Birmingham Public Health

Drug and Alcohol Stakeholder Consultation

Findings from the Consultation

May 2013

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# Introduction

The Institute of Public Care (IPC), a centre of Oxford Brookes University, was commissioned by the then Birmingham Drug and Alcohol Action Team, now Public Health Birmingham, to conduct a stakeholder consultation across the substance treatment system. The consultation has been conducted during March and April 2013 using a range of methods, as follows:

* An on-line survey, open to any relevant stakeholder to contribute.
* Focus Groups separately conducted for service users and workers and held in the premises of the three main providers, Aquarius, the Birmingham and Solihull Mental Health Community Trust, and Swanswell.
* Meetings with substance misuse service managers.
* Visits to a number of alcohol and drugs projects.
* Attendance at meetings, notably at a regular meeting of the Recovery Forum.
* Meetings with key statutory agencies, including DIP Mangers, Prison managers and Probation managers.
* One to one interviews and phone interviews.
* Written submissions by e-mail and letter.

A list of organisations and groups, which participated, is provided in Appendix 1. The present report provides a summary of the overall findings from the overall range of activities, building on an interim summary, which was presented in April 2013.

Figures collated from the various activities indicate that 320 full submissions were made to the online survey, of which just over 46% were from people identifying themselves as service users. This high level of participation reflects some very helpful support from professionals and IPC’s decision to accept written contributions from downloaded and printed survey forms, which were then manually added in by IPC staff.

The number of people who participated through focus groups, agency visits and interviews yielded a similar number, with 160 managers and staff members, 156 service users, and approximately 20 former service users working as coaches or peer mentors. Clearly a significant number of people have contributed in more than one way, but the total number of contributors is therefore in the region of 650. This is evidence of the commitment and energy which marked the consultation. Although many concerns were expressed there was a generally positive attitude and most people strongly welcomed the chance to contribute, and the alcohol and drugs service Commissioner’s willingness to have as open and inclusive a process as possible. The Commissioner has indicated that the report of findings will be made available throughout the treatment system and this too was strongly welcomed.

IPC acknowledges the support and guidance received not only from the Commissioner and his colleagues but also from officers at Public Health England who played a valuable supporting role in arranging some meetings and contributing to discussions.

IPC’s brief was to consult across 4 main areas of concern or domains:

* Prevention
* Engagement
* Treatment
* Recovery

After an initial summary of the main positives and negatives, which participants identified about the treatment system this report addresses those main headings in sequence. It then goes on to deal with structural issues, concluding with a summary which covers the main positives and negatives together with key areas where there is an apparent consensus on the need for change.

# Prevention

This domain was the subject of discussion with all groups and two specific question in the on-line survey.

The first survey question covered the broad area of primary prevention and asked the following question:

*Do you think in general substance misuse ‘prevention’ services reach the right people?*

Of 322 responses 57.5% answered ‘yes- about right’. 23.3% answered no with 19.3% answering that they did not know.

In Focus Groups and other meetings, however, there was more concern about the targeting of prevention work than the survey findings imply. The main themes which emerged for primary prevention were as follows:

