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Strategic Review of Southampton Drug Treatment System

REPORT TO DRUG ACTION TEAM PARTNERSHIP OCTOBER 2012

Recovery - a process of 'voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society' - UK Drug Policy Commission 2008.

Contents

page

Executive Summary

Recovery - a process of 'voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society' - UK Drug Policy Commission 2008.

Reason for the Review:

The 2010 Drug Strategy 'Reducing demand; Restricting Supply; Building Recovery' aims to support people to live a drug free life. Unlike previous strategies which focussed primarily on the harms caused by drug misuse, this strategy aims to go further to support individuals to choose recovery as an achievable way out of dependence. The strategy has a focus on holistic client centred approaches but also carries an expectation that a 'full recovery' is both possible and desirable for all drugs, including prescription and over the counter substances as well as severe alcohol dependence.

In January 2012 the National Treatment Agency (NTA) published '*Why Invest? – how drug treatment and recovery services work for individuals, communities and society*'. This document outlines 4 recovery steps, around which the NTA recommends that treatment service provision should be commissioned at a local level.

- **Step 1: Start treatment:** this looks at how PDUs are brought into treatment. For example via needle exchange schemes, testing on arrest, self referral or via GPs. Treatment in this step is concerned with developing engagement, providing assessment and ensuring harm reduction provision (health improvements)

- **Step 2: Stay in treatment:** This step is concerned with maintaining engagement and developing motivation for recovery via the recovery planning process. It includes the use of talking therapies and/or medication where appropriate. This step aims to ensure that drug use is decreased, crime & nuisance are reduced and health improvements are visible. It also focuses on acquiring stable housing and ensuring family and peer support reinforce treatment gains.

- **Step 3: Stopping treatment:** This includes detoxification, becoming free of dependency, developing education and employment skills and increasing support from family and peers.

- **Step 4: Sustaining recovery:** It includes ensuring that individuals take on their personal and family responsibilities, become role models, are active citizens and received continued community support.

As Southampton's drug treatment services had been commissioned before the new strategy was published, it was felt that a full review of services was required in order to assess whether the current system was fit for purpose and capable of delivering on the 2010 Drug Strategy agenda.

At the same time, there were other national and local drivers which made it necessary to review drug treatment services in Southampton. These can be summarised as:

National -

- Performance and funding formula for Drug Action Teams
- Personalisation and Self Directed support
- Quality – Outcome focussed commissioning
- Employment and meaningful activity
- Public Health Outcomes Framework
- Changes to benefits
- Police and Crime Commissioners
- Clinical Commissioning Groups

Local-

- Performance issues
- Safeguarding concerns (Serious Case Review – Child F)
- Joint Strategic Needs assessment
- The need to establish improved effective practice in services.

Scope of the Review:

This Review covers the drug treatment services commissioned by Southampton City Council, who are the lead commissioners for drug services under the terms of a section 75 agreement with NHS Southampton City (Southampton PCT) . The s75 Partnership Board is the authority that will decide how drug treatment services are commissioned following due consideration of the Strategic Review and Needs Assessment information.

The services that are deemed to be within the scope of this review are detailed within Appendix 2 attached to the report and consist of :

- The Bridge – an Open Access tier 2 service
- Drug Intervention Programme (DIP) a tier 2/3 Criminal Justice service which incorporates the delivery of the Drug Rehabilitation Requirement
- Harm Reduction and Outreach Service (SHaRP)
- Tier 3 Care Co-ordination and Rapid Prescribing service
- Morph – Service User Advocacy and peer support service
- ParentSupport Link – Families and Carers advice, information and support service.

The key aims of the review were to:

* Examine the services performance to contract;
* Make an evidence-based judgement of the relevance of the service to national and local policy objectives;
* Benchmark the service against a comparable service(s);
* Identify and assess the outcomes being achieved;
* Identify any ways in which the service could be improved;
* Set out the main options open to Commissioners in order to best meet objectives

Findings of the Review:

Data:
Data has been gathered and provided to the DAT partnership from a variety of sources and IT systems. This has proved confusing and unhelpful at times for the Drug Action Team, treatment providers and for strategic stakeholders. It has been difficult to analyse data reliably and there has been a lack of understanding amongst both commissioners and providers about which performance measures to rely on. The recent introduction of the more robust Diagnostic and Outcome Measurement Executive Summary (DOMES) is now proving helpful in allowing treatment providers and commissioners to see where performance unquestionably needs to be improved.

The introduction of a single robust data monitoring and case management system would also be helpful in providing treatment providers with a system into which all treatment providers can input information for the benefit of the service users, and which is capable of providing live information. This will enable commissioners and providers to be "smarter" at collecting and using available data in order to improve performance overall.

Service users:
Service user questionnaires were used in order to establish whether service users understood the concept of Recovery and what issues were of concern to them. Most service users had a very general understanding of what Recovery was, and overall, service users do not appear to be clear about the nature of recovery or the goals of the treatment system, which in itself is a comment upon how the treatment system has been explained to them.

Although the questionnaires were designed to ascertain information about the treatment system as a whole, respondents tended to answer in terms of their own personal experience of a particular service. Respondents often felt that they had to give positive reports of the service they receive and are often so grateful to receive any service at all that they find it difficult to view themselves as 'customers' and give constructive criticism or make recommendations for improvement.

Criminal Justice service users gave the most positive accounts of the treatment received. Service users who had been in the treatment system longest some up to 15 years) gave the most negative accounts of key working and treatment regimes.

There were no responses from service users who had left treatment. There is a considerable need to gain information from those who are no longer in contact with treatment services, those in need of aftercare and those who 'drop in and drop out' as well as those who are treatment naïve, in order to gain a broad spectrum of opinion from past, present and potential future service users on what works and what does not work for them.

Case file audit:
The case file audit was the most telling of all the exercises undertaken as part of the strategic review team. This exposed significant gaps in the care/recovery planning process, risk assessment, and in the ability of services to work in a structured way with service users over lengthy periods of time. It identified that social and recovery capital was not being built throughout treatment in a systematic way as part of a considered personalised care planning approach.

Conclusions from the Review:
This strategic review has therefore identified a number of weaknesses in the treatment system:

- The collection and analysis of data at both national and local levels and the inability to segment the treatment population.
- Not having a common understanding of what 'recovery' means

- weak care co-ordination
- poor assessment practice
- a system that is 'prescription' driven.

Successful completions within this system were being hindered by a lack of clarity in desired outcomes for both services providers and service users. An assessment process that was driven by form filling activity missed the opportunity to make every contact count and there appeared to be an absence of quality clinical supervision to both challenge assumptions about 'recovery' and develop workers interventions and skills.

There were a number of implementation gaps between practice and NTA good practice guidelines, RODT recommendations and the 2010 Drug Strategy. The findings of the Service User Questionnaire identify that greater efforts are required to obtain the views of those who have been successful in their recovery journeys, of those who have been in 'shared care' services for many years, those that 'revolve' in and out of treatment and those who are treatment naive and to recruit community recovery champions from some of these groups.

Some of the gaps identified above have been addressed by treatment services following feedback from the strategic review project manager.

The Way Forward:
The Drug Action Team Strategic Review therefore concludes that the treatment system as it is currently commissioned, no longer meets the requirements of the 2010 Drug Strategy. Current treatment providers were commissioned to provide services in line with previous strategies and have achieved varying degrees of success in meeting their performance targets. However, the existing treatment system is not enabling Southampton City Council and the Drug Action Team Partnership to meet it's obligations to service users within the city as part of the most recent Drug Strategy and the guidance issued by the National Treatment Agency.

The decision has therefore been taken, based on the findings of this strategic review, by the Section 75 Partnership Board, to commission a new drug treatment system as part of an Integrated Drug Treatment system for Southampton, through an open tender.

1. Introduction

This is an uncertain time for the drug and alcohol sector with unprecedented levels of changes in funding, Commissioning, Management and delivery structures in the drive to deliver the Government's 'Big Society' agenda. The shift of power and accountability from centralised government to local levels has begun: the election of the new Police and Crime Commissioners (PCC), the development of the Work Programme and the Troubled Families Initiative as well as the reform of the NHS. Through the introduction of the Health and Social Care Act 2012 the National Treatment Agency for Substance Misuse (NTA) will be abolished and its key functions absorbed into a new public health body, Public Health England (PHE) who will assume a full recovery leadership role for both drug and alcohol dependence from April 2013. By November 2012 the PCCs will have produced their first drafts of the Police and Crime plans and associated budgets in order that these can be cleared by March 2013. Partnership working will therefore remain as important as ever in relation to the future commissioning of drug treatment services. At a local level, Mental Health commissioning (of which drug commissioning is part) sits within the Integrated Commissioning Division and will continue to have a partnership approach to commissioning services across health and social care.

The Funding arrangements for drug treatment and recovery services in communities, prisons and for offenders was streamlined in 2011-12 to channel the majority through the Department of Health (DOH). From April 2012 a significant proportion (20%) of the central pooled budget for drug treatment will be allocated on the basis of the partnerships rate of successful completions and non-return to treatment (as reported via NDTMS). This approach is being adopted to incentivise commissioners and providers in order to improve recovery outcomes. For successful partnerships such as Redbridge in London (+22%) this will give a significant funding increase and for others such as Barnsley (-16%) a marked reduction. The Southampton Drug Action Team has seen a reduction of 3% (a budgetary reduction of £61,882). This funding formula has been accepted across government as a key benchmark for measuring recovery and will be one of the national outcome indicators by which partnerships will be held to account by PHE from 2013. The UK Drug Policy Commission (UKDPC 2012) recommends that PHE commission an independent review of this formula and establish a joint agenda with PHE and the PCC to address Strategic issues with their counterparts in the CCGs. This is especially important in ensuring that those with a dual diagnosis or low threshold mental health problems do not fall between services within the treatment system.

There is a significant challenge to Drug Action Teams and local authority commissioners over the coming period to 'deliver the 2010 Drug Strategy at the same time as negotiating the number of public service reforms and keeping the workforce motivated to develop more intensive, individualised and recovery-orientated approaches' (UK Drug Policy Commission). High workforce morale will be crucial to ensure that staff remain motivated and ambitious for each service user's recovery. The ability of the Drug Action Team Partnership to achieve the ambitions of the Drug Strategy will depend on the security of investment in treatment services as well as a clear shared vision and goal during this time of change.

Southampton Drug Action Team has identified that its current treatment system (appendix 1) was established under a previous strategic vision. The Models of Care based pathway has done well in the past to increase the numbers engaging and being retained in treatment and has been successful in reducing harm but it has also meant that many service users have remained within the treatment system for long periods, maintained on substitute medication. During the last two years the existing treatment system has worked to become more recovery focused but its performance has declined in terms of the number of successful completions (see Appendix 9 - which contains the National Treatment Agencies Diagnostic and Outcome Measurement Executive Summary reports. These graphically illustrate the sharp decline in the percentages of service users able to achieve a successful completion from treatment in 2011/12)

In January 2012 the Southampton Drug Action Team decided to undertake a Strategic Review of its drug treatment system within the changing landscape of the 2010 Drug Strategy. The issues driving this decision to radically review the whole of the drug treatment system were as follows:

- The decline in numbers of successful completions as a percentage of the number of service users in treatment
- The national drive to move towards a Recovery oriented approach,
- Safeguarding issues resulting from a serious case review
- The decision to commission a young peoples' substance misuse service (to include children and young people aged 11-24 years of age)

All of the above reasons suggested that a top level look at the direction and purpose of the drug treatment system in Southampton was required.

At the same time, the majority of the service provider contracts were coming to an end in 2012/13 and would need to be re-tendered in any event.

The review aims to determine whether or not the current treatment system is supporting the Drug Action Team partnership achieve its purpose and goals and deliver the outcomes detailed in the 2010 Drug Strategy as well as identify improvements in cost effectiveness and efficiency.

2. Scope of the Review

This Review covers the drug treatment services commissioned by Southampton City Council, who are the lead commissioners for drug services under the terms of a section 75 agreement with NHS Southampton City (Southampton PCT). The s75 Partnership Board is the authority that will decide how drug treatment services are commissioned following due consideration of the Strategic Review and Needs Assessment information.

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- Tier 3 Care Co-ordination and Rapid Prescribing service
- Morph – Service User Advocacy and peer support service
- ParentSupport Link – Families and Carers advice, information and support service.

These services support the commissioning agencies to fulfil their legal duty to offer service users drug treatment, and advice and support to people to manage their drug misuse problems, or the drug problem of a friend or family member.

The above services have been reviewed within the context of:-

National and local policy (please see Appendix 3 – Background to the Review)

The Review was led by the Drug Action Team Manager and undertaken by Colleen Homan (Project Manager – Southampton Drug Action Team) and thanks are due for the active involvement of all of the drug treatment services managers who assisted the review team throughout the process.

The key aims of the review were to:

* Examine the services performance to contract;
* Make an evidence-based judgement of the relevance of the service to national and local policy objectives;
* Benchmark the service against a comparable service(s);
* Identify and assess the outcomes being achieved;
* Identify any ways in which the service could be improved;
* Set out the main options open to Commissioners in order to best meet objectives

The Review methodology involved a combination of desk-top research, contract performance data, Surveys, attendance at stakeholder meetings, a customer Focus Group, interviews with key members of staff and advice and analysis from the National Treatment Agency.

3. Project Aims, Objectives and Methodology

Aim:

- To review whether the commissioned drug treatment provision in Southampton is fit to deliver the outcomes of the 2010 Drug Strategy and to make recommendations for future commissioning.
- Examine the services performance to contract;
- Make an evidence-based judgement of the relevance of the service to national and local policy objectives;
- Benchmark the service against a comparable service(s);
- Identify and assess the outcomes being achieved;
- Identify any ways in which the services could be improved;
- Set out the main options open to Commissioners in order to best meet objectives.

The purpose of reviewing the current system is fundamentally to ensure that in future the number of people who are successfully discharged from treatment and able to sustain their recovery is increased.

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Objectives:

- To analyse the strengths and weaknesses of the local drug treatment system and post-treatment support in delivering recovery orientated treatment.
- To analyse the factors that inhibit successful completions,
- To agree priorities for improvement and develop an action plan to address these priorities with service providers.
- To determine how commissioning processes can be used to improve successful completions and sustain recovery in Southampton for existing and future service users.

Methodology:

The review used 7 key elements based on the NTA's Building Recovery toolkit

1. **Establish a Project Team**

2. **Analysis of existing data**

Relevant NDTMS annual, quarterly and monthly data was explored alongside provider monitoring information. Various needs analysis and service user consultation reports conducted across the partnership were analysed.

3. **Service User Questionnaire**

These were based around the themes of recovery, prescribing practices and the delivery of psychosocial interventions, care/recovery planning, multi-agency working and the local use of data and information.

4. **Stakeholder Interviews**

A set of in-depth stakeholder interviews based around themes of recovery, prescribing practices and the delivery of psychosocial interventions, care planning, multi-agency working and the local use of data and information. Interviews were run as 'focus groups' where appropriate.

5. **A case file audit**

The case notes from the following sample groups were audited against the recommendations of the Recovery Oriented Drug Treatment. Women, Complex needs, Bridge only, Step up, Step down, DIP/DRR and those who are being joint worked.

6. **Stakeholder consultation and feedback events**

7. **Input from the NTA.**

8. **Findings were reviewed in line with national level literature and recommendations made.**

4. Findings

4.1. Project Team
Colleen Homan (Project Manger)
Jackie Hall (DAT Manager)
Colin McAllister (Models of Care Co-ordinator – Drug Action Team)
Aleksandra Burlinson (Principal Contracts and Partnership Officer, Supporting People)
Gavin Henderson (Commissioning Manager - Hampshire Probation Trust)
Kirsten Killander (Contracts unit, Southampton City Council)

4.2 Analysis of existing DATA

A number of relevant needs assessments across the partnership were included. In addition the following reports were analysed:

- Annual, monthly and quarterly NDTMS reports
- B2V annual report
- HMP Winchester Substance Misuse Needs Assessment 2011
- Interim Analysis of the effectiveness of the DIP on reducing acquisitive crime (2012)
- JSNA "packs" (as provided by the National Treatment Agency 2010/11)
- Morph service user led needs assessment (Autumn 2011)
- No Limits needs assessment (July 2008)
- Probation data
- Service Provider monitoring data
- Southampton DAT Needs Assessment 2010/11
- Southampton DAT Drug Treatment Plan 2011/12
- Supporting people needs analysis ()
- Substance Misuse Support Service data (2011)
- OASys data queries (Probation)
- Parent Support Link (PSL) – Families and Carers service.
- Probation Approved Premises Southampton (Landguard Road)
- Violent Crimes and Drugs

The current system of National Drug Treatment Monitoring System Reporting (NDTMS) aims to provide partnerships with information to usefully segment the treatment population into targeted groups and help identify local ambitions to improve future rates of effective treatment engagement, successful completion and sustained recovery.

There are a number of monthly and quarterly reports concerning successful completions at partnership and provider levels that can be accessed online. The quarterly reports are elicited from the Treatment Outcome Profile tool (TOP) and provide detailed evidence on the recovery progress that is actually being achieved for both drug treatment and reintegration activity like employment and housing. An 80% completion rate is needed to obtain this information. The Southampton Partnership failed to achieve this target during 2011/12 until March 2012. This leaves us with little detailed information relating to outcomes for service users in 2011/12.

The Diagnostic Outcomes Monitoring Executive Summary (DOMES) (see appendix 9) gives feedback on successful completions and outcomes and is sent out to individual partnerships. The Domes reports are useful in pointing to areas of the treatment system which may need to be further investigated using local data. At present it is very difficult to use local data to do this for a number of reasons. These are as follows:-

- The Southampton providers use different systems such as BOMIC (Society of St James) and POPPIE (Southern Health) which is problematic when services are provided jointly. They can work together but investment would be required.
- Local data is mostly initial 'flat data' presented in charts with no analysis and is generally manually collated. Raw data has no meaning. There is no standardised approach across the treatment system or wider partnership that facilitates further local investigation of NDTMS reports without considerable efforts.
- Historically, commissioning has lacked clarity in monitoring and evaluation requirements within service level agreements. This has resulted in individual providers using different reporting formats to the DAT who do not at present have sufficient resources within the DAT team, to analyse and interpret this information.
- Additional information/data requests involve additional work for providers. This can be problematic for both the DAT and treatment provider when information is 'beyond the current contractual agreement'.
- Requests for data from other DAT partners can also be problematic. With a range of systems and approaches, data is provided in a number of documents. This is time consuming to locate and it is generally left to the person who made the information request to try and make sense of the vast amount of material they are often presented with.
- Service providers collect and collate a wide array of information for the DAT commissioners. This information could be used in a systematic attempt to identify the strengths and weaknesses of treatment providers approaches, or to develop improvement strategies. However, enquiries as part of this review of services has identified that they do not do so.
- The DAT manager has also identified the need for help in interpreting and managing the volume of data provided by NDTMS and made a number of attempts to deal with this involving staff from the regional NDTMS. This initiative has lost momentum due to capacity issues at both DAT and NDMU levels.

Feedback on the partnerships decline in performance levels was presented to participants at a consultation event in February (see section 4.5). Many participants were genuinely shocked at the level of performance outlined by the Deputy Regional Manager (NTA) which suggested that the treatment system was "blocked". Monitoring undertaken by provider managers together with the DAT has identified high drop-out rates in the initial stages of treatment prior to service users being transferred from the open access (tier 2) service to the care co-ordination and prescribing service (tier 3).

