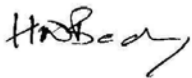
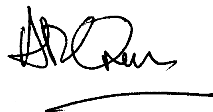
Norfolk Drug & Alcohol Partnership

Adult drug treatment plan 2009/10

Part 1: Strategic summary, needs assessment and key priorities

<table>
<tr><td colspan="2">The strategic summary incorporating the findings of the needs assessment, together with local partnership ambition for effective engagement of drug users in treatment, the funding and expenditure profile and harm reduction self audit have been approved by the Partnership and represent our collective action plan.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Harold Bodmer
Chair, Norfolk Drug & Alcohol Partnership</td><td>Tony Oram
Chair, Adult Joint Commissioning Group</td></tr>
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1. Overall direction and purpose of the partnership strategy for drug treatment

Aim and outcomes

1.1 The Norfolk Drug & Alcohol Partnership (N-DAP) seeks to achieve one overarching aim – to reduce the harm caused by the misuse of drugs and alcohol in Norfolk.[1] To achieve this aim, N-DAP has clear local outcomes to work towards. They are:

1. **A reduction in drug-related ill health**
2. **A reduction in drug-related deaths**
3. **A reduction in drug-related offending**
4. A reduction in the supply of illegal drugs
5. A reduction in alcohol-related harms
6. Today's young people prevented from becoming tomorrow's problematic substance misusers

1.1 This plan focuses on the delivery of the first three of these outcomes and complements the N-DAP Adult Joint Commissioning Strategy in providing a comprehensive commissioning framework for service delivery across all tiers of treatment identified in *Models of Care for the treatment of adult drug misusers and Models of care for alcohol misusers.* The ongoing implementation of the recently adopted N-DAP Alcohol Harm Reduction Strategy will provide the framework in which N-DAP will work together to reduce the crime and health harms arising from the misuse of alcohol in Norfolk.

1.3 In relation to Objectives 1 and 2 we will be focussing on the continued improvement of the quality and effectiveness of our drug treatment system, beginning the implementation of the N-DAP Harm Reduction Strategy (which includes further work in relation to clinical/service governance systems) and improving client pathways where required.

1.4 In relation to Objective 3 we will be focusing on maintaining DIP and the implementation of IDTS.

1.5 This plan is aligned with the Norfolk Local Area Agreement (LAA). The achievement of the outcomes listed above will help deliver many of the National Indicators (NIs) in the Norfolk LAA, specifically: NI 40 – drug users in effective treatment; NI 18 - Adult re-offending rates for those under Probation supervision; NI 21 - Dealing with local concerns about anti-social behaviour and crime issues by the local council and the police; NI 30 - Re-offending rate of prolific and other priority offenders; and 6.11 - Reduction in overall crime.

Commissioning principles

1.3 The core commissioning principles which the N-DAP Adult Joint Commissioning Group has operated under are:

i. *Models of Care – Update 2006* and 2007 Clinical Guidance forms the model for the treatment system that should be in place in Norfolk
ii. Commissioning will focus on maintaining a comprehensive treatment system for Norfolk
iii. The principle of harm minimisation will underpin service provision commissioned in Norfolk
iv. N-DAP aims to provide equal access to all treatment modalities across Norfolk, taking into account the needs of a diverse population and available resources
v. Services are developed on the basis of identified need

[1] Norfolk Drug & Alcohol Partnership Outcomes Strategy 2008-2011

vi. Services will be developed in line with good practice and effectiveness of practice will be monitored
vii. All commissioned services will have a contract, reviewed and monitored by the N-DAP Joint Commissioning Groups
viii. N-DAP will strive to ensure a range of quality services are available
ix. The development of new services will aim to complement and enhance existing service provision where appropriate
x. The development of services will involve collaboration and consultation with all relevant partners and service users
xi. All partner agencies need to take account of the impact of substance misuse on the delivery of their individual services.

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

2.1 During 2008/09 the demand for drug treatment services in Norfolk remained stable, although the treatment map does indicate increased activity within the system. As a rural county, N-DAP continually seeks to address the issues related to rurality (e.g. transport, access to services). To support the drug treatment system, in 2009/10 N-DAP will continue to build on work already undertaken to extend links with other services (e.g. housing) in order to provide holistic care for clients.

2.2 The gap analysis attached at appendix 1 provides the detail of current and future demand for these interventions as well as identifying and considering the differential impact on diverse groups, in order to provide direction for key priorities to address any negative impact.

3. Key findings of current needs assessment

A brief summary of prevalence and penetration levels, treatment system mapping, the characteristics of met and unmet need, attrition rates and treatment outcomes. The full needs assessment report has been submitted with the adult drug treatment plan.

Overview

3.1 In 2007/8, Norfolk Drug and Alcohol Partnership commissioned a team from the University of East Anglia to conduct a study of the characteristics, needs and harms associated with those not in treatment. This has been completed and their final report (see appendix 2) details findings from the study and informs this 2009/10 treatment plan. The University of Bath were also commissioned to conduct an investigation into the needs of children of parental substance misusers and substance misusers who are parents. This has been completed and the final report (see appendix 3) informs this treatment plan. An independent consultant was commissioned to deliver the Housing Needs Assessment of Substance Misusers in Norfolk. The final report was delivered in September 2008. To complement these studies, DAAT Research and Information Officers have conducted a mapping of existing services and description of client profile. Key findings from all of the needs assessment activity are outlined below.

