



Southampton City
Clinical Commissioning Group

Integrated Commissioning Unit



Substance Misuse Services Review and Redesign

Final Report

***‘Commissioning specialist services for
people concerned by their own or someone else’s use of
drugs and/ or alcohol’***

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AUGUST 2018

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1. Overview

The impacts of problematic use of drugs and alcohol to individuals, their friends, families and communities are well known. Problematic use of drugs can negatively impact physical and mental health and drive people to engage in criminality, become homeless, and disrupt personal relationships and negatively impact child development.

As well as the human cost of substance use people's use and misuse of drugs have financial implications to the public purse, whilst difficult to estimate due to the range of impacts our government has presented a number of estimates in recent years

1.1 The Impact of Drugs - National

- In **2014** the National Treatment Agency estimated that the overall annual cost of drug misuse was around £15.4 billion. £13.9 billion was due to drug-related crime, while around £0.5 billion was NHS costs for treating drug misuse.
- A **2014** report from Public Health England reported that every pound spent on drug treatment saves £2.50 in costs to society.
- In **2012**, the National Treatment Agency for Drug Misuse estimated that drug treatment and recovery systems in England prevented 4.9 million crimes in **2010-2011**, saving £960 million.
- In a **2009** policy paper on the families of drug misusers, the UK Drug Policy Commission estimated that:
 - nearly 1.5 million adults will be significantly affected by a family member's drug use;
 - the cost of the harms they experience as a result amounts to about £1.8 billion per year; and
 - the support they provide would cost the NHS or Local Authorities about £750 million to provide if it was not available.

Human and financial cost of drug addiction: House of Commons Debate Pack Nov 2017

- In **2017** Southampton City Council (SCC) Drug Health Needs assessment indicated
 - '...for each £1m disinvested from services, there could be an annual increase of 9,860 drug related crimes each year, resulting in societal costs of over £1.8million.'

Drugs Health Needs Assessment: Southampton City Council (2017)

1.2 The Impact of Alcohol - National

- Alcohol harms are estimated to cost the NHS around £3.5 billion annually
- Alcohol-related crime in the UK is estimated to cost between £8bn and £13bn per year

<https://www.alcoholconcern.org.uk/alcohol-statistics>

1.3 Southampton Drug and Alcohol Strategies

Alcohol Strategy - [Southampton Alcohol Strategy](#)

Drug Strategy - [Southampton Drug Strategy](#)

2. What is the 'need' in Southampton?

This section considers a wide range of national and local data to identify the scale of the issues to be addressed. The range and variety of data available are often limited. The following information provides a snapshot to inform the current commissioning planning.

2.1 Data available

3 key pieces of work already describe need (to a limited extent), demand and activity in Southampton:

1. Public Health England (PHE) Commissioning Support Toolkit, based on National Drug Treatment Monitoring Service (NDTMS) data
2. SCC Drugs Health Needs Assessment 2017
 - The Drugs Health Needs Assessment is available as an attachment in the Reference section at the end of this document.
3. SCC Alcohol Health Needs Assessment 2015
 - The Alcohol Needs Assessment is available here [Southampton Needs Assessment \(Public Health\)](#)

This review therefore will consider the key points from above and data from other sources both local and national. In the main nationally produced data is reported by the National Drug Treatment Monitoring Service (NDTMS). NDTMS forms part of the work of the Public Health England for Substance Misuse. All services that

provide structured treatment for drug and/or alcohol users are asked to submit data to NDTMS. This information is analysed by the National Drug Evidence Centre to produce the figures published. This interim report highlights data from the Diagnostic Outcome Monitoring Executive Summary (DOMES), Adult Successful Completions and Representations, Adult Activity Reports, Young People’s Executive Summary and the Young People’s Outcome Report. It should be noted that the publication of data reported by NDTMS has restrictions. In particular, a proportion of the data reported on activity and outcomes from 2017/18 has restrictions imposed. This means that data from this period cannot be included in publically available documents. This document, therefore, does not include this data. For the purposes of this document we have included unrestricted data from 2016/ 17.

2.2 Findings

2.2.1 Drugs, adults aged 18+

People who use opiates and/ or crack

- An estimated 1273 people in Southampton use opiates.
- When considering the last ‘full year’ data that we can publish (DOMES Q4 2016/17) the National Drug Treatment Monitoring Service (NDTMS) evidences 738 people receiving structured treatment to address their use of opiate type drugs.
- We have more need (prevalence estimates) but similar percentage of unmet need, for Opiate and or Crack Users, to the national average, i.e. a local unmet need of 49.0 % (Lower Confidence Interval (LCI) 31.6% - Upper Confidence Interval (UCI) 59.6%) compared to 50.1% (LCI 49.6% - UCI 51.8%) for England.
- The largest cohort of people who use opiates and or crack fall within the age group 35-64yrs with an estimated 821 people in this cohort.
 - The penetration rate, by age group can be seen in the table below

AGE	Prevalence estimate (LCI)	Prevalence estimate	Prevalence estimate (UCI)	No in Treatment 2016/ 17	Penetration Rate		
					Based on highest estimated prevalence	Based on average estimated prevalence	Based on lowest estimated prevalence
15-24	30	96	226	19	8%	20%	63%
35-64	598	821	1084	499	46%	61%	83%
65+	Not available	Not available	Not available	4	Not available	Not available	Not available

People aged over 65 who use drugs

Older people with drug problems in the UK fail to get the same attention as young people and this neglect may be fuelled by systemic ageism identified in this study. This includes, exclusion of older people from national drug prevalence surveys and treatment data, upper age limits in some substance misuse treatment services, “age-blindness” in some national substance misuse strategies and a constellation of ageist attitudes and prejudicial assumptions that may prevent professionals identifying and taking action with regard to drug problems. Drug prevention programmes targeted at older people have the potential to create substantial cost savings as well as reducing unnecessary suffering and loss of life but most are targeted at young people. Older people respond well to treatment for drug problems - 62% of people aged 60 and over who receive treatment in a substance misuse service complete treatment free of dependency compared to 47% of 18-59 year olds. They are half as likely to drop out of treatment as younger people. Evidence suggests that treatment outcomes can be improved further if treatment is delivered by a substance misuse service specifically for older people but few of these services exist in the UK and most that do exist are only commissioned to deliver alcohol treatment.¹

¹ [The Forgotten People: Drug Problems in Later Life -A Report for the Big Lottery Fund University of Bedfordshire \(July 2014\)](#)

People who use other drugs

Estimates for the problematic use of other drugs are harder to identify. It can be reasonably assumed that people using particularly harmful drugs like opiates and or crack have a treatment need. A proportion of people who use other drugs will also have a treatment need but it is harder to identify the proportion. But it may be useful, still, to understand the estimated level of use of other drugs. All the following data is taken from the 2015/16 Crime Survey for England and Wales and extrapolated, in the SCC 2017 Drugs needs Assessment, to local data based on Office of National Statistics (ONS) mid-year population estimates for 2015. Some individuals will have used multiple substances.

- There are 161 901 residents of Southampton aged between 16 and 59.

