Needs assessment guidance for adult drug treatment

National Treatment Agency for Substance Misuse

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<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2</td>
<td>Commissioning, monitoring and evaluation</td>
<td>28</td>
</tr>
<tr>
<td>10</td>
<td>A worked example – treatment system map</td>
<td>29</td>
</tr>
<tr>
<td>10.1</td>
<td>Building the treatment map from NDTMS data</td>
<td>30</td>
</tr>
<tr>
<td>10.1.1</td>
<td>System entry</td>
<td>30</td>
</tr>
<tr>
<td>10.1.2</td>
<td>Retention in the first 12 weeks</td>
<td>31</td>
</tr>
<tr>
<td>10.1.3</td>
<td>In treatment</td>
<td>31</td>
</tr>
<tr>
<td>10.1.4</td>
<td>Movement within the treatment system</td>
<td>31</td>
</tr>
<tr>
<td>10.1.5</td>
<td>Exiting the system</td>
<td>31</td>
</tr>
<tr>
<td>11</td>
<td>Questions and themes to consider for Tier 4 treatment mapping</td>
<td>32</td>
</tr>
<tr>
<td>12</td>
<td>Applying the bullseye for treatment planning – an example</td>
<td>35</td>
</tr>
<tr>
<td>12.1.1</td>
<td>Using the DIP data to profile clients unknown to treatment services</td>
<td>37</td>
</tr>
<tr>
<td>13</td>
<td>An example of unmet need</td>
<td>37</td>
</tr>
</tbody>
</table>
1 NTA needs assessment context and rationale

1.1 What is a needs assessment?

“A health needs assessment is a systematic method of identifying unmet health and healthcare needs of a population … and making changes to meet these unmet needs.”

A range of health needs assessment (HNA) 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 qualitative 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 an evidence-based adult drug treatment plan. 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 management. Figure 1 shows how the HNA framework could apply to the components of drug treatment planning.

![Figure 1: Health needs assessment framework – drug treatment planning](image-url)

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1.2 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 make evidence-based and ethical decisions on how needs might be most effectively met within available resources.

Effective needs assessment for drug treatment requires a process of identification of:

- What works for those in open access and structured drug treatment services and what the unmet needs are across the system
- Where the system is failing to engage and retain people
- Hidden populations and their risk profiles
- Enablers and blocks to treatment pathways (open access and structured interventions)
- 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 drug services and treatment, which then informs treatment planning and resource allocation.

Models of Care\(^2\) requires a shared understanding of the local need for drug treatment, based upon annual needs assessment reports in line with a nationally agreed methodology. The needs assessment should profile the diversity of local need for drug 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 needs assessment should consider the full range of needs of problematic drug users including the need for harm reduction services in their own right, as well as harm reduction services provided within structured drug treatment services.

This approach is designed to further refine the information available on the extent and nature of the drug problem in each partnership area, and will include a requirement to describe the socio-demographic profile of problematic drug users, as well as examining the referral routes into treatment, levels of retention with the drug treatment system and successful discharges and outcomes from treatment interventions.

1.3 Components of needs assessment

The process of needs assessment will 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 level and deciding the key questions that are to be asked at a partnership level for the current 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
- Understanding unmet need. Analysis and interpretation of 2–4, including discussion and challenge by the 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 drug treatment delivery systems and evaluating

and prioritising the identified needs, harms and gaps, appraising the options for meeting those needs

- Drawing up and implementing the adult drug treatment plan, including allocation of resources.

1.4 Assessing need: Dynamic and pragmatic

Carrying out a needs assessment should be regarded as an ongoing process that will improve year on year in its sophistication (see figure 2). It can be easy to be overwhelmed by a wide variety and volume of data and lose sight of the task in hand – to improve drug treatment. Therefore, it is important to be clear about what questions the needs assessment process will help address and answer. The process needs to be specific and gather information that helps in that endeavour.

The starting position for all partnerships is the evidence base set out in Models of Care 2006,\(^3\) which underpins the treatment planning template and guidance. It is assumed, therefore, that a need for effective drug treatment services is already evidenced, benefit can be achieved from the interventions outlined in Models of Care, and a measurable improvement can occur as a result of those interventions. The process of needs assessment should therefore focus on ensuring there is appropriate capacity within relevant services across all four tiers of commissioned services, including harm reduction initiatives – with appropriate and timely access to those services for users – together with overall improvements in the quality and range of service provision as evidenced by appropriate retention, planned discharge levels and outcomes. It is anticipated that the Treatment Outcomes Profile\(^4\) (TOP) will become a more significant part of the needs assessment process from 2008/09 onwards, as reporting becomes robust. It is also a requirement of Models of Care implementation that the needs assessment takes full account of the gender, ethnicity and other diverse needs of the target population and any unmet needs from this perspective.

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


\(^4\) Treatment Outcomes Profile (TOP). Further information available at: http://www.nta.nhs.uk/areas/outcomes_monitoring/
1.5 Cross-cutting themes

1.5.1 Diversity

There is an obligation on stakeholders involved in the needs assessment process to consider the needs of the entire community their local treatment system seeks to address. Services that have grown organically need to be reviewed based on assessments of need and local priorities.

There are many examples of excellent practice in assessing the needs of local communities. However, there are still cases where this has not yet been done in a thorough and satisfactory manner. While a local partnership may only have a small percentage of certain groups, these small numbers also need to be considered and monitored in terms of their requirements and levels of service uptake.

Care needs to be taken to examine in detail the available data that gives indications as to the different cohorts that may exist within a local area. The local expert group (see section 2) should ensure diversity is fundamental to its thinking and should cross-reference with other non-drug specific forums and consultation mechanisms (for example, those put in place by the local authority and local health bodies) to enhance the needs assessment.

A summary of statutory responsibilities in relation to diversity issues is provided as supplementary guidance at http://www.nta.nhs.uk/areas/treatment_planning/treatment_plan_general_guidance_documents.aspx.
1.5.2 Criminal justice

A large proportion of referrals to the drug treatment system come from the criminal justice system. Throughout this guidance it is expected that the needs assessment process will consider all those who require services regardless of the referral route, and that partnerships will pay specific attention to the different patterns and volume of clients through both criminal justice and other referral routes.

1.5.3 Workforce

Many of the unmet needs and gaps uncovered by the needs assessment exercise will require a response that relates to a local treatment system’s workforce. Therefore, throughout the needs assessment and planning process, the needs of the workforce that make up the local system should be considered. This includes not only frontline clinicians, but also other stakeholders. For example, the training of reception staff to understand client needs can make a big difference to the service user’s experience of treatment. Data staff need to be able to function effectively to ensure the information the partnership is basing its decisions on is as accurate as it can be. There also needs to be adequate commissioning capacity to develop and mould the local system to address identified unmet need.