* Work in schools continued generally to be seen as important, but many felt that former service users with suitable training should be at the centre of this activity, and that messages generally needed to be franker and more explicit.
* Many staff, managers and service users felt that the focus should be much more on those who were at higher risk among young people - notably those in care or leaving care; those with behavioural problems and children from families with substance misusing carers.
* It was felt that much better use could be made of social media and a better and more co-ordinated public awareness approach. It was also felt that a more common approach across agencies with shared badging and materials would be helpful.
* Some agencies had experience of a more informal outreach approach to prevention - in supermarkets to address alcohol issue, for example, and within nightclubs. It was felt that this work tended to be short term and piece meal, but was effective and merited further support. The pharmacists consulted all felt that pharmacies could contribute more fully within a co-ordinated approach.
* A theme throughout the 4 domains was that drug use was changing into a more complex and frequently shifting pattern with new drugs including ‘legal highs’, cannabis as a much more significant issue, and use of alcohol problematically within wider drug use. Many felt that prevention work now needed to adapt to this new context.
* A significant concern was the need for primary prevention to be carried forward by people in mainstream services, but that this would demand good quality materials and training. A number of mentions were specifically made about social work staff within Social Services, where many clients were said to be reluctant to engage with treatment because of their concern about what would happen to children once safeguarding issues were shared with Social Services. This is also an issue for engagement and this anxiety does seem to delay access to treatment for many substance-misusing parents.
* A key area of concern however was raised in many of the meetings about the extent to which prevention services and service information still did not reach some sectors of the population. Notable groups were Asian women, Sikh men in relation to alcohol use, and Somali men in relation to khat. A Focus Group facilitated by KIKIT for Asian women stressed the need for very basic information to be relatively available about drugs and their effects. Both KIKIT and Freshwinds stressed the central importance of cultural awareness and language. While it was recognised that the ‘community champion’ approach developed by Aquarius and Freshwinds had strengths, KIKIT particularly spoke of the need for local community based agencies to be available, given their direct reach into diverse and deprived communities such as Sparkbrook.

As one comment from many in the on-line survey indicates:

*‘I think prevention services do have an impact, but I think there is a lot more to be done to educate people from an earlier age. I think it is important to involve people who are in recovery in promoting prevention measures. Drugs can often be a 'hidden' topic within some communities and it is important we try to make drugs and drug services more openly discussed.’*

Secondary prevention was the subject of a question in the on-line survey, and also featured as an issue in all group and individual discussions.

In the survey respondents were asked to agree or disagree with the following statement

*‘In general people in Birmingham are being helped effectively and at the right time to avoid getting a more serious substance misuse or closely related problem in their future.’*

Of 324 responses 53.4% strongly agreed or agreed and a further 20.4% ‘agreed somewhat’. This is against 18% who had some level of disagreement with the statement. A flavour of the comments provided by respondents is provided by the following statements.

* *I feel that the Early Intervention Team, Aquarius, Irish in Birmingham and SIFA Fireside is working well with clients. It is a great opportunity for clients who self refer to discuss their alcohol use and build up trust to enable them to access further treatment if required and de mystify the whole process which I think can be daunting for clients and thus can prevent more serious alcohol use and the negative impacts on the family.*
* *I feel that by being able to access drug services in the GP surgery people are well served. If you have a problem you tend to go to your GP first. More advertising of the services would be beneficial.*
* *People are getting treatment instead of buying drugs. They are able to avoid bad company. They are protected from hepatitis and HIV.*
* *Plenty of treatment for people, if they want it, to choose from in Birmingham - I think services could be advertised better, maybe on billboards etc.*

Within the Focus and discussion groups six main areas of secondary prevention concern were stressed as follows:

* Among most professionals and service users there was a shared recognition of the importance of maintaining harm reduction approaches by way of sustained needle exchange, work on Blood Borne Viruses (BBV) and access to prescribing for those people at risk from ongoing substance misuse. There was an anxiety that funding reductions and a greater emphasis on recovery issues might threaten provision.
* It was generally felt that access to information for family members coping with problematic drug or alcohol use was more difficult than it should be and a number of people suggested the development of a help line specifically for family members. The issue of a more family friendly treatment system was raised in other domain areas as well.
* Many stressed that outreach provision was vital not only to hard to reach people in treatment but because of its contribution to harm reduction. A strong example of this is the work undertaken with street sex workers by SAFE. Others felt that homeless people in Birmingham did not get the attention they needed in prevention and harm reduction.
* Pharmacies clearly have an important part to play both in harm reduction on drugs and in related health areas such as reproductive health. Pharmacists contributing in interview and discussion all felt that there were options for further development of this work.
* Those involved with DIP, Probation and prison based work all shared concern at the potential for Criminal Justice based harm reduction work, including crime reduction, to be less of a priority because of financial pressures and organisational change.
* There was recognition of the crucial role of G.Ps at both primary and secondary levels of prevention/harm reduction, particularly in respect of women and those who were unlikely to seek help from other sources.

