## TITLE OF THE EVALUATION

Evaluation of the Nottingham and Nottinghamshire Substance Use/Mental Health pathway

## REFERENCE NUMBERS

NHFT R&E number: SE/2022/0030

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The sponsor and funder of this evaluation is Nottinghamshire Healthcare NHS Foundation Trust (NHFT). NHFT contributed to, and had the final decision over, the evaluation design, conduct, data analysis and interpretation, manuscript writing, and dissemination of results.

## ROLES AND RESPONSIBILITIES OF THE EVALUATION MANAGEMENT GROUP

The evaluation was overseen by the Substance Use/Mental Health Pathway Development Group. This group reviewed and approved the evaluation protocol but were not involved in delivery, data analysis or report writing. Members of this group included representatives from the following organisations: Change Grow Live; Double Impact; Nottingham City Council; Nottingham and Nottinghamshire CCGs; Nottingham Recovery Network; Nottinghamshire County Council; and Nottinghamshire Healthcare NHS Foundation Trust.

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# EXECUTIVE SUMMARY


**Background**

A new care pathway has been developed for patients with coexisting mental health and substance use problems within Nottingham and Nottinghamshire. The pathway model involves placing mental health workers in substance use services and vice versa. These workers assess and refer patients to other appropriate services whilst providing brief psychosocial interventions in the interim.

**Evaluation method**

Two methods were used: analysis of care records and qualitative interviews. Referrals/use of the pathway were assessed. Before/after patient outcomes (mental health, substance use, housing, and quality of life) and use of urgent mental health services were also evaluated.

Patients and staff were recruited for one-to-one interviews. Both pathway and non-pathway staff were interviewed. Participants shared their experiences of using, delivering or working alongside the pathway as well as recommendations for its future development.

**Results**

There were fewer onward referrals to primary and secondary care mental health services than expected. Reasons included patient ineligibility and services being inaccessible.

There were differences in the use of the pathway between provider organisations. More patients from substance use services accessed the pathway than mental health patients. This might be partly explained by when staff came into post. Though substance use patients also appeared to be receiving slightly larger amounts of support from the pathway – longer sessions, over longer periods.

There were small or no differences across most outcomes assessed. The exception was a notable drop in the proportion of patients experiencing housing issues. However, patient outcomes remain unclear due to limitations in available data.

All interviewed patients reported positive experiences of the pathway, suggesting it was appropriately tailored to their needs. SUS staff also gave very positive views of the pathway, indicating that it had filled an important service gap for their patients. LMHT staff reported less of an impact of the pathway. Pathway staff reported that working across multiple teams reduced their integration with each team and forced them to adopt a very structured routine, which limited their ability to meet the needs of patients.

Pathway and non-pathway staff reported that the current capacity of the pathway was not sufficient to meet demand. This was both in terms of staff members being spread over multiple teams, reducing their visibility and impact, and in terms of the number of patients requiring support.

**Conclusion**

The pathway appears to be functioning primarily as a care provider for patients rather than a conduit to other services. Patient and staff experiences were very positive. The pathway was seen as filling an important gap in services, and the key recommendation was to increase the capacity of the pathway.

# BACKGROUND

## Coexisting conditions: patient need and current provision

Coexisting mental health and substance use problems ('coexisting conditions') occur when individuals require support for both their mental health and use of legal and illicit substances. People experiencing coexisting conditions have previously been described as having a 'dual diagnosis'. The phenomenon of coexisting conditions is sometimes narrowly restricted to cases of severe mental illness, with a focus on psychosis (NICE, 2011). In contrast, the term is used here to encompass all mental health conditions (e.g. depression, anxiety, psychosis, bipolar disorder) of sufficient severity to warrant support from primary or secondary care mental health services.

The estimated prevalence of coexisting conditions varies between studies, services and geographic areas. One early UK study estimated that 20-37% of people in secondary mental health services and 6-15% of people in substance use settings have co-existing mental health and substance use issues (Carra and Johnson, 2009). Estimates also vary by disorder, with up to 40% of adults with psychosis thought to use substances (NICE, 2011).

Health outcomes for people with coexisting conditions are typically poorer compared to those with a single condition across a wide range of domains. Coexisting conditions are associated with comparatively worse mental health symptoms, physical health and engagement with services, increased treatment costs and increased risk of mental health relapse, hospitalisation and suicide (NCISH, 2022; NICE, 2011). Without dedicated services this group can therefore have a high level of unmet need.

People with coexisting conditions also often experience multiple disadvantages in other domains, including contact with the criminal justice system, homelessness, unemployment, trauma histories and lack of social support (Bannerjee et al., 2002; Otasowie, 2021). As such, this group has multiple needs that may not be well catered for by standard service models. Service evaluations have found that existing services for this group are complex and difficult to navigate, have long waiting lists, high eligibility thresholds and offer inflexible support (Moreton et al., 2022; Staiger et al., 2011). A long-standing concern within the UK is that people with coexisting conditions accessing substance use services are typically ineligible for referral to mental health services and vice versa (Weaver et al., 2003). These barriers hinder access to services and reduce treatment engagement amongst this group.

Recent pilot work in populations experiencing multiple disadvantages have found that the use of navigators, person-centred support and multi-agency networks and training can overcome some of the service barriers faced by people with co-existing conditions (Moreton et al., 2022).

The National Institute for Clinical Excellence (NICE) has produced guidelines for how services for people with co-existing mental health (psychosis) and substance use problems should be organised (NICE, 2016). This guidance states that relevant services should: agree joint care pathways between services; set-up information sharing between services; provide support, development opportunities and supervision for staff; put patient care plans in place; be non-judgemental and inclusive; offer flexibility; and proactively address non-engagement.

More recently, there have been two Regulation 28 Coroner Reports to Prevent Future Death issued within Nottingham and Nottinghamshire in 2016 and 2021. These reports highlighted

issues in relation to care for people with co-existing conditions. They reinforced the NICE guidance listed above by recommending continuity of care for people with coexisting conditions and coordinated commissioning and information sharing across organisations involved in their care.

The Substance Use/Mental Health Pathway Development Group drew on local intelligence, relevant research literature and NICE guidance to set-up the Substance Use/Mental Health Pathway (SU/MH pathway) for Nottingham and Nottinghamshire. The following section describes the pathway in more detail.

## Pathway service model

### Joint providers

The SU/MH pathway aims to improve joint working between substance use and mental health services. The pathway is delivered by four organisations: one substance use charity (Double Impact), one mental health service (Nottinghamshire Healthcare NHS Foundation Trust [NHFT]) and two substance use treatment services (Change, Grow, Live [CGL]; and Nottingham Recovery Network [NRN]). Double Impact and NHFT operate across Nottingham and Nottinghamshire, CGL within Nottinghamshire and NRN within Nottingham city.

### Pathway structure

The service model includes three main components:

(1) Mental health workers placed in substance use services. There are three mental health workers hosted within substance use services (SUSs). There is one worker for each of the three Place Based Partnership (PBP) areas: Mid-Nottinghamshire, Nottingham City and Nottinghamshire South. They deliver the following interventions: comprehensive assessment; referrals to primary and secondary mental health services; brief psychosocial interventions; and staff training. These workers have ‘Trusted Assessor’ status, which is designed to speed up the process of referral into secondary care.

(2) Substance use workers placed in community mental health services. There are three substance use workers hosted within community mental health teams (known locally as LMHTs). There is one worker based in each PBP area. They deliver the following interventions: joint assessments; joint care planning; brief psychosocial interventions; advice and liaison; and staff training. There are also dedicated peer support workers based in LMHTs. These workers use their lived experience to support patients to access and engage with substance use services. A separate evaluation of the peer support component of the pathway has been undertaken independently.

