JSNA Chapter: Drugs

Introduction

Bolton Drug and Alcohol Strategy and Commissioning Team (DASCT) use evidence-based commissioning to implement a treatment system with aims in line with the national 10 year Drug Strategy, *'Drugs: Protecting Families & Communities'* (2008)[1], and with those set out by the Bolton Vision Partnership. Both harm reduction and re-integration are given priority within the treatment system.

The overarching aims for Bolton are as follows:

- Protecting communities through robust enforcement to tackle drug supply, drug-related crime and anti-social behaviour
- Preventing harm to children, young people and families affected by drug misuse
- Delivering new approaches to drug treatment and social re-integration
- Public information campaigns, communications and community engagement

As part of the commissioning cycle, the DASCT conduct an annual Needs Assessment to identify the needs of drug users and misusers, gaps in current provision and where improvements could be made. This informs the Adult Drug Treatment Plan, which sets out how the drug treatment system in Bolton will deliver continual improvements to provision, contributing to delivery of the national Drug Strategy and key local partnership targets.

The 2007/08 Home Office prevalence study estimates that the prevalence of problematic drug users (PDUs - opiate and/or crack cocaine users) in Bolton is 2,788 (95% confidence interval of 2,550 – 3,306). This equates to approximately 16.30 PDUs per 1,000 of the population.

The work of the DASCT relates to adult drug users and misusers. Individuals under 18 years of age who experience problems with their or another person's substance misuse can find support at Project 360º, the young people's drug service which is commissioned by Children's Services.

Risk factors for substance misuse

Bolton is one of the largest urban centres in the North West and has a culturally diverse population of 264,800, living in some of the region's most affluent neighbourhoods, as well as some of its most deprived. The 2007 Indices of Multiple Deprivation (IMD) District Level Rankings data shows that Bolton is

[1] Home Office (2008). *Drugs: Protecting Families & Communities, The 2008 Drug Strategy*. Home Office, London.
Document can be found at http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-20082835.pdf?view=Binary

ranked 51 out of 354 in terms of the most deprived districts (where 1 is the most deprived). The number of Bolton's working age population claiming Jobseekers' Allowance (JSA) has increased over the last few years. Bolton shows a greater percentage change than the North West and Great Britain. The majority of Bolton's companies which have reduced their workforce or have cut jobs have mainly been in the manufacturing or retail sectors. The housing market has also seen a significant slowdown and repossession orders have increased.

Whilst the potential impact of the economic downturn on drug use in Bolton is unknown, the current economic situation is likely to have an impact on drug use; historically in tough economic times there has been a rise in substance misuse. Many of the effects of recession - repossessions, money problems and unemployment - are well known triggers for mental health problems and substance misuse. The added stresses and anxieties for families already experiencing a range of barriers to well-being will have future implications both for mental health services and for alcohol and drug services. There may also be an impact on the efforts of drug and alcohol misusers to recover from their dependencies as they struggle harder to overcome barriers to their re-integration into society in a time of recession.

Risks for substance users/misusers.
Please note: All the below are discussed in greater detail in 'Who is at risk and why?' later in this document.

The majority of Bolton's current in-treatment population are opiate and/or crack users. However, the problematic heroin and crack using population in Bolton is ageing: new trends of non-PDU drug use are emerging. This type of substance use tends to involve polydrug repertoires including cannabis, cocaine, alcohol, ecstasy and emerging drugs such as ketamine and legal highs like mephedrone.

There are multiple health consequences of long-term use of heroin and/or crack cocaine, including both direct effects of the drugs themselves, and effects resulting from intravenous drug use and the often chaotic and marginal lifestyle associated with addiction to Class A drugs.

Non-PDU substance users will have different risk profiles. The long-term health consequences of this type of polydrug use include cardiovascular problems, cognitive deficiencies and depression, the risk of blood-borne virus infections as a result of injecting or snorting substances, and liver disease as a result of alcohol use. There will also be long-term health effects of newer and emerging substances such as ketamine and mephedrone, though the full impact of these will not be known for several years. The DASCT are developing a Digital Strategy in order to better meet the needs of this population.

Links to: Mental Health, Alcohol.

The key issues and gaps

Key findings of the Needs Assessment were

- there is a large amount of excellent work being delivered in the implementation of the Bolton drug strategy;
- collaboration between different providers continues to improve and clients are accessing various elements of the treatment system;
- further areas for improvement have been highlighted (see below)

Analysis of the treatment system indicates that services are working together well; staff are beginning to demonstrate understanding of all that the different services have to offer clients, and new clients entering the treatment system are being encouraged and supported by staff to access its various components. However, referrals from the Tier 2 service into the treatment system can and must be increased and improved; another identified issue is the significant number of clients who have been in treatment for a longer period of time, who as a consequence may have reduced access to the opportunities offered to new clients, i.e. blood-borne virus testing and access to psycho-social interventions rather than prescribing in isolation.

Issues and gaps:

Context

Bolton is one of the largest urban centres in the North West and has a culturally diverse population of 264,800, living in some of the region's most affluent neighbourhoods, as well as some of its most deprived. The 2007 Indices of Multiple Deprivation (IMD) District Level Rankings data shows that Bolton is ranked 51 out of 354 in terms of the most deprived districts (where 1 is the most deprived). There has been a gain in Lower Super Output Areas (LSOAs) that fall within the 5% most deprived in England, which is an increase of 7 since 2004.

Bolton's population continues to change, with new communities settling in the town. This diversity presents many opportunities for the borough but also a number of challenges - not least those of community cohesion and opportunity for all.

Financial Pressures

Data for September 2009 showed that 8,447 – 5.3% of the working population in Bolton – were claiming Jobseekers' Allowance (JSA). This is an increase of 2.1% from the same time last year. Bolton shows a greater percentage change than the North West (which is at 4.7% of the working population) and Great Britain (at 4.0%). The majority of Bolton's companies which have reduced their workforce or have cut jobs have mainly been in the manufacturing or retail sectors.

