Safer Peterborough Partnership

Adult Drug Needs Assessment

2010/11

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1. Introduction

The purpose of this document is to give a detailed overview of the drug misuse profile within Peterborough. This will cover both the needs that are being met where those individuals are in treatment, and areas where additional focus is required in order to facilitate supporting individuals' not currently obtaining access into the treatment system.

The analysis and research undertaken in order to inform this needs assessment have all been completed in line with the guidance issued by the National Treatment Agency (NTA) for Substance Misuse and National Drug Treatment Monitoring System (NDTMS) Needs Assessment Guidance 2010/11. In addition to those areas recommended for review, analysis and research of data has been completed on those specific areas known to be of interest and concern within Peterborough.

The information provided within this needs assessment will form the basis of business planning for the 2011/12 Treatment Planning process.

Please note this needs assessment is subject to change due to current retender of the treatment system in Peterborough – which is due for completion for the new provision to start on the 01/04/2011

2. Aims and Objectives

The fundamental objective of this needs assessment is to provide the most rounded view possible of the needs, requirements, shortfalls and priorities locally to ensure that the treatment available and its delivery to local drug users is optimised. This will encompass all aspects of service delivery, including looking at the agencies who are responsible for service delivery.

The key areas that will be focussed on to provide detailed information to answer the above will be:

- What works well, and for whom, in the current system;
- What the unmet needs are across the system;
- Where are the gaps for drug users in the wider reintegration and treatment system;
- Where the system is failing to engage and/or retain people;
- Who are the hidden populations and what are their risk profiles;
- What are the enablers and blocks to treatment, reintegration and recovery pathways;
- What is the relationship between treatment engagement and harm profiles.

This information will feed into the treatment planning process and resource allocation. It will also provide the framework within which clear and detailed plans to drive forward and monitor performance at agency level are set out.

3. Peterborough Population Specifics

3.1 Overview of Current Service Provision in Peterborough

Peterborough currently has two drug treatment providers (one criminal Justice and one mainstream) and one alcohol treatment provider, they are:

The **Drug Interventions Programme (DIP)** offers rapid access criminal justice intervention, including:

- Key worker sessions,
- Advice and information
- Blood borne virus service
- Rapid access prescribing clinic
- Community detox
- Brief stimulant drug service
- One-to-one support
- Prison in reach
- Drug testing on arrest and required assessments
- Brief stimulant interventions

The mainstream service, **Peterborough Drugs Service,** offers open access and structured drug treatment for adults living in Peterborough, this includes:

- Key worker sessions
- Advice and information
- Needle exchange
- Drop-in service
- Blood borne virus service
- One-to-one support
- Drug counselling
- Substitute prescribing
- Community detox
- Structured day programme
- Support for parents and carers
- Stimulant drug service
- Specialist service for pregnant drug users
- Specialist service for sex workers
- Interventions for individuals subject to a Drug Rehabilitation Requirement
- Housing support

Peterborough also has a number of other services and interventions available to service users:

Pharmacies
A number of local pharmacies offer

- Needle exchange and harm reduction services
- Advice and information
- Dispensing of substitute medications and supervised consumption

GPs
There are a number of GPs in Peterborough who are involved in delivering prescribed treatment to drug users. Shared care GPs work with Peterborough Drugs Service to deliver substitute prescribing within primary care settings.

Residential Rehabilitation and inpatient Detoxification
All services can facilitate access to short term hospital based treatment and residential rehabilitation where people meet the relevant eligibility criteria.

- Inpatient drug treatment – detoxification and/or stabilisation in a local hospital ward
- Residential Rehabilitation – Intensive treatment, usually for 12 weeks with accommodation

3.2 Drug Availability and Purity

Cambridgeshire Constabulary have been conducting operations locally in the last year, such as Operation Riptide, in order to stem the flow of availability of drugs in Peterborough. Known dealers, both locally and from other areas such as London have been identified and targeted as well as activity following intelligence received from all avenues. This level of enforcement has seen an effect on the drugs available in the city, with purity levels of heroin being reduced, which has been proven by forensic tests carried out on drugs by the police as well as comments made by clients locally.

Heroin: Deals of heroin are usually around 0.1g, in line with the national average, and retail for £10. Purity of heroin fluctuates between 20 – 40% at present.

Cocaine: Purity levels between 23%, which is line with the current national average. It is currently sold at approximately 0.2g for £10.

Crack Cocaine: Crack cocaine deals are consistently 0.1g and retail for £10. The Forensic Science Service is reporting purity levels from seizures of between 20-23%.

Overall, this raises a number of concerns and recommendations, particularly around harm reduction: the fluctuations in purity raise concerns around the risk of overdosing, if an individual obtains a particularly high quality batch; and if the purity levels are consistently at the lower end of the purity range, there is increased risk injecting related harm due to the need to inject more to achieve the same effect

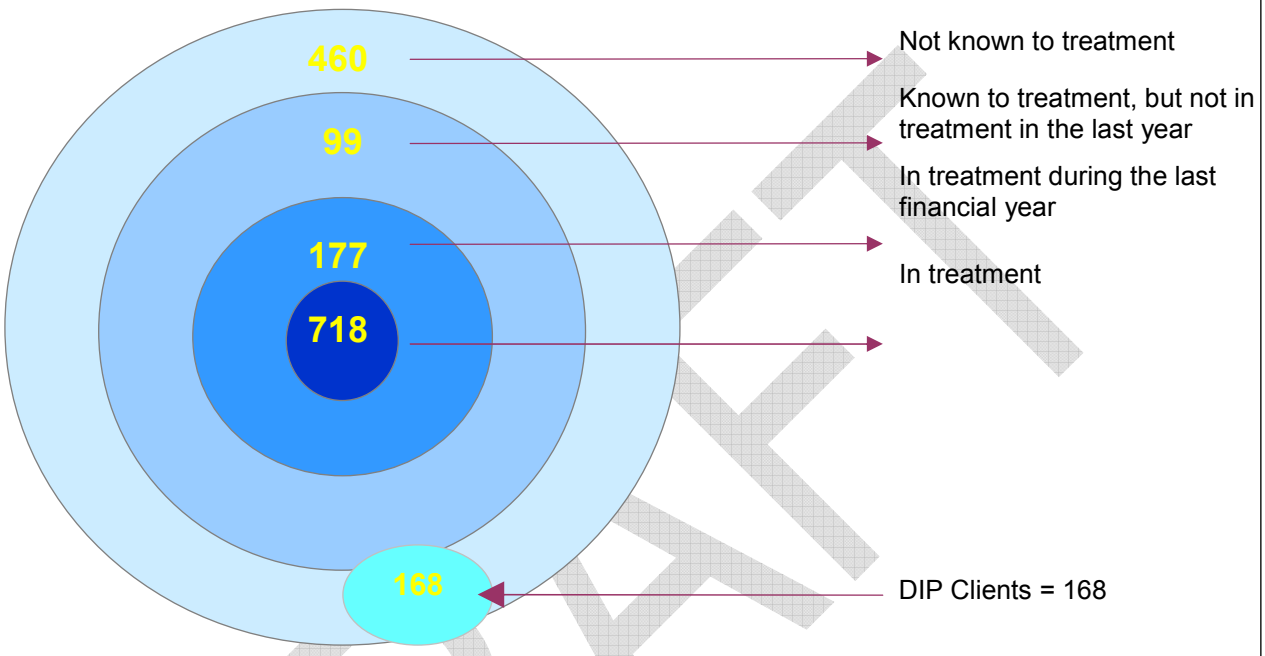
Recommendation

- Details of purity levels should be shared with the treatment agencies so they can make the service users aware as part of their harm reduction messages

3.3 Treatment Bull's Eye

The 'Treatment Bull's Eye', below, clearly displays the PDU (Problematic Drug Users) population prevalence estimated broken down by those known and unknown to the treatment system.

