THE INTEGRATED RECOVERY MODEL

How NRP service provision will work in practice

NRP is a partnership between Norfolk and Suffolk NHS Foundation Trust Drug and Alcohol Service (TADS) The Matthew Project (TMP) and the Rehabilitation for Addicted Prisoners Trust (RAPt)

NRP is commissioned by Norfolk County Council on behalf of the Norfolk Drug and Alcohol Partnership (NDAP)
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1 Introduction

This briefing has been written to explain how Norfolk Recovery Partnership’s integrated service recovery model will work in practice. It is written primarily with the professional practitioner in mind.

1.1 A basis to build on

1.1.1 The Norfolk Recovery Partnership (NRP) integrated recovery service model is based on the requirements of the commissioner, Norfolk Drug and Alcohol Partnership, for integrated community, criminal justice and prison-based interventions plus a shared philosophy between the commissioner and NRP members that recovery from drug and alcohol addiction is a unique, person-centred journey, best supported by addressing service user needs holistically.

1.1.2 With this in mind, a set of shared values have been defined and agreed as the basis on which the NRP integrated recovery model has been developed.

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<td>Locally Owned</td>
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<td>Full of Added Value</td>
<td>Promoting Recovery</td>
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1.2 The main components of the new model

1.2.1 The seven pathways to recovery (plus addressing the impacts of domestic abuse and sex working) have been major considerations when designing the new model. The model embodies these pathways by defining its own comprehensive
pathway network, enabling seamless transition between and integration of outreach, care coordination, low, high intensity and family focused interventions and aftercare support.

1.2.2 NRP will actively engage with external local agencies to build productive working relationships, agencies whose core business will enable service users’ recovery capital to increase, improving outcomes for them and their families, and ensuring they are able to maintain their recovery.

1.2.3 Service user involvement has been intrinsic to the models development, and will continue throughout its delivery lifetime.

1.2.4 NRP’s new approach to service delivery covers all modalities across all of Norfolk, with a range of intensities for both alcohol and other drugs that integrate prison and community-based services, and that sets up clear recovery pathways for prisoners being released or transferred elsewhere. This will lead to the creation of whole systems approach in which NRP ensures excellent communication about and continuity of treatment between custody and community, addressing the challenge of integration between criminal justice and non-criminal justice activity, core NRP and other mainstream services and supporting service users between locations and modalities.

1.2.5 The model has five essential components:

Three Integrated Recovery Pathways
The Open Access and Outreach Function
The Single Assessment and Care Coordination System (SACS)
Recovery Services
Aftercare Services

1.2.6 The diagrams in Appendix 1 illustrate the relationship between all five components. The first shows how these fit together from the service users view point, and the family, friends and carers perspective. The second shows how the components relate to NRP team functions and roles.
2 The Recovery Model in Practice

2.1 Introduction

2.1.1 Effective implementation of the integrated recovery service model depends on all NRP staff being fully aware of how the new model is intended to work, which means understanding the functions it comprises, the roles of individuals and teams within it, and the route people accessing services can take along the three connected recovery pathways identified.

2.1.2 There is a wealth of skill and experience within NRP that will contribute to the development and delivery of a fully integrated service. Volunteer and service user involvement will enhance the effectiveness of whichever recovery pathway is followed or intervention offered.

2.1.3 Norfolk has been divided up into 5 separate localities, centred on major population centres and the 3 prisons – creating the northern, southern, western, eastern and central localities. The goal is for the services that NRP offers to be easily accessible and readily available across all 5 localities, including the prison estate, ensuring continuity and consistency of service quality and provision, irrespective of whether a service user is in the community or in custody. NRP will also ensure that there is a seamless transition when a client moves between community and prison, and vice versa.

2.1.4 The recovery model is underpinned by the goal to fully integrate NRP service delivery with those services provided by a wider body of agencies; services that can support the individual’s recovery. This is core to the design of the model. One of the principles of the vision for the new treatment system is that it should make full use of mainstream and wider support services to enable service user recovery and quality of life improvements against required outcomes.

2.2 The Integrated Recovery Pathways (IRPs)

2.2.1 The IRPs create opportunities for people to overcome the disruption and difficulties that substance misuse causes to individuals, their families, carers, friends and the community in which they live.

2.2.2 The IRPs constitute three different aspects of a journey that, if embarked on, will create a route to recovery for people affected by their own or someone else’s substance misuse. Between them, they account for all the different impacts that people might be experiencing. The pathways followed depend on the needs of the individuals seeking help from NRP and will take into account changing needs over the course of any recovery journey undertaken. The three IRPs are:

1) **The Low Intensity Pathway**, supporting those who require information, advice, motivational interviewing, and other non-structured interventions and groups

2) **The Structured Treatment Pathway**, following a comprehensive assessment undertaken through the SACS, resulting in provision of a range of structured and more specialised interventions by the Recovery Teams

3) **The Family and Friends Pathway**, supporting family members who come to the service seeking their own support or to support a service user’s recovery journey, which will include a carer’s assessment and group/individual support.
2.3 The Integrated Recovery Service Concept – NRP’s core role

2.3.1 NRP’s Single Assessment and Care Co-ordination System (SACS) will offer a single point of contact for access to all its services, whether advice, group work, counselling, medical interventions, outreach or aftercare for service users.

2.3.2 Family, friends and carers of drug and alcohol users can also access help and advice from NRP. Those close to someone accessing the service may need support in living with an addiction and playing their part in the recovery journey.

2.3.3 Service users will have a dedicated Care Coordinator who will agree with the service user, and family and friends where appropriate, what range of interventions from low intensity through to structured will build recovery capital as part of their recovery care plan, along with what other services that wider stakeholder agencies can provide that will help in this, and will identify key workers needed to support them at different stages of their recovery journey.

2.3.4 Recovery service provision requires a suite of specific functions, support and interventions to be available that will meet the varied needs of those referred to NRP. These define what skills and experience NRP needs in its workforce and, coupled with an assessment of needs across the county, the number of staff needed in each sub-set of the recovery team. The teams will provide the interventions needed within the overarching integrated recovery service model, including specialist support for service users who receive a comprehensive assessment and require structured interventions to support their recovery journey.

2.3.5 Interventions will include structured psychosocial interventions, clinical interventions and short and long duration programmes in the prison. Service users who receive interventions from what NRP terms the Recovery Team will still be able to access Recovery Café based services and support and other aspects of the open access service needed to complement their recovery journey.

2.3.6 Recovery services are central to boosting service user recovery capital, leading to robust and sustained recovery and reducing the intensity and severity of addiction and the impact upon community that this causes.

