



Partnership: Sheffield DAAT

Drug treatment, reintegration and recovery in the community and prisons: partnership plan 2010/11

Part 1: Strategic summary, needs assessment and key priorities for 2010/11

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Part 1: Strategic summary, needs assessment and key priorities for 2010/11

Overall direction and purpose of the partnership strategy for drug treatment:

The management of substance misuse in Sheffield is through a strong partnership governance structure: Sheffield Safer Sustainable Communities Partnership is the local strategic partnership responsible for drug & alcohol treatment; activity is devolved to its strategic team the Sheffield Drug & Alcohol Action Team (DAAT) led by the Director of Substance Misuse Strategy. The DAAT staff is formally employed within the Public Health directorate of NHS Sheffield (Sheffield PCT) who hold budgets, contracts and undertake procurement activity on behalf of the partnership. The Joint Commissioning Group (JCG) is formally chaired by the Director of Public Health, a joint post between Sheffield PCT and the Local Authority. Clinical governance is the formal responsibility of the JCG and is informed by a variety of clinical reference groups focussing on prescribing practice, drug related deaths and blood borne viruses. The treatment system is commissioned in line with commissioning best practice which includes the substance misuse specific commissioning frameworks: Models of Care for Drug Misuse and Commissioning for Recovery; substance misuse specific clinical guidelines including the 2007 Drug Misuse and Dependence and NICE guidelines, and other good practice commissioning models including World Class Commissioning and Institute for Public Care guidance. The Institute of Public Care commissioning cycle summarised as “Analyse, Plan, Do, Review” is followed by annual needs assessment, treatment planning, procurement and pro active quarterly review and frequent audits. Key performance indicators for treatment are monitored through the JCG with DIP performance receiving scrutiny at the DIP Strategic Board; with combined performance activity being reported to the Safer Sustainable Communities Partnership Performance Board of which the Director of Substance Misuse Strategy is a member. Key performance indicators for the partnership include target 20 of the Local Area Agreement - to increase the proportion of drug users who are recorded as receiving effective treatment by 10% from the baseline by 2010/11 - which reflects the PSA 25, the National Treatment Agency Treatment Plan targets and Vital Signs national targets for local delivery. The Sheffield Treatment Plan sits within the context set by the core strategic documents for Sheffield:

- Sheffield First City Strategy
- City of Opportunity (Sheffield City Council)
- Achieving Balanced Health (NHS Sheffield)
- South Yorkshire Integrated Offender Management Strategy

As part of this context, the commissioning of drug services will connect to broader themes about supporting individuals, families and communities to be healthy, prosperous and successful; promoting prevention; delivering personalised care and support; supporting community cohesion; and tackling crime.

The recovery agenda, was launched as part of the National Treatment Agency’s “Treatment Effectiveness” drive in 2006, and was strengthened by the National Drug Strategy 2008 assertion that the goal of treatment was to become drug free. “Treatment system” and “recovery system” must be inter-changeable. “Recovery” has an additional meaning within the wider context of the economic downturn. It is more important than ever that the partnership delivers recovery focussed, streamlined treatment services offering value for money and improved unit costs. The partnership expressed its intention of tendering the Adult Treatment System within the 2009/10 treatment plan having recognised flaws in a treatment system which, rather than having been designed, had grown organically. These flaws had both implications for treatment effectiveness and value for money. The ending of contracts



in March 2010 provided an opportunity to design a recovery focussed, effective treatment system which was fit for the next 10 years of the current drug strategy. The partnership recognises that providing for the continued growth of treatment within fixed or reducing budgets requires smarter commissioning of services. **A key strategic priority for the partnership is to ensure the continued growth of an effective, recovery focussed, integrated, treatment system within today's budgets and with resilience for the future.**

Towards Successful Treatment Completion (2009) and the Treatment Outcomes Profile place the value of treatment firmly on outcomes and the emphasis on service factors. Pro-active quarterly monitoring of treatment providers is well established and this has been supplemented in 2009/10 with data quality and completeness audits, clinical audits and care plan audits. Improving planned discharge and drug free completions has long been a priority of the partnership. 2009/10 was dominated by addressing data problems at a provider level which marred performance against 2008/9 targets and raised questions about the accuracy of the baseline. Resourcing for the drug treatment system is dependent on the flow of high quality, accurate data to the National Treatment Agency demonstrating positive outcomes for the investment in treatment, and therefore **a key priority in 2010/11 will be to continue to address TOP compliance, data quality and completeness issues at a provider level through pro-active data audits.**

The data problems in Sheffield and the continued threat of failure of the Problematic Drug Users in Effective Treatment target focussed the partnership's attention on the ineffectiveness of Tier 2 as the conduit of referrals of treatment naïve and treatment resistant to Tier 3. Tier 2 had long been identified as having capacity problems due to reverse footfall from Tier 3. Over the years in Sheffield, Tier 2 open access has primarily become the place where Tier 3 clients drift back for key-working that should be provided by Tier 3 providers. The disjointed structure of services, some duplication at Tier 2 and no recording to NDTMS have masked how many individuals who are treatment naïve or treatment resistant are actually being reached at Tier 2. This distraction has resulted in a lack of intelligence amongst Tier 2 providers about where the "hidden" population of problematic drug users can be found suggesting a disconnection with street level users. There is considerable investment in Tier 2, but this investment needs to be more clearly directed towards the outcomes which are required. Much more of the emphasis and time at Tier 2 will need to be on innovative approaches to locating the hidden population of up to 2,000 PDUs if Sheffield is to achieve its targets. The task of the commissioners is now to reassert Tier 2 not as the safety net for Tier 3, but as the entry to Tier 3 with associated brief interventions to secure motivation, engagement and initial re-integration support. This will lead to increased penetration into the hidden population of PDUs which can be quantified through NDTMS recording at Tier 2 and allow tracking of individuals through the tiers of treatment. **Reconfiguration and tender of Tier 2 as an effective conduit into treatment is a key priority for this treatment plan.**

