



# **Evaluation of service users views of Somerset Shared Care Scheme**

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*'Honestly I wish I had a more interesting story like bad doctors, bad chemists and that...make it more interesting, but there's pretty well for me nothing to moan about and like I say it's all going alright...'. Participant number 26.*

**GLOSSARY:**

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DAAT	Drug & Alcohol Action Team
EMIS	Egton Medical Information Systems Ltd (primary care electronic record and prescription writing software)
FP10MDA	The prescription form that is used for computer generated prescriptions for certain medicines to treat addiction e.g. methadone and buprenorphine
LIMBO	Low Intensity Methadone and Buprenorphine Option
MoPSI	Models of Psychosocial Interventions
OST	Opiate Substitution Therapy (e.g. methadone, buprenorphine)
PwSI	Pharmacist with a special interest (in substance misuse)
Rx	Prescription
TP	Turning Point (Somerset)

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## **SUMMARY:**

This evaluation of shared care services in Somerset from the client's perspective was informed by information provided by 70 individuals, representing just under one third of shared care clients. Of these, 59 returned a completed questionnaire, 11 more participated in an interview (but did not complete a questionnaire) and 9 completed both an interview and a questionnaire.

Overall the majority of people were satisfied with the services they received. Most clients felt they were treated with respect by their key worker, GPs, GP surgery staff and pharmacy staff. However in a minority of cases attitude of GP reception staff, GPs not involved in shared care and pharmacy assistants were considered negative.

There were clear examples of where clients felt they received an excellent service that they could not fault and great appreciation for such services was shown. 'Lifesaving' and similar terms were used.

The role of shared care was understood by some but there were examples of where this could be improved. The role of the client within shared care was sometimes not clear, for example where responsibility for arranging repeat prescriptions or booking appointments lies. Therefore it is suggested that a review of the information provided to new shared care clients could be undertaken.

Not all participants considered themselves a partner in shared care and reported feeling disempowered. There were individual cases where relationships with key workers and GPs were considered poor. This was less of an issue with pharmacy staff because participants could more easily change the pharmacy that they attend if they were unhappy and some reported having done so.

Non punitive prescribing was a valued area of good practice. Similarly the provision of maintenance prescribing was considered very important, with past experiences of coerced detox being recounted as a bad experience. Most participants felt able to exercise some influence over their treatment, citing flexible dosing in response to need as a valuable aspect of their care. Some participants were able to contrast current situations of being able to be open and honest about their drug use with past experiences of having to hide on top illicit use for fear of losing their prescription. However for a small number this concern persisted and the fear of losing their prescription was strong.

Examples of good practice included feeling cared for and listened to by GPs; key workers 'going the extra mile' for example sending reminder text messages of appointments and making frequent contact during times of difficulty. Pharmacists who resolved prescription problems on behalf of the client were highly valued. Being treated with respect and dignity was identified as important and valued. The importance of a good therapeutic relationship with care providers was identified by the majority who participated in this evaluation and for some, the link between this and positive treatment outcomes was made.

Based on the participant feedback and following consultation with key stakeholders, **ten suggestions for improvements to shared care were identified:**

- 1) Provide information to explain the purpose and aims of shared care to all clients being transferred from the core team. Clearly explain arrangements at local (surgery) level for making appointments and facilitating the availability of timely prescriptions.
- 2) Try to provide consistency of key worker for people in shared care. Frequent change of key worker prevents a therapeutic relationship from developing and in some cases had prompted a conscious decision to 'clam up'.
- 3) Ensure the frequency of key worker appointments is meeting the needs of the client.
- 4) Give clients some say in their choice of key worker (including age and gender) and the option to change key worker if they find there are personality clashes or other valid reasons to change.
- 5) Ensure that clients are reviewed every 90 days by a GP. Ideally the GP who provides their shared care should be their own family doctor. Where this is not possible this should be explained.
- 6) Offer a low intensity service for those who are very stable and want to be 'left alone' on long term maintenance –telephone based 90 day reviews and more frequent brief checks and feedback from the community pharmacist could be utilised, with annual shared care team clinic appointments. This is similar to the 'repeat dispensing model' used for chronic illnesses.
- 7) By contrast improve and increase the range and opportunity for access to wrap around support services available for those who want higher intensity interventions e.g. one-to-one counselling, college and employment support and access to activities such as sport and art. The introduction of MoPSI by Turning Point in January 2011 will address the provision of psychosocial support.
- 8) Consider offering shared care clients surgery based evening or weekend appointments for people with full time jobs or college commitments. Home visits were also suggested for people with young children.
- 9) Consider ways to facilitate access to dental care so clients can deal with dental problems and associated self image problems from poor teeth.
- 10) Have an individual at each Turning Point office who oversees support for the generation of legal and accurate shared care prescriptions by GPs. This person would need an excellent working knowledge of the Misuse of Drugs Act (1971) requirements. Alternatively such as role could be provided by a PwSI within the DAAT.

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## **1.0 Remit**

Somerset Drug & Alcohol Team (DAAT) is a Partnership between NHS Somerset, Somerset County Council, Avon & Somerset Constabulary and the Probation Service. The DAAT commission specialist services for people with problems of drug dependency. Commissioning includes the provision of specialist prescribing and needle exchange services (TP -TP), shared care between TP, GPs and community pharmacists and pharmacy based needle exchange. Somerset PCT is responsible for addressing the health needs of people who live in the county of Somerset and part of the NHS partnership, through GP and community pharmacy contracted medical and pharmaceutical services.

Shared care is the basis on which much addiction treatment is provided in the UK. This model varies but usually comprises prescribing, usually by GPs, dispensing and when required supervision of consumption by community pharmacists and counselling and support by specialist drugs/key workers. Wrap around services may also be provided such as housing support, health screening, harm reduction and financial advice, from a variety of locally commissioned services. Variations on the exact models of service provision exist across the UK as models have developed at local level to meet local needs.

It is important when developing and planning services to consider the views and experiences of the people who use the services. The experiences and opinions of existing patients can help shape future services and inform decisions on future planning.

Somerset DAAT commissioned the University of Bath to evaluate service user's views of the shared care scheme in Somerset. The shared care service has been in place approximately 10 years, therefore it seemed timely to do so. This report presents the findings.

## **2.0 Background**

Shared care in Somerset is provided by key workers based within four TP offices, 52 GP practices and 87 pharmacies across the county. The purpose of shared care is to provide substitute opiate treatment and support for opiate dependent people who are considered to be more stable than those requiring care from within the specialist service. In an ideal world clients move to shared care after a period of stabilisation within the specialist service. Shared care is seen as normalising treatment by moving it into primary care and away from a specialist treatment centre. It also integrates the treatment of drug problems with other primary healthcare needs, allowing a most holistic approach to be taken. Shared care has developed around the UK over the past 20 years, with various models of service provision having arisen based on local needs and preference.

Shared care began in Somerset about 10 years ago. An early evaluation by Smith and Mistral of shared care in South Somerset was positive but had limited client input because the service was in its infancy<sup>1</sup>. Since this time the service has expanded and developed significantly. In 2008 TP took over the provision of specialist drugs service input from Somerset Drugs Service. Therefore it is timely to now consider service provision after the period of expansion and change.

The following aim and objectives were agreed with Somerset DAAT in the commissioning brief for this evaluation:

## **2.1 Aim**

To evaluate the views of service users on the shared care scheme provided in Somerset.

## **2.2 Objectives**

1. To describe service users understanding of the role of shared care and the various partners within it.
2. To describe the opinions of service users on aspects of the shared care scheme that are perceived to be of benefit to them
3. To describe examples of good and not so good practice, in the views of the service users, within shared care
4. To describe the opinions of service users on aspects of the shared care scheme that could be developed or changed in order to improve the service user experience
5. To consider, after consultation with other stakeholders, ways in which the service could be developed in order to respond to service user needs.

## **3.0 Evaluation methods**

First the number of clients receiving treatment through the Somerset shared care scheme at the start of this work was established. A figure of 239 was calculated, using data provided by the team leaders from the four TP offices. The proportion of clients and number of shared care workers under the umbrella of each office was as follows (February 2010):

- Bridgwater 53 client (22%) (8 shared care workers)
- Taunton 53 clients (22%) (8 shared care workers)
- Wells 65 clients (27%) (4 shared care workers)
- Yeovil 68 clients (29%) (7 shared care workers)

Team leaders and shared care workers in each TP office were consulted early on to inform the design of the study. This was considered important so as to maximise likelihood of staff engagement, gain staff support for the work and ensure the design of a study that was considered 'do-able'. Advice from the DAAT was also sought. As a consequence the following methods were developed:

### **3.1 Client Questionnaire**

A questionnaire was chosen because it could potentially allow every client in shared care in Somerset the opportunity to share their opinions, resulting in quantitative statistics about their views on the service. It also allows anonymous participation and can reach large numbers of people relatively cost effectively.

#### **3.1.1 Questionnaire design**

A self completion questionnaire was developed based on National Treatment Agency guidance on best practice in service provision and previous literature. The key areas of investigation were:

- Key worker care
- GP and GP practice staff care
- Community pharmacist and pharmacy staff care

Relevant best practice guidance in questionnaire design was followed including the provision of pens, the use of a freepost reply system and a colour printed front page<sup>2</sup>. Questionnaires were coded at drug worker + surgery level i.e. DW1 corresponded to a named drugs worker and their shared care surgery base.

Advice on drafts was sought from shared care workers in each of the four TP offices and the Somerset Shared Care Governance Group. Piloting was undertaken in South Gloucestershire by shared care workers from the Drugs and Homeless Initiative with 20 of their clients. The pilot was conducted outside Somerset to allow all potential Somerset participants to be included in the final study. The final version (v9) of the questionnaire is shown in appendix 1.

#### **3.1.2 Questionnaire distribution**

The research team (JS & HD) attended team meetings in all four TP offices. After consultation with the key workers and team leaders, it was agreed that the most appropriate method for questionnaire distribution and return was via the key worker. Written instructions for key workers to follow were developed. It was agreed that the questionnaire would be completed in appointment time and returned in a sealed envelope provided to the key worker. The key worker was asked to leave the room, if possible, while the questionnaire was being completed to encourage openness. Confidentiality was assured and the option to return a blank copy to opt out was made available. Key workers therefore did not see completed questionnaires.

