Agenda item: 2

HAMPSHIRE COUNTY COUNCIL

Decision Report

Decision Maker:	Executive Member for Adult Social Care and Public Health
Date of Decision:	30 April 2014
Decision Title:	Procurement of Adult Drug and Alcohol Treatment Services
Reference:	5526
Report From:	Director of Public Health

Contact name: Dr Christine Jackson, Deputy Director of Public Health
Jeremy Down, Joint Commissioning Manager, Drug & Alcohol Action Team (DAAT)

Tel: 02380 383330 Email: christine.jackson2@hants.gov.uk
02380 832157 jeremy.down@hants.gov.uk

1. Executive Summary

1.1 The purpose of this paper is to seek:

1.1.1 approval to go out to tender for specialist substance misuse treatment services for adult drug and alcohol misusers and their families;

1.1.2 approval to award a contract for specialist substance misuse treatment services for adult drug and alcohol misusers and their families for a maximum of 5 years, let on the basis of an initial period of 3 years with the option to extend this period by two further periods both of 12 months;

1.1.3 approval to spend, in respect of the above procurement exercise, an amount not exceeding £42,770,000.00 over 5 years.

1.2 This paper further seeks to:

- set out the background and context to the re-commissioning of the Hampshire Operational Model for Effective Recovery (HOMER) substance misuse treatment services;
- outline the project timetable for the procurement process;
- outline the financial implications arising from the re-commissioning exercise.

2. Background

2.1 The Health & Social Care Act 2012 (hereafter "the Act") identified substance misuse as a Public Health service and consequently, with effect from April 2013, commissioning responsibility for specialist treatment services was brought together under Local Authorities.

2.2 During 2008 and 2009 Hampshire County Council (hereafter “HCC”) in partnership with Hampshire Primary Care Trust (hereafter “the PCT”), undertook a countywide strategic review of adult substance misuse treatment provision. An outcome of the review was the development of the Hampshire Operational Model for Effective Recovery (hereafter “HOMER”) – an integrated treatment model which brought together tier 2 and tier 3 drug and alcohol treatment interventions and which prioritised recovery from dependence and social reintegration.

2.3 The current HOMER contract was tendered in 2010 and was awarded for a period of 2 years from April 2011 with the option to extend by a further 2 years up to March 2015.

2.4 The commissioning responsibility for HOMER passed to HCC in its entirety from April 2013 and the option to extend the contract until March 2015 was taken.

2.5 The commissioning responsibility for Tier 4 in-patient detoxification services passed to HCC from April 2013 and a single tender approval (STA) was secured to extend the existing commissioning arrangements until March 2015. This was with the express intention of aligning the commissioning of both tiers 2 & 3 community and tier 4 in-patient treatment services.

2.6 The commissioning arrangements for specialist carer support services are in the process of being extended until March 2015 via an STA, again with the express intention of aligning the recommissioning of this service to the recommissioning of the drug and alcohol treatment services.

3. Rationale for Commissioning Substance Misuse Services

3.1. Evidence of Need

3.1.1 High-level estimates of the prevalence at a county-wide level suggest that Hampshire has lower levels of illicit drug misuse than seen nationally. However, prevalence rates for drinking alcohol at both ‘harmful’ and ‘increasing or higher risk’ levels remain a significant issue which affect Hampshire residents both directly and in-directly.

Figure 1. Estimates of prevalence of substance misuse in Hampshire

Estimated number of opiate users[1]	3,540
Estimated number of crack cocaine users[1]	1,385
Estimated number injecting drug users[2]	1,446
Estimated number of alcohol dependent drinkers[2]	40,000
Estimated number drinking at ‘increasing risk’ or ‘higher risk’ levels[2]	275,000

3.1.2 It is estimated that there are around 40,000 people in Hampshire classified as ‘high risk’ or alcohol dependent drinkers. Some of these people will have high functional capacity and good incomes and this dependency will not necessarily be visible to family and colleagues. Some will be using other substances alongside alcohol. There are also about 275,000 people drinking at ‘increasing risk’ or ‘higher risk’ levels. This is where people may be experiencing health harms and also wider societal risks and consequences associated with their drinking.