(3) Substance use workers within inpatient settings. There are two substance use workers hosted within mental health inpatient settings. They deliver the following interventions: group harm-reduction and behaviour change workshops; one-to-one brief psychosocial interventions; providing advice to inpatient staff; and supporting discharge planning.

### Sub-pathways

When the SU/MH pathway was designed it was intended that patients may take one of six routes (or ‘sub-pathways’), depending on their needs. These are described in Table 1.

Table 1 Description of the six sub-pathways within the SU/MH Pathway

| # | Sub-pathway | Entry point | Patient population | Sequence of interventions |
|---|---|---|---|---|
| 1 | Access to secondary MH care | SUS | SUS patients with severe mental illness | (1) MH assessment by 'approved assessor' → (2) LMHT referral with interim psychosocial interventions → (3) Patient accesses LMHT |
| 2 | Access to primary MH care | SUS | SUS patients with common mental health problems | (1) Specialist assessment → (2) IAPT/GP/third sector referral with interim psychosocial interventions → (3) Access to primary care/charity service |
| 3 | Mental health caseload | SUS | SUS patients with moderate-severe mental disorders. Ineligible for primary care (symptoms too severe) and secondary care (symptoms not sufficiently severe) | (1) Specialist assessment → (2) Brief psychosocial interventions (up to 12 weeks) |
| 4 | Access to SUS | LMHT | LMHT patients with drug/alcohol problems requiring pharmacological treatment | (1) Specialist assessment → (2) SUS referral and brief interventions → (3) Assigned PSW → (4) Access to SUS |
| 5 | Substance use caseload | LMHT | LMHT patients with drug/alcohol problems who won't engage with standard SUS services | (a) Specialist assessment → SUS referral → Disengagement → Brief interventions and assigned PSW<br>(b) Specialist assessment → Brief interventions |
| 6 | Inpatient | Inpatient | Mental health inpatients with drug/alcohol problems | Specialist assessment → Brief interventions → Referral to SUS once discharged |

**Treatment approach**

The following treatment principles were adopted. (1) Flexibility: conducting assessments over multiple sessions if needed, conducting appointments at times and locations chosen by the patient, and not discharging patients due to missed appointments. (2) Person-centred: supporting patients with their personally identified needs, including support for housing and financial issues, and not being judgmental or prescriptive about patient's behaviour.

### Rationale for the evaluation

People with coexisting conditions have unmet care needs (Moreton et al., 2022; Staiger et al., 2011). This population is also a very high-risk cohort, particularly for suicide (NCISH, 2022), and as highlighted by the recent Preventing Future Death reports. However, there is currently little evidence to inform service commissioning for this population (Hunt et al., 2019).

The SU/MH pathway is a new service being piloted and iteratively developed by ICS partners in Nottingham and Nottinghamshire to meet the needs of this population. A service evaluation approach was used to support the on-going development of the pathway and to assess whether it is achieving the intended outcomes.

## EVALUATION QUESTIONS

**Service-user outcomes**

1. What are the mental health outcomes of individuals accessing the SU/MH pathway?
2. What are the substance use outcomes of individuals accessing the SU/MH pathway?
3. Does the SU/MH pathway improve patient's quality of life?

**Patient experience**

4. What are patients' experiences of the SU/MH pathway?
5. Does the SU/MH pathway improve users' engagement with services?

**Staff outcomes**

6. Does the SU/MH pathway improve staff competencies:
    a. SM competencies of MH staff
    b. MH competencies of SM staff

**Service-level outcomes**

7. Does the SU/MH pathway improve access to:
    a. Mental health services
    b. Substance use services
8. Does the SU/MH pathway reduce the avoidable use of urgent care services

## METHODS

### Regulatory review

Approvals were received from the relevant governance teams at CGL and Framework Housing Association (representing NRN) and NHFT. All regulatory teams reviewed the evaluation documentation and data sharing agreements were put in place.

## Evaluation design

The evaluation used a mixed methods approach including both qualitative and quantitative components. **Quantitative pre-post design:** Healthcare records were used to evaluate changes in patient outcomes between baseline and follow-up timepoints. No control group was used. **Qualitative approach:** Semi-structured interviews were used to gather stakeholders' views on the pathway.

Training workshops have previously been delivered by pathway staff for other staff caring for patients experiencing co-existing conditions and future workshops are planned. It was originally intended to evaluate these workshops as part of the evaluation to assess changes in staff competencies, but no workshops were run during the period of evaluation.

### Data collection settings

Health and care records were retrieved electronically. Staff and patient interviews were conducted either face-to-face or remotely (telephone or videoconference). Face-to-face interviews took place at participants' usual place of work or care.

## Recruitment

### Inclusion criteria

For patient participants the following criteria were used:

- Adults (18-65)
- Accessing secondary care mental health OR SUS services
- Completed an assessment with an SU/MH pathway worker
- Capacity to consent

No exclusion criteria were applied.

### Sampling approach and sample size

Three sampling approaches were used:

1. Total population sampling: Health and care records were retrieved for all patients.
2. Purposive sampling: Staff interview participants were equally balanced where possible across geography and service type.
3. Convenience sampling: Patient participants were recruited on an ad hoc basis.

The number of participants differed for each component of the evaluation. This is outlined in Table 2.

Table 2 Sampling approach and sample sizes

| Evaluation component | Sampling approach | Sample size |
|---|---|---|
| Patient outcomes | Total population | Full population |
| Staff interviews | Purposive sampling | Up to 25 |
| Patient interviews | Convenience sampling | Up to 20 |

Although estimated sample sizes are given in Table 2 interview participants were recruited until 'theoretical sufficiency' was met (Dey, 1999). The data was deemed to be sufficient when all the themes of new participants' data are consistent with that of past participants.

Staff were recruited via purposive sampling to achieve a sample that was balanced across the following criteria: roles within the pathway; host service; and geographical area. The sample size (n=25) has been calculated to include all pathway specialists (n=8, excludes PSWs) and one member of staff per host LMHT and SUS across the ICS.

Patients may have irregular schedules and struggle to attend an interview. Therefore, participants were primarily recruited using convenience sampling during routine clinical appointments.

**Participant identification**

Participants were identified and approached by gatekeepers. Service managers acted as gatekeepers for staff participants. Pathway staff acted as gatekeepers for patient participants. Staff approached everyone on their current caseload as well as recently discharged patients.

**Consent**

Anonymous health and care records of all patients were retrieved without seeking individual consent. Written and verbal consent was received for interviews from patients and staff respectively. Only individuals with capacity to consent were recruited.

All potential participants were given a Participant Information Sheet, which provides information on the evaluation, to make an informed decision over whether to take part. Potential participants were given the opportunity to ask questions and given as much time as they needed to consider their participation.

## Data collection

The types of data collected for each sub-pathway is listed in Table 3.

Table 3 Data collection methods within each sub-pathway

| **Patient group (sub-pathway #)** | **Data collection** | | |
|---|---|---|---|
| | ***Health and care records*** | ***Staff interviews*** | ***Patient interviews*** |
| SUS patients (1-3) | Yes | Yes | Yes |
| LMHT patients (4-5) | Yes | Yes | Yes |
| Inpatients (6) | No | Yes | No |

**Demographic variables**

Demographics, including sex, age, ethnicity, and deprivation, were collected. Ethnicity is reported using the categories used by NHFT. Deprivation is measured using the Indices of Multiple Deprivation (IMD), which collates multiple datasets of relative deprivation at area-level. IMD are calculated as deciles, which were categorised into ‘most deprived’ (deciles 1-2), ‘more deprived’ (3-5) and ‘less deprived’ (6-10) for the purposes of this evaluation.

