Haringey

Adult drug treatment plan 20010/11

Part 1: Strategic summary, needs assessment and key priorities

The strategic summary incorporating the findings of the needs assessment, together with local partnership ambition for effective engagement of drug users in treatment, the funding and expenditure profile, harm reduction and primary care self audits have been approved by the Partnership and represent our collective action plan.	
Signature	*Signature*

Section 1 - Overall direction and purpose of the partnership strategy for drug treatment

1.1 Strategic priorities for 20010/11

Haringey Drug and Alcohol Action Team is a multi agency partnership which sets the direction of and oversees the planning, commissioning and the monitoring of drug and alcohol treatment services for local people. It does this within the context of Haringey Sustainable Community Strategy (HCS) which aims to ensure Haringey is "A place for diverse communities that people are proud to belong to". The Sustainable Community Strategy is developed across a wide range of public and independent sector partners and is consistent with the NHS Operating Plan. The DAAT reports to the Crime and Drugs Disorder Partnership (CDRP) on progress in delivery of its key targets.

The specific purpose of local drug treatment is: *to reduce the harm caused by drug misuse to Haringey's residents (Public Service Agreement -PSA- 25)*. The treatment system aims to improve both the health and wellbeing of the community and to reduce drug related crime.

The 2010/11 Adult Drug Treatment Plan aims to embed recent achievements of 12% growth in increasing the number of problematic drug users (PDU) in effective treatment (NI 40). This plan aims to continue to improve access to services for any type of problematic drug use.

During 2010/11 Haringeys' drug treatment services will continue to drive up the effectiveness of treatment, this is measured by retention over 12 weeks or successful discharge. We will also work on the following new priorities linked to HSC and the National Drug Strategy.

- **Healthy Haringey** - In line with the 2008 Drug Strategy and Think Families : *a key priority for the partnership will be to reduce the negative impact of parental drug use on families.*

- **Safer Haringey for all** – In line with NI 38 : *we will seek to reduce the re-offending of problematic drug users*

- **Economic vitality and prosperity**– In line with Haringey Sustainable Community Strategy: *we will seek to access people into training and employment and off benefits.*

1.2 Principles and Priorities of delivery

Haringey's drug treatment services are designed to respond to the diverse needs of Haringey's drug using population; offering to them accessible, timely and appropriate drug treatment, delivered by a skilled and effective workforce. The principles and priorities of the treatment plan have been developed with representatives from service providers, communities, service users and friends and family. Principles and priorities are based upon what we do well, gaps in services and the new threats and opportunities for 2010/11

1.2.1 Principles of delivery of drug treatment 2010/11

- Commissioning will be based on World Class Commissioning standards and a robust needs assessment
- Service users and carers will be at the heart of services - we will listen to and act upon the views of partners, service users, friends and family members
- Treatment will be cost effective- we will get maximum impact/results at minimum cost
- We will regard clients as individuals, supporting client involvement and respecting client choice
- We will have high aspirations for what service users can achieve - our treatment will be outcome based
- We recognise our clients have complex needs which are much broader than the use of drugs; treatment will seek to identify and act upon a broad spectrum of risks i.e. poverty, social deprivation, domestic violence, crime.
- We will seek to reduce health inequalities and promote better access to generic health care for drug uses
- Treatment will be based upon evidence based practice (i.e. NICE) and good clinical practice/governance - we will develop a culture of shared learning
- Social reintegration will be a key objective of treatment: supporting families, promoting development of new peer networks, housing, training, voluntary work and employment
- We will 'think family' – we recognise that families can play an important role in obtaining good treatment outcomes. Drug workers have a key role in supporting drug using parents to safeguard the health and welfare of their children. We all have a role in safeguarding the welfare of children and stopping the cycle of addiction.

1.2.2 Priorities for 2010 will be set against analysis of Gaps, threats and opportunities

Gaps - **The following have been identified by providers, friends and family and service users as the *key gaps* in services that will be addressed in the 20010/11 plan**

- A cohesive access and engagement strategy
- A consistent method of working with families
- Service provision for under 25 year olds
- Reaching the treatment naive who are not accessing treatment
- Support for those leaving prison
- Access to relapse prevention, positive peer support, help in getting a daily routine
- Addressing training needs and employment barriers earlier in treatment

Threats - The following are seen as the *key threats* to be managed by this plan

- Reduction in Pooled Treatment Budget of around 13% and DIP around 14% and the impact on service delivery and staff moral

- De commissioning of the Kinesis service, the in house employment service
- Reduction of workers in the dual diagnosis service
- Reduction of access to counselling services at Eban
- Reduction of DAAT team, leading to dilution of strategic focus
- De commissioning of Citizen Advice Bureau service from aftercare provision
- Reduction of other key health and social care budgets
- Local shortage of housing

Opportunities - The following are the key *new opportunities* this plan will utilise

