Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Substance Misuse Treatment Framework for Wales

Substance Misuse Framework for Wales

Foreword

The implementation of a Substance Misuse Treatment Framework for Wales is a strategic policy commitment of the Welsh Assembly Government. It reflects the vision contained in *Wales: A Better Country The Strategic Agenda of the Welsh Assembly Government* of a sustainable future for Wales where action for social, economic and environmental improvement work together to create positive change. That vision recognises the need to support people to live healthy and independent lives. In taking forward this vision in the second Assembly term improving health is one of four key areas and one of the top ten commitments of Welsh assembly Government relates to delivering effective substance misuse treatment services

A key strategic aim of the Welsh substance misuse strategy is to increase the participation of problem substance misusers in substance misuse treatment programmes, which have a positive impact on health and their inclusion in society and in the case of offenders, programmes which have a positive impact on their offending. Mrs Edwina Hart AM MBE Minister for Social Justice and Regeneration has allocated additional funding to increase the capacity of treatment services across Wales. Improving the availability of, and access to, treatment services remains a priority in Wales.

In September 2003 a Project Board was established to produce the Framework. The Director of the Community Safety Unit chairs the Board and its membership consists of Welsh Assembly Government officials, members of the Advisory Panel on Substance Misuse and a representative of the National Public Health Service for Wales Vulnerable Adults Team. The individual components of the Framework are being developed by specialist sub groups whose membership is drawn from across Wales and reflects the diverse professions and organisations that make up the substance misuse treatment community in Wales.

The complete Substance Misuse Treatment Framework for Wales will reflect professional consensus on 'what works best' for substance misusers and its development has been informed by *Models of Care for the treatment of drug misusers* developed by the National Treatment Agency for Substance Misuse in England. The complete Framework will contain the range of substance misuse treatment services identified in the Models of Care four tiers that should be available to substance misusers within Wales. Each component will have associated Performance Standards to be published separately. The Minister for Social Justice and Regeneration has agreed that the Board completes the Framework in stages and that individual components will be rolled out on their completion.

The Substance Misuse Treatment Framework for Wales is intended to:

- Set out a national pattern for the commissioning of treatment for substance misuse which will meet the needs of diverse local populations. It will also assist in identifying gaps in services and help inform commissioning decisions in order to fill those gaps

- Support equity, parity and consistency in the commissioning and provision of substance misuse treatment and care in Wales
- Support responsible authorities and their partners, commissioners and treatment providers in advocating the provision of effective, evidence based treatment and care for substance misusers
- Assist in identifying the links between services, thus enabling the development of integrated care systems
- Identify key interventions for a defined service or care group
- Identify details of the expected level of provision
- Improve the quality of services provided and decrease variations in services provided
- Assist in ensuring that the pattern of service provision is based on assessed need
- Enable a contract for service, to incorporate a service specification that details the expected level and quality of service delivered.
- Aid in developing responses to the increase in substance misuse, for example the growth of substance misuse problems amongst young people and changing patterns of misuse and the substances misused and promote the development of services to hard to reach groups based on language and/or lifestyle
- Assist in identifying priorities for development e.g. specialist GPs and shared care schemes where they do not exist, and strengthening and expanding where they do
- Be a template against which the Welsh Assembly Government can undertake monitoring, audit and evaluation
- Improve service audit by assisting in the development and implementation of minimum standards and indicators for waiting/response times and level of provision.

The Substance Misuse Treatment Framework for Wales will assist Community Safety Partnerships in coordinating the delivery of the Welsh substance misuse strategy and support Responsible Authorities and other partners in developing high quality needs based services.

Edwina Hart MBE AM
Minister for Social Justice and Regeneration

Service Framework for Residential Rehabilitation

Service Framework for Residential Rehabilitation

1. Overview

Residential rehabilitation is a Tier 4 service. Tier 4 services are specialist drug and alcohol services offering intensive and structured programmes delivered in residential, hospital inpatient or other structured environments.

These programmes aim to engender and maintain abstinence in a residential setting. This is in recognition of the fact that some individuals with complex problems related to drug and alcohol misuse may require respite and an intense programme of support and care which cannot realistically be delivered in a community or outpatient setting.

2. Context

There is a broad array of drug and alcohol residential rehabilitation services across the UK that can be described on various levels, i.e. therapeutic orientation and milieu programme structure, intensity and duration. The degree of intensity of therapeutic support also varies quite widely across the residential services sector. Residential rehabilitation services have been pioneered and sustained mainly in the voluntary sector and by independent providers on a not-for-profit basis often with a strong religious value base. Local authority social services departments currently initiate access to residential rehabilitation programmes with treatments paid for by community care funding and supplemented from other sources (including the NHS).

Commissioners should see residential rehabilitation as a national resource with out-of-area referrals a key characteristic. Residential services may be registered under the Registered Care Homes Act (1984), now the Care Standards Act 2000, as registered nursing or care homes with or without nursing. They must comply with appropriate registration controls established by the new Care Standards Inspectorate for Wales. Residential facilities in England will be subject to a different regulatory framework.

Recent changes to the service have resulted in some de-registering in Wales and more reliance on Supported People funding opportunities enhancing community-based provision. This has added complexity to the current provider scenario in Wales.

The local assessment of need for Residential Rehabilitation should take place within the context of LHB / LA Health Social Care and Wellbeing strategies.

3. Philosophy and approach

Although the treatment philosophy, structure and intensity of residential rehabilitation services can vary, there are three broad types of rehabilitation provision:

- rehabilitation programmes based on Social Learning Theory

- 12-step programmes based on the Minnesota Model of addiction recovery treatment
- faith-based therapeutic communities.

Residential rehabilitation providers may also manage, or have access to, general houses promoting a less structured programme that favours a more individually tailored package of care for each client as part of on-going support for the client.

Residential rehabilitation programmes require their clients to be drug or alcohol free on entry. Programmes usually run from the point of client detoxification, or immediately after the completion of detoxification, and last for a period of between six weeks and 12 months.

Residential services are abstinence based and have relapse prevention as their major service outcome goal. This is accomplished by providing a safe living environment supported by staff and peers and a therapeutic programme comprising groups, lectures, individual counselling, and sometimes, family involvement.

Residential Services will also need to be sensitive to issues of ethnicity and culture.

4. Programme characteristics

Programme characteristics depend on whether the client is in the preparatory stage (in-patient or community detoxification), the rehabilitation phase (residential placement) or the support phase (low intensity "half way house" or move-on arrangements).

4.1 Preparatory stage

These services usually follow a medically supervised withdrawal programme in an in-patient or community setting (see previous section 'Inpatient substance misuse treatment') as the first stage of a rehabilitation programme that has a planned duration of 2 to 12 weeks.

Individuals referred from this preparatory phase to longer term rehabilitation should be able to access appropriate residential rehabilitation within a six week period.

4.2 Longer-term residential rehabilitation

These services generally do not provide medically supervised withdrawal services as a first treatment phase. Although the planned duration of the rehabilitation programme can vary quite widely the research evidence base suggests the effectiveness of programmes that have minimum 12-week duration.

4.3 Low-intensity residential rehabilitation and halfway house/move-on rehabilitation

Low-intensity residential rehabilitation and halfway house/move-on rehabilitation services denote forms of continuing residential care for clients who have usually completed a long-term residential therapeutic programme. Third stage and halfway houses are normally residential services linked to the main programme. Clients maintain their alcohol and drug-free status and live in a semi-independent context preparing for fully independent living in the community.

The Supporting People programme has enabled service providers to provide planned support programmes tailored to individual need for people identified with particular vulnerability including the risk of relapse. This support is given to individuals in their own home enabling them to maintain tenancies and to improve their quality of life.

5. Location

Residential Rehabilitation services should be regarded as as a resource provided in Wales. Whilst Commissioners should be concerned about appropriate access for their users, they do not necessarily have to have services provided in their geographical areas or within the Principality.

6. Service Components

Although residential rehabilitation programmes can offer diversity of treatment regimes they should provide programmes that are structured and offer the following key care components.

- maintenance of abstinence in a safe therapeutic environment
- sharing the use of facilities with other users in the rehabilitation programme
- emphasis on shared responsibility by peers, individual counselling and group therapy
- relapse prevention-oriented counselling and support
- individual support and promotion of education, training and vocational experience
- improved skills for activities of daily living
- housing advocacy and resettlement work
- aftercare and support including harm reduction advice.

7. Client group

Individuals accessing residential rehabilitation must have drug and alcohol problems and meet international Classification of Diseases (ICD10)/Diagnostic and Statistical Manual (DSM-IV) dependence criteria. They should be seeking abstinence from their main problem substance in a controlled setting. They may also include misusers in rehabilitation or individuals who have achieved a state of abstinence from their main problem substances (or all drugs), usually through successful detoxification.

Admission to residential services is voluntary, but can be part of a community sentence or post-custodial sentence from the courts. To establish eligibility a community care assessment needs to be carried out to ensure that the client meets admission criteria. Local authorities usually perform this function and pay for these services, although the assessment function may be delegated to another agency such as a community drug and alcohol team or a voluntary sector agency.

Commissioners should ensure that residential rehabilitation is available to the following groups:

- individuals who fail to achieve and maintain abstinence in a community setting
- those who express a desire to maintain abstinence and express a preference for admission to rehabilitation programmes or agree to enter this type of programme
- those who are likely to have substantial problems maintaining abstinence due to the severity of their substance dependence
- those requiring a programme of support and rehabilitation that is most suitably delivered in a residential environment
- those who are living in an environment characterised by social deprivation, including housing problems or instability, which represents a threat to relapse
- those who lack social support
- those whose social environment contains people (e.g. partners, friends) who are substance misusers and who are likely to hinder resolve or ability to maintain abstinence.

These units are adult units, that is, patients must be over the age of 18 years. Young people must be referred to child-centred programmes.

8. Access and Assessment

Access to residential rehabilitation is voluntary and has to follow on from a full assessment. The Unified Assessment process should be followed in Wales. This assessment should include, as a minimum:

- information on how referrals are made/eligibility criteria

- the minimum and maximum timescales for response
- which staff are involved and how the referral will be managed
- how the referral process will be documented and referral outcomes monitored and communicated
- costs of the service.

8.1 Assessment Criteria

Clients who are considered for residential rehabilitation will have received a specialist assessment which will have taken into account the following criteria:

- acute intoxication and/or withdrawal potential
- medical conditions and complications
- emotional/behavioural conditions and complications (e.g. psychiatric conditions, psychological or emotional/behavioural complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)
- treatment acceptance/resistance
- relapse/continued use potential
- recovery/living environment.

The client has to be evaluated on the criteria above, together with other individual psychological, medical and social factors.

9. Management

The treatment stages are described in 4 above.

These stages should take place in the context of the integrated care planning approach described elsewhere.

Individuals who are eligible for community care support should be allocated a care manager from social services or the organisation contracted by social services.

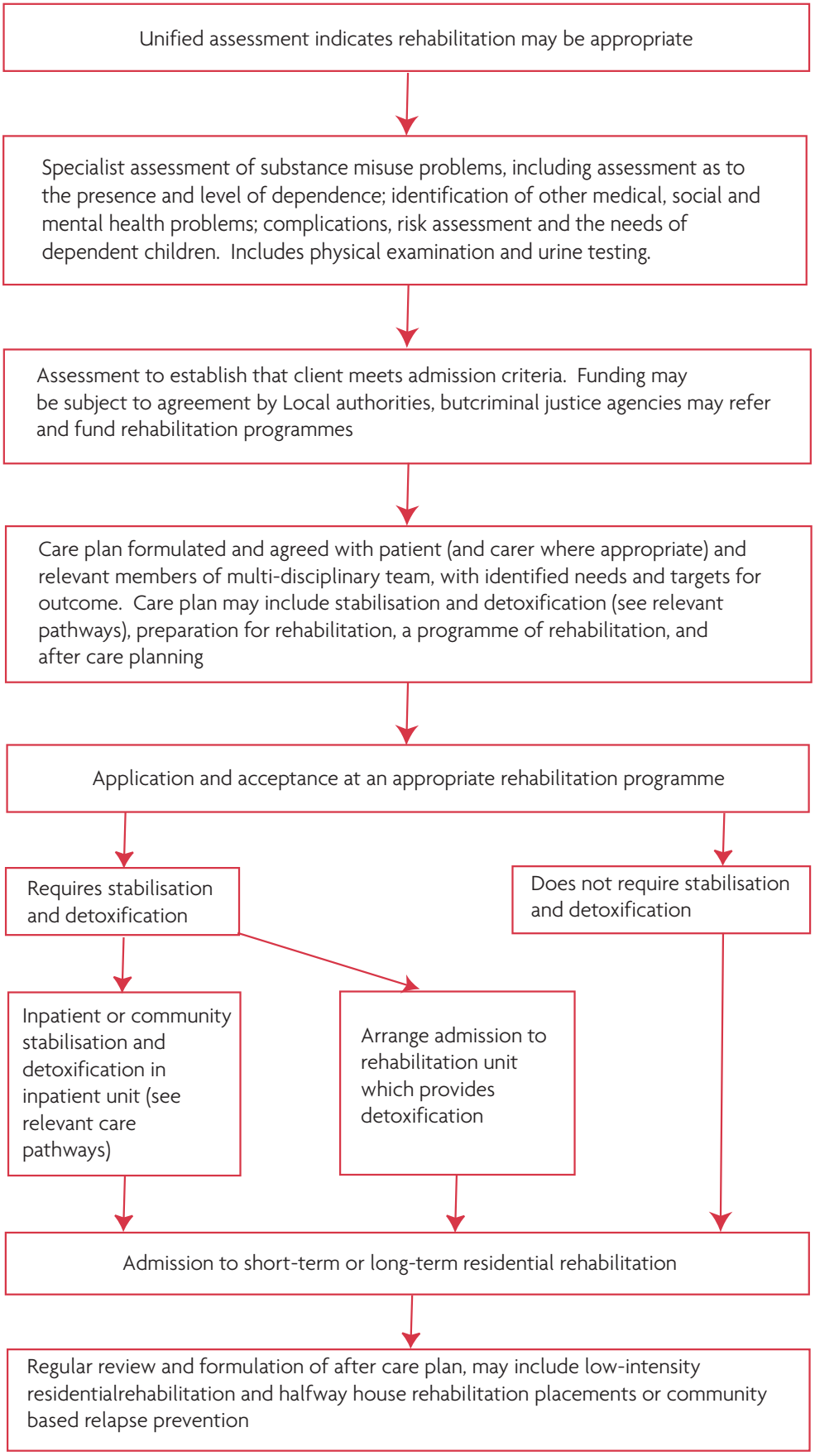
Departure from the programme and onward referral should be a planned element of the programme. This should normally be overseen by the keyworker, although some providers may have dedicated workers who facilitate onward referral and aftercare support.

Housing is a particularly important issue in the rehabilitation and integration of substance misusers who have achieved abstinence. For example "Tackling drugs in rented housing: a good practice guide" (Home Office and Department of Transport and Local Government Regions 2002) is available

as a useful point of reference.for Community Safety Partnerships. Patients may be at particular risk of drug-related death due to overdose if they leave residential rehabilitation and return to previous levels of drug and alcohol misuse. All residential rehabilitation services should educate and work with service users to reduce the risk of harm due to drug or alcohol -related death – particularly those who are discharged or leave programmes prior to completion.

Monitoring of residential care placements should take place within the overall context of locally agreed community care monitoring arrangements.

10. Integrated care pathway: Residential rehabilitation



Annex A

Research evidence base

The literature on the effectiveness of residential rehabilitation programmes remains sparse, albeit growing. Only a small number of randomised controlled trials have been conducted (see McCusker et al. 1995; 1996; 1997; Nemes et al. 1999). A relatively small number of studies have evaluated the impact of hospital inpatient units and residential rehabilitation programmes. One early English follow-up study of clients who were treated by a specialist inpatient unit found that 51% of patients were drug free at a six-month follow-up (Gossop et al. 1989). The only controlled study of inpatient and outpatient treatment of opiate withdrawal in the UK found inpatient withdrawal to be four times more effective for the proportion of patients who completed the withdrawal regime (Gossop et al. 1986).

The National Treatment Outcome Research Study (NTORS) showed that clients entering residential rehabilitation and inpatient programmes made substantial improvements in terms of abstinence from, and reduction of, illicit drug misuse, criminal activity, levels of injecting and psychological health. The study also showed that clients who stayed in treatment for a critical time (more than three months) showed better outcomes than those who left the programme at an earlier stage. It also showed that severely dependent and problematic misusers could achieve positive outcomes as a result of residential rehabilitation programmes (Gossop et al. 1999b and 2001a).

US studies have shown that outcome from longer-term residential rehabilitation programmes is related to total time spent in treatment, with episodes of at least three months associated with positive outcome (Simpson 1997). The American Drug Abuse Treatment Outcome Studies (DATOS) provided important information, especially in relation to primary crack misusers. The studies found that long-term residential programmes that retain clients for at least three months are particularly cost beneficial for highly criminal clients with severe problems. In contrast, shorter-term and less-intensive treatments appear to be adequate for most of the less problematic users, even those who have left relatively early (Simpson et al. 1999).

The majority of US studies have evaluated therapeutic community (TC) programmes. Programme length varies from short-term with aftercare to long-term programmes of more than one year's duration. US data point to the considerable success of these services for the recovering misuser. Studies show that, on average, clients receiving TC treatment have enduring post-discharge reductions in illicit drug use (DeLeon et al. 1979; Gossop et al. 1999b; Simpson and Lloyd 1979). US and UK studies have shown positive psychosocial benefits after treatment (Georgakis 1995; DeLeon and Jainchill 1982; Bennett and Rigby 1990).

Residential Rehabilitation

Bibliography

- Bennett, G. and Rigby, K. (1990) 'Psychological change during residence in a rehabilitation centre for female drug misusers. Part I. Drug misusers', Drug and Alcohol Dependence, 27, pp. 149–57.
- DeLeon, G. and Jainchill, N. (1982) 'Male and female drug abusers: social and psychological status two years after treatment in a therapeutic community', American Journal of Drug and Alcohol Abuse, 8, pp. 465–97.
- DeLeon, G., Andrews, M., Wexler, H., Jaffe, J. and Rosenthal, M. (1979) 'Therapeutic community drop-outs: criminal behaviour five years after treatment', American Journal of Drug and Alcohol Abuse, 6, pp. 253–71.
- Georgakis, A. (1995) Clouds House – an evaluation of a residential alcohol and drug dependency treatment centre, Wiltshire: The Life-Anew Trust Ltd.
- Gossop, M., Green, L., Phillips, G. and Bradley, B. (1989) 'Lapse, relapse and survival among opiate addicts after treatment', British Journal of Psychiatry, 154, pp. 348–53.
- Gossop, M., Johns, A. and Green, L. (1986) 'Opiate withdrawal: inpatient versus outpatient programmes and preferred versus random assignment to treatment', British Medical Journal, 293, pp. 697–9.
- Gossop M., Marsden J. and Stewart D. (2001a) NTORS after five years: changes in substance use, health and criminal behaviour during the five years after intake, London: Department of Health.
- Gossop, M., Marsden, J., Stewart, D. and Rolfe, A. (1999b) 'Treatment retention and one year outcomes for residential programmes in England', Drug and Alcohol Dependence, 57, pp. 89–98.
- McCusker, J., Bigelow, C., Vickers-Lahti, M., Spotts, D., Garfield, F. and Frost, R. (1997) 'Planned duration of residential drug abuse treatment: efficacy versus effectiveness', Addiction, Vol. 92, No. 11, pp. 1467–78.
- McCusker, J., Stoddard, A. M., Hindin, R. N., Garfield, F. B. and Frost, R. (1996) 'Changes in HIV risk behaviour following alternative residential programs of drug abuse treatment and AIDS education', Annals of Epidemiology, Vol. 6, No. 2, pp. 119–125.
- McCusker, J., Vickers-Lahti M., Stoddard, A. M., Hindin, R. N., Bigelow, C., Zorn, M., Garfield, M. F., Frost, R., Love, C. and Lewis, B. (1995) 'The effectiveness of alternative planned durations of residential drug abuse treatment', American Journal of Public Health, Vol. 85, No. 10, pp. 1426–29.

- Nemes, S., Wish, E. D. and Messina, N. (1999) 'Comparing the impact of standard and abbreviated treatment in a therapeutic community. Findings from the District of Columbia treatment initiative experiment', Journal of Substance Abuse Treatment, Vol. 17, No. 4, pp. 339–47.
- Simpson, D. and Lloyd, M. R. (1979) 'Client evaluation of drug abuse treatment in relation to follow-up outcomes', American Journal of Alcohol Abuse, 6, pp. 397–411.
- Simpson, D. D. (1997) 'Effectiveness of drug abuse treatment: a review of research from field settings', in Egertson, J., Fox, D. and Leshner, A. (eds) Treating drug abusers effectively, Oxford: Blackwell.
- Simpson, D. D., Joe, G. W., Fletcher, B. W., Hubbard, R. L. and Anglin, M. D. (1999) 'A national evaluation of treatment outcomes for cocaine dependence', Archives of General Psychiatry, 56 (6) , pp. 507–14.

Service Framework for Community Prescribing

Service Framework for Community Prescribing

1. Overview

Community prescribing programmes are classified as Tier 3 services in Wales and primarily (though not exclusively) involve the provision of a medically supervised substitute. The prescribing programme is the basis for providing medical and psychosocial counselling and support in an integrated approach. There is a large evidence base supporting the benefits of a wide range of harm-reduction and abstinence-oriented interventions. This framework, however, focuses on the provision of an opioid substitute (usually oral methadone, and increasingly buprenorphine) for illicit heroin, at an effective level. (Further guidance on prescribing for alcohol specific problems will be produced later). Community prescribing is increasingly recognised as being effective when provided in a primary care setting. Because of the inherent risks associated with inappropriate use of substitute medication, supervised consumption is an important feature of programmes of care.

2. Context

Community prescribing needs to take place within a context in which the co-existing physical, emotional, social and legal problems are addressed as far as possible. *The provision of counselling or other psychological interventions in partnership with specialist services must therefore complement prescribing when GP led*. Other services, therefore, should also be available to the user if required. These would include welfare advice, help with housing, employment and vocational services. Prescribing is, therefore, an enhancement of psychological therapy, rather than an intervention on its own. In this context the offer of integrated care is best practice. The treatment of opiate misusers not using pharmacotherapy can also be effective, especially – but not exclusively – for young people.

3. Philosophy and Approach

Dependent on clinical need, the following community prescribing regimes need to be available to users:

- stabilisation on substitution opioids (e.g. methadone or buprenorphine)
- withdrawal from substitution opioids (e.g. methadone or buprenorphine)
- withdrawal from opioids with non-opioid medications (e.g. lofexidine)
- maintenance on substitution opioids (e.g. methadone or buprenorphine)
- stabilisation and withdrawal from sedatives (benzodiazepines and alcohol)
- relapse-prevention prescribing (e.g. naltrexone, disulfiram and acamprosate)

- prescribing for stimulant users, including symptomatic prescribing.

Prescribing regimes for associated conditions, e.g. depression, will often complement these programmes.

The **aims** for detoxification (withdrawal) regimes are to

- minimise withdrawal symptoms
- achieve a safe detoxification programme
- engage users in treatment programmes and ongoing psychological therapies
- reduce risk of overdose following detoxification
- achieve a healthy drug-free lifestyle
- reduce the danger of contracting blood borne viruses
- improve users' overall personal and family functioning which could include an element of education
- reduce risks to the wider community of blood borne viruses.

The **aims** of substitute prescribing are to:

- assist the user to remain healthy and achieve a drug-free life
- stabilise the user, where appropriate, on an apprpriate dose of substitute medication
- reduce the use of illicit drugs
- address other drug-related problems
- reduce the risks, including risk of HIV, hepatitis B and C and other blood borne infections
- reduce the need for criminal activity to finance drug use
- reduce the risk of prescribed drugs being diverted into the illegal drug market
- Improve the user's overall personal and family functioning.

4. Clinical Governance

Clinical Governance is a process of achieving and maintaining a high quality health service for patients and is defined as a process to:

> "assure and improve clinical standards at local level throughout the NHS. This includes action to ensure risks are avoided, adverse events are rapidly detected, openly investigated and lessons learnt, good practice is rapidly disseminated and systems are in place to ensure continuous improvements in clinical care".
>
> *(NHS Wales; Putting Patients First - 1998)*

Community prescribing for substance misuse has to take place within the context of NHS Clinical Governance arrangements in Wales. Responsibility for these is delegated to Local Health Boards and NHS Trusts who will have to ensure adequate protocols are in place with voluntary sector organisations when appropriate.

Within this environment, responsibility for prescribing lies with the prescriber who signs the prescription. This responsibility cannot be delegated. A decision to prescribe and how much to prescribe depends on:

- the overall treatment plan of the individual client
- Department of Health clinical guidelines
- locally agreed protocols and prescribing guidelines
- the doctor's experience and level of training
- discussion with other members of a multidisciplinary team
- advice, where necessary, from a specialist in drug misuse. (Department of Health et al. 1999).

Prescribing will be in line with the Department of Health's clinical guidelines and will take into account the recommendations for the reduction of drug-related deaths identified in the report of the Advisory Council on the Misuse of Drugs (ACMD) (2000). Prescriptions must be written in accordance with the Misuse of Drugs Regulations Act (2001) which also applies to pharmacy practice. (A Home Office licence is required for the prescribing of diamorphine).

5. Location

Community prescribing has to be carried out by specialist substance misuse multidisciplinary teams or by general practitioners in shared care schemes with specialist services.

5.1 Specialist Substance Misuse Teams

Specialist teams should be multidisciplinary and be resourced to offer specialist treatment and referral. Although these teams are predominantly located in the statutory sector they can be successfully provided by the independent sector if the clinical governance issues are satisfactorily addressed. Community prescribing in these teams has to be undertaken by specialists who provide expertise, training and competence in drug and alcohol treatment as their main area of clinical activity. They will work in multidisciplinary teams and provide, or have access to, a full range of treatments including prescribing. Specialist teams will be expected to deal with more complex cases or with individuals with chaotic lifestyles.

5.2 GP-led prescribing and shared care

General practitioners and primary care can in Wales play a pivotal role in the treatment of substance misusers. There is an increasing evidence base as to the effectiveness of the success of primary care interventions. Their target population should be misusers whose severity of problem at contact is mild to moderate, although some GPs offering a National Enhanced Service can treat misusers with severe and complex needs.

The contractual context for the development of GP-led community prescribing has now been set for LHBs/Community Safety Partnerships in the National Enhanced Service Framework - Drug Misuse (May 2003). (See Annex B). This offers a new, resourced pathway to a substantial engagement of primary care practitioners in substance misuse treatment.

GP prescribing potentially offers more accessible services for stable users, "normalisation" of treatment in the mainstream NHS and more effective use of secondary care specialist time.

GP-led prescribing should be:

- voluntary
- guided by individual GP competence and experience
- subject to the establishment of formal written protocols with the specialist services - particularly if contractual payments are to be made
- involve a team-working approach with rapid access/referral to specialist service/teams if appropriate
- involve GP knowledge of wider service provision
- subject to the maintenance of practice registers, audit and locally agreed monitoring arrangements.

The following schemes indicate a range of options for commissioners and should be considered as priorities in 2004/5:

- the provision of substitute maintenance prescribing to opiate misusers in a formal shared care scheme by individual practitioners who have undertaken the agreed hours of additional accredited training
- the provision of substitute prescribing by individual general practitioners to patients of neighbouring practices under the National Enhanced Contract. These GPs will be expected to have undertaken the RCGP certificate course or equivalent
- the provision of home detoxification programmes in formal partnership with specialist teams or specialist agencies where the local clinical governance requirements are met

- GP practice based "specialist drug and alcohol clinics" provided in partnership with specialist teams or agencies where the local clinical governance requirements are met.

5.3 Rurality

The location of community prescribing schemes in Wales will be conditioned by rurality. GPs entering into shared care schemes may find themselves at some geographical distance from specialist services. In these circumstances new arrangements may have to be considered, e.g. different models for supervised consumption, to provide support to GPs including the use of mentoring and telemedicine schemes.

6. Supervised Consumption

Because of the risks associated with the misuse of opiate substitutes (particularly methadone) and because of the benefits to users, every Community Safety Partnership has to have contractual arrangements in place with community pharmacists for the provision of supervised consumption. Whilst decisions on the need for supervised consumption regimes are part of the clinical risk management assessment process, they are subject to key overall requirements. These are:

- all patients should be on daily-supervised consumption for the first 3 months of treatment as a minimum with consideration given during planned reduction programmes. *(The framework recognises the challenges to the provision of this standard in rural areas where balanced decisions have to be taken in the care plan and other user-friendly approaches to supervision may be appropriate)*
- agreements must be in place between specialist team, client and pharmacist (shared care) before any prescription is written or dispensed
- personal contact with the pharmacists should be made to encourage team working
- agreements must include regular feedback from pharmacist to the team which is a precondition for any remuneration
- the dispensing arrangements have to be patient-centred with particular regard to the issue of privacy and confidentiality. This may include the creation of discrete areas /rooms etc if required
- the numbers of patients receiving supervised consumption at each pharmacy should be determined locally in line with their local needs assessment. Capping could be deemed appropriate in some circumstances, e.g. if large numbers were creating an inappropriate environment
- the eligibility of pharmacists and designated pharmacy staff to participate in supervised consumption schemes is dependent on their completion of appropriate training

- where parties other than community pharmacists carry out schemes, protocols should be in place to ensure clinical governance requirements are met.

7. Client Groups

Community prescribing service users are individuals who have substance misuse problems and meet ICD-10/DSM-IV dependence criteria. While prescribing programmes are geared to the needs of opioid, alcohol and and other drugs, they should be able to supervise the prescribing for primary users of other drugs and provide adjunctive prescribing for medical complication and conditions (psychological and behavioural).

Depending on local need, commissioners, in conjunction with service providers have to ensure that they also address the requirements of the following groups of individuals who may have special needs:

- pregnant women
- those with severe physical co-morbidity
- those with mental health co-morbidity
- young people, especially those identified as vulnerable
- other locally defined groups, such as where there are child protection issues
- those on specific criminal justice initiative
- individuals discharged from prison.

8. Access

Rapid access is essential to community prescribing programmes. They are voluntary (i.e. through self-referral, GP or criminal justice referral, or through other agencies such as social services, GUM clinics, antenatal clinics, community pharmacists etc). Children and young people under 16 must receive treatment in, or in shared care with, child-centred services.

Each Community Safety Partnership will need to ensure that the geographical access to community prescribing schemes is appropriate to its user population.

9. Management

There have to be written and available protocols for agencies providing community prescribing.

The key stages in the management of community prescribing are:

- confidentiality and information sharing
- completion of National Drug Monitoring Form

- decision on type of access (routine, priority, emergency/crisis)
- access management (e.g. waiting list)
- assessment including physical and psychiatric complications of substance misuse and referral on to appropriate specialist services
- risk assessment
- preparation of individual for substitute prescribing (e.g. advice and written information about methadone, risks of overdose, etc)
- development of a care plan with full involvement of all participating services
- identification of a care co-ordinator/ linkworker etc
- provision of practical social support (e.g. housing, welfare benefits and legal advice)
- provision of counselling and other psychological interventions where appropriate
- review of treatment and care plan, and ongoing assessment (at least fortnightly initially and then at least monthly for all patients on substitution). The status of clients/patients on methadone and buprenorphine maintenance programmes must also be reviewed every three months to review what has been achieved, set new goals where appropriate and review service users' requirements
- provision of health promotion
- HIV testing where appropriate
- hepatitis testing and immunisation
- consideration of tuberculosis risk
- relapse-prevention as a component part of all treatment programmes
- access to aftercare programmes after successful detoxification
- where appropriate the provision of antagonists e.g. naltrexone for the prevention of relapse in clients who have achieved abstinence. (Psychological methods of relapse prevention and specific, focused behavioural relapse prevention approaches, which have proved to be effective, should also be available where appropriate. Individuals who have achieved abstinence are given appropriate support through further outpatient attendance, community projects or self-help groups)
- links to rehabilitation programmes
- case closure/departure planning where service user has achieved abstinence or left the programme
- data collection.

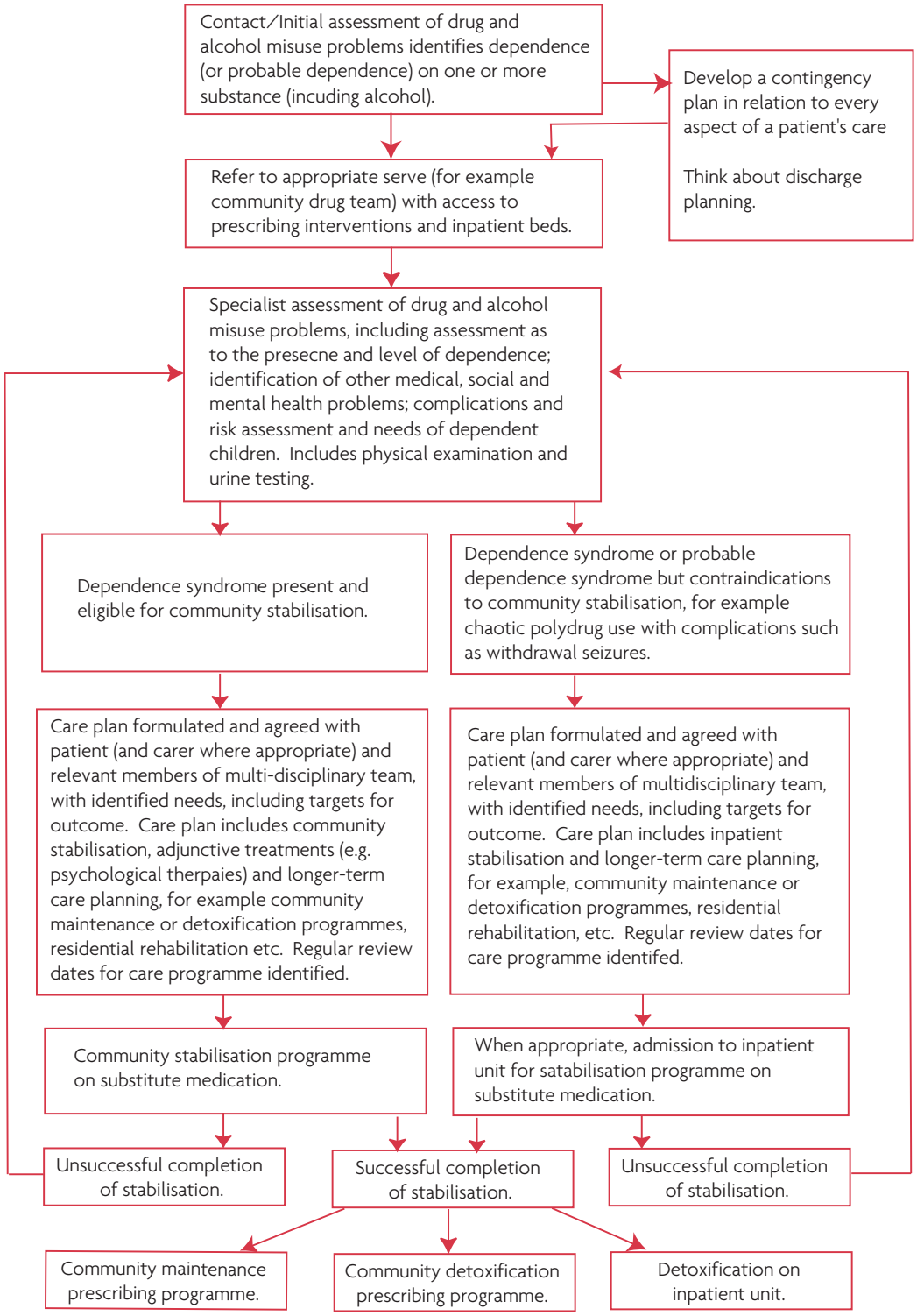
9.1 Aftercare and support

The development of an appropriate package of aftercare and support should take place in the final phase of the treatment episode for service users aiming to achieve abstinence. Relapse prevention must be a component part of the substitute treatment programme. Where appropriate, there is a change in care co-ordination and referral to other services such as residential rehabilitation, specialist housing etc. Positive outcomes are also engendered by contact with housing agencies and vocational agencies specifically aimed at substance misusers.

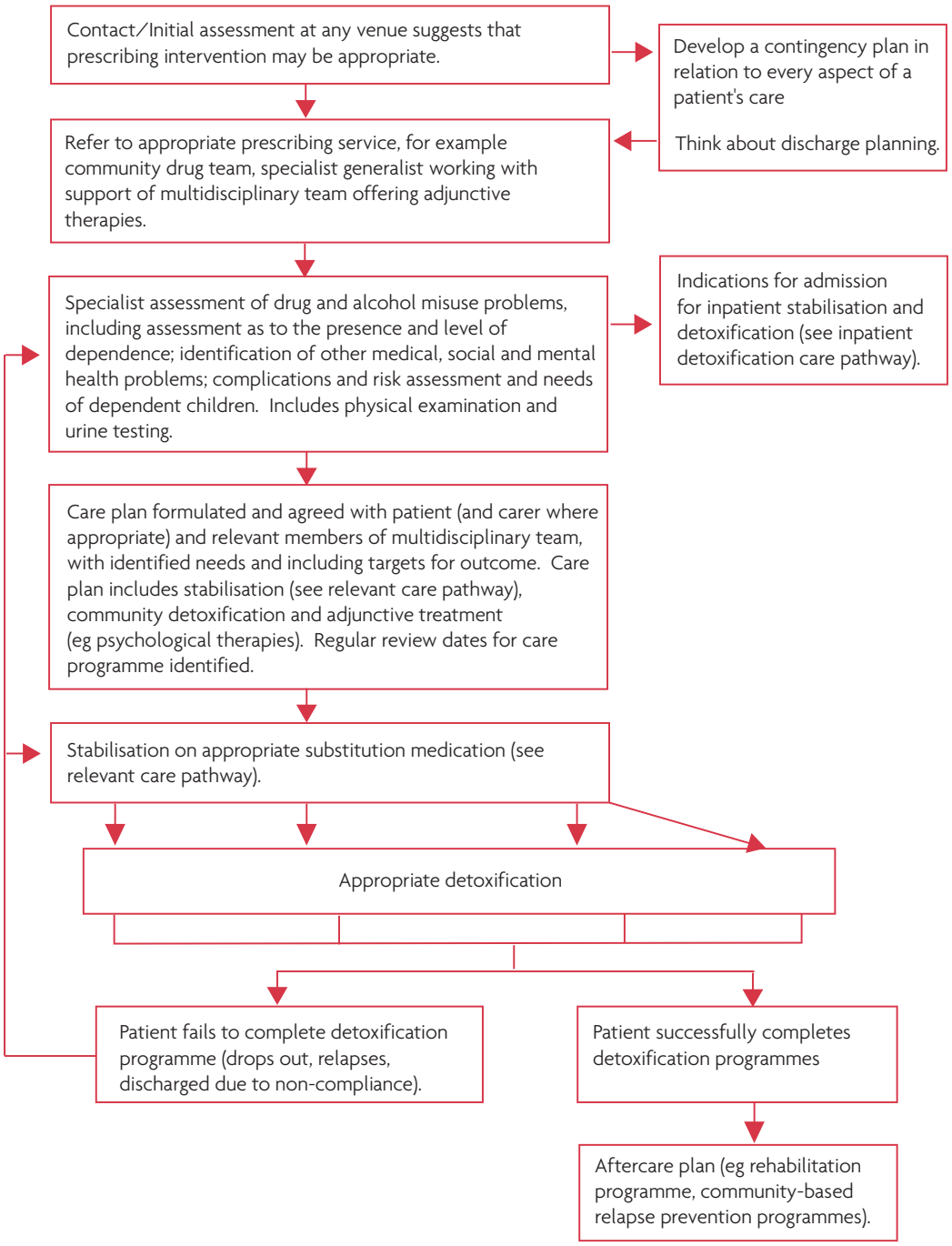
10. Care Pathways

The care pathways process for community prescribing has to be consistent with the specifications detailed elsewhere in the framework.

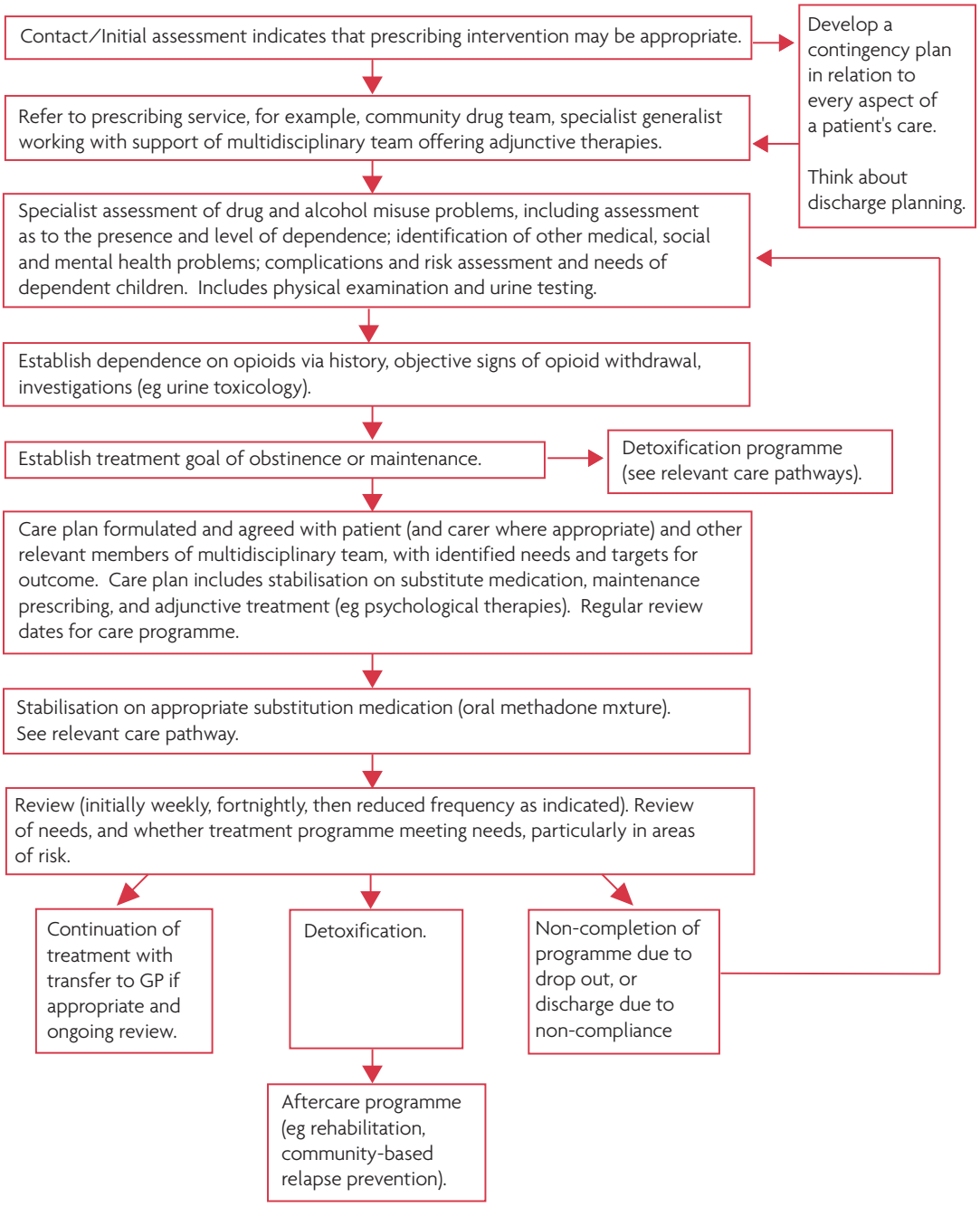
Integrated care pathway: Diagram 1
"Stabilisation on substitue medication"



Integrated care pathway: Diagram 2
"Community detoxification"



Integrated care pathway: Diagram 3
"Community maintenance prescribing for opioid dependence"



Research evidence base

Treatment environment and holistic treatment and care

Drug misuse is associated with a wide range of personal, social, economic and potential health problems. Individuals may require several different types of support over time (i.e. a continuum of care with, for example, housing support, legal advice, access to vocational agencies, etc) and these are important elements in an effective package of care. There is evidence of the importance of providing support services, especially in the first three months of treatment. However, the intensity or comprehensiveness of services, per se, is not consistently associated with improved outcomes services (Simpson et al. 1995).

A US study (Ball and Ross 1991) found that the most successful maintenance programmes had the following characteristics. They:

- did not enforce detoxification after a period of maintenance
- provided better counselling and medical services
- achieved a good level of clinic attendance by clients/patients
- maintained a close long-term relationship with patients
- had low rates of staff turnover.

Research also shows that therapeutic involvement (measured by rapport between a client and a programme counsellor, and the service user's rating of the extent to which they are committed to treatment and believe it to be effective) and counselling session attributes (as measured by the number of sessions attended, the number of health and other topics discussed) have direct positive effects on retention in, among others, outpatient methadone treatment (Joe et al. 1999; Fiorentine and Anglin 1996).

There is evidence that it is important to assess the extent to which clients are ready and motivated to make changes in substance-use behaviours. US-based research has shown that treatment readiness is related to early therapeutic engagement and retention for outpatient methadone treatment, among other factors. Treatment readiness was not only a significant predictor of engagement and retention, but was more important than socio-demographic, drug use and other background variables (Simpson et al. 1997).

Research on predictors of treatment retention in methadone treatment programmes has also shown that care management was one of the factors associated with a higher probability of retention, particularly in the first 90 days. Other factors include group participation, psychiatric services, contingency-based reinforcers and transportation assistance (Grella et al. 1997).

There is evidence of the effectiveness of psychological treatment for people on methadone treatment. In particular, those who suffer from depression can benefit from cognitive therapy and interpersonal therapy. Some of the most needy people (e.g. suicide borderline) can benefit from dialectical behavioural therapy.

Effectiveness by treatment setting

NTORS follow-up data show that overall, significant improvements in drug-related problems, health and social functioning were made among the clients of GPs and primary care services as well as those in specialist services (Gossop et al. 1999a). Other research showed that a positive treatment outcome was equally likely in either setting (Hutchinson et al. 2000b; Lewis and Bellis 2001). Effective specialist services as well as high-quality primary care have retained service users engaged in treatment.

Prescribing for opiate dependence

There is well-established research in the UK and internationally into substitution, especially with oral methadone. A meta-analysis has shown the effectiveness of methadone maintenance, across a variety of contexts, cultural and ethnic groups and study designs (Marsch 1998). For example, methadone maintenance is associated with lower levels of heroin use, reduced levels of crime, improved social functioning and a lower risk of premature mortality. Substitution programmes have also contributed to the prevention and spread of HIV. In the UK, results from NTORS show that, on average, methadone substitution programmes are positive across a broad range of substance use, injecting and sharing behaviours, health and crime (Gossop et al. 1998a). Improvements in drug taking and other problem behaviours were substantially maintained at one and two-year follow-ups. Data show substantial reduction in rates of criminal behaviour and also show improvements in psychological and physical health. There were substantial reductions in illicit drug use, injecting and sharing injecting equipment. Abstinence from heroin was more than twice that at intake and the number of regular heroin users was considerably reduced. Similar improvements were also noted in the use of stimulants and benzodiazepines (Gossop et al. 2000a, 2000b; Stewart et al. 2000).

There is evidence of greater benefit in maintaining individuals on daily methadone doses of between 60mg and 120mg. Larger doses may be required in some instances. There is evidence that under-dosing and poor initial assessment often undermine the success of English methadone programmes (Findings 2001). Research has also shown that higher doses of methadone are associated with a greater likelihood of cessation of injecting (Capelhorn et al. 1993; Lagendam et al. 2000).

Most prescribing in the UK is for oral methadone, although a national survey carried out in 1995 showed that 10% of all methadone prescriptions were issued for injectable (Strang et al. 1996b; Strang and Sheridan 1998). No outcome study has been carried out in the UK on injectable methadone

prescribing. However, an observational study has been carried out (Metrebian et al. 1998) and there are encouraging reports from clinical audit of this practice (Ford and Ryrie 1999). Injectable methadone maintenance can be suitable for more severely affected heroin addicts (Strang et al. 2000), and most particularly those who have failed to achieve change through oral formulations. There are no simple universal criteria for prescribing injectables; rather, such prescribing requires a complex clinical decision based on the suitability of the individual. Whatever criteria for injectable prescribing are identified at local levels, it is necessary that this is managed by specialists, who may need additional training.

Diamorphine is only rarely prescribed in the UK (a licence from the Home Office is needed) as a maintenance regime for a minority of people who have not been stabilised through methadone. It is estimated that 300 to 500 people currently receive a prescription of diamorphine (Sell et al. 1997; Gabbay et al. 2001). The Department of Health and the National Treatment Agency for Substance Misuse (NTA) are currently hosting an expert advisory group on diamorphine prescribing. The NTA guidance on diamorphine and other injectable opioid prescribing based on the recommendations of this group, concludes that injectable diamorphine and injectable methadone maintenance prescribing, in principle, is an appropriate drug treatment for a minority of entrenched injecting heroin misusers who do not respond to optimised oral drug treatment. Injectable diamorphine (and methadone) maintenance should therefore be part of the range of potentially available drug treatment options in each area, provided it is part of a comprehensive drug treatment system and is in line with eight key principles outlined in the guidance document (NTA 2003). An implementation strategy will be required to achieve this.

A variety of other substitutes are also used for the treatment of opiate dependence in the community. They include codeine-based substitutes, especially dihydrocodeine, currently not licensed for withdrawal but used by some clinicians and described (Department of Health et al. 1999; Macleaod et al. 1998).

Buprenorphine has recently been licensed for substitution, and there is increasing evidence of its effectiveness and relative safety as a partial agonist in comparison with full agonists such as methadone, especially in relation to overdose and drug-related death (Ling et al. 1998; Barnett et al. 2001; Petitjean et al. 2001; Auriacombe 2001, Eder et al. 1998; Strain et al. 1996). Guidance on the instalment prescribing of buprenorphine was issued by the Department of Health in March 2001 (Department of Health 2001c).

Lofexidine is prescribed for community detoxification programmes. It has been suggested that lofexidine is most suitable for patients using up to 50mg methadone or one gram of heroin daily, for those with shorter drug histories, and for non-polydrug users (Department of Health et al. 1999; also see Gowing et al. 2002). Maintenance treatment with the opiate antagonist naltrexone is available to those who have completed opiate withdrawal and require pharmaceutical assistance to maintain a drug-free state (see also 'Inpatient substance misuse treatment').

Benzodiazepine prescribing

The use of benzodiazepine is common among opiate users (see 'Inpatient substance misuse treatment'), but benzodiazepine prescribing is recommended only for withdrawal. Guidelines state that longer-term use of benzodiazepines requires adherence to the general principles of management of controlled substances (Department of Health et al. 1999). There is no evidence that the long-term prescribing of benzodiazepine reduces the harm associated with dependence on that drug. In fact, there is increasing evidence that the long-term prescribing of more than 30mg daily causes harm (Department of Health et al. 1999). When taken with opiates, benzodiazepine prescribing is a significant risk factor for drug related deaths.

Prescribing for primary stimulant users (cocaine, crack-cocaine and amphetamine)

There is concern over the use of cocaine, crack-cocaine and illegally manufactured amphetamine sulphate in the UK. There is still, however, little accurate information available about the misuse of stimulants in the UK, and especially about the nature of services required or the effectiveness of those provided. The prevalence of cocaine misuse appears to have increased greatly in the last decade, with official notifications of cocaine dependence having more than doubled between 1990 and 1995 (Marsden et al. 1998). It is estimated that the national prevalence of cocaine use is greater than that of heroin (Gossop et al. 1994b). There is also widespread use of amphetamine sulphate (Pates and Mitchell 1996).

NTORS data show that drug users who approach treatment services commonly use stimulants: 88% had used stimulants and 59% were current stimulant users. A substantial percentage of the NTORS cohort, although primarily dependent on heroin, were also frequent users of stimulants. For those clients, it is appropriate to target their stimulant use as part of the wider cluster of substance misuse problems that require treatment (Gossop et al. 2000a). Other research has found the use of cocaine by methadone maintenance clients to be associated with higher rates of criminality, health risk behaviour and other problems (Grella et al. 1995; Des Jarlais et al. 1992; Kosten et al. 1988).

For 7.5% of the NTORS cohort, stimulants were their main problem drug. Although these clients were mostly polydrug users, they were much less likely than other stimulant users to use heroin or other opiates and less likely to inject. They were, however, more likely to be heavy drinkers. The differences in substance use patterns are likely to require different clinical management (Gossop et al. 2000a).

There is evidence that dexamphetamine sulphate is currently prescribed in England and Wales for the treatment of primary amphetamine use (Fleming 1998; Bradbeer et al. 1998; White 2000; Klee et al. 2001). The Task Force to Review Services for Drug Misusers (1996) stated that there might be a place for amphetamine substitute prescribing in some cases, but further research

is needed as there is little scientific evidence for its efficacy. Department of Health guidelines suggest that such prescribing should be restricted to particular groups (Department of Health et al. 1999). There are dangers associated with stimulant prescribing and the evidence suggests that psycho-social interventions are the management of choice for stimulant misusers (see 'Stimulant users', in Chapter 3).

The Department of Health's clinical guidelines state that there is no indication for the prescribing of cocaine or methylamphetamine in the treatment of stimulant misuse. The guidelines also recommend that methylphenidate or phentermine not be prescribed (Department of Health et al. 1999). Similarly, there is currently no supporting evidence for the clinical use of carbamazepine for cocaine dependence (Lima et al. 2000). Antidepressants, such as Fluoxetine, can be effective in the management of major depressive episodes associated with stimulant use. However, care must be taken if selective serotonin re-uptake inhibitors are prescribed while cocaine or amphetamine is still taken, as toxic reactions have been described (Department of Health et al. 1999).

There is some evidence of the efficacy of disulfiram for treatment for cocaine dependence and alcohol dependence or abuse, although the use of alcohol and disulfiram could potentially cause serious physical adverse effects. There is also some evidence that disulfiram may be an effective pharmacotherapy for cocaine misuse among methadone maintained clients, even those without co-morbid alcohol misuse. Disulfiram may work with buprenorphine to reduce cocaine use in opiate users (Carroll et al. 2000; George et al. 2000; McCance-Katz et al. 1998; Petrakis et al. 2000) (see 'Stimulant users' section in Chapter 3).

To date, research shows that abstinence-based psychological treatment approaches, linking counselling and social support, have had the greatest impact on cocaine misuse (Department of Health et al. 1999). Complementary therapies, such as acupuncture, are commonly used, despite limited evidence of their effectiveness. Nonetheless, they are capable of attracting drug users to treatment settings and it is suggested that they are explored (Department of Health et al. 1999). However, the main problem remains that drug services in the UK are primarily geared to opiate dependence and there is little information about the outcome of treatment for stimulant users.

Annex B

National Enhanced Service - patients suffering from drug misuse 2 May 2003

Introduction

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

Background

Drug misuse and its complications pervade every part of society and social classes and are a problem found across the whole country.

The number of drug users in the general population is estimated to be in the regions of 150,000 – 200,000, though since the demise of the Home Office Addicts Index, exact prevalence rates are difficult to estimate accurately. Based on current estimates however, it would be expected that almost every general practitioner would have patients with drug misuse registered with them, though prevalence rates in inner cities and urban areas will be significantly higher than in rural areas.

Service outline

The following elements of the service would need to be in place already for the purpose of this NES:

- an accurate register of patients
- a sequential review as appropriate
- safe and secure practices, appropriate for the provision of such services
- a good knowledge of, and effective liaison with, local drug services and other agencies, including non-statutory services
- links between local pharmacies, primary care drug support workers, social services (including the Child Protection Service) and local mental and clinical health teams.

This national enhanced service will fund practices to be able to:

- develop and co-ordinate the care of drug users and develop practice guidelines. Practices must have knowledge of local detoxification procedures

- treat dependent drug users with support. This will be with support from, for example, shared care drug service, GPswSI, nurses with specialist interest and specialist providers. It includes the prescribing of substitute (opiate and non-opiate) drugs or antagonists using best practice as outlined in the Department of Health's drug misuse clinical guidelines or equivalent
- ensure that prescribing takes place within a context in which the co-existing physical, emotional, social and legal problems are addressed as far as possible
- participate in audit of prescribing practice
- act as a resource to practice colleagues in the care of drug users
- demonstrate additional training and continuing professional development. This should be commensurate with the level of service provision expected of a clinician in line with any national or local guidance to meet the requirements of revalidation
- maintain the safety and training of clinical and non-clinical staff
- provide care for patients outside their own registered list (if the practice has agreed to look after such patients). These patients must have an effective means of communication with the registered doctor.

The NES will be subject to the following audits on a six-monthly basis:

- audit of prescribing of substitute medication if appropriate and adherence to the minimum standards laid out by the PCO / shared care monitoring group
- audit of hepatitis B screening and immunisation data relevant to this patient population.

An annual review of service will be made to include the following:

- attendance rates
- non-attendance rates
- review against outcomes
- financial review.

Accreditation

Those doctors who have previously provided services similar to this enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

A practitioner providing enhanced services in drugs and substance misuse should have the skills to:

- identify and treat the common complications of drug misuse
- carry out an assessment of a patient's drug use
- provide harm reduction advice to a current drug user or his or her family
- test (or refer for testing) for other viruses, including HIV, and immunisation for hepatitis B to at-risk individuals
- provide drug information to carers and users as to the effects, harms and treatment options for various common drugs of use
- assess and refer appropriately, patients for drug misuse substitution treatment
- utilise the range of commonly used treatment options available for treatment including pharmacological interventions
- be aware of local policy
- work in an appropriate multidisciplinary manner.

Appraisal criteria

The appraisal criteria will include both the generalist and special interest aspects of the work.

CPD requirements

It is expected that the level of training required for a GP providing an enhanced service is identified in the GP's personal development plan and, where additional training is required, local mechanisms are found to address this.

Costs

In 2003/04 each practice contracted to provide these services will receive a £1,000 annual retainer, £500 withdrawal per patient per annum, and £350 maintenance per patient per annum, paid quarterly in arrears. These prices will be uprated by 3.225 per cent in 2004/05 and again in 2005/06.

Bibliography

- Auriacombe, M. (2001) 'Deaths attributable to methadone and buprenorphine in France', JAMA 285 (1).
- Ball, J. C. and Ross, A. (1991) The effectiveness of methadone maintenance treatment: patients, programs, services and outcomes, Vienna: Springer-Verlag.
- Barnett, P. G., Rodgers, J. H. and Bloch, D. A. (2001) 'A meta-analysis comparing buprenorphine to methadone for treatment of opiate dependence', Addiction, 96, pp. 683–90.
- Bradbeer, T. M., Fleming, P. M., Charlton, P. and Crichton, J. S. (1998) 'Survey of amphetamine prescribing in England and Wales', Drug and Alcohol Review, 17(3) pp. 299–304.
- Capelhorn, J. R., Bell, J., Kleinbaum, D. G. and Glebski, V. J. (1993) 'Methadone dose and heroin use during maintenance treatment', Addiction, 88, pp. 119–24.
- Carroll, K. M., Nich, C., Ball, S. A., McCance, E., Frankforter, T. L. and Rounsaville, B. J. (2000) 'One-year follow-up of disulfiram and psychotherapy for cocaine-alcohol users: sustained effects of treatment', Addiction, 95 (9), pp. 1335–49.
- Department of Health (2001c) Instalment prescribing of buprenorphine for the treatment of drug addiction, DH PL/CMO/2001/2,PL/CPHO/2001/2
- Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Security in Northern Ireland (1999) Drug misuse and dependence: guidelines on clinical management, London: The Stationery Office.
- Des Jarlais, D. D. C., Wenston, J., Friedman, S. R., Sotheran, J. L., Maslamsky, R. and Marmor, M. (1992) 'Crack cocaine use in a cohort of methadone maintenance patients', Journal of Substance Abuse Treatment, 9, pp. 319–25.
- Eder, H., Fischer, G., Gombas, W., Jagsch, R., Stuhlinger, G. and Kasper, S. (1998) 'Comparison of buprenorphine and methadone maintenance in opiate addicts', European Addiction Research 4, pp. 3–7.
- Findings (2001) 'Nuggets: under-dosing and poor initial assessment undermine the success of English methadone services', Findings, Issue 5, Summer 2001.
- Fiorentine, R. and Anglin, D. (1996) 'More is better: counselling participation and the effectiveness of outpatient drug treatment', Journal of Substance Abuse Treatment, 13, pp. 341–8.

