SERVICE SPECIFICATION

FOR THE PROVISION OF
EARLY SUPPORT, ASSESSMENT AND PLANNING
SUBSTANCE MISUSE SERVICE
FOR
11 – 24 YEARS OLDS
WITHIN SOUTHAMPTON

(Schedule 1 of the Agreement)

Southampton City Council

Contents

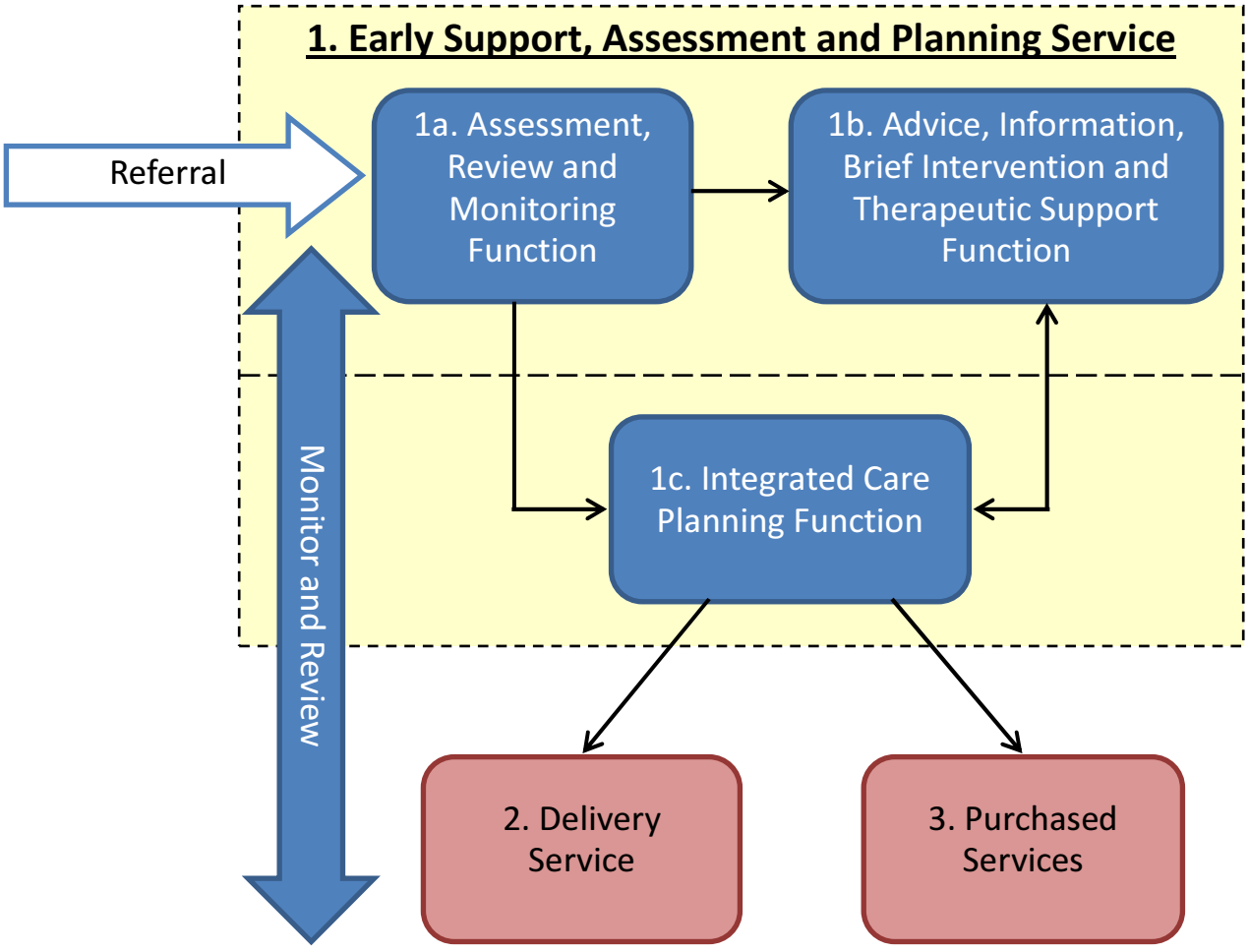
Overview of the new Drug and Alcohol Integrated Treatment Model:

Southampton and Hampshire DAAT areas were part of the National Treatment Agency (NTA) Systems Change Pilot in 2009-11, and pioneered the use of Self Directed Support and Personalisation in their substance misuse services. Southampton City Council now wishes to incorporate this approach into service provision. The new treatment pathway will therefore be commissioned in order to achieve personalised outcomes for service users.

The new integrated substance misuse treatment system will comprise 3 elements:

- Early Support, Assessment and Planning service (ESAP) for young people aged between 11 – 24 years.
- Assessment, Review, Monitoring and Recovery Planning service (ARM service - for adults aged 25 years and over)
- Service delivery (there will be one service covering young people and adults)

Figure 1: Young People's Substance Misuse Service Model



Referrals will access the Early Support, Assessment and Planning service (ESAP) (Box 1), where they will be assessed for level of need (1a) ref: figure 1.

Those requiring low level intervention will be provided with a brief intervention, advice and information (1b).

Those with more complex substance misuse problems will have their full range of needs assessed (1a). Where relevant, a *personal budget* will be agreed and allocated. Following assessment, individuals will access appropriate levels of support (commensurate with capability) in order to develop their Integrated Care Plan (1c), which must be agreed and signed off by the ESAP.

A range of services will be available to the service user through the commissioned treatment services (Box 2), with increasing flexibility to secure some services within a *Personal Budget (Box 3)*

The Integrated Action Plan will be monitored and reviewed by the ESAP throughout the individual's treatment journey with changes agreed as appropriate. The ESAP service will case manage the service user and will refer to treatment services as necessary.

Early Support, Assessment and Planning Service (this service)

Figure 1 highlights where the ESAP service model fits within the new young people's substance misuse treatment services model in Southampton.

This service will provide stages 1a, 1b and 1c of the model. Service users will either self refer or be referred to the ESAP service by other professionals. The service will provide a single point of entry in to treatment for substance misuse in Southampton. It will offer assessment and where appropriate, information, advice and brief interventions in order to provide early support to those seeking treatment for problems with substance misuse.

Following initial/full assessment, the service will provide assistance with recovery and support planning (where this is required), case management and regular review of how the service user is progressing and whether the interventions provided are delivering the required outcomes.

Once the initial or full recovery/support plan has been prepared, the service will refer the service user on to stages 2 and 3 of the treatment system as necessary, where the service user will be able to access a wide range of services and treatment opportunities.

The ESAP service will be involved with the service user at every stage of the treatment system. It will therefore be the key to the effectiveness of the model.

The ESAP assessors will have a significant role in being responsible for enabling access to drug and alcohol treatment packages from both commissioned services and from the private sector. The role will also provide advice, sign-posting and motivational and engagement work in order to keep the service users involved with services and engaged in effective treatment.

1. Introduction

1.1 This specification has been developed to set out the Southampton City Council's requirements for services in line with an early intervention, targeted support and recovery focused drug and alcohol treatment system and details the system objectives and interventions to address identified drug and alcohol related needs.

1.2 The young people's drug and alcohol service provision (up to and including 24 years old) will follow a whole-systems approach, in line with the partnership's vision for the Southampton Integrated Drug and Alcohol Treatment System. This will:

- Focus on early intervention for young people and their families
- Enable a comprehensive and integrated specialist substance misuse treatment for young people and their families
- Increase the number of young people able to achieve sustained recovery from dependence
- Reduce inequalities and improve opportunities and outcomes for disadvantaged young people

1.3 In order to achieve this we expect the provider(s) to demonstrate excellent assessment, early intervention, flexible tailored approaches and recovery planning to meet the diverse needs of children and young people. The system must be closely integrated with other local services and support networks for children, young people, adults and local communities.

2. Local outcomes required

2.1 The desired outcomes of the model will be to reduce the adverse effects of substance misuse on the development of children and young people's social, education and emotional growth and progress and achieve abstinence where appropriate. This includes:

- To improve access to assessment, prevention and service provision for vulnerable young people
- To increase the number of young people in contact with the service – supported through early intervention and completed interventions in a planned way.
- To ensure young people whose drug or alcohol misuse has already started to cause harm, or who are at risk of becoming dependent are in specialist treatment
- To reduce the number of Problematic Drug Users
- To increase the proportion of young people completing treatment drug free.
- To prevent onward Class A drug use and blood borne virus transmission.
- To impact on the cycles of inter-generational substance misuse.
- To reduce hospital attendances and/or admissions for alcohol (under 18's and adult admissions)

2.2 The service will also seek to improve outcomes that impact on several local strategic objectives

- Reduce harm overall, linked to associated risks being negated (sexual behaviour e.g. teenage pregnancy, mental health) and factors addressed (school exclusion/non attendances, worklessness, debt, housing, NEET).
- Reduce number of young people affected by domestic violence or at risk of sexual exploitation
- Improve the emotional well-being of young people and early identification of emotional and mental health needs.

- Improve mental health and well-being of young people
- Reduce health inequalities through early intervention.
- Improve educational opportunity and ensure personal development needs of all, particularly vulnerable, young people are met,
- Increase opportunities for young people and younger adults to make a positive contribution to the community
- Increase opportunities to achieve economic well-being, overcome disadvantage and make an effective transition to adult life.

3. Background Information

3.1 Southampton City Council is responsible for commissioning services in order to deliver the 2010 National Drug Strategy and the 2012 Alcohol Strategy in Southampton. For a significant number of people drug and alcohol consumption is a major cause of ill health. Drug and alcohol dependency is a complex health disorder with social causes and consequences. Drug use is linked to everything from heart and respiratory problems to psychosis and seizures, while heavy drinking is known as a causal factor in more than 60 medical conditions. Added to that is the increased likelihood of suffering violence and having unprotected sex that is seen among heavy drinkers.