- A new Chief Probation Officer with a national drug strategy background
- Transfer of Senior Probation Officer, with partnership background into Local Offender Management Unit in Probation
- New Service Level Agreements of Drug Intervention Program (DIP) and aftercare.
- Integrated offender management between the community and prisons and a new local Reducing Re-offending post developing pathways for those who are in prison under a year.
- A new harm reduction worker at DASH
- Pharmacists piloting provision of Hepatitis testing and vaccination
- A new parental substance misuse worker based in Children and Young People's services
- Completion of the Integrated Care Pathways program
- Access and engagement steering group maximising outreach capacity
- Area Based Working groups
- Integration of services with Job Centre Plus and Haringey Guarantee
- Development of protocols regarding management of rent arrears
- Development of protocols regarding access to rent deposit schemes
- Supporting People re-tender
- Potential for nurse prescriber and trainee posts at DASH

Section 2. Key findings of current needs assessment.
Needs assessment key findings

A brief summary of prevalence and penetration levels in the community
There are still a considerable number of crack and opiate users in Haringey, an estimated prevalence is 2666[1]. A significant majority use crack (80%; 2141) but, partly thanks to our specialist stimulant service Eban

[1] The associated confidence intervals 2338 and 3068. Based on estimates by University of Glasgow

commissioned in 2007, Haringey had the sixth highest proportion of crack users in treatment between 2006/07-2008/09 in London (NTA:2010)[2]. The estimate for opiate users in 2008-9 is 1936. This, alongside with drug treatment data, suggests that a poly use of crack and opiates is common, a trend by no means unique in comparison to rest of London[1]. Problem drug use mirrors the deprivation geographically. Most PDUs come from the more deprived and densely populated north east, the N17 post code area[3]. Three key drug services are now based within this area DIP, BUBIC and Eban so we would anticipate that this aids access into services

The characteristics of met and unmet need, attrition rates, and treatment outcomes

At least 60 different nationalities were represented in treatment last year and a vast majority were non white British (65%) – a need for culturally competent and language resourced workforce is evident. Women made up a quarter of the drug treatment population in 2008-9, a proportion on par with national and regional averages. However the local expert group felt that more investigation on womens needs should be done to overcome any possible barriers such as stigma or lack of childcare offered by services.

Problem drug use is likely to begin between ages 15-24. The younger population is increasingly less likely to use crack and opiates[4] but those who do are more difficult to engage with drug treatment services than the older age groups, with 71 per cent of 18-24 year olds in effective treatment against 81 per cent in Haringey overall. Young people who initially engage with treatment are also more likely to drop out. Latest data show only 20 per cent exited in a planned way against the local average of 40 per cent[5]. Clients aged 18-24 are also more prominent in the criminal justice system than in treatment

---

[2] NTA (2010) Crack use in London: Analysis of the National Drug Treatment System (NDTMS) and other data sources January 2010. NTA. Although the % of crack using clients in treatment in this financial has gone down to 32% which is lower than London average of 34%, between 1st July 2008 to 30th June 2009. However the number of drug users coming to treatment in this financial year is down overall, not just crack users.

[3] (28% of primary heroin users and 33% of primary crack users), followed by N15 (20% of crack and heroin primary users) and N22 (19%)

[4] NTA (2009) Annual Report 2008-9. NTA. Available from: http://www.nta.nhs.uk/publications/documents/nta_annual_report_08-09_(2).pdf

[5] Drug Strategy Priorities report for June to September 2009 www.ndtms.net restricted statistics.

[6] As per Drug Strategy Priorities report for 1st July 2008 to 30th June 2009. Parental status comparison with treatment effectiveness not available for 2008-9.

[7] It should be noted that treatment effectiveness is compared with a limited number of variables, other variables not analysed in NDTMS needs assessment data may be more significant. Furthermore, a difference in outcomes or effectiveness by client characteristics does not necessarily mean that the characteristic is directly correlated to treatment effectiveness. Other confounding factors may be more significant.

[8] NTA (2009) Towards Successful Treatment Completion. NTA London www.nta.nhs.uk/publications/documents/completions0909.pdf

[9] Drugscope (2008) *Welfare Reform and Problem Drug Use: Briefing Note* Available from: http://www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=E7E5C417-6E90-4C7E-A400-E860B51DB04D&mode=link&guid=985dc75ae9b3430bb646a01be4a3078d

[10] The referral categories on NDTMS are: Self , GP, Drug service statutory, Arrest Referral/DIP, service non-statutory, Other, Probation, Drug Rehabilitation Requirement – formally Drug Treatment and Testing Order (DTTO), CARAT/Prison (Care And Rehabilitation And Through-care), Psychiatry services, Connexions, PRU CLA - Children Looked, Sex Worker Project, Hospital, Psychological Services, Relative, Concerned other, Community Alcohol, Outreach, Job Centre Plus, Social Services, Education Service, Community care assessment, Accident and Emergency, Employment Service, Syringe Exchange

[11] Tier 2 is not covered by the NDTMS so treatment pathways cannot be mapped in their entirety. Also, a separate pathways mapping was done for tier four as the NDTMS needs assessment treatment map data does not combine tier 3 and four pathways.