- Fleming, P. M. (1998) 'Prescribing amphetamine to amphetamine users as a harm reduction measure', International Journal of Drug Policy, 9(5), pp. 339–44.
- Ford, C. and Ryrie, I. (1999) 'Prescribing injectable methadone in general practice', International Journal of Drug Policy, 10, pp. 39–45.
- Gabbay, M., Carmwath, T., Ford, C. and Zador, D. (2001) 'Reducing death among drug misusers: tighter legal controls on drug prescribing are not the answer', British Medical Journal, 322, pp. 749–50.
- George, T. P., Chawarski, M. C., Pakes, J., Carroll, K. M, Kosten, T. R. and Schottenfeld, R. S (2000) 'Disulfiram versus placebo for cocaine dependence in buprenorphine-maintained subjects: a preliminary trial', Biological Psychiatry 47(12), pp. 1080–86.
- Gossop, M., Marsden, J. and Stewart, D. (1998a) National Treatment Outcome Research Study: NTORS at one-year, London: Department of Health.
- Gossop, M., Marsden, J., Stewart, D. and Rolfe, A. (2000b) 'Reduction in acquisitive crime and drug use after treatment of addiction problems: one year follow-up outcomes', Drug and Alcohol Dependence, 58, pp. 165–72.
- Gossop, M., Marsden, J. and Stewart, D. (2000a) 'Treatment outcomes of stimulant misusers: one year follow-up results from the National Treatment Outcome Research Study (NTORS)', Addictive Behaviour, vol. 25 (4), pp. 509–522.
- Gossop, M., Marsden, J., Stewart, D., Lehmann, P. and Strang, J. (1999a) 'Treatment outcome among opiate addicts receiving methadone treatment in drug clinics and general practice setting: results from the National Treatment Outcome Research Study (NTORS)', British Journal of General Practice, 49, pp. 31–4.
- Gossop, M., Powis, B., Griffiths, P. and Strang, J. (1994b) 'Multiple risks for HIV and hepatitis B infection among heroin users', Drug and Alcohol Review, 13, pp. 293–300.
- Gowing, L. R., Farrell, M., Ali, R. L. and White, J. M. (2002) 'a2 A-drenergic agonists in opioid withdrawal', Addiction, 97 (1), pp. 49–58.
- Grella, C. E., Anglin, M. D. and Wugalter, S. E. (1995) 'Cocaine and crack use and HIV risk behaviours among high risk methadone maintenance clients', Drug and Alcohol Dependence, 37, pp. 15–21.
- Grella, C., Wugalter, S. and Anglin, M. D. (1997) 'Predictors in enhanced and standard methadone maintenance treatment for HIV risk reduction', Journal of Drug Issues, 27 (2), 22, pp. 329–40.
- Hutchinson, S. J., Taylor, A., Gruer, L., Barr, C. et al. (2000b) 'One-year follow-up of opiate injectors treated with oral methadone on a GP-centred programme', Addiction, 95 (7), pp. 1055–68

- Joe, G. W., Simpson, D. D. and Broome, K. M. (1999) 'Retention and patient engagement models for different treatment modalities in DATOS', Drug and Alcohol Dependence, 57, pp. 113–125.
- Klee, H., Wright, S., Carnworth, T. and Merrill, J. (2001) 'The role of substitute therapy in the treatment of problem amphetamine use', Drug and Alcohol Review, 20(4), pp. 412–29.
- Kosten, T., Rounsaville, B. and Kleber, H. (1988) 'Antecedents and consequences of cocaine abuse among opiate addicts. A 2.5 year follow up', Journal of Nervous and Mental Disease, 176, pp. 176–81.
- Langendam, M., Van Brussel, G. H. A, Coutinho, R. and Ameijden, E. (2000) 'Methadone maintenance and cessation of injecting drug use: results from the Amsterdam Cohort study', Addiction, 95(4), pp. 591–600.
- Lewis, D. and Bellis, M. (2001) 'General practice or drug clinic for methadone maintenance? A controlled comparison of treatment outcomes', International Journal of Drug Policy, 12(1), pp. 81–9.
- Ling, W., Charuvastra, C., Collins, J. F., Batki, S., Brown, L., Kintausi, P., Wesson, D., McNicholas, L., Tusel, D., Malkkerneker, U., Renner, J., Santos, E., Casadonte, P., Fye, C., Stine, S., Wang, R. and Segal, D. (1998) 'Buprenorphine maintenance treatment of opiate dependence: a multi-centre, randomised clinical trial', Addiction, 93 (4), pp. 475–86.
- Macleaod, B., Whittaker, A. and Robertson, R. (1998) 'Changes in opiate treatment during attendance at a community drug service: findings from a clinical audit', Drug and Alcohol Review, 17, pp. 19–25.
- Marsch, L. (1998) 'The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis', Addiction, 93(4), pp. 515–32.
- Marsden, J., Farrell, M., Gossop, M. and Strang, J. (1998) 'Cocaine in Britain: prevalence, problems and treatment responses', Journal of Drug Issues, 28, pp. 225–42.
- McCance-Katz, E. F., Kosten, T. R. and Jaltow, P. (1998) 'Disulfiram effects on acute cocaine administration', Drug and Alcohol Dependence 52 (1), 27–39.
- Metrebian, N., Shanahan, W., Wells, B. and Stimson, G. V. (1998) 'Feasibility of prescribing injectable heroin and methadone to opiate dependent drug users: associated health gains and harm reductions', Medical Journal of Australia, 168, pp. 596–600.
- National Treatment Agency (2003) Guidance on heroin prescribing, Forthcoming, London: NTA
- Pates, R. and Mitchell, A. (1996) 'Amphetamine use. Part II', Journal of Substance Misuse, 1, pp. 165–73.

- Petitjean, Stohler, R., Deglon, J. J., Livoti, S., Waldvogel, D., Uehlinger, C. and Ladewig, D. (2001) 'Double-blind randomized trial of buprenorphine and methadone in opiate dependence', Drug and Alcohol Dependence, 62, pp. 97–104.
- Petrakis, I. L., Carroll, K. M., Nich, C., Gordon, L. T., McCance-Katz, E. F., Frankforter, T. and Rounsaville, B. J. (2000) 'Disilfuram treatment for cocaine dependence in methadone-maintained opioid addicts', Addiction 95(2), pp. 219–28.
- Sell, L., Farrell, M. and Robson, P. (1997) 'Prescription of diamorphine, dipipanone and cocaine in England and Wales', Drug and Alcohol Review, 16, pp. 221–6.
- Simpson, D. D., Joe, G. W. and Brown, B. S. (1997) 'Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS)', Psychology of Addictive Behaviour, 11, pp. 239–60.
- Simpson, D. D., Joe, G. W., Rowan-Szal, G. and Greener, J. (1995) 'Client engagement and change during drug abuse treatment', Journal of Substance Abuse, 7, 117–34.
- Stewart, D., Gossop, M., Marsden, J. and Rolfe, A. (2000) 'Drug misuse and acquisitive crime among clients recruited to the National Treatment Outcome Research (NTORS)', Criminal Behaviour and Mental Health, 10, pp. 13–24.
- Strain, E. C., Stitzer, M. L., Leibson, I. A. and Bigelow, G. E. (1996) 'Buprenorphine versus methadone in the treatment of opioid dependence: self-reports, urinalysis, and addiction severity index', Journal of Clinical Psychopharmacology, 16, pp. 58–67.
- Strang, J., Marsden J., Cummins M., Farrell M., Finch E., Gossop., Stewart D. and Welch S. (2000) 'Randomised trial of supervised injectable versus oral methadone maintenance: report of feasibility and 6-months outcome', Addiction, 95(11), pp. 1631–45.
- Strang, J. and Sheridan, J. (1998) 'National and regional characteristics of methadone prescribing in England and Wales: local analysis of data from the 1995 national survey of community pharmacies', Journal of Substance Misuse, 3, pp. 240–6.
- Strang, J., Sheridan, J. and Barber, N. (1996b) 'Prescribing injectable and oral methadone to opiate addicts: results from the 1995 national postal survey of community pharmacists in England and Wales', British Medical Journal, 313, pp. 270–4.
- White, R. (2000) 'Dexamphetamine substitution in the treatment of amphetamine abuse: an initial investigation', Addiction, 95 (2), pp. 229–38.

Service Framework for Inpatient Treatment

Service Framework for Inpatient Treatment

Service Framework for Inpatient Treatment

1. Overview

Inpatient drug and alcohol treatment is a Tier 4 service in Wales. Inpatient drug and alcohol misuse treatment programmes are "specialised" units or beds for people with drug and alcohol misuse disorders. They provide medically supervised assessment, stabilisation and detoxification with access to 24-hour medical cover and a multidisciplinary team. Programmes need also to include a range of additional provisions such as relapse-prevention work and aftercare referral services. Inpatient provision for drug treatment can be delivered by either, designated drug and alcohol misuse beds in psychiatric wards, or in specialist inpatient units. In whatever setting the care is provided successful treatment is very dependent on pre-admission preparation. Inpatient care has also to satisfy clinical governance arrangements that in Wales are delegated to Local Health Boards and NHS Trusts. (See paragraph 4 in Community Prescribing Service Framework.)

2. Philosophy and approach

2.1 General

Many individuals with substance use dependence have difficulty achieving abstinence in the community. Inpatient programmes are therefore intended for those substance misusers whose needs require supervision in a controlled medical environment. Inpatient programmes primarily provide medically supervised withdrawal i.e. detoxification. These programmes can continue in the community as aftercare (with adjunctive prescribing such as naltrexone). Alternatively, clients can be referred to a residential rehabilitation facility where they may receive short-term programmes of counselling and relapse prevention support. (See service framework for residential rehabilitation).

2.2 Specific Prescribing Programmes

The following specific prescribing interventions need to be available in specialist inpatient treatment beds:

- stabilisation on benzodiazepines for alcohol withdrawal
- alcohol relapse prevention (e.g. disulfiram and acamprosate)
- treatment with Thiamine for alcohol misuse
- stabilisation on substitution opioids (e.g. methadone and buprenorphine)
- withdrawal from substitution opioids (e.g. methadone and buprenorphine)
- withdrawal from opioids using non-opioid medication (e.g. lofexidine)

- opioid relapse prevention (e.g. naltrexone)
- stabilisation on benzodiazepines for sedative withdrawal
- symptomatic treatment for stimulant withdrawal.

The programme duration for a withdrawal regime is essentially short term and should be between one and seven weeks with an average of about four weeks.

3. Location

Inpatient drug and alcohol misuse treatment services can be based in hospital general psychiatric units, in general hospitals (general medical beds) or in specialist dedicated inpatient units. They can also be legitimately provided by the voluntary/independent sector in partnership arrangements with the NHS where the clinical governance arrangements for medical supervision are clearly defined. (There is, however, some limited evidence that suggests that patients may achieve better outcomes for opiate dependency in dedicated inpatient units than those treated in other facilities.

Community Safety Partnerships need to ensure users have appropriate access to inpatient facilities, although they do not necessarily have to be provided from within their partnership geographical areas.

4. Aims and objectives

Prior to admission patients should be assessed using the Unified assessment Process including a specialist assessment with a full risk assessment and any issues relating to dependent children.

The key **aims** of the inpatient treatment regime following this are:

- to fully assess the degree of dependence using the appropriate assessment instruments
- to define a programme of care, ensure that a care co-ordinator is in place from community services or the inpatient facility, and develop a care plan
- to prescribe medication where indicated, according to clearly defined written protocols as part of a comprehensive programme of care
- to prescribe medication safely and effectively in order to achieve stabilisation and/or withdrawal
- to prescribe medication appropriately for relapse prevention
- to prescribe medication for psychiatric and/or physical complications and/or co-morbidity as appropriate
- to identify risk behaviour and offer appropriate counselling to enable minimisation of harm

- to offer, when appropriate, tests for hepatitis B and C and HIV with informed consent
- to offer hepatitis B immunisation
- To involve other specialists/agencies as necessary (as prescribed in Unified Assessment Process)
- to assess the longer-term treatment needs of patients and formulate an appropriate discharge care plan in accordance with the care programme approach
- to provide a period of substance-free recovery as appropriate
- to provide effective psychological interventions, such as cognitive behavioural therapy and relapse prevention therap
- to assess and refer patients for other treatments as appropriate, for example trauma therapy, family therapy, etc
- to monitor and evaluate the efficiency and effectiveness of prescribing interventions
- to monitor and evaluate the efficiency and effectiveness of psychological interventions
- to provide referral to other services as necessary.

5. Client group served

Service users should be individuals who have drug or alcohol-related problems and meet International Classification for Diseases (ICD-10)/Diagnostic and Statistical Manual (DSM-IV) dependence criteria. This group comprises individuals who are seeking abstinence from their main problem drug or drugs in a controlled medical setting. Where appropriate patients can be admitted for stabilisation on substitution medication and discharged to a community prescribing programme such as maintenance opiate prescribing. While service priorities should be geared to the withdrawal needs of opiate and alcohol misusers, they must be able to supervise the withdrawal of primary users of other drugs and provide adjunctive prescribing for medical complication and conditions when clinically required.

5.1 Target Groups

Admission to inpatient drug and alcohol misuse treatment programmes is voluntary for adults and dependent on individual clinical assessment.

The target groups for inpatient treatment include the following:

- patients physically dependent on one or more substances
- patients with physical or psychiatric complications or co-morbidity (but not acute severe mental illness)

- women who are pregnant
- patients who have failed to complete outpatient drug treatment programmes where there are significant indicators of the potential success of an inpatient regim
- patients who are unlikely to cope with outpatient detoxification due to significant personal isolation or lack of support from family or friends
- patients with withdrawal complications e.g. seizures.

Prioritisation of these target groups will be on the basis of clinical need.

5.2 Suitability for treatment

There are three categories of client for whom treatment in an inpatient facility might not be appropriate. These are individuals with:

- serious acute psychiatric morbidity, e.g. acute psychosis, requiring acute psychiatric treatment
- serious physical morbidity (e.g. life threatening physical illness)
- those for whom a risk assessment indicates that the risk would be too high.

(Facilities should be in place so that, on occasion, admissions are specially timed, for example where a couple both require inpatient treatment and their admissions may be consecutive, to avoid compromising care).

6. Access

6.1 Access to the service

Service providers have to provide timely and up-to-date information on criteria for access to the inpatient detoxification programme. This material should describe as a minimum:

- who the service is intended for (in line with stated priorities above)
- expected waiting times.

6.2 Referral pathways (See attached diagram)

There has to be clear written information about how the referral process is undertaken. This needs to address:

- how referrals are made
- response times
- which staff are involved and how the referral will be managed

- care co-ordination processes and responsibilities
- how the referral process will be documented and referral outcomes monitored and communicated.

7. Management

7.1 Treatment Phases

The client has to be fully engaged at all stages of the management of his treatment. Within this, particular attention has to be paid to pre-admission planning. The key stages are:

- all patients fully assessed by the appropriate team and referrer/GP informed
- decision is made as to eligibility for admission
- category of admission is considered: for example, e.g. priority or routine
- admission in accordance with admission category
- patients offered preparation for admission, for example, information given about the unit, information about care plans, pre-admission meetings, details of unit protocols including prescribing protocols, etc
- formulation of an agreed care plan which will include arrangements for care following discharge. This may include community care assessments for rehabilitation placements, and day programmes, etc
- patient admitted to the inpatient unit, and assessment undertaken in compliance with clear assessment protocols
- prescribing initiated (where appropriate)
- discharge planning meeting organised during patient's treatment programme to formalise ongoing care plan
- discharge to follow-up care with appropriate provision for any on-going prescribing and inform the GP in a timely manner.

7.2 Discharge for reasons of safety

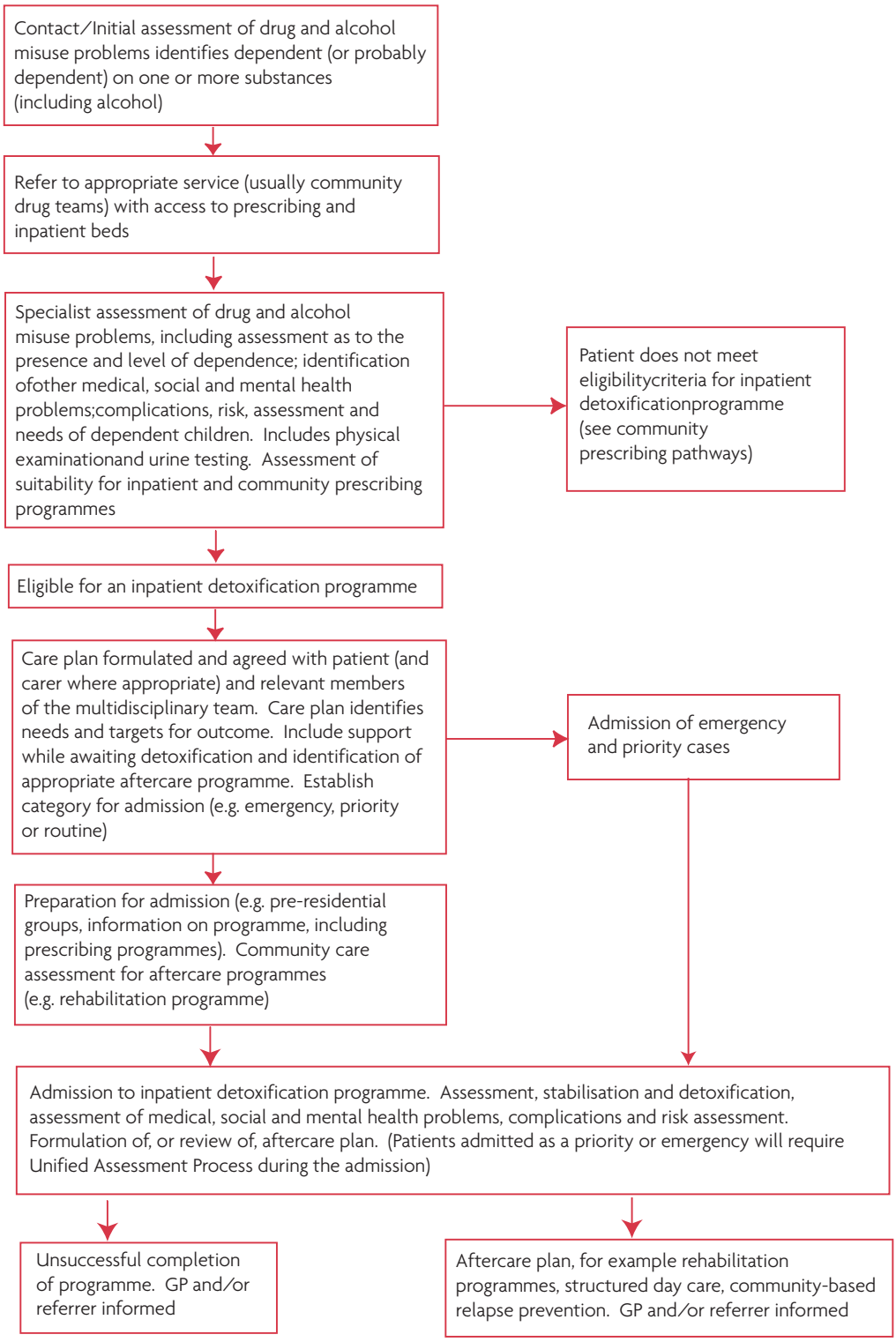
On occasion, a patient may violate treatment protocols and in some situations this may compromise the safety of other patients and staff as well as themselves. Such patients should be assessed for suitability for discharge, if necessary under the Mental Health Act. Occasionally, patients may need to be transferred to a mental health unit, requiring close liaison with mental health services (see Co-occurring Substance Misuse and Mental Health Problem section). Whatever the reason for the discharge, a discharge plan should be put in place which is sympathetic to the needs of the patient (e.g. timing), addresses alternative support arrangements and involves the patient's GP.

7.3 Discharge against medical advice

Some patients may decide to take their own discharge against medical advice. Assessment should occur in order to determine if a patient is fit to be discharged, and if necessary, a mental health assessment may be required. A clear discharge plan should be formulated for patients who are unfit for discharge and the patient's GP informed.

At the time of discharge it is critical that the clinical staff member co-ordinating the discharge provides information to the client, prior to them leaving the unit, about the potential risk of overdose and the availability of other services.

8. Integrated care pathways: Inpatient detoxification



ANNEX A

Research evidence base

Research suggests that a high proportion of patients accessing inpatient treatment can achieve successful withdrawal from opioids. A relatively small number of studies have evaluated the impact of hospital inpatient units and residential rehabilitation programmes. One early English follow-up study of patients who were treated by a specialist inpatient unit found that 51% of patients were drug-free at a six-month follow-up (Gossop et al. 1989). The only controlled study of inpatient versus outpatient treatment of opiate withdrawal in the UK found inpatient withdrawal to be four times more effective in terms of the proportion of patients who completed the withdrawal regime (Gossop et al. 1986). An uncontrolled study found that 74% of patients admitted for opiate detoxification successfully completed treatment and one-third of patients followed up one year after inpatient detoxification had been abstinent from opioids for at least one month prior to follow up (Ghodse et al. 1997). There is evidence that a dedicated substance misuse inpatient unit is associated with better outcomes in terms of completion of opioid withdrawal and abstinence from opioids after seven months than a general psychiatric ward (Strang et al. 1997b).

NTORS has shown that those clients participating in the study who were in residential treatment settings (inpatient units and residential rehabilitation units) tended to be older, have longer drug careers, be regularly using a broader range of substances (including alcohol), and have more previous contact with drug treatment services (Gossop et al. 1998c). Those clients in the cohort who were admitted to residential treatment programmes showed substantial improvements in terms of abstinence from opiates, psycho-stimulants and benzodiazepines. At one year, more than a third of all patients admitted to residential treatment programmes were abstinent from all of the target drugs and had been so for the previous three months. There were also improvements in other problem areas (injecting, sharing injecting equipment, heavy drinking and criminal behaviour). It was found that a 'critical period' of 28 days for inpatient and short-stay residential programmes predicted likelihood of achieving abstinence from opiates at one year, although improvements were also seen in patients who were discharged before this 'critical period' (Gossop et al. 1999b).

However, a proportion of patients leave inpatient treatment prior to completion, with studies reporting drop-out rates of between 18–46% (Ghodse et al. 1987; Gossop et al. 1987). Severe drug use and severe medical problems were identified as predictors of failure to complete inpatient detoxification in one study (Franken and Hendriks 1999). It is also recognised that most of the research has been conducted on inpatient treatment of opioid and polydrug (including stimulants) misuse, rather than primary stimulant users.

Turning to the evidence base for effective withdrawal agents and regimens, a variety of medications have been found to be efficacious in managing withdrawal syndromes in inpatient facilities. These include oral methadone, codeine-based medication such as dihydrocodeine and buprenorphine. Lofexidine may be used for opioid withdrawal and there is evidence that it is as efficacious as methadone in inpatient withdrawal (Bearn et al. 1996). Rapid opioid detoxification under sedation has been described, although properly controlled trials have not been performed (Seoane et al. 1997). Symptomatic relief of mild opioid withdrawal symptoms, for example by use of diphenoxylate, promethazine and propranolol, has also been described (Department of Health et al. 1999).

It is common for inpatient programmes to manage benzodiazepine withdrawal. The majority of opioid drug users presenting for treatment have a history of benzodiazepine use in the year prior to treatment and nearly half of opioid users in treatment have injected benzodiazepines (Perera et al. 1987; Strang et al. 1994). In one study, 43% of patients admitted to an inpatient unit who reported benzodiazepine misuse were found to be physically dependent on benzodiazepines, and most were successfully stabilised on a mean dose of diazepam 40mg, with a range from 20–80mg (Williams et al. 1996). Sedative withdrawal using substitution benzodiazepines, generally long-acting preparations such as diazepam, is a well-recognised treatment for benzodiazepine and alcohol dependence (Ghodse 1995a). For drug users who are found to be dependent on both sedatives (including alcohol) and opioids, it is recommended that benzodiazepine withdrawal be completed first, while the patient remains on a steady dose of substitution opioid such as oral methadone.

Primary stimulant misusers, and polydrug users whose use of drugs includes stimulants, may also be admitted to inpatient substance misuse units. Primary stimulant misusers may be admitted due to severity of withdrawal symptoms, including depressive and suicidal symptoms, or due to physical or psychiatric co-morbidity. Most studies have found that a psychosocial abstinence-based approach is most efficacious (Carroll et al. 1995b). There is little research evidence for the use of substitution stimulant prescribing in the inpatient treatment setting. However, there is a role for non-substitution prescribing for stimulant withdrawal in inpatient settings including the relief of symptoms such as anxiety, agitation and psychotic indications. The prescription of antidepressant medication for major depressive episodes associated with stimulant use may also be necessary.

Prescribing interventions for relapse prevention may be commenced during inpatient treatment. Naltrexone, an opiate antagonist, may be prescribed for opioid users following withdrawal and a period of recovery. Disulfiram may be prescribed for patients following alcohol withdrawal and for those with alcohol and cocaine problems.

Most inpatient drug misuse treatment services have a contingency management approach. Clients may be asked to agree to a contract of care that specifies that certain behaviours are not acceptable. These commonly include the use of illicit drugs, racist or sexist behaviour and violent behaviour. At the commencement of treatment these behaviours are clearly outlined as unacceptable, and patients are asked to agree this contract as a condition of accepting treatment in the unit, with the understanding that a breach of this contract will lead to a review of their treatment and possibly to discharge.

Inpatient Treatment

Bibliography

- Bearn, J., Gossop, M. and Strang, J. (1996) 'Randomised double blind comparison of lofexidine and methadone in the inpatient treatment of opiate withdrawal', Drug and Alcohol Dependence, 43, pp. 87–91.
- Carroll, K. M., Rounsaville, B. J., Nich, C., Gordon, L. and Gawin, F. (1995b) 'Integrating psychotherapy and pharmacotherapy for cocaine dependence: results from a randomised clinical trial', NIDA Research Monograph, 150, pp. 19–35.
- Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Security in Northern Ireland (1999) Drug misuse and dependence: guidelines on clinical management, London: The Stationery Office.
- Franken, I. H. A. and Hendriks, V. M. (1999) 'Predicting outcome of inpatient detoxification of substance abusers', Psychiatric Services, 50 (6), pp. 813–17.
- Ghodse, A. H. (1995a) Drugs and addictive behaviour: a guide to treatment, 2nd edn, Oxford: Blackwell Science.
- Ghodse, A. H., Dunmore, E., Sedgewick, P. M., Howse, K., Gauntlett, N. and Clancy, C. (1997) 'Changing pattern of drug use in individuals with severe drug dependence following inpatient treatment', Int J Psych Clin Pract, 1, pp. 287–94.
- Ghodse, A. H., London, M., Bewley, T. H. and Bhat, A. (1987) 'In-patient treatment for drug abuse', British Journal of Psychiatry, 151, pp. 72–5.
- Gossop, M., Green, L., Phillips, G. and Bradley, B. (1989) 'Lapse, relapse and survival among opiate addicts after treatment', British Journal of Psychiatry, 154, pp. 348–53.
- Gossop, M., Green, L., Phillips, G. and Bradley, B. (1987) 'What happens to opiate addicts immediately after treatment: a prospective follow up study', British Medical Journal, 294, pp. 1377–80.
- Gossop, M., Johns, A. and Green, L. (1986) 'Opiate withdrawal: inpatient versus outpatient programmes and preferred versus random assignment to treatment', British Medical Journal, 293, pp. 697–9.
- Gossop, M., Marsden, J., Stewart, D. and Rolfe, A. (1999b) 'Treatment retention and one year outcomes for residential programmes in England', Drug and Alcohol Dependence, 57, pp. 89–98.
- Gossop, M., Marsden, J., Stewart, D., Lehmann, P., Edwards, C., Wilson, A. and Segar, G. (1998c) 'Substance use, health and social problems of service users at 54 drug treatment agencies: intake data from the National Treatment Outcome Research Study (NTORS)', British Journal of Psychiatry, 173, pp. 166–71.

- Perera, K. M. H., Tulley, M. and Jenner, F. A. (1987) 'Use of benzodiazepines among drug addicts', British Journal of Addiction, 82, pp. 511–15.
- Seoane, A., Carrasco, G., Cabre, L., Puiggros, A., Hernandez, E., Alvarez, M., Costa, J., Molina, R. and Sobrepere, G. (1997) 'Efficacy and safety of two new methods of rapid intravenous detoxification in heroin addicts previously treated without success', British Journal of Psychiatry, 171, pp. 340–5.
- Strang, J., Griffiths, P., Abbey, J. and Gossop, M. (1994) 'Survey of use of injected benzodiazepines among drug users in Britain', British Medical Journal, 308, p. 1082.
- Strang, J., Marks, I., Dawe, S., Powell, J., Gossop, M., Richards, D. and Gray, J. (1997b) 'Type of hospital setting and treatment outcome with heroin addicts', British Journal of Psychiatry, 171, pp. 335–9.
- Williams, H., Oyefeso, A. and Ghodse, A. H. (1996) 'Benzodiazepine misuse and dependence among opiate addicts in treatment', Irish Journal of Psychological Medicine, 13 (2), pp. 62–4.

Service Framework to Meet the Needs of People with Co-occurring Substance Misuse and Mental Health Problem

A Service Framework to Meet the Needs of People with a Co-occurring Substance Misuse and Mental Health Problem.

1.0 Overview

1.1 Definition (drawn from Scottish Advisory Committee on Drugs Misuse & Scottish Advisory Committee on Alcohol Misuse document Mind the Gaps)

Substance misuse refers to the problem use of prescribed or illicit drugs, and/or alcohol.

Dual diagnosis or co-morbidity refers specifically to the co-existence of diagnosed mental health problems (irrespective of severity) and substance misuse but also a range of other conditions.

Co-occurring substance use and mental health problems is used more generally to acknowledge that not all mental health problems have been diagnosed, nor are all forms of substance use considered to be problematic.

Co-occurring substance misuse and mental health problems has therefore been adopted for use in the development of these service standards. Taken together these problems give rise to significant impairment and disability for which people affected need advice, support and services, in order to follow a more integrated life course. The severity and nature of a person's problem are liable to change over time. Each problem, however, would be significant enough to merit planned care on its own.

The intention of this framework is therefore to address the broad spectrum of mental health and substance misuse problems from mild/moderate to severe. Inevitably services will have to prioritise those in greatest need and in order to facilitate this the framework will be augmented with inclusion criteria and thresholds.

Because of the complex needs of people with a co-occurring substance misuse and mental health problem, a co-ordinated approach from a range of primary and secondary services is essential. These services will need to be provided in both statutory and non-statutory settings. Whilst the key service providers are adult mental health and specialist substance misuse teams input from non specialist providers such as housing agencies is also vital in order to deliver a comprehensive range of services. In the absence of an integrated approach from the providers of the different service components, individuals with a co-occurring substance misuse and mental health problem are potentially at risk of falling between stools. This is of particular concern given that this client group has an increased risk of suicide and/or homicide.

In order to deliver effective care, services have to be co-ordinated with clear treatment protocols and care pathways. The complexity of the care programmes required to meet these needs has given rise to increasing

challenges in both the delivery of mental health and substance misuse services. The purpose of this document is to provide a service framework for the delivery of treatment and care to those with a co-occurring substance misuse and mental health problem in Wales. It will establish a framework based on current evidence base for co-occurring substance misuse and mental health problems against which health and social care agencies can be assessed.

The emphasis within the framework is co-occurring mental health and substance misuse problems. However it is widely recognised that many people may have additional problems including one or more of the following:

- a personality disorder
- a physical disability
- a learning disability
- a physical health problem sensory impairment
- problems associated with old age.

Where people have multiple problems a range of responses from agencies in different settings will be required. This shall be delivered in line with the requirements of the Unified Assessment Process (UAP) and/or the Care Programme Approach (CPA).

2.0 Context

Mental Health is one of the top three clinical priorities of the Welsh Assembly Government. In September 2001 the strategy document "Adult Mental Health Services for Wales 'Equity, Empowerment, Effectiveness, Efficiency'" was published, setting out a ten year strategy for the development of mental health services in Wales. The strategy was supported by the publication in April 2002 of "Adult Mental Health Services 'A National Service Framework for Wales'". Both of these documents identify the need for close collaboration between services.

The strategy emphasises the importance of unambiguous clinical responsibility for individuals with a dual diagnosis and appropriate access to the services they need. The strategy also notes the need for general adult mental health services to recognise that those with alcohol and drug problems can also develop mental illnesses that require treatment. It further reaffirms that mental illness service users who misuse drugs or alcohol are a particularly vulnerable and high-risk group. The strategy cites the "Safer Services" report, which recommends that alcohol and drug services work much more closely with general adult mental health services.

In order to clarify responsibility, the strategy makes it explicit that if a service user has a psychotic illness or severe mental illness (SMI) that adult mental health services should be the **"lead"** service. In any event mental illness symptoms shall be treated by mental health services.

The substance misuse strategy "Tackling Substance Misuse in Wales - A partnership approach", (2000), identifies the need for the development of services for those with a dual diagnosis of substance misuse and severe mental health problems. Co-ordinated and effective clinical and social care following on from assessed needs is crucial to this process.

Clinicians working in this area were highlighted by the Audit Commission (2002) as reporting a lack of co-ordination in approach to patients with a dual diagnosis. This lack of co-ordination was further evident at the strategic planning stage level in the Commission's analysis.

The "Dual Diagnosis Good Practice Guide", (2002), suggests that all health and social care economies conduct a local mapping exercise to determine the local level of need in dual diagnosis.

In adopting the definition co-occurring substance misuse and mental health problems it shall be used to meet the policy objectives set out in strategies where the term dual diagnosis has previously been used.

The major strategic aims linked to successful care co-ordination for this patient population are an improvement in treatment outcomes, a reduction in the rate of suicide, homelessness and violence and an improvement in the wider public health.

They are also likely to assist in meeting the mental health gain target (HGT) "To reduce the European Age Standardised Rate from suicide (including undetermined deaths) for all ages by at least 10 per cent by 2012".

3.0 The Development of Models of Care in Wales

Four models of care have evolved in which the delivery of services to people with a co-occurring substance misuse and mental health problem can potentially be delivered these are set out in table 1 below.

Model of Treatment	Description	Issues for Consideration
1. Joint liaison/ collaborative approach	The care of patients is jointly managed by both services	• Joint working required between mental health and substance misuse services • Joint responsibility • Ensures the skills and expertise of both spheres of health care is utilised

Model of treatment	Description	Issues for Consideration
2. Parallel	Substance misuse and mental health services establish a liaison to provide the two services concurrently	• Patients are shunted between two services • Health problems are treated as separate entities • Medical responsibility is not clearly defined • Patients have to go through their details twice and build up relationships with two sets of professionals • Patients have to negotiate two diferent systems.
3. Integrated	There is concurrent provision of both psychiatric and substance misuse interventions by the same clinical team (designated service)	• Isolated from mainstream services • Views dual diagnosis as a static condition • Expensive service provision
4. Serial or consecutive	Psychiatric and substance-use disorders are treated consecutively with little communication between substance misuse and psychiatric services	• Patients are shunted between two services • Health problems treated as separate entities • Limited communication between the services. • Patients have to go through their details twice and built up relationships with two sets of profesionals • Patients have to negotiate two different systems

Abstracted from NTASM (2003, p.3)

Models 2 & 4 above are not considered acceptable models for the delivery of effective care. Model 3 would be likely to deliver effective care but does not fit comfortably with the mental health and substance misuse strategies within Wales. It is recommended therefore that model 1, the joint liaison or collaborative approach should be adopted as the preferred model for the delivery of care to people with a co-occurring substance misuse and

mental health problem. **The application of the model will require local interpretation reflecting local geographic, demographic and service configuration issues.** This will be particularly relevant in relation to the locally adopted model of service collaboration. Where link workers are introduced consideration will also need to be given to their deployment.

3.1 Liaison and Collaboration

The precise nature of liaison and collaboration will be determined by local service configuration and ultimately by the requirements of each individual case. However liaison and collaboration should include arrangements for:

- Joint training
- The clarification of clinical leadership
- The availability of a link worker or suitable alternative
- Consultancy
- Advice
- Formal joint working and shared care
- The use of UAP and CPA to assess and plan care
- The use of comprehensive assessment with CPA for those people with multiple pathology
- A single and where appropriate integrated care plan.

4.0 Service Aims and Objectives

Whichever model of provision is adopted, mental health and substance misuse services need to agree clear aims and objectives for dual diagnosis services. These should ensure:

- That a comprehensive staged approach to recovery including, where appropriate, assertive outreach, motivational interventions and provision of help to clients using skills to manage both mental health and substance misuse problems
- That people are managed at a level of care; primary or secondary, appropriate to their need
- That services are delivered by the statutory or non-statutory services or both where appropriate
- That Appropriate linkage to the criminal justice services including the police courts prison and probation services is in place
- cultural sensitivity and competence

- the availability of early interventions
- rapid access to services that should be flexible and appropriate to individual need
- broadly based interventions that include social, housing, education and employment components
- advocacy, with key workers helping service users through the care processes
- positive expectations of what can be achieved through treatment
- effective joint working protocols between mental health and substance misuse services
- joint planning
- the provision of in-reach to acute inpatient and detoxification facilities.

4.1 Service Standards

Commissioning and provider agencies need to establish effective service standards for their locally developed co-occurring substance misuse and mental health problem services. These should include as a minimum:

- The maintenance of a clear line of clinical responsibility for the patient
- A clear and agreed local definition of co-occurring substance misuse and mental health problem
- Clear and agreed care pathways
- Training plans to ensure the delivery of training and supervision at a sufficiently senior level, in substance misuse treatment for all members of the psychiatric service and equivalent training in mental health issues for substance misuse workers
- The provision of a liaison function between services. This may include where appropriate a link worker specialising in substance misuse and mental health problems to augment existing community mental health and substance misuse teams
- The provision of a single co-ordination point within mental health and alcohol and drug services ensuring access to services outside normal office hours
- The use of compatible models and conceptual frameworks for both condition

- The use of UAP and where appropriate CPA
- Clear definitions of which patients will be treated
- User involvement at all stages
- Common referral criteria and process
- Where appropriate comprehensive multidisciplinary assessment
- Access to out-reach services, community treatment, home visits, outpatient treatment, inpatient treatment and day care provision
- Involvement with patient's GP
- Retention of clients in active treatment
- Provide interventions that facilitate motivation to change
- Access to relapse prevention services
- Facilitation of reintegration into the community.

5.0 Unified Assessment Process (UAP) and Care Programme Approach

Because of the complex needs of people with a co-occurring substance misuse and mental health problem, care and treatment approaches need to be broad-based and flexible. As each person will need to be assessed individually there is no specific treatment approach. However as with all service user groups people with a co-occurring mental health and substance misuse problem will be subject to the requirements of UAP. Where appropriate their care needs shall be assessed and planned using this methodology. It is likely however due to the level of complexity associated with the needs of people with mental health problems who also misuse substances that they will be subject to the Care Programme Approach (CPA). CPA is due to be fully operational across Welsh mental health services from December 2004. The CPA will require a full need and risk assessment that addresses the following issues:

- Identification and response planning to urgent or acute problems
- Assessment of patterns of substance misuse and degree of dependence
- Assessment of physical, social and mental health problems
- Assessment of needs of dependent children and notification to appropriate services

- Consideration of the relationship between substance misuse and mental health problems
- Consideration of any interaction between medication and other substances
- Assessment of carer involvement and need
- Assessment of knowledge of harm minimisation in relation to substance misuse
- Assessment of treatment history
- Determinations of individual's expectation of treatment and their degree of motivation for change
- The need for pharmacotherapy for substance misuse
- Notification to the National Drug Treatment Monitoring System.

All clients will also have a copy of their care plan detailing the range of services available to assist their recovery.

Clients who are parents or carers may have a particular need for support to enable them to fulfil their responsibilities. Client's children may be acting in a caring capacity or may need support and in some cases the clients may pose a risk to the children or adults in their care. Referral should be made to children's or adult social services in such cases.

6.0 Groups with specific needs

Key stakeholders will need to consider the need of particular target groups as highlighted by The Health Advisory Service (2001). These target groups include:

- Older people (mental health services should explicitly address the issue of alcohol and tranquilliser misuse)
- Young people (their needs should be addressed by child centred services)
- Homeless people
- Black and minority ethnic groups (mental health assessments should take into account culture and ethnicity) in line with the Race Relations (Amendment) Act 2000
- Refugees and asylum seekers
- Those with gender specific issues (assessment and care should include eating disorders, self harm, suicide attempts and low self- esteem)

- Prisoners both whilst in detention and during transition upon release
- People with a personality disorder
- Poly-drug users with a mental health problem
- People with a learning disability
- Parents and carers of vulnerable adult.

7.0 Needs Assessment and Service Planning

Local Health Boards (LHBs) and Local Authorities (LAs), through their Community Safety Partnerships, need to be aware of the nature and the scale of co-occurring substance misuse and mental health problems within their local population. This will allow services to be targeted appropriately. Gaps in current service provision need to be identified and the voluntary sector should be resourced to play a key role in both the planning and delivery of care to this client group.

Data on co-occurring substance misuse and mental health problems are currently poor. Services should therefore be provided on the basis of perceived need incorporating what data is available. However, improved data collection methods should be pursued with partner organisations to enable future accurate needs assessments to be undertaken.

The Mental Health Strategy and NSF require that each LHB/LA will have a Local Mental Health Strategic Planning Group. They will also have a Substance Misuse Action Team responsible to the Community Safety Partnership. These groups have responsibility for developing Health Social Care and Well-Being Strategies to meet the needs of those people within their local population. In order to ensure a co-ordinated approach to provision, the planning groups must liase, share and reconcile these strategies and action plans.

8.0 Training and Qualifications

Staff, whether in mental health or substance misuse services, need to develop the skills necessary to identify and understand clients with co-occurring problems, to develop the confidence to deal with them and to be given the capacity to cope. Effective staff supervision, both clinical and managerial, is equally important. Support structures should be in place for staff of all levels to help them cope with this challenging client group.

Training and continuous professional development (CPD) is therefore vital in the development and sustaining of effective services. Training and CPD should include as a minimum:

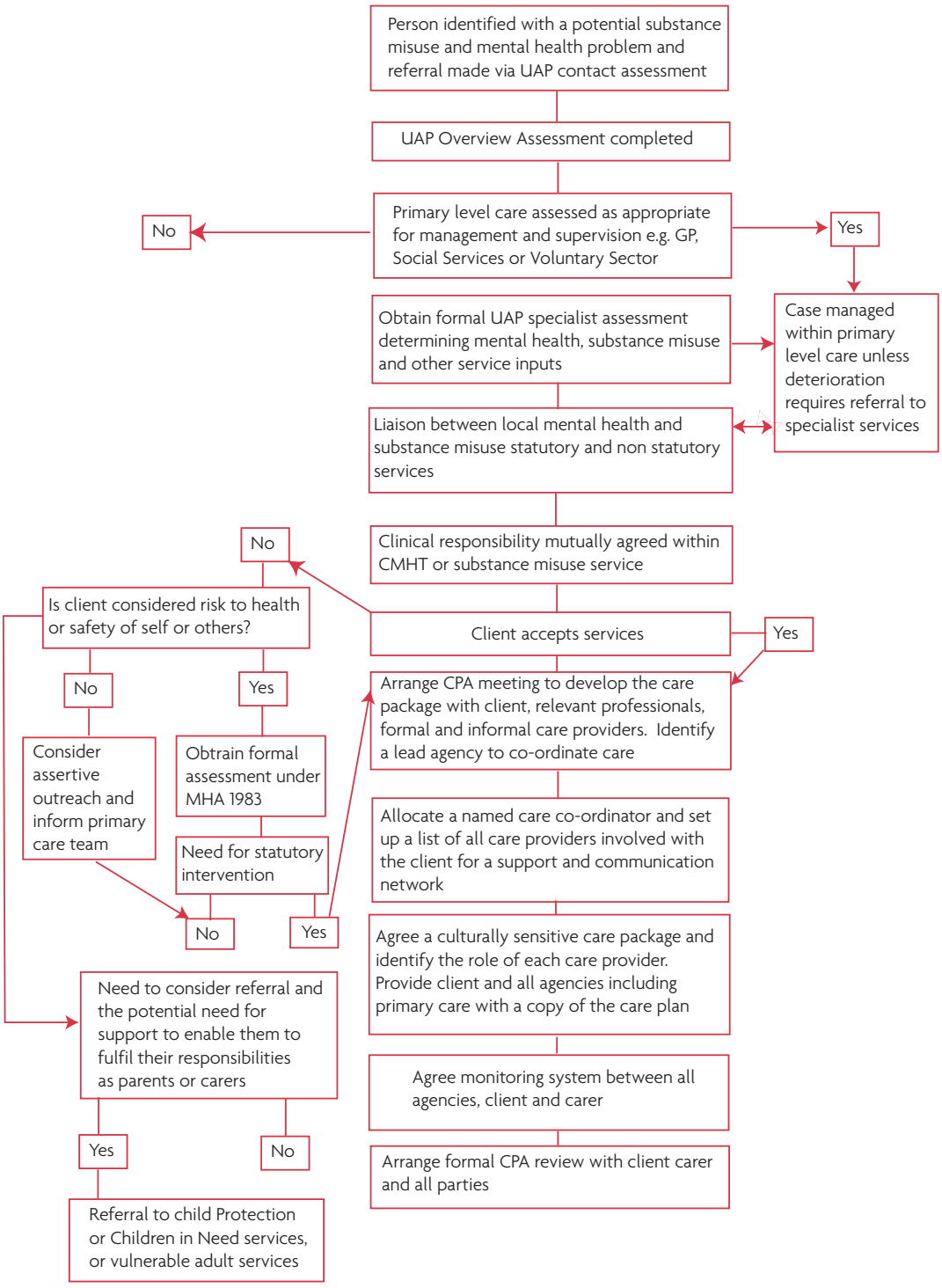
- development of assessment skills based upon substance misuse and mental health assessment frameworks basic training in substance misuse management for staff in mental health inpatient and community services

- basic training in substance misuse and mental health including self harm for staff working in Accident and Emergency and targeted general medical settings
- knowledge of drug and alcohol trends for those with mental health problems
- effective working with a range of mental health interventions and treatment approaches
- The DANOS module on co-occurring substance misuse and mental health problems
- Joint training should include mental health substance misuse and targeted staff from within the Criminal Justice Service.

It is essential that training for dealing with clients in special needs groups is undertaken by all staff. Particularly to identifying potential risks when a client is a parent or carer.

Each local area should develop a training strategy to ensure all staff working in statutory and voluntary organisations have formal training in co-occurring substance misuse and mental health problems.

9. Care Pathway for Co-occurring Mental health and substance Misuse Problems



Annex A

"Good Practice Checklist"

MINIMUM ESSENTIAL CRITERIA FOR SERVICES TO PEOPLE WITH A CO-OCCURING MENTAL HEALTH AND SUBSTANCE MISUSE PROBLEM IN WALES

1. Clear line of clinical responsibility at all times while in treatment.
2. Involvement of general practitioners in the care and management of patients.
3. Clear locally agreed definition of dual diagnosis supported by clear care pathways.
4. Provision of information on local services, which is readily available in a suitable format to users, their relatives and referring agencies.
5. A joint protocol between mental health and substance misuse teams.
6. Patient allocated to a named key worker with responsibility for co-ordinating both mental health and substance misuse services.
7. Advocacy services becoming integral to the care plans.
8. Suitably trained link-workers or suitable alternative provided from Adult Mental Health Teams.
9. A single co-ordination point within mental health and substance misuse services ensuring access to services outside normal office hours.
10. Pathways facilitating prompt referral between services to those with a co-occurrence of a mental health and substance misuse problem. Children's and vulnerable adult services need to be in place.
11. Local Health Boards and Local Authorities, through Community Safety Partnerships, undertake a regular mapping exercise to determine the local level of need based upon agreed definitions.
12. Compatible models, conceptual frameworks and a common language for both conditions.
13. Rapid access to services which must be flexible and appropriate to the individual.
14. Broad-based interventions that include social, housing, education and employment.
15. Emphasis on positive expectations of what can be achieved through treatment.
16. All stakeholders, including the client, consulted and listened to.
17. Access to outreach services.

18. Application of the Unified Assessment Process/Care Programme Approach.

19. Local training plans for all staff working in mental health and substance misuse.

20. Effective supervision and support for all staff working with people with dual diagnosis.

21. Assessment of the needs of dependent children and referral to appropriate agencies if required.

Annex B

Dual Diagnsis Framework Supporting Technical Document

Definition

There is no single agreed definition of the term dual diagnosis, which refers to two concurrent disorders. For the purposes of this document a broad, unrestricted definition will be used that encompasses the co-occurrence of drug and/or alcohol problems and a wide range of mental health problems. **NTASM (2003**).

This approach recognises the fact that not all mental health problems have been diagnosed at the time of clinical presentation.

(Krauts (1996) and Abdulrahim (2001) placed dual diagnosis within four categories:

- A primary diagnosis of a major mental illness with a subsequent diagnosis of substance misuse which adversely affects mental health
- A primary diagnosis of drug dependence with psychiatric complications leading to mental illness
- A concurrent substance misuse and psychiatric disorder
- An underlying trauma experience resulting in both substance misuse and mood disorders.

Identification of the primary diagnosis may be problematic because of the similar signs and symptoms of mental illness with indicators of intoxication and withdrawal from substances. This can lead to misdiagnosis. It is therefore necessary to interpret the symptoms according to a particular classification system such as the International Classification for Diseases, (ICD 10). **NTASM (2003**).

Mental Illness Needs Indices (MINI) scores are high in Wales as are rates of substance misuse. As a result the prevalence of dual diagnosis in Wales is significant.

1. Epidemiology

1.1 Prevalence

Dual diagnosis is recognised as a complex area of health and social care and it is hard to assess the exact levels of substance misuse in both the general population and in those with mental health problems. The existing evidence base is primarily derived from studies undertaken in America it is therefore an area requiring further research in the UK.

Studies in the UK in 1988 found that:

- 10% of psychiatric inpatients had an alcohol problem
- 40% of those with alcohol problems had a dual diagnosis.

NTASM (2003).

The most robust source of information on the prevalence of co-occurring mental illness and substance misuse in the UK is the survey of "Psychiatric Morbidity Among Adults in British Households 2000".

The data indicate that:

- less than 1% of the population are classified as being moderately or severely dependent on alcohol
- this figure increases to 2% for people with a neurotic disorder,
- 5% among those with a phobia
- 6% among those with two or more neurotic disorders.

SACDM (2003, p. 25).

Further UK data from a national survey and local studies reveal:

- Up to 3 in 4 drug using clients have been reported as having mental health problems. **SACDM (2003, p.12)**
- Over half of people with substance misuse problems are also diagnosed with a mental disorder at some point. **Drake and Essock (2001) and Little (2001, p.27)**
- Alcohol is the most common substance misused. **DOH (2002, p. 7)**
- Where drug misuse occurs it often coexists with alcohol misuse DOH **(2002, p. 7)**
- Homelessness is associated with substance misuse. **DOH (2002, p.7)**
- CMHT's report that 8-15% of their clients have dual diagnosis. **DOH (2002, p.7)**
- Prison populations have a high prevalence of dual diagnosis. **DOH (2002, p.7**)
- Co-morbidity in general practice in England has risen by 62% between 1993 and 1998. **SACDM (2003, p.12)**.

1.2 Evidence in Wales

Data on incidence and prevalence of those with dual diagnosis is not readily available in Wales, though it is possible to estimate prevalence from data collected separately on mental illness and substance misuse.

Tackling Substance Misuse in Wales (2000), describes the nature and extent of drug misuse in Wales, particularly the misuse of illegal drugs and alcohol. Using data from the Welsh Youth Health Survey it reports:

- in 1998, 42% of 15 and 16 year olds reported ever having used some kind of illicit drug
- in 1998, 13% of 11 year olds drank alcohol at least weekly, rising to 53% amongst 15 and 16 year olds.

In Wales, one in nine people suffer from mental health problems and one in two hundred has a severe mental illness, which may require substantial health and social care. The Welsh Health Survey (1998) produced the following data:

- there was increased prevalence in mental illness in Wales from 1995 to 1998
- across Wales, 14% of adults reported a mental or nervous illness
- mental ill health prevalence for the adult population across Wales is 13.6% or 305,165 individuals
- 22% of adults in Merthyr Tydfil reported a mental illness, the highest in Wales
- the prevalence of schizophrenia in Wales is about 0.2% or 4,488 individuals.

Within Wales, Merthyr Tydfil, Blaenau Gwent, and Rhondda Cynon Taff tend to have higher mental illness needs indices than other parts of Wales. However, the rural areas in Wales tend to have higher than average suicide rates. There were 240 male and 52 female deaths recorded as due to suicide and self inflicted injury in Wales in 1996. **(Better Health, Better Wales (1998)**.

2. Clinical Implications

Substance misuse among those with severe mental illness has been associated with significantly poorer outcomes, Todd et al (2002, p.792), including:

- worsening psychiatric symptoms **DOH (2002, p.9)**
- misdiagnosis due to difficulties in evaluation **Howland (1990, p. 1134**)
- increased use of institutional services **DOH (2002, p.9)**
- poor medication adherence **DOH (2002, p.9) and Rubinstein (1990, p.98)**
- increased risk of HIV infection **DOH (2002, p.9) and Drake et al (2001)**
- increased risk of suicide and violence **NTASM (2003)**
- being less responsive to treatment. **Howland (1990, p.1134) and Rubinstein (1990, p.98)**.

There are other ailments that can affect people that abuse substances. For example, intravenous drug misuse can cause venous or arterial thrombosis and cardiac disease. Furthermore, where hypodermics are shared the risk of HIV or Hepatitis B and C are increased, **Drake et al (2001)**. Smoking substances can result in respiratory diseases and long term alcohol use can result in extremes in Korsakoff's syndrome, delirium and seizures. To overlook or neglect substance misuse in the course of mental health treatment will result in poor treatment outcomes, **Drake et al (2001)**. Psychiatric symptoms can trigger the urge to drink or use drugs to self medicate. **NTASM (2003) and Philip and Johnson (2001) and Rubinstein (1990, p.100)**.

3. Public Health Implications

Social environment and life experiences are likely to be factors in the development of substance misuse by those who are seriously mentally ill but there is a dearth of empirical evidence to support this, Philip and Johnson (2001). However, drug choice is correlated with the pattern of ambient drug use in the community, Dixon, (1999). There are a number of issues that can affect public health where those with dual diagnosis are resident in the community:

- those with dual diagnosis in the community can be difficult neighbours
- living with some one with dual diagnosis can cause stress and a drain on the energy and resources of carers and family. Rubinstein (1990, p.100)
- increased contact with the criminal justice system. **DOH (2002, p.9)**
- a third of people with dual diagnosis will be sero-positive for HIV, Hepatitis B or Hepatitis **C. DOH (2002, p.9 and p.14)**
- increased rates of violence and suicidal behaviour are associated with dual diagnosis. A study of 17 reports of inquiries into homicides by mentally ill people concluded that alcohol and drug misuse was a significant factor. **Ward and Applin (1998, p. 1) and Greenfield (1996)**
- those with dual diagnosis frequently use emergency services. **Howland (1990, p.1134) and Rubinstein (1990, p.100)**.

4. Current Service Provision in Wales

4.1 Gaps in Service Provision

A review of purchasing requirements for drug and alcohol treatment facilities conducted in 1998 identified that there is a lack of services for some groups including those with dual diagnosis. **NAW (2000, p.22**).

The language of care and of strategy differs markedly between local authority, health and voluntary sector services, often leading to misunderstanding and subsequent difficulty in service provision. Those forms of working that depend upon professional or organisational identity are likely to result in a pathway of care, which is less effective than those, which work jointly. **SACDM (2003, p.49)**.

Service users nationally identified the following gaps in current services and particularly in continuing support for clients, DOH (2002, p.24):

- access to mental health services and advice in informal settings
- access to specialist services within general day support services
- longer stay residential services
- day support both dry and wet available 7 days per week
- someone to talk to
- housing support
- residential rehabilitation places that accept people with dual diagnosis.

In Wales, a baseline review of dual diagnosis service provision was undertaken in November 2003 using a telephone questionnaire. This snapshot of services revealed that while most of the Trusts provided both mental health services and substance misuse services, the majority of Trusts did not provide specific inpatient dual diagnosis beds. The majority of Trusts had no staff considered as dual diagnosis specialists working within the Community Mental Health Teams and only half the Trusts had shared care management with primary care for dual diagnosed patients.

In most Trust catchment areas there was voluntary sector provision. However, the extent of this coverage and the nature of this provision were not reported.

Finally, most Trusts had no specific strategic Service Plan for dual diagnosis. In addition, there was a lack of formal protocols or agreements with any partner agencies about service provision, inevitably leaving gaps in service. However, four of the Trusts reported that work on plans and a protocol was in progress.

Eleven Local Health Boards failed to provide data for the baseline service review, a questionnaire having been circulated to them electronically. However, from those who did respond it was apparent that few were aware of any networks or collaborations within their boundary that had dual diagnosis as part of their remit. The local planning arrangements for dual diagnosis are usually the remit of the Substance Misuse Action Team and the Mental Health Steering Group which meet separately. Several of the Boards identified the need for these separate pathways to be co-ordinated via a joint planning mechanism.

4.2 Service Utilisation

Studies in the US have found that people with a dual diagnosis seek treatment more frequently than those with one disorder. However it is apparent that there are a wide variety of barriers that impede the delivery of optimal care ranging from access to the service to the attitudes of individual clinicians. **Todd et al (2002, p.792)**.

The provision of psychiatric services by therapists with minimal formal training or experience in the treatment of substance abuse has also been cited as a barrier, **Howland (1990, p.1134)**. Research has shown that removing the barriers to the services significantly increases the consumers' quality of life, **Hays and Andrews (2003**). Other barriers relate to the structure and organisation of services within which treatment is delivered and that there is poor communication between the agencies involved. Those with dual diagnosis are frequently referred from mental health services to an alcohol and drug service and back again resulting in no service being provided at all. **DOH (2002, p.14) and Sims et al (2003, p.112)**.

Little data exists to set out a Welsh context. Consideration needs to be given as to whether there is a need to develop a specific data set for dual diagnosis

Co-occurring

Bibliography

- Abdulrahim (2001) Substance Misuse and Mental Health Co-Morbidity (Dual Diagnosis) Standards for Mental Health Services
- Department of Health (2002) Dual diagnosis good practice guide, London: Department of Health.
- Dixon Dual Diagnosis of Substance Abuse in Schizophrenia: prevalence and impact on outcomes(1999)
- Drake and Essock (2001) Implementing dual diagnosis services for clients with severe mental illness
- Drake et al (2001) Implementing dual diagnosis services for clients with severe mental illness
- Hays RA et al Service enhancement to a dual diagnosis population mental illness/substance abuse Quality Management in Healthcare (2003)
- Howland RH "Barriers to community Treatment of patients with dual diagnoses." Hospital and Community Psychiatry (1990, p. 1134)
- Krauts, M. (1996) 'Old problems – new perspectives', European Addiction Research, 2:1–2
- Little J. Treatment of dually diagnosed Clients Journal of Psychoactive drugs Vol 33 (1)Jan-March 2001 27-31
- NAW (2000, p. 22) Tackling Substance Misuse in Wales A partnership Approach
- NTASM (2002)Models of care for the treatment of Drug misusers
- Philips P and Johnson S (2001) How does drug and alcohol misuse develop among people with a psychotic illness? A literature Review Social Psychiatry and Psychiatric Epidemiology 36 269-276
- SACDM (2003 p. 12) "Mind The Gaps" 'Meeting the needs of people with Co-occurring substance misuse and mental health Problems'
- SACDM (2003, p. 49) "Mind The Gaps" 'Meeting the needs of people with Co-occurring substance misuse and mental health Problems'
- Sims et al The triangular treatment paradigm in dual diagnosis clients wiyth a mental illness Journal of substance misuse (2003, p. 112)
- Todd et al Barriers to optimal care for patients with coexisting substance use and mental health disorders Australian and New Zealand Journal of Psychiatry 36: 6 (2002, p. 792)
- Ward M and Applin C (1998 p.1) The Unlearned Lesson. London Wynne Howard Books

Needle Exchange Service Framework

Needle Exchange
Service Framework

Needle Exchange Service Framework

1. Overview

Needle and syringe exchange schemes exist within the wider context of harm reduction. These facilities aim to prevent the spread of blood-borne diseases (particularly HIV and hepatitis) and other drug-related harm, including drug-related death, as well as being important public health measures. They often have contact with substance misusers not in touch with other, specialist substance misuse treatment services. Needle exchange facilities and harm reduction initiatives should provide easy access and a user-friendly, low threshold service for **all** injecting drug users that is equitable and culturally sensitive.

Overall, needle exchange facilities and harm reduction initiatives should be regarded as tier 2 specialist substance misuse services. However, facilities are also available in tier 1 services, most particularly in community pharmacies. All tier 2, 3, and 4 services should provide a distinct harm reduction element to the treatment they provide. This should be integrated into the service specifications or service agreements developed by commissioners of substance misuse services in Wales. This document focuses on the needs of **adult** substance misusers (i.e. those aged 18 and over). Young people's issues are considered in separate guidance.

2. Context

Needle exchange facilities and harm reduction interventions can be provided by a range of statutory and voluntary sector organisations. The range and comprehensiveness of services provided varies considerably. This should be reflected in service specifications developed at local levels, as some facilities are only able to provide limited services. Service specifications should take into account the organisation's capacity and be developed, in partnership with service providers and in consultation with service users and carers. Local communities should be engaged proactively, particularly in relation to their concerns over discarded injecting equipment.

3. Philosophy and Approach

Needle exchange was established within a harm reduction approach to injecting drug use. Historically, the main stimulus to the development of harm reduction policies and initiatives, was the identification of the role of injecting drug use and the sharing of needles and syringes in the transmission of HIV/AIDS. Whilst harm reduction is primarily concerned with the deployment of effective interventions relating to all harms associated with substance misuse, primary prevention is also a compatible goal. This approach is grounded within public health principles.

Preventing the sharing of injecting equipment is a major public health issue. One of the targets of the Welsh Assembly Government's eight year strategy, Tackling Substance Misuse in Wales - A partnership approach, is to "Reduce the proportion of drug misusers who inject, and the proportion of those sharing injecting equipment over the previous three months" (The National Assembly for Wales (NAfW) 2000). Needle exchange has, not only a vital role to play in reducing the risks associated with the transmission of blood-borne viruses (BBVs) notably hepatitis B, C and HIV, but also in providing advice and information and attracting people into treatment. Other harm reduction measures such as the provision of certain items of injecting paraphernalia through needle exchanges may reduce the spread of hepatitis C virus (HCV) infection.

Commissioners must also meet the Welsh Assembly Government's agenda to reduce drug-related death and prevent overdose (ACMD 2000, NAfW 2000) and ensure that local substance misusers have access to a wide range of harm reduction initiatives.

4. Aims and Objectives

The primary aim of needle exchange services is to prevent the transmission of HIV/AIDS and other blood-borne viral infections that are spread between injecting drug users through the sharing of injecting equipment.

Additionally, needle exchange services aim to limit sexual transmission of HIV between injecting drug users as well as to the wider, non-injecting population.

Needle exchange services also aim to increase their impact through raising the awareness of, and reducing the likelihood of, other harmful effects of injecting drug use.

