



Safer Sandwell
Partnership



Sandwell Adult Drug Needs Assessment 2009/10

to inform the 2010/11 Treatment Plan

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1. 2009/10 DRUG NEEDS ASSESSMENT SUMMARY :

1.1 Changing Drug Use trends –ACCE cohort:

- 18-24s transitional pathways and relation to Adult services (roll on from last years needs assessment recommendations)
- ACCE cohort and differing drug use patterns leads to an under-representation of 18-24s in the treatment system –no referrals form DECCA to adult services - do we need a bespoke service for this group in particular or more diversification of modalities offered? Differing drug user patterns were also seen amongst differing ethnicities.
- A growing emphasis on psycho-social interventions (particularly BTEI/ITEP) to address the increasing stimulant use evidenced from ‘front end’ police test data and emergence of an ACCE cohort
- Harm Reduction messages to address awareness of the risks of sharing drug using paraphernalia (not necessarily needles) amongst those 18-24s to prevent the spread of BBVs and assist in reducing any future health care costs associated with such BBVs – especially for the ACCE cohort

1.2 Partnership/Integrated Working:

- Accepted common screening and assessment tool used across agencies to expedite referrals into treatment and appropriate course of action for inappropriate referrals
- Integrated Care Pathways work to enforce and underpin the families, employment and recovery agenda within every aspect of delivery – this will also work towards improved outcomes for clients where care coordination and co-cased managed clients needs are met holistically
- Effective information flows across providers to enable better use of intelligence to inform more effective delivery, and to enable sharing of data where care co-ordination warrants this
- Learning from the NTA ‘towards successful completions’ document 2009, with regards to improving client engagement and retention using a multi-agency/case management approach.
- An increasing move towards outcome focussed commissioning and outcome focussed performance measures
- Personalisation focussed services – linked to assessment tool to allow for personalisation of desired outcomes/ recovery for the individual client to tailor flexible provision to meet that
- Ensure future commissioning decisions and service specifications take into account findings/ key references identified from the family, recovery, treatment and Criminal Justice sections of this years needs assessment

1.3 Family:

- A commonly accepted understanding of a ‘whole family approach’ and what that means in terms of interventions and developing whole family

support plans –adding value to the individualised approach in place already

- An understanding of DAAT commissioned ‘family’ services provision within existing local services aligned to the family agenda (for example, to address the need for a single assessment process across young people and adults to better identify need and expedite the response across providers, as well as across thematic areas)
- The need to link in with available resources, service provision and contacts around the family agenda (links to C&YP commissioning; carers commissioning already underway) to mobilise all possible resources to this agenda
- A recognition where generic services around the family can be used to deliver brief interventions and the remit/overlap to specialist family services commissioned – and the right sizing/pathways underpinning that
- The value of and place of the family agenda with regards to building social capital and resilience in relation to increased positive outcomes for clients and the wider recovery agenda
- Recently released NTA & DSCF joint guidance on the development of local protocols between drug & alcohol treatment services & local safeguarding & family services –how learning /recommendations from this will need to be adapted and applied locally
- The extent of plausible crossover between the families agenda and harm reduction agenda needs to be aligned and captured in relevant local strategies and documents (e.g. the extent to which the family can play a role in reducing the risk of overdose and BBV transmission)
- A need to increase the level of family members and carers involved in a clients treatment journey to work towards increased positive outcomes for the client as well as addressing the needs of those affected by the clients drug misuse –approximately 7% of clients accessing effective treatment had a family member/carer accessing the DAAT commissioned ‘Family Support Service’

1.4 Recovery:

- A need to develop a shared vision of ‘recovery’ amongst local partners and providers to provide a framework for coordinated recovery oriented service development – do we adopt the UKDPC recovery definition locally?
- A need to develop and strengthen the links between provider organisations (treatment specific and non treatment services) with particular relevance to the reintegration agenda.
- A shift towards a recovery focussed system with relapse prevention and aftercare embedded as part of the entire treatment process/ journey – currently the system is predominantly medical and treatment focussed rather than an emphasis on reintegration and recovery
- A growing emphasis on psycho-social interventions (particularly BTEI/ITEP) as part of the ‘routes to recovery’ agenda

- The use, right sizing of, and appropriate referrals for Tier 4 services as well as the appropriate community aftercare and relapse prevention to maximise gains delivered from Tier 4 interventions. Home Office report recommends applying principles of Continuity of Care to those entering/leaving residential and inpatient care services.
- The need for structured relapse prevention and aftercare modality/ programme with appropriate links to non-commissioned services such as NA/AA/CA
- Explore potential for a 'preparation for rehab' programme and funding approval panel approach to maximise the return from Tier 4 services for clients
- Explore the use of community champions as part of the recovery agenda – and to aid any specific relapse prevention and aftercare interventions commissioned
- Address the balance needed between treatment, recovery and reintegration provision locally- potentially reducing costs by reducing the demand for later re-admission (from high levels of readmissions seen from treatment data locally)
- The place of the family agenda with regards to building social capital and resilience in relation to increased positive outcomes for clients and the wider recovery agenda
- Integration and alignment of reintegration based service provision (Employment Training Education, Structured Day Programme) linked more closely to shared care/GP prescribing community based treatment. PEC drug lead to raise awareness of substance misuse agenda, and to increase capacity for the shared care scheme.
- Explore the possibility of half way house concepts locally to encourage independent living and help to ease social reintegration as part of the recovery agenda in order to increase positive outcomes for clients
- Explore options for leisure based activities as part of the treatment, rehabilitation and reintegration process

1.5 Training & Development:

- Sharing best practice and on-going workforce training and development (and therefore the effectiveness of treatment) through a comprehensive workforce development plan for the entire treatment system to ensure, for example, responsibilities under the families agenda and the 'no wrong door' approach –& how this ties into regional workforce development worker.
- Training and awareness raising for front line services and their workers who are likely to come into contact with those who misuse substances – demand from police services particularly pertinent where DIP has been identified as the main source of treatment naïve referrals.

1.6 Drug Interventions Programme:

- DIP is the main source of identifying treatment naïve and stimulant users – drop in purity of cocaine may impact on numbers identified –

need to consider for future commissioning and right-sizing of services and to ensure appropriate interventions and packages of care in place to create accessible services with a non-opiate focus

- Decrease in trigger offences has meant a corresponding decrease in positive tests – more difficult to identify drug users (esp. stimulant users) – need for DIP workers to engage with all offenders and conduct voluntary assessments where appropriate
- Raise awareness of DIP conditional cautioning and its benefits within police stations and the Crown Prosecution Service and increase the number of applications made

1.7 Harm Reduction:

- Needle Exchange coverage is significantly below the coverage threshold needed to provide a clean needle for every injection (currently 1 clean needle for every 4 injections locally)
- Need for ‘desirable’ information in addition to essential information to be collected for those Needle Exchange providers (i.e. whether a client is accessing structured treatment, drugs used etc..) to inform of the usefulness of needle exchange services as a way to engage treatment naïve clients and increase awareness of local treatment services.
- The level of BBV/harm reduction advice and information delivered as part of the current Needle Exchange services is also something that needs to be addressed in light of the poor coverage results
- Awareness of the risks of sharing drug using paraphernalia (not necessarily needles) amongst those 18-24s to prevent the spread of BBVs and assist in reducing any future health care costs associated with such BBVs – especially for the ACCE cohort
- The Harm Reduction working group is set to reconvene in the new year 2010, with a new Harm reduction Strategy - findings point to a need to encompass the alcohol agenda alongside that of drugs (as seen from ambulance and deaths data), as well as to address young people and their substance misuse patterns (as seen from hospital episode statistics) – as key areas for the upcoming Harm Reduction Strategic Group to address.

1.8 Service User Involvement:

- Recognition of the service user group SAVE and their place within key agendas such as harm reduction and the recovery agenda– for example, offering peer led training on overdose and safer injecting; providing opportunities for peer involvement through the Rattle newsletter, promoting self confidence, attending community and training events promoting positive views of not using drugs etc. and their links to the newly commissioned ‘Hi’s and Low’s’ service user involvement service.

A need to include SAVE at each stage of any potential commissioning/ service delivery changes for input and guidance.

2. INTRODUCTION

This year (2009/2010), it has been agreed with the NTA, to conduct a refresh of last years Needs Assessment. Last year's Needs Assessment was a very comprehensive attempt at a case finding and enumeration methodology as set out in the NTA guidance, and matched a number of diverse data sets against treatment data.

There were some key findings from last year's Needs Assessment which influenced commissioning decisions and service delivery, particularly with regards to open access services and increasing modalities for stimulant users and Black and Minorities and Ethnic (BME) penetration.

Other key developments and achievements over the past year which have built on Needs Assessment findings include the completion of service reviews with all providers; introduction and implementation of Quarterly Assurance Framework with all providers; satellite services hosted from Metro Court; implementation and operationalisation of Continuity of Care guidance; and the newly commissioned Service User Involvement Service.

However, some findings are still pertinent to revisit at this stage - a link to the full 2008/9 Adult Drug Needs Assessment can be accessed via:

<http://www.sandwelldaat.co.uk/wp-content/uploads/sandwell-drug-needs-assessment-2008-2009-full.pdf>

A link to the 2008/9 Adult Drug Needs Assessment Summary can be accessed via:

<http://www.sandwelldaat.co.uk/wp-content/uploads/sandwell-drug-needs-assessment-summary-2008-2009.pdf>

3. REVISITING LAST YEAR'S NEEDS ASSESSMENT :

For the purpose of this refresh document, 2008/9 Needs Assessment key findings are listed below. These are useful to revisit at this point as such findings are still of relevance to commissioning and business planning intentions.

- **Local rate of Problematic Drug Users (PDUs) per 1,000 population is above regional or national rates** - meaning that more of our population is affected by opiate/crack use.
- **Improving access to treatment in order to increase penetration levels** – in particular for Black and Ethnic Minority) BME, stimulant and younger users. The new accommodation at Metro Court where agencies are located together to offer a 'one stop shop' approach was felt to be a particular mechanism to address this.
- **Increasing the range of interventions** - including a particular focus on harm reduction - available for BME, stimulant and younger clients who are under-represented within the treatment system.
- **A treatment system with 86% of caseload as heroin users** - this is at odds with 'front end' police drug testing & Drug Intervention Programme (DIP) data which showed an increasing proportion of crack, cocaine and cannabis users which supported the need for reinstatement of Tier 2 services to provide for such stimulant needs.
- **A focus on improving treatment outcomes for clients** - by increasing client engagement in care planning and outcome assessment. This also recognised the importance of the Personalisation Agenda and the need to consider this for future developments and guidance.
- **Retention and planned exits across the entire treatment system as an area for improvement** – but in particular for males and those aged 18-24 years, who were less likely to be retained and more likely to leave with an unplanned exit. Texting of appointment reminders, better feedback from key workers and contingency management were cited as things which could improve attendance from service user's perspective. Weekend and evening services, childcare facilities and better advertising of the range of services available were also felt to be areas for improvement from user's perspective. The NTA 'Towards Successful Completions' has been a key document taken forward with service providers around the low retention and planned exits seen locally as well as the local 'Continuity of Care' Plan for those clients entering/exiting prison.
- **An increase in the proportion of current or previous injectors to treatment** – and as such an increasing need for prompt and effective

harm reduction services. Approximately half of those with immediate harm reduction needs were accessing structured treatment against the PDU injecting estimates, though the total number requiring harm reduction services is likely to be higher with regards to older previous injectors and the higher rate of Hepatitis C seen in this age group. (Sandwell is in the 'high' prevalence band for Hepatitis C: >50% and how this relates to BBV offerance and acceptance in current treatment system).

- **Continued improvement with regards to case management and joint management of offenders** with substance misuse needs which leads to patterns of repeat offending.
- **Improved assessment and sentencing support in Court** to enable offenders to receive more timely treatment referrals and interventions.
- **Supporting the Employability Agenda through developing appropriate pathways**, as well as cross agency work for those individuals on benefits who require treatment.
- **Addressing joint working arrangements with the Children & Young Peoples Trust Partnership** in terms of harm reduction approaches and transitional pathways for the high proportion of 15-24 year olds identified as treatment naïve and as showing up in hospital episode statistics but not in treatment statistics.
- **Local drug related deaths data shows a high incidence of alcohol in combination with illicit drugs cited in cause of death** – local overdose awareness training to address this as well as safer practices communication and campaigns essential to this.
- **The level of need and demand for abstinence based modalities was considered with regards to the predominance of specialist prescribing modalities seen in the treatment system make up** – also the National Users Satisfaction Survey found people who received substitute methadone were significantly less likely to be satisfied with treatment than those who received no substitute medication.
- **A high rate of return for clients back into treatment** – support for clients leaving care and relapse prevention needed here.
- **Supporting vulnerable adults** – to work with Sandwell Safeguarding Adults Board in establishing a borough wide approach to identification and support for vulnerable adults.

This year's Needs Assessment will therefore seek to update some of the key performance and system wide data with regards to Bullseye data, Treatment Maps, Treatment Outcomes Profiles and Harm Reduction data – but with a

particular focus on key emerging priorities such as the family agenda, the recovery agenda, and the criminal justice agenda.

4. 2009/10 NEEDS ASSESSMENT: KEY DATA UPDATES:

4.1 Problematic Drug Users Estimates/ Prevalence:

Treatment naïve population (people using substances who have not engaged in treatment) – A case finding enumeration exercise from last years Needs Assessment identified that DIP was the main source of finding those treatment naïve' PDUs.

Treatment naïve 15-24yr old PDUs are the largest group identified from Glasgow estimates data – this is not seen/ reinforced from local data/evidence. Therefore, possibly a requirement for better understanding of the needs of this group which may not be focused into opiate use.

Professor Howard Parker 2007 has put forward that there are changes occurring in the patterns of drug & alcohol use:

“The critical issue with the ACCE profile is not that one substance is used in moderation but that a minority of young people are using all four drugs in purposeful combinations and to achieve specific effects including self medication... a new post heroin PDU population is being created, which looks certain to grow”

We need to consider the implications of this from a commissioning perspective – with regards to transitional arrangements between Children & Young People (CYP) to Adult services, but also the range of services commissioned which are currently primarily focused/ weighted towards the heroin-crack profile. Consideration needs to be given to the future commissioning intentions based on such emerging populations, and also the subsequent response to service delivery.

Such trends most likely translate into an even greater development in psychosocial and harm reduction interventions from providers. The knock on impact of this needs to be translated in terms of workforce development i.e. a move away from clinical/ pharmacological interventions such as substitute prescribing.

The larger proportion of treatment naïve 15-24 year olds therefore could be reflective of the above Alcohol Crack Cocaine Ecstasy (ACCE) cohort trends with regards to the perceptions of adult drug treatment available and the 'menu' not being able to cater for non-opiate user needs. Closer transitional pathways between the Tier 2 open access service (specifically commissioned to address the emerging non-opiate based needs of substance misuse) and a more structured/ formal induction phase from YP to adults could help to increase penetration for such a group.

What links are made from Tier 2 to younger people's services? Are those aged below 18 'held onto' with regards to this?

4.2 Bullseye Data:

- A copy of the bullseye data is available in Appendix 1.
- Overall penetration levels show 59% of those estimated PDUs (using smoothed estimates) have accessed or are known to treatment services locally. This is reflective of the increase in numbers accessing treatment as evidenced by successfully achieving our ambitious NI40 target set.
- With regards to injecting penetration levels, if we take the estimates to be indicative of both previous and current injectors then we can assume that we have penetrated local levels of Injecting Drug Users (IDU's) – however if the estimates are indicative of current injecting only, then we can assume a 59% penetration of those injecting IDUs – which has Needle Exchange (NX) and Harm Reduction implications. More of this will become clear in the NX prevalence calculator results.
- Penetration levels of those accessing effective treatment (in treatment 12+ weeks or 'treatment complete/drug free' if exiting treatment before 12 weeks) at 49% in contrast to overall penetration levels show that whilst we are increasing the numbers accessing treatment, the levels of those receiving effective treatment is lower.
- Of those receiving effective treatment, there has been a decrease in the proportion of those aged 15-24 receiving effective treatment and a corresponding increase in those older age groups accessing effective treatment.
- In comparison to regional bullseye data, locally, of those accessing treatment, we have a higher proportion of never injectors; those aged 15-24; and BME clients. The proportion of males and females accessing treatment is in line with regional average seen.

4.3 Treatment Map data (Tier 3):

- A copy of the Treatment Map for Tier 3 and 4 is available in Appendix 2.
- The referral source with the highest proportion of treatment naïve clients is 'other' – this shows the added value for treatment penetration of inter-agency awareness and work with non substance misuse/Criminal Justice System (CJS) focussed agencies
- GP and 'other' referrers had a higher proportion of BME clients compared to other referral sources
- Criminal Justice Service had a higher proportion of younger clients aged 15-24 than other referral sources

- GP and Arrest Referral/DIP referrals had the highest proportion of 'parents' than other referral sources
- A higher proportion of those treatment naïve referrals had never injected whereas a higher proportion of those not treatment naïve clients were opiate and crack users and were more likely to be aged 25-34.
- Of those in treatment, we can see a loss in the proportion of younger clients aged 18-24 years with regards to continuous treatment 2-4 years and 4 years+.
- Of those treatment exits, looking at the proportion of discharge codes against profile groups – 'unplanned: drop out' account for the largest proportion of all discharge codes for every profile group (age, ethnicity, gender, parent etc).
- A higher proportion of male clients leave with an unplanned exit 'prison' code than they account for proportionally against every other discharge code.
- As client age increases so too does the proportion of planned exits within that age group (treatment exit by discharge status analysis).
- Those younger clients (18-24s) account for the largest proportion of 'referred on' within that discharge coding (treatment exit by categories analysis); and those clients aged 25-34 account for the largest proportion of 'unplanned-prison' within that discharge coding (treatment exit by categories analysis).
- Those clients who were offered and who accepted a Hepatitis B intervention were the most numerous group of all possible Hepatitis B status codings– and accounted for the largest proportion of planned and unplanned exits within each exit coding. Further to this they accounted for a larger proportion of unplanned exits than they did for planned exits (treatment exit by categories analysis). This raises the question of whether such clients have had chance to receive all 3 courses of the vaccination before unplanned exit occurred. Detailed performance (green) reports indicate that of those clients who are classed as having received a HBV, the larger proportion tends to be those who have started rather than completed the course (Quarter 2 – 29% had started, but only 7% had completed).
- Of those treatment exits by time, a higher proportion of those 'drop out' or 'prison' exits occurred within 6 months of rather than after a longer time in treatment.

4.4 Treatment Map data (Tier 4):

- A copy of the Tier 4 Treatment Map is available in Appendix 2.
- The Tier 4 treatment map shows that there are very few referrals into Tier 4 services locally – 13 in total for 2008/9 – a decrease from 17 last year. Does this balance against intentions for a recovery led system?
- Unfortunately the treatment map exit data does not give us an idea of continuity of care when clients enter back into the community – this is something that should be proactively managed between the referring service and Tier 4 provider to enable effective care co-ordination and suitable further treatment – be that relapse prevention, regular monitoring, or further treatment.
- Further areas of discussion pertinent to the Tier 4 and wider recovery agenda are discussed in the Recovery section of the Needs Assessment.

