LBTH Drugs and Alcohol Services Options Appraisal
'Journeys to Recovery'

1. Introduction

1.1 This report sets out the options requested by the DAAT Board to establish the most appropriate procurement packages for the forthcoming re-procurement exercise (due for completion January 2015). The context for this work has been set by the need to re-procure existing DAAT contracts and is supported by the recently completed Substance Misuse Needs Assessment and Service Review presented to the DAAT Board on 21st February 2014.

1.2 The options laid out in section 3 below were originally outlined in the Tower Hamlets Substance Misuse Service Review report. This document seeks to expand these options and to identify the most appropriate options to take forward into the re-procurement process due to start in April 2014.

1.3 However, it is important to contextualise the various options within the parameters in which they were developed as there are a number of pressing priorities for the Tower Hamlets treatment system which include: some long term structural design issues with different services appended to it over time meaning that it has not benefitted from being planned systematically planned. A previous attempt to reconfigure the treatment system was started in 2011 but this work was abandoned due to the announcement that all substance misuse services would transfer from the PCT to the Council in April 2013.

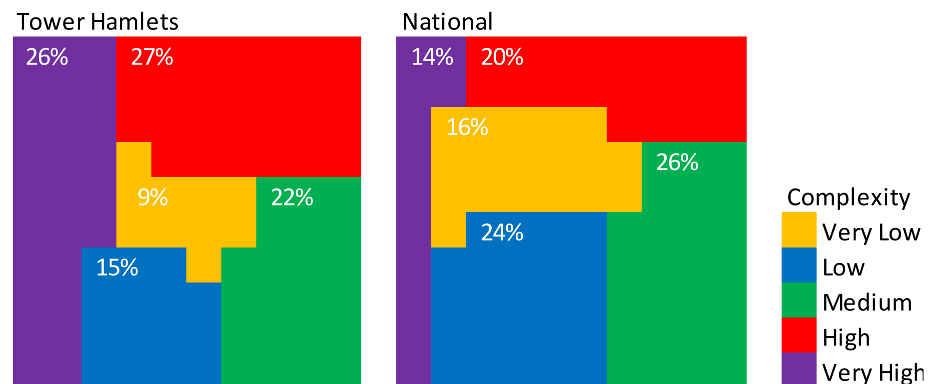
1.4 However, the time is now right to address the structure of the treatment system, to review the policy and treatment priorities of the DAAT Board and to assess the most effective model of provision for Drugs and Alcohol services in the borough.

2. Borough service priorities

2.1 The treatment system as it is now has been largely in place for over a decade. During this time there has been limited opportunity to review the treatment system as a whole and hence the system has emerged rather than being holistically planned. As a consequence, the borough has a treatment system that is focused on opiate substitution and addressing presentation through the Criminal Justice System.

2.2 Clients presenting to the treatment system are typically more complex than nationally – meaning interventions need to reflect this complexity to support clients effectively in their journey to recovery. Nonetheless the DAAT is committed to provide a treatment system that gives people the tools to maintain their lives and to build their capacity to move towards a life where drugs and alcohol do not have a negative impact on their lives and the wider community.

Figure 1: Tower Hamlets client complexity compared to national average September 2013 **(Source: NDTMS Diagnostic Recovery Toolkit September 2013 Data)**



2.3 There is a strong health focus of treatment and many service users have their opiate substitutes prescribed by local GPs under a 'Shared Care' arrangement with local treatment providers. These prescriptions are designed to stabilise and maintain these service users. However, only a small proportion of those in treatment have access to wider recovery and cessation orientated psychosocial interventions. This situation needs to change particularly as the borough is being challenged to increase its successful completions (a proxy outcome measure for recovery). Whilst it is clear that many in the treatment system are not ready to become drug and alcohol free, measures need to be put in place to support this aim and in particular the treatment system needs to be structured to enable this outcome orientation to be a central theme for the treatment in the borough.

2.4 Therefore the priorities and dynamics of the treatment system in this context are to achieve:

- Better Recovery Focus
- Improved Performance Management
- Simplified Governance structures
- Relevant staffing and capacity within the DAAT Team
- Coordination of resources and budgets to achieve strong VfM and service quality

2.5 The key priorities highlighted through the needs assessment and the service reviews were to:

- Maintain opiate priorities within the system
- Expand non-opiate provision
- Integrate drugs and alcohol services
- Rationalise and reduce number of provider
- Regularly review and scrutinise substitute prescribing
- Increase psychosocial interventions
- Build stronger recovery capital of clients
- Reduce client key worker ratios and support the role of key workers
- Increase 1-1 and group counselling/work
- Increase client readiness for structured treatment and maximise the outcomes from inpatient detox (drugs and alcohol)
- Maximise the outcomes from residential rehabilitation
- Review information management systems to better understand how best they serve strategic and service level needs

- Maintain a client focused services fit for purpose that encompasses strong client involvement and peer led recovery outcomes

3. Options

3.1 The options below are designed to structure the borough's treatment system to reflect the key points in the treatment journey and to apportion the right resources needed to support clients to move from treatment entry, through treatment and ultimately successfully exiting treatment.

3.2 Each option builds on the one before and moves towards a reducing number of providers. The reduction in providers is being sought as a way to free up resources for front end service delivery and to remove the duplication in the current treatment system. This approach allows a gradual and incremental shift from the current system to one which is being targeted by many DAATs to secure the best outcomes for local drugs and alcohol clients. Equally one will need to be mindful to ensure that all Tiers 1-4[1] are included in the treatment system and whilst the current system is focused on Tier 3 interventions, there is a real need to ensure that Tiers 1 and 2 are addressed. Tier 4 treatment is held within separate budgets and will be managed by the Tier 4 Panel accordingly.

