THE JOINT COMMISSIONING BOARD

Agenda Item 21
Brighton & Hove City Council

Subject:		**Re-tendering and Reconfiguration of Substance Misuse Services**		
Date of Meeting:		**Monday 15th September 2008**		
Report of:		**Terry Baker**		
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Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Board is asked to note that Sussex Partnership NHS Trust were served notice in March 2008 for the provision of community substance misuse services following the Drug and Alcohol Action Team (DAAT) Joint Commissioning Group decision to market test this service.

1.2 The National Treatment Agency for Substance Misuse produced updated guidance for substance misuse treatment systems in 2006 (Models of Care Update 2006), placing greater emphasis upon securing effective treatment journeys for substance misusers which include all aspects of treatment available through a single process, rather than treatment systems which require service users to attend different services for each aspect of drug treatment. This service framework requires the roles of care co-ordinator and keyworker to be merged and resourced sufficiently to allow for the effective development and delivery of all aspects of an individual's care plan.

1.3 The National Institute for Health and Clinical Excellence (NICE) produced guidance for prescribing and psychosocial treatment for drug misusers in July 2007, based upon a robust analysis of the evidence base for the effectiveness of a range of treatment options. The following interventions are supported:

- Substitute prescribing of methadone or buprenorphine for maintenance or abstinence based forms of treatment for opiate dependent people.
- Individualised care through an effective Keyworker system.
- The introduction of contingency management. This involves rewarding the service user for providing illicit drug free tests, or to complete healthcare objectives (e.g. Hepatitis B vaccination course).
- Cognitive Behavioural Therapy to treat anxiety or depression, but not to treat substance misuse problems specifically.
- The introduction of Behavioural Couples Therapy, where the partner of the substance misuser does not use substances problematically.
- Referral to self-help groups to support and sustain treatment gains.

- Support for families and carers of drug misusers, through brief interventions or up to five sessions of more intensive family support.

1.4 The Board is asked to note and approve recommendations for the re-configuration of drug treatment provision.

2. RECOMMENDATIONS:

The majority of investment in drug treatment services is derived from the Drug and Alcohol Action Team (DAAT) pooled treatment budget. The Board is asked to note that these recommendations are subject to DAAT joint commissioning group approval.

2.1 It is recommended that the Board approve the tendering of clinical aspects of drug treatment in line with NICE guidance.

2.2 It is recommended the Board approve that the City Council work with the new provider and the Primary Care Trust post tender award to agree the best model of working, for those activities currently delivered by staff seconded from the local authority to Sussex Partnership NHS Trust.

2.3 It is recommended that the Board approve the introduction of contingency management schemes within drug treatment to promote abstinence from illicit drugs and improve outcomes for health based interventions. It is recommended that the DAAT JCG, DAAT Chair and the JCB approve the precise detail of any voucher or other individual incentive scheme before it is introduced, after the contract has been awarded.

2.4 It is recommended that the Board approve the re-profiling of community based voluntary structured day care provision from voluntary sector providers, with the exception of Drug Rehabilitation Requirement programmes and the programme for substance misusing parents of children at risk. Providers delivering other group based interventions will ensure that existing care planned commitments are fulfilled, before re-profiling is completed. Commissioners will support the development of self help groups, should current levels of provision prove inadequate.

2.5 It is recommended that the Board approve the re-profiling of existing voluntary sector provision (CRI and Brighton Oasis Project) from structured day care and counselling to increased Keywork capacity (5.3 whole time equivalent staff providing100 places), family support (one whole time equivalent), and cognitive behavioural interventions to treat depression and anxiety (30 places). Services delivered by voluntary sector providers were tendered in 2005 and new contracts established in April 2006. Further market testing of these services is not therefore required at this stage.

2.6 It is recommended that the Board approve sustaining group based approaches within residential drug treatment services.

2.7 It is recommended that an analysis of need and potential uptake of Behavioural Couples Therapy is undertaken from April 2009, with a view to introducing this component subsequently, as this is yet to be introduced to the UK.