4.5 Harm Reduction & Needle Exchange:

- With regards to injecting penetration levels, if we take the Glasgow prevalence estimates to be indicative of both previous and current injectors, then we can assume that we have penetrated local levels of IDUs – however, if the estimates are indicative of current injecting only, then we can assume a 59% penetration of those injecting IDUs – which has NX and Harm Reduction implications.
- The ‘Harm Reduction Works’ Needle and Syringe Programme coverage calculator is useful to put into context whether current needle and syringe provision is adequate against the estimated number of IDUs locally. Local coverage result of 23% shows that there is a new syringe available for only 1 out of every 4.42 injections; injectors have on average 0.37 syringes per day; and the average syringe is used 4 times. The coverage results should be 100%.
- The specialist Needle and Syringe Exchange Programme (SNX) established at Metro Court to compliment local drug treatment services is not showing the desired levels of activity we had expected, this may be reflective of the above poor coverage estimates (there are on average approximately only 30 clients accessing the programme each quarter). This may be linked to the fact that the SNX programme is relatively indiscreet being in such close proximity to treatment services, where clients may feel uncomfortable to access the SNX in case of punitive responses from treatment providers.
- Improving coverage of Needle and Syringe Programmes (NSPs – inclusive of Specialist Needle Exchanges and pharmacy based needle exchanges), and the availability of treatment services, including opiate substitution therapy, are the most effective methods for reducing the

transmission of blood borne viruses amongst injecting drug users. NICE Guidance recommends a mix of generic and targeted NSP services to meet local need so that the number who have more than one sterile needle and syringe available for every injection and to increase the proportion of people from each group of injecting drug users who are in contact with NSPs.

- During 2008/9, approximately 83% (n=15/18) of NX providers were submitting data to the NEXMS (National Needle Exchange Monitoring System) – including the Specialist Needle and Syringe Exchange Programme (SNX). All other NX providers are pharmacy based who hand out ‘packs’ containing a set amount of needles and other injecting paraphernalia.
- There are, on average, approximately 600 clients accessing all NX providers each month with a yearly estimated total of between 460 - 895 clients receiving a yearly estimated total of 161,073 needles. Unfortunately, the ‘desirable’ information (such as whether NX client is also accessing treatment services) is not collected by any of our pharmacy providers. Such information would help to inform us of the usefulness of NX services as a way to engage treatment naive clients and increase awareness of local treatment services. The level of BBV/harm reduction information and advice delivered as part of the current NX services is also something that needs to be addressed in light of the poor coverage results.
- SNX data from previous years has shown a large proportion of those accessing the service (40%+) were steroid users – the current SNX service needs to increase activity levels to allow for robust data analysis of client types and whether drug use patterns are changing.
- There is a low needle return rate seen locally – a poster campaign to address the issue of discarded needles as part of ‘Not in my Neighbourhood’ week was successfully distributed to partner and community agencies in response to this low return rate.
- With regards to Blood Borne Viruses in terms of harm reduction, looking at the treatment map data exit results and green report data, those clients who were offered and who accepted a Hepatitis B intervention were the most numerous group of all possible Hepatitis B status codings and accounted for the largest proportion of planned and unplanned exits within each exit coding. Further to this, they accounted for a larger proportion of unplanned exits than they did for planned exits (treatment exit by categories analysis). This raises the question of whether such clients have had chance to receive all 3 courses of the vaccination before unplanned exit occurred. Green Reports indicate that of those clients who are classed as having received a HBV, the larger proportion tends to be those who have started rather than completed the course (Quarter 2 – 29% had started, but only 7% had completed).

- The National ‘Shooting Up’ Report 2009 states that transmission of Hep B has declined in recent years but still continues despite being preventable. Nationally, over two-thirds of IDUs have received at least one Hep B vaccine, a marked difference to the 29% seen locally. However, it needs to be noted that this is reflective of the work of just one BBV nurse from within the specialist treatment setting, therefore capacity and commissioning implications here.
- With regards to Hepatitis C locally, less than a third of those current or previous IDUs have received a Hepatitis C test - the ‘Shooting Up’ national report 2009 states that three-quarters of IDUs have ever had a Hepatitis C test - the proportion receiving a test locally therefore needs to increase in line with this. The ‘shooting up’ report also shows that transmission of Hepatitis C remains higher than in the late 1990s- with two-fifths of IDUs now infected with Hepatitis C and therefore a need to increase the number of IDUs aware of their status.
- Overall, the proportion of clients with no status recorded as part of BBV/HR interventions has reduced –which has led to an increase in the proportion who have been offered a BBV intervention. The area of focus now is to increase the subsequent uptake and completion of BBV interventions for those in structured treatment and to increase referrals to the BBV service for those in contact but not already accessing structured treatment services.

Significant findings with regards to Harm Reduction (beyond that of needle exchange and BBV findings previously mentioned) include most notably:

- The overall number of drug related hospital admissions for Sandwell residents has increased year on year since 2003/4 to 2007/8. The number of male admissions since 2003/4 has increased by 51% (from 124 to 187), and the number of female admissions since 2003/4 has increased by 56% (from 87 to 136).
- Of those drug related hospital admissions during 2007/8, only 25% were accessing structured treatment. In particular, those NOT accessing treatment tend to be younger which questions treatment accessibility for those younger users as well as targeted harm reduction for an age group more likely to be using drugs in an experimental manner as evidenced by the younger age profile for those ‘T’ codes (poisoning by narcotics/psychodysleptics) and therefore indicative of more acute episodes as opposed to those F11 codes (mental and behavioural disorders due to use of opioids) indicative of longer term/ dual diagnosis needs and characterised by an older age group (predominantly 25-34 age range).
- Temporal analysis of ambulance data 2007/8 shows a peak of incidents during late night/early morning hours of the weekend – activity pertaining to the night-time economy where alcohol is likely to

play a significant factor. This leads us to question whether use of alcohol alongside use of illicit substances as a confounding factor needs to be addressed in terms of widening the remit of harm reduction messages and treatment services where clients may be likely to also have alcohol misuse problems alongside that of drugs.

- Local drug related deaths data shows a high incidence of alcohol in combination with drugs cited in cause of death – local overdose awareness training to address the use of alcohol together with drugs (e.g. cocaethylene) as well as safer practices is essential to this end.
- TOPs data shows that in comparison to data collected re: injecting status at triage assessment, there is a lower prevalence level of clients who report they are still injecting at TOP review - meaning that a higher proportion of clients have stopped injecting after accessing treatment locally; however there is no such corresponding decrease in the proportion still injecting as review period lengthens (however care must be given to such findings where small numbers are concerned).
- TOPs data also shows that of those younger clients who answered injecting questions, whilst there was a lower proportion of those aged 18-24 who injected compared with those aged 25+, those younger clients showed a higher prevalence of sharing than older clients. Similarly, DIP clients aged 18 - 24 were more likely to have shared drug using equipment than other groups, with 23% having shared compared to 16% of both the 25 – 34 year old and 35 – 44 year old groups and 6% of those aged 45 or over.
- The Harm Reduction Working Group is set to reconvene in the new year 2010 - this will allow a forum to explore the links between services geared towards harm reduction and the data trail and subsequent data outcomes enabled by such work. In particular, there is a need to explore ambulance data, hospital data, Needle Exchange data, NDTMS BBV data as well as BBV data not recorded via NDTMS to understand total coverage of BBV interventions on the drug using population.

4.6 Treatment Outcomes Profiles:

Treatment Outcome Profiles (TOPs) are a National Outcome Monitoring tool to be used by key workers with clients who are both entering and currently in structured treatment programmes. The TOP is a series of questions asked by the key worker and answered by the client (with regards to frequency of use in the past 28 days, social functioning, housing, injecting behaviour, employment etc.) in order to measure outcomes in a meaningful way that is sensitive to change over time.

Please note that the statistics used here are for management, quality assurance and briefing purposes only – not for release into public domain until any official publication has occurred).

The National Treatment Agency has set an 80% completion level threshold for TOP starts, reviews and exits in order to allow for robust data to allow for meaningful outcomes monitoring. Further information about client behaviour and outcomes is also explored in this section beyond the completion levels for each TOP stage.

With regards to TOP starts:

- 87% of new treatment starts between 1st April 2008 and 31st March 2009 had a TOPs completed within guidance. This is above the threshold of 80% set by NTA to allow for robust data findings.
- Of those new treatment starts with regards to substance use behaviour in the past 28 days, locally, there is a higher prevalence of opiate and crack use than regionally or nationally; and corresponding lower levels of cocaine, amphetamine and cannabis use than seen regionally or nationally. This may be reflective of how treatment services are perceived – with a predominant perception that they are substitute prescribing services – it may also reflect the NDTMS reporting configuration where Tier 2 level work with such cannabis and stimulant users is not uploaded.
- Interestingly, when comparing those treatment naïve clients' TOPs to those previously in treatment, there is a lower prevalence of opiates and crack use for treatment naïve clients with a higher prevalence of cocaine, cannabis and alcohol use in the 28 days prior to entering treatment. The difference in substance types may account for the lower prevalence of injecting and sharing seen for those treatment naïve clients compared to those previously in treatment. In terms of criminal activity, there is a slightly higher prevalence of shoplifting and drug dealing for those treatment naïve clients which may reflect DIP as the main referral source of those treatment naïve clients.
- Those clients aged 25+ locally had a higher prevalence of opiates and crack use than those aged 18-24 which reflects last years' needs assessment findings that drug use patterns are changing with an emerging trend towards ACCE use for those younger clients and an ageing drug treatment population.
- The proportion of those new treatment starts who use heroin or crack daily is also higher than that seen regionally or nationally.
- Of those younger clients who answered injecting questions, whilst there was a lower proportion of those aged 18-24 who injected compared with those aged 25+, those younger clients showed a higher prevalence of sharing than older clients.
- Of those treatment starts who answered questions on criminal activity, there was a higher prevalence for shoplifting but for all

other types of crime these were at/below prevalence levels seen regionally or nationally. As expected, those CJS clients had a higher prevalence of 'shoplifting' (as well as daily shoplifting prevalence) and a higher prevalence of 'other theft' than those non-CJS clients. Similarly, those CJS clients had a lower prevalence of paid work than non-CJS clients.

- Younger clients aged 18-24 had a lower prevalence of those in paid work or education than those aged 25+. This suggests that there is more incentive needed for those younger clients to enter treatment to re-establish independence and reintegration whilst also treating substance misuse issues before such use becomes embedded and long term.
- The health and social functioning section of the TOPs treatment starts shows a much lower prevalence for those with an acute housing problem or who are at 'housing risk' than seen regionally or nationally. This may be reflective of proactive housing referral and services delivered locally via Supporting People and the Housing Project for drug users.
- Mean scores for those physical, psychological and quality of life questions answered are in line with regional and national averages (mid-way between range of 1-20).

TOP review information provides descriptive feedback for client behaviour within the 28 days prior to review TOP date and allows for a snapshot of what clients in the treatment system look like during their treatment journey. NB: Please note that this information is independent of whether a client has had a treatment start TOP.

With regards to TOP reviews:

- Review TOP compliance for 2008/9 (36% for those reviews 5-26 weeks post modality start date) is significantly below the 80% threshold level set by NTA to allow for robust data collection. The reporting period for review TOPs has since changed which has resulted in an increased compliance rate – however this increase is not consistently at the 80% threshold yet.
- Review TOPs information is given for those clients receiving a review 5 weeks to 6 months after modality start date; 6-12 months after modality start date; 1- 4 years after modality start date and 4 years+ after modality start date. Whilst the same clients do not appear in each report, it is possible to compare behaviour of clients that have been in treatment for a short period of time compared to those that have been in longer.
- If we look at the proportion of those who reported they were still using substances at treatment review compared to data collected at

triage assessment, we can see that for those clients who have been in treatment longer (denoted by a greater amount of time for the review period since modality start), the proportion still using has consistently decreased. This shows the importance of retention and effective engagement in treatment services as impacting on such reduced use and increased positive outcomes. Similarly, the mean number of days of those still using has, overall, shown a decrease as review period lengthens, with the exception of alcohol which has remained consistent as treatment length increases.

- In comparison to data collected in injecting at triage assessment, for those clients who report they are still injecting at TOP review, whilst prevalence levels are lower than those seen regionally or nationally meaning that a higher proportion of clients have stopped injecting after accessing treatment locally; there is no such corresponding decrease in the proportion still injecting as review period lengthens (however care must be given to such findings where small numbers are concerned).
- For those clients who presented to treatment with either 'No Fixed Abode' or a housing problem, at subsequent review, there was a very small proportion who reported still having NFA or a housing problem, and for those clients receiving a TOP review 1- 4 years on from presentation and more than 4 years on from presentation there were no NFA's or clients with a housing problem (better than regional and national prevalence still seen at this stage).
- As review period lengthened, the prevalence of substance use in the 28 days prior to review decreased for all substances (and was often below regional/national prevalence levels seen) -with the exception of alcohol. Further to this, of those who were still using substances at review, the percentage who were daily users, was often below the regional/national average seen except for cannabis and alcohol.
- In comparison to the prevalence levels of criminal activity seen at TOP start, the prevalence levels of criminal activity reported at review are much lower – and in contrast to the higher local prevalence than regionally/nationally seen at TOP start- are lower than regional or national at review.
- In comparison to the prevalence levels of paid work seen at TOP start, the prevalence of paid work at reviews is higher – as are mean scores for physical, psychological health and quality of life which increase as TOP review period lengthens.

4.7 Partnership Performance Summary (Quarter 2 2009/10):

More detailed analysis of those in treatment and of treatment system performance issues can be accessed from last years Needs Assessment.

To date, these continue to be namely retention and planned exits.

This year we have introduced a Quarterly Assurance Framework (QAF) as part of addressing some of these issues with service providers whereby the production and use of management information to understand and shape delivery along with identified good practice is discussed in response to identified issues.

A brief overview of partnership performance is as follows:

- NI40 is on target to achieve numbers accessing effective treatment. Last year the ambitious 13% target set was over-achieved with a final outturn of 15.6%.
- 96% of clients access treatment within 3 weeks. Locally there is a strong perception among service users that it takes a long time to get into treatment however this most likely reflects the time taken from walking through the door to receiving a prescription. National user satisfaction findings show higher levels of satisfaction for those whose comprehensive assessment took place within a week of attending services.
- An increase in the proportion of offenders who are being engaged on release from prison (Counselling and Rehabilitation Therapy (CARAT) to Criminal Justice Intervention Treatment (CJIT) transfers)
- Levels of retention at 77% are still below regional and national levels seen, and the planned exit rate (28%) remains in the bottom quartile nationally. National user satisfaction survey findings show that clients who have attended their service for between 7-12 months had the highest levels of satisfaction as did those who attended 2-4 times a week.
- ‘Prison’ and ‘drop out’ account for those not retained and leaving in an unplanned manner – the Continuity of Care Plan has helped to ensure continuous treatment for those clients entering/exiting prison, however the area of drop outs which constitutes the main source of the problem for retention and planned exits continue to remain at unacceptable levels when compared to regional and national averages and DAAT family group. Work around this via the QAF process and use of the NTA ‘towards successful completions’ document is still on-going.
- Offenders starting and successfully completing community supervision (Drug Rehabilitation Referrals (DRR's)) are just below target at this point in the year.
- TOP completion rates for start (86%); review (78%); and exits (71%) are all at or above national completion rates – however completion target of 80% for all TOPs stages needs to be met.

- DIP engagement in structured treatment remains substantially lower than the benchmark share.
- The proportion of clients with no status recorded as part of BBV/HR interventions has reduced –which has led to an increase in the proportion who have been offered a BBV intervention. The area of focus now is to increase the subsequent uptake and completion of BBV interventions for those in structured treatment and to increase referrals to the BBV service for those in contact but not already accessing structured treatment services.

4.8 Drug Strategy Priorities (Treatment Plan Part 2 Update):

The key local priorities chosen for Sandwell for 2009/10 were ‘engagement’ and ‘successful exits’ of all client cohorts. For some of these cohorts no target was set as we intended to improve collection and hence robustness of data.

- Penetration levels for key client groups (crack , BME and parents) are either at or above regional and national averages showing improved engagement of users into treatment.
- However of those accessing effective treatment (in treatment 12 weeks+, or if leaving treatment before 12 weeks with a discharge code of ‘treatment complete’ or ‘treatment complete drug free’), all priority groups show lower levels than those of regional and national proportions – this is reflective of overall retention levels which remain below regional and national levels.
- With regards to planned exits, in particular, those under 25yrs and parents show much lower levels of planned exits than regionally or nationally – this is reflective of planned exits for all clients which again, are below regional and national averages seen.

The following tables show progress against locally set targets as at Quarter 2 2009/10:

| Improved engagement – % change | | | | |
|---------------------------------------|--------------------------------------|-----------------|---------------|-----------------|
| | Locally Set Target (% Change) | Sandwell | Region | National |
| Crack | N/A | 8% | -1% | 0% |
| Parents | N/A | 6% | 0% | 0% |
| BME | 4% | 3% | -1% | 0% |
| CJS clients | 7% | 5% | -1% | 1% |
| Under 25s | N/A | 3% | 0% | 0% |

For those BME and CJS clients, good progress has been made in improving levels of engagement against the locally set target of a 4% and 7% increase respectively – however as noted above – this still leaves us below regional and national average outturn.

For those crack and parent cohorts, it was decided to first improve missing data and therefore data robustness.

| Improved successful exits - % change (all clients) | | | | |
|---|--------------------------------------|-----------------|---------------|-----------------|
| | Locally Set Target (% Change) | Sandwell | Region | National |
| Crack | 5% | 3% | 1% | -1% |
| BME | 5% | 11% | 5% | -1% |
| Parents | 5% | 17% | 5% | 0% |
| CJS | 5% | 6% | 4% | -1% |
| Under 25s | 5% | -24% | 1% | -3% |

Those clients under 25 years old show a decreased proportion leaving treatment with a successful exit. This links back to joined up working with C&YP services, as well as assessing the appropriateness of adult services for those younger adults, and whether this would warrant a bespoke service tailored to such needs.

5. FAMILIES :

5.1 Scoping the Remit & Definition

With an increased focus on the needs of families from both national and local drivers such as the ‘Think Family’ Agenda and ‘Time to Deliver’ Local Family & Parenting Support Strategy, we need to ensure that service provision for both drug and alcohol related family needs are responsive, flexible as well as being aligned to existing local mechanisms linked to the agenda.

The dislocation of individuals from their family and networks is highly impractical especially with regards to the substance misuse agenda. This section of the Needs Assessment aims to address the Government’s commitment in the 2008 Drug Strategy, *Drugs: Protecting Families and Communities* from a local perspective, to put greater emphasis on the needs of families and carers of drug users, and where parental substance misuse exists. Indeed, this agenda serves to facilitate the dual benefits of increased support for carers and families as well as the involvement of such key individuals in a users care package thereby increasing the effectiveness of the user’s treatment.

Clarity around what is meant by family & the ways in which such an understanding can be used to develop the remit and extent of services necessary is fundamental to progressing the family agenda in an effective and responsive manner.

A Cabinet Office literature review of whole family approaches emphasises the need to recognise the diversity of family forms:

Existing understandings do not always capture the diversity of family forms, traditions and histories. Extending understandings will ensure that marginalised families who face specific barriers to services are reflected in mainstream policy and provision.

The tendency to focus on individuals within the family can result in an entrenched family approach that does not add value to, or recognise the importance of relational and attachment interdependence.

Individualising approaches to family difficulties can lead to pathologising of family members, particularly mothers, and this may lead to particular frameworks for professional practice being adopted and a resistance to implementing family models of provision.

Put broadly, 3 categories for ‘thinking family’ revolve around:

1. Working with the family to support the service user (family members can be seen as partners of providing support alongside services)

2. Identifying and addressing the needs of family members (family members become seen as service users within their own right)
3. Whole Family Support (focus on shared needs & risks that cannot be dealt with from a focus on family members as individuals)

With regards to existing local family services provision based within substance misuse services, these may be seen as addressing the first two of the 3 categories reflective of possible service repertoires needed to address all aspects of a 'whole family' approach.

5.2 Tier 2 Provision:

The 'Family Support Services' service currently provided from the Open Access treatment service is aimed at "providing a range of practical interventions to assist carers with the ability to deal more effectively with issues arising from a clients drug use. These include basic drug awareness, overdose awareness, legal issues regarding drug use and paraphernalia, BBV awareness, treatment options, the criminal justice system, coping strategies, setting and keeping boundaries, support with housing, debt-crisis management, relationship skills, parenting skills and hidden harm.." (Carers Service Service Specification April 2009 -2010). The programme of care is delivered using the '5 Step' Model utilising care plans to verify risk, carers' needs and progress made and ensures carers involvement in the drug users treatment package.