**Clinical characteristics**

Patients’ clinical characteristics include data from the Health of the Nation Scales (HoNOS) and the Treatment Outcome Profile (TOPs). HoNOS is a clinician rated instrument comprising 12 items measuring behaviour, impairment, symptoms and social functioning for

those in the 18 - 64 years old age group. The 12 items cover 1 Overactive, aggressive, disruptive or agitated behaviour, 2 Non-accidental self-injury, 3 Problem-drinking or drug-taking, 4 Cognitive problems, 5 Physical illness or disability problems, 6 Problems with hallucinations & delusions, 7 Problems with depressed mood, 8 Other mental & behavioural problems, 9 Problems with relationships, 10 Problems with activities of daily living, 11 Problems with living conditions, and 12 Problems with occupation and activities.

HoNOS scores are used to assign patients into one of 21 care clusters, which can be used for proxy diagnostic purposes. Care clusters are combined in this evaluation into 'psychotic' and 'non-psychotic' superclusters.

Patient's baseline HoNOS drug and alcohol ratings are reported. These ratings can be interpreted as follows: 0=No problem during the period rated. 1=Some excessive consumption but no adverse consequences. 2=Excessive and/or harmful consumption resulting in adverse consequences, but no obvious craving or dependency. 3=Definite craving and/or dependence on alcohol or drugs. 4=Severe craving/dependence resulting in severe adverse consequences. Ratings are categorised in this report as 'low' (0-1) and 'high' (2-4).

The Treatment Outcome Profile (TOP) is a national outcome monitoring tool for substance use services. TOP assesses drug and alcohol usage and assigns patients to one of four categories: alcohol-only, opiates, alcohol and non-opiates, non-opiates only.

**Pathway service use variables**

Patients' use of the pathway and the level of support provided to them was measured using the following metrics: current and total (since inception) number of pathway users, time to first appointment, length of support, session duration, number of times patients did not attend (DNA) sessions, and number of sessions per month.

As well as DNA rates of pathway patients seeing pathway workers, the following comparison DNA rates were also collected: (i) pathway patients seeing non-pathway workers, (ii) non-pathway LMHT patients with no drug/alcohol issues seeing their usual care provider, and (iii) non-pathway LMHT patients with significant drug/alcohol issues seeing their usual care provider. DNA rates for non-pathway SUS patients was not available.

**Outcome variables**

The 12 HoNOS items were grouped into behavioural issues (items 1-3), impairment (4 and 5), symptomatic (6-8) and social problems (9-12).

The following self-reported outcomes from the TOP measure were used: psychological health ('anxiety, depression, problem emotions and feelings'), physical health ('extent of physical symptoms and bothered by illness'), and quality of life ('able to enjoy life, gets on with family and partner'). These three outcomes are all patient-rated, single items scored from 0-20. Housing outcomes were also used – whether patient has an acute housing problem, unsuitable housing, or are at risk of eviction – rated as yes or no.

Urgent mental health care services include the Crisis, Resolution and Home Treatment Team (CRHT), Intensive Community Assessment and Treatment Team (ICATT), Liaison and Diversion Service (LDS), Rapid Response Liaison Psychiatry (RRLP), and the Street Triage team. CRHT provides assessment and short-term support for adults (18-65) experiencing a

mental health crisis. ICATT provides short-term support for adults with a learning disability to avoid unnecessary inpatient admissions. LDS works with people aged 10+ with mental health problems who come into contact with criminal justice agencies. RRLP is situated within acute hospitals in Nottingham and Nottinghamshire. They support people accessing Emergency Departments or inpatient wards who present with mental health problems. The use of urgent care services was calculated as the mean number of patient contacts per month. A 'baseline' average was calculated as mean number of contacts per month prior to the patient entering the pathway. A 'follow-up' average was calculated as the mean contacts per month once the patient entered the pathway.

Repeated measures data retrieved from health and care records are listed in Table 4.

Table 4 Schedule of events (repeated measures)

| Measure | Outcome(s) | Dataset | Administration time point | |
|---|---|---|---|---|
| | | | T1 | T2 |
| HoNOS | Mental health symptoms<br>Drug/alcohol issues<br>Behavioural issues<br>Social issues | RiO (NHFT) | Between 01/01/2021 and pathway admission. Assessment closest to start date. | 3 months or more following pathway admission. |
| Treatment Outcome Profile (TOP) | Psychological health<br>Physical health<br>Quality of life<br>Drug/alcohol use | NDTMS (CGL[a]) | First session with pathway worker or shortly prior. | 6 month or discharge review conducted between pathway admission and 24/05/2023. |
| Urgent care service use | CRHT<br>ICATT<br>LDS<br>Liaison<br>Street Triage | RiO | All contacts between 01/01/2020 and pathway admission. | All contacts between pathway admission and 12/06/2023. |

[a]TOPs data was not available from NRN.

**Semi-structured interviews**

Three interview topic guides were developed for patients, pathway staff and non-pathway staff respectively. These topic guides were developed in consultation with service managers and peer support workers to ensure their relevance and clarity. The topic guides covered the following topics.

Patients: demographics (age, gender, ethnicity); mental health conditions; substances used; service use; experiences of accessing mental health and SUS; experiencing of being supported by pathway staff; suggested improvements to care.

Pathway staff: integration and joint working with LMHT/SUS teams; personal wellbeing; and suggested improvements to the pathway. Non-pathway staff: experience of working with pathway staff; impact and suggested improvements to the pathway.

## Data analysis

### Quantitative data (care records)

Descriptive statistics of all variables (percentage, mean, median) were calculated. Results were split by area (city vs county patients) and type of service accessed (LMHT vs SUS patients). 'LMHT patients' are those receiving support from a pathway worker hosted within LMHT services. 'SUS patients' are those receiving support from a pathway worker hosted within SUS services.

### Qualitative data (interviews)

Framework analysis was used to analyse the qualitative data (Gale et al., 2013). The process first involved the analyst going through the transcripts and recordings to familiarise herself with the data. Data were then inductively coded, collated into themes and used to create a working analytical framework. This was iteratively revised until no new codes emerged. The framework was then applied to the remaining data.

# RESULTS

## Patient characteristics

Patient demographics are given in Table 5 and broken down by area and sub-pathway.

Table 5 Patient demographics

| **Demographic** | **Total (%)** | **Area (%)** | | **Sub-pathway (%)[a]** | |
|---|---|---|---|---|---|
| | | City | County | LMHT | SUS |
| Age (mean) | 41 | 39 | 43 | 39 | 41 |
| Gender | | | | | |
| Men | 63.7 | 63.1 | 62.4 | 61.6 | 63.4 |
| Women | 36.3 | 36.9 | 37.6 | 38.4 | 36.6 |
| Ethnicity | | | | | |
| Asian or Asian British | 2.8 | 4.3 | 0.6 | 8.8 | 0.6 |
| Black or Black British | 3.2 | 4.3 | 1.7 | 3.2 | 3.2 |
| Mixed | 3.7 | 5.7 | 0.6 | 6.4 | 2.7 |
| Other Ethnic Groups | 1.7 | 2.5 | 0.6 | 1.6 | 1.8 |
| Unknown | 12.1 | 12.8 | 11.0 | 4.8 | 14.7 |
| White | 76.5 | 70.6 | 85.6 | 75.2 | 77.0 |
| IMD deciles | | | | | |
| 1 | 17.9 | 22.0 | 14.9 | 20.0 | 19.2 |

| | | | | | |
|---|---|---|---|---|---|
| 2 | 17.6 | 27.0 | 9.4 | 26.4 | 17.7 |
| 3 | 9.8 | 9.9 | 11.0 | 12.0 | 9.4 |
| 4 | 14.9 | 11.7 | 17.7 | 12.0 | 14.7 |
| 5 | 8.9 | 6.4 | 11.6 | 10.4 | 7.7 |
| 6 | 5.7 | 3.9 | 7.7 | 6.4 | 5.0 |
| 7 | 7.7 | 3.9 | 8.8 | 4.0 | 6.5 |
| 8 | 8.3 | 3.9 | 11.0 | 2.4 | 8.3 |
| 9 | 5.1 | 4.3 | 3.9 | 0.8 | 5.3 |
| 10 | 2.1 | 1.4 | 2.8 | 3.2 | 1.5 |
| No fixed abode | 2.1 | 5.7 | 1.1 | 2.4 | 4.7 |

The table above indicates that the typical pathway patient is a middle-aged, white male living in a relatively deprived neighbourhood. There were differences between the city and county patient populations which reflect the wider respective populations, including a wider variety of ethnicities and greater deprivation within the city. There was also a larger number of patients without settled accommodation, or of no fixed abode, within the city.

