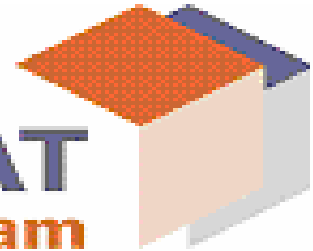


HAMPSHIRE DAAT

Drug & Alcohol Action Team



Strategic Review Information Pack

FINAL

OCTOBER 2008



Hampshire
County Council

Hampshire **NHS**
Primary Care Trust

HAMPSHIRE DAAT
Drug & Alcohol Action Team



NOTE : This FINAL version of the SRIP has been updated to include all comments received in response to the DRAFT document by the 19 September 2008

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1 Foreword

Hampshire County Council Perspective

Hampshire County Council is a top performing authority, rated as 'four star' by government. Our ambition is to keep it that way, while we continually improve our performance in the interests of the communities we serve.

Looking after Hampshire, our job is to ensure the county is safe and secure and to work towards enhancing the County's quality of place. Looking out for our residents, we want to work with them to feel safe and secure and maximise their wellbeing. Our aim is to lead and work in partnership with other organisations to remove barriers and improve choices whilst encouraging people to make their own decisions on the way they access services. The priorities are:

- Hampshire safer and more secure for all
- Maximising wellbeing
- Enhancing our quality of place

These three priorities are designed to reflect the political vision and direction of our publicly elected councillors and give a clear statement of what the Hampshire community can expect in terms of service delivery and the focus of our work as a local authority.

The PCT Perspective

Hampshire Primary Care Trust (PCT) exists to improve health and healthcare for the 1.3 million people living in the county, reduce inequalities in health and ensure that people have access to safe, high quality, efficient health services. In order to accomplish this, we work closely with local communities to develop and provide services ourselves and we commission (buy) a wide range of services from other organisations.

With the support of all our providers we will create a local system which acts seamlessly to improve the health and well-being of our population and deliver care when circumstances require this.

The DAAT Perspective

Tackling drug and alcohol related harm is not the responsibility of any single organisation or agency and success can only be achieved by a true partnership approach, ensuring that the work of local agencies is brought together effectively in a planned and co-ordinated way.

There has been a steady increase in service provision in Hampshire over the past six years, as drug and alcohol issues have gained a greater prominence on national and local agendas. However, the program will have to be cut to reflect significant reduction in funding over the next 3 years. This presents a significant challenge to all partners - but also an opportunity to undertake a root and branch review of how and why we do things the way we do and to ensure that the services we commission are fit for the future and fit for purpose to tackle drug and alcohol related harm in Hampshire.

Andrew Lloyd
Acting DAAT Chair

The Service User Perspective

The service user provides privileged access to the success of a complex treatment system. Listen carefully, harvesting the service user voice will show what works and why, where challenges remain and what to do to meet those challenges.

One development I hope to see more fully implemented is 'Peer delivery' of services. Peer delivery minimises barriers to engagement, maximising effectiveness.

This review process is our chance to recognise good practice, make use of lessons learned to continually develop a system flexible enough to meet the needs of the next ten years within the constraints of an unpredictable political cycle.

Howard Coulson
Chair Hampshire Working Group

EMMA

2 Aims of the Strategic Review

This review is being conducted in order, to rationalise current commissioning arrangements to address a significant reduction in drugs funding over the next 3 years and to ensure the coordinated development of a robust commissioning strategy for both drugs and alcohol

The Strategic Review will provide a unified and coherent analysis of all funded drug and alcohol services delivered in Hampshire taking account of evidence of met and unmet need

The outcome of the review will be a commissioning strategy which will shape the future provision of substance misuse services ensuring that :

The statutory agencies are commissioning the best possible configuration of services within the remaining available budget ¹

- provision within the overall treatment system meets the needs of the local population within those financial constraints
- service delivery provides a positive and effective contribution to the treatment agenda and meets relevant targets
- all services are effectively contracted and performance monitored.

¹ Hampshire DAAT is required by 2010/11 to reduce its annual spending by 16.5%(approx £1,00,000) against 2007/8 planned expenditure

3 Process and Timetable

STAGE 1 : The Strategic Review Information Pack

The Strategic Review Information Pack (SRIP) sets out the basis for the Review, outlining the health, social care and criminal justice framework within which the programme sits.

The document contains details on strategic and service indicators, targets and outcomes, demographics and information about the client group both nationally and within Hampshire. Details of all services currently commissioned by DAAT for those with substance misuse issues are set out including information relating to capacity, performance and utilisation.

The draft SRIP was presented to all partners and stakeholders (strategic partners, service users, carers and providers) at the beginning of the review process. At this stage all stakeholders were encouraged to read, consider and comment on the draft SRIP, to identify and confirm all data and locally defined targets / objectives within their sphere of knowledge. This document, the 'Final' SRIP has been produced as a result of the input received.

STAGE 2 : The Development Plan

A Development Plan will be produced based upon the consultation and key requirements of the statutory stakeholders, local knowledge or "intelligence" regarding needs and the views of service providers, service users and carers.

It is vital that all agencies and stakeholders play a full part in this process and that they inform and guide the review through effective participation.

STAGE 3: Implementation Phase

The Implementation Plan will set out clearly how the Development Plan is to be delivered and specify the outcome in relation to each existing service. The Plan may require the refinement and/or reconfiguration of the treatment system and services may be commissioned, decommissioned or remodeled to ensure the best possible configuration to meet need, within the available budget. Services will be effectively contracted and performance monitored.

Stakeholders in this Strategic Review include :

- Hampshire County Council Adult Services Department
- Hampshire Primary Care Trust
- Police
- Hampshire Probation Area
- Local Criminal Justice Board
- Community Safety Partnerships
- District Councils
- Voluntary sector organizations which represent and support those with substance misuse problems
- service providers of substance misuse services
- service users and carers

Commissioning Strategy

The Commissioning Strategy will be the product of the Development Plan plus the Implementation Plan.

Timetable

Stage 1	Production of Strategic Review Information Pack – to develop a clear under-standing of what services currently exist and deliver.	July 2008 – September 2008
Stage 2	Consultation with stakeholders, users and carers in order to develop proposals for the future which best meet evidenced need and budget constraints. The Development Plan is produced.	October 2008 – December 2008
Stage 3	Implementation phase : The refinement and or reconfiguration of the treatment system to meet savings targets which may include individual services being commissioned, decommissioned, or remodelled.	January 2009 – March 2010

4 Strategic Context

4a National Drug Strategic Context

UK Drug Strategy

The ten-year drug strategy, *Drugs : protecting families and communities 2008 – 2018* aims to restrict the supply of illegal drugs and reduce the demand for them. It focuses on protecting families and strengthening communities. The four strands of work within the strategy are:

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

Key policies include:

- focusing on the families where parents misuse drugs, intervening early to prevent harm to children, prioritising parents' access to treatment where children are at risk, providing intensive parenting guidance and supporting family members, such as grandparents, who take on caring responsibilities
- developing a package of support to help people in drug treatment to complete treatment to re-establish their lives, including ensuring local arrangements are in place to refer people from Jobcentres to sources of housing advice and advocacy and appropriate treatment
- using opportunities presented by the benefits system to support people in re-integrating into society and gaining employment, with a commitment to examine further how claimants can be incentivised to engage with treatment and other services
- piloting new approaches which allow a more flexible joined up and effective use of resources, including individual budgets to meet treatment and wider support needs.

The National Treatment Agency

The National Treatment Agency (NTA) is a specialist health authority, created by the Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England, to ensure that there is more treatment, better treatment and fairer treatment available to all those who need it. The overall purpose is to increase the proportion of people who successfully complete or, if appropriate, continue treatment. Priority areas of work are :

- Treatment capacity
- Retention
- Criminal justice and Drug Interventions Programme (DIP)
- Access
- Treatment delivery
- Diversity

For the planning period 2008 /11, the NTA introduced a new priority performance approach for community based services - 'Numbers in Effective Treatment '. This is

indicative of an increased emphasis on a Person Centred Planning model of care delivery and a more outcome-focussed approach to performance management.

Models of Care for Drug Misuses (MOCAD)

Models of Care for Treatment of Adult Drug Misusers² sets out a national framework for the commissioning of adult substance misuse treatment in England. Originally published in 2002, Models of Care outlined a four-Tiered model for service delivery, with increasing levels of intervention. This guidance was updated in 2006 and Models of Care: Update 2006 builds upon, clarifies and refines the four-Tier model of service provision outlined in the original 2002 framework, providing national guidance on commissioning and provision of treatment.

The guidance places a greater focus on harm reduction, with interventions integrated into all Tiers of drug treatment. Particular emphasis is placed on minimising the spread of blood-borne viruses, reducing the risks of overdose and minimising the harm to local communities, and users' partners and families.

In 2006 the NTA launched the **Treatment Effectiveness Strategy** to:

- improve the quality and effectiveness of drug treatment
- provide a greater focus on improving
- clients' journeys through more effective drug treatment
- Reintegrate users into local communities (housing, education and employment)

Drug Misuse and Dependence - UK guidelines on clinical management (DH, Sept 2007)

The "Orange Book" guidelines are written for all doctors. They are intended for those doctors who are 'generalists' in the sense that they do not have any particular expertise in drug misuse (e.g. general practitioners, physicians, surgeons and obstetricians); and for those practitioners who have varying degrees of training and expertise treating drug misuses, including specialists in drug misuse and some general practitioners.

The revised Orange Book guidelines reflect developments in the treatment of Substance Misuse in respect to:

- technical developments such as new pharmacological interventions;
- changes in the philosophy of care with an emphasis on the psychosocial interventions and broader health considerations, and support for carers and families;
- changes to treatment models with the introduction of non-medical prescribing and Primary Care-based treatment.

The Guidelines also require the implementation of robust Clinical Governance procedures that consider carers and children and the delivery of effective Harm

² [Models of Care: Update 2006](#) replaces Models of Care: Part 1 (NTA, 2002) and [Models of Care: Part 2](#) Full Reference Report (NTA, 2002) summarises much of the evidence base and is still relevant as a valuable reference source

Reduction programmes – particularly, regarding access to Hepatitis B & C testing and treatment.

4b Local Drugs Strategic Context

The Crime and Disorder Reduction Act 1998 placed a requirement on responsible authorities (local authorities, primary care trusts, police and probation) to undertake audits and development plans in relation to drug misuse. Since 1998 higher tier local authorities have been entitled to receive funding from the Adult Pooled Treatment Budget (PTB), a national budget established by the Department of Health and Home Office (and now supported by the Ministry of Justice). In Hampshire the PTB has been administered by the DAAT. To utilise this funding, the DAAT are required to:

- provide a minimum set of information on the current and planned provision of drug treatment within their area via submission of the Adult Drug Treatment Plan to the National Treatment Agency
- require any drug treatment services which receive funding to make data returns to the National Drug Treatment Monitoring System (NDTMS)

The Adult Drug Treatment Plan must be based on a comprehensive needs assessment. It should outline the DAAT's strategic direction for the delivery of effective adult drug treatment system, identify key priorities and provide detailed plans to deliver those key priorities.

4c Key Priorities identified in The Hampshire DAAT Treatment Plan 2008/9

- Deliver Financially Sustainable Treatment System
- Deliver accessible, inclusive treatment services
- Deliver safe and effective treatment programmes
- Meet the holistic needs of service users arising from or contributing to their drug misuse.

4d National Strategic context – Prisons and Probation

National Offender Management Service (NOMS) is based within the Ministry of Justice. NOMS has been restructured to join up prison and probation services, to enable Offender Management to be delivered more easily, and to strengthen and streamline commissioning to improve service efficiency and effectiveness. It is responsible for the commissioning and delivery of adult offender management services for England and Wales. By 2010 NOMS aims to have made a significant reduction in re-offending rates. NOMS will:

- protect the public
- transform the way we punish and manage offenders
- reduce re-offending
- cut crime

NOMS is responsible for three relevant Public Service Agreement (PSA) targets to reduce re-offending and the NOMS reducing re-offending agenda requires the government to tackle a wide range of factors through the seven NOMS reducing re-offending pathways by working with offenders to change their behaviour and addressing the issues that may lead them to re-offend.

- Accommodation
- Education Training and employment
- Health
- Drugs and Alcohol
- Finance benefit and debt
- Children and families
- Attitudes thinking and behaviour

NOMS will tackle offenders drug and alcohol problems:

- Address the needs of problematic drug users (PDUs) when they first come into contact with NOMS, to reduce the chances of them re-offending and help prevent the harm they cause themselves and others:
- provide end-to-end drug treatment for PDUs before, during and after sentence, co-coordinated with the Drug Interventions Programme (DIP)
- reduce drug misusing offenders' re-offending
- reduce illicit use of drugs by offenders
- reduce the physical harm caused to drug misusing offenders and others
- ensure robust links with other agencies, including DIP
- Build on the national Alcohol Harm Reduction Strategy to improve treatment and support for offenders with alcohol misuse problems.

4e National Strategic Context - Drug Interventions Programme

The Drug Interventions Programme (DIP) was introduced in 2003 as a key part of the Government's strategy for tackling drugs and reducing crime. with an overall aim to divert adult drug-misusing offenders :“*Out of Crime and Into Treatment*”. National policy with regards DIP is principally contained within:

- National Drug Strategy
- NTA Models of Care
- National Offender Management System (NOMS) Drugs Strategy
- Home Office DIP guidance

The National Drug Strategy 2008-2018³ key priority is identified as “*Protecting communities through robust enforcement to tackle drug supply, drug related crime and anti-social behaviour*”.

³ www.drugs.homeoffice.gov.uk/drug-strategy/overview/

The corresponding National Drug Strategy Action Plan 2008-2011, contains significant number of strategic objectives linked to key actions and outcomes which impact upon delivery of DIP in Hampshire. These are :

- Proactively targeting and managing drug misusing offenders
- Maximising the effectiveness of prison and community sentences
- Engaging and empowering communities with stronger, locally responsive law enforcement
- Preventing harm to communities by reducing the supply of drugs into and within the country

The National Crime Strategy 2008 -11, 'Cutting Crime – A New Partnership': states that drug misuse is key driver of crime and that drug treatment can have a significant impact upon offending behaviour. The ability to refer to specialist drug treatment services from within the criminal justice system is seen as essential to reducing offending. The National Community Safety Plan 2008-11 identifies the need to work with partners to tackle drug misuse, through interventions such as DIP.

4f Local Strategic Context - Drug Interventions Programme

The Hampshire Drug Interventions Programme is a key element for tackling drugs and reducing crime through diverting drug misusing offenders 'Out of Crime Into Treatment'.

The DIP aims to reduce drug related crime by taking advantage of opportunities within the criminal justice system for accessing and engaging drug misusing offenders and moving them into and retaining them in treatment, and supporting them away from drugs and crime.

The Hampshire DAAT area model is to have a single integrated service providing interventions and links throughout the criminal justice system. DIP interventions are based around three strands of activity:

- Criminal Justice Integrated Teams (CJIT) who access and engage with drug misusing offenders at all stages of the criminal justice system
- Providing specific treatment interventions for those subject to Drug Rehabilitation Requirement (DRR) and other statutory criminal justice drugs initiatives, including PPO
- Maintaining a 24/7 Single Point of Contact (SPOC) for information, advice and support for both professionals and clients

4g Local DIP Priorities

Four Key Priorities have been identified within the Hampshire DAAT Treatment Plan 2008-09 for the DIP programme,

- Resourcing the Drug Intervention Programme
- Aligning the Drug Interventions Programme (DIP) and Prolific & Priority Offender (PPO) programme
- Increasing client engagement
- Resourcing the Aftercare services

4h HMP Winchester Drug Strategy, Mission Statement

Winchester Prison is committed to significantly reducing the access to and demand for drugs by offenders. It aims to achieve this by developing constructive regimes that provide both opportunities to challenge and address drug misuse and incentives to change behaviour and accept support. Winchester Prison is also committed to building partnerships, working with the community and other criminal justice agencies, to ensure the offender continues to make progress on release.

Guiding principles are :

- Reducing the supply of illegal substances
- Reducing the demand for illegal substances
- Reducing the harm from illegal substances

Purpose and aims are

- To assess offenders' drug usage and the impact this has on their offending behaviour and their personal and social well being
- To reduce the supply of illicit drugs into the Prison
- To reduce the demand for illegal substances through appropriate interventions
- To provide a drug-free environment
- To provide treatment, support, and throughcare.

4j National Alcohol Strategic Context

The National Alcohol Harm Reduction Strategy⁴

The National Alcohol Harm Reduction Strategy (NAHRS) was implemented in March 2004. The document set out the policy framework for alcohol and highlighted the costs to society of alcohol-related crime, disorder and anti-social behaviour. The Strategy comprises four main strands:

- Education and Communication
- Identification and Treatment
- Alcohol Related Crime and Disorder
- Supply and Industry Responsibility

Models of Care for Alcohol Misusers (MOCAM)⁵

MOCAM gives guidance to commissioners of alcohol treatment services in developing a local stepped care approach, mirroring the models of care for drug misusers.

Safe Sensible Social: The next steps in the National Alcohol Strategy⁶

This document reviews progress since the publication of the Alcohol Harm Reduction Strategy for England (2004) and outlines further national and local action to achieve

⁴ [Alcohol Harm Reduction Strategy](#)

⁵ [Alcohol Misuse - Tackling the UK Epidemic](#) and [National Alcohol Strategy Implementation Toolkit](#)

⁶ [Safe Sensible Social](#)

long-term reductions in alcohol-related ill health and crime. It focuses on three key groups:

- Young People under 18
- 18 – 24 Year old binge drinkers,
- Harmful drinkers

4k Local Alcohol Strategic Context - the Hampshire Alcohol Strategy

The Hampshire Alcohol Strategy (2006) was developed in consultation with partner agencies and service users and was a driver for an increased awareness of the impact of alcohol misuse in Hampshire. The document encompassed a wide range of thematic issues which have been developed and incorporated into the Hampshire LAA Alcohol Flagship; leading to the development of the 10 Point Plan⁷. The 10 Point Plan addresses alcohol related issues as they affect all agencies. Actions are to :

1. Review and update the Hampshire Alcohol Strategy
2. Develop opportunities to jointly commission substance misuse services
3. Promote effective linkages between alcohol services and Supporting People services;
4. Develop and mainstream Tier 2 services for young people, their families and carers, including advice, information, brief interventions, group work etc.).
5. Develop schemes with Accident & Emergency Departments for accurate data collection and the development of alcohol worker posts
6. Develop and deliver 'Brief Intervention' training for all front line staff
7. Develop adult brief Intervention/ Tier 2 services building on existing countywide drug provision.
8. Tier 2 service provision in a criminal justice setting
9. Develop a Communications Strategy around alcohol activity
10. Promote the activities of partners and agencies in relation to developing a safe Night Time Economy

4l Local Drugs and Alcohol Context - Health

The PCT mandate is to plan and commission the range and quality of services that the public we represent need. The PCT intend to commission evidence-based, high quality, cost-effective healthcare, which is fair, personalised, effective safe, locally accountable and meets appropriate professional standards to improve the healthcare of the population.

With the support of all providers the PCT will create a local system which acts seamlessly to improve the health and well-being of the population and delivers care when ill-health requires this. In 2008/09 the PCT will seek to address health inequalities including alcohol and commission services in order to deliver improvements in the mental health and well-being of Hampshire residents.

PCT Aim 1

Improving the health and well-being of people in Hampshire by addressing health needs and reducing health inequalities and working with service users, clinicians and our communities to deliver effective NHS care in Hampshire.

⁷ http://www3.hants.gov.uk/alcohol_10_point_plan.pdf

PCT Aim 2

Commissioning a comprehensive range of high quality, efficient and effective services by commissioning in an equitable, responsive way within the resources available and in partnership with practice based commissioners, local authorities and other stakeholders.

PCT Aim 3

Ensuring that we deliver high quality, responsive, efficient and effective care which is patient focused, provides added value for money, is closely monitored to ensure delivery on agreed outcomes and is led through effective clinical leadership.

PCT Commissioning Intentions - Alcohol Services

The PCT wishes to work in partnership with councils, voluntary services and other stakeholders to achieve national target compliance for alcohol harm.

Key components are the development of A&E data collection on alcohol related attendances at Winchester and Basingstoke and targeted brief intervention services consistent with Hampshire's Alcohol Strategy and the LAA 10 point plan.

PCT Commissioning Intentions - Offender Health Care

Key components are :

- Develop a Hampshire-wide strategy for offender health care
- Re-commission health care services (including detox provision) at Winchester prison and the Immigration Removal Centre (IRC) Haslar in partnership with HMPS.

Other PCT plans

The PCT plan to include substance misuse when looking at items for inclusion as Local Enhanced Services within the GP contract. The PCT also hope to expand the existing Community Pharmacy services for supervised consumption and needle exchange.

4m Dual Diagnosis

The National Service Framework annual assessment 2007 states that PCT mental health commissioners should work in partnership with key stakeholders to ensure that the needs of people with dual diagnosis are identified and met locally and commissioned in accordance with standards published by the Health Advisory Service (2001), the Substance Misuse and Mental Health Co-Morbidity (Dual Diagnosis) Standards for Mental Health Services⁸.

4n Young People

This review must also consider how the adult treatment system interfaces with young peoples services and how transitional arrangements for young people entering adult service provision are developed and agreed.

'Assessing young people for substance misuse' published by the National Treatment Agency for Substance Misuse in 2007 provides the framework for specialist substance misuse assessment for young people approaching adulthood, or where

⁸ The term 'dual diagnosis' indicates the co-occurrence of symptoms of two or more disorders although the term .may not sufficiently capture the complex interactions between substance misuse and psychiatric disorders

the severity of their substance misuse indicates they should be retained in substance misuse treatment by transition to adult drug services.

4o Safeguarding families

The report 'Hidden Harm' was produced as the result of an inquiry carried out by the Advisory Council on the Misuse of Drugs (2003), and focused on children in the UK with a parent, parents or other guardian whose drug use has serious negative consequences for themselves and those around them. The Report considered a number of themes each of which is supported by a series of recommendations. More recently work has been undertaken nationally looking at the links between alcohol and hidden harm⁹.

The national drug strategy also places a new focus on families, addressing the needs of parents and children as individuals, as well as working with whole families to prevent drug use, reduce risk and get people into treatment. In Hampshire, a number of areas of work have been identified, through 'risk management', that respond to needs of children and families

Home Office research entitled 'Around Arrest Beyond Release' (August 2007) highlighted the potential risks posed by substance misusing offenders, to families and communities, at certain stages within the criminal justice system. This reinforced initial local research undertaken as part of the alignment of DIP and PPO.

Locally, the Hampshire Safeguarding Children's Board (HSCB) commissioned a revision of the Joint Working Protocol for safeguarding children, recognising the risks to children affected by the substance misuse of adults. This has been ratified by the local Safeguarding Board.

Work is also starting on a pilot project adopting the 'Think family' approach linking staff from substance misuses, mental health and Children's services in working with high risk families.

⁹ <http://www.turning-point.co.uk/NR/rdonlyres/33C57B5C-BB5E-49A2-8232-B77B081BDC41/0/Bottlingitup06report.pdf>

5 Indicators and Targets

5a Public Service Agreements, Departmental Strategic Objectives and National Indicators

In 2006 the Local Government white paper 'Strong and prosperous communities' promised local government greater flexibility to set priorities and greater discretion over how to meet them. As a result over 1,200 indicators previously used to measure performance have been reduced to less than 200, contained within the new National Indicator set.

In October 2007 the Government announced 30 cross-departmental Public Service Agreements (PSAs), setting out its top priorities as part of the Comprehensive Spending Review. These apply over the spending period from 2008 to 2011. The National Indicator set will be used to assess performance in relation to the PSAs.

PSA Delivery Agreement 25, 'Reduce the harm caused by alcohol and drugs is key to the DAAT strategic review, impacting on community safety, health and wellbeing of individuals and the development and wellbeing of young people and their families.

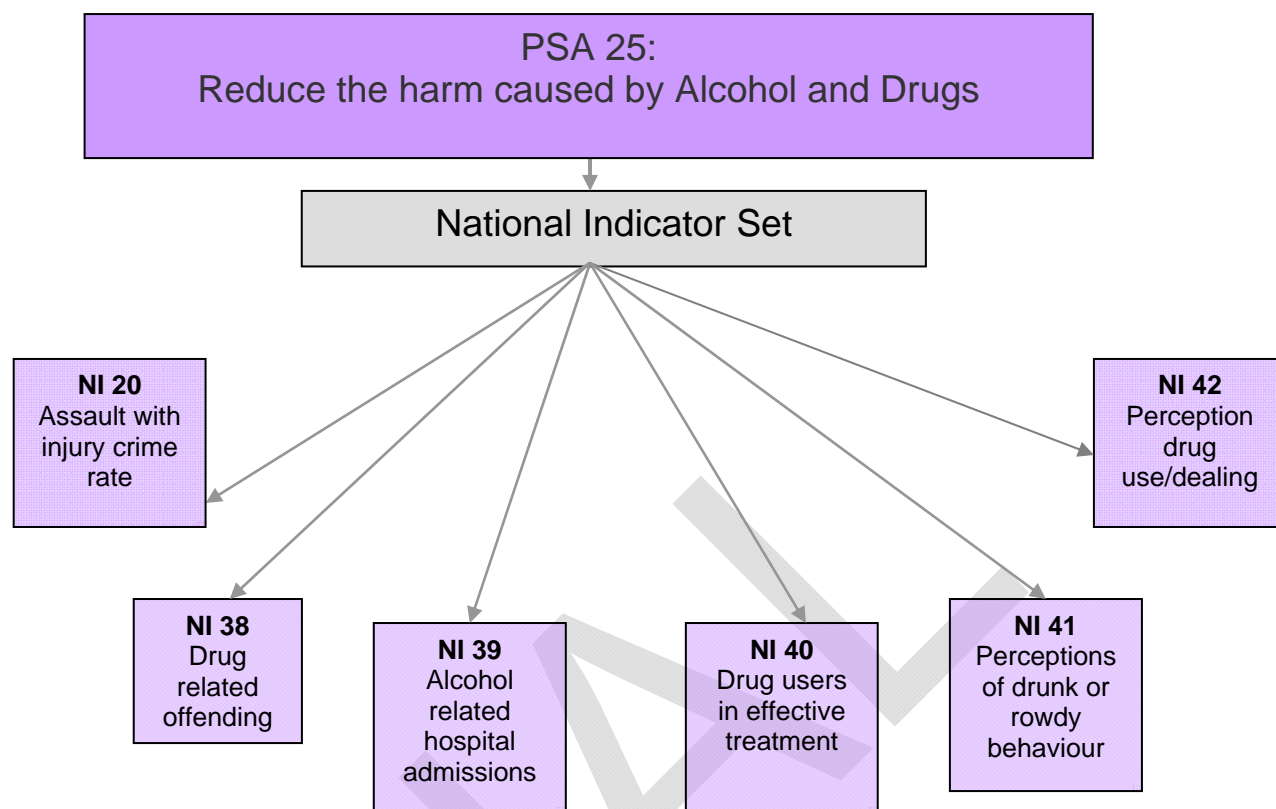
The PSA sets reducing the harms caused by alcohol and drugs as a key cross-Government priority. The PSA will be supported by the alcohol strategy published last June and the new drug strategy published on 27 February 2008. The PSA Delivery Agreement took effect from April 2008.

It is a joint alcohol and drugs PSA Delivery Agreement reflecting the fact that problem drug use and harmful alcohol use are public health and social issues and that they also have a significant impact on society, particularly deprived communities and vulnerable people

The Alcohol and Drugs PSA is closely linked to several other PSAs, for example action on young people and drugs is covered within Department of Children Schools and Families (DCSF's) PSA on increasing the number of children and young people on the path to success. It provides a framework for supporting the delivery of the new drug strategy

- reducing the harms caused to the development, achievement and well being of young people and families
- reducing the harms caused to the health and well being of drug users and those using alcohol in harmful ways
- reducing the harms caused to the community as a result of associated crime, disorder and anti-social behaviour
- increased focus on outcome indicators

The new PSA Agreement is also directly reflects the development of the national indicator set for the Local Government Performance Framework, the new Health and Social Care Outcomes and Accountability Framework, the Home Office's Assessments of Policing and Community Safety, the National Offender Management Service's (NOMS) performance management framework and the Youth Justice Board's performance management framework.



National Indicators most relevant to the Drug and Alcohol agenda:

Outcome	National Indicator	
Safer Communities	NI 20	Assault with injury crime rate PSA 25
Safer Communities	NI 30	Re Offending Rate of prolific and priority offenders HO DSO ¹⁰
Safer Communities	NI 38 ¹¹	Drug related offending rate PSA 25
Safer Communities	NI 39 ¹²	Alcohol-harm related hospital admission rates PSA 25
Safer Communities	NI 40	Drug users in effective treatment PSA 25 (linked to DH Vital Sign 14)
Safer Communities	NI 41	Perceptions of drunk or rowdy behaviour as a problem PSA 25
Safer Communities	NI 42	Perceptions of drug use or drug dealing as a problem PSA 25

¹⁰ (NOTE : The Comprehensive Spending Review also set out Departmental Strategic Objectives (which underpin the national indicators and PSA's)

¹¹ Technical definition awaited

¹² This includes both acute and chronic alcohol harm related conditions

There are also other indicators which sit within other PSA's which are relevant to the DAAT activity.

Public Service Agreement		National Indicator	
PSA 14	Increase the number of children and YP on the path to success;	NI 115	Substance misuse by young people
PSA 23	Make communities safer	NI 15	Serious violent crime rate
		NI 16	Serious acquisitive crime rate
		NI 17	Perceptions of anti social behaviour,
		NI 18	Adult reoffending rates for those under probation supervision
PSA 24	Delivering an improved criminal justice system		No specific NI

From June 2008, the new Local Area Agreements (LAAs) will be the principal means by which the PSAs are delivered.

5b Local Indicators

Hampshire Local Area Agreement (Including targets agreed by GOSE)

Theme E: Safer communities						
Improvement Priority	NI	Base	Year 1	Year 2	Year 3	Indicative Partners
Alcohol Related Public Violence	*NI 20 Assault with injury crime rate	6.14 crimes per 1000 population in 2007/08 based on mid-2006 population estimates (7,772 offences)	4.2% reduction = 5.88 crimes per 1000 population in 2008/09 based on mid-2007 population estimates	To be negotiated 2008/9 (first refresh)		*Hampshire Police, HCC, YOT, 11 district CDRP's, DAAT
Reduce adult re-offending (PPOs)	*NI 30 Re- offending rate of prolific and priority offenders	Available from June 2008	24%	First yr target only		*Hampshire Police, HCC, Probation, YOT, 11 district CDRP's
Tackle drug related offending	*NI 38 Drug related (class A) offending rate		Indicator and target setting deferred by Gvt until 2009			DAAT, Hampshire Police, HMP Winchester, Hampshire Probation Area, 11 District CDRPs
Theme F: Health and well-being						
Improvement Priority	NI	Base	Year 1	Year 2	Year 3	Indicative Partners
Tackle alcohol abuse (Alcohol Flagship – 10 point Plan)	(Local PI) LI F4: Alcohol harm related hospital admissions	Hampshire Admissions per 100,000 PSA 25	1,154	1,230	1,303	*Hampshire PCT, Hampshire Police, Hampshire DAAT, Hampshire Health and Wellbeing Partnership (HWBP)

Note : In addition to the National Indicators listed above (both at national and local level) above there are a number of additional indicators where drugs and alcohol have an impact.