[12] From 110 agency transfers in 07-08 to 192 in 08-09

[13] Haringey DAAT (2007) Improving commissioning and service delivery - Needs assessment for Haringey DAAT adult drug treatment plan 2008-2009. Available from Haringey DAAT.

overall. Since younger clients are hard to engage in effective treatment, it is no surprise that the same applies to criminal justice clients. The needs assessment also identified a significant number of PDUs (75) assessed by the Probation service who did not access drug treatment services at all in 2008-9. Client characteristics like parental status[6], gender, or drug of choice seem to make no difference on treatment effectiveness[7] in Haringey.

Furthermore, NTA's successful treatment completions guidance (NTA:2009)[8] concluded that client characteristics have less to do with outcomes than service specific issues such as organisational functioning or therapeutic relationship between a client and their keyworker. This is mainly because issues linked with drug use are complex varying from ill mental health, poor housing, childhood trauma, domestic violence and so on. The Haringey DAAT performance monitoring group have begun to explore what creates a good therapeutic relationship - service users have feed back that this relates to the skills and attitude of the worker and the organisations ability to manage and motivate its staff. Service users also value workers who are able to facilitate flexible individually tailored care plans which provide multiple interventions and services, including services outside drug treatment. This competency is likely to be linked to the functionality of the provider organisation and the DAAT, in particular their ability to create positive partnerships across health and social care systems. Haringey DAAT and its providers are taking part in NTA research into the links between functionality and performance and the findings will be embraced and used in improving commissioning systems and an updated workforce strategy.

In terms of the current quality of care planning, data from TOP, local care plan audits and service user surveys, suggests that there is a need to improve on domains other than substance misuse, ie physical and psychological health, social needs, and needs relating to the reduction in criminal involvement. The care plan audit found that criminal involvement needs were addressed in only 62 per cent of the care plans with results varying from 17 to 100 per cent between agencies. Indicative TOP results show domains do show improvement in most domains except education and employment.

Although more work needs to be done to understand the training and employment needs of our treatment population, the initial literature review suggest the difficulties they face are linked to literacy and numeracy problems, lack of educational and occupational qualifications, lack of work experience or interrupted work histories, CV gaps, requirements to disclose health problems and criminal records, fear of relapse and the need to renegotiate benefits if things go wrong, and restrictive pharmacy dispensing of substitute drugs like methadone. Organisational barriers include employer discrimination and ineffective links between drug and employment services (Drugscope:2008)[9]. Staged re-introduction to employment and the joint working between services is important (Cebulla et al: 2004) alongside. Support should start at early stages of treatment, not after treatment.

Harm reduction In 2008-9 at least 63, a tenth of drug related ambulance calls in Haringey, were related to illicit drug use, with the vast majority being in the east of the borough (72%). 86 Haringey residents were admitted to a hospital with a diagnosis of mental and behavioural disorders due to illicit drug use or

poisoning. Heroin features heavily in most calls and admissions followed by crack and cannabis. There were 59 reported drug misuse related deaths in Haringey 2000-2006 (ONS). In general drug related death rates are higher in deprived areas (Griffiths C. Romeri E. et al:2008). Harm reduction services need to continue to improve, locally we are not reaching our targets around Hep B vaccination and screening and nor are we distributing sufficient clean injecting works. Service users also report that they do not think injecting drug users realise the risks associated with sharing.

Family and friends The work around family and friends continues to grow at an encouraging pace. More work needs to be done in identifying and recording the number of carers and supporting them to access services. There is a need for more of the tier 1 agencies to play their role in referring carers to the support available for them. This in turn is an issue of raising awareness around services available for family and friends. The DAAT is in the process of empowering these agencies so that they have the information and skills to signpost and refer carers to services.

Treatment system mapping and the care pathways in operation

In 2008-9, the majority, almost half of all clients (46%) self referred into drug treatment. Criminal justice was the main referral agency counting almost third of all referrals (31%). Drug services themselves counted for tenth of referrals, as did 'other' category which includes several statutory agencies such as A & E, employment and psychological services, and family and friends and so on[10]. Only 1 per cent of service users were referred by GPs. The low referral rate has been identified in the previous needs assessments: It may be that many more GPs do signpost to drug services but clients report self referrals when they eventually present to drug treatment. Nevertheless a formal referral process is not fully established[11].The rate of onward referrals between drug treatment agencies transfers were up by 75%[12] from the previous year. Much work has gone to improve pathways and make sure treatment agencies work together better. It is important that clients are presented with all the treatment options available. During this financial year Haringey DAAT ran an Integrated Care Pathways project to tighten the links between drug treatment services and wrap around services, set clearer outcome objectives for clients, maximise the use of resources including housing and employment services and facilitate knowledge and skills share.