2.8 It is recommended that the Board approve, in line with NICE guidance, cessation of group based psycho-educational approaches to harm reduction, such as the group based hepatitis training provided by MIND. Individualised approaches should be developed within services, in particular homelessness services, pharmacies and drug treatment services to replace these.

2.9 It is recommended that the Board approve that the contract for substance misuse treatment be let with treatment for alcohol dependency as a component part. Existing alcohol treatment provision carried into this contract alongside additional PCT investment, but that a separate contract is let for a new alcohol brief interventions service.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 July 2006: The National Treatment Agency publishes "Models of Care Update 2006", which emphasises the role of the Keyworker in guiding service users through a treatment journey, which includes engagement, delivery and community reintegration phases.

3.2 July 2007: The National Institute for Health and Clinical Excellence publish guidance for treatment of drug misuse.

3.3 September 2007: The Department of Health publish updated clinical guidelines for the treatment of substance misuse, incorporating the recommendations from Models of Care and NICE guidance.

3.4 December 2008: The Commissioning Manager for Substance Misuse briefs Drug and Alcohol Action Team partners on the implications of NICE guidance.

3.5 February 2008 to June 2008: The Commissioning Manager leads a stakeholder consultation group to draft a revised care pathway for drug treatment, describing greater efficiency through the use of a single keyworker approach.

3.6 March 2008: The DAAT Joint Commissioning Group agree that clinical community based drug treatment services should be market tested.

3.7 March 2008: The DAAT JCG agrees that day programmes delivered as part of Drug Rehabilitation Requirements should be maintained in line with existing legislation.

3.8 April 2008: The PCT commission MIND to produce user led recommendations for drug treatment and comment upon the implementation of national guidance.

3.9 June 2008: Substance misuse and Children and Young People's Trust stakeholders confirm that day care elements of the successful programme for substance misusing parents of children at risk should be retained.

3.10 July to August 2008: The Commissioning Manager develops the service specification for drug misuse in line with care pathway re-design.

3.11 July 2008: CRI and Brighton Oasis Project submit proposals for re-profiling of day care staff and volunteers to deliver aspects of Keywork, family support and cognitive behavioural therapies to treat depression and anxiety for those with drug dependency.

4. CONSULTATION

4.1 Consultation with DAAT partners

Issue:	Concern that the introduction of contingency management would create adverse publicity.
Response:	Recommendations to use voucher based rather than cash based incentives. Communications leads and Chief Officers should be briefed in advance of the introduction of contingency management. This initiative should be appraised of the outcome of the current NTA pilot.

4.2 Consultation with Criminal Justice Partners

Issue:	Concern that all day programmes would be decommissioned, leaving Drug Rehabilitation Requirements (DRR) undeliverable.
Response:	Day programmes which form part of DRR should be retained until such time as NICE and Home Office guidance is harmonised.

4.3 Consultation with CYPT

Issue:	Concern that day programmes for parents who are substance misusers would be decommissioned.
Response:	POCAR day programmes should be sustained in the medium term, while greater evidence of effectiveness is established.

4.4 Consultation with service users

Issue:	Support for contingency management and single Keyworker but concern about withdrawal of group based programmes and restriction in choice.
Response:	Maintain group based programmes in DRR, POCAR and Residential options. Re-assurance that stepped model of care does not restrict choice.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

The existing PCT and Council investments in community substance misuse services, currently delivered by Sussex Partnership NHS Trust, will be made available from April 2009 for the appointed provider. The financial envelope for these services will be subject to normal budget setting protocols and will be expected to be contained within relevant inflationary and other uplifts.

Finance officer consulted: Nigel Manvell

5.2 Legal Implications:

The contracts referred to in this report are 'Part B' services for the purpose of EU procurement law and UK procurement Regulations, and therefore not subject to the full application of either. The Council is nevertheless required to comply with EU Treaty objectives of non-discrimination and openness in procurement, as well as comply with its obligation to seek Value for Money. The Council must take the Human Rights Act into account in respect of its actions but it is not considered that any individual's Human Rights Act rights would be adversely affected by the recommendations in this report.