3.2 In 2010 a new Drug strategy: reducing demand, restricting supply, building recovery: supporting people to live a drug-free life was released and is a major change to previous government policy, the 2010 strategy sets out a fundamentally different approach to preventing drug use in our communities, and in supporting recovery from drug and alcohol dependence. This strategy has two overarching aims to:

- Reduce illicit and other harmful drug use; and
- Increase the numbers recovering from their dependence.

3.3 The UK has amongst the highest rates of young people's cannabis use and binge drinking in Europe. There are some 13,000 hospital admissions linked to young people's drinking each year. Early drug and alcohol use is related to a host of educational, health or social problems.

3.4 Cannabis and alcohol are the most common substances used, though volatile substances (such as glues, gases or aerosols) also remain an issue, particularly at younger ages. Each year around 24,000 young people access specialist support for substance misuse, 90% because of cannabis or alcohol. It is important that young people's services are configured and resourced to respond to these particular needs and to offer the right support as early as possible.

3.5 In 2012/13, Southampton Tier 3 substance misuse services had the following number in treatment.

- 154 aged under 18 years (based on 2012 calendar year)
- 104 aged 18 – 24 years

4. National and Local Drivers for Change

4.1 The following documents have influenced the development of this specification:

- Drug Strategy: "Reducing Demand, Restricting Supply, Building Recovery" 2010
- Practice standards for young people with substance misuse problems, CCQ June 2012
- Alcohol Strategy 2012:
- All relevant NICE guidelines
- "Putting People First" - 2007

- "Personalisation Through Person Centred Planning" 2010
- Improving Services for Substance Misuse – National Treatment Agency
- Systematically Addressing Health Inequalities 2008 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086570
- Health and Social Care Act 2000
- Gaining Healthy Lives in a Healthier City 2012
- Building Engagement, Building Futures 2011
- Health and Social Care Act 2012
- Tackling Drugs and Alcohol - Local Governments Public Health role
- NTA, Young people's specialist substance misuse treatment: commissioning guidance 2008

5. Aims of the New Service Model (as a whole of which this service is one part)

5.1 The new drug and alcohol integrated treatment and recovery system in Southampton aims to provide a life changing, personalised substance misuse recovery pathway for the City, bespoke to the needs of individuals and communities. The Commissioners expect to build a strong and effective working relationship with the Providers, with shared values and vision regarding the delivery of the contract. The aim is to:

- Create an integrated treatment pathway that increases access to treatment and reduces the harm that problematic substance misuse causes to our communities, as well as helping people overcome dependence.
- Strengthen emphasis on providing education and early intervention to young people at risk of using substances and enable universal and targeted children's and youth services to respond to substance misuse.
- Tailor substance misuse treatment specifically to service users and their families, narrow inequalities and improve opportunities and outcomes for disadvantaged young people.
- Develop personalisation approaches to encourage people to take responsibility for their own recovery by developing own integrated care plan and potentially purchasing own services

5.2 The new service model will have the following components:

- Early Support, Assessment and Planning service (11 – 24 year olds)
- Assessment, review and monitoring service (25+ year olds)
- Delivery Service - commissioned treatment services (all ages)
- Purchased Services (all ages)

5.3 The Delivery Service will be delivered by a different provider than both the ESAP and ARMs. The ESAP and ARMs will be provided by one or two different providers

5.4 Those that aspire to making a full recovery from addiction will be enabled to do so, whilst a small number of others whose addiction may be long standing and complex, will be offered the opportunity to reduce the harms caused to their health and to the local community or to plan for the end of life in dignified and caring surroundings.

Recovery will be the primary goal of the integrated system and it is vital that the service as a whole and individual workers understand the principles of recovery. The UK Drug Policy Commission defines Recovery as:

"The process of Recovery from problematic substance misuse is characterised by voluntary sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society".

6. Objectives of Service Model (specifically in relation to young people as a whole, of which this service is one part):

- To attract, engage, assess, develop integrated care plans and retain in treatment those young people who are most at risk of harm due to their substance misuse to enable a successful outcome at the completion of treatment.
- To provide services that are easily accessible and which structure treatment around the needs of the individual by providing personalised opportunities for sustained recovery and high levels of service user choice.
- To reduce the harms associated with substance misuse to the individual, the family and the community (including social exclusion, stigma, those related to offending, drug and alcohol related illnesses and accidents, unemployment, domestic violence, family breakdown and reduced ambition for children) and encourage or promote abstinence where appropriate.
- To maintain a holistic approach to working with young people, addressing their complex and often multiple needs, not just substance misuse needs, via use of the CAF (or equivalent)
- To work alongside key partners to improve the health and wellbeing of service users, their friends and family and support young people in achieving best outcomes
- To support young people to reintegrate into their family, community, school, training or work.
- To continually recognise, respect and maintain professional boundaries when working with young people and/or their families and carers.
- To work with young people from diverse communities and with their parents or carers in relation to their treatment
- To offer user friendly, confidential substance misuse interventions, within clear information sharing protocols
- To safeguard adults, children and young people by developing effective practices and integrated approaches to safeguarding, in accordance with related national guidance, Southampton Safeguarding Children's Board (SSCB) and the Southampton Safeguarding Adults Board guidelines.
- To support young people who need continued substance misuse treatment into adulthood to access adult substance services
- To enable and support individual recovery from substance misuse and dependency and through appropriate treatment to live healthy, safe and crime free lives.
- To reduce the burden of drug and alcohol misuse on the wider public sector economy by promoting effective treatment and harm reduction responses in a range of settings including primary and community health care, mental health and criminal justice services.
- To reduce the harm caused by drugs to communities including contributing to a reduction in crime and anti-social behaviour and minimise the risks of other blood borne infections.
- To support targeted and universal children's services to meet young people's substance misuse needs
- To reduce the number of individuals who relapse and represent to treatment services within 12 months.
- To pro-actively work to re-engage individuals who have left the system prematurely.

- To ensure that service users, their family and friends are central to the development, delivery and the evaluation of services and that they are appropriately involved in the recovery process and supported to access services.
- To raise the profile of the full range of drug and alcohol services delivered within the system with potential service users and other agencies/professionals.

7. Principles of Service Delivery

The principles of providing specialist substance misuse treatment to young people are based on the Children Act 1989, 2004 and the UN Convention for the Rights of the Child (SCODA and The Children's Legal Centre, 1999). They have widely been adopted in the UK as the overarching philosophy of young people's service provision.

1. A child or young person is not an adult.
2. The overall welfare of the individual child or young person is of paramount importance.
3. The views of the young person are of central importance, and should always be sought and considered.
4. Services need to respect parental responsibility when working with a young person.
5. Services should recognise and co-operate with the local authority in carrying out its responsibilities towards children and young people.
6. A holistic approach is vital at all levels, as young people's problems tend to cross professional boundaries.
7. Services must be child/young person & family centred.
8. A comprehensive range of services needs to be provided.
9. Services must be competent to respond to the needs of the young person.
10. Services should aim to operate, in all cases, according to the principles of good practice.

The provider will operate within these and the wider principles of the service delivery for substance misuse listed below:

Partnership working: approaches to treatment and recovery which are built around a multi-agency partnership. The treatment system will engage with mainstream housing, health, education, employment, leisure, wider social care and family sectors in order to provide an holistic service to service users.

All inclusive: Recovery means different things to different people. For some, abstinence will not be immediately attainable. Both abstinent and non-abstinent pathways will therefore be available and all interventions will be underpinned by a strong ethos of harm reduction.

Family oriented: Families play an important part in supporting recovery and the treatment system will therefore need to identify and respond to the needs of the service users' family.

Enabling: empowering and enabling service users to ensure that they feel fully involved in the treatment, recovery planning process and the planning, monitoring and delivery of the service as a whole.

Personalised: services will be delivered within the philosophy of personalisation (see section 7).

Active engagement: Recovery will be viewed as a process. Lapse and re-lapse is part of the learning process but pro-active systems within the treatment service will support re-engagement

and long term support for service users leaving the treatment system.

Improving Health and Well-being of service users, carers and families: reflecting the holistic needs of service users and their friends and family.

User led: service users, their family and friends must be central to the development, delivery and the evaluation of services.

Asset Based: reflecting the valuable and unique experience of service users and using that asset to develop peer approaches in order to build recovery capital which is sustainable.

Evidence based: System performance in relation to the above outcomes and objectives will be evaluated and evidenced by the provider's achievements against the required delivery and performance expectations contained within this specification and wider contract.

Performance Orientated - having robust performance management systems that will give timely information to commissioners in order to manage performance against agreed outcomes and targets and support service delivery and development. Continuous improvement must be part of the ethos of the service.

8. Service Specification – Early Support, Assessment and Planning Service (ESAP)

8.1 Aim

The service will:

- Provide easily accessible front door and a single assessment service.
- Provide early help and brief interventions based on the service users need
- Plan and facilitate access to treatment services
- Monitor and review the treatment journey
- Enable a high quality, detailed and personalised assessment and Integrated Recovery Plan for every service user entering the treatment system
- Place the needs of service users at the core of the service, promoting their health and well-being.
- Engage with service users and motivate them to remain in effective treatment. It will raise the aspirations of service users and promote their eventual independence.
- Provide opportunities for self-development and the development of skills which will enable the service user to re-engage with their local communities.
- Encourage and enable service users to achieve their own stated goals within the treatment system, whether this is abstinence, maintenance on substitute medications or harm reduction.

8.2 Objectives

- To enable the young person to address their treatment needs by ensuring access to personalised treatment and support services, whatever their drug of choice.
- To provide support and integrated care planning processes that enable service users to identify their own needs, goals and outcomes.
- To work with other treatment providers and agencies (e.g. Probation, police, mental health services, SCC Peoples Directorate) and develop joint support and integrated care plans with service users, where appropriate.