The wider agenda of recovery and re-integration requires treatment services to have links with housing & benefits services. If treatment centres are to become recovery centres, the scale of ambition needs to grow and better strategic links must be sought with a range of partnership agencies. In 2009/10 a formal pathway was established with JobCentre+, with a dedicated lead established within the open access Tier 2 service, and bespoke training provided for staff. A bespoke drugs awareness module was delivered to a wide range of Tier 1 staff. A cohort of 15 "expert practitioners" within Tier 1 agencies received the NOCN Practitioner in Substance Misuse training; this investment needs to be matched by active utilisation of these agencies by treatment services. These linkages with Tier 1 agencies need to



be further extended if treatment services are to build personal and social capital of drug users. ***A key priority for the partnership in 2010/11 will be to promote an integrated partnership approach to drug treatment recovery and reintegration.***

Harm reduction, Needle exchange and associated services have traditionally seen themselves as suppliers of equipment and advice to allow the continuation of safer use and, until recently, there has been a reluctance to aggressively promote treatment for fear of deterring service users. In 2009/10 a successful supplementary prescribing pilot was launched in a large pharmacy in Sheffield, providing appointments within the pharmacy for service users suitable for GP prescribing in the first 12 weeks of treatment. Service users were able to access hepatitis screening, immunisation and physical healthcare services within the pharmacy as well as needle exchange and supervised consumption. The pilot evaluated well, with 58 service users, all of them prison releases, seen at the pharmacy. Out of the 58 service users seen, 54 were retained in treatment and successfully transferred into mainstream services; only 4 did not complete treatment in the community having been transferred to custody. This pilot has now been extended to attract the 50% of individuals seen at pharmacy and specialist needle exchange who are not in structured treatment with assertive approaches by Tier 2 workers and service user involvement volunteers being made to individuals identified as treatment naïve or resistant. A Harm Reduction Service was tendered in 2009/10 to provide a consistent and integrated coverage across all four tiers of treatment, and more effective approach to blood borne viruses. Any individual presenting at any agency, at any tier, should be helpfully navigated to an appropriate service for their needs; this requires ongoing work on treatment pathways, treatment information and workforce development but also requires a culture change. There needs to be an expectation that substance misusers who come to the attention of any agency because of their substance misuse, require treatment and should have treatment actively promoted to them. This requires workforce development approaches for Tier 1 and communities so that they can move beyond simple drugs awareness, into more effective screening, motivation and referral into treatment; equally Tier 2 and Harm Reduction Services need to become effective routes into treatment. ***A treatment plan priority is to ensure that there is active screening and assertive promotion of treatment to naïve and resistant individuals.***

In contrast to the hidden population of crack and opiate users, there is an increasing visible cohort of users of alcohol, cannabis, powder cocaine and other stimulants, and ecstasy and similar synthetic legal, illegal and illicit “highs” (ACCE). This profile is particularly relevant to 18-25 year olds, or younger adults. It is not yet clear, what proportion of this cohort, if any, will progress to crack or opiate use, however those younger adults coming to the attention of treatment services already experience a range of problems from their use. This creates a key strategic challenge, where targets and resourcing are associated with PDUs and high crime causing users, but the emerging cohort of drug users do not match this profile. The treatment system needs to be responsive to changing trends, and this profile would suggest a greater focus on brief interventions at Tier 1 and extended brief interventions or OSI at Tier 2/3 is required for this cohort. The “Changing Thinking Patterns” three session manual from the ITEP stable is being viewed with interest as a brief or extended brief intervention for this cohort for whom alcohol is a large part of poly drug use. The wider economic context for Sheffield as a safe night time entertainment venue, where responsible alcohol consumption is an important part of the economy, could be perversely impacted unless powder cocaine use is effectively addressed and this has increased the interest of the partnership in reaching the ACCE profile of users. Alcohol is also a significant feature of poly drug use in PDU users who continue to use alcohol alongside illicit and prescribed drugs, frequently increasing alcohol intake



as drug use reduces; drug treatment services must be equipped to address alcohol as part of poly drug use to be effective. ***A partnership priority is to ensure that appropriate, brief and effective treatment options are tailored to this emerging cohort to address hazardous and harmful drug use amongst the ACCE generation of younger adults and to ensure all alcohol use as part of poly drug use is addressed through drug treatment.***

This cohort of users has also posed a particular challenge for the Drug Interventions Programme (Tier 2b). 2008/9 saw the beginnings of a trend of powder cocaine users being identified in custody suites following violent incidents in licensed premises. This cohort impacted on transfers into the treatment system, as predominantly a brief intervention was provided as part of the package of required assessments. Low purity levels of powder cocaine in 2009/10 is believed to be the main reason for a drop in positive tests and on numbers identified through “test on arrest”. This has potentially impacted on numbers taken onto the caseload and being transferred into treatment; as a result, DIP in Sheffield is likely to suffer under new financial models. Equally, this has proved problematic for the *problematic/all drug users in effective treatment* targets as testing on arrest cannot be relied upon to identify problematic drug users: those coming into custody may increasingly be more likely to be the ACCE profile, may not test positive due to purity levels, and their “self concept” as recreational users may encourage treatment resistance and therefore impact on transfers into the treatment system. There are considerable financial implications for the partnership from this apparent changing trend of drug use, as pooled treatment budget resources are aligned to numbers of problematic (crack/opiate) drug users in effective treatment, and DIP financial models are associated with positive tests and caseload size. ***The Drug Interventions Main Grant reduced funding in 2010/11 will pose a considerable challenge to the partnership and a key priority will be to review the provision within the available resource and bring the local model into alignment with the national financial model prior to the planned re-tender.***

