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GDAS Integrated Pathways

A REVIEW WITH RECOMMENDATIONS FOR FUTURE DEVELOPMENT

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Executive Summary

The commissioning of the new Specification for Gwent is occurring during a re-configuration of policy directives. Previous policy initiatives shaped commissioning to promote recovery. Whilst this remains a priority, the current policy direction is to dissolve bureaucratic and cultural divides between services to offer clients a 'service without walls' approach. This approach recognises the multiple needs of clients and requires that they are addressed as seamlessly as possible. The considerations developed within this report are shaped by this requirement.

The Models of Psycho-Social Intervention (MOPSI) offered a new two-tiered approach to developing integrated treatment pathways in Gwent. The model has been successful in creating high retention and recovery rates amongst primary opiate users. However, the calibration of incentives needs to be reconfigured for identified populations to create greater capacity within the treatment system. This will create of an Enhanced Low Intensity treatment option for clearly identified populations, where clinical evidence supports a more flexible approach to treatment.

Those currently in demonstrable employment should be supported to sustain their social engagement in this inclusive activity as a priority. Flexibility of take-home dosing on the provision of clean urine samples should be available to this group. Buprenorphine should be considered the optional prescribing regime, and this should be supplemented with support interventions derived from the Individual Placement Support (alcohol & Drugs) model.

Older and entrenched problem opiate users (aged 50+) represent an increasing large cohort of prescribed clients. This trend will continue across the course of the Specification. These clients become increasingly vulnerable to overdose and significant health conditions, especially if they drop out of treatment. An Enhanced Low Intensity option with take home doses should be made available to this population. The Specification should also require designated times for older services users to access drop / walk in services based on a social prescribing model. The Specification will have to build in capacity for the increasing challenges that older users will bring to the service and should pilot Navigator roles to support this cohort's complex health needs.

There is an increasing national trend in overdose. This has been accounted for by the increasing age of problem opiate users, treatment exits and the use of opiates in isolation. Whilst naloxone is a vital tool in reducing overdose, this should be supported with IT analytics to identify at risk target groups to reduce the incidence.

The current DIP 24-week prescribing regime & general case management model does not align with Home Office guidance or clinical evidence and should be reconfigured in the new specification. Clients in the Drug Interventions Programme should operate on a 16-week review cycle. Their progress within the wider GDAS Open Access service should be dependent upon their progress in addressing offending *and* substance misuse issues.

In CJIT, general case management models should be reconfigured within a Risk, Need, Response framework. This has been established as the most effective framework to reduce re-offending. This model should provide the architecture of the treatment service. The DIP service will focus on the present circumstances that drive offending, based on the 8 most significant risk factors as determined by clinical research.

Research demonstrates that clients in the criminal justice system are liable to have established patterns of offending *prior* to substance use involvement, that subsequent substance involvement further escalates. Their presenting clinical profiles differ from non-offending substance user in exhibiting high rates of ADHD, personality disorder and poor impulse control. The mechanisms underlying these conditions differ from neurotic disorders such as anxiety and depression and therefore require a different treatment intervention to those in Open Access. Evidence suggests that an Adult ADHD model, combined with wider interventions pertaining to personality disorder features would be a more effective strategy in reducing offending and re-offending rates.

It must be recognised that in Open Access services, the majority of clients exhibit co-morbidities with significant mental health problems. The aims of the new Specification should realign with this reality and commission a dual diagnosis-oriented service as opposed to a standalone substance misuse service. At the same time, there are limits to the capacity that street level services can offer those with complex needs. Therefore, the Specification should stipulate the requirement to provide structured and routine interventions for primary neurotic disorders such as depression and anxiety, utilising evidence-based models. Clients with low level poor impulse control disorders may be offered support through the CJIT service provision. A Wellbeing College model may present an opportunity to offer support for a wide range of disorders and presenting complexity in a multi-agency model.

Non-responsive clients and those with psychotic disorders should be referred to statutory mental health or specialist prescribing services with rapid access and streamlined referral processes. Entry and exit points need to be agreed as a part of wider strategic partnership across Substance Misuse, Health and Mental Health sectors.

Homelessness is a key priority for the Welsh Government. Currently significant developments are occurring within Housing to reduce entrenched homelessness. The Specification will identify that the Service Provider(s) will play a critical role in supporting these Housing Services to break the revolving door of homelessness. The Specification should require the development of a Community of Practice approach for relevant and interested parties drawn from across the social welfare field to assist in the continued development and response to homelessness in Gwent.

There has been significant progress in the development of online and digital interventions in recent years, along with a strong evidence base to support their use as effective. The current treatment system is under increased demand whilst digital solutions are under-utilised. Digital support needs to be promoted as a first contact intervention. Furthermore, digital services should be developed within the Specification in terms of:

- Screening online as part of a routine triage process
- Complete and standalone digital treatment options must be available
- Digital support to augment treatment should be developed
- The use of videoconferencing should be more widely available.

Currently Concerned Other services have experienced drift in the delivery from the intended treatment pathway. The vision of a virtual team has not been fully realised. The team should be placed under the management of one Provider where a consortium of services exists. Furthermore, it should develop its own identity that is clear and separate from the Open Access services. This identity must reflect the distinct needs and concerns of its intended client group. It should look to increase its range through cultivating a community of support for concerned others. Whilst there has been some consideration of expanding the team’s role in regard to wider Gwent priorities, this is not viable within the current configuration of the team alongside the current systems of practice.

Introduction

Treatment systems across the five counties of Gwent have undergone considerable development over the last 15 years. Implementation of new commissioning structures, new models of practice and the convergence of the five counties into one multi-county treatment system under Aneurin Bevan University Health Board has revolutionised the services. The commissioning process is now entering a new phase with the movement towards commissioning on a 10 year time scale. This presents an ideal opportunity to consider key learning from the last decade, how best to integrate new policy and shifting patterns of client presentation, as well as plan for future challenges.

This review is structured around key challenges identified with the current treatment system. It combines feedback from service providers consultation process, new policy requirements and the emergent clinical evidence base to propose key considerations. Only those considerations that are agreed through the APB will move forward as recommendations to inform the development of the new Specification for Gwent.

Policy

Since the introduction of the last Gwent-wide Specification there have been a number national policy changes across Wales which share a broad policy trajectory. These policies are re-defining boundaries between agencies and creating a trans-sector policy framework. This is directing Health Boards to dissolve barriers between services to assist those with more complex needs, in seamless service delivery. The primary policy framework is *A Healthier Wales: Our Plan for Health and Social Care* which will lead the transformation of service provision across multiple sectors. In terms of drugs and alcohol, the Wales Substance Misuse Delivery Plan 2019-22 has been annexed to the Healthier Wales agenda. The Wales Substance Misuse Delivery Plan maintains its core focus from the previous strategy:

• preventing harm

• support for individuals – to improve their health and aid and maintain recovery

• supporting and protecting families

• tackling availability and protecting individuals and communities via enforcement activity

However, it has re-constituted these aims within the broader policy of Quadruple Aims in "A Healthier Wales". These are:

- QUADRUPLE AIM 1: Improve population health and wellbeing through a focus on prevention
- QUADRUPLE AIM 2: Increase the value achieved from funding of health and care through improvement, innovation, use of best practice, and eliminating waste

- QUADRUPLE AIM 3: Enrich the wellbeing, capability and engagement of the health and social care workforce
- QUADRUPLE AIM 4: Improve the experience and quality of care for individuals and families

In addition, the previous Substance Misuse Plan has undergone an expert review and wider consultation. This has identified further priorities that should be addressed within the new and emergent Substance Misuse Strategy. These priorities serve as a helpful benchmark in which to review the consultation across Gwent.

Coexistence of a substance misuse problem should not be a reason for denying a service user access to the recommended treatment usually provided by mental health services. Individuals with co-occurring mental health and substance misuse issues, as well as other addictions such as gambling and smoking, receive appropriate and timely support. This demands that the Treatment Frameworks are delivered with the aim of improving joint working with mental health services and to better support those with co-occurring problems.

Ensuring strong partnership working with housing and homelessness services to further develop the multi- disciplinary approach needed to support those who are homeless or at risk of homelessness. The Welsh Government works across all sectors in order to prevent homelessness. It requires all services to work with service users and their families and carers to improve the outcomes achieved through interventions. Many rough sleepers use substances to help them cope with life on the streets. Housing, Substance Misuse and Mental Health are areas that intrinsically interact and are dependant in terms of improving outcomes for individuals affected by these issues. Co-occurring issues / dual diagnosis is frequently identified as an issue and can also be a significant factor in serious and untoward incidents (SUI). For dual diagnosis to be managed effectively key actions have been included within both the draft Together for Mental Health and Substance Misuse Delivery Plans for 2019-22.

• Ensuring that all prisons in Wales (and HMP Eastwood Park, women's prison) have a coordinated, transparent and consistent service for those with substance misuse problems in prison, based on best practice. Our overall objective is to produce a standardised clinical pathway for the management of substance misuse in prisons in Wales. This has been identified as a key priority in the Partnership Agreement for Prison Health in Wales.

• Providing further support for families and carers of people who misuse substances. Where family support is available, carers reported the benefits of sharing experiences in peer support groups, gaining a greater understanding of addiction and how to support their loved one. In particular we know through the work on ACEs, as indicated above, that children who are raised in homes where substance misuse is an issue are, potentially, more likely to have adverse outcomes in later life. We will also focus efforts on ensuring services are joined up and effective for families who are "on the edge of care".

• Ensuring that appropriate and responsive alcohol misuse services are in place before the Public Health (Minimum Price for Alcohol) (Wales) Act 2018 is implemented.

• Improving access to services and ensuring people get the support and treatment when they need it, is critical to ensuring we reach as many people as possible. Waiting times for treatment have consistently reduced. APBs must ensure access to substance misuse services is increased, with particular attention to providing outreach to vulnerable groups and improving links with primary care services, in particular GPs. We know that access for those who live in our rural communities can be a challenge and will work with APBs to focus efforts in rural areas to improve this, in particular through outreach, integration with primary care and the use of digital technologies.

• As people are presenting with more complex issues, many affecting their ability to maintain treatment and recover, we will work to ensure we adopt a whole person approach, based on strengths and trauma informed practice. We will strengthen our multiagency working and care planning to ensure peoples' needs are met. Once people are in treatment it is important that they get the right treatment, at the right time and have choices. They should also be able to access treatment services for any other co-existing harms. For most people treatment in their community is the choice they prefer to make but we also recognise that for some residential treatment is required particularly for those with more complex problems, we will continue to ensure that for those who require this, it is available.

• Tackling dependence on prescription only medicines (POM) and over the counter medicines (OTC). The potential for dependency and withdrawal issues in relation to these medicines- which can be exacerbated by poor prescribing practices - is acknowledged. Full consideration will be given to the report from the Petitions Committee as our priorities for Substance Misuse are taken forward. The Welsh Government recognises it is important we distinguish between substance misuse, as the harmful use of substances such as drugs and alcohol; and dependence arising from the therapeutic use of medicines whether they are prescribed or purchased. In responding to the Petitions Committee report the Minister for Health and Social Services has given his commitment to this distinction.

The current commissioning framework has now shifted since the implementation of the last Specification. The last Specification in Gwent was shaped by Wales Government policy that directed Commissioners to extend the treatment services *longitudinally* with the addition of recovery-oriented services. Current Welsh Government policy now requires that services are also now expanded *laterally* to address a wider range of complex needs. This will require a significant shift in thinking, culture and attitudes from Stakeholders to grasp that commissioning will be focussed on the purchasing Integrated Pathways for *Substance Misuse with Complex Needs*, as opposed to simply *Substance Misuse*. This re-orientation is written into the considerations across this Specification Review. Furthermore, it

should be expected to be replicated in wider Gwent Services commissioning outside of the remit of this Specification.

Consideration 1: The specification should state that this is a commissioning contrast for substance misusers with complex needs as to re-orientate Stakeholders to the function of this Specification.

The Treatment System

The commissioning of the Model of Psycho-Social Intervention (MOPSI) as an integrated treatment pathway was a courageous innovation in the delivery of substance misuse services. Whilst Integrated Treatment Pathways have become a dominant service delivery model since 1985, little research has been conducted on their effectiveness (Wamel et al 2014). They are primarily designed to support clients moving through a treatment system but this becomes more challenging in terms of substance misuse, especially for opiate users. Substitute prescribing by its nature is a long-term intervention, where motivation for lifestyle change can be forestalled by:

- Complexity of the client's needs
- Fluctuation in motivational levels during treatment
- Substitute prescribing's effectiveness at reducing the stresses that often precipitate desire for change
- The chronic relapsing nature of the conditions being treated

Research suggests that different prescribing regimes for opiate users give rise to different patterns of response in clients. Highly permissible prescribing regimes tend to produce high retention rates but lower positive treatment gains. Whilst highly punitive prescribing regimes tend to produce high attrition rates but also higher positive life outcomes for those who survive (Iguchi et al 1988). The Models of Psycho-social Interventions (MOPSI) model was a bespoke treatment pathway developed in Gwent. It was a research informed attempt to square this circle by offering a balanced treatment system that would preserve the best harm reduction strategies for those with lower motivation, whilst at the same time incentivising change for those who wanted to work towards recovery. The proposed mechanism for this was the use of a contingency's management approach (NICE, 2006; Ferroni et al 2016) that offered positive reinforcements for change in the form of:

- Incremental access to take home doses
- Access to psychological support services
- Access to diversionary activity

Conversely negative reinforcements were utilised for those on low intensity options that would be offered harm reduction interventions only and remain on daily pick up. A number of contingency based programmes have been developed (Tuten et al 2012; Stitizer & Strain 2006). However, these models tend to increase resources on low treatment responders. In contrast, the MOPSI model targeted incentives at motivated clients. This was reversed in order to:

- Provide a structured recovery-oriented approach to opiate users
- Target limited psycho-social resources at those who desired these interventions
- Target resources at the most treatment responsive groups to move them out of the treatment service and create capacity
- Reduce time expenditure providing limited resources to clients who did not desire psycho-social support
- Ensure clients with low motivation for change were supported through harm reduction strategies to keep them physically safe

The MOPSI model has achieved these goals with varying degrees. In general terms, MOPSI has created a more dynamic system that increased the range of treatment modalities. This includes a significant expansion of recovery services which had been lacking previously. Prior to the implementation of MOPSI, annual positive treatment completion for opiate users had been reported in single figures. In contrast, MOPSI provided a mechanism to increase positive treatment completions amongst substitute opiate users to 1,201 from 1st May 2015 -31st December 2017 (GDAS Report). Furthermore, attrition rates have remained low. The increasing level of structure has not restricted treatment participation.

It was anticipated at the implementation stage of MOPSI that the model would mostly likely support the most treatment responsive clients to exit the system first. Over time, this would leave the least responsive groups in the Gwent treatment system. Therefore, it was always assumed that future commissioning would inevitably mean a change in focus to support these more entrenched populations. From the latest data reporting, it appears that the model has been highly successful in its primary aim and the core hypothesis of the MOPSI model has been substantiated.

Consideration 2: The MOPSI framework has proven to be a highly effective addition to the treatment system for opiate users and should be retained.

Across the five counties, Service Providers were supported to develop their own contingencies, but it was strongly recommended that the availability of take-home doses should remain the sole preserve of those clients who chose the high intensity treatment. This was in the interest of harm reduction, where it was anticipated that more chaotic clients would choose low intensity. Daily pick up and restricted access to methadone and would provide a level of frequent monitoring to those most at risk of serious harms (Gossop et al 2000; McCellen et al 1993). Feedback from Service Providers suggests that the lure of take home doses, combined with a client's desire to sustain current case worker relationships, led to a much higher number of substitute prescribing clients to opting for high intensity case management than had been anticipated. Where the MOPSI has been developed in order to retain motivated clients in the high intensity option, the established incentives nudged too many into this arm of treatment provision. This has meant that staff caseloads remain high, populated by service users with a wider variance in motivational levels. The high case load has since been acerbated by:

- Evaporation of wider support services in the post-austerity era

- Reported levels of increased complexity in clients
- An increasing percentile pool of low treatment responsive clients

High staff caseloads impede practitioner's ability to provide effective treatment and is detrimental to staff wellbeing and retention (WG, 2019). Furthermore, it will be difficult to make any significant adjustments to the current Specification whilst the ratio of high-to-low clients remains so unevenly distributed. As there are limited additional external resources, the current Specification will need to reconfigure its internal caseloads to increase capacity to address new policy and social demands.

Reconfiguring Low Intensity Case Management

Within the current Specification, the number of clients who are currently in high intensity case management needs to be reduced. This reduction in numbers needs to be informed by clinical rationale as well as the presenting needs of the clients engaged in this regime. This can be achieved by identifying treatment populations who would most benefit from a low intensity option and a re-calibration of incentives available to them on a low intensity treatment option. Contingency management allows for the re-calibration of reinforcement incentives that may steer the flow of lower motivated opiate using clients towards low intensity. Therefore, it is suggested that take home doses, contingent on clean urinalysis, is available to those on the low intensity arm of MOPSI in certain sub-populations.

Consideration 3: Take home dosing schedules should be made available to sub-populations within low intensity prescribing arm who have demonstrated stability and routinely provide negative samples.

This will require the development of a new Behavioural Contract between the client and the Service Provider. In the recent consultation process some Service Providers reported unease regarding the terminology of 'Behavioural Contracts.' The Behavioural Contract is a feature of incentive based contingency management approaches. It describes the procedure whereby expectations, incentives and interventions are agreed between the client and the practitioner. This is the name of the clinical intervention. It does not have to be the name utilised with service users. This contracting procedure can be re-branded within the Specification in more service-user friendly language.

Consideration 4: Rename Behavioural Contract to a more service user friendly term.

Low Intensity: Demonstrably Employed

Low intensity options with access to take home doses might offer a viable clinical option for those clients who need a more flexible service. One population that staff have identified for enhanced low intensity treatment is those who are in demonstrable employment. There is a paucity of research on substance misuse and employability. Those studies that do exist tend to focus on supporting people back into employment as opposed to supporting people who are already employed.

However, a review by the European Monitoring Centre for Drugs and Drug Addiction (2012) emphasised the substitute prescribing services must be more work friendly. Barriers to employment for drug users in treatment may include:

- the requirement to attend treatment on a daily basis
- the inadequate opening hours of treatment services (e.g. pharmacies)
- limited geographical coverage of treatment services

The main reason why employers are hesitant to employ drug users in treatment is that they would not want employees to take time off to attend treatment sessions (UKDPC, 2008). Therefore, one way to increase the employability of drug users in treatment could be to ensure that treatment services offer greater flexibility (e.g. longer opening hours, possibility of appointments outside regular working hours, less stringent regulations for take-home doses of OST).

Sutton et al (2004) conducted a literature review for the Department of Work & Pensions that examined the barriers that prevent drug and alcohol users from gaining employment at all, or being limited to occasional or poorly paid employment. It identified six major areas of disadvantage including:

- education / skills
- health
- social disadvantage
- provision of support services
- engaging with employers and support professionals
- dealing with stigma

Furthermore, Sutton et al (2004) explored the issue of employed drug users' participation in treatment services. The authors refer to a review of barriers to employment which found that the most frequent obstacle was gaining permission to take time off work or college to attend treatment services or pick up substitute prescriptions (Sutton et al, 2004).

Other important barriers to employment described in the same review centre on the ability of drug-using individuals to engage with services around employment hours. As services are generally situated in larger urban areas, rural drug users can find it hard to make use of available support.

Consultation with service users in employment reflected similar tensions between the demands of work and the demands of treatment. Clients wondered how employers feel about employees attending treatment sessions or picking up substitute prescriptions from a pharmacy, when they would otherwise be expected to be working. Likewise, failure to be able to collect a prescription daily has led to some to lose their employment.

'I've lost a couple of jobs because of my script 'cos I have to pick my script up every day. Because the chemist isn't there, or I have to wait, or one thing or another I can't get to work in time because the chemist isn't open early enough.' (DWP Review 2020).

To reduce the time burden on staff working with low intensity clients more flexible support and prescribing regimes could be provided to sustain service users engagement in pro-social and inclusive activity of work. Rather than fixed time one-to-one appointments, options such as evening walk-in clinics may offer greater flexibility to clients in demonstrable employment.

Consideration 5: The development of walk in clinics for those on low intensity, evening sessions for those who can demonstrate that they are in employment. The Service Provider will develop a criterion for what they will recognise as demonstrable evidence of employment and this should be set on a review schedule. Expected frequency of contact will be determined by the Service provided in consultation with services users eligible for this element of service.

Consideration 6: Demonstrably employed individuals who test negative for opiates should be offered low intensity options with take home privileges.

Similarly, the issue of receiving medication whilst in employment raises Health & Safety challenges. Consideration must be given to people in risk sensitive employment. Reducing euphoria and drowsiness is an important factor in improving functioning and sustaining employment. Buprenorphine has a reduced sedative-like effect compared to other opiates and should be considered the optimal regime for those in employment in the first instance. Recent developments in long acting Buprenorphine (Buvidal) may provide the most appropriate intervention. Buvidal can be administered weekly or monthly (Lofwall et al 2018) might be ideally suited for those managing treatment and employment demands. However, there is a significant cost implication as it is more expensive than more established treatment.

