Introduction
Cambridgeshire County Council and Public Health are currently in the process of re-tendering the adult drug and alcohol system in Cambridgeshire. As part of this process, surveys and consultations have been undertaken with a range of interested groups. These include:

- Service user survey (page 3)
- General survey (page 6)
- GP survey (page 11)
- Strategic one to one consultations (page 13)
- Stakeholder engagement events (page 20)

The purpose of this exercise was to gather qualitative feedback on the current treatment system. This report is a summary and analysis of this information which seeks to inform the re-tendering exercise and service specification by identifying strengths (‘what is working’), common issues and emerging opportunities that can aid the development of the future service. The survey and consultation information here is not attributable to individuals and will only be used for the purpose of this exercise.

This report starts with an overall summary and analysis of all comments. This is followed by both a summary and details per consultation/survey group.

Overall summary of comments from the consultations and surveys

Please note that this is a short summary, and readers are encouraged to continue reading the full report to understand the detail behind these comments.

This exercise took place between July and October 2017. Numbers contributing comments included: 48 respondents to the service user survey, 109 to the general survey and 32 to the GP survey. The one to one strategic consultations interviewed 20 managers and three stakeholder engagement events had a total of approximately 100 contributors.

What works well?
The recovery work of the treatment service received positive comments from all consultations and surveys. In particular, group work and one to one work was highly valued along with peer and volunteer support, outreach and the recovery cafe. Treatment staff showed commitment and low staff turnover meant that consistency was offered. Most respondents thought access was easy and pharmacy support was good.

Issues
- **Access and pathways**: Despite good reports of access, a proportion of responses highlighted ineffective or confusing pathways to treatment and perceived lack of out of office hours opening. Criminal justice pathways in particular were reported to vary in effectiveness. In rural areas, issues were magnified by lack of equitable provision.
- **Primary care support:** It was widely reported, including from GPs themselves, that shared care was not something that most wanted to be involved with. Reasons were because of the complexity of clients, time required and lack of expertise. An emerging group with a specific problematic drug use were patients with prescription drug and/or over the counter drug dependence; they were presenting in primary care, but not in treatment.

- **Recovery focus:** Whilst many respondents welcomed the recovery focus, a number of both service users and professionals stressed that this was not possible or wanted by all substance misusers and meant that inappropriate aims of abstinence were set when harm reduction needed to be the goal.

- **Mental health:** This came out repeatedly as an area where needs were not met, with confusion and frustration surrounding who/how substance misusers with mental health issues could be effectively treated. Service users cited mental health as a key reason why they didn’t access substance misuse treatment.

- **Older people:** Increasing numbers of older people in treatment reported that they did not ‘fit’ in a service that was designed for a much younger cohort.

**Opportunities for the future**

- **Co-location:** Extending opportunities for co-located working is desired by a range of professionals, especially as a way of working with primary care and criminal justice agencies.

- **Primary care:** Increasing GP willingness to deliver shared care requires training and ongoing support. ‘Stable’ and ‘alcohol users’ in particular were seen as appropriate for treatment in primary care. Clarity is needed regarding the treatment pathway for patients dependent on prescription medication.

- **Hospital alcohol liaison:** Given the high number of alcohol specific and related episodes, intervening with effective advice and pathways to treatment is imperative. This could include moving this role to within CPFT Psychiatry team or rethinking the definition of the role.

- **Pharmacy support:** Pharmacy staff, other professionals and service users want to see pharmacies able to deliver a wider range of interventions from identification and brief advice, to health checks. This is alongside supervised consumption and needle exchange. Needle exchange needs ‘pick and mix’ rather than pre-chosen packs.

- **Criminal justice:** Data surrounding offender access and sustained engagement in treatment requires attention so that opportunities to increase the effectiveness of pathways and provision respond to need.

- **Mental health:** Opportunities for joint working between substance misuse and mental health treatment services are seen as crucial to improve outcomes for this cohort of service users.

- **Recovery:** The overwhelming response of service users to future provision was more group work, counselling and recovery and post recovery activities. Older people want support from similar aged individuals.

- **Promotion:** The new service needs to be actively promoted to ensure easily accessible information promotes the service.

The rest of this report now gives details of all of the surveys and consultations. Each starts with a summary.
1.0 Service user survey

Key points
A total of 48 people contributed to the service user survey; only 34% (n=11) defined themselves as currently with the service, with a further 25% (n=8) in recovery. This may affect findings.

Referral and access
Three quarters of respondents said that access was ‘easy’ or ‘very easy’. There were comments about opening hours not fitting with people who were employed, and perceived lack of evening and weekend opening was seen as a barrier. ‘Fear’ and ‘mental health’ were overwhelmingly stated as the reasons that might prevent access.

Support from primary care
Respondents thought that ‘stable users’ and ‘alcohol users’ could be effectively treated by GPs in surgeries, followed by ‘people addicted to prescription or over the counter medication’. They did not think that ‘illicit users’ or those with ‘complex needs’ could adequately be treated in such settings. 89% of respondents thought that recovery workers could work from surgeries.

Specific needs
- **Family work:** Most respondents said specialist family workers should be based within the treatment service.
- **Older people:** Few people responded, but comments highlighted that it was hard for older people to engage with a service that was geared for much younger users. ‘Age appropriate peer support and groups’ had the highest score from a choice of ways to best meet needs.
- **Mental health:** There was overwhelming response that collaborative working was the best way to meet the needs of those with co-occurring mental health and substance misuse issues. Co-located workers in both agencies was advocated.
- **Criminal justice pathways:** Only a few respondents answered - with their comments being inconclusive. Only IOM pathways seemed to be working well.

What currently works well?
77% of respondents valued one to one sessions with recovery workers, followed by group work, and volunteer and peer led support. The recovery cafe was valued. There was no clear idea given as to whether users thought the service had the right balance between recovery and harm reduction.

Improvements
When asked what could be further strengthened to aid recovery, an overwhelming 87% of responses requested therapies and counselling. Also wanted by a high number of respondents was recovery based activities, abstinence and maintenance work, employment and welfare, education and training.

A total of 48 people contributed to this service user survey from around the county (44% male/ 53% female/ 3% no answer). Unfortunately, no service users aged 18-25 years contributed which may affect findings; the age band 36-45 years had the most respondents (34%, n=11). Both 46-55 years and 55+ had 25% each (n=8). The lowest numbers were in the 26-35 years band (16%, n=5). When asked to describe themselves, only 34% (n=11) were actually current service users, although a further 25% (n=8) described themselves as being in recovery. Again, this might have affected findings.

The task of encouraging service users to take part was led by a representative from the Service User Network (SUN), and took place during September and October 2017.
Responses to questions

a. Referral and access: How easy is it to refer into current treatment services?
All 48 respondents answered this question, with an overwhelming 73% (n=35) saying it was ‘very easy’ or ‘fairly easy’. Only 14.5% said it was ‘fairly difficult’ or ‘very difficult’ (n=10). ‘Don’t know’ was the response of 12.5% (n=6). For those who had difficulty, most comments were around the wait from assessment to treatment.

Whilst half (52%, n=25) of service users said that opening hours met the needs of individuals accessing the service, no clear picture emerges from the other half; 14.6% (n=7) said categorically that opening hours didn’t meet needs, but a further 29% (n=14) didn’t know and 21% (n=10) responded ‘other’. Their main comments were about opening times not fitting people who were employed, and lack of evening and weekend opening.

What factors might prevent individuals from accessing treatment services?
Two factors, ‘fear’ and ‘mental health’ were far ahead of other factors. Fear was responded to 87% (n=42) of times and mental health 89% (n=43). ‘Physical health’ (69%, n=33) and ‘lack of anonymity’ (60.4%, n=29) were the next most stated responses. 50% (n=24) responses were for ‘location of services’ and 44% (n=21) were ‘employment’. It is interesting that 50% highlighted location: When asked if services were in the right locations, 44% (n=21) said they were, and a further 33% (n=16) said ‘partly’. Only 6% said no, but 52% responded with ‘other’. Their comments mostly were about problems of rurality. Suggestions about practical solutions included online support as a practical solution, as well as more outreach and home visits. Appointments in GP surgeries was also seen as a solution by a few.

b. Support for substance misuse in primary care (GP surgery)
A high, 89% (n=43) thought that recovery workers could work out of surgeries and that this was a good venue for relapse prevention support. An almost equal number of responses (87%, n=42) said ‘psychological services’ could be offered. ‘Brief advice’ had 67% (n=32) of responses but much lower responses were for Hep B and C testing, prescribing and general healthcare.

