



***National Treatment Agency
for Substance Misuse***

Undertaking needs assessment

Drug treatment

Recovery and reintegration in the community and prisons

Publication date: July 2009

Question	Answer
What is the document?	Undertaking needs assessment – Drug Treatment: reintegration and recovery in the community and prisons. Information on undertaking an assessment of need for drug treatment, recovery and reintegration services for drug users in the community and prisons
What is its purpose?	Advice to drug partnerships on undertaking an annual needs assessment in relation to the provision of adult drug treatment and reintegration services
Publisher and date	NTA, July 2009
Who is it addressing? How big/wide is the audience?	Joint commissioning managers in drug partnership areas including those who commission healthcare and drug treatment services in prisons Strategic members of drug partnership boards in each local authority, primary care trust (PCT) area, and prisons Stakeholders who want information about needs assessment for drug treatment, recovery and reintegration services
What is it asking them to do?	Take local action to ensure an adequate assessment of need is made for community, residential and prison drug treatment and reintegration services providing advice on possible approach and links with wider statutory, strategic assessments
What is the business reason?	To inform outcome based commissioning of services in line with the requirements contained within the Department of Health World Class Commissioning programme
What if anything does this update, replace or complement?	Previous publication in July 2007
Disclaimer if possible	This document imposes no new demands or requirements on anyone working in the drug treatment field, but is intended to help commissioners and strategic partnerships (community and prisons) to meet existing commitments by providing the latest information and highlighting good practice.
Who is the contact?	NTA regional managers for regional queries or Mark.Gillyon@nta-nhs.org.uk for national queries.
DH Gateway reference	12116

Contents

	Page
Introduction and context	4
Integrated needs assessment and commissioning	5
Needs assessment definition	7
NTA approach	8
Aims and objectives	9
Components of needs assessment	9
Frequency of needs assessment	10
Local process to drive needs assessment	10
Review of existing sources of information	13
Understanding met need	13
Defining the population in need	13
Understanding unmet need	14
Gap analysis	15
Evaluation and prioritisation	17
Completing the process	18
Appendix 1 – Using routine data to identify unmet need	19
Appendix 2 – Checklist for use in evaluating and prioritizing needs	26
Appendix 3 – Publications and resources that may be useful to inform needs assessment	28

Introduction

The NTA first published information on undertaking a needs assessment of the drug treatment system in 2007. Over the last seven or eight years there have been significant improvements to the drug treatment system at a local level (allied to the growth in the pooled treatment budget). However ongoing improvements to the system are needed to enable drug users to work towards drug-free and productive lives. This document develops the previous approach to the completion of a comprehensive assessment of need within a local area (including prisons) and covers the drug treatment, reintegration and recovery agenda – see NTA Business Plan 2009-10 for more detail¹.

It is suggested that the drugs partnership in each local area should have overall responsibility for ensuring adequate assessment of need is made for community, residential and prison interventions. For the purposes of this document “partnership” therefore refers to both the community based drug partnerships and the prison partnerships responsible for the delivery of drug treatment in prisons.

Context

In 2002 the Audit Commission identified the need for housing, social care and other services to provide drug users with support to maintain progress made during treatment: enabling them to become employed, suitably housed and more self-sufficient. Engagement in drug treatment is one of the effective methods of reducing acquisitive crime and crime reduction provides one of the most important benefits of drug treatment to the community and to disadvantaged communities in particular².

The 2008 Drug Strategy³, echoing the Audit Commission’s comments in 2002 and 2004⁴, recognises that the investment and gains that have been accrued as a result of improvements in the drug treatment system need to be maintained and enhanced. The strategy identifies the need to offer real opportunities for those individuals overcoming their dependency (as a result of entering drug treatment) to reintegrate back into the community, thereby rejuvenating their social bonds, with the ultimate goal of leading drug-free lives.

The value of reintegration in securing long-term recovery from problem drug use is well recognised. This needs full engagement of all local stakeholders. The annual process of needs assessment will need to develop the community and prison based reintegration strategy, building on the strengths and capacity of the partnerships to make local decisions on priorities which are already likely to be identified in Local Area Agreements. In the prison setting, needs assessment will be an essential component of the establishment’s drug strategy and healthcare delivery plan.

Historically, drug treatment services have been described as having a sequential approach to community reintegration, with housing and jobs commonly emerging towards the end of the individual’s treatment journey. The approach now needs to develop to provide a focus on integration that runs throughout the treatment journey and beyond, reaching out into wider health and social care provision to consolidate gains made through structured drug treatment.

¹ NTA Business Plan 2009-10, www.nta.nhs.uk

² See for example Millar et al (2008) and Gossop et al (2000)

³ Drugs: protecting families and communities. The 2008 drug strategy. First Edition February 2008. <http://drugs.homeoffice.gov.uk/publication/search/drug-strategy/drug-strategy-2008-2018>

⁴ Audit Commission: Changing Habits (2002) and Drug Misuse (2004)

This approach is consistent with the wider governmental approach to personalisation. 'Putting People First'⁵ outlines a new vision of the future of social care with an emphasis on the individual's dignity, right to self determination, choice, control and power over the support services they receive.

Integrated needs assessment and commissioning

Commissioning outcome-focused services is key to delivering recovery-focused treatment. In the drug treatment sector, outcome based commissioning will need clarity about which types of interventions yield which outcomes, and what is therefore needed in treatment, recovery and reintegration systems to maximise client outcomes.

World Class Commissioning

Broad changes in NHS commissioning arising from the World Class Commissioning programme and the final report of the NHS Next Stage review, "High Quality for all"⁶, specify the competencies, processes and aims of an effective healthcare commissioning system. This represents an increased emphasis on the ability to demonstrate core commissioning skills at an organisational level accompanied by the need for strategic vision, leadership and improved service outcomes. Organisational competencies 5 and 6⁷ outline the requirement to manage knowledge and assess need and prioritise investment based on a thorough understanding of need. "High Quality Care for All", states that all NHS commissioners will be held to account on the quality of health outcomes they achieve for the populations they serve, including the most vulnerable, excluded and those with complex needs.

Evidence based commissioning

The commissioning of consistent evidence-based treatment, available to all, is needed to meet the requirements of the 2007 Clinical Guidelines on Drug Misuse and Dependence⁸, which set out a range of evidence-based treatment interventions. Some of these are well-established and effectively commissioned, others are relatively or entirely new, and will need commissioning implementation plans, based on a competent and strategic understanding of need.

To ensure the local drug treatment system including delivery in prisons, is efficient and effective, partnerships will need to have a systematic approach to reviewing provision against evidence based treatment interventions. A systematic review will facilitate commissioners to identify priorities, evaluate the options available to them within the resource constraints and make evidence based plans to meet need.

The National Institute for Clinical Evidence (NICE)⁹ produces a range of bespoke tools for commissioners to assist those working across a number of complex areas and partnerships to inform both the Joint Strategic Needs Assessment (JSNA)¹⁰ and the drug treatment, reintegration and recovery needs assessment processes. The NICE guidance on undertaking a Health Needs Assessment also provides a wealth of additional references and information regarding tools that can be used in a needs assessment.

⁵ "Putting People First: a shared vision and commitment to the transformation of adult social care"

www.dh.gov.uk/en/Publicationsandstatistics/DH_081118

⁶ High Quality Care for all. Darzi Report, DH, 2008, www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

⁷ World Class Commissioning Vision DH Gateway reference 8754. www.dh.gov.uk

⁸ Department of Health (England) and the devolved administrations (2007). Drug Misuse and Dependence: UK guidelines on Clinical Management, London. Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

http://nta.nhs.uk/areas/Clinical_guidance/clinical_guidelines/docs/clinical_guidelines_2007.pdf

⁹ See www.nice.org.uk for more details

¹⁰ Joint Strategic Needs Assessment guidance. www.dh.gov.uk/en/.../JointStrategicNeedsAssessment/index.htm

Drug Strategy

The 2008 Drug Strategy¹¹ places an additional emphasis on the commissioning of reintegration and recovery based interventions. This includes enabling drug misusers to gain education and employment, and focuses on the family and communities affected by the drug misuser, with a call for more recognition of the support that children of drug misusing parents need.