2.3.7 A menu of interventions will be available, including:

- Group work – which includes; Making Changes groups, Relapse Prevention groups and Structured Day Programmes
- Alcohol Dependency Treatment Programmes, Bridge Programme, and Stepping Stones Programme in prisons
- Family and friends groups and one-to-one support
- Volunteer/Mentoring workshops
- Support for pregnant women with substance misuse problems and parenting guidance
- Blood borne virus health screenings
- Prescribing medication to enable recovery
- One-to-one support
- Counselling
- Mental health and substance misuse liaison
- Accessing inpatient detoxification and rehabilitation placements
- Community Detoxification
- Assessments and support in Police Investigation Centres and Courts, and with Probation and Prisons through community and custodial sentences
- Working with partner agencies in housing, employment and training
- Outreach services within acute hospitals, hostels and homeless centres
- Needle Exchange

2.4 Getting connected to the recovery system

2.4.1 The Open Access and Outreach Function

2.4.1.1 This function opens up the recovery pathways for vulnerable or at risk groups through proactive intervention by substance misuse workers, including homelessness and street workers outreach, arrest referral and criminal justice interventions at Police Investigation Centres (PICs) and Courts, and liaison with acute hospital services. These interventions have operated previously but under the new service there will be greater linking of these interventions to maximise engagement.

2.4.1.2 The purpose of the Open Access function is to connect people with all recovery services, supporting self-referral, drop-in, telephone support, information via the internet, referral from statutory and third sector agencies etc. Once connected, individuals will be offered an initial assessment, perhaps at one of NRP’s open access locations, a Recovery Café, a PIC, the hostel they live in or other appropriate venue (e.g. a local GP surgery, home visit, etc). There will be five open access bases established in King’s Lynn, Norwich, Great Yarmouth, Thetford and North Walsham.

2.4.1.3 In terms of the Open Access function links to prison-based interventions, prior to being sentenced, an offender will be offered the opportunity to access treatment through contact with a community justice (CJ) worker who will have a presence in all three PICs (Wymondham, Aylsham and Gorleston) and the local Magistrates’ Courts. The CJ worker will “sell” the benefits of treatment at every opportunity, and provide timely and accurate information relating to an individual’s treatment options which will meet their needs. The new model will allow an offender access to the totality of treatment and support available across NRP.

2.4.1.4 If the offender is willing to access treatment and support at this point, they will be taken onto a CJ worker’s caseload, with every effort made to maintain the continuity of worker from the initial contact. This worker will become the care co-ordinator. If the offender is a Class A drug user and meets the criteria, they will be taken onto the criminal justice work caseload. If not, interventions will still be co-ordinated by the CJ Worker unless it is genuinely more practicable for them to have another worker (e.g. if they are already established in treatment). If the offender is not willing to engage, or subsequently disengages, this information will be made available to relevant stakeholders.

2.4.1.5 The overall aim of the CJ Worker at the pre-sentence stage is to engage the offender in effective treatment and maintain their motivation to remain in treatment. This will mean that the CJ workers can liaise closely with RAPt workers in prisons, so that treatment and support requirements are known in advance of reception at the prison should the client end up with a prison term.

2.4.1.6 Workers delivering Open Access services will also spend time in the Recovery Cafés providing another opportunity to offer the low intensity interventions expected via outreach work. The Café’s will create a safe and welcoming environment where workers will provide a menu of low level interventions as well as undertaking assessment work. Open access and peer support groups will enable those who are less motivated to establish stronger links to the service when they require them. This will include access to mutual aid groups, housing support, training and employment opportunities and local community groups.
2.4.1.7 The Open Access Service will operate in a variety of settings across Norfolk, with support also available interactively on the website. This aspect of the model includes the aim to engage service users at early stages of their alcohol and drug use, so that appropriate interventions can be offered to halt further progression to dependence.

2.4.1.8 Individuals receiving early interventions will be tracked to determine whether they continue to present with acute and/or escalating substance-related harm issues. This will be a reliable indicator of whether the services have reduced, for example, the likelihood of hospital admission for these service users.
3  Focusing on Pathways & Processes

3.1  Open Access Service

3.1.1  Walk in and booked appointments and assessments will be offered at the five main open access locations and a range of other venues, addressing the challenge of accessibility in rural Norfolk. Consultations will be offered to professionals, family and friends.

3.1.2  On arrival at one of the five main open access centres, service users will be greeted warmly by the Welcome Team of volunteers, mentors and befriender and introduced to a menu of low intensity support services, including:

- A Recovery Cafe
- Drop-in services e.g. needle exchange
- Initial Assessment including safeguarding and risk assessment, plus access to Comprehensive Assessment if required
- Community Care Assessment
- Signposting to housing/health/employment/training services, and in-reach sessions by workers from other agencies
- Recovery Community activities and Mutual Aid (AA, NA, Open activities)
- Start-up groups, peer support groups
- Family and Friends or Carer’s Assessment, Carers Group, one to one support

3.2  Single Point of Contact (SPOC)

3.2.1  There will be a primary administration base for the county with dedicated telephony team, one NRP phone number, address and website. The primary administration team will route all calls to appropriate localised centres as well as providing information and high quality advice to the caller, whether a service user, family member or professional.

3.2.2  A competent team will be available Monday to Friday 0800-1800, Thursday to 2000, responding to the needs of anyone calling to refer, seek advice or information or leave messages. The 24/7 helpline facility will be operated by Telephone Helpline Association trained Matthew Project (TMP) staff, supported by senior managers. Dedicated telephonists will answer daytime calls and forward to the appropriate services across the county. This will be a local rate and text-capable phone service between 0800 and 1800. Future innovations will include online access via email, text and social networking. An interactive website will also serve to publicise the service, its opening hours, locations, and the range of interventions available.

3.2.3  SPOC staff will be trained to high customer care standards, with thorough knowledge of all aspects of the services available. SPOC staff will offer advice about substances, information about local services, and signposting to other services (e.g. The Wellbeing Service, The Samaritans etc). Phone referrals will be taken from individuals, family, friends, GPs, Probation, Prisons and any other statutory or third sector agencies. SACS will also provide a referral route for carers and significant others.

3.3  Referral Method

3.3.1  Self referrals will be accepted via drop-in at open access centres, by telephone, letter, email and through the website. Referrals may come directly as a
result of outreach services provided in PICs, the Courts, street outreach and work by other agencies or teams within NRP.

3.4 Connecting people to the Pathways - promoting services to potential service users, friends and family

3.4.1 Awareness will be raised as a result of an on-going media and publicity strategy promoting the service, including regular media campaigns, a major county wide and local launches in each of the localities, mail outs to all key stakeholders with posters and information leaflets, radio and television coverage and the NRP website which will promote services and how to access to them.

3.5 Facilitating a wide range of referrals

3.5.1 Self-referrals and referrals from family and friends will remain a priority source. Referrals will be encouraged from all sections of the community including, Primary Care, Secondary Care, Acute Services, Housing and Employment agencies, Social Services including Children's Services, the Voluntary Sector and the Under18 Service.

3.6 Unstructured Activities

3.6.1 Available to all via Open Access, these activities will be facilitated by volunteers and service users in Recovery, family and friends, enhancing the service user’s life-skills and knowledge. Basic IT skills training will be available.

3.7 Accessibility

3.7.1 Where rural referrals are low and cannot support a specific group, individual treatment plans will focus on one to one work and referral to non-SDP initiatives for example the Relapse Prevention Courses, the Wellbeing group (Mutual Aid Group) and Abstinence groups.