A greater number of LMHT patients live in areas of relative deprivation (46% in the top IMD quintile), than SUS patients (37%). It was not possible to determine whether this was representative of broader differences between LMHT and SUS populations or if it was specific to the pathway. There were also a greater number of SUS patients of no fixed abode.

A summary of the background mental health and drug/alcohol assessments conducted with patients prior to their entry into the pathway are reported in Table 6.

Table 6 Baseline clinical characteristics

| **Demographic** | **Total (%)** | **Area (%)** | | **Sub-pathway (%)** | |
|---|---|---|---|---|---|
| | | City | County | LMHT | SUS |
| HoNOS supercluster | | | | | |
| Non-psychotic | 44.2 | 38.1 | 51.5 | 53.8 | 40.3 |
| Psychotic | 15.3 | 15.5 | 15.2 | 35.8 | 6.7 |
| Unknown | 40.3 | 46.4 | 33.3 | 10.4 | 53.0 |
| Drug and alcohol severity[a] | 1.9 | - | - | 2.4 | 1.6 |
| NDTMS categories[b] | | | | | |
| Alcohol-only | 29.2 | 22.0 | 36.7 | - | - |
| Non-opiates | 15.7 | 8.8 | 22.9 | - | - |

| | | | | | |
|---|---|---|---|---|---|
| Alcohol and non-opiates | 14.6 | 17.6 | 11.5 | - | - |
| Opiates | 40.4 | 51.6 | 28.7 | - | - |

[a]HoNOS. [b]Treatment Outcome Profile (SUS patients only).

As indicated in Table 6, there was a very large amount of missing data regarding mental health presentations and drug/alcohol severity. This was particularly true for SUS patients, for whom over half had no information. This is likely because these patients have had no contact NHFT.

The data on the types of substances used (amongst SUS patients) was more complete. The table shows that opiates were the most used substance amongst city-based patients, with alcohol being more common within the county. A greater proportion of LMHT patients came under a psychotic care cluster but again note the large amount of missing care cluster data for SUS patients. This limits interpretation, but it is likely that data were missing because these patients were otherwise not known to NHFT and thus probably had mental health conditions that did not warrant secondary care, which are typically non-psychotic conditions.

## Pathway usage

The number of patients going through the pathway since its inception and the degree of support they have received are reported in Table 7. The pathway was first implemented in Nottingham before being rolled out to the county. Therefore, a greater proportion of total patients have been since in the city, despite two-thirds of staff being based in the county, whilst approximately two-thirds of patients have been seen in the county more recently.

Table 7 Pathway service use by area and sub-pathway

| | **Total (n)** | **Area** | | **Sub-pathway** | |
|---|---|---|---|---|---|
| | | City | County | LMHT | SUS |
| Number of referrals | 468 | 56.8% | 43.2% | 27.1% | 72.9% |
| Number of users, current | 129 | 33.3% | 66.6% | 42.6% | 57.3% |
| Number of users, total | 356[a] | 53.6% | 46.3% | 29.5% | 70.5% |
| Time to first appointment, days (mean, median) | 39 (23) | 34 (26) | 39 (29) | 35 (18) | 38 (29) |
| Length of support, months (mean, median)[b] | 3.3 (2.6) | 4.2 (2.4) | 2.8 (2.6) | 2.3 (2.0) | 3.7 (2.8) |
| Session duration, mins (mean) | 51.1 | 54.5 | 48.1 | 43.3 | 57.1 |
| Sessions per month (mean) | 1.5 | 1.8 | 1.4 | 1.4 | 1.6 |

[a]This is likely to be an underestimate due to data recording issues. [b]Length of support results predominantly involve existing patients who are still on the pathway. The figures are therefore underestimates.

Most of the SUS pathway workers were in post many months before LMHT pathway workers. This helps to explain why 73% of all referrals have been to the SUS sub-pathway. However, all staff had been in post for at least 6 months by the time the current patient population was calculated, and the SUS sub-pathway was still supporting a greater proportion of patients (57%). SUS patients have also been supported for a longer time than LMHT patients, approximately a month longer on average. Finally, SUS patients were seen for longer appointments (approx. 1 hour) than LMHT patients (approx. 45 minutes).

## Engagement

The DNA rates of pathway patients is shown in Table 8. Comparative DNA rates for other services accessed by the pathway patients and rates for non-pathway patients are also shown. As shown in the Table, DNA rates are high for the pathway as a whole, with particularly high rates amongst city-based and LMHT patients.

Table 8 Session attendance: DNA rates

| | **Pathway patients** | | | | | | **Non-pathway LMHT patients** | |
|---|---|---|---|---|---|---|---|---|
| | Contacts with pathway staff | | | | | Contacts with non-pathway LMHT staff | D&A problems | No D&A problems |
| | Total | Area | | Sub-pathway | | | | |
| | | City | County | LMHT | SUS | | | |
| DNA rate (%) | 32 | 36 | 27 | 38 | 28 | 15 | 19 | 13 |

The DNA rate of patients with non-pathway staff reduced marginally from 16.2% to 15.4% after entering the pathway. Amongst NRN pathway patients for whom data was available, 6 (7%) dropped out of treatment, compared with 11% of non-pathway NRN patients.

**Pathway use and engagement across demographic groups**

Table 9 compares the degree of support provided to patients from different demographic groups: age group, gender, ethnicity, and level of deprivation.

Table 9 Pathway usage and engagement across demographic groups

| Demographic | Sub-group | Time to first appointment, days (mean, median) | Sessions per month (mean, median) | Length of support, months (mean, median) | Session duration, mins (mean) | DNAs (%) |
|---|---|---|---|---|---|---|
| Age group | 18-25 | 59 (20) | 1.7 (1) | 5.5 (3.1) | 55 | 34 |
| | 26-35 | 23 (15) | 1.7 (1) | 3.2 (1.9) | 49 | 24 |
| | 36-45 | 59 (34) | 1.3 (1) | 3.0 (2.6) | 50 | 42 |
| | 46-55 | 34 (28) | 1.4 (1) | 3.1 (2.6) | 55 | 26 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 56-65 | 32 (31) | 1.5 (1) | 2.9 (3.1) | 47 | 28 |
| | Over 65 | 0 (0) | 2.0 (2) | 3.2 (3.2) | 54 | 0 |
| Gender | Female | 30 (21) | 1.5 (1) | 2.4 (2.3) | 53 | 28 |
| | Male | 42 (28) | 1.5 (1) | 3.7 (3.0) | 51 | 32 |
| Ethnicity | Other | 34 (30) | 1.4 (1) | 2.2 (1.4) | 51 | 53 |
| | White | 39 (23) | 1.6 (1) | 3.3 (2.7) | 45 | 30 |
| Deprivation | Less deprived | 37 (23) | 1.5 (1) | 3.4 (3.6) | 51 | 24 |
| | More deprived | 42 (24) | 1.4 (1) | 3.7 (2.8) | 54 | 32 |
| | Most deprived | 36 (25) | 1.6 (1) | 2.9 (2.4) | 49 | 34 |
| | No fixed abode | 50 (50) | - | - | - | - |

Waiting times were lowest amongst the youngest (18-25) and oldest (65+) age groups as well as the most deprived group. White patients have received slightly longer periods of support than other patients. Less deprived patients were seen for slightly longer on average than more deprived groups. Though it should be noted that most patients for whom there was reliable data were still being seen within the pathway so 'length of support' estimates are provisional.

