

Ealing DAAT

Adult drug treatment plan 2006/07

Part 1: Strategic summary, national targets, partnership performance expectations and funding profile

This strategic summary, self assessment and attached planning grids 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
Collette Paul, Borough Commander	Anna Johnston, Head of Drugs & Alcohol

Section A Strategic summary

A1 Partnership drug treatment strategy

Ealing DAAT is a multi-agency strategic partnership tasked with implementing the National Drug Strategy including the treatment strand which intends to increase the numbers of illicit drug users in treatment by 100% from 1998 to 2008. Ealing DAAT has exceeded the requirements of the National Drug Strategy: during 2004/05 1,200 had been treated.

Ealing DAAT aims to improve the life chances of drug users & reduce the impact of drug related crime on the community by engaging, treating, retaining, rehabilitating & returning drug users to the community with resourceful lives, improved health & employability.

We will be developing new services to address the needs of crack & polydrug users, such as a local structured day programme. We will also develop services to meet the findings & requirements of the Models of Care Effectiveness Review (2005) & aim to ensure the holistic needs of drug users are met through direct provision & partnership across agencies, including housing & employment, to ensure drug users treatment & recovery is supported & maintained.

Clear pathways will be ensured for clients to move through modalities to achieve the best health outcomes for them. Increased efforts will be made to address the physical health needs of all drug users, not only those who are opiod prescribed but also those using primarily crack, through increased screening & vaccination & clinical provision at Tier2.

In meeting the requirements of Models of Care & the Patients Act we will involve clients throughout the planning & provision of services & their care. Increased resources will be allocated to dedicated workforce & a programme of user & carer involvement.

Furthermore, during 2006/07 the partnership will be implementing the expansion of the Drugs Intervention Programme with the Tough Choices project (Drugs Act 2005) which will have new requirements of; testing on arrest, Required Assessment and Restriction on Bail. The purpose of Tough Choices & the extension of DIP is to identify problem drug users and encourage them to seek help by attending treatment assessment. Therefore increased resources will be allocated to Tier 2-4 services to meet this expected increase in activity.

The major constraints to these planning intentions are those of workforce across the field & obtaining suitable premises for the required expansions; however the DAAT Integrated Commissioning Unit is a strong, fully staffed & experienced team that have led Ealing DAAT in exceeding the requirements of the National Drug Strategy & that can successfully meet & balance such challenges.

A2 Summary of problem drug situation

Ealing is one of the largest outer London boroughs and has a population of 300,947 on the 2001 census.

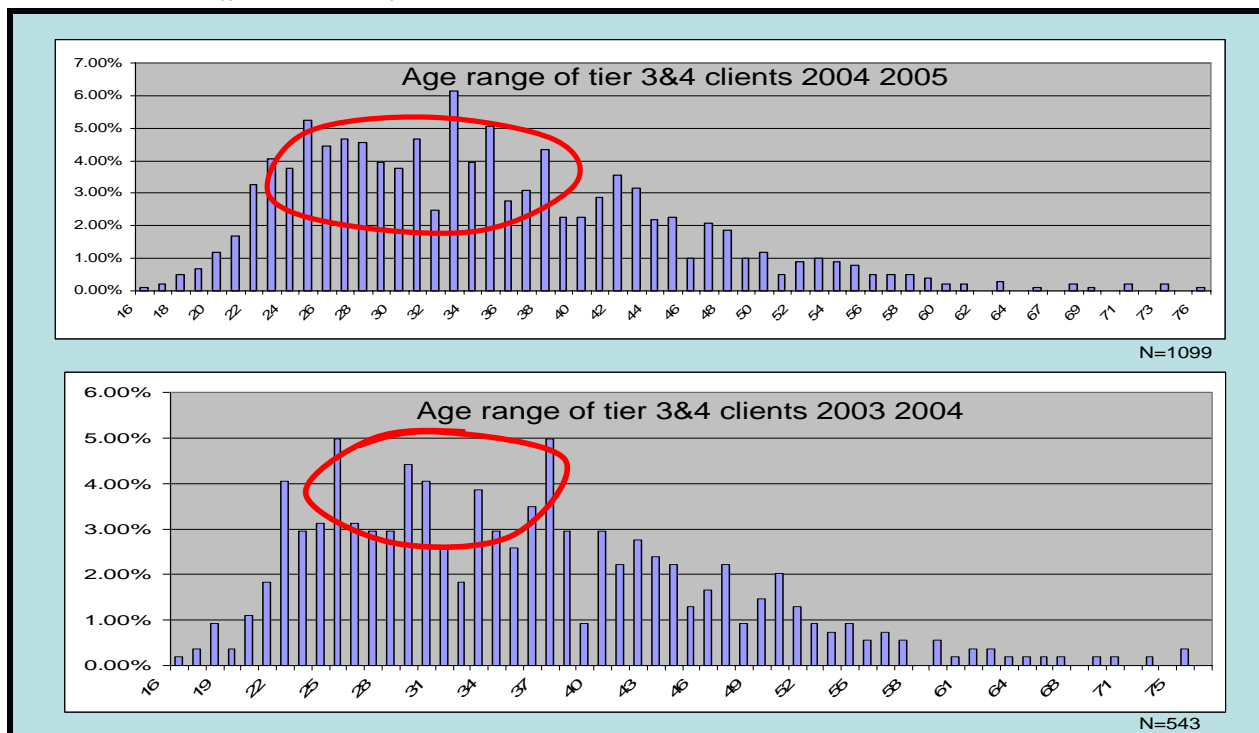
Ealing borough is renowned for its diversity which ranges from the predominantly Asian communities of Southall and its surrounding wards to the predominantly White communities around Ealing Broadway; the areas around Acton are known to have a large community of Black Caribbeans. Increasingly, Ealing is also seeing a large increase of immigrants from the former Soviet states.

