

Report to: **Cabinet**  
Date: **11 March 2008**  
By: **Director of Policy & Communications**  
Title of report: **Adult Health & Social Care Commissioning Strategies for Alcohol and Drug Misuse 2008-11**  
Purpose of report: **To give an overview of the Commissioning Strategies for Alcohol and Drug Misuse**

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## **RECOMMENDATIONS**

**The Cabinet is recommended to approve the commissioning strategies for tackling adult alcohol and drug misuse**

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### **1. Financial Appraisal**

1.1 The costs in relation to the implementation of both strategies will not fall on the County Council but the Primary Care Trusts or central allocations to the Drug & Alcohol Action Team. The briefing paper in appendix 1 outlines the cost of both strategies.

1.2 The costs in relation to the monitoring of the strategy implementation will be picked up through the mainstream resources of the Safer Communities Team.

### **2. Supporting Information**

#### Introduction

2.1 The commissioning strategies for alcohol and drug misuse have been developed for East Sussex Drug and Alcohol Action Team (DAAT), the multi-agency strategic partnership responsible for delivering national drug and alcohol strategy objectives in East Sussex. Service users and other stakeholders have been consulted as the strategies have been developed. The strategies have been considered by strategic partners at the DAAT Board.

2.2 Separate but integrated strategies are in place to tackle issues relating to children and young people and mental health. The Lead Member for Adult Social Care is to consider the Joint Commissioning Strategy for Mental Health on 15 April 2008.

2.3 This briefing paper in appendix 1 provides a summary of both the alcohol and drug commissioning strategies. It outlines the key points of each strategy, financial implications and the benefits they are intended to produce. The full strategies are attached as Appendix 2 and 3. They follow a similar format and consider national and local policy drivers, local needs, an analysis of current services, provider market and resources, changes to service models and monitoring arrangements. There is a summary of the consultation feedback in appendix 4 of this report.

2.4 Specialist treatment services for people who misuse alcohol have suffered from chronic under-investment in East Sussex. The commissioning strategy for alcohol misuse proposes a service model that is not currently resourced. The proposal will be considered by both Primary Care Trusts as part of the business plan

for 2008/9. The commissioning strategy for drug misuse is within the anticipated resource limit.

### **3. Community Safety Issues**

3.1 Both the alcohol and drug strategies will make a significant contribution to community safety in East Sussex. The national strategy is founded on a strong evidence base which demonstrates that every additional £1 of investment in drug treatment saves £9.50 to the public purse. As the waiting times and throughput of treatment services in East Sussex have improved there has been a material reduction in associated crimes, particularly in Hastings and in Eastbourne.

### **4 Conclusion and Reason for Recommendation**

4.1 The Cabinet is asked to endorse both of the commissioning strategies prior to their consideration in the Primary Care Trust Business Plan 2008/9. Both strategies will be instrumental in improving treatment services across the County which will in turn, improve both the health and safety of East Sussex residents.

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Director of Policy & Communications

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#### **BACKGROUND DOCUMENTS**

Commissioning Strategies Briefing Paper – Appendix 1  
Alcohol Misuse Commissioning Strategy – Appendix 2  
Drug Misuse Commissioning Strategy – Appendix 3  
Summary of Consultation Feedback – Appendix 4

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### Appendix 1

This briefing paper describes the commissioning strategies for alcohol and drug misuse that have been developed for East Sussex Drug and Alcohol Action Team (DAAT), the multi-agency strategic partnership responsible for delivering national drug and alcohol strategy objectives in East Sussex. Service users and other stakeholders have been consulted as the strategies have been developed. The strategies have been considered by strategic partners at the DAAT board.

Both strategies follow a similar format and consider national and local policy drivers, local needs, an analysis of current services, provider market and resources, changes to service models and monitoring arrangements.

This paper provides a summary of first the alcohol and then the drug commissioning strategy. It outlines the key points of each strategy, financial implications and the benefits they are intended to produce.

Specialist treatment services for people who misuse alcohol have suffered from chronic under-investment in East Sussex. The commissioning strategy for alcohol misuse proposes a service model that is not currently resourced. The proposal will be considered by both Primary Care Trusts as part of the business plan for 2008/9. The commissioning strategy for drug misuse is within the anticipated resource limit.

### **1. Alcohol misuse strategy – key points**

Developing a local alcohol commissioning strategy was a commitment in the East Sussex alcohol harm reduction strategy, brought into the Safer Communities Plan.

The Choosing Health white paper estimated that up to 35% of all accident and emergency attendances and ambulance costs are alcohol related. Alcohol misuse costs the NHS in England up to £1.7 billion each year. The Department of Health published the 'Alcohol Needs Assessment Research Project' and 'Alcohol Misuse Interventions: Guidance on Developing a Local Programme of Improvement' in 2005, and in 2006 published 'Models of Care for Alcohol Misuse', best practice guidance for health service organisations, local authorities and regional government offices.

The national alcohol strategy 'Safe. Sensible. Social.' Sets out the next steps to address alcohol misuse. 'Reducing alcohol harms' has been included in Public Service Agreement (PSA) 25 from April 2008, measured by reductions in alcohol-related hospital admissions (source data will be Hospital Episode Statistics).

This data is included with other indicators in the 'Local Alcohol Profiles for England' published by the North West public health observatories. The reports compare the impact of alcohol across the 354 local authorities in

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England. Authorities are 'ranked' according to the impact of alcohol locally, and charted to provide a straightforward comparison with other areas in England.

There are an estimated 6,500 dependent drinkers in East Sussex. The public health observatory data estimates there are 18,000 'harmful drinkers' - heavy alcohol consumption already resulting in physical or mental harm to the user – and 92,000 'hazardous drinkers' – behaviour which represents a high risk of future damage to the health of the drinker, but which has not yet resulted in significant physical or psychological harm.

In East Sussex, alcohol has the most impact in Hastings. Hastings is ranked in the 'worst' 3 local authorities in the South East for 10 of the 14 indicators. It is ranked 1 (i.e. worst in the South East) for alcohol related months of life lost for females. Eastbourne is ranked in the 'worst' 3 local authorities in the South East for alcohol specific hospital admissions for people aged under 18 (both male and female). Alcohol specific admissions for adult males and months of life lost are also comparatively very high.

Rother records particularly high rates of mortality from chronic liver disease and alcohol specific hospital admissions for females aged less than 18. For other indicators, the impact of alcohol is neither better nor worse than many other areas in the South East. The impact of alcohol in Lewes and Wealden is comparatively much lower than in other areas of East Sussex.

The strategy sets out a service model to address the alcohol misuse treatment needs of local people. The model implements DH guidance and reflects the local context.

The service model develops two particular areas:

- Screening and brief interventions in non-specialist settings;
- Specialist interventions delivered in community services.

### **Screening and brief interventions**

The strategy describes how 'screening' and 'brief interventions' can be delivered in non-specialist settings by adopting a workforce development approach with staff working in general health and social care contexts.

The purpose of this approach is to enable staff to identify people whose drinking is becoming problematic as early as possible, and to deliver short interventions that can effect change. This approach has a good evidence base and is promoted by the Department of Health.

This development is already within the Hastings and Rother PCT and East Sussex Downs and Weald strategic commissioning plans. The 'Choosing Health' resource allocation includes funding for alcohol and is intended to develop this type of service.

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### Specialist interventions in community settings

The strategy describes how a multi-disciplinary team will deliver specialist interventions in primary care to people whose drinking is already harmful or dependent. The evidence base describes a range of effective interventions. The service should be provided for every GP surgery in East Sussex. For more complex cases requiring medical support the strategy describes how the Local Enhanced Service operating in Hastings should be rolled out across East Sussex with support from the specialist substance misuse service and an outpatient 'ambulatory' detoxification service. This approach delivers the 'stepped care' model promoted by the Department of Health.

The demand for the service has been modelled using the needs assessment data and estimating the capacity required to provide a service for 20% of the people whose drinking behaviour is harmful or dependent.

### Alcohol misuse strategy – cost

The national Choosing Health 'alcohol' allocation is £15m of recurrent funding (not ring-fenced) provided to PCTs from 2007/8 to implement the alcohol commitments in the white paper. The resource allocated to East Sussex in 2007/8 is £148K. The strategy requires each PCT to fully allocate the choosing health 'alcohol' component from 2008/9 to develop screening and brief interventions in non-specialist settings.

	East Sussex Downs and Weald	Hastings and Rother	Total East Sussex
Screening and brief interventions	£93K	£55K	£148K

Developing specialist interventions in community settings will require new investment. There is a gap of £1.2m between the resource currently allocated to specialist alcohol services and the estimated cost of implementing the service model across East Sussex. An implementation plan has been developed that phases the development and associated costs over the three-year period of the strategy.

	East Sussex Downs and Weald PCT		Hastings and Rother PCT		East Sussex
	Recurrent investment	Additional investment required	Recurrent investment	Additional investment required	Cumulative additional investment
Current allocation	£50K		£230K		
Year 1	£400K	+ £350K	£300K	+ £70K	+ £420K
Year 2	£610K	+ £210K	£450K	+ £150K	+ £780K
Year 3	£830K	+ £220K	£610K	+ £160K	+ £1.2m

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### Health inequalities and deprivation as co-factors

The East Sussex Joint Strategic Needs Assessment (JSNA) reports that “attitudes and behaviours that affect health outcomes, such as...binge drinking...are linked to deprivation.” The commissioning strategy notes that “there is a clear link between the impact of alcohol harms and more general indicators of deprivation. The impact of alcohol misuse is particularly harmful for people whose general health is already poor.”

If service development is focused particularly in deprived areas, the opportunity to benefit may be limited by other health factors (for example smoking or diet) and the positive impact may be less than in other localities.

Ensuring the phased implementation includes a range of areas will increase the potential to demonstrate measurable improvements in the local situation.

### Alcohol misuse strategy – benefits

Investing in alcohol treatment is an ‘invest to save’ strategy. Reducing alcohol misuse will reduce health costs across emergency and elective care.

Comprehensive Spending Review 2007 introduced Public Service Agreement (PSA) 25, with a key objective to reduce the harms caused to health and well-being by frequent consumption of harmful levels of alcohol, measured by a reduction in the rate of alcohol-related hospital admissions. This is included in the LAA national indicator set as NI 39 [Alcohol-harm related hospital admission rates PSA 25]. The technical definition has not yet been published.

Measurement of local performance will be based on the methodology developed by the North West Public Health Observatory (NWPHO), which considers the alcohol related ‘attributable fraction’ for a wide range of diseases<sup>1</sup>. Hospital Episode Statistics will be used as the basis for measurement, with ICD-10 codes used to identify the number of episodes of alcohol-related hospital admissions.

The following information has been produced locally to report the number and cost of alcohol-related hospital admissions based on the NWPHO methodology. This information excludes episodes that relate purely to alcohol misuse (acute intoxication, withdrawal and so on).

PCT	Provider	Spells	PBR Cost	AF Spells	PBR Cost of AF Spells
ESDW	RXC	6550	£13,935,592	1,250	£2,666,629
ESDW	RXH	1931	£4,544,459	382	£862,333
ESDW	RWF	1126	£2,243,603	236	£455,239
				<b>1,868</b>	<b>£3,984,201</b>
HAR	RXC	6116	£13,413,325	1,229	£2,536,825

<sup>1</sup> For example, 5% of Malnutrition-related diabetes mellitus (both male and female) is alcohol-attributed.

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HAR	RXH	213	£745,530	34	£110,890
HAR	RWF	80	£148,538	20	£36,032
				<b>1,283</b>	<b>£2,683,748</b>

2006-7 Admitted patients at ESHT (RXC), BSUH (RXH) and MTW (RWF), from ESDW PCT and HAR PCT.

In East Sussex in 2006/7 there were a further 355 alcohol-specific admissions.

PCT	Spells	PBR Cost
ESDW	170	£287,937
HAR	185	£285,238

Total cost to both PCTs using the ICD-10 codes and NWPHO methodology as the basis of calculation was £7,241,124.

### 2. Drug misuse strategy – key points

Treatment for drug misuse remains a national policy priority. The two 'drug misuse' Local Delivery Plan targets are expected to remain in place.

The number of people in treatment has been increased by 50% over the last three years (to 1,544 people in 2006/7). Treatment effectiveness needs to be improved – around 25% of people drop out of treatment during the first few weeks. By 12 weeks - the point at which the evidence suggests lasting change is measurable - 65% of people remain in treatment. Only 20% of people currently leave treatment in a planned way. Around 70% of the current 'in treatment' population have completed previous treatment episodes, and re-presented for treatment following a relapse.

The strategy describes how access to effective services will be improved. Services currently under contract with Sussex Partnership NHS Trust and voluntary sector organisations will be contested by competitive tender. The service model will be redesigned to encourage treatment in primary care rather than specialist settings. The skills-mix of the teams providing specialist prescribing services will be re-specified, reducing the proportion of nursing expertise and increasing pharmacist and professional drug worker resources within the teams. The service model will encourage non-medical prescribing by suitably qualified nurses and pharmacists.

NICE published clinical guidelines in July 2007. These will be implemented by reinvesting in a service model that reflects the guidelines, including contingency management.

### Drug misuse strategy – cost

The strategy requires the ongoing commitment of the budget currently ring-fenced for drug misuse treatment. The strategy anticipates that the dedicated

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resource allocated centrally will reduce by £150K, around 3.5% of the total 2007/8 budget.

### **Drug misuse strategy – benefits**

The national strategy is founded on a strong evidence base which demonstrates that every additional £1 of investment in drug treatment saves £9.50 to the public purse. As the waiting times and throughput of treatment services in East Sussex have improved there has been a material reduction in associated crimes, particularly in Hastings and in Eastbourne.

The greatest cost benefit will be realised by increasing the effectiveness of treatment, materially increasing the number of people who improve their situation and leave treatment in a planned way. This will reduce the number of people who re-present for repeated episodes of treatment that end in an unplanned way.

Jason Mahoney, Joint Commissioning Manager

## Improving alcohol misuse treatment

2008/11

East Sussex Health and Social Care Commissioning Strategy for  
Adult Alcohol Misuse

East Sussex Drug and Alcohol Action Team

**Publication date: January 2008**



The UK Government advises that men should not regularly drink more than three to four units a day and women not more than two to three. Consistently drinking four or more units for men, and three or more for women, isn't advisable because of the progressive health risks it carries. After an episode of heavy drinking it is advisable to refrain from drinking for 48 hours.

As a general rule, pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby they should not drink more than 1 to 2 units of alcohol once or twice a week and should not get drunk.

## Improving alcohol misuse treatment

2008/11

East Sussex Health and Social Care Commissioning Strategy for Adult Alcohol Misuse

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## 1. Introduction

Safe. Sensible. Social. The Government published the next steps in the National Alcohol Strategy in June 2007. Alcohol related harm costs an estimated £1.7 billion in healthcare every year in England and Wales. If crime and disorder and loss of productivity costs are added in then the total annual cost is closer to £20 billion. These costs can be materially reduced by preventing alcohol misuse and providing treatment for those that need it.

This commissioning strategy sets out the direction for developing health and social care services for working age adults suffering alcohol misuse. It has been developed by the Drug and Alcohol Action Team (DAAT), the multi-agency strategic partnership responsible for delivering national drug and alcohol strategy objectives in East Sussex. The partnership published its harm reduction strategy in April 2006. Since then the partnership has maintained a dialogue with service users, providers and other stakeholders to ensure that local priorities inform the development of local services.

The Audit Commission (2003) defines commissioning as “the process of specifying, securing and monitoring services to meet people’s needs at a strategic level.” Meeting needs at a strategic level implies a good understanding of current and forecast needs. ‘Joint commissioning’ can be described as the process in which two or more organisations jointly take responsibility for commissioning. As a partnership that includes health, social care and criminal justice agencies the DAAT operates in a joint commissioning context.

The context for the development of health and social care services is set out in the white paper *Our health, our care, our say* (2006), further developed by the *Commissioning Framework for Health and Well Being* (DH, 2007). The development of adult health and social care will provide more control, choice and a stronger voice for individuals. Services will be provided more flexibly and closer to home. There is a shift in focus for the NHS towards improving health and well being, rather than responding to illness.

The changes are intended to put incentives in the right place to drive quality improvement, making services more responsive to the people who use them and their carers.

Commissioners are required to develop strategies that will improve choice by encouraging the people who provide services to be innovative about how those services are delivered. Current providers are encouraged to develop new services and new ways of working. Other organisations might be invited to deliver services to local people. A clear set of quality standards apply universally for all provider organisations, whether NHS or independent sector. Local people should expect good quality accessible services that are relevant to their needs wherever they live.

The partnership has consulted widely with the people affected by the strategy. The harm reduction strategy (2006) described the need to commission

services that respond appropriately to the needs of local people. This commissioning strategy sets out how that will be done.

### **Alcohol misuse**

This commissioning strategy considers the health and social care needs of working age adults suffering alcohol misuse. The strategy focuses on people who are drinking in a way that is likely to cause harm, or already does. We want to develop ways of working that quickly identify when drinking might be a problem, and respond appropriately. We particularly want to focus responses on the minority of adults who cause or experience the most harm to themselves, their communities and their families.

### **Next Steps**

The strategy describes a step-change in the way services are delivered, with a particular focus on developing services in primary care. An implementation plan will be published during 2008. Implementation will be monitored by the East Sussex Alcohol Strategy Group.

## **2. National and Local Requirements and Research**

### **National Strategy**

Reducing alcohol harms has been included in Public Service Agreement 25 from April 2008. A key objective for PSA No. 25 will be to reduce the harms caused to health and well-being by frequent consumption of harmful levels of alcohol. This will be measured by the number of alcohol-related hospital admissions.

Alcohol-related illness or injury accounts for 180,000 hospital admissions per year. In 2005, 4,160 people in England and Wales died from alcoholic liver disease. For men who are regularly drinking more than 8 units a day and women regularly drinking more than 6 units a day, or 50/35 units per week respectively, the risks of various diseases, such as liver disease, stroke etc., are significantly higher.

'Safe. Sensible. Social', describes the 'next steps' in the Government's national alcohol strategy as a series of actions to address alcohol misuse to achieve the long-term goal - "To minimise the health harms, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol, safely and responsibly."

Adult health and social care actions include a review of NHS alcohol spending, more help for people who want to drink less, guidance and information and a requirement for local alcohol strategies.

The Department of Health has published Models of Care for Alcohol Misuse (MoCAM, NTA 2006) as 'Best Practice Guidance' for health service organisations, local authorities and regional government offices. MoCAM is

explicitly linked to the Department of Health's (2004b) Standards for Better Health across a number of domains.

MoCAM is linked to other National Treatment Agency for Substance Misuse (NTA 2006a, 2006c) guidance about alcohol treatment effectiveness. It draws on the Alcohol Needs Assessment Research Project (ANARP) published by the Department of Health (2005b) and on the Department's (2005a) Alcohol Misuse Interventions: Guidance on Developing a Local Programme of Improvement.

Publication of MoCAM is explicitly identified as a significant milestone towards achieving the second aim of the Alcohol Harm Reduction Strategy for England, 'to better identify and treat alcohol misuse'. MoCAM is a direct commitment in the 'Choosing Health' white paper.

The expectation is that MoCAM will be used by PCTs working in partnership with local commissioning groups and local service providers to develop and build integrated systems that meet the needs of local people whose alcohol misuse is harmful and requires intervention or treatment.

### **Standards for Better Health**

The Department of Health's (2004) Standards for Better Health describes the level of quality that health care organisations (including NHS Foundation Trusts and private and voluntary providers of NHS care) are expected to meet. The standards cover seven domains – safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health.

There are two sets of standards:

- Core standards: which bring together and rationalise existing requirements for the health service, setting out the minimum level of service patients and service users have a right to expect; and
- developmental standards – which signal the direction of travel and provide a framework for NHS bodies to plan the delivery of services which continue to improve in line with increasing patient expectations.

Standards for Better Health forms a key part of the performance assessment by the Healthcare Commission (HC) of all health care organisations. MoCAM explicitly refers to the NTA/HC partnership work on drug treatment. The Department of Health is looking at how the work can be used as a model for alcohol interventions.

MoCAM supports local healthcare organisations to meet core and developmental standards within the following domains:

Domain	Core Standard	Developmental Standard

Clinical and cost-effectiveness	C5	D2
Accessible and responsive care	C17, C18	D11
Public Health	C22, C23	D13

Table (i) Standards for Better Health

MoCAM also refers to standards relevant to workforce issues – the NHS Knowledge and Skills Framework (KSF), Drug and Alcohol National Occupational Standards (DANOS) and social care standards for people working in registered care homes.

MoCAM sets out the key quality requirements for commissioners and providers of alcohol treatment:

#### Quality Criteria for Commissioning Alcohol treatment

- Commissioning alcohol treatment systems
- Monitoring the performance of alcohol treatment systems
- Commissioning and providing an alcohol treatment system to meet a diverse range of local population needs

#### Quality criteria for providing an evidence-based alcohol treatment system

- Screening the target population and taking action with individuals who are hazardous and harmful drinkers
- Assessing the needs of individuals with identified alcohol problems and others who may be affected
- Care planning to meet the assessed needs of those with alcohol problems
- Providing a range of structured treatment interventions to meet the needs of alcohol misusers
- Helping individuals maintain the gains they have made from alcohol treatment
- Managing alcohol treatment services

MoCAM fully describes the standards required for each criterion.

### **Treatment tiers – a stepped approach**

MoCAM adopts a ‘tiered’ conceptual models similar to that described by Models of Care for the Treatment of Drug Misuse, and other in healthcare settings. Interventions are organised within four tiers, and generally delivered within different settings (see appendix one). The model is summarised below. A more detailed summary of treatment interventions and settings is included at appendix two.

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Tier 1 interventions	Alcohol-related information and advice; screening; simple brief interventions and referral
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Tier 2 interventions	Open access, non-care-planned alcohol-specific interventions
Tier 3 interventions	Community-based, structured, care-planned alcohol treatment
Tier 4 interventions	Alcohol specialist inpatient treatment and residential rehabilitation

Table (ii) Treatment Tiers

It's important to note that the model refers to the interventions, and not to the service providing the intervention – an inpatient service may reasonably provide advice and information about safer drinking, which is readily described as a tier one intervention.

MoCAM reinforces the treatment demand model outlined in the East Sussex strategy. People whose drinking behaviour is hazardous or harmful are likely to benefit from advice, information and brief interventions. People who are dependent are likely to benefit from structured treatment. People who are severely dependent (and/or dependent with complex needs) are most likely to benefit from inpatient and residential services. Although these generalisations are useful to map demand for services, individual needs will vary and all interventions must be based on a proper assessment of need.

Problem drinking behaviour		Tier of intervention			
		Tier 1	Tier 2	Tier 3	Tier 4
more complex needs ↓	Hazardous				
	Harmful				
	Moderately dependent				
	Severely dependent				
		More intense and prolonged interventions →			

Table (iii) Stepped care

MoCAM advocates a 'stepped care' approach, where new entrants to structured treatment interventions should be assessed and receive 'the least intrusive or least prolonged intervention considered suitable for the level of need and complexity identified'. If the intervention doesn't produce the intended outcome then the clinical review should consider the need for a more intense treatment.

MoCAM highlights the importance of properly planned and effective integrated care pathways, which enable the proper coordination of care throughout the

service user's 'alcohol treatment journey'. The guidance notes that problem alcohol use may require multiple treatment episodes, particularly for those with more complex needs.

Specialist alcohol services need to be able to respond flexibly to individuals' changing needs, and to work collaboratively with other services providing more general health and social care interventions.

### **Early intervention**

Early interventions prevent longer-term health and social care costs. Identifying a pattern of 'binge drinking' (consuming double the daily recommended alcohol consumption limit) and delivering a brief intervention can prevent longer-term alcohol misuse.

In the Review of the Effectiveness of Treatment for Alcohol Problems, Raistrick, Heather and Godfrey (2006) describe distinctions between 'simple brief interventions' – structured advice taking no more than a few minutes – and 'extended brief interventions' – structured therapies taking 20-30 minutes and often involving one or more repeat sessions.

There is a strong evidence base supporting the efficacy of a range of 'brief intervention' approaches for people with less severe alcohol problems, delivered in a range of settings. There is mixed evidence on whether 'extended' interventions add anything to the effects of 'simple brief intervention' - structured advice.

### **Structured Treatment**

'Structured Treatment' should include a range of approaches and be delivered in a range of settings. Treatment options need to include interventions that focus on achieving and maintaining abstinence, particularly for those people who have impaired liver function and people who cannot maintain a safer, controlled pattern of alcohol use. Less structured interventions need to be widely accessible. The effectiveness of different popular treatment approaches has been found to be broadly similar (Project Match (1997), UKATT (2005)). Substantial and enduring treatment gains are often acquired quickly with relatively modest treatment contact – even within the first session.

Raistrick, Heather and Godfrey (2006) report the evidence base for a range of structured treatment interventions. That analysis is summarised here very briefly, much more detail is provided in the source document.

<b>Less intensive treatment</b>	
<b>Approach</b>	<b>Summary of approach &amp; evidence</b>
1. Basic treatment scheme	Three-hour assessment and advice, and a follow-up review. Effective for moderately dependent male service users with intact marriages.

<b>Less intensive treatment</b>	
<b>Approach</b>	<b>Summary of approach &amp; evidence</b>
2. Condensed cognitive behavioural therapy	Three sessions of advice using a CBT approach and leaflet-guided self-help is effective, particularly among female service users with mild to moderate dependence.
3. Brief conjoint marital therapy	A single session of advice counselling is effective for moderately dependent users with intact marriages.
4. Motivational interviewing	The principles and style of MI should inform and can enhance more extensive psychosocial treatment. Can be an effective preparation for more intensive treatments, or a cost-effective alternative to other forms of psychosocial treatment.
5. Motivational enhancement therapy	Three sessions of MET is effective for moderately dependent users, provided the service user accepts less intensive treatment and there is follow-up. MET is also a reasonable first step in a stepped care approach for more severe dependence.

<b>Alcohol focused specialist treatment</b>	
<b>Approach</b>	<b>Summary of approach &amp; evidence</b>
6. Community reinforcement approach	CRA includes a broad range of treatment approaches to engineer the service users environment to reward sobriety and ensure intoxication is unrewarded. Effective, particularly for severe alcohol dependence and with socially unstable or isolated service users.
7. Social behaviour and network therapy	SBNT was developed for the UKATT. The approach encourages social support for achieving and maintaining change over 8 weekly input sessions. UKATT compared SBNT with MET and found both approaches to be similarly effective – and MET more cost effective. People with a high level of anger at treatment entry fared better with MET.
8. Behavioural self-control training	Focused on setting limits, developing skills to reduce alcohol use and self-rewards for successful behaviours, BSCT is described as the most effective treatment modality available for service users considered suitable for a 'moderation' goal.
9. Behaviour contracting	BC involves negotiating agreement between the service user and significant others about mutual expectations and obligations. A component of treatment rather than a standalone approach.
10. Coping and social skills training	An assessment of specific social skills deficits (including interpersonal relationships, mood regulation, coping skills) is followed by skills training with goal setting and self-monitoring. Effective for moderately dependent service users, especially for people lacking social skills.
11. Cognitive	CBMT is an approach which includes the service user and

<b>Alcohol focused specialist treatment</b>	
<b>Approach</b>	<b>Summary of approach &amp; evidence</b>
behavioural marital therapy	partner and involves behavioural contracting, communication skills training and so on. A single session of CBMT can be effective for people with relatively intact relationships and moderate alcohol problems..
12. Aversion therapy	'Nausea' therapy achieved by chemical or other means, aversion therapy is not recommended and has been largely abandoned in favour of more pleasant, less dangerous and less ethically problematic approaches.
13. Cue exposure	This is described as a promising treatment approach that has insufficient evidence to justify as a standalone treatment and requires further research.
14. Relapse prevention	RP is a set of techniques and principles that should be incorporated into all specialist treatments. There is good evidence of effectiveness of the specific programme described by Marlatt and Gordon. That programme is CBT based and includes social skills training, coping skills training and behavioural rehearsal.
15. Aftercare	Planned and structured aftercare is effective in improving outcome among service users with more severe alcohol problems. There is no evidence about what approach is the most effective, but aftercare generally includes follow-up at 3, 6 and 12 months. Aftercare may not be effective for service users with less severe problems, for whom the prognosis is already good without any aftercare.
16. Extended case monitoring	ECM is a form of aftercare with continued low intensity contact (e.g. a telephone call on a tapering schedule over two years). There is very limited research – just one study – but the findings are promising.