5c Hampshire DAAT Drug Treatment Plan 08/09 - Drug Treatment Indicators and Targets

Core Indicators

Over time there has been a shift in emphasis in the national targets placed upon local partnerships from recording purely numbers into treatment, to considering retention, to considering outcomes. The new national indicator 'drug users as being recorded in effective treatment' is a result of this shift.

Drug users recorded as being in effective treatment	% change 2008/09 (from baseline year)	% change 2009/10 (from baseline year)*	% change 2010/11 (from baseline year)*
Crack and/or opiate users recorded as being in effective treatment (PDUs)	2	4	5
This indicator is embedded within the National Indicator Set and maps to the Vital Signs target VSB14.05. The % change agreed can therefore also be used within these plans ¹³			
All Drugs (18+) recorded as being in effective treatment. This indicator is embedded within the National Indicator Set.	2	tbc	tbc

The measures above are intended to drive improvements on the 2007/08 baseline (i.e. the annualised figure for that year) on the number of drug users recorded as being in effective treatment.

The first indicator measures the % change in the number of drug users using crack and/or opiates in treatment in a financial year, who are still in continuous treatment, who are discharged from the treatment system after 12 weeks or if discharged before then, were successfully discharged in a care planned way as a % change from baseline performance in 2007/08. This will include young people under the age of 18 as well as those over the age of 18.

The second indicator measures all drug users aged 18 and over recorded as being in effective treatment. The % change in the number recorded as being in effective treatment captures plans for all adults who require drug treatment regardless of the type of drug being used.

The annualised numbers for 2007/08 were made available to partnerships in August 2008 and are set out with the targets for each of the three years in the table below

Year	% Change	PDU's in Effective Treatment	All Drugs 18+ in Effective Treatment
2007/8	Baseline	1623	1844
2008/9	2%	1655	1881
2009/10	2%	1689	tbc
2010/11	1%	1705	tbc

Plans set for 2009/10 and 2010/11 will be reviewed annually through the adult drug treatment planning process against actual performance and through other local review processes as part of the LAA and PCT plan arrangements.

Currently available data

Retention and care planned discharge (Also PAF A 80)	% planned 2008/09
Percentage of new presentations to be retained in treatment for more than 12 weeks or subject to a care planned discharge within the first 12 weeks	81

Retention in treatment and care planned discharge before 12 weeks is currently the best available measure of the effectiveness of local drug treatment systems and services. Individuals not retained for at least 12 weeks are unlikely to experience long-term benefit from treatment. However, retention at 12 weeks is merely the point at which sustainable change begins to be discernible and many individuals will need to be retained in treatment for much longer, perhaps years, before they reach their treatment goals. There will also be some instances where a care planned discharge in advance of 12 weeks is part of effective drug treatment delivery.

Treatment system exits	% planned 2008/09
Individuals leaving the treatment system in a planned way	51 %

Treatment system exits require the DAAT to focus on overall performance in relation to care planned exits from the treatment system. Care planned exits from the treatment system follow the whole journey of the client and are based on the last discharge reason when the client has exited all treatment interventions (Tiers 3 and 4). This will be determined by every episode making up the treatment journey being closed. Unplanned exits from the treatment system may be indicative of poor or absent care plans which may be indicative of poor quality or ineffective treatment.

Primary care prescribing				
Primary Care Trust (PCT)	Hampshire			
Number of primary care practices in PCT area covered by partnership	146			
	2007/08		2008/09	
	Number	Percentage	Number	Percentage
Practices who are delivering primary care-based treatment within a commissioned service model	9	6%	20	14%

This target provides information on the current picture regarding the involvement of primary care in drug treatment.

In addition to these national partnership targets there are a number of other measures formerly know as 'partnership performance expectations', together with waiting times which are being used locally as proxy indicators for treatment effectiveness and quality.

Diagnostic Indicators

These indicators provide partnerships with additional information with which to make an assessment of quality within the treatment system.

Waiting times

This is defined as the wait for individuals to commence Tier 3 or 4 structured drug treatment. For the first intervention it is measured from the date of an individual's initial contact with the treatment system to the date an individual commences (or is offered an appointment to commence) care planned structured treatment, following triage/assessment.

For subsequent waits, it is measured from the date of referral on to the subsequent intervention. The targets in relation to waiting times refer to the percentage of clients who commence their first episode of treatment within three weeks, and for subsequent treatment intervention the percentage of those clients already in treatment who wait no longer than three weeks between treatment interventions.

As part of the NTA quarterly review, waiting times are subject to exceptions reporting where a significant number or pattern of waits exceed six weeks. NTA guidance in respect to Tier 3 and Tier 4 interventions states:

"The NTA have recommended that partnership plans in relation to waiting times is to establish as a norm that individuals will commence their first episode of treatment within three weeks, and that those already in treatment will wait no longer than three weeks between treatment interventions"

("Guidance for Regional Teams Performance assurance – Adult Drug Treatment System 2008/9 (Revised July 2008)")

The guidance makes no distinction between the nature of the interventions referred to and, consequently, the DAAT has imposed a blanket performance target across all treatment types.

Adults only waiting time to first treatment intervention <i>See Models of care 2006 for definitions of structured treatment interventions</i>	Planned performance %		
	2006/07	2007/08	2008/9
Inpatient drug treatment	60%	65%	98%
Residential rehabilitation	85%	85%	98%
Specialist prescribing	81%	85%	98%
Primary care/shared care prescribing	100%	100%	98%
Day programmes	85%	85%	98%
Psychosocial interventions	80%	85%	98%
Other structured treatment	-	-	

Waiting time to subsequent treatment intervention See Models of care 2006 for definitions of structured treatment interventions	Planned performance %		
	2006/07	2007/08	2008/9
Inpatient drug treatment	60	65	75%
Residential rehabilitation	85	85	75%
Specialist prescribing	81	85	75%
Primary care/shared care prescribing	100	100	75%
Day programmes	85	85	75%
Psychosocial interventions	80	85	75%
Other structured treatment	-	-	

Care Planning

Care planning is a key element of the NTA Treatment Effectiveness Strategy, recognising that the combination of good care planning, co-ordination of care and frequent reviews of care plans with service users, is the mechanism to deliver improvements to individuals' health and social functioning and reduce the public health and crime risk they pose to others. The NTA recommend that partnerships set a target in relation to care plans that requires 95% of individuals in treatment to have a written care plan, which tracks their progress and is regularly reviewed with them

Proportion of individuals starting treatment who have a care plan	Planned performance %		
	2006/07	2007/08	2008/09
	100%	95%	100%

General healthcare assessment	Planned performance %		
	2006/07	2007/08	2008/09
Percentage of new presentations completing a general healthcare assessment	60%	70%	90%

Harm reduction initiatives

The following indicators are used demonstrate harm reduction activity in relation to reducing the spread of blood borne viruses and reducing drug related deaths.¹⁴

A new target has been introduced for Tier 3 services which recognises their role in supporting service users to access HBV treatment:

"Percentage of individuals for whom Intervention Status is recorded as "Offered and Accepted" subsequently referred for Hep B vaccination"

¹⁴ Data is provided by NDTMS – only information which is reported to NDTMS will appear in performance reports

Indicators and targets

Vaccinations against Hepatitis B Virus (HBV)	Planned performance		
	2006/07	2007/08	2008/09
Percentage of new presentations offered HBV vaccinations	70%	80%	100%
Percentage of new presentations who accept the offer of HBV vaccination who commence the vaccination programme	25%	25%	To be notified

Hepatitis C Virus Screening	Planned performance		
	2006/07	2007/08	2008/09
Percentage of current or ever injectors in treatment tested for HCV	15%	20%	75%

A new supplementary target has been introduced for Tier 3 services which recognises their role in supporting service users to access HCV treatment:

Percentage of individuals for whom Intervention Status is recorded as "Offered and Accepted" subsequently referred for testing / treatment

Specialist and pharmacy-based needle exchange programmes ¹⁵	Planned performance 2006/07	Planned performance 2007/08	2008/09
Number in contact with specialist needle exchanges	500	700	700
Number in contact with community pharmacy exchange schemes	50	100	100
Total number of community pharmacies in partnership area	197	197	197
Percentage of community pharmacies providing needle exchange as a locally enhanced service (LES)	No LES ¹⁶	10%	10%
Percentage of community pharmacies providing basic healthcare advice and referral	100	100	100%

Supervised consumption	Planned performance 2006/7	Planned performance 2007/8	2008/9
Percentage of community pharmacies providing dispensing, supervised consumption and shared care as a LES	No LES	10%	10%

¹⁵ Additional targets are awaited relating to needle exchange

¹⁶ LES = Locally enhanced Service

TOPS (Treatment outcome profile)

The NTA requirements for TOPs returns are as follows :

- 80% of all new treatment journeys at Tier 3 have a Start TOP completed in accordance with national completion guidelines;
- 80% of all treatment journeys with a "compliant" Start TOP to have a Review TOP completed in line with national completion guidelines;
- 80% of all completed treatment journeys with a "compliant" Start TOP to have a Discharge TOP completed in line with national completion guidelines.

These are minimum performance requirements rather than developmental targets.

EMVA

5d Drug Interventions Programme – Indicators and Targets

The DIP commissioned drug treatment services are measured at national and regional level against three performance indicators [PI's]. These are :

Performance Indicator	Description	April – May 2008 Planned Performance
1	Percentage of adults with whom initial contact is made and who are not already on the caseload, who are assessed by the CJIT	60%
2	Percentage of adults assessed as needing a further intervention who were taken onto the caseload	85%
3	Percentage of adults taken onto the caseload who commenced treatment	95%

This data is informed by the completion of Drug Interventions Records [DIR] based on initial contact with clients, assessment, referral and treatment activity and is submitted centrally to the Home Office and NTA where monthly performance 'dashboard' data is published on a secure website - DIRweb. DIR records relate purely to new clients or those currently active on caseload.

Data is also extracted to inform NTA performance figures in relation to target numbers for offenders 'entering treatment'. The dashboards also contain additional information regarding number of DIP clients at each stage of treatment, assessment, referral or transfer.

The NTA annual target for 2007-08 for substance misusing offenders entering treatment, via DIP, was 216; the annual performance was 265. The monthly progress is shown below, the increases shown are due to changes in practice and priorities during the year. It is anticipated that the revised NTA targets for 2008-09 will introduce a target of around 265 (figure still to be confirmed as at 1/7/08).

Number of new clients entering treatment from DIP 2007- 08	Monthly target	
	07/ 08	08/09
	18	To be confirmed

Probation

Hampshire Probation Area set targets in relation to the number of Drug Rehabilitation Requirements (DRR) they expect to manage across the whole of Hampshire and IOW. The target figures are produced solely by Probation although the performance is jointly managed in agreement with the DAAT.

Drug rehabilitation requirements	Partnership target 2007-08	Proposed Partnership target 2008-09
DRR commencements	220	243
DRR successful completions	100	44

5e Alcohol - Indicators and Targets

See PSA 25, Hampshire LAA submission: Theme F Health and Wellbeing and vital signs, VSC 26.

5f Health Indicators and targets - Vital Signs

Operational Plans published by Hampshire PCT for 2008/09 – 2010/11 sets out the national requirements and national priorities relating to substance misuse. The relevant indicators and targets are is VSB 14 (National) and VSC 26 (Local Indicator) - see below

	Number of Drug Users recorded as being in effective treatment	2007/08	2008/09	2009/10	2010/11
VSB14					
VSB14_04	The number of drug users using crack and/or opiates recorded as being in structured drug treatment in a financial year who were discharged from treatment after 12 weeks or more, or who were discharged from treatment in a care planned way.	1,599	1,631	1,664	1,681
VSB14_05	The percentage change in the number of drug users using crack and/or opiates recorded as being in structured drug treatment in a financial year who were discharged from treatment after 12 weeks or more, or who were discharged from treatment in a care planned way.		+2.0%	+2.0%	+1.0%
	Percentage change from baseline year (rounded to nearest whole number)		+2%	+4%	+5%

Local Priorities

VSC 26	Rate of hospital admissions for alcohol related harm	2008_09	2009_10	2010_11
VSC26_01	2001 Census based mid-year population estimates for the respective calendar years	1,272,928	1,280,565	1,288,248
VSC26_02	Rate of hospital admissions for alcohol related harm per 100,000 population	1,154	1,230	1,303

5g Winchester Prison

As part of the prison drug strategy the following targets are set :

Indicator	Annual Target
*CARAT Drug Intervention Record assessments *CARAT stands for : <ul style="list-style-type: none"> • Counselling • Assessment • Referral • Advice • Through-care 	1150
Voluntary Drug Testing (VDT) Compacts	3060 (255 per month) Note : Each compact requires average 1.5 tests/month to validate = 383 urine tests/month
Mandatory Drug Testing Random Tests Positive Rate	10.5% positive or less
Short Duration (Drug) Programme (SDP)	120 Starts / 78 Completions
Prison Addressing Substance Related Offending Programme (PASRO)	72 Starts / 47 Completions
Detoxifications	700

5h Tier 2 Targets

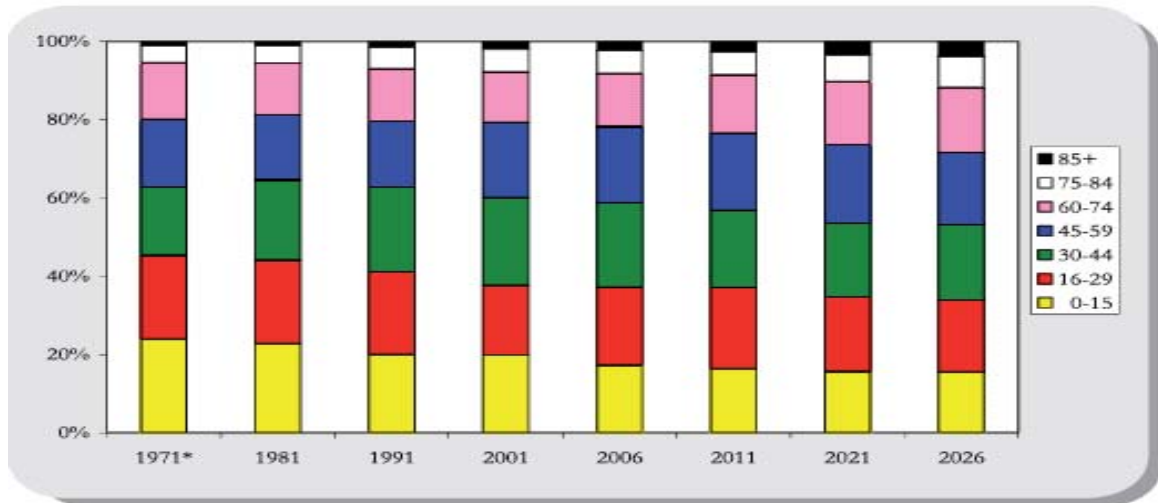
Additional targets are anticipated which relate to the delivery of Tier 2 services. Details have not yet been published.

6 Demographics

Age and Gender

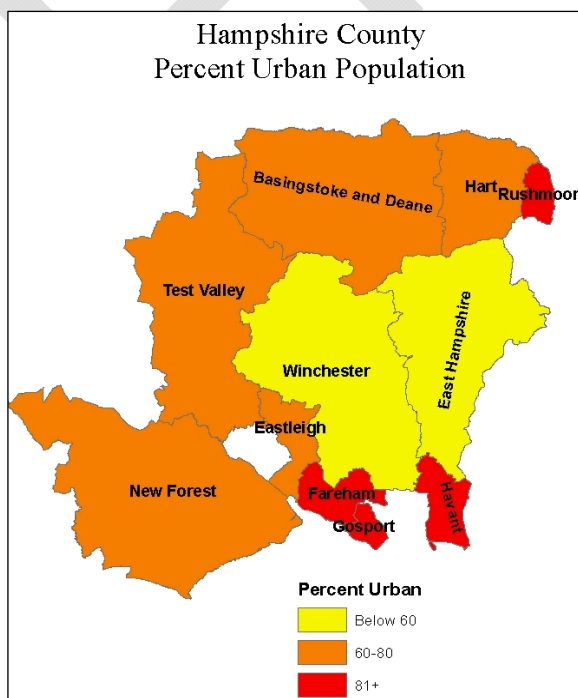
Hampshire is the third largest shire county in England with an area of 367,860 hectares and a current population of 1.26 million (2006 half-year estimate) - anticipated to grow by a further 80,000 over the next 19 years. However, it is predicted that growth will be limited to the 45 year and over age categories with younger age categories all set to decline.

Age Distribution in Hampshire (1971 – 2026)



It is anticipated that over the next 5 years (2007 to 2012), the Adult population (ie 18 years and over) will increase by 4% from 1,000,898 to 1,041,025. There will also be a slight change in the percentage split by gender for this group with males increasing from 48.2% to 48.4%.

Rural-urban Distribution



Although 85% of Hampshire is classified as rural (Quality of Life Report, 2007), the majority of people (77%) live in urban areas - most urbanised districts/boroughs being Gosport and Rushmoor with Winchester and East Hampshire the least urbanised.

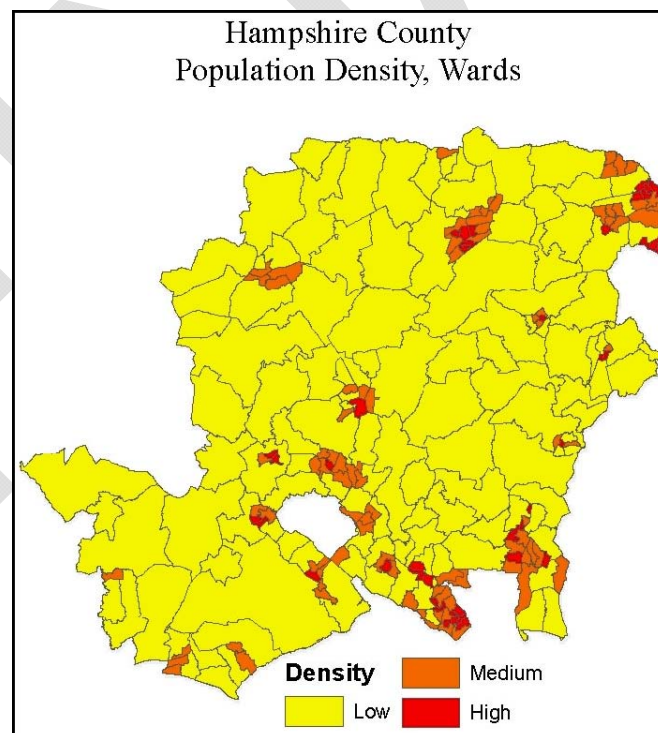
Overall 4.3% are considered to fall within the Dispersed Population category. Districts or boroughs with the highest percentage of dispersed population are East Hampshire (12.2%), Winchester (7.0%) and New Forest (6.5%).

Population Density

Population density is discussed in the Southampton University Needs Assessment Study 2008. The study states that population size needs to be interpreted within the context of the size of geographic areas in order to fully understand the pressure of population size on facilities and resources.

Population density is defined as the number of usual resident population per hectare at 2001 census. In Hampshire, among the districts/boroughs the key findings were :

- Gosport has the lowest population but the highest population density- 30 people per hectare
- Winchester and Test Valley have the lowest population density- less than 2 people per hectare but overall they have high populations
- High population--low density districts: New Forest; Basingstoke; Test Valley; Winchester
- Low population --high density districts: Eastleigh; Fareham; Havant; Gosport; East Hampshire; Rushmore and Hart
- At district level- higher the population size the lower is the population density
- At ward level - higher the population size the higher is the population density



Ethnicity & Diversity

The majority ethnic grouping within Hampshire remains “White British” at 92.6% overall (2004 census – inc. Southampton & Portsmouth). There is, though, a degree of variation across Hampshire with contribution from the higher-level “White” ethnic

grouping varying from 90.8% to 97.8% at district level. All had a majority British white population.

This does represent (relatively) significant growth, in percentage terms, for both “White Other” and “Non-White” populations from the 2001 Census position – from 3.3% to 4.5% and from 2.6% to 3.0% , respectively.

Statistically, within the Hampshire DAAT-area Basingstoke & Deane, Rushmoor and Hart (all in northern Hampshire) had the most diverse populations in terms of percentage-contribution of “White Other” and Non-White” ethnic groupings.

Economic Prosperity and Levels of Deprivation

Although typically represented as affluent, there is significant variation in economic wealth, as represented by average gross weekly earnings (AGWE), across the Hants DAAT-area. This position is impacted to some extent by variations in levels of unemployment across the county with Hart having the lowest (0.9% male; 0.5% female) and Gosport the highest (2.3% male only).

Deprivation can be difficult to define and quantify and is often associated with social exclusion. Particular instances can arise where an individual suffers ill health, is jobless or does not have regular patterns of association with others such as family, friends or work colleagues. The indices of deprivation encompass seven domains: income; employment; health & disability; education, skills & training; barriers to housing & services; crime; and living environment which are combined to form the overall Index of Multiple Deprivation (IMD). There are 1091 Super Output Areas (SOAs) in Hampshire, Portsmouth and Southampton and 279 wards. Of the seven indices, six have a similar geographical pattern with high scores found in more urban areas. Barriers to housing and services tend to be the opposite with the highest levels of deprivation found in more rural areas.

The table below shows the rank of average score for each of Hampshire’s 11 districts. A rank of 1 represents the most deprived district in England, a rank of 354 represents the least deprived district in England. Only Havant appears in the top half of the most deprived districts, with Gosport just outside. Hart is the least deprived of all districts in England.

Index of Multiple Deprivation 2004

Hampshire Districts	Rank of average SOA score
Havant	137
Gosport	189
New Forest	286
Rushmoor	287
Eastleigh	311
Basingstoke and Deane	313
Test Valley	317
East Hampshire	328
Fareham	330
Winchester	338
Hart	354

Eight more of Hampshire's districts are found in the lowest quartile of deprived districts in England. Compared to the 2000 IMD, two districts, Havant (137 <- 150) and Fareham (330 <-345) have deteriorating ranks, Rushmoor, Test Valley and Hart retain the ranks they had in 2000. These district measures mask more severe pockets of deprivation at a local area level because larger areas 'tend toward the average'. Investigation of the results at SOA level reveals the 20 most deprived areas, see below :

Index of Multiple Deprivation 2004 :Hampshire's Twenty Most Deprived Areas

Rank	SOA code	Ward / District	Rank	SOA code	Ward / District
1	01022905	Battins Havant	11	01022900	Barncroft Havant
2	01022967	Warren Park Havant	12	01022902	Barncroft Havant
3	01022903	Battins Havant	13	01022968	Warren Park Havant
4	01022933	Hart Plain Havant	14	01022966	Warren Park Havant
5	01022917	Bondfields Havant	15	01022822	Grange Gosport
6	01022906	Battins Havant	16	01023029	Holbury & N. Blackfield New Forest
7	01022970	Warren Park Havant	17	01022969	Warren Park Havant
8	01022915	Bondfields Havant	18	01022913	Bondfields Havant
9	01022934	Hart Plain Havant	19	01022844	Town Gosport
10	01022901	Barncroft Havant	20	01023126	N Town Rushmoor

As illustrated, fourteen of the twenty areas in Hampshire with the highest scores on the index are all within wards that constitute the Leigh Park area of Havant (Warren Park, Barncroft, Bondfields and Battins). Gosport (2), New Forest (1), Rushmoor (1) and Hart Plain in Havant (2) also have pockets of deprivation that are recorded as being amongst the twenty most deprived areas in Hampshire and are amongst the twenty percent most deprived areas in the country.

There are twenty-four areas in total that lie in the top twenty percent most deprived areas in the country. This provides strong evidence of the existence of one significant area of deprivation within the county (Leigh Park) and ten further pockets.

Significant Elements of Ward Level Deprivation

The table below looks at the seven domains of deprivation that were used to form the Index of Multiple Deprivation, listing the wards in which the ten most deprived areas are located for each domain.

See overleaf

**The ten most deprived areas in Hampshire for each domain of the 2004 IMD
(showing constituent ward & district of SOAs)**

Rank /Over all IMD	Ward and District	Income	Employment	Health & Disability
1	Battins Hv	Grange G	Warren Park Hv	Warren Park Hv
2	Warren Park Hv	Battins	Hv Battins	Hv Battins Hv
3	Battins Hv	Holbury & N.Blackfield NF	Hart Plain Hv	Battins Hv
4	Hart Plain Hv	Warren Park Hv	Bondfields Hv	Heron Wood R
5	Bondfields Hv	Hart Plain Hv	Battins Hv	Town G
6	Battins Hv	Bondfields Hv	Town G	Town G
7	Warren Park Hv	North Town R	Bondfields Hv	Leesland G
8	Bondfields Hv	Bursledon & Old Netley EI	Bondfields Hv	Bondfields Hv
9	Hart Plain Hv	Warren Park Hv	Fareham North W F	Hart Plain Hv
10	Barncroft Hv	Battins Hv	Hart Plain Hv	Purbrook Hv

Rank /Over all IMD	Education and training	Barriers to Housing & Services	Crime	Living Environment
1	Bondfields Hv	Downlands & Forest NF	Brockhurst G	Battins Hv
2	Warren Park Hv	Bramshaw, Copythorne North & Minstead NF	Grange G	Barncroft Hv
3	Barncroft Hv	Eversley Hr	Leesland G	Bondfields Hv
4	Barncroft Hv	Dun Valley TV	Grange G	Battins Hv
5	Hart Plain Hv	Over Wallop TV	Warren Park Hv	Barncroft Hv
6	Alamein TV	Upton Grey & Candovers B	Barncroft Hv	Barncroft Hv
7	Holbury & N. Blackfield	Holybourne & Froyle EH	Forton G	Battins Hv
8	North Town R	Burghclere B	Grange G	Warren Park Hv
9	Battins Hv	Kings Somborne & Michelmersh TV	Warren Park Hv	Barncroft Hv
10	10 Warren Park Hv	Downland EH	Warren Park Hv	Battins Hv

Of the ten areas in Havant that feature in the top-ten most deprived areas in the county as measured by the overall IMD, eight feature in three or more of the top-ten most deprived areas in the county as measured by the seven separate domains of deprivation.

The most deprived area in the county (as measured by the IMD) is located within the ward of Battins, in Havant. This area ranks as the second most deprived area in the county with respect to income deprivation, the second most deprived area in the county with respect to employment deprivation, the third most deprived area in the county with respect to health & disability, and the most deprived area in the county with respect to the living environment.

Outside of Havant, which had 41 entries in the seven top-ten domain listings, Gosport is the next most deprived district with 11 entries. Gosport wards occupy the top four most deprived positions in the crime domain and six out of the ten in that domain all together.

Five Gosport wards appear at least once in the top-ten listings: Grange, Town, Brockhurst, Forton and Leesland, with Grange (4 entries) appearing most of all.¹⁷

¹⁷ (Extracted from A Profile of Hampshire 2005)

7 Client Group Information

7a Drugs - National Overview

Figures published by the National Treatment Agency for Substance Misuse (NTA) indicate the number of drug misusers in contact with structured drug treatment services in 2006/7 has increased by 130 per cent in the eight years since 1998/9.¹⁸

Results show that 195,464 people were in contact with specialist drug treatment in England during 2006/7, an increase of 10 per cent on revised figures for 2005/6 (177,055).

More than 60,000 (75 per cent) of new clients remained in structured treatment for 12 weeks or more – when treatment is more likely to be effective – following triage assessment in 2006/7. This is a slight fall from 76 per cent in 2005/6.

The results also indicate 156,854 people (80 per cent of those in treatment in the year) had either successfully completed or were still in treatment at the end of March 2007; this is 21,764 more people than revised figures show for March 2006.

Over 27,500 (42 per cent of all those discharged) completed treatment successfully; this is 6,000 more than revised figures show for March 2006.

Around 104,000 people (53 per cent of those in treatment in the year) either came into structured drug treatment for the first time or re-entered services in 2006/7; a common factor of the chronic relapsing condition of problem substance misuse.

The most frequently reported main drugs of misuse by adult clients:

- heroin – 66 per cent (117,305)
- crack – 6 per cent (10,664)
- cocaine – 6 per cent (10,078)
- methadone or other opiates – 9 per cent (16,250)
- cannabis – 7 per cent (13,087)

The most frequently reported main drugs of misuse by clients aged under 18 years:

- cannabis – 75 per cent (11,582)
- heroin or other opiates – 7 per cent (1,036)
- crack – 1 per cent (181)
- cocaine – 5 per cent (716)

For young people under the age of 18 data is also collected on alcohol as a primary problem substance. There is no current data on alcohol for adults.¹⁹

¹⁸

http://www.nta.nhs.uk/media/media_releases/2007_media_releases/new_national_statistics_reveal_more_drug_users_in_treatment_media_release_181007.aspx

¹⁹ Supporting information is available on the NTA website at www.nta.nhs.uk

7b Drugs –Hampshire Overview Key statistics 2006/7

The latest information available from South East Public Health Observatory²⁰ published November 2007 provides the following information :

- Hampshire has a total population of 1,265,900.
- 1,890 adult residents were in treatment
- Hampshire DAT had 190 people in treatment per 100,000 population¹ aged 20 and over, lower than the South East rate of 262 per 100,000
- 74% of adult clients in treatment were male and 26% were female
- 41% of all clients resident in Hampshire DAT were aged 18-29, 89% were aged 15-44 and 98% were aged 15-64
- there were 1,029 new clients in treatment, all ages, 88% were aged 18 and over, 92% were aged 15-44 and 98% were aged 15-64
- 95% of adult clients resident in Hampshire were White British, 3% of clients' ethnicity was not collected. 93% of Hampshire adult residents are White British
- 527 clients resident in Hampshire accessed services outside this DAAT area in other South East DAAT areas
- 14 adult Hampshire clients visited agencies outside the South East region
- 37 adult non Hampshire resident clients received treatment in this DAAT
- 22% (413 individuals) of adult clients are currently injecting drug users, 14% (259 individuals) have never injected; injecting status was not given for 52% of clients

Hay Prevalence Data

Prevalence of drug using behaviours at local and national level cannot be known exactly. The Home Office and Department of Health base their strategic and financial planning on estimates produced periodically: *“National and Regional estimates of the prevalence of opiate use and/or crack cocaine use”, Hay et al (2005/6)*

The “Hay Estimate” exercise focuses on “problematic drug use” (ie. the illicit use of opiates or crack cocaine) amongst the 15 to 64 year old age group and most recently reported in 2005/6.

The “Hay Estimate” shows Hampshire as having a total of 3,003 Problematic Drug Users (PDU's) , the third highest number in the South East region. This high figure, in terms of absolute numbers of individuals, is directly influenced by the size of the overall population supported by Hampshire DAAT as can be seen from the Prevalence Rate data. (See table overleaf)

The estimated Prevalence Rate for PDU's within Hampshire is 3.67 per 1,000 population – 36% lower than the estimated regional Prevalence rate for the South East and 63% lower than the National Prevalence rate (5.72 and 9.97, respectively).

