Sheffield Needs Assessment of Adult Drug Services and Service Delivery 2016

Sheffield Drug and Alcohol Co-ordination Team

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INTRODUCTION

The 2016 Sheffield DACT Needs Assessment is the tenth annual assessment undertaken by the DACT. The overarching aim is to aid the commissioning of drug treatment in Sheffield and is part of the analyse/review quadrant of the commissioning cycle.

In 2015, based on the availability of the comprehensive needs assessment for the previous year, the decision was taken to do a summary update so that key performance and trends could be updated. This is now followed by this year's full Needs Assessment update.

All sections of the 2016 Needs Assessment have been updated with latest available data and distributed amongst key partners for review and consultation. This Needs Assessment places some emphasis on the Recovery agenda in line with the data made available nationally through the Recovery Diagnostic Toolkit produced by Public Health England (PHE). The report also looks at other aspects and successes of the treatment system in Sheffield in acknowledgement of the complexities of the client group.

All treatment data and commissioning discussed in this document is for adult drug treatment services in Sheffield.

Background

Since April 2013 commissioning of drug services has been the responsibility of the Local Authority (LA). The budget is allocated from the Public Health budget and supported by Public Health England. The Police and Crime Commissioner (PCC) contributed to the drug treatment budget in 2016.

From 2014-15 PHE devised a new method to improve comparisons between local performance and that of other areas[1]. This new method supersedes the previous opiate and non-opiate clusters. In the new method, each local area is compared to the 32 areas (called Local Outcome Comparators (LOC)) that are most similar to them in terms of complexity. There are different groups of comparators for opiate, non-opiate, and alcohol populations. The new method is similar to the 'nearest neighbour' method adopted by some local authorities but the PHE comparators for drug and alcohol use are based specifically on the complexity of the populations in substance misuse treatment and not broader similarities between the general population. This report compares Sheffield to the LOC, national average and the 7 other core cities in England.

PHE also re-grouped the cohorts of individuals in treatment. Previously there were three substance groups used in reporting: opiate, non-opiate, and alcohol. From April 2014 substance misuse reporting consists of either seven or four groups. Which of the two mutually exclusive groupings is used depends on the type of report, the group of seven used mainly for activity reporting and the group of four used in higher level reports that are more outcome-focused. The two different groupings are shown below:

Seven mutually exclusive groups	Four mutually exclusive groups
1. Opiate only 2. Opiate and alcohol 3. Opiate and non-opiate 4. Opiate, alcohol and non-opiate 5. Non-opiate only 6. Alcohol only 7. Alcohol and non-opiate	1. Opiate 2. Alcohol only 3. Non-opiate only 4. Alcohol and non-opiate

The group of seven is similar to the group of four but breaks down opiate users into four groups depending on the other substances cited as problematic by the user.

[1] Improved Reporting of Drugs and Alcohol – methodological changes, Public Health England, 2014 www.ndtms.net

In 2014 drug treatment contracts were re-tendered by Sheffield DACT with a contract start date of 1 October 2014.The new contracts are for an 'end to end' opiate service and non-opiate service. The non-opiate service provides mobile specialist needle exchange to all IV drug users, and each service now provides needle exchange provision for clients in treatment with their service. Both services are commissioned as end to end services from drop-in support through to structured treatment interventions. Each provider will deliver:

Opiates Contract	Non-opiates Contract
(SPAR) Single Point of Assessment and Referral to drug treatment	Specialist needle exchange
Pharmacological Interventions	Open access (non-opiates)
Formal Psychosocial Interventions (Opiates)	Targeted / assertive outreach
Post treatment recovery support	Formal Psychosocial Interventions (Non-opiates)
Specialist harm reduction interventions including static Needle exchange provision and vulnerable adults / dual diagnosis	Post treatment recovery support
	Universal prevention / education
	Learning Schemes

There is also a provision at the majority of pharmacies across the city to provide supervised consumption of opiate substitution prescribed medication and 16 that operate pharmacy based needle exchange.

Needs Assessment purpose
The document holds sensitive information and should be used only for purposes of the identification of drug treatment need in Sheffield and for the commissioning of drug treatment services.

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February 2017

SUMMARY

Background

Sheffield Drug and Alcohol Co-ordination Team (DACT) are a commissioning team within Sheffield City Council responsible for the commissioning of adult drug and alcohol services in the city. The current provider of both the non-opiates service and the opiates service is Sheffield Health and Social Care NHS Foundation Trust (SHSC). As of 1st October 2017 a new contract for a criminal justice service commenced, provided by Addaction. The contract is for an arrest referral scheme and Criminal Justice Integrated Team (CJIT). CJITs use a case management approach to offer access to treatment and support. This begins at an offender's first point of contact with the criminal justice system through custody, court, sentence and beyond to resettlement.

National Picture

The prevalence of Class A drug use in the last year (2015/16) was 3%, a small reduction on the previous year but higher than 2012/13 which reported a prevalence of 2.5%, the lowest proportion since 1996. The proportion of adults taking any illicit drug in the last year was 8.4%. The prevalence of any drug use in the last year is highest amongst 16-24 year olds at 18%, compared with 6.1% of 25 – 59 year olds. Frequent drug use, defined as having taken any illicit drug more than once a month on average in the last year, was at 3.3% in 2015/16, compared to 3.1% in 2014/15.[2]

In 2015/16 there was a 1.5% decrease in the number of people in structured drug treatment in England. The majority of people in treatment are between 30- 44 years, accounting for 56% of the treatment population, of which, 73% are male. Nationally 7% of opiate users, 40% of non-opiate users, and 35% of non-opiate & alcohol users had a successful discharge from treatment.

The Public Health Outcomes Framework (PHOF) targets shows the national position reported at the end of March 2016; 6.9% of the opiate treatment population and 37.4% of the non-opiate treatment population (including those citing that alcohol use was problematic alongside non-opiates) exited treatment successfully and did not represent within 6 months. This position is for completions between October 2014 and September 2015 to allow for the 6 month representation period.

Local Picture

Prevalence of Problematic Drug Use:

The seventh revision of Problematic Drug User (PDU)[3] estimates were published in April 2014[4,5] and are the prevalence estimates for 2011/12. Three PDU figures are provided for Sheffield:-

Opiate and/or Crack Use (OCU)

The Opiate and/or crack use estimates for Sheffield in 2011/12 are 4,266 PDUs, a rate of 11.5 per 1,000 population and confidence interval levels of +/-95% creating a range of between 3,877-4,808 PDUs.

Opiate prevalence *(excludes crack only use)*

The Opiate prevalence estimate for Sheffield in 2011/12 is 3,004 (+/-95% 2,445 to 3,339) and a rate of 8.1. This equates to 968 OCUs fewer than in the last estimate released in 2012. The opiate OCU equates to 70% of the total OCU (was 98%).

[2] Drug Misuse: Findings from the 2015/16 Crime Survey of England and Wales, Home Office, July 2016

[3] A Problematic Drug User (PDU) refers to someone who uses opiates[3] and/or crack cocaine. The definition includes those who use other drugs in addition to opiates and/or crack, and those who use opiates and/or crack as a secondary or tertiary substance.

[4] Measuring Different Aspects of Problem Drug Use: Methodological Developments, Home Office Online Report 16/06, Editors – Nicola Singleton, Rosemary Murray, Louise Tinsley.

[5] A range of data sources including drug treatment (NDTMS), probation (OaSYS), police and prison databases, an age range of 15 to 64 years identified and the same methodology of Capture – Recapture[5] were been used to identify the PDU

Crack prevalence *(excludes opiate only use)*
The Crack use prevalence estimate for Sheffield in 2011/12 is 2,588 (+/-95% 1,914 to 3,289) and a rate of 6.98. This equates to 379 OCUs fewer than in the last estimate released in 2012. The Crack OCU equates to 61% of total OCU (was 73%).

The Glasgow estimates suggest there are 1887 PDUs in Sheffield who have not been in contact with treatment at any time in the last two years, with +/-95% CI levels giving the parameters of between 1498 to 2429 individuals.

Drug Treatment

Sheffield DACT commissions the adult substance misuse services in Sheffield, and this report focuses primarily on the needs of the adult population (those 18+). Substance misuse services for younger people are commissioned in the city by the Vulnerable Children and Young People's Commissioning Manager and provided by The Corner.

Tier 2
Tier 2 treatment is commissioned in Sheffield to provide early interventions and a gateway in to structured treatment. It is a combination of assertive outreach, open access, the arrest referral and Criminal Justice Integrated Team (CJIT), and harm reduction services alongside a citywide network of pharmacy needle exchanges.

Demand for Tier two services is difficult to ascertain for a number of reasons. Data recording of individual activity is not comparable across services, so we do not know the numbers who are unique to tier 2 treatments across these services both in terms of Tier 2 only (not in structured treatment) or which Tier 2 clients use which Tier 2 services. For example, we know that the Non Opiates Service have seen 425 unique individuals at the needle exchange in 2015/16 but we do not know if these individuals are also on the DIP caseload for Tier 2 activity, or using the harm reduction service.

What we do know is as follows:

Table 1: Tier 2 activity

Commissioned Activity	Annual Commissioned Places/Contacts	Actual 2015/16	Q1 2016/17
Non Opiates Service Needle Exchange	1000	425	120
Dip Tier 2	No target for volume apart from DI3: 95% of those requiring treatment to be on the caseload		154 on caseload (June 2016)
Number of individuals receiving triage through SPOC / assertive outreach	n/a	449	106
Number of individuals receiving brief interventions	n/a	734	155
Pharmacy needle exchange	20 pharmacies	3,316 transactions per month (Apr-Mar average)	3,423 transactions per month (Apr-Jun 2016 average)
Harm Reduction	See "Harm reduction" section		

As the drugs services are commissioned as end to end services, contact with those clients not formally accessing a structured intervention, helps to provide better harm reduction to these individuals and may lead to engagement with structured support.

Tier 3 treatment
Attracting and then retaining a high number of people into treatment remains a key priority, alongside the current focus on recovery.

As at the end of 2015/16 52% of the opiate and/or crack PDU engaged in tiers 3 and 4 treatments. Data in the Recovery Diagnostic Toolkit tells us that 52% of those entering treatment in 2015/16 were treatment naïve.

If an individual stays in treatment 12 weeks or more it is deemed to be effective, this increases the likelihood of a successful completion, and the potential to build recovery capital. This links in with the two new national indicators from the Public Health Outcomes Framework; indicator 2.15(i) Opiate Drug users that leave drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a % of all people in treatment, and indicator 2.15(ii) Non-opiate Drug users that leave drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a % of all people in treatment.

As of Q4 2015/16 there were 2426 individuals in effective treatment in Sheffield, of which 842 were new (35%).

Of the 3750 treatment places commissioned at tier 3, 453 were not used in 2015/16, with services ranging from 53% to 126% capacity. Waiting times to treatment were all within target.

A survey was carried out with stakeholders regarding the structured treatment offer in Sheffield, the results of which can be found as appendix 6.

The Sheffield Treatment Pathway:

- SPAR: - 362 assessments in the first half of the 2015/16, 66 fewer than at the same the previous year. Data on re-zoning was not captured since the change in contracts to being all prescribing treatments under one provider, therefore no green bar for re-zonings is on the chart for the first six months of 2015/16. This data will however be made available in the future.

- 2,426 people engaged in effective treatment as at the end of 2015/16, an increase of 92 in comparison to the end of 2014/15.

- 478 opiate users engaged in PSI during 2015/16, 53% of the opiate places commissioned. 347 non-opiate users engaged in PSI during 2015/16, 87% of the non-opiate PSI places commissioned. In total 63% of all commissioned PSI places were utilised.

- 126% of the commissioned primary care prescribing places were utilised during 2015/16 and 85% of secondary care prescribing places.

- 100% of clients exiting treatment in a planned way were offered recovery support and mutual aid.

The percentage of people in structured treatment for opiates that cite the use of other substances is 66% of the opiate treatment population.

25% of the entire treatment population cite the use of cannabis, 62% of the non-opiate treatment population and 18% of opiate users.

Alcohol screening is now routine practice amongst drug treatment service providers and has enabled the providers to identify alcohol misuse that may have previously been hidden. SHSC have developed a web based screening tool, based on AUDIT, and all screening is conducted as per the AUDIT questions, alongside providing brief interventions and advice, as applicable.

Tier 4 treatment
There is no longer any target for the number of inpatient detoxes or the success rate (this has been the case since October 2014), however the target for inpatient detoxification per year prior to this was 72 which was hit in every year up to and including 2013/14. 2015/16 saw the largest number of inpatient detoxification for the last nine years. Inpatient detoxification successful completion rate has remained above (the old) target of 73% for seven of the last eight years. The exception is 2014/15, which had a contract change half way through the year.

In 2015/16 there were 34 referrals to residential rehab and a successful completion rate of 77%.

Residential Rehabilitation placements for Sheffield residents are spot purchased by Sheffield City Council, which remains responsible for the budget. Operational responsibility for assessment sits with Social Workers employed within SHSC. Oversight of this is managed through the Care Management Panel, which is attended by the DACT Strategic Commissioning Manager. SHSC hosts 5 inpatient detoxification beds in Sheffield which are located in Burbage mental health ward. DACT makes an annual contribution to the funding of this. This means currently the DACT is in a position where we can recommend changes to Tier 4 commissioning but cannot lead on the commissioning.

Recovery – Successful completions
Successful completions in Sheffield have been below the England average for a number of years, the proportion completing had also been reducing, similar to national trends. However over the last 12 months the rate of completion has remained relatively static in Sheffield, but still low. The national rate continues to decline, but remains higher than in Sheffield. Plans are in place in Sheffield to ensure that client's treatment journeys are closely monitored and steps are taken for appropriate clients to work towards successfully exiting the treatment system.

– The number of people in drug treatment during 2015/16 was 2601 (a 7.5% increase on the baseline)

– the number of people successfully exiting the drug treatment system during the period:
215 (+12% on the baseline)

– the proportion who successfully completed treatment and did not re-present within 6 months as a proportion of all in treatment as at the end of 2015/16:
3.2% for opiate users and 30.5% for non-opiate users.

The performance of successful completions and re-presentation will remain a key factor in line with the national performance measures.

Housing
In 2015/16 2% of non-opiate users reported a housing issue at the time of their 6 month review, which compares to 14% nationally. In Sheffield this relates to a very small number of clients and suggests that housing problems are not an issue for non-opiate users that enter treatment in the city.

However, among opiate users, 19% of opiate users that are still using opiates at the time of the 6 month review report a housing issue, the same proportion as reported nationally. For those not using opiates at the time of the 6 month review, the proportion reporting a housing issue is 13%, compared to 10% nationally.

Education, Training, and Employment

Education, Training and Employment (ETE) are viewed in the Drugs Strategy as key to a long term recovery, and this is also reflected in the Recovery Diagnostic Toolkit.

In 2015/16 for opiate clients receiving their first 6 month review 92% of service users that are still using opiates are unemployed, which compares to 83% nationally. 86% of service users that have stopped using Opiates by the time of the 6 month review are unemployed, which compares to 79% nationally. It is to be expected that social function is higher for people that have stopped using Opiates.

For all Opiate clients in treatment for more than 12 months the proportion that are unemployed is between 81% and 86% (data is split by length of time in treatment; 1-2 years, 2-3 years etc). This compares to 77% - 79% nationally.
For non-opiate users the percentage of clients who are unemployed after 6 months in treatment is 67%, which compares to 75% nationally. At the time of the 6 month review Crack, Cannabis, Cocaine, Amphetamine, and Alcohol use are all higher than seen nationally. Addressing the higher-than-average drug use rates amongst non-opiate users in the first 6 months of treatment may lead to improvements in unemployment rates.

Mutual Aid
The NICE Quality Statement (QS23) for drug use disorders sets out what high-quality care should include based on NICE drug misuse technology appraisals and clinical guidelines. It comprises ten quality statements, one of which recommends that people in drug treatment are offered support to access mutual aid organisations, which are defined as including SMART (Self-Management And Recovery Training) Recovery and those based on 12-step principles, eg, Narcotics Anonymous, Alcoholics Anonymous and Cocaine Anonymous.[6]

The number of groups has been steady over recent years although the number of Narcotics Anonymous groups has gone up from 2 to 7 in the past three years. Following previous needs assessments and consultations the above groups are offered at different locations in the city and spread across the week with some services providing a number of groups in a week on different days and times in order to make the groups as accessible as possible to all service users.

Mutual aid groups support the Recovery culture and all clients exiting treatment are provided with information regarding the variety of groups and options available to them.

Aftercare (Recovery Support)
Between April 2015 to March 2016 215 individuals left treatment drug free, this is the number of individuals who were entitled to receive Aftercare/Recovery Support.

The Drug treatment providers are commissioned to provide Recovery Support to all service users successfully exiting treatment. In 2015-16 100% of service users were offered recovery support interventions at the time of exit.

Service users in Recovery should be able to receive some form of support for as long as the individual needs, this can provide the person with a network of people in a similar situation and help them to maintain recovery and prevent re-entry to treatment. Particular importance is often placed on the first three months following treatment when a service user is at their most vulnerable relapse risk stage.

Diversity
71.2% of people in tier 3 treatment were male in 2015/16 which is similar to historical figures in Sheffield. 85.5% of all transactions at pharmacy needle exchanges during 2015/16 were by males.

[6] A Briefing on the evidence-based drug and alcohol treatment guidance recommendations on mutual aid, Public Health England

The most recent available data nationally is that men are more than twice as likely to use drugs as women; information for use of drugs over the past year is that 11.8% of men aged 16-59 and 5% of women aged 16-59 have used ANY drug in the past year.

Given that men are more than twice as likely to report drug use as women it is reasonable to suggest that the treatment population would be a 70%/30% split and so the current percentage spilt is not that dissimilar.

The number of service users from BME communities is below the percentage of the Sheffield BME population as a whole (12% compared to 19.%) but there are differences in each ethnic group with some being over represented and others underrepresented. Other White, White & Black African, Indian, Pakistani, Bangladeshi, other Asian, African and Chinese communities are underrepresented in our treatment system against the adult Sheffield population. White British, White Irish, White & Black Caribbean, White & Asian, Other Mixed, Caribbean, and Other are over represented in the treatment system, against the adult population.

The Opiates Service report 8 gay clients during 2015/16, with some bisexual clients however this number is fewer than 5 and therefore has not been reported on. The vast majority of clients either prefer not to say or have not been asked.

At the Non-Opiates Service there are gay, lesbian and bisexual clients reported throughout 2015/16 but again the number in each category is lower than 5 so a total cannot be obtained, and again the majority of clients either prefer not to say or have not been asked.

There are an estimated 3.6 million LGB people in the UK, 5% of total UK population[7] so the activity in the treatment system suggests LGBT drug users are underrepresented in support services.

The Opiates Service reports clients as no religion (548) Christian (347), Muslim (47), other (22) and Buddhist (fewer than 5) during 2015/16, with the rest either not being asked or declining to answer.

The Non-Opiates service reports the same groupings except for Buddhist. There are no clients declaring themselves as Sikh in the structured treatment population.

SHSC return data on disability as part of their quarterly performance return. At the Opiates service in 2015/16 only 0.7% of the caseload consider themselves to be disabled, whilst at the Non-Opiates service the question has not been asked / recorded of their clients.

Area

In recent years the areas in which clients have resided have remained similar. This year though does see some changes in the proportions but not the areas. Looking at those receiving treatment at SHSC as of the 31st March 2016, the most frequent postcode sectors given as a client's place of residence are: S5 (16.6%), S2 (13.1%), S6 (9.7%, S8 (9.5%), S13 (7.2%).

Harm reduction

Injecting drug use prevalence

The Glasgow 2013 prevalence estimate of injecting drug use amongst opiate users in Sheffield is 926. This is around 236 fewer individuals than the previous prevalence figure.

Needle exchange activity

In April 2013 Sheffield DACT moved to using PharmOutcomes recording system, which is used by all pharmacies operating both a needle exchange and a supervised consumption service.
Sheffield DACT commission pharmacy and a non-pharmacy based needle exchange. The pharmacists are paid per transaction. In 2015/16 the average number of transactions at pharmacy needle exchange was 3370 per month, much higher than the 2417 average in the 2014/15.

[7]Source: Department of Health, 2007

There are 55 pharmacies signed up to the pharmacy needle exchange scheme, however only 21 recorded monthly activity during 2015/16. The remaining 37 are signed up to provide a service, if and when the need arises[8] and following training.

Of those entering treatment in 2015/16, having been in treatment before and also having a Treatment Start Treatment Outcome Profile (TOP), 5% of individuals reported daily injecting, with 23% reporting non-daily injecting use, in comparison to 5% and 27% for both nationally respectively.

Blood Borne Viruses

Hepatitis B

Shooting Up reports that the proportion of people who inject psychoactive drugs ever infected with hepatitis B in England, Wales and Northern Ireland has halved over the past 10 years, falling from 28% in 2004 to 14% in 2014, with very few (0.58%) currently infected[9]. In Sheffield during 2015/16 35.8% of opiate service users starting a new treatment journey took up the offer of a hepatitis B vaccination and started the course of treatment.

Hepatitis C

Circa 90% of the total people infected with Hepatitis C in the UK are infected due to injecting drug use. In 2015 there were 13,000 positive test results for hepatitis C, and it is estimated that around half of those who inject psychoactive drugs have been infected with hepatitis C[10].

In 2015 there were 1326 laboratory reports of Hepatitis C in the Yorkshire and Humber region, a reduction of 187 on 2014.

Crime

In 2015/16 there were 1,547 arrests for trigger offences in Sheffield of which 46.99% were due to theft (down 8.11% on two years ago), 19.71% for burglary (up 3.81%), 11.76% for non-trigger offences (up 7.56%), 6.91% for possession of class A drugs (up 2.1%), 3.68% for possessions with intent to supply Class A drugs (up 0.58%) and 3.36% for robbery (down 1.44%).

The number of drug tests in 2015/16 was almost half of the number of drug tests in 2012/13 (2957 compared to 1500) however the number of positive tests was only marginally lower (996 compared to 966). This equates to a positive drug test rate of 34% in 2012/13 but 64.5% in 2015/16. This suggests that a change in the drug testing criteria to profiling has led to better targeting of the appropriate cohort of offenders.

Overall, 56% of positive tests had a presence of cocaine and opiates, 40% for cocaine only and 4% for opiates only (a 3% decrease from last year). Positive tests for both were the highest in every month of 2015/16 with the exception of July where it “tied” with “cocaine only”.

As at the end of 2015-16 336 individuals were active on the DIP caseload. For the whole 2015-16 year 718 referrals were made in to tier 3 treatments and 100% of clients had a recovery plan. 31% (287) of the 718 referrals commenced a structured treatment modality.

CJIT referrals into treatment made up 15% of total referrals in 2015/16. This rises to 28% if you remove those with no referral source listed[11].

2.0% of all Criminal Justice opiate clients in structured drug treatment have a successful outcome compared to 3.6% for the whole treatment system (PHE, Q4 2015/16 DOMES report). Successful completions are discussed in depth in the Recovery section; however the data here does suggest improvements can be made within criminal justice clients in tier 3 treatments.

[8] Not all pharmacies signed up to this will provide this service, some pharmacies signed up all their providers, i.e. Lloyds but only a few of those Lloyds providers intend and are in areas where needle exchange provision is required currently
[9] Shooting Up – Infections among injecting drug users in the UK: an update, 2015
[10] Shooting Up – Infections among injecting drug users in the UK 2015
[11] Adult Partnership Activity Report, Q4 2015/16, Public Health England

Families and Carers & Safeguarding Children
In terms of the prevalence of the number of carers affected, it is known that for every drug user, there are two family members affected[12]. Since the estimated PDU for Sheffield for opiate and/or crack users is 4,266 during 2011/12, then this could indicate that there are approximately 8,500 carers affected in Sheffield. Not all will require support, but for those that do, support should be made available so that they in turn can better support the person they care for.

The DACT commissioned a dedicated carers service until September 2014. However, take-up of the carers offer was below the expected level. Demand did not meet commissioned capacity and was lower than commissioned targets throughout the contract.

Since October 2014 the DACT has commissioned carer support and development through one of the 'learning schemes' at the Non Opiate Service. The Expert Carer and Carer Ambassador programmes contain some of the elements formerly delivered by the carer service, such as support and peer contact with other carers, but it also facilitates involvement in service improvement and design, as well as providing accredited learning opportunities to carers and then offering them the opportunity to use their learning and skills through placements within treatment services, supporting other carers and service users.

Safeguarding Children
Data to the end of 2015/16 tells us that 24.9% of opiate users are living with children, 11.5% of non-opiate users, 7.2% of alcohol users and 10% of alcohol with non-opiates clients. These are lower than the national proportions which are between 23% and 29%.

During 2015/16, 91 babies (7 fewer than in 2014/15) were born in Sheffield to mothers who were discussed at MAPLAG due to problematic drug and/ or alcohol misuse during pregnancy (29 were opiate users, 53 were cannabis users, 4 were other non-opiate users and 5 were alcohol users). Of the 91 babies born, 71 went home with their mother, 13 had Child in Need plans in place, 19 were subject to child protection plans and 19 were fostered.

Sheffield has a number of structures in place for the safeguarding of Children:

- All people are asked their parental status at the assessment stage.
- All services have a named child protection lead.
- All services have processes in place to refer to Safeguarding services for assistance, advice and onward referral.
- All pregnancy cases are referred to specialist pregnancy treatment.
- All midwives can refer into special midwifery treatment for drug using clients.
- All cases referred to safeguarding are discussed and onward referral to MAPLAG made when required.
- DACT to hold a quarterly safeguarding meeting with attendance from all provider services, to discuss all issues.
- Safeguarding Children Data recording Audit.

Communities
The DACT Communities and Development Officer is a key link between DACT commissioning and priorities and implementing these alongside partner organisations in Sheffield. The specific task is to lead on and address all issues regarding drug and alcohol use, which includes being a key to linking communities, partners and treatment services together.

Current work that is ongoing to tackle drug and alcohol related issues in communities and the city overall include:

[12] 'We Count Too' Home Office, 2005

Cannabis Advisory Sheffield Housing (CASH) – addressing cannabis use in residential housing that affects other residents.

Street culture in the city centre - address issues and anti-social behaviour caused by street drinkers, drug users and beggars in and around the city centre.

Drug Related Deaths

Local data for January to December 2015 has 23 recorded drugs related deaths; this is higher than the average of 18 (+/- 3) per year, which Sheffield has experienced for the last 10 years. There were 30 DRDs recorded in 2014, compared to 15 in 2013 and 19 in 2012. In 2015 of the 23 DRDs, the age range was between 22 and 61 years, and 18 of the 23 deaths were male.

At the most recent Coroners review in Sheffield (March 2016), 13 cases were discussed. 11 of the deaths discussed were male. 10 out of the 13 deaths died of a drugs overdose. Toxicology reports detected Heroin present in 8 individuals, methadone present in 7 and other opiates present in 6 (an individual may have had more than one substance detected).

The trend observed nationally is that between 2012 and 2014 the number of drug related deaths has increased each year by at least 17% (due to a delay between a death occurring and being reported 2013 and 2014 data is regarded as provisional)[13]. This is also reflected in the increase reported in Sheffield in 2014.

Using the latest Research Report for DRDs in 2012[14], which excludes deaths in which drugs of misuse may have played and incidental role (i.e. road traffic accident, suicides) we know there were 13 deaths that fulfilled the criteria of an acute drug misuse poisoning death in Sheffield. Summary of details for 2012 deaths, the average for the 10 years total is shown in *italics* after each point. The mean age of the deaths in 2012 was 38 years *(33.5 years is the average for the last 10 years)*, 92% (12) of the deaths were male *(85%),* 77% were unemployed *(76%)* and 69% lived alone *(50%).* 58% were known heroin users *(67% historically)* 57% of those with a dependence problem were in treatment at the time of death *(43%)*.

Over the past two years a quarter of the deaths were caused by stimulants such as amphetamines, MDMA and PMA, compared to a historical average of under 10%.

[13] Trends in Drug Misuse Deaths in England, 1999 to 2014, Public Health England, 2016
[14] Deaths from acute accidental overdose of drugs of misuse in Sheffield during 2011, Dr Phillip Oliver, The University of Sheffield

1.1 Prevalence Estimates

The seventh revision of the Opiate and Crack User (OCU) estimates were published in April 2014[15]. Three OCU figures are provided for Sheffield:

- Opiate and/or crack use
- Opiate use[16]
- Crack cocaine use[17]

The data also includes the estimated level of injecting drug use.

Opiate and/or crack use
The latest Opiate and/or crack use estimates for Sheffield which are based on data relating to 2011/12 are 4,266 OCUs (up 249 on the previous update of 4,017), a rate of 11.50 per 1,000 population (up 0.99 from 10.51) and confidence interval levels of +/-95% creating a range of between 3,877-4,808 OCUs (from 3,148-4,866). This range is much tighter than the previous update (a range of 931 rather than 1718) so the confidence in the numbers has increased.

The 4,266 OCU is a change of 249 higher than the estimate that was produced in 2013 (no figure was produced in 2012) and is the first time the OCU has increased since the third update. Table 2 displays how the Sheffield OCU compares to Leeds and Bradford[18], with a rate higher than Leeds and a rate lower than Bradford.

It should be noted that the population estimates used in these calculations were the first estimates to be produced by the Office for National Statistics (ONS) following the 2011 census, and this may affect the comparability with previous OCU prevalence estimates.

Table 2: Prevalence estimates and rates per 1,000 aged 15 – 64 years with -/+ 95% Confidence Intervals

	NEW OCU Estimate (April 2014)	***-/+ 95% Confidence Interval***	**Rate per 1,000 population**
Sheffield	4,266	*3,877 – 4,808*	11.5
Bradford	4,441	*4,107– 4,892*	13.1
Leeds	5,476	*4,472– 6,439*	10.7

Source: Prevalence Estimates released by Public Health England, April 2014

Opiate OCU *(excludes crack only use)*
The Opiate OCU for Sheffield in 2011/12 is 3,004 (+/-95% 2,445 to 3,339) and a rate of 8.1. This equates to 968 OCUs fewer than in the last estimate released in 2012. The opiate OCU equates to 70% of the total OCU (was 98%)

Crack OCU *(excludes opiate only use)*
The Crack OCU for Sheffield in 2011/12 is 2,588 (+/-95% 1,914 to 3,289) and a rate of 6.98. This equates to 379 OCUs fewer than in the last estimate released in 2012. The Crack OCU equates to 61% of total OCU (was 73%).

[15] A range of data sources including drug treatment (NDTMS), probation (OaSYS), police and prison databases, an age range of 15 to 64 years identified and the same methodology of Capture – Recapture are used to identify the OCU.
[16] The Opiate OCU figure includes all people who use opiates either independently or alongside any other drug. The figure excludes crack cocaine use only.
[17] The Crack Cocaine OCU figure includes all people who use crack cocaine either independently or alongside any other drug. This figure excludes opiate use unless used with crack cocaine.
[18] Part of the same Cluster grouping, Group E.

Table 3 below compares the OCU estimates from 2011/12 to those from 2010/11.

Table 3: Sheffield Prevalence rates and the difference between 2010/11 and 2011/12

	2010/11	2011/12	Difference
Opiate and/or Crack PDU	4017	4266	249 HIGHER
Opiate PDU	3972	3004	968 LOWER
Crack PDU	2967	2588	379 LOWER

Table 4: Estimated prevalence rates (per 1000 population) for Opiates, Crack and Injecting

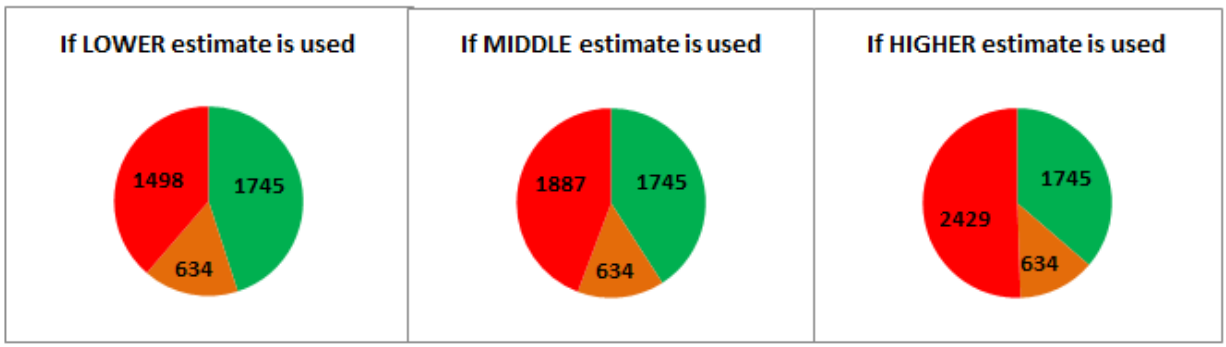
	Opiates	**Crack**	**Injecting**
Sheffield	8.1 (down 3.4)	6.98 (down 0.78)	2.50 (down 0.54)
Bradford	12.46 (down 0.25)	10.75 (down 0.31)	3.94 (down 0.93)
Leeds	9.57 (up 1.28)	6.64 (up 0.73)	3.52 (up 1.03)
Yorkshire & The Humber	9.30 (=)	5.47 (up 0.14)	3.37 (down 0.29)
England	7.32 (down 0.27)	4.76 (down 0.19)	2.49 (down 0.22)

Source: Prevalence Estimates released by Public Health England, April 2014

1.2 Individuals not in treatment

Based on the estimates provided by Public Health England and using the confidence interval levels of +/-95% the pie charts below (chart 1) display the number of OCUs who have not been known to treatment in the last two years[19], and therefore gives a visual display of the estimated proportion of OCUs not known to the treatment system. Green are those in treatment at the end of 2014/15, amber are those who are known to treatment (have been in treatment within the last two years) but were not in effective treatment at the end of the 2014/15 year, and red are those who have not been in treatment in either 2014/15 or 2013/14.

Chart 1: Estimated number of individuals not receiving treatment within the last two years based on the OCU prevalence estimate for Opiate and / or Crack users.



These estimates suggest that between 36% and 45% of the estimated OCU prevalence are currently in treatment and that between 49% and 61% of the OCU prevalence are known to treatment services (either in treatment currently or have been previously within the last two years). Therefore it is estimated that between 39% and 51% of the OCU prevalence are not known to treatment services in the last two years. It should be noted that the number of estimated individuals not known to treatment in the last two years has increased in comparison to previous estimates; this is due to an increase in

[19] Models of Care define Tier 3 as individuals who have a structured care plan and a clear structured programme of treatment.

the estimated prevalence and a decrease in the overall number of people that have accessed treatment during 2013/14 and 2014/15.

Treatment Naïve & engagement with the treatment system

Treatment naïve individuals are those that have not been in treatment before. When discussing treatment naïve individuals in treatment, these are people who had not previously been in treatment when they engaged with services.

The criminal justice route has historically been a major factor for treatment naïve referrals into the system. Addaction, the DIP drug treatment service in Sheffield, indicated that of the new individuals onto caseload around 18% are on the caseload for the first time in 2015/16. With a caseload of 383, (as of the end of 2015-16) this is around 67 treatment naïve individuals on their caseload at any one time. The caseload has increased over the last couple of years, which provides the opportunity to encourage more treatment naïve individuals into structured treatment. However, the prevalence estimates suggest that between 39% and 51% of OCUs are treatment naïve, which would suggest this cohort is underrepresented at the DIP service.

A change in testing by the Police from trigger offence testing to Profile testing also reduced the cohort of individuals that are being tested and this has impacted on referrals in to the service, and therefore referrals on to tier 3. This has also led to an increase in the number of individuals identified who are repeat referrals. During 2016 there has also been a new custody suite open servicing both Sheffield and Rotherham that led to some teething problems in maintaining processes. This is discussed in more detail in section 7: Criminal Justice, of this report.