Tier 4 Extensive amount of work was done in the Haringey DAAT needs assessment during 2007[13] on tier 4 effectiveness with help from DASH and service user representatives. This identified a limited pool of services that fully meet the needs of clients from BME groups and those with complex needs, and abstinence based aftercare once clients return to Haringey. DASH, the largest Haringey agency, has the care co-ordination role. This means that they do the reviews while clients are in tier 4 treatment and oversee their progress once tier 4 treatment has finished. The DAAT sets a target for tier 4 admissions based on 10% of the treatment population requiring inpatient services. This target has not been met and there was an underspend on the Tier 4 budget last year. We anticipate that the opening of a local inpatient unit in 2010 will significantly improve this.

Areas of further investigation in 2010 Haringey needs assessment process is ongoing with service users, family and friends, and key partners contributing to the process at all stages, including deciding key objectives and developing the methodology. Further work will take place during 2010 to better understand the needs of our treatment populations and drug users not accessing services. As decided by our expert group, the key issues for further investigation are employment and housing needs, the specific needs of women drug users and assessment of any barriers for our diverse communities.

Section 3 Likely demands for open access, harm reduction and structured drug treatment interventions.

3.1 Demand for open access

3.1.1 **Issues to be considered in creating sufficient demand to meet targets** The work done for the Integrated Care Pathway program suggests the following needs should be considered in increasing demand for drug treatment.

- *Geographic location*- Problematic Drug Users with no experience of treatment (treatment naïve) are most likely to live in the East of the Haringey ***Area Based Working Groups in targeted areas may be key sources of intelligence.***

- *Pre contemplative stage of readiness* - The treatment naïve may be pre contemplative i.e. not have considered treatment because they are either still active in/ enjoying their drug use or not fully aware of treatment options, ***This group, require as a minimum harm reduction services and advice and information, workers need to be skilled in engagement.***

- *Contemplative stage of readiness* - PDU's not in treatment may be contemplative i.e. considering that their drug use is problematic, and not accessing services for one of the following reasons: they have negative reviews of, believe it will not work for them or face barriers to treatment i.e. domestic violence. This group is still l ambivalent. ***This group may have aspirations to enter treatment linked to concerns regarding their physical health, desire to reduce criminal activity or financial factors and require positive messages about and support into treatment. Workers need to be skilled in engaging with whatever the drug user presents***

- ***Communication*** Generic workers in Haringey have contact with treatment naive and their families drug users not accessing treatment i.e. tenancy support officers are dealing with rent arrears, criminal justice services with offending, GPs with families. ***With refreshed***

training in screening and referral, these tier 1 services are potential sources of referrals into drug treatment. .

Demand during 2010/11 will be stimulated by:

1. General marketing activity will be focused on the creation of positive messages stating that '*treatment works for all.,'* Given the diversity of Haringey's community the marketing materials will highlight the choice available in treatment opportunities, the support offered to parents and will reinforce a message that services have a diverse workforce able to culturally match need.

2. Current service users and peer supporters will help us develop simple targeted/segmented materials for specific groups.

3. Friends and family members will develop materials promoting their support opportunities and ways they can assist some one else's access into treatment.

4. The outreach services supported by tier 3 treatment providers will offer targeted training and will link Area Based Working Groups and Safer Neighbourhood Teams, especially those based in the East of the borough.

5. Work will continue with Kurdish and Somali parents

6. The Drug Intervention Program (DIP) needs assessment suggests that there is unmet need within criminal justice services. This group will be engaged into treatment though integrated enforcement and treatment services i.e. probation officers referring to an in-house Eban service.

7. A lot has been learnt during 2009 from the successful development of pathways from Job Centre Plus to treatment. This will be further embedded and the learning used to better integrate treatment into tier 1 services.

8. During 2010 pharmacists offering needle exchange will be used as a source of accessing new drug users into treatment.

3.2 Demand for Harm Reduction

2.1 Issues to be considered in meeting strategic targets - Haringey has an estimated 649[14] injecting drug users, a fifth[15] are likely to be sharing and at risk of Blood Bourne Virus (BBV), levels of contraction of hepatitis are a major concern alongside the degree of un-diagnosed hepatitis C. Local service users experts have some concerns that current injecting drug users are not recognising the risks associated with the sharing of equipment and data suggest that IV users have not got sufficient access to clean injecting

[14] Associated confidence intervals 476 to 826

[15] As per national estimations by the Health Protection Agency. Source: Health Protection Agency, Health Protection Scotland, National Public Health Service for Wales, CDSC Northern Ireland, CRDHB (2009). *Shooting Up: Infections among injecting drug users in the United Kingdom 2008*.
London: Health Protection Agency (2009)

equipment. Haringey needs to increase commencement and completion of Hepatitis B vaccination and Hepatitis C testing and treatment.
The treatment population is aging and there are increasing demands for generic health issues for older drug users.