Please see supplementary guidance section of the NTA website for further information and reading around workforce issues: http://www.nta.nhs.uk/areas/treatment_planning/treatment_plan_general_guidance_documents.aspx

1.5.4 Harm reduction

Reducing harm and minimising the risks associated with substance misuse is a fundamental priority for all partnerships. It is not enough that harm reduction or harm minimisation services provide a standalone function – they need to be regarded as an essential gateway in engaging clients at the start of their treatment journey preparing and building towards successful treatment outcomes.

Preventing disease and minimising the risk of accidental death from overdose relates to all tiers of service provision. Up-to-date, understandable health promotion information and an up-to-date competent workforce are essential in supporting positive life choices for local drug-using communities.

The partnership needs assessment expert group is an ideal forum where local harm reduction and minimisation strategy groups can present their findings. The NTA recommends that the director of public health undertakes a leadership role within the expert group. The benefit of this is to provide both the clinical and community perspective when considering PCT public health commissioning, for example, primary health care vaccination for hepatitis B and responsibilities for hepatitis C packages of care and treatment. The harm reduction workforce consists of all people associated with substance misuse. The role of the clients and their families and friends should not be underestimated, especially in relation to preventing the spread of blood-borne viruses and reducing the risk and number of drug-related deaths.

The NTA will produce updated harm reduction guidance and a self assessment tool as part of the guidance for the 2008/09 adult drug treatment plan. This should be used to benchmark the partnership’s current position and assist in developing the future strategic direction to provide a whole systems approach to minimising or reducing drug-related harm.

The NTA have published guidance on general healthcare assessments, which provides details of the aspects of treatment and care associated with general wellbeing as an essential component of a client’s care plan and pathway.

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5 http://www.nta.nhs.uk/areas/treatment_planning/default.aspx
1.5.5 Carers and family members

Carers and family members are an important element of the delivery of treatment and should be fully included in the needs assessment process. Although there are examples of good practice in assessing and meeting carers’ needs, these can be neglected. However, considerable evidence demonstrates that they do have significant needs (they are often severely affected by the problem drug use and related problems of the person they are caring for), which also need to be addressed by partnerships. This is particularly the case for children of drug users and partnerships should ensure that their workforce is aware of and actively addresses the issues raised by the Hidden Harm agenda.7

There is good evidence that engaging and supporting carers not only helps the carers themselves, but can improve outcomes for problematic drug users. The evidence base suggests that family involvement helps drug misusers at all stages of the treatment journey – it assists and encourages the users to engage in treatment, it helps retention, it speeds (successful) throughput, reduces treatment drop-out, and it is associated with more positive drug-related and social outcomes.

1.5.6 Service users

Service users should be actively involved in all key aspects of decision making in relation to their care and to the planning, delivery and evaluation of service provision. This includes involvement and consultation on needs assessment, planning services, and developing and considering proposals for changes in the way services are provided and how they operate. If undertaken effectively, this achieves fundamental objectives that strengthen accountability for all stakeholders, ensures services genuinely respond to need and engenders a sense of ownership and trust. Service user involvement should be ongoing and routine – not just when major change is proposed. The system must recognise and value the benefit of listening and responding to users and see this is a catalyst for service improvement. This requires the development of constructive relationships, building strong partnerships and communicating effectively. The involvement of service users specifically in the needs assessment process should start at the beginning and continue throughout the process.

1.5.7 Housing

Up to half of the drug treatment population are insecurely or unsuitably housed. Homelessness also acts as a barrier for many people who could otherwise benefit from accessing drug treatment. Obtaining suitable housing and housing support is a critical factor in ensuring access to the treatment system and in supporting treatment outcomes for clients throughout and after their treatment journey. Housing and housing support needs can change throughout the treatment journey and clients may be able to sustain varying levels of independence at different stages. Housing support for chaotic or managed drug use may be required at some stages and abstinence-based supported housing at others.

As part of the needs assessment, partnerships need to establish the met and unmet housing and housing support needs of those who could benefit from accessing treatment, and the treatment population and those leaving treatment. Flexible pathways to a range of housing and housing support options need to be established to support the client treatment journey.

The information from the needs assessment should inform the treatment plan and relevant local strategies, for example, the local authority’s homelessness strategy and the Supporting People strategy. There are a number of models and a range of data sources, which can assist in developing a local housing and housing support needs assessment for drug users (see section 6).

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1.5.8 Skills and employment

Many drug users are without permanent employment and need support with education and training. Studies show that 80 per cent of people on Drug Rehabilitation Requirements have unmet skills and employment needs. Twenty per cent of those who responded to the NTA’s service user survey\(^8\) requested help with education and employment. Support in finding or returning to employment, and access to training or opportunities for engaging in meaningful activity, are a key part of supporting the client treatment journey and positive treatment outcomes. The level of need for skills and employment services for those in and leaving the treatment system should be established as part of the needs assessment process. This should inform the continuing development of effective pathways to relevant local services for clients.

It is recognised by the NTA that data sources to help inform this assessment need to be developed at a national, regional and local level. In the interim, there is information that can be provided by Job Centre Plus, probation and prisons which can form the basis of a developing needs assessment. Local skills, employment and treatment providers often have detailed and relevant local information. Establishing the key information gaps and planning to meet these will be an important part of the needs assessment process. Increasing the involvement of the skills and employment sector in both needs assessment and local strategic commissioning will be crucial to improving local treatment systems.

2 The local process to drive needs assessment

2.1 Steering group

Needs assessment is a strategic activity that should be closely linked to the planning process. It is recommended that the drugs partnership joint commissioning group should act as a steering group throughout the stages of the needs assessment, drawing in additional specialist support as required. 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 bring together the right group of people with a range of skills and responsibilities (including data analysts)
- To ensure that the process of needs assessment is done properly and according to guidance and best practice. This will include 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 partnership board, meeting all deadlines for consultation and submission as required (by both the partnership and the NTA national requirements)
- To ensure that the key findings are prioritised within the resources available, and then result in action.

2.2 **Expert group membership**

As part of the needs assessment process it is recommended that the JCG set up expert groups to expand upon the knowledge and skills contained within the JCG and to ensure the widest possible consultation with stakeholders. Expert groups should have 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 and criminal justice, and with data management, analysis and research expertise
- Those with an interest and experiential expertise in the issues – for example, service users, carers, the wider community
- Those who can make changes happen – for example, managers, commissioners and planners.

