

**TACKLING  
DRUGS  
CHANGING  
LIVES  
IN OLDHAM**

**Oldham Drugs and Alcohol Action Team**  
*'Oldham DAAT promotes Equality and Diversity in all its services'*

**Adult  
Needs Assessment**

Report produced December 2007 based on 2006/2007 data  
made available from the National Treatment Agency.



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## **Introduction**

This is the third year that we have followed the NTA methodology to produce a needs assessment. The needs assessment forms the beginning of the commissioning cycle, which is a dynamic process. Last year we acknowledged that, like any need assessment methodology, there are inherent strengths and weaknesses. Some of those limitations also apply this year. For example, this needs assessment is restricted to adult drug users and largely to those using opiates and cocaine or crack.

We have, for the first time also produced a separate Young people's Needs Assessment utilising data returned to us from NDTMS, however, the data quality for this has been poor and it would be quite misleading to rely on this year's young people's needs assessment to make commissioning decisions about the nature and the required levels of service.

This year we believe that the robustness of the adult data has been much improved. That does not, however, alter our view that this needs assessment needs very careful analysis and a great deal of supplementary information in order for the partnership to make informed and sensible commissioning decisions.

We believe that the 'assumption' of the model that those drug users that are not yet in treatment will have the same characteristics of those already in treatment is essentially flawed. Were we to plan to simply provide more treatment places of exactly the same type of treatment that is currently on offer there is a good chance that we would find those treatment places empty. We feel that our 'hidden population' of 'treatment naive' clients may have quite different drug profiles and may require a different type of treatment service to the services that we currently offer.

Following on from last year, we have found more evidence to support the view that the numbers of new cases of drug users whose primary drug is opiates has reached a peak and are now in decline. We are increasingly seeing a younger group of substance users coming to our notice, particularly through criminal justice portals with the ACCE profile of substance use. These clients do not want 'typical' treatment responses. Methadone maintenance is not appropriate for them. Unfortunately the findings from our ACCE pilot were not available in time to be included in this needs assessment, but the early findings will be taken into consideration when planning the strategic direction of our treatment planning.

Consultation with existing service users, ex-service users, and some substance users who are not accessing treatment together with a wide range of other stakeholders across the partnership has been a vital additional source of information, which has added depth to this needs assessment.

Unfortunately, this year's unit cost exercise has been postponed and has therefore not been available to add to the picture of how 'fit for purpose' our treatment system is. What has been central to our strategic planning this year, has been a thorough examination of the evidence base of what works in terms of harm reduction, health gain and other outcomes of treatment, including getting people off drugs and reintegrating them back into fulfilling and productive lives.

## **Executive Summary**

During November and December for the last 3 years Oldham DAAT partnership has concentrated on the 'needs assessment' phase of what is a dynamic commissioning cycle. However the actual needs assessment methodology that we follow, which involves plotting and profiling our 'in treatment' population and estimating our 'treatment naive' population is just a small part of the overall assessment of need and analysis of the nature of services required to meet that need.

Within the partnership, needs assessment is a dynamic process, which happens throughout the year. Information of the appropriateness and efficacy of our treatment services and how they work together is constantly being analysed. However, in spite of its flaws, the needs assessment process allows us to focus our thoughts on our populations 'not yet in treatment' and is certainly a useful discipline. It can help us to identify the strengths and weaknesses in our treatment system in terms of its ability to attract in those not yet in treatment and to be acceptable to and retain those currently in treatment.

This is largely an adult needs assessment, which looks at the 'in treatment' population as synonymous with the adult methadone maintenance 'in treatment' population. Abstinence based treatment populations are largely invisible. The figures are based on opiate and cocaine use and do not recognise other substances. The model does not recognise the ACCE profile and our ACCE pilot findings will need to be considered. Unfortunately the findings from the pilot were not available in time to be added into this needs assessment. This needs assessment model tells us little about the needs of the up and coming drug using generation and care must be taken that the message is not skewed.

The bull's eye calculation estimates that the number of people needing treatment who are not currently receiving it is around 260. We suspect that there are far more than 260 individuals at large in Oldham who have unmet substance related needs. Many of them will be using different substances including stimulants and alcohol and there is also emerging evidence that there are a sizable number within the BME community both male and female who have unmet substance related need. This is still being explored.

The young peoples need assessment is still in its infancy and data is far from robust, but although there are not large numbers of problematic Class A drug users amongst the young people in Oldham there are certainly large numbers whose substance use is problematic - much of this based around the ACCE profile of substance use.

The treatment naive population are seen by the model as a 'mirror image' of the in treatment population – but are just as likely to be the opposite – maybe that is why, (in spite of major efforts to make treatment non-stigmatising and accessible) they still have not come forward for treatment.

The figures for the 'in-treatment' population have demonstrated that the trend for Oldham to increase the number of women and BME clients in treatment has continued – this is supporting evidence that our strategies to attract more women and BME users into treatment is paying off and is very pleasing. There is evidence as well that once engaged the retention rate for BME clients is better than the background treatment population. This is not the case for women – we know that there are many social pressures, which make it

more difficult for women to stick to treatment; and we will explore ways to increase such retention.

Retention is generally is better than the NW and Nationally.

Successful outcomes are our biggest challenge. The low successful outcomes levels for ADS may be partially due to the wrong assignment of tier 2 clients to tier 3.

In the context of rising trends of stimulant users requiring only short-term brief interventions, we strongly support the new method of counting as successful outcomes, those who have completed treatment successfully in less than 12 weeks. This will cease to penalise agencies such as ADS who do much useful work with stimulant users as brief interventions.

Inter system transfers levels appear to demonstrate that in relative terms, clients in Oldham are being directed (following triage) to the correct treatment modality. This is demonstrating that treatment services are now beginning to work together as a real 'system'

What the methodology of this needs assessment cannot capture is the real life stories of our clients and their needs. The process is even less likely to capture qualitative information regarding the needs of children, families and carers affected by the substance misuse of others. That is why it is of paramount importance that just as much consideration is given to consultation with a range of stakeholders on issues such as this. With this in mind I would like to thank, on behalf of the DAAT all those who have taken the time and the trouble to consult with us around such sensitive issues.

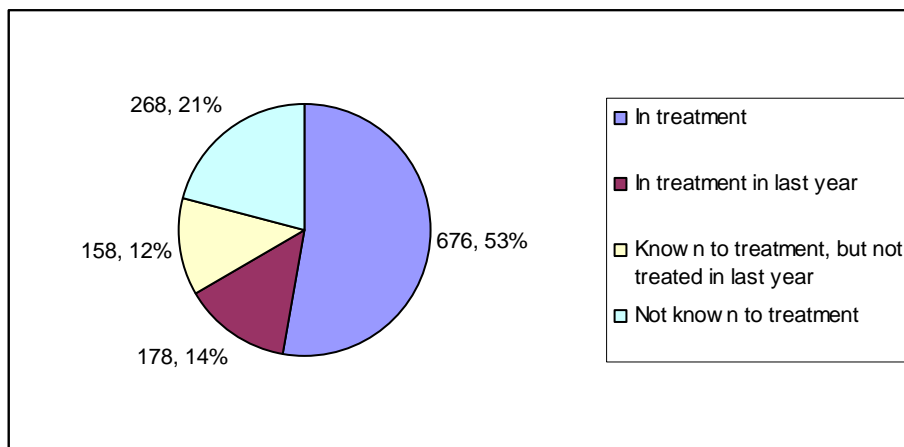
On behalf of the DAAT, I would like to thank all those who have been involved in this needs assessment and particularly Craig Wilkes who has done the bulk of the data input and initial analysis and has led the performance management group in this venture.

# **Bulls Eye Model for Oldham DAAT**

Model for Opiate and/or Crack users in 2006/2007

Looking at the bulls eye model for Oldham in the period 2006/07 it shows us that 676 people were in treatment in that year. This is a reduction of 24 people on the previous year. 178 were in treatment within the last year, this is an increase of 14 people on the previous year. 158 were known to treatment, but not treated in the last year, this is an increase of 148 people on the previous year. Some of this figure is a result of poor recording of data in 2005/06.

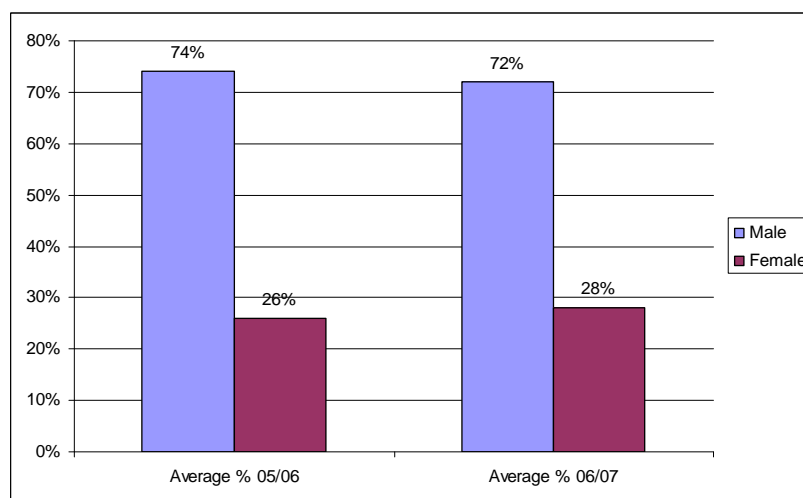
This gave a known population of 1012 which is an increase of 138 people (13.6%). If we compare this to the prevalence figure supplied to us by the Glasgow Model which is 1280 then there are currently 268 people not known to treatment in this period. These people are considered as 'Treatment Naive'. If we compare this to the previous year's figures we can see that there is an increase of 138 people known to the treatment system.



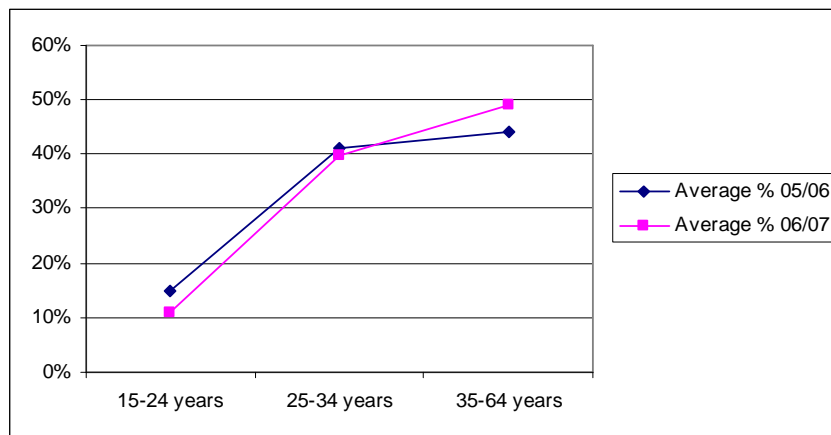
### The 'In treatment' population:

Of those in treatment 78% were male, 83% were 'White' and 13% were 'Asian or Asian British'. Only 11% of those people in treatment were aged between 15 – 24 years old and 17% stated that they were 'currently' injecting.

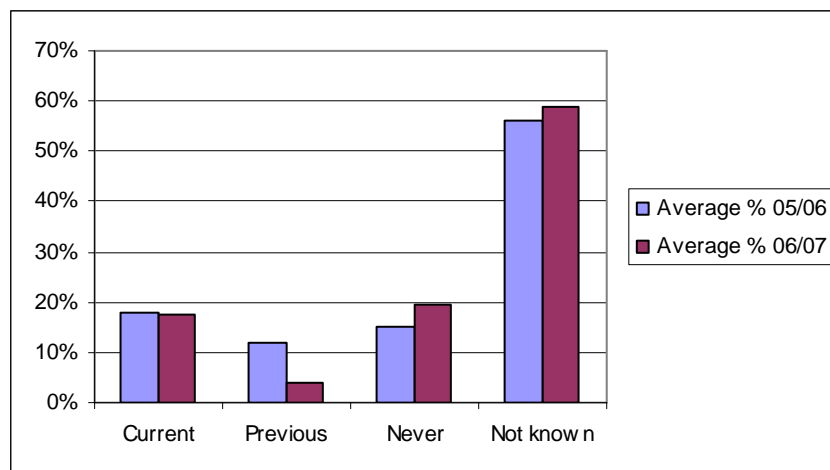
Below we can see a comparison of gender breakdown between 2006/07 and 2005/06:



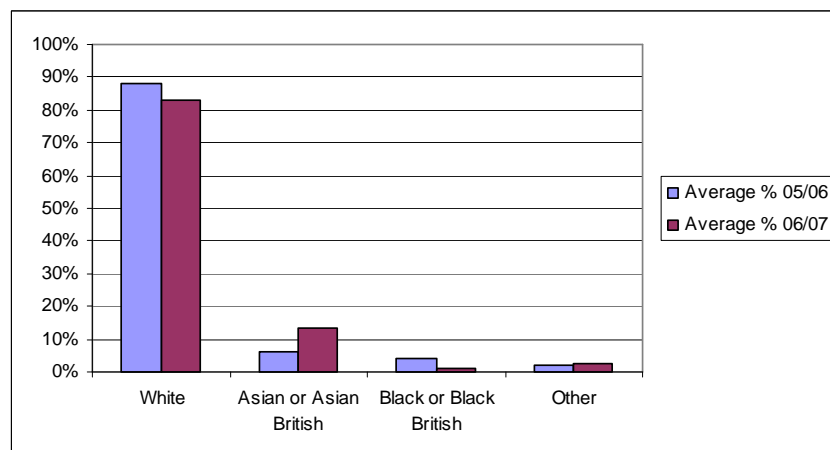
Below we can see a comparison of age groups breakdown between 2006/07 and 2005/06:



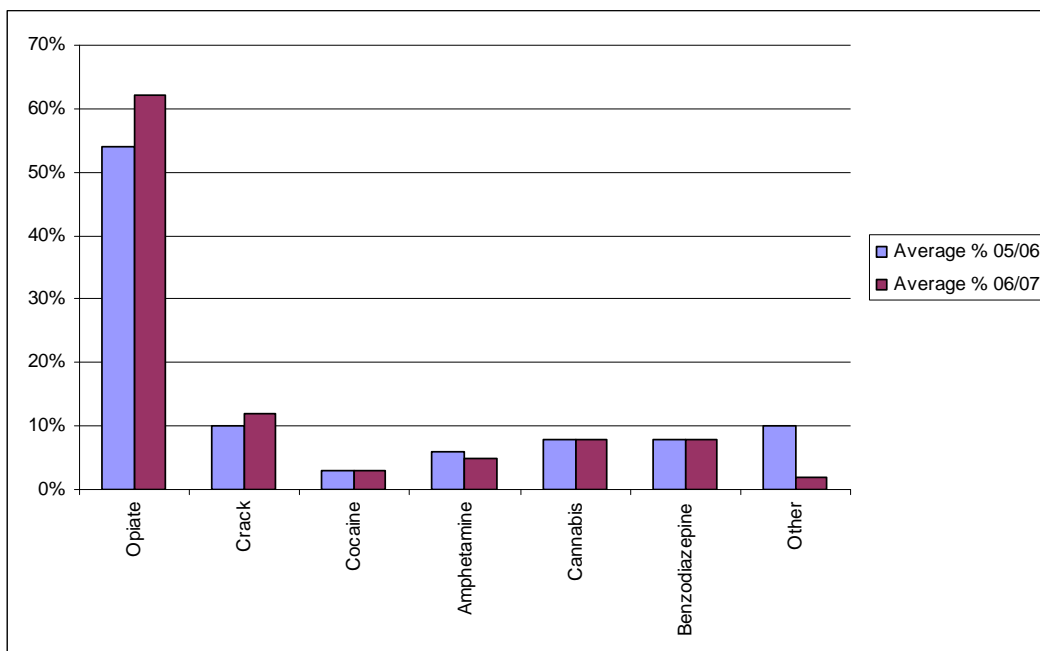
Below we can see a comparison of injecting status breakdown between 2006/07 and 2005/06:



Below we can see a comparison of ethnicity between 2006/07 and 2005/06:



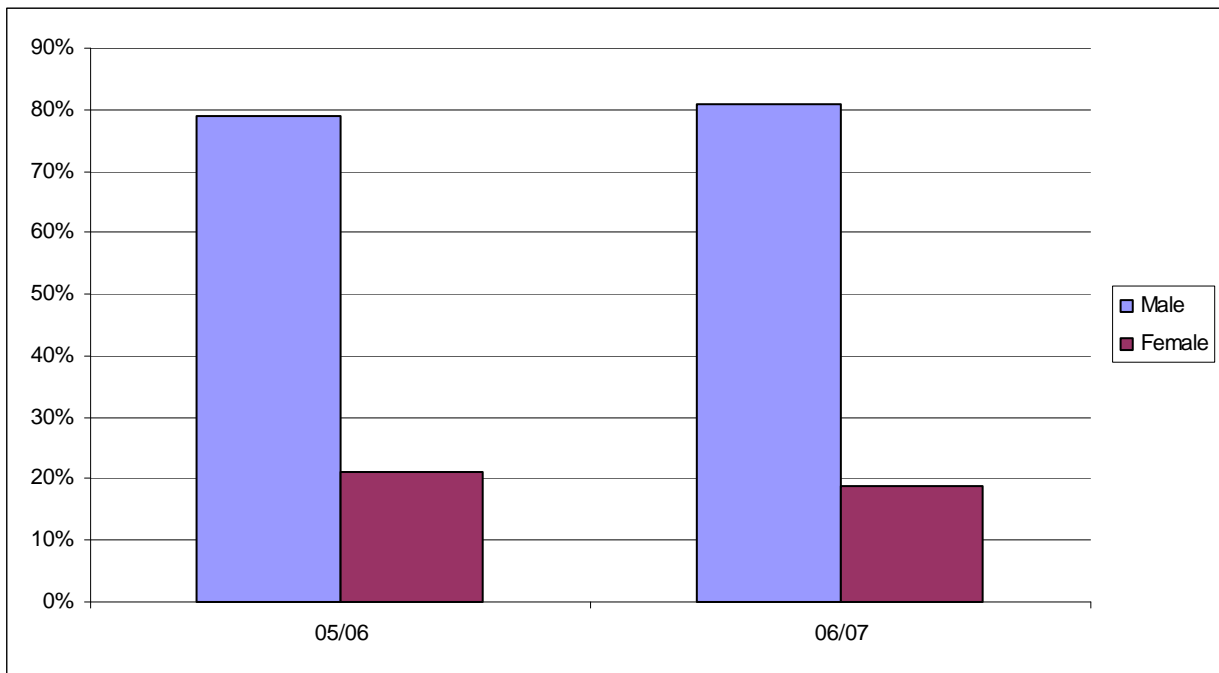
Below we can see a comparison of 'Main drug Stated' between 2005/06 and 2006/07:



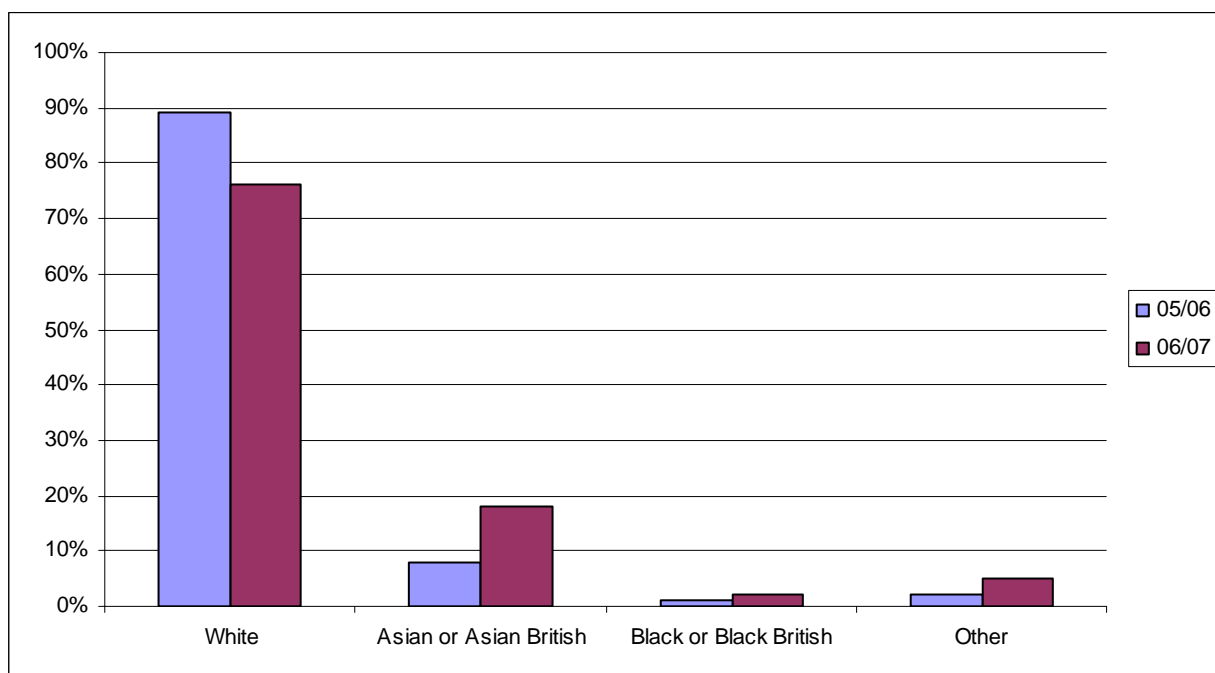
### In treatment within the last year:

The number of people that are showing as in treatment within the last year for 2006/07 is 178. This is compared to a figure of 164 people in 2005/06. 81 % of those were male compared to 79% in 2005/06. 76% were 'White' and 18% were 'Asian or Asian British'. For the previous year 2005/06 these figures were 84% were 'White' and 12% were 'Asian or Asian British'. Only 9% of those people were aged 15-24 years old compared to 13% in 2005/06. 20% stated their injecting status as 'Currently' compared to 1% in 2005/06. The reason for this increase is due to recording issues encountered in 2005/06 by ADS Oldham.

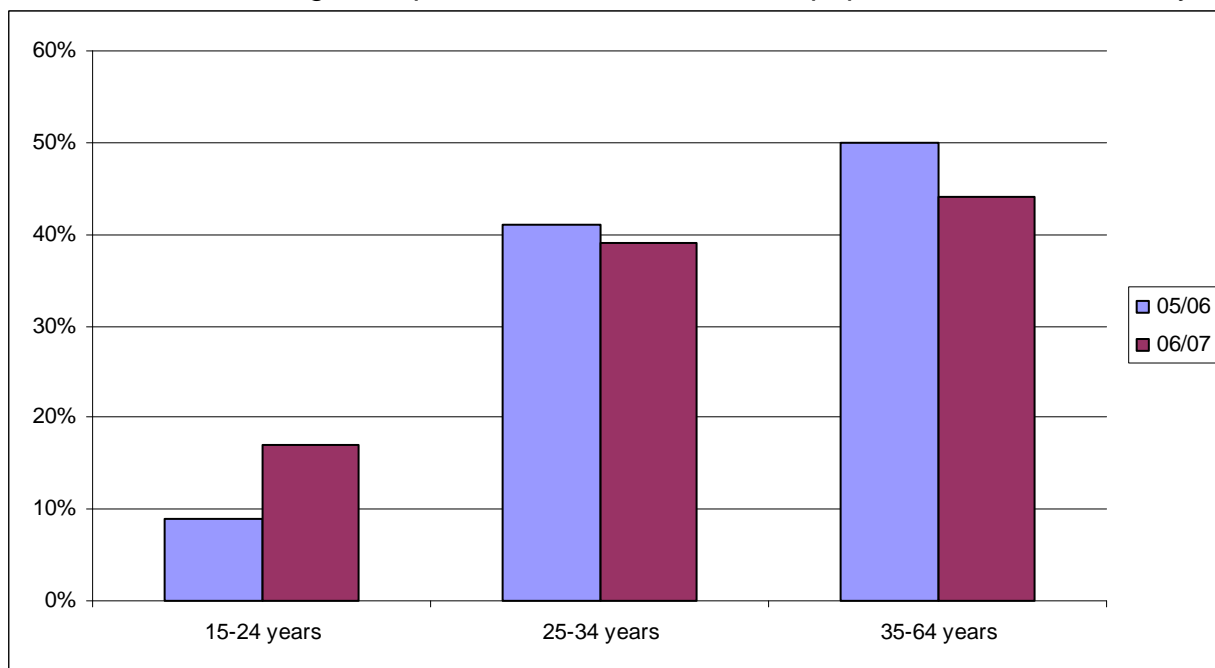
Below we can see a comparison of Gender for the 'in treatment' population within the last year:



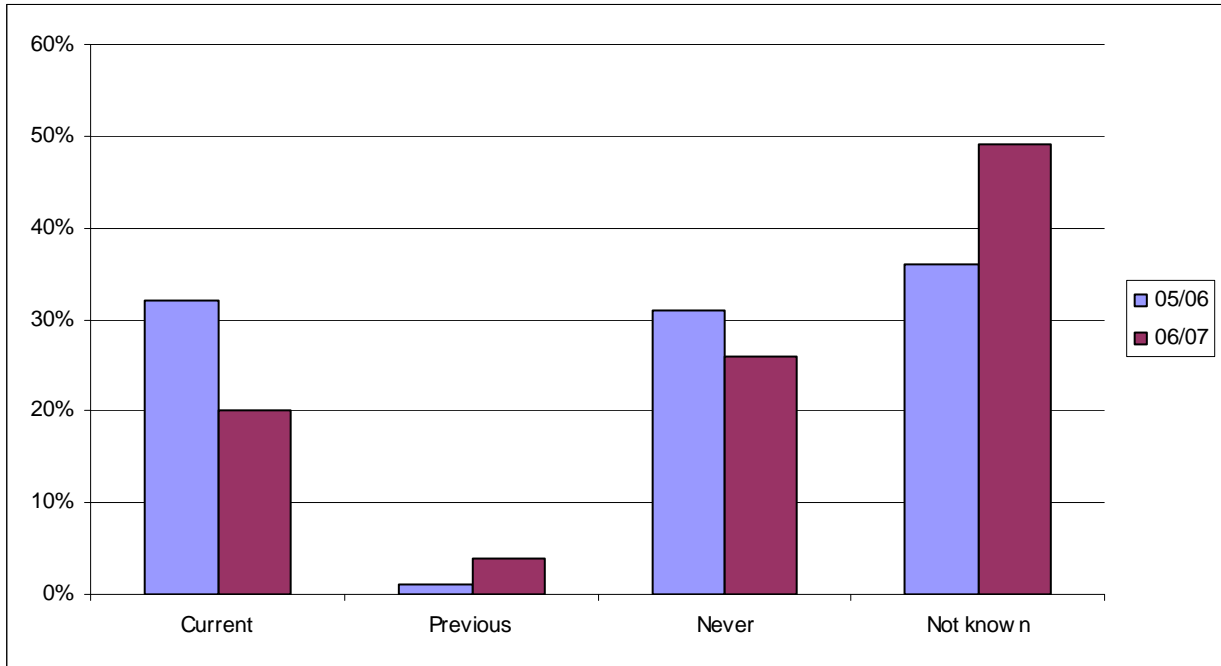
Below we can see a comparison of ethnicity for the 'in treatment population' within the last year:



Below we can see the age comparison for the 'in treatment population' within the last year:



Below we can see the injecting status for the in treatment population within the last year:



### **Known to treatment but not within the last year:**

The total number of people that belong to the 'Known to treatment, but not treated last year' is 158 people. 82% of those were male, with 84% stating their ethnicity as 'White'. The main age group for this cohort of people is 35 – 64 years old, with 49% falling into this category. This is closely followed by 41% falling into the 25 – 34 category. The data shows that 89% of these people are recorded as having an injecting status of 'Not Known'. This is due to reporting issues in previous years from recording agencies. It is for this reason that we are also unable to make comparisons with the 2005/06 period. This information shows us that the people who are not currently accessing treatment are predominantly an older white population. This would also match with the information that we have showing the people that are currently in treatment.

### The 'treatment Naïve' population:

If we look at all the data that is available to us for 2005/06 and 2006/07 we can make some informed conclusions as to what the hidden population may look like.

Based on this data and the fact the Bulls Eye model highlights that there are 268 people still 'unknown to treatment' we can deduce the following figures:

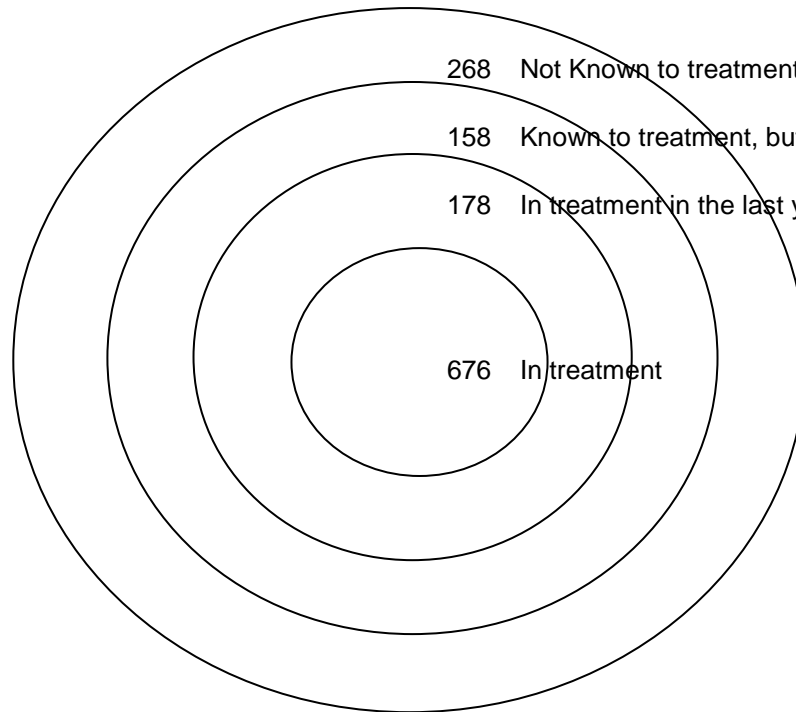
<b>Gender</b>		
Male	72%	210
Female	28%	58
<b>Ethnic group</b>		
White	83%	222
Asian or Asian British	13%	36
Black or Black British	1%	3
Other	3%	7
<b>Age on 30th September 2005</b>		
15-24 years	11%	29
25-34 years	40%	106
35-64 years	49%	131
<b>Injecting Status</b>		
Current	17%	46
Previous	4%	11
Never	19%	52
Not known	59%	157

Using this information we can suppose that 78% (210) of the population will be Male and 83% (222) of the population will belong to the ethnic group 'White'. 13% (36) of the population will belong to the ethnic group 'Asian or Asian British'. The age group of the population will be mainly 35-64 years old (49%) followed by people within the age group 25-34 years old (40%), thus leaving only 11% to fall within the age group 15-24 years old. We can also suppose that 17% of this population will currently be injecting.