3.1.3 Hampshire-specific prevalence estimates are not available for the misuse of other substances. However, prevalence information is available at national and pan-national levels and should be considered to be indicative at a local level.

The United Nations Office on Drugs and Crime[3] reports that amongst people aged 15-24 within the European Union:

- 5% of have experimented with New Psychoactive Substances (NPS or “legal highs”)
- 25% have tried cannabis;
- 10% have used drugs other than cannabis

Prevalence estimates vary by country however. The UK Advisory Council on the Misuse of Drugs (ACMD), for example, indicates that NPS use young people in UK could be far higher than the EU average reporting that an estimated 20% - 40% of young people had used the NPS mephadrone prior to its classification[4].

Seventeen percent of Hampshire young people accessing treatment for substance misuse last year reported having used substances that could be classified as NPS[5].

3.1.4 Substance misuse has a demonstrable impact upon the physical and mental well-being of individuals both as a result of direct physiological effects of the substances being misused and because of the life-styles associated with long term misuse.

Significantly increased health risks associated with long term substance misuse include:

- Death (e.g. from overdose or suicide),
- Depression and psychosis
- Serious psychiatric disorder;
- Infection from blood borne viruses (particularly HIV, hepatitis B & C)
- Increased blood pressure
- Reduced fertility
- Reduced birth weight or birth defects if used when pregnant
- Other health conditions associated with economic depravation
- Significantly increased risk of liver disease (in the case of alcohol misuse)

3.1.5 The impact on the local health care services can be demonstrated by the level of drug and/or alcohol related hospital admissions in Hampshire. This hides significant economic and social issues including safeguarding that arise prior to people coming to the attention of healthcare services.

Alcohol attributable hospital admissions (previously National Indicator NI 39) are a measure of the total burden of alcohol on all hospital treatment episodes across all patient group activities. 2010/11 figures show that Hart, Havant, Rushmoor and Gosport had admission rates higher than the South East average[2].

In the three years between April 2009 and March 2012 there were 13,268 hospital admissions for Hampshire residents attributed to substance misuse[2].

3.1.6 Estimated data for Hart, East Hampshire and Winchester demonstrate significant ‘increasing and high risk’ drinking behaviours seen in these affluent areas. However, alcohol attributable mortality rates (AAMR) in Rushmoor, Gosport and Havant are of particular concern. AAMR rates are most pronounced for females within both Gosport and Rushmoor having AAMR rates higher than either the South East or national average.

3.1.7 Substance misuse impacts upon an individual’s social functioning. Dependent drinkers and long-term drug misusers have an elevated risk of unemployment, poor housing or homelessness, relationship breakdown and social isolation; having child taken into care and being involved in domestic violence either as a victim or a perpetrator.

3.1.8 Problematic drug use can be associated with child neglect, chaotic home circumstances and exposure to drug use and criminal activity.

Nationally, parental drug misuse is cited in 29% of all serious case reviews and alcohol misuse in 27%.[6] Parental alcohol/drug problems are further implicated in 23% of child protection cases that go to care proceedings and 33% of cases that result in serious injury or death nationally.

In 2010/11, 707 child safeguarding alerts recorded by Hampshire Childrens and Families Services referenced substance misuse as the primary client category and between July 2012 and June 2013 532 of 11,571 children in need cases opened by children’s social services had the category ‘Substance Misuse by Parent/carer’ recorded.[7]

A 2004 survey estimated that 42% of drug users using treatment services had dependent children and 47% of these children lived with their parents. Approximately 9% were in care.[2] Nationally the annual cost of looking after drug using parents’ children who have been taken into care is estimated to be £42.5m.

3.1.9 National estimates published by PHE indicate that a typical heroin user who is not in treatment spends on average around £1,400 per month on drugs (2.5 times the average mortgage) and commits crime costing an average £26,074 a year.[6]

3.2 Evidence of Locally Realised Benefits from Investment[8]

3.2.1 Public Health England estimates that in 2011/12 the cost to Hampshire of opiate and crack related harm alone would have been £37.9 million if treatment services had not been in place to mitigate this.