Crime and Disorder Reduction Partnerships(CDRPs)/Community Safety Partnerships: Strategic Assessments

The statutory framework¹² regulating CDRPs requires partnerships to include the following components in a local strategic assessment:

- Analysis of the levels and patterns of crime, disorder and substance misuse
- Changes in the levels and patterns of crime, disorder and substance misuse since the last strategic assessment
- Analysis of why these changes have occurred
- Assessment of the extent to which last year's plan was implemented

Joint Strategic Needs Assessment (JSNA)

The Local Government and Public Involvement in Health Act, (2007) created the requirement for Joint Strategic Needs Assessments conducted between communities, local government and the NHS to provide a firm foundation for commissioning that improves health and social care provision and reduces inequalities. This vision of stronger partnership working is reinforced in the cross-sector concordat "Putting People First: a shared vision and commitment to the transformation of adult social care". The guidance on JSNA¹³ says that "needs assessment is an essential tool for commissioners to inform service planning and commissioning strategies". It indicates that the JSNA will contain a range of information to inform a number of local authority and PCT strategies and plans and that ensuring linkage of these plans will encourage joined-up commissioning across health and social care. The drug treatment, reintegration and recovery needs assessment and subsequent plans should seek to make a significant contribution to the JSNA process.

Prison Health Needs Assessment

In prisons, each establishment will already complete a baseline health and social care needs assessment which is reviewed and amended on an annual basis. This assessment differentiates between the need and demand for healthcare services¹⁴. In addition the prison drug strategy standard 10 requires a needs assessment for substance misuse services. Community and prison based drug partnerships will ideally wish to work together on a joint assessment of need within their partnership area.

Supporting publications

The NTA suggest that it is good practice for the outcome of any drug treatment needs assessment to have clear and demonstrable links to the wider findings of both the local Joint Strategic Needs Assessment and the Crime and Disorder Reduction Partnership Strategic Assessment.

¹¹ Drugs: protecting families and communities. The 2008 drug strategy. First Edition February 2008.

<http://drugs.homeoffice.gov.uk/publication/search/drug-strategy/drug-strategy-2008-2018>

¹² Delivering Safer Communities: A guide to effective partnership working. Guidance for Crime and Disorder Reduction Partnerships and Community Safety Partnerships. September 2007.

http://www.crimereduction.gov.uk/guidance_for_effective_partnerships.pdf

¹³ Joint Strategic Needs Assessment guidance. www.dh.gov.uk/en/.../JointStrategicNeedsAssessment/index.htm

¹⁴ Guidance – Healthcare in Prisons – a health care needs assessment (University of Birmingham 2000)

There are a range of existing and upcoming publications from the NTA and others which inform the above agenda, which partnerships may wish to refer to in the context of their next round of needs assessment. A list of these documents is included in Appendix 2.

Needs assessment definition

NICE provide a comprehensive guide which defines health needs assessment as a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities¹⁵. This NTA document is designed to focus on ensuring there is appropriate capacity within relevant drug, recovery and reintegration services. Such an assessment will need to take full account of the gender, ethnicity and other diverse needs of the target population and any unmet needs from this perspective. The assessment will also need to be undertaken in accordance with the requirements of the national guidance on undertaking an equality impact assessment¹⁶.

¹⁵ NICE guidance on Health Needs Assessment – www.nice.org.uk

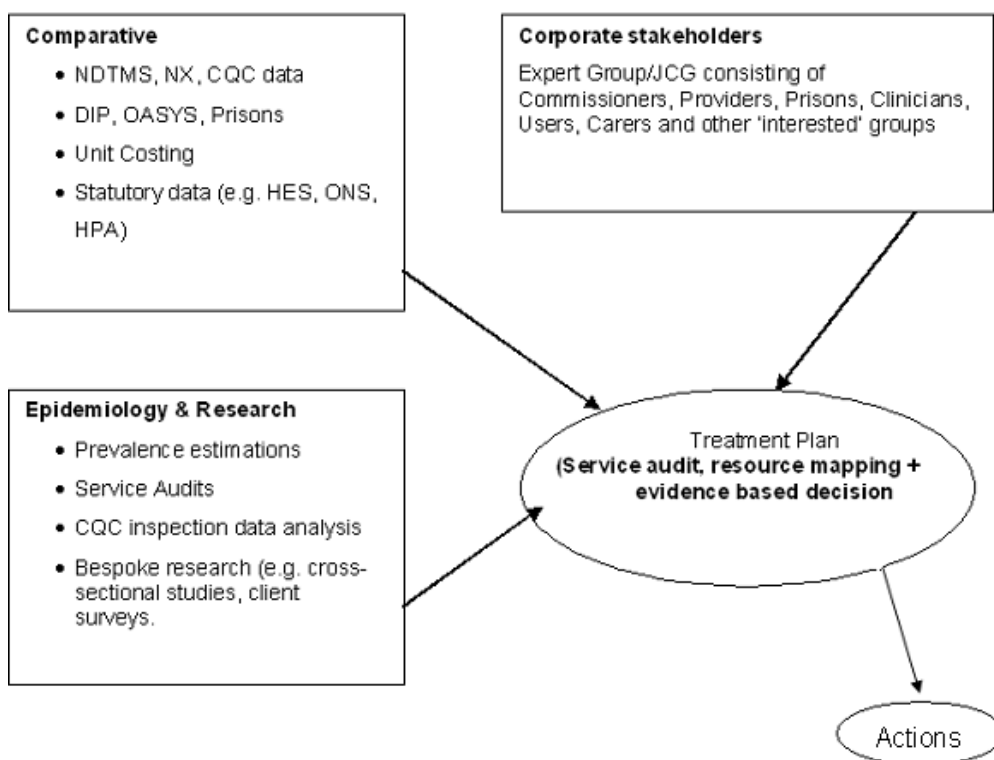
¹⁶ DH Equality impact assessment: summary tool and guidance for policy makers. www.dh.gov.uk

NTA Approach

A range of health needs assessment approaches have been suggested since the early 1990s and each has its place in the comprehensive needs assessment approach required for formulating plans that reduce the harms associated with drug use. In broad terms, these are:

- **Epidemiology and Research:** the collection, analysis and interpretation of data (both quantitative and qualitative); to generate hypotheses and answer them
- **Corporate:** determining and balancing the views of a range of local and regional stakeholders; building their commitment to the resulting action plans
- **Comparative:** assessing existing provision against service standards, national targets and other comparable areas

Combined, these provide a robust and systematic process for the production of evidence-based treatment plans. The needs assessment should be seen as a strategic process, owned and understood by stakeholders and is an integral part of treatment planning, implementation and performance assurance.



Aims and objectives

The purpose of a needs assessment is to examine, as systematically as possible, what the relative needs and harms are within different groups and settings, and make evidence-based and ethical decisions on how needs might be most effectively met within available resources.

Effective needs assessment for drug treatment, recovery and reintegration systems involves a process of identification of:

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

The identification of the above should provide a shared understanding by the partnership of the local need for services which then informs treatment planning and resource allocation.

