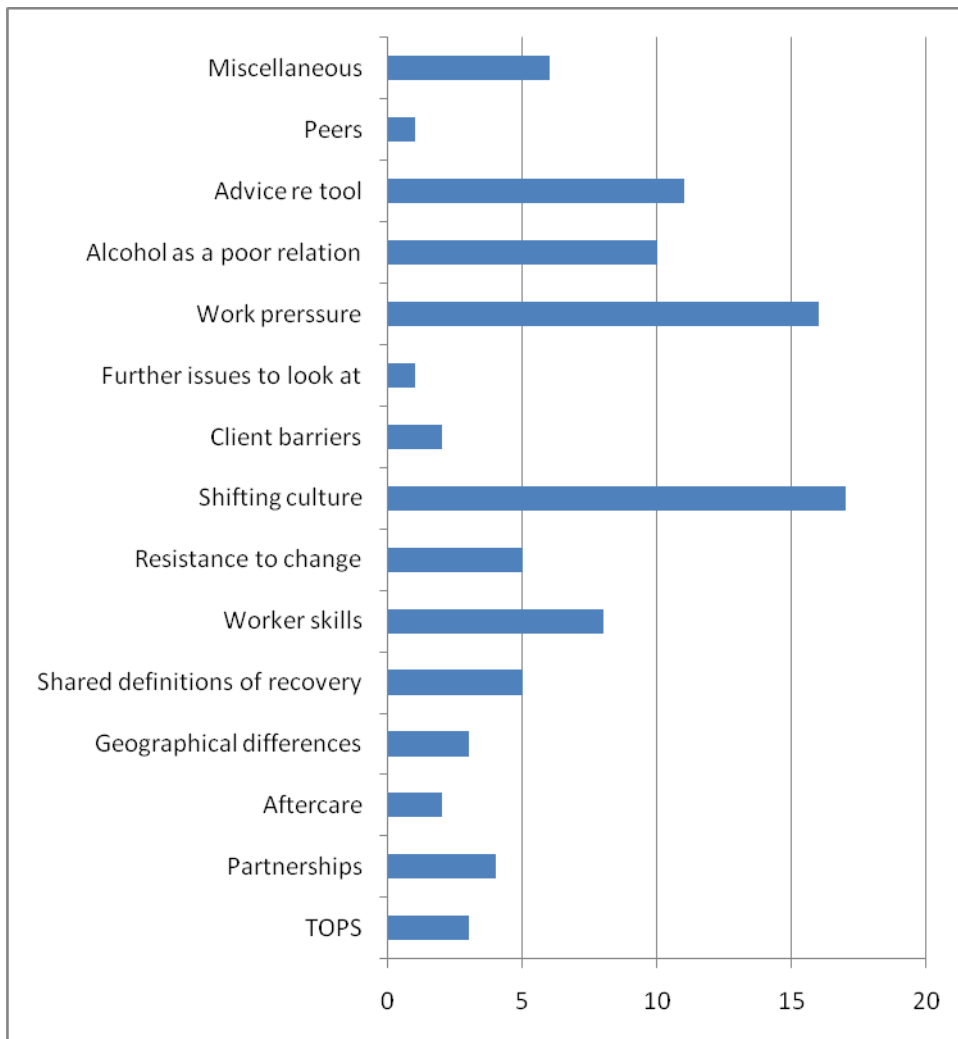
Most respondents simply used this question as an opportunity to re-iterate or re-emhasise a point that they had made earlier, particularly in relation to evidencing the changes in organisational culture (both good and bad).   For this reason we have chosen not to present most of the data here as this would simply be a repetition of points that have already been made. Rather we have chosen to include this data at appendix 5. However there were some new points made here and we do feel that is worth sharing these, particularly regarding the development of any tool that is designed to measure recovery. We also think it is worth re-producing some of the comments that staff made about work pressure and work culture as many of the staff who did this in response to question 20 had not raised this directly in relation to other questions elsewhere.

3.10.1 The development of tools

Eleven respondents gave specific advice relating to the development of tools to measure recovery. This included a plea that any tool should be of practical use and linked to an action plan. Any tool should go beyond a simple tick box, but also strive to give some narrative explanation of the story behind the box.

Not just a number. What does the number mean? It should be linked to an action plan.

Tick boxes are all very well, but you need an explanation too.

At the same time, people suggested that the tool should be user friendly. It should involve clients and staff should be involved in its development.

Something that is user friendly like ITEP

We should involve clients more

You need to consult with staff. Not all are experienced and comfortable using different tools. Staff need to understand why data is collected. Staff need to help develop it.

As one respondent so wonderfully put it: *'That is the challenge for you!'*

3.10.2 Pressure on staff and support for staff

Sixteen workers complained about the pressure of work. Some complained about the size of their caseloads asking how they were supposed to have time to engage with clients meaningfully and work towards recovery with so little time. Others complained about the pressure of trying to move clients through the system too quickly, especially alcohol clients – although these are picked up separately below in the section on alcohol clients being perceived by some as the poor relation.

If you are going to work towards recovery you need the staff and the resources to do it. We are all under loads of pressure to get clients through the system but we don't have the time to do it properly.

There is a lot of pressure. A client injecting in the neck is not going to change in three months.

Big caseloads. Up to 80. You pay lip service to paperwork. Stable clients might be seen only once every 4 weeks so if they miss a session it might be 8 weeks before you see them.

The caseloads are too big to have time to do enough psycho-social interventions.

Some clients get pushed through too quickly.

Time constraints are a problem. We get 30 minutes with a client.

While acknowledging that CRI is itself under pressure to deliver to certain targets a number of staff were critical of the management style.

They could be a bit more staff oriented. They send too many emails instead of talking to us.

Two workers were very critical what they perceived to be a lack of support and one respondent broke down and recounted to the interviewer the pressure they felt they were under.

> *I wouldn't feel comfortable going to my supervisor with a problem as it would just be seen as a weakness. We are just expected to get on with it.*

4 Discussion

The findings will be discussed in the context of the objectives we set for the work which are set out in section 1:

4.1 A snap shot of how the TUPE process had been experienced by staff

The experience of the staff group

Fifty of the staff that we interviewed had been TUPED in to CRI from another organisation and many of these staff are highly experienced practitioners (Nineteen with 1-5 years experience; 19 with more than 5 years and over a third of these with more than 10 years experience). This experience seems to represent both an opportunity and a challenge. On the one hand, the experience that the workforce already has represents a huge asset that is there to be harnessed. On the other, there is a considerable challenge in bringing together workers from such different backgrounds within a new and coherent framework. Many of the organisations that people had gained experience within had quite different operational cultures and philosophical frameworks around addiction to those of CRI and a few staff communicated a strong loyalty to previous practice models.