Latest estimates suggest that the number of under 25s taking Heroin has reduced by 37% between 2005-06 to 2010-11, and therefore the pool of Heroin users is reducing[20] (there has been no update to this). 32% of the opiate treatment population (699 people) were treatment naïve at the start of their treatment episode and 79% of treatment naïve clients (552 people) have been in treatment for more than 3 years[21]. Only 5% of the total treatment population have a drug using career length of 6 years or under. This tells us that the large majority of service users do not seek treatment early on in their drug use but also that the majority of clients entering treatment for the first time engage with services and remain in treatment. Treatment naïve individuals and those who have not had a large number of previous treatment episodes are known to have better outcomes from treatment. For example, nationally, 8% of clients with no previous treatment completed successfully during 2015/16 in comparison to 5% of clients who had 4 or more previous episodes. However, we also see nationally that completion rates are higher for those with shorter career lengths. These trends are also seen in Sheffield but the cohorts in treatment that have a short drug using career are very small and the number of clients in treatment for under 3 years is also small. Therefore, although a third of the treatment population is treatment naïve, they have a long history of drug use which keeps them in treatment for a long period of time, and both of these can lessen the likelihood of a successful completion from treatment. The fact that they remain engaged in structured treatment is a positive for the Sheffield treatment system and means those accessing service receive continued professional support.

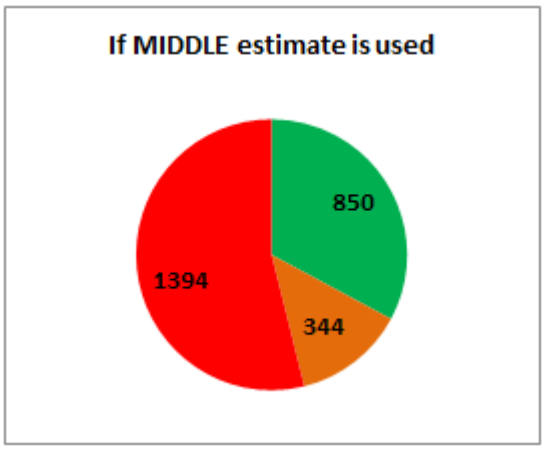
1.3 Crack Prevalence

Whilst the main prevalence figure has increased, the crack prevalence has decreased by 379, with the last two updates prior to this showing an increase. This is a significant margin and may suggest crack use in Sheffield is now decreasing, which would be further supported by another decrease in the next OCU update.

[20] Falling Drug Use: The Impact of Treatment. National Treatment Agency for Substance Misuse 2013
[21] Recovery Diagnostic Toolkit 2015-16, Public Health England

What do we know about crack use?
The crack bullseye suggests that 54% of those using crack, be it as a drug used on its own or alongside another drug, are treatment naïve, amounting to 1394 individuals.

Chart 2



Red = Not in treatment at any time in the last two years
Amber = treatment in the last two year but not at the end of 2014/15
Green = in treatment at the end of 2014/15

Of those in treatment at the end of 2014/15 47% of those using opiates were also using crack. A very small cohort of 25 individuals reported using crack without an opiate[22]. The figure of 54% treatment naïve is not much different to the figure in the last OCU estimates of 55%.

The treatment data above suggests there are very few people estimated to use Crack only, and out of 1096 crack users in treatment during 2015/16 only 46 record using crack without the use of opiates.

However, in contrast to treatment data, the opiate and / or crack use prevalence estimate is 4266 and the opiate prevalence estimate (those who use opiate on its own or alongside other substances) of 3004 suggests that there is an estimated prevalence of crack use without the use of opiates of 1262

In treatment there are over 1000 people who report using crack alongside opiates. It is therefore imperative that in Sheffield Psychosocial Interventions (PSI) continue to be offered to opiate users as PSI would provide the interventions required for crack use alongside the pharmacological intervention and PSI for opiate use.

1.4 Findings from the Crime Survey for England and Wales 2015/16

Estimates derived from responses to the crime survey for England and Wales 2015/16[23] shows that:

- 35% of people report having taken drugs at some point in their life. (Similar to previous years and the average for the last 10 years has been 35.9%)
- 8.4% of people have taken a drug in the last year. Overall this proportion has reduced since 2003/04 when a peak of around 12% of people reported using drugs in the last year. However the proportion increases to 18% when looking at only 16 – 24 year olds.
- 3% report taking a class A drug in the last year. The most commonly used drug in the last year is cannabis (6.5%) followed by cocaine (2.3%). However, last year use of cannabis has reduced from a peak of 10.7% in 2002/03.
- 4.3% of people have taken a drug in the last month, increasing to 9.1% amongst 16 – 24 year olds.

[22] Bulls-eye data 2014/15, Public Health England
[23] The Crime Survey for England and Wales is a survey of 16 – 59 year olds.

- The most commonly used drug in the last month is cannabis (3.2%) followed by cocaine (0.9%). Reported cocaine use in the last month peaked at 1.5% in 2008/09. Use of cannabis and cocaine in the last month among 16 – 24 year olds is 7.7% and 2% respectively.

SECTION 2 – Treatment at Tier 2, Tier 3 and Tier 4

Sheffield DACT commissions the adult substance misuse services in Sheffield, and this section focuses primarily on the needs of the adult population (those 18+) and the provision of substance misuse services available for them. Substance misuse services for younger people are commissioned in the city by the Vulnerable Children and Young People's Commissioning Manager.

2.1 Tier 2

Tier 2 treatment is commissioned in Sheffield to provide early interventions and a gateway in to structured treatment. It is a combination of assertive outreach, open access, the arrest referral and Criminal Justice Integrated Team (CJIT), and harm reduction services alongside a citywide network of pharmacy needle exchanges. Other than the provision of arrest referral and CJIT, all other Tier 2 level interventions are now commissioned alongside structured treatment in 'end to end' services; one for Opiates and one for Non-Opiates, which is a change from 2013/14 when Tier 2 drug treatment interventions, excluding DIP, were commissioned in a discrete Tier 2 service. Addaction and Sheffield Health and Social Care NHS Foundation Trust (SHSC) are commissioned to provide these services. SHSC also provides training to pharmacies that are new to needle exchange. The service also plays a key part in the city's BBV and Reducing Harm work, and provides the Recovery van service. These are discussed in more detail in section 6.

Demand for Tier two services is difficult to ascertain for a number of reasons. Data recording of individual activity is not comparable across services, so we do not know the numbers who are unique to tier 2 treatments across these services both in terms of Tier 2 only (not in structured treatment) or which Tier 2 clients use which Tier 2 services. For example, we know that the Non Opiates Service have seen 425 unique individuals at the needle exchange in 2015/16 but we do not know if these individuals are also on the DIP caseload for Tier 2 activity, or using the harm reduction service.

Table 5: Tier 2 activity

Commissioned Activity	Annual Commissioned Places/Contacts	Actual 2015/16	Q1 2016/17
Non Opiates Service Needle Exchange	1000	425	120
Dip Tier 2	No target for volume apart from DI3: 95% of those requiring treatment to be on the caseload		154 on caseload (June 2016)
Number of individuals receiving triage through SPOC / assertive outreach	n/a	449	106
Number of individuals receiving brief interventions	n/a	734	155
Pharmacy needle exchange	20 pharmacies	3,316 transactions per month (Apr-Mar average)	3,423 transactions per month (Apr-Jun 2016 average)
Harm Reduction	See "Harm reduction" section		

As the drugs services are commissioned as end to end services, contact with those clients not formally accessing a structured intervention, helps to provide better harm reduction to these individuals and may lead to engagement with structured support.

Needle exchange activity and data on the Harm Reduction service is provided in the Harm Reduction section (section 6), the Criminal Justice section (section 7) discusses Addaction and CJIT, and Aftercare is covered in the Recovery section (section 4).

2.2 Structured Tier 3 Treatment

Tier 3 treatment in Sheffield is recovery orientated. The headline indicator in national reporting from Public Health England (PHE) on the Public Health Outcomes Framework (PHOF) places emphasis on successful completions and sustained recovery, rather than just numbers in effective treatment, and supports the recovery agenda. Through the commissioning of tier 3 treatment the DACT aims to deliver continued benefits and recovery-orientated outcomes.

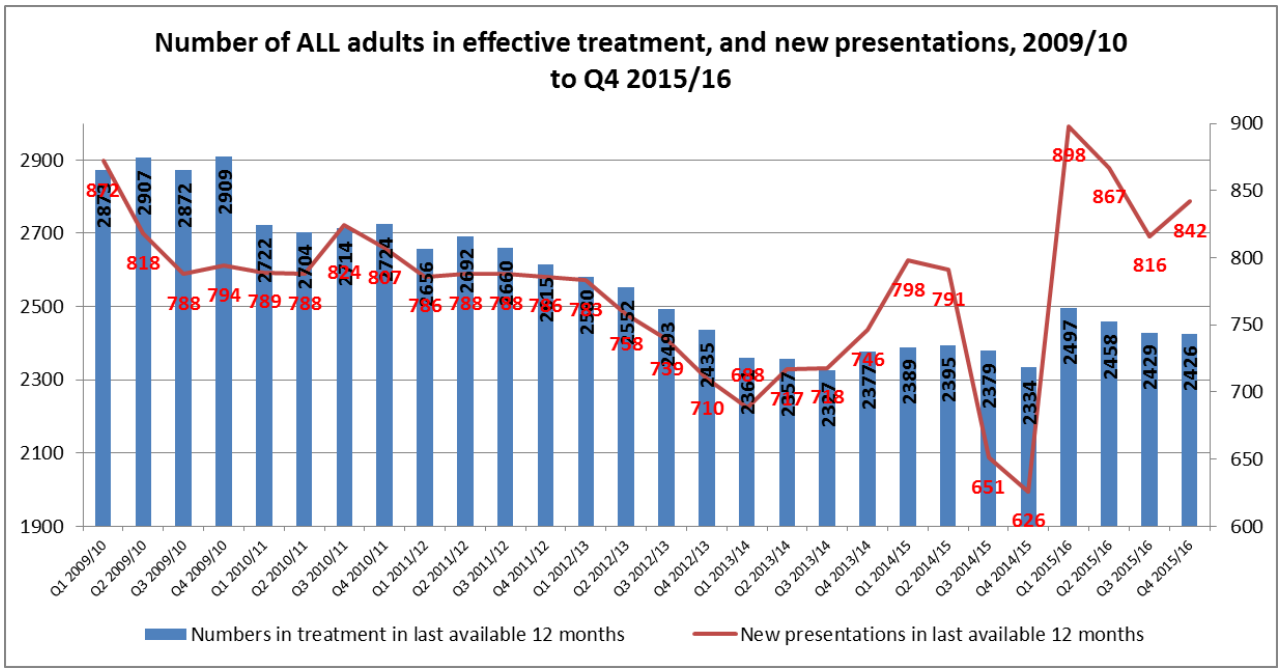
The number in effective treatment also remains a key indicator, alongside the focus on recovery. The number of people in effective treatment is a good proxy indicator for successful treatment; if an individual stays in treatment 12 weeks or more it is deemed to be effective, this increases the likelihood of a successful completion, and the potential to build any required recovery capital.

However, some individuals will complete treatment successfully in less than 12 weeks, which is also considered to be effective treatment. In order to provide the best opportunity for these service users to remain drug free, any recovery needs need to be addressed during their treatment episode and to offer post treatment recovery support. Building recovery capital increases the potential for service users to not re-present, assisting them in finding new interests, hobbies, as well as support for housing and increasing the service user's skills to assist with gaining employment, as required for each individual. Building this recovery capital can help a service user to stabilise their life. Those who complete successfully within 12 weeks are likely to have been less chaotic in their drug use and have fewer recovery capital needs, but assisting the client to address any needs they do have, or providing ongoing assistance in these areas as part of post-treatment recovery support, can be good tools to help an individual maintain their recovery.

As of October 2014, the only DACT-commissioned Tier 3 provider in Sheffield is Sheffield Health and Social Care NHS Foundation Trust (SHSC) who were successful in securing the contract for delivery of Opiate and Non-Opiate Services. Psychosocial and Pharmacological interventions are both commissioned at tier 3 with appropriate interventions provided by SHSC within both services depending on the need of the service user.

Chart 3 on the next page shows the number of ALL adults in treatment at various points over the past six years, along with the number of new presentations. After 2013/14 the number of new presentations was no longer reported as focus moved towards re-presentations.

Chart 3



As shown in the chart, overall, numbers in effective treatment have declined over the last 6 years, although numbers in 2015/16 are slightly higher than numbers seen during the two previous years. Some of this increase will be attributable to retaining a large proportion of the high number of new presentations also seen during 2015/16. The decline in new presentations seen on the chart towards the end of 2014/15 directly correlates to the start of the new drug treatment contracts and a period of time when we now know that accurate and complete data was not being submitted by the provider.

The large increase at the start of 2015/16 is also linked to this issue; once the data issues were realised and remedies put in place to accurately report data, those who had not been reported in Q3 and Q4 of 2014/15, were included in Q1 2015/16 data, making it appear that there had been a sudden increase in the number of new presentations (each reported figure is a rolling 12 month period). However, new presentation data for the whole of the 2015/16 year confirms that new presentations are currently higher than they have been in the last 5 years. If the level of new presentations remains high, this should continue to have a positive effect on the total number of people in effective treatment.

Nationally there continues to be a decline in the number of people in effective treatment with a -1.4% reduction in 2015/16.

2.3 Children and Young Adults

Young people using NPS, alcohol or IPEDs are unlikely to see themselves as needing a substance misuse service, but may well seek information on the internet.

The mobilisation of a Youth Information Advice and Counselling Service (YIACS) for 13-25 year olds with an integrated substance misuse service, offers direct access to information, advice and an assessment with the opportunity to access an intervention or specialist treatment through The Corner, young people's substance misuse service or adult services.

The YIACS is a holistic emotional wellbeing service with a youth work approach and will include an online resource for young people to access information, webinars and participate in moderated chat rooms.

The service is available to young people up to the age of 25 and supports transitions into adult services, in line with the transitions protocol in place between young people's and adults substance misuse services. There is a need to monitor the effectiveness of the YIACS and also the effectiveness of the transitions protocol. A copy of the transitional protocol is attached as Appendix 7.

2.4 Commissioned Treatment 2015/16

The DACT commissioned 3,750 treatment places at Tier 3 in 2015/16, of which 3,297 were utilised, which equalled 88%. This means that there were 453 places not used and from the table there is spare capacity across all modalities except primary care prescribing (however spaces are available in other prescribing services). PSI was the service most underused with over a third of capacity spare in total.

Table 6: Commissioned treatment places compared to utilisation 2015/15

Commissioned Service	Places 2015/16	Activity 2015/16	% utilised
Secondary care prescribing	1500	1279	**85%**
Primary care prescribing	950	1193	**126%**
Opiates PSI	900	478	**53%**
Non-Opiates PSI	400	347	**87%**
TOTALS	**3750**	**3297**	**88%**
(Prescribing total)	*2450*	*2472*	***101%***
(PSI total)	*1300*	*825*	***63%***

Nationally, there has been a fall in the prevalence of opiate and / or crack cocaine use, between 2010/11 and 2011/12 (the most recent prevalence data available) although these decreases are not considered to be statistically significant.[24] The number in treatment nationally is also decreasing. In Sheffield the numbers in treatment for opiates has increased in comparison to previous years, and have increased back to the levels seen around 2 years ago during 2014. This success has been seen following the commissioning of the new drug services contracts, providing service users with a single end-to-end service to support them through their treatment and address their recovery goals.

93% of responses from stakeholders to the consultation regarding this needs assessment thought that more opiate users should receive PSI, with 87% also thinking that a successful episode of PSI increases the likelihood that an opiate user will successfully complete their pharmacological treatment. Although it should be noted that comments received highlighted that on-going non-structured support is also required, and that PSI is a useful addition to pharmacological interventions but that its aim of PSI is not successful completion of a pharmacological intervention.

The number of people in treatment for other drugs nationally has been relatively static during 2015/16 although some small increases have been recorded during the last 6 months. This has also been seen in Sheffield; however, the non-opiate cohort size has increased whilst the non-opiate with alcohol cohort size has decreased.

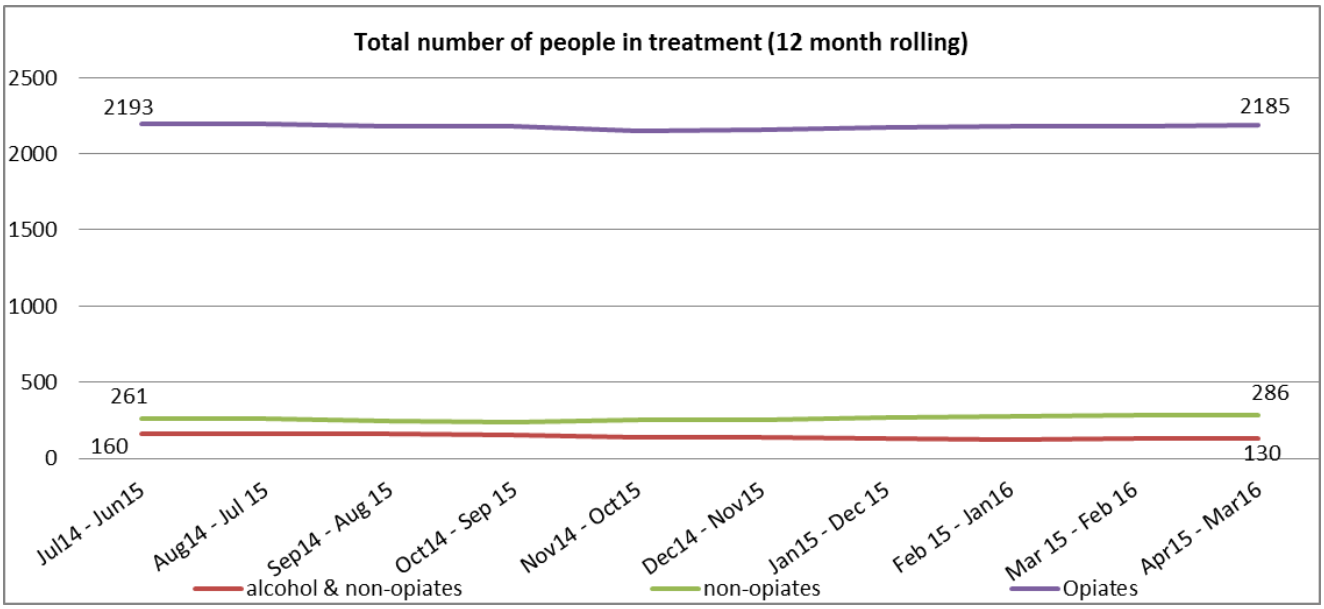
The Crime Survey of England and Wales for 2015/16 found that the number of people that have used any drug in the last 12 months was similar to the findings from the previous year; the number that had taken any drug in the last month was also similar to the previous year. The proportion of people classed as frequent drug users was also similar to the previous year. This data is in line with the trends for numbers of people in treatment.

[24] Estimates of the prevalence of opiate use and / or crack cocaine use, 2011/12: Sweep 8 report

2.5 Numbers in Treatment reported by NDTMS

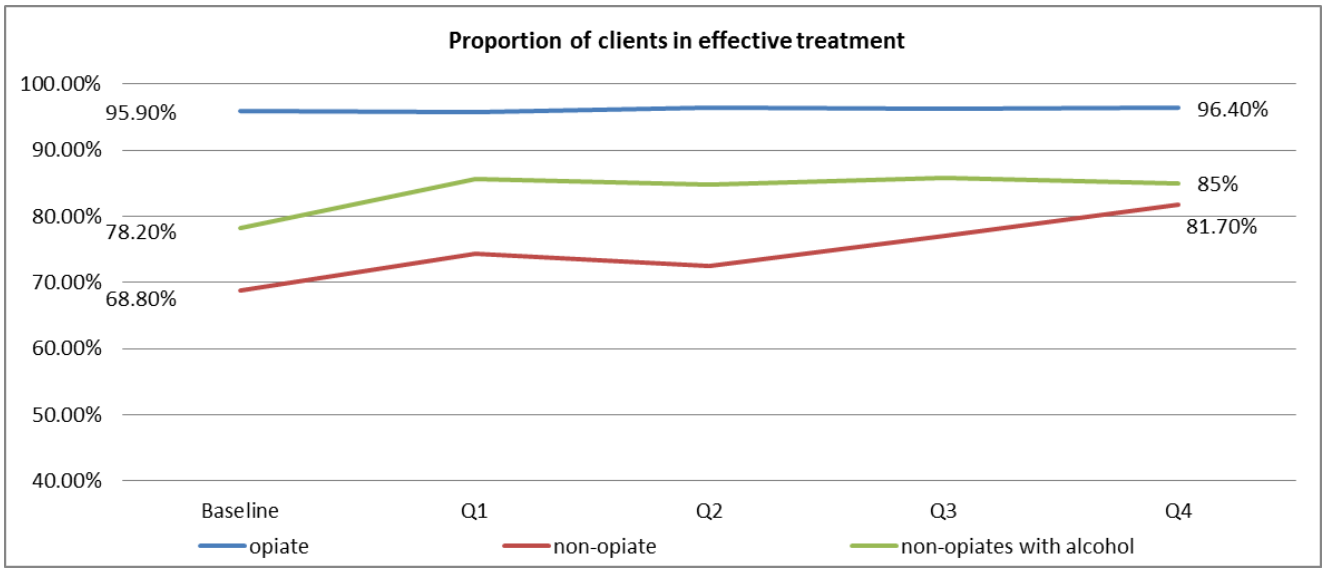
The total number of people in treatment overall in Sheffield has remained relatively static throughout 2015/16. This is particularly noticeable amongst opiate clients that had previously been reporting an ongoing decline. Both the opiate cohort and the non-opiate cohort show that they are in contrast to national trends. However, the number of people in the alcohol & non opiates cohort, the smallest cohort representing just 5% of the drug treatment population, has reduced by 19% between June 2015 and March 2016. The chart below shows data between June 2015 and March 2016, due to data issues at the start of the financial year.

Chart 4



The proportion of clients in treatment that are in effective treatment has increased during 2015/16 (see Chart 5 below). Clients whose treatment journey becomes effective are more likely to complete treatment and exit successfully.

Chart 5



The data from the two charts above tells us that although the total number in treatment has remained relatively static in 2015/16 the proportion whose treatment is effective is increasing. This is very positive and means that the current treatment system and providers are more successful at retaining clients who seek support from them and the potential for successful exit from treatment is therefore increasing. It should be noted however, that the proportion of non-opiate clients and non-opiate with alcohol clients whose treatment is effective is below the national averages which at the end of 2015/16 stood at 86.8% for non-opiate clients and 87.1% for non-opiates with alcohol clients.

The treatment system in Sheffield now needs to maintain or improve this level of performance for effective treatment and this should improve outcomes for clients.

Public Health Outcomes Framework;
Indicator 2.15(i): *Opiate* d*rug users that leave drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a % of all people in treatment.*

Indicator 2.15(ii): *Non-opiate* d*rug users that leave drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a % of all people in treatment.*

These are the national Public Health Outcomes Framework (PHOF) indicators for treatment of drug misuse. The indicator is presented as two sub-indicators to present separately the rates of treatment completion for users of opiates and those for users of all other drugs. The outcomes for these two groups vary markedly as do the proportions of the two groups in treatment in each local authority. Separation of the two groups therefore enables more meaningful comparison to be made[25].

The way the target is structured means that the percentage reported is not just for successful completions, but for people who complete and do not re-present (within 6 months of the successful completion). It is therefore a good measure of both the success and sustainability of the outcomes of treatment episodes. However, there are some noted limitations of what this measure can meaningfully indicate, due to not re-presenting to treatment not being a guaranteed indicator of not having relapsed, and the possible perverse incentive of a return to treatment where needed within 6 months being a 'failure'. Work is currently being done locally to look at progress 'in treatment episode' which could more successfully capture the complex nature of progress among this client group. Along with other major cities Sheffield is deemed to have some of the more complex drug users in the country. The target is measured against the city's baseline which for the current set of reports is for people who completed treatment during the period October 2013 to September 2014. However, locally, we also compare ourselves to the England average. Therefore, striving to achieve a similar percentage to the England average is a stretch given the calculated complexity of drug users in Sheffield, but is a positive aspiration.

Opiates
The 2015/16 baseline is for the completion period October 2014 to September 2015 (allowing for re-presentations up to 31st March 2016) and reports that in Sheffield 3.2% of the Opiate treatment population completed treatment successfully and did not re-present within 6 months. This compares to a national average of 6.8% and is also lower than the baseline figure of 5.6%. Performance against this measure reduced significantly in Sheffield during 2015/16, as shown in the data above. Forecast data suggests that performance against this measure will level out and potentially begin to show improvement during 2016/17. Also, opiate users are generally in treatment for longer periods of time, in Sheffield around 60% of opiate users have been in treatment over 2 years. Given that the total number of people in treatment has been quite stable during 2015/16, and that a higher proportion of people were retained in treatment through the year, this further supports the forecast position that performance against the PHOF target will begin to improve. There is also on-going work between the commissioner and the provider to help improve performance through successful recovery initiatives

[25] Improving Outcomes and Supporting Transparency. Part 2: Summary technical specifications of public health indicators. Public Health England updated November 2013

helping to provide service users with the best possible opportunities to get to the stage where it would be appropriate for them to exit treatment successfully.

Non-opiates

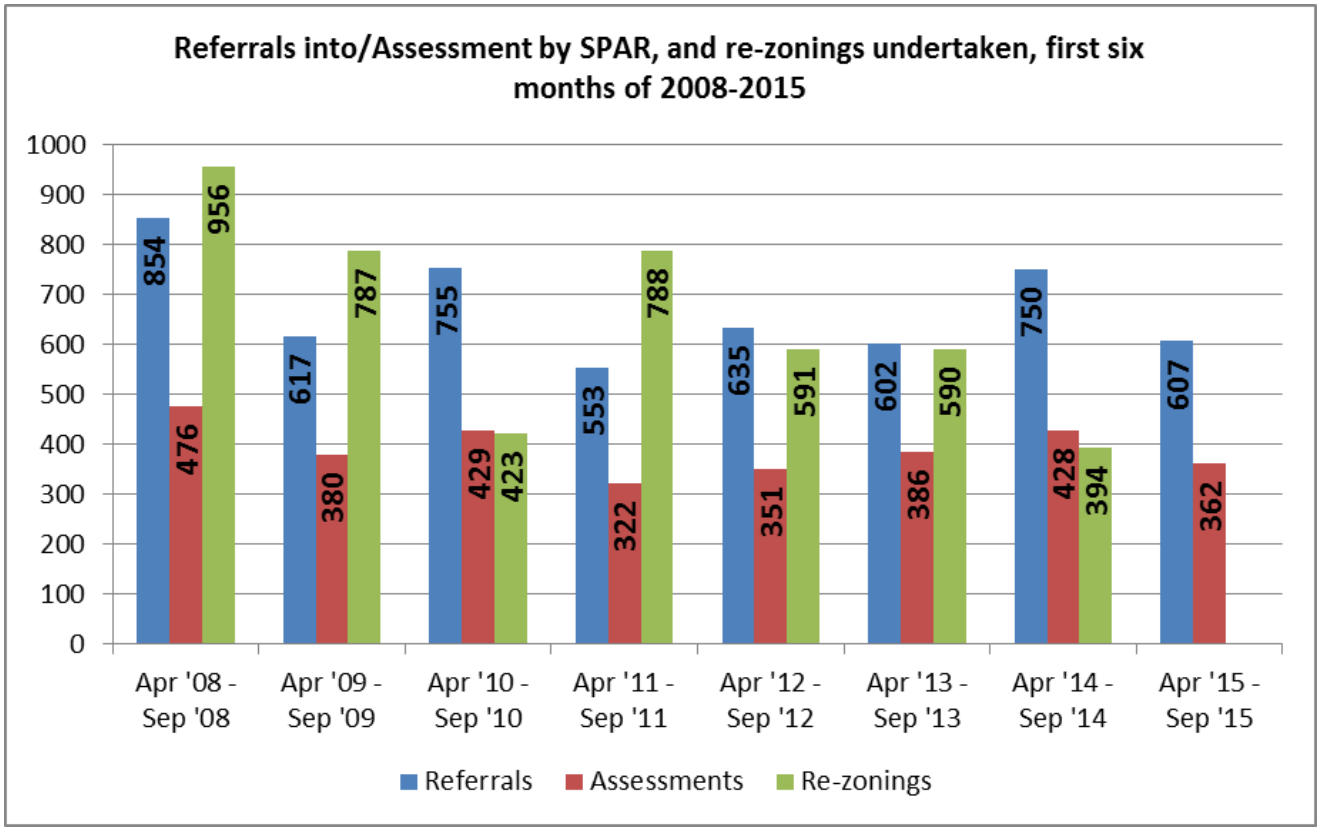
The 2015/16 baseline is for the completion period October 2014 to September 2015 (allowing for re-presentations up to 31st March 2016) and reports that in Sheffield 30.5% of the Non-Opiate treatment population completed treatment successfully and did not re-present within 6 months. This compares to a national average of 37.3% and is also lower than the baseline figure of 41.2%. The current position does however represent improvements over the last 6 months when performance having seen performance drop to around 29%. The baseline was also the highest performance recorded for Sheffield against this measure in the last couple of years. As the number of people receiving treatment is currently increasing it is expected that this will result in a greater number of successful completions in the future.

2.6 Local Treatment System Activity

SPAR

The Single Point of Assessment and Referral (SPAR) hosted by Sheffield Health & Social Care NHS Foundation Trust Substance Misuse Service, has been in operation since October 2007 with a target for 800 SPAR assessments to be undertaken per year. Activity into SPAR in the first six months of each financial year is shown on the chart below, with the blue bars showing the changes in referrals in, ranging from 553 (Q1 and Q2 2011/12) to 854 (Q1 and Q2 2008/9). Data on re-zoning was not captured since the change in contracts to being all prescribing treatments under one provider, therefore no green bar for re-zonings is on the chart for the first six months of 2015/16. However, in 2016/17 the provider will be reporting the number of people who move from primary to secondary care and vice versa.

Chart 6



The number of referrals fluctuates, as does the number of assessments. As would be expected, the larger the number of referrals, the greater the number of assessments. The number of referrals that turn into an assessment averages about 60%.

PSI

SHSC has been the sole provider of PSI in Sheffield since October 2014, with a target of 1300 people to receive PSI interventions per year (split between 900 at the Opiates Service and 400 at the Non-Opiates Service). This target was not achieved at the end of 2015/16, with 63% (825) of the capacity used (53% of Opiates and 87% of Non-Opiates capacity); just under one fifth of this figure (160, 19%) is made up of carry-over clients from the previous year.

Looking at the numbers in both prescribing and opiates PSI at SHSC during 2015/16, the PSI caseload is about one fifth of the entire prescribing caseload for the year. Orange Book guidance states that best practice of 30% of the prescribing caseload should be in PSI.

There is a need to better understand the lower than expected uptake of PSI amongst opiate users. Given that over 50% of the PSI caseload receives both a pharmacological and PSI intervention, there are a large number of clients receiving prescribing that are not taking up the offer of PSI. This is also relevant given that previously it has been suggested that the IAPT (Improving Access to Psychological Therapy) offer is an attractive option to clients as a psychosocial intervention but 2015/16 data tells us that the number of opiate users on a pharmacological intervention and also accessing IAPT peaked at 87 individuals during 2015/16. There is also an issue posed by those who have been in prescribing treatment a long time, who may be unwilling to consider PSI in the 'new' offer. However, in the period before the contracts were remodelled, the highest percentage of the prescribing caseload accessing PSI in any given year was between 3-5%, so an increase to around 20% since the contract start date is positive.

During the consultation the majority (92.86%) of respondents thought that more opiate users should receive PSI, however, 50% of respondents stated that in general opiate users that are offered PSI do not take up the offer. It should be noted that 43% of respondents did not know if opiate users take up the offer of PSI.

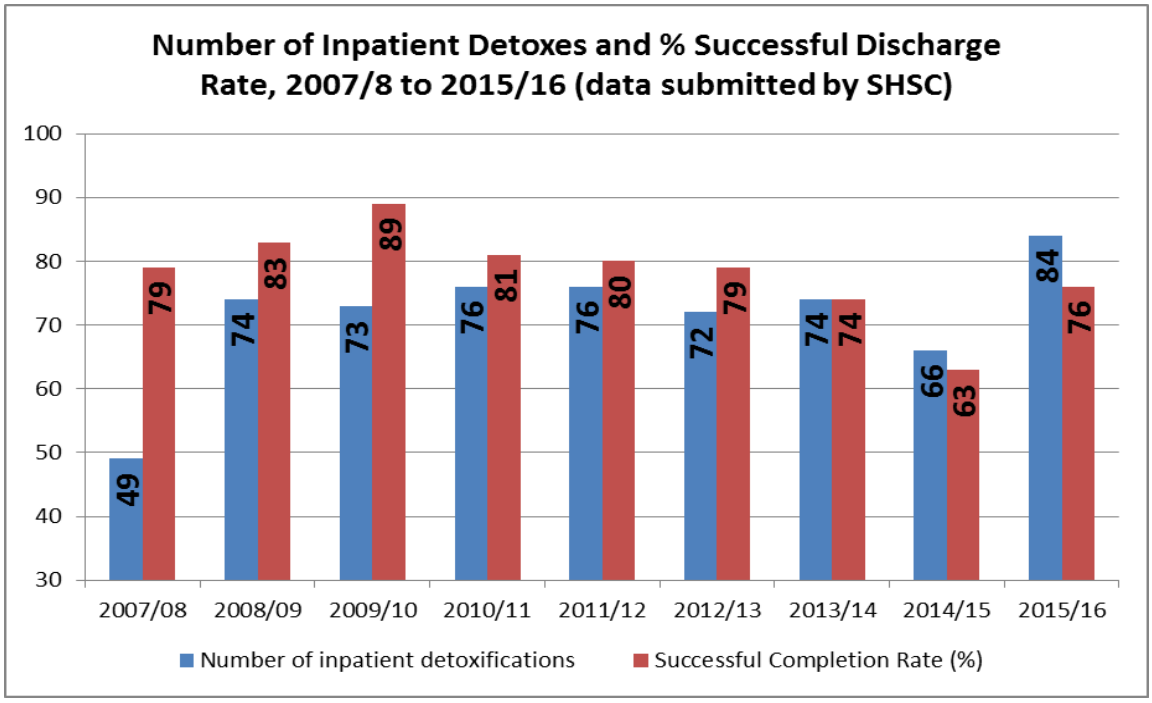
Tier 4

Residential Rehabilitation placements for Sheffield residents are spot purchased by Sheffield City Council, which remains responsible for the budget. Operational responsibility for assessment sits with Social Workers employed within SHSC. Oversight of this is managed through the Care Management Panel, which is attended by the DACT Strategic Commissioning Manager. SHSC hosts 5 inpatient detoxification beds in Sheffield which are located in Burbage mental health ward. DACT makes an annual contribution to the funding of this. This means currently the DACT is in a position where we can recommend changes to Tier 4 commissioning but cannot lead on the commissioning.

There is no longer any target for the number of inpatient detoxes or the success rate (this has been the case since October 2014), however the target for inpatient detoxification per year prior to this was 72 which was hit in every year up to and including 2013/14. 2015/16 saw the largest number of inpatient detoxification for the last nine years. Inpatient detoxification successful completion rate has remained above (the old) target of 73% for seven of the last eight years. The exception is 2014/15, which had a contract change half way through the year.