Consideration 7: Encourage those currently on methadone prescribing regimes to switch to buprenorphine regimes to reduce Health & Safety in the workplace related risks. Protocols for Buvidal will also need to be developed along with additional costing of this prescribing option.

There is a paucity of research in terms of psycho-social interventions for those in employment. The general consensus in the research is that the employable stay employed while the unemployed stay unemployed after long periods out of the workplace. However, there is a new model that has shown very promising results supporting those with severe mental health problems back into employment. The Individual Placement and Support (IPS) model is a “place-then-train” model that supports people with severe mental health difficulties into employment. The approach has assisted people with significant mental health issues to gain and sustain employment, more than doubling the sustained employment rate compared to control groups (Bond 1998; Metcalfe et al 2017). It involves:

- intensive, individual support
- a rapid job search
- placement in paid employment

- time-unlimited in-work support for both the employee and the employer
- Embedding specialist career advisors into specialist provision

A recent small-scale study with methadone maintained clients also showed very strong results with this approach (Lones et al 2018). Furthermore, in response to Dame Carol Black's review of employment for substance misusers in 2016 (Dept WP 2016) the Individual Placement and Support model has been adapted for those experiencing substance misuse problems. The IPS for Alcohol and Drug dependence (IPS-AD) is currently undergoing a multi-site Randomised Control Trial to test the approach. It is the first time a trial of this sort and scale has been attempted with this client group. Public Health England and the Government Work and Health Unit is working with local authorities to deliver the trial across seven areas of England. The IPS-AD sites provide a broad mix of characteristics – town and city; urban and rural; high and lower levels of deprivation. The results are due to be published in 2021 and will feed into future policy and service provision.

It must be recognised that the challenges of supporting those in current employment on methadone prescriptions differ to those challenges in moving unemployment substitute prescribed patients into employment. However, elements of the IPS-AD approach are designed to support those in employment and could provide a psycho-social framework to support those whose needs are not fully understood.

Consideration 8: Adapt elements of the IPS-AD to support those in employment to sustain employment.

Low Intensity: Aging Populations

A second population that might be offered take home dosage on low intensity is older users. The opiate using population is aging across the UK. In Wales, the median age for alcohol presentation has remained stable since 2104, but for opiate users it has increased from 35 years old to 37 (Welsh National Database for Substance Misuse, 2018-19). There are significant shifts in age demographics of opiate users presenting for services (see table 1). Whilst the numbers of clients presenting under the age of 40 are decreasing, the numbers presenting above this age are increasing. The needs of older drug users, and opiate users in particular, will demand a shift in treatment focus.

The number of opiate users within the Welsh treatment service is liable to increase fivefold in the next 10 years and tenfold in the next twenty years (See table 1). This is reflected in the current Gwent treatment seeking population which will also dramatic shifts in age across the duration of the Contract (see graph 1). For example, Open Access Drug and Alcohol services currently have approximately 76 clients over the age of 51. This will increase to 206 by the end of the contract, based on current figures. This means that 40 per cent of the OST cohort will be over 50 by the end of the contract. This demographic shift is not reflected in CJS population who remain much younger.

Table 8.5c: Profile of clients commencing treatment by main problematic substance: Heroin

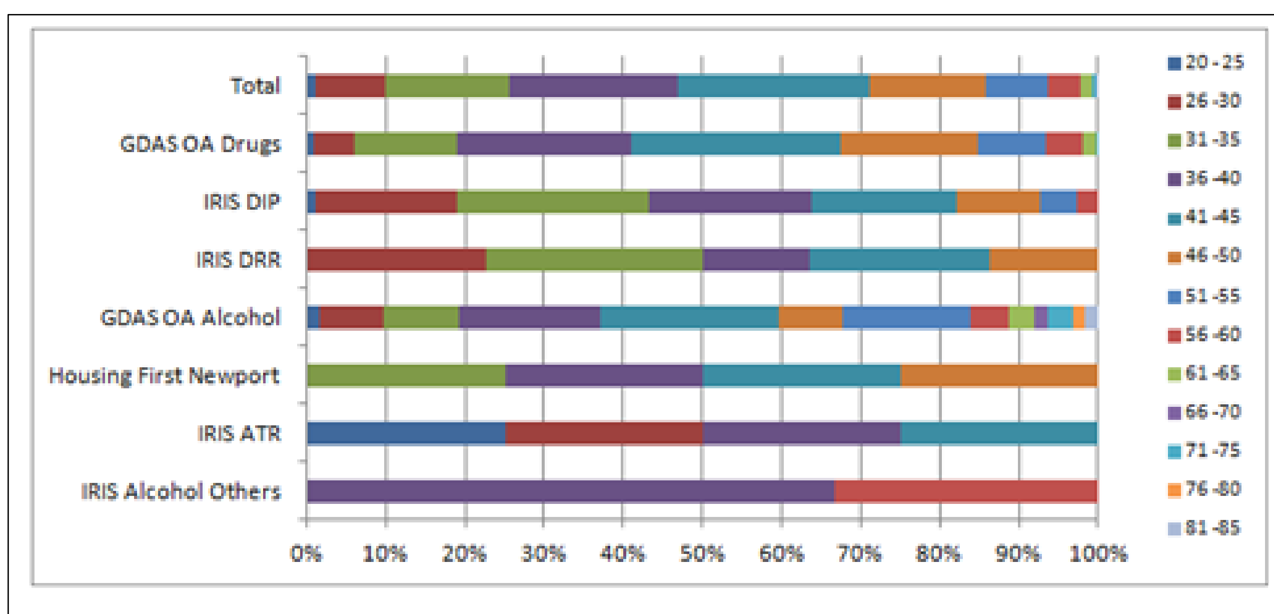
	Treatment Year									
	2014-15		2015-16		2016-17		2017-18		2018-19	
Gender	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Male	2,805	72.6	2,259	73.3	2,221	71.7	1,983	70.6	1,982	70.6
Female	1,056	27.4	821	26.7	876	28.3	825	29.4	827	29.4
Total	3,861	100	3,080	100	3,097	100	2,808	100	2,809	100
Age										
10-14	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19	21	0.5	15	0.5	17	0.5	18	0.6	12	0.4
20-29	922	23.9	649	21.1	614	19.8	509	18.1	458	16.3
30-39	1,826	47.3	1,380	44.8	1,383	44.7	1,218	43.4	1,234	43.9
40-49	911	23.6	843	27.4	882	28.5	842	30.0	868	30.9
50-59	162	4.2	174	5.6	178	5.7	210	7.5	217	7.7
60+	19	0.5	19	0.6	23	0.7	11	0.4	20	0.7
All Ages	3,861	100	3,080	100	3,097	100	2,808	100	2,809	100
Median age (a)	35	.	36	.	36	.	37	.	37	.

Source: WNDSM, NHS Wales Informatics Service

(a) The median is the middle number in a sorted list of numbers, i.e. the value where there are the same number of values below the median point as there are above it.

. Data item not applicable

Table 1: Profile of clients commencing treatment by main problematic substance heroin.



Graph 1: GDAS Service Presentation by Age

In general, the needs of older problematic drug and alcohol users has been neglected with a sparse evidence base. And within this cohort there may be distinct sub-populations who experience radically different needs. Myers et al (2000) suggested three cohorts of older problem users. These include:

- Survivors of long-term using careers who experience a wide array of accumulative physical / mental health difficulties who exhibit highly complex presentation.

- The young-old whose use escalates during transitionary periods of life such as retirement where new structure and purpose are not found.
- Old-old who are isolated and whose consumption is strongly correlated with social isolation.

For opiate prescribing services, they are more likely to meet with the long-term survivors of opiate careers as initiation into street opiates runs at a very low rate of 3 per cent past the age of 50. These survivors have complex comorbidities and are often prescribed multiple medicines. Primary and community care services will encounter increased demand for medical care from this population as the ageing process also appears to be accelerated by long-term opiate use. Rapid physiological ageing promotes multisystem disease (Reece, 2012). Older people with a history of heroin dependence have poorer physical health and social functioning than their non-dependent peers (Grella & Lovinger, 2012) and show high levels of major depression, post-traumatic stress disorder, generalised anxiety disorder, arthritis and hypertension (Rosen, Smith, & Reynolds, 2008; Rosen et al 2011).

Liver disease (through hepatitis C infection) was reported as the most common cause of mortality among ageing opioid-dependent people in an Australian cohort (Gibson, Randall, & Degenhardt, 2011). There is also emerging evidence of damage to the structural integrity of the prefrontal cortex region of the brain, even in abstinent heroin users. The prefrontal cortex is associated with the highest brain functions and effects areas such as memory and attention control (Cheng et al 2013). Awareness of drug-related cognitive impairment is important for general practitioners, memory clinic staff and community mental health services.

Hser et al (2001) followed heroin-dependent subjects for 33 years. This study found high rates of tobacco smoking, alcohol, and poly-drug use among the aged population. The study identified high morbidity rates, most notably abnormal lung and liver functions, infectious diseases, and abnormal blood glucose levels. The self-rated health status reported particularly low scores for perceived energy level and greater perceived limitations due to physical or health problems.

The mortality rates of this group are of importance. Whilst there has been increased awareness and discussion of drug related deaths in this cohort (q.v. Overdose) it must be recognised that the majority of drug users in treatment do not die from a drug-related death (i.e. acute toxicity or mental and behavioural disorders due to drug use). Beynon et al (2010) review of drug related deaths demonstrates that the likelihood of dying from a drug-related death diminishes with age. The odds of a drug user aged 40 and over dying from a ***non-drug related*** death are three times higher than a person aged less than 40 (Beynon et al 2010). Deaths from associative health conditions such as hepatitis C, aspiration pneumonia, deep vein thrombosis and endocarditis are not included in official figures on drug-related deaths (Beynon, et al, 2007). The current focus upon drug-related deaths detracts attention from other causes of premature death and in particular, the types of death which disproportionately affect older people who use drugs.

This issue has been raised by activists within the substance misuse field. The Collective Voices working group on aging have identified exclusion from mainstream health services and the fragmentation between health, community and social care sectors as a central problem. For example, many older homeless individuals may not have a GP and their life lacks the sufficient structure to attend routine appointments on pre-booked dates and times. In The Collective Voice's evidence to the ACMD's Older Drug Users Working Group, they observed that "The most recent ONS analysis of the rise in drug-related deaths in England, supported by PHE's expert group, points to the increasing vulnerability of the ageing cohort of 1980s/90s heroin users as the single most significant driver of deaths."(Collective Voice, undated).

Certainly, experiences of discrimination from health services, or the experience of feeling as though they are a 'lost cause' (Matheson & Liddle 2017) may inhibit help seeking. Likewise, age differences between older and younger services users has also been identified as a barrier to accessing services. Not only did this induce other forms of stigma, the increased health issues and frailty among older users also makes them prone to all forms of exploitation from younger service users and raises serious POVA issues. Many participants wanted specific services for older substance misusers, particularly peer support groups. Furthermore, multiple health needs in complex health care systems may deter their engagement as they are difficult systems to navigate. They also have to physically attend multi-site treatment services for associative needs. It will also require new links being forged between substance misuse agencies, specialist medical services for a wider range of chronic health conditions, end of life & palliative care services as well as gerontology.

In Our Invisible Addicts, the Royal College of Psychiatrists notes that "the current situation in terms of a policy framework for the prevention of substance misuse by older people and the planning and provision of services for its treatment is generally characterised by a disturbing silence." The report goes on to highlight that the National Service Framework for Older People, which sets quality standards for health and social care, does not "acknowledge that addiction, in its broadest or narrowest sense, is of relevance to planning service provision for older people." (RCP, 2011).

Likewise, ACMD's recent review of aging in substance misuse services identified that substance misuse services in general are ill-prepared to address a seismic shift in demographics with attended needs. Its review identified key weaknesses in the treatment systems currently in operation.

> Specialist community drug services are treating an ageing cohort of patients. Predominant among these are those with problematic opiate/opioid use.
>
> Research suggests that older drugs users, particularly opiate/opioid users, have multiple additional risk factors resulting from their deteriorating physical and mental health, difficulty in navigating complex health and social care systems and experience of stigma.
>
> There are indications which suggest that addressing the complex and varied needs of older opiate/opioid users will increasingly become a mainstream treatment activity.
>
> Specialist community drug services are insufficiently prepared to manage the complex needs of this ageing cohort, despite the increase in older drug users attending for treatment.
>
> Commissioners, providers and the specialist drug treatment workforce all need to ensure that staff are competent to meet these demands with the expected increase in complexity of treatment required by attendees.
>
> Future trends in treatment presentations of ageing cohorts are difficult to predict and careful monitoring of drug treatment populations and other metrics of drug misuse should be explored and utilised. The better recording of prevalence of substance misuse by ageing drug users will improve understanding of the ageing treatment cohort and support service planning and delivery.

ACMD Report (2018) - Ageing cohort of drug users (ACMD 2018)

Two important points are made in connection to the Specification. Firstly, the challenge of addressing older service users health needs within mainstream provision and secondly the need to monitor how age demographics shift during the course of the Specification. Within the range of the Specification, there will be a significant increase in the numbers of opiate users who cross the age 50 threshold. The currently submitted quarterly data by the Consortium only shows age breakdowns for alcohol clients, and there is a pre- and post- 50 divide. Future Quarterly Reports should give the age breakdown of those in the clinical prescribing service by age-decade. This will assist the anticipation of shifting age ranges as more clients cross this threshold. Resource allocation to this client cohort should be proportionate to this demographic shift which will increase across the duration of the Specification. As there remains such a paucity of evidence on the needs of older users, early service developments for the older opiate using clients within the Specification might best be conceived as "pilots." These early trials will help Service Providers develop more practice-based evidence approaches to supporting older people.

> Consideration 9: Report breakdown of ages related to those in Open Access prescribing to assist in the pro-rata of case management between these age ranges.

> Consideration 10: Early initiatives deployed within the Specifications should be considered as pilots for routine evaluation in order to establish best practice models during the course of the Specification.

Within this context, it is advised that the Gwent Specification adopt the recommendations of the ACMD Aging Working Group that was submitted to Parliament. These recommendations include:

• Specialist community-based drug treatment services should develop training for staff to highlight the treatments and specific risks for older drug users, particularly opiate/opioid users.

• Given the changes to the specialist community drug treatment workforce over the last five years, an assessment should be conducted of the current range and availability of skills, treatment and support available to people presenting to treatment. A particular focus should be the availability and knowledge of staff to address the complex physical and mental health issues of older drug users.

• An evaluated pilot programme to determine whether the use of the service navigator model will assist older drug users to engage more successfully in complex health and social care systems, improve the quality of care and health outcomes and be cost effective.

• Close and ongoing analysis of treatment presentation data and wider metrics of drug misusing patterns, with particular attention given to refining and standardising age categories.

Recommendations of the ACMD

There will be a dilemma in service delivery as the age balance shifts. Should the Service Provider train all staff to work with older cohorts or should they introduce specialist roles? The initial establishment of Over 50s champions to take a lead role in the development and establishment of services for the over 50s might be an ideal starting point in generating in-house evidence and responses to the aging opiate population.

Consideration 11: The specification should include the recommendations of the ACMD working group on aging with the development of an older person's navigator role. Differences between Case Management and Navigation approaches are ambiguous with some significant cross over. For the purpose of the Specification, Case Managers will support the clients through the current substance misuse service system. Whereas Care Navigators will support substance misusing clients whose needs may be better met by a wider range of external health interventions. As such, they will have a broader brokering and linkage role with age & health related interventions including gerontology and palliative care.

Consideration 12: The current assessment procedures should be reviewed to test whether they are fit for purpose for the over 50s. This might necessitate the demand for the development of a specialist Over 50s assessment. Such an assessment could provide the gate way to specialist service provision for this age cohort.

The Specification will require that the Service Provider to also establish a wider range of links and memorandum of Agreements with a broader range of gerontology-based services to support service users. End of life care will also become more a pressing issue for substance misuse services. This becomes challenging for clients and for staff teams who will have forged long-standing relationships with service users and may represent the most enduring and stable relationships in the client's life. The Service Provider should have a clear policy on the management of end of life care issues. Whilst research is still in its early development, a good practice guide to supporting substance misusers with end of life issues has been produced by Manchester Metropolitan University (Galvani et al 2019).

Consideration 13: The Service provider will need to forge links with wider gerontology-based services.

Consideration 14: As the substance misuse population ages there will be greater focus on end of life care for services in the next 10 years. It is recommended that the Service Provider develop End of Life policy and protocols within the good practice guidance of Manchester Metropolitan University.

Consideration 15: Staff should receive training and support for working with end of life care.

Consideration 16: The Service Provider should develop links and Memorandums of Agreement with Palliative care services in the area as part of their package of care for older drug users.

The established evidence base for methadone or buprenorphine maintenance regimes has largely been conducted on younger adults. There is inadequate evidence for treatment with naloxone and injectable opioids, and for using coercive methods with older users. The Royal College of Psychiatry (RCP, 2018) advise that older patients with established long-term prescribing histories are not subject to arbitrary cessation of treatment simply due to a change of Service Provider. Especially if there is no evidence of instability or deterioration in problems. Moreover, research has suggested that services need to be adapted for older drug users. Ayres et al (2012) highlighted the need to ensure that service provision is age-appropriate and that staff are trained to understand the needs and anxieties of older high-risk drug users. For example, detoxification regimes may need to be much slower and better supported medically to accommodate age-related metabolic changes.

Certainly, one primary reason reported for older client drop out of Opiate Prescribing Services is that there are too many rules and low expectations in engaging repeatedly with treatment options that have not proved effective previously. Offering the Over 50's access to take home privileges on Low Intensity options may increase treatment retention for this group to help sustain engagement. This needs to be

offset with pro-active efforts to ensure the safety of this group, particularly in terms of overdose prevention.

In contrast, the idea of recovery for older populations should not be completely abandoned. This should remain an open offer for all those in the treatment system regardless of age if they chose to do so. But a common feature of established practice approaches with older substance misusers is that they focus on quality of life issues as opposed to significant change in substitute treatment provision. As such they might be considered addiction centred (dealing with breakdown in social functioning) as opposed to dependency oriented (the elimination of tolerance and withdrawal). This might be better characterised as a Social Prescribing model. Increasing mobility issues, physical frailty, the risk of exploitation and exhaustive treatment histories suggests that the MOPSI low / high structures are not suited to the needs of this population. Take home doses amongst a stable if entrenched 50+ populations may be indicated. This should be supplemented with protected times for those over 50 years old to access services that utilise a social integration and recreational approach. This will shift the service from clinical recovery goals to enhanced wellbeing goals for this population. Co-production of these groups will be important to draw upon the lived experiences and desires of older populations. Increasing social contact may also reduce wider risks (q.v. overdose).

Consideration 17: The Service Provider will develop a protected time intervention for those over 50 on enhanced low intensity prescribing. This voluntary programme should offer social prescribing that focusses on increasing social engagement and positive activities to enhance wellbeing and promote service retention.

Service Case Study: Bristol Drugs Project (BDP) – '50 Plus Crowd'

Bristol Drugs Project's '50 Plus Crowd' service is open to anyone who is aged 50 and over and has drug and/ or alcohol problems. The service is funded by the NHS, to achieve outcomes related to improved health and wellbeing among older people, rather than more conventional 'recovery-oriented' outcomes. Currently, the majority of people using the service are those who are on long-term methadone scripts with the BDP shared care team, who have not been engaging with treatment services beyond these appointments.

Regular social activities – including swimming, yoga, dance therapy, gardening and walking – are a core part of the service, and aim to support service users to meet other people, develop a social network and build their confidence. An important part of all activities is their sustainability; BDP focus on those that service users will be able to continue engaging with once they have left the service. There is also a twice-weekly group, which meets on Wednesday afternoons and Saturday mornings.

A key aspect of the service is its flexibility; service users can 'dip in and out', and there is no pressure to attend on a regular basis. Practitioners send text messages to those who are 'on the books' of the service on a regular basis, to let them know about upcoming activities and events; service users have explained that they find this useful, and that it 'keeps the door open', which can help them to re-engage if they haven't attended for some time. Attending social activities and the regular group can be a route back into more structured treatment and engagement with the wider community.

Overdose Reduction

Closely related to aging opiate populations is the increasing trend in drug related deaths being recorded across England, Scotland, Northern Ireland and Wales. Explanations of these increases have been attributed to two areas. The first is that the rise in deaths is due to the aging population of opiate users who have accrued increased health complexities. Secondly some have suggested that the rise in deaths is due to the Recovery Agenda which has pressed opiate users into recovery prematurely, resulting in increased relapse rates and subsequent overdose.

Evidence to support aging as related to overdose has been established in numerous studies. For example, in England and Wales in the 1990s, opioid-related deaths were far more numerous and rose more steeply among the under-40s than in older groups. But from the turn of the century the under-40s began a general downward trend while the 40s and over continued to die in greater numbers (ONS 2015). This bulge in over 40s overdose rates is partly an age artefact. As less young people initiate into heroin the under 40 population is a much smaller sample compared to the aging established opiate population.