An estimated:

- 56,665 people have taken an illicit drug in their lifetime
- 13,600 people took an illicit drug last year
- 10,524 people took cannabis
- 3,562 people took powder cocaine
- 2,429 people took ecstasy

Southampton has experienced, in recent years, the impact of synthetic cannabinoid use. Anecdotally, it is a limited cohort that use this drug, predominantly people who use opiates and who are experiencing homelessness, however, the impact on their mental and physical health and the associated anti-social behaviour of the use of this drug are significant.

2.2.2 Drugs, under 18

The prevalence of drug use in young people (YP)

All the following data, which provides the prevalence of drug use in young people, is taken from the 2015/16 Crime Survey for England and Wales and extrapolated, in the SCC 2017 Drugs needs Assessment, to local data based on ONS mid-year population estimates for 2015. Some young people will have used multiple substances.

- There are 47,666 residents of Southampton aged between 16 and 24
An estimated:
 - 8,580 young people took an illicit drug last year
 - 7,531 young people took cannabis
 - 2,145 young people took ecstasy
 - 2,097 young people took powder cocaine
- PHE 'Estimates of opiate and crack cocaine use prevalence: 2014 to 2015', published in 2017 estimates that there are 96 (LCI 30 UCI 226) people aged between 15 and 24 years who use opiates and or crack resident in Southampton
- On average our current YP Substance Misuse services provides structured treatment to 218 young people and brief interventions to 1864 young people over the course of a year. 1214 young people received an educational session at school, and over 3000 young people received substance support through targeted outreach. Of those accessing structured treatment:
 - 40% are female
 - 71% are aged between 19 and 24
 - Cannabis is the most commonly presenting drug (75%)
 - Alcohol is the second most commonly presenting drug (55%)
 - Nicotine and Cocaine are the third and fourth most commonly presenting drug (22% and 17 % respectively)
- A recent snapshot of a single quarter's (Q4 2017/18) activity, from our YP provider database, evidenced
 - 96 people on the DASH caseload in this quarter
 - Gender
 - 38 (40%) female
 - 58 (60%) male

- Age
 - 33 (34%) were aged 18 or under
 - 63 (66%) were aged 19 – 24
- Drug
 - 54 (56%) reported cannabis as the primary problematic drug
 - 19 (20%) reported alcohol as the primary problematic drug

2.2.3 Women

PHE 'Estimates of opiate and crack cocaine use prevalence: 2014 to 2015', published in 2017, estimates that 343 (LCI 219-UCI 471) women in Southampton use illicit opiates. The same report estimates that 930 (LCI 735-UCI 1257) men in Southampton use illicit opiates.

NDTMS reports that of the 738 people who use opiates, who engaged in structured treatment in 2016/17, 209 were women. 529 men engaged in structured treatment in the same period

This would suggest a penetration rate of 60.93% (LCI 95.43% UCI 44.37 %) for women who use opiates. This compares with a male rate of 56.88% (LCI 71.97% - UCI 42.08%)

- Southampton Commercial Sex Worker Support Forum recently compared databases and client lists and, through this work, estimated that 60 individual women are engaging in on street prostitution in a six month period
 - Through engagement with these women we understand that women engaged in 'on street' drug use are often people with complex lives including substance use and mental health disorders.
 - The current provider provides an outreach offer to these women with multiple vulnerabilities, but further work needs to be considered to assess treatment need and improve pathways to and through substance use disorder services

2.2.4 People who Inject drugs

PHE 'Estimates of opiate and crack cocaine use prevalence: 2014 to 2015', published in 2017, estimates 636 (LCI 491 – UCI 778) people in Southampton inject drugs.

On average, 350 people access the needle exchange hub each quarter, i.e. c55% of those injecting. The actual proportion of injecting drug users using needle exchange is likely to be higher. We cannot count the number of people using pharmacy provision as the service is open access and service users do not need to give their name. Some people using the hub will pass sterile needle supplies on to others.

2.2.5 Blood Borne Virus

It is estimated that over half of people who inject drugs (PWID) in the South East of England have Hepatitis C (58%). It is estimated that nearly 47% of known Hepatitis C (HCV) cases in Southampton are PWID. A tool to estimate the burden of HCV by Local Authority area indicates that there were 636 individuals currently injecting drugs in Southampton although it must be emphasised that this is an estimate. The prevalence of Hepatitis B and HIV amongst PWID in England is estimated at 0.85% and 3% respectively.

The most recent data that we can present publically [DOMES Q42016/17 – NDTMS] indicates that Southampton's Drug and Alcohol Recovery Partnership performs well in inoculation and testing for BBV when compared with national performance

- Clients with no record of completing a course of HBV vaccinations as a proportion of eligible clients in treatment at the end of the reporting period
 - Southampton = 58.6%
 - National = 71.4%
- Clients with no record of a HCV test as a proportion of all clients in treatment at the end of the reporting period who were eligible to receive one
 - Southampton = 7.4%
 - National = 17.3%

2.2.6 Alcohol, adults aged 18+

PHE's Local Alcohol Profiles for England, estimates Southampton had **3459** (LCI 2732 UCI 4643) people drinking dependently in 2014/15². The profile also shows that 1.76% of the local adult population is estimated to be a dependent drinker, broadly similar to other authorities with a similar degree of population deprivation (1.66%) but higher than England (1.39%) but not quite to the extent of being statistically significant. It means we have an estimated 196 more dependent drinkers than if the rate for England applied.

NDTMS 'Adult Activity Report' (Q4 2016/17) indicates 587 people accessing structured treatment with an alcohol or alcohol and other drug concern

- This indicates that we are engaging with **17.0%** of our estimated dependent drinking population – leaving an 'unmet treatment need' of **83%** (LCI 78.5% UCI 87.4%)
- This correlates with nationally reported (DOMES 2017/18) unmet need for alcohol that indicates that we have a higher rate of unmet need (**87.6%**) than the national average (**82.1%**) and the difference is statistically significant.
 - Similarly, 80%-90% of people engaging with Alcohol Care Team (ACT-UHS) in University Hospital Southampton are not already known to services.

2.2.7 Alcohol use in people aged 65+

PHE's Local Alcohol Profile for England, when considering evidence from 2016/17, evidenced that Southampton experienced significantly 'worse' incidence of alcohol related admissions for people and men aged over 65 when compared to the South East Region and when compared to England as a whole. The incidence of women over 65, presenting for the same issues was regarded as 'similar' when compared to the South East Region and when compared to England as a whole.

	Rate per 100 000		
	England	South East Region	Southampton
Admission episodes for alcohol related conditions (narrow) – Over 65s (Persons)	871 per 100 000	825 per 100 000	1188 per 100 000
Admission episodes for alcohol related conditions (narrow) – Over 65s (Male)	1283 per 100 000	1233 per 100 000	1823 per 100 000
Admission episodes for alcohol related conditions (narrow) – Over 65s (Female)	542 per 100 000	491 per 100 000	690 per 100 000

Prevalence rates for people with dependant alcohol use who are aged over 65 are not available

- It is estimated that 349 (260 male – 89 Female) people aged 55 and over experience dependant use of alcohol
- In 2017/18 72 people aged 55 and over accessed structured treatment and support for alcohol use. Of those 12 were aged 65 or over

² <https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938133118/pat/6/par/E12000008/ati/102/are/E06000045>

2.2.8 Alcohol Use in people aged under 18

PHE's Local Alcohol Profile for England, when considering evidence from 2016/17, evidenced that Southampton experienced significantly 'worse' incidence of alcohol related admissions for people, men and women aged under 18 when compared to the South East Region and when compared to England as a whole.