3.2.1 Demand will be met by:

1. In 2010 dried blood spot testing will be introduced which is likely to significantly increase demand for vaccination and treatment.

2. Blood Borne Virus testing and vaccination will become a more generic roll: drugs workers and nurses will be able to test and all nurses vaccinate.

3. Pathways into Hep treatment will be embedded and all workers trained to supporting pathways into Hep C treatment. A new service will open at the North Middlesex hospital.

4. During 2010 we plan to offer pharmacy based BBV testing and vaccination, this should extend BBV services to injecting drug users who are not engaged in broader harm reduction services.

5. We will boost access to clean injecting equipment though offering exchange services via street outreach and hostels exchange.

6. We will gain better understanding of the needs of older drug users and ensure they can access generic services

3.3 Demand for structured treatment

3.3.1 Issues to be considered in meeting demand for structured treatment - To reach the new target of 1132 Haringey will need to increase the number of PDUs in effective treatment by 6% which equates to an additional 64 clients in effective treatment[16]. Capacity to meet this demand will be created though the Integrated Care Pathway program, ensuring that clients are not duplicated in services unnecessarily and not staying in structured specialist treatment beyond an optimal length of time. Whilst aiming to maintain a harm reduction approach the partnership will expect more drug users to be successfully exiting our specialist drug treatment system.

3.3.2 Demand will be met by:

1 Timely access – With increasing demand and reductions in funding we will seek to continue to ensure timely access into treatment though ensuring that services users flow though the system, moving towards successful discharge out of treatment or into GP shared care.

If changes are made to the system we anticipate an increased demand for

[16] The additional number required is pending on the outcome of 2009-10 performance against the target of 1068.
[17] Associated confidence intervals are between 1805 and 2473
[18] In 2008-9. Source: *www.ndtms.net* : Drug Strategy priorities data - restricted statistics
[19] Of all NDTMS records for active clients in 2008-9, parental status data was missing in 11%, 7% stated 'other'[19], little less than half (48%) stated of not having any children

inpatient detoxification and intend to open a local unit in April 2010

2 Stable long term maintenance clients – As more clients successfully complete stabilisation in specialist treatment we anticipate an increase in demand for community based prescribing via a GP. The group that steers this is looking at possible ways to increase capacity within resources i.e. by ensuring current cases are reviewed and treatment progressed, offering peer led support.

3 Crack users – Haringey faces significant problems from crack cocaine. The prevalence of crack users is estimated to be around 2141[17] with around 34% in treatment[18] in treatment during 2008-9. BUBIC will continue to offer community outreach, DIP will work with those in CJS and Eban will link with tier 1 services. Heavy crack users coming into treatment have serious health issues including pulmonary and cardio complications and are often malnourished, Eban the specialist crack service will continue to employ a nurse to deal with these issues. Crack users also often have psychiatric problems - the dual team offers a bride into mental health services. Crack use is linked to crime and crack users have higher reconviction rates than other drug users. As part of the plan to reduce re-offending during 2010 we will seek to better meet their criminogenic needs including education, training, employability and housing.

4 ***Under 25's*** - Needs assessment suggests that 18-25 year olds are not accessing treatment. In-Volve are commissioned to work with 18-21 year olds who identify having a drug problem, however many under 25 year olds are pre contemplative, interventions will therefore be targeted at reaching this group with advice and information about services, harm reduction advice and brief interventions. New contact with this group will be established though tier 1 services e.g. Job Centre Plus.

Due to high unit cost and funding reductions a transitional prescribing service set up to prescribe for under 25 year olds at In-volve will be reviewed.

5 ***Criminal justice*** -Monthly test data highlights an average of 30 clients test positive for opiates or crack/cocaine in the first 6 months of 2009. This is considerably lower that the 59 of previous years. This drop could relate to a number of large central London policing operations during this period which diverted officers away from local work. However there was an underlying decrease in Acquisitive Crime in the borough over the same period.

Local analysis shows that 44% of Drug Rehabilitation Requirement clients failed to engage into treatment, this is 41 clients who could have accessed treatment. A new DRR Programme commences in April 2010, its design should improve the access, assessment and retention of these clients.

In 2009 improved partnership work between CRI, magistrates, probation, crime prosecution service and the police allowed Haringey to begin to increase the numbers on Restrictions on Bail and Conditional Cautioning. This work now needs to be embedded.

There remains scope to increase the numbers in treatment and into the social

re-integration services through improved prison referral and pathways, our new DIP service will prioritise this work.

There still remain 310 treatment naïve clients recorded with Probation Offender Management Unit, a new screening and referral systems should enable more of this client group to access services .