This said. most staff tended to talk about changes in a positive way, acknowledging a number of failings in the 'old system' such as:

- A lack of ambition for clients and a propensity for some people to get stuck in treatment (especially drug clients).
- Poor referral options for additional forms of support.
- Little in the way of peer mentoring.

However there were also consistent areas of concern about the revised system some of which were expressed by those who were, in general terms, positively inclined to the changed system. These included:

Concerns about time limited treatment

A large number of staff reported a sense that there was increasing pressure to push clients through the system too quickly. This concern was reported equally by those staff who had generally positive views about the revised treatment system as it was by those who were more negative. While acknowledging the need for clients to have an impetus for change a large number of workers consistently reported feelings that for some clients the push was too great and/or came too soon. This concern was expressed particularly strongly in relation to drug clients who had been in the service for many years and for alcohol clients.

Alcohol clients as secondary concerns

Several staff reported a sense that alcohol clients were the poor relations of the Inspire Partnership. Some staff suggested that revised frameworks stipulating finite levels of intervention (and attached to Audit scores) had been introduced for alcohol clients but not for drug clients meaning time limited treatment had effectively been introduced for one group of service users but not the other. Some workers with a long background in alcohol work tended to view this as evidence of a belief that Inspire was primarily a drug service in which alcohol clients were a secondary concern. This was further exemplified by reports from some workers that they felt they were under pressure to record alcohol clients as poly-drug users, even if they only smoked an occasional bit of cannabis, because poly-drug users counted for more when it came to demonstrating contract compliance.

CRI as too focused on outcomes

Many staff reported a sense that CRI's management is too focused on outcomes as opposed to processes. Comments on this included the notions that CRI is 'hard nosed' and 'too business like', characteristics which some saw as inappropriate to the work. Some commented on the ways in which change processes are being managed. One example of this mentioned by several people was the ways that messages were conveyed to them which tended to be by e-mail rather than face to face. Some also suggested that there tended to be an emphasis on enforcing decisions with less focus on supporting staff to deliver the required outcomes. Some also mentioned in relation to this that a number of staff had lost their jobs and suggested that there is a culture in which staff are concerned about admitting gaps in knowledge or understanding for fear that they might be dismissed.

Summary

Those who commissioned this research may view some of these criticisms as unfair or inaccurate. It is clearly important that such criticisms are seen in context of the significant changes that have happened in the treatment system in the months before the interviews took place. The vast majority of workers recognized and welcomed the 'long overdue' shift in focus. However, the level of change has also inevitably led to some disruption in patterns of working and uncertainty about roles, responsibilities and the effect that the changes may have on staff and service users. We would recommend some further interviews be conducted in twelve months time to see whether and how the concerns raised in these interviews are resolved over time. This is a theme we address later in the discussion around baseline data.

4.2 A snap-shot of the views of staff about the changing culture involved in a recovery oriented service

A revised service culture

We found lots of evidence that the culture of the service has changed. Many workers talked about a revised emphasis on service users moving – or progressing - through the system and the availability of additional forms of support (such as RAMP and DEAP) made possible by the new partnerships (for example with Acorn Housing and Work Solutions). Staff also commented on the simple referral pathways with these organisations and good relationships with staff which were seen by researchers

during data collection. Other signs of change included the merging of alcohol and drugs work and working towards a revised emphasis on prescribing in which it has become one treatment tool rather than the main element of a treatment intervention.

However, a number of workers felt that each of these examples was a work in progress. For example, the new forms of support such as RAMP and DEAP are only currently available in two of the five sites something staff suggest currently limits their appeal, availability and positive impact. Also, several staff said that when CRI took over the service there had been an initial institutional drive to reduce the scripts of people who had been on long term methadone maintenance at high levels (e.g. over 100 mgs), but that these initial reductions had not been sustained. People tended to interpret this differently depending on their personal views about methadone maintenance and about CRI. However, many staff felt that there may be a small group of clients for whom long term methadone maintenance is necessary.

Defining recovery
We asked all staff about their own definitions of recovery and also about CRI's definition. Different staff offered rich and varied material in response to these questions. Most of these ideas were not incompatible with each other; however, it was clear that there was currently no coherent and shared definition of recovery across the workforce. Fourteen staff were unable to say whether their own view of recovery was consistent with CRI's and a further seven members of staff thought that their own ideas about recovery were at odds with CRI's. Given the way in which Inspire has been drawn together from different organisations this is in some ways not surprising and perhaps is more a sign of the relative newness and immaturity of the recovery model in East Lancashire than a specific criticism of CRI.

Aftercare
Something almost all staff viewed as important to recovery was aftercare. This was something that CRI communicated clearly to the researchers in the early phases of the work, suggesting that in the revised system aftercare is considered at the outset of the treatment journey. There is some evidence that those in management grades have adopted this message more completely than recovery workers who often still talked about aftercare as something that happens at the end of formal treatment. This may be evidence of the need for ideas about recovery to have time and space to mature within the organisation or it may be that management staff have been exposed more fully to CRI's thinking and ideas than those at lower levels.

Recording recovery
Most workers attempted to record recovery in one way or another and most thought that recovery measures were important to service users. However, there are large differences in the way that various tools are currently used by different workers. Some workers are comfortable and confident using tools such as ITEP, TOPS and the Alcohol Star, and demonstrate best practice by fully integrating them in to their work and fully engaging service users in their use. Others are at best lacking confidence in the use of certain tools and at worst use them instrumentally or cynically because they don't see any value in them. We found some evidence that a small number of workers complete forms such as TOPS on their own after sessions and with little or no direct input from service users simply in order to comply with the requirements of the job. Whilst training and

supervision may address some of this practice it may also be that the pressure around completing these data also leads to corrupt practice in some cases.

Time limited treatment

As alluded to above, a number of concerns were expressed about elements of how the new culture of recovery was manifesting itself. Concerns included issues related to the perceived status of alcohol clients, the perceived pressure to move some people through the system too quickly and the lack of time that workers felt that they had to attend to 'real' recovery work because of the pressure of high caseloads and paperwork. It should also be said that other workers suggested that the high caseloads of some workers arose because these staff were disinclined to discharge people rather than because caseloads in general were increasing.

4.3 Baseline data against which the KTP could measure future progress on these subjects

We feel that the findings put us in a good position to make some recommendations around the baseline data that could be used to measure progress around the development of a recovery culture within the workforce. We feel that future work could usefully undertake further examination of the following issues:

- Establishing a shared definition of recovery;
- Plotting views of staff about the merging of alcohol and drug work in terms of equality of focus and staff skills, knowledge and confidence;
- Undertaking a programme of work with staff to address the instrumental and cynical use of certain tools;
- Plotting changes in workforce views about where in the treatment journey aftercare begins;
- Plotting changes in workforce views about issues around caseload sizes, session times, and administration loads plotted in relation to case management and discharge practice; and
- Plotting the uptake of new services (RAMP, DEAP and family support) by service users from different sites to see whether availability at different sites actually influences uptake.