Effective Treatment Population Bull's Eye



- In treatment: Clients that were in contact with Tier 3 / 4 (T3/4) agencies as at 31 March 2010
- In treatment during financial year: Clients that were in contact with T3/4 agencies during 2008/09 but were not still in contact on 31 March 2010
- Known to treatment, but not treated in last year: Clients that were recorded in T3/4 treatment in 2008/09 but had no contact in 2009/10
- DIP (Drug Interventions Programme) clients: Those clients known to DIP either in the community or in prison as at 31 March 2010
- Not known to treatment: Possible PDUs not known to the T3/4 treatment system in either 2008/09 or 2009/10

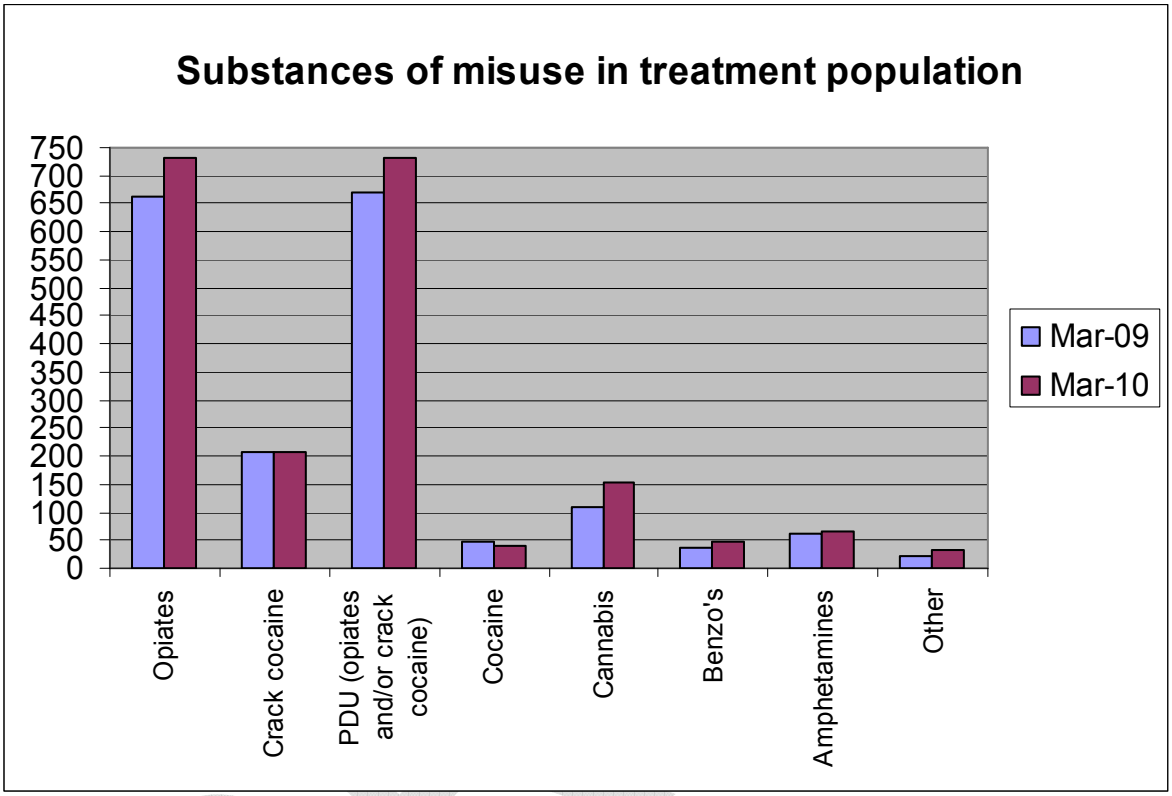
The data represented in the Bull's Eye above would suggest that within Peterborough there is a population unknown to structured treatment of 460 individuals, which is a 13.5% decrease on figures of 2008 which stood at 532.

Of this total, 168 individuals are known through the DIP and analysis of this cohort will enable a greater insight into the not in treatment population. This analysis highlighted the following two key areas of concern in engaging individuals into treatment and maintaining that through to a planned exit.

It is important to note that the PDU prevalence figures that this information is based upon are estimate, therefore caution is advised. In addition, as indicated above, the estimates have not been refreshed for this year. However, it is believed based upon all of the information that has been reviewed that they paint a true representation of the position in Peterborough.

3.4 Treatment Population

a) Substances of Misuse



The chart above shows the comparison in treatment population and the substances used in March 2009 and March 2010. In 2009 there were 1144 clients in the treatment system locally, compared to 1070 in 2010, a decrease of 74 clients (6.4%). This chart includes both male and female clients in treatment.

In 2010 the figures show that 68% (731) of all adult clients are PDUs. Despite a drop in the treatment population this shows a 10% increase on PDUs in 2009. This clearly shows that use of opiates and crack cocaine is on the increase despite a reduction in the treatment population. The use of crack cocaine has remained the same over the last two years and cocaine use has decreased by 14% (7) in 2010. The other drugs recorded have seen increases in reported use with cannabis showing the largest increase with a 41% (45) increase in clients using cannabis in 2010 compared to 2009 statistics.

There are 340 clients who reported injecting currently whilst 427 clients said they have never injected. Of the PDUs currently in treatment, 28% said they injected currently, whilst the same figure said they had never injected.

Trend data has identified a year on year increase of concurrent alcohol use in the treatment population. One of the main reasons identified locally for this is the poor purity of drugs in the current market.

A year on year increase has been seen in concurrent alcohol use in Peterborough since 2004. From six clients using alcohol alongside substances in 2004 the levels have risen to 410 clients using alcohol in 2010. This represents a massive increase and reflects the current situation in Peterborough where alcohol use is a problem in the local community.

Of the treatment population, 30% currently use alcohol and substances concurrently. Alcohol may not be the client's primary substance of misuse but it is one that needs to be considered by providers when clients access treatment. Partnership working with drugs and alcohol service providers should enable clients to receive the most relevant, effective treatment possible to address all substance misuse issues they may have.

Males are the most likely to use alcohol with other substances. Males account for 67% of those in the current treatment population who use alcohol concurrently with other substances.

SPP have recently put together posters for licensed premises and service providers raising awareness of cocaethylene, the use of alcohol and cocaine together. The concurrent use of cocaine and alcohol produces a third drug, called cocaethylene which produces more toxic results meaning an increase in the potential of harm to the user. It is hoped the posters will raise awareness of this with the local treatment population.

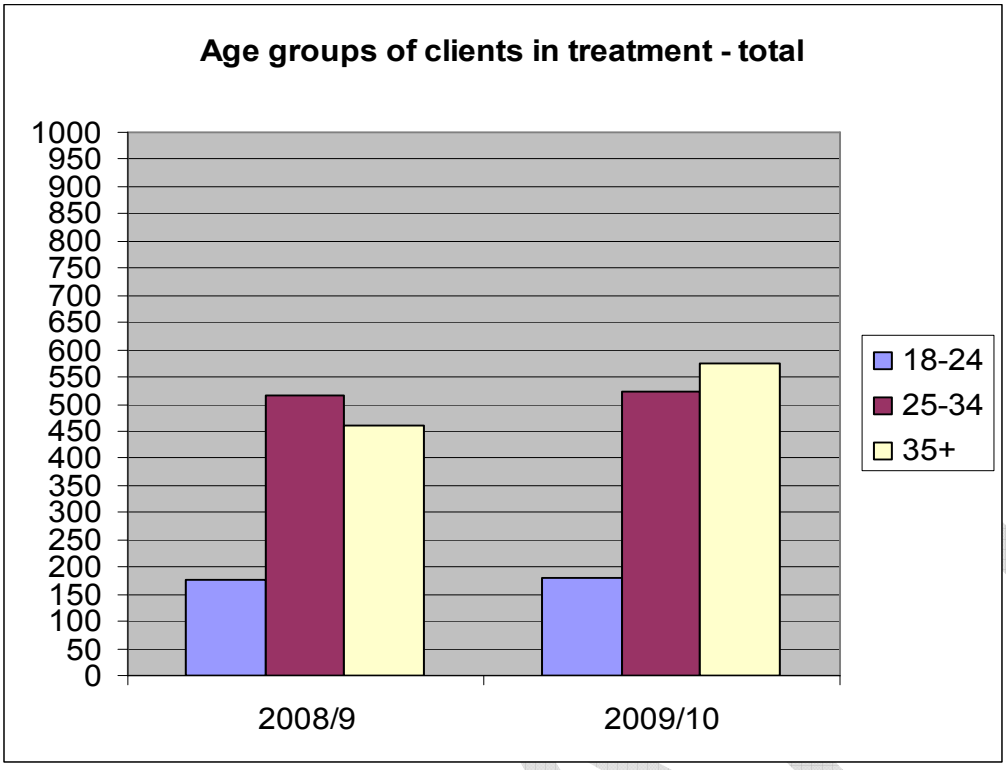
Recommendations

- Support the number of clients for whom their concurrent alcohol use is as serious as their drug misuse
- To monitor the number of cocaine only presentations into treatment as well as the number of Cocaine and Alcohol combination presentations
- Further develop/increase capacity of specific brief interventions
- Further analysis of demographics of male alcohol & cocaine user
- To continue to develop working relationships with local A&E, to improve continuity of care and improved joint working to reduce duplication and risk

