BE SAFE BOLTON STRATEGIC PARTNERSHIP

Needs Assessment for Adult Drug Treatment 2009

Draft 0.8 (Final)

EXECUTIVE SUMMARY

Introduction

The NTA Quarterly reports have consistently described the 'Drug Treatment System/ Commissioning' as 'green' (see Table 1). Performance in 'Financial Management' is also highly rated. The environment is constantly shifting and to improve and maintain performance there are still a number of areas for improvement. The reports describe DIP performance as predominantly amber; there are also some issues elsewhere which this needs assessment highlights.

The coming year will bring multiple challenges for the commissioning team, with changes to funding levels creating pressure on budgets, and the possibility of shifts in local or national administration, which the treatment system will need to respond to.

	2008/9 Q1	2008/9 Q2	2008/9 Q3	2008/9 Q4	2009/10 Q1	2009/10 Q2
Treatment System Managing & Commissioning	G	G	G	G	G	G
Drug Treatment System Delivery	G	G	G	G	A	A
DIP	A	A	A	A	R	A
Financial Management	G	G	G	G	G	G

Table 1: *Performance Overview (from Quarterly Summary Reports from NTA)*

This adult drug treatment needs assessment builds on previous years. It follows a similar format to last year in order to inform year on year comparison. This year extra NDTMS data that was not previously available has allowed the inclusion of additional gap analysis sections. The Needs Assessment will inform the 2009/10 treatment plan. The main aim is to identify the needs of the drug using population in Bolton and to examine how these needs can be effectively met using available resources within the treatment system.

Observations and Context

Prevalence

- Prevalence estimates for 2007/08 indicate that there are 2,788 PDUs in Bolton (95% confidence interval of 2,550-3,306).
- This is a decrease (not statistically significant) from the previous estimate, appearing to confirm local suggestion of a plateau in PDU numbers.
- It should be noted that there is a time lag of two years in the publication of data: most other data used in this report is from 2008/09, while prevalence estimates refer to 2007/08.

Numbers in Treatment and Treatment Penetration

- As of June 2009, Bolton has 1,434 PDUs in effective treatment, and is on-track to meet targets for 2009/10.
- This suggests that 51% of PDUs are in effective treatment.
- It is estimated that 37% of PDUs are not known to treatment services. Local feeling seems to be that this may be an overestimate of the unknown PDU population.
- The proportion of non-PDUs in effective treatment is a consistent 11-12%; it has not increased as was expected this year following the commissioning of a Tier 2 service.

Drug Use

- The Home Office estimates of opiate and crack use indicate a continuing trend toward combined opiate and crack use rather than either being used in isolation.
- Local opinion is that the number of non-PDU (i.e. not heroin and/or crack) users in Bolton may be rising as the PDU population plateaus.
- There is evidence of an emerging trend of poly drug use, particularly among young people.

Retention and Attrition

- Retention in effective treatment remains consistent at around 85%.
- Low numbers of care planned exits constitutes an ongoing issue in Bolton. Work is currently being undertaken to investigate and improve the rates of care planned exits.

Treatment Outcomes

- The treatment system in Bolton is relatively accessible to some drug strategy groups, including parents and BME clients. Services have made a commendable improvement in the proportion of clients whose parental status is recorded.
- Engagement and successful exits for under-25s are comparatively low in Bolton, though successful exits are improving.
- Bolton is endeavouring to improve effective engagement and successful exits figures for all priority groups.
- The proportion of DIP referrals failing to engage in treatment is consistently high, though the problem appears to be mainly one of initial engagement to get clients to triage.
- Only a small proportion of DIP clients are not previously known to treatment. A considerable number have previously been in treatment but did not re-enter following referral, implying they find existing treatment options unattractive. A minority of clients are offending while in treatment.

Treatment System Mapping

Referrals / Transitions

- 50% of treatment starts were self-referrals. This emphasises the high visibility of Bolton's drug treatment system and the ease with which individuals can self-refer.
- The Bolton drug treatment system receives 33% of its referrals from the criminal justice system. Clients who have had previous treatment are much more likely to come into treatment this way. This emphasises the importance of DIP in re-engagement.
- There is very little transition from the young people's service 360º, and no referrals are evident from the new Tier 2 service.
- Consistent and accurate data recording at Tier 4 is vital. Tier 4 data reported on NDTMS would benefit from improvement. Commissioners may wish to emphasise this in future conversations with both Tier 4 and local providers.

Age Profile

- It appears that a significant proportion of young PDUs are unknown to treatment, though many are known to DIP as a result of offending. This raises concerns about accessibility and engagement for this age group.
- Evidence suggests that once engaged, young adults response to treatment is just as positive as that of older people. It is important that younger drug users are encouraged to engage with treatment services.

Gender Profile

- The known PDU population is around 70% male, 30% female.
- Women are 10% more likely to drop out of treatment, but less likely to be discharged to prison.

Ethnic Profile

- Drug treatment clients in Bolton are predominantly white British.
- More ethnic diversity is found in treatment-naïve than non-naïve referrals.
- Asian / Asian British and clients from 'Other' ethnic minorities tend to spend less time in treatment.

Injecting Drug Use Profile

- 31% of clients in Bolton are current injectors; 41% have previously injected; 26% have never injected.

Accommodation Need

- Accommodation need is an important barrier to successful treatment.
- 28% of new clients in 2008/9 had a housing problem or no fixed abode.

Recommendations and Priorities

DIP Issues

As mentioned, there are several areas of DIP performance that appear to require attention.

DIP: DRR Commencements

- DRR commencements are below target, but there are reasons for this and reason to suggest the target should probably be lower.
- Despite falling commencement, DRR completions are above target, reflecting considerable effort by both Probation and drug services, joint working and a focus on quality. This good work should be continued.

DIP: Transfers from Prisons into the Community

- CARAT to CJIT transfers are a long-term issue for Bolton. A variety of factors, including IOM and IDTS, may help to improve this over the coming year.

DIP: Drug Related Reoffending

- There is some disagreement over the accuracy and implications of NI38, and its applicability as a comparative tool.
- Bolton's performance has improved to a figure of 0.96 at Quarter 1 2009/10.

Changing Drug Use Trends

- The majority of Bolton's current in-treatment population are opiate and/or crack users.
- The PDU population is ageing; new trends of non-'traditional PDU' drug use are emerging in younger users.
- There is other evidence for a possible decline of PDU numbers in Bolton; local opinion suggests a corresponding rise in different, polydrug use trends particularly among younger users.
- Non-PDU clients have different profiles in terms of their age, ethnicity, treatment needs, and outcomes.
- It is vital that the treatment system is prepared for potential changing drug use and corresponding changes in client profiles and treatment needs.

Time in Treatment

- 12% of our clients have been in treatment for 2-4 years; 16% have been in treatment for longer than 4 years
- The profile of long-term clients is older and less ethnically diverse, with a less varied substance use profile. These clients (in treatment for over 2 years) are much more likely to be heroin or crack users than users of other drugs. These clients need attention to move them on in treatment.
- They also have a different treatment profile, with a wider variety of modalities available to newer clients. Providers should be congratulated on this variety in treatment, while an aim for the coming year should be to extend this to all clients.

Non-English Speaking Clients

- Some agencies are reporting increasing contact with Eastern European clients who experience difficulty engaging as a result of not speaking English.
- Agencies should be aware of this growing need, and consideration should be given to ways of helping these clients to engage more effectively.

Parental Status

- Over half of new treatment starts in Bolton in 2008/9 were parents or had children living with them.

- The Partnership must continue to work to ensure that children of drug users in Bolton are safeguarded from harm, and that parents and carers have support available to them.

Education, Training and Employment

- Bolton has the 11th highest number of Incapacity Benefit claimants in the North West, with 235 per 100,000 individuals claiming. Further investigation during the coming year would be beneficial, even if only to determine the scope of data available.
- A major role in ETE provision will be played by the new Moving On service provided by ADS, which will be fully developing over the coming year.

Dual Diagnosis

- A high proportion of drug treatment clients in Bolton are likely to have concurrent mental health needs.
- Efforts are needed to ensure that those most likely to be overlooked (i.e. those with non-PDU drug use and less severe mental health problems) are not.

1 Introduction

1.1 Aims and Objectives

The NTA describe an annual cycle of assessing need, treatment planning, evidence-based commissioning and evaluation. As an integral part of the commissioning cycle, this needs assessment aims to investigate:

• What works well, and for whom, in the current system, and unmet needs across the system
• Where there are gaps for drug users in the wider reintegration and treatment system
• Where the system is failing to engage and/or retain people
• Hidden populations and their risk profiles
• Enablers and blocks to treatment, reintegration and recovery pathways
• The relationship between treatment engagement and harm profiles

The identification of the above should assist the partnership in quantifying and understanding the local need for services, and inform treatment planning for 2010/11.

1.2 Scope

Based on the guidance provided by the NTA, the findings and recommendations included within this needs assessment have been based on epidemiological research, a thorough analysis of national and local data for establishing the profile of met and unmet need within the drug misusing and Problem Drug Using (PDU) population of Bolton, and the analysis of supporting information relevant to the prevalence of problematic drug use. A consultation event was held to present preliminary findings of the needs assessment to key stakeholders from within the treatment system, local police, public health and community safety for challenge and comment. Their responses have been immensely valuable and are incorporated into the report.

The data used for analysis within this needs assessment has been collated from a number of sources, predominantly the National Drug Treatment Monitoring System (NDTMS), the National Drug Evidence Centre, Home Office statistics (prevalence estimates), the National Treatment Agency Performance Reports and individual service data, but also the Drugs Intervention Programme, North West Centre for Public Health, and Office for National Statistics. A full list of references is given at the end of the report.

The timescales for which research data applies has been clearly stated throughout the body of this report. Where there have been issues with data quality and accuracy or difficulties in accessing data during the needs assessment process, these instances have been commented on in the relevant sections within this report.

The demographic profile of Bolton is widely recorded in many reports[1], so is not repeated in detail here. In summary: “Bolton Metropolitan Borough has a population of just over 262,000 people and consists of four towns and many smaller communities. Bolton’s population is made up of diverse ethnic, religious and cultural groups. Data from the 2001 census show Bolton’s Black and Minority Ethnic communities to be 11% of the population. This is higher than the national average of 6%. The Borough is made up of twenty electoral wards. Of these, eight wards

[1] For example: Swain D. et al. (2008). *Strategic Threat Assessment 2008/9*. Be Safe Bolton MBC (Restricted publication).

feature within the most deprived 20% in the English Index of Multiple Deprivation (2004) contributing to Bolton's rating as the 50th most deprived borough in England"[2].

3 Understanding Met Need

There is a huge amount of excellent work being delivered in Bolton. The purpose of this Needs Assessment is to highlight areas for further improvement. The fact that it does not particularly highlight current areas of excellent performance is no reflection of the value placed on the efforts of all those involved in commissioning and delivering services.

Need in the health and social care field can respond, in part, to provision. Thus the annual update of this needs assessment will highlight previously un-reported needs. This year commissioners are increasingly confident that baseline services are in place, so focus has been widened to include some new sections, focusing on areas for potential improvement, including references to several aspects of the criminal justice system, new data on long-term clients, and education, training and employment provision, as well as revisiting areas discussed in last year's needs assessment such as 'dual diagnosis' and parenting.

The Needs Assessment is informed by a number of pieces of guidance from the National Treatment Agency (NTA) and others[3]. This document builds up thorough the pages. At its simplest a needs assessment reports on the perceived number of Problem Drug Users (PDUs) and other drugs users. The document then explores different facets of need, such as those related to different types of drug use and drug user profiles, injecting and so on. Moving on from this the report develops into gap analysis exploring the demand for treatment and ways in which current provision may be developed. Within this it is observed that different groups appear more or less likely to engage, so the report comments on sub groups of drug users. This detailed analysis leads to some clear areas where there is scope to improve services. These areas are presented as potential future commissioning priorities.

3.1 Prevalence and Penetration of Those in Drug Treatment

This section describes the size of the PDU population and some characteristics. It then compares this to the population known to treatment to describe the penetration treatment services have made into the drug using and PDU population.

2.1.1 Prevalence of PDUs in Bolton

The term PDU (Problem Drug User) is defined as 'someone who uses opiates (e.g. heroin, morphine, codeine) and/or crack cocaine. It will encompass those who 'use' as well as those that 'misuse' or 'abuse' these types of drugs. Opiates and/or crack cocaine may not be the primary drugs in use and those who also use other types of drugs in addition to opiates and crack cocaine will be included. This definition does not include people who *only* use other types of drug, such as powder cocaine, amphetamines, ecstasy, hallucinogens or cannabis'[4]. When planning for demand it is important to note that this latter group also present to drug treatment services for assistance, and may have very different presenting needs.

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[2] Roy A. with Buffin J., Fountain J. and Patel K. (2008). *Black and minority ethnic communities, drug supply and drug and alcohol use in Bolton*. UCLAN.

[3] Including : NTA (2007) Needs assessment guidance for adult drug treatment.
NTA (2008) Adult drug treatment plan 2009/10 Guidance notes on completion of the plan for local drug partnerships wishing to secure funding under the substance misuse pooled treatment budget.

[4] Home Office (2007). *Needs assessment guidance for adult drug treatment July 2007: Supplementary guidance notes for understanding and using estimates of problematic drug use obtained by CRC or MIM methods.* HO, London.

The most recent (2007/8) Home Office (HO) report[5] estimates that the prevalence of opiate and/or crack cocaine users in Bolton is 2,788 (95% confidence interval of 2,550 – 3,306).

The detailed estimates for 2004/5-2006/7 were the result of a time-limited project which has now finished. This means that the official figure for PDUs per 1,000 population is not available. The figure below has been calculated using the PDU estimate below and the Home Office 2006/7 Bolton population (aged 15-64) estimate of 171,000[5].

Year	PDU Estimate	95% Confidence intervals		PDUs per 1000 population
		High	Low	
2007/8	2,788	3,306	2,550	16.30
2006/7	2,928	3,848	2,610	17.05
2005/6	2,648	3,058	2,360	15.20
2004/5	2,650	3,327	1,973	15.28

Table 2: *PDU Prevalence: Home Office Estimates for Bolton*

The estimate for 2007/8 is lower than that for 2006/7, though the difference is not statistically significant. This suggests that the PDU population in Bolton is not rising as rapidly as suggested by last year's estimate, and corresponds to local opinion that numbers of PDUs may be reaching a plateau.

There is evidence from a number of sources that inward referral, particularly through the Criminal Justice system, is declining (see Section 4.1.4). The Home Office prevalence estimates do not support the possibility of declining PDU numbers; however there are some questions over the methodology used in calculating these. As mentioned, the figures have been calculated as part of a three-year project. Some areas were initially estimated using a capture-recapture method. In recent estimates, PDU populations are estimated based on similarity to the capture-recapture areas. Without an in-depth study of prevalence specific to Bolton, an accurate judgement cannot be made as to the size of the PDU population or treatment penetration.

Key Points:

- Prevalence estimates for 2007/08 indicate that there are 2,788 PDUs in Bolton (95% confidence interval of 2,550-3,306).
- This is a decrease (not statistically significant) from the previous estimate, appearing to confirm local suggestion of a plateau in PDU numbers.
- It should be noted that there is a time lag of two years in the publication of data: most other data used in this report is from 2008/09, while prevalence estimates refer to 2007/08.

2.1.2 Numbers in Drug Treatment

The NTA defines effective treatment as retention in treatment for 12 weeks or longer, or successful completion within that time. Numbers in effective treatment have increased over the past 14 months. At the most recent recording point (June 2009) NDTMS gives a figure of 1,434 PDUs in effective treatment. Comparing this with the Home Office estimate, this suggests that 51% of PDUs are in effective treatment.

The vast majority of people accessing drug treatment in Bolton are PDUs. However a consistent minority of users accessing treatment do so for problematic use of drugs other than heroin and crack. This non-PDU population makes up 11-12% of those in effective treatment reported to NDTMS.

[5] Hay et al. (2008). *Estimates of the prevalence of opiate use and/or crack cocaine use (2006/07) North West Region*. Home Office, London.
[5] Office for National Statistics. *Population Estimates 2006/7*. Crown Copyright. Please Note: data is rounded to the nearest hundred.

The proportion of individuals in treatment for non-heroin or crack use has not increased as anticipated during 2008/9. The implementation and embedding of the new Tier 2 service provided by Phoenix Futures was intended to enhance access to, and engagement with, treatment for this group as well as increasing referrals of PDU clients into Tier 3, but does not appear to have impacted as expected.

Key Points:

- As of June 2009, Bolton has 1,434 PDUs in effective treatment, and is on-track to meet expectations for 2009/10.
- This suggests that 51% of PDUs are in effective treatment.
- The proportion of non-PDUs in effective treatment is a consistent 11-12%; it has not increased as expected this year.

2.1.3 Types of Drug Use

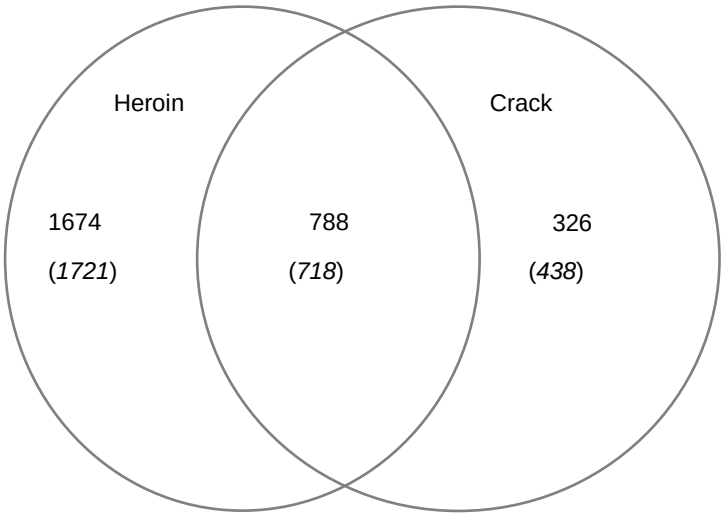

Fig. 1: *HO Estimates of the patterns of PDU drug use*
Bracketed figures indicate last year's numbers

The Home Office estimates of opiate and crack use indicate a continuing trend toward combined opiate and crack use rather than either being used in isolation.

Test on Arrest data is another source of information on drug use, and trends in drug use, in Bolton. In 2008/9, 2,952 individuals were arrested and tested for opiates or cocaine.

Drug tests as a result of Inspector's Authority (testing individuals for non-trigger offences) vary over time dependent on police priorities and crackdowns and can affect the visibility of drug use trends. As such these results are omitted from the data used here, leaving 2,631 tests successfully carried out. This data is not directly comparable with Home Office estimates as it includes all opiates, and all cocaine including both powder cocaine and crack.

Drug	**Test results for individuals (trigger offences only)**			**Change in proportion from 08/9 to 09/10**
	2007/8	**2008/9**	**2009/10 (Apr-Oct)**	
Opiates	308 (12.48%)	324 (12.31%)	214 (15.2%)	+ 2.89%
Cocaine	243 (9.85%)	221 (8.4%)	75 (5.33%)	- 3.07%
Opiates and Cocaine	320 (12.97%)	225 (8.55%)	82 (5.82%)	- 2.73%
Negative results	1,596 (64.69%)	1,861 (70.73%)	1,037 (73.65%)	+ 2.92%

Table 3: *Test on Arrest Data for opiate and crack use*

Drug test results appear to contradict the Home Office estimates, suggesting an increasing use of opiates only and a decrease in combined use of opiates and cocaine. However, trends within each year indicate that drug use can change in response to purity – for example a proportional increase in opiate use occurred during a period of known low cocaine purity from October 2008 to March 2009, after which point positive tests for cocaine begin to increase.

Data for 2009/10 shows a similar decline in positive tests (for any substance) during July and August. This led to suspicions of reduced purity, and concerns over the possibility of overdoses if purity levels subsequently rose. In response to this, staff at the Test on Arrest service provided by Arch Initiatives produced information leaflets warning clients of the dangers of both impure street substances and increasing purity. The numbers of positive tests increased from September, to a similar level as they were earlier in the year.