4.4 Initial thoughts about what a tool that measures recovery across the treatment population might look like.

This is still a work in progress and in developing a tool to measure recovery there are a number of strands of work to be undertaken and a number of influencing and limiting factors.

Defining recovery

The literature emphasises that recovery is a process which involves progress across a number of life domains which include: substance use, injecting behaviour, crime, mental health, physical health, housing, employment, education, training, family relationships and social networks. In this research there was general agreement amongst respondents about the essential under-pinning components of recovery. However, there is more work to be done with staff in order to help to develop a shared

corporate vision of what recovery is and how it might be measured across relevant life domains. There is currently no clear agreement about what the best ways of measuring recovery might be.

Measuring recovery

Most staff expressed the view that the data they found most useful in plotting recovery was qualitative. Most workers preferred the narrative qualities of case notes and care plans, which reflected their face to face discussions and their relationship with clients. In order to measure recovery at a system level there is an enormous pressure to simplify processes, actions and behaviours into measures which can be applied universally to all people in the system. This almost inevitably implies pre-determining some notion of what recovery looks like.   Essentially the quantitative measures preferred by systems leave many recovery workers feeling that the full picture of someone's journey has not been captured or has been obscured. However, the detailed narrative material in care plans, whilst relevant to workers, is equally useless at a system level. Hence, the data preferences of workers and systems pull in different directions. However, workers general dislike of quantitative data sets is worsened by feelings about what happens to this data after it is collected. Many staff feel it disappears into a black hole never to return a reality which extends the view that these data are not relevant to their work.

Hence there is an inherent tension that needs to be wrestled with. Quantitative data   can feel at odds with what many staff see as absolutely central to recovery: that is that it is very personal journey and that it is for each client to define what recovery looks like for them individually. There is a serious challenge in trying to develop a tool that is at the same time practical, simple and effective at measuring outcomes, meets the data preferences of workers, managers, commissioners and service users and that is not over-burdensome on the workforce by adding to current data collection tasks. With this in mind it is worth mentioning that TOPS is an immovable object and despite the hostility that some workers clearly feel towards it, it is here to stay, at least for the foreseeable future. The best strategy in dealing with this tool would seem to be some element of training and coaching in how to integrate it and make best use of it. This could possibly be led by those workers who are already using it effectively and have integrated it into the work they do with clients.

In relation to the wider objective, a number of tools already exist that have been designed to capture elements of recovery in different ways as outlined above. For example:

- TOPS seeks to capture recovery across the domains of substance misuse, injecting risk behaviour, crime and health and social functioning;

- The Alcohol Star (which could almost certainly be adapted for use with drug clients) seeks to monitor progress across a number of life domains including alcohol use, use of time, physical health, emotional and mental health drug misuse, offending, money and family;

- The Inclusion Web – a mental health tool - seeks to measure recovery by tracking the client's contact with positive social models and relationships in relation to both the places they go and people they trust. It addresses a number of relationship domains including: neighbourhoods and families, sport and leisure, volunteering, arts and culture, faith communities, education, employment and services;

- Granfield and Clouds *Recovery Capital Scale* which seeks to measure the extent to which individuals have the necessary resources with which to recover;

- There are also various existing tools for measuring readiness to change including a number of versions of the readiness to change ruler and Prochaska and DiClemente's stages of change model.

The challenge is in trying to develop one tool that might integrate all the relevant elements that might also provide some flexibility for the fact that people at different stages of recovery journeys might be focusing on different issues or domains. We feel that an appropriate tool needs to not only to define a set of life domains but also for each domain to create a balance between benchmarked quantitative measures and accompanying narrative. The tool should address a issues including:

- A measure and description of the service user's motivation and readiness for change;

- A measure and description of recovery capital;

- A measure and description of the service user's recovery objectives;

- A measure of substance use, injecting risk behavior and crime (as already collected in TOPS)

- A measure and description of the service user's inclusion networks and activities, the objectives for widening these and the support structures necessary to facilitate progress;

- A description of activities and measure of outcomes across a range of life domains (including, family, non-using peers, peer support networks, education, volunteering, employment, housing, mental and physical health etc). A measure and description of the extent of engagement with wider forms of support from other agencies (e.g. Acorn);

In trying to reach the next stage the authors believe that it would be sensible to establish a specific working group, ideally resourced through the KTP and made up of representatives from CRI management, main grade workers, alcohol and drug clients, the university and (possibly) LDAAT in order to reflect on the findings of this report and grapple with the issues raised with the aim of answering the questions raised in the preceding paragraphs.

5 Recommendations

1. That the strategic partnership between LDAAT, CRI and uclan that has been developed through this phase of the work should be built upon, ideally through the successful KTP. If the application is not successful, there are a number of specific actions in recommendation 2-7 below that could further support the development of this partnership.

2. That a programme of work is developed by CRI and uclan to ensure that a shared view of recovery is more fully embedded in the workforce across the service. As well as ensuring that concepts and views of recovery are more broadly and consistently developed, such a programme should also include training around the use and integration of monitoring tools in to practice. Existing good practice in this respect, as exemplified by some of the workforce, should be built upon. Uclan could not only help to develop and deliver such a programme, but could also bring the added value of accreditation of the accompanying programme.

3. That the postcodes of all those attending RAMP and DEAP should be logged over a 6-12 months period to assess the influence that location has upon uptake of these support structures. On the basis of this analysis consideration should be given to whether these forms of support need to be made more widely available across all of the 5 delivery sites. This may have resource implications which would need to be explored by CRI and LDAAT. CRI and uclan should explore whether there are aspects of the RAMP and DEAP programmes which could be accredited to further support rehabilitation and re-entry of service users into education and employment.

4. That CRI may wish to give consideration to the management and communication styles employed in certain processes. Clearly it is not for us to tell CRI how to manage its service or staff and we fully recognise the challenges involved in driving through a significant programme of change. That said we think that it would be re-miss of us not to report on the level of disgruntlement that some in the workforce communicated on this issue. We would recommend that senior management is at least made aware of these issues and that thought should be given to whether alternative styles or approaches may bring additional benefits.

5. That CRI, with LDAAT, consider the concerns levelled about the status of alcohol work within the partnership and consider ways in which these might be best addressed.

