THE ROYAL BOROUGH OF
WINDSOR AND
MAIDENHEAD

Royal Borough of Windsor and Maidenhead

Drug and alcohol services

Outcome of review and recommendations

May 2016

“The Royal Borough of Windsor & Maidenhead is a great place to live, work, play and do business supported by a modern, dynamic and successful Council”

Our vision is underpinned by four principles:

Putting residents first
Delivering value for money
Delivering together with our partners
Equipping ourselves for the future

CONTENTS

Frequently used acronyms

CQC	Care Quality Commission
DAAT	Drug and Alcohol Action Team
FTE	Full time equivalent
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
NICE	National Institute for Health and Care Excellence
OCU	Opiate/and or crack cocaine users
PHE	Public Health England
RBWM	Royal Borough of Windsor and Maidenhead
TFG	Task and Finish Group
UNODC	United Nations Office of Drug Control

This page is intentionally blank

1. EXECUTIVE SUMMARY

1.1 The role of the Drug and Alcohol Task and Finish Group (TFG) was to undertake a full review of current service delivery, benchmark the provision and performance, conduct a consultation with residents and stakeholders and generate options for future service delivery. The multi-stakeholder membership of the TFG ensured effective engagement with all key strategic partners. In addition, bespoke meetings were held with Public Health England (PHE), service providers and service users, Probation and Berkshire Healthcare Foundation Trust.

Current provision and performance

1.2 Drug and alcohol services in the Royal Borough are commissioned for adults and provided for young people by the Drug and Alcohol Action Team (DAAT). The team is responsible for:

- Commissioning drug and alcohol services for adults including the community recovery services, as well as residential placements and pharmacy schemes.
- Providing a young people's treatment and prevention service.
- Raising awareness of the dangers of drug and alcohol misuse within the local community.
- Partnership work with local agencies, in order to reduce the crime and anti-social behaviour associated with substance misuse.

1.3 Overall, in terms of prevalence and complexity factors, the needs of the Royal Borough appear to be less than those of Slough and Reading, similar to those in West Berkshire but largely higher than those of Wokingham and Bracknell.

1.4 Performance in the Royal Borough around successful treatment completions by adult service users has compared well to the other Berkshire authorities, with the September 2015 data placing the Royal Borough second for the non-opiate and alcohol cohorts and third for the combined alcohol and non-opiate cohort. There are some improvements to be gained in the opiate cohort. Performance around 'in treatment' benefits which seeks to demonstrate the positive gains experienced before people exit formal treatment showed that the Royal Borough compared well to national averages.

1.5 The directly provided young people's service performed well compared to the other Berkshire services, with the highest rates of planned exits for young people in service, in 2014/15.

Consultation

1.6 A full consultation exercise was undertaken for adult and young people's services in January and February 2016 in order to seek views on the future shape of the services. The headlines from the consultation responses were:

- Prevention was seen as a priority as a measure of success.
- There should be a range of prevention and treatment services with resources being flexibly deployed to meet changing needs.
- There should be a balance between drug and alcohol provision.
- Anyone requiring services should be able to access them although specific priority groups should be targeted.
- Those who had relapsed should be able to re-access services and access should be unlimited.

Options and models

1.7 Based on the assessment of need and the feedback from the consultation, the TFG concluded that service users of drug and alcohol services can be categorised into four outcome groups:

- Group 1: Preventing people from needing drug and alcohol services in the first place.
- Group 2: Enabling those who are chaotic users of drugs/alcohol to start to achieve stability.
- Group 3: Enabling those who are stable to work towards recovery.
- Group 4: Enabling those who are being maintained on substitute drugs to achieve full recovery.

1.8 Measures of success for each of these outcome groups were defined by the TFG with an additional overall measure of success for drug and alcohol services being value for money. The current saving for the Royal Borough is £5.51 per £1 spent – the expectation of the TFG was that any new model would maintain value for money at least at this level.

1.9 The TFG concluded that the current range of good services should continue recognising the need to evolve services in line with demand and need. A range of prevention and treatment services flexibly deployed would meet changing needs meaning that the service would not focus on specific substances but could change focus as the needs of the population change as evidenced through the Joint Strategic Needs Assessment (JSNA) and detailed data through the National Drug Monitoring System.

1.10 In order to inform decisions around the future configuration of the Royal Borough's adult substance misuse services, the interventions needed to serve the existing client group can broadly be separated into:

- Those which are fundamental for the core service model and are therefore deemed essential.
- Those which enable the core service model and are therefore deemed essential.
- Those which enhance the core service model and can therefore be deemed desirable.
- Other health treatments/services provided by the wider health economy, including mental health services, to which service users are signposted

Recommendations

1.11 The options and recommendations presented in this report are based on the TFG's current understanding of prevalence and need in the Royal Borough. However, it recognises that this is an area of work that is affected significantly by a number of variables, including demographic change, public health priorities, addiction patterns and the introduction of different drugs. It is on this basis that the TFG is recommending a flexible and responsive service delivery model. Notwithstanding the overall reduction in public health budget, the TFG is clear that the risks of not investing in drug and alcohol services are significant.

2. OVERVIEW OF CURRENT SERVICE

2.1 Drug and alcohol services in the Royal Borough are commissioned for adults and provided for young people by the Drug and Alcohol Action Team. The team, comprising 2.7 FTE officers, is responsible for:

- Commissioning drug and alcohol services for adults including the community recovery services, as well as residential placements and pharmacy schemes.
- Providing a young people's treatment and prevention service.
- Raising awareness of the dangers of drug and alcohol misuse within the local community.
- Partnership work with local agencies, in order to reduce the crime and anti-social behaviour associated with substance misuse.

2.2 Commissioning includes community tier two and three drug and alcohol services, residential rehabilitation and inpatient detoxification placements, and provision for pharmacy schemes and primary care. The latter includes:

- Supervised consumption, essential for effective opiate substitution schemes.
- Pharmacy needle exchanges, to reduce the spread of blood borne viruses.
- GP prescribing or 'Shared Care', delivering services to residents who are stable enough to move out of the specialist prescribing service.

Current adult provision in the Royal Borough

2.3 The current model of adult drug and alcohol treatment services in the Royal Borough has been in place since April 2012. The fully integrated drug and alcohol recovery service is delivered in partnership by SMART, a charity set up in 1997 to help people overcome drug and alcohol dependency, and Claremont GP Surgery in Maidenhead. The service offers community based treatment for all those who wish to gain support around their substance misuse, including those who self-refer and those who are referred as part of a criminal justice order.

2.4 The service currently delivers both one to one and group work on a wide range of topics such as peer support, relapse prevention, cognitive behavioural therapy, anxiety management and health and wellbeing recovery skills. There is nursing input in the form of a blood borne virus service, community alcohol detox and general health and wellbeing interventions.

Current young people's provision in the Royal Borough

2.5 In addition to working with clients on a one-one basis, the young people's service carries out additional prevention initiatives and targeted support to those at risk of becoming involved with substance misuse, including:

- Reaching young people through awareness sessions, presentations and workshops in schools, youth clubs and other young people's organisations.
- Running peer education training programmes for young people aged 16 and 17 years old in order to learn about drugs, alcohol and sexual health and to train them in presentation skills so that they can provide awareness sessions to their younger peers.
- Speaking to parents and foster carers at evening sessions.
- Raising awareness about the service among professionals when they attend team meetings or carry out formal training around substance misuse.

2.6 A more detailed overview of the service is at Appendix 1 to this report.

3. OBJECTIVES OF THE DRUG AND ALCOHOL TASK AND FINISH GROUP

3.1 In October 2015, prior to re-tendering the Royal Borough's drug and alcohol treatment services, Cabinet agreed that a full review should be conducted. It was agreed that the review should reflect the cross-cutting nature of substance misuse. Under the leadership of the Deputy Lead Member for Public Health, the Drug and Alcohol TFG was established, comprising elected members, representatives from the Thames Valley Police and Windsor, Ascot and Maidenhead Clinical Commissioning Group (WAM CCG), and the Berkshire Director of Public Health, supported by officers from Commissioning Adult, Children and Health Services, see Appendix 2 for the terms of reference and membership. The TFG held over 10 meetings in total each with a predefined agenda and subsequent minutes.