The following objectives are inclusive within these three broad aims:

- To offer user-friendly, non-judgmental, client-centred and confidential services
- To assist clients in remaining healthy until they are ready and willing to cease injecting and ultimately achieve a drug-free life with appropriate support
- To reduce the rate of sharing and other high risk injecting behaviours by providing sterile injecting equipment and other support
- To reduce the rate of blood-borne infections amongst injecting drug users
- To reduce drug-related deaths (immediate death through overdose and long-term e.g. through blood-borne infections)
- To promote safer injecting and safer sexual practices

- To provide focussed harm reduction advice and initiatives, including advice on overdose prevention (e.g. risks of poly-drug use and alcohol use)
- To help clients access appropriate treatment by referral to other health/specialist agencies (e.g. treatment services, genito-urinary medicine, social care and family support services)
- To facilitate access to primary care where relevant
- To ensure the safe disposal of used injecting equipment
- To encourage the access and retention of all injectors, especially the highly socially excluded, through the low-threshold nature of service delivery and interventions provided
- To discourage initiation into injecting and to encourage alternatives to injecting
- To improve the health of local communities by preventing the spread of blood-borne viruses and by reducing the rate of discarded used injecting equipment
- To reinforce the benefits of needle exchange and raise public awareness through information and education.

5. Clinical Governance

Needle exchange services and harm reduction interventions are to take place within the context of NHS clinical governance arrangements in Wales.

6. Services, Care and Interventions

The range and comprehensiveness of services, care and interventions offered by a particular service provider depends on both its capacity, and whether it is a tier 1 or tier 2 facility. This is not only relevant for community pharmacies and other tier 1 services, but also for mobile and outreach services, and where tier 2 services have limited capacity. This should be reflected in local service specifications or service agreements.

Services, care and interventions can include, but are not limited to, the following:

- Provision of a range of sterile needles and syringes
- Provision of appropriate injecting paraphernalia
- Safe disposal of used injecting equipment
- Consistent effort to maximise return of used injecting equipment
- Enhancing motivation for change and treatment readiness where relevant (e.g. through brief interventions)

- Advice on safer injecting practices (e.g. risks of sharing or lending and borrowing injecting equipment and paraphernalia)
- Health promotion and harm reduction advice and written information on an appropriate range of issues
- Periodic development of a range of harm reduction and health promotion campaigns
- Advice on the prevention of HIV, hepatitis and other infectious diseases associated with injecting drug use
- Overdose prevention and response advice and information.
- Safer injecting advice specific to the drug injected (including stimulants and steroids)
- Advice on the storage and handling of injecting equipment
- Advice on safer sex and sexual health
- Advice/interventions that discourage injecting (targeted at current injectors and current smokers of substances that can then be injected)
- Advice/interventions on drug-related harm that does not involve injecting (e.g. harm related to cannabis, ecstasy or smoking crack cocaine)
- Referral to HIV and hepatitis B and C testing and counselling
- Hepatitis A and B immunisation or referral to immunisation services
- Referral to appropriate services for advice/interventions on health, social or legal problems
- Referral to treatment services and/or tier 2 assessment where appropriate
- Facilitation of GP registration.

Advice and information should be appropriate and relevant to the needs of diverse populations and literacy levels. Where relevant, written information is available in a number of languages.

7. Location

Individual CSPs must ensure that there is appropriate coverage in their area of responsibility. In particular, they must consider issues for delivery of needle exchange services in rural areas, where appropriate. The range and mix of services available should be determined at a local level and reflect local needs.

Needle exchange services can be provided by:

- Dedicated needle exchanges and harm reduction services
- Community and hospital pharmacies

- Outreach services
- Mobile services
- Substance misuse treatment services
- Hostel needle exchanges
- GP surgeries
- Accident and emergency departments
- Other workers e.g. arrest referral workers
- Additional venues e.g. community centres, family groups.

The CSPs must ensure that the issue of discarded injecting equipment is tackled by providing appropriate facilities/services, both for injecting drug users and for the public and staff, who are exposed to this type of waste. There needs to be clear promotion of the facilities in place, and the development of additional facilities, including those expressly for the safe disposal of used equipment.

8. Client Groups

Needle exchange facilities are available to all adult injectors. Special attention should be given to the following harder to reach groups:

- Service users who are not in touch with substance misuse treatment services
- Injectors who are under-using the service; this includes but is not limited to:

  Women
  Amphetamine and cocaine/crack injectors
  Steroid injectors
  Minority ethnic injectors
  Younger injectors (see below for more information)
  Injectors in rural areas.
- Injectors who have characteristics associated with high risk injecting practices:

  Poly-drug users
  People with severe drug dependence
  Frequent injectors
  People who have recently been released from prison
  People who have left residential rehabilitation or in-patientfacilities
  People who spend more time with other injectors
  Homeless or people in poor accommodation
  Those with a sexual partner who is an injector
  Those who have dropped out of treatmentInjectors who have to travel to other areas to receive clean injecting equipment.

- Where possible, needle exchange and harm reduction facilities should also provide interventions relevent to non-injectors.

8.1 Exclusions

A person aged 17 years or under who requires treatment will normally access a young person's service. However, it is recognised that those in the transitional period between childhood and adulthood can develop at different rates, and therefore have different treatment needs. In some cases it may be more appropriate for them to be treated by an adult service. The commissioners of both adult and children's services need to have plans in place to ensure a smooth referral and transition between their services.

In all circumstances it should be clear that needle exchange should only be provided where the risk of providing needles and syringes outweighs the risk of not providing this facility. In some settings, particularly community pharmacy and outreach work, it may be necessary to refer young people to a specialist service for assessment.

Needle exchange and harm reduction initiatives are open access services, and clients should only be excluded for behaviour that has breached accepted rules and standards at the discretion of the service but within a structure of users' rights and responsibilities. Where appropriate, work is carried out to re-engage clients in the service or to refer them to more appropriate services.

Clients may be excluded following a risk assessment and if they pose a serious risk to staff, other service users and members of the public. Referral to more appropriate services is made where possible.

9. Access and Referral Pathways

When considering access, commissioners should engage with providers to ensure additional venues are available for the provision of sterile injecting equipment, such as mobile facilities or outreach teams. Other innovative interventions may be piloted, in particular, alternative facilities for the disposal of used equipment. All injecting drug users should have ready access to a needle exchange service.

Needle exchange facilities and harm reduction services are open-access services. Referrals are accepted from a variety of sources, including self-referral, and do not require contact with other substance misuse treatment and care agencies

It is good practice for clients to be assessed on their first visit and then at regular intervals. This does not need to be comprehensive (especially at tier 1) and must not be a barrier to accessing sterile injecting equipment, for the hard to reach groups in particular. Facilities operating out of tier 1 services should, as a minimum, provide the client with as much advice as possible on safer injecting practices and basic written information about harm reduction, harm reduction services and support agencies as

appropriate. The client is also referred to agencies where appropriate services are available. In community pharmacies, direct input from the pharmacist or their support staff is recommended, whenever possible.

It is good practice that tier 2 services undertake a basic assessment that includes information on drug use profile, injecting history and referral details. A flexible approach may be required. Assessment may need to be brief initially with a fuller assessment over time. Tier 2 services should carry out a risk assessment and identification of immediate risks (e.g. harm to others, physical or mental health emergencies). Further issues covered in the context of a fuller assessment include, but are not limited to:

- Harm reduction specific to the drug injected
- Alternatives to injecting
- Basic physical examination, as appropriate e.g. injecting site checks
- Risk of overdose, reducing those risks and responding to overdose
- Information on services provided by needle exchanges
- Advice on safer sex and sexual health
- Advice on access to HAV and HBV immunisation, and HBV, HCV & HIV testing
- Information on other services including treatment, health and social care.

Whenever possible, service providers should facilitate onward referral to tier 3 services.

10. Care Planning

A written and comprehensive care plan for needle exchange clients is not required. However, harm reduction work should be ongoing, with messages reinforced periodically.

It is good practice that tier 2 providers work to engage service users in the development of a brief and basic plan which identifies goals and milestones for changes in risk behaviours and harm reduction. Such a plan should, neither be a requirement for access to sterile injecting equipment, nor form a barrier to service use - particularly when a client first accesses a provider.

Within the bounds of local confidentiality guidelines, liaison with the range of health and social care organisations should be encouraged. Substance misuse treatment agencies and other health and social care professionals are highly encouraged to refer clients to needle exchange schemes.

Service providers should have directories of substance misuse treatment services in their locality, with clear information on referral and eligibility criteria. Clients should be informed of substance misuse treatment programmes available and given options for referral.

11. Management

Provider services should be working towards compliance to Quality in Alcohol and Drugs Services (QuADS) standards and to any additional standards developed by commissioners. Service specifications or service agreements will reflect the range and comprehensiveness of services to be provided according to the tier and capacity of the service provider.

Provider services should have written policies and procedures covering the following areas **as appropriate, to be reflected in the service agreement**:

- Individual assessment
- Risk assessment
- Provision of sterile injecting equipment for young people under 18. Written policies and procedures are agreed with the National Public Health Service for Wales, Child Protection Service
- Dealing with difficult or obstructive clients
- Blood spillage/needle stick injuries
- Substance use on the premises by clients
- Confidentiality and information sharing
- Referral
- Clinical waste and disposal of used equipment
- Hepatitis immunisation (staff)
- HIV, hepatitis B and C, and TB
- Maximising return of used equipment
- Reduction of drug-related death
- Lone working.

Commissioners should have written plans on improving treatment access, appropriateness and effectiveness of treatment to groups under-using the services. They should also identify:

- Gaps and priorities in service provision
- Clear objectives and measurable targets
- Timescales
- Funding and other resources available
- Monitoring requirements.

11.1 Training and competencies

Relevant occupational competencies are outlined in Drug and alcohol national occupational standards (DANOS), Skills for Health (2002).

Some of the competency statements in DANOS will be of use to community pharmacy and other tier 1 services.

Annex A

Research evidence base

Key findings

There is evidence from observational studies from several countries that, on average, the provision of needle exchange facilities is associated with a reduction of risk behaviour, including a reduction of the frequency of sharing (Hunter et al. 1995; Stimson et al. 1998a) and it is likely that needle exchange facilities have greatly contributed to the control of HIV among injectors (Des Jarlais et al. 1996; Hurley et al. 1997; Drucker et al. 1998; Peters et al. 1998). Some recent evidence from the US has shown a mixed or negative effect of needle exchanges, but the general evidence base for these interventions is positive (Marsden and Strang et al. 2000).

Research carried out in the UK shows that injectors who attend exchange schemes report lower levels of sharing, fewer sharing partners and longer periods between occasions on which they share (Donoghoe et al. 1992a, 1992b). In addition, research shows that injectors not attending needle exchanges also made changes in risk behaviour, suggesting a wider cultural change among drug misusers and injectors (Burt and Stimson 1993). Overall, the proportion of injectors sharing equipment continues to decline and sharing has become less the norm and less indiscriminate (Burt and Stimson 1993). There is also plenty of evidence highlighting the continued importance of targeting sexual and intimate relationships as a unit of behavioural change (Rhodes and Quirk 1998).

In the UK, there is evidence that the low and stable HIV prevalence rates have resulted, in part, from the quick response of policy makers and an early distribution of sterile equipment (Stimson 1995). Syringe exchanges are also likely to have contributed to public health efforts to reduce prevalence of markers of exposure to hepatitis B virus (HBV). UK studies show lower rates of HBV exposure for people with shorter injecting careers (Rhodes et al. 1996; Hunter et al. 1998), with those who start to inject after the introduction of risk-reduction interventions having considerably lower rates of HBV exposure than those injecting before harm minimisation interventions were in place (Marsden and Strang et al. 2000). All of this indicates that needle exchange facilities are effective. However, it is also important to remember that many injectors are still vulnerable to HBV infection because of poor levels of vaccination and that only a minority of drug agencies offer on-site vaccination to their clients.

National and international data show high prevalence rates of hepatitis C infection, even in cities where needle exchange facilities are widely available (Van Beek et al. 1998; Wodack and Crofts 1996; Taylor et al. 2000). It has been argued that successful interventions have lead to risk reduction; however, no intervention has resulted in the elimination of risk behaviour. Thus, whereas risk reduction has been sufficient to reduce HIV risk, the control of HCV may necessitate the use of injecting practices that guarantee the elimination of exposure to equipment contaminated with even the smallest amount of blood (Hagan and Des Jarlais 2000).

Nonetheless, there is emerging evidence from the UK that rates of HCV infection appear to be stable among injectors with a history of less than five years injecting since 1995 and there is evidence that infection among injectors is less than previously expected. This suggests that needle exchanges and other harm reduction measures are having a key role in reducing the spread of hepatitis C as well as HIV (Hope et al. 2001; Department of Health 2001b). Combined evidence strongly suggests that the promotion of safer injecting continues to be an important public health issue with regard to reducing blood-borne infections (Hunter et al. 2000).

Research in the UK and elsewhere suggests the need to intensify the provision of needle exchange facilities. Studies in Glasgow and New York show that improving the convenience and proximity of access to needle exchange facilities and increasing the numbers of needles and syringes available to injectors is likely to result in the reduction of sharing and therefore in the transmission of HCV (Hutchinson et al. 2000a; Rockwell et al. 1999). Research has also shown that injectors who had obtained sterile injecting equipment only from a 'legitimate' source (defined as needle exchange, pharmacy, drug agency, hospital or GP) were significantly less likely to have shared than those who had obtained sterile equipment from other sources such as friends, other drug misusers, sexual partners and so forth (Hutchinson et al. 2000a). This does not imply that secondary distribution of sterile injecting equipment must be stopped, as it may be the only source of clean injecting equipment for people who do not want to access services.

There is now increasing interest in the development of interventions aimed at preventing and curtailing injecting and in 'route transition interventions' (RTIs) (Hunt et al. 1999, 1998). It has been argued that policy must focus on encouraging people away from injecting in order to control HCV and overdose death (Wodack 1997; Strang et al. 1997a). Materials are now available in the UK (Derricott et al. 2001).

The development of interventions that prevent transition to injecting are also particularly needed among Bangladeshi and other South Asian heroin users, black users and users from other minority ethnic groups who exhibit much higher prevalence rates of smoking than injecting heroin.

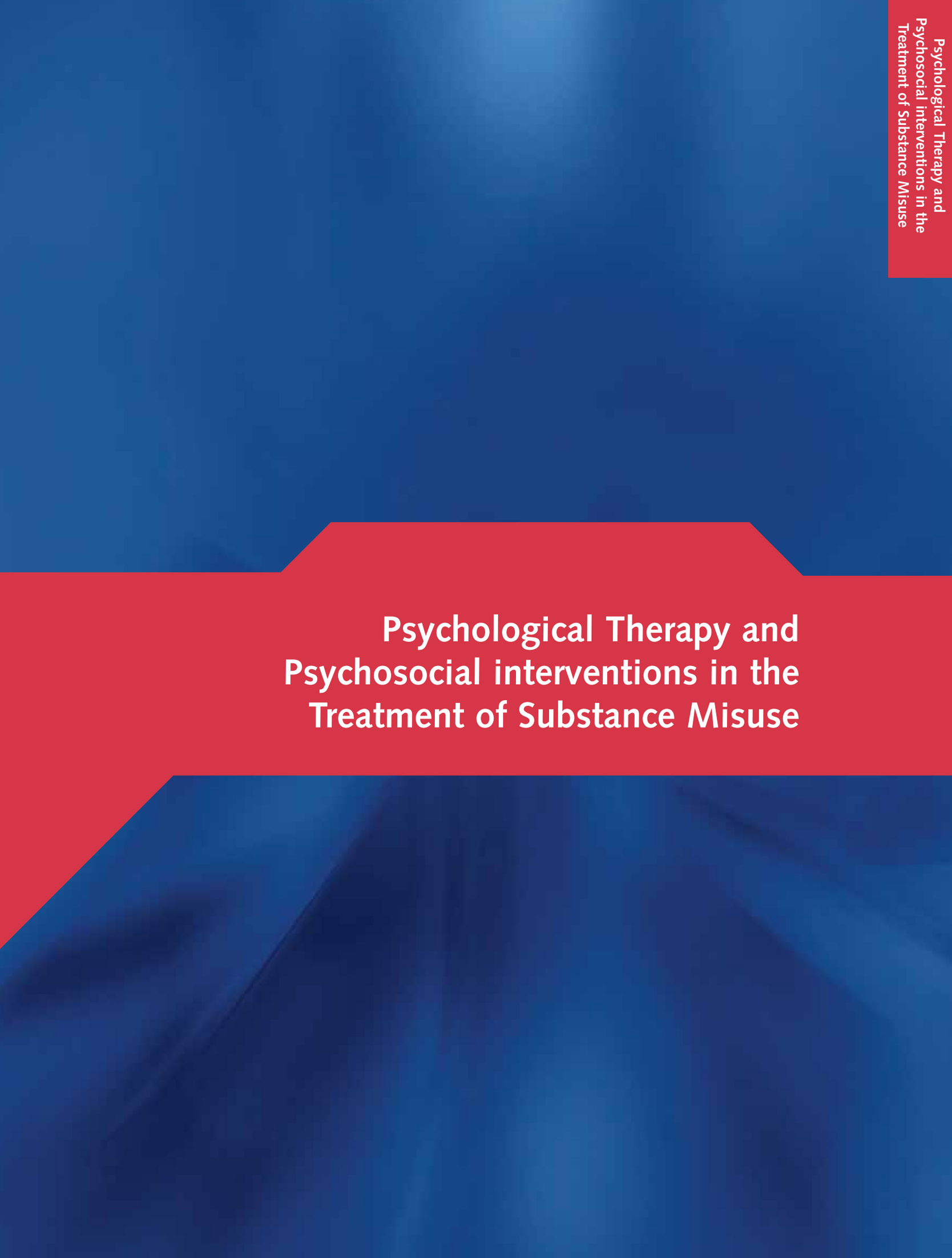
Needle Exchange

Bibliography

- Burt, J. and Stimson, G. V. (1993) Drug injectors and HIV risk reduction: strategies for protection, London: Health Education Authority.
- Department of Health (2001b) Hepatitis C – guidance for those working with drug users, London: Department of Health.
- Derricott, J., Preston, A., Hunt, N., DrugScope and Department of Health (2001) Break the cycle: 30 tear-off cards for injectors who don't want to encourage others to start injecting, Exchange Campaigns.
- Des Jarlais, D. C., Marmor, M., Paone, D., Titus, S., Shi, Q., Perlis, T., Jose, B. and Friedman, S. R. (1996) 'HIV incidence among injecting drug users in New York City Syringe exchange programmes', Lancet 348, pp. 987–91.
- Donoghoe, M. C., Dolan, K. A. and Stimson, G. V. (1992a) 'Lifestyle factors and social circumstances of syringe sharing in injecting drug users', British Journal of Addiction, 87, pp. 993–1003.
- Donoghoe, M. C., Stimson, G. V. and Dolan, K. A. (1992b) Syringe exchange in England: an overview, London: Tufnell Press.
- Drucker, E., Lurie, P., Wodack, A. and Alcabes, P. (1998) 'Measuring harm reduction: the effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV', AIDS, 12, pp. 217–30
- Hagan, H. and Des Jarlais, D. C. (2000) 'HIV and HCV infection among injecting drug users', Mount Sinai Journal of Medicine, Oct/Nov, 67(5-6), pp. 423–8.
- Hope, V., Judd, A. and Hickman, M. et al. (2001) 'Prevalence of hepatitis C virus in injecting drug users in England and Wales: is harm reduction working?', American Journal of Public Health, 91, pp. 38–42.
- Hunt, N., Griffiths, P., Southwell, M., Stillwell, G. and Strang, J. (1999) 'Preventing and curtailing injecting drug use: a review of opportunities for developing and delivering route transition interventions', Drug and Alcohol Review, 18, pp. 441–51.
- Hunt, N., Stillwell, G., Taylor, C. and Griffiths, P. (1998) 'Evaluating a brief intervention to prevent imitation into injecting', Drugs: education, prevention and policy, Vol 5, No. 2, pp. 185–94.
- Hunter, G. M., Donoghoe, M. C., Stimson, G. V., Rhodes, T. and Chalmers, C. P. (1995) 'Changes in injecting risk behaviour among drug users in London 1990–1993', AIDS, 9, pp. 493–501.
- Hunter, G., Stimson, G. V., Jones, S., Judd, A. and Hickman, M. (1998) Survey of prevalence of sharing by injecting drug users not in contact with services: an independent study carried out on behalf of the Department of Health, London: Centre for Research on Drugs and Health Behaviour.
- Hunter, G., Stimson, G. V., Judd, A., Jones, S. and Hickman, M. (2000) 'Measuring injecting risk behaviour in the second decade of harm reduction: a survey of injecting drug users in England', Addiction, 95(9), pp. 1351–61.

- Hurley, S. F., Jolley, D. J. and Kaldor, J. M. (1997) 'Effectiveness of needle exchange programmes for prevention of HIV programmes', Lancet, 349, pp. 1797–1800
- Hutchinson, S., Taylor, A., Goldberg, D. and Gruer, L. (2000a) 'Factors associated with injecting risk behaviour among serial community-wide samples of injecting drug users in Glasgow 1990–1994: implications for control and prevention and blood-borne viruses', Addiction, 95(6), pp. 931–40.
- Marsden, J. and Strang, J. with Lavoie, D., Abdulrahim, D., Hickman, M. and Scott, S. (2000) 'Epidemiologically-based needs assessment: drug misuse', in Stevens, A. and Rafferty, J. (eds) Health Care Needs Assessment, Oxford: Radcliffe.
- Peters, A., Davies, T. and Richardson, A. (1998) 'Multi-site samplers of injecting drug users in Edinburgh: prevalence and correlates for risky injecting practices', Addiction, 93(2), pp. 253–67
- Rhodes, T. and Quirk, A. (1998) 'Drug users' sexual relationships and the social organisation of risk: the sexual relationship as a site of risk management', Social Science and Medicine, 46, pp. 161–83.
- Rhodes, T., Hunter, G. M., Smitten, G. O. V., Donoghoe, M. C., Noble, A., Parry, J. and Chalmers, C. (1996) 'Prevalence of markers for hepatitis B and HIV-1 among drug injectors in London: injecting careers, positivity and risk behaviour', Addiction, 91, pp. 1457–67.
- Rockwell, R., Des Jarlais, D. C., Friedman, S. R., Perlis, T. E. and Paone, D. (1999) 'Geographical proximity, policy and utilisation of syringe exchange programmes', AIDS Care, 11, pp. 437–42.
- Stimson, G. V. (1995) 'AIDS and injecting drug use in the United Kingdom 1987–1993: The policy response and the prevention of the epidemic', Social Science and Medicine, 41, No. 5, pp. 699–716.
- Stimson, G. V., Des Jarlais, D. C. and Ball A. (eds) (1998a) Drug injecting and HIV infection: global dimensions and local responses, London: University College London Press.
- Strang, J., Griffiths, P. and Gossop, M. (1997a) 'Heroin in the United Kingdom: different forms, different origins and the relationship to routes of administration', Drug and Alcohol Review, 16, pp. 329–37.
- Taylor, A., Goldberg, D., Hutchinson, S., Cameron, S., Gore, S. M., McMenamin, J., Green, S., Pithie, A. and Fox, R. (2000) 'Prevalence of hepatitis C virus infection among injecting drug users in Glasgow (1990–1996) – are current harm reduction strategies working?', Journal of Infection 40, pp. 1–8
- Van Beek, I., Dwyer, R., Dore, G. J., Luo, K. and Kaldor, J. M. (1998) 'Infection with HIV and hepatitis C virus among injecting drug users in a prevention setting: retrospective cohort study', British Medical Journal, 317, pp. 433–7.
- Wodack, A. (1997) 'Injecting nation: achieving control of hepatitis C in Australia', Drug Alcohol Review, 16, pp. 275–84.
- Wodack, A. and Crofts, N. (1996) 'Once more into the breach: controlling hepatitis C in injecting drug users', Addiction 91, pp. 181–4.

Psychological Therapy and Psychosocial interventions in the Treatment of Substance Misuse



Psychological Therapy and Psychosocial interventions in the Treatment of Substance Misuse

1. Overview

Psychosocial interventions play a significant role in the treatment and rehabilitation of substance misusers. There is a developing, though limited, evidence base for their effectiveness from clinical trials and routine services. The evidence does suggest that "counsellor characteristics" are important criteria for success.

Providers in a number of settings across Wales are currently using a wide range of psychological and psychosocial interventions.

Psychological therapy and psychosocial interventions (which includes structured counselling) are skilled activities requiring *specific training and supervision* to be practised safely. Increasingly therapists seek accreditation from voluntary psychological associations (in addition to core professional registration where appropriate) but these activities currently remain unregulated in the UK.

Workers with generic counselling skills (see **context** below) should not equate this with their ability to be qualified to provide structured counselling or other psychological therapies.

Psychological therapy and psychosocial interventions should only be offered after a thorough assessment of the potential to benefit. They require clearly defined treatment plans, measurable goals and a review process.

The application of these interventions has to be considered carefully as there are risks to client welfare of inappropriate use. There are also risks of resource wastage as a consequence of ineffective and/or inappropriate use.

Psychological therapies and psychosocial intervention have to be provided within the NHS clinical governance arrangements within Wales which were delegated to Local Health Boards and NHS trusts in April 2003.

2. Context

The therapeutic relationship that develops between worker and client is one of the most important elements of substance misuse treatment. Counselling skills, which include non-judgemental positive regard and empathy, the use of reflective practice and an awareness of the power of non-verbal communication etc, are core skills applied by substance misuse workers. These are essential for the effective delivery of practical help, crisis intervention, advice giving and support, and prescribing programmes etc.

However a distinction must be made between the use of these counselling skills and the provision of structured counselling and the other psychological and psychosocial interventions provided.

Structured counselling and other psychological interventions can be used in all of the main treatment contexts. They are usually offered as part of a care package that may also include prescribing, education and training, and the management of physical and psychological health, and social and forensic problems.

3. Philosophy and approach

A number of theoretical approaches may be applied to the provision of psychological therapy and psychosocial interventions. The most significant are:

- "Brief interventions"
- cognitive-behavioural therapy
- motivational approaches.

With specific regard to the use of structured counselling, and in addition to the cognitive behaviour therapy approach, the Effectiveness Review (Task Force to Review Services for Drug Misusers 1996) identified other approaches, i.e.:

- 12-step addiction counselling
- gestalt and
- family therapy.

Many people working in substance misuse also have specific training in offering modularised psychological or psychosocial interventions such as motivational enhancement therapy or social and behaviour network therapy. These have often been developed and described by expert practitioners within a particular orientation and staff have been trained in these approaches to widen access to treatment. *(It is essential that supervision is available from expert therapists trained within the parent psychological orientation of the modularised therapeutic approach for competent and safe practice.)*

4. Duration of intervention

The duration of the therapeutic intervention will depend upon the assessment of client need and the type of intervention/therapy employed. This can vary along a continuum, from brief interventions through motivational interviewing and cognitive-behavioural to longer-term psychotherapeutic interventions. The anticipated term should be indicated at the beginning of the treatment. A six-week duration in brief interventions would be typical for briefer or solution-focused interventions whilst motivational enhancement therapy has been manualised based on a three session contract. Slightly longer contracts may be more typical

for formulation-driven therapy. Duration of the programme may also depend on the context in which the intervention takes place (e.g. residential rehabilitation, inpatient and community prescribing, structured day programme).

5. Staffing and competence

Psychological and psychosocial therapy has to be based on written procedures and demonstrable staff competence. This includes therapists having access to regular supervision from a member of staff skilled in the intervention being used. The emerging consensus amongst professionals is that supervision ideally be carried out by someone other than the employees direct line manger. Group supervision is also an option.

Former service users can be effective therapists providing appropriate safeguards are in place, including an adequate period of recovery before engaging in this type of work as well as adequate training and supervision.

Drug and Alcohol National Occupational Sstandards (DAN0S) have to be complied with. Services providing structured counselling should:

- employ staff who are seeking professionally accredited qualifications (e.g. BACP accredited, National Vocational Qualification (NVQ) qualified or some approved equivalent
- adhere to relevant Codes of Practice (e.g. British Association of Counselling and Psychotherapy (BACP) or UK Council of Psychotherapists (UKCP)
- have written supervision protocols, which identify the purpose, regularity and process of supervision. The four elements of this are, to seek appropriate supervision, make a supervision contract, bring work to supervision, and review supervision
- employ appropriately competent and accredited supervisors (BACP or other equivalent)
- have established, clear links with other specialist counselling services for referral and joint provision
- have clear outcome and output measures for therapeutic services
- monitor and report on outcome measures
- use outcome and other performance monitoring measures to inform strategic/business planning/service delivery and policies and practices of the service
- have established membership of Local Psychological Treatment Committees.

6. Aims and Objectives

The overall aim of psychological therapy and psychosocial interventions is to make a measurable improvement to the client's welfare and ability to function.

CAMPAG, the body charged with developing standards for advice, guidance, counselling and psychotherapy, describes the objective of counselling as *"the principled use of a relationship to provide someone with the opportunity to work towards living in a more satisfying and resourceful way".*

The intervention has to be offered to clients within a deliberately undertaken contract with clear professional boundaries. Therapists should offer a commitment to privacy and confidentiality within professional and legal limits.

7. Access

Client access to psychological therapy and psychosocial interventions is voluntary and its offer should follow on from a full assessment. Services offering these treatments should provide *written information on*:

- types of therapies offered and a statement of evidence for its relative merits for specific problems
- waiting times
- place of therapy for the treatment programme offered
- qualifications and gender of counsellors.

8. Referral pathway(s)

Referral pathway(s) mirror those for the context within which the intervention is provided (e.g. inpatient and community-based prescribing, residential rehabilitation, structured day programmes). Open-access, low-threshold services can also provide structured counselling. This can take place in conjunction with treatment provided by other organisations (e.g. prescribing services).

9. Contact and referral

Services offering psychological therapy and psychosocial interventions as part of their modality should have clear protocols for referral, whether self-referral in the case of low-threshold services, or referral from outside agencies. Within modalities, the interventions are planned as part of an overall package of care.

Services offering these therapies should have clear assessment procedures, which must be completed prior to the commencement of the intervention.

10. Management

The key management processes in the provision of psychological therapy and psychosocial interventions are:

- an assessment based upon clear procedures in line with the Unified Assessment Process in Wales (see appropriate document)

- the presenting problem identified and the preferred/indicated approach specified
- allocation to therapist in line with agreed criteria
- goals for achievement agreed and set with the service user
- therapy reviewed as part of the care plan review process (see 10.1 below)
- procedures for case/closure/transfer applied (see 10.2 below)
- service user satisfaction audited upon completion of treatment.

10.1 Care planning and review

As indicated above psychological therapy and psychosocial interventions should be planned as part of the overall package of care. The care plan should be devised in partnership with the service user. Service users should be clearly informed about all timescales relating to this component of the care plan (e.g. number of sessions, timing of sessions, timing of review of progress, etc). Goals for the therapy aspect of the care plan should be agreed and reviewed with the service user. These goals should relate to dimensions of behaviour change related to the user's substance misuse. The service user has the option to withdraw from the programme at any time.

10.2 Departure Planning

Service users may end the therapy/intervention by leaving, whether or not the aims of this treatment have been fulfilled. The after care plan must be agreed from the outset so that any other professionals/agencies involved with the client will be aware of the situation. In any case, care plans can continue with any other forms of treatment in which the client may be engaged. If the client leaves prematurely, every effort should be made to re-engage them as this can be a vulnerable time and may result in relapse or increased drug/alcohol use.

11. Aftercare/continued support

The need for further therapy may become apparent following initial assessment, during the course of therapy or on formal review of service user needs. Such services may include bereavement therapy or counselling/therapy related to physical and/or sexual abuse. The substance misuse service must have clear protocols for referral and/or shared care with these services.

Onward referral can also be considered to other modalities of care, such as substitute prescribing, residential rehabilitation or structured day programmes.

Evidence Base

Introduction

The role of psychosocial interventions in the treatment of substance misuse problems is important but not well researched. Most services, which provide treatment for substance misusers, will provide some form of structured or unstructured intervention with the possible exception of some low threshold prescribing services.

No review of the levels of skill of counsellors, training or supervision employed in the statutory and non-statutory organisations has been undertaken but it may be safely assumed that levels of competence, training and supervision vary widely across Wales. Many of the non-statutory organisations grew from self-help groups or from a genuine desire to tackle a difficult problem in a local community. They were often based on the need for practical advice and interventions to help individuals cope. Often short of money and staff, counselling training may have been low on the agenda for these agencies. In the statutory sector many staff employed are from professional backgrounds such as nursing etc, but may have had no formal training in counselling particularly when trained many years ago. But because they have a professional qualification there is an assumption that they are able to counsel clients.

In addition to these factors, in the past there has been a tension between different models of intervention. For example, the Minnesota (12-step) method relies on the concept of addiction being an untreatable illness but from which one may be in recovery. Proponents of this model may disagree with harm reduction agencies, which accept drug and alcohol use as being bio-psycho-social problems entrenched in society and for which we must try to reduce the harm done by these substances to the individual and to society. The methods of psychosocial interventions in these two examples may be very different but are attempting eventually to reach similar goals.

What works in psychosocial interventions?

Marzillier (2004) has suggested that research into psychotherapy is flawed because of the intense interpersonal relationship between the therapist and client, which is possibly the most important factor. To try to run random controlled trials for psychosocial interventions is extremely difficult because, unlike medical trials you are not treating one symptom or "illness". This is one reason why there is a paucity of good research evidence. Project Match, a very large American study that attempted to match clients for one-to-one interventions compared motivational interviewing, AA's 12-step approach and cognitive behavioural therapy. Matching effects were few and modest; motivational interviewing was best for angry clients and 12 step for those highly dependent or with pro-drinking social networks. Even with 'difficult' clients the briefer motivational therapy performed as well as more intensive therapies. All treatments seemed effective with

a range of clients; the client's readiness to change had a major positive impact on outcomes. Match also found that the therapist was as important as the treatment in successful outcomes, (Ashton, 1999).

The Task Force to Review Services for Drug Misusers 1996 (Dept. of Health 2002) found only 6 articles when they reviewed the international literature on the use of counselling in the drugs field. They found that the main points to emerge were that a) counsellor characteristics are an important factor, b) the provision of counselling with methadone prescribing improves outcomes in relation to drug use, depressive symptoms and criminal activity and c) styles of counselling vary, with less structured approaches generally used in the UK.

Many of the more structured counselling interventions used in the addiction field now are based on Motivational Interviewing. (M.I.), (Miller and Rollnick, 1991). This is a system of counselling, which encourages motivation to change, using directive and client centred methods. It helps clients to explore and resolve ambivalence. Many of the interventions described as brief interventions are based on motivational interviewing. Brief interventions were described by Hodgson (2002) as being 'up to three or four one hour sessions compared to minimal interventions which are less than 30 minutes'. Minimal interventions may be useful where contact with a problem drinker or drug user may be opportune but not ongoing, such as an A and E Department.

Alcohol

John et al (2003) found improved outcomes of participation at 6 months in self help groups after detoxification in a random controlled trial of clients receiving group treatment compared to brief motivational counselling. However this difference disappeared at 12 months. There was no difference in abstinence rates between the two groups. In a randomised controlled trial Shakeshaft et al (2002) found no differences in outcomes between brief interventions and cognitive behaviour therapy apart from brief interventions being more cost effective. In a randomised controlled trial of brief interventions compared to no interventions, with heavy alcohol users attending a needle exchange, Stein et al (2002) found that there was a decrease in drinking in both groups (an assessment effect?) but that that brief intervention group were two times more likely to report periods of 7 days or more abstinence than the control group. Wutke et al (2002) in along term follow up to brief interventions with alcohol users found that the treatment group showed significant reductions in alcohol consumption at 9 months but these differences had disappeared at a 10 year follow up.

There is evidence for effectiveness in motivational interviewing (e.g. Bien et al, (2003) who conducted a meta analysis of effectiveness of MI with alcohol interventions, CBT (Project MATCH study group 1997), Relapse prevention, (meta analysis by Irvine et al, 1999). General alcohol counselling (a combination of psycho education and humanistic approaches) was found to be effective compared to no treatment or waiting list but less effective than CBT or a 12-step approach.

Drugs

In working with opiate users MI and CBT have both been shown to be effective (e.g. Pollack et al 2002, Saunders et al 1995). McLellan et al (1993) found that counselling together with methadone treatment produced better results than methadone alone in reducing opiate use. Woody et al (1995) found that time limited, focused psychotherapy with clients receiving methadone maintenance therapy found that the clients used less cocaine, required less methadone and maintained their gains more than clients receiving drug counselling. However, this study is probably irrelevant given the almost total lack of psychotherapy services in the drug field.

In the treatment of stimulant users a relapse prevention programme was found to have positive outcomes maintained at one year compared to pharmacotherapy, (Carroll et al, 1994). This must be viewed against the fact that there are no pharmacological interventions for use with cocaine users compared with methadone treatment for opiate users. Crits-Christoph et al (1999) found in a comparison of 4 treatments that all treatments were effective but that clients receiving 12 step individual counselling were more likely to achieve and maintain abstinence. In an unpublished study for the Dept. of Health, McBride et al (2003) using a random controlled trial of Dexedrine prescribing for amphetamine users that both groups improved, both groups received motivational counselling.

All of the studies cited in the drug and alcohol section used gold standard of random controlled trials or controlled trials.

Conclusions

There is a dearth of good, reliable studies investigating psychosocial interventions in substance misuse especially looking at comparative effects of different treatments. However, there is evidence that some form of counselling is better than none, and that whatever the form of psychosocial intervention it should be a subject of training within the agency and be adequately supervised.

References

Ashton, M. (1999), Project Match: unseen colossus, **Drug and Alcohol Findings**, issue 1, pp 15-21.

Bien, T.H. Miller, W.R. and Boroughs, J.M. (1993), Motivational Interviewing with Alcohol outpatients, **Behavioural and Cognitive Psychotherapy**, vol. 21, no 4, pp 347-356.

Carroll, K., Rounsaville, B., Nich, C., Gordon, L., Wirtz, P. and Gawin, F. (1994), One year follow up of psychotherapy and pharmacotherapy for cocaine dependence: delayed emergence of psychotherapy effects, **Archives of General Psychiatry**, vol. 51, pp 989-997.

Department of Health (2002), **Models of care for substance misuse treatment**, National Treatment Agency, London.

Hodgson, R. (2002), Brief Interventions, Brief Interactions, in (eds) Petersen, T and McBride, A. **Working with substance misusers, a guide to theory and practice**, Routledge, London.

Irvin, JE., Bowers, C.A., Dunn, M.E. and Wang, M.C. (1999) Efficacy of Relapse Prevention: A Meta-Analytic Review, **Journal of Consulting and Clinical Psychology**, vol 67, no 4, pp 563-570.

John, U., Veltrup, C., Driessen, M., Wetterling, T. and Dilling, H. (2003) Motivational Intervention: an individual counselling versus a group treatment approach for alcohol dependent in patients, **Alcohol and Alcoholism**, vol 38, no. 3, pp 263-269.

Marzillier, J. (2004), The myth of evidence based psychotherapy, **The Psychologist**, vol. 17, no 7, pp 392-395.

McBride, A.J., Merrill, J., Peters, L. and Pates, R. (2003) A random controlled trial of treating amphetamine users with Dexedrine, unpublished.

McLellan, A.T., Arndt, I., Metzger, D.S., Woody, G.E. and O'Brien, C.P. (1993), The effects of psychosocial services in substance misuse treatment, **Journal of the American Medical Association,** vol. 269, no 15, pp 1953-1959.

Miller, W. and Rollnick, S. (1991), **Motivational Interviewing, preparing people to change addictive behaviour**, The Guilford Press, London.

Pollack, M.H., Penava, S.A., Bolton, E., Worthington, J., Allen, G. L., Farach, F.J. and Otto, M.W. (2002), A novel cognitive behavioural approach for treatment resistant drug dependence, **Journal of Substance Abuse Treatment**, vol. 23, no 4, pp 335-342.

Project MATCH Research Group (1997) Matching alcoholism treatments to clients heterogeneity: Project MATCH post treatment drinking outcomes, **Journal of Studies in Alcohol**, vol. 58, pp 7-29.

Saunders, B., Wilkinson, C. and Phillips, M. (1995). The impact of brief motivational intervention with opiate users attending a methadone programme. **Addiction**, vol. 90, no 3, pp 415-424.

Shakeshaft, A.P., Bowman, J.A., Burrows, S., Doran, C.M. and Sanson-Fisher, R.W. (2002), Community based alcohol counselling: a randomized clinical trial, **Addiction**, vol. 97, no 11, pp 1449-63.

Stein, M.D., Charuvastra, A., Maksad, J. and Anderson, B.J. (2002) A randomized trial of a brief intervention for needle exchangers, **Addiction**, vol. 97, no 6, pp 691-700.

Wutzke, S., Conigrave, K.M., Saunders, J.B. and Hall, W.D. (2002). The long term effectiveness of brief interventions for unsafe alcohol consumption: a 10 year follow up, **Addiction**, vol. 97, no 6, pp 665-676.

Glossary

Brief Interventions

Brief interventions refer to a short-term time limited intervention with a client. This may be as short as one 10-minute session giving objective feedback or advice to the client or advice, or may be 6 half hour sessions. The important difference from other therapies is that it is time limited and of brief duration over a prescribed period of time.

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy or "CBT" is an approach that has grown out of behavioural therapy, which involved trying to alter the behaviour of a person with prescribed methods. The recognition that humans have thought processes and emotions and that these affect our behaviour or interpretation of events led to the development of CBT. This form of therapy is used widely with people suffering from depression and anxiety and the therapist helps the client explore those thought processes and cognitions and challenges misperceptions.

Counselling

Counselling is a generic term for interventions based on the verbal interaction between counsellor and client aimed at helping the client gain an understanding of their problems. Counselling is not about the giving of advice or education but is a process of helping the client to reach solutions themselves. Most counselling is based on a Rogerian model of listening and reflection.

Family Therapy

Family Therapy works on the principle that the problem is product of a malfunctioning system (such as a family) and that, the most effective way of solving this is by working with that system i.e. the whole family. This will involve bringing together all the relevant family members (where possible) for therapeutic sessions.

Gestalt therapy

Gestalt therapy is a specialist form of therapy rarely seen in the field of substance misuse. It is based on the belief that mental processes cannot be broken down into constituent parts but that we need to achieve Gestalt (wholeness) by including all aspects of a persons cognitive functioning. The client needs to see all sides of their problems in this approach.

Motivational Approaches

Motivational approaches are a counselling style that aims to elicit behaviour change by helping clients explore and resolve ambivalence. It is directive and client centred. It helps clients increase their "readiness to change" and to understand their resistance to change.

Psychosocial interventions

This is a broad term used to denote interventions that use talking therapies as opposed to the prescription of medication. They are aimed at the client gaining an understanding of their social situation and psychological stresses or needs.

Twelve Step Counselling

Twelve step approaches are usually based in the self help movement around the philosophy of Alcoholics Anonymous. This incorporates a set of 12 beliefs about the individuals ability to accept the problems they have with alcohol (or drugs) and the fact that they need a higher "power" to help them maintain sobriety. It is also based on the belief that the individual is not cured but is in recovery with relapse always a possibility.

Good Practice Framework for the Provision of Substance Misuse Services to Homeless People and those with Accommodation Problems

Contents

PART A: Background

PART B: The standards

Good practice framework for the provision of substance misuse services to homeless people and those with accommodation problems

PART A: Background

1. Overview

Individuals who are homeless have poorer physical and mental health than the general population, and often have problems obtaining suitable treatment. Evidence suggests that in relation to substance misuse the major problems faced by this group of people are gaining access to specialist services, avoiding a return to the circumstances that lead to their original problem and securing support for a range of other needs.[1]

Homeless populations have a higher incidence of health problems than the general population, often characterised by having multiple health problems (primarily alcohol and substance misuse dependence, and mental disorders) and premature mortality.[1, 2] There is evidence that behavioural interventions for substance misuse and alcohol dependence can empower homeless people and lead to lasting health gain, as well as helping in treatment retention. Effective health interventions for substance misuse dependence include pharmaceutical interventions, hepatitis B vaccination, advice about safer injection and access to needle exchange programmes[1]. A range of good practice in relation to other needs of homeless substance misusers is also emerging[3].

It is clear that effective service interventions for this client group require:

- *engagement of homelessness service providers in the SMAT and DIP planning/commissioning processes in Wales;*
- *the establishment of effective working relationships, joint protocols and joint training between the specialist substance misuse service providers and homelessness agencies/housing authorities*.

Most recent research has focussed on the support needs of homeless people without children. There has been far less work on the possible support needs of homeless families and the assumption has tended to be that their primary, or only, need is for housing. Some homeless families may have more support needs, including substance misuse.

This framework considers the needs of the adult homeless population in Wales and needs to be considered alongside existing and developing substance misuse treatment and rehabilitation frameworks produced by the Welsh Assembly Government. These documents cover both drug and alcohol misuse. Of particular relevance are the framework for clients with co-occurring mental health and substance misuse needs and the ongoing work on Hidden Harm.[4]

Additionally this framework needs to be considered in the context of Health and Wellbeing Strategy development and Making the Connections.

2. Context

Homelessness is commonly used to describe a wide range of circumstances where people have no secure home. Homelessness is defined in legislation for the purpose of determining entitlement to help from local authorities and certain groups are defined in law as being in priority need of housing. However, in order to target substance misuse treatment services on the most difficult to engage homeless people, it is necessary to consider a wider range of clients. The housing duties owed by local authorities to homeless people with substance misuse problems will vary (see section 3). Many of the most chaotic and vulnerable people may not be in contact with housing authorities at all, but may be in touch with voluntary agencies. Therefore this framework is relevant to all agencies working with homeless people with substance misuse problems.

2.1 Definition of homelessness

There is a statutory definition of homelessness in the Housing Act 1996[5], which relates to the duties owed by local authorities. This narrow definition focuses on whether someone has somewhere they can legally occupy where it is reasonable for them to stay.

The Welsh Assembly Government has set out a broader definition within its Code of Guidance on Homelessness[6], which is more inclusive, and it is this definition which should be used in the context of this document. This definition defines homelessness as:

> *'Where a person lacks accommodation or where their tenure is not secure'.*

People covered by this definition include the following:

- *rough sleepers;*
- *those living in insecure/temporary housing (excluding assured/assured short hold tenants);*
- *those living in short term hostels, night shelters, direct access hostels;*
- *those living in bed and breakfasts;*
- *those moving frequently between relatives/friends;*
- *squatters;*
- *those unable to remain in, or return to, housing due to poor conditions, overcrowding, affordability problems, domestic violence, harassment, mental, physical and/or sexual abuse, unsuitability for physical needs;*
- *those threatened with losing their home and without suitable alternative accommodation for any reason;*
- *those required to leave by family or friends or due to relationship breakdown;*
- *those who are within three months of the end of tenancy and facing possession proceedings or threat of eviction.*

This definition recognises homelessness in a wide variety of circumstances. The following paragraphs describe some of the main settings where substance misuse services will need to be accessible for homeless people.

2.2 Rough sleepers

Although only a small proportion of homeless people sleep rough, they represent the most extreme form of homelessness and the group with the highest concentration of multiple support needs. They can be defined as:

> '*People who are sleeping, or bedded down, in the open air; people in buildings or other places not designed (suitable) for habitation*'.

This definition will include, for example, people sleeping on the streets, in doorways, in parks, in bus shelters, or buildings not designed for habitation such as barns, sheds, car parks, cars, derelict boats, stations, squats, tents, or makeshift shelters.

2.3 Hostel and night shelter residents

Night shelters normally offer basic emergency accommodation for people who have been sleeping rough, or are at risk of rough sleeping. Hostels vary widely from emergency direct access accommodation for rough sleepers, to shared accommodation for students or young workers who may have no support needs. Not all hostels accommodate homeless people and it is important to identify the target group of hostels before including them in substance misuse treatment planning. Night shelters and hostels for homeless people have, in the past, often been used by long-term homeless people as a temporary respite from homelessness and some older clients have circulated between hostels and rough sleeping for many years. As it is very difficult for people sleeping rough to access or sustain substance misuse treatment without stable accommodation, hostels offer a major opportunity for these people to take the first steps into treatment services.

2.4 Bed and breakfast (B&B) residents

Some local authorities place significant numbers of homeless families in B&Bs as temporary accommodation, often because of a shortage of permanent social housing. However, many homeless people without children also place themselves in B&Bs for lack of any alternative and people in these circumstances may be isolated and not in touch with any support services. Others may use day centres for homeless people to access some support.

2.5 Homeless families

Most recent research has focussed on the support needs of homeless people without children. There has been far less work on the possible support needs of homeless families and the assumption has tended to be that their primary, or only, need is for housing. This has perhaps happened because they are usually entitled to help with permanent housing from the local authority, whereas most homeless people without children do not have this entitlement unless they are also vulnerable and have other clear support needs such as disability or ill health. Some homeless families may have more support needs, including substance misuse.

2.6 People staying temporarily with friends and relatives

These people, sometimes referred to as the "hidden homeless", are a large and diverse group and should be regarded as homeless, or at risk of becoming so.

2.7 Squatters

Squatters should be regarded as homeless. Some may have a history of both homelessness and substance misuse.

2.8 Homeless offenders

The Welsh Assembly Government recognises the particular difficulties faced by people leaving prison. There is clear evidence that prisoners are at risk of homelessness (and of overdose) when they are discharged, and that this has an impact on re-offending. The successful resettlement of former prisoners is vital for the safety and security of the whole community. To support this work the Counselling, Assessment, Referral, Advice and Through care Services (CARATS), and other inter-agency links within the prison (e.g. Prison Link Cymru), assist homeless offenders upon release. High priority is given to anyone who is homeless and has a substance misuse problem. Harm minimisation information is also provided to all prison leavers to help with their resettlement.

There is a high incidence of substance misuse amongst former prisoners, and it is important that housing and substance misuse services work together with criminal justice agencies to aid resettlement.

Offenders released on licence are under the supervision of National Probation Service. Prior to release the Offender Manager prepares a sentence plan based on offender needs and will have identified the interventions required to build upon work undertaken during the custodial part of the sentence. Short term adult offenders (those sentenced to less than 12 months in custody) are not subject to licence supervision on release and it is more difficult to ensure progress in prison is maintained and built upon post release. The Transitional Support Scheme is designed to address the practical resettlement needs of those on short-sentences with on-going substance misuse problems. Community based services could help enhance the support by making strong links prior to a person's release to reduce the risk of the further offending.

In addition, early intervention is important for offenders at all stages of the criminal justice process as part of homelessness prevention and housing options; e.g. supported housing, floating support, temporary accommodation, general needs housing, private rented sector, etc.). The alignment of the Drug Intervention Programme and the Prolific and Other Priority Offenders scheme is also helping to support this approach.

3. Homelessness legislation issues

Homelessness legislation places a number of duties on local authorities and contributes to the context in which substance misuse treatment is provided.

Requirements of legislation on local authorities:

- *to ensure that advice and information about homelessness is available to everyone in their district, and provide specific advice to homeless people to help them find housing;*
- *to ensure that accommodation is available for people who are homeless through no fault of their own if they are in one of the priority need groups. These include families with children, pregnant women, young people, 16 and 17 year olds, former prisoners, and people who are vulnerable because of old age, ill health or a history of institutional living. Other people with substance misuse problems may be deemed to be vulnerable and in priority need (see 7.6), and the authority will have to secure housing for them;*
- *to carry out regular reviews of homelessness needs in their areas and produce homelessness strategies to meet these needs. From 2008 it is intended that this planning will be incorporated into local housing strategies, although authorities may choose to continue to have distinct homelessness strategies.*

PART B: Good Practice Guidance

4. Homelessness services (statutory and voluntary)

Voluntary and statutory homelessness services have a key role in the local infrastructure for meeting substance misuse-related need. Part of this role is to support individuals accessing treatment services. Homelessness services will need to ensure that staff are adequately trained to provide the services described below, and should liaise with the Substance Misuse Action Team (SMAT) to seek advice on appropriate training.

4.1 Assessment - specialist homeless services

When conducting a holistic assessment with a service user, specialist homelessness services should seek to identify any substance misuse needs.

Minimum requirements of identification:

- *to meet substance misuse information and advice needs;*
- *to assess substance misuse-related risk;*
- *to provide harm reduction interventions;*
- *to assess which services are relevant for identified needs;*
- *to assess need for referral to substance misuse services.*

Screening tools should be developed in collaboration with the local specialist substance misuse services. Experienced specialist substance misuse workers should train staff in using the substance misuse screening tools. Development of a joint substance misuse screening tool is recommended because the screening can be recognised by substance misuse treatment services as the first stage of a substance misuse assessment.

The following topics should be covered when screening for substance misuse:

- *current patterns and circumstances of misuse;*
- *amount used;*
- *episodes of overdose;*
- *personal concerns about use;*
- *associated problems, for example criminal justice, child care, social problems, mental and physical health;*
- *risk assessment.*

4.2 Referral to specialist treatment

Homelessness and substance misuse services should develop referral protocols in partnership. Before a referral to a substance misuse service, informed consent from the service user is required and should be documented. Before gaining consent, homelessness agency staff should ensure that service users are well informed.

Requirements of homelessness services when informing service users:

- *to understand the environment and philosophy of each organisation;*
- *to understand the type of intervention provided;*
- *to understand the criteria for service provision;*
- *to understand referral procedures and any likely problems or delays.*

This information should be shared with and explained to the service user.

4.3 Joint working protocol

Community Safety Partnerships (CSPs) should ensure that there are effective joint planning and commissioning arrangements in place to guarantee that the referral arrangements described above are based on realistic access to services. Support from the homelessness agency should also continue after a referral for treatment has been made, where consent is given.

It is important to clarify responsibilities and expectations that the partner agencies have of each other. The development of a joint working protocol is an important good practice step to improving services in this area.

Joint working protocols should include or address:

- *named responsible contacts for co-ordinating joint work in each agency;*
- *a named key worker for each service user;*
- *joint meetings and reviews to monitor progress;*
- *clear procedures on advising and informing service users and gaining consent;*
- *clear and specific lines of responsibility on all relevant matters;*
- *training needs on agency roles and referral criteria;*
- *relevant legal issues for staff.*

4.4 Psychiatric services

Homelessness services also have an important role to play in supporting clients with mental health problems. Contacts with community psychiatric services should therefore be developed.

5. Specialist substance misuse services

As indicated in the overview to this document, research suggests that the key problems faced by homeless substance misusers are:

- gaining access to full range of services appropriate to their needs;
- sustaining engagement with treatment;
- avoiding a return to the circumstances which led to their original substance misuse problems;
- securing support for a range of other needs which have limited their ability to access and sustain treatment.

5.1 Key interventions

The key interventions for specialist substance misuse services should be:

- *to consider the possibility for dealing with homeless people as priority cases;*
- *to ensure that homeless clients have access to a full range of services appropriate to their needs;*
- *to ensure effective links with street outreach work in areas where there are rough sleepers, to encourage them into treatment;*
- *to provide access points in places used by homeless people, such as day centres and hostels;*
- *wherever possible to operate an open door, non-appointment policy;*
- *to endeavour to locate services in places which can be reached by people without their own transport, for example, peripatetic services in rural areas;*
- *to conform with the minimum standards for waiting times;*
- *to provide a flexible service which allows for possible repeated relapses by clients;*
- *to liaise with housing agencies to ensure stable accommodation is available, which may be in a hostel or temporary supported housing, pending permanent re-housing;*
- *to address the psychological needs and dependencies of users;*
- *to ensure other support needs are met;*
- *to screen/assess for homelessness and refer to appropriate service;*
- *to be aware of the homelessness services in local area;*
- *to provide appropriate training to homelessness agency staff.*

6. Specialist services for homeless substance misusers

In areas with high levels of homelessness, there may be a need to commission specialist substance misuse treatment services for homeless people in addition to better access to mainstream services. Some of these services may be more able to work in flexible and innovative ways with homeless substance misusers and may be more trusted by them.

Some specialist services can be provided by competent homelessness workers, others by specialist substance misuse workers providing a satellite service within a homelessness agency.

6.1 Street outreach services

Open access substance misuse services (Tier 2 services) should be available to people sleeping rough. These would be most productively provided by joint work between substance misuse treatment services and homelessness agencies. Much of this work will be concerned with harm reduction which should encourage homeless people to stabilise their substance use and to enter accommodation.

Elements which should be included in street based harm reduction services:

- *needle exchange;*
- *advice on safer injecting, safer drinking and safer sex*;
- *advice on safer use of all substance misuses, including overdose prevention;*
- *support to access treatment;*
- *support to access other health and social care services, including primary care and benefits advice;*
- *support to ensure nutritional needs are met*.

Services should be carefully planned to ensure they play a part in encouraging people to move off the streets, rather than simply reinforcing street living. For example, they should encourage people wherever possible to go to a hostel or at least a day centre to receive additional services, rather than providing for all needs directly on the street. (Homeless substance misusers may need to develop confidence in the outreach service before they can be encouraged to more mainstream services, so this may have to be a progressive approach.)

6.2 Day centres

Tier 2 open access services should also be offered in day centres for homeless people, or on a specialist basis for substance misusers with the same approach as for street services. They should be linked to encouraging people to stabilise their use and, where applicable, move into hostels or other suitable accommodation.

Substance misuse agencies might offer peripatetic satellite services in a number of agencies. This might prove especially useful in rural areas with poor transport links. It is unlikely that community-based treatment could be effectively operated through homelessness day centres for some homeless substance misuse users, as clients require stable accommodation. However, day centres and particularly specialist medical centres for homeless people might also provide Tier 3 services, including after care services for those with stable accommodation.

6.3 Hostels, shelters and emergency provision

Tier 2 services should also be offered in hostels with significant numbers of homeless substance misusers. There are advantages in offering services on the premises, since they are likely to engage chaotic substance misusers who would not necessarily go to an external agency. Basic advice and information and initial assessments can be offered by competent hostel workers. Hostels are also a good base for harm reduction services for homeless people. More specialist services can be provided by substance misuse workers either employed by the hostel or by a substance misuse treatment service providing a satellite service in the hostel. It is essential that they are provided with professional support and supervision.

Where hostels provide for longer term stays, then separate specialist units within the hostel providing residential services might be considered (Tier 4a), including specialist services provided by statutory bodies i.e. detoxification and rehabilitation. These units can operate in self contained parts of the hostel, for example a separate floor with its own entrance. Such projects should also provide access to move-on accommodation and eventually to permanent housing. These units can encourage people into treatment who might not have otherwise accepted it and can also mean that they will not become homeless should they relapse.

Rules of notification and drug use (i.e. when authorities will be informed) should be clear and open to all clients. CSPs should be aware of the rules and regulations contained in The Misuse of Drugs Act (1971) Section 8.

7. Accommodation for homeless substance misusers

People without secure accommodation are less likely to access treatment and those leaving treatment without suitable accommodation and support are very likely to relapse. Treatment services for homeless people, such as detoxification and rehabilitation, should be linked into wider plans for accommodation and support. This need not mean an immediate move by clients into permanent housing. Hostels and supported accommodation are often more appropriate as a first step.

It is also important to ensure that adequate support is in place to prevent substance misusers from losing their accommodation. It is therefore essential that CSPs work closely with homelessness agencies and accommodation providers to plan the provision of suitable accommodation for homeless substance misusers.

Those substance misusers who have chaotic lifestyles can create agency management problems. This risk can be minimised by the provision of expert support. There will also be a need for hostels and supported housing, which are substance use free - especially for ex-substance misusers and homeless people who object to sharing accommodation with current users.

7.1 Assessing and meeting accommodation needs

The most suitable type of accommodation will depend on the individual's needs and the treatment stage they have reached. Assessing the accommodation needs of substance misusers at each stage of treatment, and ensuring they are met, is central to effective programmes for homeless substance misusers. This should inform their care plan. CSPs should ensure that substance misuse treatment services work jointly with housing agencies to include the accommodation needs of users in their care plans.

It is essential that the development of the resettlement plan should include all the service needs of the client and is made well in advance of any move out of each stage of accommodation. It will often be most effective to carry out a joint assessment with a homelessness or housing agency. Joint protocols should be agreed for the referral of homeless substance misusers to housing agencies. It is essential that referral agencies do not understate the level of substance misuse, or other support needs of clients in order to obtain accommodation for them, as this is likely to lead to a failure to ensure adequate support is in place and a high risk of renewed homelessness. Equally, CSPs should work with accommodation providers of all types to ensure that they are prepared to accept homeless substance misusers, provided care plans are in place for their support and eventual treatment.

The amount and type of accommodation and support available varies widely in different areas and SMATs should work closely with local authorities' housing and homelessness strategies and with Supporting People programmes to ensure that plans are in place for accommodation and support to meet the

needs of local substance misusers. These plans should include the need to be responsive to changing circumstances in clients' lives and to any crisis points they might experience. Consideration should be given to the provision of inclusive accommodation for all substance misuse maintenance and abstinence clients that will provide separate facilities within the same premises.

7.2 Night shelters

Traditional night shelters offer basic standard accommodation in dormitories, where residents book in each night and are not allowed inside during the day. They offer only limited support for other needs. Night shelters are unlikely to be suitable for detailed work with substance misusers, although CSPs could help them to operate as a first point of contact for harm reduction services and referral to treatment services. Night shelters could also be encouraged to help residents to move to longer term hostels as a first step to tackling their substance misuse problems.

7.3 Hostels

CSPs should be in contact with all the hostels for homeless people in their areas, through participation in the local authority homelessness planning arrangements. Hostels should be active partners in planning, and in some cases hosting substance misuse treatment services for homeless people.

Many hostels exclude substance misusers altogether, thereby making successful engagement with treatment very difficult for homeless people. Some hostels, however, can work successfully with them.

CSPs should plan jointly with hostels for accommodation, harm reduction and treatment for homeless substance misusers. Local organisations can provide good practice.

Managers need to satisfy themselves fully with the law on this subject.

7.4 Supported housing

The next step for some former substance misusers in hostels and those moving on from residential treatment will be into other forms of supported housing. Supported housing can also form a base for engagement in community treatment services. Some continuing users may also need supported housing.