## **Local Requirements**

In April 2006, East Sussex DAAT published its Alcohol Harm Reduction Strategy. The strategy describes the need to expand treatment across the treatment tiers, included as a range of objectives in the 'adult identification and treatment' section of the strategy. The objectives focus on commissioning appropriate services. This strategy sets out how that will be achieved.

Other local strategies and policy drivers include:

- East Sussex Local Area Agreement (LAA) – All Together Better. Substance misuse issues are considered at section 17.4;
- East Sussex County Council Adult Social Care Equality and Diversity Improvement Plan 2007-2010;
- East Sussex Safer Communities Plan 2007;
- Dual Diagnosis strategy 2005;
- Supporting People strategy 2005-2010

### 3. Needs Assessment

Alcohol misuse impacts upon a broad range of issues. The national alcohol harm reduction strategy reported how across England, alcohol misuse is linked with:

- 40% of violent crimes;
- 39% of deaths in fires;
- 15% of drownings;
- 1 in 7 road traffic deaths;
- 30,000 hospital admissions annually because of Alcohol Dependence;
- 150,000 hospital admissions annually because of alcohol misuse;
- 20,000 premature deaths - about a fifth because of acute problems;
- 1.2 million alcohol-related incidents every year;
- between 0.78 and 1.3 million children affected by family drinking;
- 65% of suicides.

Drawing on hospital episode statistics and other nationally available datasets, this section sets out the demand for alcohol treatment in localities across East Sussex.

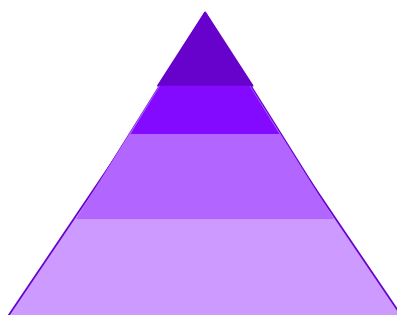
#### A conceptual framework – treatment for alcohol misuse

MoCAM identifies four main categories of alcohol misusers who may benefit from an intervention or treatment (in increasing order of severity of problem):

- Hazardous drinkers
- Harmful drinkers
- Moderately dependent drinkers
- Severely dependent drinkers

Around 21% of the population are estimated to be drinking within one of these categories.

67.1% of people are 'low risk' drinkers – their behaviour is within the recommended safer drinking limits – and 12% of people don't drink alcohol.



Severely dependent	< 0.1%
Moderately dependent	< 0.4%
Harmful drinkers	4.1%
Hazardous drinkers	16.3%

These classifications (and the definitions that support them) are included in the East Sussex alcohol harm reduction strategy (2006). MoCAM notes that categorisation of drinking behaviour is not straightforward, and that a 'severely dependent' categorisation is pragmatic, and should include 'dependent with complex needs'.

MoCAM, and the East Sussex alcohol harm reduction strategy (2006) also presents the information based on an 'average' General Practice caseload of 1800, of whom a little over 75% will be adults.

That information is summarised in the table below, giving an idea of what the national data means for a GP in an area where the impact of alcohol reflects the national average.

Classification	Cases	Suggested interventions
Severely dependent (0.1%)	1	Detoxification inpatient ambulatory (outpatient) GP-managed home detox Psychosocial support (residential / community)
Moderately dependent (1.4%)	20	Detoxification ambulatory (outpatient) GP-managed home detox Psychosocial support (residential / community)
Harmful drinkers (4.1%)	60	Brief Interventions Harm minimisation advice Psychosocial support in the community
Hazardous drinkers (16.3%)	220	Brief interventions Harm minimisation advice
Low risk drinkers (67.1%)	920	
Non drinkers (12%)	160	

Table (iv) Estimated numbers of Adults within each drinking behaviour classification in an 'average' General Practice. The model assumes an average patient list of 1,800, around 75% (1,350) adults.

The impact of alcohol in a General Practice may be greater (or less) than the national average. Information about local demand helps to shape the design of a service response across the partnership.

### Assessing local demand for services

The Alcohol Needs Assessment Research Project (ANARP) provides a web-based tool ([www.nwph.net/alcohol](http://www.nwph.net/alcohol)) to estimate the number of local people who may be classified as each type of alcohol misuser. This information should then be used to estimate the demand for different interventions and treatment services. Interventions and services should then be commissioned on the basis of the guidance about interventions for particular types of problem drinking behaviour and best value principles.

### Local Alcohol Profiles for England

The Public Health Observatories produce community health profiles for local authorities across England (see [www.communityhealthprofiles.info](http://www.communityhealthprofiles.info)) providing health information about local populations. The impact of alcohol will vary in different areas. There is a clear link between the impact of alcohol harms and

more general indicators of deprivation. The impact of alcohol misuse is particularly harmful for people whose general health is already poor.

There is also evidence that more affluent populations tend to drink more, suggesting inequality with a greater impact of alcohol upon neighbourhoods with material deprivation.

The Public Health Observatories have produced 'Local Alcohol Profiles' for England, and ranked each of the 388 Local Authorities against each indicator – Hooper et al (2006) describe the methodology in detail. Comparative data and alcohol profiles for East Sussex localities are included at appendix three. The information demonstrates that harms caused by alcohol misuse are most significant in Hastings and Eastbourne.

The 2007 Local Alcohol Profiles include prevalence estimates for hazardous and harmful drinking. The profiles estimate that there are about 92,000 hazardous drinkers and 18,000 harmful drinkers in East Sussex.

Primary Care Trust	Hazardous drinking – population			Hazardous drinking - prevalence		
	Population	Lower	Upper	Hazardous	Lower	Upper
	estimate	Confidence	Confidence	Drinking	Confidence	Confidence
		Limit	Limit	Prevalence	Limit	Limit
Hastings and Rother	31,388	28,941	33,835	22.20%	20.50%	24.00%
East Sussex Downs and Weald	60,306	55,649	64,963	22.70%	21.00%	24.50%
Total	91,694	84,590	98,798			

Primary Care Trust	Harmful drinking - population			Harmful drinking - prevalence		
	Population	Lower	Upper	Harmful	Lower	Upper
	estimate	Confidence	Confidence	Drinking	Confidence	Confidence
		Limit	Limit	Prevalence	Limit	Limit
Hastings and Rother	6,642	6,004	7,280	4.70%	4.30%	5.20%
East Sussex Downs and Weald	11,062	9,996	12,128	4.20%	3.80%	4.60%
Total	17,704	16,000	19,408			

Table (v) Hazardous and harmful drinking prevalence estimates

Compared to other areas, there are some issues that are particularly striking about East Sussex. The table below highlights areas that are scored in the upper quartile (the 25% of local authorities recording the greatest impact) nationally, with a regional (South East) ranking. A rank of '1' (out of 67 authorities) means the local authority records the greatest impact in the South East. In East Sussex, alcohol has the most impact in **Hastings**. Hastings is ranked in the 'worst' 3 local authorities in the South East for 10 of the 14 indicators. It is ranked 1 for alcohol related months of life lost for females.

**Eastbourne** is ranked in the 'worst' 3 local authorities in the South East for alcohol specific hospital admissions for people aged under 18 (both male and female). Alcohol specific admissions for adult males and months of life lost are also comparatively very high.

**Rother** records particularly high rates of mortality from chronic liver disease and alcohol specific hospital admissions for females aged less than 18. For other indicators, the impact of alcohol is neither better nor worse than many other areas in the South East and is around the national average for most indicators.

The impact of alcohol in **Lewes** and **Wealden** is comparatively much lower than in other areas of East Sussex – around half the national average for most indicators.

Local Authority	Upper Quartile Indicators	SE rank
Eastbourne	Alcohol related months of life lost – males	4
	Mortality from chronic liver disease – females	9
	Alcohol related hospital admission - males	4
	Alcohol specific hospital admission - males	10
	Alcohol specific hospital admission - females	13
	Alcohol related recorded crimes	10
	Alcohol related violent offences	8
	Alcohol related sexual offences	15
	Alcohol specific hospital admission - Under 18 males	2
	Alcohol specific hospital admission - Under 18 females	2
Hastings and St Leonards	Alcohol related months of life lost - males	2
	Alcohol related months of life lost - females	1
	Alcohol related hospital admission - males	4
	Alcohol related hospital admission - females	2
	Alcohol specific hospital admission - males	2
	Alcohol specific hospital admission - females	2
	Alcohol related recorded crimes	2
	Alcohol related violent offences	3
	Alcohol related sexual offences	3
	Alcohol specific hospital admission - Under 18 males	3
	Alcohol specific hospital admission - Under 18 females	3
Lewes	- NO UPPER QUARTILE INDICATORS -	-
Rother	Mortality from Chronic Liver Disease (male)	4
	Alcohol specific hospital admission - Under 18 males	10
	Alcohol specific hospital admission - Under 18 females	4
Wealden	- NO UPPER QUARTILE INDICATORS -	-

Table (vi) Local Alcohol Profiles – local authority upper quartile indicators

This information has been used to estimate demand across an average caseload for a GP in each local authority by taking the ‘average’ GP caseload information, ranking each local authority using the Local Alcohol Profiles for England information and multiplying the ‘average’ estimate by a factor that reflects the local situation.

Wealden	Lewes	Rother	Eastbourne	Hastings
Impact factor x 0.5	Impact factor x 0.5	Impact factor x 1.0	Impact factor x 1.5	Impact factor x 1.75

This is a pragmatic approach to estimate demand, and to give some sense of the differences between the localities. The approach gives prevalence estimates for 'harmful' drinkers within the range indicated in the LAPE estimate indicated in table (v) above, giving a measure of assurance about the method applied. Estimated demand within a practice should be adjusted according to the number of GPs and if a GP is serving a population materially different to the RCGP's (2004) 'average list size' estimate of 1,800 people (1,350 adults).

Classification	Estimated cases for each General Practitioner by local authority				
	Wealden	Lewes	Rother	Eastbourne	Hastings
Severely dependent	1	1	1	1	2
Moderately dependent	10	10	20	30	35
Harmful drinkers	30	30	60	90	105
Hazardous drinkers	110	110	220	330	385

Table (vii) Estimated prevalence by GP by local authority

It's important to note that these 'average' estimates are based on local authority boundaries and do not account for differences within each local authority. Although alcohol has a relatively low impact within Lewes, the impact within the District will be greater along the coastal strip within specific wards or super-output areas where deprivation is a factor. As a general principle, the impact of alcohol is known to be greater in deprived areas.

In 'Safe. Sensible. Social.' the Government notes that dependent drinkers may not be willing to accept treatment, and guides commissioners to ensure that local treatment systems are able to meet the demand for people needing access. The strategy refers to "International models [which] suggest that levels of service provision are likely to be too low if less than 10% of dependent drinkers are able to access treatment."

### **Drinking and homelessness**

The Department of Health (2005) has found that around half of homeless people are dependent upon alcohol. Many more are drinking in a way that is hazardous or harmful.

Anecdotally, street drinkers and other dependent alcohol misusers with complex needs who complete a detoxification in HMP Lewes have little access to any additional treatment either within the local prison or when they leave.

## **Drinking and Pregnancy**

The Department of Health (2006) information campaign clearly states that pregnant women should avoid drinking alcohol. Alcohol crosses the placenta and enters the baby's blood. Heavy drinking during pregnancy can affect the development of the foetus. In the first three months, heavy drinking can damage the developing organs and nervous system. After this, it can have the additional effect of stopping the baby from growing and developing properly.

Foetal Alcohol Syndrome (FAS) is the name given to a set of specific problems that are found in children whose mothers were drinking heavily during pregnancy. These include facial abnormalities, poor growth and severe mental and developmental problems. Partial and less severe forms of such problems typically found in the full FAS have also been described, which may be linked in some cases to less heavy alcohol consumption. This wider group is commonly referred to as Foetal Alcohol Spectrum Disorder (FASD).

Although there is still scientific uncertainty about the precise impact of low alcohol consumption on unborn babies, the Department of Health take a precautionary approach and advise that pregnant women and women trying to conceive should avoid drinking alcohol.

Hastings has both a high rate of teenage pregnancy and a high rate of alcohol specific hospital admission for people (both male and female) aged less than 18.

## **Co-morbid substance misuse and mental health problems**

The East Sussex dual diagnosis strategy (2004) describes how mental health and substance misuse services address the needs of people with co-morbid substance misuse and mental health problems.

Prevalence of 'dual diagnosis' is described as 'high, with rates varying across mental health services between 20%-80%. Alcohol is the most commonly misused substance for these service users.

Information about alcohol misuse and mental health is also provided in the 2005 annual report of the Court Assessment and Diversion Scheme. The Scheme exists to assess the mental health needs of offenders, provide advice to criminal justice services and make referrals to services that can meet the offender's needs. The report notes that of 330 assessments, 13% had a primary alcohol problem. Alcohol problems were a secondary diagnosis in 6% of cases. Almost 30% of people charged with violent offences against the person had an alcohol or substance misuse problem as well as a mental health problem.

The dual diagnosis strategy notes that access to training about substance misuse for mental health professionals is limited.

## **Crime and Disorder Priorities**

The East Sussex Safer Communities Plan highlights the need to tackle the link between alcohol and domestic violence, and Public Place Violent Crime and binge drinking. Local Multi-Agency Risk Assessment Conferences (MARACs) identify repeat domestic violence perpetrators to reduce risk for vulnerable adults. There are no dedicated 'treatment' resources for situations where alcohol is identified as a contributory factor to violent offences .

Street drinking remains a top local priority for residents in Hastings. Multi-agency approaches continue to feature as a long-term problem solving initiative.

## **4. Service, Market and Resource Analysis**

We know that access to specialist services is extremely limited, particularly for planned inpatient services. Access to 'structured psychosocial interventions' – counselling – is generally restricted to those people living in the most accessible areas who are able to access treatment at a time and in a location when the service is available, and prepared to wait for the time it takes to access treatment services.

### **Tier 1 interventions**

Local provision for 'Tier 1' interventions focuses on training staff in 'generic' services (mainstream health, social care, housing and so on). The training is delivered through two posts based within the Primary Care Trusts' public health and well-being directorate. Basic awareness training is mapped to the Drug and Alcohol National Occupational Standards (DANOS) and focuses on identification, screening and referral into treatment.

During 2006/07, training interventions were provided for 600 people. The majority of these were 441 people attending 39 single-session (morning or afternoon) workplace based courses. 87 people attended the 2-day Drug and Alcohol Basic Awareness Course (DABAC). A further 72 people attended other half-day courses.

The training is targeted towards particular professional groups. Overall the largest professional groups attending were people from mental health services (16.5%), housing and homeless services (15%) and social services (14%). People working in primary care (11.5%) and community health (10.5%) were also well-represented. The trainees included 39 police staff (6.5%).

Addressing training needs about drug misuse is the primary focus for this work. Around half of the investment in the training is dedicated towards illegal drugs rather than alcohol misuse.

### **Tier 2/3 interventions delivered by specialist alcohol services**

Local specialist alcohol services are provided by Action for Change, a voluntary sector organisation, working with Sussex Partnership NHS Trust. Action for Change provides advice and information and counselling services. Sussex Partnership NHS Trust provides nursing and medical interventions to support people who are completing detoxification in the community, and also provides access to inpatient detoxification.

Access to residential rehabilitation is provided through a social worker also based within the services.

Services are based in Hastings and Eastbourne, with clinics in Seaford, Crowborough, Lewes and Uckfield providing some access for people in rural communities. Programmes of care planned counselling are expected to last either six weeks (Brief Interventions including motivational interviewing, relapse prevention and so on) or twelve weeks (care planned counselling).

Location	Counselling sessions available / week
Crowborough	3
Eastbourne	24
Hastings	35
Lewes	3
Seaford	3
Uckfield	2

Access is severely limited, with waiting times a major barrier to services. Average waiting times for 'counselling' services across East Sussex tend to be around 12 weeks, but have extended to five months at busy times in some locations.

Activity and performance data for the service is limited. Information has been collected and then reported routinely by the partnership since October 2006. The following information provides what has been reported since then.

### **Presentations to Adult Alcohol Treatment in East Sussex**

The table below shows the new presentations to alcohol treatment that are recorded by way of a self-referral form to the service by local authority area.

Self referrals to alcohol treatment

	2006/7		2007/8
	Oct-Dec	Jan-Mar	Apr-Jun
Eastbourne	83	69	64
Wealden	12	13	14
Lewes	22	22	23
Hastings	74	75	56
Rother	35	21	18
Missing	11	15	

Other	3	1	2
	240	216	177

Self-referrals are around 70% male, 30% female. 98% describe their ethnic group as white.

Of the 235 people answering the question about accommodation, around 50% were living in rented accommodation, 30% were owner-occupiers and 12% were either living in a hostel, in temporary accommodation or supported housing. Around 2% of self-referrals are from people of no fixed abode.

Treatment interventions that have been provided for individuals in treatment with the service are shown in the table below.

Treatment interventions by agency Q4 2006/7

	Agency		Total
	Eastbourne	Hastings	
Missing data	8	25	33
Brief Intervention	7	36	43
Care Planned Counselling	15	22	37
Detox Preparation	4	1	5
Group work: Detox Prep	0	10	10
Group work: Living Skills	0	19	19
Group work: Motivational Enhancement	0	27	27
Group work: Relapse Prevention	0	14	14
Motivational Enhancement	17	19	36
Other	0	1	1
Probation Scheme Assess/CA	10	12	22
Probation/CPC	0	1	1
Relapse prevention: 12	1	5	6
Relapse prevention: 6	15	13	28
Significant Other Counselling	1	0	1
Total	78	205	283

The table above shows that 78 (27.6%) treatment interventions were provided at the Eastbourne service and 205 (72.4%) at the Hastings service.

Treatment interventions by agency Q1 2007/8

	Agency	Total

	Eastbourne	Hastings	
Missing data	4	12	16
Brief Intervention	4	13	17
Care Planned Counselling	3	10	13
Detox Preparation	0	6	6
GW: Detox Prep	0	8	8
GW: Living Skills	0	12	12
GW: Motivational Enhancement	0	19	19
GW: Relapse Prevention	0	11	11
Motivational Enhancement	11	21	32
Other	0	1	1
Probation Scheme Assess/CA	8	6	14
Probation/CPC	5	1	6
Relapse prevention: 12	1	2	3
Relapse prevention: 6	12	12	24
Total	48	134	182

The table above shows that 48 (26.4%) treatment interventions were provided at the Eastbourne service and 134 (73.6%) at the Hastings service.

### Discharges from Alcohol Treatment

'Planned' discharges include discharges where the client and counsellor agree to end the contact and when the client is referred to a more appropriate agency. 384 individuals were discharged from alcohol treatment during the last two quarters of 2006/7 and 101 (26.3%) individuals had left treatment in a planned way:

During the first three months of 2007/8, 36 individuals were discharged from alcohol treatment during the first quarter and 11 (30.6%) individuals had left treatment in a planned way:

It should be pointed out that where a 'self referral' form is received and no further contact occurs the case will eventually be closed and these closures are included in the total discharge figure.

The discharges during the two quarters are shown in the table below.

#### Adult discharges from alcohol treatment

Discharge Reason	Oct 2006 - Mar 2007	Apr-Jun 2007
Counsellor and client agreed	101	11
Client referred to a more appropriate agency	15	0
Client chose to end	113	9
No contact	120	11

Client died	9	2
In custody	15	2
Moved away	11	1
Total	384	36

It is important to note that there were a high number of closures recorded on the same day and represent clients that were in fact discharged from treatment at different times during the two quarters and therefore the data is not shown by month

### **Service user experience**

The services provided are generally rated highly by service users. During 2006/7 all of the service users who completed a user survey card rated the service provided as 'excellent' or 'good'.

However, it's important to note that there is a high drop-out rate for people who initially present, and then don't continue with treatment. It's highly likely that the length of wait for access is a major cause for drop-out, and that the people who drop out would rate their experience very poorly.

### **Inpatient detoxification and residential rehabilitation services**

Inpatient substance misuse detoxification services in East Sussex are provided by Sussex Partnership NHS Trust, directly through:

116 bed days at Haven Ward, Mill View, Hove. (for Ouse Valley patients)  
2 beds (730 bed days) on the Department of Psychiatry, Eastbourne DGH  
1 bed (365 bed days) on Woodlands mental health unit

And through a contract with South London and Maudesley Foundation Trust to provide seven 28-day alcohol detoxes for people in Hastings and Rother.

With the exception of the seven detoxes provided by South London and Maudesley, the services are available for both drug and alcohol detoxification, although primarily used for alcohol.

Other inpatient detoxes are completed in an unplanned way for people who have both elective and emergency admissions onto both surgical and psychiatric wards.

### **Residential Rehabilitation**

During 2006/7 there were 35 placements for residential rehabilitation, funded from a combination of community care and pooled treatment budget.

Of this group 22 completed their placements successfully giving an overall percentage figure for the year of successful completion of placements of 65%

21 of the total group were opiate users, 8 were alcohol users and 6 were poly substance users including amphetamines & cannabis

Of the group who failed to complete, 3 spent less than 6 weeks, 1 spent 6 weeks only in a specialist unit detox. Only 7 spent from 8 to 16 weeks

23 were male and 12 were female, reflecting the general treatment population gender split.

7 people were discharged from prison directly to a residential rehab.

21 of this group required an inpatient detoxification before residential treatment, either via the NHS services described above (primarily alcohol clients) or with a rehabilitation provider that offered a detoxification service.

In all 16 different providers were used throughout the country, the emphasis being on identifying the most appropriate placement for the individual client. Clusters tend to occur in towns like Portsmouth & Bournemouth which have a number of primary & second stage projects plus good re-settlement options via supported housing projects - which East Sussex lacks. In those cases where clients have no accommodation to return to they tend to remain in the town where their rehab provider is located where they have established support networks as well as housing options, provision which is vital in maintaining recovery.

### **Family Substance Misuse Service**

The newly-established 'family substance misuse service' has been fully operational since January 2007. Initially funded as a pilot until March 2008, the service is provided by a small team of people from different professional backgrounds who work with families who are in the child protection process. The service works jointly with prescribing services and other services as required, staff provide the 'care coordinator' function and act as the lead professional when appropriate.

The service is funded jointly through the pooled treatment budget and by Children's Services. The service delivers interventions that are directed towards the young person's 'prevention' agenda by working with families where substance misuse has been identified as a risk. The service addresses both drug and alcohol misuse. The service is referred to in the East Sussex Local Area Agreement, with an anticipated caseload of 75 people in 2007/8, 90 people in 2008/9 and 115 people during 2009/10.

### **Housing and Housing Related Support**

The Supporting People programme funds housing related support services. There are two services funded by the Supporting People programme specifically classed as supporting people with drug or alcohol problems. These are:

- Kenward Trust, The Malthouse (8 units). The primary client group is people with drug problems, secondary client group is people with alcohol problems.
- Heatherdene Ltd, Heathercrest Cottage (5 units). The primary client group is people with mental health problems, secondary client group is people with alcohol problems

In 2006/7 there were a further 25 placements funded by Supporting People in 'short term' services (either floating housing support or supported accommodation) for people with a primary alcohol problem.

During 2007/8, Supporting People will tender for a Floating Housing Support service providing support for at least 30 people across East Sussex, with a combined drug/alcohol misuse caseload mix.

Of the 215 services funded by Supporting People, only 21 have specific exclusions for people with drug or alcohol problems. The majority of long term services funded by Supporting People are for older people, and so outside the scope of this strategy. However, it's worth noting that alcohol can become a significant problem for older people. Alcohol misuse is associated with falls, depression and so on.

### **Carer Support**

During 2007/08, Rethink (a national mental health charity) is developing a twelve month pilot service for carers who are looking after people with a 'dual diagnosis' – mental health problems as well as problems with either drugs or alcohol.

### **Brief Interventions – Hastings primary care pilot**

During 2006 a brief intervention service was piloted in two primary care settings in Hastings. Although the service was well received, it was not developed beyond the pilot phase. The service did not engage with the target group of hazardous/harmful drinkers, and instead was found to provide an effective care pathway for moderately and severely dependent drinkers. The pilot established that commitment is needed right across the practice for training for staff to be effective, that dedicated time is required for the training and that placing specialist staff in primary care can increase referral and take up of specialist services for more complex cases.

### **Domestic Violence and Alcohol Interventions in Emergency Care**

A pilot service addressing alcohol misuse and domestic violence linked to the Accident and Emergency department at the Conquest Hospital in Hastings was established between 2003-2006. The service provided by a part-time specialist worker was evaluated positively by staff referring to the service, and contributed to a material reduction in repeat incidents and further attendances for emergency care. The service established the value of effective

assessment in the A&E setting, and a care pathway into specialist alcohol services.

### **HMP Lewes – alcohol treatment provision**

HMP Lewes is a category B local prison for adult males in East Sussex. It is a Victorian prison built in 1853 to hold up to 546 remand and convicted male prisoners from mainly East and West Sussex courts. The capacity of the prison will be increased from February 2008 by a further 175 places.

The healthcare service includes a 29-bed detoxification wing. Specialist nursing input is provided by two band 6 nurses employed by Sussex Partnership Trust. The substance misuse service can generally be accessed immediately following reception.

204 alcohol detoxification programmes were undertaken in 2005/06 with 207 in 2006/07, which is an average of 17 per month. There is very little additional support within prison for people once they have completed an alcohol detox. Links with services in the community are poor, essentially because there is no dedicated service within the prison (the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team only works with drug users) and there is no dedicated service for prison leavers in the community (the Criminal Justice Integrated Team (CJIT) only works with drug users) so prison leavers experience the same delays for support services as anyone else.

### **Mutual aid groups**

There is limited development of 'mutual aid' groups outside of the established meetings of local 'alcoholics anonymous' groups. There are 'alcoholics anonymous' meetings every day of the week in East Sussex<sup>1</sup>. These support groups are not directly commissioned, and provide an important route to support and recovery for many people every day.

### **Alcohol interventions delivered in non-specialist settings**

A range of interventions are provided in non-specialist settings, but either without any data being collected or without data that is collected being reported. We know that GPs are providing alcohol detoxification in the community, either with or without support from the specialist team. There are alcohol-specific hospital admissions that will include some kind of

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<sup>1</sup> To find out about local meetings, visit <http://www.aa-gb.org.uk/southeast/eastsussex/>

interventions around alcohol, but again the data about what is provided is either not collected or not reported. The East Sussex alcohol harm reduction strategy pointed to the need to improve data collection across services. New data collection approaches have been introduced in the specialist service system, but data from other sources remains limited.