The majority of participant evaluations from this event stated that the Southampton Partnership needed to become 'cleverer and smarter' with its data in order to be able to demonstrate what good work is currently happening, implying that the decline in results was not indicative of the work being conducted in services. It was felt that there may be some 'quick wins' around the work done with service users who do not receive substitute medication (there are currently over 70 people engaged with the open access service who are not uploaded to NDTMS). However the issues within the Southampton Partnership

extend beyond improving data capture. There is obviously more work to be done to make data relevant and meaningful to workers.

Within the Southampton Drug Treatment System:-

- Data collection is perceived as being collected for 'someone else's purpose' i.e. NTA or NDTMS or DAT. As a result, the value of this data is being overlooked at service level. Much information about the treatment system is being collected in the form of anecdote or casual observation which generally leads to inappropriate conclusions and actions. The use of case histories in monitoring/service reviews replaces the analysis of data and means that decisions are made on the basis of supposition and intuition.

- Whilst NDTMS can identify low performance areas and trigger partnership improvement efforts this frequently produces mixed results. Service Managers and drug workers do not find this data useful for assessing their own performance or that of their service users. This is why external or 'expert' obtained information is frequently ignored or devalued. As NDTMS data does not seem to reflect what the treatment service is trying to do with the service users, it fails to provide the workers or service users with a useful unit of analysis. Individuals can frequently act defensively to seemingly critical results such as a decline in successful completions, resulting in the under utilisation of information.

- Commissioners and providers need to become 'smarter' at collecting and using data (not just TOP) to get a better picture of what is going on locally. Management monitoring information could be used to find out the features of those unplanned exits; i.e. are they men/women? What is their level of drug use? What comprises their recovery capital? How quickly do they re-present or do they do better than those who stay in the treatment system? The analysis of local data becomes more relevant, salient and useful when it helps to answer these types of questions.

- Different sources of information are not being compared or contrasted. Needs Analyses contain valuable information hidden in pages of collated data. This information is frequently not linked back to previous or different needs analyses.

- Data from partner organisations is derived from different IT systems and can be difficult for the DAT, who are not familiar with the system, to interpret. Clarity in questions about the exact nature of the information required will reduce this workload.

- It is difficult to identify the existing and future capacity requirements of services, the immediate difficulty stems from a haphazard approach to monitoring and evaluation criteria. This was identified as one of the main treatment system weaknesses during the consultation event.

- When a particular sector does not have robust data there is a real risk that its priority on the Public Health Agenda will be lowered.

Nationally, DAT areas have been allocated into 'DAT families' cluster groupings to facilitate comparison across similar areas. The NTA annually provides Southampton with more detailed partnership and agency level data to support an in-depth assessment of the needs of their local populations and plan for treatment system developments in the following year through the Joint Strategic Needs Assessment. The Joint Strategic Needs Assessment (JSNA) data pack aims to be particularly useful for considering the reintegration needs of clients and the extent of joint working across the treatment system but is again dependent on 80% TOP completion.

JSNA results from two other DAT Partnerships in the same cluster group or family (Bournemouth and Plymouth) alongside three within geographic proximity (Portsmouth, Hampshire and Brighton & Hove) and two perceived to be successful at a national level (Coventry and Bristol) were compared (appendix 2). This comparison suggested that lessons could be learned from Bournemouth in terms of improving opiate and crack abstinence rates and the number not injecting at review. Learning form Coventry in terms of successful completion rate and Brighton and Hove regarding a significant reduction in crack use. Interestingly Bristol and Portsmouth did not have the 80% TOPs completion required to obtain higher level data. However, as is the case with the Southampton partnership this situation can change from one quarter to the next.

Members of the Project Management group attempted to contact DAT managers in the identified areas to obtain comparative information. Time constraints meant that the response was limited. The ability to make comparisons of this nature from the JSNA data is not yet realistically possible.

NDTMS reporting may be subject to change in the future and is currently subject to consultation. NDTMS aims to increase the amount of information available to the public about the profile of drug users in treatment in their locality and the quality of treatment they receive.

Current methods of data analysis do not allow partnerships to directly compare themselves to each other and this also makes comparison problematic. The National Data Monitoring Unit (NDMU) is working on methods that will make this possible in the future for Adult treatment services. Changes to the data set collected for specialist substance misuse interventions for young people have been published (NTA 2012) following consultation in 2011. The deadline for comments to ensure these changes are practical and achieve the required aims is 24th July 2012.

4:3. Service User Questionnaire

The NTA toolkit questionnaire is based around the themes of recovery, prescribing practices and the delivery of psychosocial interventions, care/recovery planning, multi-agency working and the local use of data and information was distributed. In February 2012 providers asked their service users to complete the questionnaire. To avoid duplication, service users who used more than one agency/provider were only to complete the questionnaire on one occasion. (**For information on the various drug treatment services, please see the synopsis of drug and alcohol treatment services included at Appendix 2)**

- 79 Questionnaires were completed from the following services; Families and Carers Services (PSL) (n=10), Harm Reduction and Outreach service (SHaRP) (n=18), Open Access (tier 2) service (The Bridge) (n=21), Care Co-ordination and prescribing service (tier 3) (n=12), Drugs Intervention Programme (DIP – criminal justice service) (N=11) Drug Rehabilitation Requirement (DRR) (n=7) and service user advocacy service (Morph) (n=0). The respondents were 44/73 male, 29/73 female (6 missing). Ethnicity 85% described themselves as white, British or White British).

- 18% (n=14) of respondents could loosely identify what recovery was. The majority (42%) describing detoxification with 11% describing detox/staying off. However the remaining 29% offered vague or ambiguous statements such as 'everything' or 'freedom' or 'being stable'. Overall, service users themselves do not appear to be clear about the nature of recovery or the goals of the treatment system, which in itself is a comment upon how the treatment system has been explained to them.

- The perception of respondents was that detoxification or residential rehabilitation was 'impossible' to get into. In reality there is an under spend in this area and the Models of Care Co-ordinator has been trying to encourage uptake with service managers.

- 90% of respondents attending the families and carers service (PSL) are not parents /carers of those who are engaged in the drug treatment system. These respondents could not outline the existing treatment system and had been using PSL between one and five years. Respondents from treatment services were not aware that PSL was a service that could assist in their recovery by supporting their partners, parents or carers to contribute to their treatment gains.

- From the responses given it was obvious that 72% (n=13) respondents attending the Harm Reduction service are also service users at tier 2, tier 3 and the criminal justice drug services. However their responses are of particular interest due to their use of language. Respondents describe themselves as 'clean' meaning not using on top of prescription drugs. This issue was further identified as an issue for the treatment system through the Bridge 2 Volunteering (B2V) monitoring data. Further exploration confirmed that many staff members also use 'clean' to mean that the service user is using their prescription drugs only. In recovery terms this is unhelpful and causes confusion and implies that the goals of treatment are not shared between commissioners, service providers, workers or service users.

- Although the questionnaires were designed to ascertain information about the treatment system as a whole, respondents tended to answer in terms of their own personal experience of a particular service. Respondents often feel that they have to give positive reports of the service they receive and are often so grateful to receive any service at all that they find it difficult to view themselves as 'customers' and give constructive criticism or make recommendations for improvement .

- Criminal Justice service respondents gave positive responses about their experiences of key working and the value of recovery plans. Harm reduction and open access (tier 2) respondents

focussed on the need for greater and faster access to prescribed drugs and care co-ordination and prescribing (tier 3) respondents identified the importance of help with recovery orientated activities.

- Service users expressed their concern regarding having the needle exchange services located in the open access tier 2 service as this led to service users who are still using illicit drugs in the same place as those who were trying to become abstinent.

- Respondents who had been in the drug treatment system the longest (up to 15 years) also expressed negative views about key working or recovery plans.

- Respondents were unaware of any services, beyond those that are specifically commissioned for drug treatment that could potentially have assisted in their recovery. Only 15% (n=12) of respondents mentioned services such as NA or AA as being available in Southampton. The need for aftercare services and support was identified and there was some suggestion given as to how this could be delivered through home visits and a longer period of telephone follow up as well as a dedicated helpline.

- Respondents were not able to identify any particular approaches or interventions/therapies available within the drug treatment system, responding with the names of specific commissioned services (i.e. DIP, Bridge, and New Rd) only.

- The project management team had anticipated that the questionnaire would be completed via an informal interview with a worker. However most appear to have been self -completed and it is noted that further information could have been gleaned had discussion and clarification been obtained. Although dissimilar in structure, many of the responses mirrored the results and content of the Morph service user led needs analysis (2011). As both were obtained from a similar sample, this is not a surprise, but it highlights the need to gain information from those who are no longer in contact with treatment services, those in aftercare and those who 'drop in and drop out' as well as those who are treatment naive. Future attempts should be made through the use of Privilege Access Interviewers (PAIs) as opposed to an established advocacy service such as Morph.

4:4 Stakeholder Interviews

A set of in-depth stakeholder interviews based around themes of recovery, prescribing practices and the delivery of psychosocial interventions (PSIs), care planning, multi-agency working and the local use of data and information were conducted. These were semi-structured interviews (appendix 5) run as 'focus groups' where possible. The following interviews were conducted:

Date	Agency
31.01.12	Parents Support Link
01.02.12	New Road (Southern Health)
01.02.12	Sharp
02.02.12	Society of St James
02.02.12	Drug Action Team
09.02.12	Southampton Voluntary Services (MORPH)
02.03.12	Strategic DAT Partnership

The 'contract culture' approach of the existing system has ensured that service providers are compelled to protect their own interests despite trying to work together in delivering some services.

Identifying the themes of recovery, prescribing practices and the delivery of PSIs concerning the system as a whole rather that about a particular area of expertise/service, was difficult for some respondents. Others were clearer about the opportunities that a new recovery orientated system could create for both the treatment system and themselves as providers.

A summary of the findings are as follows:

- The majority of people being supported by the **Families and Carers service (PSL)** are not supporting or caring for parents/partners or family members of the service users in commissioned drug treatment services. They may however, be supporting former service users, or loved ones who have never been in contact with drug treatment services (i.e. those who are "treatment naïve"). Although the family members and carers who attend the service are receiving valuable support the service acknowledges that it needs to do more to promote its service to existing service users in order to support recovery. This service could be utilised more fully in terms of developing community recovery champions and providing peer mentoring and support services.

- The **care co-ordination and prescribing service (tier 3)** was aware that the system had gaps in aftercare and re-integration activity. There are a huge number of service users for whom they are contracted to provide care co-ordination via one recovery plan. The Service Manager identified that recent work had been conducted to ensure that people were not "being parked" on substitute medication or in shared care. However, it was acknowledged that a significant proportion of the service user cohort in this treatment service was in receipt of substitute medication (i.e. methadone, suboxone or naltrexone). It was also identified that many cases needed to be closed. The service has employed a part time data analyst who is helping the service to look at local data and improve TOPs completion. Issues in joint working were also highlighted around case notes and information sharing.

- **The Harm Reduction and Outreach service (SHARP)** identified that they worked with a 'hard core' of drug users for whom recovery seemed difficult. Monitoring for this service is limited and in need of attention. It is unclear how many of the service users here attend other parts of the treatment service or if they are out of area. An increase in steroid use in Hampshire was also creating demands on the service although this was anecdotal. The interview focussed on many practical problems experienced in the service regarding shared premises with the open access service and the implication for harm reduction work. The service is committed to harm reduction rather than recovery principles. Staff were able to identify many new ideas for service development such as supervised consumption rooms and widening the use of a naloxone trial. They were also keen to outline the benefits of harm reduction to the Public Health agenda.

- **Open access and Drug Intervention programme services:** The voluntary treatment provider who provides these two tier 2 services, reports actively trying to change staff culture to become more recovery orientated. The open access service engages a number of clients for whom no prescription of substitute medication is available. This makes the recovery agenda more immediate for this cohort of service users. The treatment provider has been working on developing a programme of alternative activities (art, fishing, music, exercise etc) and identified that these treatment successes with cocaine users were not currently being uploaded onto NDTMS. The current system of joint working was cumbersome but attempts to make the system work were being developed. There were concerns about the numbers of service users who failed to make the transition to the care co-ordination service. It was felt by some staff that the work undertaken to develop a relationship between the service user and key worker at the tier 2 stage

of treatment was being undermined by the transfer to the tier 3 service. They were also aware that further data concerning those who dropped in and out of the system was required. The DIP criminal justice service has worked to ensure that the existing system works well in terms of the transfer of offenders between prison and community settings. However it is vital that the design of any new treatment system does not prioritise offenders and make crime appear an attractive route into treatment.

- The **MORPH** service is a **service user advocacy and peer support** oriented service. The service is based in Southampton Voluntary Services. A number of peer led groups using Smart Recovery techniques have recently commenced but it is too early to comment on their efficacy, although anecdotal reports are encouraging. MORPH has become an authoritative voice for service users representing Southampton on a number of service user fora and at DAT strategic level.

- It was difficult to get full representation from the **Strategic DAT partnership** as a DAT partnership meeting had not been arranged within the strategic review timeframe, and Chief Executive members of the Partnership have significant pressures on their diaries. However, the DAT Chair, who is the Director of Public Health for Southampton and the manager of the Community Safety Partnership, did prioritise this meeting. The DAT partnership is committed to ensuring that attention to drug and alcohol treatment continues to be one of the City's priorities in 2012/13. To evidence this, the Safe City Partnership (SCP) has made drugs and alcohol one of the three key objectives for the SCP to focus on this year, together with Violent Crime and Vulnerable Victims. The Director of Public Health in particular has a pivotal role as the Strategic Recovery Champion of the DAT Partnership and this could be utilised to ensure a joint agenda between the Health and Well being Board and the Police and crime Commissioner to ensure co-ordination and integration between the public health and criminal justice agencies.

- The Drug Action Team was the most in-depth of the interviews due to this being the principal group with an overview of the Southampton Drug Treatment System. This was a reflective interview where the DAT team members and managers acknowledged that they have worked co-operatively with treatment providers to bring treatment services closer together. The DAT had led on a number of projects that technically the providers should have undertaken such as the development of a new joint assessment tool and funding workforce ITEP training and development. Working collaboratively has also, to a small degree, protected the services from the reality of a commissioning relationship and the use of commissioning levers to deal with poor performance. The DAT is clear that it wishes to build an end-to-end drug treatment system and move away from commissioning services in isolation.

4.5 Case file audit

In order to inform the Strategic Review about the nature of work being conducted within the recovery framework, a case file audit was undertaken by a Project Team on 28th February (The team comprised of the Project Manager, DAT Manager, Models of Care Co-ordinator and representatives from the local Probation Trust and City Council). Audits were undertaken using an audit tool based on the "Recovery Oriented Drug Treatment" (RODT) recommendations published by Dr John Strang in 2011.

The project team identified nine pre determined sample groups of service users to be audited. These were as follows

- Service users who were in the early stages of the treatment system who were being key worked either by The Bridge or by the DIP but were receiving a prescription from New Road. Central notes are not currently held on these clients and so notes from both services were considered at

the same time. This was further complicated by another set of notes held by the prescribing team. The three separate files were considered for each of these service users.

- Service users attending the DIP/DRR service.
- Client who were attending the 'Step Down' or Step up' service at New Road. It is anticipated that these service users should be making considerable progress into their recovery journey.
- Service users identified as having complex needs for whom a number of other services such as mental health might be involved in their treatment.
- Those service users attending the Bridge service only. These service users will either be very new to treatment services and just starting their recovery journey or be attending for key working but not receiving substitute medication (e.g. stimulant users)
- A sample of 'Women only' who were attending the New Road service.

In total 52 sets of notes were audited from the following sample groups

1. Joint worked by New Road/Bridge (n=9)
2. Joint worked by DIP/New Road (n=2)
3. DIP (n=2)
4. DRR (n=8)
5. 'Step Down' at New Road (n=5)
6. 'Step up' at New Road (n=4)
7. Complex needs at New Road (n=5)
8. Bridge Only (n=12)
9. Women only at New Road (n=5)

Quantitative and qualitative results were provided two weeks later to each service provider manager in order that improvement plans could be identified.

Quantitative data on gender, primary and secondary drug of use, length of time in treatment and whether or not assessments (initial, comprehensive or risk) had been completed and whether or not children were present were provided to each agency where further analysis and segmentation of the treatment population could be conducted if required.

Overall the Audit Team looked at 52 sets of notes.

- 64% of cases were male and 36% were female, although the inclusion of a women only sample (n=5) will have skewed this.
- The sample was predominately White British (89%) and 4% were Black British
- The primary drug of use was 54% Heroin (n=28) with 39% (n=11) of these having no secondary drug of use. Stimulants were the primary drug of use in 21% of cases accounted for (6 being amphetamines and 5 being cocaine) 6 (11%) were primary cannabis users with 3 cases identifying as alcohol being the primary drug of use.
- Of those with a secondary drug of use 53% were Crack cocaine users (n=21). 12% Cannabis, 12% alcohol and 2 (5%) were heroin users.
- 43 (83%) had received an initial assessment and a risk assessment with 28 comprehensive assessments having been conducted. It is important to note that not all of the sample would have been expected to have had a comprehensive assessment conducted.
- In 18 (35%) cases children could be identified. Although some examples of good clinical work were noted, the quality of assessment, key working and use of psychosocial interventions was variable. Shortcomings in work on engagement, motivation (readiness, willingness and ability to make changes) were also noted.
- Assessment practice appeared mechanistic, mostly standardised form filling activity. Many issues were overlooked during the risk assessments but picked up when all the notes were looked at together. Having 3 sets of notes is problematic.

- Each service provider had various problems with note keeping and consent to share.
- Recovery plans were in place but did not generally use SMART goals and work does not appear to be recovery orientated in line with 2010 strategy.
- As part of the induction to treatment process, service users are required to attend a minimum of three meaningful contact appointments before being taken onto the caseload. This is done in order to assess the service user for readiness to change, and to enable drug workers to undertake some motivational work. The quality of the mapping work undertaken as a part of this process appears mechanistic with the required three meaningful contacts appearing to be experienced by the service user as a hurdle to obtaining a prescription.
- The quality of psychosocial interventions, a lack of care co-ordination of service users and clinical supervision of workers were identified.
- The drug treatment system is 'prescription' orientated and not recovery orientated.

Quantitative data identifying whether or not a recovery plan was seen, whether or not it was orientated towards abstinence (ABS) or reduction (RED) and using SMART goals is summarised below in table 1. It also details if the recovery plan addressed all the client's needs, if it balanced risk/ harm reduction with recovery: identified how to build on social networks and recovery capital and whether or not referrals to other recovery orientated support services were made. The Auditors also looked at whether or not the key working sessions were being conducted in line with the recovery plan and if there was any evidence of psychosocial interventions being used. Cases where the Treatment Outcome Profile (a national requirement which gives information regarding the outcomes achieved during treatment) completion was required were also identified.

Table 1: Quantitative data summary of recovery plans

group	No	Rec plan	ABS orien	RED	SMART	all needs	balance	rev REQ	social net	Rec cap	Refs	Tops missing	kw by plan	psycho
Bridge	12	8	10	2	1	3	4	**5**	2	2	0	*	4	6
NR/Bridge	9	6	2	1	0	0	3	0	1	3	0	5	0	5
Complex	5	4	5	2	4	4	3	2	4	1	2	2	1	3
Women	5	5	4	1	4	4	2	1	4	2	0	0	2	2
nr/dip	2	2	1	1	2	2	0	1	1	2		missing	1	1
step down	5	5	0	3	4	1	2	2	1	2	2	2	3	0
Step up	4	2	2	1	1	1	1	2	2	2	1	0	1	0
DIP	2	2	2	1	2	1	1	1	1	1	0	missing	1	1
DRR	8	7	7	1	4	3	3	1	4	1	3		5	7
	52 (100)	41(79%)	33(63%)	13(2%)	22 (42%)	19 (45%)	19 (36%)	15(29%)	20(38%)	16 (31%)	8 (16%)	9	18 (35%)	25 (48%)

- Denotes that TOP forms would not have been completed for this sample group as they are not uploaded to NDTMS , Missing denotes that the auditor did not record this information

Feedback about the quality of the note keeping, assessments, recovery planning and key working and psychosocial interventions has been provided for each service with suggestions for improvement in line with the requirements of good note keeping and care/treatment planning practice issued by the NTA and John Strang's RODT report.