Local opinion is that the number of non-heroin and crack users in Bolton may be rising as the PDU population plateaus. There are a number of possible explanations, including existing PDUs switching to a different drug in response to reduced purity of opiates and cocaine, or possibly to avoid receiving a positive test from Probation or police if subject to an order involving drug testing or awaiting a trial.

There is also evidence of an emerging trend of poly drug use, particularly among young people (see Section 3.3.4). In some ways this reflects Howard Parker's ACCE profile – which describes the use of Alcohol, Cannabis, Cocaine and Ecstasy – although in Bolton poly drug use seems not to be restricted to these four substances. Anecdotal evidence suggests a much wider poly drug using repertoire, including (but not exclusively) benzodiazepines, over-the-counter medication and so called 'legal highs'. A trend of concurrent alcohol and cocaine use is also apparent in the night time economy.

The needle exchange service at Bolton Drug Service (BDS) has reported an increase in attendance of steroid users – in Quarters 1 and 2 (Apr-Sep) 2009/10 these clients accounted for almost half (47%) of all new clients, overtaking heroin as the main drug recorded. This compares to just 32% of new clients in Quarter 3 (Oct-Dec) 2008/9. Increased presentations for the injectable tanning product Melanotan have also been noted, from 9 recorded during the whole year 2008/9 to 32 in Quarter 2 2009/10. There is some debate over whether provision for steroid and Melanotan users is the remit of a needle exchange situated within a Tier 3 drug service; this will be given further attention in the Harm Reduction Needs Assessment. The proportion of new presentations to the needle exchange who are heroin injectors has declined from 40.78% in Quarter 3 2008/9 to 27.7% in the first 6 months of 2009/10.

The potential increase of non-PDUs seeking treatment is important as the treatment system will need to adapt to provide for their needs, which are likely to be very different from those of heroin and crack using clients. Also, the NTA unit cost calculator is weighted towards engagement of PDUs, so a declining proportion of PDUs in treatment would have financial implications for the future.

The profile of treatment contact for clients with different presenting substances (Fig. 2) shows that those currently engaged in treatment are comparatively more likely to be PDUs, while a larger proportion of those recently engaged, but not currently, are non-PDUs. This suggests that non-PDUs require less intervention time to meet their needs, and/or the current treatment system is less effective at retaining these individuals, since they are not its traditional target audience.

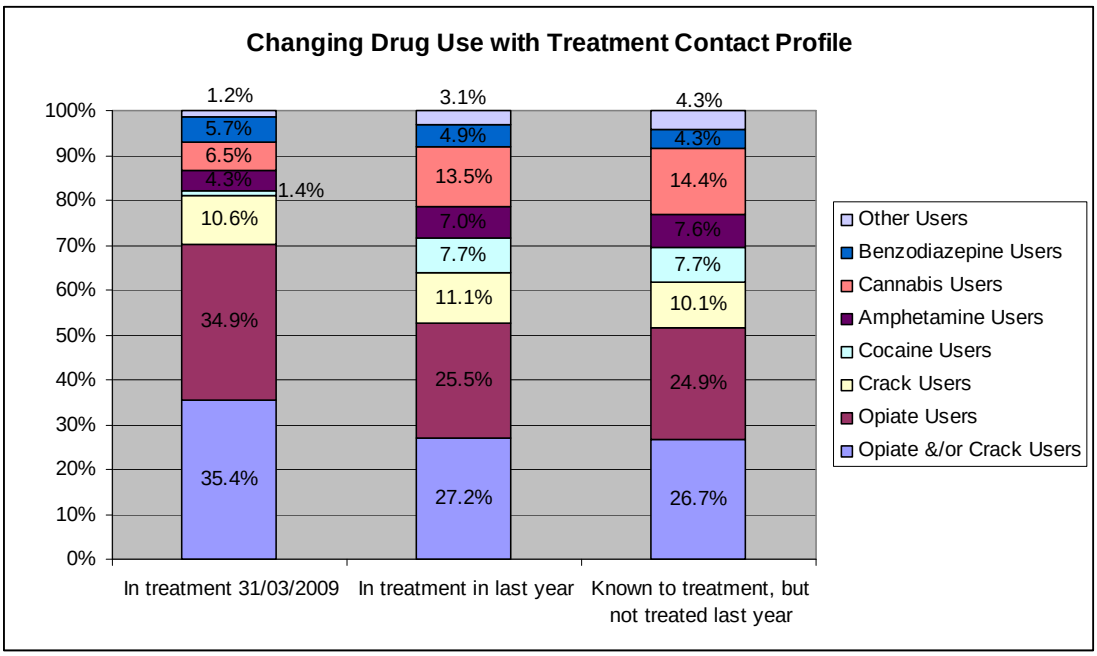

Fig. 2: *Presenting Substance and Treatment Contact Profile*

Non-PDU clients are often a more 'hidden' population than PDUs, as they tend to be less likely to seek treatment, be in treatment for a shorter time, or be in less structured treatment and thus not reported on NDTMS.

Key Points:

- The Home Office estimates of opiate and crack use indicate a continuing trend toward combined opiate and crack use rather than either being used in isolation.
- Local opinion is that the number of non-heroin and crack users in Bolton may be rising as the PDU population plateaus.
- There is evidence of an emerging trend of poly drug use, particularly among young people.

2.1.4 Retention and Attrition

Retention:

	2008/9 Q1	2008/9 Q2	2008/9 Q3	2008/9 Q4	2009/10 Q2	2009/10 Q2	Regional (2008/9 Q4)
PDUs	84%	84%	86%	86%	84%	85%	85%
All Adults	83%	83%	83%	83%	81%	81%	83%

Table 4: *New Treatment Starts Engaged in Effective Treatment*

Successful treatment is defined as a client either being retained in treatment for over 12 weeks or completing treatment within that time. The retention of new starts in effective treatment remains fairly constant in Bolton. This is also a target in the Local Area Agreement and as such is monitored on a monthly basis.

Attrition: Treatment Exits

	2008/9 Q1	2008/9 Q2	2008/9 Q3	2008/9 Q4	2009/10 Q1	2009/10 Q2
Percentage of Exits Care Planned (All Adults)	42%	33%	33%	32%	28%	30%

Table 5: *Care Planned Treatment Exits*

The proportion of care planned treatment exits in Bolton is consistently low. At Quarter 2 2009/10 less than a third (30%) of exits were care planned. This is within the bottom 50% nationally. The decline in the proportion of care planned exits seen recently is likely due to changes in the NDTMS discharge codes: from Quarter 1 2009/10, it was no longer possible to code a discharge as 'treatment complete' (i.e. care planned) where any use of opiates or crack cocaine were present, regardless of the frequency of use or other progress made by the client. This has resulted in a decline in recorded planned discharges. Regardless of the recent decline, care planned discharges are an ongoing issue for Bolton, and as such continuing effort is being made to investigate this locally.

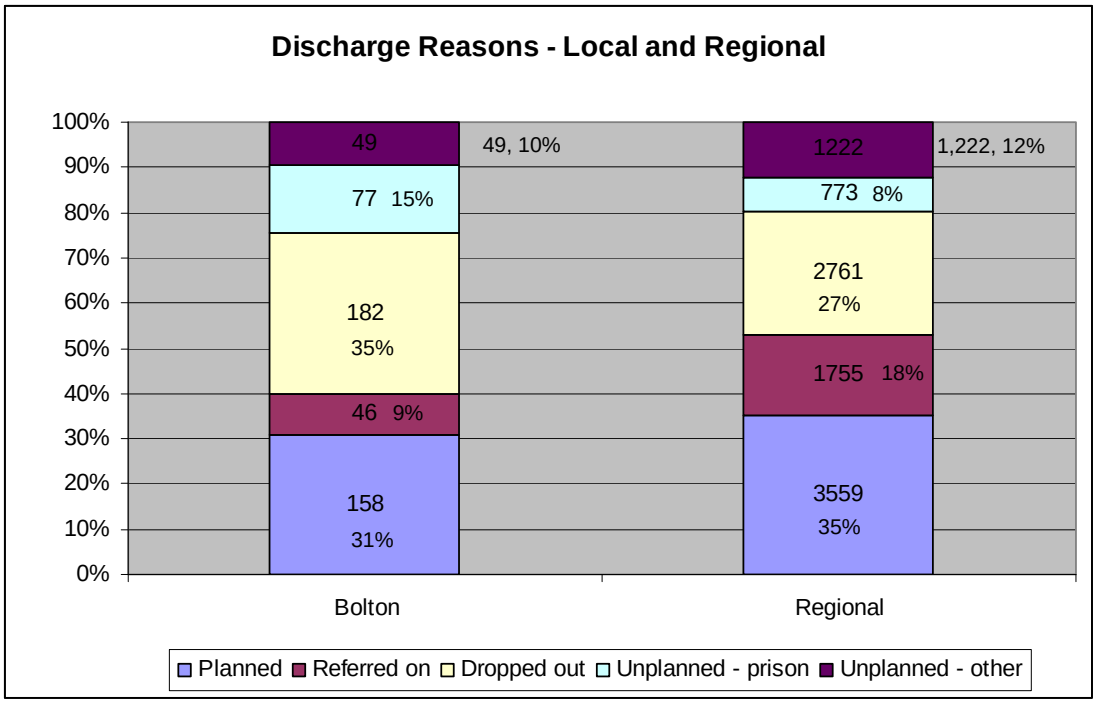

Fig. 3: *Discharge Codes for Clients Leaving the Treatment System*

Bolton appears to have a larger proportion of clients leaving the treatment system in an unplanned way, both dropping out of treatment and those clients with unplanned discharges to prison. The category 'Referred on' incorporates clients who have left the treatment system as a referral (but have not been recorded as received by another agency on NDTMS).

The NTA has requested that all North West partnerships investigate the high proportions of unplanned discharges in their areas. A more detailed piece of work was undertaken locally in August 2009[6] to investigate clients with unplanned discharges in April-June 2009. This found that almost half were transfers to another agency or to custody, categorised as unplanned because they were not recorded as received on NDTMS.

Several of the clients identified in the report as having an unplanned discharge to prison had been subsequently referred back to the same agency, suggesting that recording of the time in custody was the problem. This may improve with the onset of IDTS in prisons. The recording of a successful transfer is dependant upon both the referring and the recipient agency entering identical attributors for the client. It has recently been noted that the required attributors include DAT of residence, which presents particular problems when considering those clients referred to an out-of-area agency as a result of moving. 14% of the discharges highlighted as unplanned by NDTMS between April and

[6] Morris, J. (2009). *Unplanned Discharges Report – August 2009*. Be Safe Bolton

June were out-of-area transfers – work is currently underway to investigate whether these are in fact planned transfers which have simply not been reported.

The report also led to the identification of inflexibilities of the current NDTMS discharge codes, which do not enable them to accurately reflect some positive outcomes. For example, a discharge to sole care of GP could not be recorded as a successful transfer in Bolton, as GPs do not have NDTMS codes. The same applies to Tier 2 agencies such as the Blackpool Tower Project, and some other destinations: one client highlighted as unplanned had been transferred to the psychiatric ward at Bolton General Hospital. These transfers cannot be recorded as 'treatment complete', as from April 2009 this code is not applicable where there is continued problematic use of *any* drug, nor *any* remaining use of opiates or crack (including those prescribed by the client's GP). It seems that a gap in recording exists, such that a client may only be coded as dropping out, despite having made improvements and moving on in a care planned way that is appropriate to them. Current codes seem inadequate to capture some important work done by agency staff and progress made by clients.

Data suggests a pattern of treatment cycling (short periods in and out of treatment). As well as resulting in more discharges, this will have a negative impact on recorded numbers in effective treatment and thus future funding, since re-entering treatment within a 12-month period causes a client's original episode to be discounted. It is thought that this might affect Bolton more than some areas as a result of the time allowed to lapse between last contact and case closure. This is reported to be considerably longer in some areas than the 14 days of active follow-up given by agencies in Bolton, resulting in Bolton having a greater number of case closures, discharges, and discounted episodes of treatment. (There is no suggestion that time before case closure should be extended; there is no evidence that this benefits clients.)

This focus on discharges is continuing on a quarterly basis, investigating the causes of unplanned discharges and how they can be reduced.

The proportion of clients discharged in a care-planned way varies between agencies.

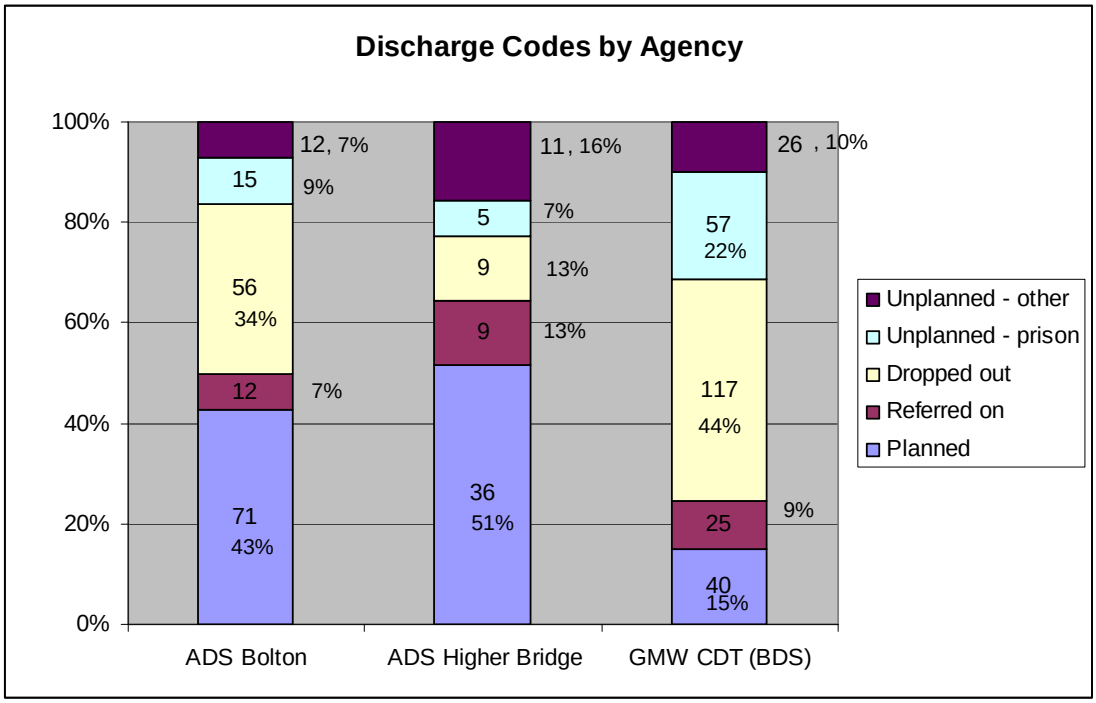

Fig. 4: *Discharge Codes for Clients Leaving Each Agency*

Clients leaving the Higher Bridge Project are more likely to do so in a care-planned way. Clients leaving BDS are more likely to drop out of treatment or to have an unplanned discharge to prison. This is not unexpected considering that BDS is more likely to work with complex and chaotic clients, while the Higher Bridge Project works with clients who are moving towards abstinence.

A brief examination of the clients leaving treatment during 2008/9 has indicated that some client groups are more likely to leave in a planned or unplanned manner. Characteristics associated with greater likelihood of dropping out of treatment include:

- Being female
- Being White British
- Being a problematic user of opiates, crack, both, or benzodiazepines

Characteristics associated with greater likelihood of having a planned exit from treatment include:

- Being Asian or Asian British
- Having a presenting substance that is cannabis, amphetamine or powder cocaine.

See Section 3 for more details.

Key Points:

- Retention in effective treatment remains consistent at around 85%.
- Low numbers of care planned exits constitutes an ongoing issue in Bolton. Work is currently being undertaken to investigate and improve the rates of care planned exits.

2.1.5 Treatment Outcomes: NDTMS Data

For the sake of simplicity, analysis of data relating to treatment outcomes will be divided into NDTMS data and local agency data.

Drug Strategy Priority Groups

Target groups identified in national drug strategy for improved treatment access, engagement, and successful exits are crack users, clients from BME backgrounds, parents, CJS (criminal justice system) clients, and under-25s. The following is data released by the NTA and concerns the 'latest 12 months that can be fully reported' (i.e. Q1 data concerns the period 1st April 2008 – 31st March 2009; Q2 covers 1st June 2008 – 30th September 2009).

Data on outcomes for parents in drug treatment is only available for Quarter 2 2009/10. This is due to recording issues caused by the static nature of the parental status field within NDTMS (which can thus only be recorded on treatment entry). The parental status fields may be updated in 2010 to enable more flexibility.

	Penetration % Q1 2009/10 (no. in effective treatment)	Penetration % Q2 2009/10 (no. in effective treatment)	Regional % Q2 2009/10	National % Q2 2009/10
Crack Clients (smoothed estimate: 1,227)	36% (446)	37% (449)	40%	37%
	% in effective treatment Q1 2009/10 (no. in effective treatment)	% in effective treatment Q2 2009/10 (no. in effective treatment)	Regional % Q2 2009/10	National % Q2 2009/10

BME	6% (108)	6% (108)	5%	11%
Parents	No data available	54% (923)	33%	30%

Table 6: *Access to Treatment*

It should be noted that the crack penetration figure is calculated from estimates of prevalence, and thus not a precise measure. Bolton penetration rates broadly follow both regional and national trends.

The treatment system in Bolton is relatively accessible to parents. Access and successful exits for BME clients are also above regional average. Given the local demographics the percentage figures describe a relative large number of BME clients in treatment. The very high proportion of parents may be a reflection of the efforts staff in Bolton have been making to capture this data in the past year.

	% new journeys engaged in effective treatment Q1 2009/10 (no. new journeys)	% new journeys engaged in effective treatment Q2 2009/10 (no. new journeys)	Regional % Q2 2009/10	National % Q2 2009/10
Crack	80% (191)	80% (171)	85%	84%
BME	76% (41)	71% (41)	82%	82%
Parents	No data available	83% (327)	86%	86%
CJS Clients	77% (220)	82% (206)	80%	80%
Under 25s	65% (127)	64% (114)	77%	78%

Table 7: *Effective Engagement of New Clients*

As noted earlier, Bolton's treatment retention is overall consistently high at around 85%. Bolton is endeavouring to improve the 'Effective Engagement' figures for priority groups.

	% clients exiting successfully Q1 2009/10 (no. exits)	% clients exiting successfully Q2 2009/10 (no. exits)	Regional % Q2 2009/10	National % Q2 2009/10
All Clients	28% (116)	33% (95)	32%	35%
Crack	21% (38)	20% (25)	24%	28%
BME	13% (8)	50% (6)	27%	38%
Parents	No data available	23% (52)	33%	37%
CJS Clients	13% (32)	14% (35)	31%	28%
Under 25s	24% (25)	33% (15)	45%	42%

Table 8: *Treatment Exits*

The main areas with performance below regional averages are engagement of BME clients and under 25s, and successful exits for most groups – as previously mentioned, work is ongoing to investigate this. However, while the numbers for 'All

clients' allows some comparison with the regional and national figures, the numbers of clients in each subgroup are very small, so percentage differences are not significant.

Engagement and successful exits for under-25s are comparatively poor in Bolton, though successful exits are improving. Bolton has a slightly younger than average PDU population: 7% of crack and/or opiate users in treatment are aged 24 or under, against a regional average of 5%. It is well recognised that drug users earlier in their using career are generally less motivated and more difficult to engage in treatment.

DIP Outcomes

Quarter 4 2008/9 (Dec 08-Feb 09)	Clients with DIP care plan who are referred for treatment	Triaged within 6 weeks of referral	Triaged within 6 weeks and starting a modality	Already in treatment at time of DIP referral	Previously in treatment but not re-entered following referral	Not previously treated (since April 2004)
Bolton	52% (n=45 of 87)	38% (n=16 of 42)	100% (n=16 of 16)	14% (n=6 of 42)	24% (n=10 of 42)	21% (n=9 of 42)
North West	47%	39%	93%	24%	10%	24%
National	50%	45%	96%	24%	10%	18%

Table 9: *DIP Referrals and Treatment Entry 2008/9*

The most notable variations from regional and national figures in each of these data sets are the numbers already in treatment, previously treated but not re-entering, and not previously treated. These differences become more pronounced over time. However, care must be taken when drawing conclusions from this due to the small numbers involved.

