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# Insights from lived experience to inform the vision for York's Drug and Alcohol Strategy

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Final report by Imogen Blood, Shelly Dulson, Astrid Hanlon, Miles Goring & Ian Wenman

LIFE
lived insights from experience

CITY OF YORK COUNCIL

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# Contents

**Acknowledgements**

The research team consisted of:

Astrid Hanlon, Miles Goring and Ian Wenman from Lived Insights from Experience (LIFE), which is an independent York-based organisation comprised of people who have direct insights from experience of multiple systems and services.

Shelly Dulson and Imogen Blood from Imogen Blood & Associates (IBA), a research consultancy which specialises in collecting and using research evidence to inform strategy and service development.

Our roles within the project are described in Section 1.

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- The Good Organisation which was incubating LIFE at the time of this commission and has supported contracting, invoicing, and information sharing agreements.

# 1. Background

## 1.1. Data collection

During the first half of 2022, Lived Insights from Experience (LIFE) in partnership with York in Recovery (YIR) were commissioned by City of York Council (CoYC) with funding from Lankelly Chase to conduct research with people accessing and working within the city's resettlement services, including hostels and other types of supported housing. This informed a wider piece of work to review the resettlement pathway for those experiencing homelessness.

In this original piece of work, a team of researchers with lived experience from LIFE and YIR had engaged and interviewed around 100 individuals, half of whom were working in services, and half of whom were accessing services. They had guided conversations with them to explore what was working, what was not, and what might be done differently within resettlement services. Many of those interviewed who were accessing resettlement services had current or historic (including familial) issues with substance use and had also accessed treatment and/or recovery services within the city.

## 1.2. Further analysis of the original data

In autumn 2022, Ruth Hine, Public Health Specialist Practitioner at CoYC approached IBA to explore the feasibility of further analysing this rich source of data to inform the development of the city's Drug and Alcohol Strategy. IBA worked with LIFE (and their host organisation, the Good Organisation) and CoYC to agree information sharing and ethics protocols, to scope the work and agree roles and outputs.

Thirty eight interviews were carried out (25 citizens and 8 staff) and with methodological support and quality assurance from Shelly Dulson and Imogen Blood at IBA, members of the LIFE team selected 30 of these interviews, which provided the most insight into drug and alcohol use, recovery, and services. They listened to and coded the audio recordings against agreed themes and identified any additional themes which emerged. Members of the LIFE and IBA teams met four times to reflect on emerging themes and draw out implications from them for drug and alcohol services and strategy. IBA led in producing this report, but this was iterated with members of the LIFE group.

## 1.3. Strengths and limitations

Only those accessing resettlement services were interviewed and this will almost certainly skew the data collected. For example, there was less discussion of employment or of the support needs of family members than we might have expected had the sample included people living in mainstream housing. However, as the research team reflected: *"the 'skew' in the sample inadvertently revealed a very focused sub-set of data. Folk in Resettlement are literally the canaries in the coal mine and as such we should urgently listen to their voices".* The original questions had been designed to draw out interviewees' perceptions of the strengths of resettlement services and their ideas for development of these services. We have worked to draw out the implications for drug and alcohol services, conscious that the team brings their own lived and professional experience to this. The findings suggest an

urgent need for better dialogue – both in individual case management, but also at a strategic level, between drug and alcohol, resettlement, and mental health services.

# 2. Individuals' circumstances and needs

In this section, we present the most commonly occurring themes from the interviews regarding individuals' circumstances and needs.

## 2.1. Trauma and mental health

Many of those interviewed described traumatic experiences which had triggered or accelerated their personal journeys into addiction and homelessness. These included bereavement, parental or personal domestic abuse, experiences of local authority care, childhood rejection by family, and experiences of sexual and physical assault and coercive control.

For these individuals and for most others interviewed, mental health challenges were intertwined with their substance use. Some effectively self-medicated with alcohol and drugs because they had not accessed mental health diagnosis or did not find the offered treatment worked for them. Almost all felt that the lack of accessible and appropriate therapeutic support was the main gap in the current system for those trying to stop using - a point we discuss in more detail in the following sections.

## 2.2. Family

Family could be both a source of trauma and a source of support – sometimes simultaneously. Some interviewees described how their addiction had, in turn, caused family breakdown and trauma for their family members. Some explained that they did not have family or that "*they don't really bother with me anymore"*, which left them alone in the system. As we saw in the previous section, family dysfunction was described as the cause of addiction and homelessness for some; others had chosen to leave their families to protect them from the effects of their substance use or had been separated from their children. This often led to further trauma, increased substance use and, in some cases, homelessness which was deemed to be 'intentional'.