The housing market has seen a significant slowdown and as of February 2009,

the Land Registry's House Price Index shows prices are 10% down in Bolton on the previous year compared to a 7% drop in Greater Manchester.

Repossession orders granted in Bolton courts rose by 14%, to 588 between Quarter 1 and Quarter 3 in 2008 (it must be noted that Bolton's courts do sometimes deal with out of Borough cases). Council tax records show that the number of unoccupied dwellings exempt from payment due to having been taken into repossession by a mortgage lender, were 132 in February 2009 and 189 as of 1st January 2010, compared to 126 in October 2008 and 52 in October 2007.

Bolton Council is facing difficult financial challenges and has implemented a Value for Money strategy to cope with real and anticipated reductions in public spending. This strategy consists of identifying savings of up to 30 per cent over a four year period. Other Be Safe partners are facing similar challenges, including health and Police.

Whilst the potential impact of the economic downturn on Bolton's drug strategy targets and performance is unknown, historically in tough economic times there has been a rise in substance misuse. We know the recession will put extra strains on families and complex family situations. The increased number of job losses locally will leave low paid and low skilled Bolton residents more vulnerable to income deprivation and there will be an increase in the number of families pushed below the poverty line. Many of the effects of recession - repossessions, money problems and unemployment - are well known triggers for mental health problems and substance misuse. The added stresses and anxieties for families already experiencing a range of barriers to well-being will have future implications for mental health services and for alcohol and drug services. The promotion of drug and alcohol treatment services which may be able to provide early identification and support for individuals will be increasingly significant. Providers and commissioners will want to monitor capacity and demand for these services. There may also be an impact on the efforts of drug and alcohol misusers to recover from their dependencies as they struggle harder to overcome barriers to their re-integration into society in a time of recession.

In addition, there is an accepted view that Government will need to cut spending on public services in order to pay off the national debt. We will need to start planning for a significant reduction in our cost base. The challenge will be to meet rising demand amid cuts in spending, particularly from 2011 onwards. The twin pressures of reduced resources and increased demand will make the next few years tough.

Supporting People funding

Supporting People must reduce recurrent spend by 9%. Agreement has been reached by the Supporting People Commissioning Group that 9% savings will be sought from provider agencies over two years (3% 2009/10 and 6% 2010/11). This will adversely affect clients accessing the substance misuse specific Floating Support services currently funded by Supporting People (PDUs, alcohol

and other drug users) and lead to a reduced service. It may also adversely affect substance misuse clients who are accessing other Supporting People funded services (e.g. services for the homeless).

Diversity

There have been some reported cases in which individuals from Eastern European backgrounds have accessed drug treatment but found engagement difficult due to language barriers.

Harm reduction

The DASCT recently commissioned a specific needs assessment into Harm Reduction in the Bolton treatment system[2], which identified evidence of good practice both strategically and operationally across Bolton, and also suggested improvements that could be made to current provision. These will be covered in detail under 'Recommendations for Commissioning', but some notable gaps include:

- Quality of data collection and monitoring across all services, particularly needle exchange services.
- Extended provision of outreach specialist harm reduction and needle exchange services, such as satellite clinics, to reach clients outside the treatment system.
- Pharmacy needle exchange services could be improved with the provision of tailored safer injecting advice and information, potential for referring clients to appropriate specialist harm reduction services, and specialist trained pharmacists working in pharmacies to provide brief harm reduction interventions. This would require training programmes for pharmacy staff in contact with drug users to improve skills and knowledge.
- Effective local Hepatitis C treatment pathways, supported by staff or volunteers accompanying clients to hospital appointments or hepatitis treatment through community services to improve access. This work will be supported by the DASCT during 2010/11 and led by NHS Bolton.
- Enquiry processes for drug- related deaths linking with the coroner's office.
- Specific services for steroid users, such as dedicated steroid clinics at the harm reduction service and the provision of advice and information to steroid users operating out of office hours; staff trained in the risks and harm reduction advice for steroids; outreach to gyms.
- Harm reduction training for non-drug treatment staff working with drug users (e.g. criminal justice, housing workers) through multi-agency training.

Drug Intervention Programme

[2] The Lifeline Project Ltd. (2010) *Bolton Harm Reduction and Tier 2 Needs Assessment*

There are a few issues around the Drug Intervention Programme (DIP), which focuses on treatment for individuals who have been identified through involvement with the criminal justice system.

There are a few issues around the Drug Intervention Programme (DIP), which focuses on treatment for individuals who have been identified through involvement with the criminal justice system.

The DIP programme has been reviewed by the Home Office and new guidance (not yet received) is expected imminently, outlining some alterations in the way DIP interventions are delivered.

There are changes to the local DIP funding allocation for 2010/2011: Bolton will receive an 11% reduction in funding. The new allocation will be £1,030,183. This reduction will impact considerably on the drug treatment system as it will necessitate the decommissioning of some service provision, as determined by the JCG.

The roll out of the Integrated Drug Treatment System (IDTS) in all prisons is likely to impact on treatment in the community in terms of more individuals being engaged in treatment in prison and therefore needing continuity of care into the community. Additionally drug related interventions will be integrated into the Integrated Offender Management (IOM) approach. Transfers from Prisons into the Community are a long-term issue for Bolton. A variety of factors, including IOM and IDTS, may help to improve this over the coming year.

Commencements for Drug Rehabilitation Requirements (DRRs – a community order requiring attendance at drug treatment) are falling below target. However, due to significant work done in collaboration, by drug services and the Probation Service, the quality of DRRs has improved and successful completions are now above target.

Engagement of DIP clients in treatment is lower than the population average. This may be related to the high proportion of DIP clients who have been in treatment previously. It is suggested that some of these clients are 'treatment fatigued', having been in and out of treatment several times, and that treatment is no longer as attractive to them. This poses additional challenges for services with regard to engagement. However, the new Home Office vision of DIP focussing on engagement, assessment and case management should improve this.