Quarters 1 and 2 2009/10 (Mar-Aug 09)	Clients with DIP care plan who are referred for treatment	Triaged within 6 weeks of referral	Triaged within 6 weeks and starting a modality	Already in treatment at time of DIP referral	Previously in treatment but not re-entered following referral	Not previously treated (since April 2004)
Bolton	24% (n=49 of 208)	47% (n=23 of 49)	95% (n=22 of 23)	10% (n=5 of 49)	33% (n=16 of 49)	13% (n=6 of 49)
North West	49%	51%	99%	20%	8%	19%
National	52%	48%	98%	22%	9%	19%

Table 10: *DIP Referrals and Treatment Entry Quarter 1 2009/10*

DIP clients referred, and proportions triaged, are below regional and national averages. The proportion of DIP referrals failing to be engaged is consistently high (45% at year end 2008/9, it increased to 58% in Quarter 1 2009/10), though the proportion of triaged clients starting a modality is high. Over the year only 1% of DIP clients were triaged but had no subsequent intervention provided. The problem appears to be one of initial engagement to get clients to triage. There are also questions around possible data issues, since data concerning referrals is taken from DIRWeb (for example, a DIR form filled out by the Test On Arrest service) while triage is recorded on NDTMS: performance is thus reliant on client attributors within the two data sets matching.

In terms of DIRWeb data and the Key Performance Indicators, there are ongoing issues with the lack of consistency between local data and the DIP Dashboards. KPI 2 in particular consistently appears lower on the monthly Dashboard than it is known to be from local evidence. This is true for a number of areas; notable exceptions are some areas in Merseyside whose data is inputted by a team at Liverpool John Moore University (LJMU), who manage DIRWeb, implying this is a data issue. Managers from the Test On Arrest service have met with advisers from LJMU in an attempt to

resolve this, and data matching work between Test On Arrest and custody has been undertaken locally; however, KPI 2 continues to be an issue.

The picture of DIP clients' treatment status seems to show that only a small proportion of the criminal justice client group are not already known to treatment. However, a higher than average proportion have previously been in treatment but did not re-enter following referral, implying that treatment may be unattractive to these clients – they may be 'treatment fatigued'. A minority of clients are offending while in treatment. If a client is re-referred by DIP while in treatment, this should trigger a review of their offending behaviour.

Restriction on Bail is a possibility to consider, and may help to improve engagement via DIP. However, in Bolton, cases can progress very rapidly through the courts, resulting in insufficient time to place effective restrictions on an individual's bail. Some work is currently underway to raise awareness among magistrates about the drug treatment options available, and increase their confidence in making referrals.

	Quarter 4 2008/9	Quarter 1 2009/10	Quarter 2 2009/10
Bolton: Number picked up (no. of referrals)	41 (61)	9 (47)	18 (48)
Bolton: %	23%	19%	38%
North West	26%	26%	31%
National	30%	32%	33%

Table 11: *Percentage of CARAT Referrals Picked Up by CJIT*

The pickup of CARAT referrals is consistently low; this is an ongoing problem for Bolton. This will be discussed further in Section 4.1.2.

NI38 is one of the local area agreement priority indicators. It is calculated by comparing the predicted and actual reoffending rates over the financial year of a cohort identified by testing positive on arrest, being subject to a DRR, or having OASys scores indicative of a 'criminogenic drug need'. The indicator was at 1.2 at year end 2008/9 (the target being 1 or below), giving Bolton the highest level of drug-related offending in the North West. This has since improved to 0.9 in Quarter 1 2009/10: indicating an actual offending level below that predicted. There are some questions over the use of NI38 as a comparative tool between areas, since the rate of re-offending is largely dependant on proactive policing strategies. It also includes breach of ASBOs – this may have a disproportionate effect in Bolton as a result of the local prostitution strategy, which uses ASBOs in an attempt to limit access to known red light areas.

DRR starts are falling below target in 2009/10, with only 55 commencements by Quarter 2 against a target of 86 (64% of target). This compares to a performance of 121% for 2008/9 (215 commencements against an annual target of 178). Bolton has previously had, and met, very high targets for DRR commencements. Reports from Probation and the courts indicate that there are now simply fewer appropriate clients to assign to DRRs. Despite falling commencements, however, success rates have improved considerably – from 33.6% at year end 2008/9, to 61.5% at the end of August 2009. Retention for 12 weeks or more (75% target) has also gone from amber to green (74.4% to 75.8%) during this time.

DIP outcomes will be discussed in more detail in Section 4.

Health outcomes

The proportion of new clients offered a healthcare assessment continues to be high (100% in Q1 2009/10). Numbers of individuals offered Hep C testing and Hep B

vaccination where appropriate have shown dramatic improvements over the previous year's data, to 49% and 96% respectively at year end 2008/9.

A Needs Assessment specifically investigating matters relating to health, harm reduction and Tier 2 services is taking place concurrently to this one. As such, these issues will not be discussed in a high level of detail in this Needs Assessment.

TOPs

Data available to partnerships from the completion of TOPs is performance linked; minimum thresholds are applied to completion rates and to date, Bolton has not met the performance target for review TOPs. Performance on treatment start TOPs was at 91% over 2008/9, and this data is now available, but without the availability of review data it is impossible to follow changes over time and assess the impact of treatment in terms of improvements in clients' health and social functioning, crime involvement and impact on substance use. It is important that efforts are made to continue the improvements in valid TOPs returns that have been seen over the past year.

Key Points:

- The treatment system in Bolton is relatively accessible to some drug strategy groups, including parents and BME clients. Services have made a commendable improvement in the proportion of clients whose parental status is recorded.
- Engagement and successful exits for under-25s are comparatively low in Bolton, though successful exits are improving.
- Bolton is endeavouring to improve effective engagement and successful exits figures for all priority groups.
- The proportion of DIP referrals failing to engage in treatment is consistently high, though the problem appears to be mainly one of initial engagement to get clients to triage.
- Only a small proportion of DIP clients are not previously known to treatment. A considerable number have previously been in treatment but did not re-enter following referral, implying they find existing treatment options unattractive. A minority of clients are offending while in treatment.

2.1.6 Treatment Outcomes: Agency Data

BDS Funnels (Appendices 1a and 1b)

Note on Data: It should be noted that there is some disparity between figures in the BDS funnels recording system and the NDTMS figures for 2008/9. Assurance has been given by GMW's Senior Information Analyst that the two data sets broadly agree. The caseloads reported by each are different since NDTMS considers all clients in treatment over the year, while the funnels system takes a snapshot at year end. The difference between treatment exits on NDTMS and case closures in the funnels can be accounted for by the fact that most clients will be in (and thus discharged from) more than one funnel. In terms of inward referrals, NDTMS shows fewer than the funnels, probably because if a client is re-referred during the year, their initial episode is discounted.

Funnels data is available for the full year data for 2008/9 (March 2009 tables) and for the first 6 months of 2009/10 (Sept 2009 tables). Some milestones have been modified between 2008/9 and 2009/10 to better reflect the treatment journey.

Generally speaking, there is substantial variance in performance between different funnels. Some areas are operating well above targets. The DRR (Drugs

Rehabilitation Requirement) funnel, for example, had more than double the target number of clients completing during 2008/9, despite Probation data indicating falling numbers being assigned DRRs.

As was noted in last year's Needs Assessment, the Specialist Medical funnel constitutes the largest group of clients, though figures this year appear to demonstrate greater movement. Using the 2008/9 totals as a rough indication (though the reported year is obviously not a closed period, and many individuals will have entered previously and left after the reported period), around 20% of those entering the funnel achieved the milestone 'Attends 3rd medical review and is stable'; 5% became drug free and 17% transferred to an external provider.

The Core funnel also holds a large group of clients. Successful completions from Core are above target; however movement from Core into 'appropriate further treatment' is lower. Ideally, we would see a pattern of movement toward clients stabilising in the Core and Specialist Medical funnels before moving to 'appropriate further treatment' or external service provision.

Client movement into and between the Intermediate and Primary Shared Care funnels is slow. Shared Care is a valuable tool for moving the care of clients into their local communities, normalising treatment and enabling access to primary healthcare services which might otherwise be missed. In Intermediate Shared Care, clients are seen by a drug worker in a community setting (such as a medical or UCAN centre), with no GP involvement. In Primary Shared Care, a GP liaison worker employed by BDS will deliver the client's treatment from their GP surgery, with the GP participating in the client's care and holding responsibility for reviewing substitute prescribing and signing prescriptions. Primary Shared Care is particularly suitable for clients who have been in treatment for a long period and are stable.

There are 55 GPs in Bolton, of whom 29 are involved in some way with the Shared Care team. 22 are providing prescribing in a Primary Shared Care setting, 6 in Intermediate Shared Care, and one provides a bespoke shared care service. The Shared Care team at BDS are involved in ongoing outreach efforts to encourage GP involvement, including approaching various GP groups and practice managers, offering RCGP training free of charge, and currently negotiating the possibility of raising awareness with training for graduate doctors. There are a variety of reassurances for GPs involved in Shared Care, with ongoing support from GP liaison workers, a two-way care pathway, and all clients covered by GMW clinical governance. Practices are actively reviewed on a monthly basis, allowing new clients to be assigned to Shared Care when places become available as a result of others moving on. Please see Appendix 4 for a map of client distribution and the locations of GPs involved in Shared Care.

In the first 6 months of 2009/10, 35 clients are recorded as having been discharged (from all BDS funnels) drug-free.

ADS Bolton Funnels (Appendix 2)

The role of Addiction, Dependency Solutions Bolton has changed considerably from the beginning of 2009/10. ADS now deliver the new Moving On service, which aims to aid re-integration through a focus on the holistic needs of the client, improvement of life skills and provision of education, training and employment opportunities. The service will encourage work placements, and provide volunteer training and qualifications in areas such as peer mentoring. The outcome data considered here covers 2008/9, during which ADS was predominantly a provider of structured day care. The new service funnels will likely require time to embed, and possibly be adapted based on experience. As such, discussion of these will be reserved until next year's Needs Assessment.

Successful completions in the 2008/9 ADS Structured Daycare funnel are above target. However, performance against the milestones does not appear as positive. It may be that clients require longer than anticipated to achieve improvements (the review milestones are set at 6 and 12 weeks). However, engagement also seems problematic, with almost half (44%) of clients referred not having received an assessment and care plan.

The Education, Training and Employment (ETE) funnel shows some very positive outcomes – with 14 clients in March 2009 being engaged in further or higher education, and 14 over the course of the year attaining sustainable employment or engaging in a work placement. The Widening Horizons funnel (ADS's volunteering programme) shows fewer volunteers than expected completing the training programme, but several going on to participate in volunteering placements for considerable lengths of time, and some attaining sustainable employment. As mentioned above, the new focus of ADS will be education, training, providing volunteering experience and preparing clients for future employment.

Higher Bridge Project Funnels (Appendices 3a and 3b)

The 'Drug Daycare' funnel shows performance above targets on clients achieving positive change and completing detox. 18 clients over the course of the year were verified abstinent post-detox and had a care-planned discharge from Higher Bridge. However, a larger number than expected were unable to complete their detox and were referred back to ADS; there were also fewer clients than expected referred on into 'Drug-Free Daycare' – this could perhaps be utilised more. While referrals into the 'Drug Daycare' funnel are fairly high, the number assessed as compliant with service criteria is below target. It may be that extra work, if possible, at first contact, or an adjustment of entry criteria, would result in more clients being able to participate, and even higher performance in terms of successful detox. The 'Drug Free Daycare' funnel, despite having lower than expected numbers of clients entering, and attaining early milestones, planned discharges of clients who have maintained abstinence are above target, while the number of clients dropping out is low.

2.2 Mapping the Treatment System

Three treatment system maps have been drawn: one showing flow into and through the whole system, and two covering referrals routes into treatment for treatment-naïve and non-treatment-naïve clients. The maps can be found in Appendices 5, 6 and 7, and are mostly self-explanatory, though some key points are highlighted below.

Map 1: Treatment System Map 2008/9 (Appendix 5)
Referrals

- 50% of treatment starts were self-referrals, above regional and national average (43% and 42% respectively). This emphasises the high visibility of Bolton's drug treatment system and the ease with which individuals can self-refer. The disparity is even greater when looking at treatment naïve clients, 58% of whom self-refer into treatment in Bolton. The regional figure is 43%. This may also help to explain why only 2% of referrals were from GPs – below the regional (5%) and national (7%) average – as individuals do not feel they have to ask their GP for a referral.

- The Bolton drug treatment system receives an unusually high proportion of its referrals from the criminal justice system – accounting for 33%. This is high compared both to North West (26%) and national (27%) averages.

Transitions

- Referrals from 'drug services' make up a notably small proportion – 10% against a regional average of 16%. This category includes referrals from Tier 2 services and young people's service 360º. Closer inspection of referrals from 'drug services' into BDS, of which there were 25, revealed that while two were from 360º, the rest were from out-of-area drug teams or ADS. None were from Phoenix Futures. Some were internal transfers, which highlights a recording issue. There is very little transition from the young people's service. This is an ongoing issue in Bolton. However, this may change as the Tier 2 service becomes fully embedded, potentially providing transition support for young users. There has not previously been an adult service targeting non heroin and crack users (traditionally the drug use profile of younger clients) and the number of heroin and crack users treated by 360º is very low; younger clients tend to engage in polydrug use aligned with the ACCE profile. With this in mind, Phoenix Futures should already present a more appropriate referral route for 360º clients. However, currently numbers remain low.

- It was also expected that the new Tier 2 service provided by Phoenix Futures would boost PDU referrals into the system – this does not appear to have happened as yet. NDTMS has no record of referrals from Phoenix Futures into Tier 3 during 2008/9; BDS agency data appears to confirm this.

Inter-agency Transfers

- Transfers between ADS, BDS and Higher Bridge are fairly numerous. These may be due to an individual's needs changing, or possibly the high visibility of the treatment system resulting in individuals feeling confident another agency can also meet their needs.

It will be interesting to see what the picture is like for 2009/10 and 2010/11 data as the new role of ADS as the 'Moving On' service becomes embedded. The treatment system may begin to have more defined routes of flow, as clients enter Tier 3 at BDS for drug treatment, and gradually move toward Higher Bridge for abstinence, ADS for ETE needs, or remain within BDS for maintenance – in Shared Care in their communities where possible, or in the Core funnel for complex clients.

Tier 4

- Direct entry at Tier 4 – according to NDTMS data, 14 individuals entered Tier 4 services without having first been engaged in the community. This is unlikely to be accurate: this data does include clients who have self-funded as well as those funding by the treatment system, but there are unlikely to have been 14 of these over a year. Another possibility is that this category includes clients referred by CARATs, although local data shows only 2 clients referred by CARATs into residential rehab during the year.
- Data supplied by the NTA does not appear to match data recorded locally. Again, this may be partly as a result of the inclusion of self-funded clients, but this cannot explain the extent of the disparity. It is possible that data recording and data consistency may pose issues at a provider level. Consistent and accurate data recording is vital in ascertaining and monitoring Tier 4 need, flow of clients into and through Tier 4 services, and treatment outcomes. Commissioners may wish to emphasise this in future conversations with both Tier 4 and local providers.
- NDTMS data does not give a clear picture of what is happening and has been highlighted in red where it has been used. Numbers referred into inpatient detox have been taken from NDTMS data; however locally collected data has been used for referrals from the drug treatment system into residential rehab as this is considered to have greater reliability (of the 20 referrals, 17 were

from BDS, 2 from CARATs and 1 from another organisation).

Map 2: Referral Routes for Treatment Naïve Clients; and Map 3: Referral Routes for Non–Naïve Clients (Appendices 6 and 7)

The NTA has provided extra referral data this year to enable more detailed analysis of treatment naïve and non-naïve referrals. In summary:

- Treatment naïve clients are more than twice as likely to be referred by their GP.
- Treatment naïve clients are much less likely to come into the treatment system via a criminal justice route (17% of treatment naïve referrals) than those who have had previous treatment (43%).
- This supports the perception that more complex, treatment cycling clients are more likely to come into contact with the criminal justice system. It also emphasises that fact that DIP is a hugely important tool for getting clients into treatment, especially for getting those who have already been in treatment back in.
- Profiling shows that clients who have been in treatment previously are more likely to be white, aged 25-34 (52%; 13% aged under 25), and almost twice as likely to be a current (33%) or previous (42%) injector than treatment naïve clients (15% and 28% respectively). Treatment naïve clients are more likely to be ethnically diverse, younger (28% aged 18-24, 36% aged 25-34), and to never have injected (55%).
- Non-naïve referrals are more likely than treatment-naïve referrals to be PDUs. Data also shows a marked proportion of new treatment-naïve referrals who are problematic powder cocaine and cannabis users, compared to those who have been in treatment previously.
- Proportion of treatment naïve clients varies by agency. BDS receive the fewest naïve referrals (25%), while 52% of referrals to Higher Bridge and 64% to ADS are treatment naïve. This fits the accepted client profile of each service: BDS cater for more complex clients who are more likely to experience a treatment cycling pattern.
- Clients referred in via the criminal justice (CJS) system are even more likely than the in-treatment population as a whole to be white, male, aged 25-34 and opiate users. They are 3% more likely than non-CJS referrals to have no fixed abode and 6% more likely to have reported a housing problem. They are slightly less likely to be a parent and are 17% more likely to have injected at some point.
- Clients who have previously been in treatment are 22% more likely than naïve clients to enter through self-referral (143 as opposed to 183). This implies that although some clients who have had previous treatment episodes may be 'treatment fatigued' (see DIP Outcome section), treatment is not prohibitively unattractive to these clients.

Key points:

- 50% of treatment starts were self-referrals. This emphasises the high visibility of Bolton's drug treatment system and the ease with which individuals can self-refer.
- The Bolton drug treatment system receives 33% of its referrals from the criminal justice system. Clients who have had previous treatment are much more likely to come into treatment this way. This emphasises the importance of DIP in re-engagement.
- There is very little transition from the young people's service 360º, and no referrals are evident from the new Tier 2 service.
- Consistent and accurate data recording at Tier 4 is vital. Tier 4 data reported on NDTMS would benefit from improvement. Commissioners may wish to emphasise this in future conversations with both Tier 4 and local providers.

3 DEFINING THE POPULATION IN NEED (BULLSEYES AND PROFILING)

The treatment Bullseye is an illustrative tool that may be used as part of a needs assessment process when seeking to define and better understand groups of PDUs based on their level of engagement with structured treatment[4]. The treatment Bullseye featured in this report uses the 2006/7 Home Office Prevalence Estimates and 2008/9 NDTMS data supplied by the NTA for the purpose of the Needs Assessments.

