Joint Commissioning Panel for Mental Health
www.jcpmh.info

Co-chaired by:

Royal College of General Practitioners
Royal College of Psychiatrists

Membership:

Mind
For better mental health

nssun

Rethink Mental Illness

The British Psychological Society
Promoting excellence in psychology

HFMA
MH Finance

Mental Health Providers Forum
Voluntary Agencies Working Together to Improve Mental Health

Mental Health Network
NHS Confederation

Royal College of Nursing

The Afya Trust

Directors of Adass
Adult Social Services

National Involvement Partnership

The New Savoy Partnership
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Ten key messages for commissioners

1. Investment in drug and alcohol services gets results. Treatment, as part of a co-ordinated public health approach is proven to be cost effective for health services and society as a whole. Disinvestment brings with it a risk of reversing the progress made over recent years.

2. A strong evidence base exists for the range of interventions that are effective in substance misuse. Commissioning should be based upon this evidence using NICE quality standards.

3. To be effective, the treatment system should be equipped to respond to the full range of complexity of need represented by those who misuse substances.

4. A skilled workforce, working under appropriate supervision and providing care within national competence frameworks, is key to delivering good outcomes.

5. Collaboration and partnership gets results. The NHS and voluntary sector have a contribution to make in the delivery of drug and alcohol services.

6. Commissioning of drug and alcohol services should be based upon accurate and up to date information about local needs.

7. Commissioners should ensure that local services have clear leadership, both clinical and managerial, and that services comply with professional and service standards.

8. Commissioning of drug and alcohol services should be outcome based and make use of available data and information.

9. Services should place recovery at the centre of their approach and commissioners should recognise recovery as central to their commissioning and strategic decision making.

10. Treatment is not simply about patients – it should address the needs of families and carers, and work with patients' wider social networks.
Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. It brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- People with mental health problems
- Carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- British Psychological Society
- Representatives of the English Strategic Health Authorities (prior to April 2013)
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning

The JCP-MH is part of the implementation arm of the government mental health strategy *No Health without Mental Health*.

The JCP-MH has two primary aims:

- to bring together people with mental health problems, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, the experience of people with mental health problems and carers, and innovative service evaluations, in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published *Practical Mental Health Commissioning*, a briefing on the key values and principles for effective mental health commissioning
- has so far published seven other practical guides on the commissioning of primary mental health care services, dementia services, liaison mental health services to acute hospitals, transition services, perinatal mental health services, public mental health services, and rehabilitation services
- provides practical guidance and a developing framework for mental health
- will support commissioners to deliver the best possible outcomes for community health and wellbeing.

**WHO IS THIS GUIDE FOR?**

This guide has been written to provide practical advice on developing and delivering local plans and strategies to commission the most effective and efficient drug and alcohol services for adults.

Based upon clinical best practice guidance and drawing upon the range of available evidence, it describes what should be expected of a modern drug and alcohol service in terms of effectiveness, outcomes and value for money.

The guide will be of particular use to:

- public health leaders who will hold responsibility for commissioning these services
- Clinical Commissioning Groups (CCGs)
- wider local authority commissioners
- and voluntary and independent sector organisations.

This guide does not cover drug and alcohol services for children or offenders, whose needs may be more specific. More information can be found in the publication *Practice Standards for Young People with Substance Misuse Problems*.
HOW WILL THIS GUIDE HELP YOU?

This guide has been written by a group of drug and alcohol professionals, people who use drug and alcohol services, and carers. The content is primarily evidence-based, but ideas deemed to be best practice by expert consensus have also been included.

By the end of this guide, readers should be better equipped to:

• understand what an effective range of drug and alcohol services should look like
• know the sorts of interventions that should be available
• understand how those interventions can contribute to achieving recovery and make improvements in public mental health and wellbeing.

In doing this, the guide describes:

• the benefits of drug and alcohol services
• the desirable team configurations for drug and alcohol services
• the policy context for drug and alcohol services

• what good quality drug and alcohol services look like
• the benefits of providing good quality drug and alcohol services
• how drug and alcohol services can make a contribution to a range of other imperatives including those in the national mental health strategy.

The guide draws upon, and signposts towards, previously published guidance and policy. Among the key documents drawn upon are:

• NICE quality standards for alcohol dependence and harmful alcohol use (QS11)\textsuperscript{11}
• Alcohol dependence and harmful alcohol use CG115 (NICE)\textsuperscript{12}
• NICE quality standards for drug use disorders (QS23)\textsuperscript{13}
• Drug misuse – psychosocial interventions CG51 (NICE)\textsuperscript{14}
• Drug misuse – opioid detoxification CG52 (NICE)\textsuperscript{15}
• Improving outcomes & supporting transparency – a public health outcomes framework for England, 2013-16 (Department of Health)\textsuperscript{16}
• The Government’s Alcohol Strategy (HM Government 2012)\textsuperscript{17}