Prevalence

3.2 A capture-recapture study commissioned by the partnership in 2003 identified that there were approximately 8,200 problematic drug misusers in Norfolk.[1] A problem drug user is defined as 'any person who experiences or causes social, psychological, physical or legal problems relating to their self-administration of a drug, including any form of drug use that involves injecting' This original capture-recapture study was later validated by a project funded by the NTA that estimated between 6,400 and 10,500 problematic drug misusers in Norfolk.[2] In contrast to these estimates,

[1] Holland R Vivancos R, Maskrey V *et al*. The prevalence of problem drug misuse in a rural county of England. J Public Health (Oxf) 2003
[2] Holland R, Ashton K, Swift L, Sadler J, Maskrey V, Harvey I. To determine the prevalence of problem drug use in a rural county of England. Report to the National Treatment Agency for Substance Misuse. University of East Anglia 2005

The University of Glasgow estimates the prevalence of opiate and crack cocaine users in Norfolk to be 3376. [3]

Penetration

3.3 The UEA needs assessment (see appendix 2) details analysis of NDTMS data for the period 1/4/04 to 31/03/07 and shows that 6,028 distinct individuals entered treatment during that period. The study compares this data with data collected from a wide variety of health, non-statutory and criminal justice sources to provide information on penetration and the characteristics of met and unmet need. Sources include: NDTMS data, hospital admission (HES) data, A&E data, mortality data, and those identified as having a drug problem by: Norfolk Constabulary, Norfolk probation, and the Arrest Referral Service.

3.4 The study shows that problem drug users identified in NDTMS and other datasets (criminal justice and health) appear to more commonly use Class 'A' drugs, implying that treatment services are successfully targeting more severe drug users. However, it is important to note that a substantial number of 'problem drug users' are found who appear to have never accessed treatment in Norfolk. These users tend to be younger and to predominantly use Class B/C drugs. In particular, this study reveals that there are a large number of cannabis users who the police have contact with but who do not enter the drug treatment system. Whether these individuals have unmet drug treatment needs or would wish to access services more suited to their needs is unknown. Survey and focus group may help identify answers to these questions and inform planning for the future.

3.5 Equally at the severe end (identified through mortality or hospital statistics) it is clear that between 25% (as identified by opiate/crack HES related admissions) and 60% (as identified by death) of severe problem drug users appear not to be accessing treatment. In contrast to findings from criminal justice, those not matched between hospital data and NDTMS tend to be older and more often female.

3.6 In addition, prescribing analysis and cost data were reviewed to establish potential numbers treated in primary care with methadone or buprenorphine outside the 'shared care' system. The authors estimate that approximately 100 individuals are receiving methadone prescriptions and up to 32 individuals are receiving buprenorphine prescriptions from their GPs outside of formal Shared Care arrangements with drug treatment programmes. The estimate suggests that approximately twice this number of clients (200 for methadone and up to 45 for buprenorphine) are receiving prescriptions from their GP for substance abuse as part of formal Shared Care arrangements. However, it is notable that within Central Norfolk more methadone appears to be prescribed outside formal Shared Care than is prescribed inside Shared Care.

3.7 The University of Bath's needs assessment for Norfolk focuses on the children of substance misusers and substance misusers who are parents. The authors conclude that treatment services in Norfolk go some way to address parental substance misuse and highlight Norfolk's pregnancy liaison protocol as an example of effective shared working practice. Focus groups and interviews reveal that service providers are happy with the range of provision available (including treatment and generic services) but would like to see more capacity, continuity of funding and inter-agency alignment. There are also concerns about equality of access in a large rural county.

3.8 The extent to which adult substance misuse services respond to substance misusers' needs as parents is unclear. The impact of substance misuse upon parenting is apparently addressed informally rather than systematically or consistently.

3.9 Monitoring of work with substance misusing parents in Norfolk is found to be lacking and/or inconsistent. It is not therefore possible to make reliable numerical estimates of met and unmet need.

[3] Hay G *et al.* Estimates of the prevalence of opiate use and/or crack cocaine use (2006/07). The Centre for Drug Misuse Research, University of Glasgow

Adult Drug Treatment System Mapping (map on page 8)

3.10 *It should be noted that the referral section of the map is only used to record the referral source at the point of entry into the treatment system. So a client with more than one treatment modality will only show up once on the treatment map.*

Numbers of less than 5 are excluded from the map in order to protect client anonymity.

Analysis of Norfolk's drug treatment system map for 2007/08 suggests that:

- Clients are most likely to enter the system via self-referral. There has been an increase in number of self-referrals from 399 last year to 470 this year. Focus group data from the UEA report suggests that word-of-mouth plays a large part in self-referrals.
- Numbers entering the system via GP referrals appear to be relatively low and inconsistent across agencies. Numbers have decreased from 76 last year to 51 this year.
- The numbers recorded as accessing treatment via the criminal justice system increased significantly between 2006/07 and 2007/08. This is partly due to the CJIT team beginning to return data. This trend has continued for 07/08 seeing an increase from 130 to 221.
- Numbers under 'Other' (which encompasses health & social services and education) have increased from 117 last year to 231 this year.
- This year has seen the addition of The Matthew Project North Norfolk and CADS Thetford to the treatment system map.
- It would appear that numbers in treatment within TADS Norwich have again increased significantly. This appears to be an actual increase rather than an effect of increased recording (verified in capacity meetings with TADS management).
- There seems to have been a lot more transfer activity between agencies compared to last year, traffic into TADS has been particularly heavy.
- There seems to have been an increase in planned discharges in 07/08, which is encouraging, however numbers of unplanned discharges are generally far higher, and have increased on last year (very markedly in some cases i.e. Norcas Norwich).

