

Birmingham Drug and Alcohol Action Team

Adult drug treatment plan 2009/10

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.

<i>Signature</i>	<i>Signature</i>
Chair, partnership name	Chair, adult joint commissioning group

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

a. Background

Problematic drug use is a public health and social issue which has a significant impact on society as a whole, but disproportionately affects the most deprived communities and the most vulnerable individuals. Around a third of acquisitive crime is believed to be undertaken to fund a drug addiction and problematic drug use destroys families and contributes to a cycle of deprivation and lost opportunity. Drug related harms are significant, wide-ranging and cost society an estimated £15.4 billion each year.

Drug treatment is the intervention with the most developed evidence of effectiveness in reducing drug related harms and the central aim of the first national Drugs Strategy (1998-2008) was to increase the availability of drugs treatment including rapid access to treatment from all parts of the criminal justice system through the Drug Interventions Program (DIP). Significant investment in treatment services resulted in doubling the number of drug misusers in treatment nationally from 100,000 in 2004/5 to 200,000 in 2007/8.

b. National Drugs Strategy 2008-2018

Treatment remains central to the new ten year national strategy, *“Drugs: Protecting Families and Communities”* (1) but with an increased emphasis on improving effectiveness, matching quantity of service with quality and a “radical new focus for treatment services on helping drug misusers to re-establish their lives through education, training and employment.”

The Department of Health, through local services commissioned by Primary Care Trusts (PCTs), is responsible for a year on year increase in “the number of drug users in effective treatment”, which forms part of Public Service Agreement 25 (PSA 25) to “Reduce the harm caused by alcohol and drugs” (2). Drugs treatment is one of six areas prioritized for PCT commissioning in Lord Darzi’s review of the NHS (3) and the annual increase in “the number of drug users in effective treatment” is included as a key performance indicator in “Vital Signs”, the framework used by Strategic Health Authorities to performance manage PCTs (4).

The indicator measures the number of crack and/or heroin users (Problematic Drug Users, or PDUs) who remain in treatment for 12 weeks or more or successfully complete their treatment in less than 12 weeks. (Research suggests that 12 weeks is the minimum length of time needed to optimize treatment outcomes for heroin users receiving Methadone Maintenance Prescribing and heroin and stimulant users receiving abstinence focussed Residential Rehabilitation services (5). Evidenced based Brief Interventions have been developed for stimulant users which can achieve positive outcomes in under 12 weeks). Delivery is assured by the National Treatment Agency through a process of annual agreement and quarterly review and

independent assessment and review is provided by the Health Care Commission and Audit Commission.

The challenge for *Drugs: Protecting Families and Communities* is “to maximise the impact of treatment for those who receive it, seizing the opportunity treatment provides to reduce the harms caused to communities, families and individuals.” *Drugs: Protecting Families and Communities* makes explicit the link between the availability of effective drugs treatment and performance against the following National Indicators (NIs) which are used to measure the progress of local areas in achieving PSA targets:

(PSA18): Promote better health and wellbeing for all

- Overall health and wellbeing (NI 119)
- All-age all cause mortality rate (NI 120)

(PSA 16): Increase the proportion of socially excluded adults in settled accommodation and employment, education or training

- Proportion of ex-offenders in settled accommodation (NI 143)
- Proportion of adults in contact with secondary mental health services in settled accommodation (NI 149)
- Proportion of ex-offenders in employment, education or training (NI 144)
- Proportion of adults in contact with secondary mental health services in employment, education or training (NI 150)

(PSA 8): Maximise employment opportunity for all

- Working age people claiming out of work benefit (NI 152)
- Working age people claiming out of work benefits in the worst performing neighbourhoods (NI 153)

(PSA 23): Make communities safer

- Overall satisfaction with local area (NI5)
- Serious violent crime rate (NI 15)
- Serious acquisitive crime rate (NI 16)
- Perceptions of anti-social behaviour (NI 17)
- Adult re-offending rates for those under probation supervision (NI 18)
- Dealing with local concerns about anti-social behaviour and crime by the local council and police (NI 21)
- Re-offending rate of prolific and priority offenders (NI 30)
- Class A drug related offending rate (NI 38)
- Levels of graffiti, litter and fly-posting (NI 195)