Changing Drug Use Trends

The majority of Bolton's current in-treatment population are opiate and/or crack users; additional problematic use of alcohol is often also found within this group.

The problematic heroin and crack using population in Bolton is ageing: new trends of drug use are emerging. In some ways these reflect Howard Parker's "ACCE" profile – which describes the use of Alcohol, Cannabis, Cocaine and Ecstasy – although in Bolton this understanding of poly substance using trends extends beyond the four highlighted by Prof. Parker's work. A trend of concurrent alcohol and cocaine use in the night time economy, and other emerging drug

use/misuse (including ketamine and mephedrone), as well as the use of steroids, are also prevalent and beginning to place demands on treatment services. These 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.

Treatment Outcomes

12% of our clients have been in treatment for 2-4 years; 16% have been in treatment for longer than 4 years. The outcome management approach which has been implemented by commissioners in Bolton has highlighted these clients who seem to have come to a "standstill" within the Specialist Prescribing service of the Tier 3 service, or within Shared Care, with ramifications for the whole treatment system. Considerable re-design of the treatment system will be conducted during 2010/11 in order to impact on this.

Parental Status

The current Drug Strategy places an emphasis on families and communities. The ACMD report Hidden Harm[3] is now six years old, the government response[4] 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[5] makes 27 recommendations that are too detailed to describe fully here. The guidance outlines joint working between drug treatment agencies and children's services, with three main aims:

- Improved joint working across drug and alcohol treatment services and children and families services
- Ensuring that children are protected from harm and their welfare needs met
- Improving outcomes for drug and alcohol service users who are parents

It is worth noting however, that many of the specific recommendations for adult drug treatment services are already working practice in Bolton – for example ensuring home visits to all clients who report living with children. In addition further work is planned this year, responding to the guidance.

The ACMD[1] estimated that there is approximately one child for every PDU, thus there are some 2,788 children of PDUs in Bolton. The most recent Bolton performance report notes that 56% (up from 52% last year) of clients in new treatment journeys report having children. Service providers are to 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

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

parental status (reduced from 36% in 2007/8). 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.

It should also be noted that pregnant women are prioritised throughout the drug treatment system in Bolton. This includes attendance at residential treatment out of the borough, such as detoxification clinics and residential rehabilitation, where this is deemed appropriate to the client's needs. This is good practice and will continue.

Concurrent Alcohol Use

Evidence suggests that concurrent alcohol use is an issue for a significant proportion of PDUs (heroin and crack cocaine users). The recent Harm Reduction Needs Assessment identified a pattern of poly drug use including heroin, crack cocaine, alcohol and benzodiazepines. The concurrent use of alcohol increases the risk of overdose and longer-term health consequences; there will also be increased social consequences both for clients and for their families. Non-PDU drug users are also likely to include alcohol in polydrug repertoires.

Some of these clients may present to drug treatment services for assistance with drug use, help with education or employment, parenting advice, or other issues. Treatment services may then need to incorporate work around alcohol into the client's care plan. This presents additional challenges for treatment services, which are currently incorporated well into individuals' drug treatment.

The complex needs of these clients can be further exacerbated by comorbidity with mental health problems, increasing the necessity for joined up working between drug services, alcohol treatment services, and mental health services.

Additional Priorities

There are several ongoing issues which will remain a priority – these include homelessness and housing; provision for parents and carers of drug users; service user involvement; education, training and employment; and clients with dual diagnosis (comorbidity of mental health and substance misuse problems).

Recommendations for Commissioning

Recommendations and Priorities

Treatment System Redesign

In early 2010/11, several changes in how the Bolton drug treatment system operates will be taking place as part of a treatment system redesign. These changes are aimed at helping clients to move on through the system, and increasing the numbers achieving abstinence.

Weekly 'options meetings' will take place, jointly run by services within the

treatment system. Both new and existing clients, including those referred through the criminal justice system, will be expected to attend these meetings, which will offer information on the treatment options available to them. Clients will be given an overview of the treatment system and the main treatment available, as well as being exposed to group settings and the ITEP Mapping techniques used in treatment; the aim being to increase clients' expectations and understanding of treatment from the start of their treatment journey, and promote client choice for individualised, needs-led care.

The options meetings will focus on key messages about motivation, engagement and recovery. Family members and concerned others will be able to attend to offer support if desired. Trained volunteer 'navigators' will also attend the meetings to give impartial advice. Detoxification staff will make regular presentations at community groups for contemplative clients, with the aim of initiating more detoxifications in the community (through Shared Care practices) making detoxification a more accessible option for clients.

It is hoped that these changes will also improve access to psychosocial treatments, promote access to detox in the community, and increase the take up of Education, Training and Employment (ETE) opportunities by clients. The meetings should also help to engage some of the 'treatment fatigued' clients who have been in and out of treatment several times, to whom treatment is starting to become less attractive, by offering a wide selection of options and giving clients control and responsibility for their own treatment journeys.

As part of the redesign, the provision of more locally-based services will be piloted (such as group work being offered in UCAN centres within the community) to facilitate community reintegration and reduce social isolation.

Priorities for financial planning
Plan for reductions in funding available through the Department of Health, the Home Office, and other organisations as appropriate (Pooled Treatment Budget, DIP funding, Supporting People etc).

Digital strategy
A drug and alcohol digital strategy is to be produced and developed which pulls together the Bolton approach and targets a wider variety of drug users. Online information provision should make information about drug use, risks, and treatment services more accessible to a younger generation of drug users, who are likely to have easy access to the internet, may prefer the option to access information anonymously and may be more comfortable engaging online rather than through a physical service. There are plans to extend online resources to include a broad range of information about the implications of using various substances, give advice and self-help tools for individuals worried about their own or other person's use, and potentially, to provide treatment support on an online basis.