Asked what range of users could be supported in such settings, 80% (n=33) said ‘stable users’, followed by 72% (n=33) responding ‘alcohol users’. Half of respondents thought that ‘people addicted to prescription/over the counter medications’ could be supported. Interestingly, 37% (n=17) did not think illicit drug users could be supported by primary care - or substance misusers with complex needs (24%, n=11). The majority (80%, n=37) thought that ‘information and brief advice’ could be given in primary care, followed by ‘health checks’ (56%, n=26) and ‘sexual health screening’ (33%, n=15).

c. Providing support for family members/loved ones of substance misusers
The highest response (67%, n=32) was for specialist family workers to be based within the treatment service. Just 10% (n=5) said it should be through a stand-alone service.

d. Are older service users’ needs met through the current model?
This was not widely answered; 21% (n=10) said yes and 12% (n=6) said no. Comments included the difficulty for an older person of working with a service geared to younger people, and in which most of the staff were young. When asked what additional support older substance misusers require to support recovery, a range of services were reported; physical health, mental health, mobility assistance, memory assisted technology, specialist recovery workers. ‘Age appropriate peer support and groups’ had the most responses. Best meeting the needs of older substance misusers was seen as via a number of ways: 24% (n=11) suggested specialist workers in the treatment service and GPs, and 22% (n=10) thought skilling up front line staff in older people’s services was required. 19% (n=9) said that working collaboratively with older people’s services would maximise support.
e. Is the current system meeting the needs of individuals experiencing both mental health and drug/alcohol difficulties?

Just over half (53%, n=25) of responses said no. Comments repeatedly stated that mental health had not been discussed. Two comments said it was particularly hard to access mental health if there were alcohol issues. Others said that they were refused by mental health services. Service users were asked if they had ever experienced certain responses from mental health services. 78% (n=33) said services treat people based on what it considers to be the primary need (i.e. mental health, drugs and alcohol). A similar 76% (n=32) said they had been excluded from IAPT services and 64% (n=27) said that they had received a crisis intervention, but then no ongoing support.

Asked what was the best way to meet the needs of individuals with co-occurring mental health and substance misuse difficulties, 95% (n=42) said collaborative working between substance misuse workers and mental health workers. 91% (n=40) wanted mental health workers co-located in substance misuse services and 82% wanted substance misuse workers co-located in mental health services. 84% (n=37) thought that support from third sector organisations such as Mind could help.

f. What elements do you particularly value and feel work well in the current treatment model?

Of the options given, the highest response was for ‘recovery worker 1-1s’ at 77% (n=36). The next was ‘group work’ at 57% (n=27), closely followed by ‘volunteer/peer led workers’ at 55% (n=26). A number of other options including relapse prevention, pre-rehab work, preparation for detox and outreach to homeless/hostels also had responses between 40-50%.

On a score of 1-10, 42% (n=19) answered with ‘4’ for the service meeting current need, this was the highest score. 31% (n=14) answered ‘3’. There were some positives comments; a few recognised that the service supported people with very complex conditions - one had found the recovery cafe a great support. Others however talked of the lack of support for mental health conditions.

g. Does the current model have a right balance between recovery and harm reduction approach?

36% (n=17) thought there was the right balance, and a further 19% (n=9) said ‘partially’. However, 23% (n=11) said the balance was not right. Comments did not really propose what the balance should be - although a number talked about the need to be clear about what was on offer for recovery after they were clean or abstinent. When asked what could be further developed to strengthen the recovery based approach, there was an overwhelming 87% (n=41) response of ‘therapies and counselling’. Response rates were also high (70-80%) for recovery based activities, abstinence and maintenance work, employment and welfare, education and training and the recovery cafe.

h. Support for individuals who are parents

The question asked whether there was enough support in place to help parents or those living with children to cope with the demands of parenting and ensure that the needs of children are met. The response rate was low with 72% (n=34) saying the question was not applicable to them. Of the few who did reply, comments were that more home visits would be beneficial.

i. Are CJ pathways/initiatives for drug/alcohol misusing offenders working effectively?

- **Prison in reach**: Most respondents said this question was not applicable to them (79%, n=35). Of the nine who did respond, eight said prison pathways were either not or only partially effective.
- **Liaison and Diversion service** (LADS): 81% said this was not applicable to them, and the responses of the eight people replying were not conclusive.
- **Conditional cautions**: There was low applicability; the seven responses were inconclusive.
- **Court based orders**: As above
- **IOM**: Although there was low applicability, seven out of eight responses said this was either good or partially good. Of all the pathways, this was the most conclusive result.
2.0 General survey

Key points
The majority (61%) of the 109 respondents were professionals. Others included family members and carers, treatment service staff or current and past service users.

Referral and access
26% said it was simple to refer into the service. Difficulties for others included lack of clarity about referral pathways and criteria. Lack of integration with mental health services was also stated.

Approximately 75% considered opening hours satisfactory or very good. Where respondents said that opening hours were poor, this was mostly about evening and Saturday opening. This is confusing as the main sites open one evening a week as well as Saturdays and suggests a lack of information. ‘Mental health’ and ‘fear’ were the main reasons preventing individuals accessing the service. Rurality was cited as a big problem regarding the location of services.

They said that engagement could increase if co-located working such as in GP surgeries, satellite hubs and more outreach was introduced.

Other locations for delivering support
Respondents said that a range of support such as recovery work, relapse prevention and brief advice could be delivered from primary care settings. In particular, they thought that primary care settings would best support those struggling with prescription medication overuse, and service users who were ‘stable’.

Pharmacies were seen as a good setting to deliver brief advice, health checks and Naloxone kits. Family support was seen as best delivered from specialist workers within the treatment service.

Specific needs of older people
There was no clear response as to whether older users were currently supported by treatment services. Meeting needs of social isolation, little social capital and their sometimes reluctance to recognise the severity of their misuse was problematic, and services seemed structured to younger populations. A harm minimisation approach was deemed best for this cohort. When asked what additional support could help recovery, ‘age appropriate peer support groups’ scored highest. Working collaboratively with older people’s services and skilling up their staff was necessary.

Mental health and substance misuse
61% said current provision did not meet needs of this cohort. The overwhelming reason was stated as due to separation of services, lack of joined up working and clients ‘falling between services’. Respondents said that collaborative working was the way to improve outcomes.

Balance of recovery and harm minimisation
It is felt that the service is too recovery focused. If this is aimed for, a range of services is required to help an individual develop strengths. ‘Therapies and counselling’ was particularly highlighted, alongside recovery based activities.

Parents and children
There was significant concern that there was not enough support for children of substance misusing parents - who often carried burdens of care. 84% said that ‘open communication with children’s services to ensure families get the right level of support at the right time’ was vital.

Criminal justice pathways
Respondents had mixed views on the effectiveness of pathways from CJ initiatives such as Liaison and Diversion, IOM and prison in-reach. Conditional Caution pathways were not considered effective.
Remit
The survey was undertaken during September and October 2017. There were 109 complete responses, of which the majority, 61% (n=66) were professionals. A further 9% (n=7) were family members/carers, 9% (n=7) were treatment service staff, 3% (n=3) were past or current service users and 16% (n=12) were ‘other’.

Responses to questions

a. Referral: How simple is it to refer into current treatment?
All 109 respondents answered this question. Out of a scale of 1-5 (very difficult - very easy) 26% (n=29) reported that this was ‘very easy’. Otherwise, responses were broadly spread ranging from 13.76% for ‘very difficult’ (n=15), 17.43% for ‘difficult’ (n=19) and 16% and 17% for points between ‘difficult’ and ‘very easy’. This suggests that for respondents, their experience of referring someone into treatment varied in ease of process.