Lawyer Consulted. Sonia Likhari, Contracts Lawyer

5.3 Equalities Implications:

Service specifications and tender evaluation criteria have been developed to ensure equalities requirements will be met. Improving access for women, LGBT and BME

groups are currently being developed through system-wide actions plans and will be included within the specification, where appropriate.

5.4 Sustainability Implications:

None. Tender evaluation will test sustainability.

5.5 Crime & Disorder Implications:

None. Criminal justice programmes will be maintained. Vouchers offered as part of contingency management will be of low individual value, so are unlikely to be misused.

5.6 Risk and Opportunity Management Implications:

Should the partnership fail to run the tendering process in time, or is unable to appoint a provider, the PCT will negotiate a contract extension with Sussex Partnership NHS Trust.

5.7 Corporate / Citywide Implications:

Aligning drug treatment to evidence based practice should promote the effectiveness of drug treatment in the city. Competitive tendering will enable the best value solution to drug treatment to be implemented.

SUPPORTING DOCUMENTATION

Appendices:

1. Summary of National Treatment Agency “Models of Care” and NICE drug misuse psychosocial interventions guidance

Documents In Members’ Rooms: None

Background Documents: None

Appendix 1

1. Summary of National Treatment Agency "Models of Care 2006"

Models of Care: Update 2006 calls for a greater focus on service users' journeys and "flow" through drug treatment systems, and improvement in delivery of effective pathways of care. This will require improved strategic partnerships between health and criminal justice, as well as improved partnerships with those responsible for housing, education and employment services. Access to such mainstream provision is vital for drug misusers in treatment, to maximise treatment gains and prevent relapse into illegal drug misuse.

Drug treatment is not an event, but a process usually involving engagement with different drug treatment services, perhaps over many years. Each client's drug treatment journey is different and depends on a range of factors including health status, relationships, nature of the drug problem and the quality of the drug treatment they receive. However, drug treatment use is often episodic, with service users dipping in and out of treatment over time. Evidence from the US suggests that an average time in treatment for someone with a heroin or crack dependence problem is five to seven years, with some heroin users requiring indefinite maintenance on substitute opioids. Evidence also tells us that service users gain cumulative benefit from a series of treatment episodes. However, the biggest improvements in client outcomes are likely to be made in the first six years of treatment.

The treatment journey is conceptualised into four overlapping components, each with key objectives. These components comprise:

- Treatment engagement
- Treatment delivery (including maintenance)
- Community integration (which underpins both delivery and treatment maintenance or completion)
- Treatment completion (for all those who chose to be drug-free and who can benefit).

Although it will be useful to see these phases of the treatment journey as conceptually separate, there is room for considerable overlap. It is important to note that the phases do not mean that treatment is a linear journey, with service users progressing through the three main phases of engagement, delivery and completion. Instead, these are the main elements of a treatment journey which may occur in a variety of combinations during a client's time in treatment. Considering these phases can be particularly helpful in informing the focus of care plans at different stages and in maintaining a focus on the treatment journey.

Treatment engagement

The treatment system needs to be able to engage people rapidly and retain them once they have entered treatment. Two issues important to improving treatment engagement are timely access to treatment and a focus on supporting retention for at least three months in structured treatment for adults with dependent drug misuse. Each drug treatment system will be assessed on its ability to engage service users on these two issues, through performance management on national waiting times and retention targets by the NTA, as outlined in the Government's treatment effectiveness strategy. During the engagement phase of treatment, service users will need to be assessed to ensure treatment can be tailored to their needs and at this stage they may benefit from motivational work focused on maximising engagement. Particular consideration may need to be given to preventing disengagement of

certain drug users (e.g. those from some Black and minority ethnic groups, younger drug users and clients with mental health and substance misuse problems). The engagement of service users may be enhanced by a specific process of induction into treatment, so it is made clear and comprehensible for individuals what are the roles and responsibilities of the service provider and what are the expectations on service users themselves.
Following assessment, care plans will be agreed with the clients and structured treatment will begin. There also needs to be more explicit commissioning of interventions that engage service users and build "therapeutic alliances", which are crucial to treatment retention and positive changes in treatment. A range of interventions to support engagement could be explicitly commissioned, including brief interventions, services for the children of drug users, advocacy and support arrangements and interventions to contact, engage and follow up people (e.g. outreach for rough sleepers, motivational interventions).