• JSNA Support Pack for Commissioners (National Treatment Agency)\textsuperscript{18}
• No Health without Mental Health (DH)\textsuperscript{1}
• Medications in recovery. Re-orientating drug dependence treatment (National Treatment Agency 2012)\textsuperscript{19}
• Commissioning for Recovery (National Treatment Agency)\textsuperscript{20}
• Drug Strategy 2010 – Reducing Demand, Restricting Supply, Building Recovery (HM Government)\textsuperscript{21}
• Healthy lives, healthy people: our strategy for public health in England (HM Government)\textsuperscript{22}
• the roles and competencies of doctors working in substance misuse\textsuperscript{23}
• Alcohol use disorders: physical complications CG100 (NICE)\textsuperscript{24}
• Alcohol disorders – preventing the development of hazardous and harmful drinking PH24 (NICE)\textsuperscript{25}

This guide does not cover non-structured interventions for non-dependent drinkers.
What are drug and alcohol services?

Effective treatment provides a central means for people dependent on drugs or alcohol to recover from their addiction and to live independent lives. It can deliver a wider range of public health and social benefits, and can also bring about economic savings at the local and national level (see page 9).

Local authority-based public health is now responsible for commissioning drug and alcohol prevention, treatment and linked recovery support. This shift will provide a platform for a more integrated approach to improving public health outcomes. This approach addresses the root causes and wider determinants of drug dependence and alcohol misuse, and the harm and impact they have on people who use drugs or alcohol, carers, families and communities (such as mental health, employment, education, crime and housing). It also delivers the greatest gains for individuals and the community.

There is no nationally agreed model for the commissioning and delivery of drug and alcohol services. The result of this has been a continuation of local plans for services that attempt to address not only local need, but also national imperatives. Although a locally based approach is important it can have the negative consequence of different and varied approaches across the country.

However, the existence of NICE quality standards, the National Drug Treatment Monitoring System, local needs assessments, Joint Strategic Needs Assessment tools and the publication of guidance such as this, means that commissioners now have a wide range of tools to enable them to commission effectively.
Drug and alcohol services are mainly provided by NHS Trusts or voluntary sector services, although the private sector also plays a smaller role in provision.

In the majority of cases, patients coming to drug and alcohol services self-refer rather than being referred by a GP. Drug and alcohol services employ a range of expertise including front line doctors, psychologists, senior nurses, and drug workers. This skill mix makes them well equipped to conduct complex work with a client group often perceived as challenging.

In the past, drug and alcohol services tended to be provided by separate drug and alcohol teams, but recently they are more commonly delivered from teams that deal with both. These aim to provide a more integrated approach, particularly for those people who have a problematic use of both substances. For some people this approach has not been successful in relation to enabling access to services (e.g. due to the stigma associated with particular types of substance misuse).

Most secondary care services tend to concentrate their interventions on people with addictions to drugs such as heroin, crack cocaine and alcohol. However, other substances, for example emerging club drugs and prescribed drugs, may be among those for which people are treated. Given the complexity of these problems and the range of needs, services are required to collaborate with other parts of the health, social care and criminal justice systems. This is essential to the delivery of effective high quality treatment.

This is especially the case when providing services to those people with co-morbid illness, (e.g. substance misuse and mental illness, or substance misuse and physical health needs). This is often because people with co-morbid illness are often excluded from general mental health services. One of the functions of drug and alcohol services is to work with this group.

In parts of the country where Drug & Alcohol Action Teams (DAATs) are in operation, these have introduced Local Area Single Assessment and Referral Systems (LASARS) as part of a national pilot of drug recovery Payment by Results. The core function of LASARS is to assess and set a tariff, refer and in some cases review achievement of outcome. They may also reduce the number of assessments that an individual has to undertake in order to access those services.

**WHO WORKS IN THESE SERVICES?**

A wide range of people from a number of disciplines and specialisms work in drug and alcohol services including:

- medical staff including specialist doctors (addiction psychiatrists and a small number of highly specialist General Practitioners)
- nurses (both mental health and general nursing)
- drug and alcohol support workers
- non-medical prescribers (especially trained nurses or pharmacists)
- peer mentors
- pharmacists
- psychologists and other specialist therapists
- people who are experts by experience
- social workers/care managers.

Those working in drug and alcohol services are expected to work to a set of national occupational standards and, potentially, also the skills framework promoted by The Substance Misuse Skills Consortium. Alongside these are the competencies required by specific professional bodies, including the Royal College of Psychiatrists, Royal College of Nursing, Royal College of General Practitioners, and those representing other allied health and social care professionals.

The Substance Misuse Skills Consortium is an independent, sector-led initiative to harness the ideas, energy and talent within the substance misuse treatment field, to maximise the ability of the workforce, and help more drug and alcohol misusers to recover. Commissioners will find helpful guidance in the Drugs and Alcohol National Occupational Standards (DANOS) framework described later in this guide (page 14), but should be aware that it does not cover all professional groups.
Why are drug and alcohol services important to commissioners?

