



APRIL 2015

Consultancy Report

Service Evaluation of 'The Junction' (The Matthew Project, Cromer)

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Background – About the Service

The Matthew Project is a charity providing advice and support for people with drug and alcohol problems in Norfolk. The adult (18 years and above) service has had a physical base at premises in Cromer since 2007, serving the North Norfolk area, as defined by the North Norfolk County Council boundary.

This service provides:

- One to one key working sessions
- Home visits
- Referrals for assessments to other agencies
- Point of contact to other Matthew Project services

The service is delivered by (currently) 5 members of staff (3 full time and 2 part time). At the time of this report there was also one volunteer assisting with group facilitation for one morning a week.

Service goals

- Supporting people with drug and alcohol related issues
- Providing innovative education about the risks of drugs and alcohol
- Empowering people to make more informed choices

The service is funded via the Big Lottery, the British Legion, and the Henry Smith Foundation. The service is provided via specific projects and work streams, currently:

1. Smart Recovery (Lottery Funding)

This is described as ‘ a science-based addiction support group where we learn self empowering skills and support each other in recovery’.

SMART Recovery advocates choice, so that those seeking recovery can choose what works best for them from a 'tool box' of methods and approaches used in meetings.

The Junction currently has SMART Recovery groups available as follows:

Cromer - Wednesday 12.30- 2.00pm

Dereham - Tuesday 2.00 - 3.30 pm

North Walsham - Friday 10.00 - 11.30 am

There is also a support group on Monday mornings in Fakenham which, although not officially a ‘SMART’ recovery group, is run according to similar principles.

2. ‘Outside the Wire’ (British Legion Funding)

This is a service aimed specifically at the drug and alcohol issues faced by ex-service personnel and their families. Managed and run by recovery workers, who are themselves ex-forces, and therefore have a particular understanding of the needs and issues faced by veterans, current serving personnel and their families.

The service offers innovative, comprehensive support which includes confidential meetings at any location across Norfolk. The Service is separately funded by The British Legion and has been up and running since June 2013. This is the first service of its kind in the UK to offer support direct to ex-service personnel. There has been considerable interest from other areas in the service, and during the time of the evaluation it was made known that the service would be extending in to Suffolk.

3. Motiv8 Service (Henry Smith Foundation funding)

Motiv8 is a project aimed at supporting people through the transition from using drug and alcohol services, to living their lives to the full.

Motiv8 offers 8 sessions as the main part of the project, helping people learn how to deal with difficult emotions and practical problem solving, right through to writing a CV and preparing for a job interview, educational course or volunteering placement.

The aim of the Motiv8 project is to support people in to living independently within 9 months of initial assessment.

Motiv8 is held across Norfolk and covers a different session each week, people can join at any time.

Sessions include:

- Motivation
- Building confidence / understanding trust

- Healthy thinking / money management
- How to search for opportunities on the internet
- Reducing barriers to employment / managing convictions
- Recognising transferable skills / how to write a CV / guidance on application forms
- Preparing for interviews
- Healthy living - including diet, routines

The following services are all supported by Lottery Funding

4. Drop In Support

A free confidential service, offering advice and information on substance misuse to drug and alcohol clients. Also a point of contact both to other services offered by The Matthew Project as well as referral into a broad range of services offered by differing agencies within the North Norfolk Area.

This service is available to anyone who wants advice or information about their own substance misuse or that of someone close to them. The drop-in service is also a route of referral for individuals to The Matthew Project, for counselling or any other services.

Currently the Drop-In services run in Cromer (Monday, Tuesday and Thursday 10am - 4 pm, Wednesday 1pm - 4 pm), Fakenham (Monday 10am - 12pm) and North Walsham (Friday 10am - 11.30am).

5. Needle Exchange

This drop-in service includes a needle exchange scheme for all substance users. Individuals can return used injecting equipment, and obtain needle exchange packs or separate needles of varying sizes, syringes and sharps bins. Other injecting equipment and condoms are also provided.

Advice and information is given about injecting practices, health-related issues such as blood borne viruses, referrals to prescribing agencies or just the opportunity to discuss individual situations and options. This service is confidential.

6. One to One Support (individual appointments)

For referred clients that are taken on and case managed following assessment, there is the opportunity to meet with a Recovery Worker on a regular basis in order to help deal with drug/alcohol problems and to discuss any other issues that may have resulted from substance misuse.

Referrals can be self-referrals (via phone or drop in) or via other agencies.

One to one support is generally offered on a weekly appointment basis initially, depending on client need. Appointments can continue without a time limit, but the general pattern was to

arrange less regular and less frequent appointments over time as clients were assessed to be making progress towards recovery and/or achieving control over their alcohol or substance misuse. Topics covered in one to one visits may include reducing/breaking a habit, relapse prevention, healthy living, motivation.

7. Home Visits

For those seeking advice and support in dealing with a drug / alcohol problem and who are unable to easily access the Junction in Cromer, the service can provide home visits for one to one support with a Recovery Worker. They are able to offer advice on such topics as: reducing/breaking a habit, relapse prevention, healthy living, motivation.

The aim is to provide a package of support that recognises that everyone is an individual, with a variety of needs that can be worked on together to address.

8. Support for Family and Friends

At the Junction the team are able to provide advice, information and someone to talk to for family and friends effected by substance misuse; either on the phone or in person; one to one or in a group. A regular carer support group currently meets fortnightly.

9. Sexual Health Advice

The service offers sexual Health Advice and Chlamydia and gonorrhoea screening. Testing kits are provided to those aged 25 and under. Age restrictions are due to funding. The service links with the Sexual health promotion unit who provide free Chlamydia testing kits and condoms.

Methods

This rapid service evaluation was undertaken as a piece of consultancy work by Dr Caitlin Notley, with input from Professor Richard Holland. Dr Notley spent time at the Junction talking with all staff involved in the project, reviewing routine data records, observing groups where appropriate and with permission of group attendees, and speaking to service users.

Quantitative data review

Data records as currently collected by the Junction were reviewed. This was to gain an understanding of routine data records currently collected, to enable reporting on current service provision. For this purpose data for the previous 12 month period was focused upon. For client contacts, the most recently available data for the last two months (November-December 2014) are reported in order to give a one off 'snapshot' view of current service provision. Further aims of the routine data review were to identify needs catered for and possibly suggest unmet needs for the North Norfolk adult population served by the Junction, and to formulate suggestions for any additional record keeping to ensure that relevant information would be available to undertake future larger scale evaluation.

Data sources reviewed were:

1. Data collected by the Junction on Referrals in to the service. This data is collected manually by recovery workers using referral forms. Referral forms are passed to the administrator/data analyst who enters all data onto an access database. Data on all contacts, including those not recorded as referrals were shared for November-December 2014.
2. Data on those clients who are assessed as being 'in treatment' are logged onto the Halo database. This comprises software which produces National Drug Treatment Monitoring System Core Dataset H (version 8) compliant extracts. The database collects information on 'in treatment' clients, and thus data on substance misuse is collected on this national database, which can be accessed for web based data entry via the internet.
3. Treatment Outcomes Profile data (TOP). This data is collected manually by key workers and entered on the HALO database. TOP data is designed to be routinely collected at treatment start, review, exit, and can also be collected post-treatment exit. TOP data is not submitted to NDTMS as the Junction is not a statutory organisation. TOP data is used to produce 'evidence' on outcomes in reports to lottery funders.
4. Alcohol outcome star data. As a treatment 'tool' the Junction pay a subscription to use the 'alcohol outcomes star'. This is a graphic of a star where clients can rate, in discussion with their recovery worker, aspects of their life in terms of functioning and general satisfaction. The domains that are rateable are:

1. Alcohol
2. Physical health
3. Use of time
4. Social networks
5. Drug use
6. Emotional health
7. Offending
8. Accommodation
9. Money
10. Family and relationships

Ratings can be quantitatively assigned and reported upon. Reports can be generated directly from the outcome star database which is accessed for web based data entry via the internet.

5. Client feedback data. Client satisfaction and ratings of service provision are collected in house by staff on paper questionnaire forms. This data is entered onto an excel spreadsheet by the administrator/data analyst.

Qualitative data collection:

Dr Notley undertook face to face interviews with all staff and volunteers currently providing services for the Junction. Interviews followed a semi-structured format (see appendix 1) but were 'informal' in that they were not recorded or transcribed. However detailed notes were taken during conversations. All observation and summary notes were checked back with relevant individuals for verification of accuracy and in order that inconsistencies / queries could be answered. As far as possible assurances of confidentiality were given and we strove for anonymity in reporting, recognising that this is difficult given the small staff team. All staff members confirmed their willingness to be interviewed and that it was acceptable for their views to be represented in summary form within this service evaluation report.

Dr Notley also undertook face to face discussions and telephone discussions with a wide range of people representing agencies interfacing with the Junction. These included an interview with a volunteer (included within the staff interview data), informal discussions with service users, observation of the 'affected others' support group, informal interviews with the volunteer counsellor, a MIND counsellor, and two further referring agencies working with the Junction. Conversations and observations were not formally recorded but detailed notes were taken. All observation and summary notes were checked back with relevant individuals for verification of accuracy and in order that inconsistencies / queries could be answered.

Results

The Junction team

The core team comprise one full time Manager, one part time receptionist/data analyst/administrator, two full time recovery workers, and one part time recovery worker. In addition, at the time of the evaluation there was one volunteer assisting with group facilitation on a part time voluntary basis, and one part time counsellor based at the Junction for 1 day per week as a student placement.

The premises at the Junction are used by a number of other agencies based on a part time 'room rental' arrangement (although financial cost is not incurred by these other agencies). These include GamCare (support and counselling for those with gambling problems), MIND (counselling service as part of the wellbeing service) and 'Mytimeactive', a health trainer service.

The setting

The Junction is based in central Cromer. Cromer is a small seaside town in North Norfolk. It is located about 45 minutes drive from Norwich. Despite its location, the town is a focal point for local rural communities. It is reasonably well served by buses reaching out to surrounding towns and villages. There are good facilities in the town, including parking, supermarkets, a range of shops and amenities. In common with many Norfolk seaside locations, the town has a somewhat different feel

in the winter months, as much of the income of the town is dependent on tourism and, perhaps to a lesser extent, fishing trades. During the summer months the town has a different atmosphere as the population of tourists increases markedly.

The Junction itself is easily accessible being located in the town centre. Despite this the premises are very discreet. Situated next door to a chocolate shop, the premises is entered via a single doorway with buzzer entry. The main premises are upstairs above the high street shop. The premises comprise of stairs and a stair lift on entry, a small entrance hall, very small kitchen and bathroom facilities, a small waiting room area, two private interview rooms, a main space (which is also the main thoroughfare to one of the interview rooms and the office). Finally the office is located to the rear of the property and houses 5 desks.

The premises is part of an older style character property. The décor is relaxed and welcoming, and certainly could be described as 'non-clinical'. The environment has a friendly feel, although the heating system appears outdated, and the layout of the building is not perfect, for example the main space where groups can meet is also used as a passageway through to one of the interview rooms (mainly used for counselling). Although not ideal, staff acknowledge this and the need to 'work around' the idiosyncrasies of the building.