Prevalence:

- ❖ Latest figures released by the NTA identify the numbers in structured drug treatment for 04/05 at 1,203
- ❖ Hickman Fisher estimates for the number of problem drug users in Ealing as 1,647. This estimate is currently under review and more accurate figures should be made available by the NTA and Glasgow University shortly.
- ❖ Nonetheless, as an indicator it suggests that 77% of the problematic cohort were engaged in treatment in 04/05.

Age range of treatment cohort:

The treatment cohort in Ealing is relatively young; the majority of our clients are in the 20-30 age-bracket. In the graph below there are two identifiable peaks one in the early 20's and another in the mid-late 30's.

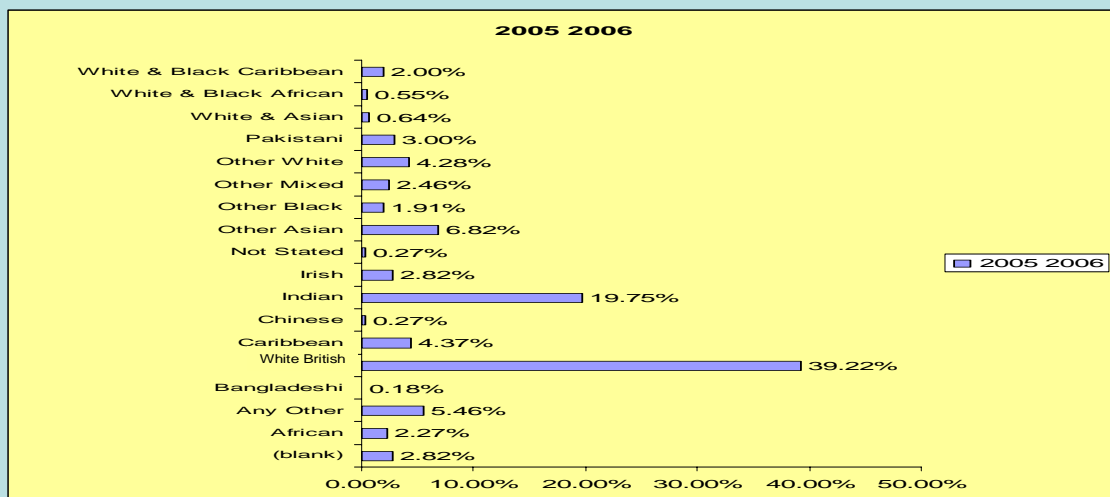


Ethnicity of treatment cohort:

Ealing's population is very diverse and this diversity is also reflected in the treatment cohort. The majority of our clients are White British (40%) followed by a large cohort of Asian Indians (20%) and a smaller cohorts of Black ethnic groups. This broadly reflects the ethnic breakdown of the borough.

Ealing's treatment population does suggest that the traditional perception of certain cultures' substance misuse patterns is not always reflective of the actual picture on the ground. Asian groups' drug use was perceived within the drug education & treatment field to be lower than the white population but this has not proved true locally.

The ethnic breakdown of the treatment cohort 2005 2006

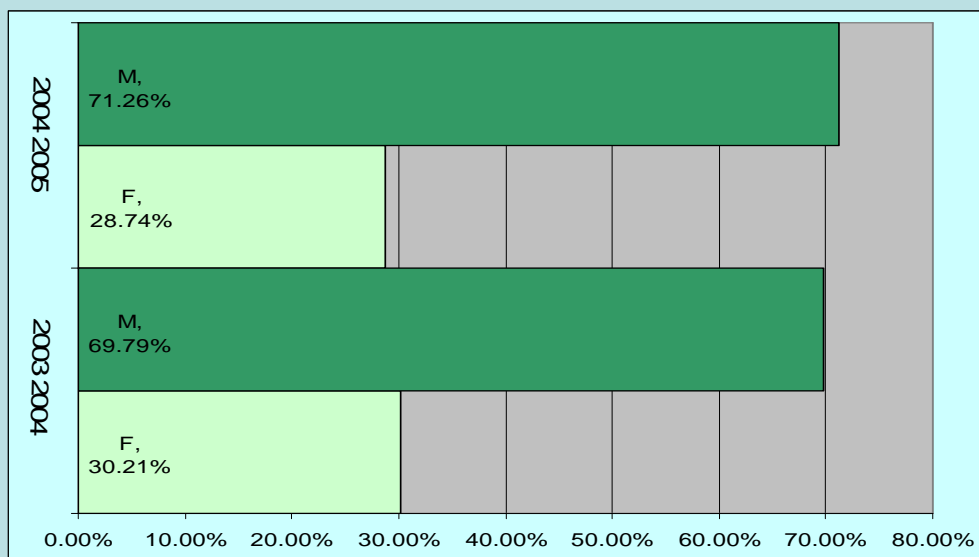


Gender and the treatment cohort:

Recent national research indicates that women are not under represented in treatment. In fact, they are less likely in the first place to become problematic users and where they do so, are more likely to enter treatment earlier (Women in Drug Treatment Services NTA 2005).

In general, the ratio of women to men is 1:3, although this ratio can change in certain geographical areas where other socio-economic variables may alter this relationship. From the graph below we can see that the 1:3 ratio is consistent for Ealing.

Gender breakdown of the treatment cohort 2005-06 2004-05



It should be noted however, that prevalence is not the only determinant of need and that most women who enter treatment have different, or more complex support needs to their male counterparts. This includes child care, child protection, abuse issues, domestic violence, mental health and sexual health.

Housing:

The provision of adequate housing is a key determinant of successful treatment outcomes. From the DIP Aftercare and Resettlement team from April to March 2004, we know that 65% of clients had unsuccessful, or unsuitable housing outcomes. These unsuitable outcomes included being housed with in private rented accommodation with no support, or remaining in volatile housing situations with family or friends. It is estimated that 20% of these clients had stopped engaging or dropped out because of the lack of suitable housing.

Furthermore we know from our treatment figures that 10% of tier 3 & 4 and 20% of tier 2 clients are NFA.

Mapping of referral pathways for clients with Dual Diagnosis revealed stringent exclusion criteria by housing providers. Most housing provision is targeted at stable clients who have completed treatment and remain drug and alcohol free. Further work will be undertaken by the partnership to influence the Homelessness and Supporting People Strategies. Housing provision by the partnership for drug users is a key component of making treatment & care packages work. It is also a requirement of the Models of Care Effectiveness Review (NTA).

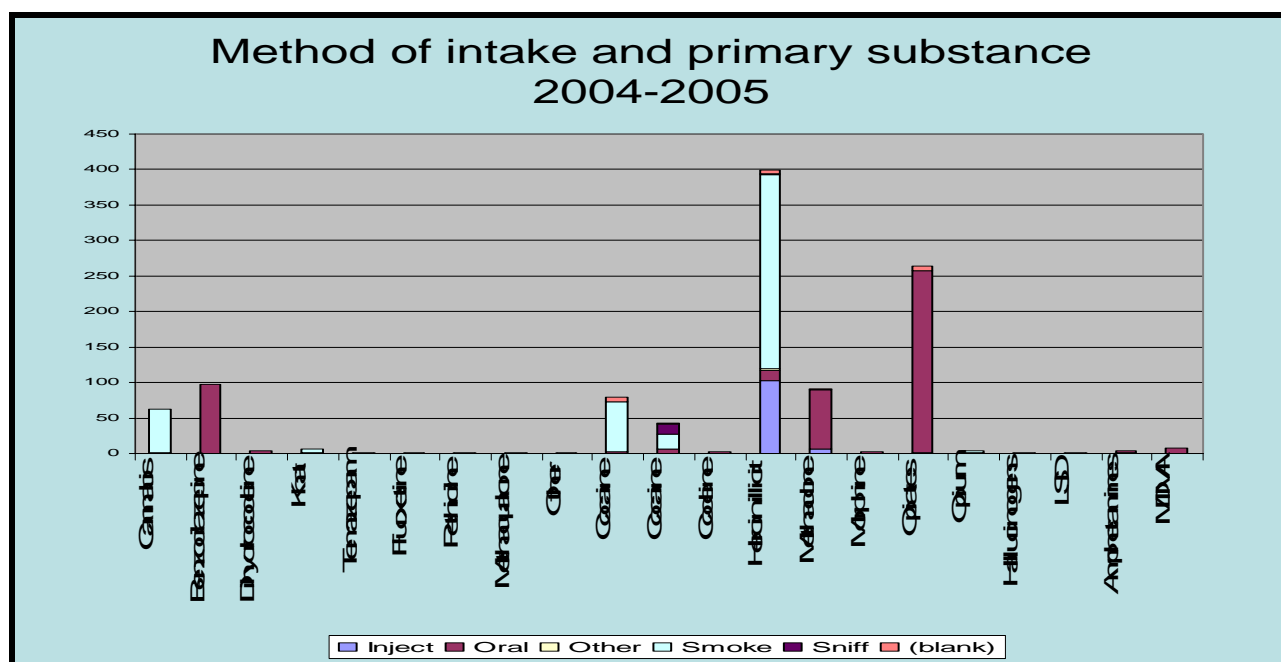
Patterns of Drug Use:

Primary Substance and Route of Administration:

Of the 1,099 (confirmed) Ealing residents accessing structured Tier 3 & 4 treatment in 2004-2005, heroin and other opiate use account for the vast majority of all primary substances. 10% of the treatment population were injecting at intake. Approximately 25% of the Heroin population in treatment were injecting when they presented to services.