3.7.2 There is additional provision for a six week rehabilitation/relapse prevention programme which is structured and needs-led. Locality specific good practice will be considered for mainstreaming into the SDP. Recovery capital opportunities will be prioritised.

3.7.3 NRP will make an intensive abstinent SDP available to a small number of service users whose recovery may be dependent on staying near family and are therefore unable to commit to a longer stay rehabilitation programme.

3.7.4 Additional interventions provision will be available for specific needs, such as female only groups. Attention will be paid to making the programme accessible, for example, looking at childcare provision.

3.8 Aftercare

3.8.1 Aftercare services are an integral part of the Open Access function. This is promoted from the commencement of treatment to encourage and support recovery from addiction. Aftercare provides clear support to prevent lapse, relapse and help realise all the positive outcomes possible from the pathway travelled.

3.8.2 Aftercare will include a stronger focus on service user-led groups and mutual aid groups that link into the local communities where service users live. There will be
opportunities for service users to access support for training and employment throughout their recovery journey, promoted through the Aftercare menu of options.

3.9 The recovery community

3.9.1 NRP will create a network of recovery communities across Norfolk, in partnership with NDAP, encouraging existing service user groups to setup their own support networks, operating autonomously and linking with other local provision including mutual aid groups. On offer will be:

- Wellbeing Groups, Mutual Aid Groups
- Extracurricular Activities – walks, healthy eating, leisure activities
- Volunteering, Mentoring and Befriending opportunities, training and workshops
- Access to Employment, Housing and Training services organisations
4 Prison links to the pathways in particular

4.1 Outreach

4.1.1 Community-based criminal justice recovery workers will attend all Norfolk PICs and Courts to engage, motivate and assess offenders with treatment needs, following this with communication with NRP colleagues in the relevant prison should an offender be remanded into custody

4.2 SACS

4.2.1 Community-based criminal justice recovery workers will care co-ordinate all criminal justice clients with a Norfolk address throughout their criminal justice recovery journeys, whether they are in the community or in custody. Non-Norfolk residents in custody will be care co-ordinated by prison-based NRP workers

4.3 Low intensity pathway

4.3.1 Peer support initiatives (PLUS programme) harm minimisation, brief interventions, motivational work, brief-solution-focussed therapy, low-intensity groups (educational/Integrated Drug Treatment System-style groups) will be available

4.4 Structured intervention pathway

4.4.1 The structured intervention pathway in prison adds the following components to the overall pathway through NRP:

- Psycho-social interventions (all 3 prison establishments)
- Stepping Stones Programme (HMP Norwich for remand and sentenced prisoners; HMP Wayland for sentenced prisoners)
- Alcohol Dependency Treatment Programme (HMP The Bure)
- Substance Dependency Treatment Programme (HMP Wayland)
- The Bridge Programme (HMP Norwich)
- Links into clinical treatment pathway – ongoing discussions with Integrated Drug Treatment System (IDTS) to culminate in joint-working protocols ensuring all elements of PSI 45/2010 are adhered to

4.5 Family and Friends pathway

4.5.1 Family, friends and carers for whom the prisoner has given consent to contact will be invited to participate in the treatment programmes of prisoners who are undertaking ADTP, SDTP and The Bridge.

4.5.2 We are looking at developing ways of working within the three prison visitors’ centres to highlight the NRP Friends and Family community-based provision and support for those whom consent to contact has not been obtained. We will work with families to broker them into support in their home communities, both into statutory services and into self-help groups.

4.6 Aftercare

4.6.1 Peer supporter training will be offered for those graduating from the in-prison programmes following assessment of their suitability and a recruitment process, with
the subsequent opportunity to engage in peer support for those detoxifying from substances as well as supporting the variety of treatment interventions being delivered in their establishments.

4.7 Pathways between prison and community

4.7.1 These operate on several levels.

- **Pathway into prison via NRP community services:** whether from PIC or court, SACS worker will immediately inform the RAPt prison team of a service users imprisonment. In the event of a service user being sent to a non-Norfolk prison, the prison team will track the client and inform the SACS team of their whereabouts.
- **Norfolk resident into prison:** retains SACS worker and has temporary named prison key worker who liaises with SACS.
- **Non Norfolk resident into prison:** prison care-coordination takes over management of the service user and liaises with home area criminal justice teams/workers.
- **Norfolk resident into Norfolk prison via transfer:** immediate referral to SACS team for worker allocation. Named prison temporary care co-ordinator liaising with the SACS worker.
- **Non-Norfolk resident into Norfolk prison via transfer:** Prison worker retains care co-ordination and liaises with home criminal justice teams/workers.
- **Women:** Norfolk residents tracked through system and meet and greet brokered on release (Joint working between SACS and psychosocial team in Peterborough prison). We will track female prisoners through the system and deploy female workers, volunteers, or peers to meet and greet on release. Unplanned releases will be followed up by ‘phone contact and staff will enquire whether the client will continue to engage.

4.7.2 RAPt will ensure that: there is close joint-working with all prison departments by prison teams and SACS, including primary healthcare, Mental Health Team (MHT), Safer Custody, Security, OCA, and Resettlement etc; there is joint care-coordination with MHT and/or primary care team for complex clients. There will be a mental health screening process for all programme clients - ratified by MHT. Pathways to Wellbeing Service in Prison and the newly commissioned Personality Disorder Team will be formulated.

4.7.3 Overall, RAPt will ensure that the service is embedded in and influencing prison care and recovery culture. Criminal justice teams/workers teams outside Norfolk will be contacted by NRP staff, volunteers, peers, fellowship, mutual aid groups will be invited to fulfil this function.

4.7.4 Norfolk residents will have meet-and-greet by NRP staff, volunteers, peers, family or fellowship members. Liaison with these support networks will be led by SACS and prison team. All relevant operational policies will be jointly Community and Prison focused.
5 Recovery service provision

5.1 Psychosocial interventions in the prisons

5.1.1 The Psychosocial Teams within the prisons will act as key workers whilst service users are in custody, and will also complete a comprehensive assessment with prisoners if they are previously unknown to community-based services. This will provide the single pathway required by commissioners for the criminal justice clients, based on enhanced communication and service consistency between the prison-based and community-based recovery teams on release, thereby reducing the risk of non-engagement and repeated cycles of offending.

5.1.2 Welcome packs will be offered to everyone, containing information about the service, community mutual aid groups, PALS complaints/suggestions forms, and the DAAT Code of Conduct. Node maps will be prominent in reception areas, demonstrating visually for service users their path through the system. Teams will provide drop-in advice and information services which will include needle exchange, injecting assessment, health screens, Chlamydia testing and smoking cessation advice.

5.2 Medical interventions

5.2.1 Specialist medical staff, which will include the Lead Clinician, will be available for the whole service to call on and will focus on prescribing elements of intervention work. They will also be supervising Nurse Prescribers, overseeing the inpatient facilities, consulting with other professionals including GPs, Acute Hospital medical staff and mental health medical staff. These specialists will provide services, cover and support between the five localities, based on the level and nature of demand for specialist medical service interventions and support required. The medical team will also provide substance misuse-related complex needs assessments for service users when appropriate.