Alternative methods of distribution such as by post and via GP receptionists were considered. The former was disregarded as it would have placed a large burden on TP administrative staff in order to protect client confidentiality, as no client names were shared with the research team. It was also felt likely to generate a poor response rate. The latter was disregarded because not all shared care clients were seen in the surgery during normal working hours so not all GP reception staff would be available. Also key workers thought that not all reception staff would be aware of the shared care status of clients.

Shared care workers were asked to return enveloped questionnaires using a freepost address to the University as and when they were completed. It was established that some clients are only seen quarterly, therefore three months was allowed for the first round distribution. In reality some individual key workers did post some questionnaires to clients whom they were unlikely to see in the near future, enclosing freepost envelopes.

### **3.1.3 Follow up of non responders**

A second wave of questionnaires was distributed to key workers three months after the first wave, with the same instructions supplied. These were printed on different coloured paper to distinguish them from the first wave. Because coding was at key worker level, each key worker received an email telling them their response rate to date and the plan for a second wave. They were asked not to give a copy of the second wave questionnaire to anyone who they remembered had already completed it or who said they had and to emphasise when giving it out that it was the same survey as distributed 3 months previously, intended for non responders.

### **3.1.4 Questionnaire data processing**

Quantitative data was analysed using Statistical Package for the Social Sciences (SPSS v14) by JS. Responses to open questions were subject to thematic analysis.

## **3.2 Client in depth interviews**

The purpose of the interviews were to explore the views expressed in the questionnaire in more depth to try to gain a deeper understanding of what lies behind the statistics. At the end of the questionnaire participants were given the opportunity to take part in an interview to discuss their views further. To volunteer participants had to complete a tear off slip on the last page providing their contact details to the University research team. They could however do this without completing the questionnaire. The research officer then telephoned the volunteer to arrange a mutually convenient time and location for the interview. Interviews were conducted either at TP offices or GP practices. A £10 High Street shopping voucher was provided as an acknowledgement and travel expenses were paid on production of tickets.

As the questionnaire took some months to administer, interviews were conducted in parallel, therefore convenience sampling was used. That is clients who expressed willingness were recruited as opposed to selecting from a pool of willing participants. Attempts were also made to ensure client representation from all four TP office locations.

Following the consent process, whereby the interviewer (HD or JS) explained the purpose and format of the interview, including confidentiality and obtained the client's agreement to participate, consent to tape record the interview was also taken.

### **3.2.1 Qualitative data analysis**

Tapes were transcribed fully and data analysis managed using the software package NVivo (v8) by JS. Data was then transcribed and subject to framework and thematic analysis using the qualitative software management tool NVivo v8. Analysis was

undertaken at three levels. Initial coding to identify salient points, axial coding to condense the first level data and then grouping to further refine the key themes, which are reported here.

### **3.3 Governance and ethics**

After reviewing the protocol, the National Research Ethics Service confirmed that NHS ethics approval was not required as this was considered a service evaluation (*personal communication J Scott and National Research Ethics Service Queries Line via email 29.10.09*). Ethical approval was granted via the University of Bath internal review system. Honorary contracts were granted by Somerset PCT (November 2009) and approval for the work obtained from the Turning Point Quality, Risk & Assurance Team (*personal communication J Scott and J. Carman via email 18.03.10*).

### **3.4 Timescale**

The evaluation began on 4<sup>th</sup> January 2010. Data collection started in March 2010 following governance approval. The 2<sup>nd</sup> reminder of the questionnaire was distributed in June 2010. In July 2010 key workers were contacted directly and informed of their response rate to date. They were asked to provide an update on how many questionnaires they had distributed and given the opportunity to request more questionnaires, two did. In September 2010 team leaders were asked to provide an estimate via their teams of the percentage of shared care clients from their office who had been given an opportunity to complete the questionnaire.

## **4.0 Findings**

The questionnaire and interview were both structured to explore views on GP practice care, key worker care and community pharmacy care as distinct topics. The results from the questionnaire will be discussed together with explanatory information identified from the interviews. This is followed by discussion of the findings relating to the objectives of the evaluation: Quotes from participants made on the questionnaires are identified by Q followed by their participant number. Quotes from the interviews are identified by P followed by their participant number.

### **4.1 Participant representation**

Information was provided by 70 individual TP clients, which represents 29% of the shared care client case load at the start of this work, or just under one third of clients. Of these, 59 returned a completed questionnaire, which represents 25% of the case load. Eleven more participated in an interview but did not complete a questionnaire. Nine participants completed both an interview and a questionnaire. The total number of interviews completed was 20. Open comments were also invited on the questionnaire. Thirty one respondents chose to make comments about their key worker or GP surgery (Q7) and 28 made comments about their pharmacy (Q8).

A further 21 (11 males and 10 females) expressed initial interest in being interviewed but either did not attend the scheduled interview (n=4), cancelled ahead of time (n= 2), changed their mind when called to arrange (n=8) or their response was received after data collection had ended (n=7). Two additional completed questionnaires were received after data analysis was completed and therefore could not be included.

Each TP office is represented in the data although the proportion of shared care clients was not evenly spread (table 1):

	<b>Completed a questionnaire</b> number (% of case load at this office)	<b>Interview</b> number (% of case load at this office)
<b>Bridgwater</b>	17 (32%)	3 (6%)
<b>Taunton</b>	18 (34%)	7 (13%)
<b>Wells</b>	9 (14%)	5 (8%)
<b>Yeovil</b>	15 (22%)	5 (7%)

Table 1: Participants in the questionnaire and interview, shown by TP office at which their key worker is based

#### 4.2 GP practice representation

At the start of this work there were 51 GP practices involved in shared care, which increased to 52 during this evaluation. Respondents to the questionnaire were from 27 different practices, representing 53% of shared care practices. Participants in the interview represented 14 (28%) of shared care practices.

#### 4.3 Key worker representation

At the start of his work there were 26 key workers working in shared care across the four TP offices. Respondents to the questionnaire had 22 different key workers meaning 85% of key workers were represented in the data. The minimum number of clients per key worker who responded was one and the largest number was 9. Four key workers had no clients respond, two from Yeovil, one from Bridgwater and one from Taunton. In total these four key workers had 20 clients. During the course of the study some key workers left their posts. Attempts were made to identify and include their replacements in the follow up wherever possible.

#### 4.4 Representativeness of data

It was considered important to try to establish whether the clients who did not respond chose not to do so or did not receive the opportunity to do so. When key workers were contacted in July 2010 (section 3.4), approximately 50% responded. About half of these indicated they had distributed all their questionnaires and the remainder saying they had not. In some cases the latter agreed to post questionnaires to the clients that they had not yet seen.

When team leader were contacted in September 2010, two team leaders responded. One indicated 100% distribution and the other suggesting 20%, although they had only received a response from a quarter of their key workers.

This makes it difficult to make any assumptions about non response and highlights the difficulties of using gatekeepers to access participants. There is a suggestion from the above that not all clients may have been given the opportunity to respond to the questionnaire but this could not be further verified.

What can be assumed is that the findings represent the views of just under one third of clients in shared care in Somerset, although many interviewees did talk about the experiences of others as well as themselves. It cannot be assumed that the remaining two thirds who have not contributed would concur with the views expressed by the participants. However in their absence this evaluation provides information that can be used to inform service development. An ongoing process of feedback would allow clients to comment on any future changes.

## 4.5 Participant demographics

### 4.5.1 Gender

Of those who returned a completed questionnaire, 41 (70%) were male and 17 (29%) were female, one person did not specify. Sixteen males and four females took part in the interviews.

### 4.5.2 Age

Fifty two participants in the questionnaire stated their age. The youngest person was 24 yrs, the oldest was 57 yrs and the average age was 40 yrs. The spread of ages can be seen in figure 1, indicating wide representation. Age was not asked in the interviews.

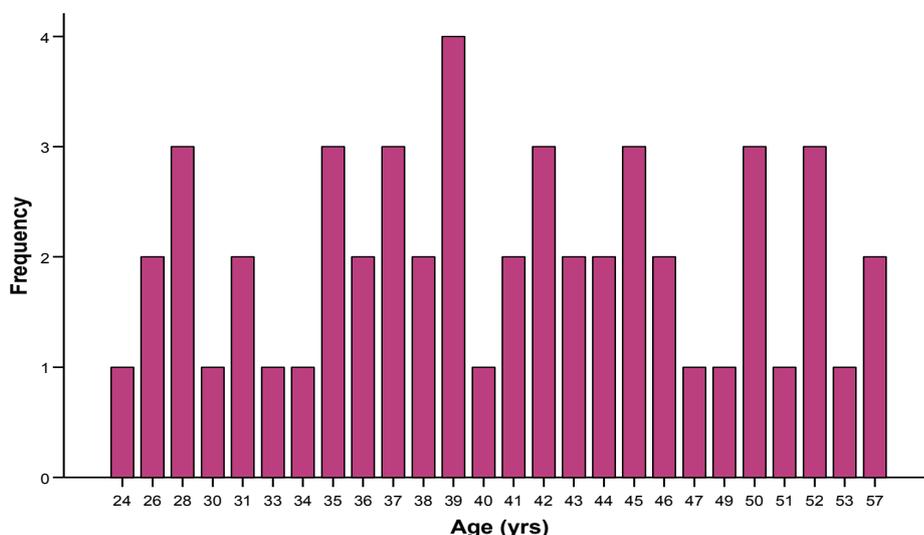


Figure 1: Age spread of participants in the questionnaire (n=52, 7 did not answer)

### 4.5.3 Length of time in shared care

The majority of questionnaire respondents had been receiving their treatment in shared care for some time; six (10%) had been in shared care less than one year; 24 (41%) had been in shared care between one and five years and 24 (41%) had been in shared care six or more years.

Of the interviewees, the average length of time in shared care was four years with this ranging from 2 months to 10 years. However it must be stated that some had difficulty in identifying when the transition was made, suggesting that the above data may be estimates or for some may represent the total length of time involved with local services for treatment.

### 4.6 Understanding of shared care

This was explored in the interviews. There were mixed findings. The minority of participants could explain shared care in detail and understood the purpose. One described it as *'three heads are better than one'* although they had obviously omitted one 'head' from this analogy. Shared care was perceived to be more convenient and a few mentioned that it was a way to free up spaces for new clients within the main TP offices.