In 2009/10 an “Abstinence Pathway” will have been developed, to process map the treatment system and ensure that the choice of abstinence is actively offered and promoted at all stages of the treatment journey. For providers, service users and carers, abstinence still equates to Tier 4. The challenge for the partnership has been to engineer a culture change so that abstinence choices can be made and maintained at all Tiers of treatment. Service users, when consulted about the tender of prescribing services, clearly stated that while stabilisation was the priority for the first 12 months in treatment, thereafter the goal changed to becoming drug free. Local Treatment Outcome Profile data suggests that, after 12 months, deterioration in daily injecting is more likely to be the outcome. ***The integration of abstinence across the treatment system and the implementation of the Abstinence Pathway will remain a key priority in 2010/11.***

The 2007 *Drug Misuse and Dependence: UK Guidelines on Clinical Management*, colloquially known as the “orange book”, clearly advocated that all treatment should have a psychosocial component, and that “perhaps” 30% of those on substitute prescribing maintenance programmes, may require **formal** psychosocial interventions (PSI). PSI was noted by the orange book, to be the first line intervention and the mainstay of treatment for stimulants use. This recommendation was embraced by the partnership who launched an investigation and consultation of PSI provision and take-up in 2008/09 and for 2010/11 ensured all specifications for prescribing services included a target of 30% of service users in formal PSI. However, Psychosocial Interventions provision remains under-used and consequently unit costs are high for each of the four providers of PSI. A bespoke “Change Toolkit” for drug workers was developed locally, with an associated training



package to support delivery of the interventions, and was well received; this will now be further developed to incorporate “International Treatment Effectiveness Project” (ITEP) materials. Resourcing four providers has also created confusion for referrers and has not led to increased choice or a better offer for service users; the same theoretical models are delivered by, in the main, similarly qualified and experience staff. ***The planned 2010/11 retender of PSI will streamline provision so that a range of formal “packages” of treatment can be offered, from an appropriately qualified workforce, under the umbrella of a single provider.***

The 2008 National Drug Strategy placed a welcome emphasis on families, carers and communities. In 2009/10 a Hidden Harm review was commissioned on behalf of the partnership, with the Safeguarding Children’s Board with the intention of creating a city wide strategy for substance misuse. The Hidden Harm Service, commissioned by the partnership, will be re-specified in the light of the findings of the review. The review focuses on processes and outcomes for substance misusing parents and their children and is intended to produce clearer pathways, protocols and processes for this area of joint working, incorporating the learning from safeguarding reviews concerning substance misuse. The Specialist Substance Misuse Pregnancy Clinic has been re-specified and tendered with a greater emphasis on clinical leadership of multi-disciplinary teams, tight care co-ordination and risk assessments leading to informed rather than automatic referral into safeguarding processes where appropriate. A city wide Carers Strategy is currently under development led by the Local Authority and NHS Sheffield, to which substance misuse carers have contributed. The partnership continues to invest in carers support services, which provide added value both as a conduit to treatment for naïve or resistant individuals and support to retain individuals in effective treatment. The carers service has participated in the National Treatment Agency Naloxone Pilot which has provided additional skills and resources for carers. A dedicated Communities Officer within the DAAT continues to work in Safer Neighbourhoods Areas where substance misuse has been identified as a problem and ensures a co-ordinated response to effectively tackle substance misuse. ***Preventing harm to children, families and communities from substance misuse, in line with the Drug Strategy 2008 will continue to be a partnership priority.***

Extensive consultation with service users, carers and communities has informed the treatment planning process including consultation with the diverse ethnic communities in Sheffield. A detailed interrogation of National Drug Treatment Monitoring Service (NDTMS) data, mapped onto interpreting data revealed that while as a whole, BME communities are well represented in treatment in Sheffield compared to the regional and national figures with some ethnic communities being well or over-represented, including newer arrivals e.g. Iranians; other well established communities are significantly under-represented, e.g. Chinese. Although the drugs of misuse, the method of use and the stigma of use differed amongst the communities consulted, strong common themes emerged. Investing in up-skilling communities was a key theme of the consultations: Tier 1 agencies within communities, local business people and other community leaders need drugs awareness skills and knowledge of the treatment system. Community learning initiatives must focus on the broad range of drugs of misuse including khat; address stigma and debt; and include role models for recovery. Despite considerable investment from the partnership, the consultation suggested there was limited impact of Tier 1 and community training and this investment needs to become more effective. Recovery or “rescue” from drug misuse was also a powerful common theme: community leaders consulted, agreed that the most powerful promotion of drug treatment was to know somebody in the community who had recovered. In 2009/10 a Service User Involvement Strategy was developed, including a refreshed



learning scheme in which former service users, who have completed drug free, become “Ambassadors” for recovery within the treatment system; the outcome of the community consultation suggests a wider role for “Ambassadors” within community and Tier 1 learning initiatives may be beneficial. ***A partnership priority will be to continue to invest in Tier 1 and community learning initiatives to increase the effectiveness and reach of the drug treatment workforce. Improving successful treatment exits to increase the visibility of successful treatment is also a priority.***

The overall direction and purpose of the partnership strategy for drug treatment in 2010/11 is to continue the work of 2009/10 in designing a drug treatment system which is fit for purpose for the 10 year period of the 2008 drug strategy and is recovery focussed, outcome based, effective, economically resilient/sustainable and provides value for public money. The partnership expectation of the treatment system, is of a recovery and re-integration system, which interfaces with the range of partnership agencies to provide 360 degrees visibility and integrated management of problematic drug use.