The needs assessment should profile the diversity of local need for treatment, including rates of morbidity and mortality (for example, infection with blood borne viruses), the degree of treatment saturation or penetration, and impact of treatment on individual health, public health and offending. The approach will benefit from a clear understanding of the socio-demographic profile of problematic drug users, including their children and families, as well as examining the referral routes into treatment, levels of effective engagement with the treatment, reintegration and recovery system and successful discharges and outcomes from treatment interventions.

The needs assessment should consider the full range of drug users needs including the need for harm reduction services in their own right¹⁷ as well as reintegration and recovery services. It should also be able to shed light on employability needs of service users and on levels of housing need amongst the treatment population.

Components of needs assessment

The process of needs assessment is likely to involve the following components:

- Establishing a local process to inform and drive the needs assessment
- Reviewing the existing sources of information available at local, regional and national levels and deciding the key questions that are to be asked at a partnership level for the needs assessment exercise
- A mapping of existing services and a description of the client profile
- Identification of needs and harms among groups currently not in treatment as well as among those in treatment

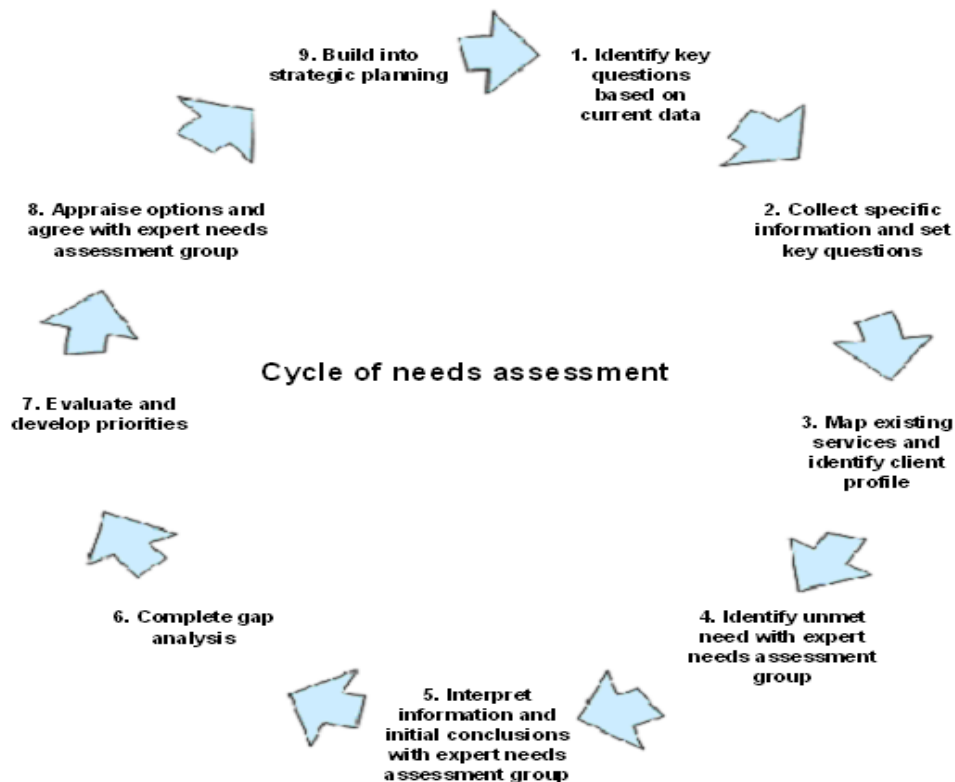
¹⁷ Partnerships may wish to consider use of the Audit Support for Needle and Syringe Programmes published by NICE in July 2009 – NICE public health guidance 18. www.nice.org.uk/PH18. This tool is made available to all PCTs and SHAs.

- Understanding unmet need; analysis and interpretation of the above, including discussion and challenge by an expert group(s) in order to draw initial conclusions
- Evaluation and prioritisation; completing a gap analysis and self assessment of the current state of both commissioning and delivery systems and evaluating and prioritising the identified needs, harms and gaps, appraising the options for meeting those needs
- Drawing up and implementing the resultant plan(s) including allocation of resources

Frequency of needs assessment

The needs assessment can be regarded as an on-going process which will improve year on year in its sophistication. It is anticipated that most systems will require a comprehensive needs assessment every three to five years, with an annual refresh.

Needs assessment is not an end in itself, but a means by which partnerships make evidence-based and pragmatic decisions about treatment, reintegration and recovery services, including harm reduction initiatives in their local communities and prisons.



The local process to drive needs assessment

Steering group

Needs assessment is a strategic activity that is closely linked to the planning process. It is desirable that the partnership joint commissioning group act as a steering group throughout the stages of the needs assessment, drawing in additional specialist support as required. For those prisons introducing drug treatment from 2010 onwards, it is suggested that the prison Integrated Drug Treatment System (IDTS) lead, the drugs partnership IDTS lead and the PCT IDTS lead act as a steering group throughout the stages of the needs assessment, drawing in additional specialist support as required for

the initial year. The suggested terms of reference for the Joint Commissioning Group (JCG) steering activity are:

- To ensure that the needs of service users are the focus of the needs assessment
- To agree the process of needs assessment for prisons within the partnership area
- To bring together people with a range of skills and responsibilities (including data analysts) i.e. identifying the right people to involve
- To ensure that the process of needs assessment is done properly including identification of what is to be assessed, ensuring questions asked are as specific and focused as possible and that the various steps of the methodology are taken effectively
- To ensure that the needs assessment is completed in a reasonable timescale and can be endorsed appropriately by the JCG and other key partnership boards, meeting all deadlines for consultation and submission
- To ensure that the key findings are prioritised within the resources available, and then result in action

Expert group membership

As part of the needs assessment process it is suggested that the JCG set up expert group(s) to expand upon the knowledge and skills contained within the JCG and to ensure the widest possible consultation with stakeholders. The expert group(s) will benefit from a balance of:

- Those whose professional roles mean that they have something to add to the process, for example, service providers from health, social care, housing, employment and criminal justice agencies as well as data management/analysis and research expertise
- Those with an interest and experiential expertise in the issues, for example service users (including those who have spent time in prison), families, carers, the wider community
- Those who can make changes happen, for example, managers, commissioners and planners

Ideally, throughout the year, the partnership will use existing consultative and involvement activities to inform the needs assessment process. As far as possible existing structures and opportunities for consultation can be used so that needs assessment is fully integrated into partnership structures, rather than adding additional demands.

Suggested timetable

It is envisaged that needs assessment will be revisited throughout the year by the JCG. The expert group element can usefully be called upon at three specific points in the needs assessment process

- To assess initial data and to critically evaluate it. The initial expert group meeting will wish to assess relevant data against local experiences, determine what other local databases could be used, and test the main analytic methods to be employed. Treatment system maps can be used. The outcome will provide the JCG steering group with information to identify the main questions to be tested in the current round of assessment. Relevant staff can then be tasked with undertaking the detailed work required to draw up interim findings
- The expert group(s) can then test the data and interim findings, and the attempts to link different data sources. Following this, discussion can focus on agreeing

the emerging key unmet needs, their relative importance and how these needs might be prioritised

- On completion of the full or refreshed needs assessment report, the expert group can be used as a testing mechanism for the final data collation and interpretation, for the initial translation into identified unmet needs and to assist with the generation of recommendations for key priorities for inclusion in the relevant plans.