However the majority of interviewees were unclear what shared care actually meant or why they received their care in this way, they had just accepted the transition when it was suggested. Some were not familiar with the term shared care at all. In general participants found it more convenient than when they had previously had to attend TP offices, citing travel to one of the four towns as difficult compared to attending a local GP practice. Some difficulties and confusion around repeat prescriptions were however expressed which had not been the case when they attended TP offices. More discussion of this topic is given in section 5.1.

### 4.7 Surgery, appointment and pharmacy convenience

In the main questionnaire respondents found their shared care GP practice and pharmacy convenient to get to, as shown in figure 2.

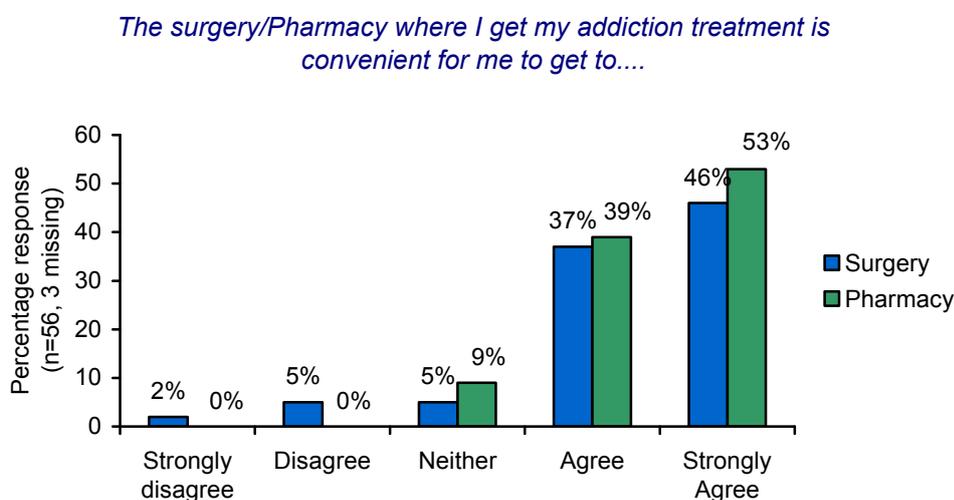


Figure 2: Convenience of surgery and pharmacy locations

In the interviews, some clients who were on daily pick up but had jobs described difficulties in juggling appointment times and pharmacy opening hours with work. However for most this had been accommodated for. Some clients who lived in rural locations did describe problems in the past, which appeared to have resolved as share care has expanded:

*'I did have walk to the chemist that was about 2 miles there and 2 miles back at the other address - that's why I said I had to get it 3 times a week' (P15)*

Figure 3 shows that most questionnaire respondents found their appointment times convenient:

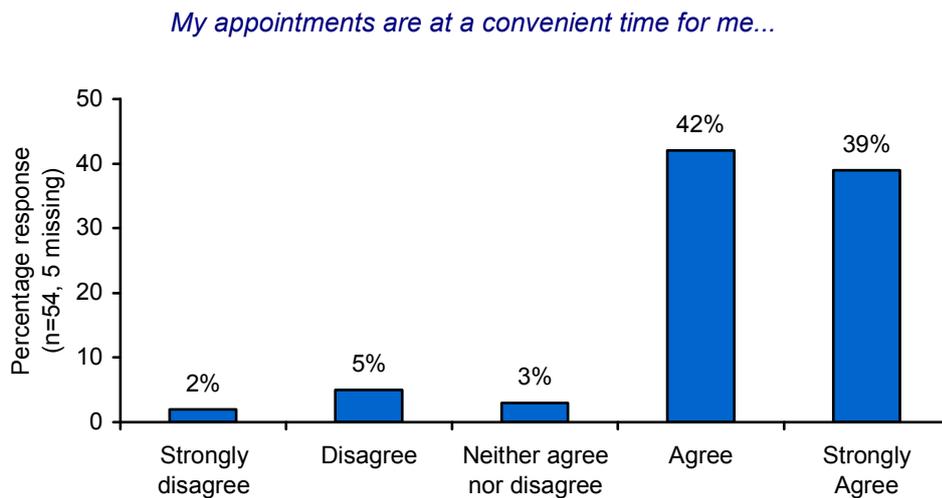


Figure 3: Convenience of appointment time at surgery

Most interviewees described being given appointments at convenient times or being able to easily change appointment times if they were not convenient. However a few interviewees reported difficulties making GP appointments and problems with continuity. They reported seeing a different GP each time for their shared care appointment or that the GP who provided shared care was not the GP who looks after their general healthcare needs, which negates some of the benefits of shared care. Some clients did not consider this a problem but others were unhappy:

*'The way it is now organised it is very hard to get an appointment with my GP and hard to see the same doctor' P21*

## 4.8 Frequency and duration of appointments with key workers and GPs

### 4.8.1 Key workers

51% (n=30) of respondents to the questionnaire met with their key worker every 2 to 4 weeks. One person met more frequently than this. Ten (17%) met 'about every two months' and 12 (20%) met 'about every three months or less'. Six people did not answer this question.

Most appointments with key workers (53%, n=31) were between 10 and 30 minutes; most felt this was 'about right' but seven felt this was 'too short'. A further 32% (n=19) of key worker appointments were between 30 minutes and one hour, all but one felt this was 'about right'. Only one person said their appointments were usually more than an hour and

three people said they were less than 10 minutes, all of whom felt this was 'about right'. No one felt their appointments were 'too long'.

From the interviews there were mixed views about the frequency and duration of meetings. Some participants felt they did not see enough of their key worker often reporting infrequent meetings or meetings every couple of months. This was often linked with frequent change of key worker (discussed later) and key worker sickness, but for others it was put down to a poor relationship with the key worker:

*'I used to come once a month but now she has changed it to twice uh once every two months, I think because she is just really fed up with seeing me really and I don't know if that is true or not and I just don't know what is going on with her at all I just can't get on with her at all' P7*

Again reported duration of appointments varied. Most interviewees felt that they had enough time with their key worker. Most who described short appointments felt when needed they could have more time with their key worker:

*'Umm yeah normally I'm in a rush anyway so it's normally me that ends it and then I'm rushing out but I've if I've needed to talk to him I've just sat there and chatted away it's not that he's ever looked at his watch and said oh I'm going to have to go, but I don't' think I've ever stayed that long that he's had to say that anyway, normally I'm only there 5 minutes and I'm out. But he never makes you feel as you've got rush or speed up or get out or anything.' P14*

#### **4.8.2 GPs**

31% (n=18) of respondents to the questionnaire met with their shared care GP every 2 to 4 weeks, 22% (n=13) met 'about every 2 months' and 27% (n=16) met 'about every 3 months or less'. Twelve people did not answer this question. There were several interviewees who reported never seeing their GP, which may explain why some missed this question out. This is illustrated by this quote from a participant who has recently detoxed after four years in shared care:

*'I never, never saw my own GP or the person that was signing my scripts, for the whole of the time that I was on shared care'. P41*

And another who saw a different GP for shared care as for their other healthcare needs:

*'Well to be quite honest with you...my GP here doesn't know anything about me, only what he has got on the computer because he hasn't met me and talked to me one to one, he doesn't know anything about my background, history anything like that sort of, nothing' P7*

One client reported that they saw the practice nurse instead of their GP for shared care, which they were happy with. Lack of GP contact was commonly reported but less frequently seen as a problem as long as there was continuity in issuing of prescriptions. For some there was general confusion about when they should be seen but again as long as there were no problems with care this was not expressed negatively:

*'I think it's supposed to be once a month but I haven't seen her [GP] for about 2 months not because I've missed an appointment she hasn't made an appointment.... I don't know if it's.. I know my key worker has spoke to her so I don't know if he's already okayed everything or everything is all sorted out anyway so they don't need to see me... but I do know that every three months or six months all three of us have a sit down and I know that's coming up soon'. P14*

Some expressed difficulties in accessing their own GP for other primary healthcare needs:

*'I have made a few appointments to see him, a doctor, a few times but I have got a different doctor, they have booked me into a different doctor -I don't know why....' P7*

This led to concerns that other GPs would see them as trying to 'scam' drugs or fears about disclosing themselves as a drug user:

*'It is not good anyway but you have to get past that and with a locum you can't get past that because they think that the only reason that you took an appointment with them is so you can go in there and blag them for some [drugs]. No I don't want to blag anyone for anything, what I want is help with my condition without having to take anything....the only pain killers I ever ask doctors for is ... I have asked him for a prescription for paracetamol, which I ain't supposed to take too many of...'* P41

....although these concerns were not always founded:

*' I went to see a doctor about my depression and stuff and...I didn't want to come down and sound as if I was down here seeking drugs because you know that I am a drug user .... because you do get people that do it and I didn't want them thinking that I... and she said 'You silly girl you should have just come down....I don't think that of you' she said 'You know you can tell the people that do and the people that don't'... P25*

46% (n=27) of questionnaire respondents said their GP appointment was usually between 10 and 30 minutes and all felt this was 'about right'. 36% (n=21) said their GP appointment was less than 10 minutes, one third of whom felt this was 'too short'. Eleven people did not answer this question, who also did not state the frequency of meeting, again supporting the suggestion that they never or rarely see their GP.