Among the reasons why drug and alcohol services are important to commissioners are:

1. drug and alcohol use can have a significant and negative impact on individuals and wider society
2. drug and alcohol use can also have a public health impact
3. considerable economic costs are associated with drug and alcohol use
4. there is a relatively common use of drugs and alcohol among the UK population
5. these harms, impacts and costs can be reduced through effective treatment, with important economic savings.

1 SOCIAL IMPACT
The Government’s drug strategy identifies that drug and alcohol problems not only negatively impact on the lives of people using these substances, but are also the “key causes of societal harm, including crime, family breakdown and poverty”21. For example:

- crime – there were 278,000 recorded drug offences in the UK in 2009/1028 and 9% of the population were engaged in illicit drug use in 2010/1129. As a society, although drugs cost the UK £15 billion each year29, investment in drug services has been estimated at approximately £1.3 billion per year28. However, drug treatment has been shown to be effective in preventing drug-related offending, with an estimated five million offences being prevented in 2010-11 alone30.

2 PUBLIC HEALTH IMPACT
The public health consequences of drug and alcohol use are also significant. The primary harms include transmission of blood borne viruses, including Hepatitis B, C and HIV. Estimates suggest that around 216,000 individuals are chronically infected with hepatitis C in the UK33.

There are also various forms of harm that may be caused by addiction to drugs or alcohol including acute harms:

- death by overdose
- intoxication
- accidental injury
- suicide
- precipitation or exacerbation of mental illnesses such as psychosis.

Chronic harms can also occur, including:

- cirrhosis and other liver damage
- consequences of injecting – for example, abscesses, vein damage, endocarditis
- sexually transmitted diseases
- dependence including withdrawal symptoms
- hypertension
- stroke
- coronary heart disease
- pancreatitis
- depression
- anxiety disorders.
3 ECONOMIC COSTS

Alcohol

There were 1.2 million alcohol-related hospital admissions during 2010/11\textsuperscript{17}. Alcohol consumption has nearly trebled since 1950 with more than seven million people drinking at harmful or hazardous levels and who together account for about 80% of all spending on alcoholic drink\textsuperscript{15}. It costs the NHS in England up to £2.7 billion a year to treat the chronic and acute effects of drinking\textsuperscript{24}. The Government’s alcohol strategy indicates that alcohol-related harm is now estimated to cost society £21 billion annually\textsuperscript{17}.

Drug use

Drug use costs the UK £15.4 billion each year, including welfare benefit expenditure costs of approximately £1.6 billion per year\textsuperscript{21}.

4 PREVALENCE

Drugs

Prevalence of substance misuse varies for different types of substances. Recent years have shown different patterns of use, with a trend towards an increase in the misuse of over the counter medicines and new substances, including those known as club drugs such as mephedrone, ketamine and legal highs.

BOX 1: REASONS FOR DRUG AND ALCOHOL USE

People use drugs and alcohol for a variety of reasons. For many people this use of substances does not turn into what is termed misuse. It is equally important to bear in mind that no-one starts using substances with the intention to develop misuse problems. Some of the reasons why people begin to use drugs and/or alcohol might include: because the initial reactions and experiences are pleasurable; response to social or family circumstances, such as bereavement/loss, unemployment, relationship difficulties, loss of accommodation; response to peer pressure; to remove stress or other psychological difficulties; criminal or other antisocial antecedents.

BOX 2: TYPES OF DRUG USE\textsuperscript{36}

Recreational use

Many people are able to use psychoactive substances in a recreational manner that causes no problems to the individual or those around them.

This pattern of use is usually characterised by moderate levels of consumption and periods when the person stops using the substance without difficulty.

Harmful use

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical or psychological.

Dependent use

Dependence has both psychological and physiological elements.

Psychological dependence involves a need for repeated doses of the drug to feel good, or avoid feeling bad.

Physiological dependence is associated with tolerance, where increased doses of the drug are required to produce the effects originally produced by lower doses, and development of withdrawal syndrome when the drug is withdrawn. Withdrawal syndrome is characterised by physiological and psychological symptoms that are specific to a particular drug. The term ‘dependence’ is often used interchangeably with ‘addiction’.


**BOX 3: PREVALENCE OF DRUG AND ALCOHOL USE**

- Estimates from the 2010/11 British Crime Survey show that 36% of adults aged 16-59 have used illicit drugs in their lifetime, which equates to almost 12 million people. Among this group, almost 9% or 2.9 million adults had used illicit drugs in the last year.

- The National Treatment Agency reported that in 2009-10 in England there were 306,000 users of opiates and/or crack cocaine corresponding to almost 1% of the adult population (this number represents the total number of users, rather than those in treatment alone). In 2011 reported use of mephedrone in the last 12 months was 1.4% and ecstasy 1.4% among 16-59 year olds.