3.1 Treatment Bullseye – All Opiate and/or Crack Users in Treatment

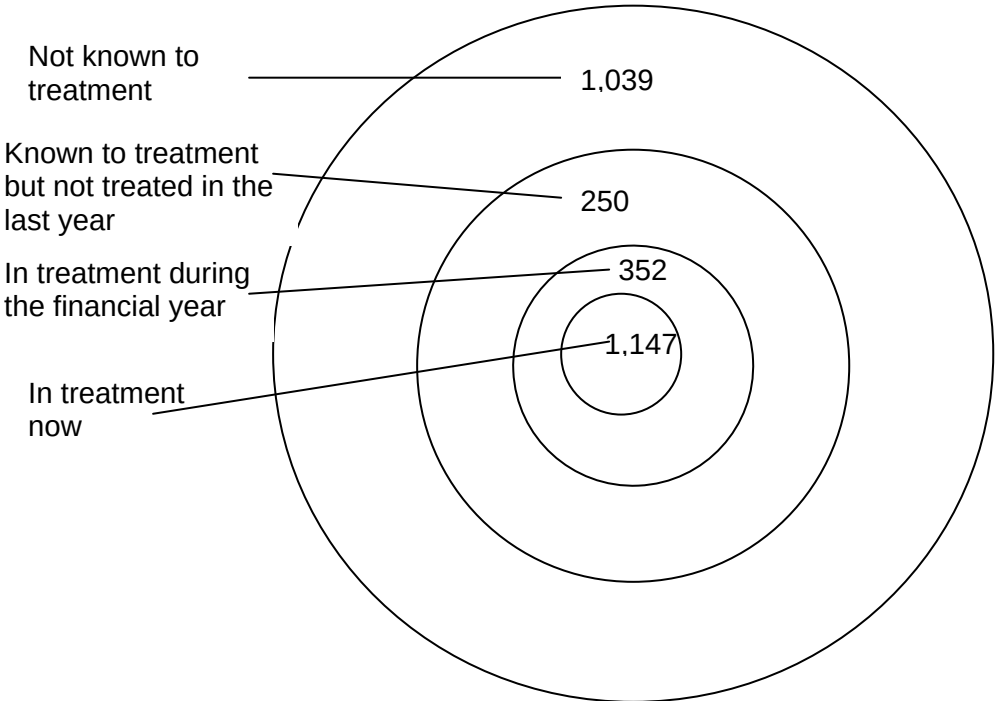

Fig. 5: *All In Treatment*

*Calculated by subtracting the PDUs in or known to treatment (1,147+352+250) from the PDU prevalence estimate (2,788).

	2007/8	2008/9	Change (no. of PDUs)	% Change
PDU Estimate	2,928	2,788	-140	-4.78%
In treatment now	1,113	1,147	34	3.05%
In treatment during the financial year	372	352	-20	-5.38%
Known to treatment but not treated in the last year	274	250	-24	-8.76%
Not known to treatment	1169	1039	-130	-11.12%

Table 12: *All PDUs in Treatment during 2007/8 and 2008/9*

Key points – All in Treatment

- The total PDU estimate has decreased by 4.78% from the previous year, from 2,928 to 2,788, the impact of which has been mainly on those not known to treatment.
- The number of PDUs in treatment has risen slightly (by 3.05%) to 1,147, while the number of PDUs not known to treatment has declined by 11.12% to 1,039.
- It is estimated that 37% of PDUs are not known to treatment services. Local feeling seems to be that this may be an overestimate of the unknown PDU population.

Please see Appendix 8 for an illustration of clients in treatment, and individuals arrested and testing positive, between March and August 2009. The Test on Arrest population is used here as an indication of those drug users not known to treatment; however this is not clear-cut since it will include some clients who are known to treatment, so no definitive conclusions may be drawn. However, what the map shows is the almost identical geographical distribution of these two groups across Bolton, with no noticeable gaps in treatment coverage.

3.2 Treatment Bullseye – All Opiate and/or Crack Users in *Effective* Treatment

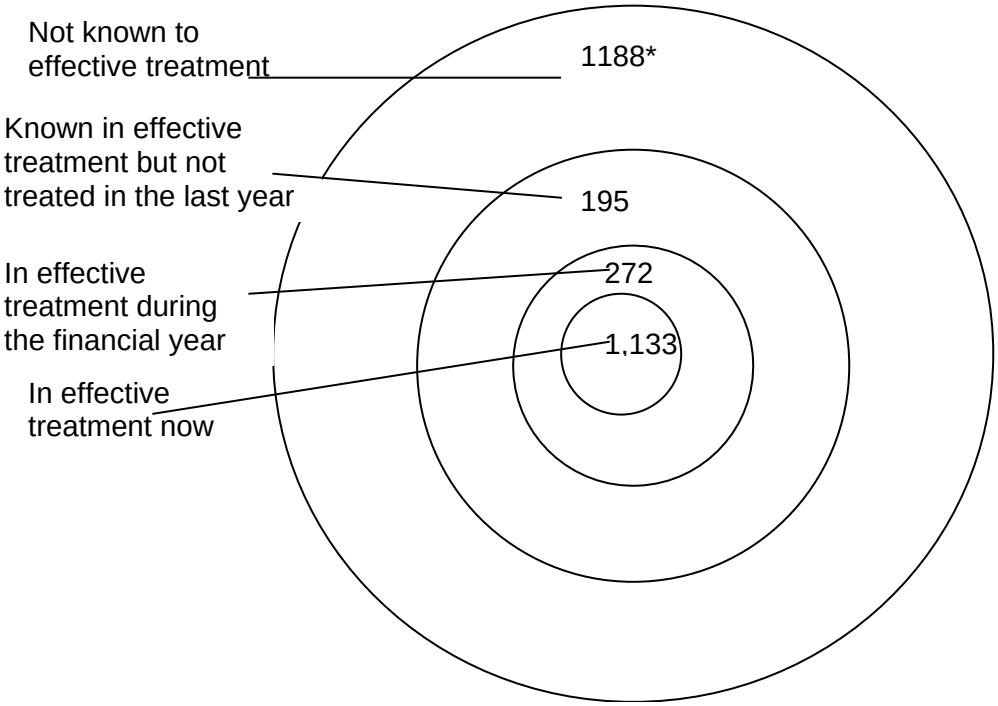

Fig. 6: *PDUs In Effective Treatment*

*Calculated by subtracting the PDUs in or known to effective treatment (1,133+272+195) from the PDU prevalence estimate (2,788).

	2007/8	2008/9	Change (no. of PDUs)	% Change
PDU Estimate	2,928	2,788	-140	-4.78%
In effective treatment now	1,102	1,133	31	2.81%
In effective treatment during the financial year	280	272	-8	-2.86%
Known in effective treatment but not treated in the last year	134	195	61	45.52%
Not known in effective treatment	1412	1188	-224	-15.86%

Table 13: *All PDUs in Effective Treatment during 2007/8 and 2008/9*

Key points – All in Effective Treatment

- The total PDU estimate has decreased by 4.78% from the previous year, from 2,928 to 2,788.
- The number of PDUs in effective treatment has risen slightly (by 2.81%) to 1,133, while the number of PDUs not known to treatment has declined by 15.86% to 1,188.

3.3 Profiling the Population

The treatment Bullseye can also be used to establish a profile of clients at each level by identifying age, gender, ethnicity and injecting status. Additional data sets such as DIP data can be projected onto the Bullseye to gain an insight into the profile of PDUs who have been in contact with DIP but not tier 3/4 treatment services.

Please Note: Since estimates regarding details of the PDU population 'not known to treatment' and 'known only to DIP' were not available this year, individuals 'known to DIP via Test on Arrest' have been used to gain an impression of the treatment naïve population.
'Known to DIP via Test on Arrest' refers to a cohort of 941 individuals arrested and having tested positive for opiates, cocaine or both during 2008/09. This will include individuals who have never entered treatment. However, as it will also include some known to treatment, this data is intended only as an indication and cannot be used to draw definite conclusions.

Unless otherwise stated, 'in treatment', 'in effective treatment', 'in treatment in last year', and 'known to treatment but not treated last year' refers to individuals treated in *all services* in the Bolton treatment system during 2008/9.

Demographics

3.3.1 AGE

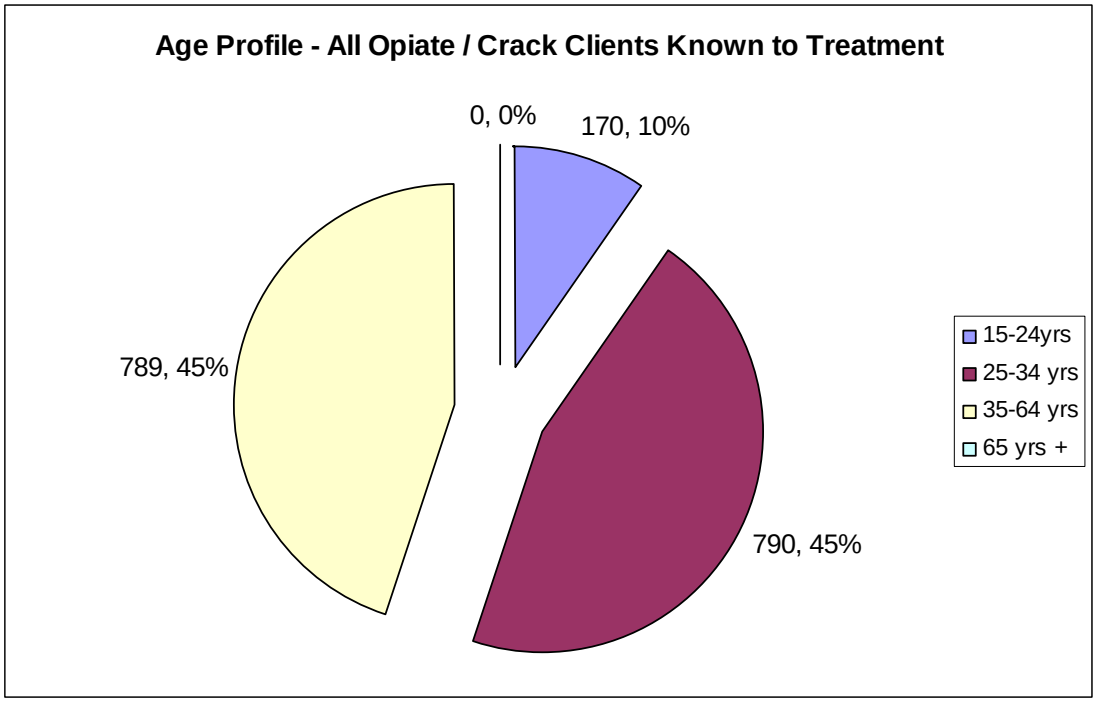

Fig. 7: *Profiling Opiate and/or Crack Users by Age*
('All Clients Known to Treatment' is calculated by 'number currently in treatment + number in treatment last year + number known to treatment but not treated last year')

Bolton's drug using population is slightly younger than the regional average (see fig. 8 below). There are no individuals over 65 in treatment.

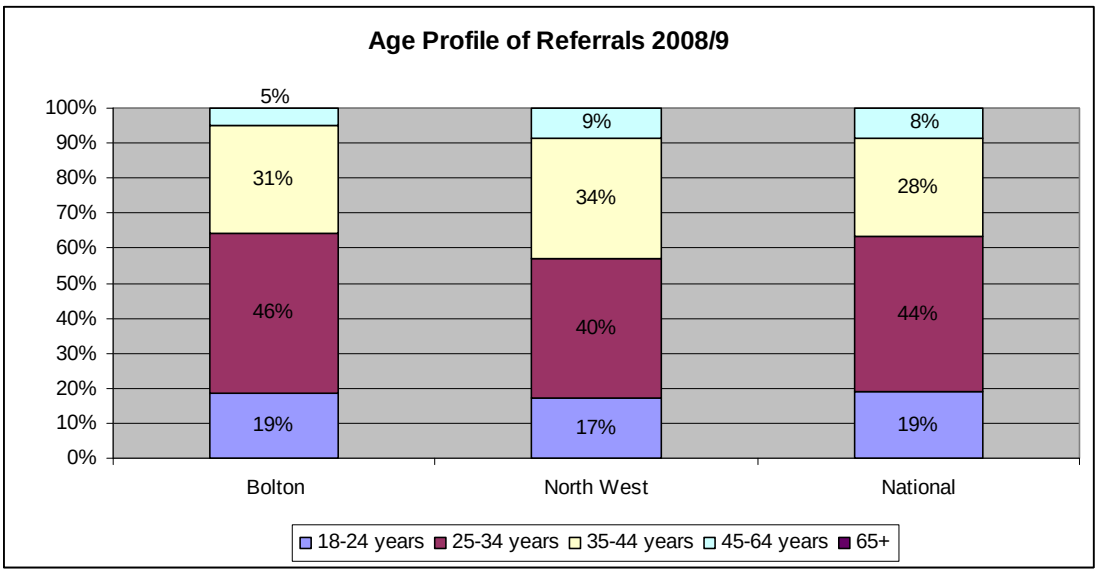

Fig. 8: *Age Profile Comparison – Referrals 2008/9*

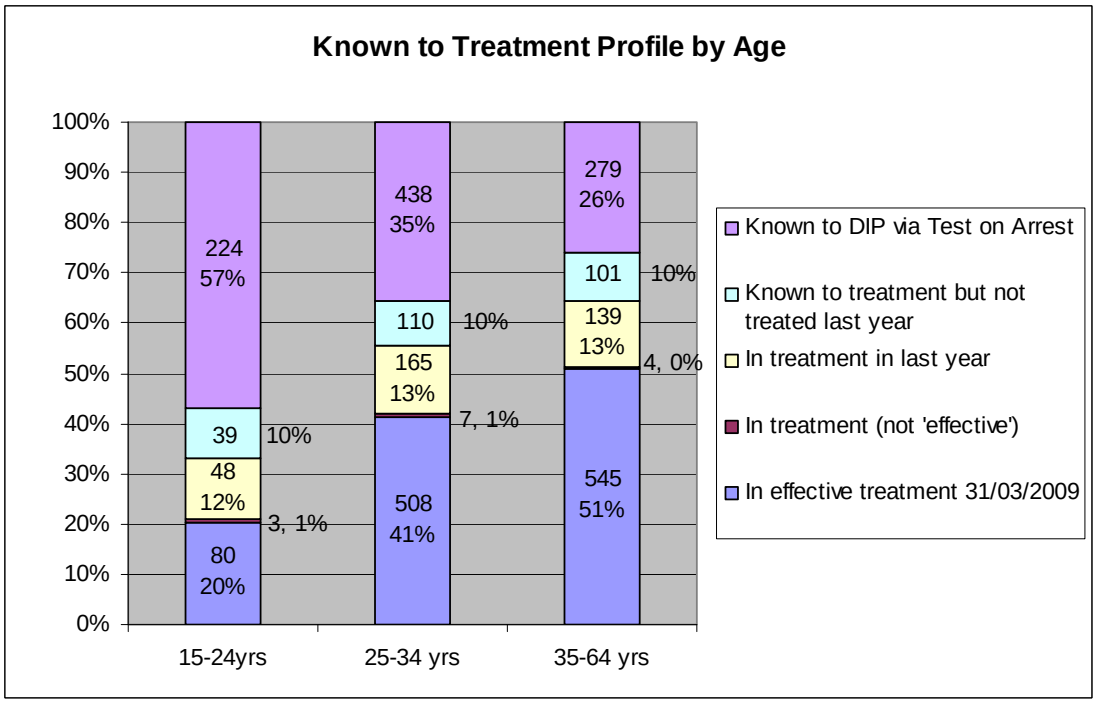

Fig. 9: *Profiling by Age and Treatment Involvement*

Despite a much smaller proportion of young PDUs being engaged currently in treatment, they appear no more likely to drop out once they are in. The likelihood of having been in treatment and left, whether within the last year or earlier, seems consistent regardless of age. Older PDUs are considerably more likely to be engaged in treatment and in effective treatment.

A significantly larger proportion of young PDUs (36% more) are known to DIP than are in treatment. A closer examination (see fig. 10 below) of the age profiles of those in treatment at year end 2008/9 as compared to those known to DIP via Test on Arrest (a significant proportion of whom can be assumed to be unknown to treatment) suggests a high proportion of young drug users unknown to treatment. This raises concerns about accessibility and engagement for this age group. Young drug users may not yet have suffered significant harm, they may not yet be affected by damage from injecting or blood borne viruses. The evidence is that once engaged young adults response to treatment is just as positive as that of older people. All endeavours to target young adults are likely to result in long-term benefits.

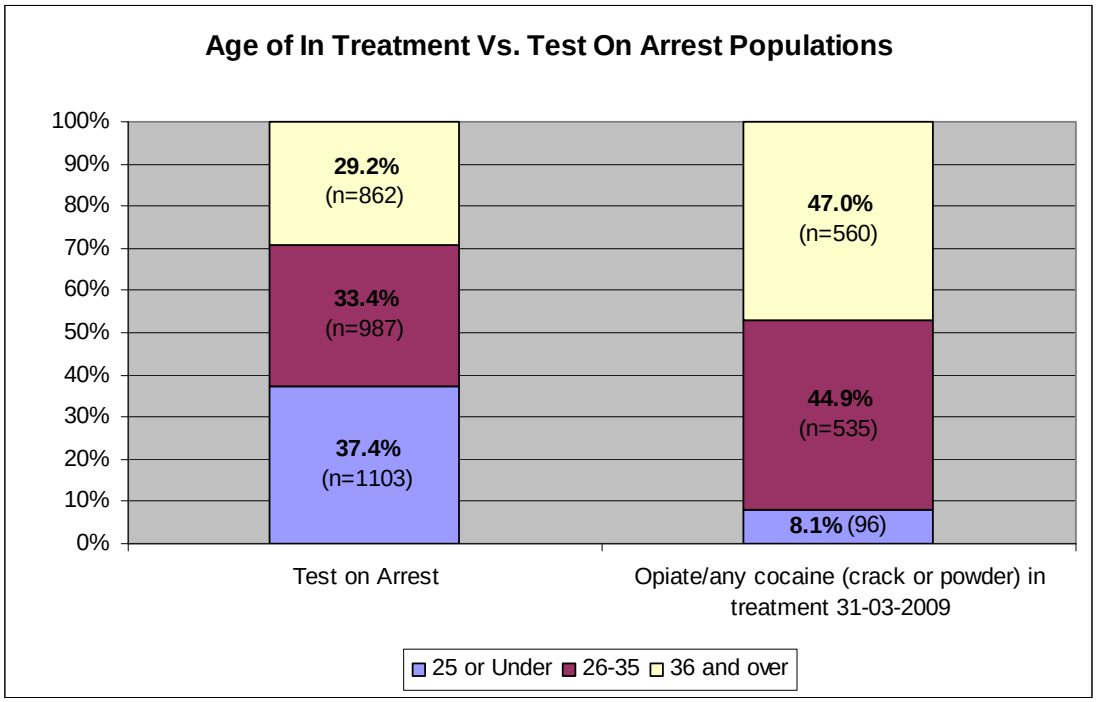

Fig. 10: *In-Treatment and Test on Arrest Age Profiles*

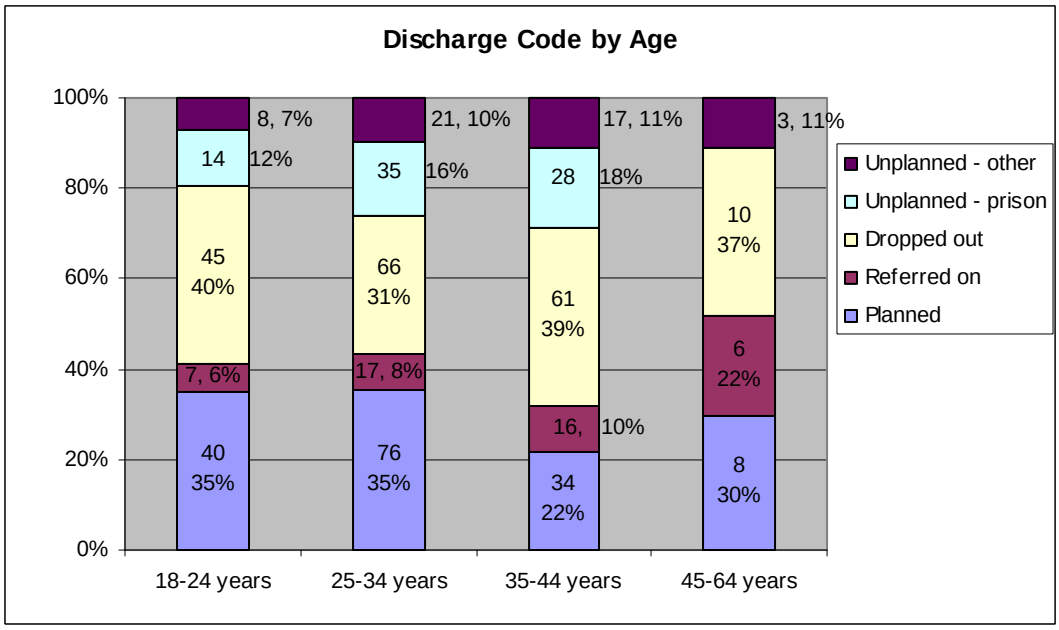

Fig. 11: *Profiling Discharges by Age*

Younger clients have a high likelihood of dropping out of treatment, but also seem likely to be discharged in a planned manner. Clients aged 35-44 are the least likely to have a planned discharge, and most likely to be discharged to prison. No clients over 45 had an unplanned discharge to prison.