When the treatment system map was presented to the expert group held at Norfolk DAAT the consensus was that is was unrepresentative regarding the referral stage treatment system. In particular many expressed the opinion that GP referrals had obviously been massively under-reported. This raises issues about how agencies are reporting data to NDTMS; further study of how referral sources are recorded is needed in order to clarify this situation.

3.11 In 2006/07, the number of Norfolk treatment providers returning data to the NDTMS was increased to include all those offering structured care planned interventions. Numbers in treatment rose accordingly. This trend has apparently continued into 2007/08. Analysis of the treatment system map supports this.

3.12 The geographical mapping exercise for N-DAP allows for analysis of the location of substance misuse service users across Norfolk, from using the partial postcode data collected by agencies. Mapping by agency found good countywide coverage by both area specific and non-area specific services. The highest concentration of male clients appeared in the most deprived areas of Norfolk (central and north Norwich, north and central Great Yarmouth and King's Lynn). The highest concentration of female clients appeared in west and north Norwich. The pattern for female clients is different from men in that there are lower concentrations and wider dispersion away from centres and encroaching into rural areas. The highest concentration of service users with alcohol as their primary substance is focused on Norwich, particularly west and north. The highest concentration of service users reporting heroin/buprenophene as their primary substance are concentrated in postcode sectors within Norwich – NR5, NR3 and NR1.

Attrition Rates

3.13 'Models of Care' informs us that optimised treatment usually involves retaining clients in drug treatment for a minimum of three months. This is the point at which treatment begins to accrue generalised long-term benefit[3]. DAAT Research and Information Officers' analysis of retention data tells us that in Norfolk there is an association between retention of 12 weeks or more and successful discharges. This does not necessarily signify a causal relationship. Retention is likely to be one of many factors contributing to a successful outcome. The NTA term this 12-week period as being in 'effective treatment', future targets set by the NTA for N-DAP stipulate numbers in effective treatment as our primary performance measure. We are expected to have 80% of clients in effective treatment from 2008/9. Opiate users, women and those in the 35-plus age group appear to be more likely to be retained. This agrees with regional and national comparators although Norfolk has a slightly wider gap between male and female. Crack, other stimulant and cannabis users and those in the under 25-age group appear to be less likely to be retained. Again, this agrees with regional and national comparators. Those from non-white ethnic groups appear to be less likely to be retained although the numbers are too small to draw definite conclusions. DIP clients, CJS clients and non CJS clients are equally retained.

Treatment Outcomes

3.14 The UEA report also details analysis of treatment outcomes as recorded via NDTMS. This shows that the proportion of Norfolk treatment episodes successfully discharged in the period 2004-07 was slightly higher than the proportion across England as a whole in 2004-05 (31% compared to 25%), mainly in relation to episodes completed not drug-free (20% compared to 13%). Compared to the numbers starting treatment, the <20 year olds and the >50s are over-represented among those successfully completing episodes, and the 20-40 year olds are under-represented. Similarly, females are slightly over-represented and males slightly under-represented. Given the low numbers of individuals from non-white backgrounds, it is difficult to comment on ethnicity as a predictor of successful treatment.

Tier 4

3.15 A tier 4 treatment system map has been completed and analysed by the needs assessment expert group. It was found to be unrepresentative of Norfolk's tier 4 treatment system. This is due to tier 4 providers not returning NDTMS data or not recording Norfolk as the DAT of residence for their clients. Monitoring of tier 4 provision will be addressed in this treatment plan.

3.16 To supplement the available tier 4 data, DAAT Research and Information Officers have conducted 'expert interviews' with the Joint Lead Commissioner for Substance Misuse for Norfolk PCT and Norfolk Social Services and the Deputy Service Manager of the Trust Alcohol and Drug Services (TADS).

3.17 The interview report demonstrates that the referral process to tier 4 treatment is managed via TADS. Self-referrals for funded tier 4 treatment, GP referrals for residential rehabilitation and clients who have engaged with TADS in the community all enter tier 4 in this way. Exceptions are <18s, >65s, self-funders and inpatient detox referrals from GPs. Where appropriate, the agency's specialist substance misuse social workers make recommendations to a funding panel. Recommended clients typically have heroin and/or alcohol as their primary substance with the proportion citing alcohol increasing. They are motivated and have engaged with treatment services in the community. Clients are means tested and are not recommended for funding where they have the means to fund themselves. There is no waiting list for consideration by the funding panel and recommendation from TADS is almost certain to result in agreement of funding. Dual diagnosis cases and pregnant clients may be given priority although the majority of Norfolk's tier 4 clients have coexisting substance misuse and mental health issues. Ethnic minorities are not seen in any

[3] National treatment Agency for Substance Misuse. Models of Care for Treatment of Adult Drug Misusers: Update 2006. NTA 2006

significant numbers and there appears to be a smaller proportion of Portuguese clients in tier 4 treatment than in community treatment.

3.18 Where clients enter tier 4 treatment via TADS, a residential rehabilitation placement follows inpatient detox. The move between modalities is usually seamless and where this is not possible, extra support is provided in the interim.

3.19 It is noted that around 50% of clients entering residential rehabilitation from Norfolk complete their treatment in a planned way.

3.20 All clients entering funded residential rehabilitation placements complete service user questionnaires at three monthly reviews and at discharge. The results of these questionnaires inform the social care team in making future recommendations. Places will only be funded in agencies on the recommended providers list. These agencies all conform to CSCI standards. DANOS competencies of agency staff are not checked as a matter of course. The experts note that it is difficult for clients to access suitable move on accommodation but that this is a national rather than a county gap. Where clients return to Norfolk, they are supported by the social care team into tier 2 provision and where possible into education and or employment. Tier 2 provision is lacking in the west of the county and this is problematic. Structured Day Programme for those wishing to remain substance free is also thought to be lacking either for aftercare or as an alternative to tier 4 treatment.