# Engagement

Many people made the point that a more developed approach to prevention would itself have a positive impact on engagement, and that policies needed to reflect the intimate connection between these two areas.

Within the on-line survey respondents were asked to agree or disagree with the following statement:

*‘In general people are being helped effectively to engage with substance misuse services and then make good use of them.’*

Of the 315 people who responded to this question a big majority of over 80% agreed at least to some extent with the statement and 17.8% ‘strongly agreed’.

Many of the comments made in survey responses acknowledged the growth in services in recent years and the efforts made to engage people. Many comments from service users were very positive about their experience, but overall some serious concerns were also expressed not only about the initial engagement process but the ways in which agencies then tackled the problem of maintaining engagement once an initial contact had been made.

Some comments covered what people thought worked best, for example:

*‘Services work best when they are easily accessible, i.e. drop ins and local community services. Also having a mix of clients at different stages helps to peer support and encourage clients to continue.’*

A number of people commented on the value of having peer mentors or supporters to help people adapt to services, especially in the early stages:

*‘Services utilising peer mentors is good practice in terms of engagement - this should be key to future delivery models in Birmingham.’*

As in the earlier comments about prevention there was concern about harder to reach groups, and the need for community organisations and co-coordinated outreach work:

*‘I think more resource to enable more proactive outreach early on in the service user's period of treatment will improve engagement.’*

Finally several comments are representative of the high level of concern about the complexity and often confusing nature of the current treatment system.

*‘Although it is good to have choice and a variety of service provision, the treatment system is confusing due to the number of different services and providers. The duplication of interventions provided across the city makes it confusing for professionals which impacts on the level of referrals made and therefore ultimately reduces engagement.’*

*‘Lots of hand-overs in the current system from one organisation to another eg between housing providers and specialist drug/alcohol treatment providers. One stop shops would provide better opportunity to engage people in holistic treatment.’*

Engagement was discussed within all Focus Groups and individual discussions. The main issues echo the on line survey, but suggest a higher level of concern. The main issues raised were as follows:

* Most people, whether workers, volunteers or service users felt that the system in Birmingham was too complex, hard to understand and as a result more difficult to access than it needed to be. They felt that a smaller number of agencies more effectively co-located within the community would be better.
* It was mentioned many times that Birmingham services needed to be marketed much more heavily with better and wider publicity and a common approach across agencies targeting demographic groups most in need and the whole population.
* A number of people with experience of living in large hostels said that they received little information about service while they were there and few had experienced efforts to encourage them to seek help. The Salvation Army was seen as an exception to this.
* Service users and former service users involved in volunteering felt that they could play a much fuller part in the attracting of people to service and in supporting individuals from the beginning.
* Some services had been working hard to develop a more welcoming approach, both in terms of the welcome environment and their initial processes. It was felt by some though that this could be taken further - drop in provision to encourage confidence, an informal café atmosphere and so on.
* There was much concern about the need to attract more women into service generally and this was even more marked in some of the BME communities. It was generally felt that marketing, the agency environment and access to women’s groups and a female staff and volunteer option all had a part to play.
* Birmingham has a number of outreach activities including a service which successfully carries out harm reduction and service access for female street sex workers. There is a need for a more co-ordinated approach to outreach. If the treatment system is to be streamlined and more ‘co-located’ the design needs to incorporate a place for outreach work.
* Birmingham has a number of BME specific providers and organisations which play a valuable part in reaching into communities, contacting hard to reach groups and ensuring that the needs of those communities are understood and responded to. Those involved saw their value as being located within their community and with a local identity. While they saw the case for a more streamlined system with fewer providers they argued strongly that they could provide trust, access and confidence in a way which the larger ‘mainstream’ agencies could not, and that any new service system needed to retain their involvement.
* Prison represented both engagement and re-engagement challenges. There was concern among prison based services and criminal justice agencies about a possible lessening of commitment because of new structures and financial constraint. People with direct experience spoke of the importance of support immediately following release and the potential for peer mentors and others to help.
* There was real concern around the system about the waste and disincentive to clients in a failure to follow common assessment processes, so that difficult issues for clients were raised again and again in separate assessments. There was a general view that this needed to be streamlined and designed out of the new system to maintain strong engagement.
* In both the engagement and treatment domains there was a general consensus on the importance of clients having fewer doors to knock on, with services more co-located into hubs, relatively locally on 3 or 4 sites. An integral part of this idea was the notion that external services - probation, employment, social services etc could have a base or contact point in these hubs as well. There was a good deal of discussion about the need to achieve reasonably local access. At present there is a co-terminosity issue about the present ARCH hubs covering ‘patches’, which are not the same as Birmingham City Council’s 3 areas. Given the establishment, now, of substance misuse services within the local authority it was felt that this anomaly needed to be addressed. There was a concern about the size of South Birmingham, which at present has both an ARCH and the Inclusions Centre, and which may need to continue with this level of coverage. At a very practical level many people, both staff and service users spoke of problems to do with cut backs in meeting fares and the high level of transport costs which people faced in using the present system.