- Investment in drug treatment services is widely recognised to have been a factor in the reduction of illicit drug use.

- Around 200,000 people get help for drug dependence in England every year, with around 135,000 being treated on any given day.

- Nearly one third of users in the last seven years successfully completed their treatment and did not return, which compares favourably to international recovery rates.

- Drug misuse in this country remains a significant factor in poor health outcomes, criminality and worklessness and continues to have far reaching effects upon individuals, families and society as a whole.

**Alcohol**

- Alcohol consumption in the UK has almost trebled since 1950 with more than 7 million people drinking at harmful or hazardous levels. Together they account for about 80% of all spending on alcoholic drink. Since 2002/03 there has been a 40% increase in admissions to hospital where the primary diagnosis was attributable to the consumption of alcohol.

- In the same period there were almost 168,000 prescription items for drugs for the treatment of alcohol dependency prescribed in primary care settings or NHS hospitals and dispensed in the community which is a 63% increase compared to 2003.

- Quantities of alcohol consumption across the population have been rising. Recent research shows that 24% of adults engage in hazardous drinking while nearly 4% engage in harmful drinking. Almost 6% of adults are known to be dependent on alcohol.

- Higher consumption of alcohol is associated with depression and the risk of suicide is eight times higher among those with current alcohol misuse or dependence. Alcohol misuse by young people is associated with a six-fold increased risk of depression.

- The Royal College of Psychiatrists report, *Our Invisible Addicts* showed that the misuse of drugs in older people (65 and over) is a problem that is likely to grow and that misuse in the over-40s has increased significantly in recent years. By 2031 there is predicted to be a 50% increase of complex substance misuse in the over 65s (e.g. excessive alcohol consumption as well as inappropriate use of prescribed and over the counter medications).

**Co-morbidity**

- The 2002 *Co-morbidity of Substance Misuse and Mental Illness Collaborative study* (COSMIC) concluded that:
  - 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems
  - 30% of the drug treatment population and over 50% of those in treatment for alcohol problems had ‘multiple morbidity’
  - 38% of drug users with a psychiatric disorder were receiving no treatment for their mental health problem

- 44% of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year.

- The term ‘co-morbidity’ covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:
  - a primary psychiatric illness precipitating or leading to substance misuse
  - substance misuse precipitating, worsening or altering the course of a psychiatric illness
  - intoxication and/or substance dependence leading to psychological symptoms
  - substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.

- The complexity of issues can make diagnosis, care and treatment more difficult, with service users being at higher risk of relapse, readmission to hospital and suicide.

- *Dual diagnosis: a challenge for the reformed NHS and for Public Health England* has reinforced the need for commissioners to develop effective services for dual diagnosis and that those services are central to the achievement of key policy objectives, including drug recovery.

**High risk groups**

- There are a number of groups of people who may be at higher risk of misuse of drugs and alcohol. As an example, recent research has shown that drug use among Lesbian Gay Bisexual and Transgender groups is higher than among their heterosexual counterparts, irrespective of gender or the different age distribution in the populations.
5 EFFECTIVE TREATMENT CAN REDUCE HARM AND INCREASE ECONOMIC SAVINGS

Commissioners know that drug and alcohol misuse affects an individual’s health and impacts their local communities. The impacts outlined in this guide should all be of interest and importance to commissioners as they seek to meet the health needs of local populations, and deliver improved public health and wellbeing.

Where provided by trained and experienced staff, the evidence base for drug and alcohol treatment is strong, demonstrating the positive impact that such services can have. From a purely economic point of view, investment in effective treatment and recovery services makes sense for commissioners as they seek to ensure good value for the public purse. The National Institute for Health and Clinical Excellence (NICE) produced clinical guidance for these services in 2007, accompanied by a Costing Report for their implementation. The Costing Report indicates that:

- the total savings through implementing the guideline attributable to healthcare have been estimated as being almost £4 million
- an additional £37 million of savings to society have been estimated outside of the NHS in the criminal justice system
- at an individual level research has shown that for every £1 spent on treatment, an estimated £2.50 is saved.

Good quality drug and alcohol services are important to commissioners for more than purely financial reasons. They can help people to achieve their recovery potential and as such benefit individuals directly. Intervening early can reduce the chances of ongoing misuse and the consequent harms it may cause, thus reducing demand on the use of NHS and other public services in the future.

This can be particularly important given the statistics in relation to co-morbidity. Within the substance misuse treatment sector, the prevalence of dual diagnosis has been estimated at around 75% for those in drug services, and 85% for those in alcohol services. In mental health service settings, prevalence studies have indicated that around one-third of people with serious mental health problems (such as psychosis and bipolar disorder) have some level of substance use problems.