	Rate per 100 000		
	England	South East Region	Southampton
Admission episodes for alcohol related conditions (narrow) – Over 65s (Persons)	34.2 per 100 000	33.9 per 100 000	50.8 per 100 000
Admission episodes for alcohol related conditions (narrow) – Over 65s (Male)	27.4 per 100 000	26.5 per 100 000	43.3 per 100 000
Admission episodes for alcohol related conditions (narrow) – Over 65s (Female)	41.3 per 100 000	41.7 per 100 000	58.8 per 100 000

	Yes			No		
	Boys	Girls	All	Boys	Girls	All
England	59.7	65.2	62.4	40.3	34.8	37.6
Southampton	60.9	65.9	63.3	39.1	34.1	36.7

What About Youth 2014 'ever had an alcoholic drink'

For the year 2017/2018 the number of young people engaged with No Limits and receiving a brief intervention around their own problematic alcohol use was 2809. Of these, 599 were over 18, and 2210 were under 18. 99 young people were engaged in structured treatment around alcohol use. Of these, 54 had alcohol as their main or only problematic substance.

2.2.9 Impact of parental substance use on the child

Local

Whilst it is acknowledged that this data may include some inconsistencies, identifying the number of episodes with drugs or alcohol noted as a factor in assessment information, within a recent consideration of Single Assessments Completed on Southampton's Children's Social Service records (PARIS), during the period 01/04/2017 and 31/03/2018, indicates the incidence and burden of individual and 'parental' substance use in Southampton as

- 2356 have parental factor recorded in the assessment
- 531 (22.5%) were recorded with alcohol as a factor = 531 (22.5%)
- 623 (26.4%) recorded with drugs as a factor = 623 (26.4%)

This indicates an average burden when compared with statistical and regional neighbours



20180314
Substance Misuse -:

Nationally reported prevalence

Problem parental alcohol and drug use: A toolkit for local authorities (PHE 2018) reports the estimated prevalence and percentage of met need and compares with national estimates.

Alcohol

Table 1: Annual met treatment need estimates, alcohol dependency 2014/15 to 2016/17					
Adults with an alcohol dependency	Southampton			Benchmark	National
	<i>Prevalence</i>	<i>Treatment</i>	<i>% met need</i>	%	%
Total number of adults with a dependency who live with children	675	76	11%	18%	21%
Total number of children who live with an adult with a dependency	1261	124	10%	17%	21%

Drugs

Table 2: Annual met treatment need estimates, opiate dependency 2014/15 to 2016/17					
Adults with an opiate dependency	Southampton			Benchmark	National
	<i>Prevalence</i>	<i>Treatment</i>	<i>% met need</i>	%	%
The number of women with a dependency who live with children	119	69	58%	61%	60%
The number of children who live with a woman with a dependency	207	127	61%	60%	60%
The number of men with a dependency who live with children	217	94	43%	45%	48%
The number of children who live with a man with a dependency	386	174	45%	44%	49%
Total number of adults with a dependency who live with children	336	163	49%	51%	52%
Total number of children who live with an adult with a dependency	593	301	51%	50%	53%

Children in Need

In 2016/17, there were 531 alcohol and 623 drug misuse episodes identified as a risk factor in children in need assessments, out of a total of 2356 records in Southampton.

Regional and national proportions are provided below for comparison.

	Risk factors identified in CIN assessments		Alcohol misuse	Drug misuse	Total assessments
	Alcohol	Drugs			
Southampton	22.5%	26.4%	531	623	2356
Regional average	18.7%	19.4%	14557	15076	77791
National average	18.0%	19.7%	18	19.7	-
Note: An assessment may have more than one factor recorded.					

2.2.10 Adult Social Services – Impact of adult substance misuse

- There is limited data available from ASC systems
 - 2,590 adult social care clients
 - 2,150 of these are in long term care (duration more than 12 months).
- 67 (3%) of these 2150 people in long term care with substance misuse as an identified care reason
 - 21 (31%) of this 67 in permanent residential or nursing care
 - 46 (69%) of this 67 receive domiciliary care in their own accommodation
 - 10 (15%) of this 67 have substance misuse as a Primary Support Reason
 - 3 (30%) of this 10 are in permanent residential or nursing care
 - 7 (70%) of this 10 receive domiciliary care in their own accommodation

2.2.11 Co Occurring Conditions

Substance use disorder with a mental health disorder

Adults and young people with coexisting severe mental illness and substance misuse have some of the worst health, wellbeing and social outcomes. It is not clear how many people in the UK have a coexisting severe mental illness and misuse substances, partly because some people in this group do not use services or get relevant care or treatment.

The National Collaborating Centre for Mental Health document, 'Severe mental illness and substance misuse (dual diagnosis): community health and social care services Draft Review 1', published in 2015 states:

Dual diagnosis refers to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage). Recent studies have estimated prevalence rates of 20-37% in secondary mental health services and 6-15% in substance misuse settings (Carrà & Johnson, 2009). However, methodological challenges including differing definitions of dual diagnosis, varying timescales for assessing comorbidity, difficulties with diagnosis including diagnostic overshadowing, and the lack of a good theoretical model of the association between severe mental illness and substance misuse, mean that it is still unclear how many people in the UK have a severe mental illness and comorbid substance misuse problems.

A proportion of people with substance misuse needs have depression, anxiety or other more common mental health conditions too. SCC Drugs needs assessment reports that:

“27% (n= 103) of people accessing adult drug treatment services in Southampton had received care from a mental health service for reasons other than substance misuse (compared with 20% nationally). The proportion of people with a comorbid mental health problem was highest in those clients using non-opiates and alcohol (40%, n= 30).”

Adverse Childhood Experience are often a significant factor in substance misuse and mental distress and ill-health. Adult trauma can also cause mental health and/or substance misuse issues, such as having served in conflict in the armed forces.

Substance use disorder with a learning difficulty

PHE guidance ‘People with learning disabilities: making reasonable adjustments’ (2018), states

Overall, the evidence indicates that people with learning disabilities are less likely to misuse substances than the general population. However, some people believe that when people with learning disabilities do drink alcohol, there’s an increased risk that they will develop a problem with it.

As increasing numbers of people with learning disabilities are living more independently in local communities they’re more likely to have access to alcohol and other drugs and, therefore, there’s a need for appropriate services to support those who misuse substances. It can be difficult to recognise that someone has mild learning disabilities, but they may still need a different approach to their treatment and support³.

Prevalence figures are unavailable to understand the impact of substance use disorders, in Southampton, for this cohort.

2.2.12 Drug Related Deaths (DRD)

The number and rate of drug related deaths in each local authority is available from the Office for National Statistics [here](#) : 46 people died in the 3 years from January 2015 to December 2017. This compares to 43 from January 2014 to December 2016. The significant majority of deaths are related to Alcohol, Benzodiazepines and Heroin in some combination

Rates are calculated to take account that the size of our population is growing and to allow us to compare ourselves to other areas.