DNA rates were largely consistent across age groups, except for the over 65s who managed to attend every appointment. White participants had nearly half the DNA rate of other participants.

## Patient outcomes

Patient outcomes before and after entering the pathway are shown in Table 10. As seen in the table there were small, or no differences seen across most outcomes. The exception was a more notable drop in the number of patients living in unsuitable housing.

Table 10 Changes in mental health, substance use, functioning, housing and quality of life

| Outcome | n | Before[a] | After[b] | Difference |
|---|---|---|---|---|
| Drug/alcohol issues[c] (mean, median) | 75 | 1.6 (2) | 1.9 (2) | 0.3 (0) |
| Behavioural issues[ce] (mean, median) | 75 | 1.1 (1) | 1.3 (1) | 0.2 (0) |
| Impairment[c] (mean, median) | 75 | 0.8 (0) | 0.9 (0) | 0.1 (0) |
| Social problems[c] (mean, median) | 75 | 1.2 (1) | 1.3 (1) | 0.1 (0) |
| Mental health symptoms[c] (mean, median) | 75 | 1.5 (2) | 1.7 (2) | 0.2 (0) |
| Psychological health[d] (mean) | 87 | 9.6 | 12.1 | 2.5 |

| | | | | |
|---|---|---|---|---|
| Physical health[d] (mean) | 87 | 9.9 | 11.2 | 1.3 |
| Quality of life[d] (mean) | 87 | 8.7 | 10.0 | 1.3 |
| Housing problem (%)[d] | 87 | 9.2 | 9.2 | 0 |
| Unsuitable housing (%)[d] | 87 | 16.1 | 6.9 | 9.2 |
| At risk of eviction (%)[d] | 87 | 5.7 | 8.0 | 2.3 |

[a]Assessment prior to entering the pathway. [b]Assessment whilst accessing the pathway or following discharge. [c]HoNOS scale. [d]Treatment Outcome Profile – CGL patients only. [e]Composite variable including drug/alcohol issues, which is also reported separately in the table.

**Referral to other services**

LMHT referrals

Six patients (2% of SUS pathway users) had been referred to LMHTs as of May 2023. Three of these referrals were accepted, with one pending at the time of writing. Pathway staff provided four explanations for why LMHT referrals are often inappropriate: (i) many pathway patients don't meet LMHT threshold criteria, (ii) long LMHT waiting times, (iii) LMHTs lack the necessary flexibility required for this patient group, and (iv) for Nottingham city patients, the single SUS site being more accessible than other service settings because it is familiar to them and centrally located.

Primary care and third sector referrals

Nine CGL patients (10%) had been referred to an IAPT provider, three (3%) to Mind and two (2%) to CRUSE Bereavement Support.

## Patient experiences

Eight patients were interviewed about their experiences of the pathway. Their personal characteristics are summarised in Table 12. The interview sample was representative of the wider patient population in terms of age, gender and type of service accessed (LMHT or SUS), but ethnic minorities and county-based patients were underrepresented. Depression and anxiety were the most common mental health conditions experienced. None of the interviewees reported experiencing psychosis. Alcohol was the primary substance used amongst most participants.

Table 11 Patient interview participant characteristics (n=8)

| | *n* | % |
|---|---|---|
| Age | 42 (mean) | |
| Gender | | |
| Female | 3 | 40 |
| Male | 5 | 60 |
| Sexual orientation | | |
| Heterosexual | 7 | 90 |
| Other | 1 | 10 |
| Ethnicity | | |
| Black British | 1 | 10 |
| White British | 7 | 90 |

| | | |
|---|---|---|
| Area | | |
| City | 7 | 90 |
| County | 1 | 10 |
| Sub-pathway | | |
| LMHT | 3 | 40 |
| SUS | 5 | 60 |
| Self-reported mental health condition | | |
| Agoraphobia | 1 | 10 |
| Anxiety | 6 | 75 |
| Borderline personality disorder | 1 | 10 |
| Depression | 7 | 90 |
| Panic disorder | 1 | 10 |
| PTSD | 3 | 40 |
| Self-harm | 1 | 10 |
| Self-reported substances used | | |
| Alcohol | 7 | 90 |
| Non-opiates | 3 | 40 |
| Opiates | 1 | 10 |

Three main themes and six sub-themes were identified to reflect the views and feedback of patients. These are listed in Table 13.

Table 12 Patient interview themes

| Main Theme | Sub-theme |
|---|---|
| Supported to make important changes | Therapeutic relationship<br>Person-centered approach |
| Addressing multiple needs | Single point of access<br>Support for different concerns |
| Expanding the service offer | Longer period of support<br>More staff capacity |

**Supported to make important changes**

Patients reported the pathway to be a helpful and supportive experience. They cited the importance of building good rapport with staff and their person-centred, flexible, and non-judgmental approach. This is captured within the sub-themes below.

*Therapeutic relationship*

Many of the patients noted the value of therapeutic relationships with staff, suggesting that the support and encouragement they provide is an integral part of the process of achieving personal change.

> *"We're able to have that rapport, which gives me confidence to be around him [pathway staff member], which I probably wouldn't have had in the past" (P33)*

*"Since I came out of hospital I've not been drinking, so it's going on now about seven months, which is the longest in my life I've ever gone…without her [pathway staff member] help I probably wouldn't have been able to do it" (P37)*

One patient also reflected on the value of developing a relationship with a single worker, commenting that this made it easier for them to build rapport and open up about previously difficult experiences.

"*It's made it a lot easier cause I just had to speak to that one set of people [pathway worker], instead of having to go to them, then go to someone else, then maybe someone else" (P37)*

*"It felt like I had known her for years…she's [pathway worker] got a good way of talking about things without being dead intrusive" (P37)*

*Person-centred approach*

The person-centred approach used within the pathway was characterised as a flexible and non-judgmental stance, with staff adjusting and adapting their work practices to meet patients' needs and maximise their ability to engage with the pathway.

*"She [pathway worker] doesn't judge me, she says…you know you're doing well, keep going, and it made me feel good about it, I feel good after the session" (P30)*

*"I need routine, so it's always the same time same day every week so that's been really helpful" (P32)*

*"He'll [pathway worker] send me a message, because I've got memory problems and focus…so he'll send me a message on the day an hour before the appointment, so I know I've got to come in" (P31)*

One patient commented that staff struck the right balance between encouraging change and not pushing people to move faster than they are comfortable or able to.

*"I'm happy with the pace…there's no pressure but there's also no complacency, so it's just where it needs to be" (P33)*

Many patients reported that staff were good at active listening and that they could be open and discuss difficult topics with them. This made patients feel more cared for and able to address long-standing issues that had been impeding their recovery.

"*I felt like he [pathway worker] listened to what I was saying" (P27)*

*"I've been overwhelmed with the support…I was always in the position that no one cared about me…but everyone's been brilliant" (P34)*

*"I'm saying things I've been shut off from for years, and it's difficult to face these things but it's helping me progress" (P31)*

**Addressing multiple needs**

*Single point of access*

A key benefit of the pathway highlighted by patients was having both services within one place. This was reported as being helpful for maximising engagement. It was also noted that

substance use and mental health difficulties are often related and that services may be most helpful when the structure of provision reflects this.

