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RiSC

Recovery in Shared Care:

Can Recovery and Harm-reduction
co-exist in a Shared Care service?

Authors

Dr Sandra Oelbaum *BSc (hons) MBChB (hons) MRCP*

GP with Special Interest in Substance Misuse

Clinical Lead, Addaction Liverpool

Claire Russell *RGN BSc MSc MBPsS*

Research Psychologist,

Research & Development Department, Addaction

Contributors

Stephen Purcell Shared Care Manager, Addaction Liverpool

Elisabeth Fraser Data Lead, Addaction Liverpool

Claire Hathaway National Data Lead, Addaction

Nick Evans Area Manager, Addaction Liverpool

Shared Care keyworkers: Pauline Antieul, Sharon Kirkpatrick,
Graham Vaughan, Carol Vidler and Amanda Wade

Administrative support: **Nikki Russell** Medical Liaison Administrator

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Executive Summary

RiSC

Recovery in Shared Care:

Can Recovery and Harm-reduction co-exist in a Shared Care service?

The RiSC study showed that proactive collaboration between Shared Care practices and the local Recovery community enabled service users to reduce their dependency on methadone and improve their physical health, mental health and psychosocial functioning. This integrated care approach enabled Recovery in a Harm-reduction setting.

Two groups of Liverpool Shared Care service users were recruited. The non-intensive group was 'treatment as normal'. The intensive group received a different model of care.

The intensive group received more frequent keyworker reviews, more focused physical and mental health interventions, had a bespoke Recovery package and were proactively encouraged to access the Recovery services with practical support to attend Recovery appointments.

In both groups a range of outcome measures looked at health, drug use and psychosocial activity.

Both groups were proactively encouraged to reduce their prescribed medication in a non-coercive manner.

A qualitative arm of the study was done independently by a local service user-led organisation and looked at a range of narrative outcomes.

Three Community Hubs were established and a Recovery Resource Document was compiled as a 'directory' of the Liverpool Recovery community.

RiSC Study Findings

Service users in the intensive group

- had significantly more time with keyworkers and peer mentors and significantly more involvement with the Recovery community
- decreased their average dose of methadone
- had better outcome measures of anxiety and self-reported health but worse outcome measures of depression
- had significantly more clinical interventions for both COPD and hepatitis C
- were able to address acute housing problems
- were much more likely to go to Recovery services
- and go to a wider variety of Recovery services

In both groups

- illicit drug use was at a very low level
- there was substantial improvement in all subjective health and well-being measures but the intensive group showed a wider range of improvements
- there was a non-significant decrease in WEMWBS scores
- there was virtually no recorded crime, but very low rates of education and employment
- there was no subjective decline in health or wellbeing whilst reducing their prescribed methadone

Aim

The Liverpool Recovery in Shared Care (RiSC) study examined whether a combination of modified prescribing (prescribing for Recovery) and proactive collaboration by Shared Care general practices with the Liverpool Recovery community (LRC) enabled people to reduce their dependency on opiate substitute therapy and improve their physical health, mental health and psychosocial functioning i.e. to recover.

Key words: Shared Care, primary care, Recovery, Liverpool Recovery community (LRC), Addaction community Recovery champion (CRC), opiate substitute therapy (OST), keyworker (KW).

Introduction

Harm reduction has always been a pragmatic way of getting people dependent on heroin into treatment, reducing damage and saving lives (1). People transferred their opiate dependency to a legal prescription. However, harm reduction does not address the issue of dependency.

Over the last few years, it has become increasingly clear that society wants to offer people on opiate substitution therapy (OST) the chance to improve their health and social functioning and reduce their drug dependency, in other words, to recover. A number of recent reports (2–5) have changed the direction of treatment for drug dependence, moving the emphasis from harm reduction to Recovery.

Likelihood of Recovery is inversely related to length of time in treatment and number of treatment episodes (4).

Increased healthy life expectancy and reducing health inequalities are outcomes for the Public Health Outcomes Framework 2013-2016 (6).

People on OST have worse health than the general population (7–10).

A recent study done collaboratively between Royal Liverpool University Hospital and Addaction Liverpool showed a high prevalence of self-reported respiratory symptoms but little treatment amongst heroin addicts (9).

Developing an integrated care model for people in Shared Care services for substance misuse may allow health inequalities to be addressed (11).

Shared Care is a well established model of delivering treatment in primary care, in the local communities close to people's homes (12). Around 1,300 people are currently prescribed by the Liverpool Shared Care Service. Geographically, the service covers the whole city and has strong support from the Liverpool GP community.

Addaction's keyworkers work in the surgeries with the prescribing GPs. The surgery therefore provides continuity of care for both the service users and their families. Caring for people in the community both normalises and de-stigmatises their treatment and the treatment is accessible because it is local.

Liverpool has a vibrant Recovery community comprised of over thirty independent services and representing the spectrum of Recovery approaches (*Appendix 5*).

Historically, prescribing services and community based Recovery services have worked in parallel.

It seems to be the case that people on OST tend not to use health services except in extreme circumstances. The most reliable point of contact with the health care system is picking up their OST prescription. There may be considerable potential for focusing relevant services around their prescription collection in order to develop a model of integrated care for this socially excluded group.

Evaluation Framework

The RiSC study was a quasi-experimental study with mixed methodology (quantitative and qualitative methods) and longitudinal design. Analyses were audit, statistical, thematic and discursive.

The RiSC study quantitative arm employed a wide range of objective health, substance misuse and psychosocial outcome measures.

The RiSC study qualitative arm looked at the subjective experience of service users, using process evaluation and service user outcome evaluations.

The planning, training, implementation and progress of the project were evaluated by a small team of researchers.

Method

Two groups of Liverpool Shared Care service users were recruited. The non-intensive group was 'treatment as normal'. The intensive group received a different model of care.

The intensive group received more frequent keyworker reviews, more focused physical and mental health interventions, had a bespoke Recovery package and were proactively encouraged to access the Recovery services.

In both groups a range of outcome measures looked at health, drug use and psychosocial activity.

Both groups were proactively encouraged to reduce their prescribed medication in a non-coercive manner (Prescribing for Recovery).

A service user identification system was used.

Four primary care sites were identified, three GP surgeries with a long history of involvement in Shared Care (Brownlow Group Practice, central Liverpool, Great Homer Street Medical Centre, Everton, north Liverpool and Vauxhall Medical Centre, Vauxhall, north Liverpool plus the Addaction Croxteth Intermediate Clinic, north Liverpool).

RiSC Study: *quantitative arm*

Non-intensive group

Prescribing for Recovery plus low intensity interface with Liverpool Recovery community.

Low intensity interface

Health and wellbeing tools administered at 0, 3 and 6 months (appendices 1 to 3).

Service user reviewed every month by keyworker.

Keyworker and service user used the Recovery Resource Document (appendix 5) as the tool for general explanation and encouragement to engage with the Recovery Services.

Self referral to appropriate Recovery Services advised.

Intensive group

Prescribing for Recovery plus high intensity interface with Liverpool Recovery community.

High intensity interface

A Recovery exposure day was held on the 29th May 2013 (CRCs, keyworkers, service users and representatives from Liverpool Recovery community).

Service user reviewed every two weeks by keyworker.

Health and wellbeing tools administered fortnightly by keyworker or CRC.

Keyworker and service user used Recovery Resource Document as the tool to identify appropriate community Recovery agencies.

Facilitated referrals and supported appointments to LRC were made by the keyworker or CRC. Each service user had a bespoke package of Recovery interventions addressing their current needs which was subject to fortnightly review.

There was proactive encouragement and innovative working with the GP practices to improve access to services for chronic obstructive pulmonary disease (COPD) and hepatitis C.

Keyworkers worked collaboratively with the CRCs in order to deliver these interventions.

Collaboration with the Recovery Community

The Liverpool Recovery Community represented a spectrum of services covering targeted interventions, behaviour change and social support. Services were provided both by professionals and peer mentors. The Liverpool Recovery Community comprised around 30 different service providers in Liverpool.