The rates of drug related deaths in Southampton has increased slightly over the last 10 years, although the increase is not statistically significant. The rate of drug-related deaths in Southampton is similar to the rate in like authorities but became higher (worse) than the England average in 2014-16. In statistical terms, numbers are still small and some fluctuation is to be expected. We understand that our local increase is likely to correlate with the reasons associated with the increase nationally, which are thought to be related to an ageing population of heroin users and drops in numbers accessing treatment. People who use drugs are particularly vulnerable on release from prison, or after any other period of (near) abstinence.

Engagement in treatment is evidenced as a significant protective factor. Comprehensive naloxone provision, including for people not actively engaged in treatment, is also a key offer that needs to be available across all cities/settings.

2.2.13 People who are Lesbian Gay Bisexual Transgender Questioning + (LGBTQ+)

There is national evidence of increased alcohol and recreational drug use among people who identify as other than heterosexual or as different to their cis-gender.

³ <https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities/substance-misuse>

Public Health England (2017) synthesised the results from a range of national surveys and estimates that 2.5% to 5.9% of adults across the country publicly describe themselves as lesbian, gay or bisexual⁴. More people again will be lesbian, gay or bisexual but not happy or ready to share it in a survey. Rates are thought to be higher in cities. The analysis did not look at transgender or queer people as national surveys have not recorded this to date.

Public Health England recently reviewed the health needs of men who have sex with men (2016⁵) and of women who have sex with women (2018⁶). Men who have sex with men are twice as likely to be dependent on alcohol and young people who are LGBT are almost twice as likely to use drugs and alcohol compared to their heterosexual peers. Women who have sex with women are also more likely to drink heavily, although the increased rate was not quantified. Additionally, a review of the needs of the LGBTQ+ community in London reported from the literature that 62% of transgender people may be dependent on alcohol⁷. The work by PHE does not identify any increased risk of opiate and/or crack use, but there may be a paucity of research in this area.

It is clear from numbers of people, who identify as LGBTQ+, entering treatment that more work needs to be done to understand the needs and to engage more people, who identify as LGBTQ+, in support and treatment

Southampton Q4 2016/17 Sexuality (new treatment journey/ episode 1/4/16 - 31/5/17)			
	Southampton		National
Heterosexual	439/514	85.4%	84.8%
Gay/ Lesbian	6/514	1.2%	2.3%
Bi- Sexual	12/514	2.3%	1.3%
Person asked and does not know or is not sure	1/514	0.2%	0.2%
Not stated	51/514	9.9%	6.9%
Other	5/514	1.0%	0.9%
Missing/ inconsistent	0/514	0%	3.5%
All clients entering treatment within the date parameters shown and sexuality as recorded at the start of their treatment journey.			

NDTMS Adult Activity Report Q4 2016/17

2.2.14 People concerned by someone else's use of drugs and alcohol

Members of the individual's social network (such as family and friends and concerned significant others) may have support needs of their own but may also be able to contribute to the treatment process. Supporting the needs of carers is now recognised as an essential component of delivering effective public health and social care services.⁸

⁴
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf

⁵
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324802/MSM_document.pdf

⁶
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713566/improving_health_and_wellbeing_LBWSW.pdf

⁷
<https://www.london.gov.uk/sites/default/files/The%20Health%20and%20Wellbeing%20of%20LGBT%20London%20FINAL.pdf>

⁸
<https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>

It is difficult to quantify the number of people affected by someone else’s use of drugs and or alcohol, anecdotally it is estimated that 75% of people accessing support for substance misuse disorders are maintaining contact with family.

2.2.15 Conclusion of local need

This report indicates that Southampton has higher need (larger prevalence rates) and similar or higher unmet need (people not accessing support or treatment) than the national average.

The needs of an aging population will require specific work to consider how best to meet their needs, particularly the cohort of older people with complex and entrenched use of alcohol.

Drug Related Deaths continue to cause concern, this is reflected as a priority of Southampton’s Drug Strategy and commissioned services will be a key contributor to this work. The costs associated with Alcohol Use Disorders to individuals, their families, friends and communities and the impact on Southampton as a whole use are significant.

Reducing alcohol-related harm is a priority of Southampton’s Alcohol Strategy and commissioned Substance Use Disorder services will be required to work with other stakeholders to reduce the burden.

Continuing to develop strong, joint working relationships, with Mental Health Services is key to addressing the needs of people with co-occurring conditions

Our services need to consider specific interventions to encourage more women to access treatment and support

There is clear evidence of unmet need when considering the impact of ‘parental’ substance misuse on the child.

3. Current Service Performance

This section considers the impact our services have in reducing the harm caused by individual’s use of drugs and or alcohol. Outcome data tends to focus on numbers of people exiting treatment in a positive way (successful completion). It is much harder to evidence the positive impact our services have in reducing harm.

3.1.1 Southampton is currently underperforming on successful completions and representation outcomes (NDTMS DOMES Q4 2016/17)

3.1.2 Public Health Outcome Framework (PHOF) 2.15 (Successful completions not representing in 6 months)

	Local (%)	Local (n)	National (%)	National (Top quartile for Comparator LAs)	Number to achieve Top Quartile
Opiate	6.3%	47/748	6.6%	7.21%-9.39%	54 - 70
Non Opiate	26.4%	67/226	37.1	42.5% - 57.61%	102 - 137
Alcohol	28.9%	38.3%	No data	No data	No data

3.1.3 Successful Completions

	Local (%)	Local (n)	National (Top quartile for Comparator LAs)	Number to achieve Top Quartile
Opiate	6.4%%	47/738	7.89% - 9.64%	59 to 71
Non Opiate	35.7%	43.37% - 62.18%	43.37% - 62.18%	49 to 69
Alcohol	34.1%	95 / 279	39.98%*	No Data
Alcohol and Non Opiate	27.3%	41 / 150	39.37% - 57.52%	60 to 86

*National Average

3.2 Waiting Times - Adults

The most recent data, that we are able to publish publically [DOMES Q42016/17 – NDTMS], indicates that Southampton’s Drug and Alcohol Recovery partnership performs well in terms of waiting times for individuals to engage with ‘first interventions’ with no incidence of people waiting longer than the target of 3 weeks wait for first interventions

Locally reported waiting times indicate that, in the most recent period with data available (Q4 2017/18) the times between comprehensive assessment and first prescribing appointment for all new referrals to Opiate Substitution Therapy (OST), in working days, were

- Shortest 0 working days
- Longest 6 working days
- Average 0.2 working days

3.3 Treatment Exits - Young people

Young Person’s NDTMS reports can split data for people aged 24 and under and people aged under 18.

Treatment exits (24 and under and under 18)

	Under 18		24 and under	
	Southampton	National	Southampton	National
Planned	68%	82%	51%	79%
Treatment Completed – drug free	14%	33%	13%	31%
Treatment Completed – occasional user	55%	49%	39%	48%

Young People’s Activity Report Q4 2016/17 (NDTMS)

3.4 Waiting Times (24 and under)

Our commissioned young people’s service consistently meets (100%) its 3 week target for first intervention following assessment compared to a national average of 98% (Young People’s Activity Report Q4 2016/17 (NDTMS))

3.5 Ethnicity

The census data from 2011 indicates that 77.7% of people (whole Southampton population/ all ages) identify themselves as White British of these, 70% of people, who are aged under 18 and accessing structured treatment, identify themselves as White British. For those aged 18 and over 83.4% who are accessing treatment identify themselves as White British

3.6 Conclusion of current service performance

Analysis of the data shows that fewer people leave our services in a planned way, drug free than the national average. Our current services are working hard to reduce the harm and facilitate recovery. More recent locally generated data indicates some significant improvements to most measures. Some further focus needs to be given to understanding the impact of substance use disorders on non-White British communities to ensure needs are met.