Diversity

3.21 Gypsies and travelers have been part of Norfolk life for hundreds of years. However, it is difficult to determine how many are traveling and/or living in Norfolk. The most reliable figures come from the twice-yearly Gypsy Caravan count that recorded an average of 416 caravans in Norfolk in six counts before July 2007[4]. These figures exclude Gypsies and Travelers living in houses. Norfolk's strategy for Gypsies and Travelers in Norfolk highlights problems in accessing health care for Norfolk families as a particular cause for concern[5].

3.22 In recent years economic migration has seen a number of groups establish themselves as part of Norfolk's diverse community. These groups include the Polish, the Lithuanians and most significantly the Portuguese.

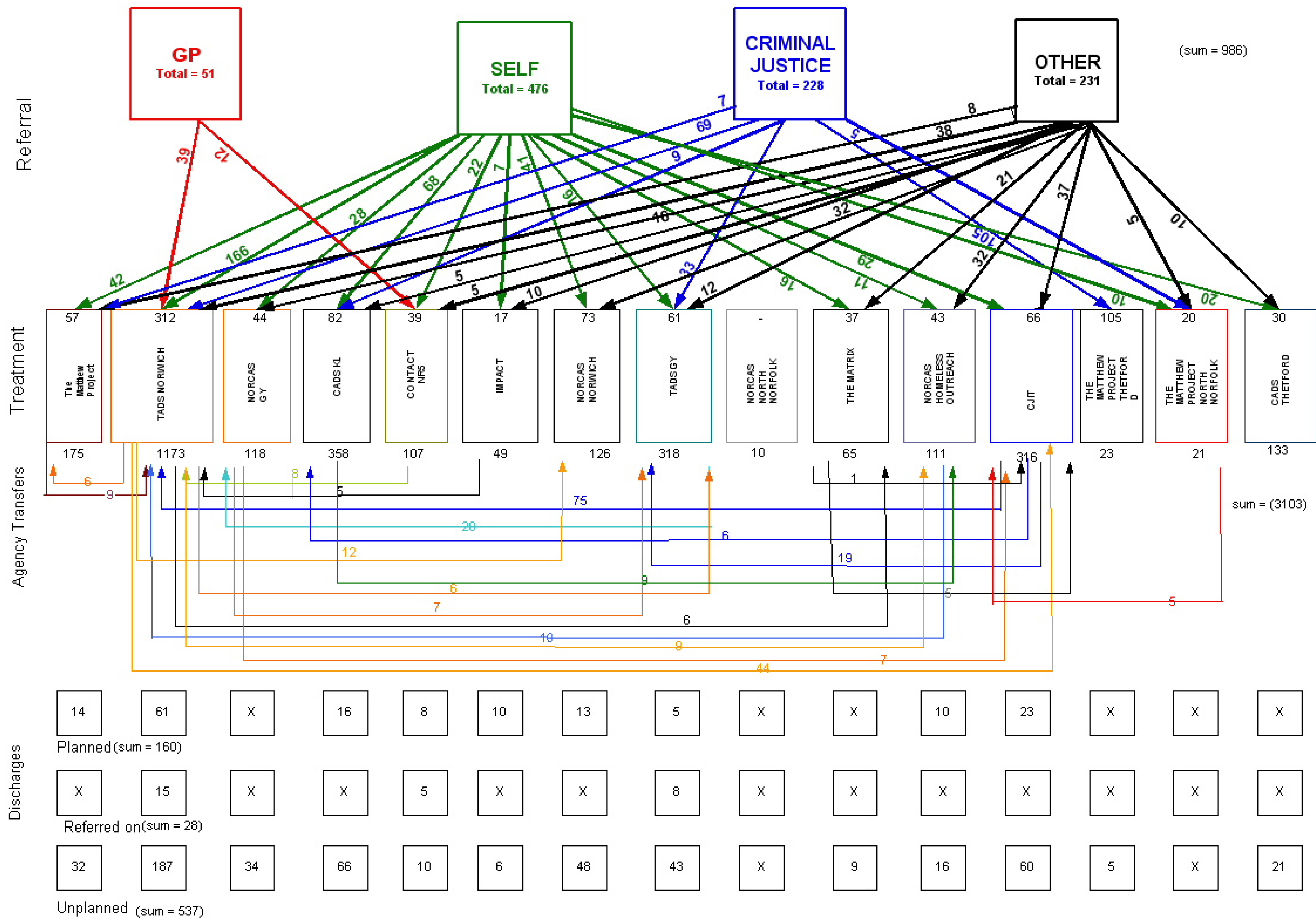
3.23 Even with this recent immigration, Norfolk remains a relatively homogenous county. Around 6.1% of the general population[6] and 3.3% of the treatment population are from minority ethnic backgrounds (if we take the term "minority ethnic" to refer to all groups that are not recorded under the "White British" ethnic group category). These low numbers make it difficult to determine from quantitative data whether Norfolk's ethnic minorities have unmet drug treatment needs.

Housing

3.24 The Housing Needs Assessment of Substance Misusers in Norfolk focused on the relationship between the Cycle of Change and the need to access suitable accommodation at the right stage in a persons treatment journey. One of the key findings from this is that getting access to the right type of accommodation at the right time was key to the continuation of a successful treatment journey, and critical to minimising the risk of lapse/relapse. Full details of the research findings and recommendations are available on the N-DAP web site at the following location (www.nordat.org.uk/housing_employment/index.htm). One immediate result of this work has been the joint commissioning by N-DAP and Supporting People of a Substance Misuse Housing Pathway service, which aims to support robust joint care planning arrangements that monitor a client's current housing provision and their progress in the Cycle of Change and plan future provision to increase effective treatment outcomes. Further findings and recommendations form the basis of the work plan of the N-DAP Housing Strategy Group.