Commissioning quality drug and alcohol services will help to address the health and well being needs of the local population, reduce the burden on services and help achieve improved value for money. Drug services have developed significantly over recent years, in part due to increased investment and clear delivery imperatives. The investment in drug services has led to improved access to services coupled to a reduction in waiting times for treatment and support:

- of the approximately 204,000 clients aged 18 and over in treatment contact during 2010-11, just over 191,000 were in treatment for 12 weeks or more, or completed treatment free of dependency before 12 weeks (93%)
- nearly all clients waited less than three weeks to commence treatment (96%) – successful completion of treatment in 2011-12 was up by almost three times the level seven years prior (approximately 11,000).

These figures tell a story of success in terms of improving access and outcomes in drug services. However they do not highlight the variation in service provision and quality across the system. In part this has been a consequence of the varying priority commissioners have placed upon investment in high quality drug and alcohol services. We also know that some services have found it hard to offer a comprehensive range of interventions and to link effectively with other services, particularly in cases of co-morbidity and complex needs.

In terms of alcohol services, there were just over 111,000 clients in contact with structured treatment aged 18 and over who cited alcohol as their primary problematic substance in 2010-11. More than four-fifths (82%) of all clients waited less than three weeks to commence treatment. The number of new treatment journeys commencing in the year increased to almost 74,000 in 2010-11. The number and proportion of successful completions also increased from approximately 31,000 (48%) in 2009-10 to nearly 36,000 (54%) in 2010-11.

These figures show improvement, but the relative lack of investment in alcohol services and minimal prioritisation of alcohol treatment explains in part why these services have been described as being patchy and in some places underdeveloped.

Commissioners need to take account of the necessity to enable providers to (a) offer the NICE guideline approved psychological and pharmacological treatments and (b) plan service developments that align with public health needs and imperatives, as well as emerging quality standards developed by NICE.
What do we know about current drug and alcohol services?

The last decade saw considerable investment in the planning and provision of drug services in England and more people have had access to services. For example in drug services, there has been a doubling in the number of people receiving treatment, while waiting times have reduced significantly.

The picture is less encouraging in relation to alcohol services. Recent reports suggest that PCTs on average spent only 0.1% of their budgets on alcohol services. The Health Select Committee reported in 2010 that many commissioners did not have a strategy for alcohol services and it was acknowledged that the picture in relation to provision was patchy. In the past 18 months the policy direction has shifted, not only in respect of drug and alcohol services but across health and social care more broadly.

Below we set out the key areas of policy that impact on the commissioning of drug and alcohol services.

GOVERNMENT STRATEGIES: DRUGS, ALCOHOL, AND MENTAL HEALTH

- The Drug Strategy: published in March 2012, this sets out the Government’s proposals to address alcohol use. It focuses on plans to deal with ‘binge drinking’. It also aims to reduce alcohol related violence and disorder and reduce the number of people drinking to damaging levels. www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary

- The mental health outcomes strategy for people of all ages: ‘No Health without Mental Health’ makes a commitment to ‘parity of esteem between mental and physical health services’, and has a clear objective to improve the physical health of those with a mental disorder. The strategy is now supported by an Implementation Framework. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

NHS REFORMS

A range of changes to the way in which services are commissioned and delivered are contained in the Health and Social Care Act. They include:

- Clinical Commissioning Groups: hold the local budget for health care and are responsible for deciding what services should be delivered and by whom. They will be accountable to NHS England.

- NHS England: will support and regulate the CCGs, and it will have a limited commissioning function in respect of specific national services.

- ‘Any Qualified Provider’: the market environment in the NHS and social care has expanded to admit a wider range of independent and voluntary sector providers.

- Health and Wellbeing Boards (HWBs): The aim of HWBs is to consider how prioritising health improvement and prevention will best deliver benefits for the health and wellbeing of the local population.

- Public Health England (PHE): PHE will take on the responsibility for the monitoring of drug treatment through its Knowledge and Information Directorate. Directors of Public Health will be located within local authorities, which will have responsibility for health improvement within their areas.

- Outcomes: Improving outcomes & supporting transparency – A public health outcomes framework for England, 2013-16 was published in early 2012. It sets out two outcome measures to improve and protect the nation’s health and wellbeing, and improve the health of the poorest fastest:
  - outcome one: increased life expectancy, i.e. taking account of the health quality as well as the length of life
  - outcome two: reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

The outcomes have four domains and a set of indicators. Table 1 (overleaf) sets out the outcomes that are of relevance to drugs and alcohol services.
The drug strategy: ‘Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life’

Commissioning which leads to good drug and alcohol services as described in this guide will support the delivery of the national drug strategy. By commissioning for outcomes and recovery, commissioners can enable services to:

- enable people to be free from dependence on drugs or alcohol
- prevent/reduce drug related deaths and blood borne viruses
- improve mental and physical health and wellbeing
- contribute to a reduction in crime and re-offending
- improve the ability of patients to access and sustain suitable accommodation

- improve the ability of patients to gain and maintain appropriate employment and/or training as part of their recovery
- provide accurate information on drugs and alcohol through substance misuse education.