### **Financial resources**

The financial resources currently available are not sufficient to meet the demand for alcohol treatment.

### **Hastings and Rother Primary Care Trust and East Sussex Downs and Weald Primary Care Trust**

The only resource allocated centrally to alcohol treatment is the 'choosing health' resource allocated to PCTs from 2007/8. This resource is recurrent (2007/8), but is not 'ring-fenced' (PCTs can allocate the resource to other priorities). The 'Choosing Health' money notionally indicated for alcohol in East Sussex in 2007/8 is £148K (Hastings and Rother PCT - £55K, East Sussex Downs and Weald PCT - £93K). The full sum will not be allocated to alcohol misuse in 2007/8, although some pilot projects may be funded by Hastings and Rother PCT.

Hastings and Rother PCT has historically funded alcohol treatment services. It has been consistently highlighted as a strategic priority - Hastings includes some of the most deprived wards in the South East and suffers some of the greatest alcohol-related harms.

### **PCT funding included in the mental health block contract**

The sum indicated does not include funding that is allocated to the alcohol service within the mental health block contract. The cost of services that the NHS Trust has historically provided under the terms of that agreement (two lead alcohol nurses, medical time, drug costs and access to inpatient beds for detoxification) should be disaggregated to provide a complete picture of the funding provided.

### **ESCC Supporting People**

This funding is directed towards a service tendered during 2007/8 specifically for substance misuse, and assumes a 50% drugs/alcohol split. As the future SP allocation is uncertain and there has been only one inflationary uplift to SP-funded services since the programme began in 2003, future allocations are assumed level.

### **ESCC Adult Social Care**

The majority of this investment is directed towards residential treatment – both staffing and individual placement costs. There is an overall sum allocated for the care of adult drug and alcohol misusers. The sum shown here assumes

that 80% is allocated to care for people with drug, rather than alcohol, misuse problems.

### Sussex Probation Area

Sussex Probation Area contracts with Action for Change to provide a service for offenders who receive an 'alcohol treatment requirement' order at court. There were 175 referrals for court-ordered counselling during 2006/7.

#### Forecast financial resources available

	£000s			
	2007/8	*2008/9	*2009/10	*2010/11
H&R PCT Choosing Health	TBC	56	57	58
Other H&R PCT	295	302	310	318
ESDW PCT Choosing Health	0	95	97	99
Other ESDW PCT	58	59	60	62
ESCC Adult Social Care	181	186	191	196
ESCC Supporting People	35	35	35	35
<b>Total</b>	<b>569</b>	<b>733</b>	<b>750</b>	<b>768</b>

\*All future resource allocations are estimates based on available information. Inflationary uplifts are assumed at 2.5% and are not guaranteed.

There are a relatively small number of organisations providing similar services in the market. The providers that supply drug treatment services in East Sussex supply services for alcohol misuse treatment in other areas. Other partnerships in the South East have contracted with organisations of a similar size and larger than the local provider. The market is characterised by a very small number of organisations that operate on a national or regional basis, and a much larger number of locality-based organisations (like Action for Change). The market can be expected to consolidate further as purchasers invest more in alcohol treatment and require compliance with increasingly demanding quality standards.

## 5. Changing the Focus of Services

The resources currently available to address alcohol misuse are not sufficient. Implementing the strategy will require additional investment now in order to

save future health costs. For areas of the strategy that are not currently funded the partnership will need to identify the source of funding.

For adults who misuse alcohol, 'Safe. Sensible. Social.' focuses on people aged 18-24 who are 'binge-drinking', and on people whose drinking behaviour is 'hazardous' or 'harmful'. This commissioning strategy adopts these principles by developing early intervention approaches, and ensuring professionals in primary care settings can easily refer into services for people whose drinking behaviour is more problematic.

The alcohol profiles highlight the demand for services in Hastings and Eastbourne, and point to problem drinking among young adults in Rother. Resources will be targeted towards those areas with the greatest need, whilst ensuring that people in rural areas have access to the same range of services, particularly services delivered in primary care settings which already address access issues.

Service developments are described using the 'tiered' model. A summary of treatment interventions and settings is included at appendix two.

As services are developed, care pathways will be developed to ensure that service users' treatment needs are addressed using a 'stepped care' approach. Specialist treatment will include 'aftercare' or 'extended case monitoring' as appropriate.

### **Tier 1 interventions**

(Alcohol-related information and advice; screening; simple brief interventions and referral)

The 'next steps' in the national alcohol strategy include a series of national alcohol campaigns that will focus on promoting the 'safer drinking' message to specific groups, already outlined. The national campaigns will be taken up and reinforced locally. The partnership will ensure that the local 'safer pubbing and clubbing' and similar information campaigns provide ready access to information about how to get help locally.

Communications and training about services will be targeted towards primary care staff, with information on HARMLESS [a local NHS intranet] about care pathways, and information about local services for patients and carers readily available in every primary care setting.

### **Developing screening and brief intervention across Tier 1 services**

The Primary Care Trusts will maintain the 'alcohol' training component for the public health specialists employed within the public health and well-being directorate.

Additionally the PCTs will utilise the 'Choosing Health' allocation for alcohol to appoint two locality-based Alcohol Intervention Specialists, one based in Eastbourne and one based in Hastings. With a professional background and

anticipated as band 7 nursing posts (or equivalent), these posts will be responsible for co-ordinating and implementing arrangements for screening, the provision of information and brief interventions within particular settings (determined locally, and summarised below), and identifying pathways to specialised treatment. There will be a small project team drawing on existing specialist staff and managers to direct the work to ensure integration with other work programmes. The training provided as a result of this work will include 'training the trainers' to ensure the development of knowledge and skills can be sustained across teams beyond the end of the project.

The choice of 'training' input will need to be varied to reflect differences in clinical settings. The input may include full-day training, lunchtime sessions, input on half-day closures etc as well as access to online resources and self-directed study. With primary care the main focus for ongoing work, it will be critical to ensure the approach is promoted appropriately across the professional groups working in primary care, with information readily available in leaflets, on the HARMLESS [NHS intranet] website and so on. Training might also include input from people who have previously experienced alcohol problems to provide 'real world' examples.

The 'brief interventions' training will develop the skills required for non-specialist staff to deliver what Raistrick, Heather and Godfrey (2006, see p79) refer to as 'simple brief interventions'. The programme will be based around the 'drink less' approach described by Babor and Higgins-Biddle (2001) and publicised by the World Health Organization.

These posts will be supported (from the 'Choosing Health' allocation for alcohol) to ensure that they can purchase additional training, book venues and so on. To encourage innovation, part of the allocation will be used to establish a 'grants' programme that will seek bids from target organisations and teams for the resources needed to develop an ongoing programme of brief intervention skills training.

This will be initiated as a three-year project. The project will develop proposals about how the work will be progressed in the future with an exit strategy at the conclusion of the project.

Settings may include:

- Primary healthcare, including pharmacists;
- Acute hospitals settings, including Accident & Emergency;
- Mental health services, particularly mental health in primary care and the crisis resolution home treatment teams;
- Social Services;
- Homelessness services;
- Antenatal clinics;
- Custody centres;
- Probation services;
- General hospital wards;
- Occupational health services.

These settings will include services provided by voluntary and community sector organisations.

Anticipated outcomes for these posts will include:

- Training about screening tools relevant to the clinical setting (e.g. the Alcohol Use Disorders Test (AUDIT) or Fast Alcohol Screening Test (FAST)) is promoted across all health and social care services;
- the local health and social care services and professional groups that provide the best opportunities for early intervention for people aged 18-24 who are 'binge-drinking', and people whose drinking behaviour is 'hazardous' or 'harmful' will be identified;
- these staff will be able to recognise problem drinking that is beyond the scope of a brief intervention and will know when & how to refer on to specialist services;
- workforce plans include the knowledge and skills required to screen for alcohol misuse and provide advice and brief interventions;
- training about screening, advice and brief intervention is routinely provided to staff in those settings to develop the necessary knowledge and skills;
- pathways to specialised treatment are clearly described and widely promoted, with threshold criteria.

This work is expected to be embedded across the partnership agencies. All contracts or service level agreements should include the staff competence requirement for provider organisations working with relevant care groups, vulnerable or disadvantaged people (for example housing related support, mental health assessments, children's services and so on).

The programme will include an impact evaluation that assesses the extent to which trainees integrate the skills and knowledge gained through the training into their work practice.

## The Fast Alcohol Screening Test - FAST

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have 8 (men)/ 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<b>Only answer the following questions if your answer above is monthly or less</b>						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

World Health Organisation 2001

<sup>1</sup> 'drink' is a single unit<sup>2</sup>. A score of 3 or more suggests you may be a 'harmful' drinker.

## Working with partnership agencies as employers

The partnership will work with local public sector employers to support work place alcohol policies by:

- Promoting alcohol-focused communications campaigns;
- disseminating the advice for 'harmful' drinkers described in the national strategy (anticipated in August 2008);
- providing guidance about information and training that enables managers and support staff to screen for alcohol problems and provide brief interventions and referral when appropriate;
- considering how managers and supervisors might benefit from any training provided locally as part of the strategy.

### Organisation

East Sussex County Council  
 East Sussex Fire and Rescue Services  
 East Sussex Downs and Weald PCT  
 Eastbourne Borough Council  
 Hastings Borough Council

### Number of employees

20,000  
 800  
 1,600

<sup>2</sup> See [www.drinkaware.co.uk](http://www.drinkaware.co.uk) for a comprehensive online unit calculator.

Hastings and Rother PCT	
East Sussex Hospitals NHS Trust	5,000
Lewes District Council	
Rother District Council	
Wealden District Council	
South East Coast Ambulance Service	2,800
Sussex Partnership NHS Trust	
Sussex Police	5,500
Sussex Probation Area	

## **Housing Related Support**

Housing related support is provided through services funded by the 'Supporting People' programme. During 2007/8 a new 'floating housing support' service will be tendered for adults suffering from substance misuse. This service should be targeted towards those people suffering alcohol misuse with a history of complex needs (including alcohol dependence, repeated treatment episodes, co-morbid physical and mental health issues and so on).

The Supporting People strategy in East Sussex describes plans to develop 'generic' floating housing support services that provide support for a number of care groups, rather than accommodation-based services. This may provide opportunities for a greater number of people receiving treatment for alcohol misuse to receive housing related support.

Staff who provide housing related support across all care groups should be required to demonstrate competence in screening and brief interventions.

## **Tier 2 Interventions**

(Open access, non-care-planned alcohol-specific interventions)

### **'Mutual aid', 'Self-Help' and 12-step groups.**

The partnership is keen to encourage and support the development of local 'mutual aid' groups. Mutual aid will include groups that identify themselves as based on 'self-help', '12-step' or other principles. Whilst these groups are not directly commissioned they can provide a fantastic source of support and effective treatment for many people. The treatment services directly commissioned by the partnership will continue to provide information about local support groups including Alcoholics Anonymous, as appropriate. Key workers will be expected to facilitate access to local groups.

The partnership will provide practical support to local groups seeking to establish themselves or to extend their reach.

## **Tier 3 interventions**

(Community-based, structured, care-planned alcohol treatment)

The financial resources currently available are not sufficient to provide the service developments outlined below. Additionally, improving identification and screening at 'tier 1' will [appropriately] increase demand for tier 3 interventions for moderately dependent users and more complex cases.

In Hastings and Rother, services can be re-specified and the financial resources reallocated. In Eastbourne, Wealden and Lewes the services can only be developed with a significant additional financial allocation.

The 'structured day care' service in Hastings will be re-specified to be included as part of the care pathway for 'ambulatory detoxification'. The resources invested in 'counselling' and other services will be respecified to provide care-planned treatment.

The current configuration of counselling services in Eastbourne and Hastings is based around the location of a particular service. The service will be re-specified to be provided in primary health care settings, and develop a service that provides access to a range of different alcohol-focused specialist treatment and less intensive approaches. The development of new primary health care centres provides an opportunity to ensure the alcohol service is included with other primary care service planning. A specialist alcohol worker will be available in every GP surgery. Although based in primary care settings, the service will also ensure care pathways are accessible for people with impaired mobility by providing home treatment, if assessed as necessary.

There will be close links with the specialist substance misuse services – the services that work with people who misuse drugs other than alcohol. For the most complex cases, and people who are experiencing problems with both alcohol and drug misuse, delivery of the service will be coordinated by the specialist substance misuse service. Some of the specialist alcohol interventions described in this section will be delivered from the premises used for drug services so that a specialist setting can be retained. This will enable closer medical supervision when appropriate, and provide access to specialist alcohol services for people who are not accessing services in primary care settings.

There will also be close links and care pathways with 'crisis' services including the [mental health] crisis resolution home treatment team, out of hours services in general practice and accident and emergency services. The purpose of these care pathways will be to ensure appropriate follow-up and treatment once the presenting crisis has been dealt with.

'Tier 3' interventions will focus on care planned treatment that provides psychosocial interventions and medically managed detoxification in the community.

Psychosocial interventions will be provided as tier 3 interventions in community settings for people identified as harmful or moderately dependent

drinkers, and for people whose drinking behaviour is already causing significant harm.

'Aftercare' or 'extended case monitoring' will routinely be provided to ensure people who access treatment are followed-up at 3,6 and 12 months.

Although the specification for services should focus on the outcomes (what happens as a result) rather than the inputs (staffing, other resources) for the service, it's important to scope the size of a team providing the service described. The following assumptions have been used to estimate the number of specialist staff required to provide a reasonable level of service:

- Each individual's need will vary, depending on the complexity of their particular situation and how well they respond to the intervention provided;
- The average duration of intervention for dependent drinkers will be 12 weeks;
- The average duration of intervention for harmful drinkers will be 6 weeks;
- each full-time specialist worker will be available for 42 weeks of the year, allowing for annual leave, training and unplanned absence;
- each full-time specialist worker will carry a caseload of 30 people, giving rise to around 100 'dependent' cases worked with each year (42/12 x 30), or around 200 'harmful' cases;
- the partnership will aim to provide enough capacity for 20% of the potential treatment population to access specialist psychosocial interventions.

There are around 271 GPs in East Sussex – 176 within the East Sussex Downs and Weald PCT area (around half in Eastbourne) and 95 in the Hastings and Rother PCT area (around half in Hastings and St Leonards).

Classification	Estimated cases for each General Practitioner by local authority				
	Wealden	Lewes	Rother	Eastbourne	Hastings
Severely dependent	1	1	1	1	2
Moderately dependent	10	10	20	30	35
Harmful drinkers	30	30	60	90	105
Hazardous drinkers	110	110	220	330	385

Estimated number of specialist workers required:

	Wealden	Lewes	Rother	Eastbourne	Hastings
Number of GPs	50	35	46	91	49
Dependent drinkers (20%)	550 (110)	385 (77)	966 (193)	2821 (564)	1813 (362)

Harmful drinkers (20%)	1500 (300)	1050 (210)	2760 (552)	8190 (1638)	5145 (1029)
Specialist workers	3	2	5	14	9

### **Community detoxification**

Community detoxification services will be provided for moderately dependent people, and people whose needs are more complex but can still be managed without requiring inpatient services.

Community detoxification will be managed either by a GP working in a primary care setting, or by a consultant psychiatrist in the substance misuse service through an 'ambulatory' outpatient detoxification service. When the service is provided by a GP, additional support and advice will be available to the GP from the specialist substance misuse service. In either case, the service will require an appropriate level of support by specialist alcohol workers.

A Local Enhanced Specification (LES) for GPs providing community alcohol detoxification in primary care detoxification was adopted by GPs in Hastings during 2006. This specification will be considered for other areas, subject to a suitable level of psycho-social support being available from specialist workers.

Sussex Partnership NHS Trust has developed proposals to establish an 'ambulatory' or outpatient detoxification service in Hastings and Eastbourne. The service development requires an appropriate level of support from specialist alcohol workers to provide support during and following the medically managed detoxification.

### **Family Substance Misuse Service**

The service will continue to be invested in by the partnership at least to the end of the current LAA targets in 2009/10, subject to positive evaluation of performance (measured by both activity and treatment outcome) and the financial resources being available to the partnership.

### **Alcohol arrest referral and conditional cautioning schemes**

The East Sussex Safer Communities Plan describes how Sussex Police and partners will establish the feasibility of introducing Alcohol Arrest Referral and Conditional Cautioning schemes at Eastbourne and Hastings Interview and Detainee Handling Centres (IDHC) by March 2009. Demonstration projects are being developed in West Sussex during 2007/8. These schemes provide a combination of brief interventions for hazardous and harmful drinkers and an additional route into structured treatment, when appropriate. The introduction of similar services in East Sussex will be contingent upon a beneficial evaluation of the West Sussex model, and sufficient treatment capacity to manage the anticipated additional demand.

## **Tier 4 interventions**

(Alcohol specialist inpatient treatment and residential rehabilitation)

'Aftercare' or 'extended case monitoring' will routinely be provided to ensure people who access treatment are followed-up at 3, 6 and 12 months.

### **Inpatient Detoxification**

The existing arrangements will be re-provided on a single site in Sussex, with double the capacity of the existing service. The service will be commissioned on a sub-regional basis in partnership with West Sussex and Brighton and Hove, with a specific number of bed-days allocated for East Sussex residents. This will require the resource allocated to beds on general psychiatric wards to be reinvested in a specialist unit, and may require additional investment. By providing the beds in a specialist unit the service will reflect national guidance about best practice.

### **Residential Rehabilitation**

The partnership will move from the current arrangements for 'spot purchasing' all residential rehabilitation services to a combination of 'block contract' and 'preferred provider' arrangements. This will produce an overall cost improvement of around 10% on the current expenditure and will enable the partnership to have much closer management control across quality measures with a smaller number of specialist providers. The partnership will ensure that the tender process continues to enable service users choice about the type of service they receive and where it is provided.

## **6. Monitoring Arrangements**

The National Drug Treatment Monitoring System (NDTMS) will be used from April 2008 to record data about alcohol treatment. NDTMS records a carefully managed dataset. Each episode of drug treatment requires around 100 data items, and partnerships are required to submit information about the treatment population with a quality standard of 99% data accuracy. This has been achieved locally, but has required substantial investment in both capital (software development) and in time to develop the information systems to collect and quality assure the data.

The current data collection system used for alcohol is based on a Microsoft Access database. Additional fields could be added to the database, but this approach would leave the system unsupported and potentially unstable. It is the partnership's intention to adopt a combined drug/alcohol information system. Unless the information system used to record NDTMS is replaced, the partnership will record information using 'Orion', the software solution procured for drug treatment services to record information that complies with the latest NDTMS core dataset.

### **Performance Indicators**

Reducing alcohol harms has been included in Public Service Agreement 25 from April 2008. A key objective for PSA 25 will be to reduce the harms caused to health and well-being by frequent consumption of harmful levels of alcohol. This will be measured by the number of alcohol-related hospital admissions. The technical definition has not yet been published. When available, this will form the primary indicator for the effectiveness of alcohol interventions.

Additional 'milestones' have been identified that will be included in the implementation plan enable measurement of implementation of the strategy:

- Local alcohol treatment pathways have been fully developed;
- alcohol screening & Brief intervention protocols are in place for Tier 1&2 interventions;
- a range of evidence based alcohol treatment interventions are available across East Sussex in an equitable way;
- protocols for collaborative & integrated working are in place to meet the more complex needs of some clients.

## Appendix One | Glossary

### **Recommended Alcohol Consumption limits**

The Department of Health advises that:

- Men should not drink more than 3–4 units of alcohol per day;
- Women should not drink more than 2–3 units of alcohol per day.
- Two non-drinking days are recommended after an episode of heavy drinking, and consistent consumption at the upper limit is not advised.

### **Binge-drinking**

Binge-drinking is defined as the consumption of 8 or more units of alcohol for men and 6 or more units for women during a single session (i.e. double the daily recommended alcohol consumption limits).

### **Hazardous drinking**

This is a pattern of heavy alcohol consumption which carries a high risk of future damage to the health of the drinker, but which has not yet resulted in significant physical or psychological harm. The Alcohol Needs Assessment Research Project (ANARP) (Department of Health et al, 2005) defines this as around 22–50 units per week for men, and 15–35 units per week for women.

### **Harmful drinking**

This can be defined as heavy alcohol consumption already resulting in physical or mental harm to the user. ANARP defines this as >50 units per week for men and >35 units per week for women. This group does not include drinkers who have developed alcohol dependence.

### **Dependent drinking**

Dependent drinking is defined in terms of psychological dependence on alcohol, with an increased desire to consume alcohol and difficulty in controlling its use despite awareness of the potential consequences.

### **Moderately dependent drinking**

Drinkers in this category show moderate levels of alcohol dependence. Moderately dependent drinkers may recognise that they have a problem with drinking, even if this has been acknowledged only reluctantly. They are unlikely to be drinking to relieve withdrawal symptoms but may experience raised tolerance, symptoms of withdrawal & impaired control over drinking behaviour

### **Severely dependent drinking or drinking with complex problems**

People in this category may have serious and long-standing problems. In traditional language, they include individuals described as 'chronic alcoholics'. People in this group will usually have experienced severe alcohol withdrawal; will exhibit a high level of tolerance; are likely to have experienced delirium tremens and/ or withdrawal fits and may be drinking to avoid withdrawal symptoms (relief drinking).

Appendix Two | Treatment tier interventions and settings

	Interventions	Settings
Tier 1	<p>Screening                      Advice &amp; information                      Brief interventions                      Onward referral                      'Shared care' with specialist alcohol services</p>	<p>Primary healthcare                      Acute hospitals settings, including                      Accident &amp; Emergency                      Psychiatric services                      Social Services                      Homelessness services                      Antenatal clinics                      Custody centres                      Probation services                      General hospital wards                      Occupational health services</p>
Tier 2	<p>Open access and outreach services providing:                      Triage assessment                      Advice, information &amp; support                      Brief interventions                      'Mutual aid' groups, e.g. Alcoholics Anonymous                      Onward referral                      'Shared care' with specialist T3/4 alcohol services</p>	<p>Specialist alcohol services                      Primary healthcare                      Acute hospital settings including                      Accident &amp; Emergency                      Psychiatric services                      Social Services                      Domestic abuse agencies                      Homelessness services                      Antenatal clinics                      Probation services                      Prison service                      Occupational health services</p>
Tier 3	<p>Comprehensive assessment                      Care planning and review                      Regular keyworking                      Community care assessment and case management                      Prescribing interventions including community detox and interventions to reduce the risk of relapse                      Structured psychosocial therapies to address alcohol misuse and co-existing conditions, e.g anxiety and/or depression                      Day programmes and structured day care                      Liaison with non-specialist services</p>	<p>Specialist alcohol services                      Outreach                      Primary healthcare</p>
Tier 4	<p>Comprehensive assessment                      Care planning and review for all inpatient and residential structured treatment                      Prescribing interventions including inpatient detox and interventions to reduce the risk of relapse                      Structured psychosocial therapies to address alcohol misuse                      Information, advice, training and 'shared care' with services providing T1/2/3 interventions</p>	<p>Specialised in-patient facilities (managed by statutory, private or voluntary sector organisations)                      Residential rehabilitation units</p>

## Appendix Three | Comparative Data and Local Alcohol Profiles

The following comparative data summarises key information gained from nationally available data sets. The data is drawn from information published by the North West Public Health Observatory ([www.nwph.net/alcohol](http://www.nwph.net/alcohol) accessed July 2007). The ratios presented here are rounded up. In the source data the information is quoted more precisely and with confidence intervals.

### National and regional comparative data, and notes.

	England		South East		Note
Binge Drinking	18.2 %		15.5 %		% of population drinking twice recommended daily amount in one episode at least once/week
	M	F	M	F	
Deaths	41541	34361	6261	5486	Number of deaths attributed to alcohol (under 75)
Months of Life Lost	10	5	8	4	Lifetime effect of alcohol in the population
Chronic Liver Disease Mortality	100	100	82	85	Standardised mortality ratios for the number of deaths from chronic liver disease mortality per 100,00 in the population
Alcohol Related Mortality	50	28	45	25	Standardised mortality ratios for the number of deaths from alcohol related mortality per 100,000 in the population
Alcohol related hospital admission	826	462	678	401	Standardised ratios describing the number of hospital admissions per 100,000 for alcohol related diagnoses based on hospital episode statistics.
Alcohol specific hospital admission	306	145	235	124	Standardised ratios describing the number of hospital admissions per 100,000 for alcohol specific diagnoses based on hospital episode statistics.
Under 18 Alcohol specific hospital admission	49	59	46	58	
Recorded crime attributed to	10		9		

alcohol			
Violent crime attributed to alcohol	7	6	

### Local comparative data

	Eastbourne	Hastings	Lewes	Rother	Wealden
Binge Drinking	14.2 %	15.7 %	12.8 %	9.7 %	11.6 %

	M	F	M	F	M	F	M	F	M	F
Deaths	103	85	95	88	77	82	97	107	114	100
Months of Life Lost	12	5	13	9	7	5	8	5	7	3

Chronic Liver Disease Mortality	123	136	117	110	83	66	142	43	72	72
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Alcohol Related Mortality	57	25	65	37	38	26	45	29	40	21
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Alcohol related hospital admission	953	504	1021	565	610	353	718	420	628	388
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Alcohol specific hospital admission	371	177	503	224	163	94	263	128	141	97
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Under 18 Alcohol specific hospital admission	134	155	128	149	36	32	71	138	47	62
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Recorded crime attributed to alcohol	12	17	8	7	5
Violent crime attributed to alcohol	10	13	6	5	4

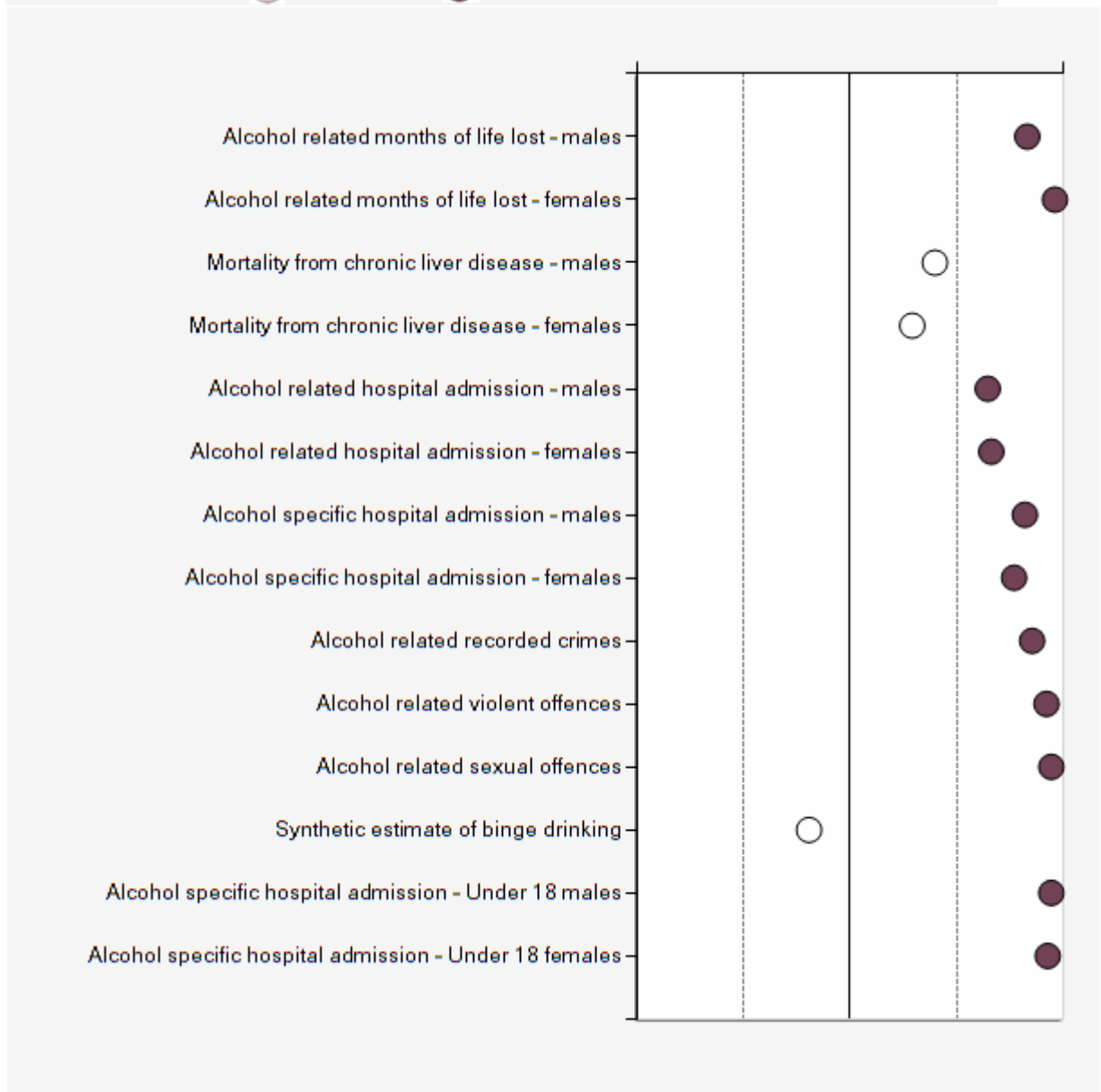
Source: North West Public Health Observatory

The following health profiles (also published by the North West Public Health Observatory) are based on the source data listed above, and compare the impact of alcohol with other authorities. Authorities are 'ranked' according to the impact of alcohol locally, and charted to provide a straightforward comparison with other areas in England.