It is recommended that the following (or their representative) are considered for membership of any expert group:

- Partnership chair
- JCG chair and members
- Director of public health
- Joint commissioning manager
- Partnership or drug action team (DAT) co-ordinator, or Drugs Strategy director
- Drug interventions programme (DIP) manager
- DIP data manager
- A representative from primary care or mental health trust – service provider
- Shared care lead (or a GP with a specialist interest)
- Pharmacist, or member of the local pharmaceutical committee
- A manager or director from non-statutory agency
- User representatives
- Carer representatives
- Local data manager
- Local National Drug Treatment Monitoring System (NDMTS) or Public Health Observatory (PHO) representative
- NTA deputy regional manager (or regional manager)
- Government Office crime or drugs team

Partnerships should specifically consider the significant contribution that the input of user groups will make to the needs assessment process. Consideration should also be given, when considering membership, as to whether the local community is significantly represented and that attention has been given to appropriate involvement from a race and gender perspective. The partnership should utilise existing consultative and involvement activities to inform the needs assessment process throughout the year. As far as possible, existing structures and opportunities for consultation should be used so that needs assessment is fully integrated into partnership structures rather than adding additional demands.

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Those with relevant local expertise need to be included when considering the housing, skills and employment needs of the local drug-using population. This can be done either as part of the expert group or through a specialist subgroup. It is recommended the following are considered for membership of the expert group or sub group:

- Local authority director of housing
- Supporting People manager
- Representative of supported housing provider
- Job Centre Plus area representative
- Representative of Progress2Work provider

2.3 Suggested timetable

It is envisaged that needs assessment will be a standing item on JCG agendas throughout the year. The expert group element can usefully be called upon at three specific points in the needs assessment process.

August to September: To assess the initial NTA data and to critically evaluate it in the context of the Home Office problematic drug user prevalence estimate\(^{10}\) (see Section 5). The initial expert group meeting should aim to assess these data against local experiences, and use the meeting to determine what other local databases could be used and to test the main analytic methods to be employed. Treatment system maps should be provided by the partnership secretariat/officers for this meeting. The outcome from this meeting should provide the JCG steering group with information to identify the main questions to be tested in this round of assessment. Partnership staff should be tasked at this stage with undertaking the detailed work required to draw up interim findings.

- October: The first part of the second meeting of expert group(s) should test the data and interim findings, and the attempts to link different data sources. The second half of the session should be designed to plan for the emerging key unmet needs.

- November to December: The third session should be held immediately prior to the completion of the full needs assessment report and should 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 adult drug treatment plan.

At around the end of the year, the JCG or Partnership Board should finalise the summary report, which will be submitted to the NTA in mid-January (See section 9). Joint commissioning groups and partnership boards should therefore ensure that appropriate events are included in their annual calendar to facilitate the above process.

2.4 Expert group process

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

- Who will be involved in working on the needs assessment process throughout
- Who is responsible for the overall management and leadership of the process throughout
- Decide how much time is needed for meetings and work between meetings

\(^{10}\) Home Office prevalence data, available at: http://www.nta.nhs.uk/areas/facts_and_figures/prevalence_data/default.aspx
• Decide how this is to be created and managed
• Decide where and when meetings will be held, including letting everyone know and booking rooms
• Circulate relevant information before the meetings, for example treatment system maps and relevant data
• Consider who should facilitate the expert group meetings, who should lead the discussions – this includes ensuring participants understand the task (and the stage the process is at), managing the time available and keeping 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 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.

3 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 local area needs for a range of harm reduction and structured drug treatment interventions. No single source of information will be able to give the total picture, but several sources taken together should give different pieces of the puzzle. While it is unlikely that it will be possible to measure needs perfectly, a clear idea of the overall picture can be gained without having all the puzzle pieces. Effort should be spent in gathering enough information to see the picture, not in gathering all the information that is available\textsuperscript{11}.

An initial task is to bring together information that is available in the local area about the delivery of services that form the local treatment 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.

Subsequent sections detail a range of data sources and approaches for the use of data to assist with needs assessment. Throughout this process it will be important to check treatment data with census data as to how representative the treatment population is and considering what this comparison means for treatment provision in the local area.

4 Understanding met need: Treatment system mapping

Before proceeding to make decisions about how identified unmet need might be met, each partnership needs to have a clear understanding of how need is currently met and where there are either gaps or areas requiring improved service delivery. This entails mapping the drug treatment system against a description of the client profile – in relation to referrals, throughput, retention and outcomes.

4.1 Purpose of mapping the treatment system

The purpose of mapping the treatment system is to 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 and retention 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.

The treatment map outlined below is a tool for producing a quantifiable measurement of the existing treatment system and any possible blockages to effective outcomes. By including the development of a simple treatment map from NDTMS data as part of the treatment planning process it is intended that:

• Partnerships will gain insights into how the system is working and for whom
• Spending decisions in the treatment plan can be evidenced using the treatment map

The model described in this document is constructed from data collected by the NDTMS in 2006/07 and, where appropriate, comparative data from 2005/06 is used. It is therefore limited to Tier 3 and 4 services. However, there is considerable merit in being able to extend the model to Tier 2 services at a local level wherever possible to inform the planning of Tier 2 and harm reduction services for those not accessing structured drug treatment.

4.2 The treatment map model: overall structured drug treatment delivery

A treatment map is a graphical representation of a treatment pathway for an individual or for groups of individuals (refer to section 10 for a worked example). The map plots how clients move through four stages of their treatment journeys, and investigates the profiles of clients at these stages. The four stages of the journey that the map divides the treatment journey into are:

• **Treatment system entry** – the referral points into the treatment system. For ease of analysis, these are limited to four referral categories: criminal justice, GP, self and other. The model can be used to compare the profiles of clients referred to an agency over,
say, the last two years, in order to identify change in presenting need over time of a local population

- **In treatment** – clients receiving Tier 3 and/or Tier 4 treatment in a service/agency. The model is concerned with understanding the difference between clients in different agencies, and in understanding what differences there are between clients that are retained for a long time (> 1 year) and clients that are not retained

- **Movement within the treatment system** – clients moving between agencies during the course of their treatment journey. The model seeks to understand the profiles of the clients that move between agencies and identify differences between clients that are referred on, and those that are not

- **Exiting the treatment system** – individuals discharged from all Tier 3 and/or Tier 4 provision and no longer within the local treatment system. The model seeks to understand the profiles of client groups that leave treatment in a planned way compared to those that leave in an unplanned way

### 4.3 The treatment map model: Tier 4 drug treatment delivery

It is suggested that, in addition to a full treatment system map, a map specifically examining Tier 4 services is produced. This entails mapping the Tier 4 element of the treatment system against a description of the client profile – in relation to referrals, throughput, retention and outcomes.

### 4.4 Purpose of Tier 4 treatment system map

A significant number of partnerships have less clarity over Tier 4 services compared to their understanding of community based services, including which facilities are used, who these are intended for and what treatment outcomes they are designed to deliver. Given the relatively small numbers of people accessing Tier 4 services, and their relative costs, partnerships will want to evaluate existing arrangements and value for money, together with the relevant key stakeholders.

