Drug treatment, reintegration and recovery in the community and prisons

Guidance notes on completion of 2010/11 plans for drug partnerships

Publication date: September 2009
Scope of guidance

This guidance is for community and prison drug partnerships. It updates and brings together adult drug treatment¹ and prison drug treatment² planning guidance published in October 2008.

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¹ DH Gateway reference 10517 and 11312. [http://www.nta.nhs.uk/areas/treatment_planning/default.aspx](http://www.nta.nhs.uk/areas/treatment_planning/default.aspx)
² DH Gateway reference 10635. [http://www.nta.nhs.uk/areas/criminal_justice/idts_treatment_planning_docs.aspx](http://www.nta.nhs.uk/areas/criminal_justice/idts_treatment_planning_docs.aspx)
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 processes.

For the purposes of this guidance the term “partnership” will be used to indicate roles and responsibilities of both community based drug partnerships and prison partnerships which have been set up specifically to deliver integrated drug treatment in prisons.

**Submission options**

For 2010/11 community based drugs partnerships and prison partnerships have two options regarding submission of their plans.

**Option 1:**
To continue to submit an adult drug treatment plan and a separate plan for each prison establishment within the geographical area. In these circumstances each partnership will need to ensure that both sets of plans are aligned to ensure continuity of care for drug users as they enter and leave prisons.

**Option 2:**
To submit a joint community based drug partnership and prison(s) plan for 2010/11.

**Agreement on option:**
The preferred option will need to be negotiated and agreed between the signatories (see below) and the National Treatment Agency (NTA) regional manager by no later than November 2009.

<table>
<thead>
<tr>
<th>Part 1 – Strategic summary</th>
<th>Option 1 – separate plans for community and prisons</th>
<th>Option 2 – joint plan across community and all prisons in area</th>
</tr>
</thead>
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<td></td>
<td>Separate Part 1 for community based delivery and for each prison</td>
<td>Joint strategic summary</td>
</tr>
<tr>
<td>Part 2 – Performance plans</td>
<td>Separate part 2a for community and part 2b for each prison</td>
<td>Separate part 2a for community and part 2b for each prison</td>
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<td>Part 3 Planning Grids</td>
<td>Separate planning grids for community and prison based delivery (one set per prison)</td>
<td>Integrated planning grids</td>
</tr>
<tr>
<td>Part 4 – Funding and expenditure</td>
<td>Separate part 4 for community and for each prison</td>
<td>Separate part 4 for community and for each prison</td>
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<td>Signatories</td>
<td>For adults – Drug Partnership Chair and Drug Partnership JCG Chair</td>
<td>Joint submission: Drug Partnership Chair JCG Chair Prison Governor/Director(s) Chief Executive PCT</td>
</tr>
<tr>
<td></td>
<td>For prisons – Drug Partnership Chair, Prison Governor/Director, Chief Executive PCT</td>
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</tbody>
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Background

The Government’s 10 year drug strategy\(^3\) builds on the successes of its predecessor in reducing overall levels of drug use, expanding and improving the treatment system and reducing drug related crime. In addition to actions to sustain these improvements, the strategy indicates significant shifts in emphasis and prioritisation, in part made possible by the achievements of the previous ten years. In particular (and reflecting the conclusions of the Advisory Council on the Misuse of Drugs “Hidden Harm” report\(^4\)), there is recognition that the potential for parental drug misuse to damage the life opportunities of their children may have received insufficient priority in the previous strategy. Reducing the negative impact of parental drug use on families is therefore a key priority in the strategy, alongside reducing drug related crime, improving the effective engagement of problem drug users, reducing the barriers to access to drug treatment and improving opportunities for drug users to enter employment and improve their housing status.

The key mechanisms through which the drug strategy will be delivered are the government’s 3 year Public Service Agreements (PSA) for 2008/11\(^5\). The Home Office (HO) is responsible for the leadership of PSA 25 – to reduce the harm caused by alcohol and drugs. This PSA sets out the Government’s commitment to produce a long term and sustainable reduction in the harms associated with alcohol and drugs.

PSA 25 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”\(^6\).

The objective of the integrated drug treatment system (IDTS) is to expand and improve the provision of drug treatment within HM Prisons\(^7\). The key elements of the IDTS\(^8\) are:

- Better targeting of interventions to match individual need
- Better treatment for people in prison in line with 2007 Clinical Guidelines on Drug Misuse and Dependence\(^9\), offering a range of effective needs-based interventions, realistic treatment opportunities, including the option to remain drug free
- Improved clinical management with the provision of opioid stabilisation and a greater number of maintenance prescriptions, for those for whom this is appropriate

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\(^5\) PSA Delivery Agreement 25: Reduce the harm caused by Alcohol and Drugs October 2007: [www.hm-treasury.gov.uk](http://www.hm-treasury.gov.uk)


\(^7\) A range of guidance materials have been issued since July 2006. Please contact the NTA regional team or IDTS regional development manager for full details.

\(^8\) Please see Gateway letter reference 9563 for full reference

• Greater integration of drug treatment generally with a particular emphasis on case management and care planning delivered by multi-disciplinary teams including CARATs (Counselling, Assessment, Referral, Advice and Throughcare)
• Strengthening links to community services, including PCTs, Criminal Justice Integrated Teams (CJITs), drug treatment providers etc.

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 (DH) and Home Office (and now supported by the Ministry of Justice). The NTA was established in 2001 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 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 2010/11 plans
b) ensure any drug treatment services which receive funding make data returns to the National Drug Treatment Monitoring System (NDTMS)
c) ensure that the drug intervention record and other linked returns are completed for prison treatment delivery

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. NTA regional teams work closely with Government Offices, the Director of Offender Management and SHAs in supporting their performance management of LAAs and PCT plans as they relate to drug treatment so that partnerships responsible for the provision of drug treatment receive a consistent response on a regional basis on drug treatment issues.

The annual agreement with partnerships and oversight of the dedicated resources provided for drug treatment are embodied within the submitted plan(s). These notes provide guidance to local partnerships who are seeking funding under the PTB or IDTS. Throughout the text links are provided to relevant guidance and materials which will provide partnerships with key information, definitions and source documents.

The plans should be based on a comprehensive needs assessment\(^\text{10}\) which will also contribute to the drugs and crime element of the joint strategic needs assessment which PCTs and local authorities now have a statutory duty to undertake on an annual basis. It is intended to outline the partnership’s strategic direction for the delivery of effective drug treatment, summarise the findings of the needs assessment, identify key priorities for drug treatment for 2010/11, provide detailed plans to deliver those key priorities and summarise the funding available and broad plans for expenditure. For 2010/11, where a comprehensive needs assessment has been completed within the last two years, partnerships have the option, with the prior agreement of the NTA regional manager, to undertake a refresh of this needs assessment.

