Project Overview

This project pilots a multi-layered, community focused support network around 12 drug and alcohol service users and reports and disseminates outcomes.

Supporting recovery through:

- settled accommodation
- community integration
- peer support
- access to health professionals through regular 1:1 and group therapy sessions in years one and 2, tapering to reduced therapeutic support in year 3

Providing quantitative and qualitative evidence demonstrating benefits of this way of working for:

- Individuals
- Commissioners
- Communities
- Policy makers

If this pilot project is successful, this new way of working has the potential to change the type of services that people receive across England.

Immediate benefits will go to local service users, their communities and local services. These benefits, along with the budgetary benefits which we expect to see, could be rolled out across the country once the efficacy of this model has been proven.

We will:

1. Pilot a model of support for people with addictions
2. Evaluate its delivery and outcomes
3. Disseminate our learning
4. Explore payment by results to develop future projects

The project will support recovering addicts by developing a therapeutic Network around them. The support has been designed to address the reasons that addicts tell us cause them to relapse and for this reason we believe it will deliver better outcomes than those achieved by other services. The problems identified and specifically addressed by the model are:

- Availability of help when someone is in distress and therefore more likely to relapse
- The automatic loss of accommodation should a relapse occur increasing the severity and length of relapse
- The need for ongoing therapeutic support
- Isolation and loneliness.

A network comprises of a number of ordinary properties scattered around a defined geographic area. Both service users and a volunteer live in these properties and work together to develop mutual support and community connections. Support workers and therapists are also attached to the Network and ensure that people get support, 1:1 therapy, and access to a therapeutic group as appropriate.

It offers:

- support from a volunteer who lives within the Network area
- support to establish community connections
- workers to provide support with tenancy and other issues
- group and individual therapy which is appropriate to the individual's stage of recovery
- facilitation of mutual support to help develop social skills, confidence, etc
- support to plan group social events
- out of hours support when needed and the flexibility to respond to people should they experience a crisis

Flexible but structured support allows people to develop skills in preparation to moving into unsupported living or less supportive settings. Support is designed to encourage people to develop coping strategies and to re-integrate into their community in a planned way.

Nice estimated in 2007 that the cost per year per drug misuse incurred by the health sector, by social care, and due to drug related death and crime is between £11,800 and £44,000 (http://www.nice.org.uk/nicemedia/live/11379/36571/36571.pdf). A three year place in a KeyRing Network costs £21,563 per service user (or £138 per week). A Network therefore needs to save between 6 months and two years of addiction for each individual to pay for itself.

A range of options are available when people are ready to move on from the therapeutic Network and many will be able to live without support directly from this setting. Other people, particularly those with enduring mental health problems or other support needs, will be ready to move on to less intensive support.

The excellent outcomes of the Network style of support have been well documented among other client groups (Care Service Efficiency Delivery (CSED) in November 2009) and with the addition of specialist therapeutic intervention we expect this model to yield exceptional results.

Quality and integration

This model addresses the problems that people who use addiction services tell us they experience by closing the gap between what they receive and what they believe they require.

We are told by addiction service users that the services that they receive do not mitigate problems and sometimes contribute to them:

- The response time between asking for help and receiving it is too long which causes relapses where people begin to self medicate (especially if mental health problems begin to emerge as people abstain from their addiction)
- Isolation and loneliness reduce hope and self worth and therefore the likelihood of continued recovery
- When people relapse they lose their home and therefore stability, often making relapse more enduring
- Relationships are lost and not replaced when leaving an intensive therapeutic setting or hostel
- There is little provision for someone in distress due to a personal crisis.
- Connection with the community is difficult as there is no-one available to support people with appropriate relationships.

The model aims to mitigate these problems with voluntary and mutual support which is based in the same neighbourhood as the service user and with access to therapists on a regular basis in years one and two and on a tapered basis in year three. We will work with housing providers to find stable accommodation and with service users to help them maintain their tenancy.

The community presence afforded by this model and our experience in identifying and working with a wide range of services and providers will enable us to support service users to become a strong self advocate and ensure that they experience integration in the services that they receive. Where needed we will advocate on their behalf.