Expert group process

Prior to holding the first expert group meeting or other consultative events it is suggested that the following is agreed by the JCG:

- Who will be involved in working on the needs assessment process
- Who is responsible for the overall management and leadership of the process
- How much time is needed for meetings and work between meetings
- How is this to be created and managed
- Where and when will meetings be held and how to ensure that relevant information is circulated before the meetings
- Who might facilitate the expert group meetings, lead the discussions and ensure participants understand the task (and the stage the process is at), manage the time available and keep to agreed ground rules
- Who is going to lead the specific pieces of work required following each meeting

When holding an expert group meeting the following checklist may be useful:

- There will need to be an introduction to the process and an explanation of which stage in the process has been reached
- Outcomes for the current stage will need to be clearly identified
- A written summary of what has been agreed should be produced and circulated
- An estimate of the time required for the tasks to be undertaken between expert groups, and for the expert group meetings themselves, should be made as part of the project plan
- Background information, concepts and definitions should be agreed and disseminated
- Issues to consider before undertaking the tasks should be clearly communicated and made available where possible before meetings
- Key questions to be addressed should be clearly communicated from the JCG to the expert groups
- Detailed procedures for undertaking each stage of the work should be agreed in advance

Review of existing sources of information

The aim of data collection is to build up a picture of the overall size and nature of the need in a local area for a range of harm reduction and treatment interventions. An initial task is to bring together information that is available in the local area and prison establishment about the delivery of services that form the local treatment, reintegration and recovery system. The aim of gathering this information is to establish the range of needs currently being met by services (including their capacity and accessibility), thus bringing into focus the gap between the needs of the target population and current service provision. This analysis will then enable key questions to be asked, for example:

- Does the range of provision meet identified local needs?
- Is there evidence of unmet need which remains to be addressed?
- Can what has been commissioned be improved upon in terms of accessibility, effectiveness and cost-efficiency?

Needs assessment involves the collection of data from a number of sources. In some cases the data will already exist in the form of routinely collected data sets, the results of local population surveys, and published or unpublished research papers. Other information will have to be collected through, for example, focus groups or one-to-one interviews with practitioners and service users. See Appendix 1 for more detail.

Understanding met need: treatment system mapping

In order to make use of the information collected, the treatment system can be mapped against a description of the client profile in relation to referrals, throughput, effective engagement and outcomes. This data is recorded via the National Drug System Monitoring System (NDTMS), and is provided to partnerships annually by the NTA with technical guidance on using the data. This will identify the numbers and type of clients that are flowing into, out of, and between services. Once a map is assembled, the expert group can then investigate the ethnicity, gender, drug use, age, discharge, employment status, housing status and the effective engagement levels of groups of individuals. This enables the identification of where there are gaps in services, under utilisation of services, or blockages in the treatment system.

Defining the population in need

Local prevalence

In order to appropriately judge the level of need in the partnership area, and make informed commissioning decisions to meet that need, it will be necessary to understand the prevalence of drug use that is causing harm to individuals and the community. Establishing prevalence is key to knowing how effective the partnership has been in providing treatment to meet need hitherto (what has been termed “treatment penetration”) and also in balancing the relative harm of drug misuse to those in treatment as well as out of treatment. It is possible, for example, that there are higher harm causing groups of drug users who are not accessing treatment (but would benefit from it) than some of the groups that are already in treatment due to historic commissioning patterns.

Partnerships may wish to consider establishing local prevalence using a case-finding and enumeration methodology. This essentially identifies groups of drug users who are accessing health, social care, employment, housing and criminal justice services but who are not accessing specialist treatment, and then quantifies and profiles these clients. The advantage of this particular method is that the data sources used relate to actual individuals (rather than being statistically modelled and therefore relating to hypothetical groups of individuals). The process of case-finding and enumeration, by

definition, enables partnerships to know where these clients are in the partnership area, their profile, and to consult with them about their needs. Any process of case-finding and enumeration to establish local prevalence should be used to add value to the nationally accepted problematic drug user (PDU) prevalence estimates as provided by the Home Office¹⁸.

Partnerships should ensure that any attributable data used at a local level for needs assessment is used within the context of the Data Protection Act and any Caldicott Guardian requirements.

Understanding unmet need

Within any local partnership area there will be groups of drug users not in contact with structured treatment services over the past two years or more. These are termed “treatment naïve” and essentially comprise a group of drug users who are believed to exist, possibly in contact with non-drug specialist services, whose needs have not yet been met. Establishing the size of that group of drug users is a matter of estimating the total population of drug users and subtracting from it those known to treatment.

Partnerships will need to develop a clear understanding of the unmet need in the local area or prison, both to ensure that there are adequate early intervention and support services in place in the partnership area and also to inform the future commissioning of structured treatment to meet these needs. By identifying groups of drug users in contact with other health, social care, employment, housing and criminal justice services, partnerships will:

- Build up a clearer picture of local prevalence, testing statistical estimates of PDUs against locally available data sources
- Develop a more sophisticated profile and understanding of groups not in treatment and factors which may influence that and thereby improve evidence-based commissioning

See Appendix 1 for some tips on research, handling and interpreting data and mapping analysis.

Appraising data

Data, qualitative or quantitative, is one form of evidence upon which decisions are made and services are planned. Sound critical appraisal skills are needed when incorporating data into JCG/expert group business. Data will allow the JCG/expert group to investigate and in turn generate a series of questions which will need challenge and discussion before a final judgment is made on the basis of it. For example:

- Is there a difference between the profiles of drug users engaged in treatment now compared to those known in the past two years or to those unknown to services?
- If so, what are these differences?
- Does the profile of drug users engaged in treatment vary by drug, gender, ethnicity, age, referral source, housing status, GP registration and so on?
- Where are the groups who fare less well?
- Why do they fare less well? What can be done?
- Is treatment engagement geographically influenced? For example, distance to travel to service, or variation in quality of service and initial assessment across the area

¹⁸ Home Office prevalence data, available at: http://www.nta.nhs.uk/areas/facts_and_figures/prevelence_data/default.aspx

- How does local NDTMS data compare, demographically, to the general population at risk? Are there discrepancies in the profile and what might explain these?
- What is the local incidence and prevalence of hepatitis C among drug users in treatment and needle exchange?
- What is the local incidence and prevalence of other blood borne viruses among drug users in treatment and needle exchange?
- What is the balance of individuals on a maintenance or abstinence based pathway? Is this balance consistent with ambitions for recovery?
- Is there unmet need which is linked to poor pathways? For example, individuals may have an employment, training or housing need but the system may not have good links to housing services or the local job centre

Gap analysis

The process of needs assessment is intended to facilitate an analysis of gaps in the local treatment system which can then be tested out with the expert group.

When undertaking the gap analysis, it may be helpful to classify the needs of the target population into a small set of categories. For example, the needs of drug users may be simply classified as:

- Health-related needs: the need for help and advice to prevent or reduce the harm associated with drug use, and for treatment to improve physical and mental health
- Addiction-specific needs: the need for treatment, care and aftercare relating to drug use
- Accommodation-related needs: the need for shelter and housing, both during times of crisis, and in the long-term. For example, if housing is identified by the expert panel as a gap, it will be necessary to draw on available data from Supporting People, local authorities, homelessness services, hostels etc.¹⁹
- Employment-related needs: the needs for training in basic skills, counselling to increase motivation, confidence and self-esteem, and the need for access to employability services and employment opportunities
- Offending-related needs: need for interventions to address offending behaviour for example, increased focus on offending within care planning, group work programmes

When considering membership of the expert group, partnerships should anticipate which members would be in a position to facilitate access to relevant data sources, for example, PCT Directors of Public Health for health data, representatives from local Health Protection Units for Health Protection Agency data.

The results of the gap analysis may be used as the basis for further exploration of needs when consulting service providers and service users about future plans to meet gaps in provision.

Partnerships may find it helpful at this stage to write up their findings on unmet need summarising the demographics of unmet need, the potential harms emanating from

¹⁹ This is not to suggest that the drugs partnership should necessarily be commissioning local employment or housing schemes but partnerships will wish to ensure that robust pathways to the mainstream services are established and functioning.

unmet need, potential numbers and whether or not they are more or less likely to be in touch with services.