5.2.2 NRP envisages prescribing in the following situations:

- time-limited and longer-term prescribing for opioid, stimulant (Amphetamine) and (in exceptional circumstances) benzodiazepine misusers. In the case of opioid misusers this will include oral and injectable medications
- prescribing medications for Alcohol Use Disorders (AUD) to promote abstinence and (in certain circumstances) controlled drinking
- detoxification for drug and alcohol misusers: community and inpatient settings. This will involve prescribing specific medications (e.g. for opioid and alcohol detoxification) and offering symptomatic treatment (e.g. for stimulants).

5.2.3 NRP has evidence-based guidelines in place for every aspect of prescribing mentioned above. These guidelines will be reviewed and updated regularly, in accordance with emerging evidence and latest national guidance (NICE, NTA). The Norfolk and Suffolk NHS Foundation Trust (NSFT) Clinical Governance Committee, Pharmaceutical Advisory Committee (PAC), and Treatment Advisory Group (TAG) (NHS Norfolk) will have input into the guidelines.

5.2.4 Prescribing will commence within seven days of need being identified via the comprehensive assessment process. NRP has highly experienced consultant psychiatrists, staff grade doctors and experienced qualified nursing staff, some of whom are non-medical prescribers who will be responsible for initiating service users onto medication in a structured manner, monitoring prescriptions and managing
detoxification programmes. NRP has detailed evidence-based prescribing guidelines in place, which will be updated regularly. Governance will be overseen by NRP’s Clinical Governance Group under the guidance of NSFTs Clinical Governance body.

5.2.5 NRP enjoys excellent working relations with all the pharmacies and the substance misuse pharmacy leads of the larger companies in the region and is aware of their opening hours and critical policies. Once a service user has commenced on medication the care coordinator will phone to inform the appropriate pharmacy (decided following discussion with the service user) about prescription details. All the pharmacies will have a telephone number to contact regarding any issues or concerns they may have. For example, NRP has existing arrangements whereby the pharmacies automatically inform the NSFT Alcohol and Drug Service (TADS) if the service user fails to pick up script for three consecutive days. This will trigger urgent assessment of the situation by the appropriate staff. NFST brings the added value of specialist pharmacy resources, with experienced and skilled pharmacists and technicians that can provide expert advice and information for GPs, service users, and hostel staff regarding drug interactions and the changing profiles of misused drugs.

5.2.6 The prescription arrangements (e.g. pick-up frequency, level of supervision) will be regularly reviewed by the care coordinator and the service user. The Medical Team will be available to provide advice on any changes to these as needed. NRP strongly believes in individualising these arrangements following careful risk assessments, taking into account personal circumstances and other needs.

5.2.7 NRP has shared care arrangements with Primary Care for prescribing for drug misusers and plans to incorporate prescribing needs for alcohol service users into this. Where GP surgeries have entered shared care, a named shared care nurse will be available for advice and support and to ensure effective and timely communication. Medical staff from NRP will provide back-up and offer assessment and advice where required.

5.2.8 NRP views prescribing as an important intervention, and an element of comprehensive treatment packages aimed at recovery. The prescribing interventions, whilst thorough, will always be combined with psychosocial interventions and will form one of the elements of individual recovery care plans. NRP will motivate people through the prescribing system by identifying the individual’s potentials via a recovery focused care plan and node-link mapping. By concentrating on people’s strengths and supporting individuals to realise their goals using a ‘smart’ approach, with psychosocial interventions a key component, this will build on the person’s recovery capital enabling them to become abstinent and continue their recovery pathway.

5.2.9 Volunteers, mentors and befrienders who are involved in all parts of the treatment system will inspire those at the start of their episode treatment to work towards recovery and those who have been in receipt of long term prescriptions, whether by specialist services or GPs will have a complete review of their needs and goals and agreed plans will be made to motivate and inspire them to work towards abstinence and onto recovery.

5.2.10 A significant proportion of service users have mental health needs. While not a requirement within the service specification, comprehensive assessments of mental health will be offered by psychiatrists and mental health nurses within NRP and advice offered to primary care and of course, NRP is able to draw on the wider Trust to deliver assessments and mental health services, so where indicated liaison with the appropriate mental health team will be arranged; there are existing pathways for effective liaison with mental health as well as physical health (e.g. Pain Clinic, Liver
Clinic) and close collaborative work is undertaken for service users with complex needs. Evidence-based psychosocial interventions (Motivational Interviewing, Cognitive Behavioural Therapy), Individual and Group Work, Family Interventions (including utilising experiential knowledge of family members in therapy), Structured Day Programme, vocational advice and training, and addressing other needs such as accommodation, are key components of the recovery process for those with complex needs. NRP sees prescribing interventions as one of the aids to stabilise and assist service users to realise their recovery goals from substance misuse and mental health.

5.2.11 NRP appreciates that individuals have unique needs and are frequently at different stages of their recovery journey. The duration of the medication assistance will be individually determined via multidisciplinary care plan reviews lead by the care coordinator, as well as prescribing reviews (by medical staff) for all service users, including those in shared care. Following extensive audits, NRP has developed evidence-based guidance to accurately identify service users likely to require long-term prescribing. The progress of all service users towards recovery will be reviewed and monitored at every stage.

5.2.12 NRP appreciates that a proportion of service users will have long-term prescribing needs to maintain the progress and gains achieved while in treatment. The special needs of this population (e.g. mental and physical health, employment and family status) will be carefully monitored and met via care planning and prescribing reviews. The rationale for long-term prescribing will be clearly delineated in the care plans and will be reviewed regularly to ensure that on-going medication assistance is essential for maintaining treatment goals. Reviews can be used to see if progress against recovery goals can be made and movement towards this can be facilitated. i.e. the rational for long term prescribing should not be set in stone.

5.3 Social Care

5.3.1 There will be a group of workers covering the whole county and offering the statutory functions of community care assessments (Section 47 NHS Community Care Act) and work with service users towards rehabilitation and personalised budgets. The team will also link in and work closely with the Family Work Team and Complex Needs Team.

5.4 Complex Needs

5.4.1 These staff support service users who have dual diagnosis issues and learning disabilities. The medical team might contribute to this, but the main remit is to ensure engagement with appropriate mainstream services, working with a recovery focus and improving stability. Workers will engage with mental health services at all intervention levels, including the Wellbeing Service, Assertive Outreach, Older Persons Services, and non-statutory services to ensure that appropriate care is received. For learning disabilities (LD) the team will liaise with LD services as well as ensuring that all documentation is appropriate for the needs of the service user. The goal will be to develop joint approaches and working with these other teams to achieve recovery goals. NRP will always look for ways to work with wider services to improve client outcomes in ever more innovative and dynamic ways, and not just for those with complex needs.

5.4.2 The staff will work closely with Housing Trusts across Norfolk, Primary Care, and 3rd sector organisations who engage with service users with complex needs and who have disengaged with secondary services. The team will provide the service
lead in Safeguarding Adults, covering meetings and training sessions, and cascading learning to all the staff within NRP through workshops and supervision.