²⁰ Further information can be obtained from <http://www.dtmu.org.uk/documents/DAT%20Profiles/2006-07/Hampshire.pdf>

Hay Estimate Table : Prevalence of opiate use and/or crack cocaine use

	Prevalence Rate (per '000's)				Individuals			
	Hampshire	South East	England	Ranking* (out of 18)	Hampshire	South East	England	Ranking*
Total PDU's	3.67	5.72	9.97	15th	3,003	30,533	3,332,090	3rd
Opiate Users	3.19	4.80	8.60	14th	2,609	25,608	286,566	3rd
Crack Cocaine Users	1.96	3.36	5.93	18th	1,600	17,909	197,568	4th
injecting Drug Users	2.16	2.49	3.90	13 th	1,766	13,269	129,977	2nd
By Age Group								
Age 15 - 24	4.26	7.04	10.07	16 th	632	7,131		3rd
Age 25 - 34	8.58	12.35	21.43	15th	1,234	12,561		3rd
Age 35 - 64	2.16	3.28	6.10	14th	1,137	10,843		3rd
By Gender								
Male			15.32					
Female			4.64					

*NOTE: 'Ranking' – refers to Hampshire's placing within the South East region. (x /18)

Age Profile of PDU Population

The Age Profile for the PDU group, shows that we have a slightly older PDU population in Hampshire than the rest of the South East region, with 21.0% PDU's aged 15-24 years (23.4% regionally) and 37.9% aged 35-64 years (35.5% regionally).

By Age Group	Hampshire	South East
Age 15 – 24	21.0%	23.4%
Age 25 - 34	41.1%	41.1%
Age 35 - 64	37.9%	35.5%

Profiling Drug Use Amongst PDU Population

Drug using behaviour	Hampshire	South East	National
Injecting Drug Use	58.8 %	43.4%	39.1%
Opiate Use	86.9%	83.9%.	86.6%
Crack Cocaine Use	53.3%	58.7%	59.5%

Activity by Locality 2007/8 <i>(Data for this section based upon NDTMS out turn figures as at March 31st 2008)</i>												
	Basingstoke	East Hants	Eastleigh	Fareham	Gosport	Hart	Havant	New Forest	Rushmoor	Test Valley	Winchester	Total
Number of individuals with a new presentation in drug treatment (YTD)	107	47	51	40	86	28	101	80	66	47	66	719
	14.9%	6.5%	7.1%	5.6%	12.0%	3.9%	14.0%	11.1%	9.2%	6.5%	9.2%	100.0%
Numbers in treatment year to date (all treatment pop, alcohol excluded)	281	125	121	110	226	97	289	176	205	147	218	1995
	14.1%	6.3%	6.1%	5.5%	11.3%	4.9%	14.5%	8.8%	10.3%	7.4%	10.9%	100.0%

Comparison of activity in by locality, shows that Basingstoke and Havant had the highest number of new presentations to services and highest number of individuals in treatment last year. Hart had the lowest level of new presentations and of individuals in treatment.

It is interesting to note that Hart also has the highest level of Average Gross Weekly Earnings within Hampshire and the lowest levels of unemployment. A direct correlation between drug misuse and economic prosperity cannot necessarily be drawn, however, as neither Basingstoke nor Havant are identified as the least economically prosperous locality in the DAAT-area.

Profile of Drug Use by Locality

Fareham has the least diverse drug profile with 79% of all Service Users identifying Heroin as their primary substance and 91% of Service Users identifying either Heroin, Methadone or Other opiates.

Hart appears to have the most diverse drug profile with only 56% of Service Users identifying Heroin as their primary substance and reflecting the highest relative use of Other Opiates (10%), Crack Cocaine (5%), Benzodiazepine (4%) and Cannabis (8%) as a primary substance.

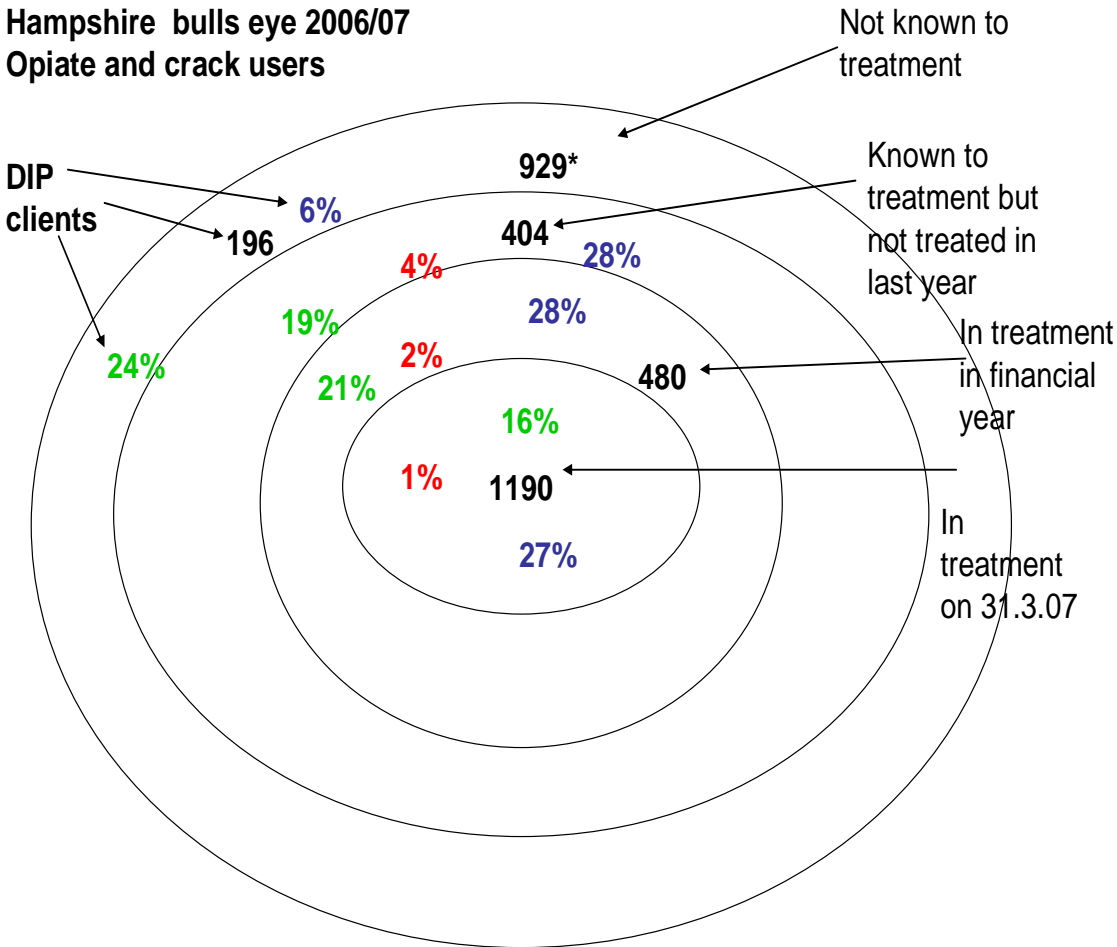
Primary Substance	Highest	Lowest
Other opiate	Hart (10%)	New Forest (2%)
Benzodiazepine	Hart (4%)	Gosport (0%)
Cocaine (powdered)	Test Valley (8%)	Rushmoor (1%)
Crack Cocaine	Hart 5%	Fareham / Winchester (0%)
Amphetamine	New Forest (9%)	Hart (0%)
Cannabis	Hart (8%)	Winchester (2%)
Methadone	Rushmoor (16%)	Gosport (3%)
Heroin	Fareham (79%)	Hart (56%)

*Note :Chart shows localities recorded the Highest & Lowest relative levels of primary usage as a percentage of locality service user population. *(X%) – the percentage of Services Users within a given locality identifying the stated substance as their primary substance of misuse*

Current population data is not available at locality level (most recent data is 2001 Census information) and it is not, therefore, possible to apply a population-based weighting to locality data or to calculate locality-level prevalence rates.

Service Penetration

Hampshire bulls eye 2006/07
Opiate and crack users



<p>KEY General treatment population Women BME groups Young people 18-24 *Based on Home office PDU estimate 05/06 of 3003</p>
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The “Bulls-Eye” provides a pictorial representation of the degree of engagement by the local PDU population at Tier 3. (the closer to the centre of the bulls-eye, the greater the degree of engagement).

It can be seen that, during 2006/7:

- 55.6% of PDU’s were in treatment at some point;
- 13.4% of PDU’s were known to services, but had not accessed Tier 3 treatment during the year;
- 31% of PDU’s were not known to Tier 3 services and have never accessed treatment.

The percentage of women within each category (27% - 28%) is consistent with the estimated number of females within the overall PDU population.

There is apparent inverse relationship between representation of service users from BME groups and level of engagement. However, in terms of actual individuals, numbers remained broadly consistent (12, 10 & 16).

It is not possible to draw any definitive conclusions regarding “Young People” as the “Hay Estimate” and Bulls-eye data employ different definitions (15-24 yrs and 18-24 yrs respectively).

Profile of Clients in Treatment for period 2004-05 to 2007-08

Data is collected in respect the age, gender and ethnicity of clients in treatment and as such it is possible to identify whether there have been any major changes in the profile of clients during the last four years or whether the profile has remained relatively unchanged.

With regard to age, as can be seen below there has been no significant change into which bands clients have fallen during the last four years. The highest prevalence has remained the 25-29 and 30-34 age bands throughout the period.

% of clients in age band				
Age band	2007/08	2006/07	2005/06	2004/05
10-14	2.1%	2.2%	2.7%	2.8%
15-19	14.2%	13.1%	12.2%	11.7%
20-24	14.8%	15.1%	19.1%	18.6%
25-29	21.2%	20.7%	18.7%	20.8%
30-34	17.6%	17.6%	17.1%	19.0%
35-39	13.7%	13.8%	14.1%	12.6%
40-44	8.4%	8.8%	7.7%	6.6%
45-49	4.3%	4.2%	4.7%	4.9%
50-54	2.8%	3.2%	2.5%	2.1%
55-59	0.7%	0.8%	0.6%	0.5%
60-64	0.2%	0.4%	0.4%	0.3%
65-69	0.0%	0.1%	0.2%	0.0%
70-74	0.0%	0.2%	0.0%	0.0%
75-79	0.0%	0.0%	0.1%	0.0%

There has been no major change in the gender split, but there has been a slight reduction in the percentage of female clients.

% of clients by gender				
Gender	2007/08	2006/07	2005/06	2004/05
Male	72.4%	71.9%	71.5%	71.3%
Female	27.6%	28.1%	28.5%	28.7%

The table overleaf illustrates that the majority of all clients in treatment are White British and there has been no significant change in the split by ethnicity during the four years being analysed.

Ethnicity	% of clients by ethnicity			
	2007/08	2006/07	2005/06	2004/05
Asian Bangladeshi	0.04%	0.05%	0.05%	0.07%
Asian Indian	0.00%	0.00%	0.00%	0.00%
Asian Pakistani	0.09%	0.00%	0.05%	0.00%
Asian Other	0.22%	0.00%	0.05%	0.00%
Black African	0.04%	0.00%	0.05%	0.00%
Black Caribbean	0.22%	0.16%	0.15%	0.55%
Black Other	0.17%	0.11%	0.00%	0.14%
Mixed White and Asian	0.22%	0.05%	0.05%	0.14%
Mixed White and Black African	0.04%	0.05%	0.10%	0.07%
Mixed White and Black Caribbean	0.34%	0.16%	0.25%	0.07%
Mixed Other	0.17%	0.05%	0.15%	0.14%
Other Ethnic Group	0.56%	0.32%	0.35%	0.62%
White British	93.46%	94.75%	93.20%	92.07%
White Irish	0.43%	0.42%	0.46%	0.28%
White Other	0.60%	0.63%	0.71%	0.90%
Not Stated	1.29%	1.05%	2.18%	1.66%
No ethnicity recorded	2.11%	2.21%	2.18%	3.31%

Duration of Treatment

Evidence based good practice suggest that positive outcomes are more likely to be realised by service users who are retained in treatment for over 12 weeks. It can be seen from the table that there has been a 50 % decrease in clients exiting the treatment under 12 weeks - over the 4 periods compared. This is suggestive of an improvement in the effectiveness of interventions offered over the same period in previous years. Equally there has been a reduction in the numbers retained for excessive lengths of time, (5 years +) ²¹

Duration of treatment / episode during four year period 2004-05 to 2007-08	2007/08	2006/07	2005/06	2004/05
	0 -11 weeks	220	303	408
12 -19 weeks	90	119	147	185
20 -52 weeks	162	281	323	310
1 year to 2 years	63	87	98	106
2 years to 5 years	26	42	43	56
5 years to 10 years	2	9	6	11
10 years +	0	1	2	2
Still in treatment	1762	1062	945	340

Perception of Drug Use and Drug Related Offences

The 2006/7 local Quality of Life poll for Hampshire County Council indicated a disparity at district-level between perceptions of drug use and actual levels of drug use (as indicated by numbers of recorded drug offences). The districts with the highest proportions of local residents who “considered that reducing the use of drugs in their area would be one of the 3 or 4 most important factors in improving their quality of life” were East Hampshire (15.1%), Test Valley (14.4%) and New Forest (13.1%). In terms of numbers of recorded Drug Related Offences these districts ranked 5th, 10th and 7th respectively. Additional client group information is available at data is available at [Appendix 3](#)

²¹ Information provided by NDTMS however the efficacy of these figures will be reviewed in light of provider comments

7c DIP National Overview

The UK Drug Policy Commission (UKDPC) recently commissioned an independent review on “Reducing Drug Use; Reducing Reoffending”. It states that the extent of the problems we face are that:

- At least 1 in 8 arrestees are estimated to be problem heroin and / or crack users
- 81% of such arrestees regularly commit acquisitive crime
- Up to a half of new prison inmates are problem drug users
- Drug related crime costs an estimated £13.5 Billion in England and Wales.

7d DIP local overview

The DIP provides interventions for substance misusing offenders with a priority for Class ‘A’ drug users. DIP guidance sets out the priorities for interventions around dependency and offending, therefore, the client profile shows a higher prevalence for Class ‘A’ in this group, compared to those engaged in treatment through other pathways. There are currently 45-50 community based offenders engaged with DIP.

Criminal Justice Data

Possession of controlled drugs for Hampshire, Apr 2005 - Mar 2006

Month	Total number of offences	Offences per 1000 population	Offences per 1000 England/Wales population
Apr-Jun 2005	757	0.4	0.6
Jul-Sep 2005	620	0.3	0.7
Oct-Dec 2005	695	0.4	0.7
Jan-Mar 2006	1109	0.6	0.8

Trafficking in controlled drugs for Hampshire, Apr 2005 - Mar 2006

Month	Total number of offences	Offences per 1000 population	Offences per 1000 England/Wales population
Apr-Jun 2005	125	0.1	0.1
Jul-Sep 2005	116	0.1	0.1
Oct-Dec 2005	345	0.2	0.1
Jan-Mar 2006	251	0.1	0.1

7e Alcohol – National Overview

The cost of alcohol misuse nationally is estimated to be £15 billion. The main costs are associated with crime and public disorder, health, family and social networks and the workplace. These include:

- 78% of assaults are committed and 88% of criminal damage occurs whilst the offender is under the influence of alcohol
- 360,000 incidents of domestic violence (around a third of all such incidents)
- Up to 150,000 hospital admissions a year are alcohol-related at an estimated cost to the NHS of £1.7billion a year
- Between 780,000 and 1.3million children are affected by parental alcohol problems and between 30% and 50% of child protection cases involve alcohol
- Drinkers under 16 are consuming twice as much alcohol as 10 years ago, 20% of suspensions are due to pupils drinking alcohol at school and 16% of excluded pupils drink alcohol every day compared with 3% of non-excluded pupils
- There are 97,000 cases of drink-driving a year, and more than 18,000 people were killed or injured in drink drive accidents in 2000
- Research suggests that a third of those sleeping rough reported heavy drinking (Bines 1994)
- The National Alcohol Strategy estimates that those attending A+E for issues where alcohol has been a contributing factor account for up to 35% of all attendances. It is estimated that alcohol related diseases account for 1 in every 26 hospital bed days and 1 in 80 day cases is attributable in some measure to alcohol misuse. (Alcohol Misuse Interventions, DH 2005). In addition, studies have shown that approximately 20% of patients admitted to hospital for illnesses unrelated to alcohol are consuming alcohol at potentially hazardous levels. (Royal College of Physicians response to the National Alcohol strategy).

7f Alcohol – Local overview

Alcohol Data Set Document

This document is a companion to the Alcohol 10 Point Plan. It collates a range of alcohol related data for Hampshire to provide baselines for the implementation of the Alcohol Ten Point Plan. Each of the actions within the Ten Point Plan is addressed, with an outline of all local, regional and national data currently available. For more information contact Mike Webb in the DAAT team. Some of these data sets are taken from the North West Public health Observatory²² and these are produced on an annual basis. Data is available on 36 indicators and where possible it has been made available at a local authority level.

²² www.nwph.net/alcohol/lape

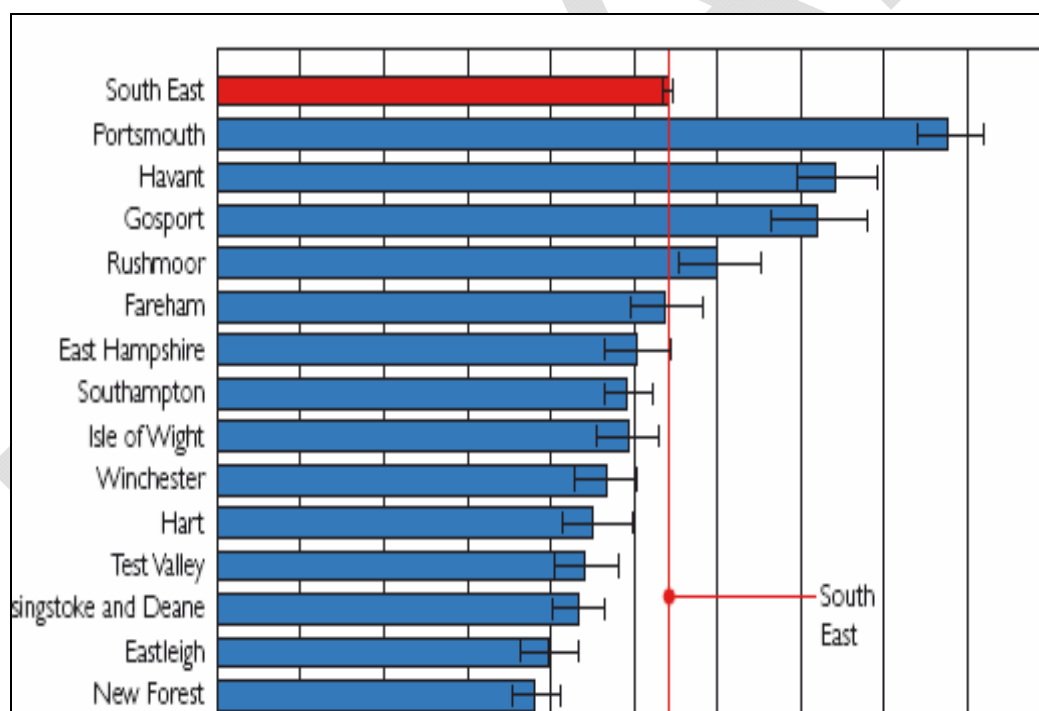
Data sets collected at district level include:

- Life lost and mortality
- Secondary care - hospital admission
- social and behavioural outcomes
- Alcohol consumption
- The alcohol economy

Alcohol Related Hospital Admissions (ARHA)

ARHA now account for 6% of all NHS hospital admissions. The level of increase is currently slowing, from 9.1% to 7.1% (08/09 – 2010 / 11). The biggest single cause of admissions is alcohol-related hypertension -35% of national total and 49% of ARA come into a hospital via A+E. The local overview is presented in the table below.

Alcohol-attributable hospital admission rate for all persons, by local authority, 2004-5. Source Hospital Episode Statistics Information Centre (2006)



Housing

Local housing data highlights the impact that those misusing alcohol have on the area in which they live. It is estimated that up to 50% of one RSLs tenants are misusing alcohol and that between 30-40% of tenancy breakdown is alcohol related. A high percentage of tenants within housing associations who have a history of alcohol misuse have experience of being evicted or abandoning tenancies. (Preventing Homelessness Report, 1996). Anecdotal evidence from a direct access hostel (2006) suggests that around 50% of tenants are using alcohol.

Anti- social behaviour

Local data suggests that a high percentage of local anti-social behaviour is alcohol related. For example, research in Fareham suggested that since May 2006 1/6 of all

101 complaints specifically relate to Young People drinking alcohol. In 2006/07, of the 289 young people in drug treatment in Hampshire, 93 young people's primary substance was alcohol and 73 young people's secondary (associated) substance was alcohol.

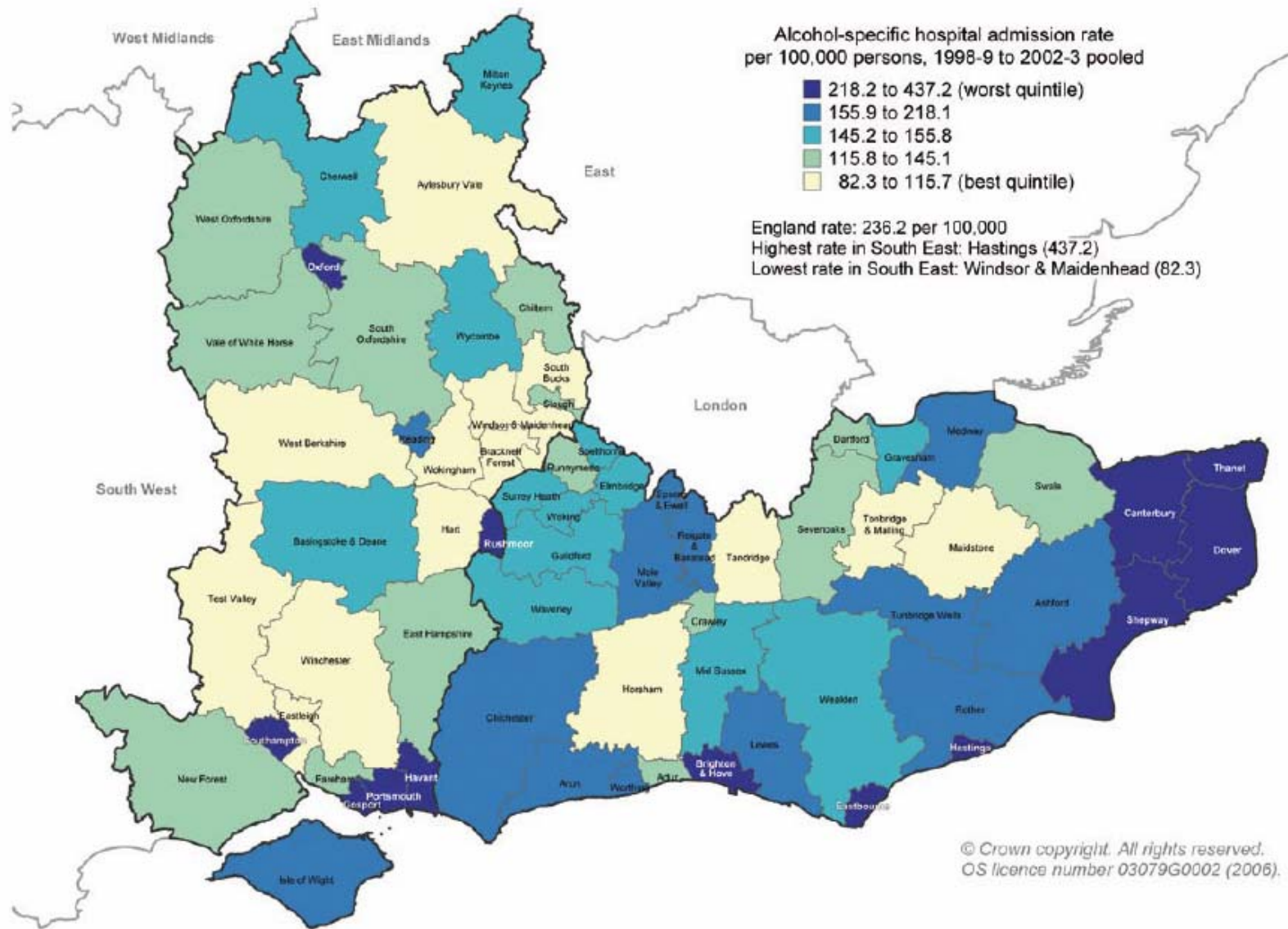
Supporting People

In Hampshire 2005 / 06, there were 3890 new clients that entered short term Supporting People funded services. Of these, 554 (14.24%) were assigned either the primary client group or secondary client group of either Alcohol or Drug Problems though we recognise clients may mask their addictions for personal reasons.

A & E : Within Hampshire in 2006 it was estimated that 2264 individuals were admitted to hospital for alcohol related issues. A survey in Frimley Park Hospital A+E showed that between 10. P.M. and 6 A.M. on a Friday and Saturday night, 93% of those surveyed were present as a result of alcohol misuse of some description.

See illustration overleaf, alcohol specific admission rate per 100,000 population 1998/9 - 2002/3(pooled)

FRIMLEY



8 Current Treatment System

In 2002 the National Treatment Agency published Models Of Care – a National framework for the commissioning of treatment for adult drug users in England. This set up a four Tier model of treatment system: (A full explanation of the Tiered structure is included at [Appendix 2](#))

TIER 1 – Non substance misuse specific services

TIER 2 – Open Access services

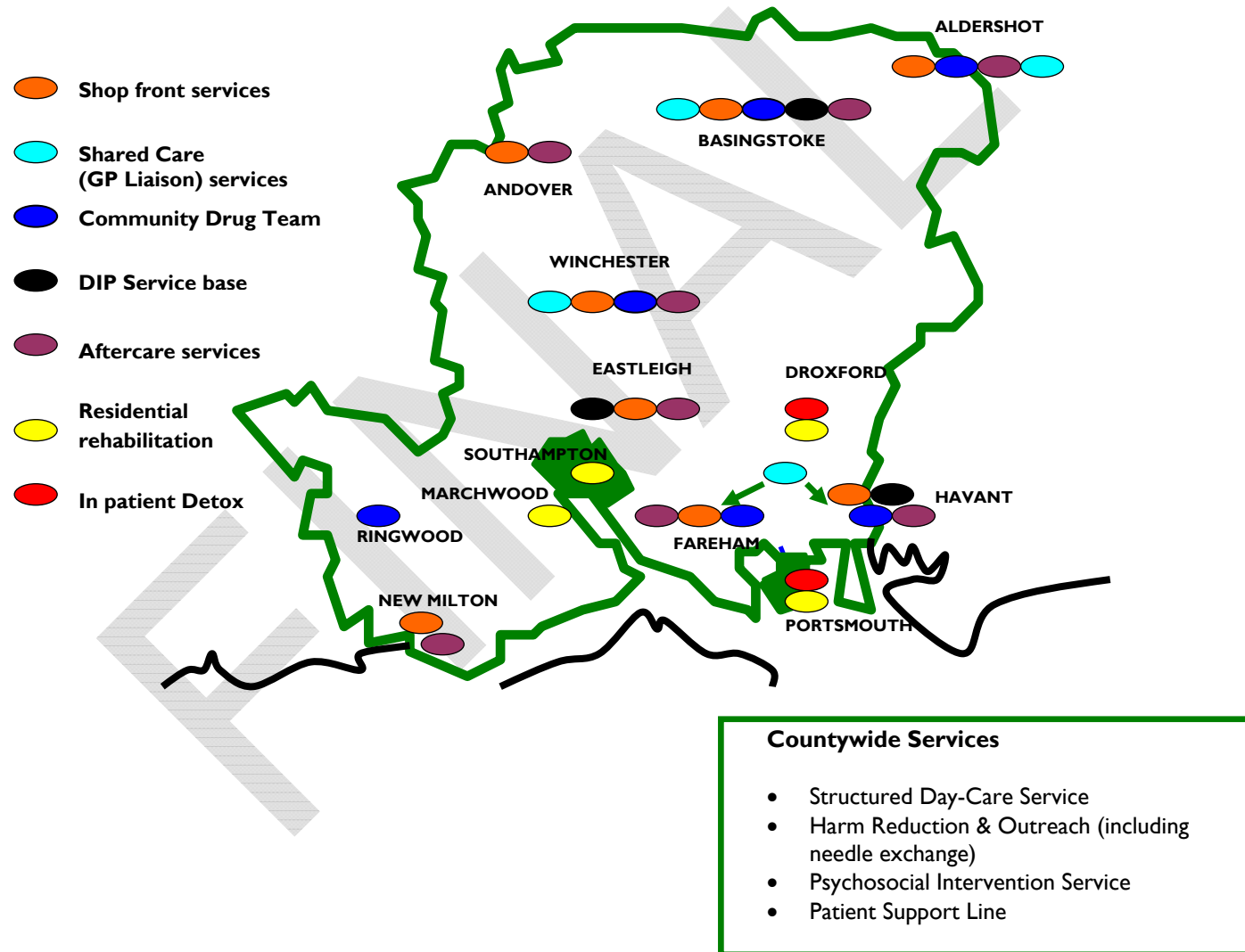
TIER 3 – Structured community based services

TIER 4 – Residential and specialist services

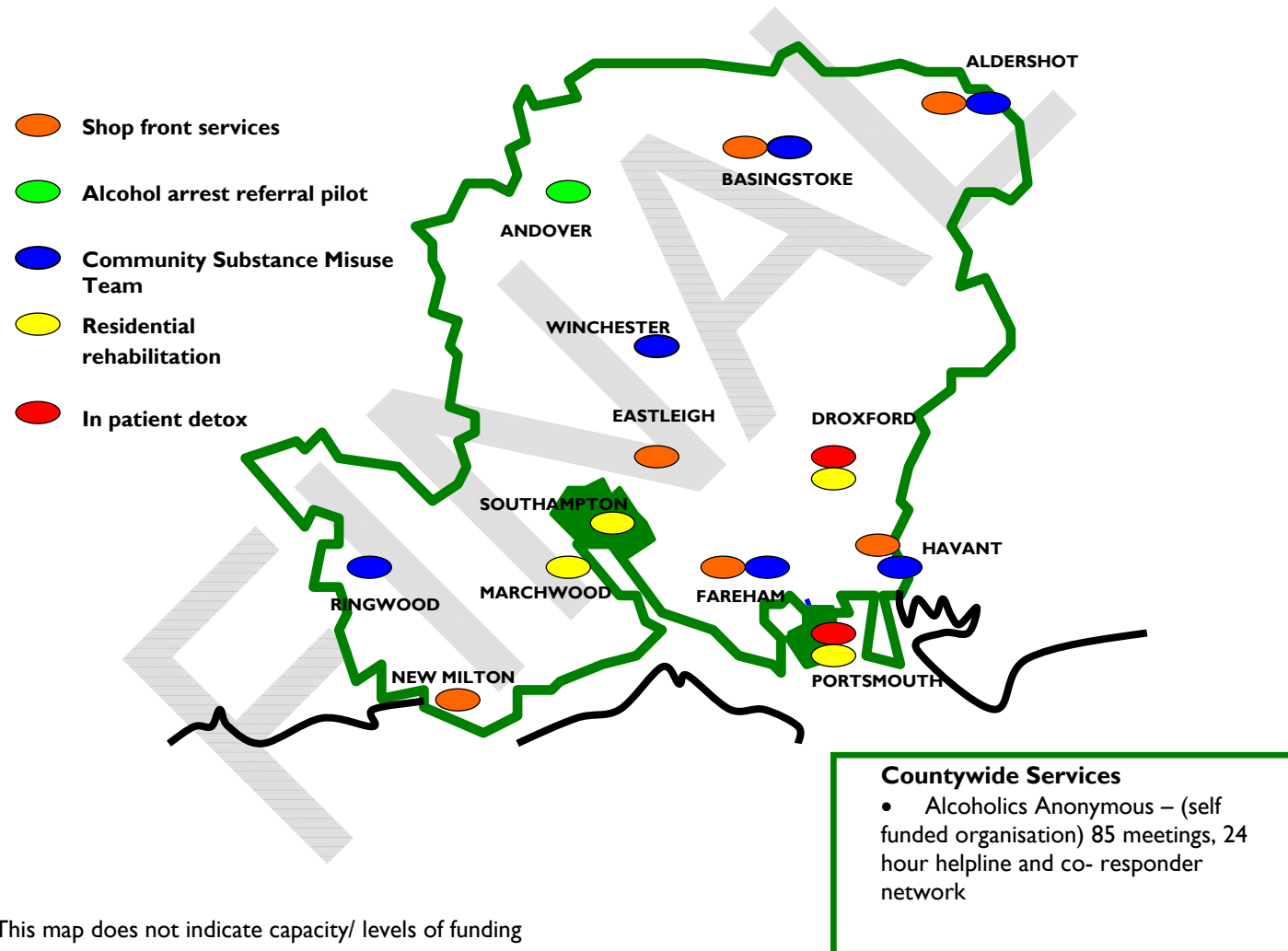
The current Hampshire Treatment System has been developed in line with this national guidance.