3.3 The emerging options are set out as options appraisal headings below:

Option **One**: Standstill (23 contracts) (leave the treatment system largely as it is) but with single point of system entry, triage and comprehensive assessment with onward referral to provider services

Option **Two**: Main treatment provider for Tier3 treatment (all drugs) separate recovery/support contracts (10-15 contracts + Alcohol). Therefore combine the main treatment provision for tier 3 treatment (opiate and non-opiate) into one contract including treatment entry, assessment, pharmacological and psychosocial interventions. This would work with targeted access points into treatment and additional recovery providers offering the full menu of recovery support

Option **Three**: Two drug + Alcohol treatment contracts one for treatment and one for recovery (2 contracts). Single Drug treatment provider for all Tiers 2-3 treatment, this option should coexist with a range of separately commissioned recovery agencies, targeting their work solely on recovery activity.

Option **Four**: Single integrated drugs and alcohol service contract. (1 Contract)

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[1] Tier 1: non-substance misuse specific services requiring interface with drug and alcohol treatment; Tier 2: open access drug and alcohol treatment services; Tier 3: structured community based drug treatment services; Tier 4 services: residential services for drug and alcohol misusers

3.4 It should be noted that the following are applicable to options Two to Six:

- Remodelling of 'Shared care' with the option for it to be managed within a service provider contract
- Comprehensive treatment modalities from treatment entry through to successful completion including Tiers [2-3] provision
- Relocation of services to a possible hub and spoke model utilising key premises across the borough (NSEW&C)
- Specialist detox/rehab providers commissioned via the Tier 4 Panel
- Utilise the current DIP based outreach team across all providers and support effective engagement and through care across the treatment system.
- Individual or consortium bids would be welcomed and there would be a requirement in the former for partnership/service agreements with provider partners to secure the aims and specified outcomes of this re-procurement process particularly if there is a mixed range of providers delivering services.

3.5 Peer and Service user focus is critical in all the options, indeed it would be hoped that the borough could support the establishment of peer led recovery support, including the establishment of recovery champions, support through volunteers to provide weekend and evening 'drop ins' and to extend service hours generally to improve access, through-care and aftercare support for clients.

3.6 In order to ensure consistency each appraisal will include:

- Option Description
- Service profiles
- Option cost and cost against current budget
- Strengths and weaknesses
- Likely service impact
- Value to the client
- Value to the treatment system
- Preconditions for success
- Procurement focus, what we expect from the providers
- Outcomes

Modelling

3.7 In terms of the modelling especially for the costs and outcomes that have been set in this appraisal we are using a baseline service cost of the 2013-14 budget. This total funding is kept consistent in all the options to ensure integrity of the model. However within this budget is reallocated to the activities critical; to the service provision and to recovery including, budgets for referral, treatment, recovery, Shared Care or GP purchased activity and Tier 4. Against each of these cost profiles we have gauged commissioning outcomes to assess this element of the options appraisal.

4. Review of each option

4.1 **Option One**: **Largely standstill** (23 contracts) (i.e. leave the treatment system as it is) but with single point of entry. Therefore within existing 'structure' establish a single point of treatment entry with triage and comprehensive assessment with onward referral to appropriate provider services

Option Description

4.1.1 The current treatment system is based on a range of providers each with their own specialisms, each with the capability of carrying out the initial triage and assessment of the client upon presentation and each with the capability to case manage and key work these clients. Whilst a common approach to assessment is taken, it is not universal and does not allow information to be shared within the whole treatment system. Many of the clients are within shared care and this has meant that whilst there is strong GP oversight to prescribing regimes (for opiate users), however there has been limited success to enhance this maintenance prescribing with effective recovery orientated treatment.

4.1.2 This option is based on the current treatment system with the least level of change, which is the need to centralise the entry into treatment with a universal assessment framework (that incorporates client consent and information sharing within the whole treatment system) and to coordinate treatment needs of people presenting to services, to redirect clients onto the most appropriate provider.

4.1.3 The DAAT currently manage 36 separate sets of commissioned activity with 23 contract holders for its Tier 1 and 3 provision. This makes Tower Hamlets a large and complex treatment system with extensive contract and commissioning management and oversight needs and potentially much duplication. The total value of these contracts is £8.187M (including the DAATB Team, T4, and all treatment, referral and recovery specialisms. This also includes all payment to GPs for locally enhanced services.

4.1.4 This option would necessitate strong cross partnership coordination of new clients so that they are effectively supported into treatment, through triage and assessment and given a clear identification of their needs and the most appropriate provider in the system to send people on to.

4.1.5 The treatment provision includes triage and comprehensive assessment, treatment planning, offering pharmacological, psychosocial and recovery and support interventions. With a broad range of treatment modalities including substitute prescribing, one to one counselling, group work, drop in sessions, structured day programmes (including abstinence based SDPs), IBAs, recovery and support, NX, harm reduction (BBV prevention), specialist services (women, BME focused) The current treatment system has within it a range of choice of providers and this should be taken into account when redirecting clients to their ongoing providers.

4.1.6 This provision offers extensive choice in treatment providers for service users in the borough, however it provided less treatment options for the client. Indeed whilst there are many treatment providers who offer both opiate and non-opiate treatment there are few discernable differences with many of these providers in the specific treatment modalities that are provided.