Following the gap analysis stage, partnerships should have a reasonably clear idea of the needs of the local area target population and will be able to use the findings of their expert group to audit and quality assure existing services against identified needs and, where necessary, de-commission services and develop new services that will go towards meeting newly identified or emerging needs.

Evaluation and Prioritisation

Defining priorities within the resources available

Priorities will need to be defined within the resources available. For example, if the needs assessment identifies that a particular group is being less effectively engaged than other groups, or that a particular service within the treatment system has comparatively poor retention, then there may be a number of strategies appropriate to address the issue. These could include:

- Work to improve continuity of care between providers within the treatment system, for example agreeing discharge protocols, mapping of client journeys, reviewing referral criteria
- Reconfiguration of existing services to address unmet need, for example, evening and weekend opening, broader/more flexible range of services offered
- Re-commissioning of individual services (or if appropriate whole treatment systems) to address unmet needs thus improving retention and successful outcomes

Essentially, the JCG needs to ask the following questions of the expert group findings:

- Was the treatment system commissioned on the basis of need or has it grown 'organically'?
- Are the services currently commissioned fit for purpose? That is, are they effective, efficient, do they meet local needs and deliver an appropriate range of services?
- Are services commissioned strategically?
- Are unnecessary gaps and duplication avoided whilst taking into account client choice and best value?
- Can the partnership work with what is in place to address the gaps identified or does it need to look at re-configuration/re-commissioning?
- Is the workforce competent and committed to delivering what is required?

Before undertaking re-commissioning of specific services, the partnership needs to be clear that the identified gap relates to the specific service provider as opposed to reflecting weaknesses in the wider system.

Response relating to treatment systems workforce

Needs assessment should prompt partnerships to review the capacity and capability of the workforce to deliver the priorities identified. Key questions may be:

- Are there issues regarding the recruitment and retention of sufficient staff and of staff with the necessary skills?
- Are there skills needs in the workforce regarding effective case management and care coordination?
- Are there skills needs in the workforce regarding the delivery of evidence based psychosocial, families and couples, prescribing and reintegration interventions?
- Are there skills needs amongst support staff to ensure effective reception services and administrative/data management support to the treatment system?
- Are there skills needs in clinical supervision, service management and commissioning?

In undertaking such a review, the partnership can draw on the material referenced in Appendices 2 and 3.

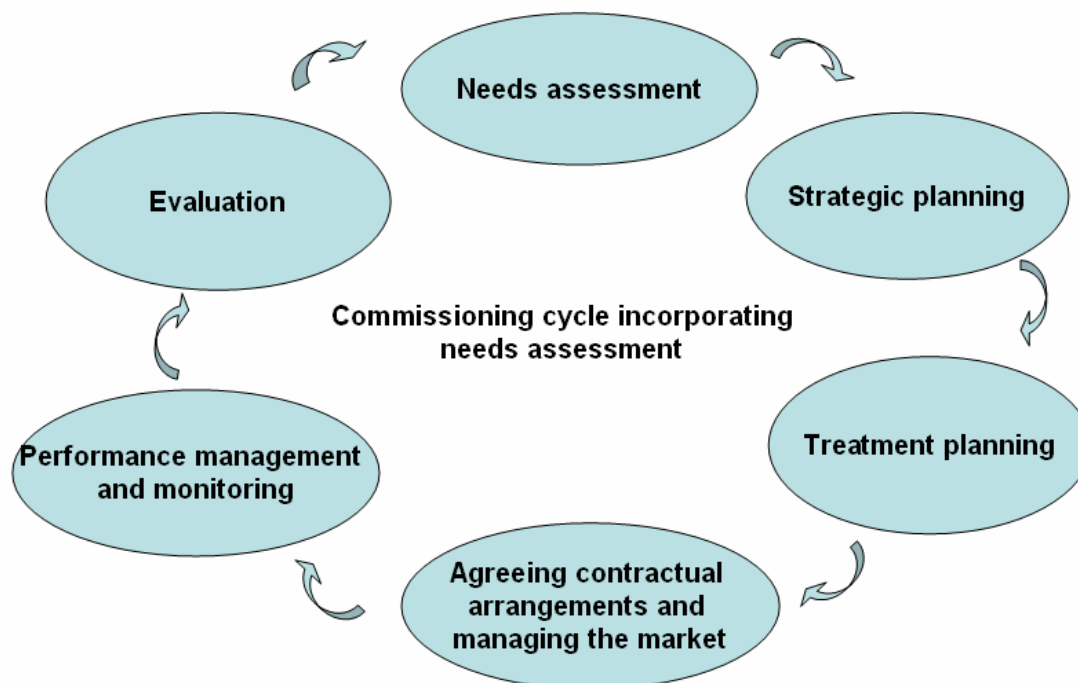
Completing the process

As part of the cycle of needs assessment, partnerships will wish to complete a summary of the needs assessment work which has been undertaken and set key priorities for the coming financial year. The summary will be a useful tool for the planning cycle each year. Details for use of the summary are included in the relevant NTA planning guidance.

Commissioning, monitoring and evaluation

Quality commissioning is based upon effective needs assessment processes and is followed up by performance assurance arrangements which monitor and evaluate the developments planned and commissioned in line with evidenced need.

There is no single approach to the commissioning or joint commissioning process, and organisations involved will wish to develop strategies that best fit their local circumstances. In all instances a commissioning cycle framework will be required alongside a quality assurance or performance management process. These two frameworks or processes will mirror each other as well as being interdependent on the needs assessment annual cycle. All will identify important factors to take into account. Monitoring and evaluation are an integral component of the process of needs assessment and evidence gathered as part of performance monitoring and management can then be used as the basis for further needs assessment.



Appendix 1

Using routine data to identify unmet need

Data sources

The National Drug Treatment Monitoring System (NDTMS) relates to the process of collecting, collating and analysing information from and for those involved in the drug treatment sector. The NDTMS is a development of the Regional Drug Misuse Databases (RDMDs), which have been in place since the late 1980s. Please see <http://www.nta.nhs.uk/areas/ndtms/default.aspx> for more details.

During the initial assessment of clients who come into contact with the Drug Interventions Programme (DIP), information about their needs is gathered using a form called the Drug Intervention Record (DIR). The Drug Interventions Record (DIR) was introduced in 2005 and is used across England and Wales in the community and prisons. Please see <http://www.nta.nhs.uk/areas/criminaljustice/default.aspx> for more details.

Whilst DIP undoubtedly provides the single largest source of data on drug users 'hidden' from the treatment system, a range of other local data sources may be available which could be used to help identify, profile and target problem drug users. Some of the data sources below may be obtainable with identifiers to enable matching, others may not but are certainly still worth obtaining to give additional quantitative 'insight' into problem drug use in the partnership area. In either case, care should be taken to consider the presence of overlapping data records in multiple datasets and the use, particularly in Tier 2 delivery datasets, of false and/or incorrect attributors. Partnerships are advised to discuss with their regional Public Health Observatories (PHO) or NDTMS teams the potential to match other sources of data against NDTMS if attributed treatment data is not available to Partnerships.

- **Needle exchange data:** this is probably the richest additional source of data on those who are either engaged at a low or intermittent level in the treatment system or are unknown to treatment. Attributable needle exchange data may be available locally and this could be matched with NDTMS data. However it has been noted that many choose to give incorrect attributor information and this will need to be taken into account in order not to overestimate those unknown to treatment. Care should also be taken to identify those appearing at needle exchange services for steroid and other performance enhancing drugs so that these can be excluded as required. If needle exchange data is not already collected a 'snapshot' survey could be carried out of clients attending the schemes allowing the anonymous profiling of demographics, drug use and if they are in contact with treatment providers.