The interviewees generally identified that GPs are busy people and had an expectation that appointments therefore needed to be kept short. However for most they felt that when needed they could spend longer with their GP:

*'I think the times that I have been to see her it's cause it's only been to sort out prescriptions and stuff it has been only fast but...I know they do have..doctors have time constraints...they have like 15 minute windows but if I ever needed to sit down with her longer as well she's always been always willing to talk. I don't think I've ever been told to like hurry up and get out. Not yet anyway'. P14*

#### **4.9 Key workers and GPs knowledge of addiction and understanding**

Most questionnaire respondents were happy or very happy with their key worker and GPs level of knowledge of addiction and understanding of their problems (figures 4 and 5):

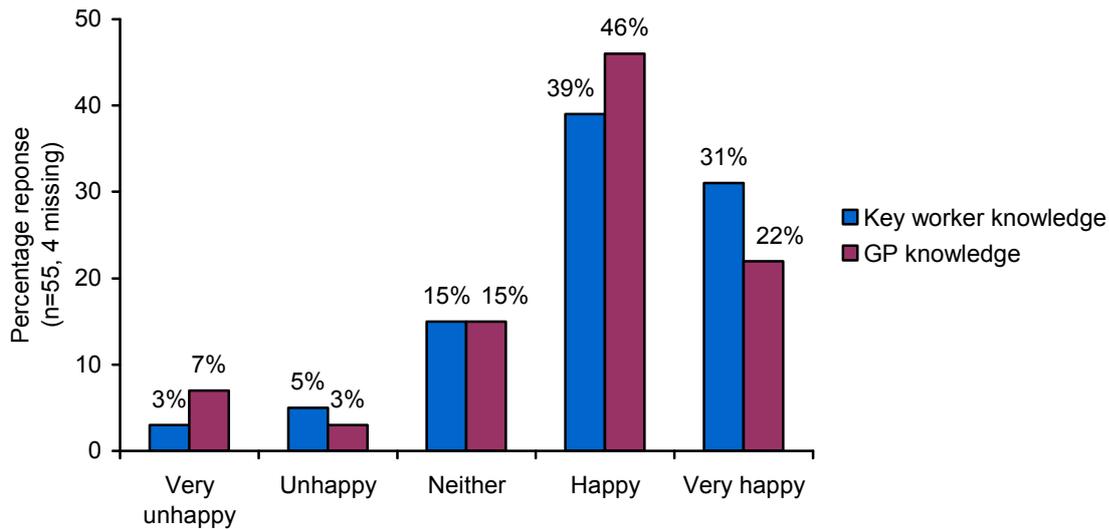


Figure 4: How happy are you with your key worker/GP's knowledge of addiction?

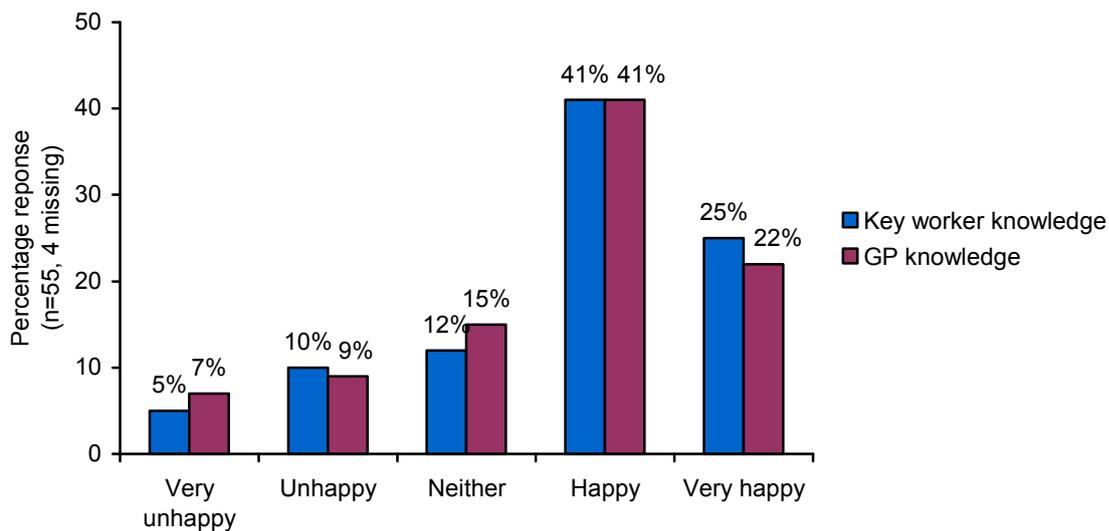


Figure 5: How happy are you with your key worker/GP's understanding of your problems?

Knowledge of addiction was not a key issue raised by interviewees. When mentioned the main topic discussed was a mixed opinion on whether to truly understand addiction a key worker or GP needs to have experienced it themselves. Some interviewees thought this was important:

*'See - my argument is that a lot of these people that are counsellors and key workers....they've never been drug addicts in their bloody life...So how do they know what to tell me, how to do everything you know, when I've been taking drugs nearly all my life!'* P23

*'The service I receive is good. But how can a doctor or drug worker know how an addiction makes you feel? Without experiencing it, all knowledge is book based. And in most cases completely wrong and of no help. e.g. Pain killers etc don't work properly.'* Q59

Whereas others felt empathy and understanding could be achieved through experience of working with drug users. Again though most felt this could not be achieved through only text books.

*'It doesn't mean they have to have used drugs themselves as long as they've got empathy... they're open and warm... anyone they can work with anyone really' P20*

*'She has not been through it but she really does understand....I hate text books that think they can tell you what your problem is...they [authors] have never been through it' P12*

#### 4.10 Respect

Very high levels of being treated with respect were shown in the questionnaire (figure 6 and 7):

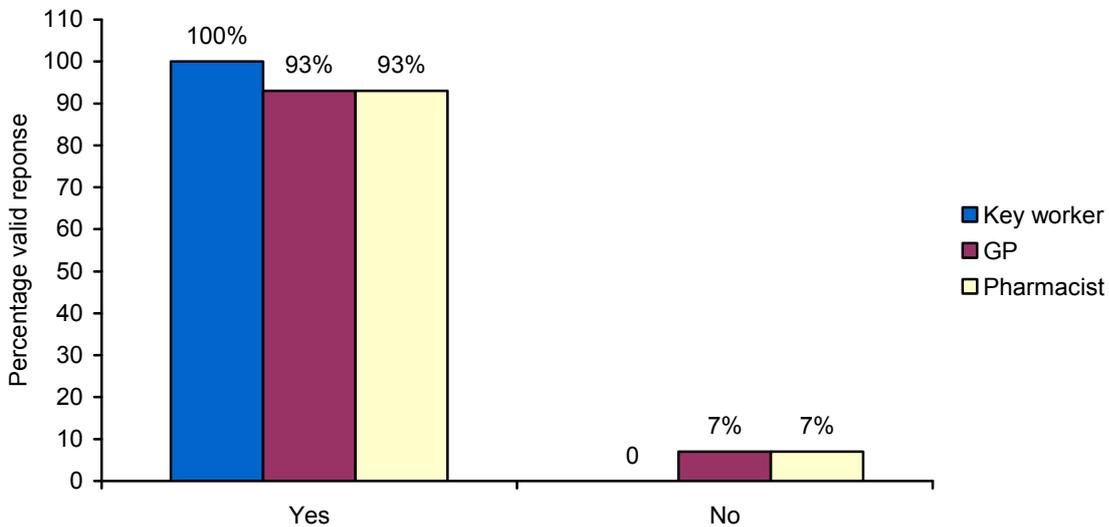


Figure 6: Do you feel treated with respect by your key worker/GP/Pharmacist? (6 people did not answer the question re GP/KW)

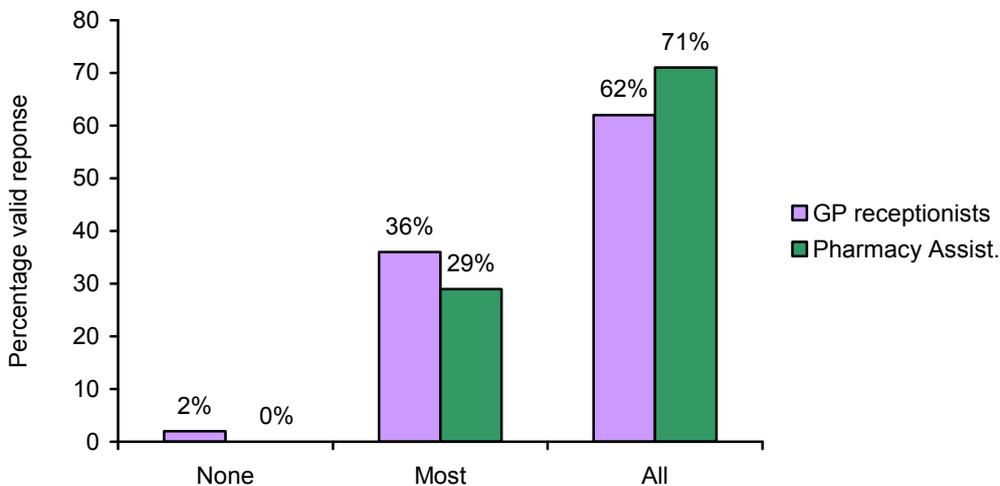


Figure 7: Do your GP surgery reception staff/Pharmacy assistants treat you with respect? (6 people did not answer this question re GP receptionists)

Respect and attitude of shared care staff was a very common issue raised in both the interviews and the open comments on the questionnaire. In the main participants felt treated with respect and emphasised how important this was to their retention in treatment and recovery. This echoed the questionnaire findings. Many recognised that respect is a give and take process:

*'If you respect them, they respect you. I've never had any problem with drug workers, GPs or reception staff' Q9*

*'The pharmacy I attend are exceptionally fantastic, they are always polite and considerate and I never feel judged in anyway and they always complement me for doing so well...'Q18*

There were a few isolated problems perceived to be related to respect from key workers:

*'All my drug worker seems interested in is when did I last shop lift. I have never shop lifted in my bloody life!' Q23.*

However in the main, even for interviewees who were unhappy with aspects of the service they received in shared care, they considered that their key workers treat them with respect:

*'The individuals are nice people but it is just a strange system' P21*

Similarly there were few concerns about GP attitudes although many interviewees noted a change in recent years and many described bad experiences in the past:

*'I can tell he is very good at his job, he is very understanding....Dr X his name is. I have had some doctors before and they are not very... they are quite rude....' P16*

Being treated kindly and with humility appears to be one of the most important factors for interviewees and was discussed much more frequently than competence, knowledge or clinical skills. This was summed up by participant 10 although similar comments were made by many interviewees:

*'It's just him, he just treats you like a human being' P10*

This is not to be confused with being 'soft'. Several clients discussed the importance of boundaries and both key workers and GPs being firm but fair:

*' He [GP] doesn't mess around he gets straight to the point. .. if I tell him something... you know if I say I've relapsed again or whatever he'll say 'Well that stupid wasn't it' or whatever. He's quite, he's more like instead of being a doctor because he's my whole family doctor as well he knows....he is more like a friend as well sort of thing so ... and every time I leave like he will shake my hand and give me a pat on the back and say well done or the opposite' P16*

*'She [key worker] can play hard ball -she ain't soft but you know where you stand with her....she wants you to do well, not mess around' P12*

There were a small number of cases of pharmacy assistants and GP reception staff being disrespectful.