A series of maps have been developed to illustrate the current treatment systems (see overleaf). Whilst these maps can provide an overview of the services available and how the system works, they do not reflect the difficulties of engaging clients across a dispersed and varied geographical area.

Current Drug Service Market



Current Alcohol Service Market



Satellite provision

The following table has been provided in response to feedback from the initial draft document. We recognise that some information is yet to be completed

Provider	Satellite Services	Timing
TIER 2		
Parent Support Link	County wide service	
Society of St James	Romsey Town Hall Totton Community Centre Hythe – Probation Family Building Ringwood (New Forest Drug Service) Fordingbridge New Milton Town Hall Lymington Community Centre	Friday 9 – 1 Monday 9 – 1 Monday 9 – 5 Wednesday 9 – 5 Thursday 11.30 – 1.30 Tuesday and Friday 9 – 1 Thursday 4.30 – 8
Phoenix Futures	Bordon Community Centre Alton Community Centre GP Surgery Hayling Island	Daily 1 – 5 Daily 12. – 4.30 Wednesday 9.30 – 12 need to contact Spotlight at Fareham for more info
CRI	Andover and Winchester	Provide Outreach Service visiting vulnerable clients at home or in other specialist services (also provide Out of Hours service)
Cranstoun DIP	Aldershot Andover Gosport New Forest	
TIER 3		
Hampshire Partnership Trust		
Rooksdown Community Alcohol Team	Bordon, Chase Hospital	

	Tadley, Drs Surgery Alton, Cottage Hospital	
Oaktree	Rent rooms in all areas from Waterside to Wiltshire eg New Milton, Lymington, Totton etc	
Spencer House	Bridge at Eastleigh ,CRi Andover CMHT Romsey ,CLEMS Winchester Desborough House, Eastleigh Trinity Centre, Winchester	
Fairfields House	To be confirmed	
Acorn Community	Main Offices, Frimley and Guildford Use Drs Surgery in Aldershot, Rushmoor and Hart	
Portsmouth City Orion	Waterlooville and Hayling Island	
Portsmouth City Avalon	Gosport	
Portsmouth City CARE	Perapatetic Service – move to cover needs across Hampshire	
Phoenix Futures	To be confirmed	
Cranstoun DIP	Aldershot Andover Gosport New Forest	

Care Coordination Approach

During 2007/8 the DAAT began the 2 year roll-out of its “Care Coordination Centred Treatment System”. The new treatment system actively promotes the managed progression of service users through their treatment journey ensuring:

- targeted delivery of services most appropriate to an individual's needs at the optimum phase of their recovery;
- optimisation of capacity at Tier 3 to support increased numbers into structured treatment;
- supported engagement with mainstream services ensuring ongoing wraparound provision and promoting continued recovery.

All substance misuse services are subject to clinical governance guidelines.

A Common Assessment Tool (CAT) has been developed by the DAAT to achieve a co-ordinated and consistent approach to the assessment of service users and to ensure that they progress through the treatment system in a manner that is fully informed by their treatment needs. The common assessment process comprises of the following stages:

- Screening and Referral
- Needs Assessment
- Comprehensive Assessment
- Outcome monitoring – TOP and the outcome wheel
- Care planning and care review
- Step-down and Aftercare

1. Screening and Referral

Screening and referral assessment is an activity that all Tiers of services should be able to carry out (i.e. includes Tier 1 non-substance misuse specialist service providers). The involvement of generic services is to ensure the needs of substance users can be identified in a broad range of settings. A screening and referral form is forwarded to the open access services, responsible for conducting the needs assessment (triage).

2. Needs Assessment (triage)

The needs assessment or triage is the filtering process that takes place within the open access services that aims to establish which intervention or Tier of service would best suit the individual drug (and/or alcohol) misuser at the time of assessment. This may involve a range of brief interventions at Tier 2 or an onward referral to the care co-ordination and planning team at Tier 3.

3. Comprehensive Assessment

Comprehensive assessments are undertaken with drug and alcohol misusers with more complex needs and/or at those who require more complex and/or structured care programmes. They are undertaken to develop a comprehensive package of care to meet the needs of service users, through effective care planning and care co-ordination.

4. Outcome monitoring – TOP and the outcome wheel

TOP is the NTA's national outcomes monitoring tool and is to be used with every service user (aged 16 and over) who enters structured (Tier 3 and 4) treatment in England. The TOP is completed at the outset of treatment, three months thereafter at care plan reviews and upon discharge from the treatment system. There is also an expectation that providers will be encouraging service users to use the Hampshire Outcome monitoring wheel.

5. Care planning and care review

Care plans are developed and agreed with all service users receiving structured care. The care plan is a structured, often multidisciplinary, task-oriented individual care pathway plan, detailing the essential steps in the care of a service user and describes the expected course of their expected treatment and care.

6. Accessing Tier 4 Services

For clients who are assessed as requiring Tier 4 services, (inpatient detox or residential rehabilitation), referrals are made by Tier 3 providers as part of their care plan. For inpatient detox clients these are able to access block purchased beds or spot purchase arrangements can be made to offer greater choice. For residential rehabilitation, all beds are spot purchased to best meet the presenting needs of the client.

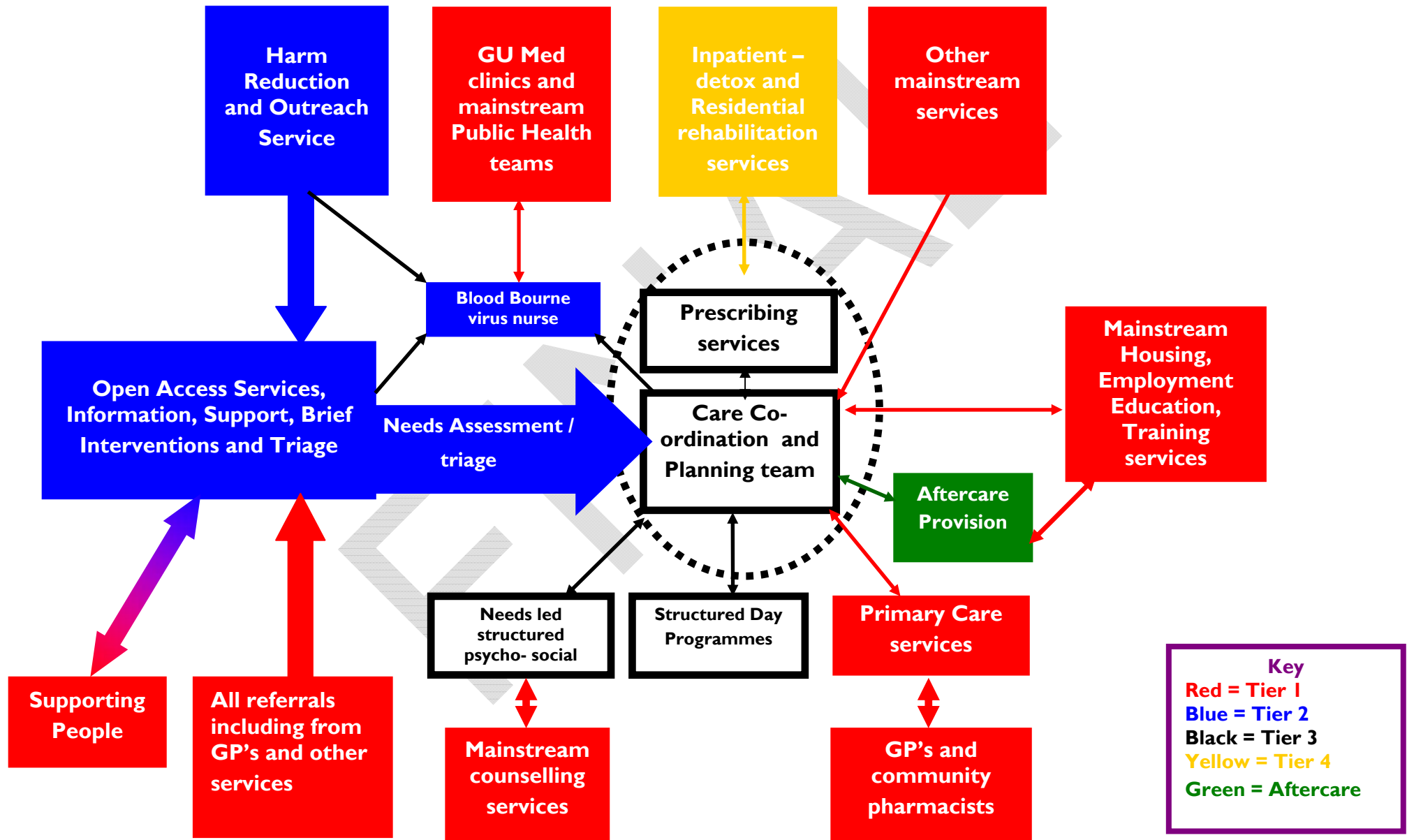
7. Step-down and Aftercare

All service users exiting Tier 2, 3 or 4 and identified as having aftercare needs are referred into aftercare services. Service Users agree an action plan which includes a individually tailored programme of activity and will be supported in achieving the identified objectives either through sign-posting to mainstream services or through key-working (dependent upon individual support needs).

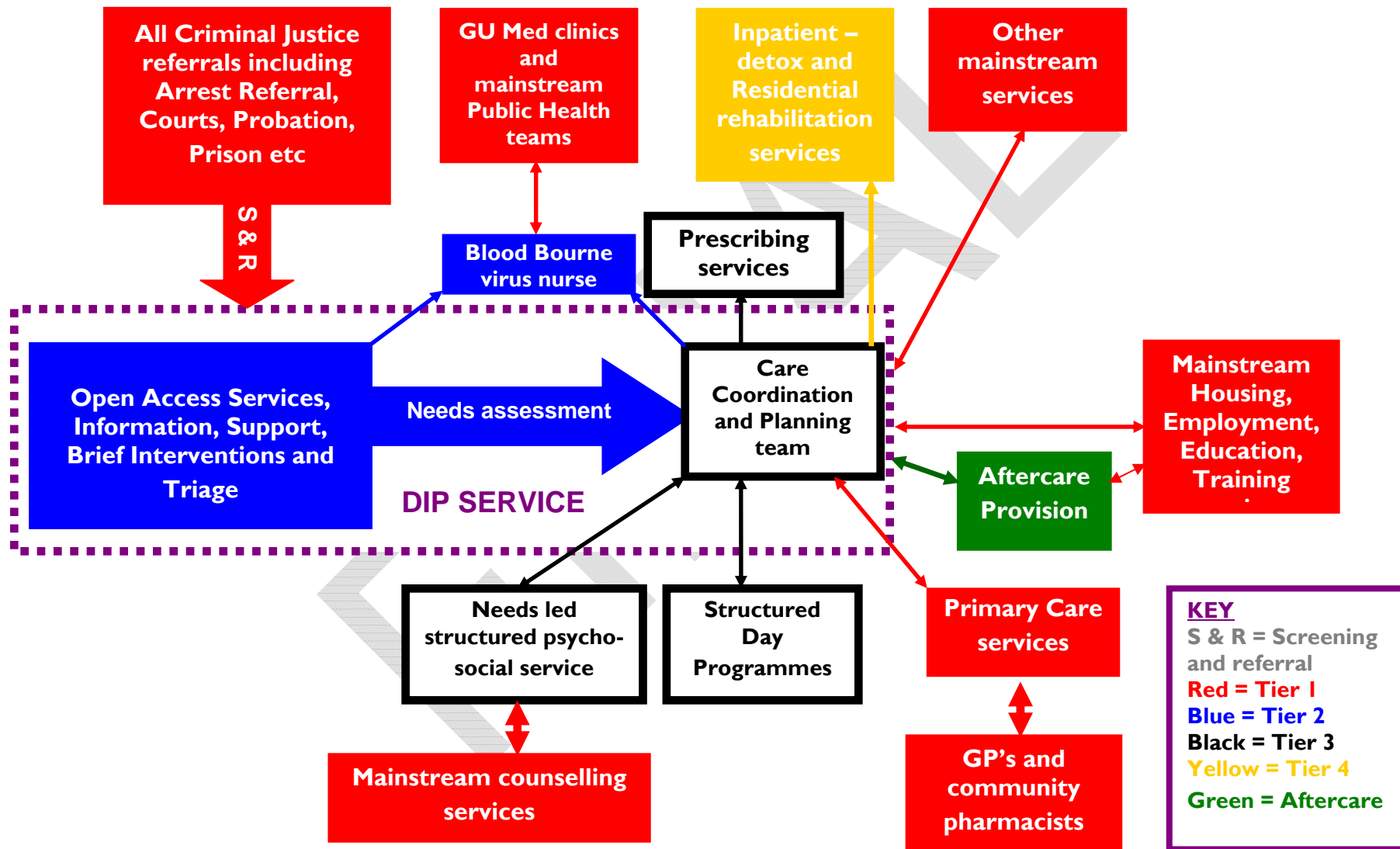
For full details see diagrams overleaf :

- Community Drug Treatment System
- Criminal Justice treatment system
- Alcohol Treatment System

The Community Drug Treatment System 2008



The Criminal Justice Treatment System 2008



Prolific and Priority Offenders (PPO)

The DIP provides interventions for PPO clients referred from within the criminal justice system. The 11 district CDRP have agreed to collectively fund extra capacity within DIP provision, for up to 50 substance misusing PPO clients (at any one time) who are in the community.

This ensures that all PPO are able to access the same level of service if they have a substance misuse problem. Case management is the statutory responsibility of the CDRP, via their strategic PPO committees; care management is delivered by the providers.

Monitoring of offending rates of these individuals is managed at local level, in conjunction with police who have access to PNC. As part of the process for aligning DIP and PPO, provisional agreement has been obtained with the Local Criminal Justice Board for monitoring of those individuals who fall within both schemes.

Winchester Prison

Many prisoners enter prison with a drug or alcohol problem and once the prisoner has been allocated their Prison Number, they are seen by a member of the health care team to ensure they receive the care that they need whilst they are in prison. The prison also have 'CARAT' workers. CARAT stands for 'Counselling, Assessment, Referral, Advice and Through care'. Everyone coming into prison who is identified as having a drug problem is assessed, given advice about their misusing, and referred to other services such as drug treatment programmes, housing, employment and external Drugs Intervention Teams to prepare for release, etc.

CARAT workers act as key workers and coordinate the care of those prisoners on their caseloads; workers can also provide basic information about drugs and their effects and ways to reduce harm; they may offer some structured one-to-one support and group work to prisoners who want to give up or cut down on their misusing. They can also refer a prisoner to a drug treatment rehabilitation programme.

HMP Winchester's CARAT services are currently staffed by an external service provider and the prison service. The accredited programmes are solely staffed by the prison service. In both cases the teams are multidisciplinary with both uniform and non uniform staff working together.

A detox service is commissioned by Hampshire Primary Care Trust comprising of a dedicated 34 bed landing on the admissions wing with two uniformed officers attached.

The Short Duration Programme course is a four/five week accredited programme (20 half day sessions over four weeks plus a review week) aimed at remand and short sentenced prisoners. PASRO (Prison addressing substance related offending) is a six/eight week programme (20 sessions over six weeks plus reports and reviews over two weeks) aimed at prisoners serving twelve months or more. Progress during the course is carefully monitored and the offenders receive on going support from programme staff and CARAT workers, as well as undertaking Voluntary Drug Tests. The course reviews are an integral part of the course and family members, Hampshire Probation Area, PPO Officers and DIP workers are invited to attend with the offender and the prison case workers.

Current treatment system

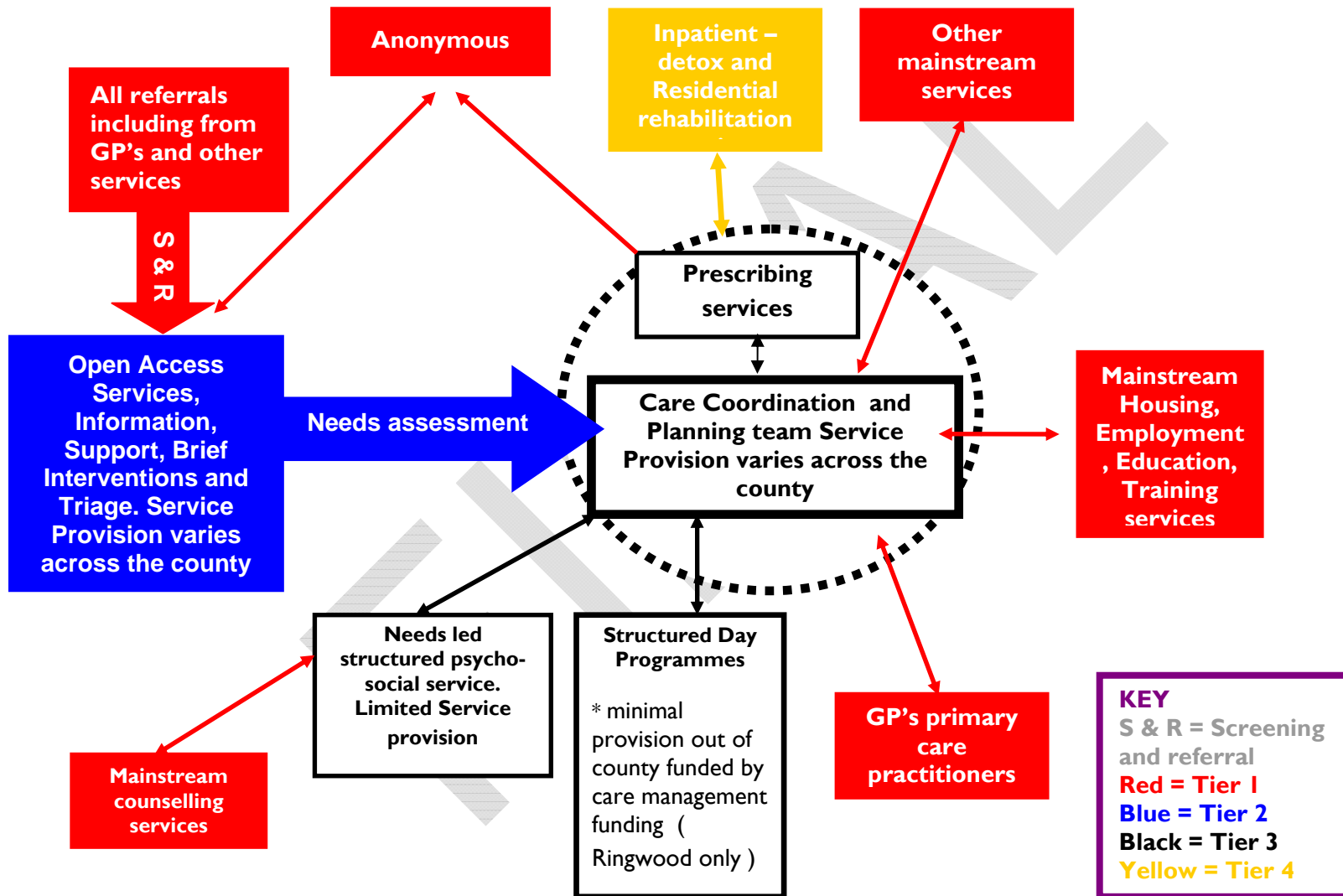
HMPS drug services are supported and monitored by the centralised Interventions and Substance Misuse Group (ISMG) and the Drug Strategy Unit at HMPS HQ. The programmes are robustly audited by ISMG in order to maintain accreditation by CSAP. ISMG have also set challenging workforce development targets including having at least 75% of non professionally qualified substance misuse staff either working towards or achieved the Health and Social Care NVQ level 3 or equivalent by the end of 2008.

Strong links exists with the community services. All appropriate DIRs are faxed to CJITs/DIPs and engagement is encouraged. To enable DIP teams to see their clients prior to release a Thursday afternoon DIP clinic is facilitated by the CARAT service for DIP teams to book appointments to attend. This is in addition to enabling telephone and other assessments to take place as resources allow.

Hampshire DIP attend the prison regularly for informal progress meetings and are currently working with HMP Winchester to develop improved links, a joint training day is planned as well as increasing opportunities for DIP staff to attend the prison.

FINAL

Alcohol Treatment System 2008



Alcohol Treatment System

Alcohol Treatment services are currently jointly commissioned between DAAT and Hampshire Primary Care Trust. Services are 'tiered' levels 1 – 4 in the same manner as drug treatment services. Guidance set out in MOCAM is now available to support and inform future commissioning decisions.

Hampshire Probation Area

Hampshire Probation Area has commissioned assessment and treatment for offenders with alcohol problems. Offenders who score 7 or more on the alcohol section of the OASys assessment tool are referred. A support worker assesses the offender and makes a recommendation to the court as to whether there should be an Alcohol Treatment Requirement (ATR). The ATR typically lasts for 6 months and is currently based on one to one interventions, although group sessions are being considered. Eight full time equivalent alcohol workers provide this service, based in the probation offices in Aldershot, Andover, Basingstoke, Winchester, Fareham, Portsmouth, Havant, Southampton, Newport, Lymington and Totton.

Andover alcohol arrest referral project

This is a pilot project running from October 2007 to October 2008 in Andover. The intervention is aimed at individuals arrested for alcohol related offences that would not normally lead to a custodial sentence. Clients are assessed and referred by the custody staff at Andover Police Station. An appointment with the service provider is made for the client usually to attend within a few days of release to receive an appropriate intervention.

Alcoholics Anonymous

Alcoholics Anonymous provides a comprehensive network of services across Hampshire for people who have identified they need help and on average provide support to approximately 1,000 people per week, with meetings taking place in 31 towns (not including Portsmouth and Southampton).

Links with other programmes

Self Directed Support Pilot

Hampshire County Council will be piloting Self Directed Support in its Basingstoke locality during 2008/9. Phase 1 of the pilot will encompass all adult care groups eligible with the exception of Mental Health and Substance Misuse. However, it is anticipated that these groups will be included in the expanded Phase 2 of the pilot. Appropriate risk assessment and governance procedures must be developed to support this initiative.

Homelessness & Housing

Homelessness and housing issues are recognised as a significant barrier to effective engagement with treatment services and consequently form a core strand of the needs assessment and care planning process at all tiers of the treatment system.

Rather than seeking to develop Substance Misuse-specific provision, Hants DAAT has sought to promote inclusion and effective, Best Value provision through work with partners agencies to improve access to mainstream services.

The Supporting People Development Plan (Homelessness Strategic Review) include the commitment that, "Support to those experiencing substance misuse problems will be

Current treatment system delivered through generic floating support services that are sensitive to the needs of this client group...” and included provision for up to 30 hours of Floating Support per locality to be co-located within Tier 2 services. This has now been delivered and data on the provision of support to substance misuse clients is contained at Section 10.

Housing-related needs are a core strand within care planning at Tier 3. Service users will either be sign-posted to or supported to access mainstream services depending on levels of individual support needs. Supporting People are currently working in partnership with Fareham and Gosport Borough Councils to develop a clean & dry hostel in Fareham. This facility is due to open in 2008/9.

Young People and substance misuse


At the present time there are no formal transitional arrangements in place in Hampshire for people moving from the young people’s substance misuse service into adult drug and/or alcohol services.

F E M I N A L

9 Financial Information

The following section provides information on the funding currently supporting the treatment system in Hampshire. It includes information about the funding received by Hampshire DAAT and where it has been possible to obtain this, the funding contributions of partner agencies.

Five Year Funding Profile²³ - Based on DAAT only funding					
Funding Source	2006/07	2007/08	2008/09	2009/10	2010/11
Adult Pooled Treatment Budget (Drugs Only)	4,969,008	4,904,734	4,742,747	4,499,766	4,094,786
DIP Main Grant	682,162	602,349	611,384		
Partnership Support (Grant)	120,111	111,711	103,000		
Young Peoples Substance Misuse Partnership Grant	1,051,460	911,015	906,805	<i>464,505</i>	<i>464,505</i>
Local Authority Secure Children's Homes Grant	28,217	28,885	29,644		
Alcohol Strategy Co-ordination	25,487	39,500	43,050		

 Young People's Budgets included for illustrative purposes only – figures in italics represent confirmed element only

The strategic priorities identified in the Adult Drug Treatment Plan for 2008/09 include the delivery of a financially sustainable treatment system. As a result of the recently announced 3-year Adult Pooled Treatment Allocation (2008/09 to 2010/11), Hampshire DAAT is required to reduce investment in drug treatment services by £1,152,885 (not including any inflationary element) over the next 3 years, when non recurring slippage elements are included. Planned expenditure in 2008/9 has already been cut. A reduction in funding of this magnitude cannot be delivered through imposed efficiency targets alone. Inevitably planned developments will need to be withdrawn and some services may be decommissioned following the strategic review process.

The following table provides information on funding received by the DAAT to support the Drug Intervention Programme.

Funding Received by DAAT from other Sources to Support DIP Activity			
Funding Source	2006/07	2007/08	2008/09
Hampshire and Isle of Wight Constabulary	79,266	81,633	81,633
County Co-ordinating Group for Community Safety *	75,596	71,623	79,423

* Formerly funded by District Community Safety Partnerships

²³ Information has been presented in a manner which ensures commercial confidentiality is not breached

The following table provides information from the Adult Drug Treatment Plan 2008/09 and provides an overview of how the DAAT is allocating the resources it has at its disposal. The funding includes The Adult Pooled Treatment Budget (Drugs Only), the DIP Main Grant, Hampshire Constabulary and County Community Safety funding for DIP and planned slippage from 2007/08. The unallocated slippage identified within the table will be carried forward into 2009/10 on a non recurring basis to offset some of the funding cut.

Adult Drug Treatment Plan 2008/09	
Activity	Budget
Planning a Local Drug Treatment System	224,000
Workforce Development	19,000
User Involvement	76,500
Carer Involvement	37,500
Harm Reduction Strategy	501,504
Information, Screening and Referral by Generic Services	12,500
Open Access Drug Intervention	651,059
Structured Community Based Drug Treatment Interventions	2,784,614
Residential & Inpatient Drug Treatment Interventions	177,400
Drug Intervention Programme	1,360,191
Unallocated Slippage	180,670
Total	6,024,938

Of this £6,024,938, the sum of £5,070,097 is invested in DAAT contracts, the remainder represents the cost of commissioning (management, staff and infrastructure costs) £230,000 (3.8%), service user and carer activity, funding for dual diagnosis, pharmacy based activity (yet to be formally commissioned/contracted), additional residential rehabilitation /care management funding.

Contracted Activity	Amount
Tier 2 (including Harm Reduction and Outreach)	1,216,341
Tier 3	2,441,165
Tier 4	147,400
DIP (Including Aftercare, 24/7, and additional DIP Prescribing ²⁴)	1,265,191
Total	5,070,097

²⁴ Additional DIP prescribing = additional funding to prescribing agencies to deliver additional capacity within prescribing clinics and cover costs of prescribed items

Financial information

There is additional funding supporting the treatment system in Hampshire, which is presently used to commission services independently by the agency concerned. However, there are proposals in place to develop a unified commissioning framework between the DAAT, PCT and Adult Services which will seek to align or pool the current funding. Once this arrangement is in place there is an opportunity for these new arrangements to encompass the funding of other partners.

The funding provided by Hampshire PCT and Adult Services includes funding for both drugs and alcohol activity.

Other Partner Funding contributing to the Treatment System		
Funding Source	Activity	2008/09
Hampshire Primary Care Trust	Tier 2, 3 and 4 provision	£4,924,474*
Hampshire County Council - Adult Services	Tier 2, 3 and 4 provision	513,000
Hampshire Probation Area	DRR and ATR **	*
HMP Winchester	CARAT / Offender Programmes/ Detox and Healthcare	*
Test Valley Community Safety Partnership	Andover Arrest Referral Pilot	14,000*

*Some of this information is missing/requires further verification.

** DRR - Drug Rehabilitation Requirement, ATR – Alcohol Treatment Requirement

PCT Investment by Tier

PCT investment split by Tier and Substance	
Tier 2 (Drug and Alcohol)	£120,765
Tier 3***(Drug and Alcohol)	£3,876,194
Tier 4 (Drug and Alcohol)	£927,515
****TOTAL	£4,924,474

***Shown at 2007/8 price base

****Excludes Prison detox service, Priory In-patient contract and salaried GP support to Homeless service

PCT funding intentions

The PCT fully supports the objective of working towards an integrated joint commissioning approach to Drug and Alcohol services which could include a pooled budget and recognises the considerable benefits of working together towards this objective.

10 Services and capacity

The services that have been included are those commissioned by the DAAT, Adult Services and Hampshire PCT and this does not provide a full picture of all substance misuse services that are currently available in Hampshire which may be provided by other agencies.

Further work will be required to complete this section of the document during the enhancement and verification process, both by the DAAT Team and other partners and stakeholders.

It is also not possible at the present time to pull out consistent information relating to service capacity, as the service have not been commissioned in this way.

Maps of service provision are provided on pages 48 and 49 and the following table provides additional information about these services.

