



*National Treatment Agency
for Substance Misuse*

**Revised adult drug treatment plan
2008/09
Guidance notes on completion of the
plan for local drug partnerships
wishing to secure funding under the
substance misuse pooled treatment
budget**

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Introduction¹

The Crime and Disorder Reduction Act 1998 placed a requirement on responsible authorities (local authorities, primary care trusts, police and probation) to undertake audits and development plans in relation to drug misuse. In many cases a Drug Action Team or other local group has been established to oversee this alongside wider local strategic needs assessment and planning processes².

The Home Office, who are responsible for the leadership of the Government Drug Strategy Public Service Delivery Agreement 25 – to reduce the harm caused by alcohol and drugs – provides the Government’s commitment to produce a long term and sustainable reduction in the harms associated with alcohol and drugs. Indicator 1 of the PSA³ measures the growth in the number of those drug users recorded as being in effective treatment and sets out the national minimum movement required for performance appraisal as 1 percentage point⁴. Measurement Annex A of PSA 25 sets this out in more detail.

The PSA references a number of key delivery levers that will support the commitment to expand effective treatment. These include the performance management of Local Strategic Partnerships by Government Offices, where provision of effective treatment is selected as a priority within their Local Area Agreement (LAA), and performance management of Primary Care Trusts (PCTs) by Strategic Health Authorities (SHAs) against the same indicator within “Vital Signs”⁵.

Since 1998 higher tier local authorities have been entitled to receive funding from the Substance Misuse Pooled Treatment Budget (PTB). This is a national budget established by the Department of Health and Home Office (and now supported by the Ministry of Justice). The National Treatment Agency for Substance Misuse (NTA) was established and has a statutory responsibility to advise the Secretary of State for Health on how funding for drug treatment should be allocated. To do this any local partnerships seeking funding under the budget are required to:

- a) provide a minimum set of information on the current and planned provision of drug treatment within their area via submission of the “Adult Drug Treatment Plan”(ADTP)
- b) require any drug treatment services which receive funding to make data returns to the National Drug Treatment Monitoring System (NDTMS)

The NTA provides support for the development of these plans and assurance of their delivery through a process of annual agreements and quarterly reviews as outlined in the Home Office’s delivery agreement for PSA 25. The NTA regional teams based in Government Offices work closely with the Government Office and SHAs in supporting their performance management of LAAs and PCT plans as they relate to drug treatment

¹ These notes have been revised since initial publication in September 2007 to take account of the publication of PSA Delivery Agreement 25: reduce the harm caused by alcohol and drugs.

² See Guidance for partnerships and PCTs, www.dh.gov.uk/en/Publications and Statistics/Publicationspolicy and guidance/DH_4086947

³ Reflected in single set of national indicators, and Department of Health Departmental Service Objective (DSO) 1.25.

⁴ For further information, go to: http://www.hm-treasury.gov.uk/media/A/4/pbr_csr07_psa25.pdf

⁵ See Department of Health’s Operating Framework for NHS 2008/09:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

so that local partnerships responsible for the provision of drug treatment receive a consistent response on a regional basis on drug treatment issues.

The annual agreement with local drug partnerships and oversight of the dedicated resources provided for drug treatment are embodied within the Adult Drug Treatment Plan. These notes provide guidance to the local partnerships with responsibility for those plans who are seeking funding under the PTB . Throughout the text links are provided to relevant guidance and materials which will provide partnerships with key information, definitions and source documents.

As in previous years the adult drug treatment plan should be based on a comprehensive needs assessment which will also contribute to the drugs and crime element of the joint strategic needs assessment which PCTs and LAs now have a statutory duty to undertake on an annual basis⁶. It is intended to outline the drugs partnership's strategic direction for the delivery of effective adult drug treatment delivery, summarise the findings of the needs assessment, identify key priorities for drug treatment for 2008/09, provide detailed plans to deliver those key priorities and summarise the funding available and broad plans for expenditure.