3.2.2 The total cost benefit accrued by Hampshire in 2011/12, in terms of costs savings and Quality Adjust Life Year (QALY) benefits, as a direct result of investment in opiate and crack treatment was £24.8 million spilt as follows:

- Estimated crime cost savings and QALY benefits £17 million
- Estimated health cost savings and QALY benefits £7.9 million

3.2.3 The accrued net benefit was £19m with an accrued benefit cost ratio (BCR) of 4.23. This shows that every £1 invested in opiate and crack treatment in Hampshire realised an accrued benefit of £4.23.

3.2.4 PHE estimates that in 2011/12, investment in opiate and crack treatment resulted in 71,096 potential crimes being avoided.

3.3 Evidence of Improving Local Outcomes

3.3.1 The HOMER model of integrated recovery-focussed treatment was introduced in April 2011 replacing the previous differentiated, harm reduction model. Data produced by PHE's National Drug Treatment Monitoring Unit (NDTMU) show significant improvements in a number of key outcomes areas over this period.

3.3.2 The primary performance indicator for drug misuse services is Public Health Outcome Framework (PHOF) indicator 2.15 – the successful completion rate - which measures successful and sustained completions from drug treatment as a percentage of all those in treatment.

3.3.3 In the 3-years from December 2010, Hampshire delivered a 39% performance improvement in the successful completion rate for opiate clients (PHOF 2.15i) and a 66% performance improvement for non-opiate clients (PHOF 2.15ii). Both of these were significantly in excess of the performance improvements seen nationally.

Care Group	Dec 2010		Dec 2013		Performance Gain	
	Local	National	Local	National	Local	National
Opiate	7.50%	6.60%	10.40%	8.10%	38.67%	22.73%
Non-Opiate	30.50%	37.50%	50.50%	40.10%	65.57%	6.93%

Fig 2 Comparison of Local and national rolling 12-month performance for PHOF Indicators 2.15i and 2.15ii

3.3.4 In January 2014, PHE expressed concerns regarding the generally low levels of reported Recovery Support work occurring in structured care across the South Central region. Hampshire was the one noted exception to this trend with 82% (5 times the regional average) of the local treatment caseload engaged in at least one Recovery Support intervention accounting. Hampshire's performance accounted for 33% of all recovery support clients in the region.

4. Contribution to National and Local Priorities

4.1 The National Drug Strategy 2010 (NDS)[9] identified three strategic themes:

- Restricting supply
- Reducing demand
- Building recovery.

The recommissioning of drug & alcohol treatment services will contribute directly to the national strategic themes of Reducing Demand and Building Recovery.

4.1.1 Reducing demand will be achieved through the promotion of harm minimisation, early engagement and intervention, and effective close working with partners such as primary care and probation.

4.1.2 Building of recovery will be achieved through the delivery of evidence-based psychosocial and pharmacological treatment interventions, but also through the promotion and development of service users' recovery capital (see 4.2 below).

4.1.3 Responsibility for the Restricting Supply agenda rests primarily with the Home Office, Her Majesty's Revenue and Customs (HMRC), the police and Trading Standards and not the drug and alcohol treatment services. Consequently, the Restricting Supply agenda does not fall within the scope of this report.

4.2 The NDS emphasised the significance of 'recovery capital' in building recovery. It defined this as the resources necessary for the individual to achieve and sustain recovery from dependence across four capital domains:

- Social capital - the resource a person has from their relationships (e.g. family, partners, children, friends and peers). This includes both support received, and commitment and obligations resulting from relationships;
- Physical capital - such as money and a safe place to live;
- Human capital – skills, mental and physical health, and a job;
- Cultural capital –values, beliefs and attitudes held by the individual.

Interventions such as the Peer Mentor and Foundations of Recovery programmes running within the current HOMER service address individuals' human and cultural capital deficits. Close working ties with Job Centre Plus, the Work Programme primes, local housing panels and accommodation providers support the development of physical capital and family interventions and mutual aid initiatives contribute to resolving social capital deficits.

