

## Oldham DAAT Strategic Summary and key priorities for 2008/9

Every year we improve our understanding of the needs of Oldham in terms of substance misuse services. The evidence base which underpins the commissioning of drug and alcohol services is growing almost daily and evidence both from National research and our local needs assessment will shape the strategic direction of our treatment plan. We plan some radical changes in direction over the coming years which we believe will unlock our treatment system and transform it from what was largely a methadone maintenance system to one with a much wider range of treatment modalities including a robust abstinence based offer which will deliver far more in terms of successful outcomes.

In response to last year's needs assessment which clearly demonstrated a changing drugs profile we embarked upon some ground breaking work by developing a 'lifestyles' based treatment modality. The pilot aimed to engage the younger cohort of clients using the ACCE profile of substances by providing a menu of opportunities for them to improve their overall lifestyle, raise self esteem, and in the process of addressing their substance misuse also improve their general health and well being and become productive members of society.

Mandatory drug testing through Test on Arrest has demonstrated a further shift towards stimulants and now we have the ACCE project we at last have a realistic treatment option to offer those who are coming through the criminal justice system (and other referral routes) who are using Alcohol, Cannabis, Cocaine, Ecstasy and other similar drugs.

The ACCE project, even in its early stages is showing great promise and is proving to be a catalyst to further change. The pilot has already demonstrated its ability to engage the most challenging of our clients and those with a history of offending who previously were not engaged in treatment. We believe the ACCE modality would also be relevant for those who have 'matured out' of opiate dependence and are seeking abstinence and relapse prevention. **Pending the final results of the ACCE pilot we are keen to realign services to enable the pilot to become a sustainable treatment offer in Oldham.**

The bulls eye estimates within the needs assessment estimates the number needing treatment in Oldham who are currently not receiving it as 260, which would suggest that penetration levels are high, but this estimate is based on an adult opiate and crack or cocaine using model and looks at those needing treatment as likely to have the same profile as those already in treatment. We feel from our other consultations and from the emerging evidence from the ACCE pilot that there may be far more people with an untreated drug problem than this, but that they are likely to be using different substances including alcohol, cannabis and stimulants. There is also emerging evidence that there are a sizable number within the BME community both male and female who have substance related need.

Planning for future demand based on our view of those who have yet to access treatment leads us to the view that ACCE style interventions and interventions designed to attract those using stimulants and less entrenched in drug misuse are likely to have more success in meeting need. We will not be increasing capacity within methadone maintenance treatment, but will be looking to provide pathways to abstinence for those less entrenched and abstinence and rehabilitation to help people who wish to move on. Those who are not quite ready to go straight to abstinence may wish to try subutex for shorter periods rather than methadone. We have found that this is a preferred choice for many of our BME

clients, but also think there is potential for many BME clients to take up abstinence based treatment.

We have been exploring the use of BME workers supported by BME volunteers to do prison in-reach visits to try and attract some of the BME prisoners with problematic drug use to enter treatment on release as we have had less success at getting them in to treatment at the point of arrest. It may be that they (and other clients) could be persuaded to take up abstinence based treatment that will be available in Manchester prison shortly. We are also working closely with the police and other partners to take opportunities through arrest referral to engage women working in the sex industry and we have begun to see a 'critical mass' taking up treatment recently.

One pleasing finding from the needs assessment is that for the second year running we have increased the number and proportion of women in treatment and also have increased the number and the proportion of BME men in treatment (almost to reflect the background population) This tells us that the strategies we put in place three years ago are paying off and we will continue along the same lines to increase accessibility for women and BME groups. Once we get BME men in treatment their retention is marginally better than the rest of the treatment population. Retention for women is not quite so good and we still have not made much impact into the female BME population so this is where we will concentrate our efforts this year. Generally though our retention rates have significantly improved (better than the NW average) and there has been a marked improvement lately which was not picked up by the needs assessment as that was based on last year's figures.