Why do you feel it is difficult to refer into current treatment services?
Comments were offered by 34 respondents. Key issues seemed to be lack of understanding or clarity about referral pathways and criteria, and then issues of waiting times. Some said that the service was too Class A focused and didn’t adequately address cannabis and prescription medication misuse. Due to the high numbers of potential clients with mental health issues, the lack of integration with mental health services was a difficulty for referrals.

b. Opening hours: How well do current opening hours meet the needs of users?
A five point scale was offered and 109 respondents answered. The largest response was ‘satisfactory’ from 36% (n=39), followed by ‘good’ at 23% (n=25). A further 15% (n=16) reported ‘very good’. However, ‘very poor’ and ‘poor’ was scored by 27% (n=29). Very broadly, this can be summarised up as 25% unhappy with opening hours and 75% considering them satisfactory to very good.

Why do you believe that current opening times do not meet the needs of individuals?
Comments were received from 68 respondents. They were overwhelmingly about opening hours, with respondents saying that these should include evening and Saturday opening. This is unfortunate as the main sites offer both and the responses suggest a lack of information. The next most mentioned area was that of the ‘drop in’ structure; this was reported to run for too short a time each day, meaning some clients would need to return the following day. The final main area regarded out of hours crisis management - and the lack of flexible support for those with chaotic lifestyles.

c. Which factors prevent individuals accessing treatment services?
All 109 respondents answered this question which listed various domains. ‘Mental health’ was identified by 77% of respondents (n=84), but this was closely followed by ‘fear’ by 74% (n=81). The ‘location of services’ was the factor stated by 50% (n=54). This was followed by several domains scoring 39% (n=43), namely ‘physical health’, ‘employment’, ‘mobility problems’. The mental health issue could be seen as the problem of lack of integration of services, but ‘fear’ is perhaps based in lack of information, promotion and understanding. For some, uncertain commitment, denial of the severity of their problem and stigma were reasons. Transport to the service was mentioned a number of times.

d. Are the current treatment service bases in the right locations?
The 109 responses are difficult to interpret; 51% (n=56) said ‘partly’, 34% (n=37) said ‘yes’ and 15% (n=16) said ‘no’. When asked for further information, respondents overwhelmingly highlighted that rurality was the main problem regarding locations - as rural populations were faced with journeys and often transport issues to get to services. Some thought that more outreach would mitigate against this. Locations also were criticised for not being on bus routes or having nearby easy parking. Several
respondents said that if services were co-located in places such as GP surgeries, or criminal justice agencies, this would help access. Satellite or hub and spoke models of location were also mentioned.

e. How would you rate the service in relation to service user engagement - and solutions?
Of the 72 respondents answering, 37% (n=27) said it was ‘satisfactory’, with a further 24% (n=17) answering ‘good’ or ‘very good’. However, 39% (n=28) said it was ‘very poor’ or ‘poor’. When asked what would make engagement easier, some of the solutions suggested were similar to those in the ‘location’ question; these included co-location of services in GP surgeries or community centres and use of satellite centres. In addition, more outreach and home visiting was thought to improve engagement alongside more flexible opening hours and longer drop in sessions. New ideas ranged from bringing in online support to improving multi agency links to make engagement easier for someone already engaged well with another agency. A number of respondents said that improved promotion and information dissemination could help engagement.

f. What support for substance misuse would you like to be available in primary care?
Although there are not wide variations in scoring, responses seem to fall into three groups.

- In the first group, comprising of the highest percentage of respondents, 82% (n=89) said ‘recovery workers working out of primary care’, 80% (n=87) said ‘relapse prevention support’ and 79% (n=86) said ‘psychological based services’.
- The next group of slightly lower responses included 64% (n=70) suggesting ‘prescribing based services’ and 62% (n=68) saying Hep B/C testing and vaccinations’.
- A third group of lower responses included 54% (n=59) response for ‘brief advice’ and 52% (n=57) for ‘generic health care’.

This question shows very clearly that respondents consider that primary care can support substance misuse treatment. Other ideas were mainly about treatment for mental health problems, followed by support for the family and children of substance misusers.

What range of users that could be supported within a primary care setting?
Of the 109 respondents, 87% (n=95) said that this could be ‘people addicted to prescription/ over the counter medication’. This was closely followed by 83% (n=91) saying ‘service users who are stable’. Slightly lower were respondents stating that ‘alcohol misusers’ could be supported - 69% (n=75). However, far fewer respondents thought that ‘illicit drug users’ - 56% (n=61) or ‘substance misusers with complex needs’ - 53% (n=58) could be supported. There were no other main areas that respondents repeatedly thought could be supported, although mental health was mentioned. A few comments were about the potential for disruption and lack of compliance that supporting substance misusers could cause.

g. Community pharmacies - what additional support could be available?
All choices offered were seen as potential support by more than 65% - and up to 79% of respondents. The most popular was ‘information and brief advice’, followed by ‘Naloxone kits’, ‘hepatitis testing and vaccinations’, ‘health checks’ and ‘sexual health screening’. This clearly indicates how valuable community pharmacies are viewed as places that can offer additional support.

h. Supporting family members and loved ones of substance misusers
The best method of support was stated as ‘specialist family workers based within treatment services’ by 60% of respondents (n=66). However, 28% (n=31) thought this should be by a ‘stand-alone family service’. Additional comments were inconclusive, supporting either model of support.

i. Older service users: Do you think needs are currently met through the current model?
Responses to this did not show a clear opinion; 39% (n=43) said ‘partly’, whilst ‘no’ and ‘yes’ were answered equally by 30% (n=33) of respondents. Further comments indicated that meeting older service users’ needs was not straightforward - they may be entrenched users, isolated with little social
capital and reluctant to recognise the severity of their substance misuse. Alongside this, there was a feeling that services were structured for a much younger population, and older users found difficulty with access, waiting rooms and lack of flexibility with support. Most clearly stated that for many, the approach needed to be one of harm minimisation.

What specific additional support needs do older substance misusers require to support recovery?
Of the choices given, ‘age appropriate peer support groups’ was responded to most often - by 83% (n=91) of respondents. ‘Mental health’ (68%, n=74), ‘memory assisted technology’ (66%, n=72), and ‘physical health’ (65%, n=71) were next. This was followed by ‘mobility assistance’ (61%, n=67) and ‘specialist recovery workers’ (54%, n=59). Additional comments did not indicate any further conclusive ideas. The overall response therefore indicates that having the peer support of people your own age is seen as important.

When asked how best can we meet the needs of older people, there were low response rates for the choices given and no clear idea of what older people’s support should look like. The highest response of 22% (n=24) was for ‘work collaboratively with older people’s services to maximise support’, ‘interventions such as assisted technology’. ‘Skilling up front line staff within older people’s services’ and ‘specialist workers within the treatment service’ both received 18% (n=20) responses. Choices of ‘age appropriate groups’, ‘support via GPs’ or ‘stand-alone service’ received 12% or less of responses.

j. Meeting the needs of individuals experiencing both mental health and substance misuse difficulties
61% (n=67) of respondents said that the current service ‘did not meet needs’, 27% (n=30) said ‘partly’ and only 11% (n=12) said ‘yes’.

Why is the current system not meeting these needs?
This section received the most comments (n=97) of the entire survey with the same key issues repeatedly highlighted. The overwhelming opinion was that the separation of services resulted in mental health services having a poor response to substance misusers. This was summarised by one respondent as needs being ‘too closely entwined to deal with separately in different services.’ The outcome was that many individuals fell between the two service areas. Problems include lack of joined up working, clear pathways and a coordinated approach. The new Dual Diagnosis strategy was welcomed but it was felt that the protocol was not widely understood and the team had not yet become embedded. Further issues included the lack of mental health knowledge and expertise within the substance misuse service.

Experiences of seeking help to address co-occurring mental health/ substance misuse needs
Respondents were asked to indicate what statements could be true about them either personally or professionally seeking help. Issues scoring over 80% included ‘not meeting the threshold for specialist secondary care mental health services’, ‘crisis intervention but no ongoing support’, ‘services treating people based on what is considered to be the primary need’. Slightly lower scores were for ‘excluded from IAPT because of current substance misuse’ and ‘too complex for drug and alcohol treatment to manage’.