4. How support and treatment should be delivered

4.1 National Guidance

Commissioned services working with and within the Public Health function are required to deliver against outcomes as set out in the [Public Health Outcomes Framework](#) (PHOF). Public Health England have stated that an effective substance misuse treatment system supports the PHOF vision, “To improve and protect the nation’s health and wellbeing, and improve the health of the poorest fastest” and impacts directly on the wider PHOF outcomes.

National guidance will be used to underpin and inform future commissioning intentions, supported by local strategies, intelligence & performance. They will also shape and inform the services that are commissioned meaning

services will be delivered from an evidence based position using all available guidance and in doing so accepting and adopting relevant updates to existing guidance as well as new guidelines as and when issued.

This is a comprehensive, but not exhaustive, list of national guidance

Drugs

- Drug misuse and dependence: UK guidelines on clinical management. Department of Health. 2017
<https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>.
- Routes to Recovery, (Psychosocial Interventions in Substance Misuse) a framework and toolkit for implementing NICE recommended treatment interventions; NTA
http://www.nta.nhs.uk/uploads/psychosocial_toolkit_june10.pdf
- Medications in Recovery – Re-orientating Drug Dependence Treatment, NTA 2012
<http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf>
- NICE Guideline CG51: Drug Misuse – Psychosocial Interventions <https://www.nice.org.uk/guidance/cg51>
- Models of Care (2002) and Models of Care Update (2006):
http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf
- NICE Public Health Guidance PH52 (Needle and syringe programmes: providing people who inject drugs with injecting equipment), 2014 <http://guidance.nice.org.uk/PH52>
- NICE Guideline CG110: Pregnancy and Complex Social Factors
<http://guidance.nice.org.uk/CG110/NICEGuidance/pdf/English>
- NICE Guideline NG58: Coexisting severe mental illness and substance misuse: community health and social care services <https://www.nice.org.uk/guidance/ng58>
- Towards successful treatment completion: A good practice guide; NTA 2009
<http://www.nta.nhs.uk/uploads/completions0909.pdf>
- NTA Overdose and Naloxone training programme for families and carers
<http://www.nta.nhs.uk/uploads/naloxonereport2011.pdf>
- Take-home naloxone for opioid overdose in people who use drugs. Public Health England. 2017.
<http://www.nta.nhs.uk/uploads/phetake-homenaloxoneforopioidoverdoseaug2017.pdf>.
- NICE guideline [NG64] Published date: February 2017 - Drug misuse prevention: targeted interventions
<https://www.nice.org.uk/guidance/ng64>.
- Drug misuse in over 16s: opioid detoxification (Clinical guideline [CG52] Published date: July 2007)
<https://www.nice.org.uk/guidance/cg52>.
- Drug use disorders in adults (Quality standard [QS23] Published date: November 2012)
<https://www.nice.org.uk/guidance/qs23>.
- Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers. Public Health England. 2017
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

Alcohol

- Models of Care for Alcohol Misuse (MOCAM), Department of Health. 2006.
https://www.alcohollearningcentre.org.uk/assets/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf.
- Alcohol-use disorders: diagnosis and management (Quality standard [QS11] Published date: August 2011)
<https://www.nice.org.uk/guidance/qs1>.
- Alcohol use disorders: Diagnosis and clinical management of alcohol-related physical complications (Clinical Guidance 100) Updated April 2017. NICE <https://www.nice.org.uk/guidance/cg100>.
- Alcohol use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence. , (Clinical Guideline 115). 2011. NICE. <https://www.nice.org.uk/guidance/cg115>.

- Alcohol use disorders: Preventing harmful drinking (Public Health Guidance 24). 2010. NICE.
<https://www.nice.org.uk/guidance/ph24>

Young People

Practice standards for young people with substance misuse problems. The Royal College of Psychiatrists. 2012.

<http://www.rcpsych.ac.uk/pdf/Practice%20standards%20for%20young%20people%20with%20substance%20misuse%20problems.pdf>.

Harm Reduction

- NICE Clinical Guidance 52: Needle & Syringe Programmes. 2014 <http://guidance.nice.org.uk/PH52>
- NICE technical analysis 114 “Methadone and Buprenorphine for the Management of Opioid Dependence” 2007
<https://www.nice.org.uk/guidance/ta114/resources/methadone-and-buprenorphine-for-the-management-of-opioid-dependence-82598072878789>.
- Drug misuse prevention: targeted interventions. NICE guideline [NG64] Published date: February 2017
<https://www.nice.org.uk/guidance/ng64>
- Public Health England. Widening the availability of Naloxone. 2017.
<https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone>.

Carers

- AdFam A Partnership Approach: Supporting Families with Multiple Needs. 2011.
https://www.adfam.org.uk/files/docs/adfam_partnership_2011.pdf

4.2 The views of stakeholders

A range of surveys have been conducted to seek the views of people who use drugs, people who engage in treatment and support, people who deliver that support and other stakeholders. This is a brief overview of what we learnt. The full reports from each of these surveys are available on request.

4.2.1 People who use our services - ADULT

There were 72 responses with a significant proportion of the responses being very positive about the services they receive

- Where there were concerns the following issues were raised
 - Need for more staff time
 - Very positive response to group work and psychosocial provision
 - Identifying (with a few exceptions) empathetic/ effective and supportive workers
 - A number of service users identified limited access to workers could be improved with more resources/ funding
 - Waiting times, particularly for ‘restarts’ too lengthy
 - Confusion around what provider does what

4.2.3 People who use our services – young people (YP)

There were 20 responses, again with a significant proportion very positive about the services they receive

- Issues raised
 - Don’t like going to New Road Centre (NRC – Adult Services hub) for health interventions
 - Need for more space for private conversations
 - Reconsider scripting arrangements with more assessments and interventions being delivered away from NRC

4.2.4 People who engage with Needle Exchange (NEx)

There were no responses from Pharmacy NEX.

22 responses from hostel or day service settings were received which were all positive about NRC NEX

- Issues raised
 - Desire/ need for more flexible, expanded, offer with more opportunities in the community, including mobile outreach
 - Response to question re Drug Related Litter (DRL) was uniformly a request for more community provision of sharps bins
 - Respondents also indicated the need to consider direct intervention with those it is able to identify who are unwilling or unable
 - Some negative comments re staff availability
 - all who mentioned this indicated this was a resource issue not a staff one

4.2.5 Staff

- A staff representatives group was formed and has provided the following thoughts and opinions
 - Current model can feel disjointed
 - Improved psycho social interventions are beneficial
 - Data management is over burdensome
 - Communication re serious incidents to frontline staff is not always good
 - Group delivery should be time limited
 - YP should have interventions delivered separately from adults
 - Differing views about the age services should move into adult setting (from age 18 or 25)
 - Alcohol work is specialised and should have a specific team
 - Harm reduction/ NEX work is specialised and should have a specific team
 - DRR/ Criminal Justice work is specialised and should have a specific team
 - Placement of MH worker in team would be very beneficial

4.2.6 Stakeholders

- 12 responses
 - Generally positive
 - Strong stakeholder relationships
 - Some confusion about multiple provider model
 - Need for more joined up working with Mental health Services
 - Need for flexible services for older people
 - Need for better local detoxification provision
 - Need to drug in reach to hospital
 - Contacting services can prove difficult

4.2.7 Primary Care

- Issues raised
 - The feedback was generally positive about current services and service model and recent improvements in the last 12 months were noted.
 - But feedback was mixed. Some said that services are responsive. Others said there was insufficient capacity – waiting times and insufficient support for clients - and not enough feedback from specialist services to primary care.
 - Dual diagnosis and community detox were noted as unmet needs.
 - Shared care was cited positively. Some respondents asked for more primary care providers to be able to offer the LCS services, including for all pharmacies to be able to offer supervised consumption.