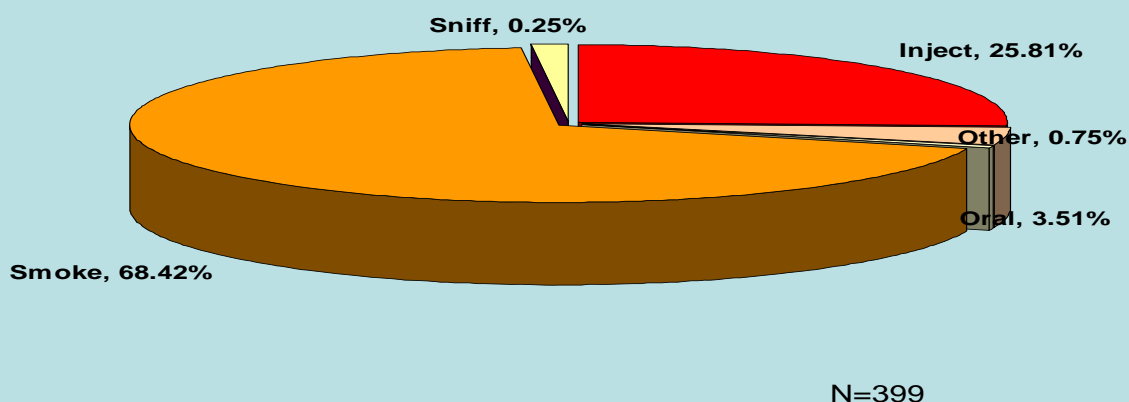
Data from Ealing DIP suggests high rates of opiate injection among clients assessed, with 21% of the heroin population injecting.

Open access Tier 2 data shows higher levels of injecting prevalence. This data is likely to be more reflective of rates in the "not-in-treatment" cohort, although this is difficult to verify. The largest amount of injecting drug use was amongst opiate users again, with 52% of opiate users injecting.



The prevalence of injecting drug use in Ealing on average is 23% of the opiate population. These users are at increased risk of infection. As a result harm minimisation projects which are focused on reducing the adverse risks associated with injecting drug use need to be prioritised.

Method of intake of heroin:



The prevalence of Crack use in Ealing:

The chart below analyses patterns of crack use for clients in Ealing's treatment agencies. In almost all cases crack cocaine is more likely to appear as a secondary drug rather than a primary drug. *This does not indicate that there is no problem with primary crack usage within the borough, on the other hand it simply indicates that existing treatment services focus on primary opiate or alcohol users.*

Within the treatment cohort crack cocaine accounts for a significant proportion of secondary drug usage and existing services must be developed to address this need.

Crack cocaine data amongst treatment provider agencies 04/05

Provider	Q1	Q2	Q3
CNWL**	Primary: 1.6% Secondary: 37.6%	Primary: 1.9% Secondary: 29%	Primary: 1.4% Secondary: 38%
Turning Point*	Not Available	Primary: 14% Secondary: 34%	Primary: 5.6% Secondary: 36%
Residential Rehab	Primary: 42% Secondary: 22%	Primary: 15% Secondary: 63%	Primary: 9% Secondary: 20%

TASHA	Primary: 1% Secondary: 0	Primary: 5.2% Secondary: 26%	Primary: 10% Secondary: 14%
Shared Care	Negligible numbers	Negligible numbers	Negligible numbers

*=Monthly Snap Shots averaged into quarters

**= As above plus refers to Cocaine usage rather than Crack usage

Prevalence of Crack within the Criminal Justice system

We get data from the Criminal Justice system through two main sources:

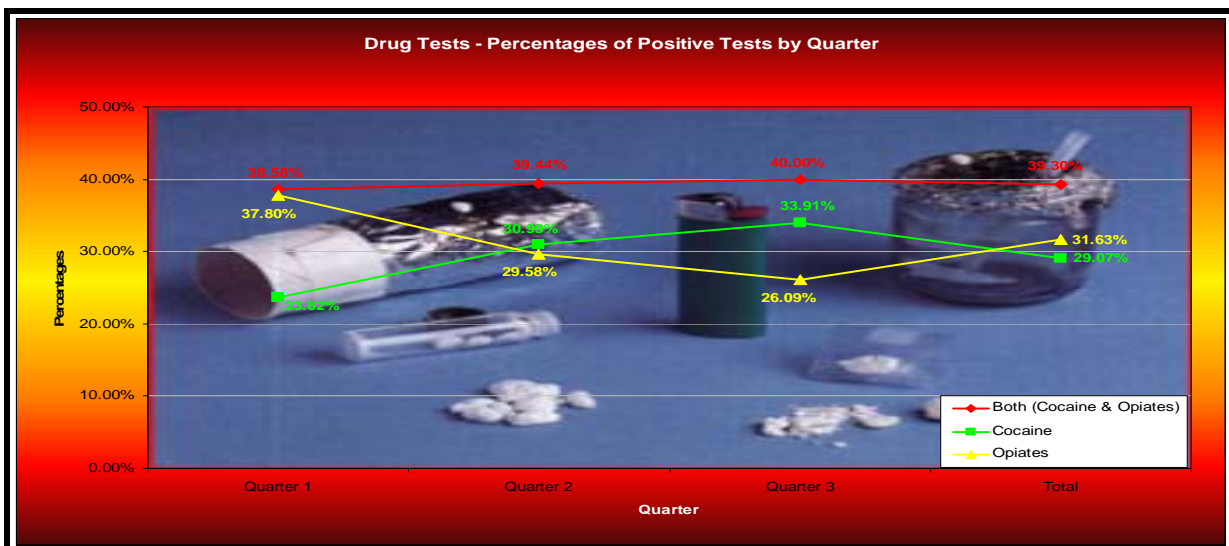
- ❖ ITDMF Assessments which are carried out by arrest referral in custody suites, prison, probation and courts and;
- ❖ The Drug Test Data which is carried out by police when an offender is charged with a trigger offence.