There was no comprehensive directory of the Liverpool Recovery Services. Addaction therefore compiled the LRC-Addaction *Recovery Resource Document* updating the Resource Document monthly (*Appendix 5*). This clarified and strengthened the Shared Care-LRC interface and was used by keyworkers, CRCs and service users in the consultations.

Community Recovery Hubs (Hubs)

Most Recovery services were based in the city centre but most service users lived around one hour's travelling time from Liverpool city centre. Three Recovery Hubs were set up in locations to reflect where service users lived. Representatives from the wider Recovery Community organisations came out to the Hubs on a rolling programme.

Outcome Measures

Study design

Retention, attendance, time spent with keyworker/CRC, care responsibilities.

Physical health

Prescribed OST medication, diagnostic and treatment measures on COPD and hepatitis C.

Mental health

PHQ-9 (depression scale), GAD-7 (anxiety scale), self-reported physical health, self-reported quality of life, self-reported psychological health, mental wellbeing (WEMWBS).

Substance misuse

Illicit and intravenous drug use, Audit (alcohol score).

Psychosocial

Referral to Recovery Services, employment, education, training, crime and housing.

COPD (8, 9) and hepatitis C (7) are the two most prevalent physical health problems amongst this service user group. However, the service users often find access to care challenging and tend to present late to secondary care (8, 9). The study developed innovative ways in which services could be delivered in primary care to this 'hard to reach group'.

Prescribing for Recovery (*Modified Prescribing*)

Service users were encouraged to reduce their OST medication using local reduction guidelines (*Appendix 6 & 7*). These were not a proscriptive formula for reduction but used in the context of enabling Recovery through improvement of physical health, mental health and psychosocial functioning.

Selection of study participants

The selection of service users for the pilot reflected the service user group in general. The following characteristics were reflected in both the low and high intensity groups:

Service users who had caring responsibilities.

Service users who were on a reducing regime of prescribed OST.

Service users who were on a maintenance dose of prescribed OST.

Service users who were on high dose methadone (>30ml).

Service users who were on low dose methadone (<30ml).

Service users who were on buprenorphine.

Service users who continued to use drugs illicitly.

Service users who drank alcohol.

Service users who were in treatment longer than 5 years.

There is evidence that people in treatment for shorter periods have a better chance of recovering (4). This is a particular challenge for Shared Care as many of the service users have both been in treatment for 10 years or more and have had numerous episodes of treatment interventions (13).

RiSC Study: *qualitative arm*

The qualitative arm of the research was done independently by Community Voice. This is a local service user-led group run by people who have been affected by drug or alcohol use.

Prior to the start of the study, Addaction held an open day at a neutral venue where Community Voice was able to meet the study participants for the first time. Several Recovery community organisations were also present and service users were encouraged to access these services.

This meeting was used to explain the overall RiSC study purpose and design and the role of Community Voice in the RiSC study. Voluntary participation was stressed and service users were encouraged to contact Community Voice at any time.

Face-to-face and telephone interviews were used to complete the surveys.

Appropriate consent was obtained.

Results

RiSC Study: *Quantitative arm*

Retention

	Number entering study	Number completing study	Number not completing study	Number lost to follow-up
Intensive	30	18	12	3
Non-intensive	33	24	9	1

60% of the intensive group completed the study, 3 service users were lost to follow up.

73% of the non-intensive group completed the study, 1 service user was lost to follow up.

Reasons for non-completion

	Personal reasons	Employment	Criminal Justice	Inpatient detox unit	Drug free/successful completion
Intensive	5	1	1	1	1
Non-intensive	2	0	3	1	3

Of those not completing the study, 33% participants became drug free or went into detox.

Of those people not completing the study 40% participants had unavoidable personal reasons.

1 person gained full-time employment.

Of those people not completing the study 22% participants were transferred to the Addaction criminal justice clinic.

Appointments

Total appointments (face-to-face plus telephone) intensive group = 300.

Total appointments (face-to-face plus telephone) non-intensive group = 86.

Face-to-face total

	Attended	% Total	Service user DNA	% Total	Cancelled by service user	% Total	Cancelled by KW	% Total
Intensive	219	73%	18	6%	3	1%	8	3%
Non-intensive	65	76%	3	3%	0	0%	0	0%

Telephone

	Successful	% Total	Unsuccessful	% Total
Intensive	52	17%	0	0%
Non-intensive	18	21%	0	0%

There were 3.5 times more total appointments in the intensive than the non-intensive group.

There were 3.4 times more face-to-face appointments in the intensive than the non-intensive group.

There were 2.9 times more telephone appointments in the intensive than the non-intensive group.

Time spent in appointments

	Average time spent with KW per fortnight	Average time spent with CRC/volunteer per fortnight
Intensive	0.64 hours	0.16 hours
Non-intensive	0.44 hours	0.04 hours

Participants in the intensive group had around 1.5 times more time with the KW than participants in the non-intensive group.

Participants in the intensive group had around four times more time with the CRCs/volunteers than participants in the non-intensive group.

Care responsibilities

Participants were asked at each attendance whether they had care responsibilities.

	Yes	% Yes	No	% No	Total
Intensive	99	37%	172	63%	271
Non-intensive	36	43%	47	57%	83

Participants identified themselves as having care responsibilities 37% of the time in the intensive and 43% of the time in the non-intensive group.

Prescribing for Recovery

Buprenorphine

	Number	Number decreasing dose	Number increasing dose	Average dose start of study	Average dose end of study
Intensive	3	3	0	5.2	4.03
Non-intensive	2	1	0	8.0	4.0

100% intensive group decreased their dose of buprenorphine.

50% non-intensive group decreased their dose of buprenorphine.

0% intensive group increased their dose of buprenorphine.

0% non-intensive group increased their dose of buprenorphine.

Number of people on buprenorphine was very small.

Methadone

	Number	Number decreasing dose	Number increasing dose	Average dose start of study	Average dose end of study
Intensive	26	10	2	52.5	49.4
Non-intensive	30	9	7	43.0	44.4

38% intensive group decreased their dose of methadone.

30% non-intensive group decreased their dose of methadone.

8% intensive group increased their dose of methadone.

23% non-intensive group increased their dose of methadone.

There was a 3.1 ml reduction in average dose of methadone over the study in the intensive group=6% reduction.

There was a 1.4 ml increase in average dose of methadone over the study in the non-intensive group=3% increase.

More people in the intensive group decreased their dose of methadone and fewer people in the intensive group increased their dose of methadone. There was a 6% reduction in the average dose of methadone in the intensive group and a 3% increase in the average dose of methadone in the non-intensive group.

Mental health diagnostic tools

PHQ-9

	Average PHQ-9 score at start of study	Average PHQ-9 score at end of study	Number of service users with improved scores	Number of service users with worsening scores	Number of service users with no change in scores
Intensive n=29	8	7	14	12	3
Non-intensive n=28	7	6	18	7	3

There was a 12.5% reduction in the PHQ-9 score in the intensive group.

There was a 14% reduction in the PHQ-9 score in the non-intensive group.

48% of the intensive group improved their score.

64% of the non-intensive group improved their score.

41% of the intensive group had worse scores.

25% of the non-intensive group had worse scores.

10% of both groups did not change their scores.

The non-intensive group showed better reduction in score, greater percentage of people with improved scores and lower percentage of people with worsening scores.

GAD-7

	Average GAD-7 score at start of study	Average GAD-7 score at end of study	Number of service users with improved scores	Number of service users with worsening scores	Number of service users with no change in scores
Intensive n=29	8	6	19	8	2
Non-intensive n=28	6	5	17	7	4

There was a 25% reduction in score in the intensive group.

There was a 17% reduction in score in the non-intensive group.

66% of the intensive group improved their scores.

60% of the non-intensive group improved their scores.

27% of the intensive group had worse scores.

25% of the non-intensive group had worse scores.

7% of the intensive group and 14% of the non-intensive group did not change their scores.

The intensive group showed better reduction in score and greater percentage of people with improved scores.

Alcohol Audit scores

	Average audit score/ score at start of study	Average audit score/ score at end of study	Number of service users with improved scores	Number of service users with worsening scores	Number of service users with no change in scores
Intensive n=29	2	2	4	2	23
Non-intensive n=28	1	1	3	2	23

Problematic drinking was at a very low level in both groups.