In addition to the warm welcoming atmosphere, positive aspects of the environment apparent related to safety. The small size of the premises meant that others were aware of who was in the property and where at all times. Whilst this may conceivably cause issues of client confidentiality, staff were extremely sensitive to this, and there was a sense of support for each other.

Review of published Needs Assessment documents

A synthesis of recent relevant published needs assessment reports was undertaken. It should be noted that the last comprehensive needs assessment report available for review was published in March 2013. A slightly more recent needs assessment published in May 2013 by the North Norfolk Clinical Commissioning Group also refers to the needs of the population of North Norfolk more specifically. Needs assessments were published before the implementation of the Norfolk Recovery Partnership (NRP) at the end of 2014. In this respect, some messages are outdated as points refer to the previous treatment system which commissioned several different treatment providers. Findings from the needs assessment documents should therefore be considered with caution in the current context of the new NRP treatment service.

Needs assessment documents reviewed were:

1. Adult Substance Misuse Needs in Norfolk Districts: North Norfolk
2. NDAP Needs Assessment 2013, 'Substance Misuse in Norfolk'
3. NDAP North Norfolk Clinical Commissioning Group: Drugs and Alcohol
4. NDAP Substance Misuse in Norfolk: Clinical Commissioning Group Area, Needs Assessments: North Norfolk (May 2013)

Key findings of relevance to The Junction Service:

(Quotations taken from the 2013 Needs Assessment 'Substance Misuse in Norfolk'):

Service Users

1. "People in treatment should be offered person-centred recovery-focused care which successfully engages them in treatment, but also offers them the best chance of moving on from that treatment" (p17). The Junction is clearly providing such a service.
2. "Everyone needs the option of individual support – but some people will also want to work in groups, and currently there are fewer groups than individual support". (p28). The Junction have set up and now run a number of recovery focused (SMART and Motiv8) groups.
3. It was reported that North Norfolk has the lowest rates across the whole of Norfolk for people in structured drug or alcohol treatment. This may represent an issue of reduced prevalence and appropriate provision, but equally may suggest significant unmet need and poor access to services. This issue should be explored in future needs assessment work.

Mental Health Needs

1. "One fifth (17%) of clients in drug and alcohol treatment in Norfolk are also receiving mental health services" (p11). This suggests that joint working arrangements with mental health services should be developed and strengthened.

Hazardous alcohol using groups

2. The NDAP Substance Misuse in Norfolk: Clinical Commissioning Group Area, Needs Assessments: North Norfolk recommends target of "alcohol brief interventions at middle aged adults (men aged 45-65 and women aged 45-54) and particularly those in high income groups". Middle aged people from high income bands are increasingly drinking at harmful levels yet often remain 'hidden' to services.

Recovery support – employment & housing

3. "Greater joint working between specialist substance misuse treatment providers and employment support advisors could improve employment opportunities for people affected by substance misuse" (p12). Employment is a key aspect of recovery that needs full support, developing employment opportunities for clients may be an effective way forward in increasing 'recovery capital'.
4. "Appropriate housing and related support are critical factors in supporting recovery. A fifth (20%) of people receiving structured drug and alcohol treatment in 2011/12, were experiencing housing problems when they commenced treatment" (p12). At present, the Junction appears to be working well with local housing providers to ensure support for the population of clients in recovery.
5. Awareness of substance misuse among employers needs to be raised (p80). Stigma amongst employers can be a major barrier to employment and recovery opportunities.

Recovery support for higher threshold clients:

1. 21% of Opiate and Cocaine users have been in treatment for more than six years. The needs assessment suggests that: "It is essential that recovery capital is assessed when a client enters treatment and that care planning includes actions to increase recovery capital accordingly. This emphasises a need for treatment services to build strong links with partner agencies to ensure that client needs are met in terms of their health, housing and employment and to help clients to build social networks that support their recovery goals". There is potentially scope for the Junction to interact more with those in treatment with NRP to deliver the lower threshold recovery support that is critical alongside medical intervention.

Relatives / Carers

2. "The value of the care and support provided to and Opiate and/or Crack User (OCU) by family members is estimated to be £3,935 per family member per annum and therefore, the total annual saving to statutory services for Norfolk is estimated to be about £17m." (p8). This is an important point and suggests that resources directed towards supporting family members of those with drug and alcohol problems may be highly cost-effective.
3. There is "a need for dedicated, publically funded service for the family and friends of those with substance misuse problems, with increased geographical equity of provision, meaning better services for those in rural areas" (p8). The Junction has established one innovative and highly regarded 'affected others' group in Cromer. There is a need for more group provision to other areas, particularly rural communities.
4. GPs are often the first point of contacted for affected others seeking help and support, there is scope for improving knowledge of the services offered by the Junction amongst GPs to enhance referrals from this source.
5. A survey of Professionals found that "people generally felt that all the relevant services were out there, but that provision was patchy and that adequate provision was needed across the whole county. It was mentioned that there were not enough opportunities for people to get together in groups in the county, and that while some services existed for spouses/partners, there was not enough for other affected others"(P33)

Prescription drugs

6. A "group of drugs that are increasingly cited as a problem by people receiving substance misuse treatment in Norfolk are 'Prescription only medications and over-the counter' drugs (POM/OTC)." This category of misuse was not raised by staff or service users as part of this service evaluation of the Junction, but is nonetheless an important consideration across Norfolk and requires surveillance.

Needle exchange

7. Needles distributed across needle exchanges in Norfolk have risen in recent years, although staff at the Junction reported a decrease in demand for needle exchange services, and numbers of needle exchange recorded contacts are low. The needs assessment data show that distribution of needle packs is lower in the North Norfolk region than across the rest of Norfolk. This is an interesting trend that needs careful scrutiny.

Socially excluded groups

8. “The proportion of Gypsies and Travellers in treatment is not known, but given that this group is socially excluded, and that socially excluded people are more vulnerable to substance use, and that this group is less likely to access mainstream services – this may represent an unmet need.” (p88)

Data Recording – general observations

Data are recorded via 5 different routes (referral forms, in-treatment data, TOPs data, alcohol star data and client satisfaction survey data). This data is then entered onto 4 different databases (access for in-house data on referrals and contacts, HALO for in-treatment data and TOP data, the external alcohol star database and excel for client satisfaction survey data). There is some duplication of data entry, and multiple possible points of data entry errors.

No formal system for data management or checking was identified. The burden of data entry rests with the administrator / data analyst.

Drop in client contacts

Data on client contacts were only made available as a snapshot of contacts undertaken during 2014. These data were made available for review as part of regular reporting to the project trustees meetings. The most recently available data on contacts is given below:

Trustees Report: Nov - Dec 2014										
CROMER										
	Drop In Database (inc Needle Exc)			Other Visitors			Total Callers	Needle Ex		
	M	F	Total	M	F	Total		M	F	Total
Nov	47	32	79	12	26	38	117	8	0	8
Dec	55	17	72	15	22	37	109	13		13
N WALSHAM										
	Drop In Database (inc Needle Exc)			Other Visitors			Total Callers	Needle Ex		
	M	F	Total	M	F	Total		M	F	Total
Nov	3	2	5	0	0	0	5	0	0	0
Dec	4	3	7	0	0	0	7	0	0	0
FAKENHAM										
	Drop In Database (inc Needle Exc)			Other Visitors			Total Callers	Needle Ex		
	M	F	Total	M	F	Total		M	F	Total
Nov	14	2	16	0	0	0	16	0	0	0
Dec	13	1	14	0	0	0	14	0	0	0
AYLSHAM										
	Drop In Database (inc Needle Exc)			Other Visitors			Total Callers	Needle Ex		
	M	F	Total	M	F	Total		M	F	Total
Nov	0	0	0	0	0	0	0	0	0	0
Dec	0	0	0	0	0	0	0	0	0	0
OTHER CONTACTS, eg community, home visit, not applicable										
	Drop In Database			<i>Other Visitors = other agency staff, other agency clients etc</i>						
	M	F	Total							
Nov	20	5	25							
Dec	21	5	26							
OUTSIDE NORTH NORFOLK (Gt Yarmouth, Diss, Dereham, King's Lynn, Norwich)										
	Drop In Database (inc Needle Exc)			Other Visitors			Total Callers	Needle Ex		
	M	F	Total	M	F	Total		M	F	Total
Nov	19	13	32	0	0	0	32	0	0	0
Dec	8	3	11	0	0	0	11	0	0	0
Lottery										
	Tops		Carers		OTW					
					TOPS		Carers			
Nov	8		8		7		2			
Dec	12		8		2		2			

Previous trustee report data show similar or lower levels of contacts, suggesting some seasonal variation. Data shown here suggest a reasonable level of drop in / brief contacts with clients who are not formally referred to the Junction (a total of 141 contacts in total, including brief contacts and referrals, per month for December across all the areas served by the Junction). This equates to

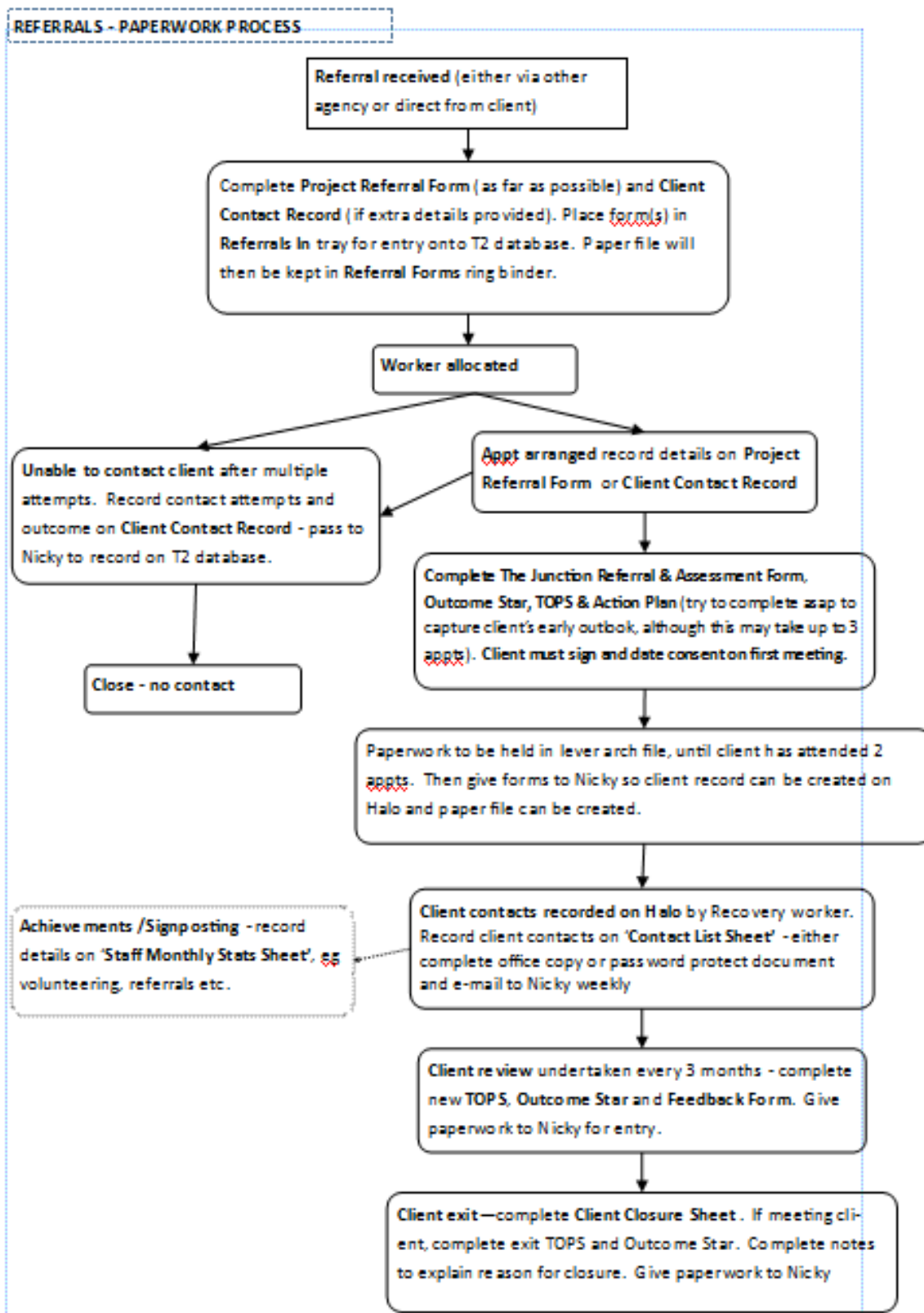
approximately 28 contacts per month per recovery worker, or approximately 7 contacts per week per recovery worker.