Successful outcomes are our biggest challenge. We feel that some of this is a reflection of ADS wrongly assigning tier 2 clients to tier 3. We are confident that the new method of counting as successes those clients who have a planned discharge before 12 weeks will be a much fairer reflection of efficacy, particularly for stimulant users. The whole emphasis of our treatment plan for this year is targeted at increasing successful outcomes. The development of abstinence based services are key to the optimum outcome of helping people to get drug free and back into meaningful and productive lives. We predict that ACCE will also deliver crime reduction and improved community safety, reduction or abstinence from substances and increased involvement in education, training and employment, but will also improve health and social functioning. Within our client group who continue to use street drugs we will work hard to reduce drug related harm including overdose and blood borne infection. Following the harm reduction strategy self assessment tool we will draw up an action plan. The main area for improvement is in a system for confidential enquiries.

At the end of the ten year anti-drugs strategy it is worth reflecting at where we find ourselves. We have responded to the NTA drive to reduce waiting times and increase the numbers in treatment. In so doing we have built up a treatment system that is dominated by methadone maintenance. Although in recent years we have made great strides in developing the range of treatment options and in Oldham, (for example, we have always had a relatively generous budget for community and hospital detoxification and rehabilitation and also offer subutex), we still have the bulk of our 'in treatment' population on methadone maintenance. Also, even though we have mechanisms in place to consider abstinence as a first option, we need to ensure that this happens far more often

**We are exploring the feasibility of introducing a single point of access. This will involve developing a small independent 'intake and assessment team' who will be able to give impartial unbiased information to clients on which treatment options are**

**available to them and the implications of each option. We will also supplement this with a DVD and booklet which sets out the basic treatment options and what clients can expect.**

The evidence base for methadone maintenance is that it will retain people in treatment and improve their health and for some it will reduce crime, but it is unlikely to help people get off drugs. Over reliance on old evidence of drug use as a chronic relapsing condition and low expectations of both drug workers and service users can lead to clients being 'trapped' in methadone maintenance treatment for years.

Research by Dr David Best found that, although it is accepted that to be effective at all, psycho-social therapy must be delivered for at least 6 hours a week, the average length of psycho-social intervention for clients in this country on methadone maintenance (once the worker has dealt with prescribing issues and paperwork) is about 6 minutes a fortnight. This adds up to about 18 hours a year – so it's little wonder that clients on methadone maintenance don't get off drugs!

On the contrary, the best chance of long-term recovery is through abstinence-based treatment. 12 steps approaches evaluate well but the recipe for success is based on the intensity of the therapeutic intervention, the therapeutic relationship and the peer support element. The chances of relapse are reduced considerably where there is a network of non-substance using support, training or employment and appropriate housing. Nevertheless, there is over a 50% chance of relapse within 90 days for those coming out of traditional rehabilitation. Over recent years there have been some models, which offer intensive therapy (usually 12 steps) within a supported housing, peer support set up, but based in the client's local community. The success rate for these is impressive with a very low relapse rate. The added advantage is that unlike the traditional model, where people have to move away and 're-invent' themselves in another location, with this model, those who become abstinent stay in the local community and become examples for others to follow. An indigenous recovery community develops, which acts as mutual relapse prevention support.

**We intend to significantly increase our abstinence based offer in Oldham. We already offer a wide range of choice in the form of community and hospital detoxification and residential rehabilitation but we will also commission a RAMP community programme for people exploring the possibility of abstinence and for those who are abstinent and want relapse prevention support. We will also commission a 12 step based intensive psychosocial programme with community based sober living support. We will explore the possibility of also introducing a non 12 step intensive psychosocial community based programme.**

Another very interesting piece of research looked at the concept of the drug-using career and found that there are 2 points where the user was amenable to getting off drugs. These points are in the early stages (when clients are less chaotic and drug use is less entrenched) and at the tail end of the 'career' (when clients are weary of the chaos and the lifestyle and have 'matured out') this second point is often prompted by a life event, such as finding a new drug free partner, becoming a parent or getting a custodial sentence. The chance of moving into successful abstinence between these points is low. What we intend to do is to use this information within the drug treatment system.

Many of the clients coming through DIP and also a large section of BME clients present at point 1 and are less entrenched in their drug use. For many of them methadone maintenance is not the best option. They should be encouraged to consider abstinence-

based treatment including the ACCE project where it is appropriate. The 12 steps philosophy is likely to be particularly acceptable to some of our BME groups as it fits well with their belief systems. For those who are maturing out, we need treatment workers to recognise this and to promote and encourage detoxification and abstinence based rehabilitation.