# Treatment

The main issues raised in this domain, both in the on-line survey and the various meetings again centred on the need for streamlining and a more intelligible pattern of service. There were inevitably different ideas about the priorities, which should be adopted within the treatment system. Most people stressed that the large number of treatment providers in Birmingham did not so much offer choice as confusion, and indeed during some focus groups both staff and service users, many of whom had been involved for some time, expressed surprise at hearing information on other services about which they had known nothing previously. This was illustrated in the survey where around one third of participants (service users and alcohol and drugs workers equally), thought the current treatment system was not being delivered effectively. Overall the main issues were as follows:

* There was general consensus that pathways and referral processes needed to be redesigned and wherever possible simplified.
* Many people from all stakeholder perspectives spoke of the ‘unhelpful competition’ between agencies. Some service users felt that they had been ‘held on to’ to keep numbers up and could have been transferred earlier. Some felt that their worker had a limited sense of the available options in any event. Many said that much depended on the qualities of your individual worker, and that there were too many transfers of worker.
* There was a general feeling that ‘navigation’ was difficult and that a more obvious case manager ‘navigator’ role was needed to follow people through. Similarly the large and developing groups of former service users volunteering within agencies felt that they could assist individuals as they went through the treatment system, helping to maintain a sense of continuity.
* There was a general sense among service users and the professionals involved that shared care was working well and should be developed further if possible - may argued strongly that the ‘normalising’ of treatment in this way also enabled it to stay local. People going through shared care, though, did need to be helped to an involvement in the social networks which are developing so strongly in Birmingham through the Recovery movement and the organisations involved in it, including the traditional fellowships.
* It was generally felt that access to prescribing had been improved and that the more co-ordinated approach of the Hubs had made a significant impact. There is some criminal justice concern though about the consequences of not having specific criminal justice workers within the Hubs, and a feeling that this has made liaison and a shared approach more difficult.
* DIP Managers, Prison based services and probation all express concern about the potential within any new structures for the work with offenders to be less clearly focused. They point out that successful operation over many years has brought many people into treatment and that the ‘fast tracking’ involved has been justifiable on the grounds of public concern, as well as the needs of offenders.
* There was a general concern among service users that treatment might become too ‘speeded up’ and that some people needed much more time than others. There is clearly value in shorter term interventions, such as those within current alcohol provision, but to work well this calls for effective assessment and ‘streaming’.
* On the whole there was a consensus for integration of drug and alcohol services. It is acknowledged that there is generally more coherence of provision on the alcohol side, but overall it was felt as wasteful and unhelpful to continue with two ‘streams’. It was felt that this was especially difficult for those with both drug and alcohol problems. It is accepted that there are some alcohol specific interventions but that these could be accommodated within well-designed integrated services. While some people spoke of the reluctance of alcohol clients to be associated in treatment with drug users, others spoke of the benefits they had gained from shared insights about addiction overall. Interestingly this perception of the value of an overall addiction approach was stronger among those furthest along their treatment journey. There were concerns about the importance of planning carefully for a more integrated approach, including the need to ensure sufficient capacity if the numbers of alcohol misusers in treatment substantially increased. A number of people, for example, pointed out the need for more availability of detoxification beds for people with alcohol problems. It was felt that integration did not necessarily mean a ‘one size fits all’ approach and that some drug and alcohol specific interventions needed to be retained. This would include perhaps different promotional approaches and prevention strategies. Essential would need to be recognised in newly designed treatment pathways. At present shared care works differently for drugs and alcohol and the implications of this also need to be considered. Staff training would be a key element in planning transition to an integrated approach.