The online resource will also offer information and signposting to support for family members, friends and carers of drug misusers. The strategy will also feature a 'professionals' area', enabling stakeholders to better understand the work of the DASCT and the treatment system and, where appropriate, make informed referrals.

Diversity
Develop appropriate materials for Eastern Europeans who may be referred for drug treatment, who do not speak English as their first language (links to digital strategy).

Harm reduction

- Improve the monitoring of drug related deaths and implement improvements in practise as a result of the learning gained from this;
- Continue to provide RCGP training to GPs;
- Develop increased effectiveness in payment mechanisms for the uptake of pharmacies (needle exchange and supervised consumption).

The recent Lifeline Harm Reduction Needs Assessment identified evidence of good practice both strategically and operationally across Bolton, and made several recommendations. The Needs Assessment and subsequent recommendations fit into a wider agenda aimed at the improvement of harm reduction interventions across the treatment system. Pending approval from the JCG, the DASCT will seek to progress all recommendations from the Harm Reduction Needs Assessment over 2010/11, in partnership with NHS Bolton, the Local Pharmaceutical Committee and drug service providers.

The recommendations put forward include:

- Development and implementation of a local harm reduction strategy involving local expert groups.
- Good quality data collection and monitoring across all services to assess need and inform planning and commissioning.

Needle Exchange and Specialist Harm Reduction Services:

- Good coverage of specialist harm reduction services and pharmacy needle exchange across the borough delivered by trained staff.
- Flexible and accessible specialist harm reduction services and pharmacies, open in evenings and weekends.
- Outreach specialist harm reduction and needle exchange services, such as satellite clinics, to reach clients outside the treatment system.
- Delivery of harm reduction interventions in non-drug treatment settings.

Delivery on a range of interventions in pharmacies, including:

- Provision of tailoring safer injecting advice and information

- Pharmacy staff referring clients to appropriate specialist harm reduction services
- Drugs workers or specialist trained pharmacists working in pharmacies to provide brief harm reduction interventions
- Private consultation room.

Blood Bourne Viruses (BBVs):

- Testing for BBVs sustained as a high priority in drugs services, aiming to test for BBVs at initial assessment.
- Availability of vaccinations for hepatitis A and B and testing for hepatitis C for clients attending drug services or specialist harm reduction services, with additional mechanisms in place to vaccinate staff working in drugs services and needle exchanges.
- Effective Hepatitis C treatment pathways, supported by staff or volunteers accompanying clients to hospital appointments or hepatitis treatment through community services to improve access.

Overdose Prevention:

- Development of a strategy for reducing drug-related overdose deaths.
- Potential to join up with neighbouring areas (within the coroner's footprint) to have a wider strategic focus and comprehension of drug related deaths that have occurred.
- Establish enquiry processes for drug- related deaths linking with the coroner's office.
- Overdose prevention and basic life support training for staff, service users and carers.
- Mechanisms to minimise the overdose risk on prison release, overdose prevention training and targeting harm reduction advice through prison and drugs workers.
- Proactive work on drug-related death prevention through locally targeted campaigns.

Services for Steroid Users:

- Dedicated steroid clinics at the harm reduction service and the provision of advice and information to steroid users operating out of office hours.
- Trained staff in the risks and harm reduction advice for steroids.
- Access to needle exchange providing appropriate equipment out of office hours and specific harm reduction advice according to need.

Staff Training and Skills:

- Harm reduction training as standard for all staff across the drug treatment system.
- Harm reduction training for non-drug treatment staff working with drug users (e.g. criminal justice, housing workers) through multi-agency training.

- Training programmes for pharmacy staff in contact with drug users to improve skills and knowledge.

Drug intervention programme (DIP)

- Implement the Home Office recommendations from the DIP review;
- Implement the Integrated Offender Management system in conjunction with partner agencies;
- Improve the engagement of CARATS referrals on release from HMP Forest Bank;
- Support the rollout of IDTS in HMP Forest Bank and consider the impact on future demand, especially of prisoners released with prescribing needs;
- Continue to progress the improvement of outcomes for clients on DRRs through effective joint working and harnessing the factors which are more likely to lead to successful completions.

Housing and homelessness

- In conjunction with partners, support on-going work to re-configure the hostel provision in Bolton, including new providers;
- Following the fieldwork within the Harm Reduction needs assessment, develop an effective approach to the provision of outreach to clients in the hostels.

Service users/carers

- Working with commissioners in Adult Social Care, develop an innovative strategy for improved effectiveness of service user/carer involvement;
- Seek and encourage opportunities for feedback of drug misusing offenders in relation to their engagement and/or non-engagement in treatment.

Parental Status

Commissioners and providers to work closely with children's and family services to integrate Hidden Harm approaches, as well as with Adult Social Care, with a view to encouraging more active involvement in drug-related work. Families and carers of drug misusing clients should be involved wherever possible in an individual's drug treatment as agreed by the client. Service providers should continue to consider the needs of and risk to all children of drug misusing parents, taking account of the local framework.

Who's at risk and why?

Risk factors for substance misuse

Bolton is one of the largest urban centres in the North West and has a culturally diverse population of 264,800, living in some of the region's most affluent neighbourhoods, as well as some of its most deprived. The 2007 Indices of Multiple Deprivation (IMD) District Level Rankings data shows that Bolton is ranked 51 out of 354 in terms of the most deprived districts (where 1 is the most deprived). There has been a gain in Lower Super Output Areas (LSOAs) that fall within the 5% most deprived in England, which is an increase of 7 since 2004.

As mentioned previously, the number of Bolton's working age population claiming Jobseekers' Allowance (JSA) has increased over the last few years. Bolton shows a greater percentage change than the North West and Great Britain. The majority of Bolton's companies which have reduced their workforce or have cut jobs have mainly been in the manufacturing or retail sectors. The housing market has also seen a significant slowdown and repossession orders have increased.