For some clients, a period of intensive support will be necessary to ensure they do not relapse or lose their tenancy. They may then be able to move on to independent housing. People with very high needs, for example those with a dual diagnosis of substance misuse and mental health problems, may need long term supported housing. The range of models of supported housing include:

- *shared houses* - where people have their own bedrooms but share facilities with other residents;
- *cluster flats* - where residents have their own flats, but there may be some communal areas such as kitchens;
- *dispersed housing* with visiting support;
- *floating support*.

7.5 The role of permanent housing in effective substance misuse treatment

Some homeless substance misusers may have histories of unemployment and posses lower skill levels. Long-term housing prospects can be in the social rented sector, private sector or owner/occupier in the local authority's homelessness strategy. Access through the private sector can be facilitated through bond schemes.

CSPs should address the local housing strategy needs of homeless substance misusers with local authorities, the private sector and RSLs, through participation in the local homelessness planning and Supporting People programmes. CSPs should also review any previous exclusions when considering applications from substance misusers.

It is acknowledged that clients engage more readily with and continue on substance misuse maintenance and abstinence programmes when living in permanent housing.

7.6 Homelessness legislation interpretation

SMATs should discuss with housing authorities the extent to which authorities should take account of substance misuse problems in assessing whether a person applying as homeless should be considered as vulnerable under the homelessness legislation and therefore entitlement to accommodation.

Substance misuse is not included in the legislation as a specific reason to consider homeless applicants as vulnerable, but authorities may consider applicants for any "*other special reason*". The 2003 Homelessness Code of Guidance states that.

"*The critical test of vulnerability for applicants...is whether, when homeless, the applicant would be less able to fend for himself than an ordinary homeless person so that he would be likely to suffer injury or detriment, in circumstances where a less vulnerable person would be able to cope without harmful effects*". Some homeless substance misusers could fall within this definition.

Each homelessness application should be considered on its merits and authorities should consider the circumstances of all substance misusers. Some may qualify as vulnerable on other grounds, for example because they have dependent children, mental health problems, or because of a combination of needs of which substance misuse is but one.

Local authorities and substance misuse treatment services should consider the ways in which problematic substance misuse can contribute to vulnerability in individual cases.

SMATs should discuss with housing authorities the importance of taking account of substance misuse problems and the need for stable accommodation for recovering misusers, in considering the vulnerability of homeless substance misusers who apply to the local authority.

7.7 Co-ordinating lettings and treatment needs

It is very important that housing is available for people leaving rehabilitation at the time they need it. If it is offered too early, for example while clients are still in residential treatment, they may be tempted to leave treatment to take up the offer. If no suitable housing is available when they leave treatment the risk of relapse is likely to be greater.

CSPs should ensure that substance misuse treatment services work jointly with all accommodation providers to co-ordinate access to accommodation with treatment timetables. For other clients who have not been accessing residential treatment, the offer of stable accommodation is, in itself, a crucial part of treatment.

7.8 Area of refocusing (resettlement)

Many people want to be housed away from the areas of former substance misuse to avoid contact with some former acquaintances and dealers. It is important that this is offered both within the landlord's stock and by mutual arrangements with other landlords. Strong social and family support can increase successful outcomes from treatment. Where clients have such support available, every effort should be made to secure housing for them close to their support networks. Clients should have care plans and care co-ordinators. Mechanisms should be in place to ensure accommodation is available for substance misusers moving into the area.

7.9 Tenancy support

CSPs need to have a central role alongside local authorities and Supporting People partnerships, in commissioning a range of housing support services for substance misusers, including homeless people. Tenancy support can help to prevent homelessness.

A range of support should be available within resources to cover the following issues:

- *choosing a new home which is suitable and at a time when the client is ready to manage their own home;*
- *Drug Intervention Programme (DIP);*
- *moving in and furnishing the home*.

Typically Supported People would assist in funding:

- *ensuring the tenant understands their rights and responsibilities, particularly the payment of rent;*
- *claiming welfare benefits;*
- *money management;*
- *basic help with personal and emotional problems;*
- *access to specialist support for mental health and substance misuse problems;*
- *resolving disputes with neighbours or the landlord;*
- *education, employment and training;*
- *helping the tenant to integrate with the local community;*

- *co-ordinating and acting as a broker for other services;*
- *emergency support if a tenant is at risk of abandoning their home*.

It is important to point out that funding for all of these services can come from a number of sources and commissioning organisations should work flexibly to meet the identified needs.

Effective tenancy support can reduce tenancy breakdown to very low levels.

Common features of successful schemes include:

- supporting people with multiple needs and not excluding them because, for example, they have both mental and substance use problems;
- providing detailed pre-tenancy support to ensure that the housing offered is suitable and people are aware of their rights and responsibilities;
- focusing on practical ways of sustaining the tenancy, rather than seeking to solve all the client's problems;
- providing multi-disciplinary services, without rigid professional boundaries between team members;
- assertive support that seeks to engage tenants with the service. (Simply offering the service is unlikely to be successful with many clients but due consideration should be taken of the clients needs);
- a flexible style of work which is often better managed by independent agencies. It is also important to clients that support workers are seen as independent of the landlord and not part of a statutory system from which many of them feel alienated;
- for tenants in need of long-term supported housing, the provision of an exit strategy;
- clear guidance and protocols for support workers in schemes.

8. Source material/references for the framework

The working group set up to produce the framework did not commission new research but relied heavily on three major source documents. Three additional resource documents are also included.

[1] **World Health Organisation** - *How can health care systems effectively deal with the major health care need of homeless needs of homeless people (2005).*

This is a Health Evidence Network (HEN) synthesis focusing on the evidence of effective treatment for the types of ill health from which homelessness people often suffer.

[2] **Home Office Research Study 258** - *Youth homelessness and substance use: report to the substance misuses and alcohol research unit (2003)*
Dr Emma Wincup, Gemma Buckland and Rhianon Baylis.

This report presents the findings of a research study of substance misuse amongst homeless young people in England and Wales over an 18 month period starting in January 2001. These findings provide the most recent experience of the needs of homeless substance misusers that dictates the content of the good practice guide.

[3] **Home Office and DOH** - *Drug Services for homeless people - good practice handbook (2002).*

This handbook was jointly commissioned by the Office of the Deputy Prime Minister Homelessness Directorate and the Home Office Substance misuse Strategy Directorate. It was produced by a multi-departmental group which included the Home Office, NTA and Department of Health. The handbook was specifically targeted at English Substance misuse action teams whose functions in Wales are to a large extent undertaken by the Substance Misuse Action Teams (SMATs) as subgroups of Community Safety Partnerships. Much of the good practice recommended in the framework is directly sourced from this handbook.

[4] Advisory Council on the Misuse of Drugs (ACMD) - **Hidden Harm** - Responding to the needs of children of problem drug users.

This report presents the findings of an inquiry by the Council that has the children of problem drug users as its centre of attention. The report estimates the number of children so affected in the UK, examines the immediate and long-term consequences of parental drug use for these children from conception through to adolescence, considers the current involvement of relevant health, social care, education, criminal justice and other services, identifies the best policy and practice here and abroad and makes policy and practice recommendations.

[5] Housing Act 1996 (ref).

[6] Code of Guidance on Homelessness (WAG) ref.

Substance Misuse Treatment Framework Information and Advisory Services

Substance Misuse Treatment Framework Information and Advisory Services

Contents

Substance Misuse Treatment Framework: Information and Advisory Services

This module primarily focuses on the provision of information and advice services in the context of adult services. Mention is made in some places to children and young persons services in regard of adults seeking information and advice in respect of younger people. However, for greater detail on the appropriate services for these groups, reference should be made to the appropriate Children and Young Persons Framework.

1. Defining Information and Advisory Services

Information and Advisory services deal with the provision of assistance and guidance in relation to identifying relevant services that match individual need and facilitating initial access to these services. Objective information can be provided in the context of enlightening people about the assistance, treatment, prevention and intervention options that may be available to them, whilst advisory services are those which help people to make contact or to interact with treatment services. Information and advice services are not expected to deliver specialist treatment interventions but signpost individuals to those services that can do so.

2. Overview

2.1 The delivery of information and advice services to people with a substance misuse problem, their family and/or carers can play a highly significant role in aiding the resolution of both direct substance misuse issues but also the surrounding anxieties of life, such as financial or legal difficulties. Through supporting and signposting access to these ancillary services they can have a major impact in readying people to tackle the substance misuse problem itself. Information and advice services are often a key entry point to treatment services and, thus, are very important.

2.2 Within the All Wales Strategy (Tackling Substance Misuse in Wales: a partnership approach) there are a number of commitments. The provision of information and advice is seen as a key prevention mechanism which can also be delivered through education programmes. It is also seen as a key aspect of supporting families, promoting safer behaviour and as a key aspect of supporting effective interventions. Thus, there are a number of key tasks which relate to the delivery of information and advice in a whole range of settings and by differing approaches.

2.3 Amongst the issues that people need information and advice on are:

- facts and information regarding substance misuse and treatment options;
- guidance and assistance in accessing specialist substance misuse services;
- housing advice and services;
- financial advice including benefits advice;
- employment and training;

- access to relationship counselling and support;
- child care advice and services;
- sexual health;
- mental health;
- disability;
- legal advice;
- young peoples services;
- needle exchange and substitute prescribing.

2.4 Consequently, information and advice services are not restricted to those provided by specialist substance misuse services. There are a whole range of other services (specialists in their own fields) that will be useful for people to access. This also means that there is a wide range of service structures and delivery methodologies applied to delivering these services. A crucial aspect of the successful delivery of these services will be communication, cooperation and information sharing between all the agencies involved.

2.5 A further key aspect is that the delivery of information and advice to individuals is not only the domain of specialist information and advisory services. At all stages of treatment and across the entire Substance Misuse Treatment Framework (SMTF), services should either provide or enable access to relevant information and advice for their service clients across a wide range of issues. This reflects the need for an holistic approach to treatment which seeks to assist service clients in all relevant aspects of their life which may, if not dealt with, inhibit the success of a treatment intervention.

3. Context

3.1 Along with the community as a whole, there are a number of key groups to which information and advice should be available:

- people with a substance misuse problem;
- families/carers of young people who are involved in substance misuse;
- substance misuse workers;
- other workers who may need to deal with the substance misuse issues, eg:
  - teachers;
  - social workers;
  - criminal justice workers;
  - health workers (physical and mental);
  - young people's workers;
- community action groups.

3.2 However, the ability of information and advice services to support people with a substance misuse problem is partly dictated by the availability of other specialist and non-specialist services.

4. Background Information

This section firstly considers the issue of service user need and the impact of such factors on the advisory service and then, secondly, it considers current examples of advisory service provision.

4.1 Information and Advice: Service Users and Service User Need

4.1.1 A number of advisory services currently exist that deal with both substance misuse and non-substance misuse issues. Most councils offer advisory services to facilitate the provision of information regarding services such as housing and financial benefits. Many substance misuse clients may at some point require access to these services. The mechanisms and methods of delivery utilised by these non-specialist can be incorporated and applied into the specialist substance misuse field. It is crucial, as outlined in the London Drug Line evaluation, that services are sufficiently promoted in order to raise client awareness.

4.1.2 Service users have wide and varied needs and this must be recognised when providing information and advisory services. Some service users will require more specialist advice and so information and advice services must ensure that these service users are referred onto appropriate services.

4.1.3 Staff of information and advice services need to ensure that service users are aware of what the service is able to offer:

- some will only offer advice,
- other may be able to offer intervention as well as advice
- some services may be able to act as facilitators to assist people in making contact with the relevant further services.
- some services may be able to offer all of the above.

4.1.4 This needs to be clear to the service user and made clear at the earliest opportunity when talking to a client.

4.1.5 In the Home Office report, "*Understanding problem drug use among young people accessing drug services: a multivariate approach using statistical modelling techniques*", the issue of defining the limits of information and advisory services is discussed. When undertaking the research it was obvious that there was a need to be very clear about what the role of the staff was. Where confusion arose it was important that staff should:

> "listen, be respectful, and make their position clear at the earliest opportunity. When parents continued to digress, the researchers explained that they were distinct from the drugs service staff again. It was also important to emphasis to parents how important their views were and to encourage them to repeat their concerns to the appropriate worker."

Such an approach can be employed in the advisory services in clarifying the boundaries of what the service can and cannot do.

4.1.6 The National Treatment Agency (NTA) in England **(Models of Care for the treatment of drug misusers)** sets the boundaries for information and advice services as providing:

> "... appropriate and professional advice and up-to-date information on all aspects of drug and alcohol misuse."

4.1.7 This to include:

> "information and advice around changing their lifestyles, minimising the complications associated with substance misuse, and accessing resources within the community."

4.1.8 In some cases people will be unsure as to what services they require. In these instances advisory services need to be able to provide enough guidance and help for the person to make an accurate and educated decision. This will require the information and advice service to be able to assess what the individual's needs are and staff will need to be appropriately skilled.

4.1.9 What is clear is that information and advice services are a key first stage to the introduction of people to the necessary intervention services. They do not provide interventions themselves except in assisting individuals in gaining appropriate information and making appropriate contacts.

4.1.10 Information and advice services also need to be able to operate and deal with a number of group issues such as faith or language. One of the key areas of service user need that must be taken into account are issues such as language (In the 2001 census 21% of people said they could read Welsh, and 20% can write Welsh) or the needs of ethnic/faith communities. In the 2001 census the majority of those from a non-white ethnic background were located mainly in Cardiff, Newport and Swansea, the overall percentage of these in relation to the overall population was 2.12%, with White British/Irish recorded as being 97.88%. With regards to specific religious background the census details that 72% of population are Christian whilst less than 1% Muslim, with regard to other religious minorities there is little or no data readily available. (Statistics: NSO)

4.1.11 This emphasises the need for effective, integrated partnership working not only within the substance misuse sector but also with all types of community groups and organisations. This will include faith and cultural groups who will be well positioned to deliver information to many parts of the community. It is important to make full use of facilities, funding and contacts that these groups in the community may have in order to deliver information on substance misuse as widely and effectively as possible.

4.1.12 When looking at the provision of advisory services within Wales it is worth bearing in mind the rurality of certain parts of Wales, in particular on the basis of national statistics, Dyfed Powys and North Wales. An effective advisory service needs to overcome such issues ensuring that all clients and not just those from an urban setting are informed. The delivery of rural services creates particular problems in ensuring reasonable access to services. Thus the design of services may differ between urban and rural areas.

4.2 Information and Advisory Services: Existing Mechanisms

4.2.1 A wide variety of mechanisms are used by information and advisory services to provide information. These range from the use of leaflets/pamphlets to internet based services.

4.2.2 Products like the comprehensive DIP directories appear most useful as they present a wide enough range of services and information for clients to be able to make an informed decision on what next steps to take. The exact effectiveness of such pieces of work in terms of informing clients is yet to be effectively measured. Systems of benchmarking and appraisal are used and in place by some advisory services in England. In particular organisations and services like FRANK and the Samaritans have an active review process where the performance and effectiveness of the service is assessed. This will be an important aspect of the national helpline in Wales, DAN. The importance of such an appraisal and review is critical especially in pilot schemes and assessing areas of need. Another key area for regular review is ensuring that particular client needs are being met.

4.2.3 More recently there has been an increasing use of internet services to provide advice and information. For example, Samaritans, which is perhaps better known for its 24-hour helpline and office service, has developed an online system. Whilst the organisation primarily provides counselling it can provide service users with practical advice and information on other services that can help them out with a whole range of life difficulties. The confidentiality and ease of access no doubt help to make this a valuable service to many people.

4.2.4 Within the substance misuse field a number of advisory services have grown up to deal with the issue, such as FRANK, the online and telephone information and advice service in England, and in Wales, DAN (it is too early to evaluate the impact of DAN) . The anti-drug FRANK campaign, launched in 2003 as part of a government initiative, makes full use of the internet. This is coupled with a public relations campaign involving televised adverts, local campaigns and a telephone service. Whilst FRANK has an active intervention role, it is also a key service in being able to provide easy access to current advice and signposting to other services. As they state in the annual review:

> "At national level FRANK would build mass recognition and become a trusted source of drug information and advice."

Within the first initial 12 months of the campaign commencement the website received 1.5 million visits and received over 30,000 emails. It appears to be a model which meets the needs of prospective clients. The Scottish Executive has established a website **(Know the Score)** which works alongside a free information line which provides access to information, advice and literature.

4.2.5 The Citizens Advice Bureau (CAB) service maintains alongside its offices an online service at www.adviceguide.co.uk, which can provide people with advice on legal, monetary and other issues. The CAB site offers advice sheets in a number of languages helping to overcome any potential language barriers. The website has a service that helps to locate the nearest CAB office and telephone advice is available from every CAB, which can be accessed through local directories. As part of their core generalist and holistic service, each CAB must provide high quality

signposting and referral services to clients as an integral part of the provision of information and advice services to the community.

As the Citizens Advice service' corporate website, www.citizensadvice.org.uk states:

> "Meeting the information and advice needs of as many people as possible is a major aspiration for the Citizens Advice service. In 2005/06, Citizens Advice spent £1,695,000 on producing accurate information for bureaux to use to advise clients and for the public to access directly."

The Citizens Advice Bureau also this year saw an 83% increase in those accessing its online service and won a national award for its online work.

4.2.6 The All Wales Schools Core Programme seeks to provide education, advice and information to young people and children between the ages of 5-16. The service offers a programme of education focussed on substance misuse. It is worth considering here the role of education as a form of preventative advisory service, in that it provides people with information before they become substance misusers. In the aspect that it seeks to provide young people with sufficient knowledge about substance misuse issues, the role of education services in delivering information and advice should not be disregarded.

4.2.7 As well as the use of information and advice in an educational or presentation format, information and advice should also be provided within the work place. Within the work place the role of the employer should be considered in terms of promoting advice and information services, often this could be done through a Health and Safety context. Employment services too can play a role in the provision of advice and information. Progress to Work provides a service that aims to help unemployed individuals with a history of problematic drug abuse back into employment. It provides support with regard to training, education and employment. It should be noted though that as with the All Wales Core Programme this is not exclusively an advisory service, rather it is firstly a service that seeks to resolve the issues, and the advisory element is a by-product of this. However, the service seeks a person centred approach and the service is delivered at the most convenient location for the service user to maximise take up. This is a key lesson in structuring information and advisory services.

4.2.8 These crossover services that provide information and advice as part of their role highlights the need for a clear definition of the role of information and advisory services in order to ensure an effective, focussed service provision which ensures that staff are not providing interventions in areas in which they are not qualified. Job Centre Plus offers not only a face to face service where clients can talk about what services are available or which people to contact. A computerised service is also available allowing service users to quickly call up information on employment issues and vacancies. The Citizens Advice Bureau has recently installed a similar system of electronic kiosks that have helped in cutting down waiting times and empowered service users as they can independently find the information they need.

4.2.9 NHS Direct is an online service which aims to provide patients with a wide variety of information on the NHS, illness and advice on coping. A number of useful features are available such as a self-help guide, a medical encyclopaedia and a search engine to locate the nearest G.P. One of the key benefits of this site is that it provides service users with enough information to make an informed decision about what they need without having to see a medical professional. In turn this frees up the medical professionals from having to see patients with minor cases or who may not need further treatment. NHS Direct is further backed up by a telephone service giving users an opportunity to talk to someone about issues. Such an integrated approach appears to be fairly common in the provision of national advisory services. This is a model that commissioners may wish to consider by utilising national helplines alongside local contact and access points.

4.2.10 Leaflets, pamphlets and posters tend to remain the most commonly used form of advisory service. Services ranging from the NHS, Prism and Cwysllt Ceredigion effectively use leaflets. The type of leaflet can range from catchall leaflets, which just describes the service, its aims and goals, to more specialist aspects of service or problems. As with the online and telephone approach there are a number of benefits and drawbacks to the approach. The chief problem being to ensure that people are receiving the leaflets particularly within a rural setting. Often leaflets are distributed from a central point eg G.P surgery or from the service's office. Another issue with leaflets is the need to keep them updated and relevant. This can be costly and these do not always reach the target audience.

4.3 Information and Advisory Services: Relevant Research

4.3.1 It is reported by the National Treatment Agency in England, that some categories of substance misusers, such as stimulant users, view access to information as a vital aspect of service delivery **(Farrell et al. 1998)**. Research on Hepatitis C amongst drug users *(Hepatitis C - guidance for those working with drug users, Department of Health)* shows that most people:

> "... want to make informed choices about their treatment and need access to up-to-date information in order to do this."

This research also shows that effective information and advice can have a good impact on altering substance misuse behaviour. It also shows that it can support a decrease in the problems associated with safer injecting and safer sex. The importance of the advice being current and staff being appropriately trained in order to deliver an effective service is also shown in this and a number of other publications. Advice on alcohol issues has been shown to reduce consumption **(Wallace *et al.* 1988)**.

4.3.2 A study by the Borders Drug and Alcohol Action Team **(Children Affected by Substance Misuse in the Family)** found that information and advice was the service most frequently delivered to both young people and adults.

4.3.3 A literature review by the Effective Interventions Unit **(Support for the Families of Drug Users: A review of the literature)** supports the need for people to have appropriate information and advice in accessing financial support as part of an overall approach. It also supports the role of information and advice in the prevention of substance misuse. This links back to the activities of the All Wales Core Project.

4.3.4 Whilst a key aspect of these services is to assist people in having a level of knowledge that increases their understanding and ability to deal with their issues, the Scottish Drug Misuse Database 2004/05, reported that the person's situation when seeking advice can have a profound effect on the ability of that information and advice to impact on enabling successful change. Thus it is not always about the service and its effectiveness but also about the individuals willingness to engage with change.

4.3.5 A study by the National Treatment Agency **(Marsden et al 2003)** showed that the provision of good information can have a significant impact on the behaviour of stimulant users. This was shown in some instances to be less effective than a more proactive intervention (motivational interviewing) in some cases but nonetheless worked well and was effective in reducing offending behaviour and improving health.

4.4 Information and Advisory Services: Summary

4.4.1 The primary ways of providing information and advisory services can be summarised as being:

- fixed office with staff and leaflets;
- fixed office as above with additional computerised information;
- distribution of leaflets, posters and contact details through as many appropriate outlets as possible (these should be as widely available through the everyday locations in the community as possible);
- internet service;
- telephone;
- travelling service;
- text to mobile;
- television/radio advice;
- education and presentations.

4.4.2 It appears unlikely that a service solely dedicated to the provision of information and advice would exist in the specialist substance misuse sector. These information and advice services will most usually be part of an overall substance misuse service delivery for both practical and economic reasons. Therefore, consideration will need to be given to the profile, standards and funding of these services rather than them being an incidental by product of the existence of intervention services.

5 Service Outcomes

5.1 The following are the expected outcomes for information and advice service delivery (whether by a specialist information and advice agency or another specialist substance misuse service):

- that the service is easily accessible to all potential service user's with particular respect to rural and urban issues;
- that access to and delivery of the service is done in such a way to reduce the risk of any stigmatisation occurring (this is important in helping individuals to overcome any reluctance in accessing services);
- that information and advice is presented in a very clear and accessible manner in the appropriate format and language;
- that service delivery and information is jargon free;
- that the information and advice given meets the needs of the service user;
- that the information and advice given enables people to access appropriate services to meet their holistic needs.

6 Methodology

Information and advice services can be delivered in a number of different ways as detailed above. The current known options from the background research are set out below with a summary of advantages and disadvantages to enable planners and commissioners to make their own judgement regarding appropriate service design for their circumstances.

Service Style	Advantages	Disadvantages
fixed office with staff and leaflets	Provision of staff on site can be useful in that service users can discuss the material available with a member of staff to ensure they are getting all the information they need	◇ Area that the office can cover is confined to a geographical location ◇ Also some service users may have access issues in respect of travel, in particular those living in rural areas
fixed office as above but also computerised information	This enables people to follow a line of enquiry at their own pace and means it is, theoretically, easier to keep information updated	◇ Some people may not be computer proficient ◇ Again the issues of access could be a problem ◇ The technology can be expensive to install, set-up and maintain
leaflets available in many contact points	Much wider distribution then having leaflets in one specific place. Possible venues include health centres, A+E, custody suites, supermarkets, libraries, council and health offices, etc	◇ Ensuring that the targeted client group are able to receive leaflets ◇ Need to ensure that information is accurate. This can be time and resource consuming ◇ There are the potential expenses in having to produce new up to date leaflets and ensuring distribution

Service Style	Advantages	Disadvantages
internet service	Offers neutral and confidential service that service users can freely access without having to give out personal information and in complete privacy Websites in general are cheap to maintain once set up, easier to update and maintain information therefore, greater relevance	◇ Not everyone has access to the net, nor is everyone computer proficient ◇ Can be a problem with ensuring that the advice is valid and not only in support of one particular approach ◇ Ensuring the age appropriateness of material across the possible spectrum of service users
telephone	In relation to service users confidentiality offers a complete neutral and unbiased service	◇ Need for staff who are able to deal with specialist needs. ◇ Issue of what time to run the service eg 24 hours or during peak times ◇ resolving the issue of call charges - should the number be freephone or not?
travelling service	Would offer a face to face contact point in which the issues can be discussed and appropriate services offered. This would be particularly appropriate for service users in rural areas	◇ Cost of such a service, in terms of initial set up cost and then maintenance costs
texts to and from mobiles	Presents a relatively cost effective way of reaching and providing service users with information	◇ Requires service users to submit information which some may not want to due to confidentiality eg telephone number
television/ radio advice	Much the same way as the internet, this presents a way to give service users advice on the topic, and also a follow-up number or website	◇ Cost of such a campaign often limits it to the sphere of national government funded initiatives
combined service	This is the model seen in England and Scotland where a website runs alongside a helpline. This offers a number of different entry levels and a range of approaches that should suit all. It ensures an integrated, consistent and objective approach	◇ There may be issues in linking the information to local resources and services. It is also difficult to provide information on the wraparound services though these can be signposted or dealt with on the helpline

Service Style	Advantages	Disadvantages
education and presentations	Such a model exists in the All Wales Core Schools Programme, and has potential for wider application. This method presents a way to provide service users with information on the dangers of substance misuse, and also as a way to deal with enquiries and to distribute advice and information on services	◇ Issues of confidence amd confidentiality, some users may not attend due to this. The presentational and educational talks would need to be promoted as a neutral event where the aim is to provide advice and information but not to criticise

7 Special Requirements

Local authorities and services are obligated under the Equality Impact Assessment (EIA) to make sure they do not discriminate and where possible that they actively promote equality. As part of the EIA an assessment of potential needs should be carried out. Some of the key groups as outlined in the EIA within an information and advice context can be seen as:

7.1 **Young People:** Young people are a particularly difficult specialist area as a number of issues crop up. There is firstly the issue of confidentiality, young people may not wish their parents to be involved or to know. Secondly a young person may feel embarrassed or afraid of the situation. The service needs to overcome this by providing an inviting and secure environment in which young people can get the information they need.

7.2 **Minority and Faith Groups:** There are a number of cultural aspects which should be taken into account when designing and delivering services. This is particularly an issue when dealing with language issues. Service users that have particular faiths will need to be dealt with as any other people, but services should avoid having any central religious bias in their approach. There will need to be sensitivity about any particular faith needs or restrictions. Language as well needs to be overcome with at least alternative language leaflets being available or interpreters on hand.

7.3 **Rural Groups:** There can be serious issues of how people can access the service. Service users in remote rural areas without their own transport or regular public transport would be unable to regularly go to service offices to collect the information they need. In addition rural communities can become isolated and advisory services need to reach out to these communities. Rural living can have its own set of stresses and these need to be dealt with (Buchan, 2002 and Boulanger *et al* 1999)

7.4 **Physical Disability:** As defined in the Disability Discrimination Act 1995 (DDA), a disability is a physical or mental impairment that has a long-term or substantial effect on a person's ability to carry out day to day tasks. There are some

8.5 million people in the UK who have some form of disability. Examples of physical disabilities include, eyesight, hearing, mobility and cognitive. All of these will require particular attention depending on the local incidence.

7.5 **Visual Impairment:** This includes people with vision problems ranging from impaired vision to no vision. This is particularly an issue when relying on web or leaflet based advice services. Leaflets and information would need to be available in Braille, large print and clearly laid out. In relation to web pages, those with no vision can use screen readers, whilst those with impaired or poor vision can utilise zoom or browser settings.

7.6 **Hearing Impairment:** As with eyesight this can range from impairment to complete deafness. This is particularly relevant when dealing with telephone communication or face-to-face consultation. With regard to face-to-face consultation sign language can help to overcome this barrier. Whilst in terms of phone lines text phones can be used so that service users can type messages and receive messages back in such a format.

7.7 **Cognitive Disabilities:** This can include disabilities such as learning disabilities and dyslexia. Learning disabilities can range from someone who has a low level mental impairment to more common factors such as poor literacy or difficulty in using computers. The use of graphics and easy to understand wording is one of the easiest and simplest ways to ensure that information is easy to access. In addition a simple and easy to follow layout for web pages will be of benefit to those with poor IT skills.

8 Service Specification

The table **opposite** *(originally said 'below' - this will need to be changed in Welsh)* sets out the essential components for each service style as already outlined. The service styles listed are based on the identified research as are the other factors such as the special requirements. It should be noted that this is a not a comprehensive list and planners and commissioners may wish to add other components.

Service Style	Essential Components			
	Location	**Staff**	**Special Equipment**	**Literature**
fixed office with staff and leaflets	Fixed to a geographic location such as city, town or village	Person Specification: Staff that are able to deal with service user enquiries and any particular information needs that service users may have. Staff will need to have a good knowledge of available services as well as of substance misuse issues Qualification: Staff should be trained in all aspects of customer care. No particular qualification predicated though some NVQs available in customer care linked to service industries	Relaxed, comfortable but smart environment in which to offer service. This should encourage those people who do not want to have contact with staff to come in and browse	Leaflets and information pamphlets on hand for service users to take away across both specialist substance misuse issues and services and other general life issues and services
fixed office as above but also computerised information	Fixed to a geographic location such as a town or village	Competent staff as above but also who can assist service users in using the computer points. May need additional training on IT issues	Computerised information system that is easy for service users to interact with and acquire the relevant information they need	Leaflets and information pamphlets on hand for service users to take away
leaflets available in many contact points	Should be distributed across geographical areas covered by the service	Staff needed to take leaflets to distribution points. Managers able to negotiate access to sites for leaflets. Access to a person with graphic design skills would be helpful	Either an external printing service is used or the service will need printing equipment	Leaflets containing accurate and up to date information. These need to be easily read by people from all educational backgrounds

Service Style	Essential Components			
	Location	**Staff**	**Special Equipment**	**Literature**
internet service	Central hub at office and website with easily accessible design	At the very least one IT trained person to maintain and update the service	A computer that can serve as a central router. Any design should be tested for accessibility and information suitability on a regular basis. It will need to be regularly reviewed and updated	Some marketing of the service through leaflets or cards can be useful in ensuring awareness of the existence of the service
travelling service	This may either be a travelling vehicle fitted out to be able to deliver literature and face-to-face information and advice service or a mobile display that can be moved from location to location	The staffing requirements are very much as above with the addition that the individual will need the appropriate driving licence. Lone working may also be an issue here	An appropriate vehicle, display equipment and information resources. There may be opportunities to undertake this with other sectors information services. Privacy and a non-stigmatising approach are important (any signage would have to be carefully done)	Leaflets and directories containing accurate and up to date information. These need to be easily read by people from all educational backgrounds

Service Style	Essential Components			
	Location	**Staff**	**Special Equipment**	**Literature**
telephone	A dedicated, freephone telephone line manned to agreed hours determined by demand and, realistically, by available funding. It must be clear that this is an information service and not a counselling service	Person Specification: Staff that are able to deal with service user enquiries and any particular information needs that service users may have. Staff will need to have a good knowledge of available services as well as of substance misuse issues Qualification: Staff should be trained in all aspects of customer care. No particular qualification predicated though some NVQs available in customer care linked to service industries	A dedicated phone line for service users with information and advice queries	Phone numbers should be made aware to service users either via leaflets or through websites, other services etc
texts to mobiles	This would normally be in response to a query although people may wish to sign up for a regular update service	The staffing requirements are very much as above together with a need to be up to date on texting mechanisms and language	Texting equipment possibly linked through a computer system rather than individual telephones	Text numbers should be made aware to clients either via leaflets or through websites, other services etc
education and presentations	Local venues such as town halls or schools, or within the service itself	Can vary and depends on presentation. Staff need to be trained in customer care and able to clearly present information	Presentation equipment and leaflets for distribution	Leaflets for distribution

9 Working with Non-Specialist Services

9.1 A key aspect of the provision of information and advice is to ensure the widest possible distribution of materials and information. This means that service planners, commissioners and providers need to work with non-specialist services to ensure that they are aware of the available services and have access to appropriate materials and information. Links will need to be made with Health Promotion Wales, existing schools programmes and criminal justice services to coordinate the provision and delivery of information resources.

9.2 There are other key areas where information should be available. These include:

- accident and emergency services;
- police and court buildings;
- educational establishments;
- libraries;
- local authority buildings;
- general practitioners/health centres;
- other health related services eg dentists.

This information should be available through a variety of media including:

- leaflets/pamphlets;
- posters;
- cd-rom.

9.3 It is imperative that links are made with the relevant organisations to co-ordinate arrangements for the delivery of information and advice that is reciprocal and enables substance misuse agencies to have access to information resources for non-specialist services. This may include the development of reciprocal arrangements for referral to services.

10 Accessibility

10.1 Information and advice services must have no restrictions regarding the types of people accessing them and have no restrictive criteria for access. These must be open access services suitable for all people and potential issues.

10.2 Where possible, services should be easy to access. This should include:

a. for services with a physical base:

- an easy to find location;
- the location to be accessible via public transport;
- easy access for people with a physical disability;
- a discrete appearance;
- a well maintained interior;
- the option for private consultation.

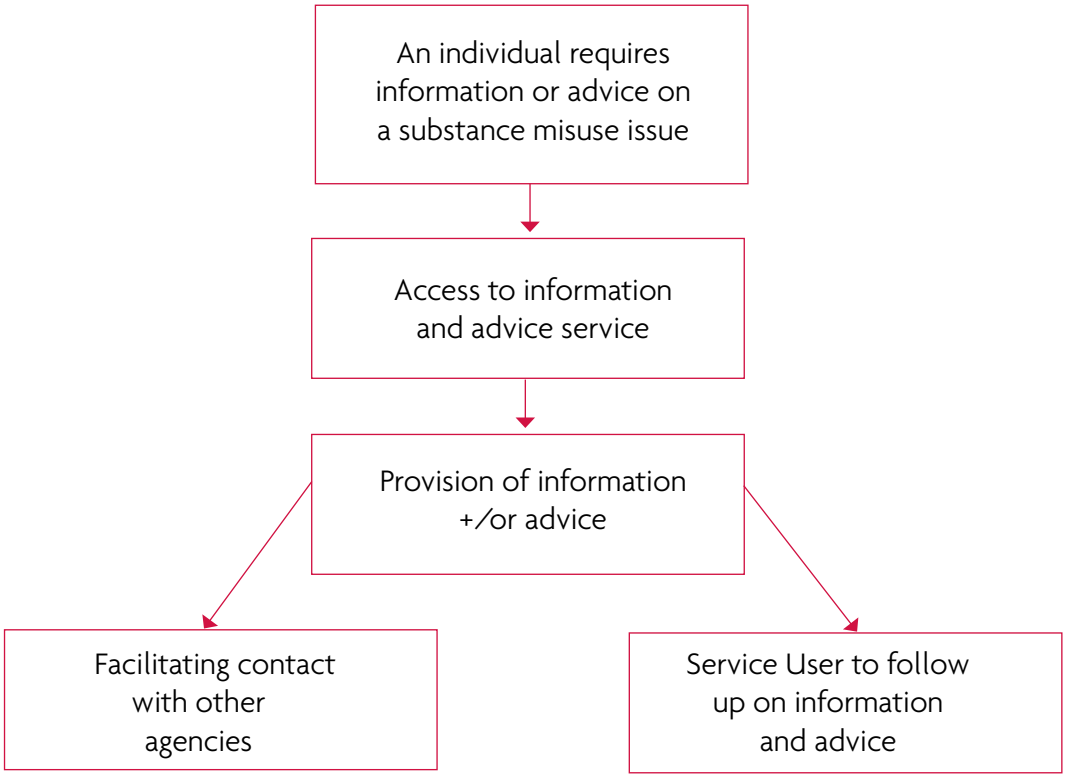
b. internet services:

- a regularly maintained and up to date website;
- a website that is easy to access, coherent and clear in its presentation of information;
- the web address is widely advertised ensuring that clients are aware of it Provides clients with links to other services and phone numbers.

c. telephone services:

- a dedicated telephone line(s);
- the number to be widely advertised.

10.3 A probable care pathway for the delivery of information and advice services is:



11 Standards and Monitoring

11.1 This Module can only set out standards for services delivered through specialist substance misuse services and not for those other services such as housing and benefit information and advice services. In respect of these any issues regarding the standard of service delivery would have to be dealt with through established links.

11.2 The following standards should be applied to the delivery of information and advice services:

a. Service and Commissioning Standards

No.	Standard	Monitoring Methods
1.	Competent and fully trained staff	Matching against National Standards and organisations job descriptions (see below)

No.	Standard	Monitoring Methods
2.	Information must be up to date and reviewed and updated regularly	Regular review of material against changes to service specifications and outlook of services. There will need to be effective change notification systems
3.	The setting of clear, focussed key objectives, that relate to the service requirements set out here, as part of the organisation's mission statement	Matching of achievement against objective. Annual reviewing and updating
4.	Service users must be able to access and find the information they require to: a) enable them to make informed decisions about their lifestyle b) enable them to make informed decisions about their treatment options c) enable them to take action to resolve other life issues not directly related to substance misuse	Annual customer satisfaction review
5.	Service users should be able to access complete information about services including accessibility, service criteria, service type as well as information about self-help and advocacy groups	Annual audit of information and annual request for updated information from local services
6.	Service users must be able to access and find the information they require in a manner that is: a) age appropriate b) takes account of any barriers that might exist (eg rurality, disability) c) is easy to access	Annual customer satisfaction review
7.	Information and advice services should be available both during and out of normal office hours	Annual customer satisfaction review Monitoring of service opening times
8.	Services must be responsive to changing technologies and service delivery opportunities to ensure that they are available and appeal as widely as possible	Commissioners and providers to review at least annually

b. Staffing Standards

The following Drug and Alcohol National Standards may be used to identify required staff competencies and skills and utilised for training and development:

Code	Title
AA1	Recognise indications of substance misuse and refer individuals to specialists
AA3	Support individuals to access and use services and facilities
AA4	Promote the equality, diversity, rights and responsibilities of individuals
AA5	Interact with individuals using telecommunications
AA6	Promote choice, well-being and the protection of all individuals
AD1	Raise awareness about substances, their use and effects
AD4	Develop and disseminate information and advice about substance misuse, health and social well-being

12 Management, Administration and Commissioning Standards

12.1 Service providers will need to ensure that there is sufficient management and administrative support to aid the proper delivery of information and advice services. If the service is part of a larger substance misuse service then their needs to be sufficient resources dedicated to the management and administration of the information and advice service. The administration of such services can be time intensive in respect of ensuring that information is contemporary, distributed as required and relevant links maintained.

12.2 It is recommended that the service is clear regarding its aims and objectives. One method of this is through having a clear mission statement. Within this mission statement the role of advisory services can be clearly defined. This would then allow sufficient allocating of staff and resources to the advisory service, especially if the service also provides interventions or consultations.

13 Future Developments

13.1 As technology advances and becomes cheaper, planners and commissioners will need to ensure that they are positioned to take full advantage of these developments as they arise. This may include such things as video links or an increasing use of online media would make a number of services available. Video linking would allow for face to face consultation without the need for staff or service user to leave their respective areas helping to overcome rural and access issues as well as maintaining privacy.

13.2 Already on the web we see the integration of advertisements for advisory services, such as FRANK, on web pages. The increasing availability and numbers accessing the net will enable such “adverts” to be employed on a greater scale and across a greater range of clients. In some sense providing non-geographically fixed advisory services. In the long run such online services as already mentioned would be more cost effective, though the issue of quality control still remains. There is

a need to ensure that service users are being provided with clear and accurate information. Methods such as those discussed in the standards and monitoring will help to ensure that service users are well informed. From the 1st September 2006, Wales' first national helpline, which seeks to provide 24 hour advice to substance misusers and anyone seeking advice or information, was established. In addition the helpline will enable service users access local treatment and support services (www.cais.co.uk.org/pages/newsinformation/dan.htm). At this time DAN exists purely as a phone line with no supporting or allied website.

13.3 Some of these technologies already exist and it is important that services are as attractive and accessible to people of all age groups as they can be.

13.4 In addition the exact defining of information and advisory services needs to be clearer and agreed. The information and advice field is a very large one and in the this module considers only a number of the aspects of the information and advice field relevant to the particular delivery of information and advice within the substance misuse sector.

Bibliography

Quality in Alcohol and Drug Services: Organisational Standards for Alcohol and Drug Treatment Services; *Childs, Baker, Armstrong, Morley, Dale-Perara, Hackland and Murray;* Alcohol Concern + SCODA (1999); London

Models of Care for the treatment of drug misusers; National Treatment Agency for Substance Misuse (2002); London

Models of Care for the treatment of adult drug misusers: Update 2006; National Treatment Agency for Substance Misuse (2006); London

Drug and Alcohol National Occupational Standards (DANOS); *Management Standards Consultancy for Skills for Health;* Skills for Health (2005); London

National Archives
www.nationalarchives.gov.uk/ERO/records/ho415/1/dpas/dil2.htm

Understanding problem drug use among young people accessing drug services: a multivariate approach using statistical modelling techniques; *Beckett, Heap, McArdle, Gilvarry, Christian, Bloor, Chrome and Frischer;* Home Office (2004); London

Census 2001 (online report); National Statistics

FRANK annual review 2002-2004
http://www.drugs.gov.uk/publication-search/frank/FRANK-review-0204?version=1

Citizens Advice Bureau
www.citizensadvice.org.uk/index/publications/annualreportarchive/annual-report-2006-html-index/annual-report-2006-html-p-12.htm#page_top

Stimulant Needs Assessment Project; *Farrell, Howes, Griffiths, Williamson and Taylor;* Department of Health (1998); London:

Hepatitis C - guidance for those working with drug users; Department of Health (2001b); London:

Randomised controlled trial of general practitioner interventions in patients with excessive alcohol consumption; *Wallace, Cutler and Haines; (1988), British Medical Journal,* 297, pp. 663-8.

Children Affected by Substance Misuse in the Family: An assessment of the nature and prevalence in the Borders; *Murray and Hogarth;* Borders Drug and Alcohol Team; (2003); Melrose

Support for the Families of Drug Users: A review of the literature; *Bancroft, Carty, Cunningham-Burley and Backett-Milburn;* Univeristy of Edinburgh; Effective Interventions Unit; Edinburgh

Farm Suicide in Rural Wales; Boulanger, Deaville, Randall-Smith and Wynn-Jones; Institute of Rural Health (1999); Newtown

A Cultural and Spatial Analysis of Adolescent Substance Misuse in Rural Wales: Final Report; Buchan; Institute of Rural Health (2002); Newtown

RNIB
www.rnib.org.uk/xpedio/groups/public/documents/PublicWebsite/public_accessibilitymyths.hcsp

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT) and Guidance for Use

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT) and Guidance for Use

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Guidance for Use

The Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT) has been developed whilst considering service user (adult only) and professional needs within the in-depth assessment process. This is in addition to its relationship to the principles of independence, standardisation, person-centred and outcome centred approaches as specified within the guidance for Local Authorities and Health Services 'Creating A Unified and Fair System For Assessing and Managing Care' (Welsh Assembly Government, 2002) and 'The Care Programme Approach for Mental Health Users' (Welsh Assembly Government, 2003).

Throughout the tool and this guidance the term substance misuse when used refers to all substances of misuse including solvents and alcohol etc.

It is assumed within these guidelines that the person completing the in-depth specialist assessment is suitably qualified, competent and experienced to undertake this role. The following guidance notes have been developed to steer the professional through the purpose of each core section and annex (as appropriate) and to provide clarity for use. Each core section and or annex should be completed by the most appropriate trained and educated professional staff. The way in which the questions are phrased within the assessment tool is designed to help you capture information. The way the questions are asked will be in accordance with professional judgement and context.

WIISMAT has been primarily designed as an in-depth assessment tool and therefore is the first stage in the specialists' systematic approach towards providing care. If WIISMAT is used in its entirety it will provide a detailed and in-depth assessment of the service user in relation to their substance misuse. The professional assessor should subsequently use existing care planning and care management documentation.

The WIISMAT has been linked to the Unified Assessment Process (see Appendix 1). This Process is not linear and has five sections within it.

Enquiry	Contact	Overview	In-depth	Comprehensive

There are three kinds of enquiry those for information, straightforward service requests and those leading to a contact assessment. The Contact assessment contains Basic Personal Information, the Seven Key Issues, User and Carer perspectives and 2 further domains. The Overview assessment comprises of twelve domains in total and their relevant sub domains. Should an assessor explore a single domain, then all the sub domains within it should be explored in their entirety.

The in-depth assessment is undertaken by a professional assessor and guided by that professional group's models of practice, experience and context of assessment.

Within a mental health context the Care Programme Approach is prescribed. However this is perceived within practice in relation to the Unified Assessment Process , the WIISMAT will form the in-depth assessment for substance misuse.

Within the Contact assessment phase of the Unified Assessment Process (see Appendix 1), the CAGE assessment tool is recommended (see Appendix 2). This has been modified slightly to reveal an early indication of potential issues in relation to both drugs and alcohol.

Within the Overview assessment phase of the Unified Assessment Process (see Appendix 1), the use of DAST-10 (Appendix 3) is recommended for assessment of drug misuse and AUDIT for assessment of alcohol misuse (see Appendix 4).

In order to complete all information requirements within the Unified Assessment, the practitioner/service should utilise the Unified Assessment and Care Management documentation already developed within their locality to support this in-depth assessment. To do this the practitioner/service must contact their Unified Assessment Process Project Manager.

The WIISMAT is designed in two parts, **PART ONE** contains seven Core Sections and **PART TWO** contains five Annexes. Firstly, you should normally aim to complete PART ONE (Core Sections) normally to be fitted in the first session with the client. Secondly, you should also aim to provide an indication of which Annexes need completion (if any) within subsequent session(s).

It may be possible to complete the core and relevant annexes within one session depending on the complexity of your client.

Services can add, amend or adapt it if required but we would strongly advise items are not deleted.

For ease of reference and to assist in compiling information for the Welsh National Database for Substance Misuse the codes for the Common Dataset are indicated where appropriate (WAG No). The dataset information not included in the tool has been listed at Appendix 5.

Preface

This is a specialist assessment; on occasions patients may not warrant this full specialist assessment if they are unlikely to enter services.

The Preface serves as an introductory section at the beginning of the WIISMAT in addition to an index. The Preface in relation to PART ONE is self explanatory. PART TWO also provides initial guidance especially in relation to the use of the Annexes. A series of questions are posed for the professional completing the assessment. These will ultimately produce an indication as to whether the Annexes need to be completed. If needed the priority order of completion of the Annexes is to be decided by the professional in partnership with the client and noted in the boxes provided.

It may be necessary in the opinion of the professional completing the assessment that some or all of the Annexes need to be completed and acted upon as a matter of urgency. This decision is the responsibility of the professional assessor and should be clearly documented in the comments section provided within the Preface. The professional assessor is required to sign and date the preface.

Part One

Core Section 1: Basic Personal Details

The Service User's Basic Personal Information (BPI) is linked to the core minimum dataset within the Unified Assessment Process (UAP). This section relates to the Enquiry assessment of the Unified Assessment Process. The first question asked within this Core Section will identify whether the client is known to the service. This affords an opportunity to retrieve previous assessments and potentially minimising duplication of this section.

The following codes are listed within the dataset and are only to be repeated within this document if there has been a change in the service provider e.g. from generic social worker to Community Drug and Alcohol Team (CDAT) or in accordance with local policy.

NHS Number

E1 code is the unique identifier allocated to a person by the NHS.

Organisation Code (Code Of Provider)

E2 code used within the minimum data set.

This is the organisation code of the organisation acting as a health care provider.

Local Patient Identifier

E3 code used within the minimum dataset

This is a number used to identify a PATIENT uniquely within a HEALTH CARE PROVIDER. It may be different from the Patient's case notes number and may be assigned automatically by the computer system. This is PERSON IDENTIFIER TYPE. Classification 'Local Patient Identifier ('PAS' Number)' for a PERSON IDENTIFIER.

Local Authority Code

E4 The identifier of a Local Authority within the UK.

Case Number

E5 Unique number assigned to a person when they are formally recognised as a social service user and have a case open for them.

E72 Person Name (Care Manager or Co-ordinator) This is the PERSON NAME where PERSON NAME TYPE classification is 'Preferred Name' of the Care Manager or Co-ordinator. NAME FORMAT CODE indicates whether it is a PERSON NAME STRUCTURED or PERSON NAME UNSTRUCTURED. Identifies the contact details for the person's care manager or care co-ordinator.

Core Section One asks for information on domiciled children or vulnerable adults, in addition to children or vulnerable adult(s) with whom the client has significant contact. The professional assessor must consider the need to refer to social services for a holistic assessment of a child/children's and/or vulnerable adult(s) needs. Please also link to the risk assessment in CORE SECTION 6: Sample Evidence Based Risk Assessment.

Domestic Abuse

Consideration has been given to the direct modified questions from Antenatal Routine Enquiry DA1 & The Partner Violence Scale. In this Section the three recommended indirect questions have been included. Also see Section 7 where the four recommended direct questions have been included from the above scale. **These questions should be asked only if the client is not accompanied by a partner.**

Confidentiality and Consent Form

Confidentiality and consent to collect and share information should be sought in accordance with the local Information Sharing Protocol (ISP) and the local Unified Assessment Process documentation and policy document.

Core Section 2: Current Substance Misuse

The professional assessor should explore the current patterns of substance misuse, including length of time they have had the problem and the impact it's having on their life.

In relation to Unified Assessment Process this section should draw on the information gained within **D4.4** *(Disease Prevention. drinking and smoking history)* and **D8.3** *(Mental health. substance misuse)* domains and sub-domains.

Alcohol

This is self explanatory and the professional assessor should use the current advice and guidance available (DoH, 2007) when describing the units of alcohol consumed by the Service User in the last 7 days. In particular the professional assessor should discuss with the Service User the extent to which the individual believes their own alcohol intake is harmful and make a judgment on this from their professional perspective.

Recent History of Substance Misuse

This requires a detailed inventory of the type, amount, route of administration and the length of episode of each substance of misuse. The financial cost of maintaining current use is also explored. The professional assessor may want to consider using the 'Maudsley Addiction Profile' (MAP) or other appropriate tool(s): in addition to the WIISMAT.

Core Section 3: Currently Prescribed Medication

It is important that the assessor records all prescribed medication as well as complementary and over the counter medication. This information will greatly assist a consulting pharmacist or 'prescriber' if you have any concerns regarding recently or currently prescribed medication.

The information in this section should initially be drawn from any data gathered within **D3.3** *(Clinical background, medication use and ability to self medicate)* from within the Overview assessment within the Unified Assessment Process.

Core Section 4: Injecting History (N.B this is not an examination)

The professional assessor needs to take a detailed injecting history from the client including marking on the diagram sites. ***This does not require a physical examination***. It is appreciated that non- health professionals may not be comfortable with asking questions about where on the body the service user is injecting. We suggest therefore that the professional assessor refer to their local protocols for guidance on how to proceed here.

This section further explores risk behaviour in association to sharing of equipment and the possibility of the client having acquired a blood/fluid borne virus as a result of this behaviour. Specific guidance is given within this CORE SECTION, however please note that the nature of some of these questions can be perceived as intrusive and the professional assessor should be sensitive to this. If the client has not been tested for blood/fluid borne viruses and a test is requested or being considered extreme caution and sensitivity should be observed and counselling offered or sought as per local guidelines and policies.

With regard to the Unified Assessment Process, the professional assessor should consider the information which may have already been gathered within **D4.3** (Disease prevention. History of screening); **D5.4** *(Personal care and wellbeing. Skin care);* **D10.2** *(Safety. Personal safety);* **10.3** *(Safety. Public safety/hazards)* of the Overview assessment.

Core Section 5: Physical & Psychological Health -Interim Assessment

N.B This CORE SECTION contains a number of very sensitive questions, in particular questions 5.11 and 5.12. Indeed all questions in this section must be approached in a sensitive manner. ***If you doubt your competency in asking these questions or you feel its too early in your therapeutic relationship with the client, please take advice from your supervisor and/or refer to local polices and guidance.***

This CORE SECTION serves as an interim assessment only. If a more detailed physical and psychological assessment is indicated following this assessment then the professional assessor is advised either to complete or make arrangements for the completion of Annexes B & C in addition. The professional assessor needs to take an interim history of both the service user's past and current psychological and physical health status including recording any disease or illness acquired through misusing drugs and alcohol.

Question 5.9 Is an opportunity to explore pregnancy status with the client and establish collaborative relationships with maternity and peri-natal services.

Question 5.11 Please ask this question sensitively and link any summary conclusions to the risk assessment at section 6.

Question 5.12 The professional assessor is prompted to consider whether to ask a question around issues of abuse which the client may have experienced. Many clients may never feel comfortable enough in any relationship whether therapeutic/professional, personal or otherwise to disclose the type of information asked here. The professional assessor must think very carefully about approaching this area with the client at all. The question is phrased as sensitively as possible but the wording and how/when the question is asked will need to be judged by the professional assessor. *It may be likely that this will not be an appropriate area to explore in the first or subsequent meeting(s). However, if the issues are raised by the individual then the professional should be prepared to respond appropriately*.

The professional assessor must consider the impact that such knowledge and discussion with the client in this context will have on them as practitioners. Consequently, they must have access to appropriate supervision.

Consideration should be given to any scales previously used within these domains to 'signpost' a service user's problem or need relating to substance misuse. In addition to this, any other medical, psychiatric problems or needs the client may have, should also be recorded and explored.

With regard to the Unified Assessment, consideration should be given to the information drawn from **E29** *(Mental Health Status)* and *domains such as* D3 *(Clinical background);* **D4** *(Disease prevention);* **D5** *(Personal care and physical wellbeing);* **D8** *(Mental health)* within the Overview assessment.

Core Section 6: Sample Evidence Based Risk Assessment

A risk assessment is compulsory for all service users. However, we recognise that there are a number of existing risk assessment tools in use within organisations which the professional assessor may required to complete. This risk assessment tool represents the minimum amount of information required by the Welsh Assembly Government and in the context of substance misuse services. Should you be required to use an alternative tool then please ensure that it includes the minimum amount of information as represented in CORE SECTION 6 (Sample Risk Assessment Tool).

A risk management plan is an expected consequence of this or any risk assessment tool.

In particular please note that section 6.7 refers to risk of harm to children and vulnerable adults. Professional assessors should be alerted to any evidence that a child or vulnerable adult's health or development is currently or likely to be impaired. The professional assessor must also be alert to identifying any current or potential risk of children or vulnerable adult(s) suffering significant harm. See also CORE SECTION 1.

If there is evidence of a risk of significant harm to any child or vulnerable adult a referral must be made to social services without delay in accordance with local child protection procedures and/or Protection of Vulnerable Adult Procedures (POVA). Professional assessors should be familiar with and act in accordance with the Guidance in Safeguarding Children Working Together under the Children Act 2004, particularly the section on substance misuse, and also the core standards set out in the National Service Framework for Children, Young Children and Maternity Services, particularly standard 5 Safeguarding and Promoting the Welfare of Children and Young People.

Guidance on how to complete and score the risk assessment tool is contained within the document. This risk assessment tool has been validated for use within England and has been adapted by the authors of WIISMAT without compromising its reliability and validity. In this risk assessment tool if the answer is yes this indicates a positive score.

NB Shaded areas indicate objective statements and you may need to verify information from other sources if possible.

Questions in BOLD and underlined *emphasise the risk factors towards children and/or vulnerable adults.*

Statements in ITALICS and underlined *indicate factors the professional assessor observes.*

With regard to the Unified Assessment, consideration should be given to information already obtained within ***E*** *(Enquiry) and* ***D10*** *(Safety).*

Domestic Violence

NB. Questions in bold with an Asterix

These questions/enquiries indicate high potential risk to children or vulnerable adult(s). Due to the nature of the questions/enquiries, it is considered imperative to respond by urgently discussing them in a multi-agency context and/or taking immediate action, based on professional judgment. Throughout the risk assessment a numerical value to most questions has been offered, however in these questions/enquiries (6.2.1a; 6.2.6a; 6.2.7a; 6.2.10a; 6.2.11a) a response in the affirmative must be regarded as a serious and immediate threat to the welfare of those involved. Immediate action should be taken to engage appropriate safeguards

Core Section 7: Forensic History

Please record here details of all offences in a chronological order with the most recent listed first and outcomes of the criminal justice system. It is important to specifically note those that have been a direct result of the person's drug and alcohol problem. Please consider information gained in CORE SECTION 6 (Sample Evidence Based Risk Assessment) and Annex E (Family History).

Consideration has been given to the direct modified questions from Antenatal Routine Enquiry DA1 & The Partner Violence Scale. In Section 1 the three recommended indirect questions have been included. However, Section 7 deals in a more direct way with domestic violence by incorporating the four recommended direct questions from the above scale.

With regard to the Unified Assessment, consideration should be given to information already gained in **E30** (Legal status), **D9** (Current Risk) and **D10** (Safety), D11 (Family History, impact of domestic abuse on child's health and development). Please record if the client has a history of domestic abuse and explore details. This is specifically related to **D10.1** (Safety abuse and neglect- risk assessment).

Part 2

Annex A: Motivation and Self Concept

The aim of the section is to explore the service user's motivation for changing their current pattern of drug and/or alcohol misuse. This includes the reasons that might be preventing the person from changing behaviour and how their self concept and motivation may be exacerbating the situation. Assessors should consider using a model of change such as Prochaska and DiClemente (1983).

With regard to the Unified Assessment, consideration should be given to information already gained in **D1** *(User's perspective)* but use it to gain the in-depth information required.

NB. You may consider completing 'The readiness to change questionnaire (RTCQ)'in the context of both drug and alcohol (Rollnick et al, 1992) or any other appropriate, relevant and validated tool.

Annex B: Psychological Examination/Observation

These must be conducted by a doctor or other appropriately trained, educated and competent staff such as Nurse Consultants, Nurse Practitioners, CPN, or those with Advanced Practice Skills and in line with local Clinical Governance protocols.

It is recommended that the assessor completes a 'Mini- Mental State Examination' which is included for your use in addition to any other appropriate scales agreed within your locality.

Annex C: Physical Examination/Observation

These must be conducted by a doctor or other appropriately trained, educated and competent staff such as Nurse Consultants, Nurse Practitioners, CPN, or those with Advanced Practice Skills and in line with local Clinical Governance protocols.

It is recognised that this format for the physical examination may not be concomitant with the professional assessor's model of physical assessment. However, the information asked for in Annex C is the minimum amount of information required by the Welsh Assembly Government.

Annex D: Social Inclusion Issues in Relation to Drug and/or Alcohol Misuse

This section is broken into subsections requiring the assessor to explore and ask questions on social issues over an above those within the Overview domain of the Unified Assessment Process and specifically in relation to their substance misuse.

With regard to the Unified Assessment, consideration should be given to information already gained in the appropriate Domains and sub-domains, see some suggestions below. The headings within Annex D are:

- **Housing**
  *Link to **D5.5** (Personal care and physical wellbeing. mobility in and around the home); **D5.6** (Personal care and physical wellbeing. climbing stairs); **D6.9** (Activities of daily living. ability to make choices and have control over environment); **D11.3** (Instrumental activities of daily living. heavy housework); **D11.4** (Instrumental activities of daily living. keeping warm); D11.6 Instrumental activities of daily living. care of the home); D12 (Immediate environment and resources.)*
- **Employment**
  *Link to **D12.4** (Immediate environment and resources. work, education, learning and participating in community activities).*
- **Benefits**
  *Link to **E6** (National Insurance Number); **D12.2** (Immediate environment and resources. level and management of finances and need for benefits advice).*
- **Education**
  *Link to **D12.4** (Immediate environment and resources. work, education, learning and participating in community activities).*
- **Mobility**
  *Link to **E31** (Disability Registration); **D5.5** (Personal care and physical wellbeing. mobility in and around the home).*
- **Driving**
  *Link to **D12.5** (Immediate environment and resources. transport needs).*

Annex E: Family History

This is an extension of the information provided within the Contact and Overview documents. It specifically asks about relevant drug and alcohol problems in any family member. It further explores the information on the service user's current support systems/networks provided by family and friends.

With regard to the Unified Assessment, consideration should be given to information already gained in **D2** (Carer perspective and need for carer assessment; **D9** (Relationships).

Summary Sheet

The Summary Sheet is the document within which key information is gathered and summarised (with the client) and outcomes of the assessment clarified. Any decisions regarding referral to a relevant professional for further alternative in-depth assessment (e.g. dietetics) should be clearly recorded and communicated to the care co-ordinator in a formal and locally agreed format.

The WIISMAT Summary Sheet provides the link with the Unified Assessment Summary Record which is the minimum amount of information which is currently required to be shared with other professionals or agencies. The professional assessor is reminded that when sharing information between professionals and/or agencies, locally agreed information sharing protocols must be followed and client must be included within this process. The WIISMAT Summary Sheet (when completed) should be kept within the Unified Assessment Summary Record.

NB If any section has not been completed please indicate the reason(s) for this.