The service is also key in supporting those treatment naïve users to access drug treatment services' thereby increasing treatment penetration. Currently, the 'Family Support Services' service is located from the overall open access service, where most of the interventions and work carried out are done so on an outreach basis, or via home visits. Therefore the need to explore whether a separate and discreet location is warranted is not paramount with regards to this service provision type.

The provider of the 'Family Support Services' service, Aquarius has recently signed up to participate in a research project 'Family Focussed Interventions' - feedback mechanisms and learning /best practice from this is key to enhancing existing interventions offered and needs to be considered in any future service specifications for increased efficacy of interventions around the family agenda.

Detailed performance information on the 'Family Support Services' service is considered within the data element of this section further on.

5.3 Tier 3 Provision:

Information about the local Community Drug & Alcohol Treatment Service (Anchor) from their Spring 2009 Service Review mentions family work, primarily in relation to their social work services: “the team’s remit is to engage with Anchor service users where concern and risk to their children have been identified”.....“if, following assessment or at any time during treatment there is concern that a service users substance misuse may be placing children or the unborn at significant risk of harm, or that children may need either a Safeguarding Plan or a Children in Need Support Plan, then a client’s case will be allocated to a social worker either to take over the key worker role or to work jointly with a key worker from the drug team” (pg19).

Furthermore, “referrals to and joint working with other agencies such as Sandwell Children & Young People’s services, housing and tenancy support services, rehabilitation, debt management, as necessary in order to support the family”.

Such work primarily takes forward the National Institute for Clinical Excellence (NICE) 2007 guidance “Safeguarding the Children of Drug Misusing Parents” locally, however, the extent to which parenting support services are involved or offered is not mentioned (the applicability of which would need to be considered on a case by case basis). Indeed, it is difficult to get an idea of the level of parenting support provision offered to either those parents with potential safeguarding implications or those with no safeguarding concerns.

The extent to which safeguarding assessment criteria are regularly addressed with all clients with children (particularly those not seen by the social work team) is not mentioned with regards to regular reviews with clients, or within key worker supervision. NICE Safeguarding Guidance advises that the checklist needs to be regularly revisited between key worker and client.

Indeed, the very recently released joint National Treatment Agency (NTA)/ Department of Children Schools and Families (DCSF) Guidance on the development of local protocols between drug and alcohol treatment services, and Local Safeguarding/Family Services will need to be considered and taken forward against existing provision and mechanisms of interagency working relationships to help strengthen those.

Similarly, from the Spring 2009 Anchor Service Review document, the identification of friends & family members with possible vaccination and harm reduction needs is not explicitly referenced or mentioned in regards to safeguarding/social work/BBV element of the service.

Support for carers is mentioned within the Anchor ‘Care Co-ordination in Drug & Alcohol Services’ Practitioner’s Guidance whereby the Open

Access family service is cited for workers to make the referral on the carer's behalf.

The Common Assessment Framework is a key part of delivering integrated & focused work around the needs of children & young people. The Anchor social work team contribute to Common Assessment Framework (CAF) assessments undertaken by the Local Authority, helping to promote integrated service provision.

5.4 Children & Young People (C&YP) Provision

With regards to specifically commissioned services from a C&YP perspective, the Aquarius service offers a programme of support for parents/carers of substance misusing children. This aims to improve outcomes for children and young people by providing a parent and carer (including grandparents) support service for the parent(s) and care(s) of the substance misusing young people, with a predominant focus on these with a Tier 3 need. It aims to deliver a preventative service through improving parenting skills, helping parents to educate their children and supporting families to stay together.

5.5 Joining up Adult & C&YP provision:

Generally there is growing evidence that adults substance misuse is a contributory factor for children being assessed as in need. This has prompted plans for a specialist post to act as a consultant to family practitioners and to hold a caseload of complex cases. There is also recognition of the need for projects which work with the children of parents/carers in treatment, as well as addressing health in pregnancy (with regards to foetal alcohol syndrome) which are being taken forward jointly between Adult and C&YP commissioners.

There may well be some 'quick wins' with regards to mapping of all local children's, parenting and family support provision against substance misuse services locally, to enable maximum collaborative working between substance misuse commissioned services and external agencies/ service areas linked to the agenda considering the plethora of relevant agencies identified from the local 'Supporting Parents & Families in Sandwell' strategy: 'Time to Deliver'.

5.6 Whole Family Approach

Overall, with regards to the service provision offered from substance misuse services around the Family Agenda, there is a sense that particular family members are catered for based on their individual needs i.e. carers, children, and users – but there is no overall sense of a *whole family approach*.

The third family category 'whole family support' which is not therefore addressed/ provided for locally when taking into consideration the

services on offer already, prompts a level of coordination amongst existing services and possibly a revision in the remit of some of those existing services into one cohesive, manageable whole.

Galvini identifies 3 theories specifically focused on family work within the substance misuse arena.

- Stress-strain-coping-support theory (Orford et al, 2005) -5 step model
- Attachment theory (Bowlby, 1971)
- Family systems theory (Bowen, 1974).

As previously mentioned the first of these three theories – the ‘5 step Model’ – is operationalised from the carers’ provision within ‘Family Support Services’ Tier 2 provider. The latter two theories may well provide a conceptual framework from which to operationalise some real ‘whole family’ based interventions.

A definition of, and characteristics of, a ‘whole family’ approach and how this differs to the other traditional and often used family based approaches is offered from the Cabinet Office literature review paper:

“rather than addressing the needs of the service user or individual family members in isolation, provision recognises and focuses on shared needs and/or the strengths apparent in interrelationships and collective assets. Whilst aspects of provision within previous categories may have been delivered to the whole family together, this model is distinctive in that the needs to be addressed and the strengths upon which solutions are to be based, are perceived to be held within the collective of the family”

However, evidence and practice examples of such whole family based approaches with regards to drug and alcohol services are notably absent in the review. This is where principles from other service areas are helpful with regards to those core elements, which can translate across service area e.g. involving families in planning and decision making, crisis resolution, community based family support, family group work, behavioural family therapy, systematic and narrative family therapy etc.

There are also some NTA and NICE guidance recommendations which enable the foundations for a family approach – most notably, workforce competencies, assessment criteria, suggestions for family meetings, communication methods and joint working which will need to be considered in more depth with regards to service specifications and commissioning decisions.

One example of a ‘whole family’ approach can be seen from the Pilot Project ‘Breaking the Cycle’ run by Addaction where: “workers look at family dynamics and use a ‘genogramme’ – a sort of sophisticated family tree to chart drug misuse – to unearth patterns of behaviour and pinpoint the psychological factors that may have a negative impact on familial relationships”... furthermore... “Breaking the Cycle is based on the skill of

an individual worker; whose advocacy on behalf of a client and their family (and the management of a caseload between agencies) sidesteps a potential mountain of bureaucracy... it works because of the project's systematic approach to evaluating impact. Addaction has developed an outcome monitoring tool to chart a family's progress, and to provide project workers with an early indication of what works (and what doesn't). The tool measures against 14 outcomes covering issues such as education, parenting skills, family finances, harmful behaviour and social competence". (Drink & Drug News: 2nd Nov 2009).

5.7 How do other service areas locally help to identify the need for family based provision/services?

From a targeted youth support angle locally, use of the CAF has combined the Framework for the Assessment of Children in Need and their Families with the main elements used in other assessments, including the Connexions APIR Framework. The CAF provides a holistic picture of a child/young person's needs. It is based on three domains:

- Developmental needs
- Parents and Carers
- Family and Environmental factors

(Targeted Youth Support Framework: Final Guidelines: October 2009). Guidelines around completing the CAF with regards to confidentiality, information sharing, person's involved, cultural and religious context can provide some useful pointers of how such an overarching assessment tool could be adapted/approached with regards to adults –and raise the possibility of a joint assessment process between children and adult services.

Sandwell Council's response to the Department of Health's 'Shaping the Future of Care Together' green paper also highlighted the importance and need for a single assessment process:

"the principle that people will have one assessment... has received strong support" furthermore to this, on discussing the barriers to making this happen it was noted:

"existing hierarchies and professional boundaries are maintained by professional training within disciplines, and supported by organisational policies which reflect the promotion of budgets"... "when there are practitioners using different models of assessment, the assessment experience for the person becomes ever more disjointed and communication is weakened"

The need for a treatment system-wide (including young people and adults) Common/Single Assessment Framework would not only help to provide more responsive services to identify need (and better identified need) but would also help expedite people into the treatment system and provision of

services against need.

5.8 Data:

In terms of intelligence around the Families' Agenda, the last Census showed that 37.43% of all Sandwell households had at least one dependent child compared with the England figure of just 29.4%. There were 9,270 lone parent households with one or more dependent children, representing 8.03% of all households compared with just 6.4% in England. This constitutes a total of 18,217 children and young people in lone parent families, representing 26.7% of the total population. (Time to Deliver: Supporting Parents & Families in Sandwell, pg 5).

The Hidden Harm Report 2003 estimated that around 3% of all children under 16 are affected by parental drug misuse – according to the estimated population figures for 2008 (MYEs, Office for National Statistics), Sandwell has 64,225 children and young people aged from 0-16: this equates to 1,926 children and young people in Sandwell being affected by parental drug misuse.

The 2004 Alcohol Harm Reduction Strategy for England estimated that 10% of all children are affected by parental alcohol misuse – this would equate to 6,423 children and young people in Sandwell affected by alcohol misuse.

A recent study from UK Drug Policy Commission(UKDPC) estimated the number of family members affected by living with a drug misuser. The estimates were based on applying the proportion of a random sample of drug misusers who responded to surveys on whether they had either a partner, parent or siblings living with them. (UKDPC: Adult Family Members and Carers, of Dependent Drug Users: prevalence, social cost, resource savings and treatment responses. November 2009).

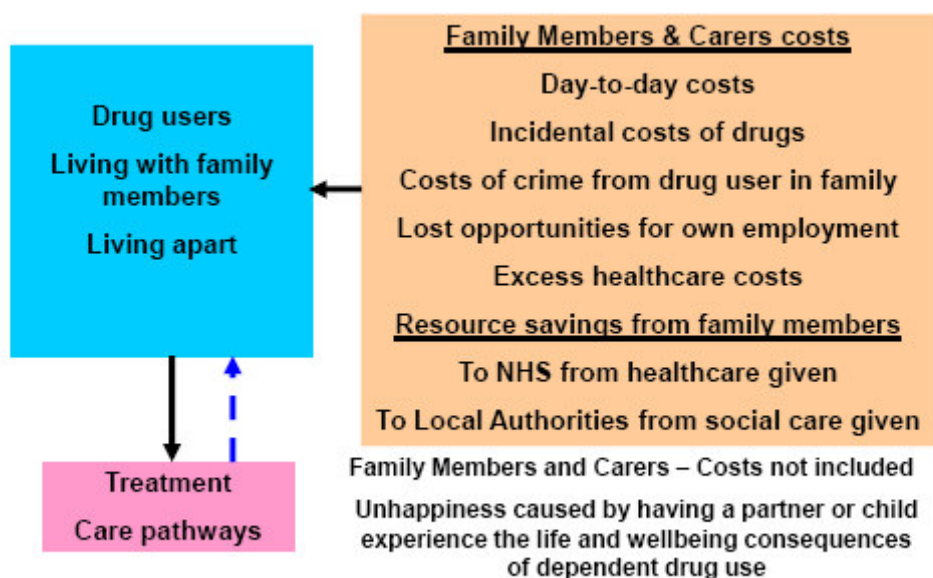
When applying these locally to the number of family members affected by living with a drug misuser we can see that for those estimated PDUs within Sandwell there are approximately 1,363 family members affected (for England the figure stands at 208,685). Obviously this only applies to those heroin and/or crack cocaine users and is worked from a sample survey which only applies to those family members *living with* a user so limitations need to be considered with this estimate. Obviously the number of family members affected for those PDUs in treatment will be smaller but it's useful to apply the proportions to smoothed PDU estimates to get an idea of the impact on the general population of Sandwell.

Interestingly, the UKDPC report goes on to estimate an annual total cost per family member and carer of £9,497 (CI: £7918-£11076).

“The role that family members and carers play in the care and support of drug misusing relatives and the hidden costs they bear are not recognised or acknowledged by a range of public bodies or government. Generally,

the users themselves and the drug treatment services are the focus of attention. This study marks the first attempt to throw light on this issue in the UK and to quantify with a conservative economic estimate the costs to family members associated with illicit drug misuse by a relative that are largely hidden to society.”

The costs and resource savings considered in the estimates are as below:



The report goes onto conclude:

“Families are a largely untapped treatment resource and a force for achieving good treatment outcomes in their drug misusing relatives. The evidence in this report suggests that policymakers need to reframe and reflect upon the negative aspects of the hidden economic costs and consider how this could be turned to advantage by embracing family treatment much more fully.”

With regards to those in adult treatment services, the 2008/9 treatment map data shows that over half (52%) of clients in contact with structured drug treatment were parents (n=555); the corresponding figure for those in alcohol services is unknown but it is anticipated that this will be part of the contract monitoring data for future where National Alcohol Monitoring Treatment Monitoring System (NATMS) data is recorded.

36% of all those in effective treatment* locally are classed as parents (a service user living with one or more children) – this is higher than the proportion which parents constitute of all those in effective treatment regionally or nationally (31% and 30% respectively).

However, if we look at the number of parents whose treatment journey starts over a specified period (July 2008-June 2009) a much lower proportion of

parents are engaged in effective treatment than regionally or nationally (79% compared with 87% and 86% respectively). Similarly, with regards to treatment exits data, a lower proportion of parents exit the treatment system successfully than regionally or nationally (30% locally compared with 34% and 37% respectively). These lower levels of effective engagement and successful exits for parents are reflective of the overall treatment system. Therefore, parents need to be a priority group identified in Part 2 of the treatment plan with regards to effective engagement and planned exits considering others affected by their substance misuse.

*To qualify for being in effective treatment a client must be either retained for 12 weeks or complete treatment successful).

(Source: Drug Strategy Priorities Report, Quarter 2, 2009/10, NDTMS).

An assessment of the number of children with substance misusing parents is not forthcoming from the Children & Young People's needs assessment, we need to identify this and check if this could be double counting the substance misusing parents with children or another cohort? We also need to quantify how many of those drug misusing adult's children we have in C& YP treatment services? How many children on the child protection register with parental/ carer sub misuse needs? All of these questions around the hard statistical evidence are identified data needs that are being addressed via the Adults and C&YP commissioners to start to be collected. Indeed those child deaths due to substance misuse e.g. co-sleeping are also another useful statistic to inform the agenda which needs to be collected.

For those children classed as 'in need', it has been noted locally that the threshold set is very high and does not inform of lower level need which could be used to inform the need for preventive family based interventions to potentially address and prevent any escalation into more problematic use if not tackled at an early stage.

Local anecdotal evidence is therefore key with regards to the Family Agenda, Feedback from the **Sandwell's Drug Education, Counselling and Confidential Advice team.** (DECCA) service has shown a level of need raised from a local school with regards to substance misusing parents. It is believed that approximately half of those children in class have parents who misuse mainly alcohol and cannabis. The need to link family based provision from a 'friendly face' located within the school with a 'no wrong door' approach needs to be understood and piloted – with possible roll out to other schools if feedback proves a real need and real impact.

With regards to treatment system provision, the Tier 2 open access 'Family Support Services' data shows that -:

- The majority of referrals to the service are self referrals, with very low levels of referrals from main structured treatment provider. Either this is reflective of a need for better promotion of the service and identification of drug user's family/carers needs from the main structured treatment

provider, or that many carers/family members are not/may not want to be linked to a 'treatment provider' and will bypass that route to access the service direct instead.

- A quarter of referrals to the service have an unknown referral source – more complete data capture is necessary to understand and increase the level of support that can be offered via all possible routes for engagement
- The majority (75%+) of those accessing the service are white and female – does this indicate non-take up or refusal of such service provision from other key groups where there maybe a real need for resilience building within those marginalised families.
- Information about the types of intervention offered do not suggest any group focussed work. The types of intervention offered consist of 1:1s; telephone support; home visits and advice/information.
- All new presentations into service have a care plan commenced.
- Those agencies listed as co-working with the service consist of: probation; police; and structured treatment providers – it would be more useful to understand the extent of co-working with other family related services such as those mentioned in the local 'Time to Deliver: Supporting Parents & Families in Sandwell' Strategy.
- Information on the number of substance misusers who have accessed services as a direct result of carer intervention is unknown – one of the central tenets of the service.
- Majority of those accessing the service have contact with a primary heroin user – how much are we penetrating related need against those ACCE family needs?

Overall, the need to engage higher levels of family members and carers throughout a client's treatment journey to work towards increased positive outcomes for the client as well as addressing the needs of those affected by the clients' drug misuse is vital. Currently the adult commissioned 'Family Support Services' have an average caseload of 75 people accessing the service – this translates to approximately 7.6% of the numbers accessing effective structured treatment for the 2008/9 FY. Source: Aquarius QAF report: Family Support Services, Quarter 1 and interim Quarter 2, 2009/10 report).

More qualitative data from the NTA annual survey of drug treatment clients showed that a third of clients felt family members and carers needed more support (an increase from the previous year).

Data on lived experience of family members is very limited. We therefore

need to acknowledge our gap in information/intelligence around the family – links to local Parenting Strategy ‘Time to Deliver’ and the move to integration at all levels especially with regards to the intention to invest in an integrated data hub system that will enable collation of all information on the family in one place (rather than the piecemeal approach of partial data from across service areas against individual family members).