How can we best meet needs?
More than half of respondents - 56% (n=61) said this should be by ‘drug and alcohol workers/ mental health workers/ primary care, working collaboratively to address co-occurring conditions’. Other choices had much lower scores; 16% (n=17) said ‘mental health workers co-located in drug/ alcohol services’ with 10% (n=11) saying ‘drug/ alcohol workers co-located in mental health services’. There
was a small response - 5% (n=6) to ‘embedding support from third sector organisations’. Further comments were that services must be driven by individual need; MEAM was a good example.

**k. Service elements and balance: What elements do you particularly value and feel work within the current treatment model?**

Respondents were asked to select any or all aspects of service from a list. The scoring range was narrow suggesting that respondents valued all service elements provided and indeed some comments stressed that all elements were equally important. The highest response was for ‘harm reduction advice (needle exchange, naloxone kits)’ at 63% (n=69), followed by ‘recovery workers 1-1s’ at 61% (n=67). All other aspects of service delivery had responses of between 28% and 51%.

**Is there the right balance between a recovery and harm reduction approach?**

The response was similar for ‘yes’ at 39% (n=43) and ‘partly’ at 35% (n=38). But 26% said ‘no’ (n=26%). In the comments following, the overwhelming response was that it was too recovery focused, often driven by targets. Some admitted that they didn’t know what the balance should be and that services should be constantly adapting and adopting good practice to meet individual’s needs. Others thought that harm reduction and recovery were on the same continuum, and the balance needed to be where the client was at - and this might be in the middle! It was felt however that not enough time was spent on developing strategies with a client which built on their strengths.

**In order to strengthen the recovery based approach, what services could be further deployed?**

A list of services such as employment and welfare, health support, therapies and mutual aid were given. Responses to all but one were above 50%. The one below was ‘volunteering’ at 44% (n=45). The service just slightly ahead of others was ‘therapies and counselling’ with 73% response (n=80), very closely followed at 71% (n=78) by ‘recovery based activities such as walking, cycling…etc’. Further comments included one that worker’s motivational interviewing skills were not developed, and that it was important not to forget friends, family and children in a recovery approach.

**How do you rate the current treatment service model in terms of meeting current need?**

Respondents were asked to score this question from 1-5 where 5 was ‘completely meets need’. Of 75 responses, 37% (n=28) responded with a ‘3’, 24% (n=18) with ‘4’ - and one response was ‘5’! 11% said it had not meet needs at all (n=8) and 27% (n=20) responded with a ‘2’.

**I. Parents and those living with children**

The first question in this section asked if there was enough support to help individuals cope with the demands of parenting and ensure that the needs of children were met. 42% (n=46) said ‘no’. 31% (n=34) said ‘yes’ and 27% (n=29) said ‘partly’. Most comments highlighted the lack of support for children of substance misusers, and their burden of care was of great concern. Issues about thresholds for social care, lack of understanding of substance misuse by social care and issues with joint working were all problematic. Some respondents stressed that support needed to be holistic and family based rather than separated into either adult services or children’s services.

**What would be beneficial for individuals who are parents or who live with children?**

The highest scoring response was ‘open communication with children’s services to ensure families get the right level of support at the right time’ at 84% (n=63). This was followed by ‘treatment services closely linked with children’s centres’ at 68% (n=51) and ‘more home visits’. ‘Comprehensive assessment of parenting capacity’ and ‘promotion of services for young carers' were 59% and 57%.

**m. Do CJ pathways and initiatives for drug and alcohol misusing offenders work effectively?**

Respondents could choose ‘yes’, ‘no’ or ‘partly’ to describe how effective a pathway was; the highest scores were rarely in the ‘yes’ category, apart from the ‘Liaison and Diversion Service’ which had 20% (n=15) responses in both ‘yes’ and ‘partly’. ‘Court based orders’ were scored most highly as ‘partly’
effective at 37% (n=28), ‘Prison in-reach’ scored 27% as ‘partly’ and ‘IOM’ scored highest as ‘partly’ at 24% (n=18). ‘Conditional Cautions’ were ‘no’ in 27% of responses (n=20). The general theme seems to be that these pathways have a mixed record of effectiveness according to respondents - this was echoed in the additional comments given.

3.0 GP survey

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Almost all GPs saw patients who asked for help with drug and alcohol problems.
- 69% regularly saw patients with problematic use of prescription medicines - this was a growing problematic group.
- 58% regularly saw patients with substance misuse and mental health issues.
- 56% regularly saw substance misuse patients with significant morbidity - 44% of GPs also saw this occasionally.
- Older, frail patients with substance misuse issues were rarely seen.

| View of the treatment service |
Almost all GPs signposted or referred to the treatment service. GPs reported that they received good feedback about the treatment service. They thought the access and proactive support good, with motivated key workers. Communication was clear and contact easy. However, they said the treatment service was not interested in prescription medication misuse. Lack of electronic communication hampered effective practice.

| Shared care |
Shared care was not something that many GPs wanted to offer. The main reasons were lack of time to train and resources; they did not think they would see enough such patients to gain expertise. Those undertaking shared care reported that it was indeed time consuming although some GPs said it worked well.

When asked what type of patients they would be willing to offer shared care to, the vast majority - 90%, said only if it was with ‘straightforward’ patients. 62% were willing to treat shared care patients with co-morbidities, but only 32% said they would be willing to offer it to all their patients.

| Supporting GPs |
Most wanted more support from the treatment service, plus support from additional services such as mental health, housing, pharmacies, housing and social care. Better multi agency liaison, training and time was needed to increase understanding and confidence to work with substance misusers. They saw hub and spoke models with specialised GPs as an effective model of treatment

Remit
The survey was sent out in September 2017 to all GPs. There were 32 responses; 65% of these (n=21) were from GP partners, with the remainder comprising other salaried or locum GPs, one nurse, one manager and three ‘other’ that included street outreach and two project workers. Please note that this does not mean that 32 different practices responded - some practices sent responses from a number of staff.

Responses to questions

a. Do you see patients who ask for help with alcohol and/or drug problems?
All but two respondents answered ‘yes’ (n=30).
b. Changing patterns of substance misuse
Respondents were given a choice of cohorts that might present with substance misuse problems - and asked to indicate which of these had presented at their practice. The bullet points below are ordered by which cohorts the most GPs say have presented to them.

- **Problematic use of prescription only medicines**: 69% (n=22) saw such individuals presenting regularly. A further 20% (n=8) saw such patients occasionally.
- **Dual diagnosis**: 58% (n=19) saw patients regularly with substance misuse and mental illness (dual diagnosis) a further 34% (n=11) saw such patients occasionally.
- **Alcohol and drug problems plus significant morbidity** (e.g. cirrhosis, COPD, chronic pain): 56% (n=18) saw such patients present. A further 44% (n=14) saw this group occasionally.
- Older frailer people with alcohol and drug misuse problems were seen occasionally - only 2 respondents reported regularly seeing this group.
- **Other**: Four respondents said that the following cohorts had also presented: Middle aged professionals, severe personality disorder (working in a secure environment), stable opioid dependent patients and internet purchase of addictive medication.


c. Signposting or referring to the drug and alcohol treatment service
91% (n=29) said that they referred or signposted to the treatment service.

d. What works well in the current drug and alcohol service model?
The survey asked for comments about what worked well. Responses clustered as follows:

- GPs had received good feedback from patients about the current service, which was clearly liked.
- The access to both drug and alcohol treatment within one organisation was valued.
- There was proactive support from the service, with motivated key-workers.
- The continuity of the staff group was seen as good.
- GPs said that communication to them was clear, and workers were contactable.

e. What does not work so well in the current drug and alcohol service model?