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

Preface:

(This information may be found in the UAP Contact Assessment)

Core Section 1 - page Basic Personal Information	**Part One** All core sections must be optimally completed during the first interview with a newly referred client. However, Core Section 1 may be already completed if the Unified Assessment Process has been adopted. These core sections represent the minimum information required within an in-depth substance misuse assessment. These core sections represent the minimum information required by commissioners.
Core Section 2- page Current Drinking or Substance Misuse	
Core Section 3- page Currently Prescribed Medication	
Core Section 4- page Injecting History	
Core Section 5- page Physical & Psychological Health- Interim Assessment	
Core Section 6- page Sample Evidence Based Risk Assessment	
Core Section 7 - page Forensic History	

Part Two

You will need to complete the Annexes below based on the client's needs. They will be completed in an order of priority that is negotiated with the client and influenced by your professional judgment.

The following questions will be considered as part of the core assessment. They are designed to assist you in determining with the client which annexes (if any) will need to be considered either in this first or later interview(s). A 'yes' answer indicates the need to complete the appropriate Annex. Please state order of priority for Annex completion.

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

	Question	Yes	No	Order of priority
Annex A - page Motivation and Self Concept	Have you concerns about the client level of motivation and why they're seeking help?			
Annex B- page Psychological Examination Observation	Have you concerns about the client's mental health?			
Annex C - page Physical Examination/ Observation	Have you concerns about the client's physical health?			
Annex D- page Social Inclusion Issues in Relation to Drug and/or Alcohol Misuse	Have you concerns about the client's social inclusion issues e.g. housing, employment, benefits, education, mobility and driving?			
Annex E - page Family History	Have you concerns about the client's social support structures and the extent of alcohol or substance misuse within these?			
Comments- In relation to urgency of Annex completion pending action.				

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

Core Section 1: Basic Personal Information

1.1 Have you ever had a specialist or in-depth assessment for alcohol and/or substance misuse before? If yes, when and briefly what was the outcome?	
Surname (WAG 2)	Forename(s) (WAG 3)
Other Name(s)	Wishes to be called:
DOB (WAG 4) Age	Gender: M/F (WAG 5)
Ethnicity: (WAG 10)	**Any Allergies:**
Religion:	
Perm. Address Postcode: (WAG 9)	Temp. Address Postcode: (WAG 9)
Tel. No:	Mobile No:
G.P Practice (WAG 87)	Address: (WAG 88/89)
GP. Name (WAG 85/86)	
Tel./FAX No	Post Code: (WAG 90)
EMERGENCY CONTACT:	
Address	Relationship:
	Tel No:
	Mobile No:
NEXT OF KIN	Relationship
Address:	Tel No:
	Mobile No:
Probation Officer: Tel No:	Social Worker: Tel No:
Other key professionals e.g. Solicitor/midwife	Tel No:
Referral route: GP/A&E/Other	National Insurance Number:
Case Number **E5**	Care Co-Coordinator **(E72-E78)**
Local Authority Code **E4 (WAG 8)**	NHS Number **E1**
Organisation Code (Code Of Provider) **E2**	Consent & Confidentiality Explained as per Local Policy Yes/No

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

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Forename (E8)(WAG 3).....

1.2 Please give details of the client's own children, children living in the same household or vulnerable adult(s). Please indicate legal status, relationship to the client, place of residence (if residence order please indicates whether there is an injunction in place) (WAG 13, 14 and 15)

Surname	Forenames	DOB	Legal Status	Relationship (e.g. own child/step child)	If not the name and address of the person the child is living with.
1					
2					
3					
4					

1.3 Please give details of any other child/children or vulnerable adult(s) with whom the client has significant involvement.

Surname	Forenames	DOB	Relationship to client	Name and address of parents
1				
2				
3				
4				

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

The following questions should only be asked if the client is not accompanied by their partner.

1.4 Is everything alright at home?

1.5 Is your partner supportive and caring?

1.6 Will you get plenty of support at home after coming here?

The assessor should consider the appropriateness of referral to social services for a holistic assessment of a child/children's and/or vulnerable adult(s) needs. Please also link to the risk assessment in CORE SECTION 6: Sample Evidence Based Risk Assessment and Annex E.

If there is a positive answer to question 1.4, 1.5 or 1.6 the assessor should ask the direct questions at Section 7.3 - 7.6.

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

Core Section 2: Current Substance Misuse
(Link to **D4.4** and **D8.3**)

Please provide either a Yes/No answer and comment as necessary
2.1 Do you currently have a substance misuse problem?
2.2 What help are you seeking?
2.3 When was the last time you misused substances?
2.4 When did you start using substances of misuse for social reasons?
2.5 When did your misuse of substances become problematic?
2.6 How do you currently fund your substance misuse? (be specific, weekly income and sources)
2.7 When did your substance misuse become a daily occurrence?
2.8 Do you get up in the night to take a relief drug or drink of alcohol?
2.9 Do you need to take drugs or alcohol to start the day?
2.10 Have you had any periods of abstinence from substances of misuse - if so when/how long?
2.11 Please describe your usual day in the context of substance misuse.
2.12 Has your substance misusing pattern changed recently? If yes, how and why?

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

2.13 Alcohol

Units consumed in the last 7 days

For up to date information regarding units of alcohol please visit Dept. of Health http://www.dh.gov.uk/en/PolicyAndGuidance/HealthAndSocialCareTopics/AlcoholMisuse/AlcoholMisuseGeneralInformation/DH_4062199 accessed at 06/09/07

Days	Spirits	Wine	Beer/ lager	Alcopop	Cider	Fortified wine	Other (specify)
Today							
Yesterday							
Day before							
Day before							
Day before							
Day before							
Day before							
Sub Totals							

Comment

Total Weekly Alcohol Units (WAG 47) .....

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

2.14 Recent History of Substance Misuse

Substance Please list the recent and current substances your client has misused in the past month	Please indicate the number of days you have misused in past month	How much do you take on a typical day?	How much do you spend on average per day, per week, or per month	What route do you use to administer the drugs?	Have you experienced any withdrawal problems?	How old were you when you started?
(WAG 25)				(WAG 27)		
(WAG 30)				(WAG 32)		
(WAG 35)				(WAG 37)		
Comment						

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

Core Section 3: Currently Prescribed Medication
(Link to **D3.3**)

3.1 Please list all your current and/or recently prescribed medication*, including both complementary and over the counter medications. (Please use a new line to record any change). (WAG 60 - 63)

Drug Name	What dosage are you taking?	When did you start taking this medication?	When did you stop taking this medication?	Indicate route of administration	How frequently are you taking this medication?	Where are you getting this medication from?
Is the client on medication requiring daily supervised consumption? Explore details						

***Please ensure that you discuss any concerns regarding recently or currently prescribed medication with a pharmacist.**

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

Core Section 4: Injecting History (N.B this is not an examination)
(Link to **D4.3; D5.4; D10.2; 10.3**)

4.1 When did you last inject?

Today	Within last Week (WAG 41)	Within last Month (WAG 41)	Within last 3 months	Within last 6 months	Within last Year	Over 1 year
Comments:						

4.2 How often do you inject?

4.3 What do you inject?

Drug	Preparation (pills, amps, etc.)	Comments
1		
2		
3		

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

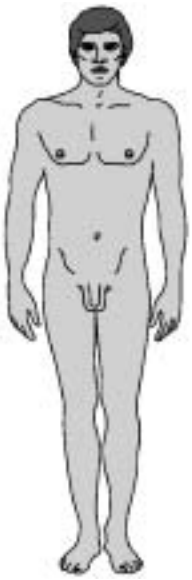
Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

4.4 Which part of your body have you injected in the last month? Please mark diagram with X's. NB. This does not require an examination. However, if possible verbally ascertain the condition of the injecting site(s).

Condition of injecting sites



4.5 Do you have any problems with injecting?

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....

Forename (E8)(WAG 3).....

4.6	Has someone else injected you within the last month?	Yes/No	Comments		
4.7	Do you access to needle exchange services?	Never	Sometimes	Usually	Always

4.8 Have you ever shared injecting equipment (WAG 42) Yes/No

If Yes, when did you last share injecting equipment?

(Please Note: Sharing is defined as anybody else's including your partner's or best friend's injecting equipment, including needles, spoons, syringes, filters and washouts)

Never	Today	Within last week	Within last month	Within last 3 months	Within last 6 months	Within last year	Over a year ago

4.9 Do you use sterilising equipment? Yes/No	Comments **Discourage Sterilisation- Always Use Clean Equipment**

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4.10 Have you been tested/ immunised for Hepatitis A virus? Yes/No	Date	Where	**If yes, Outcome** Immune Yes/No Susceptible Yes/No If no is immunisation indicated Yes/No
4.11 Have you been tested for Hepatitis B virus? Yes/No			**If yes, Outcome** If no is testing indicated Yes/No
4.12 Have you been immunised for Hepatitis B virus? (WAG 49) Yes/No			**If yes, Outcome** When is booster due? Yes/No If no, is immunisation required? Yes/No
4.13 Have you been tested for Hepatitis C virus? Yes/No			**If yes, Outcome** Antibody +ve/-ve PCR +ve/-ve Genotype:- Engaged with services Yes/No Is referral indicated Yes/No
4.14 Have you been tested for HIV virus? Yes/No			If Yes are you willing to disclose your results +ve/-ve/Not Disclosed Is referral indicated Yes/No

NOTE: If the client answers no to questions 4.10 - 4.14 ascertain if they wish to be tested and offer or refer for appropriate counselling in this context- see 'WIISMAT Guidance for Use'.

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Core Section 5: Physical & Psychological Health -Interim Assessment
(Link to **D3; D4; D5; D8**)

Physical Health- Past & current substance misuse related and other.
5.1 Have you had liver disease? Cirrhosis, Hepatitis, Jaundice etc. Yes/No (explore details)
5.2 Have you had any abscesses anywhere on your body? Yes/No (explore details)
5.3 Have you taken an overdose? Yes/No Explore details
5.4 Have you been a hospital patient? (**D3.4**) Explore details
5.5 Have you any other medical problems? For example diabetes, heart disease, respiratory problems, stroke, TB, digestive problems etc. (**D3.1**) Explore details

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Physical Health- Past & current substance misuse related and other.
5.6 Are there any issues which impact on your potential for independent living e.g. walking, personal hygiene, dressing, feeding yourself etc.
5.7 Do you have any sleeping problems? (**D5.8**) Yes/No Explore details
5.8 Have you had any fits or blackouts? Yes/No Explore details
5.9 If female, are you on contraception; Yes/No Might you be pregnant? (WAG 48) Yes/No Explore details
5.10 Do you have any problems with sensation? i.e. feeling pain or touch especially in your legs and feet; do you have difficulty with balance or walking; do you have any new problems with your eye sight. Yes /No Explore details

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Psychological Health (Link to **E29**) (Link to **D1; D9.1; D9.2**)

Past & current

Please read the guidance notes before attempting to ask the following two questions

5.11 Have you had thoughts of harming yourself?
If so, have you tried to harm yourself and/or attempted suicide? Yes/No
Explore details

Approach this question with great sensitivity and at an appropriate time within the consultation. Do not ask the question until you read and fully consider the 'WIISMAT Guidance for Use'.

5.12 Are you able to tell me whether you have experienced any form of abuse and/or trauma as a child? Yes/No
Explore details

5.13 Have you suffered from depression?
[Consider the use of an appropriate scale e.g. Beck's Depression Inventory (BDI)]. Yes/No
Explore details

5.14 Have you felt very 'paranoid' for a significant period of time e.g. people against you, wanting to harm you, which turned out not to be reality? Yes/No
Explore details

5.15 Have you felt anxious?
[Consider the use of an appropriate scale e.g. Hospital Anxiety Depression scale (HAD scale)]. Yes/No
Explore details

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5.16 Have you had any previous contact with mental health services? Yes/No Explore details
5.17 Have you experienced any problems with your memory? i.e. forgetting new information, names addresses, appointments. Yes/No Explore details
5.18 Do you have at least one hobby or interest that uses some of your time? Yes/No Explore details
5.19 Do you feel energetic most of the time? Yes/No Explore details
5.20 When you wake up in the morning do you generally look forward to the day ahead? Consider again the use of HAD scale as per 5.15. Yes/No Explore details
5.21 Is there at least one person with whom you enjoy a rewarding relationship? Yes/No Explore details
5.22 On a scale of 1 - 10: How much control do you think you have over your substance misuse? (Please circle) 1 (no control) 2 3 4 5 6 7 8 9 10 (total control)

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Core Section 6: Sample Evidence Based Risk Assessment
Harbour Drug & Alcohol Service (2005) R01 Risk Triggers & Assessment of Current Risk. 9/10 Ermington Terrace, Mutley, Plymouth PL4 6QG
(Current Risk/Past Concerns)
(Link to **E; D10**)

Please complete all sections of this risk assessment form. Please score on each category and item if the answer to that item is YES. If the answer is no, it does not get a score. If the resulting score in any category is **0-23**, this is seen as **low risk**, If the score is **24-50** this is seen as **Moderate Risk** and the Care Coordinator should discuss the result with their clinical manager and other key professionals involved in the care of the client. If the score is **51-75** this is seen as **High Risk** and the Care Coordinator should discuss the result with their clinical manager and other key professionals involved in the care of the client. The impact of adult problems and behaviour on children and vulnerable adults should always be considered. Everybody should keep the interest of children and vulnerable adults uppermost and be alert to possible indicators of abuse or neglect. Where there is actual or risk of significant harm to a child or vulnerable adult a referral to social services should be made without delay and in accordance with local multi-agency policies (see guidance notes).

NB. Questions in bold with an asterisk* indicate high potential risk to a child or vulnerable adult and must be discussed in a multi-agency context (See Guidance).

Please refer to local risk assessment, risk management, policy and protocols as appropriate to complete a risk management plan. However, as a minimum they must all cover all the issues identified here.

NB. Shaded sections indicate an area where professional judgement is required and should not be asked of the client/service user directly.

		Past Concern			Current Concern		
6.1 Indicators for Suicide Risk		No	Yes	Score	No	Yes	Score
1	Have you made a previous suicide attempt on your life? How recent?			**12**			**12**
2	Did you use a violent method i.e. hanging, jumping or shooting?			**12**			**12**
3	Do you use recreational drugs? Are you a poly drug user?			**9**			**9**
4	Do you use alcohol to excess?			**9**			**9**
5	Are you having any thoughts of self harm or suicide? Have you previously either intentionally or accidentally taken an overdose?			**5**			**5**

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		Past Concern			Current Concern		
6.1 Indicators for Suicide Risk (cont'd)		No	Yes	Score	No	Yes	Score
6	Have you considered and planned how you would kill yourself?			**5**			**5**
7	Do you believe you have little or no control over your life?			**5**			**5**
8	Are you experiencing a high level of distress/delusion/personal guilt/personal shame/low self esteem?			**5**			**5**
9	Do you feel nothing has changed since your last suicide attempt?			**4**			**4**
10	Do you live alone?			**2**			**2**
11	Are you separated, divorced, or widowed?			**2**			**2**
12	Are you unemployed or retired? Do you have meaningful daytime activity?			**2**			**2**
13	Are you male?			**1**			**1**
14	Are you over 45 years of age?			**1**			**1**
15	Are you in poor physical health?			**1**			**1**
Total							

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		Past Concern			Current Concern		
6.2 Indicators for Risk of Violence/ Aggression		No	Yes	Score	No	Yes	Score
1	Do you have thoughts of harming another person?			**12**			**12**
1a	**Do you have thoughts of harming a child (or children) or vulnerable adult (e.g. an elderly person)?**			*			*
2	Have you ever used a weapon to assault another person?			**12**			**12**
3	Have you had a previous admission to a high security unit (Prison/Special hospital)?			**9**			**9**
4	Have you had a previous admission to a low/medium security unit?			**9**			**9**
5	Is there evidence of being dangerously impulsive to others?			**5**			**5**
6	Is there a history of assault on others, requiring medical attention:			**5**			**5**
6a	**Is there a history of assault or abuse to children or vulnerable adults?**			*			*
7	Has the person threatened physical/ psychological harm to other people?			**5**			**5**
7a	**Were the other people, child/children or vulnerable adult(s)?**			*			*
8	Has the person expressed but not demonstrated aggressive behaviour?			**5**			**5**
9	Has the person expressed paranoid delusions featuring specific individuals?			**4**			**4**
10	Is there evidence (or are there reports) of sexually inappropriate behaviour?			**2**			**2**
10a	**If yes, was that behaviour toward a child/children or vulnerable adult(s)?**			*			*

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		Past Concern			Current Concern		
6.2 Indicators for Risk of Violence/ Aggression (cont'd)		No	Yes	Score	No	Yes	Score
11	Do you have convictions for violent/ sexually inappropriate behaviour?			**2**			**2**
11a	**If yes, was any conviction related to a child/children or vulnerable adult(s)**			*			*
12	Are you aware of any triggers you have which leads to your violent behaviour?			**2**			**2**
13	Do you use recreational drugs? Are you a poly drug user?			**1**			**1**
14	Do you use alcohol to excess?			**1**			**1**
15	Have you refused to take part in treatment to reduce the potential of danger from you to others?			**1**			**1**
Total							

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		Past Concern			Current Concern		
	6.3 Indicators for Risk of Neglect	No	Yes	Score	No	Yes	Score
1	Is your diet and non-alcoholic fluid intake inadequate?			**12**			**12**
2	Are you sharing injecting equipment?			**12**			**12**
3	Do you live in accommodation without electricity, gas for heat, or lighting?			**9**			**9**
4	Are you unable to manage your physical health problems? Do you have any concerns about your sexual health?			**9**			**9**
5	Do you have debts that significantly impact on your life?			**5**			**5**
6	Do you regularly experience financial difficulty? (e.g. to buy basic needs, food etc.)			**5**			**5**
7	Do most of your friends take drugs or alcohol to excess?			**5**			**5**
8	Is the client living in inadequate accommodation?			**5**			**5**
9	Does someone else do your basic food shopping?			**4**			**4**
10	Is the client unable to adequately communicate their needs?			**2**			**2**
11	Are you worried about being evicted or having your home repossessed?			**2**			**2**
12	Do you live with other alcohol or drug users?			**2**			**2**
13	Is the client unable to adequately manage their own personal hygiene?			**1**			**1**
14	Do you have little or no contact with people from your own culture?			**1**			**1**
15	Is the client's accommodation detrimental to their health?			**1**			**1**
Total							

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Assessment of Current Risk
Date of Completion:

6.4 **Risk of Suicide**
☐ Low (0-23) ☐ Moderate (24-50) ☐ Severe (51-75)

6.5 **Risk of Violence/Aggression**
☐ Low (0-23) ☐ Moderate (24-50) ☐ Severe (51-75)

6.6 **Risk of Self Neglect**
☐ Low (0-23) ☐ Moderate (24-50) ☐ Severe (51-75)

6.7 **Risk of Harm to a child/children or vulnerable adult(s) (tick yes or no)**
Yes ☐ **No** ☐

If yes, refer to Child Protection Guidelines and/or Multi Agency Child Protection Handbook/or the protection of vulnerable adult policy (POVA). See Safeguarding Children: Working Together Under The Children Act 2004

This risk assessment combined with any local risk assessment protocols will be used to inform an individual risk management plan for this client.

Signed by ..... Service User

Signed by ..... Professional

Name & Designation of professional completing risk assessment form

.....
(in CAPITAL LETTERS please)

Agency .....

Contact telephone number(s).....

Date completed .....

Line Manager's Signature ..... Date.....

Name & Designation of Line Manager

.....
(in CAPITAL LETTERS please)

Date of review .....

Signature of Professional Completing Assessment(WAG 91).....

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Core Section 7: Forensic History
(Link to **E30; D10)**
Please provide details of any of the following and indicate in your opinion if there was or is a relationship to your alcohol and/or substance behaviours.
(in chronological order) e.g. violent offences, domestic violence, criminal activity (Incl. drug related) or child abuse.

7.1 Does the client have a forensic history? Yes/No
If yes, please complete the box below.

Offence	Date of offence	Sentence	Related to drug/ alcohol use

7.2 Does the client have a history of causing domestic abuse? (D10.1) Yes/No
If yes, please complete the box below.

Approximate Date	Details (related to drug and/or alcohol use)

These questions should be asked only if a positive response has been given to questions 1.4 - 1.6.

7.3 Do you ever feel frightened of your partner or anyone else at home? Yes/No

7.4 Have you been hit, kicked, punched or otherwise hurt by someone within the past year? Yes/No

7.5 Do you feel safe in your current relationship now? Yes/No

7.6 Is there a partner from a previous relationship who is making you feel unsafe now? Yes/No

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Where there is a child/children, vulnerable adult(s) in the same household consider the impact of this history on their safety, health and development. Relate to Core Section 6 (Sample Evidence Based Risk Assessment) and ANNEX E.

Where there is evidence of domestic abuse the key worker is to encourage the client to contact the Domestic Abuse Helpline Number: 0808 80 10 800. Case/Key Worker should also offer to contact the helpline or the local domestic abuse service on behalf of the client.

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Annex A: Motivation and Self Concept
(Link to **D1**- User's Perspective)

A1.1 What were your reasons for starting drug and/or alcohol misuse (why/how)?
A1.2 What are your reasons for continuing drug and/or alcohol misuse?
A1.3 Have you made any previous attempts to change (Self only, GP, AA/NA, CAT, Residential Rehabilitation, other agency)?
A1.4 What are your specific/recurrent causes of relapse?
A1.5 What has or has not helped you in the past? What issues do you think may hinder your progress?
A1.6 What help are you seeking?
A1.7 How do you feel about yourself? (Self esteem may need appropriate scale e.g. Rosenberg Self Esteem Scale)
A1.8 How confident do you feel you are as a person?

N.B. You may consider completing 'The readiness to change questionnaire (RTCQ)' in the context of both drug and alcohol (Rollnick et al, 1992).

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Annex B: Psychological Examination/Observation

This section can be conducted by doctors and other appropriately trained and educated staff such as Nurse Consultants, Nurse Practitioners or those with Advanced Practice Skills and in line with local Clinical Governance protocols and within their competencies. A more detailed mental state examination is desirable, however, B1.1- B1.7 are a minimum enquiries. If AUDIT (Babor et al, 2001) or DAST-10 (Skinner, 1982) have not been considered you may find them (or other appropriate tools) useful in complementing this Annex.

B1.1 Please describe your service user's appearance and behaviour.

B1.2 Please describe your service user's speech.

(Questions to the service user)
B1.3 How do you feel?

B1.4 Are you experiencing any strange or unusual thoughts?
(probe for persecutory ideas/delusions)

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B1.6 Are you experiencing any hallucinations?

B1.7 Why do you think you've been referred for this assessment?

It is recommended that the assessor completes a 'Mini- Mental State Examination' if indicated, especially in alcohol related conditions. It is included for your use and can be used in addition to any other appropriate scales agreed within your locality.

B1.8 **Mini-mental State Examination**

Patient identification_____ Date_____

Necessary materials: Pencil, watch, paper: Signature_____

	Tick for a correct response
1. What day of the week is it?	
2. What is the date today?	
3. What is the month?	
4. What is the season?	
5. What is the year?	
6. Where are we now?	
7. What floor are we on? (upstairs/downstairs)	
8. In which town are we?	
9. In which county/district are we?	
10. In which country are we?	

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	Tick for a correct response
11. I am going to name three objects. After I have finished saying all three, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Apple	
Table	
Penny	
14. Now I want you to take 7 away from 100.	
15. Now take away 7 from the number you get.	
16. Now keep going until I tell you to stop.	
17. What were the three words I asked you to repeat a little while ago?	
18. What is this? (show pencil)	
19. What is this? (show watch)	
20. I am going to say something and I would like you to repeat it after me. "No ifs ands or buts".	
21. I am going to ask you to carry out some actions, please listen to the whole command before trying. "Take this piece of paper, fold it in half and put it on the floor".	
22. Please do this. (Close your eyes).	
23. Write a sentence of your choice on this piece of paper.	
24. Copy this drawing on a piece of paper.	
Total correct	

Signature of Professional Completing Assessment(WAG 91).....

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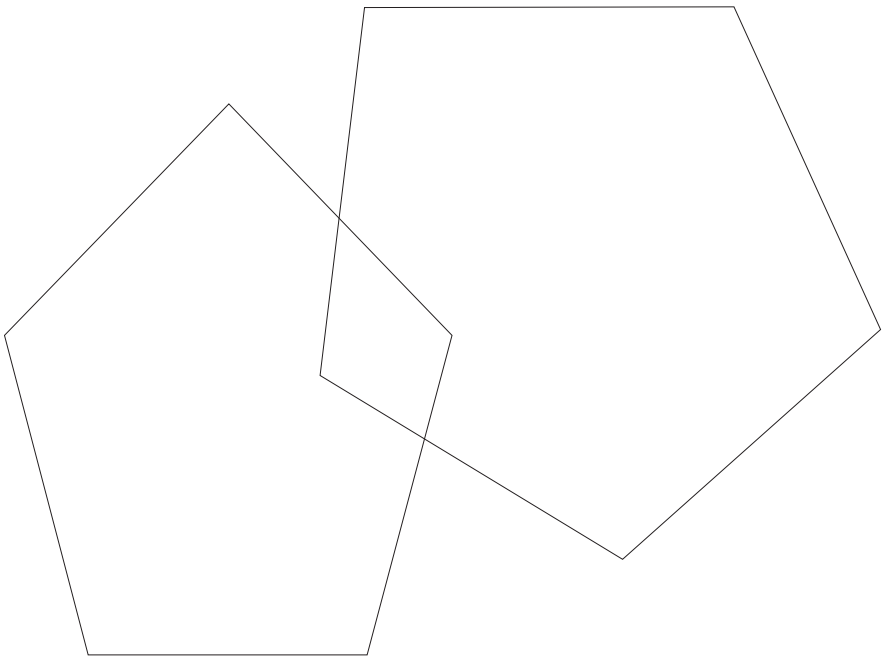

CLOSE YOUR EYES

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

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Annex C: Physical Examination/Observation

This section can be conducted by doctors and other appropriately trained and educated staff such as Nurse Consultants, Nurse Practitioners or those with Advanced Practice Skills and in line with local Clinical Governance protocols.

Please use the continuation sheet to develop your assessment.

C1.1 General Appearance and Behaviour (including intoxication/withdrawal)

C1.2 Height C1.3 Weight (evidence of recent weight loss)

C1.4 Jaundice	C1.5 Anaemia	C1.6 Cyanosis	C1.7 Clubbing	C1.8 Oedema	C1.9 Spider Nevae

C1.10 Track Marks
(sites, number, whether or not compatible with history of recent injection, evidence of poor technique, infection, hazardous sites, etc)

C1.10.1 Bruises	C1.10.2 Injuries		
C1.10.3 Self Harm/Scars	C1.10.4 Deformity		
C1.10.5 Cardiovascular system	C1.10.6 Pulse	C1.10.7 BP	
C1.10.8 Peripheral pulses	C1.10.9 JVP	C1.10.10 Apex	C1.10.11 H.S.
C1.10.12 Respiratory system	C1.10.13 Respiratory rate		
C1.10.14 Lymph nodes	C1.10.15 Trachea		
C1.10.16 Expansion	C1.10.17 TVF		
C1.10.18 Percussion	C1.10.19 B.S.		

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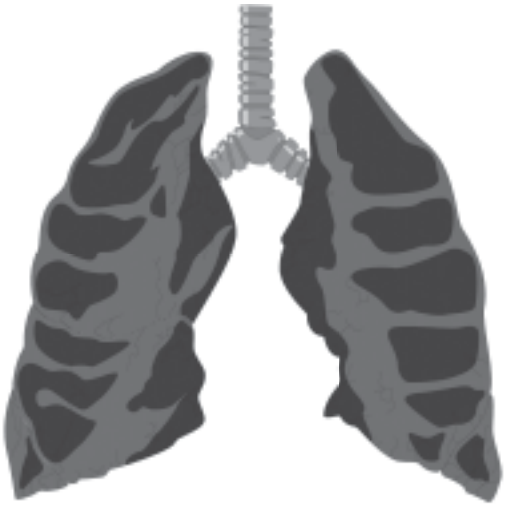
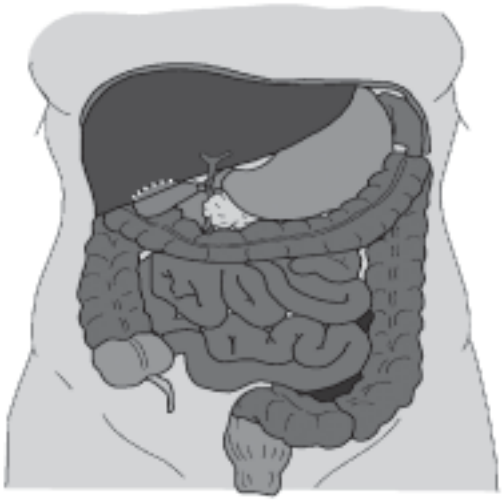
C2 Lungs



C3 Abdominal Examination



C1.30 B.S.
C1.31 P.R.

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C4 Nervous System		
C5 Tone	C6 Power	C7 Reflexes
C8 Coordination (esp. cerebellar signs)	C9 Sensation (esp. peripheral neuropathy)	
C10 Cranial nerves (esp. pupil size, nystagmus and eye movements)		
C11 Urine testing	C12 Result Test 1	C13 Result Test 2
C14 Breathalyser sample	C15 Result	C16 Result
C17 Is there a possibility of you being pregnant?	Yes/No/NA If Yes, explore details.	
Continuation sheet - Any other physical examination not identified above		

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Annex D: Social Inclusion Issues in Relation to Drug and/or Alcohol Misuse
(See suggested links below)

Housing
(Link to **D5.5; D5.6; D6.9; D11.3; D11.4; D11.6; D12**)

D1 Are you homeless or under threat of homelessness? Yes/No	Explore details as necessary and consider referral for specialist housing assessment. If there are children or vulnerable adults involved, also consider the implications for them and any welfare/ safeguarding issues which may need assessment by social services.
D1.2 Are you in receipt of housing benefit? Yes/No	
D1.3 Are you in arrears with your rent or mortgage? Yes/No	

Employment
D2

D2.1 Are you in paid employment at present? Yes/No	Explore details as necessary and consider referral to employment agency/employment training.
D2.2 If no, do you wish to work in the future? Yes/No	
If yes, further details and explore the need for employment assessment. Yes/No	

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Benefits
E6; D12.2

D2.3 Are you in receipt of any benefits? Yes/No	Explore details and consider referral to benefits agency. Also, if necessary consider how the client manages the debt and consider referral to a debt counsellor.
D2.4 Do you need assistance with benefits? Yes/No	
D2.5 Are you in debt? Yes/No	

Education
D12.4

D3.1 Can you read and write? Yes/No	Explore details and consider referral to appropriate service/agencies for adult literacy/community support.
D3.2 Do you have any qualifications? Yes/No	
D3.3 Do you want to explore the possibility of further education/qualifications? Yes/No	

Mobility
(Link to **E31; D5.5**)

D4.1 Are you capable of independent transport? Yes/No	Explore details and consider referral to appropriate service/agency e.g. physiotherapy, occupational therapy, social services.
D4.2 Do you have any physical disabilities? Yes/No	

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

Driving
(Link to **D12.5**)

D5.1 Do you drive? **Yes/No**	Please comment on actions taken.
D5.2 Do you hold a current driving licence? Yes/No The DVLA states **'If you have had, or currently suffer from a medical condition or disability that may affect your driving you must tell the Driver and Vehicle Licensing Agency (DVLA). You'll also need to provide details if you develop a new condition or disability or one that has become worse since your license was issued.**' If the assessor believes that the client whilst driving is a potential danger to themselves or to others, then the assessor must remind the client that both parties have a legal responsibility to inform the DVLA in writing as outlined above and in particular this will apply if a maintenance prescription is in use. Give the client a leaflet regarding fitness to drive. Acknowledge that this has been done. Signature:..... Print Name:.....	

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

Annex E: Family History
(Links to D2; D9)

E1.1 Are you married or have a partner? (including current partner's drug and alcohol use) Yes/No	Provide a client profile statement around these questions.
E1.2 Where were you born/ brought up?	
E1.3 Please give details about your parents (use support network map on opposite page). Yes/No	
E1.4 What is/was your relationship you're your parents (early childhood experience, childhood trauma)? Yes/No	
E1.5 Do you have any brothers and/or sisters? Yes/No	
E1.6 What is your relationship with family significant other? Yes/No	
E1.7 Have you any other relevant relatives/close friends? Yes/No	
E1.8 Are there any relevant drug and alcohol problems in any known family member, including significant others? Yes/No	

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

E1.9 What current support, if any do you have from both family and friends? Yes/No	
E2.0 Are you involved with or caring for children or dependent/ vulnerable adult(s)? Include in support network map overleaf. What is your relationship with them, are they living with you, who supports you to care for them? See also section 1 (1.2 & 1.3).	

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

E2 Please draw a map of your support network. Who's around, who's important?
(Partners, family, friends, professionals, others, pets etc.)
Be creative if you like!

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

Summary Sheet

Part One	**Needs identified from each of the sections**
Core Section 2 Current Drinking or Substance Misuse	
Core Section 3 Currently Prescribed Medication	
Core Section 4 Injecting History	
Core Section 5 Physical & Psychological Health - Interim Assessment	
Core Section 6 Sample Evidence Based Risk Assessment	
Core Section 7 Forensic History	
Part Two **Please indicate (if any) which Annex (optional) sections you have used or intend to use**	
Annex A Motivation and Self Concept	
Annex B Psychological Examination/ Observation	
Annex C Physical Examination/Observation	
Annex D Social Inclusion Issues in Relation to Drug and/or Alcohol Misuse	

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)

Local Patient Identifier (E3)

Surname (E7)(WAG 2).....
Forename (E8)(WAG 3).....

Annex E Family History	
Outcome of Assessment	
Summary of any ineligible presenting needs	
Date of Review	
Client Signature and Date	

N.B. If any core section has not been completed please indicate the reason(s).

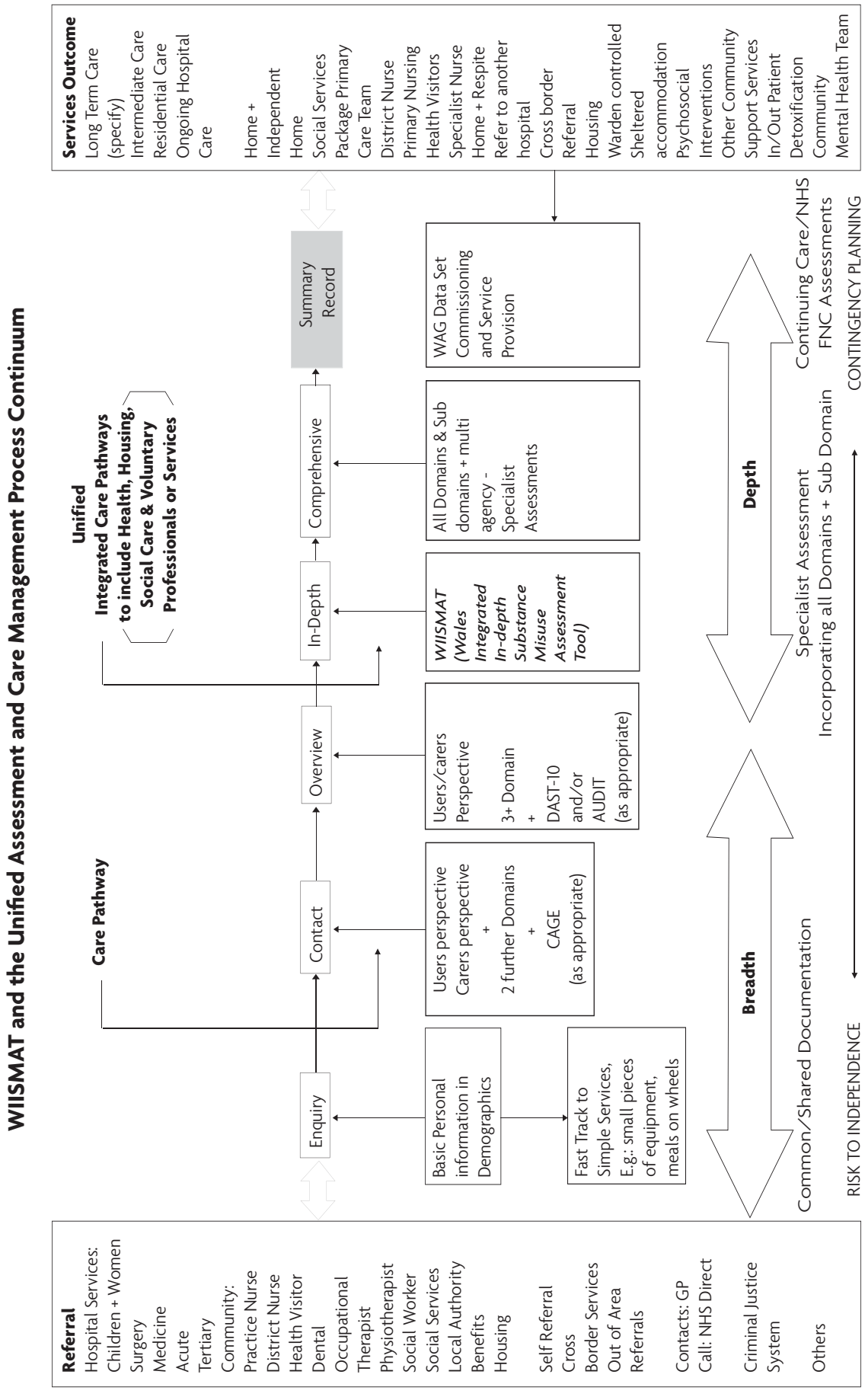
The professional assessor completing this summary is reminded that a care plan and care management documentation in accordance with your local policies/protocols will need to be completed.

Signature of Professional Completing Assessment(WAG 91).....

Print Name.....Date.....

Appendix 1: Care Pathway

This diagram highlights how WIISMAT fits into the various assessment stages of the Unified Assessment Process. It shows a potential care pathway for a service user who is being assessed for a drug and/or alcohol problem.



Appendix 2: Cut down, Annoyed, Guilty, Eye opener (CAGE)

1. Have you ever felt you should Cut down on your drug and/or alcohol use?
2. Have people Annoyed you by criticizing your drug and/or alcohol use?
3. Have you ever felt bad or Guilty about your drug and/or alcohol use?
4. Have you had an Eye opener first thing in the morning to steady nerves or get rid of withdrawal symptoms/hangover?

Scoring: One point for each positive answer

Score of 1-3 should create a high index of suspicion and warrants further evaluation.

Score of 1	80% are drug and/or alcohol dependent
Score of 2	89% are drug and/or alcohol dependent
Score of 3	99% are drug and/or alcohol dependent
Score of 4	100% are drug and/or alcohol dependent

Guidance for use

This tool should be used as a trigger for an overview and/or in-depth assessment. It is for use with a service user who is not known to current health and social care services. It is assumed that through asking the questions associated with the 7 key issues that the service user may indicate drug and/or alcohol use, which may or may not be contributing to their current presenting problem. It is then that this tool may be used by a trained non-professional member of staff during the contact stage.

Appendix 3: Drug Abuse Screen Test -10 (DAST-10)

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to?
4. Have you ever had blackouts or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse ever complain about your involvement with drugs?
7. Have you ever neglected your family or missed work because of your use of drugs?
8. Have you ever engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?

Scoring: Each positive response receives one point. Six or more positive responses indicates a need for the physician to address the problem immediately.

1-2 points = monitor patient and reassess later

3-5 points = investigate substance use further

6-8 points = address the problem immediately

Explanatory notes

This tool is for use during the overview stage and by a professional with or without a substance misuse background. Its purpose is to highlight that a drug problem is present and the service user may need to be referred for an in-depth assessment by an appropriately qualified professional working within a substance misuse service.

Appendix 4

Babor, T.F., Higgins-Biddle, J.C., Saunder, J.B., Monteiro M.G., (2001) The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care. 2nd Ed. http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf . World Health Organisation. Accessed on 24/10/07

Appendix 5 - Substance Misuse Common Data Set Not Included in WIISMAT

Item No.	Data Item	Format/ length
	Personal Details	
1	Agency Code/Practice Code	an6
6	District Area	an30
7	Town	an30
11	Agency Client Number	an15
12	1st Language	an3
	Contact Details	
16	Date of Referral	d10
17	Referral Source	an30
18	Date of Initial Contact	d10
19	Date of Initial Assessment	d10
20	Date of Full Assessment	d10
21	Date Treatment Began	d10
22	Date of Most Recent Contact	d10
23	Date Contact Ended	d10
24	Reason Contact Ended	an40
	Current Problem Profile	
26	Primary Substance Source	an30
28	Primary Substance Frequency of use	an15
29	Primary Substance Age first used	an3
31	Secondary Substance Source	an30
33	Secondary Substance Frequency of use	an15
34	Secondary Substance Age first used	an3
36	Other Substance Source	an30
38	Other Substance Frequency of use	an15
39	Other Substance Age first used	an3
40	Ever Injected	an1
43	Age first Injected	an3
44	Ever Treated Before`	an2
45	Agency Type of first treatment	an30
46	Age at first Treatment	an3

Item No.	Data Item	Format/ length
	Personal Details	
	Health Details	
50	Vaccination Provided	an1
51	Immunity Declared	an1
52	Diagnosed Mental Health Issues	an1
53	Diagnosed Mental Health Issues Description	an30
54	Self-Reporting Mental Health Issues	an1
55	Self-Reporting Mental Health Issues Description	an30
56	Physical Health/Illness	an1
57	Physical Health/Illness Description	an30
58	Other Diagnosed Health Issues	an1
59	Other Diagnosed Health Issues Description	an30
	Treatment Details	
64	Residential Rehabilitation	an1
65	Residential Detoxification	an1
66	Supervised Consumption	an1
67	Formal Shared Care Schemes with GP	an1
68	Structured Counselling	an1
69	Structured Day care Programme	an1
70	Counselling/Support, e.g., crisis intervention	an1
71	Information Only	an30
72	Needle Exchange	an1
73	Referral to Other Organisation Code 1	an6
74	Referral to Other Organisation Date 1	an10
75	Referral to Other Organisation Code 2	an6
76	Referral to Other Organisation Date 2	an10
77	Referral to Other Organisation Code 3	an6
78	Referral to Other Organisation Date 3	an10
79	Referral to Other Organisation Code 4	an6

Item No.	Data Item	Format/ length
	Personal Details	
80	Referral to Other Organisation Date 4	an10
81	Referral to Other Organisation code 5	an6
82	Referral to Other Organisation Date 5	an10
83	Referral to Other Organisation Code 6	an6
84	Referral to Other Organisation Date 6	an10

References

Department of Health (2007)
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/AlcoholMisuse/AlcoholMisuseGeneralInformation/AlcoholMisuseGeneralArticle/fs/en?CONTENT_ID=4062199&chk=J782BY accessed on 24/10/07.

Ewing JA, (1984) Detecting alcoholism, the CAGE questionnaire. Journal of the American Medical Association 252(14): 1905-1907.

Mayfield, D, McLeod, G and Hall, P (1974). The CAGE questionnaire: validation of a new alcoholism instrument. *American Journal of Psychiatry 131: 1121-3.* http://ajp.psychiatryonline.org/cgi/content/abstract/131/10/1121 accessed 24/10/07.

Prochaska J & DiClemente C (1983) Stages and process of self change of smoking: towards an integrated model of change, Journal of Consulting and Clinical Psychology 51:390-395.

Rollnick S., Heather, N., Gold, R. and Hall, W., (1992) Development of a short 'readiness to change' questionnaire for use in brief, opportunistic interventions among excessive drinkers. British Journal of Addiction **87**: 743–754.

Skinner H.A, (1982) The Drug Abuse Screening Test. Addictive Behaviour. 7: 363-371.

Welsh Assembly Government (2002) Creating a Unified and Fair System for Assessing and Managing Care. NHS Wales.

Welsh Assembly Government (2003) Mental Health Policy Wales Guidance. The Care Programme Approach for Mental Health Service Users. NHS Wales.

This document was authored by C Wallace, D Black and A Fothergill of the Welsh Institute of Health and Social Care on behalf of the Welsh Assembly Government."

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Substance Misuse Treatment Framework
Carers and Families of Substance Misusers
A Framework for the Provision of Support and Involvement Consultation Document

Her Iechyd Cymru
Health Challenge Wales

G103/07-08
ISBN: 978 0 7504 4228 2

June
CMK-22-04-030 (083)

Typeset in 12pt

Contents

1. Purpose of Document

This framework seeks both to provide guidance and promote the benefits of involving adult carers and adult family members of substance misusers in the development of policy, and in the design, planning and evaluation of services for these carers. It also seeks to promote their involvement in the development of their individual care plans.

The framework is aimed at adult carers and adult family members of substance misusers, service providers and commissioners within the statutory, voluntary and independent sectors and within the Criminal Justice System.

2. Definitions

The term 'carer' is applied to people who are unpaid and look after family members or friends who are in need of care, help or support. There is not a typical carer, and carers may often not recognise or describe themselves as such but see themselves for example, primarily as parent, partner or friend. (Welsh Assembly Government 2000).

To ensure an inclusive approach throughout this document the term 'carer' will be used in addition to family member and refers to anyone affected directly by someone else's substance misuse and whose aim is to provide support and help to them.

This document is targeted at adult carers and family members. However it is recognised that substance misuse can have significant impact on children and young carers as identified in Hidden Harm (Home Office 2003). Agencies involved with adult service users should be alert to the possibility that there are young carers in the household, and involve children's commissioning and provider bodies where this is appropriate.

3. Background

Carers' issues form an integral part of the national health and social care agenda in Wales. In recent years there has been a growing recognition of the impact that an individual's substance misuse can have on family and friends. The evidence suggests that this impact can be on physical and mental health as well as on financial issues and social functioning (Effective Interventions Unit 2002).

The devastating impact that substance misuse can have on the family and carers is well documented. In "We Count Too" (Adfam 2005) the following four key areas were identified:

- Fear and loss of control.
- Anger and betrayal.
- Guilt and responsibility.
- Shame and isolation.

The precise number of family members and carers that are affected by someone else's substance misuse is not known. It is clear however, that the impact that any one individual can have can be widespread. Velleman and Templeton (2002) suggest that for 'every substance misuser will negatively affect at least two close family members' to the extent that they will require primary healthcare service.

Substance misuse can have a major impact on carers and families as well as to the user. However, it must be recognised that carers and families have distinctly different needs and requirements for support than the person that they are providing support for.

Carers and family members of substance misusers are a diverse group and the stresses or problems that they may experience will be influenced by a number of factors which may include for example their own coping skills and mechanisms, culture and other stresses that they may be experiencing at that time in their life.

There are examples of good practice for both carer and family involvement and service provision but no single blueprint or service model which could be defined as the ideal or most effective. For services and developments to be effective they must be adapted to local need and circumstances and consist of a range of co-ordinated services to meet carers' support needs and offer choice (Department of Health 2002).

3.1 Rationale for commissioning and service provision for carers and family members

Although not specific to carers and families of substance misusers it has long been recognised that carers' health is in general less good than non-carers. A survey carried out in 2001 shows that nearly one in five – 21% of carers in the UK providing substantial care are not in good health compared to 11% of those who do not have caring responsibilities. The survey also showed that the more care a carer provides, the more likely it is that they will be in poor health, particularly if the care provided is over 50 hours a week.

In Wales, nearly 15% of all carers suffer from ill-health with 23.74% – nearly one in four of those caring for over 50 hours a week – counting themselves as being in poor health. Merthyr Tydfil has the highest percentage of all carers suffering from ill-health (18.72%), followed by Blaenau Gwent (18.08%), Rhondda Cynon Taff (17.74%), Caerphilly (17.55%) and Neath Port Talbot (17.45%). For those providing over 50 hours of care per week, over one in four (28.29%) in Merthyr Tydfil, Blaenau Gwent (28.14%) and Torfaen (26.82%) suffer from ill-health (Carers UK 2004).

Carers and family members of people who abuse substances may be difficult to identify and support. Their role may be less visible to those outside of the family or local community and together with issues such as stigma they can fail to access or not be aware of services that may be available to support them.

Research and evaluation identifies a number of positive benefits from the provision of dedicated carer support services for both the carer and user. The benefits for carers are:

- Reduces isolation.
- Increases support for the substance misuser.
- Working towards a shared goal.
- Increased awareness of substance misuse issues.
- Identification and recognition of family and carers own needs.
- Improved communication (Effective Interventions Unit 2002).

Carer and family support can have positive impact on the service users:

- Engagement in treatment.
- Retention in treatment.
- Attainment of successful outcomes (Effective Interventions Unit 2002).

4. Key Principles

The following principles are considered to be fundamental to underpin service developments or initiatives:

4.1 Co-ordinated and quality services

- Avoid duplication.
- Best use of resource.
- Effective.
- Evidence based.

4.2 Consultation and partnership

Involvement and active participation in all levels of policy, planning and reviews.

- Choice.

4.3 Equity of access to services and support regardless of age, gender, race, disability, sexual orientation, religion, culture

- Information.
- Financial security.
- Practical help.
- Recognition.
- Individuals with own rights, expertise and need.

5. Strategic Context

Carers are already recognised as key partners in the delivery of health and social wellbeing agenda in Wales. Both health and social care legislation and guidance, gives carers legal entitlements to assessment and support. Carers of substance misuse users are included in this framework.

Key strategic and policy documents include:

- Carers (Recognition and Services) Act 1995.
- Carers and Disabled Children Act 2000.
- National Health Service Reform and Health Care Professions Act 2002.
- Carers (Equal Opportunities) Act 2004.
- Creating a Unified and Fair System for Assessing and Managing Care ("unified assessment").
- Care Programme Approach.
- Work and Families Act 2006.
- Hidden Harm*. Responding to the needs of children of drug problem users*.
- Fulfilled Lives, supportive communities*. A strategy for social services in Wales over the next decade.* Cardiff: WAG.
- Designed for Life - *A world class health service for Wales.* Cardiff: WAG.
- Carers' Strategy for Wales.

The key priority areas identified for action in the 2000 Carer Strategy in Wales are:

- Health and Social Care.
- Information.
- Support.
- Young Carers.
- Carers and Employment.

The Carers Strategy consultation (Welsh Assembly Government 2006) recommends that the following key objectives for carers should be:

- They are not disadvantaged as a consequence of fulfilling their caring responsibilities.
- They are listened to, treated with respect and receive recognition for the important contribution they make in supporting people to sustain their independence.
- They are able to maintain as normal a life as possible outside of their caring role.
- They have timely access to an assessment of their own needs.
- Have access to services that will enable them to be properly supported.
- Are able to access employment, education and leisure opportunities.

Welsh Assembly Government identify that the refocused Carers Strategy will seek to ensure:

- Better constructive engagement with carers as key partners in the planning and delivery of both health and social services.
- Better assessment and care management arrangements to ensure that people receive timely and appropriate services to meet their needs.

6. Organisational Responsibilities

All organisations with a responsibility for providing services for substance misusers are additionally required to consider carers' needs. Community Safety Partnerships have a lead role in the development and commissioning of services for carers and family members. Community safety partnerships have an overarching responsibility to reduce the harm caused by substance misuse to not just individuals but communities as a whole. This includes the families and carers of substance misusers, whether or not the users are accessing treatment.

There is a growing body of research and evidence which identifies the positive benefits that the provision of dedicated support services for carers and family members can bring to the carer, family member and user. Carers provide invaluable support to those that they care for and this needs to be acknowledged by commissioners and providers to ensure that they can continue in their caring role and that their own needs are not forgotten.

When considering the development of support services for families and carers the key aims should be:

- The health and wellbeing of individual carers.
- The health and wellbeing of family members.
- Family functioning as a whole.

To develop and maintain effective family and carer support services partnerships need to consider potential funding sources. Joint agency and cross boundary working is necessary to ensure a consistent approach and to avoid duplication. A range of support services will be required and these may be from open access to specialist services.

Any developments should be based on local need assessments and will require the development of appropriate service specification and monitoring and evaluation systems.

6.1 Key responsibilities

The following key responsibilities should be considered:

- The needs of carers and families are separate and distinct needs from users.
- Local partnerships have a duty to actively involve carers in their planning processes, without dedicated support this is difficult to achieve.

- For effective carer involvement support services need to be in place for carers and family. Support services should be reflective and use family and carer experience.
- Carers and family cannot simply be fitted into established models of care for substance misuse treatment and there needs to be a clear distinction between support for family/carers and the user.

7. Carer Involvement

7.1 Effective Carer and Family Involvement in Strategic Planning, Consultation and Joint Working

Partnerships and service providers will need to review their current systems to examine how carers can be meaningfully engaged in these systems.

They need to consider:

- How carers can be involved at all stages.
- The use of jargon free language.
- Development of a systematic approach to involvement and engagement.
- Identification of information leaflets etc that carers can both contribute to and benefit from.
- Identification of a range of options to actively engage carers.
- Identification of opportunities to consult and involve carers on specific issues which they may have a specific interest or expertise.
- Provision of feedback on consultations and between national, regional and local meetings.

Sections of the community may be hard to reach and engage. The following documents containing useful information on how to engage carers:

- “We Count Too” (Adfam 2005).
- Challenging the Myth “They look after their own” (Welsh Assembly Government 2003).
- We Care Too, a good practice guide for working with black carers (Powell 2002).

7.2 Supporting carers and families to actively engage at this level

The following indicate some good practice in relation to engagement:

- Carer advocates.
- Focus groups.
- Training opportunities.
- Reimbursement of expenses (needs to reflect national and local policy).
- Buddy system.
- Offering regular feedback about input and involvement.
- Involvement in setting of the agenda and also venue and location for the meeting, and times.

- Setting up carer forums to gather collective information rather than the other way around and agencies go out to these groups.
- Have pre meetings or discuss agenda or consultation questions etc, so that questions can be considered and formulated in advance.

8. Developing Models of Service

8.1 Identifying Need

Local needs assessment and service mapping should underpin any developments and identify priority areas for development. Prior to determining which option makes most sense for the local area, it is important to ensure that full consultation has taken place with key stakeholders.

A range and choice of support services need to be provided from open access to specialist provision. Access to these services will be set by locally agreed protocols.

Service mapping of current provision will provide a useful baseline and identify local services strengths and weaknesses, gaps and possible duplication. Partnerships may be aware of some of the provision but maybe unaware of many local initiatives which may not necessarily be seen as core substance misuse services or have been developed by carers and families for example.

Carers and families have separate and distinct needs from users. Focusing on these through the provision of dedicated support services will enable them to function more effectively and provide the opportunity for users to take responsibility for their own actions. (National Treatment Agency 2006) Research and consultation has consistently identified the following as being the underlying support that carers require (National Treatment Agency 2006):

- Information.
- Respite.
- Practical help.
- Contact with other with similar experiences.
- Short and long term support.

This may then inform next steps, examples are:

- Where limited provision exists capacity building may be considered.
- Service specifications should be developed to ensure there is no over provision or duplication.
- Where the need for service provision is limited then consideration should be given to commissioning across Community Safety Partnerships.
- Some areas will have well structured generic carer provision and working through this media may offer a way to develop specialist support.
- Engagement with difficult to reach carers and families should be considered. Identify who they are and how can they be reached.

(Adapted from National Treatment Agency 2006).

8.2 Service Provision

Effective carer and family support models are characterised by being flexible and responsive to a range and diversity of need and recognise that the need for intervention and support will not necessarily be time limited. Successful care and family support services are those that identify and focus on the health and well being of their 'service user'.

A comprehensive menu for carer and family support services which offer a range and choice of interventions is set out in Chapter 6 of "We Count Too" (Adfam).

It is suggested that this should include:

- Supporting and advising carers.
- Providing information and advice.
- Respite provision.
- Support groups.
- Bereavement support.
- Engagement with criminal justice services.

Consideration must be given on how to work with and engage particular groups who are known to find it more difficult to access support e.g. men, black and minority ethnic, travellers. Targeted initiatives maybe an option for specific groups.

8.3 Levels of Support

There is a statutory duty to inform carers of their right to a carer's assessment. Carers who provide 'regular and substantial care' are entitled under current legislation to receive a carers assessment, which should lead to a care plan and possibly access to relevant support and funding, e.g. for respite, as long as their needs meet the fair access to care criteria set by the local authority. The local authority has a statutory responsibility to carry out these assessments. This responsibility can be devolved to substance misuse providers by the local authority.

Open access services could include:

- Signposting by mainstream services to the appropriate substance misuse services.
- Advice, information and education about substance misuse and treatment.
- Drop in facilities which may offer one to one support and advice.
- Harm reduction training.
- Helplines.
- Support groups.
- Structured community based support and interventions. (An assessment of need can be carried out and a care plan produced by the organisation who will be providing these services.)

Structured community based support and interventions can include:

- Structured psychosocial interventions (i.e. counselling), which may be time limited, depending on service capacity.
- Telephone or outreach based structured counselling.
- Respite and alternative therapies, where this forms part of the support plan.
- Liaison with other specialist agencies, for example social services (in relation to child protection and criminal justice services).

Specialist service provision may include:

- Short stay residential provision.
- Respite and structured programmes of therapeutic intervention designed to relieve stress, raise self-esteem and identify coping strategies.
- Group and one-to-one support therapy.

Structured services will be provided by fully trained staff, accredited by the relevant national bodies, e.g. BACCP for counsellors. (Adapted from National Treatment Agency 2006).

An assessment will be undertaken and a care plan produced and agreed with the carer by the Local Authority in accordance with the Unified and Fair Assessment system.

9. Quality Standards

The key standards for organisations in delivering quality services are:

1. Family members affected by drug use are actively involved in the organisation.

- Family members with personal experience have an effective voice in the service/group design, management, delivery, monitoring and review processes.
- The service works in partnership with other relevant local organisations and services**.**
- The service has access to other services and good networks, which they use to contribute to making sure that families get co-ordinated support.
- The service works jointly with other drugs services and family support services to maximise choice and opportunity.

2. The service is clear about its principles, aims and focus and how these will be achieved and monitored.

- The service is clear about its purpose and aims, eg whether it is focused on support and/or on campaigning.
- The service is clear about its target group(s), eg parents, grandparents, partners, children and young people.

- The service has clear monitoring and review processes in place.
- The service is clear about who it is accountable to and has a clear management structure.
- The service has an agreed development or business plan.
- The service has in place sufficient funding to deliver its aims in a sustainable manner.

3. The service has in place policies, procedures and protocols covering confidentiality and its legal responsibilities. These include:

- Confidentiality.
- Data protection and record-keeping.
- Health and Safety.
- Insurance.
- Complaints.
- Equal Opportunities.
- Legal and medical advice.
- Child protection.
- Drugs and alcohol in the workplace.
- Volunteers.
- Service specific protocols (depending on type of service provided).

4. All service staff are appropriately trained and supported.

- All staff (paid and unpaid) and management committee members/trustees receive the training they need to enable them to carry out their roles.
- All staff (paid and unpaid) have clear roles and responsibilities.
- All staff (paid and unpaid) receive regular support and supervision, including around how their personal experience impacts on their work (adapted from Adfam).

References

Adfam 2005. We count too. Good practice guide and quality standards for work with family members affected by someone else's drug use. London: Adfam.

Carers (Recognition and Services) Act 1995. (c.5) London:The Stationery Office.

Carers and Disabled Children Act 2000. (c.16) London:The Stationery Office.

Carers (Equal Opportunities)Act 2004. (c.15) London: The Stationery Office 2004.

Carers UK 2004. In poor health. The impact of caring on health. London: Carers UK.

Department of Health 2002. Developing services for carers and families of people with mental illness. London: DoH.

Home Office 2003. Hidden harm. Responding to the needs of children of drug problem users. London: Home Office.

National Health Service Reform and Health Care Professions Act 2002. (c.17) London: The Stationery Office.

National Treatment Agency for Substance Misuse 2006. NTA Guidance for local partnerships on user and carer involvement. London: NTASM.

Powell E 2002. We care too. A good practice guide for people working with black carers. London:National Black Carers Workers Network and the AFIYA Trust.

Scottish Executive 2002. *Effective interventions unit supporting families and carers* of *drug users*: A *review.* Edinburgh: SE.

Velleman R, Templeton L 2002. Family interventions in substance misuse. In Petersen T, McBride A, eds. Working with substance misusers. London: Routledge, 2002.

Welsh Assembly Government 2000. Carers' strategy for Wales. Cardiff: WAG.

Welsh Assembly Government 2000. Carers strategy in Wales implementation plan. Cardiff: WAG.

Welsh Assembly Government 2002. Creating a unified and fair system for assessing and managing care. Cardiff: WAG.

Welsh Assembly Government 2003. Challenging the myth. "They look after their own". A good practice guide. Black and Minority Ethnic (BME) Carers. Cardiff: Welsh Assembly Government.