By triangulating treatment and criminal justice databases, Pierce et al (2015) identified 198,247 individual opioid users (93% using heroin) between 2005 and 2009. Their identifiers were matched to those of people whose deaths were registered up to September 2011. Of the deaths, 3,974 were among the 198,247 opioid users. This represented a six times increase in mortality rate compared to non-users of similar age and sex. Drug-related poisonings accounted for 43% of these fatalities. This risk steadily increased by age demonstrating that age and overdose are strongly correlated:

- Age 18–24: 19 deaths over 10 years for each 1,000 opioid users.
- Age 25–34: 26 deaths over 10 years for each 1,000 opioid users.
- Age 35–44: 39 deaths over 10 years for each 1,000 opioid users.
- Age 45–64: 45 deaths over 10 years for each 1,000 opioid users.

Age Related Deaths in Populations (Pierce et al 2015)

Substitute prescribing programmes help prevent overdose deaths. For example a Welsh study (PHW 2016) covering 2014/15 found that of the overdosers who died, 40% had been in contact with substance misuse services in the past six months compared to 66% of those who survived, most of whom had been in contact very recently. These differences were attributed to "regular contact with support services [leading to] greater exposure to harm reduction advice and information, including access to fatal drug poisoning preventative measures such as Take Home Naloxone provision."

In terms of treatment exit related deaths, a PHE Report (2016) offered a more sophisticated assessment of the potential impact of treatment and overdose (from April 2005 to March 2009). Subjects were patients recorded as having received treatment for dependence on an opiate-type drug during these years. Deaths were adjusted for sex and age, whether they were recorded as injecting or also problematically using alcohol, benzodiazepines, crack cocaine or cocaine

powder/amphetamines, and whether they had been referred to treatment by the criminal justice system. This study also confirmed the high risk of leaving treatment, especially residential settings which generate abstinence partly by divorcing the user from their normal environment. Significant differences in death rates were identified.

- In Treatment Death Rate: 2.9 per 1000 people over a year
- Left Treatment Death Rate: 4.5 per 1000 people over a year
- Four Weeks Post-Treatment Death Rate: 8 per 1000 people over a year
- Beyond 4 Weeks Post Treatment Death Rate: 4.2 per 1000 people over a year

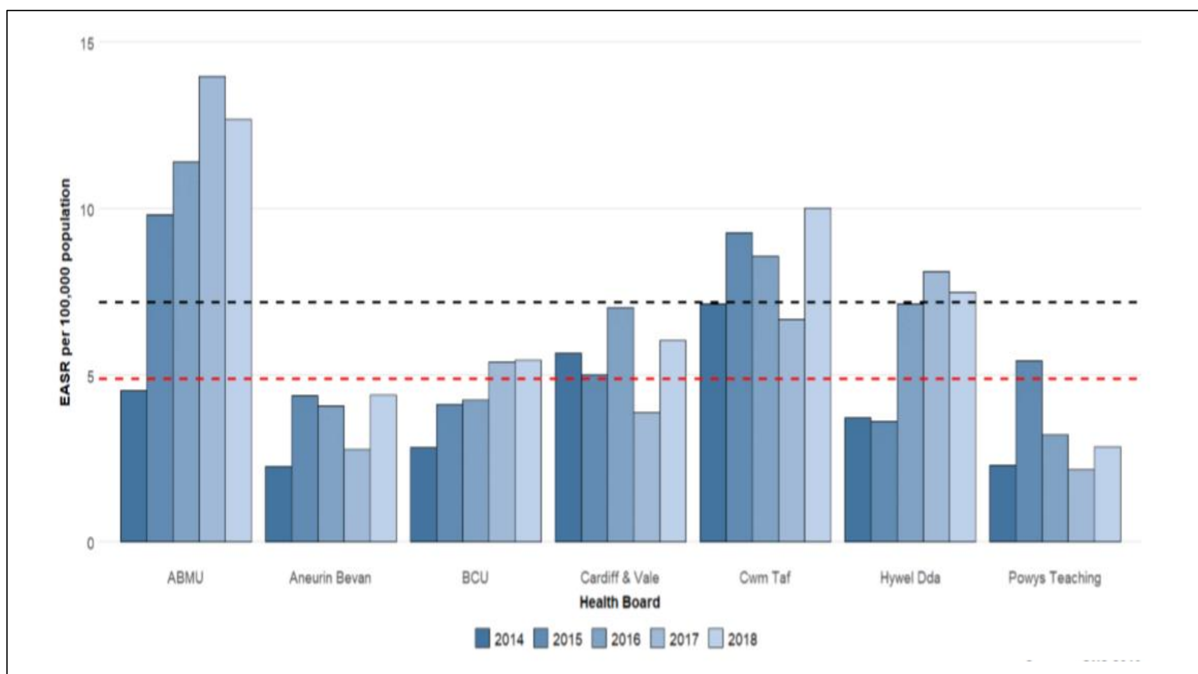
PHE Report (2016) Trends in drug misuse deaths in England: Analysis of trends in drug misuse deaths in England from 1999 to 2014.

Adjusted figures suggest that 1.73 per 1000 people die over a year in “out of treatment” conditions compared to 1 in the “in treatment” condition. Examining other treatment-exit scenarios, there was no significant difference in the risk of death after leaving treatment having ‘successfully completed’ or not. This study also found within treatment effects. Stand-alone psychological treatments did little to reduce deaths for opiate users within substitute prescribing services. Retention on substitute prescribing therefore becomes a central feature of reducing overdose for those at risk. Of the treatment modalities included in the study, only non-residential psychological support – counselling and allied approaches – was not followed by a spike in deaths in the four weeks after leaving highlighting the central importance of aftercare.

Consideration 18: Providing treatment approaches that sustain retention and engagement is of vital importance to opiate related deaths in this vulnerable group.

Consideration 19: Routine follow-up support for at least four weeks post treatment is necessary for those exiting opiate substitution therapies to reduce drug related deaths in out-patient settings.

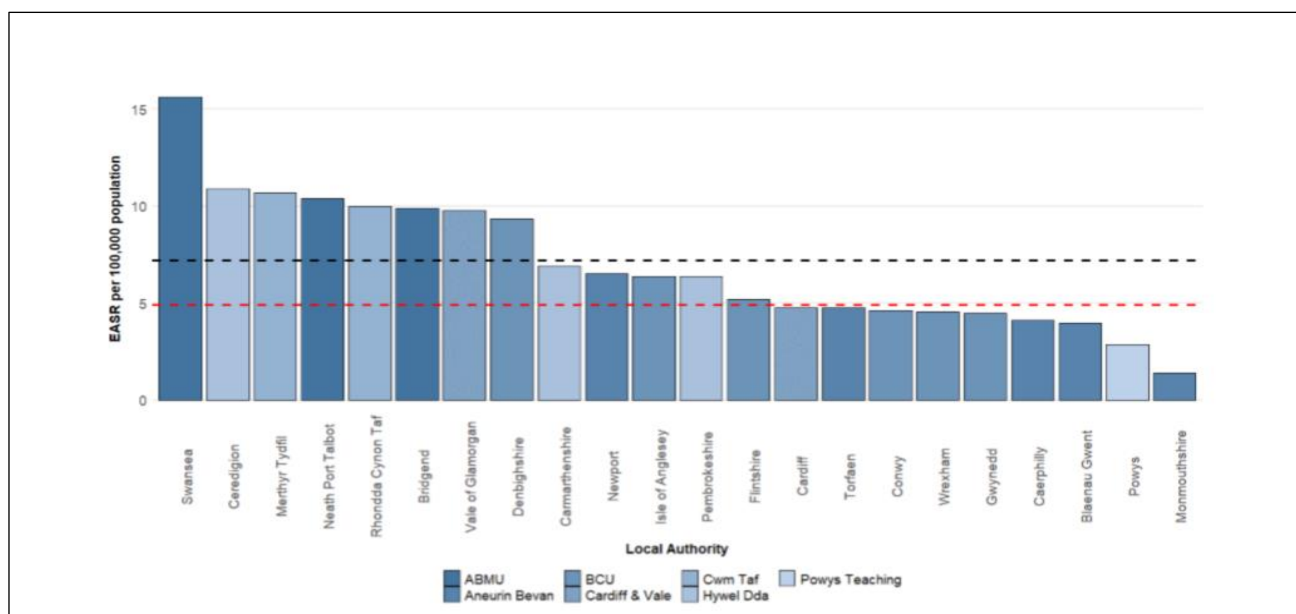
Wales does exhibit a higher national rate of overdose compared to England (Harm Reduction Database Wales 2019-see graph 2). However, the rate of deaths is not evenly spread across health boards. Gwent’s current treatment system has the second lowest overdose rate in Wales, almost half the Welsh average. This suggests that the MOPSI model has struck a balance between promoting recovery options for opiate users whilst effectively reducing harms at the same time. However, there is a modest trend toward increasing rates of overdose and this will need to be minimised. Across the 5 counties of Gwent, Newport has the highest rate of opiate related deaths and should be targeted for specific strategies to reduce the mortality rate (see graph 3).



Graph 2: EASR of Drug misuse Deaths per 1000,000 Population in Wales by Health Board, 2018 with the National Rate for Wales (Black) and England (Red)

England's average overdose rates are lower than Wales even though England do not issue naloxone kits. Instead, England has seen increased utilisation of datasets to identify at risk groups of overdose for a more targeted approach. Factors that have been identified as important risks factors are:

- Older user
- Dropping out of substitute opiate services
- Depression
- Social isolation
- Complex underlying health problems



Graph 3: EASR of Drug misuse Deaths per 1000,000 Population in Wales by Local Authority, 2018 with the National Rate for Wales (Black) and England (Red)

Overdose in the over 50s is also more liable to occur in isolation and therefore the use of Naloxone is negated as an overdose prevention strategy for this population. Instead, the use of data extraction may be an important tool of overdose reduction in isolated groups. England does not make use of Naloxone provision and has a lower rate of overdose than Wales. Services in England utilise data analysis technology to identify high risk individuals (see practice examples). Newport has been identified as the highest risk area for overdose within the Gwent region. Therefore, technology and analogue information systems for identification of at-risk older clients should be piloted in this region to generate a red flag system for explicit overdose reduction strategies with targeted individuals.

Consideration 20: Utilising data extraction to identify high risk individuals and developing targeted overdose prevention responses to minimise risk in Newport as a proof of principle pilot.

The reduction in Overdoses in England has been partly been attributed to improve targeting and identification of at-risk individuals using technology solutions:

- CGL uses data in an electronic client management system to highlight, at a case-level, clinically significant factors that have been shown to confer a higher risk of overdose. This information is used to generate a report to support case segmentation and the application of focussed interventions to meet the needs that led to the increased risk. This approach does not seek to predict overdose, but instead be a tool to support the principles of good case management. It is relatively straightforward and could be explored by any service that collects clinical data as discrete data points.
- Inclusion collects all assessment, safeguarding and risk data electronically, and uses this to generate bespoke reports for core areas of risk. They also use third-party analytic plugins to interrogate large data-sets to aid learning and practice development. Future plans include the ambition to link historical and dynamic risk information with learning from incidents to help identify immediate and potential future risks.
- Addaction uses a purpose-built data tool to identify and score characteristics that indicate additional risk or complex needs. The tool attributes scores/weighting to risk-taking behaviours and is used to identify those most at risk within a service in real time as behaviour patterns change. The tool provides information to prompt the selection of specific elements of care pathways and individually-tailored approaches to care.
- The South London and Maudsley NHS Foundation Trust (SLAM) uses a data warehouse, called CRIS, which extracts data from its clinical records. This anonymised data can then be exported and subject to a range of searches including being able to interrogate text for particular words or phrases. The data set is also linked with other data sets including, mortality data and hospital usage data. This means that predictors of death from various causes can be analysed in detail enabling clinical services to identify clients who are vulnerable to early death.

Criminal Justice Interventions

Historically, Criminal Justice Interventions had been commissioned separately from the Open Access service in Gwent. Since the merger of county services into GDAS, the Criminal Justice services have remained a distinct 'service within the service.' This has been provided by a separate Service Provider that has largely remained operating within its own pre-contract clinical model, notably fixed term 24-week opiate substitution therapies for Drug Interventions Programme recipients. However, this model as configured in the previous Specification is not in line with the Home Office requirements and is not fully integrated into the wider community treatment system. As such, this section of the proposed new specification will require greater scrutiny to understand its functions and role within the Service Specification.

Currently within the Criminal Justice Framework there three principle legal requirements that can mandate clients into treatment service. Whilst the Drug Interventions Programme has a wider remit to engage people into treatment at all available points of contact in the Criminal Justice System (see Figure 1).

Alcohol Treatment Requirement: Offenders who have an alcohol dependency which causes them to commit crime can be ordered by the court to undertake alcohol treatment. The alcohol treatment requirement provides access to a tailored treatment programme with the aim of reducing drink dependency. The requirement can last between six months and three years. Before issuing an Alcohol Treatment Requirement, the court must be satisfied that:

- The offender is dependent on alcohol and may benefit from treatment
- The offender is willing to comply with the requirement and work at reducing their addiction.

Drug Rehabilitation Requirement: Offenders who have a drug problem which causes them to commit crime can be order by the court to undertake drug treatment to:

- Help offenders produce a personal action plan so that they can identify what they must do to reduce offending and stop their use of drugs
- Explain the links between drug use and offending and how drugs affect health
- Help offenders identify realistic ways of changing their lives for the better

Treatment is carried out at a specified place and includes regular drug testing and court reviews. Lasting between six months and three years.

Rehabilitation Activity Requirements: The court can sentence individuals to a maximum number of rehabilitation activity days, which involves the service user attending a combination of appointments and activities aimed at helping them avoid reoffending.

Drug Interventions Programme: Designed to direct adult drug misusing offenders out of crime and into treatment and other support. DIP involves criminal justice and treatment agencies working together with other services to provide a tailored solution for drug misusing adults. The ambition is to get more drug users into assessment (and then treatment) rather than to prosecute people for non-attendance. As such, it spans all possible contact points with offenders from arrest to prison leave as a bridge into treatment services.

CJS Figure 1: Functions of the Criminal Justice Mandates

Criminal Justice Intervention Teams (CJIT) are responsible for the provision of Drug Interventions Programme services in line with the NTA Models of Care for Treatment of Adults Drug Misusers Update (2006) and Welsh Government Treatment

Frameworks. Whilst Alcohol and Drug orders provide specified interventions, DIP has a wider responsibility to engage offending substance users into treatment at all viable points of contact. This is primarily through the delivery of enhanced Tier 2 interventions to facilitate engagement in structured drug treatment (see figure 2).

- drug related advice, information and harm reduction interventions

- triage assessment (including where appropriate through the Required Assessment provisions of the Drugs Act 2005 following a positive drug test), and referral i.e. for comprehensive assessment and structured drug treatment where appropriate

- drawing up an initial care plan with the service user following a triage assessment

- addressing offending behaviour by ensuring appropriate services are offered

- access to prescribing services

- provision of Tier 2 interventions (including brief psychosocial interventions e.g. motivational interventions) for those accessing or who have left treatment

- considering the provision of a 24/7 phone line or out of hour arrangements particularly targeted at those vulnerable new and existing clients leaving custodial establishments and/or treatment

- a single point of contact for referrals from professionals including criminal justice agencies, CARAT teams and treatment agencies

- a case management approach using key working and care planning to ensure continuity of care

- access to structured treatment through local care pathways commissioned by the local partnership

- implementing a programme of assertive outreach when service users miss appointments

- partnership work with Probation (Offender Managers) and Prison Healthcare teams / CARAT teams

- partnership with other relevant service providers to broker access to wraparound services such as housing, employment, rebuilding family relationships, peer support, education, life skills (e.g. finance management) etc,

- to address the service user's broader range of needs on and after release from custody, at the end of a community sentence and following treatment.

However, this does not exclude CJITs being commissioned to deliver other services from other funding streams where commissioners consider this provides optimum outcomes and best value for money – for example, provision of Tier 3 services, or services for service users who are subject to a community order with a Drug Rehabilitation Requirement (DRR).

CJS Figure 2: Enhanced Tier 2 Provision within DIP

Currently, GDAS holds the majority of clients in the criminal justice pathway in the DIP treatment arm. There are 180 clients in DIP compared to 22 on DRRs and 7 on assorted ATRs. Furthermore, clients in DIP are subject to 24-week prescribing regimes which presents the possibility of revolving door treatment episodes. However, the service is beyond capacity raising significant funding issues (GDAS brief report, 2020).

The basic service model of DIP as currently delivered is based on a 24-week prescribing option combined with a standardised case management model. However, this model is not supported by clinical research for offending opiate users

and does not align itself with policy requirements of DIP delivery. International research evidence indicates that longer treatment periods are associated with improved outcomes (including reduced use of other opioids and reduced criminal activity), while short-term methadone maintenance is associated with poorer outcomes. No current data on length of time in treatment is available from Wales. However, limited evidence from the USA shows that introducing time limits to opiate prescribing is related to detrimental consequences. A review of 20 studies (Magura & Rosenblum, 2001) found high rates of relapse to opioid use after methadone treatment was discontinued. Furthermore, a higher rate of illicit opiate-positive clients has been found in clinics oriented to time-limited treatment as opposed to long-term maintenance (Banys et al 1994). Studies suggest that for offenders, treatment duration is strongly linked with positive outcomes (Peters et 2008; Zhang et al 2003) and abrupt withdrawal of treatment was associated with more crime, drug dealing and an increase in heroin users' contacts with the criminal justice system (Anglin et al 1989).

Similarly, providing opioid substitution programmes is associated with 25–33% of the fall in some types of acquisitive crime (Home Office Report 2014). Time-limiting the treatment is therefore likely to significantly increase acquisitive crime amongst opiate using offenders (see table 1).

Prescribing Duration	*Mean and median number of Charges*				*% changed in the following year*	*Number*
	Year Before		Year After			
	Mean	Medium	Mean	Medium		
Less than 3 months	2.2	2	1.1	0	44	188
3-10 months	2.1	1	1.1	0	44	228
More than 10 months	2.1	1	0.7	0	33	535

CJS Table 1: Average (mean / median) No of Drug Chargers for Trigger offences and percentage charged with Trigger offences During the Year After Prescribing Started, by Duration of first Prescribing Episode (Miller et al 2008).

The UK's National Institute for Health and Clinical Excellence (NICE) have clear guidance from the General Medical Council (GMC) to "provide effective treatments based on the best available evidence ... If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy." Time-limiting opioid substitution therapy would put a doctor in a position where they are ignoring guidance from their professional regulator giving rise to legal challenges from patients.

CJS Consideration 1: The arbitrary limit of 24 weeks for Drug Interventions Programme is not supported by the clinical research base and should be abandoned.

In terms of case management, the Drug Interventions Programme Operational Handbook (Home Office, 2009) states that the Home Office expects that all CJIT teams will ensure case management of those on DIP. In terms of length of involvement, it states:

> *"The CJIT must regularly review their caseload of service users to ensure appropriate service users are receiving the intensive case management and support they need, and that service users who have ceased either offending and/or misusing Class A drugs are moved into generic community drug services. As a minimum, a service user's status on the DIP caseload should be reviewed no later than 16 weeks after admission on the DIP caseload OR whenever a significant event occurs for the service user (which may be before the 16 week milestone). It will be for the case manager to judge what constitutes a significant event on a case-by-case basis as the service user's needs determine, and an individual may be transferred to a community drugs team at any time before 16 weeks if deemed appropriate. However, this Handbook defines the following non-exhaustive list of "significant events" where a review will take place:*
>
> *- when a service user engages/disengages in employment, training and/or education; - when a service user is successfully housed in permanent accommodation or becomes homeless; - when a service user engages/disengages with his family or other stable relationship; - when a service user enters prison; - when a service user disengages from DIP; - when a service user is arrested; - when a service user demonstrates a worsening or improvement in health; - when a service user and case manager agree that the care plan is unrealistic or counter-productive.*
>
> *It is possible that, following formal review, a service user may remain on the DIP case-load beyond 16 weeks. The criteria on whether a service user remains on the DIP case-load is not time-limited. Instead, the key criteria for remaining on the DIP caseload is whether the service user is misusing specified Class A drugs AND offending to fund their habit in relation to acquisitive criminal activity. The following table of review criteria should be used to determine appropriate case-management actions:*

Review criteria	Action
Is the service user still a Class A drug user and still offending?	If so, the service user remains on the DIP caseload, and appropriate interventions are delivered to address the service user's offending.
Is the service user still a Class A drug user but no longer offending?	If so, the service user exits the DIP caseload and is referred to other community-based treatment services that focus on Class A drug misuse.
Is the service user no longer a Class A drug user but still offending?	If so, the service user exits the DIP caseload and is referred to other locally available intensive intervention and support programmes (for example, PPO).
Is the service user no longer a Class A drug user and no longer offending?	If so, the service user should be brokered into appropriate non-CJS support services locally.
Is the service user still a Class A drug user and in prison?	If so, the CJIT case manager worker will liaise with HM Courts Service and/or CARATs service to determine the length of the service user's custody in prison. This is so that appropriate release planning arrangements can then be put in place to support the service user on release from prison custody – for more information, see guidance document: *Drug Misusing Offenders: Ensuring the continuity-of-care between community and prison.*"

Outcomes of DIP Review

Policy determines that a 16-week review should be a routine element for clients on DIP programmes. Further to this, the Home Office clearly describes the conditions which determine the response to the review. However, the responses are described in broad terms. This will need to be translated into a clear clinical definition of the terms 'non-offending' & 'drug free' in everyday treatment settings to calibrate suitability for referral within the Open Access service. Despite the current lack of clarity though, the DIP Home office guidance should be the framework that defines the Drug Integrated Treatment Pathway for offenders in GDAS.