Using this hypothesis we can also suppose that the drug breakdown of the unknown population would be as follows:

	Average % 06/07	Estimate
Opiate	62%	166
Crack	12%	32
Cocaine	3%	8
Amphetamine	5%	13
Cannabis	8%	21
Benzodiazepine	8%	21
Other	2%	5

Bulls eye Model for Oldham (the 4 rings):



**Opiate and/or Crack users**

In treatment	676
In treatment in last year	178
Known to treatment, but not treated in last year	158
Total	1012
Prevalence	1280
Not known to treatment	268



# **Treatment map for Oldham DAAT**

Treatment map for all services in 2006/2007

Referrals in: 382

Breakdown:

GP: 26  
 Self: 176  
 Criminal Justice: 83  
 Other: 97

In Treatment 06/07: 1153 (of which 921 have specified Opiate as the main drug of choice)

ADS Oldham: 287  
 Oldham CDT: 866

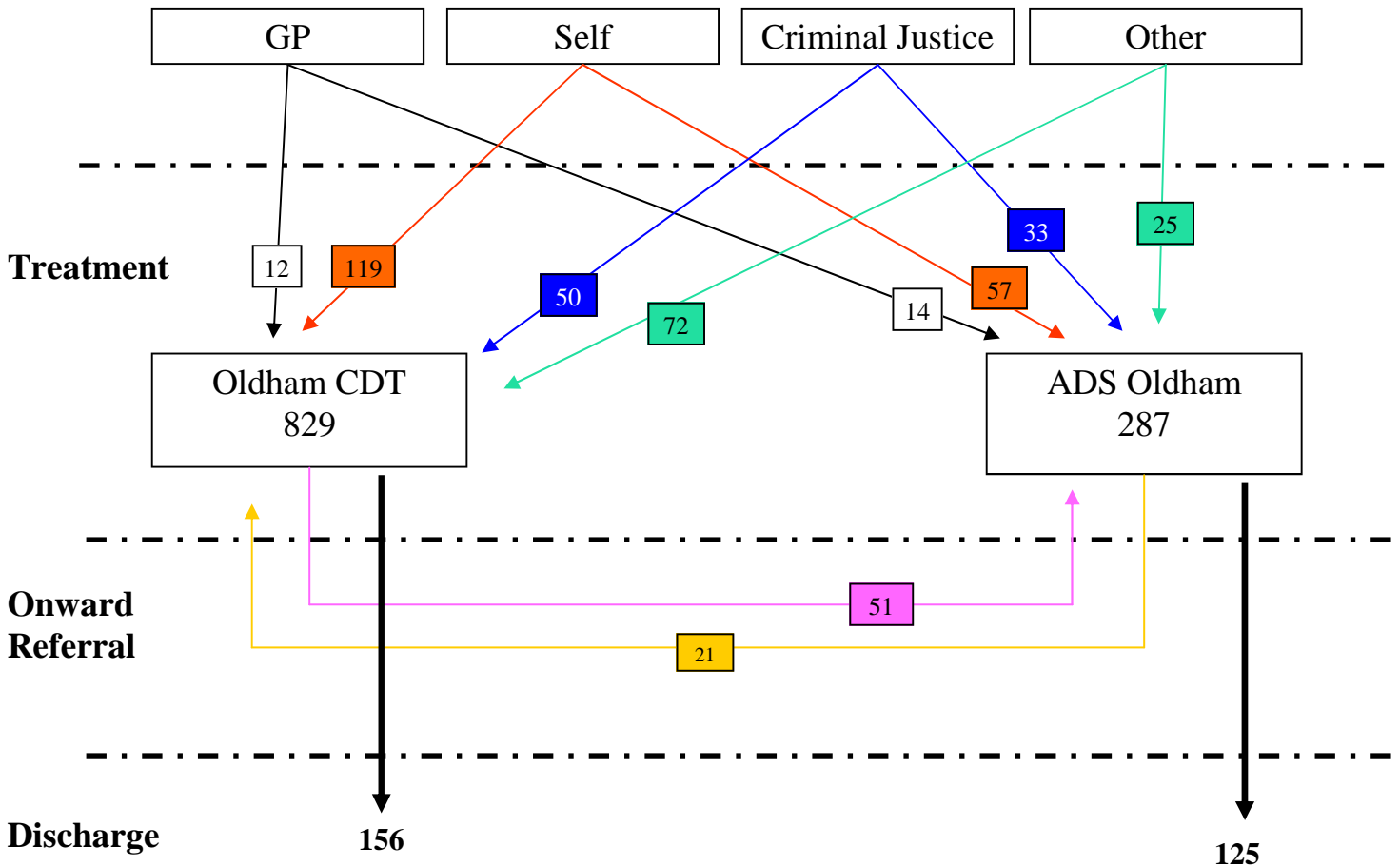
Referrals on within 21 days: 72

All Discharges: 298

Breakdown:

Successful: 75  
 Unplanned: 186  
 Referred on (but not within 21 days): 37

Referral



### **Overview: Referral Source:**

Oldham received **382** referrals in 2006/07. This is a decrease on 2005/06 of 19.2% (91 People). The main referral source in 2006/07 was 'Self' at 176 and this accounted for 46% overall. This was followed by Other, which accounted for 97, 25.3% of the overall figure. Third to this was 'Criminal Justice' with 83, 21.7% of the overall numbers leaving GP with 26, 6.8%.

Of the 382 referrals to Oldham 76.4% were male and 82% were white. The majority of referrals were aged 35 – 64 as this accounts for 40.6%.

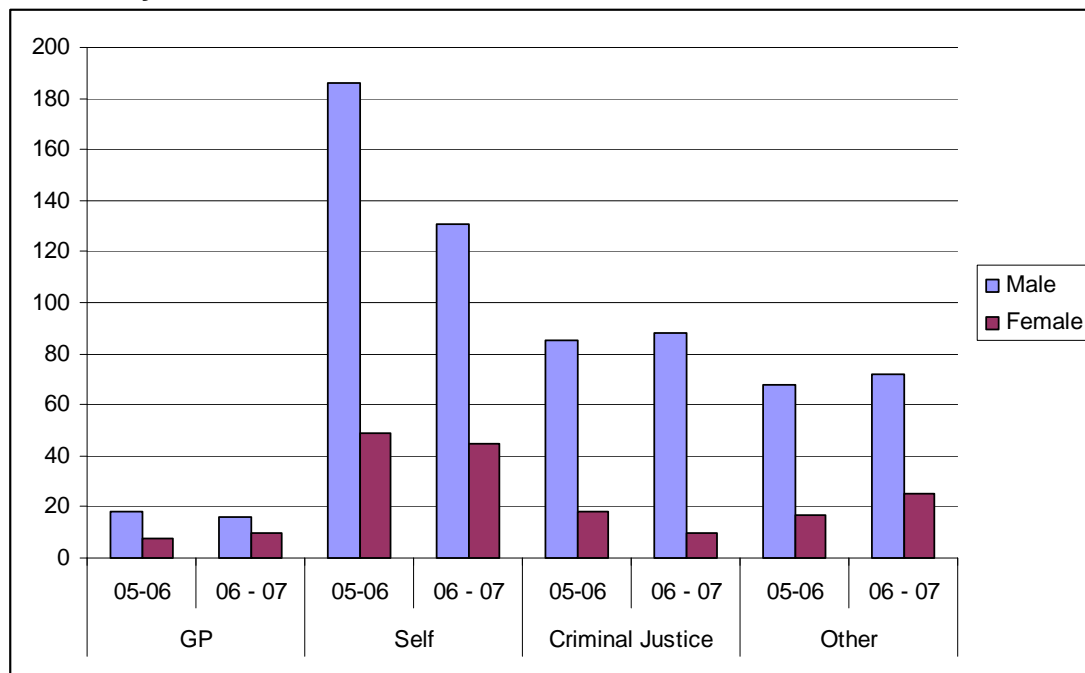
The main drug of choice for all those referred was Opiates which accounted for 66.7%, of which 71.1% had never injected. This is then followed by Cocaine at 10.5%.

### **Referral source by Agency:**

Oldham has two agencies that receive referrals. Oldham CDT (SMS) receives the majority of these. In the period 2006/07 they received 253 referrals of which the largest number came from 'Self'. This accounted for 119 or 47%. Oldham ADS is also similar, they received 129 referrals and the majority of these referrals came from 'Self'. This accounted for 57 or 44%.

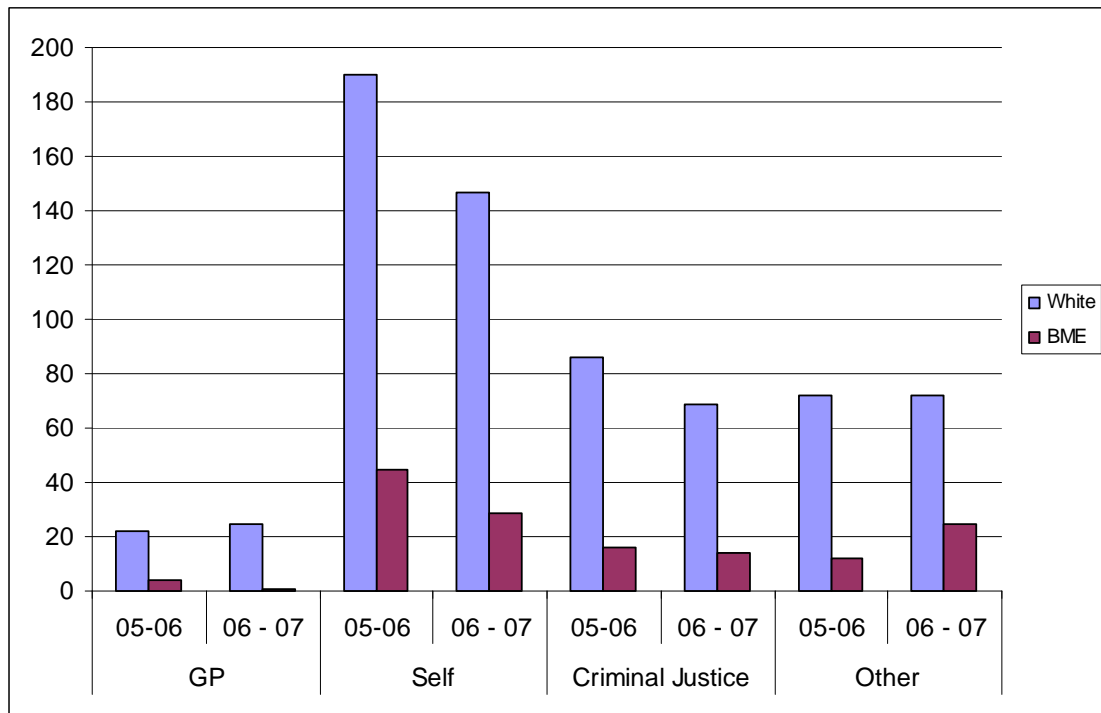
Of the people referring into Oldham CDT (SMS) 75% were male. This is a slight reduction compared to 2005/06 which was 80%. 78% of referrals were 'white' followed by 17% that were 'Asian or Asian British'. The majority of these referrals fell within the 25 – 34 years age group (45%) and 40% of referrals fell within the 35 – 64 age group.

### **Gender by referral source:**



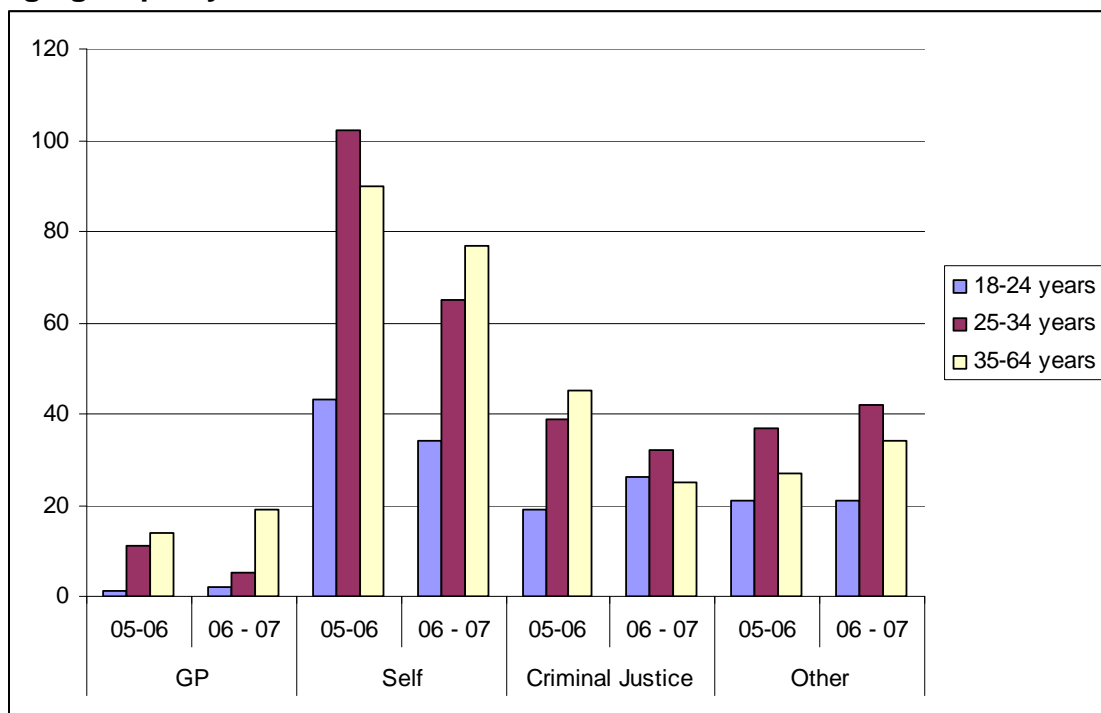
This shows us that the referral source 'Self' presents more females than any other referral source year on year closely followed by referral source 'Other'. However, the second largest referrer of males after 'Self' is 'Criminal Justice' for 2006/07 and 2005/06.

### Ethnicity by referral source:



We can see that 'White' is the majority ethnicity across all referral sources, however more people from other ethnicities present via the 'Self' referral source.

### Age groups by referral:



The referral routes 'Self' and 'GP' have seen an increase in the number of people presenting in 35-64 age group compared to the 2005/06 period. Whereas 'Criminal Justice' and 'Other' referral routes have seen an increase

in the age group 25-34 years old. All routes apart from 'Self' have seen an increase in the number of people aged 18-24 years old presenting.

### **Overview: In Treatment:**

1116 people were in treatment in Oldham in 2006/07 compared to 1247 people in 05/06. Of the 1116 in treatment 394 have been in treatment for over 2 years. Oldham CDT (SMS) had 829 in treatment (74%) compared to 855 in 05/06 which accounted for 68% of the treatment population. Of the 829 people 389 have been in treatment for over 2 years (47%). ADS Oldham had the remaining 287 (26%) in treatment and the remaining 5 (1%) in treatment for over 2 years, this is compared to 392 in treatment within 2005/06 and 45 people in treatment for more than two years at the end of 2005/06. The large fluctuation in numbers for Oldham ADS year on year is mainly due data set and reporting problems prior to this year.

The main age range for those people in treatment was 35-64. In this group there were 566 people which accounted for 50.7% compared to 57% in 05/06. Almost three quarters of those people in treatment were male (74%) and 87% were white in 06/07. This is almost identical to the breakdown for 2005/06.

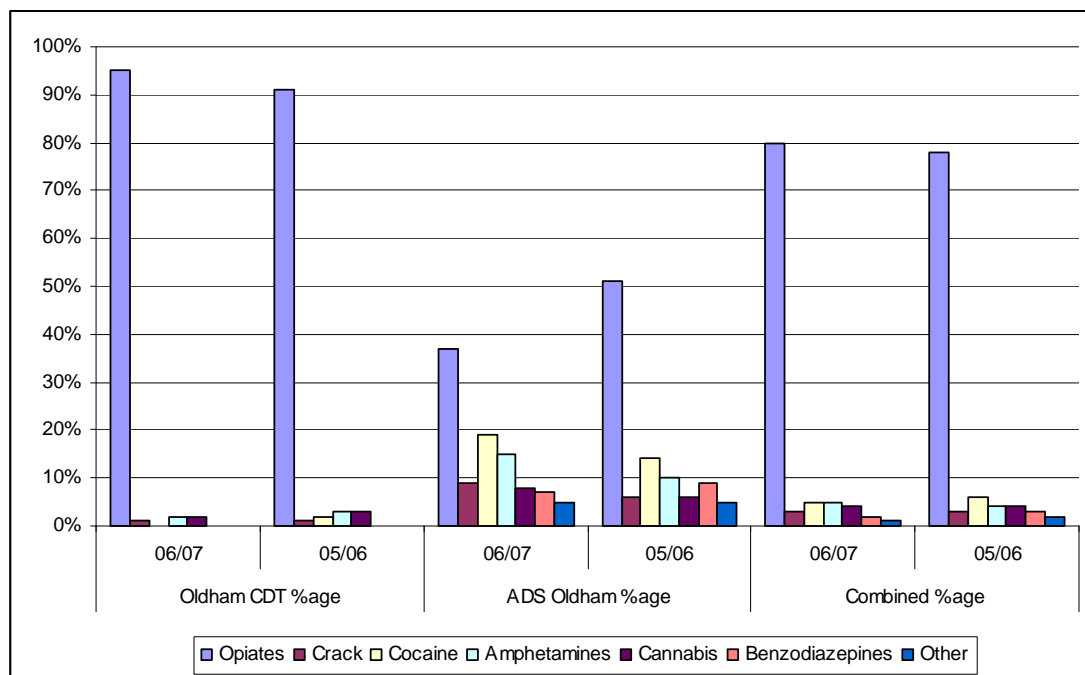
The main drug of choice for those people in treatment is Opiates (80%), followed jointly by Cocaine and Amphetamines at 5%. This breakdown is almost identical to that of 2005/06.