Family can be a motivator to recovery and can also provide hope to some. However, support to re-engage with children can be difficult and triggering to navigate, and this can be difficult for those living in hostels or other types of shared housing; this was a particular theme in interviews with mothers. One woman described the vicious circle in which she is trapped in relation to her children:

> *"…I've said there's no point in me being here if I can't have me kids… cos that's what I want is me kids, cos that's all I've ever wanted is me kids back. They got taken off me cos I was in a violent relationship. It wasn't because of drugs, you know. People think, you know, cos I'm on drugs that they got taken off me because I'm on drugs. It wasn't. I wasn't even on drugs."*

## 2.3. Emotional health

There is increasing evidence of the relationship between emotional health as both cause and effect of addiction[1] and potential for healing from connection and meaningful relationships.

Many interviewees talked about their feelings, often describing anger, powerlessness, fear and shame. The researchers reflected on their own experiences and observations, namely that 'most people's substance use is precipitated by feelings (at least initially)'

As the following quotes explain, experiences of stigma, rejection, isolation, and re-traumatisation often made it hard for people to engage with or trust in professionals, or indeed with anyone.

> *"I did struggle with the services because I'd spent so long in isolation it was difficult to actually start establishing relationships with people again. And actually start to open up about some of the things, the way I was living because there was a lot of shame, there was a lot of guilt attached to that and there was a kind of, there was a lot of labelling, so sometimes I'd be speaking with one of the workers in the hostel and they'd be really good, really supportive and other times I'd be treated just like a piece of whatever on the floor."*

> *"But I wouldn't have had anybody to talk to that was actually listening to me. I talk to myself a lot now. I do nowadays. I talk out loud when I'm doing stuff because I think I've forgotten the ability to talk because I spent so long in silence and not having communication with anybody."*

Others described challenges with suicide and self-harm linked to drug use:

> *"… a lot of issues with self-harm and suicide and stuff like that you know, through drugs and stuff like that, you know and… yeah, so I need to sort of address them issues first, you know."*

How people's interactions with services made them feel was a recurring theme in the interviews. The research team reflected that this is pivotal to services maximising their potential impact on people's recovery, yet emotional health is generally not the focus of service design, monitoring, and evaluation within substance use services.

## 2.4. Physical health

Some interviewees spoke about physical health conditions which had most likely been caused or exacerbated by substance use, such as leg ulcers or heart/ circulation issues, which were causing pain and mobility challenges.

The LIFE team reflected that, in their experience:

[1] See for example Maté, G. (2018) In the Realm of Hungry Ghosts: Close Encounters with Addiction, Vermillion

> *"Physical health needs are often pushed down the priority list or go un-noted/untreated for those using substances……there needs to be more of a dialogue around physical health as well as mental health for individuals with challenging circumstances - the whole person."*
>
> Reviewer with life experience

Clinicians sometimes fail to see the complex interactions between different mental and physical health conditions, and judgements may be made about people's use of prescription drugs. For example, one interviewee described how their Diazepam prescription had been removed while they were in hospital receiving treatment for a leg ulcer – they felt the doctor had assumed this was to help with sleep, when it had been prescribed for mental health problems. Their unsupported withdrawal from Diazepam following discharge from hospital caused significant side effects and provoked suicidal feelings.

### 2.5. Housing

Some interviewees described becoming homeless because of family breakdown, often linked to substance use. One man explained that he had taken his name off the tenancy agreement so that his ex-partner and child could access benefits and the council then judged him to have made himself intentionally homeless (and therefore found no duty to assist him with alternative accommodation). Where people reject offers of supported accommodation, leave services because they are too chaotic or stressful, or get evicted for breaking the rules, they are similarly at risk of being found intentionally homeless.

A couple of interviewees described ending up either in hospital or in prison due to their addiction, losing accommodation as a result, and being discharged with no fixed abode. Communication and processes between agencies were poor – for example being released from prison just before the weekend and told to present as homeless to the local authority, and then being told by the local authority they would need to sleep rough or find their own solution over the weekend as no other services could be provided until Monday.

For those women interviewed, recurring themes were that they had become homeless due to experiences or fear of abuse, cuckooing or exploitation.

### 2.6. Seeing the person

This section has focused on the common challenges which this group of individuals have faced and continue to face. However, the interviews also highlight people's individuality, and their experiences strengths and aspirations beyond their substance use. These may include families, friendships, interests, jobs, and skills. However, in services they tend to be defined only by their substance use.

In section 4, we reflect on how these wider assets have been and might be harnessed to promote or sustain recovery and what this means for services. First, we consider their experiences of services.

# 3. People's experiences of services and systems

In this section, we present key themes regarding the experience which those with substance use issues in the resettlement pathway have of different parts of the system and the impact of this on their substance use and wider wellbeing. Whilst we recognise that the focus here is on drug and alcohol services, it is clear from the interviewees that the effectiveness of treatment and recovery services is hugely dependent on the policies, practice, and availability of other services. In the final part of this section, we draw together whole system themes which are of particular significance to this group of people.

## 3.1. Mental health support

At the time of writing this report, the team became aware of and reviewed the recent Healthwatch publication on mental health crisis care in York[2]. There are many parallels between our findings and those of the Healthwatch report, and we highlight these here.