There were 21 contacts for needle exchange services during November-December 2014.

Referrals

The diagram below has been provided by The Junction (NJ) and shows the referral pathway for clients entering the

service.



Referrals procedure *(notes taken from information shared by NJ, project administrator)*

- 1) A **Project Referral Form** must be completed for all referrals received at The Junction (whether via phone, e-mail or in person). This must then be placed in the **Referrals In** tray so that all referrals received can be logged on the database and tracked.
- 2) Referrals pending will then be kept in the '**Referral Forms Pending Action**' lever arch file so that they are accessible by all staff.
- 3) Pages 3-6 of the Assessment Form will be completed by the Recovery Worker when the client attends their first appointment, along with Outcome Star, TOPS and Action Plan.
- 4) Client to attend minimum of 2 appts before being entered onto Halo, until then, paperwork to be kept in the **Referral Forms Pending Action** lever arch file.
- 5) Contact notes must be written for each action involving the client, including arranging / cancelling appointments, attempts to contact and third party agency contact. (If client not on Halo, notes can be typed using the **Client Contact Record** template and saved in the 'Client Notes—Not on Halo folder' on the central shared drive, these should be printed and held with the client paper record, the saved copy can then be transferred to Halo when a record is created.)
- 6) Frequency of Client contact— Clients to be contacted minimum of once every month, if unable to contact client after 3 separate attempts, over 3 weeks, then letter to be sent asking if they still would like our support, if we don't hear back, then we will assume they are now OK. (Standard closure letter is available in the Client Folder—Forms on the Central Shared Drive.)

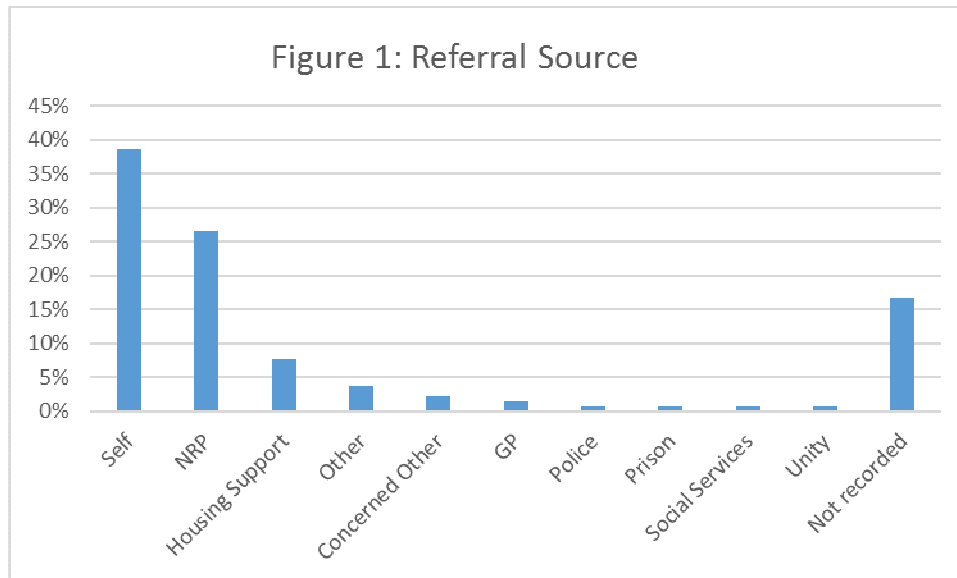
Review of Referral data

Referral data does not include one off brief contacts with clients (e.g. clients using needle exchange services or clients briefly assessed but deemed to be not in need of referral to a recovery worker, or falling outside of the Junction remit).

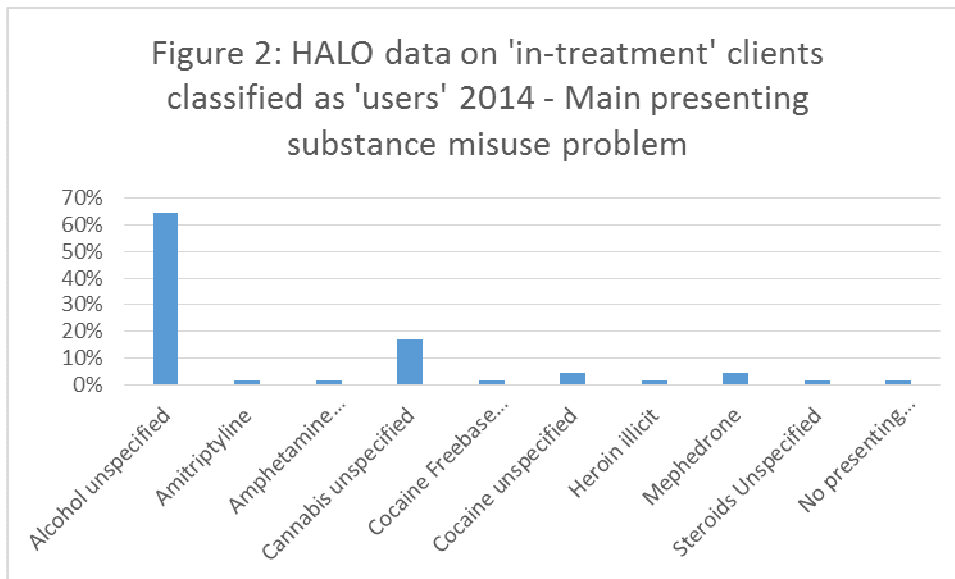
132 new referrals in total were recorded in the last year, at the point that data were extracted for review (23/02/2015). 77 clients were recorded as 'lottery' funding, and 54 clients were recorded as 'SMART' group attendees. Of the 132 new referrals, 59 individual clients were recorded as having a TOP completed between 1.1.14 and 15.12.14. 44.7% of new referrals therefore completed one or more TOP assessment. The remaining 73 clients (55.3%) did not complete a TOP assessment. This can be explained as only those referrals who go on to be 'case-managed' with data entered onto the HALO database would be asked to complete a TOP assessment. Clients referred to SMART recovery groups also do not complete a TOP assessment.

Referrals came from a number of routes – local agencies (e.g. housing, employment), GPs, the Norfolk Recovery Partnership (NRP) and self-referrals. The majority of referrals received by the

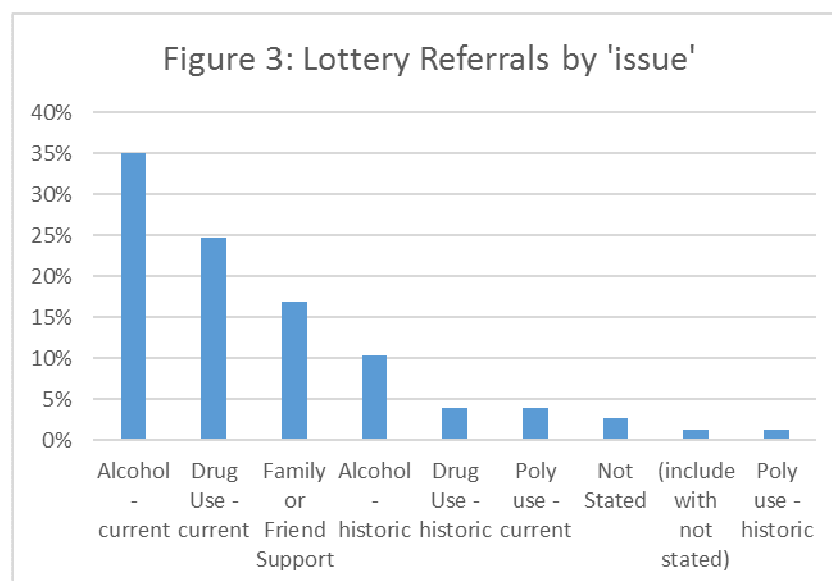
Junction in the last 12 months were self-referrals (51 people, 39%, see Figure 1), 35 referrals were from the NRP (26.5%) or did not have a source of referral recorded (22 people, 17%). There were very low numbers of referrals coming from housing support agencies (10 referrals, 7.5%), GPs (2 referrals, 1.5%). The Police, Prison service and Social services all accounted individually for 1 referral each over the last year, or less than 1% respectively of referrals.