Abbreviations:

Rec plan	= Recovery Plan
ABS orient	= Abstinence oriented
RED	= Reduction of primary substance
SMART	= Were plans specific, measurable, achievable, realistic, time-bounded?
All needs	= Were all the service users needs identified in the plan?
Balance	= Does the plan balance risk and harm reduction?
Rev REQ	=
Social net	= Were attempts made to link the service user to appropriate social networks?
Rec cap	= Recovery capital
Refs	= Were referrals made to other services as part of the recovery plan?
TOPs missing	= Treatment Outcome Profile missing
Kw by plan	=Were the key work sessions carried out in accordance with the recovery Plan?
Psycho	= Were psycho social interventions used?

A summary of the findings of the case note audit is available at appendix 17.

4.6. Stakeholder consultation and feedback events

A consultation day for stakeholders was held during the period of the strategic review.

The purpose of the day was to outline why a strategic review was being undertaken and the process that the review would follow. It was also to consult with providers, partners and stakeholders in order to identify what elements of the current system were felt to work well and what needed to be included in any re-design of the treatment system.

The new NTA Deputy Regional Manager outlined the current decline in partnership performance whist fostering support and exploration of how best to build a recovery orientated approach across the partnership. Participants were able to identify the Strength, weaknesses, opportunities and threats of the existing system and were encouraged to try and identify the essential components of a redesigned drug treatment system as well as come up with some new ideas and innovative approaches.

This was overall a positive day with favourable delegate evaluations. Delegates indicated that they valued the opportunity to be involved in the strategic review and network with other agencies across the partnership. At the commencement of the day some delegates expressed concern that "recovery" was simply being used as a euphemism for abstinence. There was also genuine shock at the performance data (see appendices 8 and 9) which has already been explored in section 4.2.

Some new ideas such as hostel based detoxification or DIY detoxification and to have one stop shops with true multidisciplinary teams/partnership working were put forward. Delegates were able to generate ideas about what type of services should be available - but this frequently stopped short at being able to articulate what activities were considered best practice. For example delegates indicated that the treatment system would benefit from more floating support and a Crisis intervention centre. Whilst ambitions such as 'to build social capital' or 'mobilise a city to support recovery' were expressed there was little idea as to how this could be achieved. However, the need to ensure that recovery champions, the DIY recovery group and NA/CA were made far more visible to service users was identified.

Delegates identified many elements that were considered to be missing from the existing system such as a 24/7 helpline, Mentoring, Aftercare, one stop Satellite provision, Life skills training such as parenting or money management and greater opportunities for work in community settings or homes . End to end management (care co-ordination) was also required.

Following on from this event, a morning feedback event for key stakeholders was held. The project team decided to utilise the day to present findings from the service users questionnaires, the case note audit and the consultation day and identify how the current treatment system providers could best prepare for the forthcoming structural and cultural changes at the following levels:-the DAT Partnership; the DAT Commissioning team; treatment providers; workforce and service Users. Group work responses can be summarised as follows:

The DAT Partnership;
Define outcomes for partnership, ensuring shared input and shared and owned across agencies/partners

The DAT Commissioning team;

- Specify better data collection and analysis

- Address data collection and analysis
- Facilitate services to work together
- Commissioning levers to ensure partnership working between providers
- Clarify relationship between DARG and DAT partnership
- More data sharing with workforce to make meaningful and relevant
- Allow creativity and experimentation in approaches to achieve outcomes rather than micro manage
- Move to outcome based commissioning

Treatment providers;

- Southern Health and SSJ improve assessment practice
- Ensure training and skills are integrated
- Use case note audit findings to improve recovery orientation
- Try to get away from 'detox' outlook
- Identify what we can learn from alcohol field approaches
- Better and more challenging clinical supervision
- Clarify information protocols on data and information sharing when joint working and explore how this can be improved

Workforce;

- In house and inter- agency training
- Clarity on care co-ordination and key working

Service Users;

- Clarity of outcomes, individual journey, length of prescribing and target dates on recovery plans
- There is currently confusion around the meaning and definition of recovery and use of the term 'drug free' is loose and misleading, as it is often used to mean "illicit drug free". This needs to be challenged. Service users should be encouraged to make informed choices about how they wish to achieve planned exits as part of their recovery plans.

5. Review findings

This is a time of austerity; public service reform and complex changes are planned. The main challenge for the Southampton Drug Action Team Partnership during this time of upheaval is to maintain the security of investment in treatment services and identify a clear shared vision and goal to allow the treatment system to deliver the 2010 Drug Strategy. At the same time the workforce must remain motivated to develop more intensive, individualised and recovery-orientated approaches. This will not be easy.

The Models of Care framework, upon which all Drug and Alcohol Action Teams were encouraged to base their commissioning strategy between 2003 and 2011, has developed a fragmented drug treatment system with tiers and service providers being separated from each other both contractually and ideologically. In addition in Southampton, drug and alcohol services are currently commissioned and managed entirely separately which means that opportunities for addressing cross addiction are more difficult to realise and this disadvantages a significant number of service users.

This strategic review has identified a number of weaknesses in the treatment system around the collection and analysis of data at both national and local levels and the inability to segment the treatment population. Other issues that have been strongly identified as important are: not having a common understanding of what 'recovery' means, weak care co-ordination, poor assessment practice and a system that is 'prescription' driven. Successful completions within this system are hindered by a lack of clarity in desired outcomes for both services providers and service users. An assessment process that is being driven by form filling activity misses the opportunity to make every contact count and there appears to be an absence of quality clinical supervision to both challenge assumptions about 'recovery' and develop workers interventions and skills.

There are a number of implementation gaps between practice and NTA good practice guidelines, RODT recommendations and the 2010 Drug Strategy. The findings of the Service User Questionnaire identify that greater efforts are required to obtain the views of those who have been successful in their recovery journeys, of those who have been in 'shared care' services for many years, those that 'revolve' in and out of treatment and those who are treatment naive and to recruit community recovery champions from some of these groups.

The case note audit outlined a number of issues, primarily the need for a capacity audit, ensuring that note keeping meets minimum standards, improving assessment practice in line with the principles and practice of assessment (appendix 14) and ensuring that quality clinical supervision is provided. This is to enable workers to examine their practice in relation to the RODT recommendations for each service user and adjust their interventions accordingly.

The system needs identified strategic, therapeutic and community recovery champions to inspire and motivate service users throughout the system. The treatment system needs to increase the type and number of interventions used in key working beyond ITEP mapping to include other psychosocial approaches such as Motivational Interviewing and Relapse Prevention. Environmental approaches such as Motivational Milieu Therapy and opportunistic brief interventions could also be considered so that every service user contact can be made to count.

The treatment system should also be capable of providing real time local data in order for the commissioning team to be able to make decisions based on evidence rather than anecdote and assumption. A robust, integrated case management and data monitoring system, which is deployed across all treatment providers, (whether the future treatment system is delivered by a prime provider, or by a framework) and which the commissioning team have access to for data interrogation purposes is an absolute necessity for meaningful data and contract management.

Debate about the exact nature of recovery is nationally gathering momentum and it is important that a shared vision of recovery is attained across the partnership. To gain acceptance and commitment the following assumptions must underpin a recovery based system in Southampton.

1. Recovery recognises the value of and works towards drug free outcomes. **Abstinence** is the goal towards which we will support and encourage all service users to aspire.

2. In addition, the goal of treatment providers should be to inspire and motivate service users to **recover** sufficiently from addiction to be able to complete treatment successfully and exit the treatment system within a reasonable time period, to be agreed with the service user at the commencement of treatment and reviewed regularly thereafter.

3. However, the treatment system recognises the valuable role of **harm reduction** and acknowledges that many people can live stable and fulfilling lives on substitute medication. There will be no forced withdrawal but individuals must be engaged in recovery orientated activities and the opportunity to review their goals in relation to abstinence must be included in care planning and review.

4. Workers will encourage service users to successfully complete treatment without putting them at risk and will regularly jointly review their situation to ensure that they are given the best chance possible to continue with their recovery journey and to re-integrate into the community.

5. Recovery means that service users will be engaged with a range of services to meet their needs: education, training and employment, housing, family support, physical and mental healthcare and where relevant prison, probation or youth justice services who need to work together. Service user networks and mutual support groups are essential. Voluntary and community groups, charities and social enterprises sectors must be encouraged and supported to get involved and mainstream services must be encouraged to remove barriers to access for people with drug problems.

6. Care plans will be individualised and service provision will embrace the principles of Personalisation and Personal Health budgets.

7. There is no single roadmap or treatment journey to recovery. Each service user's journey will be shaped by their needs and motivations and plotted in an individualised recovery plan. Strategic, therapeutic and community recovery champions will help develop options and resources within the treatment system.

Conclusions:

Commissioning for Recovery:

The 2010 Drug Strategy increased the developing focus on improving Recovery outcomes for people with drug problems. It identified the need for a range of treatment options and for support in areas such as employment and housing to help them to re-integrate into society. However, this drive for increased recovery comes at a time when all local government services are required to make significant savings. In addition, the government seeks to devolve decision making and accountability to the local level. The reforms to the NHS will have the most direct impact upon the commissioning of drug services.

The aims of commissioning in the current context are:

- to improve recovery outcomes
- to improve efficiency, (i.e. to do more with less)
- to encourage greater diversity within local markets
- involving the voluntary sector to a greater extent than ever before.
- Increase innovation within the local context
- Develop drug treatment services that are able to respond to the greater diversity in treatment needs that arise from changing patterns of drug use.

With this in mind:

Is the present drug treatment system contributing to national and strategic aims?

The treatment systems contribution to strategic aims (as contracted) has been reduced because of the changed nature of those aims since the system was commissioned under Models of Care. A Recovery Orientated Drug Treatment system now requires a wider range of services and interventions to be available than those currently commissioned.

The national agenda as outlined in the 2010 Drug Strategy also requires a more robust focus on how its investment contributes to achieving successful outcomes, and the specific contribution made by individual providers and service contracts. The current commissioned treatment system is performing poorly as regards encouraging and facilitating abstinence and planned discharge from the treatment system and is therefore hampering service users from achieving successful outcomes across the board. The strategic review and all the available performance information therefore clearly demonstrates that the drug treatment system as it is currently commissioned is not able to contribute sufficiently well to either the national strategic aims expressed in the 2010 Drug Strategy or to local aims to improve the health and well being of service users.

Does the treatment system provide good quality services?

The treatment system operates within a range of quality assurance standards applied across customer service and the employment practice of the commissioned organisations. However, the strategic review has exposed some fundamental issues and gaps in both provision and quality across the drug treatment

system. If we are to improve performance in relation to successful completions as well as improve agreed outcomes for individual service users we need to commission a wider range of quality services which are Recovery focussed and able to respond flexibly to the needs of individuals within the treatment system.

Is the treatment system delivering the required outcomes?

The report provided by the Deputy Regional Manager for the NTA at Appendix 9 concludes that:

"This report has considered prevalence, activity and performance data within the context of reviewing the whole adult treatment system in Southampton with a focus on successful completions and representations. Where appropriate this report has endeavoured to illustrate how certain areas of activity may be impacting on the rate at which people successfully leave treatment.

The partnership may wish to investigate the potential rise in opiate prevalence within the 15-24 year old sub set of the population as well as the potential increase in crack users' prevalence. If these increases are substantiated this may point to a much larger cohort of younger clients using opiates and an increase in crack users in the local area. Therefore local services will need to be reflective of the needs of these populations.

Similarly, Southampton's in-treatment activity data shows the majority of clients in the partnership area are using opiates and that a significant proportion of this population (50%) has been engaged in treatment for periods of two years or longer.

As a consequence, characteristics such as age, frequency of use and duration of treatment can all impact significantly on a range of outcomes and therefore both providers and commissioners alike need to acknowledge these factors when designing appropriate services.

The report has also highlighted how attrition at the modality, service and system-wide level can reduce abstinence and successful completions rates and in some cases may in fact be adding to system-wide complexity e.g. two or more unplanned treatment exits is one of several complexity factors used by the NTA to group partnerships into clusters.

Overall, the Southampton drug treatment system is failing to deliver performance in relation to successful completions as benchmarked against previous performance and against the national average.

Does the treatment system offer good value for money?

This review has already indicated that the current treatment system is failing to deliver the required outcomes. Therefore costs of like for like activity would not appear favourable when compared to other providers in the South East region.

In addition, the cost of people remaining in services rather than moving to recovery impacts on a wide range of other health and social care services, benefit costs and criminal justice costs.

How can services be improved?

The context of drug treatment work has changed following the introduction of the 2010 Drug Strategy which was published after the commencement of all existing drug treatment providers' contracts. Personalisation has also played a part in changing the way we think about the delivery of services and the effectiveness of the existing treatment system. From all the information presented by this strategic

review it would seem unrealistic to suppose that the new Recovery agenda could be delivered by the current system. Southampton Drug Action Team has worked with treatment providers for approximately two years to try to improve the existing system and this has proved ineffective in relation to improving successful completions and changing the culture to one of Recovery Oriented Drug Treatment.

Analysis of local market

What other agencies could provide this service?

There are a limited number of organisations that currently provide drug treatment services within Southampton City and possibly none that would be in a position to provide the full range of treatment options required to make up an integrated recovery orientated treatment system. There are two major NHS Foundation Trusts operating in the area (Solent and Southern Health), and one local voluntary organisation (Society of St James). Cranstoun drug treatment services operate in the Portsmouth area, and have previously been providers of structured day care and psychosocial counselling in the Southampton area.

In 2009, only two organisations (the two Foundation Trusts) expressed interest in the tender of the tier 3 Care Co-ordination and Prescribing service.

However, there are a number of national and local organisations who have recently expressed interest in the nationally driven commissioning of Prison drug treatment services and it is anticipated that a tender comprising the whole of the drug treatment services for the Southampton area could attract diverse interest from such organisations.

There are also a range of other agencies in the south east region, both Voluntary sector and Private that could potentially provide some elements of a drug treatment service e.g. psychosocial interventions, group-work, counselling, employment advice, detox, residential rehabilitation, harm reduction etc.

How will the local market change over the next 3 years?

Providers will need to consider their response to personalisation and any changes in commissioning practice, e.g. pricing their service differently. Voluntary organisations and community groups may need to consider the concept of charging for their services for the first time. There is potential that market diversity, sustainability and quality could all be at risk.

Providers may also need to consider services which they have not traditionally provided as there is likely to be a shift of commissioning investment into these areas, to support the policy directive of increasing personal budgets and they may need to replace lost business with new opportunities.
New providers may emerge, such as micro-providers, co-operatives or social enterprises.

More peer support initiatives that do not rely on LA funding but may provide some of the support and advocacy currently being provided through commissioned services.

Option Appraisal of Future Commissioning Approach:

	The options to consider are:-
1	Decommission the drug treatment system with no direct contract re-provision, providers offer services on a spot purchase basis as necessary.
2	Continue to commission drug treatment from current providers at similar specification.
3	Continue to commission drug treatment from current providers but to a different specification.
4	Commission new services with new specifications through an open tender. 4a : Using a prime provider model 4b : Using a Framework contract model
Option 1. Decommission the drug treatment system with no direct contract re-provision, providers offer services on a spot purchase basis as necessary.	
	Advantages: • Freeing up financial resources in the commissioning budget • Consistent with principles of personalisation • Removing any commissioning duplication • Opens market to widest range of providers (including individuals, micro-providers, and peer groups not reliant on contract funding) and increases opportunities for innovation • Maximises customer choice - people free to find information, or chose assistance from any source if they require it
	Disadvantages: • Local Authority would need to clearly demonstrate how it is meeting its duty to provide treatment to people with a substance misuse problem. • To have no commissioned services is contrary to most recent NICE and Clinical Guidelines "Drug misuse and dependence: UK guidelines on clinical management" 2007 • Potential to impact negatively on Southampton Drug Action Team performance

	• Requires funding for services to be agreed as part of direct payment • Relies on capacity /expertise in provider market to respond to individual requests and no evidence that local market would meet this requirement currently • Requires systems to be available to process Direct Payments and this is not fully developed locally • Reduces options for quality assurance • Potential to impact negatively on viability of existing treatment providers • Potential for adverse publicity and attention locally and nationally • Service user dissatisfaction or anxiety • Requires significant cultural change which may be difficult to achieve at once There is a risk if the viability of one (or more) providers of drug treatment is reduced, that the overall market base from which service provision could develop is also reduced. This may in turn impact on the council's ability to achieve value for money in the future should it wish to tender for new services.
Option 2. Continue to commission the treatment system from current providers at similar specification where possible.	
	<u>Advantages</u>: • Continuity of service provision • Avoids procurement costs • Some limited improvements could be implemented as the current providers are in agreement and able to respond.
	<u>Disadvantages</u>: • The current service specifications no longer reflect what is needed to achieve a significant increase in successful completions for service users or the Recovery agenda. • Contrary to most recent guidance i.e. Recovery Oriented Drug Treatment (RODT) • Alternative approaches to the delivery of drug treatment have been developed within the existing contracts which mean that the existing service specifications do not reflect the services provided now.

	• The current service specifications are not robust enough in terms of volume, performance requirements and outcomes • There is more recent information on needs assessment which needs to be taken into consideration when commissioning services • Does not enable market testing for innovation, best value and best provider If the changes needed to the service are substantive, SCC standing orders in relation to market testing will need to apply.
Option 3. Continue to commission drug treatment from current providers but to a different specification.	
	Advantages: • Continuation of service with least disruption to service users • Ability to implement change quickly, if agreement can be reached, as opposed to lengthy process • Option to negotiate around cost and volume, although this would be dependent on agreement • Avoids procurement costs • Supports the viability of current treatment providers.
	Disadvantages: • If changes are substantive this would breach SCC standing orders regarding procurement • No opportunity to market test which could result in improved quality, innovation and value for money • Does not give opportunity for other providers to apply for this business • Relies on co-operation and ability of current providers to implement change • Track record suggests this option has limited chance of success in achieving required change

Option 4. Commission new drug treatment system with new specifications through an open tender, either by using :

a) Prime Provider model OR

b) Commissioning separate services

Open tender advantages:

- Would enable market testing which could lead to improved, innovation, quality and value
- Would enable specification of services to more closely reflect strategic aims, the objectives of the Recovery agenda and the 2010 Drug Strategy.
- Could stimulate new and innovative businesses and increase market diversity
- Would attract the maximum range of providers
- Can be specifically tailored to need and current gaps in service
- Could support a shift to outcome based monitoring
- Would support the shift in culture required

Open tender disadvantages:

- May destabilise current providers if they are not ultimately successful in a tender
- Likely to involve some disruption to current service users
- Relies on capacity or expertise in the provider market to respond
- Providers may price services at a higher cost
- May lead to smaller local providers being "squeezed out" of the market.
- Opportunities to tender jointly with other work streams such as Alcohol, Peer Support and Carers

Advantages 4a:

- Could attract a greater range of providers.
- Greater integration of services can be achieved
- Would provide one cohesive pathway through treatment
- Could attract added value e.g. stimulate coalition bid
- Could result in better price due to economies of scale
- More economic use of contract performance resources

	• Could separate support activities from direct provision • Could increase opportunities for co-production on specification in line with personalisation principles <u>Advantages 4b:</u> • Could represent a business opportunity for a range of providers if commissioning separate services • Applicable to widest range of providers. • Could separate support activities from direct provision • Could increase opportunities for co-production on specification in line with personalisation principles
	<u>Disadvantages 4a</u>: • May lead to smaller local providers being "squeezed out" of the market. <u>Disadvantages 4b:</u> • May result in a disjointed pathway for service users who may require a range of support services • additional contract management costs

Procurement approach

The council's standard competitive tender process would apply to Option 4 a and 4b, and potentially Option 3 depending on the level of specification change required. No specific issues that would affect a decision to undertake a competitive tender have been identified.