### 3.1.1. Availability and suitability of mental health provision

As we saw in the previous section, mental ill-health and substance use are closely inter-linked. Our findings – and those of the Healthwatch report – confirm an overall lack of mental health provision. For example, interviewees – both those living and working in resettlement services, reported waiting lists of 18 weeks or more for assessment, which we understand has increased to 24 weeks since the original interviews. The lack of mental health support was felt to be the most significant gap in current services.

> *"70% of people with substance misuse issues also have a mental health problem, there seems to be funding for the substance misuse aspect of it… but the mental health support that should come alongside that is just not there and I think that's maybe where the imbalance of support is, it that substance misuse is concentrated upon and mental health is seen as a secondary consideration."*
>
> Repeat/ long-term user of substance use services

The Healthwatch report also highlighted a lack of emotional, psychological or therapeutic support, or even in some cases a lack of professional curiosity and empathy – therapeutic support was reported to be scarce, rationed and time-limited. One interviewee in the resettlement pathway research explained:

> *"When you are asking and asking and asking for counselling and you're not getting it and it's always down to figures and 'you don't tick all the boxes' – how do they know what boxes need ticking?"*

[2] Healthwatch York (2023) Breaking Point: A recent history of mental health crisis care in York, June 2023

Some of the individuals we interviewed are experiencing extremely traumatic, frightening and sometimes dangerous existences because of lack of mental health support.

The following themes from the interviews were of particular significance to those experiencing mental ill-health who are also using substances.

### 3.1.2. Substance use as a barrier in mental health support criteria

There were many comments about the inability of separate services to work with people who have inter-linked mental health and substance use challenges. Workers in resettlement services were frustrated that the Mental Health Crisis Team "*won't deal with somebody if they are under the influence of drugs or alcohol and it's like, we're expected to".* Another interviewee highlighted that "*it's really unrealistic to ask for something like abstinence before mental health treatment starts".* The following quote from someone with lived experience describes the impact of this impasse between services:

> *"When I was in my active addiction, …the battle between them [the D&A service] and mental health... Where one wouldn't help me until I got the other sorted out. That's probably where a lot of my anger, a lot of my frustration came…I didn't recognise just how ill I was and I think, may be if those two services had actually sat and talked to each other…. I would have willingly said you share whatever information you want between you, if you can help me I don't mind who does it but if you can help me..."*

Similarly, the Healthwatch report highlighted a separation between mental health and drug and alcohol services, and a 'dump and run' mentality (p.39) between these and other services, with people being discharged from mental health services for being 'too high risk' (p.42) due to their complexity.

### 3.1.3. Appointments systems and travel as a barrier

The research team reflected on how:

> *"You need a level of wellness to engage with services effectively."*

This was apparent in risk assessments and service criteria which deemed people "too poorly for us; or not poorly enough for them" but also in the many logistical hoops that individuals were required to jump through at times when they are often in emotional, mental and physical pain, living chaotic lives in and a hypervigilant state.

Keeping appointments is particularly challenging for a person in active addiction, especially where they are also experiencing significant mental health issues. For those in the resettlement pathway, this is further compounded by practical barriers relating to transport, cost, lack of people who might support you to attend, and for some, multiple appointments for different types of healthcare across the city.

One support worker explained:

> *"They expect people to go to Huntington House [local community MH service for adults] on the edge of the city, particularly for our clientele, who've got no access to money, we can't transport them there, we don't have the staff to do that. They're certainly not going to pay for taxis and buses themselves, even if they do run frequently enough out there, and then they don't attend the appointments…if they've missed two appointments, it's discharged."*

### 3.2. Drug and alcohol treatment and recovery services

The impact of reduced resources was also evident within drug and alcohol services, with people using these services feeling that the psychosocial and recovery elements had borne the brunt of cuts:

> *"This time, when using Blossom St services, it was literally a one-to-one session maybe every third or fourth week and the virtual online meeting for one hour a week on a Friday morning. Whereas, going back to [the previous contract], I had a key worker every week, the counsellor once a week for a session, we had mindfulness on a Monday, we had SMART meetings on a Tuesday…[etc…]… Fridays were a group called Next Steps for a couple of hours which kind of supported you for the weekend ahead where obviously services aren't open."*

Whilst many of those who had used the Oaktrees 12-week day rehabilitation model spoke highly of the support they had received, there was a recurring theme about the limited aftercare and the impact of this on people sustaining recovery after attending.

> *"Regardless who you are… technically, being in this environment and the pathway you go through, you should certainly get minimum of six months to a year of, I don't know, aftercare or support because… you need the guidance…just to make sure that you are doing everything you should be doing, you're not going backwards, and that you're doing it positively."*

Interviewees explained how important it was to have the right living environment and support networks in place to support recovery. Some described the challenges of engaging with the Oaktrees programme whilst living in hostel or other shared accommodation where substance use is common. Yet, on the other hand, some had succeeded in this situation through sheer determination, whilst others expressed concerns that they had been in resettlement services for years and not made aware that Oaktrees was an option. The lack of residential rehabilitation and detox places was highlighted as a key gap.