## Hastings : Profile of Alcohol Related Harm

As a measure of the level of alcohol-related impact experienced, each of the 354 Local Authorities in England has been ranked by indicator. The chart shows Hastings's rank for each indicator.

Key: Circles identify the rank position for that indicator and colours distinguish those in the lowest (light pink) and highest (dark purple) quartiles of alcohol related impact.

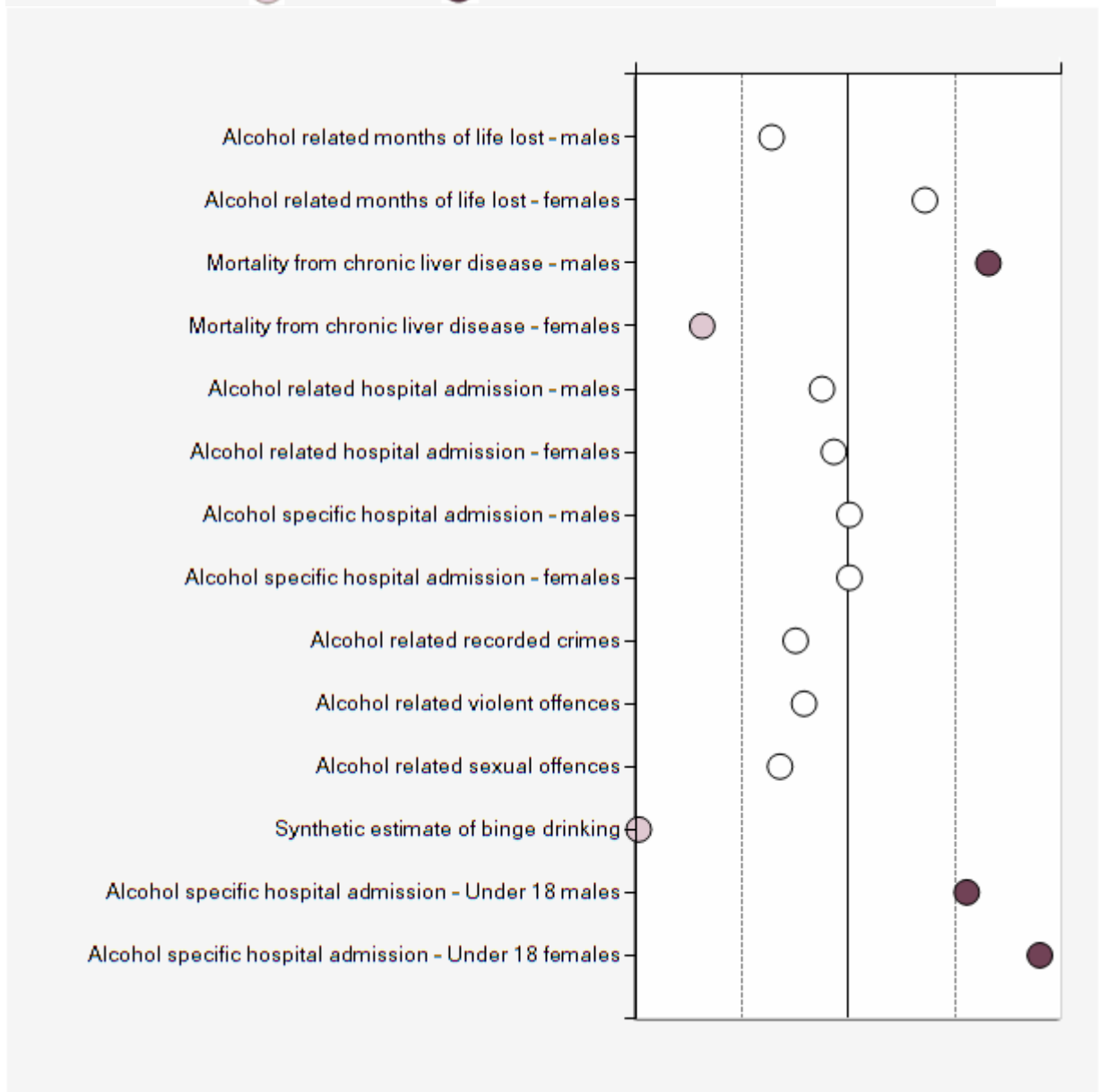


Source: Public Health Observatory: Local Alcohol Profiles for England  
 See <http://www.nwph.net/alcohol/lape/>

## Rother : Profile of Alcohol Related Harm

As a measure of the level of alcohol-related impact experienced, each of the 354 Local Authorities in England has been ranked by indicator. The chart shows Rother's rank for each indicator.

Key: Circles identify the rank position for that indicator and colours distinguish those in the lowest (light pink) and highest (dark purple) quartiles of alcohol related impact.

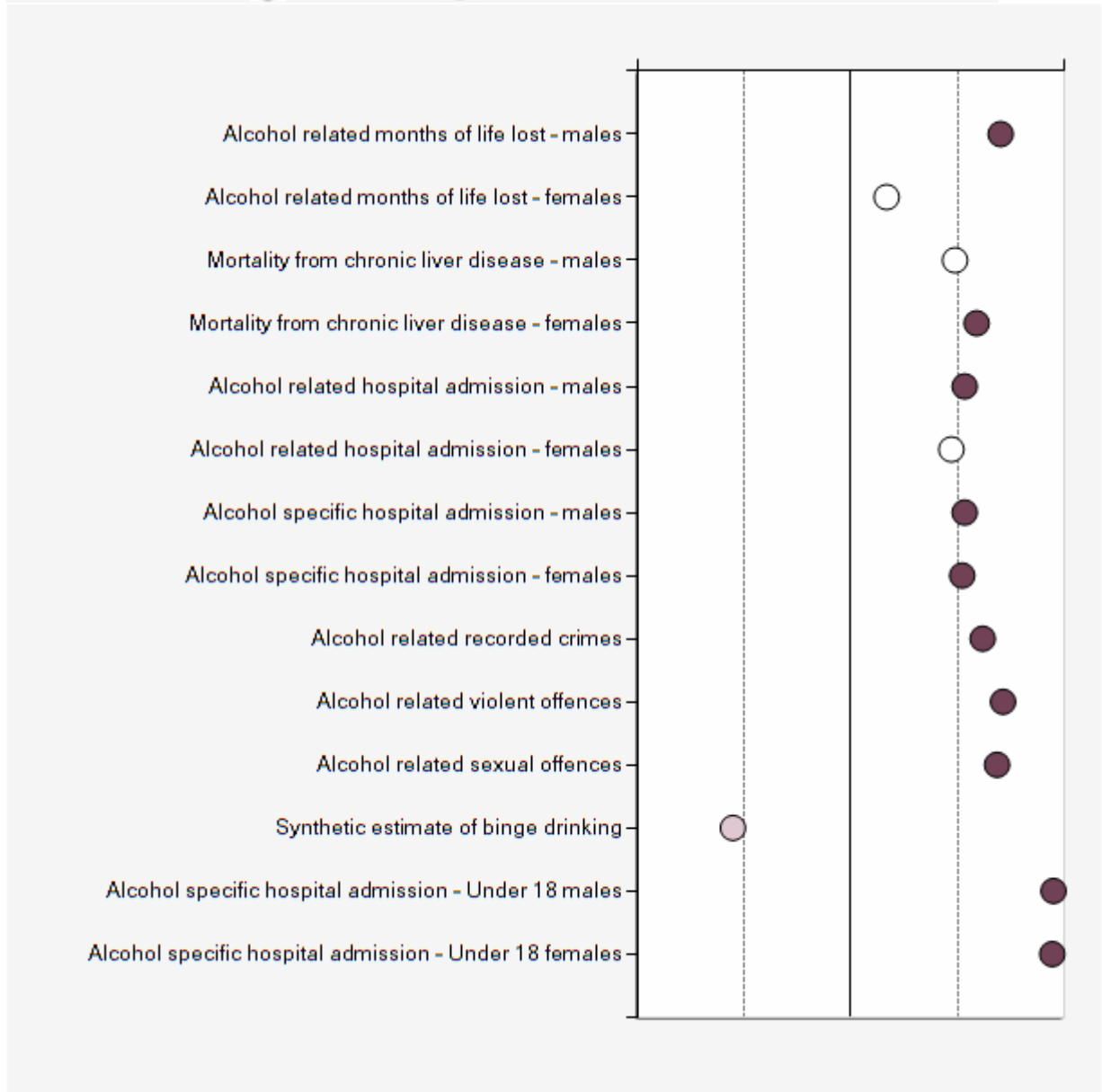


Source: Public Health Observatory: Local Alcohol Profiles for England  
 See <http://www.nwph.net/alcohol/lape/>

## Eastbourne : Profile of Alcohol Related Harm

As a measure of the level of alcohol-related impact experienced, each of the 354 Local Authorities in England has been ranked by indicator. The chart shows Eastbourne's rank for each indicator.

Key: Circles identify the rank position for that indicator and colours distinguish those in the lowest (light pink) and highest (dark purple) quartiles of alcohol related impact.





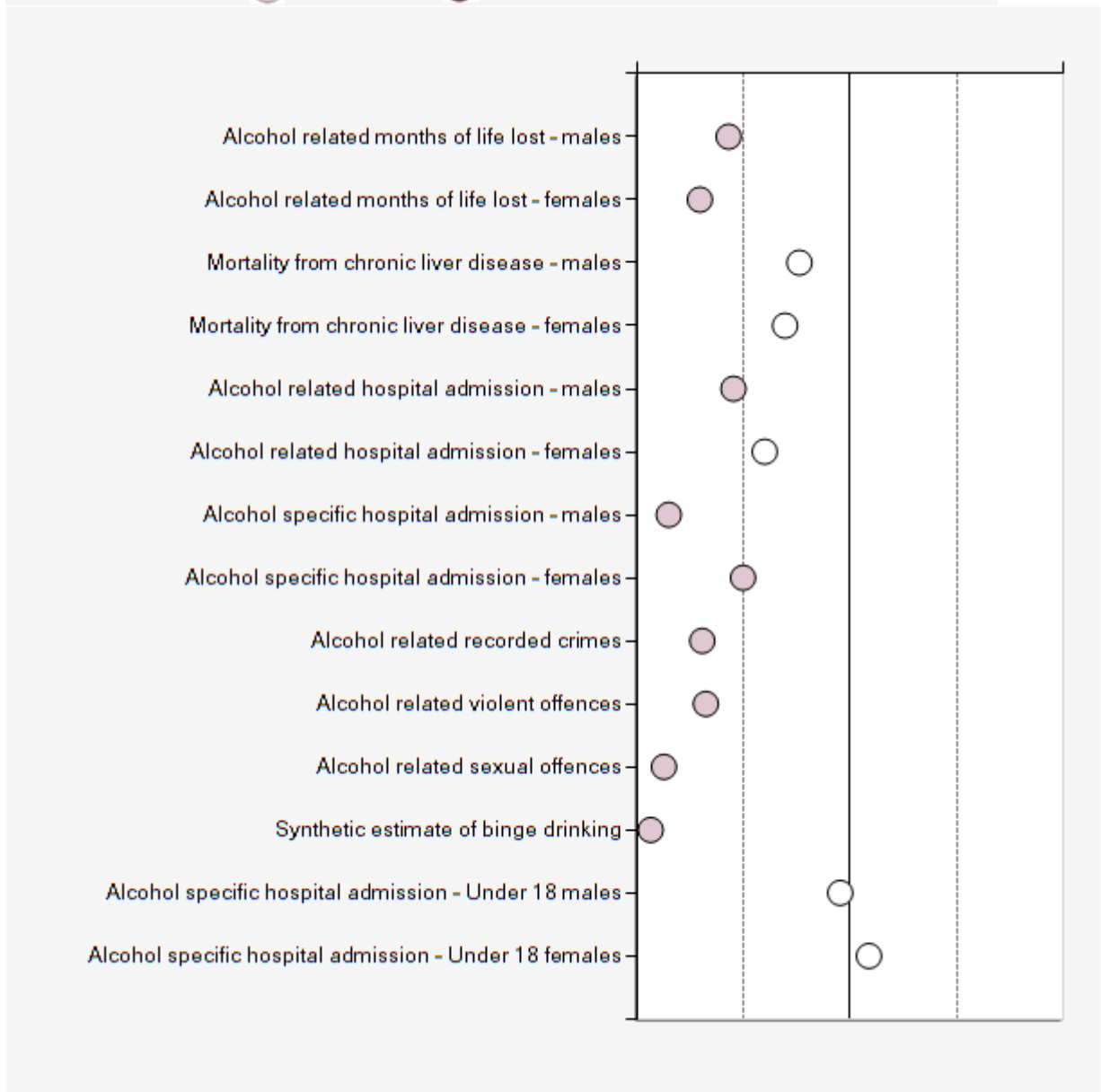
Source: Public Health Observatory: Local Alcohol Profiles for England

See <http://www.nwph.net/alcohol/lape/>

## Wealden : Profile of Alcohol Related Harm

As a measure of the level of alcohol-related impact experienced, each of the 354 Local Authorities in England has been ranked by indicator. The chart shows Wealden's rank for each indicator.

Key: Circles identify the rank position for that indicator and colours distinguish those in the lowest  and highest  quartiles of alcohol related impact.



Source:  
for England

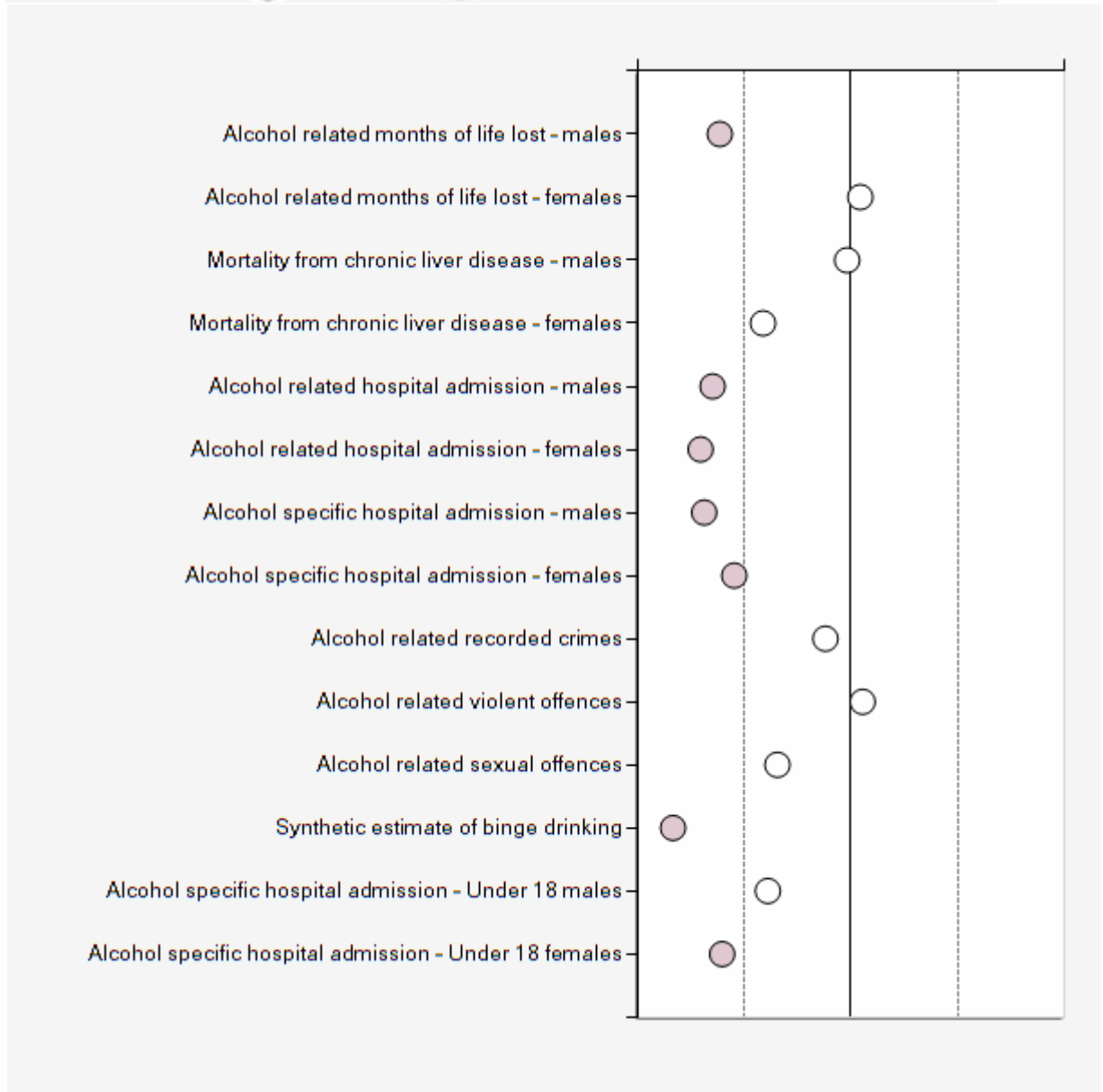
Public Health Observatory: Local Alcohol Profiles

See <http://www.nwph.net/alcohol/lape/>

## Lewes : Profile of Alcohol Related Harm

As a measure of the level of alcohol-related impact experienced, each of the 354 Local Authorities in England has been ranked by indicator. The chart shows Lewes's rank for each indicator.

Key: Circles identify the rank position for that indicator and colours distinguish those in the lowest (light pink) and highest (dark purple) quartiles of alcohol related impact.



Source:  
for England

Public Health Observatory: Local Alcohol Profiles

See <http://www.nwph.net/alcohol/lape/>

## Appendix Four | Outcome measures and performance indicators

The East Sussex Local Area Agreement 'All Together Better' (2006):

<http://www.essp.org.uk/essp/pdf/LAA.pdf>

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### **Target 17.4 Reduce the harm caused by drug and alcohol misuse**

Comments: 17.4.1 This is a national key performance indicator for Primary Care Trusts and sits within the NHS Local Delivery Plan as one of the nine key performance indicators that currently determine PCT star ratings. Due to the increasing investment announced by the Government in drug treatment, DAATs have been required to provide an additional stretch target

Lead: Drug and Alcohol Action Team (Marcus Gomm)

Partners: Voluntary and Community Sector, Primary Care Trusts

Indicators:

17.4.1 Increase participation of problem drug users in drug treatment programmes (Adult and Young People)

17.4.2 Increase number of adults with children in the child protection process receiving drug or alcohol treatment or a brief intervention

17.4.3 By March 2007 establish a comprehensive multi-agency Alcohol Strategy implementation plan

17.4.4 A reduction in the proportion of the public who perceive that drug dealing and drug use is a problem

## **Appendix Five | Social Care Outcomes**

Services will be founded on the following social care outcomes. Performance indicators will be developed that enable specific outcomes to be monitored.

### **Improving health and emotional well-being**

Services promote and facilitate the health & emotional well-being of people who use the services.

- Community are helped to understand how to stay healthy and are encouraged to do so through an excellent range of clear, accurate, accessible and well published information.
- Demonstrate link between health, well-being and investment in services.
- Demonstrates well developed and consistent joint and working well with partners.
- CPA is embedded and needs are holistically considered, working in effective partnership showing a positive impact for service users.
- People only in hospital where necessary.
- Services that prevent admission (?) support discharge in a setting which understands and acts impact the needs of individuals.
- Clear and successful mechanisms to ensure quality response to needs with evidence of successful rehabilitation and prevention.
- Social Care needs are well anticipated to inform Cament(?) and future service provisions at strategic level.
- Services work together efficiently and resources pooled to enable Joint Commissioning.

### **Improving Quality of Life**

Services promote independence and support people to live a fulfilled life making the most of their capacity and potential.

- Independent is pooled actively and consistently
- People who need care have their needs met through appropriate
- Innovative support packages are used to meet needs
- Preventative services that directly contribute to reductions in people needing higher level support.
- People with 'low incidents' conditions have a choice of specialist supported, tailored to their needs, to promote as much independence as possible.

## **Making a Positive Contribution**

People who use services are encouraged to participate fully in their community and their contribution is valued equally with other people.

- People who use services and their Carers have been actively included in development and improvement work.
- Community groups and different people are included to reflect the diversity of the Community.
- Active feedback is sought using a wide range of methods.
- Demonstrative, positive quality changes as a result of feedback.
- Coherent, innovative and effective partnership working including the private and voluntary sectors.
- Evidence of integrate service delivery meeting the needs of wider economic, social and environmental well-being of the area and improving different communities to support themselves.
- Evidence of enabling people to learn life skills to gain confidence in their wider communities.
- Evidence of Service user input into their care planning.
- Evidence of supporting and enabling people to articulate their views in range of forums.

## **Increased Choice and Control**

People and their Carers have access to choice and control of good quality services which are responsive to individual needs and preferences.

- Responding to referrals assessment care planning in a respectful and timely manner.
- Evidence that the service user's needs and preferences are central to the process.
- Service users and Carers feel adequately informed about services and individual care needs.
- Clear published routes of access to services 24/7
- Evidence of complaints being responded to promptly and consistently.
- The range of services is broad and meets varied needs offering choice and taking account of preferences.
- Evidence of promoting independence and choice by supporting people to live in their own homes.
- Evidence of increasing options for control and choice through individual budgets, direct payments and innovative development.
- Good quality accessible information services are available.
- Service Users views are well represented and advocacy services support this.

### **Freedom from Discrimination**

Those who need Social Care have equal access to services without hindrance from discrimination or prejudice; they feel safe and are safeguarded from harm.

- Clear, fair and easy to understand eligibility criteria.
- Effective monitoring of Social Care needs of the local populations and take up of services.
- Appropriate and inclusive access to services irrespective of disability, culture and gender.
- Effective and innovative activity identifies vulnerable adults at risk of social exclusion.
- Effective assessment of individual needs.
- Evidence that service users do not 'fall between services'.
- Effective safeguarding adults processes.

### **Economic well-being**

People are not financially disadvantaged and have access to economic opportunity and appropriate resources to achieve this.

- Pathway and transition plans are effective and regularly monitored and improved.
- Service users are positive about service provision and delivery.
- Service users contribute to their reviews.
- There is sustained improvement in the number of people in education, training and employment.
- Care co-ordination and advice empowers people to be independent and well prepared for life.
- There is a choice of pathways and flexibility to meet diverse needs.
- Carers are supported to enable them to continue in employment or return to work.

### **Maintaining Personal Dignity and Respect**

Services provide a confidential secure setting which respects the individual, helping to preserve people's dignity.

- Privacy and confidentiality are assumed in all contracts, supported by appropriate policies and procedures.
- People's homes are safe and secure.
- Service users report feeling safe, consulted with, listened to and responded to.
- Life chances are improved through access to leisure and healthy life styles.
- People are effectively safeguarded from abuse and neglect.

- Outcomes and regular review to ensure resources are appropriate area to meet needs and empower individuals.
- Staff use preventative support services to reduce abuse and neglect.
- Interpersonal relationship and social integration are actively encouraged with the service and the wider community.

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Appendix 3

## **Improving drug misuse treatment**

**2008/11**

East Sussex Health and Social Care Commissioning Strategy for  
Adult Drug Misuse

East Sussex Drug and Alcohol Action Team

**Publication date: January 2008**

## Improving drug misuse treatment

2008/11

East Sussex Health and Social Care Commissioning Strategy for Adult Drug Misuse

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## **Introduction**

This commissioning strategy sets out the direction for developing health and social care services for working age adults suffering drug misuse. It has been developed by the Drug and Alcohol Action Team (DAAT), the multi-agency strategic partnership responsible for delivering national drug and alcohol strategy objectives in East Sussex. The partnership maintains a dialogue with service users, providers and other stakeholders to ensure that local priorities inform the development of local services.

The Audit Commission (2003) defines commissioning as “the process of specifying, securing and monitoring services to meet people’s needs at a strategic level.” Meeting needs at a strategic level implies a good understanding of current and forecast needs. ‘Joint commissioning’ can be described as the process in which two or more organisations jointly take responsibility for commissioning. As a partnership that includes health, social care and criminal justice agencies the DAAT operates in a joint commissioning context.

The context for the development of health and social care services is set out in the white paper *Our health, our care, our say* (2006), further developed by the *Commissioning Framework for Health and Well Being* (DH, 2007). The development of adult health and social care will provide more control, choice and a stronger voice for individuals. Services will be provided more flexibly and closer to home. There is a shift in focus for the NHS towards improving health and well being, rather than responding to illness.

The changes are intended to put incentives in the right place to drive quality improvement, making services more responsive to the people who use them and their carers.

Commissioners are required to develop strategies that will improve choice by encouraging the people who provide services to be innovative about how those services are delivered. Current providers are encouraged to develop new services and new ways of working. Other organisations might be invited to deliver services to local people. A clear set of quality standards apply universally for all provider organisations, whether NHS or independent sector. Local people should expect good quality accessible services that are relevant to their needs wherever they live.

The partnership has consulted widely with the people affected by the strategy. Local people want to see services that help people who are misusing drugs to stop, and improve their lives and the lives of their families and other people in their community. This commissioning strategy sets out how that will be done.

## **The commissioning strategy for drug misuse**

This commissioning strategy considers the health and social care treatment needs of adults who misuse drugs in East Sussex. It focuses specifically on

people aged 18 – 64, and addresses both illicit drugs and non-prescribed medicines.

The strategy builds on previous work, which has seen the number of people in treatment more than double since the first national drug strategy for England and Wales was introduced in 1998. The strategy focuses on people whose drug misuse is particularly problematic, and people using the most dangerous drugs including heroin and crack cocaine.