However, given both national trend data and information from quarterly performance reports, women are currently under represented in treatment therefore some specific work around engagement and retention of women in treatment is needed:

- Further work to look at increasing the proportion of females entering treatment, as evidence provided through the NDTMS analysis, females as a proportion of the numbers in treatment are still underrepresented
- To look to work with local nurseries to support possible child care issues which may impact of attendance at services, as taking children to service has been idenfied by service users as a barrier to entering and remaining in treatment
- Analysis of NDTMS data to get a better picture of the current number of females in treatment who have children in their care and what can be done to support this
- Consider the use of shared care GP for females with children as access to local GP service maybe preferable to attending drug services, to do accessibility and easy if they have young children

b) Age groups



The table above shows an age breakdown of clients in treatment. From the table you can clearly see that the current treatment population is an ageing one. Despite there being fewer people in treatment in 2010 as there were in 2009, the treatment population has seen an increase in people in the 25-34 and 35+ age brackets. The 35+ age bracket accounts for 45% (576) of the treatment population – 6% down on 2009. The 25-34 year age bracket has remained consistent, with 521 clients fitting into this group, compared to 514 in 2009.

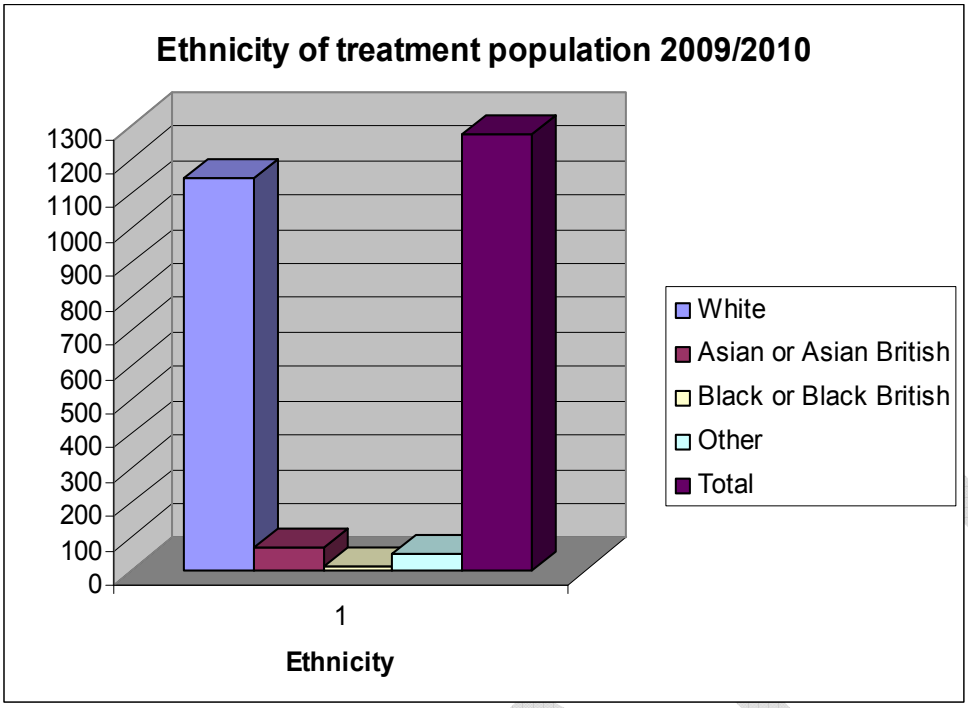
You can also see that the 18-24 age group has also remained at similar levels from 2009 to 2010. The previous needs assessment referred to Peterborough as having an ageing treatment population and this trend appears to be continuing in 2010, particularly as back in 2007, the 18-24 year old age bracket was higher than the 35+.

Of the 35+ age bracket, 45% (334) are PDU's. This is just below the East of England average of 50%.

Recommendations:

- To look at the increasing number of clients from the 25-34 age group that are still using at 35+, as this older client group may be more entrenched
- Interventions and support needed to stop the 25-34 age group from becoming longer term substitute prescribing clients especially with those aged 35 years and older
- Look at what can be done to support those currently in the 18-24 age group from becoming long term users or being on long term substitute prescribing

c) Ethnicity



Peterborough has an ethnically diverse population and this continues to change disproportionately compared to the picture nationally. According to the National Office of Statistics, Peterborough's population in mid 2009 stood at 171,500 people. Due to the varied population, and the language difficulties and cultural barriers this brings, it can be difficult to ensure that all areas of the population are fully represented within the treatment system. This may be due to certain groups not wishing to be seen accessing treatment services, cultural (mis)understandings of what treatment will and will not entail, or belief the services will only work with certain communities. Addressing the needs of the varied communities and ensuring individuals know about and are able to access treatment still requires further work.

The White population are the majority of those clients in treatment at 89% of all currently accessing treatment in Peterborough. This is an almost exact ratio to the one provided in for 2008 in the 2009/2010 Needs Assessment. The Asian client group accounts for 5.2% of those accessing treatment in the city – a 0.6% increase on figures from 2008. This still remains, and has for some years, an area of possible under-representation.

The Black client group accounts for 1.3% of the treatment population in Peterborough, whilst those from other ethnicities account for 4% of those accessing treatment locally. The Eastern European Community has, historically, been hard to engage with and promote treatment with and this should be a priority to providers locally. This is due to increases in the Eastern European population in Peterborough which could indicate potential for more people from this group needing treatment and also analysis of Drug Testing on Arrest Data for Eastern Europeans which shows a significant increase in Eastern Europeans testing positive on arrest. This is detailed in Section 6 of this document.

Recommendations:

- Continue to look at barriers to engaging Black and Minority Ethnic (BME) clients into treatment
- Work with local BME communities to promote the benefits of treatment
- Monitor the impact of the increase of A10 countries presenting for treatment
- Agree a local process for dealing with clients who officially have no recourse to public funds
- Work with partners to support the reconnection of clients who are returning to their home countries, including support to access detoxification prior to leaving where appropriate

d) Injecting Status

The table below shows the injecting status for individuals known to the treatment system either currently or previously. This indicates that Peterborough has a higher than regional average rate of drug users who are either injecting currently or have done previously. This is the same picture as was shown in last year's Needs Assessment and is in line with the historic scenario known locally.

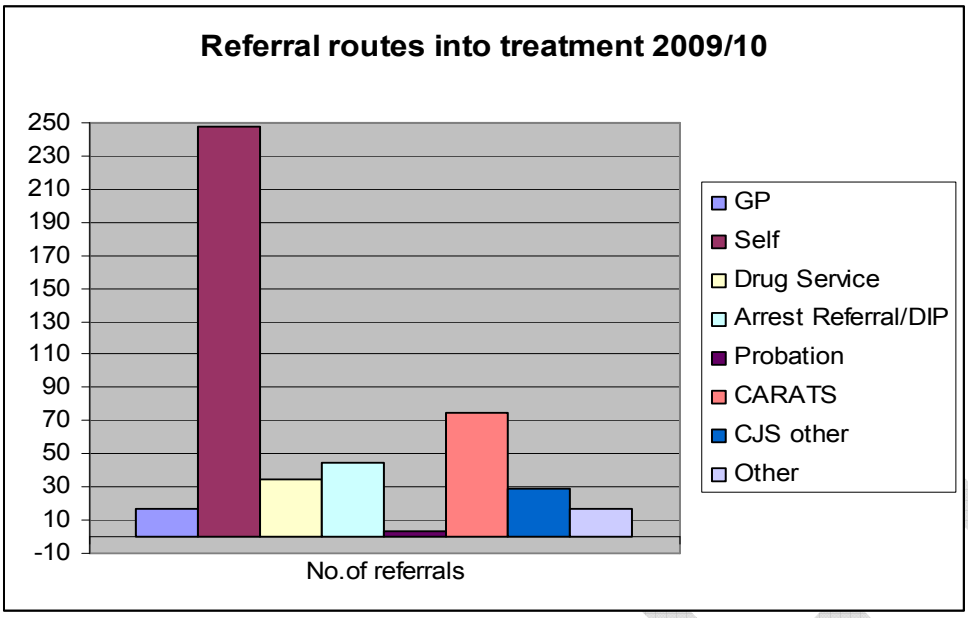
Treatment Status	Currently	Previously	Total
Currently in treatment	33.4%	27%	60.4%
In effective treatment last year	41.4%	25%	66.4%

From these figures it is clear that the number of drug users injecting has increased since the last needs assessment.