The likely demand for open access (community based), harm reduction and structured drug treatment interventions; the differential impact on diverse groups and overall plans to address negative impact:

Prescribing services were re-specified and offered to open competitive tender in 2009/10. The number of treatment places within prescribing is 3,060 with 2,060 being within primary care and 1,000 within secondary care. The majority of the 4,616 problematic drug users in the city will require a prescribing modality.

Psychosocial Interventions will be re-specified and retendered in 2010/11 and sufficient capacity will be created for 30% of those in prescribing to receive PSI in line with clinical guidelines, as well as those stimulant users and ACCE requiring PSI/OSI as a first line intervention. At present only circa 22% of those in treatment have a second treatment modality.

Structured Daycare: there will be no changes to commissioned capacity. 60 (12 week) treatment places are commissioned and additional capacity will be spot purchased where required. This modality will be offered to open competitive tender in Round 3 of Sheffield DAAT’s tender scheme.

Tier 4: There will be no changes to commissioned capacity for **Inpatient detox**, for which 5 beds are available for drugs and alcohol; or **residential rehabilitation** which is currently spot purchased. Commissioning arrangements for Tier 4 are under review and will be revised in 2010/11.

Tier 2 will be re-specified and will include the requirement of NDTMS recording and a more structured “offer” alongside provision for the most chaotic users. Capacity will be geared to the hidden population of PDUs, up to 2,500 users. Appropriate brief and extended brief interventions or ‘**Other Structured Interventions**’ (OSI) will be offered to the ACCE profile of service users.

Nb. Diversity data is impacted by incomplete data and is therefore a partial picture. This is fully explained in the local Needs Assessment, but for the purposes of the summaries provided below, should be viewed with caution. Comparisons are made with the 2001 Census; the next national census will be produced in 2011.



Gender

The estimated prevalence for females in the Opiate/crack PDU is 23%. At Tier 3, 26% of service users are female, at Tier 2 it has increased by 4% to 30%. During 2007/08 females represented 9% overall of the DIP caseload, this increased to 13% of females in 2008/09. Service provision for women is well established, with all services reflecting activity inline with the PDU gender split and with specific services for pregnant women and for street sex workers. New service specifications include provision within national gender equalities legislation and for home visits for women and wherever possible to receive treatment from a female worker.

Race

Drug treatment services are available to all communities within Sheffield, most services are located centrally to enable easy access to treatment, interpretation services are used by all providers. Data from the NHS interpreting service, for interpreters requested by treatment services, show the most popular language is Farsi, which made up 55% of interpreter requirements. This again supports the ethnicity and nationality data suggesting increasing representation of Iranian service users within the treatment system. Treatment information is available in English, Arabic, Urdu, Somali, Farsi, Portuguese, Polish, French and Kurdish reflecting the predominant communities of need within the Sheffield Treatment System and the general population.

All treatment providers are commissioned to provide a culturally appropriate service, and ethnicity information, including workforce breakdown is monitored by the DAAT at quarterly reviews. Local information shows ethnic minority clients accessing services citywide for their drug treatment although representation from the different BME communities varies with some being considerably over-represented compared to the population size within Sheffield, for example Iranian service users and some being considerably under-represented, for example Pakistani service users.

It was the view of the expert group of community leaders that ethnicity when combined with social deprivation led to higher incidence of substance misuse in some neighbourhoods in the city. Sub-cultures of drug use are specific to certain communities such as primary or sole crack use among the young black population, opiate use among the Central Asian/ Middle Eastern communities (Iranian, Iraqi and Afghani) khat use among the central African communities (e.g. Somali and Yemeni). Different cultures have different stigmas attached to both drug use and drug treatment, engagement pathways must take account of these barriers, as well as the different substances being misused. The drugs of misuse, aside from opium/heroin smoking, are more predominantly cannabis, khat and other stimulants including crack, suggesting that this need may be most effectively met by Tier 2 and OSI. There is evidence that Opiate users are able to access and use Tier 3 prescribing services. The need for development of the Tier 1 workforce and community leaders within ethnic communities has already been noted. Issues of culture and stigma are particularly relevant for Tier 2 access and engagement and culturally appropriate provision including outreach will be clearly specified when Tier 2 provision is tendered.

Age

The majority (25.29%) of service users in Sheffield are aged 30-34. Sheffield compares well to the region and national figures for engagement and successful treatment completion of under 25s. The expert group view was that most under 25s were not using PDU drugs and are more likely to be the ACCE profile. This was borne out by service user consultations. TOP data shows clients under 25 are much



more likely to be using Cocaine and Cannabis in the four weeks prior to entry to treatment than those over 25, who are much more likely to be using Opiates and Crack. The treatment system is likely to see most demand from younger adults at Tier 2, with brief and extended brief psychosocial interventions being the first line treatment for this age group who are predominantly the ACCE profile. The reconfiguration of Tier 2 needs to take accounts of the differing needs of young adults (18-25) on the ACCE profile who may require a different mode of delivery to 30 year old+ PDUs.