- To case manage the young persons treatment journey.
- To enable access to appropriate wrap around services, volunteering, meaningful activities, peer support and families and carers support.
- To accurately and regularly (i.e. every 12 weeks) review the service young persons integrated care plan, measure progress, record outcomes and update the plan, providing a blueprint for the service users journey to Recovery together with appropriate timescales for the achievement of the next segment of the journey.
- To record and monitor data in keeping with the appropriate local and national requirements.

8.3 Description of Service

8.3.1 The service is commissioned for use of all young people aged 11 – 24 years olds who are using a substance that is impacting moderately or significantly on one or more other domains of their life.

8.3.2 The service will provide a single citywide entry point and single point of contact for all young people aged 11 – 24 years old entering the treatment system and will refer service users for appropriate structured interventions

8.3.3 The service will provide outreach brief interventions and psychosocial interventions to young people who are at risk or using substances

8.3.4 The assessment and planning process will follow these distinct steps:

1. Initial Assessment (Triage)
2. Brief and crisis interventions where appropriate (i.e. where detoxification is part of the Recovery Action Plan)
3. Comprehensive Assessment (if required)
4. Integrated Care Planning
5. Sign off & budget allocation **(including access via referral to the service delivery element)**
6. Review/ monitor

8.4 Initial Assessment (Triage)

8.4.1 Young people thought to be at risk will be identified during outreach and will be briefly questioned or assessed for substance misuse and other related risks. The service will ensure questions used to identify and/or briefly assess risk are fit for purpose, appropriate to the setting, and acceptable to young people, parents or carers, and staff

8.4.2 An initial assessment will be completed in order to determine the seriousness and urgency of the individuals needs on presentation to the service (self referral , referral from other service, outreach). This will identify the most appropriate immediate type of intervention. It will also assess the client's motivation to engage in treatment and current risk factors. An interim care plan will be completed in order to address the urgent and immediate needs of the service user

8.4.3 The initial assessment will deal with the following needs:

- Crisis interventions
- Brief interventions
- Low intensity support
- Referral to other appropriate services

8.5 Comprehensive Assessment

8.5.1 Following initial assessment, if a need for structured treatment is identified the service user will then be offered an appointment for a comprehensive assessment. Whilst the young person's immediate needs are being addressed via the interim Recovery Plan, the full assessment will be completed and a full CAF (or equivalent) will be formulated, prior to commencing the most appropriate intervention(s) to address their drug and/or alcohol needs. The key principles underpinning the assessment will be:

- Young people and parents or carers (where appropriate) are offered a timely assessment of need and are informed about what to expect
- Young people and their parents or carers experience a collaborative assessment and are fully informed and involved in all decisions about their care
- Comprehensive assessments are effectively co-ordinated to support the young person's continuity of care and existing relationships with other professionals
- Assessments will be comprehensive, recovery & outcome focused and according to need

8.5.2 The service will ensure that the assessment process is user led and will, through a variety of approaches, promote self assessment and supported self assessment as a preferred method.

8.5.3 Joint assessments should also be conducted collaboratively with other agencies where this is in the best interests of the service user and agreed by them to do so. This will include: mental health service providers, social services, children and family services and housing providers or other relevant agencies.

8.5.4 Information from the assessment shall be shared with all agencies to which the service user is subsequently referred with service user consent and in line with information sharing protocols.

8.5.5 A full risk assessment shall be completed including their level of risk awareness to ensure that interventions to reduce risks are prioritised. Where risks are identified, a risk management plan will be developed, implemented and linked to the service users' integrated care plan. This must be subject to regular review. Information relating to risk will be shared and acted upon according to the local risk assessment framework. The risk assessment will take account of self-harm, risk from others, risk to others, housing, sexual exploitation, domestic violence and an appropriate action plan put in place to address these risks

8.5.6 Assessment will be available in a range of settings to suit the needs of the service user, their family and the wider strategic priorities including specialist, primary and secondary care settings

8.6 Integrated Care Planning

8.6.1 Integrated Care Planning is an integral part of the service. It will be formulated, prior to commencing the most appropriate intervention(s) to address their drug and/or alcohol needs based on the integrated assessment.

8.6.2 The care planning can be part of the assessment process by the assessor or it may be delivered separately once the assessment has been completed, this will be decided by the assessor based on the young person's needs.

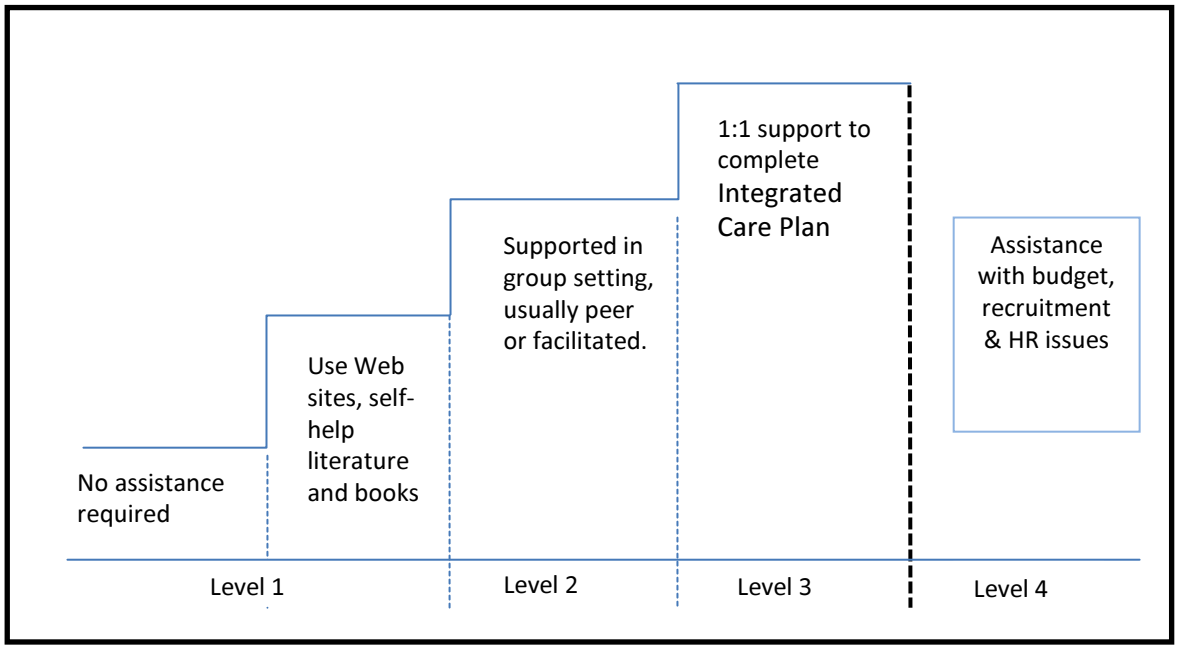
8.6.3 Individuals will be empowered to develop their own plans, using appropriate methods such as web based tools and self-help tools. The service provider will develop a range of measures to facilitate this which will be responsive to the capability of the individual. This should enable young people to mobilise their skills, assets and networks to best prepare the relevant plan for their treatment.

8.6.4 The service user will develop an Integrated Care Plan either independently or with assistance, in line with assessed level of support. Assistance may be in the form of help from others including family members or carers, peer mentors or by a member of the service, where they will be offered guided self-help to formulate the plan. The level of assistance will always be in line with the assessed level of support need for the service user:

- **Level 1**: Minimal (i.e. self-help) or no help required. Advice and information may be required to help service users complete the Integrated Care Plan themselves.
- **Level 2:** Individuals need some assistance in completing their Integrated Care Plan, likely to be in the style of peer support or group setting, with some assistance from a facilitator.
- **Level 3:** One to one support is needed to help the individual prepare their Integrated Care Plan.
- **Level 4:** Support needed with the execution and implementation of the treatment plan once agreed for example, the recruitment of Personal Assistants, setting up bank accounts and payment for services secured.

(See diagram 1)

Diagram 1 - Stepped approach to Recovery Planning:



8.6.5 Service users will be provided with clear, concise and consistent information about available services and interventions.

8.6.6 The provider will ensure that planning for treatment addresses the entire social and reintegration needs of the individual in order to sustain recovery, plan for end of life or reduce risks/harms.

8.6.7 The care plan will bring together information and where relevant the involvement of agencies and individuals to address issues such as housing, employment, finance, childcare and transport. In this way the care plan will support a sustained lifestyle change that will help to prevent relapse or best

meet the service user immediate needs. This will also create a shared responsibility for, and ownership of, successful outcomes.

8.6.8 Once the initial or integrated care plan has been completed, it will be the responsibility of the service assessor/lead practitioner to **refer** the service user to the appropriate commissioned services or signpost to providers of purchased services, in order for the service user to commence structured treatment.

8.7 Budget Allocation

8.7.1 Budget allocations are usually provided as an indicative figure to inform the planning process. The final amount will be dependent on the formation of a plan, agreed by the service user, their lead assessor and any other individual identified to be key to the decision making process (i.e. carer or professional). The Integrated Care Plan will need to be compliant with certain core requirements. This will include as a minimum:

- The plan will meet the relevant needs of the individual,
- The plan is deemed to be clinically safe (where medical interventions are being secured)
- The plan addresses areas of risk or concern highlighted in the assessment

8.7.2 Where possible, service users will be allocated the level of funding/ support available to them to meet their needs by the service. During the assessment process they will be informed about the methods by which their funding is available. For some elements the service will sit within a block contract, for other areas funding may be available as a direct payment, personal budget or indicative budget.