Recommendations

- Consider why the injecting culture continues to develop in Peterborough unlike other areas nationally where injecting is on the decline
- Develop interventions to discourage first time injectors or to engage those who have only just started injecting
- More work on safer injecting and alternatives to injecting should be used in needle exchanges and by service providers to address the increases in injecting by clients

e) Referral Routes into treatment

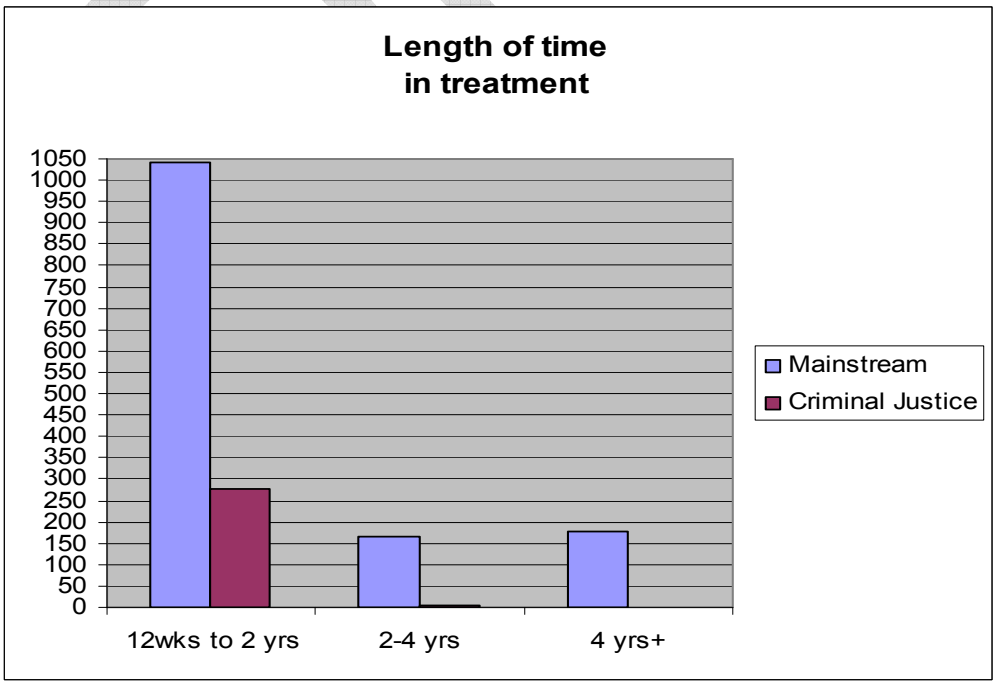


The table above shows the various referral routes that have seen clients' access treatment in Peterborough in the last year. From the table it is clear that self referrals by clients is the most used referral route with 52% (248) of all referrals coming through this route. This is below the regional figure of 70%. CARATS follow with 16% (75) referrals. It would appear from the table that GP's may need some awareness work around referring into local drug treatment as they only accounted for 3.6% (17) referrals in the last year out of a total of 469. GP referrals regionally accounted for 8% of all referral routes into treatment.

Recommendations

- Increased awareness work with GP's locally to encourage referrals of clients into treatment and discuss any potential barriers GP see to getting their patients into treatment

f) In Treatment



The previous table shows the clients in treatment in 2009/10 as well as those still in treatment, broken down into mainstream services and criminal justice. You can see that currently those in mainstream account for the vast majority of clients in treatment (79%). It is worth noting that there are more clients in the 4 yrs+ bracket than those in 2-4 years. This indicates that there is possibly more work needed around those clients currently in treatment for more than four years as they appear entrenched and with the focus on recovery need to be addressed.

Recommendation

- Work required to look into those clients currently in treatment for over four years with view to moving on in treatment with recovery agenda in mind

3.5 Modalities & Waiting Times

a) Structured Treatment Modalities (recovery treatment options)

There are a number of structured treatment modalities offered to drug users in Peterborough, these include, amongst others: specialist prescribing; a structured day programme; structured psychosocial interventions; GP prescribing; and care planning.

Data submitted by the treatment services indicating the type, or modality, of treatment accessed provides a more detailed picture of the treatment population. This showed that the main treatment type was specialist prescribing, which accounts for 32% of all modalities reported.

This was followed by structured day programme, structured psychosocial interventions and GP prescribing.

This would fit with the drug use profiles for the treatment population in that opiates are the most commonly used drug. However, the data also indicates that service users accessing substitute prescribing are not progressing on to shared care prescribing arrangements, this may be partially due to the low number of GPs in Peterborough currently involved in share care, therefore not making this a feasible option for all clients.

Relatively low rates of service users accessing the structured day programme and psychosocial provision may indicate that needs are not being met in relation to structured support to recover from drug use, in addition to prescribing interventions. The tables below show the current uptake of psychosocial interventions.

Psychosocial Modalities active in 2010/2011 YTD	Number of Clients
Contingency Management (drug specific)	30
Other Formal Psychosocial Therapy	18
Psychosocial Intervention Mental Disorder	48
Structured Psychosocial Intervention	168
TOTAL	**264**

Psychosocial Modalities Started in 2010/2011 YTD	Number of Clients
Contingency Management (drug specific)	28
Other Formal Psychosocial Therapy	12
Psychosocial Intervention Mental Disorder	42
Structured Psychosocial Intervention	0
TOTAL	**82**

Overall proportion of the total numbers in treatment receive psychosocial interventions

Partnership	Adult drug clients accessing structured treatment 2010/2011	Adult drug clients accessing psychosocial interventions 2010/2011	%
Peterborough	876	222	25.34%

NB: Total number of clients accessing psychosocial treatment in the above table will not correspond to the absolute total number of modalities delivered in the top 2 tables; this is because a client can access psychosocial interventions multiple times within the same episode of treatment or in subsequent ones

b) Waiting Times

Peterborough continues to have no waiting times greater than 3 weeks for Tier 3 interventions, which is in line with national guidance.

Overall Waiting times – first treatment intervention			
Number of valid waiting times	**Number 3 weeks and under**	**% 3 weeks and under**	**No. waits > 6 weeks**
57	57	100%	0

Recommendation:

- Further work to be done with PCT colleagues to look at the barriers with regards to GPs signing up to deliver share care for substance misuse
- Structured day programme to be reviewed with regards to what is currently offered – to be done in conjunction with service users to ensure programmes support the wider recovery journey of service users and improve uptake of these interventions.

c) Tier 4 Treatment (Residential Rehabilitation and In-patient Detoxification)

In-patient Detoxification
Peterborough has one in-patient detoxification bed located at the Cavell Centre. This bed is shared by local drugs and alcohol service providers and is managed under the premise that alcohol detox takes priority over drug detox. The arrangement works and is managed well by the providers and the SaferPeterborough Partnership. Discussion around detox and the bed usage forms part of the Residential Rehabilitation Panel meetings. With the increased work locally around raising awareness of detox and residential rehabilitation there is potential that demand for the detox bed will increase so it is important to consider other options such as spot purchasing beds elsewhere should the need arise.

Residential Rehabilitation
A total of four clients commenced residential rehabilitation placements in the last 12 months (November 2009 to November 2010). In November 2010, locally held information identifies three primary drug service users still being in residential rehabilitation placements from the local drug treatment system. Residential rehabilitation is structured in-house specialised care, planned by a case worker and a client. These placements specialise in stabilisation, detox and rehabilitation to those with substance misuse issues.

Through NDTMS data, it is evidenced that in total two service users were accessing residential rehabilitation in May 2010, which differs from local reporting. The three placements reported locally were funded through the SPP Rehab Panel, though it is worth noting the residential rehab of one client had funded their second stage treatment and therefore other sources of funding are available.

Much is being undertaken locally to increase awareness of residential rehabilitation as an option for treatment. Rehab awareness sessions are facilitated by the SPP to promote the use of residential rehabilitation with case managers from the local service providers.