- Structural issues such as opening times, and flexibility of staff.
- Communication is hampered by lack of electronic communication and updates.
- GPs do not feel equipped to support home based alcohol detox.
- Waits for detox seem long at times and sometimes waits between accessing the service and treatment starting.
- The service is not interested in prescription medicines addictions - or those that have had medication prescribed for pain; this is reported to be a growing problematic group.

f. What prevents you offering shared care?
Lack of time to acquire the knowledge, resources and training in order to provide it were key reasons. One GP considered it best undertaken where doctors are experienced and regularly exposed to such cases, which in most GP practices will not be enough. For those who do offer shared care - issues included underfunding, time and lack of training. For others - their working alongside the treatment service was reportedly working well.

g. What would encourage you to offer drug and alcohol treatment to your patients?
Almost all responses highlighted that this would only be possible with training and guidance, alongside a review of payment. An easily contactable clinician to give advice about prescribing is necessary as support.

h. What interventions could primary care offer?
All respondents said that primary care could identify and refer to the treatment agency. However, with regard to shared care, opinions differed.
○ 32% (n=9) said that shared care could be offered to all patients on their lists, but 68% said ‘no’.
○ However, 90% said that shared care could be offered to ‘straightforward’ patients - with those with complexities referred to the treatment agency.
○ 62% (n=18) said they could offer shared care for patients with comorbidities such as cirrhosis.

Additional comments were that GPs needed time and support if they were to undertake this work. Adequate remuneration was highlighted.

i. What would most support GPs in their management of drug and alcohol problems?
   • 87% of respondents (n=27) wanted more support from treatment services.
   • 90% (n=28) wanted more support from other services such as mental health services, secondary care, housing, social care, pharmacies.
   • 64% (n=20) said more training in management of drug and alcohol misuse.
   • 39% (n=12) said new ways of working such as hub and spoke models.

j. How can emerging primary care models contribute to community based drug and alcohol provision in the future?
   • More spend needs to go into patients addicted to prescription drugs
   • Hub and spoke model - with specialised GPs working there
   • Better multi agency working with liaison and training to develop skills and time to allow GPs to learn and increase in confidence - and then more time with patients
   • Opening times to fit with older users that are working full time

Other comments included that the changing pattern of drug misuse has not adapted to the increasing numbers of patients addicted to prescription medication, NPS or older OST patients.

4.0 Strategic one to one consultations

Key points

Current service meeting expectations
The current treatment service said that a number of new approaches had worked well. This included the focus on alcohol/ non-opiate clients, the pre-assessment talk that establishes ‘readiness’, increased group work and the team of recovery champions and volunteers. Other agencies said that the treatment service were always willing to listen, there were shared aims, and some of the key workers were exemplary. Other ways that expectations had been met were reported as:

• Hospital interface: Hospital liaison had improved and was more consistent and integrated. The ‘in reach’ aspect of the role allowed for following up patients post hospital and encouraging into treatment where appropriate.
• Pharmacies: Work was valued; a few staff in some pharmacies offered advice and contacted GPs when they saw misuse of prescriptions or over the counter medication.
• CJS: IOM has good communication links between treatment and probation.
• Homelessness: Strong links are now in place between the treatment service and Cambridge city hostels. The new Dual Diagnosis team, the outreach and harm reduction approach was appreciated.
• Young people’s service: Transitions from the young people’s service were going well.

Issues with the current treatment service
• Recovery focus: Whilst a recovery focus was valued, some agencies dealing with particularly marginalised people with complex needs said that recovery outcomes were not achievable and a harm reduction focus was more appropriate, but was receiving less focus.
• Primary care: This was repeatedly highlighted as an issue. Problems included lack of GP expertise and interest in supporting substance misusers. Shared care was under-used and long term physical and mental conditions presented by substance misusers needed more primary care support. In particular, how to deal with patients with dependence on prescription
medication was a significant concern.

- **Pharmacies:** Needle exchange packs were proving a wasteful way of giving out needles. The problems of the lack of a shared electronic system for sending through prescriptions from the treatment service were raised, as well as the manual logging of methadone observations.

- **Mental health:** The lack of joined up working was an issue meaning individuals ‘fell through the gaps’, and specialist mental health expertise within the treatment service was highlighted.

- **CJS:** Lack of information about where substance misusing offenders were in the system, meant it was difficult to analyse if pathways were effective or that provision was appropriate. A reported increase in 18-24 year olds with crack/ opiate use was not appearing in Public Health data. Offenders with mental health needs in particular required improved joint working. Feedback to probation about offenders in treatment was not always timely.

- **Social workers:** There was some concern that links required strengthening between social workers in the substance misuse agencies and wider social work structures.

**Opportunities for the future**

- **Primary care:** More support from GPs to offer shared care for substance misusing patients is seen as essential by many interviewees. This requires increased training and time. Clarity about treatment for patients with prescription medication dependency is needed.

- **Pharmacies:** Pharmacies are seen as a good venue to deliver advice, brief interventions and health checks in. Needle exchange packs should be changed to ‘pick and mix’.

- **Hospital interface:** This could be an opportunity to increase the effectiveness of the hospital liaison post by placing it in the Psychiatry Liaison team.

- **CJS:** Opportunities are two-fold; firstly, information gathering needs to establish who, where and what is the progress of offenders with substance misuse issues. Penetration levels in treatment need to increase; this might be via reinstating drug testing. Once data is clear about where issues are, pathways need to be strengthened and capacity ensured to increase effective outcomes for offenders. In particular this includes pre-release and prison to treatment, as well as, treatment on DRRs and ATRs. Shared case management is advocated, particularly in early parts of sentences. Co-location is recommended by interviewees as a way of increasing engagement. It would also help with communication issues of lack of feedback.

- **Family work:** The opportunity to further use and embed ‘Think Family’ might include placing recovery workers in Early Help and Children’s Social Care districts. More training is advocated for the treatment agency staff that looks at the impact of substance misusing parents on all ages of children. Transition planning would benefit from early liaison with the adult service.

- **Mental health:** Integrating mental health and substance misuse treatment would increase dramatically collaborative working. A Consultant Psychiatrist role and/or Consultant Psychologist within the treatment service was proposed - particularly to inform trauma based work. Public Health would like the treatment service to undertake a wider range of health checks.

- **Structure and standards:** Where there are opportunities for co-commissioning, these must have agreed ‘minimum standards’ in place. Co-location is seen as an opportunity by many - particularly within primary care and criminal justice settings. A shared recovery model is a positive move - but harm reduction work must be in place for those who cannot or do not want abstinence. Structural decisions also should increase where possible, outreach work and a response to trauma.

- **Partnership and outcomes:** Social care intend to be more strategically and operationally involved with the treatment service, and this is an opportunity to ensure social workers within the treatment service link effectively with their wider support systems. Round tables were highlighted as a way of sharing what to do about certain cases, and ensure that action from one agency was understood in terms of how it might affect outcomes in another.

**Remit**

These interviews were conducted with 20 strategic and managerial staff from local agencies including Criminal Justice, Mental Health, Pharmacies, Adult Services, and Health. Interviews were carried out during September and October 2017 either by phone or face to face. The consultations concentrated on the following areas: Has the current service met your expectations? Issues with the current service. What are the opportunities for the future service?
Responses to questions

a. Has the current service met your expectations?
A strategic staff member from the current treatment service was interviewed; there were a number of new approaches that they consider have worked well. This has included increasing the focus on non-opiate and alcohol clients to ensure that the service is not overly opiate focused and the introduction of the ‘pre assessment talk’ (PAT) that helps establish need and readiness - and can prevent early dropout. Group work has been increased to meet need and address capacity issues and family work has improved. The service is proud of the team of recovery champions and volunteers.

Other agencies interviewed identified several areas of delivery that had been particularly good - one said that the service has culture of being willing to listen at a senior level, and do things differently - another that the treatment agency shared similar aims to other agencies and this helped working together. Several agencies spoke of some of the key workers going ‘above and beyond’ in what they did. Together with a consistent workforce with seemingly low turnover, this helped other agencies know who to contact and built up shared understanding of clients.

Particular areas were highlighted that had met or exceeded expectations. They are as follows:

- **Hospital interface:** Hospital based staff reported that hospital liaison post had improved greatly over the course of this contract, and now works in a much more consistent and integrated manner. Liaison work overseeing the detox beds was going well. The ‘in reach’ nature of the role meant that patients could be followed up and encouraged into treatment post hospital.

- **Pharmacy work:** Interviewing the pharmacy lead, it was clear that the service has continued to develop well in what it delivers and benefited from good communication with the treatment service. It was reported that as pharmacies know their regular customers and some staff will challenge and give advice as appropriate. They will also alert GPs when over the counter medication seems to be being over-used with prescriptions.