Service profiles

4.1.7 In the last three years the treatment system has had 1,630 OCUs and 1,723 all drug users in effective treatment in 2011-12, 1,602 OCUs and 1,695 all drug users in 2012-13 and 1,389 OCUs and 1,522 all drug users in the latest reporting period in 2013-14 (October 2012 to September 2013). There are 80% men and 20% women in treatment and the treatment system reflects the ethnic diversity in the borough. Anticipated service profile will result in an

increase in the numbers entering treatment through single point of entry (circa 1560/3% growth).

Option 1 cost and cost against current budget

- The total budget for this provision is £7,406,402, this represents both management and direct treatment costs, accommodation and represents all current contract values held by the DAAT. The unit costing of provision for all drugs and alcohol services, i.e. subsidy per head of service user in treatment is £3,225.79. (I.e. £7,406,402/2296=£3,225.79)
- Essentially this options is likely to be cost neutral – although there will be the potential to reallocate some savings through the single entry point to the treatment system.

Figure 2: Cost Model for Option 3

Options Modelling	Option 1
Cost	13/14
Referral	£177,000
Treatment	£3,907,657
Recovery	£960,278
GP Purchased	£791,431
T4	£1,570,036
total	£7,406,402

- Strengths
  - Retains current variety of provision and choice
  - It's what service users know
  - Clear assessment and triage of client needs
  - Ability to control treatment system feeds and referrals
  - Better transparency of referrals
  - Increased throughputs
  - Improved breadth of service coverage
  - Faster entry to most appropriate service(s)
  - More straight-forward communications – e.g. single telephone number
- Weaknesses
  - Lack of coordinated provision
  - Reduced performance levels
  - Service duplication
  - Poor VfM
  - Legal risk
  - Maintains the likelihood of diminishing outcomes
  - Limited ability to coordinate progression through to recovery
  - Incorporates an additional client-transfer/onward referral to another provider
  - Possible bottleneck unless clear capability/ systems are in place to mitigate
  - Relies on individual assessor external to the system

- Likely service impact
  - None as at standstill
  - Continuing decline in positive outcomes
  - Less client focused
  - High numbers not moving through the treatment system
  - Improved treatment entry
  - Likely better transfer to the right provider in borough
  - Increased caseloads

- Value to the client
  - Poor recovery focus

- Increased length of time in treatment
- Little forward momentum
- More informed choice of treatment provider

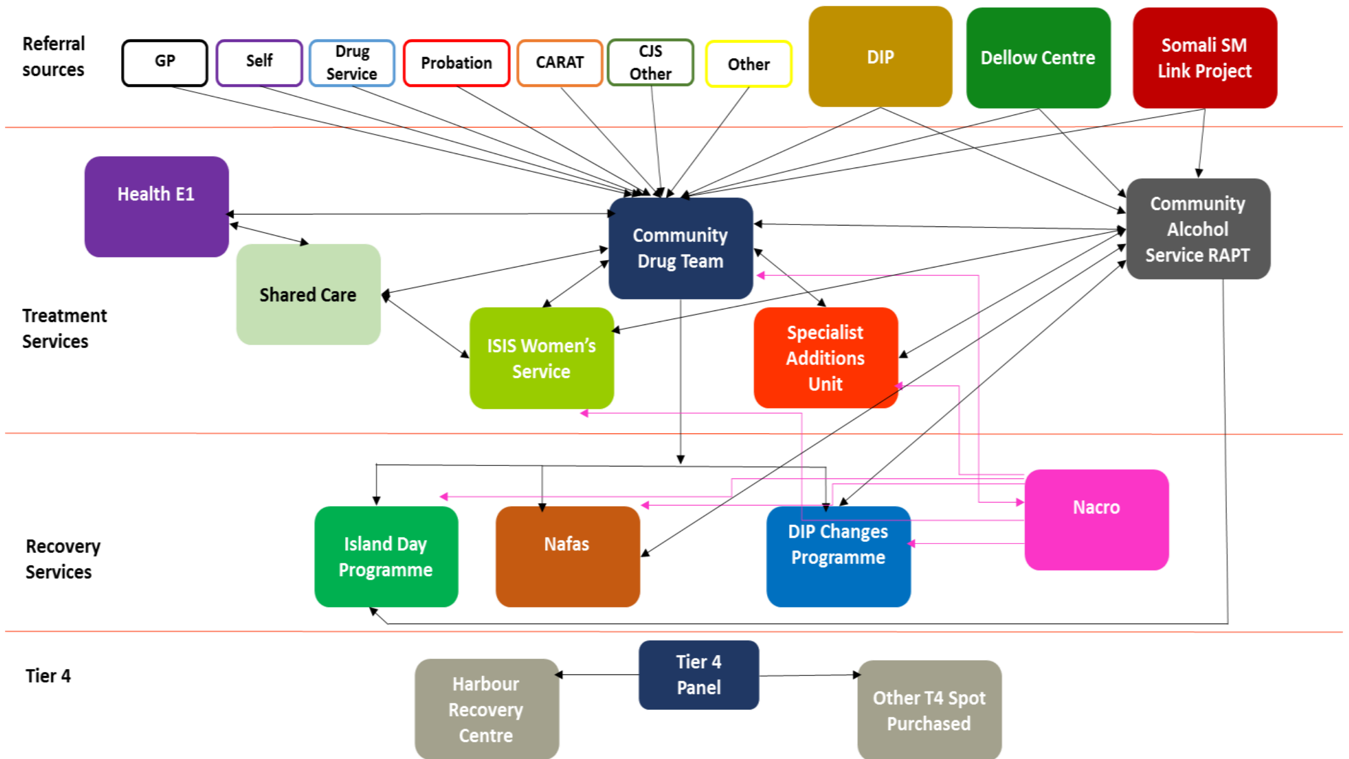
- Value to the treatment system
    - This is the system the borough currently has, the service review and needs assessment identified key areas where there are concerns in particular, the large number of contracts, the seemingly disjointed treatment system, potential duplication of services and internal contract competition. Clear need to re-procure to bring contracts in line and to meet legal procurement obligations.
    - Low value to the treatment of local people and hence a treatment system that is in need of change