Recommendations:

- Monitor the use of the detox bed at the Cavell Centre and promote its use with providers. There will also be a need to consider spot purchasing of detox beds when the one bed at Cavell is being used
- Continued work to promote in-patient detoxification and residential rehabilitation as treatment options with service providers
- To continue to run awareness sessions for case workers
- To support HMP Peterborough in using residential rehabilitation as treatment option straight from custody
- Look at standardised paperwork for in-patient detoxification and residential rehabilitation application, assessment and pre-placement work across all services, including HMP Peterborough

3.6 Treatment Outcome Profile (TOP) Reports

The Treatment Outcome Profile, (TOP) provides a standardised method for monitoring client outcomes within the drug treatment system in. England

The Partnership ensure through quarterly contract review meetings that our service providers have start, review and exit TOPS in place. These are required to meet the 80% completion target set by the National Treatment Agency (NTA). Any TOPS that fall below target are addressed in the quarterly meetings and monitored. At present, start TOPS are on target, with review TOPS and exit TOPS falling short of the 80% target.

Month	Partnership Start Top %	Partnership Review Top %	Partnership Exit Top %
April 2010	92.7% (Green)	69.8% (Red)	84.6% (Green)
May 2010	95.0% (Green)	67.6% (Red)	92.9% (Green)
June 2010	92.8% (Green)	73.1% (Amber)	66.7% (Red)
Aug 2010	75.0% (Amber)	61.6% (Red)	57.6% (Red)
Sept 2010	69.8% (Red)	43.3% (Red)	0.0% (Red)

NDTMS RAG - <70% = Red, 70%-79% = Amber, 80%-100% = Green

It is worth noting that NDTMS data reflects only those TOPS completed within specified timeframes. However it can give some indication that carer plan reviews have until recent months been done every 12 weeks in line with best practice, however the exit top performance reflects the unplanned exit rate and the work needed to improve exits both planned and unplanned.

However, TOP percentages are not reflective of the actual numbers of missing TOP which for Peterborough are very low; only three or four per month. This low number means that performance would shift from Red to Green across all three areas of TOP performance if the four missing TOPs had been completed.

Exit TOPs remain hard to improve given that some clients exit treatment in an unplanned way, meaning the caseworkers are unable to complete these. Services will again be asked to look at developing a way to ensure all planned exits have a TOP completed either via a face to face meeting or telephone call.

Recommendation:

- All services to put in place a system that ensure all new starts to treatment who have had an initial start to completed have had a review TOP done within the 6th month timeframe, however these should be done every 12 weeks in line with best practice guidance

3.7 Needle Exchange

There are 15 pharmacies in Peterborough offering needle exchange. This service allows clients to take their used needles to a pharmacy to dispose of them safely. Clients can also obtain new needle packs at the pharmacies. The packs contain syringes, needles, barrels, small sharps disposal bin, citric acid and sterile wipes. Pharmacies collect and dispose safely of any returned injecting equipment.

Injecting related harm reduction services are delivered through Peterborough Drug Services (PDS) needle exchange and open access services. PDS operate a daily needle exchange from one site based at Bridgegate Drug Services, including late night opening hours on Mondays and Thursdays. Coordination with pharmacy needle exchange services is managed through the PDS based harm reduction lead post.

The CASH (Community Action on Sexual Health) Outreach Van also provides needle exchange facilities when in the community. This outreach service goes out to areas where prostitution takes place to provide advice on sexual health and personal safety to the sex workers, as well as providing contraception and needle packs. Sex workers are also encouraged to access treatment services during office hours. In addition, to help with drug treatment, the service supports access to education, housing and benefits.

SPP will be reviewing needle packs in line with the reviews of pharmacy contracts. This will ensure all avenues, such as 'never share' needles are explored. The contracts and needle pack research will be completed in the first quarter of the next financial year. The contracts have been reviewed to ensure Peterborough offer a consistent approach to work with pharmacies and align services with that of Cambridgeshire. The needle packs are being reviewed in order to ensure that the packs are up to date, giving consideration to newer harm reduction products to improve the safety for both individual users and the wider community.[1]

Safe Sharps Disposal Bins

Safe Sharps Disposal Bins were introduced to six identified locations across Peterborough. The Partnership proactively reacts to identified drug 'hotspots' and co-ordinates work with the local Harm Reduction Lead to target these areas for intensive outreach work. In the period between

[1] The current needle exchange and supervised consumption contracts will be reviewed and updated for roll out on 1st April 2010

March 2010 and November 2010, 224 needles and three used sharps bins (portable needle bins which hold up to 10 needles) have been collected from the bins, along with some general litter.

There has been a decrease in the number of reported discarded needle finds in the community in the last quarter, and it is hoped that with continued promotion of needle bins and safe disposal of needles this will continue to decrease in the future. The Harm Reduction Group, chaired by the SaferPeterborough Partnership will continue to monitor 'hot spots' and liaise with providers and cleansing teams to ensure any needle finds are identified quickly, cleared and monitored.

4. Planned &Unplanned Exits

Planned exits still remain an area for improvement in Peterborough in 2011/2012. Services currently ensure all unplanned exits are re-engaged where possible. However further detailed work needs to be done during 2011 to identify if there are more localised trends in why people leave treatment in an unplanned way. As this remains an issue for Peterborough. From this actions and improvements can be made to reduce the number of clients who drop out.

Improved recording and data management during 2010 has increased the number of planned exits, however further work will be needed during 2011/2012 to ensure that exits, transfers and referral coding in NDTMS data are used correctly to ensure accurate reporting and to ensure the services can properly reflect client movement through the treatment system.

The data for 2010/2011 shows an improvement (drop) in unplanned exits from 61 unplanned exits in quarter one (April, May and June) to 41 unplanned exits in quarter two (July, Aug and September) a drop of 25%. This could be a result of the more focused work being done by services to monitor exits.

Planned exits for 2010/2011 are consistent with 2009/2011 with on average 35 planned exits per month across the system, there was an increase of exits in quarter one (41 exits) and this was probably due to increased staffing at the prescribing service during this time, as additional capacity was specifically commissioned to support move-on and recovery.

Recommendations:

- Further detailed work needs to be undertaken during 2011 to identify why people leave treatment in an unplanned way
- Identify improvements to be made to reduce the number of clients dropping out

5. Education, Employment & Training

The Jobcentre Plus has an important part to play in identifying potential clients and supporting them in recovery. For example, studies show that 80% of people on court orders with Drug Rehabilitation Requirements have unmet skills and employment needs and one in five of those who responded to the NTA's service user survey requested help with education and employment

As part of the Department of Works and Pensions (DWP) Drugs Strategy, PDUs in Peterborough are able to access a number of mainstream and specialist services designed to help them access treatment and incorporate their education, skills and employment aspirations into their drug treatment care plans.

To encourage those who voluntarily declare themselves to be a problematic drug user,(but not in treatment) a Jobcentre Plus personal adviser[2] can refer them to a drug treatment provider for an initial assessment to discuss their treatment options.

The role of the Personal Adviser will look to see whether drug misuse is a barrier to employment for the individual and whether or not they are already in treatment. In instances where the individual has not already engaged with drug treatment they will be referred to the JCP SPOC. Those who voluntarily agree to attend an appointment will be asked to provide consent for Jobcentre Plus to share details with the treatment provider. Where someone declares they are already engaged in treatment the adviser will seek permission from the client to contact the treatment provider to confirm they are currently engaged before marking their file accordingly.

The above process has been running for over a year; however service users still decline to declare to JCP if they are engaged in treatment or have a substance misuse. To date no referrals have been made to service in Peterborough by JCP. It is felt that this is because of a number of reasons

- JCP staff reluctant to ask about substance misuse encase they are not able to manage the clients questions
- JCP staff worried about clients reactions to the question
- Service users unwilling to declare as not sure why JCP need this information
- Service users unwilling to share information encase benefits are affected.

The Partnership has been working with local JCP leads on improving the relationship between service users and JCP as well as working with services to ensure clear and concise information about why JCP need this information is given to services users to encourage them to engage with JCP.

The Partnership and JCP are keen to look at working jointly to ensure support and guidance is offered to all service users on the upcoming government reforms to the welfare and benefits system which will affect a large proportion on the services users in Peterborough.

Currently there is no data available from JCP for Peterborough, as at this time there have been no referrals made to treatment service.