Self-reported psychological health

	Average psychological health score at beginning of study	Average psychological health score at end of study	Number of service users with improved scores	Number of service users with worsening score	Number of service users with no change in scores
Intensive n=29	10	10	15	10	4
Non-intensive n=28	12	11	9	13	6

There was no change in the average score in the intensive group.

There was a reduction of 8% in score in the non-intensive group.

52% of the intensive group improved their scores.

32% of the non-intensive group improved their scores.

34% of the intensive group had worse scores.

46% of the non-intensive group had worse scores.

14% of the intensive group and 21% of the non-intensive group did not change their scores.

The intensive group showed no change in score and the non-intensive group showed a decrease in score.

In the intensive group a greater percentage of people improved their scores and a lower percentage of people showed worsening scores compared to the non-intensive group.

A greater percentage of people in the non-intensive group showed no change in their scores.

Self-reported physical health

	Average physical health score at beginning of study	Average physical health score at end of study	Number of service users with improved scores	Number of service users with worsening scores	Number of service users with no change in scores
Intensive n=29	11	12	15	8	6
Non-intensive n=28	12	11	8	9	11

There was an improvement of 9% in score in the intensive group.

There was a reduction of 8% in score in the non-intensive group.

52% of the intensive group improved their scores.

28% of the non-intensive group improved their scores.

28% of the intensive group had worse scores.

32% of the non-intensive group had worse scores.

21% of the intensive group and 39% of the non-intensive group did not change their scores.

The intensive group showed an increase in score and the non-intensive group showed a decrease in score.

In the intensive group a greater percentage of people improved their scores and a lower percentage of people showed worsening scores compared to the non-intensive group.

A greater percentage of people in the non-intensive group showed no change in their scores.

Self-reported quality of life

	Average quality of life score at beginning of study	Average quality of life score at end of study	Number of service users with improved scores	Number of service users with worsening scores	Number of service users with no change in scores
Intensive n=29	11	13	15	8	6
Non-intensive n=28	15	13	5	14	9

There was an improvement of 18% in score in the intensive group.

There was a reduction of 13% in score in the non-intensive group.

52% of the intensive group improved their scores.

18% of the non-intensive group improved their scores.

28% of the intensive group had worse scores.

50% of the non-intensive group had worse scores.

21% of the intensive group and 32% of the non-intensive group did not change their scores.

The intensive group showed an increase in score and the non-intensive group showed a decrease in score.

In the intensive group a greater percentage of people improved their scores and a lower percentage of people showed worsening scores compared to the non-intensive group.

A greater percentage of people in the non-intensive group showed no change in their scores.

WEMWBS

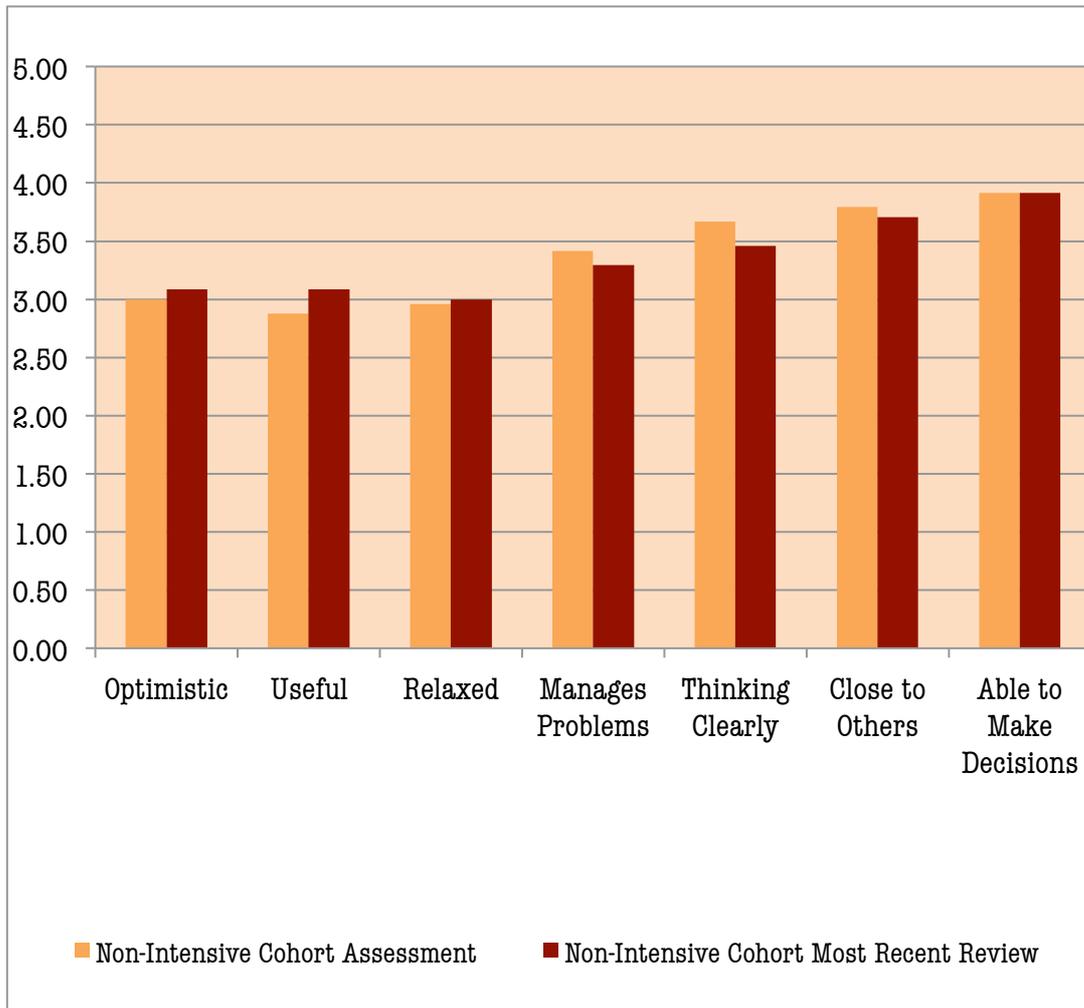
The table below highlights the wellbeing scores for service users at baseline in the intensive and non-intensive cohorts. Two bar charts also illustrate these findings. The most recent review point for the intensive cohort is also cited, alongside the sample size, including all service users who produced baseline and most review scores (one time only data points were excluded from the analysis, which does reveal a potential selection bias for this study).

Wellbeing Scores:

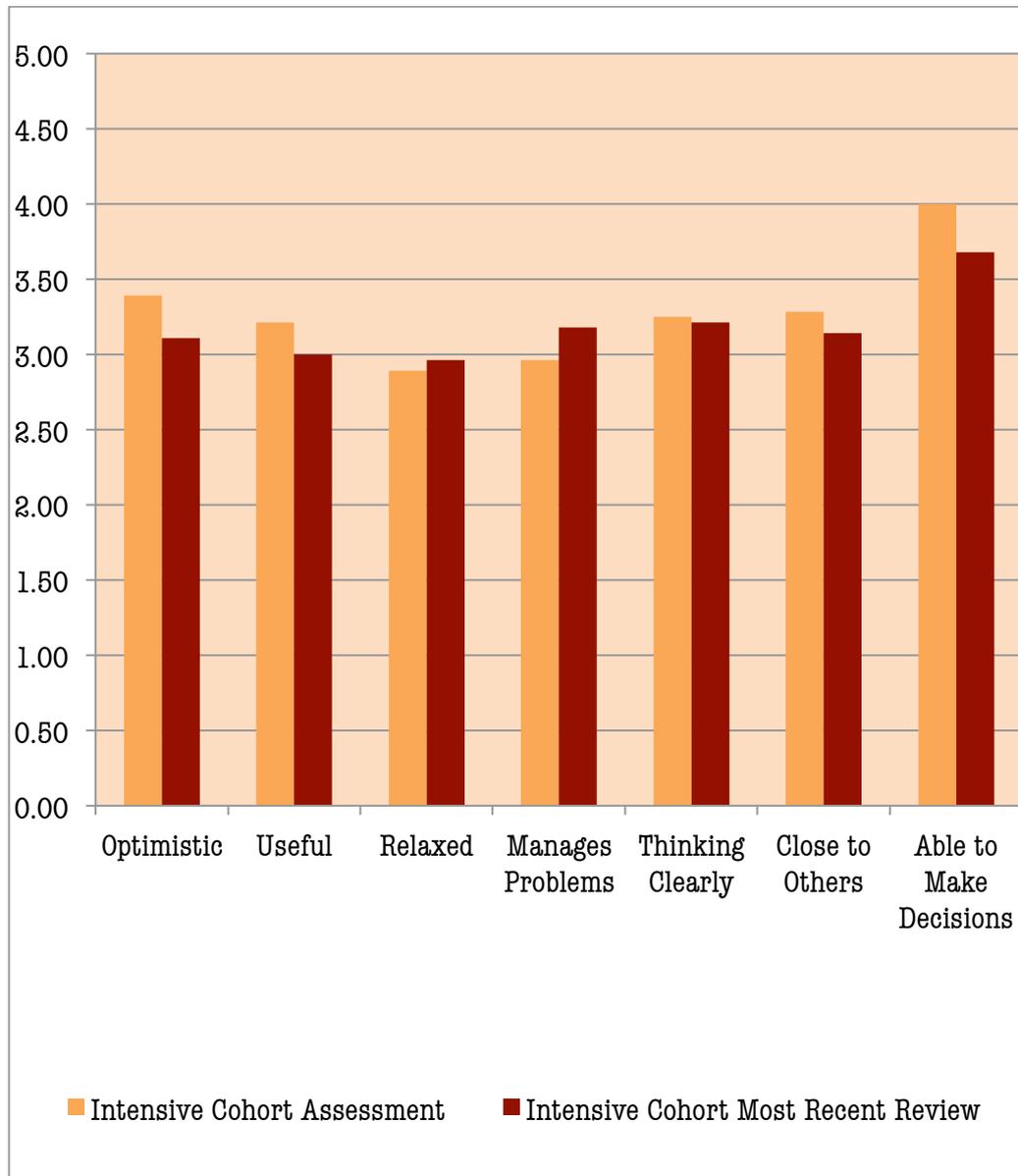
Non-intensive Cohort N=24; Intensive Cohort N=28

Wellbeing Scores	Non-intensive Cohort at Baseline	Non-intensive Cohort at Most Recent Review	Intensive Cohort at Baseline	Intensive Cohort at Most Recent Review
Total Wellbeing Score (Range 7 – 35)	23.63	23.54	23.00	22.29
Average Wellbeing Score (Range 1 – 5)	3.38	3.36	3.29	3.18

Average Wellbeing Scores: Non-intensive Cohort N=24



Average Wellbeing Scores: Intensive Cohort N=28



Whilst the total and average wellbeing scores of the non-intensive cohort were higher than the intensive cohort at baseline, this was not a statistically significant difference. Overall, for both cohorts, wellbeing total and average scores decreased slightly by the most recent review. The individual wellbeing areas on the graphs above demonstrate this general trend, across the majority of the domains.

However, these findings are not statistically significantly different.

Physical health

COPD

	Saw GP/practice nurse	Attended A&E	Was hospitalised	Used an inhaler	Treated with antibiotics/steroids
Intensive	64	1	2	32	13
Non-intensive	8	0	0	7	2

Each event was recorded throughout the study.

People in the intensive group

- saw the GP/practice nurse 8 times more than in the non-intensive group
- were seen in hospital 3 times more than in the non-intensive group
- used an inhaler 4.5 times more than in the non-intensive group
- were treated with antibiotics/steroids 6.5 times more than in the non-intensive group

The intensive group showed 5.5 times more treatment activity around COPD than the non-intensive group.

Hepatitis C

	Saw GP or practice nurse	Had hep C test	Had liver ultrasound scan	Had hep C treatment	Went for hep C counselling
Intensive	54	43	1	0	0
Non-intensive	3	3	1	1	1

Each event was recorded throughout the study.

People in the intensive group

- saw the GP/practice nurse 18 times more than in the non-intensive group
- had 14 times more hep C tests

The intensive group showed 16 times more treatment activity around hepatitis C than the non-intensive group.

Substance Misuse

Alcohol use

	Average number of days drinking at start of study	Average number of days drinking at end of study	Number of service users decreasing days drinking	Number of service users increasing days drinking	Number of service users with no change in days drinking
Intensive n=29	1	1	3	1	24
Non-intensive n=28	1	1	3	3	22

Alcohol consumption was at a low level in both groups with no significant change across the study.

Heroin use

	Average number of days using heroin at start of study	Average number of days using heroin at end of study	Number of service users decreasing days using heroin	Number of service users increasing days using heroin	Number of service users with no change in days using heroin
Intensive n=29	2	1	5	5	19
Non-intensive n=28	3	2	7	6	15

Heroin use was low in both groups.

The average number of days using heroin decreased by 50% in the intensive group and 33% in the non-intensive group.

17% intensive group and 25% non-intensive group decreased days using heroin.

17% intensive group and 21% non-intensive group increased days using heroin.

65% intensive group and 53% non-intensive group showed no change in days using heroin.

The intensive group showed a greater reduction in average days using heroin than the non-intensive group and a lower percentage of people increasing their use of heroin.

The non-intensive group had a greater percentage of people decreasing their use of heroin and fewer people showing no change in their use of heroin.

Crack cocaine use

	Average number of days using crack cocaine at start of study	Average number of days using crack cocaine at end of study	Number of service users decreasing days using crack cocaine	Number of service users increasing days using crack cocaine	Number of service users with no change in days using crack cocaine
Intensive n=29	1	1	1	5	23
Non-intensive n=28	1	1	2	1	25

Crack cocaine use was very low in both groups.

More service users in the intensive group increased their use of crack cocaine.

79% of the intensive group and 89% of the non-intensive groups showed no change in their use of crack cocaine.

Powder cocaine use

	Average number of days using powder cocaine at start of study	Average number of days using powder cocaine at end of study	Number of service users decreasing days using powder cocaine	Number of service users increasing days using powder cocaine	Number of service users with no change in days using powder cocaine
Intensive n=29	0	0	0	0	29
Non-intensive n=28	0	0	0	1	27

Powder cocaine use was very low in both groups.

100% of the intensive group and 96% of the non-intensive groups showed no change in their use of powder cocaine.

Benzodiazepine use

	Average number of days using benzodiazepine at start of study	Average number of days using benzodiazepine at end of study	Number of service users decreasing days using benzodiazepine	Number of service users increasing days using benzodiazepine	Number of service users with no change in days using benzodiazepine
Intensive n=29	0	0	1	1	27
Non-intensive n=28	0	0	0	2	26

Benzodiazepine use was very low in both groups.

93% intensive group and 93% non-intensive groups showed no change in their use of benzodiazepine.

Cannabis use

	Average number of days using cannabis at start of study	Average number of days using cannabis at end of study	Number of service users decreasing days using cannabis	Number of service users increasing days using cannabis	Number of service users with no change in days using cannabis
Intensive n=29	1	1	3	2	25
Non-intensive n=28	3	1	4	1	23

Cannabis use was very low in both groups.

86% intensive group and 82% non-intensive groups showed no change in their use of cannabis.

Other drug use

	Average number of days using other drugs at start of study	Average number of days using other drugs at end of study	Number of service users decreasing days using other drugs	Number of service users increasing days using other drugs	Number of service users with no change in days using other drugs
Intensive n=29	0	0	0	0	29
Non-intensive n=28	0	0	2	0	26

Use of other drugs was very low in both groups.

100% intensive group and 93% non-intensive groups showed no change in their use of other drugs.

Injecting drug use

	Average number of days injecting at start of study	Average number of days injecting at end of study	Number of service users decreasing days injecting	Number of service users increasing days injecting	Number of service users with no change in days injecting
Intensive n=29	0	0	0	0	29
Non-intensive n=28	0	1	0	0	27

Injecting behaviour was very low in both groups.