Tier 2 : Open Access services

Provider	Service	Commissioner	Focus	Area
Patient Support Link	<u>24/7 telephone support line for 'concerned others' family or friends</u>	DAAT	Drugs	County Wide
Society of St James	<u>The Bridge (Eastleigh & New Forest) – Open Access Shop Front</u> Triage & assessment, needle exchange (limited), drop-in, brief psycho-social interventions and semi-structured therapeutic and educational work.	DAAT PCT Adult Services	Drug & Alcohol	New Forest & Eastleigh Test Valley South-area (New Forest service currently operating from temporary site New Milton)
Phoenix Futures	<u>Spotlight (Fareham & Havant) – Open Access Shop Front</u> Triage & assessment, needle exchange, BBV-testing, drop-in, brief psycho-social interventions and semi-structured therapeutic and educational work.	DAAT PCT	Drug & Alcohol	Fareham, Gosport, Hayling Island and East Hampshire (up to Petersfield)
Phoenix Futures	<u>Phoenix Futures NNE Hants (Aldershot & Basingstoke) – Open Access Shop Front</u> Triage & assessment, needle exchange, drop-in, brief psycho-social interventions and semi-structured therapeutic and educational work.	DAAT PCT Adult Services	Drug & Alcohol	North & North East Hampshire (currently operating from temporary bases in Basingstoke & Aldershot)
CRI	<u>Andover Open Access Shop Front</u> Triage & assessment, needle exchange, drop-in, brief psycho-social interventions and semi-structured therapeutic and educational work.	DAAT Trust funding stream supporting alcohol work	Drug & Alcohol	Andover & surrounding area

Clems	<u>Winchester Open Access service</u> Triage & assessment, needle exchange, drop-in, brief psycho-social interventions and semi-structured therapeutic and educational work.	DAAT	Drug	Winchester
Cranstoun	<u>Harm Reduction & Outreach Service</u> Proactive outreach providing information, health promotion and preventative interventions including distribution and return of drug using paraphernalia	DAAT	Drugs	Countywide
Cranstoun	<u>DIP</u> Arrest Referral services, advice and information inc harm minimisation, brief interventions, triage assessment and onward referral to appropriate services for drug misusing offenders at any stage of the Criminal Justice System.	DAAT, Police County level CDRP ²⁵	Drugs	Countywide

Tier 3 : Structured community-based, care-planned substance misuse treatment

Provider	Service	Commissioner	Focus	Area
Hampshire Partnership Trust	<u>Rooksdown House Community Alcohol Team</u> Specialist prescribing, care management, community detox, psycho-social interventions and structured therapeutic and educational work.	PCT Adult Services	Alcohol only	Basingstoke and North Hampshire

²⁵ CDRP – Crime and Disorder Reduction Partnership

Hampshire Partnership Trust	<u>Spencer House Community Drug & Alcohol Team</u> Specialist prescribing, care management, community detox, psycho-social interventions & structured therapeutic & educational work.	DAAT PCT Adult Services	Drug & Alcohol	Winchester, Eastleigh & Andover areas
Hampshire Partnership Trust	<u>Oaktree Community Drug & Alcohol Team</u> Specialist prescribing, care management, psycho-social interventions, structured therapeutic and educational work.	DAAT PCT Adult Services	Drug & Alcohol	New Forest
Hampshire Partnership Trust	<u>Fairfields House Community Drug Team</u> Specialist prescribing, care management, psycho-social interventions, structured therapeutic & educational work.	DAAT PCT Adult Services	Drug only	Basingstoke
Surrey & Borders Partnership Trust	<u>Acorn Community Drug & Alcohol Team</u> Specialist prescribing, care management, psycho-social interventions, & structured therapeutic & educational work.	DAAT PCT Adult Services	Drug & Alcohol	Aldershot, and Rushmoor & Hart areas
Portsmouth City PCT	<u>Orion & Avalon Drug & Alcohol Community Teams</u> Specialist prescribing, care management, psycho-social interventions and structured therapeutic & educational work, BBV testing.	DAAT PCT Adult Services	Drug & Alcohol	Fareham, Gosport, Hayling Island and East Hampshire (up to Petersfield)
Portsmouth City PCT	<u>CARE</u> Psychosocial interventions and treatments, to improve health, social and psychological functioning.	DAAT	Drugs	Countywide

Phoenix Futures	<u>Structured Day Care</u> Day Programmes to support improvements in the physical and psychological health and social functioning of drug using individuals	DAAT	Drugs	Countywide
Cranstoun	<u>DIP</u> Work with DRR and Prolific and Priority Offenders (PPO's) clients to deliver care management, psycho-social interventions & structured therapeutic & educational activities.	DAAT	Drugs	Countywide

Tier 4: Specialist inpatient treatment and residential rehabilitation

Provider	Service	Commissioner	Focus	Area
Portsmouth City PCT	<u>Baytrees In-patient Detox Service</u> Medical assessment, stabilisation and withdrawal from problematic substances	DAAT PCT	Drug & Alcohol	County-wide
Priory Marchwood	<u>In-patient Detox Service</u> Medical assessment, stabilisation and withdrawal from problematic substances	PCT	Alcohol only	County-wide
Phoenix Futures – Alpha Service	<u>In-patient Detox and Residential Rehabilitation</u> Medical assessment, stabilisation and withdrawal from problematic substances & an accommodation based care-planned programme of therapeutic & other activities.	Adult Services	Drug & Alcohol	Countywide

See Directory for further information on opening hours and contact details etc: <http://www.hantsdaatdirectory.org.uk/>

DETAILS OF STAFFING WITHIN COMMISSIONED SERVICES ²⁶ (As at 31ST MARCH 2008)				
Name of Organisation	All			
Name of Service	All			
Staff	Permanent staff - whole time equivalent (WTE)	Temporary or agency cover (WTE)	Vacancies (WTE)	Total WTE
Joint Commissioning Staff	2	0	0	2
Service Managers	8.63	0	0	8.63
Nurses	35.56	2.3	4	41.86
Social Workers	11	0	0.6	11.6
Counsellors	3.4	0	0	3.4
Psychiatrists/Doctors	5.35	0	0	5.35
Outreach Workers	6	0	0	6
Criminal Justice Workers	16.6	0	0	16.6
Psychologists	0.2	0	0	0.2
Administration/Support Staff	21.22	0.8	0.7	22.72
Occupational Therapists	0	0	0	0
Complementary Therapists	0	0.4	0	0.4
GP Liaison workers	4.8	0	0	4.8
No of prescribing GPs (enter number not WTE)	12	0	0	12
Other - Aftercare Worker	2	0	1	3
Other - Care Coordinators	1	0	2	3
Other - Clinical Manager	1	0	0	1
Other - Community Based Drug Workers	10	0	1	11
Other - Health Care Support Workers	17.85	0	0.5	18.35
Other - unspecified	0	1	0	1
Other - Practitioner	1	0	0	1
Other - project worker	5.5	0	0	5.5
Other - Service Coordinator	0.6	0	0	0.6
Other - Substance Misuse Workers	7.8	0	0	7.8
Other - Team Manager	4	0	0	4
Other - Therapeutic Coordinator	1	0	0	1
Total	178.51	4.5	9.8	192.81

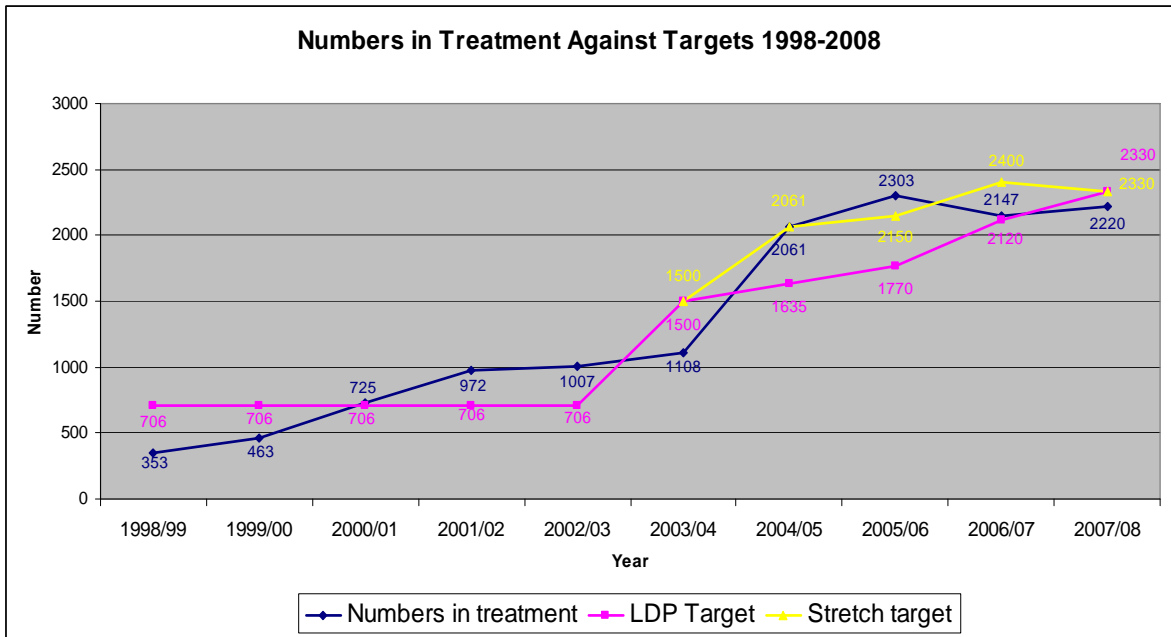
²⁶ Information supplied by provider agencies to DAAT

11 Performance & Current Activity

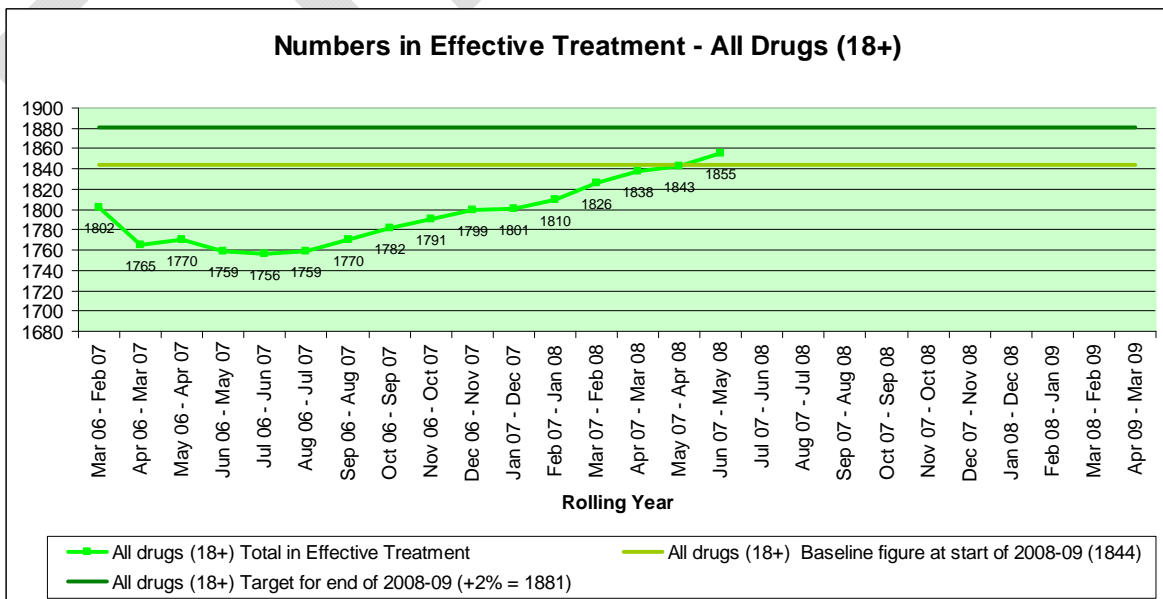
Core Targets

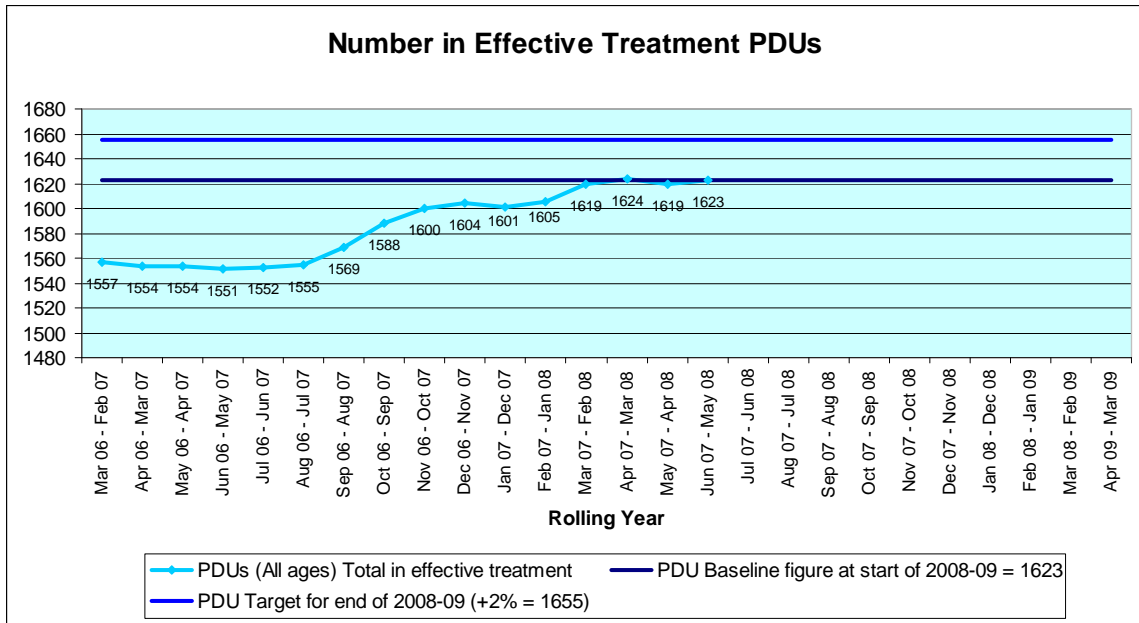
Numbers of drug users in treatment 1998 - 2008

This graph relates to performance against targets set in the first National Drug Strategy, 'Tackling drugs :Changing lives'



Numbers in Effective Treatment - All Drugs (18+)

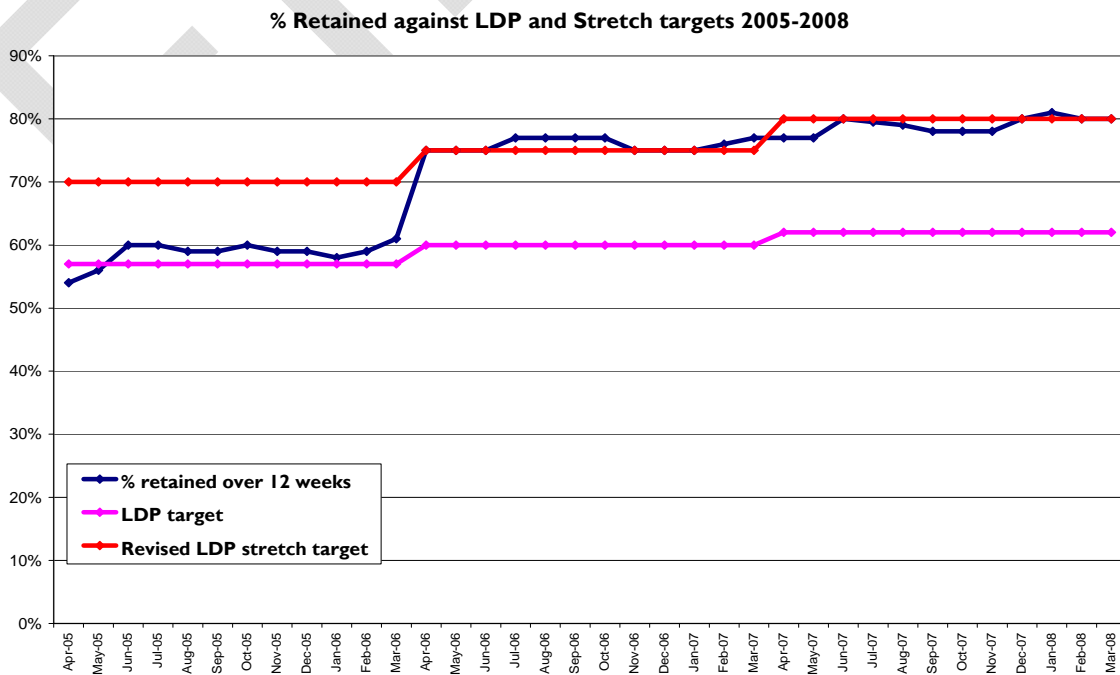


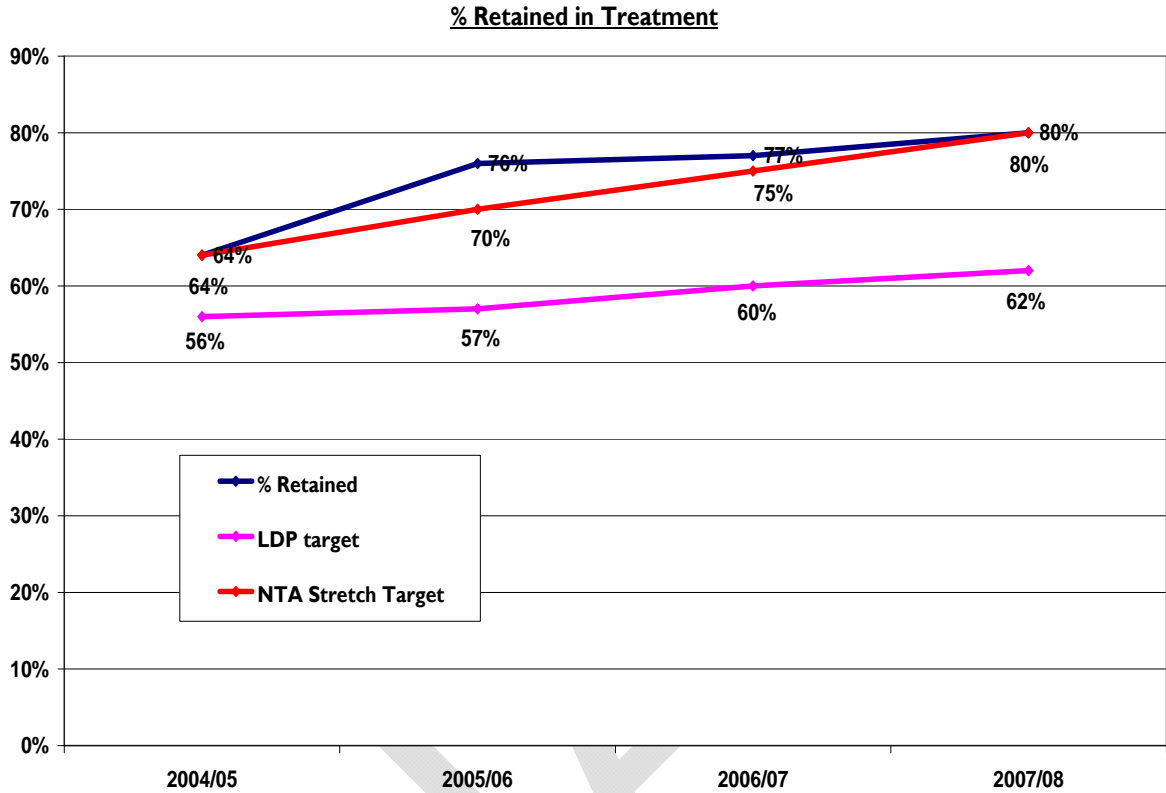


At the end of 2007/08 the NTA recorded the effective treatment rate in Hampshire at 86% which was equal with national average and 5 percentage points above the Pooled Treatment Plan target. The NTA has altered the way in which it will record effective treatment rates in the future in that the measure will now relate to new treatment journeys in a 12 month rolling year as opposed to all in treatment. The figures relating to 2007/08 were recalculated by the NTA using the new method and were recorded as being 82% in effective treatment for PDUs and 78% in effective treatment for All Drugs (18+)

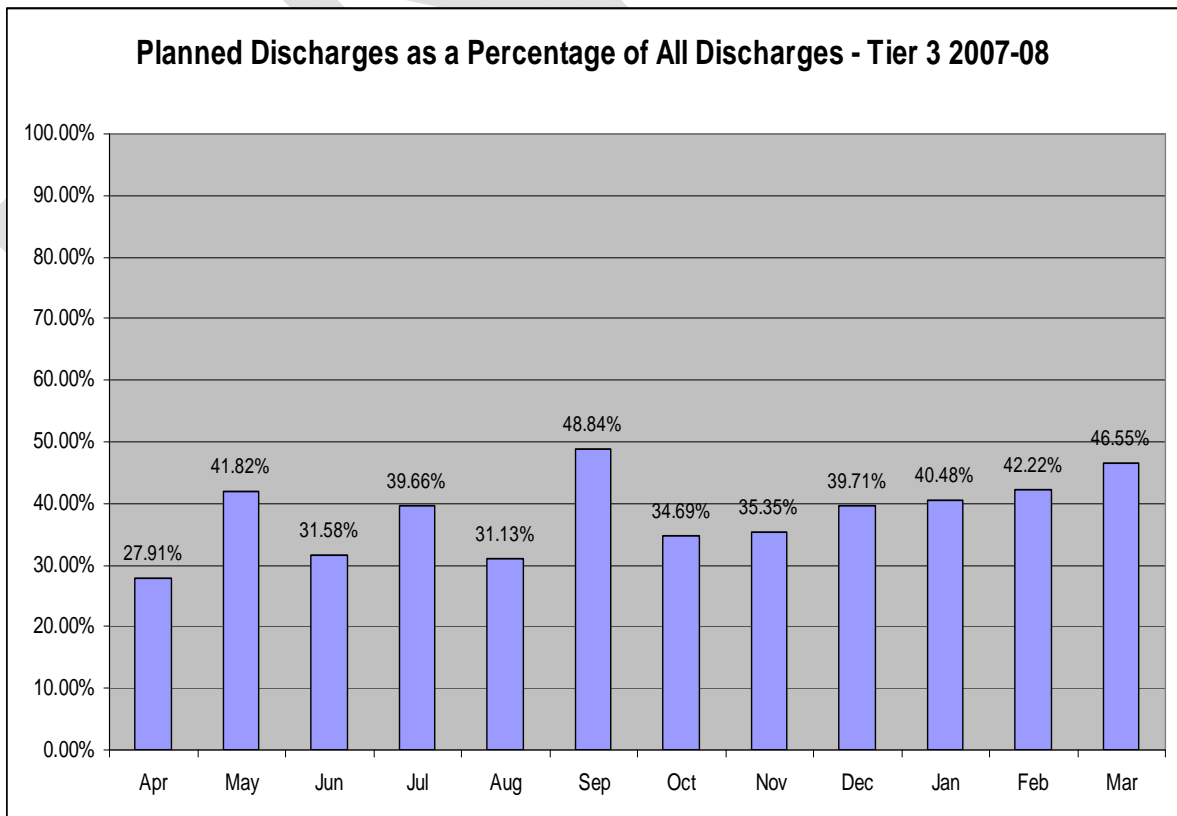
Retention in Treatment (Also PAF A80)

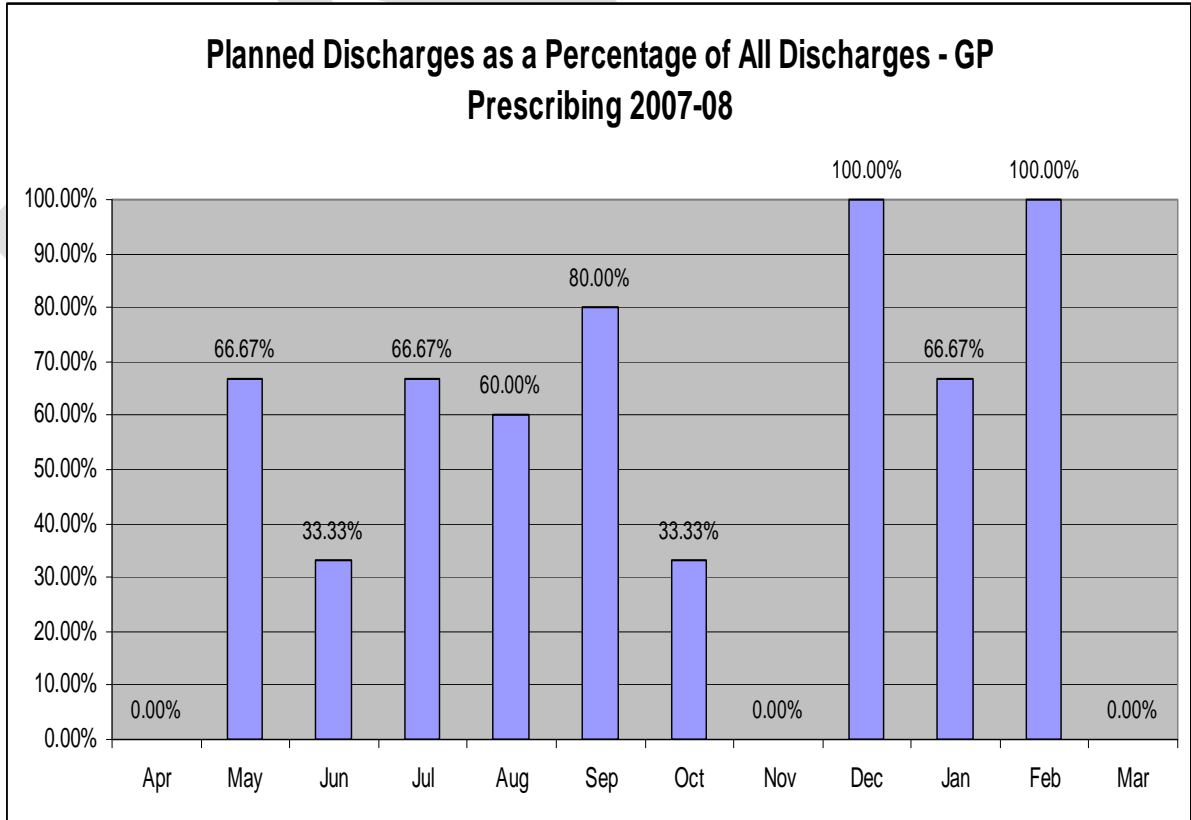
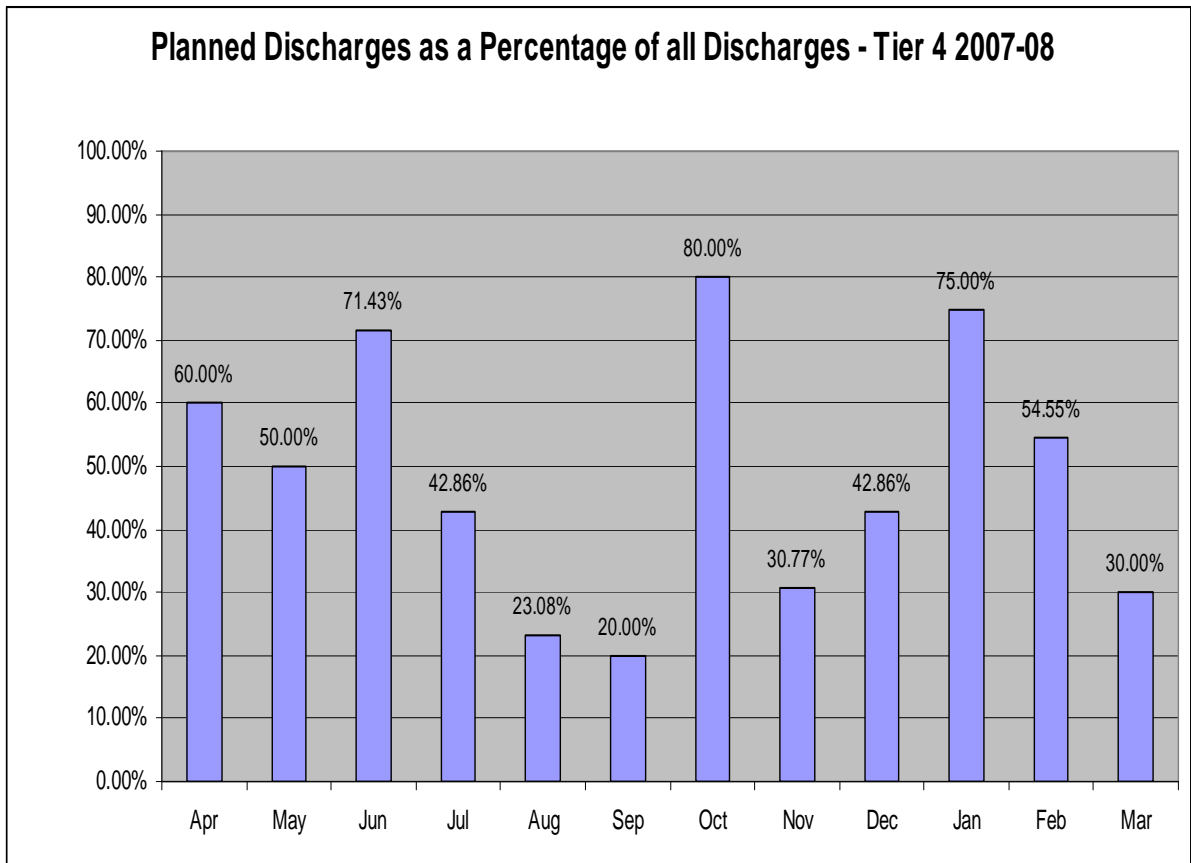
The 12 week retention rate is 80%, 4 percentage points above national average