6. That CRI, with LDAAT, establish a working group to work with uclan to develop an appropriate recovery tool. to be piloted with some staff and refined over time in comparison to other tools such as TOPS and the Alcohol Star. This programme and pilot could be published and the results shared with the NTA.

7. That a follow up study of staff is carried out between November 2011 and March 2012 in order to monitor the changes in working culture and workforce development against the baseline data contained in this study, linked to the KTP if it is successful, but resourced through other sources of not.

Appendices

Appendix 1

1.	Location	
2.	Job title / Role	
3.	Have you begun working here since CRI took over in April 2010?	Yes No
4.	If no, did you tupe transfer from another organisation	Yes No If yes, which organisation were you employed by before 1st April
5.	Length of time employed by previous organisation	
6.	How would you define recovery?	
7.	What do you think are the five most important things which support recovery	Can you rank them in order of importance? (1 should be the **most** important) 1. 2 3. 4. 5.
8.	Do you think CRI's definition of recovery is the same as yours?	Yes No If No, please explain why
9.	Do you currently record recovery progress at an individual client level as a part of your work?	Yes No If yes, what measures and tools do you use? If no, why not? If no, how do you judge or measure the success of your practice?
10.	In your opinion how important are measures of recovery to service users?	Very important ☐ Important ☐ Neither important nor unimportant ☐ Not important ☐ Of no importance ☐ Explain ranking:

11.	Do you think there are better ways of recording recovery at an individual client level than those currently available?	Yes ☐ No ☐ If yes, what would these be?
12.	How do you think CRI measures its success in delivering recovery across the treatment system in East Lancashire?	
13.	In your view is CRI's approach to measuring recovery a good one?	
14.	Please describe the data you are required to record as a regular part of your practice	CRI assessment form: TOPS 1 TOPS 2 TOPS 3 TOPS 4 Alcohol Star: Others please name: ....…… Please can you get us a blank copy of the forms/tools that you use
15.	Which of these data sets do you find most useful in measuring recovery based practice/ performance	Name: .... Explain selection:
16.	Which data sets do you find least useful in measuring recovery based practice/ performance	Name: .... Explain selection:
17.	How important is TOPS to CRI	Very important ☐ Important ☐ Neither important nor important ☐ Not important ☐ Of no importance ☐ Explain ranking:

18.	How important is TOPS to you in relation to your own practice	Very important ☐ Important ☐ Neither important nor important ☐ Not important ☐ Of no importance ☐ Explain ranking:
19.	Explain any difference between 16. and 17.	
20.	Please tell us anything else about delivering recovery based work which we have not covered in other parts of the questionnaire	

Appendix 2

Update report on initial programme of work in East Lancashire

Purpose of initial programme of work

- To gain a snap shot of how the TUPE process and the changing culture towards a recovery oriented service is going
- providing baseline data against which KTP can measure progress

Proposed outputs:

- Report
- A series of recommendations for CRI and LDAAT about training and support needs of staff in relation to recovery *and* communication and supervision processes across integrated team during transition period
- To provide a foundation for the implementation of the KTP

Update on activity:

As an initial programme of work we agreed with colleagues at LDAAT and CRI to conduct a questionnaire based study with all those delivering substance misuse related work with service users across the five sites in East Lancashire. Those to be interviewed included: Recovery Workers, DIP Recovery Workers, senior practitioners, team leaders and nurse practitioners. We have also interviewed a small number of admin workers.

We received NHS ethical approval for this programme of work on the basis that it is being used to develop the methodology for the KTP. This allowed us to proceed with the interviews without submitting a full NHS application.

The research tool was reviewed by Mark, Steve and Navin, with amendments made after review. It was also piloted prior to full roll out. We began interviews at the back end of 2010 and are still completing our final interviews. So far we have conducted n=46 interviews and have a further 10-11 to complete. We hope to complete the final interviews by the end of the first week in February and will then pull together a draft report for colleagues. We plan to present this to Navin, Mark, Steve and other interested colleagues before the end of February.

By conducting this initial programme, we have learned a great deal which we feel will be of interest to colleagues in LDAAT, CRI, the NHS and other partnership organisations. Some of what we have learned may also result in minor changes to the work programme for the KTP.

On the subject of our KTP application, I know that Navin has received the same update from David Way at the Technology Strategy Board that I have received. Essentially, ours is one of a small number of applications still being considered because it is being jointly supported by the ESRC and the TSB. It has not been rejected despite the funding criteria being changed after we submitted the application. We will update colleagues further as soon as we have any news.

If you require any further details please do not hesitate to contact me.

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Appendix 3 - Staff definitions of recovery

1. *From a workers point of view it would be to live a drug free lifestyle. From a service users point of view it might be different. Many would think that just being in treatment is recovery. This might be a harm reduction view.*

2. *Difficult to answer, it is different for different people. It depends on what stage you are at. It is about having some sort of control, escaping from the ties of addiction. It is a journey.*

3. *My initial view was that it was about abstinence but I have learned that it is much broader than this. Clients often think that recovery is abstinence based though. But I would see it in broader terms. It could include a move away from injecting or reduced drug use. It is about making your own goals and whether you have met them. It won't be about abstinence for everyone.*

4. *It means different things to different people. You might start off in a mess, be committing a lot of crime and not have a prescription so you might start by entering treatment. Some of the important issues are as follows: enter treatment, reduce criminal activity, treatment compliance, retention, level of engagement, outcome focus, improvement in quality of life – not just about drug use but also wider problems, not just about being drug free, recovery is different for different people*

5. *Depends on the individual client – everyone is different. If you are using drugs it might be about becoming stable on a small prescription and not committing crime. It might include lots of things – a better life style – going back to work – being abstinent from alcohol. As a worker it is about spending time with them (clients) and directing them in the right direction – helping them with housing, food, shopping. Helping them to get their life back; living in a house and not on a railway station, being able to look after your children. You have to take your time. You can't rush. You can't set a time to it. There is lots of 'life' stuff to negate. It becomes a revolving door if you try to rush it. It is about whatever it takes for each individual.*

6. *It is about the resettlement of the client. Looking at wrap-around services, not just about drug use. It's about their whole lifestyle. It's about them taking responsibility for themselves.*

7. *It's about moving on – moving forward. How do we move you on and move you forward.*

8. *I started in harm reduction, so it has been a big shift. It's about starting to get better, starting to improve your life in every respect. It should be client defined, setting goals and achieving them. My top 3 (priorities), as a worker, may be different to your 3 as a client. We have to negotiate – I may see a huge risk in what someone is doing, for example, so there is no point just working to their goals if they are likely to be dead before they get there.*

9. *It is a continuum. A person re-integrating in to the community – their lifestyle and family etc. It is about small changes along the way, improvements in relationships and lifestyle. For society there is a bigger picture – less crime for example.*