8.8 Direct Payments

8.8.1 The service will have responsibility for managing a budget which may be allocated to service users as a direct payment to purchase services from providers outside of the treatment system. Once the Integrated Action Plan has been completed, the assessor will need to establish the cost of any treatment packages or interventions that are not to be accessed from within the commissioned services.

8.8.2 Treatment options that fall within the criteria of the Care Management budget must be agreed with Adult Health and Social Care staff, who have the authority to agree funding. Protocols for working alongside AH&SC teams and for access to this budget will be finalised on appointment of the new service provider. Other specialist, personalised treatment options or activities may be funded via the Direct Payment budget, to be held by the ARM service.

8.8.3 The service will thus have access to two distinct resources in order to facilitate service user access to personalised treatment options.

1. Care Management budget: for service users who meet the Adult Health and Social care criteria for access to the Care Management budget (i.e. their needs must be assessed as “critical and substantial”). This is likely to include service users who require detoxification or residential rehabilitation.

2. Direct Payment Budget: The service will have responsibility for the management of the budget. The service provider will be expected to produce a protocol detailing the criteria for access to the direct payment budget in agreement with commissioners. ESAP assessors will cost any services to be purchased from this budget and present the Action

Plan to the service manager(s) who will sign off the plan together with any proposed expenditure.

8.8.4 The amount of the direct payment budget will be notified at the time of the award of the contract.

8.8.5 It is expected that the direct payment budget will increase over the life of the contract as the market develops locally. The service will therefore be expected to be aware of new service developments within the city and take an imaginative and innovative approach to encouraging the development of relevant and effective treatment and activity options for service users when developing Integrated Action Plans.

8.9 Case Management, Review and Monitoring

8.9.1 Planning, monitoring and review will be a dynamic and empowering process involving the service user and where appropriate, professionals from partner agencies involved in the service users on-going treatment. This will include the service user's family and / or significant others with service user consent.

8.9.2 The provider has responsibility for the case management of all service users, ensuring their treatment journey is appropriate, progress is being made and that ultimately service users are working towards a planned exit from treatment.

8.9.3 The provider will actively plan for and manage service users move on from structured treatment as part of the integrated care plan and motivate service users to access and engage within structured forms of treatment to meet their recovery objectives.

8.9.4 The provider will have responsibility for the completion of any appropriate review and/or monitoring tool for the individual service user. For drug users, this will be at a minimum the Treatment Outcome Profile (TOPs). For alcohol users this could be the Alcohol Outcome Star. The service will be responsible for the timely completion of all nationally required monitoring.

8.9.5 The provider will be responsible for monitoring and reviewing the Integrated Care Plan at regular 12 week intervals throughout the service user's treatment episode.

8.9.6 The provider must also meet the needs of families and carers of service users, giving the opportunity for families and carers to access the treatment system either as part of the service users' treatment or in their own right.

8.9.7 The provider will provide:

- Liaison, referral and intervention with/alongside other agencies as appropriate and relevant to the integrated care plan (including Mental Health Services, Criminal Justice Agencies, other health services, housing, education, training and employment, families and Children's Services, Childrens and Adult Safeguarding
- Follow up on those who do not attend their arranged appointment;
- Proactive engagement and encouragement for those individuals who do not wish to engage with treatment at this stage or are unmotivated;
- Encouragement and support for those complex service users who want to stabilise and "maintain";
- A focus for all communication in relation to the integrated care plan within defined timescales, including progress reports, multi-agency decision making processes and other services' responses

- Management of information capable of recording outcomes relating to the individual's engagement and recovery.
- Management of budgets relating to the purchase of services provided outside the treatment system.

8.10 Planned completion and transfer of care

8.10.1 Transfer after completing their care plan

- The provider will deliver comprehensive aftercare arrangements, including periodic contact with those who have left treatment and provision of information regarding locally available peer-to-peer support and fellowships.
- Young people and parents or carers are involved in agreeing arrangements for leaving the service and know how to re-access help if they need it
- The service should have a clear local protocol about the provision and access to other services and the referral pathways to ensure access to appropriate services across all tiers and ensure that young people are offered continuity of care when they move on from the service
- Referral should be via established referral processes and the team working with the child/young person and family/carer. Referral should not be made if consent is not given, unless there are child protection concerns.

8.10.2 Transfer to residential care

- Young people who require residential care are referred to units that meet their individual needs with effective continuing care

8.10.3 Moving onto adult services at 25 years and over

- Young people, younger adults and parents or carers are involved in agreeing arrangements for leaving the service and know how to re-access help if they need it
- The service must produce a joint transition plan with appropriate services (i.e. ARM)
- All services involved should develop protocols for transition work. These will be signed off by commissioners by end of quarter 1 of the contract
- The service must comply with the Southampton City Transition Policy
- The young person's Lead Professional should jointly work with the appropriate services to make this a seamless transition as possible

8.11 Brief Interventions, Therapeutic Work and Outreach to be provided

8.11.1 The provider will deliver the following interventions as appropriate. This will include:

- Targeted Outreach work
- Provision of information and Brief Advice
- Brief interventions
- Group education and one to one support e.g. solution focused work, Cognitive Behaviour Therapy (CBT)
- Problem solving techniques
- Follow-up work for young people disengaging in treatment
- Health Promotion and risk reduction including substance misuse, sexual health, awareness raising advice on safer drug use and need exchange (where applicable) etc…
- Advocacy – where necessary acting as a contact point for individuals engaged in drug/alcohol recovery schemes, expressing their views or acting on their behalf to help them secure the most appropriate services;

- Assertive outreach – the provision of an assessment within a variety of settings, including custody suite/s and prisons;
- Structured counselling
- Relapse prevention
- Partnership working with key providers, e.g. No Limits, YOT, CAMHS and Children and Families Services
- Assessment for needle exchange provision

Practical help and support

8.11.2 The Service will provide practical help and support either directly or through other services in line with the needs of each young person and their families or those involved with them as identified in the needs assessment. This could cover a range of options such as support with accommodation, accessing other services, accessing transport, support, via their Youth worker, with benefits application, support with Court appearances and legal obligations, registering with health services, etc.

Targeted Outreach Work

8.11.2 The Service will provide targeted outreach to young people:

- To provide education and early intervention and
- To encourage young people with problematic substance use to engage in treatment and to follow up on young people who disengage from treatment.

8.11.3 Targeted outreach will include:

- Advice and information
- Awareness raising re: drug and alcohol use
- Advice on safer use and risk reduction
- Needle exchange (when applicable)
- Information on young people support services
- One to one support
- Brief interventions
- Group education e.g. overdose prevention, units of alcohol
- Risk reduction behaviour work e.g. substance use, sexual health, etc
- Problem solving techniques
- Initial and comprehensive assessment
- Referral to support services
- Advocacy
- Follow-up work for young people disengaging in treatment

8.11.4 The Service will provide targeted outreach in services and settings where vulnerable young people meet or are using other services, this could include residential care homes, alternative learning provision, areas where young people congregate causing anti-social behaviour. The staff will target young people using substances problematically, in particular those identified by young people, e.g. alcohol and cannabis.

8.11.5 Staff will liaise with schools and colleges to provide education and early intervention work particularly on alcohol. The Service should prioritise young people aged 14 and 15 where problematic use was reported to be highest.

Health Promotion and risk reduction

8.11.6 The Service will incorporate harm reduction and promotion of health within all areas of direct service provision. Providing advice and information on the prevention of the spread of blood-borne diseases shall be a major goal of the service and reducing substance related deaths and overdoses.

8.11.7 The Service will:

- enable young people to explore issues relating to their health as a result of substance use/misuse and identify ways of achieving a healthier lifestyle
- explore sexual risk behaviours
- assist with access to testing for hepatitis B and C and HIV and to hepatitis B vaccination
- assist with access to health screening
- assist, where assessed as appropriate, with access to sterile injecting equipment and other harm reduction specialist equipment and advice

8.11.8 The Service should have in place a clear local protocol about the provision and access to such services and the referral pathways to ensure that all services are providing a consistent message to young people about access to and management of hepatitis B, C and HIV.

8.11.9 The Service will help young people, who are already infected, to become fully aware of their diagnosis and its management, and how to reduce the harmful effects of their condition and maintain their health.

Safer injecting

8.11.10 The Service will promote awareness of injecting drug use as an important risk factor for a number of infectious diseases, including hepatitis B and C, HIV, as well bacterial infections including life-threatening septicaemia and fungal infections.

8.11.11 The goals of the Service's risk reduction programme will follow Department of Health guidance which is that young people:

- do not start injecting
- stop any current injecting
- avoid initiating others
- do not share injecting equipment or paraphernalia with others
- pass on safer injecting advice to others

8.11.12 Young people who have a history of injecting or other risk related behaviour should be offered a hepatitis C test with appropriate pre and post-test counselling.

Psychosocial Interventions

8.11.12 Structured interventions should be based on identified needs that are detailed in the care plan i.e. supports the young person achieve their goals. Psychosocial interventions support young people to:

- Gain a better understanding of their substance misuse including causes and consequences
- Develop alternative methods of coping
- Make and maintain changes to their substance misuse.

8.11.13 Psychosocial interventions cover one-to-one and group work including family work where the focus of the intervention is on how the young person's substance use affects family members. Family in this sense refers to any or all individuals within the caring network which could include, parent, sibling or foster carer for example. The Service should work with family therapy services to provide this level of intervention.

8.11.13 Psychosocial interventions for one-to-one work include; motivational interviewing and solution focused interventions, cognitive behavioural therapy (all necessitating counselling skills), and structured care planned counselling.

8.11.14 Once a young person makes changes the Service will provide relapse prevention work that is young person centred and covers cognitive and behavioural skills work. The service shall utilise prevention and management strategies appropriate to young people to maximise the possibility of maintaining successful change. These will be based on relapse management steps which maximise the possibility of change, manage high risk situations, manage cravings and develop impulse control to those assessed as needing it in their care plan reviews. The Service will also provide skills training to deal with negative symptoms and develop refusal skills to deal with social pressure.