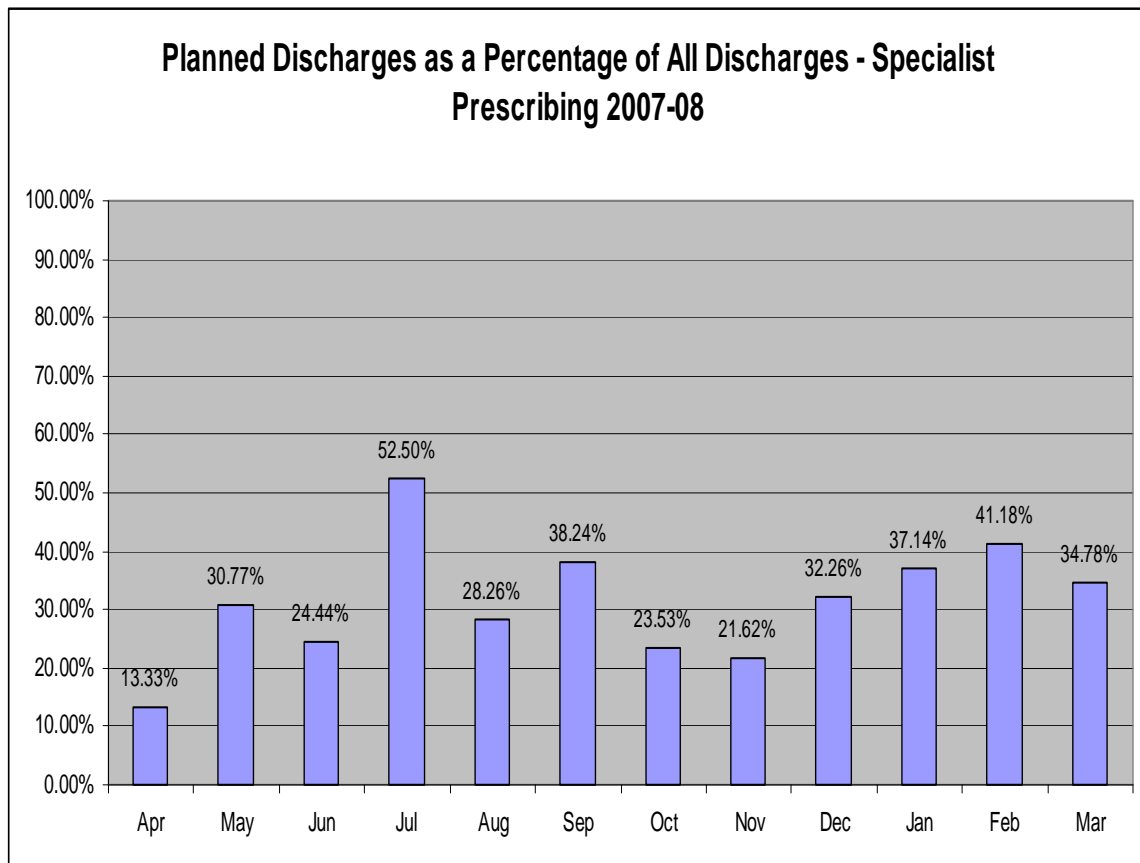




Completed Treatments and Planned Discharges







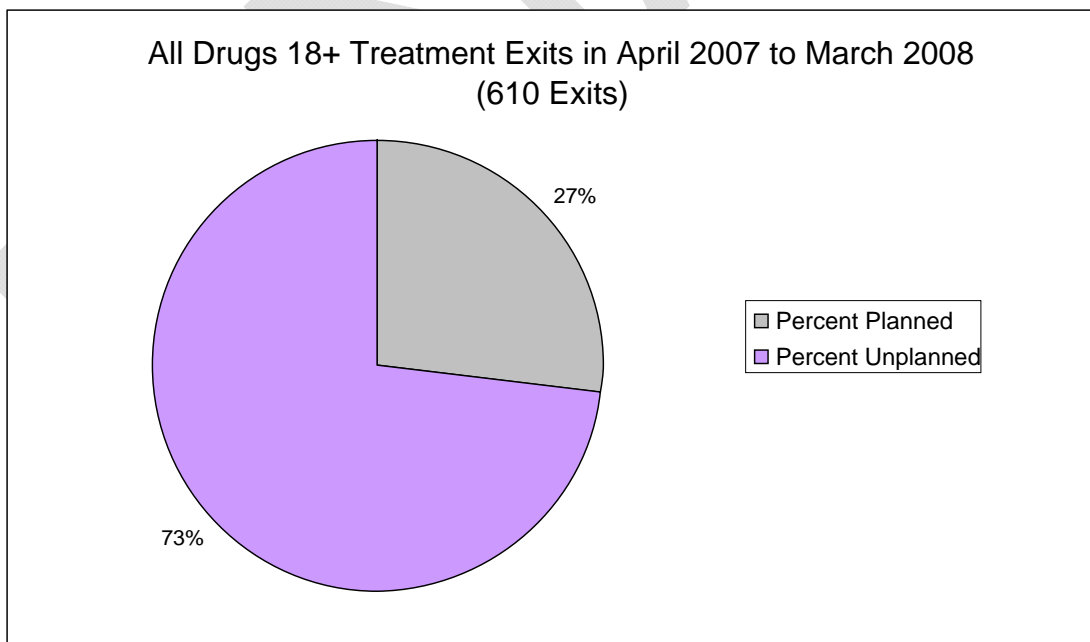
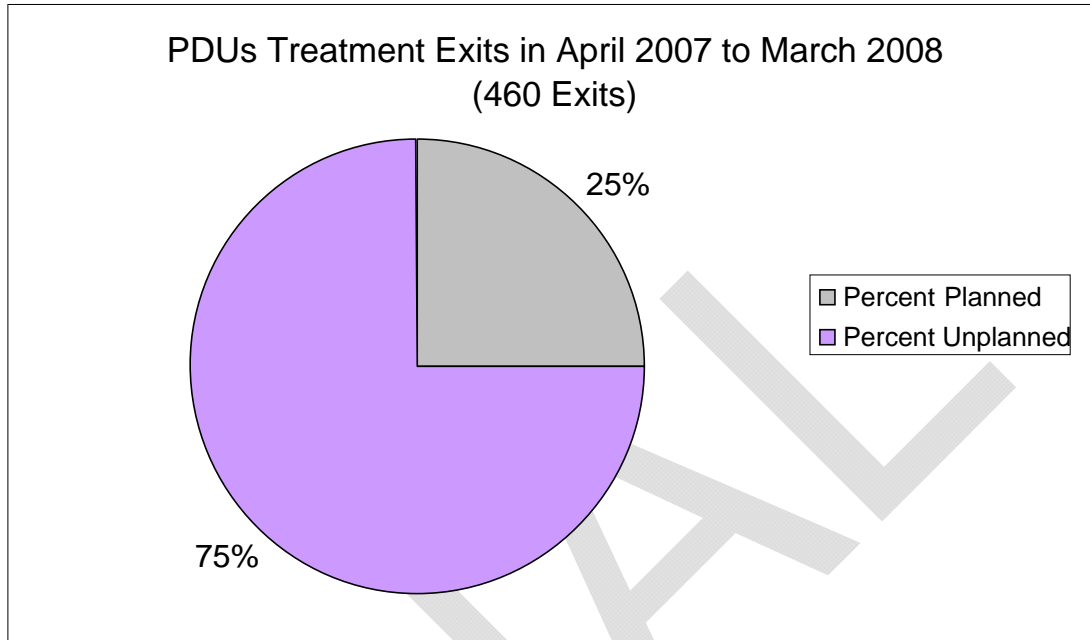
The charts above show the detail relating to planned discharges in the way that it was measured throughout 2007/08. However the NTA has now amended the way this will be recorded in that the overall planned exits will be looked at instead of the separate modalities.

Current performance : GP / shared care

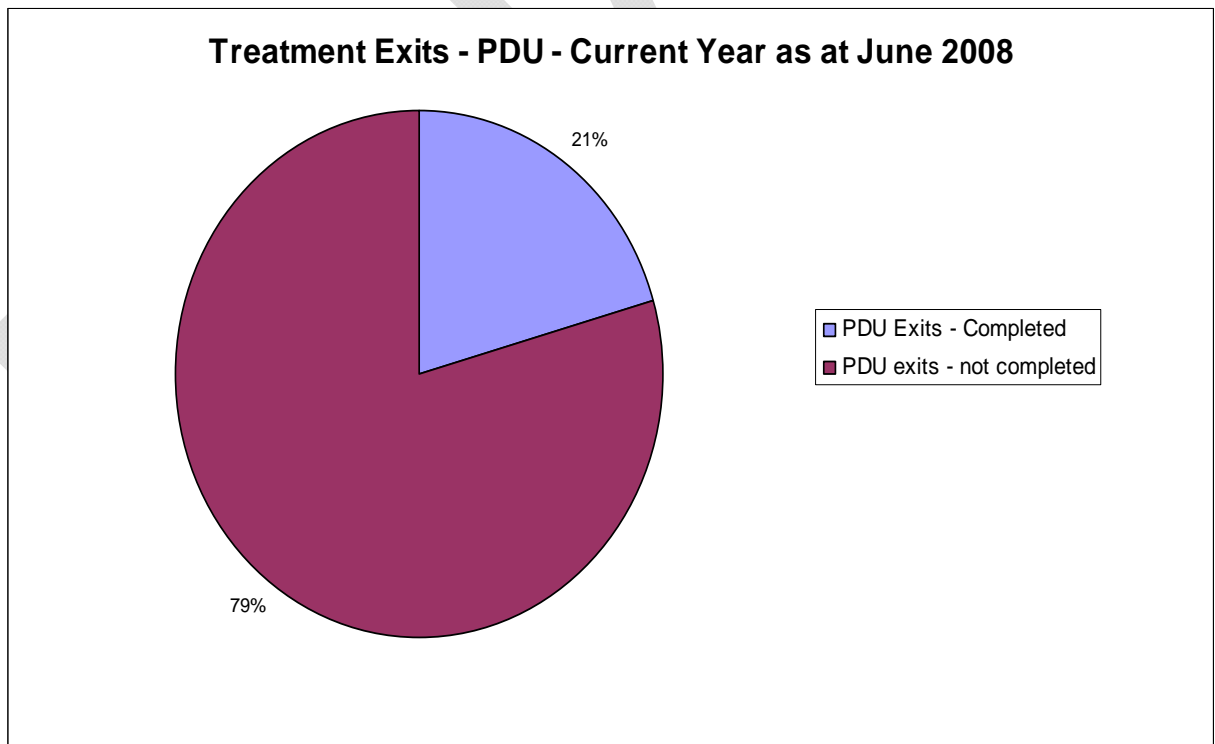
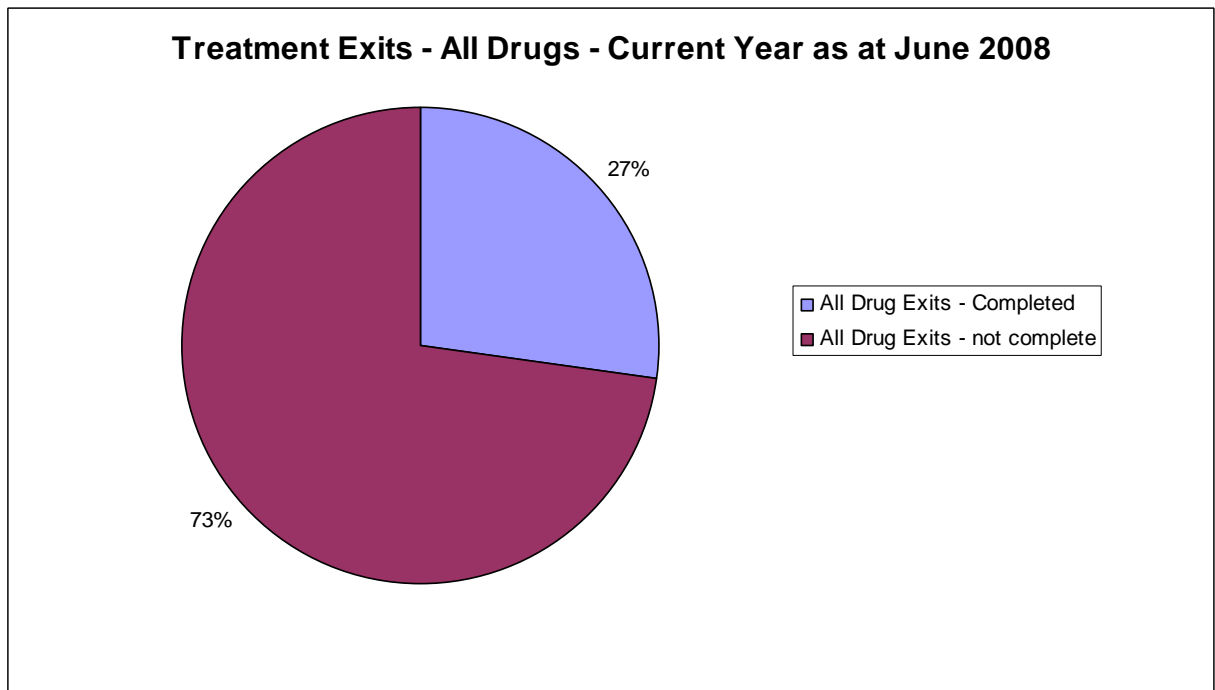
Area	Surgeries	GP's	Clients
North East (data as at Mar 08)	5	10	30
North	1	1	5
Mid Hants	3	3	16
South & East	8	12	14
New Forest	0	0	0
TOTAL	17	26	65

Problematic Drug Users

The figures relating to 2007/08 were reported to the DAAT by the NTA using this new method and the pie charts below represent the position for the year for PDUs and All Drugs (18+)

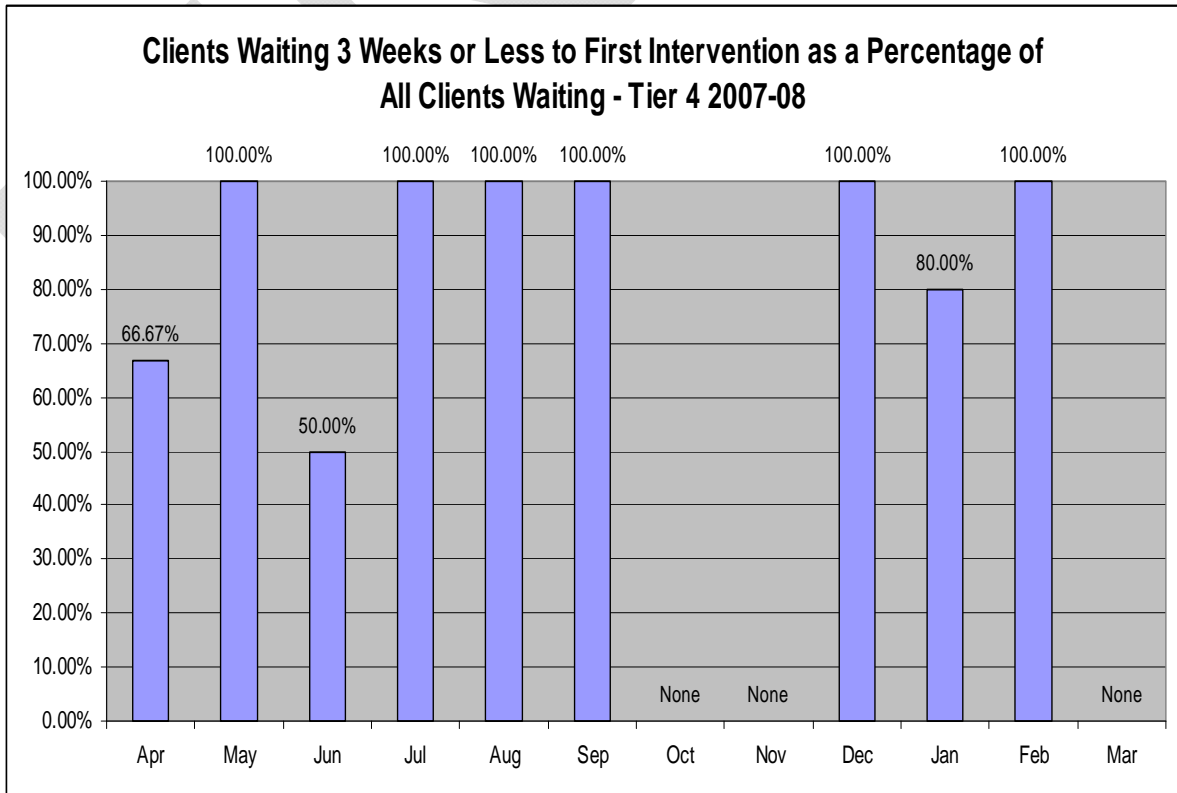
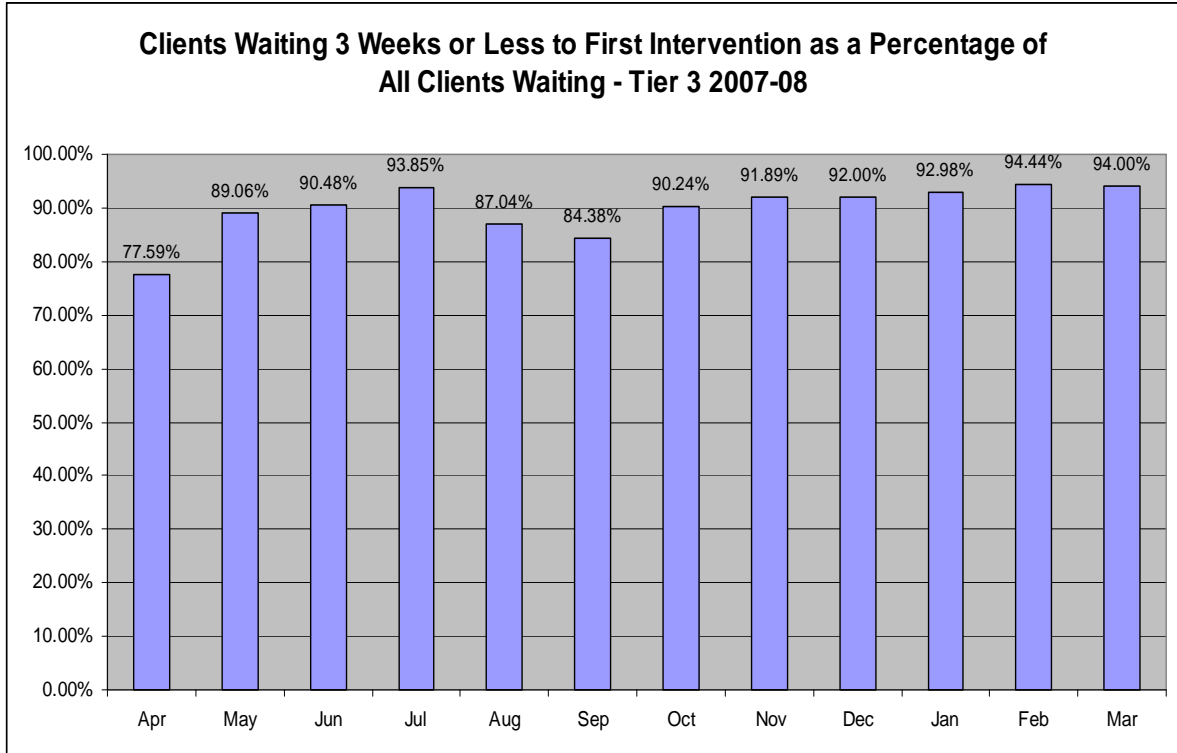


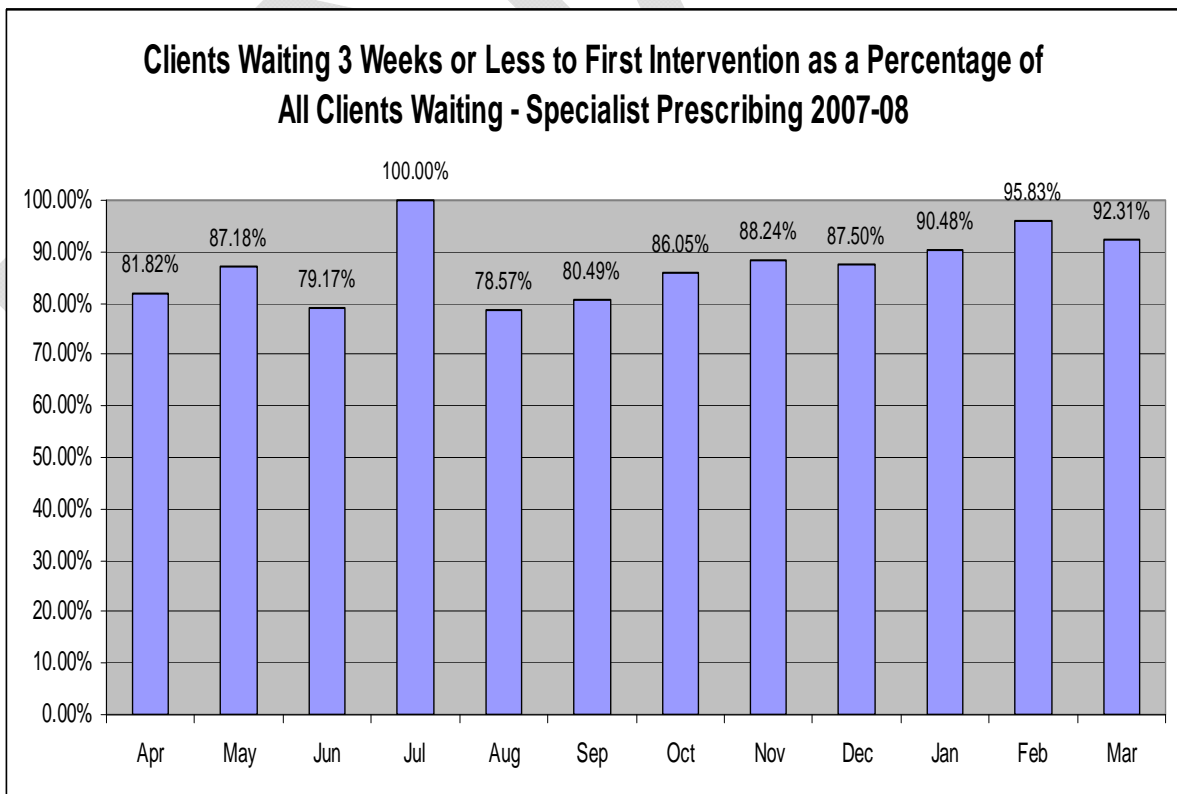
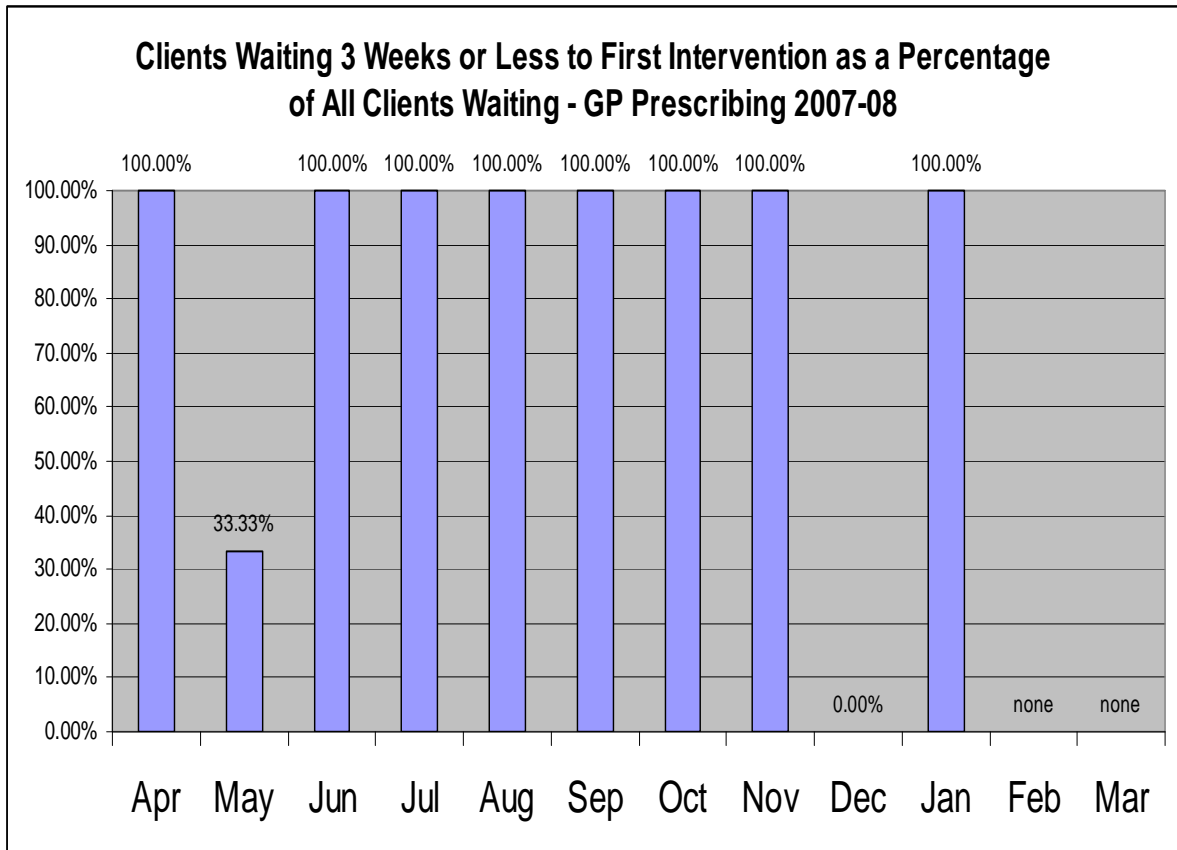
The two charts below relate to the planned exits in the first quarter of 2008/09



Diagnostic Indicators

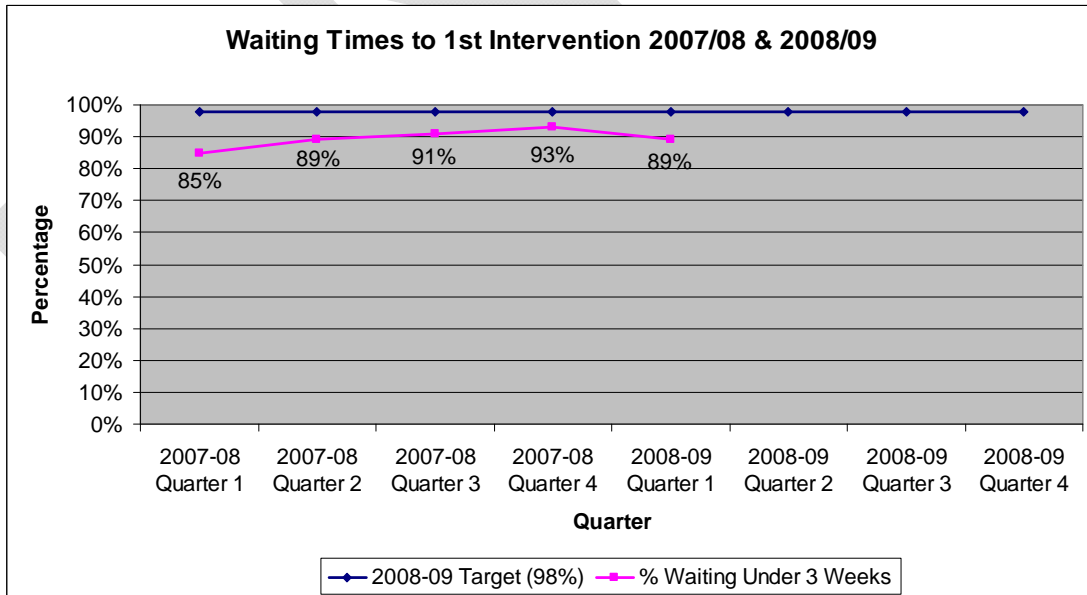
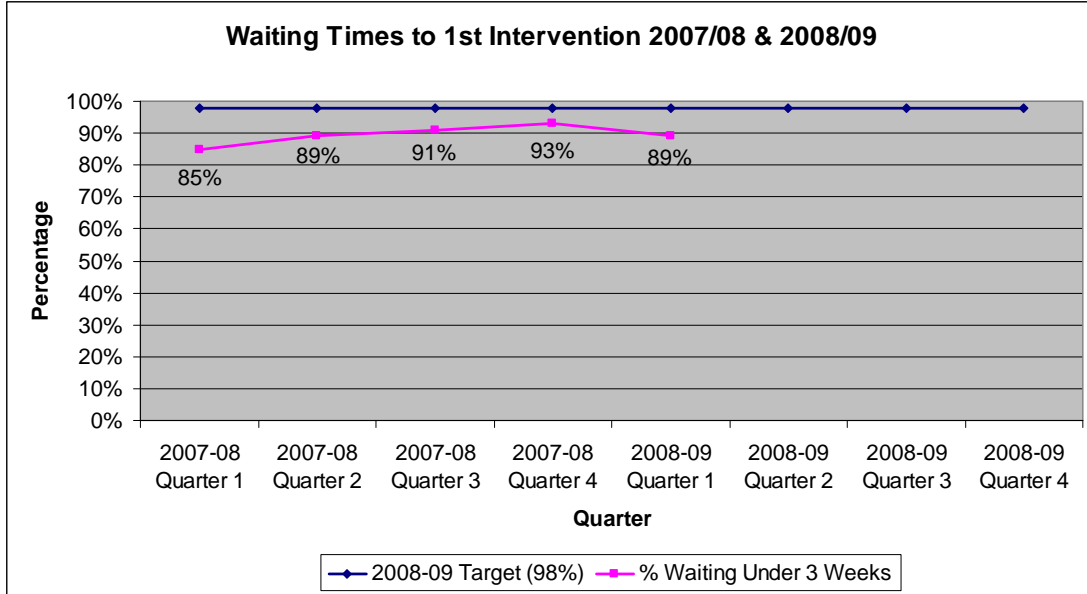
Waiting Times





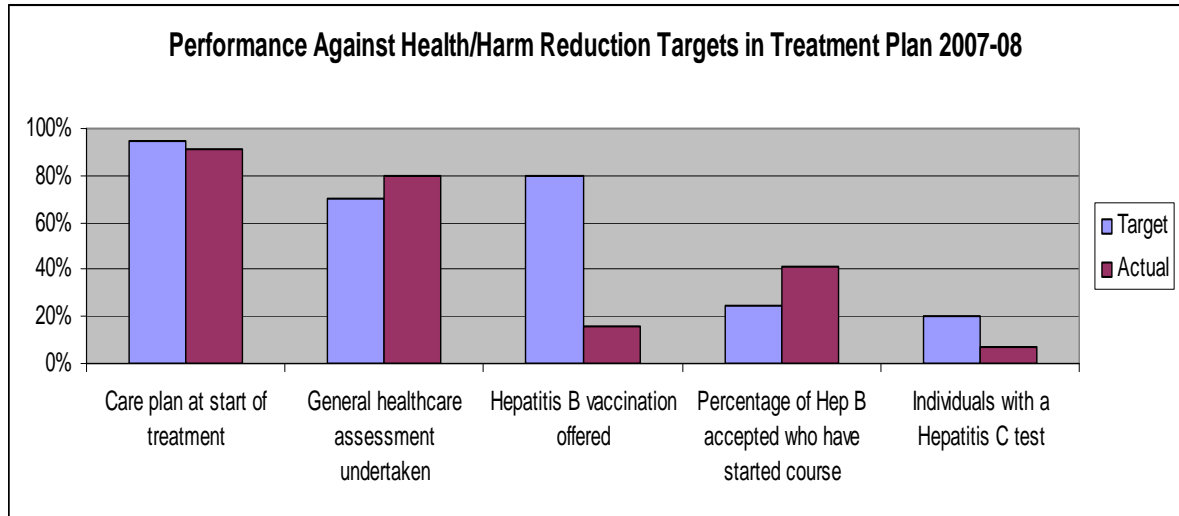
The charts above show the detail relating to waiting times in the way that it was measured throughout 2007/08. However the NTA has now amended the way this will be recorded in that the overall waiting times will be looked at instead of the separate modalities. The figures relating to 2007/08 were reported to us by the NTA using this

new method and the graphs below represent the position for 2007/08 and the first quarter of 2008/09 for waiting times to 1st Intervention and to Subsequent Intervention. For individual long waits above the target, exception reports are received by the DAAT and provider from the NTA, requiring an explanation for the wait.

