
UNIVERSITY OF
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RECOVERY ORIENTED SYSTEMS OF CARE
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Recovery facts and models

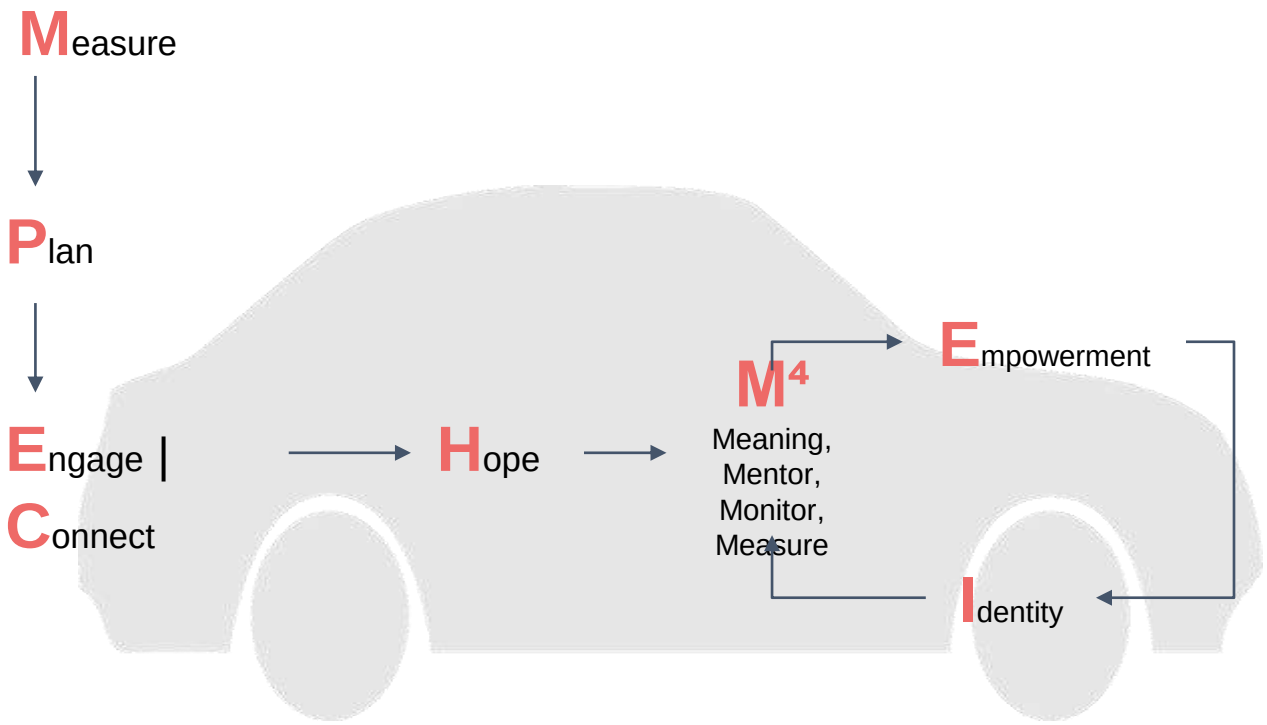
Recovery statistics

- 58% recovery rate (SAMHSA, 2009)
- Relapse reduces to 14% in year 5 (Dennis et al, 2007)
- Addiction careers average 28 years with 4-5 episodes of treatment over 8 years
- Reasons for stopping and reasons for staying stopped not the same (Best et al, 2008)

What enables recovery change?