Treatment planning timetable – 2010/11

Indicative allocations have been provided for the pooled treatment budget for 2010/11 but actual funding will depend on the numbers effectively treated in 2009. For this reason an annual resubmission of plans is required for areas seeking funding under the PTB. IDTS funding is anticipated to continue during 2010/11 at 2009/10 levels.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>By November 2009</td>
<td>Submission option agreed between plan signatories and NTA regional manager</td>
</tr>
<tr>
<td>By December 2009</td>
<td>Needs assessment, consultation and drafting of plan(s) completed for community based delivery and prison establishment(s) within the partnership local authority area</td>
</tr>
<tr>
<td>By 15th January 2010</td>
<td>Parts 1, 2, 4 and latest needs assessment report for community adult drug treatment and each prison establishment, returned to NTA</td>
</tr>
<tr>
<td>By 26th February 2010</td>
<td>Regional assessment and response to partnerships</td>
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<tr>
<td>By 19th March 2010</td>
<td>Part 2 (amended if necessary) and 3 returned to NTA, together with any revisions required for Parts 1 and 4</td>
</tr>
<tr>
<td>By 31 March 2010</td>
<td>Final sign off between NTA and partnerships. Partnerships to provide pdf version of strategic summary for publication on NTA website</td>
</tr>
<tr>
<td>April/May 2010</td>
<td>Publication of partnership strategic summary on NTA website</td>
</tr>
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The NTA guidance and Parts 2a, 2b, 3, 4a, 4b of the treatment plan are available to download from the NTA website at: [http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2010_11/treatment_planning_in_the_community_prisons_2010_11_templates_and_guidance.aspx](http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2010_11/treatment_planning_in_the_community_prisons_2010_11_templates_and_guidance.aspx)

Sample Part 1 templates are available from NTA regional teams on request. NTA regional teams will be working actively with partnerships to ensure appropriate support and guidance is available in addition to that contained herein. If you have any queries about how to complete treatment plans, please contact your NTA regional office.

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Example templates for Part 1 are provided. Where drug partnerships do not use the template provided, a covering letter supporting the plan submission from the relevant signatories should be attached. Parts 2, 3 and 4 of the treatment plan(s) should be submitted on the templates provided.
Part 1: Strategic summary, needs assessment and key priorities for 2010/11

| FORMAT | The Part 1 submission should be signed by the relevant signatories confirming that it is supported by the local strategic partnership. Please ensure that the submission is named and dated so that draft and final versions are clear. Partnerships are requested to provide a pdf version of Part 1 to the NTA regional team for publication on the NTA website once the final version is agreed. |

As part of the cycle of needs assessment, it is suggested that partnerships complete a summary of the needs assessment work which has been undertaken and set key priorities for the coming financial year. Each partnership which is seeking PTB funding or is in receipt of IDTS funding is required to provide a strategic overview (in the region of 4-6 pages of A4) as part of the 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 (community based), harm reduction and structured drug treatment interventions. It is suggested that this section identifies and considers 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 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
- 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 drug treatment, reintegration and recovery interventions in the community and prison(s) for 2010/11

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2a.1 Drug users in effective treatment

PSA delivery agreement 25 to reduce the harm caused by alcohol and drugs sets out the government vision to produce a long-term and sustainable reduction in the harms associated with alcohol and drugs. Indicator 1 measures the growth in the number of drug users recorded as being in effective treatment. The successful delivery of Indicator 1 is defined as achievement of a sustained 3% increase on the 2007/08 baseline (i.e. the annualised figure for that year) during 2008/11.

The indicator measures the percentage 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 percentage 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 indicator will be delivered via local areas in line with expectations set for 2008/11 as part of Vital Signs and LAAs (where applicable). Treatment plans for 2010/11 provide an opportunity to reflect on current performance and to set realistic plans for improvement where required. Where expectations regarding effective engagement are already being met by the local area, the focus of the NTA’s delivery assurance will shift towards support of local areas’ identification of need and planning against the wider aims for drug treatment outlined in the national drug strategy (see Section 2a.3 below for further details).

2a.1.1 Crack and/or opiate users recorded as being in effective treatment (LAA National Indicator 40 and VSB indicator 14)

Drug partnerships have set expectations for effective engagement of problem drug users via the Vital Signs and LAA processes for the three year period 2008/11. In the event of any opportunity to refresh these expectations either via the Vital Signs or LAA processes, then amended expectations can be provided in Part 2a of the submission where these apply.

2a.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. Partnerships should set expectations for 2010/11 based on progress made for all adults in 2009/10, and

13 Relates to local authority performance indicator 40 from the single set of national indicators, and Department of Health Departmental Vital Signs indicator 14. For further information on National Indicators, see: http://www.communities.gov.uk/localgovernment/performanceframeworkpartnerships/nationalindicators/
should reflect the updated needs assessment and any changes to priorities linked to the wider aims for drug treatment outlined in the national drug strategy.

2a.2 Additional partnership information – primary care

Guidance for this section of the adult drug treatment plan was revised in 2008/09 from previous years to reflect current arrangements for commissioning services in primary care. Partnerships should continue to set out information on a practice basis only in relation to delivery of adult drug treatment in primary care. Where a drug partnership area covers more than one PCT, this section of the return should be completed for each PCT. Where a drug partnership only covers part of a PCT area, then partnerships should provide information that relates to the drug partnership area and not the full PCT area.

This should include practices who provide primary care based treatment within either a local or joint commissioning group (JCG) defined 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 practice. Primary care based treatment does not include services where a GP is employed at specialist drug service to provide a prescribing service.

A self audit tool is provided to support local partnerships with the development, planning and commissioning of primary care based services as part of an integrated adult drug treatment system. Partnerships are not required to submit the audit tool.

2a.3 Local drug partnership priorities

The NTA is aware that many drugs partnerships will achieve their expectations in relation to improved effective engagement and will wish to support a shift towards local identification of need and delivery against the wider aims outlined in the national drug strategy.