4.3 The draft Hampshire Substance Misuse Strategy has developed these themes into six local strategic priorities:

a) Prevention and Education
b) Developing Recovery Capital
c) Developing Joined-Up Services to Deliver "Whole Person" Focussed Treatment
d) Improving Outcomes for Substance Misusing Criminal Justice Clients
e) Promoting Harm Minimisation
f) Tackling New Psychoactive Substances and other New Drug Misusing Behaviours.

4.4 The specialist drug & alcohol treatment services will contribute directly to the national strategic themes of Reducing Demand and Building Recovery while also addressing the six local strategic priorities identified in the draft Hampshire Substance Misuse Strategy.

4.5 The Public Health functions and commissioned services are focused to deliver against outcomes as set out in the Public Health Outcomes Framework. Public Health England has stated that an effective substance Misuse treatment system supports the Public Health Outcomes Framework (PHOF) vision, "*To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest*" and impacts directly on both of the PHOF outcomes:

- Outcome 1: Increased life expectancy;
- Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities.

4.6 The Public Health Outcomes Framework includes three substance misuse specific outcome performance indicators against which the County Council's performance is benchmarked:

- PHOF 2.15 – Successful completion of drug treatment
- PHOF 2.16 - People entering prison with substance dependence issues who are previously not known to community treatment
- PHOF 2.18 - Alcohol related admissions to hospital.

Performance against these indicators is directly contributed to by successful outcomes from our commissioned substance misuse treatment service.

4.7 Public Health England advises that substance misuse treatment makes a significant contribution, either directly or indirectly, to a further 31 Public Health outcome performance indicators.

4.8 Effective substance misuse services play a significant part in supporting the Council's corporate priorities:

- Hampshire safer and more secure for all – by promoting treatment services and encouraging users (including known offenders) to take up treatment options there is a known correlation between numbers entering treatment and a reduction in crime rates.
- Maximising wellbeing – treatment and harm minimisation services have a significant impact on the health and wellbeing of individuals, their families, carers and communities.

4.9 Treatment services will be specifically performance managed against the delivery of improvements for the following outcomes:

- Increased engagement amongst previously treatment naïve substance misusers;
- Increased successful completions (where this is defined as discharge from treatment free from dependency to primary drug of misuse without representation to treatment services within six months);
- Improvements in sustained recovery and resilience (evidenced by reductions in re-presentations to treatment);
- Protecting the health of individual and wider community through increased uptake of BBV testing and vaccination;
- Promotion of recovery-focussed treatment (evidenced through a reduction in the reliance on pharmacological interventions as the primary treatment method);

- Promotion of recovery-focussed treatment (evidenced through an increase in numbers with stable and appropriate housing and employment).

5. Procurement of specialist substance misuse services

5.1 The procurement will proceed via an open tender process in accordance with European Union (EU) Procurement Directives.

5.2 Commissioning partners and strategic stakeholders were consulted via a stakeholder event in October 2013 and will be further engaged through their membership of the Joint Commissioning Group (JCG) and Strategic DAAT.

5.3 Service users were consulted on the proposed recommissioning at a stakeholder event in January 2014 and are represented on both the JCG and Strategic DAAT Board. A further service user consultation event is planned for April 2014.

5.4 It is not proposed to make significant changes to the current HOMER treatment model. The current model was developed following extensive stakeholder consultation, is consistent with national guidance and can be shown to have delivered improvements in performance (see 3.3). However, this re-procurement will afford the opportunity to refocus aspects of the service to ensure greater effectiveness and efficiency.

5.4.1 The drug and alcohol detoxification services will be commissioned to be in line with the Department of Health's National Clinical Guidelines[10] and the new service will promote the use of community-based detoxification interventions as part of a pathway of services. The use of in-patient provision will be optimised for those complex client groups identified in the relevant clinical guidance from the National Institute for Health & Care Excellence (NICE)[11, 12] thereby ensuring that treatment is appropriately differentiated on the basis of individual need and circumstance.

5.4.2 New Psychoactive Substances (NPS) – The term NPS (often erroneously referred to as "legal highs") covers a very broad category of synthesised substances and evidence around effective interventions is still emerging. It is important that the specialist service is able to adapt to respond to the changing needs of this new client group.