- Leamy et al (2011), British Journal of Psychiatry
- CHIME
  - Connectedness
  - Hope
  - Identity
  - Meaning
  - Empowerment

The Engine of Change _ CHIME



Recovery enablers - Humphreys and Lembke (2013)

Three key areas of clear evidence-based models for recovery:

- **RECOVERY HOUSING**
- **MUTUAL AID**
- **PEER DELIVERED INTERVENTIONS**
  - **Peer models are successful because they provide the personal direction, encouragement and role modelling necessary to initiate engagement and then to support ongoing participation**

Recovery studies in Birmingham and Glasgow – GOYA (Best et al, 2011a; Best et al, 2011b)

UK Study of recovery wellbeing –better recovery wellbeing predicted by:

1. More time spent with other people in recovery

2. More time in the last week spent:

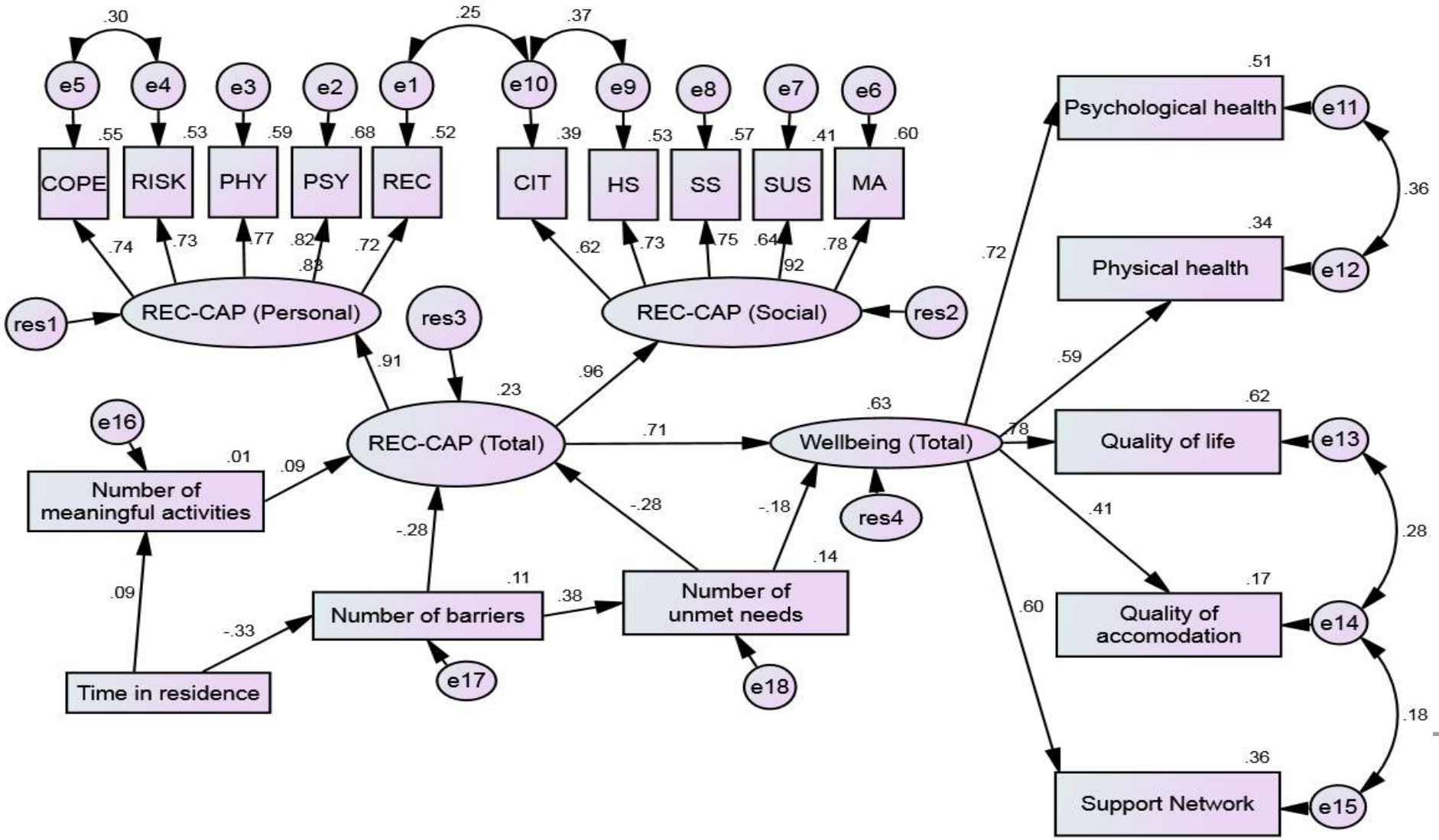
- **Childcare**
- **Engaging in community groups**
- **Volunteering**
- **Education or training**
- **Employment**

