

**Eastern Regional Forum
25th September
Norwich**

Presentations were given by Martin Barnes, Chief Executive

1. Overview of DrugScope's work
2. Drug Strategy and regional context

Comments on presentations:

Workforce issues

1. Additional training is required in the delivery of the new drugs strategy. The good work being done in our region is down to the goodwill of dedicated practitioners. We need appropriate funds in the right place. There needs to be a thorough review of how the current levels of funding have been used and how effective they have been. The National Audit Office review is welcomed as Drug and Alcohol Action Teams ([DAATS](#)) cost too much money in some areas.
2. Everything gets blamed on front line delivery when actually services do a good job in spite of the structures and their DAATS. How do we streamline the system so that funding and support gets through to where it is needed?
3. Lots of front line staff in Tier 2 services want to get qualified but aren't able to and this really exemplifies the difference between policy and practice. The existing bureaucracy makes it more difficult to treat clients. If a client with dual diagnosis comes in to the service, have to go to mental health to get funding and then substance misuse to get funding as opposed to simply being able to offer the client a service there and then.
4. There is a real issue around the morale of the workforce. The bureaucracy is overwhelming and this makes it difficult to recruit and retain good staff.
5. Good youth workers have said that the work balance between paper/ data collection and face to face time with the client group makes enjoyment of the job very difficult at times. You fill out less paperwork if you are a sufferer of cancer than a drug user seeking treatment.

Performance Management issues

1. Performance management systems were introduced so quickly that agencies were expected to respond to them straight away and this has had to happen at the expense of frontline staff. Then the Treatment Outcomes Profile ([TOP](#)) was introduced and this placed additional administrative pressure on the service, without any additional money being attached.
2. We are asked to complete TOPs forms for our young persons, and yet TOPs is not specific to young people, and they don't want to engage with it. The questions are very insensitive for young people.
3. The TOPs questions around criminal behaviour result in the appearance that treatment causes crime, as there is an increased likelihood that young people will be honest about their criminal activities after return appointments. So crime levels will appear to have gone up the longer clients have been with the service.

4. Youth Criminal Justice clients means that as service providers we have a technical duty to disclose any criminal activity that they tell us about, so why would we as practitioners bother to ask that question?
5. TOPS forms with Drug Intervention Programme ([DIP](#)) clients. If they breach their conditions, they will go straight back to jail. DIP clients are already difficult to engage with as they have heightened paranoia around enquiries into their activities or lifestyles, so why would we ask them about their criminal activity?
6. There is a shared concern that the NTA have narrowed down their area of interest to opiate/ stimulant clients who are accessing adult services, to the neglect of young persons services
7. When it suits DAATS or the National Drug Treatment Monitoring System ([NDTMS](#)) they can collect data from Tier 2 services, which means we still have to do the care planning and paperwork. Yet we don't get the recognition or support as a treatment provider but we are expected to undertake all the administrative and procedural processes without the rewards or recognition.
8. There is recognition that young persons treatment is different to adults and not simply an add on.

What works well?

1. Adult service drug workers complain about resources going in to the young persons services.: We have a Tier 2/ Tier 3 service which is accessible, so this is open to all including the most troubled 'difficult to reach' young people.
2. The National Audit Office Review on DAATS will be interesting. I don't think DAATS understand what makes a good service and, contractual reasons aside, they are also unwilling to decommission a service that doesn't appear to be working very well. Good commissioners are good and passionate leaders and bad ones are not.
3. Suffolk: There is a harm reduction service and an abstinence service operating together. There is a formal protocol in place now to share premises and share approaches to working with our clients.
4. Peterborough: A system of integrated adult services is developing between statutory and voluntary sector agencies. This is particularly good for opiate service users.
5. Luton: There is a new 6-bed respite stabilisation unit. This service is oversubscribed and involves a 10- day stay, but does not include detox as this increases the risk of relapse and overdose when they are released. This is currently the only respite centre in the country.
6. Generally, partnerships and joint working between services are better now than they have ever been. The 'harm reduction vs. abstinence' debate is theoretical rather than reflective of what is happening on the ground. Across the eastern region, services now seem to have the right remit: right amount of tier 2 and tier 3 services.
7. Norfolk: DAAT structure is very enabling and solution orientated. Face to face service to client is better. Experience and skill in the workforce is better...
8. Suffolk: Good service user involvement and stronger links with child protection.
9. Norfolk: There is good communication across agencies and with Norfolk DAAT. More specifically,
10. [Matrix Project](#) offers a range of interventions to women engaging in sex working. These include family work, psycho social interventions and harm reduction measures around their drug use.