5.9 Key Considerations:

There are key considerations underpinning delivery against the Family agenda for DAAT commissioned services – most notably:

- an understanding of our “family” provision services within existing local services aligned to the family agenda
- an understanding of our treatment & recovery led services within existing local services aligned to the family agenda
- extent of co-working needed between adults and C&YP substance misuse commissioning, and the potential for joint commissioning to enable some real added value to the agenda– (taking into account the 3 sides of the triangle –children, parents and family –not something that can be done in isolation). This should help to bridge the gap in traditional service delivery funding streams which can lead to a fractured approach focussing on separate sides of the triangle (e.g. adults funding separate to children funding).
- links to local Parenting strategy, family strategy, children’s plan – alignment of these agendas to that of planned Drug & Alcohol Strategy –is prioritisation of access to drug treatment consistent message between these?
- an understanding of all family related provision and the remits of each type of provision to allow for meaningful pathways and substance misuse provision services’ place within that linked to extent of commissioning needed
- governance structures linked to family based provision and the scope for DAAT involvement in any potential ‘pooled’ investment with other service areas /commissioners
- workforce competencies and the scope to access skilled family workers through DAAT specific provision or through generic family workers with a substance misuse remit as part of their entire remit
- a shared understanding of the family agenda in helping to support whole family thinking in order to avoid a fragmented approach & parallel conversations around the same issue- and what that translates to in terms of whole system design and service provision –how do we get to those common /shared aims? Maybe a need for Parenting Commissioner, C&YP generic commissioner at Joint Commissioning Group JCG?
- Understanding that whole families approach is not always appropriate or useful for all families or all needs. This needs to be approached from

- a quality approach rather than ‘blanket’ provision - with skilled and competent workers who can make that judgement
- Recognition of the limitations of family approach and the right to private family life– assurance and marketing approach
 - The extent/balance of medical and social model perspective necessary to service provision by type of provision
 - The role of the family as a key group in working towards reducing the risk of overdose and BBV transmission (especially for those living with current IDUs). Indeed – is there a role for such carers and family members in offering support and training to other family members and carers in a peer led manner? The extent of plausible crossover between this agenda and the local HR strategy therefore needs to be aligned and documented within that strategy.
 - The place of the family agenda with regards to building social capital and resilience in relation to increased positive outcomes for clients and the wider recovery agenda (where concerned with networks, norms and values)
 - Overall, with regards to the service provision offered from substance misuse services around the family agenda, there is a sense that particular family members are catered for based on their individual needs i.e. carers, children, and users – but there is no overall sense of a *whole family approach*. How do we make that step towards such an approach and co-ordinate /add value to the individualised approach in place already? And what are the added benefits with regards to hidden harm detection to enable more preventive work to take place before a reactionary process of safeguarding has to be reached?
 - Very recently released NTA & DCSF joint guidance on the development of local protocols between drug & alcohol treatment services & local safeguarding & family services - how learning / recommendations from this will need to be adapted and applied locally. Such protocols spell out the important role that drug workers can play in delivering a children’s plan – this needs to be explicitly referenced and considered for commissioning of services and their remit and links/working relationships with external agencies
 - Learning from the approach taken by the local Family Intervention Project –e.g. an assigned key worker to each family who coordinates and delivers practical support and more specialist interventions including a whole family support plan ranging from evidence based parenting support to diet and budget help - and how this ties in with/ works alongside both adult and children drug and alcohol services to maximum benefit
 - parents need to be a priority group identified in Part 2 of the treatment plan with regards to effective engagement and planned exits
 - a need to engage higher levels of family members and carers throughout a client’s treatment journey to work towards increased positive outcomes for the client as well as addressing the needs of those affected by the clients drug misuse
 - the need for a single assessment process (across young people and adults) to be used treatment system wide to better identify need and to expedite the response process across providers

- the need for greater intelligence to inform the agenda in order to right size provision – e.g. number of children on child protection register with parental/ carer sub misuse needs; child deaths due to substance misuse e.g. co-sleeping
- the need for DAAT representation on Local Children Safeguarding Board (LCSB)
- is there specific work around the family needs and children of prisoners/family members on community sentence that would warrant further specific inter-agency work from a CJS point of view? Working with a high risk, vulnerable group and towards the wider remit of reducing re-offending

5.10 Contract/Commissioning Implications:

- Ensure that specific clinical guidelines are addressed explicitly within service specifications e.g. Safeguarding the children of drug misusing parents (Dec 08) & the need for regular reviews against the recommended checklist between key worker & client
- Links from safeguarding assessment to inform Harm Reduction needs /BBV work & appropriate referrals
- Workforce training and development - competencies re: assessment (HR implications) / group therapy focus –do we have a local workforce strategy? Do we need one? E.g. accessibility of written materials covered within this as well as key worker competencies.
- Commissioning for outcomes – How do we measure family outcomes to help focus provision and interagency activity to monitor entire systems approach rather than fragmented / piecemeal activity
- Does existing family based intervention provided via Open access service need to be refocused/ extended/ aligned differently?
- Data sharing and information flows between substance misuse and generic services in line with Caldicott Guidance
- The GMS contains GP involvement /sign up to family, partner and carer BBV vaccinations – the extent of linkage between such GPs and referrals from the ‘Concerned Others’ service may need to be explicitly addressed and strengthened within future service specifications to further progress local HR strategy impact
- Local interagency protocol to include details of local services, referral pathways, and arrangements for the prioritisation of parents/family members. To further establish links between substance misuse treatment services and children, parenting and family services in line with joint NTA/DSCF guidance – to address NTA’s Models of Care, DCSF’s Think Family toolkit and Department of Health’s Model of Care for Alcohol Misusers (MoCAM).

6. RECOVERY :

This section aims to understand how substance misuse services can be better configured (from both within the treatment system but also externally the links needed from partner wide agencies) to enable drug users to work towards drug free and productive lives.

In 2002, the Audit Commission identified the need for housing, social care and other services to provide drug users with support to maintain progress made during treatment enabling them to become employed, suitably housed and more self sufficient. The subsequent 2008 Drug Strategy reinforces a need to offer real opportunities for those individuals overcoming their dependency (from entering drug treatment) to reintegrate back into the community to rejuvenate their social bonds with the ultimate aim of leading drug free lives.

This approach needs to happen alongside treatment – to provide a focus on integration which will run throughout the treatment journey – addressing wider health and social care needs to consolidate gains made through engaging in structured treatment.

The UKDPC final consensus statement on recovery is as follows:

“the process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and well being and participation in the rights, roles and responsibilities of society”

Dr Roy Roberston (Network newsletter 2009) advises of the implications of the UKDPC statement with regards to 3 vital elements of recovery (with particular regards to the role of GPs but which can be applied throughout our treatment system):

- personalisation and choice: recognising that a single approach will not suit all and that a clients ownership of their recovery is important in determining their own goals and steps needed to achieve those
- recovery capital: reintegration into society to build a satisfying and meaningful life –it is impossible to separate out a clients recovery in terms of health from their social network
- being positive: if the treatment provider can be positive about a clients prospects, then the client too can be positive about their route to recovery

The above UKDPC statement is useful to consider with regards to our own local treatment system and services- and whether they are genuinely recovery oriented.

With regards to service review information submitted by treatment providers, recovery focussed work is not singled out as a particular aspect/philosophy within overall service provision but seems somewhat hidden within multi-agency working and transfers on for those more stable clients: does this therefore compartmentalise the recovery agenda into piecemeal

activities/provision which may negate any added value from a shared understanding of ‘recovery’ and from combining such provision? Similarly does this embed a treatment system which is more focussed on addiction management at the expense of providing a real recovery model?

The Tier 3 specialist drug treatment service specification does state a need to address departure planning, aftercare and support but it does not explicitly place such provision within a wider recovery agenda nor prompt service delivery against the 3 key elements of recovery as sited above (personalisation; recovery capital and positivity).

There is a need for a review of specifications to explicitly reference the recovery agenda, as well as Integrated Care Pathways work across providers and partners to establish and strengthen sign up to a recovery agenda and configuration to one another from such a shared understanding.

William White’s thinking around recovery from a joint medical and social model of addiction so that recovery reconnects addiction treatment to the larger process of recovery in the community is important to site here so as to address any potential artificial demarcation of the two essential aspects in planning and future configuration of all commissioned and links to non-commissioned resources. (William White: The mobilisation of community resources to support long term addiction recovery).

Further to this, Peter Adams describes a need to move beyond the ‘particle paradigm’ with its biopsychosocial underpinnings (characterised by insufficient attention to the social aspects of addiction) towards a social paradigm: *“which shifts the focus of attention away from people as discrete individuals and towards people in terms of their relationships”*

In fact, in trying to understand where we are at with regards to recovery by merely examining any mention of said within current established service delivery does not go far enough in how thinking, treatment philosophy and whole treatment system configuration needs to be addressed. Recovery cannot just be an ‘add on’, but needs to be embedded within an appropriately configured system which has recovery underpinning every aspect of service delivery and configuration.

With such ambition for a truly recovery led model, it is impossible that such a change could be achieved within one single leap – shifting from a predominantly stabilising and maintenance led model of care to a recovery based model; shifting to a locally led approach where partners need to share performance objectives; shifting from nationally led to local systems characterised by partnership, personalisation and community embeddedness will all require, first and foremost, a shared understanding of that ambition.

The Treatment Map Summary for Tier 3 and Tier 4 are important to note here which show a need to open up wider treatment system/ through-flow (see Appendix 2) – we are getting the numbers into treatment but actually progressing people through the system is not happening – almost ‘on hold’. Is

there a need to review the Shared Care element as a transitional and reintegration mechanism rather than another maintenance provider? A need to move to a primary care recovery programme linking community based prescribing services with structured day programmes, as well as a need to increase GP community prescribing capacity (via PEC audience).

6.1 Tier 4/Rehab/Detox

Service Review information from treatment providers is useful to consider here with regards to the elements of provision offered within the local treatment system. Most notably, the specialist Tier 3 service provide for detoxification using Lofexidine in the community and inpatient settings; the initiation and safe use of Naltrexone as an opioid-antagonist to clients who have successfully abstained from opiates; management of clients with stimulant misuse by providing detoxification and maintenance on dexamphetamine when appropriate; providing safe detoxification options for clients with co-existing alcohol and opiate dependence syndrome through regular monitoring and ensuring safe prescribing.

The current Tier 3 specialist drug treatment service specification states that:

“Service providers refer clients for assessment for residential detoxification where needed”.

The extent to which Tier 4 interventions/services can be offered to clients currently accessing Tier 3 structured treatment, and the capacity available needs to be made clear to ensure appropriate referral on.

SAVE conducted a quick poll of whether service users would take up the option of Tier 4 services if offered to them- 63 clients answered positively to this statement

- A copy of the Tier 4 Treatment Map is available in Appendix 2.
- The Tier 4 treatment map shows that there are very few referrals into Tier 4 services locally – 13 in total for 2008/9 – a decrease from 17 last year. Does this balance against intentions for a recovery led system?
- Unfortunately, the treatment map exit data does not give us an idea of continuity of care when clients enter back into the community – this is something that should be proactively managed between the referring service and Tier 4 provider to enable effective care co-ordination and suitable further treatment – be that relapse prevention, regular monitoring, or further treatment.

An options appraisal of Tier 4 utilisation locally highlighted the need to consider the currently low uptake of such services for both drug and alcohol clients. Pathways work needs to be undertaken with providers in terms of examining case work to look at the process of referral and Tier 4

service take up.

A 'preparation for rehab' programme has been developed in Torquay which assists clients in understanding their motivation for and suitability for rehabilitative treatment. All clients who express an interest in rehabilitation are referred for the programme by their key worker and must complete the programme to be considered for rehabilitation by a panel which ultimately approves their funding. Such a scheme may help to increase outcomes for those entering rehabilitation services – and enable right sizing of provision for the local 'in treatment' population and appropriate referral.

Some learning from the DIP Continuity of Care Agenda is useful to consider here with regards to strengthening pathways for those clients leaving Tier 4 and being engaged once back in the community for relapse and aftercare.

6.2 Relapse and Aftercare:

Last years Needs Assessment identified a high rate of return for service users – a typical 'revolving door' syndrome where, 1 in every 2 of the cohort who left treatment during one year subsequently presented the following year. There is a need to identify any formal relapse programmes offered / incorporation of relapse into treatment interventions offered to provide adequate support and to stop individuals being continually recycled through the treatment system.

The 2007 SAVE local service user survey commented "without well thought out and consistent aftercare there is little to encourage service users to maintain a drug free life".

The service specification for Tier 3 specialist drug treatment services requires:

"Service providers to offer relapse prevention as a component part of a programme". Any mention of relapse prevention or relapse response is notably absent within Tier 3 service review information.

With regards to the role of shared care liaison workers in terms of relapse provision, the element of relapse response is as stated:

"Responding when a client's situation changes such as relapse into chaotic drug use or needs becoming more complex... (shared care liaison) workers will initially try to work with the client to address these problems by providing more intensive support and liaison with and referral to other agencies. Should the client's needs remain complex, care can be transferred to the specialist prescribing treatment service without disruption to their treatment plan".

(Anchor service review, Spring 2009, and Guidelines for the shared care of opiate misuse in Sandwell, Dr Mark Padley. May 2007)

The Aquarius alcohol service delivery element of relapse provision is as follows: After initial assessment and course of sessions delivered against identified need in the care planning process, clients are then offered ongoing support by support workers. In particular where there are any concerns with regards to a client relapsing or any potential risk of relapse, clients are immediately booked in an alcohol practitioner. This is also the same process used for those clients undergoing community detox. Such process/method/assessment used for identification of potential relapse & possibility of building this into other interventions provided locally could be usefully applied to drug treatment provision.

So far the remit seems to point towards relapse *response* over and above relapse *prevention* – for those clients still using at the end of treatment, relapse prevention should be part of the exit process.

Do we need treatment system wide ICPs for relapse protocols and treatment system wide early warning system adopted?
How do treatment providers link in with relapse prevention non-commissioned programmes?

It is also important to mention here the role of family members and wider social networks in understanding recovery goals of the individual so as to help prevent relapse and improve treatment outcomes. Is current service provision really drawing upon all available resources in preventing relapse as this is not mentioned anywhere with regards to relapse prevention or aftercare packages?

Aftercare was notably absent in the mention of services currently provided in service review submissions earlier this year – there is therefore a real need to ensure that follow up is an essential part of treatment so that we can assess and reduce potential risk factors with regard to substance misuse, to encourage protective factors for a healthy lifestyle and provide adequate support for sustained recovery and social reintegration. Indeed, in taking into account the National Drug Strategy's emphasis on enabling patients to move on from their addiction with reintegration in to mainstream society and especially into employment as key ways to help prevent relapse and therefore relieve the need for extended care, there may well be an implication that such a way out of treatment implies "a corresponding shift away from extended and/or indefinite treatment options" (JR McKay: Continuing Care Research). This must not negate the need and benefits that have been proven from long term continuing care with regards to client outcomes. Of all recommendations from McKay's review, extended and regular monitoring of the patient's progress was the key component of continuing care- and with this the recognition of changes needed in the way that continuing care is conceptualised and delivered.

Indeed, JR McKay in "The effectiveness of telephone based continuing care for alcohol and cocaine dependence: 24 month outcome study" shows that flexible aftercare regimes mixing initial support with regular phone calls

is at least as effective as entirely face to face contact, yet far less time consuming for those less relapse prone clients – and therefore saves on resources.

The use of the personalisation agenda in terms of the recovery agenda, especially with regards to relapse prevention, response and flexible aftercare. This something which could be explored/ piloted locally where a client together with their key worker could choose from a menu of reintegration and recovery based options to suit their own needs and aspirations.

6.3 Housing:

Housing is of significant importance with regards to the recovery agenda – most notably through the provision of safe, stable environment conducive to health and recovery. With regards to substance misuse there is a tradition of residential therapies through a range of halfway, three-quarter way houses and structured environments which allow for a higher level of independence and reintegration into the community than inpatient care allows. The halfway house example where residents are expected to work, pay rent, provide each other with mutual support –and which can be linked back to a specialist treatment provider if so desired, allows for a continuum of care along routes to recovery and independence which should be explored locally.

Further to this, the first randomised trial of placements in supported housing /aftercare environments showed that those in a communal housing situation experienced lower substance use, higher monthly incomes and significantly lower arrest and imprisonment rates (Jason, Olson, Ferrari et al, 2006).

We would at this point need to consider the possibility of housing options and partner buy in for such provision, but also need to consider whether such supported housing options were aimed at those already abstinent or as a support to motivate and aid recovery.

The impact of unstable housing or homelessness can have a significant impact on a client's attendance at treatment, their progression into employment/education/training, as well as higher levels of injecting risk and associated infections amongst IDUs.

Whilst the majority of clients (89%) presenting to treatment during 2008/9 had no housing problem at all, 11% had either a housing or urgent housing problem –the same proportion as the previous year.

Addressing both substance misuse and housing needs together offers best chance of a successful outcome for clients as well as increased satisfaction levels with treatment (2007 user satisfaction survey, NTA, found service users in settled/permanent accommodation reported higher levels of satisfaction and homeless users the least satisfied).

Services already aimed at supporting accommodation needs of those with substance misuse issues consist of a housing project for drug users who are already in treatment (housed approx 40 people during 2007/8) as well as the Tenancy Support Service which aims to: *“focus on supporting vulnerable groups to maintain and sustain their independence in the community. This includes drug users, people with alcohol related problems..”*

In terms of outcomes for the TSS, during 2008/9, 54 service users were in need of support to better manage their substance misuse, and 33 service users managed their substance misuse issues better.

The links between such local housing service provisions will need to be considered and aligned to any potential criteria and pathway development to possible residential therapies such as the aforementioned half way house concept. Also to note here is the un-ring fencing of Supporting People funding and any potential knock on effects with regards to engagement and retention of clients in treatment.

(Tenancy Support Service Annual Report 2008/9).

6.4 Employment and Skills:

Last years Needs Assessment findings showed with regards to the Employability Agenda that:

- over four-fifths of clients in treatment were unemployed. Parental status and accommodation status had an impact on the employment status of clients - clients with no dependent children and those in stable housing were more likely to be in regular employment than those clients with a housing problem. This suggests support for non drug issues in order to increase successful outcomes for clients.
- The 2007 National User Satisfaction Survey, NTA shows that unemployed service users showed significantly lower levels of satisfaction with treatment than those who were employed – such satisfaction is integral to retention of service users and increased positive outcomes
- a smaller proportion of IB/SDA clients citing a drug and alcohol condition compared to the regional and national average – this may well be less awareness of benefits available or less likely to disclose such information. Indeed responses to the additional services clients would like to see offered alongside treatment (Satellite Services Nov 2009 survey) showed that over 85% of respondents felt help with benefits would be either useful or very useful.

- The following table from a DWP feasibility study also reflects this fact (lower levels of benefit clients citing a drug/alcohol condition locally)– please note that these are estimates for 2006 which show the estimated percentage of PDUs on main benefits:

| Area | JSA | IS | DLA | IB | MB |
|--------------------------|-------------|-------------|-------------|-------------|-------------|
| Birmingham | 7.32 | 10.51 | 3.05 | 7.07 | 8.75 |
| Coventry | 6.42 | 7.41 | 1.90 | 4.30 | 6.03 |
| Dudley | 5.73 | 8.91 | 1.88 | 4.38 | 6.04 |
| Herefordshire, County of | 10.47 | 9.52 | 1.36 | 4.74 | 7.17 |
| Sandwell | 4.19 | 5.78 | 1.33 | 3.32 | 4.45 |
| Shropshire | 6.67 | 6.98 | 1.17 | 2.97 | 4.56 |
| Solihull | 6.47 | 7.87 | 1.77 | 3.85 | 5.65 |
| Staffordshire | 6.30 | 7.06 | 1.06 | 2.69 | 4.42 |
| Stoke-on-Trent | 8.94 | 7.54 | 1.51 | 3.30 | 5.78 |
| Telford and Wrekin | 6.40 | 5.49 | 1.09 | 3.11 | 4.53 |
| Walsall | 5.46 | 7.53 | 1.73 | 4.19 | 5.72 |
| Warwickshire | 5.68 | 7.28 | 1.23 | 3.25 | 4.86 |
| Wolverhampton | 5.31 | 7.97 | 2.08 | 4.90 | 6.26 |
| Worcestershire | 7.98 | 9.08 | 1.57 | 4.24 | 6.36 |
| West Midlands | 6.59 | 8.36 | 1.81 | 4.43 | 6.29 |

- Strengthened links with Job Centre plus (JC+) through the local Employability Agenda are necessary in order to increase treatment penetration and to engage those treatment naïve clients seen from JC+ referrals via Turning Point. The Government’s welfare reform bill will no longer go ahead with plans giving JC+ staff powers to ‘order’ benefit claimants to undergo tests for drug addiction and mandatory treatment. This will mean that those clients who are accessing treatment are more likely to be ready for treatment and hence, increased chances for successful outcomes –nevertheless the capacity for JC+ to act as a key referral source must not be underestimated and local training for screening and basic awareness/referral has been delivered to JC+ staff to this end.
- Non-PDUs were more likely to be in employment than PDUs – there is, therefore, a need to ensure appropriate accessibility of treatment services (e.g. out of office hours opening) in light of the increasing stimulant use seen.
- A mapping of all agencies and their links to the employability agenda via ‘Turning the Curve’ event with providers and partners has allowed for identification of referral pathways and integrated care pathways.