10. *It starts as soon as you walk in the door, although there are differences between those who have come voluntarily and those who have been coerced to come. It is about giving people opportunities. It is about individual goals – what do they want to aim for? How do they see recovery? What do they want to achieve? Commissioners may want something else however.*

11. *It is about people feeling in control of their lives, rather than users being controlled by medication. In this respect I see a difference for drug users and alcohol users. For many drug users is not so much about recovering from their drug use as it is about recovering from treatment. People have been in long-term treatment. The locus of control has to shift to the client. Pushing people into services and pre-defined goals runs counter to this. You can often tell if people are in control of their substance use or not. If it is the other way around people do all kinds of stuff. You can measure social stability and personal control. It is important that you don't just measure their substance use. People often need to hit rock bottom, so part of the role of services might be to try to lift the level of rock bottom for people so that they don't have to fall so far.*

12. *It is a broad concept, it includes everything: health, social, psychological, but it is individual – how do you see recovery? Externally it gets measured by social norms such as having a house, working, but this might not be shared by the user.*

13. *It is a difficult concept. My instant thought is that it is about throughput and progression through the system. In an ideal world it would be abstinence, but this is a big thing. It is about moving forward with the aim of abstinence. Look at physical health, mental health, offending etc. They are all a part of it.*

14. *It means different things for different people. It is about working towards abstinence, but people will have individual ways of getting there – with or without methadone.*

15. *It is a process. For example, if you have an injecting poly-drug user, the first step might be to become stable. That puts you on the pathway to recovery. Along the way you may need to look at a range of things – housing, psychosocial issues … At the end of the day it is about someone functioning without drugs at all and living a 'normal' life.*

16. *One part would be a journey right through to the end of the care plan. But recovery is also about the smaller steps in between. For example, being abstinent from alcohol might be the end goal, but drinking less might be a step on the way.*

17. *If someone turns up here, then I think they are demonstrating that they are willing to change. There may be some exceptions – clients who are coerced by the courts or their families – but for the most part they want to be here. Recovery is about us being able to offer them choices in relation to what they feel they feel they need. We should be able to meet these needs and progress them in their lives to a point that they can cope. CRI has a push on what is achievable – raising people aspirations. Using other users to do this is important. It is about empowerment. Users and workers need to change their view of what treatment is and work needs to be done to change this view. Treatment should not be seen as something that is done to users with them being passive. Users*

need to be active and to participate in their treatment. Other users are often best placed to challenge this view and to offer a vision of hope. That said, everybody's recovery will be different. Clients need to be ready to change first. Clients need to know where they are on the change cycle. Are they where they think they are? If they think they are somewhere where they are not, they need to be challenged. The journey can only come to an end after a prolonged period of abstinence. Users who think that recovery can mean continued use need to have their thinking challenged and you can use peers to do this. This is just the stark reality of it. Recovered users don't reflect back and say that was a brilliant period of my life.

18. *It's about what the client wants in terms of their treatment journey. For services it's about assisting them to access support services (both internally and externally) in order to achieve what they want. It's about identifying the recovery assets that they have such as family, friends, networks, faith groups … anything that will help them achieve what they want.*

19. *Bringing the service in to the 21st century. Taking it in to lots of other areas, not just drugs, other areas too. Working in partnership with other organisations. Recovery is an end goal, it is being drug free, abstinence.*

20. *To get someone to where they want to be. It doesn't have to be abstinence.*

21. *Getting a normal life back. Not being tied to a chemist. A better life, more independent, earning money. But you can't rush it. I worry that we try to push some people too fast which means that they will just come back round again. I came from a recovery background in alcohol work. Clients came in wanting a detox and we would assist them with this as well as trying to get them in to work or employment. It is harder for drug users I think, because of the way that they have been worked with in the past. We are always promoting things like Work Solutions and looking at things such as housing etc.*

22. *Client defined. It is about the clients achieving whatever they deem as recovery. A lot of people tend to think of abstinence, but it is more than this. If you are living a more stable life, that could be recovery too. It is also about offering access to other support to help in other areas of your life and then having a planned exit.*

23. *Different by client. For sex workers it is about exiting sex work and stopping illicit substance use. Rebuilding life.*

24. *It is about time. But most of my clients are high risk offenders so abstinence is not realistic for most. It is staged approach, tailored towards an end goal of abstinence.*

25. *It is very hard to come up with a textbook definition. My initial thoughts are that it is about abstinence, but in fact it is not as black and white as that. It is about the stages of recovery. For some alcohol clients it may be that they can control their drinking and they don't need to be alcohol free. I am less sure about drug users and whether they can control their drug use – I have less experience in this area.*

26. *Differs by person; stable, life OK, no chaotic behaviours and out of formal treatment and hopefully not coming back in. There is a big revolving door syndrome. I'd like to see more of them moving on and doing well. RAMP + SMARTER and Work Solutions all mean there is more support now.*

27. *It is moving on from a current lifestyle and into a chosen pathway that they go for. Progressing forward and having a self definition of recovery and workers support that I am an advocate whatever works for you.*

28. *Improving clients current lifestyle – whether abstinence or reduction in use. Working to get realistic goals but they have to decide them for themselves. Some have been in service for 10 years stuck on methadone.*

29. *Sometimes just getting them engaged is a massive part of recovery.*

30. *It depends how stable or chaotic a client is. It is often about looking at the surrounding issues to create stability and then looking at the substance use. Abstinence is best and I like the way the service is going with getting them out [more quickly].*

31. *It is a process, it is any kind of movement forward reducing use and accessing ETE. It may be measurable on a very vague scale because it is so different for different people. It is about moving away from drug services and back to the community. Away from a dependent relationship on services and little else. It begins small by coming here and when they get stable it is community centres, IT courses, and it snowballs for people as they meet other non–drug users. People often write themselves off to start with.*

32. *My thoughts are about them taking some responsibility for themselves. Before they were on maintenance for life and there was no responsibility. I think I came across quite hard and I had clients 20 years here and newer ones. When I met 20 year clients and introduced myself I said part of your recovery is getting off the script. So I make them come here to get the scripts. At Christmas we delivered the scripts and half the clients never came.*

33. *Getting people back on track, not using substances and getting life in some sort of order, employment, family ties back together and getting stability in lives, not on a script. It does mean so many things to different people. With drugs abstinence is necessary with alcohol it can be different.*

34. *It is what each individual sees it to be. Some get off H and maintain a normal life on a low dose of methadone. This is recovery if they leave street drugs and chaos behind. For me it is a fairly broad range of interpretation. It is about recovery equilibrium and mental and physical health. If you are on 40 mls of methadone and you live an exemplary life then the notion that you are not recovered is daft.*

35. *I think it is a person's journey. It is a progression of treatment including ETE and a progress.*

36. *A package of support that is offered to the client to help them achieve their goals, such as a goal that they might have, an aspiration.*

37. *It is a journey the client takes – the whole package; housing, prescribing, employment, skills, social, family. The journey can be short or long. Staff are the gatekeepers of opportunities that are available.*

38. *Reducing crime, harm reduction and abstinence.* I think CRI are dealing with semantics
   For some people stability on a long term methadone script if OK. This forced abstinence won't work. You can get stuck with clients.