Individual and Group Work with parents or carers

8.11.15 This intervention involves supporting young people in their treatment, as opposed to working with any parental use that might impact on the young person. In these circumstances the adult will be treated by adult services. The Service will need to work very closely with adult services developing protocols for joint working.

8.11.16 Interventions should be structured and can include both individual and/or group work sessions (including parenting groups), which focus on a young person's drug use involving carers or family members with or without the young person attending. Work with family members affected by a young person's drug use is included in this category even if the young person is not involved in sessions, but details of the family members are not to be recorded. Should a parent/carer require further support regards their own needs, they should be given advice and information on support services

8.11.17 The Service should have clear policies and procedures relating to working with parents and carers especially in relation to confidentiality consent, legal guardianship child protection and joint working.

9. Referral to Specialist Treatment and Interventions (provided by purchased services or Adult Treatment Provider)

9.1 Following initial assessment and integrated care planning, service users may be referred for appropriate structured interventions. The provider will ensure that information on treatment options is available for the young person

9.2 Interventions need to be delivered in a safe space, which is age appropriate and which allows access to all forms of treatment and psycho-social interventions.

9.3 This part of the system will provide access to a wide range of interventions designed to meet the needs of service users. Interventions will be evidence based and will include the following:-

- Harm reduction services (including Needle exchange)
- Criminal justice interventions (18 – 24 yr olds)
- International Treatment Effectiveness Programme (ITEP)
- Drug and Alcohol specific interventions
- Cognitive Behavioural approaches
- Group work/structured day programmes focused on recovery and providing a wider menu of options, including abstinence focus
- Community Reinforcement Approach
- Social Behaviour and Network Therapy
- Specialist pharmacological interventions e.g. substitute prescribing
- Detoxification (Community and Residential)
- Rehabilitation services
- Clinical treatment where appropriate
- Shared Care
- Re-integration and on-going Recovery Support (Aftercare)

9.4 A range of delivery methods will be employed to suit specific users and user groups.

9.5 All service users accessing specialist treatment services shall have a named key worker, who will liaise with the service users (ESAP) assessor for the purposes of reviewing progress and monitoring outcomes.

9.6 The service provider shall work in partnership with a range of local providers and statutory agencies delivering these services.

10. Links to other services

10.1 Integrated working

10.1.1 The service is expected to have a comprehensive set of policies and procedures covering all aspects of its work and especially around the legal issues of confidentiality and competence of the child to consent to more complex interventions. All policies and procedures connected with working with young people must be submitted to the Local Safeguarding Board and adhere to any latest research and recent national guidance.

10.1.2 The provider will demonstrate integrated working policy and practice with all appropriate universal, targeted and specialist providers, through the evidence of protocols, policies and procedures, and joint working care plans with children, young people and their families and carers.

10.1.3 The provider will develop joint working protocols with the following (to be signed off by commissioners by end of quarter 1 of contract

- Youth Offending Service (YOS)
- CAMHs
- Maternity Services
- Family Nurse Partnership (FNP)
- Families Matter
- Sexual Health Services
- Substance Misuse Treatment Services – ARMs and Delivery Service

10.2 Substance Misuse Treatment Services (Delivery Service)

10.2.1 The provider is expected to work closely with the Delivery Service provider, and to ensure that there are robust and appropriate protocols in place for the provision of services for young people. This is especially important where Needle exchange and substitute prescribing interventions are required.

10.2.2 The Delivery Service will provide substitute prescribing in adherence with the 'Drug Misuse and Dependence: guidelines on clinical management (Department of Health, 1999) and Department of Health's Guidance for the pharmacological management of substance misuse among young people. However, community prescribing on its own is not viewed as effective treatment. Substitute prescribing must therefore take place within a context which also addresses physical, emotional, social and legal problems and be offered with other interventions such as counselling, relapse prevention, practical issues.

10.2.3 Any programme of detoxification or stabilisation will be decided upon following a medical assessment and consultation with the ESAP lead practitioner.

10.2.4 The aims of withdrawal prescribing (as given by the NTA) are to:

- Achieve a safe detoxification programme, minimising risks of adverse events, for example seizures (alcohol and benzodiazepine withdrawal)
- Engage young people in treatment programmes and ongoing psychosocial therapies

10.2.5 The aims of substitute prescribing as given by the Department of Health (1999) are to:

- Assist the young person to remain healthy, until, with appropriate support, they can achieve a substance-free life
- Stabilised the young person, where appropriate, on substitute medication to alleviate withdrawal
- Reduce the use of illicit or non-prescribed substances
- Deal with problems related to substance misuse
- Reduce the dangers associated with substance misuse, particularly the risks of HIV, hepatitis B and C, and other blood-borne infections
- Reduce the duration of episodes of substance misuse
- Reduce the need for criminal activity to finance substances
- Reduce the risk of prescribed drugs being diverted on to the illegal drugs market
- Improve overall personal, social and family functioning

10.2.6 Abstinence from substance use will always be the ultimate goal for young people, treated by the ESAP Service, despite the recognition that relapse is possible and/or that abstinence may be a long term goal for some young people.

10.3 Youth Offending Service and Criminal Justice

10.3.1 The Service will provide a named substance misuse worker Southampton YOT practitioner who will work with children and young people in contact with the criminal justice system. The Service will provide treatment interventions which address both a young person's substance misuse and their criminal behaviour.

10.3.2 The provider will ensure that all interventions are available to those who enter the treatment system via the criminal justice system.

10.2.3 The provider will ensure that the full range of DIP interventions is delivered in line with the Drug Intervention Programme Handbook, the 2010 National Drugs Strategy and "Drug Misusing Offenders, Continuity of Care between Prison and the Community".

10.4 Education, Employment and Training and links with Job Centre Plus:

10.4.1 Drug or alcohol misuse can undermine educational achievement, interfere with learning and memory, and in some instances can be associated with repeated absences or school exclusion. In general we expect schools to liaise effectively with drug and alcohol services to tackle problems with YP's affected by substance misuse while in secondary education. For more specific problems, we would expect pupil referral units to work closely with SM services.

10.4.2 For younger adults, drug and alcohol misuse often leads to decreased opportunities to take up education, employment or training. Economic independence fosters self-belief and resilience and every opportunity must be explored to facilitate access to employment for those that are able to work. Alternative routes to employment and training, including voluntary work or setting up a social enterprise will enable individuals to develop the skills and confidence required to move on.

10.4.3 All service users should be encouraged to commit to employment, training and, in particular, voluntary work wherever possible.

10.4.4 Job Centre Plus will be the lead agency in relation to employment and training and access to appropriate benefits. The Provider will be expected to work closely with Job Centre Plus advisers to ensure all service users have access to good quality information, advice and guidance. The Provider will effectively implement the protocol agreed between Jobcentre Plus and the National Treatment Agency for Substance Misuse (Joint-Working Protocol between Jobcentre Plus and Treatment Providers, 2010: www.nta.nhs.uk)

10.4.5 The provider will implement an employment pathways strategy and delivery plan which will reflect:

- An understanding of the aspirations of service users in relation to employment and education.
- An understanding of potential barriers to employment.
- Opportunities for developing work experience options which should include supported employment and intermediate labour projects
- Potential local partners and business champions to promote employment pathways for service users.

10.5 Housing:

The Provider will work in partnership with Supporting People, Registered Social Landlords and supported accommodation providers to ensure that the most appropriate housing solution is obtained for service users who are in housing need.

10.6 Family Intervention and support:

10.6.1 The provider must demonstrate a clear commitment to the safeguarding of children and young people and the promotion of children's welfare. The Hidden Harm agenda will be embedded into service provision and service delivery will strive to improve outcomes for children and young people.

10.6.2 The provider will work in accordance with the requirement of Hampshire, Isle of Wight, Portsmouth and Southampton's Joint Working Protocol ' Safeguarding children and young people whose parents / carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress' (www.4lscb.org.uk)

10.6.3 Southampton City Council Children's Services will be the lead agency for child and family support and local child safeguarding arrangements. The Common Assessment Framework (CAF) process will be used to assess and communicate any vulnerability or safeguarding concerns to the Children's Services team (unless child protection concerns arise that require immediate referral to children's social care).

10.6.4 The provider shall ensure that every service user who has child care responsibilities is offered a referral to a Children's Centre, using the appropriate referral tool (e.g. CAF/CAF assessment, etc), and may be offered recovery interventions at a Children's Centre, whenever possible. The provider will ensure that, at agreed intervals, contract and review meetings take place in the service user's home to provide the opportunity to review the situation of the children.

10.6.5 The provider shall ensure that appropriate antenatal arrangements are in place as part of their assessment and planning process. Links shall be made with specialist antenatal provision for mothers with drug and/or alcohol issues.

10.6.6 In line with Hidden Harm and the whole family approach, the assessment will identify those service users who are parents and / or who come into regular contact with children. For these service users, a specific child needs assessment will be completed.

10.7 Domestic Violence (DV):

10.7.1 Domestic abuse is defined by the Home Office as 'any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality'.

10.7.2 Southampton City Council recognises the links between drug and/or alcohol misuse and domestic violence and works in close partnership with Southampton Community Safety team, the Independent Domestic Violence Advisor team (IDVA) and Pippa (Prevention, Intervention and Public Protection Alliance).

10.7.3 The CAADA DASH (Co-ordinated Action Against Domestic Abuse, Domestic Abuse Stalking & Harassment Risk Identification Checklist) will be used in order to assess the level of risk in relation to domestic violence.