Drug treatment delivery
Drug treatment providers need to deliver effective and evidence based drug treatment interventions, following completion of a care plan that has been agreed with the client. Drug treatment practitioners should work to build an effective therapeutic alliance with service users, encouraging full participation by them in delivering their own care plans. Good-quality drug treatment should be associated with improvement across a range of domains, including an individual's substance use, health, social functioning and in reduced public health and offending risks posed to others. In delivery of drug treatment, a greater emphasis is required on improving service users' physical and mental health, importantly for those with hepatitis C infection and for those misusing alcohol.
Increases in the use of cocaine and crack cocaine by service users may have a negative impact on client outcomes, unless this is addressed, particularly with injecting drug users.
The children, carers or significant others of service users should also be considered during care-planned treatment. The needs of the children of drug-misusing parents also require greater attention. During this phase, clients should begin to receive other interventions to meet their wider needs. These interventions could include improving housing status, getting other healthcare needs met by other health specialists (e.g. liver disease and dentistry), help with children and family issues, and provision of assistance to enable service user back to work or education. These nondrug treatment interventions should be set out in the client's care plan and links made with appropriate services to ensure the client receives them. This includes the initiation of elements of community integration.
To ensure that the delivery of drug treatment meets the client's needs in a timely way, local treatment systems must ensure continuity of care between the criminal justice system and drug treatment. This is particularly relevant for clients entering and leaving prison.
Clients who are on long-term maintenance (ideally in shared care) should be considered to be continuing in the delivery phase of treatment.

Improving community integration
Whether service users are in treatment (e.g. maintained on substitute opiate medication) or leaving treatment they should have access for social support (e.g. housing support, educational support, employment opportunities) to maximise positive gains they have made in treatment. Service users who are stable but who wish to be maintained on substitute opioid medication should have opportunities to receive social support, education and employment where appropriate.
For stable individuals who do not need to continue in specialised drug treatment services, there should be clear pathways into maintenance and monitoring in primary care settings with ongoing community integration interventions and support.

However, it is vital that such service users have explicit accessible pathways back into specialised structured drug treatment services if needed (e.g. in case of relapse). DAT partnerships should consider linking their drug treatment targets to wider mainstream targets, that relate to housing, education and employment for drug users.

Improving treatment completion

Few service users who enter drug treatment intend to be in specialist drug treatment indefinitely. For those who wish to be drug-free, commissioners and providers need to create better pathways and exits from specialist drug treatment. These pathways should include drug-related and non-drug related support. Drug treatment providers and commissioners are responsible for the drug-related support, and should form the necessary local strategic links to enable clients to access non drug-related support, including improved social support, housing, education and employment opportunities to maximise treatment gains.

This approach will require treatment systems to be configured both to create effective exit routes out of specialised drug treatment, including efficient access to Tier 4 provision for those who wish to be drug-free, and to be well integrated with primary care and other systems of support and care for those in maintenance treatment. Drug-related aftercare support, such as support groups or individualised sessions or alternatively from mutual aid groups run by Narcotics Anonymous or non-12-Step equivalent groups, has been demonstrated to sustain abstinence.