Equally, each of the 149 local partnerships will have different priorities and gaps (as described through the needs assessment process). The NTA will therefore work with partnerships in order to agree and set local priorities to deliver commitments from the national drug strategy that are listed below:

- Better access to treatment for crack users, black and minority ethnic (BME) communities and parents
- Effective engagement of new presentations to treatment in relation to crack users, BME communities, parents, criminal justice clients and those under 25

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• Improved treatment system exit (planned completion) rates for everyone in the drug treatment system
• Improved access to treatment from those in contact with Jobcentre Plus and other employment services and improved care pathways between treatment services and Jobcentre Plus
• Improved housing status for individuals during or upon leaving treatment

Where local partnerships identify need linked to the above bulleted points, then these should be included in the key priorities for 2010/11 outlined in Part 1 of the return – with the relevant indication (√) in Part 2a of the return. Baseline data supplied by the NTA will allow partnerships to express aspirations for percentage improvements against the previous year’s baseline. This is being collected to monitor local contributions to the national drug strategy. It is important to note that the NTA does not necessarily expect that improvement will occur in all of these measures in all partnership areas. The NTA will, in any event, provide partnerships with NDTMS data on the above bulleted points and regular updates based on NDTMS returns. Please see Appendix 2 for additional materials to support local partnerships needs assessment.
Part 2b: Prison partnership plans 2010/11

<table>
<thead>
<tr>
<th>FORMAT</th>
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<tbody>
<tr>
<td>Part 2b is provided in excel format. A separate Part 2b should be completed for each prison in the partnership area. Please enter the name of the prison establishment, the drugs partnership and the PCT who commissions the prison healthcare services on the front page of Part 2b and enter the name of the prison in the “footer” together with the date. This will ensure that all pages of the return are numbered, dated and named so that draft and final versions are clear.</td>
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</table>

When setting performance expectations for the clinical delivery of IDTS in the establishment, the prison partnership will need to take into consideration the performance expectations that relate to the CARAT delivery which is an integral part of the delivery of drug treatment.

2b.1 Establishment summary
Please provide details of the type of prison establishment, the operational capacity of the establishment, and the type of healthcare provision available.

2b.2 Clinical performance expectations
The details required below provide a breakdown of expected delivery that will contribute to the achievement of the prison healthcare indicators for substance misuse set for the establishment. All of the information required to monitor the expectations is collected either via the Drug Intervention Record (DIR) or by establishment healthcare teams. Reports to inform the setting of all the expectations outlined below are provided by the NTA as part of the quarterly delivery assurance arrangements.

Planned numbers for 2010/11 can be calculated by local needs assessment and national modelling, which will give expected throughput of new receptions and the expected proportions needing different types of substance misuse treatment. This will provide commissioners and performance managers with a baseline against which performance can be reviewed over the course of the year.

2b.2.1 Commencement of drug treatment

2b.2.1.1 Number of receptions
Healthcare teams have been asked to report numbers of new healthcare assessments as an indicator of new receptions. An indicator recording daily arrivals at an establishment, for example, would lead to over counting as some prisoners attend court and return to the establishment.

2b.2.1.2 Number of individuals assessed as needing treatment
This relates to the number of individuals who complete a substance misuse treatment assessment (SMTA) and are assessed as having a drug treatment need, or are transferred to the substance misuse team from another establishment or CJIT having already been assessed as needing treatment. This is defined by section 8.1 of the DIR and/or the activity form 4.5/5.1.

2b.2.1.3 Number of individuals entering drug treatment
This relates to the number taken onto the caseload of CARATs. This is defined by section 9.3 of the DIR (care plan agreed) or 4.5 of the activity form (care plan agreed since transfer).
2b.2.1.4 Percentage of individuals assessed as needing treatment who enter drug treatment
This measure will indicate what proportion of those assessed as needing treatment get taken onto the CARAT caseload and will act as a key indicator of how effectively individuals are engaged in treatment.

2b.2.2 Treatment interventions
Definitions for stabilisation, detoxification and maintenance prescribing are contained in the Department of Health guidance on Clinical Management of Drug Dependence in the Adult Prison Setting\(^\text{16}\).

Please provide details in boxes 2.2.1 – 2.2.16 of the planned numbers of IDTS clients receiving a prescribing intervention on the first night, the planned number of commencements for stabilisations, detoxifications, opioid maintenance prescribing, crack interventions, benzodiazepine reductions and intensive drug programmes for 2010/11. In each case interventions are broken down into the presenting drug as appropriate.

2b.2.3 Continuity of care on release
Each prison establishment should have in place effective arrangements for continuity of care for those being released from the prison. This involves liaising with sentence planning and resettlement teams in prison and the Offender Manager in the community. In particular those needing access to drug treatment or related support through local drug treatment services or through Criminal Justice Integrated Teams (CJITs) in the community should be referred in line with national protocols\(^\text{17}\) which include the single point of contact (SPoC) for the relevant CJIT. These arrangements should ensure that release planning provides the continuity of any clinical drug interventions in the prisoner’s home area with the relevant CJIT or treatment provider and take account of whether there is a requirement for statutory probation supervision.

2b.2.3.1 Number referred to Criminal Justice Integrated Teams (CJITs)
This relates to the number that the establishment would anticipate referring to a CJIT – via the CARAT system – on release from the establishment.

2b.2.3.2 Number picked up by CJIT
This relates to the number of individuals who are picked up by the CJIT and thereby providing continuity of care in relation to their drug treatment needs after there has been a case closure by the CARAT team.

2b.2.3.3 Percentage of referrals picked up by CJIT
It is suggested that each establishment, based on the needs assessment, will consider the proportion of individuals against the number of CARAT referrals, who are picked up by the CJIT on release. Whilst this is not under the exclusive control of the establishment, continuity of care is a critical aim of IDTS and the prison will want to actively know the successful uptake or otherwise of individuals it releases – and will want to share responsibility with community partners to improve the care pathways following release.


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. |

Where submissions follow option 2, prison partnerships may use the same format for treatment planning grids as for 2009/10 or use the four grids outlined below.

**Drug System Management:**

| Grid 1 | Commissioning a drug treatment, reintegration and recovery system |
| Grid 2 | Drug Treatment Delivery System – the Treatment Journey: |
| Grid 3 | Access to and engagement with the drug treatment system |
| Grid 4 | Effectiveness of the drug treatment system |

Partnerships may add additional planning grids for local purposes to address key priorities identified from the needs assessment process.

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.