3.2 The objective of the review was to recommend to Cabinet the most cost-effective and outcome-based drug and alcohol service model for the Royal Borough, in the light of the year on year reductions in public health grant funding announced in 2015, see Appendix 3 for details. The terms of reference for the TFG were to:

- Benchmark service outcomes.
- Review best practice.
- Develop options for future service delivery.
- Assess risk of options and mitigation.
- Consult on options.
- Conduct crime and health impact assessments on proposed options.

3.3 The review has been carried out in accordance with the Council's transformation principles of being data-driven, outcomes-orientated and evidence-based. By 2018, the Council is expected to be more self-reliant, equipped to work in new ways, quicker to respond and providing a mixed economy of service provision.

3.4 The Council's ambition is the delivery of effective and efficient services that improve outcomes of our residents. There is no preferred operating model – the important point is that any delivery model that the Council chooses provides:

- An opportunity to secure increased levels of resources to meet residents' needs through having access to different income streams.
- Scope to drive innovation, sustain and improve services, and operate in a competitive market, with less rigid procurement frameworks.
- Scope for more integrated, cross-organisational – private, public and voluntary – delivery of services tailored to residents.

3.5 The report is structured on the basis of the plan and timelines followed by the TFG including:

- An exploration of the national context and the definition of what constitutes a 'good' drug and alcohol service.
- An outline of the defined need based on a systematic review of the evidence including a detailed benchmarking analysis, consultation with key stakeholders and empirical analysis including a health and crime impact assessment.

- A thorough exploration and development of appropriate service delivery models.
- A set of recommendations for the type of DAAT service with approximate budgets and costings.

3.6 Through the consultation and bespoke meetings, other ideas were put forward which were not directly relevant to the TFG's terms of reference but these have been captured in Appendix 12 for broader learning and the wider policy context, including linkages to the Joint Health and Wellbeing Strategy (JHWS), housing strategy, homelessness and education in schools. The TFG encourages Cabinet to consider these additional insights, which may in turn want to be picked up by the Royal Borough's Policy Committee as appropriate.

4. NATIONAL CONTEXT

4.1 The National Drug Strategy is the responsibility of the Home Secretary and has been in existence, with various ambitions, since 1999. The 2010-2015 strategy[1] is centred on the ambition of recovery rather than maintenance and has two overarching aims:

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

4.2 The Strategy is structured around three key themes:

- Reducing demand by creating an environment where the majority of people who have never taken drugs continue to resist any pressures to do so, and making it easier for those that do, to stop. This is key to reducing the huge societal costs, particularly the lost ambition and potential of young drug users.
- Restricting supply – with drugs costing the UK an estimated £15.4 billion each year, the Government's aim is to make the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks.
- Building recovery in communities by working with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, and by putting the goal of recovery at the heart of all that is done.

4.3 The Strategy states that approximately 400,000 benefit claimants, around 8% of all working age benefit claimants, in England are dependent on drugs or alcohol and generate benefit expenditure costs of approximately £1.6 billion per year. If these individuals are supported to recover and contribute to society, the societal change would be significant.

4.4 A new National Drugs Strategy is due to be published this spring and will feed into future policy thinking around delivery of local services in the Royal Borough.

4.5 Appendix 4 sets out the legal position on the statutory duties around drug and alcohol services.

[1] Drug Strategy 2010: Reducing demand, restricting supply, building recovery, Home Office, 2010.

5. BEST PRACTICE IN DRUG AND ALCOHOL SERVICES

5.1 A good drug and alcohol service represents a balance of outcomes and service configuration. There is no one overarching document that describes all elements of substance misuse provision but a collection of guidance papers, from PHE and the National Institute for Health and Care Excellence (NICE). The key determinant is that there are features that any good service must display but there is no one favoured model due to the differing needs of different communities.

Prevention

5.2 Preventing harmful alcohol and drug use is central to a public health approach, which emphasises tackling the root causes of health and social harms and dependence and aims to reduce the number of people whose alcohol and drug use has a long-term negative effect on their own and their family's wellbeing. There are many factors associated with an increased risk of alcohol and drug problems among young people and adults. These are often factors that lead to other adverse outcomes and risky behaviour, such as mental health problems, offending or risky sexual behaviour.

5.3 Alcohol and drug prevention, delivered as part of a wider resilience programme, tackles the risk factors which increase the likelihood of someone suffering harm. It can help build resilience to developing alcohol and drug problems. It can also help people avoid problems by providing opportunities for alternative, healthier life choices and developing better skills and decision making. Interventions can range from targeted programmes to universal environmental or fiscal policies.

5.4 The classification of prevention interventions is the one used in the United Nations Office of Drug Control (UNODC) standards and internationally:

- **Universal** prevention strategies address an entire population. Universal prevention messages and programmes are delivered to large groups without any prior screening for risk of substance use and are aimed at preventing or delaying the start of substance use.
- **Selective** prevention serves specific sub-populations: individuals, groups, families and communities, whose risk of substance misuse is known to be higher than average, either imminently or over a lifetime. A primary advantage of focusing on vulnerable populations is that they are identifiable, and resources can be targeted by relevant agencies.
- **Indicated** prevention is aimed at people who are already using substances, are not yet experiencing dependence, but who may be showing signs of problematic use, eg, falling grades at school; absenteeism from work, antisocial behaviour, mental health problems. They are targeted with interventions to prevent their substance use and associated problems escalating.

5.5 UNODC has summarised the various types of intervention across an individual's life course[2]. It concluded that consistent and coordinated prevention activities delivered through a range of programmes and in a variety of settings, eg, at home; in school; among peers; in the workplace; throughout the local community and in the media, seem most likely to lead to positive outcomes.

[2] The international evidence on the prevention of drug and alcohol use: Summary and examples of implementation in England, Public Health England, 2015.

5.6 Evidence also suggests that modifying the environment where risky behaviour takes place can reduce harmful outcomes, eg, controlling alcohol sales, density of outlets and alcohol price, or by imposing bans on smoking of tobacco in public places.

5.7 Accurate and consistent information about the health and social impacts of alcohol and drug use is only effective when delivered alongside interventions that develop the skills and personal resources people need to avoid early initiation to drug taking and developing harmful use.

Adults

5.8 Key features of a good service are:

- Drug misuse and dependence are prevented by early identification and interventions.
- There should be prompt access to effective treatment, with a national target of less than three weeks from referral.
- Effective population-level actions should be in place to reduce alcohol-related harms.
- There should be large scale delivery of targeted brief advice, particularly for alcohol.
- There should be specialist alcohol care services for people in hospital.
- There should be interventions to address the health harms of drug and alcohol use.
- Treatment should be recovery-orientated, effective, high-quality and protective.
- Treatment should support people to sustain their recovery.
- Local authority commissioners should work closely with all relevant partners to commission high-quality, evidence-led alcohol and drug services based on outcomes.

5.9 The last four bullet points are in scope of this drug and alcohol service review.

5.10 The Care Quality Commission (CQC) is responsible for inspecting substance misuse services. New standards were released in January 2015 which focus on whether services are safe, effective, responsive and well led.

- **Safe**: clinical practice as well as evidence of robust safeguarding procedures.
- **Effective**: whether national guidance and evidence is used in practice and whether there is provision for all tiers of treatment, from early intervention to aftercare, a range of interventions offered including one to one and group work and an approach that confirms holistic health needs such as people's nutritional needs being assessed alongside their drug use.
- **Responsive**: whether the service meets the needs of the local population, can work with those who need it in a timely way and shows flexibility in approach.
- **Well led**: evidence of a robust, clearly guided workforce with embedded and well developed policies and procedures.

5.11 Overall, evidence suggests that the recovery model is only achievable through provision of holistic treatment services that include:

- Pharmacological modalities, such as prescribing or alcohol detoxification.
- Psychosocial modalities, such as one to one work, groups and counselling.