Meanwhile there was negative feedback regarding methadone scripts as a means of support, both in terms of this often being the only source of treatment/support offered and in terms of the regulation and management of scripts. One interviewee's experience of being given higher amounts than they wanted during a detox, despite insisting and

eventually returning the medication to the service suggests that people taking methadone are not always listened to as experts in what would work for them personally.

Despite these challenges, we heard positive feedback about the support received from individual workers.

> *"One day, I had somebody ring me, I wish I'd remember her name, um, she said 'how's it going?' and I said 'yeah, great' and I told her about having to give the medication back, um, and she said 'you've just made my day', she said 'we hear so many people, you know, sodding off scripts or blah, blah, blah and you're having to give medication back, like it seems like you're really serious about it'. And when I came off the phone I thought 'why can't they all be like that, she made me feel so good about myself for doing it, rather than 'you're being a pain in the arse, just do it for the 3 months', like, she was really, really lovely".*

Some people told us that they feel really cared for, and particularly valued lived experience in key workers. However, to be effective, treatment needs to be tailored to the person, and their life looked at holistically (housing, finance etc.). Much of the feedback suggests this is not currently happening due to challenges across systems and within service cultures.

### 3.3. Health and social care

Some of those interviewed reported a lack of understanding or an unwillingness or inability on the part of their GP to get involved in substance use and/or mental health treatment.

> *“As regards the engagement with your GP, it was literally, I’m struggling with my mental health and I’m using substances again and he said well we don’t deal with that anymore, this is where you need to go and that was quite a panic-y moment I suppose if I’m looking back at it now, that my GP wasn’t going to get involved in the treatment.”*

> *“My GP didn’t really understand addiction, I think I was actually teaching the GP”*

A hospital liaison worker highlighted the impact of a combination of a lack of resource in social care and a lack of clarity about how addiction impacts on mental capacity:

> *“There are a lot of people that I see, when you look at their background… there’s a huge deficit in social care, there’s a huge deficit in quality of life and they’re on the cusp again of whether they have capacity or not – they have when they are not drinking and they don’t when they are drinking, but they are predominantly in drink most of the time, most of the time is their lived experience is that they don’t have capacity, but there’s constraints around whether anyone can stick their neck out and say, well let’s say they don’t have capacity and that keeps them from accessing a*

*whole load of safeguarding strategies… I would like to see more assertive engagement with people that have got chronic and complex needs."*

### 3.4. Resettlement pathway

Although the focus of this report is on drug and alcohol services, it is important to highlight the challenges which people with substance use problems face within the resettlement pathway, given this group's heightened risk of homelessness.

There seems to be considerable variation between people's experiences of different supported housing projects, depending on scheme size, layout, staff ratio, ethos, policies and the demographics and drug and alcohol usage of other residents. As in other parts of the system, there was much praise for individual workers and the effort, care and experience they bring, despite their lack of pay and professional training. However, there is a recurring tension between managing risk and minimising harm, with reports of inflexibility or inconsistency in how alcohol or drug use are managed. This has several implications for the design and delivery of a drug and alcohol strategy:

- Some hostel settings are very challenging for those who are trying to abstain from drugs or alcohol:

  *"And the temptations that were there, people offering to get me things. There was lots of confrontation… I was very nervous going back into the hostel… I kept myself to myself and tried to avoid any confrontation, but confrontation was there in abundance if you wanted it and it added to my isolation."*

- From a prevention point of view, those experiencing homelessness who do not use drugs or alcohol problematically are at risk of increasing their usage or developing addictions in some settings.

- On the other hand, many projects have Zero Tolerance or abstinence policies which can act as an entry barrier or result in eviction where people lapse into usage or are trying to control their use.

- Although some individual workers have considerable personal and/ or professional experience, interviewees felt that there was a general lack of understanding of the impact of addiction and/or mental health within both the design and delivery of resettlement services.

  *"The linear nature of resettlement is counter to most individuals' experience with substance use - so incompatible that failure is almost inevitable. Those in recovery must adopt behaviour such as isolation and are exposed to threat, so feel fearful which again, is counter to recovery, let alone the availability of substances. The punitive nature of hostels to those using substances is counterproductive, the rules around substance use betray a lack of understanding of how substance use tends to manifest and the reasons behind it (as a system rather than at the individual level)"*

- As a result of this, some people with complex trauma have been circling around the system with periods of institutionalisation and chaotic substance use and have been previously evicted from the resettlement pathway: it can be very hard to get a second chance.

- The shortage of affordable housing in the city and the 'staircase' model in place (in which a person needs to move successfully through supported housing schemes to demonstrate their 'housing-readiness') places those with a history of problematic drug or alcohol use at significant disadvantage in trying to access the settled housing they need as a stable base for recovery.