### In treatment by Agency:

Oldham CDT provides the majority of prescribing services within Oldham. During 2006/07 they had 829 people in treatment and 389 in treatment for over 2 years, compared to 855 people in treatment and 345 in treatment for over 2 years in 2005/06. Of the 829 people in treatment through 2006/07 74% were male compared to 75% in 2005/06. 86% classified themselves as 'White' compared to 88% in 2005/06. 10% stated their ethnicity as 'Asian or Asian British' in 2006/07 compared to 9% in 2005/06. The average age group for this service was 35 – 64 which equated to 52% of the clients in 2006/07 compared to 46% in 2005/06. Second to this was the age group of 25 – 34 at 39% in 2006/07 compared to 42% in 2005/06, leaving only 9% of the people in treatment with Oldham CDT to fall within the 18 – 24 age group compared to 11% in 2005/06.

ADS Oldham is mainly responsible for stimulant users and day care and as a result they show a larger number of Cocaine users which is recorded at 19% for 2006/07 compared to 14% in 2005/06 and Amphetamine users recorded at 15% in 2006/07 compared to 10% in 2005/06. ADS Oldham's client population is not dissimilar to Oldham CDT's. The main difference is the drug of choice and this is due to the nature of the services on offer.

### Drug of main choice, Oldham CDT (SMS) compared with ADS Oldham, in treatment:



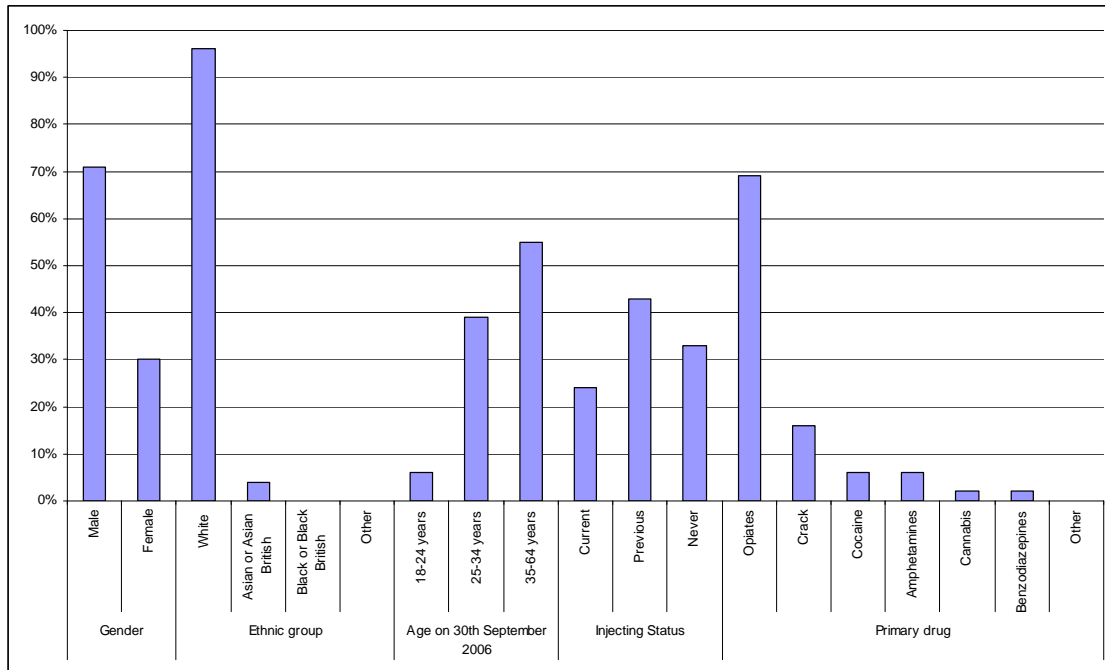
**Oldham overview: Movement within the treatment system.**

There were 72 referrals made between Oldham CDT and ADS Oldham during 2006/07 compared to 155 in 2005/06. Of these the majority were transferred by Oldham CDT (51), thus resulting in the majority of referrals being received by ADS Oldham. This is something that we would expect to see in Oldham as ADS Oldham operates a stimulant service as well as the Structured Day Programme.

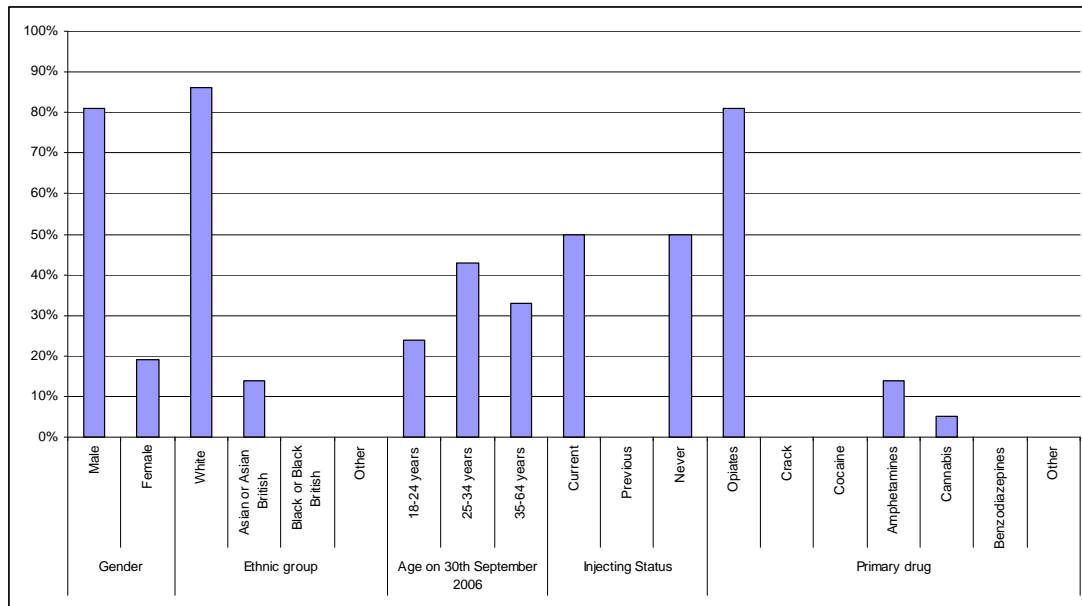
The majority of the transfers were made to ADS Oldham. Of these 71% were male in 2006/07 compared to 75% 2005/06, White 96% in 2006/07 compared to 93% in 2005/06, aged 35 – 64 years old 55% in 2006/07 compared to 41% in 2005/06 and 69% were opiate users in 2006/07 compared to 72% in 2005/06 and 43% had previously injected in 2006/07 compared to 7% in 2005/06.

Transfers made from ADS Oldham to Oldham CDT were 81% male in 2006/07 compared to 88% 2005/06, White 86% in 2006/07 compared to 88% in 2005/06, aged 25-34 years old 43% in 2006/07 compared to 53% in 2005/06 and 81% were opiate users in 2006/07 which is the same in 2005/06 and 50% had never injected in 2006/07 compared to 65% in 2005/06.

**Profile of clients transferred from Oldham CDT to Oldham ADS:**



### Profile of clients transferred from Oldham ADS to Oldham CDT:



The chart above confirms what we would expect in that most of those transferred to Oldham CDT do not have Crack use, this is the case due to the fact that Oldham CDT are the prescribing service in Oldham and ADS Oldham deal predominantly with stimulant clients.

## **Overview: Treatment exits**

There were 281 discharges from the treatment service in the period 2006/07, compared to 283 in 2005/06. Of those discharged 27% were classed as successful in 2006/07 compared to 19% in 2005/06, 62% unplanned in 2006/07 which is a reduction compared to 2005/06 which showed 72% unplanned and 11% were transferred onto another agency with is an increase of 3% compared to 2005/06. Oldham CDT had 156 discharges and ADS Oldham had 125 in 2006/07, this is compared to 193 discharges for Oldham CDT and 90 for ADS Oldham in 2005/06. Of those discharged as successful 79% were male which is a marked increase on the previous year which was 73%, 81% stated their ethnicity as 'White' in 2006/07 compared to 89% in 2005/06, 44% were recorded as being in the 35- 64 age group in 2006/07 this shows that the majority age group is different compared to last year which was 47% of the cohort belonging to the 25-34 age group and 56% stated Opiates as their main drug of choice which is a dramatic increase on the previous year which was 29%.

### **Agency exit outcomes:**

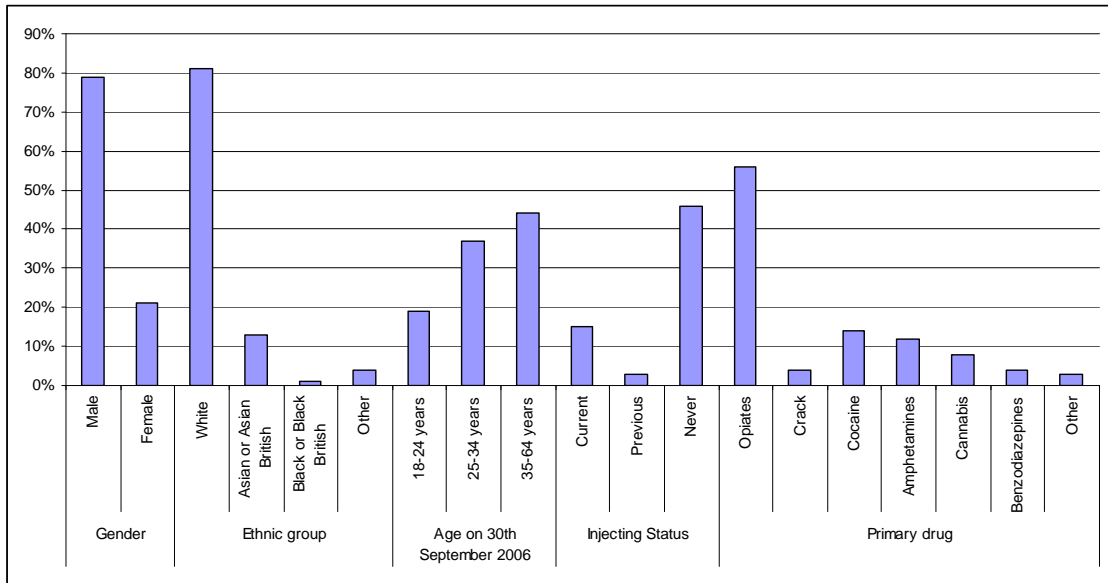
Oldham CDT discharged a total of 156 clients in 2006/07 compared to 193 clients in the period 2005/06. The majority of discharges were unplanned at 65% compared to 75% in the previous year. The majority of clients discharged whether successfully or unplanned were opiate users 88% compared to 78% in 2005/06. Of those discharged successfully 40% were aged between 35 – 64 years old which is a change compared to the previous which had 46% aged between 25 – 34. Of all the planned discharges 58% stated their ethnicity as white, compared to 84% in 2005/06. For the period 2005/06 we were not able to determine the Injecting Status of the cohort due to recording issues however, in the period 2006/07 we can now see that of all the planned exits 42% stated that they were currently injecting.

ADS Oldham discharged a total of 125 clients in 2006/07 compared to 90 during the 05/06 period. The main drug of choice on discharge stated was cocaine, with 30% stating this compared to 28% in the previous year. The majority of these clients fell within the 35 – 64 age group with 45% stating this as their age compared to 46% in 2005/06.

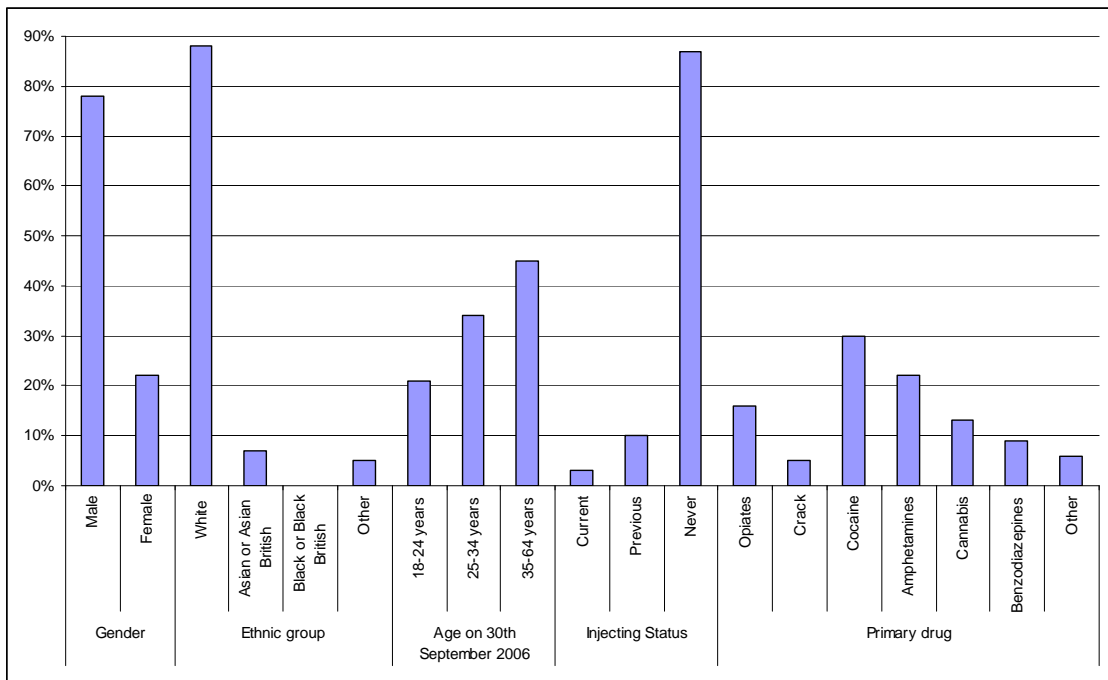
42% of these discharges were recorded as successful. This is an increase of 6% compared to the previous year. Of all the clients discharged successfully 49% stated that their main drug of choice was 'Cocaine' compared to 44% in 2005/06. This cohort of people stated that 42% had an age which fell within the 35 – 64 banding compared to 44% last year.

We would like to state that during the period 2005/06 there were data recording issues with ADS Oldham and as a result some of the year on year figures may be more exaggerated than is actually correct.