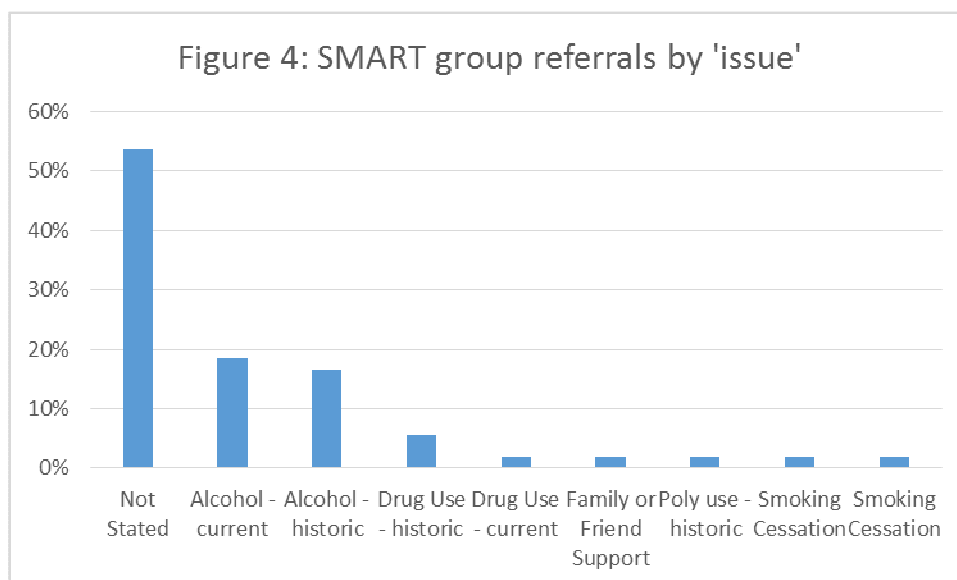
Once clients had attended a minimum of 2 appointments, the client is taken on as ‘case-managed’ and data on substance use is collected and entered onto the HALO system. In 2014, HALO data showed that 90 clients met criteria. This figure includes non-users and parents/carers who were referred. The 2014 HALO data for those clients classified as ‘users’ shows that 65 clients met criteria and details of substance use were recorded for these clients. 42 of clients (65%) recorded on HALO for 2014 were recorded as having alcohol as the main presenting problem (see Figure 2), and 11 (17%) were recorded as having cannabis as the main problem. All other substance use (as the main presenting problem) was similarly very low by substance.



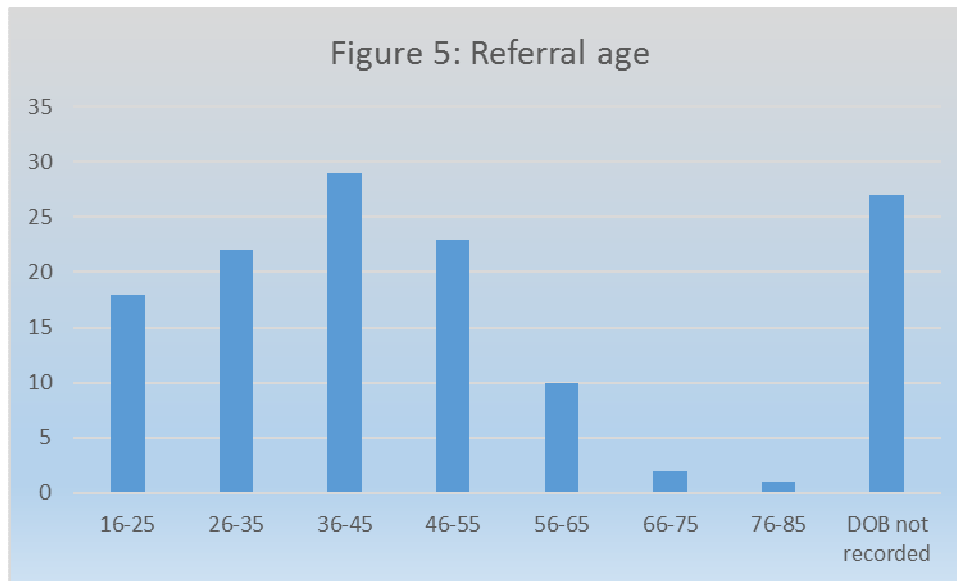
Referrals were recorded separately for the main service lottery funding (n=77), and for those attending SMART recovery groups (n=54). This was due to the fact that historically SMART groups were separately funded, and the Junction is still in receipt of separate funding for North Walsham and Dereham SMART groups. The majority of referrals for lottery funding were clients with current alcohol problems (35%) (See figure 3). Current drug users represented 25% of lottery referrals. Also of note were referrals for family/friend support, representing 17% of all lottery referrals in the last 12 months.



Referrals for SMART groups followed a similar pattern with regards to alcohol being the primary presenting issue (see Figure 4). Current or historic alcohol use accounted for 18% and 17% of referrals in the last 12 months respectively. Of note the largest category of referrals did not have a presenting main issue recorded (54%). This seems to suggest a significant data recording problem. Referrals where drug use was recorded as the primary presenting issue were significantly lower for SMART recovery groups than for the lottery funding however, with less than 2% of SMART group referrals being recorded as having a primary presenting drug problem, and just 5.5.% as having a past drug problem (Although SMART groups can be for any addictive behaviour). Feedback from the Junction staff could not identify any particular reason for the mainly alcohol clients. Possibly it was suggested that this may be because most of the referrals come through via NRP once clients had completed structured alcohol treatment. However, we do not have sufficient data to judge whether the low referrals for other substance misuse actually represents lower prevalence of this issue in this area. It was suggested that advertising more widely in the local community might encourage those with different types of addictions to attend. A recovery worker also mentioned that another reason could be that users of class A drugs are usually more chaotic whilst they are using, then they make a decision to stop, whereas alcohol can be a slower process, which may possibly make alcohol clients more amenable to the SMART recovery approach.



Most referrals were for clients aged 35-46 (see Table 2). 20% of referrals did not have a date of birth recorded. 14% of referrals were for the youngest age group service by the Junction (16-25 year olds). Referrals for those aged over 65 represented approximately 2% of all referrals over the last 12 months (Figure 2).



Treatment Outcome Profile (TOP) Data

Clients who had completed only 1 TOP

TOP data were reviewed for the previous 12 months. There were a significant number of clients who had completed only one TOP assessment (this was reported to have been because the client had not been within the service for the minimum of 3 months at this point and thus it was too soon to have a TOP assessment completed, because the client was only briefly within the service, or because the client could not be contacted for a second screen).

A total of 32 clients (54% of the 59 clients who had completed at least one TOP) were recorded as having undertaken 1 TOP assessment only in the last 12 months (see recommendation 6). 19 clients (32%) had not been within the service for 3 months at the point when data were collected. 13 clients (22%) were overdue for a TOP assessment.

Clients who had completed more than 1 TOP

33 clients in total in the last year were recorded to have completed more than 1 TOP. Of 132 referrals, this indicates that only 25% went on to be referred as 'case-managed' and were therefore applicable for repeat TOPs assessment.

Average quality of life score at treatment entrance was 11.4 out of a possible total of 20, where 20 indicates 'good' functioning, and was 14 at treatment exit, showing an average positive progression of 3 points. Within these figures there was, not unexpectedly, considerable variation and range. For example, the lowest progression documented was a fall of 15 points, and the highest progression was a rise of 15 points.

Figures were similar and comparable to quality of life figures for both psychological and physical health (see Table 1).

Table 1:

Mean TOP Scores	Start	Mean exit or last review	Median change in score
Psychological Health	12	14	+2
Physical health	14	15	0
Quality of Life	11	14	+2

Data before and after intervention were compared using a non-parametric test (Wilcoxon matched pair). Data were non-normally distributed. This analysis demonstrated that both the changes observed for psychological morbidity and QoL were statistically significant, $p=0.006$ and $p=0.004$ respectively using the Wilcoxon sign-rank test. Changes observed in physical morbidity were not statistically significant, $p=0.13$.

As this is before and after data only, with no control group, it is impossible to be sure that these changes would not have been observed with no intervention, nevertheless, they are encouraging data.

6 clients (18.2%) showed a drop in overall quality of life since being in treatment. Possibly of note was the fact that 10 clients in total (30.3%) also showed a drop in physical health, compared to 5 clients who showed a drop in psychological health. This suggests that the Junction may be providing better support for psychological health than physical health. However, these figures must be viewed with extreme caution as the number of clients who had completed more than one TOPS assessment in the last 12 months were low, and inconsistencies (e.g. sharp variations in scores over time) may be more a result of individual circumstances rather than representing the therapeutic input of the Junction.

22 clients in total (66.7%) had a recorded increase in overall quality of life score over the time of repeated TOPs assessment. 5 clients (15.2%) showed no change in their TOP quality of life assessment form.

Outcome star data

Anecdotally, key workers interviewed reported that clients found using the outcome star useful, as they were able to see in diagram form areas of their lives that they wanted to improve or work on. Equally, they were able to bolster confidence with some clients by suggesting that actually in some areas there were very positive messages. This usefulness was corroborated by a service user, who spontaneously discussed the use of the outcome star, and reported that she had found it a useful and powerful tool, particularly to look back on and remind herself that she had improved and 'come a long way'. There was a suggestion that documenting the low ebb that she was at when entering the service as a referral was helpful in order that she could remind herself of her progress and also remind herself of where she did not wish to return to.

One client commented on the client feedback form used by the service:

“I have made amazing progress thanks to the help and support from the team here in Cromer and N Walsham. When I started my star was in the 1s and 2s, now it's mainly 10s” (anonymous service user feedback form response)

Data are reported here verbatim as provided by a report directly from the Junction for Outcome Star Data 1.1.14 – 18.12.14:

Number of users whose Stars are included in this report: 32

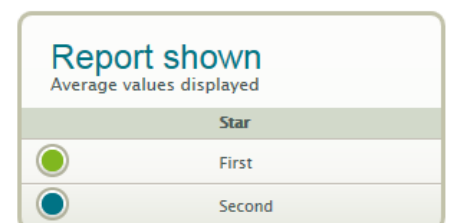
Includes clients who are current and those who have left in the last 6 months.

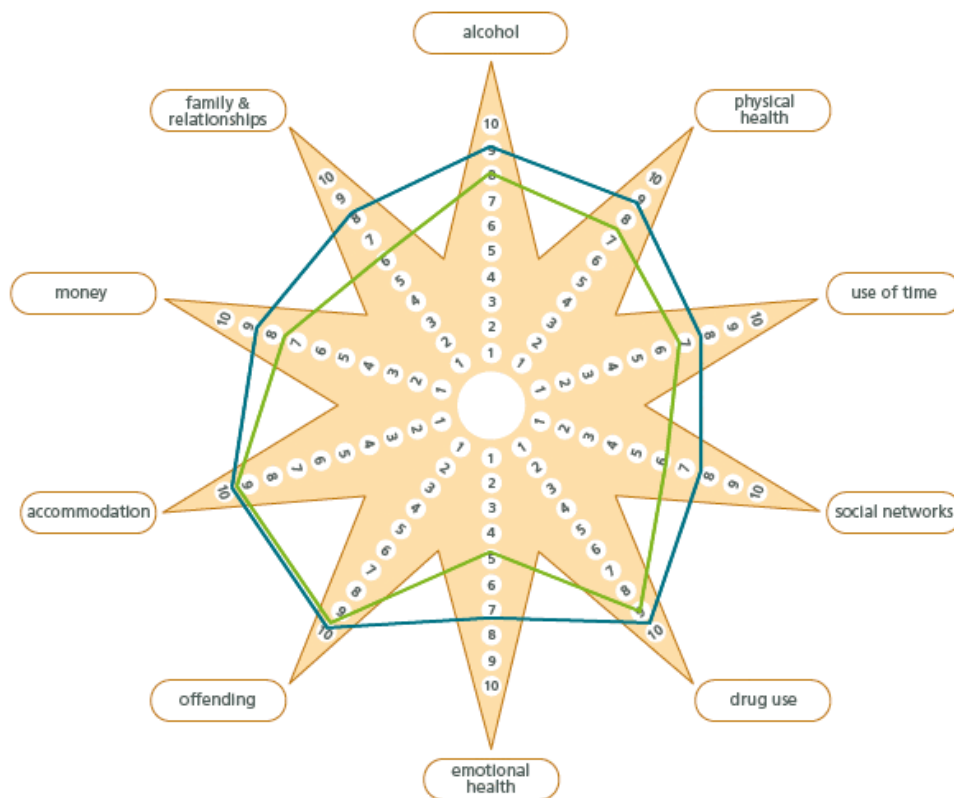
1. Average increase and decrease in scores for each scale

This table shows the average first and last scores for clients included in this report. The difference between these two is the 'change', or outcome, shown in the column on the right.