The NTA guidance and parts 2, 3 and 4 of the treatment plan are available to download from the NTA website at http://www.nta.nhs.uk/areas/treatment_planning/default.aspx. Regional NTA teams will be working actively with partnerships to ensure appropriate support and guidance in addition to that contained herein. If you have any queries about how to complete the adult drug treatment plan, please contact your NTA regional office.

Treatment planning timetable

Indicative allocations will be provided for 2008/9, 2009/10, 2010/11 but actual funding will depend on the numbers effectively treated. For this reason an annual resubmission of plans is required for areas seeking funding under the PTB.

Date	Action
By December 2007/8/9	Needs assessment, consultation and drafting of plan completed
By mid January 2008/9/10	Part 1 and 4 ⁷ , (with harm reduction strategy self audit for 2008/09), returned to NTA
By mid February 2008/9/10	Regional panel assessment and response to partnerships
By mid March 2008/9/10	Part 2 and 3 returned to NTA, together with any revisions required for Parts 1 and 4
By 31 March 2008/9/10	Final sign off between NTA and partnerships
April/May 2008/9/10	Publication of Parts 1, 2 and 4 on NTA website
By end May 2008/9/10	Final agreement reached on % planned change for effective engagement in treatment

⁶ NTA needs assessment guidance for adult drug treatment, July 2007, at: http://www.nta.nhs.uk/areas/treatment_planning/needs_assessment.aspx

⁷ Part 1 does not have a set format or template. Parts 2, 3 and 4 of the adult drug treatment plan should be submitted on the templates provided.

Part 1: Strategic summary, needs assessment and key priorities for 2008/09

As part of the cycle of needs assessment, drug strategic partnerships are recommended to complete a summary of the needs assessment work which has been undertaken⁸ and to set key priorities for the coming financial year. Each partnership which is seeking funding under the Pooled Treatment Budget is required to submit a strategic overview (in the region of 4-6 pages of A4) as part of the adult drug treatment plan submission. This should cover the following elements:

- The overall direction and purpose of the partnership strategy for drug treatment
- The likely demand for open access, harm reduction and structured drug treatment interventions. This section should identify and consider the differential impact on diverse groups and ensure that the overall plan contains actions to address negative impact
- The key findings of the current needs assessment, including a brief summary of prevalence and penetration levels, treatment system mapping, the characteristics of met and unmet need, attrition rates, and treatment outcomes
- The improvements to be made in relation to the impact of treatment in terms of its outcomes which will deliver improvements in individual drug user's health and social functioning, lower public health risks from blood borne viruses and overdose, and improvements in community safety
- The key priorities for developing open access, harm reduction and structured drug treatment interventions to meet local needs during the following financial year. This section should also include key treatment priorities which have been identified in the most recent Healthcare Commission/NTA improvement review

Part 2: Local partnership plans for the number of drug users recorded as being in effective treatment.

Drug treatment system

1. Drug users in effective treatment

PSA delivery agreement 25 – reduce the harm caused by alcohol and drugs – provides the Government vision to produce a long term and sustainable reduction in the harms associated with alcohol and drugs. Indicator 1⁹ measures the growth in the number of drug users recorded as being in effective treatment and sets out the national minimum movement required for performance appraisal as 1 percentage point. Measurement Annex A of PSA 25 sets this out in more detail¹⁰.

⁸ NTA needs assessment guidance for adult drug treatment, July 2007, at:

http://www.nta.nhs.uk/areas/treatment_planning/needs_assessment.aspx

⁹ Relates to local authority performance indicator 40 from the single set of national indicators, and Department of Health Departmental Service Objective (DSO) 1.25. For further information on National Indicators, see:

<http://www.communities.gov.uk/localgovernment/performanceframeworkpartnerships/nationalindicators/>

¹⁰ See HM Treasury website for further information around PSA 25: [http://www.hm-](http://www.hm-treasury.gov.uk/pbr_csr/psa/pbr_csr07_psacommunities.cfm)