*'... they look at you a bit funny... and there is one woman in there.... she's really snotty, but the actual pharmacist X that's there all the time is nice and friendly and a couple of the others. ....Yeah we can avoid her, we usually wait until somebody asks.... I'll hang back until somebody else comes out....it's just her attitude it's the way she talks to you, you know' P25*

*'Service is OK - pharmacists are generally fine but the assistants can be very disrespectful or ignore you' Q53*

*'I find my relationship with my doctor and drug worker is absolutely fantastic, but more respect from the surgery reception staff would be a lot better as they can be quite rude and unsensitive, apart from that everything is fantastic' Q18*

In one case an interviewee described all their GP reception staff as *'Dragons at the gate' P21.*

Where questionnaire respondents were dissatisfied with the service received from their pharmacy they described the pharmacy as 'usually having lots of locums'. However, in the majority of pharmacies where there were 'usually lots of locums' reported, participants were either 'satisfied' or 'very satisfied' with the service they received. Therefore, contrary to what was expected, there was no strong link with dissatisfaction with Pharmacy services and the use of locum pharmacists. This may be because interviewees reported that in many pharmacies that have locums they work regularly and therefore clients become known to them and they can build up a rapport. It may perhaps be with less regular locums such as agency locums where problems occur.

#### 4.11 Service and treatment satisfaction

As can be seen from figure 8, 86% of questionnaire respondents were either satisfied or very satisfied with the service they receive from their key worker and GP surgery. This rose to 94% for pharmacy services.

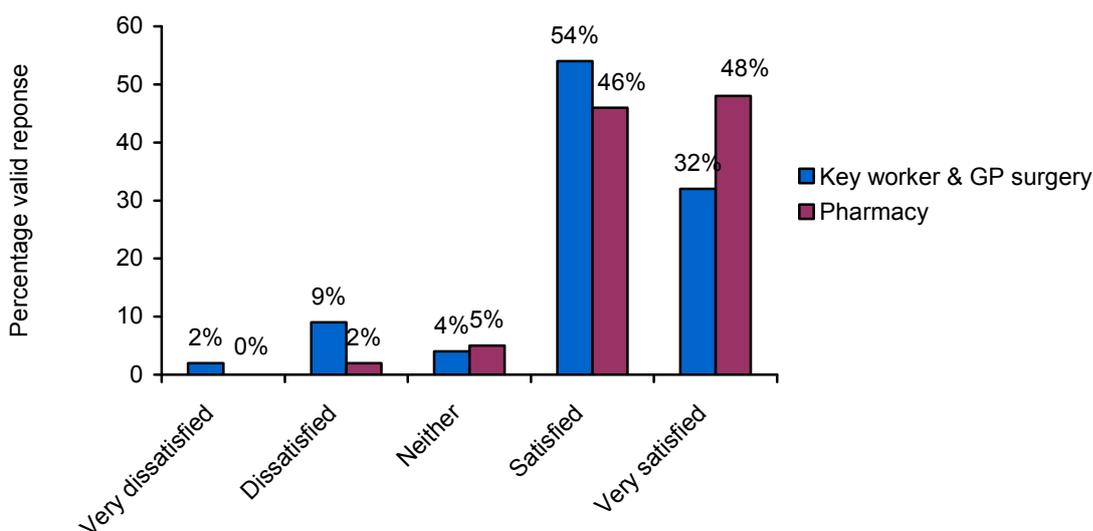


Figure 8: How satisfied are you with the service you receive from your shared care worker, GP and surgery staff / your pharmacy? (3 missing re KW & GP)

Overall satisfaction with the treatment received in shared care is shown in figure 9, where it can be seen that 85% of questionnaire respondents were either satisfied or very satisfied with their shared care treatment.

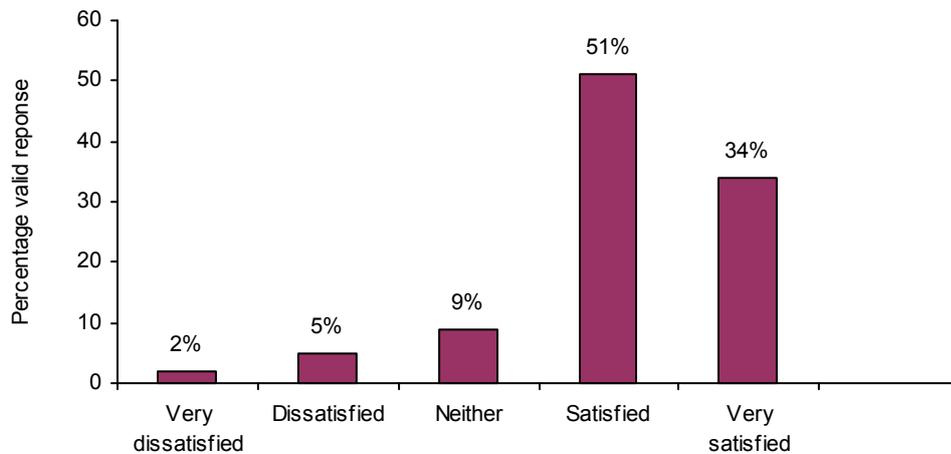


Figure 9: Overall how satisfied are you with your shared care treatment? (no missing)

Many interviewees reflected on past treatment experiences both within Somerset and in areas outside of Somerset. In the majority of cases clients felt that the treatment they were receiving now was better than their past experience. Past punitive prescribing rules such as 'three dirty urines and you lose your prescription' were considered unhelpful and clients valued being allowed to take treatment at their own pace in Somerset. Clients also highly valued being able to be honest about any on top drug use, which they felt was responded to rather than punished. Examples of good practice such as continuity of care on discharge from prison were given as key in preventing relapse.

There were a minority of interviewees who were unhappy with the current service and reflected on previous treatment provided by Somerset Drugs Service as being better than what was currently received. These clients had all experienced lack of continuity in key worker and all felt their prescription was constantly under threat, stating that the key workers had a hold over them which they felt scared of. These issues are further discussed in section 5.0.

## **5.0 Learning points for improvement and development –consideration of the objectives of this evaluation**

One of the important factors of conducting an evaluation is to identify areas for continued improvement and development. Therefore the next section reflects on the objectives of this evaluation, focusing on specific areas that were identified as problematic and offers suggestions on how they could be improved. This information is taken from the interviews and open comments received on the questionnaire, except for the statistics on supervised consumption which were taken from the questionnaire.

## 5.1 Service users understanding of the role of shared care and the various partners within it (objective 1).

As said in 4.6, some participants could describe the aims of shared care clearly but it was more common for people to just accept it as a method of service delivery without being able to describe why they were receiving their care in this way. In many cases this did not seem to matter to the service user, as long as the system 'worked' in terms of continuity of prescribing and accessibility of support. However for others the switch to shared care had meant seeing a new GP or a change in key worker which they had not expected. In some cases participants felt this gave them a lesser service than they had received in the main drugs service because they were seen less frequently or by different key workers.

There also seemed to be confusion amongst some about their responsibilities within shared care. Whereas some clients took responsibility for arranging their own prescriptions and making appointments if they needed to, others said this was the responsibility of the GP practice and the key worker. From the descriptions given it appears that the practice varies between GP surgeries and key workers, which may explain some of the confusion from the service user perspective. For example:

*'I had made a couple of appointments and not turned up to them. There'd been no communication about that, about why I hadn't even turned up to an appointment or anything which I think was strange because if they had phoned me up to see if I was coming like you did today they would have found out that I was ill'. P41*

The general lack of understanding of the role of shared care suggests that **there may be scope for improving the information that is given to clients when the switch to shared care is being offered**, including an awareness of the role of shared care, whether making this switch will mean a change in GP and/or key worker and the responsibilities of the client with regard to repeat prescriptions and appointments

## 5.2 Opinions of service users on aspects of the shared care scheme that are perceived to be of benefit to them (objective 2)

**Convenience** was the benefit most commonly identified and emphasised. This was particularly true for those living in close proximity to the GP practice compared to a TP office and for those where a 'repeat prescription service' meant the delivery of their regular prescriptions to their pharmacy on a fortnightly basis. Those who experienced regular problems with continuity of prescriptions (see below) found shared care difficult and unsettling.

Another perceived benefit of shared care that was commonly identified was the **normalisation of drug treatment**. People talked of being able to go to the GP practice or pharmacy like 'normal' patients and felt this conferred a great deal of privacy for them compared to attending a drugs service.

*Interviewer: Is it better meeting at the GPs then?*

*Participant: 'Yeah I find it is, it's a little more private because you go to the doctors surgery people you know you are like any other patient, people don't know why you are there ....but you come here for an appointment [interview was at a TP office] and you have got a big Turning Point sign...Once I went outside to have a fag with X we were*

*outside having a fag..... and someone drove past in a van and was like 'smackhead' .... so you know [pause] it wasn't nice'. P25.*

Commonly participants **valued the benefit of being treated by their own GP**, being able to clearly identify added benefits to their care that this brought where the GP concerned was their family doctor. People felt that knowledge of their medical and personal history improved the care they received and helped ensure individualised treatment:

*'All sorts of questions could be needed, to ask about me, whereas my doctor already knows me I think. I think the fact that my doctor's involved in my on-going medication, life, sort of thing because he already knows me I think it's yeah it's good that he is involved. P16*

**Good communications** and **teamwork** were perceived to also be a benefit, in terms of ensuring treatment was individualised and making sure prescriptions were available on time, both of which were seen as very important aspects of treatment.