Recommendations

- Work with JCP and SUGA to encourage service users to declare their drug use to JCP
- JCP and Partnership to identify ways of working with users to ensure the changes to the benefit system are communicated in a clear and concise manner and which gives users clear guidance and support
- Work with JCP to inform working relationships with services and service users to encourage engagement and referrals
- Work with JCP to promote all the elements of JCP available to service users who are seeking recovery

[2] Jobcentre Plus personal advisers support those in receipt of Jobseekers Allowance. Pathways to Work personal advisers support those in receipt of Employment and Support Allowance which replaced Incapacity Benefit last year

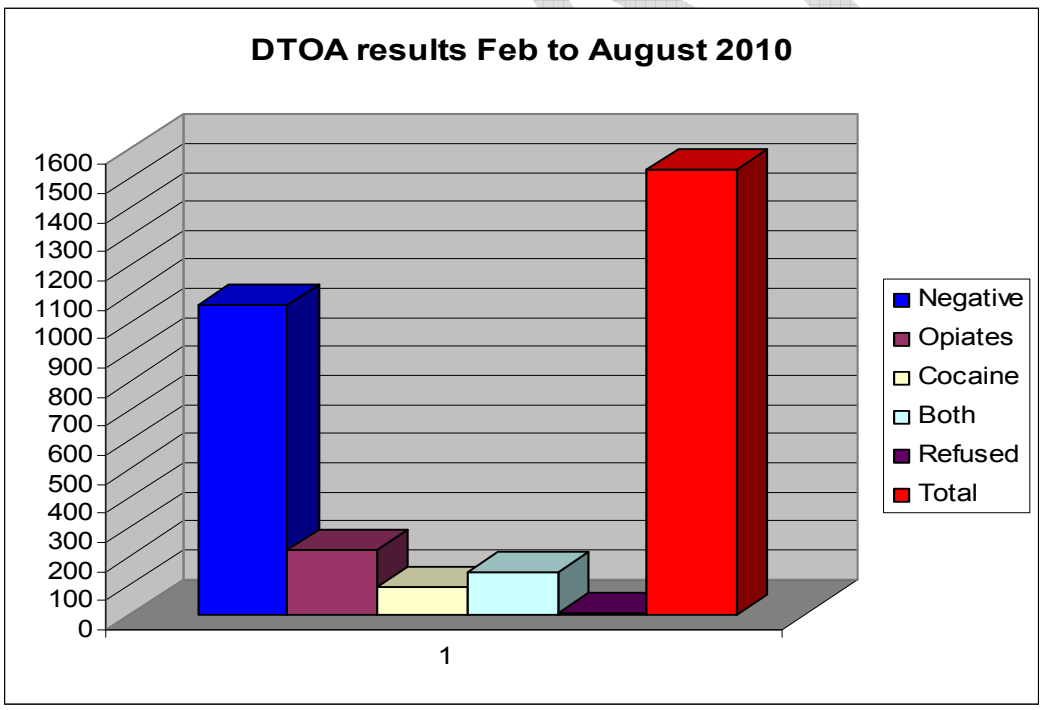
- JCP and Partnership and services to look at promotion the importance of declaring to JCP and the impact that not declaring will have under the upcoming changes to benefits systems

6. Drug Testing On Arrest Data

Extensive analysis of Drug Testing On Arrest (DTOA) data, provided by Cambridgeshire Constabulary, was undertaken in order to establish a view around the changing patterns in those drug users who have been in contact with the local criminal justice system. This has provided a useful insight into the changing patterns seen from 2009 to 2010 around demographic breakdowns of those individuals testing positive for opiates, cocaine or both.

The police can drug test an offender if they are arrested for a 'trigger offence'. Trigger offences include: theft, robbery, burglary, motor vehicle-theft, handling stolen goods, possession of an illegal drug and possession of an illegal drug with intent to supply. Testing is for heroin, crack and cocaine.

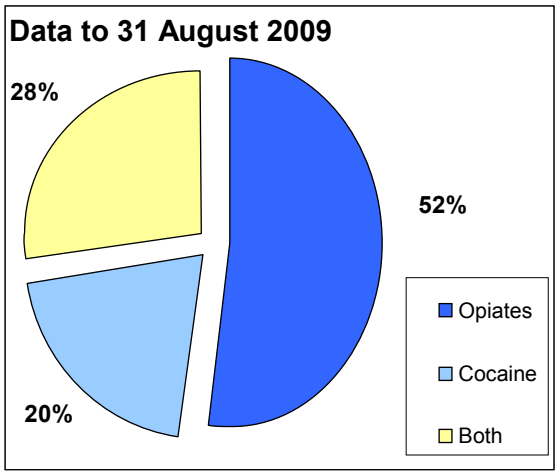
Those who test positive will be required to attend a compulsory drug assessment, even if they are not charged. The assessment, carried out by specialist drug workers, will aim to determine the extent of their drug problem and help them into treatment and other support.

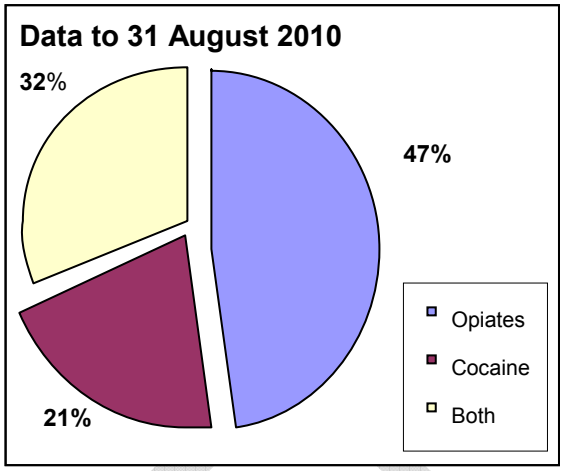


The data above shows the DTOAs carried out between February 2010 and August 2010. Of the 1533 tests carried out between these dates, there were 1065 negative results accounting for 69% of all test results. Opiates was the drug most tested positive for – on its own at 221 or 14.4% of use alongside cocaine at 146 or 9.5%. Total tests positive for opiates stand at 23.9% almost a quarter of all tests carried out. Positive testing for cocaine accounted for 95 results which accounted for 6.2% of all DTOAs carried out between February and August 2010.

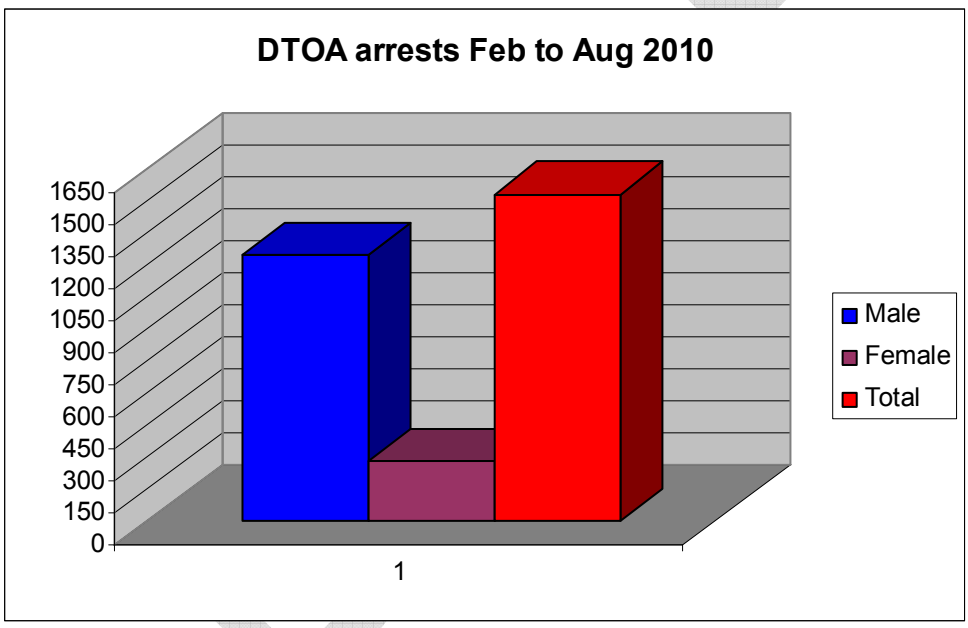
These results mirror those recorded in 2009 with Opiates being the main drug tested positive for in police custody. Negative results in 2009 also mirror those negatives to date in 2010. Use of

cocaine and also cocaine with opiates has declined slightly against figures from last year's needs assessment.





The two charts above show the comparison between the same time frames for 2009 and 2010. Again it is clear to see that the results closely mirror each other with only minor fluctuations between positive tests across opiates, cocaine or those tests proving positive for both substances.