ITDMF Assessments:

During quarter one to quarter three 04-05 there were 700 assessments, out of which 25% (146) specified crack as their primary substance. This is significantly higher than the percentage of primary crack users identified within the treatment cohort.

Drug Test Data:

The chart below shows the prevalence of cocaine usage for those arrested for a trigger offence. (Trigger Offences tend to be acquisitive crimes where evidence suggests that they are strongly correlated to drug use.)



In total, quarter one to quarter three 648 tests were attempted in this period, of which 48% (313) were positive.

Crack usage is significantly higher amongst those in the criminal justice population in

comparison with those engaged in treatment. It is not possible to establish whether this cohort is more indicative of the prevalence of cocaine within the wider population.

It is difficult to account for the variation between these figures and the treatment data. Firstly, these results come from very different sources and represent two different populations, those engaged in treatment and those engaged with the criminal justice system. It is quite possible that each population has different characteristics. For example, the high price of crack cocaine could mean that crack users are over represented in the criminal justice system.

Conversely it could reflect the fact that traditionally treatment services tend to be geared towards opiate users, therefore crack users are under represented within these services.

While causality is difficult to establish, anecdotal evidence suggests that crack users are under represented in the treatment cohort.

Prevalence of Crack from Police Activity Data:

During the past 12 months the police have closed 15 crack Houses in Ealing. The police estimate that at any one time there are between 12-18 crack houses in operation.

There are open drug markets in Ealing and these tend to be linked to the night time economy, often clustered around licensed premises and town centres. There is also a strong link to deprivation for the town centres of Southall, Northolt, Hanger Lane & Hobbayne and the Acton estates. Anecdotal evidence suggests that the town centre of Southall is linked with an open opiate market and Acton with an open crack market.

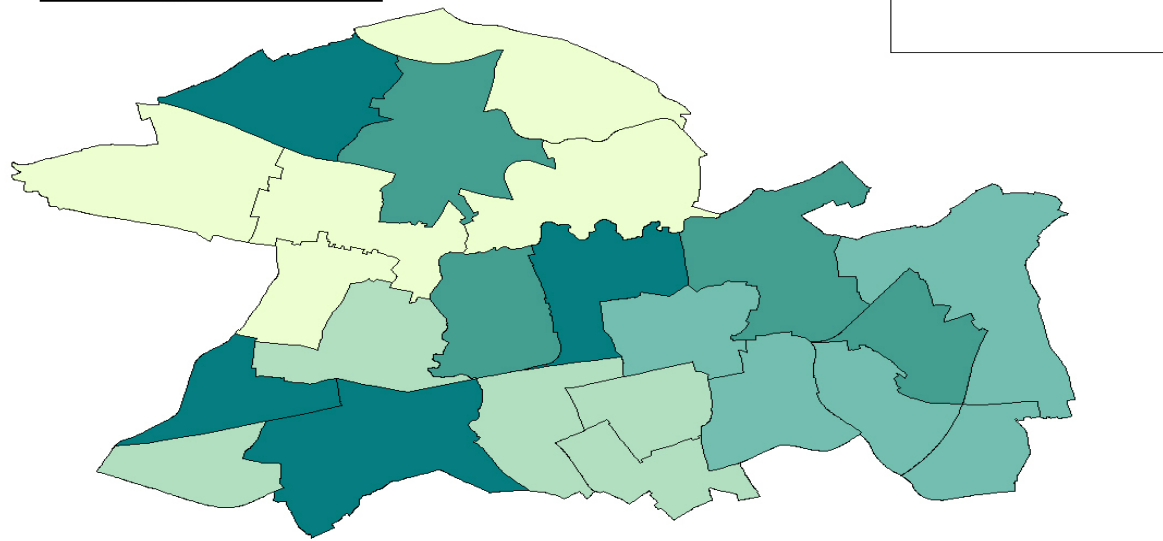
Geographic pattern of drug use:

1,477 episodes (not individuals) for structured treatment in 04/05 had full postcodes recorded - these cases were mapped to ward boundaries.