*'...three heads are better than one aren't they... do you know what I mean? I mean you get everybody's views then on your care ..... my doctor might not want me to go down to reduce as fast and then Turning Point might have a different view, so ..... I suppose it's better for everybody to be able to work it out cause they know what's best for me at the moment, I don't know really know what's good for me I suppose'. P14.*

*'It [communication] is good because they need to know what is going on. Because a few times....a lack of communication between the Pharmacy and the Doctors Surgery .... I've had to wait around for several hours before I could actually pick up my prescription' P7.*

*'Now the chemists know what is happening with the doctors and the doctors know what is happening with the Drug Workers and the Drug Workers know what is happening with the Chemists and stuff like that' [said in context of discussing past problems with unavailable prescriptions]. P10.*

### **5.3 Examples of good and not so good practice, in the views of the service users within shared care (objective 3)**

#### **5.3.1 Confidentiality**

There were no problems or concerns identified around confidentiality with respect to key workers, GPs or pharmacists. Participants felt assured that their personal information was kept confidential within the shared care team. There was however some individuals concerned about whether pharmacy counter assistants and GP reception staff would keep their information confidential, even when no actual breach had been experienced. For example:

*'My neighbour from where I live actually works in the reception and the rest of her neighbours don't know anything about my treatment and I want to keep it that way...Because if they did know I'd more than likely be evicted from where I lived ... and they wouldn't be very nice'. P7.*

This highlights the need for shared care clients to be assured that confidentiality extends to all members of the team involved in their care.

There was one report of a breach in confidentiality by pharmacy counter staff that raises the need to ensure that all staff be reminded of the importance of maintaining confidentiality at all times, both within and outside of the workplace. This participant is describing a conversation that was overheard between two pharmacy assistants outside of the workplace.

*'I have heard them talking in the town about people you know....Somebody...not necessarily a friend of mine, it's a guy who has got problems you know what I mean he is really filthy but he's a junky he has got a mental illness...you know but yeah the way they [pharmacy counter staff] were talking about him you know, you can't talk about people, they could have talked about him just talking about his general condition but to bring in the fact that 'Oh it is because he is on this and that' [medication] you know that's not right, that's not right at all you know they can discuss him being a scruffy bastard but they can't discuss what he goes into that chemist for. P41.*

### 5.3.2 Privacy, dignity and discretion

These were identified as key components of good shared care and related mainly to how participants were treated in GP reception areas and community pharmacies. These were identified as public spaces where participants felt they could be identified as a drug user by others. There were mixed experiences and examples of good and bad practice given. For example, several participants talked about the importance of being recognised and welcomed by GP reception and counter staff, the latter would then hand over prescriptions or alert the pharmacist to their presence without the need for an open discussion.

#### 5.3.2.1 Supervised consumption

Not surprisingly, supervised consumption of medication within the pharmacy raised the most discussion about privacy and discretion amongst the interviewees. Figure 10 shows the frequency of medication collection reported by those who completed the questionnaire.

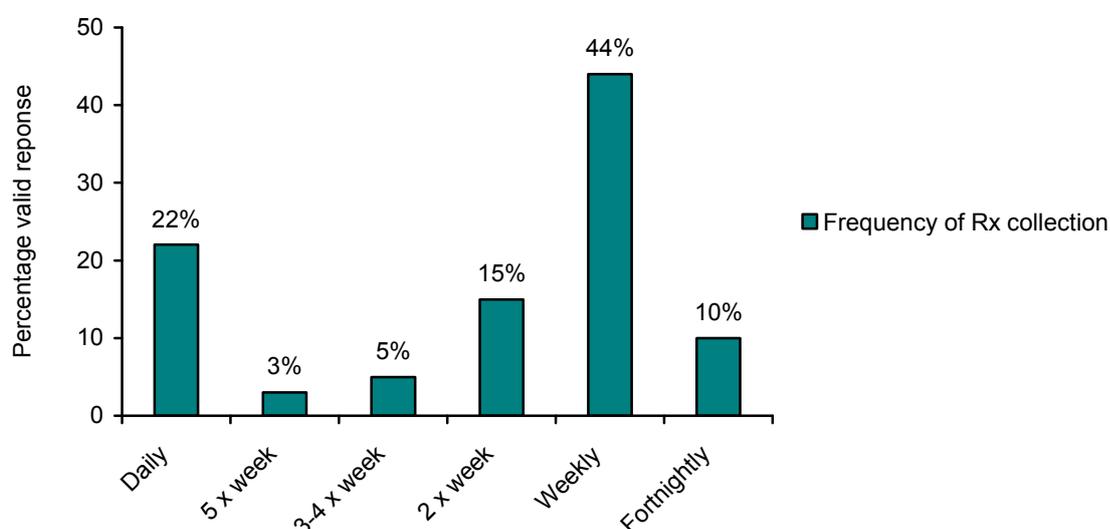


Figure 10: How often do you collect your medication from your pharmacy?

Eleven questionnaire respondents (19%) were on supervised consumption; ten of whom did this daily and one of whom did this five times a week. No one missed out these questions. There was no correlation between length of time in shared care and frequency of collection or supervised consumption. In fact half of the people currently on supervised consumption had been in shared care for six years or longer. Numbers are too small to draw any firm conclusions but there was some variability in percentage of clients on supervised consumption and TP base of the key worker. However, most drugs worker/surgery partnerships that had clients on supervised consumption also had clients on take home dosing, suggesting that the decision is based on individual clinical need rather than the policy of any individual practitioner/practice.

It must also be remembered that supervised consumption is sometimes temporarily reinstated to encourage engagement with services or at times of instability or concern about client welfare. Therefore it cannot be assumed that clients who reported currently being on supervised consumption have been so continuously.

Seventeen people answered the questionnaire question about privacy and supervised consumption. Analysis showed that seven who responded were not currently on supervised consumption, but it is assumed they had been in the past. This question was only intended for those currently on supervision. Nevertheless, of the answers received 82% (n=14) were either satisfied or very satisfied with the amount of privacy they got when taking their medication; 18% (n=3) were dissatisfied, none of whom were currently on supervised consumption.

In the interviews, no one spoke positively about their experience of supervised consumption regardless of the extent of privacy offered, although some spoke favourably of daily pick up, feeling it was a 'safer' option than taking away large quantities at a time. Some were ambivalent about supervised consumption or did not worry about being identified; however for others this had caused concern.

Supervised consumption was seen as part of the 'system' with no one blaming individual GPs, key workers or pharmacists for imposing this although it was generally disliked.

*P20: 'I mean it used to bother me at first because obviously something out of the norm in society is viewed differently you know and someone going round the corner rings about curiosity....I want to be treated like an ordinary person and I think even the people who are on supervised shouldn't have to do that but it has to be done some way and that's how it's done'.*

*P25: 'I used to hate doing that, but it has to be done I suppose, you know it's [pause] it's a small pharmacy so it is not like where you can do it privately'*

Supervised consumption was seen as something that has to be done prior to trust being gained. 'Trust' was defined as demonstration that the individual was going to take their medication and not pass it to others. This was seen as necessary before take home dosing could be provided and considered fair by most. The provision of clean urine screens was recognised as the route to this.

*P23: 'When I used to go into get mine [take away]...because they trusted me, because first of all they don't trust you see'*

### 5.3.2.2 Use of pharmacy consulting rooms

There were mixed views on the use of pharmacy consulting rooms for supervised consumption. Some felt the act of stepping into the room identified you as a drug user and therefore conferred little extra protection. Others welcomed the opportunity.

*Interviewer: 'Was there somewhere you could go and take it?'*

*P15: 'Well there was but it was a matter of getting it down your neck and going really'*

Those who described attending small pharmacies and pharmacies in village locations had particular problems with privacy, either due to a lack of private area to consume methadone or a fear of someone identifying them as being on drug treatment.

*P7: 'It was alright if there was nobody from my village there....but if there was people from the village there, which there was a couple of times, I'd just go away and I would come back you know a few minutes [later] and wait till they had gone or something, sometimes it would be awkward yes'.*

*Interviewer: 'So they didn't offer you anywhere to take it at all?'*

*P7: 'No I asked them a few times if I could go around the back because they have got a door around the back you see, I asked them a few times if I could go around there and take it, but they said we can't open that door, in case someone came in and tried to steal the medicines'*

The ability to choose which pharmacy to attend had clearly been exercised by many interviewees. Often people described past bad experiences of lack of privacy or dignity which they had overcome by switching to another pharmacy. Some described choosing to travel further rather than attend a pharmacy that they felt treated them with discrimination.

### 5.3.2.3 Discrimination within pharmacies

One particular issue that was described by several interviewees was of pharmacies that operates a 'one at a time' policy. Several interviewees described being told to wait outside until another drug treatment client had been attended to. They felt this instantly identified the reason why they and the other person were attending the pharmacy and breached their confidentiality. In addition this was felt to be undignified. One person (P10) had challenged this but others reported not doing so for fear of losing their prescription:

*P10: 'But it is just like the privacy aspect of it you know.....the pharmacist said...'Get out' and was told to say it in front of everybody and it was the way she said it but it was kind of the end of the day and she had to keep saying it and saying it and she said 'We have already told you, you have to wait outside' but I actually said to her I didn't appreciate the way you spoke to me, and the privacy of things here I thought were confidential you know and your medication and things to do with your doctors and that are confidential'.*

*P24: 'Like I say we went in and..... we didn't know this thing [rule] had been passed where there is only one user allowed in the chemist at one time and we both walked in and some lad that was in there on a script said 'Oh you've got to go outside' cause I don't like the lad anyway I thought 'Who are you telling to go outside what's it got to do with you?'....and then when she [pharmacist] came out she was like 'You've been*

*told to go outside'. [I was like] 'I don't know what you're talking about it's the first I've heard of it'. [Then they] give you a letter and explain and all that but if it had just been politely said to you the reason is because of this and that but she ended up like talking about it all in front all the customers in there about effects and abuse behaviour and all that and everyone is looking at you as like as if to say 'Oh yeah junkie thief'..*

*P25: 'You go to the chemist and there's queues of people waiting outside and if there's 4 or 5 people before you you're stood there for an hour an hour odd....I was proper uncomfortable'.*

### **5.3.3 Non punitive practice**

Many interviewees described past experiences of punitive practice, both within Somerset and elsewhere. Reference was made to 'three strikes and you are off' prescribing policies where the provision of 'dirty' urine screens resulted in removal from treatment programmes. Interviewees universally considered this unhelpful and described a culture of now being able to be more honest. Many talked of the process of changing dependent behaviour as taking time and universally the prescription of substitute medication was seen as a 'lifeline'.

*P25: 'I lived in XXX and you have got XXX Drug Project and they do a thing like you go in, you get on a prescription and that is it you have got to stop straightaway. They test you all the time, you put 3 dirty tests in and you are kicked off your script. Now if they had done that here, oh God I don't know what I would do if they did that here because it's... you cant just stop like that you know you... need to get stability first and then you know you have got to work towards it'.*

Many interviewees talked of having some control or contribution to decisions about their prescription. For example being able to negotiate dose increases when needed and dose reductions when able. This was universally valued and seen as good practice.