It is fair to say that the Turning Point Employment Training and Employment (ETE) service provision constitutes a large proportion of reintegration focussed provision. The intention for the ETE programme is to offer a way of increasing a client’s life skills providing a bridge between services and the community in general. The service specification states its main objectives as follows:

- To improve social functioning and community rehabilitation
- To identify and develop existing life skills and vocational or educational goals – taking a holistic approach to rehabilitation
- To promote personal independence and responsibility – enabling drug users to maintain family and social support networks (where they exist) while in treatment
- To encourage movement through outcome domains, including aspects of drug use, physical and psychological health and social functioning and life context
- To promote social inclusion and positive choice

The place of such provision is ever more important with regards to the whole treatment system if we are to truly work towards a reintegration and recovery focussed model of provision. Indeed the capacity for such ETE and SDP specifications to further encompass and link more closely into the recovery agenda is a key commissioning intention – where key client groups such as those referred to and returning from Tier 4 placements, and those in shared care, will be specifically targeted. The retendering process will allow for appropriate linkage of such agendas through detailed specifications and inter-agency links to this end. Such changes could include the development of the personalisation agenda as an innovative way forward to more individualised packages of rehabilitation interventions.

The ETE also links in with the Structured Day Programme and Progress 2 work element of Turning Point provision.

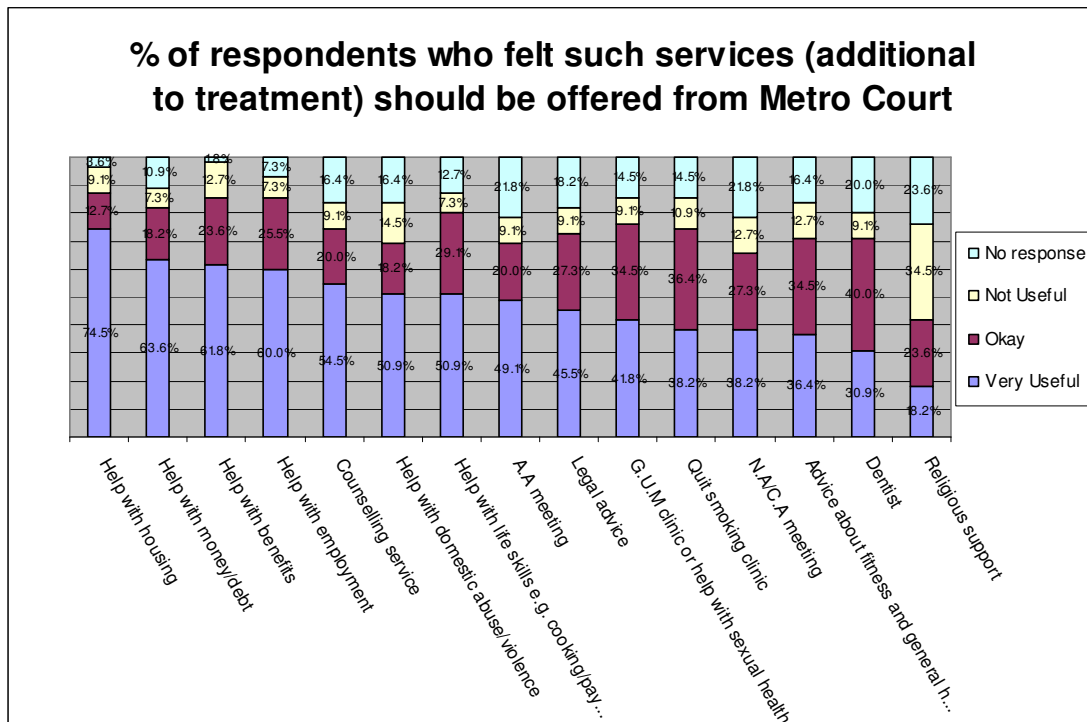
The Structured Day Programme (SDP) offers support during the maintenance and community reintegration phases of the treatment journey providing a range of tailored life skills workshops. These include money management, vocational and non vocational links, harm reduction advice, access to housing and complimentary therapies etc...

It is interesting to note here that provision or links to leisure activities seem notably absent with regards to the range of interventions offered from the local treatment system. Leisure activities are often sited with regards to the recovery agenda as these can help to develop skills and knowledge that can lead to positive social relations, family functioning and healthy ways of living. Participation in cultural and recreational activities such as sports, handicrafts and group excursions could play a really important role in the process of treatment, rehabilitation and social reintegration locally. The potential to develop strategic alliances with public/private organisations who offer such recreational activities should be explored as should the identification of a client's preferences and skills at initial assessment in helping to develop a leisure plan during the appropriate stage of treatment.

6.5 Additional Services Alongside Treatment:

Work around the ‘one stop shop’ Metro Court concept has already begun where there are now drop in sessions provided from wider partners and agencies with regards to providing non-drug issue support. In particular, Job Centre+ and Turning Point (ETE/SDP) will be providing regular drop in sessions which will help to engage the idea of employment and skills alongside benefits gained from engaging in treatment. As well as these, housing and more leisure based activities such as an Art Group will also be offered as part of the Satellite Services ‘drop in’ concept – with future plans to incorporate welfare, benefits & debt advice (CAB), and sexual health clinic drop in sessions.

The Satellite Services Survey (November 2009) asked service users what additional non-treatment specific services they would like to see available at Metro Court. The below chart shows the responses to the question where there was a high level of demand for help with housing, money, benefits, and employment. Over half of respondents felt that counselling was something they wanted to access additionally to the treatment received already, followed by help with life skills. All such services are pertinent to the Recovery Agenda – and have influenced the choice of satellite services provided via Metro Court.



In progressing the recovery agenda, the linking up of services provided via treatment providers as well as ‘non treatment’ services is key to addressing a clients whole needs and re-establishing independence. The qualitative study of the national DTORS 2009 (drug treatment outcomes research study) highlighted the need to develop and strengthen the links between provider organisations with particular relevance to the reintegration agenda.

The newly commissioned service user involvement service ‘Hi’s and Low’s’ will be another key player in terms of the recovery agenda along with the service user group SAVE. Hi’s and Low’s will provide a drop in and mobile needle exchange, provide an advocacy service with all agencies, and enable peer to peer contact. As the service develops further within the context of wider developments planned for the treatment system, there will be enhanced links to Tier 4 and the Structured Day Programme.

6.6 Considerations for DAAT:

- a shift to outcome based commissioning of services in enabling and delivering recovery focussed treatment
- clarity on which interventions yield which outcomes- other areas examples?- systematic approach to review provision against evidence based treatment interventions
- balance needed between treatment, recovery and reintegration systems locally
- how do our current services link in with/ publicise local NA/AA and other community based services beyond the DAAT commissioning remit
- connecting treatment services to the larger process of recovery is something that the North West region has done and has the best successful completion rates in the country– is there learning here that could be applied to the Sandwell treatment system?
- is the above point linked to the degree of choice allowed in the treatment process (both ill-timed episodes of too much and too little choice can contribute to high rates of treatment non-completion via clients leaving against staff advice and clients being administratively discharged) – how do we commission for more flexible, personalisation-focussed services
- clear assessment tools which will allow for personalisation of recovery for the individual client – and which allow for custom made client specific outcomes to inform of appropriate interventions to meet such outcomes
- the importance of developing a shared vision of ‘recovery’ amongst local partners and providers to provide a framework for co-ordinated recovery oriented service developments – do we adopt the UKDPC definition of recovery for Sandwell?
- integrated care pathways around the recovery agenda (potential use of a Recovery Oriented System of Care (ROIS) which places the person with the problem at the centre of the system and seeks to build forms of support throughout the community/ (Birmingham Treatment effectiveness Initiative (BTEI)– to extend to treatment providers and partners, as well as links to non-commissioned /non-statutory resources
- extent and need for agenda raising and awareness of the recovery agenda in community settings to allow for mobilisation of all relevant resources
- role of /extent for community and peer led recovery oriented services locally–and the need to link ‘treatment’ into the larger process of

recovery in the community (joining medical and social models which should not be seen as mutually exclusive). This also prompts the question of how and when the early stages of recovery are initiated in treatment.

- the integration of primary health care and substance misuse treatment – notably how to increase capacity of community based treatment offered via shared care?
- the role of family members and wider social networks in understanding recovery goals of the individual so as to help prevent relapse and improve treatment outcomes
- explore the possibility for a halfway house concept locally to encourage independent living and help to ease social reintegration
- explore options for leisure activities as part of the treatment, rehabilitation and reintegration process – including the potential to develop strategic alliances with public/private organisations who offer such recreational activities; identification of a client's preferences and skills at initial assessment in helping to develop a leisure plan through a clear and comprehensive assessment tool; and whether this could be incorporated into existing provision or would require skilled personnel to lead such activities
- emphasis needs to shift from a relapse *response* alone to that combined with relapse *prevention* – for those clients still using at the end of treatment, relapse prevention should be part of the exit process. Use of service user led training here –(as previous overdose awareness training session delivered)?
- explore potential re-balance of resources from 'reactive' treatment provision to extending treatment and aftercare as a way of potentially reducing costs by reducing the demand for later re-admission
- the role /use of the personalisation agenda in terms of the recovery agenda – especially with regards to relapse prevention, response and aftercare – as something to be explored/piloted locally
- utilisation of Tier 4 services warrants a review of care pathways both from community to Tier 4 and vice versa- to allow for re-engagement of those leaving Tier 4 for appropriate community based aftercare and relapse prevention
- explore possibility of 'preparation for rehab' programme and funding approval panel (Torquay model) to right size provision for the current 'in treatment' population and to enable appropriate referrals and increased outcomes those entering such services
- the role of the service user group SAVE and 'Hi's and Low's' in the recovery agenda

7. TRAINING & WORKFORCE DEVELOPMENT:

As part of the new Quarterly Assurance Framework used locally to assess standards of performance, quality and delivery against service specifications – training and workforce development is now an area monitored as part of the integrated governance section. This seeks to monitor the training needs and development of the local drug treatment and drug services workforce.

As part of wider treatment system intentions around the family, employability and recovery agenda, it is essential that the workforce is fully aware of overall referral and integrated care pathways processes between treatment services and referral out to other relevant non treatment services. To kick-start the process an Integrated Care pathways (ICP) workshop is to be facilitated via the DAAT for all services.

As part of the treatment planning process, workforce needs will need to be considered and addressed explicitly within future service specifications. This is also true for any World Class Commissioning standards to inform development needs of the local commissioning team.

Establishing links with mainstream workforce developments such as JC+ re: the Employability Agenda, housing services and the regional NTA Workforce Development Manager will continue to guide and steer local needs around workforce skills and training.

Service review information from the Tier 3 specialist drug treatment provider shows that:

- All staff are required to participate in compulsory induction and mandatory training covering health and safety, infection control, documentation, policies and procedures, safeguarding children and adults.
- National Vocational Qualification (NVQ) NVQ Level 3 training is provided for drug workers through the Trust, to ensure competence and professional development in line with the NTA's recommended levels of qualification. NVQ Level 3 training is also accessed via the regional NTA workforce development programme. This NVQ training is mapped to DANOS.

The Tier 2 Open access service review information states that:

- All Aquarius/Open job descriptions are Drug and Occupational National Standards (DANOS) referenced. This informs the necessary training and competency framework.

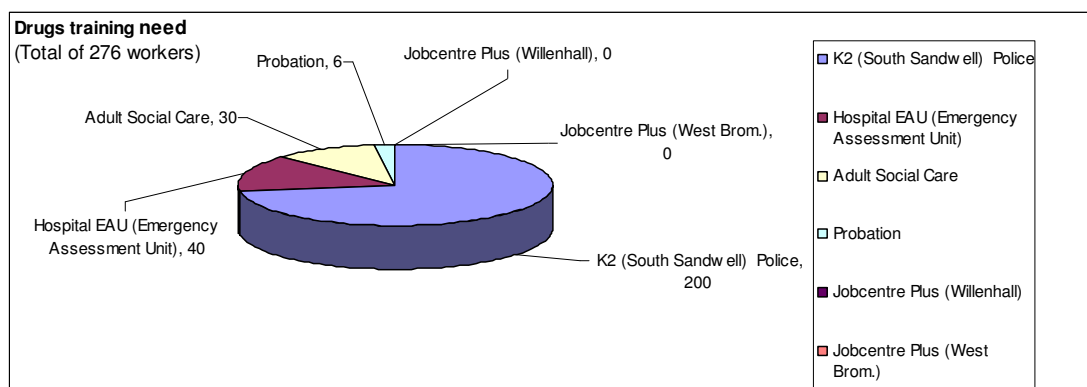
COSAS (links to offender management training) and Turning Point also have elements of workforce development – details of which were not available for this document – but will also need to be considered in any treatment system wide workforce development plans.

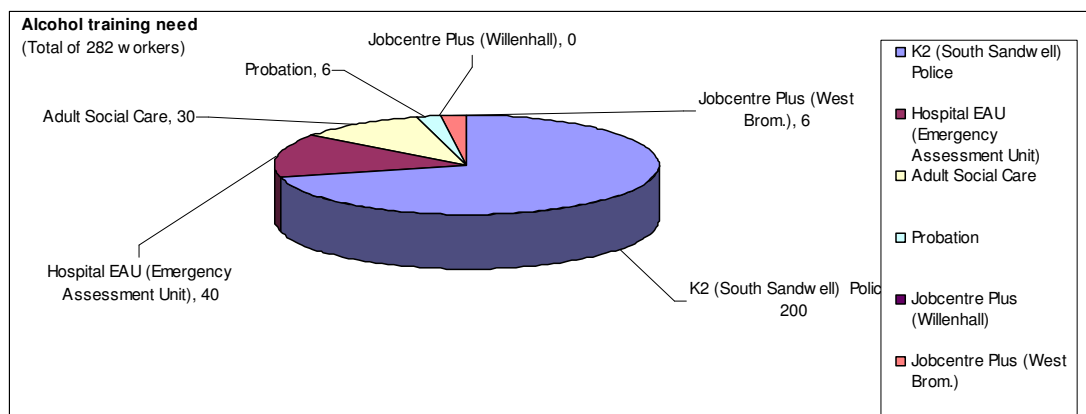
It is also important to be aware of the wider needs for training beyond those treatment and drug/alcohol specific services- namely those Tier 1 services. A Survey (produced by DAAT Training and Communications function) was sent to all local statutory organisations locally from September 2009 to November 2009 to assess the level of need and demand for drug/alcohol training (i.e. basic drug/alcohol awareness and harm reduction messages). Of those organisations who responded to the questionnaire, the majority of organisations wanted both drugs *and* alcohol training and either strongly agreed or agreed with the importance of such training for their workers. Such training is crucial in terms of referral routes into treatment in order to increase treatment penetration.

It is important to note here that there were a number of non-responses to the questionnaire from some key organisations who are vital as drug/alcohol into treatment referral routes – most notably, K1 (North Sandwell) Police; Housing; Primary Care (Provider Arm); PCT L&D Dept.; SMHFT; Community Development Sandwell (PCT Public Health); C&YP; Communities Unit (SMBC) i.e. inc. Town Teams / Neighbourhoods; Parks Management (SMBC); Street Cleansing (SMBC).

Such services could play a key role in referrals into treatment, there is therefore a wider agenda/ awareness raising needed across local partnerships which needs to support such training delivery.

The following charts display the level of demand for drugs and alcohol training locally.





Such findings will inform the nature and extent of training functions carried out / provided from the DAAT and how best these will be carried out to enable increased workforce capacity to ultimately increase treatment penetration.

The Health Behaviour Change Competence Framework is a commissioning led framework for workforce change which describes the competences required by the workforce to enable them to develop their skills in addressing the health and well being needs of the local population. Whilst the framework covers alcohol abuse, the potential to develop said for drugs is useful to consider at this point in order to align agendas and resources for an entire substance misuse approach.

The Framework facilitates service planning in terms of workforce planning and development, allowing commissioners, service and education providers and individuals to bring together the required processes and systems to realise whole workforce change that is needed rather than focusing on just one particular part of the workforce.

The Framework is split into generic levels and an intervention based level. The generic levels are those required by the entire workforce to ensure that opportunities to introduce or bring about health behaviour changes are recognised and acted upon; whereas the intervention based level focuses on competences that relate to health behaviour change approached such as CBT, solutions focused therapy, motivational interviewing etc.

The following diagram shows an example of how the framework could be used amongst all those who would be involved in workforce planning and development:

| | |
|--|---|
| <p style="text-align: center;">Service Commissioners</p> <p>Essential partnership with Human Resource and Organisational Development teams to ensure embed competence in workforce planning and development processes.</p> <p>The Health Behaviour Change Framework should be used in conjunction with up-to-date evidence on health behaviour and the effectiveness of interventions.</p> <p>Articulate the type and level of behaviour change services and workforce needed to address the needs of your population.</p> <p>Utilise in current and new community and voluntary sector health development services and contracts</p> <p>Utilise in current and new NHS providers including acute, community and mental health services and contracts</p> <p>Utilise in primary care contract</p> <p>Utilise in performance management processes to assess effectiveness, quality and health outcomes of services</p> <p>Support opportunities for service redesign</p> | <p style="text-align: center;">Education Commissioners</p> <p>Identify what education and training needs to be purchased from partner HEIs/education providers through developing a shared understanding of workforce requirements including end to end workforce planning process</p> <p>Commission competence to deliver behaviour change competence in undergraduate, post graduate and professional development provision</p> <p>Performance manage tool to assess if commissioned provision is fit for purpose.</p> <p>Source new provision and commission to address any gaps as required. Good practice guide <i>Commissioning training for behaviour change interventions: evidence and best practice in delivery</i> undertaken by NHS North West Public Health Teaching Network (Powell and Thurston 2009)</p> |
| <p style="text-align: center;">Service Providers</p> <p>Build on best practice in current services e.g. smoking cessation, weight management, occupational health services and health trainer etc</p> <p>Strategic commitment to embed behaviour change framework in all services, widening frontline delivery of behaviour change to frontline staff whether receptionist providing brief advice (level 1) or Physiotherapist providing brief interventions (level 2)</p> <p>Essential partnership with Human resource teams and line managers to ensure embed competence in job descriptions and performance appraisals.</p> <p>Ensure component of workforce planning and development processes and cycles</p> <p>Analyse the learning and development needs of the workforce in relation to behaviour change</p> <p>Link to good practice in Improved Access to Psychological Therapies services and Mental Health Services</p> | <p style="text-align: center;">HEIs/Education Providers</p> <p>Develop a shared understanding of workforce requirements with partner health and social care organisations;</p> <p>Understand the workforce needs of employers and students;</p> <p>Design and redesign programmes and modules;</p> <p>Review the learning needs of students on other programmes by using the indicative learning content</p> <p>Inform the development of any new courses.</p> <p>HEIs/Education providers should incorporate the guidance set out in the report <i>Commissioning training for behaviour change interventions: evidence and best practice in delivery</i> undertaken by NHS North West Public Health Teaching Network (Powell and Thurston 2009)</p> |
| <p style="text-align: center;">Individuals</p> <p>The Health Behaviour Change Framework can be used by the workforce as a tool for personal and professional development. For example individuals can compare their current known levels of competence against the competences within the framework and highlight those that they need to develop</p> | |

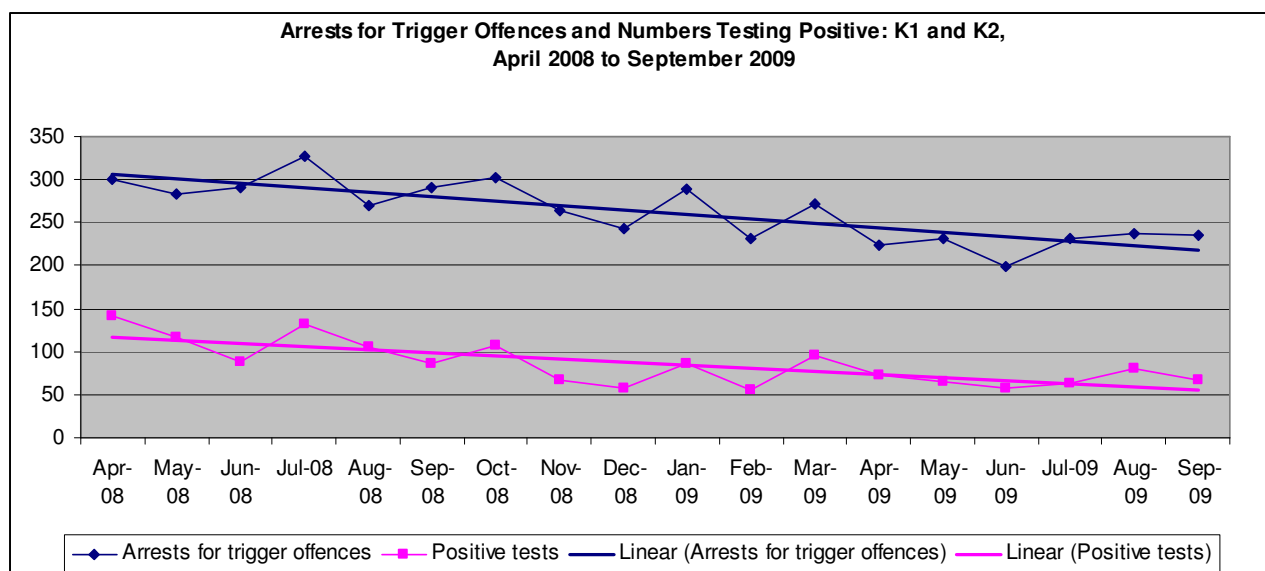
8. CRIMINAL JUSTICE: DRUG INTERVENTIONS PROGRAMME (DIP)

The Drugs Intervention Programme (DIP) is a key part of the Government’s Strategy for Tackling Drugs and Reducing Crime. Since its launch, recorded acquisitive crime has fallen by 28% Nationally.