CJS Consideration 2: 16-week structured reviews need to become a core component of DIP case management structures. The client's progress will be assessed against agreed standards and clinical tools to determine the offender's progression through the treatment system.

Offenders who meet the criteria and have no physical dependence can be rapidly placed in aftercare services. Non-offending but opiate dependant service users can transit into Open Access services. These clients must have demonstrated significant engagement in psycho-social interventions. Entry to this service must demonstrate parity with those seeking OST in community populations. Therefore, at the point of identification of non-offending status, the service user should be referred to Open Access prescribing. If there is a waiting list for Open Access prescribing, the DIP client should be placed on a waiting list and their case transferred when a vacancy has become available. They will remain under the case management of DIP until this point.

CJS Consideration 3: Non-offending & treatment engaged DIP clients can be referred to Open Access to prescribing but under the same terms of parity as community populations. They will remain prescribed and case managed by DIP until a vacancy has been identified for them on the waiting list.

Criminal Justice interventions: Specialist or Generic Provision?

A second question for the Service specification is whether the Criminal Justice elements of the service should be subsumed into the general service provision. The answer to this challenge may not lie specifically in the types of treatment provision but in the treatment needs of the population itself. There is a strong correlation between substance use and crime. The odds of offending are six times greater for crack users than non-crack users and three times greater for heroin users than non-heroin users (Bennett et al., 2008). Opiate/crack users comprise 81% of those in receipt of structured drug treatment services in England and are the group predominantly targeted by policy initiatives to divert drug-using offenders into treatment (Home Office, 2011; PHE, 2014).

At the same time, it must also be noted that many drug users do not commit any crime at all (Nurco & DuPont 1977). Research has identified two distinct sub-groups of offenders within the criminal justice substance issue services. These are offenders who go on to use drugs verses drug users who go on to offend. For example, Hayhursts et al (2017) review of 20 longitudinal studies found strong evidence that the onset of opiate use accelerates already-existing offending, particularly for theft, burglary, violence and robbery. Pierce et al (2017) studied drug use and offending compared to a non-offending group (n = 18,965 cases; n = 78,838 controls). Those testing positive for opiates had substantially higher rates of prior sanctioned offending over their life-course than those testing negative for opiates and cocaine. This finding held for both males and females. Furthermore, it found:

- opiate–positives had higher rates of offending than test-negative controls prior to their opiate-use onset
- Initiation of opiate use exacerbates existing levels of offending compared to controls
- Initiation of opiate use was associated with a larger increase in the crime for female than male users
- the effect of opiate-use initiation on historical offending differs by crime type as well as by gender

Studies have identified that offending drug users tend to exhibit an earlier age at onset of offending which correlates strongly with childhood-onset attention deficit/hyperactivity disorder, conduct disorder and drug abuse. This is combined with strong mathematical associations with aggression, psychopathy and recidivism (Gustavson et 2007; Savolainen et al, 2010).

Berryessa (2016) identified symptoms such as ADHD, reward deficiency, behavioural inhibition and attention deficits affected whether individuals will be successful in their experiences in court, probation and during incarceration. This is especially true for individuals whose ADHD diagnoses are unknown to the criminal justice system or have never been formally diagnosed. The relationships between conduct problems, attention deficit hyperactivity disorder (ADHD), depression and substance use were examined between 1994 -1999 among 900 incarcerated young offenders in South Australia, 206 of whom were reassessed when later readmitted to secure care (Putnins 2006). At the first and second assessments, conduct problems, ADHD signs, and depression scores all had significant concurrent associations with a measure of recent substance use. Prospectively, there were no significant associations between depression and substance use. At the zero-order level, both ADHD signs and conduct problems predicted future substance use. ADHD signs remained significantly predictive after controlling for concurrent associations.

These results lend support to the view that substance use is related to poor impulse control in offenders and that the arousal needs associated with increased ADHD symptoms increase the risk of substance use. There was no support for the view that substance use in this population is self-medication in response to internalizing problems. This is supported by the fact that substantial proportion of offending is opportunistic rather than pre-planned (Sutherland et al 2015).

Research suggests 45% of youths and 24% of male adults screen positive for a childhood history of ADHD, 14% of whom have persisting symptoms in adulthood. Those with persisting symptoms have a significantly younger onset of offending and higher rates of recidivism. ADHD was the most powerful predictor of violent offending, even above substance misuse. They accounted for 8-fold more institutional aggressive behavioural disturbances (critical incidents) than other non-ADHD prisoners. Critical incidents have also been associated with personality disordered patients screening positive for ADHD and detained under the Mental Health Act (Young & Thome 2011). There is also emergent but tentative evidence that the treatment outcome rates of primary offenders who use drugs differs from drug users who end up committing crimes (Best et al 2009).

Research (Young et al 2014) across 7 Probation Trusts in England and Wales found staff estimated that 7.6% of their caseload had ADHD and identified this group to have difficulties associated with neuropsychological dysfunction, lifestyle problems and compliance problems. In a follow-up study, a sub-sample of 88 offenders were screened for DSM-IV ADHD in childhood and adult symptoms found that 45.45% childhood ADHD and 20.51% adulthood ADHD. These were strongly associated with functional impairment. Thus probation staff considerably underestimated the likely rate, suggesting there are high rates of under-detection and/or misdiagnosis among offenders with ADHD in their service. The results indicate that screening provisions are needed in probation settings, together with training for staff.

These persistent finds suggest that offenders who commit crime are influenced by a different set of psychological drivers than community-based sample. This means that criminal justice services should not align themselves with Open Access provision but cultivate treatment responses based on poor-impulse control disorders. However, there is a paradox in self-presentation with many offenders tending to define themselves as substance misusers even though crime preceded their use. And desistance in crime tends to follow on from a reduction in substance use first in a sequential pattern (Coleman & Laenen 2012). Substance misuse interventions therefore should be combined with more appropriate clinical interventions.

CJS Consideration 4: Presenting population offenders differ from non-offenders and they are also governed by a different set of policy directives. As such it is not possible to develop a direct parity between Criminal Justice interventions and the wider treatment services as offending substance misusers' clinical profiles are not the same as non-offending substance misusers. Their criminal behaviour and recidivism is linked to high rates of poor impulse control disorders that will require a different treatment focus.

Risk, Need, Response Model

There is a wide profusion of treatment approaches to reduce reoffending but few share a significant evidence base at present that might elevate them beyond "promising but unproven" categorisation (Ministry of Justice 2013). However, a significant body of research has emerged to support the Risk, Needs and

Responsivity (RNR) approach to reduce offending & reoffending. A meta-analysis of young offender programmes in Europe showed that programmes adhering to RNR principles had 18% less reoffending than control groups (Losel et al 2011).

The RNR approach provides a framework for interventions with offenders the focuses explicitly on the drivers of offending behaviour as identified from research studies. The **Risk** principle states that the level of intervention should be matched to risk of reoffending, with higher risk offenders receiving more treatment. As such it determines treatment intensity. The **Need** principle asserts that *only factors directly associated with reoffending* should be systematically targeted and hazards that crime-prevention efforts fail when too much focus is paid to other social needs (Andrews, et al 2011). Therefore, general case management models are not suitable for offenders where the primary outcome is to reduce offending itself. Finally, the **Responsivity** principle recommends that programmes are matched to characteristics of the offender. Important responsivity characteristics include cognitive functioning, mental health issues, personality issues and trauma. RNR interventions are based on general personality and cognitive social learning theory (Latessa, et al 2014).

The RNR treatment model targets the central eight factors which are the most predictive of reoffending (Andrews, et al 2012) (see table 2). Assessment of these factors is used to identify those most suited for greater supervision and treatment, as well as prioritise treatment interventions. Within each of the 8 areas, subsequent interventions focus only on *dynamic risk factors*- this is to say it only addresses those risk factors which can be changed. *Static risk factors* that are fixed and cannot change. For example, a history of trauma is a *static risk factor* which cannot be changed, whereas managing intrusive memories of trauma that effect the individual currently is a *dynamic factor* that can be changed. A range of specific interventions, usually CBT oriented, are then utilised to address these dynamic risks of offending. However, some developments in the RNR model are adopting more strengths-based approaches to address needs (Serin et al 2010).

MAJOR RISK/NEED FACTOR	Indicators	Intervention goals
ANTISOCIAL PERSONALITY PATTERN	Impulsive, adventurous pleasure seeking, restlessly aggressive and irritable	Build self-management skills, teach anger management
PROCRIMINAL ATTITUDES	Rationalizations for crime, negative attitudes towards the law	Counter rationalizations with prosocial attitudes; build up a prosocial identity
SOCIAL SUPPORTS FOR CRIME	Criminal friends, isolation from prosocial others	Replace procriminal friends and associates with prosocial friends and associates
SUBSTANCE ABUSE	Abuse of alcohol and/or drugs	Reduce substance abuse, enhance alternatives to substance use

FAMILY/MARITAL RELATIONSHIPS	Inappropriate parental monitoring and disciplining, poor family relationships	Teaching parenting skills, enhance warmth and caring
SCHOOL/WORK	Poor performance, low levels of satisfactions	Enhance work/study skills, nurture interpersonal relationships within the context of work and school
PROSOCIAL RECREATIONAL ACTIVITIES	Lack of involvement in prosocial recreational/leisure activities	Encourage participation in prosocial recreational activities, teach prosocial hobbies and sports
NON-CRIMINOGENIC, MINOR NEEDS		
SELF-ESTEEM	Poor feelings of self-esteem, self-worth	
VAGUE FEELINGS OF PERSONAL DISTRESS	Anxious, feeling blue	
MAJOR MENTAL DISORDER	Schizophrenia, manic-depression	
PHYSICAL HEALTH	Physical deformity, nutrient deficiency	

CJS Table 2: Major Factors for Re-Offending Bonata & Andrews (2007)

RNR principles have been converted into inventories such as the Level of Service/Case Management Inventory (LS/CMI) and extensively trialled in Scotland. This included the introduction of the LS/CMI and the development of a shared approach to risk practice. In addition, the Multi Agency Public Protection Arrangements (MAPPA) in Scotland and England have utilised the structure to formulate its interventions. However, there is a significant cost to purchasing a licence for these tools and a similar in-house model may prove as effective.

CJS Consideration 5: Criminal Justice interventions should be oriented around the Risk-Need-Responsivity approach. The primary 8 domains should be embedded within the treatment framework, specifically in assessment, care planning and intervention packages. This structure should house a wide range of interventions that are targeted at addressing dynamic needs in these domains. This should utilise behavioural and CBT approaches as principle modalities.

The RNR model could provide the conceptual treatment framework for the CJS service. Treatment intensity will be determined by the order and a range of interventions will be provided within this framework. The framework of the preferred modality of practice in Criminal Justice setting is CBT. A recent evidence review by the Ministry of Justice suggests that CBT can reduce reoffending by between 8-10 per cent (Ministry of Justice 2013; Lipsey & Cullen 2007). The Service Provider

should offer a range of CBT-based interventions to address the 8 Risks in the service users RNR profile. Again, within the philosophy of the RNR model, these domains should be the central focus of all interventions. This could be delivered in either group or one-to-one sessions, depending on the needs of the client groups and resources available.

CJS Consideration 6: The Specification should require potential Service Providers to describe how they will embed the Risk, Need, Response framework into the care management of offending drug and alcohol users. This should include the interventions that will be provided according to the 8 domains and the format of delivery.

The new Service specification will require the Service provider to offer greater support across the needs of clients. Within the criminal justice arena this will mean that greater psychological input will be necessary to provide responses to poor impulse control disorders such as ADHD & Antisocial Personality Disorder. It is estimated that 26 per cent of offenders have ADHD (Young et al 2015). Young et al (2017) have made a comprehensive schema for practical 'best practice' treatment of ADHD as established by a cohort of professionals in the field (see figure 3). The screening and identification of ADHD should be routine in the criminal justice services, with consideration given to the adjunct specialist support.

CJS Consideration 7: Screening for ADHD should be routine amongst offenders with a history of key indicators and responses should align with good practice frameworks.

Likewise, personality disorder rates are extremely high in prison populations. Slade and Forrester (2013) identified 26 per cent of the prison population could meet a diagnosis for Personality Disorder in a high turnover UK prison. Whilst NICE (2014) reports that among people serving community sentences, an estimated 47% are likely to have a personality disorder. Among the prison population, an estimated 58% of male remand prisoners, 64% of male sentenced prisoners and 50% of female prisoners (remand and sentenced combined) have a personality disorder. This is predominantly Antisocial Personality Disorder (Roberts et al 2009) but not exclusively. Whilst they remain a significant percentage of the offending population, in their exhaustive study of treatment for offenders, NICE (2017) could not find a single randomised control trial on working with this treatment population to make any informed decision on the most effective care. In regard to personality disorder treatment, NICE concluded:

Identifying ADHD: Indicators among the offending population that suggest the presence of ADHD are:

- Symptoms of inattention, impulsivity, emotional dysregulation, and poor self-control, which are especially important and violence towards others, or self-harm and suicide
- A history of educational failure, school expulsion, inability to work, driving offences, and impulsive aggression, and/or
- A history of chronic mental health problems or of failed treatment programmes for conditions such as mood disorders, anxiety, depression, post-traumatic stress disorder, emotional instability, self-harm, and personality disorder.

In addition to common disorders seen in the offender population such as anxiety, depression, post-traumatic stress disorders, substance abuse and self-harm, borderline personality disorders among female offenders and conduct and antisocial personality disorder among males. Training is required to distinguish these disorders.

Staff ADHD awareness training Case managers, clinicians, educators, therapists, and mentors should be trained to recognize the signs and symptoms of ADHD, available treatments and expected outcomes.

Screening for adult offender Use the brief Barkley Adult ADHD Rating Scale (B-BAARS) as a primary mental health screen. If positive, the full 18-item version of the BAARS to ascertain the severity of ADHD.

If any co-morbid disorder is suspected, then the offender should be referred for a secondary screen involving a more comprehensive assessment by a multidisciplinary mental health team including nurses, psychologists, and psychiatrists. Three comprehensive semi-structured diagnostic interview tools that are suitable for adult prison populations:

- the Conners' Adult ADHD Diagnostic Interview for DSM-IV (CAADID) [37],
- the Diagnostic Interview for ADHD in adults (DIVA-2) [38, 39], and the
- ACE+ (ACE for adults) [40].

Interventions and treatment It will be necessary to educate offenders on the efficacy of multimodal treatments and expected outcomes and to obtain informed consent for permission to treat. Staff lack of knowledge about ADHD can interfere with medication administration and offender engagement in psychological treatment programme.

Pharmacological treatments for offenders Treatment with ADHD medication is effective in reducing symptoms of inattention, hyperactivity, and impulsiveness and is also reported to be associated with a significant reduction in violent reoffending (around 42%) on release from prison and similarly in criminal convictions. The offender needs to be educated on the benefits and side effects of pharmacological treatment and the implications of remaining untreated or discontinuing treatment. Drugs with a high risk of abuse, such as immediate release preparations of methylphenidate (MPH) and dexamfetamine (DEX), should be avoided in offender populations due to the potential for abuse. when these medications are taken orally. The oral administration of therapeutic doses of MPH or DEX is therefore essential in reducing the abuse potential of stimulant medications.

Long acting reparations of methylphenidate (MR MPH) that are difficult to take in any other way than by mouth (e.g. Concerta XL). Lisdexamfetamine (Elvanse) is a long acting preparation that has a unique advantage, because even if injected, the active drug is released slowly at a similar rate in to the brain as when taken by mouth. These extended release formulations are usually taken in the morning and give active control of symptoms for 8–14 h in most cases.

Pharmacological treatments for offenders with co-morbid conditions ADHD should usually be treated first, followed by a careful evaluation of the medication's effect on the co-morbid symptoms. Substance abuse is stabilised in clinical settings, so that diagnostic assessments and treatment for ADHD can proceed. Symptoms commonly shared between ADHD and co-morbid disorders may be better managed with pharmacological treatments for ADHD rather than with pharmacological treatments for the co-morbid disorders themselves. For example, low mood symptoms secondary to ADHD are alleviated more effectively by ADHD medication than with antidepressants or antipsychotics.

Non-pharmacological treatments for offenders Non-pharmacological treatments consist of psychological, educational, and occupational treatment programmes. These interventions should aim to facilitate changes in life-long patterns of poor behavioural control, increase life satisfaction, build useful skills, and help the offender plan for civilian life after release. Mentorship programmes embedded in the treatment plan are likely to be additionally beneficial.

Offender psychoeducation There is a need to change common misconceptions and stereotypes about ADHD symptoms and treatments. Mental health professionals working with prisoners with ADHD should provide a clear explanation of ADHD symptoms, treatments, and expected outcomes, and educate the offender on the potential risks of remaining untreated or discontinuing treatment.

Educational and occupational treatment programmes We recommend waiving the requirement to complete an academic course and directing offenders towards educational and occupational programmes that suit their strengths (e.g. creative, technical, and/or athletic skills). Participation in technical skill-building workshops can provide hands on experience and the opportunity to learn occupational and technical skills useful for life during and after prison.

Care management and multiagency liaison As for people with mental health problems or related complex needs, offenders with ADHD require assistance from a wide variety of supportive services and agencies. It is important that these services are accessed and coordinated during imprisonment, not only to infer maximal benefit, but to ensure continuity of care once the prisoner is released. We recommend offenders with ADHD receive a CPA or similar care management plan and are assigned a care plan coordinator to oversee the plan. We also recommend implementing a medication management plan. Offenders should be supported to access a wide variety of service in the community as in a care navigation role.

CJS Figure 3: Recommended Good Practice with offenders with ADHD

"No RCT evidence was identified for this question. The GC decided it would be inappropriate to descend the evidence hierarchy as they were aware, on the basis of their existing knowledge of the literature, that it was unlikely to be fruitful and was therefore not considered a good use of time and resource and given the very high prevalence of personality disorders among people in contact with the criminal justice system any recommendations about assessments or interventions could have significant cost impact and should not be based on low quality evidence from non-randomised studies." (NICE (2017) p.236)

Instead NICE (2017) have made a series of recommendations:

- Interventions for people with personality disorders should aim to be:
  - supportive (e.g. development of positive therapeutic relationship)
  - facilitate learning (e.g. through feedback and advice)
  - develop new behaviours (e.g. reality testing and experiencing of successful coping)
- Staff should work with people with personality disorder to develop a crisis plan including early warning signs, triggers and strategies to reduce the intensity and frequency of crises.
- The following components should be considered when developing plans for the general care and management of people with personality disorder:
  - problem solving
  - articulation and management of emotion
  - managing interpersonal relationships
  - managing impulse control
  - self-harm and medication management (including reducing poly-pharmacy)
- Plans for the general care and management of people with personality disorder should be implemented in a flexible and responsive manner
- People with personality disorders should be offered treatment for any comorbid disorders in line with recommendations in the relevant NICE clinical guideline
- The duration or intensity of psychological interventions for people with personality disorder should be increased.
- Changes to any treatments or services for people with personality disorder should be discussed carefully with the individual beforehand and extra effort should be made to engage them in a participatory process for designing and implementing their care
- Effort should be made to ensure that patients feel responsible for their care to generate a sense of self-efficacy
- A structured, phased approach should be used when changing treatments or services for people with personality disorder

Currently there is no specific service model identified for the treatment of offending substance misusers with Personality Disorder. It will be necessary to develop an inhouse treatment strategy within the DIP service. There is considerable cross over between the presenting needs of those with ADHD and Personality Disorders that

are most liable to offend (Anti-Social, Emotionally Unstable and Narcissistic disorders). The common denominators being poor impulse control and emotional dysregulation. Therefore, a *prima face* ADHD programme which includes elements that address wider issues pertaining to Personality Disorder would provide practitioners with a toolbox of skills that are more appropriate to the offending population. Whilst the evidence base remains scant of Personality Disorder, NICE have published recommendations on Antisocial (2009) and Borderline Personality disorder (2009).

CJS Consideration 8: Organisation practice policy should incorporate the recommendations of NICE on the management of personality disorder.