The emerging recovery agenda is beginning to challenge the place of long-term maintenance and also focus attention on abstinence. If there is a change in administration this shift is likely to intensify. This could be a significant issue in Bolton where we have a number of older opiate users who have been in treatment for over four years.

Key Points

- It appears that a significant proportion of young PDUs are unknown to

treatment, though many are known to DIP as a result of offending. This raises concerns about accessibility and engagement for this age group.

- Evidence suggests that once engaged, young adults response to treatment is just as positive as that of older people. It is important that younger drug users are encouraged to engage with treatment services.

3.3.2 GENDER

The known PDU population in Bolton appears to have a roughly 70% male–30% female gender split, regardless of level of contact with treatment services: it applies to those in treatment at year end 2008/9, in treatment previously, and broadly to those known to DIP through Test on Arrest (although this data set is biased toward male drug users as they are more likely to offend than females).

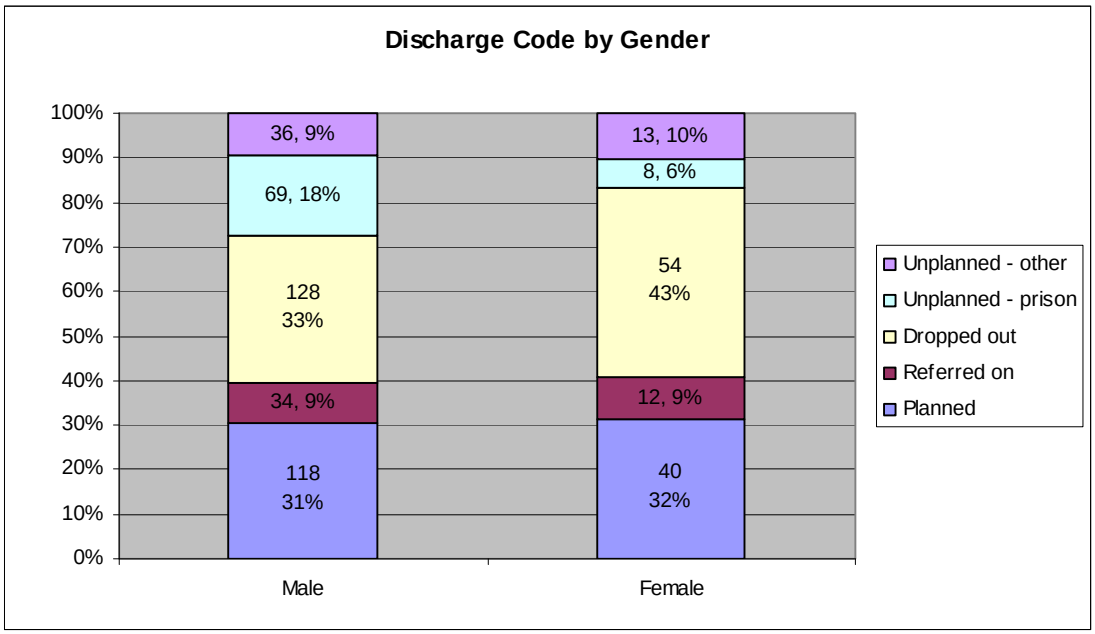

Fig. 12: *Profiling Discharges by Gender*

Proportionally, women seem much less likely to receive an unplanned discharge to prison (they are less likely to receive custodial sentences), but more likely to drop out of treatment. The proportion of onward referrals and planned discharges does not vary significantly between men and women.

Key Points

- The known PDU population is around 70% male, 30% female.
- Women are 10% more likely to drop out of treatment, but less likely to be discharged to prison.

3.3.3 ETHNICITY

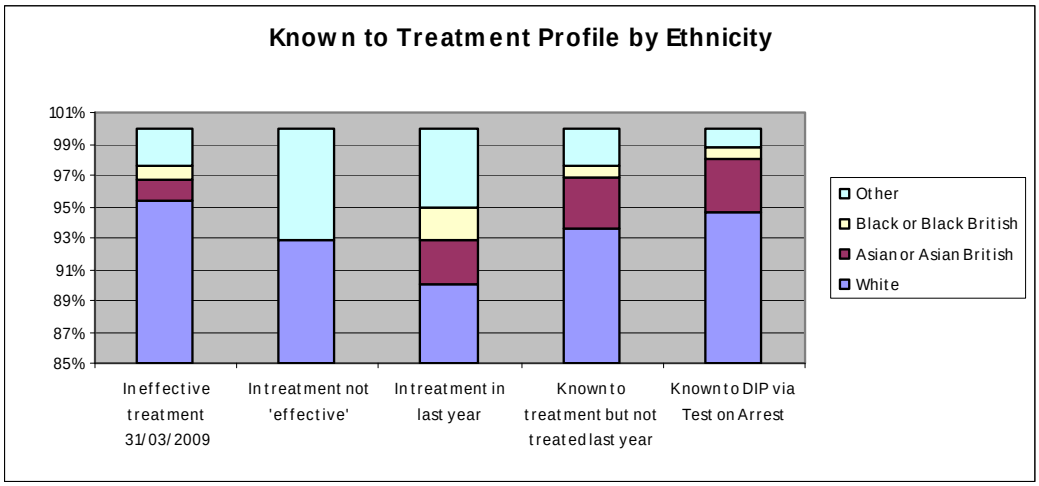

Fig. 13: *Profiling Opiate and/or Crack Users by Ethnicity*

Ethnic group	In effective treatment 31/03/2009	In treatment not 'effective'	In treatment in last year	Known to treatment but not treated last year	Known to DIP via Test on Arrest
White	1,080 (95.4%)	13 (92.9%)	315 (90%)	233 (93.6%)	891 (94.7%)
Asian or Asian British	15 (1.3%)	0 (0%)	10 (3.2%)	8 (3.2%)	32 (3.4%)
Black or Black British	10 (0.9%)	0 (0%)	7 (2.0%)	2 (0.8%)	7 (0.7%)
Other	27 (2.4%)	1 (7.1%)	18 (5.1%)	6 (2.4%)	11 (1.2%)

Table 14: *Profiling by Ethnicity*

Data from the 2001 census shows that Black and minority ethnic (BME) communities make up 11% of Bolton's population. This is higher than the national average of 6%. However, this does not appear to be reflected in the in-treatment population, with an average of 5% of those currently in treatment having their ethnicity recorded as 'Black or Black British', 'Asian or Asian British', or 'Other', and less than 2% having been born outside the UK. This may be due to lack of engagement, although it is entirely possible that prevalence of drug use is simply not as high in these populations. The 2008 UCLAN report[7]describes patterns of drug use amongst BME members of communities in Bolton. The report states:

"Given the age profile of South Asian communities in Bolton and the additional risk factors faced by some groups it could be suggested that these figures indicate that South Asians are underrepresented in Bolton's drug treatment system. Many respondents from the treatment system and in different communities felt that this was true. However, it is impossible to translate the data on drug treatment clients into statements on the prevalence of problematic drug use in these different groups. That said, several people suggested they knew of South Asian problematic drug users in Bolton who do not access treatment services."

Whilst the report describes a predominance of the ACCE profile of drugs and notes indications of an underrepresentation in treatment, it does not offer an estimate of prevalence.

[7] Roy A, Buffin J, Fountain J and Patel K. (2008). *Black and minority ethnic communities, drug supply and drug and alcohol use in Bolton*.

The majority of Bolton's drug treatment clients are white British. Care must be taken in interpreting the above data due to the small numbers involved, particularly of black or black British clients.

Referral data shows that treatment naïve referrals are more ethnically diverse, with 7% having a recorded ethnicity other than white British, as opposed to 5% of non-naïve referrals. Also, clients referred by the criminal justice system (CJS) are more likely to be white British (96%) than those referred from other sources (93%). In 2008/9, 3% of non-CJS referrals were Asian/Asian British, 2% Black/Black British, and 3% from other ethnic backgrounds. However, Test on Arrest results do show a slight increase in the proportion of individuals with a positive drug tests who were from BME backgrounds between April 2008 and October 2009. The proportion of individuals whose ethnicity was recorded as something other than White European rose from 4.17% of positive tests to 12.57%, with some fluctuation.

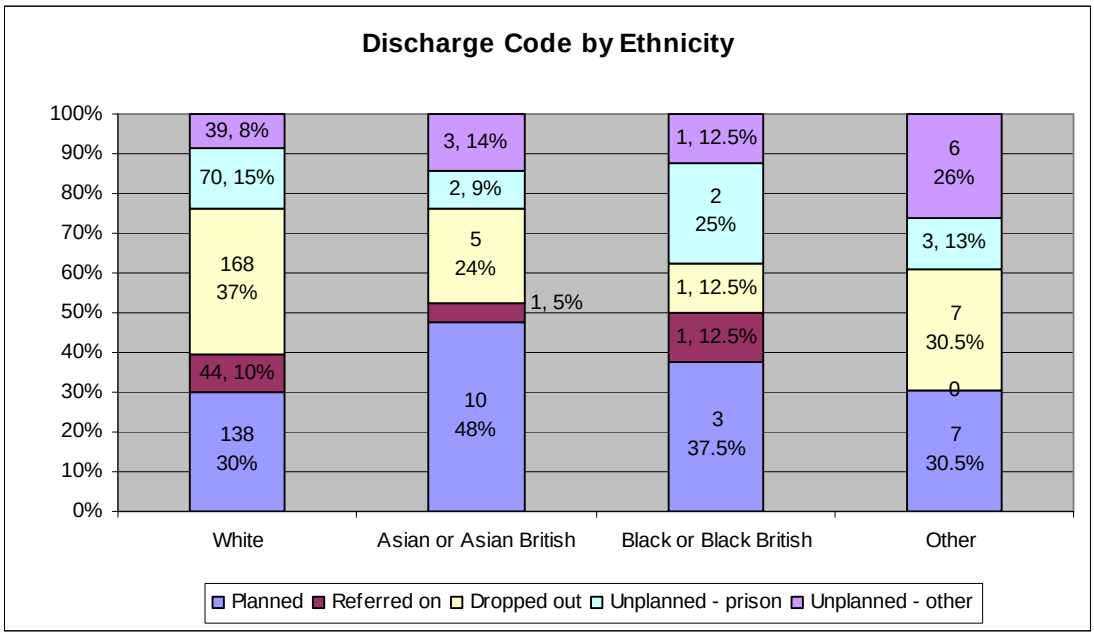

Fig. 14: *Discharges by Ethnicity*

It appears that Bolton's Asian or Asian British clients are less likely to drop out or have an unplanned discharge to prison than their white counterparts. Again care must be taken due to the low numbers involved.

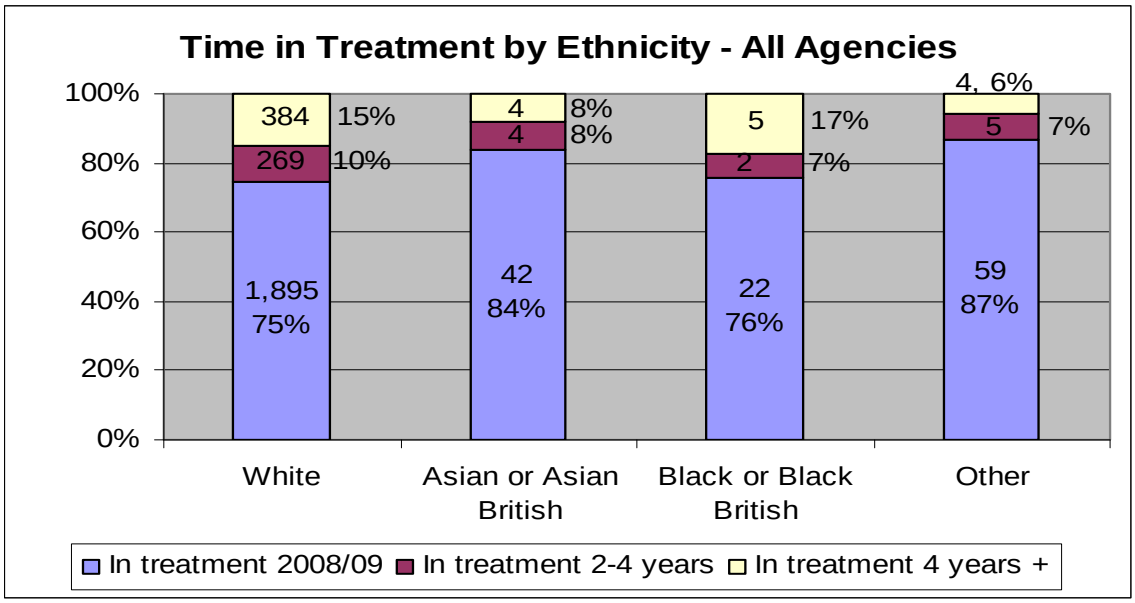

Fig. 15: *Time in Treatment by Ethnicity*

Culturally different communities have different expectations for treatment. White British or Black/Black British individuals are more likely to have spent a longer time in treatment. Asian/Asian British and those from other ethnic minorities are more likely to spend shorter times in treatment. This is supported by anecdotal reports from the Higher Bridge Project (Bolton's abstinence service) that clients from Asian backgrounds prefer to move relatively swiftly through the treatment system to abstinence. The Higher Bridge Project is particularly effective at engaging Asian clients, who accounted for 5% of their in-treatment population in 2008/9 (compared with 3% in treatment at ADS and 2% at BDS). This is perceived to be due to the agency's clear abstinence focus.

The number of 'White Other' clients recorded in the Quarterly NTA reports seems to be increasing, with 14 reported year-to-date in 2009/10. There are anecdotal reports from the agencies involved of these clients experiencing some problems due to language difficulties. This will be discussed in more detail in Section 4.3.

Key Points

- Drug treatment clients in Bolton are predominantly white British.
- More ethnic diversity is found in treatment-naïve than non-naïve referrals.
- Asian / Asian British and clients from 'Other' ethnic minorities tend to spend less time in treatment.

3.3.4 DRUG USE

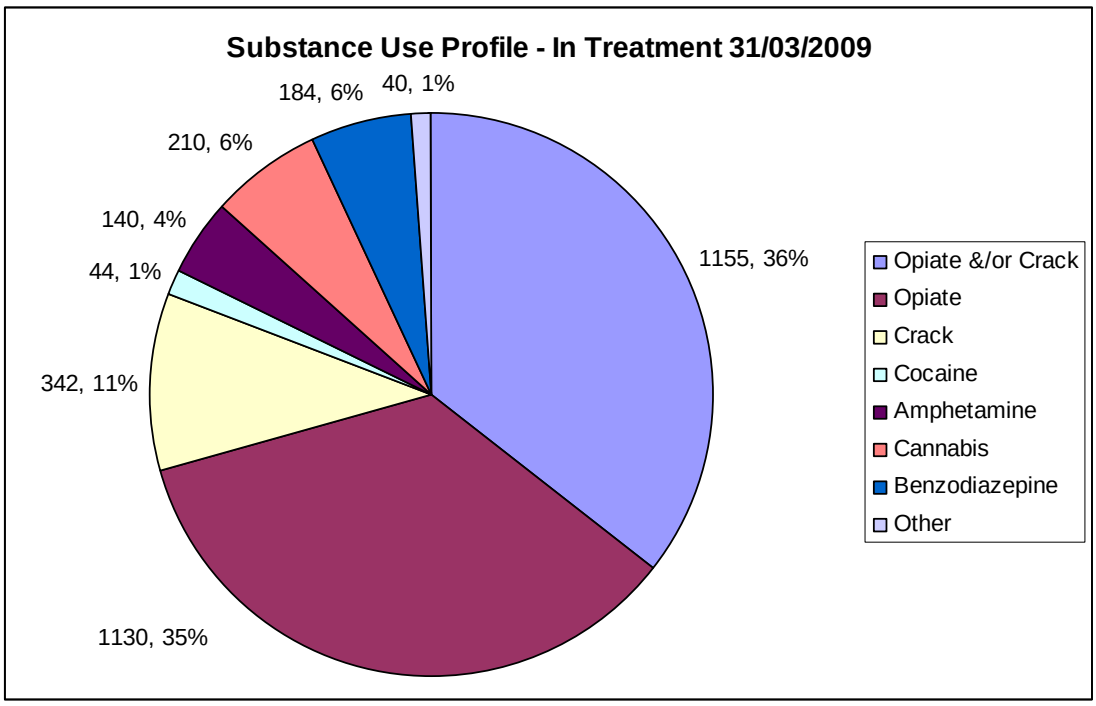

Fig. 16: *Substance Use of the Current In-Treatment Population*

The majority of Bolton's in-treatment population are opiate and/or crack users. However, use of other substances is also an issue, and these individuals often have different profiles, needs, and treatment outcomes.

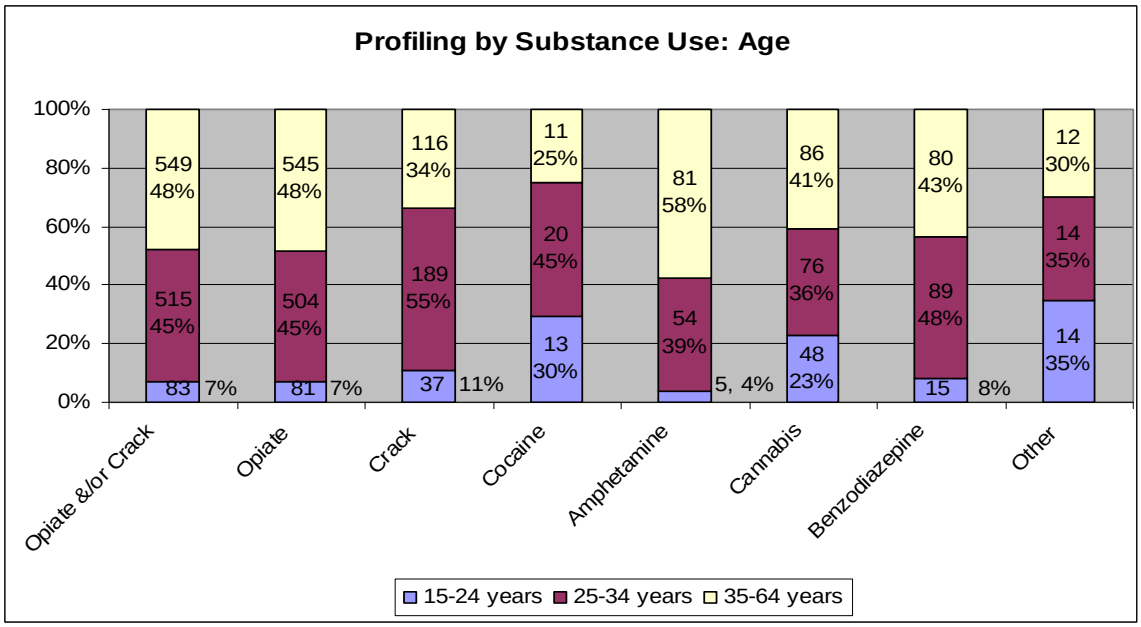

Fig. 17: *Age Profile of Different Drug Users*

Bolton shows a similar pattern to the rest of the North West in that we have an ageing PDU population[8].

The data shows relatively few young opiate/crack, benzodiazepine or amphetamine users. There seem to be a greater number of problematic younger users of cannabis

[8] Hurst, A, Beynon, C, Hughes, S, Marr, A and McVeigh, J (2007). *NDTMS themed report: Patterns of mortality amongst injecting and non-injecting drug users in contact with treatment services in the North West of England, 2003/04-2005/06.* Liverpool JMU Centre for Public Health, Liverpool.

and powder cocaine (caution should be exercised due to small numbers of cocaine users in the in-treatment data sample). The apparent trends are the emerging use of drugs corresponding to an ACCE-type profile, and the engagement in this profile of use by younger individuals. Test on Arrest data also shows that younger offenders are more likely to test positive for cocaine. It is possible that the apparent high proportion of young drug users unknown to treatment (see section 3.3.1) may find treatment unattractive because of a lack of provision specific to this ACCE-type drug use profile. It is vital that efforts are made to engage this younger population in treatment. The Tier 2 service provided by Phoenix Futures should be the ideal tool with which to accomplish this.