> *"They [mental health and substance use services] should be working together, cause mental health and substance, they come as a pair…a lot of the reason why people take substances is because of their mental health" (P30)*

> *"Having mental health and drug and alcohol services in one place helped…one million percent difference" (P37)*

> *"If it's on your doorstep and everything is in one place, you've got a lot more chance of people going and seeking help" (P37)*

*Support for different concerns*

Several patients commented that pathway workers supported them with issues beyond substance use and mental health, including housing and financial problems.

> *"She [pathway worker] has supported me with drug and alcohol advice, and also housing advice…so it's combined" (P30)*

**Expanding the service offer**

Patients generally offered positive feedback about the pathway, and the majority did not make any recommendations for changing the service offer. However, some patients suggested that longer periods of support and greater capacity within the pathway would be required.

*Longer period of support*

One patient reflected on the benefits they had derived from accessing the pathway, but felt that it should be offered for longer periods of time.

> *"It would be helpful if it could go on for longer" (P37)*

*More staff capacity*

Another patient reported that his worker was overworked and reflected that if staff are overworked, they may not be as able to provide good quality support.

> *"I mean he seems like really overworked…maybe if you could have someone help or support with that, that would be great, cause obviously if he's overworked, he's not as able to provide as good care" (P32)*

## Pathway staff experiences

All staff involved in delivering the pathway (n=11) were interviewed, including community-based and inpatient pathway workers and managers. Five themes were identified from the interview data, with nine sub-themes (see Table 14). These are described and discussed below, with reference made to any relevant differences between service type (LMHT/SUS) and area (city/county).

Table 13 Pathway staff interview themes

| Main Theme | Sub-theme |
|---|---|
| A different way of working | Partnership approach<br>Tolerating engagement issues<br>Flexible, patient-centered approach |
| Nuanced perspective of recovery | Progress and change are multifaceted |
| Inadequate provision within the system | Falling in the gaps between services<br>Limited resources |
| Challenges of implementation | Integrating with host teams<br>Capacity to support patients' ineligible for other services<br>Access to other professionals |
| Supportive team structure | |

**A different way of working**

All pathway staff acknowledged that patients with co-existing conditions required a different way of working. This included collaboration between mental health and substance use workers, managing a lack of patient engagement, and adopting a flexible, holistic approach to meet diverse needs, including social and practical support.

*Partnership approach*

Pathway staff emphasised the importance of working collaboratively with staff in their host teams. This was to develop effective working relationships, upskill each other and maximising patient engagement.

> *"It's taken some time to build up the working relationships with professionals, but now were at the point where they're identifying and seeking us out, and I guess they feel we're part of their team now" (P12)*

> *"I think we've learnt off each other, which is the beauty of it" (P23)*

Two participants also reflected on the importance of partnership working for managing and navigating complexity and influencing patient outcomes, describing that patients have reaped benefits from pathway staff collaborating and adopting a partnership approach to their work.

> *"You have to have good relationships with your partner agencies and work together, because if they [patients] are open to lots of different services and it's hard for them to navigate, we need to at least be working together well" (P2)*

> *"We've needed to have more of a team approach for dealing with this level of complexity" (P2)*

*Tolerating engagement issues*

It was acknowledged that poor levels of engagement would be common amongst this patient population. Therefore, staff believed that different expectations around engagement and approaches to manage lack of engagement were required with this population.

> *"Looking at working out what you can do to help people engage, rather than writing them off and booting them out of services" (P9)*

> *"it's a lot of flexibility, and benefit of the doubt working,…and not the kind of viewpoint of two strikes you're out, or three strikes…they [CGL] keep them on a rolling caseload if they fall off script" (P1)*

*Flexible, patient-centred approach*

All pathway staff commented on the importance of a flexible, person-centred approach to address both engagement issues and the various needs of patients.

> *"Dynamic ways of working and being creative" (P4)*

> *"It's about meeting the person where they are,….you can't always go into being able to solve everything. Sometimes it's enabling the person just to tell their story and working out what's important to them" (P2)*

One participant reflected on the difficulties this population may experience in developing effective working alliances, and described the importance of developing a consistent and trusting therapeutic relationship, as being fundamental for support clients with co-existing substance use and mental health difficulties;

> *"It's important for this client group to have one point of contact, one worker, so that consistency is huge, and in services there is a lot of change in staff,…none of that particularly helps,…they need to have consistency and trust before they can work on anything else" (P2)*

**Flexible perspective of recovery**

Many of the pathway staff expressed inclusive views of what may constitute recovery and clinical progress for this patient population. This was largely emphasised by the mental health workers hosted within substance use services, however all staff appeared to acknowledge the importance of having flexible and dynamic views of what makes recovery meaningful, and the idea that this is unique to individual patients.

*Progress and change are multifaceted*

Staff described recovery as being multifaceted, idiosyncratic, and typically non-linear. They noted the importance of acknowledging small wins, managing expectations for change.

> *"Appreciating that some people may take years to get to a point where they're not using" (P3)*

*"Expectations of the level of change you're going to enact with somebody need to be lower, doesn't mean people can't make massive changes to their lives but it's about small wins with people" (P2)*

*"Quite often we get involved in activities that are not really related to substance use, but they're certainly related to recovery" (P12)*

Some staff sought to sought to achieve intermediate personal outcomes for patients such as feeling empowered, autonomous and in control.

*"Making them [patients] feel empowered and autonomous, which they may not have had experience of, particularly within healthcare settings in the past, they have probably been disempowered or stigmatised" (P4)*

Two LMHT-based participants acknowledged that patients would have their own conceptions of recovery which need to be respected. Recovery for some patients may involve improving their quality of life rather than achieving abstinence.

*"You might have someone who doesn't want to reduce their alcohol usage, they don't feel ready… So sometimes it's working with somebody in terms of quality of life" (P2)*

*"A lot of people don't want to be abstinent, they just want a bit more control,…people can come and go, come and go, come and go, and it's just part of their recovery" (P3)*

**Inadequate provision within the system**

Many pathway staff described a sense of frustration that existing services often do not meet the needs of people with co-existing conditions. This appeared to be present across all staff groups, from both substance use and mental health services, but voiced as having slightly more of an impact within LMHT and inpatient units. Many of the pathway staff also spoke of the limited capacity within the pathway itself.

*Falling in the gaps between services*

Several pathway staff described a 'catch 22' scenario, whereby services users are frequently denied access to services and support for difficulties with both mental health and substance use, due to experiencing these concurrently.

*"A big problem is probably people being told they need to sort their substance use out before they can engage in mental health services" (P2)*

*"They [patients] might get told that they're not unwell enough to have treatment [in secondary care]…they might then go to an IAPT service that say's you're too risky for us and then they're still between services" (P2)*

*Limited resources*

Whilst many staff feel the pathway is working well, several staff members noted that it was under-staffed with generally only one staff member covering multiple teams in each area.

*"We need a treatment pathway, service, that is robust…let's be honest it's not is it, it's one worker, that is not a service" (P5)*

*"The pathway's just a baseline model, having one person in-reaching into substance use services providing mental health support for the whole of the city is not enough" (P2)*

County staff described more difficulties working across multiple teams as they needed to cover wider geographical areas. The implications of this included staff isolation and not being able to offer the required flexibility to patients.

*"There's a lot of travel potentially, and because we want to be flexible with services users, we're trying not to make patients fit a round peg in a square hole" (P36)*

*"I can't be in two places at once" (P28)*

**Challenges of implementation**

Some of the pathway staff thought that getting embedded and integrated into host teams had been a challenge, particularly those staff who covered multiple teams. Staff also thought the current capacity of the pathway was insufficient to meet patient demand across the system.