Where needle exchange data is available but without attributors, it should be borne in mind that many drug misusers are known to attend at multiple exchanges, and also at treatment services, therefore caution should be used when this data contributes to quantitative 'insight' and the support of the local expert group should be sought in interpretation.

- **Hospital Episodes Statistics (HES):** these are available from PHOs and contain records of all hospital admissions in a year, for those aged 16 – 64 years. This data is available from 1996/97 enabling trends to be factored into your analysis. The HES data does carry attributors (date of birth, full postcode, sex and ethnicity) however, access to this sensitive data will not be widely available but may be supported in digest form from the PHOs. It should be noted that there is variation both across and within regions with regard to the collection of comorbid diagnoses

and an understanding of this variation as applied to the local area should be sought from the appropriate PHO.

Drug Related Diagnoses

The most useful records are likely to be based on episodes of treatment that have drug related diagnoses that are *probably* due to drugs misuse (F11, F12, F13, F14, F15, F16, F18, F19, X42, X62, Y12). These diagnoses are broadly ‘mental and behavioural disorders’ due to the use of illicit drugs, and poisoning by illicit drugs. A full list of definitions can be found below. These may occur as primary or subsequent diagnoses and analysis should reflect that. There are many other diagnoses that are relevant to drugs *use*, but not necessarily persistent *misuse*.

F11	Mental and behavioural disorders due to use of opioids
F12	Mental and behavioural disorders due to use of cannabinoids
F13	Mental and behavioural disorders due to use of sedatives or hypnotics
F14	Mental and behavioural disorders due to use of cocaine
F15	Mental and behavioural disorders due to use of stimulants, including caffeine
F16	Mental and behavioural disorders due to use of hallucinogens
F18	Mental and behavioural disorders due to use of volatile solvents
F19	Mental and behavioural disorders due to use of multiple drug use and use of other psychoactive substances
X42	Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
X62	Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
Y12	Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent

Suppression of data

In order to ensure the confidentiality of patients, all data items that indicate small numbers of clients i.e. below six individuals, will be suppressed to ensure that individuals cannot be identified.

Breaking down the data

A practical breakdown of the data for most drugs partnerships is by: local authority, age (under 18, 18–29, 30–39, 40–59 and 60+), and sex. Partnerships with a significant number of BME clients may also find it useful to add ethnicity to this breakdown. However in most cases ethnicity is most usefully analysed independently to avoid problems due to small numbers. HES stores ethnicity data in the same format as NDTMS, therefore groups of clients can be analysed, i.e. white, mixed, asian/ asian British, etc.

The breakdown suggested would mean that most partnerships would have data available in most fields. Data at each end of the age range - under 18s and over 60s - may be patchy.

Coterminosity

All drug partnerships are based on Tier 1 local authority boundaries and therefore it is possible to select HES data on this field and avoid difficulties with coterminosity issues. HES can aggregate data to smaller 2001 Census Output Areas which may also be useful for geographical mapping where these skills are available within the partnership.

HES Query Definition

The process for using the web-based HES query definition used to construct the data aggregation is set out below. Access to this system is through the local PHO and in some cases, through PCTs.

1. From classes and objects select the following result objects:

LA of residence

- From geographical (derived) data/residence
- Substitute 2001 Census Output Area here if required

Gender

- From patient data

Age at start of episode

- From patient data
- All ages, as opposed to age groups, need to be selected here, and then aggregated outside HES to form suitable age bands for substance misuse needs assessment

Ethnic category

- From patient data

Total Patients

- From statistics/ungrossed/finished consultant episodes

2. Choose the following pre defined condition:

- Finished consultant episodes

3. Save and close the data manager

- This will produce an empty report

4. Use the HES Wizard to select the diagnoses described above

5. Refresh the report

- This will produce the desired report.

The data will need to be removed from the HES system and aggregated locally to produce suitable partnership data.

Further information : Please contact your regional NDTMS team for further information.

- **Prescribing Analyses and Cost data (PACT)** records all prescriptions issued within a PCT area. It can identify where clients are being prescribed outside of formal shared care and specialist GP schemes and the total volume of methadone/buprenorphine being prescribed and the number of prescriptions issued for methadone/buprenorphine and other symptomatic prescribing.
- **Health Protection Agency data:** disease notifications, prevalence data, surveillance systems may be available for analyses on blood-borne virus morbidity but is of variable quality across and within regions.

- **Office of National Statistics (ONS) data** on drug-related deaths.
- **Joint Strategic Needs Assessment data:** information and analysis will have already been collected around drug misusers and crime within each Partnership area and could be re-used in the context of needs assessment for drug treatment.
- **Other health services data:** NHS walk-in centres, Accident and Emergency departments, minor injuries units, sexual health/HIV services, community mental health services and primary care/GP practices will all work with drug users not in contact with drug services. They may already collect some data on drug use but if not it would be worth discussing with PCT colleagues the potential for this in future. Where ambulance policies are in place around overdose, this data may also be extremely useful particularly in terms of trends in incidence.
- **Consultation with users:** user involvement documents (surveys, notes from patient consultation meetings etc.) will provide a rich source of information about user experience and suggestions for improvement.
- **Criminal justice data** – in addition to the DIP data provided by the NTA, each partnership area will have the full Drug Interventions Record (DIR) database available (without attributors in non-intensive areas). Probation areas and prisons collect assessment data through the Offender Assessment System (OASys) tool together with local police and crime statistics and locally derived information in relation to prolific and persistent offenders.
- **Prison-related data:** the aim of data collection is to build up a picture of the overall size and nature of the prison's needs for harm reduction, structured drug treatment interventions and continuity of care processes. No single source of information will be able to give the total picture, but several sources taken together may give different pieces of the puzzle. Some data will routinely exist and be made available regionally or nationally. Other information will be collected locally and in different ways, such as user surveys or particular research projects for instance.

Core throughput data from the Interventions and Substance Misuse Group (ISMG): ISMG collects monthly data, usually via the office of the Director of Offender Management, known as invoice calculators. Subject to this being available at an establishment level, this may be a helpful source of information to contribute to the needs assessment process

Core data provided via Drug Intervention Record (DIR) reports

This will provide quarterly reports from 2008/09 onwards on:

- Number of individuals commencing drug treatment
- Number of individuals referred by CARATs and picked up by Criminal Justice Intervention Teams (CJIT) at end of sentence
- Clinical performance
- Continuity of care performance
- New treatment commencements
- Treatment intervention commencements
- Releases
- Drug user profile (ethnicity and presenting substance)

Offender Health Development Plan and Health Needs Assessment

The latest prison healthcare needs assessment is likely to contain a wealth of information about the general healthcare needs of prisoners, covering major healthcare issues such as epilepsy, asthma and diabetes, Health Protection Agency data, the prevalence of mental health issues, and the prevalence of alcohol,

cannabis, stimulant and opiate dependence. Such information will help assess the adequacy of care pathways between drug treatment and other health provision in the prison.

The Prison Drug Strategy Group Standard 10 Annual Needs Assessment

The prison drug strategy group has responsibility for the overall drug strategy in the prison, including treatment, and must produce an annual assessment of local drug and alcohol treatment needs and priorities, including staff training needs. This needs assessment will include data on key performance targets, drug testing programmes and attendance on drug treatment programmes. Ideally the findings and priorities of this assessment would aim to be integrated with the timing and content of the IDTS needs assessment.

Other prison data

Each prison may well have its own particular sources of qualitative and other information available, a recent survey of families for instance, a particular study into blood borne virus rates, information from the disinfecting tablet scheme giving clues to unmet need, reports from the resettlement team etc. These will all help to create the overall picture.