5.4.3 Carers Support – Following consultation with service users and stakeholders it is proposed to integrate the existing carers support provision with the specialist treatment service.

This recognises the concern raised in the National Treatment Agency (NTA) guidance to commissioners "Supporting and Involving Carers" (NTA, 2008) that:

> "*There is a risk that mainstream generic carer centres do not have the specific substance misuse expertise required to provide relevant services for substance misuse families and carers.*"

It will also:

- promote the involvement of carers and family members in the care of service users – noted by the NTA as beneficial in securing positive outcomes for both groups;
- enable the coordination of support and recovery planning for both carers and service users;
- facilitate the delivery of evidence-based family and couples focussed interventions;
- deliver operational and financial efficiencies that will ensure greater cost effectiveness.

5.5 **Key procurement milestones**

October 2013	Stakeholder consultation event
January 2014	Service user consultation event
April 2014	Service user consultation event
April 2014	Secure permissions to spend & to procure
June 2014	Publish tender in OJEU, In-Tend and other media
September 2014	Publish ITT documents on In-Tend
October 2014	Tender evaluation
November 2014	Notification of award of tender
April 2015	Service goes live

6. Impact and Implications

6.1 Legal

6.1.1 It is for the Executive Member as Decision Maker to have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act and advance equality of opportunity and foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

6.2 Financial

6.2.1. Substance misuse treatment services are core Public Health services within an identified funding stream within the Public Health Allocation.

6.2.2 The required funding (£8,554,000 per annum) is affordable within the existing Public Health Allocation.

6.2.3 It is anticipated that the Public Health Grant will be reviewed by the Department of Health (DH) on an annual basis. The contract will, therefore, allow for the varying of baseline funding in line with any variations to the funding received by HCC from DH.

6.2.4 It should be noted that DH guidance relating to the use of the Public Health Allocation does not anticipate a reduction in the level of investment in substance misuse treatment.

6.2.5 The costs of tendering have been identified in this year's DAAT budget.

6.3 Equalities Impact Assessment

6.3.1 In compiling this report account has been taken of the requirements of the Corporate Equalities Plan and Race Scheme. The Hampshire DAAT diversity statement states that it is committed to securing genuine equality of opportunity, recognising the many differences between people and avoiding or overcoming discrimination, whether required by law or not, in all aspects of its activity by positively valuing different perspectives and skills.

6.3.2 The Hampshire DAAT ensures through its contracting and contract review processes that all service providers demonstrate equality of access to, and quality of treatment across, all groups of potential service users and that all services shall respond positively to the diverse needs of all service users, including cultural, religious, language, gender, sexuality, disability, age and communication need.

6.3.3 The equality impact assessment undertaken in support of this report considers the potential impact on individuals and groups exhibiting one of more of the protected characteristics identified in the Equality Act. Additional consideration has been given to other specific groups whose propensity to misuse substances or to engage with treatment services may be impacted by other characteristics or circumstances.

The findings are summarised below (see 6.3.4-6). However, Appendix B provides further detail of the anticipated impacts for the following characteristics or groups:

- Gender
- Age
- Ethnicity
- Disability (including mental ill health)
- Sexual orientation
- Faith and religion
- Carers
- Dispersed rural communities and those affected by travel poverty

6.3.4 There are no material changes proposed to the existing model of delivery for tier 2 and 3 community-based services. Consequently it is not anticipated that the re-procurement of these elements of the treatment system will have any negative impact upon any particular group of clients.

The recommissioning does provide the opportunity to deliver a range of positive enhancements that will either be of benefit to the general client group as a whole or to more specific identified groups of clients. This will include:

- An expansion of the geographic spread of services thereby enhancing local access to the benefit of clients affected by mobility issues and travel poverty or living in dispersed rural communities;
- The focusing of dedicated resources on engaging with specific client groups and communities including older adults, NPS and club drug users and black and minority ethnic (BME) communities.

6.3.5 The recommissioning project will result in changes to model of provision for clients requiring tier 4 in-patient detoxification. Devolution of the of the tier 4 budget will facilitate the commissioning of detoxification placements from a broader a range of providers allowing clients to be placed with providers that are equipped to meet specific care needs (e.g. all female units, parent and child facilities and faith-based provision) or which are more conveniently geographically situated.