What isn't working quite so well?

1. The effectiveness of commissioning varies across the region. Some DAAT commissioners just don't seem to have the full competencies required to undertake their roles.
2. The money being allocated to adult orientated services which means there is not enough around prevention work. We should be working around the causes of substance misuse, especially in young people. This prevention work in young people needs to be done before their behaviour becomes entrenched.

3. Mental health services are unable to keep up with the demand for dual diagnosis services, especially for young people. In our county, we have one psychiatrist coming in one day a week in order to work with clients with complex needs. That is the total provision for the county and is not adequate.
4. Transition services for young people into adult services. Some clients are leaving the Youth Offending Team ([YOT](#)) and can't cope with the diminished levels of support that they are receiving.
5. Successful commissioning is dependent upon the individual and the role and therefore the effectiveness of the Joint Commissioning Group. There can be a lack of consultation in commissioning practices and the operation of commissioning processes comes down to power and personality. Its a numbers game as DAATs just have to get people into services, especially when it comes to DIP clients. Nobody asks what if they don't want to go into treatment. The DIP process is faulty.
6. Inequity of level of service provided based upon how good the local DAAT is at commissioning the right services. Personality is also an important factor for whether different providers get local contracts.
7. The drug and alcohol split is very detrimental for most clients who have both of those support needs. Money is attached to class A drug use and not alcohol as the primary support need. There is a need for greater synergy at practice and policy level (locally and nationally) to have greater synergy of approaches between drugs and alcohol.
8. Drug services need to and want to play a much bigger role in the whole public health agenda aside from the criminal justice approach, which is where the money goes. This misses out on wider public health agenda of health inequalities.
9. Rural problems, in terms of rising fuel costs and how much more difficult this makes travel both for clients in accessing treatment and staff in terms of reaching clients in rural areas. This is the case across both mental health and substance misuse fields.
10. End of Custody License ([ECL](#)) from prison. 18 day early release doesn't work with DIP and what you end up with is a client leaving prison with 18 days worth of grant and no housing, turning up homeless. Grant is a cash benefit (usually around £90). Concern exacerbated by having low levels of heroin tolerance from time spent in prison, which increases the risk of overdose.
11. The tightening of eligibility criteria for accessing services seems to work by precluding rather than including people from services. This will eventually result in individuals problems being becoming more acute if they can't access the right service early on.

What would you like to see done differently?

1. Transitional workers with smaller case loads to avoid the problems of high levels of support in a young persons service vs. low-level support across adult services. This would work towards bridging the support gap faced by young people moving from young persons into adult services.
2. Young persons services can and should do more to facilitate the transition from young people's services to adult services in relation to forward planning. This could mean supporting attending appointments or facilitating meetings in familiar places with agencies that clients may be accessing in the future. Good advance planning and cooperation with adult services will enable a good, supported client handover.
3. Tier 3 young persons services to do joint assessment with psychosis teams around young people with dual diagnosis needs. We need improved professional relationships with informal team building type exercises, team meetings.
4. In relation to housing, there needs to be a change in policy for under-18 year olds so that they cannot be deemed to have made themselves intentionally homeless by leaving their family home. More generally this feeds in to improving the culture of policy making and statutory services attitudes towards meeting their duty of care to clients.
5. There needs to be more integrated mental health and substance misuse services for young people and more preventative outreach and community work for a more systemic approach including the

families in the local neighbourhood. The costs are miniscule in comparison to the criminal justice and health costs at the other end of service delivery.

6. Better risk management approaches as most chaotic and problematic clients tend to be excluded from the services precisely because of their behaviour, when actually they are the clients that are most in need of help. If services are going to be commissioned to be open access, this comes with associated risks and the need to protect staff.
7. Training being available to voluntary sector agencies. My experience working within a Youth Offending Team is that training and its associated needs are built into budgets and not an add on that is subject to discretionary cutbacks. This creates a potential skills/ knowledge inequity between voluntary sector and statutory sector workers and organisations.