* High care residential services in Birmingham now focus on Park House, which provides both detox and residential treatment. While formerly Birmingham made significant numbers of external residential rehabilitation placements financial constraint now means that all placements go through the Park House facility. Inevitably there were mixed views about this, but a general acceptance of the situation. There was a strong feeling that more places for both detox and treatment were need within the Birmingham provision and that this was an urgent priority.
* A number of service users spoke strongly about their sense that they had been ‘parked on methadone’ and overall a view that people should be given the chance to reduce or seek abstinence more consistently.
* There were, however, some people with long stabilised maintenance use who were anxious about the prospect of being ‘forced along’ within the new Recovery focused world. It may be, in any event, that future planning will need to take account of the longer term needs of an ageing population of these clients.
* As indicated earlier there were many references to the need for more family friendly services generally, and indeed some family specific provision, especially for parents and carers. Some agencies, such as Aquarius have established such interventions and the Hubs and community agencies generally have also begun to tackle these needs. Most people felt that these issues should be a key priority in the designing of a new pattern of services.
* Some contributors felt that the treatment system overall was very ‘medicalised’ and that it was time to look for a broader based approach with more emphasis on psycho-social approaches, peer support and a generally more holistic approach to people’s lives. Pharmacists also felt that they could play a bigger role, including contributing to some prescribing, given recently established pharmacist qualifications for this work.
* On other areas of public care the importance of advocacy has been identified as key to the implementation of personalisation. Advocacy, currently provided in Birmingham by DATUS will need to be further developed assuming that choice and personalisation will in due course be implemented in drug and alcohol treatment.
* Prison based staff expressed real concerns about the quality of handover into the community. They felt that a more streamlined service could help, and there was also a clear role for peer support in meeting people on release. They also felt, though that an over arching aim should be the harmonisation of information exchange, and standardised assessment.
* Transition from young people’s services is not seen as particularly effective and could be improved by a newly developed pathway and better shared understanding between young people’s and adult services about transition issues and the needs of younger service users.
* The idea of having integrated services around 3 or 4 co-located hubs across the city was generally popular, and many pointed out that this would allow some other general services, such as Social Services to have a more accessible contact point. The following on line survey comment makes this point clearly:

*‘Birmingham's system would be more effective if it was divided into areas each with an integrated service. Each area should have a similar specification and pathway but deliver to meet the needs of local populations. There is lots of good treatment available in Birmingham which can sometimes get lost in the chaos of the system and impact on the outcomes and progression of service users. If professionals are confused, service users must find the system difficult to navigate’*

# Recovery

This was the final domain addressed in both the on-line survey and all group and individual discussions.

In the survey respondents were asked whether they agreed with the following statement

*‘In general Birmingham's substance misuse treatment system works effectively on the recovery agenda.’*

Of the 304 people who answered this question 74% agreed at least to some extent and 13.5% strongly agreed.