4.2.8 Carers

- 16 responses received from people engaging with Parent Support Link
 - Most responses included positive reflections around provision of services to their family member/ friend
 - Services are accessible (5)
 - Services are effective (9)
 - A number of concerns were raised when asked 'what doesn't work so well?'
 - Open access area can be chaotic/ intimidating (6)
 - Staff can be unhelpful (3)
 - Poor family involvement/ communication (6)
 - Not enough staff/ resources (4)
 - Rehab is difficult to access (3)
 - 'Unfriendly staff'

4.3 Other recent pieces of work (adult and YP)

4.3.1 Street Based Vulnerable Adult Review (SBVAR)

Southampton City Council and Clinical Governance Group's Integrated Commissioning Unit (ICU) recently conducted a review to

- Gain an understanding of issues that compound and increase the current rise of street based vulnerable adults, often noticeable through increased levels of street begging and homelessness.
- Explore evidence based/best practice options to reduce the prevalence of street based vulnerable adults leading to street begging and homelessness
- Inform commissioning intentions for homelessness, substance misuse and other related areas.
- As part of this review 41 people, experiencing homelessness and/or engaging in begging behaviours were surveyed. The findings from this survey included
- 74% (20) of the 27 people who said they were 'rough sleeping' reported alcohol use or dependence and/or drug use or dependence.
- 13 of this 27 reported a substance use problem were already known to the local service.
 - An additional 3 had engaged previously.
- Of the 26 people who were engaging in begging behaviours 92% (24) reported alcohol use or dependence and/or drug use or dependence
 - 22 stating they used the funds raised to acquire drugs and or alcohol, although 14 said they also used the funds for other things including food, accommodation, bills, debts and phone credit.
- 15 were known to substance misuse services
 - 4 had engaged with substance misuse services previously
 - 5 were 'not known to substance misuse services'.
- In narrative responses a significant number of people recognised that drugs and alcohol were negatively affecting their life chances
- A small proportion identified that they found it difficult to engage with support
- SBVAR Recommendations
- **To continue to do what we do well.** We must not lose sight of the current levels of support and work within Southampton helping those who find themselves homeless, or on the brink of homelessness.
- **To engage people with complex needs better.** We need to look at options to address issues around complexity and in doing so
 - Recognise the role substance misuse services will have during the initial points of contact.
 - Improve existing and new pathways
 - Provide a responsive mechanism (e.g. Collaborative Assessment panel) for people with complex needs
 - Ensure staff training provides a good understanding around supporting individuals with mental ill health

- **To investigate further new models of support and their potential in Southampton.**
 - Coordinate and promote local support services
 - Explore the use of housing first and alternative housing models (e.g. containers)
- **To target information to young people who experience adverse childhood experiences to prevent future homelessness**
 - Incorporate awareness and targeted support in new relevant tenders (e.g. counselling in schools, Safe House & Team House, a new peer support model and CAMHS transformation project)
 - Build on current work at No limits, engaging with Homeless young people, joint working with HVASt, specialist crisis worker providing harm reduction and brief interventions and enabling pathway into treatment, as well as access to health, sexual health services and basic needs such as shower, laundry. Also undertaking risk assessments and supporting young people affected by exploitation.
- **Coordinate enforcement with support.**
- **Sign up to a local charter for homeless individuals.**

Conclusion

Recommendations from this report highlight the need, for services commencing support and treatment in 2019, to work with services for people experiencing homelessness to improve pathways and joint working.

4.3.2 Learning from the Homeless Vulnerable Adult Support Team

SCC were awarded £398 000 from the Department of Communities and Local Government (DCLG) 'Rough Sleepers Grant' to tackle the complex, multiple factors that can drive treatment resistant drinkers and/or illicit drug users toward a life of entrenched rough sleeping, utilising Alcohol Concern's 'Blue Light Principles'. Based in Southampton's Homeless Day Centre, the Homeless Vulnerable Adult Support Team (H-VAST), delivered by Two Saints Ltd, commenced support in April 2017.

Although only half way through this Department of Communities and Local Government funded project, significant, positive outcomes are already being delivered.

The role of services, for people concerned by their use of drugs and/or alcohol, working innovatively and flexibly with bespoke interventions based on 'Blue Light' (Alcohol Concern) principles has been fundamental to the initial success of this project. Any future service will be informed by the learning delivered by this project.

4.3.3 SCC Scrutiny Enquiry into Drug Related Litter (DRL)

SCC recently conducted a scrutiny enquiry into DRL to understand the reasons for the prevalence and impact of drug related litter in Southampton, to review progress being made in Southampton to tackle drug related litter and to scope what more could be done.

This enquiry concluded that whilst the prevalence of this problem is not as pervasive as some other areas the incidence of this type of activity still has an impact on individuals and communities and presents a potential health risk, particularly to the people who inject drugs and those working with people who inject drugs and clean-up drug litter. The enquiry acknowledged the good work is already being delivered.

The enquiry recommendations included that consideration should be given to the provision of Needle exchange (NEx) services, in particular to ensure the best possible provision is delivered within the resources available.

In addition to the considerations given to the provision of NEx, the enquiry also recommended consideration of the provision of sharps bins, a robust evaluation to fully assess the potential benefits a medically-supervised pilot drug consumption room could bring to Southampton and a need to assess the possible benefits, to Southampton, of including Heroin Assisted Therapy (HAT) and/ or injectable methadone as part of our provision of services for people with Substance Use Disorders

4.4 Other considerations

Homelessness, UHS and Behaviour Change

During the early stages of the review and redesign, three themes emerged

- Substance misuse and homelessness and exploring the option of merging some or all of homeless & substance misuse contracts.
- The possible configurations of both community substance misuse services with hospital based alcohol services.
- Substance misuse and behaviour change approach, again exploring the option of merging some or all of the behaviour change & substance misuse contracts

To take a first look at these emerging themes a small focus group was held involving key staff within the ICU (Associate director, 2 senior commissioners and the service development officer working on the review and redesign). The following outlines the key discussion points and proposals.

4.4.1 Substance Misuse and Homelessness

Driver

The concept of merging homeless and substance misuse contracts originated from the Leader of the Council learning about changes in other local authority areas and exploring the potential to amalgamate a range of voluntary sector funded by the Council.