5.4.3 For service users with mental health problems this will ensure that this complex and vulnerable group access the specialist healthcare that is required and for clients with learning disabilities this will increase the ability of staff to respond to the complexity of communication problems.

5.5 Family Work

5.5.1 Key workers offering family interventions will do so for service users who have children and/or trigger Section 47 Children Act 1989 requirements or who are pregnant. Workers will continue to operate within the framework of the pregnancy protocol established by Trust Alcohol and Drug Service (TADS) with ante-natal services. Workers will attend core groups and case conferences and lead on Safeguarding Children activity and field participants for all related meetings and training sessions, cascading learning to all NRP staff.

5.5.2 This team will also offer intensive parenting support (pre and post birth) and will be central in ensuring safe pregnancy for mother and child, newborn health and development and assist with the assessment and development of parenting capacity to improve children’s development and parental wellbeing. There is also a range of other work undertaken, such as connecting people with Al-Anon, family support networks, carers assessments and more. NRP recognises the impact of addiction on family life and family members and has planned to address these wide ranging issues via the services these workers provide and those they can connect people with.

5.6 Shared Care

5.6.1 Norfolk Recovery Partnership (NRP) will build on its excellent relationships with Norfolk GPs in the existing shared care scheme, developing existing practices, and ensuring current treatment continues on transition into the new system. NRP will work with existing GP partners to extend GP shared care arrangements in both rural and urban settings by encouraging other GP surgeries not currently in the scheme to join. NRP will hold regular briefing forums with current GP partners and those interested in joining to explain in more detail recovery focused services and links to shared care. NRP will look to take this work forward in partnership with the DAAT and Norfolk County Council, who hold the shared care contracts, and continue to develop collective understanding and commitment to this aspect of the recovery pathway as part of achieving service user care plan goals.

5.6.2 Current shared care surgeries have a dedicated liaison nurse to support work with substance misuse clients who are in treatment and registered at their practice and TADS medical staff are available for telephone advice and support. Medical and substance misuse-related complex needs assessment and advice is offered at the GPs request and this will continue. Where required, these assessments may lead to a referral to mainstream mental health services. GPs will be offered on-going support and training around specialist substance use issues pertaining to shared care. Partnership staff will deliver this as part of informal GP meetings and there will be an opportunity for GPs to attend an annual evening forum for update and networking purposes. This will build on the success of existing local GP forums.

5.6.3 GPs are central to the recovery of the service user and it is imperative that GP surgeries and their staff are fully aware of NRP and what it can offer. NRP is committed to delivering a transparent, communicative service to ensure that the GPs
are aware of the service mission statement and referral pathways. It will be vital that existing shared care GPs are fully aware of the new service. Continuity of care is imperative for the service user and therefore GPs will be kept in touch and up to speed with all changes by a Care Coordinator.

5.6.4 NRP will offer information directly to GPs through forums, newsletters and meetings to ensure communication reaches all relevant bodies, sectors and professionals.

5.6.5 NRP will develop a training and vision process to be delivered to shared care GPs to encourage and further develop the recovery agenda within primary care. Many GPs currently involved with NRP are aware of the recovery model and are supported by NRP to move towards this in collaboration with the service user.

5.6.6 NRP envisages that GPs will be able to refer those who have been identified as having need for community alcohol detoxification directly. The Joint Strategic Needs Assessment for Norfolk and the Needs Assessment undertaken by the DAAT outlines the prevalence of harmful drinking in the county, with 16% (c.86,000 people) binge drinking, and an alcohol dependence prevalence of 81 per 1000 in the age range 16 to 64 year. In recent years, the Norfolk and Norwich Gastroenterology Department has seen an increasing number of younger people, and younger women, presenting with health issues related to increased binge drinking trends. NRP recognises the public health concern for many GPs around harmful and hazardous drinking. Where NRP offers direct links into a home detoxification service, for those who need detoxification and/or brief interventions, this will reduce bed days in acute hospitals and assist GPs in intervening earlier.

5.6.7 Where shared care arrangements exist, service users will be encouraged to be reviewed by both their GP and Care Coordinator at the same time every three months or sooner if necessary. This enables three way communication that encourages the GP to be involved with the care of the substance using service user; allows immediate referral or treatment for physical health needs as deemed necessary by the GP; and enables the Care Coordinator to ensure that recovery capital is considered alongside generic primary care needs, ensuring a holistic care planning approach for each service user. Medical staff within TADS will provide back up and where necessary offer specialist assessment and advice.

5.6.8 All care plans, risk assessments and recovery progress reports will be shared with GPs as part of the treatment journey to recovery. The GP will be clearly identified as a significant player in the recovery journey, especially at the point when a service user becomes ready for shared care. Local arrangements will be made within the shared care partnerships for responsibilities regarding provision of Hepatitis B vaccination programs and Blood Borne Virus (BBV) screening.

5.6.9 Regular clinics will be held within GP surgeries, allowing for Partnership staff to be a visible, accessible resource for primary care and GPs. This will enhance the profile of liaison support and hence the reputation of NRP. Clinics in GP surgeries offer service users the opportunity to be seen within their community, reducing the potential stigma associated with attendance at substance misuse bases. This can give the service user a real sense of moving forward in their recovery.

5.6.10 In accordance with shared care arrangements, the shared care liaison nurse will ensure that the GP practice is supported to record the categories of patients in order to claim payment accordingly. NRP will support GPs in accessing and liaising with the commissioners regarding the Local Enhanced Service.
5.7 **Health Promotion**

5.7.1 This is an important element of recovery service provision, being part of taking a holistic view of recovery needs. Nurses will be running start-up clinics for all new prescriptions and review clinics for all service users who are in receipt of recovery services. They will provide health screening and Hepatitis B vaccinations for service users. These nurses will also act as first point of contact for community pharmacists and will establish partnerships with nominated community pharmacies to develop review clinics at their premises.

5.8 **Acute Hospital Liaison**

5.8.1 NRP will field onsite clinical nurse specialists (including non-medical prescribers) who will accept referrals from and liaise with all acute hospital departments, as well as supporting the open access service. Direct referrals from patients, relatives or carers will also be accepted, leading to assessment, fast track into drug and alcohol treatment, advice, signposting, brief interventions, titrations, monitoring and prescribing. This will facilitate reduced hospital admissions.

5.8.2 Onsite joint assessments will be conducted with mental health, older peoples and learning disability liaison teams, and Social Services. NRP will work jointly with pain management teams and conduct monthly outpatient Chronic Opiate Clinics, established for opiate dependent patients with pain management issues.

5.8.3 NRP will work closely with maternity units (including single point of contact referral); monthly multi-disciplinary meetings will be held to review pregnant individuals with alcohol/substance misuse problems. Close working with gastroenterology teams will enable triage of alcohol dependent patients with liver disease when appropriate. Current collaborative detoxification arrangements enable early discharge and aftercare support via appropriate community services (drug/alcohol, GP, mental health). This will help prevent re-admissions.

5.8.4 Multi-disciplinary team meetings will be conducted with Accident and Emergency (A&E) departments monthly, and multi-disciplinary patient safety walkabouts attended. Teaching for medical and non-medical staff of all grades on training days will increase awareness of drug and alcohol issues. Clinical guidelines for drug and alcohol treatment will be regularly updated. Collaboration with hospital and community pharmacists will enable safe and effective prescribing.