- Focus on the other aspects of a person's life that stops them moving forward, such as housing, employment, family breakdown, physical or mental health etc.

Young people

5.12 Evidence shows that very few young people develop dependency. Those who use drugs or alcohol problematically are likely to be vulnerable and experiencing a range of problems, of which substance misuse is one. Therefore, the aim is to address all needs, rather than addressing substance misuse in isolation.

5.13 The majority of young people accessing specialist drug and alcohol interventions have problems with alcohol and cannabis requiring psychosocial, harm reduction and family interventions, rather than treatment for addiction, which most adults require. Most young people only need to engage with specialist drug and alcohol interventions for a short period of time, often weeks, before continuing with further support elsewhere, within an integrated care plan.

5.14 The emphasis within the young people's strand of the National Drug Strategy 2010-2015 is on protecting young people by preventing or delaying the onset of substance use. The Strategy advocates for:

- The provision of good quality education and advice to young people and their parents.
- Targeted support to prevent drug or alcohol misuse.
- Early interventions to avoid any escalation of risk and harm when such problems first arise.

5.15 However, evidence does suggest that specialist substance misuse interventions, such as one to one psychosocial support and harm reduction, contribute to improved health and wellbeing, better educational attendance and achievement, reductions in the numbers of young people not in education, employment or training and reduced risk taking behaviour, such as offending, smoking and unprotected sex.

6. DRUG AND ALCOHOL SERVICES IN THE ROYAL BOROUGH

6.1 The JHWS builds on the JSNA and sets out how key local health and wellbeing issues in the Royal Borough need to be addressed. The Strategy is designed to enable residents to help themselves and to support partners to secure key health and wellbeing issues within their priorities and strategic plans.

6.2 Within the emerging Strategy are two key priorities relating to drug and alcohol services within the theme of Supporting a Healthy Population – specifically Priority 2 and Priority 4, see figure 1.

Figure 1: Theme 1, Joint Health and Wellbeing Strategy

Theme 1 – Supporting a Healthy Population

Priority 1 – Enable more children and adults to be at a healthy weight.
Priority 2 – Lower risky levels of alcohol intake.
Priority 3 – Get more people to be more active more often.
Priority 4 – Empower people to be educated to 'Self Care'.

Drugs

6.3 The Royal Borough's JSNA states that locally, around three people in every 1,000 living in the Royal Borough of Windsor and Maidenhead are in drug treatment. Local information shows that out of 279 clients, the most prevalent drug is heroin, followed by cannabis and then cocaine. Clients' planned exits continue to improve year on year, and successful completions for opiate clients are above national performance.

6.4 Locally, the DAAT has continued to focus on reducing harm and ultimately aim for abstinence, through a range of treatment interventions. Additional priorities have been to create stronger links with mental health services, increase the number of clients being screened for and vaccinated against blood-borne viruses and to deliver a robust communications strategy. In addition, the team has continued to develop the 'recovery' agenda, ensuring clients are able to positively contribute towards their communities.

6.5 Since the integration of the drug and alcohol service, there has been an increase in the number of alcohol clients. Local information shows that in 2011-2012, 32% of clients were in treatment for alcohol problems, which rose to 44% in 2012-2013. Overall, the number of heroin and crack users is reducing and there is an increase in the use of legal highs and 'party drugs', such as MDMA and mephedrone. The percentage of clients with a dual diagnosis – substance misuse and mental health problems – has risen.

6.6 SMART has been recognised as working with a greater percentage of complex clients than would be reasonably expected by the inherent social factors within the Royal Borough.

Alcohol

6.7 The Local Alcohol Profiles for England show that admissions to hospital that are estimated to be due to alcohol have risen slightly over the past five years for both men and women living in the Royal Borough. They still remain below the national and South East region averages, as well as the average for local authorities with similar levels of deprivation. Around 11 in every 100,000 people under 75 locally die as a result of liver disease. This is lower than the national figure and comparable to the average of local authorities with similar levels of deprivation.

6.8 Around 20 people of working age in every 100,000 are claiming Incapacity Benefit or Severe Disablement Allowance with the main reason to not work being alcoholism. This is fewer than the average nationally and in the South East. Crime attributable to alcohol has decreased over the past five years to a rate of fewer than seven crimes per 1,000 people. This is lower than the national average, although higher than the

South East region average. Violent crime estimated to be due to alcohol was falling in the Royal Borough although recent data suggests the figure is rising.

6.9 Overall, the numbers of adults accessing treatment has risen from 141 in 2011-2012 to 215 in 2012-2013. In addition, in common with the national increase in those experiencing problematic drinking over the age of 50, the age of those entering treatment has increased locally.

6.10 A survey conducted of 756 young people, aged between 13 and 17, in June 2013. Indicated that the substances used by young people in the last year were alcohol, 84%, tobacco, 42%, cannabis, 22%, MDMA/ecstasy, 7%, legal highs, 6% and mephedrone, 6%. Only a very small number of respondents admitted to having tried cocaine, ketamine and speed, less than 10 in each case, and none stated that they had tried heroin.

6.11 The use of party drugs such as MDMA and Ecstasy has increased in prevalence, but the numbers using them are still low in comparison to alcohol and cannabis. A small number of clients are in treatment for mephedrone use, but numbers have fallen. Cannabis remains the most commonly used drug amongst young people. However, substances are often used in combination, illustrated by the high incidence of cannabis and alcohol use.

Adult prevalence and performance

6.12 In broad terms, the Royal Borough is considered to have a level of need which is "consistent" with the rest of the country. This is a categorisation given by PHE in their 'Healthier Lives' mapping. All authorities have a formulated estimation of the prevalence of opiate/and or crack cocaine users (OCU) per 1000 of the population aged 15 to 64.

6.13 At 6.2 per 1000, prevalence of opiate/and or crack cocaine users in the Royal Borough is average in terms of the national picture for England. However, in comparison with the other 15 authorities who are in the comparative socio economic group (decile 10 least deprived in England), the Royal Borough and Bath and North East Somerset are the only two authorities considered to have a higher than average level of need. The estimation of 6.2 per 1000 adults, equates to 582 heroin and or crack users in the community who could be accessing treatment. This would represent a significant increase from current numbers in service.

6.14 In terms of alcohol use, the data is not entirely equivalent. However, the North West Public Health Observatory publishes estimations of drinking populations for each authority which shows that 16.6% of residents in the Royal Borough are estimated to be at 'increasing risk' due to alcohol consumption and 6.8% at 'high risk'. The Berkshire alcohol needs assessments showed that, of the Berkshire authorities, the Royal Borough was third in terms of both male and female alcohol related mortality rates, although this is below the national averages. The Royal Borough was also ranked third in Berkshire in terms of alcohol related recorded crime. Emergency admissions to hospital are measured by Clinical Commissioning Group area and for liver disease for 2013/2014, were higher in Windsor and Maidenhead than in Wokingham or Bracknell and Ascot.

Adult performance

6.15 Adult drug and alcohol treatment is primarily judged upon **successful completions** which is the number of people completing treatment who are either abstinent or have significantly reduced their substance misuse. However, significant reduction does not count as a 'success' if the substance is a Class A drug. As at September 2015, latest data available, there had been 525 successful completions in the Royal Borough, 229 for opiates, 41 for non-opiates, 172 for alcohol and 83 for alcohol and non-opiate.

6.16 Whilst important, successful completions only measure those exiting treatment in a planned way as a proportion of all those 'in treatment' at any one time. The measure does not necessarily show the benefits for all of those who remain in the service but are not yet ready to leave. For example, if a person is maintaining their employment and home but is still on a low dose of methadone, they cannot yet be counted as a successful completion, yet there would be clear benefits to the individual as well as the economy.

6.17 Another measure is the percentage of service users in '**effective treatment**' which is the number of people who have remained in treatment for 12 weeks or more, a length of time which has been evidenced as being likely to have significantly reduced substance use and improved other outcomes for the service user. In 2014-2015, the Royal Borough performed equal to, or better than, the national averages, with 98.2% of opiate users, 97.3% of non-opiate users and 97.5% of alcohol and non-opiate users.