The results show that five wards Cleveland, Northolt, Mandeville, Southall Broadway, Norwood Green had high numbers in treatment.

Individuals receiving treatment within Ealing for all categories of drug use.

Individuals Receiving Treatment In Ealing 2004/2005



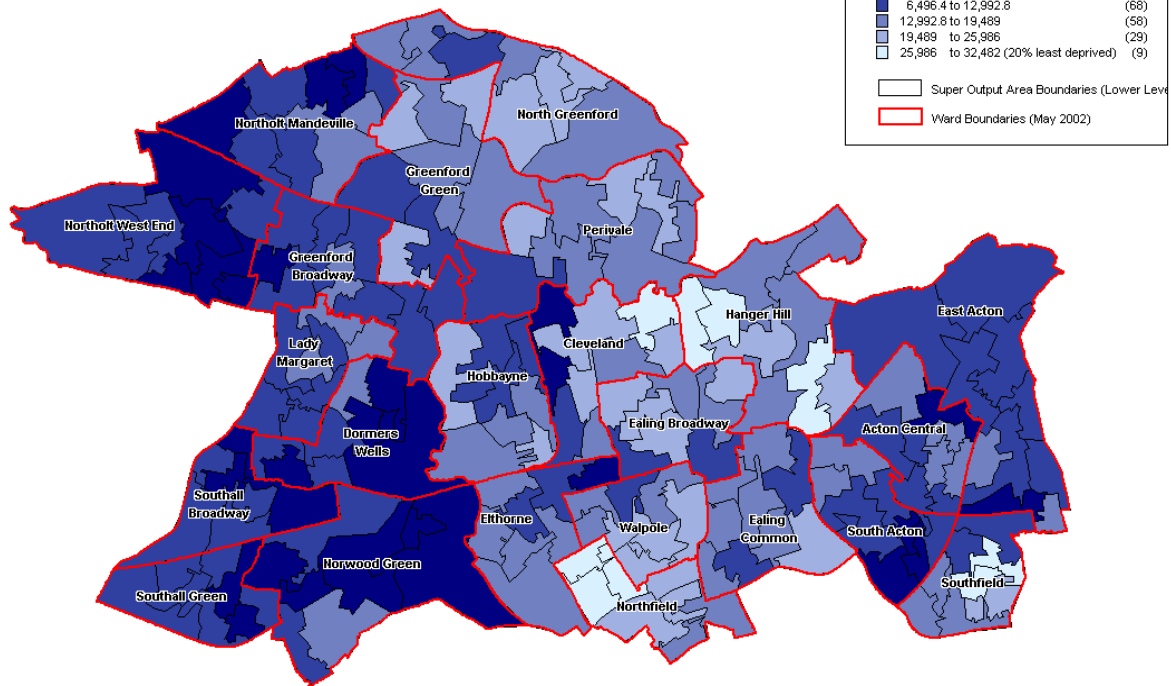
Deprivation:

National research has shown a strong correlation between socio-economic disadvantage and becoming a problematic substance misuser. In Ealing, we have mapped our treatment population to ward level and found that the areas where concentrations are highest coincide with areas of high deprivation.

In the Index of Multiple Deprivation, Ealing ranks as 2% less deprived than the London average, but 4% more deprived than West London and 9% more deprived than England averages.

9 of Ealing 195 Super Output Areas (5%) are in the top 10% most deprived in England in terms of multiple deprivation; 31 (16%) are in the top 20% most deprived in England. 23 of Ealing's Super Output Areas (12%) are in the top 20% most deprived in London and 49 (25%) are in the top 20% most deprived in West London.

Index of Multiple Deprivation 2004 by Super Output Area - National Quintiles



Source: ODPM Indices of Deprivation 2004. Crown Copyright.

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 Corporate Research and Intelligence Team, Ealing Council

Target Setting:

LDP stretch targets are based on projections of the numbers of new presentations and discharge rates over the next 3 years based on performance in April to October 2005.

Retention targets were set in consultation with the expert data group based on the unique characteristics of Ealing's population. Ealing has performed well in 04/05 with a retention of 77%. We believe that there are some factors within Ealing which will affect our ability to achieve increased retention, however we agree to meet the national target of 85% by 2008. This is based on the services being able to pro-actively respond to the following challenges.

- 16% of Ealing's in treatment population are referred from the criminal justice system; these clients have lower retention rates than their counterparts. In addition the numbers of individuals entering via this route is set to increase with improved performance and changes to the operation of the scheme such as testing on arrest.
- Ealing has a large Asian population who are successfully retained in treatment. However, recently there has been a large increase of Eastern Europeans, Somali and Africans within the borough. As this is relatively recent, we are not yet successfully engaging these populations who may also have particular ambivalences to engaging with institutions.
- Figures show that Ealing has been successful in retaining stimulant users compared to the national average. This population accounts for 13% of the total treatment cohort. We believe based on Drug Test Data and anecdotal evidence from outreach agencies, that this population are under represented in traditional treatment services. We plan to improve our engagement of this cohort which is likely to negatively affect our retention rates. We will be monitoring the retention of stimulant users in services via ndtms data and will seek to improve poor performance via

regular local data meetings.