Scale	Initial	Final	Change
Alcohol	8.0	9.0	1.0
Physical health	7.4	8.7	1.2
Use of time	6.7	7.6	0.9
Social networks	6.2	7.6	1.4
Drug use	9.0	9.6	0.6
Emotional health	4.7	7.3	2.6
Offending	9.6	9.8	0.3
Accommodation	9.4	9.6	0.2
Money	7.4	8.6	1.2
Family and relationships	6.1	8.2	2.1
Average	7.5	8.6	1.1

Data shown as star:





This shows that, on average, clients of the Junction who completed the outcome star improved their own self ratings over time. Of particular note is the largest improvement visible in the area of emotional health. This corroborates the views and perceptions of the strengths of the Junction service from a staff perspective, where emotional and low level psychological support was thought to be a key benefit of the service. This improvement also suggests that the targeting of the work of the Junction, at low level addictive behaviours and at recovery, is relevant and seems to be effective from a client perspective overall.

However, all conclusions drawn should be tentative, as the outcome star data presented here are drawn from only small numbers of referred clients.

2. Percentage increase and decrease for each scale

This table shows the average proportion of the clients included in the report whose score for a scale has increased, decreased or stayed the same.

Scale	Decrease	No change	Increase
Alcohol	13 %	49 %	38 %
Physical health	13 %	34 %	53 %
Use of time	22 %	28 %	50 %
Social networks	16 %	28 %	56 %

Drug use	6 %	69 %	25 %
Emotional health	9 %	13 %	78 %
Offending	3 %	88 %	9 %
Accommodation	9 %	82 %	9 %
Money	13 %	46 %	41 %
Family and relationships	6 %	25 %	69 %

These figures show that across the board, more clients reported increases in all of the areas assessed by the outcome start than those who reported decreases. Although many clients reported no change (most strikingly in the areas of offending and accommodation), larger increases in self reported outcomes are noted in the domains also captured by TOPs data, particularly emotional health, physical health, use of time and social networks.

3. Percentage change across all scales

This table shows the proportion of the clients included in this report who are making progress, staying the same or slipping back based on their overall Star score, i.e. an average of their scores for each scale. A 'big' increase or decrease is defined as more than one point up or down across all scales. 'No change' means an average change per scale of between -0.25 and + 0.25

Big Decrease	Small Decrease	No change	Small Increase	Big Increase
3 %	9 %	19 %	22 %	47 %

The following section of the outcome star data gives comparison between The Junction data and all organizations nationally that also use the outcome star.

The data Includes clients who are current and those who have left the service in the last 6 months.

What does this report show?

This report compares the average start point and outcomes for the Junction with an average for similar types of service and client groups across all organisations using the same Star (and using the Star Online) (Number of users whose Stars are included in this report: 4600).

As this data is reported directly via the outcome star software, the comparability of the 'similar types of service' is not known, and therefore that aspect has not been commented upon for this report. The outcome star report itself suggests that the data 'can give managers some information to benchmark their service but needs to be treated with caution as many factors affect the outcomes, including the length of time clients stay with a service'.

By default it shows outcomes for all current service users, including those clients who have left within the last three months 'and does not include readings that were identified as having been retrospectively completed by a worker. The Star Charts included are the first and most recent for each service user included.

When service users and staff do not agree to a Star reading, two versions can be stored on the Star Online: a 'service user only version' and a 'worker only version'. By default, this report only shows readings that have been agreed by a worker (i.e. 'joint & worker only').

1. Average increase and decrease in scores for each scale

This table shows the average first and last scores for clients included in this report. The difference between these two is the 'change', or outcome, shown in the column on the right.

Service	Initial	Final	Change
The Junction	7.5	8.6	1.1
Star Online benchmark	6.9	7.7	0.8

This data suggest that the Junction, in comparison to other similar services also using the outcome star software, is performing slightly beyond other services, on average.

2. Percentage increase and decrease for each scale

This table shows the average proportion of the clients included in the report whose score for a scale has increased, decreased or stayed the same.

Service	Decrease	No change	Increase
The Junction	11 %	46 %	43 %
Star Online benchmark	16 %	42 %	42 %

3. Percentage change across all scales

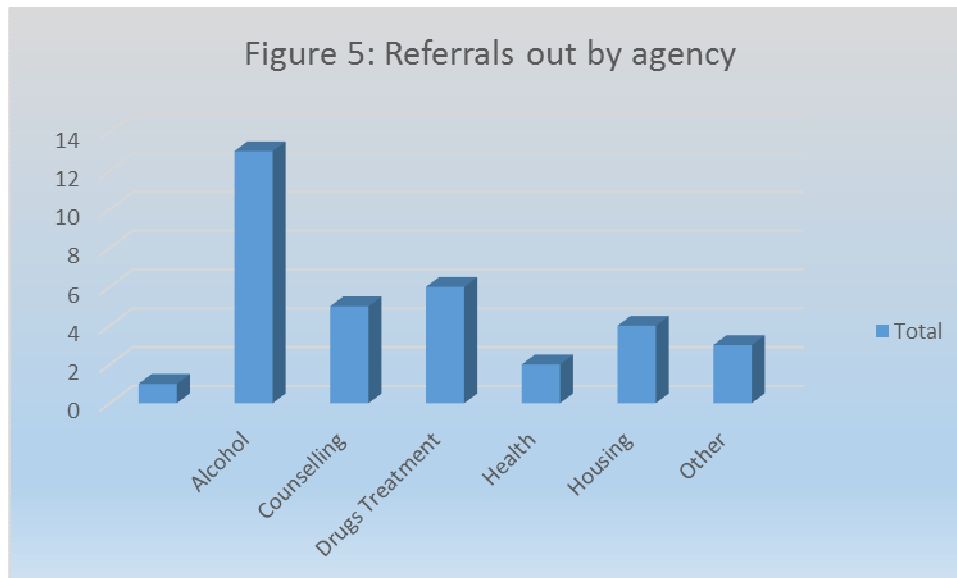
This table shows the proportion of the clients included in this report who are making progress, staying the same or slipping back based on their overall Star score, i.e. an average of their scores for each scale. A 'big' increase or decrease is defined as more than one point up or down across all scales. 'No change' means an average change per scale of between -0.25 and + 0.25

Service	Big Decrease	Small Decrease	No change	Small Increase	Big Increase
The Junction	3 %	9 %	19 %	22 %	47 %
Star Online benchmark	9 %	8 %	18 %	22 %	43 %

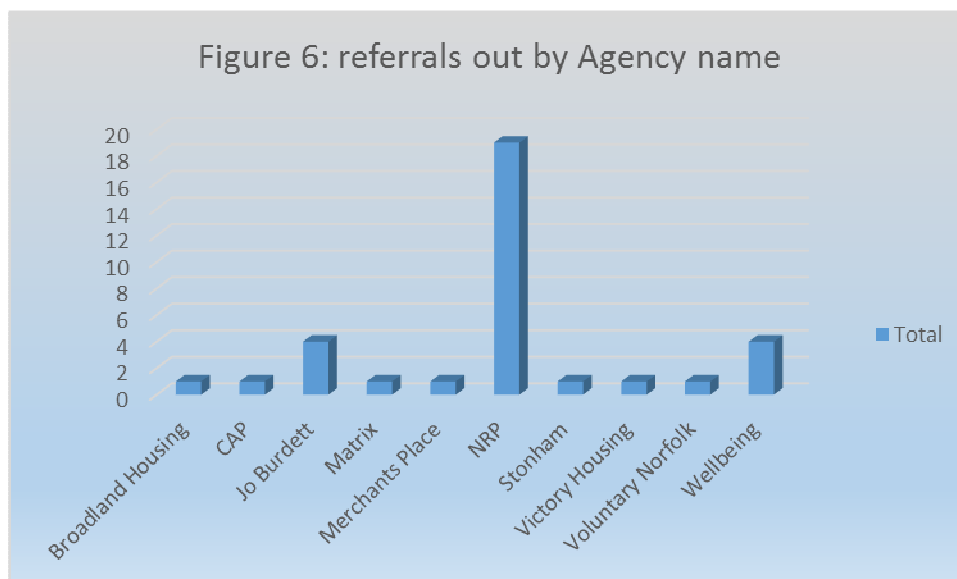
In summary, these data seem to suggest that as a service the Junction is tending to do slightly better than other services also using the outcome star, in terms of documented % increases.

Referrals out

Data for 2014 shows that a total of 34 referrals were made out of the Junction to other agencies. Generally, Figure 5 shows that referrals out were for alcohol (38.2%), with referrals for housing, counselling, drug treatment and 'other' all being at similarly low levels.



By agency, over half of all referrals out (55.9%) were to NRP, corresponding with the referral out data for alcohol, as these referrals represent problematic alcohol use requiring medical intervention, so falling within the remit of NRP rather than the Junction. Feedback from staff was that guidance on referrals out suggested that any client reportedly drinking more than 20 units of alcohol a week would fall within the NRP remit and out of the remit of the Junction service (Figure 6, below).



Client feedback data – Summary of quantitative data

On exit from the service, clients are asked to complete a brief feedback questionnaire about their experiences of the service provided by the Junction. A copy of the current feedback form is provided (appendix 2). In 2014, a total of 46 client feedback forms were completed.

The first rateable question asks clients ‘How much improvement do you think you have made since coming to the Matthew project?’ responses are overwhelmingly positive, although this question may be considered somewhat leading, and the rating scale used does not allow for clients to give a negative response below improvement = none. 76% of survey responses indicated that they felt either ‘a lot’ of improvement, or ‘great’ in terms of ‘the way I feel about myself’ since coming to the Junction.

Supporting the outcome star data reported above, client feedback showed the highest positive response in terms of improvement in emotional health. 83% of respondents reported either ‘a lot’ or ‘great’ improvement in this area, compared to 58% for physical health (still a considerably positive response). 70% reported ‘a lot’ or ‘great’ improvement in ‘relationships with other people’, whilst 65% reported ‘a lot’ or ‘great’ improvement in controlling/reducing alcohol use.

Ratings of the Junction staff were positive across all domains. However, ratings for the drop in rooms (premises) were more mixed. Although no ratings of ‘poor’ were given at all, 16% of respondents rated the drop in rooms as only ‘okay’ or ‘good’, with 56% rating the rooms as ‘very good’ or ‘great’.