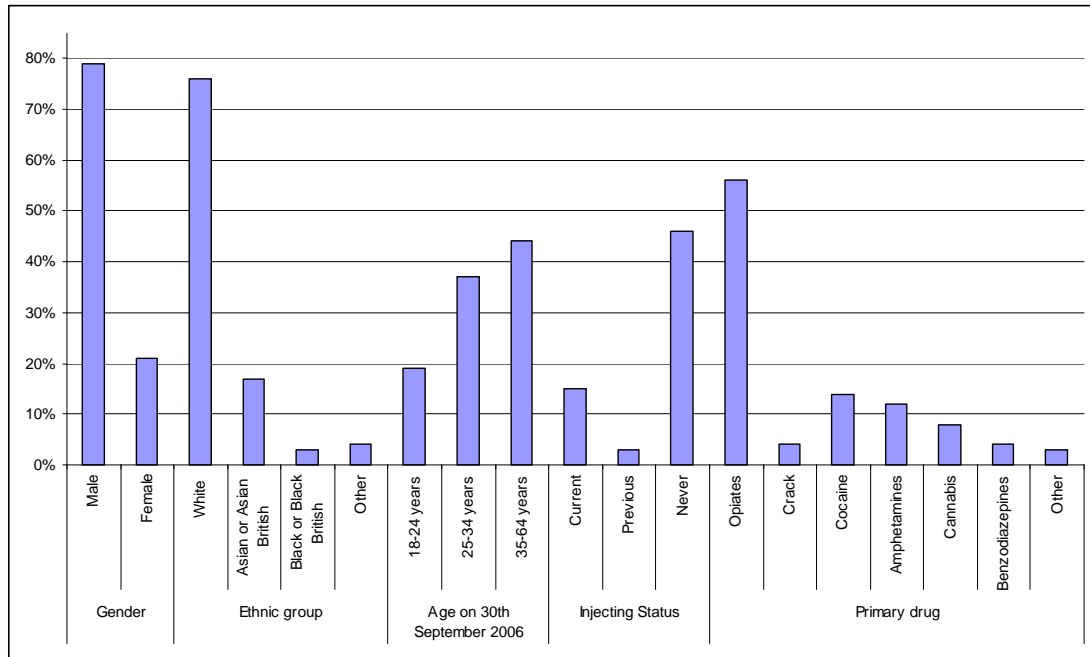
### Profile for ADS Oldham and Oldham CDT combined:



### Profile for ADS Oldham:



## Profile for Oldham CDT:





# **Retention within Oldham**

Retention of all people retained with new presentations in  
2006/2007

## **Partnership client profile 2006/07:**

Gender	Local	Region	National
Male	76	74	74
Female	24	26	26

Age	Local	Region	National
Under 25yrs	26	18	21
25 - 34yrs	36	42	45
Over 35yrs	38	40	34

Ethnicity	Local	Region	National
White	82	93	83
Mixed	2	1	3
Asian	14	2	4
Black	1	1	5
Other	1	0	1

Main Drug	Local	Region	National
Opiate	54	45	48
Crack	3	3	6
Opiate and Crack	12	25	22
Other stimulant	17	15	12
Cannabis	9	9	9
Benzodiazepines	2	1	1
Other	3	2	2

Discharge Reason	Local	Regional	National
Planned discharge	28	19	23
Unplanned discharge	59	62	61
Referred on	12	19	16

Referral Route	Local	Region	National
DIP Clients	17	9	10
CJS Clients	29	28	29
Non CJS Clients	71	72	71

Retention	Local	Regional	National
Triaged only	8	6	6
Less 12 weeks	14	17	19
12+ weeks	78	77	75

Looking at this data we can see that locally the ratio of females retained in treatment is 24% which is only 2% lower than the national and regional averages. This is a steady increase compared to the 2005/06 overall retention rate which showed that 20% of the retained treatment population were female compared to a national average of 26%.

The ratio of people being retained in treatment who are under the age of 25 has seen a dramatic increase on the previous year. In 06/07 this equated to 26% whereas in 05/06 the figure was only 20%, which was 3% lower than the national average. During 06/07 we have also seen that Oldham has risen above the national average by 5% and also 8% above the region. This data also shows that Oldham is above the regional average by 4% for people aged over 35. However, for the age group 25 – 34 years Oldham is still considerably lower than the national and regional averages.

If we look at the Ethnicity figures for Oldham we can see that the number of people recorded as 'Asian' is significantly higher than the rest of the region and the nation. Oldham has recorded a figure of 14% compared to 2% regionally and 4% nationally. The number of people recorded as 'Asian' in 05/06 was recorded as 13%. If we combine all of the non 'White' groups together we can see that Oldham is currently running at 18% compared to 4% for the region and 13% for the nation. The overall BME population as recorded in 05/06 is 15% compared to 6% regionally and 12% nationally.

The number of people that are recorded as Opiate users in Oldham is 6% greater than the national figure of 48% at 54% and 9% greater than the regional average. This is a reduction of 10% compared to 05/06. The number of people recorded as being either a crack user or opiate and crack user is lower than the national and regional averages. The number of people recorded as using 'Other stimulant' is also 5% higher than the national average and 2% higher than the regional average at 17%

When looking at the discharges 12% have been recorded as 'referred on' compared to only 3% in 05/06. However the 06/07 figure is 4% lower than the national figure and 7% lower than the regional figure. Unplanned discharges were 59% which is 2% lower than the national average. This is a 13% increase compared to the 05/06 period which was 46%.

If we look at the referral route data we can see that the predominant referrer is Non CJS at 71%. This figure is the same as the national average and 1% lower than the Regional average. Oldham does have a high level of referrals from DIP compared to the national and regional averages. Overall CJS referrals are the same as the regional and national averages. Unfortunately it is not possible to compare the retention referral rates with the period 05/06 as they were not available.

If we finally look at the retention figures we can see that 8% are recorded as 'triaged only' compared to 6% both nationally and regionally. This is half the figure that was recorded in 05/06 of 16%. The less than 12 week retention figure is 14% compared to 17% regionally and 19% nationally. This is compared to 11% in 05/06. The numbers kept in treatment for 12+ weeks is slightly higher than the national average of 75% at 78% and slightly higher than the regional figure which is 77%. This is a 1% decrease compared to last year

at	76%.
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## Partnership Treatment Exit reasons:

### Overall discharges

	Planned discharges	% planned discharge	Unplanned discharges	% unplanned discharge	discharges referred on	% referred on
Total	53	28%	111	59%	23	12%
North West	1265	19%	4024	62%	1239	19%
National	8991	23%	23795	61%	6390	16%

### Retained Exits

	Planned Exits retained	% planned discharge	Unplanned Exits retained	% unplanned discharge	Exits referred on	% Exits referred on
Total	33	33%	63	63%	4	4%
North West	824	24%	1939	57%	650	19%
National	5685	29%	10633	55%	3138	16%

### < 12 weeks Exits

	Planned Exits retained < 12 weeks	% Planned Exits retained < 12 weeks	Unplanned Exits retained < 12 weeks	% Unplanned Exits retained < 12 weeks	Exits referred on < 12 weeks	% Exits referred on < 12 weeks
Total	14	25%	32	57%	10	18%
North West	393	17%	1436	63%	445	20%
National	2926	20%	9506	65%	2291	16%

### Exits triaged only

	Planned Exits triaged only	% Planned Exits triaged only	Unplanned Exits triaged only	% Unplanned Exits triaged only	Referred on Exits triaged only	% Referred on Exits triaged only
Total	6	19%	16	52%	9	29%
North West	48	6%	649	77%	144	17%
National	380	8%	3656	73%	961	19%

The table above shows all exits from treatment for the period 06/07. This data is split into 4 groups:

- **Overall discharges** – summary of all treatment exits within Oldham
- **Retained Exits** – these are all the people who have been engaged in treatment for more than 12 weeks with Oldham.
- **< Than 12 weeks exits** – these are all the clients that have commenced interventions but have been discharged under 12 weeks in Oldham.
- **Exits triaged only** – these are all the clients that have been discharged under 12 weeks but have not had interventions commenced.

**Overall discharges:**

Oldham's planned discharges for the period are 5% higher than the national average at 28% and 9% higher than the regional average. As a result unplanned discharges are lower than national and regional averages at 59%. However, the number of people referred on is recorded at 12%, this is 4% lower than the national average and 7% lower than the regional average.

**Retained exits:**

Planned discharges in Oldham are higher than the national and regional averages at 33%. Oldham also has a higher unplanned discharge rate of 63% compared to 55% nationally and 57% regionally.

**< 12 weeks Exits:**

Oldham again has a higher number of people leaving the system in a planned fashion than both the region and nation at 25%. Also the number of unplanned exits is recorded at only 57% compared to 65% nationally and 63% regionally. In this cohort of people the number referred on is 18% which is in between the regional and national figures.

**Exits triaged only:**

The figures for this category show us that Oldham is significantly higher than both the region and the national figures at referring people on, with a figure of 29%. Oldham also has a considerably lower number of unplanned exits at only 52% compared to 73% nationally and 77% regionally. In addition to these two figures we can also see that Oldham is extremely higher than other areas at planned exits in this cohort at 19% compared to 8% and 6% nationally and regionally.

Overall we can see that Oldham has a high level of planned discharges for all exits with a lower unplanned discharge rate. This informs us that interventions being offered and provided to clients have a more successful outcome than other areas. However, we can also see that we have a lower referral on rate.

Oldham is predominantly more effective with people who are discharged having only had a triage. Oldham is much more effective at transferring people on at this stage compared to other stages due to Oldham having clearly defined and structured agencies. This definition allows workers to ensure that the client is directed to the appropriate service at the triage stage.

The number of people transferred on whilst being in treatment for over 12 weeks is considerably lower than the rest of the country. This could be due to the fact that Oldham's treatment providers are very diverse and flexible in the services that they offer, and when a client has engaged with treatment in the appropriate specific agency all the clients needs can be addressed within that agency.

This data demonstrates that Oldham is more successful at engaging clients and retaining them compared to other areas.

## **Agency Client Profile:**

### Retention - agency profile

	%	%
<b>Gender</b>	ADS	SMS
Male	79	75
Female	21	25

<b>Age</b>	ADS	SMS
Under 25yrs	31	17
25 - 34yrs	27	43
Over 35yrs	42	40

<b>Ethnicity</b>	ADS	SMS
White	90	78
Mixed	1	7
Asian	7	18
Black	1	1
Other	2	1

<b>Main Drug</b>	ADS	SMS
Opiate	25	75
Crack	6	1
Opiate and Crack	6	16
Other stimulant	38	4
Cannabis	14	3
Benzodiazepines	5	0
Other	7	0

	%	%
<b>Discharge Reason</b>	ADS	SMS
Planned discharge	48	12
Unplanned discharge	51	63
Referred on	1	25

<b>Referral Route</b>	ADS	SMS
DIP Clients	23	15
CJS Clients	37	27
Non CJS Clients	63	73

<b>Retention</b>	ADS	SMS
Triaged only	18	6
Less 12 weeks	23	10
12+ weeks	59	84

Looking at this data we can see that locally ADS Oldham have more women in treatment than Oldham CDT with 21%.

Looking at the age groups for the two agencies we can see that ADS Oldham are seeing more of the younger adult population. This is mainly due to the fact that ADS Oldham are the boroughs Stimulant provider and research within the borough has shown that the stimulant cohort is mainly a young one.

Oldham CDT has a significantly higher number of people who are recorded as 'Asian' compared to ADS Oldham, Oldham CDT has seen a steady increase in the numbers of people recorded as 'Asian' over the past two years.

The main drug profiles for Oldham CDT and ADS Oldham are what we would expect to see. ADS Oldham has a higher number of stimulant users and a lower number of opiate users as they are the main suppliers of the stimulant services and Structured Day Care within the borough. Whereas Oldham CDT has a higher number of people recorded as Opiate users. Again we would expect to see this, as Oldham CDT is the main provider of Tier 3 prescribing services.

ADS Oldham has a significantly higher level of Planned discharges compared to Oldham CDT. This is mainly due to the fact that as a provider of stimulant

services in the borough and Structured Day care services the interventions that are offered are over a shorter period of time and as such have a much more structured outcome process. In addition to this we can also see that Oldham CDT have carried out the majority of transfer on exits. This is mainly due to the fact that clients are referred/self present to Oldham CDT due to an opiates being the main drug of choice and at the initial assessment/triage other drugs can be identified, thus leading to a referral to ADS Oldham for these issues.

Referrals from DIP are the highest into ADS Oldham at 23% compared to only 15% for Oldham CDT. This would confirm what we are seeing in the DIP currently, in that predominantly clients are testing positive for stimulants, a summary of which can be seen in appendix 1. However, the number of people that have come from 'Non' criminal justice routes is 10% higher in Oldham CDT. This can be due to GP and healthcare professionals referring directly in for this type of drug as well as people self presenting.

If we finally look at the retention figures we can see that ADS Oldham has much higher level of people being triaged at 18% compared to Oldham CDT at 6%. This is due to the profile of the client group that they are seeing. ADS Oldham do not offer a substitute prescription service and as result the service sees a higher number of people not continuing into treatment. Oldham CDT do offer a prescription service and have more success in retaining people for longer than 12 weeks. They have recorded that 84% have been retained for 12 weeks or ore compared to 59% in ADS Oldham.

This table shows a comparison of the two agencies within Oldham.

**Overall discharges**

	Planned discharges	% planned discharge	Unplanned discharges	% unplanned discharge	discharges referred on	% referred on
ADS	46	48%	49	51%	1	1%
SMS	13	12%	69	63%	27	25%

**Retained Exits**

	Planned Exits retained	% planned discharge	Unplanned Exits retained	% unplanned discharge	Exits referred on	% Exits referred on
ADS	24	60%	15	38%	1	3%
SMS	12	18%	48	74%	5	8%

**< 12 weeks Exits**

	Planned Exits retained < 12 weeks	% Planned Exits retained < 12 weeks	Unplanned Exits retained < 12 weeks	% Unplanned Exits retained < 12 weeks	Exits referred on < 12 weeks	% Exits referred on < 12 weeks
ADS	17	50%	17	50%	0	0%
SMS	0	0%	19	68%	9	32%

**Exits triaged only**

	Planned Exits triaged only	% Planned Exits triaged only	Unplanned Exits triaged only	% Unplanned Exits triaged only	Referred on Exits triaged only	% Referred on Exits triaged only
ADS	5	23%	17	77%	0	0%
SMS	1	6%	2	13%	13	81%

The table above shows the exit patterns for the two treatment agencies within Oldham

**Overall discharges:**

As we can see ADS Oldham has significantly more Planned Discharges than Oldham CDT. This is mainly due to the fact that ADS Oldham deals predominantly with stimulant users and as such has generally shorter programmes for their interventions which allows the interest of the client to be held for longer whilst the outcomes are achieved.

Oldham CDT has a much higher level of people being transferred on. This is due to the fact that they are the main providers of prescription services within the borough and such when the primary opiate use has been addressed it is often then identified that the client can have secondary use of other substances, of these substances Stimulants are the main choice and as a result these clients are then referred onto ADS Oldham for stimulant work and structured day care interventions.

**Retained exits:**

The data that is available within this section demonstrates the same principles as the data that is in Overall discharges.

### **< 12 weeks Exits:**

When looking at the number of people that have been retained for under 12 weeks we can see that the trends are the same as in the other categories. ADS Oldham has 50% with planned exits whilst Oldham CDT has none. Oldham CDT is the largest referrer on with 32% compared to 0% for ADS Oldham.

### ***Exits triaged only:***

The trends in this category are somewhat the same as the above categories apart from the fact that ADS Oldham has a large number of people who are recorded as Unplanned exits with 77% compared to 13% at Oldham CDT. This is mainly due to the type of client that ADS Oldham serves, as the main provider of interventions for Stimulant work and Structured Day Programmes the average client seen is a young chaotic person who feels that their drug use is something that is acceptable as they partake in it with their friends and as a result have a tendency to walk away from service at or before triage because they feel that they 'do not belong there'.

Over all we can see that the trends within each agency are what we would expect to see. However, there are a large number of people exiting from ADS Oldham at Triaged only, this is something that we can look at addressing, this could be due to inappropriate referrals, services available or the location in which these services are being offered.

## **Tier 4 Treatment map for Oldham DAAT**

The data returned for Tier 4 treatment within Oldham does not display the accurate picture.

This is due to the fact that Oldham operates a Tier 4 service out of the Local Hospital, however, this service has never been setup as an NDTMS Reporting agency.

As a result of this Oldham need to setup this service as a Tier 4 reporting agency as a priority.