A concept, which is well understood by our colleagues in the National Offender Management Service, also has relevance to this. There is evidence that methadone maintenance may actually prolong the criminal careers of some as methadone acts as a buffer to reduce the chaos in their lives. This allows them to tolerate their life style for longer and delays 'maturing out'. Clients in our drug treatment system are not all the same. Some are 'high criminal thinkers' – primarily criminals who happen to use drugs. Some are 'low criminal thinkers' – primarily substance users who may or may not use crime to fund their drug habit. The criminal careers of the former are likely to be artificially extended by methadone maintenances and they would fair much better in abstinence-based treatment, whereas the later will reduce their crime if they have methadone.

**We will develop mechanisms through the single point of access 'intake and assessment team' to encouraging clients to make appropriate treatment choices and in partnership with the offender management service we will develop psychosocial intervention programmes which cater for distinct groups with different levels of criminogenic need. Early indications from the ACCE pilot are that there is potential for the ACCE model to be adapted as one alternative for high criminal thinkers. Also as there is a programme commencing in Manchester prison shortly which will deliver steps 1-5 of a 12 step programme. Therefore commissioning of the 12 steps community based intervention (with sober living house provision) along with RAMP will be a suitable follow on for clients coming out of Manchester prison back to Oldham**

We will consult with clients to ensure that those who have aspirations to move on in their lives and get into training and employment are given every support and encouragement. **For those who are not yet ready to move on we will focus on harm minimisation and look at what level of care is safe and acceptable for them.**

**We will continue to develop services for children affected by the substance misuse of others, build support for families affected by substance misuse and support the carers of substance misusers.**

Over the course of the ten year strategy, we have successfully responded to the NTA call to reduce waiting times and provide treatment capacity. We pride ourselves in Oldham that this has not been at the expense of safety and quality. We have had excellent results for 2 years running with the Health Care Commission findings and we anticipate a promising result with the review which is soon to get underway this year. All providers will review their practice in line with recent NICE guidance documents and the UK 'Clinical Guidelines'. We put our HCC improvement plan into action last year to ensure that service users were aware of the options for optimum methadone dosage. Our weakest score for last year was against the needs assessment process, but as the score was based on the previous year we feel that we had already put in any necessary action to make our needs assessment process more robust. Indeed, we were praised by the NTA on an exemplary needs assessment process last year. We have achieved all this within a relatively low unit cost and even though we feel we do provide good value for money we will work hard to ensure we make continuous improvements in terms of treatment outcomes.

These improved treatment outcomes will come about by building mechanisms to create fair unbiased access to the most appropriate treatment modality by creating a single point of access.

Oldham DAAT is committed to ensuring that the workforce has access to support to ensure that the standard of training and the journey towards DANOS competencies is not relaxed. We will continue to build on our investment and currently 100% of staff in young people and adult services have or are working towards externally validated evidence of competence in the 'core and generic core' units set out in the wider Health and Social Care national occupational standards and all 'DANOS compulsory' units in one specialist unit. We will take steps to ensure that staff have the right level of IT support and administrative support to allow them to practice the skills they have developed. We will ensure that clients with different criminogenic need are offered appropriate psychosocial interventions which are delivered by trained staff and have the correct level of intensity. One of the major factors which will help to 'unblock' the treatment system and improve outcomes will be the development of a robust abstinence based offer for those less entrenched in drug use and for those who are maturing out and wish to be drug free. We also feel strongly that to engage the younger ACCE cohort we will need to roll out the ACCE pilot to make it a robust and permanent treatment option. We feel that there is great potential for this model to improve general health and social functioning along with reductions in substance use and its related harm and offending. We view the ACCE pilot as a social inclusion model and can see the potential to roll out some of the methods used for clients with other drug profiles. As we review our through care and aftercare support and what we used to call structured day care, we will be looking at the success of the interventions that have been used in the ACCE pilot.

Oldham DAAT has always placed a high priority on housing, education, training and employment with the understanding that they are key to helping substance misusing clients move forward. We will prioritise through care support for clients in order for them to aspire to fulfilling drug free and productive lives. In the current economic climate, working towards getting clients back into economic self-sufficiency has never been more challenging or more vital than it is in Oldham at present. Our client group is no different to any other. They simply aspire to the normal things in life: to be good parents, to have a reasonable home and to have a reasonable job and hold things together themselves. We will do everything possible to help them attain their aspirations.