This relatively high consensus is reflected in comments made, and the following contributions give a flavour of some of the key points made:

Although throughout the consultation there was concern about poor connection between mental health and substance misuse services there are some examples of this working well:

*‘I am doing well towards my recovery and I am regularly reducing my prescription but to do this I have needed support around my mental health so that I can achieve this. I now go to see a counselor and I have a psychiatrist to help me. My drug worker helped arrange this. That is good practice.’*

Many people felt that the work done by service user and mutual aid groups was crucial - the following statement is an example:

*‘Good practice includes Breaking Free Online and support for service user involvement. The Treatment and Recovery provider forums are good to keep services reflecting on practice and delivery. Mutual aid needs to be integrated more fully with treatment and not on the periphery of a drug treatment system. Recovery support initiatives such as Peer Mentoring, the Recovery Kitchen and interventions at Community Rehab Services will be crucial to sustaining long term recovery through a provision of aftercare that will skill up individuals and support that recovery.’*

Another statement develops this point:

*‘Organisations such as DATUS and ASPIRE are really strong and developing well. More could be done in this area, i.e. supporting Changes UK in developing more houses for socially assisted detox. Providers with a track record or working with recovery groups should be recognised as part of the tender process. The recovery walk will also help put Birmingham on the map recovery wise but more events such as celebration events are welcome. I understand that services such as ARCH host NA groups and SMART - more of this needs to be encouraged.’*

As in the other domains there is an awareness of the importance of a holistic approach which includes families, as indicated in the following statement:

*‘A clear Families and Carers pathway as part of an integrated service would support long term recovery.’*

Throughout the Focus Group and other discussions a running theme was the level of energy and enthusiasm within Birmingham’s Recovery community. On a number of occasions people spoke of Birmingham being ‘on fire’ in this respect. This owes a great deal to the commitment and determination of the leaders involved, and a result the main representative group, the Recovery Forum has a very high level of attendance and participation. Against this backdrop the main issues which emerged were as follows:

* There is a need for a locally ‘owned’ and inclusive definition of recovery, which incorporates all those who are making changes in their lives and seek further change.
* Many agencies are now using Peer Mentors, or Recovery Champions. As indicated earlier many feel that they could do more as volunteers within the system. The role, regardless of title, seems to be similar across agencies and some felt that again there would be advantage in having a more common designation. Some also felt that efforts on training and support could be pooled across agencies. It was also felt that more could be done to tackle restrictions and delays within the system on accreditation, CRB checking and so on.
* A number of people felt that some further resourcing should be committed to those running the Forum to enable work to develop including its role as the main representative group. This should not, though, compromise its independence.
* Many service users and former service users expressed a strong view about the vital importance of people having access to constructive activity as part of their new lifestyle, particularly at a time when finding employment may be difficult. It was felt that a coherent approach by the Council to extending volunteer opportunities would be really helpful. While many people wish to volunteer with drug and alcohol services, as indicated above, there are others who wish to work as volunteers outside it.
* Access to support communities and networks is also seen as crucial and many NA and AA members contributed to the consultation. Some made the point that while support for NA and AA is embedded in a number of agencies there are others where staff may be less well informed about the Fellowships, or do not perceive their value. They felt that this was a significant training issue, which could only be addressed by direct contact and attendance at a meeting. Birmingham also has a developing provision of SMART Choices, a more recent network, and a facilitator was interviewed within the consultation. The establishment of another option is attractive to many service users and is seen as very helpful in extending the choice of networks.
* There was much discussion about the issue of training and employment and some contacts were made with providers and users of those services. They were generally positively regarded, but it was acknowledged generally that the constraints of the current employment situation and benefit changes were serious pressures which would affect some people’s recovery.
* Similarly many people were concerned about the lack of available accommodation. The Birmingham City council based after care service for those who have been in Park House provides a well integrated after care provision, which makes much use of volunteers.
* The Changes agency in effect provides an alternative recovery based model for treatment and after care using follow up houses leased on the private market. This sense of a wider role for recovery based agencies suggests an effective model, which may have scope for further development.
* There was an overriding concern that shorter treatment periods might mean people being forced to independent living earlier than was sustainable for them. This is a significant message for the new treatment system and flexibility will be needed. It is clear that access to and involvement in a recovery network should be an aim of all case planning.