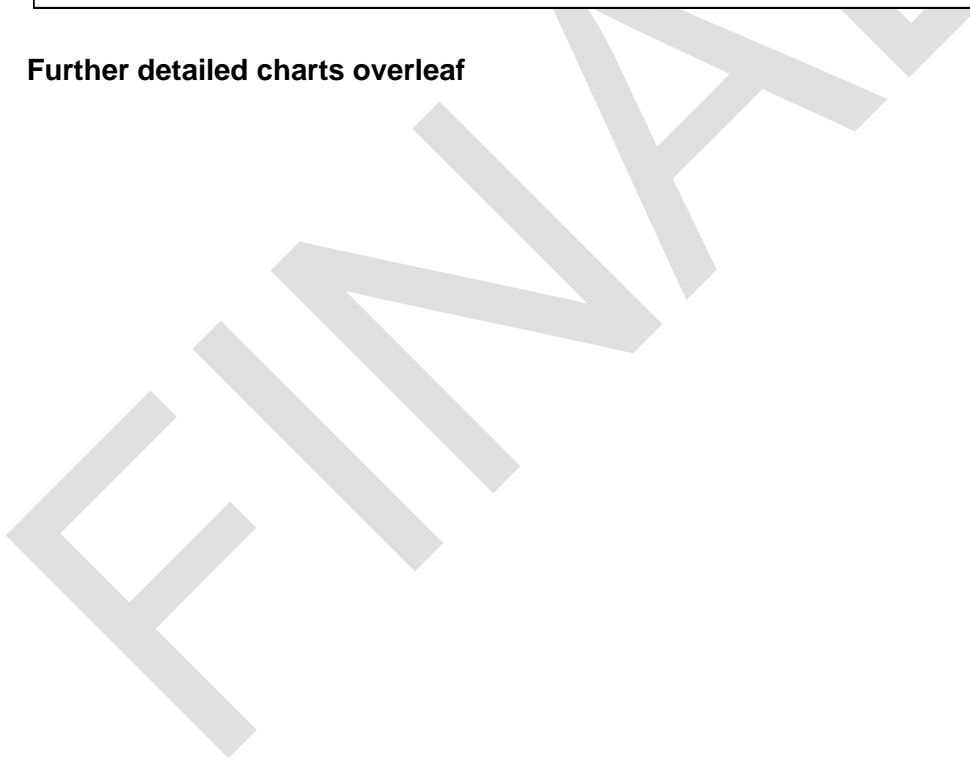


Harm Reduction

The DAAT was rated “Fair/Good” against specific Harm Reduction criteria in the Healthcare Commission Review



Further detailed charts overleaf



Care Planning Process

Care Planning		Health Assessment	
Number of interventions/modalities starting in the year	1047	Number of individuals starting a new treatment journey	813
Number with care plan at start of treatment	952	Number where general healthcare assessment completed	651
Percentage with care plan at start of treatment	91%	Percentage with general healthcare assessment	80%
Target for percentage with care plan at start of treatment	95%	Target for general healthcare assessment completion	70%

Vaccinations against Hepatitis B Virus (HBV)		Hepatitis C Virus Screening	
Number of individuals starting a new treatment journey	813	Number of individuals in treatment previously/currently injecting	1086
Number offered Hep B vaccination	128	Number of individuals with a Hepatitis C test	72
Percentage offered Hep B vaccination	16%	Percentage with a Hepatitis C test	7%
Target for offer of Hep B vaccination	80%	Target for individuals with a Hepatitis C test	20%
Number accepted offer of Hep B vaccination	69		
Number who have started a course of Hepatitis B vaccination	28		
Percentage of accepted who have started course	41%		
Target for those who accept that start course	25%		

Summary of Adult Services funded residential treatment placements for substance misuse clients April 2003- March 2008

Year	Male	Female	Drug	Alcohol	Dual diagnosis	Total
2003/04	34	24	31	27		58
2004/05	38	21	28	28	3	59
2005/06	25	15	22	18		40
2006/07	22	11	15	18		33
2007/08	42	22	33	29	2	64
Total	157	91	125	118	5	254

Residential Rehabilitation Placements made by locality							
Year	NE Hants	Basingstoke	Winchester	New Forest	Fareham & Gosport	Havant	Total
2003/04	10	5	2	18	18	5	58
2004/05	3	2	13	14	22	5	59
2005/06	6	0	16	8	10	0	40
2006/07	4	4	11	9	3	1	33
2007/08	6	10	23	7	10	8	64

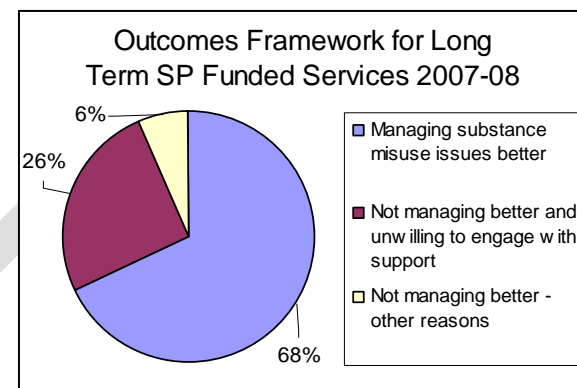
Residential Rehabilitation activity by substance Hampshire substance misuse care management activity April 2007 - March 2008 Summary	
Drugs	35
Alcohol:	29
TOTAL Number in treatment	64

Residential Rehabilitation activity by gender Hampshire substance misuse care management activity April 2007 - March 2008 Summary	
Males	42
Females	22
TOTAL Number in treatment	64

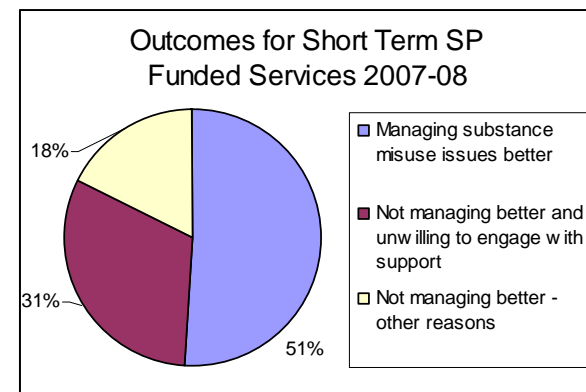
Supporting People Client Record Data (Substance Misuse) 2007-08

Details of Clients in Hampshire Supporting People Funded Services where the Primary or Secondary Client Group is Recorded as Substance Misuse 2007-08					
No of Clients		701	% of all SP clients		14.40%
Gender %	Male	67%	Female	31%	Unknown 2%
					Previous Accommodation Type %
					Any other temp accom 2.6%
					Approved probation hostel 1.1%
					Bed and breakfast 1.3%
					Children's home/foster care 0.1%
					Direct access hostel 6.4%
					Foyer 3.3%
					General needs local auth tenant 10.6%
					General needs RSL/HA tenant 13.6%
					Hospital 1.3%
					Living with family 10.4%
					Mobile Home/Caravan 0.4%
					Other 3.4%
					Owner occupier 1.1%
					Prison 4.3%
					Private rented 7.0%
					Residential care home 0.1%
					Rough sleeping 16.4%
					Sheltered housing 0.9%
					Short life housing 0.1%
					Staying with friends 8.3%
					Supported housing 6.7%
					Tied home or renting with job 0.0%
					Unknown 0.0%
					Women's refuge 0.6%
Age %		Economic Status %			
16-17	5.7%	Full Time Work	3.9%		
18-19	9.6%	Part Time Work	2.7%		
20-24	20.5%	Govt Training	0.1%		
25-29	14.0%	Student	1.3%		
30-44	30.8%	Job Seeker	28.1%		
45-59	14.6%	Not Seeking Work	18.4%		
60-64	1.6%	Long Term Sick/Disabled	40.4%		
65-74	1.1%	Retired	2.3%		
75-84	0.4%	Other	1.0%		
85-89	0.0%	Unknown	1.9%		
90+	0.0%				
Unknown	1.7%				
Ethnic Origin %		Previous Location %			
White British	95.0%	In Hampshire	92.4%		
White Other	2.0%	Out of county	7.6%		
Mixed (All)	0.9%				
Asian/Asian British	0.1%	Statutory Frameworks			
Black/Black British	0.3%	Care Managed	5.8%		
Chinese/Other	0.4%	Enhanced CPA	3.0%		
Unknown	1.3%	Probation	22.3%		
		DIP	11.4%		
		MAPPAs	2.6%		

Outcomes Framework for Long Term SP Funded Services	
Total number of forms received	798
Number where alcohol or drug problems recorded as primary or secondary client group	26
Number where need for support to better manage substance misuse issues identified	31
Percentage where need for support to better manage substance misuse issues identified	3.9%
Number where substance misuse issues are being better managed	21
Percentage where substance misuse issues are being better managed	67.7%
Number where client needs ongoing support	10
Percentage where client needs ongoing support	32.3%
Number where substance misuse issues are not being better managed	10
Reason given as 'client unwilling to engage with support'	80.0%



Outcomes Framework for Short Term SP Funded Services	
Total number of forms received	2766
Number where alcohol or drug problems recorded as primary or secondary client group	449
Number where need for support to better manage substance misuse issues identified	518
Percentage where need for support to better manage substance misuse issues identified	18.7%
Number where substance misuse issues are being better managed	263
Percentage where substance misuse issues are being better managed	50.8%
Number where substance misuse issues are not being better managed	255
Reason given as 'client unwilling to engage with support'	63.9%



Drug Interventions Programme

PI's	Description	07-08 Annual Performance	08-09 Apr-May Performance
1	60% of adults with whom initial contact is made and who are not already on the caseload to be assessed by the CJIT	71%	100%
2	85% of adults assessed on needing a further intervention to have a care plan drawn up and agreed	74%	82%
3	95% of adults taken onto the caseload to engage in treatment [2007-08 target]	93%	
	Adults taken onto the caseload who commenced treatment [2008-09 target] Target = 95%		100%

The NTA annual target for 2007-08 for substance misusing offenders entering treatment, via DIP, was 216; the annual performance was 265.

Monthly progress is shown below, increases shown are due to changes in practice and priorities during the year. It is anticipated that the revised NTA targets for 2008-09 will introduce a target of around 265 (figure still to be confirmed as at 1/7/08).

Number of new clients entering treatment from DIP 2007-08						
Monthly target	Numbers Apr 07 Final	Numbers May 07 final	Numbers Jun 07 Final	Numbers Jul 07 Final	Numbers Aug 07 Final	Numbers Sep 07 Final
18	14	7	17	16	18	20
	Numbers Oct 07 Final	Numbers Nov 07 Final	Numbers Dec 07 Final	Numbers Jan 08 Final	Numbers Feb 08 Final	Numbers Mar 08 Final
	19	43	18	31	38	24

Health - Vital Signs

VSC 26	Rate of hospital admissions for alcohol related harm	2008_09	2009_10	2010_11
VSC26_01	2001 Census based mid-year population estimates for the respective calendar years	1,272,928	1,280,565	1,288,248
VSC26_02	Rate of hospital admissions for alcohol related harm per 100,000 population	1,154	1,230	1,303

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Probation targets

	Partnership target 2007-08	Partnership performance 2007-08	Proposed Partnership target 2008-09
DRR commencements	220	243	243
DRR successful completions	100	60	44

Between January and December 2007, 1385 offenders in Hampshire were referred to CRi for assessment, and of these, around 600 were recommended for ATRs (almost half of those referred).

Diversity

Responsiveness of services re gender and age is measured by performance data which confirms satisfactory performance. In terms of gender split by locality, there is no significant deviation from the county-wide average (male 72%, female 28%).:

- New Forest recorded the highest level of female services users as a percentage of locality SU population (32%),
- East Hampshire had the lowest (22%).

Statistically, relative numbers in treatment appear proportionate to Hampshire's ethnic make-up overall, however actual numbers of individuals engaged remain low; there is no active outreach specifically targeting new immigrant communities and there is no culturally-specific carer support work undertaken. However, it is felt that further work needs to be undertaken in promoting accessible and appropriate provision for Black & Minority Ethnic groupings and for users for whom opiates and crack are not the primary drug of choice.

- Basingstoke has the most ethnically diverse Service User population with only 90% of individuals in treatment last year recorded as White British. Of the remaining 10% - 8% were from 7 different ethnic groupings; 2% had no ethnicity recorded.
- Havant had the least ethnically diverse Service User population with 99% recorded as White British (the remaining 1% had no ethnicity recorded).

EMVA

12 Challenges and Constraints

This section of the document is intended to 'flag' issues that need to be addressed or considered as part of the review process.

As part of the process of developing this Strategic Review information pack (SRIP) partners and stakeholders were invited to add to the initial draft of this section to ensure a comprehensive assessment of the challenges and constraints to be considered as part of the review. The issues documented here are not an exhaustive list but are provided to support the process and prompt discussion.

The responses and feedback received by the 19 September 2008 have been acknowledged and many are now included below. Individual responses will be provided to stakeholders who raised other issues in their feedback which were not applicable for inclusion here.

Meeting the changing national agenda

The substance misuse use treatment system must reflect the changing national agenda, notably the changes in the new national drug Strategy, Drugs, Protecting families and communities, and the increased emphasis on alcohol reduction.

Deliver Financially Sustainable Treatment System

As a result of the 3-year Pooled Treatment Allocation, (2008/9 to 2010/11) Hampshire DAAT is required to reduce investment in drug treatment services by £995,535 (16.5%) against the 2007/8 planned in year expenditure levels by 2010/11 as a direct result of the NTA allocation. An additional non recurring sum of £157, 350 has already been removed.

Review commissioning arrangements across partner agencies.

Rationalisation of current arrangements of the DAAT, PCT, Adult Services and potentially other partners could deliver both cash and time resource efficiencies. Is the current funding for residential rehabilitation sufficient ?

Contracting approach

A significant proportion of Tier 4 services are currently spot purchased. Changing to block contracts could deliver commissioners negotiating opportunity, however, this would need to be balanced with the desire to offer service choice.

How do we maximise access to Tier 4 services?

Longer contracts provide stability and allow development between tendering. How best can this be achieved given funding uncertainties ?

Alcohol

The nature of the current funding system means that commissioners are constrained by how the monies can be applied – ie the Adult Pooled Treatment Budget cannot be used to deliver services for alcohol only clients.

Recognising the deficit in funding for alcohol services, how best do we commission a range of services with sufficient capacity to respond to evidenced need ?

There are some concerns over whether alcohol and drug services should be combined.

If they are, what safeguards will be needed to ensure that demand and funding pressures are recognised and addressed ?

How do we avoid alcohol referrals from flooding drug specific services?

Will service users be willing to access combined services ?

Is there a view that mixed groups of drug and alcohol clients do or do not provide the best outcomes ?

Diversity

Further work needs to be undertaken to ensure there is accessible and appropriate provision for black & minority ethnic groups and users for whom opiates and crack are not the primary drug of choice.

How do we best access potential service users not yet in contact with agencies?

Transition Arrangements

Transitional arrangements for young people are of great concern.

How can we create greater links across not only children and families services but also mental health and other clients groups ?

Hidden Harm

How do we ensure that the risks posed to children and families by individuals with substance misuse and/or mental health issues are effectively managed ?

Treatment system

How do we engage the range of providers necessary to ensure a full and comprehensive treatment system, including GPs, education, employment and other care groups (children and families, older person, and mental health

The role of GPs

Increased GP involvement in shared care is a vital component of the current and future treatment journey.

How do we ensure that the consultation and the on-going delivery of the substance misuse treatment system includes GPs and Practice Managers to reflect the growing need for their involvement in shared care ?

Carers

How can carers be provided with the support they need?

Can organisations such as AA assist ?

Can 1:1 support be provided without the need to resort to private counselling ?

Targets and indicators

How do we ensure that targets are both realistic and appropriately assigned to the correct agencies and services ?

How can the treatment system be developed to ensure that Tier 1 service providers are fully aware of their role in the effective treatment of substance misusers? (eg GPs, BBV nurses, hospital departments etc.)

Configuration of services

How do we ensure that the configuration of services best meets the needs of the population ?

13 Further Information

All documents can be obtained from the DAAT website or directly from the DAAT team. <http://www3.hants.gov.uk/education/dat.htm>

If you have any enquiries you can contact a member of the DAAT team on:

Telephone 01962 826025
Fax 01962 863554

Address Hampshire DAAT
Capitol House
12-13 Bridge Street
Winchester
SO23 0HL

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Appendix 1 Strategic Review Process

1. Develop Strategic Review and Information Pack

Production of the Strategic Review Information Pack (SRIP) to contain high level information and data

Distribute SRIP July
Target date for issue of verified and enhanced version end September

2. Launch of Process, Presentation to all parties and seek verification of all details

The review will be formally launched at an event on 23 July 2008. This will be followed up in all relevant forums to all stake-holders by presentations and discussion at appropriate forums.

All stakeholders to be given the opportunity to see and comment on enhanced SRIP

Identify further locally defined targets/objectives and needs information.

3. Consultation Phase

Over a three month period extensive consultation will be carried out with with all stakeholders to inform the future pattern of substance misuse services - to look at the big picture and the detail with strategic partners / providers/ service users / carers

Extensive series of meetings
October to December

4. Produce and agree a Development Plan

At end of a three month period of consultation a Development Plan will be produced bringing together the results of all consultation carried out .The Plan will be agreed by strategic partners, eg

- The Executive Member for Social care
- PCT
- DAAT

Complete by end of January

5. Implementation Plan

Service level implementation plan developed to operationalise the commissioning intentions set out in the Development Plan

The plan will provide a detailed timetable for change to ensure any changes are part of a managed process. Services may be re-commissioned, remodelled or decommissioned

March 2009

1. Strategic Review Information Pack (SRIP)

This contains high level information and data:

This will be produced centrally with information gathered from a range of sources including :

- Substance misuse national policy framework
- Targets of statutory partners, Health, Social Care, Criminal Justice
- Budget information and funding streams
- Current supply details (substance misuse and alcohol split into Tier 1,2,3,4)
- Performance information
- Client group information
- Any other relevant data, including demographic information, GIS data, etc

2. Presentation to all parties

The process and draft SRIP are presented to the Substance Misuse groups / governing bodies using a standard presentation as a starting point for discussions.



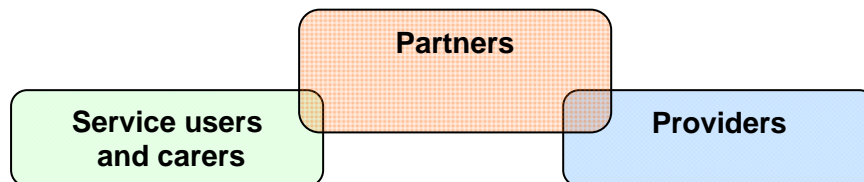
Process to be adopted:

- stakeholders will be given the opportunity to consider and comment on the draft SRIP
- stakeholders will be asked to identify locally defined targets / objectives
- further needs information gathering will take place
- DAAT seek to confirm data where possible
- contact with providers may take place in a variety of forms; meetings, phone calls etc
- A validated SRIP, (the Final SRIP) will be produced as a result of the input received at this stage

3. Consultation

Consultation will be undertaken with service users and carers, providers and statutory partners over a three month period.

The focus of the discussions will centre on how best to meet need and agreed objectives.



The approach adopted will include :

- A round of meetings undertaken over a three month period
- Stakeholders will be given the opportunity to see and comment on the final SRIP and to contribute to the development of the future pattern of services
- The focus is on priorities, needs, investment and service configuration.
- Discussions will outline the direction of travel for services and inform the development plan
- Conclusions will be drawn from discussions with partners, providers and service users and carers
- The conclusions will be recorded in the form of a report summarising the input from each set of meetings

4. Produce and Sign Off Development Plan

The Development Plan will be an aggregated and coherent plan for all Substance Misuse services at county level, which meets identified need and budgetary constraints.

5. Implementation Plan

The implementation plan is produced by the DAAT Team and will include fully detailed commissioning decisions :

- the service model
- capacity
- budget
- actual service providers or identify opportunities for tendering

The plan will provide a detailed timetable for change to ensure any changes are part of a managed process. Services may be re-commissioned, remodelled or decommissioned.

Tendering will take place in accordance with agreed HCC policy where required.

Services will be effectively contracted with appropriate service specifications and subject to quarterly performance monitoring.

**Implementation Plan
formally approved**

Appendix 2 Treatment System

Service Definitions

Tier 1 Non Drug Treatment Specific Services

Tier 1 consists of services offered by a wide range of professionals (e.g. primary care medical services, generic social workers, teachers, community pharmacists, probation officers, housing officers, homeless persons units). Services work with a wide range of clients including substance misusers, but their sole purpose is not simply substance misuse. Tier 1 services may include:

- Access to full range of health, social care, housing and other services.
- Substance misuse screening, assessment and referral mechanisms to substance misuse services from generic, health, social care, housing and criminal justice services.
- Management of substance misusers in generic health, social care and criminal justice settings.
- Health promotion advice and information.
- Hepatitis B vaccination programmes for substance misusers and their families. Alternatively, if investments in vaccinations are made within Tier 2, 3 or 4 services, they can be recorded in the relevant grid.

Tier 2

• Open Access Services

Services within this Tier aim to provide accessible services for a wide range of substance misusers referred from a variety of sources, including self-referrals. The aim of the treatment in this Tier is to help substance misusers to engage in treatment without necessarily requiring a high level of commitment to more structured programmes or a complex or lengthy assessment process. Services include needle exchange programmes and other harm reduction measures, substance misuse advice and information services and ad hoc support not delivered in a structured programme of care.

• Advice and Information

Advice and information services provide accurate, appropriate and factual information which is accessible and meaningful (in terms of context, language and comprehensibility) to the recipient. Access to advice and information should be provided by services in Tier 1, and may be a core component of services in Tier 2. Specific services offering advice and information are characteristic of open access services. However, staff in all treatment Tiers should provide the provision of advice and information on substance-related issues.

• Harm reduction services (including needle exchange)

Needle and syringe exchange schemes were developed within the wider context of harm minimisation or risk reduction, which refers to the reduction of the various forms of drug-related harm, including social, medical, legal, and financial problems, until the substance misuser is ready and able to come off. They are important for preventing blood-borne diseases, most particularly HIV and hepatitis as well as being important public health measures. The majority of needle exchange schemes are those where sterile needles and syringes are given out and their safe disposal is offered.

• Assessment and care management

Assessment and care management should encourage the substance misuser to seek appropriate help and to assist their access to and engagement in treatment, whilst accepting the individual substance misuser's choice as to whether they accept treatment or not.

Care management should facilitate access to a programme of integrated and co-ordinated health and social care and to minimise disengagement ('drop out') from the treatment system. All substance misusers should have access to appropriate and effective assessment and Care Co-ordination. As a distinct service, this has been offered by Community Care teams operated in social service departments. But this should not be the exclusive territory of social workers or local authority care managers. A wide range of professionals need to be able to undertake Care Co-ordination.

Other Tier 2 services may include:

- Other services that minimise the spread of blood-borne disease
- Services that minimise risk of overdose
- Outreach services targeting high risk and local priority groups
- Motivational and brief interventions for drug and alcohol service users.

Tier 3

Structured Community Based Services

This Tier can be defined as providing services solely for substance misusers in a structured programme of care. Services include structured cognitive behaviour therapy programmes, structured methadone maintenance programmes, community detoxification, or structured day care (either provided as a drug-free programme or as an adjunct to methadone treatment). Structured community-based aftercare programmes for individuals leaving prisons are also included in Tier 3.

The principal expectation is that the substance misuser attending these services will have agreed to a structured programme of care which places certain requirements on attendance and behaviour (e.g. a certain number of days or hours attendance per week, review of programme is triggered if attendance is irregular).

Community prescribing (Specialist) - Community prescribing programmes involve the provision of a medically supervised drug substitute to an illicit drug misuser. The substitute can be used to maintain the individual's tolerance to the drug of misuse or to facilitate withdrawal through a reduction programme. The prescribing programme is the basis for providing medical and psychosocial counselling and support. Community Drug Teams (CDTs) usually deliver specialist services or Drug Dependency Units (DDUs) operated by NHS Trusts. Community prescribing (GPs) -Community prescribing programmes involve the provision of a medically supervised drug substitute to an illicit substance misuser. The substitute can be used to maintain the individual's tolerance to the drug of misuse or to facilitate withdrawal through a reduction programme. The prescribing programme is the basis for providing medical and psychosocial counselling and support. These services are delivered in general practice but often in liaison with specialist services using shared care protocols.

Structured care-planned counselling - Care-planned counselling is defined as formal structured one-to-one counselling approaches with assessment, clearly defined treatment

plans, treatment goals and regular reviews, as opposed to advice and information, drop-in support and informal key-working.

Structured day programmes - Structured day programmes provide intensive community-based support, treatment and rehabilitation. They should offer clear programmes of defined activities for a fixed period of time with specified attendance criteria – usually four to five days a week.

Aftercare services - There are two distinct activities that could be included under the Aftercare Services heading:

- Services that aim to smooth the linkages between drug treatment services in prison and those in the community. Examples include projects aimed at ensuring the continuation of substitute prescriptions as patients enter and leave the prison system and services aimed at picking up referrals from CARAT teams, and successfully placing them in appropriate community based services on release
- Services that work to help those who have stabilised their lives through treatment, to make progress in employment, training or housing. For example: projects that provide stabilised misusers with volunteered or paid employment opportunities. or projects that provide stabilised misusers with supported or subsidised accommodation.

Other Tier 3 services may include:

- Liaison substance misuse services for acute medical and psychiatric sectors.
- Liaison substance misuse services for local social services and social care sectors.
- Specialist structured community based detoxification services.

Tier 4 - Residential and Inpatient Services

Services in this Tier are aimed at those individuals with a high level of presenting need. Services in this Tier include inpatient drug treatment, including detoxification and residential rehabilitation. Tier 4 services usually require a higher level of motivation and commitment from the substance misuser than for services in lower Tiers.

Inpatient detoxification -Inpatient substance misuse treatment programmes are specialised units for people with substance misuse disorders or inpatient services delivered in general medical or general psychiatric facilities. Inpatient services also include episodes of detoxification purchased from independent sector units. They provide medically supervised assessment, stabilisation and withdrawal with 24-hour medical cover and a multidisciplinary team.

Residential rehabilitation - Residential rehabilitation services are specialist services offering intensive and structured programmes delivered in controlled residential or hospital environments. These services are mainly available in the independent sector and including therapeutic communities, concept houses, 12 step Minnesota model programmes and general houses including those with a faith-based philosophy.

Appendix 3 Extract from Southampton University Needs Assessment 2008

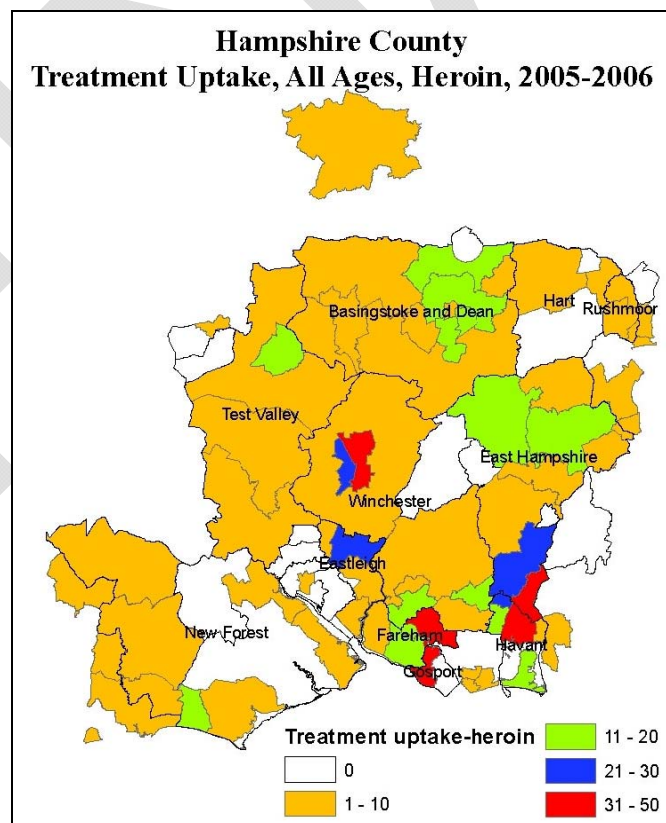
Young People and Substance Use, Hampshire DAAT Need Assessment Study- June 2008, Pages 119 - 126

Type of drug new clients using

In this section the focus is on the type of drug used by those who accessed Hampshire DAAT services during 2005-2006 as a new client. It is important when looking at type of drug that these data sets highlight access to drug treatment services by areas rather than trends in use of particular drugs by areas. It may be that where there is lower drug services access for particular substances eg cocaine that there is a perception by cocaine users that drug services are not set up to meet their needs or offer them a suitable service. Among new clients using Hampshire DAAT drug treatment the highest number were Heroin users. From the total number of 1,290 new clients 682 (53%) were Heroin users.

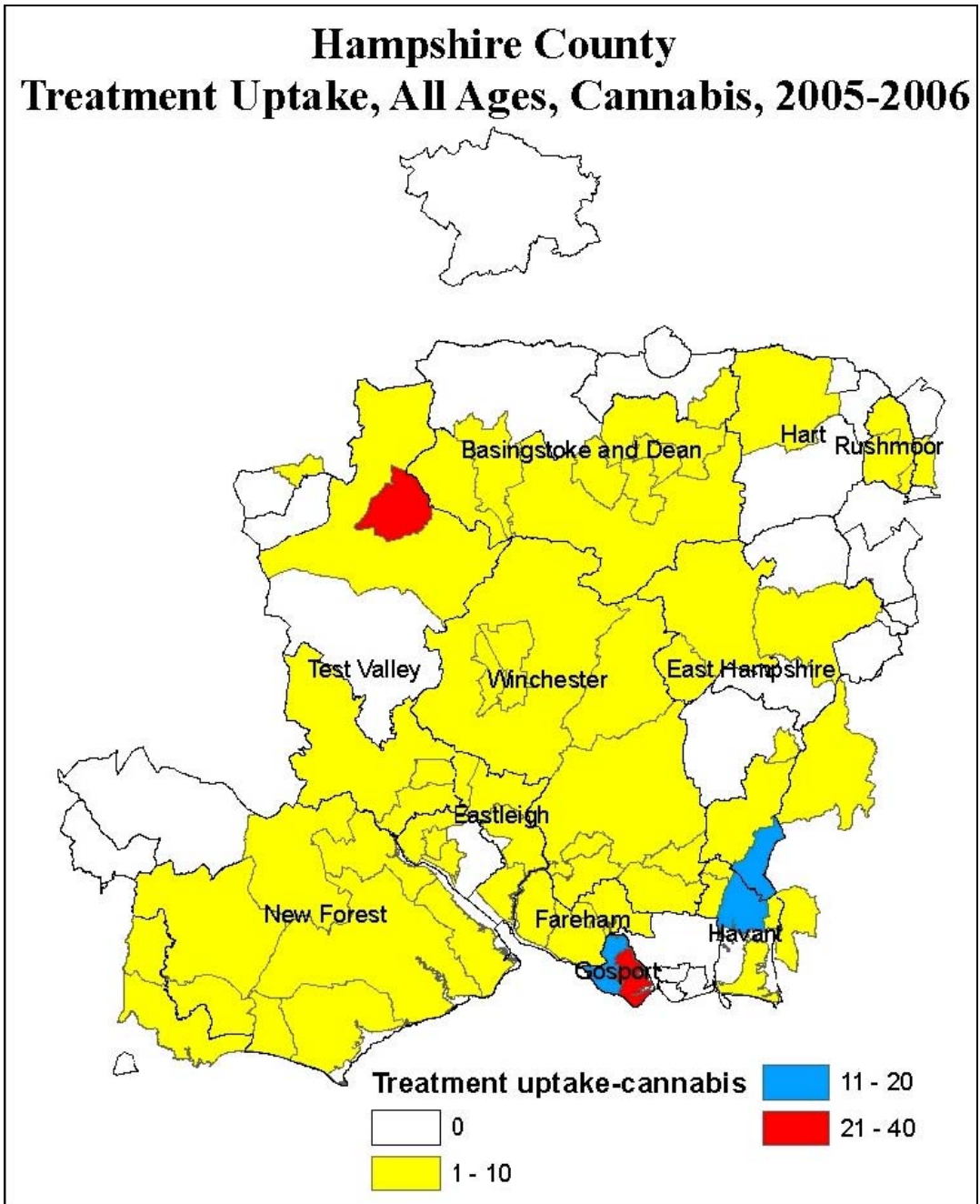
Number of new clients using Hampshire DAAT by primary drug : 984

The map 'Treatment uptake, all ages, Heroin, Hampshire, 2005-2006' using postcode level data and Hampshire county map shows distribution of Heroin users in Hampshire accessing drug treatment services. The highest number of new clients with Heroin use was found in some pockets in Havant, Gosport, Winchester, Fareham and East Hampshire. Some users have also come from outside the Hampshire area.