#### 4.4.1 The Tier 4 treatment map model

It is recognised that in many partnership areas there will not be as much data available compared to Tier 3 services, and small numbers will need careful interpretation.

The Tier 4 map plots how clients move through the relevant stages of their treatment journeys, and investigates the profiles of clients at these stages. The four stages of the journey that the map divides the treatment journey into are:

- **Tier 4 treatment system entry** – the referral points into Tier 4 services

- **In treatment** – clients receiving Tier 4 treatment in a service/agency. The model is concerned with understanding the difference between clients in different agencies, and in understanding what differences there are between clients that are retained for a long time and clients who drop out of services early

- **Movement within the treatment system** – clients moving into and out of Tier 4 agencies during the course of their treatment journey. The model seeks to understand the profiles of the clients that move between agencies and identify differences between clients that are referred on, and those that are not

- **Exiting the treatment system** – individuals discharged from Tier 4 provision back to Tier 3 services or no longer within the local treatment system. The model seeks to understand the profiles of client groups that leave treatment in a planned way compared to those that leave in an unplanned way
Section 11 provides questions and themes to consider alongside data and information source suggestions which may be of assistance.

5 Defining the population in need: The treatment bullseye

As part of the needs assessment exercise it is important to establish the definition of problem drug user that the partnership wishes to address. There is no one definition of problem drug user that will adequately meet all agendas. The adult drug treatment plan is designed as a tool to ensure a drug treatment system is developed and implemented in all areas to deliver services as described in Models of Care. This will include services for those referred from the criminal justice system including those on community sentences, in custodial settings and on release from custody. The needs assessment described in this guidance underpins this planning and delivery framework.

5.1 Investigating prevalence

5.1.1 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 problem drug use. 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.

The NTA recommend that partnerships establish local prevalence using a case-finding and enumeration methodology which essentially identifies groups of drug users who are accessing health, social care and criminal justice services but who are not accessing specialist drug treatment and then quantifying and profiling these clients. The advantage of this particular method is that data sources used relates to actual individuals (rather than statistically modelled and therefore hypothetical groups of individuals) and the process of case-finding and enumeration does, by definition, enable 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 as provided by the Home Office.  

5.1.2 National estimates of prevalence of problematic drug users

The Home Office has commissioned a three year research study to produce prevalence estimates of problematic drug users at partnership, regional and national levels. The coverage of this study relates to problematic drug users who use opiates and/or crack cocaine (as well as other drugs). While it is accepted that local areas will identify other problematic drug users (and will wish to provide relevant and appropriate services for these PDUs), it is an expectation that all partnerships will utilise these Home Office estimates as part of their needs assessment process each year. Guidance is to be provided by the Home Office as to the most effective way of applying these estimates, which also illustrates the contexts in which these estimates might be used and highlights their strengths and limitations.

A small number of partnerships may assess that the prevalence estimate as provided by the Home Office research is significantly different to their understanding of the prevalence in their area. Where it is considered that this will significantly affect the needs assessment process, partnerships should seek advice from their NTA regional team as to how the estimate may be reviewed.

5.2 Using the treatment bullseye as a tool to define the population in need

Core matched data is provided in aggregate form to all partnerships by the NTA. This data meets all relevant criteria in terms of data protection. 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.

The treatment bullseye is an illustrative tool that may be used as part of a needs assessment process when seeking to define and better understand groups of problematic drug users based on their level of engagement with treatment services. The centre of the bullseye represents clients currently being treated. Clients in the outer ring represent those that are unknown to structured drug treatment services. Rings between these two are differentiated through their levels of contact with treatment services. Figure 3 is an example of the way a problematic drug using population may be segmented.

![Figure 3: Segmentation of PDU population based on treatment service use](image-url)

The bullseye seeks to identify what the factors are that influence a treatment system’s capability to retain problematic drug users as close as possible to the centre of the bullseye. It does this through profiling clients within each ring of the bullseye (age, gender, ethnicity, drug use etc). This is done so that differences between clients that are successfully engaged and those that are not can be better understood.

In order to get the most out of the bullseye, it is desirable to have multiple data sources available. This is so that the data sources can be cross referenced, and the profiles of clients of different services can be better understood. Figure 4 shows how a second source of data may be overlaid onto the first to create a “slice” through the bullseye.
Once the data sources are matched as in figure 4, there will be clients in the outer ring of the bullseye that are known to the second data source, but not to treatment services. The profile of these clients can therefore provide a window into the profile of the wider population of treatment naive PDU. This process can be repeated using multiple data sources, and a composite picture can be built up (see figure 5).

**Figure 4: Second data set overlaid on the treatment bullseye**

A worked example of a treatment bullseye is provided in section 12, which explains how to populate the bullseye.

**Figure 5: Example of multiple data sources matched onto bullseye**
6 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” in the bullseye – they are essentially 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 total population of drug users (see section 5) and subtracting from it those known to treatment. This section outlines how partnerships might begin to investigate this unmet need in more detail using locally available data sources and small-scale research, in addition to undertaking the initial work outlined previously.

Partnerships will need to develop a clear understanding of the unmet need in their local areas, to ensure that there are adequate early intervention and support services (Tier 1 and 2) in place in the partnership area and to inform the future commissioning of structured treatment (Tier 3 and 4) to meet these needs. By identifying groups of drug users in contact with other health, social care 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, factors which may be influencing that, and thereby improving evidence-based commissioning.

6.1 Using routine data to identify unmet need

While the Drug Interventions Programme undoubtedly provides the single largest source of data on drug users hidden from the treatment system, a range of other local data sources can be used to help identify, profile and target problematic drug users. Some of the data sources listed below may be obtainable, with identifiers, to enable matching; others may not but are certainly still worth obtaining to give additional quantitative insight into problematic drug use in the partnership area. Partnerships should discuss with their regional PHO or NDTMS team the potential to match other sources of data against NDTMS.

- **Needle exchange data** 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 can be matched with NDTMS data. However it has been noted that many choose to give incorrect attributer information and this will need to be taken into account in order not to over estimate those unknown to treatment. 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

- **Hospital Episodes Statistics (HES)** are available from Public Health Observatories and contain records of all hospital admissions in a year, by PCT area, for those aged 16–64 years, and were admitted with a primary diagnosis with an ICD10 code F10-F19 (Psychiatric Admissions: Substance Misuse). This data is available from 1996/97 and enables trend data to be factored into an analysis.

- **The General Practice Research Database (GPRD)** contains longitudinal data on over three million randomly sampled patients in GP practices across England, including demographic profiles, clinical diagnoses, drugs prescribed and immunisation details. This could be used to compare incidence and prevalence in general practice with NDTMS and local data sources. Local public health colleagues will be well-placed to advise on access and its uses


19
• **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, total volumes of methadone and buprenorphine prescribed and the number of prescriptions issued for methadone and buprenorphine and other symptomatic prescribing.