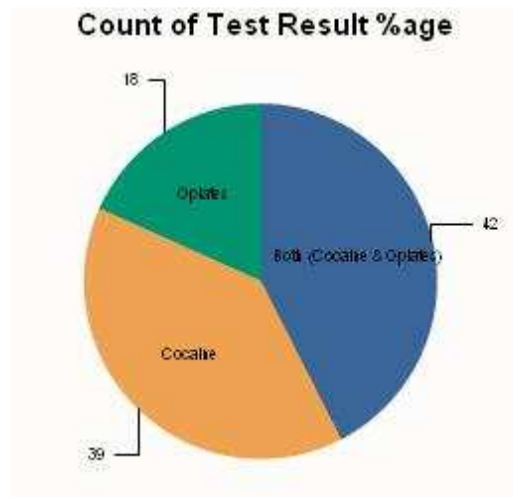
## Appendix 1

Below is the data for April – November 2007

Total number of positive tests: 419

Total number of individuals testing positive: 326

	Total Both (Cocaine & Opiates)	Cocaine	Opiates
<b>Total</b>	<b>419</b>	<b>178</b>	<b>77</b>
April 2007	46	24	8
May 2007	50	22	11
June 2007	61	19	14
July 2007	49	17	14
August 2007	61	29	9
September 2007	46	23	5
October 2007	48	17	10
November 2007	58	27	6

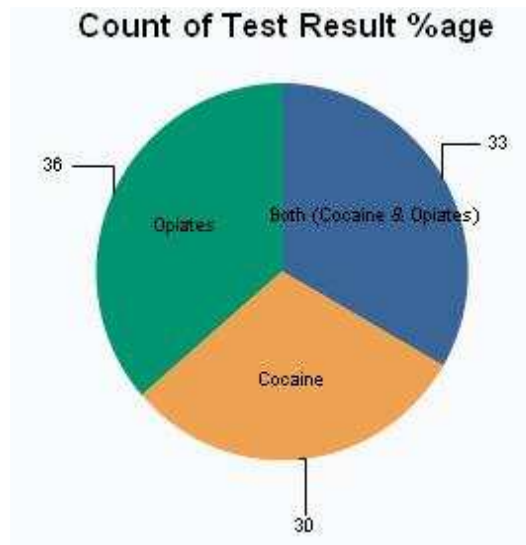


The data below shows the same period last year:

**Total number of positive tests: 426**

**Total number of individuals testing positive: 329**

	TotalBoth (Cocaine & Opiates)	Cocaine	Opiates
<b>Total</b>	<b>426</b>	<b>142</b>	<b>155</b>
April 2006	59	18	28
May 2006	45	16	16
June 2006	63	22	25
July 2006	53	17	18
August 2006	55	25	16
September 2006	47	12	14
October 2006	54	13	15
November 2006	50	19	23



This data shows us that despite the fact that there has only been a 2% reduction in the number of people testing positive there has been a significant reduction in the number of people testing positive for opiates year on year, this reduction equates to 50%, it also shows us that there has been a 21% increase in the number of people testing positive for cocaine. As a result we have also seen a 20% increase in the number of people testing positive for both.

## Appendix 2

### Treatment Workers consultation Group

#### Group work 1

A. What do we do with those clients who just want methadone maintenance? What is the minimum level of service, which is safe, moral and builds in systems to ensure that there are mechanisms to motivate clients to 'move on' to abstinence or move on in their lives? (15 minutes)

#### 7<sup>th</sup> January 2008

Staff did appear to be perplexed by this question, and much time was spent teasing out which client group we meant. Staff appeared quite 'protective' about seeing people regularly and seeing people less frequently was a difficult concept to point out. They were concerned that we may 'not catch people when most motivated' etc... I pointed out that we were talking about the 'I'm okay leave me alone type client' and also that there would be a systematic review process. I think that had this group would have been better having first an awareness of question b first to improve the relevance of question a.

With such, suggestions for minimum standards were:-

- At least monthly appts?
  - To ensure minimum medical review.
  - Clients having options around this issue.
  - Contingency planning (so client could phone anytime etc)
  - Improved duty sessions
  - Groups to cover some bare minimum facts including:
    - a) harm minimisation
    - b) relapse prevention
    - c) blood borne viruses
    - d) Methadone group ( to talk about using it properly etc).
- This would ease time up for the workers.

B. Can we organise our treatment system so that staff with the right skills and experience are involved in the critical work of psychosocial intervention to help clients address their addiction.

We need to recognise that assessment of clients, managing prescribing and monitoring progress eg TOPs etc also involve a high level of clinical skill however if we don't release staff to do this work what is the likely impact on their job satisfaction? Discuss and look at possible models to 'unlock' the situation. (15 minutes)

#### 7<sup>th</sup> January 2008

- Improved admin support to help eg with filing, typing, data imputing – need to be full time and not just undertake reception responsibilities.
- Reduce caseloads – varies depending on role. Therefore need more staff.

- Message receiving – don't need to see clients more than twice a month.
- Improved working environment for clients and staff.
- 'One stop shop' a variety of services under one roof.
- Prescription clerk/Data Clerk – often joint role (Tameside/Rochdale have this model).
- 1/3 of workers time is spent data inputting/filing.
- Joint funded posts often result in additional admin burdens.
- 'Induction' Team may be useful to introduce clients to services, triage, Hep C vaccinations etc, abstinence offer.

## **Group work 2**

Would ACCE clients and those in recovery (matured out) mix together? What are the pros and cons? Are there some 'ACCE style' activities, which would help the recovery clients to avoid relapse. (10 minutes)

## **Abstinence workshop**

Do presentation up to the 12 steps slide .....

Then.....

**Get group to pick out the elements from the 12 steps model which you think contribute to its success. (10 minutes)**

Then do last slide – elements of the model

Then.....

**Get group to look at what elements could be adopted to make up a CBT based model or a 'God free' model, which would do the job – could it be community based? 10 minutes**

**What is the range of abstinence-based services that we should work towards offering in Oldham? Who could/should be involved in the delivery? (10 mins)**

## **Housing and 12 step treatment workshop**

After the presentation discuss...

Advantages and disadvantages of House on the Hill vs local model

Groups which would benefit most from HoH or Local (10 mins)

## **RAMP**

How could we make RAMP work in Oldham – (NB ACORN/ADAS have been approached by Kenyon House to deliver RAMP in GM would that work for us or do we need a local Oldham based model?)

**7<sup>th</sup> January 2008**

Needs to be kept local to retain clients and run alongside Treatment providers

How should we offer the therapeutic intervention of the programme? Tender out? utilise existing resources or a combination?

**7<sup>th</sup> January 2008**

Depends on skill base of local staff

Is there a market? Could we join forces with Tameside? (15 mins).

**7<sup>th</sup> January 2008**

- Would be difficult to get off ground initially, but yes by joining with Tameside, would give clients ability to move out of area for a short time if required.
- General point for immediate action – Need to be 3 way meetings between SMS worker, Threshold and client going forward.
- Threshold needs to attend staff meetings in Oldham

## Appendix 3

### CONSULTATION ON THE 'DRUGS: OUR COMMUNITY, YOUR SAY' PAPER

#### **SECTION A: BUILDING A NEW DRUG STRATEGY**

**1a. Are these the right aims for the strategy?**

**1b. Which are the most important and why?**

#### **SECTION B: YOUNG PEOPLE, EDUCATION AND FAMILIES**

**2. What is the most effective way to keep children off and away from drugs?**

- Disenfranchised young people and experimental young people are two target groups
- Empower young people to have coping skills and resilience
- Experiment – normal – allow information to be available so that it can be done safely
- Build coping mechanisms
- Availability of structured meaningful/activities!

**3. How should parents, guardians and carers be supported to protect children from using drugs?**

- Schools need a robust mechanism of communicating about drugs
- Information shots annually
- Distributed at school gates etc information for parents
- How to talk to your children about drugs – 2 way, communication between child and parent e.g. Stan's book about drugs, incorporate into Parenting Strategy, extended schools
- Face to face support
- Drug information, where to find it, schools news
- Newsletters
- Structured role on programme, regular alerts
- Multi - agency family directory
- Extended schools agenda

**4. What needs to happen to achieve more effective joint work between children's services and drug services in support of young people?**

See Q 5

**5. What might an effective system look like that identifies problems early, provides integrated prevention services and ensures that other services are available when required?**

Family teams work:

- Screening, Tier 2 intervention in primary schools
- A&E, Primary Care to pick up children presenting at an early age
- System process to trigger direct referrals to substance misuse services

Children's workforce:

- National training to deal with young people and substance misuse
- Make staff accountable for referrals

**6. What needs to happen to ensure that children's and adult services work together effectively to safeguard and improve the well-being of children and young people affected by substance misuse?**

- Information sharing – good practice and systems established
- Implementation of Contact point
- System to pick up young children at the earliest stage
- Pick up children via adult services – automatic referral to Children Of Substance Misusing Others (COSMO) service if parents are in drug service
- Information sharing, good practice, system process
- Screening at early stages
- Early intervention service in schools
- Parenting Network

**7a. What role should education in schools and other settings play in reducing the harms caused by drugs?**

- Good accessible knowledge for young people
- A comprehensive programme i.e. attitudes, skill, knowledge

**7b. What should drug education aim to achieve, when should it start and how might it be improved?**

- Should start in primary school
- Good drug education i.e. breakdown of delivery of each key stage
- Support mechanisms for schools to deliver education

Key stages 1 to 4 - what is currently happening:

- Not a standard format in school, depends on what is happening in school and local area
- Robust mechanisms to monitor the quality of delivery
- Resource, if possible, support school and teacher to deliver drug education
- Support to be extended to younger ages and also support to families – primary schools
- Enforcement through OFSTED inspection
- Good accessible knowledge and facts
- A planned robust approach to drug education
- Efficient and consistent drug education from primary to secondary school

- Feedback to teacher on how things are being delivered
- Resource packs for consistent delivery – standardisation
- Local authority accountability
- Structured input by Youth Service of the delivery of drugs education in schools
- Feedback for teachers via OFSTED on quality and quantity of delivery

## **SECTION C: PUBLIC INFORMATION CAMPAIGNS**

### **8. What role should drug information campaigns play, what should they aim to achieve and how could this be measured?**

#### Role & Aims:

- Harm minimisation messages
- Abstinence messages
- Combining drug and alcohol messages
- Targeting parents/carers, young people and adults
- Remove fear/stigma linked to asking for help

#### Measure:

- Via focus groups for local campaigns

### **9a Should there be different approaches to information campaigns, such as harder messages on drugs (e.g. shock tactics or legal consequences)?**

- Visual images of impact on body useful tool
- Information campaigns need to be more localised where possible
- Use of free papers - good way to reach local community
- Legal consequences need to be followed through in reality for celebrities too
- Shock tactics good for prevention but not necessarily for existing users

### **9b. Who is being missed out?**

- Alcohol users
- Home drinkers
- Poly-drug users
- Adults with no parental responsibility
- Parents/carers-how to reach the most vulnerable?
- BME communities with no/low levels of English
- Primary children

### **10a Should drugs and/or substance abuse campaigns be targeted at the under-11 age group?**

- Yes, with the right support and the right quality/content of information
- Needs to be part of a wider programme of healthy lifestyles - increasing exercise, healthy eating etc. (e.g. 'Crucial Crew in Oldham is a good example of this approach).

### **10b. If so, at how young a group?**

- Age 7 upwards with right support.

## **11. How can information campaigns best help our children to keep away from drugs?**

- By providing local service information/referral routes
- Place emphasis on the fact that children/ young people can receive confidential advice and help
- Provide a safe environment for children to ask questions
- Use lot's of different circulation routes – e.g. schools, TV, radio, website, local press, young people magazines, health professionals, youth clubs, posters, bus, mobiles etc
- Information campaigns not enough - need to be a holistic approach in terms of building parenting strategies and improving young people's self confidence to deal with a wide range of issues

## **12. Is there a place for role models, including those drawn from peer groups, in drug information campaigns?**

- Definitely – peer mentors need to be someone young people can relate to e.g. soap/music/sport personalities or other young people
- Maybe using ex users to act as peer mentors for young people/go into schools
- Need to look at home drinking too - no boundaries in some families re. alcohol
- Not enough focus on alcohol in the FRANK campaign
- Crucial Crew – good example for reaching Year 6's – need to reach parents/grandparents though too
- Not enough funds for marketing and communication
- Run 'OASIS (i.e. our Young Peoples Service) Surgery' in local paper to reach parents/grandparents
- Confidence building for young people required

## **SECTION D: DRUG TREATMENT, SOCIAL CARE & SUPPORT FOR DRUG USERS IN RE-ESTABLISHING THEIR LIVES**

### **13. Where is drug treatment succeeding and where are the gaps?**

#### Alcohol:

- Alcohol/Stimulant Services/Cannabis – effectiveness - dependent - non dependent about retention – plan around the gold plan
- Rehab – support – housing support – after treatment

### **14. How can drug treatment be made more cost-effective so that existing resources can go further?**

#### Rehab:

- Rehab always seem to have to go out of the Borough – why is this?
- Is it always the right thing for the client?
- Rehab requires monitoring 6mm & 12mm
- Possible rehab is just housing, a roof over the head but not preparing for real life
- Care management of clients right through the rehab and beyond

### **16a. What can be done to help local partnerships meet the needs of drug users?**

Outcomes:

- Better links between the various bodies on partnerships, performance management/outcomes to feed to other groups so there is a greater understanding.
- Clear pathways showing what is on offer and how they may contribute.

**16b. How could local accountability and performance management systems support this?**

- Outcomes would/could be used to promote our needs to the wider partnership.
- NTORS – National Treatment Outcome Research Study

**18. What can be done to ensure that effective drug treatment is provided both to offenders in prison and in the community, ensuring continuity of care between the two?**

- Aim: Seamless transition from prison
- Gaps: Communication between prison and services
- Possible ongoing communication from CDT to client in prison

**19a. What more should be done to facilitate better access for drug users to the mainstream services they need to help re-establish their lives (eg supported housing, employment, education, training and healthcare)?**

- No drug specific work – no ongoing support
- Need longer term ongoing support

**SECTION E: PROTECTING THE COMMUNITY FROM DRUG-RELATED CRIME AND RE-OFFENDING**

**20. What are the most effective ways of reducing drug-related crime and re-offending?**

- More direction to reduction of supply – target bigger dealers
- Prisons seeing more stimulant use – now the majority
- Bring back awareness for kids in schools – visits by offenders etc
- Peer role models for younger people has positive effects
- Is the level of targeting at the correct point – shouldn't need to have high level of criminal activity before getting enhanced service
- For all higher level for information sharing between all partners – that information is available
- More open invitations for prisons at DIP as in Manchester, Salford & Trafford
- Positive rates for subutex
- DIPs sharing information with prisons & Forest Bank Prison - don't see that currently
- Aiming at YP to ensure that information and support is made available to educate early on
- More support made available to parents and carers
- Family support available through police engagement
- Community TVs with adverts i.e. in pubs etc
- Leaflets in school to raise awareness
- Local radio and newspapers
- Specialised campaigns to target audiences directly

- Police need dedicated drug units to ensure that knowledge is available to staff
- More training available for police and other colleagues
- Agencies to make themselves more open to police and known to them
- Prison release communication
- One assessment form
- Supply reduction
- Diverting monies to Tier 1 and Tier 4 services

**21. What is the best way of ensuring that all partners are engaged in dealing with drug-related crime?**

- Develop links with education for information and support
- Database – care co-ordination, led by DAAT

**22. What is the best way to determine and agree local priorities and strategies?**

- Multi agency meetings

**23. How can local communities better work together to tackle drug related crime?**

- Better communication to local residents i.e. home watch
- Encourage testing in the workplace
- Pubs and clubs engagement
- Funding needs to be made more readily available
- Not strong enough links to prison
- Prison has a captive audience and that opportunities should be used
- Prison link work to be continued
- Better awareness made available to other agencies
- Links between drugs and domestic violence
- Time within prisons need to be pushed within Oldham
- Look at all of cohort in HMP rather than a focus on PPO only
- Invite more people to joint meetings
- Money for prevention needs to be highlighted and pushed
- Look at funding strategies available from different pots
- Shorter sentences are not helping as people know that they don't have to engage
- Early release scheme is causing huge problems due to work being done and planned then released early
- Raise awareness of additional funding streams
- Education in schools
- Work support
- Housing support

**24. Are existing funding and delivery structures effective or do changes need to be introduced (in order to truly embed programmes like DIP into 'business as usual'?)**

- ACCE

**25. How can commissioning and co-commissioning arrangements best be applied to the whole drug strategy, and what role should regional offender managers and other stakeholders (e.g. primary care trusts, local authorities and the Dept for Work & Pensions) have in commissioning and co-commissioning drug treatment for offenders?**

- PPO monies are these best directed elsewhere

**26. Proposals to provide statutory provision on release for offenders with prison sentences of less than 12 months have been deferred. In their absence, are there arrangements – other than DIP – that could help to provide continuity of care on release for this group of drug-misusing offenders?**

