Appendix 1 – Consultation

Introduction

The consultation period started on the 8th January and closed at the end of April 2019. During this time we consulted with a vast number of people with an interest in this process, including the current commissioned services workforce, people from stakeholder organisations, current and former service users, and people experiencing substance use disorders who were not currently in treatment. See full list below of those consulted:

Agency/Venue	Type of Consultation	Volume
Addaction	1:1	9
Addaction	Group	27
Sheffield Health & Social Care (SHSC) – Non Opiate & Alcohol Service	Group	11
Sheffield Health & Social Care – Non Opiate Service	1:1	7
Sheffield Health & Social Care – Alcohol Service	1:1	8
Substance Misuse Commissioned Services Managers	Group	6
Sheffield Health & Social Care – Opiate Service	Group	24
Sheffield Health & Social Care – Opiate Service	Group	20
Sheffield Health & Social Care – Opiate	1:1	19
Sheffield Alcohol Support Service (SASS)	Group	10
Salvation Army	1:1	6
Substance Misuse Operational Group (Drink Wise Age Well, SASS, The Corner, South Yorkshire Police & SHSC)	Group	10
Ambassador Group (Service Users)	Group	9
SMART Group (Self-Management and Recovery Training)	Group	7
Service Users via waiting room within the Opiate Service	1:1	16
SURRG (Service User Reference & Recovery Group)	Group	7
South Yorkshire Police – IOM Sergeant	1:1	1
Drug & Alcohol Coordination Team (DACT)	1:1	1
Drink Wise Age Well (Service Users)	Questionnaire	8
Addaction – Breakfast Club (Service Users)	Group	6
SASS – Service Users	Questionnaire	12
Available to all, of which 27 were Service Users and 2 members of the public	Citizen Space Survey Paper Survey	31 24

In addition to the above, we offered to consult with one further service, who didn't engage in the process. In total, we consulted with 279 people of which 78 (28%) were service users.

Methodology

We offered 1:1 consultations with the incumbent provider's commissioned workforce from Sheffield Health & Social Care and Addaction and asked for individuals to come forward from each of the delivery areas. Of the 88 staff members at Sheffield Health and Social Care; 34 (39%) staff members engaged in a 1:1 consultation interview.

Consultation Process

Of those consulted with on a 1:1 basis; they were each asked a set of 13 questions:-

- 9 x generic questions - for example: does your service make the most of volunteers and what do you think PSI (psychosocial interventions) delivery should look like?
- 4 x service specific questions - for example: what does the current needle exchange provision work like and how should the call volumes be managed within this service to ensure effective communication?

For the group based consultations and on-line questionnaire there were 4 primary questions mirroring the questions we asked in the 1:1 consultations to ensure consistency across all services. These questions focused on the wider systematic treatment system for example: what works well and what doesn't work well in the current treatment system and do you think there is anything missing from current service provision. All questions were open questions to allow participants maximum opportunity to give their views without being led.

The questionnaire was available on-line via Citizen Space to the general public and links to it were emailed across networks widely including publication via social media, for example, on Twitter where the tweet with the link to the survey had nearly 3000 views. The questionnaire was also promoted at local operational and strategic meetings and was made available at each provider service, in the waiting area in paper copy format.

A bespoke questionnaire was developed for service user groups (SMART groups) and two recovery services worked specifically with their own service users to complete the questionnaire, which asked about recovery opportunities and their experiences treatment. A group session was held with workers of these services.

Service users were approached in the waiting areas in the opiate service and structured one to one conversations were held, with those who agreed to engage. Group sessions were held with our service user group including those individuals who're in recovery via the Ambassador scheme and those actively in addiction via a SMART recovery group.

Key Themes

On the whole, people fed back consistently on the same themes. We have identified these which are discussed in turn:-

Theme 1 – Model

One integrated substance misuse (drugs and alcohol) treatment service was considered the best outcome to address communication between services, partnership working, information sharing, movement/fluidity of clients and resources. However, several people were of the opinion that service users should continue to be segregated by substance particularly alcohol and opiate users in order to manage waiting room dynamics.