[treasury.gov.uk/pbr_csr/psa/pbr_csr07_psacommunities.cfm](http://www.hm-treasury.gov.uk/pbr_csr/psa/pbr_csr07_psacommunities.cfm)

The measure is intended to drive improvements on the 2007/08 baseline (i.e. the annualised figure for that year) the number of drug users recorded as being in effective treatment. This indicator measures the % change in the number of drug users using crack and/or opiates in treatment in a financial year, who are still in continuous treatment, who are discharged from the treatment system after 12 weeks or if discharged before then, were successfully discharged in a care planned way as a % change from baseline performance in 2007/08. This will include young people under the age of 18 as well as those over the age of 18.

The national commitment will clearly only be delivered if local areas take action to improve performance. It is envisaged that local drug partnerships will use the treatment planning process to reflect on their current performance and to set realistic plans for growth. These plans can be used within Local Area Agreements and PCT plans where action on drugs is prioritised as requiring significant attention.

When setting the percentage change for drug users in effective treatment, partnerships should consider the findings of the drug treatment needs assessment exercise, as well as the broader findings of the local Joint Strategic Needs Assessment. As part of this assessment partnerships should set ambitions for those engaged in effective treatment that increase penetration where this is identified as a key priority for the partnership.

Partnerships are provided with information that shows 2006/07 performance for effective engagement in treatment and predicted performance for 2007/08. When considering the percentage change at a local level, partnerships are recommended to take account of resources available and the findings of the local needs assessment.

As the annualised number for 2007/08 will not be available to partnerships until August 2008, the local plans outlined in the March 2008 submission should be expressed in % terms. Partnerships will have an opportunity to discuss this with NTA regional teams during January and February 2008. This can be translated into a number once the 2007/08 baseline is established. The % change will be finally agreed between NTA and drug partnerships by the end of May 2008. .

1.1 Crack and/or opiate users recorded as being in effective treatment (National Indicator 40 and indicator within 'Vital Signs')

The % change in crack and or opiate users recorded as being in effective treatment specifically relates to the national commitment contained within PSA 25 and is focused on a subset of the overall number engaged in effective treatment.

Figures agreed here could be used as the basis for a priority identified within the Local Area Agreement and will be used to determine PCT plans on this indicator.

It will be helpful for partnerships to reflect on their current performance alongside the prevalence estimates for crack and/or opiate users that are provided through Home Office estimates with a view to increasing treatment penetration where performance is below the national average.

Plans set for 2009/10 and 2010/11 will be reviewed annually through the adult drug treatment planning process against actual performance and through other local review processes as part of the LAA and PCT plan arrangements.

1.2 All adults recorded as being in effective treatment

The % change in the number recorded as being in effective treatment captures plans for all **adults** who require drug treatment regardless of the type of drug being used. It is included here to support partnerships in considering their plans for all drug users as identified through needs assessment. Plans are recommended to reflect improved performance in relation to effective engagement in drug treatment

2. Retention in treatment and care planned discharge before 12 weeks

Planning for treatment retention will contribute to the delivery of the national PSA commitment and is recommended for partnerships to better understand the performance of their overall drug treatment system.

Retention is currently the best available measure of the effectiveness of local drug treatment systems and services. Individuals not retained for at least 12 weeks are unlikely to experience long-term benefit from treatment. However, retention at 12 weeks is merely the point at which sustainable change begins to be discernible and many individuals will need to be retained in treatment for much longer, perhaps years, before they reach their treatment goals¹¹. There will be some instances where a care planned discharge in advance of 12 weeks is part of effective drug treatment delivery. All partnerships are recommended to plan on the basis of improving retention for new presentations (and where appropriate, care planned discharge before 12 weeks within the drug treatment system) as a core component of developing performance within the drug treatment system. Baseline data for 2006/07 and 2007/08 (predicted) will be provided to partnerships to assist with local setting of ambition in this respect.