Considering gender profiles for different presenting substances, there is little variation from the typical 70%-30% gender split. Greater representation of females seems to exist in the more 'traditional' PDU types of drug use i.e. heroin, crack; a lesser proportion of females are in treatment for cannabis, cocaine, and benzodiazepine use. This may be due to fewer women using these substances, fewer perceiving their use as problematic, or treatment being less attractive to female users of these substances.

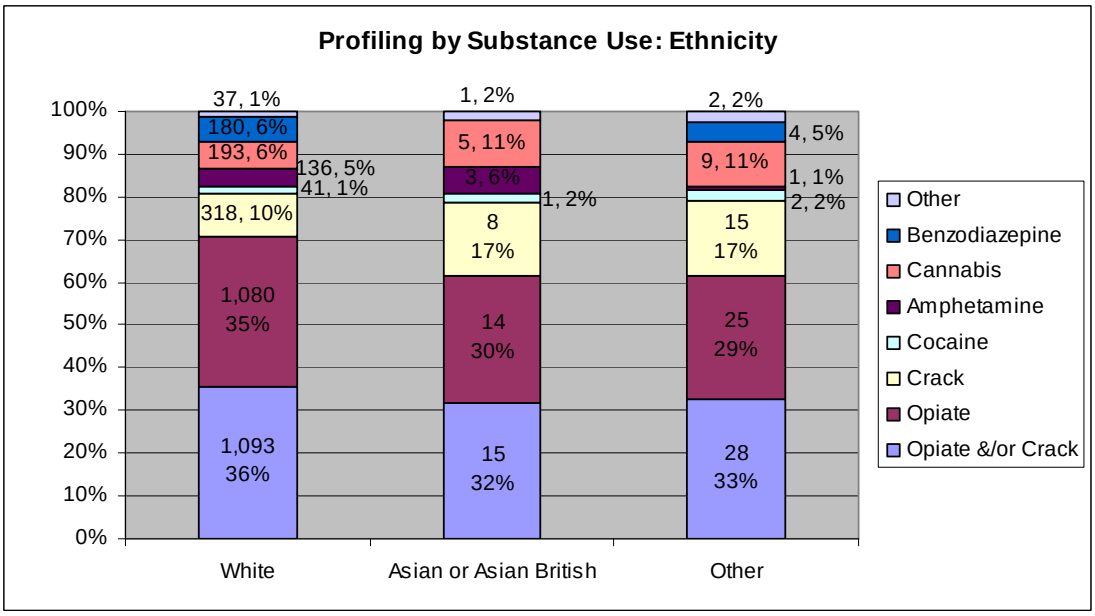

Fig. 18: *Ethnicity Profile of Different Drug Users*
Data for Black /Black British clients has been omitted as the numbers (24 individuals in total) were too small to draw meaningful conclusions.

Asian clients and those from other ethnic backgrounds seem more likely to present with problematic crack or cannabis use than their white British counterparts, and Asian clients were less likely to be using benzodiazepines (none recorded). Needle exchange staff report that clients attending the needle exchange to obtain equipment for injecting steroids are most commonly young Asian/Asian British males. However, as data is not routinely available on a client-by-client basis this cannot be verified and tracked effectively.

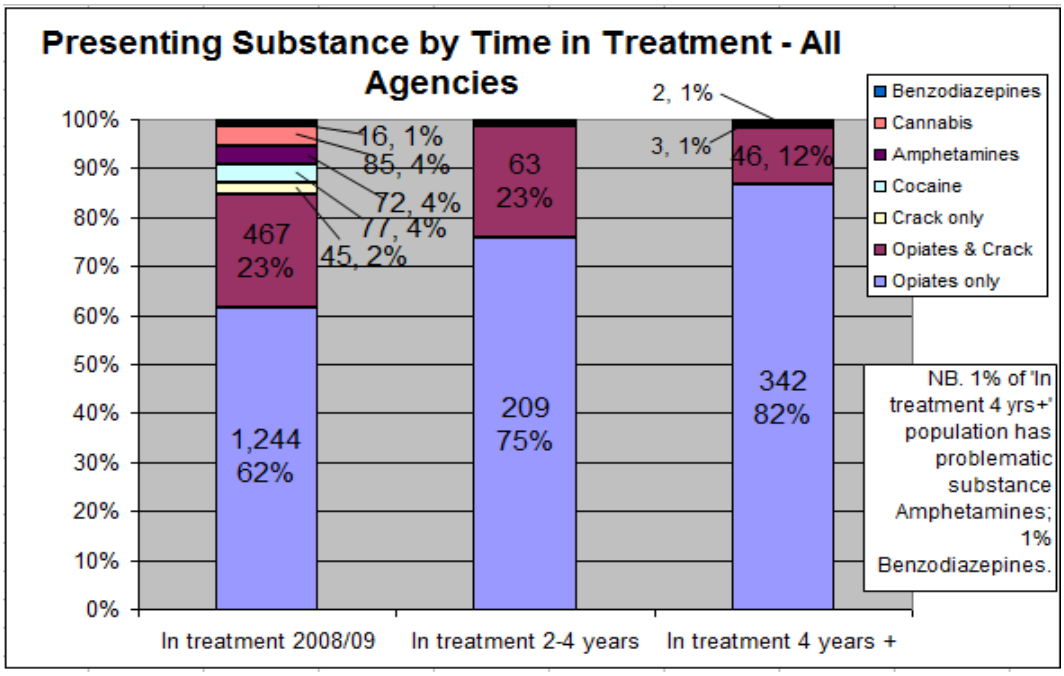

Fig. 19: *Drug Use Profile of Short-Term and Long-Term Clients*

Those who have been in treatment for a substantial length of time are more likely to be problematic heroin and/or crack users. This illustrates the impact of long-term substitute prescribing and stabilisation as a treatment goal. Moving long-term prescribed clients toward abstinence may require a potentially difficult shift in clients' expectations of what 'being in drug treatment' means.

The joint use of heroin and crack accounts for a larger proportion of problematic use in the groups of clients in treatment last year or for 2-4 years than for clients in treatment for a longer period, indicating that this use profile continues to become more common.

Clients whose problematic use is not of heroin and crack (non-PDUs) are much less likely to have been in treatment for a long period. This corresponds to other evidence that this drug use trend is a more recent development, and that brief interventions are more appropriate for this group. Retention in effective treatment figures show that although the proportion of all adults (both PDUs and non-PDUs) retained in treatment for *over* 12 weeks is consistently lower than that of PDUs, the proportion of all adults successfully completing treatment *within* 12 weeks is consistently higher. This indicates that non-PDUs are more likely to be treated successfully using brief interventions.

Treatment outcomes can vary depending on substance use.

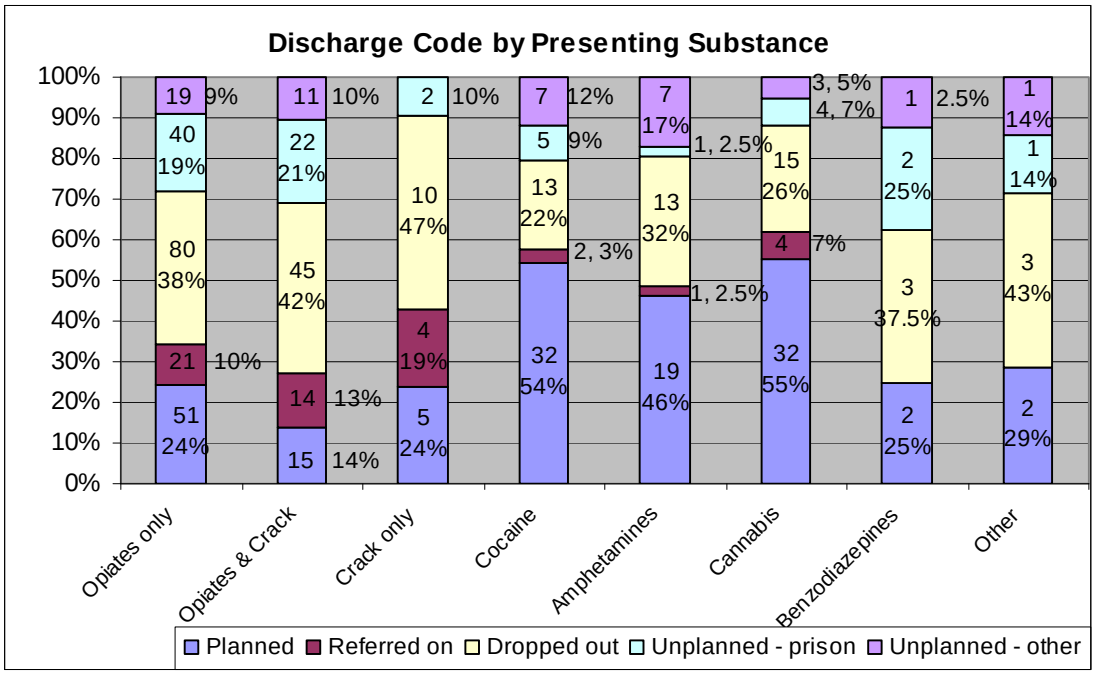

Fig. 20: *Drug Use Profile and Treatment Outcomes*

Clients who experience problematic use of opiates, crack (and particularly the two together) or benzodiazepines were more likely to have dropped out or had an unplanned discharge to prison than those using cocaine, cannabis or amphetamine, and less likely to have been discharged in a planned way. Care must be taken when interpreting this data, particularly in relation to the categories 'Benzodiazepines' and 'Other', due to the small numbers involved (8 and 7 individuals respectively).

This corresponds to evidence that non-treatment-naïve referrals are more likely than treatment-naïve referrals to be opiate or opiate and crack users (see Fig. 21 below). Data also shows a marked difference in the proportion of problematic cocaine and cannabis users being referred into treatment, from those who have been in treatment previously to new treatment-naïve referrals. This suggests that very few problematic cocaine users re-enter treatment, and/or that powder cocaine use is a rising trend.

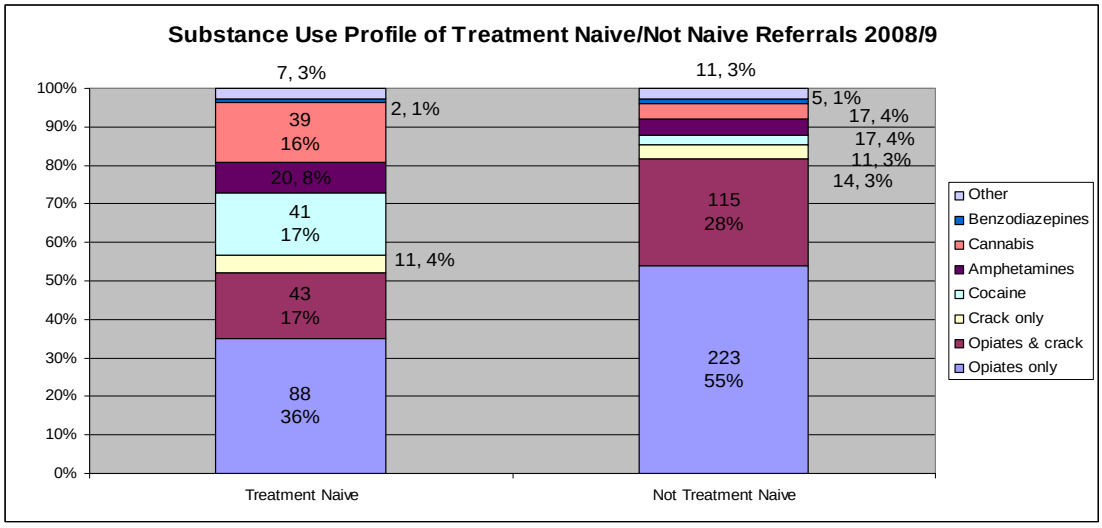

Fig. 21: *Treatment Naïve and Non-Naïve Referrals: Drug Use Profiles*

Key Points

- The majority of Bolton's in-treatment population are opiate and/or crack users.
- The PDU population is ageing; new trends of non-'traditional PDU' drug use are emerging in younger users.

- Non-PDU clients have different profiles in terms of their age, ethnicity, treatment needs, and outcomes.
- Long-term clients (in treatment for over 2 years) are much more likely to be heroin or crack users than users of other drugs. These clients need attention to move them on in treatment.

3.3.5 INJECTING STATUS

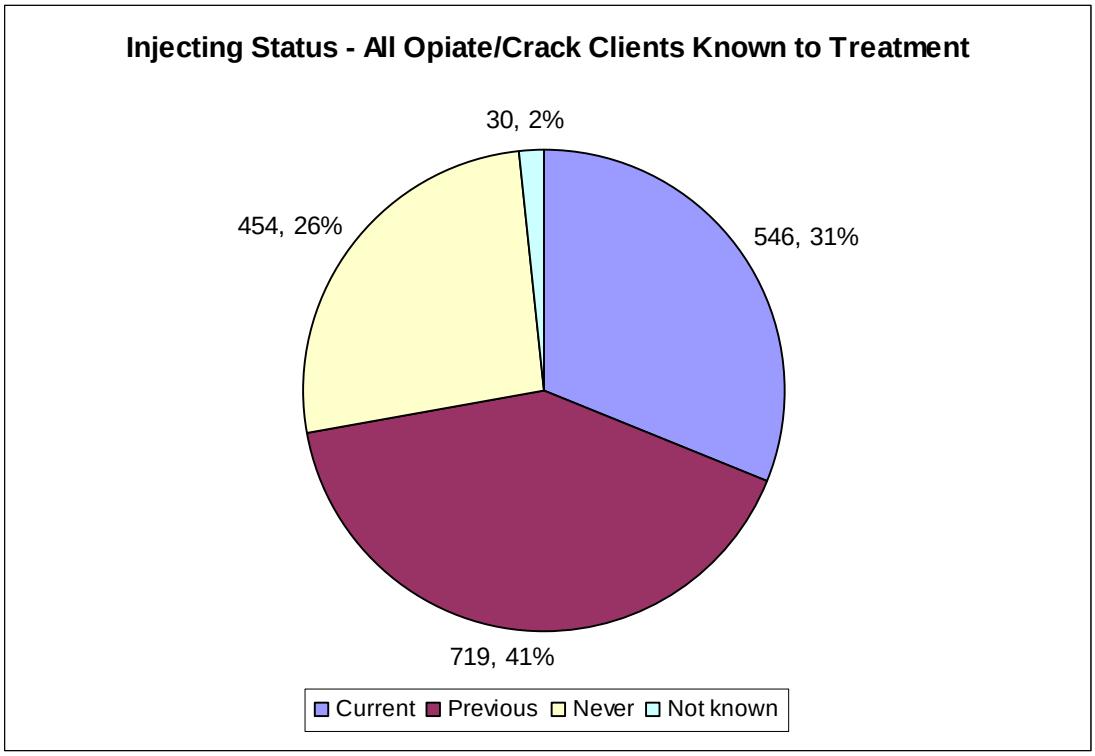

Fig. 22: *Profiling Opiate and/or Crack Users by Injecting Status*
('All Clients Known to Treatment' calculated by 'number currently in treatment + number in treatment last year + number known to treatment but not treated last year')

The known PDU population is split fairly evenly into previous and current injectors and those who have never injected. This pattern remains fairly consistent regardless of level of engagement with the treatment system, with the exception of the cohort currently in treatment at year end 2008/9, of which 5-10% more than average were previous injectors and 5-10% fewer had never injected.

Analysis of referral data shows that treatment naïve clients are more likely to have never injected, while non-naïve referrals are almost twice as likely to be a current (33%) or previous (42%) injector than treatment naïve clients (15% and 28% respectively).

The injecting profiles of clients in treatment for 2-4 years and for over 4 years appear similar to that of the current in-treatment population. However, as this is not an updateable field on NDTMS, this will be their injecting status at treatment start. The only regular updates to this information are during TOPs reviews; we do not currently have access to the data from these.

Key Points

- 31% of clients in Bolton are current injectors; 41% have previously injected; 26% have never injected.

3.3.6 PARENTAL STATUS

The current Drug Strategy places an emphasis on families and communities. The ACMD report Hidden Harm[9] is now six years old, the government response[10] accepting most of the recommendations is four years old. New guidance jointly published by the NTA, the Department for Children, Schools and Families, and the Department of Health[11] makes 27 recommendations that are too detailed to describe fully here. One recommendation is that the Local Safeguarding Board has a standing agenda item on substance misuse, this would be a suitable place to ensure that all parties are aware of the expectations that are now placed upon them.

ACMD estimated that there is approximately one child for every PDU, thus there are some 2,788 children of PDUs in Bolton. NDTMS now records whether those in treatment have dependant children, though the aggregated reports record the number of parents rather than children (which reflects the general misinterpretation of the Children's Act; the child is paramount and is not an appendage to the client). The most recent DAT Performance report notes that 56% (up from 52% last year) of clients in new treatment journeys report having children. Drug workers should be commended on the massive improvement in data quality in the last year, only 1% of new clients in treatment in 2008/9 have no record on NDTMS of their parental status (reduced from 36% in 2007/8).

It should be noted that available parental status information only concerns new treatment starts rather than all clients. This is because most agencies' data systems report this as a static field, following NDTMS requirements, so data is collected on treatment entry only. If the field is changed to enable updating on NDTMS, service data systems should follow suit.

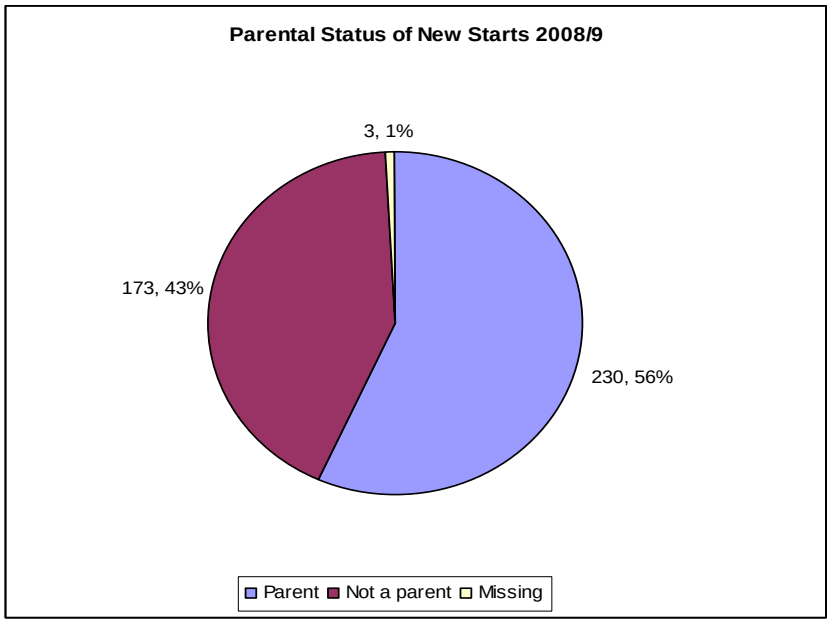

Fig. 23: *Parental Status of New Clients in 2007/8 and 2008/9*

The data available from NDTMs shows that over half of new treatment starts in 2008/9 were parents or had children living with them. This picture seems fairly constant; it has not changed from 2007/8. 44% of treatment naïve referrals in

[9] The Advisory Council for the Misuse of Drugs. (2003). *Hidden Harm, Responding to the Needs of Children of Problem Drug Users*. Home Office, London.
[10] DCSF (2005). *Government Response to Hidden Harm: the Report of an Inquiry by the Advisory Council on the Misuse of Drugs.* DCSF, London.
[11] DCSF, DH and NTA. (2009). *Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services.*

2008/9 were parents, fewer than non-naïve referrals, of whom 57% were parents. This may be due to the younger profile of treatment naïve clients (see profiling by Age). Data on treatment access, engagement, and exits for parents in drug treatment (see section 2.1.5) indicate that the Bolton treatment system is easily accessible to parents, though figures for engagement and successful exits are less encouraging.