*P26: 'Yeah he always asks yeah he always asks he doesn't just do it without saying. In XXXX that's what he was doing like.... 'Right you're dropping 5ml this week', you know that really bugged me yeah he [previous GP] didn't want to talk about it but he [new GP] asks me first like each time like'.*

### **5.3.4 Relationship with Key worker**

The client relationship with the key worker was clearly central to the treatment experience of many interviewees. It is well established in the literature that the quality of the therapeutic relationship between practitioner/prescriber and client can influence engagement in treatment and outcomes.

The majority of interviewees spoke of good relationships with their key worker. However, there were some for whom the relationship was considered poor, which caused them distress. In some cases two different interviewees with the same key worker described very different relationships. This highlights the importance of matching personalities in therapeutic relationships.

*P7: 'The staff at Turning Point are pretty good. My key worker at the moment XXX we don't seem to get on..... I don't know why we clashed but we have clashed for some reason and I just don't know why, we just.. I don't know... we just don't get on at all'*

Some interviewees described people they knew dropping out of treatment because of the poor relationship they had with their key worker or other shared care staff and the negative feelings of self worth this created. However for these interviewees the need for a prescription meant they accepted poor therapeutic relationships in order to retain their prescribed medication.

Some interviewees felt victimised by their key workers. Whether this is the case or not is beyond the scope of this study but there were a minority of interviewees who reported such feelings:

*P21: 'I am made to beg - I live under a constant fear of my prescription being taken away from me.....'*

*P41: 'Suddenly when she started taking over she saw my name and things started going wrong with my scripts'*

### **5.3.5 Feeling valued and understood**

Linked to what has been discussed above, the importance of feeling valued and understood was identified by many. Although the provision of a prescription was the central aspect of shared care for many, the difference in how pleasant the treatment experience was perceived to be often related to how valued and understood the client felt to be. This in turn related to how willing the client was to engage in appointments and accept advice.

*P41: 'You asked me a question about what I think has changed with this doctor. It is continuity of treatment and she is more hands on with my case and I think that ....is really important with people who are coming off drugs because they are up and down like yoyos and you know, your personality completely changes when you are coming off drugs from when you are on it you know and you are coping mechanisms change and some people haven't even got coping mechanisms have they, it has always been drugs'*

### **5.3.6 The personal touch/ going the 'extra mile'**

Several interviewees identified good practice as when care providers did something that they felt was 'extra' or 'personal'. Examples included pharmacists sorting out prescription problems on behalf of the client, doctors allowing extra time in appointments for the client to talk and key workers making contact during times of difficulty, accompanying clients to court, sorting out problems with housing, benefits, etc.

Further examples are illustrated by these quotes:

*P14: 'Normally he [key worker] rings me back anyway like if I try and get in contact with him or if I've got an appointment he'll text me in the morning and say don't forget you've got an appointment at 12 cause he knows what my memory is like. So that's you know what I mean not many people would do that, wouldn't text you and*

*remind you that you've got an appointment.....I've never had key workers that text you and remind you and stuff but yeah he's a good bloke'*

*P12: 'She [key worker] seems to care....I have her mobile number for emergencies. You feel that personal thing, cause she's given you her mobile and that'*

*P41: 'She [GP] takes the time, she treats you like a human being'*

### **5.3.7 Frequency of contact with GP and key worker**

There was mixed views on frequency of contact with GPs. Many saw their GPs every 90 days or sooner. However in some cases contact was minimal or non existent. For some this was not a problem as they felt if they needed to see their GP they could arrange this. However for others it was seen as a problem.

*P41: 'I never, never saw my own GP or the person that was signing my scripts, for the whole of the time that I was on shared care'.*

Also for some, the doctor they saw for shared care was not their family doctor and therefore if they needed to see the GP because of illness they would be seen by a different doctor. Some found this difficult as they wanted to be cared for by someone who knew them and their history, without fear of being judged or having to explain their situation again.

*P8: 'Four years later after trying and failing to even see the same doctor twice in a row'.*

Some participants felt they did not see their key worker frequently enough.

*P16: 'Apart from that he is alright but he is never here when I need him to be, I will turn up to an appointment and he is off sick all the time and he has to travel to get here so he's not here every time'*

Some felt able to arrange appointments if needed but others had a clear expectation that the key worker should lead on arranging appointments. Some suggested evening appointments for those in work and home visits for those with young children.

## **5.4 Aspects of the shared care scheme that could be developed or changed in order to improve the service user experience (objective 4)**

### **5.4.1 Feeling disempowered in the system**

This was not the feeling of the majority who took part in this study. However for a few, feeling disempowered caused them great concern and stress over their treatment. In particular participants feared things being 'done to them' or things going wrong that they could not control.

There was particular stress around prescriptions not being available when needed. This was in some cases linked to apparent confusion over where responsibilities lie. Some thought their prescription was managed like other repeat prescriptions at their surgery,

stating that they had requested for it to be sent to their pharmacy. Others reported being responsible for ordering a repeat prescription on a fortnightly basis. In other cases clients reported that key workers organised their prescriptions and dropped them off at the pharmacy for them. In all cases participants had experienced problems of prescriptions not being available in the pharmacy when needed. From the stories of errors that were told, there was some suggestion that some clients may be confused about who is meant to do what with respect to organising their prescription. This was particularly true of reports where partners or friends received their prescriptions from other surgeries under a different system. It is appreciated that each GP practice may wish to organise their repeat shared care prescriptions in their own way. Therefore it is suggested that clarification of the procedures in place at each surgery are given to clients in order to correct any misconceptions.

*Q30: '[Surgery reception staff] sometimes they treat me like I'm not even there and can be quite rude. They also tend to lose my weekly prescription quite a lot and try to make it sound like I didn't request my prescription. Happened at least 30 times in the past'*

#### **5.4.2 Consistency of key workers**

Many interviewees described present or past problems with inconsistency in key workers. Some reported having had long standing therapeutic relationships with key workers they valued that were no longer in post. What had followed was a period of seeing several different key workers. In all cases this was considered a problem. Many interviewees described reluctance to 'open up' to someone unknown to them or someone they feared may not remain their key worker for very long. This was seen as a barrier to treatment. In some cases where the interviewee was experiencing personal difficulties or mental health problems they reported severe distress from this situation, especially where they also reported minimal GP contact.

*P25: 'I've had so many, we had someone to begin with.. I can't even remember who it was, then they were only here for a couple of weeks and then I had another one, they were here for about a week, next time I came they had another one so and we have had X now for a while'*

*P23: 'I've seen loads [pause] I had one and she was a young girl and she was as good as gold really nice you know and then she, she got me to meet this other woman who I didn't know I had never met her and umm [pause] she gives me an appointment ... they seemed to swap and change you know'*

*Q42: 'The only comment I have is that sometimes there is great inconsistency in which drug worker I have. In 2009 I had 3 and am luckily enough this year to have only had one'*

#### **5.4.3 Being treated as a 'normal patient'**

Being treated like anyone else was seen as an important feature of shared care and valued. Suggestions for improvement were made when participants felt they were treated differently. Examples include being made to wait outside the pharmacy if another drug user is in the pharmacy, lack of privacy for supervised consumption, not being allowed to

make appointments with their own GP and having to disclose their drug treatment in GP reception areas, for example if ordering a repeat prescription.

#### **5.4.4 Communications**

Some participants suggested that communications between shared care staff could be improved. For example between GPs and key workers:

*Q32 'Better communication between the drug service and doctors providing shared care as it seems important information about patient's care and well being are either being overlooked or ignored completely by the doctors side of things'.*

#### **5.4.5 More access to counselling and other wrap around services**

Whereas many interviewees were happy to be 'left alone' or felt if they needed support they could contact their key worker, others felt a lack of support. In particular it was suggested that more access to one to one counselling would be beneficial to help prevent relapse. Additional wrap around services such as the provision of recreational activities were also suggested by a few.

*P24: 'I think it something they should do, encourage more like things like that, for some people it does make a difference' [referring to a past outdoor activities experience with Turning Point]*

#### **5.4.6 Pharmacy services –quick, discreet and private**

Interviewees' perception of a good pharmacy service was one where they were treated like 'normal customers' and felt they were treated with respect and discretion. They also rated highly pharmacies where they did not have to wait long to collect their medication and could get 'in and out'. Privacy, as said, created mixed views with the use of private rooms for supervised consumption being valued by some and disliked by others who felt it identified them. However, there was clear appreciation of being offered privacy as it was seen as a sign of respect, therefore it is advocated that all clients are offered to consume their medication in the private room and that this is repeated periodically if initially refused.

#### **5.4.7 Staff training**

A few interviewees suggested staff training is needed amongst shared care staff, although this was by no means a majority view and many reported feeling that their GP and key worker were very knowledgeable.

*'I genuinely feel that the staff are much more important than the facilities offered. I do not feel that the staff have been properly trained or even have the correct ethos. During my treatment staff have complained about their jobs, filled in forms on my behalf without my consent, and one particular drug worker completely demolished any sense of my positivity. A first meeting between client and worker has to be positive, the relationship is imperative'*

### **5.4.8 Waiting lists**

Many interviewees discussed initial difficulties getting into drug treatment, describing long waiting lists as a barrier to motivation and action. However many recognised this situation has changed recently and indeed those who had been in treatment for shorter lengths of time did not identify such problems.

### **5.4.9 Diamorphine prescribing**

The issue of alternatives to methadone and buprenorphine was raised by a few participants. Mainly this related to the prescription of pharmaceutical diamorphine. Some had read reports of 'heroin trials' elsewhere and identified that this may bring treatment benefits to those for whom methadone and buprenorphine had not supported any sustained change.