Disability is a local data source on NDTMS, but is not collected nationally. Pilots have started at local providers to collect this data and report back on any challenges; this will be reported back at the start of 2010/11. New service specifications include home visits for those with disabilities, including temporary disabilities and the provision of all treatment from Disability Discrimination Act compliant premises.

Sexual Orientation is a local data source on NDTMS, but is not collected nationally. Pilots have started at local providers to collect this data and report back on any challenges; this will be reported back at the start of 2010/11. In the absence of this data there is no evidence that can be provided for differential access or need related to sexual orientation. Specific substance misuse leaflets targeted at “men who have sex with men” are produced by the Centre for HIV and Sexual Health.

Religion/Belief is a local data source on NDTMS, but is not collected nationally. Pilots have started at various providers to collect this data and report back on any challenges; this will be reported back at the start of 2010/11. While this data is not collated locally, there is a high correlation between country of birth/ethnicity and Muslim faith; whilst some ethnic groups of Muslim faith are well or over represented in the treatment system (Iraqi/Iranian); some are significantly under represented (Pakistani). Khat, which is predominantly used in East African and Yemeni communities, which are significant communities within Sheffield, can either be halal or haraam within the Muslim faith, however because of the debt created by khat misuse, it can be highly stigmatised. To attempt to separate ethnicity, culture and religious belief in terms of some of the ethnic communities in Sheffield is counter-intuitive. Treatment services within Sheffield, particularly at Tier 2, will need to take account of religious belief and faith needs, culture and stigma as well as different patterns of substance misuse amongst different ethnic communities.

Key findings of current needs assessment, including a brief summary of prevalence and penetration levels in the community, the demand for drug treatment in prison establishments, treatment system mapping and the care pathways in operation, the characteristics of met and unmet need, attrition rates and treatment outcomes.

Prevalence of Problematic Drug Use

The Problem Drug Use (PDU) for people using **opiate and/or crack use** is an estimated 4,616 (-/+95% Confidence Interval: 4,149 – 5,262).

The PDU for people using **opiates** (defined as opiates only or opiates and crack cocaine) in Sheffield is 4,123, a rate of 11.28 per 1000 population and equates to 89% of the total PDU.

The PDU for people using **crack cocaine** (defined as crack only or crack cocaine and opiates) in Sheffield is 2,744, a rate of 6.78 per 1000 population which equates to 59% of total PDU.



Engagement in treatment – Tier 2 activity continues to increase with more than 2,704 advice and information sessions or other short term intervention support activities undertaken with service users between April and September 2009. A considerable number of Tier 3 service users are still using Tier 2 services.

49% of the opiate and/or crack PDU engaged in Tiers 3 and 4 treatment during 2008/09 (decrease of 1% from 2007/08). An estimated 39% were treatment naïve (decrease of 5% from 2007/08) compared with 49% of the crack PDU (decrease of 6% from 2007/08).

The effectiveness of drug treatment requires further work; by the end of quarter 4 of 2008/09, 42% had a planned discharge (third quartile), but by end of quarter 1 of 2009/08 it had dropped to 26.5%, and down to the bottom quartile.

The retention rate for Sheffield for 2008/09 was 93% for both PDU and all adults in effective treatment against a target of 90%. Despite good retention overall, Sheffield has a small but significant number of clients stuck in a “revolving door” engaging, dropping out and re-engaging in treatment which impacts on successful treatment completions: DIP clients made up only 24% of revolving door clients and therefore this cannot be accounted for by criminal justice referrals. 2 clients had a maximum of 7 modalities and 131 clients had 3 modalities. This suggests that “revolving door” clients may be presenting at a range of services but not be meaningfully engaged or receiving care co-ordination. This needs to improve.

The Sheffield Treatment Pathway – 2,874 people (an increase of 92 on 2007/8) effectively engaged with prescribing services, 701 people (an increase of 30 on 2007/08) engaged with PSI and 114 (an increase of 28 on 2007/8) with structured day care.

During 2008/09 there were 904 new assessments and 2,071 re-zoning assessments conducted for prescribing, totalling 3,031 against a target of 1,982. The “did not attend” (DNA) rate was 45% during 2008/09.

So far during 2009/10, 380 new assessments and 621 re-zoning assessments have been conducted for prescribing, totalling 1,167. The “did not attend” (DNA) rate has however decreased by 5% to 40%.

Although the improvement in DNA rates is welcomed, the number of assessments completed in 2009/10 represents a decrease in activity of 20%. This needs to be very closely monitored, because it represents a fall in the number of new PDUs entering treatment.

The tender of prescribing services has placed an increased focus on treatment system flow; providers will be expected to progress their caseload through the treatment system providing effective, recovery focussed treatment and at the same time engaging increasing numbers of new people into treatment. The partnership has set a target for prescribers to ensure 30% of service users receive PSI in line with clinical guidelines. Key-working in all modalities needs to be improved and effective identification and referral of clients into PSI are to be addressed through the tendering process next financial year 2010/11.

At Tier 4 work continues to improve the number of referrals into Tier 4 treatment and to implement an abstinence pathway. By the end of 2009/10 a preferred provider list for residential rehabilitation will be in place for use alongside the new abstinence



pathway. This will be based on an agreed set of criteria and confirmed in a meeting of appropriate professionals. The list will then be publicised among providers and will aim to ensure a consistent approach to the use of residential rehabilitation facilities with high quality services and outcomes.

Drug – Poly-drug use is now the norm in Sheffield, with most service users using crack and opiates and 21% using at least three drugs. The numbers of service users using 2 drugs increased from 50% in 2005/06 to 63% in 2008/09. Treatment options for crack use in Sheffield scored ‘high’ on the improvement review, however more options need to be explored to further encourage crack users to engage with treatment. 57% of service users named crack as their second problem substance (an increase of 3% on 2007/8). Prescribing services see a large number of clients with heroin and crack use, but this is not reflected in referrals for PSI which should be the first line intervention for crack use.