These are among some of the central elements that the drug strategy seeks to deliver.

The Government’s alcohol strategy

Effective alcohol services will support the delivery of the objectives described in the Government’s alcohol strategy. Commissioners should commission services that will:

- contribute to a reduction in the number of alcohol-related deaths
- a reduction in the number of adults drinking above the NHS guidelines.

These are among some of the central elements that the alcohol strategy seeks to deliver.

NICE guidelines

Drug and alcohol services should be commissioned to provide a range of interventions, including those recommended by NICE. Of particular importance is the need for commissioners to ensure services will deliver NICE guideline TA114 in respect of the management of opioid dependence and NICE Guideline CG51 in respect of psychosocial interventions for drug misuse.

Drug and alcohol services should also be able to demonstrate adherence to the NICE quality standards (boxes 6 and 7).

| TABLE 1 |
| Domain | Improving the wider determinants of health | Health improvement | Health protection | Healthcare public health and preventing premature mortality |
| Indicators | People with mental illness or disability in settled accommodation | Hospital admissions caused as a result of self-harm | People presenting with HIV at a late stage of infection | Mortality from causes considered preventable |
| Re-offending | Successful completion of drug treatment | Public sector organisations with board-approved sustainable development management plans | Mortality from liver disease |
| Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness | People entering prison with substance misuse issues who are previously not known to community treatment | | Mortality from communicable diseases |
| Domestic abuse | Alcohol related admissions to hospital | | Suicide |
| Violent crime (including sexual violence) | Self reported wellbeing | | Excess under 75 mortality in adults with serious mental illness |
| Statutory homelessness | | | |
What would a good drug and alcohol service look like?

A good drug and alcohol service should be comprised of a number of elements. This section sets out some of the key issues for commissioners to think about.

**KEY COMPONENTS OF A GOOD QUALITY SERVICE**

A comprehensive drug and alcohol service will have the following features:

* Assessment of patients’ needs
  - the provision of comprehensive assessment of need, including risk assessment using recognised tools
  - ensuring that assessment of need includes not only the needs that arise from their substance use, but identifies the recovery goals and outcomes the service will seek to achieve with the patient
  - taking account of the physical needs of the patient including the harms associated with substance misuse, including blood borne virus screening
  - taking account of the psychiatric and psychological needs of the patient, including psychosis, depression, cognitive impairment and broader issues of health and wellbeing
  - taking account of social factors including housing and homelessness, employment and social and family networks.

* The provision of a range of interventions, which may include:
  - structured psychological and psycho-social interventions – commissioners should refer to NICE guidance and quality standards for more information about specific interventions
  - appropriate and timely access to prescribing including opioid substitution therapy including methadone, buprenorphine, giving access to injectable treatments where this is clinically indicated
  - medically assisted withdrawal for alcohol, opioids and other drugs
  - access to appropriate in-patient beds for those people who require a period of admission
  - peer led support – where people provide knowledge, experience, emotional, social or practical help to each other (peer support relies on the assets, skills and knowledge in the community, and the recognition that local people can offer help in ways that are sometimes more effective than professional help)55
  - a directory of all local services should be available to both professionals and the public – commissioners should ensure that such a directory exists in a range of ways that enable easy access to information
  - signposting to other services, such as needle exchange, sexual health, housing, employment, mental health services including talking therapies
  - be a source of information and advice to other services, including colleagues in primary care, general hospitals, adult social care and children’s services
  - fulfil responsibilities relating to child protection and adult and child safeguarding
  - the provision of support for families and carers, including the conducting of carer assessments to identify support needs.

**Workforce standards**

Commissioners will need to commission drug and alcohol services that can demonstrate that they meet the necessary statutory standards as set out by the relevant professional regulatory bodies.

Individual professionals working in drug and alcohol services should be able to demonstrate and meet a range of core standards and competencies.

There are a number of other advisory and regulatory bodies including NICE, CQC and Royal Colleges of Psychiatrists and General Practitioners, Nursing & Midwifery Council, General Medical Council, British Pharmaceutical Association, British Psychological Society, the Health Care Professions Council, and British Association of Social Workers.

This guide has described the range of professionals that are often employed in drug and alcohol services. To be able to provide the right range of interventions and services, commissioners and providers will need to ensure there is a mix of appropriately qualified and skilled staff working within the service.