Whilst the potential impact of the economic downturn on drug use in Bolton is unknown, the current economic situation is likely to have an impact on drug use; historically in tough economic times there has been a rise in substance misuse. We know the recession will put an extra strain on families and complex family situations. The increased number of job losses locally will leave low paid and low skilled Bolton residents more vulnerable to income deprivation and there will be an increase in the number of families pushed below the poverty line. Many of the effects of recession - repossessions, money problems and unemployment - are well known triggers for mental health problems and substance misuse. The added stresses and anxieties for families already experiencing a range of barriers to well-being will have future implications both for mental health services and for alcohol and drug services. There may also be an impact on the efforts of drug and alcohol misusers to recover from their dependencies as they struggle harder to overcome barriers to their re-integration into society in a time of recession.

We know that deprivation is associated with higher levels of substance misuse; the current economic climate is likely to increase pressures on individuals and families in Bolton who are already struggling, and put them at greater risk of substance misuse problems. There are also issues affecting drug users currently in treatment. For example, accommodation need is recognised as an important barrier to successful treatment; 28% of new clients in 2008/9 had a housing problem or no fixed abode.

Risks for substance users/misusers.

It is worth noting that a substantial number of individuals will use drugs recreationally without ever experiencing significant problems, becoming addicted or entering treatment. However, some will, and different types of drug use profile

are likely to put users at risk of varying health and social issues.

The majority of Bolton's current in-treatment population are opiate and/or crack users. However, the problematic heroin and crack using population in Bolton is ageing: new trends of drug use are emerging. In some ways these reflect Howard Parker's "ACCE" profile – which describes the use of Alcohol, Cannabis, Cocaine and Ecstasy – although in Bolton this understanding of poly substance using trends extends beyond the four highlighted by Prof. Parker's work. A trend of concurrent alcohol and cocaine use in the night time economy, and other emerging drug use/misuse (including ketamine and mephedrone), as well as the use of steroids, are also prevalent.

There are multiple health consequences of long-term use of heroin and/or crack cocaine, including both direct effects of the drugs themselves, and effects resulting from intravenous drug use and the often chaotic and marginal lifestyle associated with addiction to Class A drugs. The NTA's Theme Report[6] on mortality patterns among drug users in the North West discusses numerous causes of morbidity and mortality to which drug users are more vulnerable than the general population. Death from overdose is a risk for individuals using depressant substances such as opiates, and this risk may be higher for longer-term drug users: the likelihood of an overdose resulting in fatality increases with successive overdoses. There risk of overdose is also increased by reduced tolerance; for example after an individual has completed a detoxification, or on release from prison. The introduction of IDTS in prisons should reduce the risks of overdose when clients are released; support is also in place within the Bolton treatment system for clients completing detoxification.

Intravenous drug users are vulnerable to various infectious diseases – viral infections such as Hepatitis B and C, HIV, and bacterial infections such as tetanus, endocarditis and *Staphylcoccus aureus.* The use of crack cocaine, when smoked, has been linked with bronchitis and pulmonary oedema, with the increase in blood pressure and heart rate from the use of cocaine being associated with cardiac failure and myocardial infarction. There is also evidence that individuals with a history of drug problems often encounter issues predisposing them to suicide, such as poor mental health, physical illness and social isolation. There are also issues raised by the epidemiology of the PDU drug use in Bolton. The PDU population is ageing: both their age and correspondingly longer drug-using careers leave older drug users more susceptible to the long-term health consequences of Class A drug use.

A proportion of the deaths discussed in the NDTMS Theme Report were due to

[6] 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.

alcohol-related causes (predominantly cirrhosis or cancer of the liver), highlighting the impact of concurrent alcohol use on the health of drug users. The Lifeline Harm Reduction Needs Assessment also identified other polydrug repertoires among the PDU population, including the use of opiates, alcohol, benzodiazepines, crack cocaine and injected amphetamine. The combination of multiple depressants (such as alcohol, opiates and benzodiazepines) increases the risk of overdose for individuals.

Non-PDU substance users will have different risk profiles. As discussed previously, this type of substance use tends to involve polydrug repertoires including cannabis, cocaine, alcohol, ecstasy and emerging drugs such as ketamine and legal highs like mephedrone.

The long-term health risks of this type of polydrug use include cardiovascular problems (there is, for example, increased risk of heart attacks and sudden death as a consequence of combining cocaine and alcohol use) and liver disease as a result of alcohol use. There are risks of venous damage or infection as a result of injecting drugs; it is also possible to contract blood-borne viruses via the sharing of notes for snorting substances. Long-term use of ecstasy has been associated with memory problems and other cognitive deficiencies, and depression. There will also be long-term health effects of newer and emerging substances such as ketamine and mephedrone, though the full impact of these will not be known for several years.

The development of the DASCT's Digital Strategy should enable us to better meet the needs of this population. During 2008/9 and 2009/10 the DASCT has developed an online resource, www.drinkingwithcharlie.co.uk, providing information about the health implications of using cocaine and alcohol in combination. The website offers advice and self-help tools for individuals worried about their own or other person's use, and provides details of where to get help in the Bolton area. There are plans to extend online resources to include information about other non-PDU substance use, and potentially, to provide treatment support on an online basis. Online information provision should make information about drug use, risks and treatment services more accessible to a younger generation of non-PDU drug users, who are likely to have easy access to the internet, may prefer the option to access information anonymously and may find it easier to engage with treatment in this manner.

The level of need in the population

Prevalence

Heroin use increased in Bolton during the mid-to-late 1990s (Bolton is one of the "second wave" areas in terms of epidemiology).