In 2007/08 18% of all DIP contacts were using powder cocaine, in 2008/09 this increased to 21%. Treatment appears to be appropriate at Tier 2b; however some Tier 3 services have noticed an increase in the number of non PDU drug clients entering PSI treatment. There is anecdotal evidence from providers, communities and service user consultation, as well as Tier 2 local data, that under 25s are not using PDU drugs and are more likely to be the ACCE profile.

Providers believe that alcohol use has increased; it is often part of a client’s poly drug use and is frequently becoming the dependant substance once a client is maintained for their drug use, with clients separated into two groups, less complex and complex alcohol users. Opportunities to provide the most appropriate treatment need exploring.

Diversity – At Tier 2 White & Asian, Other Mixed, Indian, Pakistani, Bangladeshi, Other Asian and Chinese are all under represented in the treatment system, while White & Black Caribbean, White & Black African, Caribbean, African and Other Black are all over represented.

At Tier 3 Indian, Pakistani, Chinese and Bangladeshi communities are under represented in our treatment system while Mixed/ Dual heritage and Other Asian (which includes Iran and Iraq) are over represented in the treatment system.

1,737 service users have stated their nationality as United Kingdom, the second highest nationality stated is Iranian with 1.45% and this percentage continues to grow; 20 new service users into treatment in 2008/9 were Iranian. New nationalities entering the treatment system during 2008/09 were Afghani and Angolan.

The number of service users from BME communities in treatment is reflective of the Sheffield BME population, treatment information is becoming available in a number of languages and services are all commissioned to provide a culturally aware service.

In 2008/09 30% of service users in Tier 2 and 26% in Tier 3 were female. The percentage of females in Tier 3 services has dropped by 1% from the previous year.

Area – The most frequent postcodes of residence for clients in structured treatment and entering DIP are S5 (19%), S2 (18%), S8 (10%) and S6 (8%). The DAAT’s strategy continues to provide centralised services alongside a growing citywide shared care and pharmacy network located in key areas of need.



Harm reduction – The Harm Reduction Strategy for Sheffield was implemented in April 2008 and a Blood Borne Virus Strategy has now been signed off. Sheffield has five targets for Hepatitis B/C: the first four are national targets set by the NTA, the fifth is a local target agreed through the Blood Borne Virus Group.

More individuals are being vaccinated and tested year on year. Sheffield has a Viral Hepatitis Service at the Royal Hallamshire Hospital which offers a clinical service for people infected with hepatitis B and C and those co-infected with HIV. Protocols are in place between primary care and the hepatitis service to facilitate prompt access to the specialist team. Referrals to the Hepatitis C clinic show a year on year increase, reflecting greater number being tested, with outreach work and telephone reminder improving attendance. The Community Treatment Pathway for Deep Vein Thrombosis (DVT) has now been running for close to a year. The outreach nurses have received 38 referrals for clients with DVT. 31 of these clients have either completed a three month course of low molecular weight heparin or are currently in treatment.

The DAAT currently commissions two Blood Borne Virus co-coordinators, with a remit to co-ordinate BBV testing services across the treatment system. A new single harm reduction service has been commissioned for 2010/11 providing a consistent harm reduction approach integrated across all 4 tiers of treatment from a single provider that will ensure a more consistent approach across the city.

The pharmacy needle exchange service undertakes an annual survey during the month of August. The number of people using the needle exchange in August 2009 was 908 individuals, down 358 from the same month in 2008, and down 656 from the same month in 2006 – or a 47% reduction over three years. This compares with the number of transactions decreasing by 37% in the same 2 year period.

Of those engaged in structured treatment in 2008/09, 26.8% of opiate and/or crack users with a recorded injecting status on NDTMS stated that they currently injected and 44.4% stated that they had previously injected¹. The never injected figure of 26.8% is a reduction on the previous year (29.6%), and is the third consecutive year that a reduction has been noted, which suggests a reduction in injecting culture.

Housing – In 2008/09 2.5% of new presentations (down from 16% in 2007/08) stated drugs as a primary reason for seeking housing assistance (3.68% nationally) and 10.8% stated drugs as a second reason. In 2008/09, 5% of clients who answered the question stated that they had an urgent housing problem (No Fixed Abode), with 14% stating they had a housing problem (living in temporary accommodation). The DAAT commissions drug workers to undertake Tier 2 outreach with people who are living in hostel accommodation and misuse drugs. The DAAT increased the level of funding from two to three workers during 2008/9 because of the demand for this service; the workers had achieved their annual targets to provide advice and information by Quarter One.

A drug use and housing strategy has been written for Sheffield, and is currently out for consultation. Tier 1 training on drug awareness was also delivered to housing staff during 2008/9 and received positive feedback from those attending.

Crime – In 2008/9 there were 14,128 reported serious acquisitive crimes in Sheffield, a decrease of 4% on the previous year. Other theft and handling offences have also decreased substantially compared to the previous year. One of the emerging issues

¹ NTA Bullseye data 2006/07 locally adjusted



is regarding the falling number of positive tests. Since peaking in May 2008 with 175 positive tests (out of a possible 472 arrested for a trigger offence giving a 39% conversion rate) there has been a steady decrease in the number of people being arrested for a trigger offence and in the number testing positive.