5.8.5 Data analysis will be undertaken in partnership with the Acute Hospitals to examine activity within A&E, outpatient and inpatient departments including non-elective admissions and number of bed stays. Retrospective data can be obtained to identify patterns of admissions. Qualitative data will be obtained by patient reported outcomes and staff feedback surveys.

5.8.6 NRP’s countywide integrated electronic patient record system will enable in-depth analysis of data across all pathways of the service and identification of drug-related hospital admissions and A&E attendances. We will work with commissioners to institute a system of checking hospital admissions and A&E attendances against our client database (subject to confidentiality agreements) and match prolific A&E attendees, or frequent admissions to hospitals, against GP lists to encourage early interventions in primary care. Evidence-based interventions targeted at at-risk groups have been successfully provided by partners in previous projects and will continue in the future.
5.9 Community Detox

5.9.1 NSFT will cover the county and offer community detoxification after assessment. The workers responsible for this element of the service will take priority requests for detoxification from the acute hospitals (who require specialist rapid response) at the point of a comprehensive assessment as well as from the wider group of recovery service workers in the overall system. They will also liaise with the specialist inpatient facilities. Workers will provide prompt opportunities for detoxification in communities or inpatient units enabling individual abstinence focused interventions for those with high recovery capital.

5.10 Volunteers

5.10.1 Norfolk Recovery Partnership recognises the vital role volunteering can play in a service user's recovery journey as well as the contribution volunteers can make to enhance the overall quality of service provision and welcomes the variety of roles that volunteers can provide to enrich the experience for users of the service. NRP accepts and promotes the vision of the National Drug Strategy that the treatment sector should promote social action by service users by encouraging and enabling people to become more active in society. NRP has a history of successful engagement with communities where local community champions have been deployed effectively to address issues of confidence around safety when supporting recovery in the community.

5.10.2 Volunteers or mentors who are in recovery can offer inspiration and support to other service users, and provide essential links to the recovery community. They can be natural outreach workers who can access treatment naive users and support re-engagement and social inclusion. To support this, efforts will be made to recruit volunteers from all ethnic communities and hard to reach groups.

5.10.3 Across the Partnership the recruitment process will be:

- informally meeting with the Volunteer Co-ordinator or local manager to discuss their interest in volunteering. The Partnership will ensure that individuals in recovery have established protective support networks to prevent relapse and re-addiction
- availability of the volunteer will be considered (RAPt expects 2 full days per week for prisons and 1 full day per week for community) as well as what the volunteer is hoping to gain from the role, their experience with service user groups; where they live and where they can reasonably be expected to travel to, and the suitability of the candidate to learn from teams and work with NRP and other service user groups and networks, e.g. Service Users Network Norfolk (SUNN)
- clear processes for terminating voluntary positions under agreed circumstances (including relapse and breach of confidentiality) will be fully outlined prior to commencing placement
- a role description will be agreed for the individual. Elements of the partnership will have generic roles e.g. supporting group activities, recovery café, peer supporters, supporting detoxification and some roles will be individually agreed. To protect service user confidentiality and autonomy, a clear contract will be agreed between service user, mentor and worker
- an application process will require two references and a Criminal Records Bureau (CRB) check to be completed. Previous offending need not preclude individuals from undertaking volunteering roles in the community teams. In these instances a risk assessment will be undertaken and closer supervision will occur
• once satisfactory references have been received induction training will be
provided, including Safeguarding, Personal Safety, Health and Safety,
Information Security and Confidentiality and induction to the partnership
model and services. Within prisons this will include Prison Security, key
training and Assessment Care in Custody Teamwork (ACCT) training
• volunteers and mentors will undergo training programmes in drug and alcohol
awareness, ensuring accurate information is fed into recovery communities.
Personal and social development training will also be offered to support
volunteers and mentors in maintaining boundaries, preventing relapse and re-
addiction
• within prisons, volunteers undertake additional processes of Prison Security
Clearance and successfully attending ISS training
• volunteers will receive information on internal jobs advertised throughout the
Partnership.

5.10.4 All staff within the service will support volunteers in mentor roles, ensuring
they:
• respect the role the volunteer provides
• treat volunteers with dignity
• report any concerns/issues regarding volunteers conduct (if unable to discuss
directly with volunteer) to the supervisor.

5.10.5 The Volunteers supervisor will:
• provide monthly supervision to ensure the volunteer receives the help,
support and information in their role required and undertakes the functions
described in the Role Description
• managing day-to-day difficulties
• identify training and development needs that arise and arrange that these are
met.

5.10.6 The Team Managers will:
• ensure staff within the working area are clear about the role of volunteers and
promote good working relationships with volunteers
• ensure the procedure for identifying volunteer opportunities and recruitment
• ensure day-to-day supervision for volunteers is available
• manage any difficulties identified by staff or the supervisor.

5.10.7 Within the unique and challenging environments of prisons, RAPt offer a
comprehensive volunteering programme (accredited by Volunteering England) which
includes:
• initial fortnightly supervision until learning is assured and demonstrated
• quarterly reviews with placement supervisor and volunteer coordinator to
assess area(s) of development required in role & for future career objectives
• access to internal training. RAPts Learning & Development Department will
augment prison training by delivering ‘Boundaries, Confidentiality and Prison
Security’, and ‘Safeguarding’ to all volunteers before they are deployed in
prisons.

5.10.8 Particularly relevant prison training is that given to Peer Supporters including:
training in ‘Giving feedback’ (reflecting on own attitudes and behaviours that may get in the way of giving effective feedback, designed to equip them with the tools necessary to give honest, respectful and impartial feedback)

‘Self-Care and Stress Management’ (This training is provided to peer supporters because crucial to their role is the need to find a balance between supporting staff members and supporting their fellow inmate)

a ‘buddy’ system for informal support from a named member of staff throughout the first 6 months in both prison and community projects.

5.10.9 There will be continued personal development activity for volunteers across the Partnership through regular co-ordinated training modules that will enable achievements within their volunteering career to be recognised and developed e.g. forming appropriate professional boundaries, harm minimisation, treatment interventions training, diversity training. Drawing on best practice from within NRP, a robust programme of management training for partnership staff will be developed to ensure continued and appropriate staff support of volunteers and mentors. NRP will encourage graduates of its services to become volunteers for the NRP or other appropriate organisations via its partnership with ‘Voluntary Norfolk’ and close relationships with Narcotics Anonymous, Alcoholics Anonymous and other Mutual Aid Organisations.
6 The role of an NRP Care Co-ordinator

6.1 Continuous care coordination is a major touchstone for the new service. Continuity of care coordination is one of the central features of the specification requirements of the commissioner. The role of the care coordinator has been defined in NRP as follows:

- To develop, manage and review documented recovery/care plans based on ongoing assessment (including risk assessment), to build up service users recovery capital. To be accountable for the completion of TOPS and Alcohol Star or any other treatment outcome tool commissioned to use.
- To ensure that recovery/care plans take account of the service users presenting needs, and their culture, ethnicity, gender and sexuality.
- To carry out ongoing risk assessment and co-ordinate an appropriate risk management plan.
- To work towards engaging and retaining the service user in the treatment and care system.
- To co-ordinate care across the 3 providers of NRP.
- To co-ordinate care across the range of health and social care agencies.
- To facilitate service user to access other appropriate services.
- To generate referrals.
- To advise other professionals involved in the care of the service user of changes in circumstances of the service user which may require a review or change of the recovery/care plan.
- To ensure the essential and appropriate information is shared between agencies.
- To develop contingency and crisis management plans for service users with complex needs where required.
- To maintain regular contact with the service user.