In response to the question ‘overall do you feel you have been helped by the Matthew Project, 78% of respondents answered ‘great’ and 17% of respondents answered ‘very good’. One person answered only ‘good’ and the final respondent did not answer this question. In sum, it is fair to say that overwhelmingly client feedback to the survey was extremely positive.

On the client feedback form respondents were given the opportunity to leave further free text comments. 19 people (of the 46 total respondents) took the opportunity to leave comments. All 19 of these comments were positive. Respondents talked about recovery, mentioning support, feeling listened to, regaining control of alcohol use, improved self-esteem, and the quick response of the service. As an illustration:

“(Recovery worker’s) support, insight, guidance & inspiration have underpinned my recovery. I am finally rediscovering myself and feel like a whole person. (Anonymous quote from feedback form respondent’s comments)

Client feedback – Qualitative data

As part of the evaluation consultation process two service users were able to meet with CN for approximately an hour. After the purpose of the evaluation was explained, they freely talked about their own histories and stories, and gave feedback on their experiences of referral and ongoing contact with The Junction. Although detailed notes were kept, client stories are not retold here for reasons of confidentiality and to maintain client anonymity.

In summary Client 1 had had previous serious alcohol problems and also housing problems. She had had medical intervention for her alcohol problem, but had been helped by the Junction subsequently to regain control over drinking and would now class herself as a ‘controlled’ drinker.

Client 2 reported problematic daily amphetamine use, and had been supported by the Junction to completely stop using.

It should be noted that the service users consulted were volunteers (they volunteered to have a conversation with CN), and thus they may be considered to be particularly keen and motivated, as opposed to representing the views of the 'average' client.

Reports were extremely positive overall. 2 further service users provided written letters of positive support (appendix 3).

Helpful things about the service

Both clients discussed the importance of speaking to a recovery worker who was felt to be understanding. Talking to someone who had 'been through it themselves' was valued as it was felt helpful to 'speak to someone who understands'.

One of the service users commented on the length of appointments, suggesting that it is helpful to have 'a whole hour to talk' and contrasted this with past medical care for alcohol problems, where key workers seemed more constrained by short appointments. Just 'having someone to talk to' for an extended period of time was commented upon as being helpful and valued.

The availability and accessibility of recovery workers was commented upon. Being able to send a text to the recovery worker was mentioned as being very helpful.

The non-judgemental approach of the service was discussed. It was felt that there was freedom to discuss issues without fear of being judged. Relapse was mentioned, and it was felt that this was accepted if it occurred, rather than being punitively punished, e.g. by removal of service support.

The intuitive recovery group approach was mentioned as having been helpful.

Although one of the service users did not frequently attend the Junction for support anymore, it was commented that 'I know where they are if I need them'. There was a sense of open ended support and that someone supportive would be there if there was a relapse problem.

Promotion of the Junction via the foodbank service was mentioned, showing the close relationship of the service with other local services.

The Junction Premises / location

Without the Junction it was discussed that there would be a need for clients to travel to the NRP premises in North Walsham. This was thought to be potentially very difficult, as one of the service users in particular felt that clients would not be able to afford to travel and preferred to be seen locally.

Unhelpful things about the service and wider service provision

It was reported that mental health team intervention had been unhelpful. Historically, it was reported that there had been 'no help' due to depression combined with alcohol problems, so the difficulty had been that needs were not met by any one service (e.g. the alcohol team had been unable to help due to the depression diagnosis, but the mental health team had not intervened due to alcohol problems).

It was felt that extended opening hours for the drop in service would be beneficial, although it was also appreciated that text messages would be answered out of hours.

Recovery

In general terms, both clients discussed the need to 'do it for yourself', i.e. that motivation towards recovery had to 'come from within'.

Unmet needs / suggestions for improvement of the Junction service

It was felt that the service should be more widely publicised. It was reported that 'many people don't know the Junction is here'. On the one hand the discreet nature of the premises was appreciated, but it was felt that more promotion of the service and community awareness would be a positive thing.

Generally, it was felt that the Junction provided a valuable service to a group for whom no other service existed. It was suggested that more could be done though, as one service user said that 'there is a large unmet need for alcohol clients not accessing services'. It was strongly expressed that there would be a huge gap in support without the service, and that both service users would recommend the service to anyone in need.

Qualitative staff interviews

5 informal staff interviews were undertaken and 1 informal interview with a volunteer (the only volunteer identified as currently working with The Junction). For the purposes of this reporting, the volunteer is included as a 'staff member'. This was a total sample of all staff currently employed by The Junction. Feedback is reported below around informal interview topics.

1. Background training and previous experiences

Staff came to the Junction from a variety of backgrounds. 3 staff members were ex-service personnel, representing all three of the armed forces. This was felt to be a strength of the service, especially with regards to the 'outside the wire' service for ex-service personnel.

1 staff member was an ex-service user who had progressed through recovery, volunteering, and was now a full time recovery worker. A further member of staff had initially undertaken a social work placement at the Junction, and had become a part time staff member following a period of volunteering.

2. What does the role involve? Typical day/week?

Recovery workers reported extremely varied and full working days. Days were split between group facilitation and one to one appointments with clients. Appointments could be either based at the Junction or Home visits. For the 'Outside the Wire' recovery worker, all one to one appointments were home visits, and thus the role for that individual included considerable travel across the county.

Case loads were described as 'manageable' at around 20-30 clients per whole time recovery worker. Recovery workers are relatively autonomous and manage their own caseloads. They are prompted by the administrator when clients require review / assessment.

Other work includes writing up notes, planning training, being available for drop ins and needle exchange.

All workers routinely liaise and works closely with NRP. Referrals are also made for counselling, voluntary Norfolk for voluntary work, housing agencies (Genesis and Flagship), to group support

(SMART groups and motiv8), to CRUSE (bereavement counselling), and to the MATRIX project (sex workers).

3. Perception of range of client needs

It was felt by all the staff that the core client group are alcohol users and low level substance users. The needs are around recovery and reintegration, and also relapse prevention. The project is attracting lower level not so chaotic people who need short term support only. Most clients were described as 'not too chaotic'. One worker felt that clients were more likely to be binge drinkers than long term chronic alcoholics – so their problems did not fit within the remit of NRP, or sometimes clients had been discharged from NRP. Sometimes clients might crossover with NRP remit but attended the Junction as they did not want to engage with NRP due to bad experiences.

Most clients approaching the Junction were felt to be motivated and want to engage with recovery services.

There were fewer longer term clients and use of the needle exchange was reported to be infrequent.

There is reportedly high rates of dual diagnosis – low level anxiety and depression mainly that do not fall within the remit of the wellbeing service. Grief and loss are often big issues for clients that may have been an underlying factor behind their alcohol or substance misuse.

For clients specifically seen by the 'Outside the wire' initiative, it was reported that most clients are those struggling with integrating into civilian life after coming out of the forces. Some clients turn to alcohol and drugs as a means of coping. Or they have a reaction to the things they have witnessed and experienced. They have no other help with dealing with these experiences. There are reportedly high rates of mental health issues that are undiagnosed or missed within the forces, as often people don't want to admit there is anything wrong. There is a culture of maintaining face and getting on with it. It is only when people leave the forces that the extent of problems may become apparent. Needs can vary. E.g. clients may have PTSD from war experiences as far back as the Falkland's, or from serving in Northern Ireland.

Mainstream services are not best placed to deal with ex-service personnel. Ex-service people can be very guarded about their experiences, and often will only open up if they are speaking to others who are also ex-forces. A key need of this group is to be seen by ex-forces workers. Clients often need more contact and time than other clients as they have so much 'bottled up'. Ex-forces people are often not comfortable talking to civilians, including GPs, counsellors, family and friends, so can feel very isolated.

The 'outside the wire' service reportedly sees a mix of older and younger clients. (50/50).

For young people the typical pattern is that they have signed off and left the forces due to an inability to cope. They often have been unable to admit there was a problem. They may have anger management issues and find it difficult to reintegrate to civilian life.

Housing can be an issue as when people come out of the forces they lose their homes too. This is very hard for young families. Often people end up back with their parents which can be difficult. Often there is family break up to compound the problems.

There is a reportedly an ongoing drinking culture within the forces. Not drugs so much due to routine testing, but some clients have been discharged due to drug use. The key need is to assist

clients to reach understanding that civilian street is not as 'anti' as they think it is. Helping clients to change their mind set.

Referrals to the outside the wire service come from 'walking with wounded'. Also 'combat stress'. GPs in the area are also reasonably well aware of the service so there have been a few referrals via this route, but the service still in it's infancy.

4. Changes in service provided by the Junction over time (then and now)

It was reported that in more recent times the service has shifted and now carries out more one to one outreach work as opposed to fixed appointments.

There is a perception amongst staff that when NRP was established some 'work was taken away from the Junction'. Now, apart from ex-service people seen through 'outside the wire', anyone drinking more than 20 units a week would fall within NRP remit. These people may be discharged and come back into the Matthew Project though following medical intervention. It was reported that due to this client profiles and needs had changed considerably in the last 18 months and needs were now lower intensity than in the past.

The needle exchange service is used less now than it had been in the past. It is still regularly used, but by a small cohort of regular attendees.

So clients have changed a lot in last 18 months, and especially since NRP has established its premises in North Walsham (end of 2014).

The outside the wire service is still in its infancy. Although funding is fragile, further funding for the next 12 months had just been confirmed and the service was being extended into Suffolk.

5. What is working well at the Junction?

Overwhelmingly all staff members commented on the team cohesiveness amongst staff. Morale was high, and it was felt that there was good communication and supportiveness between staff members. One worker commented that 'the team is balanced with a range of strengths' so it was felt that other colleagues could be asked for support when it was needed.

The manager reported that he welcomed a non-linear management style where all staff were treated equally. He mentioned the Christian ethos of the Matthew project, yet suggested that religion was not at the forefront of their work and not 'rammed down clients necks', yet underpinned the caring, accepting approach. The manager also discussed encouraging creativity and 'ownership' and discussed the development of the carer support group that one recovery worker had set up and continued to facilitate. In relation to this specifically, it was commented that 'there was nothing available for carers/affected others before the development of the carers group'.

In terms of Outside the Wire specifically – it was felt hugely important for clients to talk to someone who is ex-forces. There is a common ground that is very important. Only ex-forces people were felt to be able to understand the hierarchy, the acronyms etc. having recovery worker backgrounds in all 3 of the armed forces was felt to be a particular strength of this service, and something quite unique.

Referrals to other services were reported to work well, and relationships with other local services were positive. It was felt that the service was well known by other agencies. Being on a first name basis with other agencies was felt to be very useful.

The building was felt to be a nice inviting, non-clinical environment. It was commented that the building was perhaps particularly accessible to women and was easily accessible through its open access drop in. The accessible central location of the premises was felt to be positive, and most of the workers felt that it is important to have a local service with a local base, as it is important to have a physical base for drop in and it is invaluable to have 'information at your fingertips' when clients need it – access to internet, printers etc. to meet clients needs.

The accessibility and availability of the service via the drop in service was felt to be very positive as clients could be seen very quickly when needed. It was commented that 'Immediate contact and information is so critical to clients and a key benefit of the service'.