6.18 **Unplanned exits** from the service measures the new presentations who had an unplanned exit, or were transferred before the 12 weeks had been completed. The Royal Borough performed better than national averages meaning less drop outs were occurring at a crucial point and therefore benefits of treatment should have been gleaned by more service users – 5.8% of opiate users, 0% of non-opiate users, 3% of alcohol and non-opiate users and 3.8% of alcohol users.

6.19 Service users' drug and alcohol use is recorded at a six month review. The figures for 2014-2015 show that most services users in the Royal Borough have already secured significant benefits from treatment, see table 1.

Table 1: Abstinence and reliably improved rates, 2014-2015

Main substance	RBWM abstinence rate	National abstinence rate	RBWM reliably improved rate	National reliably improved rate
Opiate	26%	41%	26%	25%
Crack	67%	49%	3%	13%
Cocaine	77%	69%	13%	9%
Alcohol (adjunctive)	19%	31%	18%	16%

6.20 Employment rates are measured by recording all those who had worked for more than 10 days out of the previous 28 at the point of successfully leaving treatment. The Royal Borough is consistently above the national average at 47.6% for opiate users compared with 22.9%, and 44.8% for non-opiate users compared with 32.3%.

Young people's performance

6.21 In the Royal Borough, the two Young People's Substance Misuse Workers provide one to one treatment work and the prevention work. There were 79 young people in

treatment during 2013-14. The Royal Borough had a slightly greater percentage of young people who were 13 or under in treatment, 8% compared with 6% nationally. The Borough has a significantly higher percentage of 14 and 15 year olds in treatment, 49% compared with 35% nationally. This is due to the service's success in getting young people into treatment at an early age before their problems become severe or complex.

6.22 In quarter one of 2015/16, the Royal Borough compares favourably with the other Berkshire authorities in terms of number in treatment, third highest with 68, and percentage of planned exit rates, second highest with 83%. Planned exit refers to those that have stopped using all substances, or only occasionally using non Class A substances, as well as having reached the goals in their treatment plan.

Value for money and return on investment

6.23 In terms of overall value for money, the latest PHE Value for Money tool showed that the Royal Borough offered a saving of £5.51 for every £1 spent. This compares favourably with the national average of £2.50 saved for every £1 spent. This is due to the likely costs that would be incurred by the wider community, namely health and criminal justice services and other local authority costs.

6.24 In early 2015, a specific piece of work was undertaken in order to compare the Royal Borough with Wokingham in terms of value for money as Wokingham had the lowest spend in Berkshire. In terms of relative demand for drugs and alcohol, the spend ratio in the Royal Borough was proportionate. In addition, a cost per head comparison between Wokingham and the Royal Borough was carried out based on 2014-15 data. The current average cost per person per day in the Royal Borough was £5.52, compared with £6.04 per head per day in Wokingham.

6.25 Full information on prevalence and performance in relation to drug and alcohol services in the Royal Borough is set out in the Benchmarking and Best Practice Report, see Appendix 5.

7. FEEDBACK FROM RESIDENT AND STAKEHOLDER CONSULTATION

7.1 Two online surveys were undertaken between 15 January and 12 February 2016 – one focussed on adult treatment services and the other on services for young people. The survey web link was emailed to a wide range of internal and external partners and could also be accessed via the Royal Borough website allowing residents and users to participate. Forty seven respondents completed the adult drug and alcohol services consultation and 23 completed the young people's survey. The respondents were made up of both those feeding back individual opinions and those who were answering on behalf of an organisation. Detailed feedback from the surveys, including the questions and methodology, is available in Appendix 6 of this report.

7.2 In addition, bespoke meetings were held with key stakeholders during January 2016 to inform the outcome of the review and provide more detailed insights on current best practice and service models

Summary of the online consultation feedback – adult services

7.3 The headlines from the consultation responses were:

- Prevention was seen as a priority as a measure of success.

- Adult drug and alcohol service should provide a range of prevention and treatment services with resources being flexibly deployed to meet changing needs.
- There should be a balance between drug and alcohol provision.
- Those requiring services should be able to access them.
- Those who had relapsed should be able to re-access services and access should be unlimited.

7.4 When asked about the future focus of the service, over 75% of respondents felt it should have a wide range of drug and alcohol provision that offers prevention alongside treatment as opposed to a service with more emphasis on particular elements. Over 90% of respondents felt that the service should be flexible rather than targeted towards specific needs. The majority of respondents, 60%, felt that the service should not focus on any specific substances.

7.5 The view that the service should be needs led came through in a number of the comments. Sixty seven per cent of respondents felt that alcohol and drugs should have equal standing and a further 25% of people felt that provision should be needs led. One hundred per cent of respondents felt that service users should be able to access further treatment after relapse and 63% felt that access should be unlimited.

7.6 Nearly three quarters of respondents felt that different groups of service users should be looked at in different ways and with different expectations. Eighty seven per cent of respondents felt that it would be reasonable to categorise service users into three outcome groups:

- Enabling those who are chaotic users of drugs/alcohol to start to achieve stability.
- Enabling those who are stable to work towards recovery.
- Enabling those who are being maintained on substitute drugs to achieve full recovery.

7.7 In relation to priority groups, parents with safeguarding issues were ranked highest followed by those with mental health conditions, pregnant women and those who were high risk/dependent drug and alcohol users. Those using legal highs and recreational drug users/binge drinkers were given the lowest priority. The majority of respondents, 64%, wanted a holistic service which offered a full range of both prevention and treatment services. Desirable elements of the service should be, group work followed by education and skills, outreach work and prevention work.

7.8 Seventy six per cent of respondents felt that there should be one contract for both recovery and prescribing services. Just over half of respondents, 53%, felt it would not be a good idea to buy the service with other Berkshire authorities on the basis that the service needed to be able to meet local needs, the six local authorities were very different and there was a risk that the service would be diluted.

7.9 Partner organisations completing the survey were asked to state what their priority was from the service. Accessibility received the most responses, 28%, followed by recovery, 22%, and an effective/reliable service, 17%. In relation to targets or plans that may be impacted by these services, 41% stated that their organisation may be affected. Twenty five per cent of respondents stated that there were future developments in their service area which may impact upon this agenda.

7.10 Respondents were offered three options in relation to how success could be defined for different types of service users, see point 7.6. For both chaotic and stable users, success was defined as someone leaving the service and being abstinent from any use or managing their use. For service users being maintained on substitute drugs, success was defined as someone leaving the service and being abstinent from any use or not re-presenting.

7.11 Success for stakeholders was defined by 43% of respondents as the effectiveness of the service in preventing people from needing the services in the first place. The remaining respondents felt that success could be measured through users becoming productive and having successful lives, a reduction in crime and a reduction in ill health/hospital admissions.

7.12 For both partners and residents, success was defined as the reduction of crime and antisocial behaviour followed by increased knowledge to discourage and/or avoid misuse. Value for money was also stated as a measure of success.

Summary of the online consultation feedback – young people's services

7.13 When asked what the future focus of the service, 52% of respondents felt it should have a wide range of drug and alcohol provision that offers prevention alongside treatment as opposed to a service with more emphasis on particular elements. As with the adults survey, over 90% of respondents felt that the service should be flexible. 64% felt that the service should not focus on any specific substances.

7.14 When asked when prevention work should begin, the most popular response was Year 6, 10-11 years, followed by Year 7, 11-12 years.

7.15 Respondents felt that priority should be given to young people involved in/at risk of child sexual exploitation followed by those with mental health conditions, young people on a child protection plan and young offenders or those at risk of offending. Young carers and those with physical health conditions were given the lowest priority.

7.16 In terms of the essential elements of the future service, as with the adults' survey, the majority of respondents, 64%, wanted a holistic service. Desirable elements of the future service were training/raising awareness with other professionals, information/ support for parents and prevention work. Sixty five per cent of respondents said that the specialist young people's treatment service should be separate from the adult service with 71% agreeing that it should be provided with other young people's services.