6.3.6 Cares support groups and family interventions are already sited within the HOMER hubs and this will not be changed under the recommissioning proposals. However, the integration of the support planning and management functions will deliver greater synergies between the treatment of drug and alcohol users and their carers. It is anticipated that proactively encouraging engagement with the treatment services will result in an increase in the number of carers with access to a carer needs assessment and appropriate structured support.

6.4. Human Resources

6.4.1. The Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246) are designed to protect the rights of employees in a transfer situation enabling them to enjoy the same terms and conditions, with continuity of employment, as formerly. Where there is a transfer of the services to a new employer then these may apply to staff who are delivering currently contracted services.

6.4.2. There are no HCC employed staff employed within the currently contracted services. It is not anticipated that any HCC employed staff will be impacted by the recommissioning process.

7. Recommendations

It is recommended that the Executive Member for Adult Social Care and Public Health gives approval to go out to tender and to award the contract for specialist substance misuse treatment services for adult drug and alcohol misusers and their families for a maximum of 5 years (let on the basis of an initial period of 3 years with the option to extend this period by two further periods both of 12 months) up to a maximum value of £42,770,000.00 over the full 5 year term.

References

1. Public Health England, 'Alcohol and drugs - JSNA support pack: Hampshire. Key data to support planning for effective drugs prevention, treatment and recovery' (2011)
2. Hampshire County Council, 'Joint Strategic Needs Assessment ' (2011)
3. United Nations Office on Drugs and Crime http://www.unodc.org/wdr/en/nps.html (2011/12)
4. UK Advisory Council on the Misuse of Drugs, 'Consideration of the Novel Psychoactive Substances ('Legal Highs')' (2011)
5. Locally reported activity data – source: Catch 22 (2013)
6. Public Health England, 'Alcohol and drugs prevention, treatment and recovery: why invest?' (2011)
7. Locally reported activity data – source: HCC Children's Services (2012/13)
8. Public Health England https://www.ndtms.net/VFMTool.aspx
9. HM Government, 'Drug Strategy 2010. Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life' (2010)
10. Department of Health, 'Drug Misuse & Dependence. UK guidelines on clinical management' (2007)
11. NICE, 'Clinical Guidelines 52 - Drug misuse – opioid detoxification' (2007)
12. NICE, 'Clinical Guidelines 115 - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence' (2011).

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	Yes
Corporate Business plan link number (if appropriate):	
Maximising well-being:	Yes
Corporate Business plan link number (if appropriate):	
Enhancing our quality of place:	No
Corporate Business plan link number (if appropriate):	

Other Significant Links

Links to previous Member decisions:		
Title	Reference	Date
Public Health Budget 2013/14 report to Cabinet	4746	25 March 2013
Public Health Budget report to Cabinet	5020	22 July 2013
Inpatient Substance misuse Service	5531	21 March 2014
Substance Misuse Strategic Review - Formal Consultation	Executive Member Adult Social Care	1 October 2008
Approval of the next stage of the Substance Misuse Strategic Review - The Development Plan (following consultation)	Executive Member Adult Social Care	26 June 2009

Direct links to specific legislation or Government Directives	
Title	Date
The Health and Social Care Act 2012	2012

"Drug Strategy 2010. Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life" (HM Govt, 2010)	2010
"Drug misuse and Dependence: UK guidelines on clinical management" (DH, 2007)	2007
"Improving outcomes and supporting transparency Part 2: Summary technical specifications of public health indicators" (DH, 2012)	2012

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:

Hampshire DAAT ensures through its contracting and contract review processes that all service providers demonstrate equality of access to, and quality of treatment across, all groups of potential service users and that all services shall respond positively to the needs of diverse drug users, including cultural, religious, language, gender, sexuality, disability, age and communication need.

Consideration of Impact on Clients with Protected Characteristics and Other Key Groups

Gender

It is noted that drug and alcohol use differs between genders. However, the resources within the service are fully integrated across drugs and alcohol allowing the service to be flexible in its response to presenting demand.