Supplementary guidance to support the treatment planning process includes:

- National Treatment Agency (2009) *Undertaking needs assessment – drug treatment, reintegration and recovery in the community and prisons*
- National Treatment Agency (2009) *Workforce development*
- National Treatment Agency (2008) *Harm reduction strategy – partnership self audit tool kit*
- National Treatment Agency (2008) *Self audit tool to support the planning, commissioning and monitoring of primary care components of adult drug treatment systems*

For the above please see:


- PSO 3550
- HM Prison Service(2002) CARATs PSO 3630
- Prison performance standard 65 CARATs
[http://www.hmprisonservice.gov.uk/assets/documents/10003A9465_CARATs_may08.pdf](http://www.hmprisonservice.gov.uk/assets/documents/10003A9465_CARATs_may08.pdf)
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 successfully over a 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 2010/11**

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

**Actions and milestones (Delivery plan)**

Good 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 can be used to provide a full set of actions to implement the objective with identified milestones. These need to be specific and measurable to allow for effective quarterly performance monitoring. The delivery plan can be used to identify the named post holder(s) who will be taking responsibility on behalf of the partnership (community or prison) or Joint Commissioning Group (JCG) to ensure that the action occurs or the milestone is met. Objectives can be numbered and the template can be extended to accommodate the full number of objectives that the partnership has for each grid. Objectives will benefit from being

- Specific
- Measurable
- Attainable
- Realistic
- Timed

**Expected outcomes**

Use this box to include a brief account of the expected outcomes for each objective – and how it will contribute to the delivery of the key priority to which it is linked.
Part 4a Substance Misuse Pooled Treatment Budget, mainstream funding and expenditure

| FORMAT | Part 4a is provided in excel format. Separate templates are provided for community and prison based returns. It is suggested that the name of the partnership is entered on the front page of Part 4a and in the “footer” together with the date. This will ensure that all pages of the return are numbered, dated and named. |

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 to be made available in full to the Joint Commissioning Group (JCG) or other strategic decision making forum.

Table 1: Funding source 2010/11

1.1 Substance misuse pooled treatment budget (PTB)
Enter the figures allocated to the partnership for adult drug treatment 2010/11. Indicative figures for 2010/11 were provided to partnerships in the January 2008 announcement and may be used to assist with planning until publication of actual PTB for 2010/11. It is anticipated that details of the PTB 2010/11 will be available prior to the January 2010 draft submission date.

1.2 Substance misuse pooled treatment budget under-spend carried forward from previous year
Partnerships are expected to spend against their commissioning intentions and not have any slippage to carry forward. However, in the event where this does happen then enter separately any PTB under-spend from previous year to be carried from 2009/10 to 2010/11. Partnerships are expected to ensure that appropriate brokerage arrangements are made in year where any under spend is anticipated. **This latter figure should be updated for the final submission stage in March 2010.**

1.3 Drug Intervention Programme (DIP) main grant
Funding for DIP is published by the Home Office as an overall grant amount which covers all elements of DIP funding available. Once the Home Office 2010/11 allocations are announced these should be included under section 1.3.

Mainstream investments

It is a condition of use of the PTB 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.

1.4 Police
This section is to specify all investment from the police. This may include additional investment in custody suite interventions or other investments supporting drug treatment including drug testing which is locally funded.
1.5 PCT mainstream investment
This section is to 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 that the NTA regional team is aware of the gaps in information.

1.6 Social services
This section is to include all social services/local authority investment in drug treatment services including community care funding.

1.7 Section 31/28a/75 funding
Where section 31, 28a or 75 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: do not enter funding in 1.7 if entries have been made in 1.5 and/or 1.6.

1.8 Probation partners
This section is to include all partnership funding from Probation partners that supports the delivery of the drug treatment system.
Please note: This does not include the offender management element of drug rehabilitation requirements.

1.9 Supporting People
This section is to 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.

1.10 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.

1.11 Department of Health capital funding
Additional capital funding to bolster capacity and quality within the treatment sector was announced on 3 June 2009. Where a partnership received an allocation, enter the amount in 2009/10.

1.12 Department of Health capital funding carried forward from previous year
Partnerships are expected to spend any allocated Department of Health capital funding in-year according to their plan or allocation and not have any slippage to carry forward. However in the event where slippage does happen then enter separately any Department of Health capital funding under-spend from previous year to be carried from 2008/09 to 2009/10 and from 2009/10 to 2010/11. Do not include any capital under-spend in rows 1.2 or 1.11 above. The facility for this carry forward should be confirmed by the relevant Director of Finance.

1.13 Total funding for adult drug treatment and DIP delivery (1.1 – 1.12 inclusive)
This is calculated automatically.
Table 2: Expenditure profile – 2010/11
This table should provide a breakdown of the funding source for the elements of the commissioning framework listed in the table. The total of all funding in cell M15 should equal the funding available in column 1.13 of Table 1 for 2010/11.

**Row 1:** Commissioning system: include details for the partnership and commissioning infrastructure. Please include details of any posts linked to workforce, user and carer involvement, harm reduction or reintegration strategy in the relevant rows below.

**Row 2:** Workforce: include details of any partnership costs identified by direct employment of any workforce posts (salary, on costs and non-pay costs associated with the post). It will be assumed that any running costs, accommodation overheads and IT will be included in the commissioning system costs in row 1. Also include any funding allocated by the partnership for training events run by the partnership in relation to the workforce agenda and all other expenditure at partnership level in relation to general workforce development.

**Row 3:** User involvement: include details of any partnership costs identified by direct employment of any user involvement posts (salary, on costs and non-pay costs associated with the post). It will be assumed that any running costs, accommodation overheads and IT will be included in the commissioning system costs in row 1. Also include any other expenditure by the partnership on user involvement (for example, support to user groups, travel expenses for users, conferences and events).

**Row 4:** Carer involvement: include details of any partnership costs identified by direct employment of any carer involvement posts (salary, on costs and non-pay costs associated with the post). It will be assumed that any running costs, accommodation overheads and IT will be included in the commissioning system costs in row 1. Also include all other expenditure by the partnership on carer involvement (for example, service level agreements with organisations to provide a service to families and carers, support to carer groups, travel expenses for carers, conferences and events).

**Row 5:** Harm reduction strategy: include details of any partnership costs identified by direct employment of any partnership harm reduction posts (salary, on costs and non-pay costs associated with the post). It will be assumed that any running costs, accommodation overheads and IT will be included in the commissioning system costs in row 1. Also include any other expenditure by the partnership on the harm reduction strategy at partnership level that is not included elsewhere in this return. (e.g. harm reduction partnership events).

**Row 6:** Delivery of partnership reintegration strategy: include details of any partnership costs identified by direct employment of any partnership reintegration posts (for example, employment or housing advisor)(salary, on costs and non pay costs associated with the post). It will be assumed that any running costs, accommodation overheads and IT will be included in the commissioning system costs in row 1. Also include any other expenditure by the partnership on the reintegration strategy that is not included elsewhere in this return (for example housing bonds).

**Row 7:** Open access drug treatment services: include costs of all contracts for open access services including needle exchange.
Row 8: Structured community treatment services: include costs for all contracts for community based structured drug treatment interventions reported to NDTMS.

Row 9: Inpatient services: include costs for all inpatient drug treatment interventions which usually involve short episodes of hospital-based (or equivalent) drug and alcohol medical treatment. The three main settings for inpatient treatment are general hospital psychiatric units; specialist drug misuse inpatient units in hospitals; and residential rehabilitation units (often as a precursor to the rehabilitation programme).