In 2008/09 there were 5,133 arrests for trigger offences in Sheffield, of which 54.2% were due to theft, 15.5% for burglary and 6.4% for possession or possession with intent to supply. These figures are almost identical to the figures obtained in the 2007/08 period. 5,065 drug tests were undertaken in 2008/09 resulting in 33.7% being positive which is almost 8% less than last year. The three main drugs have all decreased in purity when compared to last years figures; cocaine has seen the most dramatic decrease with a drop of 21% in purity followed by heroin with a 12.3% drop. Crack cocaine purity seems to be fairly consistent compared to the other two drugs with a decrease of only 1.4% although this is the lowest figure we have seen for crack cocaine purity. DIP in 2009/10 is above target on all 4 of the Key Performance Indicators and has been since January 2009.

Families and Carers – An estimated 9,232 family and carers are affected by opiate and crack users in Sheffield. During 2008/09 RODA took 431 telephone calls from carers, they undertook 159 carer triage assessments; against a target of 120, 20 carer comprehensive assessments and 29 one to one structured emotional support sessions.

The Family and Friends Support Pathway was updated in 2008 and signed off by the Family and Friends Alliance, a group who meet to discuss specific carer's issues. The pathway guides a client to the most appropriate carer support service for their individual needs, whilst simultaneously promoting city-wide family and carers support services. Sheffield Local Authority is currently writing a city wide strategy; "Sheffield, A city where every carer matters: A joint strategy for transforming the lives of carers in Sheffield 2010-2013".

Eighty two babies were born in Sheffield to mothers who were referred to the Multi-Agency Pregnancy Liaison and Assessment Group due to drug or alcohol misuse during pregnancy, of which 68 babies went home with their mothers. The Specialist Substance Misuse Pregnancy Clinic has been re-specified and tendered with a greater emphasis on clinical leadership of multi-disciplinary teams, tight care co-ordination and risk assessments leading to informed rather than automatic referral into safeguarding processes where appropriate.

Communities - 4 out of the 10 Neighbourhood Areas (SNAs) have prioritised drug use and dealing linked to anti-social behaviour as one of their top four priorities. They are Burngreave, Ecclesfield Broomhall and Sharrow . SNA areas work closely with the DAAT Communities and Development officer on all planned events where drug and alcohol are to be addressed, drug treatment is promoted and referrals into drug treatment are monitored. Consistency in reporting drug activity in each SNA areas needs to be continually addressed in during 2010/11.

Drugs Related Deaths – Between April 2008 and March 2009 there were 18 recorded drug related deaths, of which one was female. The presence of Class A drugs (heroin, cocaine and/or ecstasy) were recorded in 4 of the deaths. Methadone (either prescribed or illicit) and alcohol are mentioned in 9 of the deaths. All drug related deaths are investigated and overdose prevention courses are ongoing throughout the year. In September 2009 Sheffield services PCASS and RODA jointly launched a pilot scheme for take home Naloxone. The pilot involves issuing Naloxone to partners/family/carers of drug users who can then issue the life saving



Naloxone before the arrival of the emergency services providing much needed treatment at the earliest time. The people in receipt of this have been trained in OD, resuscitation and intra muscular administration of Naloxone.

The impact of treatment: The improvements to be made in relation to the **impact of treatment** in terms of its outcomes which will deliver improvements in the individual drug users health and social functioning, lower public health risks from blood borne viruses and overdose and improvements in community safety.

Outcomes The key improvement in terms of the impact of treatment and outcomes in Sheffield is to increase the proportion of individuals completing treatment with a planned discharge with a positive discharge reason; treatment should be seen to work and families and communities should be readily able to come up with examples of individuals who are living more meaningful drug free lives as a result of effective treatment. Community consultation has confirmed that physical evidence in the form of recovered individuals returning to their communities is the most powerful weapon in overcoming stigma and “selling” treatment. The Ambassador Scheme, training drug free former service users to become role models for recovery is a useful starting point however recovery needs a greater number of champions within families and communities. The tendering of Sheffield’s treatment system aims to bring system change in delivering more recovery focussed treatment and this will need to continue to be a focus of scrutiny in pro-active monitoring of services. Sheffield has struggled to move out of the bottom quartile for planned discharge and this continues to be a focus for improvement both in terms of data and care planning audits. TOP data suggests that over 12 months in treatment leads to poorer outcomes and this needs to be urgently addressed; a far more rigorous approach to treatment effectiveness and psychosocial change has been specified within substitute prescribing services.

Health The General Healthcare Assessment and the Treatment Outcome Profile provide a useful barometer of health along the treatment journey. As compliance grows, Sheffield is beginning to be able to make use of TOP data to enhance treatment effectiveness; health self-assessment scores are part of that picture. The newly specified and re-tendered ‘Harm Reduction Service’ which will commence in Q1 2010/11 includes the provision across the four tiers of treatment of a consistent general healthcare assessment, blood borne virus screening and immunisation, treatment for physical health conditions relating to injecting drug use, overdose prevention, advice and training and onward referral to a wide range of general healthcare services. The Harm Reduction Service will not replace the provision of harm reduction advice and information which is embedded within all service specifications, but will provide an additional vehicle through which harm reduction interventions will be delivered. This is likely to most benefit those service users who are not in prescribing modalities and therefore do not have access to medical personnel.