10.7.4 High risk cases will be referred to a Multi-Agency Risk Assessment Conference (MARAC). (MARAC is a multi-agency meeting, which has the safety of high risk victims of domestic abuse as its focus. By bringing together all agencies involved to share information a coordinated safety plan can be put together quickly and effectively.) The provider will be expected to fully engage in the MARAC process, to flag and tag their systems, identify representatives to attend the MARAC meetings and to share information and offer actions.

10.7.5 Medium and standard risk cases should be referred via the PIPPA point of contact.

10.8 Sexual Health Services:

10.8.1 A significant number of drug and alcohol users within Southampton are engaged in the sex market. Many of those involved are likely to experience violence, abuse and rape from partners, peers and strangers. Research suggests that many of those involved will have experienced similar issues as children. The successful provider will be expected to offer information, advice and support to those service users who disclose that they are engaging in sex work or other risk taking behaviour in relation to their sexual health. The assessors will work closely and effectively with partners in primary and secondary care, particularly within Contraceptive Services and Genito-Urinary Medicine to ensure they have an up to date knowledge and understanding of referral and treatment routes. Appropriate support e.g. counselling or mediation, will be included within the Integrated Assessment Plan.

10.8.2 Sexual health services to be delivered will be agreed with the commissioners. As a minimum, it is expected that service users will be provided with free condoms and Chlamydia screening.

10.8.3 Clear protocols and accountability must be in place, particularly with the Public Protection Unit of Southampton Constabulary, to ensure the safeguarding of vulnerable adults and/or young people at risk of sexual exploitation.

10.9 General Health Needs:

10.9.1 The Provider will be expected to work in partnership with a range of health professionals, e.g. dentistry, GP practices and smoking cessation, to ensure that the general health needs of service users are addressed within the treatment and recovery plan, both in community and prison settings.

10.9.2 The provider will be required to offer healthy living advice, particularly in relation to healthy eating, exercise, sexual health and smoking cessation and will support and encourage attendance at mainstream health services e.g. GP surgeries, breast screening, cervical screening etc.

10.9.3 The service will pay attention to the need to link to acute health services in local hospitals in relation to patients identified as having an alcohol related illness. Links will also need to be built with local GP's and pharmacies to encourage appropriate screening and with the Liver Unit.

10.9.4 The service will link, where appropriate, with outreach hepatology clinics to facilitate engagement with the testing and treatment of blood borne virus (BBV)

10.10 Residential Rehabilitation Provider

10.10.1 The funding for residential rehabilitation is outside the scope of this specification and the provider will not fund these. Funding for residential rehabilitation is provided through Southampton City Council (SCC). Service users requiring a residential rehabilitation modality of care will have a Social Care Fair Access to Care (FACS) assessment completed by a competent assessor and in adherence to SCC guidelines and eligibility criteria.

10.10.2 The provider will ensure that full information is available, as required, in order to inform sound decisions about which rehabilitation option is appropriate for each service user. This will include thorough assessment and preparation, and where required, attendance at panel meetings. It will also include evaluation and review of placements, as well as a major emphasis on aftercare planning and support and relapse prevention as appropriate to the individuals needs.

10.10.3 The assessor and the provider key worker will remain responsible for tracking the service user's progress on their treatment journey whilst they are in residential rehabilitation including TOPs recording, outcome star recording and other data collection and recording.

10.10.4 Southampton City Council is increasingly developing personal budget approaches to funding and the delivery of services for those eligible for Social Care support. The provider needs to be cognisant of the fact that some service users may already be in receipt of personal budgets and also the fact that although these are not currently used to support clients accessing residential rehabilitation or substance misuse services this may change in the future. In such circumstances the provider will work with both SCC and the commissioners to develop the necessary service delivery approaches as required.

10.11 Dual Diagnosis:

For the purposes of this specification, dual diagnosis is defined as being:

Individuals with both diagnosed severe and enduring mental health illness and problematic drug and/or alcohol use. This includes any drug use which is seen to be either exacerbating the symptoms of a mental illness or interfering with an effective treatment response.

Considerable work has already been completed in Southampton to improve appropriate and effective communication between substance misuse and Children and Adolescent Mental Health Services (CAMHS) and adult mental health services. We are now able to provide a much improved integrated and inclusive treatment response from mental health services and the drug and alcohol treatment system for individuals presenting with a dual diagnosis need.

Statutory mental health services will have the lead responsibility for the management of service users with a dual diagnosis need.

The provider will work within the existing framework and will work with commissioners and partners to review and strengthen pathways and operational protocols should a need to do so be identified.

10.12 Support for children and young people in care

The Service will establish arrangements with Children's Services who will provide generic supported foster care and residential child care placements with care planned substance misuse treatment. That is, where the young person's care and housing arrangements have been made for social care needs (not primarily related to their substance misuse treatment needs) but where the young person does have substance misuse treatment needs.

To work with social care to provide substance misuse data in accordance with Department for Education (DfE) Statistics SSDA return guidance notes Children Looked After in England http://media.education.gov.uk/assets/files/pdf/s/ssda903%20guidance%20notes%202011-12.pdf

10.13 Support for children, young people and young adults in school, further education colleges and universities

As part of the Community based provision, the Service will establish effective links with the City's

12 secondary school, three further education establishments and universities. This will be to deliver general prevention messages and to support referral processes into provision. This work will be done through the distribution of general communication materials as well as individual school/college/university visits, designed to support self referrals and to help direct education welfare and support staff who work with those at risk or those known to have substance misuse issues.

10.14 Work with complex families:

10.14.1 The provider will work in partnership with the Southampton City Council Families Matter Co-ordinator to deliver services which meet the needs of substance using families across all areas of Southampton City.

10.14.2 The provider will work with the Southampton City Council Children and Families strategy lead to offer awareness raising training around meeting the needs of substance using parents and their children.

10.14.3 The provider will work actively to increase referral rates from the substance use treatment system to city parenting programmes if appropriate.

10.15 Advice, support and training for other services

The Service will provide consultancy and advice in response to queries made from services and other general enquiries from other allied services needing guidance.

The Manager of the service will organise clinical supervision from a trained member of the team for all workers from agencies working with young people, who have completed the Tier 2 substance training (targeted services).

The service will provide Tier 2 substance misuse training and guidance to staff working with young people in universal services and targeted services

The service will actively participate in the gathering and dissemination of up to date information and advice on the purity, contamination and other concerns associated with illicit drug use

11. Eligibility criteria:

11.1 The Service shall be provided to Service Users who meet the following criteria: -

- Young person under the age of 25 who are 'Using a substance that is impacting moderately or significantly on one or more other domains of their life'
- They shall be resident in or have a connection with Southampton City

11.2 No young person should be denied a service; all services are expected to be inclusive (within the Equality and Diversity framework of Southampton City Council).

12. Service user Involvement:

12.1.1 The Health and Social Care Act 2001 requires drug treatment commissioners and providers to consult with and involve service users in the planning and development of services. NTA Guidance for local partnerships on user and carer involvement describes user and carer involvement as

"central to developing any organisation or service". The providers will therefore facilitate a range of service user led interventions and activities that will support and enhance the treatment options offered as part of the Recovery Action Plan (RAP)

12.1.2 This will include as a minimum

- The active engagement of service users as active partners in their own treatment
- The participation of service users in the design and development of treatment programmes.
- Provision of a forum for current and former service users to comment upon the range and quality of services offered in the City and to raise any concerns over access to services.
- Encouragement and support for service users to contribute to consultation.
- Keeping service users informed of developments in services.
- Undertaking specific pieces of work such as campaigns on particular issues, and other pieces of work as jointly agreed.
- Developing mechanisms which allow anonymous feedback from service users and carers and demonstrating to commissioners that this is happening.

12.1.3 The provider will ensure that all service users (and family members if appropriate), are aware of their rights and responsibilities at the point of engagement with the service specifically around information sharing and consent.

12.1.4 The provider will ensure that there is a clear policy governing the recruitment of ex-service users both as paid staff and volunteers in consultation with the DAAT.

12.1.5 The provider will develop links and pathways between the service, the service user forum, families and carers and with young carers.

12.1.6 The provider will promote regular consultation with service users in order for service user views and experiences to be used as a tool for performance monitoring and continuous service improvement.

12.1.7 The overall desired outcome is the active engagement of drug users in their treatment and in the shaping of local drug treatment services thereby increasing the participation of problem drug users in drug treatment programmes, which have a positive impact on health and crime.

12.2 Peer/Mutual Aid Support:

12.2.1 A key element identified in the Recovery Oriented Drug Treatment (RODT) model as described by Professor John Strang et al (2011) is the need for the provision of specific interventions designed for those who have achieved abstinence in order to promote sustained recovery from long term drug and or alcohol use.

12.2.2 The provider will utilise the emerging evidence base around recovery and work with recovering drug and or alcohol users to support the development of non-clinical, non-professional peer support groups across the city.

12.2.3 The provider will be responsible for ensuring pathways into these groups are accessible for all service users through-out the delivery service.

12.2.4 The provider will support the identification and development of "Recovery champions" to promote the peer-led recovery agenda locally.

12.2.5 The provider will develop working links with the Fellowship and other mutual aid groups to ensure that a variety of peer support meetings are effectively promoted.

12.2.6 The provider will ensure that the following peer led activities will be developed and delivered as part of the work of this service:

- Peer mentoring
- Peer advocacy as required.
- Recruitment and support of volunteers to undertake the above

.

12.3 Families and Carer Services:

12.3.1 The provider will operate a Families and Carers Information, support and advice service in order to enable the families and carers of people with a substance misuse problem to access timely information, support and advice relating to how they cope and deal with the person they are caring for.

12.3.2 In addition the new Service will signpost carers for a specialist carers assessment provided by local care management teams where appropriate, followed by providing support to the carer, so that the carer is sustained and is able to meet their own needs appropriately.