# Structure issues

During the period of consultation the NTA became part of Public Health England, and the Birmingham DAAT was subsumed into the Public Health Department of Birmingham City Council. It was clear that these changes had major implications for future planning and management of services and several views were expressed which are summarised as follows:

* The establishment of a new joint Commissioning structure seemed to many people to be a top priority, and that this would also offer the opportunity to ensure service user representation at all levels.
* The interface at strategic and commissioning level between Public Health and Criminal Justice is seen as a key concern particularly by criminal justice and DIP managers who feel that dialogue has been more limited in recent times, and that there needs to be a regular agreed forum to address commissioning and planning issues.

# Summary of strengths and weaknesses from the consultation, and the implications for change.

The main strengths identified in the consultation can be summarised as follows:

* Many contributors pointed to the growth in services in recent years and the generally positive approach of providers.
* Many involved in alcohol services felt that they now operated coherently following successful re-organisation and that links between the lead agency and others were sound. Some felt concerned that this might be lost if an integrated approach was adopted.
* The movement in drug services into the ARCH Hubs was seen as having achieved improvements, though many felt that this needed to go much further.
* The shared care scheme and the ‘normality’ it represented for people were seen very positively.
* Harm reduction services were well developed, and there was some effective outreach work, which some felt could be better coordinated.
* There were positive contributions from community based BME organisations, though there were concerns about unmet need from some hard to reach groups.
* There was a generally positive feeling about service user involvement within the treatment system, but a recognition that this need to go further, and that the representative organisations and service user led initiatives needed more support.
* The involvement of Peer Mentors, Recovery Champions and other treatment-experienced volunteers was seen as a strong area, which needed further development.
* The strong and energetic Recovery Community in Birmingham was seen by many as the most distinctive strength of all, and that this needed support and further encouragement.

The main weaknesses can be summarised as follows:

* The system overall is very complex and cumbersome with too many providers and significant elements of unhelpful competition. The diverse location of services around the city caused confusion and travel costs which many found a serious disincentive.
* Although efforts have been made to implement standardised approaches though a common assessment tool and a single point of contact these elements are not well adhered to and wasteful delays and duplication occur. Many service users felt particularly strongly about being involved in painful repeat assessment.
* Generally people felt that information about services, and the promotion of them were not strong areas.
* Links and collaboration with mental health services were seen as poor.
* The provision for drug and alcohol services constituted separate streams which was seen as wasteful and confusing, although efforts had been made by the main agencies to make cross over links for those with dual diagnosis.
* It was felt by many that services overall were insufficiently family friendly.
* Transition from young people’s services to adult services were not seen as being effective because of the complexity and a more coordinated approach was necessary.
* Links between Criminal Justice agencies and the treatment system had been weakening and this had implications for crime rates and engagement.
* There were still weaknesses in ‘equal access’ to treatment - women were underrepresented, especially from BME groups and there were similar concerns for other minority groups.

Overall the results of the consultation suggest the following main areas where there is a reasonable degree of consensus about the need for change