The partnership particularly wants to focus responses on the minority of adults who cause or experience the most harm to themselves, their communities and their families. The aim is to deliver a service system that quickly engages people with services that help them to make the changes necessary to improve their lives. For the people who need to be sustained in treatment we expect to provide that treatment close to home in a way that doesn't encourage people to stay in treatment longer than necessary. For people who are ready to leave treatment we expect to help them to complete their treatment programmes in a planned way. We expect everyone to achieve improvements as a result of their contact with drug treatment services.

### **Next steps**

This commissioning strategy sets out the direction for service development to 2011. The partnership will continue to develop a treatment plan each year. The partnership's Joint Commissioning Group will monitor delivery. Annual treatment plans make sure that the partnership is accountable for delivering the strategy, making best use of the resource available.

## **2. National and Local Requirements and Research**

### **National Strategy**

The national drug strategy is currently being updated - the consultation paper 'Drugs: Our Community, Your Say' was published in July 2007. The aims laid out in the consultation paper build on the previous drugs strategy (Home Office, 2002). Treatment is described as the 'cornerstone' of the drugs strategy, with strong local leadership building partnerships that ensure local services improve people's lives.

The consultation paper describes how the new strategy will continue to focus on improving treatment outcomes and cost effectiveness, ensuring that there is an effective link between treatment in the community and prisons and that local systems achieve the right balance of 'abstinence' and 'maintenance' treatments.

### **National policy drivers**

There are a number of national policy drivers that the commissioning strategy needs to reflect. Key policy documents and national strategies include:

- Models of care for Drug Misuse (2006)
- National Institute for Health and Clinical Excellence (NICE) Guidance
  - CG51 - Drug Misuse: Psychosocial interventions
  - CG52 - Drug Misuse: Opioid detoxification
  - TA114 – Drug Misuse: Methadone and buprenorphine
  - TA115 – Drug Misuse: Naltrexone
- Drug Misuse and Dependence – Guidelines on Clinical Management: Update 2007
- Mental Health Policy Implementation Guide - Dual Diagnosis Good Practice, Department of Health (2002)
- Integrated Drug Treatment System (IDTS) guidance

### **NTA Treatment Effectiveness Strategy**

We know that treatment works, and that measurable gains can be sustained when people are retained in treatment for at least 12 weeks. Godfrey et al (2004) established that every £1 invested in treatment produces £9.50 of savings in health and criminal justice costs. Service users often have chaotic lifestyles, and will benefit from different interventions at different times. The NTA (2006) has noted that “the biggest improvements in client outcomes are likely to be made in the first six years of treatment...”

The NTA treatment effectiveness strategy is all about engaging people in treatment programmes that respond effectively to their needs and sustaining that engagement to improve treatment outcomes.

### **The aims of treatment and management of drug misuse**

The National Institute of Health and Clinical Excellence (NICE, 2007) describes how there are three broad approaches to the treatment and management of drug misuse:

- Harm reduction;
- Maintenance-oriented treatments;
- Abstinence-oriented treatments.

The 2007 national drug strategy consultation paper underlines the importance of ensuring the right balance between services that maintain people in treatment (for example substitute prescribing programmes), and services that enable people to become and remain abstinent from drug use altogether.

### **NICE Guidance – Psychosocial Interventions**

NICE (2007) clinical guidelines for drug misuse – psychosocial interventions considers the evidence base for the psychosocial aspects of treatment. The guidance describes the evidence base for treatment effectiveness and makes recommendations for practice, summarised in Appendix One.

For East Sussex, critical messages to be drawn from the guidelines include:

### **Interventions for people not in structured treatment programmes**

- Brief interventions are effective for 'limited contact' services like needle exchange, and a maximum of two sessions (of 10-45 minutes) should be offered;
- Voucher-based contingency management approaches should be considered to improve compliance with testing (and immunisation, if relevant) for Hepatitis B/C, HIV and TB;
- Information and advice about blood-borne viruses, sexual health and injecting risk should be provided opportunistically in individual settings, routine 'psychoeducational' groups should be avoided.

### **Psychological Interventions**

- Cognitive Behavioural Therapy (CBT) for relapse prevention is more effective than brief interventions for cannabis users when delivered in individual settings but not in a group and not for users of other drugs;
- Cognitive behavioural therapy (CBT), although widely used does not generally improve treatment outcomes for people who are receiving methadone maintenance or who present with a 'stimulant' drug problem<sup>1</sup>;
- Contingency management (rewarding treatment compliance with prizes, vouchers or clinic privileges) is effective when coupled with methadone maintenance therapy (MMT), but not with buprenorphine;
- There is an additive effect for people receiving '12 step' interventions alongside other drug treatment, compared to people receiving only 12 step or another treatment intervention alone;
- Although the research base is limited, there is no evidence that psychodynamic approaches are effective.
- There is no evidence of the effectiveness of 'multi modal' treatment programmes – sometimes known as structured day care services.
- Clinical recommendations for services provided in a custodial (prison) setting are broadly similar as for community settings. The nature of the rewards offered as a contingency management approach may vary.
- Carers are most effectively supported by self-help groups and guided self-help (for example provided with self-help literature).

### **NICE Guidance – Prescribing Interventions**

NICE (2007) Technology Appraisal 114 describes how methadone and buprenorphine have a similar efficacy, and estimates that approximately 30% of a treatment population will be prescribed buprenorphine rather than methadone. The relevance of the guidance to the commissioning strategy is essentially about the cost difference between methadone and buprenorphine.

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<sup>1</sup> NICE has produced other guidance about the effectiveness of CBT for treating anxiety and depression. Many service users will present with symptoms of anxiety and depression. Effective treatment can be provided in the substance misuse service setting.

NICE published a cost template with the guidance. For 'average' doses, buprenorphine is approximately four times the cost of methadone.

### **Co-morbid substance misuse and mental health problems**

Policy guidance on 'dual diagnosis' from the Department of Health requires each local area to develop a service strategy which works towards an integrated treatment model - problems are addressed at the same time, in one setting, by one team. For people with severe mental illness, this integrated approach should be provided by mainstream mental health services. For people with less severe mental health problems treatment should be provided by substance misuse services. People with a dual diagnosis also have contact with a variety of other agencies (for example primary care, criminal justice and housing). It is important that all these services work collaboratively to ensure that users' needs are addressed. In addition to a service strategy, the DoH guidance indicated that a training strategy is required to address the knowledge and skill deficits of staff. Training must be available to all disciplines, and qualified and unqualified staff should be included. It is the responsibility of both the Local Implementation Team and Drug and Alcohol Action Team (DAAT) to ensure that the policy guidance is implemented.

### **Integrated Drug Treatment System – IDTS**

The Integrated Drug Treatment Strategy (IDTS) is a new approach being rolled out to selected prisons by the National Offender Management Team. The programme is funded by the Department of Health to improve the clinical and psychosocial services for substance misusers in prisons. IDTS will ensure drug treatment provision is equitable in different prisons and will integrate drug treatment methods between the community and the prison.

### **East Sussex policy drivers**

The commissioning strategy has been developed in the context of other local strategies and policies including:

- East Sussex Local Area Agreement (LAA) – All Together Better. Substance misuse issues are considered at section 17.4;
- East Sussex County Council Adult Social Care Equality and Diversity Improvement Plan 2007-2010;
- East Sussex Safer Communities Plan 2007;
- East Sussex DAAT Harm Reduction Strategy (2007);
- Dual Diagnosis strategy 2005
- Pan-Sussex Reducing Supply strategy 2007;
- Supporting People strategy 2005-2010

### **3. Needs Assessment**

The purpose of the needs assessment is to profile the diversity of local need for drug treatment. The needs assessment includes rates of morbidity and mortality, the degree of treatment saturation or penetration, and the impact of treatment on individual health, public health and offending. The full needs assessment is published on the partnership's website, a short summary is included here.

#### **Problem Drug User**

In this context, 'drugs' refers to psychoactive drugs including illicit drugs and non-prescribed pharmaceutical preparations. The 'in treatment' population will include people who are taking prescribed pharmaceutical preparations.

The needs assessment refers to the 'problem drug user' (PDU) population. The needs assessment has adopted the definition of a PDU used by Hay et al (2006): "Use of opiates and/or the use of crack cocaine."

The total PDU population will include people who have a recent history of problems, although currently controlled by engagement with drug treatment. This definition was used by Hay et al "because of practical difficulties in identifying problem users" of other drugs. It has been adopted here for the same reason.

#### **Home Office Problem Drug User (PDU) estimates**

The University of Glasgow and National Drug Evidence Centre produced an estimate of the number of problem drug users in East Sussex using the 'capture-recapture' method. This estimate was published as the first 'sweep' of a three-year study. The estimate, based on data available for 2004/05 when the adult 'in treatment' population included 752 people, is that there are between 1,561 and 2,404 PDUs living in East Sussex. The estimate was re-assessed in the second annual 'sweep' of the 3 year project using 2005/6 data. The assessment showed that the national prevalence estimates for problem drug use remained stable across the two years.

Based on available data, the partnership's PDU estimate has been revised upwards from 1,858 PDUs to 97.5% of the range - 2,344 PDUs.

The Hay et al estimates of the East Sussex PDU population are shown in the following tables by gender, age, injecting status and primary substance. The 'penetration level' in the tables below use the estimate gauge the level of treatment penetration – people known to the treatment system - and of the 'treatment naïve' population.

## Treatment bullseye

The needs assessment adopts a segmentation approach. The total estimated PDU population is segmented according to contact with the treatment system to produce a 'treatment bullseye' (see figure i). The approach uses two central data sources, the National Drug Treatment Monitoring System (NDTMS) and Drug Interventions Programme (DIP) data, plus any other locally available data sources to class the estimated PDU population by treatment status. Those PDUs currently in contact with the treatment system are at the centre of the 'treatment bullseye', with information about the other PDU segments organised as bands around this core group. The further out the circle, the less reliable the data.

This method should ensure that all of the available information sources collated nationally can be combined with local expertise to deliver a coherent and evidence-based segmentation of the local estimated PDU population to inform planning.

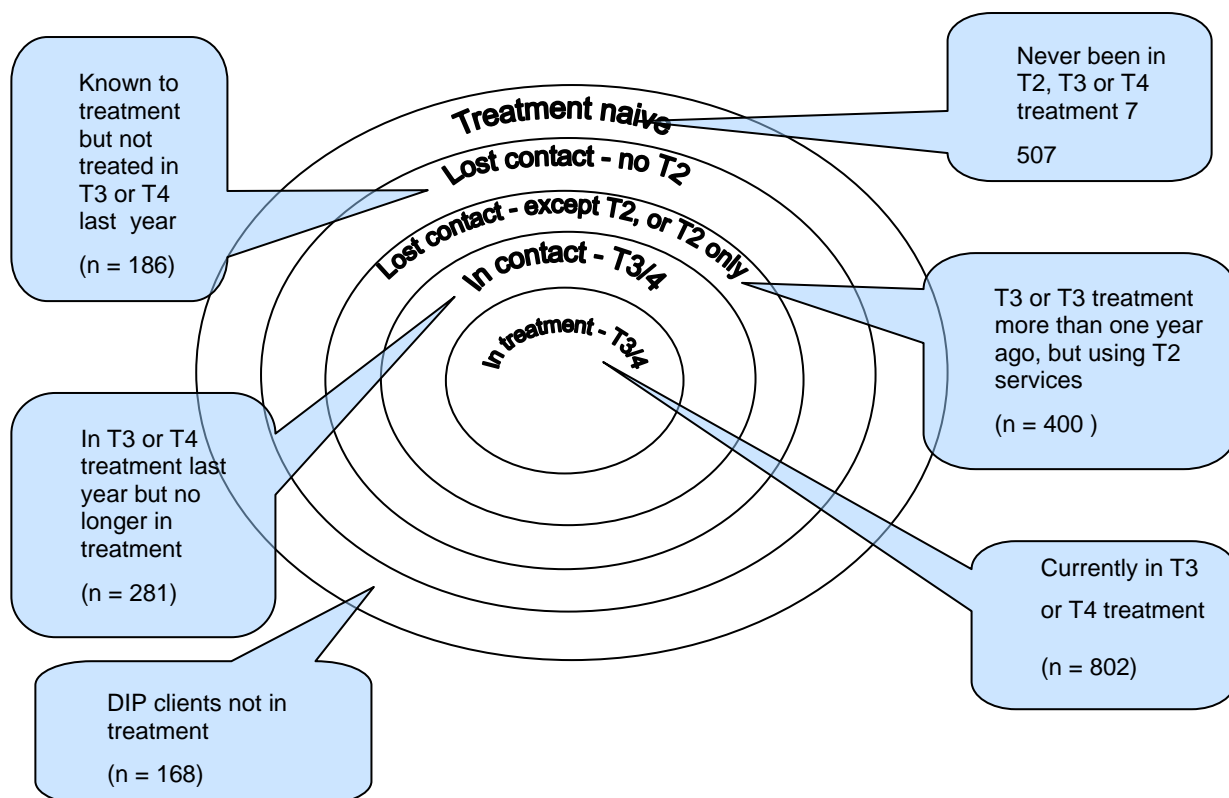


Figure 1: Treatment bullseye – estimated PDU population

The approach uses two central data sources, the National Drug Treatment Monitoring System (NDTMS) and Drug Interventions Programme (DIP) data, plus any other locally available data sources to class the estimated PDU population by treatment status. Those PDUs currently in contact with the treatment system are at the centre of the 'treatment bullseye', with information

about the other PDU segments organised as bands around this core group. The further out the circle, the less reliable the data.

Those currently in tier 3/4 treatment	802
Those in tier 3/4 treatment more than 1 year ago and using tier 2 services	400
Known to treatment but not treated in 2006/07	186
In treatment last year (2005/06) but no longer in treatment	281
DIP clients not in treatment	168
Total 'known' PDUs	1837
'treatment naïve' PDUs not in contact with the treatment system (using the PDU estimate of 2344)	507
Treatment penetration	78%

**Gender of treatment naïve population**

	PDU estimate %	Estimated treatment naïve population
Male	72.6	368
Female	27.4	139

**Age of treatment naïve population**

	PDU estimate %	Estimated treatment naïve population
15-24 year old	16.9	86
25-34 year old	44.4	225
35-64 year old	38.7	196

**Injecting status of treatment naïve population**

	PDU estimate %	Estimated treatment naïve population
Injectors	39.5	200
Non-injectors	60.5	307

**Main problem substance of treatment naïve population**

	PDU estimate %	Estimated treatment naïve population
Opiate (and or crack cocaine) users	100%	507
Crack users	61.0%	309

Effectively, using the estimates and the confidence intervals, it would suggest that there are between 21 and 507 PDUs who are treatment naïve living in the county. East Sussex have adopted the higher perhaps more realistic figure of 507 PDUs. Of the treatment naïve population, the estimates would suggest that

- 368 (72.6%) are male and 139 (27.4%) female
- 225 (44.7%) are aged between 25-34
- 196 (38.7%) are aged between 35-64
- 200 (39.5%) are injecting drug users
- 309 (61.0%) are crack users

The full needs assessment includes a 'treatment map' that describes the path through treatment. In East Sussex, the service system has been designed with the open access services acting as 'gatekeeper' to specialist services, which are the referral source for GP shared care and in-patient/residential services. The partnership generally uses local in-patient services. During 2006/7 there were 35 placements to 16 out-of-area residential rehabilitation providers.

The needs assessment describes how around 70% of people who access treatment have previously been in treatment.

The age of people presenting to treatment at the time of their triage assessment is within 5% of the PDU estimates suggested by Hay et al (2006). 39% of people were between 25-34 when they presented to treatment and 44% were aged between 35-64.

Ethnicity was declared in 96.6% of cases, although not a mandatory field during 2006/07. 96.3% of the new presentations to treatment where ethnicity was declared were white British, white Other or white Irish. This is very similar (within 0.2%) of local population estimates<sup>2</sup>. In relation to the non-white groups, the proportion in treatment is broadly similar to that of the population estimates.

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<sup>2</sup> See 'East Sussex in Figures' at <http://www.esif.org.uk/>

The NDTMS data shows that of the 1161 presentations to treatment, 923 people were referred to a treatment modality meaning that 238 (20.5%) were not. There is little difference between females where 21.2% show no modality and males, where 20.1% show no modality so 20% would appear to be consistent but when compared to the average of 9% across the south east and 6% nationally, the figure is high. This group leave treatment in an unplanned way, indicating that they present for treatment, are assessed as suitable and then do not initiate. More than 80% of people who are initiated on a treatment programme that includes specialist prescribing are retained in treatment for at least 12 weeks. This 'early drop out' has been identified as a problem caused by a delay introduced during the assessment process. The introduction of a 'single assessment' during January 2008 is intended to address this issue. The commissioning strategy describes how the prescribing service will be co-located with the non-medical provider to maximise the resources used to fully engage each client with their treatment programme as quickly as possible.

587 (92.2%) people discharged during the period were discharged before they had been in treatment for 1 year. We already know that 238 were discharged before starting a treatment modality. A further 349 people initiated treatment but left within 1 year. We can also say that of the 587 leaving before 1 year, 91.9% of females and 92.3% of males discharged were in this group therefore a similar proportion across males and females.

128 (45.1%) females completed their treatment intervention in a planned way and 224 (36.67) of males. The percentage of males who left their treatment episode in a planned way was 17.9% so it would appear that a higher percentage of males leave their treatment intervention in a planned way than their treatment episode. A significantly higher proportion of females left treatment in a planned way. Only 14% of people left treatment 'drug free'.

The percentage of young people leaving treatment in a planned way (treatment complete, treatment complete and drug free or referred on) at the end of June 2007 was 61%. The adult data has been analysed to see whether the adult treatment population includes people who had previously received treatment within the young people's service. The analysis sought matching client attributes and included all adult presentations to treatment since January 2006 and young people 19 and over (or who would be) from the under 19's service. Only 8 individuals who had presented to adult treatment had previously been in treatment with the young people's service: 2 were male and 6, female. The number of individuals moving between the young people's service and the adult services is small and we can be relatively confident that when young people leave treatment they do not appear to be presenting to adult drug treatment at a later date.

The Health Protection Agency (HPA) estimates that East Sussex has a 'medium' prevalence of Hepatitis C of between 25% and 50%. For areas in

this band after around 13 years of injecting half of IDUs will have been exposed to HCV. The partnership joined the HPA Unlinked Anonymous Prevalence Mapping Programme during 2007/8 to inform local prevalence estimates for Hepatitis B and C and HIV infection.

### **Assumptions about the treatment naïve population**

Using the PDU estimates provided with caution, we can assume that there are up to 507 PDUs not in treatment (calculated using the 2344 estimate) equating to a minimum 78.4% penetration level in East Sussex. Of the treatment naïve population, the estimates would suggest that

- 368 (72.6%) will be male and 139 (27.4%) female;
- 225 (44.7%) will be aged between 25-34;
- 196 (38.7%) will be aged between 35-64;
- 96.3% will be white, white Irish or white other;
- 309 (61.0%) will be crack users;
- between 200 and 359 of the treatment naïve PDU are likely to be currently injecting or have previously injected;
- between 64 and 115 of the treatment naïve injecting population might be infected with Hepatitis B;
- between 84 and 150 of the treatment naïve injecting population might be infected with Hepatitis C;
- 20% (101) of the 'treatment naïve' population will have a housing need;
- 25% will live outside of Eastbourne and Hastings;
- up to 52% of the treatment naïve population have children living with them, a partner, family member or in care.

### **Local analysis of triage only cases**

Local data has been interrogated in relation to 'triage only' clients for presentations between 1st January and 30th September 2007. During this period, there were 1307 triage assessments carried out and 283 (21.7%) of the potential treatment episodes were discharged without the client having received a comprehensive assessment.

Of those 283 discharges, the triage outcome recorded in the adult case management system (though not an NDTMS field), Orion is shown below:

#### **Triage outcome of triage only cases**

Triage Outcome	East Sussex	Hastings &	Total
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	Downs & Weald	Rother	
Comprehensive assessment (including medical) at SMS	55	99	154
Comprehensive assessment (social care and health)	52	21	73
Other service	13	1	14
Advice and information	7	10	17
Not appropriate	0	2	2
Not known	0	1	1
Other	10	12	22
Total	137	146	283

227 (80.2%) of the triages for those episodes discharged following the triage assessment, had an outcome of referral for comprehensive assessment and should in theory, have resulted in a treatment modality starting within 3 weeks. The number of triage only cases was proportionally similar across the Eastbourne and Hastings services. The 'single assessment' due to be implemented will effectively mean that a client will receive their full assessment during one appointment and where appropriate, treatment may start within one or two days, provider capacity allowing. The intention is that clients will not 'drop out' from treatment after their triage assessment but before their treatment begins.

### Treatment Duration

For retention, the partnership had a target of 70% of people entering treatment for 06/07, to remain in treatment for at least 12 weeks, the target rising to 80% in 07/08. This is one of the Primary Care Trust Local Delivery Plan (LDP) targets. During 06/07 and into 2007/8, performance dipped to below target at 65%. The primary cause is people who leave treatment having completed a 'triage' (initial) assessment, before completing further assessments and initiating treatment.

More than 80% of people who are initiated on a prescribing regime remain in treatment for 12 weeks or more. Improving engagement during these critical first few weeks is a priority.

Using the NDTMS data, of the 637 adults discharged from treatment during 2006/07, the duration of their treatment episode at the point of discharge is shown in the table below.

#### Duration of treatment at discharge from treatment

		Frequency	%
Duration of	0 to 1 year	587	92.2

	2 to 3 years	27	4.2
	4 to 5 years	12	1.9
	6 to 10 years	5	.8
	11 + years	6	.9
	Total	637	100

587 (92.2%) people discharged during the period were discharged before they had been in treatment for 1 year. The 92% figure is true for both male and female service users. This is significantly higher than the figures shown in the 2005/06 needs assessment where 61% of people who were discharged had been in treatment for less than 1 year.

### Discharges by treatment episode/gender

The total number of discharges is shown in the table below by gender.

#### Discharges from treatment by gender

		Female	Male	Total
Discharge Reason	Treatment completed drug free	12	14	26
	Treatment completed	44	65	109
	Referred on	15	27	42
	Other	2	5	7
	Not known	0	1	1
	Treatment declined by client	1	2	3
	Inappropriate referral	0	1	1
	Treatment withdrawn	13	34	47
	No appropriate treatment available	1	2	3
	Dropped out/left	90	218	308
	Moved away	2	7	9
	Prison	15	57	72
	Died	2	7	9
Total		197	440	637

Overall, 177 (27.8%) episodes were discharged in a planned way, against targets at the time of between 53% and 83% for successful completions (as they are different for each intervention). 71 (36%) females left treatment in a planned way, compared to 79 (17.9%) males. Of the 177 planned discharges, a much lower percentage of people, 14.7%, completed their treatment 'drug

free' than 'treatment completed'. The national average number of people leaving treatment 'drug free' is 9%<sup>3</sup>.

### **Criminal Justice Integrated Teams**

In East Sussex, the Criminal Justice Integrated Team (CJIT) delivers services from two discrete bases in Eastbourne (serving Eastbourne, Wealden and Lewes) and in Hastings (serving Hastings and Rother). The CJIT works with people referred from police, prison and the courts – particularly targeting prolific and other priority offenders with a history of drug misuse.

In each location there is an open access ('tier 2') service that provides the gateway into the local treatment system, a common assessment process, a range of services providing care-planned treatment ('tier 3') interventions and a multi-agency panel that oversees the operation of the local treatment system.

Using the data available on DIRWeb - the Drugs Interventions Programme performance management system - the discharge reasons from the DIP caseload are shown in the table below.

#### **Discharge reasons from the DIP caseload**

		%	Total
Closure reason	Treatment completed	15.8%	22
	Transferred to prison	15.8%	22
	Disengaged from CJIT	59.8%	83
	Other	1.4%	2
	Died	1.4%	2
	Transferred to another DAT	5.8%	8
Total			139

The figures in the table above relate to the cases that were discharged between 1st April 2007 and 30th November (though data for November is provisional). Only 15.8% of individuals who had been on the DIP caseload

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<sup>3</sup> Batty, D. *MPs and Experts Condemn Drug Treatment*, Guardian 18/10/07 available at <http://www.guardian.co.uk/drugs/Story/0,,2193784,00.html> (accessed 7/1/08)

were discharged as 'treatment complete'. 15.8% of individuals were discharged because they were transferred to prison and 59.8% disengaged and were discharged.

Of the 64 other individuals not shown here, who were 'suspended' from the DIP caseload, in 38 (59.4%) cases, the suspension was due to the length of time to be spent in custody and the DIR was forwarded to the CARAT team. In 26 (40.6%) cases, the individuals were sentenced to a community Drug Rehabilitation Requirement.

Overall this means that of the 204 combined suspensions and closed cases, 60 (29.4%) of individuals were sentenced to a custodial sentence, 38 (12.7%) sentenced to a DRR and 83 (40.7%) disengaged.

## Housing

Between 1st April and 30th September 2007, 365 new clients entered into various Supporting People funded support services, based on Client Record forms which are completed between the service provider and the service user. Certain services are excluded on the Client Record form (very sheltered housing, sheltered housing with warden, almshouse, peripatetic warden and leasehold scheme). Of the 365 individuals, as primary issues, 8 were at risk of offending and 4 had substance misuse problems. As secondary issues, 13 were at risk of offending and 16 had substance misuse issues.

NDTMS data for 06/07 is shown in the table below.

### Accommodation status

		Female	Male	Total
Accommodation status	Missing data	213	462	675
	No fixed abode	16	59	75
	Temporary	13	37	50
	Supported housing	3	7	10
	Rented	100	196	296
	Hostel	1	2	3
	Owned property	12	40	52
Total		358	803	1161

It should be noted that a high proportion of the missing data relates to people in treatment prior to the introduction of the new field. Where completed

though, 75 (15.4%) of people declared themselves to be of no fixed abode and 50 (10.3%) living in temporary accommodation.

The previous needs assessment found that 16.9% of people were of no fixed abode and that 8% lived in temporary housing so the balance has shifted slightly. The Housing Needs Assessment was carried out in East Sussex during 2005 and using the Drug Strategy Directorate formula, it suggested 20% of substance misusers have a housing related need. We can therefore assume that 20% (101) of the 'treatment naive' population have a housing need. The same data is shown in the table below by Local Authority.

**Accommodation status by LA**

		Eastbourne	Hastings	Lewes	Rother	Wealden	Total
Accommodation status	Missing data	295	237	53	65	25	675
	No fixed abode	37	35	0	3	0	75
	Temporary	34	10	0	6	0	50
	Supported housing	6	3	0	1	0	10
	Rented	90	149	15	27	15	296
	Hostel	1	1	1	0	0	3
	Owned property	29	8	7	3	5	52
Total		492	443	76	105	45	1161

33.6% and 33% of people in treatment living in Eastbourne and Wealden respectively are living in rented accommodation. Eastbourne shows the highest proportion of people living in temporary accommodation at 6.9%.

**Drug Related Deaths**

There is an East Sussex multi-agency group that focuses specifically on reducing drug related deaths, which reports to the DAAT partnership board. The group monitors drug related deaths in East Sussex and oversees the implementation of actions to reduce drug related deaths.

East Sussex has adopted the definition of a 'drug related death' provided by the Office of National Statistics (2000) "...deaths where the underlying cause is poisoning, drug abuse or drug dependence, and where any of the substances are controlled under the Misuse of Drugs Act (1971)."