- **Police:** intensive DIP areas are required to drug test offenders committing “trigger offences”. Data on positive test results, along with arrests for possession of drugs, represents a valuable insight to the drug using population of an area. Police Intelligence Units will also have a wealth of useful information around drug supply/market/price/availability trends which are produced for regular, operational Tactical Assessments which may be accessible in some form.
- **Skills and employment:** local skills, employment and treatment providers may have relevant information on needs and take up of these services from the treatment and drug using population. Data can also be accessed from:
 - Using the JobCentrePlus Progress2Work and Link Up web based management information tools, JobCentre managers can access information at a regional, district and provider level on take up of services, referral source including drug treatment provider, age, gender and ethnicity.
 - OASys: probation information managers can access information on numbers of offenders with employment or training needs who also have a drug problem to varying levels.
- **Housing services:** supported housing, assertive outreach, floating support and tenancy support services provided by the local authority or voluntary sector may provide rich sources of data on clients not in contact with drug services but with problem drug use. The following data sources can inform needs assessment for housing and housing support:
 - Supporting People Client Record (Department for Communities and Local Government), data on numbers of people entering supported housing or receiving floating support who have a drug problem as a primary or secondary need. Drug partnerships received quarterly from NTA.
 - CORE housing association data - records the number of people placed in specialist supported housing designated as accommodation for people with drug problems. Available from the CORE website. <http://core.tenantservicesauthority.org/>
 - Local authority homelessness statistics: numbers of people who have been accepted as homeless because of a drug problem. Available from local authority homelessness or housing strategy team.

Another useful housing needs reference source is:

- Clean Break. A toolkit for developing integrated housing and care pathways for drug users. Available at: www.homeless.org.uk/cleanbreak

- **Social services:** data on different care groups (for example, mental health, children and families, learning disabilities and older people) where substance misuse was part of the presenting profile for the client or the carer should be available to partnerships although there are variations in the collection of the indicators.
- **Local audit data:** annual or one off audits for community and health projects may yield useful data for mapping unmet need: Neighbourhood Renewal/Community Regeneration planning, Lottery Grant Bids, Market Mapping, annual public health implementation plans and any partnership sponsored service user/carers surveys or focus group information. If this data is not usable now, it would be worth trying to ensure input to any future audits to see if it is possible to collect data that can contribute to future needs assessments.

If data is not available from a particular source already, it may be possible to agree the future collection of data routinely, or for a given period of time, so that the partnership can develop needs assessment in future years.

Needs assessment is expected to be an ongoing process, developed from year to year and incorporating additional stakeholders as they become engaged. Partnerships should expect to develop each year's assessment from their previous work rather than re-inventing the wheel each time.

Research

Sometimes routine data is not collected or available, or is not collected in an appropriate manner in order for it to be used in building up a profile of the unmet need. In these cases, it may be helpful to carry out some research (e.g. a cross-sectional study). Such approaches can be helpful in answering specific questions or hypotheses generated by expert opinion or examination of routine data. It would also be advisable to obtain input at an early stage from an experienced health researcher, for example, the Director of Public Health, where possible. It is essential to have a robust methodology so that any findings are as reliable as possible.

Qualitative research can also be highly valuable in exploring issues and responding accurately through commissioning, and need not require vast expense and long term projects. Interviews, questionnaires and focus groups with robust methodologies can be quickly and easily carried out and provide a powerful supplementary evidence base for commissioning decisions.

It may be worth building links with local academic departments and agreeing a set of research questions for their students to carry out, for example trainees on public health trainee schemes. Further detailed guidance on both qualitative and quantitative methods for health services research can be found in "Research methods in health"²⁰.

One area for particular consideration, where there is currently a lack of routine data collection relates to carers and family members' needs. Three suggested methods for tackling this, are:

²⁰ Bowling, A. (2002) Research methods in health: investigating health and health services. Open University Press

- Involvement of carer/family member groups in the expert group and via them, canvassing of opinion as to need at a local level
- Routine collection of data from service users as to their contact with carers/family members
- Undertake preliminary survey work to assess those carers/family members in less frequent contact but who are still worried, distressed or otherwise negatively affected

Handling and interpreting data

Ideally partnerships will have the specialist advice (or services) of an analyst or statistician when handling quantitative data. Some basic principles to bear in mind are:

- Check consistency of case definition: data sources need to focus on the group the partnerships want to investigate (for example, all PDUs 15–44 years, or 19–64 years, or only some classes of drugs and so on)
- Consider the completeness of data: if the data is only partial it will bias the findings unless it is a random sample
- Data sharing and consent protocols will need to be established if sharing attributable data across agency boundaries
- When matching data sets remove duplicates wherever possible. Ideally there will be sufficient identifiers to be able to match data and remove potential duplicates, building a robust quantitative picture of drug users in and out of treatment
- Check there are enough data fields of interest to be able to profile and compare groups (for example, age, gender, ethnicity, geographic area, drug types, etc.)

Mapping analysis

A number of the needs assessments produced by partnerships over recent years have made use of techniques to geographically map areas of potential unmet need. These techniques revolve around correlating the known prevalence rates of the in treatment population for a given area (ward or postcode district level) with some other proxy indicator of substance misuse prevalence.

Examples of these techniques include using the following data sources as the comparator to the known in treatment population prevalence; commercially available consumer classification systems whereby certain community profiles are associated typically with elevated drug and alcohol abuse, class A/B drug possession offence rates, positive drug test rates, and certain indicators from the Indices of Deprivation that show a strong correlation to substance misuse.

Correlation of this type identifies those areas where the in treatment population is lower than expected. Further information on the use of such mapping techniques is provided on the NTA website, at:

http://www.nta.nhs.uk/areas/treatment_planning/docs/nta_supplementary_guidance_notes_%20geographical_mapping_areas_potential_unmet_need.pdf

Appendix 2

Checklist for use in evaluating and prioritising needs

The Effective Interventions Unit guidance²¹ provides a useful checklist that partnerships may wish to use at this stage of the process:

- What proportion of your target population have indicated that they have a particular need?
- What are the areas of agreement between service providers and your target population about the target population's needs? What are the areas of disagreement?
- Have you identified any areas of need among your target population that practitioners were largely unaware of?
- Which of the needs of your target population are currently being met, and which are not being met?
- Which services are easy for your target population to access and why? What are the barriers for your target population in having their needs met?
- What are the risks to your target population (or other people) in not having their needs met?
- How confident do you feel that the information you have gathered is broadly representative of the views of your target population and local practitioners?
- To what extent do existing services have the capacity and ability to meet the identified needs?
- Is funding being directed where it is most needed?
- What are the implications for the planning and funding/resource allocation processes?
- To what extent do existing partnership priorities fit in with the needs identified in the assessment?

Appraising the options for meeting prioritised needs

There may be a number of options available to meet the prioritised needs identified. The evidence in favour of each option will need to be weighed up. Again the Effective Interventions Unit guidance²² provides a useful checklist that partnerships may wish to use at this stage of the process:

Impact

- What changes would have the greatest positive impact in meeting the needs of your target population?
- Do the identified needs relate to a local or a national priority?

²¹ Scottish Executive, Effective Interventions Unit, (2004). Needs assessment: A practical guide to assessing local needs for services for drug users. www.scotland.gov.uk/publications

²² Scottish Executive, Effective Interventions Unit, (2004). Needs assessment: A practical guide to assessing local needs for services for drug users. www.scotland.gov.uk/publications

- What would be the implications of not addressing the needs of your target population?