7.17 Unlike the adult survey, 53% of respondents agreed that it would be a good idea to buy the service with other Berkshire authorities to make the best use of money.

7.18 For partners, any future service must meet the needs of young people, followed by support for young people and prevention and treatment. When asked what they could contribute to service delivery, partners indicated additional support for clients, partnership working and advice/guidance. In relation to targets or plans that may be impacted by these services, 25% of partners stated that their organisation may be affected. A further 25% stated that there were future developments in their service area which may impact upon this agenda.

7.19 For young people with complex needs, success was defined by respondents as someone leaving the service and being abstinent from any use or managing their use. For occasional users, it was someone leaving the service and understanding and managing the risk.

7.20 For stakeholders, success was defined as the effectiveness of the service in preventing people from needing the services in the first place. For partners and residents, success was defined as increased awareness to discourage and/or avoid misuse. As with the adult service, just over half of the respondents measured success in terms of value for money.

The Task Finish Group and bespoke meetings

7.21 Bespoke meetings were held with key stakeholders to seek their views, see table 2:

Table 2: Summary of key points from bespoke meetings

Agency	Key points
Probation	• Substance misuse treatment plays a significant part in the reduction of crime. • A 'good' service is seen as being flexible, accessible and needing to address a range of issues including lower level alcohol use and the use of legal highs. • A robust structured day programme of varied groups was viewed as an essential feature for Probation in order to fulfil the requirements of court orders.
Berkshire Healthcare Foundation Trust	• Substance misuse services have strong links with mental health and around a third of Community Mental Health Team service users also misuse substances. • There was not one model of treatment service that was seen as preferable as it must reflect local need but it must be flexible and work closely with mental health services. • Suggestions around measuring performance in areas which would be impacted upon by treatment were suggested including admission and re-admission rates.
Public Health England (PHE)	• A 'gold standard' service would be a seven day a week service with assertive outreach bringing service users into treatment, linking to housing and employment. • It is important to have specialist young people's knowledge in place. • Prevention is very important and equally as important is the ability to monitor child sexual exploitation links and other key risk factors. • Good information sharing strategies and a flexibility of approach need to be in place. • Separating drug and alcohol services, whilst possible, was not considered to be an effective use of resources. A better joined up approach with GPs offering the initial advice and possible referral is needed • Whilst it could appear that a lot of money is spent on a few people, all aspects of the service are important in terms of

Agency	Key points
	outcomes for residents. • There were definite advantages in keeping the model small, in terms of the number of authorities involved in commissioning, in order to focus on local community needs.
Service Manager, SMART	• Some users were more entrenched than others and that whilst small numbers may never change and were extremely difficult to engage, for the majority there would be elements of success. • There were a small group of homeless service users (10-12 people) who would not be able to become stable until they had their accommodation issues solved.
GP, Claremont Surgery	• Although working with those with more problematic drug use (Tier 3), it is key to work with people at the lower levels to stop their drug use from becoming entrenched. Just focusing on those who were the most problematic would lead to there being more people at this high level. • Concerns were expressed that some service models were moving away from fortnightly GP scripting appointments to monthly or even bi-monthly appointments. Scripts are signed in advance by the GP and the clinic worker then makes the decision whether or not to give the service user their script.

7.22 Bespoke meetings were also held with service users at SMART, see boxes 1 and 2 for their views.

Box 1: Views from Service User A

Success was difficult to measure over a short period of time when addicts had often been using drugs for many years. A had first used heroin at the age of 13 and had spent more of his life on it than off it. His previous experience of treatment had just involved being given a script without any of his problems being tackled. However, at SMART his mental health and lifestyle were being looked at to aid long term change. A explained that he had been depressed to the point of being suicidal and that suicide was an easy way out for an addict. It was a peaceful option. He has been supported by the service and is at the point of having a diagnosis for his condition. Previously things had been missed.

A would like to have normal every day problems like everyone else and that success is to have a better day than yesterday. He views addiction as a cancer that eats away at you.

If there wasn't another service available like SMART, A would not know where to turn. He might try to get help from another borough, but he may go back to taking drugs and committing crime. He explained that being scripted kept him away from crime and that there was also the family aspect to the service. He has two children and a partner and Social Services were now satisfied that there were no risks to his children.

A thought that more opportunities for residential rehabilitation would be a positive thing. Less than 10 service users go a year and many people just give up before they get there as the requirements are so strict. He also thought that the current three year contract for service providers is too short as it takes services some time to bed in and put their roots down.

Box 2: Views of Service User B

B stated that the service had saved her life. She had accepted that she was an alcoholic four years ago and had tried to stop drinking over that time, but it was only when she came to SMART six months ago that she had made progress. She had now been sober for 12 weeks, had lost 2st 7lbs in weight and had recently been signed off by Social Services.

She did not feel she was judged at SMART and she liked the fact that the service dealt with the whole person and not just the alcohol. Currently, she comes into SMART three times a week and attends a minimum of three AA meetings. She had found the Anxiety Management Group and the Health and Wellbeing group very helpful. She also thought that groups gave a purpose to a service user's day. Boredom had been one of her triggers to drink.

For B, success would be complete abstinence rather than controlled drinking. She considers herself to be in 'healthy recovery' and that SMART had been her bridge to normal living. She feels that those in recovery should help those who are not and would like to volunteer for SMART to give something back. Her next step will be to get a job in 2016.

7.23 A key learning was the importance of having a welcoming, safe location which:

- Service users were encouraged to visit, not just for appointments, at any time during the day.
- Provided a non-clinical environment for group sessions.
- Provided a space to meet other clients in order to access a support group of people aiming for the same outcome.
- Enabled service users to be able to remove themselves from a situation that was providing a temptation.

8. ANALYSIS OF NEED AND DEFINITION OF SUCCESS

8.1 Based on the assessment of need and the feedback from the consultation, service users of drug and alcohol services can be categorised into four outcome groups:

- Group 1: Preventing people from needing drug and alcohol services in the first place.
- Group 2: Enabling those who are chaotic users of drugs/alcohol to start to achieve stability.
- Group 3: Enabling those who are stable to work towards recovery.
- Group 4: Enabling those who are being maintained on substitute drugs to achieve full recovery.

8.2 Clearly, demand in each of the outcome groups will change over time, but the aim will be to move service users through to full recovery. Whilst there will be a small

number of people whose use will never change, for the majority there will be elements of success.

8.3 Measures of success for each of these outcome groups have been defined, see table 3. However, in addition, the overall measure of success for drug and alcohol services would be value for money using PHE's Value for Money tool, see points 6.20 and 6.21. The current saving for the Royal Borough is £5.51 per £1 spent – the expectation would be to maintain value for money at least at this level.

Table 3: Measures of success

Outcome group	Measures of success
Group 1	• Reduction in number of service users requiring treatment. • Number of people reporting increased awareness which discouraged/avoided misuse (self-reported survey).
Group 2	• Percentage of service users exiting the service and being able to self-manage their use. • Percentage of service users maintaining employment. • Percentage of service users exiting the service and being abstinent from any use. • Reduction in number of referrals to children's safeguarding services where drugs and alcohol are the main presenting issues.
Group 3	• Percentage of service users exiting the service and being abstinent from any use. • Percentage of service users exiting the service and not re-presenting.
Group 4	• Percentage of service users exiting the service and not re-presenting. • Percentage of service users exiting the service and being abstinent from any use. • Reduction in ill health/hospital admissions.

8.4 In relation to the self-reported survey, see Group 1 in table 3 above, it is acknowledged that seeking the views of young people, potentially through a survey undertaken in schools, will be more straightforward to secure. All the evidence suggests that discouraging use at a young age secures more positive outcomes in the longer term and therefore, focusing on a survey of younger people will help to refine the Royal Borough's prevention strategy moving forward.