Key Points

- Over half of new treatment starts in Bolton in 2008/9 were parents or had children living with them.

3.3.7 ACCOMMODATION NEED

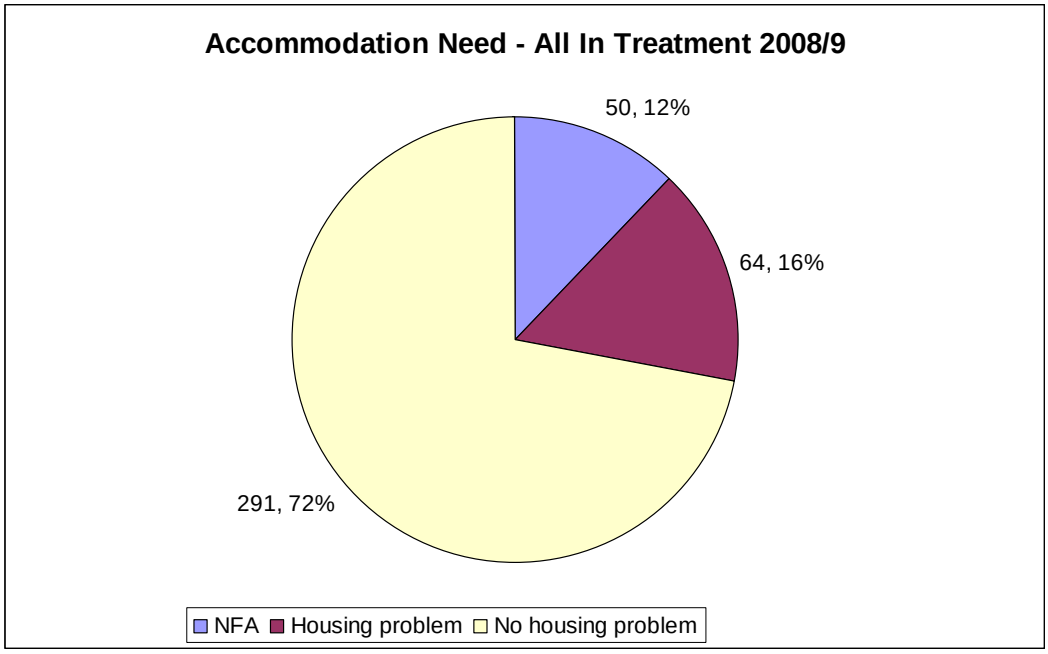

Fig. 24: *Proportions of New Treatment Journeys with Accommodation Need*

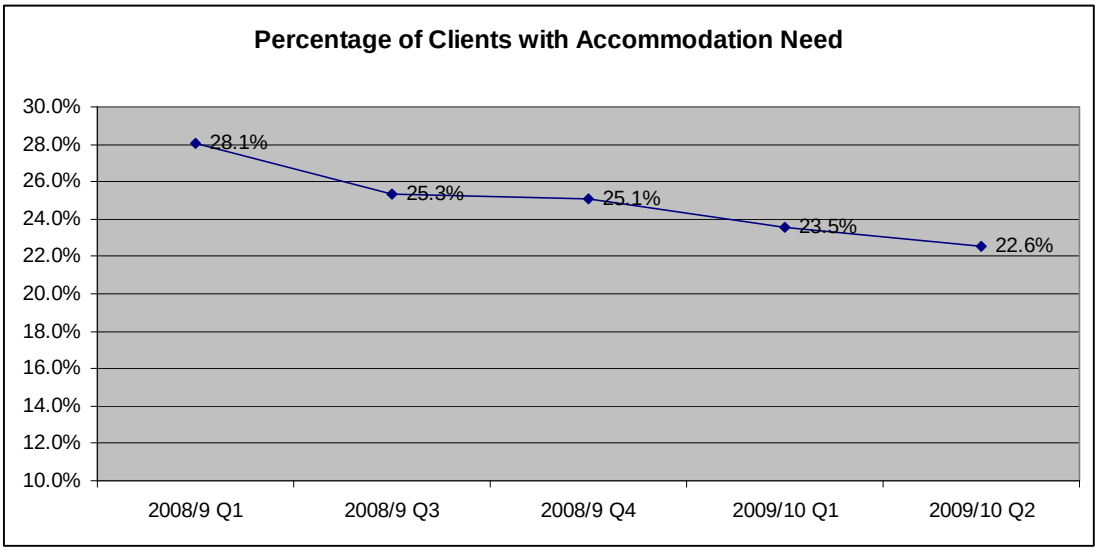

Fig. 25: *Accommodation Need in Bolton*

Secure accommodation underpins positive treatment outcomes. Maslow's Hierarchy of Needs[12] describes a commonly accepted view that therapeutic relationships can only be built when certain basic needs are met, this includes accommodation. *'Drug*

[12] Maslow. A. (1943). *A Theory of Human Motivation*.

Misuse and the Environment'[13] notes that people living in over-crowded and sub-standard accommodation are more likely to share injecting equipment and more likely to contract hepatitis, HIV and Tuberculosis[6]. The Bolton Needs Assessment 2006 (DrugScope) also highlighted lack of secure accommodation as an important barrier to treatment.

28% of drug users starting treatment in 2008/9 had some sort of housing need. Quarterly reporting from the NTA suggests that an average of 9.4% of new treatment starts over the year had no fixed abode (NFA).

Looking at accommodation need related to referral source, clients referred by 'Other' referrals sources, a category which includes hospital departments and court referrals, are most likely to experience housing need. Clients referred by CARATs are most likely to have an urgent housing need, emphasising the importance of supporting clients who are referred on release from prison. Self-referred clients and those who have been referred by their GP are least likely to experience housing need. New referrals who were not treatment naïve were slightly more likely to have a housing problem – 28% had some level of accommodation need as opposed to 24% of naïve referrals.

BMBC's Supporting People Department currently provide a floating support service which offers advice and support to vulnerable clients with the aim of maintaining secure tenancies. The service, which includes advice on debts and rent, and assistance in negotiating with agencies and landlords, is funded to work with alcohol, drug and ACCE profile clients, and is hosted by ADS Wood Street. This has proved invaluable for drug treatment clients; however, funding for the provision of this floating support is at risk in future years as a result of financial pressures.

Key Points

- Accommodation need is an important barrier to successful treatment.
- 28% of new clients in 2008/9 had a housing problem or no fixed abode.

3.3.8 Dual Diagnosis

Dual Diagnosis describes concurrent mental health and substance misuse problems, a Dual Diagnosis Needs Assessment for Bolton reported in May 2009[14]. The definition is broad and includes a spectrum ranging from a PDU experiencing severe and enduring mental health problems to a recreational drug user with, for example, mild anxiety.

As with the general population the most common substance used by people with any form of mental health issue is alcohol, regular drinkers may occasionally use illicit drugs. The figure below offers a summary of the prevalence estimates for Bolton; these are purely indicative and are based on a range of academic studies:

[13] Advisory Council for the Misuse of Drugs (1998). *Drug Misuse and the Environment*. ACMD, London.
[14] Centre for Public Innovation (2009), *Bolton Dual Diagnosis Review March 2009*, CPI.

Common mental health problems and PDUs Up to 1,290.	Severe and enduring mental health problems AND severe drug problems Approximately 810
Common mental health problems and regular drug use More than 3,000	Severe and enduring mental health problems; may use drugs, but no serious drug problems Approximately 5,490

Fig. 26: *Generic description and estimate of prevalence*.

The key message from the above is that some form of mental health issue is the norm amongst the PDU population. The NTA Regional Comparison report for Quarter 4 2008/9 stated that 134 clients (20% of new treatment starts) during the year had been recorded as having concurrent mental health needs. This is likely indicative of a much higher figure, as reporting is largely dependant on diagnosis, and/or admission by clients, of mental health issues.

Key Points

- 134 clients (20% of new treatment starts) during 2008/9 were recorded as having concurrent mental health needs. This is likely an absolute minimum.

4 Gap Analysis

4.1 DIP Issues

4.1.1 DIP – DRRs

DRR starts are falling below target in 2009/10, with only 55 commencements by Quarter 2 against a target of 86 (64% of target). This compares to a performance of 121% for 2008/9 (215 commencements against an annual target of 178). The low number of commencements is due to a variety of factors. DRR targets are set at a regional level, and divided locally by Greater Manchester Probation. Local opinion is that consistent high achievement in the past (commencements were 23% above target in Quarter 1 2008/09) has resulted in Bolton holding the responsibility for a large proportion of Greater Manchester's DRR commencement target. Reports from Probation and the courts indicate that the number of appropriate clients to assign to DRR orders has decreased. This coincides with reports from the Test on Arrest service of a higher than usual proportion of negative tests, even for known drug-users, or offenders stating they had used, leading to speculation about reduced purity or switching drug use (see Section 4.1.4).

The dearth of suitable DRR clients seems to reflect a similar trend for all offending, not only drug-related. Probation registered 120 fewer case starts over June, July and August 2009 than the same months in 2008. Police now have increased powers to impose sanctions before cases reach the courts, possibly resulting in fewer cases appropriate for community orders.

Rates of successful DRR completions, however, have improved considerably – from 33.6% at year end 2008/9, to 61.5% at the end of August 2009. At the end of

Quarter 1 2009/10 successful completions were 23% above the local target[15]. Retention for 12 weeks or more (75% target) has also gone from amber to green (74% to 76%) during this time. This implies that despite a reduction in the volume of referrals, more of those actually being made are appropriate.

The improved success rates may result from the focus that has been placed on DRRs in Bolton recently, with a return to having a specialist team at Probation working exclusively with DRR clients. Also joint training has taken place between BDS and Probation staff, and a joint working group has been set up with BDS and Probation staff to work on health and offending issues together. There has been considerable emphasis on improving the quality of orders, with an ongoing project looking into what constitutes a successful DRR client – this will draw on regional (the GM Probation report mentioned below) and local data, and should enable Probation and drug services to better target resources to improve success.

A Probation worker has been assigned to work specifically with female DRR clients, in response to a higher than usual proportion of women on DRRs, and research suggesting they are less likely to successfully complete the order. Research shows that women tend to be more likely to be breached than men[16]. A report by Greater Manchester Probation Trust stated that although women traditionally make up a smaller proportion of DRR clients, they are more likely than men to experience need related to: accommodation (56% of women vs. 47% of men); relationships (73% vs. 46%); financial management (61% vs. 58%) and emotional wellbeing (66% vs. 51%). These proportions are the averages across Greater Manchester, and reflect national patterns[17] and also what Corston[18] says we should expect to find in female offenders.

Bolton was identified in the report as having an increasing trend towards BME individuals being given DRRs, rising from 8% to 17% between April 2008 and June 2009. This reflects a general upward trend in the proportion of BME individuals with positive drug tests during 2008/9 and 2009/10 (see section 3.3.3).

The same Probation report also indicated that Bolton has the second highest proportion of DRR clients with Dual Diagnosis status in the area, at 16%. The majority of Dual Diagnosis clients in the GM area were male; 84% of cases fell within the age range 26-44.

[15] Keech, P. (2009). *GMPT Performance on National Indicators (August 09) BOLTON*. Greater Manchester Probation Trust, Manchester.
[16] McFarlane, M. (2009). *Women's Strategy Baseline Data 2008/2009*. Greater Manchester Probation Trust, Manchester.
[17] Gavan, C. (2009). *Drug Rehabilitation Requirements*. Greater Manchester Probation Trust, Manchester.
[18] Baroness Corston. (2007). *The Corston Report: a review of women with particular vulnerabilities in the criminal justice system*. Home Office.

District where Order held	DRR Length in Months											
	6				9				12			
	Unsuccessful		Successful		Unsuccessful		Successful		Unsuccessful		Successful	
Bolton	37	57.8%	27	42.2%	17	70.8%	7	29.2%	51	89.5%	6	10.5%
Bury	27	57.4%	20	42.6%	3	75.0%	1	25.0%	4	66.7%	2	33.3%
City	68	61.8%	42	38.2%	8	100.0%	0	0.0%	54	83.1%	11	16.9%
Oldham	24	51.1%	23	48.9%	7	70.0%	3	30.0%	4	40.0%	6	60.0%
Rochdale	20	58.8%	14	41.2%	7	53.8%	6	46.2%	18	78.3%	5	21.7%
Salford	16	28.1%	41	71.9%	4	57.1%	3	42.9%	17	73.9%	6	26.1%
Stockport	12	48.0%	13	52.0%	0	0.0%	3	100.0%	22	84.6%	4	15.4%
Tameside	26	60.5%	17	39.5%	2	100.0%	0	0.0%	8	80.0%	2	20.0%
Trafford	6	40.0%	9	60.0%	1	50.0%	1	50.0%	16	94.1%	1	5.9%
Wigan	26	48.1%	28	51.9%	1	50.0%	1	50.0%	26	70.3%	11	29.7%
Other	0	0.0%	1	100.0%	0	-	0	-	1	100.0%	0	0.0%
Total	**262**	**52.7%**	**235**	**47.3%**	**50**	**66.7%**	**25**	**33.3%**	**221**	**80.4%**	**54**	**19.6%**

Table 14 : *Data from 'Drug Rehabilitation Requirements' report by Greater Manchester Probation Trust: DRR Completions, April 2008-June 2009.*

The same report suggests that several other factors affect DRR success. Factors identified as increasing the likelihood of a DRR failing included:

- Length of DRR: a major factor, order length seems to be inversely related to performance (see Table 14). Six month orders have the highest success rates, while 12 month DRRs have the lowest success rates. During the data period looked at in the report, Bolton had a higher than average number of 12-month DRRs. The proportion of assigned DRRs over 6 months in length dropped slightly between April and October 2009 for Greater Manchester as a whole (from 30% to 27%). Bolton saw a much larger decrease in 6-month DRRs from 40% in April to 23% in October. This may have contributed to the rise in successful completions.
- Being of white British ethnicity. Length of DRR appeared to have no effect on success for BME individuals, affecting only white British clients.
- Being female: men have higher success rates than women on both 6 month (3% difference) and 12 month (11% difference) DRRs. Female DRR clients are more likely to experience need related to accommodation, emotional wellbeing and relationships, and financial management, than their male counterparts.
- Being aged 22-34: there is a drop in successful completion rates for this age group, even on 6 month DRRs. Clients aged 18-21 and over 35 had the highest success rates on 6-month orders.

Key Points:

- DRR commencements are below target, but there are reasons for this and reason to suggest the target should probably be lower.
- Despite falling commencement, DRR completions are above target, reflecting considerable effort by both Probation and drug services, joint working and a focus on quality. This good work should be continued.

4.1.2 DIP – CARAT-CJIT Transfers and Prison Release

Effective case transfer from prisons to the community has been a long-term issue for Bolton. The pickup of CARAT-CJIT transfers has improved in Quarter 2 to 38%, but is still comparatively low. This does not apply only to Bolton, and there are several possible explanations.

The CARATs' referral targets may sometimes result in clients being referred inappropriately. For example, BDS report some clients referred very early in a long custodial sentence, or to a service inappropriate for their substance use profile (in which case they will be referred on to an appropriate agency). These clients may not present to treatment; if they do they will not be accepted onto the agency's caseload, thus may consequently appear to be non-received transfers. Inappropriate referrals

could possibly be reduced by aligning CARAT referral targets with those for community providers. In general, drug treatment agencies in Bolton have a good relationship with HMP Forest Bank, where the majority of offenders from Bolton are sentenced, but every prison will handle drug treatment clients and referrals differently, so ensuring relationships with other institutions are reinforced can only be beneficial. The introduction of Integrated Offender Management (IOM) may improve links between prisons and community and prevent inappropriate referrals. The roll out of the Integrated Drug Treatment System (IDTS) across North West prisons will impact on the pattern of prison referrals and will lead to more referrals requiring a prescription on release. As with all prison releases the peak demand will be on Fridays.

Existing clients sent to prison for short sentences can also be problematic. Bolton may be disproportionately affected by some of the issues around these clients: a recent GMAC Reducing Reoffending report states that Bolton accounts for 12% of offenders serving less than 12 months and then released back into Greater Manchester[19]. This makes Bolton the highest importer of this offender type within the conurbation. Under these circumstances, BDS will keep a client's case open to prevent them having to be reassessed, however when CARATs re-refer them on release a new case will not be opened and this can appear as a failed transfer. Continuity does seem to exist in these cases, but is not adequately reported. This may improve as NDTMS begins to be used in prisons.

Returning to illicit opiate use following a term of imprisonment is a major risk factor for drug overdose. It is also important to consider the impact of prison on other variables, such as accommodation need, that prison release clients may need additional help with as a consequence of their custodial sentence.

Key Points

- CARAT to CJIT transfers are a long-term issue for Bolton. A variety of factors, including IOM and IDTS, may help to improve this over the coming year.

4.1.3 DIP – Reoffending:

Drug-related reoffending (NI38) is a partnership target aimed at reducing Class A drug-related re-offending. It is calculated by comparing the predicted and actual reoffending rates over the financial year of a specified cohort. The cohort is identified at year start by testing positive on arrest, being subject to a DRR, or having OASys scores indicative of a 'criminogenic drug need' relating to a specified drug, including heroin, crack, powder cocaine, other opiates, non-prescription methadone, and other misuse of prescription drugs. The indicator was at 1.2 at year end 2008/9 (the target being 1.0 or below), giving Bolton the highest level of drug-related offending in the North West. However, other data gives a different picture. GMAC's Reducing Reoffending report states that of GM areas: Salford, Bolton and Rochdale have the highest volume of prisoners released to them, yet these areas also have the lowest rate re-offending by the same offenders.

Based on the most recent (Quarter 1 2009/10) reports from the Home Office, Bolton's performance on NI38 has improved. The figure is now at 0.96, indicating that the actual reoffending level is below that predicted.

There are also some questions over the use of NI38 as a comparative tool between areas, since the rate of re-offending is largely dependant on proactive policing strategies. It also includes breach of ASBOs – this may have a disproportionate

[19] Winstanley, S. (2009). *Reducing Reoffending Chapter*. Greater Manchester Against Crime (GMAC) Central Team, Manchester.

effect in Bolton as a result of the local prostitution strategy, which uses ASBOs in an attempt to limit access to known red light areas.

Probation monitor a selection of other National Indicators which may be relevant to the drug treatment system: these include PPO Reoffending (NI30) and Local Adult Reoffending (NI18). Bolton's performance on these indicators should be tracked by the Commissioning Team where possible.

Key Points

- There is disagreement over the accuracy and implications of NI38, and its applicability as a comparative tool.
- Bolton's performance has improved to a figure of 0.96 at Quarter 1 2009/10.

4.1.4 DIP –Declining Referrals / ToA

Positive tests have fluctuated over 2008/9 and 2009/10, with particularly noticeable periods of low positives in October 2008 and July-August 2009. The most recent period coincides with reports from the Test on Arrest service of a higher than usual proportion of negative tests by known drug-using offenders, or offenders who stated they had used, leading to speculation about purity. There have been some anecdotal reports from Probation staff concerning clients switching their drug use to Class B drugs such as amphetamine (which Probation do not test for) or alcohol use, in circumstances where a positive test could result in further sentencing. However, it is unlikely that switching use could account for variations in Test on Arrest results. There are also some questions over the sensitivity of the drug tests used in the custody suite.

The proportion of new clients presenting to the Needle Exchange who are heroin injectors has reduced from 41% (n=73) to 28% (n=44) between Quarter 3 2008/9 and Quarters 1 and 2 2009/10.