Measuring outcomes

We believe that by providing the community focused, joined up service that service users tell us they want we will see improved outcomes for them including:

- Increased incidence of the requisites for recovery as identified by the recovery model:
- A reduction in relapse and associated distress
- Early intervention meaning that difficulties do not escalate
- A reduction in loneliness and low self esteem
- An increase in meaningful activity such as volunteering, mutual support
- An increase in coping skills, resilience and resourcefulness
- Improved outcomes around wellbeing, quality of life, relationships, personal aspirations as identified through individual support planning
- Greater self awareness and improved social skills
- And towards the end of the project, an increase in economic activity

The above benefits will be measured by assessing each individual using a modified outcomes star or similar tool.

- This will be undertaken upon each service user's on entry to the project and at regular (6 monthly) intervals throughout their time with us providing a linear study of service users, progress throughout the life of the project
- An experienced researcher will be consulted and commissioned
- We will compare these outcomes against national statistics for similar client groups wherever possible.
- The overall aim will be to provide a clear indication of whether this type of intervention provides better outcomes for individuals than current service offerings.

Community benefits will be measured by a community survey which asks people who they feel about their area. This will be undertaken at the start of the project and at 12 month intervals.

This project will study the effects of the Network on 12 people. The NHS information Centre's report revealed that in 2009/10, 44,585 people were admitted to hospital due to a drug-related mental health or behavioural disorder. Many of this cohort would be appropriately placed in a network such as this.

Productivity of services

Ultimately, productivity will be measured in whether relapse rates are sufficiently reduced to offset the higher costs which might be associated with this type of prevention model in years one and two, and whether people are equipped to move on to less supportive settings in year three, freeing up places for new service users. We believe that by providing a therapeutic network, we can prevent the costly escalation of problems which result in more intensive interventions and relapses.

We want to prove that the model can deliver the prerequisites to recovery and that when delivered in this way, these prerequisites save money.

We would expect the model to show:

- A reduction in relapse and associated costs
- A reduction in costs relating to our service users incurred by Health, Social Services, Housing, Criminal Justice System, etc
- An increase in volunteering
- Improved outcomes for individuals around wellbeing, quality of life, relationships, personal aspirations
- And towards the end of the project, an increase in service user economic a ctivity
- Lasting long-term effect

We will:

- Compare the outcomes in terms of distance travelled for service users and money saved by these changes on an annual and end of project basis.
- Compare these outcomes against national statistics for similar client groups wherever possible.
- Where possible we will take the widest possible view of 'whole costs' both before entry and during the project
- Quantify the economic worth of service users' volunteering activates
- Provide a clear indication of whether this type of intervention makes good financial sense.

Service users will experience a more joined up and effective service which will provide them with better outcomes. They will have access to support when they need it most. It is this support in a crisis which they tell us is so important. We will help them access other community based support as required, supporting them to be self advocates and to get the things they need for their recovery journey. We will do this by:

- Understanding and mapping the community such that we know what s available
- Support planning with each service user
- Providing informal, flexible support through the volunteer and facilitated mutual support
- Providing easy access to therapists

This planned but responsive approach means that service users get the most from their support.

CSED found that other health and care services were more effective when KeyRing was supporting their clients. This was due to stability of home life meaning fewer missed appointments and better compliance with instructions around medication, etc. For example, GPs will find appointments with service users easier as the service user will have been supported to prepare for the appointment, there may be fewer calls for an emergency ambulance as people will have access to support for non emergency situations.

We will quantify savings in terms of money saved and time reduced in using crisis/emergency services. We will do this on an annual basis and for the overall project. We will also work with our researcher and consultant to ascertain what the distance travelled by the service user through the life of the project is likely to mean for future service levels and costs. We will do this by looking at the sort of service they needed before joining the project, what they require at the end and how this translates into costs. We will also look at where people made frequent calls to social services, the ambulance service, etc, why this was and what community based

resources and coping strategies they have developed which are likely to prevent a reoccurrence of this behaviour at the end of the project.

Supporting people to take control

The recovery model is all about people taking control of their own journey and this project has been designed to provide optimum opportunities for people to do this.

KeyRing supports people to develop their own resourcefulness, rather than doing things for people. CSED noted our efficacy in this area saying; “LSNs were potentially very cost effective as they... encourage service users to develop their skills and confidence by encouraging them to do things for themselves rather than be dependent on support”.