3. Treatment system exits

In the interest of better understanding of the overall treatment system it is suggested that partnerships should also focus on overall performance in relation to care planned exits from the treatment system. Care planned exits from the treatment system follows the whole journey of the client and is based on the last discharge reason when the client has exited all treatment interventions (tiers 3 and 4). This will be determined by every episode making up the treatment journey being closed. Baseline data for 2006/07 and 2007/08 (predicted) will be provided to partnerships to assist with local setting of ambition around planned % increase for 2008/09.

Additional partnership information

In addition to setting out local drugs partnerships' ambition in relation to effective engagement in treatment the adult treatment plan should outline local consideration of primary care with regards to drug treatment. This will be helpful to local partnerships to establish the current picture regarding the involvement of primary care in drug treatment.

4. Primary care

Guidance for this section of the adult drug treatment plan has been revised from previous years to reflect current arrangements for commissioning services in primary care. Partnerships should now set out information on a practice basis only in relation to delivery of adult drug treatment in primary care. Where a drugs partnership area covers more than one primary care trust (PCT), this section of the return should be provided for each PCT. Where a drugs partnership only covers part of a PCT area, then partnerships

¹¹ Detailed guidance and the methodology for calculating retention is available at: www.nta.nhs.uk

should provide information that relates to the drugs partnership area and not the full PCT area.

This should include practices who provide primary care based treatment within either a locally or joint commissioning group (JCG) defined shared care arrangement or practices who are delivering primary care based treatment within any other commissioned service model.

Primary care-based drug treatment services are delivered from a base where the principal activity is the delivery of general medical services (GMS). This may include bespoke drug treatment services based in primary care where the psychosocial and drug worker support comes wholly from within the practice¹². Primary care based treatment does not include services where a GP is employed at specialist drug service to provide a prescribing service.

Part 3: Planning Grids

FORMAT	It is suggested that the name of the partnership is entered on the front page of the treatment planning grids and in the “footer” together with the date. This will ensure that all pages of the return are numbered, dated and named. The boxes throughout the planning grids will expand to the text that partnerships wish to enter. Page breaks can be added at the start or end of sections where necessary to keep tables together.
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It is good practice for drug partnerships to complete a grid for each of the following aspects:

- Drug System Management:**
- Grid 1 Commissioning a local drug treatment system
- Drug Treatment Delivery System – the Treatment Journey:**
- Grid 2 Access and engagement with the drug treatment system
- Grid 3 Retention in and effectiveness of the drug treatment system
- Grid 4 Outcomes, discharge and exit from the drug treatment system

Partnerships may of course add additional planning grids for other local purposes. Best practice plans will address key priorities identified from the needs assessment process but also address the following cross cutting themes where relevant:

- Diversity
- Criminal justice
- Workforce
- Harm reduction
- Carers and family members
- Service users
- Housing
- Skills and employment

¹² Drug Misuse and dependence: UK guidelines on clinical management (2007), Department of Health, http://www.nta.nhs.uk/areas/Clinical_guidance/clinical_guidelines/docs/clinical_guidelines_2007.pdf provides guidance on drug treatment in a primary care setting

Further information on these cross cutting themes is contained within NTA's needs assessment guidance¹³.

For 2008/09, the planning grids provide a framework within which partnerships can report on the objectives and delivery plans that have been agreed to take forward the key priorities identified and resourced by way of the needs assessment process. A checklist of areas to assist partnerships as to where key priority objectives might be most appropriately placed is attached at appendix 1. This checklist is neither exhaustive nor mandatory as to where objectives should be included.

Supplementary guidance to support the treatment planning process includes information and references for partnerships in relation to:

- Models of Care: Update 2006
- Drug Misuse and Dependence Guidelines on Clinical Management 2007m and associated suite of NICE guidance and technology appraisals
- Needs assessment guidance, July 2007
- Information systems, October 2007
- Supplementary guidance to support needs assessment including guidance on using HES, mapping tools and understanding prevalence estimates
- Problem drug user population estimates (December 2005) – provided to partnerships by the Home Office, summer 2006
- Definitions and measurement of waiting times – August 2006
- Workforce development, October 2007
- Harm reduction strategy – partnership self audit tool kit – revised 2007
- Developing accommodation strategies across partnerships

This guidance can be found on the NTA website: www.nta.nhs.uk

Completing the planning grids

Guidance is provided below for each box. The boxes can be expanded to accommodate full objectives and delivery plans.