100% intensive group and 96% non-intensive groups showed no change in their use of injected drugs.

Psychosocial activity

Shoplifting

	Average number of days shoplifting at start of study	Average number of days shoplifting at end of study	Number of service users decreasing days shoplifting	Number of service users increasing days shoplifting	Number of service users with no change in days shoplifting
Intensive n=29	0	0	0	1	28
Non-intensive n=28	0	0	0	0	28

There was almost no shoplifting in either group.

Drug selling

	Average number of days drug selling at start of study	Average number of days drug selling at end of study	Number of service users decreasing days drug selling	Number of service users increasing days drug selling	Number of service users with no change in days drug selling
Intensive n=29	0	0	0	1	28
Non-intensive n=28	0	0	0	0	28

There was almost no drug selling in either group.

Other theft

	Average number of days other theft at start of study	Average number of days other theft at end of study	Number of service users decreasing days other theft	Number of service users increasing days other theft	Number of service users with no change in days other theft
Intensive n=29	0	0	0	0	28
Non-intensive n=28	0	0	0	0	28

There was no theft in either group.

Assault

	Average number of days assault at start of study	Average number of days assault at end of study	Number of service users decreasing days assault	Number of service users increasing days assault	Number of service users with no change in days assault
Intensive n=29	0	0	0	0	29
Non-intensive n=28	0	0	0	0	28

There was no assault committed by either group.

Housing problems

	Number of service users with acute housing problems at start of study	Number of service users with acute housing problems at end of study	Number of service users at risk of eviction at start of study	Number of service users at risk of eviction at end of study
Intensive n=29	7	4	2	1
Non-intensive n=28	2	3	1	2

The number of service users in the intensive group with acute housing problems decreased by 55%.

The number of service users in the non-intensive group with acute housing problems increased by 66%.

Working

	Number of service users working at start of study	Number of service users working at end of study	Number of service users in education at start of study	Number of service users in education at end of study
Intensive n=29	0	1	0	0
Non-intensive n=28	3	2	2	1

1 service user from the intensive group started working. 96% were not working.

92% of the non-intensive group were not working.

100% of the intensive group were not in education.

96% of the non-intensive group were not in education.

Rates of education and employment for both groups were extremely low.

Referrals to Recovery agencies

	Number of referrals to Recovery Agencies
Intensive	313
Non-intensive	81

There were almost 4 times as many total referrals to Recovery agencies from the intensive than the non-intensive group.

Number of referrals to different agencies

Number of referrals to different agencies	Intensive	Non-intensive
Hubs	85	36
Addaction Recovery Services	43	26
Housing agencies	43	1
Detox	27	2
Education/Employment/Training	61	10
Advice and information	47	5
Recovery champion training	5	0

Referral to different agencies as percentage of total referrals

	Intensive	Non-intensive
Hubs	27%	44%
Addaction Recovery Services	14%	32%
Housing agencies	14%	1%
Detox	9%	3%
Education/Employment/Training	19%	12%
Advice and information	15%	6%
Recovery champion training	2%	0%

There were virtually no referrals from the non-intensive group to housing agencies.

Most referrals from the non-intensive group were to the Addaction Community Recovery Hubs (44%) and Addaction Recovery Services (32%). There were a smaller number of referrals to employment/education/training (12%), advice/information agencies (6%), detox units (3%) and housing agencies (1%). There were no referrals to Recovery Champion Training.

In the intensive group there were markedly more referrals to employment/education/training (19%), advice/information agencies (15%), housing agencies (14%), detox units (9%) and 2% referrals were for Recovery Champion training.

In the intensive group the percentage of referrals to Addaction Community Hubs was around half that of the non-intensive group and the percentage of referrals to Addaction Recovery Services was around one-third that of the non-intensive group.

In the intensive group the absolute figures show that referrals to Addaction Community Hubs were twice that of the non-intensive group and referrals to Addaction Recovery Services were almost twice that of the non-intensive group.

This reflects the wider range of referrals from the intensive group compared to the non-intensive group.

Recovery Hubs

Recovery Hubs	North Liverpool	Dingle	South Liverpool
Number of meetings	29	19	1
Number of guest speakers	28	14	1
Cumulative total Shared Care service users	233	80	5
Cumulative total former Shared Care service users	4	5	0
Cumulative total guests of service users	19	10	2
Cumulative total staff/CRCs/volunteers	271	117	20
Cumulative total service user DNA	130	38	18

The north Liverpool Hub was very successful, the Dingle Hub reasonably successful and the South Liverpool Hub unsuccessful. The North and Dingle Hubs continue to run successfully.

RiSC Study: *qualitative arm*

Contacts were a mixture of face-to-face interviews (total 22) and telephone contacts.

Telephone contact (conducted throughout study)	Number of replies
First contact	18
Second contact	14
Third contact	12
Fourth contact	14
Fifth contact	27

The effectiveness of telephone contacts improved throughout the study.

General Questionnaire

	Intensive	Non-intensive
How have you been feeling over the last month?	<p>“Very motivated, really want to achieve this goal!”</p> <p>“Up and down.”</p> <p>“Should have done this a long time ago, better late than never.”</p>	<p>“Very stable at the moment, very confident I won’t use again.”</p> <p>“Clean from street drugs.”</p> <p>“Just stopped my script and without my keyworkers support I know I wouldn’t have done it – respect to the staff at Addaction.”</p> <p>“Very down at the moment.”</p> <p>“Up and down.”</p>
Do you feel different now than before the beginning of June?	<p>9 people answered “no”.</p> <p>“Keep getting motivated with the good feedback that I get, makes you want to go further.”</p>	<p>7 people answered “no”</p> <p>7 people answered “yes”</p> <p>“Yes I feel enthusiastic.”</p>
What else would you like to be doing to make these months positive?	<p>“More places to attend for families in Recovery where you can take children.’</p> <p>“Getting active and starting at a gym.”</p> <p>Training was also a regular theme.</p> <p>One person added that they “feel more listened too rather than talked at, this has made a big difference in my Recovery.”</p>	<p>The main theme in response to this was that people wanted to fill their time in getting back into employment and doing training courses. Also to do more exercise and improve their health.</p>
Has anything else changed during this time?	<p>Most of the service users felt stable and that they were coping with the reductions well.</p>	<p>Four service users have stopped having scripts and have gained full time employment or education.</p>
Is there anything Addaction could be doing, that they haven’t yet done?	<p>All the responses to this question showed that Addaction has been doing everything they can to support this group of service users.</p>	<p>All service users were positive about the support that they are receiving from Addaction.</p>

There was very good feedback overall from service users in both the intensive and non-intensive groups.

Wellbeing Questionnaire

‘I’ve been feeling optimistic about the future’

	Intensive % increase or decrease over study period	Non-intensive % increase or decrease over study period
None of the time	-75%	-33%
Rarely	-100%	0%
Some of the time	-75%	-33%
Often	-17%	133%
All of the time	125%	0%
Total	30	30

Both groups became more optimistic over the study period.

By the end of the study, the intensive group showed marked movement to feeling optimistic **all of the time**.

The non-intensive group **often** felt optimistic.

‘I’ve been feeling useful’

	Intensive % increase or decrease over study period	Non-intensive % increase or decrease over study period
None of the time	-50%	0%
Rarely	-100%	0%
Some of the time	-36%	-18%
Often	40%	67%
All of the time	117%	0%
Total	30	30

Both groups felt more useful over the study period.

By the end of the study, the intensive group showed marked movement to feeling useful **all of the time**.

The non-intensive group **often** felt useful.

'I've been feeling relaxed'

	Intensive % increase or decrease	Non-intensive % increase or decrease
None of the time	0%	0%
Rarely	-33%	-33%
Some of the time	0%	-14%
Often	-13%	200%
All of the time	18%	0%
Total	30	30

Both groups felt more relaxed over the study period.

By the end of the study, the intensive group showed slight movement towards feeling relaxed **all of the time**.

The non-intensive group showed marked movement feeling relaxed **often**.