6.2 Who operates as a Care Coordinator

- Criminal Justice Workers, Shared Care Nurses and Recovery Workers
- Criminal Justice Workers will take service users who have been referred/sign posted from PICs, Courts (DRR, ATR's etc) Prison etc.
- Shared Care Nurses will take people from GP surgeries signed up to the Shared Care agreement.
- Recovery Workers will take all others.
- There will be these 3 teams within each of the 5 localities, including covering the 3 prisons.

6.3 If the Care Co-ordinator changes:

- Service users shall be kept informed at all times of who their allocated care co-ordinator is and shall be informed in writing in advance of any change to this (and reason for change).
- If the allocated care co-ordinator is changed, all agencies involved in the delivery of care shall be informed in writing, including contact details of the new care co-ordinator.
- In the event of change of care co-ordinator, the new care co-ordinator shall use the existing recovery/care plan until review stage to ensure continuity for the service user.
7 Individual worker roles (the Recovery Team)

7.1 Overview

7.1.1 Working from the five open access bases, the three Prisons plus other facilities like GP surgeries, community hospitals, community pharmacies and other NRP and community buildings, individual roles have been defined within the integrated recovery service organisational structure, to ensure effective management and coordination of service provision and to provide the appropriate managerial support, governance overview and professional development opportunities for staff.

7.1.2 At the same time, the organisational structure must ensure that the model’s requirement for flexibility and creativity, both in terms of staff roles and the functions performed, is achieved in reality. For example, someone employed as a recovery worker may still find that they deliver some aspects of another role e.g. assessment, family work, complex needs interventions, or psychosocial interventions (e.g. running some groups each year). However, in broad terms, the following roles have been identified as integral to successful delivery of the NRP recovery service model:

7.2 Open access workers

7.2.1 Norfolk and Suffolk Foundation Trust Alcohol and Drug Service (TADS) and The Matthew Project (TMP) will employ the staff focused on open access service provision.

7.3 Recovery workers

7.3.1 These will be TMP staff. Recovery workers will undertake assessments and care co-ordination work. The recovery workers will also take part in psycho social interventions at as part of the low intensity and structured treatment pathways.

7.4 Community Justice workers

7.4.1 This will consist of CJT TMP staff and NSFT Nurses providing assessment and care co-ordination to those pre & post sentence and those upon court treatment orders. They will also take part in psychosocial interventions at high & low intensity.

7.4.2 The community justice worker remains the care coordinator for individuals, whether in custody or in the community, thus determining whether they require continued treatment, aftercare support or referral into local agencies to support their continued recovery. If the released prisoner is subject to supervision on licence by the Probation Service and has a licence condition to engage in treatment, they will liaise with the Offender Manager in the same way as for the DRR/ATR pathway.

7.4.3 The community justice worker will continue their role as care co-ordinator during a DRR or ATR and this continues on completion of both requirements if the client is engaged in and continues to require treatment. Otherwise, the offender will be provided with any appropriate referrals into local agencies to support their continued recovery. There will be post-discharge follow-up seeking information that recovery is being maintained or if further treatment is required.

7.5 Shared care workers

7.5.1 These NSFT Nurses will be the links to primary care in those surgeries actively participating in the shared care scheme. These staff will undertake assessment and care coordination work. The staff will also take part in psycho social interventions at high and low intensity.
7.6  **Psychosocial workers in prison**

7.6.1  These will be the RAPt staff working in prison, providing services previously fulfilled by CARAT staff.

7.7  **Health promotion staff**

7.7.1  These NSFT Nurses will be providing screening and ongoing interventions to those at risk of the greatest health harm, in partnership with specialist services. These workers will also oversee the monitoring of prescriptions on behalf of recovery workers, and participate in the start-up clinics.

7.8  **Detox staff**

7.8.1  This will be a dedicated NSFT team undertaking all the detox activity, both for alcohol and drugs.

7.9  **Homeless outreach staff**

7.9.1  These will be the staff that work closely with homelessness organisations and engage homeless clients into treatment

7.10  **Psychosocial interventions staff**

7.10.1  These staff, drawn from across NSFT, TMP and RAPt, will be providing comparable psychosocial interventions across the community and prisons. This also includes counselling, group work and psychologist interventions.

7.11  **Medical staff**

7.11.1  The medical team will be providing medical interventions and specialist mental health assessments.

7.12  **Social care staff**

7.12.1  The Social Care staff will provide the community care assessments for service users and care co-ordinate these clients.

7.13  **Complex needs staff**

7.13.1  This is a role which has been centralised from the previous arrangements for NSFT where complex needs clients were care co-ordinated by the relevant (GP Practice) shared care staff. These staff will work with the most complex clients at the time that increased activity is most required.

7.13.2  Complex needs clients will be care co-ordinated by the recovery workers, community criminal justice workers and shared care nurses from the integrated service. The complex needs staff will be available to provide increased input when acute illness is becoming evident or when engaging mainstream mental health services is required. This team will be the lead for Safeguarding Adults.

7.14  **Families work staff**

7.14.1  These will be NSFT staff that support pregnant women throughout their pregnancies and work closely with all the relevant organisations to ensure good parenting as well as organising a parenting course in partnership with Norfolk County Council. They will also work with families and friends. This team will be the leads for Safeguarding Children.
8  **Psychosocial interventions (inc group programmes)**

8.1 **Introduction**

8.1.1 All psychosocial groups will be recovery focused and there will be an expectation that all service users will be offered and encouraged to attend appropriate groups. These groups will feed into the mutual aid groups within the recovery communities. This will increase the individual’s human recovery capital by improving ability to create positive relationships for sustained recovery. There will be an expectation that staff across the service will facilitate at least 2 groups a year and that volunteers (service users and others) will be core to the running of these groups. The Structured Day Programme (SDP) will be available in the 3 main areas (west, central and east), and service users will be able to reclaim travel costs. Groups for the criminal justice team will be programmed weekly depending on the needs of the service user as part of their orders.

8.1.2 There will be a group of qualified therapists who will run sessions across the service for one to one counselling and therapy. The team will include volunteer and trainee counsellors. Staff across the service who have skills in counselling will also be used within this team to offer specific interventions e.g. Neuro-Linguistic Programming (NLP) or Cognitive Analytical Therapy (CAT). This team will be supervised by the service Psychologist who will also offer limited sessions.