The programme identifies drug misusing offenders via drug testing in custody suites following an arrest for a “trigger” offence. Trigger offences include acquisitive crime and possession of specified Class A drugs, there is also scope for Inspector’s Authority Testing where evidence suggests that a non-trigger offence has been committed as a result of Class A drug use. Those testing positive are required to undergo an assessment with a drug worker (required assessment) and if appropriate are then referred to drug services for treatment.

In Sandwell, the programme was launched in 2004, initially only offenders who were charged with a trigger offence were drug tested. Test on arrest was established in both West Bromwich and Smethwick custody suites in April 2006 alongside required assessment.

8.1 Test on Arrest:



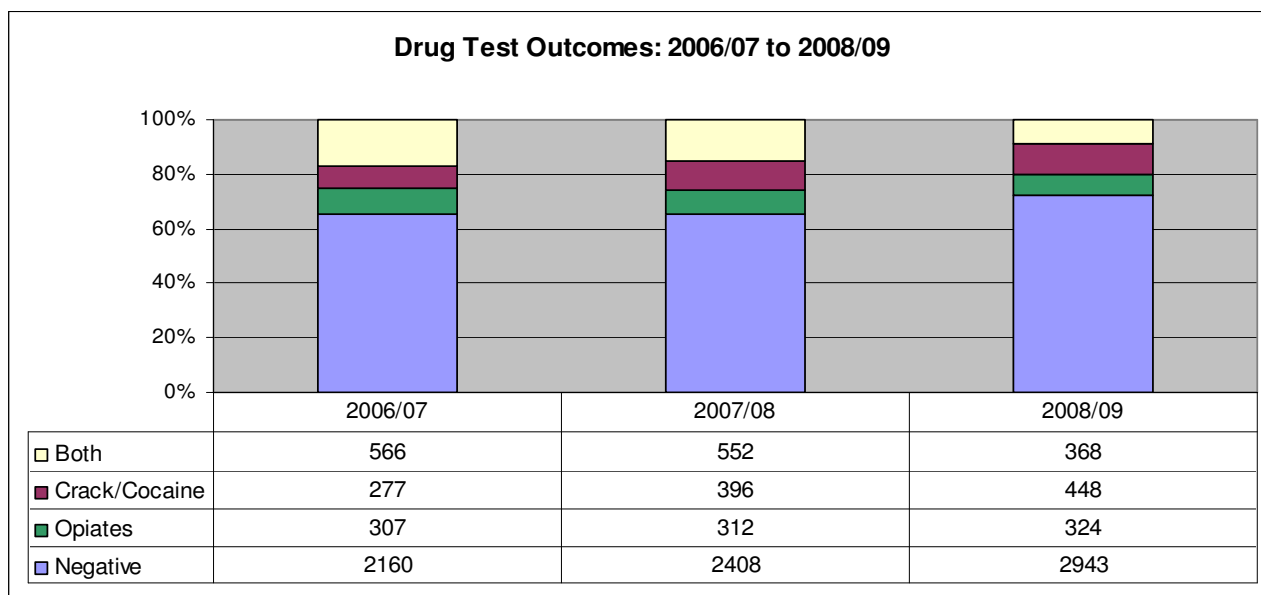
Arrests for trigger offences have fallen slightly throughout 2008/09, which is reflective of a 8.3% drop in total recorded crime (including serious acquisitive crime – 7.2%, burglary – 16.2% and vehicle crime – 5.1%) across Sandwell. Similarly numbers testing positive have fallen affecting the numbers Class A drug users identified and assessed via mandatory drug testing.

It is important DIP workers continue to engage with all offenders and conduct voluntary assessments where appropriate, particularly where offenders have previously been identified as Class A drug users via testing legislation.

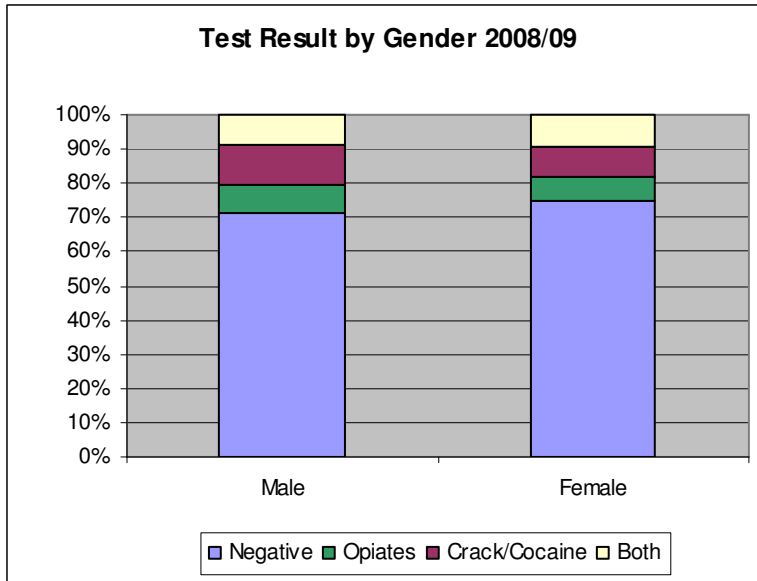
Recommendation:

- Data should continue to be monitored as reductions in front end activity may have implications for deployment of staff resources.

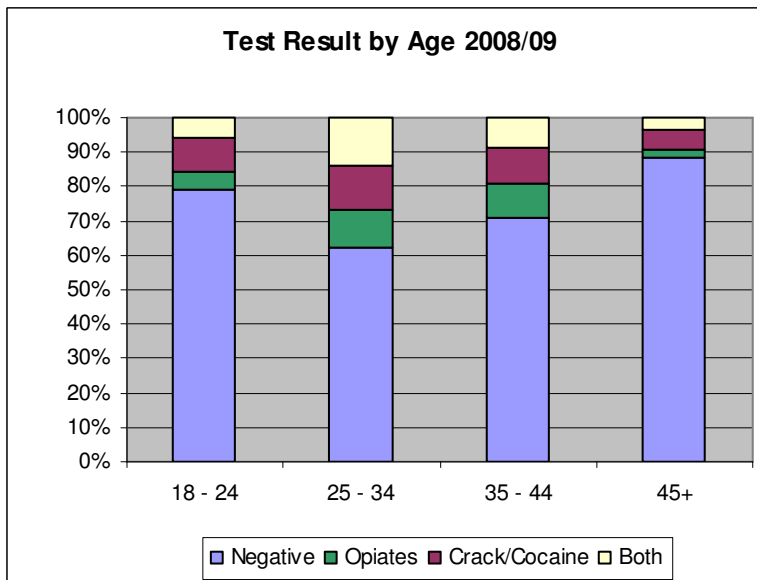
The chart below shows outcomes for drug tests conducted in custody suites in Sandwell for the period April 2006 to March 2009 (does not include outcomes for tests where the result was subsequently overturned following further analysis by the Forensic Science service):



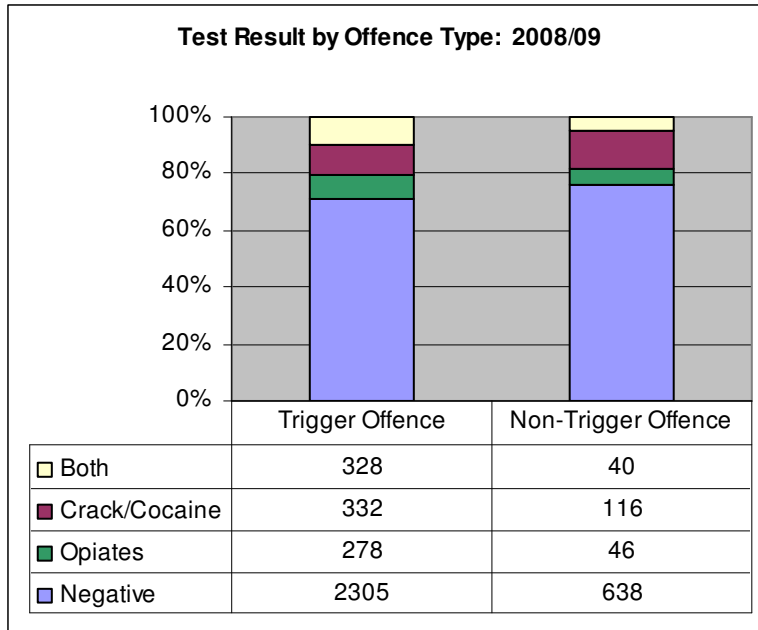
- Between 2006/07 and 2008/09:
 - The proportion testing positive has fallen year on year from 37% to
 - The proportion of those testing positive for crack/cocaine has risen from 8% to 11%
 - The proportion of those testing positive for opiates has reduced from 9% to 8% and the proportion testing positive for both opiates and crack/cocaine from 17% to 9%.
- The number of positive samples taken has reduced from 1262 in 2007/08 to 1140 in 2008/09.
- In 2008/09 Sandwell showed a lower rate of positive tests (28%) than the national average of 34% and the West Midlands average of 33%.



- 14% of those testing positive were female and 86% male.
- 25% (157) of females tested positive and 28% (983) of males.
- Males were more likely to test positive for crack/cocaine and females more likely to test positive for both heroin and crack/cocaine.



- 21% of 18 – 24 year olds tested positive compared to 38% of 25 – 34 year olds, 29% of 35 – 44 year olds and 11% of those aged 45 years or over.
- In total 69% of all those testing positive were aged 25 years or over.
- Both the 18 – 24 year old group and the 45 year + group were more likely to test positive for crack/cocaine

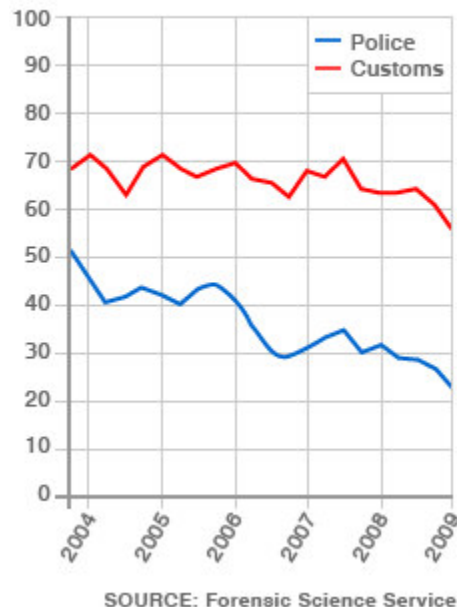


- Those tested for trigger offences were more likely to test positive than those tested for non-trigger offences and more likely to test positive for both opiates and crack/cocaine. Trigger offences accounted for 82% of all positive tests with those arrested for theft, burglary and Class A drugs offences the most likely to test positive.
- Those tested for non-trigger offences, particularly non-trigger drugs offences (e.g. possession of Class B), were more likely to test positive for crack/cocaine.

- 52% of all positive tests were taken following an arrest for theft. Of these 28% were not resident in Sandwell suggesting that offenders are coming into the borough from other areas in order to commit acquisitive crime.

It was not possible to analyse drug test data in respect of ethnicity due to the amount of conflicting and missing data on the police drug test recorder.

PURITY OF COCAINE SEIZED IN THE UK 2003-2009
Mean purity %



It should be noted that drug testing data for the first 6 months of 2009/10 shows that there has been a sharp decrease in the numbers testing positive for crack/cocaine, from 11% in 08/09 to 6%. At this stage it is not clear as to the reasons why and it is possible that the drop is linked to a fall in the purity levels of crack/cocaine as opposed to a fall in the actual numbers using the drug. The chart shows how purity levels have fallen since 2004.

The needs assessment for 2010-11 will investigate this further when full data for 2009-10 is available.

8.2 Drug Interventions Programme (DIP) Assessments:

In 2008/09 drug workers in Sandwell conducted 824 assessments in police custody. In total 696 individuals were assessed as some offenders were seen more than once during the 12-month period. 494 (71%) individuals were resident in Sandwell, a slight reduction on the previous year where 505 Sandwell residents were assessed.

Residence of DIP Clients:

The table below shows where those offenders who were assessed via DIP were resident at the time of their latest contact with the service.

| Area | n | % |
|---------------|-----|-----|
| Sandwell | 494 | 71% |
| Birmingham | 94 | 14% |
| Dudley | 56 | 8% |
| Walsall | 18 | 3% |
| Wolverhampton | 17 | 2% |
| Other | 17 | 2% |

- There has been increase in the proportion of individuals assessed in Sandwell who are not resident in the borough, from 24% in 2007/08 to 29% in 2008/09.
- In total 220 assessments were conducted with offenders not resident in Sandwell, 81% of these were carried out following an arrest for an acquisitive crime particularly shoplifting (40%) burglary (10%), vehicle crime (10%) and theft – other (8%).

Recommendations:

- Encourage West Midlands Police to make use of bail conditions in order to prevent out of area offenders from entering Sandwell to re-offend.
- Investigate why offenders are coming in to Sandwell to commit acquisitive crime in order to identify preventative measures.

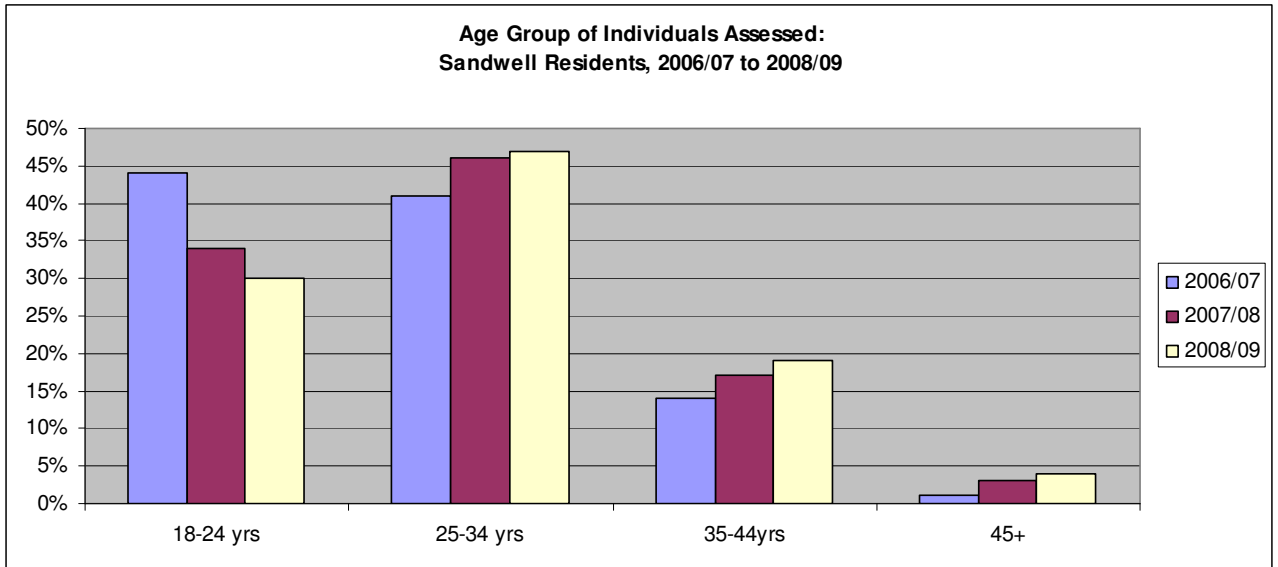
DIP Clients Resident in Sandwell:

Understanding the needs of those assessed who are resident in Sandwell is essential to ensure appropriate drug treatment services are in place in order to address the health and social needs of offenders and thus reduce drug related crime. The following sections detail information collected from Sandwell residents as part of their DIP assessment.

Gender, Ethnicity and Age:

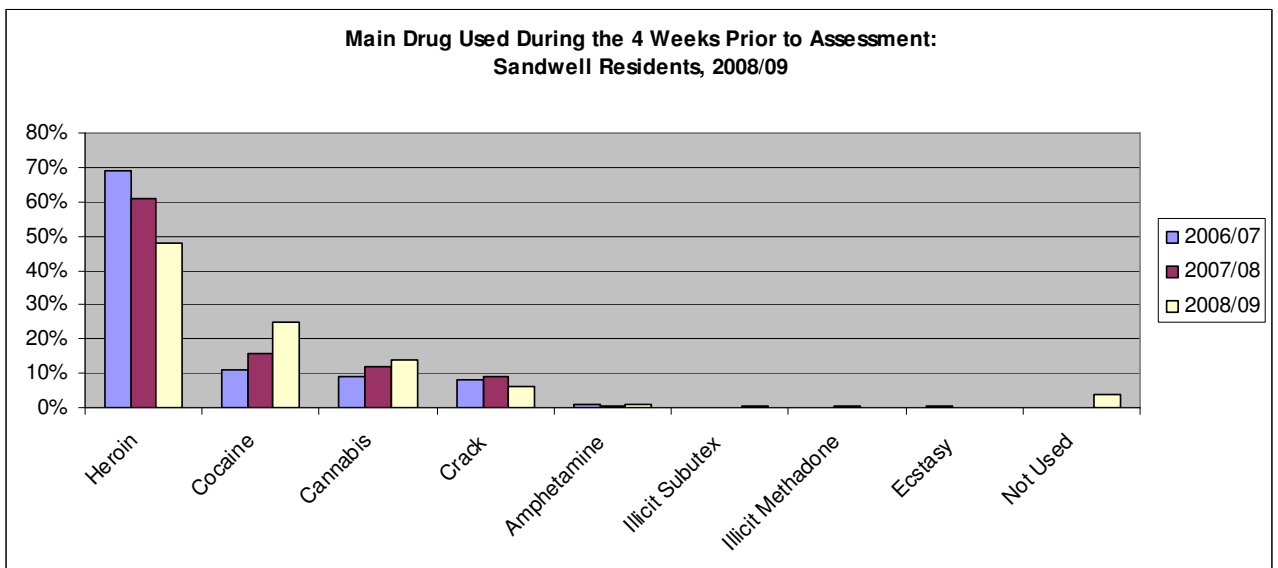
- Of the 494 individuals assessed, 433 (88%) were male and 61 (12%) female. This is reflective of those testing positive in custody.

- 71% of those assessed were white, 13% asian, 10% black and 5% dual heritage.
- Nearly half of those assessed (47%) were aged 25 – 34 yrs. Those aged 18 – 24 yrs accounted for 30% of the cohort, 19% were aged 35 – 44 yrs and 4% were over 45 yrs.