Males make up the majority of the DTOAs accounting for 81% (1249) of those tested. This percentage mirrors that of the general treatment population male to female ratio, and also of the proportion of arrestees. There are no statistics to compare these statistics to from 2009 but it would be envisaged a similar ratio would be seen if figures had been available, bearing in mind the overall treatment population ratio has remained consistently at similar levels since 2008.

Of the 284 females tested, 36.6% (104) provided positive test results, with 44.2%% of those positive tests proving positive for opiates. Add this to those who tested positive alongside cocaine and results show total positives for opiates of 87.5% (91). Of the males tested on arrest, 28% (360) provided positive tests. Opiates was the drug most tested positive for on its own at 48.6% or combined with opiates found alongside cocaine at 28.6% meaning opiate positives accounted for 77.2% of all drugs found in positive tests.

Opiates continue to be the most problematic drug of those tested on arrest which again mirrors those findings of the treatment population as a whole. A larger proportion of females than males testing positive were for opiates.
The table below shows a breakdown of positive drug tests on arrest by nationality. It is worth noting that the 2010 figures are to the end of August so do not reflect a full year.

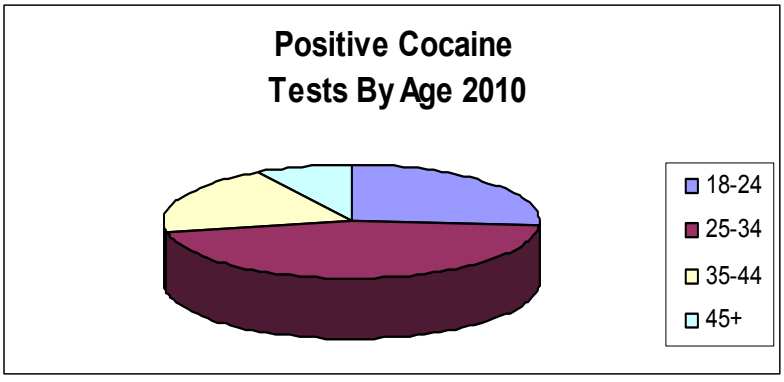
DTOA Data 1 January to 31 August 2009		2008 Figures	2010 Figures	Percentage Change from 2008
All Positive Tests	British	661	379	-42.6%
	Lithuanian	10	6	-40%
	Slovakian	6	21	250%
	Portugese	30	10	-66.6%
	Polish	1	9	800%
	Latvian	0	11	1100%
	Czech	5	8	60%
	Other	18	18	0%
Positive Total		**730**	**454**	**-37.80**

Despite only having figures to August 2010, it is possible to predict some estimates. Figures for those DTOAs who declared their ethnic background as British in 2010 should see a reduction of approx 95 positive tests for example, based on average monthly reported statistics.

Figures for DTOAs for individuals from Latvia were not recorded in 2008, so therefore will show a significant increase. Polish and Slovakians who were drug tested on arrest in police custody will also show increases in positive testing. This may be due to year on year increases in these groups arriving in the city. These factors can lead to drug use, criminal activity and homelessness, which could see an increase in those arrested and tested by Police, meaning the figures for this group are likely to continue to rise.

Portugese clients drug tested on arrest in Peterborough in 2008 were the second highest nationality to test positive on arrest. However, this is predicted to change in 2010, with Slovakian and Latvians looking likely to have higher rate of positive tests on arrest in Peterborough. The increases in numbers from other nationalities apart from British mean additional work for DTOA staff and the DIP as there is the additional consideration of the language barriers and the need for interpreters.

The pie chart below details how substances that those tested positive on arrest for vary with age. The 25-34 year old age bracket account for 53% of positives for all drug types when tested on arrest. This means that of the 468 drug tests on arrest resulting in a positive result, 248 of these were those in the 25-34 age group.



From the start of 2010 to the end of October there were 221 Inspector's Authority drug tests for violent crime. Offences that fall under this bracket are:

- Public order
- Assault, ABH or common
- Criminal damage
- Rape/sexual Offences
- Possession of offensive weapon
- Threats to kill

Inspector's Authority testing was under utilised previously, but since 2010 these tests have increased and seen one fifth of all tests result in a positive sample. From the test carried out under Inspector's Authority in 2010 to the end of October there have been 45 positive tests recorded. There were 10 positive tests for both opiates and cocaine, 10 for cocaine alone and 25 for opiates. A total of 20% of all Inspector's Authority tests proved positive. This demonstrates the usefulness of these tests.

7. Prison Data

HMP Peterborough is the country's only dual estate (male and female) purpose built prison.

The female side of the prison has a capacity of 360 and it accepts female prisoners from all over the country, but mainly from the following areas – Nottinghamshire, Lincolnshire, Leicestershire, Cambridgeshire, Northamptonshire and Norfolk and Suffolk.

The female prison includes a 12 place mother and baby unit. It holds both remand and sentence prisoners, including young offenders aged 18-21

The male side is a "category B local" prison with a capacity of 624 and serves the local courts for remand, as well as sentenced prisoners.

Both sides have dedicated healthcare units, and separation and care units. They also have a dedicated drug treatment wing which is staffed all the time to be able to monitor and observe substance misuse clients going through either stabilisation or detoxification.

These wings have dedicated nursing staff as well as the additional support of CARATs (Counselling, Assessment, Referral, Advice and throughcare) workers

HMP Peterborough offers both a clinical and psychosocial programme to substance misusers, this includes detoxification and maintenance support as well as one to one and groupwork interventions. This is know as the integrated drug treatment system in prison (IDTS).

HMP Peterborough currently has 132 or 21% of the male population engaged with IDTS (integrated Drug Treatment System), of which 102 (77%) are on maintance prescribing with 30 (23%) currently undergoing detoxification.

There are 87 or 24% of the Females population engaged with IDTS, of which 62 (71%) are on maintance prescribing and 25 (29%) currently being detoxed.

The current CARATS caseloads are 109 (female) and 100 (Males), this means that currently there are 32 male IDTS clients not engaging with additional support. However on the female side they have an additional 22 females receiving support for substance misuse problems that are not requiring medical interventions (drugs Free, Stimulant or cannabis users) Carats work with everyone coming into prison who is identified as having a drug problem and wishes to engage in support in addressing their drug problem.

HMP Peterborough will be conducting their own needs assessment for 2010/2011 – Please refer to this for specific data and details

8. Probation Data

The Drug Rehabilitation Requirement (DRR) has evolved from the Drug Treatment and Testing Order (DTTO). Its aim is to bring persistent and dependant drug misusing offenders into a closely supervised multi-agency programme of treatment, in order to effectively break the links between their drug misuse and their offending. An order can last a minimum of 6 months and up to a maximum of 3 years, within a Community Order with a Supervision Requirement.

Between 1st July 2009 and 31st March 2010 there were 51 adults on active Drug Rehabilitation Requirements (DRRs) with 49 of these being PDUs.

Twenty-nine PDUs commenced a new treatment episode between April 2009 and March 2010, with 15 being retained in effective treatment during the same period for 12 weeks or more. 13 PDUs were identified as not being in effective treatment. There were no planned exits recorded during this time period.

The total of adults subject to a DRR commencing a new treatment episode between April 2009 and March 2010 totalled 32. Sixteen were retained in effective treatment for 12 weeks or more over the same period of time with one exiting treatment in a planned way. Fourteen adults were identified as not being in effective treatment.

Additional data to be added before final submission

9. Drug Related Deaths

The following table shows the level of Drug Related Deaths (DRDs) – (see Appendix A for the NTA definition) within each of the partnerships that make up the East of England region. It is evident that over the three year period covered (2006 – 2008), Peterborough, by head of population, has a standard mortality ratio of 2.41. The Eastern Region mortality ratio stands at 1.00, indicating that the Peterborough DRD rate is over double the Regional rate.

It is worth noting, however, that this review is materially impacted by the 2007 figure of 12 DRDs. If the three year period review had been 2004-2006, then Peterborough would have experienced a mortality ratio of around 1.15, more in line with the average seen elsewhere. Peterborough had 9% of all DRDs in the Eastern Region in 2008.