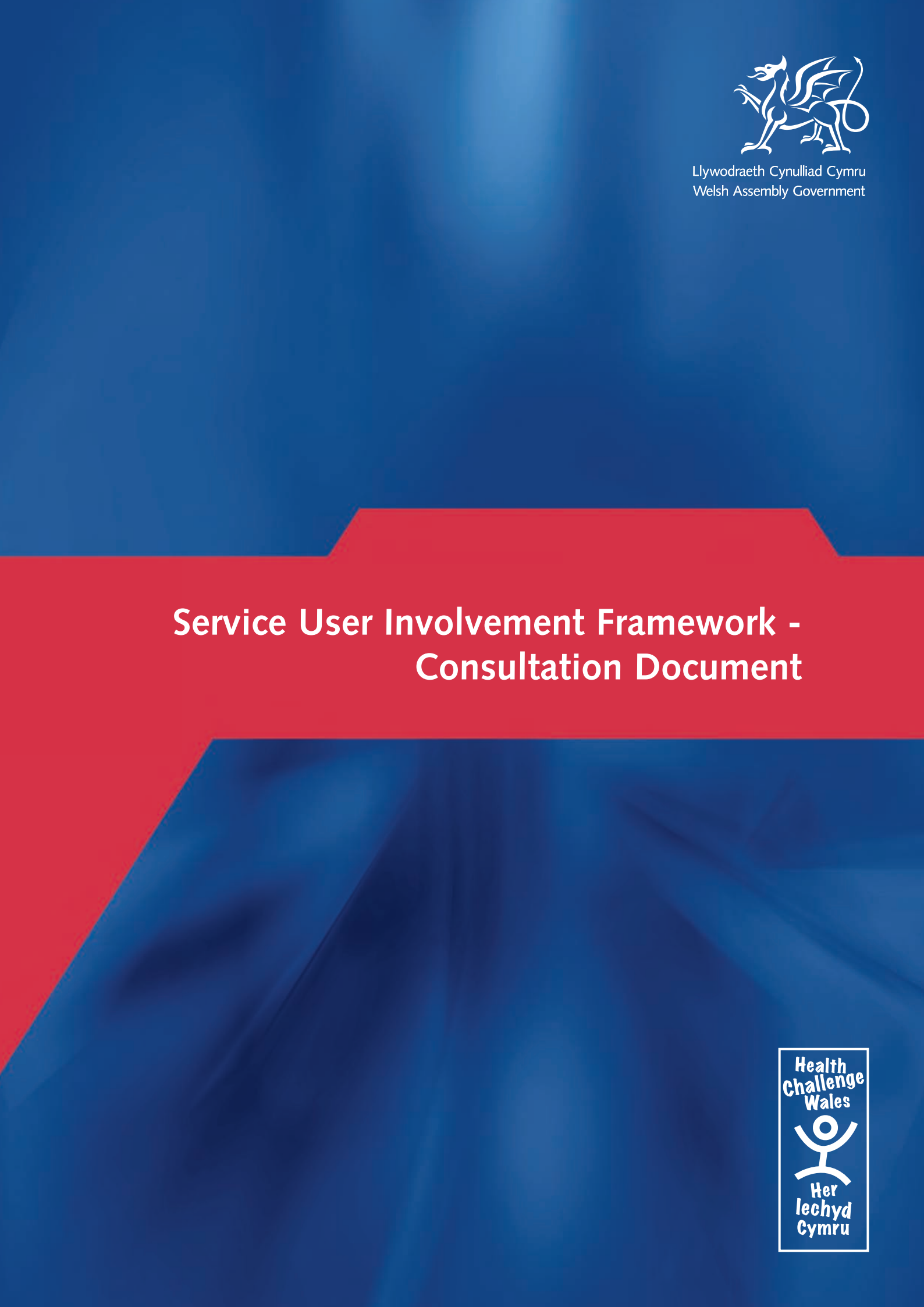
Welsh Assembly Government 2003. *Mental health policy guidance. The care programme approach for mental health service users. A unified and fair system for assessing and managing care.* Cardiff: WAG.

Welsh Assembly Government 2005. Designed for life - A world class health service for Wales. Cardiff: WAG.

Welsh Assembly Government 2006. Carers' strategy consultation document. Cardiff: WAG.

Welsh Assembly Government 2006. Fulfilled lives, supportive communities. A strategy for social services in Wales over the next decade. Cardiff: WAG.

Work and Families Act 2006. (c.18) London: The Stationery Office.



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Service User Involvement Framework - Consultation Document

Health Challenge Wales
Her Iechyd Cymru

G/626/06-07
ISBN 978 0 7504 4177 3

August
CMK-22-04-030(064)

Typeset in 12pt

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Appendices

1. Background

1.1 Until quite recently people who misused drugs, or were at risk of drug misuse were rarely involved in helping to develop the health and welfare services that they needed. Many substance misusers did not recognise that they had anything to offer to the development of substance misuse policy and practice at every level. Indeed people who misuse drugs are often seen as having very little to offer governments, services and the community. In reality nothing could be further from the truth.

1.2 During the past twenty years, and throughout the world people who misuse drugs and who use substance misuse services are increasingly being recognised as crucial components in the development of effective services.

1.3 Early examples of service user and drug misuser involvement groups were founded in the Netherlands through an organisation called Junky Bond which has since been amalgamated with an Amsterdam service called Belangenvereniging Druggebruikers MDHG, and the USA (the National Association of Methadone Advocates 1973). More recently active service user and drug user groups have been developed in Germany, Australia, Canada and Switzerland.

1.4 The development of patients' power within the UK health fields and especially in the learning disability sector and mental health sector showed successful involvement in similarly stigmatised patients. In the mid 1980s the HIV/AIDS epidemic gave added impetus to the need to improve services to people who misuse drugs and were at risk from blood borne viruses. The involvement of people with HIV was an essential component.

1.5 Section 11 of the Health and Social Care Act 2001 conferred a new statutory duty on the NHS in Wales to make arrangements with the aim of involving patients and the public in the planning and decision making processes of that body. Section 11 applies to all NHS organisations, including national agencies, strategic health authorities and local trusts. It also applies to non-NHS service providers who provide services to patients through contracts and service level agreements or a commissioning partnership where the NHS is one of the partners.

1.6 In England the National Treatment Agency has been developing a programme for substance misuse service user involvement alongside such groups as the Alliance (an advocacy group), the Drug Users Forum etc.

1.7 The Welsh Assembly Government is also committed to encouraging service user involvement in planning, design and delivery of substance misuse services. Guidance to Community Safety Partnerships stresses the need for effective service user involvement in development and delivery of Local Substance Misuse Action Plans.

1.8 The Welsh Assembly Government maintains a close interest in developments in service user involvement, and concluded that more could be done to encourage it in Wales.

1.9 A specialist sub group consisting of external stakeholders, including service providers and past service users and Assembly officials was established to produce a service user involvement good practice guidance as part of the Substance Misuse Treatment Framework (SMTF). Service users were extensively involved in reviewing this document throughout its production and their comments have been taken into consideration and included where appropriate.

2. Principles of Service User Involvement

2.1 Service users clearly have unique experiences, skills and abilities that enable them to provide 'expert advice' in this field. Substance misuse strategies and services are likely to be more effective if they are developed and delivered with the direct involvement of the people who use them.

3. Aim

3.1 This document seeks to promote the benefits of involving service users in the development of policy, and in the design, planning, delivery and evaluation of substance misuse services, at all levels.

3.2 It is aimed at substance misuse service users, service providers and commissioners within the statutory, voluntary and independent sectors and within the Criminal Justice System where appropriate.

4. Objectives of Service User Involvement

4.1 Substance misuse service users need to be involved at every level of the development, delivery, and review of substance misuse services in order to:

- ensure that substance misuse services are developed to meet the needs of service users;
- ensure that substance misuse services provided are of good quality; and
- ensure the delivery of positive treatment outcomes for the individuals.

4.2 Service commissioners should ensure that service users are able to:

- have their views considered in the development of new strategies and services;
- contribute to the review and performance management of existing strategies and services;
- receive information on planning and delivering of new services in an accessible and jargon-free format;
- contribute to meetings and decision making, whilst having their own needs taken into account – this will include practical help (e.g. expenses or other payment; the timing and placement of meetings, etc) and support (help to deal with jargon, stress, power imbalances); and

- access appropriate training and mentoring support to enable them to contribute to planning arenas.

4.3 Service providers should ensure that service users:

- have easy access to clear information on all the services available;
- have access to information on available treatment options;
- are fully involved in the development and review of their individual care plan and have their needs and goals incorporated into this plan;
- receive information on how to make comments, complaints and compliments about the services that they receive; and
- contribute to the evaluation of the services.

4.4 It should be remembered that user involvement is a dynamic process and innovative methods of engaging with service users should be sought on an on-going basis.

5. Benefits of Service User Involvement

5.1 The meaningful involvement of service users offers benefits to both individuals and the community at a strategic level.

5.2 At a commissioning level, service user involvement in the design and review of services can:

- ensure that services are relevant to local needs;
- ensure that services are accountable to service users;
- enable service users to voice their opinion on services and identify good practice and areas of concern; and
- provide a vehicle through which consultation on future action plans can be undertaken.

5.3 Working in partnership with service users can benefit substance misuse service providers through:

- creating more opportunities for people who use or want to use services to get involved;
- encouraging a sense of ownership of services on the part of service users;
- assisting in the dissemination of information and education;
- encouraging more people into treatment and remain in treatment to a successful outcome;
- assisting in developing a skilled and responsive workforce;

- developing innovative ways of working that improve service quality;
- ensuring that services meet clients needs; and
- providing service users with an opportunity to be valued and develop new skills that enhance treatment outcomes.

5.4 The active involvement of service users in the shaping and delivery of substance misuse services benefits individuals and the broader substance misusing community through:

- providing opportunities to be valued and heard;
- enabling users to develop a sense of empowerment;
- providing opportunities to share and allow others to benefit from their unique experience and expertise;
- providing opportunities for the acquisition of new skills and interests;
- the development of mutual support networks;
- ensuring that services received are relevant to their needs; and
- providing opportunities for individuals to become “health activists” for other substance misusers.

6. 'The Ladder of Participation' - Example of a Model of Service User Involvement

6.1 Service users should have the freedom and choice to participate in the design, delivery and review of substance misuse services in a range of ways, fluctuating between them as they choose.

6.2 Historically, a ladder of participation has been used to describe the ways in which a service user may wish to become involved.

Rung 7	**Initiating** Service users generate ideas for action and make all the major decisions. Staff are available for consultation but do not take charge. For example a service user group being responsible for commissioning decisions.
Rung 6	**Implementing** Service users are given responsibility for a project and its outcomes. An example of this could be service users operating a needle exchange service.
Rung 5	**Decision Sharing** Service users share responsibility for decision making with staff. This could include being involved in the recruitment of staff members within a project.
Rung 4	**Representation** Service users represent the views of their peers on specific items, this might be through service users forums or message boards.
Rung 3	**Consultation** Staff generate ideas and make key decisions, but consult service users. Staff take service users views into account and give feedback on decisions and action. For example, consulting on proposed changes to opening hours within a service.
Rung 2	**Positive Contributions** Service users are asked for their views on something but don't have any say about how these questions are asked or what happens to any of the information they gave. An example of this could be an annual service user satisfaction survey carried out within agencies, where the questionnaire is developed by staff.
Rung 1	**Information** Service users are given information by staff. They may passively consume this (poster, leaflets) or actively (meetings that give information). Staff have control of the information, deciding what, when and how it is shared with service users.

Susan Lawrence (Adapted from Hear by Right/Roger Hart/Arnstein)

6.3 Service users may choose to be involved at one level over another due to their personal strengths, circumstances or the nature or organisation that they are in contact with. For example in-patient detoxification services may offer different opportunities for involvement compared to open-access drop-in services.

6.4 Commissioners and providers should strive to provide opportunities for involvement at all seven levels of the ladder wherever possible.

7. Putting the Method into Practice

7.1 The involvement of service users will require planned input of resources - both worker time and money. (e.g. it may take longer to achieve some outcomes, where consultation with users takes place, it may be more expensive to ensure documents are in a jargon free form).

7.2 A number of Substance Misuse Action Teams and provider services employ service user development officers to support a range of involvement activities. Whilst all staff need to be involving service users in their work, it is sometimes helpful to establish a lead worker (See Appendix 3).

7.3 The following activities can be supported by such roles or conducted independently.

User led initiatives

- **Volunteering, advocacy, mentoring and peer support**

  Involving people who are in a position to reflect on their own experiences of treatment services and who wish to provide support to others.

- **Peer education**

  This includes the dissemination of harm reduction advice using peer educators and can be an effective way of providing information to groups that we have more difficulty engaging.

- **Service user forum**

  This could be in the form of a self-help group, peer support, lobbying, campaigning or information sharing group. Speakers and trainers may be invited to speak on topics selected by the membership. Providers and commissioners may also seek the views of these groups. On-line message boards can offer opportunities for service users to contact one another on a national or even global basis to share views and experiences.

- **Advisory or reference groups**

  Commissioners and providers may wish to support service user reference groups in recognition of the expertise that service users have in the field. These groups will be consulted on specific issues, for example when services are commissioned or redesigned.

Provider/commissioner led initiatives

- **Surgeries/face to face interviews**

  Some clients may feel more comfortable sharing their views in person. Managers and commissioners may choose to conduct open surgeries within agencies, forums, GP clinics and on an outreach basis to gather the views of service users.

- **Stand alone events**

  These might be generic or single issue events to consult on specific issues or to gather information on need.

- **Service user representation on planning teams**

  Service users should be represented on the Advisory Panel on Substance Misuse (APOSM), Community Safety Partnerships, Substance Misuse Action Teams and other planning groups. Within organisations there may be opportunities for service users to be involved in team meetings or planning events.

- **Regular surveys, questionnaires and suggestion boxes**

  Many agencies conduct annual surveys or exit questionnaires. This information can highlight areas for immediate service improvement and change.

- **Development and operation of services**

  An example of this work is Needle Exchanges and information services and production of magazines.

8. Engaging Service Users With Special Needs

8.1 Organisations in Wales have had mixed success in engaging substance misusers from special needs and hard to reach groups. However, appropriate training, support and planning will help to improve and encourage the engagement of these services users:

- whilst all information should be in a clear jargon free language, some service users may need information in other ways, e.g. other languages (both written and verbal), easy read, Braille etc;

- for some cultures and groups limiting the meetings to members of that group only may make it more comfortable for them to participate (e.g. women, young people, older people, abstinent service users);
- however don't assume that because someone has a special need that they would necessarily only need or want a different service;
- be aware of service users special holidays, events or activities (Holy days, school times, chemist pick up times etc). Be aware of times of day, places, safety and transport; and
- there are many different special need groups and communities and service user involvement is a key way of ensuring our strategies and services are accessible to all.

Appendices

These appendices are examples of tools that you may find helpful.

1. Checklist for Service User Involvement .
2. Sample Charter for Service User Involvement .
3. Personal Qualities.
4. Skills Required.
5. Skills for Workers .
6. Involvement Forums .
7. Mapping Service User Involvement Activities
8. Developing a service user involvement strategy and implementation plan.
9. Links for service user websites.

Appendix 1

Checklist for Service User Involvement

Service commissioners and providers can use the following tool to evaluate the current level of service user involvement in their work. The list is not comprehensive but aims to trigger further consideration of how to involve and consult with service users.

Means of participation	Tick
Commissioning and Planning Structures	
Does your partnership actively seek to involve service users in its work?	
Has your partnership or group considered user involvement when developing its terms of reference and structures?	
Is user involvement meetings-based or are other mechanisms employed?	
Is information on the structure and aims of the partnership or group readily available to service users?	
Do commissioners and planners have a clear understanding of the importance of user involvement?	
Are service users involved in the needs assessment process?	
Are service users involved in the development of service specifications to meet identified need?	
Are there opportunities for service users to be involved in the commissioning or procurement process?	
Are service users involved in the monitoring and evaluation of services?	
Is performance and activity information fed back to service users?	
Are changes and developments reported to service users?	
Would commissioners accept the finding of user-led research?	
Are there regular opportunities for service users to provide feedback on services either as an individual or as a group?	
Do commissioners allocate resources to support service user involvement?	
Are service users asked how they would like to be involved in commissioning?	
Do you regularly review your approach to service user involvement?	
Meetings	
Are meetings held at times and in locations that are accessible to and appropriate for service users?	
Are your meetings promoted in areas where service users will be?	
Are minutes of your meetings readily available to service users?	
Are you able to provide training and support to service users wishing to participate in meetings?	
Are you able to give enough time for service users to prepare for meetings?	
Do you support service users by meeting their out of pocket expenses incurred through attending meetings?	
Do you use jargon and technical terms in your meetings?	

Means of participation	Tick
Do those present have a clear understanding of the importance of user involvement?	
Do you use means of communication other than e-mail?	
Is the structure and culture of your meeting such that service users will feel able to contribute?	
Service Providers	
Do you have a service user charter?	
Is information on how to make complaints or pay compliments made available to service users?	
Are staff trained in delivering client-centred support and involving service users in their care plans?	
Are clients able to access advocacy support?	
Are service users involved in the staff recruitment process?	
Are there regular opportunities for service users to provide feedback on services either as an individual or as a group?	
Is there regular interaction between service users and senior management?	
Are service users aware of who the commissioners of the service are?	
Are service users involved in the development and review of their care plans?	
Are service users involved when changes are made to the service base e.g. redecoration or renovation?	
Are service users involved when changes are made to the structure of the service e.g. opening times, staff structures, out of hours support?	
Are service users or ex-service users involved on your board of management?	
Do service users have the opportunity to use their skills to support the delivery of the service e.g. peer support, befriending at drop-in?	
Are service users involved in budget setting or management?	
Are there opportunities for service users to represent the organisation?	
Do you operate any peer education or user led assertive outreach schemes?	
Do you involve service users in the delivery of harm reduction messages?	
Is the advice of service users sought when seeking to work with specific groups e.g. black and minority ethnic groups, stimulant users, etc.?	
Are service users asked how they would like to be involved in services?	
Are service users involved in the induction and general training of staff?	
Are service users involved in the induction of new service users?	
Do you advertise and promote service user forums?	
Are service users informed of the range of treatment options available to them?	
Are service users encouraged to take a proactive lead in the development and review of their own care plan?	
Do you regularly review your approach to service user involvement?	

Appendix 2

Sample Charter for Service User Involvement

Design and Planning of Services

Involving service users in the process of planning services should lead to services that are more responsive to the needs of people who use them.

Personal planning of services

Service users have a right to:

- be full partners in the planning for their own service needs and in the design and drawing up of their own care plans;
- have access to independent advocacy; and
- be present when their needs are assessed and their services planned and reviewed.

Joint planning and commissioning of services

Service users have a right to:

- be treated as full and equal partners within the planning process;
- be supported during meetings;
- have meetings held in an appropriate format, at appropriate times and in appropriate venues;
- have other mechanisms available for ensuring effective involvement, e.g. representatives of planning groups visiting user and carer meetings to obtain views;
- be involved in the formal processes for gathering the views of service users and carers separately and seeing them integrated into the planning structure;
- receive remuneration for expenses incurred during involvement in planning processes;
- receive information in good time to enable effective consultation;
- receive quality training;
- have clearly agreed roles and responsibilities; and
- be kept informed about how their contributions have influenced planning and service delivery.

Service Delivery and Monitoring

Service user involvement in the delivery and monitoring of services will make services more responsive to need.

Service users have a right to:

- be treated as full and equal partners and fully involved in the delivery of services;
- be involved in the recruitment and induction of staff as appropriate and be supported to do so;
- have their views taken into account and be provided with feedback if they are not satisfied with services offered;
- be made aware of alternative services where these exist;
- be informed of how to make a comment or complaint and have them fed into the monitoring and evaluation process;
- be given the opportunity to inform service providers of whether or not their identified needs are being met; and
- be involved in the design and collation of monitoring and evaluation procedures and be informed of the results of monitoring and evaluation of services.

Appendix 3

Personal Qualities

(From “Lessons Learnt”, London Drug User Involvement Project,
Greater London Authority) Some approaches, tools and good practice for improving drug user involvement.

Personal qualities

One of the most significant findings of this project is the identification of specific personal qualities that are essential to successful user involvement initiatives.

Interviews with professionals and drug users who had played pioneering roles in the field showed that they shared key personal qualities:

- **energy** - the key activists scored highly in an energy audit score sheet;
- the work in Lambeth, in particular, showed that people with high levels of energy are likely to last the distance in developing projects;
- **belief in a common good** - the activists interviewed showed a strong sense of not only being interested in making things better for themselves but for other users as well;
- **solution focused** - many people are aware of the problems that they and others face, however, only a few relate to or focus on solving them;
- **sense of personal responsibility** - the activists distinguished themselves by seeing themselves as part of the solution; and
- **focus on results** - they measured progress by results achieved, rather than the process used to get them.

Skills

Some models of user involvement that were explored during the project showed that both users and staff need to be geared-up for involvement to work successfully. The core skills needed may be different in the two groups and may also vary from one organisational context to another and between one user and another.

Equipping users

Drug users have often been viewed as unreliable, incapable of organising things well, or unable to manage resources effectively and competently. Work on this project challenged these views. Drug users are an extremely broad and diverse group displaying a wide range of skills and competencies. There are many examples of well-run and successful drug user led initiatives.

Appendix 4

Skills Required

(From “Lessons Learnt”, London Drug User Involvement Project,
Greater London Authority) Some approaches, tools and good practice for improving drug user involvement.

New skills

This project identified the need for providing users with specific training to support them in user involvement initiatives. The training should support individuals who may not be accustomed to working in organisational or professional contexts.

Training on organisational issues should include the following:

- basic finance and budgeting;
- approaches to planning and strategy development;
- meetings and communications, including minute-taking and chairing; and
- basic understanding of national drug strategies.

Equipping to deliver

This is an exciting area of skills development; successful service delivery by users is a powerful weapon to counter the negative perceptions and generalisations that exist about drug users.

Examples of successful service delivery include: training and equipping users to conduct Models of Care mapping work; engaging users to develop, manage and deliver a small scale Real Time Community Change project; involving service users in delivery of peer to peer training in harm minimisation.

Some of the skills needed for service delivery are outlined above; these additional ones could also be considered:

- information and research - improved knowledge of basic research skills and methodologies can help users bid for and run either full research projects or their components; and
- training and education - users have a vital role to play in educating both other users and professionals. Developing and improving presentation skills and delivering quality training are important in furthering this.

Appendix 5

Skills for Workers

(From “Lessons Learnt”, London Drug User Involvement Project,
Greater London Authority) Some approaches, tools and good practice for improving drug user involvement.

Equipping staff and agencies

Much emphasis has been placed on equipping users. J Bentley, from the Alcohol Recovery Project, stresses the importance of also investing time in skilling up and equipping staff to work with users.

It is important not to underestimate the degree of attitudinal change needed when staff and organisations are asked to relate to drug users in entirely different ways.

Staff training areas to consider are:

- Consultation and informing. Consultation is one of the first steps on Arnstein’s ladder. Staff need to be skilled in the different approaches and techniques to collating and disseminating information and feed back from users.
- Educating and encouraging peers. Staff leading user involvement initiatives need to communicate with colleagues about the reasons for and benefits of user involvement.
- Mentoring. During the project several user activists identified the importance of the mentoring and support they had received from staff members.

Make progress

Drug users are still an excluded group. Many user involvement initiatives are still at the information and consulting stages of Arnstein’s Ladder. Investment and commitment to training of both users and agencies is therefore vital in moving from this stage.

Appendix 6

Involvement Forums

(From “Lessons Learnt”, London Drug User Involvement Project,
Greater London Authority) Some approaches, tools and good practice for improving drug user involvement.

In the project pilots, forums were found to be popular ways of furthering drug user involvement. Their flexible and open nature suited the exploratory and developmental approach to user involvement.

Forums can and do work well and are a good means to:

- open dialogue and build relationships between different groups;
- keep users informed, especially those without easy access to e-mail or telephone;
- allow individuals to have different degrees of commitment to user involvement; and
- encouraging members to voice concerns or air views in a context removed from direct service provision.

Forums and Arnstein

User involvement strategies that are solely based on forums are located around the lower (consultation and information) rungs of Arnstein’s Ladder of Participation.

Users are attracted to involvement activity by different issues and they characteristically have different levels of commitment and expectations. It is therefore important to realise that forums, by themselves, cannot meet the needs and expectations of all users.

It is possible to identify three distinct groups of users:

- **Group A**

  A group highly committed to user involvement and very keen to be involved in furthering it.

- **Group B**

  A group that agrees in principle will follow a strong lead and may also be prepared to give a limited amount of energy to furthering involvement.

- **Group C**

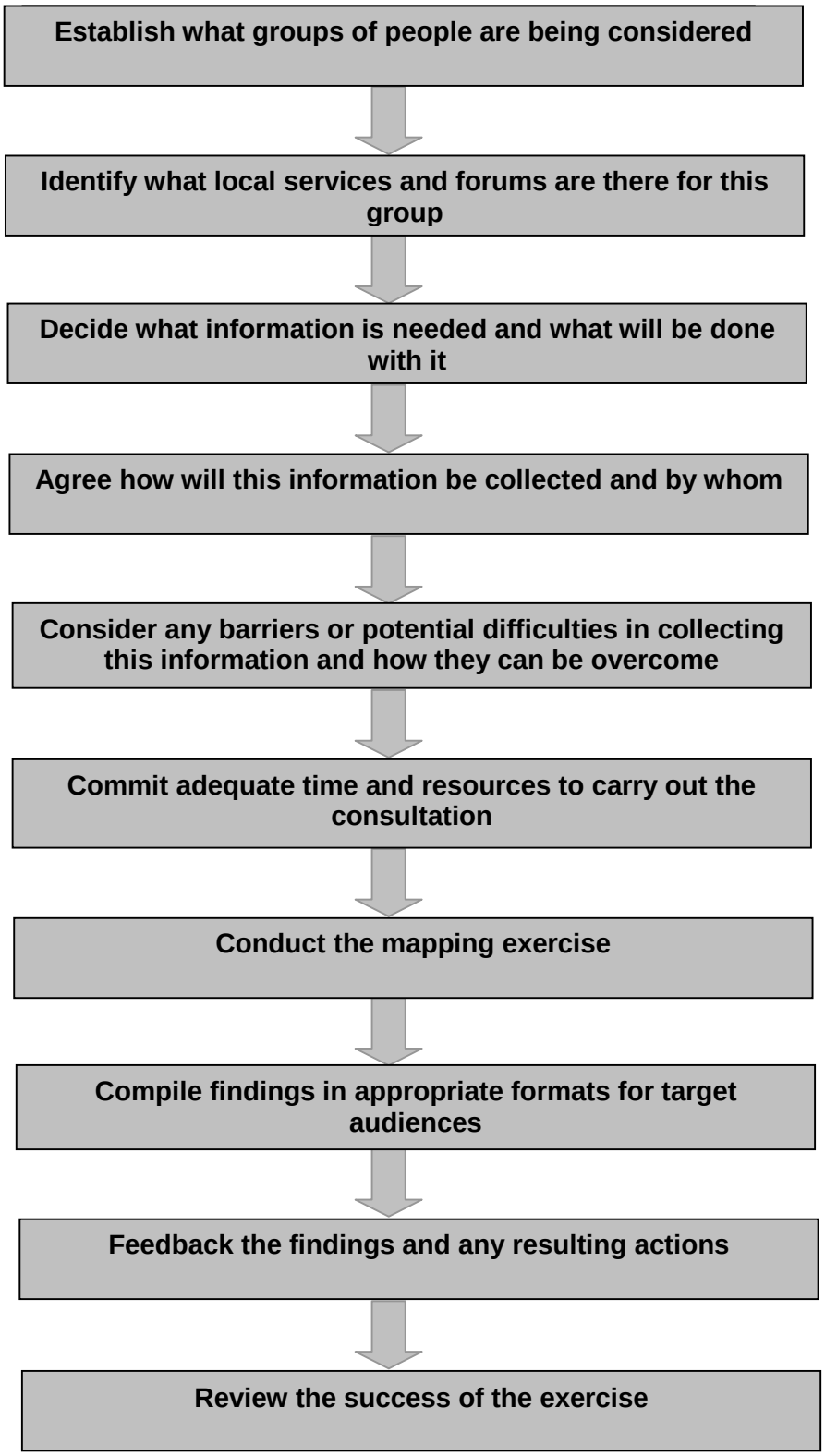
  A group resistant to user involvement who are not willing to contribute in any significant way.

The forum approach works well with users of Group B, where there is not significant commitment but users are kept informed and are given the opportunity to communicate about issues that affect them.

Used in isolation, forums are less likely to be effective with people in Groups A and C, where different approaches may be more appropriate.

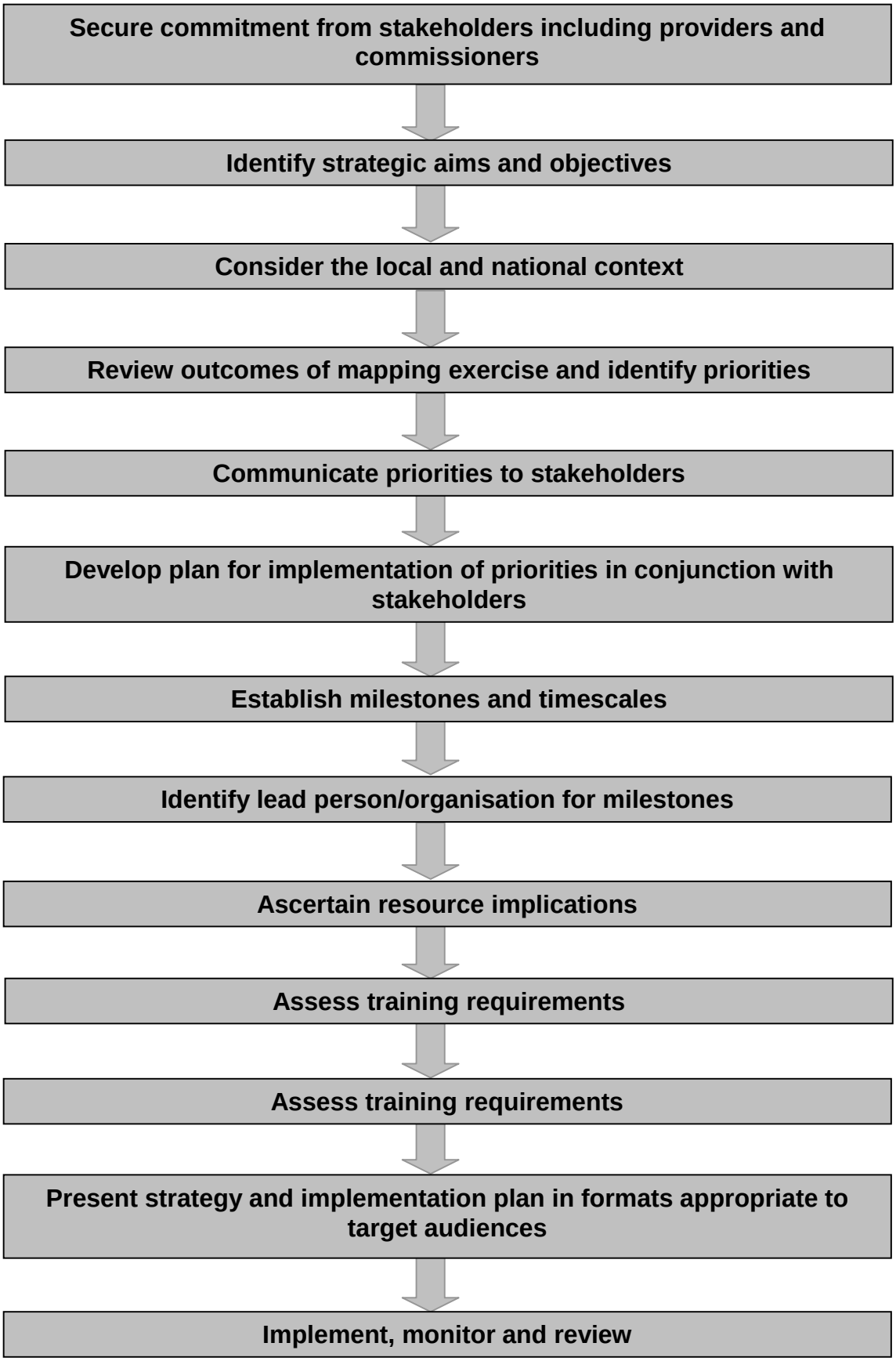
Appendix 7

Mapping Service User Involvement Activities



Appendix 8

Developing a Service User Involvement Strategy & Implementation Plan



Appendix 9

Links for service user websites

http://www.nta.nhs.uk

http://new.wales.gov.uk/topics/health/nhswales/healthservice/qualitystandardsandsafety/signposts/?lang=en

http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=67

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Framework Guidance for Community Safety Partnerships to Commission Substance Misuse Services

G/200/05-06
ISBN 0 7504 3982 3

November
CMK-22-10-024

Typeset in 12pt

Contents

Appendices

Framework Guidance for CSPs to Commission Substance Misuse Services

INTRODUCTION

Community Safety Partnerships (CSPs) in Wales have the responsibility to commission a wide range of services to address substance misuse problems in their local communities, including inter alia ring-fenced discretionary NHS budgets. This involves taking a common strategic approach to meeting the needs of the populations they serve. Without a rigorous, systematic and strategic approach, the efficiency and effectiveness of services for their community will be undermined, and there is a greater risk that services will be poor quality, will overlap, be poorly used or fail to deliver the outcomes needed. For some CSPs commissioning is a relatively new and untested activity, so this document is designed to provide a straightforward framework for developing and implementing commissioning strategies.

This guidance has been produced to inform and support CSPs in discharging that responsibility. It is also to assist in the implementation of a series of modules from the Welsh Assembly Government, which constitute the Substance Misuse Treatment Framework. Further information about the Framework is included in Appendix 2. Its purpose is also to encourage the continued development of a joint approach to commissioning and to provide CSPs with a framework to undertake this task.

To ensure that Community Safety Partnerships adopt a consistent approach to implementing this framework, the Welsh Assembly Government will consider the need to establish a process to review it's implementation.

As you read the document you will see that it emphasises the importance of the following complementary approaches:

- Taking a strategic and systematic approach to commissioning services from across the public, private and voluntary sectors to meet the needs of the whole population who misuse drugs and alcohol.
- Promoting a joint approach between agencies within CSPs to commission services that ensure service users receive the most cost-effective and appropriate services to meet their needs.
- Jointly commissioning across CSP boundaries on a regional basis where appropriate.

The first section of this document outlines the framework for commissioning by CSPs in Wales and provides definitions, which clarify differences between commissioning, purchasing and contracting. It then sets out the four-stage framework for commissioning which involves the following activities; analyse, plan, do and review. Each of the sections that follow consider a stage of the framework and the activities that CSPs will need to undertake to manage that stage effectively. Each stage includes a

check list and flow chart to assist progress. Finally, reference materials to support each stage of the commissioning cycle are included in the Appendices.

Whilst this guide has particular relevance for the commissioning of substance misuse services, it is hoped that the generic commissioning framework used has wider relevance to the commissioning of other services which fall under the remit of CSPs.

1 COMMISSIONING

1.1 BACKGROUND

Until April 2003 responsibility for co-ordinating the delivery of substance misuse services at local level rested with 5 Drug and Alcohol Action Teams (DAATS), which were coterminous with the Welsh Area Health Authorities. Responsibility for planning and implementing actions to tackle substance misuse at the local level now rests with the 22 Community Safety Partnerships (CSP) in Wales.

In 2003 the NHS in Wales was reorganised. The 5 Health Authorities were replaced by 22 Local Health Boards (LHBs) whose boundaries mirror those of local authorities. Sections 97 and 98 of the Police Reform Act 2002 also came into force in Wales in April 2003 and made various amendments to the Crime and Disorder Act 1998. Section 6 of the 1998 Act (as amended) requires responsible authorities in Wales to formulate and implement, in addition to a strategy for the reduction of crime and disorder, a strategy for combating substance misuse in the relevant local government area. The responsible authorities are the local authority, chief officer of police, police authority, fire authority and the health authority (Local Health Board). Responsibility for planning and delivering services to tackle substance misuse at the local level therefore now rests with the responsible authorities and their partners within the 22 Community Safety Partnerships (CSP) in Wales.

To assist CSPs the Substance Misuse Advisory Regional Teams (SMARTS) have been established by the Welsh Assembly Government in the four Welsh police areas. Their main role is to provide strategic support to the CSPs and to assist with the delivery of the Welsh substance misuse strategy and local substance misuse action plans on the ground. Consequently they have a role in encouraging the development of joint commissioning.

1.2 DEFINING COMMISSIONING

There are many definitions of commissioning (see Appendix 4), but the following definition perhaps best captures the key elements of the commissioning task for CSPs:

'Commissioning is the process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies or by the private or voluntary sectors.'
(The Audit Commission, 'Making Ends Meet', October 2003).

The definition has these particular strengths, it emphasises:

- The importance of meeting needs at a strategic level.
- The importance of understanding the needs of all people within a target population.
- The importance of analysing capacity across the range of available services.
- The importance of commissioning services to meet the needs of service users, no matter who provides them.

Joint commissioning is an important aspect of effective inter-agency working, and can be defined as:

'The process in which two or more organisations act together to co-ordinate the commissioning of service(s), taking joint responsibility for the translation of strategy into action.' (Guidance Notes for Completion of Local Substance Misuse Action Plans in Wales 2005-2008).

To explore the range of approaches that can be taken to joint commissioning you should use the Matrix for Analysing Approaches to Commissioning in Appendix 1. This matrix helps you to analyse where your CSP is in terms of its approach to commissioning, and to consider how you might like to develop in future in order to operate more effectively.

1.3 PURCHASING AND CONTRACTING

Although this document is concerned with commissioning, it is useful to have an understanding of, and to establish the difference between the term 'commissioning' and closely related activities, such as 'contracting' and 'purchasing'. There are many definitions of purchasing and contracting (see Appendix 4), but the following particularly helps to clarify the difference:

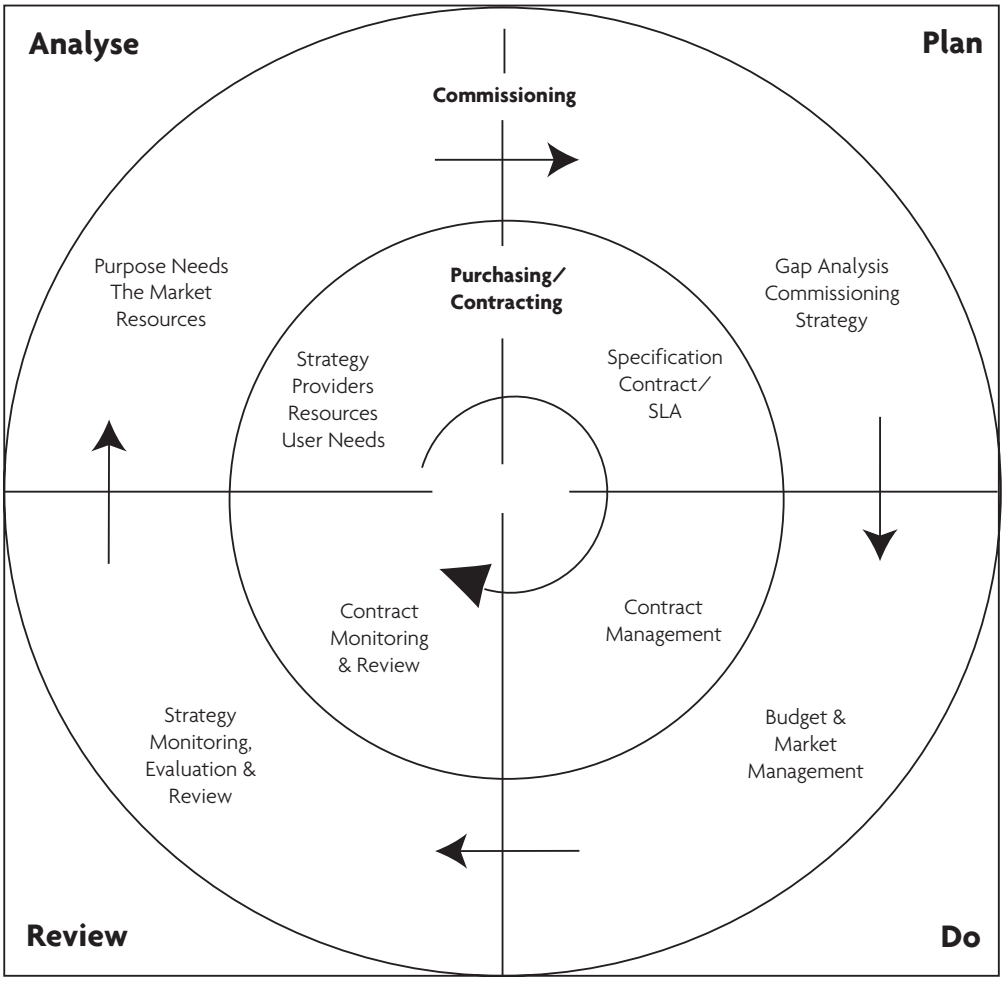
'Purchasing is the process of securing or buying services and contracting is putting the purchasing of services in a legally binding agreement.'
(The Audit Commission, 'Making Ends Meet', October 2003.)

Contracting is putting the purchasing of services in a legally binding agreement. (The Audit Commission, 'Making Ends Meet', October 2003.)

Purchasing and contracting are very closely linked, and cover a wide range of activities undertaken with and for people with substance misuse issues including, for example, agreeing a contract or service level agreement with a provider to deliver a certain service and monitoring the success of that service. Such activities can be undertaken by care managers, contract managers for the CSP or, indeed, by an individual service user who has agreed to manage their own care under a direct payments arrangement. They need to be undertaken, however, within the context of an overall commissioning framework, if they are to contribute to the achievement of efficient and effective services which meet the needs of the population for whom the CSP has responsibility. Commissioning therefore subsumes contracting and purchasing, although they are all intended to achieve efficient and effective service.

1.4 A FRAMEWORK FOR COMMISSIONING

The activities involved in commissioning are shown in the diagram below.



The framework places commissioning within a 4 stage cycle involving the following tasks:

- **Analysis:** Understanding the purpose of the agencies involved, the needs they must address, and the environment in which they operate.
- **Planning:** Identifying the gaps between what is needed and what is available, and planning how these gaps will be addressed.
- **Doing:** Ensuring that the services needed are delivered as planned.
- **Reviewing:** Monitoring the impact of services, and evaluating the extent to which they have achieved the purpose intended.

Following the commissioning cycle round, the **analysis stage** involves activities such as:

- Clarifying the overall purpose and strategic aims and the research and knowledge basis for the services.
- Needs analysis, identifying the current and likely future needs of the whole population for the relevant services – this can involve considering population trends as well as trends in alcohol or drug use, to build up a picture of likely future need.

- Market analysis, mapping and reviewing existing services and contracts, across health, social care, criminal justice and the voluntary sector, understanding provider strengths and weaknesses and identifying opportunities for improvement or change in providers.
- Resource analysis, identifying the resources currently available, and agreeing the future resources, across agencies, which will be allocated to meet the needs of the substance misusing population.

The **planning stage** of the commissioning cycle is concerned with identifying how commissioning agencies will promote the development of services to meet the needs of the population concerned. This involves:

- Gap analysis, using available information, to review the whole system and identify what is needed in the future.
- Specifying strategic commissioning intentions.
- Planning, by writing a commissioning strategy which identifies clear service development priorities.

The **doing stage** of the commissioning cycle is concerned with activities to ensure that providers deliver their services in ways which efficiently and effectively deliver the priorities and targets set out in the commissioning strategy. This can involve:

- Managing the balance of services. Ensuring that services are sustainable, and offer value for money. Ensuring a good mix of service providers, offering users an element of choice in how their needs are met.
- Making effective arrangements for specifying services, which clearly describe the nature and extent of services you wish to purchase.
- Making effective arrangements for selecting the most appropriate service providers, who will deliver good quality services that offer best value for money.
- Making arrangements to ensure service quality, including identifying the quality assurance criteria that should be included in contracts in order to ensure services meet the standards you require.
- Procuring new services and de-commissioning services that do not meet the needs of your client group.

Finally, the **reviewing stage** of the commissioning cycle involves monitoring, evaluation and review of the commissioning strategy, establishing the extent to which the priorities and targets in the strategy have been met, and identifying what changes need to be made to the strategy or to services as a result. This can involve:

- Pulling together information from individual contracts or service level agreements.
- Analysing whether strategic commissioning objectives are being met.

- Analysing any changes in population need, reviewing the overall impact of services, and considering the effectiveness of service models across the market to respond to the different needs of people with substance misuse issues.
- Identifying revisions needed to the strategic priorities and targets.

The rest of this document explains in more detail the four stages of the commissioning cycle, and describes the activities that CSPs will have to undertake to manage commissioning effectively at each of these stages.

CHECKLIST: A FRAMEWORK FOR COMMISSIONING

Before moving on to consider the initial analysis stage of the commissioning cycle check that you have:

- Completed a self-assessment tool. ☐
- Matrix for analysing approaches to commissioning (Appendix 1). ☐

This matrix will help you to analyse where your CSP is now in terms of it's approach to commissioning and where you think you would to be in order to operate more effectively.

2 THE ANALYSIS STAGE – GATHERING INTELLIGENCE

2.1 INTRODUCTION

The analysis stage of the commissioning cycle involves the following activities, which will help you to establish the basis for your commissioning strategy:

- Clarifying the purpose and the strategic aims of the CSP, taking account of All-Wales and local substance misuse priorities.
- Undertaking needs analysis.
- Undertaking a market analysis, mapping existing services, including contracting arrangements and the quality of services.
- Analysing the resource base for the commissioning strategy.

These activities are considered in turn below.

2.2 THE PURPOSE AND STRATEGIC AIMS OF THE CSP

The reason for this activity is to establish a common perspective across the CSP about the purpose and strategic aims of substance misuse services, based on the national and local priorities for tackling substance misuse. This vision sets the scene for the commissioning strategy. It explains what

must be included in the strategy, defines the boundaries of the population covered by substance misuse services and specifies which partner agencies are involved in developing and agreeing the strategy. All-Wales and local strategic drivers should inform the CSP's broad strategic aims, and these need to be underpinned by shared values.

To produce an agreed statement of purpose and strategic aims for your CSP, you need to consider the areas outlined in the sections below:

- The membership, roles and values of your CSP.
- Establishing a commissioning group.
- The national agenda, research and best practice in tackling substance misuse in Wales.
- The local agenda.

2.2.1 Membership, Roles and Values of your CSP

You will also need to identify the various roles and responsibilities of the agencies and individuals within your CSP.

The 22 Community Safety Partnerships (CSP) in Wales have a remit to ensure the delivery of substance misuse services for their local area. A number of different agencies work within CSPs and they are in turn required to work with partners across the public, private and voluntary sectors. Not all agencies involved in CSPs are commissioners. The main commissioning agencies are likely to be the Local Health Board, local authority, police services and Regional Offender Manager (ROM). It is important to be clear about those agencies that do have a responsibility for commissioning, and ultimately make the decisions about where money is spent on services, and those, such as service providers, users and carers, who are stakeholders and have a different role, to help commissioners make the best commissioning decisions for their community. However, in order for the commissioning process to be most effective it needs to be fully inclusive, with the CSPs ensuring that all stakeholders understand how and when to make their contributions.

Therefore, having identified those agencies which are involved in developing the strategic framework, it is important that their respective roles, and the resources required from each, should be agreed and clearly stated.

2.2.2 Establish a Commissioning Group

Community Safety Partnerships (CSPs) should establish a commissioning group within the Substance Misuse Action Team. This brings together representatives of the responsible authorities and other service commissioners, for example, representatives of the National Probation Service, the Prison Service and Job Centre Plus. The purpose of this group should be to oversee the implementation of the commissioning strategy in a co-ordinated way.

2.2.3 The National Agenda, Research and Best Practice

The first task is to identify and justify the key policies and principles which will underpin your commissioning strategy, by selecting key themes from the national context for substance misuse services, and from research, national guidance and good practice.

To help with this task, Appendix 2 contains summaries of relevant national policy and guidance, outlines of other legislation, research and good practice.

2.2.4 The Local Agenda

You need to analyse the current priorities for your CSP, including for example:

- **Local Strategic Drivers**

In addition to national policy and research identified in 2.2.1 above, any relevant local strategic drivers should also be included. For example, it is important that the CSP strategy reflects the overarching Community Safety Strategy for each CSP area. Local strategic aims for substance misuse may also be derived from other relevant sources such as the local Health, Social Care and Well-Being Strategy, local crime reduction targets or local crime and disorder strategies. An example of how one CSP links with other strategy groups is included in Appendix 3.

- **Boundaries for Commissioning Substance Misuse Services**

The boundaries for commissioning substance misuse services should be clearly defined in terms of the client group and geographical area. Therefore, those for whom services are being commissioned should be specified. For example, your commissioning strategy may concentrate on adults misusing opiates and alcohol who are aged 16-59, their families and carers, living in the local authority area. If particular services are to be jointly commissioned with other CSPs, across particular geographical areas and/or service user groups, then this should be clearly stated.

CHECKLIST: THE PURPOSE AND STRATEGIC AIMS OF THE CSP

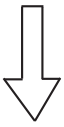
Before moving on to the next element of this stage, check that you have:

- Clarified the membership, roles and values of your CSP. ☐
- Established a commissioning group. ☐
- Clarified the links to other CSPs and regional and national arrangements. ☐
- Analysed national agenda, research and best practice in tackling substance misuse in Wales. ☐
- Analysed your local agencies' agendas. ☐
- Produced an agreed statement of purpose and strategic aims for your CSP. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed the first element of the analysis stage of the commissioning cycle:

CSP Purpose and Strategic Aims



You are now ready to move onto the next element, needs analysis.

2.3 NEEDS ANALYSIS

The needs analysis stage of the commissioning cycle is concerned with ensuring that commissioning intentions are informed by an understanding of need in relation to the availability and quality of service provision and the volume and nature of substance misuse locally. A fully comprehensive needs analysis would cover each of the activities described in the sections below:

- Demographic analysis including public health analysis.
- Findings from service user and carer research.
- Consultation with service providers.

It is likely that agencies within the CSP will already have collected some of the information required and it is worth checking documents such as your local Substance Misuse Action Plan, Crime Audit etc.

2.3.1 Demographic Analysis

The purpose of undertaking a demographic analysis is to estimate the level and location of need in relation to substance misuse across the population served by your CSP. In order to do this effectively, the following types of data are needed:

- Population data disaggregated by age, gender, ethnicity, location and mobility patterns.
- National prevalence rates for drug and alcohol misuse disaggregated by age, gender, ethnicity and location.
- Numbers of people known to substance misuse services.
- The range of substances misused within the population and their relative prevalence and incidence.

In order to establish a baseline estimate of the level and location of need, prevalence rates derived from research can be applied to population data. By comparing the prevalence of people in need of substance misuse services, with the numbers and types of users actually known to be receiving substance misuse services, it is possible to estimate the degree of unmet need, in relation to particular groups of the population, types of services and geographical location.

Appendix 5 contains information about, and links to, helpful sources of information to inform your demographic analysis, including public health data sources.

2.3.2 Findings from Service User and Carer Research

An important element in assessing need is to consider the relevant needs identified directly by those people who have used substance misuse services, and their families and carers. At this point in the commissioning

cycle it may be most useful to consider existing national or local user and carer research or findings from recent local consultations with service users and carers, including their views on the extent of substance misuse issues and desired outcomes.

2.3.3 Consultation with Service Providers

Service providers are able to draw on their day-to-day contact with service users and their carers, as well as their practical knowledge of what works well, to inform the needs analysis stage of the commissioning cycle. The perspectives of managers and practitioners from provider agencies are a valuable element, and can be collected by:

- Meetings with individual service providers.
- Service provider forums.
- Focus groups.
- Questionnaires.

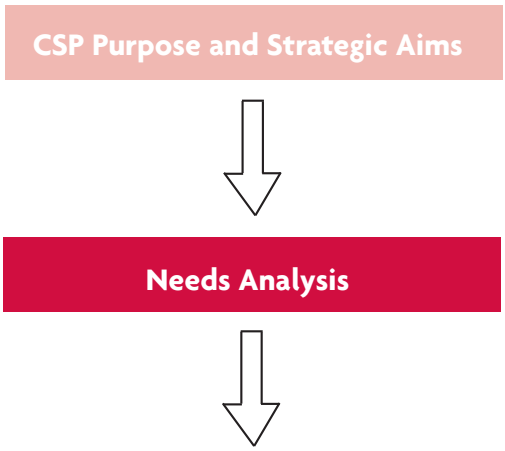
CHECKLIST: NEEDS ANALYSIS

Before moving onto the next element of this stage check that you have completed a comprehensive needs analysis, including:

- Demographic analysis including public health analysis. ☐
- Findings from service user and carer research. ☐
- Consultation with service providers. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed the following elements of the analysis stage of the commissioning cycle:



You are now ready to move onto the next element, market analysis.

2.4 MARKET ANALYSIS

In this element of the analysis stage of the commissioning cycle you are trying to get an overall picture of the current range and quality of services available to service users in your area. To do this, a combination of four activities is useful:

- Mapping existing substance misuse services.
- Mapping existing contract arrangements.
- Analysing the quality of services.
- Consulting with service users, families and carers.

2.4.1 Mapping Existing Substance Misuse Services

Mapping existing substance misuse services is an important element of strategic planning and you need to build up a picture, for example of:

- Availability and location of current services across providers.
- Accessibility of services - are there barriers to service access because of factors such as language, geographical location, opening times, building design or stigma attached to attendance?
- Balance between public, private and voluntary services, and the range and scope of the different providers in the market.
- Range of services provided by each individual provider.
- Cost of services.
- Workforce – are there enough, sufficiently skilled staff available?
- Sustainability - how robust is the market?

Ways of collecting this information include: gathering information via questionnaires; reviewing annual reports of service providers; holding meetings with groups of providers; and conducting interviews with individual service managers. A number of these activities can be carried out in conjunction with the needs analysis activities described in 2.3.3.

2.4.2 Mapping Existing Contract Arrangements

You also need to review existing contract arrangements, to help you to build up a picture of the capacity for change and development in services. You need to analyse existing contracts considering the following:

- What are the range and types of contracts in place?
- How long have these contracts been in place?
- How much spot purchasing is done?
- Are contracts service, volume or outcome driven?
- What is the balance between the independent and statutory sector?

In addition to reviewing the contracts themselves, it is useful to get additional perspectives on their effectiveness by, for example:

- Interviewing providers to explore the extent to which they consider service demand actually reflects contracts.
- Interviewing contract managers to explore the extent to which they consider activity actually reflects contracts.

Appendix 6 includes some sources that may help you to map contract arrangements.

2.4.3 Analysing the Quality of Services

It is important that commissioners analyse the quality and effectiveness of the services that are provided to ensure that they are actually addressing the detailed needs of the service users and carers. Analysing service quality is therefore a key element at this stage of the commissioning cycle, and it is important to ensure a degree of objectivity in your analysis. It is not always possible or advisable to analyse the quality of all aspects of services at one time – you will need to identify priorities. You may, for example, decide to concentrate on one of the following:

- Acceptability of services – do they meet client's requirements/are they satisfied with these services?
- Equity – is there any unwarranted exclusion of clients to services as a result of policy or practice on, for example, race, gender or language?
- Efficiency – for example, are there significant waiting times for services?
- Effectiveness – what are the outcomes of treatment or care?
- Sustainability – are services commissioned in a way which will promote long-term development?
- Appropriateness – what is the degree of alignment between the assessed needs of service users and the services actually provided?
- Co-ordination – do services provide effectively co-ordinated packages of care?
- Do services provide value for money against available benchmarking information?

There are different approaches which can be used to undertake an analysis of service quality, the choice of which will depend on the aspects of the service you decide to focus on. The approach might include a combination of the following activities:

- Reviewing previous inspections of local services.
- Undertaking an audit of a relevant sample of cases and care plans to compare service user's experiences with good practice standards.

- Reviewing the treatment and support provided in a selection of cases by interviewing the service user, carers and professionals involved.
- Analysing services delivered against the Substance Misuse Treatment Frameworks for Wales, (see Appendix 2).
- Reviewing compliments, complaints and serious incident reports.

Refer to Appendix 7 for some sources of information relating to the analysis of service quality.

2.4.4 Consultation with Service Users, Families and Carers

Engaging with service users, families and carers in reviewing services is one of the most valuable activities at this stage of commissioning but it can also be the most challenging. The purpose of consultation is to draw on the experience of users and carers and their views about the impact that the services they have received has had on their lives. It may be helpful to consider the following approaches to consultation with service users and their families:

- Joining regular meetings of existing networks/user support groups.
- Written consultation/questionnaires.
- Running specific focus groups.
- One-to one or small group structured interviews, possibly undertaken by agency staff or service users.
- In-depth user-profile interviews.

In certain circumstances methods for consultation with service users and carers will require medical ethics approval, and this may need to be checked with the Local Health Board. Appendix 7 contains sources of information on service user consultation.

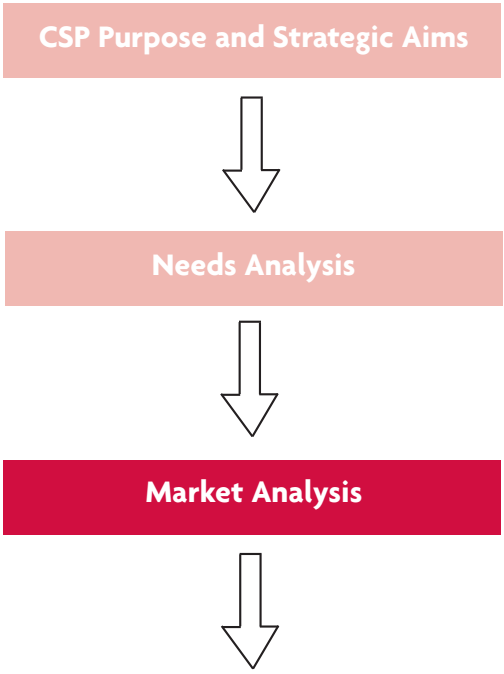
CHECKLIST: MARKET ANALYSIS

Before moving onto the next element of this stage check that you have completed your market analysis and:

- Mapped existing substance misuse services. ☐
- Mapped existing contract arrangements. ☐
- Analysed the quality of services. ☐
- Consulted with service users, families and carers. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed these elements of the analysis stage of the commissioning cycle:



You are now ready to move onto the next element, resource analysis.

2.5 RESOURCE ANALYSIS

In addition to the activities described above, at this stage you also need to consider the existing and potential resource base available for commissioning substance misuse services. To do this you need access to:

- The current and potential future budgets available for commissioning substance misuse services.
- A breakdown of how budgets are allocated.
- An analysis of the extent to which budgets are committed, and where they may be flexible in the future.
- A breakdown between capital and revenue spend.
- Information about the distribution of resources between different sectors, service user groups and across the tiers of service provision.
- An analysis of the allocation of resources mapped against strategic priorities.
- Information about the existence of available resources in complimentary strategic initiatives such as, for example, Supporting People, Cymorth, the NHS Estates Strategy, or the investment plans of national voluntary sector organisations.
- Sustainability and the balance between core and grant funding including an analysis of the risks attached to reliance on short-term funding.
- Availability of matched funding schemes and where resources should be made available for this.
- Identifying future capital needs for substance misuse service developments.
- Identifying areas where future savings or investment might be made.

Appendix 8 contains some sources which may help you to analyse resources.

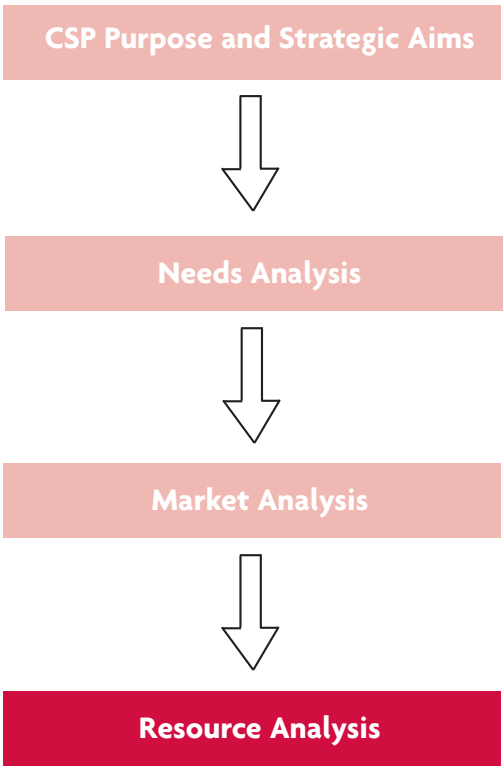
CHECKLIST: RESOURCE ANALYSIS

Before moving onto the next stage, check that you have:

- Identified the current and future substance misuse services budget. ☐
- Identified the global budget and broken down the budget allocation. ☐
- Identified potential areas for future savings or investments. ☐
- Identified all alternative sources of funding/resources. ☐
- Allocated resources against strategic priorities. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed all of the elements in the analysis stage of the commissioning cycle:



You are now ready to move onto the planning stage of the commissioning cycle.

3 THE PLANNING STAGE – DEVELOPING THE COMMISSIONING STRATEGY

3.1 INTRODUCTION

You should now have all the information that you need to allow you to develop and begin to write your commissioning strategy using the information obtained from your needs, market and resource analysis. You will be in a position to identify gaps in current service provision and your CSP will be able to proceed to prioritise the allocation of resources to meet these gaps having regard to strategic priorities and identified need.

3.2 GAP ANALYSIS

To achieve successful commissioning you first need to carry out a gap analysis involving the following activities to establish gaps between identified needs (obtained from your needs analysis) and existing provision (obtained from your market analysis).

- Review the data you have collected in your needs analysis stage about the nature, extent and location of service need.
- Review the data you have collected in your market analysis about the extent to which services currently meet those needs and are likely to meet them in the future.

- Review quality and consultation data about what sorts of services are most effective and efficient, and whether these types of services are currently being delivered.
- Complete a list of identified gaps across the tiers of service provision and across the service user groups. In doing this you should consider:
    - Are there any gaps in particular types of services?
    - Is there an absence of service within a particular community?
    - Are some services weak or of poor quality?
    - Are some services in inappropriate locations or inaccessible?
    - Is there an over-provision of particular services?
    - Is there an over-provision of services within particular communities?
    - Is the funding for particular services sustainable?

Having identified the gaps in service provision you will need to carry out a risk assessment of the impact of these gaps in service on achieving the outcomes that you identified when determining your strategic aims.

Appendix 9 contains some sources to help you carry out a gap analysis and develop your strategic commissioning intentions.

