

**North East Lincolnshire
Safer Communities Partnership**

Adult drug treatment plan 2009/10

**Part 1: Strategic summary, needs
assessment and key priorities**

The strategic summary incorporating the findings of the needs assessment, together with local partnership ambition for effective engagement of drug users in treatment, the funding and expenditure profile, harm reduction and primary care self audits have been approved by the Partnership and represent our collective action plan.

<i>Signature</i>	<i>Signature</i>
Chair, partnership name Chief Superintendent David Hilditch	Chair, adult joint commissioning group Paul Pike

Overall direction and purpose of the partnership strategy for drug treatment

North East Lincolnshire Safer Communities Partnership selected its Partnership Priorities through the process of carrying out a Joint Strategic Intelligence Assessment in the spring of 2008, in compliance with the amended Crime and Disorder Act. Last years' adult and young person's drugs needs assessments fed into that process, resulting in drug misuse becoming a Partnership Priority. That process is now being repeated, and once again drug misuse will remain a Priority. As such the adult treatment plan must fulfil two complementary purposes –

1. The main purpose is to continue to develop the NEL Drug Treatment system in order to minimise the harms to individuals, families and the wider community caused by illegal drugs, by providing easy access to effective drug treatment and harm reduction activities for all that need them. This must include implementation of the relevant sections of the new national drug strategy 'Drugs: protecting families and communities'.

2. At the same time it must strategically support the wider aims of the Partnership in reducing crime, disorder and substance misuse. Thus in particular the drug treatment system must support efforts to reduce re-offending by ensuring effective 'pathways' into treatment via the Criminal Justice System and from other Partnership offender interventions such as Anti Social Behaviour, Family Intervention Programme etc.

The DAAT and the service providers within our system have not been quick to respond to the growing emphasis on 'outcomes' and we find ourselves in the lowest quartile nationally for planned discharges. The local culture within our predominantly opiate based drug treatment services is one of long term methadone maintenance, and there needs to be a new focus upon more individualised care planning, in order to achieve more planned treatment completions. Such a change in attitudes within DAAT and treatment services needs to be matched with opportunities within the locality for access to housing, training and jobs in order to maintain and support the progress made in drug treatment. The necessary support from partner organisations to deliver these vital aids to long term stability has improved slowly over recent years but still remains ad hoc and uncoordinated. The current harsh economic climate will make this task harder. However, the locally developing Economic Wellbeing Strategy utilising the Working Neighbourhoods Fund, new Job Centre Plus Drugs Coordinators Post and improving coordination of the reducing re-offending agenda will help in this respect (see Treatment Plan for details)

Likely demand for open access, harm reduction and structured drug treatment interventions.

In this year's needs assessment we have utilised the median PDU Glasgow prevalence figure of 1326 and the Bulls Eye process shows that 65% of that total were in treatment as at 31.3.08, with a further 15% having had previous treatment contact. This suggests a treatment naïve population of about 20%, an obviously high penetration level. When this is considered alongside waiting times within national guidelines and national and local surveys telling us our services are 'friendly and welcoming', we feel likely demand for open access, harm reduction and structured treatment remains manageable within what we expect to be a static or reducing budget. Concerns remain amongst the Expert Group as to when a 'ceiling' for numbers in treatment is reached. This is not a concern about the system's ability to cope but of what is a realistic penetration level? This position is echoed within the needs assessment, as statistical predictive modelling suggests an actual decline in

numbers in treatment next year and thereafter, as the population of NEL shrinks. Clearly with targets to increase the numbers in effective treatment, this will present a problem and efforts to attract those not currently engaging must be stepped up. One potential way of doing this will be to examine out of hours expansion, but within budget constraints this may prove difficult.

There is considerable analysis of the Crack problem in NEL within the needs assessment and this reveals the drug is generally taken as an adjunct to other substances, as a 'treat' and prevalence levels are lower than regionally and nationally. However, we have unearthed some concerns at the level of training within provider services and about our knowledge of 'what works'. This is addressed in the Plan.

Our services are gender friendly as NDTMS shows, and we continue to attract underserved groups such as prostitutes and the homeless by means of several 'outreach/harm reduction' initiatives. Offenders are heavily represented within the treatment system, with DIP and DRR continuing to engage from the CJ system. However, the Expert Group has identified two problematic areas in relation to this group. We are experiencing too high a drop out rate as offenders move into community services, with increasing DNA levels, and we would still like to do better in retaining prisoners upon their release. These two areas of improvement will feature in the Plan.

Last year's Plan identified a dearth of knowledge about BME groups and expressed an intention to improve that understanding in order to examine if our services are accessible to them, but we have failed to do that. The recent HCC Review into Diversity showed us as only 'fair' in this respect and an action plan to improve is in development and will be included within the Plan.