[4] http://www.norfolk.gov.uk/consumption/groups/public/documents/abstract/ncc054480.xls
[5] South Norfolk Council. A Strategy for Gypsies and Travellers in Norfolk 2005-2008. South Norfolk Council
[6] http://www.norfolkdata.net

Adult Drug Treatment System Map



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

4.1 N-DAP will seek to make improvements in individual drug user's health and social functioning by continuing to implement and work with the Treatment Outcomes Profile and by continuing to strengthen the links, interface and co-ordination arrangements both between substance misuse treatment agencies and wider agencies.

4.2 N-DAP will seek to lower public health risks from blood borne viruses and overdose by establishing a Harm Reduction Governance Group to oversee the new N-DAP Harm Reduction Strategy. Both this group and the Adult Joint Commissioning Group will continue to address the performance of N-DAP against its harm reduction and healthcare indicators and targets.

4.3 N-DAP will seek to make improvements in community safety by maintaining and improving its strong Drug Interventions Programme and strong links with both the Constabulary and Crime and Disorder Reduction Partnerships.

4.4 N-DAP will continue to ensure appropriate implementation of the 2007 Clinical Guidelines and NICE guidance, recognising the role of clinical governance mechanisms in ensuring the quality and safety of drug treatment services by implementing an annual report template, which includes clinical/practice governance reporting, and by drawing on the clinical governance expertise and support of NHS Norfolk.

5. Key priorities for 2009/10

5.1 The key priorities identified in this section are a result of the following areas of work: development of the N-DAP Adult Joint Commissioning Strategy; needs assessment; gap analysis; analysis of the Healthcare Commission/NTA joint service review results; and N-DAP treatment planning days.

5.2 In broad terms, the key priorities are for developing open access, harm reduction and structured drug treatment interventions to meet local needs during 2009/10 and beyond. They include links to the government's National Drug Strategy commitments, notably:

i. Improving planned completion rates for everyone in the drug treatment system
ii. Improving the numbers of individuals in employment during or upon leaving treatment
iii. Better access to treatment for traditionally under-served groups – for example BME clients and clients who have dependent children
iv. Better access to treatment for crack users
v. Improving levels of effective engagement for crack clients, criminal justice clients and those under 25, BME clients and parents
vi. Improving housing status for individuals during or upon leaving treatment

5.3 The 'SMART' objectives to underpin these key priorities – and improvements outlined in section 4 – will be detailed in Part 3, which will also make clear the relationship between these improvements and priorities, and improvement in effective engagement of drug users in treatment, together with improvements in retention levels, planned discharges and penetration of problem drug users.

Key priorities:

5.4 The key priority for 2009/10 is to commence delivery of the new commissioning intentions adopted by N-DAP for the period 2008 – 2012. Each commissioning intention is therefore a high-level priority in its own right. The focus of this and successive treatment plans is to ensure that we achieve what we intend and outline in the N-DAP Adult Joint Commissioning Strategy. The majority of the commissioning intentions require work to be undertaken across the next 3 financial years. The actions within this plan will only include those required in the 2009/2010 year. It is important that we set out key milestones for each high-level priority in each year so that we may track progress of delivery against commissioning intention. In addition, we also need to ensure that our commissioning intentions also correspond to national policy expectations. The following section, therefore, sets out each commissioning intention as a priority, with narrative to explain links to the National Drug Strategy and broad descriptions and rationale for the activity to be undertaken. This is followed by other priorities also to be pursued.

5.5 The priorities based on commissioning intentions A1 to A8 to be pursued are:

A1: To part-fund The Matrix Project – Sex Industry Outreach Service, subject to sufficient other funding being secured, which will be reviewed on an annual basis.

The priority enables us to reinvest savings within the treatment system to support other commissioning intentions and priorities. In 2009/2010 we will ensure that the project is secured by gaining agreement on the future contractual arrangements between all funding agencies.

This is directly linked to National Drug Strategy priorities of Access, Effective Engagement of new clients, Treatment exits, Employment, and Housing, plus wider health improvement.

A2: Secure countywide provision of Models of Care Tier 1, Tier 2 and Tier 3 Interventions (excluding community and specialist prescribing), subject to available funding and identified needs

In 2009/2010 we will concentrate on improving the equity and effectiveness of provision (in line with clinical governance principles) and enabling more seamless referral and joint working processes between providers across all parts of the treatment system and beyond. This will include strengthening pathways between treatment services, housing, employment and training and mental health, seeking pathways to enable increased engagement of PDUs who have never accessed treatment and expanding both the volume and potentially the type of Tier 2 services in the west of Norfolk.

This priority is directly linked to National Drug Strategy priorities of Access, Treatment exits and Effective Engagement of new clients.

A3: (i) Secure county-wide provision of Models of Care Tier 3 interventions, specifically community and specialist prescribing interventions, and provision of the clinical service for the Drug Interventions Programme, subject to available funding and identified needs

A3: (ii) Undertake a consultation on enabling transition to increased shared care arrangements

As per priority A2 in 2009/2010 the key areas for development will focus on treatment equity and effectiveness and the continued strengthening of care pathways and routes into treatment. In addition to this we will explore options for increasing shared care arrangements (to be integrated into further commissioning activity required in 2010/2011

and 2011/2012), further develop clinical/service governance arrangements and begin implementation of the N-DAP Harm Reduction Strategy.