Partnership	DRDs 2006	DRDs 2007	DRDs 2008	Average DRDs 2006-08	Population aged 15+ mid 2006-08	Rate/100,000 population	Expected deaths	Standard mortality ratio
Southend-on-Sea	6	11	8	8.33	399,239	7.36	10.20	2.83

Peterborough	6	12	11	9.67	394,283	6.26	10.40	2.41
Norfolk	25	41	25	30.33	2,124,733	4.28	55.20	1.65
Luton	4	3	7	4.67	449,006	3.12	11.7	1.20
Cambridgeshire	14	14	14	14.00	1,485,552	2.83	38.60	1.09
Thurrock	3	3	1	2.33	360,342	1.94	9.40	0.75
Bedfordshire	6	6	8	6.67	995,002	2.01	25.90	0.77
Essex	23	24	14	20.33	3,402,564	1.79	88.40	0.69
Hertfordshire	11	12	23	15.33	2,600,506	1.77	67.60	0.68
Suffolk	6	11	11	9.33	1,756,810	1.59	45.70	0.61
East of England	**104**	**137**	**122**	**121.00**	**13,968,037**	**2.60**	**363.00**	**1.00**

Ward name	DRDs 2006	DRDs 2007	DRDs 2008	Average DRDs 2006-08	Population aged 15+ mid 2006-08	Rate/100,000 population	Expected deaths	Standard mortality ratio
East	2	1		1.00	22,182	13.52	0.58	5.15
Paston	1	2	1	1.33	18,271	21.89	0.48	8.33
West			1	0.33	20,458	4.89	0.54	1.86
Barnack		1		0.33	6,694	14.94	0.18	5.68
Bretton North			1	0.33	22,599	4.42	0.59	1.68
Dogsthorpe		2		0.66	21,222	9.42	0.56	3.59
Stanground East		1		0.33	7,395	13.52	0.19	5.14
Stanground Central			2	0.66	20,779	9.63	0.55	3.66
Fletton	1	1	1	1.00	22,079	13.59	0.58	5.17
Walton			1	0.33	13,173	7.59	0.35	2.89
North	1		2	1.00	13,037	23.01	0.34	8.75
Ravensthorpe		1	2	1.00	17,159	17.48	0.45	6.65
Orton Waterville		1		0.33	19,920	5.02	0.52	1.91
Park	1			0.33	20,874	4.79	0.55	1.82
Central		1		0.33	22,938	4.36	0.60	1.66
Orton Longueville		1		0.33	24,049	4.16	0.63	1.58

Paston and Fletton have seen drug related deaths in each of the 3 years documented in the table above. In 2008 there was 1 less DRD than those recorded in 2007, though 2007 doubled those DRDs recorded in 2006.

10. SUGA Survey

Strong service user involvement has been established over the past two years, and SUGA (Service Users Giving Advice) now play a key role in commissioning and contract monitoring of services. ***SUGA were unable to complete a survey this year. However the partnership will be seeking a survey to be done at the start of 2011 to allow for a refresh of this assessment in April 2011***

11. Key Findings & Recommendations

- Details of purity levels should be shared with the treatment agencies so they can make the service users aware as part of their harm reduction messages
- Support the number of clients for whom their concurrent alcohol use is as serious as their drug misuse
- To monitor the number of cocaine only presentations into treatment as well as the number of Cocaine and Alcohol combination presentations
- Further develop/increase capacity of specific brief interventions
- Further analysis of demographics of male alcohol & cocaine user
- To continue to develop working relationships with local A&E, to improve continuity of care and improved joint working to reduce duplication and risk
- Further work to look at increasing the proportion of females entering treatment, as evidence provided through the NDTMS analysis, females as a proportion of the numbers in treatment are still underrepresented
- To look to work with local nurseries to support possible child care issues which may impact of attendance at services, as taking children to service has been idenfied by service users as a barrier to entering and remaining in treatment
- Analysis of NDTMS data to get a better picture of the current number of females in treatment who have children in their care and what can be done to support this
- Look at the use of shared care GP for females with children as access to local GP service maybe preferable to attending drug services, to do accessibility and easy if they have young children
- To look at the increasing number of clients from the 25-34 age group that are still using at 35+, as this older client group may be more entrenched
- Interventions and support needed to stop the 25-34 age group from becoming longer term substitute prescribing clients especially with those aged 35 years and older
- Look at what can be done to support those currently in the 18-24 age group from becoming long term users or being on long term substitute prescribing
- To continue to look at barriers to engaging BME clients into treatment
- Work with local BME communities to promote the benefits of treatment
- Monitor the impact of the increase of A8 & A10 countries presenting for treatment (including increase need for translation service, increased pressure to the treatment services and system etc)
- Partnership to confirm local process for dealing with clients who officially have no recourse to public funds

- Work with partners to support the reconnection of clients who are returning to their home countries, including support to access detoxification prior to leaving where appropriate

- To look at why the injecting culture continues to develop in Peterborough unlike other areas nationally where injecting is on the decline

- To look at methods of discouraging first time injectors or to engage those who have only just started injecting

- More work on safer injecting and alternatives to injecting should be used in needle exchanges and by service providers to address the increases in injecting by clients

- Increased awareness work with GP's locally to encourage referrals of clients into treatment and discuss any potential barriers GP see to getting their patients into treatment

- Work required to look into those clients currently in treatment for over four years with view to moving on in treatment with recovery agenda in mind

- Further work to be done with PCT colleagues to look at the barriers with regards to GPs signing up to deliver share care for substance misuse

- Structure day programme to be reviewed with regards to what is currently offered – to be done in conjunction with service users to ensure programmes support the wider recovery journey of service users and improve uptake of these interventions

- Monitor the use of the detox bed at the Cavell Centre and promote its use with providers. There will also be a need to consider spot purchases of detox beds when the one bed at Cavell is being used

- Continued work to promote tier 4 as a treatment option with service

- To continue to run tier 4 provider session for case workers

- To support HMP Peterborough in using tier 4 as treatment option straight from custody

- Look at standardised paperwork for tier 4 application, assessment and pre placement work across all service including HMP Peterborough

- All services to put in place a system that ensure all new starts to treatment who have had an initial start to completed have had a review TOP done within the 6th month timeframe, however these should be done every 12 weeks in line with best practice guidance

- Local level work needs to be done during 2011 to at more localised trends in why people leave treatment in an unplanned way as currently we only use the NDTMS codes which do not allow for a more localised picture of drop out

- From localised information see if any improvements can be made to reduce the number of drop outs

- Work with JCP and SUGA to look at process of getting service users to declare to JCP

- JCP and Partnership to look at ways of work with users to ensure the changes to the benefit system are communicated in a clear and concise manager and which give users clear guidance and support

- Work with JCP to inform working relationships with services and service users to encourage engagement and referrals
- Work with JCP to promote all the elements of JCP available to service users who are seeking recovery
- JCP and Partnership and services to look at promotion the importance of declaring to JCP and the impact that not declaring will have under the upcoming changes to benefits systems
- Consider any new areas highlighted within the upcoming drugs strategy (December 2010)

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Probation Service

Appendix A – Drug-Related Deaths Definition

Since 1993, the Office for National Statistics (ONS) has reported the numbers of 'drug-related deaths' in England and Wales. Deaths from 'drug-related poisonings' due to drug abuse and drug dependence involving illegal drugs are reported as part of wider 'drug-related poisonings' dataset, involving both legal and illegal drugs.

Drug-related deaths are hard to define and to quantify. There is no one definition of what is meant by drug-related death. However, the NTA uses the definition set out by the Office of National Statistics (ONS), who produces national data on drug-related deaths:

'Deaths where the underlying cause is poisoning, drug abuse, or drug dependence and where any of the substances are controlled under the Misuse of Drugs Act (1971).' (ONS: 2006)

Types of drug-related deaths

There are two broad categories of drug-related death:

1. Sudden-onset deaths – typically associated with overdose

Sudden-onset drug-related death is associated with overdose caused by opiate-based drugs (heroin or methadone), which are implicated in 70 per cent of cases . Often this type of mortality involves the use of opiates with other depressant drugs like alcohol and benzodiazepines.
The UK research evidence base clearly highlights who is most likely to die from an overdose and when that death is most likely to occur:

Who? This type of death is particularly noted amongst opiate drug users with a reduced tolerance

When? Such opiate drug users are particularly vulnerable in the transitional periods of their drug using career. For instance when:

- Leaving prison
- Discharged from drug treatment (especially 'unplanned' discharges)
- Leaving residential drug treatment (Tier 4)

2. Gradual-onset deaths - associated with blood borne viruses (BBV)

Gradual-onset drug-related deaths occur from BBVs such as hepatitis C and B viruses and the Human Immunodeficiency Virus (HIV), which may lead to death many years after the first initial transmission of the infection.

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