CJS Consideration 9: All staff working within the Criminal Justice settings should be trained in understanding personality disorder and how its presentation and symptoms differ from mental illness in line with the Personality Disorders BREAKING THE CYCLE OF REJECTION THE PERSONALITY DISORDER CAPABILITIES FRAMEWORK National Institute for Mental Health in England.

CJS Consideration 10: Better identification of personality disordered offenders may lead to greater utilisation of the Offender Personality Disorder pathway. The service provider should ensure clarity of referral thresholds within the role in a wider pathway's framework.

The treatment of poor impulse control individuals is liable to be longer than treatment of other populations and often places a higher emotional and psychological demand on staff. Moving offending populations into Open Access services will place a greater demand on community-based practitioners. A critical feature of such a transition is that the level of impulsivity has improved to a degree that sustaining treatment engagement and participation is possible without additional demands made on the Open Access services.

CJS Consideration 11: Better identification of Personality Disordered offenders may lead to greater utilisation of the Offender Personality Disorder pathway in Gwent. The Service Provider should ensure clarity of referral thresholds within the role in a wider pathway's framework.

Certainly, the pervasive myth that personality disorder is untreatable remains a major impediment to the investment of resources to support personality disorder. This myth has its roots in the fact that the core symptoms of personality disorder do not respond to pharmacological treatment, beside symptom management. Psycho-social outcomes are very positive for personality disorder and often exceed the outcomes for most mental health disorders. Fairly brief interventions can have an enduring effect on mild to moderate severity of personality disorder (PSP, undated). Reviews of outcomes consistently show positive gains. Less than 50% of patients diagnosed with PDs retained these diagnoses over time. Four rigorous large-scale (Skodol 2008) studies of the naturalistic course of PDs indicate:

- personality psychopathology improves over time at unexpectedly significant rates

- maladaptive personality traits are more stable than PD diagnoses
- although personality psychopathology improves, residual effects can be seen in the form of persistent functional impairment, continuing behavioural problems, reduced future quality of life, and ongoing Axis I psychopathology

At 2 Year follow-up, Personality Disorder (Grillo 2004) groups had slower time to remission than the Mayor Depressive Disorder groups:

- PD remission rates range from 50%
- 61% Schizotypal
- 38% for Obsessive Compulsive

The rates for spontaneous remission and improvement of antisocial and psychopathic personality disorders are possibly relatively high (Martens 2000):

- higher for women than for men
- In the fourth decade of life, most of the antisocial and psychopathic personalities are in remission

The 10-year course of BPD /Emotionally Unstable PD (Gunderson et al 2011) is characterized by:

- high rates of remission
- low rates of relapse
- severe and persistent impairment in social functioning.

Women in the Criminal Justice System

Specific consideration needs to be given to women in the criminal justice systems. Research demonstrates women move into problematic substance misuse at a much faster rate than men, with 25 per cent of women achieving dependency within 1 month of use (Anglin et al 1987). Female, and especially pregnant, drug users suffer greater social stigma than men and often suffer a greater severity of addiction with physical and psychological reactions (Simpson & Mcnulty 2008). Among young women who go on to engage in antisocial behaviour or offending in early adulthood, the rates of psychiatric co-morbidity are higher than they are for boys (Rosenfield & Mouzon 2013). Nearly all studies cited previously have identified that women's offending is liable to increase more dramatically than men's once initiation of drug use begins. Furthermore, they are more likely to commit crime in order to fund other people's drug or alcohol use (Hser et al 1987).

Her Majesty's Prison and Probation Service Wales (HMPPS), part of the Ministry of Justice, and the Welsh Government are working in partnership to develop a joint "blueprint" for Wales, for the delivery of appropriate provision for Welsh women in, and at risk of entering the Criminal Justice System. This will take account of both the devolved (Welsh Government) and non-devolved (Ministry of Justice) landscape. The blueprint will set out a shared ambition to establish and embed a Whole System Approach within Wales, from prevention and early intervention through to resettlement and reintegration. It will also address the question of alternatives to

custody for Welsh women, as well as a distinct approach to supporting offenders, their families, and women at risk of offending.

CJS Consideration 12: The Service Provider will adopt the recommended procedures and practices from the imminent review of supporting female offenders in Wales.

Models of Practice

Reasoning and Rehabilitation 2 ADHD (R&R2ADHD). R&R2ADHD is a treatment programme based on cognitive behaviour therapy designed to build pro-social competence and may be used in non-offender and prison populations. It can be administered to all offenders irrespective of age and gender and completed in approximately 2 months. The programme's short duration, comprised of 15 treatment sessions deliverable up to 2 times per week, makes it favourable to ensure completion. R&R2ADHD has an additional advantage of being suitable for both youth and adult offenders. Furthermore, mentorship is embedded within the programme — whereof an assigned coach or mentor meets one-on-one with the offender between sessions to help them consolidate and apply newly learned skills in their daily life. While the evidence for R&R2ADHD efficacy is predominantly community based with a majority of male samples, results from a pilot trial at Her Majesty's Prison Youth Offender Institution (HMP/ YOI) Feltham (a level 3 youth offender institution in the UK) indicated high rates of completion and universally positive feedback from enrolled youth offenders. We observed that the positive impact of R&R2ADHD on the youth offenders with ADHD at HMP/YOI Feltham was even more significant when prison staff were involved in the treatment programme. Oftentimes prison staff and officers have an established rapport with offenders, and involving them seems to improve offender engagement in the treatment programme. According to the 2013 London Mayor's Office for Policing and Crime (MOPAC) report, R&R2ADHD was mentioned as an example of good practice and has received the full support of London prison governors and lead staff. Other psychological approaches that may be helpful include cognitive remediation therapy (CRT) and dialectical behavioural therapy (DBT). CRT applies techniques historically used to treat individuals with traumatic brain injury (e.g. deficits in planning, time management, and attention, impulse control). DBT was developed for the treatment of borderline personality disorder. Ideally, psychological interventions should take an eclectic approach drawing on these paradigms as well as cognitive behaviour therapy (CBT). The Young-Bramham Programme, is one such CBT intervention that can be used for adolescents and adults with ADHD.

Reasoning and Rehabilitation 2 ADHD Programme

Core Symptom Modules
Attention Module
Memory Module
Organisation and Time-Management Module
Impulsivity Module
Comorbid and Associated Problem Modules
Problem-Solving Module
Interpersonal Relationships Module
Anxiety Module
Frustration and Anger Module
Low-Mood and Depression Module
Sleep Module Substance Misuse Module
The Future Module
Preparing for the Future Module

The Young-Bramham programme structure (Young & Bramham 2012)

Liverpool Resettle project is an innovative community risk assessment and case management service which aims to manage and treat adult men assessed as high risk who have mental health problems that include serious problems of personality. It is based on wider service philosophies and drivers of mental health and probation services. Its aims relate to recovery, improving wellbeing, facilitating rehabilitation and social inclusion, harm reduction and the prevention of reoffending. Work with participants begins while they are in prison and extends to the project in the community for up to two years.

The Resettle model adopts a relationship-based approach in order to foster engagement and offer intensive support, individual case management and intervention to address both risk and need. There is a strong ethos of service user engagement and belief in the importance of continuity of relationship (including during periods of recall). Resettle is staffed by an integrated multi-agency team of health and criminal justice staff who are supported by a range of other agencies to deliver multi-modal and coherent interventions to this group of high-risk offenders.

Resettle provides a crisis line, available out of hours, and participants are encouraged to use this if faced with a crisis. It is also available to accommodation providers and family members as appropriate. The aim of any contact is to encourage and develop confidence in self-management and problem solving skills. Furthermore, in addition to their daily attendance at the project, the participants are given the opportunity to work with volunteers who offer support to address social isolation and to promote community integration (Resettle Plus).

Liverpool Resettle Project

Sova Support Link supports adults with lifelong psychological needs and a history of offending. It aims to improve their quality of life and enable them to live successfully as part of their local community. This is done by recruiting, training and supervising volunteer mentors, who work together in groups (known as hubs), to support an ex-offender, both practically and emotionally.

Each volunteer is asked to commit to meeting the ex-offender they're matched with for no more than five hours per week for at least 12 months. Volunteers receive specialist training, regular support and supervision to support them in their role. As well as working with a team of fellow mentors, volunteers also work closely with other professionals involved in the ex-offender's life. Sova Support Link covers the whole of London.

Sova Support Link

Complexity: Mental Health

It must be recognised that high levels of complexity will not solely present in Criminal Justice Services. High levels of co-morbidity have been found in populations seeking help for drug and alcohol in Open Access services (Weaver et al 2003 see table 2). Likewise the Welsh Government reports that 75 per cent of substance misusers seeking help experience co-occurring mental health issues (Welsh Government 2015). Equally, studies have found high adjunct drug and alcohol use amongst community mental health teams, however the levels of usage tend to be much lower and unlikely to result in a referral to a drug and alcohol specialist service. What is clear is that there is a significant crossover between drug and alcohol use and mental health difficulties though there remains difficulty in identifying these patients within staff teams.

	Drug service patients (n=216)			Alcohol service patients (n=62)		
	n	(%)	Exact binomial 95% CI	n	(%)	Exact binomial 95% CI
Non-substance-induced psychotic disorders	17	(8)	4.7–12.3	12	(19)	10.4–31.4
Schizophrenia	6	(3)	1.0–5.9	2	(3)	0.4–11.2
Bipolar affective disorder	1	(1)	0.01–2.6	3	(5)	1.0–13.5
Non-specific psychosis	10	(5)	2.2–8.3	7	(11)	4.7–21.9
Personality disorder	80	(37)	30.6–43.9	33	(53)	40.1–66.0
Affective and/or anxiety disorder	146	(68)	60.9–73.8	50	(81)	68.6–89.6
Severe depression	58	(27)	21.1–33.3	21	(34)	22.3–47.0
Mild depression	87	(40)	33.7–47.1	29	(47)	34.0–59.9
Severe anxiety	41	(19)	14.0–24.9	20	(32)	20.9–45.3
Summary						
No disorder	55	(25)	19.8–31.8	9	(15)	6.9–25.8
Psychiatric disorder present	161	(75)	68.2–80.2	53	(85)	74.2–93.1
Prevalence of comorbidity						
No comorbid psychiatric disorder	55	(26)	19.8–31.8	9	(15)	6.9–25.8
Low potential for referral (disorder present, but no additional vulnerability criteria)	122	(57)	49.6–63.2	33	(53)	40.1–66.0
High potential for referral[1]	39	(18)	13.2–23.8	20	(32)	20.9–45.3
Severe depression plus vulnerability criteria	22	(10)	6.5–15.0	8	(13)	5.7–23.9
Psychosis plus vulnerability criteria	17	(8)	4.7–12.3	12	(19)	10.4–31.4)

Table 2. Drug and alcohol service patients: prevalence rates of psychiatric disorders of non-referable and referable comorbidity Weaver et al (2003

The prevalence of co-occurring conditions in mental health and alcohol/drug settings is so high that it is vital for all services to be competent to respond to these needs. Dual diagnosis should be perceived as the norm in treatment presentation and services should be commissioned on this assumption rather than singular diagnosis.

There are several treatment planning frameworks available for dual diagnosis clients.

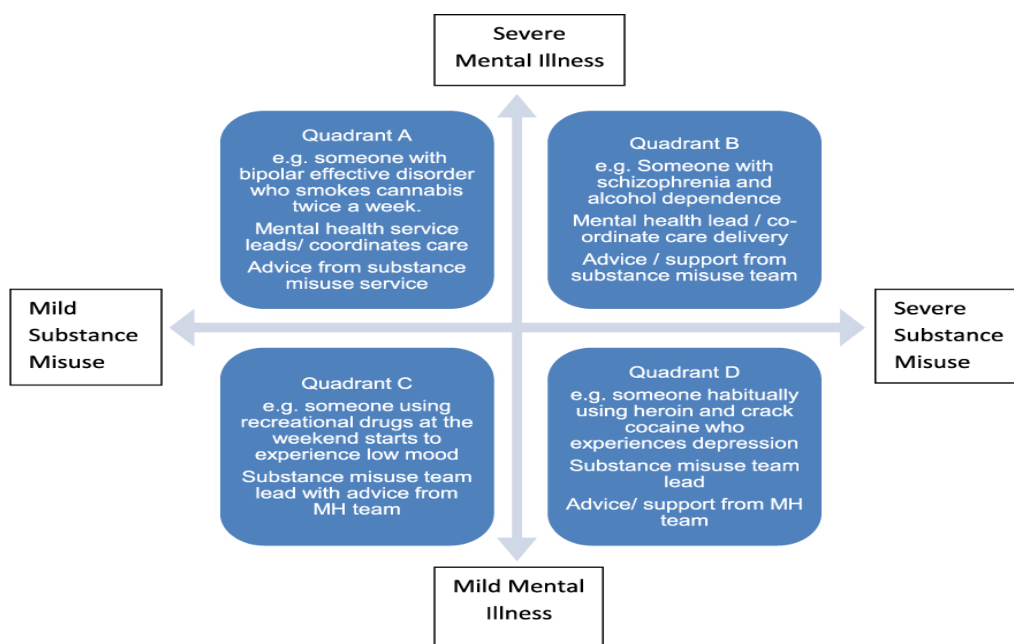
- Sequential Treatment: One disorder is addressed first by one agency followed sequentially with treatment for the second presenting disorder by the second agency.
- Parallel: Both disorders are addressed concurrently but by separate providers
- Integrated: Both disorders are addressed concurrently by one specialised multi-discipline team.

These definitions of service models are standard in the dual diagnosis research base. However, these are coarse definitions that agencies rarely conform to in actual practice. For example, sequential treatment can be seen as a negative response when it requires that clients address substance misuse problems before mental health services will assess them. Conversely, research suggests that reductions in drinking can increase people's liability to remit from depression and anxiety if the substance is *causing* the mental health effect. In this situation, sequencing treatment for clinically informed reasons is indicated.

Furthermore, whilst *integrated* treatment systems are recommended as the 'gold standard' for dual diagnosis treatment, this is not supported by clinical evidence. For

example, Torchalla et al (2012) metanalysis found that *integrated* and *non-integrated* models demonstrate similar outcomes. Whilst Rosenheck et al (2003) found the reductions in drug use were greater in *parallel* services than in *integrated*. Furthermore, NICE does not recommend the use of specialist dual diagnosis teams as they are not currently supported by the evidence base. (Important Note: NICE does support specialist dual diagnosis practitioners, particularly in clinical lead roles, in multidisciplinary teams).

Another method of managing dual diagnosis services is through the measurement of complexity. A popular example is the Quadrant model (sometimes referred to as the Shropshire model in the UK). This model provides a framework to place patients by levels of cross-referenced need:



The Quadrant Model

However, the Quadrant model is not based on any clinical evidence but is a theoretical framework based on perceptions of client need. Research has found mixed results for client placements based on severity. Matching service intensity to symptom severity has only shown positive gains in highly severe cases and these were limited (Chen et al 2006). The same study found that treatment intensity made little difference to outcomes in moderate to low levels of severity where structured interventions were helpful. This is a critical issue in Open Access services. Furthermore, the Quadrant Model directs clients with the most complex needs toward statutory mental health systems. However, this is where the largest block to services access resides and the model offers no further guidance to the entry of dual diagnosis clients into mental health services. The quadrant model also supposes that the only provider of mental health interventions are statutory mental health serivces. The reality is that a wide range of psycho-social interventions can be provided by substance misuse across this threshold of mental health support.

It is important to recognise that people do recover from dual diagnosis, even in the case of psychotic disorders (Green et al 2015). A 10-year follow-up (Drake et al 2003) showed that steady movement toward recovery is the modal path. In this

study, dual diagnosis clients themselves identified recovery outcomes and cut-offs. This included living independently, working in a competitive job, having regular contact with friends who were not substance users, expressing positive quality of life, actively managing substance use disorder and controlling psychiatric symptoms. Again, the major findings of this study were that improvements tended to be sequential:

- clients improved on all outcomes over 10 years
- the six domains were minimally related to one another
- the timing and sequence of movement toward recovery varied widely across clients. In other words, some became employed first, while others made progress in other domains first.
- Recovery occurs in individual patterns, domains and rates
- early mortality is common among those who did not attain remission of their substance use disorders.

Patterns of Recovery in Dual Diagnosis Clients (Drake et al 2006)

Healthcare Inspectorate Wales published a report “Substance Misuse Services in Wales: Are they meeting the needs of service users and their families?” (HIW 2010, updated 2018)) found that “the links between substance misuse services and mental health services were considered to be significantly “underdeveloped”. A number of issues were cited as to why this is the case including:

Unclear lines of accountability which resulted in a lack of responsibility for implementation.

- The concerns of both substance misuse and mental health services that joint working can result in one service shifting responsibility for service users onto the other.
- A lack of understanding about how service users with varying degrees of need should be treated and which agency would be expected to take the lead.
- Cultural assumptions surrounding both mental health and substance misuse service users, and the need to challenge those assumptions.

The original framework has therefore been revised to take account of:

- National criteria to be incorporated into jointly agreed local care pathways for each APB / LMHPB area.
- Lessons learned from case studies to illustrate how the framework is to be applied in a variety of situations.
- Training requirements.
- Clear lines of accountability and responsibility for implementing the framework.
- Prudent Healthcare principles
- Welsh Language needs of service users

Healthcare Inspectorate Wales (2010)

The Welsh Government *Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problems* states:

"The importance of unambiguous clinical responsibility and access to appropriate services is crucial, as is the need for adult mental health services and CAMHS to recognise that those with alcohol and drug problems can also develop mental illnesses that require treatment."

More recently, The Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem (WG 2015) sets out requirements that reshape services for dual diagnosis clients. This includes:

- Interventions are delivered in a timely manner
- Services deliver holistic, recovery focused care and treatment matched to the needs of the service user
- Services ensure effective communication both within and between agencies and with service users, through locally agreed care pathways and treatment protocols including clear arrangements for the transition of children and young people from CAMHS to adult services
- Services are accessible and appropriate to the population they serve addressing the needs of those whose first language is Welsh and the needs of people with protected characteristics
- Services integrate and operate within the principles of co-production and prudent health and social care
- Services have effective leadership and well-established governance and accountability systems to audit the improvement in the delivery of dual diagnosis services
- Services ensure unambiguous clinical responsibility for the delivery of effective care and treatment.
- Services ensure a competent well trained and supervised workforce
- Services enable ease of access to appropriate services for people with dual diagnosis

Requirements of the Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem (WG 2015)

Consideration 21: The specification should be developed in line with the requirements of the "Substance Misuse Services in Wales: Are they meeting the needs of service users and their families?" (HIW 2010) and The Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem (WG 2015)

Currently there is no evidence-base to support the idea that there is an optimal treatment framework for dual diagnosis clients. The central problem is that most current clinical models of dual diagnosis assume that dual diagnosis are a sub-population *within* Open Access services that require their own response. However, research within substance misuse treatment seeking populations demonstrates that Dual Diagnosis *are* the Open Access population. This suggests that addressing both mental health issues and substance misuse needs to become a mainstream function

of services rather than an adjunct specialism with the limitations on capacity and resources that brings.

This will require significant organisational and cultural change across both substance misuse and mental health services at a strategic level with the establishment of common agreement on joint service aims and objectives encompassing both substance misuse, mental health and specialist commissioning. Substance misuse services need to develop the capacity to address the typical incumbent clinical issues they are likely to encounter (primarily neurotic disorders and personality disorders). Whilst mental health and mental health rehabilitative service should encompass key components of addictions work as a core feature of their interventions for what are typically lower order substance misuse patterns. This is unlikely to occur without significant strategic investment.

Consideration 22: Leads for Mental Health and Substance Misuse in the Health Board and APB, should agree upon joint mission statement and objectives to create common purpose in frameworks and treatment delivery. Subsequent treatment commissioning should operate within these locally agreed prioritises and regular audit should be conducted to ensure that they policies are operationalised and effective.

Within this Specification, the Service Provider will be expected to provide structured interventions for those who are exhibiting symptoms of neurotic disorders such as anxiety and depression. Research shows that there is a particularly strong linkage in these morbidities with problematic alcohol consumption. These clients present in ambulatory outpatient settings that would suggest that they experience low to moderate levels of disorder. This assumption is supported by wider research (Weaver et al 2003). This population are as sensitive to low threshold and mid-range structured interventions as non-substance misusing treatment populations (McLellan, et al 1983; Gaspers et 2017; Kazanov et al 2020; Oslin 2005). Consideration should be given to the timing of initiation of these interventions post-stabilisation, in order to reduce the risk of symptom acerbation.

Greater confidence and capacity to address low to moderate neurotic disorders may be helpful in alleviating pressure on specialist mental health services. Treatment resistant or complex depressions as determined by NICE (2009) should be referred to specialist services. This will require a number of key developments:

Consideration 23: Depression and anxiety disorders are a common feature of those presenting for care planned interventions with the substance misuse services. Therefore, the Service Provider should offer evidenced-based structured interventions in accordance with NICE (2009) recommendations to address these complexities as standard. This could be delivered as;

- Groups
- Planned element of case management
- Structured one to one session

The Service Specification should require potential bidders to state the models and format of delivery of specific packages of care. They should explain how they will integrate these approaches within the current care planning frameworks.