*Integrating with host teams*

Pathway staff working across multiple teams described challenges of integrating with those teams as they typically only worked with each team for one day a week.

*"You're not there everyday, you're just there once in a while so the integration of our posts into different teams can be really hard" (P3)*

For some staff there were also issues around organisational lines of supervision and access to training within host teams.

*"I think we need to come under someone [in the host team], so if there's any training in the acute settings that we're not missed out of that loop" (P12)*

*Insufficient capacity to support patients*

Pathway staff also commented on experiences of working with patients whose needs were too severe for primary care, but not severe enough for secondary care. Staff felt the pathway could provide them with the necessary care in theory but stated that the pathway could not meet the level of demand.

*"We can't meet the demand necessarily of providing that treatment in the gap…we are doing our best, but yeah, there is a lot of demand" (P2)*

*Access to other professionals*

Staff noted that specialist support was sometimes required but was generally difficult to access. This included access to staff who could provide prescriptions and advice on medication or therapy guidance for patients experiencing trauma and complex personal issues.

*"Often the psychologists in teams will provide supervision for the workers to then provide more complex interventions" (P2).*

*"Prescribing for both substance use and mental health would be really good" (P9)*

### Supportive team structure

Staff felt able to access good support from within their teams and from management, reflecting on the importance of whole team discussions, regular catch ups, and the implications of this for helping them manage and mitigate risk.

> *"There's more of a team approach to working with this client group, so they don't feel on their own, which is really key in terms of relationships but it's also about support and protecting from burnout, because they are managing a lot of risk" (P2)*

> *"It feels like if you need support from other members of the team, they are always there" (P10)*

## Non-pathway staff experiences

Eighteen non-pathway staff were interviewed. Seven were recruited from LMHTs, 12 from SUS, and one from inpatient services. All participants worked in city-based services except two. Two main themes were identified with five sub-themes (see Table 15).

Table 14 Non-pathway staff interview themes

| Main Themes | Sub-themes |
|---|---|
| Linking up services | Sharing knowledge<br>Improving accessibility |
| Ongoing challenges | Data administration<br>Not meeting demand<br>Stretched across host teams |

### Linking up services

Non-pathway staff felt that having access to a pathway worker within their service had facilitated the sharing of knowledge through collaborative working. They also thought that having in-house pathway workers provided more accessible substance use and mental health support.

*Sharing knowledge*

Within SUS services, workers commented that pathway staff had shared their knowledge of mental health difficulties. This was less evident within LMHT services.

> *"He's [pathway worker] given me advice on how to work with individuals, it helped me engage them [service users] better" (P15)*

*Improving accessibility*

SUS staff reported that the pathway provided a more accessible source of mental health support compared to what had been available previously.

> *"Provides a link between secondary mental health and ourselves, which therefore co-case management supports the service user and they have a better understanding of the mental health pathway and the expectations within it" (P16)*

*"Getting people referred into mental health services was really long winded, but the pathway worker coming along has cut a massive chunk of that out…it's been far more efficient, far more accessible" (P15)*

LMHT and inpatient staff also reported benefits from easy access to pathway staff based within their teams.

*"There's an easy bridge now into NRN [SUS service]…we never had that previously, there was no connection between the two services,…it's been really useful having that link between" (P13)*

*"It's been a really nice boost…because we've got in reach workers on site, they're working together well" (P25)*

**Ongoing challenges**

*Data administration*

Two participants described the issues with recording clinical notes on different electronic systems. Each of the organisations involved in the pathway use different recording systems for clinical information. This has caused difficulties with being able to access appropriate information when needed and doubles the amount of data administration required of pathway staff.

*"Mental health services use RiO, we don't…even though I can read RiO I can't put anything on there, which is unhelpful when trying to look at an individual person's care…and for the pathway worker, it means they're recording the same information in two different places" (P7)*

*Not meeting demand*

Nearly all the participants, regardless of service or area, reflected that whilst support offered by the pathway was helpful, they felt it did not fully meet the demand they were seeing within their services.

*"We could probably eat up another worker, to be honest" (P17)*

*"He [pathway worker] has a high caseload…he could do with, or we could do with having more than just one here…our work is quite demanding" (P15)*

*Stretched across host teams*

Some of the LMHT staff also commented on the low visibility of pathway workers who worked across three or four teams.

*"She [pathway working] can't always be there…she's obviously stretched across different teams or different responsibilities…if she was there for all our meetings, that would be ideal" (P24)*

*"I'm just basically not seeing her as much as I thought I might" (P19)*

In summary, nearly all staff (both pathway and non-pathway) acknowledged that the pathway was not sufficiently staffed to meet the demand of patients across the system.

# DISCUSSION

## Main findings

**Mixed achievement of original pathway aims**

The aims of the SU/MH pathway include providing quicker access to mental health services; providing easier access to substance use support; supporting 'difficult to engage' patients; and advising and upskilling staff. One of the key aims was to improve access to mental health services for adults accessing drug and alcohol services with co-existing conditions. However, this evaluation found that very few pathway patients were being referred to secondary care (LMHTs). The reasons for this included patients' not meeting secondary care thresholds, and LMHT services not being accessible due to waiting times, inflexibility, or location. Similarly, only about 1 in 10 patients had been referred to primary care (IAPT). Therefore, the pathway is not primarily operating as a conduit to other services but instead as the final care destination for most patients.

One of the major reasons that the pathway has not provided greater access to secondary care services is that many patients were thought to be ineligible for these services and so not referred. Thus, even if other barriers to LMHTs were overcome, this raises the question of which service is the most appropriate to provide care for this patient group. When asked who is best placed to support patients whose needs fell in between primary and secondary care most of those interviewed suggested that the pathway itself could provide the necessary care. It may be appropriate to transform the pathway into a case-holding team for the following reasons. Pathway staff have clinical experience with patients with co-existing conditions and can provide psychosocial interventions and flexible appointments for this population. Waiting times for the pathway are also much shorter than for LMHTs and clinic sessions are held in locations which are accessible and familiar to patients.

Transforming the pathway into a case-holding team may raise resourcing issues if a significant proportion of the patient population requires medium-to-long term care. The pathway was originally designed to provide care for up to three months whilst patients were on waiting lists for other services. Estimates from this evaluation suggest that approximately one-quarter of the patient population will require support for four months or longer, with a small number requiring care for at least a year.

Another aim of the pathway was to better support those who have not engaged well with other services. The evaluation found mixed results in this regard. The available data suggested that slightly fewer pathway users were discharged due to disengagement than other SUS patients, with the latter being expected to engage better. This suggests that the pathway is helping to maintain contact with patients, who are not being lost to services as they may have been previously. On the other hand, within the LMHT part of the pathway, patients missed appointments with pathway staff over twice as often as they did with non-pathway staff. The reason(s) for this high DNA rate was not identified in the evaluation. Equivalent DNA rates with non-pathway SUS staff were unavailable so appointment attendance could not be compared within this part of the pathway.

One of the final aims of the pathway was to advise and upskill other staff. Again, there were mixed findings with regards to this aim. SUS staff all agreed that pathway workers provided them with a valuable source of advice and guidance for supporting patients with coexisting conditions, with pathway workers often sitting in on their appointments when requested. In particular, SUS staff expressed a greater understanding of the mental health services. However, there was less evidence that SUS staff had learnt to provide any mental health support to patients themselves or know how to manage mental health crises. Meanwhile, LMHT staff did not indicate that the pathway had improved their knowledge or skills in supporting patients with co-existing conditions. Overall, it appears that simply working alongside pathway workers for typically one day per week for up to one year (when the pathway began) does not lead to a full transfer of knowledge and upskilling of other staff. Notably, training workshops for non-pathway staff have not yet been delivered so the impact of these could not be assessed. Training workshops are being planned now that all pathway staff are in post.