Work towards this priority will need to take account of improving retention of crack, other stimulant and cannabis users and those aged under 25, who appear less likely to be retained. Developing more shared care needs to take into account the willingness of General Practitioners countywide to deliver such services, and there may be cost prohibitions. The consultation will need to consider the opportunities and risks of remodelling Tier 3 community and specialist prescribing interventions to free resources (staff and/or funding) to increase shared care provision in the primary setting. Work on this priority will take into account the identified need to retain the knowledge and experience of existing providers and capacity issues among Tier 3 provider agencies.

This priority is directly linked to National Drug Strategy priorities of Access, Treatment exits and Effective Engagement of new clients.

A4: Secure county-wide availability of structured day programmes (SDP), subject to available funding and identified needs

This priority will be actioned in 2010/2011 in readiness for commissioning activity required to take place in 2011/2012.

This priority is directly linked to National Drug Strategy priorities of Access, Treatment exits and Effective Engagement of new clients and Employment.

A5: To evaluate the county-wide specialist homeless outreach service

Our goal for 2009/2010 is to better define the outcomes achieved from this service in readiness for future commissioning activity when, if necessary, it may be remodelled to better serve the treatment system, both in terms of national priorities and client needs, and in the light of wider N-DAP action on housing issues (e.g. the housing needs assessment work recently completed and the recently commissioned Housing and Substance Misuse Pathway's Service, funded jointly with Supporting People). This will also link in with the on-going work programme of the N-DAP Housing Strategy Group aimed at tackling the housing issues faced by substance misusers.

This priority is directly linked with the National Drug Strategy priority for Housing and Employment.

A6: To maintain the Drug Interventions Programme (DIP)

In 2009/2010 we will concentrate on completing a whole service cost review exercise of the DIP programme, with the aim of aiding the assessment of potential service reconfiguration in 2011/2012 if necessary and we will review and revise the county DIP strategy to consider current and emerging developments, including IDTS implementation.

This priority is directly linked to National Drug Strategy priorities of Access, Effective Engagement of new clients, Treatment exits, Employment, and Housing.

A7: To develop work with families and parents who are substance misusers

We will use the commissioning process to enable more seamless referral and joint working between providers, both within the adult system and between the adult and young people's elements of the treatment system overall. This work will link in with development of new

integrated services for young people as part of wider work on service commissioning and provision in Norfolk, being led by the Children and Young Peoples Partnership Trust.

This priority is directly linked to National Drug Strategy priorities of Access, Treatment exits and Effective Engagement of new clients.

A8: To improve Tier 4 services: inpatient treatment and residential rehabilitation where possible, and/or appropriate.

We will evaluate the recommendations suggested by the Healthcare Commission and National Treatment Agency 2007/08 joint service review, and embed these into the treatment system where this is deemed appropriate.

This priority is directly linked to National Drug Strategy priorities of Access, Treatment exits and Effective Engagement of new clients.

5.6 Other priorities to be pursued are:

OP1: To improve treatment service provision for offenders

We will support HMP Wayland and HMP Norwich in the development and delivery of an Integrated Drug Treatment System for prisoners. In doing so, we will ensure that there are seamless referral routes between Prisons and the Criminal Justice Integrated Teams (CJIT's) and community-based services (including housing and employment) once a prisoner is released back into the community. This will be linked to work on delivery of the Norfolk Harm Reduction Strategy, with a specific focus on reducing drug-related deaths. Further details concerning this priority will be set out in the IDTS Treatment Plans for HMP Wayland and HMP Norwich. It will also link to referral pathways and activity around DRR's in Norfolk.

This priority is directly linked to National Drug Strategy priorities of Access, Effective Engagement of new clients, Treatment exits, Employment, and Housing.

OP2: To implement the Norfolk Alcohol Harm Reduction Strategy.

Whilst this is a treatment plan focused on tackling drug misuse, N-DAP members feel that the extent to which alcohol misuse is so often found alongside other drug misuse must be acknowledged. Links with drug misuse and capacity issues facing drug and alcohol treatment provider agencies will be taken into account in developing action plans to support the delivery of the newly adopted Norfolk Alcohol Harm Reduction Strategy 2008-2012. Shared areas of work will be identified as the supporting action plans for the Strategy are developed, and taken forward jointly where appropriate.

This priority is linked to National Drug Strategy priorities of Access, Effective Engagement of new clients, Treatment exits, Employment, and Housing.

5.7 **OP3** - Improving performance and measuring outcomes.

In general, we will be paying extra attention to performance within individual agencies as a means of driving improvements on overall N-DAP performance and meeting our local partnership targets outlined in Part 2, meeting with service managers every quarter to review their agency's performance. We will focus on continued improvement with TOP compliance and other key indicators of success, with a special focus on planned discharge performance and numbers in effective treatment.

Appendix 1: Gap analysis to support adult drug treatment plan 2009/10 Part 1: Strategic summary, needs assessment and key priorities

1. Gap analysis

1.1 Successful commissioning and planning is dependent on a gap analysis that establishes gaps between identified needs (obtained from a needs assessment) and existing provision (obtained from a market analysis, or in this case a contract review).

1.2 An effective gap analysis needs to:

i. Review the nature, extent and location of service need (demographics and numbers).
ii. Review the extent to which services currently meet needs (quality assuring services against identified needs) and are likely to meet needs in future.
iii. Produce a list of identified gaps across modalities/service user groups.
iv. Identify risks and harms in relation to service gaps.