Consideration 24: Practitioners in substance misuse services will require training and support in the development of skills sets to address depression and anxiety and the Specification should require detailed proposals in the Training and Staff Development of the contract.

Personality Disorder also feature heavily in presentation to substance misuse services. Like mental health disorders, Personality Disorders occur on a spectrum of severity and can vary in levels of social functioning. This means that many personality disordered individuals would be amenable to psycho-social treatment. As reviewed in the Criminal Justice Section, treatment programmes can be developed for poor impulse control disorders and this could offer a joint resource for both non-offending Personality Disorders with substance misuse problems.

Consideration 25: Treatment of Personality Disorder can be jointly delivered or accessed via with Criminal Justice community services. Non-offending PD clients should retain a case management within Open Access services.

Psychotic illness features rarely in Open Access service provision but makes huge demands on staff teams when it does. Community-based substance misuse services are simply not equipped to manage these patients in the community when their symptoms are florid. Therefore, those with psychotic disorders such as psychosis (drug induced or otherwise), bipolar or schizoaffective disorders should be referred to specialist services as a matter of urgency. These clients will need to be given priority status in referral to eliminate protracted waiting times and reduce enforced Sectioning of this population.

Consideration 26: In order to develop a coherent integrated treatment pathway for dually diagnosed clients with psychotic symptoms, rapid access referral processes need to be established between Substance Misuse Services and Statutory Mental Health Providers and only be revised as a part of a system review rather than unilaterally by Providers.

Based on the consultation process in Gwent (2020), across substance misuse providers, it appears particularly challenging to make referrals to the specialist GSSMS services and CMHTs. In terms of the specialist substance misuse service, Joint Allocation Meetings are proving valuable. However, the eligibility criteria for entry into statutory services is vulnerable to change and referral process are sometimes protracted for vulnerable people with complex needs. The feedback from the consultation process suggests that GSSMS is not fully integrated into the pathway within the wider Gwent treatment system. This is not in harmony to the requirements of Welsh Government Framework (2015) that stipulates:

• Duties under the Mental Health (Wales) Measure 2010 are appropriately met by health boards and local authorities
• Jointly-agreed local care pathways and protocols are in place for every area and are regularly reviewed. Copies of pathways must be provided to, and will be published by, Welsh Government
• Joint audits are planned and undertaken every two years (as a minimum) and must include an audit of effective clinical leadership, resolution of professional differences of opinion and delivery of competency based training
• Members of statutory and non-statutory substance misuse and mental health services' staff are appropriately trained to recognise and respond to people with dual diagnosis in line with the requirements
• Service users are actively involved in the design and evaluation of local services through the joint audit systems
• Appropriate aggregated outcome data is made available (this should be through existing data reporting systems such as TOPS/Mental Health Core Data set, HONOS, self-assessment through 'Service User Lens', etc.)
• Appropriate information technology systems are introduced to improve interagency information sharing and to effectively capture and analyse data on service activity, outcomes and partnership working.
The Welsh Community Care Information System (WCCIS) rolled out across Wales from 2015 should be considered as a means of achieving these aims.

Requirements-Service Framework for the Treatment of People with a Co-Occurring Mental Health and Substance Misuse Problem (2015)

Therefore, in addition to the development of the Specification, wider treatment integration needs to be implemented.

Consideration 27: GSSMS & statutory Mental Health services must be configured to operate within agreed integrated treated pathways that states commonly agreed and routine practice, including:

- Established and consistent eligibility criteria
- Routine feedback on the progress of clients on waiting lists
- Its function with a Gwent-wide Treatment Pathway for dual diagnosis clients
- The packages of care offered within the Gwent-wide treatment system
- Named specialist interventions offered to the presenting client group that address their client cohorts more complex needs
- Reported clinical outcomes and outputs in line with Open Access service requirements

Furthermore, case studies of the experiences of dual diagnosis clients in Gwent reveal highly fragmented services provision. The Welsh Government policy is to move services to much closer levels of integration and remove bureaucratic barriers to service facilitation. Direct Access Dual Diagnosis staff have been highly effective at engaging with individuals with complex needs. This level of direct access

engagement will be vital to support complex needs into mental health services. However, bureaucratic barriers like the capacity to make direct referral to CMHTs significantly lengthen the time of referral and have a hugely demoralising effect on vulnerable clients who subsequently enter the service. This will seriously impinge the wider treatment systems aims, particularly in supporting vulnerable populations.

In terms of models of practice, linking Substance Misuse Services with Statutory Mental Health teams via collaborative processes has been the primary model utilised nationally, especially in parallel treatment systems. This has included:

- Collocations in buildings
- Practitioners placements in wider service teams
- Joint assessment
- Co- and joint training
- Cross sector training
- Specialist training across teams in dual diagnosis management

No direct studies have been conducted on collaborative approaches between disciplines. Some research has suggested that training in dual diagnosis supports substance misuse practitioners at 18 months follow up. However, it does not impact on the practices of mental health teams over the same period (Hughes et al 2003). Collaborative practice may assist to breakdown cultural divides between the two sectors that operate with different cultural practices. Substance misuse services adopt empathetically engaged models whilst mental health services tend to operate on a detached, observational models (Orlinsky & Ronnestad 2010). The creation of node links between these sectors may facilitate referral and mutual assistance for clients.

Consideration 28: The Service Provider should establish routine collaborative practice with mental health services across a range of interactions including:

- Co-location in buildings
- Practitioners placements in wider service teams
- Joint assessment
- Co and joint training
- Specialist training across teams in dual diagnosis management
- Specific consideration should also include the involvement of mental health services in JAM meetings

Comorbid severe mental illness and substance misuse occur in 15% of patients attending community mental health teams. Although these patients have poorer outcomes than those without comorbidity, historically they have been inadequately provided for by existing addiction and mental health services. In Richmond, UK, a new service was developed for people with dual diagnosis without extra staffing or financial resources. The model comprised three components: a link worker from the community drug and alcohol team who works with individual mental health teams to offer advice and attend multidisciplinary meetings; a five-day training in dual diagnosis for staff; and a protocol for joint working of patients by both mental health and substance misuse teams.

The major issue in implementing the model was engaging staff, but overall referral pathways between teams have improved. In addition, the majority of dual diagnosis patients attend joint appointments, and 80 members of staff have completed dual diagnosis training. The Dual Diagnosis Good Practice Guide provides a comprehensive template for developing a dual diagnosis service even in the face of no extra resources. It has taken two years for the model to become fully integrated into mental health services, but on balance has been considered a success by staff and patients.

Richmond Dual Diagnosis Service Model (Whicher & Abou-Saleh 2009)

The **Matrix Model** is essentially a strategy for managing dual diagnosis across a range of agencies. It is a way of implementing partnership working across services and commissioning structures. The Matrix Model was born out of hard experience at the coalface of dual diagnosis treatment at a tier four service in Bristol. A very common experience, which many may recognise, was that clients with complex mental health and addiction needs were being sent from 'pillar to post' in their treatment. Things needed to change. Here is a method of how things can change. Briefly, professionals in the drug/alcohol and mental health fields co-locate, working with clients in each other's workspaces. In doing this, they create nodes of integration. These nodes of integration link through parallel working to create a matrix. Outcome and key recommendation is that professionals in the drug/alcohol and mental health fields co-locate in each other's agencies, adopting an assertive outreach approach to working with dual diagnosis/complex-needs clients.

The Matrix Model Bristol (Brendon, 2009)

The expansion of services to better support dual diagnosis clients will place new demands on staff teams, who may feel less confident in addressing mental health needs. This is especially true in the early phases of development. Sharing experiences and knowledge may be vital in developing both confidence and skill sets. Therefore, it may be helpful to include an Innovations Group. This will be an open group for practitioners to meet and exchange ideas, practices and knowledge for working with stuck or entrenched clients. Any staff member may bring a client or client issue to the group for a collective consultation on ideas and strategies to support the client moving forward. These are not necessarily mandated approaches but a peer review model to pool the accumulative experiences of the teams.

Consideration 29: The inclusion of a monthly innovations peer review meeting to help support staff teams who are working with stuck or entrenched clients with complex needs.

A more pioneering approach to address the complexity of service user presentation could be the development of a Wellbeing College model. Recovery Colleges offer educational courses about recovery and mental health which are co-produced by mental health professionals and experts by lived experience. Previous evaluations have found positive effects of Recovery Colleges on a range of outcomes including wellbeing, recovery and quality of life. Whilst these have been developed primarily in the mental health field, the cross over for service users with attendant mental health complexity means the model could have relevance for this group. Sessions are delivered as short training sessions (typically 2 hours long) on a wide variety of subjects within mental health but with a focus on recovery and well being. As such they do not provide formal group therapy but are psycho-educational in nature. Besides raising awareness they offer practical tools and skills that have helped those with lived experience in a more didactic & discussion format. This reduces the demand for ongoing therapeutic engagement. Service users can book onto course online and many Wellbeing Colleges now offer online sessions.

A recent study of wellbeing college effectiveness (Bourne et al 2017) used archival data to analyse service use before and after participants registered with the Recovery College ($n = 463$). Participants acted as their own control. Students who attended the Recovery College showed significant reductions in occupied hospital bed days, admissions, admissions under section and community contacts in the 18 months post compared with the 18 months before registering. Reductions in service use were greater for those who completed a course than those who registered but did not complete a course. These findings suggest that attending College courses is associated with reduced service use. The reductions equate to non-cashable cost-savings of £1200 per registered student and £1760 for students who completed a course. Further research is needed to investigate causality.

The development of a Wellbeing College could also be developed as a multi-agency model. The Service Provider would host the College but would invite courses and trainers from a wider range of sectors to provide specialist input to create a curriculum. This would include mental health but as a wider range of topics relating to complexity that affect substance misusing populations. This could include debt, welfare rights, domestic violence and other common pressures that clients face.

Consideration 30: As service users face a wider range of social pressures and mental health complexity with limited external resources, a Wellbeing College model might serve to meet a wide range of need in a cost effective format. The model would utilise co-production in the development of a curriculum and call upon multi-agency involvement in developing interventions for those in active use. This would be a critical step in bridging the divides between services. This may also de-centralise ‘recovery’ based services across a wider range of providers and venues.

Second Step is a large mental health housing charity operating over four counties of England. It has a highly developed and effective Wellbeing College and its operation can be reviewed at https://www.second-step.co.uk/wellbeing-college/bristol-wellbeing-college-live-sessions/

Homelessness

Close to the issue of dual diagnosis is chronic and entrenched homelessness. Housing is one of 20 areas in which the UK Parliament transferred legislative power to the National Assembly for Wales, and devolution has increased policy divergence across the four home nations of the UK (CIH Cymru, 2014). One of the most significant housing policy developments has been the Housing (Wales) Act 2014, which introduced new statutory homelessness prevention and relief duties.

Stage 1: Substance misuse: The experiences that tended to happen earliest, if they happened at all, were: abusing solvents, glue or gas; leaving home or care; using hard drugs; developing a problematic relationship with alcohol and/or street drinking.

Stage 2: Transition to street lifestyles: There was then a group of experiences that, if the occurred, tended to do so in the early–middle part of individual Multiple Exclusion homelessness (MEH) sequences. These included: becoming anxious or depressed; survival shoplifting; engagement in survival sex work; being the victim of a violent crime; sofa-surfing; and spending time in prison. These experiences seem indicative of deepening problems bringing people closer to extreme exclusion and street lifestyles. Also featuring in this early–middle-ranked set of experiences was one adverse life event: being made redundant.

Stage 3: Confirmed street lifestyle: Next, there was a set of experiences that typically occurred in the middle– late phase of individual MEH sequences and seemed to confirm a transition to street lifestyles. These included: sleeping rough; begging; and intravenous drug use. Being admitted to hospital with a mental health issue also tended to first occur in this phase, as did two of the specified adverse life events: becoming bankrupt and getting divorced.

Stage 4 'Official' homelessness: Finally, there was a set of experiences that tended to happen late in individual MEH sequences. These included the more 'official' forms of homelessness (applying to the council as homeless and staying in hostels or other temporary accommodation) and the remaining adverse life events (being evicted or repossessed and the death of a partner)

Stage of Development for Multiple Exclusion Homelessness

A number of mental health charities have noted that mental health data in Wales is very limited, making it challenging to understand the extent and consequences of mental ill health and what is required to alleviate these problems (Mental Health Foundation 2016; Hafal, 2017). Shelter Cymri (2018) has estimated that there are 350 street homeless individuals in Wales as of 2018, which is expressive of a rising trend. In Gwent, the Gwent Homelessness Reviews 2018 breakdown of the homeless population was identified as:

- Caerphilly 18
- Monmouthshire 6
- Newport 22
- Torfaen 1
- Blaenau: No Data Submitted

In Gwent the number of visible street homeless is highest in Newport. Whilst there are many reasons for homelessness, they have a high concordance with mental health, substance misuse and dual diagnosis needs. However, the Gwent Homelessness Review 2018 reports a very low correlation for street homeless

combined with substance misuse or mental health. Of the service user surveyed, the 165 respondents outlined what they felt were the most important priorities to be focused on to prevent and resolve homelessness. Few homeless respondents reported access to drug and alcohol or dual diagnosis services was a major barrier to overcome homelessness. However, wider Service Providers did report this as more of a pressing issue across area of Gwent. This may illustrate fragmentation that can exist between housing and substance misuse services or simply a low take up of people in active use amongst the survey participants.

Priorities Number Access to social housing	113
Affordable housing to rent privately	86
Immediate access to housing for someone who is homeless	57
Temporary/emergency housing	51
Accommodation that includes support for vulnerable people	44
Affordable housing to buy	37
Mental health support	37
Early intervention advice and support	32
Being housed close to friends/family	25
Rough sleeping	24

Answers given by the 165 respondents that completed the service user survey: reasons that individuals believe contributed to them being homeless or threatened with homelessness (Gwent Housing Strategy)

Greater inter-agency working between the two service sectors has been the focus on Scottish initiatives to reduce homelessness and should be a key feature of this element of the specification. The Gwent Homelessness Strategy does make a number of recommendations pertinent to the development of the Specification. Whilst there was significant praise for substance misuse services in the strategy, it also identified:

- Little provision for co-occurring needs (e.g. substance misuse, mental health, and learning difficulty)
- Mental health and substance misuse teams to work together.
- Much quicker access to substance misuse services
- Relationships with mental health and substance misuse services - rapid reaction protocol
- Work hard with substance misuse and mental health services to ensure their quick engagement to support people
- Priorities – preventing homelessness - greater support mechanisms around emotional support, substance misuse, relationship issues, financial advice, mental health, NEETS

Recommendations from the Gwent Housing Strategy

Many of these concerns have already been addressed in the Dual Diagnosis section. However, closer linkage between substance misuse outreach services does seem indicated in some areas.

Consideration 31: The establishment of a pathway from homelessness services into substance misuse services through co-location of outreach services in relevant Housing support services. This should aim to provide:

- Rapid assessment for substance misuse service entry
- Evaluation of priority need
- Support housing staff to help clients sustain their tenancy where indicated by substance misuse problems

Substance misuse practice approaches to improving outcomes of this population have mostly focussed on:

- Improving integration between substance misuse and homeless services
- Reducing the barriers to treatment with more flexible prescribing routines for those who are dependent on opiates and street homeless.
- Decentralising services to the street-level in order to actively engage those that are street homeless.

Increasingly, Housing services are developing their own models of practice to address entrenched and long-term homelessness. These models not only offer different intervention but also have different aims and objectives. A further complexity is that many Housing models align themselves to recognised models in name only. For example, in the original Housing First model, there was no requirement for housed individuals to engage in any support services. Whereas in many of the Welsh Housing First approaches, engagement is seen as necessary. Likewise, the Psychologically Informed Environments (PIE) model is not a set of defined interventions but offers guiding principles which are expressed uniquely by each agency.

Housing First: As opposed to traditional *stepped care* approaches to housing, the Housing First model presumes that housing is a basic right. As such, homeless individuals should be offered long term, quality housing regardless of their willingness or motivation to utilise any adjunct services, including mental health or substance misuse.

Psychologically Informed Environments: This is a service improvement model based on best practices. It offers five broad guiding principles to help Housing Services define their understanding of clients' psychological drivers, foster positive relationships, shape environments to influence behaviours, provide ongoing support to staff and evaluating outcomes. PIE does not specify what frameworks, models or methods should be adopted, but supports agencies to develop their own model based on their values, client needs and local commissioning landscapes.

Critical Time Interventions: This is a three phased approached developed to support long term homeless, hospital stay or prisoners to make successful transition into housing. The model is staged in intensity and co-opts family and landlords and professionals in wrap around care. It orientates clients to their new housing neighbourhoods and identifies ongoing supports from the client's previous support networks. Support is phased out on a rigid 9 months schedule, leaving the client and the support networks to remain self-sustaining.

Assertive Community Treatment (ACT): This is a practice that offers treatment, rehabilitation, and support services, using a person centred, recovery-based approach, to individuals who have been diagnosed with a severe and persistent mental illness. Assertive Community Treatment services are provided to individuals by a mobile, multi-disciplinary team in community settings.

Intensive Case Management: ICM is a team-based recovery oriented approach that supports individuals through one-to-one case management, the goal of which is to help clients maintain their housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. The duration of the service is determined by the needs of the client, with the goal of transitioning to mainstream services as soon as possible.

Summary of Emergent Housing Specific Models

Housing Service Providers often have greater flexibility in the types of services and support that they are able to offer. Models of practice tend to evolve on an agency wide basis rather than by local or national frameworks. The Welsh Government's "Good Practice Framework for the Provision of Substance Misuse Services to Homeless People and those with Accommodation Problems" requires the following considerations that would also be appropriate for outreach and detached services in substance misuse:

Requirements of Outreach and Direct Access 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

Welsh Government's "Good Practice Framework for the Provision of Substance Misuse Services to Homeless People and those with Accommodation Problems

Welsh Government research suggests that the key problems faced by homeless substance misusers are primarily gaining access to a full range of services appropriate to their needs. This is influenced by homeless individuals' difficulties in sustaining engagement with treatment when living in chaotic and unpredictable life situations. This makes avoiding a return to the prior circumstances which led to their substance misuse problems a treatment priority. Securing support for a range of other needs which limits homeless people's ability to access and sustain contact is also necessary. Furthermore, the requirements of substance misuse services are specifically identified as:

Consideration 32: 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 services
• to be aware of the homelessness services in local area
• to provide appropriate training to homelessness agency staff

Welsh Government's "Good Practice Framework for the Provision of Substance Misuse Services to Homeless People and those with Accommodation Problems

In relation to specific services for the homeless population, the Welsh Government Good Practice also recommends the following interventions:

Consideration 33: Outreach elements should include 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

Consideration 34: Day Centres / Tier 2 Open Access should provide:

- 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.

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.

In terms of interventions, a large-scale review (Zerger 2002) identified the first challenge is in the engagement process. Barriers to successful engagement include disaffiliation or social isolation, distrust of authorities, mobility and multiplicity of needs. Some of the methods recommended to counter these barriers include assertive outreach (making initial contact with an individual in his or her own environment and persisting in contact when engagement falters); provision of housing or other practical assistance; and creating a safe, non-threatening environment.

One of the most consistent findings in this research is the direct association between the length of time spent in treatment and positive outcomes. Yet the challenge of

retaining clients in substance abuse treatment is intensified when the target population is homeless. Drop-out rates of two-thirds or more are common and a return to homelessness often translates directly into a relapse issue.

In light of a dramatic increase in HIV amongst street homeless drug users in Glasgow, local NHS service reviewed the needs of homeless that street inject (Tweed et al 2018). In response, NHS Greater Glasgow and Clyde (NHSGGC) and Glasgow City Alcohol & Drugs Partnership (ADP) initiated this project to review the health needs of people who inject drugs in public places in Glasgow city centre. They made a series of recommendations for the development of existing services for homeless population and recommendations for further development.

Recommendations for the development of existing services in Glasgow

1. Develop multi-disciplinary co-ordination between agencies, in order to address the multiple forms of disadvantage they experience and the wider social determinants of public injecting. Several stakeholders identified a need for better integration and communication across relevant sectors, including health, social care, housing, and criminal justice.

2. Support the development of a peer network for harm reduction aimed at current injecting drug users, analogous to – and linked with – successful local peer-led recovery initiatives.

3. Review models of delivery for specialist addiction services to ensure they are able to meet the needs of this population, with particular reference to access, engagement, and harm reduction. Staff highlighted a need for more flexible and intensive services, greater specialist outreach, and potentially, a dedicated city centre community addiction team.

4. Maximise the capacity of the existing Assertive Outreach service to provide injecting equipment during evenings, and shift existing contracts with city-centre outlets to sites with extended opening hours.

5. A multi-faceted public health response is required, integrating evidence from international examples of best practice with considerations of local need. A number of novel interventions, supported by research evidence, local stakeholder feedback, and expert bodies, offer the potential to greatly reduce the health harms experienced by this group.