- **CJS:** IOM has good communication links between probation and treatment service.

- **Housing/ homelessness:** Links are reported to be much stronger between all Cambridge city hostels and the treatment service thanks to the new outreach worker. Particularly valued are family work, the recovery champion approach, the new Dual Diagnosis street team, the outreach and harm reduction approach.

- **Young people’s treatment service/ Transitions:** It was reported by the young people’s service that transitions were working well, and had benefited from joint training within the LSCB framework. There were examples of good joint working if a child of a substance misusing parent is known to the young people’s service.

b. Issues with the current service

Recovery focus
‘Recovery focus’ was raised by the agencies that were working with particularly marginalised people such as the homeless. They felt that the recovery focus and associated outcomes were not always achievable for their clients and a harm reduction approach was more meaningful. Comments included: 'The service presumes that treatment starts when someone gets to the door - our clients have huge levels of fear, misunderstanding, bad past experiences and need 'pre-door' work'.
Primary care
Primary care was repeatedly raised as an issue. There were several facets to this:

- **Expertise**: There were concerns that as GPs did not have the necessary expertise to deal with the issues that substance misusers had; in some cases there was not the interest. One interviewee was worried that when the current GPs who did have knowledge and were willing to support substance misusers retired, this would leave very few indeed unless future training was widespread.
- **Prescription medication**: The most repeatedly mentioned issue was that of what the response to prescription medicine dependence. There were concerns from some that the treatment service was not meeting the needs of such individuals - but others said that GPs still do not have an overview of issues of prescription addiction and the complexities of prescribing when someone is using illegal drugs. More training was called for and clear pathways.
- **Shared care**: It was reported that there was a lack of interest from GPs regarding shared care, and primary care pick-ups.
- **Long term conditions**: Concern was expressed that substance misusers with long term conditions were not being adequately treated and that primary care should be more involved with the presentations of physical and mental conditions.

Pharmacy / harm reduction
Whilst pharmacy work was thought well of, both pharmacies and other agencies said that the current needle exchange packs were a wasteful way of providing needles. There was also a resource inefficiency regarding the lack of electronic systems; with no electronic transfer of prescriptions to pharmacies - all are delivered by hand. All methadone observations have to be recorded manually; this is time consuming. ‘Pharma Outcomes’ were recommended as an electronic system already used in different parts of the health system.

Mental health
Frustration was felt at the lack of join up surrounding support from mental health service; individuals fell through gaps. Over time, mental health specialism within the treatment service has reduced, meaning that understanding complex clients and responding with trauma based treatment was lacking.

CJS
It was reported that insufficient information and data meant that understanding identification systems, pathways and capacity was sometimes difficult to evaluate. This was the case with the Liaison and Diversion Scheme that needed discussion around their kpi’s to inform what capacity was needed in the treatment service. It was estimated in interview that 30-40% of offenders have substance misuse needs, but criminal justice agencies were not always sure where they were in the system and their progress. This was not helped by some referral routes such as court pathways and timescales seemed overly complicated. But even where offenders were engaged with the treatment service, NPS said that lack of consistent updates and feedback meant that offender managers were not always aware of emerging problems that needed to be tackled. The ‘workability and sharing’ of the ECINS system meant that professionals with access were cautious about what information to add to it. Criminal justice agency staff reported that following changes of role in the treatment service, specific criminal justice expertise there was lost and this had impacted on understanding and pathway effectiveness.

Offenders leaving prison needed to see that harm reduction was relevant to them and that the treatment service could support them in this; travel to treatment could be an issue. Further problems were about substance misusers who ‘fall through the cracks’. This was an urgent issue for those with
co-occurring mental health conditions; a pilot in Peterborough, whilst out of the remit of this area, was indicating how a mental health nurse secondment into the treatment service - with access to the health record system, informed triage and assessment and speeded up processes. It was reported that numbers of young people (18-24 years) in the criminal justice system misusing cocaine and opiates were being seen in police force data, but were not identified in Public Health data. Less drug testing was now undertaken although the ‘receipts’ given out after tests had been a useful motivating tool. Drug testing on arrest does take place - and it was important that Cambridgeshire residents arrested and tested out of county had clear pathways to the Cambridgeshire treatment service.

**Social work**

Social workers within the treatment service provided a valuable function; a number of social workers had been TUPE’d into the treatment service at the beginning of the current contract; links with wider social work provision such as training and supervision might require further integration.

c. What are the opportunities for the future?

**Pharmacies**

Pharmacies themselves and the treatment agency said that their familiarity with clients and customers means they are a valuable venue to provide brief interventions and work even more collaboratively with the treatment service. Interventions such as BBV and health checks were suggested. Needle exchange needs to be ‘pick and mix’ - and this interaction can be used as an advice point. Examples were given of the Peterborough trialled initiatives including Naloxone distribution, Hep B and C tests and mini health checks that had seen a successful take up.

Pharmacies could also be usefully alert to customers presenting with vulnerabilities and offer advice, as well as to the general population. As part of the Peterborough initiatives, alcohol screening had been offered to all customers resulting 1,008 Audit Cs being completed, 160 brief interventions and 33 referrals to treatment. This greater role for pharmacies was highlighted as especially valuable in rural areas to undertake identification, advice and referral to treatment if necessary.

A pharmacist prescriber in the treatment agency was advocated to overcome the complexities associated with an individual who was using illicit drugs as well as prescribed medication.

**Hospital interface**

Some interviewees wondered if the hospital liaison post could be more effective if it became a CPFT position within the Psychiatry Liaison team. Public Health would like to see the treatment agency increasing health assessments, brief interventions, smoking advice, physical health, sexual health, and cardiovascular checks. The Hep C pathways needs to be robust.

**Primary care**

GP care was reported to be the weakest part of the partnership arrangement. Most interviews discussed how primary care could be more involved with treating substance misusers. The new Federation Model was highlighted as a possible opportunity for this. Central however was the need for more GPs to be trained up in skills to gain confidence - and for recovery staff available to support GPs. The future specification is a welcome opportunity for clarity about how to cater for patients addicted to prescribed medication and OTC, benzodiazepines and amphetamines- and require more support than GP can offer. This must include the NICE quality standards currently in development.

**CJS**

Issues in the criminal justice system give plenty of opportunities for the future and are critical if the criminal justice/ treatment interface is to become more effective. Opportunities include:
- **Data and strengthening pathways**: Much more accurate information collection and sharing underpins any future work in order to understand the numbers of offenders with substance misuse issues, if they are in treatment, where they are with regard to treatment and their progress. In turn, this could then help strengthen pathways to treatment and increase penetration rates, and ensure initiatives such as Liaison and Diversion and Conditional Cautions are used effectively and to capacity. It would also indicate where outreach is necessary. Improved joint working with mental health that could access relevant client health information would improve identification and speed of pathway to relevant treatment. Prison releases from some prisons were still arriving in hostels with little or no notice - the link roles need to be considered for all relevant local prisons. The pre-release to release pathway for short term prisoners is an area for attention, as well as a rethink about the treatment aspect of DRRs and ATRs. Pathways could also be strengthened by a robust single point of contact. It was wondered if the treatment service could be part of joint care planning, especially in early sentence, and if outcome setting could be aligned. Whilst group work is a necessary part of treatment for many, the associated risks of mixing with others who are not aiming for abstinence requires a different approach perhaps. New opportunities also include strengthening prevention and early intervention work for offenders on the cusp of drug or alcohol misuse.

- It is important to ask potential providers about how they intend to work across all sections of the CJS, and how joint outcomes with this sector might be evidenced. Aligned to this is a need to make sure the new service disseminates clearly what it actually has on offer. Some interviewees said they did not have information such as opening times, groups and programmes run - so it was difficult to urge people to refer themselves if treatment wasn’t part of an order.

- **Drug testing**: This is an opportunity to reconsider the use of drug testing as a proactive way of working with CJS agencies to increase the numbers of offenders in treatment. It is known that one nearby county has 10% more CJ cohort in treatment with reinstated drug testing being part of the increase in treatment naive offenders being directed to treatment. This county only drug test those who have a second trigger offence in 12 months and they insist on an appointment with a drug worker. Such processes need police buy in. Whilst OPCC cannot invest anymore in treatment, there could be opportunities via a tri-force arrangement to implement drug testing effectively, using other county support.