There is also attrition in the Required Assessment process, Haringey DIP received 113 follow up appointment requests from other boroughs in the first six months of 2009. However only 61 attended. The new treatment plan will show how we intend to work more closely with colleagues from other boroughs to reduce this attrition.

6 ***Different impacts on different groups –*** Haringey's treatment system is generally reflective of the diversity of the borough, however the following key work areas of work need to be actioned to ensure equality is maintained

Women *–26%* of the treatment population are women, as numbers in treatment rise proportionality will be maintained through: publicity of women only services/sessions, review of pathways and care for pregnant drug users and improvement of services for parents

Parents/families – Over a third (38%) of the treatment population are parents[19] In light of the new 'Think Family' program, during 2010 the DAAT partnership will work with the Safeguarding Board to review our pathways of care for all drug using parents and their children. The 'Think Family' program is a new national program that aims to improve the outcomes for the most at risk families i.e. families with complex needs including poverty, unemployment, poor mental health and substance misuse. Local Family Intervention Programs (FIP) aims to improve the outcomes for 'whole families', Haringey Children's and Young Peoples services have an existing 'FIP in Youth Services and will be applying for a scheme based on housing. During 2010 the DAAT Joint Commissioning Manager will work with the FIP manager to ensure that substance misuse services are integrated into FIPs and the learning and best practice is rolled out into all family work.

The overall approach in Haringey will be to ensure that services for drug users and services for children and young people work together in a whole family approach; agencies used to working with an individual will be encouraged to 'Think Family' to ensure parents are given clear and consistent messages which strengthen families ability to protect children.

The adult and young persons substance misuse commissioner will implement the changes though setting up a parenting forum for children's services and drugs agencies to implement think family, oversee strategy and exchange good practice

Work planned for 2010/11 includes

- continued attendance of the DAAT representative on the Safeguarding Board and Children's services on the DAAT
- remapping of pathways and protocols between drug services, children and young peoples services and family programmes

- review of communication and information sharing policy and pathways
- training to roll out new pathways and use of pre CAF assessment
- training in identifying early any parenting issues
- design and training in use of simple tools for supporting parenting

Race and ethnicity - Haringey has a diverse population and this is reflected in access to treatment with almost half of service users in treatment being from BME groups. There are at least 60 different nationalities represented in Haringey's treatment services, Bringing Unity Back Into the Community (BUBIC) is a peer support service, which during 2010 will continue to play an important role in community engagement. Haringey has a diverse and transient population which is increasingly being reflected by high levels of demand for interpreters and culturally competent workers, therefore during 2010/11 our workforce strategy will continue to map and match our workforce to need. Examples of current work include employment of a worker at SHOC who is non British and can communicate with migrant sex workers, sponsorship of a trainee drugs worker who is polish.

Female Sex workers – Haringey has both on and off street sex workers, drug use is more common in on street sex work (around 92% being PDUs). Sexual Health on Call (SHOC) offers services to this group and we will continue to fund them to provide tier 2 drugs work. Until 2009/10 SHOC had an on site direct access prescribing service, high unit costs and reductions in funding meant the prescribing element of the service had to be decommissioned. Women are now supported into mainstream prescribing services by SHOC this does create a barrier to them.

Disability – Many of our service users have a physical disability. This becomes more of an issue with an aging client group. Some commissioned service buildings are not Disability Discrimination Act compliant therefore we required them to ensure that they can deliver a provision at a site that is compliant.

3.4 Demand for Aftercare

The number of those who are successfully discharged from treatment continues to rise; the aftercare service will be re-tendered by April 2010. This gives us an opportunity to review provision with an expectation that relapse prevention is universally available, social re-integration is introduced earlier in a care plan and that peer led services are promoted to improve service user choice.

Section 4 - Improvements to be made in relation to the impact of treatment in terms of its outcomes

Haringey DAAT manages delivery of effective treatment though a number of steering groups, which are listed below.

- performance management group
- clinical governance group
- employment and training group
- access and engagement group
- shared care group
- harm reduction group
- communities and availability group

Each of these groups has a term of reference and a work-plan, which is linked to the objectives in the treatment planning grids. Key experts are included within the steering group including service user representatives. The groups report into a large provider forum and to the Drug and Alcohol Joint Commissioning group.

Service users key role – key to the improvement of outcomes is the ability of service users to shape treatment . During 2009 Haringey made significant progress in developing user involvement, all services have local meetings run by users and most services now have a representative on the Haringey User Group (HUG). HUG representative are now beginning to drive though changes in commissioning e.g. they attend strategic groups, they have designed and run their own service user satisfaction survey, they are now on all DAAT tender panels, they run their own recovery service, they attend conference on behalf of the DAAT. We are currently completing role descriptions and induction program for user reps/ HUG representatives. Training, support and remuneration are provided to all representatives.