Considerations

- Since the initial idea was raised, there has been an increased understanding and awareness about the complexity within both service areas and limited overlap between the two services.
- There is a high number of homeless who have a substance misuse disorder, but not all homeless are using substances.
- The numbers in substance misuse service who are homeless or living in unstable accommodation is low (snapshot shows 87 individuals out of a caseload of circa 700).
- There may be an argument for a stronger (contractual) relationship between the alcohol accommodation and the substance misuse service.
- A number of options were explored
 - Improving the level of integration between service areas for example homeless workforce being able to respond better to substance misuse issues, and substance misuse staff have greater understanding and skills regarding accommodation issues
 - Partial merging of service areas. For example some of the homeless services (assessment centre) within substance misuse services or moving some of the substance misuse service within the homeless contracts.
 - Full integration of services whether homeless contracts merged with substance misuse or vice versa.
- A single workforce working with those who are homeless and have a substance misuse disorder has resulted in positive benefits for the service in Portsmouth (one case holder addressing and supporting the individual on multiple issues, albeit not specialist areas of substance misuse)
- There are equal, if not greater challenges in the pathways and joint working with mental health services for both substance misuse and homeless services. Concerns this could get worse if homelessness and substance misuse services were combined.
- Two large service areas should not be designed around a smaller element of the services.
- If combined, there would need to be a lot of clarity and detail in the service specification.
- No evidence base for merging these service areas. While not a reason, it was recognised there is existing fragility in the current substance misuse services. There should be greater certainty before a new approach is tested.
- The overall performance of substance misuse is poor. There is scope to source more data specific to those who are homeless or in unstable accommodation. This could include information from the Street Based Vulnerable Adult work and H-VAST (Homeless Vulnerable Adult Support Team), identify how pathways could make things better. These could be added as KPI's to contracts.

- Any significant change would require formal consultation. This would result in a further request to extend the current contracts. This is likely to be met with a challenge from legal services.
- More capacity is needed to work with the group of individuals with more complex needs (substance misuse, homeless and no recourse to public funds (NRPF)).

Recommendations

Future commissioned services will aim to address the following recommendations. Any recommendations that are 'out of the scope' of commissioned services will be considered in the broader work of Southampton City Council's Public Health and Integrated Commissioning Unit

To improve the level of integration between service areas and in doing so consider:

- Critical look at contracts and ensure there are requirements around improved integrated working between service areas.
- Improved integrated working between services areas is reflected in robust KPI's, including evidence of improved pathways.
- Pursue a more dedicated resource, located within homeless healthcare to work with the cohort of homeless individuals who also have substance misuse disorder.

4.4.2 Reconfigure community substance misuse services & hospital based alcohol services.

Driver

Historically the hospital based alcohol service has been developed in isolation from the wider substance misuse contracts. A question raised during discussions challenged whether this should change. Two distinct areas were discussed; detox and in-reach services.

Considerations

- Since the closure of Portsmouth based detox, individuals are required to travel to Poole to access a more specialist detox. The use of the local hospital in Southampton could be easier for most clients needing specialist detox.
- Current working between community and hospital based services is improving, but has taken time to establish. A change of provider in the future, without change in service configuration set back the current working relationships. The use of honorary contracts has helped.
- Locating in-reach staff within a larger team (e.g. community) allows for more flexibility to cover work requirements.
- Psychiatric liaison teams elsewhere are quite large. Initially appeared Southampton was a smaller team, but the sum of all service areas actually resulted in a comparable resource. Ensuring all service areas sit under one structure and seen as one team could address this issue.
- Merging of services within one contract may result in savings.
- There are 3 detox options locally
 1. Those engaging in community who need detox find a detox provider, usually rehab or other settings. For complex problems they usually go to Poole at a cost of £2800 per client.
 2. Those who present to hospital settings for other reasons (leg break, operation), and identified as needing a detox, are commenced on relevant medication for withdrawals. Usually UHS charge for these as a complex case, attracting a higher tariff. There is no guarantee the detox will be completed - once injury sorted, or presenting issue is sorted - they are discharged.
 3. Home detox - small provision of community detox. Engaged in Sub M service (6 per month est.)

Ideally these three options would be linked up, particularly at the point of discharge from hospital to home detox. However, this isn't happening.
- Other areas have shown that an ambulatory detox in the local hospital for those discharged from hospital have a higher rate of engagement than those referred to community detox. Concerns about the cost of this service and the overlap with UHS charging extra for detox cases (as set out in point 2 above)

- Pathways out of hospital to community detox need to be improved.
- The community provider has a strong influence over who gets in to what detox.
- Any additional detox capacity in UHS would need to be contracted separately and ensure issues of double payment and market rates are addressed.

Recommendation

Future commissioned services will aim to address the following recommendations. Any recommendations that are 'out of the scope' of commissioned services will be considered in the broader work of Southampton City Council's Public Health and Integrated Commissioning Unit

To retain a degree of separation between the hospital and community based substance misuse services and in doing so

- Review and improve pathways from hospital treatment into community detox
- Invite UHS to present business case for ambulatory detox, with clear evidence financial benefits greater than investment.
- Explore the use of local hospital setting for specialist detox provision at comparable market rates.

4.4.3 Substance misuse and behaviour change

Driver

Elements within the behaviour change service overlaps with substance misuse services, notably alcohol and possibly smoking cessation. This raised a query whether there was potential to merge some of the behaviour change contract with the substance misuse service. The focus could only be on specific elements; alcohol and smoking cessation so could never be a full integration of behaviour change (which includes weight management, physical activity, mini health checks and other activities) with substance misuse.

IAPT and behaviour change would require a separate discussion.

Considerations

- There could be opportunities for substance misuse staff to link into other services and upskill their workforce around alcohol and smoking.
- Work has been undertaken in recent years to establish a strong early intervention and prevention approach. Putting the alcohol and smoking elements into the substance misuse contract detracts from this.
- Previous discussions looking at moving some resources from substance misuse budgets to community navigation was not pursued because of the importance attached to the early intervention and prevention agenda.
- Current timescales are not aligned; with behaviour change running to 2020 (substance misuse runs July 2019).
- The CCG, ICU and Public Health are exploring how smoking cessation can be delivered across all commissioned providers
- Public Health keen to keep a community offer smoking cessation as there is no strong evidence and it isn't a national driver to move smoking cessation services into substance misuse services.
- The Public Health grant ends in March 2020. If future funding arrangements offer less funding, then the behaviour change offer might need to change. The evidence base is less clear for some behaviour change activities than for substance misuse treatment and harm minimisation. Many areas across the country already offer less behaviour change support than Southampton.
- Current services have a history of providing alcohol brief interventions. Since this has been transferred into mainstream services it has diluted the focus. Currently brief interventions are provided by phone by 2 whole time equivalent staff members. This could be expanded or they could train up other staff.
- Providers should be delivering behaviour change within their service delivery model. Smoking cessation is important to reduce drug-related deaths, reduce deaths attributable to smoking, increase social inclusion and support people in their recovery from substance misuse difficulties. Emerging evidence shows it is harder to be abstinent from drugs or alcohol if you continue to smoke.
- It could be possible for some funding to move to substance misuse to pick up some brief intervention at broader scale.