- **Co-location**: More co-located working is needed; this will help engagement levels and multi-agency working, especially with offenders with complex needs. Other counties embed workers within probation and police custody and have noted increased engagement levels.

**Family**

One interviewee asked that the 'Think Family' approach was always integral to support, from the initial assessment point onwards. Was there the opportunity for recovery workers be linked to Early Help and CSC District teams? This would provide a more sustainable way of providing partnership working with key agencies rather than specific provision for children of substance misusing parents.

- **Training**: The young people’s treatment service would like to see more ‘age appropriate’ training in the adult service to ensure the differing needs of ages up to 18 are understood. There also needs to be a method statement about how the provider will work to meet the needs of children.

- **Transitions**: It would benefit a young person who is needing to the adult service if a period of joint sessions took place between both services and the young person. This should be 3-6 month before a transition.
Mental health
The opportunity for formally integrating mental health and substance misuse treatment so that effective collaborative working can occur was repeatedly stated. It was also suggested that a Consultant Psychiatrist and/or Clinical Psychologist role in the treatment service would be advantageous to inform trauma based work that needed to be the model of working with complex cases. Couples therapy was mentioned by several interviewees as a necessary therapy that should be offered. Regarding older people, mental health pathways for over 65s are met through CCG neighbourhood teams - this will need attention in any future integrated planning.

Structure and standards
Several opportunities were recommended for future service provision:

- **Co-commissioning**: This could be with RIP (Recovery Inclusion Project) but ‘minimum expectations’ must be agreed within any specification.
- **Co-location**: Co-location opportunities to embed workers within other agencies were repeatedly mentioned. This was highlighted particularly for criminal justice work and GPs. What is crucial is that pathways are aligned - for example with PRISM. In areas away from main treatment venues, it was wondered if small hubs could operate.
- **Recovery**: The new specification gave the opportunity for more effective working through a shared recovery model with the health provider, with similar outcomes and integrated with the Recovery College. This could even include co-produced social enterprises currently being considered by mental health commissioners that could be linked to substance misuse.
- **Harm reduction**: In any model of recovery, the opportunity for harm reduction work must not be side-lined - for example, increased delivery of sessions in hostels on harm reduction. Particularly needle exchange was recommended. There must be consideration of harm reduction for alcohol misusers who want to manage consumption enough to stabilise in other areas of their lives.
- **Outreach**: Outreach needs to be more assertive to engage in treatment complex clients and include a focus on pre-treatment (this might inc taking them to visit the service to allay fears).
- **Other opportunities include**:
  - Opinions differed as to whether older people should be treated within or separately to the treatment service.
  - The current Tier 4 social worker can remain as it is in the new contract.

Partnership and outcomes
A range of opportunities were suggested:

- **Social Care intend to be more strategically and operationally involved with substance misuse treatment.** This is an opportunity to ensure that social workers in the treatment agency are not isolated from social work colleagues and standards.
- **Partnership work needs to have round tables at times to decide what to do - eg someone refusing treatment. Outcomes need to be shared with other agencies - eg if script is taken away it will have issues on other agencies so needs to be a joint decision.**
- **Could the ‘Making Safeguarding Personal’ outcome setting be used - and then coordinated by the social worker with health input?**
5.0 Stakeholder engagement events

Key points

What works / what do we value?
Specific aspects of service delivery that worked well included Recovery Hub in Cambridge and Ely and the countywide delivery of family work. The emphasis on needs led, individualised interventions was valued as well as group work provision. Highly praised was the community pharmacy work for supervised consumption and the reduction in time between detox and further treatment. Multi-agency working was valued included reportedly good links with many agencies to promote pro-active support; examples included MASH, IOM and social care for family work.

What is not working / identified gaps?
Despite many positive aspects of delivery - rurality caused issues with equitability - especially regarding provision of group work and outreach - and transport access to services. More group work was requested for all areas - with more in-depth sessions on mental health. Whilst weekend opening was appreciated by those using it - there was a low uptake. Overall, it was felt that the entire service and what it offered was not promoted well enough.

Service provision for the increasing numbers of older people in longer term treatment was repeatedly mentioned, as well as difficulties for those with mental health issues. The lack of a dedicated housing officer at Inclusion was highlighted along with access to move on housing. Although significant effort had gone into improving multi-agency links, with some resultant successes, sometimes joined up working was hampered by confusion over pathways resulting in duplication.

How can we do things differently?
Co-located hubs were widely advocated - with a review of opening hours to ensure that these times met the needs of service users. Communicating what the treatment service did needs clarity and updated dissemination to both partner agencies and the clients themselves; a wider use of social media should be more fully used. Holistic working was vital to ensure all a service user’s needs were identified and worked with. Increased group support was repeatedly highlighted and recovery and relapse prevention support for older, long term clients. Improved engagement with mental health services is vital, with availability of support for clients who are still misusing substances.

This section gives the details behind the above summary about what was said at the three stakeholder events held in July 2017. The attendance total was approximately 100 people.

Responses to questions

Engagement and availability

What works/ what do we value? Service provision
- Locality offices cover the county well geographically - with services supporting EU populations.
- Walk-in sessions work well as does outreach work for homeless people. The process to detox was reported to work well.
- The weekend service is valued - particularly for those for whom weekday attendance is difficult.
- Peer support groups are ‘very beneficial’, family and friends work is valued.
- Support that works well is also the Recovery Hub in Cambridge and Ely and the volunteering programme in Ramsey has good feedback.
Pharmacy links for supervised consumption are good and speed of prescribing following release from prison is good.

The Liaison and Diversion scheme is reported to work well.

Good work is being undertaken with domestic and sexual violence workers.

Inclusion have manuals available of mental health services.

What is not working/ identified gaps?

Service provision

Some contributors said services did not respond to what service users wanted. Weekend opening had a low uptake, and many weekday morning appointments were missed. A lack of holistic working was mentioned - the entire individual and not just their substance misuse needed working with. Group sessions about mental health were reported to not be in enough depth.

Rurality: The rurality of the county and transport have created problems - with some service users travelling across county to services. Outreach work was particularly affected - especially with hard to reach groups. Volunteering was more difficult to arrange in some rural locations.

Information: Gaps in the dissemination of information were highlighted including the advertising of what services Inclusion offered, and in particular, what support was available after treatment - such as relapse prevention groups. Lack of information about benefits was mentioned. There were mixed messages about abstinence and controlled drinking. Some thought there was the absence of a clear prevention or ‘brand’ message.

Older people: All events raised the gap in service regarding older people. Sometimes there was a perceived barrier by an older person who wasn’t comfortable working with young staff.

Young people: Transition processes between young people and adult service was mentioned.

Sex workers: Lack of support was reported.

Housing: Flexible prevention work in supported housing was not working well.

Mental health: Thresholds, accessibility, waiting times and support after hospital were all mentioned as gaps. Lack of crisis services - for example regarding sectioning was a gap in Hunts/Fenland. The lack of Sanctuary provision for Wisbech was mentioned.

Work with other agencies: Issues with health services included the Queen Elizabeth Hospital and Primary Care not engaging at the commencement of treatment - or taking patients back. Issues with Criminal Justice services included police PICs and courts.

How can we do things differently?

Service provision

Map provision across the county to show exactly what is available and consider co-located one-stop shop hubs. Review hours to consider some later opening in evenings and Saturday/Sunday openings - and promote the opening times. Reimburse travel.

Make services more holistic allowing service users to choose where they can access services and ensure ‘diverse range of client perspectives’ are covered.

Service to engage with the whole family.

Increase outreach provision - this could include a recovery bus that travels the county.

Increase group sessions and peer support and long term relapse prevention groups. Introduce an older people’s specialist worker, and links with older people’s specialist services.

Re-introduce youth workers and ensure robust transitions from young people’s services.

Embedded therapeutic services within the treatment service.

And improving work with other agencies including:

Pharmacies, training and referral pathways around DV/SV and links between services and more collaborative working with police to see violent clients at police stations.

Links to develop could include training for Neighbourhood Watch, links with dentistry and support and awareness in schools.

Mental health services delivering group sessions. CAMH delivering peer mentoring?