5. Introduce and evaluate a pilot safer injecting facility in the city centre, to address the unacceptable burden of health and social harms caused by public injecting. However, any such initiative would require a robust, prospective evaluation – including an economic component – to confirm whether the benefits observed in other cities are transferable to the local context.

6. Introduce and evaluate a pilot service for heroin-assisted treatment for people who continue to use street heroin despite optimal opioid substitution therapy.

7. Incorporate questions on public injecting into routine assessments in existing services and into ad-hoc surveys (such as NESI) in order to enhance our understanding of the prevalence of public injecting and to monitor the impact of new interventions.

In terms of pharmacotherapy, research suggests that homeless populations do respond to contingency based prescribing (Tracey et al 2009). However, low barrier buprenorphine for street homeless people has also been piloted in San Francisco by Carter et al (2019). Among the 95 persons in this sample, medical and psychiatric comorbidities and co-occurring substance use were common. They were provided with an initial prescription for 3–7 days of buprenorphine/naloxone, and had weekly visits early in treatment. With written instructions, patients managed their own “home” induction at the location of their choice and are able to titrate to a typical

initial dose of 16 mg. Some patients appropriately transitioned to methadone maintenance or office-based opioid treatment through traditional primary care clinics during the study period. When the research team was aware of these transitions, these patients were considered to be retained in care while receiving treatment through the new provider.

The percentages of patients retained in care at 1, 3, 6, 9 and 12 months were 63%, 53%, 44%, 38%, and 26%, respectively. In contrast, the percentages of patients retained on buprenorphine at 1, 3, 6, 9 and 12 months were 37%, 27%, 27%, 26%, and 18%, respectively. Twenty-three percent of patients had at least one opioid-negative, buprenorphine-positive test result. One patient died from fentanyl overdose, and four patients presented on six occasions for non-fatal overdoses requiring naloxone.

Not all studies have found support for low barrier prescribing. In a randomised control, office-based Buprenorphine showed equivalent outcomes for both housed and homeless clients (Alford et al 2007). Another study of homeless populations and medication adherence found that amongst a sample of 716 participants, 26% reported nonadherence. This rate is almost identical to the average rate of nonadherence in a meta-analysis of studies conducted in a broad range of patient populations (Hunter et al 2015). This study did suggest that homelessness non-adherence was slightly higher than in other groups, but this was predicted by younger age and positive alcohol screens on AUDIT and not housing status.

There is ample agreement in this body of literature that any effective treatment for this population must foster interagency collaboration to keep homeless populations in treatment, regardless of prescribing regimes on offer. This is also necessary to meet the multiple needs of homeless clients in a context of scarce community resources. Much of the existing research compares integrated models of service delivery with models that link clients to existing community services. These studies are largely descriptive rather than based on Randomised Control methods. For example, several qualitative studies have attempted to illustrate the depth of the complexities involved, and the associated strengths and weaknesses of, both models.

Few studies have examined the effectiveness of the integrated treatment model and those that have produce inconclusive findings. However, inconsistent evidence from the Homeless Strategy for Gwent does indicate a degree of fragmentation between housing, substance misuse providers and clients with complex needs. This suggests a strategy to increase integrated practice for homelessness. However, pan-Gwent wide responses to homelessness in substance misuse population would probably not be warranted to address the needs of what has been identified as a small population. Modification of generic services may be the best option in areas with few homeless people with a history of substance misuse. Practice integration may be a more proportionate response than the development of integrated services. A number of UK models exist that have successful achieved this aim.

Sefton Council

The housing support team secured funding from the Government's Rough Sleepers Initiative to pay for the equivalent of a day's work from a clinical nurse prescriber. This allowed them to get a Mersey Care nurse to work directly with the Light for Life outreach service. The nurse started accompanying the homeless service on its rounds in the town centre in early 2019. The funding covered the backfill for the nurse. The nurse, carries out assessments, books the clients in for appointments and has even been able to hand out anti-overdose drug treatment naloxone.

Outreach work is conducted on a Thursday morning and the nurse is available at a nearby clinic in the afternoon for the clients to drop-in for further advice, organise access to services and hand out any prescriptions they may need. This has engaged 12 rough sleepers since the project started in January 2019. Half of them are now actively involved with treatment. It is quite common to find someone who engages for a while and then stops. This service can provide the link that re-engages them.

The Sefton Council Approach (Sefton Outreach Model, 2019)

Good Practice model: In West Cumbria, the Cornes team established a 'community of practice' (COP) as a means of improving joint working around the issue of multiple exclusion homelessness. This brought together different practitioners who had a real passion for the topic (not 'organisational' representatives). The initial pilot ran for four sessions and the COP is now being continued by its members (a social worker, a probation officer, a housing support worker, an advice worker, a mental health worker, a drugs worker and a researcher from this project). Members bring practice challenges and anonymised 'cases' to each session and seek support and help from the community. Although not common practice, this COP has actively sought to promote the inclusion of former service users by virtue of their status as 'experts by experience'. While still in the early stages of development, the COP has been described by its members as a 'lighthouse' for practice values and principles and a means of achieving real changes in approaches to joint working that are of direct benefit to people who use services.

Communities of Practice Model (McDonagh 2012)

Consideration 35: The Outreach Teams should take a lead role in establishing a Community of Practice (CoP) model with a wide range of statutory and non-statutory stake holders to develop responses to local homeless populations. The constitution, frequency, aims and structure of these multi-agency meetings should be decided by the established group. Service user involvement should also be included. The CoP should also consider capacity to identify and support specific vulnerable people who are street homeless.

Consideration 36: The identified lead key worker needs to be established in the relationship between Housing and substance misuse service to avoid duplication. It would be assumed that the Housing Services would take a lead role up to the point that a client has achieved stable housing when the lead care role might then switch to substance misuse services. Clear information sharing protocols need to be established between Housing and Substance Misuse Services.

Digital and Online Interventions

Digital interventions could dramatically increase access to substance misuse interventions, especially in rural communities or where there is restrictive hours. However, many believe that digital based therapies may not feel like a genuine intervention without the symbols of their therapeutic process and engagement with another human being. Despite these reservations, the last decade has witnessed a dramatic increase in the number of online and digital substance misuse services available. Online interventions for drinking problems are more common than those for illegal drugs. The majority are delivered using a computer-based web platform, as opposed to a mobile platform (for example via an ‘app’ downloaded to a phone or tablet). Currently, digital interventions fall into one of three categories:

- Unguided standalone apps that provide treatment directly to the individuals
- Augmenting apps that add support to human-human interventions which intensify treatment
- Therapy online delivers real time human interventions such as counselling or group work through social contact programmes such as Teams or Zoom

Whilst digital interventions can increase access to a wider range population they still require:

- Access to IT / Smart phone technology
- Literacy and IT competence
- Appropriate screening of severity to reduce harms

Reviews have found positive outcomes from digital interventions. Meta-analysis has found encouraging effects for digital interventions to address nicotine, alcohol, cannabis, opioids, cocaine and amphetamines (Riper et al 2014; Tait et al 2013; Graham et al 2016; Boumparis et al 2017). They also demonstrate small but significant effects in decreasing substance use among various target populations at treatment completion and at follow-up. A systematic review of ‘digital’ brief interventions from the Cochrane Collaboration (2017) (which helps to facilitate evidence-based choices about health interventions) found that personalised advice using computers or mobile devices helps reduce heavy drinking more effectively than doing nothing or providing only general health information. Furthermore, in a smaller pool of studies in Cochrane review, found that digital interventions can match the effectiveness of interventions with doctors or nurses. More than three-quarters of the studies showed a short-term decrease in use that was maintained six months later. Only two studies included a 12-month follow-up.

The participants in the studies were mostly adults between 30 and 46 years old (an age group presumed to be receptive to technology). Less than a quarter reported having previously consulted a professional for drug or alcohol-related problems, the majority presented with high risk or problem drinking and/or drug use. Outside the context of a trial, this profile was broadly replicated in a study of people accessing help for problem drinking via the internet, suggesting the results of trials may be applicable to people seeking help in the real world.

Online self-help is now an established modality for mental health problems within the UK National Health Service (NHS Self Help Website) with evidence of comparable outcomes between self-help therapies and face-to-face therapies for some types of mental health problems and disorders. In particular, the National Institute for Health and Care Excellence (NICE) recommends computerised cognitive-behavioural therapy for the treatment of neurotic disorders as a resource that could be tapped into for the nearly three-quarters of clients of Britain's drug and alcohol services suffering from mental health problems.

Research demonstrates that digital interventions are more likely to attract people with lower order substance problems with more of the 'recovery capital' needed to lift themselves out of trouble without therapist intervention. Often these are characterised by high functioning problem drinkers who retain a stake in mainstream society in the form of relationships, jobs, families and a reputation to lose. Access to computer-based support might assist those users, who may be less likely to seek face-to-face help, to access inexpensive and short interventions. Digital interventions may appeal as a more proportionate response to the lower severity of their problems.

A German study (Baumannab et al, 2017) tested whether people with different day-to-day drinking patterns benefitted differently from two computerised brief alcohol interventions. It randomly allocated 1,243 'at risk' job-seekers drinkers to:

(1) an intervention tailored to their motivational stage

(2) a non-stage tailored intervention

(3) a control group receiving assessment only

Four distinct patterns were observed. Those whose consumption was at the lower end were found to benefit more from stage-tailored brief alcohol interventions than non-stage tailored brief alcohol interventions and assessment only. As the authors identified, this is one core target population for brief interventions that is typically not reached. A key difference between the stage-tailored and non-stage tailored interventions was that the former reserved feedback about self-regulating drinking for those in later motivational stages of change, while the latter encouraged all participants to apply self-regulatory strategies. In line with the stages of change model (and broader transtheoretical model of behavioural change), the findings indicated that people in earlier motivational stages improved most when *not* encouraged to use self-regulatory strategies. Likewise in a Canadian study (Cunningham et al, 2010), it was only the top 50 per cent of risky drinkers among a general adult sample who reduced their consumption and alcohol-related risk levels after being given access to a web-based brief intervention.

The best known British alcohol self-help free-access web-based intervention is "Down Your Drink" (https://www.downyourdrink.org.uk/). It offers set programmes

from a one-hour brief interventions spanning several weeks. It also gives the user greater control over the use they make of the site. The approach remained based on principles and techniques derived from motivational interviewing and cognitive-behavioural therapies. Data from the first 10,000 people who registered revealed that most were in their 30s and 40s, half were women, nearly two-thirds were married or living with a partner, just 4% were unemployed and most reported occupations from higher socioeconomic strata. About 17% completed the full six weeks programme and of these, 57% returned an outcome questionnaire. On average they were now at substantially lower risk, functioning better and living much improved lives. Results from surveys sent to pilot programme completers indicated that three quarters had never previously sought help for their drinking (Linke et al 2007).

SMART Recovery (https://www.smartrecovery.org/new-addiction-recovery-web-app/) have also released a digital treatment programme for addictions, rather than specific type of use, i.e. alcohol alone. In a randomised control trial (Campbell et al 2016) of 189 problem drinkers, participants did as well in the stand-alone digital programme as they did in SMART recovery groups. Each group showed significant improvement on wide number of measures.

Attrition rates do seem more of an issue in digital interventions. Hazardous alcohol consumption appears to be a key factor of the dropout rate in a Web-based alcohol intervention study. Thus, it is important to develop strategies to keep participants who are at high risk in web-based interventions (Radke et al 2017). Appeal and ergonomic design appear important in this process.

Several studies have found that brief interventions for drug misuse have superior effectiveness to no-treatment controls. In a two-arm randomised clinical trial (Schwartz et al 2014), 360 adult primary care patients with moderate-risk drug scores on the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) were randomly assigned on a 1 : 1 basis to a computerised brief intervention (CBI) or to an in-person brief intervention (IBI) delivered by a behavioural health counsellor. The IBI and CBI conditions did not differ at 3 months on global ASSIST drug scores or drug-positive hair tests. There was a statistically significant advantage of CBI over IBI in substance-specific ASSIST scores for marijuana at 3 months.

Since the inception of the last Specification, standalone online digital self-help has advanced considerably along with the research base to supports its use. Furthermore, acceptability of online resources has also increased across Stakeholders and the general population. Currently, access to self-help materials in GDAS digital therapies is limited to pen and paper self-help manuals and these are somewhat lost on websites proving information to potential clients. Whilst these were innovations in the last Specification, self-help expectancies have risen in the ensuing years. These materials will need to be updated and digitalised to keep the Service in line with current trends in treatment delivery formats. The new Specification should include substantial revision of current access to self-help materials and be more prominent in its promotion online.

Consideration 37: The Specification should explicitly require Service Providers to express how they will promote digital interventions. These materials will primarily target lower end severity of problems including alcohol, cannabis & cannabinoids as well sundry interventions for high energy drinks. Online Screening tools will be required for user's suitability and could offer online pre-treatment assessment options.

There are a number of options how this may be applied with different cost implications. These options are:

- Screener online followed by a library of free apps and online resources available from other digital Providers (Down your Drink, Overcome Addictions etc).
- Screener online followed by inhouse developed digital treatment platforms
- Screener online and purchasing a licensed for a commercial digital Provider.

There a number of high-quality online interventions that are free and can be compiled as a library of resources for clients. However, they unlikely to be available in the Welsh language.

Digital Therapy as an Adjunct to Treatment

While principles of cognitive-behavioural therapy are commonly found in computer-driven programmes, and have a high level of empirical support for the treatment of drug and alcohol use disorders in general, a phenomenon in research called the 'implementation cliff' means that a drop-off in benefit often occurs when interventions leave highly controlled settings. In so far as this is due to the intervention becoming less well implemented, modern technologies may give scope to curb this by offering a flexible, low-cost, standardised means of disseminating cognitive-behavioural and other therapies in a range of novel settings and populations.

A study by Fals-Stewart & Lam (2010) examined the comparative efficacy of cognitive rehabilitation as an intervention for substance misuse. Patients with substance use disorders entering long-term residential care (N = 160) were randomly assigned to one of two conditions: (a) standard treatment plus computer-assisted cognitive rehabilitation (CACR), which was designed to improve cognitive performance in areas such as problem solving, attention, memory, and information processing speed; and (b) an equally intensive attention control condition consisting of standard treatment plus a computer-assisted typing tutorial (CATT). Intent-to-treat analyses showed that, compared with those randomized to CATT, patients who received CACR were significantly more engaged in treatment (e.g., higher ratings of positive participation by treatment staff, higher ratings of therapeutic alliance), more committed to treatment (e.g. longer stays in residence) and reported better long-term outcomes (e.g. higher percentage of days abstinent after treatment).

An example of an adjunct based technology system is a Web-based psychosocial skills training intervention for individuals with substance use disorders. The therapeutic education system is built on the validated Community Reinforcement Approach to behaviour change. Its digitalised online support programme has 65 interactive multimedia modules based on basic cognitive behavioural skills. The therapeutic education system is self-directed, includes functionality to build

individualised treatment plans, assesses a patient's understanding of material, and adjusts the pace and level of repetition of material to promote skills mastery. Its interactive videos help individuals learn specific behaviours (e.g., progressive muscle relaxation). It also includes an optional system for delivering and tracking earnings of incentives for targeted behaviour (e.g., participation in therapy sessions, drug-negative urine samples) in the context of a contingency management and motivational incentives positive reinforcement paradigm. Clinicians can view summaries of patients' therapeutic education system progress on their computers and can integrate the therapeutic education system usage data into counselling sessions if they choose.

The therapeutic education system has been evaluated in several randomised, controlled trials. The first randomised, controlled trial found that the therapeutic education system produced drug abstinence rates equivalent to comparable therapy delivered exclusively by highly trained clinicians and significantly greater abstinence rates than standard treatment (Bickle et al 2009). A separate trial demonstrated that when the therapeutic education system replaced a portion of standard addiction treatment (i.e., reducing face-to-face contact), abstinence rates were significantly greater than those produced by standard treatment alone (Marsch et a 2011).

Other models have focus on more discreet aspects of service with some mixed results. Dunna et al (2017) developed and evaluated an easily-disseminated opioid overdose educational intervention and compared computerised versus pamphlet delivery. While the computer-delivered intervention may have advantages in terms of cost and reach as a delivery method, it was not found to have any benefits over pamphlet delivery on the outcomes measured. Knowledge increased across the board and was well-sustained at the one and three-month follow-ups among people receiving the computer and written pamphlets, and there was a significant reduction in the risk factor of 'using opioids while alone'.

Consideration 38: Adjunct supporting online resources should be more fully developed within the context of the Specification. Ideally the development of supplementary digital support could draw upon the lived experiences of service users as well as professional input. It is suggests that peer support groups participant in the creation of adjunct support and information services in digital formats. These should not just be focussed on recovery but on wider aspects of the services, such as reducing use on top, controlled drinking and wider mental health issues.

Finally, the emergence of videoconferencing has elevated telephone-based intervention delivery into a new realm of virtual in room experience. This can increase personalised interventions amongst those who find it hard to access services. The specification should recognise this method of delivery for these clients. However, it will need to be supported by protocols regarding confidentiality to create safe online therapeutic environments.

Consideration 39: Videoconferencing options should be included in the delivery of face-to-face treatment modalities. This may be especially helpful for those with dependents such as concerned others as well as for clients in rural communities. Platforms of delivery will require security encryption in both one to one or group formats. Clear security protocols will also need to be developed and agreed with the APB.

Boswyns Mind Gym

Most computerised interventions offer CBT support for recovery. There is an increasing interest in how different computer games and activities exercise specific neural areas of the brain. This has provided effective in a number of disorders such as intrusive thoughts, reducing cravings, and improving impulse control. This led to the development of the MindGym at Boswyns detoxification unit, Cornwall. Here patients engage with a wide range of specified computer games on a regular basis to improve neural functioning in a number of areas. Flanker Tests and Go Stop task have been found to improve impulse control. Working memory tests can reduce cravings for drugs and alcohol. Whilst Tetris has a large evidence base to support its use in reducing intrusive memory in PTSD. This is a pioneering approach and in early development.

Case Management Continuity

Substance use disorders require a complex range of care because of its chronic nature and the multiple psychosocial problems involved. Current outpatient programs often have difficulties in delivering and coordinating ongoing care and access to different health-care providers. Various case management models have been developed, first for patients with psychiatric disorders and then for patients with SUD, in order to improve treatment outcomes. However, there is often a lack of clarity about what types of care management are being applied and practitioners may be utilising vague and inconsistent approaches within an agency itself. Within a complex integrated treatment pathway, sustaining case management relationships may become compromised by the need for multiple input and the client's progression through the pathway itself. This discontinuity may disrupt the therapeutic process.

It is difficult to isolate the effectiveness of case management continuity. For example, a systematic review (Penzenstadler et al 2017) found only fourteen studies were of sufficient quality to be included. Furthermore, differences between studies in outcome measures, populations included, and intervention characteristics made it difficult to compare results. Most of these studies reported improvement in some of the chosen outcomes. Treatment adherence mostly improved, but substance use was reported to decrease in only a third of the studies. Overall functioning improved in about half of the studies. The two of the studies included did not find any significant improvements in. Both these studies were conducted on incarcerated or paroled patients. Furthermore, a third study found negative outcomes of case management with Criminal Justice clients. This emphasises the necessity for greater clarity of case management with offenders.

There is some evidence that case management continuity is more important for clients with more complex needs. A study examined a pilot project in Philadelphia that attempted to expand the access to and continuity of addiction treatment by focusing on the 15% of patients who received multiple detoxification-only (MDO) treatments each year. Clinical Case Managers at five detoxification centres encouraged these patients to continue care following detoxification from methadone in residential, or outpatient rehabilitation and sustain improvements. Over three

years, 890 MDO patients were case managed and had received assessment, referral, and transport to health care and sober living. The sub-sample of case-managed MDO patients showed a 55% reduction in detoxification-only admissions, a 70% increase in use of rehabilitation, and a twenty-day increase in the average length of stay per episode (McLellen et al 2005).

Research on the impact of the therapeutic alliance and case management outcomes is surprisingly sparse (Howgego et al 2003). Within these limitations, studies have found a correlation between the strength of the alliance and case management outcomes (Neal & Rosenheck, 1995). However, outcomes appear to take a longer period of time to achieve. McLellan et al (1999) found no effects of case management in the 12 months after implementation but did find effects after 26 months. They concluded that there was a strong influence of various system variables—for example, program fidelity and availability and accessibility of services—and recommended extensive training and supervision to foster collaboration and precontracting of services to ascertain their availability. Certainly, continuity of care over extended periods was necessary for treatment gains to occur.

Conversely, several commentators have noted that the effectiveness of case management does not simply reside in the practitioner but depends largely on its integration within a comprehensive network of wider services (Ogbourne & Rush 1983). Furthermore, research suggests that case management tends to support in-house referral far more effectively than engagement with external service providers (Friedmann et al 2000).