Identification of key priorities following needs assessment which are developed in each planning grid

The planning grids have been developed and used over a successfully over number of years to support partnerships in setting objectives and in supporting achievement by thinking through the actions required and setting milestones. Where relevant this can also include key actions that are required to improve commissioning or drug treatment delivery

Objectives for 2008/09

Partnerships may include as many objectives as they wish in each grid

Actions and milestones (Delivery plan)

Best practice planning grids will contain the relevant objectives to address the key priorities within the plan. The planning template is designed so that each objective can be followed by actions and milestones that are specifically related to the objective. The delivery plan should provide a full set of actions to implement the objective with identified milestones. These should be

¹³ NTA needs assessment guidance for adult drug treatment, July 2007. section 1.5, at: http://www.nta.nhs.uk/areas/treatment_planning/needs_assessment.aspx

specific and measurable to allow for effective quarterly performance monitoring. The delivery plan should identify the named postholder who will be taking responsibility on behalf of the partnership or Joint Commissioning Group (JCG) to ensure that the action occurs or the milestone is met.

Objectives should be numbered and the template should be extended to accommodate the full number of objectives that the partnership has for each grid. Objectives should be

- Specific
- Measurable
- Attainable
- Realistic
- Timed

Part 4: Substance Misuse Pooled Treatment Budget, mainstream funding and expenditure

As part of ongoing NTA assurance of spending against the dedicated resources provided for drug treatment through the substance misuse pooled treatment budget partnerships are requested to record information on investment from all agencies for funding drug treatment services for **adults** which should be available in full to the joint commissioning group (JCG). For 2008/09 plans, Part 4 is provided in excel format.

Table 1: Funding source 2008/09

1.1 Substance misuse pooled treatment budget (SMPTB)

Partnerships should enter the figures allocated to the partnership for 2007/08, as announced in January 2007. This return is the total pooled treatment budget figure including the pooled treatment budget, the SMPTB capital allocation, young people's partnership grant for young people's treatment, the funding channelled through the SHA 'bundle' and the element reserved for allocation in June 2007 against 2006/07 performance. These figures are contained in Column E of Annex A or Column Q of Annex B (these are the same figures in both spreadsheets) attached to Paul Hayes communication dated 22 January 2007. Please note that additional capital allocations for the tier 4 developments in 2007/08 and 2008/09 should be recorded in row 1.13. Details on 2008/09 allocation to follow.

1.2 Pooled treatment budget allocation for young people's specialist substance misuse treatment

Partnerships should deduct the amount allocated and redirected to the young people's specialist substance misuse treatment budget from the published allocations in line with the figures published in January 2007. Details on 2008/09 allocation to follow.

1.3 Substance misuse pooled treatment budget available for adult drug treatment (1.1 minus 1.2).

This is calculated automatically in excel.

1.4 Substance misuse pooled treatment budget underspend carried forward from previous year

Partnerships should enter separately any SMPTB slippage that was carried forward from the previous financial year into 2007/08 plus any slippage anticipated being carried from 2007/08 to 2008/09. **This latter figure should be updated for the final submission stage in March 2008.**

1.5 DIP main grant

Funding for DIP is published by the Home Office as an overall grant amount which covers all elements of DIP funding now available. Allocations from the Home Office for 2007/08 were published on 11 May 2007. Where any carry forward (maximum allowed 2%) from 2006/07 occurred, please add a supplementary row as 1.5 (a). This guidance will be updated once the DIP main grant for 2008/09 is published.

Mainstream investments

It is a condition of use of the pooled treatment budget that it is ring-fenced and protected (cannot be spent on purposes other than drug treatment). It is also a condition that mainstream commitments should be at least maintained (which includes being uplifted for inflation). Guidance was issued to partnership chief officers in March 2001 to this effect and has been reiterated in a number of communiqués, including Probation Service Circular PC47/2004.