- Preconditions for success
    - Universal assessment framework with common screening, triage, comprehensive form, that will support information sharing protocols and client consent
    - Large amount of time and resource from DAAT
    - Continued DATA FOCUS
    - Payment by Results (PbR)
    - Comprehensive training and induction for assessors

- Procurement focus, what we expect from the providers
    - Partnership working and consensus on who provides what treatment, when and how

- Likely Outcomes
    - 2296 in treatment (D&A)
    - 404 successful completions
    - Opiate Successful completions as % of total in treatment 4.97%
    - 62 Representations within 6 months (D&A) in full year
    - Training and skills and competence:
    - Training and skills and competence of staff teams will need to be clearly specified against national benchmarks (including PHE and NICE)
    - Clinical Governance

Figure 3: Option 1 treatment model 'Journeys to Recovery'



4.2 **Option Two**: Main treatment provider for tier 3 treatment (all drugs) separate referral/recovery/support contracts (10-15 contracts) plus one alcohol treatment provider. Therefore, this option combines the main treatment provision for tier 3 treatment (opiate and non-opiate) into one contract including treatment entry, assessment, pharmacological and psychosocial interventions into a single contract.

Option Description

4.2.1 Main drug treatment provider for all drug users (opiate and non-opiate) that would combine drug treatment currently delivered through the SAU, CDT and ISIS, offering pharmacological and psychosocial treatment interventions. Psychosocial interventions would be available to all clients at all stages of their recovery journey. This will include targeted interventions to key clients groups (e.g. Homeless and complex clients with chaotic patterns of drug and alcohol use. Integrated care pathways will be essential to manage the flow of clients into treatment and their onward treatment journeys. One alcohol treatment provider will provide treatment interventions for clients presenting with primary alcohol use and dual dependency.

4.2.2 Pathways for clients using both drugs and alcohol will need to be established and managed (this may require concurrent or sequential treatment on the basis of substance use).

4.2.3 Drug and alcohol client treatment to recovery journeys should be facilitated with clear links and pathways into recovery/support providers so that this is available alongside or following structured treatment. Having service user involvement at the core of this service with weekend and evening provision [and holiday] will increase the recovery capital of existing clients in treatment and new clients new to treatment.

4.2.4 Access to treatment via the main drug treatment provider and alcohol treatment provider with onward referrals through the universal assessment framework to specialist or recovery/support services will minimise the contract and commissioning management and duplication of services.

4.2.5 The treatment provision will mirror, that in option 1 but contained within one main drug treatment provider and one alcohol provider with a range of support/recovery providers that will offer satellites/surgeries to drug and alcohol treatment providers, facilitate client access to mutual aid groups and other recovery support groups (as evidenced in best practice to recovery) and work in tandem with structured treatment to offer a recovery focused model to treatment.

Service profiles

4.2.6 It is anticipated this will increase the number of known non-opiate drug users (circa 1,590 4-6%) and corresponding presentations to treatment.

Option 2 cost and cost against current budget

- The total budget for this provision is £7,406,402, this represents management and direct treatment costs, accommodation and represents all current contract values held by the DAAT. The unit costing of provision for all drugs and alcohol services, i.e. subsidy per head of service user in treatment is £2,932.53. (i.e. £7,406,402/2526=£2,932.53)

- Essentially this options is likely to be cost neutral in total but it does rely on greater investment in referrals to the system, increased funding to the treatment component, retention but linkage of recovery activity, and a slight reduction in GP purchased services (based on the targeted declining numbers in shared care and a reduction in the T4 total allocation)

Figure 4: Cost Model for Option 3

Options Modelling	Option 2
Cost	14/15
Referral	£277,000
Treatment	£4,007,657
Recovery	£960,278
GP Purchased	£691,431
T4	£1,470,036
total	£7,406,402

- Strengths
  - Improved information sharing
  - Better response to complex clients
  - Better referral to non-complex and other clients
  - More recovery focused
  - Improved system throughput flows Better oversight of entire treatment journey

- Weaknesses
  - One large provider (potentially consortium) operating under a single contract
  - More coordination needed with support providers
  - Potential risks of clients disengaging between providers
  - Potential compromise on data quality control
  - Compromise model – which could be considered uneconomic to deliver

- Likely service impact
  - Greater capacity to respond to long- term opiate clients in borough with clinical treatment including access to psychosocial and recovery/support interventions
  - More Consistent and co-ordinated recovery and support provision
  - Better treatment response to diverse needs
  - Better coordination of treatment for clients

- Value to the client
  - Improved treatment options for client
  - Clarity of treatment journey from entry to recovery with recovery capital built into to treatment planning
  - Improved sequencing of treatment

- Value to the treatment system
  - Defined treatment and recovery/support options offering choice and clarity for clients
  - Improved rates of clients successfully completing treatment and borough outcomes performance
  - Clear definition of roles and responsibilities