These factors, in combination with fewer DRR starts and decreasing PDU estimates, indicate a possible decline in the number of opiate and crack cocaine users requiring and entering the drug treatment system. A variety of data suggests that the use of heroin and crack in Bolton may be declining as the PDU population ages, and use of other substances by a younger population increasing. This will have an effect on existing services. The Test on Arrest service in particular has experienced periods with fewer clients than it was designed and implemented to work with, with number of positive tests fluctuating from 116 to just 47 per month during 2008/9, raising the question of where to direct any excess resources of this service at such times. This will be discussed further in the Harm Reduction Needs Assessment. However, the potential for large-scale changes in the presenting needs of new clients as a result of shifting trends in drug use is one that requires attention. It should be noted that although data is indicative of a declining PDU population, concrete conclusions about drug use patterns cannot be drawn. There have also been some recent reports of young PDUs: a small number of young heroin users have presented to 360 during Quarter 1 and 2 of 2009/10.

The Home Office prevalence estimates do not support the possibility of declining PDU numbers; however there are some questions over the methodology used in calculating these. While initial figures were estimated using a more reliable capture-recapture method, more recent estimates of the PDU population are simply based on earlier estimates. Without an in-depth study of prevalence specific to Bolton, an accurate judgement cannot be made as to the size of the PDU population or treatment penetration.

Key Points

- There is evidence for a possible decline of PDU numbers in Bolton; local opinion suggests a corresponding rise in different, polydrug use trends particularly among younger users.
- It is vital that the treatment system is prepared for potential changing drug use and corresponding changes in client profiles and treatment needs.

4.2 Time in Treatment

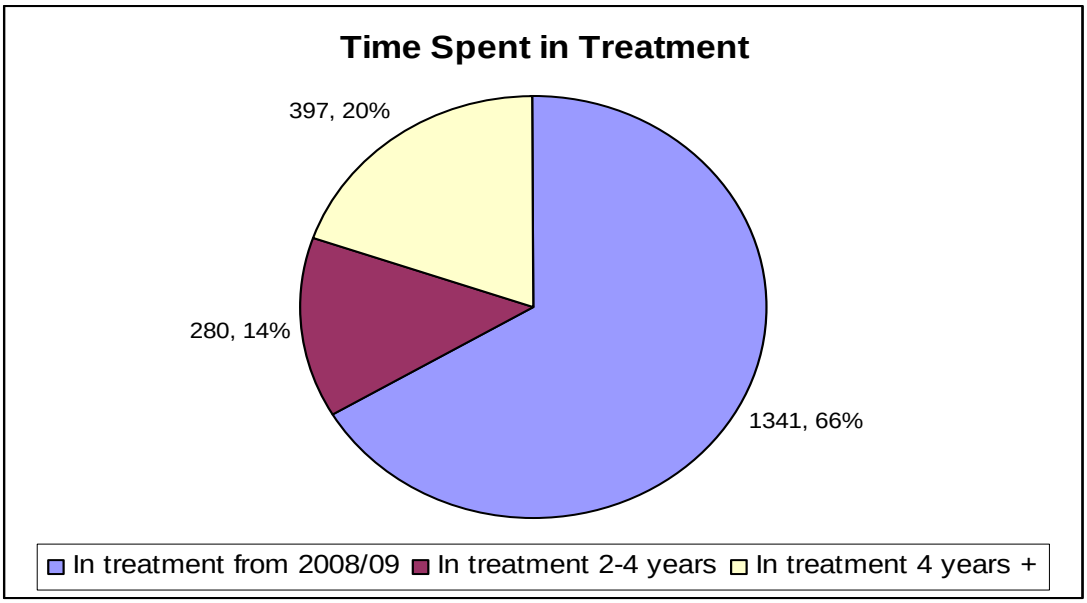

Fig. 27: *Proportion of Clients in Treatment for 2-4 and Over 4 Years.*

20% of our clients have been in treatment for 4 years or more. The profile of these clients is older (those in treatment 4 years+ are twice as likely to be aged 45-64 than those in treatment for less time), less ethnically diverse (97% white British), and by far most likely to use opiates only (87%) or opiates and crack (12%). They appear no more or less likely to be a parent, or to be an injector. However this judgement can only be made concerning the situation when they began treatment, as Parental Status and Injecting Status are not updateable fields.

Adjunctive alcohol use is more common for those who have entered treatment more recently – 7% of clients in treatment 2008/9, compared to 5% of those in treatment for more than 2 years and 1% of those in treatment for more than 4 years.

Of those who have been in treatment for between 2 and 4 years, 97% are in treatment at BDS and 3% at ADS. Of those who have been in treatment for 4 years and over, 99% are at BDS, and 1% at ADS.

Individuals entering treatment during 2008/9 are engaged in a wide variety of modalities. However, NDTMS data (see Fig. 28) shows a different picture for those in treatment for longer periods. The vast majority of these long-term clients are in treatment consisting only of prescribing. Ideally, this pattern would be formed in reverse, with fewer clients requiring substitute prescribing from the central drug service over time, and more moving into other interventions and Shared Care. Prescribing by GPs appears from the above data to be fairly constant, suggesting that Primary Shared Care is being made less use of than is ideal.

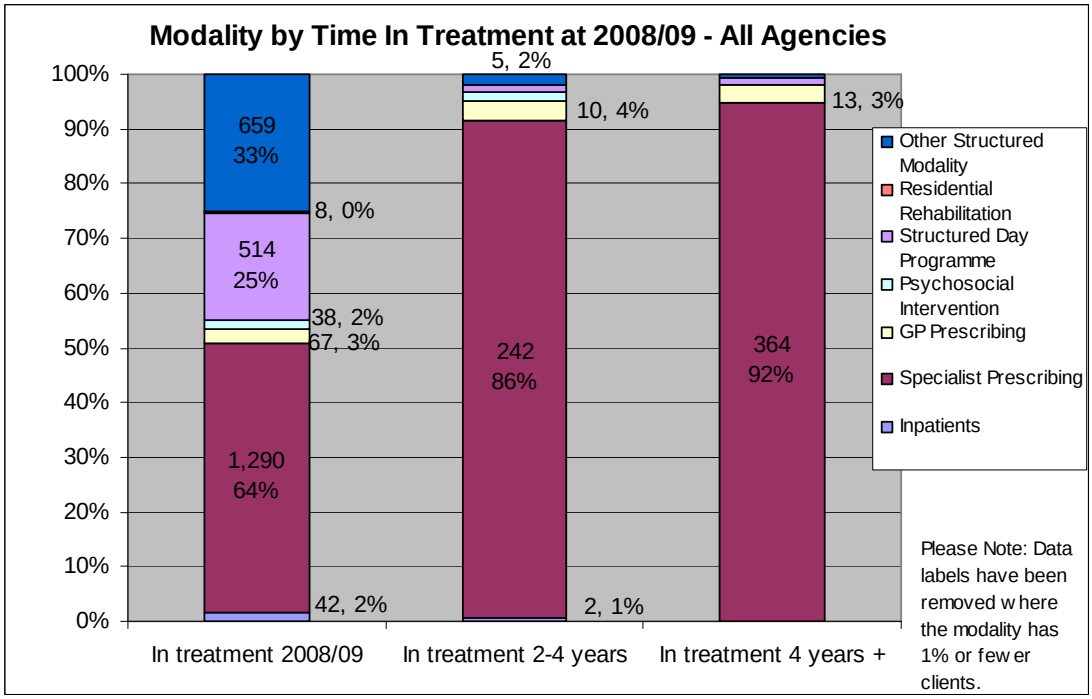

Fig. 28: *Treatment Modalities of Clients in Treatment for 2-4 and Over 4 Years.*

One of the aims for the treatment system during 2008/9 was to embed the provision of other modalities (such as psychosocial interventions) for new clients: this has evidently been done very successfully, and the focus must now be on extending this provision to longer-term clients.

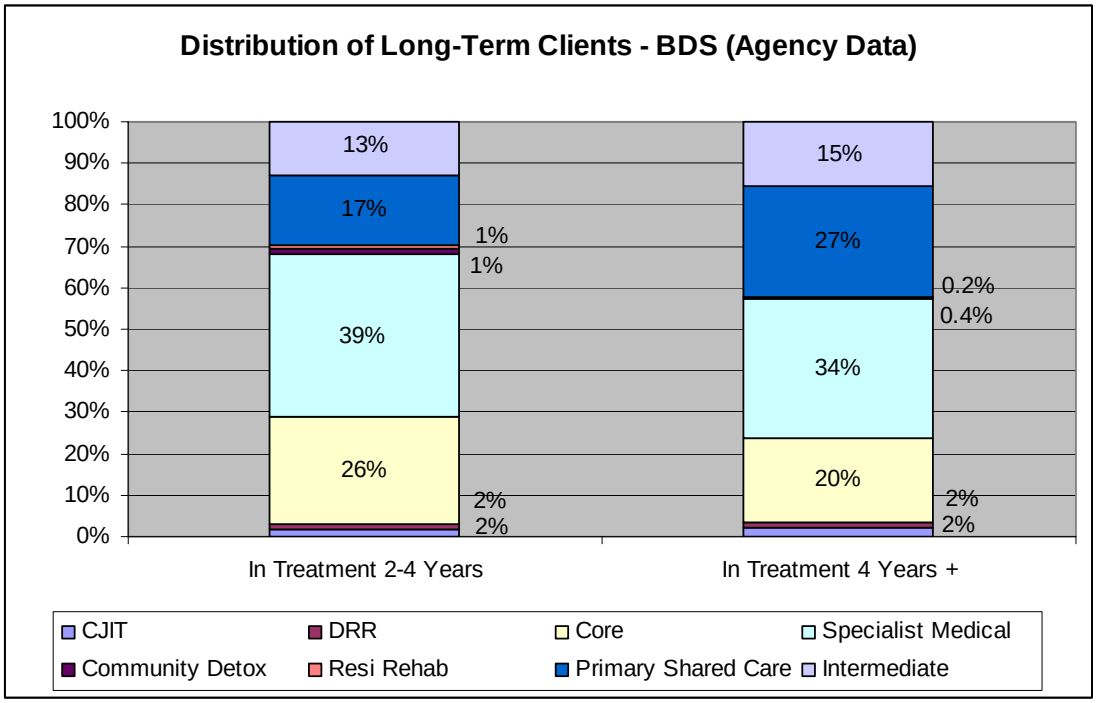

Fig. 29: *Modality Breakdown of Long-Term Clients in Treatment at BDS*

Agency data from BDS gives a clearer picture of long-term clients. A substantial proportion are in treatment in Primary Shared Care, which refers to clients whose care is managed by their GP, or Intermediate Shared Care, which covers clients who are suitable for Primary Care but managed by BDS (see Section 2.1.6 for further comments on Shared Care provision).

Department of Health guidelines state that "Longer-term prescribing should be

reviewed at regular intervals (usually at least three-monthly) and should be part of a broader programme of care planned social and psychological support"[20]. The first point to make here is the necessity of ensuring that an adequate degree of psychological and social support is available to clients on long-term scripts. The second is in relation to the regularity with which clients are reviewed. A frequency of 3 months or longer is indicative of a professional judgment that the client is stable. Data from BDS funnels for 2008/9 was used to investigate this. Of those in treatment at BDS for between 2 and 4 years, 12% had not been seen in the previous three months (as of year end 08/09); for those in treatment for 4 years or more, 7% had not been reviewed in this time. The majority of these clients are managed in Primary Shared Care, though a few remain in Core and Specialist Prescribing funnels. These clients are potential candidates for movement into Shared Care.

Recovery

We expect to see increased national focus on recovery in the future, and this may lead to services being placed under some pressure to reduce maintenance prescribing. If this occurs it will raise a number of issues, including potential rigidity of attitudes among clients and staff, and the necessity of changing expectations (longer-term clients, who may have given the expectation of long-term maintenance prescribing on initial entry to treatment, may perceive that change is being forced and resent this).

There are also resource issues: those who are very stable currently demand few resources, but extending all modalities to all clients and encouraging cessation of drug use will require additional psychological, social and medical support. A broad consideration and redesign of the treatment system in Bolton is currently underway, with the goal of working within current resources whilst enabling more clients to access a wider variety of interventions, including the ability to do so within their own community, and move towards abstinence.

Drug–Related Deaths

A consequence of abstinence-directed change could be increased relapse amongst a long-term stable and in many cases aging drug user cohort. This carries dangers of overdose.

It is also important to recognise the increased risks faces by an ageing drug-using population such as that in Bolton. Almost half of known deaths among service users over the past three years have been contributed to by chronic physical health conditions. Some of these, such as diabetes, may have been exacerbated by using drugs, while others, like Hepatitis C, may have been acquired as a direct result of an individual's drug use. This emphasises the importance of continuing to ensure that all new treatment commencements receive a healthcare assessment, and that adequate medical care is provided to all clients.

Key Points

- 12% of our clients have been in treatment for 2-4 years; 16% have been in treatment for longer than 4 years
- The profile of long-term clients is older and less ethnically diverse, with a less varied substance use profile. They also have a different treatment profile, with a wider variety of modalities available to newer clients.
- Providers should be congratulated on this variety in treatment, while an aim for the coming year should be to extend this to all clients.

[20] Department of Health (2007). *Drug Misuse and dependence: UK Guidelines on Clinical management.* DH, London.

4.3 Non-English Speakers

Numbers of 'White Other' clients are slowly increasing (according to Quarterly NTA reports), with 14 in treatment year-to-date in 2009/10. This is a tiny proportion of the in-treatment population (1%), but is significant as this category was barely populated a few years ago. These individuals, who appear to be mainly Eastern European clients, have been reported as coming into contact with treatment services both through Test on Arrest and self-presentation at Bentley House. Anecdotal reports from the services involved indicate problems with engagement due to language barriers. It may therefore be that the numbers represented in NTA 'in treatment' figures is falsely low.

It is important to find ways of helping these clients to access and engage with treatment. Some treatment system advertising and information materials have previously been translated for the benefit of non-English speakers among Bolton's Asian population; a similar initiative may improve engagement for Eastern European clients. It should also be considered that this new client population may have different treatment needs to existing client groups in other ways.

Key Points

- Agencies should be aware of this growing need, and consideration should be given to ways of helping these clients to engage more effectively.

4.4 Parents and Families

As discussed in Section 3.3.6, a substantial proportion of Bolton drug treatment clients are parents or have children residing with them. Various agencies have set out guidance for the protection of children from harm resulting from parental 'problem drug use', defined by the Advisory Council on the Misuse of Drugs as drug use which has *'serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them'*[21]. New joint guidance for drug treatment services and parenting and families services[22] makes numerous recommendations, which commissioners should be aware of. These can be found in Appendix 9.

The government's Families at Risk review[23] set out plans to support families experiencing the most entrenched problems – including substance misuse and poor mental health – to reduce the impact that this has on their children. Bolton holds Pathfinder status for the Think Family project; a specialist intervention team has been composed to provide intensive support to identified families as part of a three-year pilot funded by Think Family. Families are offered this support if they are identified as being problematic or on the verge of being at risk.

Think Family aims to promote joint working between Children's and Adult Services to offer families appropriate support tailored to their needs. A significant proportion of families involved in Think Family will experience some form of problematic substance misuse. In terms of the responsibility for drug treatment services, this involves attending meetings with other Adult and Children's Services to co-ordinate

[21] The Advisory Council for the Misuse of Drugs. (2003). *Hidden Harm, Responding to the Needs of Children of Problem Drug Users*. Home Office, London.

[22] Department for Children, Schools and Families, Department of Health and National Treatment Agency for Substance Misuse. (2009). *Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services.* DCSF, DH & NTA, London.

[23] Cabinet Office (2008). *Think Family: Improving the Life Chances of Families at Risk*. CO, London.

interventions for particular families. It is also possible for families to be referred into the Think Family project from drug treatment services.

A pilot aimed at improving the interventions available to parents in drug treatment is currently underway with the assistance of the BMBC Parenting Team. A skills audit for ADS staff will be undertaken, assessing the skills gap in terms of communication and help for clients around parenting. This will be followed by an evaluation of the current ADS parenting programme, with client involvement, to assess their needs and preferences for parenting support. This will enable appropriate staff training and the design of more beneficial interventions, and will subsequently be implemented across the rest of the treatment system.

Support is also available for the parents and carers of drug users in Bolton through the Harbour Project. Harbour is a voluntary support organisation for parents, carers and families of substance misusers, providing practical and emotional support, factual information, advice and training through regular Group Meetings and a confidential 7 day telephone Helpline Service.

The service Harbour provides is comprehensive and valuable; however, early reports from a service user-led assessment of the treatment system indicate that the effective promotion of their services (by other organisations within the treatment system) to those who might benefit may be lacking. Members of Harbour have also suggested that the importance of their role in successful treatment can be underestimated, and that their input could be valued more both in the practicalities of treatment and at the planning stages of treatment system design. Parents and carers are currently consulted on changes within the treatment system, via Harbour, once a proposal has been drafted. Thus they are involved in treatment system development at the same point in the process as other key stakeholders. However, it is recognised that the consultation process, for all stakeholders involved, could be made more substantial by allowing more time for consideration and greater scope for input into the design of innovations.

There is now an additional local focus on Safeguarding Adults – the new FWIN system (Force Wide Identification Number) is intended to enable a 'flag' to be placed on individuals with problematic or repeat presentations at various services (A&E for example). Safeguarding focus meetings are planned, to be called by stakeholders on a case-by-case basis as necessary. At this stage, it appears that the main requirement for drug services will be to provide information about individuals identified through this system, and attend focus meetings, which may be onerous in terms of time. It is as yet unclear whether drug treatment providers will have the ability to flag an individual as at-risk or call a Safeguarding Adults meeting.

Key Points

- The Partnership must continue to work to ensure that children of drug users in Bolton are safeguarded from harm and that parents and carers have support available to them.

4.5 Education, Training and Employment

Data from the North West Public Health Observatory (October 2009) indicates that Bolton has the 11th highest number of Incapacity Benefit claimants in the North West, with 235 per 100,000 individuals claiming. Further investigation to explore the profile of these individuals during the coming year would be beneficial, even if only to determine the scope of data available.

There is clearly a major role to be played in ETE provision by the new Moving On service provided by ADS, which will be fully developing over the coming year.

4.6 Dual Diagnosis

The concurrence of mental health problems and substance misuse, commonly termed Dual Diagnosis, is recognised as a common issue for treatment system clients (see Section 3.3.8). 20% of new clients in 2008/9 were reported as having mental health issues. This is likely to be indicative of a much higher figure, as reporting is dependent on disclosure of symptoms to keyworkers, who may otherwise struggle to identify mental health problems. In line with Department of Health guidance[24], those with severe and enduring mental health issues are 'mainstreamed' and receive a service from statutory mental health services. Drug treatment services engage well with PDUs who experience common mental health problems.

It is important to recognise that the problems precipitated by drug use are likely to be greater if the user is already experiencing some form of mental health problem. The Bolton Dual Diagnosis Needs Assessment report[25] described that the needs of those with dual diagnosis are far greater than for people with a single issue. The challenge for both commissioners and providers in Bolton is that the drug use is frequently non-PDU, and frequently at a level that would not normally trigger a response from specialist services. Those individuals with the greatest risk of being overlooked by treatment services are those who do not have severe enough mental health problems *or* drug use to give one service clear ownership of their case. In addition many people in this cohort are leading chaotic lives and are not in a position to engage well with structured services, thus many present to drop in services such as the homeless day programmes. The Hostel Liaison service is likely to encounter and provide valuable support to these individuals.

The Dual Diagnosis Needs Assessment report made 15 recommendations; perhaps the most urgent is to ensure that drug use does not debar those with common mental health problems from accessing help. In the mental health world the Recovery Agenda is reducing opportunities for long-term support groups, which are particularly valued by this group. The Improving Access to Psychological Therapies (IAPT) programme is a major new investment in services to address common mental health issues and should be open to drug users, where the drug use is not the primary problem. The strategic challenge is to ensure those in need do not fall between drug services and IAPT services.

Key Points

- A high proportion of drug treatment clients in Bolton are likely to have concurrent mental health needs.
- Efforts are needed to ensure that those most likely to be overlooked (i.e. those with non-PDU drug use and less severe mental health problems) are not.

[24] Department of Health (2002). Mental health policy implementation guide: Dual diagnosis good practice guide. DH, London.

[25] Centre for Public Innovation (2009), *Bolton Dual Diagnosis Review March 2009*, CPI.