Theme 2 – Location

The general consensus was that the location of services should remain in the city centre, due to ease in terms of accessibility for service users and key partners. However, a city centre location was also perceived as a barrier for some people accessing treatment and suggestions were made to increase the number of community based hubs in the outer parameter areas. This will be specified for the new contract.

Co-location with criminal Justice partners such as South Yorkshire Police and the Probation Service is paramount to coordinated activity and the positive engagement of clients.

We need to review the use of the current treatment locations to utilise them more successfully for the volume of presenting clients.

There was a debate about using different buildings/ locations based on typology of substance or based on progression through treatment – with no overall consensus. However, it was universally recognised that people that use alcohol and non-opiates, and the criminal justice and opiate service users were more suitability aligned if this was an area for specific commissioning recommendations to be made.

Theme 3 – Open access to treatment

There is a genuine need and appetite to keep these services open access in the city, which provides immediate access to a worker, an assessment and pharmacological treatment if appropriate. It was seen as a positive way to engage with service users and encourage entry (re-entry) into treatment, for those who require it. However, the feedback also highlighted challenges of this model. It was acknowledged that the system is open to abuse and that it perhaps *'reduces the value of a prescription',* with people *'not valuing treatment as they take it for granted',* in some cases.

It was stated that open access does not work for all service users, all of the time, particularly those that cycle in and out treatment multiple times due to their complex lives. The consultation was clear there needs to be an alternative offer for this group and the commissioning process will pursue this. In summary open access needs to be flexible, needs led, and have consistency to establish boundaries, motivate change and promote engagement. A different offer is required for the 'revolving door' cohort and those that are hard to reach.

Theme 4 – Pharmacological Treatment (prescribing/medication based treatment)

There has been a significant increase in caseload numbers in both the opiate and alcohol contracts during current delivery periods. The introduction of nurse prescribers have benefited both services, and the workers in the alcohol service shared that the multi-disciplinary team of nurse prescribers, doctors and PSI workers worked well, this was echoed in service user feedback. However the increase in opiate service users has created pressure to provide *'IAPT based talking therapies such as motivational interviewing and brief interventions'*, alongside the clinical requirements of issuing a opioid substitute therapy prescription.

Of the service users consulted in the opiate service, all but two were using illicit substances on top of their prescription and none of the service users considered themselves as being in 'recovery' from substance use, which highlighted a need for improved 'recovery identity' in future treatment services and greater exploration of the part that medication assisted treatment plays in recovery.

People would like to see flexibility in their treatment offer, an offer that is client led, dynamic and strengths based. Staff members shared that the frequency of appointments should be based on client need and not process driven and that it would be positive for commissioners to allow more flexibility for services to operate flexibly.

The number of drug workers providing practical and motivational support is small compared to the significant number of clients in the opiate service. This means access to a drug worker can be limited and more opportunistic. Service users told us that they want to be challenged about their drug use and want regular encouragement to change their patterns of behaviour.

Service users told us that they wanted to tell their story once and be assessed once; therefore a consistent drug worker / key worker was preferred. The planned integrated treatment model will support this comprehensively.

It was stated that a different offer should be considered for those addicted to over the counter/prescribed pain killers which is a growing area of need; these service users fed back that they did not see the necessity in providing a urine sample at each appointment, and saw this as a barrier to a trusting relationship with their key worker, (urine sampling is delivered in line with clinical guidance but there is some flexibility).

It was stated the issuing prescriptions as an operational process needs to be efficient and responsive to best utilise both clinical and administration staff's time.

An increase in nurse led prescribing has been viewed as a positive move, this was seen as a more efficient and cost effective process and all consultees suggested that this resource should be increased in the new contract period.

There is a good pharmacy network for those that require supervised consumption. However, people would like to see greater trust in service users, in terms of pick up requirements.

People would like to see the introduction of an on-line digital based offer – e.g. web chat or text based facilities.

Views on reimbursement of travel expenses was varied and based on a number of sometimes seemingly inconsistent criteria. It was explained that this was a difficult process to implement and often created conflict within the service. The general consensus was that this should not continue in the new contract period, however, it has, for many individuals played an effective contingency management role and therefore discussions about this approach should be explored during the commissioning process.