Haringey currently has a service user on the NTA London service users forum and would want to continue to ensure good representation

4.1 Harm reduction outcomes

In 2010/11 we will drive up performance around BBV testing and vaccination -The new 2010-12 Harm Reduction Strategy will create improvements in terms of access to, and completion of BBV testing and vaccination. We aim to ensure that 98% of new presentations to drug treatment will be offered vaccination, 75% of those who have accepted vaccination will be vaccinated, 55% of the 'at risk group' will be tested for hepatitis C.

In 2010/11 we will revisit existing health promotion messages and ensure that key health promotion messages reach drug users – We will improve dissemination of messages regarding harm reduction and overdose by training tier 1 providers and drug users to deliver key messages.

Work in this area will be driven by the Harm Reduction Steering Group based

on a self assessment and action plan (Appendix 1)

4.2 Number in Effective treatment – engagement, retention and successful discharge

In 2010/11 we will maintain and improve on delivery of effective treatment –

4.2.1 **Access/engagement** – Targets for engagement in drug treatment are set to increase in 2010/11.The reduction of PTB allocation will impact on tier 2 services and may impact on our ability to access and engage service users into Tier 3. Drop in sessions may have to be reduced and it is likely that we will have to reduce the number of sites for Tier 3. To counteract this, services will seek to create economies of scale through using a more mixed workforce, which will include trainees and volunteers; they will also work together to co-ordinate open access sessions. In addition a new mentoring service will support new service users into treatment

DIP services will also need to be rationalised to maximise its penetration rate due to the impact from a reduced budget and by a reduction in offending. The CJIT will improve on its Case Management by having a greater focus on outcomes. More emphasis will be put on prison releases, short term offenders, increasing the application of Conditional Cautioning; awards of Restriction on Bail, engagement of non-drug related offenders who misuse drugs and DRR engagement and retention through a new DRR programme.

We intend to review the DIP operational processes in line with the new DIP Operational Handbook and Drug Misusing Offenders: Ensuring the Continuity of Care between prison and community

4.2.2 **Retention and treatment effectiveness** – Haringey will maintain continue to ensure that treatment is effective through embedding work already in progress: we will complete the ICP work, commission a new day service and expand clinical prescribing options. There will continue to be an emphasis on quality and continuous improvement though service user audit (TOP, satisfaction surveys), provider self audit and learning though participating in pilots. Much of this work will be directed by the Clinical Governance Group though its work plan.

Treatment Outcome Profile will be used by the case managers and service users to monitor whether a care plan is facilitating improvement over a range of domains including substance misuse, health, social functioning and offending; thus improving the overall wellbeing of a drug user. This information will be performance managed at both the service and DAAT level.

Underlying mental health problems are a key issue for many drug users, during 2010 there will be a reduction in the dual diagnosis service; a strategy will be developed by April to ensure that those with dual diagnosis issues receive services.

21% of PDUs' report alcohol as a secondary drug, needs mapping suggest this is a causal factor in drop out and relapse, HAGA (alcohol project) will be

funded to offer training to key workers and to provide alcohol community detoxification within drug services.

4.4.3 **Improving completion –** Although still a high performing area, during 2009 Haringey has had a drop in successful completions, part of this is due to the change in definition of successful. Data suggests that this year's plan needs to revisit success for crack users and BME groups, but to pay particular interest to those in the CJS and under 25year olds. So in 2010 our aim will be to continue to promote exit into:

- Abstinence via detoxification and rehabilitation- ***we are commissioning a new local service which will be designed to meet the needs of crack users.***
- Aftercare service – ***we will be re-commissioned with a stronger peer led/self help element***
- GP community prescribing – ***we aim to continue to provide good access into***

Only those with complex needs, unable to stabilise will remain in longer term specialist treatment.

Workforce - The skills and attitudes of managers and workers have been shown to significantly contribute the successful outcomes for service users, all managers in Haringey have or are in the process of completing a management qualification, currently 90% of those delivering treatment have an NVQ or professional qualification and our workforce is trained to use ITEP.

Continuous Professional Development will be a key driver in the Haringey 2010 workforce development plan. Our clients have complex and changing needs often linked to where they are in a change process and so during 2010/11 we plan to review these needs. ***We will map need against job role competencies, the results of the care plan audit and TOP outcomes, and then we will use this information to develop interagency training plans. This work will be steered by the clinical governance group.***

Haringey during 2010/11 intend to increase treatment exits whilst maintaining a strong ethos of harm reduction, recognising drug misuse is a relapsing condition we will ensure that there is a clear referral pathway for rapid re-entry back into more intensive care.