8.1.3 Norfolk Recovery Partnership (NRP) has embedded psychosocial interventions firmly within its philosophy, with implementation evident at all stages of the service user’s journey. There will be a menu of structured psychosocial interventions based on specific models, with a core team of practitioners, highly skilled in delivering psychosocial interventions, coordinating structured interventions and disseminating knowledge and skills to other staff; ensuring clear pathways and capacity to deliver the wide choice of interventions available. An emphasis on quality assurance enables the service to confidently deliver interventions in a range of settings, with the core set of skills being generalised across the three defined substance using groups. Service users will be strongly supported to be meaningfully involved in the delivery of interventions.

8.2 **Core principles behind psychosocial interventions**

8.2.1 The core principles underpinning all psychosocial interventions (including Structured Day Programmes) are:

- clear formulation and aim, developed and reviewed with the service user, meeting individual needs as identified in their recovery care plan
- peer education and support will be a central component of groups
- psychosocial interventions are delivered within a framework of supervision and training designed to ensure competence, quality and safe practice, as well as maintaining momentum and enthusiasm in delivering interventions.
- a training programme will be delivered to all NRP staff, exploring the skills needed in delivering evidence based psychosocial interventions and developing an understanding of models of addiction and emotional distress
- partners, supportive family members, carers and friends are essential allies in supporting service users and when appropriate informing the service they receive. They will be actively encouraged to attend and participate in psychosocial interventions aiming to increase knowledge and understanding for community integration and long term recovery
• Psychosocial interventions will aim to mobilise recovery capital, recognising the importance of increasing access to mainstream and community services.

8.3 Menu of Psychosocial Interventions

8.3.1 International Treatment Effectiveness Programme (ITEP)

ITEP is the core psychosocial model adopted by the service. It will be used throughout the service user’s journey to recovery by all practitioners, in all localities. Within the Prisons Birmingham Treatment Effectiveness Intervention is used (BTEI) which is adapted from ITEP. ITEP/BTEI Champions will be nominated throughout NRP who will continue to embed the programme within the model.


8.3.2 Motivational interviewing (MI)

MI will be a core skill used by all practitioners within individual sessions and within groups.

8.3.3 Brief Interventions

Will be available in the Prisons and Community for non-dependent alcohol users, and will be offered individually and in groups.

8.3.4 Recovery Orientated Groups

A menu of groups are available for the service user’s recovery journey: The groups will take place at the five main bases and three prisons and in community setting e.g. Under-1-Roof in Norwich, Charing Cross Centre.

8.3.5 Correctional Services Accreditation Panel (CSAP) Accredited Abstinence based/twelve-step treatment

The recent NICE guidelines reviewed evidence from seven studies for the effectiveness of 12-step fellowships as interventions for drug dependence and concluded that they were effective/ significantly improved drug use outcomes (NICE, 2007, p.181).
Research evidence: Residential centres (approximately 50% twelve-step) were found to be effective in reducing most forms of drug use at five year follow up: NTORS - Gossop et al., 2008; large scale trial showed that twelve-step treatment lead to more superior abstinence outcomes than CBT: Moos et al., 1999; Humphreys et al., 1999.
9 Conclusion

9.1 The new model NRP will be delivering promises to be a radical and innovative step forward in the provision of drug and alcohol services across Norfolk. However, this ambition will only be realised if staff, commissioners, stakeholders, service users, their families, friends and carers fully understand what is available, how to make it accessible and who needs to do what, where, when, why, how, with what resources and over what timeframe to support recovery journeys. This briefing note has been prepared to help this understanding to grow.

9.2 Overall, NRP has put together an integrated recovery system that maximises the potential for successful recovery journeys for service users that can also meet the needs of their families, friends and carers. It is founded on the principle of achieving equitable and ready access across Norfolk and of maximising recovery capital for service users by fully integrating what it can provide with the services and support available from a range of other agencies.

Briefing ends.

Compiled and edited by Chris Strivens and Tony Oram

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Diagram 1 - NRP Recovery Model from the service user perspective

Referral Sources include GPs, A&E, Self, Family and Friends, Social Services, Police, Third Sector Agencies etc.

Single Assessment and Care Coordination System

PICs & Courts Outreach, Homelessness outreach; Acute Hospital Liaison; Prison Reception and liaison with Prison Healthcare; 24/7 helpline; Recovery Cafes, hosted by Volunteers / Mentors / Befrienders; Drop-in, Needle Exchange, Harm Reduction, and Brief Interventions; web site; Carers Assessments; and Comprehensive Assessments by Recovery Coordinators, Criminal Justice Team, and Shared Care Coordinators, leading to ...

...THE STRUCTURED SERVICE USER PATHWAY...

...WHICH STARTS WITH.... A COMPREHENSIVE ASSESSMENT...

...LEADS TO A STRUCTURED TREATMENT and RECOVERY PLAN, CARE COORDINATED THROUGHOUT, WITH INTERVENTIONS DRAWN FROM...

...THE RECOVERY SERVICES MENU INCLUDING...

Medical services
Therapeutic & Counselling Interventions
Family Work
Complex Needs Services

Prison Psychosocial Programmes
Social Care Services and Support
Health Promotion
Group Work

Aftercare
Wellbeing Groups, Peer Support, Open Activities
Links to Housing Support, Training & Employment
Links to Community Groups & Mutual Aid Groups
Social Enterprise, Charitable Fundraising

Recovery in the Community

Open Activities
Housing Support
Training & Employment
Community Groups
Mutual Aid Groups

Diagram 1 - NRP Recovery Model from the service user perspective

Referral Sources include GPs, A&E, Self, Family and Friends, Social Services, Police, Third Sector Agencies etc.
Diagram 2 - NRP Recovery Model from team structure and functions perspective

Referral Sources include GPs, A&E, Self, Family and Friends, Social Services, Police, Third Sector Agencies etc.

**Open Access Team**
- Recovery Cafe hosted by Volunteers/Mentors/Befrienders
- Recovery Coordinators, Criminal Justice Team, Shared Care, Primary Care Liaison, Drop-in, Needle Exchange, Harm Reduction, Brief Interventions

**Structured Service User Pathway**
- Comprehensive Assessment and Care-Coordination System (SACS) including 24/7 helpline

**Structured Treatment**
- Health Promotion: Smoking Cessation
- Sexual Health: Prison: Psychosocial
- Short Programmes
- Long Programmes
- Medical: Prescribing & Reviews
- Mental Health: Assessment, Liaise with Primary Care
- Complex Needs: Dual Diagnosis
- Learning Difficulties
- Safeguarding Adults Leads
- Social Care: Safeguarding Conf.
- Community Care Assessments for Rehabilitation

**Low Level**
- Structured Services
- SACS
- Open Groups
- Other Support

**Low Intensity**

**Outreach**
- (Open Access Team)
- Homelessness & Street Workers outreach
- Acute Hospital Liaison

**Aftercare**
- (Open Access Team)
- Wellbeing Groups, Peer Support, Open Activities
- Links to Housing Support, Training & Employment
- Links to Community Groups & Mutual Aid Groups
- Social Enterprise, Charitable Fundraising

**Open Activities**
- Recovery in the Community