8.5 More detailed value for money measures could also be determined across a wider range of services – for example around reducing the number of children subject to child protection plans and/or the number taken into care where drugs and alcohol are the main presenting issue. The estimated cost per child on a child protection plan per annum is £16,260[3] and per child in care per annum is £36,000[4].

[3] Data derived from *The Cost of Troubled Families*, Department of Communities and Local Government, January 2013.

[4] Data derived from *Children in Care in England*, House of Commons Library, August 2014.

8.6 Based on the analysis of need, future service provision for **adults** should comprise:

- A range of prevention and treatment services which are flexibly deployed to meet changing needs. This means that the service would not focus on specific substances but could change focus as the needs of the population change as evidenced through the JSNA and detailed data through the National Drug Monitoring System.
- There needs to be an equal emphasis on drugs and alcohol within the service but given the higher numbers, prevention should be major focus in relation to alcohol. This would also link to the priority outlined in the emerging JHWS, see point 6.2.
- These services would be best commissioned externally rather than seeking to provide in-house. Existing contracts evidence good engagement from service users and good performance in terms of treatment.
- It is acknowledged that the wider workforce will provide a significant amount of prevention services and part of the role of the commissioner will be quality assure the provision of these services. Appropriate resources will need to be secured to undertake this activity.
- Wider partner engagement in terms of alignment of plans and activities across health, other local authority and criminal justice organisations is vital to ensure that there is a breadth of service provision for all service users.
- In addition to specialised prevention interventions, more generic prevention activity should be embedded in the practice of all front line workers.
- Good access to the services for all are required, including for those who need to access further treatment after relapse.
- Whilst offering access to all, priority groups for services should be:
  - Parents with safeguarding issues.
  - Users with mental health conditions.
  - Pregnant women.
  - High risk/dependent drug and alcohol users.

8.7 Based on the analysis of need, future service provision for **young people** should comprise:

- A range of prevention and treatment services which are flexibly deployed to meet changing needs. This means that the service would not focus on specific substances but could change focus as the needs of the population change as evidenced through the JSNA and detailed data through the National Drug Monitoring System.
- Given the evidence that very few young people develop dependency and that those who misuse drugs or alcohol are likely to be vulnerable and experiencing a range of problems, the maximum benefit would be achieved through delivering in an integrated way with other services aimed at young people.
- On that basis and given existing good engagement and performance, continuing to provide the services in-house would be most effective.
- It is acknowledged that the wider workforce will provide a significant amount of prevention services and part of the role of the commissioner will be quality assure the provision of these services. Appropriate resources will need to be secured to undertake this activity.
- Wider partner engagement in terms of alignment of plans and activities across all organisations delivering services to young people is vital to ensure that there is a breadth of service provision for all service users.

- In addition to specialised prevention interventions, more generic prevention activity should be embedded in the practice of all front line workers.
- Whilst offering access to all, priority groups for services should be:
  - Young people involved in/at risk of child sexual exploitation.
  - Those with mental health conditions.
  - Young people on a child protection plan.
  - Young offenders/those at risk of offending.

9. PROPOSED OPTIONS

Commissioning and coordination

9.1 The current DAAT is resourced through an operational manager post and two commissioning officer posts. These posts provide contract management for the two contracts, raise awareness of existing and new substances, carry out prevention work, coordinate the work around drug and alcohol across the Royal Borough and work with local partners to reduce crime and anti-social behaviour associated with substance misuse. The annual costs associated with this work is £117K and the TFG recommends that these are retained in order to provide quality assurance future provision and permit additional emphasis on preventative activities and the prevention agenda.

Elements of service – adults

9.2 In order to inform decisions around the future configuration of the Royal Borough's adult substance misuse services, the interventions needed to serve the existing client group can broadly be separated into:

- Those which are fundamental for the core service model and are therefore deemed essential.
- Those which enable the core service model and are therefore deemed essential.
- Those which enhance the core service model and can therefore be deemed desirable.
- Other health treatments/services provided by the wider health economy, including mental health services, to which service users are signposted, see Appendix 7.

9.3 The different elements defined within each of the above groups are based directly on the benchmarking analysis and consultation feedback described above, and the defined measures of success set out in table 3.

9.4 Any treatment service must balance psychosocial provision with pharmacological interventions. A core service model should include a number of elements:

- Assessment and screening, including risk assessments.
- Referrals, signposting and interagency working, including safeguarding.
- One to one support work which can include structured psychosocial work and unstructured work such as identifying triggers, goal setting and care planning.
- Structured and unstructured group work.
- Substitute prescribing for opiate users.
- Drug testing for both prescribing clients and those on Drug Rehabilitation Requirements (Probation Orders).
- Criminal justice specific interventions.
- Adequately trained and supported staff at every level of delivery.

9.5 In line with the Council's transformation principles, the **core service model** has been broken down into "invoiceable" elements and associated opportunities, see table 4 for detailed requirements and estimated annual costs and Appendix 8. These estimates are based in historical analysis and future costing projections. Return on investment is detailed in point 9.8.

Table 4: Detailed core service requirements and estimated annual costs

Requirement	**Estimated costs per annum**	**Notes/opportunities**
Service management costs (1 FTE service manager and 1 FTE team leader)	£67K *	For the prescribing element of the service, some sort of clinical governance/ management is required in addition to non-clinical staff/service management.
Organisation management costs (senior management input and HR support)	£35K *	This can vary greatly depending on what the provider can offer, eg centrally placed training leads, clinical specialist etc.
Assessment worker (1 FTE)	£22K *	Initial assessments of all clients, including early identification of all risks
Recovery workers (10 FTEs)	£240K *	Salary levels will vary depending on skills, experience and qualifications.
Prescribing staff	£145K **	Nurse and doctor input, including clinical provision at multiple venues and extended hours.
Alcohol detox – 0.5FTE band 6 nurse	£18K *	This has to be delivered by a clinically trained worker such as a prescribing nurse.
Blood borne vaccine nurse – half a day per week nurse time	£7K *	Vaccinations against and screening for blood borne viruses is an important part of provision and requires a clinical worker.
Dual diagnosis – two days per week from a nurse or other worker	£12K*	This cost represents a non-clinical member of staff and is therefore minimal in terms of costs required. This particular area would benefit from a joint agreement with local mental health services.
Administrative costs	£32K *	This would pay for 1FTE administrator and includes consumables and office costs.
Accommodation costs	£40K	The provision of a suitable building with appropriate facilities, easily accessible.
Supplies and services		
Case management system	£10K *	Needs to be compliant with the National Drug Treatment Management System.

Requirement	Estimated costs per annum	Notes/opportunities
Staff training	£10K *	To cover basic standard training, not any specialist training which may be required.
Needle exchange – consumables and some worker time	£2K	Needles and associated safety equipment have to be purchased. A pharmacy needle exchange is in place; however, the service needle exchange offers harm reduction advice and potentially an access point to treatment.
Literature/promotion for the service	£2K	Designing and publishing leaflets posters and flyers to advertise and promote the full range of services available.
Supervised consumption	£20K	Providing a local pharmacy support network to ensure clients have access to medication
Medication costs	£35K	The cost of opioid substitute medication
Laboratory costs	£3K	The provision of accurate drug testing and analysis.
Clinical waste and testing equipment	£2K	The purchase of and disposal of drug testing equipment.
Drug testing for other services – consumables and laboratory costs	£2K	Social care often require drug testing which has to be accounted for.
Estimated TOTAL	**£704K**	

* The items indicated roughly equate to the current Recovery Service model. However, they represent a reduction of around £80K per annum as they are based on current market testing figures and therefore represent a proposed saving.

** The prescribing service cost is an increase of around £25K per annum in order to ensure prescribing is available within extended hours to aid those who are in employment. This is a key access consideration and consistent with best practice evidence to support people in work and in turn reduce associated costs from users not working.

Note: All other costs are paid for through the DAAT budget, outside of the current service contract cost but are essential in order to deliver a community treatment service. However, they equate to similar spend to current levels.