The 2007/08 Home Office (HO) prevalence study for Problem Drug users (PDUs - opiate and/or crack cocaine users) estimates that the prevalence of problematic drug users in Bolton is 2,788 (95% confidence interval of 2,550 –

3,306). This equates to approximately 16.30 PDUs per 1,000 of the population. This estimate is a decrease on the previous studies (see Table 1 below) and, although not statistically significant, confirms local perceptions that the PDU population in Bolton may have begun to plateau. It should be noted that there is a time lag of two years in the publication of data: the prevalence estimates published in 2009 refer to 2007/08.

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 1: *PDU Prevalence: Home Office Estimates for Bolton*

The total PDU estimate has, therefore, 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.

Penetration

As of September 2009, Bolton has 1,443 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 hoped this year following the commissioning of a Tier 2 service.

Characteristics of the Known Drug Using Population

Previous Home Office estimates included some detail regarding gender and age distribution of those drug users not known to treatment. This has not been provided for the most recent estimates. As a result, detailed profile data is only available on those clients in contact with drug treatment agencies. The following demographics relate to clients in treatment during 2008/9.

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.

The evidence suggests that women are more likely to drop out of treatment than men, but less likely to be discharged to prison.

Greater representation of women seems to exist in treatment for heroin or crack use; 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.

Ethnic Profile
Drug treatment clients in Bolton are predominantly white British. A 2008 report on Black and Minority Ethnic (BME) communities and drug use in Bolton by UCLAN[7] suggests that BME individuals are possibly under-represented in drug treatment. The same report describes a predominance of the ACCE (alcohol, cannabis, cocaine and ecstasy) profile of drug use among these communities comparative to the population as a whole, indicating that their profiles and treatment needs are likely to be different. A recent needs assessment by Lifeline, focussing on Harm Reduction[8], has identified a growing population of steroid users, particularly from black and minority ethnic backgrounds.

Asian / Asian British and clients from 'Other' ethnic minorities tend to spend less time in treatment. This is supported by evidence from the Higher Bridge Project (Bolton's abstinence-focused service) that clients from Asian backgrounds tend to prefer to move swiftly through the treatment system to abstinence, and may also reflect their drug use profile.

Drug Use Profile
The majority of Bolton's in-treatment population are opiate and/or crack users. 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 through treatment and aid their reintegration into communities.

The recent Lifeline Harm Reduction Needs Assessment identified a high

[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.*
[8] The Lifeline Project Ltd. (2010) *Bolton Harm Reduction and Tier 2 Needs Assessment*

incidence of problematic benzodiazepine use, and a small but significant population of injecting amphetamine users. Both types of drug use tended to be used as part of a polydrug repertoire involving heroin, crack, benzodiazepines and sometimes amphetamine (in several cases amphetamine was reported by users as a substitute due to poor quality crack cocaine).

However, use of other substances is also an issue, and There is evidence from a number of sources for changes in drug use, away from 'traditional' PDU i.e. heroin and crack cocaine use.

The PDU population is ageing; and other profiles or non-PDU drug use/misuse emerging, including polydrug use involving alcohol, cannabis, cocaine, ecstasy, ketamine and emerging legal highs such as mephedrone, as well as the use of steroids (see below).

Test on Arrest data shows that younger offenders (under 24) are much more likely to test positive for cocaine only (possibly indicating powder cocaine use, due to links between cocaine use, alcohol use and the night-time economy) than for opiates or a combination of the two.

Non-PDU clients often have different profiles, needs, and treatment outcomes. The potential increase of non-PDUs seeking treatment is significant as the treatment system will need to adapt to provide for these clients' needs. In addition, 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 recent Lifeline Harm Reduction Needs Assessment identified a growing population of steroid users. In Quarters 1 and 2 (Apr-Sep) of 2009/10 these clients accounted for almost half (47%) of all new presentations to the central needle exchange at Bolton Drug Service, 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.

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

Drug Strategy Priority Groups

Target groups identified in national drug strategy for improved treatment access, engagement, and successful exits include crack cocaine users, clients from black and minority ethnic (BME) backgrounds, parents, CJS (criminal justice system) clients, and under-25s. We are also working to improve engagement for treatment naïve and treatment fatigued clients who may find engaging with services difficult.

Quarter 3 data indicates that improved access, engagement and successful exits have been achieved for almost all priority groups. Especially notable is the improved engagement for BME, CJS and under-25 clients, which, having previously been low, has improved beyond regional and national averages; and also a dramatic improvement in successful exits for all groups. This is especially true for BME clients, whose successful exits have improved by 33%, and under 25s, whose successful exits have improved by 13%. We continue to work to improve effective engagement and successful exits figures for all priority groups.

Current services in relation to need

The Drug Treatment System
There are several organisations in Bolton providing services for drug users.

Bolton Drug Service (BDS)
Bolton Drug Service is Bolton's Tier 3 service and caters for clients over the age of 18 who are in need of structured interventions. BDS provides maintenance prescribing, psychosocial interventions, community detoxification and referral to residential detox and rehabilitation if required and appropriate.
Individuals may self-refer for treatment or be referred by (for example) a doctor or criminal justice agencies.

Shared Care
The Shared Care team at Bolton Drug Service works closely with many GPs in the area. This allows a number of people to receive drug treatment from their GP's surgery as part of their treatment and care plan.

Drugs Intervention Programme (DIP) and the Criminal Justice Interventions Team (CJIT)
BDS encompasses the Criminal Justice Interventions Team who carry out Drug Intervention Programme (DIP) interventions. A priority in Bolton is ensuring that the quality of treatment does not differ between clients who have entered treatment through the criminal justice system, and clients of the core service who have entered through other routes.

Arch Initiatives – Test on Arrest
The Drugs Act 2005[9] includes a provision where an individual is aged 18 or over to carry out a drug test following arrest for a trigger offence (these are offences commonly associated with drug use). An individual may also be tested following arrest for other offences if a police officer of Inspector rank or above suspects specified Class A drug use contributed to the offence. This initiative enables us to identify adults misusing specified Class A earlier in their contact with the criminal justice system, to steer them into treatment and away from crime as soon as possible.