The Drugs and Alcohol National Occupational Standards (DANOS) specify the standards of performance that people in the drugs and alcohol field should be working to. They also describe the knowledge and skills workers need in order to perform to the required standard. DANOS can be used to ensure that services have a competent workforce and that everyone has the knowledge and skills to deliver services to the required quality standards57.
A good drug and alcohol service will usually function best as a specialist, integrated team that includes a range of professional health and social care staff, under single management. Commissioners and patients should expect any services to have at its core the aim of providing a holistic and personalised care package for patients that is both tailored to their specific needs and which is focused on recovery. The Expert Reference Group that has developed this guide, has produced the set of core principles described below to assist commissioners. These state that a good drug and alcohol service should be:

- commissioned on the basis of local need and recognise the motivations that underpin drug and alcohol use
- staffed by an appropriately qualified and skilled group of staff working within agreed standards of competence with the necessary levels of supervision and support – there should be sufficient staff to ensure there is the capacity to maintain the service
- able to manage the full range of complexity of need, including being able to address the issues of co-morbidity including mental and associated physical health needs
- providing interventions that are evidence based and should implement the relevant NICE guidance
- providing a therapeutic environment for patients that is non-judgmental where they can expect to receive a good quality assessment of their needs and a range of evidence based treatments
- working with patients to enhance their recovery potential and address not only their substance dependence but also the other factors impacted by that dependence, including housing, employment and social and family networks
- providing continuity of care in supporting people in recovery
- establishing, maintaining and building on good links with other services, including mental health services and have a good knowledge of other local resources
- using data and information to enable regular and accurate performance monitoring and review of effectiveness and outcomes
- providing value for money to commissioners and the public purse.

Commissioners will be able to review performance by using data from the National Drug Treatment Monitoring System (NDTMS) and use other NHS and social care national outcome frameworks to ensure delivery of improved outcomes.

The DANOS standards are applicable to a range of professionals working in substance misuse services including commissioners of substance misuse services, drugs and alcohol workers, psychiatrists, psychotherapists, social workers and probation officers who regularly work with substance misusers.

The sorts of skills that should be expected to be present within drug and alcohol services should include:

- assessment of substance misuse
- risk assessment and management
- care planning
- knowledge of the law in respect of drugs and alcohol
- knowledge of other relevant legislation including the Mental Health Act, the Mental Capacity Act and Safeguarding
- knowledge of other local services and agencies including the criminal justice system, housing, adult social care, children’s services.

Commissioners and providers should also be able to ensure that the workforce is suitably equipped to meet the quality standards described by NICE for the delivery of specific intervention in drug and alcohol services.

Outcomes

There is increasing emphasis on the delivery of outcomes in health services, not just in terms of the wider public health outcomes described earlier in this guide, but more specifically those that apply to the service provided and the outcomes experienced by the patient. Commissioners may apply their own outcomes at local level, in partnership with providers, as part of their planning and review processes.
Practical Mental Health Commissioning

COMMISSIONING PROCESS

The commissioning process has been well described in a range of JCP-MH guides, including *Practical Mental Health Commissioning*, published in March 2011.

The National Treatment Agency has also developed specific guidance for the commissioning of recovery focused drug and alcohol services with a set of resources to support the Joint Strategic Needs Assessment process.

Both documents provide commissioners with helpful information about the commissioning process and are recommended for further reference. Alongside those documents, the *top-tips* in *Box 5* should help commissioners in their thinking when commissioning a drug and alcohol service.

**BOX 5: COMMISSIONING PRINCIPLES**

- the commissioning process is a continuous cycle through three key stages: strategic planning, procuring services and monitoring and evaluation – commissioning should be a dynamic process that is about identifying and prioritising need and apportioning resources to meet those needs and achieve positive outcomes in a spiral of continuous improvement.

- examine the current services, statutory, independent and voluntary sector to determine what exists now and what might be needed in the future – understand the drug and alcohol treatment system locally, and address recovery challenges.

- the Joint Strategic Needs Assessment process should be used to establish local patterns of need and in partnership with other stakeholders agree local priorities for investment and development and decommissioning where necessary – taking account of service re-design, changing service models and practice, and ensuring the provision of an appropriately skilled and experienced workforce.

- ensure that service providers are able to deliver a range of services, with an appropriate mix of staff that will effectively address the complexity of issues that those with addiction present – this should include co-morbidity with mental health and physical health problems.

- ensure there is an appropriate range of services that are able to meet demand and secure required clinical treatment, reintegration and recovery outcomes, and decide which provider(s) will best meet the local needs and procure clinically effective services. In doing so commissioners should be particularly mindful of issues of quality and patient safety, and where appropriate commissioners should stimulate the local market to ensure the value for money, the right range of provision and improved outcomes.

- use the national benchmarks as a guide for quality and standards including NICE guidance for drug and alcohol services and interventions, CQC standards and relevant good practice guidance. Work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes, and ensure linkage to clinical and corporate governance requirements and monitor delivery, effectiveness, outcomes and costs.
**Box 6: NICE Quality Standards for Alcohol Dependence and Harmful Use**

**Statement 1**
Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.

**Statement 2**
Health and social care staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice.

**Statement 3**
People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment.

**Statement 4**
People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff.

**Statement 5**
Adults accessing specialist alcohol services for alcohol misuse receive a comprehensive assessment that includes the use of validated measures.