Row 10: Residential rehabilitation services: include costs for all residential rehabilitation interventions which usually consist of a range of treatment delivery models or programmes to address drug and alcohol misuse, including abstinence orientated drug interventions within the context of residential accommodation. There is a range of residential rehabilitation services, which include drug and alcohol residential rehabilitation services whose programmes to suit the needs of different service users. These programmes follow a number of broad approaches including therapeutic communities, 12-Step programmes and faith-based programmes; residential drug and alcohol crisis intervention services; residential treatment programmes for specific client groups; second stage’ rehabilitation in drug-free supported accommodation where a client often moves after completing an episode of care in a residential rehabilitation unit, and where they continue to have a care plan, and receive key work and a range of drug and non-drug-related support; other supported accommodation, with the rehabilitation interventions provided at a different nearby site(s).

Row 11: Drug interventions programme: include all costs associated with the DIP programme and CJIT infrastructure that are not included above (for example, a criminal justice post based within the partnership should be included in the commissioning infrastructure costs with the funding identified from the DIP budget rather than in row 16).
Part 4b: IDTS funding and budget profile 2010/11

| FORMAT | Part 4b is provided in excel format. Separate templates are provided for community based and prison based returns. It is suggested that the name of the partnership is entered on the front page of Part 4b and in the “footer” together with the date. This will ensure that all pages of the return are numbered, dated and named. |

It is intended that IDTS funding is spent on the development of clinical drug treatment within prisons in the given partnership area. Although allocated via PCTs, the funding should be viewed as partnership money to be spent on delivery plans within the prison, jointly agreed between the PCT Chief Executive, Chair of the drugs partnership, and the Prison Governor, all of whom are required signatories for the IDTS treatment plan. PCT or prison funding already allocated to the delivery of drug treatment in the prison should also be included in the funding profile.

Table 1: Funding Sources
Insert for both 2009/10 and 2010/11 the funding available, not only from specific IDTS funding, but also from mainstream healthcare funding, other sources of funding, any under-spend from the previous year, and CARAT funding (for information only).

Table 2: Expenditure Profile
The categories commissioned in column B can be expanded with new rows to include particular local detail if necessary.

Care should be taken to ensure that for each category of spend details are entered along the row as to how much of the planned annual expenditure on that category is to come from each of the funding sources itemised in table 1. Reading down the columns will then automatically show a breakdown of how each of the funding sources will be spent over the year, and, when added up along the bottom row, give a grand total of all planned expenditure in 2010/11.
Appendix 1 – Supplementary guidance for planning grids 2010/11

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

Introduction

Partnerships should bear the following in mind:

- The 2007 clinical guidelines and the 2008 national Drug Strategy recommend that treatment systems provide the full range of effective drug treatment and reintegration interventions. This requires strong clinical governance within services and across partnerships
- Systems need to pay particular attention to the reintegration and recovery of drug misusers as part of the delivery of effective drug treatment. This is likely to need development of stronger links with employment, training and housing agencies at a local level
- 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 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 in all areas of the treatment system
- The diverse needs of communities within the partnership area or catchment group need to be reflected throughout the planning grids and the implementation arrangements for these plans

Drug system management

Planning grid 1 focuses on the commissioning system. Drug treatment systems are complex and require appropriate management and support. The checklist included in this section takes account of the competencies required by World Class Commissioning18.

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 suggests how partnerships might evaluate the service user treatment journey including retention in treatment for long enough to impact on behaviour, provision of a care plan which identifies their recovery, reintegration and drug treatment 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 deliver improvements in community safety.

When setting objectives based on the needs assessment findings partnerships may wish to use the following checklist:

<table>
<thead>
<tr>
<th>Drug System Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td><strong>Planning Grid 1</strong></td>
</tr>
<tr>
<td>Commissioning a drug treatment, reintegration and recovery system in the community and prisons</td>
</tr>
<tr>
<td>Commissioning functions are fit for purpose. <em>World Class Commissioning competence 1 – locally lead the NHS</em></td>
</tr>
<tr>
<td>Commissioning mechanisms have formal strategic partnership involvement with key stakeholders including health, social care, criminal justice (community and custody), housing and employment and resettlement services, drug treatment providers and drug users, families and carers. <em>World Class Commissioning competence 2 – work with community partners</em></td>
</tr>
<tr>
<td>Service users, families and carers are involved in the full cycle of commissioning and resources and investment are available to cover appropriate remuneration, expenses and organisational costs. <em>World Class commissioning competence 3 – engage with public and patients</em></td>
</tr>
<tr>
<td>Plans reflect the requirements of the 2008 Drug Strategy and the 2007 clinical guidelines. This includes a focus on reducing harm to individuals, children, families and communities, ensuring availability of the full range of recommended pharmacological and psychosocial interventions, improving drug users journeys through the drug treatment system, supporting the drug users recovery and reintegration into the community, predicting client flow through the recovery, reintegration and treatment system and improving the effectiveness of the system. <em>World Class Commissioning competencies 4 – collaborate with clinicians and 8 – promote improvement and innovation</em></td>
</tr>
<tr>
<td>Annual needs assessments are conducted in line with nationally agreed methodology, profile the diversity of need for recovery, reintegration and drug treatment services, and addresses rates of morbidity and mortality, the degree of saturation or penetration, gaps in provision and the impact of services on individual health, public health and offending. <em>World Class Commissioning competencies 5 – manage knowledge and assess need, and 7 – stimulate the market</em></td>
</tr>
<tr>
<td>Partnerships can demonstrate best practice in handling public money, contracting with providers and monitoring of service level agreements (in line with the NHS standard contract where applicable). <em>World Class Commissioning competencies 6 – prioritise investment, 9 – secure procurement skills and 11 – make sound financial investments</em></td>
</tr>
<tr>
<td>Partnerships performance manage systems of drug treatment using data and key performance indicators in line with all national and partnership organisations requirements and plans. <em>World Class Commissioning competence 10 – manage the local health system</em></td>
</tr>
</tbody>
</table>

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19 Minimum expectations for prisons are set out in the IDTS Implementation Project Initiation document [http://www.nta.nhs.uk/areas/criminal_justice/docs/idts/IDTS_PID_template_v1.0_240408.doc](http://www.nta.nhs.uk/areas/criminal_justice/docs/idts/IDTS_PID_template_v1.0_240408.doc)


See page 18 for commissioning cycle


Adult and IDTS drug treatment plan 2010/11 – Guidance notes for partnerships  
DH Gateway reference: 12441  
September 2009
Partnerships oversee the DIP 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; DIP cases are engaged effectively in structured treatment.