• **Health Protection Agency** data on disease notifications, prevalence data and surveillance systems.

• **Office of National Statistics (ONS)** data on drug-related deaths.

• **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. Other useful sources of information are counselling, assessment, referral, advice and throughcare (CARAT) reports and other information from the prison service. Contact with the regional area office for HM Prison Service is a source of information that can be explored by local partnerships.

• **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.

• **Other health services data.** NHS walk-in centres, A&E departments, minor injuries units, sexual health and HIV services, community mental health services, and primary care and GP practices will all work with drug users not in contact with drug services. They may already collect some data on drug use; if not, it would be worth discussing with PCT colleagues the potential for this in future.

• **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:
  - Job Centre Plus, Progress2Work and Link Up web-based management information tool. Job Centre managers can access information at at 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 have problem drug use. The following data sources can inform needs assessment for housing and housing support:
  - Supporting People Client Record (CLG) – numbers of people entering supported housing or receiving floating support who have a drug problem as a primary or secondary need. 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, [www.core.ac.uk](http://www.core.ac.uk)
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 teams.

NDTMS 06/07 data on housing.

OASys – Probation information managers can access information on numbers of offenders with accommodation problems who also have a drug problem to varying levels.

Clean Break is another useful reference source for housing needs. A toolkit for developing integrated housing and care pathways for drug users is 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.

- Local audit data – annual or one off audits for community and health projects may yield useful data for mapping unmet need, for example for crime and drugs audits, neighbourhood renewal and community regeneration planning, lottery grant bids, annual public health implementation plans. 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 an agency 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.

6.2 Research

Sometimes routine data is not collected or available to use, 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 (such as 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 get input at an early stage from an experienced health researcher (such as a 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 the public health trainee scheme.

Further detailed guidance on both qualitative and quantitative methods for health services research can be found in Research Methods in Health.¹³

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:

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

6.3 Mapping analysis

A number of the needs assessments produced as part of the 2006/07 planning round 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.

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/treatment_plan_general_guidance_documents.aspx.

6.4 Handling and interpreting data

Ideally partnerships should get the specialist advice (or services) of an analyst or statistician when handling quantitative data in particular. 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 aged 15–44 years, aged 19–64 years, or only particular classes of drugs)
- 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 datasets, 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 and types of drug).

6.5 Appraising data

Data, qualitative or quantitative, is one form of evidence upon which decisions are made and services are planned. Properly handled it can provide a robust rationale, but if mishandled can be very misleading. Sound critical appraisal skills are therefore required when incorporating data into JCG and expert group business.

The key thing to remember is that data and its analysis do not make decisions. What it should allow JCGs and expert groups to do is 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 it vary by drug, gender, ethnicity, age, referral source, housing status, GP registration and so on?
• Where are the groups who fair less well?
• Why do they fair 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)
• 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?

7 Gap analysis

Completion of the bullseye as part of the process of needs assessment is intended to facilitate an analysis of gaps in the local drug treatment system which can then be tested out with the expert group, normally at the second meeting stage. This gap analysis should not focus solely on the NDTMS data available to the partnerships, but should also include additional data sources including (but not limited to) those outlined in section 6.

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 needs for help and advice to prevent or reduce the harm associated with drug use, and for treatment to improve physical and mental health. Useful data sources could include Hospital Episodes Statistics (HES), Needle Exchange and other Tier 2 data, General Practice Research Database (GPRD), PACT (Prescribing Analyses and Cost), Health Protection Agency Tier 2 provider data, other health data, social services data and anecdotal information from service users, carers, providers and the expert group.
• Addiction-specific needs – the need for treatment, care and aftercare relating to drug use. Useful data sources as above.
• 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 bodies such as Supporting People, local authorities, homelessness services and hostels.
• 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. Useful data sources are local audit information and Department for Work and Pensions statistics
• Offending-related needs – the need for interventions to address offending behaviour, for example an increased focus on offending within care planning and group work programmes (adult treatment interventions within criminal justice settings should be considered as part of the wider treatment system and would therefore come under addiction-specific needs). OASys data from the probation service would prove useful to
build up a picture of criminogenic need, supplemented by information from service users, carers and providers on unmet need among those not under statutory supervision.

When considering membership of the expert group, partnerships should anticipate which members would be in a position to facilitate access to data sources outlined above, for example, PCT directors of public health for health data and 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 unmet need, potential numbers and whether or not they are more or less likely to be in touch with services. This will assist with summarising and prioritising identified gaps. An example is shown in section 13.

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, decommission services and develop new services that will go towards meeting newly identified or emerging needs.

8 Evaluation and prioritisation

The Effective Interventions Unit guidance\(^\text{14}\) provides a useful checklist that partnerships may wish to utilise at this stage of the process:

- What proportion of your target population has indicated 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, and resource allocation processes?

To what extent do existing partnership priorities fit in with the needs identified in the assessment?

8.1 Defining priorities within the resources available

Decisions about actions are required which will depend upon defining priorities within the resources available and ensuring that needs identified for action fit with either local or national priorities.

For example, if the needs assessment identifies that a particular group is being retained less well than other groups, or that a particular service within the treatment system has comparatively poor retention, then there may 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 client journeys and reviewing referral criteria
- Reconfiguration of existing services to address unmet need, for example evening and weekend opening, and broader and more flexible ranges of services offered
- Recommissioning 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 satisfactory? That is, are they effective, efficient, do they meet local needs and deliver an appropriate range of services in line with Models of Care?
- Are services commissioned strategically?
- Are unnecessary gaps and duplication avoided while 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 reconfiguration or recommissioning?
- Is the workforce across open access, harm reduction and structured drug treatment services competent and committed to delivering what is required?

Before undertaking recommissioning 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.

The partnership should involve service users and providers in making these decisions.

8.2 Response relating to treatment systems workforce

Consideration will be required in relation to unmet needs and gaps identified across the workforce for both providers and commissioners

8.2.1 Workforce competence

The drugs sector in England is based on the concept that staff in direct contact with clients need to be competent to work with vulnerable adults. This applies equally to paid staff and volunteers. Specific qualifications (for example, nursing, social work, probation officer) can be taken as indicators of competence that mean that an individual coming into the drugs field

would primarily need training in specific substance misuse issues. For individuals without such qualifications, thorough training (coupled with the supervision and annual appraisals that all staff should receive) needs to be put in place by provider agencies. As new needs are identified, appropriate training will have to be identified and job descriptions modified accordingly.

Competencies are a signal from the organisation to the individual of the expected areas and levels of performance. They provide the individual with a map or indication of the behaviours that will be valued. National Occupational Standards (NOS) are statements of the skills, knowledge and understanding needed in employment and clearly define the outcomes of competent performance (QCA’s definition).