**Statement 6**
Children and young people accessing specialist services for alcohol use receive a comprehensive assessment that includes the use of validated measures.

**Statement 7**
Families and carers of people who misuse alcohol have their own needs identified, including those associated with risk of harm, and are offered information and support.

**Statement 8**
People needing medically assisted alcohol withdrawal are offered treatment within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric co-morbidities.

**Statement 9**
People needing medically assisted alcohol withdrawal receive medication using drug regimens appropriate to the setting in which the withdrawal is managed in accordance with NICE guidance.

**Statement 10**
People with suspected, or at high risk of developing, Wernicke’s encephalopathy are offered thiamine in accordance with NICE guidance.

**Statement 11**
Adults who misuse alcohol are offered evidence-based psychological interventions, and those with alcohol dependence that is moderate or severe can in addition access relapse prevention medication in accordance with NICE guidance.

**Statement 12**
Children and young people accessing specialist services for alcohol use are offered individual cognitive behavioural therapy, or if they have significant comorbidities or limited social support, a multi component programme of care including family or systems therapy.

**Statement 13**
People receiving specialist treatment for alcohol misuse have regular treatment outcome reviews, which are used to plan subsequent care.
The quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for people with drug use disorders.

**Statement 1**
People who inject drugs have access to needle and syringe programmes in accordance with NICE guidance.

**Statement 2**
People in drug treatment are offered a comprehensive assessment.

**Statement 3**
Families and carers of people with drug use disorders are offered an assessment of their needs.

**Statement 4**
People accessing drug treatment services are offered testing and referral for treatment for hepatitis B, hepatitis C and HIV and vaccination for hepatitis B.

**Statement 5**
People in drug treatment are given information and advice about the following treatment options: harm-reduction, maintenance, detoxification and abstinence.

**Statement 6**
People in drug treatment are offered appropriate psychosocial interventions by their keyworker.

**Statement 7**
People in drug treatment are offered support to access services that promote recovery and reintegration including housing, education, employment, personal finance, healthcare and mutual aid.

**Statement 8**
People in drug treatment are offered appropriate formal psychosocial interventions and/or psychological treatments.

**Statement 9**
People who have achieved abstinence are offered continued treatment or support for at least six months.

**Statement 10**
People in drug treatment are given information and advice on the NICE eligibility criteria for residential rehabilitative treatment.

**BOX 7: NICE QUALITY STANDARD FOR DRUG USE DISORDERS**

What would a good drug and alcohol service look like? (continued)
Supporting the delivery of the mental health strategy

The JCP-MH believes that commissioning which leads to good drug and alcohol services as described in this guide will support the delivery of *No Health without Mental Health*.

**Shared objective 1:**
More people will have good mental health.
Commissioning effective drug and alcohol services will enable the identification of associated mental health problems and ensure access to appropriate assessment, diagnosis treatment and support.

**Shared objective 2:**
more people with mental health problems will recover.
Many people with drug and alcohol problems have co-morbidity, therefore effective services will be able to jointly work with people, alongside mental health services utilising a recovery oriented approach that enables them to achieve greater independence and enhance their prospects of sustained recovery.

**Shared objective 3:**
more people with mental health problems will have good physical health.
Ensuring the provision of effective drug and alcohol services will enable those people who have co-morbid mental health problems to have their physical health needs properly assessed and treated. The identification of these needs and action to address them will result in improved physical health.

**Shared objective 4:**
more people will have a positive experience of care and support.
Addressing drug and alcohol dependency alongside mental health problems (where they are present) can improve the chances of the patient experiencing a more holistic service that should have a positive impact on their health and wellbeing. A joined-up approach is more likely to improve a person’s experience of services. The use of peer support and mutual aid can be a helpful means through which to engage those who use services in a contribution, not only to recovery, but to building a positive experience of care and treatment for others.

**Shared objective 5:**
fewer people will suffer avoidable harm.
Assessing the risk of harm and providing a service that will have as one of its aims an objective to reduce it should help to reduce the incidence of harm, reduce the need for future intervention such as hospital admission and ongoing treatment, and provide patients with strategies for remaining free from both harm and dependence on drugs and/or alcohol.

**Shared objective 6:**
fewer people will experience stigma and discrimination.
By commissioning services that recognise the connections and linkages between drug and alcohol misuse and mental health problems, commissioners will be actively addressing the stigma and discrimination that many people experience as a consequence of their addiction and/or mental health needs.
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**Development process**

This guide has been written by a group of drug and alcohol service experts, in consultation with patients and carers. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts. Final revisions to the guide were made by the Chair of the Expert Reference Group in collaboration with the JCP’s Editorial Board (comprised of the two co-chairs of the JCP-MH, one user representative, one carer representative, and technical and project management support staff).

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This guide was led and written by Steve Appleton, Owen Bowden Jones, and Chris Fitch.

**Steve Appleton**

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