12.3.3 The provider will also recognise the role that families can play in recovery and will actively encourage their involvement in treatment, thus reducing the impact of drug use on family life and children. The provider will therefore:

- Work in partnership with adult services, generic carers services and relevant agencies in order to provide a co-ordinated and holistic approach to providing support and advice services for the families and carers of drug users.
- Reduce the harm caused by the misuse of drugs, by offering confidential and appropriate advice and support to parents, family members and carers that have been affected by another person's drug use.
- Improve the health, well-being and social functioning of drug users and their carers by supporting families, carers and friends to offer continued support to drug users in order to assist them to complete treatment.
- Enable families and carers to form and access community networks and services following an intervention and period of support offered by this service.
- Provide a non-judgmental and inclusive service which treats all carers with dignity and respecting gender, sexual orientation, age, physical and mental health, ability, religion, culture, social background and lifestyle choice.
- Increase the number of families and carers of drug users engaging in treatment who are able to access effective support in the community.

12.3.4 Families and carers will be recognised as experts by experience and their expertise will be utilised and valued.

12.3.5 This part of the service will be delivered in a variety of ways appropriate to the needs of individual family members/carers. This could take the form of guided self-help in the form of information, support and signposting delivered via websites, social networking sites, Skype, telephone etc.

12.3.6 The provider will facilitate access to locality based support groups which are easy to access and which provide immediate help to those family members in need. These may be generic carers

groups or specialist groups designed to address the specific needs of this care group.

12.3.7 This part of the service should offer a time-limited intervention to those who access it. The duration of the support for each individual or family will vary according to the complexity of their need, but the expectation is that the maximum duration of support will not exceed two years. The assessment and planning process will set the maximum duration for each service user, with a clear plan for ending the support.

12.3.8 It is expected that a successful period of support and intervention for the families will result in them being able to sustain themselves and link into various support networks and services in the community.

12.3.9 The range of support to be offered to families and carers is outlined below. The type and level of support offered to any individual or family will be dependent on their identified needs. We will rely on the provider to identify and offer the support most likely to meet agreed carer outcomes.

- This part of the service will provide information and advice which will address the difficulties of living with/supporting a member of the family or friend who has a substance misuse problem. It will provide information to enable carers to make informed decisions about their lifestyles. The delivery model will be designed to offer a motivational interview that supports and encourages carers to address difficulties and to improve their health and well-being.
- The provider will enable service users to access "drop in" sessions at appropriate locations as available.
- The provider will offer guided self-help, typically consisting of a single session with accompanying written material.
- The provider will provide an outreach service for those families and carers who may have difficulties in accessing the premises or groups available.
- The provider will provide access to a network of locality based mutual aid / peer support groups. The Service Provider will enable and facilitate carers who wish to set up their own local support groups where this is sustainable.
- The service will help family members and carers who wish to train as volunteers and support them in running and facilitating the self-help community groups.
- Provision for Carers will take into account their individual health and social care needs.
- The provider must ensure that staff ask families and carers about and discuss concerns regarding the impact of drug misuse on themselves and other family members including children. They will also:
    - Offer family members and carers access to an assessment of their personal, social and mental health needs, provided by Adult Services.
    - Provide verbal and written information on the impact of drug misuse on service users, families and carers, as well as information about detoxification and the settings in which it may take place

13. Access to Services

13.1 The provider will work with service users, carers, family members and the Commissioners to reduce any barriers to access and will work towards a culture of proactive engagement.

13.2 The provider will demonstrate innovation in developing a range of delivery options that recognises the changing methods of communication, including written, verbal, audio-visual, assertive outreach and detached work.

13.3 The provider will ensure equity of access for all groups, to deliver a non-judgemental and inclusive service, respecting age, colour, race, nationality, ethnic or national origin, marital status, mental or physical disability, religion or religious belief or philosophical belief, sex, sexuality (including sexual orientation), culture and social background.

13.4 Services will be flexible to meet demand; this will include making services available some evenings and weekends, as agreed with the Commissioners.

13.5 The provider will ensure that contact details and referral routes into the service are widely publicised in a range of contexts and formats. From the first point of contact individuals will be made welcome, well informed and responsible for their own recovery.

13.6 The provider will be proactive in working with partners to utilise community venues that can be accessed by Service Users, thereby reducing stigma and encouraging access to services.

13.7 The Provider must be aware of and respond to the needs of service users from under-represented groups and must ensure that there are adequate arrangements to ensure that these groups are aware of and able to access treatment services. Particular consideration should be given to;

- The establishment of specific group venues
- The use of satellite venues, including primary care settings, and home visits
- Opening hours that are not prohibitive to any client groups
- Outreach work

14. Service Access Standards and Response Times

14.1 The Service will provide promotional information, in appropriate formats and locations in order to raise awareness of the Service.

14.2 The Service Provider will provide an up to date website which includes information that explains what the Service provides, how to access the Service and signposting to other accredited services.

14.3 The Service will make available and develop self-help materials which can be given to individuals and to partner organisations to assist them in working with people with drug and alcohol problems. The overall aim is to maximise the interventions of other agencies and teams in working with people who may then not require referral to higher intensity services.

14.4 The Services will provide a first contact by telephone or in person within two (2) Working Days of the initial referral.

14.5 The Service shall ensure that service users commence structured treatment within fourteen (14) Working Days from the date of the first contact/appointment.

14.6 Where possible all Service Users will be offered a choice of working with either a female or male worker as appropriate.

15. Service Time and Location

15.1 We are seeking to increase the number of people receiving information, advice and structured

treatment about their drinking and drug taking behavior. This can be delivered through a number of channels which should not be limited to fixed office bases and face to face contact. It could, for example be delivered through on-line and telephone facilities.

15.2 Where face to face contact is required this should include access at core times during the working week (core times are usually 9.00am to 5.00pm, Monday to Friday though this is subject to discussion and agreement) and include some access in the evening and on weekends, at times which are convenient and suitable to Service Users. This should be at least one evening and one weekend session per week and cover at least 8 hours per week. These times will be subject to future discussion and negotiation and subject to monitoring information on take up of service at various times.

15.3 Services will be able to flexibly respond to changes in need regarding access times by, for example, shifting the balance of access time from daytime to evening opening. Changes will be by prior agreement with the commissioners.

15.4 The Services will be delivered from accessible locations based in Southampton and arranged by the service provider.

16. Personalisation

16.1 Personalisation is the process by which services provided by the local authority are adapted to suit the personal needs of the service user. This means that all service users retain choice and control over the services they receive, along with greater emphasis on prevention and early intervention where possible.

16.2 Service users will be supported to develop their own Integrated Assessment Plan. Once completed, this will have sequenced interventions and activities as agreed with the service user and providers as necessary. The assessor will "sign off" the plan following completion and will take responsibility for agreeing with the service user the most appropriate way for the plan and the indicative budget to be managed throughout treatment.

16.3 Service users will be supported to access generic services to help them develop their own RAP, including peer support networks and other services which support the take up of Direct Payments.

16.4 The service will need to be able to adapt to changes arising as a result of the implementation of Personal Budget and Personnel Health Budgets. This includes enabling people to take a Direct Payment if they meet the eligibility for Local authority funding and linking people into other services which support and encourage people to take a direct payment.

Purchased Services

16.6 The service will have responsibility for holding a budget to be used in the purchase of services outside of the commissioned treatment system. The provider for delivery of services will be expected to develop a range of services which can be purchased separately from the commissioned services over the course of the contract, building flexibility and greater choice for service users. This will mean that eventually a greater proportion of the budget will incrementally be spent on purchased services and less on block purchased commissioned services over the life of the contract.

For example:

Service	Year 1	Year 2	Year 3
ARMS/ESAP	£X	£X	£X
Delivery Service	90%	85%	80%
Purchased services	10%	15%	20%

NB: ***The investment in the block contracted services is expected to reduce over the course of the contract alongside an increase in people accessing services through Direct Payments or Personal Health Budgets. The investment in the ESAP/ARM contract will remain constant.***

Purchased services may be delivered by the Delivery of services provider or by other providers, depending on service user choice.

17. System Outcomes

17.1 The provider will work in partnership with Southampton City Council and the Commissioners to contribute towards the delivery of the following national Drug Strategy 2010 and Alcohol Strategy 2012 outcomes:

- Recovery from dependence on drugs or alcohol;
- Prevention of drug and alcohol related deaths;
- Prevention of infection by Blood Borne Viruses;
- Reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvement in mental and physical well being;
- Improved relationships with family members, partners and friends;

17.2 The service will also contribute to improve outcomes that impact on several local strategic objectives

- Reduce harm overall, linked to associated risks being negated (sexual behaviour e.g. teenage pregnancy, mental health) and factors addressed (school exclusion/non attendances, worklessness, debt, housing, NEET).
- Reduce number of young people affected by domestic violence or at risk of sexual exploitation
- Improve the emotional well-being of young people and early identification of emotional and mental health needs.
- Improve mental health and well-being of young people
- Reduce health inequalities through early intervention.
- Improve educational opportunity and ensure personal development needs of all, particularly vulnerable, young people are met,
- Increase opportunities for young people and younger adults to make a positive contribution to the community
- Increase opportunities to achieve economic well-being, overcome disadvantage and make an effective transition to adult life.

17.3 Tackling drug and alcohol related issues is one of the priorities in the Community Safety Strategy and underpins the intention to reduce crime and anti-social behaviour and improve quality of life and the city environment.

18. Monitoring

18.1 The service will ensure all data is submitted to NDTMS by reporting deadlines

18.2 The Council and the Service Provider shall meet once every Quarter during the Contract Period to monitor the performance and delivery of the Services in accordance with this Service Specification.

18.3 The Council's Representative or his or her deputy may undertake periodic monitoring visits and will meet the Service Provider's Representative. The Service Provider shall provide additional monitoring information on these occasions if required by the Council.