Activity for inpatient detox since 2007/8 is shown in Chart 7 on the next page

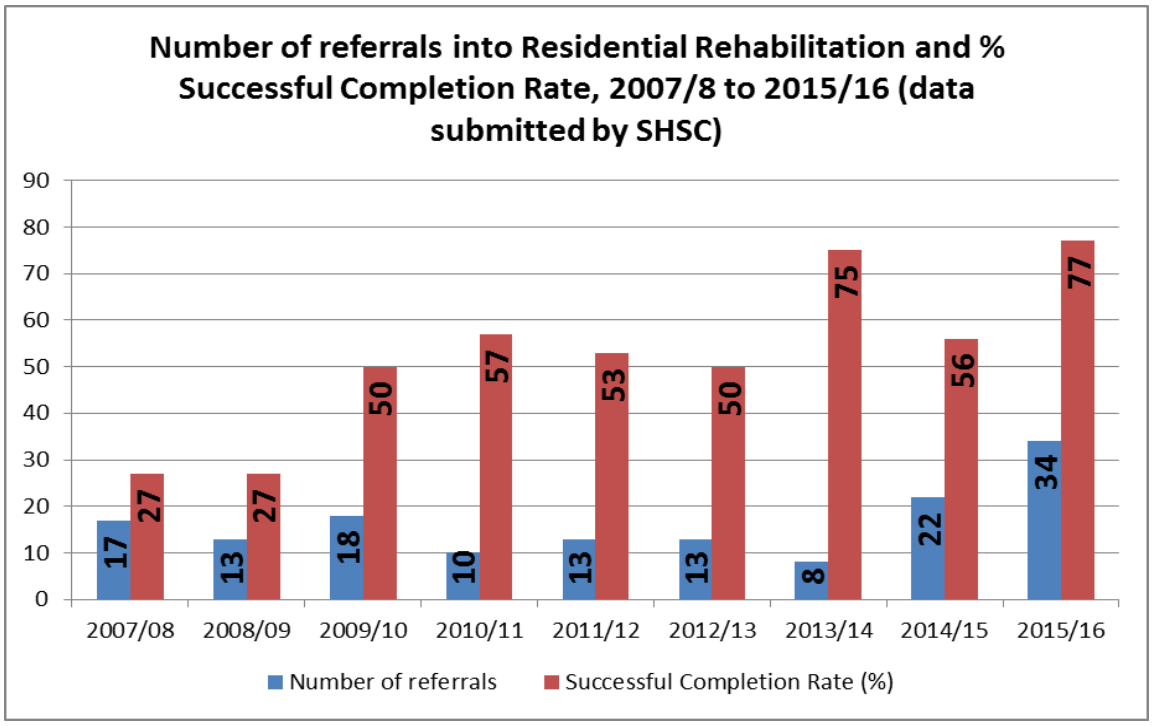
Chart 7 – Inpatient Detox, 2007/8 to 2015/16



The current position is that demand for inpatient detox for drug users has remained broadly similar for the past eight years, and increased in the most recent year. Data for 2016/17 will help to forecast if this is a change in trend.

There is no longer any target for the number of residential rehabs or the success rate (this has been the case since October 2014), however the target for residential rehab places per year prior to this was 27. The successful completion target rate for residential rehab was 62%. Historically, both metrics have fallen below the (old) targets, see Chart 8.

Chart 8 – Residential Rehab, 2007/8 to 2015/16



The chart shows that the number of referrals into residential rehab remained below target until the last financial year when there was a spike in referrals. Two of the last three years have also seen a successful completion rate above the (old) target of 62%. Again, 2014/15 numbers are poorer because of changes to the contract mid-year.

Thirteen different residential rehabilitation houses were used in the last financial year. Residential Rehabilitation places are purchased on an individual basis within a reasonable distance from Sheffield to maximise the support to clients, based on outcome criteria agreed by the Care Management Panel. However, exceptions are made where specialist provision is required at a greater distance.

The increases in 2015/16 for both inpatient detoxification and residential rehabilitation places highlight the need for this provision to continue to be available to appropriate service users.

SECTION 3 – Drug Misuse

3.1 Substance Use

Around 40% of the drug treatment population use either opiates only or non-opiates only. The other 60% either mix the use of opiates with non-opiates, use alongside alcohol, or use opiates, non-opiates and alcohol. Table 7 below shows the proportion of the drug treatment population in 2015/16 that cite the use of each of the substances listed. As the table is for drug treatment clients, those who cited the use of alcohol will have done so alongside the use of at least one other substance.

Table 7: Substances used by clients 2015/16

Opiates	43.6%
Opiates and crack	40.4%
Crack	1.8%
Benzodiazepines	11.3%
Amphetamines	3.7%
Cocaine	7.3%
Hallucinogens	0.4%
Ecstasy	1.0%
Cannabis	25.1%
Solvents	0.2%
Barbiturates	0.0%
Major tranquilisers	0.0%
Anti-depressants	0.3%
Alcohol	12.0%
Other drugs (excluding Novel Psychoactive Substances)	1.8%
Novel psychoactive substances	0.2%
Prescription drugs	3.0%
N/A	0.0%

A person can list the use of more than one substance and therefore the total in the chart above will equal more than 100%. This is with the exception of the three groups listed at the top of the table. For example, a client in the opiates and crack group will not also appear in the opiates group.

Overall, 84% of the drug treatment population use opiates and 42.2% use crack. After that Cannabis, alcohol and benzodiazepines are the most commonly used substances amongst the treatment population.

We also know that drug users new to treatment in 2015/16 20% use alcohol 9 days or more a month, 12% use benzodiazepines, 11% use Crack between 1 and 6 days and 1% use amphetamines. These proportions are also similar for opiate users that are not new to treatment (have had a previous episode).

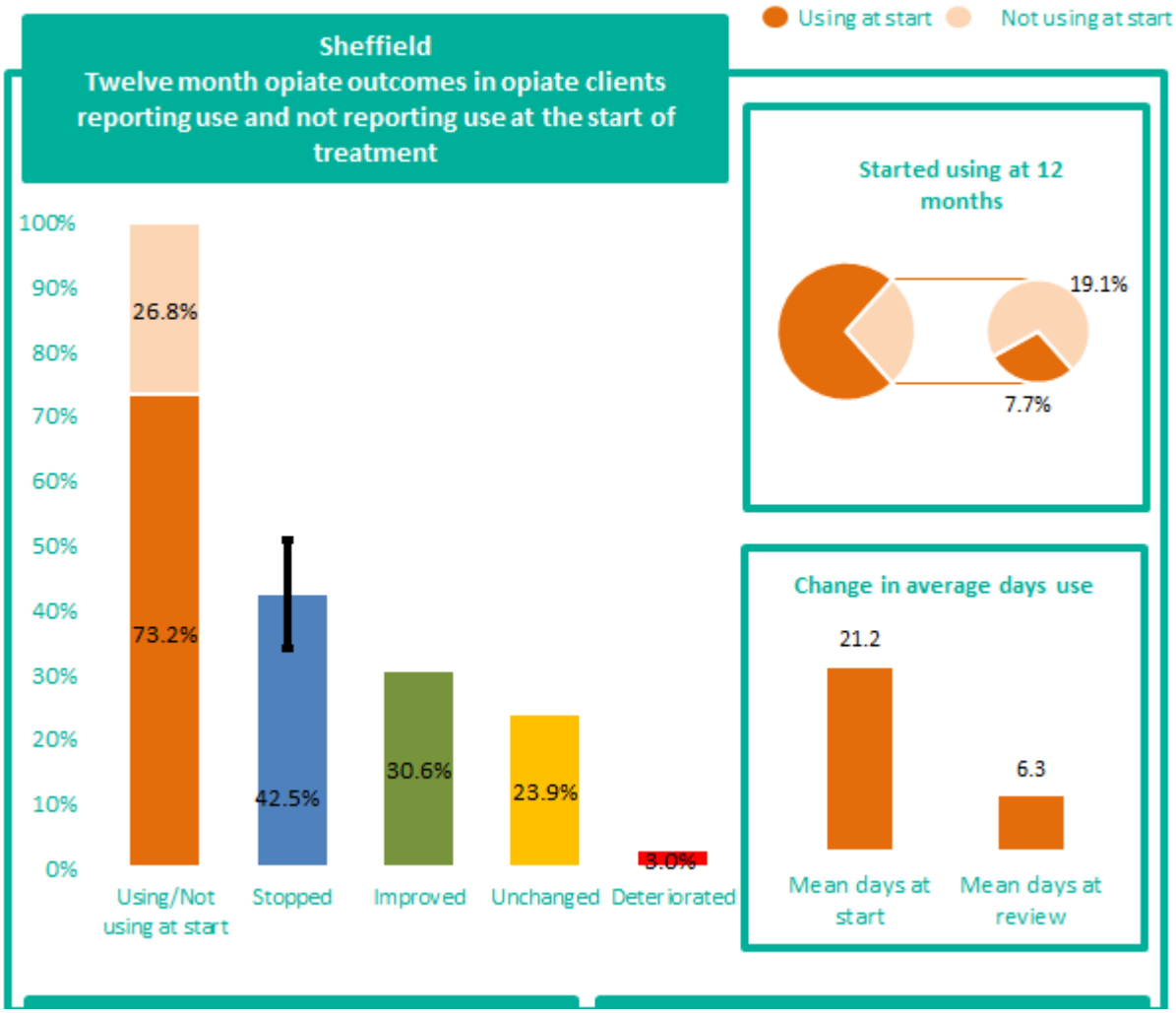
3.2 Opiate Using Clients

Chart 9 on the next page from the Recovery Diagnostic Toolkit[26] shows the 12 month outcomes for opiate users in 2015-16. The first bar on the chart shows the percentage of opiate users that were and were not using in the 28 days before they started treatment. The next four bars show the change

[26] Produced by Public Health England, 2015/16

in opiate use by these clients at the time of their 12 month review. Use is split into four categories; stopped, improved, unchanged, and deteriorated. For service users that have stopped using by the 12 month review an upper and lower expected performance rate is shown by a black line. Based on the complexity of clients in Sheffield, it is expected that the proportion that stop using opiates will fall within this range. The pie chart in the table presents the proportion of opiate clients who were not using at the start of treatment that have started using at the time of their 12 month review. Finally, the small bar chart at the bottom right shows the change in the average number of days clients have used opiates between starting treatment and the 12 month review.

Chart 9: 12 month review for opiate using clients in treatment



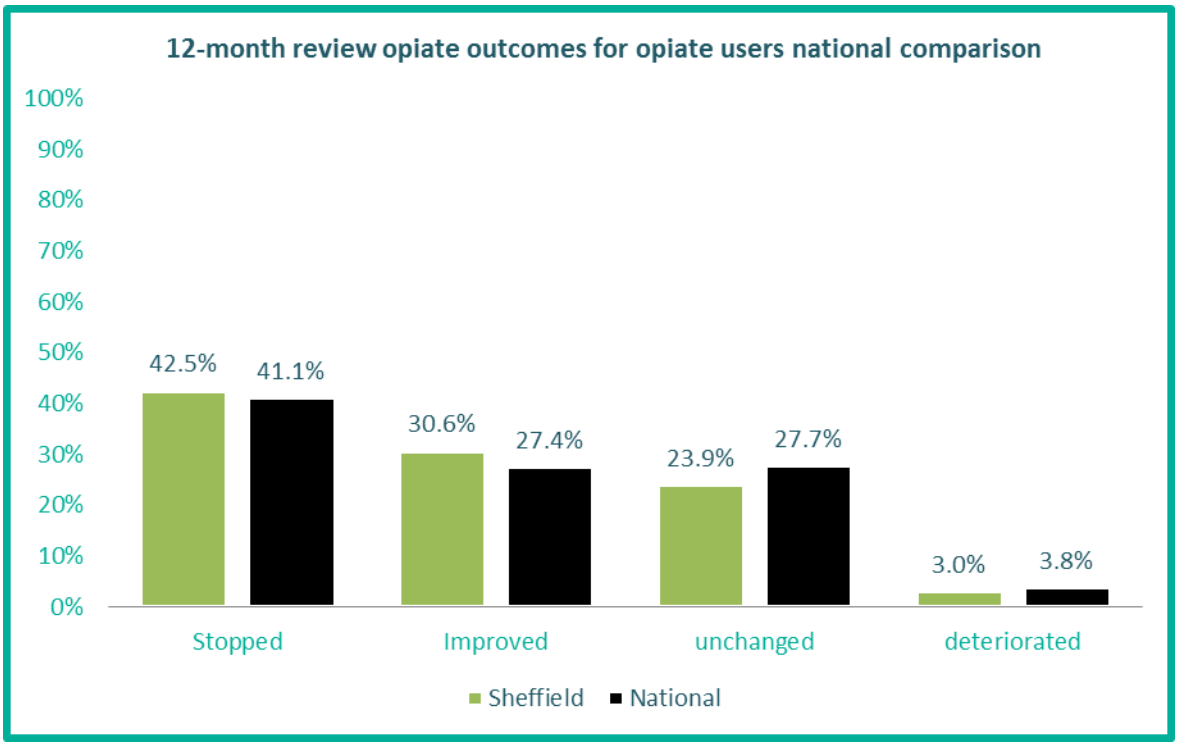
The chart shows us that 73.2% of clients are using Opiates at the start of treatment. However, by the 12 month review, 42.5% of these service users have stopped using. This falls within the expected performance rate for Sheffield. A further 30.6% have improved (reduced) their Opiate use and 23.9% are unchanged. 3% of those using at the start of treatment have increased their use by the time of the 12 month review, which is a larger proportion than reported in previous years.

26.8% of opiate clients starting treatment in 2015/16 were not using opiates when they commenced treatment. By the time of the 12 month review this 26.8% can be split to say that 19.1% were still not using opiates but 7.7% had started to use opiates whilst in treatment. This does not represent large numbers but starting to use Opiates again, reduces the likelihood for these individuals to complete treatment successfully. However, there is the possibility that these service users were not honest at the time of their initial assessment. It could also be that these individuals were prison leavers who had been detoxed in prison or entered the treatment provider on a prescription but have relapsed once back in the community. Whilst the majority do not start using opiates during the first 12 months of treatment it would be beneficial to understand more about the reasons why 7.7% have started using

opiates following engagement with treatment, although it should be noted that this is the same proportion as is seen nationally.

The final bar chart above shows that the average number of days using drugs in a 28 day period reduces greatly by the 12 month review. This provides a positive insight into the success of treatment during the first 12 months, and also that treatment will last over one year for many opiate using service users. For clients that were using opiates at the start of their treatment and had a 12-month review, the mean day's opiate use reduced from 21.2 days to 6.3 days.

Chart 10: 12 month review for opiate using clients in treatment national comparison



Linking in to the potential to complete treatment successfully, the chart above shows us that out of the people who were using opiates at the start of treatment, 73.1% have either stopped using opiates or have improved on the number of days they use, by the 12 month review. This compares to 68.5% nationally. Also, 3.8% of people using opiates at the start of treatment have deteriorated in their use nationally which compares to 3% in Sheffield. Although the Sheffield percentages are similar to the national averages, performance has deteriorated in comparison to the 2012/13 data reported in the last Needs Assessment.

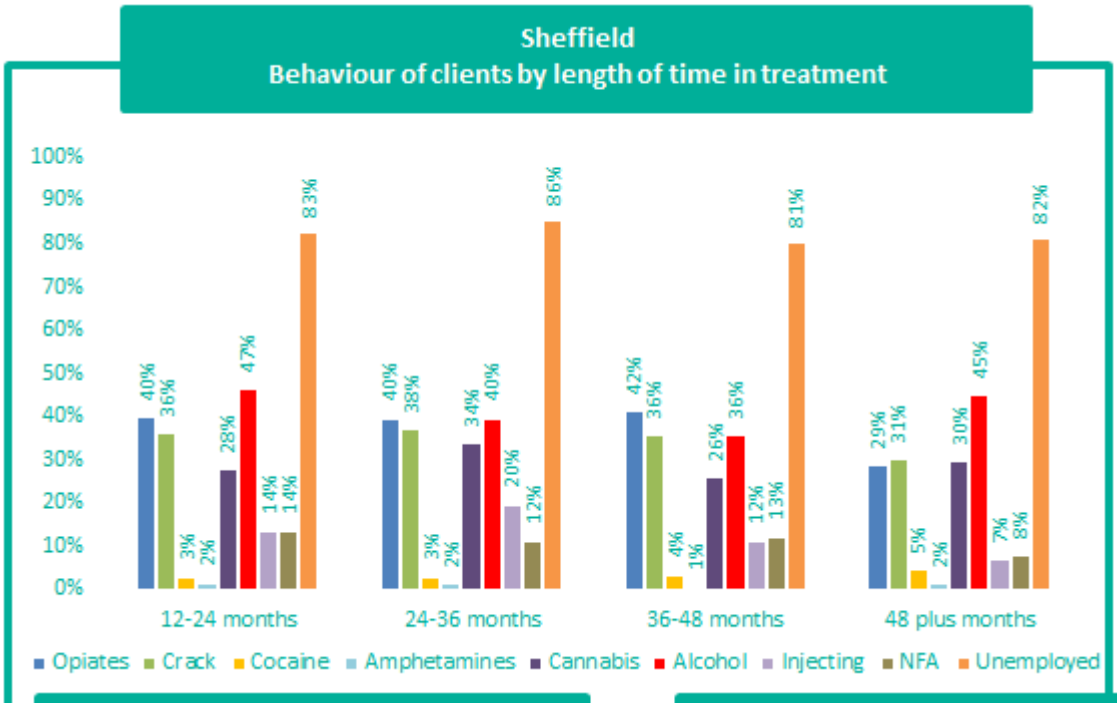
The chart on the next page shows the proportion of opiate clients in Sheffield who continue to use various drugs as reported at their latest review in the 2015-16 year. The chart is grouped by length of time in treatment and also shows the proportion of clients who continue to inject, have No Fixed Abode (NFA), or are unemployed. The chart shows that for clients in treatment longer than one year around 40% continue to use Opiates, for up to 4 years post treatment start. The data for 2015/16 shows that this proportion does not reduce until a client has been in treatment 4 years+. Crack use, Cannabis use and alcohol use also remain high. A much smaller proportion use Cocaine and amphetamines but no improvement in use is shown the longer a client is in treatment. Evidence suggests that stopping illicit opiate use at these longer lengths of time in treatment has been shown to increase the likelihood of a client achieving a successful completion about 10 times compared to clients that are still using[27]. Clients still using Opiates after 12 months in treatment need to be supported further to reduce these percentages and increase successful completions for opiate using

[27] Recovery Diagnostic Toolkit 2015-16, Public Health England

clients. It can also be seen on the chart below that alcohol use is between 36% and 47% for all treatment lengths.

100% of respondents to the consultation stated that they thought opportunities were missed to support more people who are in treatment to stop using opiates.

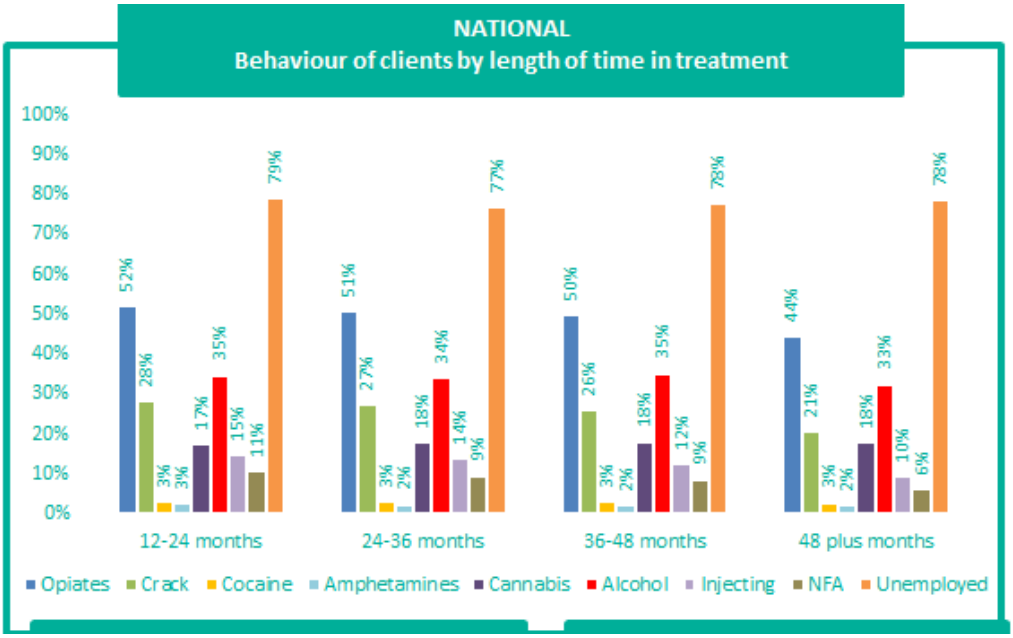
Chart 11 - Using Behaviour of Opiate Clients in Treatment 1 Year + in Sheffield



The chart also shows us that overall No Fixed Abode (NFA) reduces slightly the longer an individual is in treatment which represents an increase in an individual's recovery capital. However, unemployment percentages remain above 80% for all treatment lengths, suggesting that the Sheffield treatment system does not support clients to gain this piece of recovery capital. The percentage of clients that inject shows improvement for clients in treatment over 3 years. It is suggested that the use of other drugs and / or alcohol is often down to the user wanting to substitute and compensate for the reduction in their opiate use.

The chart on the next page shows the same information as Chart 11 above but is the overall percentages for opiate users in treatment in England.

Chart 12 - Using Behaviour of Opiate Clients in Treatment 1 Year + Nationally



Comparing Charts 11 and 12 shows us that although around 40% of opiate users continue to use opiates in Sheffield without a reduction in the proportion until 4 years+ of treatment, this is lower than the national percentages of around 50%. The proportion that inject is similar to the national average, with the exception of those in treatment 24 – 36 months. Sheffield does not perform as well as the overall England performance for crack, cannabis or alcohol use.

Although rates of opiate use for service users in Sheffield are below the national average, there are still 30% of clients in treatment for longer than 4 years who are still using opiates. The proportion is greater for clients in treatment between 1 and 4 years. It is also a higher proportion than has previously been reported for Sheffield. Further improved performance in this area has the potential to improve the successful completion rates. Given that the successful completion rate among opiate users in Sheffield is currently amongst the lowest in the country and that around 37% of opiate users in treatment have been in treatment for more than 6 years, opportunities to reduce drug consumption and increase recovery capital should be explored.

The NFA percentage is slightly more in Sheffield than the national average but does reduce over time. The unemployment rate in Sheffield is also higher than the national average. Both employment and permanent housing can be important contributors to building recovery capital.

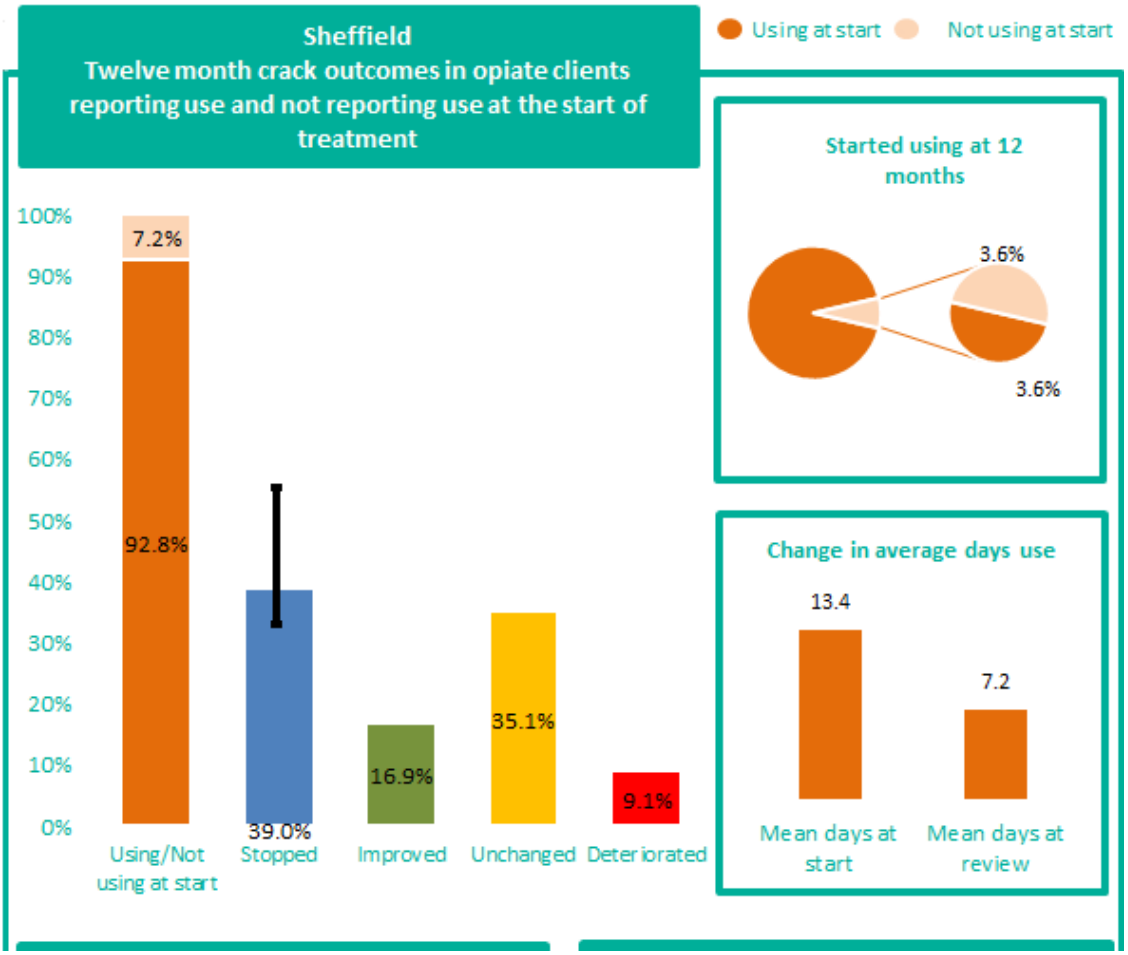
It has been suggested that people who now present for opiate use do so because of issues caused by the drug misuse, rather than for their drug use, i.e. employment, health or housing issues. Some of these individuals have been using for a number of years but have not previously presented because they were able to ‘manage’ their addiction until one of the factors given above became a problem. This is particularly relevant during times of austerity. The Recovery Diagnostic Toolkit tells us that those who stop using Opiates make substantive improvements in other areas of their lives (including housing and employment issues) in comparison to those who continue to use Opiates. The charts above show that opiate use is below the national average, which is encouraging, but that unemployment and homelessness are higher. Therefore, if rates of opiate use can be improved this leaves the potential for improvements in housing and employment and would provide more service users with better opportunities to recover from their addiction and would assist in preventing relapse. Also, those with more stable situations are more likely to stop using opiates, so improvements in either drug use or personal situation can lead to improvements in the other.

3.3 Crack Use

Overall 42.2% of drug users in treatment cite the use of crack as a problematic substance. This comprises of 40.4% of the treatment population that use crack alongside opiates and 1.8% who use crack but not opiates, although they may use other non-opiate substances.

As discussed above, stopping the use of illicit substances increases the likelihood that a service user will leave treatment successfully. Chart 13 on the next page shows the using habits of service users who present with crack alongside the use of opiates (since this makes up the majority of crack users in treatment) at the time of their 12 month review.

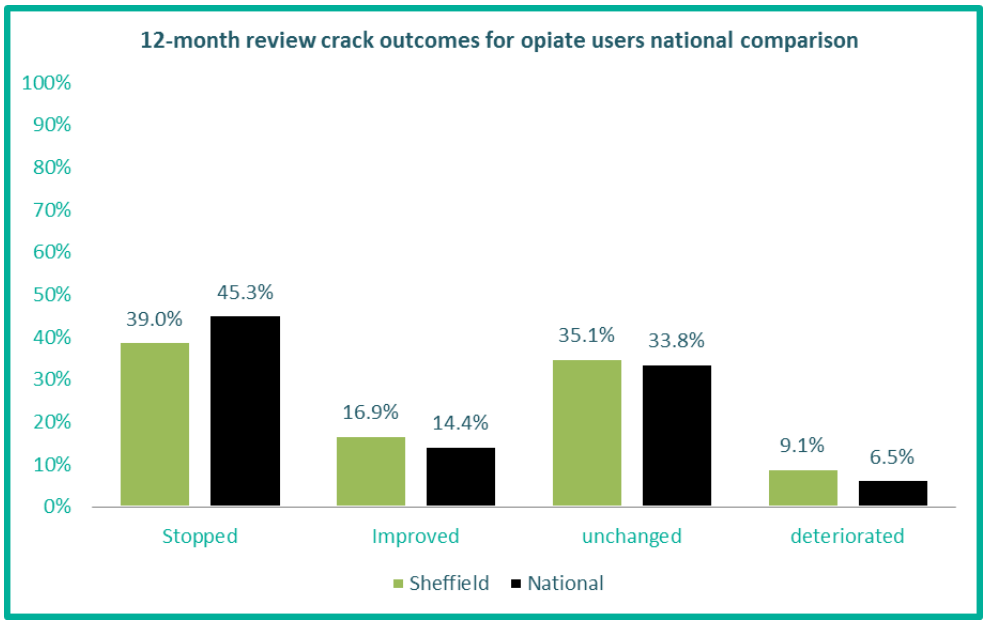
Chart 13 - Crack users 12 month review outcomes



The chart above shows that a large majority (92.8%) of those citing opiates and crack as problematic substances are using crack at the start of treatment. Out of the 7.2% not actually using crack at the start of treatment half of them (3.6%) have started using crack by the time of the 12 month review.

The chart also shows us that 39% have stopped using crack by the time of the 12 month review, and 16.9% have improved their use. However, use of crack has remained unchanged for 35% of service users and 9.1% have seen their use increase after 12 months in treatment. Average day's use of crack does reduce despite this from a mean of 13.4 days per month to 7.2 days per month.

Chart 14 - Crack users 12 month review outcomes national comparison



It can be seen that there is a lower percentage in Sheffield that have stopped using Crack and a higher percentage that are unchanged at the 12 month review, in comparison to the England average. In Sheffield, Crack users have historically been a cohort that does not have as high a successful outcomes rate as the general treatment population. This is supported by the rates in the chart above. Similar to the use of opiates for clients in treatment, improvements in the rate of crack use (and other drug use), would have the potential to increase the number of people exiting treatment successfully.

3.4 Non OCU drugs – 'other drugs use'

Previous consultations have suggested that there was not enough treatment resource specifically commissioned for the non-opiate drug using population, *'the treatment offer speaks mainly to Heroin users'*. Since then, the re-tendering of services saw a new contract awarded to offer a service specific for non-opiate users. Since the start of this contract in October 2014 there has been a 20% increase in the number of non-opiate users accessing treatment in a 12 month period.

Cocaine use

Cocaine was the second most commonly used drug among people aged 16 – 59 in 2015/16, with 2.2% of people stating that they had used the drug in the last year. 0.8% of people used cocaine in the last month. However, both of these percentages are a reduction on the previous year. These percentages are higher amongst the 16 – 24 age group although it is the third most commonly used drug amongst this group. 4.4% of this age group have used cocaine in the past year, a reduction on the previous year. 2% of 16 – 24 year olds have used cocaine in the last month, a slight increase on the previous year.[28]

7.3% of the drug treatment population in Sheffield list cocaine as one of their problematic substances. Just under half of these clients also use opiates. 4% of the treatment population use cocaine either on its own, alongside other non-opiate substances or alongside alcohol. Looking only at non-opiate users in treatment (including those that use non-opiates alongside alcohol) clients using cocaine make up 25% of the non-opiate treatment population.

[28] Drug Misuse: Findings from the 2015/16 Crime Survey for England Wales, Office for National Statistics, Home Office.

Cannabis use
Cannabis is the most commonly used drug in England and Wales, with 6.5% of adults aged 16 – 59 using it in 2015/16, and 3.2% having used it in the last month. These percentages represent a reduction on the previous year. 37% of cannabis users were considered frequent users (had used the drug more than once a month on average in the last year)[29]. These percentages were higher amongst the 16 – 24 year old age group who had 15.8% using cannabis in the last year and 7.7% having used in the last month. 36% of 16 – 24 year olds were considered frequent users.

In Sheffield 25.1% of the drug treatment population cite cannabis use as one of their problematic substances. Amongst the non-opiate treatment cohort 61% of the non-opiate treatment population and 18% of the opiate treatment population cite the use of cannabis as problematic at the start of treatment.

Steroids
In 2015/16 119 people attended the tier 2 Juice Clinic in Sheffield. This is a Harm Reduction group for Steroid users where they can get advice, have blood tests, and receive clean needles. They are also now able to access PSI through the service. This group do not usually take other drugs, they are sensitive about their body image, and do not see themselves as drug users. They work cycles of steroids to improve their body image. This group can be hard to engage in tier 3 treatment, particularly as they do not see themselves to be 'like' other drug users, but the Juice Clinic provides an open door to services where the tier 2 service can engage them. The work that needs focus is engaging steroid users in tier 3 treatment as well as increasing the numbers attending the Juice Clinic. In 2015/16 there were no steroid users engaged in tier 3 treatment in Sheffield.

New Psychoactive Substances (NPS)
NPS are now illegal in the UK following the passing of the Psychoactive Substance Act (2016). Due to the nature of these substances, providers have to aim to keep up with the new emerging substances. This can present difficulties as the effects of the new substances are not known until individuals present for support and information can be shared amongst providers across the country. The Crime Survey for England and Wales reports a 3rd year reduction in the use of mephedrone in the last 12 months. The survey also estimates that 0.7% of adults aged 16 – 59 used NPS during 2015/16. For people aged 16 – 24 2.6% have used NPS during the year. These percentages are similar to the findings in 2014/15.

The treatment system in Sheffield is acutely aware of the NPS market, due to the number of Head-shops selling the substance prior to the change in law, but few people have presented to treatment. In 2015/16 just 0.2% of the drug treatment population cited the use of NPS.

Khat
Khat was reclassified in the United Kingdom in 2014 to a class C drug making it illegal to buy, sell, share and use. It is a green leaf shrub that has been chewed for many years by people in the Horn of Africa and the Arabian Peninsula. It can now be found across Europe, particularly amongst groups of emigrants and refugees from countries such as Somalia, Ethiopia and the Yemen. In Sheffield these groups were targeted with information on the re-classification and how to get support in Sheffield. Since the reclassification there have been no presentations to structured treatment by Khat users.

Alcohol and Drug use
It has been highlighted that alcohol misuse is increasing within the drug using community. People are using in excess and it has become a problematic drug for a number of people. Drug using clients entering treatment have an Alcohol Use Disorder Identification Test (AUDIT) in order to assess the individual's level of drinking. The treatment provider have seen that the implementation of AUDIT for all drug users has confirmed the perception that many drug users in treatment drink alcohol above the recommended limits and could benefit from some form of intervention. It is also common for people in

[29] Drug Misuse: Findings from the 2012-13 Crime Survey for England and Wales.