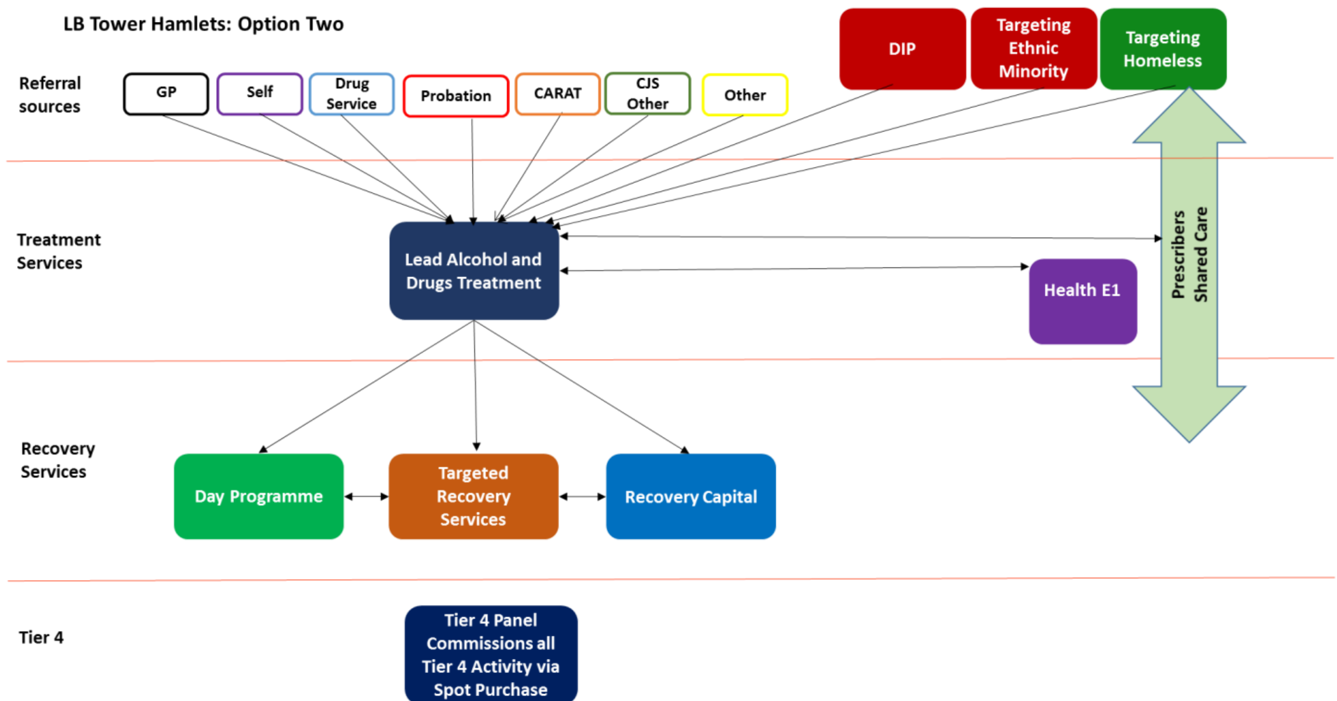
- Preconditions for success
  - Universal assessment framework with common screening, triage, comprehensive form, that will support requirements of minimum data sets
  - Agreed criteria and understanding of the offer of interventions between main treatment provider and recovery/support providers

- Agreed care co-ordination roles / systems

- Procurement focus, what we expect from the providers
  - Universal assessment framework
  - Clearly defined treatment options at pathways for clients (in particular to and from targeted services)
  - Treatment options to be client focused and complementary of one another
  - Uniformity of service provision across the treatment system within clear criteria for clients referrals
  - Competent workforce with local relationships and knowledge
  - Appropriate and adequate referral activity to supporting providers
  - Agreed information sharing protocols and standards between providers and use of common IM system
  - Partnership working and consensus on who provides what treatment, when and how

- Likely Outcomes
  - 2525 in treatment (D&A)
  - 492 successful completions
  - Opiate Successful completions as % of total in treatment 4.97%
  - 56 Representations (D&A) in year
  - Training and skills and competence of staff teams will need to be clearly specified against national benchmarks (including PHE and NICE).
  - Clinical Governance: this would be managed through the main provider who would need to have a strong clinical capability to oversee this important aspect of this work. It is likely that this will be a consortium with strong clinical leadership.

Figure 5: Option 2 treatment model 'Journeys to Recovery'



4.3 **Option Three**: Two drug + Alcohol treatment contracts one for treatment and one for recovery (2 contracts). Single Drug treatment provider for Tiers 2-3 treatment, this option would coexist with a number of separately commissioned recovery agencies, targeting their work solely on recovery activity.

Option Description

4.3.1 One singe Tier 2-3 drug treatment provider for all drug users (opiate and non-opiate) and one alcohol treatment provider. Offering pharmacological and psychosocial treatment interventions, as with option 2 psychosocial interventions will be available to clients at all stages of their recovery journey. Within this model targeted provision will exist with key client groups such as homeless and chaotic clients with those with complex patterns of drug and alcohol use.

4.3.2 Pharmacological interventions include assessment and stabilisation, maintenance, relapse prevention and withdrawal. Psychosocial interventions include motivational interviewing, solution focused brief therapy, cognitive behaviour therapy, counselling, structured day programmes. Recovery and support encompasses a whole host of services including ETE, family/parenting support, facilitated access to mutual aid groups and mental health focused psychosocial interventions to support recovery, group work and day programmes.