As seen in the chart above, there has been a year-on-year increase in the proportion of individuals assessed who are 25 years and over and a decrease in the proportion of those aged between 18 - 24 years.

Drug Use:

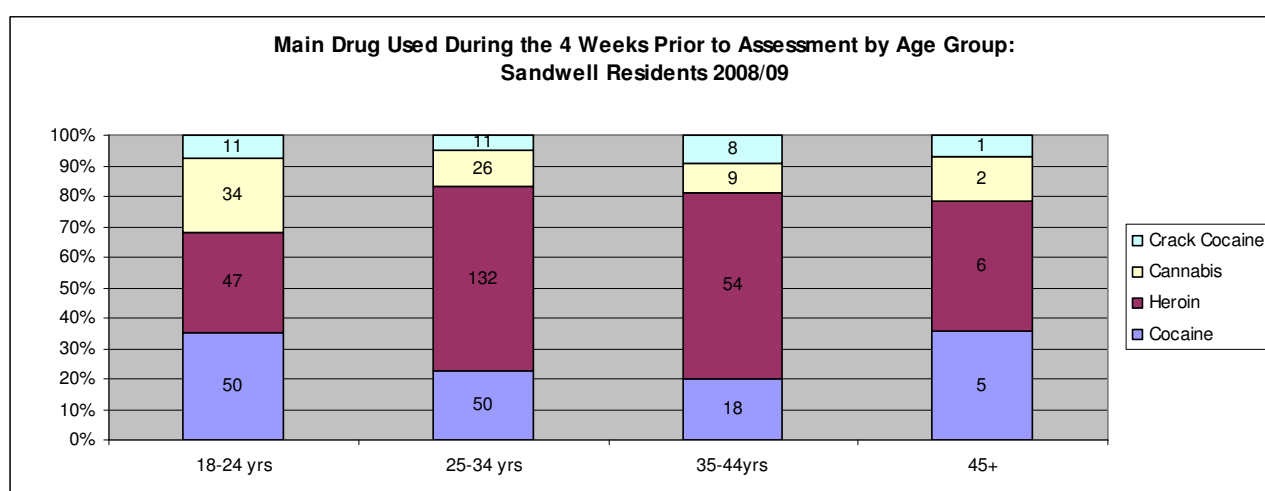


- The chart above shows that the proportion of Sandwell residents assessed as using heroin as main drug has decreased from 69% in 2006/07 to 48% in 2008/09,

- The proportion of individuals reporting cocaine as main drug has increased from 11% in 2006/07 to 25% in 2008/09.
- Main drug cannabis use has increased year-on-year from 2006/07 to 2008/09.
- Main drug crack cocaine use increased in 2007/08 and then decreased to its lowest levels ever in 2008/09.
- Although just 4% of individuals reported crack cocaine as main drug, in total 34% of those assessed stated that they had used the drug in the 4 weeks prior to assessment. Of those stating heroin as main drug, 55% had also used crack cocaine.
- There have been no reports of methamphetamine use by Sandwell residents who have been assessed by DIP.
- 21% of those assessed had previously injected drugs.
- 17% had previously shared drug using equipment such as needles, spoons, filters and tubes for snorting drugs. 8% had shared equipment during the 4 weeks prior to assessment.
- 42% of those who had used illicit drugs in the 4 weeks prior to assessment reported that they had also used alcohol. 72% of those using cocaine as main drug reported that they also drank alcohol, 53% of main drug cannabis users, 35% of main drug crack cocaine users and 25% of main drug heroin users. Combinations of alcohol and drugs, particularly alcohol and Class A drugs, are potentially lethal and can significantly increase the risk of overdose and damage to health.

Recommendation:

- Raise awareness of the dangers and risk to health of combining Class A drugs and alcohol.

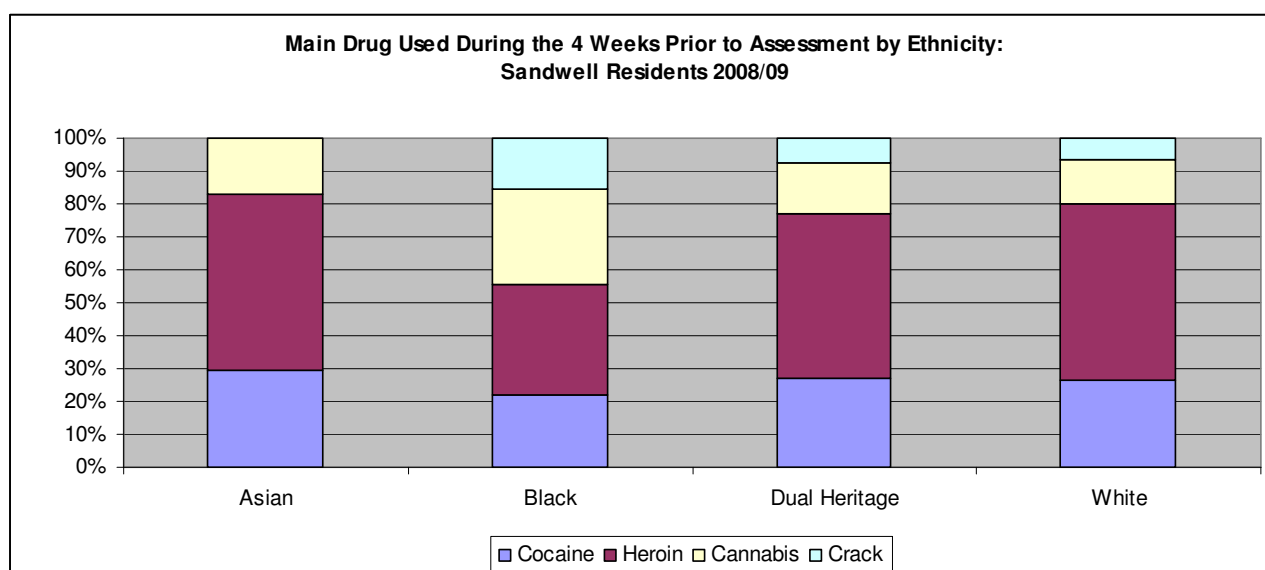


- Those in the 18 - 24 yr old group were less likely to use heroin as their main drug than other age groups and more likely to use cocaine or cannabis. The British Crime Survey 2008/09 found that within this age group cocaine use has increased whilst opiate use has reduced. This profile of drug use amongst younger people is increasingly referred to as ACCE (Alcohol, Cocaine, Cannabis and Ecstasy).

- Older age groups were more likely to use heroin. 57% of those in both the 25 - 34 yr and 35 - 44 yr age groups stated heroin as their main drug compared to 31% of 18 – 24 yr olds.
- 18 - 24 year olds were less likely to have injected drugs than older age groups; 13% had previously injected drugs compared to 26% of 25 - 34 year olds, 22% of 35 - 44 year olds and 17% of those aged 45 or over.
- The 18 - 24 year old group were more likely to have shared drug using equipment than other groups, with 23% having shared compared to 16% of both the 25 – 34 year old and 35 – 44 year old groups and 6% of those aged 45 or over. Sharing drug using equipment can lead to contracting blood born viruses such as HIV and Hepatitis.
- Older age groups were more likely to have received drug treatment during the 2 years prior to assessment than the 18 – 24 year old group. This may be reflective of patterns of drug use as older age groups were more likely to use heroin and therefore more likely to present to treatment for substitute opiate prescribing. It may also suggest that treatment services are more focused on treatment for opiate use.

Recommendations:

- Increase the number of stimulant users entering treatment and ensure appropriate interventions and packages of care are in place in order to create attractive and accessible services with a non-opiate focus.
- Ensure services are able to provide support to those who use combinations of different drugs in conjunction with alcohol, for example the “ACCE” cohort. In addition to this ensure brief interventions are available to prevent those individuals whose drug use is its early stages from becoming problematic in the future, particularly in relation to younger age groups.
- Raise awareness of the risks of sharing drug using equipment, including injecting paraphernalia, crack pipes and tubes for snorting, particularly amongst the 18 -24 year old age group to prevent the spread of blood borne viruses and assist in reducing any future costs in terms of treating conditions such as hepatitis C.

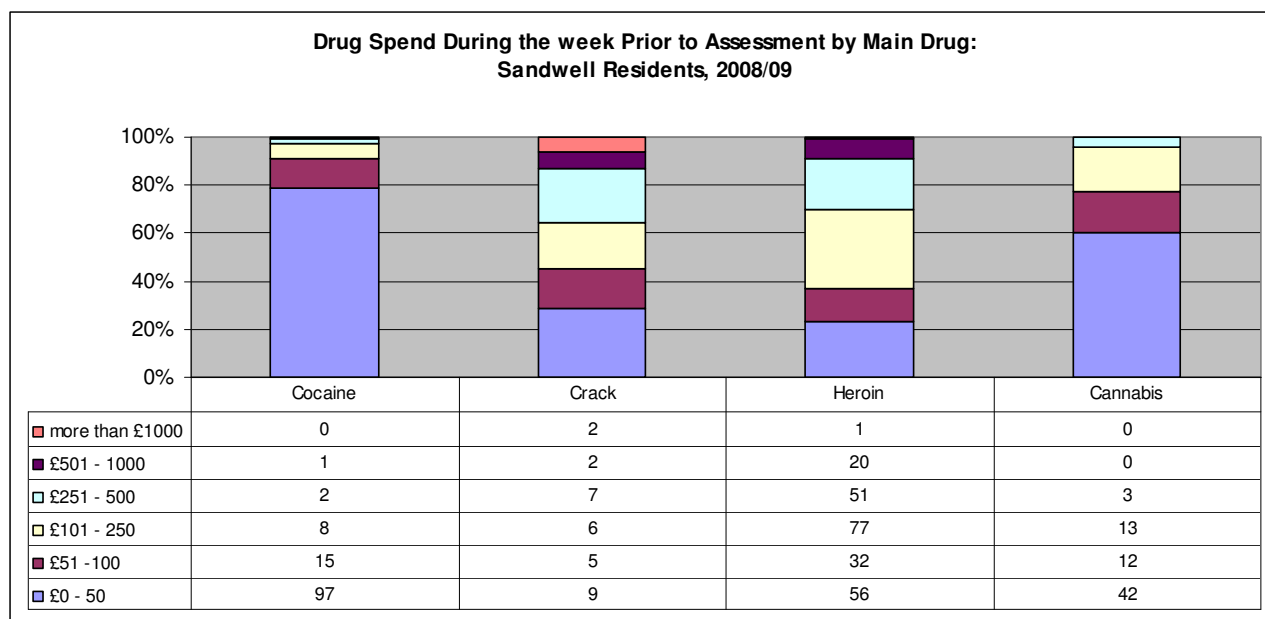


- 33% of those who described their ethnic background as Black stated heroin as their main drug compared to 50% of Dual Heritage clients, 53% of Asian clients and 54% of white clients. The Black cohort were more likely to use cannabis or crack cocaine as main drug than other groups.
- Asian, Dual Heritage and White groups showed similar patterns of main drug use with the exception of crack cocaine; no one who described their ethnic background as Asian stated that crack cocaine was their main drug.
- The British Crime Survey 2008/09 found that adults aged 16 – 59 from a White ethnic group had higher levels of drug use than those from a non-White background with the exception of dual heritage groups.
- Those from a White background were more likely to be current or previous injectors, 24% compared to 10% of those from a Black ethnic group, 11% of Asian groups and 19% of Dual Heritage groups.
- Recommendations by DPAS (Delivering Drug Services to Black and Minority Ethnic Communities, 2001) state:
“that if drug services are to meet the needs of Black and minority ethnic communities they must diversify in terms of the substances/modes of use on which they focus and the models of intervention on which they rest. A shift away from opiate injecting and the development of services with a holistic, therapeutic and social focus are particularly – although – not exclusively – important to meeting the needs of Black and minority ethnic communities.”

Drug Spend:

| | Total | % |
|-----------------|-------|-----|
| £0 - 50 | 207 | 44% |
| £51 -100 | 66 | 14% |
| £101 - 250 | 106 | 22% |
| £251 - 500 | 64 | 14% |
| £501 -1000 | 23 | 5% |
| more than £1000 | 3 | >1% |
| Not specified | 3 | >1% |

- Although the most common spend range was between £0 - 50, it should be noted that the majority of those assessed, 56%, spent over £50 on illicit drugs during the week prior to assessment. 42% had spent £100 or more and nearly 20% over £250.



- Main drug heroin and crack users had higher weekly drug spends than either cocaine or cannabis users. It has been widely researched and evidenced that many heroin and crack cocaine users fund their drug use through crime. Data shows that just 12% of heroin users and 13% of crack cocaine users were in regular employment at the time of assessment and therefore, in view of the amounts spent each week, it is unlikely that the majority of this cohort are able to fund their drug use by legitimate means.
- 80% of main drug cocaine users stated that they spent £50 or less per week on illicit drugs and 53% were in regular employment at the time of assessment.
- 60% of main drug cannabis users stated that they spent £50 or less per week on illicit drugs. 20% of this group reported that they were in regular employment at the time of assessment. A higher proportion of main drug cannabis users spent over £50 per week on illicit drugs than the main drug cocaine group, however the cannabis users were more likely to use a combination of different drugs which may account for the higher weekly drug spend.

Offending:

- 61% of individuals resident in Sandwell had been assessed by a drug worker as a result of an arrest for an acquisitive offence and 39% had been assessed following arrest for a non-acquisitive offence.
- Of the acquisitive offenders, 35% had been arrested for shoplifting, 23% theft other, 16% burglary, 9% theft of/from vehicles and 7% robbery.
- Of the non-acquisitive offenders 34% had been arrested for possession of drugs, 10% wounding/assault, 7% criminal damage, 6% driving offences and 5% drunk and disorderly.
- 73% of those who had committed an acquisitive offence were unemployed compared to 32% of those arrested for a non-acquisitive offence.

- 51% of the acquisitive offence cohort had spent more than £100 on illicit drugs during the week prior to arrest and assessment compared to 32% of the non-acquisitive offence cohort.
- 79% of main drug heroin users and 80% of main drug crack cocaine users had been assessed following an arrest for an acquisitive offence.
- 35% of main drug cocaine users had been assessed following an arrest for an acquisitive offence however, a recent report by the UK Drug Policy Commission (Cocaine Trade Inquiry, June 2009) states that in relation to cocaine use “there is little evidence to suggest a strong link with prolific, acquisitive crime”.
- 49% of main drug cannabis users had been arrested for an acquisitive offence however, as with cocaine, a report by the Advisory Council on the Misuse of Drugs (Cannabis Classification and Public Health, 2008) suggests that “there is little real evidence that cannabis is a significant cause of acquisitive crime or of antisocial behaviour”. It is possible that the high rate of unemployment within this cohort could contribute towards the higher rate of acquisitive crime.

Recommendation:

- Use DIP and related drug treatment services as a mechanism for engaging drug users with employment and training services as well as other wrap-around services such as housing support.

8.3 Engagement and Treatment:

A report by the National Treatment Agency, (Breaking the Link: The Role of Drug Treatment in Tackling Crime, 2009) states that the crimes committed by drug users in the United Kingdom cost society £13.9 bn a year, *“treatment can help these people to control and eventually overcome their addiction and so break the link between their drug use and crime”*. The report also states that *“studies have shown that the average amount offenders spent on drugs fell from £400 a week at the start of treatment to £25 a week at the follow up stage”*.

It should be noted that Sandwell are not achieving their regional benchmark share of 32 clients per month for DIP numbers into treatment. As mentioned previously, the profile of DIP clients appears to be changing and it is vital that services are available for those DIP clients who are not dependant on opiates. Of the 494 individuals resident in Sandwell and assessed via DIP, 223 (45%) were referred to drug treatment services with the majority of these (79%) being main drug heroin users.

Where a referral was not made the most common reason was “assessment sufficient intervention”. In many cases this may be a true reflection, however, where offenders are using drugs and are unemployed it is questionable as to how drug use is funded, particularly where high drug spends are apparent and the offenders only source of income is benefits.

DIP services need to provide a holistic approach and should not be solely

reliant on prescribing services.

Referral Episodes

During 2008/09 there were a total of 449 referral episodes to the DIP caseload (on behalf of 352 individuals), 254 (57%) resulted in engagement in at least one modality with a treatment provider, as shown in the table below.

| Referral Source | Referral episodes | % of all referral episodes | Referral episodes resulting in engagement | % of referral episodes resulting in engagement |
|--------------------------------------|-------------------|----------------------------|---|--|
| Assessed in the community | 245 | 55% | 132 | 54% |
| <i>Custody Suite</i> | 237 | 53% | 126 | 53% |
| <i>Courts</i> | 5 | 1% | 3 | 60% |
| <i>Treatment Agency</i> | 3 | 1% | 3 | 100% |
| Transferred from Prison | 149 | 33% | 69 | 46% |
| Re-engaged following case suspension | 39 | 9% | 39 | 100% |
| Transfer from another DAT area | 16 | 4% | 13 | 81% |
| Total | 449 | - | 254 | 57% |

Referrals from prison were least likely to result in engagement with treatment. However, following the commissioning of a new Single Point of Contact provider in March 2009, data for the first 6 months of 2009/10 shows that engagement rates have improved to 58%. There has also been an increase in numbers “picked up” by Sandwell DIP. NTA reports show that Sandwell prison pick up rates for 2009/10 are above both the regional and national average. Further improvements are expected following the currently on-going implementation of the Continuity of Care Action Plan which was derived from “Drug Misusing Offenders: Ensuring the continuity of care between prison and the community” (Home Office, June 2009).

It is anticipated that every client referred from prison will receive a pre-release meeting either face-to-face, by telephone or via video link. Face-to-face meetings will take place with clients referred from prisons within a 50 mile radius of Sandwell (plus Eastwood Park prison for females) and the remainder via telephone or video link. 2008/09 shows that of 149 referrals from prison, 108 (72%) would have qualified for a face-to-face meeting.

“Throughcare and Aftercare: Approaches and Promising Practice in Service Delivery for Clients Released From Prison or Leaving Residential Rehabilitation (Home Office, 2005) found that *“Aftercare clients appeared more willing to engage with services when a persistent and non-judgemental approach was adopted by staff. In particular regular contact*

with potential clients in institutions, as well as regular visits and phone calls in the community, seemed to result in higher levels of engagement.”

Furthermore, *“Many Counselling Assessment Referral and Advice Teams (CARAT) workers felt that pre-release meetings with an aftercare worker improved a prisoner’s chances of engaging with services after release”.*

It is also hoped that Sandwell DIP will be able to provide a prison pick up service so that clients most at risk of relapse and re-offending can be collected from the prison gates on the day of release. “Throughcare and Aftercare: Approaches and Promising Practice in Service Delivery for Clients Released From Prison or Leaving Residential Rehabilitation (Home Office, 2005) states that *“Aftercare staff had found that attrition (drop out) from services was reduced if, in appropriate cases, clients were collected from the prison gates on the day of release. This should be considered an option as part of a discharge plan for high risk clients.”*

- 54% of referral episodes following assessment in the community resulted in engagement with treatment.
- Although 81% of transfers from other DAT areas resulted in engagement, numbers are low. Home Office figures show that Sandwell DIP only picked up 18% of all those recorded by other DAT areas as being transferred to Sandwell.
- All of those re-engaged following case suspension were PPOs,

Individuals at Latest Contact with DIP:

In total 352 individuals were referred to the DIP caseload, of these 213 (61%) engaged in a modality during their latest contact with the service. However, of those for whom assessment data is available (n = 199), 45 (23%) were already in generic services at the time of referral.

325 (92%) individuals received a referral to tier 3 services with 186 (57%) engaging – 182 in specialist prescribing, 4 in GP prescribing. Two of the individuals also engaged in structured counselling. 94 of those who engaged in modalities have since been closed. 27 cases (15% of those who engaged) were closed as dropping out, 51 (27%) were closed due to being sentenced to custody, 6 (3%) completed treatment as planned, 6 were closed for “other” reasons and 4 (2%) were referred on.