IMPROVEMENTS TO CURRENT SERVICES:

Southampton DAT continues to work with existing providers to improve service delivery. Improvement plans have been requested and received from both treatment providers which the DAT is monitoring in contract reviews.

In addition, contract reviews are robust and where required, have increased in frequency.

Other commissioning/procurement issues:

The following suggestions for consideration are for improving the commissioning of this service overall. They are not dependent on a specific option being selected.

* Ensure service is accessible to all groups and diversities;

* Consider better use of technology – phone, Skype, web, text etc in service delivery;

* Have improved targets and monitoring;

* Consider options for achieving payment by results;

* Ensure flexibility in treatment system as take up of treatment provision is likely to increase as services improve and can be accessed by cohorts of potential service users not currently able or willing to access the system.

Recommendations:

The overall recommendation of this strategic review is that the current drug treatment system in Southampton should be recommissioned (option 4 of the Option Appraisal).

It is anticipated that by proceeding to tender, the treatment system can be tailored to more closely reflect both National and local strategic objectives and to provide best value for money, an important advantage in the current economic climate.

Appendix 1

Drug Action Team commissioned drug treatment services currently available in Southampton:

The Bridge is an Open Access service (tier 2). It is open five days a week and is the **first point of contact** for people who want help with drugs in Southampton. The Bridge offers advice and information, harm reduction, one to one and group work and referral to other services or agencies. The Bridge also provides access to Southern Health NHS Foundation Trust's care coordination and rapid prescribing service for people who need substitute prescribing for heroin and some other drugs.

Address: The Bridge, 14-18 College Street, Southampton, SO14 3EJ
Telephone: 02380 881 400

The Drug Intervention Programme (DIP) provides a similar range of services to The Bridge (tier 2/3) but is specifically for people who use drugs and who are involved with criminal justice agencies. The DIP also provides drug treatment for offenders subject to a Court Order which includes Probation supervision as part of a **Drug Rehabilitation Requirement (DRR).**

Telephone: 02380 881 409

The New Road Centre (Southern Health NHS Foundation Trust) is a tier 3 service which has responsibility for assessment, prescribing, care coordination and care management services. New Road Centre accommodates the **Children Services Link Worker.** This service provides support for families, and acts as a link between drug services and children's services when there are concerns over parenting.

The service also provides a link to the Outreach Hepatology Nurse service and the specialist liver services situated at Southampton University Hospital.

2 The Carronades, New Road, Southampton SO14 0AA Tel: 02380 71 71 71

Shared Care is the name given to a scheme in which stable opiate service users are treated and monitored by GPs. The service is supported by the Drug Action Team but is not a directly commissioned service.

Parent Support Link (PSL) supports and informs people affected by someone else's drug use. The service raises awareness of issues connected to drug use in the family. It is able to offer advice and information on how to identify the basic signs and symptoms of drug misuse and to provide support to families and carers of drug users. It also provides a 24 hour telephone support service, one to one support and group work.

Southampton User Advocacy Service: MORPH
MORPH works closely with people who use drugs, treatment providers, commissioners and the wider community offering advice, peer support and advocacy.

DASH Youth Drug and Alcohol Project offering confidential support and advice for drug, alcohol or solvent problems to anyone under 19 years who lives in Southampton.

Southampton HArm Reduction Partnership (SHARP)

Based at The Bridge, SHARP has two components **:**

Assertive Outreach Service ~ Providing outreach to facilitate groups that are under represented or may need additional support to enter treatment. SHARP works with service users who are struggling to remain in treatment and with those who have dropped out.

Harm Reduction ~ As well as the provision of sterile injecting equipment (needle exchange services) SHARP provides advice, information and care to reduce the harm of taking drugs including safe injecting techniques, alternatives to injecting, wound care, BBV testing and inoculations, health checks and referral to further treatment services.

The service offers a specialist needle exchange service for steroid users.

SHARP also works with a number of pharmacies and hostels in the City to offer Needle Exchange and Harm Reduction Services

Address: 4, The Carronades, New Road Southampton, SO14 0AA

Telephone: 02380 237 540/ 07939 089 998

Appendix 2

Background to the Review

The 2010 Drug Strategy 'Reducing demand; Restricting Supply; Building Recovery' aims to support people to live a drug free life. Unlike previous strategies which focussed primarily on the harms caused by drug misuse, this strategy aims to go further to support individuals to choose recovery as an achievable way out of dependence. The strategy has a focus on holistic client centred approaches but also carries an expectation that a 'full recovery' is both possible and desirable for all drugs, including prescription and over the counter substances as well as severe alcohol dependence.

Monaghan (2012) argues that although contemporary drug policy remains underpinned by the notion that certain kinds of drug and drug use are linked to certain kinds of criminality (the drugs-crime nexus) the way in which the government aims to reduce crime rates has changed. Since 2008 there has been a growing disillusionment with methadone maintenance treatment and a move towards abstinence. Recently the less well defined term 'recovery' has replaced abstinence which Monaghan argues is part of a re-emerging moralisation underpinning UK social policy.

The 1998 drug strategy 'Tackling Drugs to build a Better Britain' set out objectives to expand treatment services and set key performance targets to increase the numbers in treatment to obtain positive impacts on health and crime. The result of this approach was that treatment success was determined by the number of drug users entering treatment rather than by the outcomes achieved by those individuals. Methadone was a central feature of the approach, with evidence to support its use in reducing criminality and helping to reduce heroin use in the short term and lead to abstinence in the long term. Critics have claimed that it perversely incentivised individuals to commit crime as the quickest way to access treatment services.

In 2008 the New Labour Government Strategy 'Drugs: Protecting Families and Communities 'made a more explicit attempt to foster behaviour change in Problem Drug Users. Although maintenance in the short term would be permitted it also introduced the potential for consequences in welfare benefits if individuals failed to change their behaviour and work towards a goal of abstinence. McKeganey (2011) details how a moral stance with certain behaviours being stigmatised can have positive benefits to society. He uses the successful drink-driving campaigns that encourage the viewpoint that those who drink and drive are socially irresponsible, to illustrate this. Others such as Nutt and Macken (2011) outline how a focus on abstinence creates more problems than it solves and that this should be a choice rather than an imposition.

The less well defined term 'recovery' has now replaced abstinence. Recovery is defined as *an individual, person centred journey as opposed to an end state and one that will mean different things to different people*. However the potential for recovery is hindered by the lack of clarity about what it entails.

The 2010 Coalition Government Drug strategy 'Reducing Demand, Restricting Supply and Building Recovery: Supporting people to live a drug free life (Home Office 2010) states

We will create a recovery system that focuses not only on getting people into treatment and meeting process-driven targets, but getting them into full recovery and off drugs and alcohol for good, it is only through this permanent change that individuals will cease offending, stop harming themselves and their communities and successfully contribute to society.

In 2002 the NTA developed 'Models of Care for the Treatment of Adult Drug Misusers' as a national service framework for the commissioning of treatment in England. The model outlined best practice in treatment provision, and was updated in 2006 to further build on the 4 tiers of intervention concept. The approach assigned different levels of assessment to different tiers and focussed on the effective co-ordination of care through care planning, the development of integrated care pathways and high quality commissioning and service delivery. Some partnerships do continue to use the Models of Care framework but nationally this is 'withering on the vine' (NTA 2012). Others like Southampton are looking to restructure and re-commission services within an updated framework.

In 2011 the Building Recovery in Communities Consultation (BRiC) was conducted by the NTA to develop a new recovery orientated framework to replace models of Care. The consultation ended in May 2011 and guidance was eagerly awaited. However, in March 2012 the inter-Ministerial group decided against provision of guidance from the centre in the context of the continued shift to localism.

In January 2012 the NTA published '*Why Invest? – how drug treatment and recovery services work for individuals, communities and society'*. This document outlines 4 recovery steps around which treatment service provision should be commissioned at a local level.

- **Step 1: Start treatment:** this looks at how PDUs are brought into treatment. For example via needle exchange schemes, testing on arrest, self referral or via GPs. Treatment in this step is concerned with developing engagement, providing assessment and ensuring harm reduction provision (health improvements)

- **Step 2: Stay in treatment:** This step is concerned with maintaining engagement and developing motivation for recovery via the recovery planning process. It includes the use of talking therapies and/or medication where appropriate. This step aims to ensure that drug use is decreased, crime & nuisance are reduced and health improvements are visible. It also focuses on acquiring stable housing and ensuring family and peer support reinforce treatment gains.

- **Step 3: Stopping treatment:** This includes detoxification, becoming free of dependency, developing education and employment skills and increasing support from family and peers.

- **Step 4: Sustaining recovery:** It includes ensuring that individuals take on their personal and family responsibilities, become role models, are active citizens and received continued community support.

To deliver on the Coalition Governments ambitions Cabinet Ministers from the Department of Health, Department for Work and Pensions, Ministry of Justice, HM Treasury, Department for Education, Communities and Local Government, The Cabinet office and The Home Office have been brought together to oversee and deliver the implementation of the 2010 Drug Strategy to enable people to overcome dependence and achieve sustainable recovery. This Inter- Ministerial Group published 'Putting Full Recovery First 'in March 2012 to outline a new framework for building a new treatment system under Public Health England (PHE). In April 2012 the UK Recovery Federation, UK Harm Reduction Alliance and the National Users Network responded to outline how the framework overlooks decades of evidence in drug treatment and will result in 'more harm than good reducing levels of engagement and placing the future of many people living stable and fulfilling lives assisted by Opiate Substitute Therapy (OST) in jeopardy by implementing withdrawal under duress'. They were also concerned that 'Putting Full Recovery First' was overlooking the Public Health Agenda of lowering the incidence of HIV and Hepatitis and called for a consultation with key stakeholders to develop a more rational and meaningful policy document.

Commissioning services to tackling drug misuse will be most successful when they are based on local needs and delivered as part of an integrated local response through the Joint Strategic Needs Assessment (JSNA) and prioritised in the new local Health and well being Strategy. The NTA has already distributed JSNA support materials to local drug partnerships to assist in this process and will provide support to DAT partnerships during the forthcoming transition to PHE. At present there is no data available to provide a national picture of the extent of levels of re-design or re commissioning in light of the Drug Strategy or a model or best practice.

UKDCP (2012) identified that there is no single approach or model for commissioning Drug treatment and recovery services. In recently submitted evidence to the Home Office Affairs Select Committee: Drug Policy Review 2012 (NTA 2012) a number of approaches to commissioning was identified. Commissioning in successful areas such as Lambeth, Hounslow and Wandsworth are based on a consortium approach where one contract with a single main provider who co-ordinated an integrated approach with multiple organisations working together to deliver a range of interventions. Others such as Redbridge (the DAT area who will receive the highest national increase in their 2012 PTB as a result of their successful performance) have different contracts with different providers. Other models are also working equally well - but what really matters is the quality of joint working.

Lord Henley Chair of the Inter-Ministerial Group has identified that

..*The difficulties in the transformation of a treatment system from one that concentrated on engaging and retaining people in treatment to one that can deliver recovery outcomes should not be underestimated.*

The national drug strategy (2010) highlights the role of recovery champions at three levels who will promote a culture of ambition and support the increasing achievement of recovery outcomes across the drug treatment system. The NTA has provided a comprehensive list of functions and responsibilities of Recovery champions which should form the basis of their recruitment (NTA 2012 – appendix 6.2) More focussed work on recovery champion development is required in Southampton. The underlying assumption that everyone involved in the partnership is a champion in one way or another means that these roles are not fulfilled.

PHE will work closely with the newly formed Recovery Partnership (Substance Misuse Skills Consortium, the Recovery Group UK and Drugscope) and will report directly to the Inter-Ministerial Group. The aim in the creation of this Recovery Partnership is to challenge the attitudes and practice of those working in the treatment system and further develop workforce resources to support best practice.

A recent joint letter from the Department of Health, The Home Office and Ministry of Justice (3rd April 2012) to Local Authority Chief Executives outlines five key principles that will underpin a recovery system.

1. All relevant partners must collaborate to commission services based on outcomes for individuals, families and communities.

2. Recovery is initiated by ensuring that drug dependent individuals have prompt access to appropriate interventions and ensuring that the transfer of drug dependent offenders between prison and community settings is managed seamlessly.

3. Treatment services are high quality and deliver a broad range of effective interventions which prepare service users for recovery whilst continuing to protect them and communities from the risks of drug misuse.

4. Treatment services are to provide individually tailored packages of care and recovery support that are regularly reviewed to encourage service users to successfully complete treatment without putting them at risk.

5. Treatment services must join with community support networks and local partners to support people in sustaining long term recovery so they integrate back into society and do not need to return to treatment.

It is most important to note that policy on paper is not the same as policy in practice and there will inevitably be 'implementation gaps' in the treatment system. In January 2012 the NTA published 'Building recovery locally: A toolkit for improving successful completions and sustaining recovery.' The toolkit contains a series of work templates to build and improve effective recovery orientated drug and alcohol treatment systems and identify the implementation gaps.

As recovery is an individual person centred journey, and the length of time required by clients to complete drug treatment may vary. The project approach of the toolkit facilitates review of reintegration and outcome support activity with those drug users who are not yet ready to fully cease substitute prescribing or their substance of dependence.

National Drivers for Change:

2010 Drug Strategy: "Reducing Demand, Restricting Supply, Building Recovery";
This strategy sets out a fundamentally different approach to tackling drugs and an entirely new ambition to reduce drug use and dependence. It applies to dependence on all drugs, including prescription and over-the-counter medicines. It recognises that severe alcohol dependence raises similar issues and that treatment providers are often one and the same. It sets out that services provided in the community and in prison must be more integrated. Drugs matter to the whole of society, and have a profound and negative effect on communities, families and individuals. The 2010 strategy therefore sets out how the Government will target criminals seeking to profit from others' misery, protect young people by preventing drug use and how recovery reforms will offer the individual with a drug problem the best chance of recovery and enable them to make a full contribution to their local communities.

The 2010 strategy makes it clear that individuals are accountable for their actions and increases the responsibility of individuals to work with those who are there to support them to tackle and overcome their dependence. Amongst those ready to help are thousands of people who have overcome their own drug and alcohol dependence.

This work will be structured around three themes:
• **Reducing demand** – creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so, and making it easier for those that do to stop. This is key to reducing the huge societal costs, particularly the lost ambition and potential of young drug users.
• **Restricting supply** - drugs cost the UK £15.4 billion each year. It is intended to make the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks;
and
• **Building recovery in communities** – local commissioners are tasked to work with people who want to take the necessary steps to tackle their dependency on drugs and alcohol. Drug treatment services must offer a route out of dependence by putting the goal of recovery at the heart of all that they do. Approximately 400,000 benefit claimants (around 8% of all working age benefit claimants) in England are

dependent on drugs or alcohol and generate benefit expenditure costs of approximately £1.6 billion per year. If these individuals are supported to recover and contribute to society, the change could be huge.

Personalisation:

Personalisation is one of the key drivers for health and social care. In essence, this means people who have care and support needs being supported to achieve the outcomes they want in their lives, in ways that best suit them. For many people, this can mean utilising universal community services (e.g. advice and information, housing, transport, leisure, education etc) to enable them to stay healthy and actively involved in their communities for longer. But, where more targeted support services are needed, this means people having the information and the means to take more control over their care arrangements and have more choice about services. The emphasis is on prevention of the need for more specialist support services by involving the whole community, and achieving efficiencies through better partnership working between relevant agencies and organisations.

Personalisation matches in to the broader context of Government policy direction for all public services - to achieve better services for less money, to improve service productivity and to stimulate innovation to drive the wider growth of the UK economy. The emphasis is on removing barriers to services or service provision, increasing local people /community's choice, involvement and control in services and to have improved accountability for the quality and value of services. This includes a shift of resources and focus towards prevention and early intervention to improve health and wellbeing and enable better self management of care, improved reablement and recovery outcomes.

Quality

We have identified that we need to place more emphasis on ensuring the quality of service people receive is good enough. There is a renewed Government direction on measuring performance. Better **outcomes** for people will become the key measure across health, public health and social care. Three new "Outcomes Frameworks" have been established, measuring quality and safety as well as increasing public accountability for the differences services should help make in peoples' lives. This links very closely to further national policy development on **"payment by results"** commissioning such as is being tested in 8 drug and alcohol recovery programmes currently. We have a legal duty to ensure "best value" in how we spend public money. We must consider social, economic and environmental outcomes to help us spend less, spend well and spend wisely as we respond to personalisation**.**

Employment and meaningful activity:

Employment plays a central role in the lives of individuals. Access to paid work enables people to contribute to their communities increasing self-esteem and well-being and prevents people living in poverty, which is linked with a number of health and social care problems. Alternatively, unemployment can contribute to feelings of hopelessness, cause social isolation and ensure people are trapped in poverty. In addition, increasing access to paid work for people with disabilities challenges stigma and the way people with certain conditions are viewed by society.

There is significant evidence on the value of work for people with mental health conditions, including substance misuse and Learning Disabilities and increasingly, retaining or returning to work is a crucial factor in an individual's recovery irrespective of the health and social care issues they face. This is why we will incorporate issues around access to paid work in our commissioning work.

Public Health Outcomes Framework:
The Public Health Outcomes Framework 'Healthy lives, healthy people: improving outcomes and supporting transparency (DOH 2012) sets out the desired outcomes for public health and how these will be measured.
The framework concentrates on two high-level outcomes to be achieved across the public health system. These are:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities

The outcomes reflect a focus not only on how long people live but on how well they live at all stages of life. The second outcome focuses attention on reducing health inequalities between people, communities and areas. Using a measure of both life expectancy and healthy life expectancy will enable the use of the most reliable information available to understand the nature of health inequalities both within areas and between areas.

A set of supporting public health indicators will help focus understanding of progress year by year nationally and locally on those things that matter most to public health. The indicators, which cover the full spectrum of public health and what can be currently realistically measured, are grouped into four 'domains':

- improving the wider determinants of health
- health improvement
- health protection
- healthcare public health and preventing premature mortality.

The new Public Health Outcomes Framework contains a total of 66 key indicators focussed on overarching high level outcomes of increasing life expectancy and reduced difference in life expectancy and healthy life expectancy. Whilst only three of these outcomes are drug and alcohol specific, this does not mean that others are not relevant – care and treatment for drug users should be holistic. People often have a wide range of health problems; health screening is an integral part of the assessment process for people with substance misuse problems as they have often neglected many aspects of their health and well-being. As a result, many ex-users have lower life expectancy not only due to drug use but as a result of the life style that often goes with this.