9.6 The main costs associated with the core service are related directly to employees. Clinical staff time is required for substitute prescribing or other interventions such as community alcohol detoxes but the majority of the client support or 'recovery' work is carried out by generic 'recovery' workers. The breakdown of an average recovery worker's week, holding a baseload of 30 clients would be:

- One to one client work – 15 hours direct contact.
- Harm reduction work to additional 'tier two' service users – one hour.

- One to one preparation and planning/case note completion post contact – 15 hours.
- Group work delivery – two hours.
- Group work preparation and post group evaluations – two hours.
- Prescribing clinic support – two hours.
- Meeting attendance and partnership working – one hour.
- Referrals for clients, signposting and report writing – one hour.

This average baseload is consistent with other areas and in line with best practice guidelines for treatment of drugs and alcohol addictions.

9.7 In addition to the minimum core service model, there are other services which would be required to **enable** the core model to operate effectively and efficiently and are therefore also categorised as essential enablers. Many of these services could be further enhanced by working with partners and this is a possible angle to explore further. Without these services, users are far less likely to transition away from chaotic lifestyles or move to recovery in a timely and cost-effective way, which in turn would likely lead to increased downstream costs and a consequential negative financial and social impact to residents and RBWM. These services have similarly been broken down into "invoiceable" elements, see table 5 for detailed elements and estimated annual costs. These are services which are not currently provided through the DAAT, but which through the analysis of need have been identified as important to the delivery of the core model and given increased user demand and trends

Table 5: Detailed enabling service requirements and estimated annual costs

Requirement	Estimated costs per annum	Notes/opportunities
Aftercare support/ mutual aid	£10K	Aftercare provision for those stepping down from structured treatment.
Shared care – 0.5FTE development worker	£10K	GPs who prescribing opiate substitutes within their own surgeries must be supported by the service as must the client. Development work with GPs is also required locally in order to move this scheme forward.
Outreach work/ wider community work – 1FTE worker	£30K	This could involve detached work with street drinkers, outreach into homes of those too unwell to visit the service as well as projects such as community drop ins, night time economy work etc.
In-reach to prison and hospital – 1FTE worker	£30K	Similar work to the outreach work but with a specific focus on work in prison settings pre-release, police custody or hospitals.
Health and wellbeing	£15K	Ranging from training workers to deliver low level health prevention interventions and giving brief advice, to buying in other service or nurse time.
Employment/training support – licensing	£15K	Covering more basic skills, CV support and links to the workplace.

Requirement	Estimated costs per annum	Notes/opportunities
and accreditation of groups, client IT equipment or a part time post to support this area of work		
Family work – 1FTE family support worker	£30K	Covering carers support, couples therapy, family support etc.
Estimated TOTAL:	**£140K**	

9.8 There is a further set of services that would enhance the core service model and its associated enabling services and which could be deemed as **desirable**, see table 6. These are particularly pertinent given the variable type of service user and associated changes in user demand and the wider social environment and context when considering drugs and alcohol. Evidence shows that trends associated with the type of drug and alcohol addiction are unpredictable and highly variable. As with the enabling elements, these services are not currently provided through the DAAT or are supported at a low level through other public health funding.

Table 6: Detailed desirable service requirements and estimated annual costs

Requirement	Estimated costs per annum	Notes/opportunities
Counselling – 0.5FTE trained counsellor	£18K	The employed person would also be responsible for utilising volunteer trainee counsellors who would but need to be supervised.
Alternative therapies	£3K	Alternative therapies such as relaxation and reflexology are often utilised to aid recovery.
Online recovery programme, for example, Break Free Online	£10K	This is used as an additional tool for service users or others with low level issues who do not require the full service.
Additional recovery interventions, eg sports sessions, cookery, creativity, gardening.	£5K	Recovery interventions are important as often people have to find alternative positive ways to spend their time.
Mentoring/ volunteering scheme – supervision or a part time coordinator post	£5K	Volunteers can be an important addition to provision; how they are supported, trained and managed depends on capacity.
Contingency for	£50K	A proactive and flexible resilience for future

Requirement	Estimated costs per annum	Notes/opportunities
demographic changes		trends and developments in drugs, drug use, population etc.
Estimated TOTAL:	**£91K**	

Return on investment

9.9 Return on investment calculations are based on an assessment of psychosocial provision and pharmacological interventions which should be balanced in any treatment programme. Based on the core and enabling service requirements set out in tables 4 and 5, the return on investment figures have been outlined in Table 7. Using the latest PHE calculator, these are arrived at by using the previous year's official treatment figures (the numbers accessing the service during 2014/15) against the money spent on each part of the service, in order to calculate the average cost of treating each person per day. It should be noted that a significant part of the return on investment from such services will by definition be qualitative and difficult to capture in pure monetary terms. This is particularly relevant in terms of downstream costs from events avoided and the overall value of preventative aspects of the service and treatment.

Table 7: Return on investment

Assessment	Return on investment	Core and enabling service elements used in the calculation
Community drug treatment – pharmacological	Royal Borough = **£3.18** per person per day. National published average span = £6.56-£9.06 per person per day.	Service management costs, organisation management costs, assessment worker, recovery works, prescribing staff, blood borne vaccine nurse, dual diagnosis, administrative costs, accommodation costs, needle exchange, laboratory/ testing costs, medication costs, supervised consumption, shared care payments
Community drug treatment - psychosocial	Royal Borough = **£4.49** per person per day. National published average span = £8.45-£11.29 per person per day.	Counselling, staff training, outreach work, in-reach to prison and hospital, health and wellbeing, employment/training support, family work, aftercare support.
Community alcohol treatment – psychosocial	Royal Borough = **£7.06** per person per day. National published average	Alcohol detox, counselling, staff training, outreach work, in-reach to prison and hospital, health and

Assessment	Return on investment	Core and enabling service elements used in the calculation
	span = £8.26-£16.02 per person per day.	wellbeing, employment/training support, family work, aftercare support.

9.10 As Table 7 shows, local return on investment compares favourably to the national average highlighting the value of the service. Ensuring the service is focused on future imperative and changing demand with a clear definition and measurement of success will be important to maximise future return on investment to residents and the benefits to service users.

Elements of service – young people

9.11 The TFG has concluded that, in terms of the young people's service, it would best be delivered in an integrated way with other children's services. This is because:

- Substance misuse is generally just one of a range of problems being experienced by a young person and therefore an integrated support plan working through a wide range of services is most appropriate.
- Young people generally do not develop dependency. Most young people only need to engage with specialist drug and alcohol interventions for a short period of time, often weeks, before continuing with further support elsewhere.
- Preventing or delaying the onset of substance misuse depends on the provision of good quality education and advice to young people and their parents which can be delivered more effectively through the wider children's workforce.
- Employing a small number of specialist substance misuse workers targeting young people with particular substance misuse needs will contribute positively to wider positive outcomes for children and young people. The direct provision through two substance misuse workers is appropriate for the level of need and should be continued.

9.12 The DAAT currently employs two young people's substance misuse workers at an annual cost of £69K, including on costs, supplies and services. The TFG recommends retaining this resource in order to deliver this part of the service.

Signposting

9.13 A key function of the current drugs and alcohol service is signposting users to other relevant services across the Royal Borough. The TFG has concluded this is an essential part of any future service and an area that warrants further exploration and definition. Such services include, amongst others, local mental health services, GP services and outreach programmes.

9.14 To ensure any future service model is optimised to account for this important and relatively inexpensive component of the service, it is recommended a comprehensive operational action plan be formulated to ensure this signposting is maximised and identifies relevant gaps in the wider local health economy. This would also potentially provide additional opportunities for greater integration across services consistent with the JSNA and JHWS. It is proposed this item be taken to the Local Health and Wellbeing Board for further scrutiny and analysis.

Health, crime and equalities impact assessments

9.15 Health, crime and equalities impact assessments have been undertaken. These are important to evaluate the proposed options and recommendations. The full assessments are at Appendices 9, 10 and 11. Three health impact assessments were undertaken, one by the GP lead, one by Berkshire Healthcare Foundation Trust and one by the Director of Public Health. In summary, the assessments concluded:

- **GP Assessment** – the draft options were assessed as having a positive impact on mental and physical health, and diet and nutrition, where the importance of the prevention work that the DAAT enables was noted. The model, as it stands being very similar to what is already in place, was not assessed as having any adverse impact on primary care access to services.