4.3.3 Both drug and alcohol treatment provider will establish integrated pathways from treatment options through to recovery. This model would allow for better case management and care coordination (similar to the DIP model). This will provide a platform to prepare clients for tier 4 treatment where appropriate. It may necessitate operating at more than one site (to manage abstinence based treatment options and ensure appropriate demarcation of service provision for different types of clients e.g. non-dependent and dependent). As with option 2, effective pathways for clients using both drugs and alcohol will need to be established.

4.3.4 One treatment recovery provider (with peer/service user involvement) will offer the support to enable clients' access to recovery options. A provider focused on recovery and support service should scope the potential of evening, weekend and holiday time services (as well the potential for peer led services). This should further be embedded with clear programmes of ongoing post treatment support to sustained recovery.

4.3.5 Access to treatment via a single point of entry within a universal assessment framework, spread over three contracts will further minimise the contract and commissioning management and minimise duplication of services.

4.3.6 The treatment provision will mirror, that in Option 2 but contained within 2 drug treatment providers (treatment and recovery focused) and 1 alcohol treatment provider. With scope for evening and weekend provision.

Service profiles

4.3.7 Anticipated service profile will result in increase in the numbers entering treatment through single point of entry (circa 1590/5% growth) with improved levels of non-opiate using clients presenting to treatment.

Option 3 cost and cost against current budget

- The total budget for this provision is £7,406,402, this represents management and direct treatment costs, accommodation and represents all current contract values held by the DAAT. The unit costing of provision for all drugs and alcohol services, i.e. subsidy per head of service user in treatment is £2,688.15 (i.e. £7,406,402/2755=£2,688.15)
- Essentially this options is likely to be cost neutral in total but it does rely on greater investment in referrals to the system, increased funding to the treatment component, retention but linkage of recovery activity, and a slight reduction in GP purchased services (based on the targeted declining numbers in shared care and a reduction in the T4 total allocation)

Figure 6: Cost Model for Option 3

Options Modelling	Option 3
Cost	14/15
Referral	£377,000
Treatment	£4,207,657
Recovery	£960,278
GP Purchased	£591,431
T4	£1,270,036
total	£7,406,402

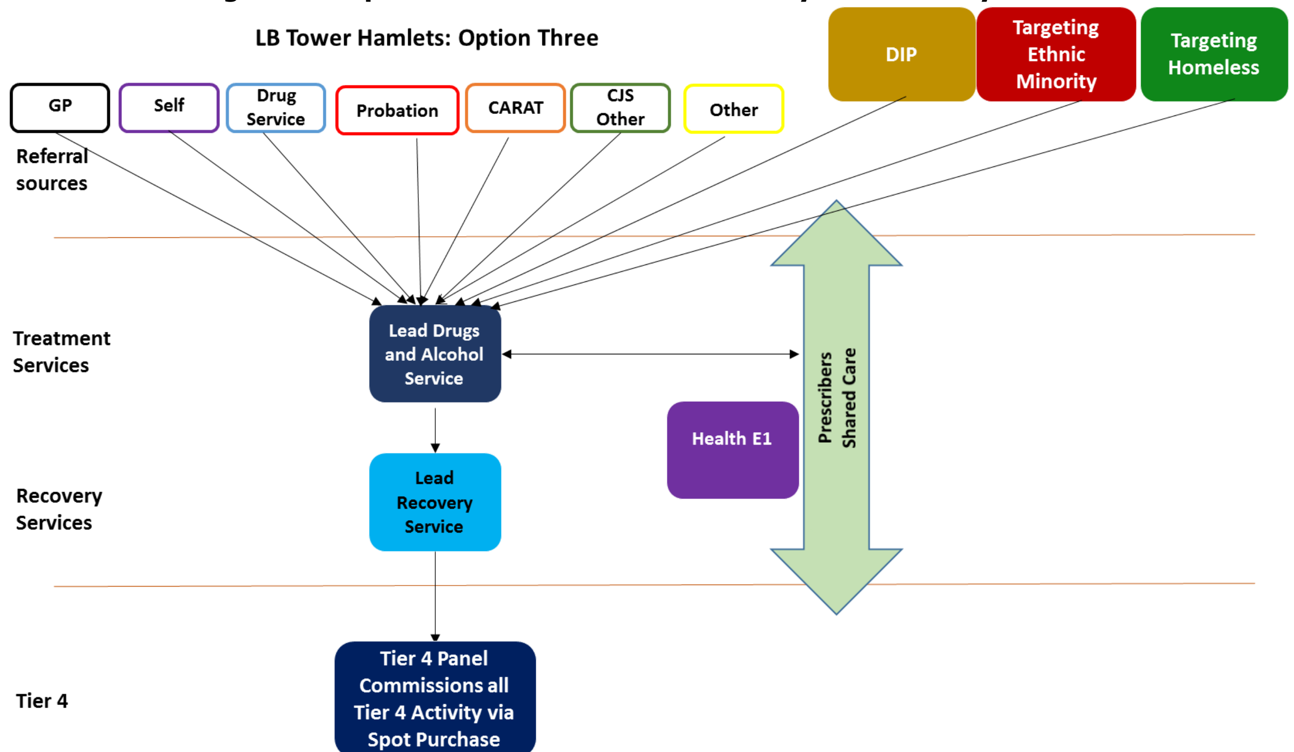
- Strengths
    - Seamless tiers 1-3 interventions at all points up to recovery activity
    - Better coordination of provider resources
    - Improved provision low complexity clients
    - Improved referrals (opiate, non-opiate and even alcohol)
    - Strong recovery focus
- Weaknesses
    - Single treatment provider could expose the treatment system to financial risk
    - Need for better flexibility to ensure full recovery contracts
    - Potential risks of clients disengaging between alcohol and drug treatment (vice versa)
    - Need for improved system management processes Disjointed treatment journeys for those with concomitant drug and alcohol problems
    - 2 part care co-ordination
- Likely service impact
    - Improved outcomes
    - Improved case management and care coordination
    - More recovery focus to treatment system
    - Better access to treatment and visible treatment journey through to recovery
    - Better treatment readiness into tier 4 provision
- Value to the client
    - Clarity on treatment options and support with recovery
    - Better capability to support treatment readiness
    - Broadening of treatment catchments
    - Improve attrition rates
    - Simplified system visible
    - Improved progression
- Value to the treatment system
    - Clear routes in, through and out of treatment
    - Little scope for duplication of services
    - Service worker understanding of the system enhanced