- **Best et al (2013): The role of abstinence and activity in promoting wellbeing among drug users engaged in treatment. *Journal of Substance Abuse Treatment*, 30 (4), 397-406.**

  The study assessed changes in meaningful activities in three English Drug Action Team areas over the course of one year
  Drug treatment participants split into four categories
  - **initiated meaningful activities**
  - **maintained meaningful activities**
  - **stopped meaningful activities**
  - **no meaningful activities**

  Quality of life and wellbeing higher (and more abstinence) in those who started or maintained meaningful activities
  Stopping associated with decreases in all three wellbeing measures

Time in residence + meaningful activities to positive outcomes (EARR)



Inclusive cities paper

Best & Colman (in review)

Central idea: no one should walk the recovery path alone. An inclusive city promotes participation, inclusion, full and equal citizenship to all her citizens, also to those in recovery

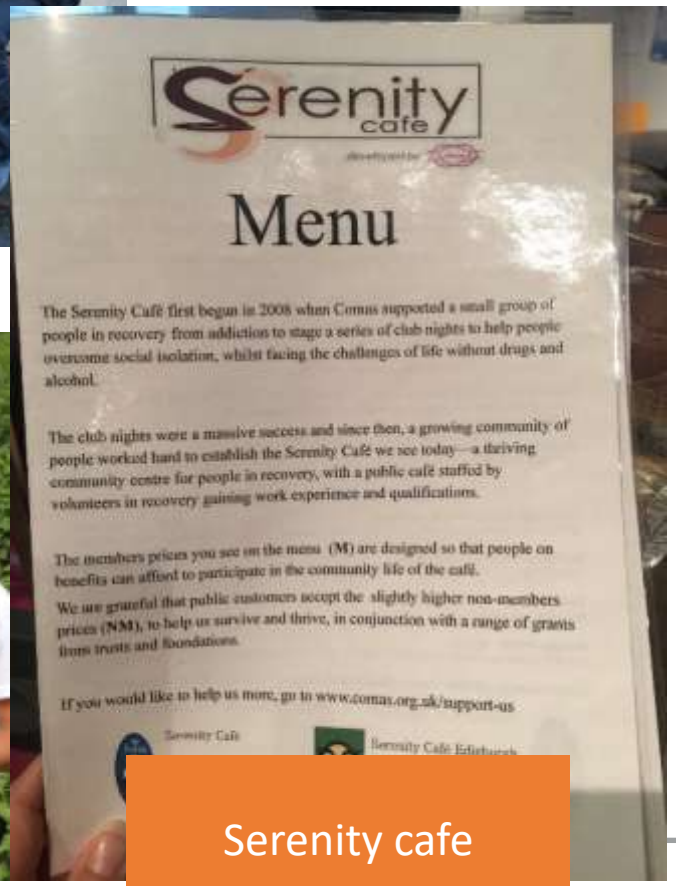
Central aim:

1) challenge social exclusion at city level
2) make recovery visible, celebrate it and create a safe environment supportive to recovery
   - *"Recovery is contagious"*

Beneficial for the person in recovery, as well as for the community as a whole

- *"The helper principle"*

Jobs, Friends & Houses



Serenity cafe

Radio Gaga

San Patrignano

Recovery bike ride

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Sensitivity: Internal

How to build inclusive cities?