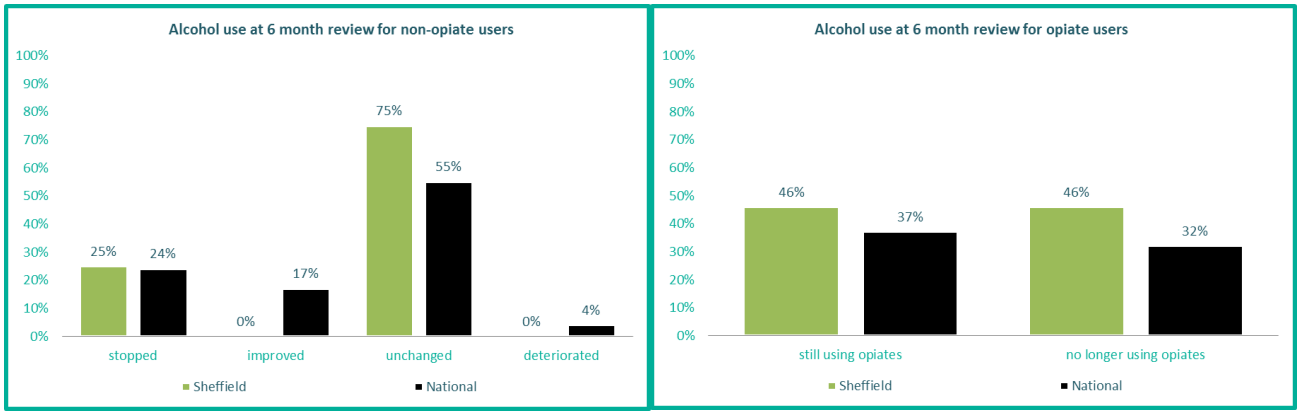
treatment to increase their drinking levels as a way of compensating for reducing or stopping drug use. As discussed earlier, it is known that around 44% of opiate users who have been in treatment longer than one year continue to use alcohol. Although not all of this use will be above the recommended limits.

The use of AUDIT gives the providers a good measuring tool and provides a platform for discussing alcohol use with service users; it has led to an increased awareness amongst service users that the providers can help with alcohol problems, and enables it to be addressed as part of the person's treatment. Discussing alcohol use with drug users is the norm now that screening using AUDIT is taking place as routine.

Drug and Alcohol Use data

Of those in drug treatment during 2015/16 12% cited the use of alcohol as one of their 3 most problematic substances, 8% of clients using opiates and 31% of non-opiate clients. Alcohol use is the fourth most commonly used substance by drug users in treatment after opiates, crack and cannabis. However, we also know that around 44% of opiate users in treatment 1 year+ use alcohol, and we also know that for non-opiate clients who were using alcohol at the start of treatment, 75% do not improve their alcohol consumption by the time of their first 6 month review. Excessive alcohol use can negatively impact on successful completions of treatment. The charts below show alcohol use amongst the treatment population at the time of their 6 month review. It should be noted however, that alcohol use is defined as any alcohol use in the 28 days prior to the 6 month review. Therefore the percentage does not necessarily represent dependent or high risk drinkers.

Chart 15 - 6 month review outcomes 2015-16



Opiate users: The opiate users chart shows that 46% of service users still using opiates at the 6 month review are drinking alcohol; this compares to 37% nationally. 46% of opiate clients no longer using opiates at the 6 month review are drinking alcohol; this compares to 32% nationally. The alcohol use proportions for Sheffield are higher than the national average for both groups (still using Opiates and not using Opiates). The data shows that in Sheffield the proportion of clients using alcohol is the same amongst both clients using opiates and those that have stopped using opiates at the time of the 6 month review and remains around 40% for clients in treatment longer than this. Alcohol use in Sheffield remains above the national average regardless of how long they have been in treatment.

Non opiate users: For non-opiate users the chart shows the level of alcohol use at their 6 month review, split into four groups; stopped, improved, unchanged, and deteriorated. No one has reported deterioration in alcohol use at their 6 month review, and this compares to 4% nationally. 25% have stopped using alcohol, a slightly higher proportion than the national average. Unchanged is recorded for 75% of service users and this compares to 55% nationally. More needs to be done in Sheffield to increase the proportion that have reduced their alcohol consumption by the time of the 6 month review, but it is encouraging that no-one has reported their alcohol use has deteriorated during their first 6 months in treatment.

SECTION 4 – Successful Completions and Recovery

4.1 National Guidance

In January 2014 Public Health England, released an updated briefing titled *Turning Evidence into Practice: Helping service users to engage with treatment and stay the course*[30]. The briefing states that '*Treatment for successful recovery starts with effective engagement, with early identification of needs and goals, and quickly providing support for immediate priorities.'* The briefing highlights 13 key areas that should be adopted to provide recovery focused treatment from the start, and that by being recovery focussed at the start of treatment increases the likelihood of completing treatment successfully.

The 13 key areas are:

- First impressions: Promoting what services offer.
- First contact: Experience of first contact can be crucial for engagement.
- Inviting Environments that don't stigmatise users: conveys a message that services value its users and their well-being.
- Encouraging reminders and cues: sending reminders is associated with better retention.
- Waiting times and rapid access to treatment: Rapid access makes it easier to engage opioid users more effectively and enhance early reductions in harm.
- Making services accessible: addressing common barriers to treatment access can have a positive impact on attendance and engagement in treatment.
- Transport: Providing and / or paying for transport can help engage people who find it hard to get to the location of service providers.
- Flexible access: Flexible opening times can help engage service users.
- Childcare: Studies suggest that women with children are more likely to stay in treatment if the service can offer childcare facilities.
- Equality & Diversity: Effective services assess the needs of the population they serve and respond appropriately.
- Recovery visibility: Creating a visible, pro-recovery environment.
- Formal induction: Clear, well-planned approaches to induction that provide information and adequate time to discuss with service users exactly what treatment entails.
- Accompanying entry and reaching out to service users: Fast-track system to treatment for prison leavers and well planned outreach services for at-risk groups.

In Sheffield, the main key areas are implemented at service providers but there are some gaps. The current treatment provider has recently made improvements to the client waiting rooms, each service provides evening appointments one day a week, and in 2015/16 no one waited in excess of the national 3 week wait standard for a first appointment. Recovery is promoted well in Sheffield, not just within and by the treatment provider, but also through regular campaigns and the on-going work of the Communities Development Officer at the DACT.

Successfully completing treatment and sustaining recovery is a key theme in the Sheffield treatment model. Post treatment recovery support options are offered to all clients reaching the end of their treatment for a 6 month period, which includes in-house support provided by the commissioned provider as well as information regarding other community support groups.

Since 2012-13 NDTMS has published data in relation to the Public Health Outcomes Framework indicator (PHOF); indicator 2.15 '*Drug users that leave drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a % of all people in treatment.'* Performance against this indicator is compared to baseline performance as well as the top quartile range for comparator DAT areas. This target is formally monitored and is one of the national

[30] http://www.nta.nhs.uk/Turning-evidence-into-practice-Optimising-opioid-substitution-treatment.aspx

targets on the PHOF. The indicator is measured separately for opiate clients and non-opiate clients as completion rates vary greatly between these two groups.

Latest data for Sheffield as at Q2 2016-17 against the PHOF indicator states that 3.7% of opiate users in treatment and 32.8% of non-opiate users in treatment have successfully completed treatment and not re-presented within 6 months. This is an increase of 0.46% and 1.91% against the baseline for opiate and non-opiate users respectively.

This indicator measures the successful completion rate and also the re-presentation rate. Monitoring the percentage of people that do not re-present within 6 months following successful completion of treatment provides a measure of the success of the treatment episode and recovery from addiction. A successful completion means that the individual has exited treatment drug free or 'occasional' use of a drug that the service user has not been in treatment for the misuse of. During the treatment episode a service user is given support to build recovery capital. If the service user is given the correct skills and tools to implement change in their life, reduce risk-taking behaviour, and to prevent relapse they are much less likely to re-present to treatment.

The *'recovery-orientated drug treatment an interim report' by Professor John Strang, chair of the expert group' (2011)*[31] recommended 12 steps that would improve the recovery orientation of treatments that include prescribing. These steps would ensure there is appropriate support for patients to achieve the best secure gains. A compliance audit was undertaken by the DACT and service providers and consulted with the Recovery Task Group. The 12 steps were reviewed and actions agreed, as appropriate, in order to understand how Sheffield's recovery focus matched with the Strang recommendations.

In 2012 a further report by Professor John Strang '*Medications in Recovery: Re-orientating drug dependence treatment*'[32], highlighted the importance of supporting an individual's ambition to lead a drug free life, but that coming off opioid substitute treatment prematurely and exiting treatment prematurely, can harm the individual particularly if they then relapse. It also acknowledges that not everyone who comes into treatment will overcome their dependence, and therefore stresses the importance of creating a treatment system that makes every effort to provide the right package of support to maximise every individual's chances of recovery.

These two Strang papers set out the importance of recovery focussed treatment and having embedded these practices, the DACT strives to achieve the best successful completions and re-presentation rates possible. Through the regular monitoring of performance indicators and identifying changes in performance, the DACT aims to maintain levels of performance and to instigate changes in the system as appropriate to improve performance.

In the consultation document issued in 2016 on the renewed 'Orange Book' clinical guidance, particular note was made that it was never appropriate for clinicians or services to 'push' an abstinence based treatment intervention over a maintenance based one, and that it was unethical to do so. This may in part be due to the increased pressure on services to exit people from treatment quickly, and prevent their re-presentation, in order to perform better against the PHOF targets.

Whilst the Sheffield treatment system does focus on recovery and promoting all available options to service users, this is not done at the expense of the client's needs from treatment, nor is abstinence based treatment given enhanced status for those for whom it is not currently suitable, in order to feed an increase in successful completion performance reported nationally. Using only this indicator as a measure of success and quality of treatment can be counterproductive to the population served. Opiate users are particularly known to have complex needs, and large cities are known to have clients with some of the highest complexity factors. The limitations of the PHOF is that it does not give any 'progress in treatment' information or analysis and as such places excessive emphasis on leaving treatment and not returning when this may not be in the best interests of the client.

[31] http://www.nta.nhs.uk/recovery-orientated-drug-treatment.aspx
[32] www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

In a recent blog post the Director of Public Health in Sheffield wrote *'There seems an approach of using the indicators in to make exiting treatment the only outcome with a value…. Recovery is a good thing, nobody disputes this. However, there are no indicators nationally that reward quality of treatment or within treatment progress etc.*

All services can cite lots of stories of chaotic, needle sharing, regular offending, Hep or HIV positive homeless person who starts off just engaging with NEX to get clean works. Often later, usually with timing that reflects the needs of those users, they later comes into treatment, are stabilised on methadone, has their wrap around needs met, engaged in appointments, gets housing sorted, benefits, into treatment for their physical health issues, stops injecting or use on top, and is maintained for a long period, no longer offending, not spreading infection via shared use, has some structure and commitments that they can stick to.

This is not 'recovery' as is defined by the 2010 strategy, but for this group their life quality, and their detrimental impact on services is so much better but that doesn't exist as we a) haven't exited them and b) they will likely have been in treatment for over 6 years etc.[33]

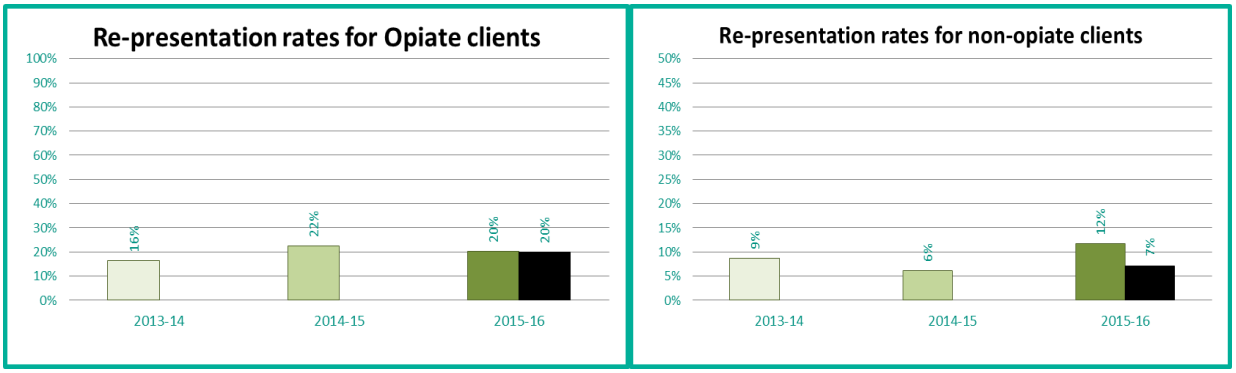
It is therefore important to highlight that in Sheffield as at the end of 2015/16 34% of opiate users in treatment have been in treatment for 6 years or more. This means they have received one continuous treatment journey for that period of time and maintained their engagement with the treatment provider. 37% of all opiate clients in treatment have a drug using career length of more than 21 years, meaning that their lifestyle and behaviours are very much ingrained as their way of life and continued treatment and support is required to break this cycle. We also know that completion rates amongst those that have a longer treatment episode and those with longer drug using career lengths are lower and therefore the continued engagement of these clients is a success of the treatment system and quality of the support provided in Sheffield. It should also be noted here that 70% of treatment naïve opiate clients (those without a previous treatment episode) have been in treatment for 6 years or more. This further highlights a success in the local treatment system as it shows that the treatment system is successful at engaging clients at their most chaotic and when vulnerability is high, this engagement leads to their improved health and quality of life as described in the Director of Public Health's blog post.

4.2 Local Performance

The Recovery Diagnostic Toolkit shows the successful completion rate and re-presentation rate for the last three years in comparison to the average of outcome comparators. The charts below show the data reported in the toolkit (Green shaded bars are Sheffield; black bars are the comparator averages):

Chart 16

[33] https://gregfellpublichealth.wordpress.com/2016/10/11/drug-recovery-versus-maintenance-and-the-smart-use-of-indicators/



In terms of opiate clients, the completion rate for 2015-16 is the same as 2014-15 however, it has reduced by 2% in comparison to 2013-14. At the end of 2015-16 the percentage of opiate clients completing treatment is 2% below the comparator percentage. Following a reduction in completion rates, the rate has stabilised at 4% and the DACT and treatment providers are proactively working to maintain and improve this level of completions.

In terms of non-opiate clients, the DACT again performs lower than the comparator average for completion rates. In 2015-16 33% of non-opiate users successfully completed treatment, which is 3% lower than 2014-15 and 5% lower than 2013-14. In 2015-16 the comparator completion rate for non-opiate clients was 39%. The current position of 33% does represent an improvement on performance during much of 2015/16.

In terms of re-presentation rates; the rate for opiate users is the same as the comparator average and is lower than the re-presentation rate reported in 2014/15, however, this is continually monitored through performance management mechanisms with the provider with the aim of achieving further improvements on this rate. As there are very few 'new' Heroin users to treatment, those that do exist generally have high levels of complexity and / or drug taking career length, and re-presentation rates amongst opiate users are generally higher than for non-opiate users.

The re-presentation rate for non-opiate clients is reported as being high in comparison to previous years and is higher than the comparator average. However, this proportion can vary greatly month on month. For example, in 2014/15 the 6% re-presentations refer to 6 clients and the 12% in 2015/16 refer to 9 clients.

The treatment system in Sheffield needs to be mindful that an increase in successful completions is not at the expense of re-presentation rates (i.e. an increase in the re-presentation rate); multiple treatment episodes lessen the likelihood that treatment will be completed successfully.

The treatment system in Sheffield needs to utilise initiatives to tailor the treatment offer to individuals which will mean that each individual can receive appropriate treatment for their needs, and this will in turn improve successful completions. Building recovery capital appropriate to the individual during the treatment episode can also lead to improved re-presentation rates.

4.3 Recovery Capital

'Recovery Capital' describes a service users array of social, physical, personal and cultural resources and support. Evidence suggests that service users with more of these resources are generally better able to maintain abstinence, comply with medication, avoid relapse etc. They are better positioned to move through and out of treatment, and rapidly reintegrate with their communities.[34]

As outlined above, helping a service user to overcome their addiction and lead a drug-free life is not just about direct support with pharmacological / psychosocial interventions. A successful completion

[34] Recovery Diagnostic Toolkit, Public Health England (2015/16)

of treatment is much more likely to be sustained through helping the service user to tackle other aspects of their life and to address the wider issues that may have contributed to the decision to use drugs. This could be a variety of different reasons from boredom to mental health issues, employment, financial, or housing problems that have led the individual to feel they are unable to cope.

By helping an individual to address these factors as well as the actual substance misuse, they are better equipped to lead a more fulfilled life following treatment, which improves the potential to not relapse.

Building recovery capital can include learning or improving skills that can transfer to employment, taking up new hobbies, and also being supported to address housing and benefit problems.

4.4 Education, Training and Employment (ETE)

Education, Training and Employment (ETE) are viewed in the national drugs strategy (2010) as key to a long term recovery.

The Recovery Diagnostic Toolkit states that recovery capital items are at their most beneficial when the client has stopped using drugs.

Opiate clients: what we know about opiate clients is that during 2015-16 at the 6 month review 92% of service users that are still using opiates are unemployed, which compares to 83% nationally. 86% of service users that have stopped using Opiates by the time of the 6 month review are unemployed, which compares to 79% nationally. It is to be expected that social function is higher for people that have stopped using Opiates.

For all Opiate clients in treatment for more than 12 months the proportion that are unemployed is between 81% and 86% (data is split by length of time in treatment; 1-2 years, 2-3 years etc). This compares to 77% - 79% nationally. Although both nationally and locally unemployment rates are high, any improvements that can be made on this rate can provide more people with better structure in their life and build recovery capital. It is encouraging to see that unemployment rates for people in treatment three years or more begin to reduce down to 81%. Sheffield therefore has higher unemployment rates than are seen nationally for Opiate users in treatment.

Non-opiate clients: For non-opiate users the percentage of clients who are unemployed after 6 months in treatment is 67%, which compares to 75% nationally. At the time of the 6 month review Crack, Cannabis, Cocaine, Amphetamine, and Alcohol use are all higher than seen nationally. Addressing the higher-than-average drug use rates amongst non-opiate users in the first 6 months of treatment may lead to improvements in unemployment rates.

The current position in Sheffield is to build on what is already available to clients, develop new pathways into education, employment and training opportunities and to see the numbers increase for those engaging in ETE, during and post treatment.

In Sheffield the non-opiates service is commissioned to provide learning schemes to people in drug treatment in Sheffield. The purpose of this service strand is to prepare individuals for long term recovery, equipping service users with structured opportunities to develop a range of skills, including “soft skills” in order to be able to make good use of recovery opportunities in Sheffield. Learning schemes are promoted to all of those in formal structured treatment in Sheffield and to those in recovery support. For those not yet in formal structured treatment, peer mentor schemes are appropriate and demonstrate to people struggling to engage in structured treatment that recovery is possible. Making recovery visible is believed to heighten treatment ambitions and motivate individuals to work towards recovery.

As well as peer support and family and friend ambassador schemes, the service is also contracted to provide a formal structured supported setting to develop employment skills including “soft skills” of regular attendance, punctuality and interpersonal skills.

There are many providers of courses and other opportunities to the unemployed, both statutory and non-statutory, and it is not intended to duplicate these. Instead, the service provider must ‘add value’ by providing a free venue where such courses can be delivered to substance misusing individuals or individuals in recovery; by providing support to those individuals to attend courses or programmes, including reminders to attend and mentoring the learning as part of key work.

4.5 Housing

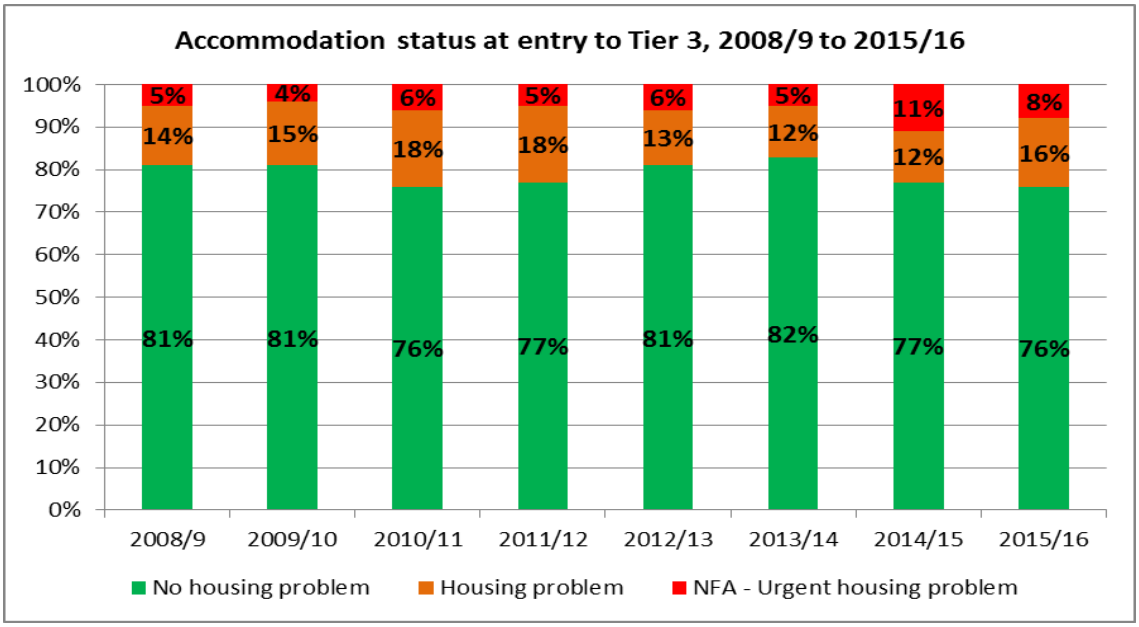
An individual’s housing status can play a big role in their overall health and wellbeing. It is also an important contributor to a person’s recovery capital. The Recovery Diagnostic Toolkit also tells us that having a housing problem or being of No Fixed Abode (NFA) increases the complexity of a client. Increased complexity reduces the likelihood of leaving treatment successfully. In 2015/16 national data tells us that service users in the lowest complexity group are fifteen times more likely to achieve a successful completion than those in the very high complexity group.

In 2015/16 2% of non-opiate users reported a housing issue at the time of their 6 month review, which compares to 14% nationally. In Sheffield this relates to a very small number of clients and suggests that housing problems are not an issue for non-opiate users that enter treatment in the city.

However, among opiate users, 19% of opiate users that are still using opiates at the time of the 6 month review report a housing issue, the same proportion as reported nationally. For those not using opiates at the time of the 6 month review, the proportion reporting a housing issue is 13%, compared to 10% nationally. For opiate users we also know that the proportion of clients reporting that they are of no fixed abode is higher than the national average. For example, 14% of opiate clients in Sheffield who had been in treatment for 1 – 2 years during 2015/16 reported being of no fixed abode, compared to 11% nationally. The proportion does reduce the longer a person is treatment; for example for clients in treatment 4 years or more during 2015/16 8% reported being of no fixed abode in Sheffield, but the proportions remain higher than the national average.

Data for all clients in treatment is shown in the chart below.

Chart 17: Accommodation status at entry to treatment at Tier 3



The No Fixed Abode figure varies by city for 2015/16. In Sheffield it is 8% (down 3% from 2014/15 but both years still historically higher than the six previous years); Leeds has 7.1% of clients with NFA, Bradford 5.1%, Newcastle 8.4% and Nottingham 10.7%.

4.6 Mutual Aid

The NICE Quality Statement (QS23) for drug use disorders sets out what high-quality care should include based on NICE drug misuse technology appraisals and clinical guidelines. It comprises ten quality statements, one of which recommends that people in drug treatment are offered support to access mutual aid organisations, which are defined as including SMART (Self-Management And Recovery Training) Recovery and those based on 12-step principles, eg, Narcotics Anonymous, Alcoholics Anonymous and Cocaine Anonymous.[35]

The provision of Mutual Aid groups in Sheffield, as of the 20th October 2016, was as follows:[36]

- 7 Narcotics Anonymous group
- 17 Alcoholics Anonymous groups
- 6 Smart Recovery group

The number of groups has been steady over recent years although the number of Narcotics Anonymous groups has gone up from 2 to 7 in the past three years. Following previous needs assessments and consultations the above groups are offered at different locations in the city and spread across the week with some services providing a number of groups in a week on different days and times in order to make the groups as accessible as possible to all service users.

Mutual aid groups support the Recovery culture and all clients exiting treatment are provided with information regarding the variety of groups and options available to them.

4.7 Aftercare (Recovery Support)

Between April 2015 and March 2016 215 individuals left treatment drug free, this 8.3% proportion of all in treatment is lower than the national proportion (15.2%), however, this is the number of individuals who were entitled to receive Aftercare/Recovery Support.

The Drug treatment providers are commissioned to provide Recovery Support to all service users successfully exiting treatment. In 2015-16 100% of service users were offered recovery support interventions at the time of exit. 74% of opiate users accepted the offer of recovery support interventions. Data for non-opiate users shows that between July and December 2015 20% of clients accepted the offer of recovery support.

In order for the aftercare service to be most effective there is recognition that links between mutual aid, support groups and multi-agency working needs to be at an optimum.

Service users in Recovery should be able to receive some form of support for as long as the individual needs, this can provide the person with a network of people in a similar situation and help them to maintain recovery and prevent re-entry to treatment. Particular importance is often placed on the first three months following treatment when a service user is at their most vulnerable relapse risk stage.

[35] A Briefing on the evidence-based drug and alcohol treatment guidance recommendations on mutual aid, Public Health England
[36] http://sheffielddact.org.uk/drugs-alcohol/help-and-support/mutual-aid-support-groups-for-drugs-and-alcohol/

4.8 Other Recovery Capital

If a service user requires any or all of the above support during or at the end of treatment, by ensuring that the individual receives the support they need, a service provider is able to build the clients recovery capital which puts them in a much better position to overcome their addiction and not relapse.

Specific help for such things as employment, finance, and housing, helps the individual to stabilise their life and attendance at mutual aid groups can give a service user a good support network of other people who may be experiencing similar problems in life, particularly those related to their substance misuse.

An important part of recovery is to assist the individual in changing their habits, so that they do not slip back to their old routine following treatment. If the use of drugs has taken over the person's life for example, when they stop using drugs they may find it difficult to fill their time, and boredom can lead to relapse. Therefore another good way to build recovery capital is to help the client find new interests and hobbies and increase their social capital. In Sheffield there have been 5-a-side football competitions, Pool competitions, and knitting and reading clubs. There is also a women's group, art groups, and 'Tea and Toast' groups at Addaction.

During the past 1 – 2 years the social media presence of the recovery community in Sheffield has seen a big increase. Dedicated social media accounts are used to promote services and groups available in Sheffield and to highlight the positive impact that the available support has had on service users lives. The use of social media allows service users to keep up to date and access available groups at any time that suits the individual and has raised the profile of the work going on, with the Sheffield Recovery Community Facebook page now having over 1000 'likes' on Facebook, and the 'Sheffield Faces of Recovery' campaign run during 2016 raising the profile on recovery and general Local Authority social media sites.

4.9 Improvements in health and quality of life

If service users report improvements in health and quality of life at their review meetings it suggests that they are making moves towards recovery, fully engaging with the treatment they are receiving, and placing themselves in a better position to sustain their recovery following treatment. Improvements are usually greater amongst those people who stop using drugs.

The charts on the next page are from the Recovery Diagnostic Toolkit and show the health and quality of life outcomes of Opiate users in 2015-16 at the time of their 6 month review. Based on the changes the service users have made in their drug use they are put into one of four categories; stopped, improved, unchanged, or deteriorated. In the charts a value **above 0** indicates an increase in the health and well-being of clients in that category, a value **below 0** indicates that it has fallen. In general, you would expect to see increased health scores for clients who have stopped or improved their drug use.

On Charts 18 and 19 on the next page the black bars represent the national scores and the coloured bars represent the Sheffield scores.

Chart 18

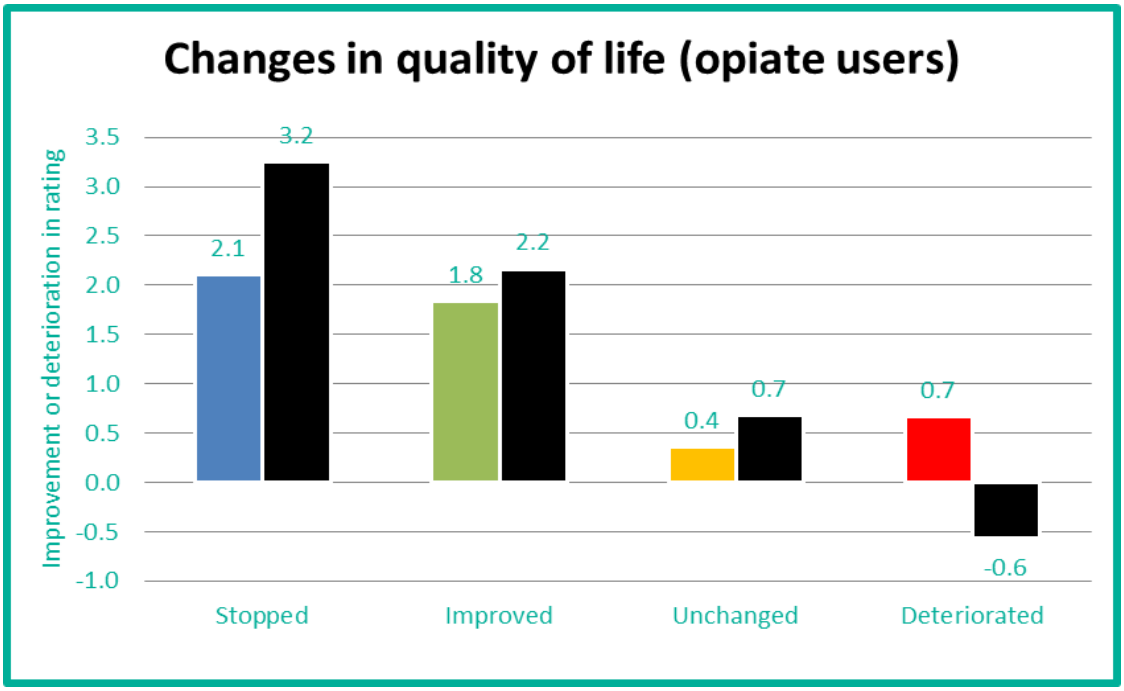
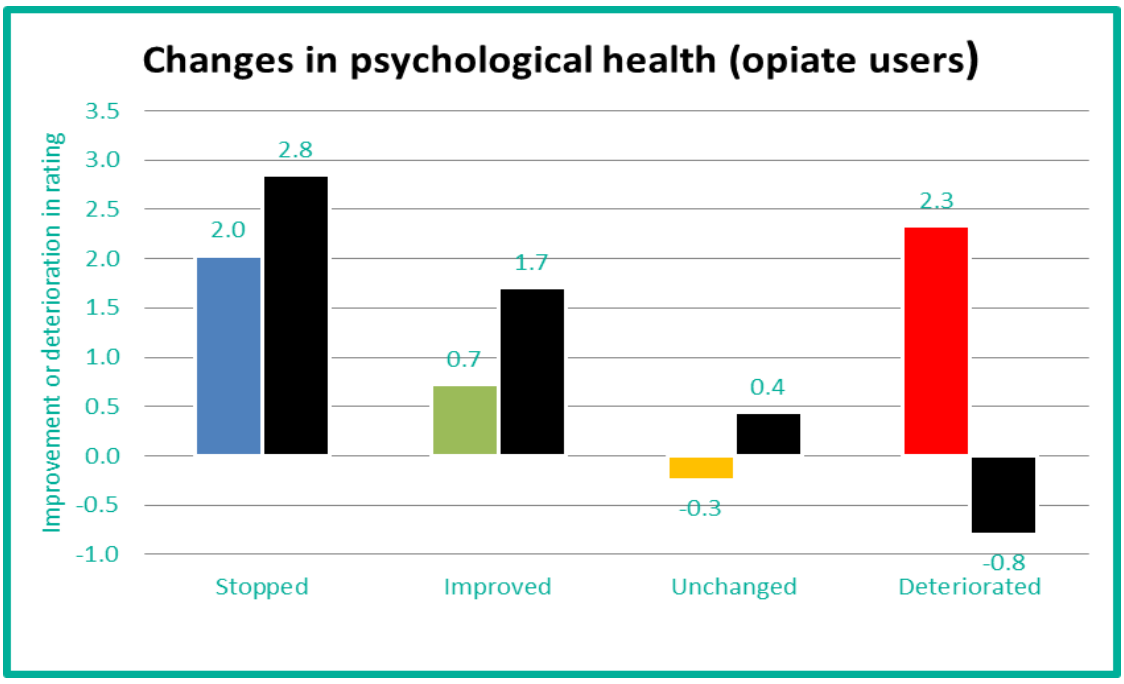


Chart 18 above shows that all opiate users reported improvements in their quality of life at the time of their six month review. This includes users whose drug use had deteriorated at the time of the review. The ratings given are slightly below the national rating for users who have stopped, improved or not changed their use. It should be noted however, that Opiate users whose drug use had deteriorated reported an increase in the quality of life since treatment start, a trend which continues when you look at psychological health, (see below) and might be related to the impact of engaging in treatment. Interestingly, those reporting no change in their drug use reported a slightly worse psychological health score.

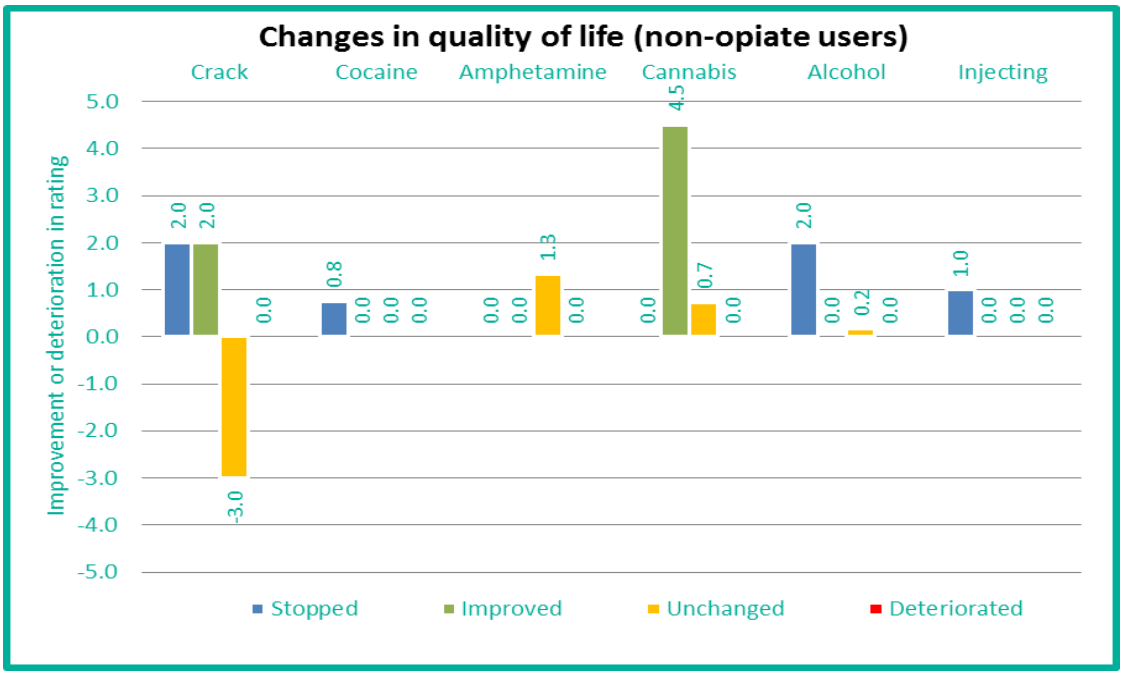
Chart 19



We can also see in the chart above that reported improvements in psychological health for people who have stopped using or improved their drug use are lower than the national average reported scores. Those reporting no change in their drug use reported a slightly worse psychological health score.

Chart 20 below shows the change in quality of life for non-opiate users at the time of their 6 month review, and is split by drug used.

Chart 20



The chart above shows that the majority of non-opiate service users in Sheffield report an improved quality of life at the time of the 6 month review. This highlights the improvements that can be made within 6 months of an individual entering structured treatment. However, attention should be paid to Crack users, where the quality of life has deteriorated for users who have an unchanged level of Crack use, with deterioration also shown in there psychological health. Numbers are small, it should be noted that in 2015-16 there were just 86 people in treatment who cited Amphetamines as any of their three problem substances and 37 for Crack not in conjunction with heroin.