18.4 The Service User's Representative and Council's Representative or his or her deputy shall participate and contribute to Council surveys and consultation exercises where relevant or requested.

18.5 The Service Provider will allow reasonable access to authorised representatives of the Care Quality Commission and/or Southampton's Local Involvement Network in the exercise of powers conferred on it to enter and view specified premises providing publicly funded health and social care services.

18.6 The Service Provider will provide routine data and monitoring information. It will also include individual and Service outcomes obtained using an accredited monitoring tool

19. Performance Indicators

19.1 The following performance targets are set for 2014-15. The outreach service function is to target young people who are using substances, provide harm reduction and brief intervention. Where the young person's needs meet treatment criteria they will be referred for comprehensive assessment. All data will be reported with a breakdown by age range – under 18s and 18 – 24 year olds.

Local Outcomes required

No	Performance Indicator	Target	Reporting frequency
1. Outreach and Brief Interventions			
1a	The number of young people and young adults receiving alcohol and/or drug brief intervention	1,500 per annum	Quarterly
1b	The number of young people contacted through targeted outreach	3,000 per annum	Quarterly
2. Entry to Services			
2a	95% of referrals are offered a triage/initial assessment within 2 working days	95%	Quarterly
2b	95% of new referrals receive a comprehensive assessment within 5 working days (after triage/initial assessment)	95%	Quarterly
2c	95% of first Interventions have a waiting time of less than 2 weeks from date of referral (based on modality start date and date of referral)	95% 100% < 3 wks	Quarterly
3. Numbers in Specialist Substance Misuse Services			

3a	The number of new referral who are seen at the Tier 3 Substance Misuse service	120 per annum 11 – 17 yr olds 180 per annum 18 – 24 year olds	Quarterly
4. In Services			
4a	95% of care plan are in place within 2 weeks of the young person's treatment start date.	95%	Quarterly
4b	95% of care plans are reviewed after the comprehensive assessment within 12 weeks	95%	Quarterly
4c	95% of new referrals joint worked with other services	95%	Quarterly
4d	95% of new referrals have a key worker assigned	95%	Quarterly
5. Exiting Services			
5a	90% of young people should leave treatment in an agreed and planned way.	90% Threshold – above national avg	Quarterly
6. Treatment Outcome Profiles			
6a	95% TOPs recorded at - Start - Review - Exit (of planned exits)	95%	Quarterly

20. Management information

20.1 In order to assess service performance and aid future planning the provider will be required to be able to collect and collate information to demonstrate contract requirements, agreed outcomes for the service and service users, compliance with performance indicators, service take-up against agreed contracted volumes and financial information. This includes, but is not limited to:

20.2 The service shall produce a Quarterly report in a format agreed between the Council and the Service Provider containing the above key performance indicator information which will be presented to the Council at least two weeks prior to the next Quarterly monitoring meeting and discussed with the Council at that meeting.

20.3 The service should make use of an information sharing agreement which allows partner agencies to share information about the customer as appropriate and needed;

20.4 The service will report by the same sub categories as within the NTA Young Peoples Partnership Executive Summary Reports e.g. referral sources, age range breakdown in same categories as NTA report.

20.5 The 'service user' database will record those people who are registered with the Service. A user ID number will be allocated to each new registration, which will remain with that person throughout their current and any future Service involvement. The database for people entering into treatment with the Service provides the following quarterly dataset detail

20.6 The provider will report on the following information on a quarterly basis with a breakdown by 11 – 17 and 18 – 24 yrs

Management information number	Management information	Reporting frequency
Referrals and Service Activity		
1.	Number of new referrals	Quarterly
2.	Number of new referrals who received comprehensive assessment	Quarterly
3.	Number new referrals accessing treatment service	Quarterly
4.	Number of young people currently in treatment	Quarterly
5.	Referral source of referrals	Quarterly
6.	Breakdown by age (of referrals and attending service)	Quarterly
7.	Gender breakdown of YP (of referrals and attending service)	Quarterly
8.	Ethnicity breakdown of YP (of referrals and attending service)	Quarterly
9.	Number of young people by vulnerability: school excludees, young offenders, young homeless, sexually exploited, young people with mental health problems, 'looked after' young people, young people with behavioural problems, young people of substance misusing parents.	Quarterly
10.	Drugs used, route of use, and risk behaviour (primary, secondary, poly-drug, method of administration, stimulant use, prevalence of IV users sharing)	Quarterly
11.	Number of new referrals who received comprehensive assessment	Quarterly
12.	Waiting times for treatment services (minimum, maximum and average)	Quarterly
13.	Number with integrated care plans drawn up	Quarterly
14.	Number on substitute prescribing	Quarterly
15.	Numbers and types of outcomes (planned exits, disciplinary exits, self exits, number remanded to custody, referrals to inpatient care, referral to more appropriate services etc.	Quarterly
16.	Number of young people using needle exchange service	Quarterly
17.	Numbers referred for vaccination programmes	Quarterly
Outreach		
18.	Number of young people received outreach on drugs and alcohol issues in in generic settings - Number of young people seen in schools / colleges - Number of young people at risk received seen through targeted outreach - Number of young people contacted by targeted outreach Including information on referring agency, demographic profile and risk factors	Quarterly

Management information number	Management information	Reporting frequency
Referrals and Service Activity		
1.	Number of new referrals	Quarterly
2.	Number of new referrals who received comprehensive assessment	Quarterly
3.	Number new referrals accessing treatment service	Quarterly
4.	Number of young people currently in treatment	Quarterly
5.	Referral source of referrals	Quarterly
6.	Breakdown by age (of referrals and attending service)	Quarterly
7.	Gender breakdown of YP (of referrals and attending service)	Quarterly
8.	Ethnicity breakdown of YP (of referrals and attending service)	Quarterly
9.	Number of young people by vulnerability: school excludees, young offenders, young homeless, sexually exploited, young people with mental health problems, 'looked after' young people, young people with behavioural problems, young people of substance misusing parents.	Quarterly
10.	Drugs used, route of use, and risk behaviour (primary, secondary, poly-drug, method of administration, stimulant use, prevalence of IV users sharing)	Quarterly
11.	Number of new referrals who received comprehensive assessment	Quarterly
12.	Waiting times for treatment services (minimum, maximum and average)	Quarterly
13.	Number with integrated care plans drawn up	Quarterly
14.	Number on substitute prescribing	Quarterly
15.	Numbers and types of outcomes (planned exits, disciplinary exits, self exits, number remanded to custody, referrals to inpatient care, referral to more appropriate services etc.	Quarterly
16.	Number of young people using needle exchange service	Quarterly
17.	Numbers referred for vaccination programmes	Quarterly
Outreach		
19.	Brief Interventions on drugs alcohol issues to individuals - Young people offered Tier 2 support - Young People receiving Brief Interventions on alcohol - Young People receiving Brief Interventions on drugs Including information on referring agency, demographic profile and risk factors	Quarterly

Long Term Outcome Monitoring

20.5 As a guideline young people should be contacted by the service 3 months and then 6 months after they complete treatment. The service should also consider other creative and innovative ways in keeping contact with young people that leave treatment.

20.6 The purpose of this is to seek their views on the services impact on key aspects of their lives such as alcohol/substance misuse, mental health and wellbeing, housing, employment and education.

20.7 The service will present the long term outcome feedback through the quarterly performance monitoring reviews.

21. Workforce Requirements

The Service Provider will ensure that staff:

- Are appropriately experienced, qualified and trained;
- Have received appropriate induction, supervision (management and clinical)
- Receive annual appraisal;
- Are CRB checked where appropriate;
- Have received training in the use of processes and equipment;
- Are trained in Child and Adult Safeguarding and Safe Issues and generic risk assessment

Workforce planning should address:

- Capacity and flexibility to respond to the likely pattern of demand; and
- Appropriate grade of staff to provide specified service, avoiding use of highly qualified staff for routine interventions.

22. Safeguarding and Multi-Agency Safeguarding Hub developments (updated November 2013)

Multi Agency Safeguarding Hub:
Southampton City Council is currently in the process of setting up a Multi-Agency Safeguarding Hub (MASH). This will be a centre and co-located team which brings together agencies (and their information) in order to identify risks to children at the earliest possible point and respond with the most effective interventions.

MASH allows the multi-agency safeguarding team to carry out a joint confidential screening, research and referral of vulnerable children. Agencies work together to ensure vulnerable children are identified and properly cared for and protected.

The purpose of the MASH:
The purpose of the MASH is to make the best decisions which will keep children safe. This will in turn ensure timely and necessary interventions, improving the outcomes for vulnerable children.

Agencies included in the MASH:

- Children's Social care
- Police
- Health (including substance misuse services)
- Education
- Probation
- Housing
- Youth Offending Service

How the MASH will work:
Concerns relating to the safeguarding or welfare of a child will be considered by the MASH screening team including self referrals, multi-agency referrals, and referrals from the Police, another local authority or an anonymous referral.

Information is collected from all the partner agencies within the timescales set by the Head of the MASH. The most urgent cases will be turned around within two hours.

All information is collated and the MASH reviews and analyses the information received from partner agencies and writes a summary of that information on a MASH record. The MASH recommends what further action should be taken.

Substance misuse services will be expected to input into the MASH and how this will take place is currently being discussed and developed. It is the intention of the commissioners that all substance misuse providers will need to work closely with Children's services and all other partners in order to provide information and a swift and comprehensive assessment whenever children are felt to be at risk of harm. The resource required for this work is already included in the price of this contract and there will be no additional funding available.

In addition it is intended that the ESAP service will work very closely with the new Early Help (5-19 years) team being formed as part of the Children's Transformation work being undertaken by Southampton City Council. This may require some co-location of resources with the Early Help team, although it is not anticipated that this means that there will be any additional caseload.