Benefit changes:
In May 2012 in a speech to Alcoholics Anonymous the Minister for Work and Pensions stated that the state should intervene further to help drug and alcohol addicts recover and make them employable in future. Iain Duncan Smith has argued that addicts who are unable to work are being let down by the welfare system. The possible removal of benefits from people refusing treatment will be an option but a "hypothetical" one.

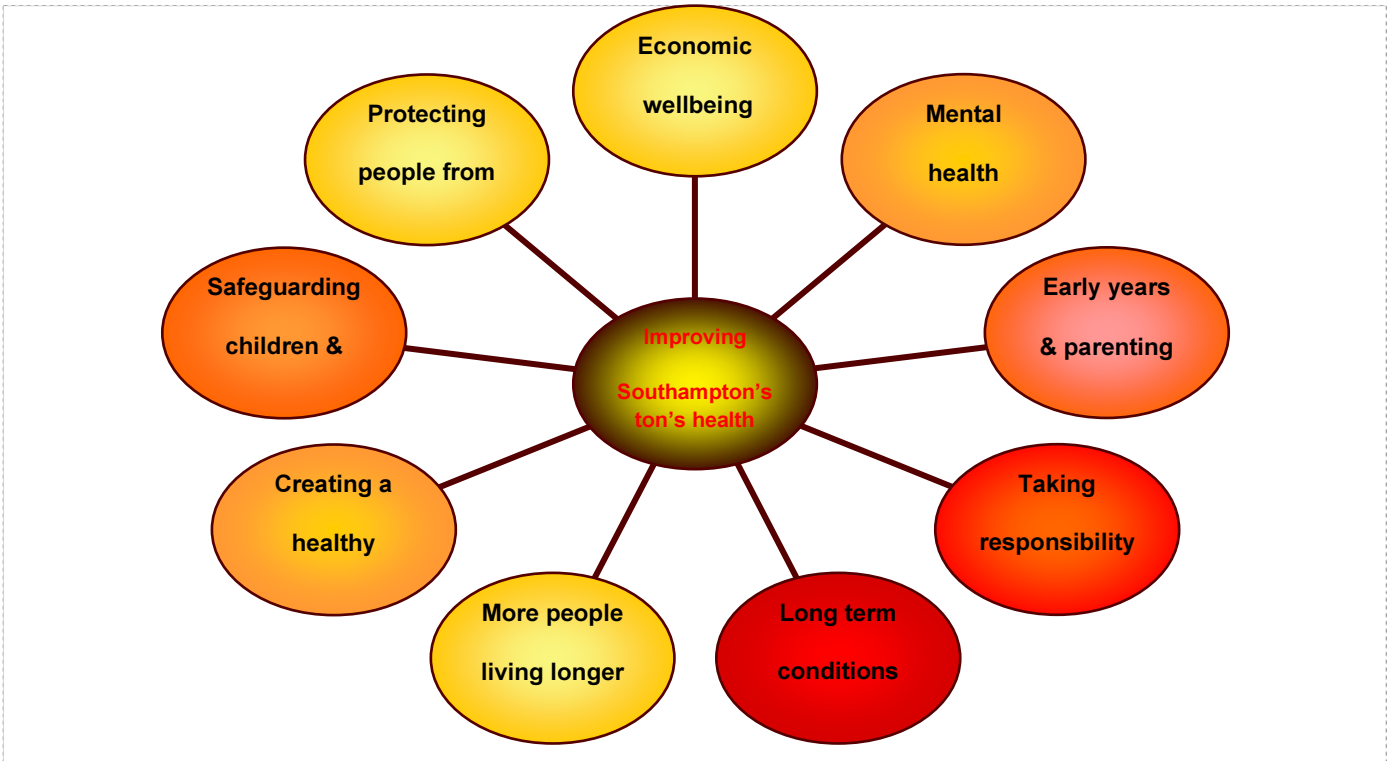
In 2010, the Home Office considered plans to remove benefits from addicts who refused treatment as part of the government's drug strategy but these were not pursued. According to the Department for Work and Pensions, 40,000 people claim incapacity benefits - citing alcoholism as their primary condition. Of these, about a third have been claiming for more than a decade. The government also says 80% of the UK's 400,000 "problem drug users" are claiming out-of-work benefits. The Coalition Government therefore plans to review the current outdated benefits system which fails to get people off drugs and put their lives on track.

Southampton Drug Action Team works closely with partners such as the Job Centre Plus in order to be aware of any impending changes in the law or policy and to facilitate education training and employment opportunities for service users.

Local Drivers for Change:

Local drivers broadly mirror the national drivers e.g. the 2010 Drug Strategy, personalisation, better outcomes, effective prevention, value for money and increasing demand. Local priorities for health and social care have been identified through a process of service user consultation, review of current service provision, trend analysis (of demographics, social, health, economic and environmental issues) and data analysis of spend and budget. Full information on all the issues is available in the Joint Strategic Needs Assessment "Gaining Healthier Lives in a Healthier City", the Health and Wellbeing Strategic Plan 2009-12, the NHS Southampton City Commissioning Strategy, the City Plan and the Southampton Connect Plan 2011-14.

Joint Strategic Needs Assessment:
The joint Strategic Needs Assessment has identified 9 key themes which identify the key areas of need that local government and health services will need to address in order to improve the health and wellbeing of people living in the city and reduce health inequalities.



The four main local issues driving our Joint Commissioning Strategy are:
(i) Prevention and maximising independence
(ii) Personalisation
(iii) Quality
(iv) Best value

These issues will underpin all of our commissioning work irrespective of the specialist needs of some individuals.

Safeguarding:
In 2011, a Serious Case Review was initiated following an incident where the child of a service user in Southampton was able to gain access to, and ingest her mothers' methadone. Fortunately, this was a "near miss" and although the child was seriously affected and was hospitalised, she did not die.

Southampton Drug Action Team and drug treatment provider organisations have co-operated fully in the Serious Case Review process and have used this incident to thoroughly review drug treatment services approach to Safeguarding. As a result, the Drug Action Team has adopted the Southampton Safeguarding Children Board's "Safeguarding Standards" for all future commissioning of drug treatment services. The DAT has also commenced work with the Safeguarding Vulnerable Adult's Development Manager to progress service understanding and best practice in relation to the protection of vulnerable adults within drug treatment services.

Police and Crime Commissioners:

It is anticipated that the introduction of the new police and crime commissioners will:

- provide a strong and powerful voice for communities and represent views about how crime is prevented and its consequences are tackled
- have a statutory duty to set a police and crime plan for their force area and a budget that focuses on working in partnership to cut crime, as well as maintaining an efficient and effective police force
- be able to commission services from outside of the police force
- work with chief constables and local partners such as probation, health, education and local voluntary organisations to fulfil their commitments to not only fight crime and antisocial behaviour, but to prevent it, in order to deliver safer streets for their community
- be required to work with community safety and criminal justice partners - reciprocal duties in this area are deliberately broad and flexible, to allow working arrangements to develop in a way that is most meaningful locally, leaving room for innovation

  PCCs will need to work with community safety partners, criminal justice agencies and the voluntary sector to help deliver what's important, locally.
  Where partnerships work well they can prevent duplication, reduce costs and tackle issues by using a joined-up approach. To be effective partnerships need to be based on action.
  The public will expect PCCs to use their mandate to lead the way; to galvanise others, challenge silos while always looking to cut crime. PCCs will be in a strong position to drive action and collaboration across a range of agencies and partnerships, and may provide an opportunity for even greater local reform.

  The PCC will combine the funding streams which are currently allocated to Community Safety Partnerships and the Drug Intervention Programme. It will therefore be essential to engage with the newly elected PCC at an early stage in order to discuss the need for secure and continued funding for drug treatment for offenders within the drug treatment system.

Clinical Commissioning Groups:

'Equity and excellence – Liberating the NHS' - the white paper published by the Government earlier this year, set out a vision for the NHS which will change the way the NHS works to offer patients outcomes that are among the best in the world. It plans to do this by providing people with more information about their treatment options and a greater say in their health and care so that 'no decision about me, without me' becomes the norm.

The White Paper and its accompanying documents *Liberating the NHS: Commissioning for Patients* and *Increasing democratic legitimacy in health*, propose to give **clinical commissioning groups** (CCG's) responsibility for improving the population's health. It offers them the power to do this by moving commissioning and resource allocation decisions as close to the patient as possible on the basis that clinicians are best placed to understand local health needs.

Part of this vision is that consortia will be given freedom and responsibility for commissioning care for their local communities. Subject to the outcomes of consultation on the Government's White Paper and parliamentary approval, over the next two years clinicians will take an increasing role in allocating NHS resources. By April 2013 clinical commissioning groups will be accountable to their local communities and the NHS Commissioning Board for most NHS commissioning.

The White Paper however, makes it clear that it is for practices to decide how they organise themselves into clinical commissioning groups and we are keen to ensure that this happens in this region.

Clinicians have been encouraged to come together as groups in shadow form as soon as possible, building on practice-based commissioning groups where practices wish.

On 21 October 2010, Andrew Lansley, Secretary of State for Health announced a 'pathfinder' programme aimed to identify and support groups of GP practices who are keen to take on the new commissioning role.

Specifically the programme will:

- identify and support groups of practices that are keen to make faster progress under existing arrangements, and can demonstrate their capacity and capability to take on additional responsibility for commissioning services;
- enable GPs, working with other health and care professionals, to test different design concepts for GP consortia and identify any issues and areas of learning early so that these can be shared more widely;
- create learning networks across the country to ensure that experience and best practice are spread and that pathfinders support other local groups that are less developed, and
- involve front line clinicians more in delivering improved quality and productivity to ensure that the NHS continues to provide high quality care to all patients

Appendix 3

Effective Practice

"Recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment….an aspirational and person-centred process' (Scottish Government, 2008, p.23)."

There is much research on the effectiveness of various treatment regimes (see Drugscope database for reviews of practice in substance misuse treatment field). This constitutes a brief review of various elements of treatment together with some indications as to whether the research base supports their claim to be 'effective'.

Recovery capital

Granfield and Cloud (2008) define recovery capital as 'the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drug] problems'. Granfield and Cloud have argued that people who have access to greater reserves of recovery capital are better able to address problems than those who do not have such access. In their 2010 report on 'Whole Person Recovery', the Royal Society for the Arts have outlined what they consider to be the core components of recovery capital:

- Housing;
- Physical and mental health;
- Purposeful activity: education, training and employment;
- Peer support;
- Family and friends.

In the above list, the first three of these would be regarded as 'personal' recovery capital and the last two as 'social' recovery capital – in other words, recovery capital does not merely apply to 'traits' or personal strengths but also to what social supports they can draw upon. Collective recovery capital is based on the idea that recovery is contagious and that people who are exposed to individuals and groups who are embodying the recovery experience are more likely to be influenced and to benefit from this model. For example, an individuals chances of becoming obese increases by 57% if they have a friend who is obese. Moreover, if the friend is perceived to be a close friend then the risk rate is further increased. In other words, the likelihood of recovery is greatly enhanced if the person has access to recovery champions and recovery groups who can be integrated into their daily routines. In contrast, individuals who are surrounded by active addiction have a powerful social draw to that lifestyle. For this reason, it is important that attempts to improve social capital build on the three levels of support:

- Personal recovery capital;
- Social recovery capital;
- Collective or community recovery capital.

In addition, the idea of strengths as a core predictor of outcome is increasing in prominence. White and Cloud (2008) have reviewed evidence to suggest that a better predictor of long-term outcomes and long-term recovery than pathology levels or measures of multiple morbidity is recovery capital. Therefore, programmes that aim to build recovery capital are more likely to experience long-term success.

Alcohol studies (Litt and colleagues 2007) show that:

- the addition of just one abstinent person to a social network increased the probability of abstinence for the next year by 27%.
- Engaging in abstinent social networks also results in increases in self-efficacy and coping skills.
- Programmes designed to enable support for recovering individuals by recovery management check-ups increase recovery rates and also improve treatment re-engagement if relapse occurs.

For the reasons outlined above, a treatment system which promotes and supports service users to become abstinent and which increases their store of Recovery Capital, will foster greater success and will help to sustain recovery in the long term.

Detoxification:

Detoxification is a managed process of withdrawal of addictive substances (usually heroin and opiates) from the service users' body. How best to detoxify a patient is primarily a clinical decision, but patients may be able to choose between shorter-lasting but more intense approaches, or longer, gentler approaches. Detoxification can be hastened with antagonistic medication, eased through the use of painkillers or sedation, or prolonged through tapered doses of substitutes such as methadone. The full process of withdrawal can also be avoided by replacing illegal opiate use with a prescribed opiate substitute. Depending on the severity of the patient's drug dependency and their general health, detoxification can take place at home, with medication prescribed by a GP, in hospital or in a residential unit established for the purpose. More radical approaches have included putting individuals under heavy sedation or general anaesthetic for the duration of detoxification. This allows them to avoid much of the experience of withdrawal. Recent evidence has suggested that the risk of complications (including death) substantially outweigh the observed benefits of these approaches. For this reason, NICE guidelines now state that neither should be offered to patients as a detoxification strategy.

Although the painful symptoms of withdrawal figure widely in the public's imagination, it is usually far from the most dangerous or difficult stage of drug rehabilitation. The symptoms, though subjectively experienced as intense, are physically similar to a bout of flu. In cases of particularly dependent addicts, symptoms can involve muscle aches, profuse sweating, nausea and diarrhoea.

Detoxification on its own hardly ever constitutes a successful treatment because addicts tend to relapse and return to drug use, often at the earliest opportunity, unless they are offered further intervention. Rather than being the first stage of recovery, detoxification on its own increases risks of overdose and other complications.

Psychosocial interventions:

While clinical treatments can usually be measured for effectiveness by the form and function of the prescribed drug, psychosocial interventions can be harder to pin down and define. Some of the most effective practitioners utilise a number of different therapies and vary their approach according to what an individual addict responds to best. As a result, they depend more on specific implementation, the competency of practitioners, and local context.

Psychosocial interventions can be broadly divided into those that aim for abstinence or full recovery, and those that aim at tackling problematic thoughts and behaviour associated with drug use as part of a harm reduction intervention. Other distinguishing features include the length of interventions and their intensity, especially frequency of attendance and the focus applied to individuals. These sometimes seem to be more significant features in predicting outcomes than the content or therapeutic dynamic of the treatment, with more intense programmes producing consistently better outcomes.

12 step programmes:

Perhaps the most prominent full recovery focused psychosocial approach is the 12-step model, as used by, among others, Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous. 12-step conceptualises addiction as a disease that can be controlled *only* through refraining from drug use and maintaining sobriety. The disease can never be cured. The approach can take the form of a structured programme, provided in the community, within a prison, or in a residential rehabilitation clinic. Residential programmes usually take 6 to 12 weeks but can last as long as 18 months. Within this structure, a very wide variety of treatment approaches might be used. Key therapies used in 12-step rehabilitation programmes include:

Psychodynamic therapy, Reality therapy, group therapy, motivational interviewing, motivational enhancement therapy, cognitive behavioural therapy, Gestalt, Family systems, Images & poetry, Creative therapies (art, music, dance, drama), Humanistic, Yalom's Group Treatment, Transactional analysis, Rogerian, Psychosynthesis, Complementary therapies, Genesis relapse prevention.

There are also less structured self-help fellowships, which can provide a 'sense of purpose and belonging' and mentors who can provide a constant example of living a drug free life. Individuals who pass through a structured programme are expected to continue their recovery by participating in a local fellowship.

The programme has an avowed spiritual, though non-denominational, component: participants must admit the unmanageability of their lifestyle and seek a higher power for help and guidance in staying away from all drug use and maintaining sobriety. The core of the programme is about shifting self-centred and destructive behaviours towards helping others and having regard for their feelings. In this sense, apologising to people you have wronged and supporting other addicts are important personal developments in the programme. Perhaps the most significant feature of 12-step fellowships is that they continually present individuals who were dependent addicts but have gone on to live entirely drug free lives. This might be contrasted with clinical settings where the general experience will be one of chronic and relapsing drug abuse, which, when presented to drug users, might become a self-fulfilling and self-reproducing problem.

Generally, 12-step approaches are considered incompatible with harm reduction interventions, which are often seen as an attempt at controlled drug use.

However, objective evidence that the 12-step approach significantly enhances likelihood of abstinence in comparison with natural remission or other interventions is lacking.

Therapeutic Communities

Therapeutic Communities (TCs) resemble drug free residential rehabilitation clinics and 12-step fellowships in so far as they attempt to bring drug users and former users together to help each other recover. The difference is that while 12-step, at its core, is about confronting drug using beliefs and behaviours in a very direct manner, TCs place a greater emphasis on building up alternative modes of behaviour, as well as social structures, to replace the aberrant ones that accompany drug addiction. For those who lack the sort of relationships present in workplaces and families, these environments can provide a productive routine and lifestyle guidance. Since they usually involve developing a whole community and alternative peer group at a particular location, these are typically intensive and long-term programmes. They are able to transform some people's lives, especially those who are able to stay the full course, but can be counter-productive for those ill-suited to the community, leading to early drop-outs or expulsion if an addict relapses into drug use.

Concrete evidence proving efficacy of TCs compared with other treatments is not strong at this stage.

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy is a 'talking therapy' designed to uncover self-defeating patterns of thinking which lie at the heart of depression, anxiety and guilt. Of all talking therapies in general, it has perhaps the most robust evidence of efficacy. It can be used to tackle problematic drug using behaviour specifically, or deal with other patterns of behaviour that may underlie problematic drug use.

Unlike 12-step, CBT does not identify addiction as an incurable disease, but as problematic behaviour that can be modified, leaving open the possibility that some individuals may be able to control their drug use. As a result, CBT can be provided alongside drug maintenance treatments such as methadone prescribing. Programmes tend to be of shorter duration and less intensity than 12-step programmes and TC approaches, making it flexible and easier to fit around other routines and interventions. This makes CBT attractive when it comes to resourcing and planning treatments, but it is often insufficient to foster a transformative change of behaviour amongst seriously addicted individuals.

Although there is evidence that CBT is more effective at tackling drug abuse than no treatment at all, there is less evidence to show that it improves on other treatment alternatives. In addition, there is not all that much evidence of effectiveness for offenders and prisoners, especially as currently provided in the British prison system.

Opioid Substitution:

A widespread approach to tackling heroin dependency, and one with particular support among healthcare practitioners, is Opioid Replacement or Substitution Therapy. This involves replacing an addict's use of heroin with a less dangerous substance. The most common approach is Methadone Maintenance Therapy (buprenorphine is another common alternative with comparable outcomes), and is usually taken orally. Methadone is a long lasting opioid agonist. If applied correctly to replace heroin, methadone abolishes withdrawal within 24 hours, although for some addicts there remains some minor

chronic symptoms of withdrawal. Moreover, methadone blunts the effect of subsequent heroin use and offers some protection against overdose. This simultaneously reduces an addict's incentive to carry on taking illegal drugs, while making bad outcomes slightly less likely should they lapse.

Supporters for Opioid Substitution Therapy tend to emphasise how, for many users, heroin addiction is *'a chronic relapsing condition'*, even a lifelong disorder; a condition where management can relieve many related problems, if not necessarily the fundamental problem of dependency. One 2004 United Nations report summarised the benefits of substitution as follows:

- Reduced transmission of HIV (for intravenous users)
- Keeping more drug addicts in treatment and consistently reducing their use of illegal street drugs
- Reductions in death rates for addicts who are using a substitute rather than heroin itself
- Pregnant women are less likely to suffer complications at birth and the harm to unborn children is reduced
- More involvement in legitimate employment and higher incomes
- Lower levels of criminal involvement, especially in drug-related criminal behaviour18

However, there are also weaknesses to this approach. Full recovery advocates suggest that the 'chronic relapsing condition' model too often becomes a self-fulfilling prophecy, with a lack of confidence in more robust approaches to recovery leading directly to a lack of focus on treatments that could lead to genuine lasting recovery. Methadone and other heroin substitutes still carry a significant risk of fatal overdose, particularly when starting the treatment. Withdrawal effects from methadone last significantly longer than heroin, making it a potential barrier to drug free recovery. Moreover, it is possible for treatments intended for specific individuals to be diverted into an illicit trade.