1.3 The Adult Joint Commissioning Group and the wider N-DAP membership has reviewed this gap analysis and evaluated and prioritised the identified needs, harms and gaps and appraised options for meeting those needs. This work has formed the basis for deciding upon key priorities for the 2009-10 Adult Treatment Plan.

1.4 It must be noted that some of the issues identified may be carried over from the 2008-2009 year. Further issues may also need taking forward from the 2009-10 treatment planning process and not all issues identified may be resolved even in financial year 2010-11.

2. Nature, extent and location of service need

2.1 Prevalence

i. A study funded by the NTA (2005) estimated that there were between 6,400 and 10,500 problematic drug misusers in Norfolk.
ii. A study conducted by the University of Glasgow (2006/07) estimated that the prevalence of opiate and crack cocaine users in Norfolk was 3376.

2.2 Penetration

i. Norfolk achieved 2710 episodes of treatment in 2007/08.
ii. Between 01.04.04 and 31.03.08, a total of 6,190 distinct individuals entered treatment.
iii. Problem drug users appear to more commonly use Class A drugs. Our needs assessment concludes that treatment services are successfully targeting more severe drug users.
iv. A substantial number of 'problem drug users' have never accessed treatment in Norfolk, these tend to be younger users, predominantly using Class B/C drugs.
v. There are large numbers of cannabis users who the police have contact with but who do not otherwise enter the drug treatment system. Their needs in terms of treatment or services are unknown, as this research was outside of the scope of the UEA needs assessment. Clearly though, this is an important demographic, especially as individuals tend to be younger and at risk of an escalation of their habit in future (especially if they enter the criminal justice system). Further research into this area should be prioritised.

vi. Between 45% (opiate/crack HES related admissions) and 60% (identified by death) of severe problem drug users appear not to be accessing treatment. Mis-matches between hospital and NDTMS data tend to be older and more often female.

vii. Outside formal 'shared care' arrangements – approximately 100 individuals are receiving methadone prescriptions and around 30 are receiving buprenorphine prescriptions from their GP. This is more pronounced in central Norfolk.

viii. Approximately 200 individuals are receiving methadone prescriptions under formal shared care arrangements and 45 receiving buprenorphine prescriptions.

ix. Norfolk's treatment services go some way to address parental substance misuse and Norfolk's pregnancy liaison protocol is an example of effective shared working practice.

x. Service users are most likely to enter Norfolk's treatment system via self-referral. Entries via GP referrals are low and inconsistent across agencies. Numbers entering via the criminal justice system have continued to increase significantly since 2005/06, partly because of better data recording procedures. Anecdotally, service providers believe that the GP referral data available grossly underestimates the actual referral volume. This requires further investigation.

xi. Referrals to residential rehabilitation are managed via the Trust Alcohol and Drug Service (TADS). Referred service users will have engaged with community services and will typically have heroin and/or alcohol as their primary substance – with those citing alcohol increasing.

xii. For Tier 4 services, dual diagnosis cases and pregnant clients may be given priority although the majority of Norfolk's Tier 4 clients have coexisting substance misuse and mental health issues.

2.3 Attrition rates

i. There appears to be an association between retention of 12 weeks or more and successful discharges.

ii. Opiate users, women and people aged 35+ appear more likely to be retained.

iii. Crack, stimulant and cannabis users and those aged under 25 appear less likely to be retained.

iv. People from BME groups appear less likely to be retained – but the numbers are too small to draw definite conclusions.

2.4 Treatment outcomes

2.4.1 Data suggests 34% of treatment episodes were successfully discharged between 2004/08.

2.4.2 Amongst those successfully completing episodes of treatment:

i. People aged under 20 are over-represented

ii. People aged over 50 are over-represented

iii. People aged between 20 and 40 are under-represented

iv. Females are slightly over-represented

v. Males are slightly under-represented

vi. There is not enough data on BME groups to draw conclusions.

2.4.3. Around 53% of clients entering residential rehabilitation from Norfolk complete their treatment in a planned way.

3. Extent to which services currently meet needs

3.1 The 2008 round of contract reviews coupled with the findings from the UEA needs assessment strongly suggest that current service provision goes a very long way towards meeting current service needs in Norfolk. However, we remain alert to the findings in terms of penetration and attrition rates, and recognise the need to move further forward with work on employment and housing issues for substance misusers.

3.2 A separate improvement plan has been voluntarily drawn up to address areas of weak or fair performance and to maintain areas of good or excellent performance as identified in the 2006/07 and 2007/08 Joint Healthcare Commission/NTA reviews. The improvement plan informed this gap analysis.

4. Extent to which services are likely to meet needs in future

4.1 These are the key points from the 2008 contract reviews, which indicate issues which may impact on services in the future:

i. The west of the county remains under-served in terms of 'Tier 2' provision.
ii. Disinvestment had resulted in several issues:
   a. Current levels of service would be at risk if any further cuts were made. Capacity within services had already reduced;
   b. Many agencies proposed to meet further funding cuts by cutting administrative posts, therefore further reducing the capacity of practitioners and workers;
   c. A 'hold' on recruitment was already occurring in agencies in response to concern about future budget cuts, again affecting service capacity; and
   d. Further disinvestment in the system was perceived as putting rural and outreach services at risk.
iii. Agencies continued to report a significant number of alcohol referrals.