1.6 Police

This should include all investment from the police which may include additional investment in custody suite interventions or other investments supporting drug treatment.

1.7 PCT mainstream investment

This should include all investment from PCTs in drug treatment services. This should include both direct and indirect costs associated with the delivery of treatment services including prescribing and pharmacy costs, primary care contracts etc. Where full costs are not identified, please ensure the NTA regional team is aware of the gaps in information.

1.8 Social services

This should include all social services/local authority investment in drug treatment services including community care funding

1.9 Section 31/28a funding

Where section 31 or 28a funding arrangements have been made, this can be entered as pooled budget in this row rather than on the separate rows provided in this return. **Please note that you should not enter funding in 1.9 if you have made entries in 1.7 and/or 1.8.**

1.10 Probation – partnerships

This should include all partnership funding from the probation area which supports the delivery of the drug treatment system. This should not include the offender management element of drug rehabilitation requirements.

1.11 Supporting People

This should reflect the specific investment from Supporting People funding for services for drug users which is part of their overall care package. This may

include “aftercare” accommodation for individuals who have received a tier 4 residential intervention.

1.12 Other

Use the ‘other’ category for streams of funding that come from sources not listed above, but which the partnership has some involvement in planning for adult drug treatment. This could include, for example, regeneration monies or ‘Single Pot’ funding, but should not include charitable donations unless they are explicitly planned and spent through the JCG. Please do not use this category for investments by JCG members that the partnership finds difficult to categorise (e.g. joint finance).

1.13 Department of Health tier 4 capital

Additional capital funding to bolster capacity and quality within the tier 4 sector was announced on 22nd February 2007. Where a partnership received an allocation as part of the national bidding process, enter the amount for 2007/08 and 2008/09 in this row. All other capital received as part of the SMPTB for 2007/08 should be included in 1.1 above.

1.14 Total funding for adult drug treatment and DIP delivery (1.3 – 1.13 inclusive)

This is calculated automatically in excel.

Table 2: Expenditure profile – 2008/09

This table should provide a breakdown of the funding source against the commissioning framework that is provided in *Models of Care: Update 2006*¹⁴. The source of funding for each aspect of the commissioning framework in broad terms should be entered across the spreadsheet. The total of all funding in cell N15 should equal the funding available in column 1.14 of table 1 for 2008/09.

¹⁴ *Models of Care for Treatment of Adult Drug Misusers: update 2006*, NTA:
http://www.nta.nhs.uk/areas/models_of_care/default.aspx

Appendix 1 – Supplementary guidance for planning grids 2008/09

The following guidance is not exhaustive or mandatory in terms of how partnerships determine where objectives should be included within the planning grids.

Cross cutting themes

The needs assessment guidance provides a summary of the areas that it is recommended partnerships should be considering across all the planning grids. Relevant objectives should therefore be included in planning grids where gaps and needs are identified in relation to cross cutting themes.

Partnerships should bear the following in mind:

- The required improvements in the drug treatment sector cannot be achieved without significant attention to the workforce agenda, and a step change in the training and professional development of these employees
- The involvement of users and carers in the design of the local treatment system and their involvement throughout the implementation, monitoring, review and evaluation processes and the development of advocacy services is an essential element of developing effective drug treatment systems.
- Effective harm reduction requires a strategy that spans partner agencies and is delivered at all tiers of the treatment system
- The diverse needs of communities within the partnership area need to be reflected throughout the planning grids and the implementation arrangements for these plans

Drug system management

Drug treatment systems are complex and require appropriate management and support. The checklist included in this section includes the commissioning standards contained within *Models of care: Update 2006*¹⁵. When setting objectives based on the needs assessment findings partnerships may wish to consider the following areas for inclusion within planning grid 1 where appropriate:

Planning Grid 1 - Commissioning a local drug treatment system

- Local commissioning mechanisms require more formal strategic partnerships with key stakeholders including health, social care, criminal justice, housing and employment services, drug treatment providers and local drug users and carers
- Annual needs assessments should be more fully conducted in line with nationally agreed methodology to profile the diversity of local need for drug treatment which includes rates of morbidity and mortality, the degree of treatment saturation or

¹⁵ *Models of care for Treatment of Adult Drug Misusers: Update 2006*, NTA:
http://www.nta.nhs.uk/areas/models_of_care/default.aspx

penetration, and the impact of treatment on individual health, public health and offending

- The partnership should develop a clearer understanding of the extent to which services at all tiers meet the different needs of diverse communities and gaps in service provision, and should identify the actions required to address gaps within the roll out of the treatment effectiveness strategy
- The adult drug treatment plan should be amended to be more in line with *Models of care: Update 2006* with focus on reducing harm to individuals and communities, improving clients' journeys through treatment, predicting client flow through local treatment systems and improving the effectiveness of local drug treatment systems
- The partnership should demonstrate best practice in handling public money, contracting with providers and monitoring of service level agreements
- The partnership should performance manage local systems of drug treatment using data and key performance indicators in line with all partnership organisations requirements and plans
- Commissioning functions require review to be "fit for purpose" and have involvement from key stakeholders at an appropriate level of seniority to deliver a strategic response
- Commissioning mechanisms should be developed in terms of formal arrangements with local drug user groups, service providers, carers and other key stakeholders to enable consultation and involvement in the planning, commissioning and review of the local drug treatment system
- DIP steering groups, comprising key local partners including prisons, Crown Prosecution Service and police working with government office and NTA, should: oversee implementation of the programme, including: review or development to ensure effective work with users who cause most harm, including Prolific and Priority Offenders (PPOs); ensuring that DIP priorities are fully taken into consideration and are properly reflected in local commissioning and treatment planning processes, and that DIP cases are engaged effectively in structured treatment
- Information systems should be compliant with the National Drug Treatment Monitoring System (NDTMS), have appropriate data and information sharing protocols and forward planning investment plans for the purchase or development of IT systems to meet the clinical and NDTMS needs of providers
- Information and delivery systems should be developed to ensure that the treatment outcomes monitoring instrument (the Treatment Outcomes Profile or TOP) is used at the start of treatment and in care plan reviews and reported through NDTMS

Drug treatment delivery system – the treatment journey

Planning grids 2, 3 and 4 focus on improving the impact of treatment, alongside consolidation of improvements in access and capacity. This requires partnerships to evaluate the service user treatment journey including retention in treatment for long enough to impact on behaviour, have a care plan which identifies their needs and a programme of action to deliver their treatment goals, promote progression through the system for all individuals including support for positive lifestyles including access to stable accommodation, education, training and employment. The outcome of the treatment journey should deliver improvements in individual drug user's health and social functioning, lower public health risks from blood borne viruses and overdose, and improvements in community safety.

When setting objectives based on the needs assessment findings partnerships may wish to consider the following areas for inclusion within the planning grids where appropriate.