Connection to the community is a fundamental part of KeyRing’s values. Such a connection is about ensuring reciprocity and we have found that a small group of 12 people can be a catalyst to improving the community. This means that service users can begin to have a positive impact in their community and take responsibility for its improvement. Whilst doing this, they are defining the nature their Support Network, developing contacts and relationships and are therefore taking greater control and responsibility for their lives and recovery. The skills which they learn in the safety of their regular Network meetings and therapy sessions can be put in practice in the community. The presence of staff, therapists and volunteers helps people to develop appropriate relationships and old patterns of behaviour can be addressed, enabling people to develop skills and connections which will outlive the life of the project and enable them to take lasting control over their lives.

The use of local volunteers ensures that people supporting the project have a sense of connection to the community and are well placed to encourage engagement and ownership.

An example of community connections in a current Network demonstrates this principle. When one of the service users had a baby it became clear that the local nursery was in need of some funds to improve their out-door play area. Service users hired bikes from the local park and held a sponsored bike ride to help out. The bike provider donated the hire fees to help boost the funds. The relationship with the bike hire facility developed so that some of the service users used the bikes regularly and one became a key holder.

The skills which developed, the standing of service users in the community and their sense of what can be achieved was changed through this action and resulted in service users feeling that they had greater control over their lives.

Evaluation

The main aims of this project are to save money by:

- Reducing relapse rates
- Reducing the need for long – term support

The success of the project will therefore be judged on these outcomes and evaluation will make it clear as to what extent these have been achieved.

We will look at relapse rates for other provision and compare duration and associated costs.

In the third year we will look at people's ability to move on to no support of lower support options.

However, in order for learning from this project to be fully utilised we will need to provide greater depth of analysis.

As with dissemination of information, evaluation will need to serve many audiences and we will therefore need to collect and interpret various data .

Policy makers will want to know whether the project is effective in saving money across the board, whether there were any risks which needed particular attention, how the project compares with other interventions and to see an extrapolation of what might have happened without the project.

Local Authority or health commissioners will want to know more about cost savings within their area of budgetary responsibility, and to know whether project outcomes are aligned to their priorities and sit well with other services.

Referring social workers will want to know about efficacy, our costs per individual in comparison with other services and our style of support

Individual commissioners (personal budget holders etc) will want to know more about the service user experience, outcomes against their own aspirations and efficacy.

Local community figures will want to know what the project meant for the local community.

In order to service the variety of information needs we will need to 'begin with the end in mind' and ensure that throughout the life of the project we ask the right groups the right questions in the right way.

We will evaluate things such as:

- Efficiency of set-up
- Referrals – equality, routes, numbers
- Voids – length, cost, reasons
- Effects of attrition
- Outcomes for service users against support plans
- Outcomes for individuals against public health and social care frameworks
- Outcomes for service users against Supporting People funded projects
- Distance travelled towards independence by service users
- Effectiveness of tools such as WRAP
- Presence/development of prerequisites for recovery
- Relapse rates, duration and associated costs
- Long term costs savings broken down to be relevant to various audiences
- Outcomes against government policy (future relevance)
- Satisfaction or service users, people referring and partner agencies
- Effectiveness of relationships with partner agencies.
- Outcomes for the local community.
- The experience of volunteers – satisfaction, problems, career development, learning.

Due to its fluidity service user outcomes will be measured at 6 monthly intervals, data from professionals and the community will be collected on an annual basis.

Much of the service user data will be collected in the course of support planning and review using a questionnaire. Other data about the service user experience will be collected at network meetings, taking the form of focus group. We may consider using art or a similar medium to gain information from service users but this will depend on their preferences.

The opinions of professionals will be collected with a questionnaire-guided discussion.

Information on costs will be collected on a monthly basis using our accounting systems and market intelligence.

Information regarding volunteers will be collected during fortnightly review meetings.

Information will be collected from the community via community groups using focus groups and questionnaires.

KeyRing has engaged independent evaluators in the past and will do so for this project. We will ensure that this person is well qualified and experienced in evaluating projects for health and social care and reporting their findings to high level strategic bodies.