There were six referrals to Open Sandwell for tier 2 interventions, who commenced service provision in Sandwell in January 2009. Of these four engaged with the service and two went on to complete their treatment as planned.

COSAS worked with 49 of the individuals referred, including Priority and Prolific Offenders (PPO’s) and High Causing Crime Users (HCCU’s).

NTA figures for 2008/09 show that 78% of DIP clients were retained in effective treatment with tier 3 providers lower than both the regional and national averages (86% and 81% respectively).

Recommendations:

- Increase numbers taken on the DIP caseload in order to achieve the regional benchmark share and contribute towards NI 40: Number of drug users recorded as being in effective treatment, NI 38: Drug related (Class A) offending and NI 16: Serious acquisitive crime rate.
- Increase the number of stimulant users entering treatment and ensure appropriate interventions and packages of care are in place in order to create attractive and accessible services with a non-opiate focus.
- Ensure services are able to provide support to those who use combinations of different drugs in conjunction with alcohol, for example the “ACCE” cohort. In addition to this ensure brief interventions are available to prevent those individuals whose drug use is in its early stages from becoming problematic in the future.
- Improve numbers picked up following referral from other DAAT areas.
- Complete the implementation of the Continuity of Care Action Plan and monitor the effectiveness of interventions anticipated to increase client engagement upon release from prison.
- Investigate ways of improving client engagement and retention using a multi-agency/case management approach.

8.4 Conditional Cautioning:

DIP Conditional Cautioning can be an effective way of engaging drug misusing offenders in treatment, particularly in the case of first time offenders. Home Office research shows that four out of five people who are given Conditional Cautions are found to comply with the conditions. The conditions attached to a DIP Conditional Caution can range from a requirement to attend a single session with a DIP drugs worker to a three session condition with a follow up.

DIP Conditional Cautioning was introduced in Sandwell at the beginning of 2009 however, data suggests that to date it has been under-utilised. Drug workers have conducted just three Conditional Caution assessments with offenders resident in Sandwell in order to support applications by the police to the Crown Prosecution Service. Only one of these applications was successful.

Recommendation:

- Raise awareness of DIP Conditional Cautioning and its benefits within police stations and the Crown Prosecution Service and increase the number of applications made.

8.5 Restrictions on Bail:

Restrictions on Bail (RoB) was introduced in Sandwell in 2005. It is granted by the courts and offenders who test positive for heroin and/or crack cocaine can be denied bail if they fail to attend drug treatment services. Similarly if an offender fails to attend treatment whilst on bail they can be arrested and charged with breach of bail conditions.

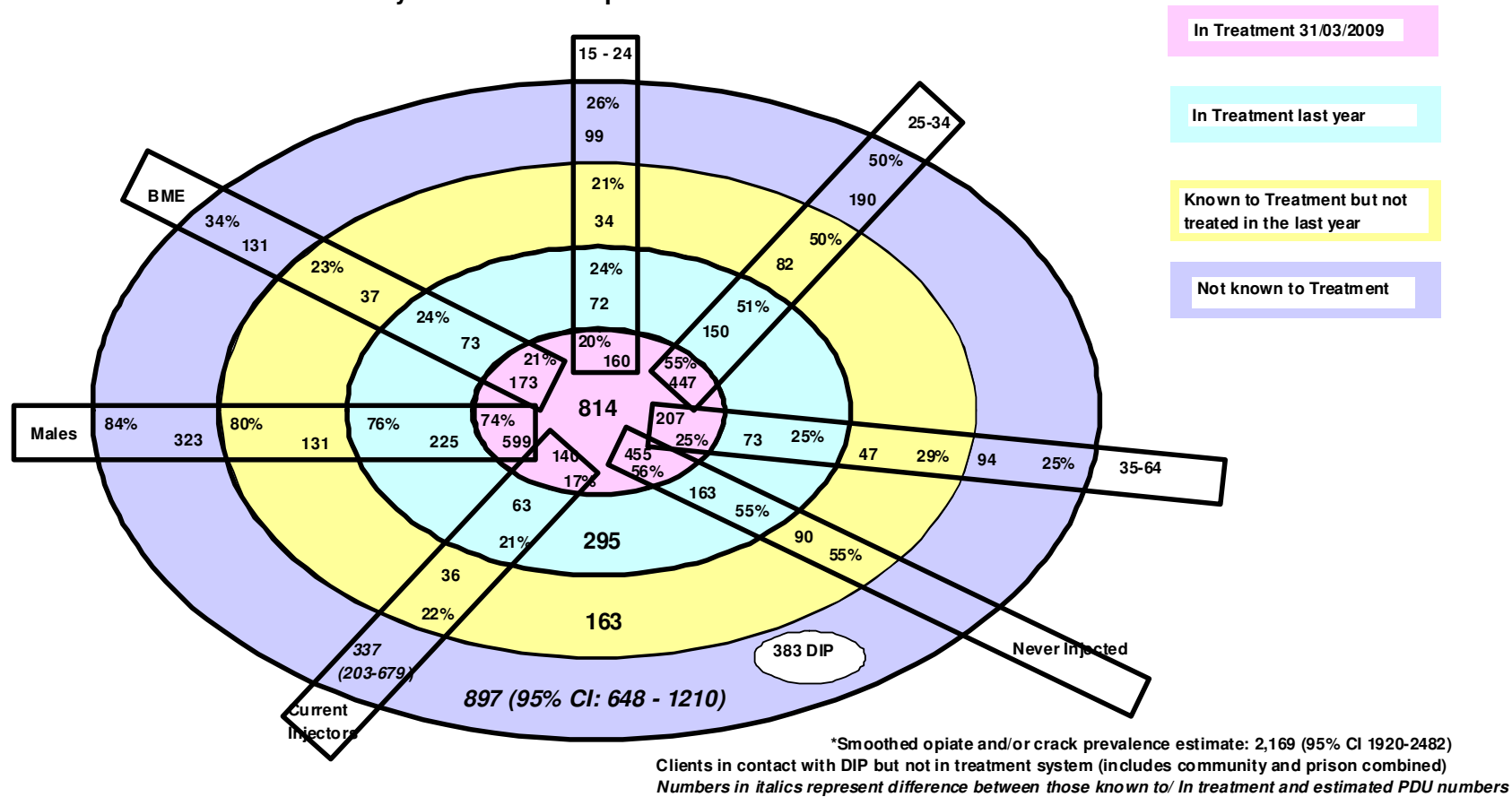
In 2008/09 there were 573 applications to the courts for RoB. 22% (n=125) of applications were approved and 58% (n=73) of those granted RoB completed it successfully.

8.6 High Crime Causing Users (HCCUs):

In 2008/09 there were a total of 1140 positive tests in Sandwell taken from 823 individuals. Offenders who give a positive drug test on three or more occasions in a 12-month period can be referred to the High Crime Causing Users Project which aims to provide additional support to encourage engagement in drug treatment services and reduce offending. It is aimed at individuals whose offending does not warrant PPO status but is still having a negative impact on both themselves and the community. From when the project went live in November 2007 to March 2009, 52 individuals have been identified and referred for support, 26 from West Bromwich police station and 27 from Smethwick.

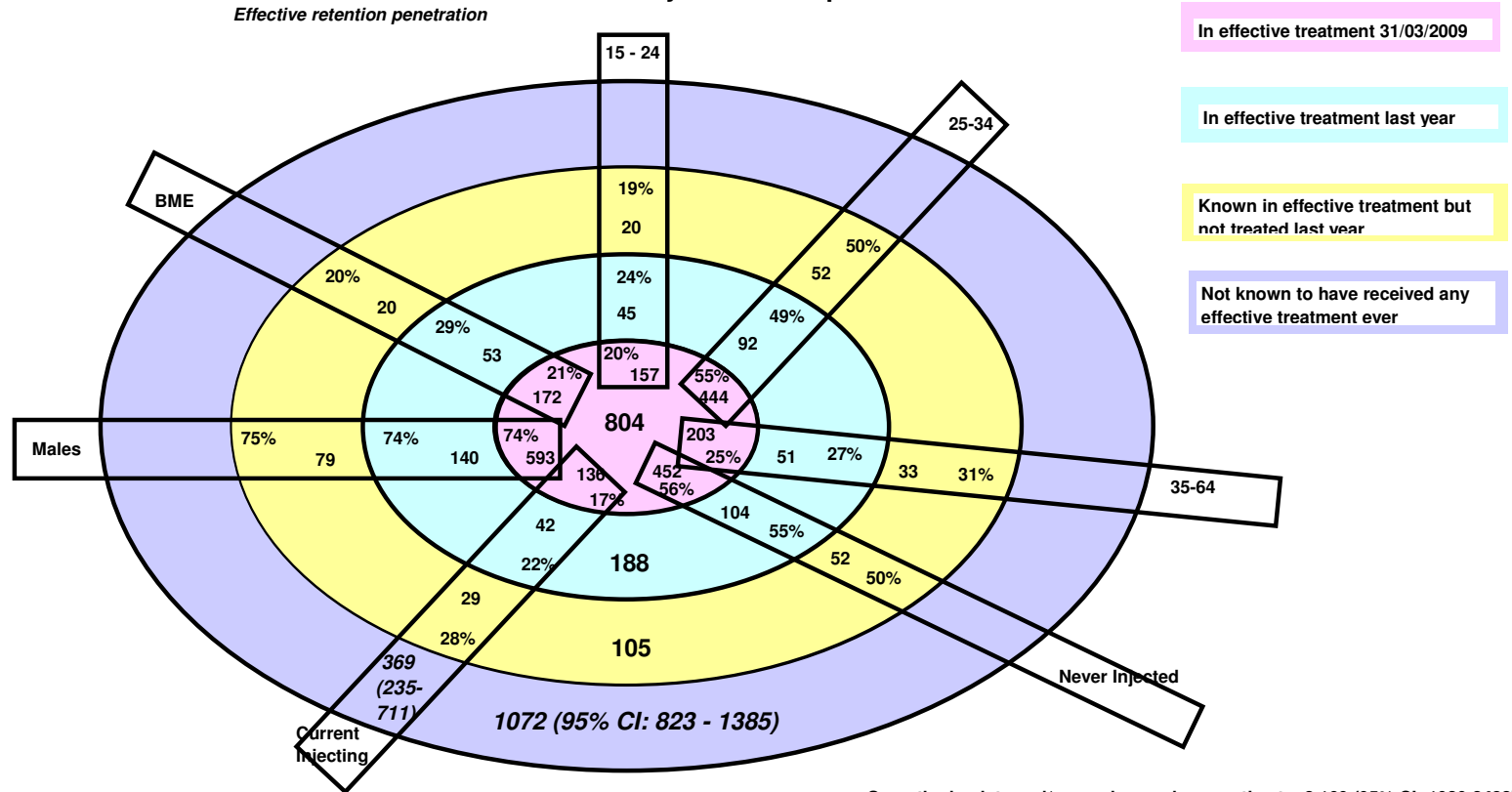
Appendix 1:

NDTMS Bullseye Data 2008/9: Opiate and/or Crack Cocaine



*Note there are no age breakdown estimates for smoothed estimates - hence clients in contact with DIP but not treatment system have been used in the outer age circles. Also the estimates do not state whether the injecting estimates refer to just current injectors (as has been presumed in the displayed bullseye) or whether they refer to both current and previous injectors - if the latter is the case then it is fair to say that we have penetrated levels of estimated IDUs.

NDTMS Effective Treatment Bullseye 2008/9: Opiate and/or Crack Cocaine
Effective retention penetration

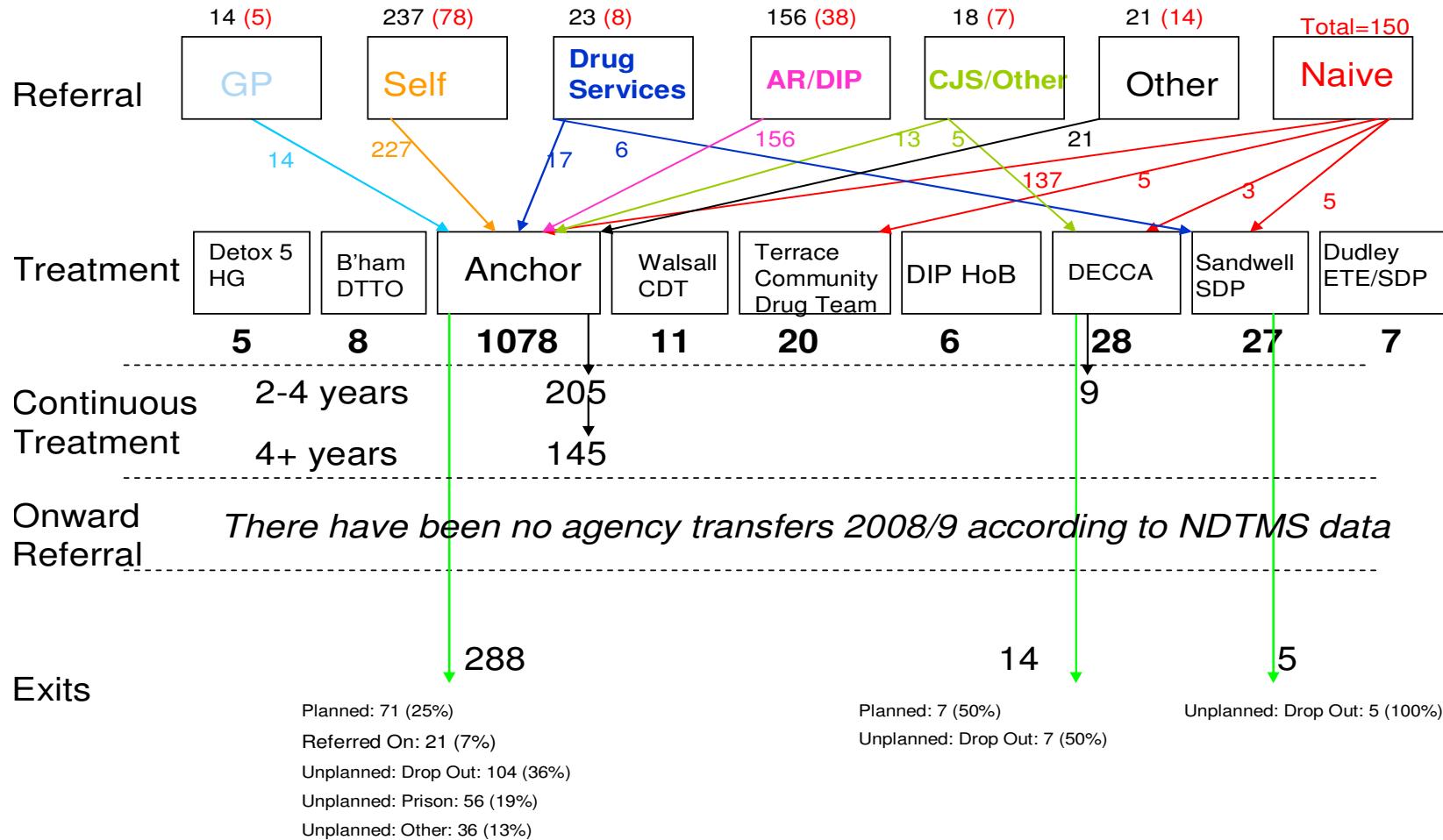


Smoothed opiate and/or crack prevalence estimate: 2,169 (95% CI: 1920-2482)
 Figures in *Italics* display difference between those effectively retained in treatment and PDU estimates- (effective treatment penetration)

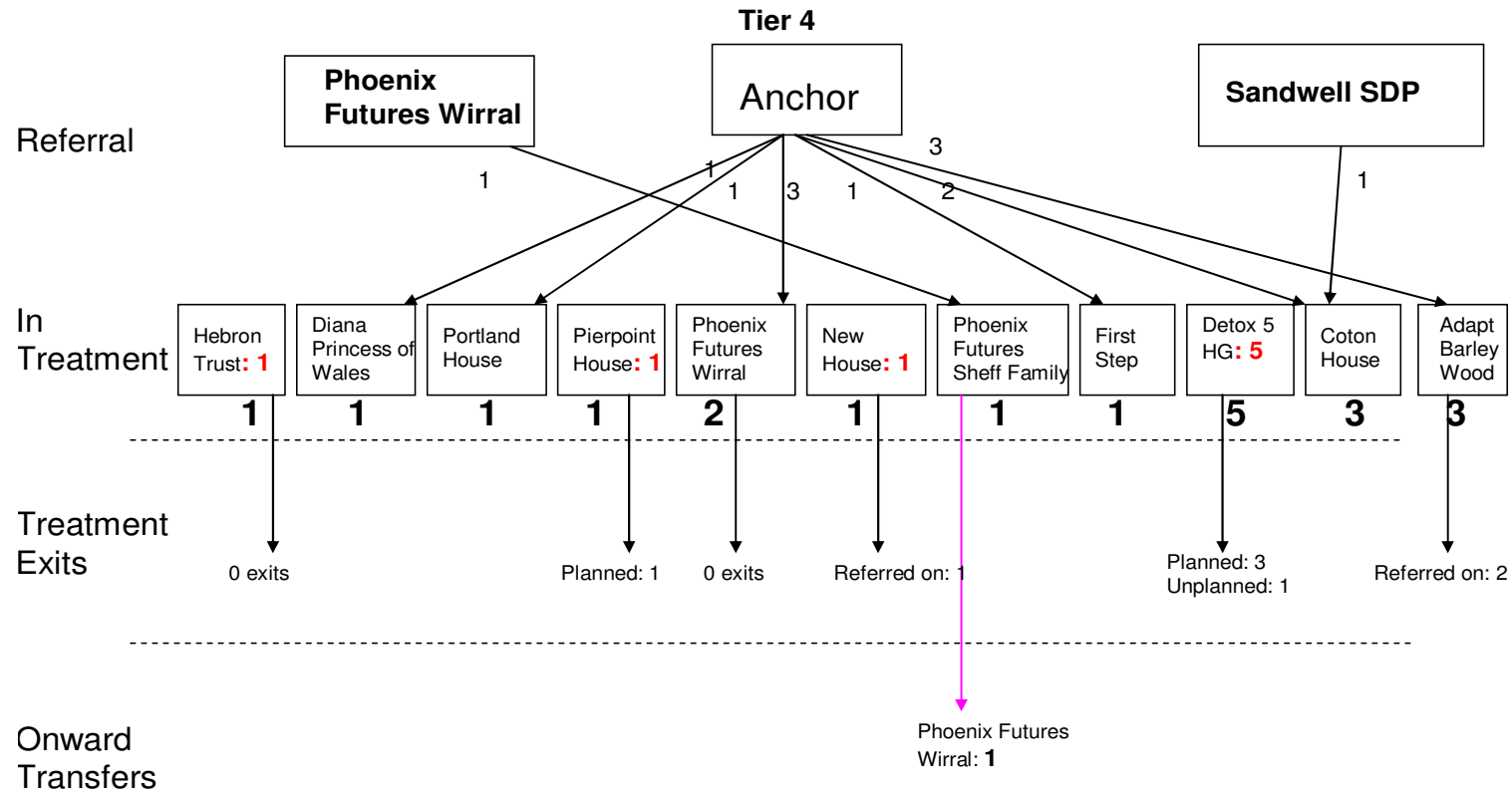
Note that smoothed estimates do not give an age, ethnicity or gender breakdown - therefore the outer circle has no effective treatment naïve estimates for these groups. Injecting estimates are taken to mean those 'current' injectors.

Appendix 2:

Treatment Map Summary 2008/9: Tier 3



Treatment Map Summary 2008/9



Those agencies with a red number beside them indicate the number of treatment starts at that agency – so should be counted additionally to referral numbers into them