Both competencies and NOS can be used by:

- Individuals, to help them develop their own knowledge and skills, improve their own performance and gain credit for their achievements
- People who offer education and training through identifying individuals’ learning needs, defining the learning outcomes which individuals need to achieve, and acting as the basis of qualifications
- Workers and agencies to improve the quality of the services they offer

8.2.2 Training needs analysis

Once the gaps and priorities in workforce competency have been identified as a result of the needs assessment process, it may be desirable to commission an analysis of training need. Guidance on this process will be published by the NTA during 2007.

8.2.3 Commissioning responses

Once gaps in the local workforce’s competence have been identified, a view should be taken by the commissioning partnership as to how this may be addressed. Contracts will often include management charges and training budgets. Where new requirements emerge, commissioners may consider providing specific training input for the local workforce or introducing more innovative schemes such as mentoring, secondments between agencies or peer support groups.

8.2.4 Commissioning capacity

The role of partnership commissioning staff has changed immeasurably over recent years, and arrangements should be made to ensure that commissioners have the training and support they require to do their job effectively. Oxford Brookes University has recently developed a course for developing commissioning skills, and is one such example, as is the forthcoming NTA programme for commissioners and JCG chairs.

8.2.5 Appraising the options for meeting prioritised needs

There may be a number of options available to meet the prioritised needs identified. These will need consideration and the evidence in favour of each option will need to be weighed up. Again, the EIU guidance\(^\text{15}\) provides a useful checklist that partnerships may wish to utilise at this stage of the process:

- 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?

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

8.2.6 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?

8.2.7 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?

8.2.8 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?

9 Completing the process

9.1 Adult drug treatment planning

As part of the cycle of needs assessment, drug strategic partnerships should complete a summary of the needs assessment work in line with this guidance, and set key priorities for the coming financial year. The summary will be required as part of the annual adult drug treatment plan draft submission to the NTA in January. This summary should be presented on behalf of the drug strategic partnership as part of the strategic overview which will be required. The strategic overview which will be required as part of the adult drug treatment plan submission should be presented in the following format:

• The overall direction and purpose of the partnership strategy for drug treatment
• The likely demand for open access, harm reduction and structured drug treatment interventions. This section must identify and consider the differential impact on diverse groups and ensure that the overall plan contains actions to address negative impact
• The key findings of the current needs assessment, including a brief summary of prevalence and penetration levels, treatment system mapping, the characteristics of met and unmet need, attrition rates, and treatment outcomes
• The improvements to be made in relation to the impact of treatment in terms of its outcomes, which will deliver improvements in individual drug user’s health and social functioning, lower public health risks from blood-borne viruses and overdose, and improvements in community safety
The key priorities for developing open access harm reduction and structured drug treatment interventions to meet local needs during the following financial year. This section should also include key treatment priorities which have been identified in the most recent Healthcare Commission and NTA Improvement Review.

9.2 Commissioning, monitoring and evaluation

Quality commissioning should meet the diverse needs of all potential users of substance misuse services as well as the needs of wider communities. It is commissioning that strives to achieve, at local levels, treatment systems that are effective, efficient, relevant, accessible and equitable. Quality commissioning is based upon effective needs assessment processes and is followed up by performance management arrangements which monitor and evaluate the developments planned and commissioned in line with evidenced need.

There is no single best approach to the commissioning or joint commissioning process and organisations involved must 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.

The commissioning cycle in Figure 6 has been developed from the Department of Health model. It identifies the activities required for effective joint commissioning alongside needs assessment. Further details and steps in the commissioning cycle can be found in Commissioning Definitions and Frameworks16.

![Commissioning cycle diagram]

Figure 6: Commissioning cycle

Monitoring and evaluation are an integral component of the process of needs assessment and evidence gathered as part of performance monitoring and management. They can then be used as the basis for further needs assessment.

10 A worked example – treatment system map

Figure 7 shows how a single individual’s treatment journey during the course of a year can be visually represented. The map shows that the client self referred to agency A during the course of the year. Agency A then referred onto agency D. Agency A discharged the client during the course of the year, but agency D did not. Therefore, each arrow represents an element of the treatment journey.

To produce a full systems map, all client journeys though the treatment system in the course of a financial year are plotted on the same map.
Figure 8 gives an example of a treatment map after all the client journeys over a period are added together. The number of times that an element of a treatment journey happens during the year is shown on the diagram (next to the arrow). It is these groups of clients that the map investigates though profiling, and it is these profiles that are used to identify local need.

10.1 Building the treatment map from NDTMS data

The NDTMS provides a spreadsheet with the data required to build a treatment map to each partnership area. The data in the spreadsheet relates to activity in 2006/07 and where appropriate, 2005/06. Each workbook gives a set of profiles for the groups of clients at one stage of the treatment journey. The data contained in the tables is described below. A detailed specification of the data and definitions is provided with the data.

10.1.1 System entry

To simplify the model, the referral sources used on the NDTMS are grouped into four categories: self referrals, criminal justice, GP and other. A client profile table is provided for those groups in the NDTMS spreadsheet which is sent to each partnership.

The data provided about clients starting their journeys at each referral point is available for each referrer to an agency, so each provider can have up to four tables (one each for self referrals, criminal justice, GP and other).

The data also allows the referrals from that source to that provider to be compared over the last two financial years. Changes in the profile of clients being referred will often be linked to a changing need within the treatment population.
10.1.2 Retention in the first 12 weeks

Data will be provided profiling the clients that have entered the treatment system and how well these profile groups have been retained. This data will be reported at both an agency and partnership level allowing detailed analysis and identification of where retention is weak and strong and the comparison against regional and national performance.

It will be important to look at particular cohorts that drop out and their key identifiers – for example, is drop out linked to particular ethnicity or gender or drug use etc.

10.1.3 In treatment

The agency profiles are provided for all agencies from a partnership area in 2006/07. This data provides a demographic breakdown of the clients, but also provides some information about what activity is recorded taking place within the treatment provider. This activity includes individuals’ hepatitis B and C status at the end of the year and a breakdown of the interventions that were provided.

A second set of data is also provided that examines the population that have been treated within the agency for over one year. Examining the difference between these groups will commonly be useful in understanding where blockages occur in the system (groups of clients that stay for a long time), and where there is a treatment need that is not adequately met (groups of clients that rarely stay with a provider for a long time).

10.1.4 Movement within the treatment system

The third stage of the treatment journey on the map is the movement of clients between treatment providers. The figures provided on the spreadsheets are for clients who were being seen by one provider when they were referred to a second.

The data therefore represents flow of clients in one direction. The spreadsheet for this partnership area also has a second table that profiles the clients that moved from agency B to agency A.