Information systems are compliant with the National Drug Treatment Monitoring System (NDTMS) and the drug intervention recording system (DIR), have appropriate data and information sharing protocols and forward planning investment plans for the purchase or development of IT systems to meet the clinical, NDTMS and DIR needs of providers.

Community based information and delivery systems ensure that the Treatment Outcomes Profile (TOP) is administered within two weeks either side of treatment start and thereafter at required intervals (minimum 26 review periods), and within two weeks either side of treatment exit to track progress and measure impact, and is reported through NDTMS.

Partnerships have a workforce strategy and improvement plan which covers both partnership and provider requirements in relation to recruitment, education, training, and workforce activities including induction, individual training plans, appraisal, supervision, continuing professional development, job descriptions and person specifications in line with the Drug and Alcohol National Standards (DANOS) and other relevant national occupational standards.

### Drug treatment delivery system – the treatment journey

**Planning Grid 2**

**Access and engagement with the drug treatment system**

<table>
<thead>
<tr>
<th>Screening, assessment and referral arrangements for structured drug treatment are sufficient to identify recovery, reintegration and drug treatment needs which inform care planning from open access services and CJITs and are routinely undertaken on reception to prisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision for recovery, reintegration and drug treatment needs is appropriate to drug users from all backgrounds and characteristics within the catchment area</td>
</tr>
<tr>
<td>All agencies working with children, their parents, young people and their families take all reasonable measures to ensure that the risks of harm to children’s welfare are minimised, and when there are concerns about children and young people’s welfare, all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures agreed with children and young people’s services in full partnership with other local agencies</td>
</tr>
<tr>
<td>All agencies have agreed policies for the monitoring of delivery of services in full compliance with the Human Rights Act and the six strands of equality legislation: ethnicity, gender, disability, age, sexual orientation and religion or belief</td>
</tr>
<tr>
<td>Waiting times for community based interventions provide timely access and are within three weeks of referral</td>
</tr>
<tr>
<td>CJIT has sufficient capacity and appropriate working hours and practices to cover custody suites and courts in line with DIP priorities and demand, including the need to carry out Required Assessments promptly, and Restriction on Bail relevant assessments where necessary and/or accept and continue intervention for those referred from other CJITs</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>CJIT has arrangements in place to facilitate engagement of prisoners on the day of release into treatment services where appropriate</td>
</tr>
<tr>
<td>Arrangements are in place to accept and continue treatment on temporary release, transfer between establishments and on release from prison</td>
</tr>
<tr>
<td>Relevant information exchange arrangements are in place using appropriate protocols and processes to ensure effective inter-agency working and to support continuity of care (for example, between community and custody based services, in relation to specific groups such as prolific and priority offenders etc)</td>
</tr>
<tr>
<td>A network of advocacy and support services is available which includes access to drug related support and mutual aid groups</td>
</tr>
<tr>
<td>Providers, including prisons, display a service user charter, including user consultation arrangements, and promote access to advocacy for drug users</td>
</tr>
</tbody>
</table>

| **Planning Grid 3**  |
| **Effectiveness of drug treatment system** |
| All service users in community based services, including offenders, are retained in treatment for more than 12 weeks, or are subject to a care planned discharge before 12 weeks |
| All service users engaged in community based structured drug treatment have a Treatment Outcome Profile (TOP) administered within two weeks either side of treatment start and thereafter at required intervals (minimum 26 review periods), and within two weeks either side of treatment exit to track progress and measure impact |
| All service users are 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 are co-ordinated across a range of services and cover areas related to drug and alcohol use, physical and psychological health, criminal involvement and offending, and recovery and reintegration needs including employment and housing requirements |
| Comprehensive and robust case management arrangements are in place within the CJIT and prison setting |
| Effective continuity of care arrangements are in place between community based and residential drug treatment and residential rehabilitation services including aftercare and relapse prevention services |
| Effective continuity of care arrangements are in place between prisons (for transfers and court appearances), CJITs and specialist treatment providers (on release) |
| Annual qualitative audits of care plans are undertaken in all provider services |
| Annual clinical audits of a range of aspects of delivery are undertaken in all provider services in line with the guidance outlined in the 2007 Clinical Guidelines |
| Clinical governance mechanisms for assuring the quality and safety of drug treatment services are in place |
| A system of both clinical and management supervision is in place which includes continuous professional development planning |
| Individuals receive information, advice, injecting equipment and brief interventions and treatment to help reduce potential harm due to the |
transmission of blood borne viruses, drug related infections and overdose, and improves their physical health in line with the 2007 Clinical Guidelines

Individuals are offered hepatitis B vaccinations and, where accepted, immunisation is carried out. Where not accepted, the issue is reviewed as part of the care plan review process

Individuals are offered hepatitis C screening and, where accepted, have access to screening, counselling and treatment where appropriate. Where not accepted, the issue is reviewed as part of care plan process

Individuals are offered access to other health screening where appropriate

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

Full range of evidence based residential and community structured treatment interventions as outlined in the 2007 Clinical Guidelines are available 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 – including services for drug misusing offenders in DIP and subject to community based court orders

All those in treatment have access to drug related support and mutual aid

| Planning Grid 4 |
|-----------------|---------------------------------|
| Continuing reintegration and recovery, outcomes, discharge and exit from the drug treatment system |
| Partnership has a written strategic plan, including operational protocols with Jobcentre Plus and Fresh Start (in prisons) to increase access to education, training and employment by drug users in order to assist stabilisation and resettlement. This includes drug systems having defined pathways for referrals from Jobcentre Plus to drug treatment services and drug services having defined pathways for referrals from drug treatment to Jobcentre Plus for support in accessing training, skills and employment opportunities |
| 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 on housing is supported by an action plan which ensures all key partners have shared definitions, objectives and outcomes with specific operational protocols between the partnership, the local authority Supporting People team and housing providers |
| Partnership has undertaken a local assessment of met and unmet need for housing and housing support for drug users including those who are also offenders and those being released from prisons |
| Partnership has identified current performance in terms of planned and unplanned discharges from treatment with plans in place to improve performance year on year |
| SLAs with all service providers clearly stipulate planned discharge performance expectations and are reviewed quarterly with providers |
| All those who leave 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 |

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23 NTA regional teams have a toolkit available for use with partnerships to review provision against the 2007 Clinical Guidelines
Appendix 2 Implementing “Drugs: protecting families and communities”

Additional materials to support local drug partnerships needs assessment
October 2009

Introduction
The Government’s 2008 drug strategy builds on the successes of its predecessor in reducing overall levels of drug use, expanding and improving the treatment system and reducing drug related crime. In addition to actions to sustain these improvements, the strategy indicates significant shifts in emphasis and prioritisation, in part made possible by the achievements of the previous ten years. Key priorities in the new strategy include addressing the impact of parental drug misuse on their children, reducing drug related crime, improving the effective engagement of problem drug users, reducing the barriers to access to drug treatment. The strategy also places a much greater emphasis on improving opportunities for drug users to re-establish their lives through addressing their barriers to work. This includes improving access to training, skills and employment and improving drug users’ housing status.