The Test on Arrest service provides custody suite coverage to enable prompt assessment of individuals who test positive for opiates or cocaine. Arch Initiatives are a major referral route into treatment, providing harm reduction advice, thorough assessment, and referral into structured treatment where it is deemed necessary and the individual agrees.

Addiction Dependency Solutions (ADS) Moving On Service
Bolton ADS is part of a charitable organisation that works with people over 18 years old who have a drug problem. They focus on treatment, education, training and employment needs to help people develop personally, gain new skills and achieve their goals in terms of treatment, life and work.

(ADS at Wood Street are also the single point of contact for alcohol treatment in Bolton).

The Higher Bridge Project
The Higher Bridge Project is a partnership between ADS and BDS. It is an abstinence-focused service including a community detoxification programme, and provides advice and treatment for anyone over 18 living in Bolton who is interested in moving towards abstinence. It is this service that provides Bolton's community based detox programme.

Phoenix Futures
Phoenix Futures is an open-access, drop-in service providing more short-term interventions for people who are experiencing problems with drugs, as well as for concerned friends and relatives of drug users. They provide advice on harm minimisation, healthy living and the effects of substances to recreational (non-PDU) drug users and their significant others.

Phoenix Futures are also a route into the treatment system for treatment naïve heroin and crack cocaine users who need more structured treatment or substitute prescribing.

Central Needle Exchange and Pharmacy Needle Exchange Provision
The Central Needle Exchange service is located at BDS, offering needle

[9] http://www.opsi.gov.uk/acts/acts2005/ukpga_20050017_en_1

exchange services to all injecting drug users, as well as healthcare provision and safer injecting advice. The peripheral pharmacy-based needle exchanges offer a needle exchange service only. Pharmacy involvement in Bolton is significant, with 19 out of 60 pharmacies providing needle exchange services.

Reachout (Urban Outreach)
Reachout is one of several projects provided in Bolton by Urban Outreach, a local community sector organisation, to support sex workers and facilitate their exit from prostitution. Reachout operates a drop-in run on Monday and Thursday evenings, specifically aimed at street sex workers and providing a needle exchange service and health and harm reduction advice. This service aims to provide advice and guidance as well as an opportunity to engage individuals into treatment.

Pharmacy Involvement
As mentioned above, 32% (19 out of 60) pharmacies in Bolton provide needle exchange services. In addition, 36 pharmacies provide an observed consumption service for clients on methadone or buprenorphine prescriptions.
Recent evidence from the Lifeline Harm Reduction Needs Assessment suggests that injecting opiate or crack users now tend to make use of these peripheral services, while steroid users are more likely to attend the central exchange at BDS. This emphasises the key role pharmacists can play in providing harm reduction advice, and potentially signposting into treatment, to injecting PDUs. The 2010/11 Treatment Plan includes plans to enhance the breadth and quality of service provided by pharmacy needle exchanges.

The Harbour Project
Support is also available for the parents and carers of drug users in Bolton through the Harbour Project. The Harbour Project is a voluntary support organisation (part funded by the Drugs JCG) 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.

Bolton User Group Service (BUGS)
BUGS are funded by the DASCT and meet regularly with the intention of allowing service users to make their opinions heard and contribute to discussions and decisions made concerning treatment services in Bolton.

Peer Support Groups
Clients in the Bolton treatment system are provided with information about peer support organisations which are active in the area, including Narcotics Anonymous, Alcoholics Anonymous and SMART Recovery, and encouraged to participate in activities and groups that they feel are appropriate to their needs.

Although not commissioned directly from the DASCT as they are voluntary organisations, these groups play a crucial role within the overall treatment

system and offer more choice to clients engaged with treatment.

Projected service use and outcomes in 3-5 years and 5-10 years

Non-PDU Drug Use

As mentioned previously, trends in drug use appear to be shifting, with fewer young PDUs (heroin and crack users) emerging, and a growing trend toward poly drug use of 'recreational drugs' among younger users. In Bolton, for example, we have seen a trend of concurrent alcohol and powder cocaine use in the night time economy, and some reports of the use of ketamine and 'legal highs' including mephadrone. There has also, as mentioned, been an increase in steroid users presenting to the needle exchange.

It is expected that these trends will continue, and that this will impact on services required, as these 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 changing drug use and corresponding changes in client profiles and treatment needs.

The development of the DASCT's Digital Strategy should enable us to better meet the needs of this population. Online information provision should make information about drug use, risks and treatment services more accessible to a younger generation of drug users, who may prefer the option to access information anonymously.

The long-term health risks of this type of polydrug use include cardiovascular problems (there is, for example, increased risk of heart attacks and sudden death as a consequence of combining cocaine and alcohol use) and liver disease as a result of alcohol use. There are risks of venous damage or infection as a result of injecting drugs. There will also be long-term health effects of newer and emerging substances such as ketamine and mephedrone, though the full impact of these will not be known for several years.

PDU Drug Use

The Lifeline Harm Reduction Needs Assessment also identified polydrug use among the PDU population, including the combined use of opiates, alcohol, benzodiazepines, crack cocaine and injected amphetamine. The combination of multiple depressants (such as alcohol, opiates and benzodiazepines) increases the risk of overdose for individuals.

There are also issues raised by the epidemiology of the PDU drug use in Bolton. The PDU population is ageing: both their age and correspondingly longer drug-using careers leave older drug users more susceptible to the long-term health consequences of Class A drug use.