10.1.5 Exiting the system

The final part of the treatment journey that the map examines is the exit from the system. This is the point at which the client is discharged from the last provider they attend during their treatment journey.

The profiles of clients who were discharged are broken into three groups – the first group are clients who left the agency after completing their treatment in a planned manner. The second group are those that were referred on to another provider. The third group are those that left treatment in an unplanned way.

Partnerships should consider how far they can further analyse whether different groups such as women, BME groups, criminal justice referrals, prison releases etc. fare better or worse within the drug treatment system – and consider how far this is linked to the availability or accessibility of relevant services. Geographical mapping of treatment data is also a useful exercise mapped against other indicators of need (for example deprivation). Regional NDTMS teams and public health observatories can assist with providing this data to partnerships.
11 Questions and themes to consider for Tier 4 treatment mapping

<table>
<thead>
<tr>
<th>Questions or themes</th>
<th>Data/information sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have other needs assessments been undertaken within or by the partnership on the need for Tier 4 services?</td>
<td>Social services/NHS/NOMS needs assessment</td>
</tr>
<tr>
<td>Tier 4 treatment system entry</td>
<td></td>
</tr>
</tbody>
</table>
| What are the referral points into Tier 4 services. Is there a difference between numbers referred and numbers accessing treatment? Are there any blockages to accessing Tier 4 services? | NDTMS data set Social care activity data Placing teams data Consider:  
  - Actual recorded admissions to services (ensuring that figures from tier 1 Primary Care, social services Community Care and DIP/Probation are captured as well as partnership figures)  
  - Recorded referrals that were not admitted, using the data sources above. Especially important is social services rejections for funding  
  - Referrals direct to providers if possible (this would involve speaking to the most likely recipients of such referrals – may not be feasible).  
  - Non-dedicated units detoxing patients. How do we capture this information? |
| What might future demand look like?                                               | Consider:  
  - Projections of demand based on general projections of year to year change  
  - Projections from Probation/DIP of DRRs with requirement for Tier 4 services, prison releases with requirement for residential rehab etc  
  - Figures from statutory LA/PCT needs assessments for both residential rehab and In-patient  
  - Consultation with user groups/other community groups about potential need. |
<p>| In treatment                                                                      |                                                                                          |
| What is the profile of clients currently accessing Tier 4 treatment interventions – gender, ethnicity, age, drug use, retention levels | NDTMS data set (August 2007) Social care activity data Provider data |
| Is the profile for the overall population of adults in structured drug treatment services different for the Tier 4 population? | NDTMS data set DIP data Adult treatment system map |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a framework to provide information on access, service provision, eligibility and suitability criteria and choice? How does this affect the map?</td>
<td>Placing teams data, Social services data, Expert group feedback, Service user feedback, Parent/family feedback</td>
</tr>
<tr>
<td>Waiting times – are there any blockages in the system? Does this match service user experience?</td>
<td>NTA waiting times information, Expert group feedback, Service user feedback, Parent/family feedback</td>
</tr>
<tr>
<td>What is the current expenditure on Tier 4 services? Is there sufficient funding to meet current referral levels and perceived future demand?</td>
<td>Adult drug treatment plan, Community care reports to JCG, PCT finance reports, Expert group feedback, Service user feedback, Parent/family feedback</td>
</tr>
<tr>
<td>How are Tier 4 services currently commissioned? Are services commissioned fully within the partnership commissioning arrangements or are other agencies also commissioning services?</td>
<td>Social services, PCT, Expert group feedback, Service user feedback, Partnership performance management information</td>
</tr>
<tr>
<td>Consider: • Existing/intended commissioning in collaboration with other partnerships • Protocol for setting budgets/referral levels in place to cover social services funding • Specific eligibility criteria agreed for entry to residential rehab between social services and partnership</td>
<td></td>
</tr>
<tr>
<td>Movement within the Tier 4 system</td>
<td>Provider data, Social services data</td>
</tr>
<tr>
<td>How do clients move within the Tier 4 system – for example, from detox to RR; from RR to supported accommodation etc. Are there specific points of attrition or positive outcomes?</td>
<td>Provider data, Social services data</td>
</tr>
<tr>
<td>Exiting the Tier 4 treatment system</td>
<td>NDTMS data, Social services</td>
</tr>
<tr>
<td>Length of stay, planned discharge, retention rates, outcome profiles</td>
<td>Contract management information – either partnership or social services, Service user satisfaction survey results, Expert group feedback, Service user feedback</td>
</tr>
<tr>
<td>How are providers performance managed and evaluated – and how is client satisfaction assessed?</td>
<td>Contract management information – either partnership or social services, Service user satisfaction survey results, Expert group feedback, Service user feedback</td>
</tr>
<tr>
<td>Question</td>
<td>Data Sources</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Is there access to appropriate accommodation and support following Tier 4 interventions?</td>
<td>Housing providers, Supporting people data, Local authority data, DAAT information, Expert group feedback, Service user feedback</td>
</tr>
<tr>
<td>Consider:</td>
<td></td>
</tr>
<tr>
<td>• Number of units of supported housing commissioned through Supporting People available to those needing aftercare for drug treatment</td>
<td></td>
</tr>
<tr>
<td>• Number of units of floating support commissioned through Supporting People available to those needing aftercare for drug treatment</td>
<td></td>
</tr>
<tr>
<td>• Housing with prioritised referral for those needing aftercare, other than that Supporting People funded.</td>
<td></td>
</tr>
<tr>
<td>• How could we project what accommodation needs are likely to be taken into account for planned/unplanned discharges?</td>
<td></td>
</tr>
</tbody>
</table>

| Are there appropriate aftercare or support packages set up as part of the care planning process? | Tier 3 data, Placing team data, Provider data, Expert group feedback, Service user feedback |
| Consider:                                                                 |                                                                              |
| • Number of residential rehab referrals returning to the partnership area per year (historical and projected) |
| • DIP/Probation projections of prison releases, DRR completions requiring aftercare |
| • Number of referrals through established routes to supported housing for aftercare |
12 Applying the bullseye for treatment planning – an example

The following exercise uses the bullseye model to attempt to profile problematic drug users that are currently not known to Tier 3 and 4 treatment services. This exercise is only one of many potential applications of the bullseye model for treatment planning, but has the advantage that it can be developed using data that is centrally held, and can therefore be provided to partnerships and be used as part of the treatment planning process. Development of the bullseye using matched data from data sources not held centrally would further improve the model.