The evidence for the value of methadone as a way of easing people into drug free recovery, by lowering doses slowly over a period of time (tapering), is limited. A Cochrane Review found that, while methadone eased the symptoms of withdrawal, 'the majority of patients relapsed to heroin use'. Methadone performed only moderately better than placebo with slightly fewer programme drop-outs. With these mediocre results for methadone alone, there is a broad consensus that methadone is usually insufficient to foster recovery, whether that is defined as living a drug free life or, at least, a life that is not defined by drug misuse. At the same time, methadone is defended as a way of bringing individuals into treatment that would otherwise refuse to engage with treatment services at all and continue regularly taking street drugs.

Opioid antagonists:

While most pharmacological interventions fit more easily into the harm reduction approach, an exception is the use of opioid antagonists, which block the effects of illegal drug use. The goal in this case is to cultivate and maintain abstinence. As a result, unlike opioid maintenance, opioid antagonists can be used in conjunction with abstinence-focused therapies. Rather than substitute heroin with a more controlled, but frequently as addictive, substance, opioid antagonists actively counter the effects of heroin. If compliance with the treatment is maintained following a successful detoxification, it can help willing addicts remain completely free of opiates. The most commonly used antagonist is Naltrexone. It blocks the euphoric effects of heroin, acting as a significant deterrent to injecting while on the treatment.

More controversial is how to apply this treatment in a public health setting. The main issues are ensuring continued compliance with treatment, and, ideally, inducing long term abstinence from heroin. As Minozzi et al. explain:

[N]altrexone has good pharmacodynamics and pharmacokinetic properties. However, from an applied perspective, the medication has little application since the medication compliance rates are very poor.

Other essential elements of Effective Practice:

Treatment Pathway(s):

A treatment pathway which is relatively simple and easy to navigate is essential, so that both service users and staff understand the defined routes into and out of treatment. Southampton Drug Action Team is currently working on designing the new treatment pathways. However, from our extensive consultation during the period of the strategic review, the following general principles have been established:

1. Routes **into** treatment need to be streamlined and applicable to all service users regardless of the drug of choice. (Although treatment modalities may vary following assessment)

2. The system needs to provide treatment in line with local expressed need

3. Efficient, robust and holistic Recovery co-ordination is needed. This needs to be delivered on an "end to end" basis throughout treatment.

4. Service users need to be aware of how they can exit treatment successfully from any point on the treatment pathway.

5. Service user choice needs to be maximised.

Assessment:

Screening and assessment processes help to identify what is at the core of the service users substance misuse problems and are at the heart of the treatment process, enabling workers and service users to understand which interventions are likely to work effectively. Screening processes should identify the severity of substance misuse to establish if a full assessment is necessary. Assessments should be undertaken by a specialist in substance misuse and can be conducted using questionnaires or diagnostic interviews. There are a wide range of screening and assessment tools available that have undergone some form of validation. However, they have not been compared to determine which are most effective. The use of objective screening tools and referral criteria could enhance appropriate access to substance misuse services. Screening tools and assessment processes must be formally linked to each other, and to treatment interventions, to realise their full benefits

Individual Needs:

Treatment must be individualised to reflect the needs and goals of the person seeking help with their substance misuse problem. Individual needs that require special attention are likely to be: ethnicity, gender, mental health, type of substance.

The needs of families and carers need to be considered as well as the service user, from initial assessment onwards, with regular reviews to ensure that families and carers needs are met throughout the treatment process.

Communication:

The role of communication between practitioners and the service user cannot be underestimated. Three prominent features of communication revealed in the evidence base and legal guidance include:

- working relationship or therapeutic alliance

- respect and pro social modelling

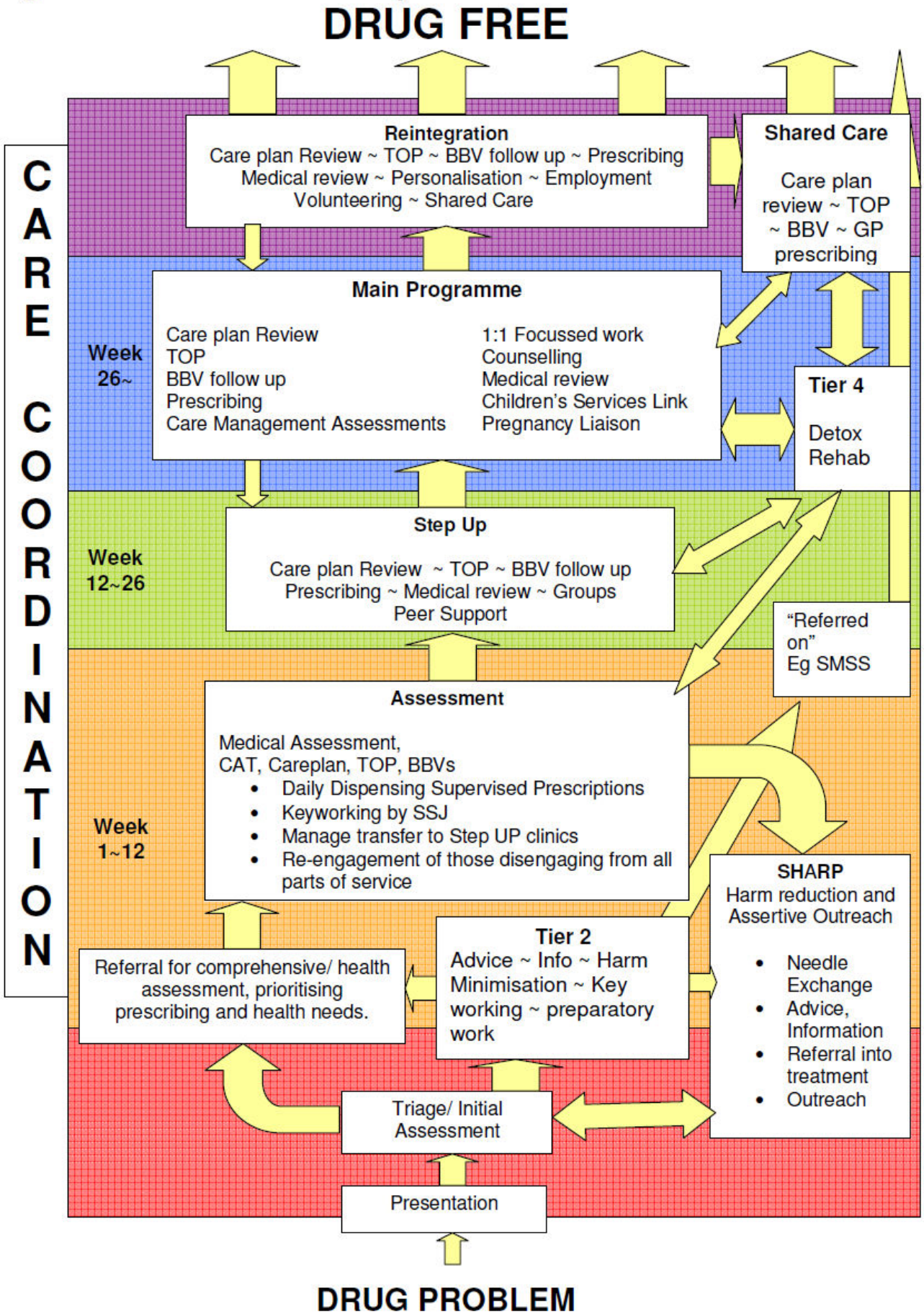
- information sharing.

Peer support and mentoring:

Service users must be able to see from the minute that they contact drug treatment services, that there are others who have successfully recovered from addiction. Peer support networks are an intrinsic part of the treatment system and without the presence of peer volunteers and workers within services, we cannot hope to maximise the number of people who are able to benefit from drug treatment services. Peer support networks provide both Recovery Champions and Recovery Capital, the importance of which cannot be over-emphasised.

Appendix 4 - Current Model of Service Provision (Southampton)

Drug Service Treatment Pathway



Appendix 5 – Suggested Method of writing outcomes

Outcome Examples

Step	Outcome	What can help achieve the outcome?
1	Inject drug more safely and reduce the risk of Hepatitis B, Hepatitis C, HIV viruses and infections such as TB	• Provision of clean injecting equipment form needle exchanges in the following locations (identify) • Pharmacy participation in • Teach safer drug use techniques includeing where appropriate safer injecting skills • Provision of HIV, Hepatitis and TB testing and vaccination programmes where available. • Brief interventions to prevent initiation into injecting behaviour
2	Develop motivation for change and ensure readiness, willingness and ability to engage with treatment services and undertake change	• Negotiated recovery plan with clear set of tangible actions and steps to build recovery capital within a given timeframe • Talking therapies such as Motivational interviewing to help resolve practical problems and ambivalence about recovery

Appendix 6 – Championing Recovery in Drug Treatment

Championing recovery in drug treatment (NTA 2012)

The national drug strategy (2010) highlights the role of recovery champions at three levels who will promote a culture of ambition and support the increasing achievement of recovery outcomes across their drug treatment systems:

Strategic recovery champions – leaders such as locally elected councillors, LA chief executives, Directors of Public Health and Drug and Alcohol Commissioners, who promote the recovery orientated system

Therapeutic recovery champions – drug treatment service providers working in local treatment services (and prisons) and/or a champion working across the local treatment system. The key focus of this role is ensuring the visibility and availability of recovery in drug treatment services.

Community recovery champions – usually people who are already in recovery; these roles not only demonstrate visible pathways to recovery for individuals, they can also act as catalysts of change in services and across treatment systems. They will be encouraged to mentor and support their peers and promote peer support and mutual aid approaches.

Strategic recovery champion

- The strategic recovery champion should have sufficient authority in the partnership (and prison if there is one in the locality) to influence overall strategy development through for example, health and well-being boards and criminal justice groups
- The strategic recovery champion would use their influence to promote the benefits and outcomes of drug treatment to strategic partners, including elected members, and make the case for continued investment.
- The strategic recovery champion would work with senior partnership representatives to (ensure there are sufficient systems to) monitor the availability and use of abstinence based drug services and the rate of successful completions from drug treatment in the locality
- The strategic recovery champion would use their influence to integrate/connect drug treatment systems with other systems and services which support recovery, including but not exclusively;
  - The criminal justice system and offender management programmes
  - Employment, training and volunteering services
  - Housing
  - Family services (which address safeguarding, support parents in treatment, and which include the wider family in supporting adult family members in treatment)
  - Mental health services
  - Mutual aid provision/recovery communities
  - Peer support services
  - Clinical commissioning groups
- The strategic recovery champion would ensure that there are communication pathways through which therapeutic and community recovery champions can highlight local issues impacting on recovery opportunities.

Therapeutic recovery champions

- Therapeutic recovery champions will wish to develop, review and improve inter-agency working across drug treatment services and support the development of joint case management approaches (consideration should be given to working with shared care services and improving continuity of care between prison and community based treatment)
- Therapeutic recovery champions will also develop inter-agency working/connections with generic services supporting recovery, ensuring that these are integral to the treatment system, including, but not exclusively;
  - The criminal justice system and offender management programmes
  - Employment, training and volunteering services
  - Housing
  - Family services (which address safeguarding, support parents in treatment, and which include the wider family in supporting adult family members in treatment)
  - Mental health services
  - Mutual aid provision/recovery communities
  - Peer support services
- Therapeutic recovery champions may review case management processes/undertake case file reviews with the aim of improving recovery focussed case management and joint working approaches
- Therapeutic recovery champions will wish to have local processes to monitor the availability and use of abstinence based drug services and the rate of successful completions from drug treatment in the locality
- Therapeutic recovery champions may provide (access to) training for frontline staff to support drug treatment services in developing an increasingly recovery orientated inspirational staff group
- Therapeutic recovery champions will wish to communicate regularly with community recovery champions/service user representatives

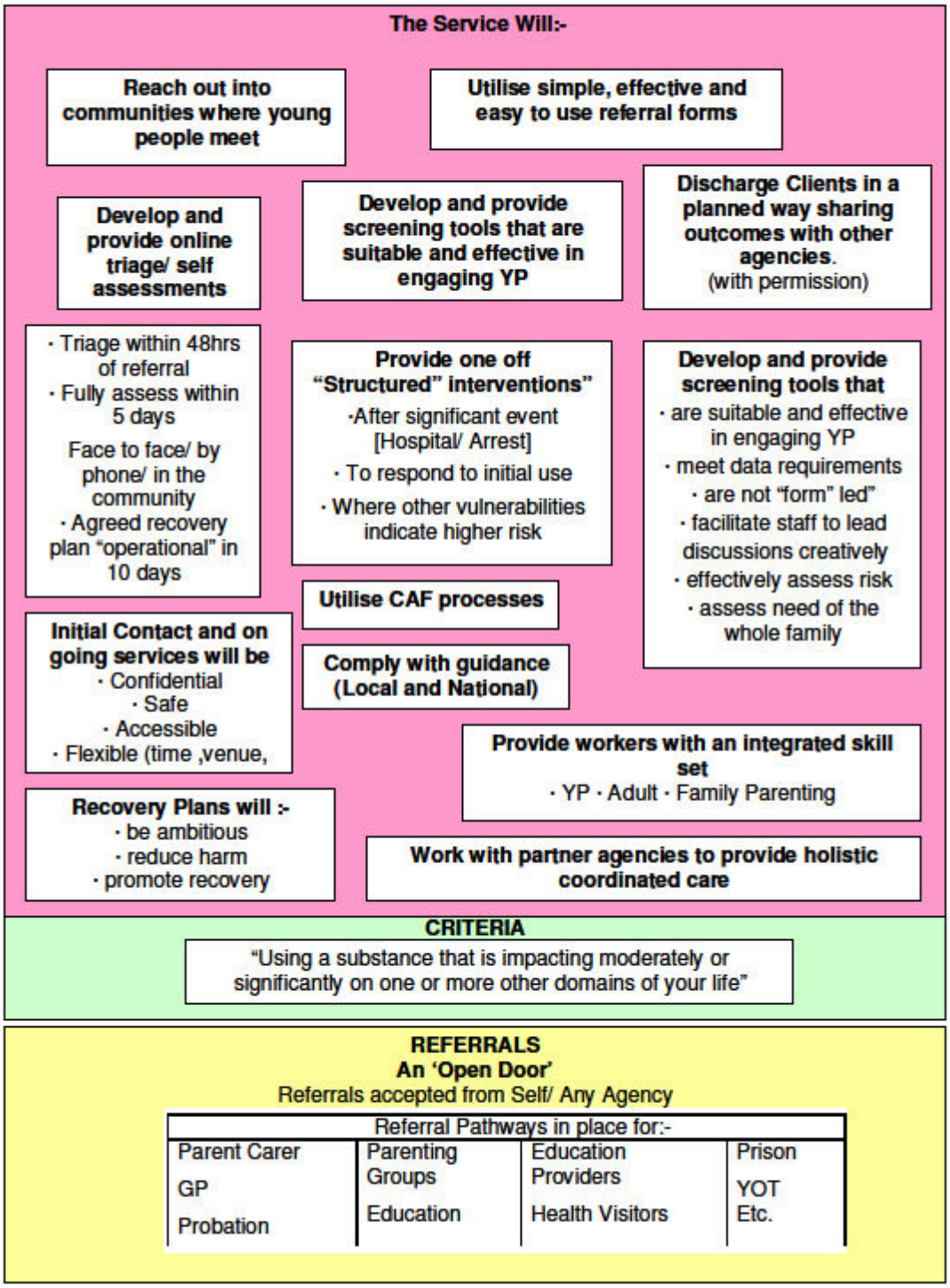
Community recovery champions

- Community recovery champions will wish to offer partnerships feedback on progress by treatment services in implementing true recovery orientated treatment
- Community recovery champions will be willing to engage with service users at all points across the treatment system, promoting recovery potential and building ambition
- Community recovery champions will wish to develop/promote pathways to a full range of mutual aid and peer support services, allowing people to decide for themselves which service may be of benefit
- Community recovery champions will wish to develop pathways to a range of community and voluntary services and between custody and the community which could meet the recovery support needs of local clients

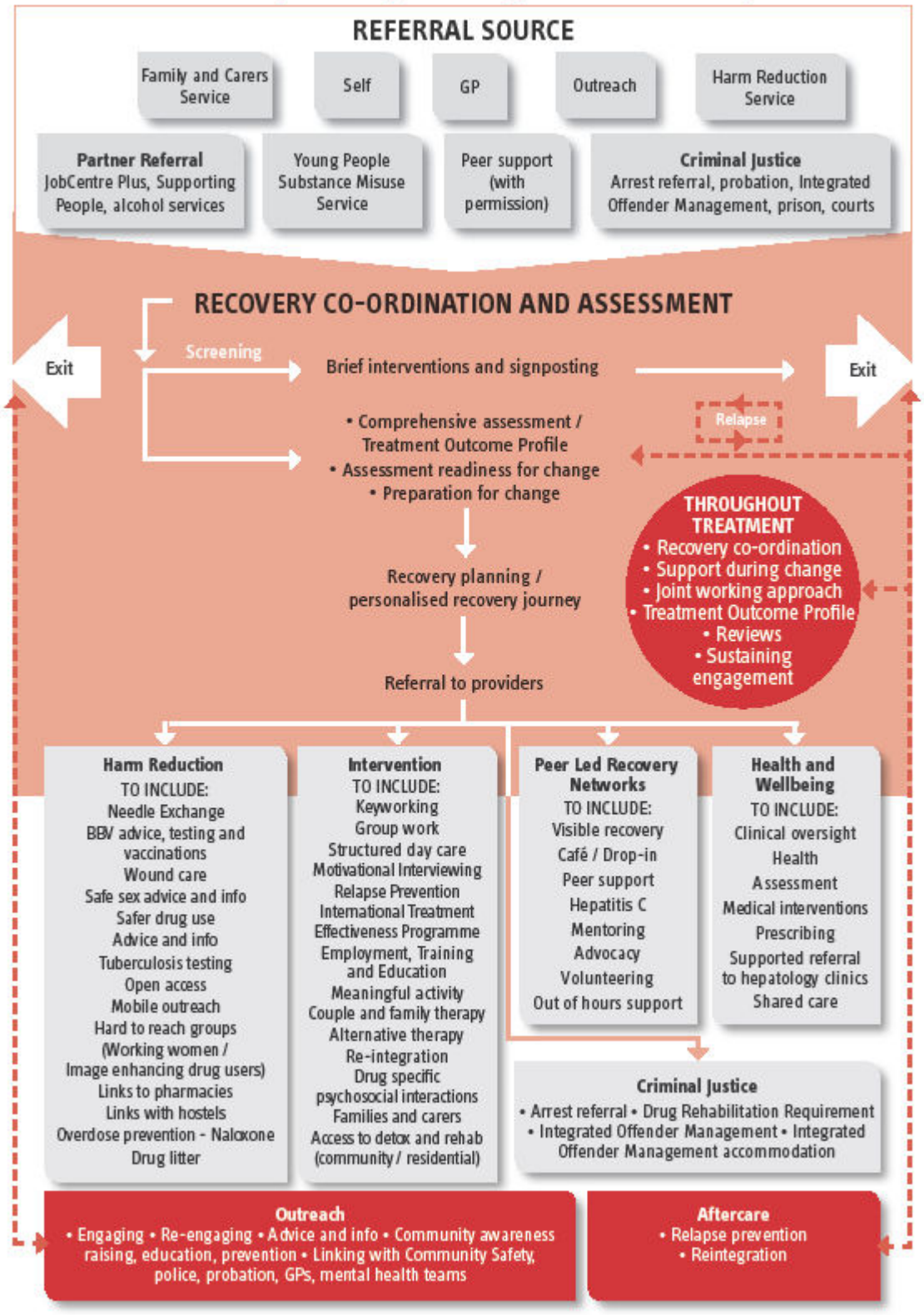
Community recovery champions may wish to promote the benefit of drug treatment and recovery systems across a range of stakeholders.