Some interventions are delivered on a group basis; there is provision to run single sex groups or deliver interventions on an individual one-to-one basis where this is deemed necessary.

The allocation of key-workers takes account of gender and clients may request same-sex key-workers.

The change in tier 4 commissioning arrangements will allow for the placing of clients at single-sex units where this is requested or deemed necessary.

Disability

Commissioned services have a legal duty to comply with the provisions of the Equality Act including in respect to engagement, physical access and communication.

All sites will need to make provision for physical and sensory impairment access needs and services will be required to employ a range of accessible communication tools.

The use of satellite sites, home visits, accessible media and internet-based tools and mobile treatment units will be used to facilitate access for clients with mobility impairments.

Estimates of the prevalence of dual diagnosis (the presence of concurrent drug or alcohol misuse and mental illness) vary from 21% to 73%. Although the statutory lead for managing dual diagnosis remains with adult mental health services, the substance misuse service employs qualified mental health clinicians and is able to respond appropriately to the needs dual diagnosis clients.

Ethnicity

Cultural norms are known to be influencing factors in attitudes towards the misuse of substances and the willingness to engage with treatment services.

Treatment services work closely with local borough and district colleagues and community leaders to develop constructive relationships with local BME communities and to ensure that service delivery techniques, information and promotion are culturally appropriate.

The delivery of interventions in gender-specific groups at satellite sites away from main hubs, a differential approach to the involvement of carers, translation of treatment materials, the use of complimentary therapies and the engagement with culturally-specific mutual aid groups are all ways in which services have adapted to facilitate the needs of BME communities in Hampshire.

Age

Age is known to be an influencing factor in the propensity to misuse substances, the profile of substances used and the willingness to engage with treatment services.

The appointing of peer recovery champions, the use of age-specific "pods" (supportive therapeutic treatment groups), engagement with age-specific community services and the differentiation of treatment interventions to target different substances of misuse (e.g. club drugs) are all techniques that have been shown to be effective in engaging clients from different age groups.

Close work with the young persons treatment service and the introduction of robust transition arrangements has helped to reduce the risk of ensure that young people disengaging from treatment when they reach adulthood.

Research undertaken by the Royal College of Psychiatry and others has identified the previously hidden issue of substance misuse amongst older adults. Work will be undertaken with the Older Adults Team to ensure that the proposed service model makes appropriate and accessible provision for this client group.

Sexual Orientation

Emerging evidence from Central North West London NHS Trust's Club Drug Clinic indicates specific substance misusing presentations, such as the use of certain NPS drugs and stimulants, maybe more prevalent amongst gay men.

The proposed treatment model will encompass interventions specific to the recreational use of NPS and other club drugs.

Faith and Religion

Although mainstream structured treatment interventions do not adopt a faith-bias, some complimentary therapies and the 12-step approach practiced by the Fellowship movement (e.g. Narcotics Anonymous) do have a strong spiritual focus. Whilst extremely helpful to some faith groups, this may not be universally the case.

The service model recognises that a range of interventions must be provided that allow clients to engage in a manner that is consistent with their personal beliefs. The facilitation of the secular SMART programme will be delivered along side the promotion of access to Fellowship groups.

Practitioners will additionally be expected to maintain an empathetic understanding of clients' belief systems and to facilitate access to local faith groups were this may be beneficial.

Carers

The current carers provision consists of a telephone helpline and a group-based programme delivered from the HOMER hub sites. The integration of this provision within the wider treatment service is not, therefore, considered to present any potential negative impact upon carers – there will still be the requirement for a helpline and carers are already engaging with the co-located group programme.

The integration of the services does, however, offer significant opportunity to enhance the support provided to carers through earlier identification and engagement; the introduction of whole-family assessment and recovery planning and the expansion of the range evidence-based family and couples interventions delivered as part of a managed recovery pathway.

Dispersed Rural Communities and Individuals Affected by Travel Poverty

The current HOMER service delivers services from a network of locality "hubs" providing local one-stop-shop access a full range of treatment and support services on a 6 day-a-week basis. Access is further enhanced through the use of smaller satellite sites in shared community facilities (an approach that has been particularly effective in promoting access in the New Forest and East Hampshire), in-reach workers working within supported accommodation projects and home visits.