Charts 18-20 suggest that overall both opiate and non-opiate service users in Sheffield are given the correct support in order to improve their quality life. This will include both the direct support for drug use and support for other problems in their life, as applicable to the individual. This is very positive and will make a good contribution towards successful completions of treatment and re-presentation rates.

A persons achievement through treatment, changes to health and wellbeing, and building of recovery is captured through the Treatment Outcome Profile (TOP). The quality of the data received by the DACT to monitor this is wholly dependent on the TOP being completed regularly and in a timely manner. There is therefore a continued need to monitor compliance in completing TOP information which in turn will allow for appropriate on-going monitoring of performance, where actions can be put in place to address any areas of concern that may be hindering service users from achieving all of their recovery goals and gaining all of the required recovery capital that is available and applicable to them.

SECTION 5 – Diversity & Demographics

5.1 Gender

The most recent available data nationally is that men are more than twice as likely to use drugs as women; information for use of drugs over the past year is that 11.8% of men aged 16-59 and 5% of women aged 16-59 have used ANY drug in the past year. When looking at specific drugs in the same time period and the same age band of 25-59, the split is 2.6%/0.8% for powdered cocaine, 6.6%/2.1% for cannabis, and 1.2%/0.4% for ecstasy, for males and females respectively[37].

71.2% of people in tier 3 treatment were male in 2015/16 which is similar to historical figures in Sheffield. 85.5% of all transactions at pharmacy needle exchanges during 2015/16 were by males.

Given that men are more than twice as likely to report drug use as women it is reasonable to suggest that the treatment population would be a 70%/30% split and so the current percentage spilt is not that dissimilar.

5.2 Structured Treatment

3,429 individuals were in Tier 3 treatment at some point in 2015/16, the following table (see next page) breaks down their recorded ethnicity.

Table 8 - Breakdown of ethnicity in structured treatment in Sheffield at any point during 2015/16, compared to breakdown of ethnicity in the 2011 Census

Ethnicity	Numbers in structured treatment	Percentage in structured treatment	Sheffield Population	% Sheffield Population	Representation in treatment system?
White British	2843	88.16%	446,837	80.85%	over represented
White Irish	19	0.59%	2,891	0.52%	over represented
Other White	57	1.77%	12,816	2.32%	**under represented**
White & Black Caribbean	43	1.33%	5,450	0.99%	over represented
White & Black African	4	0.12%	1,296	0.23%	**under represented**
White & Asian	24	0.74%	3,490	0.63%	over represented
Other Mixed	24	0.74%	3,053	0.55%	over represented
Indian	11	0.34%	5,868	1.06%	**under represented**
Pakistani	61	1.89%	21,990	3.98%	**under represented**
Bangladeshi	6	0.19%	3,326	0.60%	**under represented**
Other Asian	23	0.71%	5,803	1.05%	**under represented**
Caribbean	37	1.15%	5,506	1.00%	over represented
African	14	0.43%	11,543	2.09%	**under represented**
Other Black	17	0.53%	3,033	0.55%	**under represented**
Chinese	0	0.00%	7,398	1.34%	**under represented**
Other	42	1.30%	3,966	0.72%	over represented
Total	**3225**	100.00%	**552,698**	**100**	
Not stated	195				
Missing ethnicity Code	9				
Total	**3429**				

[37] Drug Misuse Appendix tables: Findings from the 2015/16 Crime Survey for England and Wales

Other White, White & Black African, Indian, Pakistani, Bangladeshi, other Asian, African and Chinese communities are underrepresented in our treatment system against the adult Sheffield population. White British, White Irish, White & Black Caribbean, White & Asian, Other Mixed, Caribbean, and Other are over represented in the treatment system, against the adult population. 12% of Sheffield clients in structured treatment are from a BME community compared to the city's 19%[38] BME population.

5.3 Nationality of Clients in Structured Treatment

Public Health England (PHE) released data to us stating the top 10 nationality both a) in treatment, and b) new into treatment in 2015/16. The first two places in both lists are taken up by both the UK and "not known" (which is due to current known data quality issue); however the next eight on the list are as follows:

Table 9

In treatment during 2015/16	NEW in treatment during 2015/16
Iran (31 clients)	Poland (12 clients)
Poland (16)	Iran (9)
Portugal (13)	Portugal (7)
Slovakia (9)	Slovakia (6)
Somalia (8)	Pakistan (5)
Pakistan (7)	Somalia (5)
Lithuania (4)	India (2)
Czech Republic (3)	Czech Republic (2)

The number of people citing Pakistan as their nationality is much lower than the number of people stating their ethnicity as Pakistani (61 compared to 7). This will be due to many of the 61 not being born in Pakistan. This data can help services to develop to meet the needs of the diverse population in Sheffield.

5.4 Drug treatment for the BME communities

Drug treatment services are available to all communities within Sheffield, most services are located centrally to enable easy access to treatment, verbal translation services are available for all providers via SCAIS (Sheffield Community Access and Interpreting Service). All treatment providers are commissioned to provide a culturally appropriate service, and ethnicity information, including workforce breakdown is monitored by the DACT at quarterly reviews. Local information is showing that ethnic minority clients are accessing services citywide for their drug treatment, although as shown above a lower BME population exists in the client population than the population of Sheffield as a whole. Drug use occurs across all BME groups, however, due to cultural differences, there are differences between the different communities and services need to be prepared to respond to them appropriately.

[38] Office of National Statistics, 2011 Census.

5.5 Drug Treatment Workforce

The drug treatment workforce is diverse, with 85% White British and a higher BME proportion than the treatment population, however some treatment services are less diverse than others. The table below shows the ethnicity of the drug treatment workforce. Twenty-seven members of SHSC drug staff have not disclosed their ethnicity on monitoring forms.

Table 10 - Ethnicity of drug treatment workforce at SHSC (where ethnicity was provided), August 2016

Ethnicity	Numbers	Percentage
White British	51	85%
White Other	0	0%
White Irish	1	1.7%
Asian or Asian British (Bangladeshi	1	1.7%
Asian or Asian British (Indian)	4	6.7%
Asian or Asian British (Pakistani)	0	0%
Asian (Other)	0	0%
Black of Black British (African)	1	1.7%
Black or Black British (Caribbean)	1	1.7%
Black (Other)	0	0%
Mixed White and Black African	0	0%
Mixed White and Black Caribbean	0	0%
Mixed Other	0	0%
Other Ethnic Background	1	0%
Total	**60**	

SCAIS provide interpreters to all drug treatment services, the table below details the number of interpreters used and the language of the interpreters at both SHSC services between April 2015 and March 2016:

Table 11 - Number of interpreting sessions provided by SCAIS to drug treatment providers, April 2015 to March 2016

Arabic	14	10%
British Sign Language	9	6%
Bulgarian	6	4%
Czech	1	1%
Farsi	16	11%
Hungarian	1	1%
Italian	1	1%
Kurdish Sorani	8	6%
Latvian	1	1%
Lithuanian	1	1%
Nepali	2	1%
Polish	42	29%
Portuguese	10	7%
Punjabi	1	1%
Russian	10	7%
Slovak	9	6%
Somali	2	1%
Tigrinya	2	1%
Thai	1	1%
Urdu	6	4%
Total	**143**	**100%**

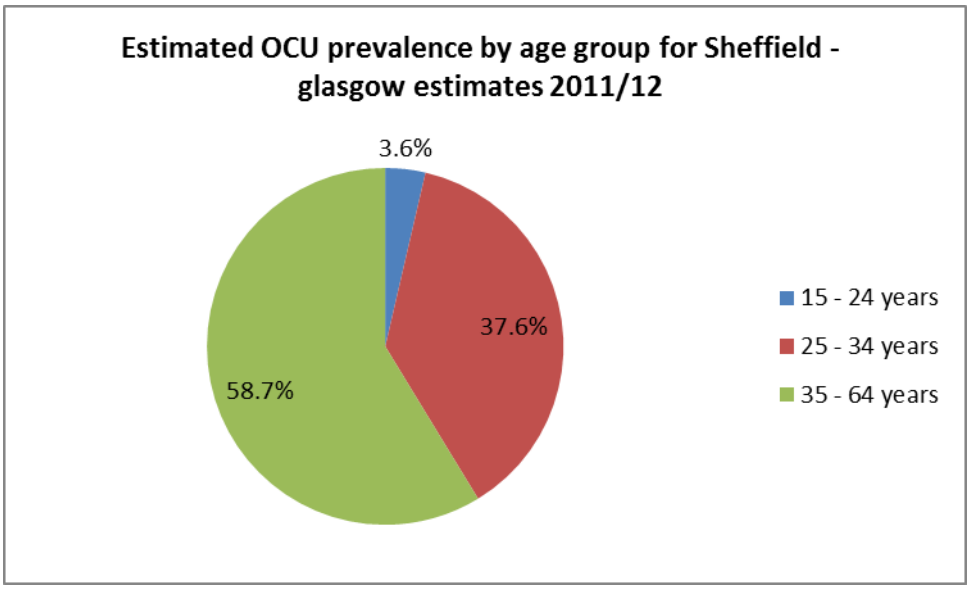
The most popular language for translation is Polish, which made up 29% of interpreter requirements Three years ago Farsi was the most popular with 35%. The Non-Opiates service accounted for 61% of the requests with the Opiates accounting for the rest. Addaction account for zero requests during the above timescale which was the same in 2012/13, some investigation needs to take place as to why; are they aware of the service, do they use police interpreting services? The number of total interpretations was also down from 2012/13, where there were 263; the treatment system three years ago was spread across many more providers.

The Sheffield DACT Website (www.sheffielddact.org.uk) includes a 'translate' option so that all content can be viewed in different languages from a choice of 58.

5.6 Factors that affect Successful Outcomes: Age

An estimated 3.6% of Sheffield's OCU (Opiates and/or Crack Users) are aged between 15 to 24 years, 37.6% are aged 25 to 34, and 58.7% are aged 35 to 64 years (see Chart 21).

Chart 21 - Glasgow Estimate for OCU users in Sheffield – by Age



These proportions have massively changed over the last 5 years. For example, in the 2006/7 estimates 27% were estimated to be in the 15 – 24 years age group. The change in these estimations reflects what we see in treatment with an older treatment population that remain engaged in structured treatment for a long period of time.

National data for Opiate and/or Crack use shows that the proportion of those aged 15 – 24 years engaged in Tier 3 or 4 treatments at the end of 2014/15 is 2%; which is a decrease of 1% from two years ago. Those aged 35 and over represent 69% of the treatment population (up 3% from two years ago) which further shows an aging treatment population.

The table below details the ages of Tier 3 service users in treatment at any point during 2015/16 (with a comparison from 3 years ago in brackets). Looking at three years ago, the percentage for every age group younger than 44 has decreased, which points to a much older treatment population. The number of over 65's in treatment has trebled since 2013. Feedback from frontline staff suggests they are seeing more physical health problems due to long term drug and alcohol use, but also due to age, particularly among Opiate users. For some, it is the worsening health problems that lead the individual to treatment rather than the actual drug use

Table 12 - Age range of Tier 3 service users, 2015/16 (2012/13 percentages in brackets)

Age Group of Tier 3	Numbers in Tier 3 Treatment during 2015/16	Percentage (2012/13 in brackets)
18	16	0.5%(0.8%)
19	15	0.4%(0.1%)
20-24	127	3.7%(4.9%)
25-29	269	7.8%(10.2%)
30-34	573	16.7%(22.4%)
35-39	708	20.6%(23.1%)
40-44	686	20%(20.5%)
45-49	499	14.6%(9.9%)
50-54	292	8.5%(4.6%)
55-59	136	4%(2.1%)
60-64	66	1.9%(1.0%)
65+	42	1.2%(0.4%)
Total	**3429**	**100.0%**

In terms of drug use, the bullseye data from the end of 2014/15 shows that 8% of people aged 15-24 in treatment cite Cocaine and Amphetamine as a problem substance, yet only 2% cite both opiates and crack together. However 8% do cite crack without an opiate.

5.7 Factors that affect Successful Outcomes: Sexual orientation, religion and disability

Sexual orientation has been reported to NDTMS for a number of years, with religion/disability being recent additions. As a DACT we have asked providers to provide as this information as part of their quarterly returns in order to build a greater understanding of the needs of individuals in treatment. At the moment using this local data is more reliable than using NDTMS figures due to current problems with the dataset submitted by the provider to NDTMS. Local data has therefore been used in this section.

Disability
SHSC return data on disability as part of their quarterly performance return. At the Opiates service in 2015/16, only 0.7% of the caseload consider themselves to be disabled, whilst at the Non-Opiates service the question has not been asked / recorded of their clients. Nationally, 16% of working age adults are registered disabled in the general population[39] and so cautions needs to be used when looking at the SHSC Opiates Service figure as this is significantly different.

All treatment services are compliant with the Disability Discrimination Act with regards to providing access and service provision to meet the needs of their clients. This includes within the treatment system; home visits for BBV care and leg ulcer service.

Lesbian, Gay, Bisexual and Transgender (LGBT)
The Opiates Service report 8 gay clients during 2015/16, with some bisexual clients however this number is fewer than 5 and therefore has not been reported on. The vast majority of clients either prefer not to say or have not been asked.

At the Non-Opiates Service there are gay, lesbian and bisexual clients reported throughout 2015/16 but again the number in each category is fewer than 5 so a total cannot be obtained, and again the majority of clients either prefer not to say or have not been asked.

[39] Office of Disability Issues. Department of Work and Pensions, Disability Facts and Figures, January 2014

There are an estimated 3.6 million LGB people in the UK, 5% of total UK population[40] so the activity in the treatment system suggests LGBT drug users are underrepresented in support services.

Religion
The Opiates Service reports clients as no religion (548) Christian (347), Muslim (47), other (22) and Buddhist (fewer than 5) during 2015/16, with the rest either not being asked or declining to answer.

The Non-Opiates service reports the same groupings except for Buddhist. There are no clients declaring themselves as Sikh in the structured treatment population.

Area
In recent years the areas in which clients have resided have remained similar. This year though does see some changes in the proportions but not the areas. Looking at those receiving treatment at SHSC as of the 31st March 2016, the postcode split is as follows (see table on the next page).

Table 13 - Postcode split of those in Structured Treatment at SHSC, all drug services, as of 31st March 2016

Postcode sector	Count
S5	16.6%
S2	13.1%
S6	9.7%
S8	9.5%
S13	7.2%
S3	6.1%
S14	4.0%
S9	3.9%
S20	3.8%
S12	3.6%
S4	3.6%
S35	3.4%
S10	3.1%
S11	3.0%
S7	1.9%
S1	1.9%
S17	1.4%
S36	0.9%
Other	1.7%
Not Stated	1.6%

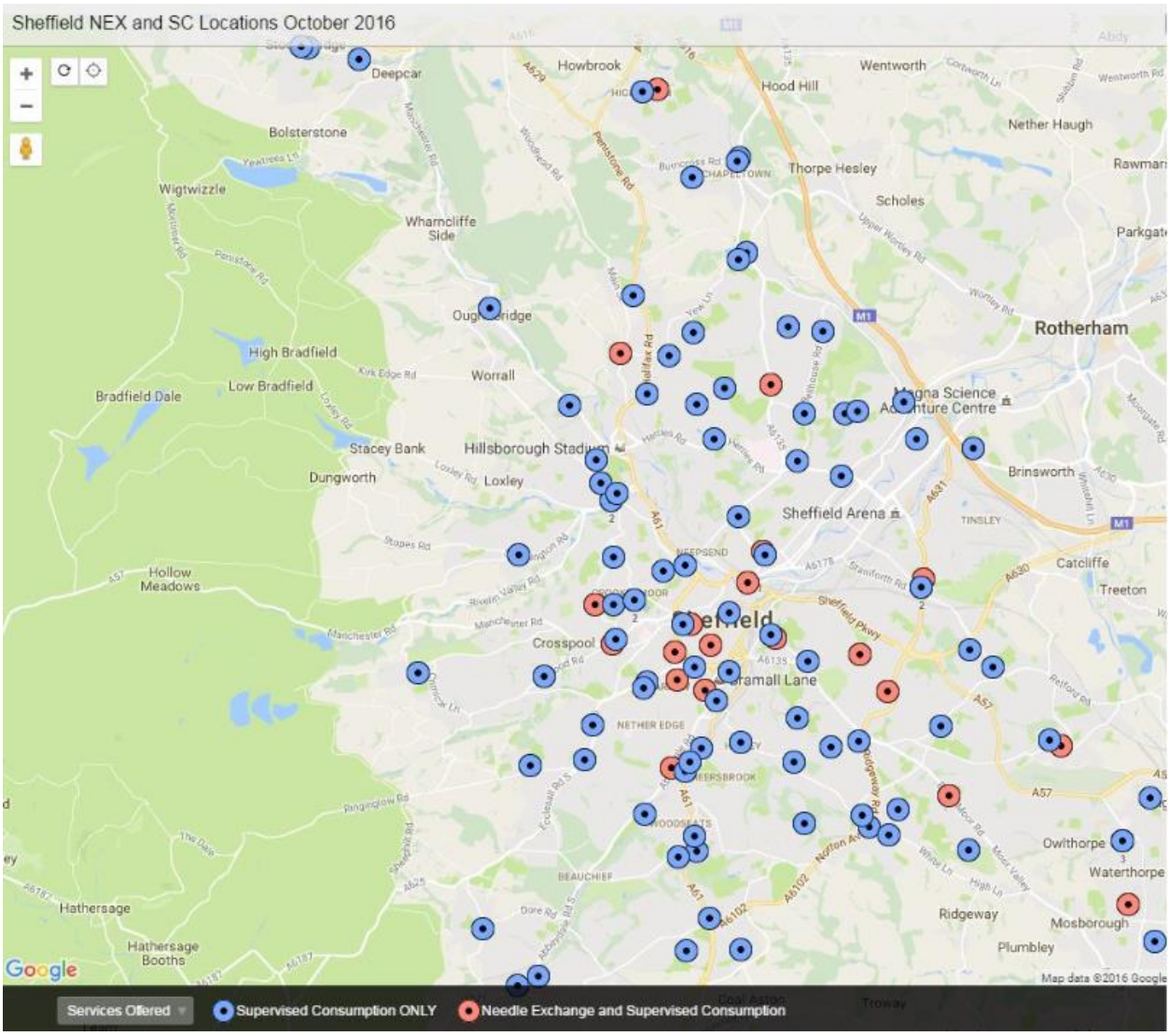
Looking at the same figures from six years ago, S5 and S2 both had 18% of the treatment populations. They are still both top of the 2015/16 list but the percentages have decreased. S6 and S8 remaining similar to the figure from six years ago (8% and 9% respectively)

The DACT's strategy in Sheffield is to have centralised treatment services with all Tier 2 and tier 3 treatment provisions within the ring road of Sheffield city centre, alongside Pharmacy based supervised consumption and needle exchange scheme provided more widely across a geographical spread in Sheffield. There are two locality prescribing clinics delivered outside of the city centre, and the recovery van visits sites across Sheffield each week. This treatment system has been in place

[40]Source: Department of Health, 2007

since October 2014. A map of all pharmacies signed to a contract to provide supervised consumption and needle exchange is shown on the next page.

Map 1: Map of pharmacy and recovery van locations



Pharmacy provision is citywide, and the Recovery van (now operated by SHSC) covers additional areas with need and where there are gaps in Pharmacy Needle Exchange. One such location is High Green in North Sheffield. Over the last couple of years, numbers utilising the recovery van have reduced. The recovery van reviews the locations quarterly and has been visiting new locations across the city to try and engage more drug users.

Domestic Abuse

For clients of drug treatment services there is not yet any national routine data collection requirement with regard to an individual's risk of being a victim of domestic abuse, nor are questions asked to ascertain if the individual is or has been a perpetrator of domestic abuse. However the new NDTMS Core Data Set to be released in April 2017 includes a question on domestic abuse, this is currently out for consultation.

However, The National Coalition against domestic violence[41] provides a useful summary to drug and alcohol use and domestic violence. *'While substance abuse does not cause domestic violence, there is a statistical correlation between the two issues (1). Studies of domestic violence frequently indicate*

[41] www.ncadv.org

high rates of alcohol and other drug use by perpetrators during abuse (2). Not only do batterers tend to abuse drugs and alcohol, but domestic violence also increases the probability that victims will use alcohol and drugs to cope with abuse (3). The issues of domestic violence and substance abuse can interact with and exacerbate each other and should be treated simultaneously (4).'[42]
Locally, domestic abuse services have been asked to report on a quarterly basis the number of service users that they refer to a drug or alcohol service, however, activity remains very low.

What we do know about the link between drug and alcohol misuse and instances of domestic abuse is as follows:

- Data from the Office for National Statistics looking at the 2014-15 year found that[43]:-
    - 10% of victims of partner abuse believed that the perpetrator was under the influence of illicit drugs at the time of the abuse.
    - Female victims were more likely to perceive that the perpetrator was under the influence of illicit drugs, 12% compared to 3% of male victims.
    - 1% of victims reported being under the influence of illicit drugs the last time they suffered abuse from a partner.
- Howarth et al (2009) found that 54% of MARAC cases had a perpetrator who misused alcohol and 39% who misused drugs.
- The CSEW states the following '*Around 3 times as many adults aged between 16 and 59 who had taken illicit drugs in the last year reported being a victim of partner abuse compared with those who hadn't taken drugs in the last year (11% compared with 4% or all victims)*[44]*'.*
- The CSEW 2015 estimates that 10%[45] of all incidents have a perpetrator who was under the influence of drugs (3% of males and 12% of female perpetrators) and 1% of (2% male and 1% female) victims in incidents are under the influence of drugs[46]. Therefore when an incident takes place, it is 10 times more likely that the perpetrator will be under the influence of drugs than the victim. The data does not provide further insight into the proportion of incidents where both the victim and the perpetrator were under the influence of drugs at the time of the incident.
- Drug / alcohol services in Sheffield referred 19 clients to domestic abuse services in 2015/16 and there were 12 referrals from domestic abuse services to drug or alcohol services. This compares to there being 96 individuals receiving support from domestic abuse services that stated they were problematic drug or alcohol users.
- In Sheffield drug and alcohol services refer to and are part of the core attendance list for MARAC.

[42] The National Coalition Against Domestic Violence (NCADV) cites the following references (1) Fazzone, Patricia Anne, et al. (2) Substance Abuse Treatment and Domestic Violence: Treatment Improvement Protocol." U.S. Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information, (3) "Making the Link: Domestic Violence & Alcohol and Other Drugs." U.S. Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information. (4) Fazzone, Patricia Anne, et al.
[43] Crime Statistics, focus on Violent Crime and Sexual Offences, Chapter 4 – Intimate Personal Violence and Partner Abuse, Office for National Statistics, Published February 2016.
[44] Intimate personal violence and partner abuse March 2015, http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2015/chapter4intimatepersonalviolenceandpartnerabuse#nature-of-partner-abuse-influence-of-alcohol-and-illicit-drugs
[45] CSEW Appendix table 4.20 Influence of alcohol and drugs in incidents of partner abuse experi3nced in the last years, by sex, year ending March 2015.
[46] Based on the latest domestic abuse incident.

SECTION 6 – Harm Reduction

6.1 Injecting drug use

The most recent prevalence estimates for injecting drug use in England (for 2011/12)[47] estimates that there are just over 87,000 predicted injectors (down from 93,000 in the prevalence estimate issued prior to this one). This is a continuation of the declining trend in the number of injecting drug users over the past decade. However, there has been an increase in the number of people injecting other drugs. Although Heroin remains the most commonly injected drug, the number of people who report injecting amphetamines of amphetamine type drugs as their main drug has risen from 3.9% in 2004 to 12% in 2014.[48]

The prevalence figures for Sheffield show a similar decrease in injecting behaviour for opiate and / or crack users. The estimated number of people who inject is 926 (down from the last available figure of 1,162 which was issued two years prior) and equates to 22% of the total PDU (compared to 29% of the old estimate). This has been on a downward trend for the last few updates. However, this is at odds with the locally observed trends of increased transactions in pharmacy needle exchanges, increased incidence of needle waste litter. This is therefore likely to be attributed to higher recorded numbers of individuals injecting steroids and other non-opiate drugs being reported through the non-opiate service.

The numbers of those currently injecting on entry to treatment has gone down by almost half in three years: the number who cited they currently injecting on entry to treatment in 2015/16 was 11.7%. In 2012/13 this figure was 20%. Of the rest, 16.7% stated they had previously injected and 71.4% never had.

Research found that 91% of current and former injecting drug users in England, Wales and Northern Ireland had used a needle exchange in 2012[49]. It is unknown what proportion of those entering treatment have used a needle exchange in the past, or still use a needle exchange, however if the 91% is applied to the proportion we know were injecting or previously injecting new in treatment in 2015/16 (354 clients) this suggests there are 32 people new into treatment in 2015/16 who have never used a needle exchange.

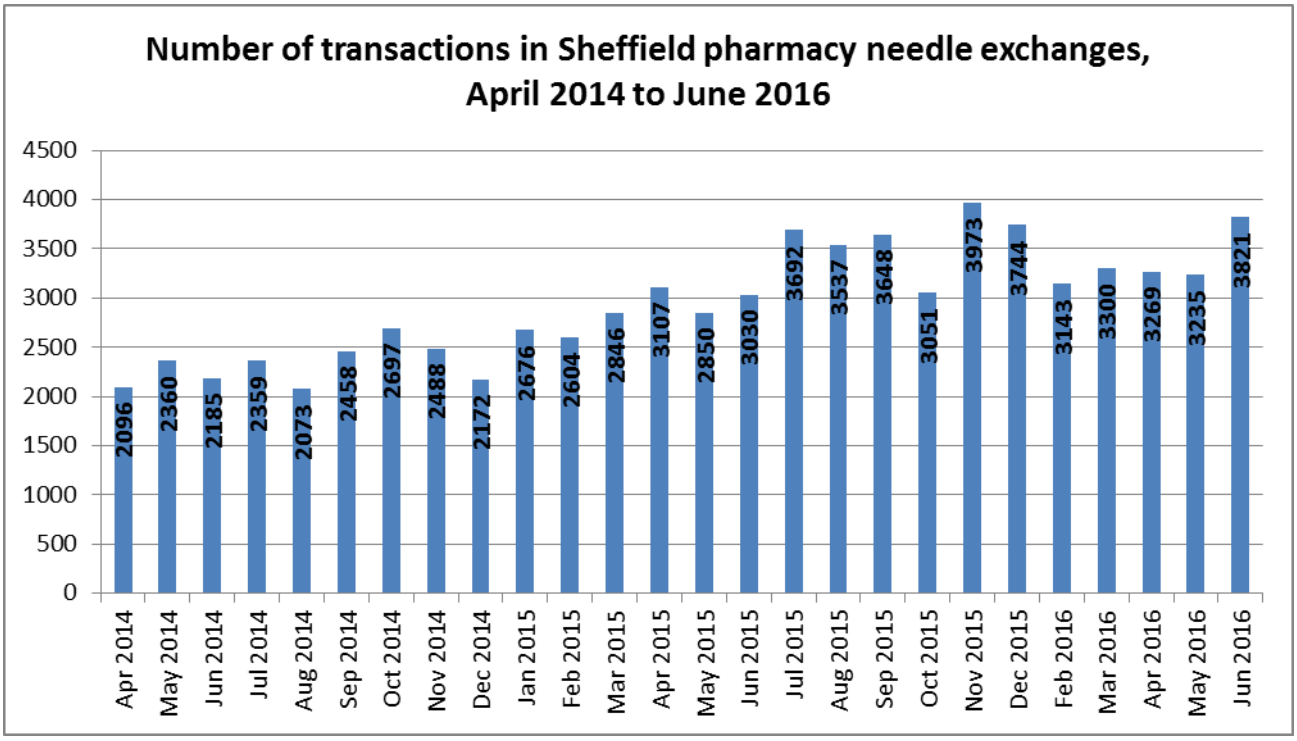
6.2 Sheffield Needle Exchange Activity

Needle exchange recording/reporting has undergone a number of changes in the last few years, with a number of different systems being used to record needle exchange data. In April 2013 Sheffield DACT moved to using PharmOutcomes recording system, which is used by all pharmacies operating both a needle exchange and a supervised consumption service, and for the remainder of this year there are some holes in the data as the changeover occurred. Data from the 2014/15 and 2015/16 financial years, however is robust and all services are used to the system.

Chart 22 on the next page shows the number of needle exchange transactions in pharmacies every month since April 2014 (up to and including June 2016). January 2016 has been excluded as a change was made to reporting in that month which has resulted in the data for that month being lost:

[47] Estimates of the prevalence of opiate and/or crack cocaine use (2011/12), Glasgow prevalence estimation, Liverpool John Moores University
[48] Shooting up: Infections among people who inject drugs in the UK, 2014. An update, November 2015
[49] Shooting Up, *'Infections among injecting drug users in the United Kingdom 2009 – An update: November 2013'.*

Chart 22: Number of transactions in Sheffield pharmacy needle exchanges, April 2014 to June 2016



Although there is some fluctuation in the number of transactions per month, the general trend has been of an increasing number of transactions. This is a buck in the trend noticed by the biggest provider pharmacy (Wicker) between 2006 and 2010 that monitored the number of transactions in the January of those years and in the period of four years the number of transactions decreased from 3129 to 1804. Therefore the number of transactions now is back to the levels seen by the Wicker 10 years ago.

In terms of which pharmacy is the busiest, looking at a snapshot of the last three full months (May-July 2016) the busiest pharmacy is the Wicker Pharmacy which accounted for 49% of the total transactions in Sheffield. Swift Pharmacy in Burngreave accounted for 19%, Lloyds Alderson Road 10.5%, and sixteen other pharmacies accounted for the remaining 21.5%

The increase in pharmacy transactions is at odds with a decrease at the Non-Opiates Service, which is discussed in detail next.

6.3 Needle Exchange at treatment services

Specialist needle exchange is available at the Non Opiates and Opiate Services (provided by SHSC) have been commissioned to provide specialist needle exchange service since October 2014 (prior to this it was CRI). The Non Opiate Service also delivers the recovery van which provides mobile needle exchange and outreach. Providers have struggled to provide accurate data surrounding the number of transactions and individuals using both the needle exchange and the mobile van (see later for details of the van) however it is clear that use of both the van and the needle exchange at the site has decreased over the last few years, in stark comparison to an increase seen at pharmacies (which was discussed earlier). This could be simply that people are now using more of the locality based needle exchanges (pharmacy) rather than the treatment provider needle exchange.

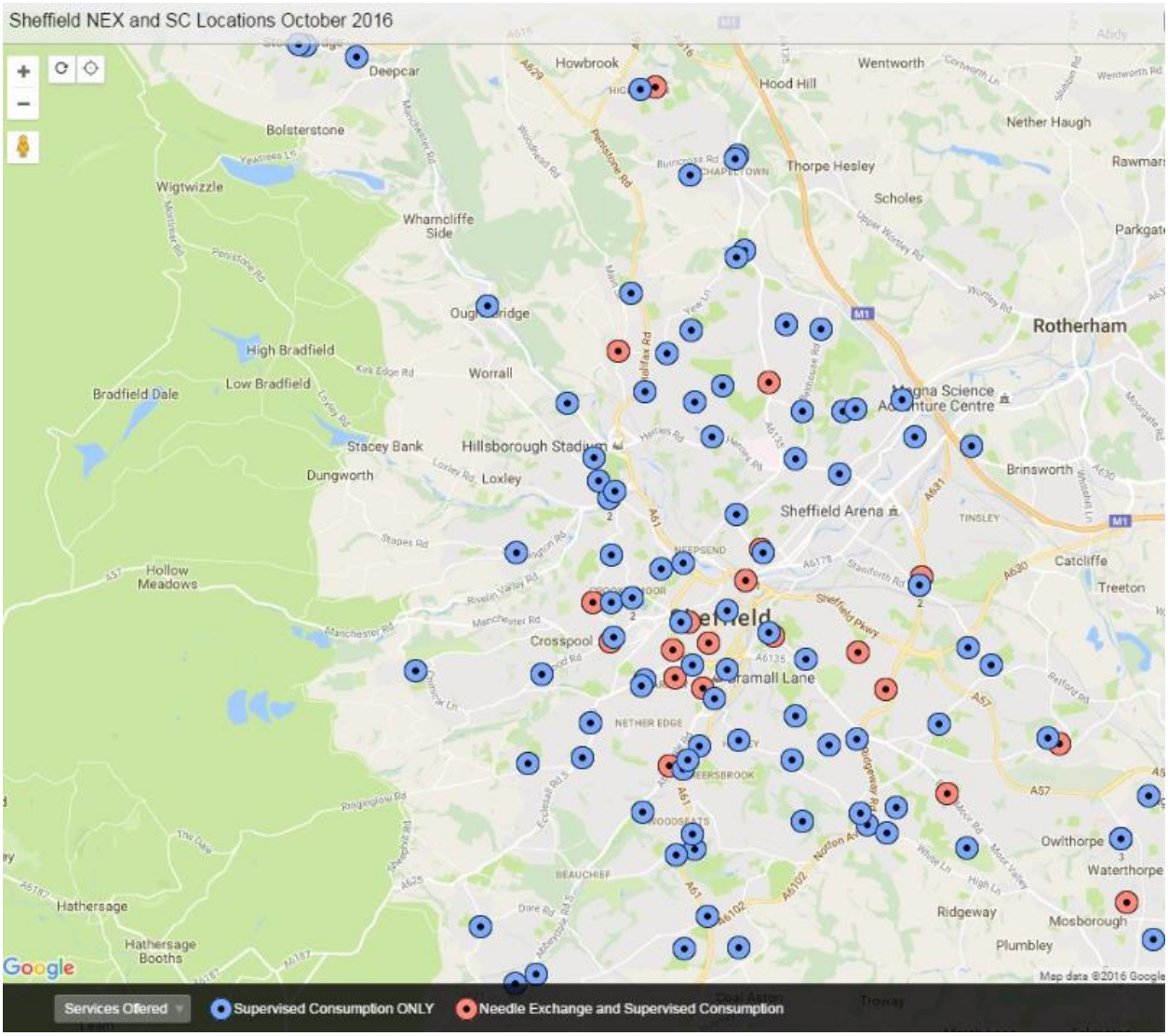
6.4 Commissioning

Sheffield DACT commission pharmacy and specialist needle exchanges for Sheffield. The pharmacists are paid per transaction assuming this transaction is reported in the correct way on the PharmOutcomes system. Sheffield DACT also pays for all the needle exchange stock.

There are 55 pharmacies signed up to the pharmacy needle exchange scheme, however only 21 recorded monthly activity during 2015/16. The remaining 37 are signed up to provide a service, if and when the need arises[50] and following training.

The map below shows locations where there are pharmacies in the city that provide supervised consumption and also those that provide a needle exchange as well as supervised consumption.

Map 2



The recovery van (operated by SHSC) currently (as of Q1 2016/17) provides additional outreach needle exchange provision in 5 locations across the city (see below table). Historically the van served as many as 12 locations however a number of factors (low demand, issues with landlords of land) have reduced this considerably. Due to the reduction in demand for the mobile needle exchange the

[50] Not all pharmacies signed up to this will provide this service, some pharmacies signed up all their providers, i.e. Lloyds but only a few of those Lloyds providers intend and are in areas where needle exchange provision is required currently

use of the recovery van should be reviewed and changed if necessary to provide the best outreach service.