- There is emerging evidence locally (as well as internationally) that Housing First models and other housing-led models such as 'training flats' can be effective for this group, but there are only a small number of places available in York at present.

### 3.5. Criminal justice

The criminalisation of drug use and the links to offending are well-established; however, the interviews also highlighted the risk of criminalisation resulting from associated mental illness. People felt that their behaviours had been misinterpreted as dangerous by staff in services and the Police subsequently called. For example:

> *"…I was going through an episode [mental health episode] I wasn't aware of my actions and I needed a doctor… not to go to the police station… if someone is having an episode, not to just assume they are a danger - ring the police – because if they see blue lights in uniform it's going to make them worse…"*

As the LIFE team highlighted, untreated addiction will almost inevitably result in institutionalisation, whether in prison or hospital. Some individuals felt that prison was the only place they could get off drugs. One person spoke positively of the help received in a recovery wing within a prison. Specialist staff run groups for those motivated to address their substance use and, most importantly for him, this created a community of people aligned to recovery:

> *"The community on [the recovery wing] is brilliant, because it's all people in the same situation, wanting to come off drink or drugs"*

A real point of system weakness seems to be the transition from prison to the community – several interviewees had experienced gaps and breakdowns in communication between prison, the Shelter resettlement service, and local authorities, which left them sleeping rough or sofa-surfing. There were examples in which Probation was able to secure housing outcomes for individuals. However, some people spoke of being placed on release in hostels where drink and drugs were widely available and relapsing back into substance use following a period of recovery in prison.

Probation appears to have significant influence and there were examples of officers being able to flex other parts of the system, including making effective referrals to drug treatment and recovery services.

## 3.6. Employment and benefits

There was relatively little discussion about employment, given that most interviewees were in the resettlement pathway – some were not well enough to work, given mental health, addiction and/or physical health challenges, and the rents in supported housing (usually covered by Housing Benefit) can be a barrier to those who are closer to employment. However, the following vignette highlights how DWP policy and practice may jeopardise recovery:

> *"I was on the basic universal credit, when I was at Oaktrees it was fine, there was no pressure. The moment I left Oaktrees, there's pressure on there to get back to work and they referred me to an employment agency…my head at the time I found them very…I felt I was getting pressured by them to get a job……..I got a random phone call off the woman saying 'we've found the perfect job for you, four hours a week cleaning in Clifton Moor' and I had no way to get there and I felt like they were just trying to push me into anything…I couldn't cope with it, where now I've had help through… the Never Give Up/ Restore project… I was put in touch with somebody who worked there as a volunteer… they looked into the situation with the Job Centre and filled out the forms…Some of the forms are crazy – I would like to say I'm quite an educated bloke but the forms just blew my mind some of the times and you put the wrong thing down and you can get into real issues…so that was a big weight off, once she filled all the forms out, contacted the Job Centre, everything is sorted out so I'm still, at the moment, not getting any pressure from them…"*

## 3.7. Overarching themes

There were some recurring and system-wide challenges for this group of people which seem to cut across services.

### 3.7.1. Impact of support ending and/or worker leaving or changing

There were many comments about the negative impact of losing a worker, particularly for those who have experienced past trauma and may have issues around attachment: one woman spoke of being 'broken hearted' when she found out her probation officer was leaving. Many interviewees described feeling that they kept having to 'start again', which can have real implications for their movement through the system and hence their prospects of recovery.

Others explained how they did not know who to contact and felt 'fobbed off' following staff changeover or struggled with the 'loss of connection' when one-to-one drug and alcohol

support came to an end at a time led by service policy rather than their own needs. This contrasts with the feelings of pride and achievement reported by others who were discharged by services at what felt like the right time. Lack of continuity can have a particularly negative impact on those trying to come to terms with past abuse:

> *"It all comes back to abuse. That needs dealing with and you can't keep speaking to different people on a whim about it. It's something you keep really close to your chest, so when you do open up, if the person who you've opened up to, then vanishes – you're stuck with these raw wounds that you cannot then patch up because you've patched up all your life."*

Of course, it is not just a case of retaining a worker, but also of getting the 'right' worker in the first place. This was generally felt to be a case of 'luck' (or lack of it), and whilst there will always be variation between individual workers' personalities and styles, the research team reflected that there should be a fundamental consistency of approach. This might be achieved by values-based recruitment, training, development, mentoring and reflective practice.

### 3.7.2. Inflexible and punitive systems

Requiring people in active addiction to attend fixed appointments and penalising them if they fail to attend was felt to be unrealistic, especially where they are also experiencing mental and/or physical illness and challenges such as homelessness. Resettlement support workers explained:

> *"[speaker one] sometimes they'll have two or three appointments, and they are all over the city... [speaker two] and if they are delayed with one it knocks onto the next one… [speaker one] chances are that they are not going to venture out three times in a week…"*

> *"they need to take on board that working with this client group, that is kind of expected, you've got to persevere, I guess their caseloads must be high and they are under pressure to see people"*

Sanctions and exclusions from services can be experienced as punitive – whether this is because someone has failed to attend, broken rules, or not met service criteria. The research team highlighted how punishing people in addiction is a sure-fire way to impede engagement and recovery. This can increase people's sense of shame, stigma or apathy hopelessness and leave them unsupported and in high-risk situations.