NDTMS compliance is to receive more attention via regular local data meetings, which will monitor data quality via rolling targets.

A3 Partnership key treatment priorities

- Increase BBV testing & vaccination
- Expand needle exchange provision: increase sites & provide full paraphernalia
- Commission outreach post for the homeless
- Respecify Tier 2 provision to provide general health assessments
- Respecify Tier 2 to increase structured crack treatment provision & pathway for crack users
- Implement Care Co-ordination model across all providers & commission Care Co-ordinator at Tier 3 prescribing agency

- Increase capacity at Tier 3 prescribing
- Increase investment in GP Shared Care via NES & new LES
- Consolidate Care Pathways for crack & Shared Care
- Commission comprehensive Tier 3 Structured Day Programme to provide DRR & non CJ placements, including crack specific treatment models
- Increase I/P detox provision
- Commission Alcohol LES to include those with concomitant drug dependence
- Increase Residential Rehab provision
- Provide integrated IT system for all drug & alcohol providers
- Commission drug user & carer involvement officer
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Section B National targets

B1 Numbers of drug users in treatment (adults and young people)

B1.1 Estimated number of problem drug users (PDU) in partnership area	1,647	Source	Hickman Fisher (revised estimates)
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Data to be used is always DAT of residence		Performance 2004/05	Target 2005/06	Target 2006/07	Target 2007/08
B1.2 Total number in treatment	LDP(T43)	1,203	990	1,238	1,480
	Partnership target		1,484	1,600	1,680
B1.3 Percentage change over previous year	LDP	172%	-21%*	25%	20%
	Partnership target		23%	7%	5%
B1.4 Percentage of PDUs in treatment	LDP	73%	60%	75%	89%
	Partnership target		83%	92%	97%

*Please note that a reduction in activity would be required to align with the LDP target in 05/06 due to increased performance in 04/05

B2 Retention rates

Data to be used is always DAT of residence		Performance 2004/05	Target 2005/06	Target 2006/07	Target 2007/08
B2.2 Percentage retained in treatment for 12 weeks or more	LDP	48%	48%	50%	52%
	Partnership target	77%	80%	83%	85%

B3 Waiting times targets

First treatment intervention	Partnership performance %	Planned performance %		
	31 Dec 2005	31 March 2006	31 March 2007	31 March 2008
Inpatient drug treatment	37% met 2 week target	53%	69%	85%
Residential rehabilitation		83%	84%	85%

	83%			
Specialist prescribing	52%	63%	74%	85%
GP prescribing	92%	85%	85%	85%
Structured day programmes	100%	85%	85%	85%
Counselling	100%	85%	85%	85%
Other structured treatment			85%	85%

*Waiting Times as of Oct-November, December waiting times not available until January

** Following new NTA Waiting Time guidance, CNWL to agree how to implement as they have used different definitions to date

Subsequent treatment intervention	Partnership performance %	Planned performance %		
	31 Dec 2005	31 March 2006	31 March 2007	31 March 2008
Inpatient drug treatment	37% met 2 week target	53%	69%	85%
Residential rehabilitation	83%	83%	84%	85%
Specialist prescribing	52%	63%	74%	85%
GP prescribing	92%	85%	85%	85%
Structured day programmes	100%	85%	85%	85%
Counselling	100%	85%	85%	85%
Other structured treatment			85%	85%

Section C Partnership performance expectations

Drug treatment system – partnership performance plans

C1 Successful completions

Successful completions = discharges who complete treatment or are referred on for other services	National average 2004/5	Partnership performance %	Planned performance %		
		2004/05	2005/06	2006/07	2007/08
Inpatient drug treatment	38%	67%	68%	70%	72%
Residential rehabilitation	40%	20%	30%	50%	62%

Specialist prescribing	30%	43%	47%	51%	56%
GP prescribing	30%	47%	49%	51%	53%
Structured day programmes	31%	11%	26%	41%	58%
Counselling	30%	44%	49%	54%	61%
Other structured treatment	32%	97%	60%	65%	65%

C2 a Places in treatment

	Actual number of places commissioned		Proposed number of places to be commissioned	
	2004/05	2005/06	2006/07	2007/08
Inpatient treatment	19	30	40	50
Residential rehabilitation	44	44	54	60tbc
Specialist prescribing	400	565	627	700tbc
GP prescribing	83	241	270	350
Structured day programmes	12	76	142	160
Counselling	89	162	300	350
Other structured treatment	N/A		550	650

C2 b Care Planning

Year	Baseline performance 2005/06	Planned Performance	
		2006/07	2007/08
Proportion of individuals starting treatment who have a care plan		80%	100%

C3 Primary care prescribing services

	Actual %	Planned performance %		
		2005/06	2006/07	2007/08
C3.1 Percentage of all GPs prescribing	22%			
C3.2 Percentage of GPs in shared care	28%	33%	35%	38%
C3.3 Percentage of GP practices in shared care	27%	33%	35%	38%