Developing needs assessment
NTA needs assessment guidance outlines a systematic method of identifying the unmet needs of the local population, and includes a process for evaluating and prioritising unmet needs within the resources available which is documented by drug partnerships through the treatment plans each year.

The national commitments outlined in the drug strategy can only be delivered via local areas taking action against the key priorities. The NTA is aware that each of the 149 local drug partnerships will have different priorities and gaps (as established through the needs assessment process). The summary materials presented below are therefore provided to support drug partnerships where unmet needs are identified in relation to access to treatment, effective engagement in treatment, planned completion rates, training, skills and employment and housing status. Whilst these materials will relate to all those accessing treatment, already in treatment or leaving the drug treatment system, it is suggested that each drug partnership may wish to consider whether or not there is evidence to suggest there is unmet need which remains to be addressed in relation to the following cross cutting issues:

- Access to treatment for crack users, BME communities and parents
- Effective engagement of new presentations to treatment in relation to crack users, BME communities, parents, criminal justice clients and those under 25
- Improved treatment system exits (planned completions) for everyone, and in particular for crack users, BME communities, parents, criminal justice clients and those under 25
- Access to treatment from those in contact with Jobcentre Plus and other employment services

• Improvements in care pathways and training, skills and employment care planning between treatment services and Jobcentre Plus for those stabilised in treatment or leaving treatment
• Improvements in provision of housing and housing support for those accessing treatment, in treatment or leaving treatment

These materials are presented in three sections. Section 1 covers access to treatment, effective engagement in treatment and planned completion rates. Section 2 covers training and employment developments for drug users. Section 3 covers housing developments.

1. Overcoming barriers to access, effective engagement in treatment and improved planned completion of treatment

Local stakeholders involved in the needs assessment process will wish to consider the needs of the entire community their local treatment system seeks to address. A summary of statutory responsibilities in relation to diversity issues is provided as part of the needs assessment guidance26. Drug partnerships should also be aware of the need to undertake impact assessments as part of planning and implementation of services27.

NTA needs assessment guidance recommends that before proceeding to make decisions about how identified unmet need might be met, each partnership needs to have a clear understanding of how treatment need is currently met and where there are either gaps or areas requiring improved service delivery. This entails mapping the drug treatment system against a description of the client profile in relation to access to treatment, throughput, effective engagement and exits. A full data set is provided by the NTA each year to drug partnerships to facilitate treatment system mapping.

In order to focus attention on the priorities outlined in the Drug Strategy, additional data28 is also provided which focuses specifically on

• Partnership, regional and national profile in relation to access to treatment for crack users and parents. Data in relation to the profile of BME clients is set out in the full data set which can be used to compare access for BME groups against the local population profile
• Partnership, regional and national profile in relation to effective engagement of new clients who are crack users, from BME groups, parents, criminal justice referrals, and under 25s
• Partnership, regional and national profile in relation to treatment exits in the last twelve months for clients who are crack users, from BME groups, parents, criminal justice referrals, and under 25s

This enables partnerships to undertake specific treatment system mapping in relation to these priority groups where the data indicates that improvements may be required in the local area.

27 See, for example, [www.nta.nhs.uk/areas/diversity/docs/promoting_equality_and_diversity.pdf](http://www.nta.nhs.uk/areas/diversity/docs/promoting_equality_and_diversity.pdf)
28 NDTMS data to be provided by the NTA to partnerships in relation to access, effective engagement, treatment exits, employment and housing from October 2008 onwards
Barriers to access and lack of effective engagement in treatment can be influenced by a wide variety of factors such as:

- Increasing or inappropriate waiting times
- Lack of appropriate services to meet specific needs (for example, abstinence based services, crack services, co-morbidity services)
- Lack of geographical spread of services
- Lack of facilities or appropriately focused services for those with children (for example, taking into account childcare needs)
- Lack of specialist services for pregnant drug users
- Attitude/culture/history of existing services
- Processes and procedures that can inhibit access to services (e.g. appointment procedures, movement between services/buildings)
- Poor care pathways between services – this can include criminal justice interventions – DIP and release from prisons, open access services and pathways between community based and residential drug treatment services
- Poor continuity of care arrangements for the resettlement of offenders in the community on release from custody
- Lack of flexible approaches, such as opening hours, lack of choice offered for appointment times, lack of flexibility in responding to non attenders, etc

Undertaking a thorough and cyclical process of needs assessment, planning, implementation and review will assist partnerships in identifying which, if any, of the above factors require attention in their local area. By examining as systematically as possible what the relative needs and harms are within different groups in the local area, and making evidence based and ethical decisions on how these needs might be most effectively be met within existing resources is key to delivering the improvements outlined in the drug strategy.

Penetration levels, as estimated by comparing the number of crack users accessing treatment compared to the prevalence of crack users in the local area (based on prevalence estimates produced by the University of Glasgow on behalf of the Home Office), vary widely across England29. Those partnerships with low penetration or low levels of effective engagement of crack users may wish to examine this in more detail as part of the needs assessment process, with a particular concentration on whether or not the issues relate to those with primary crack presentation or poly drug use.

Drug treatment systems are generally more effective at engaging and retaining primary opiate users in treatment than crack users whilst crack use as a secondary drug is increasingly prevalent in most partnership areas. Partnerships will be aware that the NICE drug misuse: psychosocial interventions (2007)30 and the 2007 Clinical Guidelines31 recommend evidence based psychosocial interventions for crack and other stimulant users.

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29 University of Glasgow research published in December 2007 on the NTA website: related:www.nta.nhs.uk/areas/facts_and_figures/prevalence_data/docs/0607/default.aspx
The British Psychological Society (BPS), commissioned by the NTA has produced and published a toolkit for providers and commissioners\(^\text{32}\) in order to assist the planning and delivery of psychosocial interventions. This includes the following:

- Clear definitions of core competencies for practitioners or key workers with regard to the delivery of counselling/psychosocial interventions/psychological therapies
- A framework against which services can assess what they are currently providing, and the extent to which their current provision is aligned with/differs from NICE guidelines and professional and practice guidelines
- Guidance on how to address any gaps in services with regard to the provision of such interventions
- Guidance on how practitioners (identified as competent), can lead on the implementation of the toolkit in their service/partnership organisation
- A detailed library of the relevant manuals and protocols

There is an increasing body of evidence demonstrating the effectiveness of pharmacological and psychosocial interventions for the treatment of drug misuse\(^\text{33}\). For clients to achieve most benefit from these interventions they need to be engaged and retained in treatment and leave in a planned way having achieved the goals set out in their care or treatment plan. Existing indicators suggest that there is significant potential to increase the number of clients who successfully complete treatment. Performance across partnerships varies widely and there is much that can be learnt from those services that have already achieved low levels of unplanned discharge.