39. *Having a start and end point; having someone come in with a huge load of problems and going out with less. It is an ongoing process and never finished as you can't really cure addiction.*

40. *An end in sight.*

41. *Looking at a more therapeutic approach to treatment as a pose to scripts – look at external factors and leading them towards a more normal life.*

42. *It depends as there are; [there are] different models. I still accommodate previous models into this new system. It is about holistic working, activities of daily living, Maslow's hierarchy of needs.*

43. *People coming into treatment who want to change. Recovery is more than just a script it's about clients making changes in their lifestyle and being signposted to the necessary areas of support.*

44. *Holistic approach which empowers people to move forward so they feel that their lives are not dominated by any substance they are taking. That they feel they are in control not the substance.*

45. *Seeing personal circumstances and history of substance misuse and putting in a structured plan with a multi agency approach aimed at recovery.*

46. *I think recovery is a good model. In [names other service] we worked in this model already. People came and we empowered them and they moved on. When CRI came in they were just handing out scripts and I found it really depressing. People were using on top and they still got scripts.*

47. *People needing the system less, needing less support or no support, coping strategies for themselves*

48. *It has to be tailor made to the individual. It is not clear cut that you will get off and that's it. You have to look holistically at barriers to that before moving on. The barriers can be hard to shift.*

49. *Abstinence or to create a better lifestyle and better quality of life. Ideally abstinence but not a necessity*

50. *Journey for a substance misuser to be comfortable in the journey.*

51. *I see it as helping someone with every aspect of their life and helping them get to where they want to be.*

52. *Nothing – it could mean a thousand things. To most clients it doesn't mean anything. No money has been pumped in here [in this area] for years, [we are into the] third*

generation of alcohol and drug users, education is poor, no understanding of treatment. ... Some have got brains but very few.

53. *Recovery for me is way of life, it's about giving something back where you have lost and putting something back. There are different qualities of recovery. In a simple sense it is abstinence from drugs but just taking that away still leaves people with a shit life.*

54. *Varies due to what you are recovering from. With substance misuse it is acknowledging and accepting that you have a problem and starting the journey. You are never cured but can get back to health, self worth, job, family and tackle goals.*

55. *Working with a client to where they want to get to.*

56. *Helping people along the way and referring on to other services and improving quality of life. Getting over the dependency on the substance.*

Appendix 4 – Quotes in relation to similarity or difference of staff Vs CRI definitions of recovery

Comments from those who said CRIs definition of recovery was the same as their own

1. *I thought initially that CRI's view was just about abstinence, but I understand now that it isn't. I do worry that the speed of what they expect us to do is too quick however. They want us to rush clients through.*

2. *Pretty much the same. Having short-term plans.*

3. *It's about people moving along. Having short-term goals, leading on to longer term ones. It's about moving on – not being stuck in treatment. Not being a methadone car park*

4. *There is no tension that I am aware of. I have never seen a statement from CRI saying this is what they think recovery is, but in some ways I wouldn't want to define it too closely because it is different for different people. Small steps for people can lead to big steps.*

5. *Very similar yes. It is different from NHS. … they are very focused on the worker opening up options whereas the NHS was all about the script, clinical component and maintenance in treatment. It has changed a lot, things were stagnant before. Prescriving has changed.*

6. *CRI took over and it was 'recovery, recovery' it is about educating staff and clients. A lot of clients view methadone as a necessity, the system has let them think that and the methadone car park is banded about a lot. There needs to be an exit strategy. They want movement through the system and they don't want stagnation, they want aims and goals and clarity for clients and practitioners about exit from the system.*

7. *I like the way they are working and what they are offering as a service. The Service User and peer stuff and Work Solutions and abstinence groups and counseling in Acorn and aftercare under the same umbrella provides a much better range of options. But they don't see clients as individuals, they are imposing time periods on treatment; for example, six interventions over twelve weeks for alcohol clients. There is still a need for more on mental health and some resistance from mental health services.*

8. *It starts as soon as people walk in through the door. This means changing the way people think, both clients and workers.*

9. *Initially I did not think so, there was talk of people being exited unless the reduced right down on scripts and giving clean urines. I was concerned about the older clientele and that reducing scripts may create more problems. Initially it set off down this road and everyone on more than 100mls was reduced down quickly but they did not continue to reduce. A quarter of the clients are on high doses of methadone with no change in the script for a substantial period and continue to use on top; and they have not been reduced. CRI has brought RAMP and work solutions in which is all good.*

10. *I got my definition from CRI – I didn't know what recovery was before. I came from a criminal justice background. My practice has changed a lot. Now I say 'I don't want to see you in 6 months, 12 months, 5 years time, whatever'.*

11. *Yes – the overall aim is not just about treading water. It is having a goal to aim for. It is time focused too.*

12. *Yes – we are singing off the same hymn sheet. Things like RAMP, DEAP and work solutions are good packages for recovery. DEAP and RAMP need to be developed across the piste however. They are not available in Clitheroe. Client shave to travel.*

13. *It has not been easy for them – people did not want to change. A lot were TUPED over on large salaries and have never looked at discharges. This is a measure of what the service has to offer and what the worker is doing what they are supposed to and the client is recovered. Lots of workers have no discharges, cause it is easy to keep them on and there is little proper work. CRI is changing this.*

14. *Some drug workers say they have no hope for the SUs and are just giving out a script – cynical.*

15. *The same – bang on. I started out in harm minimization, but I have changed. Recovery starts as soon as you walk in the door.*

16. *I think it is similar yes. I was surprised when I came here from my previous job as a drug worker in a prison how many people here had been on methadone for so long.*

17. *CRI view is the same as mine. A client has been on methadone for 18 years. You have to move people on.*

18. *I think so it is hard to say otherwise as I have not worked for other organizations. People here who have worked in the NHS have struggled with the changed agenda. It is a different way of working. It is very different for people but once they start seeing results they start to feel encouraged to work in a new way. Time limited treatment is not particularly realistic and I am not sure how it will work. That said I am very passionate that people should not be sat on a script for 20 years. People do take different times to move forward. It may motivate some to have a time limit but may not work for others. The turnover for alcohol clients is high and it is a totally different recovery. People do a detox and get in a safe place and then feel they can drink just weekends and it snowballs. The only problem here is the time with clients and you don't feel you have enough to do therapeutic work.*

19. *Same ethos of looking beyond the script and looking at all that is going on for them.*

20. *Yes – although they might use different words. But it is very similar.   They (we – I am part of CRI) don't promote people coming to the service forever and a day. We want to see a positive change towards a crime and drug free lifestyle.*

21. *It is through to abstinence although not sure whether their view of timescales is the same. I have clients who have been on methadone for 12 years, the main issue is psychological dependence and they can't envisage living without it. Been on 100-120 mls for more than 10*

years so we have to work on a staged reduction. If people use on top we are looking at reducing down.