This is a narrower definition than that used by Ghodse et al (2005)<sup>4</sup> in the annual report of the national programme of substance abuse deaths ('np-SAD') published by the International Centre for Drugs Policy "...a relevant death where any of the following criteria are met at a completed inquest, fatal accident inquiry or similar investigation:

- One or more psychoactive substances directly implicated in death;
- History of dependence or abuse of psychoactive drugs;
- Presence of Controlled Drugs at post mortem; or
- Cases of deaths directly due to drugs but with no inquest."

Np-SAD relies on returns from coroners, which has implications for consistency of classification and for completeness of returns. Whilst this makes it difficult to make direct comparisons between different areas, the national programme provides a useful basis for historical comparison of mortality rates.

**Np-SAD death rate**

East Sussex Np-SAD annual death rate / 100,000		
Year	Rate / 100,000	N
2001	4.00	16
2002	5.97	24
2003	9.32	36
2004	5.68	23
2005	.098	4
2006	5.66	23

The increase in 2003 to a reported annual death rate of 9.32/100,000 may be explained by a note in the report of the local confidential inquiry, McDonnell and Bennett (2004)<sup>5</sup>. The report notes that late in 2004 the coroner reported "a further 12 deaths [from 2003] which may have had an opiate associated with the death were submitted by the coroner, after re-checking the definition used [by St Georges Hospital]". This suggests that reports to Np-SAD in previous years may have been under-reported. None of the additional 12 deaths met the local (i.e. Office of National Statistics) definition, underlining

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<sup>4</sup> Ghodse H, Corkery J, Schifano F, Oyefeso A, Bannister D, Annan J. (2005) *Drug-Related Deaths in the UK Annual Report 2005*. International Centre for Drugs Policy.

<sup>5</sup> McDonnell, J. and Bennett, J. (2004) *Drug Deaths in East Sussex*. Unpublished.

the importance of monitoring and reporting locally to the commissioning process. With the release of the 2006 report<sup>6</sup> was included a revised text stating that the number of deaths in 2005 was under reported due to an administration error. The figure of 4 is incorrect and 20 deaths for 2005 were reported to the DAAT. It is of course possible that the Np-SAD figures will be revised to reflect the higher figure for 2005 in due course. Early in 2007 the Np-SAD contacted the East Sussex Coroner and deaths are now being correctly reported using a slightly broader definition and it is possible that this might result in a perceived increase in the number of drug related deaths across the county.

**Deaths included in the local drug related deaths inquiries within the ONS definition**

2004	15
2005	12
2006	19
Total	46

The table above shows the total number of deaths, where Inquests have been received, that have been included in the drug related death inquiry process.

### **Confidential Inquiries**

A sub-group of the drug related deaths steering group manages confidential inquiries into local drug related deaths. The purpose of the confidential inquiry process is to identify opportunities to improve systems and practice, to learn from the incident and seek to prevent similar incidents in the future. The most recent report available is authored by Dr Anthony Glasper, Dr Bettina Baier and Karen Burch (2007) and relates to deaths where the Coroner's Inquest was received by the DAAT during 1st January 2004 and 31st December 2005. Dr Anthony Glasper, consultant psychiatrist with responsibility for drug and alcohol misuse, leads the group. All deaths recorded by the coroner that meet the definition (indicated above) are included in the confidential inquiry. Information about deaths is collected, post-inquest, using an agreed minimum data-set.

Overall twenty-two deaths over the two-year period were included in the confidential inquiry. Of these, five (all in 2004) were people who had recently left prison – three within a few days. Eleven of the deaths were people who were suffering from a mental illness at the time of their death and not in treatment with specialist substance misuse treatment services. These people could be considered 'dual diagnosis', with a history of co-morbid drug misuse

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<sup>6</sup> Ghodse H, Corkery J, Oyefeso A, Schifano F, Tonia, T (2006) *Drug-Related Deaths in the UK Annual Report 2006*. International Centre for Drugs Policy

and mental health problems. In ten cases, alcohol would have contributed to the death.

Providers report that the confidential inquiry process has so far had a limited impact on practice. This is considered to be primarily a function of the time delay between a drug related death and feedback from the confidential inquiry. For that reason, the latest inquiry process is underway and includes all deaths where the Inquest has been received by the DAAT between 1st January 2006 and 31st December 2007, regardless of the date of death.

So far, a total of 35 Inquests have been received and 9 deaths have definitely been excluded from the inquiry because the cause of death was outside the ONS definition. A further 2 cases are likely to be excluded but a final decision is awaited leaving a total of 23 deaths to be explored in detail. The final report will be available during April 2008.

Being in treatment is a highly protective factor that reduces the risk of drug related death. The risk of accidental opioid overdose is much higher during the first few weeks after leaving treatment. None of the deaths considered by the 2004/5 Confidential Inquiry were of people known to treatment services. However, the majority of people leaving treatment in East Sussex do so in an unplanned way, suggesting a high risk of drug related death.

### **Co-morbid substance misuse and mental health problems**

In a recent local needs assessment, Nicholls (2002) looked at the number of people with a dual diagnosis of substance misuse and mental illness who were in contact with community mental health services. In line with published literature, the local data suggests that 10% to 20% of people in contact with the community mental health services also have a substance misuse problem. This is consistent with the published literature. The proportion of the caseload in the assertive outreach team is estimated to be double this amount (40%).

Analysis of the substance misuse service data between April 2005 and September 2006 indicates that around 15% of people receiving a service for drug misuse were also in treatment with mental health services.

Of 400 responses to a question about 'whether you have previously overdosed', 166 (41.5%) said that they had and 39 of these individuals had been in treatment with mental health services. There is no information as to whether the overdoses were intentional.

Of the 215 responses to a question about 'self harming', 53 (24.9%) people reported that they had previously self harmed. All 53 reported that they had previously overdosed and 23 of these individuals had reported that they were in treatment with mental health services. Everyone who has highlighted that

they are or have previously self harmed should be identified and overdose risk management interventions should be included in their care plan.

### **Sussex Police data about availability**

East Sussex Police produce a quarterly Drugs Market Profile using appropriate drug treatment data alongside crime data. The profile examines the nature of the Class A drugs market in Sussex. It includes performance information and outlines the current intelligence picture surrounding the supply and distribution of Class A drugs.

The most recent profile suggests that drug markets within East Sussex, particularly in Eastbourne and Hastings areas are that of a closed market. The 'hotspots' within Hastings suffer deprivations and the profile proposes a relationship between deprivation and crime. The Eastbourne area continues to be affected by the supply of class A drugs through several suppliers. In both areas dealing would appear to have shifted to premises rather than street dealing. There have been a number of operations to address these issues which have involved liaison working between drug treatment services and the police in the use of outreach work where supply is interrupted.

### **Treatment system performance**

From October 2007, the National Drug Treatment Monitoring System (NDTMS) will be used to monitor treatment outcomes for everyone in treatment. Until that data is available, the effectiveness of treatment systems is assessed using a number of 'proxy' measures – waiting times, retention for 12 weeks and planned discharge rates.

For waiting times, the partnership has a target of 85% of people entering treatment within three weeks of referral. Any case waiting more than six week is an 'exceptional wait', requiring further investigation and actions to address any problems identified. Waiting times are generally within target in Eastbourne, but have dropped slightly below target in Hastings during 2007/8. The service system is operating above planned capacity and being fully utilised, creating a barrier for new cases. To address this, the partnership plans to continue the expansion of 'shared care' services in primary care, enabling more stable patients to be referred out of secondary care to free-up treatment places in the specialist team.

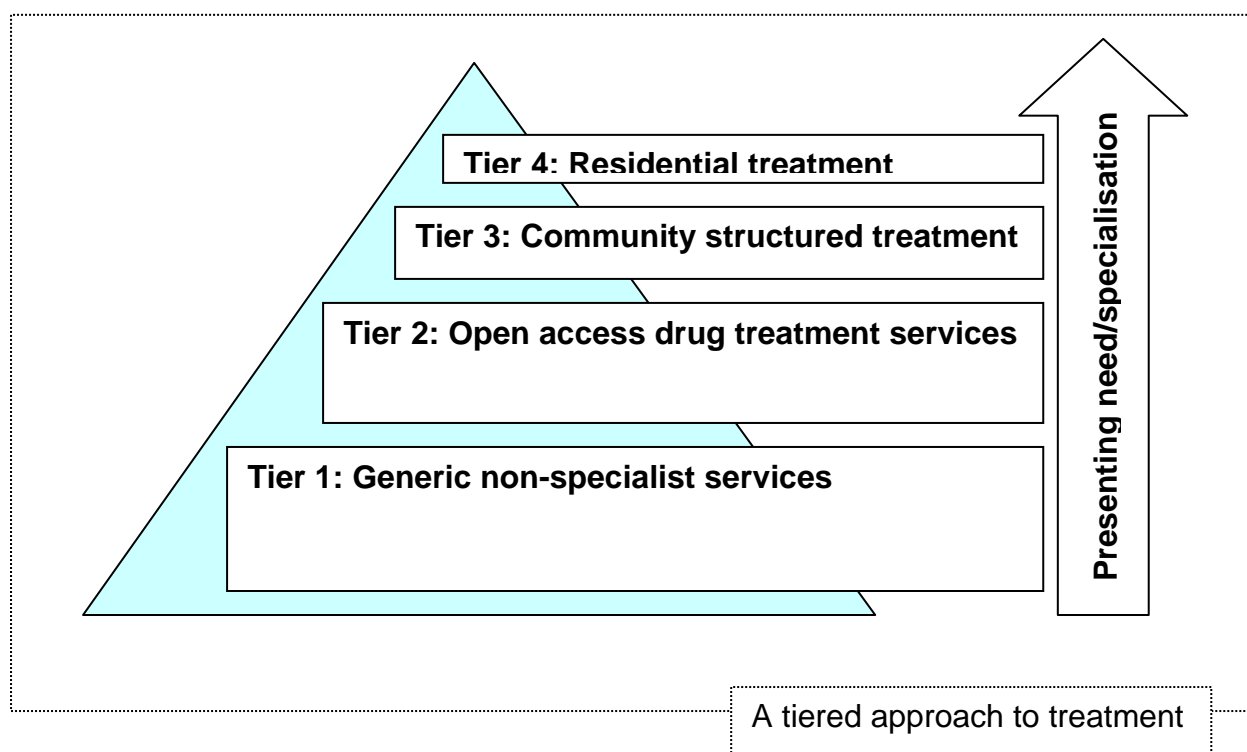
For retention, the partnership has a target of 70% of people entering treatment during 2006/7 to remain in treatment for at least twelve weeks, rising to 80% in 2007/8. This is one of the Primary Care Trust's Local Delivery plan (LDP) targets. During 2006/7 performance dipped below target, at 65%. The primary cause is people who leave treatment having completed a 'triage' (initial) assessment, before completing further assessments and initiating treatment – currently about 25% of people leave treatment with only the triage assessment completed. More than 80% of people who are initiated on a

prescribing regime remain in treatment for twelve weeks or more. Improving engagement during these critical first few weeks must be a priority.

## Service, Market and Resource Analysis

### Treatment system structure – treatment tiers

Services provide interventions that are grouped into one of four tiers according to the specialisation of the service and the degree of presenting need of the service user. There are different ‘treatment modalities’ – types of intervention – that are provided within each tier.



### Care coordination – an integrated treatment system

Once someone has been assessed and accepted into the treatment system their treatment needs are discussed with them and written into a care plan. The care plan describes treatment goals, what interventions are planned to help the person to achieve those goals, when the interventions will start and which agency will provide them. The care plan also describes the review period, and names the care coordinator.

The Care coordinator is responsible for ensuring that care is delivered as described by the plan, and for ensuring that the care plan is reviewed and changed if the care plan no longer meets the service user's needs. The care coordinator is generally the person with whom the service user will have most frequent contact. As most of the people accessing treatment services have a

prescribing need it is the prescribing service (provided by Sussex Partnership NHS Trust) that has responsibility for care coordination for most service users.

Local audits of care coordination in 2005/6 and 2006/7 identified a series of system deficiencies. There has been progress with the recommended service system improvements, but providers continue to describe care coordination as a weakness, citing lack of capacity as the cause of the problem.

### **Tier 1 interventions**

Local provision for 'Tier 1' interventions focuses on training staff in 'generic' services (mainstream health, social care, housing and so on). The training is delivered through two posts based within the Primary Care Trusts' public health and well-being directorate. Basic awareness training is mapped to the Drug and Alcohol National Occupational Standards (DANOS) and focuses on identification, screening and referral into treatment.

During 2006/07, training interventions were provided for 600 people. The majority of these were 441 people attending 39 single-session (morning or afternoon) workplace based courses. 87 people attended the 2-day Drug and Alcohol Basic Awareness Course (DABAC). A further 72 people attended other half-day courses.

The training is targeted towards particular professional groups. Overall the largest professional groups attending were people from mental health services (16.5%), housing and homeless services (15%) and social services (14%). People working in primary care (11.5%) and community health (10.5%) were also well-represented. The trainees included 39 police staff (6.5%).

### **Tier 2 interventions delivered in tier 1 settings**

In Eastbourne, additional information, advice and needle exchange services are delivered through the Salvation Army Citadel by the homeless health visitor (managed by East Sussex Downs and Weald PCT within the public health and well being directorate). The health visitor works closely with the static needle exchange service to provide the service on Mondays and Wednesdays during the day and Tuesday evenings. Many other homeless people and families are met in other settings (hostels and temporary accommodation), providing the opportunity to engage with some of the most vulnerable drug misusers. There is good information sharing and joint visits with the CJIT for people leaving prison.

### **The Drug Interventions Programme and Criminal Justice Integrated Team**

The 'Drug Interventions Programme' (DIP) is a national programme that works to move people out of crime and into treatment. There are DIP 'intensive' (high crime) and 'non-intensive' (comparatively less crime) areas. In common with much of the South east, East Sussex is a non-intensive DIP area. The partnership receives dedicated funding to provide a Criminal Justice

Integrated Team (CJIT) that delivers tier 2 interventions. The CJIT is a small team of community based workers that works with people identified by the criminal justice system (at the point of arrest, leaving prison and so on). The CJIT provides 'rapid access' to prescribing (within 5 days) and a case management approach to ensure offenders are engaged within the treatment system.

The CJIT works closely with the Prolific and other Priority Offenders (PPO) team – most PPOs have a history of drug misuse and more than a third nationally are known to have a current drug problem. Information sharing is generally good, with the CJIT represented at PPO panels and working jointly as required.

Targets for the CJIT focus on bringing 14 people into the treatment system each month, ensuring that once people are assessed as suitable contact is maintained until they are engaged.

Since April 2007 all 'non-intensive' areas have been able to seek approval to become 'intensive' DIPs on a self-funded basis. The Drugs Act 2005 enables testing on arrest for trigger offences and required assessments for people with positive drug screens, but these are only 'switched on' in 'intensive areas. Not attending a required assessment is a criminal offence, providing the opportunity to follow-up offenders who misuse drugs with an enforcement option not otherwise available. Once an application to become an 'intensive' area on a self-funding basis has been approved the approach must be sustained, requiring an ongoing local commitment to fund the testing, assessment and follow-on treatment for all relevant offenders.

### **Smoking cessation service and cannabis**

The Hastings 'smoking cessation' service provided by Hastings and Rother PCT has been addressing cannabis misuse with people who present to the service since September 2006.

All service users are screened, and offered help to stop smoking cannabis at the same time as they access the tobacco smoking cessation service. A clinic specifically to address cannabis is available once each week, although many users address their cannabis use within the context of the regular 'smoking cessation' service. The additional clinic receives around 1 new referral each week, working with up to eight users at any one time providing information and support to reduce cannabis use.

### **Local specialist community drug treatment services – Tier 2/3**

Local specialist drug services are provided by Addaction (Hastings and Rother) and CRI (Eastbourne, Wealden and Lewes) – both voluntary sector organisations - working jointly with Sussex Partnership NHS Trust. Addaction and CRI provide a 'gateway' into the treatment system – no appointment is required, and anyone can arrive or telephone, be assessed and access the treatment system as appropriate. These gateway services provide 'tier 2'

interventions including advice, information and needle exchange, and 'tier 3' interventions including structured counselling and day care services. These services are provided from office bases in Hastings and Eastbourne, with 'satellite' services provided from a small number of other locations.

Once someone is identified as suitable for treatment by one of the gateway services, they are referred on for a more comprehensive assessment and a medical assessment before any prescribing treatment is initiated.

Sussex Partnership NHS Trust provides specialist prescribing services to support people who are either being maintained on substitute medication or completing detoxification in the community. Service users generally attend daily for the first three months, then move from daily supervised consumption to pick-up from a pharmacist when 'clean' specimens are provided. The Trust also provides access to inpatient detoxification. Access to residential rehabilitation is provided through a social work team located with Sussex Partnership NHS Trust.

### **Prescribing Interventions – methadone and buprenorphine**

Annual prescribing audits consider the drugs being prescribed in East Sussex by the 'specialist' and 'GP shared care' services. The 2006 audit found a marked variation in prescribing practice. In the specialist service, less than 5% of the treatment population were prescribed buprenorphine. The average methadone maintenance dose of 60mg is within 'best practice' guidance.

There is a clear difference in the prescribing approaches used in primary care settings, compared to the specialist service. In the GP shared care service, buprenorphine was prescribed to 25% of the people in treatment in Hastings and Rother, and 50% of the people in treatment in East Sussex Downs and Weald.

### **Service user experience**

There are different experiences reported across the treatment system. Service users are invited to attend monthly 'clinics' to provide feedback about services. Services also provide 'feedback cards' at each site, and take part in service user surveys – both the national survey that the NTA runs, and local surveys managed by the local service user involvement group, 'Stumped'.

Feedback is most commonly provided about the specialist prescribing service, which provides treatment for the largest number of people.

In the 'harm reduction' programme (a supervised consumption clinic for people whose medication is dispensed daily), users often report that the service can feel busy and impersonal, with limited time available for individual users. The service is available for several hours each morning without appointment, so that users can make flexible use of the clinic time that's available. In practice, when a number of people arrive at the same time it can lead to people queuing to access the service.

Some people find it difficult to make progress without additional support, but aren't able to access adequate support in the time available to them.

Feedback about the open access services is generally positive.

### **Drug Rehabilitation Requirement**

Offenders who are sentenced to a drug rehabilitation requirement are required to undergo a treatment programme that includes testing, psychosocial and psychoeducational group work and (for opioid users) substitute prescribing. Offenders are generally required to attend treatment for 9-12 months, although orders may be revoked early if the person is making good progress with their treatment and has stopped offending. There are forty places across East Sussex, with performance targets in 2007/8 for 111 orders commenced and 34 orders successfully completed. Sussex Probation Area do not anticipate any material change to these targets over the course of the strategy. It's likely that the performance focus will be successful completions.

### **Interventions provided in primary care settings**

Services are also provided by community pharmacists and by GPs offering 'enhanced services'. Enhanced services enable community pharmacists to provide needle exchange and supervised consumption (of methadone, substitute medication) and GPs who prescribe to patients within a 'shared care' arrangement. The route into 'shared care' is generally by referral from the specialist prescribing service, once the patient has stabilised on substitute opioid medication (that is methadone or buprenorphine). There are a number of doctors providing this service in Hastings, and one each in Uckfield, Lewes and Eastbourne. Some of these doctors see patients who are registered with another GP.

### **Family Substance Misuse Service**

The newly-established 'family substance misuse service' has been fully operational since January 2007. Initially funded as a pilot until March 2008, the service is provided by a small team of people from different professional backgrounds who work with families who are in the child protection process. The service works jointly with prescribing services and other services as required, staff provide the 'care coordinator' function and act as the lead professional when appropriate.

The service is funded jointly through the pooled treatment budget and by Children's Services. The service delivers interventions that are directed towards the young person's 'prevention' agenda by working with families where substance misuse has been identified as a risk. The service addresses both drug and alcohol misuse. The service is referred to in the East Sussex Local Area Agreement, with an anticipated caseload of 75 people in 2007/8, 90 people in 2008/9 and 115 people during 2009/10.

### **Tier 4 interventions**

Inpatient substance misuse detoxification services in East Sussex are provided by Sussex Partnership NHS Trust, directly through:

- 116 bed days at Haven Ward, Mill View, Hove. (for Ouse Valley patients);
- 2 beds (730 bed days) on the Department of Psychiatry, Eastbourne DGH;
- 1 bed (365 bed days) on Woodlands mental health unit.

And through a contract with South London and Maudesley Foundation Trust to provide seven 28-day alcohol detoxes for people in Hastings and Rother.

With the exception of the seven detoxes provided by South London and Maudesley, the services are available for both drug and alcohol detoxification, although primarily used for alcohol.

### **Residential Rehabilitation**

During 2006/7 there were 35 placements for residential rehabilitation, funded from a combination of community care and pooled treatment budget.

Of this group 22 completed their placements successfully giving an overall percentage figure for the year of successful completion of placements of 65%

21 of the total group were opiate users, 8 were alcohol users and 6 were poly substance users including amphetamines & cannabis

Of the group who failed to complete, 3 spent less than 6 weeks, 1 spent 6 weeks only in a specialist unit detox. Only 7 spent from 8 to 16 weeks

23 were male and 12 were female, reflecting the general treatment population gender split.

7 people were discharged from prison directly to a residential rehab.

21 of this group required an inpatient detoxification before residential treatment, either via the NHS services described above (primarily alcohol clients) or with a rehabilitation provider that offered a detoxification service.

In all 16 different providers were used throughout the country, the emphasis being on identifying the most appropriate placement for the individual client. Clusters tend to occur in towns like Portsmouth & Bournemouth which have a number of primary & second stage projects plus good re-settlement options via supported housing projects - which East Sussex lacks. In those cases where clients have no accommodation to return to they tend to remain in the town where their rehab provider is located where they have established support networks as well as housing options, provision which is vital in maintaining recovery.

## **HMP Lewes – substance misuse interventions**

HMP Lewes is a category B local prison for adult males in East Sussex. It is a Victorian prison built in 1853 to hold up to 546 remand and convicted male prisoners from mainly East and West Sussex courts. The capacity of the prison will be increased from February 2008 by a further 175 places.

The healthcare service includes a 29-bed detoxification wing. Specialist nursing input is provided by two band 6 nurses. The substance misuse service can generally be accessed immediately following reception.

In common with the rest of the prison estate, HMP Lewes provides both mandatory and voluntary drug testing. HMP Lewes provides a manualised cognitive behavioural therapy (CBT) groupwork programme ('Prison Addressing Substances Related Offending' or P-ASRO). CRI delivers the CARATS (Counselling, Assessment, Referral, Advice & Throughcare Service) at the prison, which makes links with community services on release for offenders who have a history of drug misuse.

A number of operational issues have been identified by the Healthcare team at HMP Lewes:

- There are insufficient resources to currently manage the services efficiently and no cover available for the existing substance misuse nurse;
- additional therapies such as acupuncture are required;
- protected time of prison officers to undertake VDT and MDT is also essential to tackle substance misuse;
- drugs are known to be used as currency on the Wings – leading to overdose on occasions necessitating hospital admission;
- methadone and buprenorphine are the main drugs used for managed withdrawal (detoxification) and maintenance. Currently this is increasing across the whole prison estate and the administration of these is under-review as becoming more resource intensive;
- 528 drug detox programmes were undertaken in 2005/06 increasing to 576 for 2006/07 with an average of 43 per month commenced - approximately 20% of admissions last year.

As an establishment without IDTS funding, the prison is expected to provide a range of clinical and psycho-social interventions which address the needs of prisoners who misuse substances. Interventions should include all of the following:

- Opiate substitution programme;
- first night prescribing for drug and alcohol problems (where applicable);
- opiate stabilisation programme;
- advice and information prior to discharge;
- pre-discharge risk assessment.

HM Inspector of Prisons completed an inspection at HMP Lewes during August 2007. The inspection included the Healthcare Commission, and

considered the substance misuse services with other aspects of healthcare at HMP Lewes.

The inspection found that the substance misuse service generally was excellent, and was positive about the dedicated detox wing. The inspection found that Patient Group Directions (PGD) including drug detox prescribing at the first night centre were safe. The following recommendations were provided to address service demands:

- Increase SMS Nurses to ensure 24 hour cover in future;
- increase SMS Nurses to enable cover at Reception;
- establish GP cover to enable treatment to begin on 1st night in prison for opiate users;
- establish psycho-social support of Detox Wing;
- establish improved support for prisoners transferring from Detox Wing to ordinary location;
- establish Dual Diagnosis Link Nurse between SMS & mental health.

For people leaving prison, homelessness and inadequate housing can increase the risk of problem drug use.

### **Co-morbid substance misuse and mental health problems**

The East Sussex dual diagnosis strategy describes how mental health and substance misuse services address the needs of people with co-morbid substance misuse and mental health problems. There isn't a dedicated team, but the services do work jointly with cases where both the mental health and substance misuse needs are severe or complex. The dual diagnosis clinical network meets regularly.

### **Housing and Housing Related Support**

The Supporting People programme funds housing related support services. There are two services funded by the Supporting People programme specifically classed as supporting people with drug or alcohol problems. These are:

- Kenward Trust, The Malthouse (8 units). The primary client group is people with drug problems, secondary client group is people with alcohol problems.
- Heatherdene Ltd, Heathercrest Cottage (5 units). The primary client group is people with mental health problems, secondary client group is people with alcohol problems

In 2006/7 there were a further 19 placements funded by Supporting People in 'short term' services (either floating housing support or supported accommodation) for people with a primary drug problem.

During 2007/8, Supporting People will tender for a Floating Housing Support service providing support for at least 30 people across East Sussex, with a combined drug/alcohol misuse caseload mix.

Of the 215 services funded by Supporting People, only 21 have specific exclusions for people with drug or alcohol problems.

### **Carer Support**

During 2007/08, Rethink (a national mental health charity) is developing a twelve month pilot service for carers who are looking after people with a 'dual diagnosis' – mental health problems as well as problems with either drugs or alcohol.

### **Workforce development**

A discrete 'workforce development' strategy is being developed on a pan-Sussex basis during 2007/8. The strategy will consider the range of workforce issues relevant to partnerships in East Sussex, West Sussex and Brighton and Hove.

### **Financial resources**

The overall resource available for drug misuse treatment is anticipated to reduce by around 2.5% in real terms over the course of the strategy.

If future allocations attracted an inflationary uplift only (assumed 2.5%) then for 2010/11 the financial resource available would be £4.85m. The strategy assumes an allocation in 2010/11 of £4.7m.

Notes about sources of funding and assumptions about future income flows:

### **Pooled treatment budget (PTB)**

Centrally allocated and currently 'ring-fenced' (it can only be spent on treatment for drug misuse) the pooled treatment budget has been the primary source of new investment. One of the conditions of grant is that mainstream funding has to be maintained (with an inflationary uplift) to ensure that the PTB isn't used to replace mainstream funding. The National Treatment Agency has indicated that the PTB will remain until 2010/11, but is likely to reduce by £50m nationally over the next three years and future allocations cannot be confirmed. The indicative allocations provided here were published in January 2008, and are subject to change. Some partnerships will see increases/reductions as allocations will in part be based on measures of cost-effectiveness - this approach benefited East Sussex in 2007/8. This strategy assumes the indicative allocation is actual, but this is at risk.

### **Drug Interventions Programme**

Centrally allocated and 'ring-fenced', this resource is provided to fund the Criminal Justice Integrated Team (CJIT). The allocation was reduced by 10% in 2007/8. Future allocations are expected to be level. Any reduction would

mean a reduction in the resource available specifically for the CJIT but would not affect other aspects of the treatment system.