*P20: 'I don't think they'll change it in anyway unless they want to start giving us Diamorphine hydrochloride, but they won't cause it's too expensive. I know there's trials in other areas they're doing that I think its Bristol, London, Brighton and North Leicester I'm not quite sure'.*

*P23: 'And they are watching people in, I think it is either Switzerland or Belgium or somewhere, I think it is Belgium, they are watching over there because they have got loads of people all gone back to work and everything you know because they have given them the diamorphine and they have slowly weaned them down off the diamorphine and it is working. But over here they won't give it'.*

## **5.5 To consider, after consultation with other stakeholders, ways in which the service could be developed in order to respond to service user needs (objective 5)**

### **5.5.1 Feedback from stakeholders**

A web based copy of the draft version of this report was made available to all GPs and community pharmacies in Somerset involved in shared care. The pharmacies were notified of this by letter and invited to comment. The GPs were notified via the Local Medical Committee by email. One comment was received from a community pharmacist. This pharmacist highlighted and explained the prescription difficulties that had been described by some participants (section 5.4):

- Practices that use the EMIS software system have difficulties generating legal prescriptions because EMIS is not designed for use with the FP10MDA prescription. EMIS is unable to produce an unambiguous table with every day's dose clearly indicated. The Misuse of Drugs Act (1971) requires dose to be stated on the prescription; even if it is the same as the amount to be dispensed daily dose has to be separately stated. The system is also unable to add the necessary wording to allow patients to pick up doses the day before pharmacies are closed or to pick up remaining days doses when they have missed the initial dose. Hence this may explain why some interviewees described difficulties with prescriptions which they or their pharmacist had to sort out.
- A solution to the above that had been used was GP's handwriting scripts. However, this meant the audit trail was very difficult to follow and clients were not receiving

their scripts in advance as they had been used to. It was also more difficult for the GP's to remember the legal requirements so that many of the scripts had to be sent back to be amended. On many occasions clients had to obtain emergency scripts as they had not been done in advanced.

- The final difficulty this pharmacist raised was that from the TP end there is not one individual (per office) who oversees support for the generation of legal and accurate shared care prescriptions. They suggested this may be a solution to resolving the above.

Comments from DAAT representatives and TP management were received during a presentation of key point findings on 25.10.10. The main issue raised by participants which it was felt has been resolved was that of long waiting lists. The TP service has achieved short waiting lists and is now moving to a system of 'Limbo' (Low Intensity Methadone and Buprenorphine Option) clinics which will remove waiting lists for prescriptions.

An additional issue that is being addressed is that of counselling and support. A new TP system for psychosocial interventions 'Models of Psychosocial Interventions' (MoPSI) is being introduced in January 2011 and will improve access of shared care clients to psychosocial support.

It was reported that evening appointments had been trialled and were not attended, but it is unclear if this was offered to all shared care clients or just clients seen at TP offices.

The issue of pharmaceutical diamorphine was discussed. It is felt to be prohibitively expensive and therefore could not be considered at this time for provision in Somerset.

### **5.5.2 Outstanding suggestions for improvement made by participants and stakeholders:**

- 1) Provide information to explain the purpose and aims of shared care to all clients being transferred from the core team. Clearly explain arrangements at local (surgery) level for making appointments and facilitating the availability of timely prescriptions.
- 2) Try to provide consistency of key worker for people in shared care. Frequent change of key worker prevents a therapeutic relationship from developing and in some cases had prompted a conscious decision to 'clam up'.
- 3) Ensure the frequency of key worker appointments is meeting the needs of the client.
- 4) Give clients some say in their choice of key worker (including age and gender) and the option to change key worker if they find there are personality clashes or other valid reasons to change.
- 5) Ensure that clients are reviewed every 90 days by a GP. Ideally the GP who provides their shared care should be their own family doctor. Where this is not possible this should be explained.
- 6) Offer a low intensity service for those who are very stable and want to be 'left alone' on long term maintenance –telephone based 90 day reviews and more frequent brief checks and feedback from the community pharmacist could be utilised, with annual

shared care team clinic appointments. This is similar to the 'repeat dispensing model' used for chronic illnesses.

- 7) By contrast improve and increase the range and opportunity for access to wrap around support services available for those who want higher intensity interventions e.g. one-to-one counselling, college and employment support and access to activities such as sport and art. The introduction of MoPSI, as described above, will address the provision of psychosocial support.
- 8) Consider offering shared care clients surgery based evening or weekend appointments for people with full time jobs or college commitments. Home visits were also suggested for people with young children.
- 9) Consider ways to facilitate access to dental care so clients can deal with dental problems and associated self image problems from poor teeth.
- 10) Have an individual at each Turning Point office who oversees support for the generation of legal and accurate shared care prescriptions. This person would need an excellent working knowledge of the Misuse of Drugs Act (1971) requirements. Alternatively such as role could be provided by a PwSI within the DAAT.

### **References:**

1. Smith, E and Mistral, W. (2002). *Shared Care in South Somerset PCG*. University of Bath/AWP: Mental Health R&D Unit.
2. Edwards P, Roberts I, Clarke M, DiGuseppi C, Pratap S, Wentz R, Kwan I (2002). *Increasing response rates to postal questionnaires: systematic review*. BMJ 324:1183.

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## Service Users' views of shared care in Somerset

### Introduction

We want to know what you think about your drug treatment to see if it can be improved. We are inviting everyone in Somerset who gets treated for drug addiction at their GP surgery (also called shared care) to fill in this questionnaire. It is anonymous. The opinions you and others tell us will be used to improve services. It is **confidential**.

The questionnaire will take no more than **10 minutes** to complete. If you **would like** to complete the questionnaire, please do so then seal it in the envelope provided before handing it back to the member of staff who gave it to you, or posting it back to the University of Bath in the FREEPOST envelope provided (you do not need to put a stamp on it).

If you **do not want** to complete the questionnaire, please put the blank questionnaire in the envelope provided and hand it back to the member of staff who gave it to you or post it back to the University of Bath in the FREEPOST envelope provided (you do not need to put a stamp on it). This makes it easier for you to say no as no one knows if you filled it in or not.

If you would like help with completing the questionnaire please ask your drug worker. If you have any other questions please contact **Hannah Dawson** at the University of Bath on **01225 384215**.

### Important

- **All your answers will be kept confidential**
- Your answers will not be shown to any members of staff at your GP surgery, TP or Pharmacy
- **You do not need to put your name on the questionnaire**
- Please answer **all** the questions



*Teamwork image courtesy of [www.lumaxart.com](http://www.lumaxart.com)*



## Thinking about the care you receive from your shared care GP and your drug worker...

1. Please read the phrases on the left and tick one box for each statement that best matches your opinion

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
<i>The GP surgery where I get my addiction treatment is convenient for me to get to...</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>My appointments are at a convenient time for me...</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How often do you usually meet with your...

### Your Drug Worker

Once a week or more often

Every 2 to 4 weeks

About every 2 months

About every 3 months or less

### Your Doctor (GP)

Once a week or more often

Every 2 to 4 weeks

About every 2 months

About every 3 months or less

3. How long are your appointments with...

### Your Drug Worker

Less than 10 minutes

10 to 30 minutes

30 to 60 minutes

More than one hour

### Your Doctor (GP)

Less than 10 minutes

10 to 30 minutes

30 to 60 minutes

More than one hour

*Do you feel this is enough time for you? Is your appointment:*

About Right

Too Short

Too long

*Do you feel this is enough time for you? Is your appointment:*

About Right

Too Short

Too long

**4. How happy are you with your...**

	<b>Very happy</b>	<b>Happy</b>	<b>Neither happy nor unhappy</b>	<b>Unhappy</b>	<b>Very Unhappy</b>
<i>Drug worker's knowledge of addiction?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Doctor's knowledge of addiction?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Drug worker's understanding of your problems?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Doctor's understanding of your problems?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. We're interested if you feel treated with respect by your...**

**Your Drug Worker    Your Doctor (GP)    GP Surgery Reception Staff**

Yes   
No

Yes   
No

They all treat me with respect   
Most of them treat me with respect   
None of them treat me with respect

**6. How satisfied are you with the service you receive from your drug worker, GP and surgery staff?**

<b>Very satisfied</b>	<b>Satisfied</b>	<b>Neither satisfied nor dissatisfied</b>	<b>Dissatisfied</b>	<b>Very dissatisfied</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7. Please tell us any comments you have about the service you receive from your drug worker, GP or the surgery reception staff:**

**Thinking about the pharmacy you go to...**

**1. How often do you have to collect your medication (methadone/Subutex etc) from the pharmacy?**

Daily		2 times a week	<input type="checkbox"/>
<input type="checkbox"/>		Weekly	<input type="checkbox"/>
5 times a week	<input type="checkbox"/>	Fortnightly	<input type="checkbox"/>
4 times a week	<input type="checkbox"/>		
3 times a week	<input type="checkbox"/>		

**2. Please tick the box which best matches your opinion**

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neither agree nor disagree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
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*My pharmacy is convenient to get to...*

<input type="checkbox"/>				
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**3. Does your pharmacy usually have the same Pharmacist(s)?**

Usually I see the same Pharmacist(s)

There are usually lots of Locum (temporary) Pharmacist(s)

**4. Do the Pharmacist(s) treat you with respect?**

Yes

No

**5. Do the Pharmacy Assistants treat you with respect?**

They all treat me with respect

Most of them treat me with respect

None of them treat me with respect

**6. Do you have to take any of your doses of your medication in the pharmacy (supervised consumption)?**

Yes

No

*If you do, how satisfied are you with the amount of privacy you get when taking your medication?*

<b>Very satisfied</b>	<b>Satisfied</b>	<b>Neither satisfied nor dissatisfied</b>	<b>Dissatisfied</b>	<b>Very dissatisfied</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7. How satisfied are you with the service you receive from your Pharmacy?**

**Very  
satisfied**

**Satisfied**

**Neither  
satisfied nor  
dissatisfied**

**Dissatisfied**

**Very  
dissatisfied**

**8. Please tell us any comments you have about the service you receive from your Pharmacy**

**9. Overall how satisfied are you with your shared care treatment?**

**Very  
satisfied**

**Satisfied**

**Neither  
satisfied nor  
dissatisfied**

**Dissatisfied**

**Very  
dissatisfied**

**10. Please tell us what could make your treatment better**

## Please tell us about you

### 1. Are you...

Male  Female

### 2. What is your age?

\_\_\_\_\_ years

### 3. How long have you been receiving your treatment in shared care?

Less than 3 months   
1 to 5 years   
6 or more years   
Don't know

.....

## Thank you for completing this questionnaire!

**Please seal your completed questionnaire in the envelope provided and hand it back to the member of staff who gave it to you or post it back to the University of Bath.**

**Please keep the pen as a token thank you.**