22. *It is to get them in, to get them stable on methadone, titrate them down and either suboxone or cessation alongside psychosocial interventions. RAMP and Work Solutions are here in this building. I agree with CRI that people need an impetus to move. I have a client who is 55 years old, on methadone and diazepam and temazepam, he is now on a reduction on temazepam and he is amazed at the changes and he is up and ready for it and he is getting his life back. He was the most difficult client because he was not up for changing*

23. *I agree with the time limits (i.e. to get them out of the system as an aspiration). CRI has put resources around them.*

24. *In a lot of ways yes, but I think CRI see things very black and white. Recovery is different for everyone. When people move from chaos to shared care that is a big step.*

25. *I like how committed CRI are to it, the vigour about getting people unstuck and committed to getting people through the system. But in terms of the recovery agenda as a whole, I don't know if things have changed that much. The goal has always been abstinence but not everyone wants to be abstinent. The question is still where have you been and where do you want to be. But I like how they link to other services and a lot more is available now.*

26. *It has changed a lot in the last 10 years from HR and maintenance to get em in, assess, get the catalogue out and get people out. The whole package is much better than before, as the aftercare support but there is a bit of push and pull. Some people [meaning staff and clients] are stuck in the old NHS and now it is catalogue and informed choice.*

27. *I think they have done well, the treatment side of things needed shifting for a while and they have changed a lot of things.*

Comments from those who felt their own definition was similar to CRI's

1. *The emphasis for CRI is perhaps a bit too much on throughput. But pre-CRI, interventions for alcohol were hit and miss. I like the model now. It is bounded, well-defined and time limited.*

2. *Pretty similar, yes. But I have some concerns about the practice of it. Some clients have been here on and off for 15 years. It is OK to impose a new regime and new clients, but some of the older clients don't like it. Some of them welcome it, but not all of them. Some of them feel they are being bull-dozed in to it. They are not ready. It makes for a hostile working relationship which I can cope with because at least I have known some of them for a long time. But for some of the new workers it is harder.*

3. *Sort of, CRI's stance would be about all the goals being achieved. It will be different for different people. The emphasis is on making a planned discharge.*

4. *Sort of, it is pretty similar, but I am worried about the time limit that it put on treatment.*

5. *Similar – but I do have some concerns about the speed with which people are moved through. For example with the alcohol audit tool, people scoring under 20 only get a bit of advice and information. People who score over 20 get 6 sessions and then we have to move them on in to DEAP or RAMP. But we are sometimes pushing people on when they are not ready. I had a client who was referred on to DEAP, but she wanted to come back and see me.*

6. *Very similar. Not miles apart. But we all see the recovery differently as it is different for different people.*

Comments from those who felt their own definition was not the same as CRI's

1. *Recovery to them is in the system and out of the system, but this just might manifest as a revolving door.*

2. *Safer communities' healthy lives is the motto. We work for the individual hence it is difficult to define a system level agenda and workers are less interested in this. Unfortunately at the higher levels it is about numbers as that is how they get paid.*

3. *CRI have a time factor on recovery. This won't work. It should be individual.*

4. *They sell it well in the training and it sounds like the way I want it to be. In the tender it is about budget and pressure to push people through too fast which is a different set of interests. The training is inspiring and we do get supported through the issues.*

5. *CRI want people to come in on a limited timescale and to achieve recovery. People come in who have been using a long time and it is not acceptable. There is a lot of pressure to get people through the system*

6. *Their idea of recovery is about rushing people through making them fit our outcomes and this is not helpful. I know the government is leading this but it does not always help. Some can change quickly, but some people have had such awful experiences and are so traumatized.*

7. *CRI's notion of recovery is about people being 100% clean. I prefer a client centred approach rather than following the government down the road of forcing people in a specific direction.*

Comments from those who answered 'don't know'

1. *I don't know what CRI's view is. I am not clear how CRI views recovery, but I am clear that recovery is not just about abstinence.*

2. *In some respect yes, they have good ideas I would like to take forward. The expectation and what can be achieved are two different things. Its more about paper and statistics than the person. It is not just CRI it was true of LCFT. At this early stage of takeover I can see that it is important to get numbers into the system. It might change. The TUPE was quite poor – I came from a senior position and am no longer on that level. They do not recognize my clinical work as I was not a nurse.*

3. *I don't know what their definition of recovery is.*

4. *Have not seen the CRI definition, but the private sector is a massive gulf from NHS in terms of how they define recovery; one minute they are a charity and the next a business. These are different modes of working. In 30 minute appointments you struggle to get everything done in this timescale. To them it is admin and to me a vocation. I get my admin work marked by administrators.*

5. *On the face of it is very black and white. It is presented to the outside world as being about becoming drug and alcohol free. But actually within the organization what we do is very different. One thing I have heard is that we (the new service) are a lot less punitive (e.g. in terms of not stopping scripts) than we used to be (i.e. the old service). I think CRI is more focused on drugs than alcohol though.*

6. *I suppose it is a fairly good fit in terms of definitions but not always in terms of the best way of achieving things. My experience of CRI is that they are very business oriented, they would not have grown so quickly if they had not been. At times they seem quite hard nosed and that if people are not up to speed they get rid of them. That makes people feel they can't be honest about what they don't know. My concern is that because of the size of the contracts smaller providers are not able to submit tenders. It makes life easier for L-DAAT and the PCT but in terms of choice it is not that healthy or vibrant. If you look at documents around commissioning it says that SUs should have choice and in East Lancs but that is no longer the case. It will be interesting to see whether integrated services work. Very often the drivers for change are quite different for drug and alcohol clients. People talk about moving to a notion of recovery but we have always worked that way with alcohol clients. When we look at the pathways it is 6 sessions even for dependent drinkers whereas there is no such notion for drug clients. My feeling is that Inspire is still a prescribing service and it does not feel as if alcohol is on an equal footing.*