- Nothing currently in place and there should be to support people on release.
- Very big issues with lack of available accommodation for people on release – not able to reintegrate
- More properties need to be made available
- More outreach resources are needed to be made available for work around supporting families that face a substance misuser coming back into the home
- Numbers of people engaging with CARATS is much more non-PPO than PPO
- More sanctions could be in place for people engaging in prison with CARAT ie if this test positive they should be engaged
- Agencies need to be co-located utilising the ‘one stop shop’ idea
- Collection at gate, showing them where they are going, where they need to go, signposting, information
- Workers should be passing information about clients to other workers to avoid repetition of information needed to be given and completed.
- Lack of life skills – Tier 4 services under used, pounds not being spent
- Lack of housing In Oldham
- Lack of outreach
- Volunteers

**SECTION F: ENFORCEMENT AND SUPPLY ACTIVITY**

**27a. How can forces best build confidence that drug supply is being effectively tackled locally?**

- Challenging public’s perception of how drug use is being tackled by publicity
- More community events to involve public
- Anonymous communications/initiatives that are taken forward
- Understanding ‘police targets’ \*\*\* as supplier
- Effective communication of public intelligence
- When police are told of dealers, why leave it so long before action?
- Public perception through media. Public Knowledge of strategies
- Police have force wide teams and not local networks. Insufficient police resources and PCSOs have no power.
- More communication i.e. text in details of suppliers.
- Public perception – media fuelled – community events don’t attract community
- Perception is police forces don’t deal with supply networks locally only at county ‘drug squad’/community not sale not dealt with it. Maybe down to not enough officer – hard time for community officer

**27b Do the police and local communities have all the powers they need to tackle anti-social behaviour related to drug dealing and use?**

- Are there the powers needed and appropriate
- Do we tackle the root cause/or move them on

- What powers are available – anti social behaviour
- Police have extensive powers but insufficient bodies to carry it out
- Multi agency involvement.
- Enforcement power -OK not enough.
- Resources – if evict and more people only moves problem doesn't solve. Should be joint up working, getting best result for individual not just 'more ASB' look at root cause

## **28. What role should communities play in tackling drug dealers and drug supply?**

- Assumption that someone else has reported the problem
- Improve the understanding of police intelligence
- Improved understanding of 'impact of drug use'
- Landlords 'view that' reporting will be black marked
- Report it. Supply intelligence to police and don't assume somebody else will do it.
- Explain to public that they don't always act straight away. A picture will be built and then action taken.
- Licensed premises may be reluctant to report as it may be a black mark against the premises.
- Don't assume someone else has made the phone call to report it to the police.
- Feel confident any information shared with police is acted as a dealt with in confidence
- Police need to explain difference between crime solving and intelligence gathering
- Does it depend on type of drugs – landlord – pub responsibility – intelligence reporting

## **29. Which organisations might be able to assist in assessing the impact of supply-side activities in communities?**

- DAAT
- OASIS for young people
- Police
- ADS
- Can it be dealt with Community councils??

There are also wider agencies who can assist:

- PCT
- Schools
- Police
- DAAT
- Council place conditions on licenses they issue
- Police feed through community councils and community obtain info
- Drug Prevention Strategies
- Campaigns through school/OASIS/Connexions FRANK
- Something before treatment – ADS/SMS/OASYS
- Community Groups, something before drugs becoming a problem
- Community Councils

## **30. To what extent how should the UK tackle potential threats (such as methamphetamine) as opposed to establish drugs (such as heroin)? Methamphetamine is commonly referred to in the media as 'crystal meth'; it has many street names including 'ice'**

- Police/SOCA should be dealing with all illegal drug threats international/locally! But what impact does the ability to manufacture/import impact on local communities
- Increasing activity and not diverting attentions
- Fashions change, which drugs are top this year may change next year
- Shouldn't divert attention should increase supplies
- Fashion/trends
- Not much information available on use, maybe needs more information out there to help prevention/information before start using

**31a Do you think that there are ways in which the UK's broad approach to working with governments in priority drug producing, transit and consumer countries to tackle the causes and effects of drug problems and the harms caused to the UK can be developed and improved?**

- SOCA HMPC
- What do we do with drug manufacturing at a local level? Nationally we can be more effective.
- Enforcement will improve between countries but the UK must up its operation to deal with - factories locally
- An international issue – not particularly local involvement

**31b. How might this be achieved?**

- -Ensuring that the right systems are there.
- Importing should be left to high level agencies
- Ensure communication between agencies in other countries
- Communication/inter-agency at international level not for local communities

**32. How might we better measure the impact of supply and enforcement activity?**

- Media reporting of results and enforcement
- Possible effects
- What support is available to users
- Media attention – publish results in operations
- Removing the source works
- Join up treatment agencies
- See reports on the news
- See local dealers removed
- See notes from reporting incidents
- What will the positive impact be – reduce crime, improve life
- Focused operations – tackle dealers – offer support, get treatment, options out there

**SECTION G: BROAD STRATEGIC QUESTIONS**

**33a. What are the most effective ways of preventing and reducing the harms caused to young people and families by drugs?**

**&**

**33b. Do young peoples and adult services need to work more closely together?**

**&**

**34. How can we improve the effectiveness of specialist drug treatment services and help drug users to re-establish themselves in the community?**

- Specialist Drug treatment -Gap – greater emphasis on abstinence – Social Inclusion Agenda
- Need to include housing, education, employment
- Re-Establish in Community - UPA experience
- Recovery coach – long term re-establishment back in the community
- Significant investment – need professionals to let go/have over control
- 12 steps – a number of schemes ‘loosely based on 12 steps – abstinence makes it easier for client to engage with education/work
- Alcohol – young people, very few need to move direct to abstinence programme. May well require help with ‘controlled’ drinking/harm minimisation
- Patient Choice – Need to ensure that if patient decided that abstinence is their choice, they do not have to go through treatment/methadone before they are allowed to so? - Medical flexibility?
- Increasingly opiate users are in older age range established on methadone for many years. Some are choosing not to enter treatment, because they do not want to take methadone

### **35. What more could be done to reduce the impact of drugs and associated crime on local communities?**

- Wrong wording, ‘war on drugs’, will there be a clear outcome? Does the word war related to supply war on drugs related harm
- Regulate drugs, take away the symptom of crime
- Are we responding to the fear of crime?
- Terminology – mixed blessing
- Do we treat crime not drug misuse
- Hope future, young people growing up social exclusion handed on to our young people
- Lifetime investment, this is a human condition, people will always want to change their mood
- HIV prevention services have changed to crime prevention services
- Look towards abstinence
- Does the treatment system empower addiction
- DIP useful as early intervention

### **36. How can we further reduce the supply of drugs and improve education and the prevention of importation?**

- Heroin – identify driver
- Money – criminality, small and large scale
- Structure for control – regulate
- Seizure of assets
- Change perception of drug dealing
- Communities – attitude shift
- Alternative synthetic drug, International collaboration, re-inforcement
- Internal drug market in supply and traffic routes – poor countries
- Reduce demand through health education
- Supply vs demand
- Structured reward processes, informants etc
- Importation + publicity + base need

**37a. What could we do more efficiently?**

**&**

**37b. Where is value for money not being delivered?**

- Focus on money on dependent and problematic but what would happen if we refocused it (i.e. those we currently treat)
- Should we widen the net?
- What is a problematic drug user
- Driver of crime v's health
- Changes would possibly make good treatment
- Systems more vulnerable
- Impact of unwilling (coerced) on willing participants
- Security and long term planning (funny money and short notice on renewals)

**39a. Do you think cannabis should be reclassified? Are there other changes that you would wish to see and if so why?**

- Cannabis reclassification – different responses
- B vs C of no consequence to average user
- B vs C of no consequence to eg who experience
- B vs C is of no consequence re supply and cultivation (esp re skunk)
- Does B vs C act as a deterrent?
- 'Blue skunk disease' – look at differential tariff for cultivation/supply vs personal use

## Appendix 4

### CONSULTATION FEEDBACK ON OLDHAM DAAT PRIORITIES 2007/2008

#### ALCOHOL

This group explored:

- **What the main priorities should be on a reduced budget;**
- **The implications of shifting local resources from drugs to alcohol;**
- **The most crucial positions in terms of delivering a holistic 'substance misuse' service for Oldham clients.**

The group identified:

- More education is required re. drink driving and how much you can drink and how long it takes to leave the body
- A stronger push for less alcohol promotions in supermarkets
- More power is needed to challenge irresponsible promotions
- Concern re. increase in measures for spirits
- Education is required re. sensible drinking to teenagers – social awareness of the harm of drinking licenses
- Drinking at home is more of an issue than going to the pub
- Better Education is required e.g. we say 'stop smoking' but we don't say 'STOP DRINKING'
- Early stage prevention approaches required for teenagers
- Binge drinking 'norm' - change of attitudes required
- Hard hitting campaign regarding drinking is needed
- More police enforcement in the morning e.g. road blocks to prevent drink driving
- More school based interventions required where alcohol and sex messages are combined together
- Try to reduce young girls smoking to reduce weight and then drinking alcohol
- Empower staff nurses to promote responsible drinking
- Better training for GP's required
- Robust help and support for employees and policies for employers are needed
- Focus on prevention prior to the problem occurring
- Concern re. saturation of off -licences in the Borough
- Concern about advertising services as this problem could be far too big for current services to deal with
- Alcohol although an issue, is only classed an issue when the word crime is attached to it.
- Drugs is an illegal pastime – addiction, however alcohol is not seen that way by home office etc, although leads to crime and ill health
- It was felt by service users that they had nowhere to go and once they find a service provider it was too late

#### ABSTINENCE

This group identified the barriers for people who would like to achieve abstinence:

- Fear of change
- Overwhelmed

- Change of environment, culture, drug use community
- Family, partner, children
- Boredom
- Geographical availability
- Funding

The group also fundamentally questioned the Drug Strategy - does it address the epidemiology of addiction?

- The last 10 years have identified possibly what is needed – we think so
- Now we would like to see a self supporting industry – “recovery communities”

## **CHILDREN OF SUBSTANCE MISUSING OTHERS (COSMO) SERVICE**

**This group explored how this service could be mainstreamed and the focus/ direction of the Project Coordinator: The group identified there was a need to:**

- **Establish a Steering Group**
- Include possible ex/or service users on the steering group
- Build closer links with the Education Welfare Service
- Draw on the experience and insight of Grandparents
- Build on existing evidence in this field
- Identify how this service can be linked to CAF
- Identify key players – ensuring there is not duplication
- Identify if there are existing forums where COSMO can sit.

## **ALCOHOL, CANNABIS, COCAINE & ECSTASY (ACCE) PROJECT**

This group reviewed the aims and objectives of the project and made the following observations:

- The project will be evaluated via TOP’s but there is also a need to ensure there are locally negotiated evaluations methods in place to measure the impact on other organisations and communities. Key indicators of success could perhaps be access into ETE, service user feedback etc. It was however questioned whether the TOPs framework is appropriate for young people?
- The group liked the model but felt that we need to think broader than the 4 ACCE drugs. Perhaps shift the focus into ‘lifestyle choice’ instead of ‘drug of choice’.
- It was acknowledged that the project needs to link with existing initiatives and services e.g. The RAP project.
- The group felt that it needs to be clearly outlined what are the key indicators of project success - lower criminal activity? Lowered drug use? Engaged in Education, Training and Employment?
- The group agreed that project aims and referral routes need to be communicated more widely to partner agencies
- The group identified that that steroid users are excluded from the ACCE initiative as well as from our local strategy.
- The group acknowledged that the model is relatively resource intensive

## **RESETTLEMENT**

The Group looked at the current measures in place for individuals in prison who needed to access support structures in order to manage their drug use, avoid relapse or remain abstinent on release. Provisions were looked at for prisoners at all stages of the criminal justice system and due for release on Automatic Unconditional Licence (ACR), End of Custody Licence (ECL) or on Licence/ Parole restrictions. The group considered three key questions:

- What are the issues for short-term offenders coming out of a drug free wing?
- What are the implications for Oldham (Housing/ Employment)?
- Who should pick these individuals up (NA Network, recovery Community etc)?

The Current measures in place at HMP Manchester were discussed and included the 12 Steps Programme and the Short Duration Programme. Current treatment systems were compared against the Reduction and Motivation Programme (RAMP). This included looking at the four main areas of RAMP;

- 12 Steps Programme (RAMP).
- Primary Residential Treatment.
- Second Stage Housing.
- Independent Living and Employment.

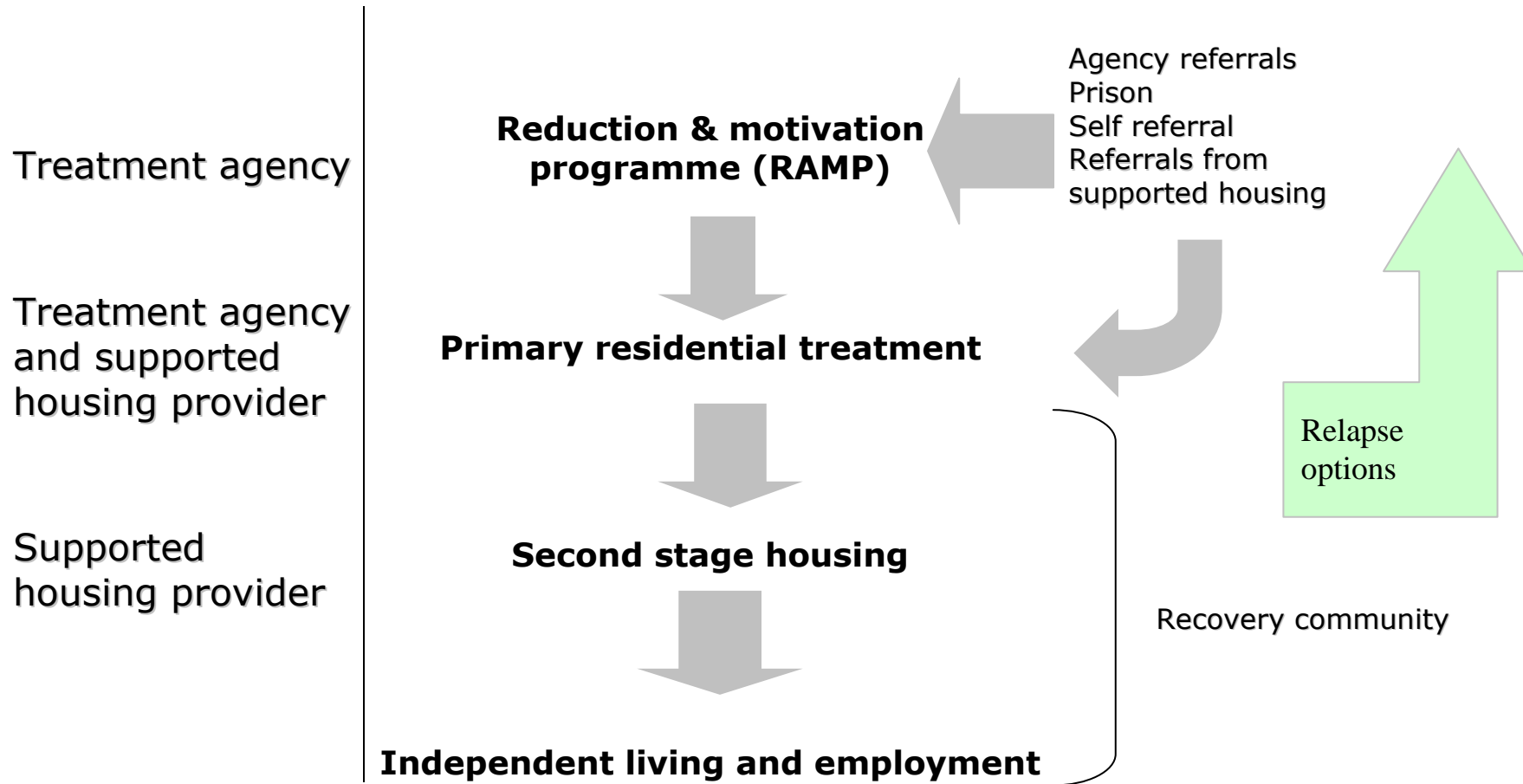
Areas of good practice were considered including those currently in place in Stockport. Key concerns included identifying the issues for Short-term Prisoners coming out of Drug Free wings in Prisons into the Community. Ensuring that they have access to good Housing/ Life Skills Training and goods support structures in the community that followed on from the progress made in prison.