The HCC Review also examined our approach to access to tier 4 services, which are all currently out of area, and here again we only scored 'fair'. The suggestion is that we do not provide good access to such services, nor ensure those services and our interactions with them are effective. Here again an action plan to remedy the situation is being developed and will be part of the Plan.

NDTMS data suggests that we are also performing badly in relation to providing action against blood borne viruses. The Expert Group are convinced that the appropriate action is being taken but it is not being recorded in care plans and /or not transferred onto NDTMS. We need to ensure the Care Plans and data reflect the true position.

Key findings of current needs assessment.

The Bull's Eye process suggests that the treatment naïve in NEL has dropped from 27% in 2007 to nearer 20% in 2008. The gender split of those in treatment remains similar to last year with 33% being female, against an estimated female PDU population of 25%. As in previous years the vast majority of service users are white (98.9%), aged predominantly in a 25 to 39 years age group, and heroin is the main problem drug by far.

Treatment Mapping remains 'unsatisfactory' in terms of the data but as each year's map is produced an increasingly complex map is revealed showing that referrals and cooperation between the providers continues to increase and improve. The map illustrates our 'poor' performance in relation to planned discharges and access to tier 4, already outlined.

Several recommendations from last year's assessment remain a problem and are revisited this year - TOP compliance – improving but still demanding attention; hepatitis data not reflecting the reality of activity; can we afford and operate out of hours services?; improve access to training and employment and what will remain our key priority – how to improve the number of planned discharges.

Analysis of the local crack problem has revealed a local need for improved training already outlined in earlier sections.

'Drugs: Protecting families and communities' has focussed our assessment on how our services interact with the extended families of service users, and there are a number of recommendations surrounding Hidden Harm, carer services and family and carer involvement. In addition suggestions are made about how to involve the wider community in increasing access to drug treatment and harm reduction whilst improving their perceptions of drug use and dealing as a local problem (PSA 25).

Reducing re-offending is a cross cutting theme within the needs assessment and highlights the links between NEL's high crime rate and drug and alcohol misuse. CJ drug and alcohol services are regarded as performing well but with two specific areas of development identified. The first is a need to reduce the DNA rate as offenders move from DIP into community services, and the second is to continue and extend the excellent work of DIP with prisons, so that more offenders re-engage upon release. The need to better coordinate reducing re-offending generally is discussed and a new post within the Partnership, attached to the DAAT will progress that agenda in 2009, benefitting both offenders and non offenders alike.

As stated above more Planned Discharges with positive outcomes will be our key priority in 2009/10. In addition to the work that will take place in treatment services, outlined in the Plan, more effort will be applied to providing access to employment, in order to provide the chance of longer term stability. This will be via a locally developing Economic Wellbeing Strategy funded by the Working Neighbourhoods Fund, the new Job Centre Plus Drug Coordinators and a local Reducing Re-offending Action Plan.

The recent HCC review on Diversity and Tier 4 has revealed several shortcomings addressed in a specific action plan and these are included in the needs assessment and treatment plan.

Within these broad key findings are several specific issues such as a need to investigate the increasing levels of supervised methadone prescriptions and poor referral from services into our Structured Day Programme

Improvements to be made in relation to the impact of treatment in terms of its outcomes.

Earlier sections of this report have made reference to several of the broad improvements necessary to create better outcomes for treatment users and these feature heavily in the Treatment Plan. However this is such a key issue for NEL DAAT that all the actions contained at various points within the Treatment Plan have been pulled together in an **Improving Planned Discharges Action Plan. This can be found as an appendix.**

Key Priorities for 2009/10.

1. Improved data

- Planned Discharge
- Treatment Outcome Profiles
- BBV
- Parental status and dependant children

2. Ongoing improvements to existing local services

- Revision of all service level agreements and service specifications
- Access and engagement of crack/cocaine users
- Audit process
- Supervised methadone scheme
- Out of hours
- Review the Structured Day Programme
- Training and Workforce Development
- Access to ECG testing

3. Deliver 'Drugs: protecting families and communities

- Carer support
- Hidden harm
- Family and Carer involvement in treatment
- Community engagement in harm reduction and access to treatment

4. Diversity (Healthcare Commission review)

- Better Understanding, access and engagement

5. Improving Tier 4 Services (Healthcare Commission Review)

- Improved contracting
- Preferred provider
- Through care and after care

6. Improving outcomes

- Increase planned discharge
- Use of TOP data
- Mutual aid and support groups

7. Reducing re-offending

- Develop a local Reducing Re-offending Action Plan
- Reduce DNA rate from DIP into community services
- Increase DIP access upon prison release

8. Access to Employment

- NEL Economic Wellbeing Strategy
- New Job Centre Plus Drugs Coordinators