Social Functioning Improvements in social functioning are most likely to be brought about by effective informal or formal psychosocial interventions as a key component of treatment. “Change Toolkit” training for drug workers will continue to be delivered and the drug treatment workforce will be encouraged to learn from and use evidence based resources including the ITEP approach and manuals. Formal Structured Psychosocial Interventions will be offered for open competitive tender in 2010/11 and will include a minimum qualification and supervised practice for those delivering interventions and an emphasis on a broad range of group and individual evidence based treatment packages. Care Plan audits are carried out twice yearly by DAAT staff and will continue to be used as a qualitative measure of treatment, to identify



where service users are not progressing within their treatment journey or where insufficiently challenging or measurable recovery goals are set for service users. Re-specified and re-tendered prescribing services, commence in Q1 2010/11 and include the performance indicator that 30% of the caseload should be receiving formal PSI in line with UK Clinical Guidelines; this will be proactively monitored throughout the contract term.

Blood borne viruses The newly specified and tendered 'Harm Reduction Service' which will commence in Q1 2010/11 includes the provision across the four tiers of treatment of a consistent blood borne virus screening and immunisation service. The specification covers two distinct service models: assertive outreach and open access provision for those not in formal treatment who are accessing Tier 1 & 2 and a more structured service for those in Tier 3 & 4. A single provider of this service providing immunisation and screening data to other treatment providers and GPs will provide a clearer flow of information and more reliable data to NDTMS.

Overdose The newly specified and tendered 'Harm Reduction Service' which will commence in Q1 2010/11 includes the provision across the four tiers of treatment of overdose prevention advice and training, targeted at those in highest need. The service through providing broader harm reduction interventions across the tiers of treatment, will be well placed to identify those most in need of formal training

Community Safety

DAAT continues to provide a staff resource to Safer Neighbourhood Areas to effectively manage issues of substance misuse. DIP is effectively meeting all key performance indicators. A Criminal Justice Task Group which includes DAAT, Police, Probation, Crown Prosecution Service the CJIT and treatment providers meets regularly to provide a co-ordinated response to substance misuse issues; an example of this is the "Violence Pilot" due to commence in Q4 of 2009/10, and is a 3 month pilot adding a list of violent offences to the "trigger offences" so that perpetrators can be drug tested under "Inspector's Authority". Co-ordinated work between DAAT and the Police has enabled the provision of a drug worker presence following operations such as "crack house closure" to provide a route into treatment for hidden PDUs, and the provision of carer's information for families following police operations in households.

The key priorities for developing drug treatment, reintegration and recovery interventions in the community and prisons for 2010/11:

PROCUREMENT: A key strategic priority for the partnership is to ensure the continued growth of an effective, recovery focussed, integrated, treatment system within today's budgets and with resilience for the future.

DATA: A key priority in 2010/11 will be to continue to address data quality and completeness issues at a provider level through pro-active data audits.

PDUs INTO TREATMENT: A key priority for the partnership in 2010/11 will be to promote an integrated partnership approach to drug treatment and achieve the Problematic Drug Users in Effective Treatment target: reconfiguration and tender of Tier 2 as an effective conduit into treatment is a key priority for this treatment plan.

PROMOTING TREATMENT: All agencies, including Tier 1, should be skilled in identifying substance misusing individuals and assertively promoting treatment. All



services need to effectively address stigma and cultural issues in relation to drug use and attract diverse users into treatment. Workforce development initiatives need to enhance screening and motivational skills, and cultural awareness particularly at Tier 1 and 2 to engage treatment naïve and resistant users into treatment. Those coming to the attention of support and enforcement agencies are not recreational users and require treatment. Re-specifying all treatment services so that they promote readiness for treatment and provide a conduit into effective treatment is a key priority for this treatment plan and will be a particular priority in the reconfiguration of Tier 2. A partnership priority will be to continue to invest in Tier 1 and community learning initiatives to increase the effectiveness and reach of the drug treatment workforce.

ACCE: A partnership priority is to ensure that appropriate, brief and effective treatment options are tailored to this emerging cohort to address hazardous and harmful drug use amongst the ACCE generation of younger adults. Tier 2 will need to offer brief structured interventions, whilst Tier 3 psychosocial interventions will also need to have appropriate tailored treatment packages for this community of need.

DIP: The Drug Interventions Main Grant reduced funding in 2010/11 will pose a considerable challenge to the partnership and a key priority will be to review the provision within the available resource and more closely configure local provision to national models for the planned re-tender of services.

ABSTINENCE: The integration of abstinence across the treatment system and the implementation of the Abstinence Pathway will remain a key priority in 2010/11.

PSYCHOSOCIAL COMPONENTS: The planned 2010/11 retender of PSI will streamline provision so that a range of formal “packages” of treatment can be offered, from an appropriately qualified workforce, by a single provider. PSI has been specified in detail within the “Orange book” and Core Data Set G changes suggest further demarcation of this modality; the current “offer” of treatment, lags behind what is recommended and what will be recorded and this needs to be addressed within the tendering of this modality.

CLINICAL PATHWAYS: Improving the quality of the treatment experience in line with Models of Care (2006), through more effective care planning, care co-ordination, integrated care pathways and key working remains a priority; care plan audits will continue in 2010/11.

FAMILIES & COMMUNITIES: Preventing harm to children, families and communities from substance misuse, in line with the Drug Strategy 2008 will continue to be a partnership priority. A partnership priority will be to continue to invest in Tier 1 and community learning initiatives to increase the effectiveness and reach of the drug treatment workforce.

SUCCESSFUL TREATMENT: Role models for recovery, and word of mouth, that treatment works are the most effective tools in promoting treatment; Sheffield needs to continue to address poor successful treatment completion to grow the number of recovery champions. Communities need to see drug users returning drug free to have confidence in treatment and reduce stigma. Increasing successful treatment exits continues to be a key priority for the partnership; growing the number of ambassadors for treatment and role models for recovery is a new priority.