Several promising examples

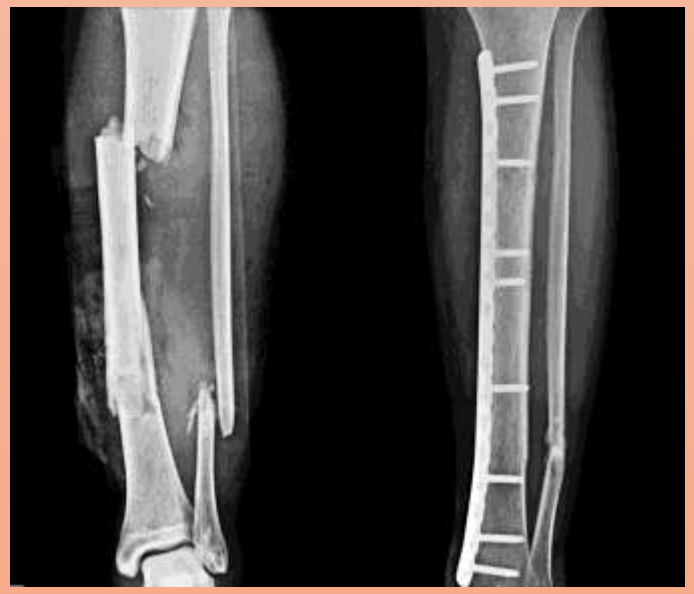
- Small actions or big actions (according to mindset & resources available)

The most important step however, is to **bring it all together** and to create partnerships

For example in Ghent:

1. Bring several actors from different organisations responsible for housing, employment, social welfare,… together. Include people in recovery as well!
2. Make an overview of existing practices for people in recovery
3. Identify gaps
4. Define the city's mission, vision statement, goals (short- term and long-term) and actions towards people in recovery
5. Monitor, evaluate and adapt!

ACUTE CARE MODEL



CHRONIC CARE MODEL

A **process** that takes time to achieve and effort to maintain

Voluntarily-sustained

Accrual of positive benefits

Requires aspirations and hope

No one path to recovery

Requires **control over substance use** (although it is not sufficient on its own)

Maximises health and well-being, encompassing both physical & mental good health

A satisfying and meaningful life, as defined by the person themselves, involving **participation in the rights, roles and responsibilities of society**

Post-treatment Recovery Environment

INPATIENT UNITS

RESIDENTIAL REHABILITATION

HARM REDUCTION SERVICES

MEDICAL TREATMENT SERVICES

MENTAL HEALTH SERVICES

Treatment Attraction & Access

Engagement & Retention

Behaviour Change:
Substance use
Other behaviours

Post-Treatment Monitoring & Support

Assertive Linkage to Recovery Community

RECOVERY COACHING

RECOVERY COMMUNITY CENTRES

SOCIAL ACTIVITIES

LERO & RECOVERY COMMUNITY

RECOVERY HOUSING

RE-ENTRY SUPPORT SERVICES

EMPLOYMENT SUPPORT

ADVOCACY

SCHOOLS & UNIVERSITIES

ACUTE CARE + MEDICAL STABILIZATION + LONG-TERM RECOVERY MANAGEMENT + RECOVERY SUPPORT SERVICES

MUTUAL AID GROUPS

CLINICAL SERVICES

Return to full levels of funding
Re-instatement of all the tiers of service

Investment in delivery of psychosocial interventions

Investment in staff training and supervision

Strategies to re-integrate with the NHS

COMMISSIONING & OVERSIGHT

Working together

LIVED EXPERIENCE RECOVERY ORGANISATIONS

Greater respect
Ring-fenced funding within ROIS

Development of quality standards
Investment in staff training and supervision

Development of Recovery Community Centres

Investment in employment, housing, schools & universities

- Person-centred
- Inclusive of family and other ally involvement
- Individualised and comprehensive services across the lifespan
- Systems anchored in the community
- Continuity of care
- Partnership–consultant relationships
- Strength-based
- Culturally responsive
- Responsiveness to personal belief systems
- Commitment to peer recovery support services
- Integrated services
- System-wide education and training

- Inclusion of the voices and experiences of recovering individuals and their families
- Ongoing monitoring and evaluation
- Evidence driven
- Research based
- Adequately and flexibly funded

Standards for LERO's (CHIME)

Creating scaffolding, not cages

Organisational standards for LERO's - where is the organisation in relation to each of the five standards. (working towards / achieved / Excellent)

Individual standards – what a member can expect but equally bring to the LERO