Changeability

- Which things can be changed and effectively improved by partner agencies?
- What evidence is there of effective interventions for the target population?
- What changes are required following the publication of National Institute for Health and Clinical Excellence (NICE) guidelines and other clinical guidance on substance misuse?
- Are there other local, professional or organisational policies that set out guidelines on what should be done?

Acceptability

- Which of the options for change are likely to be most acceptable to the target population, to the wider community, to service providers and practitioners, and to commissioners and managers?
- What might be the “knock-on” effects or unintended consequences of making a change?

Resource feasibility

- What resources are required to implement the proposed changes?
- Can existing resources be used differently?
- What resources will be released if ineffective actions are stopped?
- Are there other resources available that have not been considered before?
- Which of the actions will achieve the greatest impact for the resources used?

Appendix 3

Publications and resources that may be useful to inform needs assessment

Carers

National Treatment Agency for Substance Misuse (2008) *Supporting and involving carers: a guide for commissioners and providers*. Aims to lay out the evidence base for why it is desirable for commissioners and providers to ensure carers are supported in their own right and (where appropriate) involved in users' treatment journeys.

[http://www.nta.nhs.uk/publications/documents/supporting_and_involving_carers\(2008\)_0509.pdf](http://www.nta.nhs.uk/publications/documents/supporting_and_involving_carers(2008)_0509.pdf)

Clinical guidelines

Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK guidelines on Clinical Management*, London. Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

http://www.nta.nhs.uk/areas/Clinical_guidance/clinical_guidelines/docs/clinical_guidelines_2007.pdf

Please note: NTA regional teams have access to a range of materials that can be made available to assist in assessment of clinical governance arrangements and to audit systems in relation to compliance with the 2007 Clinical Guidelines. Please contact your NTA regional team.

Commissioning

National Treatment Agency for Substance Misuse (forthcoming) *Commissioning for recovery: guidance on commissioning drug treatment and reintegration services for adult drug misusers* (draft title) Consultation draft to be published in Autumn 2009

Community based criminal justice needs assessment

Drug Interventions Programme(DIP):

http://www.nta.nhs.uk/areas/criminal_justice/drug_interventions_programmes.aspx

Diversity

National Treatment Agency for Substance Misuse (2007) *Needs assessment guidance for adult drug treatment: Supplementary Guidance for Diversity Legislation 2007*.

http://www.nta.nhs.uk/areas/treatment_planning/docs/diversity_supplementary_guidance_140807.pdf

Employment

National Treatment Agency for Substance Misuse (2009) *Planning, commissioning and delivering the training and employment pathway for problem drug users: Developing practice for drug partnerships, Jobcentre Plus and drug treatment providers*.

http://www.nta.nhs.uk/publications/documents/planning_commissioning_and_delivering_the_training_and_employment_pathway_for_problem_drug_users.pdf

The document aims to highlight the elements of clear and effective referral pathways between drug treatment and employment services, clarifying the respective roles and responsibilities of the treatment sector, Jobcentre Plus advisers and new Jobcentre Plus drug coordinators to be based within Jobcentre Plus and funded by the Department of Health.

Specifically, section 2 *Drug partnerships and Jobcentre Plus – Strategic development of local pathways* focuses on:

- Assessing training, employment and community reintegration needs (section 2.1)
- Drugs employment pathways as part of adult drug treatment planning (section 2.2)
- The role of Jobcentre Plus drugs coordinators in drug needs assessments, treatment plans and wider partnership work (section 2.3)

Families

National Treatment Agency for Substance Misuse (forthcoming) *Undertaking needs assessment. Drug treatment, reintegration and recovery in the community and prisons. Supplementary advice in relation to Families and Carers*. Due for publication Autumn 2009

Harm reduction

National Treatment Agency for Substance Misuse (2008) *Harm Reduction Strategy: Guidance and Partnership self Audit Tool to Support Adult Drug Treatment Plan 2009/10*.

http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2009_10/docs/harm_reduction_strategy_final_2009_10.doc

This document has a lengthy reference list which may be useful to partnerships.

Publications to support harm reduction needs assessment include:

National Institute for Clinical Excellence (2009). *Needle and Syringe Programmes: Audit Support, Implementing NICE guidance*. NICE public health guidance 18.

<http://www.nice.org.uk/nicemedia/pdf/PH18AuditSupport.doc>

Department of Health/National Treatment Agency for Substance Misuse, 2007, *Reducing Drug Related Harm: An Action Plan*:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074850

Advisory Council on the Misuse of Drugs (2000) *Reducing Drug-related Deaths*. A report by the Advisory Council on the Misuse of Drugs. London: Home Office.

<http://drugs.homeoffice.gov.uk/publication-search/acmd/reducing-drug-related-deaths/>

Department of Health website, sexual health information:

<http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/sexualhealth/index.htm>

Department of Health (2004) *Hepatitis C Action Plan for England*, Department of Health: London:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084713.pdf

Health Protection Agency (2008) *Shooting Up: Infections Among Injecting Drug Users in the United Kingdom 2007: an update*. London: Health Protection Agency.

http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1224833091685

Department of Health, 2005, *Choosing better oral health: An oral health plan for England*. London, Department of Health

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251

Royal College of General Practitioners (2007) *Guidance for the Prevention, Testing, Treatment and Management of Hepatitis C in Primary Care*.
<http://www.rcgp.org.uk/pdf.aspx?page=6839>

National Treatment Agency for Substance Misuse (2006) *Best Practice Guidance for Commissioners and Providers of Pharmaceutical Services for Drug Users*.
http://www.nta.nhs.uk/publications/documents/nta_best_practice_pharma_services_for_drug_users_pharmguide06.pdf

National Treatment Agency for Substance Misuse (2006), *Findings of a survey of needle exchanges in England*, National Treatment Agency for Substance Misuse, 2006
http://www.nta.nhs.uk/publications/documents/nta_findings_survey_needle_exchanges_2005_rb17.pdf

United Kingdom Harm Reduction Alliance website: www.ukhra.org

Prison needs assessment

Marshall, T, Simpson, S, Stevens, A (2000) *Healthcare in Prisons – a health care needs assessment*. Department of Public Health and Epidemiology, University of Birmingham.

HM Prison Service (2006). *HM Prison Performance Standards*
http://www.hmprisonservice.gov.uk/assets/documents/10001E7B10_drug_strategy_jul_06.pdf. Update pending.

Safeguarding Children

Advisory Council on the Misuse of Drugs (2003). *Hidden Harm: Responding to the needs of children of drug users*.

<http://www.drugs.gov.uk/publication-search/acmd/hidden-harm>

National Treatment Agency for Substance Misuse (2008) *Safeguarding the children of drug misusing parents*.

http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2009_10/docs/safeguarding_the_children_of_drug_misusing_parents_1208.pdf

Tier 4

National Treatment Agency for Substance Misuse (2009) *Tier 4 Needs assessment guidance*. Due for publication Autumn 2009

Treatment planning following needs assessment

Adult drug treatment planning guidance for drugs partnerships available at http://www.nta.nhs.uk/areas/treatment_planning/default.aspx including additional materials to support local drug partnerships needs assessment in relation to barriers to access, employment and housing.

IDTS treatment planning – guidance notes on completion of the plan for prison establishments, primary care trusts and drug partnerships.

http://www.nta.nhs.uk/areas/criminal_justice/idts_treatment_planning_docs.aspx

Combined and updated guidance on community and prison treatment planning to be published Autumn 2009

Workforce

National Treatment Agency for Substance Misuse (2008) *Workforce development – adult drug treatment plans*. To be updated October 2009

http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2009_10/docs/workforce_development_notes_08.doc

Drug and Alcohol National Occupational Standards:

<http://www.alcohol-drugs.co.uk/DANOS.htm>