To use the bullseye as an effective tool, it is necessary to have at least two datasets that can be matched and an estimate of the total population in the target group. The data that is provided by the NTA to partnerships for this purpose in spreadsheets is figures produced from:

- Home Office prevalence estimates for crack and heroin use
- Local NDTMS 2006/07 data.
- Drug Interventions Programme (DIP) data

When using NDTMS data to populate the bullseye, it should be remembered that it does not include Tier 2 data. Consequently the bullseye should not be used to plan for Tier 2 provision unless Tier 2 data can be added. However partnerships should make every effort to establish the level of need for harm reduction services for the proportion of problematic drug users who are not currently accessing structured drug treatment interventions. Where partnerships have access to identified Tier 2 and NDTMS data, it is recommended that these are combined together into one treatment dataset. However, as this will not be normally available, this application of the bullseye will be limited to the version of the bullseye shown in figure 9.

![Figure 9: Tier 3 and 4 version of bullseye with NDTMS data for crack and heroin PDUs](image)

Another limitation of the application of the bullseye presented here is that the Home Office prevalence estimates are only for problematic heroin and crack use. This application of the bullseye will therefore only model the unmet need for treatment among heroin and crack users.
users. However, where there are local prevalence estimates for other forms of PDU, these can be added to the model.

The application of the bullseye presented here is therefore capable of providing some insight into the profiles of crack and heroin using individuals that are currently not known to treatment services. This information should be useful for service planning, as these are the clients who are expected to be referred to treatment services over the next two to three years in significant numbers as a result of the increased activity of the drug interventions programme and the changes to drug treatment within the prison estate.

Table 1 shows the data that is provided on the spreadsheet that is used to populate the bullseye. The spreadsheet provided by the NTA contains both DIP and NDTMS tables for crack and heroin use (a similar breakdown for PDUs who do not use crack and heroin is also provided, but without prevalence estimates).

<table>
<thead>
<tr>
<th></th>
<th>In treatment</th>
<th>In treatment in last year</th>
<th>Known to treatment, but not treated in last year</th>
<th>Total known to Treatment</th>
<th>Prevalence estimate</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>300</td>
<td>280</td>
<td>220</td>
<td>800</td>
<td>1400</td>
<td>100</td>
</tr>
<tr>
<td>Female</td>
<td>120</td>
<td>100</td>
<td>90</td>
<td>310</td>
<td>660</td>
<td>100</td>
</tr>
<tr>
<td>White</td>
<td>350</td>
<td>310</td>
<td>250</td>
<td>910</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>50</td>
<td>50</td>
<td>40</td>
<td>140</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>18</td>
<td>20</td>
<td>15</td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>100</td>
<td>100</td>
<td>80</td>
<td>280</td>
<td>610</td>
<td>60</td>
</tr>
<tr>
<td>25-34</td>
<td>210</td>
<td>180</td>
<td>140</td>
<td>530</td>
<td>890</td>
<td>110</td>
</tr>
<tr>
<td>35+</td>
<td>110</td>
<td>100</td>
<td>90</td>
<td>390</td>
<td>660</td>
<td>120</td>
</tr>
<tr>
<td>Injectors</td>
<td>200</td>
<td>200</td>
<td>180</td>
<td>580</td>
<td>710</td>
<td>100</td>
</tr>
<tr>
<td>Non-injectors</td>
<td>200</td>
<td>150</td>
<td>100</td>
<td>450</td>
<td>1450</td>
<td>200</td>
</tr>
<tr>
<td>Not known</td>
<td>20</td>
<td>30</td>
<td>30</td>
<td>80</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Crack and heroin NDTMS data used to populate bullseye

Figure 10 gives an example of how the data in Table 1 can be represented on a bullseye. In this case, the number of individuals in the outer ring (950) are estimated by subtracting the number of clients known to treatment services from the prevalence estimate (with a prevalence estimate of 2,060, subtract 420, 310 and 380 to arrive at 950).
It should be noted that the prevalence estimate provided by the Home Office has a confidence interval associated with it. The confidence interval supplies the margin of error within which the prevalence estimate has a 95 per cent probability of being correct. So if the prevalence figure supplied for the above were $2,060 \pm 200$, the outer ring should be assumed to lie in the region of $950 \pm 200$.

12.1.1 Using the DIP data to profile clients unknown to treatment services

The purpose of the exercise is to attempt to profile as accurately as possible the estimated 950 clients that do not appear (and therefore cannot be profiled) on the NDTMS. This can be done by profiling the 210 of these clients that have had a DIP contact, and can therefore be profiled through the DIP data.

It should be noted that the profile of clients known to DIP is likely to be a biased representation of the total group. The degree to which DIP clients are non-typical of problematic drug users generally can be estimated by comparing the profiles of clients in the inner three rings. So, if a comparison of the clients known to treatment and DIP in the inner three rings showed that DIP clients were more likely to be younger, with a higher prevalence of crack use than those known to treatment services, this should also be assumed for the clients that are known to DIP in the outer ring of the bullseye.

Once any systematic bias identified in the inner rings of the bullseye are applied to the profiles of DIP clients in the outer ring of the bullseye, a picture should begin to emerge of the age, gender, ethnicity and injecting status patterns of the 950 (+ 200) clients that are unknown to treatment.

13 An example of unmet need

Figure 11 shows the group of clients identified, the possible harms, the potential numbers requiring a service, and whether or not they are more or less likely to be in touch with structured drug treatment interventions.
**Figure 11: Profiles of unmet need**

<table>
<thead>
<tr>
<th>Harms</th>
<th>Numbers</th>
<th>In/out of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless (roofless)</td>
<td>Drug use likely to be more intense &amp; risky – therefore health and criminal harms more likely, overdose &amp; mortality risk high. Mental health issues more likely, high alcohol use.</td>
<td>Estimated 100 roofless in the city centre at one time. 15 out of 108 new presentations to treatment in Q2 were no fixed address.</td>
</tr>
<tr>
<td>Homeless (not roofless)</td>
<td>‘Sofa surfers’, housing issues but not sleeping rough. Similar issues to roofless – possibly less intense combinations of all factors?</td>
<td>70% of DIP cohort have housing issues. ~800 PDUs at risk. View was that most of the opiate using PDU population will have some issues with housing at some point.</td>
</tr>
<tr>
<td>Released from prison</td>
<td>Overdose &amp; mortality risk, particularly where detoxed in prison. Without support (including treatment) likely to return to crime, risky health behaviours. Overlap with homeless.</td>
<td>Q2 05: 44 referrals from DIP team, 118 new clients identified by CARATs. 57 releases informed to DIP teams.</td>
</tr>
<tr>
<td>Serious mental illness</td>
<td>Drug use impacts on ability to respond to treatment for mental health issues. SMI makes them more difficult to engage in drug treatment.</td>
<td>Service A had 56 health problems identified in July 2006; 11 were on CPA, 45 were self-harming.</td>
</tr>
<tr>
<td>Sex workers</td>
<td>Risk of sexual health harms; more likely to be using crack as well as heroin.</td>
<td>250 known to Service B, 90% are drug users (opiates &amp; crack).</td>
</tr>
</tbody>
</table>