5. Identified gaps across modalities/service user groups

5.1 Gaps in particular types of services

i. 'Tier 2' provision in the west of the county.
ii. Specialist workers for pregnant substance misusers.
iii. Capacity for alcohol treatment referrals. This is starting to be addressed by the allocation of new funding by NHS Norfolk and NHS Great Yarmouth and Waveney to support actions focused on reducing alcohol-related hospital admissions in Norfolk.
iv. Links, interface and co-ordination with wider non-substance misuse services, for example:
   - 'Move on' accommodation for service users leaving Tier 4 treatment (as reflected nationally).
   - Structured Day Programme for those wishing to remain substance free (e.g. aftercare or alternative to Tier 4).
   - Support for parents who are substance misusers.
   - Transition support for young people moving to adult-focused services

5.2 Absences of service within a particular community

i. Younger Class B/C drug users are not engaging with the treatment system – cannot make assumptions about services needed.

ii. Cannabis users who have had contact with the Police – cannot make assumptions about services needed.
iii. Women with acute substance misuse problems not accessing treatment – requires further investigation and cannot make assumptions about services needed.
iv. Despite no definite conclusions – engagement/retention of BME drug users needs to be monitored. (Norfolk's strategy for Gypsies and Travellers in Norfolk highlights problems in accessing health care for Norfolk families as a particular cause for concern).
v. Lesbian, gay and bisexual individuals with substance misuse problems – a literature review was conducted in 2008/09. Findings and analysis will be used to consider ways to further improve treatment access for LGB individuals during 2009/10.
vi. Stimulant users

5.3 Any services which are weak or of poor quality

i. None.
ii. Strengthening links between services in terms of increased inter-agency referrals and supporting improved end-to-end management of people accessing services requires additional work. The treatment map on page 8 of the main Part 1 document demonstrates an increase in inter-agency referrals compared with 2007/08.

5.4 Any services which are in inappropriate locations or inaccessible

As a large, rural county, Norfolk does have issues with the geographical area the treatment agencies need to cover. Agencies have to factor in extra resources for travel time and some service users can experience difficulties in getting to specialist services.

5.5 Any over-provision of particular services

None.

5.6 Any over-provision of services within particular communities

None.

It could be argued that access to modalities is not equitable because of the focus on Tier 3 community based provision and lack of sign-up of GP and primary care services.

5.7 Whether the funding for particular services is sustainable

With funding granted on a year-to-year basis and the risk to public expenditure caused by the "credit crunch" the entire treatment system is vulnerable to changes in funding. For all agencies, the uncertainty of knowing whether funding will be available for the following financial year can impact on maintaining a sustainable service, despite having a contract in place. Budget modeling work revealed a high risk of deficits in the medium term. The Adult Joint Commissioning Strategy has started to address this issue by reducing funding to some agencies and redirecting this to sustain or enhance treatment provision, but we have yet to achieve a fully balanced budget for N-DAP in the medium term. This will be an important consideration in terms of the priorities identified above.

6. Identified risks and harms in relation to service gaps

6.1 Issues

i. N-DAP runs the risk of losing out on strengths of treatment system/services by not understanding areas of success (e.g. retaining women in treatment) and commissioning accordingly.

ii. Rurality – service users unable to access treatment because of lack of access to information/travel issues.
iii. Funding – capacity levels of overall treatment system because of budget constraints.
iv. Monitoring of and enhancing work with parents who are substance misusers.
v. Engagement with and sign-up of GPs and primary care services.
vi. Difficulty for agencies in accommodating increasing alcohol referrals.
vii. Continued difficulty around mental health/dual diagnosis referrals and care co-ordination.
viii. Transitional arrangements between young people's and adult services.
ix. Practical support to increase service user involvement throughout the county.

6.2 Gaps and associated risk/harm

Gap	Risk/Harm
Tier 2 provision in the west of the county	Pressure on existing services bridging the gap Insufficient of harm reduction advice and information and referral into clinical/structured treatment Insufficient aftercare following residential rehabilitation
Specialist workers for pregnant substance misusers	Pressure on existing services Insufficient correct advice and support for pregnant substance misusers Norfolk's pregnancy liaison protocol highlighted as an example of effective shared working practice
Alcohol treatment capacity	Pressure on existing services, particularly where agencies have dual drug and alcohol treatment remit
Links, interface and co-ordination within treatment system and with wider non-substance misuse services (see earlier examples)	Lack of support – relapse
Younger Class B/C drug users are not engaging with the treatment system – cannot make assumptions about services needed	Unclear at present – possible need for focussed preventative work targeting younger Class B/C drug users/cannabis users (not yet clear what, if any, services needed)
Cannabis users who have had contact with the Police – cannot make assumptions about services needed	Unclear at present – possible need for focussed preventative work targeting younger (18 to 25 years old) Class B/C drug users/cannabis users (not yet clear what, if any, services needed). See UEA Needs Assessment Final Report: Appendix 2.
Women with acute substance misuse problems not accessing treatment – requires further investigation	Unclear at present – possible need for targeted resources to work with women with acute substance misuse problems.
Despite no definite conclusions – engagement/retention of BME drug users needs to be monitored	Unclear at present – requires monitoring and further investigation

Gap	Risk/Harm
Consistent approach and sufficient range of services for parents who are substance misusers	Focus groups and interviews reveal that service providers are happy with the range of provision available (including treatment and generic services) but would like to see more capacity, continuity of funding and inter-agency alignment.
Transition support for young people moving to adult-focused services	Potential loss of vulnerable young people from treatment services
Lesbian, gay and bisexual individuals with substance misuse problems	Early findings from literature review suggest on-going sense of stigma among LGB community from service providers Early findings from literature review suggest 18-24 year old LGB's almost twice as likely to use illegal substances compared with wider community, but substances used tend to be different e.g. LSD and Ecstasy Insufficient focus on impact of 'softer' drugs on the LGB community Missing 'early warnings' on new trends in drug misuse that may appear among the wider community