The implications for Oldham for following a RAMP process would relate to the provision of accommodation in Hostel/ Independent tenancies and which sector would be able to provide a service, public/ private. The group were also keen to consider how such a programme would be funded to support or use existing housing provision in the community and whether this would be affected by the type of treatment provided: Psycho- Social which moved away from 'Distance Detox' provision currently in place.

Present support structures available in the community would need to improve in order to be able to implement a RAMP approach in the Oldham area. But all involved thought that the local DAAT needed to prioritise such a provision in order to improve the long-term benefits for those individuals on release. General questions that need to be taken forward included whether individuals would be allowed to relapse in the community or would this result in them being evicted from their supported accommodation and the RAMP process. Three key concerns were recorded;

1. There needed to be the right support for recovering users on release from custody.
2. Relevant Accommodation/ Housing Provision would need to be identified.
3. Right provision for substance user including Abstinence/ Relapse Provisions and entry into treatment and aftercare services would have to be incorporated into a RAMP provision in order to support the developing 'recovering community.'

## A Model for Abstinent treatment, supported housing and recovering communities



### **RAMP (12 weeks)**

Ramp works either as a stand alone intervention or as part of aftercare and relapse prevention. For men and women 18+ (alcohol or other drugs) suitable for DRR clients. Core belief is that all those attending can achieve abstinence. Behaviour modelling by abstinent peers is key to this. It is a 24 session rolling group work programme which can be entered at any point in the 12 week cycle.

Phase 1 initial assessment and stabilisation

Phase 2 structured group work – reviews and referrals to detox and rehab including admission to ADAS intensive programme or ‘the house on the hill’

Phase 3 individual care packages including aftercare and support groups – referral on.

### **Primary Programme (12 weeks)**

Between 6-8 residents living in or near the treatment centre – rolling 12 step programme (steps 1-5 in primary programme) Intensive group work 9am-4pm mon-fri exploring nature of addiction and how it impacts.

Residents expected to attend group meetings and NA meetings evenings and weekends.

### **Second Stage Housing (12 weeks +)**

3 clients share a house. All have come from primary programme, one or two of the trio have been abstinent for some time. Big element of peer support. They live together, support each other through abstinence and travel together to the centre (nearby) where the 12 steps programme (steps 6-12) are delivered during the day. They are expected to attend NA meetings outside these ‘office hours’. The halfway house offers a structured living program to aid the individual in his or her effort to re-enter society as a responsible and productive citizen.

They are affordable alcohol and drug free environments which are not in an artificial ‘bubble’ like the ‘house on the hill’ but are in the locality. The client learns to deal with his/her addiction on their own ‘turf’ Clients are encouraged to be good neighbours

### **Indigenous Recovery Community**

As more clients become abstinent responsible citizens we build up a ‘critical mass’ of recovered clients who act as role models and mentors to others. Current users see what those who were like them have achieved. The recovery community are encouraged to volunteer to help others to get to where they have.

**Costs to DAAT** – estimated that for roughly the cost of 3-5 residential rehabs we could ‘buy in’ the 12 step therapy for 32 clients in 1 year

## Appendix 5

### Oldham Drug Intervention Programme

#### Introduction

**1.1** This document will focus on the key areas of service provision and delivery for the Oldham Drug Intervention Programme (ODIP) during the period of 2007. It will also highlight the overall performance and future demands being placed on the programme at a local and national level; Identifying key performance areas and potential threats for service delivery during 2008.

**1.2** The last 12 months have seen a period of intense change for the Oldham Drug Intervention Programme. There has been a drive to improve performance in relation to meeting local and national targets. In order to achieve this ODIP has been restructured so that it focuses on the areas most relevant to local practice and national requirements. There have been two reports published recently that have influenced and supported practice; Managing Drug Misusers Under Probation Supervision and a Home Office report; The Drug Interventions Programme: addressing drug use and offending through 'Tough Choices' (Home Office Research Dept; Nov 2007).

**1.3** There has also been a specific request from the Home Office that Drug Intervention Programmes (DIP) pay attention to the impact of 'Street Workers' in their local area. Due to the drug related behaviour that may be a trigger/ influencing factor upon their actions. A further priority has been to increase the engagement of Minority Ethnic Groups in the DIP process. This is in addition to the continual focus on Prolific and Priority Offenders, Required Assessment procedures, Restriction on Bail and Prison Release.

#### Overall Performance in 2007

**2.1** The monthly performance figures for 2007 indicated that ODIP had been making steady improvements in reaching Key Performance Indicators / Compacts set by the Home Office. Overall, performance has tended to be just outside of the compact targets needed to be achieved in relation to Compacts 2 – 4. Although, when ODIP is compared on a regional basis or against those Compacts provided nationally for Drug Intervention Programmes, our performance is comparable and in the majority of cases significantly better.

**2.2** The revision of the Drug Intervention Record (DIR) also impacted on the need for DIPs to ensure that they were recording their practice effectively. The review of the content and format of the Drug Interventions Record and the DIP management information system that is derived from it was revised by the Home Office in early 2007. As a result this introduced the new Follow-up Assessment, which was a provision within Section.10 of the Drugs Act 2005 and allowed for a second assessment to be carried out on clients testing positive through Test on Arrest. The Required Follow-up Assessment was introduced on 1<sup>st</sup> April 2007. This was an additional intervention that provided a further opportunity to engage with drug users after arrest and following their initial contact with Test on Arrest workers within the custody suite. It is intended that when appropriate, that the assessment will be used to draw up a constructive care plan for drug users and enable an appropriate referral into treatment. The Follow-up Assessment (the second of the two required assessments) carries the same levels of enforcement for failing to attend as the Required Initial Assessment. This change in the assessment procedures has had a substantial impact on ODIP due to the increased numbers of assessments being carried out by the team. The subsequent breaches for those clients that have failed to attend that have needed to be instigated has also increased workloads and stretched resources. However, it's recognised that this is a possible trend that has been experienced by the majority of Intensive DIP Areas.

**2.3 On average ODIP has been conducting 88 assessments per month in order to meet the Required/ Follow-up Assessment Procedures and complete Drug Intervention Records. The majority of referrals have come via Test on Arrest, Criminal Justice, Prison Release and those clients entering the DIP process voluntarily. Required/ Initial Assessments have remained at around 60 per month with the majority being completed in the Oldham Custody Suite. Subsequent failures to attend Required Assessment appointments have been constant at around 14 per month, which has resulted in enforcement action being taken through the Oldham Operational Policing Unit.**

**2.4 The ODIP 'active caseload' has stayed in the region of 140 cases being supervised at any time. Restriction on Bail (ROB) provisions have resulted in ODIP monitoring and assessing up to 21 clients/offenders per month and reporting back to the appropriate Magistrates Courts. The remainder of the caseload is due to those individuals accessing service after coming through the Required Assessment Procedure or being referred via Criminal Justice Agencies, including the Prolific and Priority Offenders (PPO) Scheme. However, over 40% of clients are those being referred by Counselling, Assessment, Referral, Advice and Throughcare Teams (CARATs) or via the Probation Service on/or before their release from Prison. This number has been steadily increasing due the number of prisoners being released from custody early subject to End of Custody Licences/ Home Detention Curfews (HDC) or on standard Licence/ Parole conditions.**

**2.5 An additional focus on performance has been to address concerns that the Drug Intervention Programme (DIP) nationally could be under performing in three key areas:**

- Overall effectiveness.
- Not increasing and sustaining the numbers of drug users entering 'Tier 3 Treatment Provision.'
- Reducing Drug Related Crime or re-offending rates.

As a result of these concerns Oldham DIP in conjunction with the Drug and Alcohol Action Team (DAAT) has been going through a period of re-appraisal. This has been in order to review and assess current local working practices and treatment provisions. This has been in order to evaluate whether the Drug Intervention Programme in Oldham should/ needs to undergo a degree of realignment in relation to the provision of services. Including looking at possible changes in how ODIP works directly with Tier 3 Services and the current working practices/ arrangements in place with those agencies in which the DIP process feeds into.

#### ODIP Team Structure

**3.1 The DIP Team in Oldham is currently made up of 12 workers seconded from Addictions and Dependency Solutions (ADS). In this cohort 4 workers provide cover to the Oldham Custody Suite through Test on Arrest/Initial Assessment provision on a shift pattern basis. The ongoing need for effective Court liaison and management of the Restriction on Bail process has also made it necessary to provide a permanent ODIP presence at Oldham Magistrates Court.**

**3.2 The remainder of ODIP Team has been restructured in order to provide an effective case management structure. The Team has moved away from generic caseloads to more identifiable 'specialist roles.' The five members of the Case Management Team now have identified individual responsibility for specific areas of practice. The four individual areas being Prolific and Priority Offenders (PPOs), Probation Liaison, Prison Link and the Alcohol, Cannabis, Cocaine and Ecstasy (ACCE) Programme. Due to the increased demand on Prison Link/ Release element of the Team, it has been necessary to move to having two Case Managers to cover this area of work. The management of the Office Duty Provision (Required Follow-up Assessments), Restriction on Bail and assessment of voluntary clients is split equally across the Team on a rota basis. The 12 workers are supervised between two Team**

Leaders, who have responsibility for the Supervision of team members and ensuring the quality of case management/ assessments being completed. This has allowed greater accountability and scrutiny of practice to be undertaken and taken forward through the supervision and case management process.

#### Professional Development of Personnel

**4.1 All ODIP personnel are required to demonstrate their ability to meet local set minimum competencies in relation to their knowledge and understanding. This is to ensure that the delivery of service to clients and the Case Managers ability to provide 'effective' treatment plans is kept at a constantly high standard. All of the team are required to attend regular training events commissioned through the local DAAT to improve knowledge or understanding of key practice areas or treatment provision. This has been in addition to any relevant training identified as being necessary through their individual supervision and appraisal process.**

**4.2 In Order to ensure that ODIP Personnel are trained above the standards set by the Operational Process Guidance for Implementation of Testing on Arrest, Required Assessment and Restriction on Bail. All Team Members are currently completing an Open University/ Federation of Drug and Alcohol Professionals (FDAP) Award. Over the last two years Oldham DAAT has invested a significant amount of money into coordinating and funding a local training calendar, as well as providing staff with opportunities to demonstrate externally validated evidence of their competence in key Drug and Alcohol National Occupational Standards (DANOS).**

#### Ongoing Priorities

**5.1 It is essential that ODIP continues to meet its 'core operational' duties and priorities to ensure that its credibility remains high. Service delivery needs to be kept at a constantly high standard in order to meet the justified expectations of clients, treatment services, criminal justice agencies and Government.**

**5.2 The key operational areas in relation to those set by the Home Office in the Operational Process Guidance for Implementation of Testing on Arrest, Required Assessment and Restriction on Bail need to be achieved. This also needs to be reflected in the Compact performance achieved locally and when compared against services regionally and nationally.**

**5.3 There has been a continued focus on ensuring that DIP in Oldham meets and provides a service to Prolific and Priority Offenders. The requirements set in the Home Office White Paper "Rebalancing the criminal justice system in favour of the law-abiding majority: Cutting crime, reducing re-offending and protecting the public" was published on 20<sup>th</sup> July 2006. The paper commits districts to combine their Prolific and Priority Offenders Programme with the Drug Interventions Programme and overhaul the approach to dealing with high-harm drug users. It is recognised that there is an identifiable cohort of drug using and highly prolific offenders that overlap both DIP and PPO programmes. To meet this aim the Oldham Prolific and Priority Offender Team have been based in the ODIP Building since 2<sup>nd</sup> April 2007.**

**5.4 Increasing Client Engagement (ICE) has been an ongoing priority since July 2006. Drug Intervention Programmes have been asked to ensure that they are tackling the 6 main objectives. Oldham has continued to strive to meet or improve upon the objectives set in relation to:**

- Improving the recruitment and retention of workers.
- Managers to direct resources and efforts into appropriate client groups.
- Contribute to ensuring the most appropriate pathways for each client into treatment.

- To ensure appropriate services are available for all.
- To ensure that all DIP services and treatment are communicated to all.
- **Ensuring that all DATA processes are clear, appropriate and communicated to all relevant parties.**

**5.5 The changing trends of the types of substances misused locally needs to be recognised and incorporated into the way ODIP provides services to clients/ offenders. One significant change in recent months is the emerging trends of opiate versus stimulant use. In Oldham we are seeing increasing number of users testing positive for both cocaine and Opiates and the trend has shown that the numbers of Opiate users has been decreasing over the last 12 months. The ACCE Programme ensures that there is a provision for younger users who may fall between current provisions. This is due to the number of individual failing to take up treatment after the Follow-up Assessment but who are using Alcohol, Cannabis, Cocaine and Ecstasy.**

### Threats to Performance

**6.1 There are threats to the operation performance of the Oldham Drug Intervention Programme. These can be broken down into five specific areas:**

- 1. Retention of staff and absenteeism through illness.**
- 2. The Impact that Integrated Drug Treatment Systems will have on service delivery and what DIP will be required to deliver: The rollout of IDTS will ensure that offenders receive seamless support and are retained in treatment after release from custody. This may place further demands on ODIP.**
- 3. Increased workload Impacted on by the release of prisoners from custody due to End of Custody Licences, which occurs at short notice.**
- 4. The need to move towards an integrated team: ensuring that Treatment Workers (Tier 3) are located with CJIT Teams and Probation Service in the same premises.**
- 5. The need to ensure that BME/ Female clients/ offenders are reflected at a higher level on ODIP caseload. This will require the targeting of under represented groups in the community before, during and after they enter the criminal justice system or DIP Process.**

### Key Priorities and Future Objectives for ODIP in 2008/ 2009

**7.1 In order to meet our operational requirements it is going to be necessary to target those individuals who have entered the criminal justice system and provide an 'enhanced level of support.' This will require a more proactive move to 'outreach' work in the community in order to engage with under represented groups. There also needs to be a specific focus on BME communities and female users. While at the same time recognising that trends in substance misuse have started to change and there is now a growing population of ACCE users who are falling in-between service provision.**

**7.2 Changes in the Operational Guidance for Drug Intervention Programmes have also impacted upon those individuals subject to a Drug Rehabilitation Requirement being excluded from service. This has resulted in a reduction in the recognised caseload of ODIP for a group of clients who were traditionally seen to be a core target group. Although a local arrangement continues to stay in operation for these clients, a more formal arrangement is needed.**

**7.3 In order to engage with those clients who have traditionally breached the Required Assessment Procedure a more flexible approach may need to be taken. This is to encourage attendance but at the same time still allowing for the enforcement of those clients/ offenders intentionally failing to keep appointments for Required Assessments or on Restriction on Bail from Courts.**

**7.4 The re-alignment of Prolific and Priority Offenders (PPOs) and the Drug Intervention Programme have resulted in a closer working relationship with the National Probation Service in relation to this targeted group of Offenders. This arrangement needs to continue and ODIPs contribution at Persistent Offender Management Meetings (POMAN) and Oldham Joint Agency Group (OJAG) will be an ongoing commitment in order to meet Home Office Requirements.**

**7.5 The possible introduction of a TIER 3 Substance Misuse Worker based in the ODIP offices to work alongside the ODIP and Probation Teams may also have a positive impact on the number of clients engaging with TIER 3 services.**

**7.6 In summary; it is prudent to be concerned about the efficiency of DIP and more specifically ODIP. Although, it should be recognised that our recent performance has been following the national trend. In order to improve:**

- **Overall effectiveness.**
- **Increasing and sustaining the numbers of drug users entering 'Tier 3 Treatment Provision.'**
- **Reducing Drug Related Crime.**
- **Ensuring overall value for Money.**

**It will be necessary to develop or implement the above areas over the next 12 months. However, this will have to be achieved in a climate where reduced funding and budget restraints will be extremely probable in the next financial year.**

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