Table 14

Jordanthorpe
Southey Green
Burngreave
High Green
Parsons Cross

Of those entering treatment in 2015/16, having been in treatment before and also having a Treatment Start TOP, 5% of individuals reported daily injecting, with 23% reporting non-daily injecting use, in comparison to 5% and 27% for both nationally respectively. For those who are treatment naïve entering treatment, these figures decrease to 1% and 16% respectively, in comparison to 2% and 17% nationally.[51]

6.5 Sharing

The Health Protection Agency's annual 'Shooting Up' report 2015 suggests that the rate of sharing any injecting equipment has fallen from 28% in 2004 to 17% in 2014. This may account for the increase in needle exchange transactions in Sheffield as users are more likely to obtain works for themselves rather than sharing others.

'Never share' needles, which discourage sharing of equipment are available in all needle exchanges across the city and a minimum criteria of stock is set by DACT and will be reviewed annually.

Sheffield DACT specifies that all needle exchange provision in the city should be delivered in line with NICE Guidance for Needle and Syringe Programmes which was reviewed in 2014, including requirements such as no limit on equipment given out (within reason), over 100% coverage for injecting drug users, and a 'pick and mix' needle exchange offer to allow service users to access the equipment they need, rather than pre-packaged kits of specific combinations.

6.6 Bin returns

'*The number of syringes exchanged can be used as an outcome measure of Needle exchange effectiveness. The logic is simple: the higher the return rate, the less time dirty needles are in circulation, the greater the likelihood that Injecting Drug Users (IDU) are using clean needles more often, and the lower the probability that IDUs in the NEP population share injection equipment'*[52]*.* The research found that of 26 studies a return rate of 90% was found, however return rates ranged from 15% (Italy) to 112% (UK). The return rate for needle exchanges is unknown as recording is currently poor; however, Pharmacies in Sheffield have adopted the use of PharmOutcomes, an online tool and database where Pharmacies record their activity. In 2015/16 the specialist needle exchange gave out 322 bins during the year and had 187 bins handed into them. This equates to a return rate of 58%. l

A bin return also provides a further opportunity to provide a treatment intervention to the client.

[51] Public Health England Recovery Diagnostic Toolkit, March 2016
[52] K, Ksobiech (2004) 'Return Rates for Needle Exchange Programs: A Common Criticism Answered', Harm Reduction Journal 2004, 1:2, Harm Reduction Journal 2004, 1:2 http://www.harmreductionjournal.com/content/1/1/2

6.7 Harm Reduction advice and information

The DACT commissions the needle exchanges at the Non-Opiates and Opiates Service to provide a full comprehensive Harm Reduction service at needle exchange, so safer advice and information are given. The aim is to reduce the health harms associated with injecting drug use, but also to encourage individuals into more in depth treatment, almost acting as a conduit into further treatment. In 2015/16 the needle exchange gave overdose prevention advice to 214 clients, safer injecting advice to 506 clients, and 27 were referred for Hep B/C testing/immunisation.

The opportunities are available to encourage more people into structured treatment, if they are made by the worker/pharmacist. The Audit Commission (2002), and supported by the NTA in their successful completion report in 2009[53] explore this opportunity further. They describe pharmacists as an underused point of contact for the drug misusing population, and pharmacists with training and more contact with the prescribing service/s would benefit the client further[54]. The report uses the example of supervision for prescribed treatment where a client may frequent the pharmacy up to five times a week; however the same can be applied to those providing needle exchanges, even if the frequency of attendance is less. In addition the NICE guidance for needle exchange provision (2009)[55] also says *"If needle exchange schemes are run well, they can help doctors, nurses and pharmacists make direct contact with people who are injecting and who often have no other contact with health services. This is an important first step towards encouraging them to seek treatment, to think about using non-injecting methods of drug use or quitting their habit altogether".* In terms of the recovery agenda and the approach toward the first step of drug treatment, needle exchange is certainly a starting point and an opportunity to explore further at engagement in treatment and a step towards recovery.

6.8 Blood Borne Virus (BBV)

Hepatitis B Prevalence

Shooting Up reports that the proportion of people who inject psychoactive drugs ever infected with hepatitis B in England, Wales and Northern Ireland has halved over the past 10 years, falling from 28% in 2004 to 14% in 2014, with very few (0.58%) currently infected[56].

Nationally, the prevalence of antibodies to the hepatitis B core antigen (a marker of past or present infection) among people injecting psychoactive drugs has reduced from 28% in 2006 to 13% in 2015. Rates among drug users who first injected within the last 3 years have remained below the overall rate and were 3.5% in 2015.[57]

In Sheffield during 2015/16 35.8% of opiate service users starting a new treatment journey took up the offer of a hepatitis B vaccination and started the course of treatment. 16% of those who started a course of hepatitis B vaccination in the year are recorded as having completed the treatment. However, due to data recording issues experienced in the year this percentage is likely to be understated.

Hepatitis C Prevalence

Circa 90% of the total people infected with Hepatitis C in the UK are infected due to injecting drug use. In 2015 there were 13,000 positive test results for hepatitis C, and it is estimated that around half of those who inject psychoactive drugs have been infected with hepatitis C[58]. It is also estimated that around half of injecting drug users in the UK are aware of their HCV antibody positive status[59]. In

[53] NTA Towards successful treatment completion, A good practice guide, p 30
[54] Drug Misuse 2004, Reducing the Local Impact, http://www.audit-commission.gov.uk/localgov/nationalstudies/Pages/drugmisuse2004_copy.aspx
[55] Needle and syringe programmes: providing people who inject drugs with injecting equipment (PH18), NICE guidelines (2009)
[56] Shooting Up – Infections among injecting drug users in the UK: an update, 2015
[57] Health Protection Report, Infection Reports, Volume 10 Number 23, Public Health England https://www.gov.uk/government/statistics/people-who-inject-drugs-hiv-and-viral-hepatitis-monitoring
[58] Shooting Up – Infections among injecting drug users in the UK 2015
[59] Hepatitis C in the UK 2016, Public Health England.

order to reduce the levels of undiagnosed infections it is necessary to increase testing of individuals in at risk groups. In Sheffield at the end of 2015/16 99.9% of people in treatment eligible[60] for a hepatitis C test had received a test.[61]

In 2015, 86% of IDUs participating in the UAM survey reported ever having had a voluntary confidential test for HCV, whilst (NDTMS) data reports that 18.9% of IDUs in treatment in England have no record of having received at test for hepatitis C, in Sheffield the proportion with no record of having a test is 0.1% of all people in treatment, as at the end of 2015/16. This is an improvement on the previous year when 3.9% of eligible clients had no record of having received a hepatitis C test.

NDTMS data for 2015/16 also tells us that 15% of current or previous injectors that started a new treatment intervention accepted the offer of a Hepatitis C test, although it should be noted that 34% of clients did not have a hepatitis C status recorded. 87% of those that accepted the test are recorded as having received the test.

The Shooting Up (2015) report shows that the proportion of IDUs who take up the offer of voluntary confidential testing for hepatitis C has increased from 71% in 2005 to 86% in 2015.

In 2015 there were 1326 laboratory reports of Hepatitis C in the Yorkshire and Humber region, a reduction of 187 on 2014.

HIV Prevalence

New diagnosis of HIV in injecting drug users in 2015 as reported in the Shooting Up report accounted for 3% (182/6095) of all new HIV diagnoses in the UK[62]. The number of new HIV diagnoses among IDUs increased in 2015, having reported 111 new cases in 2012 (1.7%).

HIV prevalence among IDUs in 2015 was similar to that seen in recent years, at 1%. If this rate is applied to the prevalence estimates for injecting drug use for Sheffield then this would mean up to 12 individuals who currently inject drugs could have HIV. Applying the percentage to the overall estimated OCU prevalence of 4266 (95% confidence interval 3,877 – 4,808) could mean up to 48 OCU individuals in Sheffield have HIV.

Among IDUs, the proportion taking up the offer of HIV testing increased from 66% in 2005 to 79% in 2012 and has fluctuated between 76% and 79% since then; with 79% of IDUs taking part in the UAM survey in 2015 reported having had a voluntary confidential test for HIV.

In 2015 84% were aware of their HIV infection; this is much higher than in 2005 when 47% were aware of their HIV infection.

Any new cases of HIV and their associated ‘at risk’ group of associates are discussed by the Harm Reduction service working alongside the team at the CCG, RHH and the DACT to identify the source and reduce the harm that maybe caused to others, whilst providing treatment to the individuals concerned. The same applies to any sudden increase in Hep C diagnosis.

Harm Reduction Service Provision

Since 2010/11 Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) has been commissioned to provide a harm reduction service, providing BBV interventions (testing, wound care, onward referral for hospital treatment where necessary, General health care assessment and overdose prevention) to all drug users, across tier 2 and tier 3.

Testing for Hep B, C and HIV are routine for all clients who accept the offer (Made at assessment for structured treatment or at review). The BBV Strategy states that screening will continue to be offered

[60] During assessment a clinician will determine if it is appropriate to offer a hepatitis c test based on the clients risk taking behaviour.
[61] Diagnostic Outcome Measures Executive Summary (DOMES) Report, NDTMS, Q4 2015/16.
[62] HIV in the UK 2015, Public Health England, November 2016 https://www.gov.uk/government/statistics/hiv-annual-data-tables

to drug users who refuse the initial offer, DNA their appointment, or don't complete the course, and that re-testing whilst in treatment will be offered to clients who remain at risk.

Wound Care

33%[63] (2% higher than in 2014, and the highest proportion since 2010) of injecting drug users have experienced an abscess, sore or open wound in the past year. These infections can also be an issue to people who inject image and performance enhancing drugs; 14% of this group reported ever having had an abscess, sore or open wound. When a wound has been present for longer than 6 weeks it is classified as an ulcer (Royal College of Nursing Guidelines). Studies have shown that over 90% of injecting drug users suffer from venous disease the pre-cursor condition to venous ulceration, and venous disease is a de-generative condition which will worsen with age. This is a particularly significant statistic for Sheffield as the existing population of injecting drug users gets older.

Shooting Up (2011) reported that crack has a shorter lasting effect than heroin and therefore is more frequently injected; as a result crack users who inject are more likely to suffer symptoms that require wound care. However, Shooting Up (2015) reports that there is continued reduction in the number of individuals injecting heroin and / or crack cocaine but that the injection of other psychoactive drugs, such as amphetamines and amphetamine-type drugs has become more common. These substances are often injected by people who have injected other types of drugs but the use of stimulants has been associated with higher levels of risk behaviours and lower levels of intervention uptake.

In Sheffield during 2015/16 244 individuals received wound care from the commissioned provider and a total of 2837 wound care interventions were delivered.

Emerging demands

Since 2013 Sheffield treatment providers have offered a drop in service known as 'Juice Clinic'. This is a free and confidential clinic for Performance and Image Enhancing Drugs (PIED) users. The clinic runs in the evening on a Wednesday and offers; safer injecting advice, testosterone level checks, Liver Function Tests (LFT), Steroid advice, Cholesterol monitoring, injecting site examination, clean injecting equipment, nutrition advice, and other related health issues. In 2015/16 there was an average of 12 clinics held per quarter and 119 individuals accessed the clinic during the year.

[63] Shooting Up report (2015)

SECTION 7 – Criminal Justice

7.1 Drugs Intervention Programme

The Drugs Interventions Programme (DIP) was decommissioned by the Home Office as a national programme in 2013. Following this, Public Health England (PHE) took responsibility for collating and reporting the data for criminal justice interventions.

DIP continued in that form in Sheffield after this date and was provided by Addaction. The contract ended on 30th September 2016. The DACT re-tendered a new service which commenced on 1st October 2016 and which is being delivered by Addaction who were successful in the tender. The contract is for an arrest referral scheme and Criminal Justice Integrated Team (CJIT). CJITs use a case management approach to offer access to treatment and support. This begins at an offender's first point of contact with the criminal justice system through custody, court, sentence and beyond to resettlement. The CJIT delivers:

- Identification and assessment
- Case management
- Continuity of care
- Court Liaison
- Drug Rehabilitation Requirements (DRR)

Identification and assessment is achieved through drug testing following an individual in custody being profiled (former trigger offence based criteria were not resulting in a high enough proportion of positive tests) and where at least one of the following local testing criteria is met:

- Arrested for a Heroin, Cocaine, or Crack related offence
- Tested positive for drugs in the last 3 years
- Heroin, Cocaine or Crack use disclosed on the Police Risk Assessment
- Are there any Police National Computer warning marker or a caution / conviction for Heroin, Cocaine or Crack in the last 3 years?
- Suspicion that Heroin, Cocaine or Crack caused or contributed to the commission of the offence
- DIP worker request drug test
- Offender requesting medical attention for Heroin, Cocaine or Crack withdrawal
- Arrest related to domestic violence / abuse.
- Arrested for theft and aged between 25 and 29 years.
- Arrested for burglary and aged 18 years or over.

The South Yorkshire Police and Crime Commissioner (PCC) provide funding towards the DIP contract. The PCC funding accounts for 30% with the remaining 70% coming from the Public Health budget allocation.

7.2 Integrated Offender Management (IOM)

Integrated Offender Management (IOM) was implemented in its present form in July 2012. In Sheffield, IOM is delivered by the Police and Probation Service under the direction of the Crime & Disorder Reduction Partnership (CDRP) and within the county-wide steer of the Local Criminal Justice Board (LCJB). A county-wide model for IOM called IMPACT (Integrated Model of Partners Addressing Crime Together) is in place, including the cohort of offenders to be targeted. This sees the police, probation and treatment provider working together in partnership with, amongst other priority offenders, those individuals who have had a prison sentence of less than a year, who would otherwise have no statutory offender management. IOM is co-located with Addaction and an IOM Information Sharing Protocol is in place to allow information sharing between the IOM team and Addaction. The aim of IOM is to provide the right intervention to the right offender at the right time; to

achieve this, IOM creates a dynamic environment where different agencies can offer different approaches to meet the needs of the offender and manage the risks the offender poses to the community.

In South Yorkshire the local IOM partnership is called 'COMPASS' and brings together police, SYCRC and CJIT staff in a co-location arrangement. IOM in South Yorkshire has to date focused on offenders committing Serious Acquisitive Crime. Recent reviews of COMPASS have explored the possibility of expanding the current offending criteria to include the perpetrators of domestic abuse, Organised Crime Gangs and foreign nationals. CJIT will also be expected to work with these cohorts of offenders when drug use plays any part in their offending and fully comply with any new requirements resulting from an expanded cohort.

In 2015/16 100% of IOM clients on the Addaction caseload received Police input into their case management.

7.3 Dashboard performance

The five national indicators in 2015-16 (and for 2016/17), called Diagnostic Indicators were:

1. *No longer monitored*
2. 95% of those testing positive to have an initial assessment
3. 85% of those assessed as needing a further intervention to be taken onto caseload
4. 95% of those taken onto the caseload to receive treatment
5. Adults referred to the Criminal Justice Intervention Team (CJIT) from a prison, which was reported on by the CJIT (Sheffield DIP).

There is also the target of "85% of eligible bailees receive Restrictions on Bail (ROB)."

Chart 23 - DIP DI2-5 plus ROB performance, Q1 2015/16 to Q1 2016/17

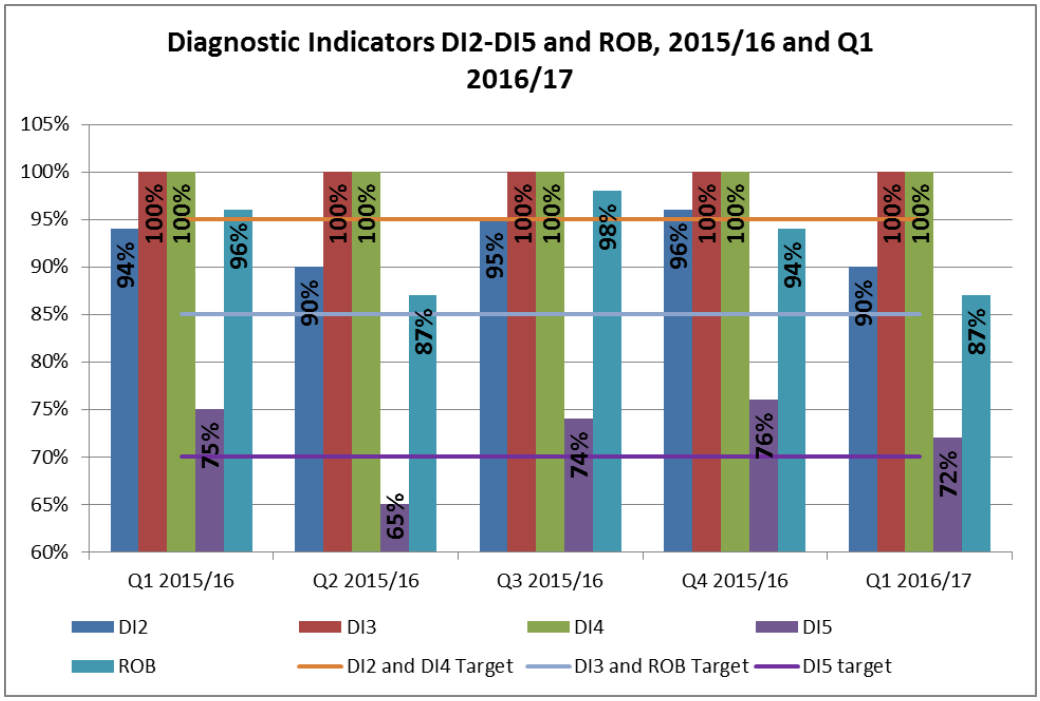


Table 15 - DI5 performance, Q1 2015/16 to Q1 2016/17

	A	B	%
Q1 2015/16	48	64	75%
Q2 2015/16	34	52	65%
Q3 2015/16	45	61	74%
Q4 2015/16	38	50	76%
Q1 2016/17	43	60	72%

During 2015/16 there was a period when DI2 was not green, i.e. dropped below 95%, DI3 and 5 slipped below target slightly for one quarter, and DI4 was on target for the year, as was the ROB performance.

7.4 Trigger offences, profile testing and drug testing

Drug testing is undertaken on individuals who are arrested for a trigger offence (last year 100% achieved), and on a number of individuals who commit a non-trigger offence but are known drug users, or the offence is also associated with drug use.

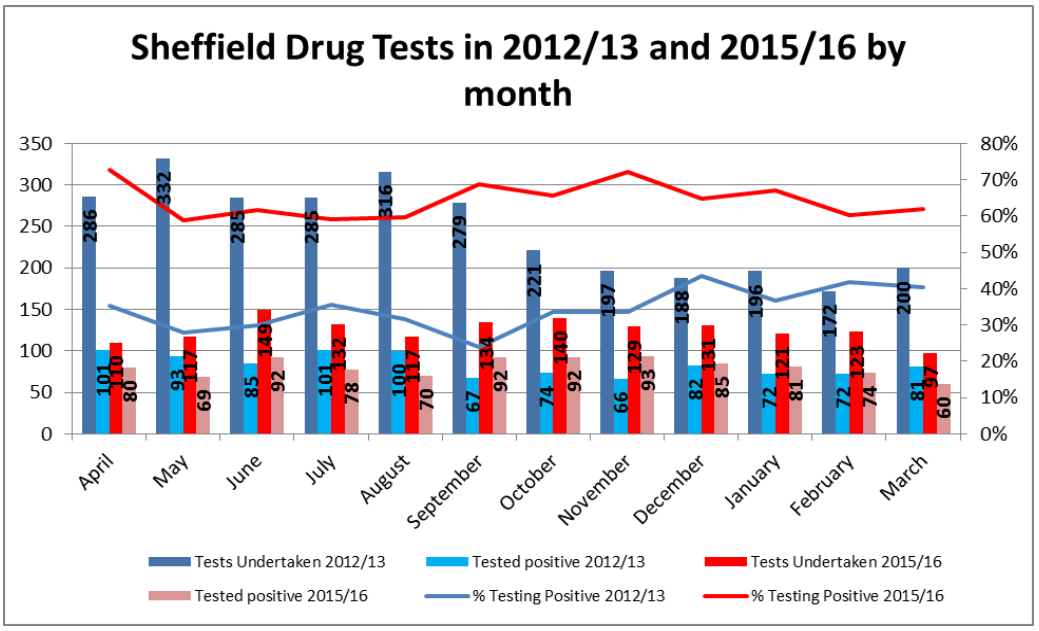
Table 16 – Number of arrests by trigger offence in 2015/16

Trigger offence	Count	%
Theft	727	46.99%
Begging	3	0.19%
Burglary	305	19.71%
Robbery	52	3.36%
Possession of specified Class A	107	6.91%
Non-trigger offence	182	11.76%
Fraud (section 1)	7	0.45%
Possession w/l to supply Class A	57	3.68%
Going equipped	7	0.45%
TWOC	14	0.90%
Attempted theft	9	0.58%
Supply of specified Class A	29	1.87%
Handling stolen goods	5	0.32%
Attempted burglary	20	1.29%
Aggravated burglary	14	0.90%
Aggravated vehicle taking	1	0.06%
Attempted robbery	7	0.45%
Production of specified Class A	1	0.06%
Total	**1547**	

In 2015/16 there were 1,547 arrests for trigger offences in Sheffield of which 46.99% were due to theft (down 8.11% on two years ago), 19.71% for burglary (up 3.81%), 11.76% for non-trigger offences (up 7.56%), 6.91% for possession of class A drugs (up 2.1%), 3.68% for possessions with intent to supply Class A drugs (up 0.58%) and 3.36% for robbery (down 1.44%).

7.5 DIP Testing

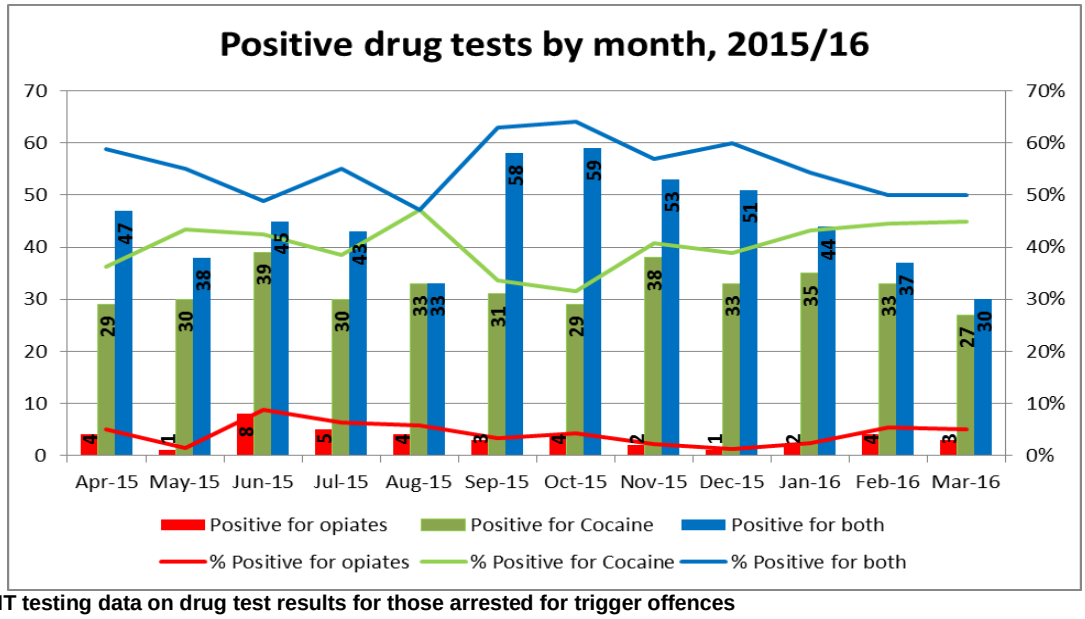
Chart 24: Drug Testing in 2012/13 and 2015/16



The number of drug tests in 2015/16 was almost half of the number of drug tests in 2012/13 (2957 compared to 1500) however the number of positive tests was only marginally lower (996 compared to 966). This equates to a positive drug test rate of 34% in 2012/13 but 64.5% in 2015/16. This suggests that a change in the drug testing criteria to profiling has led to better targeting of the appropriate cohort of offenders. However, more recently during 2016/17, the number of people tested and the number of positive tests have both reduced, leading to a reduction in the number of people on the Addaction caseload. This has been attributed to a change in the location of the custody suite and the DACT, Addaction and the Police are currently working to address this.

Chart 25 shows the positive test data by month. Overall, 56% of positive tests had a presence of cocaine and opiates, 40% for cocaine only and 4% for opiates only (a 3% decrease from last year). Positive tests for both were the highest in every month of 2015/16 with the exception of July where it "tied" with "cocaine only".

Chart 25 - Positive DIP drug tests by drug identified

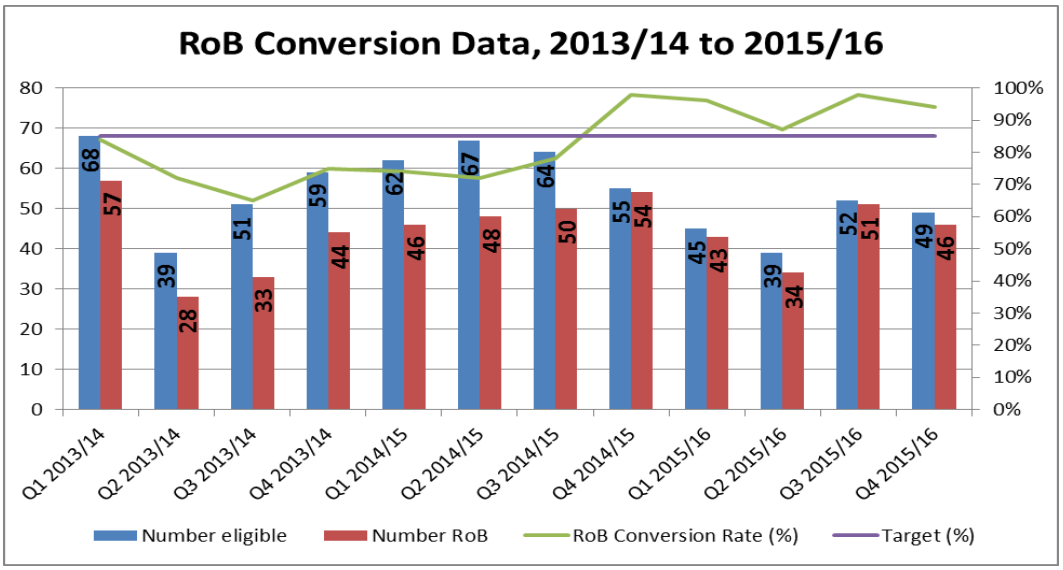


Source: CJIT testing data on drug test results for those arrested for trigger offences

7.6 Restrictions on Bail (RoB)

This service is delivered by Addaction. Sheffield DACT commissions a local target of 85% of those RoB eligible (arrested for a trigger offence, test positive and aged 18 years old or over), if given bail to be given RoB as a condition of their bail. This target has been achieved for the last six quarters (seven quarters if you include the most recent Q1 2016/17 data which is not on the chart below) after a period of it being under the target. The general trend for numbers eligible for RoB has been a decreasing one, as Chart 26 shows:

Chart 26: ROB Conversion rates, Q1 2013/14 to Q4 2015/16

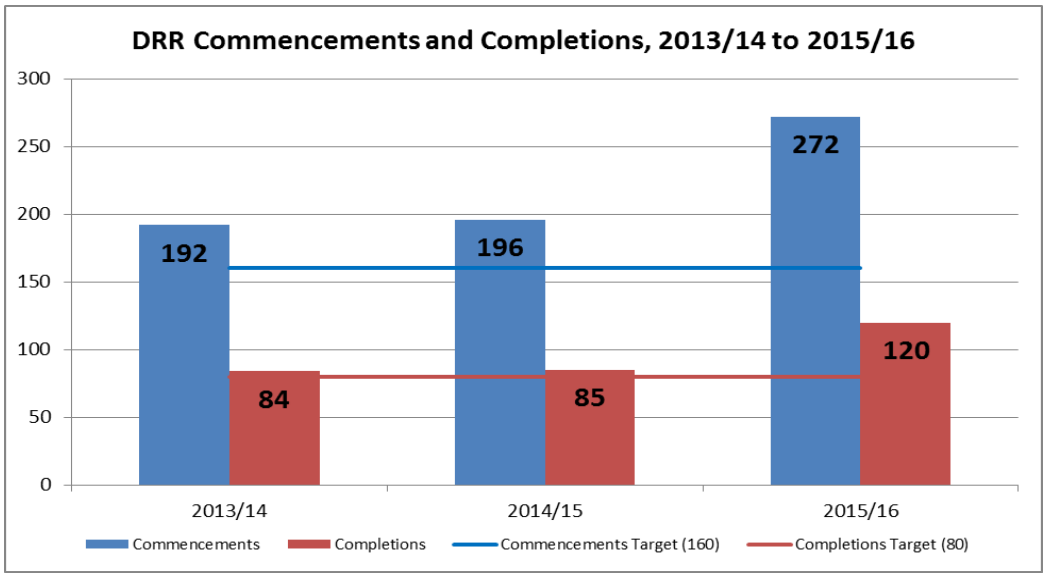


7.7 Drug Rehabilitation Requirement (DRR)

This service is delivered by Addaction and has been since July 2012. DRR is likely to take over from RoB when a person completes their bail requirements and is sentenced by the court. The Drug Rehabilitation Requirement (DRR) is one of the 12 requirements which can be included in a community sentence and is the main delivery route for drug interventions within community sentences for adult offenders.

Historically, performance had been reducing for starts but increasing for completions; however Addaction have seen this trend change and over the last few years both the target for starts and completions has been achieved.

Chart 27 - Performance for DRR Starts and Successful completions since first full year of Addaction contract



7.8 Drug Treatment

As at the end of 2015-16 336 individuals were active on the DIP caseload. For the whole 2015-16 year 718 referrals were made in to tier 3 treatments and 100% of clients had a recovery plan. 31% (287) of the 718 referrals commenced a structured treatment modality.

CJIT referrals into treatment made up 15% of total referrals in 2015/16. This rises to 28% if you remove those with no referral source listed[64].

The criminal justice cohort is, at times, more difficult to engage by the fact the individual has been coerced into treatment. Their motives (such as a more lenient sentence) for being there are different to the general treatment population and so the desired outcomes the individual has are also different. As the motives are different to the general treatment population, the support they receive can also be hindered by their associates and lifestyle, as the general treatment population are more likely to be willing to change these things to assist them to lead a drug free life.

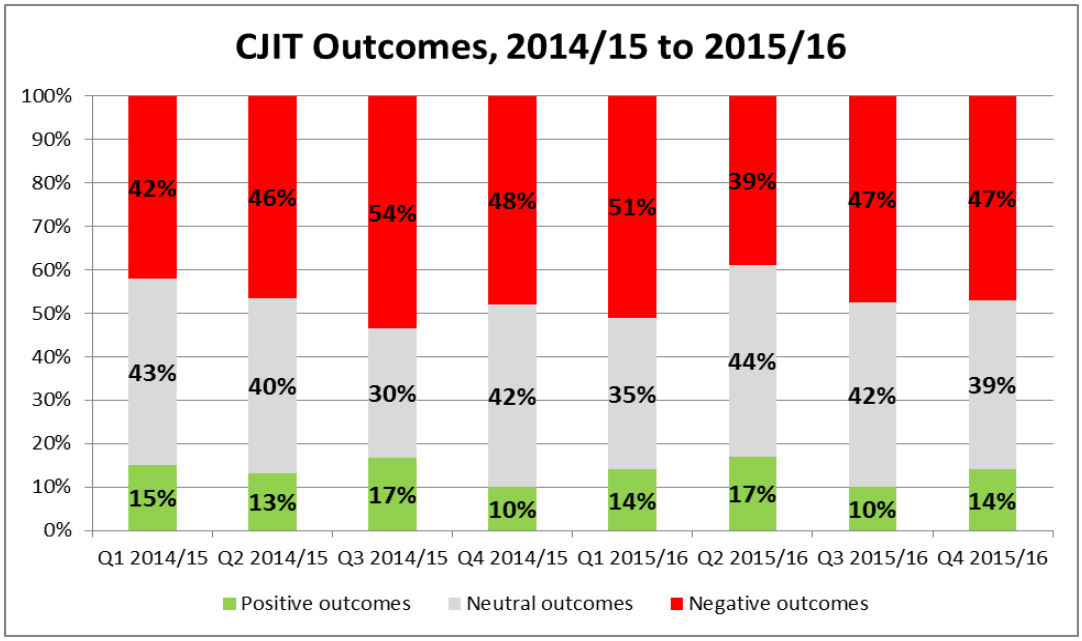
Prescribing referrals for prison releases are picked up within 24 hours, providing every opportunity for the individual to receive a prescription and not buy Heroin. However, for prison releases, the accommodation that the person may find themselves in following release can be counterproductive. For example, if a person leaves prison and goes to a hostel, there may be other drug users at the hostel. Floating support is now provided by DISC (Developing Initiatives for Support in the Community) and is made available at hostels to mitigate this risk.

7.9 Treatment Outcomes

The exit reasons given at closure from the caseload are shown for the past two full financial years, by quarter, in the chart on the next page.

[64] Adult Partnership Activity Report, Q4 2015/16, Public Health England

Chart 28 – CJIT Outcomes, 2014/15 to 2015/16



The overall positive rate out of all exits in 2015/16 was 14%.

2.0% of all Criminal Justice opiate clients in structured drug treatment have a successful outcome compared to 3.6% for the whole treatment system (PHE, Q4 2015/16 DOMES report). Successful completions are discussed in depth in the Recovery section; however the data here does suggest improvements can be made within criminal justice clients in tier 3 treatments.

Overall, we can see that performance against the criminal justice contract has seen improvements over recent years and the service now consistently meets most of its targets. However, there is still a need to continue best efforts to successfully engage as many of these clients in structured treatment as possible.

SECTION 8 – Families, Carers & Safeguarding Children

8.1 Carers

The HM Government drug strategy (2010) states that engaging carers in treatment can lead to better outcomes of drug treatment for the individuals using drugs. The strategy also states that "one of the best predictors of recovery being sustained is an individual's recovery capital [which includes] social capital, the resource a person has from their relationships (e.g. family, partners, children, friends and peers)." *Medications in Recovery* (2012) goes further and states that "family and other social network support can be vital to recovery as they contribute to a person's social recovery capital".

It is also known that the impact of drug misuse can impact carers and family members of the drug using individual. In terms of the prevalence of the number of carers affected, it is known that for every drug user, there are two family members affected[65]. Since the estimated PDU for Sheffield for opiate and/or crack users is 4,266 during 2011/12, then this could indicate that there are approximately 8,500 carers affected in Sheffield. Not all will require support, but for those that do, support should be made available so that they in turn can better support the person they care for.

The DACT commissioned a dedicated carers service until September 2014. However, take-up of the carers offer was below the expected level. Demand did not meet commissioned capacity and was lower than commissioned targets throughout the contract.

The Family and Friends Support Pathway was updated in 2008 and signed off by the Alliance, a group who meet to discuss specific carer's issues. The pathway guides a client to the most appropriate carer support service for their individual needs, whilst simultaneously promoting city-wide family and carers support services.

Sheffield Local Authority has written a city wide strategy; Sheffield, A city where every carer matters: A joint strategy for transforming the lives of carers in Sheffield 2010-2013, with input from Sheffield DACT and other partners.

Since October 2014 the DACT has commissioned carer support and development through one of the 'learning schemes' at the Non Opiate Service. The Expert Carer and Carer Ambassador programmes contain some of the elements formerly delivered by the carer service, such as support and peer contact with other carers, but it also facilitates involvement in service improvement and design, as well as providing accredited learning opportunities to carers and then offering them the opportunity to use their learning and skills through placements within treatment services, supporting other carers and service users.