Theme 5 – Psycho-Social Interventions (PSI) / talking therapies and mental health

The current approach to PSI offer differs across the contract areas. There was a general consensus that the offer within the alcohol service works well as they deliver a broad spectrum of PSI from brief interventions/ motivational interviewing (which helps to establish engagement with treatment) through to trauma based interventions, which is often client led. However, caseloads in the alcohol service are high, which impacts on the allotted time for appointments and flexibility of appointments offered. This needs to be addressed in the new contract period.

Staff stated that clients are presenting more often with complex mental health needs, which includes a history of trauma. Staff members feel like they're *"plugging a gap that mental health services should be providing"* and that they would hugely benefit from hands on expertise from this area of work such as a co-location arrangement or specific training and development opportunities to strengthen the workforce.

The Opiate service currently offers a 12 week structured PSI programme which is seen to be too rigid for some service users to engage in due to their own complexities and the nature of their substance misuse. This offer is underutilised; however, when service users do engage with PSI, the experience is thought to be positive and has good outcomes. It was felt that practitioners may be too 'quick' to refer service users into PSI when focus should be initially given to the basic hierarchy of need i.e. stable housing and working to motivate change though the provision of brief interventions and extended brief interventions in the lead up to more in-depth PSI treatment, similar to the current alcohol offer.

The acronym PSI has negative connotations for both service users and workers. Therefore any future changes to PSI delivery should include a name change to make them more accessible; i.e. 'talking therapies'.

IAPT is often not appropriate for people using illicit substances, and CBT is not applicable for the majority of people in treatment. The offer in the new contract period should be stepped in intensity across all the substance areas, and be trauma informed including exploring adverse childhood experiences and their impact on people's substance use.

In the new contract period there should be a menu of talking therapy options at every stage of a client's treatment journey and an offer that includes a range of PSI – including on a one on one basis and also group offer aligned to the 'cycle of change'; e.g. motivation to engage, relapse prevention, with service users wanting the reintroduction of holistic therapies and more group based activities.

Service users said access to mental health services is difficult; staff members said that communication and pathways with mental health services needs focus. Dual diagnosis will be addressed in the commissioning process.

It was explained that for those individuals with dual diagnosis (co-morbid mental health condition and drug use) there was a need to work differently with mental health services. It was explained that more emphasis is needed to explore and understand how they got to where they got to in the first place; consideration should be given to better pathways for those who require mental health treatment, having access to mental health workers to support the treatment service and possible co-location arrangements including a dual diagnosis clinic.

Theme 6 – Harm Reduction/Needle Exchange/Mobile Van

The needle exchange and harm reduction interventions are considered *"the start of recovery"* and current delivery in the non-opiate service is considered *'gold standard'* by many people and it is felt this should be replicated more closely in the Opiate service. It was stated that the needle exchange was not always a priority in the Opiate service due to competing demands. Access to clean drug paraphernalia in the clinical rooms was generally well received, however caused some issues for staff in terms of harm reduction/recovery.

People supported the continued availability of a needle exchange at both sites (if both sites continue), which would include continued access to equipment in a clinical setting and wanted to see the continuation of the JUICE (steroid and image and performance enhancing drugs) clinic. There was a recognised need for the introduction of a needle exchange database/case management system to record activity and better manage client care.

There was a general consensus that the current recovery van / mobile needle exchange has been inconsistently used. It takes time to repair and it is expensive operationally (as it requires 2 workers). It was felt that branding on the van created stigma and was a barrier to engagement and that it would be better if the van was completely anonymised. Some people felt this resource should go. However, there were some who felt if it was to be continued then it should be prioritised, utilised regularly and for other purposes such as undertaking outreach and undertaking harm reduction initiatives at festivals etc. This will be reflected in our renewed focus on outreach provision as a result of this consultation period and our experiences over the past few years of delivering the contract.

Theme 7 – Criminal Justice

The overall consensus on the current criminal justice offer is the need for the continued provision within police custody, prison and courts. It was consistently recognised that partnership working and effective communication with key stakeholders (including staff members) is vital with treatment providers, the police; agencies such as court, prison and the custody suite are also paramount.