Although the focus in services is on individuals who 'disengage', it was striking that one interviewee who has been circling around the system, describing 'services disengaging'. There was a sense of pointlessness and even hypocrisy where it was felt that services were setting people up to fail with unrealistic expectations whilst 'box-ticking' and cutting corners in their own service delivery.

### 3.7.3. Services operating in silos

The interviews contain many examples of people's substance use, treatment and recovery being impacted by challenges in other areas of their lives, such as their mental or physical health, housing, family circumstances, or benefits. A holistic, multi-agency response is required; yet we heard many examples of people being passed 'from pillar to post', with missed opportunities to share information and create a coordinated response.

In following section, we begin to draw out the evidence of what works from the interview data and use this to suggest ideas and underpinning principles for an improved system response.

# 4. What promotes recovery and wellbeing?

In this section, we present themes from the interviews about what has helped, or what would help people with addictions. We were struck by how simple many of the things were which people told us promoted recovery – someone listening to them and trying to understand; connecting meaningfully with other members of a group or community – yet how complex it is to provide or facilitate these things consistently in current over-stretched and siloed systems.

In this section, we recommend principles which should underpin both future strategy and be considered throughout the design, delivery and performance monitoring of drug and alcohol support. The second part of the section draws together practical suggestions from the lived experience engagement to improve systems and services.

## 4.1. Principles

**Providing a trauma-informed service**

This research provides further evidence of the link between trauma and addiction for many people, and it also highlights ways in which services can re-traumatise people, for example by ending relationships with workers abruptly, or by 'punishing' people for their behaviours.

A trauma-informed review of drug and alcohol services should include physical spaces, as well as processes and practice. For example, the cramped and clinical entrance to the Blossom Street service was highlighted in our research team reflection meetings.

Many of the following principles link to this overarching theme of reducing the risk of services re-traumatising people and creating the conditions in which healing is possible.

**A gendered approach**

Despite the relatively small sample size, it was the women interviewed often had different experiences and faced different risks to the men – for example, their substance use was more likely to be linked to domestic abuse, coercive control and the removal of children[3].

As a minimum, services should be gender-informed, with:

- Training and supervision which ensures workers identify and respond effectively to women's trauma,
- Good signposting links to domestic abuse and children's services, and
- The choice of a female worker.
- A recognition of the needs of trans or non-binary people.

Commissioners and providers should also explore the feasibility of creating women-only spaces (perhaps at certain times of the week, or pop-up services/ support groups in existing spaces for women, such as the York Women's Wellness Centre), and ensuring links with

[3] See for example Agenda's work on Women and Alcohol

local support groups and organisations for trans and non-binary people, such as Generate and the York LGBT Forum.

**Taking the time to listen**

As the following quote illustrates powerfully, people really value the time and space to talk with a worker with whom they have built connection and trust.

> *"She used to meet me here once a fortnight where I felt safe, and we would talk for an hour easily, but she wasn't watching her watch. So, I didn't feel like I was having to rush into things and getting into things gently, but just as soon as you get to that point where you are establishing trust, it gets whipped away…you've got one foot that you are ready to put on that bridge, and all of a sudden it stops and the bridge is gone and it starts again, and you get back to nearly one foot on that bridge, and it stops again and this goes over and over and over until you're broken down because you just can't take it all the time. You need continuity of care…I think it's essential with people like me."*

As well as access to emotional support from a trusted worker, the research team also felt that individuals should have the option of psychotherapy to support recovery. The interviews, and the Healthwatch report, highlight a huge gap in talking therapies and emotional support within mental health services; drug and alcohol services cannot depend on referrals to NHS Talking Therapies securing the services people need within the timeframes required, so consideration should be given to more direct commissioning of therapeutic input for those in recovery.

**Continuity of care**

The value of maintaining a relationship with one worker was a common theme in many of the interviews, including the quote above. As we have seen, where people have experienced often repeated trauma in their lives, the loss of connection can have a huge impact on them emotionally, re-traumatising them since they have experienced a greater sense of vulnerability by opening up to workers, and thereby reducing their trust in services.

Staff turnover, changes in service contracts, and 'cliff-edges' at the end of time-limited (rather than person-centred) interventions were described as impacting negatively on this.

Whilst some endings may be unavoidable, they could be better planned for at the level of the individual (e.g., with as much warning and handover or step-down as possible) and reduced at system level, (e.g., by changing staff terms and conditions to include longer notice periods, ensuring that transition planning is prioritised when contracts are re-commissioned, and by providing long-term drop in options and linkages into peer and community support, as suggested below).