Planning Grid 2 - Access and engagement with the drug treatment system

- Screening, assessment and referral for structured drug treatment from open access services including CJITs (tier 2 referrals to tier 3 and 4 services) in sufficient detail to identify drug treatment needs and inform individual care plans (where required)
- Open access and DIP drug interventions which attract and motivate drug misusers into local treatment systems including engagement with offenders (tier 2 interventions)
- Service provision is based on local need providing access that is appropriate to service users from all backgrounds and characteristics within the partnership area
- Waiting times within national targets and providing timely access to structured drug treatment interventions
- Management and, where required, reduction of waiting times action plan which includes delivery of NTA improvement programme and includes routine review and exceptions reporting of all waiting times of over six weeks
- Criminal Justice Interventions Team to deliver DIP in the local area. Sufficient capacity, and appropriate working hours/practices to cover custody suites and courts (Crown and Magistrate) in line with DIP priorities and demand, including the need to carry out Required Assessments promptly (intensive areas only), and Restriction on Bail relevant assessments where necessary. Facilitates engagement of prisoners on day of release into treatment services where appropriate
- CJIT assessment of target offender population i.e. those testing positive or those arrested/charged with trigger offences
- Arrangements to accept and continue treatment for those who live in local areas, referred to them from other CJITs, including those who have been required to have a Required Assessment or have been given Restriction on Bail conditions
- Waiting times for DIP clients accessing structured treatment (including CJIT case management) and particularly substitute prescribing where appropriate
- Where restriction on bail is implemented, effective arrangements to communicate test results to courts and undertake assessment and follow on treatment
- Relevant information exchange using appropriate protocols and processes to ensure effective inter-agency working and to support continuity of care e.g. Prison, Prolific and Priority Offenders

Planning Grid 3 - Retention in and effectiveness of drug treatment system

- Target of retention in treatment of more than 12 weeks achieved or bettered with all client groups including offenders
- Management and, where required, improvement of retention rates action plan
- Each service user is supported to improve their health, social circumstances and well being by the provision of a written individually tailored care plan which tracks their progress and is regularly reviewed
- Care plans cover areas related to drug and alcohol use, physical and psychological health, criminal involvement and offending and social functioning
- Annual qualitative audits of care plans are undertaken in all provider services
- Individuals receive information, advice, injecting equipment and brief interventions and treatment to help reduce potential harm due to the transmission of blood borne virus's, drug related infections and overdose, and improves their physical health
- Service user's "significant others" have access to support and interventions to reduce harm related to drug misuse including access to support in their own right.
- Drug treatment services identify and record the existence of clients' dependent children and contribute actively to meeting their needs either directly or through

referral to or liaison with other appropriate services, including those in the non-statutory sector. This includes protocols that set out arrangements between drug and alcohol services and child protection services.

- Full range of evidence based structured treatment interventions as outlined in *Models of care: Update 2006* including appropriate choice of treatment objectives and services to support abstinence and stable maintenance outcomes with services equipped to tackle stimulant, opiate and poly drug use
- Effective continuity of care arrangements between tier 3 services, inpatient drug treatment and residential rehabilitation including aftercare and relapse prevention services
- Comprehensive and robust case management arrangements in place within the CJIT
- Effective continuity of care arrangements between prisons, CJITs and specialist treatment providers
- Range of drug treatment interventions for drug misusing offenders in DIP
- Range of drug treatment interventions for drug misusing offenders subject to community based court orders

Planning Grid 4 - Outcomes, discharge and exit from the drug treatment system

- Drug services have defined pathways to enable service users to integrate into the community during and following the completion of treatment, including access to appropriate housing, education and mainstream health
- A range of aftercare, 'move on' and support services are commissioned within specialist services to facilitate clients' transition from specialist drug services into wider resettlement, aftercare and community integration services
- Partnership (including all relevant stakeholders) has a written joint strategy explicitly linked to the local authority Homelessness Strategy and Supporting People strategy to increase access to housing and housing support by drug users in order to assist stabilisation and resettlement
- Joint strategy is supported by an action plan which ensures all key partners have shared definitions, objectives and outcomes
- Partnership has undertaken a local assessment of met and unmet need for housing and housing support by drug users
- Links with housing provision through local authorities to ensure DIP client needs are taken into account
- Specific operational protocols between the partnership, the local authority Supporting People team and housing providers
- Partnership has a written strategic plan including operational protocols with local skills councils and Jobcentre Plus to increase access to education, training and employment by drug users in order to assist stabilisation and resettlement
- Partnership has identified current performance in terms of planned and unplanned discharges from treatment with plans in place to improve performance year on year
- Service level agreements with all service providers clearly stipulate planned discharge performance expectations and are reviewed quarterly with agencies
- All those who have left structured drug treatment have access to drug related support and mutual aid groups. This includes easy access back to structured drug treatment in the case of relapse.