The NTA's Theme Report[10] on mortality patterns among drug users in the North West discusses numerous causes of morbidity and mortality to which drug users are more vulnerable than the general population. Intravenous drug users are vulnerable to various infectious diseases – viral infections such as Hepatitis B and C, HIV, and bacterial infections such as tetanus, endocarditis and *Staphylcoccus aureus.* These can result in considerable levels of morbidity and mortality. The use of crack cocaine, when smoked, has been linked with bronchitis and pulmonary oedema, with the increase in blood pressure and heart rate from the use of cocaine being associated with cardiac failure and myocardial infarction. There is also evidence that individuals with a history of drug problems often encounter issues predisposing them to suicide, such as poor mental health, physical illness and social isolation. A proportion of the deaths discussed in the Theme Report were due to alcohol-related causes (predominantly cirrhosis or cancer of the liver), highlighting the impact of concurrent alcohol use on the health of drug users.

All these long-term health effects, likely to become increasingly common as the PDU population continues to age, will need to be addressed, necessitating effective health assessments and referral pathways into mainstream primary and secondary care services for those who require it.

Expert opinion and evidence base

Major sources of guidance for drug treatment are:

- UK Clinical Guidelines on Drug Misuse and Dependence[11], which were produced in 1999 and updated in 2007

- Models of Care for the Treatment of Adult Drug Misusers
- Models of Care sets out a national framework for the commissioning of adult treatment for drug misuse in England. It is published in two parts:
  - Part one[12] is for drug treatment commissioners and those responsible for local implementation.
  - Part two[13] is a detailed reference document for drug treatment managers and providers, and those responsible for assuring quality and appropriate delivery of local drug treatment services.

[10] 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.

[11] Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive (update 2007). *Drug misuse and dependence, UK guidelines on clinical management*. (http://www.nta.nhs.uk/publications/documents/clinical_guidelines_2007.pdf)

[12] National Treatment Agency for Substance Misuse (2002). *Models of care for treatment of adult drug misusers. Part 1: Summary for commissioners and managers responsible for implementation* (http://www.nta.nhs.uk/publications/documents/nta_modelsofcare1_2002_moc1.pdf)

- Models of Care was updated in 2006[14].

The NTA also offer substantial guidance on drug treatment, including good practice guides for care planning, psychological interventions, maintenance prescribing; as well as on commissioning and needs assessment, which can be found on their website[15].

The annual Needs Assessment undertaken by the DASCT provides a comprehensive and locally-focused review of need and current service provision, including recommendations for adaption of the treatment system to better meet need in Bolton.

Evidence to Inform De-commissioning of Services

Any evidence relating to commissioning or de-commissioning of services is carefully considered and actions are agreed by the Drugs Joint Commissioning Group (JCG).

Unmet needs and service gaps

Two areas which will be a focus of work over the coming year are the expansion and refinement of provision based in pharmacies across Bolton, and the further development of Shared Care.

Pharmacy Provision

The recent Lifeline Harm Reduction Needs Assessment identified discrepancies across the needle exchange facilities provided by pharmacies in Bolton – in terms of the level of use these exchanges received and also the level of service provided. The same needs assessment highlighted the movement of PDU injectors, higher proportions of whom are now likely to use the peripheral pharmacy needle exchange services, while the emerging steroid using population tended to make use of the central needle exchange at BDS. The assessment suggested that the most comprehensive specialist harm reduction advice, and links into treatment, were most readily available at the central exchange. This has raised some concerns over the service received by these PDU individuals, as needle exchange services may be the initial or only contact some of these individuals have with treatment services.

The needs assessment made a series of recommendations concerning needle exchange, both centrally and in pharmacies. These included:

- Delivery on a range of interventions in pharmacies, including provision of tailored safer injecting advice and information, pharmacy staff referring clients to appropriate specialist harm reduction services, the provision of

[13] National Treatment Agency for Substance Misuse (2002). *Models of care for treatment of adult drug misusers. Part 2: Full reference report* (http://www.nta.nhs.uk/publications/documents/nta_modelsofcare2_2002_moc2.pdf)
[14] National Treatment Agency for Substance Misuse (2006). *Models of care for treatment of adult drug misusers: Update 2006* (http://www.nta.nhs.uk/publications/documents/nta_modelsofcare_update_2006_moc3.pdf)
[15] http://www.nta.nhs.uk/publications/publications.aspx?CategoryID=36

specialised brief harm reduction interventions, private consultation room (where possible).

- Further training and regular refresher training should be a requisite for pharmacies providing needle exchange services.
- Outreach specialist harm reduction and needle exchange services, such as satellite clinics, to reach clients outside the treatment system.
- Delivery of harm reduction interventions in non-drug treatment settings.

Shared Care

There is a need for a greater number of doctors to be involved with Shared Care. Shared Care is a valuable tool for moving the care of clients into their local communities, normalising treatment and improving 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. There are 55 GPs in Bolton, of whom 29 are involved in some way with the Shared Care team.

The Shared Care team at Bolton Drug Service (BDS) are involved in ongoing outreach efforts to encourage GP involvement, including approaching various GP groups and practice managers, offering the RCGP Certificate in the Management of Drug Misuse in Primary Care, Part 1 training free of charge, as well as 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. All these efforts must be maintained to encourage more GP practices to become involved.

De-commissioning of Services

Any commissioning or de-commissioning of services is carefully considered and agreed by the Drugs Joint Commissioning Group (JCG)

Recommendations for Commissioning

Any commissioning or de-commissioning of services is carefully considered and agreed by the Drugs Joint Commissioning Group (JCG)

Recommendations for needs assessment work

The DASCT completes an annual Needs Assessment as part of the commissioning cycle. This will continue. The DASCT also has a history of commissioning additional needs assessments into specific areas where deemed

necessary and where funding is available – for example, the recent needs assessment by Lifeline focusing on harm reduction. Again, as far as possible (within financial constraints) this practice will continue.
Key contacts *Leads within Council and PCT* *Key commissioning groups*
Sandie Saunders, Commissioning Manager, Drugs and Alcohol, Bolton Council Drugs Joint Commissioning Group (Chair, Jan Hutchinson, Director of Public Health)