In order to reinforce effective partnership working locally to “maximize the impact” of drugs treatment, the PSA indicator “number of drug users in

effective treatment” is also reflected in the set of 198 National Indicators for Local Strategic Partnerships, where it is listed as NI 115 (6), plus the Assessments of Policing and Community Safety and National Offender Management performance management systems, creating a comprehensive matrix of governance and accountability that minimises reporting and monitoring burdens.

c. Drugs treatment in Birmingham

Drugs treatment services in Birmingham are commissioned by the Birmingham Drug and Alcohol Team (BDAAT) on behalf of Birmingham’s three PCTs, Heart of Birmingham teaching PCT, Birmingham East and North PCT and Birmingham South PCT. BDAAT’s long term strategic aim for drugs treatment is to make a significant contribution to Birmingham’s achievement of the ambitions and vision that are set out in the local Sustainable Community Strategy, *Birmingham 2026: Our vision for the future* (7) by reducing drug related harm to communities, families and individuals in Birmingham.

The number of drug misusers in treatment in Birmingham has increased from 4,394 in 2004/5 to 6,057 in 2007/8, of whom 5,350 were using heroin and/or crack. The performance target for 2008/9 is to increase the number of heroin and/or crack users in effective treatment by 7% to 5,725 followed by a further increase of 2% to 5,840 in 2009/10. By the end of the second quarter of 2008/9 there were 5,521 heroin and/or crack users in effective treatment in Birmingham, an increase of 3.2% on 2007/8.

Improving commissioning is at the heart of delivering the NHS’s health agenda for the future and “World Class Commissioning” is the Department of Health’s “statement of intent, aimed at delivering outstanding performance in the way we commission health and social care services in the NHS” (8). In order to achieve a year on year increase in the number of heroin and/or crack users in effective treatment and maximise the impact on families and communities in Birmingham, BDAAT will move towards World Class Commissioning of treatment outcomes by developing a Commissioning Framework and Assurance System against which World Class Commissioning outcomes, competencies and governance can be audited.

World Class Commissioning “encourages commissioners to actively shape local services to deliver a wider choice of more personalised, high quality, health and care solutions” and BDAAT will commence a three year service transformation and redesign program in April 2009 to increase efficiency through value for money investments, increase positive outcomes for service users and their families, develop new care pathways for people misusing both drugs and alcohol and meet the diverse and evolving needs of local communities. BDAAT remains committed to a balanced treatment system in which a range of options are available to benefit drug misusers at different times in their lives, including harm reduction services, structured treatments such as substitute prescribing and psychosocial interventions and also

residential and community detox and rehabilitation programs for drug misusers aspiring to become abstinent from their drug of dependence.

The service transformation and redesign program will “maximize the impact of drugs treatment” on the achievement of the following objectives in Birmingham’s Local Area Agreement, *Working Together for a Better Birmingham* (9), which contains the key priorities to be addressed in order to achieve the ambitions and vision that are set out in *Birmingham 2026: Our vision for the future*:

- Reduce inequalities in health and mortality across Birmingham and support more people to choose healthy lifestyles and improve their wellbeing
- Increase employment and reduce poverty across all communities through targeted interventions to support people from welfare into work
- Improve Birmingham’s neighbourhoods, particularly the least affluent ones, in terms of deprivation, service delivery and overall quality of life for residents
- Tackle serious acquisitive crime, and increase public and investor confidence in neighbourhoods by dealing with local crime, disorder and anti-social behaviour and securing cleaner, greener and safer neighbourhoods and public spaces
- Reduce re-offending through the improved management of offenders and effective treatment of drug and alcohol using offenders

2. Likely demand for open access, harm reduction and structured drug treatment interventions.

The most recent estimates by Glasgow University (10) suggest that there are approximately 11,274 PDUs in Birmingham. Approximately 10,573 are using opiates only or as the main drug and 6,395 using crack only or as the main drug.