8.2 Safeguarding Children

'Parents are the most important factor in a child's wellbeing and therefore it is critical that children and adult services are provided, which in some cases will enable the child to remain living safely within their family whilst their parent's substance misuse is being addressed'[66]*.*

Sheffield has a number of structures in place for the safeguarding of Children:

- All people are asked their parental status at the assessment stage.
- All services have a named child protection lead.
- All services have processes in place to refer to Safeguarding services for assistance, advice and onward referral.
- All pregnancy cases are referred to specialist pregnancy treatment.

[65] 'We Count Too' Home Office, 2005
[66] National Drugs Strategy 2010

- All midwives can refer into special midwifery treatment for drug using clients.
- All cases referred to safeguarding are discussed and onward referral to MAPLAG made when required.
- DACT to hold a quarterly safeguarding meeting with attendance from all provider services, to discuss all issues.
- Safeguarding Children Data recording Audit.

Data to the end of 2015/16 tells us that 24.9% of opiate users are living with children, 11.5% of non-opiate users, 7.2% of alcohol users and 10% of alcohol with non-opiates clients. These are lower than the national proportions which are between 23% and 29%. However, this data should be treated with caution due to data quality issues experienced by the provider, as the proportions are lower than previously reported for Sheffield. It also highlights the need for ongoing work with the provider to improve data quality and then maintain its robustness in order to facilitate commissioning decisions.

The WAM (What About Me) Hidden Harm Service support children and young people affected by substance misuse in the household through individual and group work and respite activities, and have a referral pathway to Sheffield Young Carers and Interchange young people's counselling service.

8.3 Pregnant Women

From October 2014, all pregnant drug users are referred to the appropriate treatment intervention, whether the specialist opiate clinic at the Opiate Service or formal PSI for non-opiates users.

The Provider treats pregnant opiate drug misusers within a specialist clinic within the Opiates Service. Pregnant women who are not opiate users are referred to the Non-Opiates Service who then takes responsibility for writing to the Substance Misuse Specialist Midwives and will assess for Safeguarding issues.

The Provider offers a package of PSI and recovery support interventions from a family focussed perspective interventions to non-opiate using pregnant women.

Between July 2015 and June 2016, 17 service users presented to the specialist pregnancy clinic. At the start of the period 30 women were already accessing the clinic meaning that altogether 47 pregnant females were supported via the clinic. Of the 17 new, 12 were opiate users, 4 were non-opiate users and 1 was an alcohol user.

Both services work in partnership with the Specialist Substance Misuse Midwives at Jessop's Hospital, Substance Misuse Social Workers and other professionals in a multi-disciplinary team, and there are weekly multi-disciplinary meeting to discuss cases, update care plans, and refer to Multi Agency Pregnancy Liaison & Assessment Group (MAPLAG), where safeguarding issues are identified. There is formal notification to Safeguarding Children's Board MAPLAG where the effect of substance misuse or concordance with treatment may pose a risk to children.

8.4 Multi-Agency Pregnancy Liaison and Assessment Group (MAPLAG)

MAPLAG is a Safeguarding Children's Board meeting. The purpose is to screen cases so that only those that need to be are referred into the social care system. The Safeguarding Children team are commissioned to convene 12 panels each year. The last 4 years the number of panels held has averaged 26, highlighting the importance of these panels to continue.

Currently the criteria for pregnant women to be discussed in MAPLAG are; any problematic drug use during current pregnancy, any problematic or dependent drinking during current pregnancy or a suspicion of drug use where indicators of use are evident, but not disclosed.

During 2015/16, 91 babies (7 fewer than in 2014/15) were born in Sheffield to mothers who were discussed at MAPLAG due to problematic drug and/ or alcohol misuse during pregnancy (29 were opiate users, 53 were cannabis users, 4 were other non-opiate users and 5 were alcohol users). Of the 91 babies born, 71 went home with their mother, 13 had Child in Need plans in place, 19 were subject to child protection plans and 19 were fostered.

Children subject to child protection plans

The proportion of children subject to child protection plans whose parents misuse substances (drugs and/or alcohol) fluctuated between 43% and 52% of all children subject to a child protection plan. The attendance of the substance misuse services at child protection conferences is monitored by DACT on a quarterly basis and is well attended by all relevant agencies.

All cases referred to Safeguarding children are discussed in the monthly safeguarding children meeting and the lead for the service and key worker attended to discuss the case. Referrals to MAPLAG are made as required.

Within drug treatment, there is a continual need to develop both the skills and the confidence to work effectively with substance misusing families. The majority of parents presenting for drug treatment are likely to need some additional support for their family. If services form effective partnerships with the full range of parenting and family services available, we can meet these needs. In addition, working in a family orientated way has much to contribute to the recovery agenda, particularly in relation to social re-integration.

SECTION 9 - Communities

9.1. Working in Communities

The DACT Communities and Development Officer is a key link between DACT commissioning and priorities and implementing these alongside partner organisations in Sheffield. The specific task is to lead on and address all issues regarding drug and alcohol use, which includes being a key to linking communities, partners and treatment services together.

Historically the role of the Communities and Development Officer worked in partnership with policing Safer Neighbourhood Teams. The officer chaired the substance misuse group to address drug related issues local to each neighbourhood team.

Following a restructure within the Police force, which saw the end of the Safer Neighbourhood Officer role, these groups have ceased to exist. In order to cover some of the gaps left following the cessation of these groups the Communities and Development Officer now leads on the work to respond to the street culture within the city centre, this is described in more detail in section 9.3

Cannabis Advisory Sheffield Housing (CASH) - Established in 2014 CASH is a way for landlords, the Police and support providers to work together to address cannabis use in residential housing, especially where the properties are in close proximity to each other (e.g. flats) and where the drug use is affecting other residents (e.g. smells, noise, anti-social behaviour). Initially the scheme was rolled out across three of the more problematic Safer Neighbourhood Areas in Sheffield. Despite the disbandment of the Safer Neighbourhood Teams, CASH remains in the city as an initiative but has been focussed on the South East of the city. The reason for this is due to a pilot in this area of the city that the CASH scheme has been able to feed into; Housing Plus. Following the success of the pilot, Housing Plus is due to be expanded further across the city which will increase the coverage of the CASH scheme, assisting area teams and partners in addressing cannabis use, supporting those using cannabis, and also supporting the wider community affected by others cannabis use.

9.2 Responding to Street Culture in the City Centre

Areas within the city centre have become social meeting points, creating a problematic “street culture” these groups are commonly referred to as “street drinkers” however the group is much more complex than this and includes individuals with mental health problems, drug users, the homeless and street beggars. In addition to this, some individuals in this group have multiple support needs and ineffective contact with services can reinforce their chaotic lifestyle, making them hard to engage in support services. There is also evidence to suggest that they engage with services when their needs are acute and when the costs of intervention are at its highest.

The DACT has agreed to take a lead on responding to these issues, there are three themes to the work.

Multi agency working group to target individuals of concern

The main function/role of the Multiagency Working Group responding to ASB & Street Culture within the city centre is a preventative one. The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life (Care Act 2015). The overall aims of the group is to prevent adult safeguarding interventions and to better manage and meet the support needs of individuals of concern and respond to individuals Anti-Social Behaviour within the city centre. (Note, the group has a city centre remit)

The first multi-agency meeting took place in Jan 2015 and since then there have been 5 more subsequent meetings, up to date there has been strong support, buy in and attendance at meetings from all the following agencies:

- Faith based groups, providing Soup Kitchen, lunch clubs and Street Pastors
- Drugs and Alcohol SHSC
- SYP
- Archer
- Bens
- SASS
- Addaction
- Big Issue
- Housing Independence
- British Transport Police
- East Midland Trains
- Public Health
- Adult Safeguarding Lead, SCC

Recently all the housing independence commissioned supported accommodation providers and the Deputy Director Sheffield Health & Social care Trust have been attending.

Community Safety & Enforcement
To work with existing enforcement officers, SYP, city centre ambassadors, outreach workers to engage with this client group but to also take enforcement action against known persistent offenders, disperse groups of individuals (Suspected, known or to be causing ASB). This work commenced in July 2015.

Awareness campaign/Positive behaviour – Anti Begging Campaign
In September 2016 the Anti-begging Campaign was re-launched in Sheffield. The aim of the campaign is to reduce the incidence of begging in Sheffield by educating the public that there are a number of avenues of support in place already for people who beg and to encourage members of the public to give directly to local charities instead.

9.3 Mutual Aid

To support service user recovery there are a number of ways in which service users can support each other and build a network of peers. Mutual aid groups such as Narcotics Anonymous operate throughout the city; these are discussed further in Section 4: Successful Completions and Recovery.

There is also a Service User Recovery Reference Group (SURRG), co-ordinated by Sheffield DACTs Communities Development Officer. This group meets monthly and brings together various groups/organisations and people in recovery to work together to provide support and raise awareness that recovery is possible.

A Facebook group also exists for the Sheffield Recovery Community, which is currently followed/liked by 1,293 individuals. The page operates to promote recovery events throughout Sheffield and as a place for people to gain support and information.

9.4 Safer Night time Economy

Best Bar None is a national award scheme supported by the Home Office and the drinks industry which is aimed primarily at promoting responsible management and operation of alcohol licensed premises. The purpose of the Best Bar None scheme is to reduce alcohol related crime and disorder, build positive relationships between licenced trade, police and local authorities, improve knowledge

and skills of those working with and in licensed premises, and to reduce the harmful effects of binge drinking.[67]

For premises to become Best Bar None recognised they must meet a set of minimum standards, responsible owners are recognised at an awards ceremony with category winners and an overall winner.

Sheffield has an active Best Bar None Scheme operating in the city centre and Ecclesall Road area of the city.

Sheffield is also Purple Flag accredited, and was the first city in Yorkshire to be awarded the status. The status is awarded to town centres that meet or surpass the standards of excellence in managing the evening and night time economy.

[67] http://bbnuk.com/

SECTION 10 – Drug Related Deaths and Near Misses

10.1. Drug Related Deaths (DRD) Definition

The NTA report 'Drug related deaths: setting up a local procedure' published in 2011 outlines 15 best practice points for DAATs review and observation of all drug related deaths, which fit the definition *'A death where the underlying cause is poisoning, drug abuse or drug dependence and where any substances controlled under the Misuse of Drugs Act (1971) are used'.*

Sheffield uses the definition above, but also includes acute, chronic and suicide deaths.

In line with the NTA recommendations, Sheffield uses two approaches to reviewing & investigating DRDs:

- Confidential enquiries based on statistical evidence
- Drug-death review involving specific evidence- gathering and investigation.

Reports published by PHE[68] and the ONS[69] for drug related deaths up to 2014 include the following cause groups as a DRD:

a) Deaths where the underlying cause of death has been coded as mental and behavioural disorders due to psychoactive substance use (excluding alcohol, tobacco and volatile solvents).

b) Deaths where the underlying cause of death has been coded to one of the following categories and where a drug controlled under the Misuse of Drugs Act 1971 was mentioned on the death certificate:
   - Accidental poisoning by drugs, medicaments and biological substances
   - Intentional self-poisoning by drugs, medicaments and biological substances
   - Poisoning by drugs, medicaments and biological substances, undetermined intent
   - Assault by drugs, medicaments and biological substances.
   - Mental and behavioural disorders due to use of volatile solvents.

10.2. Investigation into the DRDs

All DRD deaths are brought to the attention of the DACT via contact from the service provider working with the deceased/police/coroner and followed by a serious untoward incident form if coming from the service provider.

All deaths are checked against NDTMS to assess contact with any Sheffield treatment services around the time of the death. The Sheffield Coroner is then contacted with a list of cases that the DACT is interested in reviewing.

A bi-annual confidential review meeting is held to discuss DRDs in the previous 6 month period, though often covers deaths that occurred before this period due to inevitable delays in outcomes from inquests that are held for some deaths. The meeting is convened by the DACT and has representatives from all service providers, the Coroner, and the DACT. At these meetings, a confidential inquiry-type approach is used to ascertain treatment contact prior to death and raise any issues[70]. Learning points from the Sheffield confidential review are then circulated in the form of a narrative report with recommendations and points of vigilance.

[68] Trends in Drug Misuse Deaths in England, 1999 to 2014, Public Health England, 2016
[69] Deaths Related to Drug Poisoning in England and Wales: 2014 registrations, ONS September 2015
[70] Service providers and / or GPs not represented at the meeting may be contacted to request relevant information

Sheffield DACT also commissions the University of Sheffield to conduct an annual epidemiological-type investigation into acute non-accidental DRDs. The report provides detailed information about the demographic characteristics of those who died; the timing and circumstances around their death; and all drugs involved, to observe trends such as use of drugs, early warning signs, the role of prescribed medication and risk factors.

10.3. Drug Related Deaths in Sheffield

Local data for January to December 2015 has 23 recorded drugs related deaths; this is higher than the average of 18 (+/- 3) per year, which Sheffield has experienced for the last 10 years. There were 30 DRDs recorded in 2014, compared to 15 in 2013 and 19 in 2012. In 2015 of the 23 DRDs, the age range was between 22 and 61 years, and 18 of the 23 deaths were male.

At the most recent Coroners review in Sheffield (March 2016), 13 cases were discussed. 11 of the deaths discussed were male. 10 out of the 13 deaths died of a drugs overdose. Toxicology reports detected Heroin present in 8 individuals, methadone present in 7 and other opiates present in 6 (an individual may have had more than one substance detected).

The most recent DACT report commissioned of Phillip Oliver which is an independent review to examine the current state of acute accidental drug misuse deaths within the city of Sheffield and shows information on deaths from 2012[71]. The report is written following the conclusion of the Coroner's review which can take up to two years to complete.

In 2012, 13 deaths fulfilled the criteria of an acute drug misuse poisoning death in Sheffield.

Summary of details for 2012 deaths, the average for the 10 years total is shown in *italics* after each point. The mean age of the deaths in 2012 was 38 years *(33.5 years is the average for the last 10 years)*, 92% (12) of the deaths were male *(85%),* 77% were unemployed *(76%)* and 69% lived alone *(50%).* 58% were known heroin users *(67% historically)* 57% of those with a dependence problem were in treatment at the time of death *(43%)*.

Over the past two years a quarter of the deaths were caused by stimulants such as amphetamines, MDMA and PMA, compared to a historical average of less than 10%.

10.4. National Drug Related Death Data

The trend observed nationally is that between 2012 and 2014 the number of drug related deaths has increased each year by at least 17% (due to a delay between a death occurring and being reported 2013 and 2014 data is regarded as provisional)[72]. This is also reflected in the increase reported in Sheffield in 2014.

Nationally the large majority of drug related deaths include the mention of at least one opiate. Changes in drug misuse deaths over time are largely accounted for by changes in deaths involving an opiate. For example, opiate deaths increased by at least 21% in 2013. Alcohol is the second most common substance citied, although to be included it must be recorded alongside an illicit substance. Since 2006 the number of drug related deaths where a NPS is citied have increased, and in 2012 65 deaths (4% of all DRD in the year) citied NPS against a drug misuse death. However, provisional 2013 data suggests that this has reduced to 3% of all deaths.

[71] Research Report: Deaths from acute accidental overdose of drugs of misuse in Sheffield during 2012, Dr. Oliver, P. Dr Rowse, G.
[72] Trends in Drug Misuse Deaths in England, 1999 to 2014, Public Health England, 2016

10.5. Overdose prevention training – commissioned by DACT

DACT commissions overdose prevention tools and techniques training from the Opiates Service. In 2015/16 five training sessions were held and 28 service users and 30 staff members received the training. This is much fewer than the 192 service users and 66 staff members that received training in 2013/14. The number of individuals trained in 2014/15 is not currently available but we do know that six training sessions were held in the year.

The DACT should liaise with the provider to ensure that the offer of the training is still reaching a large proportion of the appropriate service users and staff members and that the training package still meets the expected requirements.

10.6. Naloxone

From 1st October 2015 the law in the UK around naloxone use and availability changed. The Human Medicines Regulations 2015 were amended to enable the prescription only medicine naloxone hydrochloride to be supplied by drug treatment services for the purpose of saving life in an emergency.

Naloxone reverses the effect of opiate overdose if given promptly. It can be supplied to anyone:

- Currently using illicit opiates
- Receiving opioid substitution therapy
- Leaving prison with a history of drug use
- That has previously used opiates.

With the agreement of someone eligible for take-home naloxone, it can also be provided to their family members, carers, peers and friends[73].

In Sheffield service users issued with Naloxone must have been trained in how and when to administer it, alongside a peer or carer, before they are able to take home the medicine. The service user will then be able to administer the naloxone if needed and the carer to the service user if they overdose. Service users eligible in Sheffield are those who are deemed to be at high risk of overdose but are assessed as an individual who can be relied upon to use naloxone in an appropriate manner. Training for service users must include clear information about the necessity to always ring an ambulance despite administering the Naloxone due to the risk of overdosing again when the Naloxone has worked and a service user may use again afterwards. The Provider must be clear and have written evidence that the service user understands this risk before allowing them to proceed. In 2016 legislation was changed regarding Naloxone and on the back of this, some hostels and temporary housing providers in Sheffield who house individuals at risk of overdose have been issued with Naloxone to use on their tenants if and when required.

Data for 2015/16 from the Yorkshire Ambulance Service (YAS) for the whole of Yorkshire and the Humber shows that naloxone was administered by paramedics in Sheffield a total of 151 times accounting for 12.5% of all naloxone use by the ambulance service. The Sheffield Clinical Commissioning Group (CCG) area had the 2nd largest number of naloxone administrations by YAS paramedics in the year.

In the first 6 months of 2016 the opiate drug treatment service in Sheffield issued 21 Naloxone kits, one of which was a re-issue to replace a kit that had been used.

[73] http://www.naloxone.org.uk/index.php/lawpolicy/law/uklaw1

10.7. Near Misses

It is known that a number of drug related deaths from acute drug toxicity have experienced a near miss in the past. However, data collection around near misses is not robust. We know that the ambulance service records opiate overdoses (indeed any drug overdoses) under the much more generic heading of ‘poisoning incident’ making data difficult to obtain. A task group reporting to the regional Harm Reduction meeting to ascertain the number of near misses was inconclusive due to issues with data collection and disparity across the region.

10.8. Contaminated Drugs Warnings

When a contaminated drugs warning alert is received in the DACT (from any source) it is checked for provenance and then circulated to the treatment providers and the accident and emergency department at the Northern General Hospital, so they can be alert to any new threats. Drug warnings are also added to PharmOutcomes, a web based tool used by pharmacies to invoice the DACT for supervised consumption and needle / paraphernalia transactions. This means that when it is known that contaminated drugs are or may be in circulation in Sheffield, there is wide coverage amongst partners and known drug users.

SECTION 11 – Gap Analysis / Opportunities to Explore

The following list summarises the key issues identified in the Needs Assessment and lists options available to further meet the need of drug misusers in Sheffield. A number of gaps and opportunities from previous Needs Assessments have been addressed through proactive collaborative work with providers, and also through the commissioning of new contracts.

Tier 2 (assertive outreach, open access, CJIT and needle exchange)

- We need to continue to engage with service users – national data suggests injecting amongst opiate and crack users is on the decline. However, locally we have seen an increase in volumes of transactions in pharmacy needle exchange, and needle exchanges are the first point of treatment for many service users. Injecting of other substances such as NPS and steroids is likely to be contributing to the increase in needle exchange activity and we need to better understand these service users, who may only be in contact with tier 2 services, given that reported use of NPS by people in structured treatment remains very low.
- Improve recording of number of clients referred to structured treatment following contact at tier-2. This would provide some insight in to the people currently accessing tier-2 including needle exchange.
- Maximise the opportunities to engage treatment naïve individuals.
- Review the use of the Recovery van as a mobile needle exchange.
- Overall, performance against the criminal justice contract has seen improvements over recent years and the service now consistently meets most of its targets. However, there is still a need to continue best efforts to successfully engage as many of these clients in structured treatment as possible, given that they are likely to be 'treatment resistant' in comparison to other service users.
- Continue to work with partners to address the reduced number of drug tests carried out at the custody suite and subsequent reduction in number of people on the Addaction caseload.
- Monitor effectiveness of YIACS in providing information, advice and access to treatment for young adults.

Tier 3

- Continue to work towards 30% of prescribing clients receiving PSI treatment and increase the proportion of commissioned Opiate PSI places that are utilised per annum.
- Understand and address any barriers that prevent more prescribing clients from receiving PSI treatment.
- Maintain or improve the proportion of clients whose drug treatment becomes effective treatment (in treatment for 12 weeks+ or successfully complete treatment within 12 weeks).
- Continue efforts to increase performance against the PHOF targets.
- Understand the reason why some clients who report not using the problematic substance at the start of treatment, start using within the first 12 months of treatment.
- The treatment system in Sheffield needs to utilise initiatives to tailor the treatment offer to individuals which will mean that each individual can receive appropriate treatment for their needs, and this will in turn improve successful completions.

Recovery focused treatment – improve numbers leaving drug free and give service users the tools to increase the potential to remain drug free

- There is a need to build on what is already available to clients, develop new pathways into education, employment and training opportunities and to see the numbers increase for those engaging in ETE, during and post treatment.
- Links between mutual aid, support groups and multi-agency working needs to be maintained at an optimum.
- Improve the recovery focus for opiate service users as appropriate, particularly those who have been on methadone for a number of years.

- Explore the possibility of linking in with more voluntary sector organisations as a way of building service user skills through a wider range of volunteering opportunities.
- Achieve the PHOF performance target for Opiate and Non-opiate drug users to be ‘similar to the England average’.
- There is a need to reduce the proportion of opiate clients still using opiates and other substances after long periods of time in treatment.
- Explore opportunities to increase recovery capital.
- Keep re-presentation rates lower than the comparator average.

Harm reduction

- Collect better data on the people accessing needle exchange and the drugs that they use.
- Review the use of the Recovery Van so that its purpose can meet the needs of drug users in the city.
- Ensure that the offer for overdose prevention training is reaching as many appropriate service users as possible, as well as staff members, and that the training package still meets requirements.

SECTION 12 - CONCLUSION

The Needs Assessment is an integral part of the treatment planning process. Its purpose is to provide an evidence base that evaluates the effectiveness of current services and seeks to identify the unmet needs of those who currently engage with services and those who don't. It is a key resource in specifying treatment services.

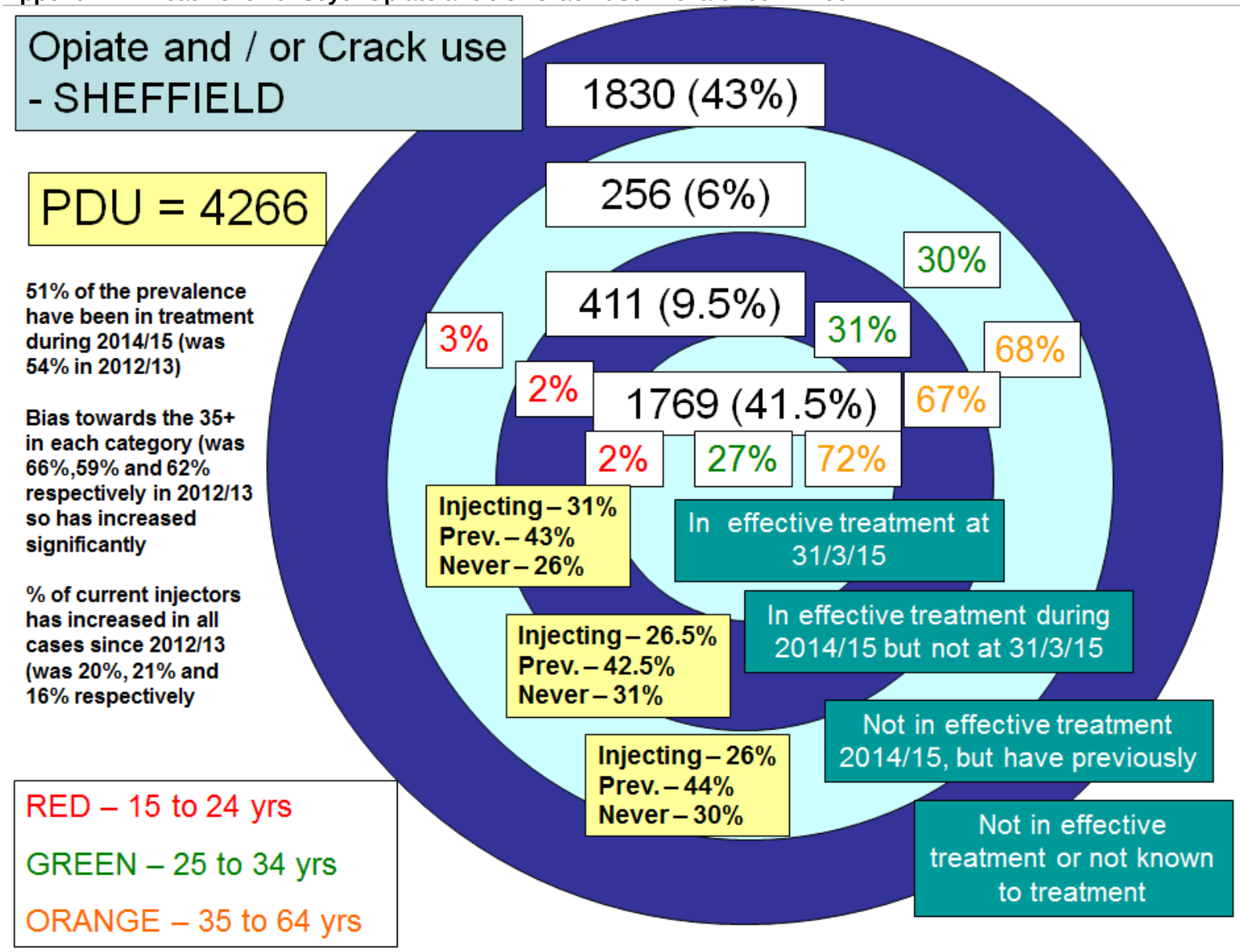
This Needs Assessment process has brought together different data sources to show what we know about general drug use in England, estimated prevalence of problematic drug use and the profile of drug users in treatment.

The current contracts that commenced in October 2014 aimed to address some of the needs and opportunities identified in previous needs assessments. This needs assessment has been able to evidence the impact that the new contracts have had in Sheffield, through increased numbers in treatment and an increase in the proportion of clients that are retained in effective treatment.

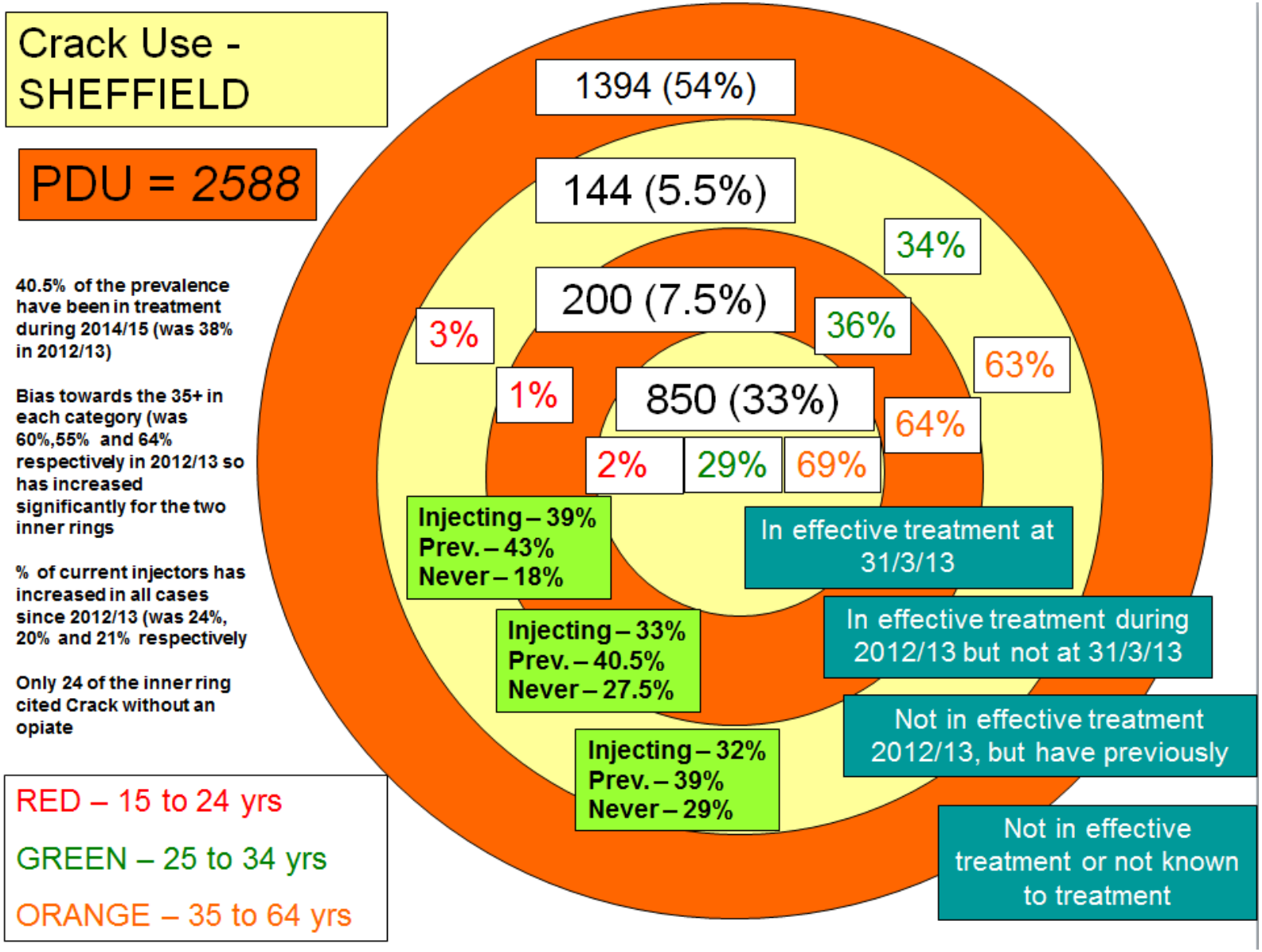
The needs assessment has identified gaps and opportunities to explore (section 11) in the current provision to further enhance the treatment provided and improve outcomes for service users. These should be reviewed through appropriate commissioning mechanisms and decisions made as to how best to address the areas of need, along with identifying the needs and gaps of most concern and therefore highest priority.

A further needs assessment should be completed in roughly 12 months' time to review areas addressed since the publication of this needs assessment and to identify gaps and needs that remain or are newly identified.

Appendix 1: Treatment Bullseye. Opiate and / or Crack use Prevalence = 4266



Appendix 2: Treatment Bullseye, Crack use Prevalence = 2588



Appendix 3: Needle Exchange provision in Sheffield

Pharmacy Needle Exchanges

- Wicker Pharmacy (Wicker, S3)
- Lloyds Pharmacy (Alderson Road, off London Road, S2)
- Boots (The Moor, S1)
- Boots (Manor Park Centre, S2)
- Co-Operative Pharmacy (Prince of Wales Road, S2)
- Lloyds Pharmacy (Duke Street, behind Park Hill Flats, S2)
- Rowlands Pharmacy (Barnsley Road, Sheffield Lane Top, S5)
- Lloyds Pharmacy (Porterbrook Medical Centre, near Broomhall, S11)
- Lloyds Pharmacy (Woodhouse Market Square, S13)
- Lloyds Pharmacy (Westfield Centre, S20)
- Lloyds Pharmacy (Birley Moor Road, Frecheville, S12)
- Day Lewis Pharmacy (Crookes, S10)
- Abbeydale Pharmacy (Abbeydale Road, S7)
- Barnfield and Allen (Wolfe Road, S6)
- Swift Pharmacy (Gower Street, S4)
- Lo's Pharmacy (Broomhall, S3)
- Sheffield Late Night Pharmacy (Fulwood Road, S10)
- Hillsborough Pharmacy (S6)
- High Green Pharmacy (S35)

Other Provision

The Non-Opiates Service (operated by SHSC FT) – Sidney Street, S1
Mobile van operated by the Non-Opiates Services

APPENDIX 4:- Areas of Sheffield by postcode

S1: City Centre

S2: Manor, Manor Park, Arbourthorne, Wybourn, Norfolk Park, Highfield, Lowfield

S3: Pitsmoor, Burngreave, Shirecliffe

S4: Grimesthorpe, Burngreave, Shirecliffe

S5: Firth Park, Longley, Southey Green, Southey, Shiregreen, Sheffield Lane Top, High Greave

S6: Hillsborough, Stannington, Malin Bridge, Loxley, Wisewood, Wadsley, Wadsley Bridge, Birley Carr, Middlewood, Wadsley Park Village, Walkley, Rivelin, Rivelin Bank, Upperthorpe, Bradfield, Foxhill, Dungworth, Hollow Meadows

S7: Nether Edge, Kenwood, Sharrow, Sharrow Vale, Carterknowle, Millhouses, Abbeydale

S8: Woodseats, Norton, Norton Woodseats, Meersbrook, Heeley, Meadowhead, Beauchief, Greenhill, Lowedges, Batemoor, Jordanthorpe

S9: Wincobank, Attercliffe, Darnall, High Hazels

S10: Fulwood, Ranmoor, Broomhill, Lodgemoor, Crookes, Crookesmoor, Tapton, Crosspool, Sandygate, Stumperlowe

S11: Ecclesall, Banner Cross, Ringinglow, Greystones, High Storrs, Whirlowdale, Bents Green, Whitely Woods, Parkhead, Hunters Bar, Brincliffe, Bannerdale, Redmires

S12: Gleadless, Gleadless Common, Gleadless Townend, Charnock, Intake, Frecheville, Birley, Base Green, Herdings, Hollins End, Hackenthorpe, Ridgeway

S13: Handsworth, Stradbroke, Richmond, Normanton Springs, Woodhouse

S14: Gleadless Valley, Hemsworth

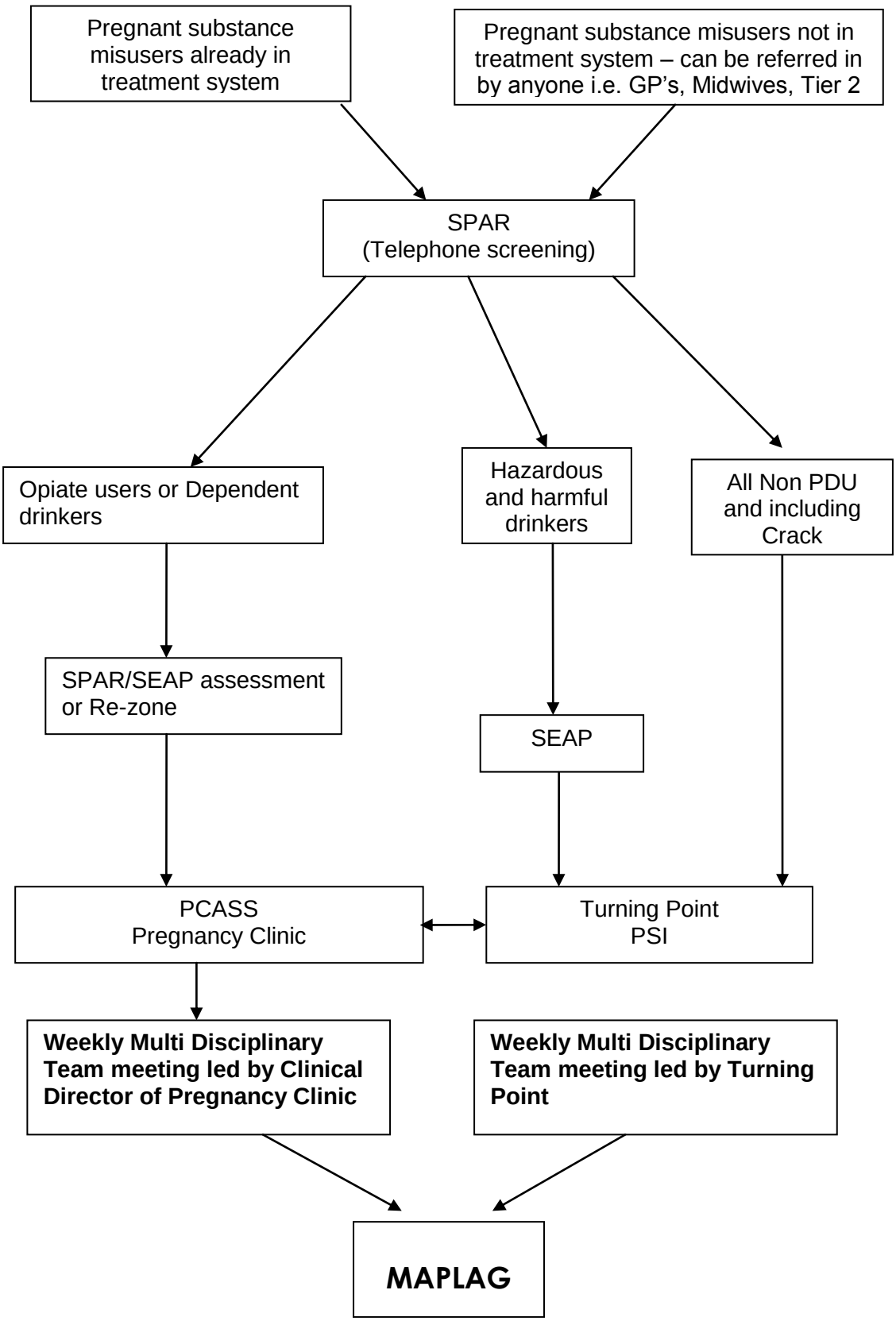
S17: Totley, Totley Brook, Totley Rise, Bradway, Dore

S20: Owlthorpe, Sothall, Beighton, Waterthorpe, Westfield, Halfway, Mosborough, Ridgeway

S21: Killamarsh, Renishaw

S35: Oughtibridge, Worrall, Wharncliffe Side, Chapeltown, Grenoside, Ecclesfield, Burncross, High Green, Wortley

APPENDIX 5 - PATHWAY FOR PREGNANT DRUG/ALCOHOL USERS



APPENDIX 6 – Responses to Needs Assessment Survey

As part of the needs assessment process stakeholders have been asked a series of questions in regard to the treatment offer in Sheffield for opiate and non-opiate users. The results of the survey along with feedback received about the questions asked are given below.