### **Primary Care Trusts**

The majority of this investment is included in the block contract for services with Sussex Partnership NHS Trust, based on the resource allocated to substance misuse services before the pooled treatment budget was introduced.

### **ESCC Adult Social Care**

The majority of this investment is directed towards residential treatment. There is an overall sum allocated for the care of adult drug and alcohol misusers. The sum shown here assumes that 70% is allocated to care for people with drug, rather than alcohol, misuse problems.

### **ESCC Supporting People (SP)**

This funding is directed towards a service tendered during 2007/8 specifically for substance misuse, and assumes a 50% drugs/alcohol split. As the future SP allocation is uncertain and there has been only one inflationary uplift to SP-funded services since the programme began in 2003, future allocations are assumed level.

### **Sussex Probation Area**

This funding supports the treatment interventions provided to offenders who a subject to a Drug Rehabilitation Requirement (DRR).

**Forecast financial resources available**

	£000s			
	2007/8	*2008/9	*2009/10	*2010/11
Pooled treatment budget	2,055	2,073	2,096	2,132
Drug Interventions Programme	357	357	357	357
Primary Care Trusts	1,583	1,623	1,663	1,705
ESCC Adult Social Care	406	416	427	437
ESCC Supporting People	35	35	35	35
Sussex Probation Area	34	35	36	37
Other potential sources of funding				
<b>Total</b>	<b>4,470</b>	<b>4,539</b>	<b>4,614</b>	<b>4,703</b>

\*All future resource allocations are estimates based on available information. Inflationary uplifts are assumed at 2.5% and are not guaranteed.

## **5. Changing the Focus of Services**

The anticipated reduction in resources available for drug misuse treatment will be coupled with efficiencies to make the treatment system more cost effective. Resources will be shifted from specialist to primary care settings, increasing the number of people receiving treatment in primary care.

The emphasis of the treatment system will be shifted from a 'medical model' to a 'social care' whole person approach. The treatment system will treat people holistically, ensuring that all of their needs are properly assessed, and that the treatment response provides medical and social care interventions as required.

The focus on the 'engagement' phase of treatment programmes – the first few weeks and months when the service user is starting treatment – will require services to make the assessment process simpler, initiate prescribing more quickly, provide more meaningful contact to develop a therapeutic alliance and to pro-actively follow-up people if they start to disengage from their treatment programme.

The skills-mix of the teams providing specialist prescribing services will be re-specified, reducing the proportion of nursing expertise and increasing pharmacist and professional drug worker resources within the teams. The specialist prescribing services will be co-located with other services to maximise opportunities for skill-sharing within locality teams. Responsibility for care planning and care-coordination will be allocated properly to the part of the treatment system in most frequent contact with the service user, rather than automatically with the prescribing/dispensing service.

The NICE psychosocial guidance will be implemented by disinvesting from services providing cognitive behavioural and psycho-educational approaches, and investing instead in services that adopt a more pragmatic 'key-work' approach.

The greatest cost efficiency will be gained by increasing the effectiveness of treatment, materially increasing the number of people who improve their situation and leave treatment in a planned way. This will reduce the number of people who re-present for repeated episodes of treatment that end in an unplanned way.

### **Harm Reduction**

In its harm reduction strategy, East Sussex DAAT (2007) describes the range of 'harm reduction' services available across the treatment 'tiers'. There is strong support for developing harm reduction services further. The harm reduction strategy has not been duplicated here – treatment plans will continue to include those developments, coupled with the changes described below.

### **Tier 1 interventions**

The investment in developing competence across generic services ('tier 1 training') will be continued at the current level. The training will be targeted at specific professional groups including staff working in emergency services, mental health treatment, adult social care, children's services and housing/homelessness settings. The professional groups to be targeted will be discussed in more detail in the workforce development strategy, due for publication by March 2008. Training will focus on identification and screening, and delivering brief interventions including 'training the trainers' to enable agencies to embed the development of relevant knowledge and skills in their own workforce development planning.

Communications and training about services will be targeted towards primary care staff, with information on HARMLESS [a local NHS intranet] about care pathways.

### **Tier 2 Interventions**

The investment in 'open access' services including needle exchange and advice and information in Hastings and in Eastbourne will be maintained. During the course of the strategy both of these services should be re-tendered to ensure that the market is tested and that the services represent best value.

Needle exchange services will be expanded through enhanced service arrangements with community pharmacists in line with the partnership's 'harm reduction' strategy (2007).

The NICE guidance (CG51) about psychosocial interventions includes guidance about brief interventions for 'limited contact' service users – people using the needle exchange or at first contact with service system. The 'gateway' services will provide a maximum of 2 sessions of 10-45 minutes. Staff will be trained to ensure that 'Brief Interventions' are delivered consistently and opportunistically.

The NICE guidance (CG51) about psychosocial interventions includes guidance about contingency contracting for Hepatitis B vaccination programmes. The partnership's harm reduction strategy already describes the benefit of nursing input to the needle exchange service in Eastbourne, and the intention to provide a similar service in Hastings. Hepatitis B Vaccination programmes in both localities will be amended, adopting a 'contingency contracting' approach – providing incentives to present for follow-up vaccinations until the vaccination programme is completed using a combined HAV/HBV vaccination.

Needle exchange providers will be expected to facilitate links with other relevant healthcare services including hepatology, wound care, leg ulcer management and so on. These interventions should be available on-site at the static needle exchange without an appointment, possibly delivered as a routine clinical service that is available on a regular basis.

### **Criminal Justice Integrated Team (CJIT)**

The Pan-Sussex Reducing Supply Strategy describes plans to develop a 'CJIT Management' structure, based on the principles employed in 'Intensive DIP' (high crime) areas. The partnership will adopt the principles to address 'hot spot' crime areas, and will not apply to become an 'Intensive DIP' area on a self-funding basis. This will bring the treatment and enforcement agencies closer together, with the intention to increase engagement with treatment and further impact upon drug related offending. This will be particularly important for work with people identified as prolific and other priority offenders ('PPOs') who also misuse drugs.

The partnership will develop plans to co-locate the PPO teams and CJIT for at least part of each week, ensuring a closer physical alignment of these teams helps both to work more effectively.

### **Smoking cessation service and cannabis**

The Hastings 'smoking cessation' service will be maintained. Commissioners will consider how this service could be extended to be included across all of the smoking cessation services provided in East Sussex.

The smoking cessation service also provides smoking cessation training to enable people working in other settings to deliver smoking cessation interventions alongside the other aspects of their work. This training will be introduced into all of the specialist drug treatment services.

### **Tier 3 interventions**

The investment in structured treatment will be adjusted to increase the proportion of services provided in primary care. Services will be re-specified to reflect the new NICE guidance about psychosocial interventions. During the course of the strategy services across East Sussex will be tendered using the new specifications to ensure that the market is tested and that the services represent best value. Specifications will be focused on achieving the social care outcomes included at Appendix 3.

### **Shifting the balance between primary and secondary care**

The partnership will encourage more GP involvement in 'shared care' arrangements by promoting use of the 'enhanced services' agreement for shared care, particularly in Rother and in Eastbourne where take-up is limited.

More services will be delivered in primary care settings by increasing supervised dispensing and needle exchange in community pharmacies. Doctors involved in the 'shared care' scheme will be encouraged to initiate prescribing when it is appropriate for them to do so – in less complex cases, where there are suitable supervised dispensing arrangements and when the doctor is happy to competently manage this phase of the treatment.

The case mix for the specialist prescribing team will be targeted towards working with more complex cases, including joint working 'dual diagnosis' cases (people who are experience mental health problems, as well as substance misuse), people whose drinking behaviour is also problematic and so on.

### **Changing the skills mix of specialist teams**

Medical and non-medical services will be brought together on a single site in each urban location to develop multi-agency teams that include staff from different professional groups working more closely together. The skills mix of the teams will be adjusted to increase the proportion of qualified drug workers.

Over the period of the strategy the specialist teams will include independent nurse prescribers and pharmacist independent prescribers to expand the range of professionals who can prescribe to individual service users.

### **Care Coordination and Case management**

The relationship between the service user and the care coordinator (or 'key worker') is critical, and the basis for effective care planning and case management. The key worker role will form the central delivery point for treatment. The frequency of contact between the key worker and service user will be increased during the 'engagement phase' of treatment. The key worker will have demonstrated that they have the relevant DANOS competences, but may not come from a nursing background.

The key worker will be required to liaise with the full range of health and social care services, and will particularly focus on ensuring that any transition between services – the point where drop-out might be most likely - is carefully managed.

The key worker will be responsible for ensuring that the service system makes every effort to re-engage people who start to disengage from treatment as early as possible, and ensuring that all service users leaving care planned treatment have an aftercare plan.

### **'Wraparound' support**

'Wraparound' support describes interventions that focus on the education, training, housing and employment support needs of service users.

The specialist services will enhance links with the full range of 'wraparound' services, providing services on-site in the specialist setting wherever possible by providing weekly clinics, access to specialist staff and so on.

The full range of services available should include

- Housing advice
- Benefits advice

- Legal advice
- Employment services
- Sexual health services
- Dietician
- Wound management
- Mental health interventions – fear factor, beating the blues

### **Implementing NICE psychosocial interventions guidance**

NICE (2007) has described the evidence base for psychosocial interventions. Implementing the guidance locally will require some significant changes to the way services are delivered.

The current arrangements for multi-modal treatment programmes ('structured day programmes') will be reviewed, with a view to decommissioning psycho-educational group-work and CBT interventions that are delivered alongside methadone maintenance programmes or for stimulant users.

Contingency management will be introduced during the period of the strategy. Contingency management requires regular contact with the key worker during the first few weeks and months of treatment, and less frequent contact as treatment progresses. Each contact includes drug screening, and negative drug screens are rewarded.

For people receiving methadone maintenance treatment, key worker contacts will include:

- |           |                 |            |
|-----------|-----------------|------------|
| ▪ Wk 1-3  | 3 contacts/week | 3 x 30 min |
| ▪ Wk 4-6  | 2 contacts/week | 2 x 30 min |
| ▪ Wk 7-12 | 1 contact/week  | 1 x 30 min |

Then 'standard care' – 1 contact/fortnight 1 x 30 min

The key worker responsible for delivering the interventions will be the professional in most frequent contact with the service user and will act as the service user's care coordinator.

NICE recommends 'rewards' for clean screens of:

- Vouchers 1/week (assuming clean screens) for first 12 weeks. £5-£10/week.
- Vouchers for clean screens at six months, 9 months, 12 months. £20

As an alternative to vouchers, the guidance recommends considering 'clinic privilege' and 'prize' entry. Service users will be involved in the design of the reward system.

It will be critical to ensure that:

- goals (for example no illicit drug use) are agreed with service user;

- the relationship between the incentive and behaviour is understood;
- The incentive – prize choices/cash/voucher – is individualised, with choice available and perceived as such by service user, and supports a healthy and drug free lifestyle.

### **Prescribing Interventions – methadone and buprenorphine**

NICE (2007) Technology Appraisal 114 (methadone and buprenorphine) describes the expectation that prescribing services will generally be prescribing methadone/buprenorphine as a 70/30 ratio. Achieving this ratio isn't a requirement - as prescribing practice will vary according to local demand and so on

In the costing template for TA114, NICE notes that “the decision about which drug to use should be made on a case by case basis whilst taking into account a number of factors; this creates a high degree of uncertainty when attempting to calculate future prescribing practice. Estimates of the percentage of people that will receive buprenorphine ranged from 20% to 40%, with this switch occurring over a 5 year period.” Prescribing practice should be anticipated to change with an increasing proportion of service users prescribed buprenorphine over the period of the strategy.

Buprenorphine is also available in a tablet combined with naloxone (an opioid antagonist) as 'suboxone'. Dissolved under the tongue, the tablet has less abuse potential than buprenorphine as the naloxone will precipitate a withdrawal effect if the tablet is injected. Prescribers will be encouraged to consider adopting suboxone in place of buprenorphine.

The partnership will continue to monitor the use of methadone/buprenorphine through annual prescribing audits completed by the specialist prescribing service, and seek a review of clinical practice when appropriate.

### **'Self-Help' and 12-step ('anonymous' or 'fellowship') groups.**

The partnership is keen to encourage and support the further development of 'self-help' and '12-step' or 'fellowship' groups (including narcotics anonymous, cocaine anonymous, alcoholics anonymous and so on). Whilst these groups are not directly commissioned they can provide a fantastic source of support and effective treatment for many people. The treatment services directly commissioned by the partnership will continue to provide information about local groups, as appropriate. Key workers will be expected to facilitate access.

The partnership will provide practical support to local groups seeking to establish themselves or to extend their reach.

### **Family Substance Misuse Service**

The service will continue to be invested in by the partnership at least to the end of the current LAA targets in 2009/10, subject to positive evaluation of

performance (measured by both activity and treatment outcome) and the financial resources being available to the partnership.

### **Links between substance misuse and 'crisis' services**

There will be close links between the specialist 'drug' and 'alcohol' substance misuse services. For the most complex cases, and people who are experiencing problems with both alcohol and drug misuse, delivery of the service will be coordinated by the specialist substance misuse service. Some specialist alcohol interventions will be delivered from the premises used for drug services. This will enable closer medical supervision when appropriate, and provide access to specialist alcohol services for people who are not accessing services in primary care settings.

There will also be close links and care pathways with 'crisis' services including the [mental health] crisis resolution home treatment team, out of hours services in general practice and accident and emergency services. The purpose of these care pathways will be to ensure appropriate follow-up and treatment once the presenting crisis has been dealt with.

As is currently the case, the 'out of hours' GP service will not be expected to provide a substance misuse service.

### **Tier 4 interventions**

#### **Inpatient Detoxification**

The partnership will support the development of the specialist in-patient unit (either at its current location in Hove or at another location) by Sussex Partnership Trust to increase the existing service from a 5-bed unit to a 14-bed unit, with a block contract arrangement for a proportion of those beds allocated to East Sussex. This will require the reallocation of resource from beds currently being used in East Sussex.

#### **Residential rehabilitation**

The partnership will move from the current arrangements for 'spot purchasing' all residential rehabilitation services to a combination of 'block contract' and 'preferred provider' arrangements. This will produce an overall cost improvement of around 10% on the current expenditure and will enable the partnership to have much closer management control across quality measures with a smaller number of specialist providers. The partnership will ensure that the tender process continues to enable service users choice about the type of service they receive and where it is provided.

#### **HMP Lewes – substance misuse interventions**

HMP Lewes is a category B local prison for adult males in East Sussex. It is a Victorian prison built in 1853 to hold up to 546 remand and convicted male

prisoners from mainly East and West Sussex courts. The capacity of the prison will be increased from February 2008 by a further 175 places.

It is unclear whether HMP Lewes will be included in the IDTS roll-out before 2011. If it is, either on a fully-funded or partially-funded basis, then the partnership will work with the HMP Lewes Healthcare team to develop services in line with the IDTS specification.

If the establishment continues to not receive IDTS funding the partnership will focus on achieving the level of service required for similar establishments (described earlier), and on implementing the recommendations following the 2007 inspection.

### **Housing Related Support**

Housing related support is provided through services funded by the 'Supporting People' programme. During 2007/8 a new 'floating housing support' service will be tendered for adults suffering from substance misuse. The Supporting People strategy in East Sussex describes plans to develop 'generic' floating housing support services that provide support for a number of care groups, rather than accommodation-based services. This will provide opportunities for a greater number of people within the treatment system to receive housing related support.

### **'Dual diagnosis' – mental health and substance misuse problems**

The East Sussex dual diagnosis strategy describes how substance misuse services will work with mental health services to develop service responses that respond appropriately to the needs of people suffering with both substance misuse and mental health problems.

For people suffering 'mild' mental health problems including anxiety and depression and when the service user is not already in contact with specialist mental health services (including the primary care mental health teams) the substance misuse services will provide evidence-based interventions. This may require additional training to ensure that key workers are competent to screen for mental health problems and provide interventions that are appropriate. In partnership with mental health commissioners, the partnership will consider introducing Computerised Cognitive Behavioural Therapy included in NICE guidance (Feb 2006) for mild and moderate depression (CCBT 'Beating the blues') and panic and phobia (CCBT 'FearFighter').

For more complex cases the services will jointly, with a clear agreement about which service is the lead.

### **Carer support development**

Carer support services will be based on self-help mutual aid groups. The partnership will support groups by providing access to practical support,

accommodation, information and advice. The partnership aims to have carer support groups that are self-sustaining in each urban location.

### **Workforce Development**

The partnership will publish a renewed workforce development strategy with West Sussex and Brighton and Hove during 2007/8. The strategy will describe how the partnership will work to develop a culturally competent workforce that is confident and knowledgeable, delivery culturally appropriate care.

## 6. Monitoring Arrangements

### National Drug Treatment monitoring System – NDTMS

From October 2007, the National Drug Treatment Monitoring System (NDTMS) will be used to monitor treatment outcomes for everyone in treatment. The outcome instrument used is called the Treatment Outcomes Profile (TOP). The TOP is used to record each service user's current situation across four outcome domains - (1) substance use, (2) injecting risk behaviour, (3) crime and (4) health and social functioning. A 'baseline' TOP is applied at assessment (or next care plan review, if the person is already in treatment) and then re-applied at every care plan review (and at planned discharge) – at least once every three months.

TOP forms part of the NDTMS core data set E (CDS-E), a comprehensive data set that includes around 100 data items for every person in treatment. Data quality is performance managed, and partnerships are required to supply data that is at least 99% accurate every month.

NDTMS CDS-E (and any subsequent data sets that are advised over the course of the strategy) will form the basis for monitoring performance.

Performance targets are agreed by the partnership with the NTA in an annual treatment plan.

<b>Consultation question: Monitoring arrangements</b>
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- |   |
|---|
| <ul style="list-style-type: none"><li>▪ How will you know whether the strategy is effective?</li><li>▪ What will need to be measured to demonstrate that?</li></ul> |
|---|

## **Appendix One | NICE Guidance – Psychosocial Interventions**

NICE (2007) clinical guidelines for drug misuse – psychosocial interventions considers the evidence base for the psychosocial aspects of treatment. The guidance describes the evidence base for treatment effectiveness and makes recommendations for practice, summarised below. The guidelines include definitions of the treatment approaches described (see page 104 in the consultation draft).

### **Interventions for people not in structured treatment programmes**

- Brief interventions are effective for 'limited contact' services like needle exchange, and a maximum of two sessions (of 10-45 minutes) should be offered;
- Voucher-based contingency management approaches should be considered to improve compliance with testing (and immunisation, if relevant) for Hepatitis B/C, HIV and TB;
- Information and advice about blood-borne viruses, sexual health and injecting risk should be provided opportunistically in individual settings, routine 'psychoeducational' groups should be avoided.

### **Psychological Interventions alone**

- Contingency management (rewarding treatment compliance with prizes, vouchers or clinic privileges) is effective should be introduced for stimulant users;
- Individual Cognitive Behavioural Therapy (CBT) should be considered for cannabis users, focusing on relapse prevention strategies over programmes of at least twelve weeks;
- CBT should not be routinely provided for stimulant users or people receiving methadone maintenance<sup>7</sup>;
- Behavioural couples therapy (a programme lasting at least twelve weeks based on CBT principles) should be considered for people who misuse cocaine or heroin or have completed an opiate detoxification.

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<sup>7</sup> Separate NICE guidance about the effectiveness of CBT for treating anxiety and depression is important to note. Many service users will present with symptoms of anxiety and depression that can be effectively treated by providing relevant interventions in the substance misuse service setting.

### **Psychological Interventions with opiate agonist (methadone or buprenorphine) maintenance treatment**

- Contingency management is effective when coupled with methadone maintenance therapy (MMT), but not with buprenorphine;
- Behavioural couples therapy should be considered for people who continue to use illicit drugs when in opiate agonist maintenance treatment.

### **Psychological Interventions with opiate antagonist (naltrexone) maintenance treatment**

- Contingency management should be considered for all service users;
- Family or couples-based interventions should be considered for people in contact with significant others

### **Self-help groups**

- There is an additive effect for people receiving '12 step' interventions alongside other drug treatment, compared to people receiving only 12 step or another treatment intervention alone. Staff should routinely provide information about self-help groups and facilitate initial contact as appropriate.
- Although the research base is limited, there is no evidence that psychodynamic approaches are effective.
- There is no evidence of the effectiveness of 'multi modal' treatment programmes – sometimes known as structured day care services.
- Clinical recommendations for services provided in a custodial (prison) setting are broadly similar as for community settings. The nature of the rewards offered as a contingency management approach may vary.
- Carers are most effectively supported by self-help groups and guided self-help (for example provided with self-help literature).

## **Appendix Two | Outcome measures and performance indicators**

The East Sussex Local Area Agreement 'All Together Better' (2006):

<http://www.essp.org.uk/essp/pdf/LAA.pdf>

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### **Target 17.4 Reduce the harm caused by drug and alcohol misuse**

Comments: 17.4.1 This is a national key performance indicator for Primary Care Trusts and sits within the NHS Local Delivery Plan as one of the nine key performance indicators that currently determine PCT star ratings. Due to the increasing investment announced by the Government in drug treatment, DAATs have been required to provide an additional stretch target

Lead: Drug and Alcohol Action Team (Marcus Gomm)

Partners: Voluntary and Community Sector, Primary Care Trusts

Indicators:

17.4.1 Increase participation of problem drug users in drug treatment programmes (Adult and Young People)

17.4.2 Increase number of adults with children in the child protection process receiving drug or alcohol treatment or a brief intervention

17.4.3 By March 2007 establish a comprehensive multi-agency Alcohol Strategy implementation plan

17.4.4 A reduction in the proportion of the public who perceive that drug dealing and drug use is a problem

## Targets to be agreed with the National treatment Agency 2008/9

The performance targets listed here are DRAFT and yet to be agreed as Part 2 of the partnership's 2008/9 treatment plan. \*Plans set for 2009/10 and 2010/11 will be reviewed annually through the treatment planning process. Treatment plans are published on the partnership's website.

<b>1. Drug users recorded as being in effective treatment</b>	<b>% change 2008/09 (from baseline year)</b>	<b>% change 2009/10 (from baseline year)*</b>	<b>% change 2010/11 (from baseline year)*</b>
1.1 Crack and/or opiate users recorded as being in effective treatment. This indicator is embedded within the National Indicator Set and appears within Vital Signs. The % change agreed can therefore also be used within these plans <sup>8</sup>	6		

1.2 All adult drug users recorded as being in effective treatment	% change 2008/09 (from baseline)
	6

<b>2. Retention and care planned discharge</b>	<b>% planned 2008/09</b>
Percentage of new presentations to be retained in treatment for more than 12 weeks or subject to a care planned discharge within the first 12 weeks	72

<b>3. Treatment system exits</b>	<b>% planned 2008/09</b>
Individuals leaving the treatment system in a planned way	TBC

<sup>8</sup> The measure is to improve on the 2007/08 baseline (i.e. the annualised figure for that year) the number of drug users recorded as being in effective treatment. This indicator measures the % change in the number of drug users using crack and/or opiates in treatment in a financial year, who are still in continuous treatment, who are discharged from the treatment system after 12 weeks or if discharged before then, were successfully discharged in a care planned way as a % change from baseline performance in 2007/08. This will include young people under the age of 18 as well as those over the age of 18.

## **Appendix Three | Social Care Outcomes**

Services will be founded on the following social care outcomes. Performance indicators will be developed that enable specific outcomes to be monitored.

### **Improving health and emotional well-being**

Services promote and facilitate the health & emotional well-being of people who use the services.

- Community are helped to understand how to stay healthy and are encouraged to do so through an excellent range of clear, accurate, accessible and well published information.
- Demonstrate link between health, well-being and investment in services.
- Demonstrates well developed and consistent join and working well with partners.
- CPA is embedded and needs are holistically considered, working in effective partnership showing a positive impact for service users.
- People only in hospital where necessary.
- Services that prevent admission (?) support discharge in a setting which understands and acts impact the needs of individuals.
- Clear and successful mechanisms to ensure quality response to needs with evidence of successful rehabilitation and prevention.
- Social Care needs are well anticipated to inform Cament(?) and future service provisions at strategic level.
- Services work together efficiently and resources pooled to enable Joint Commissioning.

### **Improving Quality of Life**

Services promote independence and support people to live a fulfilled life making the most of their capacity and potential.

- Independent is pooled actively and consistently
- People who need care have their needs met through appropriate
- Innovative support packages are used to meet needs
- Preventative services that directly contribute to reductions in people needing higher level support.
- People with 'low incidents' conditions have a choice of specialist supported, tailored to their needs, to promote as much independence as possible.

### **Making a Positive Contribution**

People who use services are encouraged to participate fully in their community and their contribution is valued equally with other people.

- People who use services and their Carers have been actively included in development and improvement work.

- Community groups and different people are included to reflect the diversity of the Community.
- Active feedback is sought using a wide range of methods.
- Demonstrative, positive quality changes as a result of feedback.
- Coherent, innovative and effective partnership working including the private and voluntary sectors.
- Evidence of integrate service delivery meeting the needs of wider economic, social and environmental well-being of the area and improving different communities to support themselves.
- Evidence of enabling people to learn life skills to gain confidence in their wider communities.
- Evidence of Service user input into their care planning.
- Evidence of supporting and enabling people to articulate their views in range of forums.

### **Increased Choice and Control**

People and their Carers have access to choice and control of good quality services which are responsive to individual needs and preferences.

- Responding to referrals assessment care planning in a respectful and timely manner.
- Evidence that the service user's needs and preferences are central to the process.
- Service users and Carers feel adequately informed about services and individual care needs.
- Clear published routes of access to services 24/7
- Evidence of complaints being responded to promptly and consistently.
- The range of services is broad and meets varied needs offering choice and taking account of preferences.
- Evidence of promoting independence and choice by supporting people to live in their own homes.
- Evidence of increasing options for control and choice through individual budgets, direct payments and innovative development.
- Good quality accessible information services are available.
- Service Users views are well represented and advocacy services support this.

### **Freedom from Discrimination**

Those who need Social Care have equal access to services without hindrance from discrimination or prejudice; they feel safe and are safeguarded from harm.

- Clear, fair and easy to understand eligibility criteria.
- Effective monitoring of Social Care needs of the local populations and take up of services.
- Appropriate and inclusive access to services irrespective of disability, culture and gender.

- Effective and innovative activity identifies vulnerable adults at risk of sound exclusion.
- Effective assessment of individual needs.
- Evidences that service users do not 'fall between services'.
- Effective safeguarding adults processes.

### **Economic well-being**

People are not financially disadvantaged and have access to economic opportunity and appropriate resources to achieve this.

- Pathway and transition plans are effective and regularly monitored and improved.
- Service users are positive about service provision and delivery.
- Service users contribute to their reviews.
- There is sustained improvement in the number of people in education, training and employment.
- Care co-ordination and advice employers people to be independent and well prepared for life.
- There is a choice of pathways and flexibility to meet diverse needs.
- Carers are supported to enable them to continue in employment or return to work.

### **Maintaining Personal Dignity and Respect**

Services provide a confidential secure setting which respects the individual, helping to preserve people's dignity.

- Privacy and confidentiality are assumed in all contracts, supported by appropriate policies and procedures.
- People's homes are safe and secure.
- Service users report feeling safe, consulted with, listened to and responded to.
- Life chances are improved through access to leisure and healthy life styles.
- People are effectively safeguarded from abuse and neglect.
- Outcomes and regular review to ensure resources are appropriate area to meet needs and empower individuals.
- Staff use preventative support services to reduce abuse and neglect.
- Interpersonal relationship and social integration are actively encouraged with the service and the wider community.