Theme 7a – Custody Suite

Individuals explained that changes within the wider Criminal Justice System such as changes to police legislation, including the option to voluntarily attend a police station without being arrested, had reduced overall activity. Whilst current custody coverage 'captures' the business periods/peak testing times; it was suggested that the hours of coverage could be reduced or adjusted to reflect these changes, and therefore use worker resource in a different way such as having a greater emphasis on preventative work addressing offending and reoffending via street outreach. It was explained that going forward, there is a greater need for flexibility to adapt to the external changes that are happening locally and nationally and will continue to do so. Future outreach provision will be utilised to move quickly in response to local need. Getting the balance between time spent in custody and time spent undertaking preventative work in the community needs to be considered. It was shared that for some individuals in custody, it was the most appropriate time to assess them comprehensively but for others it was the wrong time and a different offer could be explored.

Good links with the custody staff and liaison and diversion need to be maintained.

Current criminal justice targets need reviewing to reflect changes in current drug use and offending behaviour, be less process driven and more outcomes focused. This will be addressed in the new specification.

Outreach within this current service offer is a unique selling point and the ability to conduct home visits and accompaniment to appointments needs to be explored within the new offer.

The current criminal justice offer is to work with individuals using opiates and crack cocaine. It was shared with us that there is a need to explore drug testing beyond this and the offer in custody, in line with new drug trends such as cannabis and NPS.

Theme 7b – Prison

People felt that the use of peer support within the Criminal Justice System i.e. to facilitate a prison pick-up should be available within the new contract period.

Effective in-reach prior to release to establish support needs of prisoners and to link in with the treatment provider if continuation of prescribing is required.

A consistent theme is that people are often released from prison without accommodation, which impacts on their treatment and engagement. It also leads to re-offending and license recall.

Theme 7c – Court

It was explained there is a need to establish robust links with liaison and diversion, this service has been recently re-commissioned and pathways and partnership work with this service is essential. Collective feedback suggested that it is difficult to keep the momentum going with court staff/judges due to ongoing change and the differing offer between Sheffield and Rotherham treatment services.

Theme 8 – Volunteer offer

There was a general consensus that the ambassador scheme for individuals in substance misuse recovery was positive in the current commissioning arrangements and should continue. It was shared that the opportunities for volunteering by peers at the end of the ambassador scheme can be limited, particularly within the clinical treatment services and this was primarily due to worker capacity and their ability to offer a meaningful volunteer placement opportunity with sufficient supervision. This is an area for consideration in the new contract.

There was a general consensus that ambassadors, peers and other volunteers were well utilised in the criminal justice service; there is a community engagement co-ordinator role who recruits and supervises volunteers, makes links with the neighbouring universities and other partners to build the recovery/volunteer offer. This was overwhelmingly seen as a positive and growing area and will be highlighted for expansion in the new contract.

There are no current volunteers in the opiate, alcohol and non-opiate service. It was felt this was a missed opportunity, e.g. options for counsellors earning their 100 hours post training, linking in with universities beyond the current offer of clinical placements. This will be responded to in the above developments.

It was shared that a quality offer for volunteers requires consistent supervision, a solid induction period, structure to their role and meaningful opportunities. It should not replace a paid workforce, but rather enhance the service delivery than replace it.

Theme 9 – Group Work and Peer Support

Service users voiced an interest in a consistent group support offer. However, for those not involved in a group currently such as SMART, they and many of the clinical staff were unaware of the groups available. Therefore, there is a need for more awareness of the group work offer.

There was a general consensus that where groups were happening (e.g. breakfast club, SMART, art club) that these were well received by workers and service users, and supported service users in their recovery and engagement with treatment provision or

criminal justice based interventions. It was felt that more could be done, and there could be different groups offered for people at different points of their treatment and recovery journey, with some being worker led and some worker and peer led.

Furthermore, workers and service users felt there were opportunities to be explored to base groups in communities (many service users said groups helped to reduce their isolation and social integration) but also to link in with established groups in communities; focusing in with each individual's interests.

There are limited structured group sessions available at present in the opiate, alcohol and non-opiate service, although the SMART group for alcohol was well received. Access to SMART, NA and other mutual aid groups across the city was seen as a positive for those who attended these groups. Having a 'recovery hub' was also suggested.