**Comparisons between different parts of the pathway**

There are some differences in how the SUS and LMHT sub-pathways have been used so far. There were slightly more SUS patients than LMHT patients. SUS patients were also having longer appointments as well as being supported over a longer period. Most of the SUS-based pathway staff had been in post longer than the LMHT-based staff, with some of the latter only receiving referrals within the past 3-6 months. Therefore, the SUS staff may have established stronger links and visibility within their host teams and subsequently have received more referrals. That said, given that there are more institutional barriers to mental health support for SUS patients compared to substance misuse support for LMHT patients, it is plausible that there is also a greater need for the SU/MH pathway within SUS services compared to LMHTs. The longer sessions and length of support given to SUS patients also may reflect a greater need for the pathway within SUS services.

It may be noted that city-based patients also had a longer mean duration of support than county-based patients, though this was skewed by a small number of patients requiring long-term support. Nonetheless, this may reflect some overall differences between city and county patient populations. City-based patients were more likely to use opiates, and to live in more deprived areas, than county-based patients. Both opiate use (compared to non-opiate use) and deprivation have been associated with poorer treatment outcomes (Burkinshaw et al., 2017). Most of the patients of no fixed abode were also based within the city. Overall, this may suggest that a greater proportion of city patients will have more complex needs than county patients and that those requiring long-term support are more likely to be based in the city.

**Patient outcomes and experiences**

All the interviewed patients reported positive experiences of the pathway and stated that the quality of their care had improved. The treatment approach of pathway workers (flexible, person-centred) was particularly welcomed, and patients reported that their key needs were being met. There were only small or no changes in the measures of mental health, substance use and quality of life. However, there were substantial limitations in the outcome evaluation (see Limitations section), with the patient outcomes not being adequately assessed. Therefore, patient outcomes largely remain unclear. Amongst SUS patients for

whom we collected more robust data, there was a reduction in the number of people living in unsuitable housing, a small improvement in psychological health and a marginal improvement in quality of life.

**Staff experiences and recommendations**

SUS staff had very positive views of the pathway. SUS-based pathway workers were primarily viewed as a mental health service in of themselves rather than a conduit to formal mental health services. In this regard, having ready access to in-house mental health support was seen as very valuable, as there is a high level of mental health problems within the SUS patient population, and there was perceived lack of support previously. LMHT staff had more modest views of the pathway. Staff suggested this was primarily because the LMHT-based pathway workers were stretched across multiple teams and so were less visible and had less impact. It may also be because there is less of a need for the pathway within LMHT services as most of mental health patients can readily access SUS services already. Pathway staff themselves also reported positive experiences of working within the pathway. Despite working across a wide geographical area and three provider organisations staff felt supported and well-integrated as a team.

Patients generally reported positive experiences and hence did not offer any recommendations for the further development of the pathway. Meanwhile, pathway and non-pathway staff offered one main suggestion: increase the capacity of the pathway. All staff believed that demand for the pathway was currently outstripping capacity, with some indications that demand might increase once pathway staff became more embedded and visible within their host services. Therefore, the recruitment of additional staff members was recommended. The most common suggestion was to employ more mental health/substance use practitioners. A couple of people specifically suggested it would be helpful to involve other specialists, such as a medic who could prescribe both substance use and psychiatric medication, and a clinical psychologist who could provide guidance on in-depth psychosocial interventions for patients with more complex needs.

## Limitations

There were several questions which this evaluation was unable to answer or provide only a limited answer to. These concerned (1) patient mental health, substance use and urgent care outcomes, (2) engagement with services, and (3) staff competencies.

First, changes in patient mental health and substance use outcomes were influenced by the timeframe across which the measures were administered. Due to limited availability of routine clinical outcome data, the baseline assessments for some measures went back as far as January 2021 and likely did not reflect patients' status at the point of entry into the pathway. Substance use outcomes were also assessed using the HoNOS, which is less reliable than TOPs data. Similarly, the availability of only 2-3 months of service data also meant that it was difficult to assess changes in patients' use of urgent care services. The use of urgent care services is typically intermittent, so longer-term follow-up is warranted. Overall, the data available from health and care records was incomplete. Data were unreliable for the first 12-16 months of the pathway when recording systems were still being set up, there was missing data overall, and the types of missing data varied across the three provider organisations. This constrains any inferences regarding patient outcomes, as well

as some pathway use indicators, given that only the most recent data covering ~2 month period could be considered reliable.

Second, one of the evaluation findings was that patients appeared to be engaging better with non-pathway staff in LMHT teams compared to pathway staff. This was unexpected given that the pathway is specifically designed to meet the needs of this patient group. The finding could not be explained from the interviews with patients, who generally expressed that they were able to engage well with the pathway. However, a convenience sampling design was used to recruit patients, and many patients did not turn up to sessions. Therefore, it seems likely that the interview sample consisted predominantly of patients who were engaging relatively well with the pathway. It would have been useful to specifically recruit patients who were struggling to attend appointments to hear of their experiences.

Third, one of the aims of the pathway is to disseminated knowledge and skills amongst staff outside of the pathway. However, it was not possible to directly assess changes in non-pathway staff competencies because no training sessions occurred during the period of evaluation.

Finally, there are some limitations in the comparisons across geography (city, county) and service type (LMHT, SUS). The interview samples were over-represented by staff and patients based in the city. It is possible that there are different experiences of the pathway for those based in the county. Though it can be noted that the patient interview sample was actually more representative of the county population across the categories measured, as there was a closer match in terms of ethnicity and substances used. Furthermore, the key issue that emerged from interviews with county-based pathway staff involved the geographical spread of services and the impact this had on their visibility and ability to achieve an impact in any one service. This is consistent with the finding from city-based services where a single pathway staff member was similarly stretched over multiple teams. It appears unlikely that the geographical spread of services has had a significant impact upon individual patients' experience, with county patients receiving a similar number of sessions per month, of a similar length, to city patients.

This evaluation also sought to compare outcomes and service use across different parts of the pathway. However, given the relatively small numbers of staff employed within the pathway, this often meant that the analysis was comparing the caseloads of individual members of staff. It is to be expected that individual staff will take somewhat idiosyncratic approaches to the delivery of care, as well as having different levels of training and experience. This is likely to have influenced the findings to some degree and the comparative data across geography and service type should be interpreted in this light.

## Recommendations

**Consider increasing the capacity of the pathway**

The pathway appears to be effectively operating as a case-holding team rather than a conduit to other services. Many pathway patients appear to be ineligible for other services, particularly SUS patients for secondary care. Therefore, the pathway is currently the primary care provider for this population. If the pathway continues to function in this manner, then it is not sufficiently resourced to meet the level of patient need across the system and further staff recruitment is warranted. In terms of the structure of the pathway, staff members

working across 3-4 teams had low visibility and impact. Recruiting enough staff to place one member of staff in each SUS site or LMHT would remove this issue. Some larger sites, such as the single SUS site for Nottingham city, likely require at least two staff members.

**Conduct a further evaluation**

The pathway was still in development during the period of this evaluation, including recruiting staff into roles and setting up data recording procedures. This was partly the reason why the evaluation was unable to answer questions about patient outcomes and there was limited data on pathway usage. Some preliminary findings of this evaluation therefore require confirmation in a future evaluation once the pathway is firmly established. Patients' use of urgent care services also needs to be assessed. If the pathway was found to help stabilise this patient population such that they reduced their use of emergency services, this may provide a business case for further investment in the pathway to increase capacity as recommended above.

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