- 4,146 PDUs (37%) are not known by treatment or DIP services
- 3,856 PDUs using opiates only or as the main drug (36%) are not known by treatment or DIP services as compared to 3,468 PDUs using crack only or as the main drug (55%)
- 1,277 PDUs aged 16-24 (54%) are not known by treatment or DIP services, as compared to 1,694 PDUs aged 25-34 (32%) and 1,140 PDUs aged 35-64 (32%)

The Glasgow University estimates suggest that there has been a marked decrease of heroin and/or crack use among 15-24 year olds and an increase in the number aged 35-64 years, reflecting national trends towards an aging PDU population as fewer young people begin to use heroin and/or crack. National epidemiological data and local anecdotal evidence suggests increasing “normalisation” of recreational poly drug use (cocaine, alcohol and

cannabis) among 15-24 year olds which can become problematic. The Glasgow University estimates for Birmingham may reflect a wider definition of “PDU” including problematic use of combinations of cocaine, alcohol and cannabis and the local treatment system must respond to these changing trends even though BDAAT receives significantly less funding to provide effective treatment for cocaine and cannabis users and these services do not count towards performance against the “number of drug users in effective treatment” National Indicator.

There is a relatively large young Pakistani population in Birmingham and this population is under-represented within the local treatment population. National research suggests a different pattern of drug use amongst young Pakistanis with high prevalence rates of non-injecting heroin use but this hypothesis has not been tested locally. BDAAT has not undertaken any assessment of the needs of other ethnic groups and new communities in Birmingham.

The most recent Glasgow University estimate of the number of injecting PDUs in Birmingham is 1,715, suggesting a decrease in injecting rates. There were only 270 current injectors and 381 previous injectors engaged in structured drugs treatment in 2007/8, suggesting that 946 injecting PDUs (60%) are currently not known to DIP or structured treatment services. The estimated prevalence rate of hepatitis C amongst injecting drug mis-users is 45%, or 772 people in Birmingham.

HMP Birmingham is the largest “Category B” male prison in Europe and was a pilot site for the “Integrated Drug Treatment System” (IDTS) which is the national program to roll out drugs treatment in prisons. Current funding for IDTS in HMP Birmingham is insufficient to meet the level of need and the Heart of Birmingham Teaching Primary Care Trust has made additional investment while a bid for additional investment is being prepared. Data on potential demand for structured treatment and harm reduction services from drug users leaving HMP Birmingham and other prisons is currently not available and developing an appropriate monitoring system will be a priority in 2008/9.

3. Key findings of current needs assessment.

a. Access-key points

The overall number of new referrals fell from 2523 in 2006/7 to 2437 in 2007/8 and there was a slight decrease in the proportion of referrals from the criminal-justice system from 42% to 38%. The vast majority of service users (94%) had to wait only 3 weeks or less for their first treatment intervention.

There was no significant change in the proportion of referrals by ethnic group between 2006/7 and 2007/8, with Black drug mis-users accounting for 9% of all new referrals (as compared to 6.1% of Birmingham’s population) and Asian drug mis-users accounting for 15% of all new referrals (as compared to 19.5%

of Birmingham's population). No recent audits have been carried out to evaluate the "cultural competence" of local treatment services.

The proportion of primary opiate users fell from 77% in 2006/7 to 73% in 2007/8 while the proportion using powdered cocaine as their main drug increased from 7% to 9% during the same period. Referrals for drug misusers using either crack cocaine or powdered cocaine as the main drug are over represented in referrals from the criminal justice system, with 53% of referrals for crack cocaine and 46% of referrals for powdered cocaine coming through DIP.

b. In treatment-key points

Only 17% of people in treatment are aged 15-24, while 50% are aged 25-34. Psychosocial interventions are the single biggest structured intervention, accounting for 51% of all structured interventions. Prescribing interventions account for the second highest proportion of structured interventions, Specialist Prescribing accounting for 24% of all structured interventions and GP Prescribing for 15% of all structured interventions.

Current commissioned capacity in Structured Day Care and Other Structured Interventions is under utilised, with Structured Day Care accounting for only 1% of structured interventions and Other Structured Interventions for only 7%. Inpatient Detox and Residential Rehabilitation accounted for less than 2% of all structured interventions. There are no specific Structured Day Care programmes for people who have achieved abstinence. A new residential "Centre of Excellence" is due to open in August 2009 which will significantly increase the capacity for Inpatient and Community Detox, Residential Rehabilitation and abstinence based Structured Day Care.