Time given to clients during appointments was felt to be very important and a key strength of service provision – clients were usually given an hour per appointment as standard, but provision was reportedly very flexible, so clients had much more time than with clinical appointments.

The provision of one to one outreach appointments was felt to be working very well, and met a need for rural clients who could not travel, either because they could not afford to or because they were fearful about travel.

The accepting nature of the service was felt to be very beneficial. One worker discussed how clients were afforded 'multiple chances and the benefit of the doubt'. It was discussed how sometimes it takes people many chances until they get things right, and having a service that is not time limited or punitive was felt to be very important in supporting people.

6. What is working less well / requires improvement?

Although comments about team working were incredibly positive, one issue that was raised was the small size of the team. It was reportedly difficult if someone leaves, is on holiday, or needs to take sick leave. This puts pressure on the rest of the team.

All staff members commented on the reliance on bidding for charitable funding and the insecurity that this brought. It was felt that this could impact on staff and moral, and was sometimes a source of stress for individual staff members.

One staff member commented that the Building is expensive to maintain, and was unsure of the continued benefits of having a physical base in Cromer when possibly the service could be run more as outreach with a presence in an increased number of small North Norfolk towns.

Although all staff felt that the Junction undertook very important work for which there was a definite need, it was felt that recognition for 'low level' recovery work is minimal. The underlying work and support given to clients was reported to be 'immense'. Staff felt that their work is vital in preventing people from re-entering clinical services (NRP), but this was difficult to quantify or capture. It was felt that greater recognition and funding would be appropriate, as the prevention of multiple treatment episodes is important and has cost saving implications.

In terms of Outside the Wire it was suggested that it would be helpful to have a small expenses budget for service users – to help with bus fares etc. if needed. There was also no budget for advertising / PR, which would be beneficial.

Some felt that referrals from other agencies could be improved. It was suggested that increased awareness of what the Junction can offer would be beneficial, as it was felt that some NRP workers were not aware of their work.

It was felt that some increased awareness raising of the carer support group would be beneficial. For example GPs were mentioned as a group to potentially target for awareness raising.

Varied relationships with GPs were reported. Sometimes there was a perception that GPs are working 'against' them – the focus was sometimes more on prescribing, and sometimes over-prescribing, whereas the Junction focus is on reduction of substance use and recovery.

It was reported that groups are currently quite poorly attended, although they are only just up and running in some areas.

7. Perceptions of unmet client needs

Three of the six staff members interviewed discussed mental health issues and saw this as a key unmet need of the client group served by The Junction. They felt that they were playing a vital role through key working in addressing and supporting 'low level' undiagnosed mental health needs, including depression and anxiety. It was discussed that often anxiety would be mixed with alcohol use, and frequently housing was discussed as a problem that also contributed to anxiety. However, they felt that there were many more unmet needs that they were not able to deal with. One member of staff saw mental health needs as 'a major problem'. It was discussed that, for their point of view, most clients seemed not to 'fit' with mental health services. Clients seemed to get 'parked' on anti depressants and left alone, which could in turn impact on their substance misuse.

Often clients did not meet the threshold for referral to the Wellbeing service, yet their level of unmet mental health need was still significant. More than one staff member discussed the vital role that the Junction paid in providing long term support to people in recovery. However it was felt that there was a need for more availability of counselling, to support and assist clients with dealing with long term issues that may even have impacted on their initial substance misuse.

Experiences of referral to the wellbeing service were mixed – some staff reported positive liaison and working relationships, but others had not experienced good reports, and had problems with making referrals. One issue was that clients may have to wait for a considerable time if referred before seeing a counsellor, and this was felt to be a gap in service provision.

Other potential areas of unmet need that were mentioned during staff interviews were

- Support / rehabilitation for domestic violence perpetrators
- Support for employment
- Support and education around 'legal highs' and new emergent substances. It was mentioned that there is 'an epidemic' of methadone use locally. Although the perception was that this substance was being used mainly by young people, it is conceivable that trends in use may transpose to the adult population. It was thought that use of this substance could impact on crime and employment. Methadone was described as a very 'moreish' drug which could quickly impact on usage and lifestyle / habits.

- One member of staff felt that a similar service was also need for under 18s and suggested that it might work to have recovery workers geographically based (embedded in communities), but responsible for both young people and adults.
- It was discussed by one member of staff that there are a group of people for whom it is very difficult to support change. Clients who say they want help and start to engage with services, yet don't really change their behaviour were seen as a difficult problem. There was uncertainty as to the best way to intervene with these people.
- Transport is a problem for many clients.

8. How would you like to see The Junction develop?

Unanimously staff felt that the Junction delivered an important service and should continue to provide such a service. In addition, all of the staff expressed views on ways in which the service might usefully develop and expand or move forward in the future.

Three staff members drew attention to the geographical limitations of the service and suggested that the service should be delivered across the county, such that the existing provision might be replicated in other areas. One staff member discussed a view that the service worked well as an outreach service, having a physical but not constant presence, whether in the form of group meetings or regular key worker visits at a community venue. This raised the question of whether the service might be run entirely as an outreach service. This was a vision that was shared by another staff member, who suggested that the Junction could be managed by a small Norwich based office, with more resources then being available for outreach key working. A different member of staff similarly suggested that they believed a worker placed in each small market town would be effective. Possibly to cover adults and children – such an embedded service could provide outreach and services where needed rather than having a physical base.

Others, and particularly the service users interviewed, suggested that the physical premises in Cromer was very important. They liked having a central 'base' and somewhere to go. However, others felt that for more rural clients even Cromer was difficult to get to, and these clients might therefore benefit more from wider outreach services.

Two staff members discussed the lack of volunteers. It was mentioned that the Matthew Project as a whole had previously been very active in supporting volunteers and particularly ex-service users but this had declined in recent years. It was discussed that involving ex-service users could be beneficial both for clients (who appreciated talking to someone who was perceived to understand what they were going through), but also for the ex-service users themselves as part of their own recovery (engaging in meaningful activity, having a sense of 'giving back' and gaining vital work experience). It was mentioned that there is a volunteer's coordinator within the Matthew project, but this person is only in post for 1 day per week to cover the whole Matthew Project organisation across Norfolk. It was expressed that there therefore was a need to expand volunteer involvement. However, it was also recognised that there were potential difficulties with volunteer and ex-service user involvement. Volunteers need very careful management. Volunteers can be time and resource intensive, and may not stay around for long (perhaps completely appropriately, but this could be difficult for the project to manage). There were also felt to be confidentiality issues working in rural areas. One member of staff suggested that the support group for affected others could feasibly become self-sustaining, or could perhaps be overseen by a volunteer.

One staff member discussed how she would like to see some sort of more formalised social / practical role of the service. For many clients it was felt that alcohol use is part of socialising. Therefore to provide a social venue (possibly with food) but away from alcohol might be beneficial in allowing people to build social networks and have needed friendships with others, but away from alcohol use.

Finally it was suggested that capturing new clients was challenging, and that many clients were long term or previously known to the service. It was felt that there was a need for increased advertising and awareness raising to capture new clients.

9. Strengths and weaknesses of the service

In addition to the detailed views on what was working well currently at the Junction and how the service might be developed, staff were asked to give brief feedback on strengths and weaknesses. Views corroborated data already reported and can be summarised as:

Perceived Strengths:

- The team
- Flexibility
- Service based on and responsive to client needs

Weaknesses of the service

- Being dependent on funding
- Small size of the team
- Lack of service user involvement

10. Development needs / training needs and wishes

Staff were asked to consider their own training and development needs. Feedback given on this aspect was generally very brief, suggesting that staff were generally satisfied with training received and felt that their own development was nurtured within the organisation.

In terms of ongoing development, possible areas for future training mentioned were:

- More access to what is going on around the country. Learning from other areas. What is and isn't working.
- More in-depth mental health knowledge and training would be beneficial. Would like to undertake accredited training in this area.
- More training in dealing with grief and loss.
- Would like to widen range of training generally, e.g. alternative therapies.

Views of interfacing agencies / individuals.

Two counsellors from linked agencies who had weekly use of the Junction premises were informally interviewed. A representative of the local foodbank (interfacing agency) was also informally interviewed.

Views of the Junction service provision were very positive. All interviewees felt that the service was excellent and met a clear local need. It was expressed that the service provided valuable support for a group of people with low threshold needs that would not otherwise be catered for.

The importance of open access services and outreach was emphasised. One interviewee felt that this could usefully be extended with increased funding to provide weekend access or out of hour's support, as support was often needed during times of crisis. It was also felt that the physical base in Cromer was important for many local clients, who found it difficult to travel at all when they were feeling unwell. Having this local physical base worked well for counselling purposes, therefore, and it was discussed that clients attending the premises for counselling, even if not drug or alcohol related, did not express a sense of stigma in attending the premises.

One interviewee discussed the need for the service to be extended, suggesting that there was considerable need for low level mental health needs in particular to be addressed. Formal counselling for those with more significant needs was also felt to be something positive that the Junction could offer, although it was felt that need far outweighed the available provision. One interviewee cautioned that the staff working for the Junction were all incredibly committed and dedicated, but this could be a problem as they were often thought to work above and beyond their funded hours, and this could possibly give the impression that the service is able to deliver more for the current funding than it might actually sustainably be able to continue to offer.

Although liaison with local services was thought to be good, it was suggested that The Junction was still not widely known about, and that more work might be done to promote the service.

Conclusions

This evaluation was undertaken in a short timescale with limited resources. We were constrained by the quantitative data available. Although referral data and drop in data give an indication of recovery worker caseload, it was difficult to form an impression of day to day caseloads of recovery workers. Qualitative data achieved a complete sample of staff, but only drew on the views of 2 selected service users. Review of published needs assessment documentation only covered the period prior to the implementation of the NRP treatment system. Despite these caveats, review of qualitative and quantitative data suggest that the service currently provided by the Junction is effective at meeting the needs of existing clients with low threshold alcohol and substance misuse issues in the North Norfolk area. Clients referred to the service generally improve slightly in terms of quality of life and substance misuse during their time 'in treatment' with the service, as evidenced by statistically significant improvement in TOP quality of life scores, and alcohol star data.

Both staff and service users reported high levels of satisfaction with the current service. Staff morale is high. Caseloads are manageable, affording staff time to work closely with individual clients. This is valued and deemed helpful by both staff and service users. Staff feel well supported by their direct line management arrangements, and unanimously discussed team cohesiveness and satisfaction with open communication and good team working practices.

Staff and interfacing agencies interviewed suggested that in the future it may be beneficial to expand the service to cover the whole Norfolk area. The current focus on North Norfolk seems to have afforded staff the benefit of developing good local links and liaison with local services and interfacing agencies, but there is a clear gap in provision across the rest of Norfolk. The 'Outside the wire' service for ex-services personnel, which covers the whole of the county, provides a model for a specialist outreach service that may possibly be adopted by the Junction for drug and alcohol clients.

Some staff suggested that the service could work on a purely outreach basis, with key workers located within towns. However, other staff and service users were convinced that a physical base and premises for drop in in Cromer were hugely valued and important. This is an issue that would benefit from further discussion in moving forward.