And improved information: Better promotion is needed: An online directory to list companies that might offer opportunities and more use of social media. In addition, there needs to be increased
awareness of the open access to treatment and signpost to long term support after treatment - e.g. AA, fellowships etc.

Interventions

What works/what do we value? Service delivery
Initial access - e.g. walk in, needle exchange and BBV work were reported to be good. Individualised interventions that are needs led and not time bound, peer support and group work, alternative therapies. Times between detox and treatment and Jimmy’s abstinence house.
And in addition:
● Family/carer support: Support with clear information about what is involved in treatment - with specialist treatment services happy for family member/friend to attend appointments with service user. Family and friends groups; the Carers’ Trust is receiving more referrals.
● Recovery: The recovery cafe and activities work well and long term recovery support including 1-1 work with Recovery Workers.

Links with other agencies: Engagement between services and relationship building. There are positive links with social care for family/carer work and Inclusion support with housing and links with DIP offender accommodation. MASH links are good for domestic abuse. There is a good service from Cambridgeshire prisons - with vital link worker. And good links with IOM. Some good mental health work exists, such as an in-reach worker goes weekly to Fenland services.

What is not working/identified gaps? Service provision
● Rural issues, specifically for Fenland include issues with group work, travel to detox, mutual aid. Psychological evaluations go to Peterborough rather than Addenbrookes - seen problematic.
● Referral issues - including Primary Care referring patients in who do not need specialist treatment, and referrals out to other services are made - but seem ad hoc.
● Discharge process from inclusion sometimes appears too quick (Cambridge).
● Balance between individual’s freedom of choice - and their ideas about treatment and delivery.
● Issues include: ‘Clean time’ between detox and rehab still too long, access to inpatient detox for older people, a cannabis programme and a family engagement worker to work with entire family like FIP. Long term clients needed to be supported in the community by other services than specialist services such as GPs. There is no hospital liaison at Hinchingbrooke.
● Workforce development includes ECINS case management not being used as well as it could be.
● Mental health/dual diagnosis requires systemic change. There is a lack of clarity over expectations and communication between primary/secondary care - and Inclusion. Language misunderstandings and poor recognition of different ways people present. Support is needed for those not meeting thresholds for secondary mental health care. Data not used sufficiently.
● Housing/homelessness has a lack of community support, move on housing and no dedicated housing officer in Inclusion. In Cambridge, have to go through Jimmy’s which was reported as not always ideal.
● Criminal Justice has seen a reduction in work- for example, ATRs - 3 appointments may not be enough and drug testing not used as frequently as in past. Prison workers do not attend monthly IOM meetings.

How can we do things differently? Service provision
Co-location and integration of services and provision in a hub was highlighted, with space for other services such as housing, debt management. Improved locations and better information dissemination of what services are available. Services must be replicated around the country - to improve provision in rural areas. Other points included:
● Improve waiting and treatment times, especially between detox and rehab.
• More prevention work, services for older people, those with long term conditions and alcohol related disorders, mutual aid and peer support. A bigger role for group work.
• No penalty for re-presentations to service.
• More support for Tier 3 clients stepping down to Tier 2 - better use of community resources.

Links with other services: Mental health links were highlighted most, with a need for more resources, such as a mental health worker seconded to Inclusion and training on dual diagnosis.
• All services needed better pathway understanding and joint protocols. There needed to be flexibility on Consent to Share.
• Joint clinics with services such as dental, sexual health, smoking were advocated, with better partnership working with joined up family/ carer work. Bench could help with community service.

Integration and collaboration

What works/ what do we value? Service provision
Information sharing between the drug and alcohol services and professionals and good working relationships. Working with addiction rather than the substance is valued.
• Community pharmacies are good including needle exchange uptake. ‘Never hear a bad word’.
• Hep B 12 week programme and support groups.
• Family work is developing and working well - with good uptake for groups and workshops.
• Engaging homeless clients has improving: more provision for young males is becoming available.

Links with other services
• Pooled partnership budgets (such as IOM) helps more people with common aims between partners and good communication.
• Good links and communication with Access Surgery -it has a range of services and links to groups and networks. GP referrals, communication and understanding not to rush treatment.
• Integration between medical care and wider services.
• Liaison with safeguarding includes joint training.
• Good links with refuges for domestic abuse, City Council teams relating to needles - identification of patterns and then referral to Inclusion. Richmond Fellowship, Mind, AA and Crisis Team. The Wellbeing Service works in partnership with Inclusion. Mind and Richmond Fellowship will only help those who have stopped using. Housing links good with Axiom - good feedback from them regarding payment/debt - and Luminus (Fenland) support with offenders
• Criminal Justice: There are good links with the Offender Service and prison Link Worker who provides good feedback. There still needs to be new and developing pathways developed to aid partnership working - eg referrals to Inclusion.

What is not working/ identified gaps? Service provision
• Length of time between referred to support and receiving support affects motivation.
• Although staff are motivated, ideas discussed in meetings are not always shared with them.
• Service users say they are ‘bottom of the pile’, help is unpredictable and staff pushed for time.
• Volume of needles has increased - cost implications. More used needles being found.

Links with other services
Criminal justice clients can be too chaotic to engage. Offender Needs Assessment highlights some are not accessing or given access to treatment. Prison to community support - must be picked up in the community.
• Lack of integration and joined up working and lack of sharing of pathways- affects aspects such as referral on to other services and can result in duplication.
• Some issues about length of time post-discharge from hospital and being seen in services.
• Lack of work around trauma.
● **Mental health:** Effective working for mental health is gap. Criteria for service is too high, waiting lists long and too few dual diagnosis assessments completed. Substance misuse is used as an ‘excuse’ by mental health services and a barrier to access. Mental health services say the presentation is down to the substance misuse - not mental health.

● **Specific needs:** More support needed for older men with history of sexual abuse.

**How can we do things differently? Service provision**

The specification to be more outcomes focused with fewer ‘mini details’ and the new service needs to be much better promoted. It could better use social media to support recovery and technology.

- A key area is mental health. There needs to be better availability and engagement with mental health services and hospitals and three way assessments. More group work is asked for, around ‘wellbeing’ and low level mental health (anxiety) issues. Equip staff with appropriate skills to screen for mental health/ dual diagnosis and domestic abuse.

- There needs to be more: family work, 18-25 prevention work and peers to support older populations and more flexibility and balance around visits, group work and phone or video support. An internet cafe and drop in for self-help would be beneficial.

- Steroid use needs investigation and Off Watch work.

- Make sure ‘top down’ decisions are shared with staff.

**Links with other services**

More integration and ensure sharing between services and pathways and contact details for countywide services are maintained and circulated.

- Community pharmacies could to do formal screening, carry Naloxone kits, BBV testing and issue needles on a supply and demand basis rather than standard pack of 10. More bins?

- Police / prison carry Naloxone.

**6.0 Conclusion**

The five different surveys and consultations were able to capture comments from a wide range of respondents. Certain themes have repeatedly come out.

The recovery work of the treatment service is valued, and in particular the group work and one to one support of key workers, peers and volunteers. Most think that access is straightforward and workers are committed to helping substance misusers in treatment reach goals. Pharmacy support is good.

Nevertheless, issues remain; access and pathway problems mean that some substance misusers remain out of treatment - and whilst a recovery focus is welcomed, it must also meet the needs of those for whom harm reduction is the aim.

Primary care is a key area of concern, with low levels of sign up to shared care. Rising numbers of patients are presenting to GPs with dependence on prescription and over the counter medication, challenging ways of working.

Substance misusers with mental health problems continue to ‘fall through gaps’ with lack of join up by services. Service users cited ‘mental health’ as a key reason why they did not access substance misuse treatment.

However, it is a sign of optimism that respondents from all the surveys and consultations saw opportunities for the future. Re-designing the treatment model to balance recovery and harm reduction is advocated, with co-located working in health and criminal justice settings. Key is an agreed way of effective joint working between the substance misuse and mental health services, and
increased primary care participation. And finally, a good service requires promotion; this is not currently effective leaving both potential service users and other professionals confused about what good support is offered - this needs attention when the new service delivery is agreed to help anyone at any time know how they can access support.

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