Only 15% of people in treatment during 2007/8 were transferred between agencies during the year, for example only 9% of people receiving a Specialist Prescribing service were transferred to GP Prescribing services and only 1.4% of people in treatment were transferred into inpatient and residential services, suggesting that there are significant blockages within the treatment system.

During 2008/9 the Birmingham Treatment Effectiveness Initiative (BTEI) was implemented. This was developed from the Treatment Effectiveness Initiative piloted by the National Treatment Agency in 2005 to improve the quality of treatment delivery and to improve the options available to workers in delivering evidence-based Care Planning and Brief Interventions for stimulant users. The initiative resulted in substantial improvements in treatment engagement, psychological functioning and treatment motivation, resulting in an increase in treatment retention with 84% of people in treatment being retained for 12 weeks or more and a significant increase in the proportion of stimulant users exiting treatment successfully in less than 12 weeks.

c. Treatment exits-key points

The percentage of planned treatment exits is the same for White, Black and Asian drug misusers (18%) and there are no significant difference in the percentage of planned exits for males (19%) and females (20%).

Planned treatment exits are significantly higher for the 18-24 age group (29%) than for the 25-34 age group (15%) and the 35-64 age group (18%).

Planned exits for cocaine users (32%) and cannabis users (40%) are much higher than for primary opiate users (13%) and primary crack users (17%).

d. Harm reduction-key points

Most needle exchange users are male (85%) and White (93%) and the majority are aged 25-34 (53%) while only 9% are aged under 24%. Injectors in the youngest age group tend to use pharmacy needle exchange services rather than specialist needle exchange services.

New sterile injecting equipment is used for approximately 28% of all injections and the primary substance injected by specialist needle exchange users is heroin (48%), followed by cocaine (23%) and steroids (19%). Only 47% of previously or currently injecting drug users commencing treatment in 2007/8 were offered a hepatitis C intervention.

The number of drug related deaths increased from 18 in 2005 to 41 in 2006 but fell again to 28 in 2007. The average age of drug related death fatalities over the last 3 years is 37 years but 14 were aged under 25 and only a very small minority were engaged in treatment. However, a large proportion were in full time employment.

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

a. Commissioning a local drug treatment system: The first year of the service transformation and redesign program will be focussed on mapping and reviewing current service provision, pathways and performance against the diverse needs of local communities. Other specific improvements planned include:

- Developing a Commissioning Framework and Assurance System to increase stakeholder involvement in commissioning activities and against which World Class Commissioning outcomes, competencies and governance can be audited
- Developing strategic links between BDAAT Adult Drugs JCG and the Safer Birmingham partnership's Offender Management Core Priority Group to further integrate the DIP program and Prolific and other Priority Offenders Strategy

- Developing and implementing BDAAT Communications Strategy to increase involvement of key stakeholders in commissioning activities and win local public and political support by increasing awareness of the benefits of drugs treatment to Birmingham

b. Access: BDAAT now operates a “single point of contact” for non criminal justice services and following the agreement of appropriate pathways, social marketing campaigns will be used to increase the numbers in treatment from the following under-served groups:

- Primary crack users
- Problematic drug users aged 16-24
- Injecting drug users accessing needle exchange services
- Young Pakistani heroin users

c. In treatment: Improvements to improve the effectiveness of treatment in 2009/10 include:

- Review all services and pathways as part of the three year service transformation and redesign program
- An increasing focus on treatment outcomes and the impact of treatment on drug use, health, social functioning and offending behaviour as measured by the Treatment Outcome Profile
- Developing and implementing a Quality Assurance System for all commissioned services, incorporating clinical standards and governance arrangements where appropriate, as part of the Commissioning Framework and Assurance System
- Develop a joint strategy with mental health commissioners for the development of services for people with a dual diagnosis

d. Treatment exit: the new residential Centre of Excellence is planned to open at the end of the second quarter in 2009 and demonstrates BDAAT’s ambition to support drug misusers aspiring to become abstinent from their drug of dependence. The new centre will provide both community based and residential detox and rehabilitation services. BDAAT and local service users will develop a shared strategic vision to develop peer support and the mobilisation of other community resources to support sustained recovery from problematic drug use. Specific improvements for treatment exit in 2009/10 include:

- Develop care pathways for both residential and community based detox and rehabilitation programs
- Develop Structured Day Care and Community Integration opportunities for people leaving treatment
- Work in partnership with Birmingham University and DATUS, a local service user organisation, to research how community resources have been and can be mobilised to support people recovering from problematic heroin use
- Support the further development of peer support groups

- Develop a working relationship with Jobcentre Plus Drugs Coordinators to establish clear two-way pathways between treatment services and Jobcentre Plus programmes

e. Harm reduction: a new three year Harm Reduction Strategy will be in place by April 2009 to implement the Department of Health's *Reducing Drug Related Harm: An Action Plan* (11). Specific improvements planned for 2009/10 include:

- Increasing low threshold and structured harm reduction interventions for injectors, including peer education, particularly for people injecting cocaine and steroids
- Improving learning outcomes from drug related deaths by improving the exchange and management of relevant information
- Roll out of naloxone training and prescribing
- Increase the proportion of injecting drug mis-users commencing treatment who are offered hepatitis C interventions

5. Key priorities for 2009/10

BDAAT's key priorities for adult drugs treatment in Birmingham for 2009/10 reflect the key strategic aims of the national drugs strategy, the needs and aspirations of service users who have been consulted and the successful achievement of those objectives in Birmingham's Local Area Agreement, *Working Together for a Better Birmingham*, which are listed above.

More specifically, these priorities will impact on Birmingham's performance against the following National Indicators which have been included in *Working Together for a Better Birmingham* because improved performance is vital to achieving the ambitions and vision that are set out in *Birmingham 2026: Our vision for the future*:

- All-age all cause mortality rate (NI 120)
- Working age people claiming out of work benefits in the worst performing neighbourhoods (NI 153)
- Proportion of children living in poverty (NI 116)
- Overall/general satisfaction with local area (NI 5)
- Serious violent crime rate (NI 15)
- Gun crime rate (NI 29)
- Serious acquisitive crime rate (NI 16)
- Dealing with local concerns about anti-social behaviour and crime by the local council and police (NI 21)
- Re-offending rate of prolific and priority offenders (NI 30)
- Drug related (class A) offending rate (NI 38)

BDAAT's key priorities for adult drugs treatment in Birmingham for 2009/10 are:

- Increase the number of problematic drug users in effective treatment, particularly those currently under-represented in the treatment population (primary crack users, problematic drug users aged under 24 years and young Pakistani Problematic drug users)
- Reduce drug related (class A) offending through rapid access to treatment from all parts of the criminal justice system
- Support long term recovery by increasing opportunities to become abstinent from drug of dependence and improving access to education, training, employment and housing
- Contribute to the safeguarding children and young people by improving treatment and support for parents misusing drugs
- Commence implementation of a three year local Harm Reduction Strategy with a specific first year focus on increasing the range of appropriate harm reduction and structured treatment interventions available for injecting drug users

Notes

- (1) Home Office (2008) *Drugs: protecting families and communities* Home Office: London
- (2) HM Treasury (2007) *PSA Delivery Agreement 25: Reduce the Harm Caused by Alcohol and Drugs* HMSO: London
- (3) Department of Health (2008) *High Quality Care for All: NHS Next Stage Review – Final Report* DoH: London
- (4) Department of Health (2008) *Operational Plans 2008/9 – 2010/11: National Planning Guidance and “Vital Signs”* DoH: London
- (5) National Treatment Agency for Substance Misuse (2005) *Retaining Clients in Drug Treatment* DoH: London
- (6) Department for Local Communities and Local Government (2007) *The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of National Indicators* DCLG: London
- (7) Birmingham City Council (2008) *Birmingham 2026: Our vision for the future* BCC: Birmingham
- (8) Department of Health (2007) *World Class Commissioning: Vision* DoH: London
- (9) Birmingham City Council (2008) *Birmingham LAA 2008/11: Working together for a better Birmingham* BCC: Birmingham
- (10) Hay, G. Et al (2008) *National and regional estimates of the prevalence of opiate use and/ or crack cocaine use 2006/07: a summary of key findings.* Home Office Research Report 9 Home Office : London
- (11) Department of Health (2007) *Reducing Drug Related Harm: An Action Plan* DoH: London