7. *We have not had that much training on the recovery model. The promised training has not been delivered. What is CRIs definition. The KWs are all frustrated with the lack of training. There is no consolidated model, it is wait and see and let things settle. Alcohol workers feel added on to drug workers and the last 9 months have been quite frustrating because ADS was further on in recovery work than CRI is.*

8. *Not sure what CRIs definition is. I feel like people are products in the care industry and it is a sausage factory approach. They have a formula and some people don't fit it. I am looking at a unique individual whereas they pass people through the system more quickly in order to meet contract requirements.*

9. *I don't know what their definition of recovery is. No one has explained it to me.*

10. *Hard to tell at the moment. There is a lot of pushing services on to people and hoping that it will make a difference. This is not just coming from CRI but from the NTA as well.*

11. *Yes in that it is about giving people opportunities – for example via groups and work solutions. But no in other ways. I beg to differ about the intensity of the input. Everything has to be time limited now. For alcohol it is 6 half hour sessions. For drugs it is get your script down and out.*

I know a lot of people got stuck in the old system, but some can't reduce. There is a risk that they will just go back to using.

12. *It is whether it is realistic. I agree with what they say about recovery but when you have overloaded staff delivering it is hard. I have worked in maintenance and it was no good. There were experienced agency workers with caseloads of 80 who have been replaced with young inexperienced staff and chaos will come. I see 10 people on some days, some for 10 mins and some for 45 mins, but I always book for 30 mins. They all collect the scripts here, when we sent them out to the chemists people did not come in. I have worked in other places where they sent them out and the DNAs will go up. I lot of people are still rolling up for a script and we are still prescription led. I don't think people have been reduced.*

13. *Similar, I see it as a business. CRI's view is not always realistic (e.g. get them in and get them out approach does not sit well). OK for those who are not dependent. Someone from CRI said 'you can offer them what you can offer them and then discharge'.*

14. *A lot of service users think they don't need support anymore and you think they do. You tell them that they can come back if something goes wrong. They get too much confidence too quickly. For example alcohol clients who get down to 2 nights drinking from 5 or 6 and then three months down the line they come back. You can't always put a time limit on recovery everyone is different. With alcohol 6 brief interventions over 12 weeks is good but some people need more. For those who have been in services for 10 years plus they may change but you can't expect it too quickly. We are all getting confused about tier 2 and 3. CRI is not creating clarity re the tiers.*

Appendix 5 – Additional points made in relation to an open question (section 3.10)

The shift to a recovery oriented service

Seventeen respondents cited ways in which they had witnessed a definite shift towards a more recovery oriented service since CRI had taken over the contract in East Lancashire. Evidence for this shift came from comments that people made about a new emphasis on recovery, on moving people on and on having much more to offer people. A number of workers specifically cited their ability to refer clients in to programmes such as DEAP and RAMP as something that had improved in the new system.

There has been a shift with CRI. In the old NHS service people got scripts for 20 years.

The emphasis on recovery is good.

People are working to a recovery model now.

From Lancashire Care it has massively improved and it is very positive. Lancadshire Care provided one to one and that was it. There is much more to offer people now.

I like CRI's philosophy better than Lancashire Care's. You get a bit more autonomy and we can refer on to things and it is not a car park.

The most important thing is that all I had to offer previously was the relationship whereas now there are lots of other things to offer.

The integration of drug and alcohol work

A number of workers cited the integration of drug and alcohol work as evidence of a new way of working, although this was not always welcomed or seen as something positive.

It has been a learning curve working with alcohol clients

The integration of drug and alcohol work is scary. I am more comfortable with drugs.

Transition from alcohol to drugs is hard. I never had a desire to work with drug clients.

CRI can't get their head around the fact that I have never worked with alcohol clients and it is not generic.

Preparing clients for the revised service

One worker said that they did not think that enough had been done to prepare clients for the shift and that some older standing clients in particular had struggled with the change.

> *As workers we knew what was coming, but clients weren't involved or consulted. For the new ones that is OK. But the older ones who have been here for 20 years have just had it imposed on them. There should have been better preparation.*

Service elements no longer available

Despite acknowledging that a number of new things were now available that previously were not, two workers also complained that some of the old services that had been offered prior to the establishment of Inspire had been lost.

> *ADS had a lot of aftercare groups and these have gone. Lots have complained about this.*

> *We used to have a facility for people to wash their clothes and learn to cook and budget.*

Developing a shared vision of recovery

Five workers said that they thought that further work was needed on developing a shared vision of what recovery meant.

> *Whose version of recovery are we measuring? The clients or ours?*

> *They could do with a brief presentation to all staff about what the CRI model of recovery is.*

> *Recovery gets viewed too simply. Either you take drugs or you don't. What does recovery mean? There is no agreement. Is it abstinence? Is it not committing crime? Is it not committing certain types of offences? We need to define recovery.*

Resistance to change amongst some staff

Five also talked about the resistance to change from some staff and one talked openly about their own resistance.

> *There are still a lot of the old dynamics within the team. Prejudices towards recovery. People come and deliver a training session and the staff take the piss. Old staff have ago at new staff and say what so inspiring about Inspire. A lot of it is quite juvenile.*

I get a buzz out of seeing people recover and see the changes people make. Some staff have lost their motivation.

I would prefer to be back under the NHS because the whole focus was on clients rather than on stats and targets

Skills development

Eight talked about specific skills that the workforce needed to develop. Some of these related to how workers integrated recovery measures in to their practice; some related to the need for more training for alcohol workers to enable them to work with drug users; and some related to other areas such as specific specialist areas such as child protection.

The workers skill in introducing paperwork is important

How do workers use recovery measures as tools for intervention rather than just monitoring tools?

I am mainly an alcohol worker and that is my expertise. I have a lot to learn about working with drug clients.

We have a lot of alcohol workers titrating scripts on minimum training.

Alcohol clients

Eight respondents said that they felt that alcohol clients received a second rate service compared to drug clients. This manifested itself explicitly in the fact that alcohol clients were limited to the number of treatment sessions they could receive. Workers also complained about a less tangible sense of inequality however, reporting a sense that *'everything is focused around drug clients.'*

Alcohol clients get six 30 minute sessions.

There is an inequality between drug and alcohol clients.

TOPS

Three workers took the opportunity to re-iterate their criticism of TOPS, complaining in particular about the difficulties they perceived around the questions to do with crime and drug use. They also re-emphasised the fact that they felt that the answers that clients gave to questions could depend on the day that they were asked and the mood that they were in.

Limited availability of some services on some sites

Three workers also chose to use the opportunity to talk about the current unevenness of service availability across the sub-region, bemoaning the lack of some services, such as RAMP, DEAP and Work Solutions in Clitheroe and Pendle.

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