Opiate Users

Q1. Do you think that more opiate users should receive PSI?

Yes	14	93.33%
No	0	0.00%
Don't know	1	6.67%

- If they are ready
- If they are motivated and in a good place
- Difficult question as there is clearly an evidence base for PSI Intervention but evidence also indicates that unless you find a suitable way of mainstreaming PSI linking it directly to another treatment modality e.g. prescribing, then service users are reluctant to engage in what they see as something that is additional (but not essential).
- however a combination of structured and non-structured session should be on offer given the variation in clinical presentation amongst the treatment population

Q2. Do you think that a successful episode of structured PSI increases the likelihood that a service user will be able to successfully complete their pharmacological treatment?

Yes	13	86.67%
No	1	6.67%
Don't know	1	6.67%

- This is because service users not only require structured PSI support but they also require ongoing support.
- PSI interventions, particularly those interventions aimed at enhancing 'coping strategies' regarding anxiety / mood difficulties (those difficulties that heighten potential for return to illicit drug as a means as a coping mechanism) play a very valuable role in supporting certain individuals recovery journey.
- PSI is a useful adjunct to pharmacological interventions. The goal of PSI is not successful completion of pharmacological intervention but aims to enable the individual develop skills that support them in achieving abstinence from illicit drug use , undertake useful psychological interventions to address comorbid illness (depression and anxiety) and other factors that continue to put the individual at risk of using illicit substances or are maintaining on going drug use . Supports the development of necessary life skills and enhance the chances of successful recovery. Recovery outcomes need to be measured across a range of parameters i.e. abstinence from illicit drug use , improved social well-being and health , return to regular employment , reduced criminal activity etc. , the parameter complete pharmacological treatment is mainly an external one that does not necessarily take into account this factor and instead takes on a binary approach of on pharmacological intervention or off pharmacological interventions and does not reflect clinical reality for most patients .

Q3. Do you think that there are missed opportunities that could reduce the number of people still using opiates when they have been in treatment for long periods of time?

Yes	15	100.00%
No	0	0.00%
Don't know	0	0.00%

- Clients get stuck on a prescription
- Although opiate treatment services do have by definition have an aging population some of who have been in treatment for decades and who are illicit drug free , there are clearly numbers of individuals in treatment who use opiates illicitly (on both a frequent and infrequent basis). The above cohort of patients are often the most resistive to change as they still have attachments linked to their illicit substance use, attachments that can appear resistive to treatment intervention. It is perhaps worth considering what specific interventions / strategies for this treatment resistant group could be employed over and above a purely harm reductionist level of intervention e.g. linking attendance at motivational enhancement 1:1 / group sessions to on-going script management.
- Annual multiagency review of care plans but the logistics of such an approach would be challenging.

Q4. Do opiate users that are offered structured PSI generally take up the offer?

Yes	1	6.67%
No	8	53.33%
Don't know	6	40.00%

- Previously poor experience with providers, service users don't seem to have faith in service offered.
- when referring clients for opiate psi we are not aware if the treatment has been offered by FWC and if FWC workers have acknowledged a referral has been made. when discussing psi with our clients and referring on we don't receive correspondence back from fwc and the clients generally state they see a prescriber once ever few weeks. I appreciate the workers have large caseloads so if other agencies could provide psi this may provide more opportunities for clients to receive it
- They do generally take up the offer but due to substantial wait times this can often be a barrier for service users
- No and Yes ...is probably the better answer...service users agree in the main to the suggestion of engagement with PSI (because in essence, if explained properly to a service user engagement in PSI is a sensible common sense way of heightening a person's ability to remain opiate / drug free) ...Opiate service users appear reluctant to engage in PSI (high than normal DNA rates to formal PSI interventions) post its initial offer because by its very nature askes an individual to 'get fully involved' in their recovery in this in itself can be challenging given the accepted culture linked to treatment which is often linked to 'someone or something doing something to me to make me better'.

Q5. Do you think that those that don't take up the offer of structured PSI should be offered the intervention periodically during their time in treatment?

Yes	15	100.00%
No	0	0.00%
Don't know	0	0.00%

- Cycle of change would suggest that this would be beneficial
- PSI should be re-revisited at every recovery plan review
- Yes, service users have the ability to change a view or a perspective linked to their treatment plan as they develop in treatment hence the offer should be made based on service user presentation on a regular basis.

Q6. Do you think that barriers exist that stop service users taking up an offer of PSI?

Yes	9	60.00%
No	4	26.67%
Don't know	2	13.33%

- feedback from service users has not been positive regarding PSI. Some report that they have not had any response following referral, have not had an apt offered following initial assessment, have been turned away from the service due to working being absent & had no offer of support whilst allocated worker not a work.
- Poor experience previously Long waiting times
- Over load of appointments.
- Lack of timely appointments and consistency of workers. Also a lack of understanding at what it actually entails.
- attending multiple appointments per week often stops people from wanting to commit to another appointment
- Wait times Placing service users into clinics as opposed to 1:1 support Lack of communication between key stake holders
- Services in Sheffield work hard to engage service users in a treatment offer....a better view of taking forward an agenda of engagement in PSI is to think in terms of how do I normalise the offer of PSI...In the same way that engagement in a prescribing modality appears embedded in the psyche of service users as an anticipated and subsequently provide treatment offer e.g. PSI offer to all suitable new patients entering treatment commencement of offer in first 6 - 12 weeks post prescribing treatment initiation.
- Most of the barriers to PSI within the core service have been reduced, the core challenge relates to patient choice and their ability to maintain engagement long term. Restricting appointments to weekly and six to eight sessions per episode while allowing for systemic structure loses out on flexibility in the context of complexity. Some more flexibility in terms of the interval between psi review and duration of intervention will be of benefit.

Q7. Are there opportunities to increase recovery capital that are not currently met within the treatment system and may hinder some service users from gaining the recovery capital they need? (Including housing, education and training, benefit claim assistance, social network)

Yes	11	73.33%
No	1	6.67%
Don't know	3	20.00%

- when accessing benefits this often takes a long periods of time leaving client in housing arrears people often struggle to try group work when they have never done this before and find this daunting - workers don't have enough time to sit in with clients to make them feel more comfortable. workers don't have enough time to accompany to other services or activities that may increase recovery capital
- Agencies working in silo
- Services and commissioners of service have limited financial resources but making sure that as many clinical staff as possible understand what is and isn't available as a social care / intervention offer in the city will always be needed.
- More joined up thinking and working across different service providers will be of benefit. Improved support for patients within the criminal justice system that helps reduce the cycle of starting and stopping benefits, housing related issues that occur within this process. Utilising a contingency management approach to supporting engagement with recovery oriented interventions in the community. Utilising recovery champions in non-health agencies to help combat stigma

Non-opiate users

Q1. From your experience what are the reasons for clients leaving treatment in an unplanned way, are there any recurring themes?

- change in circumstances, arrested & sentenced, change of worker, services not being responsive, lack of continuity of care
- One rule for all - doesn't always meet the needs of individuals, lack of tailoring and person centred approaches to treatments
- Restlessness with being in treatment. Increased substance use. hopelessness and mental health
- Clients happy with their drug use
- Due to the approach of workers/agencies within the recovery system. By ensuring meeting targets are met and not to benefit the client. The treatment process doesn't seem to focus around clients, it focuses around procedures and targets
- Clients not being ready to access support or put in the work to make changes. Clients believing services and workers have a magic wand to make things better for them then realising this is not the case. Clients not receiving the level of support they have been led to believe they will get.
- lack of motivation to address substance needs/not their priority/they believe their use is recreational
- clients often believe that there use is recreational and do not see an issue with it and therefore don't need treatment no substitute prescribing so clients often don't think 1-1 work would help
- The absence of pharmacological intervention in treatment, limited opportunities for assessment of mental health comorbidity, patient choice, patient complexity

Q2. Do you think that opportunities are missed at the start of treatment that may reduce the number of people that exit treatment early (within the first 3 months) in an unplanned way, what more could be done?

Yes	6	60.00%
No	0	0.00%
Don’t kno	4	40.00%

- more assertive outreach, contingency management, more use of peer mentors

- Extra support to people who are treatment naïve Outreach services, home visits etc
- A mandatory pathway for those leaving prison and better repercussions for missing appointments.
- Better engagement at the initial stages with clients and managing expectations. Better communication regarding appointments etc and between services. Better cover for workers that are off sick or on AL.

Q3. Do you think there are gaps in the current treatment offer that if addressed, may reduce the number of clients with multiple previous treatment episodes and /or reduce the average number of previous episodes per client? Are there recurring needs that clients do not have met?

Yes	7	70.00%
No	0	0.00%
Don't kno	3	30.00%

Q4. Do you think that post treatment recovery support does reduce the likelihood of a client re-presenting to structured treatment?

Yes	8	80.00%
No	1	10.00%
Don't kno	1	10.00%

- Relapse prevention work Recovery capital - increasing recovery community/asset based community development Support someone to 'be clean' as this presents it own challenges
- Yes if clients can be involved in the recovery community
- there is limited evidence in clinical populations that this works on the contrary patients seem to want to distance themselves from services once they have completed treatment , however there is a subset of patients that have more complex needs that benefit from post treatment support . Options of how this can be supported via recovery communities should be explored as this is likely to have a multipronged effective as well as promoting self-efficacy.

Q5. Are there opportunities to increase recovery capital among service users that are not currently met within the treatment system and may hinder some service users from gaining the recovery capital they need? (including housing, education and training, benefit claim assistance, social network)

- Yes
- Don't know
- Yes. Better links needed between all the above services.
- having an easier way for clients to access benefit support within treatment providers may support clients to address their social needs.
- More joined up thinking and working across different service providers will be of benefit .
- improved support for patients within the criminal justice system that helps reduce the cycle of starting and stopping benefits , housing related issues that occur within this process .
- utilising a contingency management approach to supporting engagement with recovery oriented interventions in the community .
- Utilising recovery champions in non-health agencies to help combat stigma

Appendix 7

Transitional and Intergenerational Substance Misuse Protocol: Children's and Young People to Adult Services

Contents:

1. Introduction

The aim of this protocol is that there should be an "all ages" approach to substance misuse in Sheffield. This protocol provides local guidance on:

- How to manage the transition and engagement of substance misusing 18 to 19 year olds and young people up to the age of 25 with additional vulnerabilities, e.g. learning disabilities, in mental health treatment, care leavers, young people in the justice system, accessing YIACS, or other needs agreed with line manager, to adult drug and alcohol services;

- How to provide support to children of substance misusing adults who require substance misuse interventions in their own right;

- How to provide support to young people in households affected by intergenerational substance misuse;

The protocol is primarily designed for children's and adult's substance misuse services, but may be relevant for other external organisations.

The protocol sets out agreed good practice guidelines for seamless transfer of service users between services; this is important, because engagement and retention in treatment is a key indicator for improved social functioning in other areas of life.

The guiding principle is that services should be provided on the basis of need not on the criterion of age enabling clinicians to make decisions as to the most appropriate service for young people.

2. Aims of the Transitional Process

The aims of the transitional process are:

- To ensure that the needs of the young people are being met by the most appropriate service available, extending access to young people's substance misuse service beyond 18 where indicated and appropriate;
- To ensure that if the assessed clinical needs of the young person at 17+ would be best met within adult services that this provision will be made available immediately with provision for additional support made;
- To ensure the thorough handover of care responsibilities from the young people's services to the appropriate adult treatment service;
- To provide effective discharge of the young person from the young people's services and at the same time secure engagement with the adult service.
- To remove any barriers to the young person continuing in treatment as they reach 18 years old.
- To prepare the young person for the differences between the young people's services and adult treatment services and ensure where possible, through joint working, that these differences do not result in disengagement.
- To examine whether sibling or parental or a significant adult in a young person's life's substance misuse (including alcohol) is impacting on the recovery of the young person.

3. Transitions

As a young person approaches their 18th birthday the substance misuse workers in the young people's services should start preparation for a possible transfer to adult services. A care plan review should be held for every young person in treatment with the young people's services, at least 8 weeks before their 18th birthday. . The care plan review should assess whether or not it is appropriate to initiate the transition procedure based on the following criteria:

- Clinical need;
- Level of maturity;
- Level of vulnerability;
- Transitional arrangements with other services (i.e. Youth Justice Service, health services etc.);
- Identified learning disability;
- Do they have siblings or parents that are misusing drugs and/or alcohol and is this impacting their own ability to recover from substance misuse?

All young people remaining in the young people's services for any significant period past their 18th birthday should be monitored and reviewed. Exceptional decisions taken to retain young people in the young people's services should be reported quarterly to the Commissioning Manager for Vulnerable Children Young People and the DACT Strategic Commissioning Manager for Drugs and Alcohol (adult services).

The National Treatment Agency's (now Public Health England) 2008 'Guidance on commissioning young people's specialist substance misuse treatment services' states the following:

'… Some flexibility in terms of upper age limits can be accommodated, provided that the need is best met in a young person's service and staff have the competence and capacity to meet the needs. Similarly some young people may best have their needs met in adult services where specialist interventions may be more highly developed than in the local young people's specialist substance misuse treatment service. Specialist substance misuse treatment for young people is funded on the basis that early intervention will prevent many young people from needing to access adult substance misuse services. All young people in substance misuse treatment will benefit from a transitional care plan devised prior to their 18th birthday, this can be used to identify on-going needs and the organisations best able to meet these needs. In order to plan transitional arrangements, service providers of adult and young people's substance misuse services will need to work together. Transition to and from children's to adult services occurs at different ages, developmental stages, or at an agency's cut-off point. For example youth offending teams, (CAMHS), and Looked After Children teams may have different arrangements. Transitional arrangements will need to ensure that these different arrangements are included in the care plan if relevant.'

If a young person presents to the young people's services at the age of 18 years, they should be referred to adult treatment services unless the service is of the clear clinical opinion that their needs would be better met in the young people's services, based on the criteria above. If the decision is taken to refer a young person under 18 into adult services, all subsequent care plan reviews should refer back to the criteria to ensure that transition is an ongoing consideration of the young person's treatment journey. The Commissioning Manager Children Young People and DACT Strategic Commissioning Manager for Drugs and Alcohol should be made aware of any exceptional cases where transition to adult services has not taken place within the young person's 18th year.

4. Transition Procedure

4.1 Triage Assessment

When a young person is identified as needing and ready to transfer to adult services the young people's services should contact the following services provided by Sheffield Health and Social Care:

- **Alcohol** 0114 226 3000), services provided from Matilda Street, Sheffield.
- **Opiate Drug Misuse -** 0845 245 0370), services provided from The Fitzwilliam Centre, Fitzwilliam Street, Sheffield.
- **Non-opiates drug misuse** (0114 272 1481) – services provided from Sidney Street Sheffield.

The appropriate service will nominate a member of staff to work with the young people's services on the transition of the young person into adult services The young person, their young people's services key worker and where appropriate, their carers and family members, should be fully involved in the process.

A young person transferring to adult services should not have to undergo repeated assessments by different service providers; the young people's services should provide the worker with as much information as possible with the consent of the young person. The worker should only need a brief meeting with the young person in order to complete a triage assessment and identify the most suitable adult treatment for the young person. The young people's services worker will arrange a meeting to discuss the outcome of the triage assessment and agree a transitional care plan.

For young people accessing a service through the YIACS (Youth Information Advice and Counselling Service), up to the age of 25, the triage and support into appropriate services will be provided by YIACS staff. The young people's substance misuse service will be integrated within the YIACS, and the protocol covers the transition arrangements for young people who have vulnerabilities such as care leavers or young people in the justice system who may need supported and phased transition to adult services by agreement with young people and adult service providers.

4.2 Transitional Care Plan and Meeting

This initial transitional care plan meeting should not be overly formal and should form a part of a young person's usual appointment with the young people's services. This is to avoid overwhelming the young person with too many appointments related to their transition before the formal, multi-agency transitional care planning meeting takes place.

Transitional care planning should take account of the wider system of support in place for the young person. Other support services may have different transition points. Services involved in the wider care and support of the young person need to be informed and updated where appropriate when the young person's drug or alcohol treatment service provision changes.

The transitional care plan should also include measures aimed to ensure that the young person does not drop out of the treatment system. Care should not be formally transferred until the young person is engaged fully with the new adult service provider.

During the transitional care plan meeting the young people's services' worker should do the following:

- Ensure that the young person is given clear information about the adult treatment being proposed and made aware of the differences in criteria and treatment between young people and adult treatment. For example, adult services do not provide assertive outreach in the same way as the young people's services and the young person will be expected to attend clinic appointments rather than have workers visit them.
- Be prepared to address and manage any anxieties the young person may have about the transition process.
- Seek the young person's consent to share personal information and care details with the adult service.
- Be alert for any signs that the young person is at risk of disengaging from treatment. If the young person at any point in the transition process disengages before the transitional process is complete the young people's services' worker is responsible for ensuring that all steps are taken to re-engage the young person with services.

- Examine whether siblings or parental or significant adult substance or alcohol misuse is impacting on the recovery of the young person in treatment. If the workers identify sibling or parental or significant adult substance misuse, they show the young person how they can be referred into treatment.

The transitional care plan should be finalised and agreed. All action points should have a named person with responsibility for ensuring the action is completed. This meeting should also cover:

- Date and time of first appointment with the adult services and whether or not the young person wants the young people's services' worker to attend (such requests by the young person should be accommodated).
- Any difficulties with travel to the adult service should be identified and resolved.
- Arrangements for transfer of the young person's notes/file.
- The formal date of planned discharge by the young people's service.
- Whether or not referrals to treatment for siblings or parents or significant adults have been accepted and how that is progressing.

During the transitional meeting the key worker from the adult service should:

- Be aware of the specific issues and concerns a young person might have about the transition process and take account of these issues.
- Be mindful that the young person may not understand some of the adult treatment service 'jargon' and acronyms and as much as possible this should be avoided.
- Be aware that young people are accustomed to high levels of support and may need additional support from the adult treatment service to ensure that they continue to engage in treatment.

4.3 Follow-up Contact

The young people's services worker and the key worker from the adult service should agree a communication plan to cover the period between the young person's first appointment with adult services and the formal discharge from the young people's services.

The regularity of communication between the workers, the format (meetings or telephone discussions) and the duration will be determined by the complexity of the young person's problems and how well they are adapting to adult treatment services. Workers need to be very flexible at this stage of the transition process and be prepared to meet and retain contact with each other for as long as the young person's needs dictate. Workers should not lose sight of the fact that welfare of the young person is paramount and communication between the services should be retained for as long as necessary. Again the progress or lack of progress of the siblings or parents or significant adults own treatment can also be reviewed.

The key worker from the **adult service** will follow up with the key worker from the young people's services, the young person, their carer and any other relevant individual that has been involved in the transitional process.

This contact should be used to ensure that all action points in the transitional care plan have been completed and that the young person has settled within the adult service and is fully engaged in their treatment.

The meeting should also provide effective discharge of the young person from the young people's services and discharge/ care transfer documentation should also be completed by the young people's services worker. Again the progress or lack of progress of the siblings or parents or significant adults own treatment can also be reviewed, if necessary.

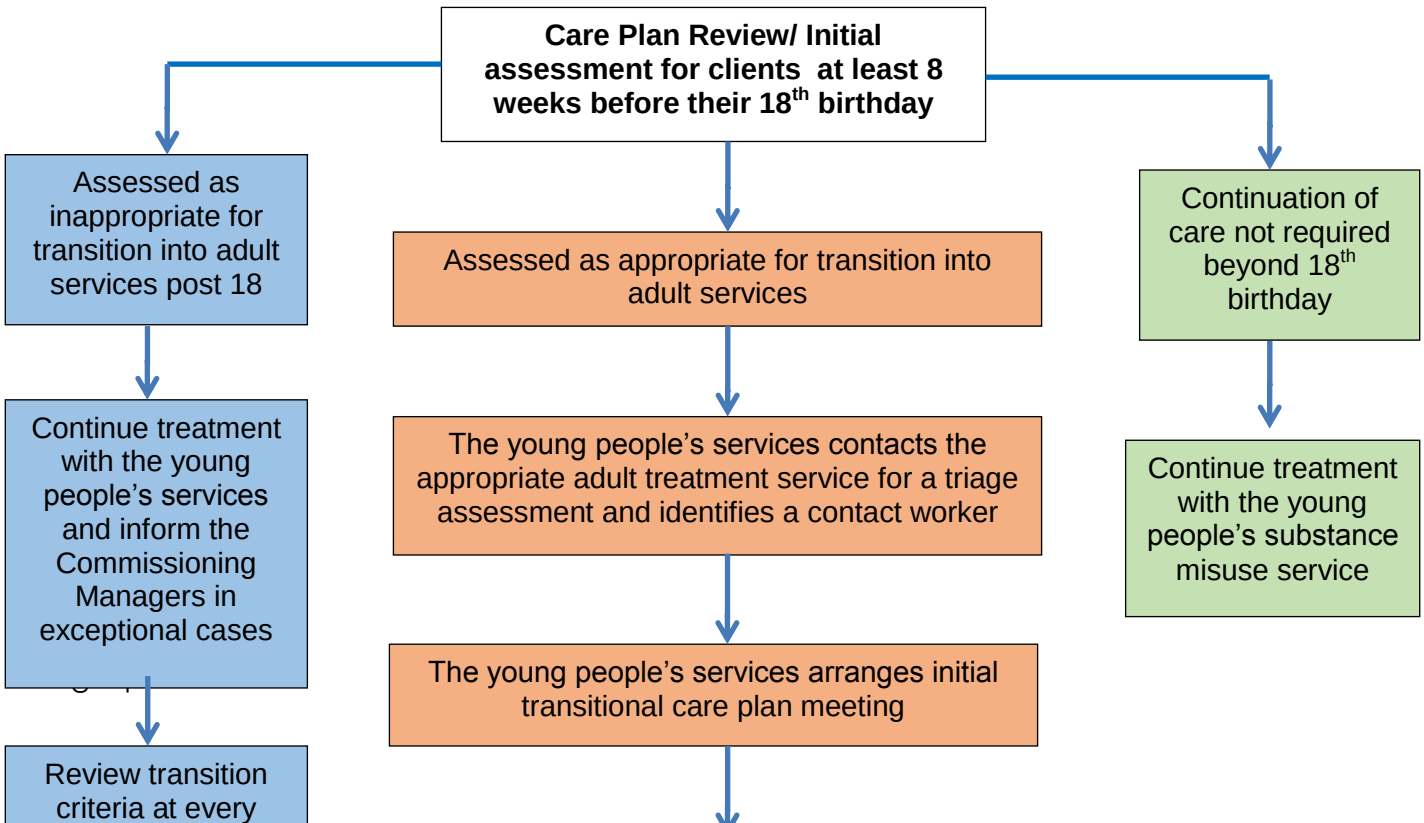
4.4 Managing Transitional Care Planning Meetings

Transitional care planning meetings may be complex and will involve a number of different parties. Some potential issues to consider:

- The meeting should be chaired by the young people's services worker. The Chairperson is responsible for ensuing notes are taken by a professional present at the meeting.
- The meeting may be quite daunting for the young person as it will involve people they don't know.
- The meeting should ensure that there is a balance between the provision of information about the young person's needs and issues without breaches of confidentiality occurring or the young person feeling patronised or 'talked about'.
- The Chairperson should ensure that the young person is not 'over assessed' or put in the position of retelling their story at every meeting.
- Any care plan actions need to be clearly understood by everyone involved and recorded clearly with a copy for everyone involved.
- Responsibility for actions should be shared and should not fall entirely to one worker or agency.
- Opportunities should be taken throughout the meeting to recap on what has been agreed and to ensure that everyone understands the process.

Having agreed any care plans actions, the young people's services worker has the authority, with the consent of the client, to follow them up with the adult service to ascertain their outcome from adult treatment interventions. If there are issues with the actions agreed not being implemented, another meeting may be arranged to resolve the concerns.

4.5 Transition Pathway from the young people's services to Adult Services



5. Out of area transitions

Where possible the above procedure should remain the same for all out of area transitions. This includes young people transitioning to either adult or y.p service in another local authority area.

Out of area transitions can sometimes happen without prior notice and can therefore be difficult to manage. Transitions planning should be carried out in partnership with young people and their families/carers to ensure that they are fully consulted and given adequate information and support about services that are available. They should be fully engaged in any decision making process and as far as possible given real choices.

The following points need to be considered:

- Contact with the Y.P – YPSMS worker needs to establish contact with the y.p where possible and check in around their move and well-being. This might be direct or need to be established through our professionals/family/carers.
- Where appropriate discuss transitioning with in their area as soon as possible to ensure continuity of care and support.
- YPSMS worker to gather contact and referral details of the SMS appropriate to y.p in that area and agree with y.p who is going to contact service.
- Ensure you have verbal consent (written if possible) to share the y.p details with the SMS and contact them to discuss a transition into their service.
- Where possible (distance/travel) a 3-way meeting should be set up, as outlined above, to transfer care to the new SMS ensuring all relevant substance use, risk and safeguarding information is passed on via an appropriate secure method.
- If a 3-way is not possible the YPSMS should discuss the transition via telephone/email and follow up until complete, ensuring that the y.p is aware and feels involved as part of these discussions.
- If a y.p decides that they don't want to engage with the SMS as this time, YPSMS worker should provide them and any other relevant professionals/parents/carers, with details of the service should they want to access support in the future.

6. Appeals against transition decisions

In the unlikely event that difficulties arise and services don't agree with the transition or how it is being managed then they should meet to resolve the issue: if the issue can't be resolved then it should be referred to the commissioners for resolution.

If the service user doesn't agree with the transition then they should contact their keyworker to express their concerns and a further transitional care planning meeting should be arranged by the young people's service worker.

Where the commissioners don't agree with the transition, they should meet to resolve the issue and communicate any actions that will resolve the issue/s to the young people's services and adults services.

7. Intergenerational Substance Misuse

In adult treatment services the treatment and other interventions are provided within a package of care with an identified key worker. The care planning process is the essential component of the client treatment journey. There is a focus on service user's participation in the care planning process, where they are involved in producing and agreeing their care plans.

The care plans usually take place on a 12 week basis, but care plan reviews can be triggered for example when the service user has been arrested for a trigger offence and tested positive for drugs, or experienced any significant life event or change in risk that may impact their treatment and substance misuse.

The service users have a range of needs, from simple to highly complex and this is reflected in the care plan and the intensity of care co-ordination. The key worker co-ordinates care in most cases. The care planning process is for setting goals based on the needs identified by an assessment and planning interventions to meet those goals with the client. Care plans follow four key domains:

- Drug and Alcohol Misuse
- Health (physical and psychological)
- Offending
- Social function (including housing, employment and relationships whether partner or parenting role).

In the care plan it is useful to ask about recovery capital in its broadest sense including family. These questions may elicit information about other family members' substance misuse or caring responsibilities that their children may have to take on. If intergenerational substance misuse issues are identified here are a number of issues that may arise:

- **Hidden harm** – Where children who are not using are identified the key worker records the details of the children and completes the Sheffield Every Child Matters Form and if a risk is identified then social services should be informed, ideally by the Common Assessment Framework (CAF). This will form one of the topics going forward in future care plan reviews.

- **Young Carers** – Where children are identified as being a carer to the substance misusing parent the key worker can suggest a referral to What about Me (WAM) or the Sheffield Young Carers. This again will form one of the topics going forward in future care plan reviews.

- **Young Adults misusing drugs** – where a young person is identified as misusing drugs and/ or alcohol and is not in treatment the keyworker can suggest getting a

referral to the young people's services, so they can commence treatment. If they are in treatment this should also be a topic in the care plan review. This again will form one of the topics going forward in future care plan reviews.

- **An adult/ partner misusing drugs** – where the partner is identified as misusing drugs and/ or alcohol and is not in treatment the keyworker can suggest getting a referral to the appropriate adult treatment, so they can commence treatment. If they are in treatment this should also be a topic in the care plan review. This again will form one of the topics going forward in future care plan reviews.

Throughout the whole care plan process it is important to ensure service users are treated as effectively as possible; therefore any factor impacting on a person's recovery needs to be closely examined in care plan reviews. It is therefore important to have good communication between young people's services and Adult Services as part of a whole family approach to treating the substance misuse in the family.

8. Conclusion

- This protocol has covered transitional and intergenerational substance misuse.
- It is recommending a whole family/all ages approach to substance misuse.
- The overarching principles are recovery and meeting clinical need.
- It is intended that this protocol will be primarily used in children and adult's substance misuse services settings.
- However it may be a useful reference document for other external organisations that come into contact with children, young people or adults with substance misuse issues

8.1 Appendix 1– Adult Drug & Alcohol Services

Sheffield adult treatment for service users with substance misuse who live in Sheffield, whether drugs and/ or alcohol is currently provided as separate alcohol, opiate and non-opiate services. The goal of treatment is to be drug and/ or alcohol free. There is the following treatment for adults in Sheffield:

Opiate Users:

- SPAR (Single Point of Assessment and Referral) assessment.
- Open access Needle Exchange (Opiate Users only) /support.
- Pharmacological (prescribing) interventions.
- Psychosocial Interventions;
- Post treatment recovery support.
- Harm reduction/woundcare.
- Access to referral to inpatient detox and residential rehabilitation

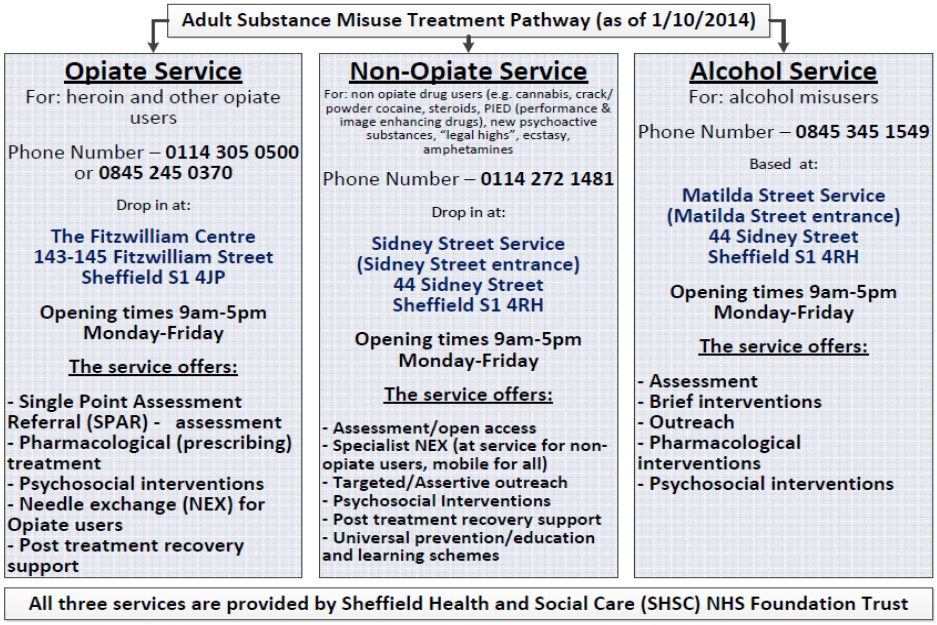
Non Opiate Users:

- Single Point of Contact and assessment;
- Open access support and Needle Exchange (Opiate Users only)
- Mobile provision of Needle Exchange (van and bikes – all IV drug users),
- Outreach harm reduction form Opiate Service into Non Opiate Service;

- Psychosocial Interventions.
- Access to Learning Schemes (for both Opiate and Non Opiate clients);
- Post treatment recovery support.
- Access to referral for residential rehabilitation

Alcohol Users:

- Single entry and assessment point/screening
- Brief interventions and extended brief interventions
- Psychosocial interventions
- Pharmacological interventions
- Post treatment recovery support



8.2 Appendix 2 – Children & Young People's Drug & Alcohol Services

The Corner
Sheffield Young People's Substance Misuse Service

cgl

Who are we?

The Corner is a young person's substance misuse service working with any young people between the ages of 8 and 18 who live in Sheffield. We offer a flexible, non-judgmental, confidential and accessible service.

Central to everything we do is that we are young person-centred, meaning that the support we provide is led by the needs of young people and change is not imposed upon them. We aim to provide the support, education and personal resources to enable young people to make sustained and lasting change.

What we offer

- **One-to-one** young person-centred interventions which promote positive change. This can include advice and information on drugs, harm reduction and structured psychosocial sessions. We have a prescribing service and we offer prescribing treatment to young people where required as part of a clinical treatment plan.
- **Group work** sessions for young people, which provide education and advice to prevent and reduce the harms of drugs and alcohol. These sessions are run across the city in a wide range of venues and are tailored to suit the needs of each client group.
- **Training courses** for professionals working with young people in Sheffield. These are available free of charge to anyone supporting young people in our city. We have a rolling programme of training days and we can also provide in-house training tailored to the needs of each organisation. If you want something more informal like us to attend your service team meeting please get in touch.
- We offer **telephone advice** and information to young people, their families and workers. Call for more information and ask to speak to one of our duty workers – **0114 275 2051**

How to make a referral

For any information or queries regarding referrals please contact us on **0114 275 2051**

Email completed referral forms to: Thecorner.sheffield@cgl.org.uk

Post completed referral forms to 91 Division Street, Sheffield, S1 4GE

How to book onto one of our training courses

Visit our website where you will find dates for our next available training sessions, including Basic Substance Misuse Aware and NPS (legal highs) training.

www.thecornersheffield.com