4.4.4 **Improving community re integration** –During 2010/11 *w*e intend to continue to improve the social, educational and employment support available to drug users

Education Training and Employment (ETE) –Kinesis is an ETE service based within an alcohol agency which has been commissioned by the DAAT to deliver training and education to drug users; due to reductions in funding the DAAT can no longer fund a specialist drug ETE service and so Kinesis will no longer be funded in 2010/11. However we recognise that ETE is an area where services will need to be developed as TOP data identifies that generally drug users feel they are not making gains in ETE: it is accepted that this group faces many complex barriers to employment. The HCS has key targets

around economic rejuvenation and so during 2010 we intend to tap into the resources available to meet the Council's economic rejuvenation targets and to use their expertise to improve access; work has already begun with Haringey Guarantee the Councils umbrella ETE resource and Job Centre Plus to develop clear pathways between drug treatment and ETE providers. We will shortly produce an in-depth needs assessment which will identify skills gaps. By April there will be a new road map identifying the steps drug users need to make to progress their ETE aspirations, this will aim to introduce ETE objectives as soon as possible in a recovery program. Work will also be done to link into Fresh start in Prisons.

Provision of suitable accommodation- NDTMS data indicates that housing remains an issue a third (33%) of Haringey treatment population reported a housing problem in 2008-9, of which over a tenth (14%) were identified as urgent[20].

Access to good quality housing is a key issue for many of Haringey's residents; the DAAT will aim to create improvements for drug users by linking into targets within the local Housing and Supporting People strategies. To underpin this we will aim to create a joint strategies and operational protocols.

Reducing numbers in temporary accommodation - The HSC aims to reduce the numbers in temporary accommodation. The DAAT will support this target though close working with temporary accommodation agencies. We will seek to stabilise the drug use of those in temporary accommodation. Once stabile we will aim to provide move on accommodation into drug and alcohol specific supported accommodation, where they can receive tailored support. For those completing treatment we will support move on into private sector accommodation though the councils rent deposit scheme.

Key improvements will be

- ***For temporary accommodation*** – agreed pathways with the Apex House Access team and closer work with housing providers to ensure good care planning.
- ***For supported accommodation*** – the re-tendering process will ensure that the housing providers contract embeds a new robust relationship with drug treatment providers
- ***For rent deposit scheme*** – agreement on criteria and pathways into and work with services to promote this as an alternative to council provision.

Reduction of rent arrears - Reduction of rent arrears is also a key council objective, during 2010 the DAAT will establish how many of ou
r clients and their families have rent issues and then we will work with the housing and council tax services to reduce arrears and evictions.

[20] Out of 1159 individuals who reported housing status in 2008-9

Section 5. Key priorities for 2010/11

Our key priorities for 2010/11 will be to :

5.1 Harm reduction

- Driving up testing and vaccination though rolling out general nurse and key worker testing and vaccination
- Improving successfully access for those with Hep C into specialist treatment, though having clear referral pathways and improved support
- Improving access to harm reduction messages though training up tier 1 providers and drug uses and working more closely with pharmacists and delivering more street based harm reduction services. .
- Reducing the impact of alcohol misuse on drug treatment though training drug workers to offer Alcohol Brief Interventions
- Ensuring the needs of older drug uses are being met, though identifying need and referral pathways.

5.2 Open Access

- Develop marketing materials and strategy: both generic and targeted materials
- Develop an access and engagement strategy overseen by a steering group
- Provide training and communication pathways for tier 1 services.
- Improve co-ordination between agencies regarding maximising availability of open access
- Reduce need for interpreters though development of a workforce that reflects local populations.
- Work with tier 1 to access 18-25 year olds with pre contemplative services

.

5.3 Retention

- Use the DIP Needs Assessment to plan reductions in attrition
- Improve access into treatment for those leaving prison.
- Review service needs of 18-25 year old service users
- Produce a new service level agreement for structured day care.
- Ensure that there is access to dual diagnosis services
- Develop a work plan for the clinical governance group.
- Use service user feedback and the outcomes of the TOP, to improve treatment delivery.
- Develop a workforce training plan which ensures workers have the right skills
- Ensure that sex workers continue to access treatment
- Improve access to community alcohol detoxification for poly drug users with a history of poor retention.

5.4 Exits

- Develop a menu of clear treatment outcomes for drug users
- Review capacity of the GP Shared Care scheme

- Continue to provide counselling service through EBAN
- Development of a North London Inpatient detoxification facility
- Develop a new SLA for Haringey Aftercare Service, promoting peer support and ensuring that maintenance of recovery goals is not left until the final part of treatment.

5.5 Community re-integration

- Continue to build support for friends and families of drug users.
- Improve access to volunteering and training for ex drug users seeking employment, working closely with JCP and Haringey Guarantee
- To improve housing opportunities
- Support the development of user led social activities

5.6 Think Family work

- Liaison with the FIP manager
- development of protocols and pathways
- provision of training
- auditing against safeguarding requirements to ensure that structures and services robustly reflect NTA/DCSF guidance
- development of materials for drugs workers around parenting
- development of maternity services for drug using mothers at North Middlesex

6.6 Workforce development

- Completion of a workforce audit, managed by the clinical governance group
- Development of trainee posts and nurse prescribing
- Development of service users to deliver on harm reduction agenda