Groups around employment, training and skills building and links with ETE services were also suggested as potential opportunities. Learning from Sheffield's involvement in the Individual Placement Support (IPS) PHE trial will be used to inform this in the newly commissioned contract.

Theme 10 – Communication and IT

All workers and partners shared that there were significant difficulties experienced when trying to contact treatment providers via telephone. Service users shared that they don't like the current telephone system and gave examples of particular difficulties which impacted them. The consensus was a more efficient telephone system for managing this is required in the new contract period making it as easy as possible for service users as the priority, but also other professionals, to be able to contact the service.

Feedback from the consultation was unanimous in its request that IT efficiency was a priority in the new contract period.

Theme 11 – Rehab/inpatient detox

It was explained that the interface between inpatient detox and community treatment has changed overtime, and there is a need for this process to be more streamlined and effective. However, the provision of inpatient detox and residential rehab spot purchasing is not in the scope of this re-tender and so this feedback will be applied elsewhere.

Theme 12 – Health/Wound Care Offer

The wound care offer was seen as very positive by all and considered as a service that should continue. Linking this service with hostels was considered a positive from past practice, but something that had since been withdrawn due to staffing capacity issues and should be recommenced.

It was shared that there is an aging cohort of opiate users and that the physical healthcare needs of this cohort are increasing. General consensus was that further addressing healthcare and wellbeing needs should be factored into future commissioning requirements,

with this being an area that could secure additional funding. A number of suggestions to address health issues of service users were shared by clinicians including:-

- Significantly improving the links and pathways (due to continuation of prescribing needs) with GP practices. Clinicians are reliant on good communication with GPs practices to understand current health care provision and this should be given focus;
- Keeping the pregnancy clinic and consider additional resource for in-reach into the maternity units;
- Consider a female only offer/clinic in line with national drug strategy;
- Retain good links into Hep C treatment; working in partnership with the hospitals and offering onsite Hep C treatment/ satellite clinics;
- The general consensus from staff members is that greater flexibility to conduct home visits should be permitted particularly where patients are deemed clinically appropriate;
- Consideration of a new harm reduction clinic / hub to focus on wound care, BBV interventions and general health and wellbeing check such as blood pressure checks etc.;
- Consideration of adopting the principles of Patient Activation Measures (PAM), where workers support service users to better manage their own long term health conditions and social prescribing.
- Continuing to work more effectively with GPs to continue alcohol relapse prevention medication.

Theme 13 – Outreach

Outreach provision was generally seen as being under resourced currently, but many shared the need for this has increased and activity should be planned in the next contract period. It was felt that further outreach provision could create the flex between responding to emerging trends, linking in with complex people and with hostels and vulnerable people's services, engaging with key partners i.e. the police and used to engage criminal justice clients.

Recommendations for future commissioning arrangements

The following should be considered:-

- Commission one integrated treatment service, which includes all substance use treatment and a criminal justice provision, with elements of city centre and locality / community based provision.
- A treatment system that is open access, that provides a specialist response to those with complex needs or those that are cycling in and out of treatment (revolving door cohort), which is flexible, is challenging, whilst motivating and client led.
- Pharmacological and psychosocial treatment should go hand in hand, with BIs, EBIs and PSI offer to all and specialist talking therapies on a one to one and group basis with a key focus on mental health and a conduit into mental health services.

- A group work offer for all stages of the recovery journey to enhance motivation, engagement, longer term abstinence and reduce the need for individuals to re-presentation to treatment.
- Effective partnership working with key partners, including police, courts, probation, hostels, GPs and hospitals.
- A criminal justice offer that meets statutory requirements and maximised opportunities to engage individuals involved in the criminal justice system to disrupt offending behaviour and engage with drug treatment
- An outreach offer into communities and in-reach into key partner agencies with an emphasis on prevention.
- Continued needle exchange provision that is gold standard and continuation of the JUICE clinic.
- Introduction of a health hub to focus specifically on physical health care needs - including wound care, harm reduction and BBV interventions.
- A proficient IT and telephony system for service users, concerned others and professionals to use.

Disclaimer: Due to the volume of the consultation responses; they have been grouped into the themes for this document. The records of all the consultation that took place are held by Sheffield Drug and Alcohol Co-ordination Team.

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