Appendix 7 - Suggested Models for Service Provision:

DRAFT SKETCH OF SUGGESTED YP (11 – 24 SERVICE)



Southampton Integrated Drug Treatment Pathway



Diagnostic Outcomes Monitoring Executive Summary — Quarter 4

Select partnership: **Southampton**

Opiate cluster: **Cluster D**

1 Investment

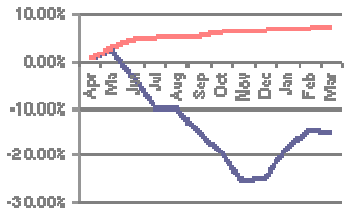
£ 2,872,523

PTB	DIP	Mainstream	Other
£ 1,857,578	£ 293,745	£ 608,600	£ 112,600

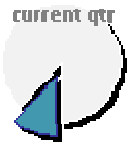
2 Successful completions

Percentage growth in successful completions since 2010/11

	Local	Travel from prev qrtr	Cluster average	National
Opiate	-22%		7%	11%
Non Opiate	-4%			4%
All	**-15%**	9%		**7%**

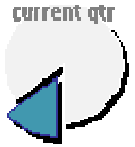


		Local	Top quartile range for cluster	National
Successful completions	Opiate	7%	10% to 15%	9%



as a percentage of total number in treatment	Non Opiate	42%			40%
	All	**12%**	1%		**15%**

		Local		Top quartile range for cluster	National
Proportion who successfully completed treatment and re-present during 2011/12	Opiate	22%		13% to 9%	15%
	Non Opiate	2%			4%
	All	**14%**	-1%		**10%**

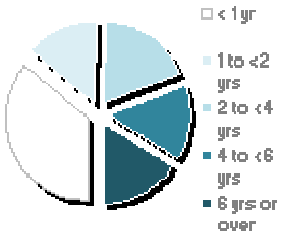


Criminal Justice clients

	Local		National
Successful completions as a percentage of total CJ clients in treatment	**16%**	2%	**14%**
Proportion who successfully completed treatment and re-present during 2011/12	**8%**	-1%	**10%**

3 In treatment

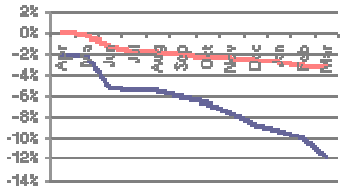
	Years	Local	Travel from prev qrtr	National
Proportion of clients still in treatment for longer than one year	1 to <2 yrs	15%	-2%	14%
	2 to <4 yrs	19%	-1%	21%
	4 to <6 yrs	15%	0%	14%
	6 yrs or over	16%	1%	21%



Average length of time in treatment (years)	2.4	0.1	2.9
Criminal Justice clients			
Average length of time in treatment (years)	0.9	0.0	1.7
Proportion of the treatment population	34%	1%	24%

4 Effective Treatment

		Local	Travel from prev qrtr	National
Growth in clients in effective treatment since 2010/11	Opiate	-11%		-4%
	Non Opiate	-20%		-1%
	All	**-12%**	-3%	**-3%**



5 Reduced drug use, housing and employment outcomes

		Local	Travel from prev qrtr	National
Opiate abstinence and reliably improved: 6 month review in last 12 months	Opiate	61%	-1%	69%
Crack abstinence and reliably improved: 6 month review in last 12 months	Opiate	60%	12%	62%
	Non Opiate	100%	0%	58%
Cocaine abstinence and reliably improved: 6 month review in last 12 months	Non Opiate	80%	30%	67%
No longer injecting: 6 month review in last 12 months	Opiate	35%	-15%	61%

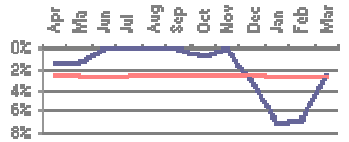
Clients successfully completing treatment with no reported housing need (Exit TOP)	All	75%	-10%	84%
Clients successfully completing treatment working >= 10 days in last 28 at exit	Opiate	19%	-1%	21%
	Non Opiate	22%	-2%	28%

6 Waiting Times

Red: over 10%

Green: 10% or under

	Local	Travel from prev qrtr	National
Percentage of clients waiting over 3 weeks to start first intervention	2%	-1%	3%
Number of clients waiting over 6 weeks to start first intervention	0	0	140

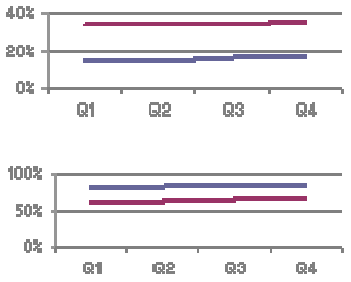


7 Harm Reduction

Red: under 90%

Green: 90% or over

	Local	Travel from prev qrtr	National
Percentage of new presentations YtD who accepted HBV vaccinations	21%	5%	34%
Percentage in treatment previously or currently injecting who received a HCV test	86%	2%	66%



8 Parents and

New presentations YtD

All in treatment at end of qtr

Families

	Local	National	Local	National
Individuals who live with children	56		185	
	16%	27%	21%	33%
Individuals who are parents but do not live with any children	151		302	
	43%	25%	35%	20%
Individuals with incomplete data	2		2	
	1%	1%	0%	4%

Southampton Data Report

Southampton Drug Treatment Data Analysis Report to Support the Partnership Strategic Review

Contents

Summary of Findings

Key Points based on data extracted from the Glasgow Prevalence Data:

- Prevalence for opiate users is down and this fits with the national trend
- Potential 5% increase in crack users prevalence between 2008/09 and 2009/10 which is at odds with the national trend (requires local evidence to substantiate).
- Potential increase of 38% in opiate prevalence amongst 15-24 year olds further investigation at a local level required to substantiate)
- Treatment penetration rate for opiate users of 57%
- Opiate prevalence in Southampton shows a younger population (55%)

Key points from Southampton's In-treatment activity data;

- Opiate users make up a majority of Southampton's in-treatment population
- Generally low levels of crack use as primary drug of choice
- The average client profile of someone engaged in drug treatment in Southampton is that of a white British male under the age of 40 who misuses opiates
- Reported current injecting status is 37%, higher than the national figure of 18%
- Significant numbers of clients in treatment for over two years and 1 in 6 in for over six years.
- Average length of time in treatment is 2.4 years

Key points from Southampton's Modality Performance data;

- Modalities with a high turnover of clients such as specialist prescribing also have a significant proportion leaving in an unplanned way.
- Opiate users make up the majority of the modality "drop-out" rate in Southampton
- "Other structured treatment" is the only modality where more clients leave in a planned way (89 or 51%) than those who leave in an unplanned way (87 or 49%)

Key points from attrition data:

- Significant proportion of DIP clients (32%) are already engaged in treatment services when seen by a DIP worker
- Successful inter-agency transfer rate in Southampton is on average 80%, however this figure varies between services with The New Road Centre successfully transferring 28% of clients.
- Practice or reporting issues may be contributing to attrition rates.
- Partnership may wish to investigate services with high or higher than average unplanned discharges.

Key Points highlighted from TOP Outcome Data:

- Southampton is within the expected range for opiate users who achieve abstinence at six months;
- Over half of opiate users with up to six months exposure to treatment had initiated opiate use at point of TOP review;
- General improvements across a range of outcomes but still relatively low numbers

Key Points from Southampton's Successful Completions & Representations Data:

- 118 (all) clients' were recorded as leaving drug treatment successfully in Southampton YTD (11/12);
- Current performance for successful completions in Southampton is outside of top quartile range for opiate users;
- Falling opiate in-treatment population may be impacting on successful completion rate;
- 14% of those successfully completing treatment in Southampton re-presented to services in year;
- 35% of re-presentations occurred in October 2011;
- Average representations occur 4 months after leaving treatment.

1. Introduction

In March 2012 Southampton partnership undertook a strategic review of the drug treatment system. This report has been compiled to assist the partnership in reviewing the current treatment system. This report considers several data sources including annual, quarterly and monthly statistic and where appropriate provides commentary on this data in order to highlight areas that potentially impact of service delivery such as successful completions and representations.

2. Prevalence of Substance Misuse in Southampton

The University of Glasgow, in conjunction with The National Drug Evidence Centre (NDEC) AT THE University of Manchester, have for several years produced annual prevalence estimates for both opiate and crack using populations across England. The data contained in the prevalence estimates provide partnerships with information on the likely presence and distribution of opiate and crack amongst the general population.

The latest prevalence report published by Glasgow University and NDEC relates to data captured in 2009/10 and the report compares this data with the previous year's (2008/09) in order to chart increases or decreases in opiate and/or crack using (OCUs) population

Figure 1 provides an overview of the prevalence for OCUs as well as separate profiles for opiate, crack and injecting drug users at national, regional and partnership level.

Figure 1: Prevalence Estimates 2009/10

	Number of users											
	OCU	Lower bound 95% CI	Upper bound 95% CI	Opiate users	Lower bound 95% CI	Upper bound 95% CI	Crack users	Lower bound 95% CI	Upper bound 95% CI	Injecting	Lower Bound 95% CI	Upper bound 95% CI
Southampton	1,526	1,035	2,009	1,321	1,039	1,600	1,126	712	1,551	492	437	578
South East	36,145	31,521	40,764	30,656	28,003	33,740	21,021	17,141	25,917	11,376	9,667	13,321
England	306,150	299,094	316,916	264,072	260,023	271,048	184,247	177,534	195,526	103,185	100,085	107,544

The 2009/10 data in figure 1 above suggests that nationally OCU prevalence stood at 306,150 which is a fall of 15,079 or around 5% from the previous year's estimate of 321,229.

When broken down for opiate users, the prevalence data suggests that at a national level this has gone up slightly to 264,072, although due to an overlap in confidence intervals between the two time periods, researchers cannot be confident that the increase in opiate use is statistically significant.

When the prevalence data is examined at a partnership level and broken down to age ranges it does appear to show two developments that require further investigation.

Figure 2: Opiate Prevalence in Southampton

Region	DAT Area	2009/10			2008/09		
		Opiate users	Lower bound 95% CI	Upper bound 95% CI	Opiate users	Lower bound 95% CI	Upper bound 95% CI
South East	Southampton	1,321	1,039	1,600	1,354	1,207	1,757

The 2009/10 prevalence data indicates a slight decrease in the opiate using population of Southampton with the mid-point estimate reported to be 1,321. This is a decrease of approximately 33 or around 2.5% from the previous year's figure. This fits with national trend as previously mentioned, however to assist in confirming this trend the partnership may wish to use local data in order gain a fuller picture of substance misuses in Southampton.

Of particular interest is when examining the data under specific age profiles the data shows a potential increase in opiate prevalence amongst one particular demographic as illustrated in Figure 3 below.

Figure 3: Opiate Use in Southampton by Age Group

Region	DAT Area	2009/10			2008/09		
South East	Southampton	Opiate Users			Opiate Users		
Age Groups		15-24	25-34	35-64	15-24	25-34	35-64
Mid-point Estimate		279	446	596	202	559	592

The largest increase in opiate prevalence across Southampton appears to be amongst the 15-24 age groups with estimated numbers up from 202 in 2008/09 to 279 in 2009/10. This is an overall increase estimate of 38% from the previous year.

The potential increase in opiate prevalence with a sub-set of the population warrants further investigation locally before any specific conclusions can be reached.

However, if substantiated locally, the increase in this age profile may have implications for services across Southampton as age has been shown to be a determining factor in client attrition i.e. studies found that younger clients were far more likely to leave treatment in an unplanned way that older clients (Beynon et al, 2007). Ensuring local adult and young people's services can support the needs of this specific population may help to reduce both client attrition and to improve the overall rate at which people successfully complete treatment and sustain recovery.

Southampton's year to date (YTD) current in-treatment population for opiate users is 755 and based on the 2009/10 prevalence figures outlined above this gives the partnership a treatment penetration rate of 57%.

According to the data outlined in figure 3 above, opiate prevalence in Southampton shows the demographics to be of a younger age population, with 725 or 55% aged less than 35 years and 596 or 45%.

Figure 4: Crack Prevalence in Southampton

Region	DAT Area	2009/10			2008/09		
		Crack users	Lower bound 95% CI	Upper bound 95% CI	Crack users	Lower bound 95% CI	Upper bound 95% CI
South East	Southampton	1,126	712	1,551	1,071	941	1,257

The 2009/10 prevalence data indicates an increase in the crack using population of Southampton with the mid-point estimate reported to be 1,126 for 2001/10. This is an increase of approximately 55 or around 5% from the previous year's figure and is at odds with the national trend which saw a decrease of 2.5% from 2008/09 to 2009/10.

Key Points based on data extracted from the Glasgow Prevalence Data:

- Prevalence for opiate users is down and this fits with the national trend
- Potential 5% increase in crack users prevalence between 2008/09 and 2009/10 which is at odds with the national trend (requires local evidence to substantiate).
- Potential increase of 38% in opiate prevalence amongst 15-24 year olds further investigation at a local level required to substantiate)
- Treatment penetration rate for opiate users of 57%
- Opiate prevalence in Southampton shows a younger population (55%)

3. Southampton In-Treatment Activity Data

Southampton's In-treatment population is taken from the latest YTD figures on ndtms up to March 2011 and the latest Quarter 4 (11/12) data reports:

- All in – treatment YTD: 866
- Male: 640 or 74%
- Female: 226 or 26%
- Ethnicity: 86% white British; 14% other
- Heroin as primary drug of choice: 669 clients cite heroin as their primary drug of choice with 292 or 44% of this number also reporting crack as the secondary drug.
- Other opiates: 71
- Crack as primary drug of choice: 21 clients cite crack as their primary drug of choice with 8 reporting heroin as secondary problematic drug
- Number of individuals starting a new treatment journey (YTD): 352
- Number of new treatment journeys who currently inject: 130 or 37%
- Number of new treatment journeys with previous injecting history: 62 or 18%
- Number of new treatment journeys who have never injected: 157 or 45%
- Criminal Justice Clients as a proportion of the treatment system: 34%

Figure 5: Age Profile of All In–Treatment Population (YTD 2011)

Age Range:	18 - 29	30 – 39	40 – 64
% of Treatment population	30%	38%	31%

Figure 6: Length of Time in Treatment

	Years	Local	Travel from prev qrtr	National
Proportion of clients still in treatment for longer than one year	1 to <2 yrs	15%	⇩ -2%	14%
	2 to <4 yrs	19%	⇩ -1%	21%
	4 to <6 yrs	15%	⇨ 0%	14%
	6 yrs or over	16%	⇧ 1%	21%
Average length of time in treatment (years)		2.4	⇧ 0.1	2.9
Criminal Justice clients				
Average length of time in treatment (years)		0.9	⇨ 0.0	1.7
Proportion of the treatment population		34%	⇧ 1%	24%

The treatment population in Southampton is made up primarily of those who misuse opiates and these account for around 79% of the overall treatment population. Males are the predominate gender group accessing services whereas only around 1 in 4 of the treatment population recorded as female. Additionally, the majority of those who services in Southampton cite their ethnic identity as white British (86%) against 14% who describe themselves as either non-British or non-White British. Southampton's treatment population is generally split between those under 40 (68%) and those aged 40 plus (31%).

There are low numbers of clients in treatment who use crack as a primary drug of choice (21) but relatively high numbers of opiate users who cite crack as being a problematic secondary drug (292). Furthermore Southampton's treatment population consists of clients referred via the criminal justice system with this cohort making up 34% of the in-treatment population.

Clients who have started a new treatment journey this year (YTD, March 2011) who declare currently injecting is 37%, compared to 18% nationally. While 18% state they previously injected. Interestingly 45% or 157 of new treatment journeys state they have never injected.

Figure 6 shows, half of the clients currently engaged in treatment in Southampton have been there for over two years (50%) with 16% or 1 in 6 having been there for over six years. The average length of time in treatment stands at 2.4 years which is

slightly lower than the national average at 2.9 years. This suggests a sizeable proportion of the treatment population being held within the system for long periods of time.

Key points from Southampton's In-treatment activity data;

- Opiate users make up a majority of Southampton's in-treatment population
- Generally low levels of crack use as primary drug of choice
- The average client profile of someone engaged in drug treatment in Southampton is that of a white British male under the age of 40 who misuses opiates
- Reported current injecting status is 37%, higher than the national figure of 18%
- Significant numbers of clients in treatment for over two years and 1 in 6 in for over six years.
- Average length of time in treatment is 2.4 years

4. Modality Performance Data

Modalities define the type of interventions that are delivered to clients and these can include both clinical and non-clinical services. The information below provides an overview of YTD figures (2001/12) in Southampton for those clients exiting a modality in either a planned or unplanned way. It is important to note that leaving a modality in an unplanned way does not necessarily mean that a person has dropped out of the wider treatment system only that they are recorded as not completing this part of their treatment journey.

Modality exit status (YTD – up to 31st March 2012)

Specialist prescribing:

- Recorded modality exits: 391
- The number of this modality with planned exit: 175 or 45%
- The number of this modality with unplanned exit: 213 or 55%

Structured day programme:

- Recorded modality exits: 94
- The number of this modality with planned exit: 48 or 51%
- The number of this modality with unplanned exit: 42 or 45%

Other formal psychosocial therapy:

- Recorded modality exits: 109
- The number of this modality with planned exit: 48 or 44%
- The number of this modality with unplanned exit: 61 or 56%

Other structured treatments:

- Recorded modality exits: 176
- The number of this modality with planned exit: 89 or 51%
- The number of this modality with unplanned exit: 87 or 49%

The data provided above shows the number of clients who left the treatment modality in an unplanned way (403) exceeds those who left in a planned way (360). The modalities with the highest turn-over of clients is specialist prescribing (213 or 55%) followed by other structured treatment (87 or 49%) and other formal psychosocial therapy with 61 or 56% of unplanned exits. These three modalities have more clients leave in a unplanned way than those who leave in a planned way, therefore it could be assumed these services are not achieving the stated aims and objectives of the modality.

The modality that seems to be performing best (YTD) is Southampton is Structured Day Programme which has a planned exit rate of 51%. Other structured treatments are generally described as any form of structured, therapeutic activity not captured as part of the other defined modalities and on the whole seems to work best with non-opiate users. Further investigation at a partnership level would help to provide additional information on which client groups benefited most from this type of intervention and may help to support in the development of evidence based practice.

The YTD data on treatment modalities points to a relatively high attrition rate for specialist prescribing and therefore may warrant further investigation at a local level to ascertain if there any specific reasons for this rate of client drop out.

Key points from Southampton's Modality Performance data;

- Modalities with a high turnover of clients such as specialist prescribing also have a significant proportion leaving in an unplanned way.
- Opiate users make up the majority of the modality "drop-out" rate in Southampton
- "Other structured treatment" is the only modality where more clients leave in a planned way (89 or 51%) than those who leave in an unplanned way (87 or 49%)

5. Points of Attrition in the Southampton Treatment System

This section of the report examines client attrition from treatment within the areas of DIP and inter-agency transfers.