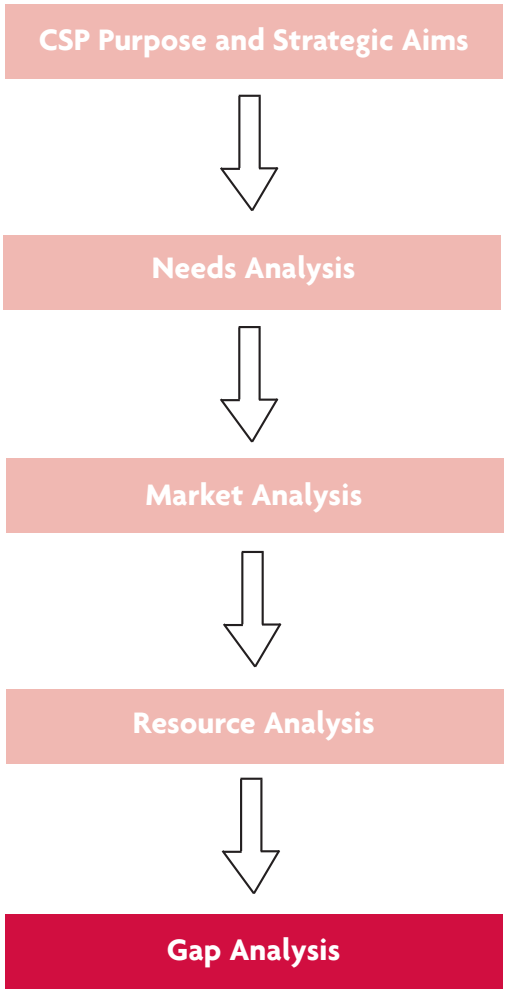
CHECKLIST: GAP ANALYSIS

Before moving onto the next stage, check that you have:

- Reviewed the nature, extent and location of service need. ☐
- Reviewed the extent to which services currently meet needs. ☐
- Completed a list of identified gaps across tiers/ service user groups. ☐
- Identified risks in relation to service gaps. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed the first element of the planning stage:



You are now ready to move onto the next element, prioritisation and strategic commissioning intentions.

3.3 PRIORITISATION AND STRATEGIC COMMISSIONING INTENTIONS

Having carried out your assessment of the risks associated with the gaps in service provision you are now in a position to move on to prioritise the allocation of resources across the service user groups and tiers of services and identify shortfalls. This may mean:

- Continuing to invest in existing services.
- Disinvesting in or de-commissioning certain existing services.
- Commissioning new services.
- Re-configuring existing services.

In carrying out this process you will need to consider the legal implications of existing contractual arrangements. In determining which of these activities should take place you will need to be guided by the strategic aims and outcomes that you identified at the beginning of this process.

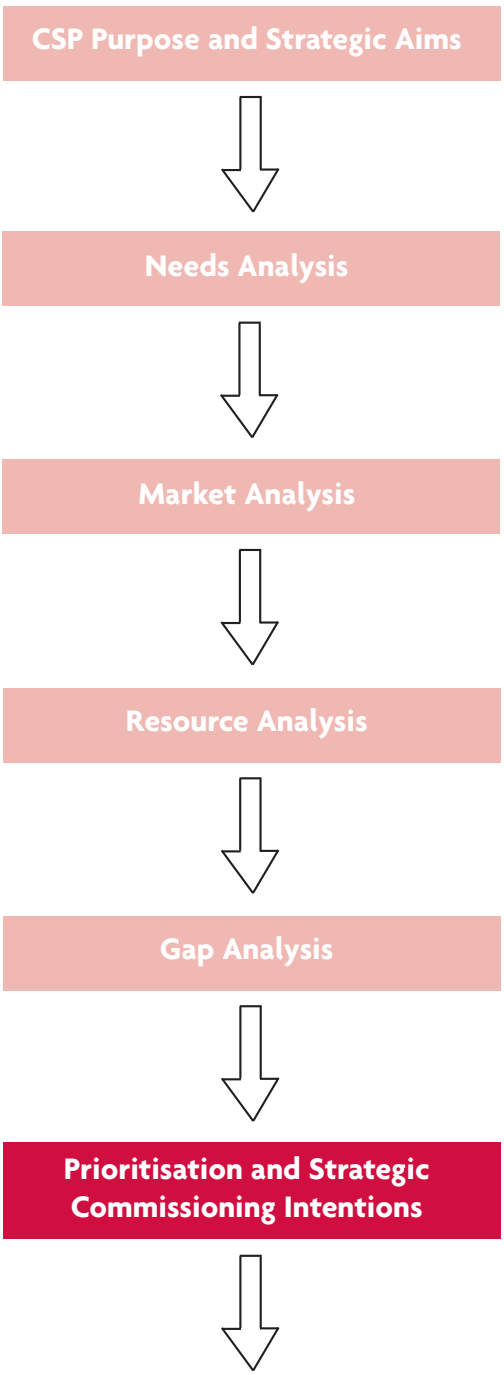
CHECKLIST: PRIORITISATION AND STRATEGIC COMMISSIONING INTENTIONS

Before moving onto the next stage, check that you have:

- Clarified your strategic commissioning intentions. ☐
- Prioritised allocation of resources in accordance with your strategic commissioning intentions. ☐
- Considered the legal implications of any changes to existing services. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed the following elements of the planning stage:



You are now ready to move onto producing the commissioning strategy.

3.4 PRODUCING THE COMMISSIONING STRATEGY

At this point you need to:

- Write your strategy.
- Consult on the strategy with all stakeholders.
- Obtain the formal agreement of the CSP to the strategy.
- Obtain the endorsement of the relevant commissioning agencies through their decision-making structures.
- Obtain formal agreement of agencies committing resources to the strategy through their budget processes.
- Inform existing providers of the future commissioning intentions.
- Publish the document.

3.4.1 What Should you Include in your Commissioning Strategy?

Writing your strategy is the point at which all of your work so far is drawn together into a succinct analysis. Your strategy document should at least include the following elements:

- Introduction
- National Guidance and Research
- Needs Assessment
- Market Analysis
- Financial Position
- Service development
- Monitoring Arrangements

Appendix 10 contains more detail on each of these elements.

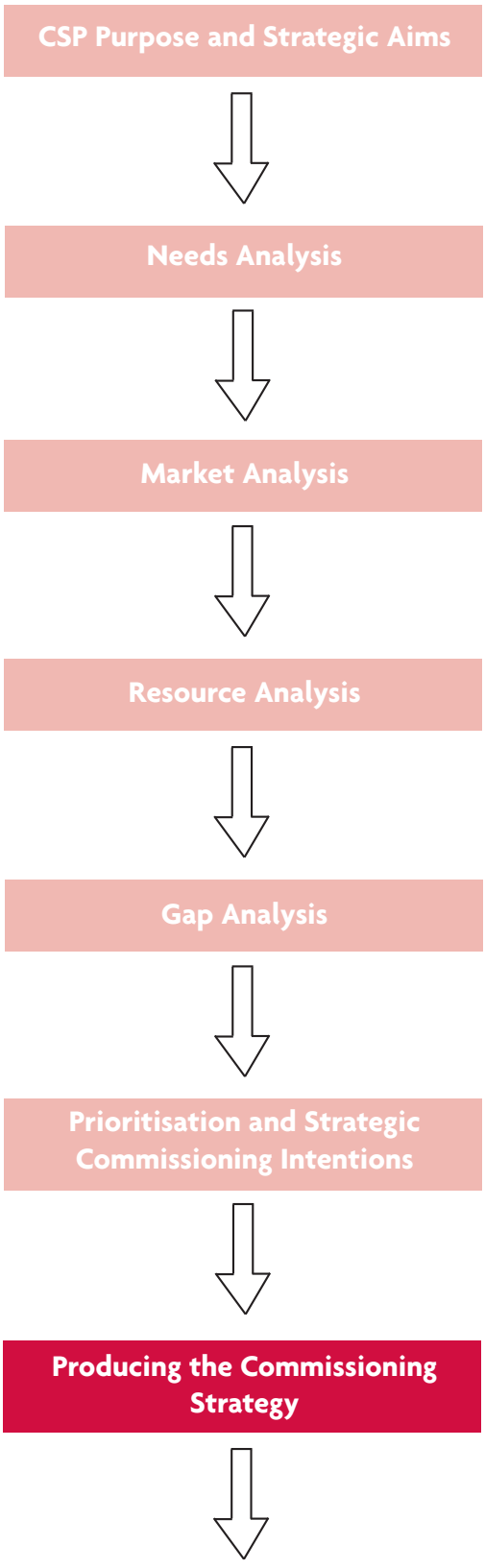
CHECKLIST: PRODUCING THE COMMISSIONING STRATEGY

Before moving onto the next stage check that you have:

- Written your commissioning strategy document. ☐
- Consulted on the strategy, and had it formally agreed by all commissioning agencies involved in the CSP. ☐
- Published the document. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed all three elements of the planning stage of the commissioning cycle:



You are now ready to move onto the next stage of the commissioning cycle, managing the market.

4 THE DOING STAGE – MANAGING THE MARKET

4.1 INTRODUCTION

The next stage of the commissioning cycle deals with the day-to-day tasks of market management, particularly developing the range of services you have identified you need in your strategy. Market management is the key element in the commissioning cycle, through which you shape and influence services to best meet the needs of people with substance misuse issues. This stage includes the following elements:

- Managing service balance.
- Making arrangements for specifying services.
- Making arrangements for selecting service providers.
- Making arrangements for contracting.
- Ensuring quality.
- Identifying potential new providers - what possible alternative suppliers of services are there, and what kind of services might they offer?
- Researching substance misuse services elsewhere in the UK, and opportunities to maintain and/or develop existing services.

4.2 MANAGING SERVICE BALANCE

It is important for commissioners to influence the market on a day-to-day basis in ways that meet the needs of their service user groups and help achieve the aims of the commissioning strategy. One way of clarifying the balance you are looking to achieve is to complete a statement informed by your strategy that identifies how you will address the following areas:

- The mix of providers: ensuring that there is a mix of service providers to ensure the range of needs identified in the needs assessment are adequately catered for, and that services are viable and sustainable in the long term.
- Degree of competition: competition between service providers which may help to ensure value for money.
- Degree of choice: ideally, service users, their families and carers should have a choice of services in order to select the service which best meets their needs.
- Incentives for providers: commissioners should attempt to create incentives for new providers to enter the market or existing providers to offer new services.
- Joint commissioning: the extent to which pooling resources between CSPs can be cost effective.
- Service Sustainability: considering, for example, whether to give more money to less agencies, to ensure continuation and growth of services.

You will then need to undertake activities to achieve any changes you require in the service balance. Some aspects you will need to consider include:

- Re-configuring existing services – you will need to explore the extent to which existing providers have the capacity or desire to revise their services, and whether required changes could be successfully implemented.
- Investing further in existing services – this is often seen as the most straightforward of options, but careful consideration needs to be given to ensuring that additional benefits are likely to be gained from further investment.
- De-commissioning services – although often difficult and controversial, de-commissioning is a crucial option for commissioners requiring resources to develop new services. It is sometimes appropriate to end existing contracts or service level agreements, particularly where an existing service is not meeting the needs of the population, and appears unlikely to be able to do so. However careful consideration should be given to: identifying those areas which need to be de-commissioned as part of the overall commissioning strategy; agreeing the objectives of de-commissioning with all of the relevant decision makers from

the commissioning agencies in the CSP; and developing exit strategies that seek to minimise the impact on existing service users.

- Commissioning new services – you may need, for example, to identify substance misuse service providers elsewhere in the UK, and what opportunities there might be to work with them or existing local providers to develop new services.

Appendix 11 contains some references that may help you to manage service balance.

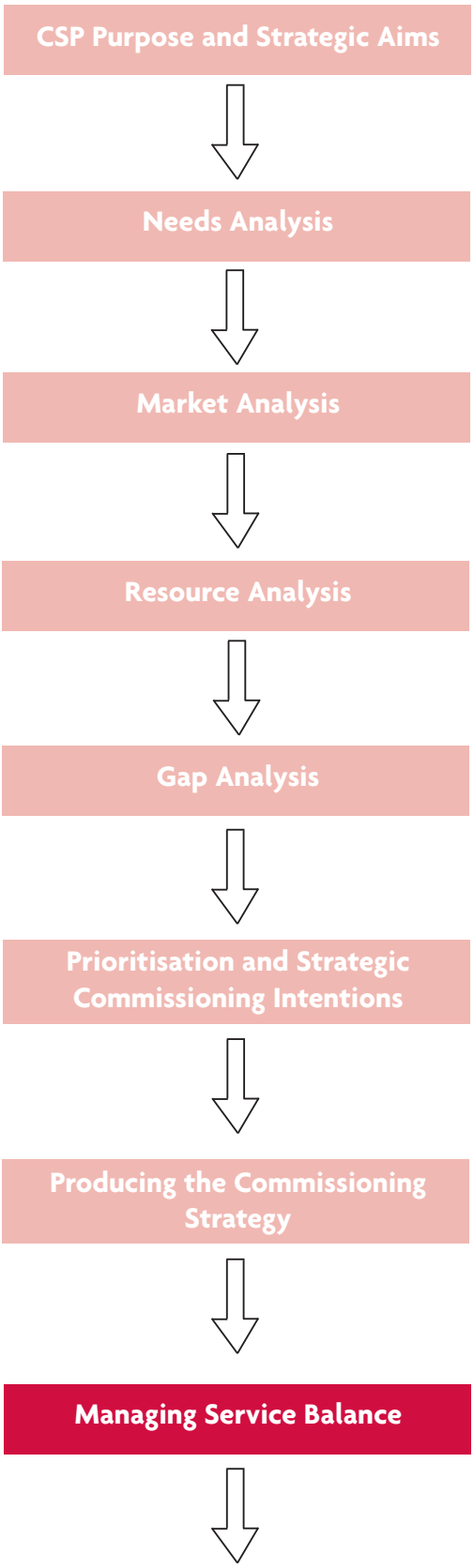
CHECKLIST: MANAGING SERVICE BALANCE

Before moving onto the next element check that you have:

- Completed a statement informed by your commissioning strategy which specifies the service balance you are aiming for. ☐
- Planned the activities required to achieve changes in service balance. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed the first element of this stage in the commissioning cycle:



You are now ready to move onto the remaining elements, all of which deal with the processes required to ensure that service balance is managed in ways which are fair, legal, effective and efficient.

4.3 ARRANGEMENTS FOR SPECIFYING SERVICES

Service specifications describe the nature and extent of the service you wish to purchase and they can be structured in different ways. They must focus on the outputs and outcomes you want the service to achieve but can have varying levels up to and including specifying every aspect of the service to be provided. You should develop or review a service specification for each of the services you have identified in your commissioning strategy. You may need to ensure that:

- Specifications will reflect identified needs.
- Specifications will take account of issues of language, race and gender.
- Specifications will meet commissioning strategy objectives.
- Specifications will reflect nationally accepted best practice.
- Specifications will include specific locally agreed principles and values.
- Specifications will include specific national standards/ related targets.
- Specification will include expectations in relation to staffing levels, training, qualification and experience.
- Specifications will comply with local or national service standards and guidance.
- Specifications will include a standardised range of output and outcome measures.

You will need to ensure that the proposed arrangements are clear and agreed by all CSP members.

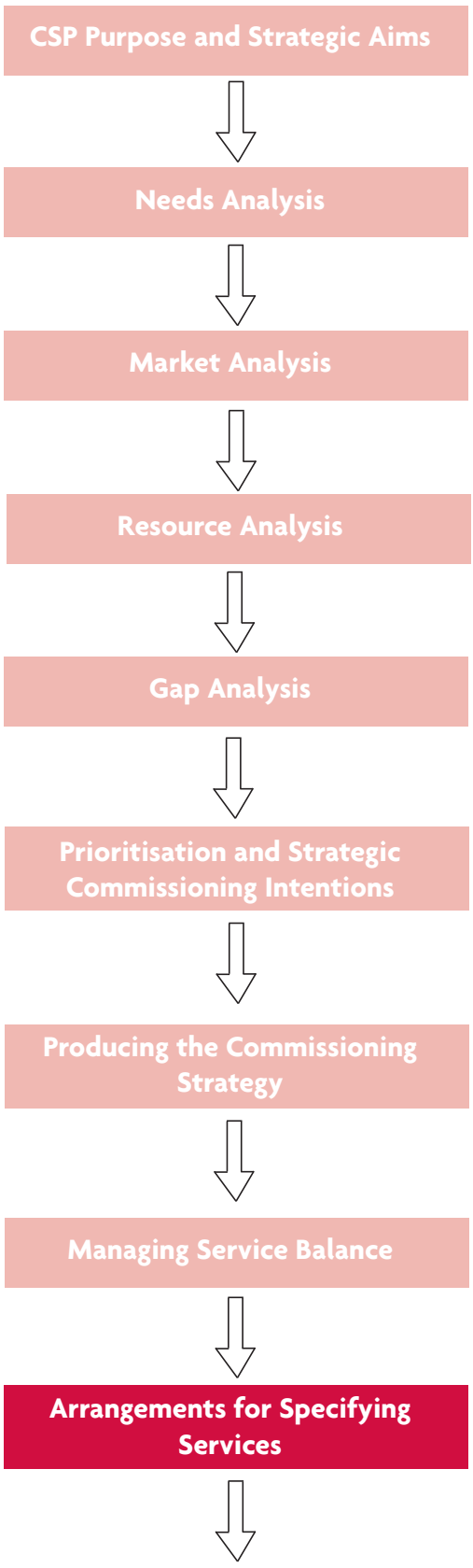
CHECKLIST: ARRANGEMENTS FOR SPECIFYING SERVICES

Before moving onto the next stage check that you have made the necessary arrangements to ensure:

- Clear arrangements have been made and agreed by all CSP members for specifying services. ☐
- Specifications are developed for all services in your commissioning strategy. ☐
- All existing service specifications are reviewed and amended where required. ☐

Your Progress

You should now have completed the following elements of the commissioning process:



You are now ready to move onto the next element, arrangements for selecting service providers.

4.4 ARRANGEMENTS FOR SELECTING SERVICE PROVIDERS

This element is concerned with determining processes that will ensure the most appropriate providers are selected to deliver good quality services that offer the best value for money. Your CSP partners need to agree:

- Which agency is going to lead the tendering process?
- How tenders are to be evaluated against specified criteria.
- How risk assessments regarding the viability of provider organisations are to be undertaken.
- What arrangements are to be made for involving all commissioning agencies in the selection process.

Appendix 12 contains some references which may help you to make the arrangements for selecting service providers.

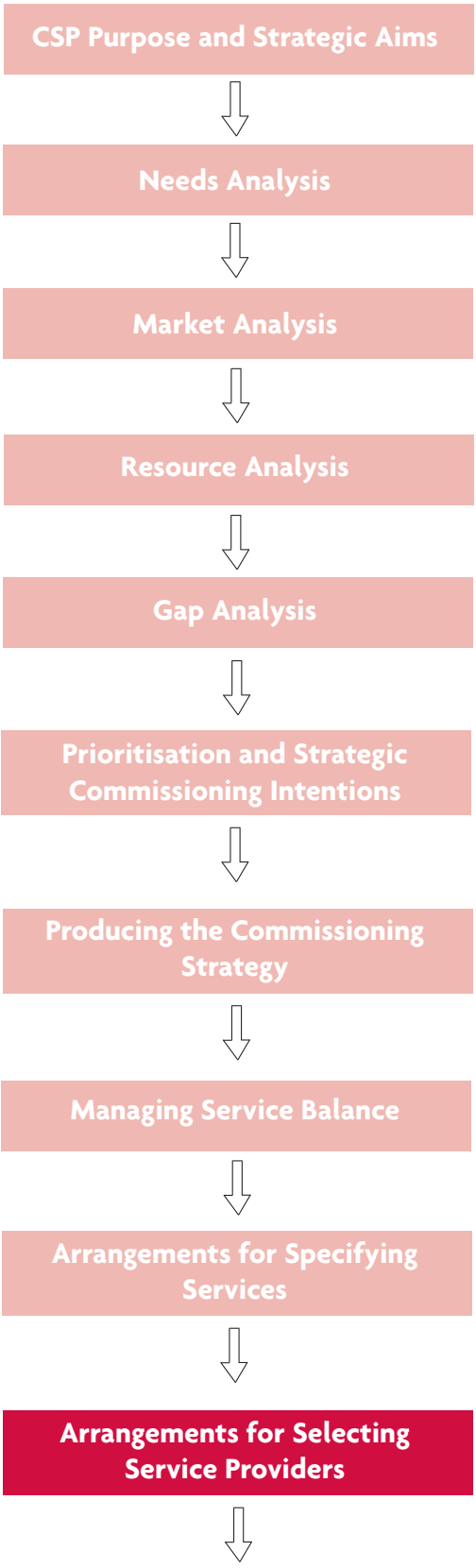
CHECKLIST: ARRANGEMENTS FOR SELECTING SERVICE PROVIDERS

Before moving onto the next element check that you have:

- Agreed a lead agency for the tendering process. ☐
- Agreed an evaluation criteria for tenders. ☐
- Agreed arrangements for risk assessment of providers. ☐
- Agreed arrangements for the selection process. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed three elements of the doing stage of the commissioning cycle:



You are now ready to move onto the next element, arrangements for contracting.

4.5 ARRANGEMENTS FOR CONTRACTING

You will need to make formal arrangements for contracting which are agreed by the CSP. They will need to be legal and acceptable to all members and realistically designed to meet the size and nature of the services involved. CSPs need to be aware that this may be a lengthy process which may take 3-6 months. Some of the issues which will need to be agreed by the CSP agencies will include:

- Which agency is to be the lead agency for contracting services?
- Whether a contract manager is required for larger contracts, who this should be and if resources need to be allocated for this.
- Type of contracts to be used e.g. block, spot, cost and/or volume.
- The format for contract conditions/clauses, which cover all contingencies including for example: the contract period and timescale; recording and reviewing arrangements; specific expectations of the provider, such as health and safety, confidentiality, insurance etc; options for variations/extensions; dispute resolution; termination or suspension.

Appendix 13 contains some references which may help you to make the arrangements for contracting.

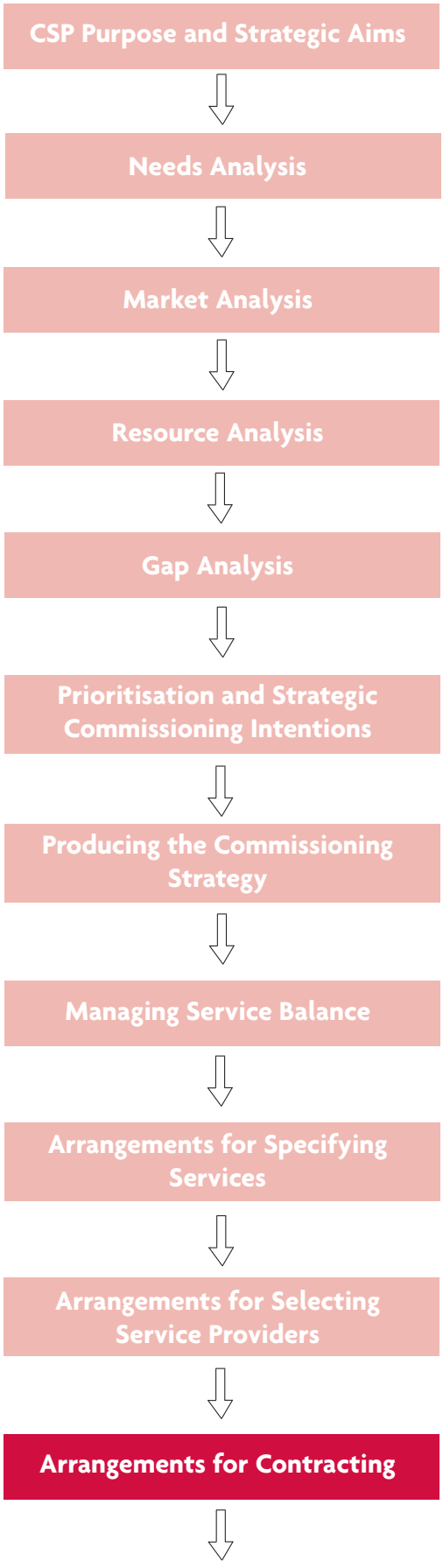
CHECKLIST: ARRANGEMENTS FOR CONTRACTING

Before moving onto the next stage check that you have:

- Agreed a lead agency for contracting services. ☐
- Agreed the types and format of contracts to be used. ☐
- Agreed who should be contract manager (if required). ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed four elements of this stage of the commissioning cycle:



You are now ready to move onto the next element, ensuring quality.

4.6 ENSURING QUALITY

In addition to the arrangements for setting and managing contracts, you need also to develop quality assurance criteria that can be included in contracts. Quality assurance criteria might include the following:

- Your expectations about how providers will minimise barriers to accessing services.
- Your expectations about how providers will ensure service users are not excluded on the basis of language, race, gender, disability etc.
- Your expectations about provider inputs into the single assessment process, integrated care pathways, care planning and review and/or care co-ordination.
- Your expectations about the type of outputs and outcomes providers are expected to report to demonstrate the extent to which their service is achieving its objectives.
- Your expectations about how providers will demonstrate that their service is cost effective and represents best value.
- Your expectations about levels of training and qualifications of staff employed by providers.
- Your expectations about how providers will ensure that national and local standards are met constantly.

It may be helpful to set up a team of commissioners and service providers to develop quality assurance criteria. A seemingly simple term such as 'accessibility,' for example, could entail a number of factors such as:

- Is the service available at times and in locations that would suit the client group?
- Does the service have an appropriate physical environment?
- Do service providers have access to Welsh-speaking staff? Is the service able to deliver the service through the medium of Welsh?
- Does the provider have regard to diversity, within its staff group?
- Can clients self-refer or do they need to be referred by an agency?

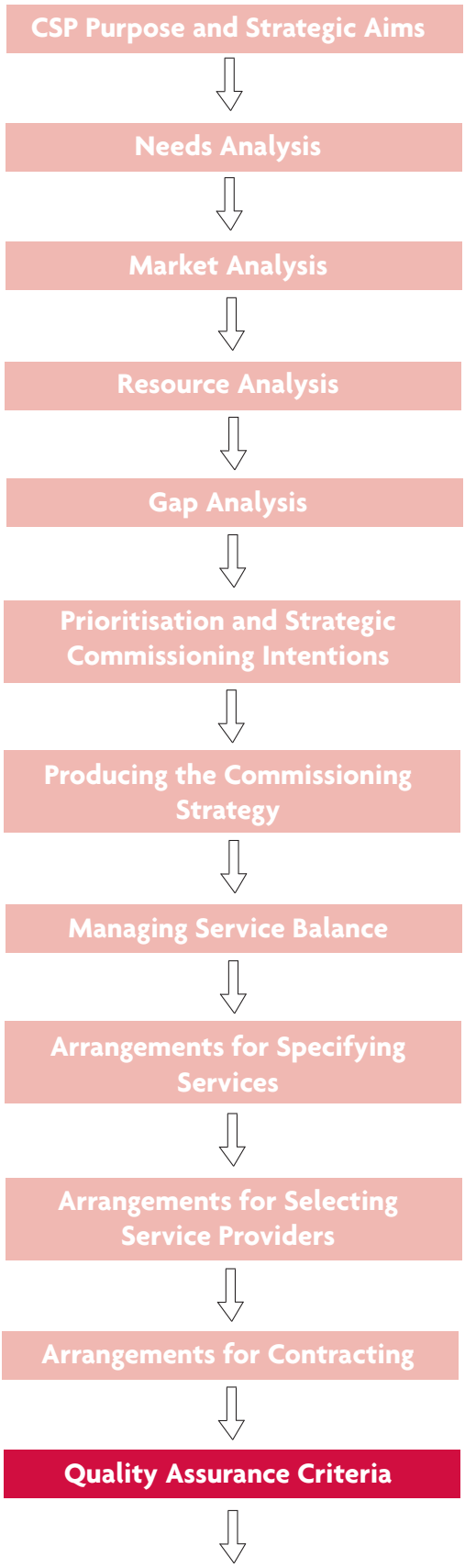
CHECKLIST: ENSURING QUALITY

Before moving on to the next stage, check that you have:

- Developed and agreed appropriate quality assurance criteria. ☐
- Included the criteria in contracts. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed all of the 5 elements in this stage:



You are now ready to move onto the next element, identifying potential new providers.

4.7 IDENTIFYING POTENTIAL NEW PROVIDERS

- What possible alternative suppliers of services are here?
- What kind of services might they offer?

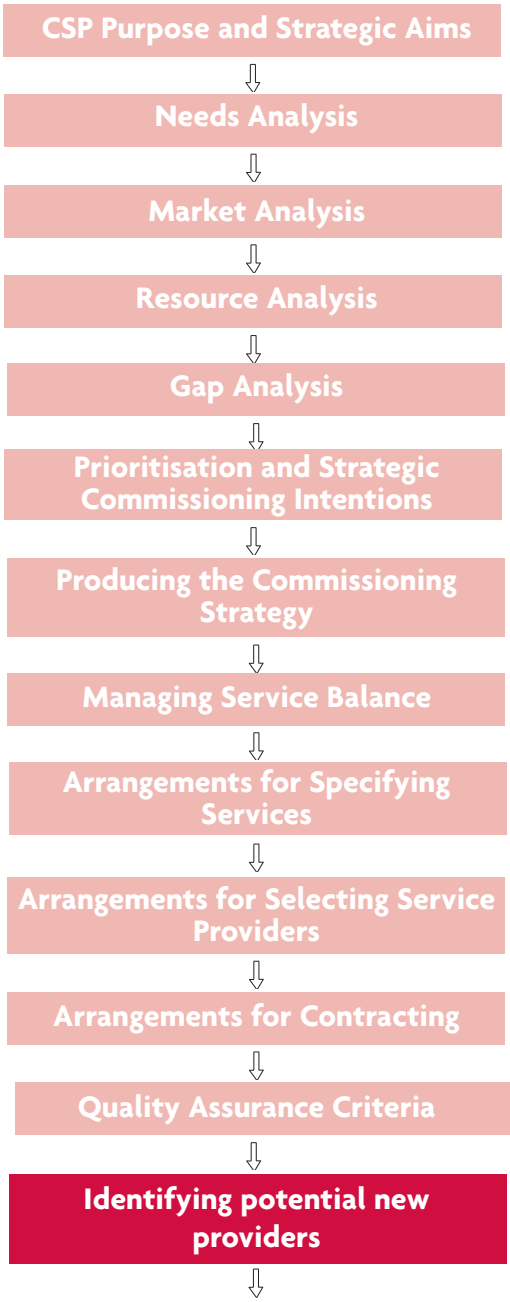
CHECKLIST: IDENTIFYING POTENTIAL NEW PROVIDERS

Before moving on to the next stage, check that you have:

- Identified any possible alternative suppliers. ☐
- Confirmed what kind of services they offer. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed the all of the 5 elements in this stage:



You are now ready to move onto the next element, researching substance misuse services.

4.8 RESEARCHING SUBSTANCE MISUSE SERVICES

- Research services elsewhere in the UK.
- Consider opportunities to maintain and/or develop existing services.

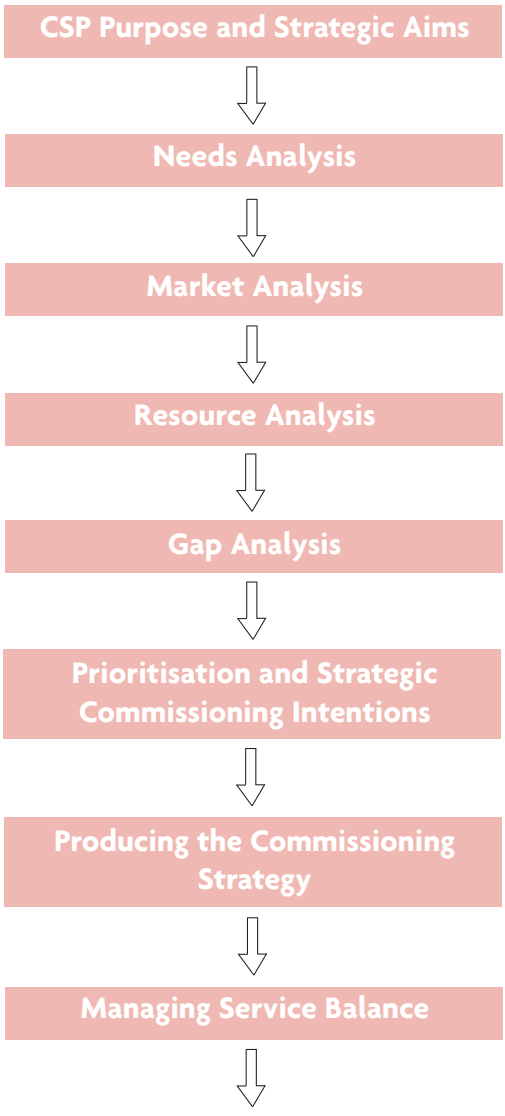
CHECKLIST: RESEARCHING SUBSTANCE MISUSE SERVICES

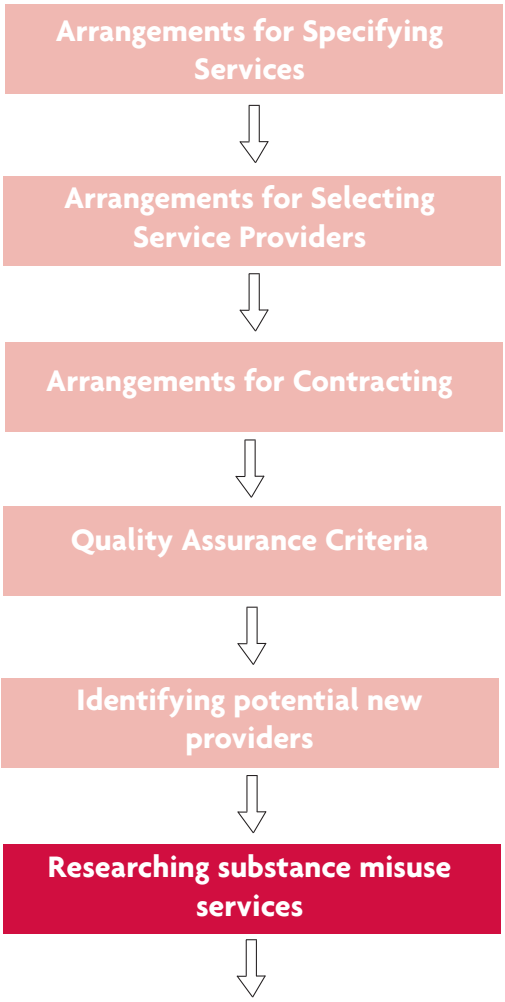
Before moving on to the next stage, check that you have:

- Completed a research of substance misuse services elsewhere in the UK. ☐
- Considered opportunities to maintain and/or develop existing services. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you should now have completed all of the 5 elements in this stage:





You are now ready to move onto the final stage of the commissioning cycle. The initial element of this final stage is strategy monitoring.

5 THE REVIEW STAGE – STRATEGY MONITORING, EVALUATION AND REVIEW

5.1 INTRODUCTION

This final stage of the commissioning cycle is concerned with monitoring, evaluating and reviewing the commissioning strategy and its impact, to determine whether the strategic objectives of the strategy are being met, the effectiveness of the services being commissioned and the impact of the commissioning strategy on tackling substance misuse.

5.2 MONITORING

Monitoring activities should allow the CSP to regularly ask questions about the services it is commissioning, such as the following:

- How are services performing against the agreed specification? (see section 4.4)
- Are services meeting assessed need?
- Are services being provided, to the required standard?
- How much do they cost and are they providing value for money?
- Are appropriate services being commissioned?

- To what extent are services meeting commissioning objectives?
- What are the views of service providers, service users, stakeholders and the wider public about the effectiveness of services?

And about the effectiveness of the strategy itself, such as:

- Are the gaps in service need being met?
- Do commissioning priorities need to be changed?
- Do services need to be commissioned differently?
- Is there a need to review and reconfigure existing services?

In order that the CSPs are in a position to undertake regular reviews of the commissioning strategy you need to monitor activity, performance and impact of services using the information from the new All-Wales Database and other corresponding information covering finance, user outcomes and possibly drug/alcohol crime related figures.

It will be important to set the parameters for reporting in terms of frequency and type of reports. Service providers have agreed to report in to the new database on a monthly basis (though those with high volume levels have indicated they will be reporting in fortnightly). During the work to develop the standardised reporting feature of the new system, partnerships and providers have indicated a preference for quarterly standard reports which will be available at individual provider level, partnership, regional and All-Wales levels. For the purposes of reviewing commissioning strategies, quarterly reports to inform reviews would seem the most pragmatic approach and would allow partnerships and providers to use the information contained in the new database and exploit it to its fullest potential.

All data submitted to the new database will be subject to standard validation tests. However, this will not validate the reliability of the source information so it will be important for partnerships to consider whether any data quality audits at source are required.

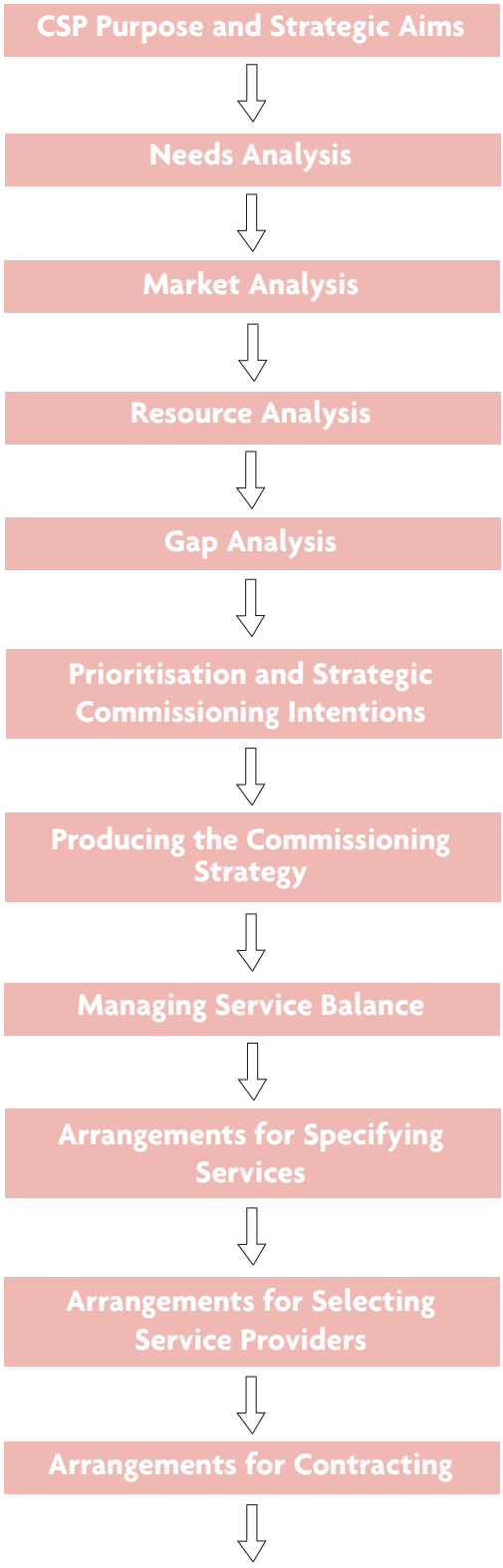
CHECKLIST: MONITORING

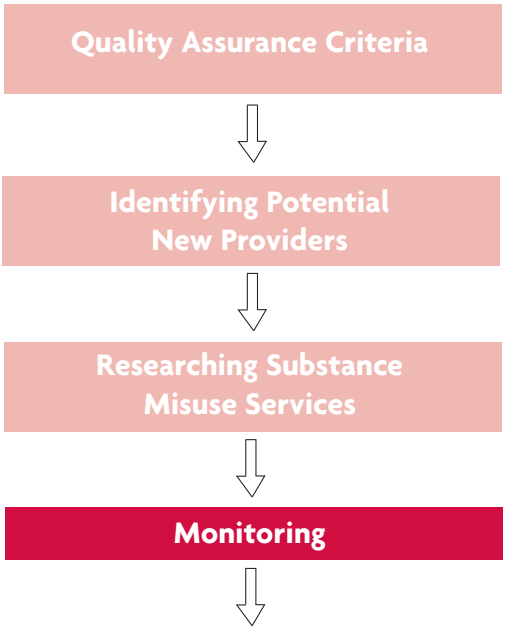
Before moving onto the next stage check that you have:

- Put in place formed mechanisms for the monitoring and analysis of data. ☐
- Assessed performance against service specifications. ☐
- Consulted with stakeholders about service effectiveness. ☐
- Identified and agreed any changes to the commissioning strategy. ☐

Your Progress

If you have ticked all of the boxes in the checklist you should now have completed the following elements of the reviewing stage:





You are now ready to move onto the next element, evaluation and review.

5.3 EVALUATION AND REVIEW

To complement these ongoing monitoring arrangements, it will be important for CSPs to establish formal mechanisms to evaluate the information collected, to inform periodic review of commissioned services and the performance of the strategy as a whole. By evaluating and reviewing the services you are commissioning, you are kept informed of the arrangements that you have put in place. Things that you may wish to consider are:

- Establish a strategy review group comprising, for example members of the CSP, (e.g. LHB, LA, Police, Probation), service providers and service users.
- Agreeing terms of reference for the review group to use to consider activity, performance and outcomes for service users and its implications.
- Agreeing regular points in the year where data will be collected and analysed.
- Agreeing how performance problems identified by the monitoring information will be addressed by the CSP.
- Agreeing how recommendations from the group about changes to commissioning priorities and consequent review of resource allocation will be considered and formally adopted by the CSP.
- Considering how national policy and legislation impact on commissioning priorities?

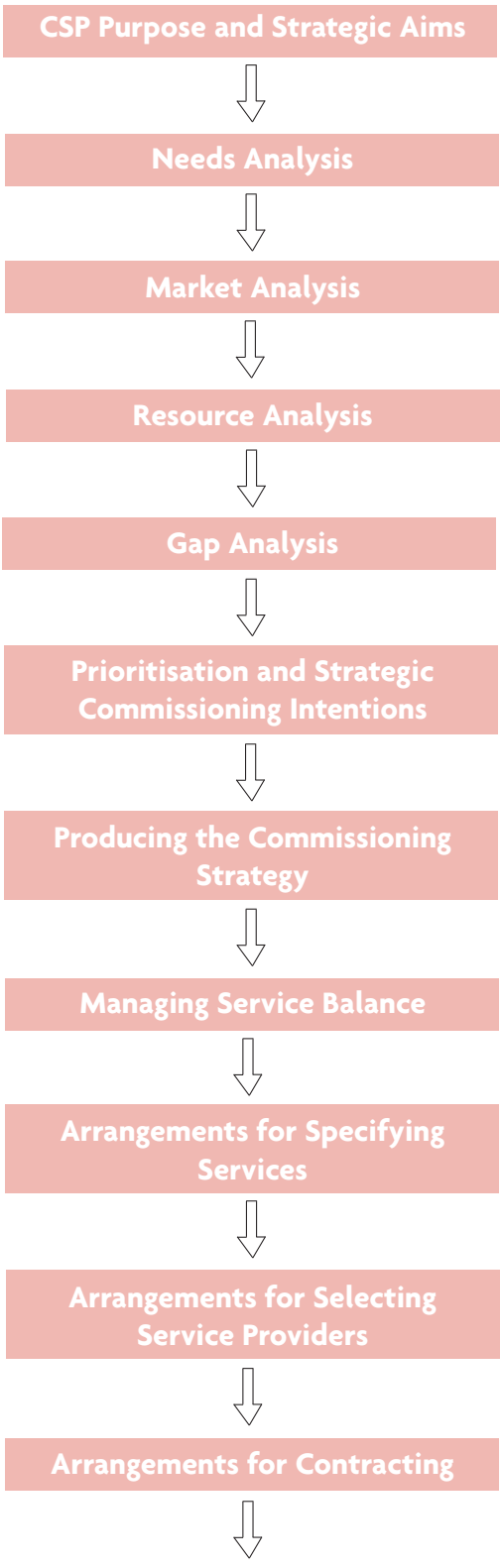
CHECKLIST: EVALUATION AND REVIEW

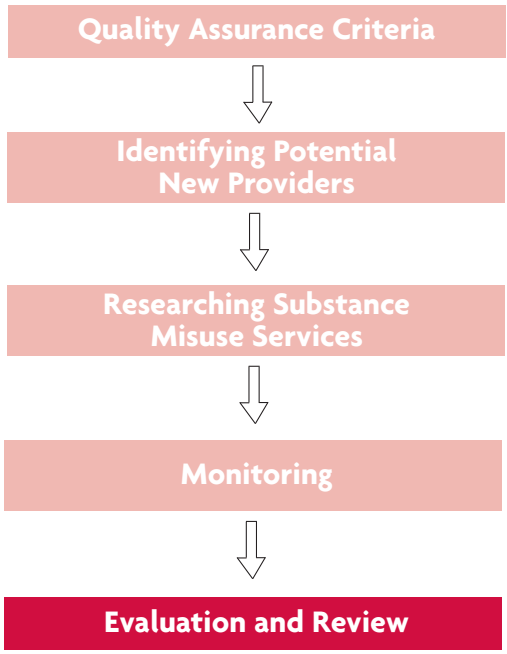
Check that you have:

- Put in place arrangements to ensure regular evaluation and reviews (by the CSP) of the information that is being collected. ☐
- Put in place arrangements that enable the CSP to respond to changing commissioning priorities, which arise from the evaluation and reviewing activity. ☐

Your Progress

If you have ticked all of the boxes in the checklist, you have now completed the evaluation and review element of the final monitoring stage of the commissioning cycle.





An outline of all the stages and elements in the commissioning cycle can be found in Appendix 14.

APPENDIX 1

MATRIX FOR ANALYSING APPROACHES TO COMMISSIONING

This appendix is designed as a self-assessment tool for you to use as you prepare to work with partner agencies on the CSP to develop a commissioning strategy. The matrix will enable help you to analyse:

- where your CSP is now in terms of it's joint approach to commissioning; and
- where you think you would like to be to function more effectively.

Based on materials including; Integrated Working: A Guide (Integrated Care Network 2004), A Catalyst for Change (Department of Health, 2004) and Making Ends Meet (Audit Commission, 2003), and work by the Institute of Public Care at Oxford Brookes University, this matrix can be used to analyse the extent to which different aspect of the commissioning process are integrated across agencies. The matrix considers the following areas:

- Purpose and strategy.
- Needs and market intelligence.
- Stakeholder engagement.
- Resource allocation and management.
- Market monitoring and management.
- Commissioning function.

The matrix also differentiates between the following 4 levels of integration:

- Separate Approaches: Actions and decisions are arrived at independently and without co-ordination.
- Parallel Approaches: Objectives, plans, actions and decisions are arrived at with reference to other agencies.
- Joint Approaches: Objectives, plans, actions and decisions are developed in partnership by separate agencies.
- Integrated Approaches: Objectives, plans, actions and decisions are arrived at through a single organisation or network.

Examples of activities at each level are described in the matrix.

Areas	Separate Approaches Objectives, plans, decisions and actions are arrived at independently and without co-ordination.	Parallel Approaches Objectives, plans, decisions and actions are arrived at with reference to other agencies.	Joint Approaches Objectives, plans, decisions and actions are arrived at in partnership by separate agencies.	Integrated Approaches Objectives, plans, decisions and actions are arrived at through a single organisation or network.
Purpose and Strategy	• Agencies develop services to meet their own priorities. • Single agency planning documents do not include key partner's priorities and drivers. • Single-agency commissioning strategies.	• Systematic analysis of partner agency perspectives, issues and concerns. • Liaison in the production of separate strategies. • Strategies reference and address partner's issues.	• Shared commitment to improve outcomes across client group. • Joint strategy development teams producing common strategies.	• Inclusive planning and decision process as an integral partner. • A transparent relationship between integrated bodies. • Single agency with one commissioning function.
Needs and Market Intelligence	• Needs analysis is undertaken independently, and deals with very specific aspects of population need. • Agencies use provider intelligence for the purpose of identifying their own commissioning priorities only.	• Separate needs analyses shared by agencies. • Separate cost, benchmarking and general market intelligence shared by agencies.	• Jointly designed population needs analysis. • Joint working groups to review market mix.	• Single projects undertaking needs and market analysis and using these to inform commissioning and contracting priorities. • Single research, analysis, public health teams.
Stakeholder Engagement	• Public meetings, conferences, feedback are designed and delivered independently.	• Information from service users or service providers is shared when clearly relevant.	• Agencies jointly design and manage consultation and feedback activities.	• A single team is responsible for systematic planning and delivery of provider consultation to inform a single strategy.

Areas	Separate Approaches **Objectives, plans, decisions and actions are arrived at independently and without co-ordination.**	Parallel Approaches **Objectives, plans, decisions and actions are arrived at with reference to other agencies.**	Joint Approaches **Objectives, plans, decisions and actions are arrived at in partnership by separate agencies.**	Integrated Approaches **Objectives, plans, decisions and actions are arrived at through a single organisation or network.**
Resource allocation and management	• Budgets are used solely to meet self-determined objectives. • The financial impact of services and policies on other agencies is not considered.	• Agencies allocate some resources to address issues of common concern.	• Agencies identify pooled budgets for particular areas, and a joint approach to decision making on budget allocation to meet common objectives.	• Pooled budgets within a single agency or network, to meet combined needs identified for the population.
Market monitoring and management	• Market monitoring sited in single organisation. A fragmented approach to use of providers and resources. • Provider performance information not shared between agencies.	• Contracting, tendering and monitoring arrangements shared to promote commonality and consistency. • Agencies inform each other of purchasing intentions.	• Multi-agency groups ensure contract terms are realistic and deliverable by providers. • Sharing of risk with market development.	• Integrated monitoring and review arrangements that result in a shared understanding of the effectiveness of current services and the evidence for changes in the future.
Commissioning Functions	• Agencies have their own teams to support their commissioning activities.	• Agencies liaise re: commissioning activities (e.g. needs analysis, monitoring of individual agency strategies) in order to support common commissioning objectives. • Identified common training and development needs within agencies.	• Emerging hybrid roles support a joint strategic commissioning function across agencies. • A clear understanding of the resources and skills required to provide support to joint strategic commissioning. • Joint appointments of commissioning staff.	• Integrated commissioning function, e.g. a single manager with responsibility for managing commissioning and contracting within a single organisation or network.

APPENDIX 2

THE NATIONAL AGENDA

This appendix relates to section 2.2.3 in the document and will be useful when you are identifying the key policies and principles which underpin your commissioning strategy. The appendix contains summaries of and links to:

- National Policy and Guidance.
- Research.
- Best Practice.

NATIONAL POLICY AND GUIDANCE

Many of the following sources are Welsh documents, some are published in England but apply to the whole of the UK; others which do not apply directly to Wales are also included as they may provide useful reference materials.

Tackling Substance Misuse in Wales (2000)

The Welsh Assembly Government's eight year strategy *Tackling Substance Misuse in Wales: A Partnership Approach* was launched in May 2000 and can be accessed at the National Assembly's website at www.wales.gov.uk

The document explains that substance misuse in Wales is a complex, dynamic and multi-faceted problem that involves both illegal and legal substances. Not only does it impact on the lives of those who misuse substances, from those who experiment to those who are heavily dependent, but also upon their families and communities.

The strategy covers the full range of substances that are misused in Wales, including:

- Illegal drugs such as heroin, cocaine, ecstasy, amphetamines, LSD, cannabis.
- Alcohol.
- Prescription only medicines such as anabolic steroids and benzodiazepines.
- Over-the-counter medicines such as preparations containing codeine or ephedrine, and
- Volatile substances such as aerosol propellants, butane, solvents and glues.

Whilst there are features that distinguish illegal drugs from other substances that are misused, they are brought together in this strategy for the following reasons:

- Similar factors may lead to the misuse of both legal and illegal substances and there is some overlap in the responses that are needed to deal with the problems that arise from their misuse.
- The misuse of different substances often results in similar physical, psychological and social problems, and
- Individuals frequently misuse a combination of substances.

The four key aims of *Tackling Substance Misuse in Wales* are:

- Children, young people and adults: to help children, young people and adults resist substance misuse in order to achieve their full potential in society, and to promote sensible drinking in the context of a health lifestyle.
- Families and Communities: to protect families and communities from anti-social and criminal behaviour and health risks associated with substance misuse.
- Treatment: to enable people with substance misuse problems to overcome them and live healthy and fulfilling lives and in the case of offenders, crime-free lives.
- Availability: to stifle the availability of illegal drugs on our streets and inappropriate availability of other substances.

Tackling Substance Misuse in Wales: A Partnership Approach can be found at: www.wales.gov.uk/subisocialpolicy/content/direct/misuse.htm

Local Substance Misuse Action Plans in Wales: Guidance Notes For Completion 2005-2008

This statutory guidance has been issued by the Welsh Assembly Government on behalf of the National Assembly for Wales for the development of Local Substance Misuse Action Plans. It provides advice to responsible authorities on the development of these plans. The guidance can be accessed at:
http://www.wales.gov.uk/subicsu/content/keypubs/smap-2005-08-guidance-e.pdf

Local Substance Misuse Action Plans (LSMAPs) in Wales (2004)

Examples of some of the LSMAPs can be accessed via the following CSP websites:

Bridgend	www.bridgend.gov.uk
Blaenau Gwent	www.blaenau-gwent.gov.uk
Caerphilly	www.caerphilly.gov.uk
Cardiff	www.cardiff.gov.uk
Carmarthenshire	Website being developed

Flintshire	Website being developed
Merthyr Tydfil	www.wales.nhs.uk/lhg/documents/substance%20misuse%20action%20plan.pdf
Neath Port Talbot	www.npt.gov.uk/communitysafety
Newport	www.newport.gov.uk
Pembrokeshire	www.pembrokeshire.gov.uk
Powys	www.csg.powys.org.uk
Rhondda Cynon Taff	www.rhondda-cynon-taff.gov.uk
Swansea	www.saferswansea.org.uk
Torfaen	www.torfaen.gov.uk
Vale of Glamorgan	www.valeofglamorgan.gov.uk
Wrexham	Website being developed

Health, Social Care and Well-being Strategies. Policy Guidance (2003)

This guidance from the Welsh Assembly Government supports the statutory guidance set out in 'Health, Social Care and Well-being Strategies: Preparing a Strategy'. It provides advice to local authorities, local health boards, NHS Trusts, Health Commission Wales (Specialist Services), Community Health Councils (CHCs), County Voluntary Councils (CVCs), voluntary organisations, local businesses and other organisations, patients, service users and carers and local communities on the implementation of the Welsh Assembly Government's policy on Health, Social Care and Well-being Strategies. The HSCWB Policy Guidance can be accessed at: http://www.wales.gov.uk/subihealth/content/keypubs/pdf/policy-guide-e.pdf

Welsh Health Circular (2004) 083. Annual Priorities and Planning Guidance for the Service and Financial Framework 2005-06

This circular (for action by: NHS Trust, Local Health Boards and Health Commission Wales) sets out the Welsh Assembly Government's expectations for the preparation of Service and Financial Frameworks (SaFFs) for 2005-06. The SaFFs set out the delivery plans agreed by the Service to achieve the Welsh Assembly Government's priorities and requirements alongside local priorities, within the context of the financial resources provided.

Better Health, Better Wales Strategic Framework (1998)

Better Health, Better Wales sets out an approach to tackling the underlying causes of ill-health and states the following aims:

- Preventing disease and substantially improving the health and well-being of people in Wales.
- Bringing the level of those with the poorest health up to the level of those with the best health.
- Improving the health and well-being of children.
- Encouraging individual responsibility for health.

- Improving the health and safety of people at work by:
    - Ensuring that health impact is a consideration on everyone's agenda in policy development and implementation.
    - Using new forms of collaboration to achieve better results and better value for money.
    - Directing efforts at local levels to ensure health and social care decisions are taken together by local representatives, professionals and administrators.
    - Making better information on health at local levels available to the public and others to inform healthy choices.
    - Directing research programmes to address the links between poor health and other factors which contribute to health and well-being in Wales.

The values under-pinning this approach are:

Fairness - everybody should have access to treatment and services according to their needs - health and well-being should not depend on where you live.

Effectiveness - health policy should be based on the most up-to-date information and practice in order to prevent disease and promote health.

Efficiency - the public, private and voluntary sectors should use their resources to achieve best value for money to reduce avoidable ill-health.

Responsiveness - individuals should have access to the information they need to make informed choices about health and social care.

Integration - inter-agency collaboration through shared decision-making should improve the health and well-being of individuals and communities.

Accountability - each organisation should be accountable for its responsibilities for health and well-being.

Flexibility - management systems must be flexible enough to respond to local circumstances and needs while also enabling private, public and other organisations to deliver health improvements.

The document stated that a medium to long-term strategy was needed to tackle the causes of inequalities in health status and it required short, medium and long-term aims with appropriate indicators and targets to monitor progress and demonstrate achievements. The starting point is:

- Planning health improvement beyond the next 5 years.
- Building on existing health gain targets.
- Researching the links between poor living conditions and poor health.

- Developing additional indicators/targets relating to inequalities and health determinants.
- Partnership and collaboration at community, local and central levels.
- Innovative use of available resources across boundaries.
- Promotion of joint professional training, research and development, and information sharing.
- Appropriate structural and organisational development.

The document explains that the strategy was to be taken forward under the arrangements for the National Assembly for Wales from 1999. To provide the basis for action, the Welsh Office published an Action Plan in September 1998 based on the framework outlined in this document and informed by responses to the consultation.

Copies of *Better Health, Better Wales* can be accessed at: http://www.archive.official-documents.co.uk/document/cm39/3922/e-cntnt.htm

The National Policing Plan (2002)

The first annual *National Policing Plan* for the police service in England and Wales was published following the passage of the Police Reform Act 2002. The National Policing Plan found at: www.policereform.gov.uk/docs was published by the Home Secretary after consultation with the Association of Chief Police Officers, the Association of Police Authorities and other key stakeholders represented on the National Police Forum. Before the *National Policing Plan* there was no single place where the Government's priorities, performance indicators and plans for new developments came together. The Plan changes that by setting out strategic national priorities for the police service and the indicators against which the performance of the service is to be judged.

The Plan provides the strategic national overview against which chief officers and police authorities should prepare their own local three-year strategy plans and annual policing plans. Three-year plans are another innovation introduced by the Police Reform Act, aimed at strengthening police authorities' capacity to focus on the medium to longer-term direction of the force. Under the Act, chief officers and police authorities must have regard to the *National Policing Plan* when preparing and issuing their plans. The primary objective for the police service for the Plan's three year duration is to deliver improved police performance and greater public reassurance with particular regard to the following priorities:

- Tackling anti-social behaviour and disorder.
- Reducing volume, street, drug-related and violent and gun crime in line with local and national targets.
- Combating serious and organised crime operating across force boundaries.

- Increasing the number of offences brought to justice.

In pursuing these strategic priorities the police service must work in partnership with other national and local agencies.

Local three-year strategy plans www.policereform.gov.uk/docs/guid3yr_strategy.pdf and annual policing plans must, while contributing to the delivery of national priorities, reflect local circumstances and be responsive to local needs. It is vitally important that police authorities and chief police officers engage and consult their local communities to identify how far national and local priorities should be reflected in forces' plans and what the appropriate local targets should be.

Models of Care for Treatment of Adult Drug Misusers (2002)

Models of Care was published by the National Treatment Agency (NTA) in 2002. The NTA has a remit to increase the availability, capacity and effectiveness of treatment for drug misuse in England. *Models of Care* sets out a national framework for the commissioning of adult treatment for drug misuse in England and was published in two parts:

- Part one: a document for drug commissioners and those responsible for local implementation.
- Part two: a detailed reference document for drug treatment managers and providers, and for those responsible for assuring the quality and appropriate delivery of local drug treatment services.

It should be noted that *Models of Care* does not cover alcohol misuse. Copies of *Models of Care* can be ordered from nta.enquiries@nta.gsi.gov.uk

Changing Habits: The Commissioning and Management of Community Drug Treatment Services for Adults (2002)

This reports on the results of a study undertaken by the Audit Commission to review the provision of community-based drug treatment services for adults, identify any problems and suggest how these could be overcome. The report sets out practical recommendations to enable drug action teams (Community Safety Partnerships in Wales), local commissioners and service providers, to review their specialist services and joint commissioning arrangements. The report can be found at www.audit-commission.gov.uk

Designed for Life

A new vision is required, to update *Improving Health in Wales* and describe what kind of health and social care services the people of Wales can expect by 2015.

In particular, the vision will aim to:

- improve health and reduce, and where possible eliminate, inequalities in health

- support the role of citizens in promoting their health, individually an collectively
- develop the role of local communities in creating and sustaining health
- promote independence, service user involvement and clinical and professional leadership
- re-cast the role of all elements of health and social care so that the citizen will be seen and treated by high quality staff at home or locally - or passed quickly to excellent specialist care, where this is needed
- provide quality assured clinical treatment and care appropriate to need, and based on evidence
- strengthen accountability, developing a more corporate approach in NHS Wales so that organisations work together rather than separately
- ensure full public health engagement at both local and national levels.

The 10-year vision does not just clearly state aspirations, but also highlights the challenging decisions and difficult changes which will be required to build new health and social care services for Wales.

Designed for Care

The Welsh Assembly Government are committed to working with their partners over the coming year to develop a comprehensive social care and social services framework which will parallel Designed for Life.

Healthcare Standards for Wales

The Healthcare Standards set out in this document have been developed with the following objectives in mind:

- to promote care based on shared values that can be adopted universally, ensuring that quality services are patient and user centred and provided equitably, robustly and ethically across the full breadth of services we provide, no matter what the setting;
- to establish a basis for continuous improvement to help ensure that additional resources made available deliver the improved levels of patient care the people of Wales have a right reasonably to expect; to provide a framework both for self-assessment by all healthcare organisations and for external review and investigation by Healthcare Inspectorate Wales;
- to help clarify the current complicated array of standards and guidance on the NHS, independent and voluntary sectors, with a view to, over time, simplifying and rationalising expectations on the service; and

- to enhance the reputation of the NHS in Wales as a model employer, commissioner and provider of services which delivers the benefits of improved services equitably to all members of society.

The healthcare standards will also provide a solid base on which healthcare organisations can build and achieve the new and more challenging expectations for patient care set out in the Welsh Assembly Government's 10-year strategy, *'Designed for Life'*, which is being published in parallel with *'Healthcare Standards for Wales'*.