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#### Appendix 4

The consultation drafts of the commissioning strategies were published in September 2007. There were 11 formal written responses. There were also responses provided at four focus groups with service users and other stakeholders. Feedback was also provided by service providers and service users at the treatment performance group and at the alcohol strategy group.

Consultation feedback was generally positive about the direction of travel described by both commissioning strategies. A number of individuals and organisations expressed some very supportive and encouraging statements about both the general direction and some of the detail of the strategies. There were also a number of queries and issues raised during the consultation process that are dealt with here.

The comments here are limited to specific issues that were identified by the consultation and require a response. Some comments summarise a number of similar comments. This report excludes more general feedback, positive comments and queries or comments that are outside the scope of the commissioning strategy (about other strategies, for example).

Feedback	Response
The review of the effectiveness of treatment for alcohol problems provides more detail about 'what works'. This could be included in the strategy.	Key findings from the review have been summarised in the 'national and local requirements and research' section.
The strategy needs a timeline for implementation and information about how implementation will be monitored.	The introduction now includes 'Next Steps'. An implementation plan will be published later in 2008. Implementation will be monitored by the East Sussex Alcohol Strategy Group.
Although the overall picture for 'Lewes' district may be better than other areas, there are particular areas of deprivation along the coastal strip.	This is now included in the 'needs assessment' section.
It's important to be clear about what 'brief interventions' is.	Key findings from the Raistrick, Heather and Godfrey (2006) review have been summarised in the 'national and local requirements and research' section.
The 'settings' for tier 1 development should include services provided by voluntary and community sector organisations.	This is now included in the 'changing the focus' section.

Pharmacists should also benefit from screening and brief intervention training.	This is now included in the 'changing the focus' section.
It's important to consider out of hours services.	There should be effective care pathways from 'crisis' services into alcohol treatment. This is now included in the 'changing the focus' section.
Primary care staff will need support to make decisions about hazardous/harmful and moderately dependent drinking. To develop new skills there could be input to half-day closures on an afternoon, case studies, information on HARMLESS etc.	This is now included in the 'changing the focus' section.
Implementing the strategy will require effective communication with primary care staff a particular focus.	This is now included in the final strategy.
There needs to be more information about promoting the services in primary care, making it clear that primary care is the main focus.	This is now included in the 'changing the focus' section. The primary care focus is also mentioned early in the document in the 'next steps' section.
The needs assessment is section applies a scientific approach to estimating numbers, which is welcome. However, it chooses to highlight two groups with no particular logic, and by so doing does not make reference to other distinguishing groups. These include Significant Others (MOCAM p.60), and Dual Diagnosis or Co-Morbid clients.	The 'needs assessment' section includes the 'hazardous' and 'harmful' estimates provided by the ANARP and key data from the local alcohol profiles for England. Homelessness and teenage pregnancy were co-factors that were highlighted by stakeholders during the initial consultation. More information about 'dual diagnosis' is now included in the 'needs assessment' section.
Work undertaken at A/E dept at Conquest hospital with part time specialist worker was seen as very successful from the whole spectrum of different wards & departments with in the hospital. There is data & evaluation evidence.	This is now referred to in the 'service, market and resource analysis' section.
There is data from Lewes Prison regarding detoxification. CARATS is purely drug focused. There has been no investment for effective alcohol pathways on release.	This information is already included in the 'service, market and resource analysis' section.
There is routine collection of evaluation data (CORE) for the	This 'preliminary' evaluative information has been used to

Group work programme, & the preliminary results indicate positive benefits & shifts in general psychological functioning.	reassess the value of the programme as part of an outpatient detoxification programme for dependent service users.
Clarity is required about 12 step groups and AA. 12 step groups are NOT the same as AA. The Effectiveness Review (p. 143) draws attention to 'those low in dependency do better in CBT than TSF,' and conversely.	References to '12 step' have been broadened by adopting the term 'mutual aid' groups, which will include AA and other groups. A summary of research drawn from Raistrick, Heather and Godfrey (2006) is included in the 'national and local requirements and research' section.
Brief Interventions – Hastings Primary Care Pilot.	This section has been revised.
Accurate Probation Data AfC received 175 referrals for court ordered counselling for 2006/07. Q4 07 - 37 referrals.	This information has been included in the 'service, market and resource analysis' section.
There is a need to define Brief Interventions more carefully. It should follow the guidance set out in the Effectiveness Review (p.79) to add clarity.	This information has been included in the 'changing the focus' section.
The Tier 1 proposal has flaws; BI are good with older adults, but attention and proposals should be made for the younger adult for whom BI are not evidenced as so effective.	There is no referenced basis for this statement. The Raistrick, Heather and Godfrey (2006) Review does not make this distinction.
The Tier 2 proposals do not follow the MoCAM guidance, which suggest that these are delivered in Open Access and Outreach. Mutual aid groups, of which AA is an example, are described in MoCAM as one of the interventions, rather than where or how the intervention is delivered. In addition, AA is only appropriate for those choosing abstinence. Whilst this may be a desired outcome for dependent drinkers, if the shift to the lower risk end is developed, it is very unlikely that either the young binge drinker or the 'middle class wine drinker' is likely to choose this option.	'Tier 2' denotes an intervention rather than a setting. Mutual aid groups are specifically identified as a tier 2 intervention by MoCAM in section 2.2.1.  'Open access' and 'outreach' models are intended to maximise access to services. The strategy focuses particularly on developing access to structured treatment through primary care settings.
The Tier 3 proposals do not describe a rationale for the de-commissioning of the existing Structured Day Care. It is also inaccurate to describe the existing services as being	The 'preliminary' evaluative information was not available when the draft strategy was produced. The information has been used to reassess the value of the programme as part of an

<p>entirely based around service location. They are, in addition, delivered in a range of community health settings. Further expansion has been limited by the resource investment from commissioners, and by the availability of space in community health settings. The proposals talk about the new primary health care centres without delineating a timetable for their opening.</p>	<p>outpatient detoxification programme for dependent service users. The document already lists the community health settings from which services are available and notes that access is very limited. The document makes a case for further investment on the basis of limited access and capacity. Further information about primary health care centre development will be provided by the PCTs over the course of the strategy.</p>
<p>The proposals do not match the detail set out in MoCAM for the interventions and settings for Tier 3 services. In particular, 'Tier 3 interventions are normally delivered in specialised alcohol treatment services with their own premises in the community...'</p> <p>Action for Change considers that the move towards embedding specialist workers in primary care settings as being an excellent development, but observes that both the space required, and the agreement needed from those working in and running primary care settings may be more patchy than this strategy envisages. An issue that has been raised is around anonymity as many service users appreciate having different off site locations that are not attached to their surgery.</p>	<p>This interpretation of MoCAM assumes that the settings described are a 'blueprint' for a local service model. The strategy adopts the critical aspects of a stepped-care model and describes the tier 3 interventions.</p> <p>The implementation plan will describe how service development should be phased, ensuring that services are developed in step with local primary care priorities and in practices where the development is fully supported.</p> <p>The consultation identified support for some specialist services being delivered from the same site as drug services, providing a treatment delivery option that is not within the primary care setting. This is included in the 'changing the focus' section.</p>
<p>Action for Change sees the development of medically managed detoxification in community settings as being important. However community detoxification is a process requiring effective management of the client through a process that is longer than the prescribing of any drugs to assist either in the management of withdrawal or in the reductions of cravings.</p>	<p>The 'preliminary' evaluative information has been used to reassess the value of the programme as part of an outpatient detoxification programme for moderately dependent service users.</p>
<p>There are many intricacies to consider when basing specialist workers in off site locations due to dynamics &amp; work loads of</p>	<p>Any organisation providing the services described will be required to demonstrate it has the competence to manage</p>

host organisation.	these intricacies. This will be included in a service specification in due course.
When screening is implemented in Tier 1 services there is a strong likelihood that heavy dependant drinkers will be picked up that are beyond the remit of simple advice these individuals will need to be directed to the Specialist worker for ongoing assessment & motivational work & referral onto Treatment services.	The 'stepped' service model describes this care pathway. The point has now been emphasised in the 'changing the focus' section for tier 1 and tier 3 interventions.
How will you know whether the strategy is effective? When Local alcohol treatment pathways have been fully developed.	This is now included in the 'monitoring' section.
How will you know whether the strategy is effective? When clear alcohol screening & Brief intervention protocols are in place for Tier 1&2 interventions	This is now included in the 'monitoring' section.
How will you know whether the strategy is effective? When a range of evidence based alcohol treatment interventions are available across East Sussex in an equitable way.	This is now included in the 'monitoring' section.
How will you know whether the strategy is effective? When protocols for collaborative & integrated working are in place to meet the more complex needs of some clients.	This is now included in the 'monitoring' section.
Regarding the current monitoring arrangements, the current data system has been developed by East Sussex DAAT & the additional fields required for 2008 could be added to existing data rather than introducing an external system.	This is now included in the 'monitoring' section.
How is it envisaged that this proposed programme of brief intervention skills training will link in with the Screening & Brief Interventions training offered by the PCT Health promotion Specialists for Substance Misuse/specialist services?	There will be a project team that draws on existing services and directs the work. This is now included in the 'changing the focus' section.
There is no highlighting of the need to tackle the link between alcohol and domestic violence, and PPVC and binge drinking. I	This is now included in the 'national and local requirements and research' section. The 'changing the focus' section now refers

<p>would ask that these issues are highlighted as the crime reduction priorities. Certainly there are offender diversion programmes for PPVC offenders elsewhere in the country that have been effective, as as with the drug offenders, our persistent DV offenders tend to have alcohol problems and should be prioritised.</p>	<p>to the conditional cautioning and alcohol arrest referral schemes being trialled in West Sussex and referred to in the Safer Communities Plan.</p>
<p>The street drinking issue remains a top local priority for residents in Hastings and should feature as a long-term problem solving initiative.</p>	<p>This is now included in the 'national and local requirements and research' section. The 'changing the focus' section now refers to the conditional cautioning and alcohol arrest referral schemes being trialled in West Sussex and referred to in the Safer Communities Plan.</p>
<p>GP access was viewed positively, but identified as a risk to delivery of the strategy as it relied upon GPs being willing to work with specialist alcohol workers and host the staff.</p>	<p>The implementation plan will be 'phased' to increase access to services over the period of the strategy. Service development will start by working with practices that already support the approach outlined in the strategy.</p>
<p>It was suggested that the 'tier 1' training described would benefit from involving service users to provide 'real world' examples of the impact of alcohol misuse, and to challenge assumptions about problem drinking behaviour.</p>	<p>This is now included in the 'changing the focus' section.</p>
<p>The skills mix of the 'specialist alcohol worker' teams was queried, and there was support for the principle that there should be a multi-disciplinary team rather than a team of qualified nurses. The lack of a suitable number of potential people to fill the workforce requirement was identified as a risk.</p>	<p>There is a discrete workforce strategy to increase the capacity and skills of the workforce in relation to both generalist and specialist drug and alcohol workforce roles.</p>
<p>Access in primary care settings was highlighted as a potential limiting factor for people who don't use primary care services – particular groups highlighted were vulnerably housed and homeless people, chaotic drinkers, people leaving prison and other people not registered with a GP. There was a request to</p>	<p>The 'changing the focus' section now includes a reference to some specialist alcohol services being delivered from premises used for drug services to provide another open access route into alcohol treatment.</p>

ensure access without GP referral, possibly by providing access in other settings.	
It was mentioned that for some people, they may recognise their '14 bottle of wine/week' drinking is a problem, but not want to go to the GP to discuss. A specialist setting provides a more discreet service for those people.	The 'changing the focus' section now includes a reference to some specialist alcohol services being delivered from premises used for drug services to provide another open access route into alcohol treatment.
There is a need for more services for alcohol misuse in HMP Lewes.	
It was noted that there is a risk that raising the profile of alcohol problems may lead to an increase in demand for treatment, and that the service planned may not be able to cope with demand.	The needs assessment estimates the demand for service. The proposed service model is designed to provide a service for 20% of the potential treatment population, which reflects best practice guidance.
The provider organisations represented felt that the proposals didn't provide enough for people who needed more than individual interventions to address their alcohol misuse. There was a specific request to develop 'day programme' services for alcohol misuse that deliver 'individual key work and group work'. There was also a comment that 'day programmes' form a critical part of ambulatory (or out-patient) detoxification programmes.	The proposals reflect the evidence base. The 'changing the focus' section now refers re-specifying the existing structured day programme as part of an outpatient detoxification programme for dependent service users.
There is a need to ensure proper after-care following inpatient detox.	The 'stepped' service model describes this care pathway. The point has now been emphasised in the 'changing the focus' section for tier 3 and tier 4 interventions.
There was support for a model combining delivery of 'specialist' drug and alcohol services for people with more a established dependence on alcohol, and more complex health and care needs.	The 'changing the focus' section now includes a reference to some specialist alcohol services being delivered from premises used for drug services to provide another open access route into alcohol treatment.
It's important to ensure delivery of the alcohol service to people with a 'dual diagnosis' – comorbid mental health and alcohol	The 'changing the focus' section refers specifically to mental health teams in the 'tier 1' section.

problems.	
The introduction of the A&E data collection will provide more information to support service development.	This is being taken forward within the current Safer Communities Plan.
GP access was viewed positively. However, there was a broad range of personal experience with GPs – between ‘terrific’ and ‘appalling’. Training for primary care staff needed to include training for GPs, and for reception staff. There needs to be local guidance about how alcohol misuse is treated, and the guidance needs to be readily available to locums, too. There should be basic information and advice about alcohol and how to get help in every practice with other ‘health’ leaflets.	This is now emphasised in the ‘tier 1’ / ‘changing the focus’ section.
The group were universally supportive about the importance of having somewhere to go where they could meet other people who had been through similar experiences. The facilitated group work programme was also valued, although there was less personal experience of this rather than ‘self help’ or ‘mutual aid’ groups. This was seen as important as well as ‘12 step’ groups, that people felt relied on abstinence as a goal and weren’t as approachable. There was a lot of discussion about the value of the group and individual members to support relapse prevention.	The ‘preliminary’ evaluative information has been used to reassess the value of the programme as part of an outpatient detoxification programme for moderately dependent service users.
There was a perceived benefit of receiving a service from a non-statutory provider. This was an individual case, and centred around the person’s experience of other professionals’ concern about her children, rather than her needs, when her drinking problem was identified. Her experience in the non-statutory setting was that her needs were acknowledged too. [note – the non-statutory provider has a strong track record for working within a safeguarding children context, so this	The market-testing approach is intended to encourage interest from a range of provider organisations.

experience is unlikely to reflect a lack of appropriate child protection activity by the non-statutory organisation].	
There was a lot of support for the principle of aftercare and lapse/relapse support. This was gained from groups, from individual networks gained through treatment, from communities of interest including faith. There was a feeling that current post-detox support is limited and inadequate.	The 'stepped' service model describes this care pathway. The point has now been emphasised in the 'changing the focus' section for tier 3 and tier 4 interventions.
Home visits were particularly welcomed for people experiencing anxiety states including agoraphobia.	This is now included in the 'changing the focus' section.
The proposed two "band 7" nursing or equivalent posts, how would these roles work effectively with our existing alcohol liaison nurse's and other allied professionals. It is also hoped that frontline mental health staff would benefit from the training to achieve consistency where ever in the system the individual is.	This is now included in the 'changing the focus' section.
With reference to the FAST screening tool the feedback from the clinical team was that whilst appropriate in many settings that the preferred option was to maintain a choice of tools. The AUDIT tool was felt to be more appropriate in certain settings.	This is now included in the 'changing the focus' section.
There is also a need to train staff in health & social care services to know when & how to refer on to specialist services.	This is now included in the 'changing the focus' section.
There is still some confusion around what are the threshold criteria.	The criteria for referral into different aspects of the service model (using the 'stepped care' approach) will be developed as part of a more detailed service specification.
Your paper has triggered some concern about the best way to deliver psycho-social interventions within the statutory services and make best use of the very limited psychology and psychological resource in the service working in partnership with the voluntary organisations. We would welcome further	The market-testing approach is intended to encourage interest from a range of provider organisations.

discussions about this.	
One of the outcomes of the Hastings Primary Care Pilot study identified that having a specialist worker located within the GP surgery acted as a deterrent for primary health care staff to carry out a screening assessment and then deliver a BI. What measures might need to be in place to ensure that this does not occur?	The pilot found that having a specialist worker providing brief interventions located in the surgery led to an increase in referrals requiring specialist intervention, i.e. beyond the scope of the specialist worker's remit. The strategy has adopted this learning, placing specialist workers providing specialist interventions in primary care.
The NTA document 'Review of the Effectiveness of Treatment for Alcohol Problems' (NTA 2006) identifies that harmful drinkers may also be dependent (albeit usually moderate).	The 'Review...' notes that ICD-10 guidelines state that harmful use should be excluded in the presence of a dependence syndrome. The Review assumes that 'harmful' drinkers are likely to have a mild degree of dependence. As there is no definition for this it has not been included in the glossary – suggesting that a 'harmful drinker' might also be 'moderately dependent' confuses the distinction.
The 'Review...' expands [moderately dependent] and identifies physiological signs and symptoms of withdrawal as: evidence of raised tolerance, symptoms of withdrawal & impaired control over drinking behaviour.	This is now included in the 'glossary' section.
The 'Review...' clearly identifies that many in this group will usually have experienced severe alcohol withdrawal; will exhibit a high level of tolerance; are likely to have experienced delirium tremens and/ or withdrawal fits and may be drinking to avoid withdrawal symptoms (relief drinking).	This is now included in the 'glossary' section.
Screening & Brief Interventions training for Tier 1 services – this training will need to be evaluated & monitored in order to assess to what extent Tier 1 workers integrate the skills and knowledge gained through the training into their work practices. An estimate could then be made as to the numbers of hazardous/harmful drinkers receiving a brief intervention.	The need for evaluation has been included in the 'changing the focus' section.  It's unclear how this would lead to an estimate of the numbers of brief interventions delivered. The performance measure focuses on the outcome of a reduction in hospital admissions.

<p>The consultation draft includes positive proposals for extending/developing services, in particular at Tier 1 and Tier 4. The document does not give a clear vision of how changes will be embedded in and supported by well-developed services currently focusing on Tier2/ 3 interventions.</p>	<p>The 'changing the focus' section describes how the investment currently allocated to tier 3 interventions will be reinvested in the revised tier 3 service model.</p>
<p>Increasing screening and referral activity (Tier 1) will create greater demand for Tier 2/3 interventions, this is not addressed in the consultation draft.</p>	<p>The commissioning strategy clearly describes a material increase in the capacity of services delivering tier 3 interventions in community settings for people identified as harmful or moderately dependent drinkers, and for people whose drinking behaviour is already causing significant harm.</p>
<p>The local specialist alcohol agency (AFC) provides services that match major aspects of national strategy. The standards of best practice met by this service are not fully acknowledged in the consultation document and it is not clear how it is proposed to incorporate the current organisational structure/ current practices in the future.</p>	<p>Assuming that investment for a material expansion is made available there will be a tender for services. The timetable for this will be made explicit in the implementation plan that will be published later in 2008.</p>
<p>The group-work programme based in Hastings operates according to best practice guidelines and is structured to provide a cost-efficient service. It represents a core psychosocial intervention with the potential to offer support across a range of service user categories and service tiers. The de-commissioning of this service will create a significant 'gap' in the provision of alcohol treatment as defined by national strategy in particular MoCam guidance.</p>	<p>Service users and providers spoke very positively about the group-work programme. The opportunity for peer support was particularly welcomed by service users. The service will be re-specified to form part of the care pathway for ambulatory detox.</p>

Consultation feedback – commissioning strategy for drug misusers.

Feedback	Response
The strategy needs a timeline for implementation and information about how implementation will be monitored.	The introduction now includes 'Next Steps'. The DAAT's annual treatment planning cycle will plan delivery, monitored by the partnership's Joint Commissioning Group.
The strategy needs to address 'out of hours' abuse and the pressure for OOH GPs to prescribe. There should be support in the OOH service.	There should be effective care pathways from 'crisis' services into drug treatment. This is now included in the 'changing the focus' section.
There should be education about the service for primary care staff and information on HARMLESS about care pathways.	This has been included in the final strategy.
Practice Based Commissioning groups should be approached to discuss an organisational structure for delivery.	This approach will be adopted when the plan to recommission prescribing services is being implemented.
The strategy does not dedicate specific resources to deal with people requiring tier two interventions before accessing structured treatment.	The strategy describes how services delivering tier 2 interventions will be expanded in pharmacy settings and maintained in the 'static' sites. The enhancements described during the 'engagement' phase of tier 3 interventions should ensure that PDUs who are ambivalent about treatment but ready to start will be properly engaged and successfully retained in treatment.
Offering only two opportunistic sessions in limited contact services (e.g. needle exchange) only provides enough scope to address the most basic of risk behaviours.	The NICE clinical guidelines describe the benefit of brief interventions for limited contact services. The intention is to ensure 'limited contact' services are viewed as an opportunity for a brief intervention. If a service user is able to engage in a more structured treatment intervention then this should be offered.
Discontinuing the structured day programme limits the menu of options for a client presenting with a substance misuse issue for whom contingency management might not work.	The intention of the strategy is to provide a more flexible and individual approach to care. NICE clinical guidelines indicate that there is a strong evidence base for contingency

	management, whereas there is not for multi-modal therapy including psycho-educational approaches.
The housing information had a high level of key data missing. It is our opinion that housing is an issue that has not been given the necessary focus of the forthcoming strategy.	The data available from NDTMS has been refreshed in the needs assessment. It remains a poorly populated aspect of the data collected, although data collection is improving. Improving data about housing need will continue to be a focus for the annual needs assessment. There is a material focus on substance misuse need in the 'Supporting People' strategy, produced by ESCC and reviewed in 2007/8.
With the plans for expansion of Lewes prison it is likely we will see an increase in the numbers of people presenting with a housing need and it is proposed that a needs assessment be undertaken concerning the provision of low threshold shelter such as a bail hostel within the locality.	The housing need will be highlighted in the strategy. The suggested needs assessment is outside the scope of the commissioning strategy.
There are a small group of service users, those in full time employment, who at present have difficulty accessing services.	The specification for services will include a requirement to provide out of hours services. Expansion of pharmacy supervised consumption will also benefit this group.
Carers also tell us that their experience has not been good when trying to find out information and support for themselves when their family member is in treatment or will not access treatment.	
Steroid users still only get the minimum of service despite being one of the larger groups accessing the service.	The priority groups for investment are directed by the national strategy, which focuses on people using heroin and/or cocaine.
Brief interventions for 'limited contact' services like needle exchange rarely form part of a structured intervention and therefore cannot be limited in either time or frequency; brief interventions within a needle exchange setting happen as and when the need arises. Are Brief interventions being used misrepresented as Solution focused Therapy?	The NICE clinical guidelines describe the benefit of brief interventions for limited contact services. The intention is to ensure 'limited contact' services are viewed as an opportunity for a brief intervention.

<p>If [voucher based contingency management] is to be rolled out where will the resources be coming from?</p>	<p>Services will be recommissioned to ensure that they reflect the NICE clinical guidelines.</p>
<p>We have always held that a variety of response are needed for a diverse client group and what is usually covered by the term CBT is often a mix of different approaches and would be covered by a structured keywork programme.</p>	<p>Cognitive Behavioural Therapy or CBT is a specified therapeutic approach. The NICE clinical guidelines are clear about when CBT is effective and when it is not.</p>
<p>How does [structured day care] differ from Structured Day Programme?</p>	<p>In the way that NICE refer to this the terms refer to similar services.</p>
<p>If [contingency management] is instead of what is currently provided by CRI in T3 then this is severe reduction in the provision and does not equate to the stated intention “ The treatment system will treat people holistically, ensuring that all of their needs are properly assessed, and that the treatment response provides medical and social care interventions as required”. The provision of vouchers would now seem to be politically sensitive and would in any case be very costly.</p>	<p>The partnership is required to implement NICE clinical guidelines. The intention of the strategy is to provide a more flexible and individual approach to care. The provision of a more effective treatment system will deliver value for money over the longer term.</p>
<p>Current service delivery involves a limited number of nursing staff care co-ordinating a large number of clients. Whilst supporting a team concept of diverse and mixed skills we would hope that rather than reducing the proportion of nursing input it would enable the existing cohort of nursing staff to utilise and focus on using their special expertise-</p> <p>Examples (not exhaustive) would be-</p> <ul style="list-style-type: none"> <li>• increased needle exchange input</li> <li>• Harm reduction</li> <li>• Nurse prescribing</li> <li>• Mental and physical health screening and the wider liaison.</li> </ul>	<p>The intention is to ensure that professional groups are enabled to make best use of the skills they bring to a multi-disciplinary team.</p>

<p>As with the alcohol strategy there seems little focus on the importance of access to psychological therapies across the tiers in order to aid recovery and prevent relapse.</p>	<p>The NICE clinical guidelines 51 explicitly refer to the therapeutic alliance with the 'keyworker' as the primary psychosocial intervention.</p>
<p><b>Inpatient Detoxification</b> We are supportive of clients having access to in-patient detoxes in a specialist unit and are pleased to welcome a move from current arrangements, which take place on psychiatric wards. However, we also see it as important that carers and family are supported to visit clients if they are in units some distance away from their home, which may involve financial support to ensure that clients are not isolated.</p>	<p>The strategy does not make any provision for this additional cost.</p>
<p><b>Residential Rehabilitation</b> We have therefore identified a number of providers looking at quality of their programme, geographical location and referral on to 2nd and 3rd stage provision who we use most regularly (including good resettlement options).</p>	<p>The partnership will complete a competitive tender to ensure that the providers selected to deliver these service meet locally agreed criteria and represent value for money. Selection criteria for providers will be agreed with a range of stakeholders.</p>
<p>In accessing an appropriate rehab for our clients from providers, we look at the following important criteria: Disability, Wheel chair access, Dual Diagnosis, Women only projects, Parents with children, Clients who need to relocate to be near family, Faith, Cultural appropriateness, Choice of therapeutic programme. We feel the above information should be taken into account in any provision of rehab contracts.</p>	<p>The partnership will complete a competitive tender to ensure that the providers selected to deliver these service meet locally agreed criteria and represent value for money. Selection criteria for providers will be agreed with a range of stakeholders.</p>
<p><b>Group Work Within Structured Day Care Services</b> We would like to note that the report discusses evidence for not supporting 'group work' i.e. structured day care services. In our clients experience it is a valuable preparation for a residential programme where they are expected to engage in groups on a daily basis. The benefits of 'group work' include peer support,</p>	<p>The partnership is required to implement NICE clinical guidelines. The intention of the strategy is to provide a more flexible and individual approach to care.</p>

<p>awareness of boundaries, time keeping and learning to manage with others in a group setting. They also include being able to give and receive feedback in a structured way. Although the research outcomes may be based on outcomes achieving abstinence, we would like to emphasise that this work can be the gateway for service users to enter the rehabilitative process, i.e., moving from 'precontemplation' through to contemplation, that is, from harm reduction to abstinence.</p>	
<p>We of course encourage and support our clients' to access self help groups' such as AA, NA etc. However clients' report there can be difficulties around the 'spiritual' aspect of this kind of support group and lack of privacy both before and during these groups</p>	<p>The partnership is required to implement NICE clinical guidelines. Whilst these groups may not suit all service users, practitioners are expected to continue to encourage and support service users to access mutual aid groups.</p>