Quantitative data reviewed showed relatively low referral rates to the service, although this service evaluation did not undertake formal comparison to other similar services, so this observation is tentative. Quantitative data were of mixed accuracy, presenting some data interpretation issues, particularly around completion of TOP data (see recommendation 6). Alcohol star data were deemed a useful tool, but completion rates were low.

Referrals to and from interfacing agencies appeared to be working generally well. However, there were problems with long waiting time for referrals to mental health services, and a lack of available counselling. Referrals to and from NRP for medical intervention seemed to be working well, but it was felt that better publicity of the service to GPs may beneficially impact on this route of referral. This was particularly raised as an issue in the published needs assessment document reviewed, with regards to support for affected others.

In terms of unmet needs, data collected for this report captured the views of service users, staff and published needs assessment documents. A common theme was the perception of a large group of middle aged people, probably in employment and of reasonably high income, who were using alcohol at hazardous levels. Although the North Norfolk CCG needs assessment did not collect alcohol data specifically for the North Norfolk region, this identified need draws on national data and is echoed in the views of staff and service users. This suggests that this group should be targeted by future service provision. Similarly, those with undiagnosed or 'low level' mental health needs were identified as a priority group in need of support by staff, service users and in the published needs assessment literature.

Qualitative data showed extremely positive perceptions and opinions of the Junction Service. The Service is well thought of by staff, service users and interfacing agencies. Although it was thought that the service could expand and develop geographically, perhaps focusing more on middle aged people with alcohol difficulties not currently accessing services, and those with unmet mental health needs, the importance on regular contact with low level clients that is not time limited was emphasised as benefitting supporting those in recovery.

Implications / recommendations

From the data provided, the service offered by the Junction appears to be a high quality valued service, where individuals are afforded time to talk and build a relationship with recovery workers. This is valued by both clients and staff. Indications from effectiveness data (TOP and Outcome Star) are that the service is helping clients. However, we have no comparable controls and therefore this data must be interpreted with caution. The following recommendations are noted:

Data Recording

This was a difficult evaluation to undertake from a quantitative perspective. It is unclear exactly what activity is handled on a day to day basis by recovery workers. At face value, a service managing 132 referrals per year with 5 members of staff needs careful review. However, we could not assess how many clients were ongoing at the start of the previous year, or how long clients are retained in treatment. We also had feedback from staff that caseloads varied weekly, and that supporting individuals sometimes required much more intensive input but at other times workload would be quieter. Although we have brief data on drop in and needle exchange contacts, it was therefore difficult to illuminate the day to day workload of workers. In order to properly assess the service in the future the following data recording issues are recommended:

1. It is recommended that data recording process be reviewed. Ideally one bespoke database would be used for primary data entry which would interface with other shared databases. This would avoid duplication and limit the potential for data entry errors.
2. A system for data management and for checking accuracy of data entry should be established. Ideally this would be independent of the organisation but could quite simply involve checking a % of data entry records for accuracy.
3. 53.7% of referrals did not have a presenting main issue recorded for referral data to SMART recovery groups. This needs investigating and record keeping should endeavour to attempt to record a brief reason for referral to SMART recovery groups.
4. Anecdotally outcome star data was reported as being useful from both a staff and service user (n=1) perspective. However, numbers of clients completing outcome stars was low (32 clients during 2014). Consideration should be given to the relative cost of this tool compared to the effectiveness and perceived usefulness. It may be possible to incorporate the benefits of 'charting' client progress in other less costly ways.
5. It is suggested that a redesign of the client feedback form be undertaken to ask a range of positive/negative questions, so as to be non-leading.
6. In undertaking this evaluation report there was some difficulty in interpretation of TOPs data. For example, data on clients who had completed only 1 TOP assessment presented on page 18 of this report were taken for a report compiled for the lottery funder in December 2014 and there is some uncertainty about these figures (see also recommendation 1).

Meeting unmet client needs

7. Staff and interfacing agencies discussed significant levels of unmet mental health need. Many clients suffered from anxiety or depression. Referrals to mental health services were difficult and there was a lack of availability of counselling.

8. There is scope for the Junction to interact more with those in treatment for problematic opiate and cocaine use with NRP to deliver the lower threshold recovery support that is critical alongside medical intervention.
9. There is also scope for the Junction to work alongside NRP with more severe alcohol problems where clients are receiving medical intervention. The Junction may be able to provide holistic support for these clients to complement medical intervention.
10. It is recommended that the Junction could play a central role in increasing support for and uptake of mutual aid options, including service user involvement, peer support, volunteering and support for affected others. Consideration of increased out of hours support provision to support the needs of those in crisis, or to fit in with those in full time employment.

Wider geographical service provision

11. The issue of wider provision (county wide) beyond the North Norfolk boundaries was raised by staff, service users and in the review of relevant needs assessment documents. This may be particularly relevant as levels of substance and alcohol misuse in North Norfolk are documented within needs assessment reports as being lower than across other areas of Norfolk. Widening the geographical remit of the service offered by the Junction should be a key point for wider consultation and consideration.
12. Support services for affected others might usefully be extended county-wide to meet perceptions of patchy service provision.

Improved publicity / awareness raising

13. Wider publicity about the service provision was mentioned by staff, service users and key stakeholders interfacing with the Junction. This should be investigated as a matter of priority to ensure that service provision is fully utilised by those that need it.
14. Improve awareness of the service offered by the Junction amongst GPs.
15. Improve awareness amongst employers of drug and alcohol problems and the work of the Junction, to tackle stigma and facilitate increased employment opportunities for those in recovery.
16. Continue to foster and build good working relationships with local housing schemes sympathetic to the recovery needs of drug and alcohol clients.
17. Awareness raising / outreach support to middle aged high income groups identified as at risk for increasingly engaging in harmful levels of alcohol consumption.

Improved needs assessment evidence

18. There is a need for up to date needs assessment work to capture potential unmet needs of people with drug and alcohol issues in both North Norfolk and Norfolk as a whole. The last comprehensive needs assessment was published in March 2013, with a North Norfolk specific report in May 2013, prior to the implementation of the Norfolk Recovery Partnership.

Acknowledgements

We would like to thank all the Junction staff for candidly sharing their views, and for assisting with the many queries and clarifications.

Thank you to the service users who shared their views and the carers who allowed informal observation of their support group meeting.

Thank you to Vivienne Maskrey for proof reading the report.

References:

National Treatment Agency for Substance Misuse (NTA) 2010. Treatment Outcomes Profile (TOP) The protocol for reporting TOP: A keyworkers guide. Accessed online 19/3/2015:
http://www.nta.nhs.uk/uploads/treatment_outcomes_profile_keyworkers_guide_final_110110.pdf

Adult Substance Misuse Needs in Norfolk Districts: North Norfolk

NDAP Needs Assessment 2013, 'Substance Misuse in Norfolk'

NDAP North Norfolk Clinical Commissioning Group: Drugs and Alcohol

NDAP Substance Misuse in Norfolk: Clinical Commissioning Group Area, Needs Assessments: North Norfolk

List of Appendices:

1. Staff interview topic guide
2. Copy of client feedback form used by the Junction currently
3. Service user letters / testimonials

Appendix 1 – question areas / topics explored during informal staff interviews

1. Staff title and role
2. Background training and previous experiences
3. What does the role involve? Typical day/week?
4. Perception of range of client needs
5. Changes in service provided by the Junction over time (then and now)
6. What is working well at the Junction?
7. What is working less well / requires improvement?
8. Perceptions of unmet client needs
9. How would you like to see The Junction develop?
10. Strengths and weaknesses of the service
11. Development needs / training needs and wishes
12. Any other comments

CLIENT FEEDBACK FORM

The staff at The Matthew Project want to ensure our services are of the highest quality and that your needs are being met. In order that we might be able to monitor our work, we would be grateful if you could spare us the time to fill in this form.

Your comments are confidential. To ensure confidentiality, please seal the form in the envelope provided. Thank you for your time.

Your initials	Today's date:
How often do you come to the Matthew Project? First time / occasionally / weekly / more than once a week	Who do you see?
Do you come for support with (please circle): <div style="display: flex; justify-content: space-around; width: 100%;"> alcohol drugs caring for someone else? </div>	

If referred to the project: by who :-	
Self referred: How did you find out about the project :-	

On a scale of 0 to 3 how much improvement do you think you have made since coming to The Matthew Project regarding:

	None	Some	A lot	Great	Does not apply
The way I feel about myself	0	1	2	3	N/A
My physical health	0	1	2	3	N/A
My emotional health	0	1	2	3	N/A
Control/reducing use of drugs	0	1	2	3	N/A
Control/reducing use of alcohol	0	1	2	3	N/A
Relationships with other people	0	1	2	3	N/A

Please complete the next page

On a scale of 0 to 4 how would you rate The Matthew Project and/or the person with whom you have had appointments in the following areas?

	Poor	Okay	Good	Very Good	Great
Making you feel welcome	0	1	2	3	4
Explaining confidentiality	0	1	2	3	4
Telephone manner	0	1	2	3	4
Understanding your problems	0	1	2	3	4
Did you feel listened to	0	1	2	3	4
How were the drop in rooms	0	1	2	3	4

Overall do you feel you have been helped by The Matthew Project?

	0	1	2	3	4
--	---	---	---	---	---

Any other comments:

Can we anonymously use your comments to help with our work? YES / NO

03/03/2015

To Whom it may concern,

My name is

I started using the junction around 3 years ago after a progressive alcohol and depressive time in my life.

I sought help after things became so bad for me that i attempted suicide and spiralled into a very dark place.

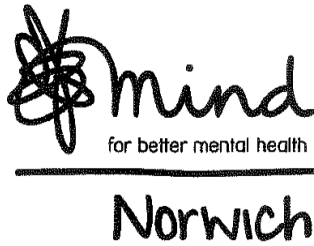
I can honestly, and with all my heart say that without Toby, Andy and everyone else who i have sought help from over the years through the Matthew project, I would not have made it and would have left my wife and children without a husband and father.

Myself, my wife Rosie and our eldest daughter Karoline are all still using the services provided through the junction after involvement by social services and all their advice and counselling has kept the whole family together through some very dark times.

It would be an extreme blow to All the people who have been helped and all the potential future clients who could miss out on the very best care and advice if funding is stopped.

In summary, the loss of funding would be a massive blow to not just our family but to the entire Cromer district

Yours sincerely



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As an employee of Mind, I have been using, free of charge, a small counselling room at The Junction for the last eight months. My colleague used the same room for several years before that.

The manager and staff at The Junction have always made me feel welcome; they are friendly, helpful and were very supportive when one of my clients became unwell at the start of a session.

They are respectful of my client's privacy, who have to pass through their lobby and busy office to access the counselling room.

Although the staff are busy seeing clients and working with groups, the atmosphere is relaxed and they always have time to answer any queries I might have.

It is a really nice environment to work in, and a real insight into the valuable service they provide in this area.

Tracey Blackett

Wellbeing Service Counsellor (BACP Accred)