Criminal justice – Drug Interventions Programme (DIP)

C4 Custody suite and court based interventions – non-intensive DIP areas only. Please note performance requirements for intensive DIP areas are agreed via Compact targets

	Expected performance 2005/06	Planned performance 2006/07	Planned performance 2007/08
C4.1 Proportion of adults who are not on the CJIT caseload with whom contact is made, who are assessed by CJIT	85%	85%	85%
C4.2 Proportion of adults assessed by the CJIT as needing a further intervention who are taken onto the caseload	60%	65%	70%
C4.3 Proportion of adults taken onto caseload who engage in treatment	90%	90%	95%

C5 Throughcare/aftercare – non-intensive DIP areas only

	Expected performance 2005/06	Planned performance 2006/07	Planned performance 2007/08
C5.1 Number of CARAT referrals from prisons	180	200	240
C5.2 Proportion of CARAT clients for whom follow up action was taken by CJIT	TBC	TBC	TBC

Criminal justice – community sentences

C6 Community sentence with drug rehabilitation requirement (including DTTOs)

	Performance 2004/05	NPD Target 2005/06	NPD Target 2006/07 (if known)	NPD Target 2007/08 (if known)
C6.1 Commencements	76 (107% of target)	82	83	To be set by Home Office
C6.2 Successful completions (number)	6 (43% of target)	17	27	To be set by Home Office

Harm reduction initiatives

C7 Vaccinations against Hepatitis B Virus (HBV)

	Performance	Planned performance		
	2004/05	2005/6	2006/07	2007/08
Number of individuals offered HBV vaccinations	110	110	300	1200
Number of individuals who take up HBV vaccinations	58	56	130	600

C8 Proportion of current or ever injecting drug users tested for Hepatitis C Virus (HCV)

	Performance	Planned performance		
	2004/05	2005/6	2006/07	2007/08
Percentage of current or ever injecting drug users tested for HCV	32%	33%	50%	70%

C9 General healthcare assessment

	Performance	Planned performance		
	2004/05	2005/6	2006/07	2007/08
Number of individuals receiving a general healthcare assessment		700	900	1,100

C10 Specialist and pharmacy-base needle exchange programmes

	Performance	Planned performance		
	2004/05	2005/06	2006/07	2007/08
C10.1 Number attending specialist needle exchange	137	200	250	300
C10.2 Number in contact with pharmacy exchange schemes	200	400	600	700
C10.3 Total number of pharmacies in partnership area		70		
C10.4 Percentage of pharmacies in scheme	15%	21%	25%	30%

Housing

C11 Supported housing

	Baseline	Expected performance	Planned performance	
	2004/05	2005/06	2006/07	2007/08
Numbers of drug users entering housing support*	96	96	100	105

As measured by the Single Client Record Form, the number of primary and secondary needs drug users entering Supporting People services. Please note there may be some over accounting with these numbers.

Section D Substance misuse pooled treatment budget (SMPTB) allocation and funding profile

	SMPTB allocation	2004/05	2005/06	2006/07	2007/08
D1	Total substance misuse pooled treatment budget (SMPTB)	2,188,000	2,480,000	3,030,690	TBC
D2	SMPTB allocation to Young People's Partnership Grant	154,000	154,000	223,000	TBC

Please detail all funding available to the joint commissioning group to support delivery of the partnership treatment plan.

	Funding profile	2004/05	2005/06	2006/07	2007/08
D3	SMPTB available for adult drug treatment (D1 minus D2)	2,034,000	2,326,000	2,807,690	3,962,650
D4	SMPTB underspend carried forward from previous year	40,000	- 13,841	56,500	TBC
D5	DIP main grant	834,723	834,723	1,127,746	TBC
D6	HO Arrest Referral (Workforce Development Grant)	58,773	58,773	n/a	TBC
D7	PCT mainstream	2,159,714	2,395,039	2,453,401	TBC
D8	Social services	402,461	425,368	420,358	TBC
D9	Probation – partnerships	-	-	-	TBC
D10	Supporting people	-	-	-	TBC
D11	Other (please list below)				
	Partnership Support Grant	72,034	72,034	72,034	TBC
	Neighbourhood and Crime Reduction	-	9,299	-	TBC
	DIP Apprenticeship scheme		5,000	20,000	
	RoB Coordinator			20,000	
D12	Total funding for adult drug treatment and DIP delivery (D3 – D12 inclusive)	5,601,705	6,107,395	6,977,729	TBC

Has the partnership created a pooled budget for adult drug treatment, fully available to the joint commissioning group?

NO

Partnerships in receipt of the SMPTB since 2001 must maintain mainstream investments, including inflation uprating, which is subject to audit checking. Lead PCT directors of finance will be required to verify this through the local delivery plan (LDP) reporting process.

Have **all** mainstream funding commitments been maintained and inflation uplifted?*

YES / NO

*If the answer is NO, please supply a written explanation as an appendix to this strategic summary.