* There is support for the introduction of perhaps four integrated service centres across Birmingham. So far as possible they would co-locate services, and also provide a base for other non substance misuse services which regularly require close liaison on clients - Social Services, Housing and Employment, for example. The centres would also form a base for outreach services, which should be better coordinated.
* Generally the shared care scheme is working well and should be developed as far as possible.
* There should be a major reduction in the number of provider organisations, with a standardised approach to sub-contracting for smaller providers, so that some diversity of provision is maintained.
* Some communities present major challenges in terms of access and cultural difference. It is important that they are sustained within the new structure, and that they continue to be community based. Potentially they could also play an agreed role in terms of cultural intelligence, training and needs assessment.
* A new treatment system should integrate drug and alcohol services, but this should be based on detailed planning and a recognition of the need for some distinctive components.
* A common assessment system and newly designed pathways should be developed to ensure consistency and a more easily monitored treatment system.
* A newly designed treatment system should be more family focused and inclusive. At present this is not felt to be the case.
* There should be work towards better sharing of data and common IT systems. There is general recognition though that complexity and costs will mean that progress takes time.
* A new promotional and marketing strategy should be developed to accompany the Commissioning strategy. This should cross reference other Public health strategies and plans.
* There is an understanding generally of the concentration of residential care on Park House, though many continue to regret the lack of choice which this means. There is a substantial need to increase beds, especially for alcohol detoxification.
* There is concern that rapid access to treatment is maintained especially for more vulnerable groups.
* Harm Reduction work should be sustained and this is seen as highly relevant to the new Public Health context of substance misuse work.
* The potential for an enhanced role for pharmacies should be explored.
* There is very strong support for the further development of a Recovery based service in Birmingham and the user led and mutual aid groups need to be supported, including those elements which provide services- advocacy and after care are clear examples.
* There is a strong consensus that Birmingham needs a generally accepted definition of ‘Recovery’ and generally people want this to be as inclusive a definition as possible.
* Treatment periods need to be as short as is consistent with an individual’s recovery but most people seek an individualised approach which does not have rigid limits.
* The scope of volunteering is considerable and should be developed through Peer Mentoring and other schemes. Some people especially in the current employment climate would welcome wider volunteering opportunities however, outside the substance misuse world.
* Efforts need to be made to bridge the gaps which appear to be developing between Criminal Justice and the treatment system, especially at strategic level.
* Changes in the young people’s system need to be planned jointly with Public Health.
* The consultation process has demonstrated considerable enthusiasm for ongoing engagement of service users and providers in the change process, and this will have implications for process and time scale.

These 20 points reflect the main issues raised through discussion of the four domains. There was certainly a wide range of views, and a number of people would dissent from certain of these priorities. Nonetheless these are the most obvious and more generally accepted views which emerged.

Appendix 1

Summary of contributing organisations and groups

Many individuals contributed to both the on line survey and at face to face consultation meetings, some of which were agency based, and some thematic. Additionally some individuals contributed through phone interviews or in writing. In accordance with our commitment to anonymity the following list covers organisations and groupings rather than naming contributors individually.

* The interface at strategic and commissioning level between Public Health and Criminal Justice is seen as a key concern particularly by Criminal Justice and DIP managers who feel that dialogue has been more limited in recent times, and that there needs to be a regular agreed forum to address commissioning and planning issues.
* Staff, service users and volunteers from Addaction.
* Members of Alcoholics Anonymous.
* Staff and service users from Aquarius including a family group.
* Staff and service users from each of the 4 Birmingham and Solihull Mental Health Foundation Trust ARCH services - North, South, East and Central & West.
* Staff and service users from Changes U.K.
* Manager from DATUS.
* Senior Manager from Birmingham Council Children’s Services.
* Manager and Officers from the Birmingham DIP- Drug Intervention Programme.
* Staff members from the Employment and Education Support Project (EESPRO).
* Managers from Freshwinds/ BROSIS.
* Staff and service users from Inclusions.
* Staff members from Irish in Birmingham.
* Manager from Job Centre Plus.
* Staff and service users at KIKIT, and a Focus Group of locally concerned people from Sparkbrook and Sparkhill convened by KIKIT.
* Manager from Lifeline.
* Members of Narcotics Anonymous.
* Staff, residents and volunteers from Park House and Summerhill House.
* Staff from Pertemps People Development Group.
* Pharmacists from Boots, Lloyds and an independent pharmacy.
* Staff, service users and volunteers from Phoenix Futures.
* Officers from Public Health Birmingham - formerly the Birmingham DAAT.
* Officers from Public Health England - formerly the NTA Regional Office.
* Staff from the SAFE project.
* A SMART Recovery Champion and SMART Recovery participants.
* Managers from Staffordshire and West Midlands Probation Trust.
* Staff and service users from the Substance Misuse Recovery Service.
* Members of SUGAR - Service User Groups about Recovery.
* Officers and members of the Birmingham Recovery Forum.
* Staff and service users at Swanswell.
* Staff service users and volunteers from Turning Point.
* Managers and members of the Drug Strategy Group Winson Green Prison.