Improving community integration and treatment completion may require some drug treatment system or service redesign, including:

- As well as planning for numbers in treatment and numbers of clients retained in treatment, commissioners should plan for numbers of planned client exits from treatment
- Investing in quality drug treatment delivery to maximise gains and service users' improvement in treatment (whether achieving stability on maintenance treatment or achieving effective abstinence)
- Enhancing routes to treatment completion or, for stable patients who no longer need specialist care, better routes to community maintenance in primary care settings
- Commissioning a range of aftercare provision for service users to follow structured treatment, as a development of Tier 2 interventions, and ensuring a range of other support mechanisms for ex-service users (e.g. drug-free support such as Narcotics Anonymous or equivalents)
- Investing in strategic partnerships with housing, education and employment, together with bespoke initiatives for drug misusers aimed at reintegration.

2. Summary of NICE drug misuse psychosocial interventions guidance

2.1 Person-centred care

Treatment and care should take into account service users' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow service users to reach informed decisions about their care. If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

2.2 Supporting families and carers

● Discuss with families and carers the impact of drug misuse on themselves and other family members, including children.

– Offer an assessment of their personal, social and mental health needs.

– Give advice and written information on the impact of drug misuse.

● Where the needs of families and carers have been identified:

– offer guided self-help (usually a single session with written material provided)

– inform them about support groups for example, self-help groups specifically for families and carers and facilitate contact.

● If families and carers continue to have significant problems, consider offering individual family meetings (normally at least five weekly sessions). These should:

– provide information and education about drug misuse
– help to identify sources of stress related to drug misuse
– promote effective coping behaviours.

2.3 Brief interventions and self-help

● At routine contacts and opportunistically (for example, at needle and syringe exchanges), provide information and advice to all people who misuse drugs about reducing exposure to blood-borne viruses.

– Give advice on reducing sexual and injection risk behaviours.

– Consider offering testing for blood-borne viruses.

● Do not routinely provide group-based psychoeducational interventions that give information about reducing exposure to blood-borne viruses and/or about reducing sexual and injection risk behaviours.

● If concerns about drug misuse are identified by the service user or a staff member, offer opportunistic brief interventions focused on motivation to people:

– in limited contact with drug services (for example, those attending a needle and syringe exchange or primary care settings)

– not in contact with drug services (for example, in primary or secondary care settings, occupational health or tertiary education).

These interventions should:

– normally consist of two sessions each lasting 10–45 minutes

– explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback.

● Routinely provide information about self-help groups.
  – These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous.
  – Consider facilitating initial contact, for example by making the appointment, arranging transport and accompanying the person to the first session.

2.4 Formal Psychosocial Interventions

2.4.1 Contingency management

Drug services should introduce contingency management programmes to reduce illicit drug use and/or promote:

● engagement with services for people receiving methadone maintenance treatment

● abstinence and/or engagement with services for people who primarily misuse stimulants.

Contingency management to improve physical healthcare

● For people at risk of physical health problems resulting from drug misuse, consider offering material incentives (for example, shopping vouchers worth up to £10) for concordance with or completion of specified harm-reduction interventions, in particular for:
  – hepatitis B/C and HIV testing
  – hepatitis B immunisation
  – tuberculosis testing.

2.4.2 Behavioural couples therapy

● Consider behavioural couples therapy for people who are in close contact with a non-drug-misusing partner and who present for treatment of stimulant or opioid misuse, including those who continue to use illicit drugs while receiving opioid maintenance treatment or after completing opioid detoxification. The intervention should:
  – focus on the service user's drug misuse
  – consist of at least 12 weekly sessions.

2.4.3 Cognitive behavioural therapy and psychodynamic therapy

● Consider evidence-based psychological treatments (in particular, cognitive behavioural therapy [CBT]) for comorbid depression and anxiety disorders in line with existing NICE guidance for people who:
  misuse cannabis or stimulants
  have achieved abstinence or are stabilised on opioid maintenance treatment.

● Do not routinely offer CBT and psychodynamic therapy focused on the treatment of drug misuse to people who misuse cannabis or stimulants or those receiving opioid maintenance treatment.

- The evidence related to intensive outpatient treatments and day treatments does not support the notion that 'more is better' when comparing more intensive treatments to standard outpatient treatment in relation to drug use outcomes.