Whilst there are good indications that retention rates in drug treatment are increasing, services need to build on these successes as too many people are still dropping out of treatment. The procedures and practices of individual services have a significant impact on whether clients complete effective drug treatment.

Towards successful treatment completions: a good practice guide\(^\text{34}\) examines data from NDTMS to identify factors associated with unplanned discharges, reviews some of the literature on engagement and retention in treatment and looks at good practice and procedures to enhance engagement that assist with clients who are failing to respond to treatment and need to have their treatment optimised. The guide also covers procedures to follow when considering the withdrawal of treatment.

### 2. Training and Employment Opportunities for drug users

Many drug users find it difficult to enter into and remain in employment, and need support with education, training and/or skills. Studies show that 80% of people on court orders with drug rehabilitation requirements have unmet skills and employment needs. Twenty percent of those who responded to the NTA service user survey\(^\text{35}\) requested

help with education and employment. Support to find or return to employment and access to training and skills, or opportunities for engaging in meaningful activity are a key part of supporting the client treatment journey and positive treatment outcomes. The level of need for training, skills and employment services for those in and leaving the treatment system should be established as part of the needs assessment process. This should inform the continuing development of effective pathways to relevant local services for clients.

The Department of Health has committed £9m over three financial years to fund Jobcentre Plus drugs coordinators across England. These coordinators will act as a regional and local resource in the development and coordination of the employment and drugs pathway. A key element of their work will be to work with drug partnerships to inform needs assessments in relation to training, skills and employment.

Each region will have a Jobcentre Plus drugs coordinator who, in partnership with NTA regional teams, will oversee the delivery of the work of local and district level Jobcentre Plus drugs coordinators.

It is recognised by the NTA that data sources to help inform this assessment need to be developed at a national, regional and local level. The NTA is currently investigating what additional NDTMS data regarding the employment status of those in treatment in each local drug partnership area can be provided to assist with mapping current arrangements. District Jobcentre Plus drug coordinators may be able to facilitate access to general Jobcentre Plus Labour Market System (LMS) data at a partnerships level to support a greater degree of understanding of issues at a local level.

Establishing the key information gaps and planning to meet these will be an important part of the needs assessment process. Increasing the involvement of the training, skills and employment sector in both needs assessment and local strategic commissioning will be crucial to improving local treatment systems.

To deliver one of the drug strategy commitments, from April 2009 if a benefit claimant in receipt of Jobseeker’s Allowance or an individual in receipt of Employment Support Allowance discloses that opioid and/or crack cocaine use is a barrier to work the Jobcentre Plus adviser will discuss with the client whether an initial appointment with a local drug treatment provider is appropriate, and if so, make a referral.

Jobcentre Plus will be seeking confirmation from affected clients that they have indeed attended that appointment. Where clients consent, transfer of information back to Jobcentre Plus by treatment providers may help both parties provide a more joined-up and client-focused service. It is therefore suggested that drug partnerships, providers and Jobcentre Plus work together to agree local information-sharing protocols.

These developments also highlight the necessity of strengthening care pathways between treatment services and Jobcentre Plus to allow people who have been stabilised in drug treatment and/or who are ready to complete their treatment to gain personalised and meaningful support to enable them to look for work. Both elements will require the strengthening of the local links between drug partnerships and senior managers in Jobcentre Plus as well as the much closer working of Progress to Work with drug treatment providers than is currently commonly the case.

Further details with regards to Jobcentre Plus drug coordinators and the wider implications of the welfare reform agenda for drug users can be found in Planning,
commissioning and delivering the training and employment pathway for problem drug users published by the NTA in May 2009

Promoting practice between local drug partnerships and education, training and employment provision for DIP clients was published by the Home Office in January 2006. This gives some useful ideas for drug partnerships about the arrangements that should be in place in each area to create and sustain partnerships between education, training and employment provision and drug treatment providers.

3. Housing

Nationally out of approximately 80,000 adults starting new treatment journeys in 2008/09 8% (6,500) said they were of no fixed abode or had an urgent housing problem and another 15% reported that they were having housing problems of some description. Homelessness acts as a barrier for many people who could otherwise benefit from accessing drug treatment. Obtaining suitable housing and housing support is a critical factor in ensuring access to the treatment system and in supporting treatment outcomes for clients throughout and after their treatment journey. Housing and housing support needs can change throughout the treatment journey. Clients may be able to sustain varying levels of independence at different stages. Housing support for those drug users experiencing unstable and unsettled lives may be required at some stages and abstinence based supported housing at others.

As part of the needs assessment partnerships should establish the met and unmet housing and housing support needs of those who could benefit from accessing treatment, the treatment population and those leaving treatment. Flexible pathways to a range of housing and housing support options need to be established or developed to support the client treatment journey.

Information from the needs assessment should inform the treatment plan and relevant local strategies, for example, the local authority homelessness strategy and Supporting People strategy. There are a number of models and a range of data sources which can assist in developing a local housing and housing support needs assessment for drug users, including:

- Improving Practice in Housing for Drug Users – A Partnership Project 2008. A practice paper developed to share examples of improving practice in housing drug users at a strategic and service delivery level across England
- Assessing the level of expected drug-related need for support housing: A guide for DATA guide for DAT/CDRP partnerships and Supporting People teams. Drug Strategy Directorate, Home Office, 2004
- Drug services for homeless people: a good practice guide. Office of the Deputy Prime Minister, 2002

36 National Treatment Agency (2009) Planning, commissioning and delivering the training and employment pathway for problem drug users
37 http://www.drugs.org.uk
38 Available at http://drugs.homeoffice.gov.uk/drug-interventions-programme/guidance/throughcare-aftercare/HousingandHomelessness
39 Available at http://www.nta.nhs.uk/areas/treatment_planning/docs/needs_assessment_ho_04.pdf
40 Available at http://drugs.homeoffice.gov.uk/publication-search/dip/drug-services-homeless-people.pdf
• Homelessness code of guidance for local authorities. Office of the Deputy Prime Minister, 2006


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