**Holistic assessment and support**

The interviews have highlighted the inter-connection between mental and physical health, trauma and addiction and shown how challenges with housing, benefits, relationships, etc. can impede recovery.

The barriers to accessing mental health support for those in active addiction have also emerged as a clear theme from the interviews. Given the current challenges for this group – or indeed for anyone – trying to access formal mental health support, drug and alcohol, services need to be better equipped to provide at least some mental health support directly. In the most complex cases, there should be referral routes to dual diagnosis specialists or multi-disciplinary meetings with mental health professionals to provide a coordinated (rather than a 'hot potato' approach).

Treatment for addiction also needs to be planned to take account of the wider social determinants and the risks and strengths for individuals. This means asking about, signposting, and advocating for individuals across a range of needs, from housing to benefits. This may require additional training or resources for workers as highlighted in the following quote:

> *"My role is around substance use, recovery and harm reduction, people come with everything and homelessness is part of the picture…when you make homelessness applications to CYC, you get all these documents about the different sections of housing law….. I can't understand it, how is [the person I am supporting] meant to understand! So, it would be good to have some system wide training around housing law."*

Another key aspect of a truly holistic service is to see people as members of a family unit – albeit often estranged where people are in resettlement services – rather than only as individuals.

**Letting people re-join services without judgement following relapse or disengagement**

Services and systems need to be designed in such a way that, whilst recovery is incentivised, relapse is viewed as a normal part of the change process. Interviewees particularly valued being given 'another chance':

> *"What they do at Oaktrees is great, I've never been turned away…I ended up doing it five times."*

> *"….people are coming back and giving me trust and a chance again which is really really good. Good people as well who actually want me to do well, which is a really positive thing which I haven't had."*

**Giving people as much choice and control over their treatment as possible**

Clearly resources are stretched, and treatment options may be limited; however, the interviews suggest that people would benefit from information about their options and honest adult conversations about what these might require from them. This includes having

some say in prescribing decisions, whether support is accessed on a one-to-one or group basis, or where and how detox is managed.

**Identifying and supporting interests and positive connections**

Several interviewees highlighted how critical it is to their recovery to build or re-build meaningful activities and connections. This is likely to be a gradual process, which may require support from agencies or peers to identify their interests, find existing groups and communities, and link into these.

> *"I need to find something constructive to do with my time instead of just sat about…I find I struggle a lot with my social situation sometimes, I get a lot of anxiety and that…"*

> *"in other [services] I've been in, they haven't asked me what'll take your mind off using as much…but she [meaning in the current service] did. Because I got clean…she just said 'if you are just sat in your room, one day you might get bored and take it', I know I'm stronger than that so she said 'what do you like to do and we can sort it, you don't have to but if you want to we will?'"*

**Access to others with lived experience**

People with lived experience can represent their community more broadly which may help strengthen links to community, they have a different understanding of key concepts related to services, can comprehend addiction, and can establish trust more quickly, key to engagement. The research team liked the idea of 'contagious recovery'. There was some discussion about how and which key points in a person's journey, commissioned services can best support and link people into lived experience-led groups and initiatives.

The group also welcomed the fact that insights from lived experience have been sought in developing York's Drug and Alcohol Strategy and hope that there will be ongoing work to hear the voices of people with lived experience in the development and oversight of the strategy.

## 4.2. Practical ideas for improvement

In this section, we present some of the ideas to further develop drug and alcohol services within a multi-agency landscape proposed by interviewees, or by the research team having reflected on the findings.

**Providing effective training for workers across the system**:

This might include training delivered by drug and alcohol specialists to workers in the rest of the system (e.g., supported housing staff, GPs, etc) on understanding addiction and

introductory techniques for supporting people around addiction (e.g. motivational interviewing, cognitive analytic/ behavioural therapy)

It might also include further training and clinical supervision for staff working in drug and alcohol services in relation to mental health support and working with survivors of trauma.

**Providing in-reach services into hostels**

Rather than expecting hostel residents to attend off-site appointments:

> *"I think it would help if in hostels, this could be a way forward, there was a mental health worker and maybe even in the hostel a drug and alcohol worker… so rather than having to always access another service it was onsite"*

This could build on some of LIFE's previous work developing a collaborative blueprint for transition accommodation, which proposed the idea of co-locating accommodation spaces with hub-style community facilities where services could be based, enabling better access to services for residents[4].

**Supported housing which is designated 'wet' and 'dry'**

The research team reflected that the city's largest hostel was effectively operating as a 'wet' hostel but without the infrastructure to safely support this. Official designation of 'wet' and 'dry' schemes with policies, staffing, and physical spaces planned accordingly might be one way of managing this moving forwards.