'I've been dealing with my problems well'

	Intensive % increase or decrease	Non-intensive % increase or decrease
None of the time	-33%	0%
Rarely	0%	-33%
Some of the time	-53%	-20%
Often	75%	0%
All of the time	100%	0%
Total	30	30

By the end of the study, the intensive group showed marked movement to dealing with their problems well **all of the time** or **often**.

The non-intensive group showed no movement to dealing with their problems **all the time** or **often**.

‘I’ve been thinking clearly’

	Intensive % increase or decrease	Non-intensive % increase or decrease
None of the time	0%	-33%
Rarely	-50%	-33%
Some of the time	-29%	0%
Often	-36%	-29%
All of the time	78%	350%
Total	30	30

Both groups thought more clearly over the study period.

By the end of the study, the intensive group showed movement to thinking clearly **all of the time**.

The non-intensive group showed marked movement to thinking clearly **all of the time**.

‘I’ve been feeling close to other people’

	Intensive % increase or decrease	Non-intensive % increase or decrease
None of the time	0%	-40%
Rarely	-25%	-42%
Some of the time	0%	-25%
Often	-33%	75%
All of the time	30%	100%
Total	30	30

Both groups felt closer to other people over the study period.

By the end of the study, the intensive group showed movement to feeling closer to other people **all of the time**.

The non-intensive group showed marked movement to feeling closer to other people **all of the time** or **often**.

‘I’ve been able to make up my own mind about things’

	Intensive % increase or decrease	Non-intensive % increase or decrease
None of the time	0%	0%
Rarely	0%	-33%
Some of the time	-29%	20%
Often	-13%	-14%
All of the time	64%	33%
Total	30	30

Both groups felt more able to make up their own mind about things over the study period.

By the end of the study, the intensive group showed marked movement to making up their own mind about things **all of the time**.

The non- intensive group showed movement towards making up their own mind about things **all of the time**.

Overall findings

Over the study both groups showed substantial improvement on all subjective measures.

The intensive group showed considerably more improvement in feeling optimistic and useful, dealing with problems and making up their own mind. The non-intensive group showed considerably more improvement in feeling relaxed and closer to other people, and thinking clearly.

Overall, participants were very happy with the support and direction that they received from Addaction. There was no subjective decline in health or wellbeing while reducing their prescribed methadone/buprenorphine

Summary of Results

The RiSC study design was robust with high attendance rates and 7% participants lost to follow up.

It is noteworthy that around 40% of participants had caring responsibilities.

Substance misuse

In the intensive group participants had 3.5 times more appointments, 150% more time with the keyworker and 400% more time with the CRC/volunteer compared to the non-intensive group.

In the intensive group average dose of methadone decreased, a greater percentage of participants decreased their methadone dose and a lower percentage of participants increased their methadone dose compared to the non-intensive group.

The number of service users in the study on buprenorphine was very small (8% study).

In both groups there was a low level of heroin use and a very low level of problematic drinking, crack and powder cocaine use, benzodiazepine use, cannabis use, other drug use and injecting drug use.

Mental health

In the non-intensive group there was a greater improvement in PHQ-9 (depression) score, greater percentage of people with improved scores and lower percentage of people with worsening PHQ-9 scores compared to the intensive group.

In the intensive group there was greater improvement in GAD-7 (anxiety) score and a greater percentage of people with improved scores compared to the non-intensive group.

In the intensive group there were improved average scores of self-reported psychological health, physical health and quality of life compared to the non-intensive group.

Also in the intensive group there was a greater percentage of participants with improving self-reported scores and a lower percentage of participants with worsening self-reported scores compared to the non-intensive group.

The recorded WEMWBS data showed a non-significant decline in scores in both groups. This is not in line with the self-reported data and the overall findings from the qualitative arm of the study.

It is possible that the experience of wellbeing as recorded by WEMWBS is not particularly distinct between the two cohorts or at either time point of measurement. One explanation for the absence of difference is that both cohorts report relatively high wellbeing (in line with the national normed data) at both time points.

Physical health

In the intensive group there was 5.5 times more treatment activity around COPD than in the non-intensive group.

In the intensive group there was 11 times more treatment activity around hepatitis C than in the non-intensive group.

Psychosocial activity

There was virtually no recorded crime in either group.

Rates of education and employment for both groups were extremely low.

In the intensive group, there was a significant impact addressing acute housing problems compared to the non-intensive group. There were virtually no referrals from the non-intensive group to housing agencies.

In the intensive group there were almost 4 times as many referrals, to a much wider range of Recovery Services than in the non-intensive group.

Both groups had a majority of referrals to the Addaction Community Hubs and Addaction Recovery Services.

In the intensive group there were significantly more referrals to employment/education/training, advice/information agencies, housing agencies, detox units and referrals for Recovery Champion Training.

Qualitative arm

Over the study both groups showed substantial improvement on all subjective measures.

The intensive group showed considerably more improvement in feeling optimistic, useful, dealing with problems and making up their own mind. The non-intensive group showed considerably more improvement in feeling relaxed, closer to other people and thinking clearly.

Overall, participants were very happy with the support and direction that they received from Addaction. There was no subjective decline in health or wellbeing whilst reducing their prescribed methadone/buprenorphine.

Conclusions

The RiSC study design was robust with high attendance rates and less than 7% participants lost to follow up.

Around 40% of participants had caring responsibilities.

The low levels of alcohol use, heroin use, illicit and injecting drug use and low levels of recorded crime demonstrate that allocation of service users to Shared Care had been appropriate.

The RiSC model of care was successful in delivering significantly more face-to-face time from both keyworkers and Recovery champions.

The service users in the intensive group improved on most measures. They reported reduced doses of prescribed methadone, improved anxiety scores, improved self-reported physical health, psychological health and quality of life measures, improved COPD and hepatitis C interventions and improved housing. The non-intensive group reported improved depression scores.

Wellbeing results overall were inconclusive. The WEMWBS data showed a (non-significant) decline in both groups, which may be related to the high levels of wellbeing reported at the start of the study. The self-reported indicators of wellbeing showed an overall improvement but with some differences between the intensive and non-intensive groups.

The wellbeing results indicate that a 'Recovery journey' is a complex process during which individuals will be challenged by previous aspects of their lives.

The RiSC model of care (intensive group) was successful in delivering a much greater and wider variety of Recovery interventions to service users. Two out of three of the Addaction community Recovery Hubs were successful.

The qualitative study undertaken independently by Community Voice showed that service users improved their wellbeing and had a subjectively positive experience whilst engaging in a service focused on Recovery and reducing their prescribed medication.

The RiSC model enabled Recovery in a Harm Reduction setting.

The RiSC study has developed a new integrated care model for the treatment of dependency. It encouraged service users to reduce their prescribed medication while proactively collaborating with the Liverpool Recovery community and Shared Care general practices. This has enabled service users to reduce their drug dependency while simultaneously improving their physical health, psychological health and psychosocial functioning.

Suggestions for Further Research

The RiSC study has highlighted the complexity of collecting reliable psychological data in a cohort of people with substance misuse problems. Further research to elucidate this would be valuable.

RiSC is a study of a service refocus and modification to bring Recovery to a Harm-reduction service. Further work to develop the RiSC outcomes (covering physical health, mental health and psychosocial indicators) as PHE key performance indicators alongside current indicators would facilitate the spread of Recovery through resistant services, enthuse staff and inspire service users.

The refocus of the Shared Care service from Harm-reduction to Recovery is now taking place across the whole of the Liverpool Shared Care service. Ongoing study would be very informative.

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Appendices

Appendix 1

WEMWBS

Mental wellbeing was measured using the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS).

The scale consists of seven items or statements that relate to wellbeing. Depending on the frequency with which a service user experiences each of the situations cited on the statements, a score between one and five will be allocated.

An example of a statement is: "I have been dealing with problems well".

The frequency scores are operationally defined as: 1–None of the time; 2–Rarely; 3–Some of the time; 4–Often; 5–All of the time. Each statement is positively expressed. Therefore, experiences that occur frequently are given a high score, which in turn indicates greater mental health or wellbeing.

Using the short version of the scale, the lowest possible score, indicating the absence of wellbeing is seven. This would indicate that the person did not experience any aspect of wellbeing, at any time.