Health Challenge Wales

Health Challenge Wales is not another 'programme', 'strategy' or 'framework' but a single focus for everyone's efforts to improve health. It is a means by which everyone - organisations in all sectors and individuals of all ages - can be challenged to do more to improve health. It's something behind which everyone can put their support as part of a co-ordinated and sustained national effort.

Department of Health Guidance on Substance Misuse

From the web-link below you can click on a number of other links for substance misuse, for example:

- General information about substance misuse.
- A-Z of substance misuse guidance and publications.
- Evaluation of pump-priming drug prevention projects in health action zones.
- Substance misuse websites.

http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SubstanceMisuse/fs/en

A Review of Drugs Policy and Proposals for the Future by Association of Chief Police Officers (2002)

The review is divided into two sections. The first part reviews the progress being achieved within the government strategy and the second part outlines the ACPO's policy proposals to achieve the government drugs objectives. The overall aim of the ACPO Drugs Policy is to disrupt and reduce supply while at the same time working to achieve demand reduction. A full account of the review can be found at:
http://www.acpo.police.uk/policies/ACPO%20Drugs%20Policy.doc

All Wales Youth Offending Strategy (2004)

This strategy, launched in July 2004, sets out the way to prevent young people in Wales from offending and incorporates the aims of both the Youth Justice Board and Welsh Assembly Government policies. It lays a shared foundation which should ensure that Youth Offending Teams and other agencies are able to work more effectively to prevent offending by

young people in Wales. A full account of the strategy can be found at: http://www.wales.gov.uk/subicsu/content/youth/strategy-e.pdf

Bold Steps. National Probation Service for England and Wales 2004-2005 Business Plan

This plan summarises the priorities, objectives and targets for the National Probation Service for England and Wales in 2004-2005. The primary audience is managers and senior managers and local plans should reflect the targets from the national plan. Delivery of 'Bold Steps' will underpin the longer term aims of the Criminal Justice Act and the move towards implementation of the National Offender Management Service (NOMS). Bold Steps can be accessed at: http://www.probation.homeoffice.gov.uk/files/pdf/BoldSteps.pdf

Child and Adolescent Mental Health Services for Wales. Everybody's Business Consultation Strategy Document (June 2000)

The CAMHS Strategy document contains a section relating to services for children who use or misuse substances. The CAMHS Consultation Strategy Document can be accessed at: http://www.wales.gov.uk/subihealth/content/consultations/menhealth/childandadolescentmentalheal_e.htm

Health Behaviour in School-aged Children (HBSC) Survey (2004)

This short report is the second in a series of Health Behaviour in School-aged Children (HBSC) briefings aimed at highlighting aspects of young people's health targeted in the Welsh Assembly Government's key policies and programmes on adolescent health. The report compares Wales with selected HBSC countries, with a focus on tobacco smoking, cannabis use and alcohol use. The HBSC Survey can be accessed at: http://www.cmo.wales.gov.uk/content/publications/reports/hbsc2-e.pdf

Tackling Domestic Abuse – The All Wales National Strategy (Draft) A Joint Agency Approach (June 2004)

This document sets out the Welsh Assembly Government's strategy to tackle domestic abuse. The strategy is the result of collaboration between the Welsh Assembly Government and a wide cross-section of Welsh agencies and organisations. The strategy's primary objective is to provide the much-needed structural 'backbone' to direct domestic abuse intervention across Wales. It aims to facilitate the development and implementation of a 'joined-up' problem-solving approach which addresses domestic abuse holistically – providing protection for individuals who suffer domestic abuse and simultaneously addressing the causes of domestic abuse. A full account of the strategy can be found at: http://www.wales.gov.uk/subicsu/content/domestic/dv-strategy-e.htm

Drug Misuse 2004. Reducing the local impact

This Criminal Justice National Report published by the Audit Commission in November 2004, provides an update on the 2002 Audit Commission study, *Changing Habits*. The report is aimed at decision makers in local authorities, education services, Welsh local health boards (LHBs)/English primary care trusts (PCTs), police, probation and prison services. The report looks beyond community treatment to determine how well the national drug strategy is being delivered locally. Whilst alcohol misuse falls outside the scope of the report, many of the recommendations are relevant to those who seek to reduce it. Although the report is concerned primarily with England, fieldwork was carried out in Wales.

The report traces two improvement journeys, illustrated using fictional stories. The first is for substance misusing individuals and the second for local agencies and partnerships. Both paths include the following three stages: recognising the problem; finding the right route; and maintaining progress. The report recognises the progress that has been made since 2002; and makes recommendations for local agencies and government to:

- Improve the focus on the drug user and carer.
- Provide 'follow-on' services, enabling drug users to complete the recovery journey.
- Reduce reliance on short-term funding streams, encouraging mainstream solutions; and
- Develop strategic regulation.

A full copy of the report can be found at www.audit-commission.gov.uk

Hidden Harm. Responding to the needs of children of problem drug users (2003)

This document reports on the findings of the Prevention Working Group of the Advisory Council on the Misuse of Drugs who carried out an in-depth inquiry between 2000 and 2003 into parental problem drug use, and its actual and potential effects on children. Problem drug use was defined as drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. The report is aimed at policy makers, service providers and others and can be accessed at:
http://www.drugs.gov.uk/ReportsandPublications/NationalStrategy/1054733801

Substance Misuse Treatment Frameworks (2004)

A Substance Misuse Treatment Framework Board was established in Wales during 2004, including Assembly officials and specialists from the substance misuse field. The Framework will enable responsible authorities and their partners in CSPs to compare the performance of services commissioned in their areas against agreed national standards.

The first stage has focused on the following service frameworks:

- Service Framework for Inpatient Treatment.
- Service Framework to Meet the Needs of People with a Co-occurring Substance Misuse and Mental Health Problem.
- Service Framework for Community Prescribing.
- Service Framework for Residential Rehabilitation.
- Needle Exchange Service Framework.

The Service Frameworks are available from: http://www.wales.gov.uk

National Reducing Re-offending Action Plan (July 2004)

The Reducing Re-offending National Action Plan aims to reduce re-offending through improved strategic direction and joined up working. It contains over sixty national action points, covering all the key areas, or pathways, to support the rehabilitation of offenders, with suggested activities for each, for those working at the regional and local level. The plan supports and builds on the changes which are taking place to reduce re-offending through the creation of a National Offender Management Service (NOMS). A complementary strategy is being developed in Wales, led by the Prison and Probation Services and the Welsh Assembly Government. The National Reducing Re-offending Action Plan can be accessed at: www.homeoffice.gov.uk/docs3/5505reoffending.pdf

Home Office Prolific and other Priority Offender (PPO) Strategy

The PPO Strategy is a single, coherent initiative in three complimentary strands to reduce crime and re-offending by targeting those who offend most or otherwise cause most harm to their communities. The three strands are Prevent and Deter, Catch and Convict and Rehabilitate and Resettle and the following guidance is designed to enable and support national implementation.

Catch and Convict (July 2004)
Rehabilitate and Resettle (September 2004)
Prevent and Deter (September 2004)

The Guidance documents are available at: www.crimereduction.gov.uk/ppo.

Throughcare and Aftercare in Wales (August 2004-6)

The Home Office has made funding available for Throughcare and Aftercare, as part of the Criminal Justice Interventions Programme (CJIP). £5 million has been devolved to the Welsh Assembly Government for implementation of Throughcare and Aftercare schemes in Wales for each of the years 2004/5 and 2005/6. Throughcare and Aftercare in Wales are to be introduced at a regional level, based on the four criminal justice regions in Wales. This document offers the four Shadow Regional Management

Boards (SRMBs) guidance on what elements Regional Implementation Plans should include, with flexibility to develop schemes that address local/regional need. Throughcare and Aftercare in Wales can be accessed at:
http://www.wales.gov.uk/subicsu/content/keypubs/care-guidance-e.pdf

National Strategy to Tackle Homelessness in Wales (March 2003)

The National Homelessness Strategy aims to tackle homelessness at local levels, and to ensure that the aims, objectives and targets of the Welsh Assembly Government to reduce the level and impact of homelessness and eliminate the need for rough sleeping are met. The Strategy contains a sub-section on substance misuse amongst homeless people, and can be accessed at: http://www.housing.wales.gov.uk/pdf.asp?a=j6

Supporting People in Wales (September 2001)

This paper contains a 'decisions' section which details the Welsh Assembly Government's position in relation to the arrangements for Supporting People and a guidance section which provides information on preparation for implementation of Supporting People. It can be accessed at:
http://www.housing.wales.gov.uk/index.asp?task=content&a=k1

Criminal Justice Act 2003

The Criminal Justice Act 2003 aims to implement the policies set out in the Government's White Paper, Justice for All (July 2002). It contains key features which relate to drug test results and bail and extensions in the age for drug testing. The Criminal Justice Act 2003 can be accessed at:
http://www.hmso.gov.uk/acts/acts2003/20030044.htm

NATIONAL AND INTERNATIONAL RESEARCH

National Advisory Committee on Drugs (Ireland)

The National Advisory Committee on Drugs (NACD) was established to assist in the continued need to improve knowledge and understanding of problem drug use. The goal of the NACD is to advise the Government on problem drug use in Ireland in relation to prevalence, prevention consequences and treatment based on their analysis and interpretation of research findings. http://www.nacd.ie/

A Review of Harm Reduction Approaches in Ireland and Evidence from the International Literature

In 2002, the National Advisory Committee on Drugs (NACD) commissioned a review of the international literature on harm reduction and of services available in Ireland, as part of its response to Action 100 in the *National Drug Strategy 2001-2008*. Following open tender, Dublin City University was awarded the contract. The research team reviewed the international literature and carried out primary research in health services in Ireland on approaches to harm reduction. This report considers the evidence and the summary here presents the key findings.
http://www.nacd.ie/publications/prevention_hr.html

Links to international substance abuse bodies, agencies and research

This website offers links to a range of substance abuse bodies in Ireland, the United Kingdom, the European Union, Australia and New Zealand, North America and other countries worldwide.
http://www.nacd.ie/links/index.html

Evaluation of Drug Testing in the Criminal Justice System. (July 2004)

This report outlines the findings of the evaluation of drug testing in the criminal justice system in nine pilot sites across England and Wales, which began in September 2001. It follows two earlier papers published by the Home Office, outlining interim research findings and a Development and Practice Report.
www.homeoffice.gov.uk/rds/pdfs04/hors286.pdf

Drug Treatment and Testing Orders Early Lessons (March 2004)

This paper by the National Audit Office examines the progress made in implementing the Drug Treatment and Testing Orders and early evidence of its impact. The first phase of the audit was carried out in collaboration with Probation who published the findings of their thematic inspection of the implementation of DTTO in England and Wales, in March 2003. This paper reports on the second phase of the audit which took place in August and September 2003.
www.nao.org.uk/publications/nao_reports/03-04/0304366.pdf

The Correctional Services Review - Managing Offenders Reducing Crime (December 2003)

This review of the correctional services in England and Wales (the Carter Report) forms the background to the establishment of the National Offender Management Service (NOMS).
www.homeoffice.gov.uk/doc2/managingoffenders.pdf

GOOD PRACTICE

Youth Justice Board

The YJB website contains links to substance misuse portals for practitioners in relation to substance misuse in community and custody and the key elements of effective practice.
http://www.youth-justice-board.gov.uk/YouthJusticeBoard/

NIMHE

The National Institute for Mental Health in England launched in June 2002, works with those involved in mental health to implement positive change; taking a lead in connecting mental health research, development, delivery, monitoring and review. NIMHE is made up of eight development centres; national work programmes and a mental health research network. The website contains details of current joint projects including 'Opening doors' with the National Treatment Agency (NTA) which is aimed at providers and commissioners of drug treatment services and aims to reduce maximum waiting times. http://www.nimhe.org.uk/

NICE

NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. On 1 April 2005 NICE joined with the Health Development Agency to become the new National Institute for Health and Clinical Excellence (also to be known as NICE).

Drugscope

DrugScope is the UK's leading independent centre of expertise on drugs, undertaking research at local, national and international levels, as well as: providing quality drug information; promoting effective responses to drug taking; advising on policy making and encouraging informed debate. The website contains a good practice and research section, covering key issues in drugs – crime; education and prevention; health; availability and community safety, with links to the relevant documents and/or websites.
http://www.drugscope.org.uk/goodpractice/home.asp

Alcohol Concern

Alcohol Concern is the national voluntary agency on alcohol misuse, playing a key role in promoting and advising on the development of national alcohol policy and providing the principle source of information on alcohol to the public, professionals and government. The 'knowledge base' section on the website covers: planning and strategies; health; population groups; treatment issues and services; social issues; crime and disorder and prevention. http://www.alcoholconcern.org.uk/

Solve It

The Solve It website contains up to date information and dissemination of information and statistics relating to volatile substance abuse. http://www.solveitonline.co.uk/

Scottish Executive

The Scottish Executive website contains links to good practice guidance and papers, particularly in relation to children, young people and their families affected by substance misuse. http://www.scotland.gov.uk/Home

The State of Play. Positive Futures Progress Report. (Home Office, September 2004)

Positive Futures, is a national social inclusion programme that uses sport and leisure activities to engage with disadvantaged and socially marginalised young people. It is currently delivered through 107 projects located in areas that are among the most deprived 20% in England and Wales and aims to have a positive influence on participants' substance misuse, physical activity and offending behaviour. This report provides information about the progress of Positive Futures in the last year as well as information about new research.
http://www.drugs.gov.uk/ReportsandPublications/YoungPeople/1097142067/FuturesLoRes.pdf

Drugs Prevention Initiative – Guidance on Good Practice (Home Office, 1998)

This good practice guidance sets out some of the key findings from the Drugs Prevention Initiative programme of work over the previous eight years. In addition to those themes addressed in the national strategy *Tackling Drugs to Build Better Britain*, the good practice guide covers the following cross-cutting themes – integration, training, racial and cultural diversity, and information/communications – which are crucial to the effectiveness of any drugs prevention strategy.
http://www.drugs.gov.uk/ReportsandPublications/Communications/1035547666/GuidanceGoodPractice.pdf

Drugs Prevention Initiative – Developing Local Drugs Prevention Strategies (Home Office, 1998)

This drugs prevention initiative guidance is aimed primarily at Drug Action Teams to help inform their decisions on how to address drugs prevention work at a local level. It is a summary of learning from the Home Office DPI over the last five years, including a review of wider research evidence where available.
http://www.drugs.gov.uk/ReportsandPublications/Communications/1035544217/dvlpnglcldrgsprvntn_strategies.pdf

Commissioning Standards. Drug and Alcohol Treatment and Care (2001)

This manual was developed by the Health Advisory Service (HAS) as a resource for drug and alcohol teams, and particularly for commissioners of treatment and care. The manual provides an instrument for assessment and audit and a tool for practice development that is based on a framework of explicit, evidence based standards, which can be adapted to meet local needs. The manual is divided into two main sections: section one outlines the aims, objectives, development and focus of the standards; section two contains the standards, subdivided into: a) standards tackling the main elements of the commissioning function; b) standards pertaining to meeting the needs of specific groups (including young people, minority ethnic populations and substance misuse and mental health co-morbidity); c) standards dealing with harm minimisation related issues and d) standards pertaining to structured care. The manual can be accessed at:
http://www.nta.nhs.uk/programme/guidance/SMAS_Comm_standards.pdf

Audit Commission guide to good practice in commissioning

This is a website for managing the money in social services and contains a commissioning module which contains a section on Sources, with case studies and examples of good practice. It also links to papers, models documents and data sets which can be adapted for local use.
http://www.joint-reviews.gov.uk/money/frameCommissioning.html

APPENDIX 3

CSP LINKS WITH OTHER STRATEGY GROUPS

This appendix relates to section 2.2.4 in the document, and is an example of how one CSP links with other strategy groups.

APPENDIX 4

EXAMPLE GLOSSARY

This appendix relates to sections 1.2 and 1.3, providing further definitions, as well as providing a reference for section 3.4, the planning stage of the commissioning framework. The Glossary of Terms from the Guidance Notes for Completion of Local Substance Misuse Action Plans in Wales 2005-2008 forms the core of this appendix, with some additional key words and explanations relating to commissioning and substance misuse.

(The) Advisory Council on the Misuse of Drugs (ACMD)

The Advisory Council on the Misuse of Drugs is a statutory and non-executive non-departmental public body, which is established under the Misuse of Drugs Act 1971. The terms of reference of the Advisory Council are set out in Section 1 of the Misuse of Drugs Act 1971.

There are normally around 35 members of the Advisory Council, but there should not be less than 20, and they are appointed by the Secretary of State. They must include representatives of the practices of medicine, dentistry, veterinary medicine and pharmacy, the pharmaceutical industry, and chemistry other than pharmaceutical chemistry; and people who have a wide and recent experience of social problems connected with the misuse of drugs.

Committees and working groups may be appointed by the Council to report to it on any matter referred to them by the Council. Committees and the working groups include some co-opted members who are not also members of the Council. There is currently a Prevention Working Group which is undertaking work on the current nature of first and persisting substance misuse by young people and the factors that underlie these. It is intended that the report will be completed by Spring 2006.

All Wales Schools Programme

With effect from September 2004, all schools in Wales will have the opportunity to be receiving the police core schools programme. The programme consists of 15 lesson programmes in three groupings. Each grouping is a five-step programme plan from Key Stage 1 to Key Stage 4. The first grouping is on drugs and substance misuse, the second grouping is on social behaviour and community and the third grouping is on safety. Under a three year funding plan from the Welsh Assembly Government a total of 70 police officers will deliver the programme to all schools. Each of the four police forces within Wales has a seconded teacher in post responsible for the training of the police officers, links with education, development of the programme and ensuring the quality of delivery. With effect from September 2004, an All Wales Co-ordinator will be in post.

ApoSM

One of the key themes of the Welsh Substance Misuse Strategy is working in partnership at national and local levels. As a result, the Advisory Panel on Substance Misuse (APoSM) was established in 2001, and the following terms of reference were agreed:

- to oversee the implementation of the Welsh substance misuse strategy and to advise on its development;
- to advise on substance misuse issues and operational arrangements; and
- to advise on the impact of policy developments in related fields.

The APoSM consists of experts from a number of fields – health, covering general practice, pharmacists and the voluntary sector, criminal justice, including police, prison and probation services, education, local authorities and is attended by officials of the Welsh Assembly Government. The APoSM has considered several issues including the prescribing of controlled drugs, and the implementation of Drug and Alcohol National Occupational Standards. APoSM also considers UK initiatives.

Arrest referral schemes

Arrest referral schemes operate on an entirely voluntary basis. All arrestees are made aware of the scheme when received into custody and asked whether they want to see an independent substance misuse worker. If they accept the offer, they are seen and assessed by the worker who will then make arrangements for them to be referred to an appropriate treatment agency.

Assessment

Begins before, and continues through, each treatment episode. The assessment, which takes place before the service user commences treatment, is **not** part of the treatment process. Effective assessment should encourage the substance misuser to seek appropriate help and to assist their access to and engagement in treatment, whilst accepting the individual substance misuser's choice as to whether they accept treatment or not.

Assessment should be an ongoing process rather than a one-off event, as an individual's needs are likely to evolve over time. Review and reassessment at regular intervals are necessary for good care planning and co-ordination.

Audit

A cyclical evaluation and measurement of important features of a service.

Carer

A person who looks after family members, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.

CARAT

Counselling Assessment Referral Advice and Throughcare (CARAT) services were made available in all prison establishments from October 1999. CARAT services are designed to provide treatment and support for drug misusers while they are in prison, through liaison with prison healthcare and by acting as an interface between prison and community service provision. CARAT services are commissioned by the Prison Service and are provided by substance misuse specialist treatment services. The CARAT teams are not prison service staff but provide direct assessment and treatment services within the prison environment.

Care management/planning/pathways

Care management should facilitate access to a programme of integrated and co-ordinated health and social care and to minimise drop out from the treatment system.

A care plan describes the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment. Care planning ensures that service provision is client-centred and helps continuity between service providers. It also ensures that a range of needs are addressed.

Collaborative Commissioning

The process by which two of more agencies pool resources to implement a common strategy for providing services.

Commissioning

The process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies or by the private or voluntary sectors. (Audit Commission, 'Making Ends Meet' 2003)

The strategic activity of assessing needs, resources and current services, and developing a strategy to make best of available resources to meet identified needs. It involves the determination of priorities, the purchasing of appropriate services and their evaluation. (WAG, 'Local Substance Misuse Action Plans in Wales: Guidance Notes 2005-2008')

A strategic view of services and resources set against need, and a plan to get the best fit from available resources.
(T. Bamford, Commissioning and Purchasing, 2001)

Contracting

Putting the purchasing of services in a legally binding agreement.
(The Audit Commission, 'Making Ends Meet', October 2003.)

Co-occurring Substance Misuse and Mental Health Problems (Dual Diagnosis)

Co-existing mental health problems and substance misuse.

Decommissioning

The process of planning and managing a reduction in service activity or terminating a contract in line with commissioning objectives.

Detoxification

Detoxification describes the way in which a drug is eliminated from the drug user's body, often with the help of a doctor and/or specialist drug worker. This is often a gradual process and may take a number of days or weeks. It can involve the use of other drugs to help deal with symptoms of withdrawal.

Drug and Alcohol National Occupational Standards (DANOS)

National Occupational Standards describe competence-based performance in the workplace. They state from the perspective of employers, workers, regulatory bodies and Government interests, the quality of service and outcomes expected. The DANOS standards are the agreed specification of the standard of performance required by substance misuse workers wherever they are working in the sector. They provide criteria for assessing performance both for internal performance management and appraisal purposes and for external assessment and certification (possibly in the future as part of NVQs and SVQs). They also provide a curriculum of the knowledge and skills required, phrased in terms of learning outcomes that can be used for designing and evaluating learning programmes. They are also intended to have wider human resource management and development uses such as in job design and evaluation, recruitment and selection, induction, reward, succession planning, promotion, redeployment, and career and personal development.

Drug Dependence

Defined by the WHO (1993) as a 'cluster of physiological, behavioural and cognitive phenomena or variable intensity, in which the use of a psychoactive drug (or drugs) taken on a high priority'. The state is

characterised by a 'preoccupation with a desire to obtain and take the drugs and persistent drug seeking behaviour. Determinants and the problematic consequences of drug dependence may be biological, psychological or social and usually interact'. The degree of psychological dependence may be approximated to the amount of negative effect experienced in the absence of the desired drug. Repeated use of some drugs (for example, opioids) leads to physiological changes in the drug taker, such as that when the drug is not present a physiological withdrawal symptoms result. These are rapidly relieved by further use of the drug. The physical dependence is broadly equivalent to 'addiction'. Not all drug users are drug dependent.

Drug Treatment and Testing Orders

Established as part of the Crime and Disorder Act 1998, Drug Treatment and Testing Orders (DTTOs) replaced the power to add a requirement for drug treatment to a probation order. The purpose of the DTTO is to break the link between drug use and crime. It can be imposed on any offender over 18 who has a dependency on or propensity to misuse drugs and for whom treatment may be helpful.

DTTOs oblige the offender to:

- Undergo treatment as specified for a set period of between six months and three years.
- Be tested regularly for drug use.
- Attend regular court review hearings at which progress under the Order will be reviewed.

Drug testing is mandatory and courts regularly review the offender's progress. If testing requirements are not met and/or attendance at mandatory treatment is not adhered to, the court can revoke a DTTO and re-sentence the offender. DTTOs cannot be imposed without the consent of the offender.

Drug Related Deaths

Immediate or virtually immediate deaths may arise directly from the pharmacological action of the drug. They may occur as a result of a 'normal' dose, an accidental overdose or deliberate overdose (suicide) by the user. Less directly the drug may cause the taker to lose their normal judgement or control, leading to an accident. Less directly still, the taking of drugs may lead to violent behaviour which causes death to others; to the deaths of children through accidental overdose of a drug which has fallen into their hands; and to accidents notably in road vehicles, killing third parties. A range of definitions exist for what constitutes a drug related death. The ACMD define a drug related death as 'Deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971 were involved.'

Evaluation

Analysis of a project, programme, or policy to assess how successful or otherwise it has been, and what lessons can be learnt for the future.

Harm reduction services

These were developed within the wider context of harm minimisation or risk reduction, which refers to the reduction of the various forms of drug-related harm, including social, medical, legal, and financial problems. They are important for preventing blood-borne diseases, most particularly HIV and hepatitis, as well as being important public health measures. The majority of needle exchange schemes are those where sterile needles and syringes are given out and their safe disposal is offered.

Hidden Harm

The UK's Advisory Council on the Misuse of Drugs has published a report of an inquiry, which focused on children with a parent, parents or other guardian whose drug use has serious negative consequences for themselves and those around them. The report makes a total of 48 recommendations and has implications for a range of policy areas.

Include – Turnaround

Turnaround is an Assembly-funded pilot project run by INCLUDE. It targets young people aged 14-19 who have engaged in significant substance misuse and are at risk of social exclusion. It aims to transform their lifestyle and enable them to actively participate in mainstream education and employment. Where Turnaround is operating in their areas, CSPs should ensure that links have been established with the project.

Inpatient detoxification

Specialised units for people with substance misuse disorders or inpatient services delivered in general medical or general psychiatric facilities. Inpatient services also include episodes of detoxification purchased from independent sector units. They provide medically supervised assessment, stabilisation and withdrawal with 24-hour medical cover and a multidisciplinary team.

Joint commissioning

The process in which two or more organisations act together to co-ordinate the commissioning of service(s), taking joint responsibility for the translation of strategy into action. Joint commissioning should be seen as:

a) A strategic activity for agencies to share and discuss their overall perspectives and strategies.

b) A more detailed problem-solving tool for tackling specific difficulties.

Joint purchasing

Two or more agencies co-ordinating the actual buying of services, generally within the context of joint commissioning.

Macro-commissioning

The process of meeting needs at a strategic level for whole groups of service users and/or whole populations.

Micro-commissioning

The process of meeting needs at an individual level.

Needle, syringe exchange (NSE) schemes

Schemes set up in the 1980s in response to the spread of HIV (the virus that leads to AIDS) and hepatitis amongst injecting drug users. They aim to ensure that drug injectors do not share injecting equipment and that they use their own clean 'works' when they do inject. As well as giving out clean injecting equipment and collecting in used 'works' these services often offer information and advice, health check ups, safer sex advice and condoms etc. Schemes are based within drug projects but others operate from Community Drug and Alcohol Teams, hospitals or pharmacies. Some also use outreach workers who meet injectors on the streets or in their homes, where they are unwilling or unable to access an alternative provision.

Needs assessment/review

Aims to establish the nature and extent of substance misuse in a specific area to assess whether the currently available services address that need. This information will help to plan, commission and deliver services.

Non statutory sector

Voluntary, independent and private sector provision which accounts for many substance misuse services across Wales.

Objective

Statement of what a plan is intended to achieve, a description of intended outcome, to reduce or increase the level/occurrence of a certain factor. An objective should be Specific, Measurable, Agreed, Realistic, Timed, Evaluated and Reviewed.

Outputs

Activities involved in actually delivering the service, often a measure of 'throughput', and so distinguishable from outcomes. For example, 'The service will offer 1000 clients per year individualised pathways to

employment'; 'capacity of service X increased by 40 clients per year'; 'the service distributed 10,000 leaflets and posters providing information on drug services throughout the area'.

Procurement

A term used at corporate level in local authorities with equivalent meaning to strategic commissioning in social services.

Purchasing

The process of securing or buying services. (The Audit Commission, 'Making Ends Meet', October 2003)

The operational activity set within the context of commissioning, of applying resources to buy services in order to meet needs, either at a macro/population level or at a micro/individual level. (Guidance Notes for Completion of Local Substance Misuse Action Plans in Wales 2005-2008).

Residential rehabilitation

Specialist services offering intensive and structured programmes delivered in controlled residential or hospital environments. These services are mainly available in the independent sector and including therapeutic communities, concept houses, 12 step Minnesota model programmes and general houses including those with a faith-based philosophy.

Service Level Agreements

Written undertakings agreed between purchasing and providing agencies.

Shared care

The joint participation of substance misuse services, GPs, and community pharmacists in the care of substance misusers and involving the prescribing of substitute drugs for the treatment of addiction (eg methadone).

Single shared assessment

Simplifies the assessment process and reduces bureaucracy to make best use of resources and achieve better outcomes for individual service users. Should include single shared assessment procedures, tools, and protocols for sharing information and obtaining clients' consent.

Social Care Markets

Description of how purchasers and providers of social care services do business with one another. As in all markets, there are different combinations of purchasers and providers, interacting differently in all the service sectors for each service user group and sometimes differently within the same authority, as, for example, between urban and rural areas in what are termed different market segments.

Specialist

A practitioner who provides expertise, training and competence in substance misuse as their main activity.

Specialist substance misuse service

A service which provides specialist specific assistance to individuals with substance misuse problems.

Stakeholders

All relevant parties including councillors, managers and staff of local authorities, other related commissioning bodies, such as health, service providers in the statutory, private and voluntary sector, and, above all, service users and their carers and their associated advocacy organisations.

Statutory sector

Substance misuse services delivered through statutory bodies e.g. NHS and Local Authorities.

Structured care-planned counselling

Formal structured one-to-one counselling approaches with assessment, clearly defined treatment plans, treatment goals and regular reviews, as opposed to advice and information, drop-in support and informal key-working.

Structured day programmes

Intensive community-based support, treatment and rehabilitation. They should offer clear programmes of defined activities for a fixed period of time with specified attendance criteria.

Structured substance misuse treatment

Treatment which follows assessment and is delivered according to a care plan with clear goals and is reviewed as appropriate with the client. It may include a number of concurrent or sequential treatment interventions. Categories of structured treatment include:

- Community specialist prescribing.
- Community GP prescribing/shared care.
- Structured counselling.
- Structured day services.
- Inpatient care (eg detoxification, stabilisation during pregnancy).
- Residential rehabilitation.
- Community or home detoxification.

Substances

Substance Misuse Commissioning Strategies and The Local Substance Misuse Action Plan should link to the Welsh strategy and cover the following substances:

- Illegal drugs such as heroin, cocaine, ecstasy, amphetamines, LSD, cannabis; alcohol.
- Prescription only medicines such as anabolic steroids and benzodiazepines.
- Over the counter medicines such as preparations containing codeine or ephedrine, and
- Volatile substances such as aerosol propellants, butane, solvents, glue.

Substance misuse

Consumption of illegal drugs, alcohol, prescription-only medicines, over the counter medicines and/or solvents which leads a person to experience physical, psychological or social (including legal) problems. Substance misuse may cause harm to the individual, their significant others or the wider community.

Substance Misuse Advisory Regional Team

Teams comprised of members of Welsh Assembly Government staff and based on Police Authority boundaries. Their main role is to provide a strategic level of support to the partnerships and to assist with the delivery of the substance misuse strategy on the ground. In addition, they will assist the responsible authorities and their partners in the implementation and delivery of the Local Substance Misuse Action Plan and undertake the monitoring of the information management arrangements that the responsible authorities and their partners have in place to measure provision and quality of services.

Substance misuse lead person

The nominated individual given authority by the responsible authorities and their partners to take forward work on the development of the Local Substance Misuse Action Plan. They would have a liaison and co-ordination role and would be responsible for ensuring that the Local Substance Misuse Action Plan is completed with due regard to guidance issued by the Welsh Assembly Government.

Substance misuse treatment

Description of a range of interventions which are intended to remedy an identified problem or condition.

Substitute prescribing

The provision of a medically supervised substitute to a substance misuser. The substitute can be used to maintain the individual's tolerance to the substance of misuse or to facilitate withdrawal through a reduction programme. The prescribing programme is the basis for providing medical and psychosocial counselling and support. Specialist services are usually delivered by Community Drug and Alcohol Teams (CDATs) operated by NHS Trusts. It can also be delivered in general practice often in liaison with specialist services using shared care protocols.

Targeted services

A service, which provides access to information and other services for specific and/or particularly vulnerable service user groups who, may have complex needs.

The four tiers

Tier 1 – Non Substance Misuse Treatment Specific Services

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

Tier 2 – Open Access Services

- Services providing 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 in this tier 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

- Providing services solely for substance misusers in a structured programme of care. Services within this Tier include structured cognitive behaviour therapy programmes, structured substitute medication 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.

Tier 4 (a) – Residential and Inpatient Services

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

Throughcare and Aftercare

Throughcare and Aftercare forms part of the Home Office's Drugs Intervention Programme (DIP) and has been rolled out across England and Wales from April 2004. The Throughcare and Aftercare Scheme will be a significant new service for drug misusers, and partnerships will need to ensure that implementation of the scheme is properly reflected in their Local Substance Misuse Action Plans.

Transitional Support Scheme

The scheme is designed to provide support for up to 12 weeks to discharged prisoners serving less than 12 months and who have an acknowledged problem with substance misuse. The nature of the support will be as individual as each beneficiary and their personal action plan.

Waiting times

Length of time that substance misusers wait before being seen by a service worker.

APPENDIX 5

NEEDS ANALYSIS

This appendix relates to section 2.3 in the document and contains some sources which may assist you in undertaking population needs analysis, including:

- Demographic analysis.
- Public health analysis.

DEMOGRAPHIC ANALYSIS

Office for National Statistics (ONS)

The ONS provides information and statistical data about Britain's economy, population and society at national and local level. Summaries and detailed data are published on the website at: www.statistics.gov.uk

Statistical Directorate for Wales

The Statistical Directorate for Wales collects, processes, interprets and publishes information about the economic and social condition of Wales; and promotes the use of that information in decision making within government and beyond. It covers a wide range of topics including demography, health, housing, education, training, agriculture, industry, the economy, local government, transport, the environment and the Welsh language. http://www.wales.gov.uk/keypubstatisticsforwales/index.htm

Historic Digest of Crime Statistics for Wales

This digest of crime statistics provides information on: Demographics; Crime levels, types and trends; Drugs, alcohol and crime; Anti-social behaviour; Road safety; Fire; Local authorities; Police; CPS race monitoring; Courts; Prisons; Probation; Youth offending teams and Education. http://www.wales.gov.uk/subicsu/content/historical/index-e.htm

Evidence of Drugs and Alcohol Problems among Probation Cases in Wales (2003)

This research used the case record management system (CRAMS) to provide an estimate of the prevalence of drug and alcohol-related problems among probationers. Examination of sentencing (Drug Treatment and Testing Orders, additional requirements) and offences added another seven per cent to the assessment of substance misuse. http://www.wales.gov.uk/subicsu/content/keypubs/drug-alc-may03-e.pdf

Welsh Index of Multiple Deprivation

The Welsh Index of Multiple Deprivation replaces the existing Welsh Index of Socio-Economic Conditions. The earlier Index was developed in the 1980s and used eight ward-level indicators. It was originally prepared for targeting urban regeneration funds, and so did not specifically reflect rural deprivation. In 1999 the Welsh Office (now the National Assembly for Wales) in partnership with the Welsh Local Government Association awarded a contract to a team from Oxford University to develop a new Welsh Index of Multiple Deprivation. This is their report.

The aim of the Welsh Index of Multiple Deprivation is to model levels of deprivation in Wales and support policy development and the targeting of resources. The previous deprivation index used the Census of population as the main source of small area data. The new Index is based on more direct measures of deprivation at the small area level, some of which are based on new sources of administrative data.

Multiple deprivation is represented as being made up of distinct dimensions or domains of deprivation: income, employment, health, education, housing, and access to services. This approach allows the domains to be used separately to identify geographical areas having particular kinds of deprivation, or combined to form the overall Index of Multiple Deprivation. The Index has been designed so that it can be updated when new data become available and can be revised by incorporating new data sources. http://www.wales.gov.uk/keypubstatisticsforwales/content/publication/social/2000/deprivation/intro_e.htm

Prevalence rates

Reports and publications relating to research on prevalence rates can be found at: http://www.drugs.gov.uk/ReportsandPublications

Prevalence of Drug Use: Key Findings from the 2002/03 British Crime Survey

The British Crime Survey (BCS) is a large national survey of adults who live in a representative cross-section of private households in England and Wales. This publication reports on the findings of an investigation into drug-taking among 16-59 year olds and can be found at: http://www.homeoffice.gov.uk/rds/pdfs2/r229.pdf

The Dynamics of Drug Misuse: Assessing Changes in Prevalence

This research has three components:

- Estimating period prevalence of problem drug use during 2000-01 via multi-sample capture-recapture techniques.
- Estimating period prevalence of problem drug use during 1997 and 2000-01 via multivariate indicator methods.
- Estimating trends in heroin use incidence between 1986 and 2000 via lag correction methods.

A full copy of the report can be found at
http://www.drugs.gov.uk/ReportsandPublications/ResearchDevelopmentStatisticsRDS/1090247878/rdsolr3504.pdf

Geographical Variations in Drug Use: Key Findings From the 2001-02 British Crime Survey

This report looks at the geographical variations in drug use for 16-59 year olds in England and Wales. It uses the British Crime Survey (BCS) to examine the prevalence and trends of the most commonly used drugs and how these differ within Government Office Region, ACORN areas and inner city, rural and urban areas. It also analyses patterns of drug use by physical disorder in the area and population size in Police Force Areas. A full copy of the report can be ordered at: publications.rds@homeoffice.gsi.gov.uk

The Impact of Drug Treatment and Testing Orders on Offending: Two-Year Reconviction Results

Drug Treatment and Testing Orders (DTTOs) were introduced as a new community sentence under the Crime and Disorder Act 1998. This report summarises the impact of the order on reconviction rates two years after the start of the order. A full copy of the report can be ordered at: publications.rds@homeoffice.gsi.gov.uk

Estimating the Prevalence of Problematic and Injecting Drug Use for Drug Action Team Areas in England: A Feasibility Study Using the Multiple Indicator Method

The aim of the project is to examine the feasibility of using the Multiple Indicator Method (MIM) to produce prevalence estimates for problematic and injecting drug use for Drug Action Teams (DATs) in England in 2001.
A full copy of the report can be ordered from:
publications.rds@homeoffice.gsi.gov.uk

PUBLIC HEALTH ANALYSIS

National Public Health Service for Wales

The National Public Health Service for Wales (NPHS) brings together the public health resources of the five former health authorities in Wales, including input from academic departments - with those of the Public Health Laboratory Service in Wales.
http://www.wales.nhs.uk/sites/home.cfm?orgid=368

Welsh Health Survey: October 2003-March 2004 (provisional results)

The Welsh Health Survey is a cross-sectional study that examines levels of ill health, lifestyle factors, use of healthcare services and satisfaction with healthcare services. The survey relies on self-completion questionnaires and therefore reflects people's own understanding of their health, rather than a clinical assessment of their medical conditions and the services they have used. This survey relates to alcohol use.
http://www.wales.gov.uk/keypubstatisticsforwales/content/publication/health/2004/sdr82-2004/sdr82-2004.htm

Health Needs Assessments HSCWBS - for 22 CSP areas

This website provides links to needs assessments (a picture of the health, social care and well being needs) for different areas of Wales. The needs assessment can be used to identify:

- The current health, social care and well being state/needs of a local population.
- The existing provision of health, social care and well being services to a local population.
- Any identified gaps or deficiencies in the provision of health and well being services to the local population.
- The needs assessment identifies key health, social care and well being priorities based on the local population's needs and is helpful in deciding which essential services should be provided.
http://www.wales.nhs.uk/sites/page.cfm?orgid=368&pid=2716

APPENDIX 6

MARKET ANALYSIS

This appendix relates to Section 2.4 of the document and contains some sources for carrying out market analysis including:

- Service mapping.
- Mapping existing contracts.
- Consultation with service provider.

SERVICE MAPPING

Models of Care (2002)

Models of Care was published by the National Treatment Agency (NTA) in 2002 and sets out a national framework for the commissioning of adult treatment for drug misuse in England. The framework presents 4 tiers, within which to develop local services for those with substance misuse problems.

This four-tier model of service provision can be used as a guide or framework in which to place existing services, for example:

- Tier 1: Non-substance misuse specific services requiring interface with drug and alcohol treatment.
- Tier 2: Open access drug and alcohol treatment services.
- Tier 3: Structured community-based drug treatment services.
- Tier 4: Residential services for drug and alcohol misusers.

It should be noted that Models of Care does not cover alcohol misuse. Copies of Models of Care can be ordered from: nta.enquiries@nta.gsi.gov.uk

Resource Pack for Commissioners

The National Treatment Agency (NTA) is in the process of creating a resource pack for commissioners of drug treatment systems. Section 4 of this pack, which is still under development, will include a section on service mapping. Section 4 – 'Assessing Local Needs and Service Mapping' can be accessed at: http://www.nta.nhs.uk/

DrugScope Mapping Report 1999; Treatment and Care Provision in England for Young Drug Misusers

This report maps the treatment and care provision for young drug misusers and provides information about service mapping techniques. http://www.drugscope.org.uk/library/librarysection/libraryhome.asp

MAPPING EXISTING CONTRACTS

The CJC Guide to the Commissioning of Social Care

The purpose of this guide published by CIPFA, ADSS and ADSW is to help those in social care agencies with responsibility for the joint commissioning of services. Part 14 of the guide is concerned with the management and review of contracts. www.ipf.co.uk/bestvalue/bvq/CJC

Commissioning and Purchasing (Chapter 5) by Terry Bamford (Routledge, 2001)

Chapter 5 of this book covers 'contracting' and explains:

- How to understand the different types of contract used in social care.
- Potential pitfalls in the contract process.
- When to involve lawyers and when to ignore them.
- How to minimize the risk to the organization in contracting.

Audit Commission – Commissioning in Social Care

This is a website for managing the money in social services and contains a commissioning module which explains:

- Key Questions: These self assessment questions link to other parts of the module to move from an initial overview to a deeper analysis of how to improve practice.
- Key Themes: This section identifies the important elements of managing resources and summarises the impact of different approaches.
- Sources: This section contains case studies and examples of good practice. It also links to papers, models documents and data sets which can be adapted for local use.
  http://www.joint-reviews.gov.uk/money/frameCommissioning.html

CONSULTATION WITH SERVICE PROVIDERS

Voluntary Sector Scheme, Chapter 4: Procedure for consultation with the Voluntary sector in Wales (WAG)

This Chapter sets out the Welsh Assembly Government's agreed procedures for consultation on policy changes and new policy developments which affect voluntary and community organisations.
http://www.wales.gov.uk/themesvoluntarysector/content/voluntarysectorscheme/chapter4-e.htm

An Assessment of the Contribution of selected Voluntary Sector Providers to the Treatment of Substance Misuse (2004)

This document reports on the review of the Voluntary Sector Treatment services carried out by the Welsh Institute for Health and Social Care between December 2003 and March 2004. The aim of the review of treatment services offered by voluntary sector organisations was to ascertain the nature and extent of available services; whether or not there is any duplication; the extent of integration and co-ordination of services; service quality and effectiveness; measuring of outcomes; and value for money. http://www.wales.gov.uk/subicsu/content/keypubs/index-e.htm

APPENDIX 7

AUDITING AND MANAGING SERVICE QUALITY

This appendix relates to sections 2.4.3 and 2.4.4 of the document and contains some sources relating to quality issues including:

- Assessing service quality.
- Consulting with service users, families and carers.

SERVICE QUALITY

Audit Commission – Making Ends Meet. Commissioning Social Care

Making Ends Meet is a website for managing the money in social services and contains a commissioning module which explains:

- Key Questions: These self assessment questions link to other parts of the module to move from an initial overview to a deeper analysis of how to improve practice.
  http://www.joint-reviews.gov.uk/money/frameCommissioning.html

Commissioning and Purchasing by Terry Bamford (Routledge, 2001)

Chapter 7 discusses 'purchasing quality care' and explains:

- The various dimensions of quality in social care.
- How to build quality standards into purchasing policy.
- How to monitor and measure quality in the performance of the contract or agreement.

Quality in Alcohol and Drugs Services (QuADS)

A diagnostic and development software tool for drug and alcohol treatment services. Applicable QuADS standards are identified for service providers, so that they can provide evidence of the degree to which they are complying with the standards. https://www.drugscope.org.uk

CONSULTING WITH SERVICE USERS, FAMILIES AND CARERS

All-Wales Unit – Supporting Social Services

This award winning interactive website allows Local Authority Social Services managers, practitioners and elected members to access a wide range of information. A report about keeping together families in which parents have a substance misuse problem is available on this site.
http://www.allwalesunit.gov.uk/INDEX.CFM?ARTICLEID=19

Signposts Two. A practical guide to public and patient involvement in Wales (2003)

This is an update of the original version of Signposts, which was published and distributed by the National Assembly for Wales in 2001. Signposts Two

is designed to be used primarily by NHS organisations in Wales, although will also be a valuable resource to those with an interest in public and patient involvement. The guide includes: descriptions of approaches and methods to engaging communities, with case studies of Welsh initiatives; the training and development needs of staff in relation to effective patient and public involvement; and the development of joint working, looking specifically at ways of bridging any gaps between health and social care. http://www.wales.gov.uk/subihealth/content/nhs/signposts/signposts2-e.pdf

Improvement Leaders' Guide to Involving Patients and Carers (NHS Modernisation Agency, 2002)

The guide offers a framework for patient involvement and provides some practical examples of approaches that have been used to involve patients in improving care; including: focus groups; patient shadowing; patient diaries; questionnaires and critical friends groups. One example sited the review of mental health services for which they developed new roles of 'user and carer champions' as equal members of the project team. http://www.modern.nhs.uk/improvementguides

Alcohol, Drugs and Mental Health Problems: Working With Families (2003)

This report is based on a project that looked at the interfaces within and between services for families where a parent has persistent mental health, alcohol or drug problems. www.scie.org.uk

Has Service User Participation made a difference to Social Care Services? (2004)

This paper, published in March 2004, brings together the main findings from six reviews that looked at whether service user participation made a difference to changing and improving social care services. The reviews drew on information about user involvement in England and Wales and relevant information from Northern Ireland and Scotland, dating from 1992-2002. The paper looks at how user participation can be improved upon, including involving users in different ways and issues to be considered when planning and putting into place service user participation to make services better. The findings from this piece of work will form the basis of SCIE practice guides on service user participation. www.scie.org.uk

Getting Over the Wall. How the NHS is Improving the Patient's Experience (2004)

The purpose of this document is to help the NHS to shift the focus of its patient and public involvement work from activity and process, to outputs and outcomes. In this way it will be able to get over or demolish 'the wall' described by the Commission for Health Improvement's report, 'Involvement to Improvement' produced in February 2004. The document explores how organisations need to shift the focus of their work with service users to focus upon outputs from these involvement activities, considering in particular on how organisations listen and respond to service user contributions. www.dh.gov.uk/Publications

APPENDIX 8

RESOURCE ANALYSIS

This appendix relates to section 2.5 of the document and may be helpful in considering the resource base for services.

Audit Commission – Making Ends Meet. Commissioning Social Care

This is a website for managing the money in social services and contains a commissioning module which identifies the important elements of managing resources and summarises the impact of different approaches. Section 2.6 of this site considers 'Delivering Value for Money' and there is also a module which specifically covers financial management, including: strategic financial planning; setting annual budgets; managing budgets and organisational arrangements and capacity.
http://www.joint-reviews.gov.uk/money/frameCommissioning.html

A Catalyst for Change. Driving Change in the Strategic Commissioning of non-acute Services for Older People
(Social Care Change Agent Team and Warwick Insight, 2004)

This workbook written for the Department of Health is aimed at senior managers involved in whole system partnerships, to assist them in identifying and acting upon their key priorities for change, providing a systematic approach to identifying what stage they are at in their commissioning roles, and subsequently identifying the critical activities that will take them forward in the successful development of services that their communities need. The workbook contains a section on maximising use of resources, which includes: understanding mix of resources available; flexibility of resources, adaptability, versatility; performance management of resources across the system; developing resources in line with future requirements and facilitating workforce availability and skill levels.
http://www.dh.gov.uk/assetRoot/04/07/29/49/04072949.pdf

APPENDIX 9

DEVELOPING THE COMMISSIONING STRATEGY

This appendix relates to sections 3.2 and 3.3 of the document and contains sources for developing the commissioning strategy including:

- Gap analysis.
- Prioiritisation and strategic commissioning intentions.

GAP ANALYSIS

Audit Commission – Making Ends Meet. Commissioning Social Care

Making Ends Meet is a website for managing the money in social services and contains a commissioning module in which section 2.5.3 identifies how to build up knowledge of the social care market.
http://www.joint-reviews.gov.uk/money/frameCommissioning.html

Models of Care for Treatment of Adult Drug Misusers (2002)

Models of Care was published by the National Treatment Agency (NTA) in 2002 and sets out a national framework for the commissioning of adult treatment for drug misuse in England. Copies of *Models of Care* can be ordered from nta.enquiries@nta.gsi.gov.uk

Changing Habits: The Commissioning and Management of Community Drug Treatment Services for Adults (2002)

Changing Habits report on the results of a study undertaken by the Audit Commission to review the provision of community-based drug treatment services for adults, identify any problems and suggest how these could be overcome. The report sets out practical recommendations to enable drug action teams (Community Safety Partnerships in Wales), local commissioners and service providers, to review their specialist services and joint commissioning arrangements. The report can be found at www.audit-commission.gov.uk

PRIORITISATION AND STRATEGIC COMMISSIONING INTENTIONS

Tackling Substance Misuse in Wales: A Partnership Approach (2000)

The Welsh Assembly Government's eight year strategy *Tackling Substance Misuse in Wales: A Partnership Approach* was launched in May 2000, and can be accessed at the National Assembly's website at: www.wales.gov.uk

Models of Care for Treatment of Adult Drug Misusers (2002)

Models of Care was published by the National Treatment Agency (NTA) in 2002 and sets out a national framework for the commissioning of adult treatment for drug misuse in England. Copies of *Models of Care* can be ordered from: nta.enquiries@nta.gsi.gov.uk

Changing Habits: The Commissioning and Management of Community Drug Treatment Services for Adults (2002)

Changing Habits report on the results of a study undertaken by the Audit Commission to review the provision of community-based drug treatment services for adults, identify any problems and suggest how these could be overcome. The report sets out practical recommendations to enable drug action teams (Community Safety Partnerships in Wales), local commissioners and service providers, to review their specialist services and joint commissioning arrangements. The report can be found at www.audit-commission.gov.uk

Drugs Prevention Initiative – Guidance on Good Practice (Home Office, 1998)

This good practice guidance sets out some of the key findings from the Drugs Prevention Initiative programme of work over the previous eight years. In addition to those themes addressed in the national strategy *Tackling Drugs to Build A Better Britain*, the good practice guide covers the following cross-cutting themes – integration, training, racial and cultural diversity, and information/communications – which are crucial to the effectiveness of any drugs prevention strategy. This document can be found at:
http://www.drugs.gov.uk/ReportsandPublications/Communications/1035547666/GuidanceGoodPractice.pdf

Drugs Prevention Initiative – Developing Local Drugs Prevention Strategies (Home Office, 1998)

This drugs prevention initiative guidance is aimed primarily at Drug Action Teams to help inform their decisions on how to address drugs prevention work at a local level. It is a summary of learning from the Home Office DPI over the last five years, including a review of wider research evidence where available. This document can be found at:
http://www.drugs.gov.uk/ReportsandPublications/Communications/1035544217/dvlpnglcldrgsprvntn_strategies.pdf

Drugs Prevention and Community Development: Principles of Good Practice (Home Office, 1995)

The report identifies some of the key issues involved in making community development work with drugs prevention and makes recommendations which should be of value not only to the Drugs Prevention Initiative in planning future work, but also to others who are taking forward drugs prevention or other work, such as local regeneration, in the community. A full copy of the report can be found at:
http://www.drugs.gov.uk/ReportsandPublications/DPIResearch/1033751394/1033751404.pdf

APPENDIX 10

WRITING YOUR COMMISSIONING STRATEGY

This appendix relates to section 3.4 in the document and provides an outline of what elements you might include in your commissioning strategy.

Introduction

The introduction states the purpose and strategic aims of the substance misuse services to be commissioned by the CSP and its constituent partners, set within the context of the wider strategic agenda including the Community Plan and Health, Social Care and Well Being Strategy and specifies the partner agencies that have responsibility for the commissioning strategy. It defines the service user group and provides a brief picture of substance misuse services, indicating the current arrangements, local and Welsh national strategic drivers and links to other plans and strategies. The introduction will state the CSP priority objectives, the outcomes that the strategy is trying to achieve and the time frame for the strategy. It may also contain a definition of commissioning. Often, there will be a brief description of how the strategy was developed i.e. the process or methodology undertaken.

National Guidance and Research

This section should contain a brief outline of the main messages from research, national guidance and good practice that have informed the strategy. The key drivers for change should be highlighted and it is particularly important that any links with or 'must dos' from legislation, national guidance, Substance Misuse Treatment Framework or local commitments are clearly stated.

Needs Assessment

It is not necessary for a strategy to provide all the details of your needs analysis as this is usually contained in separate document(s). Key themes should be identified however, along with supporting information analysing demographic trends, social care, health, housing and criminal justice information, as well as users and carers views on services and their desired outcomes which support those themes. Service provider perspectives may also be included. The critical judgement is what needs to be included to help readers understand the strategy, your objectives and the rationale behind them.

Market Analysis

This section should provide an overview description of existing services, a wider look at the market and an assessment of the current gaps in services.

It should outline existing services and their use and provide an overview of the existing contracting/SLA arrangements. Depending on the depth of information required, the description may also include information on service quality and effectiveness, for example referral and assessment mechanisms, take-up of services, occupancy/vacancy levels, outcomes of services and waiting times. A look at substance misuse services in other parts of the country could be included to see what opportunities are likely to exist in the area for maintaining and developing existing services and what opportunities there are for attracting new suppliers. The section could also include an assessment of likely future market wide commissioning issues such as workforce availability, property price and availability, and an overall assessment of the robustness of the market.

Financial Position

This section has two linked elements, firstly the cost of and charges for services and secondly, the planned investment in future services. The key factor in this section is the overall financial investment available to the commissioners, including all available resources, such as grant and core funding, and how this is likely to increase or decrease over the term of the strategy.

Service Development

This section is the hub of the strategy. The section should set out the proposals and recommendations to improve substance misuse services and the shifts in provision required. It should state the preferred contracting options for future commissioning. The development of a new strategy gives the opportunity for planners and commissioners to reshape provision, decommission services and develop new ones, based on needs, research evidence, national guidance and good practice. Whatever models are developed however, a reality check is also needed, in terms of the investment available and the market potential. It is also necessary to consider whether the re-configuration of existing services is necessary and what impact this is likely to have. The section should conclude with clear statements as to the way forward, including objectives and funding.

Monitoring Arrangements

Monitoring arrangements have a cost consequence for both commissioners and providers and thus should be carefully considered at this point. It may be appropriate to include an assessment of the effectiveness of current monitoring and performance management arrangements, if changes to the systems are necessary. It is important to describe clearly how both the strategy and services/contracts will be monitored in the future.

Evaluation and Review

You will need to specify the arrangements for evaluating and reviewing both service provision and the strategy itself.

The strategy may also have an attached action plan, glossary (see Appendix 4 for an example glossary) and other appendices, such as the full needs analysis, if necessary.

APPENDIX 11

MANAGING SERVICE BALANCE

This appendix relates to section 4.2 in the document and contains some sources which may help with managing service balance.

Welsh Local Government Association (WLGA)

Originally established Syniad in April 1999, the Improvement and Development Arm of the WLGA provides a range of services, networking opportunities and signposting. The overall aim is to help local government in Wales improve performance and achieve high standards for the benefit of service users and communities. The WLGA Improvement and Development Arm can be accessed at:
http://www.wlga.gov.uk/improvement/mainpage.htm

IDeA Knowledge website

IDeA was created by and for local government in England and Wales and is independent of central government and regulatory bodies. IDeA has a section on procurement and provides a free procurement advisory service. Access the IDeA Knowledge website at: http://www.idea.gov.uk

Audit Commission – Making Ends Meet. Commissioning Social Care

Making Ends Meet is a website for managing the money in social services and contains a commissioning module which explains:

- Key Questions: These self assessment questions link to other parts of the module to move from an initial overview to a deeper analysis of how to improve practice.
- Key Themes: This section identifies the important elements of managing resources and summarises the impact of different approaches.
- Sources: This section contains case studies and examples of good practice. It also links to papers, models documents and data sets which can be adapted for local use.
  http://www.joint-reviews.gov.uk/money/frameCommissioning.html

Changing Habits: The Commissioning and Management of Community Drug Treatment Services for Adults (2002)

Changing Habits reports on the results of a study undertaken by the Audit Commission to review the provision of community-based drug treatment services for adults, identify any problems and suggest how these could be overcome. The report sets out practical recommendations to enable Community Safety Partnerships (drug action teams in England), local commissioners and service providers, to review their specialist services and joint commissioning arrangements.
http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=6388FB53-A9BC-4325-BF80-BB39980199AA

APPENDIX 12

SELECTING PROVIDERS

This appendix relates to section 4.4 in the document and contains some useful sources in making arrangements for selecting providers.

The CJC Guide to the Commissioning of Social Care (2003)

Published by CIPFA, ADSS and ADSW. Part 11, 'Selecting Tenderers' explains about the criteria and evidence in tender selection and how the make the selection. www.ipf.co.uk/bestvalue/bvq/CJC

Commissioning and Purchasing by Terry Bamford (Routledge, 2001)

Chapter 5 discusses 'contracting,' including sections on: preferred provider lists; tendering; and selection procedures.

APPENDIX 13

ARRANGING CONTRACTS

This appendix relates to section 4.5 in the document and contains some resources which may be useful in making arrangements for contracting.

Modern Procurement Practice in Local Government (2003)

The Improvement and Development Agency (I&DeA) the free procurement advisory service for local government, have developed procurement best practice guidance under the National Procurement Strategy to support authorities. Volume 1, Chapter 3 addresses, 'Managing Contracts and Supplier Relationships,' including: What is contract management?; Why is contract management important?; Critical factors for success and different types of contract. http://www.idea.gov.uk

Commissioning and Purchasing by Terry Bamford (Routledge, 2001)

Chapter 5 discusses 'contracting,' covering the following areas: when do you need a contract; knowing what you want; contract conditions; and monitoring contracts.

The CJC Guide to the Commissioning of Social Care (2003)

Published by CIPFA, ADSS and ADSW. Part 10, 'Drafting Contracts' includes: types of contract; contract periods; pricing mechanisms; package size; contract conditions and specifications and documentation. Part 14, 'Contract Management' includes: typing up the documentation; signing contracts; designating the contract officer; early briefing; review meetings; quality control; cost control; keeping contracts up to date; defects, default and dispute resolution and notice to service providers.
www.ipf.co.uk/bestvalue/bvq/CJC

Basic Guide to Contract and Procurement Law (2003)

This I&DeA document provides an introduction to contract law and the procurement regulations for local authorities in England and Wales. It provides basic information on relevant law and procedures which local authorities should follow when entering into contractual arrangements.
http://www.wlga.gov.uk/Procurement/prog-guidance-docs/guide-to-proc-and-proc-law.pdf

APPENDIX 14

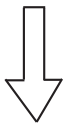
COMMISSIONING FLOWCHART

Arrangements for Specifying Services

Arrangements for Selecting Service Providers

Arrangements for Contracting

Quality Assurance Criteria



REVIEW

Monitoring

Evaluation and Review

Clarifying the CSP Purpose and Strategic Aims

- Clarified the membership, roles and values of your CSP, including membership of a commissioning group
- Established a commissioning group
- Clarified the links to other CSPs and regional and national arrangements
- Analysed national agenda, research and best practice in tackling substance misuse in Wales
- Analysed your local agencies agenda
- Produced and agreed statement of purpose and strategic aims for your CSP

Undertaking Population Needs Analysis

- Consultation with service providers
- Findings from service user and carer research
- Demographic analysis including public health analysis

Undertaking a Market Analysis

- Mapped existing substance misuse services
- Mapped existing contract arrangements
- Analysed the quality of services
- Consulted with service users, families and carers

Resource Analysis

- Allocated resources against strategic priorities
- Identified all alternative sources of funding/resources
- Identified potential areas for future savings or investment
- Identified the global budget and broken down the budget allocation
- Identified the current & future substance misuse services budget

Gap Analysis

- Reviewed the nature, extent and location of service need
- Reviewed the extent to which services currently meet needs
- Completed a list of identified gaps across tiers/service user groups
- Identified risks in relation to service gaps

Prioritisation and strategic Commissioning Intentions

- Considered the legal implications of any changes to existing services
- Prioritised allocation of resources in accordance with your strategic commissioning intentions
- Clarified your strategic commissioning intentions

Producing the Commissioning Strategy

- Written your commissioning strategy document
- Consulted on the strategy, and had it formally agreed by all commissioning agencies involved in the CSP
- Published the document

Managing Service Balance

- Planned the activities required to achieve changes in service balance
- Completed a statement informed by your commissioning strategy which specifies the service balance you are aiming for

Arrangements for Specifying Services

- Clear arrangements have been made and agreed by all CSP members for specifying services
- Specifications are developed for all services in your commissioning strategy
- All existing service specifications are reviewed and amended where required

Arrangements for Selecting Service Providers

- Agreed a lead agency for the tendering process
- Agreed an evaluation criteria for tenders
- Agreed arrangements for risk assessment of providers
- Agreed arrangements for the selection process

Processes for Contracting

- Agreed a lead agency for contracting services
- Agreed the types and format of contracts to be used
- Agreed who should be contract manager (if required)

Ensuring Quality

- Developed and agreed appropriate quality assurance criteria
- Include the criteria in contracts

Identifying potential new providers

- Identified any possible alternative suppliers
- Confirmed what kind of services they offer

Researching Substance Misuse Services

- Completed a research of substance misuse services elsewhere in the UK
- Considered opportunities to maintain and/or develop existing services

Monitoring

- Put in place formed mechanisms for the monitoring and analysis of data
- Assessed performance against service specifications
- Consulted with stakeholders about service effectiveness
- Identified and agreed any changes to the commissioning strategy

Strategy Evaluation and Review

- Put in place arrangements to ensure regular evaluation and reviews (by the CSP) of the information that is being collected
- Put in place arrangements that enable the CSP to respond to changing the commissioning priorities, which arise from the evaluation and reviewing activity