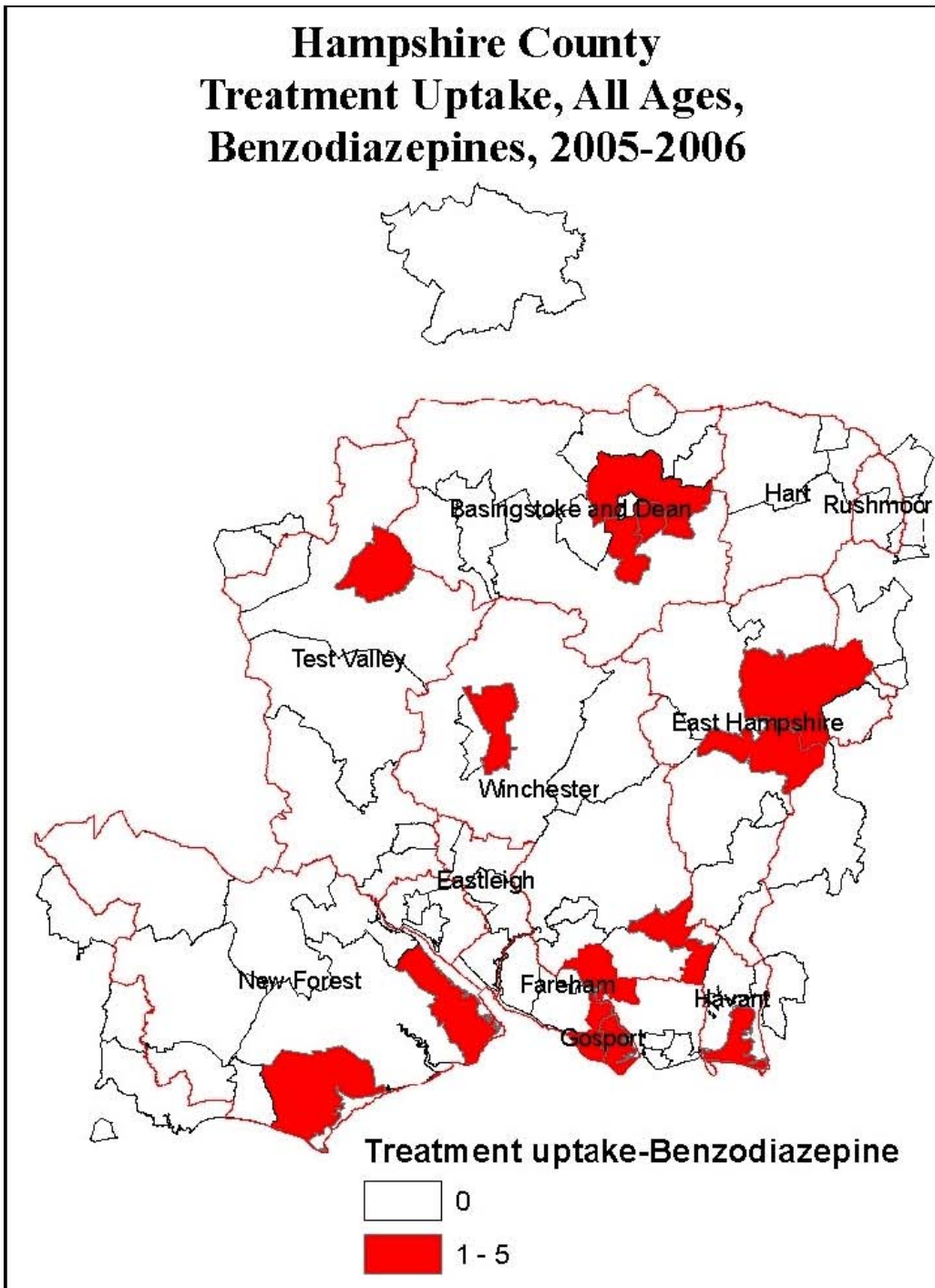


Map 'Treatment uptake, all ages, Cannabis, Hampshire 2005-2006'

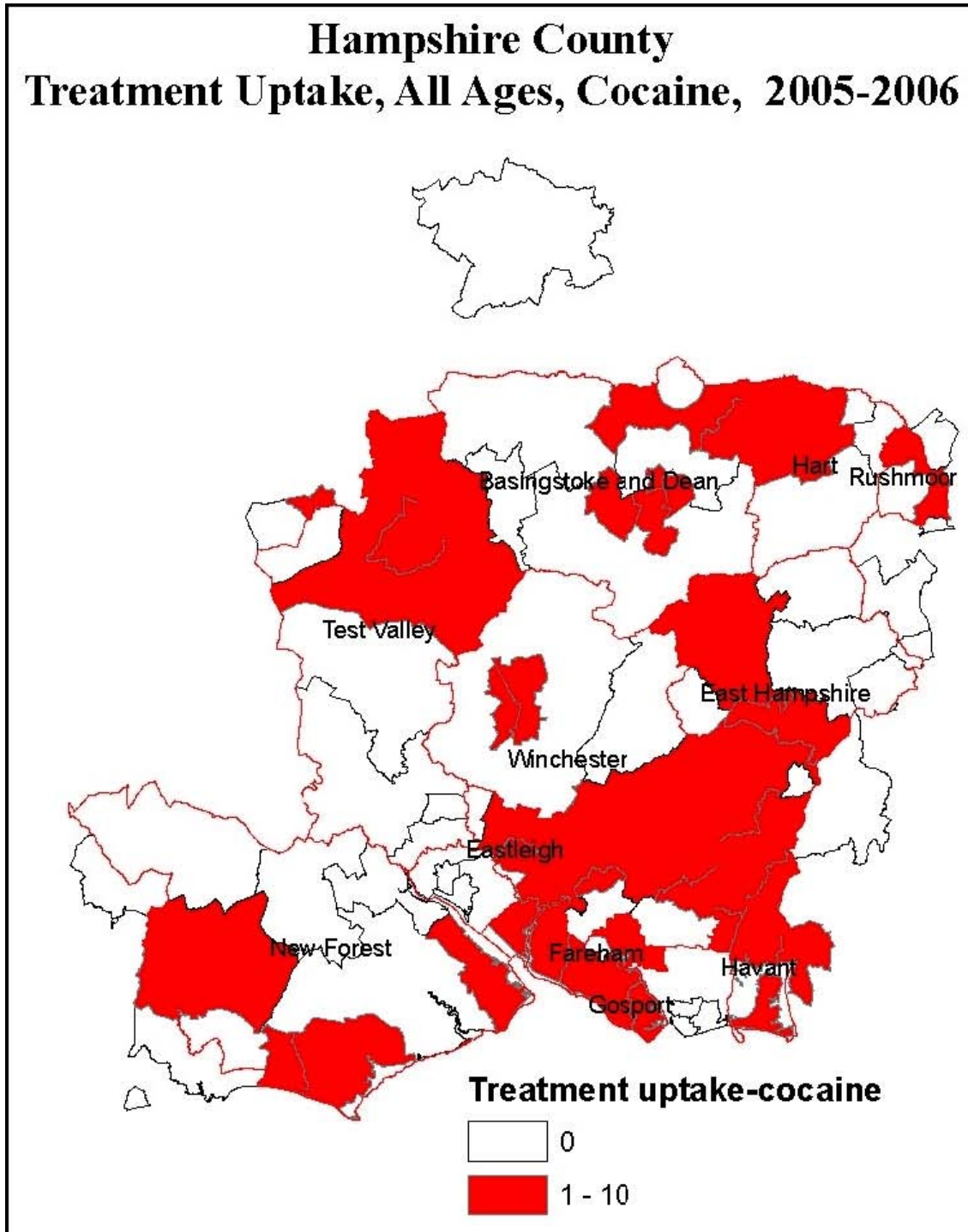
shows the distribution of Cannabis users who accessed drug treatment from Hampshire DAAT during 2005-2006. There were 256 Cannabis users (20% of the total users who undertook drug treatment) who undertook new drug treatment during 2005-2006 in Hampshire DAAT. Among Cannabis users who undertook treatment from Hampshire DAAT services were from pockets of Gosport and Test Valley. As evident from the map there was a uniform uptake from all postcode areas in Hampshire.



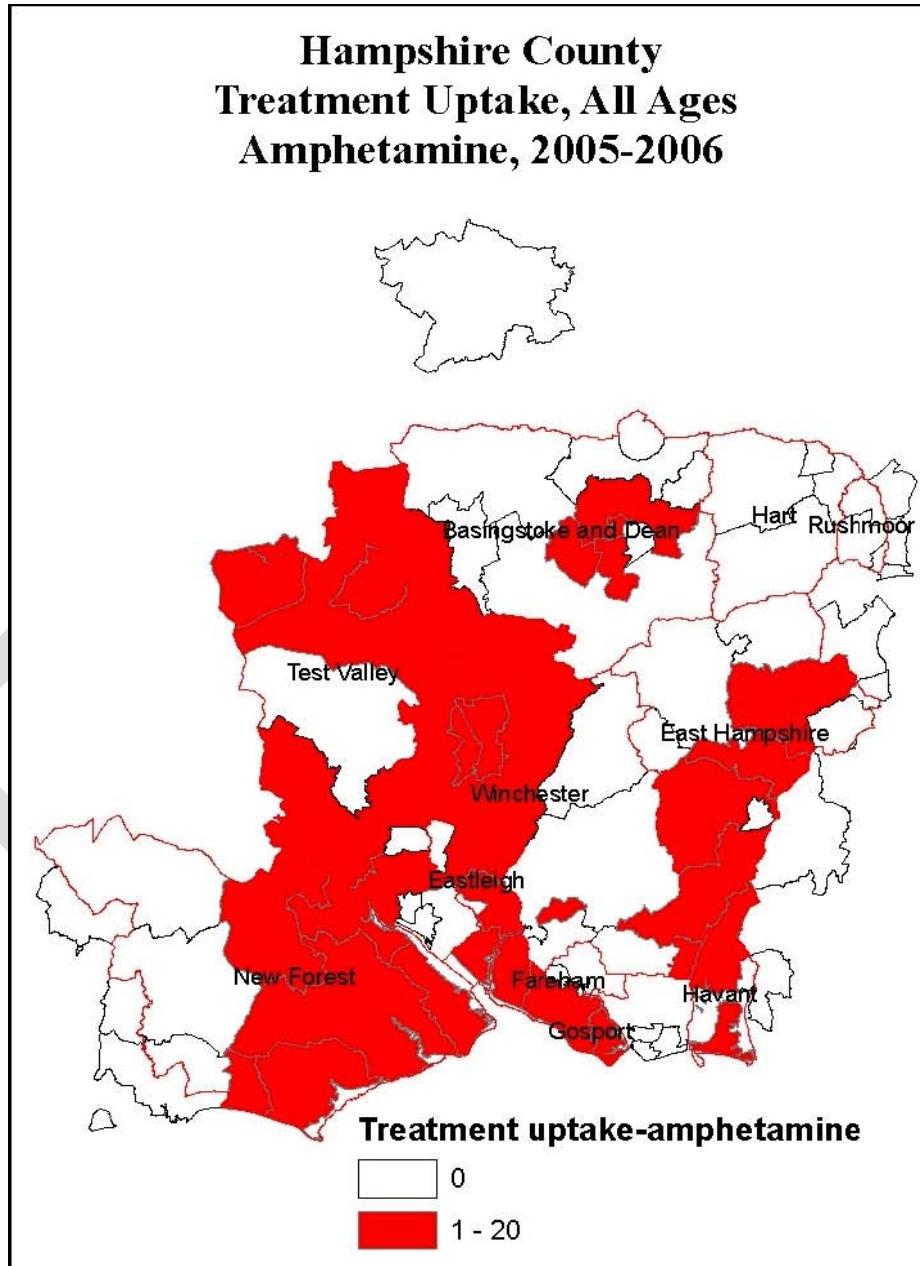
Map 'Treatment uptake, all ages, Benzodiazepines, Hampshire, 2005-2006, shows the distribution of Benzodiazepines users who accessed drug treatment. There were only 22 Benzodiazepines users who availed drug treatment in Hampshire during 2005-2006. Unlike Heroin and Cannabis, only few have accessed DAAT services Hampshire. However, their distribution is dispersed in the district. They have come all districts except Hart and Rushmoor.



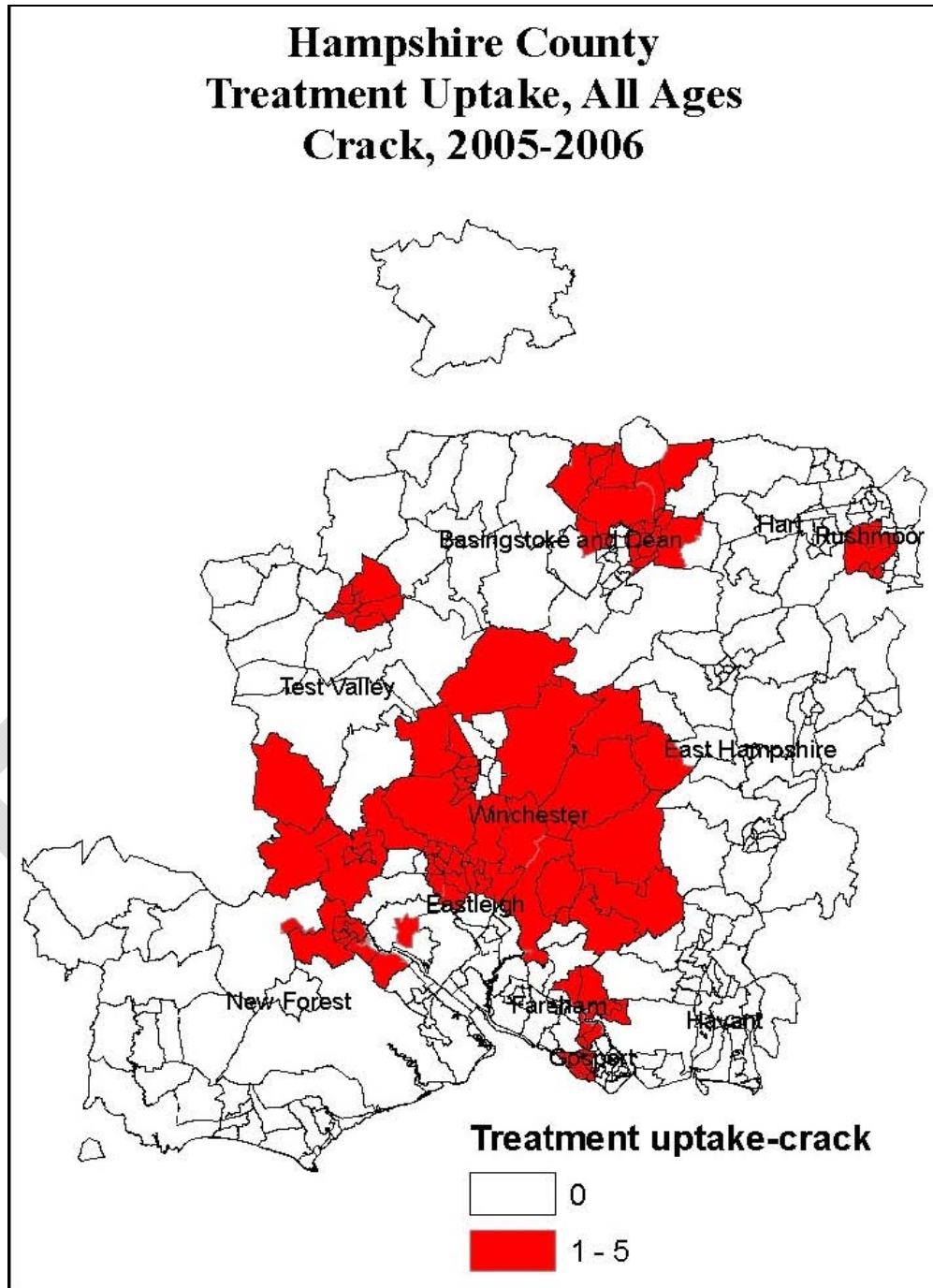
Map 'Treatment uptake, all ages, Cocaine, Hampshire 2005-2006 shows the distribution of cocaine users who have accessed drug treatment from Hampshire DAAT. In total there were 81 cocaine users (6%) who have accessed drug treatment. Their distribution indicates their presence in certain pockets of all districts in Hampshire. However, as seen from the map, there are several areas in Hampshire where none reported taking drug treatment for cocaine.



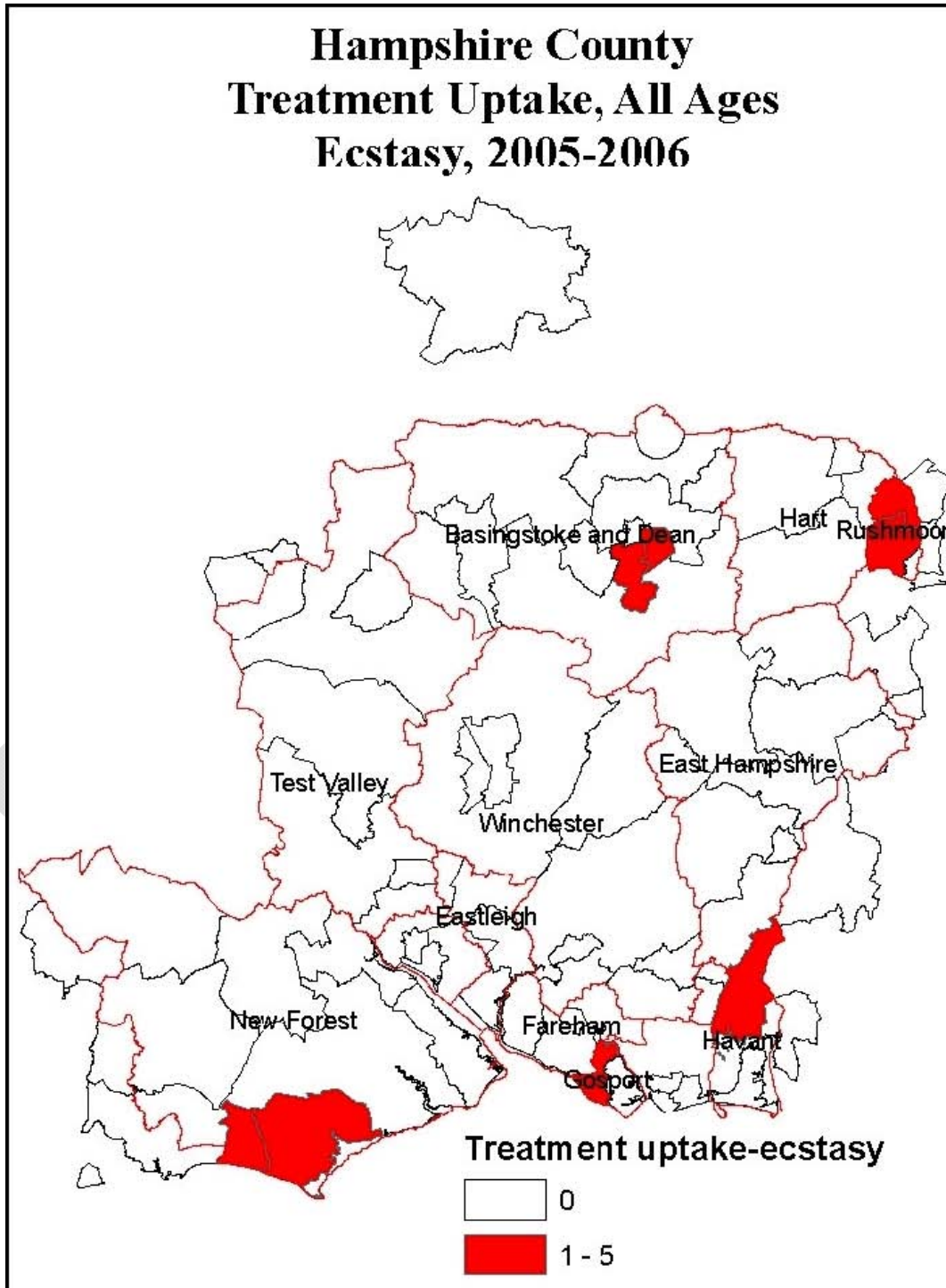
Map 'Treatment uptake, all ages, amphetamine 2005- 2006', shows the distribution of new clients using treatment services in Hampshire DAAT area. There were 95 (about 8% of the total new clients using Hampshire DAAT services during 2005-2006) amphetamine users in Hampshire who undertook drug treatment during 2005-2006. Amphetamine users who undertook treatment came from all districts except Hart and Rushmoor. However, there are many parts of Hampshire where no amphetamine users undertook drug treatment from Hampshire DAAT. But is not clear whether this is not due to lack of amphetamine users in those postcode areas or they were not accessing services.



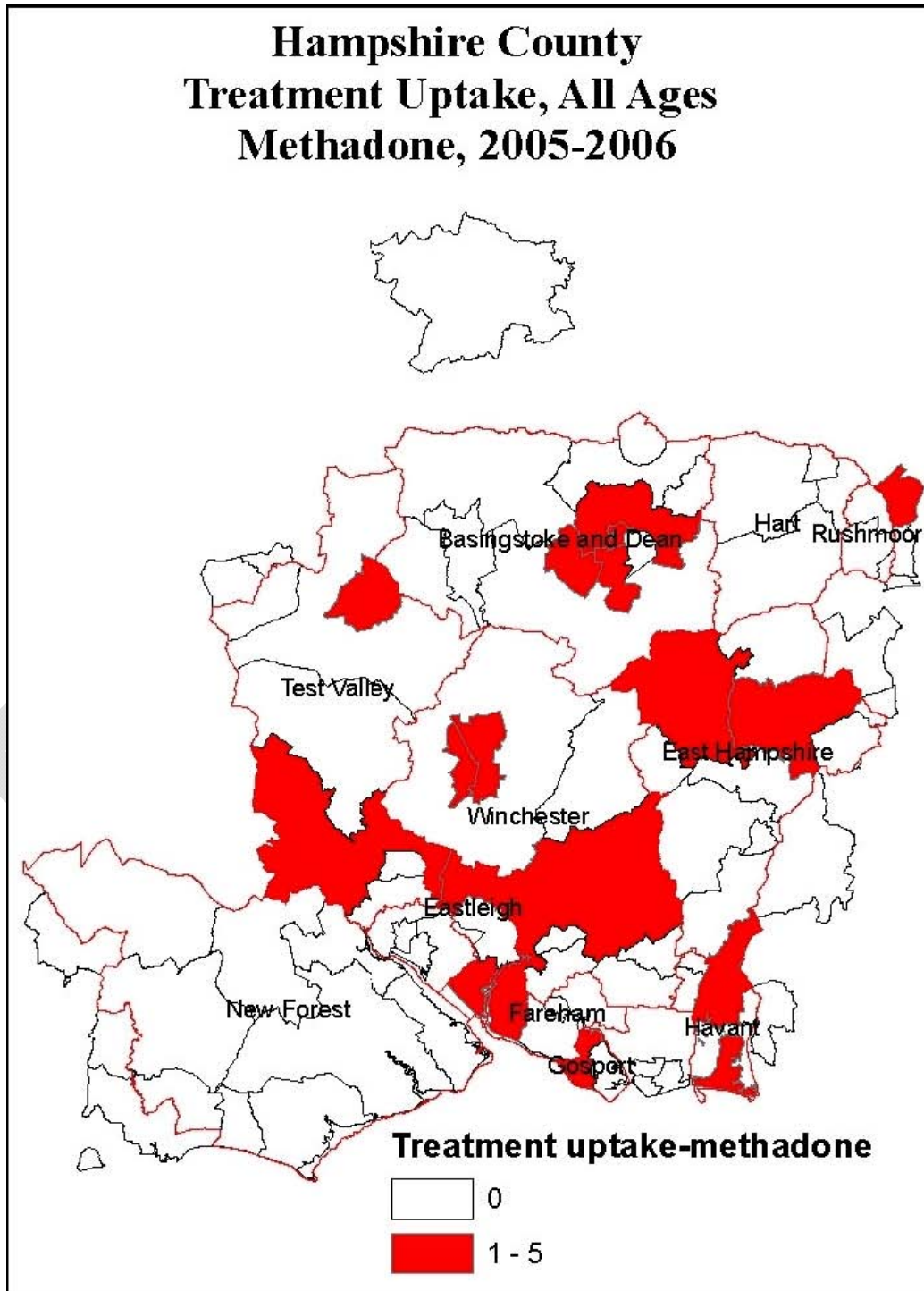
Map 'Treatment Uptake, All Ages, Crack, 2005-2006' demonstrates the distribution people using drug treatment from Hampshire DAAT who were using crack. During 2005-2006 there were 37 crack users who undertook drug treatment from Hampshire DAAT. Unlike other drugs crack users who undertook drug treatment from Hampshire DAAT were mainly from the central Hampshire, Winchester in particular. It is interesting to note that substantial areas of many districts do not have crack users taking treatment from Hampshire DAAT



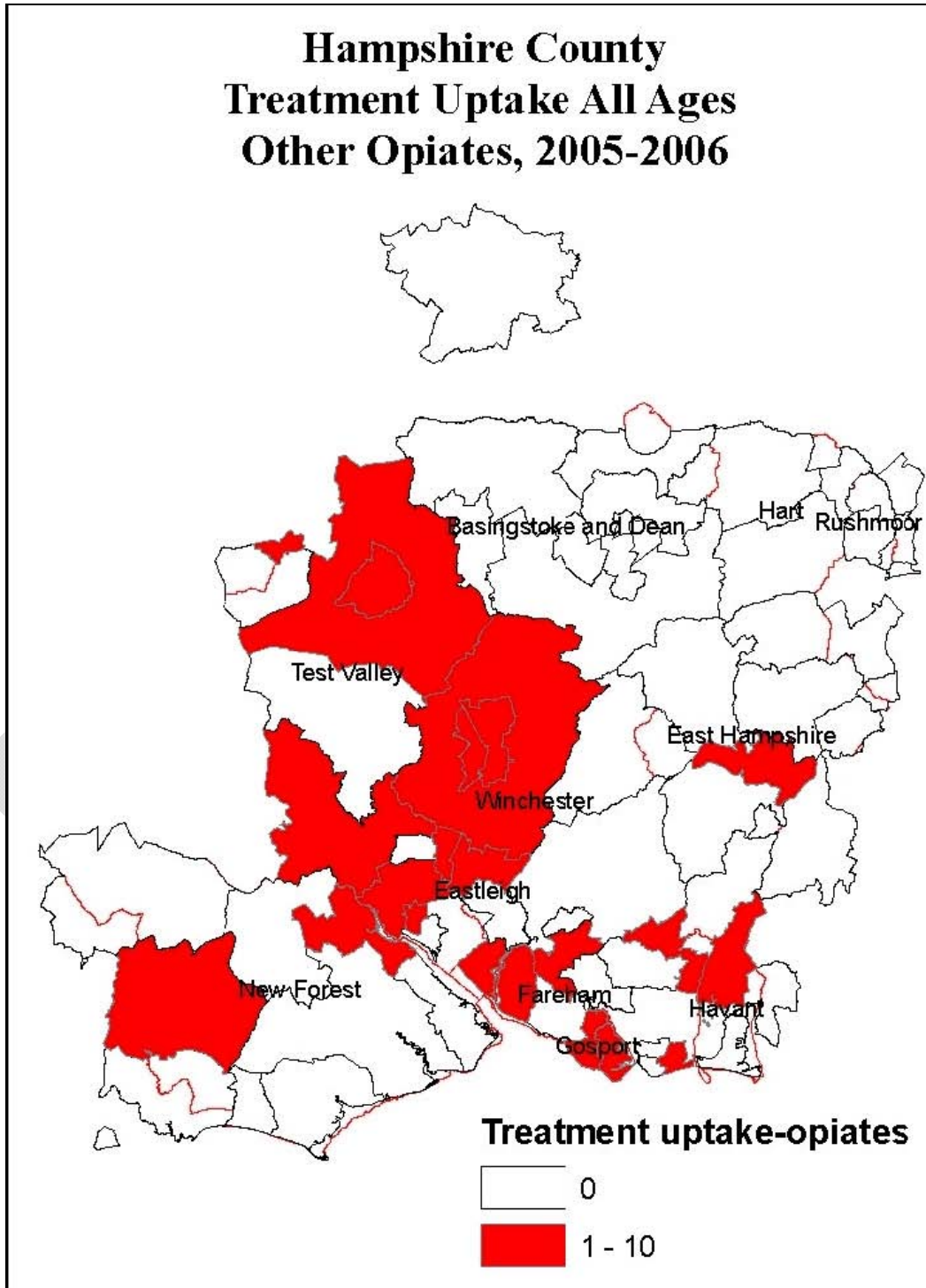
Map 'Treatment Uptake, All Ages, Ecstasy, 2005-2006', shows the distribution of Ecstasy users who undertook drug treatment from Hampshire DAAT during 2005-2006. There were only 10 Ecstasy users (from a total of 1290 new clients seeking drug treatment from Hampshire DAAT) in Hampshire who undertook drug treatment. Ecstasy users who undertook drug treatment came from pockets of New Forest, Gosport, Havant, Rushmoor and Basingstoke.



Map 'Treatment Uptake, All Ages, Methadone, 2005-2006' illustrates the distribution of methadone users who undertook drug treatment in Hampshire DAAT. There were 37 methadone (from the total 1290) users who undertook drug treatment from Hampshire DAAT. Red panels in the map show the postcode areas in Hampshire where methadone users who undertook treatment from Hampshire DAAT. Methadone users who undertook drug treatment came from certain pockets in all districts, except New Forest.



Map 'Treatment Uptake, All Ages, Other Opiates, 2005-2006' shows the distribution of opiate users in Hampshire who undertook drug treatment in Hampshire areas during 2005-2006. There were 38 opiate users in Hampshire who undertook drug treatment in Hampshire DAAT area. Other Opiate users who undertook treatment came from all districts expect Hart and Rushmoor. As can be seen other opiate service use is more concentrated in the northern districts of Hampshire.



The map 'Hampshire County, Treatment Uptake All Ages, Polydrug, 2005-2006' the distribution of polydrug users who undertook treatment from Hampshire DAAT during 2005-2006.