The highest possible score, indicating high wellbeing is thirty-five. This would indicate that the person experienced every aspect of wellbeing, all of the time.

The wellbeing scale is reliable and valid. The findings from the analysis of the scale have been externally evaluated and published in a peer-reviewed journal.

Appendix 2

PHQ-9

Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a depression module, which scores each of the 9 DSM-IV criteria as 0 (not at all) to 3 (nearly every day). It has been validated for use in Primary Care.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?				
Trouble concentrating on things, such as reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself in some way?				
Total= <input type="text"/> /27				

PHQ-9 score ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression. It can be used over the telephone.

Depression Severity:

0-4 None

5-9 Mild depression

10-14 Moderate depression

15-19 Moderately severe depression

20-27 Severe depression

Appendix 3

GAD-7

Please read each statement and record a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way speak with a qualified health professional.

0 = Not at all 1 = several days 2 = more than half the days 3 = nearly every day

Feeling nervous, anxious or on edge	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>
Worrying too much about different things	<input type="checkbox"/>
Trouble relaxing	<input type="checkbox"/>
Being so restless that it is hard to sit still	<input type="checkbox"/>
Becoming easily annoyed or irritable	<input type="checkbox"/>
Feeling afraid as if something awful might happen	<input type="checkbox"/>

Total score

Scoring Guide

Normal 0-4 Mild 5-9 Moderate 10-14 Severe 15-21

The maximum score of the GAD-7 is 21, lower scores are better.

The total score is simply the sum of the question items one through seven. Scores of 5, 10 and 15 are taken as the cut off points for mild, moderate and severe anxiety respectively. When used as a screening tool, further evaluation is recommended should the score be 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for generalised anxiety disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%), and post traumatic stress disorder (sensitivity 66%, specificity 81%).

Appendix 4

Qualitative Arm Questionnaire

The questionnaires were asked during the months of June to December 2013. The same questionnaire was used in both the intensive and non-intensive groups.

Questionnaire 1 - General

How have you been feeling in the last month?

Do you feel different now than the beginning of June?

What else would you like to be doing to make these months positive?

Has anything else changed during this time?

Is there anything Addaction could be doing, that they haven't yet done?

Questionnaire 2 - Service user wellbeing

I've been feeling optimistic about the future.

I've been feeling useful.

I've been feeling relaxed.

I've been dealing with my problems well.

I've been thinking clearly.

I've been feeling close to other people.

I've been able to make up my own mind about things.

The service users were given the following scale to record their answers:

None of the time

Rarely

Some of the time

Often

All of the time

Appendix 5

Recovery Resource Document developed by the RiSC group

Addaction Liverpool Services

Liverpool Shared Care, Paul Thompson Centre 83-93 Stonebridge Lane, Croxteth L11 4SJ. 0151-522 2420. Opening times Monday to Friday 9am-5pm. Wednesday and Thursday each fortnight evening clinic facility 5pm-8pm.

Liverpool Shared Care, Gateway 8 Maryland Street, Liverpool L1 9DE. 0151-702 0655. Opening times Monday and Friday 9am-5pm, Tuesday 9am-6pm, Wednesday and Thursday 9am-7pm.

Liverpool Recovery Service, Gateway 8 Maryland Street, Liverpool L1 9DE. 0151-702 0655. Opening times Monday and Friday 9am-5pm, Tuesday 9am-6pm, Wednesday and Thursday 9am-7pm.

Liverpool Recovery Service, Croxteth 83-93 Stonebridge Lane, Croxteth, L11 4SJ. 0151-546 1141. Opening times Monday and Friday 9am-5pm, Tuesday-8pm, Wednesday 9am-6pm and Thursday 9am-7pm.

Liverpool DIP 4 Roscoe Street, Liverpool, L1 2SX. 0151-706 7888. Opening times Monday, Tuesday, Thursday and Friday 9am-5pm. Wednesday 9am-7pm. Custody Suites Monday to Friday 8am-10 pm, Saturday and Sunday 8am-4pm. Liverpool Magistrates Court Monday to Friday 8.30am-4.30pm. Saturday/Sunday closed.

Young Addaction 65-67 Hanover Street, Liverpool L1 3DY. 0151-706 9747. Opening times Monday to Saturday 9am-5pm.

Breaking the Cycle based at Young Addaction. 0151-706 9747. Provides support for families experiencing drug or alcohol problems.

Addaction Community Recovery Hubs

North Liverpool Hub Walton Cornerstone, 2 Liston Street, (off Bedford Road, opposite Walton Church) Liverpool, L4 5RT. Every Friday from 12pm-2pm

Dingle Hub Florence Institute Trust Ltd (The Florrie) 377-401 Mill Street, Liverpool, L8 4RB. Every Wednesday 12pm-2pm.

Alcohol services

Windsor Clinic 0151-529 2450. Alcohol community and inpatient detox service based in grounds of Aintree hospital.

LCAS 0151-529 4504. Community-based service at 18 locations across Liverpool. Alcohol assessment and brief interventions.

AA Alcoholics Anonymous 0845-769 7555. Twelve step group fellowship meetings at venues across Liverpool.

Housing Support agencies

NACRO 0151-708 1171. Housing support, bedroom tax, repairs, furniture, 1:1 support, based in Kensington, will work anywhere in Liverpool.

NACRO Accommodation Floating Support 0151-261 0679. Provides advice, information and support for people with housing issues.

Whitechapel Centre 0151-207 7617. Provides a range of services to support homeless and rough sleepers, including advice on securing social housing tenancies, and supported housing issues.

Basement 0151-707 1515. Provides support for vulnerably housed, homeless and rough sleepers.

Adullam 33 Derby Road, Old Swan L13 6SL. 0151-220 4400. Provides supported housing and floating support for vulnerable people.

Bridge House Project 0151-280 5680. Abstinent semi-supported housing, mixed accommodation.

YMCA 0151-600 3530 Semi-supported mixed accommodation.

Salvation Army 0151-252 6100. Semi-supported mixed accommodation.

Progressive Lifestyles 47 Walton Road L4 4AF. 0151-298 9220. Provides semi-supported adult male accommodation.

Croft Housing Association 63 Rocky Lane, Anfield L6 4BB. 0151-345 1846/0151-345 3224 (Male Only) Office opening hours Monday to Friday 8am-18:30pm. Supported adult male accommodation

NWPC Ltd and Excel housing solutions 0151-3292772. Fax 0151-3458199. Supported mixed accommodation.

Nugent Care 99 Edge Lane, Liverpool L7 2PE. Housing support unit. Supported accommodation.

Nugent Care 0151-261 2035. Rent deposit guarantee & housing support scheme.

Nugent Care 0151-235 2345. Working Together team: in partnership with Liverpool Mutual Homes offering floating support to tenants.

Nugent Care 0151-261 2035. Welfare material aid and benefits service. Provides home starter packs, including pots and pans.

New Start 49 Prospect Vale, Fairfield, Liverpool L6 8PF. 0151-281 8808. Supported accommodation.

Shelter 3rd floor, Colonial Chambers, 3-11 Temple Street, Liverpool, L2 5RH. 0344-515 1900. Opening hours Monday to Friday 9am-5pm. Offers practical support, advice and solutions affecting housing.

Detox & Residential facilities

Kevin White Unit 0151-330 8074. Offers comprehensive residential detox inpatient facility for service users in and around Merseyside.

Parkview 0151-228 9167. Twelve step residential Recovery centre for persons suffering from drug and alcohol problems.

Fellowship support groups

AA Alcoholics Anonymous 0845-769 7555. Twelve step fellowship meetings at venues across Liverpool

NA Narcotics Anonymous 0300-999 1212. Twelve step fellowship meetings at venues across Liverpool.

CA Cocaine Anonymous 0300-111 2285. Twelve step fellowship meetings at venues across Liverpool.

Abstinence-based services

Art & Soul 58 Hope Street L1 9BZ. 0151-709 4841. Creative and holistic sessions to relieve boredom and introduce structure and foster peer support.