- **BHFT assessment –** this assessment was caveated with the comment that until the budget envelope had been decided, it was not possible to undertake a full assessment of the model. As a result, the BHFT assessment was that the proposals would have a potentially negative impact on the areas assessed.

- **Public Health –** the Public Health assessment, undertaken by the Berkshire Director of Public Health and Public Health England, was that due to the public health funding reductions, the proposal could potentially have a negative impact on all the areas assessed. If the core model was not retained, as recommended, it could increase the pressure on other health services, wider care and safeguarding services and lead to an increase in crime and anti-social behaviour**.**

- **Crime Impact Assessment –** the draft proposals were assessed by Thames Valley Police as having no adverse impact on the perception and fear of crime, acquisitive crime, serious/organised crime and numbers in custody. Negative impacts were potentially assessed in relation to antisocial behaviour, violent crime and domestic abuse.

- **Equalities Impact Assessment –** The assessment concluded that there would be no adverse impact of the proposals, subject to ongoing monitoring of the service to ensure that it is meeting diverse needs. The focus on a range of priority groups, such as those with mental health needs, is assessed as having a positive impact on vulnerable groups. The fact that the service will be available to all priority groups is also a beneficial impact.

Procurement

9.16 The TFG recognised that there is a national reduction in the Public Health Grant, as part of central government's deficit reduction programme, and this forms the majority of the budget for drug and alcohol services, see Appendix 3. It is likely that the contribution from the Police and Crime Commissioner will also reduce. Ultimately, the budget is a matter for Cabinet and, although the TFG was aware of the budgetary constraints, it has presented options in accordance with the defined need as based on the available evidence, best practice guidelines and analysis.

9.17 To secure the greatest efficiencies, the final contract should be based on payment of a core amount, with further payments based on achieving results that meet the outcomes specified. This would be in the form of a performance matrix that scores successful completions, abstinence and managed intake against complexity of need.

9.18 Efficiencies from the current adult contract and service costs would be sought through future procurement. Previous discussions with the market support the fact that efficiencies between £50K and £100K can be delivered from these contracts by being innovative about the service model and specification.

9.19 Whatever the chosen service model, the future adult service will be subject to a procurement process in order to implement a new contract/s by 1 April 2017. The procurement method would benefit from as much flexibility as possible, ensuring the Royal Borough is able to negotiate best value for the residents.

9.20 Taking the above into consideration, the recommended procurement route, would be to utilise the more flexible negotiated tender methodology. Whilst a negotiated tender process benefits from the selection process at a pre-qualification stage, it also allows the purchaser flexibility to negotiate the model and terms of the contract further prior to award. This ensures that innovation from providers and ideas from commissioners can be included in the final model.

9.21 The current young people's service is small and it is unlikely that efficiencies would be secured through an open market tender in isolation. Consultation feedback was clear that integration with wider young people's services was preferable to integration with adult drug and alcohol services. The focus on prevention for this service would also work well with the wider provision of services for children and young people.

Risks

9.22 The options and recommendations presented in this report are based on the TFG's current understanding of prevalence and need in the Royal Borough. However, it recognises that this is an area of work that is affected significantly by a number of variables, including demographic change, public health priorities, addiction patterns and the introduction of different drugs. It is on this basis that the TFG is recommending a flexible and responsive service delivery model.

9.23 Notwithstanding the overall reduction in public health budget, the TFG is clear that the risks of not investing in drug and alcohol services are:

- An increase in crime and antisocial behaviour, in particularly acquisitive crime and violent crime.
- An increase in cases of domestic abuse.
- An increase in numbers of people moving from risky drinking levels to dependency and the resulting impact on health services amongst others.
- An increase in those presenting with physical health issues in primary care, specialist services and acute service.
- An increase in those presenting with mental health issues in primary care, specialist services and acute services.
- An increase in the numbers of both drug and alcohol related deaths.
- An increase in the numbers of both children and adults in the community who require safeguarding services.
- An increase in the number of families who are unable to remain together due to safeguarding issues.
- An increase in unemployment and of young people who are NEET (not in education or employment.
- An increase in homelessness.

9.24 The comprehensive benchmarking analysis, national evidence and local stakeholder consultation clearly demonstrate these risks.

9.25 The financial impact of all of the above would be significant. The Public Health England scenario planning 'Cost Effectiveness Tool' shows that if the service budget was reduced to this level, there would be an estimated 7,475 additional crimes in the borough, including shoplifting, burglary, theft of and from a vehicle and robbery taking place in 2016/17 which would have been prevented if there were no reductions made.

9.26 In terms of economic costs due to the resulting increased crime locally, the tool predicts it would cost the Borough's criminal justice services an additional £1.47m over one year. Furthermore, the costs to health would be predicted to be an additional £541K. The TFG has unequivocally concluded that it is essential to avert these costs and consequences through the investment of an appropriate and sufficient drugs and alcohol service as proposed in this report.

10. RECOMMENDATIONS

10.1 The recommendations of the Drug and Alcohol TFG in relation to the **commissioning** of drug and alcohol services in the Royal Borough are to:

- Retain the current commissioning staff of one manager and two commissioning officers, annual costs £117K (no additional cost), to ensure tight contract management, effective coordination across all services and specialist advice and guidance.
- Carry out a systematic review of the services provided by other agencies in the Royal Borough for drug and alcohol substance misusers in order to provide assurance around quality and breadth of provision.

10.2 The recommendations of the Drug and Alcohol TFG in relation to **adults** are to:

- At a minimum, commission the essential core service model at an estimated annual cost of approximately £704K, see table 4.
- Commission the essential enabling services required to ensure maximum impact of the core service model at an estimated annual cost of approximately £140K or at least a significant proportion of these services according to priority to allow for effective implementation, see table 5.
- Work with partners to ensure that the services which enhance the core service model and its enabling services at an estimated annual cost of £91K, see table 6, are provided within the Royal Borough. The costs of these additional services could be split across local partners and be implemented in an integrated fashion based on the JHWS and JSNA. Undertake a feasibility study to assess opportunities in this area with a detailed budget proposal to follow to assess cost-effectiveness and financial viability.
- Deploy a flexible negotiated tender methodology in order to secure maximum efficiencies from the procurement process.

10.3 The total cost of the recommendations in relation to adults for the core and enabling services, at point 10.2, is approximately £844K which is £76K less than the current spend on adults of £920K based on current market testing and equates to a 8.2% reduction in spend.

10.4 The recommendations of the Drug and Alcohol TFG in relation to **young people** are to:

- Move the current young people's substance misuse workers into children's early help services to enable integration with the wider children's service delivery, at the current annual cost of £69K (no additional cost). This is viewed as the only credible and viable option.

11. APPENDICES

Appendix 1: Overview of current service

Appendix 2: Drug and Alcohol TFG terms of reference and membership

Appendix 3: Public Health grant and reduction

Appendix 4: Legal position on the statutory duties around substance misuse

Appendix 5: Benchmarking and Best Practice report, December 2015

Appendix 6: Consultation output, February 2016

Appendix 7: Guidance for the delivery of specific treatment modalities

Appendix 8: Other services working with the DAAT

Appendix 9: Health impact assessments, March 2016

Appendix 10: Crime impact assessment, March 2016

Appendix 11: Equalities impact assessment, March 2016

Appendix 12: Wider learning points provided during the review

Document Name	Drug and alcohol services – outcome of review and recommendations, May 2016		
Document Author	Drug and Alcohol Task and Finish Group		
Document owner	Cllr Stuart Carroll, Deputy Lead Member for Public Health		
Accessibility	Available in other formats on request		
How this document was created	Version 1	Task and Finish Group	March-April 2016
	Version 2	Cabinet	May 2016
Circulation restrictions	None		
Review date	Not applicable		