This access will be further supplemented in the new service through the use of two bespoke 'mobile treatment units' – camper van style vehicles adapted to provide facilities for the delivery of a range of clinical and psychosocial interventions. The service will further operate telephone helplines for both service user and carers.

The integration of carers services within the community service means that carers will also benefit from this improved local access.

The proposed changes in the approach to the provision of in-patient services will allow the placing of clients at a range of appropriately accredited providers across the county rather than at the single Portsmouth unit currently

used. This has the potential to significantly decrease travel requirements for clients and their carers who are not resident within the South East of the county.

2. Impact on Crime and Disorder:

The County Council has a legal obligation under Section 17 of the Crime and Disorder Act 1998 to consider the impact of all decisions it makes on the prevention of crime.

The proposal in this report aims to improve the safety of vulnerable Hampshire residents and reduce the risk of crime occurring.

There are elements of the substance misuse treatment system that interface directly and indirectly with the criminal justice system and impact upon community safety across the county. In carrying out this strategic review we have been mindful of these links and have ensured that we have an overview of both the substance misuse strategic review and the community safety strategic review and have been involved in the development and detail of both reviews.

3. Climate Change:

a) How does what is being proposed impact on our carbon footprint / energy consumption?

The re-commissioned treatment system will have regard to the accessibility of services to the client and will include the physical accessibility, i.e. proximity to public transport and the use of satellite provision to take the service into localities to reduce the burden of travel placed upon service users. An increase in local purchasing due to personalisation may also reduce carbon footprint through reduced travel.

b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

As the procurement process develops, a requirement to consider the need to adapt to climate change, and be resilient to its longer term impacts will be taken into account in the detailed planning and development of the Invitation to Tender (ITT). Prospective service providers will be required to demonstrate that they have considered climate change in developing their service delivery model.

Service Definitions – By Tier

Tier 1 - Non Drug Treatment Specific Services

Tier 1 consists of services offered by a wide range of professionals (e.g. primary care medical services, generic social workers, teachers, community pharmacists, probation officers, housing officers, homeless persons units). Services work with a wide range of clients including substance misusers, but their sole purpose is not simply substance misuse. Tier 1 services may include:

- Access to full range of health, social care, housing and other services.
- Substance misuse screening, assessment and referral mechanisms to substance misuse services from generic, health, social care, housing and criminal justice services.
- Management of substance misusers in generic health, social care and criminal justice settings.
- Health promotion advice and information.
- Hepatitis B vaccination programmes for substance misusers and their families. Alternatively, if investments in vaccinations are made within Tier 2, 3 or 4 services, they can be recorded in the relevant grid.

Tier 2 - Open Access Services

Services within this Tier aim to provide accessible services for a wide range of substance misusers referred from a variety of sources, including self-referrals. The aim of the treatment in this Tier is to help substance misusers to engage in treatment without necessarily requiring a high level of commitment to more structured programmes or a complex or lengthy assessment process. Services include needle exchange programmes and other harm reduction measures, substance misuse advice and information services and ad hoc support not delivered in a structured programme of care.

Tier 3 - Structured Community Based Services

This Tier can be defined as providing services solely for substance misusers in a structured programme of care. Services include structured cognitive behaviour therapy programmes, structured methadone maintenance programmes, community detoxification, or structured day care (either provided as a drug-free programme or as an adjunct to methadone treatment). Structured community-based aftercare programmes for individuals leaving prisons are also included in Tier 3.

The principal expectation is that the substance misuser attending these services will have agreed to a structured programme of care which places certain requirements on attendance and behaviour (e.g. a certain number of days or hours attendance per week, review of programme is triggered if attendance is irregular).

Tier 4 - Residential and Inpatient Services

Services in this Tier are aimed at those individuals with a high level of presenting need. Services in this Tier include inpatient drug treatment, including detoxification and residential rehabilitation. Tier 4 services usually require a higher level of motivation and commitment from the substance misuser than for services in lower Tiers.