Sharp (Action on Addiction) 0151-703 0679. Offers structured abstinence day treatment programme for men and women with drug and alcohol problems, twelve step philosophy and ITEP mapping groups.

Employment/Education/Training

Transit 44 Castle Street L2 7LA. 0151-258 1199. Open 9:30am-4:30pm. Refreshments, travel pass, IT training, Breaking Free Online, Liverpool history, life coaching, creative writing, substance misuse awareness, Wednesday coffee mornings, relaxation & awareness classes.

Hope Club 44 Castle Street L2 7LA, and other Liverpool sites. 0151-258 1199. Advice and guidance on voluntary work, employment, CV building, training, CRB disclosure advice, job searches.

Independence Initiatives Balliol Road, Bootle L20 7EH. 0151-284 1100. Opening hours Monday to Friday 9:30-5pm. Normally 12-week programme. IT skills, basic budgeting, cooking on budget, sewing, design, drama, music, creative writing, holistic courses, Tai Chi, gym, street dance, swimming.

Genie in the Gutter 88 Rodney Street Liverpool L1 9AR. 0151-703 9053. Provides creative opportunities and training.

The Brink 15-21 Parr St, Liverpool L1 4JN. 0151-703 0582. Multi-purpose venue for the Recovery community to eat, drink and socialise with the mainstream public, promoting health, connection and collaborative events.

Other Support Services

WHISC 0151-707 1826. Women's health information and treatment support service.

RASA 0151-707 4327. Rape and sexual abuse support service.

Voice for Change 0151-345 8499. Based in Waterloo but Liverpool-wide support service for people affected by domestic violence, both victims and perpetrators.

Armistead Centre 0151-227 1893. Support service for gay, lesbian, bisexual and transgender people and male and female sex workers.

Brook Advisory Service 0151-207 4000 Monday to Friday 10am-6pm, Saturday 11am-3pm. Offering sexual health advice and information, including contraception advice.

Worst Kept Secret 0800-028 3398. Monday to Friday 3pm-6pm. 24 hour support service for people affected by domestic violence.

PSS 0151-702 5555. Support for young people and families affected by substance misuse.

Dare to Care 0151-709 9528. Provides a range of alternative therapies, including acupuncture, to BME communities.

Women's Turnaround Project 0759-586 3133. Support for women offenders.

The Reader Organisation 0151-207 7207. Therapeutic group reading intervention that enhances confidence, social interaction skills and has evidence base for improved mental wellbeing.

NSPCC 0844-892 0264. Provides support to pregnant women with young children, where substance misuse is a factor.

Careline Adult Service 0151-233 3800. Children's Service 0151-233 3700. A 24/7 contact centre for social care enquiries and referrals for children, adults and homeless families.

Wheel Meet Again www.sctliverpool.com. Over 50's social activities group throughout the city.

Poppy Centre Social Club 179 Townsend Lane, Clubmoor, Liverpool, L13 9DY. 0151-256 2543. Fax 0151-256 2568. Social centre for people over 50.

Advice & Information

Community Voice 0151-294 3013. Service user involvement project, advocacy, mediation, signposting and referrals. Provides a volunteer programme and training facilitation.

Vauxhall Community Law 0151-482 2001. Accepts referrals for debt and housing issues.

Liverpool Direct 0151-233 3000. One stop telephone SPOC for help, advice and support on a vast range of issues related to safeguarding referrals, social housing, bin collections, dog fouling and environmental issues.

Citizens Advice Bureau 0844-848 7700. Advice and information for all matters of social and legal issues.

Liverpool Veterans Project Liverpool Veterans HQ, 239 Breck Road, Everton, L15 6PT. 0151-261 9878. Provides support to ex-servicemen and women and for those leaving the services and residing in the Liverpool area.

Advocacy Rights Hub Unit 13, 7th Floor, Gostins Building, 32-36 Hanover Street, L1 4LN. 0151-707 1900 or 07842-552 878. Open Monday to Friday 9am-5pm. An independent service putting people in Liverpool in touch with any support they might need. Advocacy, information, advice and community activities.

Centre 56 Rumney Rd, Liverpool, Merseyside L4 1UB. 0151-727 1355. Fax 0151-922 2998. Open Monday to Friday 9.30am-5.30pm. Nursery hours Monday to Friday 9am-2.45pm. After school club open Monday to Friday 4-6pm. Provides information sessions and support for women and children who have suffered or are at risk of domestic abuse.

LCAS Clinic Venues – 2013

All LCAS referrals need to be sent to **Windsor Clinic**, University Hospital Aintree, Longmoor Lane, Liverpool L9 7AL.
0151-529 2450. Fax 0151-529 2454.

Belle Vale Health Centre Hedgefield Road, Liverpool L25 2XE. 0151-234 1100.
Fax 0151-488 6601

Breeze Hill Neighbourhood Centre 1-3 Rice Lane, Walton L9 1AD.
Tel 0151-295 3500 Fax 0151 295 3501

Brownlow Group Practice 70 Pembroke Place, Liverpool, L69 3GF.
Tel 0151-285 4578 Fax 0151-295 9323

Childwall Fiveways 215 Childwall Road, Childwall Fiveways Roundabout, Liverpool, L15 6UT.
Tel 0151-295 9333 Fax 0151-295 9301

Croxteth Family Health Centre 40 Altcross Road, Liverpool, L11 OBS.
Tel 0151-295 9191 Fax 0151-545 0768

DART Building 3-5 Rodney Street, City Centre, Liverpool, L1 9ED.
Tel 0151-709 0516 Fax 0151-234 5870

Great Homer Street MC 32 Conway Street, Everton, Liverpool, L5 3SF.
Tel 0151-207 8268 Fax 0151-207 3016

Hunts Cross 79 Hillfoot Road, Hunts Cross, Liverpool, L25 OND.
Tel 0151-486 1428 Fax 0151-336 9890

Kensington Neighbourhood Health Centre 155-157 Edge Lane, Kensington, L7 2PH
Tel 0151-295 3636 Fax 0151-295 3631

Mere Lane Neighbourhood Health Centre Mere Lane, Anfield, L5 0QW.
Tel 0151-295 9600 Fax 0151-295 9621

Picton Health Centre 137 Earle Road, Liverpool, L7 6HD.
Tel 0151-295 3333 Fax 0151-295 3334

Princes Park Health Centre Bentley Road, Princes Park, Liverpool, L8 OSY.
Tel 0151-295 9222 Fax 0151-295 9223

Ropewalks City Centre 28 Argyle Street, Liverpool, L1 5DL.
Tel 0151-295 9852 Fax 0151-295 9843

South Liverpool NHS Treatment Centre 32 Church Road, Liverpool, L19 2LW.
Tel 0151-295 9100 Fax 0151-295 9101

Speke Neighbourhood Health Centre South Parade, Speke, Liverpool, L24 2SF.
Tel 0151-295 8866 Fax 0151-295 8801

Townsend Medical Centre 98 Townsend Lane, Anfield, Liverpool, L6 OBB.
Tel 0151-295 9500 Fax 0151-295 9501

Windsor Clinic University Hospital Aintree, Longmoor Lane, Liverpool, L9 7AL.
Tel 0151-529 2450 Fax 0151-529 2454

Yewtree Dovecot, Berryford Road, Liverpool, L14 4ED.
Tel 0151-296 7972

Appendix 6

Methadone Reduction Guidelines

Methadone	Reduction
50ml and above	5ml per week
30 to 50ml	5ml every 2 to 3 weeks
10 to 30ml	2 to 3 ml every 2 to 3 weeks
5 to 10 ml	1 ml every week

Appendix 7

Buprenorphine Reduction Guidelines

Standard community reduction course for Buprenorphine

Day	Daily Dose (mg)						
1	8	11	4	21	1.6	31	0.8
2	8	12	4	22	1.6	32	0.8
3	8	13	2.8	23	1.6	33	0.4
4	8	14	2.8	24	1.6	34	0.4
5	6	15	2.8	25	1.2	35	0.4
6	6	16	2.8	26	1.2		
7	6	17	2	27	1.2		
8	6	18	2	28	1.2		
9	4	19	2	29	0.8		
10	4	20	2	30	0.8		