Recommendations

Future commissioned services will aim to address the following recommendations. Any recommendations that are 'out of the scope' of commissioned services will be considered in the broader work of Southampton City Council's Public Health and Integrated Commissioning Unit

To ensure the current and future substance misuse services incorporate brief interventions around smoking cessation into service delivery model for both service users and staff. Ideally future services will also support their service users in 'quit attempts' directly too.

For future services to continue to provide a range of alcohol support and for them additionally to be local experts, and possibly trainers, in brief interventions for alcohol.

There was no support to bring elements of the current commissioned behaviour change service within the substance misuse contract.

4.5 Finance

Overview

SCC currently, directly commissions three providers, under five different contracts

Adult contracts <ul style="list-style-type: none">Adult Care Coordination and Health Interventions (ARM)Adult Tier 1 & 2 Alcohol Service (Southampton Brief Advice and Counselling Service – SABICS)Adult Psychosocial Interventions Service)	£2,226,022	Includes support for carers and advocacy services Provides young people clinical interventions
Young people contracts <ul style="list-style-type: none">Young Peoples Service (DASH) provided by No LimitsDASH Structured Interventions Service	£541,568	

NB – The Public Health Grant will be withdrawn from April 2020. There is no information currently as to where funding for services will be drawn from although commitment from SCC to fulfil the life of the contract.

NB – Office of the Police and Crime Commissioner (OPCC) grant is subject, currently, to an annual review and application process.

These contracts share two additional budgets

Budget Name	Purpose	Value (2018/19)
Care Management Budget	Residential Rehabilitation	£151 800
Purchased Services Budget	Detoxification, externally provided 'Day Rehab' and other groups and interventions not directly commissioned based on need of service users	£177,800

In addition Southampton Clinical Commissioning Group (CCG) are currently funding 2 x WTE equivalent posts

- 1 x WTE In Reach Worker – SSJ - £35 000
- 1 X WTE Hospital/ Alcohol Care Coordinator – CGL - £35 000

In addition SCC provide 1.5 WTE seconded Social workers – CGL - £55 700

In addition SCC funds a MASH navigator post - CGL

Current Staffing Levels

Service	Staff WTE		
No Limits	Non Clinical	11	
CGL (incl CCG Funded Care coordinator and 1.5 WTE seconded social workers and separately funded MASH Navigator)	Data/ Admin	3.6	30.7
	Clinical	6.2	
	Non Clinical	20.9	
SSJ (incl CCG funded 1 x WTE In Reach worker)	Non Clinical	9.55	
TOTAL	Total YP		11
	Total Adult		41.25
	Total		52.25

Other financial considerations

Care Management Budget (CMB)

Currently only to be used to fund residential rehabilitation. This budget was subject to a significant reduction this year and is currently under some strain. Further conversations, already in train, need to be had with the Care Management Budget holder to consider the best use of this budget including the consideration of the provision of Day Rehab, perhaps combining elements of CMB and purchased service budget to fund

OPCC funding

OPCC funding is awarded annually and contributes to the adult contracts. There is a need to engage with OPCC to secure longer term commitment of funding to meet need

CCG funding

CCG have committed £35k per annum through the life of the contract to support a reduction in hospital admissions. Further discussion with CCG should explore any additional funding opportunities

5. Buildings

Services for people concerned by their use of drugs and alcohol are delivered from a city centre hub that is comprised of three buildings. Commissioned services rent these 3 buildings from private landlords. The three different buildings have three separate tenancies that are due to end in the near future. Current providers have previously raised concerns that the current buildings are limited in their suitability. Historically, providers have found acquiring permission to deliver services from new buildings difficult

6. The Model for specialist services for people concerned by their or someone else's use of drugs and/ or alcohol' 2019

It is our intention to commission services that have harm reduction as the principle aim and 'recovery' as a desirable and achievable outcome.

In Southampton, recovery is defined as

Voluntarily - sustained control over problematic substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.

Services will be tasked with improving successful completions, reducing representations whilst maintaining robust and effective harm reduction interventions to reduce drug related deaths, the incidence of blood borne virus infections and the broader harms to individuals, their friends, families and communities

Services will be expected to work proactively, flexibly and collaboratively with stakeholders to increase engagement and improve outcomes of those impacted by substance use disorders

Futures services are expected to provide a comparable service offer to our current provision albeit with some, variation in the way the service model is configured.

SCC will seek to commission services that provide support and interventions that engage with people over the life course.

There is no intention, currently to separate alcohol from drug services. However it is an intention to work with providers to consider how better to 'present' alcohol services to the population with consideration to be given to deliver a distinct route of entry into support and some separation of interventions for people with alcohol use disorder, some of whom have, historically, been reluctant to approach integrated services.

All services will work with people with the following problematic substance use:

- Alcohol
- Opiates and crack cocaine and other illegal substances
- Prescribed medication that is being used problematically
- Prescription medication that is being used illicitly
- Performance and Image Enhancing Drugs
 - Interventions to reduce harm including needle exchange
 - Interventions to address any other, identified, drug use

Services will be delivered in the following way

- Services will continue to be open access.
- Shared care, needle exchange and supervised consumption will continue to be provided in primary care through different contracts.
- Services will be required to work with and within the criminal justice setting
- Services will be required to engage with safeguarding adult and children processes
- Services will contribute in local and national drug and alcohol campaigns and will champion the needs of people with drug and alcohol concerns at every opportunity and will work to reduce the stigma and promote their needs.
- Services will be delivered using principles as set out in the Department of Health's Drug misuse and dependence UK guidelines on clinical management.
- The core of our treatment system will be the building of good therapeutic alliances between staff and people engaging in treatment and support.

Therapeutic alliance

A good therapeutic alliance is crucial to the delivery of any treatment intervention, medical or psychosocial. When a stronger helping relationship is established, service users are more likely to complete treatment, actively explore problems, experience less distress and a more pleasant mood, abstain from alcohol and drugs during treatment, and achieve better long-term substance use outcomes⁹.

⁹ Drug misuse and dependence: UK guidelines on clinical management [DOH:2017]

5.1 How services will be structured

It is our intention to procure services in two lots with the possibility of one provider bidding for both Lots 1 and 2.

- Lot 1: **Young person service** (24 years of age and under)
- Lot 2: **Adult service** (25 years of age and over) including carer support
- Lot 3: **Advocacy** (18 years and over)

It is our intention to ensure the provision of Independent advocacy for people engaging with services for people concerned by their own or someone else's use of drugs and/ or alcohol.

It is our intention, subject to approval, for these new services to be procured to commence on the 1st of July 2019 for a maximum period of 7 years (5 years with a possible extension of 2 years)

The following services will continue to be sourced through partners or other commissioning routes

- Shared care, Pharmacy needle exchange and Pharmacy based supervised consumption
- Hepatology nurse
- Social workers
- MASH worker
- Alcohol team within UHS
- YP Worker in Youth Offending Service (YOS)

APPENDIX / Further Reading

1. [Human and financial cost of drug addiction: House of Commons Debate Pack Nov 2017](#) Link

2. **YP Substance Misuse Commissioning Guidance (PHE)**



Young_people_sub
stance_misuse_comr

3. **Drugs Health Needs Assessment: Southampton City Council (2017)**



Drugs needs
assessment CMT bri

4. [Our Invisible Addicts - RCP](#) Link

5. [SCC. Drug Related Litter Report](#) Link

6. **Street Based Vulnerable Adult Report**



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