A recent study examined what was effective in case management treatment delivery based on a synthesis of 14 per reviewed research studies (Savic et al 2017). It found that ensuring integrated care is included within service specifications of commissioning bodies and is adequately funded was central to outcomes. Cultivating positive inter-agency relationships underpinned and enabled the implementation of most strategies identified. Staff training in identifying and responding to needs beyond clinicians' primary area of expertise was considered important at a service level. However, some studies highlight the need to move beyond discrete training events and towards longer term coaching-type activities focussed on implementation and capacity building. Sharing of client information (subject to informed consent) was critical for most integrated care strategies. Case-management was found to be a particularly good approach to responding to the needs of clients with multiple and complex needs. At the clinical level, screening in areas beyond a clinician's primary area of practice was a common strategy for facilitating referral and integrated care, as was joint care planning.

In summary, the use of case management with complex cases is liable to promote service engagement. This is a key component of service provision that should be preserved within the integrated treatment system. However, there are also limits on the range of interventions that one practitioner might also be able to employ effectively. Practitioners may find it difficult to remain in tune with the complex needs of clients across the spectrum of presenting need- from homeless to recovery. It may also be difficult for them to remain cognisant of external service developments that might be pertinent to all clients in their care. Practitioners may become more effective when they are specialists within the over-arching treatment pathway rather than a jack of all trades throughout the system.

Therefore, it may be appropriate to designate *zones of practice* where continuity of care is sustained. This may accord with the description of service functions. This might include Engagement with chaotic, street clients with its focus on stabilisation, meeting basic needs and housing priorities. The Participation Zone where clients are stabilised on their treatment regimes and are able to engage in ongoing psycho-social interventions. And Recovery Zone for those progressing into independent lives beyond service involvement.

Consideration 40: In order to preserve continuity of care within the wider treatment system, case management should be zoned, sustaining ongoing care within each zone of the service system. This should offer support for those in Engagement, Participation and Recovery zones of the system.

In the Netherlands, a Delphi study was organised to reach a broad consensus on the core features of case management, resulting in a manual that will serve as a touchstone for the future development, implementation, and evaluation of case management. The Delphi method comprises a series of questionnaires sent to a preselected group of experts—for example, clients, case managers, and program directors—who respond to the problems posed individually and who are able to refine their views as the group's work progresses. It is believed that the group will converge toward the best response through this consensus process, based on structuring of the information flow and feedback to the participants.

The Delphi Model (Fiander & Burns 2000)

Family Services

The final area to examine is the role of family services within the treatment system. Family interventions are a designated service for concerned others affected by a loved one’s drug or alcohol use. At the inception of the Specification this was designated a virtual team, with a concerned other practitioner holding responsibility for each county of the service. This would be managed through the GDAS service. However, there seem to be a number of issues regarding the service that might be understood as therapeutic drift.

It appears in the ensuing period the service for concerned others has experienced drift from the original inception. This may be due to:

- Management by a non-dedicated service
- Management across services
- Significant changes in the staff team and number of staff available
- Information regarding concerned other services are ‘lost’ in a wider treatment system
- The service has become de-prioritised in a wider range of service developments

Consideration 41: In order to reduce therapeutic drift it will be more appropriate if the Concerned Other team are managed by one Provider in the case of a consortium bid to ensure consistency of practice and fidelity to the treatment pathway.

A review of current online presence for concerned other services in Gwent is revealing. The information currently being provided online is inappropriate for concerned others. They will understand little of professional terminology used on the GDAS site and may find the health policy included in other partners sites anxiety promoting. Furthermore, there is a dearth of information that is non-specific to the needs of concerned others, i.e. health policy documents, alcohol unit calculator and calorie calculator. There is no 'voice' that addresses the specific needs of concerned others and how the service might assist them.

Plus, the web pages look indiscernible from services targeting drug and alcohol users. This may be reflective of the aims of the concerned other service becoming diluted as it has merged in a much bigger treatment framework. Plus, the wider agency may not have the skill set to understand the clinical application of a more specialised intervention outside of the substance misuse field. This should be revised, with consideration given to furbishing the concerned other service to its own website or distinct website landing page.

Consideration 42: In order to create a virtual team the concerned other service should develop its own dedicated online presence which features information more appropriate to concerned other needs. This should provide services described in lay-terms, sources of information and support as well as testimonials from concerned others.

Many of the issues pertaining to employed substance misusers applies equally to concerned others. Concerned others are not only more likely to be in employment, but this out-of-home role often offers sanctuary from the pressures of living with a problematic user. This means that concerned others protect their employment at all costs making taking time out to attend appointments very difficult for them. Therefore, the creation of more out-hours support could be linked through the website / page. This might include an online video conferencing intervention service but also the creation of support groups in online forums for mutual aid. Word of mouth may also be a most effective form of promoting the service.

Consideration 43: Support for concerned others can be delivered through technology solutions which may be better suited to their needs. This might include online interventions, support groups and forums to create a community of care for those with very specific and shared needs.

The gross number of problematic drug users is in decline especially amongst young initiates. This is liable to reduce the number of overall referrals for concerned other services. Families of problematic drug users are liable to seek professional help at a much faster rate than families of problem drinkers. However, certainly in the post-Covid period, a rise in alcohol consumption and related domestic abuse is likely to have increased creating continued demand for a small but highly specialised service.

A drop in referrals to the service has also corresponded with a drop in staff numbers. Currently two practitioners are covering the Gwent region as opposed to the initial staff contingent of five. With many of the original development team having left the service, it appears that the succession of work practices have not transferred as readily to new staff members which may have diluted the clinical focus of the team. Without a common management framework, or opportunity to share practice, also allows drift to progress further.

Consideration 44: Review staff induction processes to ensure new practitioners are primed for the specific and unique requirements of the Concerned Other service which may diverge from the accepted practices of the wider agency. The Specification needs to ensure that the virtual team members have protected time to share common practice issues.

As the Concerned Other service is a specialist service within substance misuse services, closer attention is need to the fidelity of the models currently being offered. In previous times, the development of bespoke IT solutions was important in helping team stay focussed on the four central aims of the service, tracking client movement within the agreed pathways and reporting outcomes in a defined process of intervention. With some re-configuration of the Concerned Other service, it is unclear whether the IT system has been adapted to account for these changes or whether the team has switched to Pal Base client management. If this is the case, then a helpful fidelity tool may have been lost, increasing the risk of drift in staff practice.

Consideration 45: Review the current utilisation of IT frameworks and whether they are able to support fidelity of delivery in the concerned other service.

These changes should be adopted prior to a Concerned Other specific promotion campaign in Gwent. Local media, including newspapers and radio should be utilised to promote the work of the service as distinct from mainstream drug and alcohol provision. This should direct potential services users to distinct web landing pages which are configured to their specific needs and challenges. The service should also review its current contact will likely sources of referral, social services, GPs, IAPT services and domestic abuse services.

Consideration 46: A programme of promotion of the service should be done once all other recommendations are implemented. The Concerned Other service should look to develop its own referral base as separate from the mainstream drug and alcohol services.

There has been some discussion regarding the deployment of the Concerned Other services to reduce the incidence of children who enter into care in Gwent. This would be difficult because of the way the service is currently configured. There is a considerable divergence between the support needs of concerned others and the interventions necessary to reduce the frequency of Child Protection. The Concerned Other service is not a primarily parenting model or even currently adapted for

delivery to under 18s. The team may have an important role as a component of a multi-agency child protection response where one partner is experiencing substance misuse problems and the other parent is not. To re-orientate the team to providing input into the parenting capacity of substance misusing adult would be a significant transition in the team's skill set. This would need to connect to a larger reappraisal of the current services aimed at reducing the number of children going into care. It would appear that the multi-team focus, current panoply or interventions and relational engagement currently being offered families with children at risk is not effective. It may be more apposite to undertake a systemic review of these service before annexing more teams into the delivery of services.

Consideration 47: Service for Concerned Others are not currently configured to develop parenting capacity. The service could support family members to influence change in substance misusing partners, without this relational leverage they are not equipped to address wider parenting issues under the current specification. This is unlikely to address systemic issues that currently reside the teams that support families. A larger scale review of current family services may be a more appropriate strategy.

The MOPSI model was an innovation in the development of Integrated Treatment Pathways. It has been successful in transforming the current provision of substance misuse services across Gwent. The garnered experience of 5 years of delivery, shifting focus in policy direction and the changing demographics of those presenting for services demands some refinement of the model. This has largely been informed by revisiting the central aim of MOPIS which was to ensure appropriate levels of service were offered to clients who were most receptive. The model had the capacity to recalibrate the client flow through the adjustment of contingent incentives, but this has been an under-utilised feature of the system to date. This review offers an opportunity to pin point where such adjustments can be made to meet the wider and more complex needs of the current client cohort.

Considerations

Considerations	**Notes**
Consideration 1: The specification should state that this is a commissioning contrast for substance misusers with complex needs as to re-orientate Stakeholders to the function of this Specification.	
Consideration 2: The MOPSI framework has proven to be a highly effective addition to the treatment system for opiate users and should be retained.	
Consideration 3: Take home dosing schedules should be made available to sub-populations within low intensity prescribing arm who have demonstrated stability and routinely provide negative samples.	
Consideration 4: Rename Behavioural Contract to a more service user friendly term.	
Consideration 5: The development of walk in clinics for those on low intensity, evening sessions for those who can demonstrate that they are in employment. The Service Provider will develop a criterion for what they will recognise as demonstrable evidence of employment and this should be set on a review schedule. Expected frequency of contact will be determined by the Service provided in consultation with services users eligible for this element of service.	
Consideration 6: Demonstrably employed individuals who test negative for opiates should be offered low intensity options with take home privileges.	
Consideration 7: Encourage those currently on methadone prescribing regimes to switch to buprenorphine regimes to reduce Health & Safety in the workplace related risks. Protocols for Buvidal will also need to be developed along with additional costing of this prescribing option.	
Consideration 8: Adapt elements of the IPS-AD to support those in employment to sustain employment	
Consideration 9: Report breakdown of ages related to those in Open Access prescribing to assist in the pro-rata of case management between these age ranges.	
Consideration 10: Early initiatives deployed within the Specifications should be considered as pilots for routine evaluation in order to establish best practice models during the course of the Specification.	
Consideration 11: The specification should include the recommendations of the ACMD working group on aging with the development of an older person's navigator role. Differences between Case Management and Navigation approaches are ambiguous with some significant cross over. For the purpose of the Specification, Case Managers will support the clients through the current substance misuse service system. Whereas Care	

Navigators will support substance misusing clients whose needs may be better met by a wider range of external health interventions. As such, they will have a broader brokering and linkage role with age & health related interventions including gerontology and palliative care.	
Consideration 12: The current assessment procedures should be reviewed to test whether they are fit for purpose for the over 50s. This might necessitate the demand for the development of a specialist Over 50s assessment. Such an assessment could provide the gate way to specialist service provision for this age cohort.	
Consideration 13: The Service provider will need to forge links with wider gerontology-based services.	
Consideration 14: As the substance misuse population ages there will be greater focus on end of life care for services in the next 10 years. It is recommended that the Service Provider develop End of Life policy and protocols within the good practice guidance of Manchester Metropolitan University.	
Consideration 15: Staff should receive training and support for working with end of life care.	
Consideration 16: The Service Provider should develop links and memorandums of Agreement with Palliative care services in the area as part of their package of care for older drug users.	
Consideration 17: The Service Provider will develop a protected time intervention for those over 50 on enhanced low intensity prescribing. This voluntary programme should offer a social prescribing that focusses on increasing social engagement and positive activities to enhance wellbeing and promote service retention.	
Consideration 18: Providing treatment approaches that sustain retention and engagement is of vital importance to opiate related deaths in this vulnerable group.	
Consideration 19: Routine follow-up support for at least four weeks post treatment is necessary for those exiting opiate substitution therapies to reduce drug related deaths in out-patient settings.	
Consideration 20: Utilising data extraction to identify high risk individuals and developing targeted overdose prevention responses to minimise risk in Newport as a proof of principle pilot.	
Consideration 21: The specification should be developed in line with the requirements of the “Substance Misuse Services in Wales: Are they meeting the needs of service users and their families?” (HIW 2010) and The Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem (WG 2015)	
Consideration 22: Leads for Mental Health and Substance Misuse from the Health Board and APBs should agree upon joint mission statement and objectives to create common purpose in frameworks and treatment delivery. Subsequent treatment commissioning should operate within these locally agreed prioritises and regular audit should be conducted to ensure that they policies are operationalised and effective.	

Consideration 23: Depression and anxiety disorders are a common feature of those presenting for care planned interventions with the substance misuse services. Therefore, the Service Provider should offer evidenced-based structure interventions in accordance with NICE (2009) recommendations to address these complexities as standard. This could be delivered as; • Groups • Planned element of case management • Structured one to one session The Service Specification should require potential bidders to state the models and format of delivery of specific packages of care. They should explain how they will integrate these approaches within the current care planning frameworks.	
Consideration 24: Practitioners in substance misuse services will require training and support in the development of skills sets to address depression and anxiety and the Specification should require detailed proposals in the Training and Staff Development of the contract.	
Consideration 25: Treatment of Personality Disorder can be jointly delivered or accessed via with Criminal Justice community services. Non-offending PD clients should retain a case management within Open Access services.	
Consideration 26: In order to develop a coherent integrated treatment pathway for dually diagnosed clients with psychotic symptoms, rapid access refers processes need to be established between Substance Misuse Services and Statutory Mental Health Providers and only be revised as a part of a system review rather than unilaterally by Providers.	
Consideration 27: GSSMS & statutory Mental Health services must be configured to operate within agreed integrated treated pathways that states commonly agreed and routine practice, including: • Established and consistent eligibility criteria • Routine feedback on the progress of clients on waiting lists • Its function with a Gwent-wide Treatment Pathway for dual diagnosis clients • The packages of care offered within the Gwent-wide treatment system • Named specialist interventions offered to the presenting client group that address their client cohorts more complex needs Reported clinical outcomes and outputs in line with Open Access service requirements	
Consideration 28: The Service Provider should establish routine collaborative practice with mental health services across a range of interactions including: • Co-locations in buildings • Practitioners placements in wider service teams • Joint assessment • Co and joint training • Specialist training across teams in dual diagnosis management • Specific consideration should also include the involvement of mental health services in JAM meetings	

Consideration 29: The inclusion of a monthly innovations peer review meeting to help support staff teams who are working with stuck or entrenched clients with complex needs.	
Consideration 30: As service users face a wider range of social pressures and mental health complexity with limited external resources, a Wellbeing College model might serve to meet a wide range of need in a cost-effective format. The model would utilise co-production in the development of a curriculum and call upon multi-agency involvement in developing interventions for those in active use. This would be a critical step in bridging the divides between services. This may also de-centralise 'recovery' based services across a wider range of providers and venues.	
Consideration 31: The establishment of a pathway from homelessness services into substance misuse services through co-location of outreach services in relevant Housing support services. This should aim to provide: • Rapid assessment for substance misuse service entry • Evaluation of priority need Support housing staff to help clients sustain their tenancy where indicated by substance misuse problems	
Consideration 32: 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	
Consideration 33: Outreach elements should include 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	
Consideration 34: Day Centres / Tier 2 Open Access should provide: • 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.	
Consideration 35: The Outreach Teams should take a lead role in establishing a Community of Practice (CoP) model with a wide range of statutory and non-statutory stake holders to develop responses to local homeless populations. The constitution, frequency, aims and structure of these multi-agency meetings should be decided by the established group. Service user involvement should also be included. The CoP should also consider capacity to identify and support specific vulnerable people who are street homeless.	
Consideration 36: The identified lead key worker needs to be established in the relationship between Housing and substance misuse service to avoid duplication. It would be assumed that the Housing Services would take a lead role up to the point that a client has achieved stable housing when the lead care role might then switch to substance misuse services. Clear information sharing protocols need to be established between Housing and Substance Misuse Services.	
Consideration 37: The Specification should explicitly require Service Providers to express how they will promote digital interventions. These materials will primarily target lower end severity of problems including alcohol, cannabis & cannabinoids as well as sundry interventions for high energy drinks. Online Screening tools will be required for user's suitability and could offer online pre-treatment assessment options. There are a number of options how this may be applied with different cost implications. These options are: • Screener online followed by a library of free apps and online resources available from other digital Providers (Down your Drink, Overcome Addictions etc). • Screener online followed by inhouse developed digital treatment platforms • Screener online and purchasing a licensed for a commercial digital Provider. There a number of high-quality online interventions that are free and can be compiled as a library of resources for clients. However, they unlikely to be available in the Welsh language.	

Consideration 38: Adjunct supporting online resources should be more fully developed within the context of the Specification. Ideally the development of supplementary digital support could draw upon the lived experiences of service users as well as professional input. It is suggested that peer support groups participate in the creation of adjunct support and information services in digital formats. These should not just be focussed on recovery but on wider aspects of the services, such as reducing use on top, controlled drinking and wider mental health issues.	
Consideration 39: Videoconferencing options should be included in the delivery of face-to-face treatment modalities. This may be especially helpful for those with dependents such as concerned others as well as for clients in rural communities. Platforms of delivery will require security encryption in both one to one or group formats. Clear security protocols will also need to be developed and agreed with the LHB.	
Consideration 40: In order to preserve continuity of care within the wider treatment system, case management should be zoned, sustaining ongoing care within each zone of the service system. This should offer support for those in Engagement, Participation and Recovery zones of the system.	
Consideration 41: In order to reduce therapeutic drift it will be more appropriate if the Concerned Other team are managed by one Provider in the case of a consortium bid to ensure consistency of practice and fidelity to the treatment pathway.	
Consideration 42: In order to create a virtual team the concerned other service should develop its own dedicated online presence which features information more appropriate to concerned other needs. This should provide services described in lay-terms, sources of information and support as well as testimonials from concerned others.	
Consideration 43: Support for concerned others can be delivered through technology solutions which may be better suited to their needs. This might include online interventions, support groups and forums to create a community of care for those with very specific and shared needs.	
Consideration 44: Review staff induction processes to ensure new practitioners are primed for the specific and unique requirements of the Concerned Other service which may diverge from the accepted practices of the wider agency. The Specification needs to ensure that the virtual team members have protected time to share common practice issues.	
Consideration 45: Review the current utilisation of IT frameworks and whether they are able to support fidelity of delivery in the concerned other service.	
Consideration 46: A programme of promotion of the service should be done once all other recommendations are implemented. The Concerned Other service should look to develop its own referral base as separate from the mainstream drug and alcohol services.	
Consideration 47: Service for Concerned Others are not currently configured to develop parenting capacity. The service could support family members to influence change in substance misusing partners, without this relational leverage they are not equipped to address wider parenting issues under the current specification.	

This is unlikely to address systemic issues that currently reside the teams that support families.	
CJS Consideration 1: The arbitrary limit of 24 weeks for Drug Interventions Programme is not supported by the clinical research base and should be abandoned.	
CJS Consideration 2: 16-week structured reviews need to become a core component of DIP case management structures. The client's progress will be assessed against agreed standards and clinical tools to determine the offender's progression through the treatment system.	
CJS Consideration 3: Non-offending & treatment engaged DIP clients can be referred to Open Access prescribing but under the same terms of parity as community populations. They will remain prescribed and case managed by DIP until a vacancy has been identified for them on the waiting list.	
CJS Consideration 4: Presenting population offenders differ from non-offenders and they are also governed by a different set of policy directives. As such it is not possible to develop a direct parity between Criminal Justice interventions and the wider treatment services as offending substance misusers' clinical profiles are not the same as non-offending substance misusers. Their criminal behaviour and recidivism is linked to high rates of poor impulse control disorders that will require a different treatment focus.	
CJS Consideration 5: Criminal Justice interventions should be oriented around the Risk-Need-Responsivity approach. The primary 8 domains should be embedded within the treatment framework, specifically in assessment, care planning and intervention packages. This structure should house a wide range of intervention that are targeted at addressing dynamic needs in these domains. This should utilise behavioural and CBT approaches as principle modalities.	
CJS Consideration 6: The Specification should require potential Service Providers to describe how they will embed the Risk, Need, Response framework into the care management of offending drug and alcohol users. This should include the interventions that will be provided according to the 8 domains and the format of delivery.	
CJS Consideration 7: Screening for ADHD should be routine amongst offenders with a history of key indicators and responses should align with good practice frameworks.	
CJS Consideration 8: Organisation practice policy should incorporate the recommendations of NICE on the management of personality disorder.	
CJS Consideration 9: All staff working within the Criminal Justice settings should be trained in understanding personality disorder and how its presentation and symptoms differ from mental illness in line with the Personality Disorders BREAKING THE CYCLE OF REJECTION THE PERSONALITY DISORDER CAPABILITIES FRAMEWORK National Institute for Mental Health in England.	
CJS Consideration 10: Better identification of personality disordered offenders may lead to greater utilisation of the Offender Personality Disorder pathway. The service provider should ensure clarity of referral thresholds within the role in a wider pathway's framework.	
CJS Consideration 11: Better identification of Personality Disordered offenders may lead to greater utilisation of the	

Offender Personality Disorder pathway in Gwent. The Service Provider should ensure clarity of referral thresholds within the role in a wider pathway's framework.	
CJS Consideration 12: The Service Provider will adopt the recommended procedures and practices from the imminent review of supporting female offenders in Wales.	

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