> *"It sounds daft but I think you should have a certain area where you can have a drink, I know it's not going to happen, obviously it'll be monitored and the first sign of any aggro and you'd be out."*

As one worker reflected:

> *"Their life is so chaotic that asking them to jump through any kind of hoop at that stage is virtually impossible for them. Provide the security and then ask."*

**Access to longer term, drop-in style support**

As an alternative to systems which effectively ration resources by offering time limited interventions through set appointments those able to attend (and with the ensuing 'cliff edges' of support), support could be accessed more flexibly as needed via drop-in sessions, perhaps at a community or multi-agency hub.

[4] A Place for me: Collaborative Blueprint for Transition Accommodation, by LIFE, Bauman Lyons, Good organisation, York Design Week, 2020

**Greater clarity around expectations and boundaries**

Given the risk of re-traumatising people, it is important to plan and prepare for endings and handovers and also to clarify and agree mutual expectations between workers and clients from the outset. This could take the form of a Memorandum of Understanding or similar between workers and individuals on their respective boundaries within a relational way of working.

**More residential rehabilitation and detox places**

Interviewees highlighted a severe lack of residential rehabilitation and detox places. Given the challenges of attending Oaktrees whilst living in shared houses and hostels alongside others who are using/ drinking, an additional option might be to combine 'dry' supported housing provision, a Housing First tenancy or trainer flats with the Oaktrees model.

**Strengthen links to community**

Interviewees explained how meaningful connections to peer and mainstream community groups were essential to their recovery.

> *"kept myself busy, one of the positive aspects of the [Multiple & Complex Needs] network is that because I'm busy I don't get time to worry and get myself in a state..." "put me in touch with a lot of people that I admire and respect…give me a sense of self-worth again…"*
>
> *"I ended up volunteering….., which I'm still doing to this day, and I did find that a huge support"*

Others felt that a community hub or centre, attracting a range of people to different activities would be beneficial.

> *"For me, the SMART meetings are my way of attending services without attending services. I think there's room for improvement – there's talk of a community hub, where different services work within the same building so people accessing services are provided with a clearer pathway in terms of support…"*
>
> *"I know what's missing, there's nothing for no one to do so I think that's why people take more drink and drugs… if you haven't got a job and you've got nowt to do, basically… a centre, different things, I don't know, if someone's interested in art, gardening, cookery, a centre that's got different activities for people"*

The Lived Experience research team felt that such a hub needed to be community rather than service-led and be inclusive of those in recovery and wider citizens to be effective[5].

[5] We liked, for example, The Brink – a dry bar run as a social enterprise in Liverpool

> *"You need to be normalised in society, mixing with people and slowly becoming part of humanity, not just being segregated with your own kind"*
>
> Lived experience researcher

Another approach might be to link individuals into groups and activities based on their interests through existing social prescribers or local area coordinators in the city. The research team also suggested that Personal Health Budgets – or access to similar flexible person-led funding – could help to facilitate individual recovery.

**Better multi-agency coordination for people with multiple needs**

The findings have highlighted the need for a more coordinated approach across agencies. One interviewee suggested a single care and support plan as a mechanism for this; other potential models include Team around the Person[6] meetings, or a lead keyworker, which might be the worker who has the closest relationship or is best placed to act as coordinator.

Effective multi-agency coordination is as critical post-treatment as it is before or during treatment. If people are to have time to recover, heal and re-connect they not only need to be linked into community support and secure housing, but also to avoid being pressured into employment too quickly, as we heard in section 3.6.

**Monitor experience and process, not short-term outcomes**

The research team expressed concerns about the way in which 'success' and 'performance' are measured and the impact this can have on the culture in services and on individuals using them. The focus on 'throughput' and 'successful completion' of programmes can miss the impact on feelings and quality of life for an individual – whether positive or negative. The culture in services can be quick to categorise people into those who are 'good', 'ready to change', 'worthy' of treatment and those who are not.

If metrics are to be used, they should focus on wellness, emotional health, social capital, individuals' goals, and quality of life, perhaps also monitoring the numbers of people who are excluded from services, for example, due to missed appointments.

> *"with services being focused on outcomes a lot.....we've always been outcomes focused, what do you want to achieve, where's your goals, care plans are orientated that way and the process towards those goals has always been assumed and I think we need to make that explicit'.*
>
> *"....well the outcomes would shift to looking at values based living rather than things that have been achieved".*

[6] For example, see details of the model being used in Sheffield health and social care: https://www.sheffieldhcp.org.uk/what-we-do/integrating-care/delivery-groups/ageing-well/anticipatory-care/team-around-the-person/

## 4.3. Concluding reflections

We hope that the insights into how this group of people experience drug and alcohol and associated services in York - what works and what is needed, can prompt systemic thinking to build services around the person, rather than around the processes of different siloed agencies and services. The starting point for this, as summed up by a member of the research team, is that:

> *"Success stems from a person sensing compassion, neutrality and non-judgement. The common denominator of fruitful engagement was the key worker and their catalytic influence. We need more opportunities for folk to have this space. To have consistency of staff to build those pivotal relationships."*