- Preconditions for success
  - Universal assessment framework
  - Partnership working between drug, alcohol treatment and recovery services
  - Agreed IM information system and sharing protocols will need to be established
  - Agreed service ethos to be developed
  - Agreed definitions for reporting purposes

- Procurement focus, what we expect from the providers
  - Universal assessment framework
  - Clearly defined treatment options at pathways for clients between drugs, alcohol treatment and recovery/support services
  - Treatment options to be client focused and complementary of one another
  - Uniformity of service provision across the treatment system within clear criteria for clients referrals
  - Competent workforce with local relationships and knowledge
  - Dedicated analytical capacity to ensure assessments are complaint with core datasets
  - Partnership working and consensus on who provides what treatment, when and how

- Likely Outcomes
  - 2755 in treatment (D&A)
  - 525 successful completions
  - Opiate Successful completions as % of total in treatment 5.8%
  - 50 Representations (D&A) in year
  - Training and skills and competence of staff teams will need to be clearly specified against national benchmarks (including PHE and NICE).
  - Clinical Governance: this would be managed through the lead D&A service provider who would need to have a strong clinical capability to oversee this important aspect of this work. It is likely that this will be a consortium with strong clinical leadership.

Figure 7: Option 3 treatment model 'Journeys to Recovery'



4.4 **Option Four**: Single integrated drugs and alcohol service contract. (1 Contract)

Option Description

4.4.1 One single integrated substance misuse (drugs and alcohol) treatment and recovery service that will facilitate multi-disciplinary working with a range of low level and high complex need clients. Delivering recovery and support alongside drug and alcohol treatment. This model would support complete case management and care coordination continuously throughout treatment and beyond, for clients.

4.4.2 As with option 4, this will further reduce the scale of the contract management work required (from numerous contracts to one). There is a sizeable proportion of clients using drugs and alcohol simultaneously and for the majority this presents chaotic patterns of substance misuse. A fully integrated service will enable the most effective treatment provision and potential of positive outcomes.

4.4.3 The treatment provision will mirror, that in Option 3 but contained within a single lead drug and alcohol treatment provider. This model will further enable data quality control for the purposes of performance management through a single case management and IM system.

Service profiles

4.4.4 Anticipated service profile will result in increase in the numbers entering treatment through single point of entry (circa 1600/6-7% growth) with a corresponding increase in non-opiate clients presenting to treatment.

Option 4 cost and cost against current budget

- The total budget for this provision is £7,406,402, this represents management and direct treatment costs, accommodation and represents all current contract values held by the DAAT. The unit costing of provision for all drugs and alcohol services, i.e. subsidy per head of service user in treatment is £2,604.22 (i.e. £7,406,402/2844=£2,604.22)
- Essentially this options is likely to be cost neutral in total but it does rely on greater investment in referrals to the system, increased funding to the treatment component, retention but linkage of recovery activity, and a slight reduction in GP purchased services (based on the targeted declining numbers in shared care and a reduction in the T4 total allocation)

Figure 8: Cost Model for Option 4

Options Modelling	Option 4
Cost	14/15
Referral	£477,000
Treatment	£4,307,657
Recovery	£960,278
GP Purchased	£541,431
T4	£1,120,036
total	£7,406,402

- Strengths
  - Comprehensive integrated provision for drugs and alcohol clients
  - Improved service outcomes
  - Better coordination of provider resources
  - Call on greater skill set from providers
  - Reduced DAAT staffing requirements and resources
  - Could allow for more treatment innovation

- Weaknesses
  - Financial exposure to single provider
  - Safeguards would need to be put in place to ensure that provision is set on a strong financial footing, a lead 'provider' in a consortium would best support this
  - Local providers could become marginalised if standards set too high
  - May not be attractive to / possible for smaller / local providers
  - No clear journey for clients using drugs and alcohol concurrently
  - Efficiencies would need to be balanced with impacts on local economy

- Likely service impact
  - Integrated approach to drugs and alcohol with integrated service
  - Treatment journeys and care planning would be held within a single provider
  - Seamless integrated transition through treatment and recovery for clients to benefit from outcomes
  - More recovery focus to treatment system
  - Better access to treatment journey
  - Better treatment readiness
  - Better able to respond to treatment failure or disengagement

- Value to the client
  - Better capability to support treatment readiness
  - Broadening of treatment catchments
  - More intuitive capability for clients
  - Better integrated drugs and alcohol services

- Value to the treatment system
  - Single entry points in, through and out of treatment, irrespective of primary substance
  - Little scope for duplication of services
  - Single and visible branding