Figure 7: Criminal Justice Clients in Southampton (YTD 2011/12)

Criminal Justice Clients	Q1	Q2	Q3	Q4
No of DIP referrals YTD 11/12	27	25	19	47
No/% of DIP referrals already in treatment	12 (44%)	9 (36%)	5 (26%)	15 (32%)
No of new DIP referrals referred into treatment	15	16	14	32
% of new DIP referrals not picked up in treatment and who have never been in treatment	2 (13%)	3 (19%)	3 (21%)	4 (13%)

YTD DIP referrals for Southampton show an increase across each quarter culminating with 47 referrals in Q4. However, a significant proportion of these referrals were already in treatment at the time they were referred, suggesting a sizeable number (15 or 32%) were committing further offences whist still in contact with treatment services. Additionally, data for Q4 suggests that of the 32 'new' DIP clients referred into treatment 4 were found not to engage and were treatment naive i.e. no matched treatment episodes since 2004/5. This shows that of the new DIP referrals made in Q4 87% were picked up by the treatment service.

Figure 8: Inter-Agency Transfers

	Number in treatment in the last 12 months (o18)	Number of clients transferred - not in custody - latest 12 months	Number of clients transferred and continuing treatment in partnership	Number of clients transferred and resuming treatment outside of partnership	Percentage of all clients in treatment successfully transferred
Parent Organisation Name and agency	April 2010 to March 2011 Baseline	April 2011 to March 2012	April 2011 to March 2012	April 2011 to March 2012	April 2011 to March 2012
⊟Society of St James	336	54	40	4	15.3%
Southampton DIP	336	54	40	4	15.3%
⊟Hampshire Partnership Foundation Trust	890	95	78	3	9.9%
The New Road Centre	679	14	2	2	0.6%
Southampton DIP Prescribing	211	81	76	1	51.7%

On average the successful client transfer rate for Southampton as a whole seems to be around 80% i.e. Society of St James transferred 54 clients between April to March 2012of which 44 (81%) resumed treatment either in the partnership area or in another DAAT. Similarly, The New Road Centre transferred 14 clients during the same time period of which 4 (28.5%) where successfully picked by the receiving

service with the remaining 10 people (71%) not recorded as being in treatment either in the partnership area or anywhere else in the country.

The partnership may wish to investigate client attrition with the service providers in order to ascertain if this is due to practice issues or reporting issues. Client attrition may also be due to some inconsistencies in the way that activity is reported at a provider level i.e. some clients may be 'dropping down' to Tier 2 provision (aftercare/reintegration) following a period of structured treatment but the departure of the 'structured' treatment element is not being captured as a successful completion due to misunderstandings of how to report this activity e.g. the transferring agency may view the person as still in 'contact' with treatment even though all treatment modalities have been successfully completed.

Key points from attrition data:

- Significant proportion of DIP clients (32%) are already engaged in treatment services when seen by a DIP worker
- Successful inter-agency transfer rate in Southampton is on average 80%, however this figure varies between services with The New Road Centre successfully transferring 28% of clients.
- Practice or reporting issues may be contributing to attrition rates.
- Partnership may wish to investigate services with high or higher than average unplanned discharges.

6. Southampton Outcome and Performance Activity Data

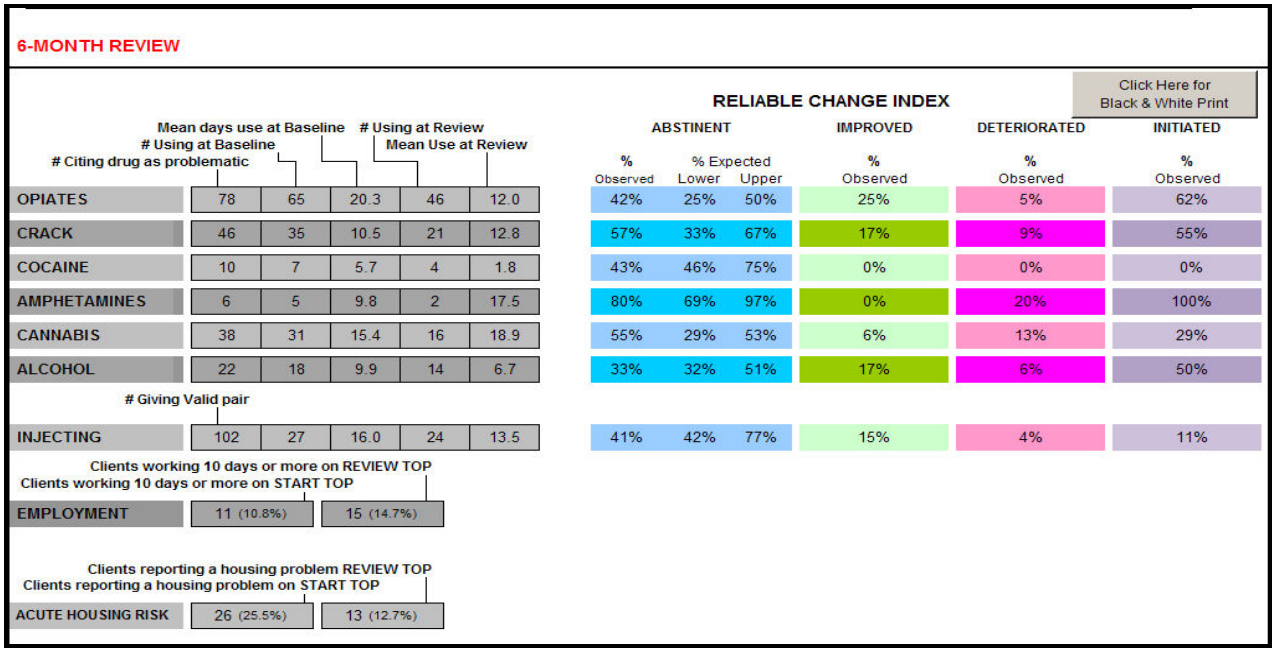
Supporting clients to achieve freedom from dependency and helping them to reintegrate back into their local communities through becoming economically active or engaged in some form of meaningful activity are key aims of the 2010 Drug Strategy and at a local level these aims are monitored through the use of the Treatment Outcomes Profile (TOP) and then reported back to partnerships through the TOP Quarterly Outcomes Report (QOP)

TOP Quarterly Outcomes Report

The TOP Quarterly Outcomes Report (QOR) provides outcome information for the initial six month period of treatment as well as reporting the outcomes accrued at planned exit. The primary outcomes monitored by the QOR include: abstinence or reduction in drug / alcohol usage; employment; injecting status; and acute housing risk. The QOR provides an overall summary of performance and also a drill down section that allows partnerships' to segment treatment populations based on age, gender, ethnicity etc.

Figures 8 and 9 below provide summary outcomes data for both the review and exit stages of treatment (taken from the latest Quarter 4 TOP Outcomes Report for Southampton).

Figure 9: Summary of Outcomes at Review stage (6 months)



6-MONTH REVIEW

Click Here for Black & White Print

	# Citing drug as problematic	# Using at Baseline	Mean days use at Baseline	# Using at Review	Mean Use at Review	RELIABLE CHANGE INDEX: ABSTINENT % Observed	ABSTINENT % Expected Lower	ABSTINENT % Expected Upper	IMPROVED % Observed	DETERIORATED % Observed	INITIATED % Observed
OPIATES	78	65	20.3	46	12.0	42%	25%	50%	25%	5%	62%
CRACK	46	35	10.5	21	12.8	57%	33%	67%	17%	9%	55%
COCAINE	10	7	5.7	4	1.8	43%	46%	75%	0%	0%	0%
AMPHETAMINES	6	5	9.8	2	17.5	80%	69%	97%	0%	20%	100%
CANNABIS	38	31	15.4	16	18.9	55%	29%	53%	6%	13%	29%
ALCOHOL	22	18	9.9	14	6.7	33%	32%	51%	17%	6%	50%

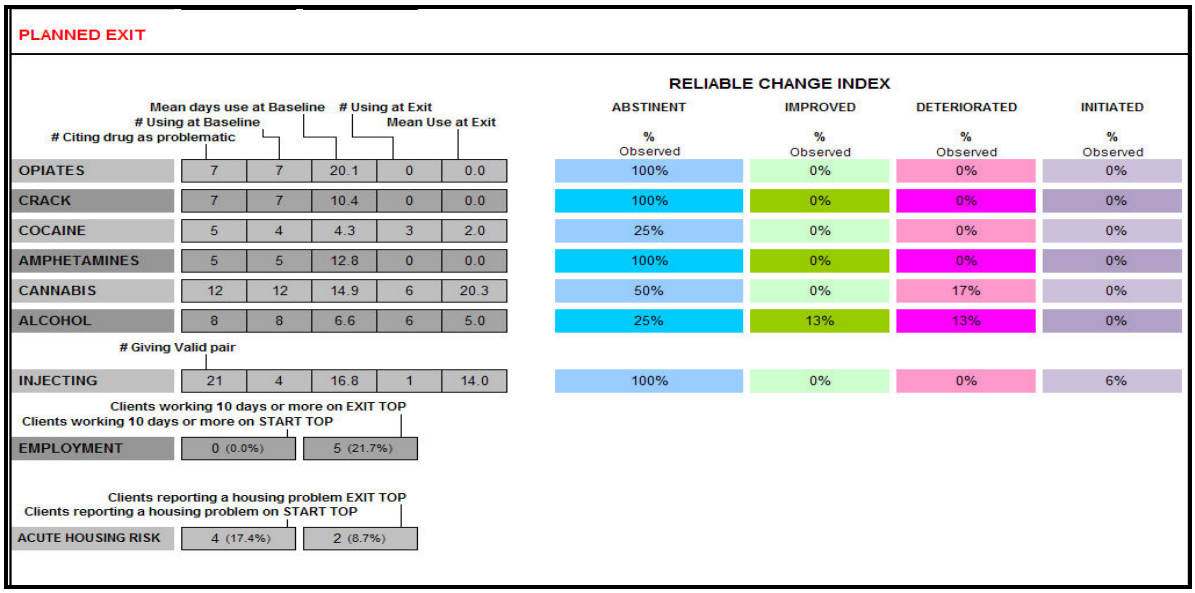
	# Giving Valid pair										
INJECTING	102	27	16.0	24	13.5	41%	42%	77%	15%	4%	11%

	Clients working 10 days or more on REVIEW TOP	Clients working 10 days or more on START TOP
EMPLOYMENT	11 (10.8%)	15 (14.7%)

	Clients reporting a housing problem REVIEW TOP	Clients reporting a housing problem on START TOP
ACUTE HOUSING RISK	26 (25.5%)	13 (12.7%)

The data reflected in Figure 8 above shows that in Quarter 4 there were 78 clients citing opiate use as problematic at assessment stage and that 65 people stated that they were actually using opiates at the point of entry into treatment. At review stage, the number of clients using opiates had dropped to 46 (a fall of 19 from baseline) and the frequency of use had also dropped from 20.3 to 12 days. The percentage of clients achieving abstinence at TOP review (5-26 weeks) was 42% which is comfortably within Southampton's complexity group range of 25% - 50%. However, around 62% of clients had initiated opiate use by the time they had completed a TOP review (5-26 weeks) which suggests that following up to six months exposure to treatment more than a half of people had started using opiates again.

Figure 10: Summary of Outcomes at Exit Stage



PLANNED EXIT

	Mean days use at Baseline	# Using at Baseline	# Citing drug as problematic	# Using at Exit	Mean Use at Exit	RELIABLE CHANGE INDEX ABSTINENT % Observed	IMPROVED % Observed	DETERIORATED % Observed	INITIATED % Observed
OPIATES	7	7	20.1	0	0.0	100%	0%	0%	0%
CRACK	7	7	10.4	0	0.0	100%	0%	0%	0%
COCAINE	5	4	4.3	3	2.0	25%	0%	0%	0%
AMPHETAMINES	5	5	12.8	0	0.0	100%	0%	0%	0%
CANNABIS	12	12	14.9	6	20.3	50%	0%	17%	0%
ALCOHOL	8	8	6.6	6	5.0	25%	13%	13%	0%
INJECTING	21	4	# Giving Valid pair 16.8	1	14.0	100%	0%	0%	6%

	Clients working 10 days or more on START TOP	Clients working 10 days or more on EXIT TOP
EMPLOYMENT	0 (0.0%)	5 (21.7%)

	Clients reporting a housing problem on START TOP	Clients reporting a housing problem EXIT TOP
ACUTE HOUSING RISK	4 (17.4%)	2 (8.7%)

According to planned exit TOP data, all clients who stated they were using opiates at baseline (assessment stage) left treatment drug free. All of the clients who cited crack use at the beginning of their treatment journey, who then went on to complete an Exit TOP, left treatment drug free or free of drug of dependency. Additionally, in the other outcome domains of injecting, employment and acute housing risk there were similar reported improvements with the data suggesting that all of the clients who had cited current injecting at Triage, except one, had ceased injecting by exit; five clients reported working for 10 days or more; and the two client who reported acute housing risk at assessment stage left treatment with access to stable accommodation.

Key Points highlighted from TOP Outcome Data:

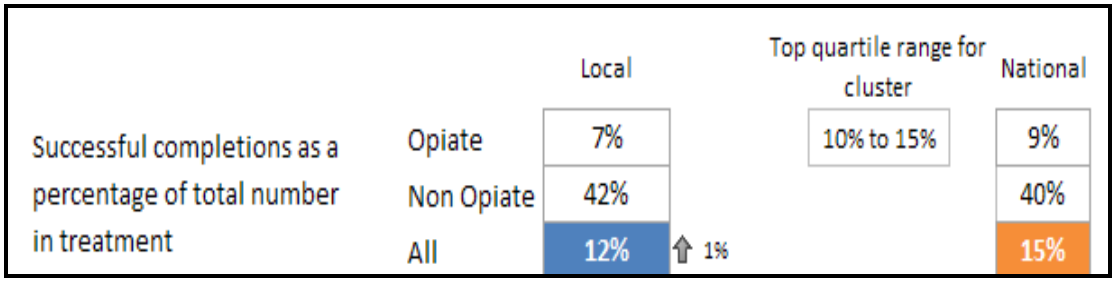
- ❖ Southampton is within the expected range for opiate users who achieve abstinence at six months;
- ❖ Over half of opiate users with up to six months exposure to treatment had initiated opiate use at point of TOP review;
- ❖ General improvements across a range of outcomes but still relatively low numbers

7. Successful Completions and Representations

Successful completions are now a key indicator of drug treatment performance and subsequently carry a specific monetary reward element linked to the percentage of clients leaving treatment successfully and not representing to treatment services within six months.

Figure 11 below provides an overview of the current position of successful completions as of March 2012.

Figure 11: Successful completions as a percentage of the total number in treatment in Southampton



Quarter 4 data for Southampton shows that 7% or approximately 1 in 10 of the opiate using population had left treatment successfully and under a half (42%) of non-opiate users also completed treatment drug free during this period. However, this performance currently places Southampton outside of the top quartile Cluster D range for opiate users (10 -15%).

Improving the performance of successful completions is, of course, about increasing the rate (numerator) at which clients successfully complete treatment but equally is related to the size of the in-treatment population (the denominator from which the measure is drawn) as any increase or decrease in this denominator will ultimately impact on the metric as a whole.

For example, in Southampton the opiate in-treatment population has fallen from 755 in 2011/12 to 741 in 2012/13 (YTD) and as a consequence the pool of clients from which this measure is drawn is also smaller than in the previous year.

It is feasible to achieve good performance in this part of the metric even where there is a failing in-treatment population providing the rate at which clients successfully leave treatment is proportionate to the overall in-treatment population (the denominator).

The other significant part of the successful completions metric is that of re-presentations and Figure 11 below provides an illustration of the YTD position:

Figure 12: Southampton Re-presentations YTD (up to March 2012) for all clients

		April	May	June	July	August	September	October	November	December	January	February	March	Not re-presented
April	9	1	1	0	0	0	0	0						7
May	9		0	0	0	1	0	1	1					6
June	5			0	0	0	0	0	0	0				5
July	12				0	0	0	1	0	1	0			10
August	8					0	0	1	0	0	0	0		7
September	12						0	3	1	0	0	0	0	8
October	8							0	0	2	0	0	1	5
November	8								0	0	0	1	0	7
December	14									0	0	0	0	14
January	19										0	0	1	18
February	9											0	0	9
March	5												0	5

Overall YTD, 118 clients' were recorded as leaving drug treatment successfully in Southampton and of this number 17 or 14% re-presented to services in year. The highest concentration of re-presentations happened in October 2011 with 6 people or 35% of the total number of representations coming back into drug treatment during this month.

On average people tend to re-present to services in Southampton within 4 months after leaving treatment suggesting 1 in 10 of clients relapse relatively soon after leaving treatment.

Further interrogation of local data should yield additional information on the types of reasons given by clients for relapse and re-presentations but national data suggests that re-presentations are often linked to a lack of post-treatment reintegration support such as access to education, training and/or employment.

Key Points from Southampton's Successful Completions & Representations Data:

- 118 (all) clients' were recorded as leaving drug treatment successfully in Southampton YTD (11/12);
- Current performance for successful completions in Southampton is outside of top quartile range for opiate users;
- Falling opiate in-treatment population may be impacting on successful completion rate;
- 14% of those successfully completing treatment in Southampton re-presented to services in year;
- 35% of re-presentations occurred in October 2011;
- Average representations occur 4 months after leaving treatment.

8. Conclusion

This report has considered prevalence, activity and performance data within the context of reviewing the whole adult treatment system in Southampton with a focus on successful completions and representations. Where appropriate this report has endeavoured to illustrate how certain areas of activity may be impacting on the rate at which people successfully leave treatment.

The partnership my wish to investigate the potential rise in opiate prevalence within the 15-24 year old sub set of the population as well as the potential increase in crack users prevalence. If these increases are substantiated this may point to a much larger cohort of younger clients using opiates and an increase in crack users in the local area. Therefore local services will need to be reflective of the needs of these populations.

Similarly, Southampton's in-treatment activity data shows the majority of clients in the partnership area are using opiates and that a significant proportion of this population (50%) has been engaged in treatment for periods of two years or longer.

As a consequence, characteristics such as age, frequency of use and duration of treatment can all impact significantly on a range of outcomes and therefore both providers and commissioners alike need to acknowledge these factors when designing appropriate services.

The report has also highlighted how attrition at the modality, service and system-wide level can reduce abstinence and successful completions rates and in some cases may in fact be adding to system-wide complexity e.g. two or more unplanned treatment exits is one of several complexity factors used by the NTA to group partnerships into clusters.

The nature of data means that it can only capture a snapshot of activity at a single point in time and by definition is always looking back over what has already taken place and thus this report needs to be supported by locally held evidence in order to substantiate some of its key findings.

Appendix A

Cluster group D - complexity of opiate users

Northamptonshire	Oldham	Ealing
Stockton-on-Tees	Newcastle upon Tyne	Blackburn with Darwen
Plymouth	Sunderland	Devon
Rochdale	Wolverhampton	Dudley
Rotherham	Bournemouth	Southampton
Cheshire	Derby	Norfolk
Walsall	Lewisham	Greenwich
Derbyshire	Lincolnshire	East Sussex
Cumbria	Calderdale	Blackpool
North East Lincolnshire	Kirklees	Kent
Wirral	Essex	Coventry

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