- Preconditions for success
  - Universal assessment framework
  - Agreed IM system and reporting requirements

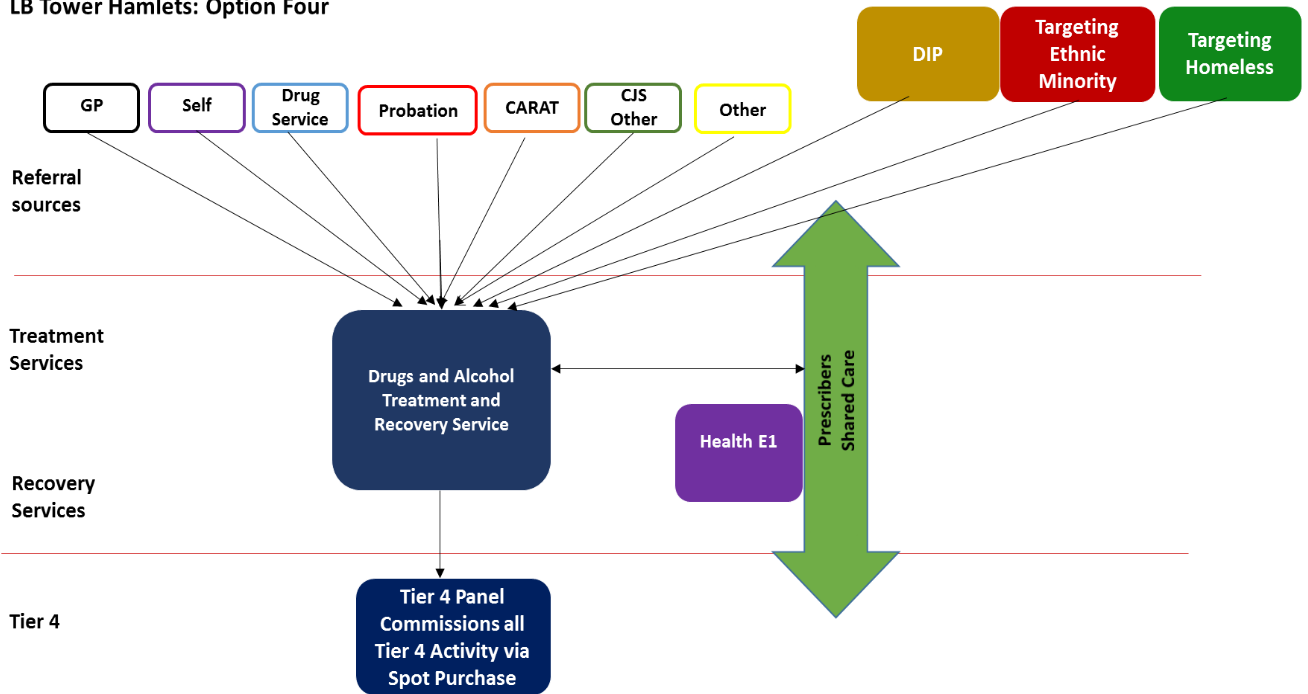
- Procurement focus, what we expect from the providers
  - Universal assessment framework
  - Clearly defined treatment options and pathways for clients between drugs, alcohol treatment and recovery/support services
  - Treatment options to be client focused and complementary of one another
  - Highly skilled and competent workforce
  - Dedicated analytical capacity to ensure the assessment framework is complaint with core data sets
  - Good understanding of local need and branding
  - Partnership working and consensus on who provides what treatment, when and how

- Likely Outcomes Modelled
  - 2844 in treatment (D&A)
  - 608 successful completions
  - Opiate Successful completions as % of total in treatment 7.25%
  - 43 Representations within 6 months (D&A) in full year
  - Training and skills and competence of staff teams will need to be

clearly specified against national benchmarks (including PHE and NICE).

- Clinical Governance: this would be managed through the lead D&A service provider who would need to have a strong clinical capability to oversee this important aspect of this work. It is likely that this will be a consortium with strong clinical leadership.

Figure 9: Option 4 treatment model 'Journeys to Recovery'



5. Recommendations for Consideration

5.1 This appraisal has reviewed the treatment system options that have emerged out of the Needs Assessment and Service Review processes carried out in December 13 and January 14 respectively. It would be the recommendation of this report that the key driver for all these options is the need to transform the borough's treatment system into one that better supports service clients throughout their journey to recovery. In short to support all elements of treatment from initial referral, stabilisation and maintenance, through to psychosocial treatment to address addiction and to equip clients with the tools to support lasting drug and alcohol free recovery.

5.2 In this case all treatment options have focused on this journey and seek to ensure that the right resources are in place to fulfil this commitment which is both locally and nationally seen as the aim of structured drugs and alcohol treatment. Clearly not all clients will be able to fulfil this personal voyage but it is the ambition of the borough to ensure that resources are in place throughout the treatment system to support clients to take full advantage of the treatment provided and thus achieve the goal of drug and alcohol free existence.

5.3 On this basis this report would recommend that:

- Option 1 has the least capability to delivery this goal and should be discarded.
- The DAAT Board review and discuss Options 2, 3 and 4 to identify the option it feels would best deliver this goal and which best fits the demands of the clients in Tower Hamlets.
- Once this is agreed by the DAAT Board, officers from the DAAT should work up the chosen option into its procurement packages and lots, which can then be taken through the Tower Hamlets procurement process and onto Cabinet for approval to commence the re-procurement exercise.